UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended June 30, 2025

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number: 001-42679

Omada Health, Inc.
(Exact name of registrant as specified in its charter)

Delaware	**45-2355015**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
611 Gateway Blvd, Suite 120 South San Francisco, California	**94080**
(Address of principal executive offices)	(Zip Code)

(888) 987-8337

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common stock, $0.001 par value per share	OMDA	The Nasdaq Stock Market LLC

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.

Yes ☐ No ☒

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files).

Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☐	Accelerated filer	☐
Non-accelerated filer	☒	Smaller reporting company	☐
		Emerging growth company	☒

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act).

Yes ☐ No ☒

The registrant had 57,574,921 shares of common stock, $0.001 par value per share, outstanding as of August 5, 2025.

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Cautionary Note Regarding Forward-Looking Statements

This Quarterly Report on Form 10-Q, including, without limitation, statements under the heading "Management's Discussion and Analysis of Financial Condition and Results of Operations," includes forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and the Private Securities Litigation Reform Act of 1995. These forward-looking statements can be identified by the use of forward-looking terminology, including the words "believe," "estimate," "anticipate," "expect," "assume," "imply," "intend," "plan," "may," "will," "potential," "project," "predict," "continue," "could," "confident," "confidence," or "should," or, in each case, their plural, their negative or other variations, or comparable terminology. There can be no assurance that actual results will not materially differ from expectations. Such statements include, but are not limited to, any statements relating to our financial and business performance, including with respect to the Omada Health platform, our marketing campaigns, investments in innovation, the solutions accessible on our platform, and our infrastructure, and the underlying assumptions with respect to the foregoing; statements relating to events and trends relevant to us, including with respect to our regulatory environment, financial condition, results of operations, short- and long-term business operations, objectives, and financial needs; expectations regarding our mobile applications, market acceptance, user experience, customer retention, brand development, our ability to invest and generate a return on any such investment, customer acquisition costs, operating efficiencies and leverage (including our fulfillment capabilities), the effect of any pricing decisions, changes in our product and offering mix, the timing and market acceptance of any new products or offerings, the timing and anticipated effect of any pending or recently completed acquisitions, the success of our business model, our market opportunity, our ability to scale our business and expand internationally, the growth of certain of our specialties, our ability to innovate on and expand the scope of our offerings and experiences, including through the use of data analytics and artificial intelligence, our ability to reinvest into the customer experience, our ability to comply with the extensive, complex, and evolving legal and regulatory requirements applicable to our business, including without limitation state and federal healthcare, privacy and consumer protection laws and regulations, and the effect or outcome of litigation or governmental actions in relation to any such legal and regulatory requirements. We caution you that the foregoing list does not contain all of the forward-looking statements made in this Quarterly Report on Form 10-Q.

The forward-looking statements contained in this Quarterly Report on Form 10-Q are based on our current expectations and beliefs concerning future developments and their potential effects on us. Future developments affecting us may not be those that we have anticipated. These forward-looking statements involve a number of risks, uncertainties (some of which are beyond our control), and other assumptions that may cause actual results or performance to be materially different from those expressed or implied by these forward-looking statements. These risks and uncertainties include, but are not limited to, those factors discussed in Part I, Item 2, "Management's Discussion and Analysis of Financial Condition and Results of Operations" and Part II, Item 1A, "Risk Factors" in this Quarterly Report on Form 10-Q, as well as other documents that may be filed by us from time to time with the U.S. Securities and Exchange Commission. Should one or more of these risks or uncertainties materialize, or should any of our assumptions prove incorrect, actual results may vary in material respects from those projected in these forward-looking statements. Moreover, we operate in a very competitive and rapidly changing environment. New risks and uncertainties emerge from time to time, and it is not possible for us to predict all risks and uncertainties that could have an impact on the forward-looking statements contained in this Quarterly Report on Form 10-Q. The results, events, and circumstances reflected in the forward-looking statements may not be achieved or occur, and actual results, events, or circumstances could differ materially from those described in the forward-looking statements.

The forward-looking statements made in this Quarterly Report on Form 10-Q relate only to events as of the date on which the statements are made available. We undertake no obligation (and expressly disclaim any obligation) to update or revise any forward-looking statements, whether as a result of new information, future events or otherwise, except as may be required under applicable securities laws.

In addition, statements that "we believe" and similar statements reflect our beliefs and opinions on the relevant subject. These statements are based upon information available to us as of the date of this Quarterly Report on Form 10-Q, and while we believe such information forms a reasonable basis for such statements, such information may be limited or incomplete, and our statements should not be read to indicate that we have conducted an exhaustive inquiry into, or review of, all potentially available relevant information. These statements are inherently uncertain, and you are cautioned not to unduly rely upon these statements.

You should read this Quarterly Report on Form 10-Q and the documents that we reference in this Quarterly Report on Form 10-Q and have filed as exhibits to this Quarterly Report on Form 10-Q, completely and with the understanding that our actual future results may be materially different from what we expect. We qualify all of the forward-looking statements in this Quarterly Report on Form 10-Q by these cautionary statements.

Item 1. Financial Statements (unaudited)

OMADA HEALTH, INC.
CONDENSED CONSOLIDATED BALANCE SHEETS
(in thousands, except per-share data, unaudited)

	June 30, 2025	December 31, 2024
Assets		
Current assets		
Cash and cash equivalents	$ 223,146	$ 76,392
Accounts receivable, net [1]	33,287	23,417
Inventory	3,469	3,296
Deferred commissions, current	3,453	3,017
Prepaid expenses and other current assets	7,750	6,937
Total current assets	271,105	113,059
Property and equipment, net	6,484	5,625
Operating lease right-of-use asset	65	447
Deferred commissions, non-current	8,552	9,214
Intangible assets, net	3,291	4,263
Goodwill	13,240	13,240
Other assets	234	5,044
Total assets	$ 302,971	$ 150,892
Liabilities, redeemable convertible preferred stock and stockholders' equity (deficit)		
Current liabilities		
Accounts payable	$ 7,403	$ 4,168
Accrued expenses and other current liabilities [2]	25,060	29,840
Operating lease liability, current	-	415
Deferred revenue [3]	25,525	19,530
Total current liabilities	57,988	53,953
Long term debt	29,966	29,771
Warrant liabilities, non-current	430	2,252
Other liabilities, non-current	373	285
Total liabilities	88,757	86,261
Commitments and contingencies (Note 6)		
Redeemable convertible preferred stock, $0.001 par value per share; no shares and 120,689 shares authorized as of June 30, 2025 and December 31, 2024, respectively; no shares and 118,219 shares issued and outstanding as of June 30, 2025 and December 31, 2024, respectively, net of issuance costs	-	449,034
Stockholders' equity (deficit)		
Common stock, $0.001 par value per share; 750,000 and 181,500 shares authorized as of June 30, 2025 and December 31, 2024, respectively; 57,321 and 8,157 shares issued and outstanding as of June 30, 2025 and December 31, 2024, respectively	56	8
Additional paid-in capital	672,883	59,555
Accumulated deficit	(458,725)	(443,966)
Total stockholders' equity (deficit)	214,214	(384,403)
Total liabilities, redeemable convertible preferred stock and stockholders' equity (deficit)	$ 302,971	$ 150,892

(1) Includes amounts from a related party of $15.1 million and $13.2 million as of June 30, 2025 and December 31, 2024, respectively.
(2) Includes amounts from a related party of $3.9 million and $2.2 million as of June 30, 2025 and December 31, 2024, respectively.
(3) Includes amounts from a related party of $18.7 million and $13.2 million as of June 30, 2025 and December 31, 2024, respectively.

See accompanying notes to unaudited condensed consolidated financial statements.

OMADA HEALTH, INC.
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS AND COMPREHENSIVE LOSS
(in thousands, except per-share data, unaudited)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2025	2024	2025	2024
Revenue				
Services [1]	$ 56,960	$ 38,351	$ 106,456	$ 70,255
Hardware [2]	4,411	2,861	9,878	6,052
Total revenue	61,371	41,212	116,334	76,307
Cost of revenue				-
Services [3]	12,673	10,759	25,417	21,055
Hardware	8,392	5,619	18,711	13,070
Total cost of revenue	21,065	16,378	44,128	34,125
Gross profit	40,306	24,834	72,206	42,182
Operating expenses				
Research and development [4]	10,024	8,987	18,830	17,883
Sales and marketing [5]	22,318	15,191	42,488	32,387
General and administrative [6]	12,308	10,693	23,628	19,942
Total operating expenses	44,650	34,871	84,946	70,212
Operating loss	(4,344)	(10,037)	(12,740)	(28,030)
Other expense, net				-
Interest expense	1,094	1,132	2,168	2,262
Interest income	(863)	(85)	(1,405)	(614)
Change in fair value of warrant liabilities	736	(392)	1,256	(17)
Total other expense, net	967	655	2,019	1,631
Loss before provision for income taxes	(5,311)	(10,692)	(14,759)	(29,661)
Provision for income taxes	-	-	-	-
Net loss and comprehensive loss	$ (5,311)	$ (10,692)	$ (14,759)	$ (29,661)
Net loss per share - basic and diluted	$ (0.24)	$ (1.40)	$ (0.98)	$ (3.92)
Weighted-average shares outstanding - basic and diluted	21,971	7,649	15,107	7,571

(1) Includes amounts from a related party of $36.5 million and $21.2 million for the three months ended June 30, 2025 and 2024, respectively and $66.4 million and $38.6 million for the six months ended June 30, 2025 and 2024, respectively.

(2) Includes amounts from a related party of $2.6 million and $1.5 million for the three months ended June 30, 2025 and 2024, respectively and $6.0 million and $3.0 million for the six months ended June 30, 2025 and 2024, respectively.

(3) Includes amounts from a related party of $1.2 million and $0.8 million for the three months ended June 30, 2025 and 2024, respectively and $2.4 million and $1.7 million for the six months ended June 30, 2025 and 2024, respectively.

(4) Includes amounts from a related party of $0.5 million and $0.4 million for the three months ended June 30, 2025 and 2024, respectively and $1.0 million and $0.8 million for the six months ended June 30, 2025 and 2024, respectively.

(5) Includes amounts from a related party of $6.6 million and $3.6 million for the three months ended June 30, 2025 and 2024, respectively and $12.2 million and $7.2 million for the six months ended June 30, 2025 and 2024, respectively.

(6) Includes amounts from a related party of $0.4 million and $0.2 million for the three months ended June 30, 2025 and 2024, respectively and $0.7 million and $0.5 million for the six months ended June 30, 2025 and 2024, respectively.

See accompanying notes to unaudited condensed consolidated financial statements.

OMADA HEALTH, INC.
CONDENSED CONSOLIDATED STATEMENTS OF REDEEMABLE CONVERTIBLE PREFERRED STOCK AND STOCKHOLDERS' EQUITY (DEFICIT)
(in thousands, unaudited)

Three and Six Months Ended June 30, 2025

	Redeemable Convertible Preferred Stock		Common Stock		Additional Paid-in Capital	Accumulated Deficit	Total Stockholders' Equity (Deficit)
	Shares	Amount	Shares	Amount			
Balance as of December 31, 2024	118,219	$ 449,034	8,157	$ 8	$ 59,555	$ (443,966)	$ (384,403)
Issuance of common stock upon exercise of stock options	-	-	205	-	919	-	919
Share-based compensation expense	-	-	-	-	2,883	-	2,883
Net loss and comprehensive loss	-	-	-	-	-	(9,448)	(9,448)
Balance as of March 31, 2025	118,219	$ 449,034	8,362	$ 8	$ 63,357	$ (453,414)	$ (390,049)
Issuance of common stock upon exercise of stock options	-	-	392	-	2,989	-	2,989
Issuance of common stock in connection with initial public offering, net of underwriting discounts and commissions and offering costs	-	-	9,085	9	151,591	-	151,600
Conversion of redeemable convertible preferred stock to common stock in connection with initial public offering	(118,446)	(452,112)	39,482	39	452,073	-	452,112
Automatic cashless exercise of all outstanding Series B redeemable convertible preferred stock warrants	92	493	-	-	-	-	-
Cashless exercise of all outstanding Series D redeemable convertible preferred stock warrants	135	2,585	-	-	-	-	-
Share-based compensation expense	-	-	-	-	2,873	-	2,873
Net loss and comprehensive loss	-	-	-	-	-	(5,311)	(5,311)
Balance as of June 30, 2025	-	$ -	57,321	$ 56	$ 672,883	$ (458,725)	$ 214,214

Three and Six Months Ended June 30, 2024

	Redeemable Convertible Preferred Stock		Common Stock		Additional Paid-in Capital	Accumulated Deficit	Total Stockholders' Deficit
	Shares	Amount	Shares	Amount			
Balance as of December 31, 2023	118,219	$ 449,034	7,388	$ 7	$ 46,710	$ (396,829)	$ (350,112)
Issuance of common stock upon exercise of stock options	-	-	216	-	988	-	988
Share-based compensation expense	-	-	-	-	2,887	-	2,887
Net loss and comprehensive loss	-	-	-	-	-	(18,969)	(18,969)
Balance as of March 31, 2024	118,219	$ 449,034	7,604	$ 7	$ 50,585	$ (415,798)	$ (365,206)
Issuance of common stock upon exercise of stock options	-	-	113	-	391	-	391
Share-based compensation expense	-	-	-	-	2,106	-	2,106
Net loss and comprehensive loss	-	-	-	-	-	(10,692)	(10,692)
Balance as of June 30, 2024	118,219	$ 449,034	7,717	$ 7	$ 53,082	$ (426,490)	$ (373,401)

See accompanying notes to unaudited condensed consolidated financial statements.

OMADA HEALTH, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(in thousands, unaudited)

	Six Months Ended June 30,	
	2025	2024
Operating activities		
Net loss	$ (14,759)	$ (29,661)
Adjustments to reconcile net loss to net cash used in operating activities		
Depreciation and amortization	2,685	2,296
Share-based compensation	5,674	4,948
Loss on disposal of property and equipment	2	1
Amortization of debt issuance costs	252	193
Non-cash operating lease expense	382	358
Change in fair value of warrants	1,256	(17)
Provision for credit losses [1]	490	489
Amortization of deferred commissions	1,561	1,208
Changes in operating assets and liabilities		
Accounts receivable [2]	(10,360)	(9,834)
Inventory	(173)	1,487
Prepaid expenses and other current assets	(870)	(495)
Deferred commissions	(1,423)	(3,661)
Other non-current assets	118	210
Accounts payable	1,016	(1,170)
Operating lease liabilities	(415)	(381)
Accrued expenses and other current liabilities [3]	(4,780)	(3,061)
Deferred revenue [4]	5,995	8,252
Other non-current liabilities	89	90
Net cash used in operating activities	(13,260)	(28,748)
Investing activities		
Purchases of property and equipment	(586)	(336)
Capitalized internal-use software costs	(1,913)	(1,490)
Net cash used in investing activities	(2,499)	(1,826)
Financing activities		
Proceeds from exercise of stock options	3,908	1,379
Payment of deferred offering costs	(1,927)	(2,277)
Proceeds from initial public offering, net of underwriting discounts and commissions	160,532	-
Net cash provided by (used in) financing activities	162,513	(898)
Net increase (decrease) in cash and cash equivalents	146,754	(31,472)
Cash and cash equivalents at beginning of period	76,392	115,643
Cash and cash equivalents at end of period	$ 223,146	$ 84,171

(1) Includes changes in related party balances of $(0.3) million and $0.1 million for the six months ended June 30, 2025 and 2024, respectively.
(2) Includes changes in related party balances of $1.9 million and $5.5 million for the six months ended June 30, 2025 and 2024, respectively.
(3) Includes changes in related party balances of $1.7 million and $0.8 million for the six months ended June 30, 2025 and 2024, respectively.
(4) Includes changes in related party balances of $5.5 million and $5.8 million for the six months ended June 30, 2025 and 2024, respectively.

See accompanying notes to unaudited condensed consolidated financial statements.

OMADA HEALTH, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(in thousands, unaudited)

	Six Months Ended June 30,	
	2025	2024
Supplemental disclosure of cash flow information		
Cash paid during the period for:		
Interest	$ 1,824	$ 1,942
Supplemental disclosure of noncash investing and financing activities		
Share-based compensation expense capitalized in internal-use software	$ 82	$ 45
Unpaid deferred offering costs included in accounts payable	2,356	661
Unpaid property and equipment included in accounts payable	59	-
Net share settlement of redeemable convertible preferred stock warrant liability in connection with Series B redeemable convertible preferred stock warrant exercise	493	-
Net share settlement of redeemable convertible preferred stock warrant liability in connection with Series D redeemable convertible preferred stock warrant exercise	2,585	-
Conversion of redeemable convertible preferred stock in connection with initial public offering	452,112	-

OMADA HEALTH, INC.
NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

1. Description of Business

Omada Health, Inc. (together with its subsidiary and consolidated professional corporation, the "Company" or "Omada") offers cardiometabolic programs for prediabetes, diabetes, and hypertension; a physical therapy program to address musculoskeletal ("MSK") conditions; additional support for members taking glucagon-like peptide-1 agonists ("GLP-1") in its cardiometabolic programs ("GLP-1 Care Tracks"); and behavioral health support across all programs. The Company was incorporated in the State of Delaware in April 2011, and its primary office is located in South San Francisco, California. The Company has a remote-first flexible work policy, which provides support and opportunities for employees to work remotely or in an office.

2. Summary of Significant Accounting Policies

Basis of Presentation

The condensed consolidated financial statements have been prepared in conformity with accounting principles generally accepted in the United States of America ("U.S. GAAP"). The condensed consolidated financial statements include the accounts of Omada Health Inc., its subsidiary, Physera, Inc., and a professional corporation, Physera Physical Therapy Group, PC ("PPTG" or the "professional corporation"), which was determined to be a variable interest entity ("VIE") for which Omada is the primary beneficiary. All intercompany balances and transactions have been eliminated in consolidation. The unaudited condensed consolidated financial statements have been prepared on the same basis as the audited consolidated financial statements and reflect, in the opinion of management, all the adjustments of a normal, recurring nature that are necessary for the fair statement of the Company's financial position, results of operations, and cash flows for the interim periods but are not necessarily indicative of the results expected for the full year or any other period.

These condensed consolidated financial statements should be read in conjunction with the Company's audited financial statements and notes included in the final prospectus the Company filed with the U.S. Securities and Exchange Commission pursuant to Rule 424(b)(4) under the Securities Act of 1933, as amended (the "Securities Act"), on June 9, 2025 (the "Prospectus").

Variable Interest Entity

The Company determines at the inception of each arrangement whether an entity in which the Company has made an investment or in which the Company has other variable interests is considered a VIE. The professional corporation is considered a VIE since it does not have sufficient equity to finance its activities without additional subordinated financial support. An enterprise having a controlling financial interest in a VIE must consolidate the VIE if it is considered the primary beneficiary, which is described as having both (1) the power to direct the activities of a VIE that most significantly impact the VIE's economic performance and (2) the obligation to absorb losses of the VIE that potentially could be significant to the VIE or the right to receive benefits from the VIE that potentially could be significant to the VIE.

The condensed consolidated balance sheets as of June 30, 2025 and December 31, 2024 include assets of the consolidated VIE, which can only be used to settle obligations of the VIE, and liabilities of the consolidated VIE. As of June 30, 2025, after the elimination of intercompany transaction balances, assets of the consolidated VIE totaled $0.6 million, and liabilities of the consolidated VIE totaled $0.2 million. As of December 31, 2024, after the elimination of intercompany transaction balances, assets of the consolidated VIE totaled $0.9 million, and liabilities of the consolidated VIE totaled $0.2 million.

OMADA HEALTH, INC.
NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

Reverse Stock Split

On May 27, 2025, the Company amended its restated certificate of incorporation, as amended, to effect a reverse stock split of shares of the Company's common stock on a one-for-three basis (the "Reverse Stock Split"). The common stock warrants and options to purchase common stock were subsequently adjusted as a result of the Reverse Stock Split. All impacted share and per-share information included in these consolidated financial statements and notes thereto have been retroactively adjusted to give effect to the Reverse Stock Split. In connection with the one-for-three reverse split of the Company's common stock effected on May 27, 2025, the conversion price for each series of the Company's redeemable convertible preferred stock was adjusted such that each share of redeemable convertible preferred stock became convertible into one-third of a share of the Company's common stock.

Initial Public Offering

On June 9, 2025, the Company completed its initial public offering (the "IPO") of 9,085,000 shares of its common stock, which includes the exercise in full by the underwriters of their option to purchase from the Company 1,185,000 shares of the Company's common stock, at a price to the public of $19.00 per share. The gross proceeds to the Company from the IPO were $172.6 million and the net proceeds amounted to $151.6 million, after deducting underwriting discounts and commissions and offering expenses payable by the Company. Immediately prior to the closing of the IPO, each outstanding share of the Company's Series A, Series B, Series C, Series C-1, Series D, Series D-1, and Series E redeemable convertible preferred stock, including shares of redeemable convertible preferred stock issued upon the exercise of Series B and Series D redeemable convertible preferred stock warrants, converted into one-third of a share of the Company's common stock (see Note 7 for additional information).

Use of Estimates

The preparation of condensed consolidated financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the condensed consolidated financial statements and the reported amounts of income and expense during the reporting period. The Company's significant estimates and assumptions made in the accompanying condensed consolidated financial statements include, but are not limited to, determining standalone selling price for performance obligations in contracts with customers and variable consideration, the period of benefit for deferred commissions, the fair value of common stock warrants, the fair value of redeemable convertible preferred stock warrants, the valuation and assumptions underlying share-based compensation including the per-share fair value of the Company's common stock prior to the Company's IPO, the assessment of useful life and recoverability of long-lived assets, and the valuation of deferred tax assets, reserves for uncertain tax positions. By their nature, estimates are subject to an inherent degree of uncertainty and actual results could differ from those estimates. The Company bases its estimates on historical experience and on various other assumptions that are believed to be reasonable. Actual results may differ from those estimates or assumptions.

Significant Accounting Policies

There have been no material changes to the Company's significant accounting policies from the audited consolidated financial statements for the fiscal year ended December 31, 2024, included in the Prospectus.

Segment and Geographic Information

The Company considers operating segments to be components of the Company in which separate financial information is available and is evaluated regularly by the Company's chief operating decision maker ("CODM") in deciding how to allocate resources and in assessing performance. The CODM for the Company is the Chief Executive Officer. The CODM reviews financial information on a consolidated basis to make decisions about how to allocate resources and how to measure the Company's performance. The Company has determined that it has one operating and reportable segment (refer to Note 10 for additional information).

OMADA HEALTH, INC.
NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

Concentrations of Credit Risk and Significant Customers and Channel Partners

Financial instruments that potentially subject the Company to concentrations of credit risk consist principally of cash and cash equivalents and accounts receivable. The Company holds cash at major financial institutions that often exceed Federal Deposit Insurance Corporation insured limits. The Company manages its credit risk associated with cash concentrations by concentrating its cash deposits in high quality financial institutions and by periodically evaluating the credit quality of the primary financial institutions holding such deposits. The carrying value of cash approximates fair value. Historically, the Company has not experienced any losses due to such cash concentrations.

Concentrations of credit risk with respect to accounts receivable are primarily limited to certain customers and channel partners to which the Company makes substantial sales. Significant customers and channel partners are those which represent 10% or more of the accounts receivable balance or revenue for the periods presented. Customers and channel partners that accounted for 10% or more of accounts receivable, net as of June 30, 2025 and December 31, 2024 or 10% or more of revenue for the three and six months ended June 30, 2025 and 2024 were as follows:

	Accounts Receivable, net		Revenue			
	As of		Three Months Ended June 30,		Six Months Ended June 30,	
	June 30, 2025	December 31, 2024	2025	2024	2025	2024
Partner A	27%	29%	32%	37%	31%	37%
Partner B	19%	28%	33%	18%	32%	18%

Partner A and Partner B are each affiliates of The Cigna Group (refer to Note 9 for additional information).

Fair Value of Financial Instruments

Certain financial instruments are required to be recorded at fair value. Other financial instruments, including cash and cash equivalents are recorded at cost, which approximates fair value. Additionally, the carrying amounts of accounts receivable, prepaid expenses and other current assets, accounts payable, accrued expenses and other current liabilities approximate fair value due to their short-term nature.

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. To increase the comparability of fair value measures, the following hierarchy prioritizes the inputs to valuation methodologies used to measure fair value:

Level 1 inputs: Quoted prices for identical assets and liabilities in active markets.

Level 2 inputs: Assets and liabilities based on observable market data for similar instruments, such as quoted prices for similar assets or liabilities or other inputs that are observable or can be corroborated by observable market data.

Level 3 inputs: Unobservable inputs reflecting the Company’s assumptions, consistent with reasonably available assumptions made by other market participants. These valuations require judgment.

The fair value hierarchy also requires an entity to maximize the use of observable inputs and minimizes the use of unobservable inputs when measuring fair value.

Contract Assets

Contract assets include amounts related to the Company’s enforceable right to consideration for completed performance obligations that cannot be invoiced yet under the terms of the contract. Contract assets relate primarily to hardware revenue that is recognized upon shipment and has not yet been invoiced. The contract assets are transferred to accounts receivable, net when the rights become unconditional. As of June 30, 2025 and December 31, 2024, the Company had $0.8 million and $0.5 million short-term contract assets, respectively, included in prepaid expenses and other current assets in the condensed consolidated balance sheets.

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Deferred Revenue

Deferred revenue consists primarily of payments received and accounts receivable recorded in advance of the delivery or completion of the services. Deferred revenue associated with upfront payments for enrollment is generally recognized over the estimated benefit period to the member of twelve months. As of June 30, 2025 and December 31, 2024, deferred revenue was classified as a current liability based on the anticipated recognition period of twelve months or less. During the six months ended June 30, 2025, the Company recognized revenue of $15.0 million that was included in the corresponding deferred revenue balance at the beginning of the year.

Deferred Offering Costs

Deferred offering costs, consisting of legal, accounting, and other fees and costs relating to the IPO are capitalized within other assets on the condensed consolidated balance sheets. The deferred offering costs were offset against the proceeds received by the Company upon the closing of the IPO. At the closing of the IPO, $9.0 million of deferred offering costs were reclassified to additional paid-in capital within stockholders' equity (deficit) and $4.8 million of IPO costs were deferred and capitalized as of December 31, 2024.

New Accounting Pronouncements Not Yet Adopted

In December 2023, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2023-09, Income Taxes (Topic 740): Improvements to Income Tax Disclosures ("ASU 2023-09"). ASU 2023-09 requires disaggregated information about a reporting entity's effective tax rate reconciliation as well as information on income taxes paid. The updates in this ASU may be applied on a prospective or retrospective application basis and are effective for annual periods beginning after December 15, 2025. Early adoption is permitted. The Company is currently evaluating the impact of the new standard on its condensed consolidated financial statements.

In November 2024, the FASB issued ASU 2024-03, Disaggregation of Income Statement Expenses, which requires disclosures about specific types of expenses included in the expense captions presented on the face of the income statement as well as disclosures about selling expenses. The new guidance is effective for annual reporting periods beginning after December 15, 2026 and interim reporting periods beginning after December 15, 2027. Early adoption is permitted. The requirements will be applied prospectively with the option for retrospective application. The Company is currently evaluating the impact of the new standard on its condensed consolidated financial statement disclosures.

3. Fair Value Measurements

The following table presents information about the Company's financial assets and liabilities measured at fair value on a recurring basis based on the fair value hierarchy as follows (in thousands):

	As of June 30, 2025			
	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents				
Money market funds	$ 207,831	$ -	$ -	$ 207,831
Total	$ 207,831	$ -	$ -	$ 207,831
Liabilities				
Warrant liabilities	$ -	$ -	$ 430	$ 430
Total	$ -	$ -	$ 430	$ 430

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	As of December 31, 2024			
	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents				
Money market funds	$ 64,501	$ -	$ -	$ 64,501
Total	$ 64,501	$ -	$ -	$ 64,501
Liabilities				
Warrant liabilities	$ -	$ -	$ 2,252	$ 2,252
Total	$ -	$ -	$ 2,252	$ 2,252

Level 3 liabilities that are measured at fair value on a recurring basis consist of redeemable convertible preferred stock warrant liabilities and common stock warrant liabilities associated with warrants issued in connection with the Company's financing arrangements (refer to Note 5 and Note 7 for additional information). The Company's previously outstanding Series B redeemable convertible preferred stock warrants were automatically cashless exercised on May 19, 2025, and the Company's previously outstanding Series D redeemable convertible preferred stock warrants were cashless exercised on June 9, 2025. The shares of Series B and Series D redeemable convertible preferred stock issued in connection with such warrant exercises were subsequently converted into shares of the Company's common stock in connection with the IPO, on June 9, 2025. Accordingly, no preferred stock warrant liabilities remained outstanding as of June 30, 2025.

The fair values of the outstanding common warrants are measured using the Black-Scholes option-pricing model. Inputs used to determine estimated fair value include the estimated fair value of the underlying stock at the valuation measurement date, the remaining contractual term of the warrants, risk-free interest rates, expected dividends, and the expected volatility of the underlying stock. The carrying value of long-term debt approximates its fair value based on Level 2 inputs as the principal amounts outstanding are subject to variable interest rates that are based on market rates (see Note 5 for additional information).

The following tables present the quantitative information regarding Level 3 fair value measurements of the warrant liabilities:

	As of June 30, 2025
	Common
Stock price	$ 18.30
Exercise price	$ 3.24
Remaining term (in years)	2.2
Risk-free interest rate	3.72 %
Expected volatility	63 %
Expected dividend yield	0 %

	As of December 31, 2024		
	Series B	Series D	Common
Stock price	$ 3.41	$ 4.55	$ 7.68
Exercise price	$ 1.18	$ 5.04	$ 3.24
Remaining term (in years)	1.0	5.4	2.7
Risk-free interest rate	4.21 %	4.38 %	4.27 %
Expected volatility	67 %	66 %	66 %
Expected dividend yield	0 %	0 %	0 %

The following table sets forth a summary of changes in fair value of Level 3 liabilities (in thousands):

Balance as of December 31, 2024	$ 2,252
Remeasurement of warrant liabilities	520
Balance as of March 31, 2025	2,772
Remeasurement of warrant liabilities	736
Cashless exercise of redeemable convertible preferred stock warrants	(3,078)
Balance as of June 30, 2025	$ 430

Balance as of December 31, 2023	$ 2,470
Remeasurement of warrant liabilities	375
Balance as of March 31, 2024	2,845
Remeasurement of warrant liabilities	(392)
Balance as of June 30, 2024	$ 2,453

The Company recognizes transfers among Level 1, Level 2, and Level 3 classifications as of the actual date of the events or change in circumstances that caused the transfers. There were no transfers between fair value measurement levels during the periods presented.

4. Consolidated Balance Sheet Components

Accounts Receivable, Net

Accounts receivable, net consists of the following (in thousands):

	As of	
	June 30, 2025	December 31, 2024
Billed accounts receivable	$ 11,251	$ 9,483
Unbilled accounts receivable	23,454	15,919
Allowance for credit losses	(1,418)	(1,985)
Total accounts receivable, net	$ 33,287	$ 23,417

A roll forward of the Company's allowance for credit losses is as follows (in thousands):

	Three Months Ended June 30,	
	2025	2024
Balance at beginning of period	$ (2,103)	$ (738)
Provision for credit losses, net	141	(327)
Other adjustments and write-offs	544	177
Balance at end of period	$ (1,418)	$ (888)

	Six Months Ended June 30,	
	2025	2024
Balance at beginning of period	$ (1,985)	$ (630)
Provision for credit losses, net	(490)	(489)
Other adjustments and write-offs	1,057	231
Balance at end of period	$ (1,418)	$ (888)

Inventory

Inventory is comprised of finished goods inventory. There was no reserve for excess and obsolete inventory recorded as of June 30, 2025 and December 31, 2024.

5. Financing Arrangements

The Company's financing arrangements consists of the following (in thousands):

	As of	
	June 30, 2025	December 31, 2024
Term loan	$ 30,000	$ 30,000
Revolving line of credit	963	963
Debt issuance costs, net	(997)	(1,192)
Long term debt	$ 29,966	$ 29,771

MidCap Credit Agreement

In June 2023, the Company entered into a financing agreement with Physera, Inc., MidCap Funding IV Trust ("MidCap"), as administrative agent, MidCap Financial Trust, as term loan servicer, certain funds managed by MidCap, as lenders, and the lenders, additional borrowers, and guarantors from time to time party thereto (as amended, restated, amended and restated, supplemented, or otherwise modified from time to time, the "MidCap Credit Agreement") for a senior secured term loan (the "MidCap Term Facility") in an aggregate principal amount of up to $60.0 million, with up to $30.0 million available upon the initial closing date and up to $30.0 million (the "Second Tranche") available for draw from October 2024 through March 2025 conditional upon achievement of $120.0 million of trailing 12-month revenue (the "Revenue Condition") and $60.0 million liquidity. On March 7, 2025, the Company entered into an amendment to the MidCap Credit Agreement which, among other things, (i) extended the availability of the Second Tranche until December 31, 2025 and (ii) modified the Revenue Condition to require trailing 12-month revenue of $165.0 million if the Second Tranche is advanced during the first fiscal quarter of 2025, $170.0 million if the Second Tranche is advanced during the second fiscal quarter of 2025, $175.0 million if the Second Tranche is advanced during the third fiscal quarter of 2025, and $180.0 million if the Second Tranche is advanced during the fourth fiscal quarter of 2025. Upon the initial closing date of the MidCap Credit Agreement, the Company drew down on $30.0 million of the MidCap Term Facility and used a portion of the proceeds to repay the outstanding principal balance (including prepayment premium) and accrued interest on a prior credit agreement with Perceptive Credit Holdings, III, LP. The MidCap Term Facility is interest-only for 48 months. At the end of the initial interest-only period, the Company can elect to extend the interest-only period an additional 12 months if the Company meets a certain trailing 12-month revenue level (the "Minimum Net Revenue") and no event of default has occurred and is continuing. The MidCap Credit Agreement also includes a revolving line of credit facility (the "MidCap Revolving Facility") allowing for up to $20.0 million in revolving borrowings. The availability of the MidCap Revolving Facility is calculated as a percentage of the Company's outstanding accounts receivable and inventory balances ("Availability"). The Company is required to maintain a minimum drawn balance on the MidCap Revolving Facility of no less than 20% of Availability, or will be required to pay a fee equal to the MidCap Revolving Facility interest rate on the difference between the amount of revolving loans drawn and 20% of Availability. Upon the initial closing date of the MidCap Credit Agreement, the Company drew $1.0 million on the MidCap Revolving Facility. The maturity date of the MidCap Term Facility and the MidCap Revolving Facility is June 1, 2028.

Interest is charged on any outstanding principal of the MidCap Term Facility at the sum of (i) the one-month forward-looking term SOFR, plus 0.10% ("Adjusted SOFR"), plus 7.00%, subject to a floor of 2.50%. Interest on the MidCap Revolving Facility is charged at the sum of Adjusted SOFR, plus 4.00%, subject to a floor of 2.50%. Both interest rates are reset monthly. The effective interest rate for the three months ended June 30, 2025 and 2024 on the MidCap Term Facility was 13.4% and 14.4%, respectively, and 11.2% and 12.0%, respectively, on the MidCap Revolving Facility. The effective interest rate for the six months ended June 30, 2025 and 2024 on the MidCap Term Facility was 13.4% and 14.4%, respectively, and 11.3% and 12.3%, respectively, on the MidCap Revolving Facility.

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A fully nonrefundable origination fee of 1.00% of the $60 million MidCap Term Facility ($0.6 million) was paid upon the effective date of the MidCap Credit Agreement. The Company was also required to pay all of the lender legal fees and out-of-pocket expenses totaling $0.7 million. Additionally, an annual administrative fee of 0.25% of the amount borrowed under the MidCap Term Facility is due annually. At the time of final payment of the MidCap Term Facility, the Company will pay a fee of 3% on the amount borrowed under the MidCap Term Facility.

A fully nonrefundable origination fee of 0.5% of the $20 million MidCap Revolving Facility ($0.1 million) was paid upon the closing of the MidCap Credit Agreement. The Company shall pay a collateral management fee of 0.5% per annum on the outstanding balance of the MidCap Revolving Facility, payable monthly in arrears. Additionally, the Company will pay an unused line fee of 0.50% per annum of the average unused portion of the MidCap Revolving Facility, payable monthly in arrears. The Company incurred other debt issuance costs of $0.4 million related to other fees paid to the lender and legal fees incurred by the Company.

In connection with the March 7, 2025 amendment to the MidCap Credit Agreement, the Company incurred debt issuance costs of $0.2 million. As the Company has not borrowed against the Second Tranche modified in the amendment, the debt issuance costs are classified in prepaid expenses and other current assets in the condensed consolidated balance sheets as of June 30, 2025.

With respect to any prepayment of all or any portion of the outstanding principal amount of MidCap Term Facility, or permanent reduction of the commitments under the MidCap Revolving Facility, a prepayment premium or deferred revolving origination fee, as applicable, will be due as follows: 3% if prepaid or reduced, as applicable, before June 1, 2024, 2% if prepaid or reduced, as applicable, between June 2, 2024 and June 1, 2025, and 1% if prepaid or reduced, as applicable, thereafter.

The MidCap Credit Agreement includes customary covenants for a facility of this type, including monthly reporting requirements and, at any time that liquidity is less than 1.50x the outstanding principal balance of the MidCap Term Facility, a financial covenant to maintain minimum trailing 12-month net revenue levels specified in the MidCap Credit Agreement. The MidCap Credit Agreement also contains various covenants that limit the Company's ability to, among other things: sell, transfer, lease, or dispose of its assets subject to certain exclusions; create, incur, assume, guarantee, or assume additional indebtedness, other than certain permitted indebtedness; encumber or permit liens on any of its assets other than certain permitted liens; make restricted payments, including paying cash dividends on, repurchasing or making distributions with respect to any of its capital stock; make specified investments; consolidate, merge with, or acquire any other entity, or sell or otherwise dispose of all or substantially all of its assets; and enter into certain transactions with its affiliates, in each case, subject to certain exceptions, baskets, and thresholds set forth in the MidCap Credit Agreement. As of June 30, 2025 and December 31, 2024, the Company was in compliance with its financial covenants.

Interest expense related to amortization of the debt discount for long-term debt for the three months ended June 30, 2025 and 2024 was $0.1 million and $0.1 million, respectively, and for the six months ended June 30, 2025 and 2024 was $0.2 million and $0.2 million, respectively, and is included in interest expense.

The Company believes that it is probable that it will meet the Minimum Net Revenue and will elect to extend the interest-only period for an additional 12 months. The future maturities of the financing arrangements in aggregate as of June 30, 2025 are as follows (in thousands):

Remainder of 2025	$ -
2026	-
2027	-
2028	30,963
Total future payments	30,963
Less: Unamortized debt issuance costs	(997)
Total financing arrangements	$ 29,966

On July 31, 2025, the Company fully repaid outstanding amounts under the MidCap Term Facility and MidCap Revolving Facility (see Note 13 for additional information).

6. Commitments and Contingencies

Legal Matters

From time to time, the Company may become subject to legal proceedings, claims, and litigation arising in the ordinary course of business. The Company is not presently a party to any such litigation the outcome of which, the Company believes, if determined adversely to the Company, would individually, or taken together, have a material adverse effect on the Company's business, operating results, cash flows, or financial condition.

Indemnification

In the ordinary course of business, the Company includes in its agreements indemnification provisions of varying scope and terms pursuant to which it agrees to indemnify customers, channel partners, suppliers, vendors, lessors, business partners, and other parties with respect to certain matters, including, but not limited to, losses arising out of the breach of such agreements, services to be provided by the Company, or from intellectual property infringement claims made by third parties. The term of these indemnification provisions generally survive the termination of the agreements indefinitely. The maximum potential amount of future payments the Company could be required to make under these arrangements is not determinable. No demands have ever been made upon the Company to provide indemnification under such agreements, and there are no claims under those indemnification terms that the Company is aware of that could have a material effect on the condensed consolidated balance sheets, condensed consolidated statements of operations and comprehensive loss, or condensed consolidated statements of cash flows. Accordingly, the Company had no liabilities recorded for these provisions as of June 30, 2025 and December 31, 2024.

Other Commitments

Other contractual commitments primarily consist of technology and cloud services related to the Company's daily business operations. As of June 30, 2025, future minimum payments under the Company's non-cancellable purchase commitments, for the years ended December 31, were as follows (in thousands):

Remainder of 2025	$	4,177
2026		5,060
2027		2,409
2028		703
2029		-
Thereafter		-
Total	$	12,349

The purchase obligation amounts do not represent the entire anticipated purchases in the future but represent only those items for which the Company is contractually obligated. The majority of the Company's goods and services are purchased as needed, with no unconditional commitment. For this reason, these amounts do not provide an indication of the Company's expected future cash outflows related to purchases.

In addition to the amounts above, the repayment of outstanding amounts under the MidCap Credit Agreement in an aggregate principal amount of $31.0 million is due on June 1, 2028. Refer to Note 5 for further information regarding the MidCap Credit Agreement. On July 31, 2025, the Company fully repaid outstanding amounts under the MidCap Term Facility and MidCap Revolving Facility (see Note 13 for additional information).

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7. Mezzanine and Stockholders' Equity (Deficit)

Common and Preferred Stock

In connection with the closing of its IPO, on June 9, 2025, the Company's restated certificate of incorporation was amended and restated to authorize 750,000,000 shares of common stock, par value $0.001 per share, and 10,000,000 shares of preferred stock, par value $0.001 per share. No shares of preferred stock were outstanding as of June 30, 2025.

The total shares of the Company's common stock reserved for issuance on an as-converted basis are as follows (in thousands):

	As of	
	June 30, 2025	December 31, 2024
Redeemable convertible preferred stock	—	39,406
Redeemable convertible preferred stock warrants	—	259
Outstanding RSU's	630	—
Common stock warrants	43	43
Common stock options outstanding	11,981	11,069
Common stock shares available for future grants	10,419	3,294
Shares available for purchase under the ESPP	1,121	—
Total shares of common stock reserved	24,194	$ 54,071

Redeemable Convertible Preferred Stock

The Company previously issued shares of redeemable convertible preferred stock. Immediately prior to the closing of the IPO on June 9, 2025, all 118,218,801 shares of the Company's Series A, Series B, Series C, Series C-1, Series D, Series D-1, and Series E redeemable convertible preferred stock, excluding shares issued upon the exercise of Series B and Series D convertible redeemable preferred stock warrants disclosed below, converted into an aggregate of 39,406,221 shares of the Company's common stock (after adjusting the conversion ratios of the redeemable convertible preferred stock to give effect to the Reverse Stock Split), and such shares of redeemable convertible preferred stock were cancelled, retired, and eliminated from the shares of stock that the Company is authorized to issue and shall not be reissued by the Company. Following the IPO and as of June 30, 2025, no shares of redeemable convertible preferred stock were outstanding.

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Redeemable Convertible Preferred Stock and Common Stock Warrants

The Company previously issued common and redeemable convertible preferred stock warrants in connection with certain notes payable and debt financing transactions. Common stock warrants outstanding as of June 30, 2025 and redeemable convertible preferred stock warrants and common stock warrants outstanding as of December 31, 2024 are as follows (in thousands, except for per share data):

As of June 30, 2025

Stock Series	Date Issued	Expiration Date	Exercise Price Per Share	Number of Shares	Fair Value
Common	August 29, 2017	August 29, 2027	$ 3.24	43	$ 430
Total					$ 430

As of December 31, 2024

Stock Series	Date Issued	Expiration Date	Exercise Price Per Share	Number of Shares	Fair Value
Series B	May 20, 2015	May 19, 2025	$ 1.18	118	$ 273
Series D	May 18, 2020	May 18, 2030	$ 5.04	660	1,751
Common	August 29, 2017	August 29, 2027	$ 3.24	43	228
Total					$ 2,252

In August 2017, the Company issued warrants to purchase common stock in conjunction with a loan and security agreement with Silicon Valley Bank ("SVB"). The number of shares that the holder may purchase is equal to 43,420 and is related to a borrowing under the agreement. The warrants will be automatically exercised under the cashless exercise method upon the expiration date of each respective warrant or upon a cash or public acquisition. The warrants issued allow SVB to acquire shares of common stock at an exercise price of $3.24 per share and expire ten years after issuance. These warrants were concluded to be liabilities accounted for at fair value, using the Black-Scholes pricing model, on the date of issuance with subsequent remeasurements recorded in earnings. The fair value on the date of issuance was recorded as warrant liabilities and debt discount. The debt discount was fully amortized upon the debt being repaid in May 2020. The change in fair value for the three and six months ended June 30, 2025 resulted in a loss of $0.1 million and a loss of $0.2 million, respectively, and for the three and six months ended June 30, 2024 was a gain of less than $0.1 million and a loss of $0.1 million, respectively.

As of December 31, 2024, the Company had outstanding warrants to purchase shares of the Company's Series B and Series D redeemable convertible preferred stock that were classified as liabilities. The change in fair value of Series B redeemable convertible preferred stock warrants for the three and six months ended June 30, 2025 resulted in a loss of $0.1 and a loss of $0.2 million, respectively, and for the three and six months ended June 30, 2024 resulted in a gain of less than $0.1 million and a loss of less than $0.1 million, respectively. The change in fair value of Series D redeemable convertible preferred stock warrants for the three and six months ended June 30, 2025 was a loss of $0.6 million and a loss of $0.8 million, respectively, and for the three and six months ended June 30, 2024 was a gain of $0.3 million and gain of $0.1 million, respectively.

On May 19, 2025, the Company's outstanding Series B redeemable convertible preferred stock warrants were automatically cashless exercised upon expiration resulting in the issuance of 92,194 shares of Series B redeemable convertible preferred stock, which subsequently converted into 30,731 shares of common stock immediately prior to the closing of the IPO.

On June 9, 2025, the Company's Series D redeemable convertible preferred stock warrants were cashless exercised resulting in the issuance of 135,143 shares of Series D redeemable convertible preferred stock which subsequently converted into 45,047 shares of common stock immediately prior to the closing of the IPO.

Following the closing of the IPO, no redeemable convertible preferred stock warrants were outstanding.

8. Share-Based Compensation

2011 Equity Incentive Plan

Pursuant to the terms of the 2025 Plan (as defined below), any shares subject to outstanding options originally granted under the Company's 2011 Equity Incentive Plan (the "2011 Plan") that terminate, expire, or lapse for any reason without the delivery of shares to the holder thereof shall become available for issuance pursuant to awards granted under the 2025 Plan. In connection with the effectiveness of the 2025 Plan, the 2011 Plan terminated, and no further awards will be granted under the 2011 Plan. However, all outstanding awards will continue to be governed by their existing terms.

2025 Equity Incentive Plan

In connection with the IPO, the Company's board of directors adopted, and its stockholders approved, the 2025 Incentive Award Plan (the "2025 Plan"), which became effective on the day prior to the effectiveness of the Company's Registration Statement on Form S-1. Under the 2025 Plan, 5,045,541 shares of the Company's common stock were initially reserved for issuance pursuant to a variety of stock-based compensation awards, including stock options, stock appreciation rights, restricted stock awards, restricted stock unit ("RSU") awards, and other stock-based awards. The number of shares initially reserved for issuance pursuant to awards under the 2025 Plan will be increased by (i) the number of shares represented by awards outstanding under the 2011 Plan ("Prior Plan Awards") that become available for issuance under the applicable counting provisions following the effective date of the 2025 Plan and (ii) an annual increase on the first day of each calendar year beginning in calendar year 2026 and ending in calendar year 2035, equal to the lesser of (A) 5% of the shares of the Company's common stock outstanding (on an as-converted basis) on the last day of the immediately preceding fiscal year and (B) such smaller number of shares of stock as determined by the Company's board of directors; provided, however, that no more than 15,136,624 shares of common stock may be issued upon the exercise of incentive stock options ("ISOs"). Terms of stock awards, including vesting requirements, are determined by the Company's board of directors or by a committee authorized by the Company's board of directors, subject to provisions of the 2025 Plan. The term of any stock option granted under the 2025 Plan cannot exceed ten years. Generally, awards granted by the Company vest over four years, but may be granted with different vesting terms. In conjunction with the effectiveness of the 2025 Plan, the 2011 Plan terminated, and no further awards will be granted under the 2011 Plan, although all outstanding awards under the 2011 Plan will continue to be governed by their existing terms. As of June 30, 2025, 10,419,368 shares were available for future issuance pursuant to the 2025 Plan.

2025 Employee Stock Purchase Plan

In connection with the IPO, the Company's board of directors adopted, and its stockholders approved, the 2025 Employee Stock Purchase Plan (the "2025 ESPP"), which became effective on the day prior to the effectiveness of the Company's Registration Statement on Form S-1, with an initial reserve of 1,121,231 shares of the Company's common stock. The 2025 ESPP allows eligible employees to purchase shares of the Company's common stock at a discount through payroll deductions of up to 15% of their compensation, subject to plan limitations. Such payroll deductions will be expressed as a whole number percentage, and the accumulated deductions will be applied to the purchase of shares of common stock on each purchase date. However, a participant may not purchase more than 666 shares of common stock in each offering period and may not subscribe for more than $25,000 in fair market value of shares of common stock (determined at the time the option is granted) during any calendar year. The ESPP administrator has the authority to change these limitations for any subsequent offering period. Unless otherwise determined by the Company's board of directors, employees are able to purchase shares at 85% of the lower of the fair market value of the Company's common stock on the first date of an offering or on the purchase date. The length of the offering periods under the ESPP will be determined by the plan administrator and may be up to 27 months long. The number of shares of the Company's common stock reserved for issuance under the 2025 ESPP will automatically increase on January 1 of each year for a period of ten years, beginning on January 1, 2026 and continuing through December 31, 2035, by the lesser of (i) 1% of the shares of common stock outstanding (on an as-converted basis) on the last day of the immediately preceding fiscal year and (ii) such number of shares of common stock as determined by the board of directors; provided, however, no more than 6,727,388 shares of common stock may be issued under the ESPP. The shares reserved for issuance under the ESPP may be authorized but unissued shares or reacquired shares. As of June 30, 2025, the first offering period under the 2025 ESPP had not commenced.

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Stock-based Compensation Expense

A summary of share-based compensation expense recognized in the condensed consolidated statement of operations and comprehensive loss is as follows (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2025	2024	2025	2024
Services cost of revenue	$ 33	$ 53	$ 71	$ 105
Research and development	528	465	1,023	797
Sales and marketing	884	635	1,614	1,367
General and administrative	1,385	926	2,966	2,679
Total share-based compensation expense	$ 2,830	$ 2,079	$ 5,674	$ 4,948

As of June 30, 2025, there was approximately $22.8 million of total unrecognized compensation costs related to unvested stock options, which is expected to be recognized over the weighted-average period of 3.0 years using the straight-line method.

The Company's RSUs vest based on the terms in the grant agreements and generally vest ratably over a period of between one and four years from the vesting commencement date. During the three and six months ended June 30, 2025, the Company issued 630,000 restricted stock units with weighted-average grant date fair value of $18.85 per share.

As of June 30, 2025, there was approximately $11.6 million of unrecognized stock-based compensation expense related to unvested RSUs, which is expected to be recognized over a weighted-average period of 3.6 years.

Secondary Stock Transactions

Certain former employees sold no shares and less than 0.1 million shares of the Company's common stock during each of the three months ended June 30, 2025 and 2024, at purchase prices in excess of the then-current fair market value to existing investors of the Company, respectively.

During the six months ended June 30, 2025 and 2024, certain former employees sold 0.2 million and 0.5 million shares of the Company's common stock, respectively, at purchase prices in excess of the then-current fair market value to existing investors of the Company.

As a result, the Company recorded $0 and less than $0.1 million in share-based compensation expense during the three months ended June 30, 2025 and 2024, respectively, and $0.4 million and $1.0 million in share-based compensation expense during the six months ended June 30, 2025 and 2024, respectively, for the excess of the purchase price paid by these investors over the fair value of shares sold.

9. Related Party

Commercial Arrangements with Cigna and its Affiliates

The Company's customers, channel partners, and vendors include affiliates of The Cigna Group, which beneficially owns more than 5% of the Company's outstanding capital stock through Cigna Ventures, LLC. The Company has entered into agreements with these affiliates that, among other things, provide for the provision of the Company's programs to eligible individuals covered by these affiliates and, in certain cases, for the provision of services by such affiliates in connection with the administration of the Company's programs. The Company also has agreements with these affiliates for the provision of certain benefits provided to the Company's employees. Pursuant to these agreements, in addition to the amounts disclosed in the condensed consolidated balance sheets, condensed consolidated statements of operations and comprehensive loss, and condensed consolidated statements of cash flows, affiliates of The Cigna Group made payments to the Company of $35.8 million and $21.5 million during the three months ended June 30, 2025 and 2024, respectively, and $66.8 million and $40.7 million during the six months ended June 30, 2025 and 2024, respectively. Additionally, the Company made payments to affiliates of The Cigna Group of $6.2 million and $4.6 million during the three months ended June 30, 2025 and 2024, respectively, and $11.0 million and $8.2 million during the six months ended June 30, 2025 and 2024, respectively.

10. Segment Reporting

The Company has one operating and reportable segment, which includes all virtual care program product offerings. The CODM manages the allocation of resources and assesses performance at the operating segment level.

The CODM reviews information presented on a consolidated basis for purposes of making operating decisions, assessing financial performance, and allocating resources. The CODM assesses performance and decides how to allocate resources based on components reported on the condensed consolidated statement of operations including consolidated net loss. The CODM uses net loss to evaluate the return on assets and to determine investment opportunities related to development of new virtual care service offerings, new technologies, and platform enhancements. The CODM also uses net loss to monitor budget versus actual results.

The Company's segment net loss and significant expenses for the three and six months ended June 30, 2025 and 2024, consisted of the following (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2025	2024	2025	2024
Revenue	$ 61,371	$ 41,212	$ 116,334	$ 76,307
Cost of revenue [1]	21,065	16,378	44,128	34,125
Employee compensation [2]	32,194	26,824	60,914	54,671
Other segment items [3]	13,423	8,702	26,051	17,172
Consolidated net loss from operations	$ (5,311)	$ (10,692)	$ (14,759)	$ (29,661)

(1) Depreciation and amortization included in cost of revenue was $1.2 million and $1.0 million for the three months ended June 30, 2025 and 2024, respectively, and $2.4 million and $2.0 million for the six months ended June 30, 2025 and 2024, respectively.
(2) Employee compensation is part of research and development, sales and marketing and general and administrative expenses and includes salaries, share-based compensation expense, sales commissions, employee bonuses, benefits, and other employee related expenses.
(3) Other segment items include third-party consulting services and professional services, software and infrastructure, hosting, marketing and advertising, and other income and other expenses.

All of the Company's long-lived assets were located in the U.S., and all revenue was earned in the U.S. as of December 31, 2024 and for the three and six months ended June 30, 2025 and 2024.

11. Income Taxes

The Company's geographical distribution of its losses before provision for income taxes during each period relates to the U.S. The Company did not record a provision for income tax expense or benefit for the three and six months ended June 30, 2025 and 2024.

OMADA HEALTH, INC.
NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

12. Net Loss Per Share Attributable to Common Stockholders

Basic and diluted net loss per share attributable to common stockholders was calculated as follows (in thousands, except per share amounts):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2025	2024	2025	2024
Numerator:				
Net loss attributable to common stockholders	$ (5,311)	$ (10,692)	$ (14,759)	$ (29,661)
Denominator:				
Weighted-average number of shares used in computing net loss per share attributable to common stockholders, basic and diluted	21,971	7,649	15,107	7,571
Net loss per share attributable to common stockholders, basic and diluted	$ (0.24)	$ (1.40)	$ (0.98)	$ (3.92)

As the Company was in a loss position for the three and six months ended June 30, 2025 and 2024, basic net loss per share is the same as diluted net loss per share as the inclusion of all potential shares of common stock outstanding would have been anti-dilutive. Potentially dilutive securities that were not included in the diluted per-share calculations because they would have been anti-dilutive were as follows (in thousands):

	As of June 30,	
	2025	2024
Redeemable convertible preferred stock on an as-converted basis	-	39,406
Common stock options outstanding	11,981	11,069
RSUs outstanding	630	-
Redeemable convertible preferred stock warrants on an as-converted basis	-	259
Common stock warrants	43	43
Total	12,654	50,777

13. Subsequent Events

The Company has evaluated subsequent events for recognition and measurement purposes through August 8, 2025, which is the date the condensed consolidated financial statements were available to be issued.

On July 31, 2025, the Company fully repaid outstanding amounts under the MidCap Term Facility and MidCap Revolving Facility with the principal and accrued interest balances of $31.0 million and $0.4 million, respectively, ahead of their contractual maturity on June 1, 2028.

On July 4, 2025, the One Big Beautiful Bill Act (“OBBBA”) was enacted in the U.S. The OBBBA includes significant provisions, such as the permanent extension of certain expiring provisions of the Tax Cuts and Jobs Act, modifications to the international tax framework and the restoration of favorable tax treatment for certain business provisions. The legislation has multiple effective dates, with certain provisions effective in 2025 and others implemented through 2027. The Company is currently assessing the impact on its consolidated financial statements.

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion and analysis of our financial condition and results of operations should be read in conjunction with our unaudited condensed consolidated financial statements and the related notes included elsewhere in this Quarterly Report on Form 10-Q. This discussion contains forward-looking statements that involve risks and uncertainties. Our actual results could differ materially from management's expectations as a result of various factors, including, but not limited to, those discussed in the sections titled "Risk Factors" and "Special Note Regarding Forward-Looking Statements."

Overview

Our mission is to bend the curve. Our hope is that, one day, tomorrow's epidemiologists will notice a bend in disease curves, wonder what might be happening, and conclude that part of that impact has been Omada. As part of that mission, we strive to inspire and enable people to make lasting health changes on their own terms. We deliver virtual care ***between*** doctor's visits, providing an engaging, personalized, and integrated experience for our members that is designed to improve their health while delivering value for the employers, health plans, health systems, pharmacy benefit managers ("PBMs"), and other entities that cover the cost of our programs.

Our virtual care programs are rooted in evidence and combine relationship-based, human-led clinical care with purpose-built technology. We call this approach Compassionate Intelligence. We work to develop trust with each member and use technology to help us personalize their experience, enabling us to unlock results at scale.

We sell our programs to customers that cover the cost for covered individuals. Our customers include employers that cover our programs for their employees and their dependents, health systems that cover our programs for patients, and any other entity that is financially responsible for costs of our programs for a population of covered lives. We also work closely with health plans and PBMs that either cover our programs for a portion of their members as our customers or act as channel partners reselling our programs to their own end customers. Our channel partners' end customers typically consist of employers that cover our programs for their employees and their dependents. In general, our customers cover the cost of our programs for our members, except that members in our physical therapy program may incur copays, coinsurance, or deductibles, depending on plan design, much like in-person physical therapy.

We launched our initial program in diabetes prevention and weight health in 2012, with the goal of showing that a virtual program could achieve the same clinical results as its in-person archetype. Through feedback from our customers, channel partners, members, and the market at large, we then recognized the need to create an integrated, multi-condition care platform to address multiple, commonly comorbid, chronic conditions. Today, we offer cardiometabolic programs for prediabetes, diabetes, and hypertension; a physical therapy program to address musculoskeletal ("MSK") conditions; additional support for members taking glucagon-like peptide-1 agonists ("GLP-1") in our cardiometabolic programs ("GLP-1 Care Tracks"); and behavioral health support across all programs. As we have expanded, we have kept our integrated human and technology approach at the center of our business model and have continued to base our program design on clinically validated evidence.

Since our founding, our programs have had a meaningful, positive impact. As of June 30, 2025, we had over 752,000 total members enrolled in one or more programs. We count a member as enrolled in a program to the extent their participation was billed at least once in the preceding 12 months. We believe our programs serve a clear need for our customers and channel partners as well as our members, which is reinforced by our strong customer satisfaction and member engagement rates. We consider members to be still engaged after one year or two years in the program if, during their twelfth or twenty-fourth month of program participation in a cardiometabolic program, they complete at least one interaction with us, such as logging in or interacting with the Omada mobile app, sending messages to Omada Care Team members, or recording metrics such as weight, blood pressure, or blood glucose values.

Our History

Since launching our first program in 2012, we observed a demand from our customers and channel partners for us to expand beyond diabetes prevention and weight management and into other conditions, such as the treatment and management of diabetes, hypertension, and MSK conditions. The significant overlap across these chronic conditions created a natural growth avenue by enabling a coordinated, context-informed care approach across conditions.

- ***Omada for Prevention & Weight Health***: Omada for Prevention & Weight Health, our first program launched in 2012, focuses on prediabetes and weight management, two critical elements of preventing diabetes and heart

disease. Informed by guidelines and recommendations set by the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention (the "CDC"), the goal of the program is to enable members to lose weight, maintain a healthy weight, and increase physical activity. We pair members with a dedicated health coach for the entirety of their experience and support them with a connected scale, a personalized learning path, and support from peer groups to build community.

In 2018, demand from customers and channel partners, member need, and clinically appropriate interventions came together in an opportunity to expand our offering to support members with diabetes and hypertension leveraging our existing, flexible platform. Considering this market need and feedback, we decided to launch Omada for Diabetes, Omada for Hypertension, and the combined Omada for Diabetes and Hypertension programs. We refer to these, along with our Omada Prevention & Weight Health program, as our cardiometabolic programs.

- ***Omada for Diabetes***: Launched in 2018, Omada for Diabetes is designed to help members with type 1 or type 2 diabetes achieve stable blood glucose levels and meet and reach their goals for reducing hemoglobin A1C ("A1C") (a measure of blood glucose levels over the past three months) based in part on treatment guidelines from the American Diabetes Association. Because most people with type 2 diabetes have obesity or are overweight, we also support members with reaching and maintaining a healthy weight through modifications in diet, exercise, and other behaviors. Members are paired with a dedicated, professionally trained health coach who acts as their primary contact, except in the case of members living with type 1 diabetes, whose primary contact is a Certified Diabetes Care and Education Specialist. Care Teams for members with type 2 diabetes also include a Certified Diabetes Care and Education Specialist, in addition to the member's primary contact. Members are also provided with connected third-party devices based on their needs, which can include a connected scale and a blood glucose meter. We can also facilitate prescriptions for connected glucose monitor sensors at certain points in the program through a third-party care partner to improve understanding of behavior and blood glucose levels. As in our Prevention & Weight Health program, members are engaged with a personalized learning path and supported by peer groups.

- ***Omada for Hypertension***: Launched in 2018, Omada for Hypertension is designed to help reduce members' blood pressure and help them maintain healthy blood pressure based on clinical protocols recommended by the American Medical Association, the American College of Cardiology, and the American Heart Association. As with type 2 diabetes, hypertension is often comorbid with obesity. We help members in need of weight management support in reaching and maintaining a healthy weight through modifications to diet, exercise, and other behaviors. Members are paired with a dedicated, professionally trained health coach and a Certified Diabetes Care and Education Specialist who provide support and resources to improve blood pressure control through connected blood pressure monitors, secure asynchronous messaging, and group board discussions, as well as frequent and proactive check-ins. As in our Prevention & Weight Health program, members are engaged with a personalized learning path and supported by peer groups.

- ***Omada for MSK***: Launched in 2020, Omada for MSK connects individuals to licensed physical therapists for consultation and virtual treatment. Our program provides members access to treatment in as little as 24 hours from enrollment. We match clinically eligible patients with a dedicated physical therapist and provide ongoing access through video visits and asynchronous chat. Omada-affiliated physical therapists assign evidence-based treatment exercises and stretches to members, and the program helps members complete their prescribed care path at the recommended cadence. Physical therapists can assess patient progress through form analysis (by video), range of motion (by computer vision technology), and patient reports (in-app feedback). Members can also access an individualized education curriculum to help build healthy habits that support recovery and long-term health. Our education library includes hundreds of pieces of content, ranging from articles to interactive media and videos.

- ***Omada GLP-1 Care Tracks***: First launched in 2023, the initial version of Omada's GLP-1 Care Track, currently embedded in our cardiometabolic programs, is designed to support members on a GLP-1 therapy—while also engaged in one of those programs—to enable their success before, during, and after GLP-1 therapy. Omada does not develop or prescribe GLP-1 therapies. Rather, our GLP-1 Care Tracks are intended to build and enhance outcomes from the combination of our virtual programs and the member's medication, with the ultimate goal of supporting members to achieve and maintain weight loss long-term—even after they decide to discontinue GLP-1 therapy. While the initial version of our GLP-1 Care Track is embedded in each of our cardiometabolic programs, customers and channel partners are also able to purchase an enhanced version (the "Enhanced GLP-1 Care Track"), which includes more specialized programming and support.

Business Model Overview

We have experienced strong growth since our inception. Revenue increased 49% to $61.4 million from $41.2 million for the three months ended June 30, 2025 and 2024, respectively, and increased 52% to $116.3 million from $76.3 million for the six months ended June 30, 2025 and 2024, respectively. We incurred net losses of $5.3 million and $10.7 million for the three months ended June 30, 2025 and 2024, respectively, and $14.8 million and $29.7 million for the six months ended June 30, 2025 and 2024, respectively.

We sell our programs to customers that cover the cost for covered individuals. Our customers include employers that cover our programs for their employees and their dependents, health systems that cover our programs for patients, and any other entity that is financially responsible for costs of our programs for a population of covered lives. We also work closely with health plans and PBMs that either cover our programs for a portion of their members as our customers or act as channel partners reselling our programs to their own end customers. Our channel partners' end customers typically consist of employers that cover our programs for their employees and their dependents. In general, our customers cover the cost of our programs for our members, except that members in our physical therapy program may incur copays, coinsurance, or deductibles, depending on plan design, much like in-person physical therapy.

We generate revenue from sales to our customers and channel partners for the services that we provide to members. We generate services revenue by providing access to our programs for prevention & weight health, diabetes, hypertension, and MSK conditions and hardware revenue from connected third-party devices, which are provided to the member upon enrollment in our cardiometabolic programs. Upfront payments or billings received from customers and channel partners are initially recorded as deferred revenue on the balance sheet and recognized as revenue as we fulfill our obligations.

Go-To-Market Strategy

Our go-to-market strategy follows a business-to-business-to-consumer ("B2B2C") motion, and as of June 30, 2025, we had over 752,000 total members enrolled in one or more programs that were billable in the preceding 12 months. We sell primarily to employers, who either contract with Omada directly or obtain access to our programs through a channel partner, such as a health plan or PBM, and a key part of our go-to-market strategy is winning new employer contracts during the annual benefits selling season. During that time, our sales and marketing team engages with human resources professionals, benefits managers, and decision makers across various industries to sign up new customers. We sell our programs directly to customers and through channel partners. This selling season typically spans from late spring to early fall, aligning implementation with benefits enrollment schedules and allowing us to launch our products for customers at the start of the following year.

The remainder of our revenue is derived from our inclusion as a benefit in fully insured health plans, from PBMs through specific therapeutic programs, or via health systems that assume the cost of care for their patients. We leverage our partner sales team, which engages with health plans and PBMs, to identify new, and expand existing, partner channels through which we can sell directly to partners' end customers or access and enroll their members.

Enrollment and Outreach

After a customer or channel partner contracts with us, we collaborate to support enrollment of covered employees or dependents, covered health plan or PBM members, or patients. Our customer experience and partner management teams, account executives, and engineering and product teams work together to support technical implementation and launch of outreach communications before members begin enrolling into our programs. We work with our customers and channel partners to increase awareness through outreach campaigns designed to inform eligible members of their ability to join the respective Omada program. Outreach campaigns can be led by the customer or channel partner or led by Omada, leveraging our preferred methods and materials. The cost of our enrollment and outreach teams are recognized primarily within sales and marketing expense.

Care Team and Devices

Once a member enrolls in an Omada program, we support the member with an Omada Care Team and our member-facing application, and we provide the member with a set of connected third-party devices. Each Care Team consists of a primary health coach or specialist, additional relevant specialists where applicable, and/or a licensed physical therapist, depending on the program. Member Support Agents also provide device and platform support to members across all programs, via phone, email, and self-service support articles. The connected third-party devices supplied in connection with our programs can include scales, blood pressure monitors, blood glucose monitors, and continuous glucose monitors. The cost of our Care Team and our connected third-party devices are all recognized within cost of revenue.

Key Factors Affecting Our Performance

We believe that our future growth, success, and performance are dependent on many factors, including those set forth below. While these factors present significant opportunities for us, they also represent the challenges that we must successfully address in order to grow our business and improve our results of operations.

Acquisition of New Customers and Channel Partners

We believe there is substantial opportunity to further grow our base of customers and channel partners in our large addressable market. Historically, we have relied on a limited number of customers and channel partners, including employers, health plans, PBMs, health systems, and government entities, for a substantial portion of our total sales. Our customers include employers that cover our programs for their employees and their dependents and health systems that cover our programs for patients, among other types of customers. In addition, our channel partners, which include certain of the health plans, PBMs, and other entities that we work with, operate as resellers of our programs to their employer customers or other end customers, which can limit an end customer's ability to continue purchasing our programs if the customer no longer works with a particular channel partner. Some of the health plans and PBMs we work with as channel partners also cover our programs directly, for a portion of their own members, as our customers.

We seek to grow our business by acquiring more covered lives across multiple buyer categories: selling to new customers and channel partners as well as expanding within our existing channel partners to new lines of business. Our diverse go-to-market strategy affords us flexibility to pursue growth via multiple distinct channels, including through new channels and in lines of business where we have yet to place significant focus, such as Medicare Advantage.

Customer and Channel Partner Retention

Our ability to increase revenue depends on maintaining relationships with customers and channel partners over time, driving both renewal revenue and expansion revenue as customers and channel partners add new programs to provide to their member base. We have invested and plan to continue to invest across our data, analytics, operations, and customer success capabilities to build the infrastructure that supports our go-to-market approach.

Program Expansion within Existing Customer Base

We believe that the ability to grow the share of revenue that we generate from existing customers is a key driver of long-term growth. We have seen significant expansion over time as existing customers and channel partners have added our newer Diabetes and Hypertension programs, and we remain focused on driving multi-program adoption as a key growth lever. We believe there is still opportunity to continue multi-condition expansion.

Member Enrollment

Having served over one million members since launch, there is still significant opportunity to enroll more members. We are focused on achieving higher enrollment rates by helping more customers and channel partners adopt our outreach best practices, including enabling Omada-led outreach campaigns, implementing strategies to reach individuals with known risk, and evaluating new enrollment strategies and channels.

Member Engagement and Outcomes

Member engagement in our programs and the clinical outcomes and cost savings of our offerings affect the market acceptance and adoption of our programs. Most of our customers pay fees to us based on member enrollment and/or engagement with our programs, and our contracts generally may provide that we are obligated to repay a portion of our fees if our programs fail to deliver certain member engagement targets, clinical outcomes, or cost savings.

Investments in Growth

We expect to continue to focus on long-term growth of our core business, while selectively investing in areas that enhance our platform, programs, or operations. Though our focus remains on continued progress in our current care areas, we monitor the needs of our customers and channel partners, and we believe we are well positioned to respond to their requirements organically or, where appropriate, to add new capabilities through partnerships and potential acquisitions.

Key Metric

We monitor the following key metric to help us evaluate our business, measure our performance, identify trends affecting our business, formulate business plans, and make strategic decisions.

Total Members

A member is a person who is enrolled in one of our virtual care programs and that generated a billing event in the preceding 12 months. We believe growth in the number of members is a key indicator of the performance of our business for both investors and management as we monitor the performance of our business, as members primarily drive services revenue. The number of members depends, in part, on our ability to successfully market our services to new customers and channel partners, our ability to sell additional programs to existing customers and channel partners, and our ability to promote awareness of our programs among covered individuals and to encourage their enrollment.

	As of March 31,		As of June 30,	
	2025	2024	2025	2024
Total Members	679,000	461,000	752,000	496,000

Key Components of Results of Operations

Revenue

We generate services revenue from our customers by providing access to our virtual care programs in which our Care Teams implement clinically validated behavior change protocols for individuals living with prediabetes and weight management issues, diabetes, and hypertension (collectively referred to as “cardiometabolic” conditions) and MSK conditions over the term of the program. Our MSK program generally includes a fixed, upfront consultation fee and an additional fee for members that opt in to a physical therapist-guided treatment plan. We use a number of pricing models for our cardiometabolic programs. In general, our legacy pricing models for cardiometabolic programs may include a fixed, upfront enrollment fee and include variable monthly fees which are based on either outcomes or milestones for the respective member service period. In general, our latest pricing models for cardiometabolic programs are based on the respective member’s level of activity in the program. Each month, members that have completed a minimum number of qualifying activities during an agreed-upon backward-looking measurement period are considered billable members. The length of the measurement period and the qualifying activities may vary based on negotiations with customers and channel partners. Most activity measurement periods are defined as the preceding three or six months, and in most cases, members are considered active if they complete three activities during that period, such as logging in or interacting with the Omada mobile app, sending messages to Omada Care Team members, or recording metrics such as weight, blood pressure, or blood glucose values.

The price for Omada for Diabetes and Omada for Hypertension is generally higher than the price for Omada for Prevention & Weight Health to account for the higher costs of delivering those programs, including additional included devices and increased Care Team support appropriate for those conditions. We typically bill for our services monthly, in arrears. We recognize a portion of revenue upfront upon hardware delivery or initial consultation and the remaining revenue over the period members have access to our virtual care programs. In general, among our members in cardiometabolic programs, members in Omada for Diabetes and Omada for Hypertension remain active and enrolled in our programs for longer periods than members in Omada for Prevention & Weight Health. In addition to the overall number of members, our quarterly revenues reflect the mix of members enrolled in our various programs and the pricing models for these programs.

Sales from or through our top five health plan and PBM partners, including any sales to these entities as customers and sales through these entities as channel partners, represented 76% and 69% of our revenue for the three months ended June 30, 2025 and 2024, respectively, and 75% and 68% for the six months ended June 30, 2025 and 2024, respectively.

Significant customers and channel partners are those which represent 10% or more of the accounts receivable balance or revenue for the periods presented. Customers and channel partners that accounted for 10% or more of accounts receivable, net as of June 30, 2025 and December 31, 2024 or 10% or more of revenue as of and for the three and six months ended June 30, 2025 and 2024 were as follows:

	Accounts Receivable, net		Revenue			
	As of		Three Months Ended June 30,		Six Months Ended June 30,	
	June 30, 2025	December 31, 2024	2025	2024	2025	2024
Partner A	27%	29%	32%	37%	31%	37%
Partner B	19%	28%	33%	18%	32%	18%

Each of these health plans or PBMs are affiliates of The Cigna Group.

Cost of Revenue

Cost of revenue consists of expenses that are directly related to or closely correlated to the delivery of our virtual care programs and member support. Cost of services revenue include salaries, share-based compensation expense, bonuses, benefits, travel, and meals and entertainment expenses (collectively, "personnel costs"), data server management expense, hosting costs, connectivity fees for cellular devices, and the amortization of capitalized internal-use software and developed technology. Cost of hardware revenue includes equipment costs, shipping and logistics costs, and provisions for excess and obsolete inventory. Most of the devices delivered in connection with our programs are manufactured in China and may be manufactured in other international markets in the future, and we expect that the prices of these devices may increase as a result of recent tariffs and any new or increased tariffs in the future.

Gross Profit and Gross Margin

Gross profit is total revenue less total cost of revenue. Gross margin is gross profit expressed as a percentage of revenue. Gross profit and gross margin have been and will continue to be affected by various factors, including the acquisition of new customers and channel partners, renewals of existing agreements, sales of additional programs to our existing customers, the mix of programs covered by our customers and channel partners and members enrolled in those programs, the timing of members enrolling in our programs, the costs associated with third-party data server management and third-party hosting services, costs of hardware, economies of scale, and the extent to which we introduce new features or functionality or expand our Care Teams and hire other additional personnel.

Operating Expenses

Our operating expenses consist of research and development ("R&D"), sales and marketing, and general and administrative expenses. Personnel costs are the most significant component of operating expenses. Operating expenses also include professional and consulting services and the allocation of shared general corporate expenses primarily related to technology.

Research and Development

Our R&D expenses support our efforts to add new features and content to our programs and to ensure the reliability and scalability of our virtual care platform. R&D expenses consist primarily of personnel costs and the allocation of shared general corporate expenses primarily related to technology. R&D costs are expensed as incurred.

We expect to make continued investments in our virtual care platform in connection with our future growth.

Sales and Marketing

Sales and marketing expenses consist of personnel costs, commissions for our sales and marketing teams, administrative and marketing fees that we pay to channel partners for their services, promotional marketing materials, and advertising costs. Sales and marketing expenses also include costs for third-party consulting services and the allocation of shared general corporate expenses primarily related to technology.

The sales and marketing teams are responsible for growing and maintaining our relationships with customers and channel partners and increasing enrollments.

General and Administrative

General and administrative expenses consist of personnel costs for our finance, legal, compliance, human resources, and administrative teams, software and infrastructure costs, professional fees, and the allocation of shared general corporate expenses primarily related to technology.

We expect general and administrative expenses to increase in absolute dollars as we grow our operations and incur additional expenses associated with operating as a public company. Increased expenses as a result of operating as a public company include expenses necessary to comply with the rules and regulations applicable to companies listed on a national securities exchange and related compliance and reporting obligations pursuant to the rules and regulations of the SEC, as well as higher expenses for general and director and officer insurance, investor relations, and other third-party consulting services.

Other Expense, Net

Interest Income

Interest income consists of income earned on our cash and cash equivalents.

Interest Expense

Interest expense consists of interest costs associated with our debt financing, including amortization of debt issuance costs.

Change in Fair Value of Warrant Liabilities

We classify our redeemable convertible preferred stock warrants and common stock warrants as liabilities on our condensed consolidated balance sheets. We remeasure the warrant liabilities to fair value at each reporting date and recognize changes in the fair value of the warrant liabilities in our consolidated statements of operations. We will continue to adjust the warrant liabilities for changes in fair value until the earlier of the expiration or exercise of the redeemable convertible preferred stock warrants and common stock warrants.

Provision for Income Taxes

We are subject to income taxes in U.S federal, state, and local jurisdictions in which we conduct business. We maintain a full valuation allowance on our federal and state deferred tax assets as we have concluded that it is not more likely than not that the deferred tax assets will be realized.

We account for uncertain tax positions in accordance with Accounting Standards Codification ("ASC") 740-10, *Accounting for Uncertainty in Income Taxes*. We recognize the tax effects of an uncertain tax position only if it is more likely than not to be sustained based solely on its technical merits as of the reporting date and only in an amount more likely than not to be sustained upon review by the tax authorities. Interest and penalties related to uncertain tax positions are classified in the condensed consolidated financial statements as income tax expense.

On July 4, 2025, the One Big Beautiful Bill Act ("OBBBA") was enacted in the U.S. The OBBBA includes significant provisions, such as the permanent extension of certain expiring provisions of the Tax Cuts and Jobs Act, modifications to the international tax framework and the restoration of favorable tax treatment for certain business provisions. The legislation has multiple effective dates, with certain provisions effective in 2025 and others implemented through 2027. We are currently assessing its impact on our consolidated financial statements.

Results of Operations

The following table sets forth our results of operations for each of the periods presented:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2025	2024	2025	2024
	(in thousands)		(in thousands)	
Revenue				
Services	$ 56,960	$ 38,351	$ 106,456	$ 70,255
Hardware	4,411	2,861	9,878	6,052
Total revenue	61,371	41,212	116,334	76,307
Cost of revenue				-
Services[(1)(2)(3)]	12,673	10,759	25,417	21,055
Hardware	8,392	5,619	18,711	13,070
Total cost of revenue	21,065	16,378	44,128	34,125
Gross profit	40,306	24,834	72,206	42,182
Operating expenses				
Research and development[(1)(3)]	10,024	8,987	18,830	17,883
Sales and marketing[(1)(2)(3)]	22,318	15,191	42,488	32,387
General and administrative[(1)(3)]	12,308	10,693	23,628	19,942
Total operating expenses	44,650	34,871	84,946	70,212
Operating loss	(4,344)	(10,037)	(12,740)	(28,030)
Other expense, net				-
Interest expense	1,094	1,132	2,168	2,262
Interest income	(863)	(85)	(1,405)	(614)
Change in fair value of warrant liabilities	736	(392)	1,256	(17)
Total other expense, net	967	655	2,019	1,631
Loss before provision for income taxes	(5,311)	(10,692)	(14,759)	(29,661)
Provision for income taxes	-	-	-	-
Net loss and comprehensive loss	$ (5,311)	$ (10,692)	$ (14,759)	$ (29,661)

(1) Includes share-based compensation expense as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2025	2024	2025	2024
	(in thousands)		(in thousands)	
Cost of services revenue	$ 33	$ 53	$ 71	$ 105
Research and development	528	465	1,023	797
Sales and marketing	884	635	1,614	1,367
General and administrative	1,385	926	2,966	2,679
Total share-based compensation expense	$ 2,830	$ 2,079	$ 5,674	$ 4,948

(2) Includes amortization of intangible assets as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2025	2024	2025	2024
	(in thousands)		(in thousands)	
Cost of services revenue	$ 439	$ 439	$ 878	$ 878
Sales and marketing	31	63	94	126
Total amortization of intangible assets	$ 470	$ 502	$ 972	$ 1,004

(3) Includes depreciation and amortization as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2025	2024	2025	2024
	(in thousands)		(in thousands)	
Cost of services revenue	$ 786	$ 568	$ 1,527	$ 1,100
Research and development	20	22	38	41
Sales and marketing	29	31	56	58
General and administrative	47	48	92	93
Total depreciation and amortization[(i)]	$ 882	$ 669	$ 1,713	$ 1,292

(i) Depreciation and amortization includes depreciation of property and equipment and amortization of capitalized internal-use software costs.

Percentage of Revenue Data

	Three Months Ended June 30,		Six Months Ended June 30,	
	2025	2024	2025	2024
	(as a percentage of revenue)			
Revenue				
Services	93 %	93 %	92 %	92 %
Hardware	7	7	8	8
Total Revenue	100	100	100	100
Cost of revenue				
Services	21	26	22	28
Hardware	14	14	16	17
Total cost of revenue	35	40	38	45
Gross profit	65	60	62	55
Operating expenses				
Research and development	16	22	16	23
Sales and marketing	36	37	37	42
General and administrative	20	26	20	26
Total operating expenses	72	85	73	91
Operating loss	(7)	(25)	(11)	(36)
Other expense, net				
Interest expense	2	2	2	3
Interest income	(1)	—	(1)	(1)
Change in fair value of warrant liabilities	1	(1)	1	—
Total other expense, net	2	1	2	2
Loss before provision for income taxes	(9)	(26)	(13)	(38)
Provision for income taxes	—	—	—	—
Net loss and comprehensive loss	(9)%	(26)%	(13)%	(38)%

Comparison of the Three and Six Months Ended June 30, 2025 and 2024

Revenue

	Three Months Ended June 30,				Six Months Ended June 30,			
	2025	2024	$ Change	% Change	2025	2024	$ Change	% Change
	(in thousands, except percentages)							
Services	$ 56,960	$ 38,351	$ 18,609	49 %	$ 106,456	$ 70,255	$ 36,201	52 %
Hardware	4,411	2,861	1,550	54 %	9,878	6,052	3,826	63 %
Total revenue	$ 61,371	$ 41,212	$ 20,159	49 %	$ 116,334	$ 76,307	$ 40,027	52 %

Total revenue increased by $20.2 million, or 49%, for the three months ended June 30, 2025 compared to the three months ended June 30, 2024 . Total revenue increased $40.0 million, or 52%, for the six months ended June 30, 2025 compared to the six months ended June 30, 2024.

Three Months Ended June 30, 2025 Compared with the Same Period in 2024

Services revenue increased by $18.6 million, or 49%, for the three months ended June 30, 2025 compared to the three months ended June 30, 2024, primarily driven by an increase of $19.0 million related to growth in total members, with the average number of total members during the three months ended June 30, 2025 increasing by 50% compared to the average for the three months ended June 30, 2024.

Hardware revenue increased by $1.6 million, or 54%, for the three months ended June 30, 2025 compared to the three months ended June 30, 2024, primarily driven by a 44% increase in total members, reflecting new members enrolled in our programs compared to the prior-year period, which directly drove the number of devices that we delivered.

Six Months Ended June 30, 2025 Compared with the Same Period in 2024

Services revenue increased by $36.2 million, or 52%, for the six months ended June 30, 2025 compared to the six months ended June 30, 2024, primarily driven by an increase of $35.3 million related to growth in total members, with the average number of total members during the six months ended June 30, 2025 increasing by 49% compared to the average for the six months ended June 30, 2024, and by $0.9 million related to higher average fees per member compared to prior-year.

Hardware revenue increased by $3.8 million, or 63%, for the six months ended June 30, 2025 compared to the six months ended June 30, 2024, primarily driven by a 52% increase in total members, reflecting new members enrolled in our programs compared to the prior-year period, which directly drove the number of devices that we delivered.

Cost of Revenue

	Three Months Ended June 30,				Six Months Ended June 30,			
	2025	2024	$ Change	% Change	2025	2024	$ Change	% Change
	(in thousands, except percentages)							
Services	$ 12,673	$ 10,759	$ 1,914	18%	$ 25,417	$ 21,055	$ 4,362	21%
Hardware	8,392	5,619	$ 2,773	49%	18,711	13,070	$ 5,641	43%
Total cost of revenue	$ 21,065	$ 16,378	$ 4,687	29%	$ 44,128	$ 34,125	$ 10,003	29%

Total cost of revenue increased by $4.7 million, or 29%, for the three months ended June 30, 2025 compared to the three months ended June 30, 2024 . Total cost of revenue increased $10.0 million, or 29%, for the six months ended June 30, 2025 compared to the six months ended June 30, 2024.

Three Months Ended June 30, 2025 Compared with the Same Period in 2024

Cost of services revenue increased by $1.9 million, or 18%, for the three months ended June 30, 2025 compared to the three months ended June 30, 2024, primarily driven by a $1.6 million increase in personnel costs related in part to an increase in headcount, a $0.2 million increase in technology support and product costs to support the growth in our total members, and a $0.1 million increase in amortization of capitalized internal-use software costs.

Cost of hardware revenue increased by $2.8 million, or 49%, for the three months ended June 30, 2025 compared to the three months ended June 30, 2024, primarily driven by a 44% increase in total members, reflecting new members enrolled in our programs compared to the prior-year period, which drove new devices, supplies, and fulfillment costs.

Six Months Ended June 30, 2025 Compared with the Same Period in 2024

Cost of services revenue increased $4.4 million, or 21%, for the six months ended June 30, 2025 compared to the six months ended June 30, 2024, primarily driven by a $3.7 million increase in personnel costs related in part to an increase in headcount, a $0.3 million increase in technology support and product costs to support the growth in our total members, and a $0.4 million increase in amortization of capitalized internal-use software costs.

Cost of hardware revenue increased by $5.6 million, or 43%, for the six months ended June 30, 2025 compared to the six months ended June 30, 2024, primarily driven by a 52% increase in total members, reflecting new members enrolled in our programs compared to the prior-year period, which drove new devices, supplies, and fulfillment costs.

Gross Profit and Gross Margin

	Three Months Ended June 30,				Six Months Ended June 30,			
	2025	2024	$ Change	% Change	2025	2024	$ Change	% Change
	(in thousands, except percentages)							
Gross profit	$ 40,306	$ 24,834	$ 15,472	62 %	$ 72,206	$ 42,182	$ 30,024	71 %
Gross margin	65.7 %	60.3 %		5.4 ppt	62.1 %	55.3 %		6.8 ppt

Three Months Ended June 30, 2025 Compared with the Same Period in 2024

Gross profit increased by $15.5 million, or 62%, for the three months ended June 30, 2025 compared to the three months ended June 30, 2024, driven by a 44% increase in total members and by a decrease in personnel costs per total member needed to support enrolled members as a result of strategic efficiency initiatives such as improving the effectiveness of our Care Team interventions and Care Team time management ("Care Team efficiency initiatives"), as well as the expanded use of supporting technologies, such as tools that can surface helpful templates for our Care Team's consideration in frequently recurring scenarios ("Care Team message support").

Gross margin expanded by 5.4 percentage points for the three months ended June 30, 2025 compared to the three months ended June 30, 2024.The expansion of gross margin was primarily driven by lower personnel costs per total member needed to support enrolled members as a result of Care Team efficiency initiatives as well as the expanded use of supporting technologies, such as tools for Care Team message support.

Six Months Ended June 30, 2025 Compared with the Same Period in 2024

Gross profit increased by $30.0 million, or 71%, for the six months ended June 30, 2025 compared to the six months ended June 30, 2024, driven by a 52% increase in total members and a decrease in personnel costs per total member needed to support enrolled members as a result of Care Team efficiency initiatives, as well as the expanded use of supporting technologies, such as tools for Care Team message support.

Gross margin expanded by 6.8 percentage points for the six months ended June 30, 2025 compared to the six months ended June 30, 2024. The expansion of gross margin was primarily driven by lower personnel costs per total member needed to support enrolled members as a result of Care Team efficiency initiatives, as well as the expanded use of supporting technologies, such as tools for Care Team message support.

Operating Expenses

Research and Development

	Three Months Ended June 30,				Six Months Ended June 30,			
	2025	2024	$ Change	% Change	2025	2024	$ Change	% Change
	(in thousands, except percentages)							
Research and development	$ 10,024	$ 8,987	$ 1,037	12%	$ 18,830	$ 17,883	$ 947	5%

Three Months Ended June 30, 2025 Compared with the Same Period in 2024

Research and development expenses increased by $1.0 million, or 12%, for the three months ended June 30, 2025 compared to the three months ended June 30, 2024, primarily driven by a $0.7 million increase in personnel costs related primarily to an increase in headcount and increases in compensation expenses per employee, and a $0.3 million increase in technology infrastructure expenses and professional and outside services costs.

Six Months Ended June 30, 2025 Compared with the Same Period in 2024

Research and development expenses increased $0.9 million, or 5%, for the six months ended June 30, 2025 compared to the six months ended June 30, 2024, primarily driven by a $0.4 million increase in personnel costs related primarily to an increase in headcount and stock-based compensation per employee and a $0.5 million increase in technology infrastructure expenses and professional and outside services costs.

Sales and Marketing

	Three Months Ended June 30,				Six Months Ended June 30,			
	2025	2024	$ Change	% Change	2025	2024	$ Change	% Change
	(in thousands, except percentages)							
Sales and marketing	$ 22,318	$ 15,191	$ 7,127	47%	$ 42,488	$ 32,387	$ 10,101	31%

Three Months Ended June 30, 2025 Compared with the Same Period in 2024

Sales and marketing expenses increased by $7.1 million, or 47%, for the three months ended June 30, 2025 compared to the three months ended June 30, 2024, primarily driven by a $4.1 million increase in administrative and marketing fees that we paid to channel partners for their services in support of our member enrollments, a $1.8 million increase in personnel costs related primarily to an increase in headcount and increases in compensation expenses per employee, and a $1.2 million increase in other marketing and technology infrastructure expenses.

Six Months Ended June 30, 2025 Compared with the Same Period in 2024

Sales and marketing expenses increased by $10.1 million, or 31%, for the six months ended June 30, 2025 compared to the six months ended June 30, 2024, primarily driven by a $6.0 million increase in administrative and marketing fees that we paid to channel partners for their services in support of our member enrollments, a $2.6 million increase in personnel costs related primarily to an increase in headcount and increases in compensation expenses per employee, and a $1.7 million increase in advertising and marketing expenses, offset by a $0.2 million decrease in professional and outside services.

General and Administrative

	Three Months Ended June 30,				Six Months Ended June 30,			
	2025	2024	$ Change	% Change	2025	2024	$ Change	% Change
	(in thousands, except percentages)							
General and Administrative	$ 12,308	$ 10,693	$ 1,615	15%	$ 23,628	$ 19,942	$ 3,686	18%

Three Months Ended June 30, 2025 Compared with the Same Period in 2024

General and administrative expenses increased by $1.6 million, or 15%, for the three months ended June 30, 2025 compared to the three months ended June 30, 2024, primarily driven by a $1.8 million increase in personnel costs related primarily to an increase in headcount, increases in compensation expenses per employee, and increased travel and entertainment costs associated with our IPO, and a $0.5 increase in technology infrastructure expenses, which were offset by a $0.5 decrease in professional and outside services expenses related to financial statement audits and preparing for public company operations and a $0.2 million decrease in other general and administrative expenses.

Six Months Ended June 30, 2025 Compared with the Same Period in 2024

General and administrative expenses increased by $3.7 million, or 18%, for the six months ended June 30, 2025 compared to the six months ended June 30, 2024, primarily driven by a $1.9 million increase in personnel costs related primarily to an increase in headcount, increases in compensation expenses per employee, and increased travel and entertainment costs associated with our IPO, a $0.8 million increase in technology infrastructure expenses, a $0.5 million increase in professional and outside services costs related to financial statement audits and preparing for public company operations, and a $0.5 million increase in other general and administrative expenses.

Other Expense, Net

Interest Expense

	Three Months Ended June 30,				Six Months Ended June 30,			
	2025	2024	$ Change	% Change	2025	2024	$ Change	% Change
	(in thousands, except percentages)							
Interest Expense	$ 1,094	$ 1,132	$ (38)	(3)%	$ 2,168	$ 2,262	$ (94)	(4)%

Three Months Ended June 30, 2025 Compared with the Same Period in 2024

There were no significant changes to the business related to our debt and other interest generating liabilities for the three months ended June 30, 2025 compared to the three months ended June 30, 2024.

Six Months Ended June 30, 2025 Compared with the Same Period in 2024

There were no significant changes to the business related to our debt and other interest generating liabilities for the six months ended June 30, 2025 compared to the six months ended June 30, 2024.

Interest Income

	Three Months Ended June 30,				Six Months Ended June 30,			
	2025	2024	$ Change	% Change	2025	2024	$ Change	% Change
	(in thousands, except percentages)							
Interest Income	$ 863	$ 85	$ 778	915%	$ 1,405	$ 614	$ 791	129%

Three Months Ended June 30, 2025 Compared with the Same Period in 2024

Interest income increased by $0.8 million, or 915%, for the three months ended June 30, 2025 compared to the three months ended June 30, 2024, primarily driven by interest earned from the increase in cash and cash equivalents from IPO proceeds.

Six Months Ended June 30, 2025 Compared with the Same Period in 2024

Interest income increased by $0.8 million, or 129%, for the six months ended June 30, 2025 compared to the six months ended June 30, 2024, primarily driven by interest earned from the increase in cash and cash equivalents from IPO proceeds.

Change in Fair Value of Warrant Liabilities

	Three Months Ended June 30,				Six Months Ended June 30,			
	2025	2024	$ Change	% Change	2025	2024	$ Change	% Change
	(in thousands, except percentages)							
Change in fair value of warrant liabilities	$ 736	$ (392)	$ 1,128	(288)%	$ 1,256	$ (17)	$ 1,273	(7488)%

Three Months Ended June 30, 2025 Compared with the Same Period in 2024

The change in fair value of warrant liabilities increased by $1.1 million, or (288%), for the three months ended June 30, 2025 compared to the three months ended June 30, 2024, primarily driven by changes in the stock price, expected stock volatility, risk-free rate, and reduction in time to expiry.

Six Months Ended June 30, 2025 Compared with the Same Period in 2024

The change in fair value of warrant liabilities increased by $1.3 million, or (7488%), for the six months ended June 30, 2025 compared to the six months ended June 30, 2024, primarily driven by changes in the stock price, expected stock volatility, risk-free rate, and reduction in time to expiry.

Trends

Seasonality

We typically close a higher percentage of sales to new customers, as well as renewals or expansions with existing customers, in the second and third quarters, aligning with benefits enrollment schedules and allowing us to launch our products at the start of the following year. This seasonality generally leads to higher new member enrollment in the first and second quarters, resulting in increased Care Team costs to support the newly enrolled members. These higher new member enrollments also require shipments of new devices to newly enrolled members in the same quarter of enrollment or the beginning of the following quarter and increased hardware revenue in those periods. These increased costs result in lower overall gross margins in those quarters and there is typically a decrease in these costs in subsequent quarters. After the effects of these early program costs of new enrollments, increases in the number of members will generally be reflected in increased revenue in subsequent quarters as services revenue is generally recognized in arrears after the provision of our virtual care programs begins.

Obesity and Weight Management

While Omada does not develop or prescribe GLP-1 therapies, we believe the approval of several GLP-1s to treat diabetes and obesity alongside changes in diet and exercise has the potential to increase interest in cardiometabolic programs such as ours. The GLP-1 treatment landscape is relatively new and evolving, and the continued growth of GLP-1 prescriptions may drive fluctuations in demand for our cardiometabolic programs and impact revenue in future periods.

GLP-1 therapies have driven significant spending related to cardiometabolic conditions and obesity, with combined global sales of Ozempic, Rybelsus, Wegovy, and Mounjaro reaching approximately $41.4 billion in 2024, a 73% increase compared to 2023, according to public filings by the respective drug manufacturers. GLP-1 therapies can represent a significant cost burden to employers and other entities (including health plans and PBMs). For example, employers pay for GLP-1 therapies with list prices that can exceed $1,000 per month. However, the lasting value derived from the prescription alone may be limited without long-term behavior change. As of June 30, 2025, FDA-approved labels guided that GLP-1 therapies prescribed in adults for obesity or chronic weight management should be prescribed concurrently with a behavioral and lifestyle treatment plan. Accordingly, we believe that the growth in GLP-1 medication prescriptions may also result in increased interest in lifestyle modification programs such as our cardiometabolic programs, which can support members on a GLP-1 therapy.

The GLP-1 treatment landscape is relatively new and evolving, and actions by employers, health plans, PBMs, pharmaceutical companies, regulators, and other third parties could impact the adoption of our GLP-1 Care Tracks. While our GLP-1 Care Tracks are designed to be offered only to eligible members who are also engaged in one of our cardiometabolic programs, demand for those cardiometabolic programs could fluctuate and impact our financial condition.

Liquidity and Capital Resources

Since our inception, we have financed our operations primarily through proceeds from issuance of our redeemable convertible preferred stock, debt financing agreements, and cash generated from the sale of our products and services. As of June 30, 2025, our principal sources of liquidity were cash and cash equivalents of $223.1 million and working capital of $213.1 million. Cash and cash equivalents are composed of cash held in sweep accounts, checking accounts, and money market funds. Our principal use of cash is to fund our operations and invest in R&D to support our growth.

We have generated significant losses from operations and negative cash flows from operating activities in the past, as reflected in our accumulated deficit of $458.7 million as of June 30, 2025. We believe that our current cash and cash equivalents will be sufficient to fund our operations for at least the next 12 months. Our future capital requirements, however, will depend on many factors, including our growth rate, the timing and extent of our sales and marketing and R&D expenditures, the continuing market acceptance of our products and services, and the use of cash to fund potential mergers or acquisitions. In the event that additional financing is required from outside sources, we may seek to raise additional funds through equity, equity-linked arrangements, and debt. If we are unable to raise additional capital when desired and on acceptable terms, our business, results of operations, and financial condition could be materially and adversely affected.

In June 2023, we entered into a financing arrangement with Physera, Inc., MidCap Funding IV Trust ("MidCap"), as administrative agent, MidCap Financial Trust, as term loan servicer, certain funds managed by MidCap, as lenders, and the lenders, additional borrowers, and guarantors from time to time party thereto (as amended, restated, amended and restated, supplemented, or otherwise modified from time to time, the "MidCap Credit Agreement"), for a senior secured term loan (the "MidCap Term Facility") in an aggregate principal amount of up to $60.0 million, with up to $30.0 million available upon the initial closing date and up to $30.0 million (the "Second Tranche") available for draw from October 2024 through March 2025 conditional upon achievement of $120.0 million of trailing 12-month revenue (the "Revenue Condition") and $60.0 million liquidity. On March 7, 2025, we entered into an amendment to the MidCap Credit Agreement which, among other things, (i) extended the availability of the Second Tranche until December 31, 2025 and (ii) modified the Revenue Condition to require trailing 12-month revenue of $165.0 million if the Second Tranche is advanced during the first fiscal quarter of 2025, $170.0 million if the Second Tranche is advanced during the second fiscal quarter of 2025, $175.0 million if the Second Tranche is advanced during the third fiscal quarter of 2025 and $180.0 million if the Second Tranche is advanced during the fourth fiscal quarter of 2025. Upon the initial closing date of the MidCap Credit Agreement, we drew down on $30.0 million of the MidCap Term Facility and used a portion of the proceeds to repay the outstanding principal balance (including prepayment premium) and accrued interest on the Perceptive Credit Agreement. The MidCap Term Facility is interest-only for 48 months. At the end of the initial interest-only period, we can elect to extend the interest-only period an additional 12 months if we meet a certain trailing 12-month revenue level (the "Minimum Net Revenue") and no event of default has occurred and is continuing. The MidCap Credit Agreement also includes a revolving line of credit facility (the "MidCap Revolving Facility") allowing for up to $20.0 million in revolving borrowings. The availability of the MidCap Revolving Facility is calculated as a percentage of our outstanding accounts receivable and inventory balances ("Availability"). We are required to maintain a minimum drawn balance on the MidCap Revolving Facility of no less than 20% of Availability, or will be required to pay a fee equal to the MidCap Revolving Facility interest rate on the difference between the amount of revolving loans drawn and 20% of Availability. Upon the initial closing date of the MidCap Credit Agreement, we drew $1.0 million on the MidCap Revolving Facility. The maturity date of the MidCap Term Facility and the MidCap Revolving Facility is June 1, 2028. As of each of June 30, 2025 and 2024, the outstanding balance on the MidCap Term Facility was $30.0 million and the outstanding balance on the MidCap Revolving Facility was $1.0 million.

Interest is charged on any outstanding principal of the MidCap Term Facility at the sum of the one-month forward-looking term SOFR rate plus 0.10% ("Adjusted SOFR"), plus 7.00%, subject to a floor of 2.50%. Interest on the MidCap Revolving Facility is charged at the sum of Adjusted SOFR plus 4.00%, subject to a floor of 2.50%. Both interest rates are reset monthly. The effective interest rate for the three months ended June 30, 2025 and 2024, was 13.4% and 14.4%, respectively, on the MidCap Term Facility, and 11.2% and 12.0%, respectively, on the MidCap Revolving Facility. The effective interest rate for the six months ended June 30, 2025 and 2024 on the MidCap Term Facility was 13.4% and 14.4%, respectively, and 11.3% and 12.3% on the MidCap Revolving Facility, respectively.

MidCap Credit Agreement includes customary covenants for a facility of this type, including monthly reporting requirements and, at any time that liquidity is less than 1.50x the outstanding principal balance of the MidCap Term Facility, a financial covenant to maintain minimum trailing 12-month net revenue levels specified in the MidCap Credit Agreement. The MidCap Credit Agreement also contains various covenants that limit our ability to, among other things: sell, transfer, lease, or dispose of our assets subject to certain exclusions; create, incur, assume, guarantee, or assume additional indebtedness, other than certain permitted indebtedness; encumber or permit liens on any of our assets other than certain permitted liens; make restricted payments, including paying cash dividends on, repurchasing or making distributions with respect to any of our capital stock; make specified investments; consolidate, merge with, or acquire any other entity, or sell or otherwise dispose of all or substantially all of our assets; and enter into certain transactions with our affiliates, in each case, subject to certain exceptions, baskets, and thresholds set forth in the MidCap Credit Agreement. As of June 30, 2025, we were in compliance with our financial covenants.

On June 9, 2025, we completed our IPO of 9,085,000 shares of our common stock, which includes the exercise in full by the underwriters of their option to purchase from us 1,185,000 shares of our common stock, at a price to the public of $19.00 per share. The gross proceeds to us from the IPO were $172.6 million and $151.6 million, after deducting $12.0 million underwriting discounts and commissions and $9.0 million estimated offering expenses payable by us. Immediately prior to the closing of the IPO, each outstanding share of our Series A, Series B, Series C, Series C-1, Series D, Series D-1, and Series E redeemable convertible preferred stock, including shares of redeemable convertible preferred stock issued upon the exercise of Series B and Series D redeemable convertible preferred stock warrants, converted into one-third of a share our common stock.

On July 31, 2025, we fully repaid outstanding amounts under the MidCap Term Facility and MidCap Revolving Facility, with cumulative principal and accrued interest balances of $31.0 million and $0.4 million, respectively, ahead of their contractual maturity on June 1, 2028. The extinguishment will reduce future interest expense and eliminate related debt covenants.

Cash Flows

The following table summarizes our cash flows for the periods presented:

	Six Months Ended June 30,	
	2025	2024
	(in thousands)	
Net cash used in operating activities	$ (13,260)	$ (28,748)
Net cash used in investing activities	$ (2,499)	$ (1,826)
Net cash provided by (used in) financing activities	$ 162,513	$ (898)

Operating Activities

Our largest source of operating cash flows is cash collections from our customers who purchase access to our programs for their members. Our primary use of cash in operating activities is for personnel and related expenses, marketing expenses, and third-party hosting and software costs. We have incurred negative cash flows from operating activities and have supplemented working capital requirements through net proceeds from the sale of redeemable convertible preferred stock and proceeds from debt financing arrangements.

Net cash used in operating activities during the six months ended June 30, 2025 of $13.3 million was the result of a $14.8 million net loss, adjusted for $12.3 million of non-cash adjustments and $10.8 million of net cash outflow from changes in operating assets and liabilities. The non-cash adjustments consisted primarily of $5.7 million of share-based compensation expense, $2.7 million of depreciation and amortization expense, $1.6 million of amortization of deferred commissions, a $1.3 million increase in the fair value of warrant liabilities, a $0.5 million increase in the provision for credit losses, $0.4 million of amortization of operating lease right-of-use assets, and $0.3 million of amortization of debt issuance costs. The net cash outflow from changes in operating assets and liabilities was primarily the result of an $10.4 million increase in accounts receivable, a $4.8 million decrease in accrued expenses and other current liabilities, a $0.9 million increase in prepaid and other current assets, a $1.4 million increase in deferred commissions, a $0.4 million decrease in operating lease liabilities, and a $0.2 million increase in inventory, partially offset by a $6.0 million increase in deferred revenue, a $1.0 million increase in accounts payable, a $0.1 million decrease in other non-current assets, and a $0.1 million increase in other non-current liabilities.

Net cash used in operating activities during the six months ended June 30, 2024 of $28.7 million was the result of a $29.7 million net loss, adjusted for $9.5 million of non-cash adjustments and $8.5 million of net cash outflow from changes in operating assets and liabilities. The non-cash adjustments consisted primarily of $4.9 million in share-based compensation expense, $2.3 million of depreciation and amortization expense, $1.2 million of amortization of deferred commissions, $0.5 million increase in the provision for credit losses, $0.4 million of amortization of operating lease right-of-use assets, and $0.2 million of amortization of debt issuance costs. The net cash outflow from changes in operating assets and liabilities was primarily the result of a $9.8 million increase in accounts receivable, a $0.5 million increase in prepaid and other current assets, a $3.7 million increase in deferred commissions, a $0.4 million decrease in operating lease liabilities, a $1.2 million decrease in accounts payable, and a $3.1 million decrease in accrued expenses and other current liabilities, partially offset by a $8.3 million increase in deferred revenue, a $1.5 million decrease in inventory, a $0.2 million decrease in other non-current assets, and a $0.1 million increase in other non-current liabilities.

Investing Activities

Net cash used in investing activities during the six months ended June 30, 2025 of $2.5 million was the result of purchases of property and equipment of $0.6 million and capitalized internal-use software costs of $1.9 million.

Net cash used in investing activities during the six months ended June 30, 2024 of $1.8 million was the result of purchases of property and equipment of $0.3 million and capitalized internal-use software costs of $1.5 million.

Financing Activities

Net cash provided by financing activities for the six months ended June 30, 2025 of $162.5 million was the result of $160.5 million of proceeds from the IPO net of underwriting discounts and commissions and $3.9 million of proceeds from the exercise of stock options, partially offset by $1.9 million of payments for offering expenses.

Net cash used by financing activities for the six months ended June 30, 2024 of $0.9 million was the result of $2.3 million of payments for offering expenses, partially offset by $1.4 million of proceeds from the exercise of stock options.

Contractual Obligations and Other Commitments

Operating lease commitments. Our operating lease commitments primarily consist of the lease of our corporate offices. As of June 30, 2025, we had fixed lease payment obligations of less than $1 million, all of which is expected to be paid within 12 months.

Purchase commitments. Our unconditional purchase commitments primarily consist of technology and cloud services related to our daily business operations. As of June 30, 2025, we had $4.2 million of unconditional purchase commitments due in 2025 and $8.2 million due in 2026 and thereafter. The purchase obligation amounts do not represent the entire anticipated purchases in the future but represent only those items for which we are contractually obligated. The majority of our goods and services are purchased as needed, with no unconditional commitment. For this reason, these amounts do not provide an indication of our expected future cash outflows related to purchases. See Note 6 to our unaudited condensed consolidated financial statements included elsewhere in this Quarterly Report on Form 10-Q.

Indemnification Agreements

In the ordinary course of business, we include in our agreements indemnification provisions of varying scope and terms pursuant to which we agree to indemnify customers, channel partners, suppliers, vendors, lessors, business partners, and other parties with respect to certain matters, including, but not limited to, losses arising out of the breach of such agreements, services to be provided by us, or from intellectual property infringement claims made by third parties. The term of these indemnification provisions generally survive the termination of the agreements indefinitely. The maximum potential amount of future payments we could be required to make under these arrangements is not determinable. No demands have ever been made upon us to provide indemnification under such agreements, and there are no claims under those indemnification terms that we are aware of that could have a material effect on our consolidated balance sheets, consolidated statements of operations and comprehensive loss, or consolidated statements of cash flows. As a result, we believe the fair value of these agreements is minimal.

In addition, we have entered into separate indemnification agreements with our directors and certain officers and other employees that require us, among other things, to indemnify them against certain liabilities that may arise by reason of their status or service as directors, officers, and employees.

Emerging Growth Company Status

We qualify as an "emerging growth company," as defined in the JOBS Act. As an emerging growth company, we may take advantage of specified reduced disclosure and other requirements that are otherwise applicable generally to public companies. These provisions include: (i) being permitted to present only two years of audited financial statements, in addition to any required unaudited interim financial statements, with correspondingly reduced "Management's Discussion and Analysis of Financial Condition and Results of Operations" disclosure in this Quarterly Report on Form 10-Q; (ii) reduced disclosure about our executive compensation arrangements; (iii) not being required to hold advisory votes on executive compensation or to obtain stockholder approval of any golden parachute arrangements not previously approved; (iv) an exemption from the auditor attestation requirement in the assessment of our internal control over financial reporting pursuant to the Sarbanes-Oxley Act of 2002; and (v) an exemption from compliance with the requirements of the Public Company Accounting Oversight Board regarding the communication of critical audit matters in the auditor's report on the financial statements.

We may take advantage of these exemptions for up to five years or such earlier time that we are no longer an emerging growth company. We would cease to be an emerging growth company on the date that is the earliest of (i) the last day of the fiscal year in which we have total annual gross revenues of $1.235 billion or more; (ii) the last day of our fiscal year following the fifth anniversary of the date of the completion of our IPO; (iii) the date on which we have issued more than $1.0 billion in nonconvertible debt during the previous three years; or (iv) the date on which we are deemed to be a large accelerated filer under the rules of the SEC. We may choose to take advantage of some but not all of these exemptions. We have taken advantage of reduced reporting requirements in this Quarterly Report on Form 10-Q. Accordingly, the information contained herein may be different from the information you receive from other public companies in which you hold stock. Additionally, the JOBS Act provides that an emerging growth company can take advantage of an extended transition period for complying with new or revised accounting standards. This allows an emerging growth company to delay the adoption of certain accounting standards until those standards would otherwise apply to private companies. We have elected to avail ourselves of this exemption, and therefore, while we are an emerging growth company, we will not be subject to new or revised accounting standards at the same time that they become applicable to other public companies that are not emerging growth companies. As a result of this election, our unaudited condensed consolidated financial statements may not be comparable to those of other public companies that comply with new or revised accounting pronouncements as of public company effective dates. We may choose to early adopt any new or revised accounting standards whenever such early adoption is permitted for private companies.

Critical Accounting Policies and Estimates

Our condensed consolidated financial statements and the related notes thereto included elsewhere in this Quarterly Report on Form 10-Q are prepared in accordance with GAAP. The preparation of condensed consolidated financial statements in accordance with GAAP requires us to make certain estimates, judgements, and assumptions that affect the reported amounts of assets and liabilities and the related disclosures as of the date of the financial statements, as well as reported amounts of revenue and expenses during the period presented. We base our estimates on historical experience and on various other assumptions that we believe to be reasonable under the circumstances. Actual results could differ significantly from our estimates. To the extent that there are differences between our estimates and actual results, our future financial statement presentation, financial condition, results of operations, and cash flows could be affected. There have been no material changes to our critical accounting policies and estimates as described in our Prospectus.

Recently Issued Accounting Pronouncements Adopted

For more information on recently issued accounting pronouncements, see Note 2 to our unaudited condensed consolidated financial statements included elsewhere in this Quarterly Report on Form 10-Q for more information.

New Accounting Pronouncements Not Yet Adopted

For more information on new accounting pronouncements not yet adopted, see Note 2 to our unaudited condensed consolidated financial statements included elsewhere in this Quarterly Report on Form 10-Q for more information.

Item 3. Quantitative and Qualitative Disclosures about Market Risk

We are exposed to certain market risks in the ordinary course of our business. Market risk represents the risk of loss that may impact our financial position due to adverse changes in financial market prices and rates.

Interest Rate Risk

We are exposed to market risk related to changes in interest rates. We had cash and cash equivalents of $223.1 million as of June 30, 2025 and $76.4 million as of December 31, 2024. Our cash and cash equivalents consist of cash held in sweep accounts, checking accounts, and money market funds. The cash and cash equivalents are held primarily for working capital purposes. Such interest earning instruments carry a degree of interest rate risk. We had financing arrangements, described above, with $31.0 million outstanding as of June 30, 2025 and December 31, 2024. Our financing arrangements subject us to a variable amount of interest on the principal balance outstanding and could be adversely impacted by rising interest rates in the future. The effect of a hypothetical 10% change in interest rates would not have had a material impact on our unaudited condensed consolidated financial statements for the three months ended June 30, 2025.

Inflation Risk

While we continue to see demand for our virtual care programs, we believe that current macroeconomic factors, including the impact of inflation and tariffs, are impacting customer and channel partner spending decisions. Given the current macroeconomic environment, we continue to look for ways to manage costs and mitigate any changes in the purchasing behavior of our customers and channel partners that may occur due to significant inflationary pressure, tariffs, or other factors. If our costs, in particular labor, sales and marketing, and cloud hosting costs, become subject to sustained or increased inflationary or other macroeconomic pressure, we may be unable to fully offset such higher costs through price increases, which could harm our business, financial condition, and results of operations.

Item 4. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

Our management, with the participation of our principal executive officer and principal financial officer, evaluated the effectiveness of our disclosure controls and procedures, as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the "Exchange Act"), as of the end of the period covered by this Quarterly Report on Form 10-Q. Based on that evaluation, our principal executive officer and principal financial officer concluded that, as of June 30, 2025, our disclosure controls and procedures were not effective at the reasonable assurance level due to the material weaknesses in our internal control over financial reporting described below.

Previously Reported Material Weaknesses in Internal Control Over Financial Reporting

A material weakness is a deficiency or combination of deficiencies in our internal control over financial reporting such that there is a reasonable possibility that a material misstatement of our annual or interim consolidated financial statements would not be prevented or detected on a timely basis.

As disclosed in Part II, Item 1A, "Risk Factors" in this Quarterly Report on Form 10-Q, we previously identified material weaknesses in our internal control over financial reporting related to (i) inadequate segregation of duties within our financial reporting process, leading to certain duties being performed by the same individuals, (ii) an insufficient complement of personnel with an appropriate level of technical knowledge to properly account for significant transactions, and (iii) inadequate formalized processes and control activities to support the financial close and reporting process, including the review of financial information, account analysis, and journal entries. We have concluded that these material weaknesses existed because we did not have the necessary business processes, systems, personnel, and related internal controls. The deficiencies identified did not result in a material misstatement to our financial statements.

Remediation Efforts to Address Previously Identified Material Weaknesses

We have taken and will continue to take action to remediate these material weaknesses, including:

- implementing processes and controls to better identify and manage segregation of duties risks;
- designing and implementing controls related to significant accounts and disclosures to achieve complete, accurate, and timely financial accounting, reporting, and disclosures, including controls over account reconciliations, segregation of duties, and the preparation and review of journal entries;

- continuing to hire additional accounting, finance, and operations resources with appropriate and sufficient technical expertise and to better allow for segregation of conflicting duties; and

- consulting with experts on technical accounting matters, internal controls, and in the preparation of our financial statements.

We believe we are making progress toward achieving effectiveness of our internal control over financial reporting. The actions that we are taking are subject to ongoing management review and audit committee oversight. We will not be able to conclude whether the steps we are taking will fully remediate the material weaknesses in our internal control over financial reporting until we have completed our remediation efforts and subsequently evaluated their design and effectiveness over a sufficient period of time, and management concludes, through testing, that these are operating effectively. We may also conclude that additional measures are required to remediate the material weaknesses in our internal control over financial reporting.

Changes in Internal Control Over Financial Reporting

Except for the remediation measures we are taking in connection with the material weaknesses described above, there were no changes in our internal control over financial reporting, as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act, during the three months ended June 30, 2025 that materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Limitation on Effectiveness of Controls and Procedures

In designing and evaluating our disclosure controls and procedures, management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives. In addition, the design of disclosure controls and procedures must reflect the fact that there are resource constraints and that management is required to apply judgment in evaluating the benefits of possible controls and procedures relative to their costs.

Part II - Other Information

Item 1. Legal Proceedings

From time to time, we are subject to legal proceedings and claims arising in the ordinary course of our business. We are not currently party to any proceeding the outcome of which we believe, if determined adversely to us, would individually or in the aggregate have a material adverse effect on our business, financial condition, or results of operations.

Item 1A. Risk Factors

Certain factors may have a material adverse effect on our business, financial condition, results of operations, and prospects. You should carefully consider the risks described below, as well as the other information in this Quarterly Report on Form 10-Q, including our unaudited condensed consolidated financial statements and the related notes and "Management's Discussion and Analysis of Financial Condition and Results of Operations" included elsewhere in this Quarterly Report on Form 10-Q. The occurrence of any of the events or developments described below could have a material adverse effect on our business, financial condition, results of operations, and prospects. In such an event, the market price of our common stock could decline, and you may lose all or part of your investment. Additional risks and uncertainties not presently known to us or that we currently believe are not material may also impair our business, financial condition, results of operations, and prospects.

Risk Factor Summary

Our business is subject to a number of risks of which you should be aware before making a decision to invest in our common stock, including those described more fully below in this Quarterly Report on Form 10-Q. The following is a summary of principal risks and uncertainties that could materially adversely affect our business, results of operations, financial condition, and prospects. This summary should be read in conjunction with the "Risk Factors" section and should not be relied upon as an exhaustive summary of the material risks and uncertainties facing our business.

- We have a limited operating history and have grown significantly in a short period of time. If we fail to manage our growth effectively, our business could be materially and adversely affected.
- We have a history of net losses, and we may not achieve or maintain profitability in the future.
- The failure of our programs to achieve and maintain market acceptance could result in us achieving sales below our expectations, which would cause our business, financial condition, results of operations, and prospects to be materially and adversely affected.
- The market for our programs is new, rapidly evolving, and increasingly competitive, as the healthcare industry in the U.S. is undergoing significant structural change, which makes it difficult to forecast demand for our programs.
- We operate in a very competitive industry, and if we fail to compete successfully against our existing or potential competitors, some of whom may have greater resources than us, our business, financial condition, results of operations, and prospects could be materially and adversely affected.
- Competitive solutions or other technological breakthroughs for the monitoring, treatment, or prevention of chronic conditions or technological developments may adversely affect demand for our programs.
- The growth of our business relies, in part, on the growth and success of our customers and channel partners such as health plans, PBMs, and other resellers, and revenue from member enrollment, which are difficult to predict and are affected by factors outside of our control.
- If the number of individuals covered by employers, health plans, PBMs, health systems, government entities, or other existing or potential customers decreases, or the number of programs they cover decreases, our member enrollment may decline, and our revenue will likely decrease, which could materially and adversely affect our business, financial condition, results of operations, and prospects.

- Our revenue depends on member engagement in our programs and the clinical outcomes and cost savings of our offerings, and our failure to achieve and maintain meaningful member engagement, clinical outcomes, and/or cost savings could materially and adversely affect our business, financial condition, results of operations, and prospects.

- We incur significant upfront costs in establishing and expanding our relationships with employers, health plans, PBMs, health systems, government entities, and other existing and potential customers and channel partners, and if we are unable to maintain and grow these relationships over time, we are likely to fail to recover these costs, which could have a material adverse effect on our business, financial condition, results of operations, and prospects.

- A substantial portion of our sales comes from or through a limited number of customers and channel partners that operate as resellers.

- If we are unable to attract new customers and channel partners and increase member enrollment from new and existing customers and channel partners, our revenue growth could be slower than we expect, and our business may be adversely affected.

- We will need to increase the size of our organization, including our Care Teams, and we may experience difficulties in managing growth and attracting talent. A deterioration in our relationships with our employees and other service providers could have an adverse impact on our business.

- We depend on a limited number of third-party suppliers for certain devices and other supplies that we deliver to members in connection with our programs, for cellular device connectivity, and for certain complementary healthcare services provided by external partners, such as prescriptions or physician referrals, and the loss of any of these suppliers or partners, or their inability to support our required volume, could materially and adversely affect our business, financial condition, results of operations, and prospects.

- We experience seasonality in our business, which may cause fluctuations in our financial results.

- Our information technology ("IT") systems and those of our affiliated professional entities, or those used by our third-party service providers, vendors, business partners, or other contractors or consultants, may fail or suffer cybersecurity incidents, data breaches, and other disruptions, which could result in a material disruption of our systems or programs, compromise confidential information related to our business or of our customers or channel partners, including protected health information ("PHI") and other sensitive or personal information of employees, covered individuals, and members, or prevent us from accessing critical information, potentially exposing us to liability or otherwise materially and adversely affecting our business, financial condition, results of operations, and prospects.

- We operate in a highly regulated industry and changes in regulations or the implementation of existing regulations could affect our operations.

- Our use and disclosure of personal information, including health information, is subject to federal and state privacy and security laws and regulations, and our or our affiliated professional entities' actual or perceived failure to comply with such laws and regulations or to adequately secure the personal information we hold could result in significant liability or reputational harm and, in turn, a material adverse effect on our business, financial condition, results of operations, and prospects.

- If we or our affiliated professional entities fail to comply with federal and state healthcare regulatory laws, we could be subject to penalties, including, but not limited to, administrative, civil and criminal penalties, damages, fines, disgorgement, exclusion from participation in governmental healthcare programs, and the curtailment of our operations, any of which could materially and adversely affect our business, financial condition, results of operations, and prospects.

- Legislative or regulatory healthcare reforms or reductions in government spending may make it more difficult and costly to produce, market, and distribute our programs or to do so profitably.

- We have identified material weaknesses in our internal control over financial reporting. If our remediation of the material weaknesses is not effective, or if we experience additional material weaknesses in the future or otherwise fail to maintain an effective system of internal controls in the future, we may not be able to accurately or timely report our results of operations or financial condition, which may adversely affect investor confidence in us and, as a result, the value of our common stock.

Risks Relating to Our Business and Industry

We have a limited operating history and have grown significantly in a short period of time. If we fail to manage our growth effectively, our business could be materially and adversely affected.

We were organized in 2011 and began offering Omada for Prevention & Weight Health in 2012. Accordingly, we have a limited operating history, which makes an evaluation of our future prospects difficult. Our results of operations have fluctuated in the past, and we expect our future quarterly and annual results of operations to fluctuate as we focus on increasing the demand for our programs. We may need to make business decisions that could adversely affect our results of operations and prospects, such as modifications to our pricing strategy, business structure, or operations.

We have experienced recent rapid growth. This growth has placed significant demands on our management and financial, operational, technological, and other resources, and we expect that any future growth will continue to place significant demands on our management and other resources and will require us to continue developing and improving our financial, operational, and other internal controls. In particular, continued growth increases the challenges involved in a number of areas, including recruiting and retaining sufficient skilled personnel, providing adequate training and supervision to maintain our high quality standards, and preserving our culture and values. We may not be able to address these challenges in a cost-effective manner, or at all. As we grow, we may also need to invest significant resources to improve and expand our technological systems, including reworking any existing technology and/or documenting existing features, and we may not be able to do so in a cost-effective manner or at all. If we are unable to efficiently update or further improve our technology infrastructure, we may need to hire additional personnel, including Care Team members, to support our programs and any future growth, which could limit our ability to achieve economies of scale. If we do not effectively manage our growth, we may not be able to execute on our business plan, respond to competitive pressures, take advantage of market opportunities, satisfy requirements from our customers and channel partners, or maintain high-quality offerings, and our business, financial condition, results of operations, and prospects could be materially and adversely affected.

We have a history of net losses, and we may not achieve or maintain profitability in the future.

We have incurred net losses since our inception, and we may incur net losses in the future. For the three months ended June 30, 2025 and 2024, we incurred net losses of $5.3 million and $10.7 million, respectively. For the six months ended June 30, 2025 and 2024, we incurred net losses of $14.8 million and $29.7 million, respectively. As of June 30, 2025, we had an accumulated deficit of $458.7 million. We also expect our operating expenses to increase in future periods, and if our revenue growth does not increase to more than offset these anticipated increases in our operating expenses, we may not be able to achieve or maintain profitability, and our business, financial condition, results of operations, and prospects will be harmed. Since inception, we have spent, and intend to continue to spend, significant funds to develop our programs, to develop our customer support resources, to scale our offerings, and to recruit and retain key talent. Some of these investments may not yield the revenue gains we anticipate and reduce our operating margin. If our investments are not successful, and if we are unable to successfully develop, commercialize, and market our programs to customers and channel partners, our ability to increase revenue may be adversely affected. In addition to the expected costs to grow our business, we also expect to incur significant additional legal, accounting, and other expenses as a newly public company. If we fail to increase our revenue to exceed the increases in our operating expenses, we will not be able to achieve or maintain profitability in the future.

The failure of our programs to achieve and maintain market acceptance could result in us achieving sales below our expectations, which would cause our business, financial condition, results of operations, and prospects to be materially and adversely affected.

Our current business strategy is highly dependent on our programs achieving and maintaining market acceptance. Market acceptance and adoption of our programs depend on our achieving and maintaining meaningful member engagement, clinical outcomes, and costs savings, and on educating employers, health plans, PBMs, health systems, government entities, and other customers and channel partners as to the distinct features, ease-of-use, and other perceived benefits of our programs as compared to competitive solutions and programs. If we are not successful in demonstrating to existing and potential customers and channel partners the benefits of our programs, or if we are not able to achieve the support of employers, health plans, PBMs, health systems, government entities, and other existing or potential customers or channel partners for our programs, our sales may decline, or we may fail to increase our sales in line with our forecasts.

Achieving and maintaining market acceptance of our programs could be negatively impacted by many factors, including:

- the failure of our programs to achieve wide acceptance among people living with or at risk for chronic conditions, employers, health plans, PBMs, health systems, government entities, other existing or potential customers and channel partners, and key opinion leaders in the treatment community;
- lack of evidence or peer-reviewed publication of clinical evidence supporting the efficacy, ease-of-use, cost-savings, safety, or other perceived benefits of our current or future programs or features, or perceived lack of compelling evidence, over competitive offerings or other currently available methodologies;
- perceived risks associated with the use of our programs or similar solutions or technologies generally, including perceived risks regarding patient confidentiality, data privacy, artificial intelligence ("AI"), and cybersecurity;
- the introduction of competitive solutions or other advancements in healthcare or drugs and the rate of acceptance of those solutions and advancements as compared to our programs; and
- results of clinical and financial studies relating to chronic condition programs or similar competitive solutions.

In addition, our programs may be perceived by employers, health plans, PBMs, health systems, government entities, and other existing or potential customers and channel partners or our current or prospective members to be more complicated or less effective than other healthcare approaches. People may be unwilling to change their current health regimens, and existing or potential customers may be unwilling to change their benefits practices.

The market for our programs is new, rapidly evolving, and increasingly competitive, as the healthcare industry in the U.S. is undergoing significant structural change, which makes it difficult to forecast demand for our programs.

The virtual care market is relatively new, unproven, and rapidly evolving, and it is uncertain whether it will achieve and sustain high levels of demand, customer acceptance, and market adoption. The COVID-19 pandemic increased utilization of virtual-first care services, but long-term demand for virtual care is uncertain. Our future financial performance will depend in part on growth in this market and on our ability to adapt to emerging demands of our customers and channel partners. It is difficult to predict the future growth rate and size of our target market. The forecasts that we use to anticipate expected growth for our business and revenue rely on assumptions and metrics that are difficult to estimate accurately, including but not limited to anticipated enrollment rates, our number of enrolled members, our ability to secure and retain business from new customers and channel partners or to secure additional business from additional customers and channel partners, the anticipated timing of securing that business, member engagement levels in our programs, and member outcomes from our programs, and our assumptions and estimates may not be accurate. In addition, the estimates of market opportunity and forecasts of market growth included in our Registration Statement on Form S-1, or any of the other documents we file or furnish with the Securities and Exchange Commission (the "SEC"), may prove to be inaccurate, and even if the market in which we compete achieves the forecasted growth, our business could fail to grow at similar rates, if at all. Negative publicity concerning our programs or our market as a whole could limit market acceptance of our programs. If our existing or potential customers, channel partners, and members do not perceive the benefits of our programs, or if our programs do not drive member enrollment, then our market may not develop at all, or it may develop more slowly than we expect. Our success will depend to a substantial extent on the willingness of existing and potential customers to increase their coverage of and support for our programs and our ability to demonstrate the value of our programs to our existing and potential customers and channel partners. If these entities do not recognize or acknowledge the benefits of our programs or if we are unable to reduce healthcare costs or drive positive health outcomes, then the market for our programs might not develop at all, or it might develop more slowly than we expect. Similarly, negative publicity or negative customer or member sentiment regarding patient confidentiality, data privacy, AI, and cybersecurity in the context of technology-enabled healthcare or concerns experienced by us or our competitors could limit market acceptance of our programs. We face additional risks related to cybersecurity. See the risk factor titled "*Our information technology ("IT") systems and those of our affiliated professional entities, or those used by our third-party service providers, vendors, business partners, or other contractors or consultants, may fail or suffer cybersecurity incidents, data breaches, and other disruptions, which could result in a material disruption of our systems or programs, compromise confidential information related to our business or of our customers or channel partners, including protected health information ("PHI") and other sensitive or personal information of employees, covered individuals, and members, or prevent us from accessing critical information, potentially exposing us to liability or otherwise materially and adversely affecting our business, financial condition, results of operations, and prospects*" and other risks under the section titled "—Risks Relating to Cybersecurity, Information Systems, and Intellectual Property."

The healthcare industry in the U.S. is undergoing significant structural change and is rapidly evolving. We believe demand for our programs has been driven in large part by rapidly growing costs in the traditional healthcare system, the movement toward patient-centricity and more personalized healthcare, and advances in technology. Widespread acceptance of personalized healthcare is critical to our future growth and success. A reduction in the growth of personalized healthcare could reduce the demand for our programs and result in a lower revenue growth rate or decreased revenue. Additionally, we sell our programs using innovative pricing models, primarily charging for members who enroll and engage rather than at a population level, and the adoption of these models is still relatively new, especially in the healthcare industry. If companies do not shift to these types of models and these models do not achieve widespread adoption, or if there is a reduction in demand for products and services using models such as these, our business, financial condition, results of operations, and prospects could be materially and adversely affected.

Additionally, if healthcare benefits trends shift or entirely new technologies, treatments, or drugs are developed that replace existing offerings, our existing or future programs could be rendered obsolete, and our business could be adversely affected. In addition, we may experience difficulties with software development, industry standards, design, or marketing that could delay or prevent our development, introduction, or implementation of new or enhanced programs.

We operate in a very competitive industry, and if we fail to compete successfully against our existing or potential competitors, some of whom may have greater resources than us, our business, financial condition, results of operations, and prospects could be materially and adversely affected.

While our market is in an early stage of development, it is evolving rapidly and becoming increasingly competitive, and we expect it to attract increased competition. We currently face competition from a range of digital health companies, including direct competition from competitors offering cardiometabolic programs, such as Hello Heart Inc., Lark Technologies, Inc., Livongo (via Teladoc Health, Inc.), Onduo LLC, Vida Health, Inc., and Virta Health Corp.; competitors offering only MSK programs, such as Hinge Health, Inc. and SWORD Health, Inc.; and those that offer both cardiometabolic and MSK programs, such as DarioHealth Corp. In some cases, our competitors also include enterprise companies that are focused on or may enter the healthcare industry generally, including initiatives and partnerships launched by these large companies, and those that offer point solutions for a single chronic condition. These companies, which may offer their solutions at lower prices, are continuing to develop additional products and becoming more sophisticated and effective. In addition, large, well-financed healthcare providers and health plans have in some cases developed their own platforms or tools and may provide these solutions at discounted prices. Competition from specialized software providers or device manufacturers, which may facilitate the collection of data but offer limited interpretation, feedback, or guidance, and other parties will result in continued pricing pressures, which are likely to lead to price declines in certain product areas, which could negatively impact our sales, profitability, and market share. Consumer technology companies may also offer solutions that feature health coaching, health advice, or other health services that may affect the demand for our programs. In addition, healthcare providers may choose not to implement a digital health solution at all and instead may continue to rely on traditional, in-person approaches to healthcare. Moreover, our programs and systems are designed to comply with rules and regulations applicable to healthcare providers, and as a result, we must enter into contracts that appropriately reflect the obligations of a healthcare provider, including data privacy and healthcare regulatory requirements. We compete with wellness vendors whose products and services are not designed to comply with these rules and regulations and therefore may be preferred by potential customers and channel partners who view our programs and related healthcare provider requirements as overly complex or otherwise undesirable. The loss of potential customers and channel partners as a result of our status as a healthcare provider may have a material and adverse effect on our business, financial condition, results of operations, and prospects.

Some of our competitors may have, or new competitors or alliances may emerge that have, greater name and brand recognition, greater market share, a larger customer base, more or larger channel partner relationships, more widely adopted proprietary technologies, greater marketing expertise, larger sales forces, longer operating histories, or significantly greater resources than we do and may be able to offer solutions similar to ours at a more attractive price than we can, or may be acquired by third parties with greater available resources. In addition, our competitors have established, and may in the future establish, cooperative relationships with vendors of complementary products, technologies, or services to increase the availability of their solutions in the marketplace. Our competitors could also be better positioned to serve certain markets, which could create additional price pressure. As a result, our competitors may be able to respond more quickly and effectively than we can to new or changing opportunities, technologies, standards, or requirements from customers and channel partners and may have the ability to initiate or withstand substantial price competition. In light of these factors, even if our programs are more effective than those of our competitors, existing or potential customers and channel partners may accept competitive solutions in lieu of purchasing our programs. If we are unable to successfully compete, our business, financial condition, results of operations, and prospects could be materially and adversely affected.

Competitive solutions or other technological breakthroughs for the monitoring, treatment, or prevention of chronic conditions or technological developments may adversely affect demand for our programs.

Our ability to achieve our strategic objectives will depend, among other things, on our ability to develop and commercialize programs for the monitoring, treatment, and prevention of chronic conditions that offer distinct features, are easy-to-use, provide measurable and meaningful cost savings to customers and channel partners, and are more appealing than available alternatives. Our competitors, as well as a number of other companies, within and outside the healthcare industry, are pursuing new delivery devices, delivery technologies, sensing technologies, procedures, drugs, and other therapies and services for the monitoring, treatment, and prevention of chronic conditions. Any technological breakthroughs in monitoring, treatment, or prevention could reduce the potential market for our programs, which would significantly reduce our sales.

The introduction by competitors of solutions that claim to be superior to our programs may create market confusion, which may make it difficult for potential customers and channel partners to differentiate the benefits of our programs over competitive products. In addition, the entry of multiple new products may lead some of our competitors to employ pricing strategies that could adversely affect the pricing of our programs. If a competitor develops a product that competes with or is perceived to be superior to our programs, or if a competitor employs strategies that place downward pressure on pricing within our industry, our sales may decline significantly or may not increase in line with our forecasts, either of which would materially and adversely affect our business, financial condition, results of operations, and prospects.

The growth of our business relies, in part, on the growth and success of our customers and channel partners such as health plans, PBMs, and other resellers, and revenue from member enrollment, which are difficult to predict and are affected by factors outside of our control.

We enter into agreements with our customers and channel partners under which our fees are dependent in part upon the number of covered individuals that are enrolled in our programs each month. If the number of members covered for our programs by one or more of our customers or channel partners were to be reduced, such decrease would lead to a decrease in our revenue. The growth forecasts of our customers and channel partners are also subject to significant uncertainty and are based on assumptions and estimates that may prove o be inaccurate, and member enrollment in our programs could fail to grow at anticipated rates, or at all.

In addition, some fees are subject to repayment pursuant to performance guarantees if certain clinical outcomes or other performance criteria are not met, which in some cases depend on the behavior of our members, such as their continued engagement with our programs, and other factors not entirely within our control. These clinical performance guarantees vary by program and track outcomes that are relevant to the specific condition. For example, most clinical performance guarantees for our Omada for Prevention & Weight Loss program measure percentage weight loss; most clinical performance guarantees for Omada for Diabetes measure reduction in A1C; most clinical performance guarantees for Omada for Hypertension measure reduction in blood pressure; and most clinical performance guarantees for Omada for MSK measure cost savings associated with the program, reductions in a member's intent to seek surgery, or reductions in pain.

Additionally, we generally enter into non-exclusive agreements with our channel partners, including health plans, PBMs, and other resellers, which rely in part on their customer sales, which are affected by factors outside of our control. Where channel partners do offer our programs exclusively, those channel partners may nevertheless choose to terminate those agreements or choose to no longer offer our programs exclusively. If the number of customers represented by one or more of our channel partners were to be reduced by a material amount or if our channel partners were to refer their customers to our competitors, such decreases may lead to a decrease in our total number of customers, member enrollment rate, and in our revenue, which could materially and adversely affect our business, financial condition, results of operations, and prospects. In addition, growth forecasts of our channel partners are subject to significant uncertainty and are based on assumptions and estimates that may prove to be inaccurate.

If the number of individuals covered by employers, health plans, PBMs, health systems, government entities, or other existing or potential customers decreases, or the number of programs they cover decreases, our member enrollment may decline, and our revenue will likely decrease, which could materially and adversely affect our business, financial condition, results of operations, and prospects.

Our fees are generally dependent in part upon the number of covered individuals that are enrolled in our programs each month. Various factors may lead to a decrease in the number of individuals covered by our customers and channel partners and the number of programs they cover, including, but not limited to, the following:

- natural attrition of individuals covered by our customers;
- failure of our customers or channel partners to adopt or maintain effective business practices;
- changes in the nature or operations of our customers or channel partners;
- continued acceptance of our programs for existing and new chronic conditions by covered individuals;
- the timing of development and release of new programs;

- features and functionality that are lower-cost alternatives introduced by us or our competitors;
- government regulations, including the scope of government-sponsored healthcare;
- technological changes and developments within the markets we serve;
- changes in economic conditions; and
- changes in the prevalence of different types of chronic conditions.

If the number of individuals covered by employers, health plans, PBMs, health systems, government entities, or other existing or potential customers decreases, or the number of programs they cover decreases, for any reason, our member enrollment may decline. We also seek to collect member cost-sharing amounts, such as copayments, co-insurance, or deductibles, directly from some members in connection with our MSK program, which we may be unable to collect. Any of these events could cause our revenue to decrease, which could materially and adversely affect our business, financial condition, results of operations, and prospects.

Our revenue depends on member engagement in our programs and the clinical outcomes and cost savings of our offerings, and our failure to achieve and maintain meaningful member engagement, clinical outcomes, and/or cost savings could materially and adversely affect our business, financial condition, results of operations, and prospects.

Member engagement in our programs and the clinical outcomes and cost savings of our offerings affect the market acceptance and adoption of our programs. Most of our customers and channel partners pay fees to us based on member enrollment and/or engagement with our programs, and our contracts generally may provide that we are obligated to repay a portion of our fees if our programs fail to deliver certain member engagement, clinical outcomes, or cost savings. If we are unable to demonstrate positive clinical outcomes for our members, including if claims analyses or other studies fail to support the efficacy of our programs, we may receive less revenue from outcomes-based pricing models or be obligated to repay certain fees under our service-level agreements or performance guarantees, and existing and potential customers and channel partners may decide not to cover our programs at desirable prices or at all. In many cases, we incur high upfront costs to secure customers and channel partners, implement our programs, enroll members, and deliver our programs to those members, and our ability to recover those costs over time depends on sustained member engagement, positive clinical outcomes, and meaningful cost savings. As we scale delivery of our programs, we may experience difficulty in achieving and maintaining desired levels of member engagement, clinical outcomes, and cost savings for our customers and channel partners, and, as a result, our past performance may not be indicative of our ability to achieve positive member engagement, clinical outcomes, and cost savings in future periods. We assume the risk that the cost of providing our programs will exceed the compensation we receive. If we fail to achieve or maintain meaningful member engagement, clinical outcomes, and cost savings for our customers and channel partners, our business, financial condition, results of operations, and prospects could be materially and adversely affected.

We incur significant upfront costs in establishing and expanding our relationships with employers, health plans, PBMs, health systems, government entities, and other existing and potential customers and channel partners, and if we are unable to maintain and grow these relationships over time, we are likely to fail to recover these costs, which could have a material adverse effect on our business, financial condition, results of operations, and prospects.

We devote significant resources to establish and expand upon our relationships with employers, health plans, PBMs, health systems, government entities, and other existing and potential customers and channel partners to offer and implement our programs. This is particularly so in the case of large organizations, including health plans and PBMs, and government entities, that often request or require specific features, functions, or integrations unique to their particular business processes. Accordingly, our results of operations will depend in substantial part on our ability to enroll individuals covered by our customers and channel partners to participate in our programs, deliver a successful experience for customers, channel partners, and members, and persuade existing and potential customers and channel partners to maintain and grow their relationship with us over time. Additionally, as our business grows, our costs in acquiring customers and channel partners could outpace our build-up of recurring revenue, and we may be unable to reduce our total operating costs through economies of scale such that we are unable to achieve profitability. If we fail to achieve appropriate economies of scale, if our investments in these relationships fail to materialize, or if we fail to manage or anticipate the evolution and demand of our billing model, our enrollment rate may decrease, and our business, financial condition, results of operations, and prospects could be materially and adversely affected.

We incur significant upfront costs in establishing our relationships with members, and if we are unable to maintain member engagement over time, we are likely to fail to recover these costs, which could have a material adverse effect on our business, financial condition, results of operations, and prospects.

We devote significant resources to securing access to customers, channel partners, and their covered individuals, informing covered individuals that our programs are available to them, and enrolling covered individuals as members in our programs. We also incur significant upfront costs in providing devices and supplies to members upon enrollment in our programs. Accordingly, our results of operations and prospects will depend in substantial part on our ability to deliver a successful experience for members and maintain member engagement over time. Additionally, as our business grows, our upfront member acquisition and enrollment costs could outpace our build-up of recurring revenue, and we may be unable to reduce our total operating costs through economies of scale such that we are unable to achieve profitability. If we fail to achieve appropriate economies of scale, fail to maintain sufficient member engagement, or fail to manage or anticipate the evolution and demand of our billing model, our business, financial condition, results of operations, and prospects could be materially and adversely affected.

A substantial portion of our sales comes from or through a limited number of customers and channel partners that operate as resellers.

Historically, we have relied on a limited number of customers, including employers, health plans, PBMs, health systems, government entities, and other entities that pay for the cost of our programs, and channel partners, including health plans and PBMs, for a substantial portion of our total sales. Our customers include employers that cover our programs for their employees and their dependents and health systems that cover our programs for patients, among other types of customers. In addition, our channel partners, which include certain of the health plans, PBMs, and other entities that we work with, operate as resellers of our programs to their employer customers or other end customers. Some of the health plans and PBMs we work with as channel partners also cover our programs directly, for a portion of their own members, as our customers. Sales from or through our top five health plan and PBM partners, including any sales to these entities as customers and sales through these entities as channel partners, represented 76% and 69% of our revenue for the three months ended June 30, 2025 and 2024, respectively, and 75% and 68% of our revenue for the six months ended June 30, 2025 and 2024, respectively. As of and for the three months ended June 30, 2025, we had one health plan or PBM that accounted for 27% of our accounts receivable, net and 32% of our revenue, and a second health plan or PBM that accounted for 19% of our accounts receivable, net and 33% of our revenue. For the six months ended June 30, 2025, we had one health plan or PBM that accounted for 31% of our revenue, and a second health plan or PBM that accounted for 32% of our revenue, As of and for the three months ended June 30, 2024, we had one health plan or PBM that accounted for 29% of our accounts receivable, net and 37% of our revenue, and a second health plan or PBM that accounted for 28% of our accounts receivable, net and 18% of our revenue. For the six months ended June 30, 2024, we had one health plan or PBM that accounted for 37% of our revenue, and a second health plan or PBM that accounted for 18% of our revenue. Each of these health plans or PBMs are affiliates of The Cigna Group. In general, our customers and channel partners work with us on a non-exclusive basis. If we are unable to establish, maintain, or grow these relationships over time or if customers or channel partners refer business to our competitors instead, we are likely to fail to recover these costs and our results of operations and prospects will suffer. The loss of any of our key customers or channel partners could negatively impact our revenue as we work to obtain new customers or establish replacement channel partner relationships. Contracts with our key customers and channel partners may be terminated before their term expires for various reasons, subject to certain conditions. For example, most of our contracts are terminable for convenience by our customers and channel partners, subject to a notice period. Certain contracts may be terminated immediately by the customer or channel partner if we go bankrupt, if we lose applicable licenses or are suspended or debarred from participation in government-funded healthcare programs, or if we fail to comply with certain specified laws.

We could also lose customers if those customers contract for our programs through a health plan or other channel partner and subsequently elect to migrate to a new health plan or channel partner with which we do not have an existing contractual relationship for certain programs or at all or are not able to establish a new contractual relationship. Additionally, mergers and acquisitions involving us, our customers, our channel partners, or their competitors could lead to cancellation or non-renewal of our contracts with those customers or channel partners or by the acquiring or combining companies, thereby reducing the number of our existing and potential customers, channel partners, and members. Acquisitions involving our customers or channel partners could also lead to a loss of customers, channel partners, or members if we are not contracted, or are unable to obtain a contract, with the acquiring company or its benefit providers or channel partners. In order to grow our business, we anticipate that we will continue to depend on our relationships with third parties, including our channel partners. Identifying channel partners and negotiating and documenting relationships with them requires significant time and resources. Our competitors may be effective in providing incentives to third parties to favor their products or services or to prevent or reduce enrollments in, or utilization of, our programs. If we are unsuccessful in establishing or maintaining our relationships with third parties, our ability to compete in the marketplace or to grow our revenue could be impaired, and our results of operations and prospects may suffer. Even if we are successful, these relationships may not result in increased use of our programs by customers, channel partners, or members or increased revenue.

If we are unable to attract new customers and channel partners and increase member enrollment from new and existing customers and channel partners, our revenue growth could be slower than we expect, and our business may be adversely affected.

We generate, and expect to continue to generate, revenue from member enrollment and engagement in our programs. As a result, widespread acceptance and use of virtual-first care for chronic conditions in general, and our platform in particular, is critical to our future growth and success. If the market fails to grow or grows more slowly than we currently anticipate, demand for our programs could be negatively affected.

Our ability to achieve significant growth in revenue in the future will depend, in large part, upon our ability to attract new customers and channel partners. If we fail to attract new customers and channel partners and fail to maintain and expand new relationships, our revenue may grow more slowly than we expect, may not grow at all, or may decline, and our business may be adversely affected. Once we enter into an agreement with a customer or channel partner, our revenue will depend on the number of covered individuals we successfully enroll as members and their ongoing engagement in the programs. Demand for virtual-first care for chronic conditions in general, and our platform in particular, is affected by a number of factors, many of which are beyond our control. Some of these potential factors include:

- awareness of our programs and the adoption of technology in healthcare generally;
- availability of products and services that compete with ours;
- ease of adoption and use;
- features and program experience;
- performance;
- brand;
- data privacy and cybersecurity; and
- pricing.

Our future revenue growth also depends upon increasing member enrollment with existing customers and channel partners. If we are not successful in increasing member enrollment in the programs currently contracted for by our customers and channel partners (or future programs our customers or channel partners contract for over time), or if our customers or channel partners do not renew their agreements or renew their agreements with us at lower prices or on less favorable terms, our revenue may grow more slowly than expected, may not grow at all, or may decline.

Customer and channel partner renewals may decline or fluctuate as a result of a number of factors, including the breadth of early deployment of our programs, meaningful reductions in our customers' spending levels, changes in their business models and use cases, the actual or perceived clinical outcomes or cost savings of our programs, satisfaction or dissatisfaction with our programs among our customers and channel partners, our pricing or pricing structure, the pricing or capabilities of products or services offered by our competitors, or the effects of economic conditions. Any prolonged shutdown of a significant portion of global economic activity or a downturn in the global or domestic economy, including as a result of a pandemic or public health threat (such as the COVID-19 pandemic), would adversely affect the industries in which our customers and channel partners operate, which could adversely affect their willingness or ability to renew their agreements with us. If our customers or channel partners do not renew their agreements with us, or renew on terms less favorable to us, our revenue may decline.

Potential members' failure to enroll after a customer or channel partner enters into an agreement with us could materially and adversely affect our business, financial condition, results of operations, and prospects.

We believe our future success will depend in part on our ability to increase both the speed and success of member enrollment, by improving our member outreach, engagement, and enrollment methodology, hiring and training qualified professionals, and increasing our ability to integrate into large-scale, complex technology environments. In some cases, customers and channel partners initially enter into an agreement with us for one or more of our programs, but, for a variety of potential reasons, covered individuals fail to ultimately enroll at the expected volume. For example, the conditions that our programs address may be less prevalent among the covered individuals than we expect and/or our customers and channel partners may provide limited contact information for outreach campaigns or otherwise not adequately enable or permit outreach campaigns to covered individuals generally or at our preferred timing. In addition, we rely on email outreach to enroll covered individuals, and from time to time, the interfaces, features, or policies of email applications, email service providers, mobile device operating systems, or other relevant software are altered or updated, which may adversely impact our ability to effectively reach covered individuals to facilitate their enrollment, and as a result, could materially and adversely affect member enrollment rates. For these and other reasons, our forecasts may not accurately estimate enrollment rates or the number of enrolled members. For additional information on the assumptions we rely on to anticipate expected growth for our business and revenue, see the risk factor titled "*The market for our programs is new, rapidly evolving, and increasingly competitive, as the healthcare industry in the U.S. is undergoing significant structural change, which makes it difficult to forecast demand for our programs*." If we are unable to achieve the expected volume of member enrollment, or unable to do so in a timely manner, customers and channel partners are unlikely to renew their agreements with us and/or expand their agreements with us to include additional programs, and we would not be able to generate future revenue from those relationships, and our business, financial condition, results of operations, and prospects could be materially and adversely affected.

If our customers or channel partners are unwilling or unable to conduct or enable outreach campaigns directed at covered individuals, we may not enroll members at the rates we expect, which may adversely affect our business, financial condition, results of operations, and prospects.

We rely largely on information supplied by our customers and channel partners to conduct outreach campaigns directed at covered individuals, and though we often assist with these outreach campaigns, we do not control our customers' or channel partners' enrollment outreach schedules. As a result, if they are unwilling or unable to supply information needed for outreach campaigns or are unwilling or unable to enable outreach campaigns generally, or if enrollment launch dates are delayed, we could fail to meet our enrollment and revenue expectations, which may adversely impact our business, financial condition, results of operations, and prospects.

The size of the addressable markets for our programs are estimates and may be smaller than we believe.

Our estimate of the total addressable market for our programs is based on a number of internal and third-party estimates. While we believe these factors have historically provided and may continue to provide us with effective tools in estimating the total market for prediabetes and diabetes, hypertension, musculoskeletal conditions, and our programs, these estimates may not be correct, and the conditions supporting our estimates may change at any time, thereby reducing the predictive accuracy of these underlying factors. As a result, our estimates of the total addressable market for our programs may prove to be incorrect. In addition, changes in underlying causes or risk factors for the conditions that our programs address, such as the impact of GLP-1 drugs on obesity, could impact our estimates of the total addressable market. If the actual number of members who would benefit from our programs and the total addressable market for our programs is smaller than we have estimated, our future growth could be adversely impacted.

We will need to increase the size of our organization, including our Care Teams, and we may experience difficulties in managing growth and attracting talent. A deterioration in our relationships with our employees and other service providers could have an adverse impact on our business.

As of June 30, 2025, we employed 859 full-time employees, which includes our health coaches and other Care Team members as well as individuals across sales and marketing, research and development, and general and administrative functions. In the future, we expect to expand our managerial, clinical, scientific, technological, operational, finance, and other resources in order to manage our operations and continue our program development activities. Our management and personnel, systems, and facilities currently in place may not be adequate to support this future growth. In particular, we rely in large part on our Care Teams for the delivery of our programs, and we may be unable to scale our Care Teams efficiently to manage costs through economies of scale due to limitations on the number of members that our Care Teams are able to support. If we fail to do so, we may incur significant costs, which could have a material adverse effect on our business, financial condition, results of operations, and prospects, and negatively impact our ability to achieve or maintain profitability in the future.

Our need to effectively execute our growth strategy requires that we efficiently identify, recruit, retain, incentivize, and integrate additional talent, and maintaining good relationships with our employees and other service providers is crucial to our operations. Our employees may attempt to unionize, which could limit our ability to manage our workforce effectively, cause disruptions to our operations, including as a result of strikes, work stoppages, or other labor disputes, and otherwise materially and adversely affect our business, financial condition, results of operations, and prospects.

If the shift by companies to adopt business models billed based on enrollments, engagement, and/or outcomes, and, in particular, the market for our programs, develops more slowly than we expect, our growth may slow or stall, and our business, financial condition, results of operations, and prospects could be materially and adversely affected.

Our success depends on companies shifting to business models billed based on enrollments, engagement, and/or outcomes and choosing to adopt healthcare products and services through such models. The adoption of these types of health management programs is still relatively new, and enterprises may choose not to shift their business models or, if they do, may decide that they do not need a healthcare solution that offers the range of services that we offer. Accordingly, it is difficult to predict adoption rates and demand for our programs, the future growth rate and size of our market, or the entry of competitive solutions. Factors that may affect market acceptance of our programs include:

- the number of companies shifting to these business models;
- the number of consumers and businesses adopting new, flexible ways to consume products and services;
- our success in informing covered individuals that our programs are available to them and the number of covered individuals that choose to enroll in our programs;
- the security capabilities, reliability, and availability of cloud-based services;
- concerns from customers, channel partners, or members with entrusting a third party to store and manage their data, especially health-related, confidential, or sensitive data;
- our ability to minimize the time and resources required to launch our programs;
- our ability to maintain member engagement and high levels of member satisfaction;
- our ability to provide measurable and meaningful cost savings to existing and potential customers and channel partners;
- our ability to deliver upgrades and other changes to our programs without disruption to our customers, channel partners, or members;
- the level of customization or configuration we offer within our programs; and
- the price, cost-savings, performance, and availability of competing products and services.

The markets for products and services billed based on enrollments, engagement, and/or outcomes generally, and for solutions for chronic conditions in particular, may not develop further or may develop more slowly than we expect. If companies do not shift to these business models and these health management tools do not achieve widespread adoption, or if there is a reduction in demand for these types of products and services or health management tools due to technological challenges, weakening economic conditions, data privacy or cybersecurity concerns, decreases in corporate spending, a lack of acceptance among prospective members, or otherwise, our business, financial condition, results of operations, and prospects could be materially and adversely affected.

Our programs may result in member harm or injury.

Our programs are designed under the oversight of qualified healthcare professionals, and we train our Care Teams to comply with appropriate standards and protocol for delivery of care and the recognition and management of escalation events. Our success depends in part on the ability of our healthcare professionals to obtain and maintain all necessary licenses, certifications, permits, and other approvals, and to provide services to members in compliance with applicable laws, including scope of practice laws, as well as our policies. Nevertheless, if future results or experience indicate that our programs cause unexpected or serious complications or other unforeseen negative effects, our members may seek significant compensation from us or our affiliated professional entities or cease using our platform and programs, or our customers or channel partners could cease doing business with us. We may also be contractually required to indemnify and hold harmless third parties, such as customers or channel partners, from the costs of member harm or injury. There can be no assurance that provisions typically included in our terms with members or in our agreements with our customers and channel partners that attempt to limit exposure to legal claims would be enforceable or adequate or would protect us or our affiliated professional entities from liabilities or damages. Even if a claim is not successful, any claim brought against us or our affiliated professional entities would likely be time-consuming and costly to defend and could seriously damage our reputation and brand, our business, or the business of our affiliated professional entities. In addition, we may not carry insurance sufficient to compensate us for any losses that may result from such claims. As a result, we or our affiliated professional entities could face significant legal liability or harm to our or our affiliated professional entities' reputation, business, financial condition, results of operations, and prospects.

Any disruption of service at our third-party data centers and hosting providers, including Amazon Web Services, or at software-as-a-service ("SaaS") companies or other vendors could interrupt or delay our ability to deliver our programs to our customers, channel partners, and members and harm our business, financial condition, results of operations, and prospects.

We currently host our platform, serve our customers, channel partners, and members, and support our operations primarily from third-party data centers and hosting providers, including Amazon Web Services ("AWS"), a provider of cloud infrastructure services, and we also rely on other services provided by SaaS companies and other vendors. We expect this dependence on third parties to continue. We do not have control over the operations of the facilities of our data center providers or hosting providers, including AWS, SaaS companies, or other vendors. These facilities are vulnerable to damage or interruption from earthquakes, hurricanes, floods, fires, cyberattacks, terrorist attacks, power losses, telecommunications failures, public health emergencies, and similar events. The occurrence of a natural disaster or an act of terrorism, a decision to close the facilities without adequate notice, or other unanticipated problems could result in lengthy interruptions in our ability to deliver our programs. The facilities also could be subject to break-ins, computer viruses, sabotage, intentional acts of vandalism, and other misconduct. The continued and uninterrupted performance of our programs and connected devices provided in connection with our programs is critical to our success. We may experience material interruptions, disruptions, outages, and other performance problems to our systems as a result of third-party data centers and hosting providers, including AWS, SaaS companies, or other vendors. Because our programs are used by our members to manage chronic conditions, it is critical that our programs and related connected devices be accessible without significant interruption or degradation of performance. Members may become dissatisfied by any system failure that interrupts our ability to provide our programs to them or that impacts the functionality of the connected devices provided in connection with our programs. Outages could lead to the triggering of our service-level agreements or performance guarantees and the issuance of repayments to our customers and channel partners, in which case, we may not be fully indemnified for such losses pursuant to our agreement with AWS, SaaS providers, or other vendors. We may not be able to easily switch our AWS operations to another cloud provider if there are disruptions or interference with our use of AWS. Sustained or repeated system failures would reduce the attractiveness of our programs to customers, channel partners, and members and result in contract terminations, thereby reducing revenue and harming our business, financial condition, results of operations, and prospects. Moreover, negative publicity arising from these types of disruptions could damage our reputation and may adversely impact use and adoption of our programs. We may not carry sufficient business interruption insurance to compensate us for losses that may occur as a result of any events that cause interruptions in our ability to deliver our programs. To the extent we do not effectively respond to any such interruptions, upgrade our systems as needed, and continually develop our technology and network architecture to accommodate traffic, our business, financial condition, results of operations, and prospects could be materially and adversely affected. Furthermore, our disaster recovery systems and those of third parties with which we do business may not function as intended or may fail to adequately protect our critical business information in the event of a significant business interruption, which may cause cybersecurity breaches or the loss of data or functionality and could, in turn, lead to a material adverse effect on our business, financial condition results of operations, and prospects.

Our third-party data center and hosting providers, including AWS, SaaS providers, and other vendors do not have an obligation to renew their agreements with us on commercially reasonable terms, or at all. If we are unable to renew our agreements with these providers on commercially reasonable terms, if our agreements with our providers are prematurely terminated, or if in the future we add additional data center or hosting providers, we may experience costs or downtime in connection with the transfer to, or the addition of, new providers. If these providers were to increase the cost of their services, we may have to increase the price of our programs, and our business, financial condition, results of operations, and prospects could be harmed.

We depend on a limited number of third-party suppliers for certain devices and other supplies that we deliver to members in connection with our programs, for cellular device connectivity, and for certain complementary healthcare services provided by external partners, such as prescriptions or physician referrals, and the loss of any of these suppliers or partners, or their inability to support our required volume, could materially and adversely affect our business, financial condition, results of operations, and prospects.

Most of our contracts with customers and channel partners require that we deliver certain connected devices and other supplies to new members within a certain period of time, and certain of our contracts also provide that we will coordinate with external partners for certain healthcare services complementary to our programs, such as certain prescriptions or physician referrals. If we are unable to meet these obligations, our customers and channel partners may decide to terminate their contracts.

We rely on a limited number of suppliers for devices and supplies that we deliver in connection with our programs, including wireless scales, blood pressure monitors, blood glucose monitors, and other supplies, and a limited number of third parties for cellular device connections. We utilize a single supplier and exclusive partner for continuous glucose monitors provided in Omada for Diabetes and work with a single distributor for delivery of the continuous glucose monitors. We also rely on a limited number of external partners to supply certain healthcare services complementary to but not included in our programs, such as prescriptions for continuous glucose monitors or physician referrals to physical therapy, where required.

For our business strategy to be successful, our suppliers and partners must be able to provide us with devices, supplies, connectivity, and services in sufficient quantities, in compliance with regulatory requirements and quality control standards, in accordance with agreed-upon specifications, at acceptable costs, and on a timely basis. Increases in our program sales, whether forecasted or unanticipated, could strain the ability of our suppliers and partners to deliver an increasingly large supply of devices, supplies, connectivity, or services in a manner that meets these various requirements. Our suppliers and partners may encounter problems that limit their ability to supply products, supplies, and services for us, or that result in increases in the prices they charge us for such products, supplies, and services, including financial difficulties, labor shortages, the imposition of new trade protection measures, such as tariffs and other duties, and shutdowns related to epidemics, pandemics, or other health crises, and, for our device and supply partners, shipping delays, damage to their manufacturing equipment or facilities, or challenges with establishing and operating new facilities in new jurisdictions. Quality or performance failures of these devices, supplies, connectivity, or services or changes in our partners' financial or business condition could disrupt our ability to supply quality devices and supplies to our members or to connect them to quality services, which could have a material adverse effect on our business, financial condition, results of operations, and prospects.

We are dependent on a limited number of third-party manufacturers and suppliers who operate in international markets, which exposes us to foreign operational and political risks that may harm our business.

We rely on a limited number of manufacturers and suppliers for devices and supplies that we deliver in connection with our programs, including wireless scales, blood pressure monitors, blood glucose monitors, and other supplies, and, among other things, certain of the technology and raw materials used in the manufacturing of those devices and supplies. Most of the devices and supplies delivered in connection with our programs are currently manufactured in China and may be manufactured in other international markets in the future. Our reliance on an international supply chain exposes us to risks and uncertainties, including:

- controlling quality of supplies;
- trade protection measures, such as tariffs and other duties, especially in light of previous and potential future actions by the Trump Administration signaling more aggressive trade policies, which could exacerbate trade disputes between the U.S. and several foreign countries, including China, as well as sanctions and export control measures targeting certain countries, and increases in the prices of devices and supplies delivered in connection with our programs;
- political, social, and economic instability;
- the outbreak of contagious diseases, such as COVID-19;
- laws and business practices that favor local companies;
- interruptions and limitations in telecommunication services, shipping services, or logistics;
- product or material delays or disruption;
- import and export license requirements and restrictions;
- difficulties in the protection of intellectual property;
- exchange controls, currency restrictions, and fluctuations in currency values; and
- potential adverse tax consequences.

If any of these risks were to materialize, our third-party manufacturers and suppliers may be unable to provide the devices and other supplies in the required amounts or at the contracted cost. As a result, we may need to contract with new manufacturers and suppliers, which could increase our costs and delay the delivery of devices and other supplies to our members. Our contracts with customers and channel partners generally provide that we will deliver devices and supplies to members at the beginning of their participation in our programs, and any failure to do so could materially and adversely affect our business, financial condition, results of operations, and prospects.

If manufacturers and suppliers are unable to procure raw materials or semi-finished products or to produce the devices provided in connection with our programs, our business may suffer.

If the suppliers or third-party manufacturers of the devices provided in connection with our programs experience shortages, limited access to, or increased costs of certain raw materials and other semi-finished or finished goods, it may result in production delays or delays in deliveries to members of the connected devices and other supplies provided in connection with our programs. Production by one or more manufacturers or suppliers may be suspended or delayed, temporarily or permanently, due to economic or technical problems such as the insolvency of the manufacturer, the failure of the manufacturing facilities, or disruption of the production process, all of which are beyond our control. Any shortage, delay, or interruption in the availability of the connected devices and supplies provided in connection with our programs may negatively affect our ability to meet demand. As a result, our business may be unable to offer a satisfactory experience to customers, channel partners, and members, which could have a material adverse effect on our business, financial condition, results of operations, and prospects.

We experience seasonality in our business, which may cause fluctuations in our financial results.

Historically, we have experienced, and expect to continue to experience, seasonality in our business, with a higher number of closed sales in the late spring and early fall and higher enrollment launch rates in the first and second quarters of the year. We believe that this results in part from the timing of open enrollment periods of many of our customers. We may be affected by seasonal trends in the future, particularly as our business matures. These effects may become more pronounced as we target larger organizations with larger budgets for use of our programs. These factors may contribute to substantial fluctuations in our quarterly results of operations. Because of these fluctuations, among other factors, it is possible that in future periods our results of operations will fall below the expectations of securities analysts or investors, in which case the market price of our common stock would likely decrease. These fluctuations, among other factors, also mean that our results of operations in any particular period may not be relied upon as an indication of future performance.

We or the third parties upon whom we depend may be adversely affected by natural disasters and other catastrophic events, and our business continuity and disaster recovery plans may not adequately protect us from a serious natural disaster or other catastrophic event. Any interruption in our operations or the operations of third parties who supply the devices and other supplies provided in connection with our programs, connectivity of those devices, or services complementary to our programs may have a material adverse effect on our business, financial condition, results of operations, and prospects.

Severe weather, natural disasters, and other catastrophic events, including pandemics or other public health crises (such as the COVID-19 pandemic), earthquakes, tsunamis, hurricanes, floods, fires, explosions, accidents, power outages, cyberattacks, telecommunications failures, mechanical failures, unscheduled downtimes, civil unrest, strikes, transportation interruptions, unpermitted discharges or releases of toxic or hazardous substances, other environmental risks, wars or other conflicts (including wars in Ukraine and the Middle East), sabotage, terrorist attacks, or other intentional acts of vandalism or misconduct could severely disrupt our operations, or the operations of third parties who supply the devices and other supplies provided in connection with our programs, connectivity of those devices, or services complementary to our programs, and have a material adverse effect on our business, financial condition, results of operations, and prospects.

If a natural disaster or other catastrophic event occurs that prevents us or third-party suppliers from using all or a significant portion of our or their headquarters or other facilities, that damages critical infrastructure, such as our enterprise financial systems or manufacturing resource planning and enterprise quality systems, or that otherwise disrupts operations, it may be difficult or, in certain cases, impossible, for us to continue our business for a substantial period of time. A mechanical failure or disruption affecting any major operating line may result in a disruption to our ability to supply customers, channel partners, and members, and standby capacity may not be available. The disaster recovery and business continuity plans we have in place currently are limited and are unlikely to prove adequate in the event of a serious disaster or similar catastrophic event. The potential impact of any disruption would depend on the nature and extent of the damage caused by a disaster. We may incur substantial expenses as a result of the limited nature of our disaster recovery and business continuity plans, which, particularly when taken together with our lack of earthquake insurance, could have a material adverse effect on our business, financial condition, results of operations, and prospects.

Our corporate headquarters has historically been located in the San Francisco Bay Area, which has experienced both severe earthquakes and wildfires. We do not carry earthquake insurance. Furthermore, integral parties in our supply chain are similarly vulnerable to natural disasters or other sudden, unforeseen, and severe adverse events. If such an event were to affect our supply chain, it could have a material adverse effect on our business, financial condition, results of operations, and prospects.

We are subject to a number of risks related to the credit card and debit card payments we accept.

We accept payments from a limited number of members who pay member cost-sharing amounts, such as copayments, deductibles, or co-insurance, for our programs and pay those amounts through credit and debit card transactions. We receive these payments through third-party providers, which subjects us to compliance with the rules of the payment card networks (including the payment card industry data security standards) and laws and regulations governing electronic funds transfers, which could change or be reinterpreted to make it more difficult for us to comply. Although we primarily rely on these third-party providers for payment processing, to the extent a data breach of payment data occurs on our or their systems, we may be liable for significant costs incurred by customers, channel partners, banks, and other third parties or subject to fines and higher transaction fees, or our ability to accept or facilitate certain types of payments may be impaired. In the event of any fraud, if we fail to adequately control fraudulent transactions, we may face civil liability, diminished public perception of our security measures, and significantly higher payment-related costs, each of which could have a material adverse effect on our business, financial condition, results of operations, and prospects.

Any failure on our part to comply fully with the foregoing laws, rules, and regulations also may subject us to fines, penalties, damages, and civil liability, and may result in the loss of our ability to accept credit and debit card payments. Further, there is no guarantee that such compliance will prevent illegal or improper use of our payment systems or the theft, loss, or misuse of data pertaining to bank accounts, credit and debit cards, card holders, and transactions.

We use AI and machine learning to operate certain features of our programs and to enable certain business processes, which due to a changing regulatory landscape, could adversely affect our business, financial condition, and results of operations.

We use AI, machine learning, and automated decision-making technologies, including AI and machine learning algorithms and models (collectively, "AI technologies"), to generate and surface insights to our Care Teams as part of our efforts to increase their efficiency and productivity and to power certain member-facing features of our programs intended to deliver only educational resources, recommendations, or support, in each case, for maintaining or encouraging a healthy lifestyle. We anticipate making significant investments to continuously improve our use of such technologies. There are significant risks involved in the development and deployment of AI technologies, and there can be no assurance that our or our third-party service providers' or partners' use of these technologies will perform as expected, enhance our products or services, or be beneficial to our business, including our efficiency or profitability. For example, the continued use of any AI technologies in our products and services, or those of our third-party service providers and partners, may give rise to risks related to, among other things, inaccurate, biased, or harmful recommendations, data privacy, confidentiality, cybersecurity and data provenance concerns, new or enhanced governmental or regulatory scrutiny, litigation or other legal liability, ethical concerns, negative perceptions as to AI among customers, channel partners, or members, and other complications that could erode confidence in our brand, harm our reputation, and adversely affect our business, financial condition, results of operations, and prospects. While we have instituted policies applicable to our Care Teams and other employees and consultants that govern the development and use of AI, these individuals may breach or violate the terms of these policies and we may not have adequate remedies for any such breach or violation. Further, our ability to continue to develop or use such technologies may be dependent on access to specific third-party software and infrastructure, such as processing hardware or third-party AI technologies, and we cannot control the availability or pricing of such third-party software and infrastructure, especially in a highly competitive environment. In addition, market acceptance and consumer perceptions of AI technologies is uncertain.

We face significant competition from other companies with respect to utilizing AI technologies. To the extent AI technology development and utilization from our industry competitors proves to be successful, or more successful than our approach, demand for our programs, and thus our business, could be adversely affected. If we cannot develop, offer, or deploy new AI technologies as effectively, as quickly, and/or as cost-effectively as our competitors, or if we cannot access the infrastructure needed to continue our development, our operating results, relationships with customers and channel partners, and growth could be materially and adversely affected.

The rapid evolution of AI technologies will require the application of resources to develop, test, maintain, and improve our programs to help ensure that the AI technologies are, and remain, accurate and efficient. We expect our AI technology initiatives will over time require increased investment in technology infrastructure and may require additional specialized headcount. The continuous development, testing, maintenance, and deployment of our AI technologies may also increase the cost profile of our offerings and may involve unforeseen difficulties including material performance problems, undetected defects, or errors. We may encounter technical obstacles, and it is possible that we may discover additional problems that may prevent our AI technologies from operating properly, which could adversely affect our business.

The regulatory framework for AI is rapidly evolving, and many federal, state, and foreign governmental bodies and agencies have introduced and/or are currently considering additional laws and regulations. The Trump Administration has rescinded an executive order relating to the safe and secure development and deployment of AI technologies that was previously implemented by the Biden Administration. The Trump Administration then issued a new executive order that, among other things, requires certain agencies to develop and submit to the President action plans to "sustain and enhance America's global AI dominance," and to specifically review all rulemaking taken pursuant to the rescinded Biden executive order and, if possible, rescind any such rulemaking to the extent it is inconsistent with, or presents a barrier to, the Trump Administration's new executive order. Thus, the Trump Administration may continue to rescind other existing federal orders and/or administrative policies relating to AI technologies or may implement new executive orders and/or other rulemaking relating to AI technologies in the future. Any such changes at the federal level could require us to expend significant resources to modify our programs, services, or operations to ensure compliance or remain competitive. U.S. legislation related to AI technologies has also been introduced at the federal level and is advancing at the state level. For example, the California Privacy Protection Agency is currently in the process of finalizing regulations under the California Consumer Privacy Act, as amended by the California Privacy Rights Act of 2018 (collectively, the "CCPA"), regarding the use of automated decision-making and providing disclosures to consumers regarding such use. California also enacted several new laws in 2024 that further regulate use of AI technologies and provide consumers with additional protections around companies' use of AI technologies, such as requiring companies to disclose certain uses of generative AI. Other states have also passed AI-focused legislation, such as Colorado's Artificial Intelligence Act, which will require developers and deployers of "high-risk" AI systems to implement certain safeguards against algorithmic discrimination, and Utah's Artificial Intelligence Policy Act, which establishes disclosure requirements and accountability measures for the use of generative AI in certain consumer interactions. New laws, rules, directives, and regulations governing AI technologies and changes to existing ones may adversely affect the ability of our business to use or rely on certain AI technologies. Implementation standards and enforcement practice are likely to remain uncertain for the foreseeable future, and we cannot yet determine the impact future laws, regulations, standards, or perception of their requirements may have on our programs and our business. We may not always be able to anticipate how to respond to these new or updated laws or regulations, and they may affect our ability to use AI technologies. Further, the cost to comply with such laws or regulations, or decisions and/or guidance interpreting existing laws, including the redesign of our platform or programs to achieve compliance, could be significant and could increase our operating expenses, and we may be at increased risk of claims against us. Any actual or perceived failure to comply with evolving regulatory frameworks around the development and use of AI technologies could materially and adversely affect our brand, reputation, business, financial condition, results of operations, and prospects.

If we fail to attract and retain senior leadership and key clinical, scientific, and technology employees and other service providers, our business may be materially and adversely affected.

Our success depends in part on our continued ability to attract, retain, and motivate highly qualified leadership and clinical and scientific talent. We are highly dependent upon our senior leadership, particularly our Co-Founder and Chief Executive Officer, Sean Duffy, our President, Wei-Li Shao, and our Chief Financial Officer, Steve Cook, as well as our senior clinical, scientific, and technology employees and other service providers and other members of our senior management team. Mr. Duffy, Mr. Shao, Mr. Cook, and other members of our senior management team are at-will employees, which means that they could resign or be terminated for any reason at any time. The unplanned loss of the services of any of our members of senior leadership could materially and adversely affect our business until a suitable replacement can be found, which may not be immediate and could require us to expend significant resources.

Competition for qualified talent in the digital health field in general is intense due to the limited number of individuals who possess the training, skills, and experience required by our industry. In addition, our future growth and success also depend on our ability to attract, recruit, develop, and retain skilled managerial, clinical, scientific, sales, administration, operating, and technical employees and other service providers. We will continue to review, and where necessary, strengthen, our senior leadership as the needs of our business develop, including through internal promotion and external hires. However, there may be a limited number of persons with the requisite competencies to serve in these positions, and we cannot assure you that we would be able to locate or employ such qualified talent on terms acceptable to us, or at all. Therefore, the unplanned loss of one or more of our key employees or other service providers, or our failure to attract and retain additional key employees or other service providers, could have a material adverse effect on our business, financial condition, results of operations, and prospects. In addition, to the extent we hire talent from competitors, we may be subject to allegations that such employees or other service providers have divulged proprietary or other confidential information.

In addition, our success is dependent upon our continued ability to recruit and maintain the personnel for our member-facing Care Teams, composed of health coaches, relevant specialists, and licensed physical therapists. Our Care Teams are intended to remain with a member throughout their entire journey with Omada. If we are unable to recruit and retain Care Team personnel, our ability to provide continuity of care to our members may suffer, and our business may be adversely affected.

We rely largely on our direct sales force, and if we are unable to maintain or expand our sales force, it could impede our growth or harm our business.

We rely largely on our direct sales force to market and sell our products to customers and channel partners. We do not have any long-term employment contracts with the members of our direct sales force. Our results of operations are directly dependent upon the sales and marketing efforts of our sales and customer support teams. If our employees fail to adequately promote, market, and sell our products, our sales could significantly decrease. If our sales and marketing representatives fail to achieve their objectives, we may not enter into agreements with new customers or channel partners or maintain existing agreements, and member enrollment could decrease or may not increase at levels that are in line with our forecasts. As we launch new programs, expand our program offerings, and increase our marketing efforts with respect to existing programs, we will need to expand the reach of our marketing and sales networks. Our future success will depend largely on our ability to continue to hire, train, retain, and motivate skilled employees with significant technical knowledge in various areas. New hires require training and take time to achieve full productivity.

Additionally, other companies in our industry may rely predominantly or in part on third-party resellers or other distributors. Our direct sales force may subject us to higher fixed costs than those of any competitors that market their products through independent third parties, due to the costs associated with employee benefits, training, and managing sales personnel. As a result, we could be at a competitive disadvantage. Additionally, these fixed costs may slow our ability to reduce costs in the face of a sudden decline in demand for our programs, which could have a material adverse effect on our business, financial condition, results of operations, and prospects.

A decline in the prevalence of employer-sponsored healthcare could have a material adverse effect on our business, financial condition, results of operations, and prospects.

We currently derive a large portion of our revenue from our arrangements with customers that purchase healthcare for their employees (via insurance or self-funded benefit plans), either through direct contracts with us or through our relationships with our channel partners, including health plans, PBMs, and other resellers. These customers provide benefits for all or a portion of their employees who, in turn, may become eligible members. A large part of the demand for our programs among customers depends on the need of these employers to manage the costs of healthcare services that they pay on behalf of their employees. Various factors, including changes in the healthcare insurance market or in government regulation of the healthcare industry, could cause a decline in employer-sponsored healthcare, which could adversely affect the market for our programs and negatively affect our business and results of operations. Some experts have predicted that future healthcare reform will encourage employer-sponsored health insurance to become significantly less prevalent as employees migrate to obtaining their own insurance over state-sponsored insurance marketplaces. Other changes or developments in U.S. health insurance markets, including efforts to create a single-payer or government-run health insurance program, could also have a material adverse effect on our business, financial condition, results of operations, and prospects. If any of these changes were to occur, there is no guarantee that we would be able to compensate for the loss in revenue derived from customers by increasing member acquisition through other channels, and our business, financial condition, results of operations, and prospects could be materially and adversely affected.

Our sales and implementation cycle can be long and unpredictable and requires considerable time and expense. As a result, our sales and revenue are difficult to predict and may vary substantially from period to period, which may cause our results of operations to fluctuate significantly.

The timing of our sales and related revenue recognition is difficult to predict because of the length and unpredictability of our sales cycle, particularly with respect to large organizations and government entities. The sales cycle for our programs from initial contact with a potential customer or channel partner to member enrollment launch varies widely, ranging in some cases to over a year. Some of our customers and channel partners, especially in the case of large organizations and government entities, undertake a significant and prolonged evaluation process, including to determine whether our programs meet their unique healthcare needs, which frequently involves evaluation of not only our programs but also other available solutions, which results in extended sales cycles. Our sales efforts involve educating our customers and channel partners about the ease of use, technical capabilities, and potential benefits of our programs. During the sales cycle, we expend significant time and money on sales and marketing activities, which lowers our operating margins, particularly if no sale occurs. For example, there may be unexpected delays in the internal procurement processes of our customers and channel partners, particularly for some larger organizations and government entities for which our programs represent a small percentage of their total procurement activity. There are many other customer-specific factors that contribute to the timing of purchases and resulting timing of our revenue recognition, including the strategic importance of a particular project to a customer or channel partner, budgetary constraints, funding authorization, and changes in their personnel. In addition, the significance and timing of our program enhancements and the introduction of new products or solutions by our competitors may also affect purchases. Even if a customer or channel partner decides to purchase our programs, there are many factors affecting the timing of our recognition of revenue, which makes our revenue difficult to forecast. For example, once a customer or channel partner enters into an agreement with us, we work with them to identify the eligible population and then launch an enrollment process. Time from signing to launch typically takes an average of approximately three months. As part of the enrollment process, we incur significant expense explaining the benefits of our programs again to potential members to encourage them to enroll. We do not receive any payment from our customers or channel partners until members enroll and begin using our programs, which could be months following signing an agreement for our programs. Moreover, our contracts with customers and channel partners generally may provide that some fees are subject to repayment if certain clinical outcomes or other performance criteria are not met. For all of these reasons, it is difficult to predict whether a sale will be completed, the particular period in which a sale will be completed, the period in which revenue from a sale will be recognized, or the amount of revenue that we will ultimately recognize.

It is possible that in the future we may experience even longer sales cycles, more complex customer and channel partner needs, higher upfront sales costs, and less predictability in completing some of our sales as we continue to expand our direct sales force and channel partner relationships, expand into new territories, and market additional programs to potential customers and channel partners. If our sales cycle lengthens or our substantial upfront sales and implementation investments do not result in sufficient sales to justify our investments, our revenue could be lower than expected, and it could have a material adverse effect on our business, financial condition, results of operations, and prospects.

Any failure to offer high-quality support for our customers, channel partners, and members may adversely affect our relationships with our existing and prospective customers, channel partners, and members and, in turn, our business, financial condition, results of operations, and prospects.

Our customers and channel partners, in implementing our programs, and our members, in using our programs, depend on our support teams to resolve issues in a timely manner. We may be unable to respond quickly enough to accommodate short-term increases in demand for support. We also may be unable to modify the nature, scope, and delivery of our programs or support for customers, channel partners, and members to compete with changes in solutions provided by our competitors. Increased demand for support could increase costs and adversely affect our financial condition, results of operations, and prospects. Our sales are highly dependent on our reputation and on positive recommendations from our existing customers, channel partners, and members. Any failure to maintain high-quality support, or a market perception that we do not maintain high-quality customer or member support, could adversely affect our reputation and our ability to sell our programs and, in turn, our business, financial condition, results of operations, and prospects.

If we fail to develop widespread brand awareness cost-effectively or are subject to widespread negative media coverage, our business may suffer.

We believe that developing and maintaining widespread awareness of our brand in a cost-effective manner is critical to achieving widespread adoption of our programs and attracting new customers, channel partners, and members. Our brand promotion activities may not generate awareness among customers, channel partners, or members or increase revenue, and even if they do, any increase in revenue may not offset the expenses we incur in building our brand. If we fail to successfully promote and maintain our brand, or incur substantial expenses in doing so, we may fail to attract or retain customers, channel partners, or members necessary to realize a sufficient return on our brand-building efforts or to achieve the widespread brand awareness that is critical for broad adoption of our programs.

In addition, unfavorable publicity regarding us or our management, our business, our programs, our peer reviewed publications or studies, the healthcare industry generally and/or virtual care providers specifically, litigation or regulatory activity, or our data privacy, cybersecurity, AI, or safety practices, or those of our business partners or other participants in our industry, could materially and adversely affect our reputation. For example, news media outlets may from time to time provide negative coverage regarding virtual care, including with respect to the effectiveness of virtual care programs. If public perception is influenced by claims that virtual care programs are not effective for treating chronic conditions, whether related to our programs or those of our competitors, our programs may not be accepted by potential customers, channel partners, or members. Moreover, negative publicity regarding the virtual care industry generally may result in increased regulation and legislative review of industry practices that further increase the costs of doing business. Any negative media coverage or public perceptions about us or our industry, regardless of the accuracy of such reporting or perceptions, may have an adverse impact on our business and reputation, as well as have an adverse effect on our ability to attract and retain customers, channel partners, members, or employees, and result in decreased revenue, which could materially and adversely affect our business, financial condition, results of operations, and prospects.

If we are not able to develop and release new programs and services or to develop and release successful enhancements to, new features for, and modifications to our existing programs, services, and platform, our business, financial condition, results of operations, and prospects could be materially and adversely affected.

The markets in which we operate are characterized by rapid technological change, frequent new product and service introductions and enhancements, changing demands from customers and channel partners, updates to clinical guidelines and best practices, and evolving industry standards. The introduction of new drugs, changes in clinical guidelines or healthcare benefits, or the evolution of products and services embodying new technologies can quickly make existing products and services obsolete and unmarketable. In particular, the rapid pace of innovation in AI and machine learning can lead to the development of new, improved, or more cost-effective solutions that could render our programs and offerings less competitive or obsolete. Additionally, changes in laws and regulations could impact the usefulness of our programs and could necessitate changes or modifications to our programs to accommodate such changes.

We invest substantial resources in researching and developing new programs and enhancing our programs and platform by incorporating additional features, improving functionality, and adding other improvements to meet market demands and our members' evolving needs. The success of any enhancements or improvements to our platform, programs, or any new programs depends on several factors, including timely completion, competitive pricing, adequate quality testing, integration with new and existing technologies in our programs platform and third-party partners' technologies, clinical results, cost effectiveness, and overall market acceptance. Our development of programs also depends on rights or interests in certain intellectual property, which we or third parties on which we rely may own or license. We may not succeed in developing, marketing, and delivering on a timely and cost-effective basis enhancements or improvements to our platform, programs, or any new programs that respond to continued changes in market demands or new requirements from customers or channel partners, and any enhancements or improvements to our platform, programs, or any new programs may not achieve market acceptance or may otherwise be negatively impacted by third-party actions that are outside of our control. For example, we have developed GLP-1 Care Tracks to support members who are engaged in one of our cardiometabolic programs to enable their success before, during, and after GLP-1 therapy. The GLP-1 therapeutic space is new and rapidly evolving, and actions by employers, health plans, PBMs, pharmaceutical companies, and other third parties. including federal, state, or local governments, could negatively impact the adoption of our GLP-1 Care Tracks. For example, if pharmaceutical companies restrict cost rebates or other incentives for GLP-1s for employers who place conditions on the use of GLP-1s (such as participation in our program), market acceptance of our GLP-1 Care Tracks could be materially and adversely affected. Conversely, certain health plans, PBMs, employers, or other customers or channel partners may require that members enroll in, and engage with, one of our GLP-1 Care Tracks as a condition of receiving GLP-1 prescriptions. When health plans, PBMs, employers, or other customers or channel partners require that members enroll in, and engage with, one of our GLP-1 Care Tracks as a condition of receiving GLP-1 prescriptions, we may provide data reporting that those customers and channel partners use in their review or adjudication of prescription requests. If our data reporting systems or processes are delayed, disrupted, or otherwise fail to work as intended, the prescription processes of our customers and channel partners may be negatively affected, which may result in delayed prescriptions, which in turn could cause member harm or materially and adversely impact our relationships with customers and channel partners. Although, as of June 30, 2025, FDA-approved labels guided that GLP-1 therapies prescribed in adults for obesity or chronic weight management should be prescribed concurrently with a behavioral and lifestyle treatment plan, members could react negatively to these requirements. Although these conditions are not imposed by Omada directly, members could nevertheless attribute these requirements to us and develop a negative perception of us or our programs and our business, which could harm our brand and reputation. Moreover, if the use of GLP-1 therapy for weight loss receives negative publicity and/or one or more GLP-1s are determined to be harmful, the use of GLP-1s for weight loss could decline, which would reduce demand for our GLP-1 Care Tracks and, in turn, our business, financial condition, results of operations, and prospects may be materially and adversely affected.

Since developing our platform and programs and acquiring new technologies is complex, the timetable for the release of new programs and enhancements to existing programs and our platform is difficult to predict, and we may not offer new programs and updates to existing programs and our platform as rapidly as our customers or channel partners require or expect. Any new programs or updates to our platform that we develop or acquire may not be introduced in a timely or cost-effective manner, may contain errors or defects, or may not achieve the broad market acceptance necessary to generate sufficient revenue. Moreover, even if we introduce new programs, we may experience a decline in revenue of our existing programs that is not offset by revenue from the new programs. For example, customers and channel partners may delay making purchases of new programs to permit them to make a more thorough evaluation of these programs or until industry and marketplace reviews become widely available. Some customers or channel partners may hesitate to migrate to a new platform or program due to concerns regarding the performance of the new platform or program. This could result in a temporary or permanent revenue shortfall and materially and adversely affect our business, financial condition, results of operations, and prospects.

To the extent we expand internationally we will face additional business, political, regulatory, operational, financial, and economic risks, any of which could increase our costs, hinder our growth, and harm our business, financial condition, results of operations, and prospects.

Historically, substantially all of our sales have been to customers and channel partners in the U.S. Expanding our business to attract customers, channel partners, and members in countries other than the U.S. in the future may be an element of our long-term business strategy and, to the extent we enter into international markets in the future, there are significant costs and risks inherent in conducting business in international markets. In addition, expansion into foreign markets would impose additional burdens on our executive and administrative personnel, finance, and legal teams, research and marketing teams, and general managerial resources. If we expand, or attempt to expand, into foreign markets, we will be subject to new business and regulatory risks, including:

- multiple, conflicting, and changing laws and regulations such as tax laws, privacy, data protection, and AI-related laws and regulations, export and import restrictions, employment laws, regulatory requirements, and other governmental approvals, permits, and licenses, which may be more difficult to comply with than U.S. laws and regulations;
- obtaining regulatory approvals or clearances where required for the sale of our programs and the delivery of connected devices provided in connection with our programs in various countries;
- increased management, infrastructure, and legal compliance costs associated with having customers, channel partners, and members in multiple jurisdictions;
- requirements to maintain data and the processing of that data on servers located within the U.S. or in such other countries;
- protecting and enforcing our intellectual property rights;
- complexities associated with managing multiple payer reimbursement regimes, including government payers;
- logistics and regulations associated with shipping our wireless scales, blood pressure monitors, blood glucose monitors, and other connected devices and supplies;
- competition from companies with significant market share in international markets and with a better understanding of user preferences in such markets;
- financial risks, such as longer payment cycles, difficulty collecting accounts receivable, the effect of local and regional financial pressures on demand and payment for our programs, and exposure to foreign currency exchange rate fluctuations;
- natural disasters, political and economic instability, including wars, terrorism, political unrest, public health threats or outbreaks of disease (including a pandemic similar to the COVID-19 pandemic), boycotts, curtailment of trade, and other market restrictions; and
- regulatory and compliance risks that relate to maintaining accurate information and control over activities subject to regulation under the Foreign Corrupt Practices Act (the “FCPA”).

Our ability to continue to expand our business and to attract talented employees, customers, channel partners, and members in various international markets will require considerable management attention and resources and is subject to the challenges of supporting a rapidly growing business in an environment of multiple languages, cultures, customs, legal systems, alternative dispute resolution systems, regulatory systems, and commercial infrastructures. We have limited experience with regulatory environments and market practices internationally, and we may not be able to penetrate or successfully operate in new markets. We may also encounter difficulty expanding into international markets because of limited brand recognition in certain parts of the world, leading to delayed acceptance of our programs by customers and channel partners in these international markets. If we are unable to expand internationally and manage the complexity of international operations successfully, it could have a material adverse effect on our business, financial condition, results of operations, and prospects. If our efforts to introduce our products into foreign markets are not successful, we may have expended significant resources without realizing the expected benefit. Ultimately, the investment required for expansion into foreign markets could exceed the results of operations generated from this expansion.

We may be unable to successfully execute on our growth initiatives, business strategies, or operating plans.

We are continually executing on growth initiatives, strategies, and operating plans designed to enhance our business and enhance the efficacy of our programs, which may include expanding our programs to address additional chronic conditions. The anticipated benefits from these efforts are based on several assumptions that may prove to be inaccurate. Moreover, we may not be able to successfully complete these growth initiatives, strategies, and operating plans and realize all of the benefits, including growth targets and cost savings, that we expect to achieve or it may be more costly to do so than we anticipate. A variety of risks could cause us not to realize some or all of the expected benefits, including delays in the anticipated timing of activities related to such growth initiatives, strategies, and operating plans, increased difficulty and cost in implementing these efforts, including difficulties in complying with changing regulatory requirements, and the incurrence of other unexpected costs associated with operating our business. Moreover, our continued implementation of these programs may disrupt our operations and performance. As a result, we cannot assure you that we will realize these benefits. If, for any reason, the benefits we realize are less than our estimates or the implementation of these growth initiatives, strategies, and operating plans adversely affect our operations or cost more or take longer to effectuate than we expect, or if our assumptions prove inaccurate, our business, financial condition, results of operations, and prospects may be materially and adversely affected.

If the licensed physical therapists who provide services to our members are characterized as employees, our business, financial condition, and results of operations could be materially and adversely affected.

We enter into agreements with a professional corporation, Physera Physical Therapy Group, PC (“PPTG”), which enters into contracts with licensed physical therapists pursuant to which they render professional services to our members. PPTG typically engages most of these physical therapists as independent contractors, not employees. An independent contractor is generally distinguished from an employee by his or her degree of autonomy and independence in providing services. A high degree of autonomy and independence is generally indicative of a contractor relationship, while a high degree of control is generally indicative of an employment relationship. Although we believe that these physical therapists are properly characterized as independent contractors, tax or other regulatory authorities may in the future challenge our characterization of these relationships. If such regulatory authorities or state, federal, or foreign courts were to determine that these providers or experts are employees and not independent contractors, PPTG would be required to withhold income taxes, to withhold and pay social security, Medicare, and similar taxes and to pay unemployment and other related payroll taxes. PPTG would also be liable for unpaid past taxes and subject to penalties and could also potentially face claims for overtime or benefits. The costs of defending, settling, or resolving any claims relating to the independent contractor status of the physical therapists could be material. Further, any such reclassification could force us to restructure our relationship with PPTG, could force PPTG to modify its relationships with physical therapists, and could add complexity to our business model. As a result, any determination that these physical therapists are employees could have a material adverse effect on our business, financial condition, and results of operations.

Risks Relating to Cybersecurity, Information Systems, and Intellectual Property

Our information technology ("IT") systems and those of our affiliated professional entities, or those used by our third-party service providers, vendors, business partners, or other contractors or consultants, may fail or suffer cybersecurity incidents, data breaches, and other disruptions, which could result in a material disruption of our systems or programs, compromise confidential information related to our business or of our customers or channel partners, including protected health information ("PHI") and other sensitive or personal information of employees, covered individuals, and members, or prevent us from accessing critical information, potentially exposing us to liability or otherwise materially and adversely affecting our business, financial condition, results of operations, and prospects.

We collect and maintain information in digital form that is necessary to conduct our business, and we are increasingly dependent on IT systems and infrastructure to operate our business, including our member-facing mobile and web-based applications, any customer-facing aspects of our platform, and the systems we use for our own operations. In the ordinary course of our business, we collect, store, and transmit large amounts of confidential information, including intellectual property, proprietary business information, and personal information (including PHI) of our affiliated professional entities, customers, channel partners, members, employees (including with respect to our self-insured ERISA plans), consultants, contractors, third-party payers, business partners, and others. We have also outsourced elements of our IT systems and infrastructure, and as a result, a number of third-party service providers and vendors have access to our confidential information, the confidential information of customers and channel partners, and/or sensitive or personal information of covered individuals and members. We cannot conduct audits or formal evaluations of all aspects of all of our third-party service providers' and vendors' IT systems, and even where we do conduct audits or evaluations, we cannot be sure that our audits or evaluations will be comprehensive or that third-party service providers and vendors have sufficient measures in place to ensure the confidentiality, integrity, and availability of their IT systems and confidential information.

We face evolving cybersecurity risks that threaten the confidentiality, integrity, and availability of our IT systems and those of our affiliated professional entities, third-party service providers, vendors, business partners, and other contractors or consultants, and confidential information and data stored therein, including from diverse threat actors and attack vectors, including attack, damage, and interruption from computer viruses and malware (e.g., ransomware), natural disasters, terrorism, war, telecommunication, network, and electrical failures, hacking, cyberattacks, phishing attacks, and other social engineering schemes, malicious code, employee theft or misuse, human or technological error, fraud, denial or degradation of service attacks, sophisticated nation-state and nation-state-supported actors, or unauthorized access or use by persons inside our organization, or persons with access to systems inside our organization. These risks may be exacerbated in the remote work environment. Moreover, the risk of a cybersecurity incident, breach, or disruption, particularly through cyberattacks or cyber intrusion, including by computer hackers, foreign governments, and cyber terrorists, has generally increased as the number, intensity, and sophistication of attempted attacks and intrusions from around the world have increased. Due to the recent Russia-Ukraine conflict, there have been publicized threats to increase hacking activity against the critical infrastructure of any nation or organization that is supportive of Ukraine. Cyberattacks are expected to continue to accelerate on a global basis in frequency and magnitude as threat actors are becoming increasingly sophisticated in using techniques and tools—including AI—that circumvent security controls, evade detection, and remove or obfuscate forensic evidence.

The costs to us to investigate and mitigate information security incidents including bugs, viruses, worms, malicious software programs, inadvertent exposure of confidential information or security incidents arising from human or technological error, and other causes of security vulnerabilities could be significant, and while we have implemented certain cybersecurity measures designed to protect the confidentiality, integrity, and availability of confidential information and our IT systems, including from system failure, accident, and security breach, there can be no assurance that our cybersecurity risk management program and processes will be fully implemented, complied with, or effective. The techniques used to obtain unauthorized access to, or to sabotage, systems change frequently and often are not recognized until launched against a target, and we may be unable to anticipate these techniques or implement adequate preventative measures. Even if identified, we may be unable to adequately investigate or remediate incidents or breaches. We may also experience security breaches that may remain undetected for an extended period. Any security incident or other adverse impact to the availability, integrity, or confidentiality of our information systems or confidential information could result in unexpected interruptions, delays, disruption of our programs and our business operations, cessation of service, negative publicity and reputational impacts, significant financial liability to our members, customers, channel partners, regulators, or others, loss of customers or channel partners, loss of members, and other harm to our business and our competitive position, whether due to a loss of our trade secrets or other proprietary information or other disruptions.

We and certain of our third-party service providers and vendors are from time to time subject to cyberattacks and security incidents. For example, Delta Dental of California and affiliates, a dental insurance carrier for employees enrolled in our self-insured ERISA plan, was impacted by a security incident in May 2023 resulting from a vulnerability in a third-party file transfer software, MOVEit, that compromised certain of our employees' personal information, but did not materially impact our business or operations. Further, in February 2024, Change Healthcare, an insurance claims processing vendor, experienced a cyberattack forcing the shutdown of its claims processing systems and potentially exposing sensitive data (the "Change Healthcare Incident"). Based on information shared to date, we do not believe the Change Healthcare Incident has materially affected our business, operations, or data. We do, however, rely on similar service providers and clearinghouses to process eligibility for certain of our members and their claims. Any cybersecurity incident, outage, or interruption impacting the systems of such service providers and clearinghouses could result in delays in our ability to process insurance claims, collect payments, and confirm insurance eligibility for members and require us to turn to alternative channels for such services, which may not be available on commercially reasonable terms, or be able to be accessed or implemented in a timely manner. While we do not believe that we have experienced any significant system failure, accident, or security breach to date, if we, our affiliated professional entities, service providers, vendors, business partners, other contractors, or consultants were to experience a significant cybersecurity breach of our or their IT systems or data or other significant cybersecurity incident, the costs associated with the incident response, investigation, system restoration or remediation, notification to customers and channel partners, regulators, and others, and future compliance costs could be material. In addition, our remediation efforts, or those of our vendors or service providers, may not be successful. Any cybersecurity incident affecting us, our affiliated professional entities, service providers, vendors, business partners, other contractors, consultants, or our industry, whether real or perceived, could harm our reputation, erode confidence in the effectiveness of our security measures, and lead to regulatory scrutiny. We could incur or be exposed to potential liability, including class action and other litigation exposure. There can be no assurance that provisions typically included in our terms with members or in our agreements with our customers and channel partners that attempt to limit exposure to legal claims would be enforceable or adequate or would protect us from liabilities or damages. Even if a claim is not successful, any claim brought against us would likely be time-consuming and costly to defend and could seriously damage our reputation, brand, or business. Any cybersecurity incident affecting us could also, subject us to regulatory action, investigation, or enforcement action, any of which could potentially result in penalties, fines, and significant legal liability. In addition, our competitive position could be harmed, and the further development and commercialization of our programs could be delayed. Any or all of the foregoing could materially and adversely affect our business, financial condition, results of operations, and prospects.

We have contractual and legal obligations to notify relevant stakeholders of certain cybersecurity incidents and data breaches. Most jurisdictions have enacted laws requiring companies to notify individuals, regulatory authorities, and others (including, in certain cases, the media) of cybersecurity incidents or data breaches involving certain types or quantities of data. For example, we are subject to an increasing number of reporting obligations in respect of material cybersecurity incidents. These reporting requirements have been proposed or implemented by a number of regulators in different jurisdictions, may vary in their scope and application, and could contain conflicting requirements. Certain of these rules and regulations may require us to report a cybersecurity incident before we have been able to fully assess its impact, or contain and remediate the underlying issue. Efforts to comply with such reporting requirements could divert management's attention from our incident response and could potentially reveal system vulnerabilities to threat actors. Failure to timely report incidents under these rules could also result in monetary fines, sanctions, or subject us to other forms of liability. Such mandatory disclosures are costly, could lead to negative publicity, may cause our customers, channel partners, or members to lose confidence in the effectiveness of our security measures, and require us to expend significant capital and other resources to respond to, or alleviate problems caused by, the actual or perceived cybersecurity incident or data breach and otherwise comply with the multitude of foreign, federal, state, and local laws and regulations relating to the unauthorized access to, or use or disclosure of, personal information (including PHI). Because we utilize third-party vendors and service providers, such as AWS and other cloud services that support our member-facing mobile and web-based applications, customer-facing aspects of our platform, and our own internal operations, successful cyberattacks that disrupt or result in unauthorized access to third-party IT systems can materially impact our operations and financial results. Such third parties, and the services they provide, which may be outside of our direct control, are subject to the same risk of experiencing, and have experienced, outages, other failures, and security breaches described above. Further, if we or our third-party vendors or service providers fail to detect or remediate in a timely manner a cybersecurity incident or an incident that otherwise affects a large amount of data of one or more customers or channel partners, or if we suffer an incident that impacts our ability to operate our programs, we may suffer damage to our reputation and our brand, and our business, financial condition, results of operations, and prospects may be materially and adversely affected.

Further, although we maintain insurance coverage, our insurance coverage may not cover all or any costs and liabilities incurred in relation to a cybersecurity incident or data breach, including indemnification obligations or other liabilities. In addition, we cannot be sure that our existing insurance coverage and coverage for errors and omissions will continue to be available on acceptable terms or that our insurers will not deny coverage as to any future claim. Our risks are likely to increase as we continue to expand our platform, grow the number of customers, channel partners, and members that we serve, and process, store, and transmit increasingly large amounts of proprietary, sensitive and other confidential information.

Our proprietary technology may not operate properly, which could damage our reputation, give rise to claims against us, or divert application of our resources from other purposes, any of which could materially and adversely harm our business, financial condition, results of operations, and prospects.

Proprietary software development is time-consuming, expensive, and complex, and may involve unforeseen difficulties. Technical obstacles, problems, or design defects may prevent our proprietary technology from operating properly. If our platform or programs do not function reliably, malfunction, or fail to achieve the expectations of our customers, channel partners, or members in terms of performance, our customers, channel partners, members, or other business partners could assert liability claims against us, our customers, channel partners, and other business partners could attempt to cancel their contracts with us, or our members could disenroll from our programs. There can be no assurance that provisions typically included in our agreements with customers, channel partners, or other business partners or in our user agreements with members that attempt to limit our exposure to claims would be enforceable or adequate or would otherwise protect us from liabilities or damages with respect to any particular claim. Even if unsuccessful, a claim brought against us by any of our customers, channel partners, members, or other business partners would likely be time-consuming and costly to defend and could seriously damage our reputation and brand and impair our ability to attract or maintain business.

The software underlying our platform is highly complex and may contain undetected errors or vulnerabilities, some of which may only be discovered after the code has been used by our members or other third parties. Any real or perceived errors, failures, bugs, malicious code, or other vulnerabilities discovered in our code or in open source or commercial software that may be integrated into our (or our vendors' and service providers') software could result in negative publicity and damage to our reputation, loss of customers and channel partners, loss of members, loss of, or delay in, market acceptance of our programs, loss of competitive position, loss of revenue, or liability for damages, overpayments, and/or underpayments, any of which could harm our member enrollment rates or cause us to lose members. Similarly, any real or perceived errors, failures, design flaws, or defects in the connected devices or other supplies provided in connection with our programs could have similar negative results. In such an event, we may be required or may choose to divert resources from other purposes or expend additional resources in order to help correct the problem. Such efforts could be costly, or ultimately unsuccessful. Even if we are successful at remediating any issues, we may experience damage to our reputation and brand, and our business, financial condition, results of operations, and prospects could be materially and adversely harmed.

Our business depends upon the interoperability of our programs and related connected devices across a number of devices, operating systems, and third-party applications that we do not control.

Our platform relies in part on interoperability with a range of diverse devices, operating systems, and third-party applications. We are dependent on the accessibility of our programs and related connected devices across these third-party operating systems and applications that we do not control. Third-party services and products are constantly evolving, and we may not be able to modify our platform to assure its compatibility with that of other third parties following development changes. Should the interoperability of our platform, programs, and related connected devices across devices, operating systems, and third-party applications decrease, or if our members are unable to easily and seamlessly access our applications or information stored in our platform, our business, financial condition, results of operations, and prospects could be materially and adversely harmed.

Our business depends on continued and unimpeded access to Internet or mobile connections for our programs and the related connected devices. If we or our members experience disruptions in service or if Internet or mobile service providers are able to block, degrade, or charge for access to our programs or the functionality of connected devices provided in connection with our programs, we could incur additional expenses and the loss of members.

We depend on the ability of our members to access the Internet and/or mobile connections. Currently, this access is provided by companies that have significant market power in the mobile, broadband, and Internet access marketplace, including incumbent telephone companies, cable companies, mobile communications companies, government-owned service providers, device manufacturers, and operating system providers, any of whom could take actions that restrict, degrade, disrupt, or increase the cost of member access to our programs and the functionality of connected devices that we provide in connection with our programs, which would, in turn, negatively impact our business. The adoption of any laws or regulations that adversely affect the growth, popularity, or use of the Internet or mobile connections, including laws or practices limiting Internet neutrality, could decrease the demand for, or the usage of, our programs, increase our cost of doing business, and adversely affect our results of operations. See "*—Changes in the regulation of the Internet could adversely affect our business*." We also rely on other companies to maintain reliable network systems that provide adequate speed, data capacity, and security to us and our members. As Internet and mobile device usage continue to experience growth in the number of users, frequency of use, and amount of data transmitted, the infrastructure that we and our members rely on may be unable to support the demands placed upon it. The failure of the infrastructure that we or our members rely on, even for a short period of time, could undermine our operations and harm our business, financial condition, results of operations, and prospects.

Our success depends in part on our proprietary technology, and if we are unable to obtain, maintain, or successfully enforce our intellectual property rights, the commercial value of our programs will be adversely affected, and our competitive position, business, financial condition, results of operations, and prospects could be materially and adversely affected.

Our success and ability to compete may depend in part on our ability to maintain and enforce existing intellectual property rights and to obtain, maintain, and enforce further intellectual property protection for our programs, both in the U.S. and in other countries. We attempt to protect our intellectual property rights through a combination of patent, trademark, copyright, and trade secret laws, as well as licensing agreements and confidentiality procedures and contractual protections with our employees, affiliates, customers, channel partners, and other business partners. Our inability to obtain, maintain, protect, or enforce our intellectual property rights could result in our competitors offering similar products, which could harm our competitive position.

We rely in limited part on our portfolio of issued patents and pending patent applications in the U.S. to protect our intellectual property and our competitive position. However, the patent positions of technology and virtual care companies, including our patent position, may involve complex legal and factual questions, and, therefore, the scope, validity, and enforceability of any patent claims that we may obtain cannot be predicted with certainty. Accordingly, we cannot provide any assurances that any of our issued patents have included, or that any of our currently pending or future patent applications that mature into issued patents will include, claims with a scope that meaningfully protects our programs. Our pending and future patent applications may not result in the issuance of patents or, if issued, may not issue in a form that will be advantageous to us. Additionally, the issuance of a patent is not conclusive as to its inventorship, scope, validity, or enforceability, and any patents issued to us may be challenged, narrowed, invalidated, held unenforceable, or circumvented, or may not be sufficiently broad to prevent third parties from producing competing programs similar in design to our programs. Such proceedings could include supplemental examination or contested post-grant proceedings such as review, reexamination, interference, or derivation proceedings challenging our patent rights. Further, patent protection must ultimately be sought on a country-by-country basis, which is an expensive and time-consuming process with uncertain outcomes and we have not sought patent protection outside of the U.S. We may fail to file a patent application in a foreign jurisdiction where patent protection is ultimately desirable, and we may be precluded from doing so at a later date. For so long as we do not have patent protection outside of the U.S., our ability to protect uses of our technology by competitors in foreign jurisdictions may be limited.

Changes in either patent laws or in interpretations of patent laws may diminish the value of our current or future intellectual property or narrow the scope of our patent protection, which in turn could diminish the commercial value of our programs. There can be no assurance that any of our patents, any patents licensed to us, or any patents which we may be issued in the future will provide us with a competitive advantage or afford us protection against infringement by others, or that the patents will not be successfully challenged or circumvented by third parties, including our competitors. Further, there can be no assurance that we will have adequate resources to enforce our patents. Any of the foregoing could have a material adverse effect on our competitive position, business, financial condition, results of operations, and prospects.

In addition, we also have agreements with our employees, consultants, and other third parties who may be involved in the conception or development of intellectual property that impose confidentiality obligations on them and obligate them to assign their inventions to us; however, these agreements may not be self-executing, not all relevant employees, consultants, or other third parties may enter into such agreements, or employees, consultants, or other third parties may breach or violate the terms of these agreements, and we may not have adequate remedies for any such breach or violation. Furthermore, individuals executing agreements with us may have preexisting or competing obligations to third parties, and thus an agreement with us may be ineffective in perfecting ownership of intellectual property developed by those individuals. Any of the foregoing could have a material adverse effect on our competitive position, business, financial condition, results of operations, and prospects.

In addition to contractual measures, we protect the confidential nature of our proprietary information using commonly accepted physical and technological security measures. Such measures may not, for example, in the case of misappropriation of a trade secret by an employee, consultant, or other third party with authorized access, provide adequate protection for our proprietary information. Our security measures may not prevent an employee, consultant, or other third party from misappropriating our trade secrets and providing them to a competitor, and any recourse we take against such misconduct may not provide an adequate remedy to protect our interests fully. Monitoring unauthorized uses and disclosures is difficult, and we do not know whether the steps we have taken to protect our intellectual property or confidential or proprietary information, such as our trade secrets, will be effective. Unauthorized parties may also attempt to copy or reverse engineer certain aspects of our programs that we consider proprietary. Enforcing a claim that a party illegally disclosed or misappropriated a trade secret can be difficult, expensive, and time-consuming, and the outcome is unpredictable. Even though we use commonly accepted security measures, trade secret violations are often a matter of state law, and the criteria for protection of trade secrets can vary among different jurisdictions. In addition, trade secrets may otherwise become known or be independently developed by others, including our competitors, in a manner that could prevent legal recourse by us. Further, the laws of some foreign countries do not protect intellectual property rights to the same extent as the laws of the U.S. Many companies have encountered significant problems in protecting and defending intellectual property rights in certain foreign jurisdictions, particularly with respect to trade secret rights. This could make it difficult for us to stop infringement or the misappropriation of our other intellectual property rights. If any of our intellectual property or confidential or proprietary information, such as our trade secrets, were to be disclosed or misappropriated, or if any such information was independently developed by a competitor, it could have a material adverse effect on our competitive position, business, financial condition, results of operations, and prospects.

If our trademarks and trade names are not adequately protected, we may not be able to build name recognition in our markets of interest and our competitive position, business, financial condition, results of operations, and prospects could be materially and adversely affected.

We rely on our trademarks, trade names, and brand names to distinguish our programs from the programs of our competitors and have registered or applied to register many of these trademarks. There can be no assurance that our trademark applications will be approved. Third parties may also oppose our trademark applications or otherwise challenge our use of the trademarks, and our trademarks may be circumvented or declared generic. In the event that our trademarks are successfully challenged, we could be forced to rebrand our programs, which could result in loss of brand recognition and could require us to devote resources to advertising and marketing new brands. Further, there can be no assurance that competitors will not infringe our trademarks or that we will have adequate resources to enforce our trademarks. Additionally, we entered into a co-existence agreement with a third party with respect to trademarks with the word "Omada" that, among other things, places certain restrictions on both the third party's and our ability to register, and to challenge the third party's registration of, trademarks with the word "Omada" in certain product and service classes, in order to mitigate any risk of confusion. Any disputes concerning this co-existence agreement may cause us to incur significant litigation costs, which could have a material adverse effect on our competitive position, business, financial condition, results of operations, and prospects. In addition, third parties may file for registration of trademarks similar or identical to our trademarks, thereby impeding our ability to build brand identity and possibly leading to market confusion. Moreover, third parties may file first for our trademarks in certain countries. If they succeed in registering or developing common law rights in such trademarks, and if we are not successful in challenging such third-party rights, we may not be able to use these trademarks to develop brand recognition in those jurisdictions.

We also license third parties to use our trademarks. In an effort to preserve our trademark rights, we include license terms in our agreements with these third parties, which govern the use of our trademarks and require our licensees to abide by certain use restrictions. Although we make efforts to monitor the use of our trademarks by our licensees, there can be no assurance that these efforts will be sufficient to ensure that our licensees abide by the terms of their licenses. In the event that our licensees fail to do so, our trademark rights could be diluted. Any of the foregoing could have a material adverse effect on our competitive position, business, financial condition, results of operations, and prospects.

We may become involved in lawsuits to protect or enforce our intellectual property rights, which could be expensive, time consuming, and unsuccessful.

Third parties, including our competitors, could be infringing, misappropriating, or otherwise violating our intellectual property rights. We do not regularly conduct monitoring for unauthorized use of our intellectual property at this time. From time to time, we seek to analyze our competitors' programs or seek to enforce our rights against potential infringement, misappropriation, or violation of our intellectual property rights. However, the steps we take to protect our intellectual property rights may not be adequate to enforce our rights against such infringement, misappropriation, or violation. We may not be able to detect unauthorized use of, or take appropriate steps to enforce, our intellectual property rights. Any inability to meaningfully enforce our intellectual property rights could harm our ability to compete and reduce demand for our programs.

From time to time, we may be involved in lawsuits to protect or enforce our intellectual property rights. An adverse result in any litigation proceeding could harm our business. In any lawsuit that we bring to enforce our intellectual property rights, a court may refuse to stop the other party from using the technology at issue on grounds that our intellectual property rights do not cover the technology in question. If we initiate legal proceedings against a third party to enforce a patent covering a program, the defendant could counterclaim that such patent is invalid or unenforceable. In patent litigation in the U.S., defendant counterclaims alleging invalidity or unenforceability are commonplace. Grounds for a validity challenge could be an alleged failure to meet any of several statutory requirements, including lack of novelty, obviousness, or non-enablement. Grounds for an unenforceability assertion could be an allegation that someone connected with prosecution of the patent withheld relevant information from the U.S. Patent and Trademark Office or made a misleading statement during prosecution. Third parties also may raise similar claims before administrative bodies in the U.S. or abroad, even outside the context of litigation. Mechanisms for such challenges include re-examination, post-grant review, *inter partes* review, interference proceedings, derivation proceedings, and equivalent proceedings in foreign jurisdictions (e.g., opposition proceedings). Such proceedings could result in the revocation of, cancellation of, or amendment to our patents in such a way that they no longer cover our programs, or any future programs that we may develop.

The outcome following legal assertions of invalidity and unenforceability is unpredictable. With respect to the validity question, for example, we cannot be certain that there is no invalidating prior art of which we and the patent examiner were unaware during prosecution. If a third party were to prevail on a legal assertion of invalidity or unenforceability, we would lose at least part, and perhaps all, of the patent protection on our programs. Such a loss of patent protection could have a material adverse effect on our business, financial condition, results of operations, and prospects.

Because of the substantial amount of discovery required in connection with intellectual property litigation, there is a risk that some of our confidential information could be compromised by disclosure during litigation. There could also be public announcements of the results of hearing, motions, or other interim developments. If securities analysts or investors perceive these results to be negative, it could have a material adverse effect on the price of shares of our common stock. Even if we ultimately prevail, a court may decide not to grant an injunction against further infringing activity and instead award only monetary damages, which may not be an adequate remedy. Furthermore, the monetary cost of such litigation and the diversion of the attention of our management could outweigh any benefit we receive as a result of the proceedings. Uncertainties resulting from the initiation and continuation of patent litigation or other proceedings could have a material adverse effect on our business, financial condition, results of operations, and prospects.

If we infringe, misappropriate, or otherwise violate the intellectual property rights of third parties or are subject to an intellectual property infringement or misappropriation claim, our ability to grow our business may be severely limited, and our business could be adversely affected.

From time to time, we may be the subject of threatened or actual patent or other litigation. Patent and other types of intellectual property litigation can involve complex factual and legal questions, and their outcome is uncertain. We cannot be certain or guarantee that we do not infringe existing patents or that we will not infringe patents that may be granted in the future. Our programs may infringe, or third parties may claim that they infringe, intellectual property rights covered by patents or patent applications under which we do not hold licenses or other rights. Third parties may own or control these patents and patent applications in the U.S. and abroad. These third parties may bring claims against us that would cause us to incur substantial expenses and, if successfully asserted against us, could cause us to pay substantial damages. Further, if a patent infringement or other intellectual property-related lawsuit is brought against us, we could be forced to stop or delay sales of the program that is the subject of the suit. From time to time, we may receive letters from third parties drawing our attention to their patent rights. As the market for digital health solutions in the U.S. expands and more patents are issued, the risk increases that there may be patents issued to third parties that relate to our products and technology of which we are not aware or that we must challenge to continue our operations as currently contemplated. The defense and prosecution of intellectual property lawsuits could result in substantial expense to us and significant diversion of effort by our technical and management personnel. An adverse determination of any litigation or interference proceeding to which we may become a party could subject us to significant liabilities such as monetary damages, including treble damages and attorneys' fees if we are found to have willfully infringed a patent or other intellectual property right. Further, we may be required to redesign the applicable technology in a non-infringing manner, which may not be commercially feasible. As a result of patent infringement claims, or in order to avoid potential claims, we may choose or be required to seek a license from the third party and be required to pay significant license fees, royalties or both. Licenses may not be available on commercially reasonable terms, or at all, in which event our business would be materially and adversely affected. Even if we were able to obtain a license, the rights may be nonexclusive, which could result in our competitors gaining access to the same intellectual property. Ultimately, if we are unable to obtain such licenses, we could be forced to cease some aspect of our business operations, which could harm our business significantly.

If we fail to comply with our obligations under license or technology agreements with third parties, we may be required to pay damages, and we could lose license rights that are critical to our business.

We license certain intellectual property, including technologies, content, and software from third parties, that is important to our business, and in the future we may enter into additional agreements that provide us with licenses to valuable intellectual property, content, or technology. For example, certain of our customers and channel partners also provide us with limited rights to use their trademarks and trade names in conducting outreach campaigns directed at covered individuals. Disputes also may arise between us and our licensors regarding the intellectual property licensed to us under any license agreement, including disputes related to:

- the scope of rights granted under the license agreement and other interpretation-related issues;
- our compliance with reporting, financial, or other obligations under the license agreement;

- the amounts of royalties or other payments due under the license agreement;
- whether and the extent to which we infringe, misappropriate, or otherwise violate intellectual property rights of the licensor that are not subject to the license agreement;
- our right to sublicense applicable rights to third parties;
- our right to transfer or assign the license; and
- the ownership of intellectual property and know-how resulting from the joint creation or use of intellectual property by our licensors and us and our partners.

If we do not prevail in such disputes or if we fail to comply with any of the obligations under our license agreements, we may lose any or all of our rights under such license agreements or be required to pay damages, and the licensor may have the right to terminate the license. Termination by the licensor of certain of our license agreements would cause us to lose valuable rights, and could prevent us from selling our programs and services or adversely impact our ability to commercialize future programs and services. Our business may suffer if any current or future licenses terminate, if the licensors fail to abide by the terms of the license, if the licensors fail to enforce licensed patents against infringing third parties, if the licensed intellectual property is found to be invalid or unenforceable, or if we are unable to enter into necessary licenses on acceptable terms. In addition, our rights to certain technologies are licensed to us on a non-exclusive basis. The owners of these non-exclusively licensed technologies are therefore free to license them to third parties, including our competitors, on terms that may be superior to those offered to us, which could place us at a competitive disadvantage. In addition, the agreements under which we license intellectual property or technology from third parties are generally complex, and certain provisions in such agreements may be susceptible to multiple interpretations. The resolution of any contract interpretation disagreement that may arise could narrow what we believe to be the scope of our rights to the relevant intellectual property or technology or increase what we believe to be our financial or other obligations under the relevant agreement. Any of the foregoing could harm our competitive position, business, financial condition, results of operations, and prospects.

Our software platform contains, and may in the future contain, open source software, which may pose particular risks to our proprietary software, products, and services in a manner that could have a material and adverse effect on our business, financial condition, results of operations, and prospects.

We use open source software in connection with our software platform and anticipate using open source software in the future. The terms of certain open source licenses to which we are subject have not been interpreted by U.S. or foreign courts, and there is a risk that open source software licenses could be construed in a manner that imposes unanticipated conditions or restrictions on our platform, including requiring us to disclose our proprietary source code to the public. While we monitor our use of open source software and try to ensure that none is used in a manner that would require us to disclose our proprietary source code or that would otherwise breach the terms of an open source agreement, such a use could inadvertently occur, or could be claimed to have occurred, in part because open source license terms can be ambiguous. Additionally, we could face claims from third parties claiming ownership of, or demanding the release of, any open source software or derivative works that we have developed using such software, which could include proprietary source code, or otherwise seeking to enforce the terms of the applicable open source license. These claims could result in litigation and could require us to make our software source code freely available, purchase a costly license, or cease offering our platform unless and until we can re-engineer such source code in a manner that avoids infringement. This re-engineering process could require us to expend significant additional research and development resources, and we may not be able to complete the re-engineering process successfully. In addition to risks related to license requirements, use of certain open source software can lead to greater risks than use of third-party commercial software, as open source licensors generally do not provide support, warranties, indemnification, or other contractual protection regarding infringement claims or the quality of the code. There is little legal precedent in this area, and any actual or claimed requirement to disclose our proprietary source code or pay damages for breach of contract could harm our business and could help third parties, including our competitors, develop technology that is similar to or superior to ours. Any of the foregoing could harm our competitive position, business, financial condition, results of operations, and prospects.

Risks Relating to Governmental Regulation and Legal Matters

We operate in a highly regulated industry and changes in regulations or the implementation of existing regulations could affect our operations.

Our programs and our business activities are subject to rigorous regulation in the jurisdictions in which we operate. In particular, these laws govern the delivery of healthcare, including regulations concerning health information privacy, scope of practice, licensure, the corporate practice of physical therapy, fraud and abuse, exclusion and debarment, anti-kickback obligations, false claims, patient referrals, fee splitting, regulation of devices, and other aspects of healthcare delivery, as well as requirements for coverage and reimbursement by private health insurance providers and government payers. Our business may be affected by changes in any such laws and regulations, as well as by changes to the conditions for coverage and member financial responsibility for certain types of healthcare, the way in which reimbursement is calculated, or the ability to obtain coverage. There are also numerous regulatory schemes, including with respect to data interoperability and information blocking, that do not currently apply to our programs or our business but that we could become subject to in the future as a result of regulatory changes.

The regulations that cover, or that in the future could cover, our programs and our business can be burdensome and subject to change on short notice, exposing us to the risk of increased costs and business disruption, and regulatory requirements may affect or delay our ability to market our new programs. Regulatory authorities and legislators have been recently increasing their scrutiny of the healthcare industry, and there are ongoing regulatory efforts to reduce healthcare costs that may intensify in the future. For example, the U.S. Congress recently considered legislative reforms to PBM fee structures, and the Trump Administration has signaled its intent to pursue drug pricing reform. New laws or regulations that negatively impact health plans, PBMs, or other customers or channel partners could materially and adversely affect our business, financial condition, results of operations, and prospects. Our business is also sensitive to any changes in tort and product liability laws.

Our use and disclosure of personal information, including health information, is subject to federal and state privacy and security laws and regulations, and our or our affiliated professional entities' actual or perceived failure to comply with such laws and regulations or to adequately secure the personal information we hold could result in significant liability or reputational harm and, in turn, a material adverse effect on our business, financial condition, results of operations, and prospects.

The global data protection landscape is rapidly evolving, and there has been an increasing focus on data privacy and protection issues with the potential to affect our business. We and our affiliated professional entities are, or may become, subject to numerous federal, state, and foreign laws, requirements, and regulations governing the collection, transmission, use, processing, disclosure, storage, retention, security, and other processing of personal information, such as information that we may collect in connection with conducting our business in the U.S. and abroad. Implementation standards and enforcement practices are likely to remain uncertain for the foreseeable future, and we cannot yet determine the impact future laws, regulations, standards, or perception of their requirements may have on our business. This evolution may create uncertainty in our business, affect our ability to operate in certain jurisdictions or to collect, store, transfer, use, and share personal information, necessitate the acceptance of more onerous obligations in our contracts, result in liability, or impose additional costs on us. The cost of compliance with these laws, regulations, and standards, including costs related to organizational changes, modifying our data processing practices and policies, implementing additional protection technologies, training employees, and engaging consultants, is high and is likely to increase in the future. Any failure or perceived failure by us to comply with federal, state, or foreign laws or regulations, our internal policies and procedures, or our contracts governing our processing of personal information could result in negative publicity, government investigations and enforcement actions, fines, public censure, claims by third parties, damage to our reputation, loss of goodwill, and loss of customers, channel partners, or members, any of which could have a material adverse effect on our business, financial condition, results of operations, and prospects.

In the ordinary course of our business, we and our affiliated professional entities collect and store confidential information, including PHI, personal information, intellectual property, and proprietary business information owned or controlled by ourselves or our customers, channel partners, members, covered individuals, third-party payers, business partners, and other parties. We also collect and store personal and sensitive information of our employees, consultants, and contractors. We manage and maintain our applications and data utilizing cloud-based data centers for personal information. We utilize external security and infrastructure vendors to manage parts of our data centers. As a healthcare provider and, at times, a business associate of our customers and channel partners, we and our affiliated professional entities must comply with the federal Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act, and their implementing regulations (collectively, "HIPAA"). We also must comply with HIPAA in regard to certain of our self-insured health benefits for our employees and their dependents. HIPAA establishes privacy and security standards that limit the use and disclosure of PHI and imposes privacy, security, and breach notification obligations on certain healthcare providers, health plans, and healthcare clearinghouses, known as covered entities, as well as their business associates that perform certain services that involve creating, receiving, maintaining, or transmitting individually identifiable health information for or on behalf of such covered entities, and their covered subcontractors. We and our affiliated professional entities must comply with HIPAA requirements, including the implementation of administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and availability of individually identifiable health information.

Entities that are found to be in violation of HIPAA as the result of a breach of unsecured PHI, a complaint about privacy practices, or an audit by the U.S. Department of Health and Human Services ("HHS") may be subject to significant civil, criminal, and administrative fines and penalties and/or additional reporting and oversight obligations if required to enter into a resolution agreement and corrective action plan with HHS to settle allegations of HIPAA non-compliance. HIPAA imposes mandatory penalties for certain violations; however, a single breach incident can result in violations of multiple standards, which could result in significant fines. HIPAA also authorizes state attorneys general to file suit on behalf of their residents and enables courts to award damages, costs, and attorneys' fees related to violations of HIPAA in connection with those suits. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for violations of HIPAA, its standards have been used as the basis for duty of care in state civil suits such as those for negligence or recklessness in the misuse or breach of PHI. Any such penalties or lawsuits could harm our business, financial condition, results of operations, prospects, and reputation.

HIPAA further requires that individuals be notified in certain instances of unauthorized acquisition, access, use, or disclosure of their unsecured PHI. Covered entities must report breaches of unsecured PHI to affected individuals without unreasonable delay, not to exceed 60 days following discovery of the breach by a covered entity or its agents. Notification also must be made to the HHS Office for Civil Rights and, in certain circumstances involving large breaches, to the media. Business associates must report breaches of unsecured PHI to covered entities within 60 days of discovery of the breach by the business associate or its agents or such shorter period as may be provided for in contractual agreements. A non-permitted use or disclosure of PHI is presumed to be a breach under HIPAA unless the covered entity or business associate establishes that there is a low probability the information has been compromised consistent with requirements enumerated in HIPAA. Any obligations to send such notifications could severely damage our reputation and affect the confidence of our customers, channel partners, and members.

Certain states have also adopted comparable privacy and security laws and regulations, some of which may be more stringent than HIPAA. Such laws and regulations will be subject to interpretation by various courts and other governmental authorities, thus creating potentially complex compliance issues for us, our affiliated professional entities, and our future customers, channel partners, and strategic partners. For example, the CCPA requires covered businesses that process the personal information of California residents to, among other things: (i) provide certain disclosures to California residents regarding the business's collection, use, and disclosure of their personal information; (ii) receive and respond to requests from California residents to access, delete, and correct their personal information, or to opt out of certain disclosures of their personal information; and (iii) enter into specific contractual provisions with service providers that process California resident personal information on the business's behalf. Additional compliance investment and potential business process changes may be required. Similar laws have been passed in other states and are continuing to be proposed at the state and federal level, including a new comprehensive federal data protection law to which we would become subject to, reflecting a trend toward more stringent privacy legislation in the U.S. The enactment of such laws may have potentially conflicting requirements that would make compliance challenging.

Furthermore, the U.S. Federal Trade Commission ("FTC") and many state attorneys general continue to enforce federal and state consumer protection laws against companies that mislead customers about HIPAA compliance, make deceptive statements about privacy and data sharing in privacy policies, fail to limit third-party use of PHI and certain other personal information, fail to implement policies to protect PHI and certain other personal information, and use online collection, use, dissemination, and security practices that appear to be unfair or deceptive. For example, according to the FTC, failing to take appropriate steps to keep consumers' personal information secure can constitute unfair acts or practices in or affecting commerce in violation of Section 5(a) of the Federal Trade Commission Act. The FTC expects a company's data security measures to be reasonable and appropriate in light of the sensitivity and volume of consumer information it holds, the size and complexity of its business and the cost of available tools to improve security and reduce vulnerabilities. Additionally, federal and state consumer protection laws are increasingly being applied by FTC and state attorneys general to regulate the collection, use, storage, and disclosure of personal information, through websites or otherwise, and to regulate the presentation of website content. There are also a number of legislative proposals in the U.S., at both the federal and state level, that could impose new obligations in areas such as e-commerce and other related legislation or liability for copyright infringement by third parties. We cannot yet determine the impact that these future laws, regulations, and standards may have on our business.

Although we and our affiliated professional entities work to comply with applicable laws, regulations and standards, our contractual obligations, and other legal obligations, these requirements are evolving and may be modified, interpreted, and applied in an inconsistent manner from one jurisdiction to another, and may conflict with one another or other legal obligations with which we must comply. Any failure or perceived failure by us, our affiliated professional entities, or our employees, representatives, contractors, consultants, or other third parties to comply with such requirements or adequately address privacy and security concerns, even if unfounded, could result in additional cost and liability to us, damage to our reputation, negative publicity, members curtailing their use of, or ceasing to use, our programs and/or the loss of customers, channel partners, or covered individuals, loss of goodwill, significant costs for remediation, notification to individuals, and for measures to prevent future non-compliance, each which may materially and adversely affect our business, financial condition, results of operations, and prospects. Any losses, costs, or liabilities may not be covered by, or may exceed the coverage limits of, applicable insurance policies.

If we or our affiliated professional entities fail to comply with federal and state healthcare regulatory laws, we could be subject to penalties, including, but not limited to, administrative, civil and criminal penalties, damages, fines, disgorgement, exclusion from participation in governmental healthcare programs, and the curtailment of our operations, any of which could materially and adversely affect our business, financial condition, results of operations, and prospects.

We and our affiliated professional entities are subject to broadly applicable fraud and abuse and other healthcare laws and regulations. These laws may constrain the business or financial arrangements and relationships through which we and our affiliated professional entities conduct our operations, including sales and marketing practices directed at potential customers and channel partners, benefit outreach practices directed at covered individuals, consumer incentives, and other promotional programs, and other business practices. Such laws include, without limitation:

- the federal Anti-Kickback Statute, which prohibits, among other things, persons or entities from knowingly and willfully soliciting, offering, receiving, or providing any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, to induce or reward, or in return for, either the referral of an individual for, or the purchase, lease, order, or recommendation of, any good, facility, item or service, for which payment may be made, in whole or in part, under U.S. federal and state healthcare programs such as Medicare, state Medicaid programs, and TRICARE. A person or entity does not need to have actual knowledge of the statute or specific intent to violate it in order to have committed a violation;

- the federal physician self-referral law, the Stark Law, which, subject to limited exceptions, prohibits physicians from referring Medicare or Medicaid patients to an entity for the provision of certain designated health services ("DHS"), if the physician or a member of such physician's immediate family has a direct or indirect financial relationship (including an ownership interest or a compensation arrangement) with the entity, and prohibits the entity from billing Medicare or Medicaid for such DHS;

- the federal false claims laws, including the False Claims Act, which can be enforced through whistleblower actions, which, among other things, impose criminal and civil penalties against individuals or entities for knowingly presenting, or causing to be presented, to the U.S. federal government, claims for payment or approval that are false or fraudulent, knowingly making, using or causing to be made or used, a false record or statement material to a false or fraudulent claim, or from knowingly making a false statement to avoid, decrease, or conceal an obligation to pay money to the U.S. federal government. In addition, the government may assert that a claim including items and services resulting from a violation of the federal Anti-Kickback Statute or Stark Law constitutes a false or fraudulent claim for purposes of the False Claims Act;

- the federal Civil Monetary Penalties Law, which prohibits, among other things, an individual or entity from offering remuneration to a federal healthcare program beneficiary that the individual or entity knows or should know is likely to influence the beneficiary to order or receive healthcare items or services from a particular provider;

- HIPAA, which imposes criminal and civil liability for, among other things, knowingly and willfully executing, or attempting to execute, a scheme to defraud any healthcare benefit program, or knowingly and willfully falsifying, concealing, or covering up a material fact or making any materially false statement, in connection with the delivery of, or payment for, healthcare benefits, items, or services. Similar to the U.S. federal Anti-Kickback Statute, a person or entity does not need to have actual knowledge of the statute or specific intent to violate it in order to have committed a violation;

- a provision of the federal Social Security Act that imposes criminal penalties on healthcare providers who fail to disclose or refund known overpayments;

- state law equivalents of each of the above federal laws, including state anti-kickback, self-referral, and false claims laws that apply more broadly to healthcare items or services paid by all payers, including self-pay patients and private insurers, that govern our interactions with consumers or restrict payments that may be made to healthcare providers and other potential referral sources;

- the Federal Trade Commission Act and federal and state consumer protection, advertisement, and unfair competition laws, which broadly regulate marketplace activities and activities that potentially harm consumers;

- the FCPA, which prohibits, among other things, U.S. companies and their employees and agents from authorizing, promising, offering, or providing, directly or indirectly, corrupt or improper payments or anything else of value to foreign government officials, employees of public international organizations and foreign government owned or affiliated entities, candidates for foreign political office, and foreign political parties or officials thereof;

- requirements pertaining to compliance program obligations and record retention, among others, applicable to our business as a first-tier or downstream entity providing certain services to Medicare Advantage organizations, Medicaid managed care plans, or other entities that administer government healthcare programs; and

- requirements applicable to our business at times in providing services to fulfill government contracts (typically as a subcontractor). In providing those services, we are required to comply with applicable government contract requirements such as the U.S. Federal Acquisition Regulation (the "FAR") and agency regulations supplementing the FAR. Our failure to comply with these laws and regulations may expose us to reputational harm, criminal prosecution, suspension and debarment, breach of contract actions, and the False Claims Act, as well as other remedial measures.

Ensuring that our internal operations and future business arrangements with third parties comply with applicable healthcare laws and regulations will involve substantial costs. It is possible that governmental authorities will conclude that our business practices, including our financial arrangements with customers and channel partners, any lead generation agreements for acquiring customers or channel partners, and any outreach initiatives directed at covered individuals, do not comply with current or future statutes, regulations, agency guidance, or case law involving applicable fraud and abuse or other healthcare laws and regulations. If our or our affiliated professional entities' operations are found to be in violation of any of the laws described above or any other governmental laws and regulations that may apply to us, we may be subject to significant penalties, including civil, criminal, and administrative penalties, damages, fines, exclusion from government-funded healthcare programs, including Medicare, state Medicaid programs, TRICARE, or similar programs in other countries or jurisdictions, disgorgement, imprisonment, contractual damages, reputational harm, diminished profits, and the curtailment or restructuring of our operations. We or our affiliated professional entities may also be contractually required to indemnify and hold harmless third parties, such as customers or channel partners, from the costs of any failure to comply with applicable law. Further, defending against any such actions can be costly and time-consuming and may require significant personnel resources. Even if we are successful in defending against any such actions that may be brought against us, our business may be impaired.

The U.S. Food and Drug Administration (the "FDA") may modify its enforcement policies with respect to medical software products, and our software applications may become subject to extensive regulatory requirements, which may increase the cost of conducting, or otherwise harm, our business.

We develop and offer certain software applications, some of which involve the use of AI technologies, to our members and coaches. The FDA may regulate medical or health-related software, including machine learning functionality and predictive algorithms, if such software falls within the definition of a "medical device" under the Federal Food, Drug, and Cosmetic Act ("FDCA"). Medical devices are subject to extensive and rigorous regulation by the FDA and by other federal, state, and local authorities.

The FDCA and related regulations govern the conditions of safety, efficacy, clearance, approval, manufacturing, quality system requirements, labeling, packaging, distribution, storage, recordkeeping, reporting, marketing, advertising, and promotion of medical devices. However, historically, the FDA has exercised enforcement discretion for certain low-risk software functions and has issued several guidance documents outlining its approach to the regulation of software as a medical device. In addition, the 21st Century Cures Act amended the FDCA to exclude from the definition of "medical device" certain medical-related software, including software used for administrative support functions at a healthcare facility, software intended for maintaining or encouraging a healthy lifestyle, software designed to store electronic health records, software for transferring, storing, or displaying medical device data or in vitro diagnostic data, and certain clinical decision support software. We believe our current software applications for our Care Teams generally provide clinical decision support functionality that is exempt from the FDCA's definition of a "medical device." Our current software applications and AI technologies only deliver recommendations directly to members in a manner intended for maintaining or encouraging a healthy lifestyle, and we believe that this functionality is also exempt from the FDCA's definition of a "medical device." Therefore, we believe that our software applications are not currently regulated by the FDA as medical devices or otherwise subject to FDA's current enforcement discretion policies applicable to software. However, there is a risk that the FDA could disagree with our determination if, for example, it is perceived that we are providing, or if we unintentionally provide, automated diagnoses or automated delivery of healthcare to our members. Additionally, the FDA could alter its enforcement discretion policies or our strategy for the use of AI and software could change. Any of the above may subject our software applications to more stringent medical device regulations.

If the FDA determines that any of our current or future software applications are regulated as medical devices and not otherwise subject to enforcement discretion, we would become subject to various requirements under the FDCA and the FDA's implementing regulations. If this occurs, we may be required to cease marketing or to recall our applications until we obtain the requisite clearances or approvals, which would entail significant cost and could harm our reputation, business, financial condition, results of operations, and prospects. The process of seeking clearance or approval can be expensive and time-consuming, and there is no guarantee that we would be successful in obtaining the necessary approvals.

Our failure to comply with applicable regulatory requirements could result in enforcement action by the FDA, or comparable state or foreign regulatory authorities, including: untitled letters, warning letters, fines, injunctions, consent decrees and civil penalties, recalls, termination of distribution, administrative detentions, seizure of our products, operating restrictions, partial suspension or total shutdown of production, delays in or refusal to grant clearances or approvals, prohibitions on sales of our products, and criminal prosecution. Any of these sanctions could result in higher than anticipated costs or lower than anticipated sales and have a material adverse effect on our reputation, business, financial condition, results of operations, and prospects.

We are dependent on our relationships with affiliated professional entities, which we do not own, to provide physical therapy services, and our business would be adversely affected if those relationships were disrupted or if our arrangements with such affiliated professional entities or our customers or channel partners are found to violate state laws prohibiting the corporate practice of physical therapy or fee splitting.

The laws of many states, including states in which many of our customers and channel partners are located, prohibit us from exercising control over the medical judgments or decisions of physical therapists and from engaging in certain financial arrangements, such as splitting professional fees with physical therapists. These laws and their interpretations vary from state to state and are enforced by state courts and regulatory authorities, each with broad discretion, and are subject to change and to evolving interpretations by state boards of physical therapy and state attorneys general, among others. We enter into agreements with a professional corporation, PPTG, which enters into contracts with licensed physical therapists pursuant to which they render professional services. Our agreements include management services agreements with PPTG pursuant to which the professional entity reserves exclusive control and responsibility for all aspects of the practice of physical therapy and the delivery of medical services. In addition, we enter into contracts with our customers and channel partners on behalf of PPTG to deliver professional services in exchange for fees. Changes in, or subsequent interpretations of, the corporate practice of physical therapy or fee-splitting prohibitions could circumscribe our business operations, and state officials who administer these laws or other third parties may successfully challenge our existing organization and contractual arrangements. If such a claim were successful, we could be subject to civil and criminal penalties and could be required to restructure or terminate the applicable contractual arrangements. A determination that these arrangements violate state statutes, or our inability to successfully restructure our relationships with PPTG to comply with these statutes, could eliminate customers and channel partners located in certain states from the market for our programs, which would have a material adverse effect on our business, financial condition, results of operations, and prospects. State corporate practice of physical therapy doctrines also often impose penalties on physical therapists themselves for aiding the corporate practice of physical therapy, which could discourage physical therapists from providing services needed for our programs. We do not own PPTG, which is wholly owned by licensed physical therapists. While we expect that this relationship will continue, we cannot guarantee that it will. A material change in our relationship with PPTG, whether resulting from a dispute among the entities, a change in government regulation, or the loss of these affiliations, could impair our ability to provide services to our members and could have a material adverse effect on our business, financial condition, results of operations, and prospects. In addition, the arrangement in which we have entered to comply with state corporate practice of physical therapy doctrines could subject us to additional scrutiny by federal and state regulatory bodies regarding federal and state fraud, waste, and abuse laws. Any scrutiny, investigation, or litigation with regard to our arrangement with PPTG could have a material adverse effect on our business, financial condition, results of operations, and prospects.

We, our affiliated professional entities, and our other business partners may become subject to medical liability claims, which could cause us to incur significant expenses and may require us to pay significant damages if not covered by insurance.

Our business entails the risk of medical liability claims against both us, our affiliated professional entities, and our other business partners. Successful medical liability claims could result in substantial damage awards that exceed the limits of any insurance coverage. In addition, professional liability insurance is expensive and insurance premiums may increase significantly in the future, particularly as we expand our services. As a result, adequate professional liability insurance may not be available to us, our affiliated professional entities, or our other business partners at acceptable costs or at all.

Any claims made against us may adversely affect our business or reputation, and any claims that are not fully covered by insurance could be costly to defend against, result in substantial damage awards against us, and divert the attention of our management and our partners from our operations, which could have a material adverse effect on our business, financial condition, results of operations, and prospects.

We are subject to risks from legal and arbitration proceedings that may prevent us from pursuing our business activities or require us to incur additional costs in defending against claims or paying damages.

We may become subject to legal disputes and regulatory proceedings in connection with our business activities involving, among other things, product liability, product defects, intellectual property infringement, employment matters, and/or alleged violations of other applicable laws in various jurisdictions. We may not be insured against all potential damages that may arise out of any claims to which we may be party in the ordinary course of our business. A negative outcome of these proceedings may prevent us from pursuing certain activities and/or require us to incur additional costs in order to do so and pay damages.

The outcome of pending or potential future legal and arbitration proceedings is difficult to predict with certainty. In the event of a negative outcome of any material legal or arbitration proceeding, whether based on a judgment or a settlement agreement, we could be obligated to make substantial payments, which could have a material adverse effect on our business, financial condition, results of operations, and prospects. In addition, the costs related to litigation and arbitration proceedings may be significant, and any legal or arbitration proceedings could have a material adverse effect on our business, financial condition, results of operations, and prospects.

Failure to comply with the FCPA, economic and trade sanctions regulations, and similar laws could subject us to penalties and other adverse consequences.

We are subject to the FCPA and other laws in the U.S. and elsewhere that prohibit improper payments or offers of payments to foreign governments and their officials and political parties for the purpose of obtaining or retaining business. Certain suppliers and manufacturers of devices and supplies provided in connection with our programs are located in countries known to experience corruption. Business activities in these countries create the risk of unauthorized payments or offers of payments by one of our employees, contractors, or agents that could be in violation of various laws, including the FCPA and anti-bribery laws in these countries, even though these parties are not always subject to our control. While we have implemented policies and procedures designed to discourage these practices by our employees, consultants, and agents and to identify and address potentially impermissible transactions under such laws and regulations, we cannot assure you that none of our employees, consultants, and agents will take actions in violation of our policies, for which we may be ultimately responsible.

We are also subject to certain economic and trade sanctions programs that are administered by the U.S. Department of the Treasury's Office of Foreign Assets Control which prohibit or restrict transactions to or from or dealings with specified countries, their governments, and in certain circumstances, their nationals, and with individuals and entities that are specially-designated nationals of those countries, narcotics traffickers, and terrorists or terrorist organizations.

Failure to comply with any of these laws and regulations or changes in this regulatory environment, including changing interpretations and the implementation of new or varying regulatory requirements by the government, may result in significant financial penalties or reputational harm, which could adversely affect our business, financial condition, results of operations, and prospects.

Changes in the regulation of the Internet could adversely affect our business.

Laws, rules, and regulations governing Internet communications, advertising, and e-commerce are dynamic, and the extent of future government regulation is uncertain. Federal and state regulations govern various aspects of our online business, including intellectual property ownership and infringement, trade secrets, the distribution of electronic communications, marketing, and advertising, user privacy and data security, search engines, and Internet tracking technologies. Future taxation on the use of the Internet or e-commerce transactions could also be imposed. Existing or future regulation or taxation could increase our operating expenses and expose us to significant liabilities. To the extent any such regulations require us to take actions that negatively impact us, they could have a material adverse effect on our business, financial condition, results of operations, and prospects.

Legislative or regulatory healthcare reforms or reductions in government spending may make it more difficult and costly to produce, market, and distribute our programs or to do so profitably.

Recent political, economic, and regulatory influences are subjecting the healthcare industry to fundamental changes. Federal and state governments in the U.S. and foreign governments continue to propose and pass new legislation and regulations designed to contain or reduce the cost of healthcare, improve quality of care, and expand access to healthcare. For example, the Patient Protection and Affordable Care Act, as amended by the Healthcare and Education Reconciliation Act (the "ACA"), made major changes in how healthcare is delivered and reimbursed and increased access to health insurance by the uninsured and underinsured population of the U.S. The ACA, among other things, increased the number of individuals eligible for Medicaid and private insurance coverage, implemented reimbursement policies that tie payment to quality, facilitated the creation of accountable care organizations that may use capitation and other alternative payment methodologies, strengthened enforcement of fraud, waste, and abuse laws, and encouraged the use of IT.

In addition, the ACA requires (with limited exceptions) that private health plans cover certain recommended preventive services without imposing member cost-sharing. For these purposes, "preventive services" refer to services selected by certain agencies, including the U.S. Preventive Services Task Force. Qualified health plans for individuals and the small-group market must also cover certain "essential benefits," including chronic disease management, although those plans may meet that ACA requirement with other services and are not required to cover Omada's programs specifically. Any changes to these coverage requirements and/or cost-sharing prohibitions could materially and adversely affect our business, financial condition, and results of operations.

Separately, individuals covered by high-deductible health plans may receive preventive care, including certain preventive services identified by agencies like the U.S. Preventive Services Task Force and certain other items identified by the U.S. Internal Revenue Service (the "IRS"), without cost-sharing, even if the high deductible has not yet been met, while remaining eligible to make health savings account ("HSA") contributions. Additionally, high-deductible health plan participants will remain eligible to make HSA contributions even if, before their high deductible has been met, they receive disease management or wellness programs that do not provide significant benefits in the nature of medical care or treatment, without cost-sharing and if they receive telehealth services.

Although the ACA's delegation to the U.S. Preventive Services Task Force to recommend preventive services for ACA-compliant plans was challenged in *Braidwood Management Inc., et al. v. Xavier Becerra, et al.*, the authority to make that delegation was confirmed by the U.S. Supreme Court in June 2025. As a result, the U.S. Preventive Services Task Force recommendations that are approved by the Secretary of Health and Human Services are mandatory for ACA-compliant plans. Additionally, the IRS has issued guidance indicating that those same recommended services will continue to be considered preventive care that does not affect HSA eligibility for a high-deductible plan participant. Nevertheless, any future changes to this guidance or to the types of care that high-deductible health plan participants may receive without cost-sharing may require us to collect cost-sharing for those individuals, cause fewer customers and channel partners to make our programs available, cause fewer covered individuals to choose to enroll in our programs, and materially and adversely affect our business, financial condition, results of operations, and prospects.

Other legislative changes have been adopted since the ACA was enacted. These changes include aggregate reductions to Medicare payments to providers, which began in 2013 and, due to subsequent legislative amendments, will stay in effect through 2032, with the exception of a temporary suspension from May 1, 2020 through March 31, 2022, unless additional Congressional action is taken. In January 2013, the American Taxpayer Relief Act of 2012 was signed into law, which, among other things, further reduced Medicare payments to several types of providers, including hospitals, imaging centers, and cancer treatment centers, and increased the statute of limitations period for the government to recover overpayments to providers from three to five years. Most recently, the One Big Beautiful Bill Act, which was enacted in July 2025, imposes significant reductions in the funding of the Medicaid program. Such reductions are expected to decrease the number of persons enrolled in Medicaid and reduce the services covered by Medicaid.

New laws may result in additional reductions in Medicare, Medicaid and other healthcare funding, which may materially and adversely affect demand for our programs among customers, channel partners, and members and affordability for our programs and, accordingly, our business, financial condition, results of operations, and prospects. Federal, state, or local budget cuts and cancellation of grants to state and local health departments and other agencies have reduced, and may continue to reduce, the number of individuals covered by those government funds for our programs. Additional changes that may affect our business include the expansion of new programs such as Medicare payment for performance initiatives for physicians under the Medicare Access and CHIP Reauthorization Act of 2015, which first affected physician payment in 2019. At this time, it is unclear how the introduction of the Medicare quality payment program will impact overall healthcare reimbursement. Such changes in the regulatory environment may also result in changes to our payer mix that may affect our operations and revenue. Further, the ACA may adversely affect payers by increasing medical costs generally, which could have an effect on the industry and potentially impact our business and revenue as payers seek to offset these increases by reducing costs in other areas. Certain of these provisions are still being implemented, and the full impact of these changes on us cannot be determined at this time. We expect that additional state and federal healthcare reform measures will be adopted in the future, any of which could limit the amounts that federal and state governments and other third-party payers will pay for healthcare products and services, which could materially and adversely affect our business, financial condition, results of operations, and prospects.

We are subject to consumer protection laws that regulate our marketing and benefit outreach practices and prohibit unfair or deceptive acts or practices. Our actual or perceived failure to comply with such obligations could harm our business, and changes in such regulations or laws could require us to modify our programs or marketing, advertising, or benefit outreach efforts.

In connection with the marketing or advertisement of our programs to potential customers and channel partners and our benefit outreach to covered individuals, we could be the target of claims relating to false, misleading, deceptive, or otherwise noncompliant advertising, marketing, or outreach practices, including under the auspices of the FTC and state consumer protection statutes. To the extent we use third parties to assist with or conduct any marketing, advertising, or benefit outreach regarding our programs, we could be liable for, or face reputational harm as a result of, their practices if, for example, they fail to comply with applicable statutory and regulatory requirements.

If we are found to have breached any consumer protection, advertising, unfair competition, or other laws or regulations, we may be subject to enforcement actions that require us to change our marketing or advertising to potential customers and channel partners, our benefit outreach to covered individuals, and other business practices in a manner which may negatively impact us. This could also result in litigation, fines, penalties, and adverse publicity that could cause reputational harm and loss of trust from customers, channel partners, and members, which could have a material adverse effect on our business, financial condition, results of operations, and prospects.

Certain of the devices and supplies provided in connection with our programs are subject to extensive government regulation at the federal and state level, and any failure by the producers of such devices to comply with applicable requirements could harm our business.

Certain of the devices provided in connection with our programs, including blood pressure monitors and blood glucose monitors (including continuous glucose monitors), are medical devices that are subject to extensive regulation in the U.S., including by the FDA and state agencies. The FDA regulates, among other things, the design, development, research, manufacture, testing, packaging, distribution, storage, recordkeeping, reporting, labeling, marketing, promotion, advertising, sale, import, and export of devices. We rely on third parties to supply and manufacture the devices provided in connection with our programs. Applicable medical device regulations are complex and have tended to become more stringent over time, and regulatory changes could result in restrictions on the ability of our manufacturers to supply the devices that we provide to members in connection with our programs.

Certain of the connected devices we provide to our members, including the blood glucose monitors and blood pressure monitors, have received 510(k) clearance. In the 510(k) clearance process, before a device may be marketed, the FDA must determine that the proposed device is "substantially equivalent" to a legally marketed "predicate" device, which includes a device that has been previously cleared through the 510(k) process, a device that was legally marketed prior to May 28, 1976 (a pre-amendments device), a device that was originally on the U.S. market pursuant to an approved premarket approval ("PMA") application and later down-classified, or a 510(k)-exempt device. To be "substantially equivalent," the proposed device must have the same intended use as the predicate device and either have the same technological characteristics as the predicate device or have different technological characteristics and not raise different questions of safety or effectiveness than the predicate device. Clinical data are sometimes required to support substantial equivalence. In the PMA process, the FDA must determine that a proposed device is safe and effective for its intended use based, in part, on extensive data, including, but not limited to, technical, pre-clinical, clinical trial, manufacturing and labeling data. The PMA process is typically required for devices that are deemed to pose the greatest risk, such as life-sustaining, life-supporting or implantable devices.

Certain modifications made to products cleared through a 510(k) may require a new 510(k) clearance. Both the PMA approval and the 510(k) clearance process can be expensive, lengthy, and uncertain. We do not manufacture, reprocess, remanufacture, export, or act as an initial importer or specification developer for the medical devices we provide to members, nor have we sought or obtained 510(k) clearance, PMA approval, or other marketing authorizations for the connected devices provided in connection with our programs. We remain wholly reliant on our suppliers and contract manufacturers to obtain the requisite marketing authorizations for their products and to comply with their respective obligations to comply with applicable FDA regulations and other legal requirements. We cannot assure you that our suppliers and contract manufacturers will comply with applicable laws and regulation, nor can we assure that any particular medical device we may seek to provide in connection with our programs will be approved or cleared by the FDA in the manner in which we expect. Any failures by our suppliers or third-party manufacturers to comply with applicable laws or regulations enforced by the FDA and comparable regulatory authorities, or any delay or failure by such parties to obtain necessary regulatory clearances or approvals for the devices we use in connection with our programs, if required in the future, could harm our business.

If our third-party suppliers fail to comply with the FDA's Quality Systems Regulation or similar foreign regulations, our ability to distribute the connected devices that are provided to members in connection with our programs could be impaired.

Certain of our third-party suppliers are required to comply with the FDA's Quality System Regulation ("QSR") and similar foreign regulations, which cover the methods and documentation of the design, testing, production, control, quality assurance, labeling, packaging, sterilization, storage, and shipping of the connected devices that are provided to members in connection with our programs. The FDA and foreign regulators audit compliance with the QSR and similar foreign regulations through periodic announced and unannounced inspections of manufacturing and other facilities. The FDA or foreign regulators may impose inspections or audits at any time.

We cannot guarantee that our third-party suppliers will take the necessary steps to comply with applicable regulations, and their failure to do so could cause delays in the manufacture and delivery of our products. In addition, a third-party supplier's failure to comply with applicable FDA requirements or later discovery of previously unknown problems with the connected devices or manufacturing processes for the connected devices could result in, among other things:

- suspension or withdrawal of future clearances or approvals;
- seizures or recalls of the connected devices;
- total or partial suspension of production or distribution for the connected devices;
- administrative or judicially imposed sanctions against the connected devices; and
- refusal to permit the import or export of the connected devices;

Any of these actions could significantly and negatively impact supply of the connected devices that we are required to provide to members in connection with our programs. If any of these events occurs, our reputation could be harmed, we could be exposed to product liability claims, and we could lose customers and channel partners and suffer reduced revenue and increased costs.

Our business could be adversely affected by legal challenges to our business model or by actions restricting our ability to provide the full range of our services in certain jurisdictions.

Our ability to conduct our business in a particular U.S. state is directly dependent upon the applicable laws governing virtual healthcare and healthcare delivery in general in such location, which vary from state to state and are subject to changing political, regulatory, and other influences. With respect to virtual care services, in the past, state medical and physical therapy boards have established new rules or interpreted existing rules in a manner that has limited or restricted our and our affiliated professional entities' ability to conduct business as it was conducted in other states. Some of these actions have resulted in litigation and the suspension or modification of virtual care operations in certain states. Although we do not believe that any services provided by us include physician services, the extent to which a state regulatory authority considers particular actions or relationships to constitute practicing medicine is subject to change and to evolving interpretations by medical boards and state attorneys general, among others, each with broad discretion, and requirements for the practice of physical therapy may apply to services we provide in Omada for MSK. Accordingly, we must monitor our compliance with laws in every jurisdiction in which we operate, on an ongoing basis, and we cannot provide assurance that our activities and arrangements, if challenged, will be found to be in compliance with applicable laws.

Additionally, it is possible that the laws and rules governing the provision of healthcare, including virtual healthcare, in one or more jurisdictions may change in a manner deleterious to our business. For example, in August 2024, Illinois passed an amendment to the Illinois Physical Therapy Act, effective as of January 2025, that limits physical therapists' ability to provide physical therapy via telehealth to patients in Illinois. The amendment requires, among other things, that initial physical therapy evaluations without a referral or established diagnosis be performed in person and cannot be performed via telehealth unless necessary to address a documented hardship, including geographical, physical, or weather-related conditions. Further, the amendment states that the use of telehealth as a primary means of delivering physical therapy must be an exception supported by documentation. The amendment also requires that a physical therapist providing virtual care must have the capacity to provide in-person care within Illinois. Since the passage of this amendment, we have made adjustments to the manner in which we offer our platform and programs in Illinois to comply with these requirements. The Illinois legislature recently passed an amendment that would allow a physical therapist to provide physical therapy via telehealth to patients in Illinois if one of the following criteria is met: (i) the patient has a referral or diagnosis from a health care professional; (ii) the patient has an established relationship with the physical therapist; or (iii) the physical therapist has the capacity to perform or facilitate a referral for an in-person, hands-on examination or re-examination by a physical therapist at any time throughout the course of the patient's care, as needed. The amendment was sent to the governor of Illinois on June 27, 2025 and remained before the governor as of August 5, 2025.

Increased regulation and legislative review of virtual healthcare practices could further increase our costs of doing business. Authorities may not agree with our interpretation of existing or future legislation and regulation, which may require us to incur additional costs. Further, states may pass new measures, including measures similar to those in Illinois, which may restrict the delivery of virtual physical therapy or add new requirements, including requirements that members receiving physical therapy have the right to request and receive in-person care. If states pass additional measures, we may need to make adjustments to the delivery of our platform and programs in those jurisdictions, which could make it difficult and more expensive to operate our business in general or to operate our business in those states, which could materially and adversely affect our business, financial condition, results of operations, and prospects.

If a legal challenge to our activities and arrangements is successful, or an adverse change in the relevant laws were to occur, and we were unable to adapt our business model accordingly, our operations as well as the operations of our affiliated professional entities in the affected jurisdictions would be disrupted, which could have a material adverse effect on our business, financial condition, results of operations, and prospects. Failure to comply with these laws could also result in professional discipline for the affiliated professional entities' providers or civil or criminal penalties.

Risks Relating to Financial and Accounting Matters

Our ability to use our net operating loss carryforwards and other tax attributes may be limited due to certain provisions of the Internal Revenue Code or state tax law.

We have incurred substantial losses during our history and may never achieve profitability. U.S. federal net operating loss carryforwards ("NOLs") we generated in tax years through December 31, 2017 may be carried forward for 20 years and may fully offset taxable income in the year utilized, and federal NOLs we generated in tax years beginning after December 31, 2017 may be carried forward indefinitely but may only be used to offset 80% of our taxable income annually for tax years beginning after December 31, 2020.

Realization of these NOLs depends on future taxable income, and there is a risk that our existing NOLs could expire unused and be unavailable to offset future taxable income, which could adversely affect our results of operations.

In addition, under Sections 382 and 383 of the Internal Revenue Code of 1986, as amended, if a corporation undergoes an "ownership change," the corporation's ability to use its pre-change federal NOLs and other tax attributes (such as tax credits) to offset its post-change taxable income and taxes may be limited. In general, an "ownership change" occurs if there is a greater than 50 percentage point change (by value) in a corporation's equity ownership by certain stockholders over a rolling three-year period. We may experience ownership changes in the future as a result of subsequent shifts in our stock ownership (some of which shifts are outside our control). As a result, our ability to use pre-change federal NOLs and other tax attributes to offset future taxable income and taxes could be subject to limitations. Similar provisions of state tax law may also apply. For these reasons, even if we achieve profitability, we may be unable to use a material portion of our NOLs and other tax attributes, which could materially and adversely affect our business, financial condition, results of operations, and prospects.

Our effective tax rate may vary significantly from period to period.

Various internal and external factors may have favorable or unfavorable effects on our future effective tax rate. These factors include, but are not limited to, changes in tax laws, regulations, or rates, both within and outside the U.S., structural changes in our business, new accounting pronouncements or changes to existing accounting pronouncements, non-deductible goodwill impairments, changing interpretations of existing tax laws or regulations, changes in the relative proportions of revenue and income before taxes in the various jurisdictions in which we operate that have different statutory tax rates, the future levels of tax benefits of equity-based compensation, changes in overall levels of pretax earnings, or changes in the valuation of our deferred tax assets and liabilities. Additionally, we could be challenged by state and local tax authorities as to the propriety of our sales tax compliance, and our results could be materially impacted by these compliance determinations.

In addition, our effective tax rate may vary significantly depending on the market price of our common stock. The tax effects of the accounting for share-based compensation may significantly impact our effective tax rate from period to period. In periods in which the market price of our common stock is higher than the grant price of the share-based compensation vesting in that period, we will recognize excess tax benefits that will decrease our effective tax rate. In future periods in which our stock price is lower than the grant price of the share-based compensation vesting in that period, our effective tax rate may increase. The amount and value of share-based compensation issued relative to our earnings in a particular period will also affect the magnitude of the impact of share-based compensation on our effective tax rate. These tax effects are dependent on the market price of our common stock, which we do not control, and a decline in our stock price could significantly increase our effective tax rate and adversely affect our financial condition.

Changes in tax laws or tax rulings could adversely affect our effective tax rates, results of operations, and financial condition.

The tax regimes we are subject to or operate under are unsettled and may be subject to significant change. This challenge will continue to increase as we expand our operations globally. Changes in tax laws, issuance of new tax rulings, or changes in interpretations of existing laws could cause us to be subject to additional income- based taxes and non-income-based taxes, including payroll, sales, use, value-added, digital, net worth, property, and goods and services taxes, which in turn could adversely affect our results of operations and financial condition. In particular, the U.S. government may enact significant changes to the taxation of business entities including, among others, an increase in the corporate income tax rate, the imposition of minimum taxes or surtaxes on certain types of income, significant changes to the taxation of income derived from international operations, and it may enact further limitations on the deductibility of business interest. For example, on August 16, 2022, the Inflation Reduction Act (the "IRA") was signed into law in the U.S. Among other changes, the IRA, along with subsequent regulations, imposes a minimum tax on certain corporations with book income of at least $1 billion, subject to certain adjustments, and a 1% excise tax on certain stock buybacks and similar corporate actions.

In addition, many countries in the European Union, as well as a number of other countries and organizations, have recently proposed or recommended changes to existing tax laws or have enacted new laws that could impact our tax obligations in the future. We are unable to predict what changes to the tax laws of the U.S. and other jurisdictions may be proposed or enacted in the future or what effect such changes would have on our business. Any of these or similar developments or changes to tax laws or rulings (which changes may have retroactive application) could adversely affect our effective tax rate and our results of operations and financial condition.

The applicability of sales, use, and other tax laws or regulations on our business is uncertain. Adverse tax laws or regulations could be enacted or existing laws could be applied to us, our customers, or our channel partners, which could subject us to additional tax liability and related interest and penalties, increase the costs of our programs, and adversely impact our business.

The application of federal, state, local, and international tax laws to services provided electronically is evolving. New income, sales, use, value-added, or other tax laws, statutes, rules, regulations, or ordinances could be enacted at any time (possibly with retroactive effect) and could be applied solely or disproportionately to services provided over the Internet or could otherwise materially affect our results of operations and financial condition.

In addition, state, local, and foreign tax jurisdictions have differing rules and regulations governing sales, use, value-added, and other taxes, and these rules and regulations can be complex and are subject to varying interpretations that may change over time. Existing tax laws, statutes, rules, regulations, or ordinances could be interpreted, changed, modified, or applied adversely to us (possibly with retroactive effect). We have not collected sales taxes in all jurisdictions in which our customers and members are located, and we believe we may have exposure for potential sales tax liability, including interest and penalties, for which we have established a reserve in our financial statements, and any sales tax exposure may be material to our operating results. Although our contracts with customers and channel partners typically provide that our customers and channel partners must pay all applicable sales and similar taxes, they may be reluctant to pay back taxes and associated interest or penalties, or we may determine that it would not be commercially feasible to seek reimbursement. In addition, we, our customers, or our channel partners could be required to pay additional tax amounts on both future as well as prior sales, and possibly fines or penalties and interest for past due taxes. If we are required to collect and pay back taxes and associated interest and penalties, and if the amount we are required to collect and pay exceeds our estimates and reserves, or if we are unsuccessful in collecting such amounts from our customers or channel partners, we could incur substantial unplanned expenses, thereby adversely impacting our operating results and cash flows. Imposition of such taxes on our services going forward or collection of sales tax from our customers or channel partners in respect of prior sales could also adversely affect our sales activity and have a negative impact on our operating results and cash flows.

One or more states may seek to impose incremental or new sales, use, value added, or other tax collection obligations on us, including for past sales by us or our channel partners. A successful assertion by a state, country, or other jurisdiction that we should have been or should be collecting additional sales, use, value added, or other taxes on our programs could, among other things, result in substantial tax liabilities for past sales, create significant administrative burdens for us, discourage members from utilizing our programs or otherwise harm our business, results of operations, and financial condition.

Our cash deposits with financial institutions exceed insured limits.

We maintain the majority of our cash and cash equivalents in accounts with one or more U.S. financial institutions, and our deposits at these institutions exceed insured limits. Market conditions can impact the viability of financial institutions. In the event of failure of any of the financial institutions where we maintain our cash and cash equivalents, there can be no assurance that we would be able to access uninsured funds in a timely manner or at all. For example, bank failures in early 2023 impacted the timing of the collection of our receivables as we switched depositories. Any inability to access or delay in accessing these funds could adversely affect our business and financial condition.

Changes in accounting principles or the interpretation thereof by the Financial Accounting Standards Board ("FASB") affecting consolidation of entities could impact our consolidation of total revenues derived from PPTG.

Our financial statements are consolidated and include the accounts of PPTG, a professional corporation owned and operated by physical therapists that was determined to be a variable interest entity ("VIE") for which we are the primary beneficiary, which consolidation is effected in accordance with applicable accounting rules. In the event of a change in accounting principles promulgated by FASB or in FASB's interpretation of its principles, an adverse determination by a regulatory agency or a court, or a change in federal or state law relating to the ability to maintain present agreements or arrangements with PPTG, we may not be permitted to continue to consolidate the total revenues of PPTG. While our revenues derived from PPTG are not material, in the event PPTG revenues were to become a material portion of our revenues in the future, any inability to include the accounts of PPTG in our financial statements could adversely affect our business, results of operations, and financial condition.

Risks Relating to Our Common Stock

We are an "emerging growth company," and we cannot be certain if the reduced reporting requirements applicable to emerging growth companies will make our common stock less attractive to investors.

We are an "emerging growth company," as defined in the JOBS Act. We will remain an "emerging growth company" until the earliest to occur of:

- the last day of the fiscal year during which our total annual revenue equals or exceeds $1.235 billion (subject to adjustment for inflation);
- the last day of the fiscal year following the fifth anniversary of our IPO;
- the date on which we have, during the previous three-year period, issued more than $1 billion in non-convertible debt; or
- the date on which we are deemed to be a "large accelerated filer" under the Exchange Act.

As a result of our "emerging growth company" status, we may take advantage of exemptions from various reporting requirements that would otherwise be applicable to public companies including, but not limited to, reduced disclosure obligations regarding executive compensation in our periodic reports and proxy statements and exemptions from the requirements of holding a nonbinding advisory vote on executive compensation and stockholder approval of any golden parachute payments not previously approved.

Investors may find our common stock less attractive because we may rely on these exemptions. If some investors find our common stock less attractive as a result, there may be a less active trading market for our common stock and the market price of our common stock may be adversely affected and more volatile.

We will continue to incur increased costs and be subject to additional regulations and requirements as a result of recently becoming a public company, which could lower our profits or make it more difficult to run our business.

As a public company, we will continue to incur significant legal, accounting, and other expenses that we did not incur as a private company, including costs associated with public company reporting requirements. We also have incurred and will continue to incur costs associated with the Sarbanes-Oxley Act and related rules implemented by the SEC and the exchange our securities are listed on. The expenses generally incurred by public companies for reporting and corporate governance purposes have been increasing. We expect these rules and regulations to increase our legal and financial

compliance costs and to make some activities more time-consuming and costly, although we are currently unable to estimate these costs with any degree of certainty. These laws and regulations also could make it more difficult or costly for us to obtain certain types of insurance, including director and officer liability insurance, and we may be forced to accept reduced policy limits and coverage or incur substantially higher costs to obtain the same or similar coverage. These laws and regulations could also make it more difficult for us to attract and retain qualified persons to serve on our board of directors, on our board committees, or as our executive officers. Furthermore, if we are unable to satisfy our obligations as a public company, we could be subject to delisting of our common stock, fines, sanctions, other regulatory action, and potentially civil litigation.

We have identified material weaknesses in our internal control over financial reporting. If our remediation of the material weaknesses is not effective, or if we experience additional material weaknesses in the future or otherwise fail to maintain an effective system of internal controls in the future, we may not be able to accurately or timely report our results of operations or financial condition, which may adversely affect investor confidence in us and, as a result, the value of our common stock.

As a public company, we are required to maintain internal control over financial reporting and to report any material weaknesses in such internal controls. In addition, beginning with our second annual report on Form 10-K, we are now required to furnish a report by management on the effectiveness of our internal control over financial reporting, pursuant to Section 404 of the Sarbanes-Oxley Act. Effective internal control over financial reporting is necessary for us to provide reliable and timely financial reports and, together with adequate disclosure controls and procedures, are designed to reasonably detect and prevent fraud. Any failure to implement required new or improved controls, or difficulties encountered in their implementation, could cause us to fail to meet our reporting obligations. The process of designing, implementing, and testing the internal control over financial reporting required to comply with this obligation is time consuming, costly, and complicated.

We have experienced control deficiencies, including material weaknesses, in our internal control over financial reporting and may experience control deficiencies in the future. In preparing the financial statements as of and for the years ended December 31, 2024 and 2023, we identified material weaknesses in our internal control over financial reporting. A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of our annual or interim financial statements will not be prevented or detected on a timely basis. Management determined they had not fully maintained all components of the framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (the "COSO"), a system for establishing internal controls. Specifically, the control deficiencies related to: (i) inadequate segregation of duties within our financial reporting process, leading to certain duties being performed by the same individuals, (ii) an insufficient complement of personnel with an appropriate level of technical knowledge to properly account for significant transactions, and (iii) inadequate formalized processes and control activities to support the financial close and reporting process, including the review of financial information, account analysis, and journal entries.

These material weaknesses resulted in adjustments to the financial statements.

In response to the identified material weaknesses, we are committed to improving our internal control over financial reporting by implementing a remediation plan that includes:

- hiring additional qualified professionals with appropriate levels of knowledge and experience to assist in the timely resolution of accounting issues in non-routine or complex transactions;
- implementing additional procedures to ensure a greater degree of segregation of duties and refining processes for user access within financial reporting;
- investing in additional technology infrastructure and refinement to enhance monitoring of financial transactions and exceptions and to promote related data integrity;
- further developing and documenting formal business processes and controls related to financial reporting; and
- instituting a system of independent reviews of our financial information, accounting analyses, and related disclosures by knowledgeable personnel.

While we believe that these efforts will improve our internal control over financial reporting, the design and implementation of our remediation is ongoing and will require validation and testing of the design and operating effectiveness of our internal controls over a sustained period of financial reporting cycles. Our remediation actions are subject to ongoing review by our senior management and oversight from our audit committee. We will not be able to conclude whether these remediation actions will fully remediate the material weaknesses in our internal control over financial reporting until we have completed our remediation efforts and subsequent evaluation of their effectiveness.

We cannot assure you that the measures we have taken to date, and are continuing to implement, will be sufficient to remediate the material weaknesses we have identified or avoid potential future material weaknesses. If the steps we take do not correct the material weaknesses in a timely manner, we will be unable to conclude that we maintain effective internal control over financial reporting. Accordingly, there could continue to be a reasonable possibility that a material misstatement of our financial statements would not be prevented or detected on a timely basis.

If we fail to remediate our existing material weaknesses or identify new material weaknesses in our internal controls over financial reporting, if we are unable to comply with the requirements of Section 404 of the Sarbanes-Oxley Act in a timely manner, if we are unable to conclude that our internal controls over financial reporting are effective, or if our independent registered public accounting firm is unable to express an opinion as to the effectiveness of our internal controls over financial reporting when we are no longer an emerging growth company, investors may lose confidence in the accuracy and completeness of our financial reports and the market price of our common stock could be negatively affected. As a result of such failures, we could also become subject to investigations by the stock exchange on which our securities are listed, the SEC, or other regulatory authorities, and become subject to litigation from investors and stockholders, which could harm our reputation and financial condition or divert financial and management resources from our regular business activities.

We do not intend to pay dividends in the foreseeable future. As a result, your ability to achieve a return on your investment will depend on appreciation in the market price of our common stock.

We have never declared or paid cash dividends on our capital stock, and we do not currently intend to pay any cash dividends on our capital stock in the foreseeable future. We currently intend to retain all available funds and any future earnings to fund the development and expansion of our business. Any future determination related to dividend policy will be made at the discretion of our board of directors, subject to applicable laws, and will depend upon, among other factors, our results of operations, prospects, financial condition, contractual restrictions, and capital requirements. Additionally, our ability to pay cash dividends on our capital stock may be limited by the terms of any future debt or preferred securities we issue or any future credit facilities we enter into. Accordingly, investors must for the foreseeable future rely on sales of their common stock after price appreciation, which may never occur, as the only way to realize any future gains on their investments.

If our operating and financial performance in any given period does not meet any guidance that we provide to the public, the market price of our common stock may decline.

We may, but are not obligated to, provide public guidance on our expected operating and financial results for future periods. Any such guidance will be composed of forward-looking statements subject to the risks and uncertainties described in this Quarterly Report on Form 10-Q and in our other public filings and public statements. Our actual results may not always be in line with or exceed any guidance we have provided, especially in times of economic uncertainty. If actual circumstances differ from those in our assumptions, our operating and financial results could fall below our publicly announced guidance or the expectations of investors. If, in the future, our operating or financial results for a particular period do not meet any guidance we provide or the expectations of investment analysts or investors generally, or if we reduce our guidance for future periods, the market price of our common stock may decline. Even if we do issue public guidance, there can be no assurance that we will continue to do so in the future.

We might require additional capital to support business growth, and this capital might not be available on terms favorable to us, or at all, and may dilute existing stockholders' ownership of our common stock.

We intend to continue to make investments to support our business growth and may require additional funds to respond to business challenges and opportunities, including the need to develop new programs, enhance our existing programs, enhance our operating infrastructure, expand internationally, and acquire complementary businesses and technologies. In order to achieve these objectives, we may make future commitments of capital resources. Accordingly, we may need to engage in equity or debt financings to secure additional funds. If we raise additional funds through further issuances of equity or convertible debt securities, our existing stockholders could suffer significant dilution, and any new equity securities we issue could have rights, preferences, and privileges superior to those of holders of our common stock. In addition, the incurrence of indebtedness would increase our fixed obligations and include covenants or other restrictions that would impede our ability to manage our operations. Further, if additional financing is needed, we may not be able to obtain additional financing on terms favorable to us, or at all. Our inability to obtain adequate financing or financing on terms satisfactory to us, when we require it, could significantly limit our ability to continue supporting our business growth and responding to business challenges and opportunities.

Our principal stockholders and management own a significant percentage of our stock and will be able to exert significant control over matters subject to stockholder approval.

Our executive officers, directors, holders of 5% or more of our capital stock and their respective affiliates own a significant percentage of our stock and have the ability to influence us through this ownership position. These stockholders may be able to exert significant control over matters requiring stockholder approval, including elections of directors, amendments of our organizational documents, or approval of any merger, sale of assets, or other major corporate transaction. This may prevent or discourage unsolicited acquisition proposals or offers for our common stock that you may feel are in your best interest as one of our stockholders.

Sales of a substantial number of shares of our common stock in the public market could cause our stock price to fall.

The trading price of our common stock could decline as a result of sales of a large number of shares of our common stock in the public market after our IPO, and the perception that these sales could occur may also depress the trading price of our common stock. As of June 30, 2025, we had 57,321,000 shares of common stock outstanding and no shares of preferred stock outstanding. Of these shares, all of the shares of our common stock sold in the IPO are freely tradable, without restriction, in the public market. The remaining shares of our common stock will become available for sale under the terms of lock-up agreements entered into between the holders of those shares and the underwriters of our IPO, or market standoff provisions in agreements with us.

Our directors and our executive officers and certain other record holders that together represent a substantial majority of our outstanding common stock and securities directly or indirectly convertible into or exercisable or exchangeable for our common stock have entered into lock-up agreements with the underwriters of our IPO. The lock-up agreements pertaining to our IPO include restrictions on the sale, transfer, or other disposition of shares during the period ending 180 days from the date of the Prospectus (such period, the "restricted period"). Furthermore, most of the holders of our outstanding common stock and securities directly or indirectly convertible into or exercisable or exchangeable for our common stock are subject to market standoff agreements with us that restrict the sale, transfer, or other disposition of shares during the restricted period. After the restricted period expires, substantially all of the securities subject to such lock-up and market standoff restrictions will be eligible for sale in the public market subject to compliance with applicable securities laws.

Upon the completion of the IPO, the holders of approximately 39.4 million shares of our common stock were entitled to rights with respect to the registration of their shares under the Securities Act, subject to vesting schedules and to the lock-up agreements and market standoff agreements described above. Registration of these shares under the Securities Act would result in the shares becoming freely tradable without restriction under the Securities Act, except for shares purchased by affiliates. Any sales of securities by these stockholders could have a material adverse effect on the trading price of our common stock.

Provisions in our charter documents and under Delaware law could discourage a takeover that stockholders may consider favorable and may lead to entrenchment of management.

Our restated certificate of incorporation and amended and restated bylaws contain provisions that could delay or prevent changes in control or changes in our management without the consent of our board of directors. These provisions include the following:

- a classified board of directors with three-year staggered terms, which may delay the ability of stockholders to change the membership of a majority of our board of directors;
- no cumulative voting in the election of directors, which limits the ability of minority stockholders to elect director candidates;
- the exclusive right of our board of directors to elect a director to fill a vacancy created by the expansion of the board of directors or the resignation, death, or removal of a director, which prevents stockholders from being able to fill vacancies on our board of directors;
- the ability of our board of directors to authorize the issuance of shares of preferred stock and to determine the price and other terms of those shares, including preferences and voting rights, without stockholder approval, which could result in significant dilution to our common stockholders (including upon the conversion of any such shares of preferred stock into common stock) and could also be used to significantly dilute the ownership of a hostile acquirer;
- the ability of our board of directors to alter our amended and restated bylaws without obtaining stockholder approval;
- the required approval of at least 66 2/3% of the shares entitled to vote at an election of directors to adopt, amend, or repeal our amended and restated bylaws or to repeal certain provisions of our restated certificate of incorporation;
- a prohibition on stockholder action by written consent, which forces stockholder action to be taken at an annual or special meeting of our stockholders;
- the requirement that a special meeting of stockholders may be called only by our board of directors, which may delay the ability of our stockholders to force consideration of a proposal or to take action, including the removal of directors; and
- advance notice procedures that stockholders must comply with in order to nominate candidates to our board of directors or to propose matters to be acted upon at a stockholders' meeting, which may discourage or deter a potential acquirer from conducting a solicitation of proxies to elect the acquirer's own slate of directors or otherwise attempting to obtain control of us.

We are also subject to the anti-takeover provisions contained in Section 203 of the General Corporation Law of the State of Delaware (the "Delaware General Corporation Law"). Under Section 203, a corporation may not, in general, engage in a business combination with any holder of 15% or more of its capital stock unless the holder has held the stock for three years or, among other exceptions, the board of directors has approved the transaction.

Claims for indemnification by our directors, officers, and other employees or agents may reduce our available funds to satisfy successful third-party claims against us and may reduce the amount of money available to us.

Our restated certificate of incorporation and amended and restated bylaws provide that we will indemnify our directors and officers, in each case to the fullest extent permitted by Delaware law.

In addition, as permitted by Section 145 of the Delaware General Corporation Law, our amended and restated bylaws and our indemnification agreements that we have entered into with our directors, officers, and certain other employees provide that:

- We will indemnify our directors and officers for serving us in those capacities or for serving other business enterprises at our request, to the fullest extent permitted by Delaware law. Delaware law provides that a corporation may indemnify such person if such person acted in good faith and in a manner such person reasonably believed to be in or not opposed to the best interests of the registrant and, with respect to any criminal proceeding, had no reasonable cause to believe such person's conduct was unlawful.

- We may, in our discretion, indemnify employees and agents in those circumstances where indemnification is permitted by applicable law.

- We are required to advance expenses, as incurred, to our directors and officers in connection with defending a proceeding, except that such directors or officers shall undertake to repay such advances if it is ultimately determined that such person is not entitled to indemnification.

- We will not be obligated pursuant to our amended and restated bylaws to indemnify a person with respect to proceedings initiated by that person against us or our other indemnitees, except with respect to proceedings authorized by our board of directors or brought to enforce a right to indemnification.

- The rights conferred in our amended and restated bylaws are not exclusive, and we are authorized to enter into indemnification agreements with our directors, officers, employees and agents and to obtain insurance to indemnify such persons.

- We may not retroactively amend our amended and restated bylaw provisions to reduce our indemnification obligations to directors, officers, employees, and agents.

Our restated certificate of incorporation and amended and restated bylaws provide that the Court of Chancery of the State of Delaware is the exclusive forum for certain disputes between us and our stockholders, which could limit our stockholders' ability to obtain a favorable judicial forum for disputes with us or our directors, officers or employees.

Our restated certificate of incorporation and amended and restated bylaws provide that the Court of Chancery of the State of Delaware (or, in the event that the Court of Chancery does not have jurisdiction, the federal district court for the District of Delaware or other state courts of the State of Delaware) is the exclusive forum for any derivative action or proceeding brought on our behalf, any action asserting a claim of breach of fiduciary duty, any action asserting a claim against us arising pursuant to the Delaware General Corporation Law, our restated certificate of incorporation or our amended and restated bylaws, or any action asserting a claim against us that is governed by the internal affairs doctrine; provided that, the exclusive forum provision does not apply to suits brought to enforce any liability or duty created by the Exchange Act or any other claim for which the federal courts have exclusive jurisdiction; and provided further that, if and only if the Court of Chancery of the State of Delaware dismisses any such action for lack of subject matter jurisdiction, such action may be brought in another state or federal court sitting in the State of Delaware. Our restated certificate of incorporation and amended and restated bylaws also provide that the federal district courts of the United States of America are the exclusive forum for the resolution of any complaint asserting a cause of action against us or any of our directors, officers, employees, or agents and arising under the Securities Act. Nothing in our restated certificate of incorporation or amended and restated bylaws precludes stockholders that assert claims under the Exchange Act from bringing such claims in state or federal court, subject to applicable law.

We believe these provisions may benefit us by providing increased consistency in the application of Delaware law and federal securities laws by chancellors and judges, as applicable, particularly experienced in resolving corporate disputes, efficient administration of cases on a more expedited schedule relative to other forums, and protection against the burdens of multi-forum litigation. However, this choice of forum provision may limit a stockholder's ability to bring a claim in a judicial forum that it finds favorable for disputes with us or any of our directors, officers, other employees, or stockholders, which may discourage lawsuits with respect to such claims (including by making it more costly for stockholders to bring such claims), although our stockholders will not be deemed to have waived our compliance with federal securities laws and the rules and regulations thereunder. Furthermore, the enforceability of similar choice of forum provisions in other companies' certificates of incorporation has been challenged in legal proceedings, and it is possible that a court could find these types of provisions to be inapplicable or unenforceable. While the Delaware courts have determined that such choice of forum provisions are facially valid, a stockholder may nevertheless seek to bring a claim in a venue other than those designated in the exclusive forum provisions, and there can be no assurance that such provisions will be enforced by a court in those other jurisdictions. If a court were to find the choice of forum provision contained in our restated certificate of incorporation and amended and restated bylaws to be inapplicable or unenforceable in an action, we may incur additional costs associated with resolving such action in other jurisdictions, which could adversely affect our business, financial condition, results of operations, and prospects.

The market price of our common stock may be volatile, which could cause the value of your investment to decline.

Even if an active trading market develops, the market price of our common stock may be highly volatile and could be subject to wide fluctuations. Securities markets worldwide experience significant price and volume fluctuations. This market volatility, as well as general economic, market, or political conditions, could reduce the market price of our common stock regardless of our operating performance. In addition, our results of operations could be below the expectations of public market analysts and investors due to a number of potential factors, including variations in our quarterly results of operations, additions or departures of key management personnel, failure to meet analysts' earnings estimates, publication of research reports about our industry, litigation and government investigations, data privacy and security-related events, changes or proposed changes in laws or regulations or differing interpretations or enforcement thereof affecting our business, adverse market reaction to any indebtedness we may incur or securities we may issue in the future, changes in market valuations of similar companies or speculation in the press or investment community, announcements by our competitors, adverse publicity about the technology or virtual care industry, or individual scandals, and, in response, the market price of our common stock could decrease significantly. You may be unable to resell your shares of common stock at or above the IPO price.

Stock markets experience extreme price and volume fluctuations. In the past, following periods of volatility in the overall market and the market price of a company's securities, securities class action litigation has often been instituted against these companies. Such litigation, if instituted against us, could result in substantial costs and a diversion of our management's attention and resources.

If securities or industry analysts do not continue to publish research or reports about our business, or if they issue an adverse or misleading opinion regarding our stock, our stock price and trading volume could decline.

The trading market for our common stock is influenced by the research and reports that industry or securities analysts publish about us or our business. If any of the analysts who cover us issue an adverse or misleading opinion regarding us, our business model, our intellectual property, or our stock performance, or if our results of operations fail to meet the expectations of analysts, our stock price would likely decline. If one or more of these analysts cease coverage of us or fail to publish reports on us regularly, we could lose visibility in the financial markets, which in turn could cause our stock price or trading volume to decline.

General Risk Factors

If we engage in acquisitions or strategic transactions or partnerships, it may increase our capital requirements, dilute our stockholders, cause us to incur debt or assume contingent liabilities, and subject us to other risks.

From time to time we may evaluate various acquisitions and strategic transactions or partnerships, including licensing or acquiring complementary offerings, intellectual property rights, technologies, or businesses. Any acquisition or strategic transaction or partnership may entail numerous risks, including:

- increased operating expenses and cash requirements;

- the assumption of additional indebtedness or contingent liabilities;
- goodwill impairment;
- assimilation of operations, intellectual property, and offerings of an acquired company, including difficulties associated with integrating new personnel;
- the diversion of our management's attention from our existing programs and initiatives in pursuing such a strategic merger or acquisition;
- loss of key personnel and uncertainties in our ability to maintain key business relationships;
- uncertainties associated with the other party to such a transaction, including the prospects of that party and their existing products or product candidates and regulatory approvals; and
- our inability to generate revenue from acquired technology and/or offerings sufficient to meet our objectives in undertaking the acquisition or even to offset the associated acquisition and maintenance costs.

If we undertake acquisitions or strategic transactions or partnerships, we may issue dilutive securities, assume or incur debt obligations, incur large one-time expenses, and acquire intangible assets that could result in significant future amortization expense. Acquisitions or strategic transactions or partnerships could also result in costly litigation or liabilities for any breach of representation or warranties made in connection with those transactions.

The identification of these transactions can be difficult, time-consuming, and costly, and the transactions may not result in the benefits we anticipate. We may not be able to locate suitable opportunities for acquisitions or strategic transactions or partnerships, and even if we do locate such opportunities we may not be able to successfully bid for or obtain them on favorable terms, if at all, due to competitive factors or lack of sufficient resources. This inability could impair our ability to grow or obtain access to technology or products that may be important to the development of our business. Entering into negotiations for transactions that are not ultimately consummated may also result in diversion of management time and significant out-of-pocket costs. In addition, any acquisitions or strategic transactions or partnerships that we announce could be viewed negatively by our customers and channel partners, our members, our investors, or the public.

Economic uncertainties or downturns in the general economy or the industries in which we or our customers or channel partners operate could disproportionately affect the demand for our programs and negatively impact our business, financial condition, results of operations, and prospects.

Economic downturns, market volatility, inflation, tariffs, and uncertainty make it potentially very difficult for us and our customers and channel partners to accurately forecast and plan future business activities. During challenging economic times, our customers or channel partners may have difficulty gaining timely access to sufficient credit or obtaining credit on reasonable terms, which could impair their ability to make timely payments to us and adversely affect our revenue. Bank failures have had and in the future may have a similar impact on the ability or willingness of our customers and channel partners to make payments to us and the timing of collection of our receivables. If that were to occur, our financial results could be harmed. Furthermore, we have customers in a variety of different industries. A significant downturn in the economic activity attributable to any particular industry may cause organizations to react by reducing their capital and operating expenditures in general or by specifically reducing their spending on healthcare matters, including chronic care programs. In addition, our customers or channel partners may delay or cancel healthcare projects or seek to lower their costs by renegotiating contracts. To the extent purchases of our programs are perceived by existing or potential customers and channel partners to be discretionary, our revenue may be disproportionately affected by delays or reductions in general healthcare spending. Also, competitors may respond to challenging market conditions by lowering prices and attempting to lure away our business.

Further, challenging economic conditions, including as a result of increased inflation and tariffs, may impair the ability of our customers and channel partners to pay for the services they already have purchased from us, and as a result, our write-offs of accounts receivable could increase. We cannot predict the timing, strength, or duration of any economic slowdown or recovery. If the condition of the general economy or markets in which we operate worsens, our business, financial condition, results of operations, and prospects could be materially and adversely affected.

In addition, certain of our physical therapy members are covered under health plans that require the member to cover a portion of their own healthcare expenses through the payment of member cost-sharing amounts, such as copayments, deductibles, or co-insurance. PPTG may not be able to collect the full amounts due with respect to these payments that are the member's financial responsibility. To the extent permitted by law, amounts not covered by third-party payers are the obligations of individual members for which PPTG may not receive whole or partial payment. Any increase in cost shifting from third-party payers to individual members, including as a result of high deductible plans for members, increases our collection costs and reduces overall collections, which we may not be able to offset such additional costs with sufficient revenue.

Item 2. Unregistered Sales of Equity Securities and Use of Proceeds

Equity Plan-Related Issuances

During the three months ended June 30, 2025, we granted to our directors, officers, employees, consultants, and other service providers options to purchase an aggregate of 327,013 shares of our common stock under our 2011 Stock Plan (as amended, the "2011 Plan") and 2025 Incentive Award Plan.

During the three months ended June 30, 2025, we granted to our directors, officers, employees, consultants, and other service providers an aggregate of 630,328 restricted stock units be settled in shares of our common stock, under our 2025 Incentive Award Plan.

During the three months ended June 30, 2025, we issued and sold to our directors, officers, employees, consultants, and other service providers an aggregate of 391,883 shares of our common stock upon the exercise of stock options under our 2011 Plan.

Exercise prices under our 2011 Plan and 2025 Incentive Award Plan ranged from $2.6 to $10.9 per share, for an aggregate purchase price of $2.8 million.

On May 19, 2025, all outstanding warrants to acquire shares of our Series B redeemable convertible preferred stock were automatically cashless exercised in accordance with their terms, resulting in the issuance of 92,194 shares of our Series B redeemable convertible preferred stock, which shares were subsequently converted into 30,731 shares of our common stock in connection with our initial public offering ("IPO"). We received no proceeds in connection with the exercise of the Series B redeemable convertible preferred stock warrants or the subsequent conversion of the shares of preferred stock into shares of common stock.

On June 9, 2025, the holder of all outstanding warrants to acquire shares of our Series D redeemable convertible preferred stock cashless exercised such warrants, resulting in the issuance of 135,143 shares of our Series D redeemable convertible preferred stock, which shares were subsequently converted into 45,047 shares of our common stock in connection with our IPO. We received no proceeds in connection with the exercise of the Series D redeemable convertible preferred stock warrants or the subsequent conversion of the shares of redeemable convertible preferred stock into shares of common stock.

None of the foregoing transactions involved any underwriters, underwriting discounts or commissions, or any public offering. The offers, sales, and issuances of the securities described above were deemed to be exempt from registration under Rule 701 promulgated under the Securities Act, as transactions under compensatory benefits plans and contracts relating to compensation, or under Section 4(a)(2) of the Securities Act as a transaction by an issuer not involving a public offering. The recipients of the securities in each of these transactions represented their intentions to acquire the securities for investment only and not with a view to or for sale in connection with any distribution thereof, and appropriate legends were placed upon the stock certificates issued in these transactions. All recipients had adequate access, through their relationships with us, to information about us. The sales of these securities were made without any general solicitation or advertising.

Use of Proceeds

On June 9, 2025, we completed our IPO, in which we issued and sold 9,085,000 shares of common stock, which includes the exercise in full by the underwriters of their option to purchase from us 1,185,000 shares of our common stock, at a public offering price of $19.00 per share. We received proceeds of approximately $151.6 million, after deducting underwriting discounts and commissions of $12.0 million and estimated offering expenses of $9.0 million. All shares sold

were registered pursuant to a registration statement on Form S-1 (File No. 333-287156), as amended (the "Registration Statement"), declared effective by the U.S. Securities and Exchange Commission on June 5, 2025. Morgan Stanley & Co, LLC, Goldman Sachs & Co. LLC, and J.P. Morgan Securities LLC acted as representatives of the underwriters for the offering. The offering terminated after the sale of all securities registered pursuant to the Registration Statement. No payments for such expenses were made directly or indirectly to (i) any of our officers or directors or their associates, (ii) any persons owning 10% or more of any class of our equity securities, or (iii) any of our affiliates.

We used a portion of the net proceeds from our IPO to repay outstanding borrowings under the MidCap Credit Agreement. There has been no material change in the expected use of the net proceeds from our IPO as described in our Prospectus.

Issuer Purchases of Equity Securities

None.

Item 3. Defaults Upon Senior Securities

Not Applicable.

Item 4. Mine Safety Disclosures

Not Applicable.

Item 5. Other Information

During the three months ended June 30, 2025, none of our directors or officers adopted, modified, or terminated a "Rule 10b5-1 trading arrangement" or "non-Rule 10b5-1 trading arrangement," as each term is defined in Item 408(a) of Regulation S-K.

Item 6. Exhibits

See the Exhibit Index attached to this registration statement, which Exhibit Index is incorporated herein by reference.

Schedules not listed above have been omitted because the information required to be set forth therein is not applicable or is shown in the financial statements or notes thereto.

Exhibit Number	Exhibit Description	Incorporated by Reference			Filed Herewith
		Form	Date	Number	
3.1	Restated Certificate of Incorporation	8-K	6/9/2025	3.1	
3.2	Amended and Restated Bylaws	8-K	6/9/2025	3.2	
4.1	Form of Common Stock Certificate.	S-1	5/9/2025	4.2	
4.2	Amended and Restated Investors' Rights Agreement, dated December 22, 2021, by and among Omada Health, Inc. and the investors listed therein.	S-1	5/9/2025	4.3	
10.1(a)†^	Services Agreement, dated as of February 1, 2018, by and between Omada Health, Inc. and Cigna Health and Life Insurance Company.	S-1	5/9/2025	10.3(a)	
10.1(b)†	Amendment No. 1 to Services Agreement, dated as of February 1, 2018, by and between Omada Health, Inc. and Cigna Health and Life Insurance Company.	S-1	5/9/2025	10.3(b)	
10.2(a)†^	Master Services Agreement, dated January 1, 2020, by and between Express Scripts Holding Company, Inc. and Omada Health, Inc.	S-1	5/9/2025	10.4(a)	
10.2(b)†	Amendment No. 1 to Master Services Agreement, dated as of July 22, 2021, by and between Evernorth Health, Inc., f/k/a Express Scripts Health and Welfare Plan and Express Scripts Holding Company, Inc. (f/k/a ESHC), and Omada Health, Inc.	S-1	5/9/2025	10.4(b)	
10.2(c)†	Amendment No. 2 to Master Services Agreement, dated as of February 14, 2023, by and between Evernorth Health, Inc., f/k/a Express Scripts Holding Company, Inc., and Omada Health, Inc.	S-1	5/9/2025	10.4(c)	
10.3(a)†^	Administrative Services Agreement, dated as of January 1, 2020, by and between Omada Health, Inc. and Cigna Health and Life Insurance Company.	S-1	5/9/2025	10.5(a)	
10.3(b)†	Amendment No. 1 to Administrative Services Agreement, dated as of April 6, 2021, by and between Omada Health, Inc. and Cigna Health and Life Insurance Company.	S-1	5/9/2025	10.5(b)	
10.3(c)†	Amendment No. 2 to Administrative Service Agreement, dated as of March 7, 2022, by and between Omada Health, Inc. and Cigna Health and Life Insurance Company.	S-1	5/9/2025	10.5(c)	
10.4†^	Administrative Services Agreement, dated as of December 13, 2022, by and between Omada Health, Inc. and Allegiance Benefit Plan Management, Inc.	S-1	5/9/2025	10.6	
10.5(a)†^	Ancillary Services Agreement, dated as of May 31, 2018, by and between Omada Health, Inc. and Cigna Health Corporation.				X
10.5(b)†	Amendment No. 1 to Ancillary Services Agreement, dated as of January 1, 2019, by and between Omada Health, Inc. and Cigna Health Corporation.	S-1	5/9/2025	10.7(b)	

Exhibit Number	Exhibit Description	Incorporated by Reference			Filed Herewith
		Form	Date	Number	
10.5(c)†	Amendment No. 2 to Ancillary Services Agreement, dated as of January 16, 2019, by and between Omada Health, Inc. and Cigna Health Corporation.	S-1	5/9/2025	10.7(c)	
10.5(d)†	Amendment No. 3 to Ancillary Services Agreement, dated as of January 1, 2020, by and between Omada Health, Inc., and Cigna Health Corporation.	S-1	5/9/2025	10.7(d)	
10.5(e)	Amendment No. 4 to Ancillary Services Agreement, dated as of June 1, 2025, by and between Omada Health, Inc., and Cigna Health Corporation.	S-1/A	5/29/2025	10.7(e)	
10.6(a)#	2011 Stock Plan.	S-1	5/9/2025	10.8(a)	
10.6(b)#	Form Agreements under 2011 Stock Plan.	S-1/A	5/29/2025	10.8(b)	
10.7(a)#	2025 Incentive Award Plan.	S-1/A	5/29/2025	10.9(a)	
10.7(b)#	Form Agreements under 2025 Incentive Award Plan.	S-1	5/9/2025	10.9(b)	
10.8#	2025 Employee Stock Purchase Plan.	S-1/A	5/29/2025	10.10	
10.9#	Non-Employee Director Compensation Program.	S-1	5/9/2025	10.11	
10.10#	Form of Indemnification Agreement for Directors and Officers.	S-1	5/9/2025	10.12	
10.11#	Offer Letter, by and between Omada Health, Inc. and Steve Cook.	S-1	5/9/2025	10.13	
10.12#	Offer Letter, by and between Omada Health, Inc. and Wei-Li Shao.	S-1	5/9/2025	10.14	
10.13#	Form of Change in Control and Severance Agreement for Officers.	S-1	5/9/2025	10.15	
31.1	Certification of Principal Executive Officer Pursuant to Rules 13a-14(a) and 15d-14(a) under the Securities Exchange Act of 1934, as Adopted Pursuant to Section 202 of the Sarbanes-Oxley Act of 2002.				X
31.2	Certification of Principal Financial Officer Pursuant to Rules 13a-14(a) and 15d-14(a) under the Securities Exchange Act of 1934, as Adopted Pursuant to Section 202 of the Sarbanes-Oxley Act of 2002.				X
32.1*	Certification of Principal Executive Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.				X
32.2*	Certification of Principal Financial Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.				X

Exhibit Number	Exhibit Description	Incorporated by Reference			Filed Herewith
		Form	Date	Number	
101	The following financial information from Omada, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2025 formatted in Inline XBRL (Extensible Business Reporting Language) includes: (i) the Condensed Consolidated Balance Sheets, (ii) the Condensed Consolidated Statements of Operations and Comprehensive Loss, (iii) the Condensed Consolidated Statements of Redeemable Convertible Preferred Stock and Stockholders' Equity (Deficit), (iv) the Condensed Consolidated Statements of Cash Flows, and (v) Notes to the Condensed Consolidated Financial Statements.				X
104	Cover Page Interactive Data File (formatted as Inline XBRL and contained in Exhibit 101).				X

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# Indicates management contract or compensatory plan.

† Portions of the exhibit, marked by brackets, have been omitted in accordance with Item 601(b)(10) of Regulation S-K because the omitted information (i) is not material and (ii) is the type of information that Omada Health, Inc. treats as private or confidential.

^ Portions of this exhibit have been omitted in accordance with Item 601(a)(5) of Regulation S-K. Omada Health, Inc. undertakes to furnish a copy of all omitted schedules and exhibits to the SEC upon its request.

*The certifications attached as Exhibit 32.1 and Exhibit 32.2 that accompany this Quarterly Report on Form 10-Q are deemed furnished and not filed with the Securities and Exchange Commission and are not to be incorporated by reference into any filing of Omada Health, Inc. under the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended, whether made before or after the date of this Quarterly Report on Form 10-Q, irrespective of any general incorporation language contained in such filing.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

OMADA HEALTH, INC.

Date: August 8, 2025

By: /s/ Steve Cook

Steve Cook
Chief Financial Officer
(Duly Authorized Officer and Principal Financial Officer)

[***] Certain information in this document has been excluded pursuant to Regulation S-K, Item 601(b)(10). Such excluded information is not material and would likely cause competitive harm to the registrant if publicly disclosed.

Exhibit 10.5(a)

Ancillary Services Agreement

This Ancillary Services Agreement ("Agreement") is between Cigna Health Corporation on behalf of itself and its affiliates and subsidiaries ("Cigna") and Omada Health, Inc. ("Provider") and is effective upon Cigna's execution and implementation of the Agreement into its administrative systems. Provider will be notified of the Effective Date via Cigna's return of the signed contract to Provider, and will be indicated in the space below.

Effective Date: May 31, 2018

Cigna and Provider hereby agree, that upon the Effective Date, a) that certain Master Services Agreement dated September 28, 2015, by and between Provider and Cigna, together with that Certain Statement of Work No. 1, entered into pursuant thereto, each as amended to date (the "Prior Agreement") shall terminate and b) all Participants (as defined in the Prior Agreement) enrolled pursuant to the Prior Agreement shall be considered Program Participants under this Agreement.

SECTION 1. DEFINITIONS

1.1 Administrative Guidelines

means the rules, policies and procedures adopted by Cigna or a Payor to be followed by Provider in providing services and doing business with Cigna and Payors under this Agreement.

1.2 Active & Fit Direct

means a reduced-cost gym membership program arranged for by Cigna through [***].

1.3 ASO Client Account

means an organization, such as an employer, which contracts with Cigna for the provision of self-insured medical coverage for its Members.

1.4 [***]

means a [***] as referenced in the attached Exhibit A.

1.5 Benefit Plan

means a certificate of coverage, summary plan description or other document or agreement which specifies the health care services to be provided or reimbursed for the benefit of a Participant.

1.6 [***]

means a [***] as referenced in the milestone achievements in the attached Exhibit A.

1.7 Clinically Qualified Participants

means Participants who complete the online enrollment process and agree to the Provider's Participant Agreements.

1.8 Clinical Enrollment Criteria

means the demographic and/or medical criteria by which a Participant is evaluated for the potential acceptance into the Program.

1.9 Cigna Affiliate

means any subsidiary or affiliate of Cigna Corporation.

1.10 Coinsurance

means a payment that is the financial responsibility of the Participant under a Benefit Plan for Covered Services that is calculated as [***] or, if [***] or as [***].

1.11 Copayment

means a payment that is the financial responsibility of the Participant under a Benefit Plan for Covered Services that is calculated as [***].

1.12 Covered Services

means those health care services for which a Participant is entitled to receive coverage under the terms and conditions of the Participant's Benefit Plan.

1.13 Data Files

means the format, frequency and method of data to be shared by Provider, to Cigna for reporting purposes in the Agreement or otherwise in writing.

1.14 Deductible

means a payment for Covered Services calculated as [***] that is the financial responsibility of the Participant under a Benefit Plan prior to qualifying for reimbursement for subsequent health care costs under the terms of a Benefit Plan.

1.15 [***]

means the [***] for each Program Participant.

1.16 [***]

means the [***] as referenced in the attached Exhibit A.

1.17 Home Medical Equipment

means the Services to be provided by Provider as outlined in this Agreement, the Services Agreement and consist of Provider's online program for Participants at risk for diabetes and cardiovascular disease.

1.18 Home Setting

means the Participant's primary place of residence or the residence where Participant is receiving Home Medical Equipment services.

1.19 [***]

means the [***] as referenced in the attached Exhibit A to the Agreement.

1.20 Medically Necessary/Medical Necessity

means services and supplies that satisfy the Medical Necessity requirements under the applicable Benefit Plan. No service is a Covered Service unless it is Medically Necessary.

1.21 NDA

means the Mutual Confidentiality and Non-Disclosure Agreement dated December 11, 2014, as amended between Cigna and Provider.

1.22 Participant

means any individual, or eligible dependent of such individual, whether referred to as "Insured", "Subscriber", "Member", "Participant", "Enrollee", "Dependent", or similar designation, who is eligible and enrolled to receive Covered Services.

1.23 Participant Agreements

means Provider's Terms of Use, Privacy Policy and Notice of HIPAA Practices (all of which are accessible at go.omadahealth.com).

1.24 Participating Provider

means a hospital, physician or group of physicians, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services with regard to the Benefit Plan covering the Participant.

1.25 Payor

means the person or entity obligated to a Participant to provide reimbursement for Covered Services under the Participant's Benefit Plan and which Cigna has agreed may access services under this Agreement.

1.26 Pre-Existing Account

shall have the meaning given such term in Section 4.3.

1.27 Prior Agreement

Agreement as outlined in the Cigna Master Service Agreement that was in effect September 28, 2015.

1.29 Program

means an online program administered by Provider for Participants who are at risk for diabetes and cardiovascular disease, which consists of its proprietary technology platform and systems (including, without limitation, hardware, software, algorithms and other underlying technology or components of or used to provide the Program and any Covered Services or other health care services provided by Provider in combination therewith) and any proprietary information, technical information, data, content, documentation and other materials related thereto.

1.30 Program Participant

means a Clinically Qualified Participant that enrolls into the Provider's online Program.

1.31 Project Developments

shall have the meaning given such term in Section 6.5.

1.32 Quality Management

means the program described in the Administrative Guidelines relating to the quality of Covered Services provided to Participants.

1.33 Residual Rights.

shall have the meaning given to such term in Section 6.8.

1.34 Start Dates

means the date on which a new Clinically Qualified Program Participant receives an email from Provider notifying him or her that he or she may access the first lesson of the curriculum.

1.35 Services Agreement

CHLIC Services Agreement describing Cigna responsibilities to Provider

1.36 Third-Party

An entity indirectly involved with the Agreement but is not a principal party to the arrangement.

1.37 Transition Date

shall have the meaning given such term in Section 4.3.

1.38 Utilization Management

means a process to review and determine whether certain health care services provided or to be provided are Medically Necessary and in accordance with the Administrative Guidelines.

1.39 Work Product

means a deliverable under this Agreement that is produced by Omada specifically for Cigna to achieve the objectives of this Agreement and which the parties mutually agree in writing shall be treated as Work Product for purposes of Section 6.3.

SECTION 2. DUTIES OF PROVIDER

2.1 Provider Services.

Provider shall provide Covered Services to Participants upon the terms and conditions set forth in this Agreement and the Administrative Guidelines. All services provided by Provider within the scope of Provider's practice or license must be provided on a participating basis. Regardless of Provider's physical location, all aspects of Provider's practice are participating under the terms of this Agreement unless Covered Services are provided under the terms of another applicable Cigna participation agreement.

2.2 Standards.

Provider shall provide Covered Services with the same standard of care, skill and diligence customarily used by similar providers in the community, the requirements of applicable law, and the standards of applicable accreditation organizations. Provider shall provide Covered Services to all Participants [***], under [***], and with [***]. Provider shall not differentiate or discriminate in the treatment of any Participant because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status, veteran's status, handicap or source of payment. Provider shall assure that all health care providers who perform any of the services for which Provider is responsible under this Agreement maintain all necessary licenses or certifications required by state and federal law. Provider shall [***] restrict, suspend, or terminate any such health care provider from providing services to Participants under this Agreement if such provider ceases to meet the licensing/certification requirements or other professional standards described in this Agreement.

2.2.1 Provider, and CIGNA shall act in accordance with the terms of this Agreement, the Services Agreement, and applicable attached Exhibits. Except as otherwise stated in this Agreement, the rates set forth in this Agreement shall be payment in full for all services provided to Participants pursuant to this Agreement as outlined in Exhibit A and Exhibit A-1.

2.2.2 Provider will provide advance written notice to Cigna of any Material Change to the Covered Services. For purposes of this Agreement, "Material Change" means any change [***] of the Covered Services as of the Effective Date that will [***] the Program Participants use of the Covered Services.

2.2.3 Subject to the terms and condition of this Agreement, Provider shall (a) Arrange for the provision of Home Medical Equipment to Participants in Home Setting; render Covered Services to Participants [***], in accordance with [***], and with [***].

(b) not [***];

(c) Provider will ensure that the Home Medical Equipment supplied to Participant is in good working order and condition. Provider shall arrange for [***] all necessary maintenance and/or repair for Equipment (including provision of all necessary parts, mechanisms and devices) in order to maintain the Equipment in good condition and working order; provided that such maintenance and/or repair is required as a result of normal wear and tear (as defined by warranty), or a defect in, the Home Medical Equipment.

2.2.4 Subject to the terms and condition of this Agreement, Provider shall be required to maintain an accurate inventory of Home Medical Equipment and supplies, as applicable, for each Participant, to the extent necessary to provide Home Setting services under this Agreement, and shall make these inventory records available to Cigna upon request.

2.2.5 Provider shall ensure that its facilities and employees, maintain a neat, clean and professional appearance at all times.

2.2.6 Provider will dedicate on a full-time basis (and part-time, as required) the services of appropriate personnel to coordinate the implementation of this Agreement on both local and national levels, and to manage the day-to-day work relationship with Cigna. Provider will meet with designated Cigna personnel upon request to review Provider's performance, Participant utilization and quality improvement initiatives.

2.2.7 Provider and Cigna agree to meet at least on a [***] to assist Cigna in staying abreast of innovations in Home Medical Equipment services and to work with Cigna to see that these services are being appropriately applied to Participants.

2.3 Branded Product

Provider shall ensure that its Participant and Provider collateral materials, customer and provider service representatives, and internet portals shall provide a seamless, Cigna-branded experience for Participants consistent with Cigna's product and requirements for branding and display as agreed to by the parties. Branded experience shall incorporate as agreed by the parties (a) Cigna logos, branding, on

letterhead to Participants in relation to Cigna specific programs, and (b) integration of critical information into Cigna systems, which shall happen [***] after implementation of this Agreement, and which shall include but not be limited to information regarding [***].

2.4 Insurance/Application for Participation Information.

Provider shall maintain general and professional liability coverage [***], give Cigna evidence of such coverage upon request and provide Cigna with [***] written notice of a material modification or termination of such insurance. Provider shall also notify Cigna in writing within [***] days of any material change in the information contained in Provider's application for participation with Cigna.

2.5 Administrative Guidelines.

Provider shall comply with the Administrative Guidelines. Some or all Administrative Guidelines may be communicated in the form of a provider reference manual, in other written materials distributed by Cigna to Provider and/or at a website identified by Cigna. Administrative Guidelines may change from time to time. Cigna will give Provider advance notice of material changes to Administrative Guidelines.

2.6 Quality Management.

Provider shall comply with the requirements of and participate in Quality Management as specified in the Administrative Guidelines.

2.7 Utilization Management.

Provider shall comply with the requirements of and participate in Utilization Management as specified in this Agreement and the Administrative Guidelines. [***] for failure to comply with such Utilization Management requirements, and Provider [***]. Cigna's Utilization Management requirements include, but are not limited to, the following: a) [***] from Cigna or its designee for those services and procedures for which it is required as specified in the Administrative Guidelines; b) Provider must provide Cigna or Cigna's designee with all of the information requested by Cigna or its designee to [***]; and c) Provider will refer Participants to and/or use Participating Providers for the provision of Covered Services [***]. If Provider inappropriately refers a Participant to a non-Participating Provider [***], and thereby cause the Participant to [***], Cigna or a Cigna Affiliate may, in its [***]. If this occurs, Cigna or a Cigna Affiliate may [***] for such services [***].

2.8 Enrollment of Clinically Qualified Participants in the Covered Services; Provision of Covered Services.

Provider will enroll in the Covered Services, any Participant who [***]. Provider will not accept for enrollment in the Covered Services any Participants [***]. As participant enrollment allows, Provider will [***].

2.9 Records.

Provider and Cigna shall maintain the confidentiality of all confidential information, including medical records and documents relating to Participants as may be required by applicable law and for the period of time required by law and regulations. Medical records of Participants and any other records containing individually identifiable information relating to Participants will be regarded as confidential, and Provider and Cigna shall comply with applicable federal and state law regarding such records. Provider shall provide Participants with a notice of HIPAA privacy practices regarding legally permitted disclosure of records and information necessary to Provider to carry out its utilization management, quality improvement, claims management and payment and other relevant programs regulations which allow Provider to disclose such information to Cigna for such purposes. Upon request, Provider will provide Cigna with a copy of Participants' medical records and other records maintained by Provider relating to Participants. These records shall be provided to Cigna [***] and [***] and will also be made available during normal business hours for inspection by Cigna, Cigna's designee, accreditation organizations, or to any governmental agency that requires access to these records. This provision survives the termination of this Agreement. Cigna agrees to abide by the confidentiality obligations set forth in this Agreement.

2.10 Cooperation with Cigna and Cigna Affiliates.

Provider shall cooperate with Cigna in the implementation of Cigna's Participant appeal procedure. Provider shall also cooperate with Cigna and Cigna Affiliates in implementing those policies and programs as may be reasonably requested by Cigna or a Cigna Affiliate for purposes of Cigna's or the Cigna Affiliate's business operations or required by Cigna or a Cigna Affiliate to comply with applicable law or accreditation requirements.

2.11 Reporting and Data.

Provider and Cigna will mutually agree, on the format, frequency and method of data files to be shared by Provider, to Cigna for reporting purposes in the Agreement or otherwise in writing ("Data Files"). This Service Level measures whether the Data Files provided by Provider match the agreed format, frequency and method. Provider will

make available to Cigna the Data Files [***] as measured by the Provider and the Cigna. "[***]" shall mean that the Data File is available to Cigna by the [***]. "[***]" shall mean that the Data File matches the [***], including the data elements and record headers. This Service Level is calculated by dividing the [***].

2.11.1 Provider's compensation for the reports, studies, information exchanges and data access delineated in this section and associated exhibits is fully incorporated in the rates and/or fee schedules and associated exhibits attached hereto. Provider shall receive no additional compensation for the reports, studies, information exchanges and data access. Provider agrees to collect data necessary to complete each report listed in the Performance Standards, Exhibit B to the Agreement.

2.12 Adhoc Reporting.

Provider agrees to furnish ad hoc reports to Cigna upon reasonable request by Cigna to an individual designated by Provider. Provider agrees to provide most simple ad hoc reports requested within [***] working days.

2.13 Quality Assurance Program

Provider will maintain a quality assurance program (including process improvement initiatives) on Participants on a [***] basis, and report to Cigna the results of such initiatives each [***] as outlined in the attached Performance Standards, Exhibit B. Cigna may conduct satisfaction surveys on Participants, and Cigna personnel and will supply Provider with the results of any such satisfaction surveys. The format of the quality assurance initiatives shall be [***]. The format of the satisfaction surveys will be developed by Cigna with input from Provider.

2.14 [***]

As used in this Section 2.14, the following terms have the meaning indicated:

"**Clinical Referral Customer**" means [***], but is limited to deployments or contracts where [***] clinical entities or groups (i.e., health system, provider groups, care teams, etc.) refer eligible individuals directly to the Program with limited involvement from Provider.

"**Commercial Business Customer**" means all commercial customers of Omada based in the United States, except for Medicare Advantage Business and Clinical Referral Customers.

"**Excluded Customers**" means all [***] for the delivery of the Omada Program to [***] in the United States other than [***] (e.g., [***], etc.).

"**Excluded Plans**" means:

1. [***]
2. [***]
3. [***]
4. [***]
5. [***]
6. [***]
7. [***]

"**Medicare Advantage Business Customer**" means all commercial customers based in the United States with whom Omada has entered into a contract for the delivery of the Omada Program for a Medicare Advantage program.

"**Net Pricing**" means the net fees charged by Provider for the Covered Services for each Participant's [***] of the Covered Services [***].

The Net Pricing for the Covered Services under this Agreement for Cigna's commercial and Medicare Advantage clients shall be [***], or [***], as applicable, following the effective date of this Agreement.

The Net Pricing for Covered Services under this Agreement for Cigna's delivery system alliance (DSA) partners and Cigna collaborative care (CCC) arrangements with provider delivery systems (without regard to location) shall be [***].

[***] in this Section 2.14., then Provider will [***] as required by this Section 2.14 for [***] set forth in such third party agreement for the [***] following the effective date of such third party agreement).

This Section 2.14 applies only to new agreements (or new statements of work under existing agreements) with third parties entered into on or after the effective date of this Agreement.

This Section 2.14 does not apply with respect to any agreements with Excluded Customers or Excluded Plans. However, if any of the Excluded Plans is competing with Cigna with respect to an existing Cigna client or a prospective client of Cigna, Provider shall, upon request by Cigna, [***]. This Section 2.14 shall be enforceable only to the extent permitted by applicable law.

2.15 Performance Standards

Provider shall perform its obligations under this Agreement in accordance with the standards set forth in Exhibit B to the Agreement. In the event that Provider fails to achieve a performance standard, the [***] the table as set forth in Exhibit B to the Agreement.

2.16 Notice of Taxes, Assessments or Surcharges

Fees for the Covered Services provided for in this Agreement are exclusive of any taxes associated with the purchase thereof (which shall be the responsibility of Payors). In the

event that Provider learns that a tax, assessment or surcharge is imposed by a governmental entity upon the charges made by Omada for the Covered Services, Omada shall provide Cigna written notice without unreasonable delay following a final determination that such tax, assessment, or surcharge shall apply.

SECTION 3. DUTIES OF CIGNA

3.1 Payors, Benefit Plan Types, Notice of Changes to Benefit Plan Types.

Cigna may allow Payors to access Provider's services under this Agreement for the following Benefit Plan types: a) Benefit Plans where Participants are offered a network of Participating Providers and are required or given the option to select a Primary Care Physician; b) Benefit Plans where Participants are offered a network of Participating Providers and are not required or given the option to select a Primary Care Physician; and c) Benefit Plans where Participants are not offered a network of Participating Providers from which they may receive Covered Services. Benefit Plans may include workers' compensation plans. Cigna will give Provider advance notice if Cigna changes this list of Benefit Plan types for which Payors may access Provider's services under this Agreement.

3.2 Benefit Information.

Cigna will give Provider access to benefit information concerning the type, scope and duration of benefits to which a Participant is entitled as specified in the Administrative Guidelines.

3.3 Participant and Participating Provider Identification.

Cigna will establish a system of Participant identification and will identify Participating Providers to those Payors and Participants who are offered a network of Participating Providers. However, Cigna makes no representations or guarantees concerning the number of Participants that will be referred to Provider as a result of this Agreement and [***].

Cigna may, where agreed to by an existing Cigna client, [***].

SECTION 4. COMPENSATION

4.1 Payments.

Payments for Covered Services will be the lesser of the billed charge or the applicable fee under Exhibit A and Exhibit A-1, subject to the Administrative Guidelines and minus any applicable Copayments, Coinsurance and Deductibles. The rates in this Agreement will be payment in full for all services furnished to Participants under this Agreement. Provider shall look solely to Payor for payment for Covered Services except for Copayments, Coinsurance and Deductibles. Provider shall submit claims for Covered Services at the location identified by Cigna and in the manner and format specified in this Agreement and the Administrative Guidelines. Claims for Covered Services must be submitted within [***] days of the date of service or, if Payor is the secondary payor, within [***] days of the date of the explanation of payment from the primary payor. Claims received after this [***] day period may be denied except as provided in the Administrative Guidelines, and Provider shall not bill Cigna, the Payor or the Participant for those denied services. Amounts due and owing under this Agreement with respect to complete claims for Covered Services will be payable within the timeframes required by applicable law.

4.2 Claims/Billing

Cigna agrees to authorize Provider to bill claims for all Participants via electronic submission means agreed upon between the parties using submitted information including:

a) NPI: [***]

b) Tax ID: [***]

c) Product service code (CPT code): [***]

d) Place of service code: [***] and

e) ICD-10 codes as set forth below (or as otherwise noted in the Services Agreement, Statement of Work, or agreed by the Provider and Cigna in writing):

ICD-10	Description
[***]	[***]

[***]	[***]
[***]	[***]
[***]	[***]
[***]	[***]
[***]	[***]
[***]	[***]

Cigna agrees to accept and pay valid claims submitted by Provider for all Participants in accordance with the payment terms set forth in Exhibit A and A-1 to the Agreement.

4.3 Pre-Existing Accounts & Transition Dates.

There are certain ASO Client Accounts identified as "Legacy Accounts" in the Prior Agreement with respect to which Provider has provided Covered Services prior to the Effective Date of this Agreement pursuant to the Prior Agreement the (the "Pre- Existing Accounts"). The pricing for Program Participants associated with Pre- Existing Accounts with Start Dates before the applicable Transition Date shall be as set forth in Exhibit A to the Agreement, and Provider will be authorized to bill claims for such Program Participants using such pricing for fees incurred on or prior to the [***]. Cigna and Provider shall agree separately in writing upon the date upon which the pricing set forth in Exhibit A-1 shall apply to newly enrolled Participants from each Pre-Existing Account ("Transition Date"). The pricing for all Program Participants not associated with Pre-Existing Accounts and for all Program Participants associated with Pre- Existing Accounts with Start Dates on or after the applicable Transition Date shall be as set forth in Exhibit A-1 to the Agreement.

4.4 Underpayments.

If Provider believes a Covered Service has been underpaid, Provider must submit a written request for an appeal or adjustment with Cigna or its designee within [***] days from the date of Payor's payment or explanation of payment. The request must be submitted in accordance with the dispute resolution process set out in the Administrative Guidelines. Requests for appeals or adjustments submitted after this date may be denied for payment, and Provider will not be permitted to bill Cigna, the Payor or the Participant for those services.

4.5 Copayments, Coinsurance and Deductibles.

Provider may charge Participants applicable Copayments, Coinsurance and Deductibles in accordance with the process set out in the Administrative Guidelines.

4.6 Limitations on Billing Participants.

Provider shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Participants or persons other than the applicable Payor for Covered Services or for any amounts denied or not paid under this Agreement due to Provider's failure to comply with the requirements of Cigna's or its designee's Utilization Management Program or other Administrative Guidelines, or failure to file a timely claim or appeal. This provision

does not prohibit collection of any applicable Copayments, Coinsurance and Deductibles. This provision survives termination of this Agreement, is intended to be for the benefit of Participants, and supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Participant or persons acting on the Participant's behalf. Modifications to this section will become effective no earlier than the date permitted by applicable law.

4.7 Billing Patients Who Cease To Be Participants.

Provider may bill a patient directly for any services provided following the date that patient ceases to be a Participant, and Payor has no obligation to pay for services for such patients.

4.8 Participant Incentives Prohibited.

Provider shall not directly or indirectly establish, arrange, encourage, participate in or offer any Participant incentive.

(a) Participant Incentive means any arrangement by Provider:

(1) to reduce or satisfy a Participant's cost-sharing obligations (including, but not limited to Copayments, Deductible and/or Coinsurance);

(2) to pay on behalf of or reimburse a Participant for any portion of the Participant's costs for coverage under a policy or plan insured or administered by Cigna or a Cigna Affiliate;

(3) that provides a Participant with any form of material, financial incentive (other than the reimbursement terms under this Agreement), to receive Covered Services from Provider or its affiliates.

(b) In the event of non-compliance with this provision:

(1) Cigna may terminate this Agreement, such non-compliance being a "material breach" of this Agreement;

(2) Provider shall not be entitled to reimbursement under this Agreement with respect to Covered Services provided to a Participant in connection with a Participant Incentive, and;

(3) Cigna may take such other action appropriate to enforce this provision.

4.9 Non-Medically Necessary Services.

Provider shall not charge a Participant for a service that is not Medically Necessary unless, in advance of providing the service, Provider has notified the Participant that the particular service will not be covered and the Participant acknowledges in writing that he or she will be responsible for payment for such service.

4.10 Reimbursement of Amounts Collected In Error.

If Provider collects payment from a Participant when not permitted to collect under either this Agreement or the Administrative Guidelines, Provider must repay the amount within [***] of a request from Cigna or the Participant or of the date Provider has knowledge of the error. If Provider fails to make the repayments, then Cigna may (but is not obligated to) reimburse the Participant the amount inappropriately paid and then withhold this amount from future payments.

4.11 Overpayments.

Provider shall refund to Cigna any excess payment made by a Payor to Provider if Provider is for any reason overpaid for health care services or supplies. Cigna may, at its option, deduct the excess payment from other amounts payable, and Provider will be notified of any such deduction as specified in the Administrative Guidelines.

4.12 Audits.

Upon reasonable notice and during regular business hours, Cigna or its designee will have the right to review and make copies of all records maintained by Provider with respect to all payments received by Provider from all sources for Covered Services provided to Participants. Cigna or its designee will have the right to conduct audits of such records and may audit its own records to determine if amounts have been properly paid under this Agreement. Any amounts determined to be due and owing as a result of such audits must be promptly paid or, at the option of the party to whom such amounts are owed, offset against amounts due and owing by such party hereunder. This provision survives the termination of this Agreement.

4.13 Coordination of Benefits.

Certain claims for Covered Services are claims for which another payor may be primarily responsible under coordination of benefit (COB) rules. Provider may pursue those claims in accordance with the process set out in the Administrative Guidelines. Cigna's payment as secondary payor (non-Medicare). Cigna's payment when added to the amount payable from other sources under the applicable COB rules, will be [***], and is subject to the terms and conditions of the Participant's health benefit plan and applicable state and federal law. Use of applicable COB provisions may result in a payment from Cigna that, when added to the amount payable from other sources, is [***]. Payment may, however, be in a lesser amount as determined by the terms of the participant's benefit plan.

Medicare is the primary payor. When the Cigna plan is the secondary payor to Medicare, Provider and Cigna are required to follow Medicare billing rules. Payment will be made in accordance with all applicable Medicare requirements, including but not limited to Medicare COB rules. The Medicare COB rules require Cigna's financial responsibility as the secondary payor to be limited to the Participant's financial liability (i.e., the applicable Medicare copayment, coinsurance, and/or deductible) after application of the Medicare-approved amount. The Medicare payment plus the Participant liability (applicable Medicare copayment, coinsurance, and/or deductible) amounts constitute payment in full, and Provider is prohibited from collecting any monies in excess of this amount.

4.14 Applicability of the Rates.

The rates in this Agreement apply to all services provided to Participants in the Benefit Plan types covered by this Agreement, including services covered under a Participant's in or out-of-network benefits, and whether the Payor or Participant is financially responsible for payment.

4.15 Excluded Services.

This Agreement excludes services that Cigna has elected to obtain under an arrangement between Cigna or a Cigna Affiliate and a national or regional vendor or provider or a capitated provider, except as otherwise agreed by Cigna. Provider will not be reimbursed and will not bill Participants for any such excluded services. If Cigna notifies Provider that it no longer chooses to exclude a particular service from this Agreement, that service will no longer be excluded and those services will be reimbursed as specified in Exhibit A and Exhibit A-1.

4.16 Provider Facilities.

This Agreement shall specifically exclude those services rendered at Provider facilities other than those facilities agreed upon and utilized as of the Effective Date unless otherwise agreed in writing by Cigna.

SECTION 5. TERM AND TERMINATION

5.1 Term of This Agreement.

This Agreement begins on the Effective Date and continues from year to year unless terminated as set forth below.

5.2 How This Agreement Can Be Terminated.

Either Provider or Cigna can terminate this Agreement at any time by providing at least 60 days advance written notice. Either Provider or Cigna can terminate this Agreement immediately if the other becomes insolvent. Cigna can terminate this Agreement immediately (or upon such longer notice required by applicable law, if any) if Provider no longer maintains the licenses required to perform its duties under this Agreement, Provider is disciplined by any licensing, regulatory, accreditation organization, or any other professional organization with jurisdiction over Provider, or if Provider no longer satisfies Cigna's credentialing requirements. Upon termination of this Agreement for any reason, the rights of each party terminate, except as provided in this Agreement. Termination will not release Provider or Cigna from obligations under this Agreement prior to the effective date of termination.

5.3 Services Upon Termination.

Unless otherwise directed by Cigna, following termination of this Agreement, Provider shall continue to provide Covered Services for those Participants who meet the applicable clinical criteria, completed the on-line enrollment process, and agreed to the Participant Agreement prior to termination of the Agreement. Provider shall continue to provide Covered Services to such Participants so long as the [***] following the notice of termination.

Payment for Covered Services provided to any such Participant after termination of this Agreement shall be in accordance with the terms of the Participant's Benefit Plan.

SECTION 6. GENERAL PROVISIONS

6.1 Confidentiality.

The parties acknowledge that, as a result of this Agreement, each may have access to certain trade secrets or other confidential and proprietary information of the other. Each party shall hold such trade secrets and other confidential and proprietary information as governed by the existing NDA, including the terms and conditions of this Agreement, in confidence and shall not use or disclose such information, either by publication or otherwise, to any person without the prior written consent of the other party except as may be required by law and except as may be required to fulfill the rights and obligations set forth in this Agreement. This provision shall not be construed to prohibit Cigna from disclosing information to Cigna Affiliates or the agents or subcontractors of Cigna or Cigna Affiliates or from disclosing the terms and conditions of this Agreement, including reimbursement rates, to existing or potential Payors, Participants or other customers of Cigna or Cigna Affiliates or their representatives. This provision shall survive the termination of this Agreement.

Nothing in this provision shall be construed to prohibit communications necessary or appropriate for the delivery of health care services, communications regarding coverage and coverage appeal rights or any other communications expressly protected under applicable law.

6.2 Independent Parties.

Provider is an independent contractor. Cigna and Provider do not have an employer- employee, principal-agent, partnership, or similar relationship. Nothing in this Agreement, including Provider's participation in care collaboration, population management, pay for performance, Quality Management, Utilization Management, and other similar programs, nor any coverage determination made by Cigna or a Payor, is intended to interfere with or affect Provider's independent judgment in providing health care services to its patients. Nothing in the Agreement is intended to create any right for Cigna or any other party to intervene in or influence your medical decision-making regarding any Participant.

6.3 Provider Materials.

Provider will own all rights, title and interests in and to:

(i) the Program;

(ii) any modifications, improvements, derivative works or enhancements to the Program, and

(iii) all Intellectual Property Rights related to the foregoing, in each case that are:

(a) owned or licensed prior to the Effective Date;

(b) developed or created during the term of this Agreement, whether created or developed solely by employees or agents of Provider or by employees or agents of Provider jointly with employees or agents of Cigna during the term of this Agreement (excluding any Work Product and, except as provided in Section 6.6, Project Developments), or

(c) created independently of the Covered Services delivered to Cigna and without reliance upon Cigna-provided data (collectively, the "Provider Materials").

Provider hereby grants to Cigna a perpetual, irrevocable, worldwide, fully-paid, royalty-free, nonexclusive license to, and to allow Cigna authorized users, including its employees, agents, contractors, members, customers or providers to, access, copy, modify, use and distribute such Provider Materials to the extent required to use the Work Product.

6.4 Project Developments.

For purposes of this Agreement, the following terms shall be defined as follows:

(a) "Collaboration Activities" shall mean the activities of the parties related to the implementation of the Covered Services for Cigna and/or the deployment of the Covered Services to Cigna clients involving both parties' participation or the use of Intellectual Property Rights of both parties for purposes of such activities, whether joint works (as such term is defined in the U.S. Copyright Act) or otherwise.

(b) "Project Developments" shall mean all materials, tools, inventions, content, works of authorship and all other work product made, conceived or developed by the parties in the course of performing the Collaboration Activities under this Agreement, including all Intellectual Property Rights therein.

(c) "Intellectual Property Rights" shall mean all copyrights, patents, trade secrets, proprietary know-how, and all other intellectual property rights now or hereafter known, and all applications and registrations therefor, but expressly excluding all trademarks of each Party.

6.5 Ownership of Project Developments.

All Project Developments made in performance of the Collaboration Activities shall be described and mutually agreed upon by the Parties in a Project Addendum to this Agreement. Each Party (as the "Assignor") hereby transfers and grants to the other Party (as the "Assignee") all right, title and interest that the Assignor may have in any Project Developments in a Project Addendum. At the Assignee's request and expense, the Assignor shall assist and cooperate with the Assignee in all reasonable respects and shall execute documents and take further acts as reasonably requested by the Assignee to acquire, transfer, maintain and enforce patent, copyright, trademark, trade secret and other legal protection for the Project Developments and any Intellectual Property Rights in the Project Developments, in each case, where such Project Developments are expressly stated as owned by the Assignee in a Project Addendum. To the extent that any Project Developments are not identified in a Project Addendum (or are identified therein but ownership of the same is not defined), the following terms shall apply: (i) any Project Developments made by employees or agents of Provider with employees or agents of Cigna in performance

of the Collaboration Activities, and all Intellectual Property Rights in the foregoing Project Developments, shall be the joint property of Provider and Cigna, which either may exploit in any manner it chooses as its sole discretion without any right of accounting or sharing of expenses obligation; (ii) any Project Developments made by employees or agents of Provider independently without any participation from employees or agents of Cigna in performance of the Collaboration Activities, and all Intellectual Property Rights therein, shall be the sole property of Provider to exploit in any manner it chooses at its sole discretion; and (iii) any Project Developments made by employees or agents of Cigna independently without any participation from employees or agents of Provider in performance of the Collaboration Activities, and all Intellectual Property Rights therein, shall be the sole property of Cigna to exploit in any manner it chooses at its sole discretion. Notwithstanding anything to the contrary set forth in this Agreement, Cigna is granted no rights in the Provider Materials, and Provider will own all right, title and interest in and to any software or technical modifications, improvements, derivative works or enhancements to the Provider Materials, and any feedback provided with respect thereto, including all Intellectual Property Rights therein, whether created or developed solely by employees or agents of Provider or by employees or agents of Provider jointly with employees or agents of Cigna during the term of this Agreement.

6.6 License.

Provider grants to Cigna a non-exclusive, royalty-free, fully-paid up, limited right and license to use the Project Developments specified as owned by Provider hereunder, including in the Project Addendum, solely for purposes of (i) performing Cigna's obligations under the Collaboration Activities and (ii) exercising Cigna's rights as expressly specified in the Project Addendum, in each case during the term of this Agreement (unless expressly stated to survive in such Project Addendum).

Cigna grants to Provider a non-exclusive, royalty-free, fully-paid up, limited right and license to use the Project Developments specified as owned by Cigna hereunder, including in the Project Addendum, solely for purposes of (i) performing Provider's obligations under the Collaboration Activities and (ii) exercising Provider's rights as expressly specified in the Project Addendum, in each case during the term of this Agreement (unless expressly stated to survive in such Project Addendum). All rights not granted hereunder are expressly reserved unless mutually agreed upon in a separate written license grant.

6.7 Residual Rights.

(a) Definition. "Residual Rights" means information, including ideas, concepts, know-how, or techniques, in intangible form related to the Confidential Information that is incidentally retained in the unaided memory of the Receiving Party that has had authorized access to the Disclosing Party's Confidential Information, so long as the Receiving Party has made no effort to refresh its recollection by reference to or use of such Confidential Information, nor has studied such Confidential Information for the purpose of replicating the same from memory for use of the same by the Receiving Party.

(b) No Liability for Good Faith Use. Each Party may assign or reassign its employees who have had access to the Confidential Information of the other (including without

limitation Project Developments made in performance of the Collaboration Activities) to work on projects that may involve technology that is similar to the technology that may constitute Confidential Information of the other. The Receiving Party shall have no obligation to limit or restrict the tasks, duties or responsibilities of any persons receiving Confidential Information of the Disclosing Party; to obtain the Disclosing Party's consent to any person being assigned to any such task, duty or responsibility; or to pay the Disclosing Party royalties or any other form of compensation for anything resulting from the use of Residual Rights, provided that (i) the foregoing shall not, however, be deemed to grant any license under any patent rights or copyrights of the Disclosing Party and (ii) no employee of a Party is entitled to use an idea, concept, technique, or process unless the employee believes in good faith that his or her knowledge of the idea, concept technique or process did not come from the Confidential Information of the other Party.

6.8 Limitation of Liability.

(A) NEITHER PARTY WILL BE LIABLE TO THE OTHER FOR ANY INDIRECT, INCIDENTAL, SPECIAL OR CONSEQUENTIAL DAMAGES (INCLUDING LOST REVENUE, PROFITS OR SAVINGS OR COSTS INCURRED IN OBTAINING REPLACEMENT SERVICES) OR PUNITIVE DAMAGES, IN EACH CASE, ARISING OUT OF OR RELATING TO ITS PERFORMANCE OR NON-PERFORMANCE UNDER THIS AGREEMENT.

(B) NEITHER PARTY WILL BE LIABLE TO THE OTHER FOR DIRECT DAMAGES WITH RESPECT TO ANY SINGLE INCIDENT ARISING OUT OF OR RELATED TO THIS AGREEMENT THAT EXCEEDS THE GREATER OF:

(i) THE AMOUNT PAID BY CIGNA FOR THE SERVICES IN THE [***] MONTHS PRIOR TO THE ACT GIVING RISE TO THE LIABILITY, OR

(ii) $[***]; PROVIDED, THAT IN NO EVENT WILL EITHER PARTY'S AGGREGATE AND CUMULATIVE LIABILITY ARISING OUR OF OT RELATED TO THIS AGREEMENT EXCEED THE [***] HEREUNDER.

THE LIMITATIONS OF LIABILITY SET FORTH IN CLAUSE 6.9(B) ABOVE ONLY SHALL NOT APPLY TO ANY LIABILITY ARISING FROM (i) A BREACH OF A PARTY'S CONFIDENTIALITY, INFORMATION PROTECTION, OR PRIVACY OBLIGATIONS, OR (ii) INDEMNIFICATION OBLIGATIONS UNDER THIS AGREEMENT, INCLUDING THOSE ARISING FROM CLAIMS RELATED TO INFRINGEMENT OR OTHER VIOLATION OF A THIRD PARTY'S INTELLECTUAL PROPERTY OR OTHER PROPRIETARY RIGHT, OR (iii) ARISING FROM A PARTY'S GROSS NEGLIGENCE, FRAUD, WILLFUL MISCONDUCT OR INTENTIONAL BREACH OF THIS AGREEMENT. FOR THE AVOIDANCE OF DOUBT, THE ITEMS LISTED IN THIS PARAGRAPH SHALL NOT BE EXCEPTIONS TO THE LIMITATION ON LIABILITY SET FORTH IN CLAUSE 6.9(A) ABOVE.

THE FOREGOING LIMITATIONS OF LIABILITY SHALL APPLY TO ANY THEORY OF LIABILITY, WHETHER BASED ON WARRANTY, CONTRACT, STATUTE, TORT

(INCLUDING NEGLIGENCE) OR OTHERWISE, AND WHETHER OR NOT THE LIABLE PARTY HAS BEEN INFORMED OF THE POSSIBILITY OF ANY SUCH DAMAGE, AND EVEN IF A REMEDY SET FORTH HEREIN IS FOUND TO HAVE FAILED OF ITS ESSENTIAL PURPOSE.

6.9 Indemnification.

Each party will indemnify, defend and hold harmless the other party, its affiliates, and their respective officers, directors, employees, agents, successors and assigns from and against any claims, causes of action, suits, investigations, and administrative or other proceedings, and all related demands, damages, liabilities, fines, penalties, assessments, costs and expenses (including attorneys' fees and defense costs), brought by a Third Party and arising directly from or in connection with any material breach of this Agreement or any negligent acts or omissions or willful misconduct that directly results in any bodily injury, death or loss of or damage to tangible property, or other damages arising from the performance of or failure to perform, its obligations under this Agreement, unless it is determined that the liability was the direct consequence of negligence or willful misconduct on the part of the other party, its agents or employees.

In addition, Provider will indemnify, defend and hold harmless Cigna, its affiliates, and their respective officers, directors, employees, agents, successors and assigns from and against any claims, causes of action, suits, investigations, and administrative or other proceedings, and all related demands, damages, liabilities, fines, penalties, assessments, costs and expenses (including attorneys' fees and defense costs), brought by a Third Party arising from or in connection with any of the following:

(i) The [***] by Provider, its subcontractors or the Provider's personnel, or any failure to [***] obligations under this Agreement.

(ii) Infringement or misappropriation of the patent, copyright, trademark, trade secret or other intellectual property or proprietary rights of a third party with regard to the Program or other services provided by Provider. Provider will have no liability for any such claim under this Section 6.9(ii) to the extent that (i) the claims arises from specifications or other material provided by Cigna, (ii) such claim is based on the indemnified party's use of a version of the Program altered by Cigna or the indemnified party or (iii) such claim is based on the indemnified party's use of a superseded version of the Program if infringement or misappropriation would have been avoided by the use of a subsequent version of the Program that was provided to Cigna by Provider. For the avoidance of doubt, in the event that some or all of the Program is held or is reasonably believed by Provider to infringe or misappropriate, Provider may in its discretion and [***].

The indemnified party will notify the indemnifying party as promptly as practicable of any claims for which the indemnifying party is obligated to provide indemnification hereunder, and the indemnifying party will confirm to the indemnified party no less than [***] prior to the date on which a response to such claim is due, that the indemnifying party will control the defense of such claim. The indemnified party may, at its own expense, participate in the defense of such claim with its own counsel. No settlement of a claim that involves a remedy other than the payment of money by the indemnifying party or requires any admission of fault on the part of indemnified party will be entered into without the prior written consent of the indemnified party. This provision shall survive the termination of this Agreement.

6.10 Internal Dispute Resolution.

Disputes that might arise between the parties regarding the performance or interpretation of the Agreement must first be resolved through the applicable internal dispute resolution process outlined in the Administrative Guidelines. In the event the dispute is not resolved through that process, either party can request in writing that the parties attempt in good faith to resolve the dispute promptly by negotiation between designated representatives of the parties who have authority to settle the dispute. If the matter is not resolved within [***] days of such a request, either party may initiate arbitration by providing written notice to the other. With respect to a payment or termination dispute (excluding termination with notice), Provider must submit a request for arbitration within [***] months of the date of the letter communicating the final decision under Cigna's internal dispute resolution process unless applicable law specifically requires a longer time period to request arbitration. If arbitration is not requested within that [***] month period, Cigna's final decision under its internal dispute resolution process will be binding on Provider, and Provider shall not bill Cigna, Payor or the Participant for any payment denied because of the failure to timely submit a request for arbitration.

6.11 Arbitration.

If the dispute is not resolved through Cigna's internal dispute resolution process, the controversy shall be resolved through binding arbitration. The arbitration shall be conducted in [***] days in accordance with the Rules of the American Arbitration Association then in effect, and which to the extent of the subject matter of the arbitration, shall be binding not only on all parties to the agreement, but on any other entity controlled by, in control of or under common control with the party to the extent that such affiliate joins in the arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Each party shall assume its own costs, but the compensation and expenses of the arbitrator and any administrative fees or costs shall be borne equally by the parties. The decision of the arbitrator shall be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator. The parties intend this alternative dispute resolution procedure to be a private undertaking and agree that an arbitration conducted under this provision shall not be consolidated with an arbitration involving other parties, and that the arbitrator shall be without power to conduct an arbitration on a class basis. Judgment upon the award rendered by the arbitrator may be entered in any court of competent jurisdiction.

6.12 Material Adverse Change Amendments.

For amendments that are a material adverse change in the terms of this Agreement, Cigna can amend this Agreement by providing [***] days advance written notice except if a shorter notice period is required to comply with changes in applicable law. The change will become effective at the end of the [***] day notice period or, if applicable, the shorter notice period required to comply with changes in applicable law. If Provider objects to the material adverse change and notifies Cigna of its intent to terminate within [***] days of the date of the notice of amendment, the termination will be effective at the end of the [***] day notice of the material adverse change or, if applicable, at the end of the shorter notice period required to comply with changes in applicable law, unless Cigna agrees to retract the amendment, in which case the Agreement will remain in force without the proposed amendment.

6.13 All Other Amendments.

For amendments that are not material adverse changes in the terms of this Agreement, Cigna can amend this Agreement by providing [***] days advance written notice to Provider. Alternatively, both parties can agree in writing to amend this Agreement.

6.14 Assignment and Delegation.

Neither Cigna nor Provider may assign this Agreement nor any rights or obligations thereunder without the written consent of the other party, which consent will not be unreasonably withheld; provided, however, that any reference to Cigna or Provider includes any successor in interest to Cigna or Provider, as applicable, and Cigna and Provider, as applicable, may assign their respective duties, rights and interests under this Agreement in whole or in part to an affiliate. Cigna may without consent of Provider delegate its obligations under this Agreement to a Third Party provided, however, that, to the extent that it delegates its duties under this Agreement to a Third Party, it will require any such Third Party to perform such duties consistent with the terms and conditions of this Agreement to the extent applicable. Any such delegation shall not operate to release Cigna from it liability under this Agreement. Provider may not delegate any of its obligations under this Agreement without Cigna's written consent which consent shall not be unreasonably withheld. Any such delegation shall not operate to release Provider from its liability under this Agreement. Provider may not engage any off-shore entity to perform any of the services, without prior written consent of Cigna, which consent shall not unreasonably be withheld.

If Provider delegates any of its responsibilities under this Agreement to another party, it shall ensure that its agreement with such party shall include a provision requiring such Third Party to:

(a) refrain from disclosing any Cigna confidential or proprietary information to a third party and treat any and all confidential or proprietary information of Cigna as confidential;

(b) distribute any Cigna confidential or proprietary information only to such of its employees as may need to know such information for the purpose of performing their responsibilities under the agreement with Provider.

6.15 Sale of Business/Change in Management.

If, during the term of this Agreement, Provider desires (i) to sell, transfer or convey its business or any substantial portion of its business assets to another entity, or Provider is the subject of a sale, transfer or conveyance of its business by another entity, or (ii) Provider enters into a management contract with another entity, Provider shall advise Cigna as soon as practicable in writing but in no event less than [***], in order to obtain Cigna's written consent as to which Cigna participating provider agreement applies, if any, to services rendered by you or the surviving entity, on a post-transaction basis. Failure to provide [***] and obtain Cigna's written consent will result in Cigna determining which, if any, Cigna participating provider agreement applies to services rendered on a post-transaction basis. Dependent upon when Cigna learns of the transaction, this may result in a retroactive adjustment to reimbursement and an overpayment recovery process. Provider warrants and covenants that this Agreement will be part of the transfer, and will be assumed by the new entity and that the new entity will honor and be fully bound by the terms and conditions of this Agreement unless the new entity already has an agreement with Cigna or a Cigna Affiliate, in which case Cigna, in its sole discretion, will determine which Agreement will prevail. Notwithstanding the above, if Cigna, in its sole discretion, is of the opinion that the Agreement cannot be satisfactorily performed by the assuming entity or does not want to do business with that entity for whatever reason, Cigna may terminate this Agreement by giving Provider [***] day's written notice, notwithstanding any other provision in the Agreement.

6.15.1 This Agreement shall not, without Cigna's written consent, be applicable to any [***] or similar agreement or arrangement with Provider or Provider affiliate. Provider shall notify Cigna [***] any such acquisition or arrangement.

6.16 Use of Name

Provider agrees that Cigna may include descriptive information about Provider in literature distributed to existing or potential Participants, Participating Providers and Payors. That information will include, but not be limited to, Provider's name, telephone number, address, and specialties. Provider may identify itself as a Participating Provider with respect to those Benefit Plan types in which Provider participates with Cigna. Provider's use of Cigna's name or a Cigna Affiliate's name, or any other use of Provider's name by Cigna will be upon prior written approval or as the parties may agree.

6.17 Notices

Any notice required under this Agreement must be in writing and sent by United States mail, postage prepaid, to Cigna and Provider at the addresses below. Cigna

may also notify Provider by sending an electronic notice with automatic receipt verification to Provider's e-mail address below. Either party can change the address for notices by giving written notice of the change to the other party in the manner just described.

6.18 Non-Solicitation

During the term of this Agreement and for a period of [***] from the date of termination, Provider shall not [***], nor shall Cigna or Provider actively solicit any employees of the other to be employed by or contracted with the other party in any capacity related to services to be performed under this Agreement during this Agreement, and for a period of [***] thereafter without the other party's written consent. Nothing in this Section 6.19 shall prohibit either party from making general solicitations or advertisements in newspapers, websites or other general communication methods for employment not directly targeted at employees of the other party.

6.19 Governing Law/Regulatory Addenda.

Applicable federal law and the law of the jurisdiction where Provider is domiciled governs this Agreement. One or more regulatory addenda may be attached to the Agreement setting out provisions that are required by law with respect to Covered Services rendered to certain Participants (i.e. Participants under an insured plan). These provisions are incorporated into this Agreement to the extent required by law and as specified in such Addenda.

6.20 Waiver of Breach/Severability/Entire Agreement/Copy of Original Agreement.

If any party waives a breach of any provision of this Agreement, it will not operate as a waiver of any subsequent breach. If any portion of this Agreement is unenforceable for any reason, it will not affect the enforceability of any remaining portions. This Agreement, including any exhibits to this Agreement, contains all of the terms and conditions agreed upon and supersedes all other agreements between the parties, either oral or in writing, regarding the subject matter. A copy of this fully executed Agreement is an acceptable substitute for the original fully executed Agreement.

6.21 Force Majeure.

In the event that performance by Cigna or Provider of any covenant, duty or obligation imposed under this Agreement becomes impossible or impracticable because of the occurrence of an event of force majeure, including, without limitation, acts of war, insurrection, civil strife and commotion, labor unrest or acts of God, then performance of such covenant, duty or obligation by such party shall be excused during the continuance of such event of force majeure; provided, however, that such performance by such party shall be accomplished as soon as reasonably practicable after such event of force majeure has ceased.

6.22 Information Protection Obligations.

Attachment C is hereby attached to, and incorporated by reference into, this Agreement.

AGREED AND ACCEPTED BY:

Provider: Omada Health, Inc.

Address: 500 Sansome Street, Suite 200

San Francisco, CA 94111

Email Address: legal@omadahealth.com

By: /s/ Sean Duffy
Printed Name: Sean Duffy
Title: Chief Executive Officer

Date Signed: May 31, 2018

Federal Tax ID: [***]

National Provider Identifier: [***]

AND

Cigna Health Corporation on behalf of its affiliates and subsidiaries
Address: 900 Cottage Grove Road, Wilde
Hartford, CT 06152
Attention: AVP of National Ancillary Provider Contracting

By: /s/ Alan M. Muney, MD
Printed Name: Alan M. Muney, MD
Title: CMO, EVP Total Health and Network

Date Signed: May 31, 2018

ADDENDUM TO PROVIDER AGREEMENT FOR THE STATE OF ALABAMA

The provisions set forth in this Addendum are being added to the Agreement with the provider named in the Agreement (hereafter referred as "Provider") to comply with legislative and regulatory requirements of the State of Alabama regarding provider contracts with providers rendering health care services in the State of Alabama. To the extent that such state laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of the Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

I

1. Provider shall mean "Provider," "Hospital," "Group and/or Represented Provider," System and/or Represented Provider" as named in the Agreement, or as otherwise set forth in the Agreement.

II

Payor may only retroactively deny, adjust or seek recoupment for reimbursement made to Provider (a) during the 12 month period after the date Payor paid such claim; or (b) the expiration of the same period of time that Provider is required to submit claims pursuant to Provider's contract, whichever date occurs first. Except that Payor may retroactively deny, adjust or recoup reimbursement for Covered Services subject to coordination of benefits with another carrier, the Alabama Medicaid Agency, or to Medicare claims, except the Medicare+Choice plan, during the 18 month period after the date Payor paid such claim.

(a.) The above provision does not apply if Payor retroactively denies, adjusts or recoups reimbursement to Provider because: (1) the information submitted to the Payor was fraudulent; or (2) the claim submitted to Payor was a duplicate claim.

(b.) Payor must give Provider notice specifying the reason for retroactively denying, adjusting or recouping reimbursement. Notice may be in paper or electronic format, but Provider must agree to accept notice by electronic media.

(c.) If Provider disputes the retroactive denial, adjustment, or recoupment on all or a portion of a claim, Provider must notify Payor within 30 days after receipt of notice.

(d.) If the retroactive denial, adjustment or recoupment deals with a medical necessity determination, level of service determination, coding error, or billing irregularity, retroactive denial, adjustment or recoupment must be reconciled to specific claim.

III

The following is provided in accordance with Act No. 2015-320 (Code of Alabama § 27-1-17.1).

IF A COVERED HEALTH CARE PROVIDER REQUESTS PAYMENT UNDER A HEALTH INSURANCE PLAN FROM A HEALTH INSURER OR ITS CONTRACTED VENDOR OR A REGIONAL CARE ORGANIZATION BE MADE USING ACH ELECTRONIC FUNDS TRANSFER, THAT REQUEST MUST BE HONORED. FURTHERMORE, SUCH A REQUEST MAY NOT BE USED TO DELAY OR REJECT A TRANSACTION, OR ATTEMPT TO ADVERSELY AFFECT THE COVERED HEALTH CARE PROVIDER.

ADDENDUM TO PROVIDER AGREEMENT FOR THE STATE OF ALASKA

The provisions set forth in this Addendum are being added to the Agreement with the provider named in the Agreement (hereafter referred as the "Provider") to comply with legislative and regulatory requirements of the State of Alaska regarding provider contracts with providers rendering health care services in the State of Alaska. To the extent that such Alaska laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of the Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) Emergency Services. The term "Emergency" means health care services that are provided by a hospital or other emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention would reasonably be expected by a prudent person who possesses an average knowledge of health and medicine to result in the placing of the Participant's health in serious jeopardy, or a serious impairment to bodily functions, or, a serious dysfunction of a bodily organ or part.

(2) Clean Claim. The term "Clean Claim" means a claim that does not have a defect, impropriety or circumstance requiring special treatment that precludes timely payment on the claim.

(3) Termination. To the extent that the Agreement contains a provision allowing discretionary termination of the Agreement, such provision shall apply equitably to both Provider and Cigna.

(4) Dispute Resolution. In the event of a dispute between Cigna and Provider, a fair, prompt and mutual dispute resolution process shall be used. Provider and Cigna will hold an initial meeting at which Provider and Cigna are present or are represented by individuals with authority regarding the matters in dispute. The meeting shall be held within ten (10) working days after Cigna receives written notice of the dispute or gives written notice to Provider, unless Provider and Cigna agree in writing to a different schedule. If, within thirty (30) days following the initial meeting, Cigna and Provider have not resolved the dispute, the dispute shall be submitted to mediation directed by a mediator who is mutually agreeable to Cigna and Provider and who is not regularly under contract to or employed by either Cigna or Provider. Each party shall bear its proportionate share of the cost of mediation, including the mediator fees. If, after a period of sixty (60) days following commencement of mediation, Cigna and Provider are unable to resolve the dispute, either party may seek other relief allowed by law. Cigna and Provider agree to negotiate in good faith at the initial meeting and in mediation. Prior to the initiation of the mutual dispute resolution process set forth herein, at the Provider's

discretion, and to the extent permitted by Alaska Stat. § 21.07.010, Cigna and Provider may attempt to resolve payment disputes in accordance with the payment dispute resolution procedures set forth in the Administrative Guidelines.

(5) Communication with Participants. In accordance with Alaska Stat. § 21.07.010(a)(5), Cigna shall not penalize Provider or terminate Agreement because Provider acts as an advocate of a Participant in seeking appropriate, medically necessary health care services. Cigna shall not interfere with Provider's ability to openly communicate with a Participant about all appropriate diagnostic testing and treatment options.

(6) Financial Inducements or Incentives. In accordance with Alaska Stat. § 21.07.010(b)(1), this Agreement shall not be interpreted to contain direct financial incentives to Provider for withholding Covered Services that are medically necessary. Nothing herein, however, shall be construed to prohibit incentives to Provider for efficient management of the utilization and cost of Covered Services.

(7) Product Participation and Compensation. Nothing in this Agreement shall be interpreted to require Provider to contract for all products currently offered or that may be offered in the future by Cigna. Nothing in this Agreement shall be interpreted to require Provider to accept from Cigna or Payor the same rate of compensation for Covered Services rendered as that which Provider has contracted for with another managed care entity.

(8) Indemnification. In accordance with Alaska Stat. § 21.07.010(c), nothing in this Agreement shall require Provider to indemnify or hold harmless Cigna for the acts or conduct of Cigna.

(9) Effect of Termination and Liabilities After Termination. If a Participant is pregnant or being actively treated by Provider on the date of termination of this Agreement, the Participant may continue to receive Covered Services from Provider as described herein and this Agreement shall remain in force with respect to the continuing treatment. The Participant shall be treated for the purposes of benefit determination or claim payment as if Provider were still under agreement with Cigna. However, treatment is required to continue only while the Participant's coverage remains in effect and until the end of the medically necessary treatment for the condition, disease, illness or injury, if the Participant has a terminal (life expectancy of less than one year) condition, disease, illness or injury or for the period that is the longest of the following: the end of the current plan year; up to 90 days after the termination date, if the event triggering the right to continuing treatment is part of an ongoing course of treatment; or, through completion of postpartum care, if the Participant is pregnant on the date of termination.

(10) Claims and Overpayment Recovery. To the extent required by Applicable Law, Cigna and Provider shall comply with the provisions of Alaska Stat. § 21.36.495, as may be amended from time to time. The recovery of overpayments, if any, shall be conducted in accordance with Alaska Stat. § 21.36.125, as may be amended from time to time, and Bulletin B 07-06 as applicable.

(11) Covered Services. Upon request, Cigna shall make available to Provider information that identifies Covered Services.

ADDENDUM TO ANCILLARY AGREEMENT
FOR THE STATE OF ARKANSAS

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Arkansas regarding provider contracts with providers rendering health care services in the State of Arkansas. To the extent that such Arkansas laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) Pursuant to the requirements of Arkansas Code Title 23 Chapter 104:

(a) Except in cases of fraud committed by Provider, Payor may only exercise recoupment for reimbursement from Provider during the 18 month period after the date that Payor paid the claim submitted by Provider.

(b) If Payor exercises recoupment from Provider under this section, Payor shall give Provider a written or electronic statement specifying the basis for the retroactive denial and the statement shall contain, at a minimum, the information required by subsection (e) below.

(c) If Payor determines that payment was made for services not covered under Participant's Benefit Plan, Payor shall give written notice to Provider of its intent to exercise recoupment and may:

(1) Request a refund from Provider; or

(2) Make a recoupment of the payment from Provider in accordance with subsection (e).

(d) Notwithstanding subsection (a) above, if Payor or an agent contracted to provide eligibility verification, verifies that an individual is a Participant and if Provider provides health care services to the individual in reliance on such verification, Payor may not thereafter retroactively deny a claim on the basis that the individual is not a Participant unless such retroactive denial occurs within 120 days of the date that Payor paid the claim; otherwise Payor is barred from making such recoupment unless there was fraud by Provider.

(e) If Payor chooses to recoup from Provider amounts previously paid under a retroactively denied claim pursuant to subsections (a) or (c), Payor shall provide Provider written documentation that specifies:

(1) The amount of the recoupment;

(2) The person's name to whom the recoupment applies;

(3) Patient identification number;

(4) Date or dates of service;

(5) The health care service or services on which the recoupment is based;

(6) The pending claims being recouped or that future claims will be recouped; and

(7) Specific reason for the recoupment.

(2) Upon termination of the Agreement, Provider may, at the option of Participant, continue to provide Covered Services for a current episode of an acute condition for which a Participant was under Provider's care at the time of such termination so long as Participant retains eligibility under a Benefit Plan, until the earlier of completion of such services, or the expiration of 90 days. During the period of continued care, Provider shall be deemed to continue to be a Participating Provider for purposes of reimbursement, utilization management and quality of care. Provider shall be compensated for Covered Services provided to any such Participant in accordance with the compensation arrangements of the terminated Agreement until 90 days following termination. Provider has no obligation under the Agreement to provide services to individuals who cease to be Participants.

(3) The Agreement may permit network rental arrangements which allow Cigna to sell, lease, assign, convey, or otherwise grant access to Provider's health care services, discounted rates, or fees established in the Agreement.

ADDENDUM TO ANCILLARY AGREEMENT FOR THE STATE OF ARIZONA

The provisions set forth in this Addendum are being 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 such Arizona laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

1. The Overpayments provision of the Agreement is amended to add the following sentence:

In the case of a non-Medicare HMO plan offered by Cigna or an insured plan offered by a Cigna Affiliate, and except in cases of fraud, Cigna will adjust or request adjustment of the payment of a claim within one year after the date Cigna has paid the claim, unless the parties agree to a mutually applicable longer period of time.

2. The Underpayments provision of the Agreement is hereby deleted and replaced with the following:

The following applies in the event that Provider believes Provider has been underpaid for a Covered Service. In the case of a non-Medicare HMO plan offered by Cigna or an insured plan offered by a Cigna Affiliate, and except in cases of fraud, Provider must submit a written request for an appeal or adjustment with Cigna or its designee within one year from the date of Cigna's payment or explanation of payment, unless the parties agree to a mutually applicable longer period of time. In the case of a self- insured plan administered by a Cigna Affiliate, Provider must submit a written request for an appeal or adjustment with Cigna or its designee within 180 days from the date of Payor's payment or explanation of payment. All requests for appeal or adjustment must be submitted in accordance with Cigna's provider payment appeal process set forth in the Administrative Guidelines. Requests for appeals or adjustments submitted after the date specified may be denied for payment, and Provider will not be permitted to bill Cigna, Payor or the Participant for those services for which payment was denied.

3. In the event of Cigna's insolvency, Provider shall continue to provide Covered Services to Participants covered under an HMO Benefit Plan at the same rates and subject to the same terms and conditions established in the Agreement, until the earliest of the following:

a. The expiration of Participant's contract period or 60 days from the date insolvency is declared, whichever is later.

b. The date the receiver notifies the court and Participating Providers of the receiver's determination that Cigna's plan for the risk of insolvency is inadequate to pay the costs of continuation of benefits for the period described in subsection a., above.

c. A determination by the court that Cigna is either unable to pay, or unable to provide adequate assurance that it will be able to pay, Participating Providers' claims for Covered Services that were rendered to Participants after Cigna is declared insolvent.

d. A determination by the court that continuation of the Agreement would constitute undue hardship to Provider.

e. A determination by the court that Cigna has satisfied its obligations to all Participants under its HMO Benefit Plans.

ADDENDUM TO AGREEMENT FOR THE STATE OF CALIFORNIA

The provisions set forth in this Addendum are being added to the Agreement with the provider named in the Agreement (hereafter referred as the "Provider") to comply with legislative and regulatory requirements of the State of California regarding provider contracts with providers rendering health care services in the State of California. To the extent that such California laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

1. California Department of Insurance Requirements for Contracts between Network Providers and Insurers. The following provisions are required by Title 10 California Code of Regulations Section 2240.4 and shall apply to health care services rendered by the Provider with respect to Participants insured by Cigna Health and Life Insurance Company (CHLIC):

(a) Provider shall not make any additional charges to Participants for rendering Covered Services except as provided for in the contract between CHLIC and the Participant (or the employer group under which the Participant is entitled to health coverage).

(b) The parties acknowledge that Provider's primary consideration shall be the quality of the health care services rendered to the Participants.

(c) Provider shall not discriminate against any Participant in the provision of Covered Services on the basis of sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status, health insurance coverage, utilization of medical or mental health services or supplies, or other unlawful basis including without limitation, the filing by such Participant of any complaint, grievance, or legal action against a provider.

(d) The Agreement including this Addendum and any exhibits or documents referenced therein contains all the terms and conditions agreed upon by the parties pertaining to the rendering of Covered Services by the Provider to Participants.

2. Language Assistance Program (LAP) Requirements. The following provision is required by (i) CA Health and Safety Code Section 1367.04 and Title 28 California Code of Regulations Section 1300.67.04 with respect to services rendered by Provider to Participants covered by Cigna HealthCare of California, Inc. and (ii) CA Insurance Code Section 10133.8 and Title 10 California Code of Regulations Section 2538.3 with respect to services rendered by Provider to Participants insured by CHLIC.

(a) Cigna shall establish and maintain an ongoing language assistance program to ensure Limited English Proficient ("LEP") Participants have appropriate access to language assistance while accessing health care services as required by the LAP laws referred above. Provider shall cooperate and comply, as applicable, with Cigna's Language Assistance Program; however, Cigna shall maintain ongoing administrative and financial responsibility for implementing and operating on an ongoing basis the Language Assistance Program for Participants. The term "Limited English Proficient" shall have the same meaning as set forth in the LAP laws cited above.

3. Changes to Agreement applicable to Cigna HealthCare of California, Inc. The following provisions apply with respect to services rendered by Provider to Participants covered by Cigna HealthCare of California, Inc. and amend and supersede the corresponding term in the base Agreement. The underscored language reflects the changes made to the corresponding term in the base Agreement as required by the California Department of Managed Health Care.

Emergency Medical Condition

means a medical condition manifesting itself by acute symptoms of sufficient severity (including active labor and severe pain) such that a reasonable layperson could reasonably expect the absence of immediate medical attention to result in (i) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part. Emergency Services means those Covered Services that are (i) required by a Participant for the evaluation or stabilization of an Emergency Medical Condition, and (ii) furnished by a health care provider qualified to furnish Emergency Services. Where applicable, Emergency Services also means an additional screening, examination, and evaluation by an appropriate provider to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

Records.

Provider shall maintain such medical records and documents relating to Participants as may be required by applicable law. All of such records shall be maintained for the period of time of at least two (2) years. Cigna and Provider agree that medical records of Participants and any other records containing individually identifiable information with respect to Participants shall be regarded as confidential, and both shall comply with applicable federal and state law regarding such records. Provider shall be

responsible for obtaining Participants' consent to or authorization for the disclosure of private and medical record information in connection with any such disclosures required under this Agreement to the extent such consent or authorization is required by applicable law. Upon request by Cigna, Provider shall provide to Cigna a copy of Participants' medical records and other records maintained by Provider relating to Participants for purposes of conducting quality assurance and peer review, case management and utilization reviews, credentialing, payment adjudication and processing, resolving Participant grievances and appeals and other activities reasonably necessary for the proper administration of the Benefit Plans. Provider shall provide such records to Cigna at no charge and within the timeframes reasonably requested by Cigna. Provider shall also make Participant's medical records and other records maintained by Provider relating to Participants available during normal business hours for inspection by Cigna, Cigna's designee, accreditation organizations, or to any governmental agency that requires access to such information. This provision survives the termination of this Agreement.

Payments.

Provider will be paid for Covered Services rendered to Participants in accordance with the fee schedule and reimbursement terms set forth in Exhibit A to this Agreement, subject to the Administrative Guidelines and minus any applicable Copayments, Coinsurance and Deductibles. The rates in this Agreement will be payment in full for all services furnished to Participants under this Agreement. Provider must submit claims in the manner and format specified in this Agreement and the Administrative Guidelines for all Covered Services within 90 days of the date those services are rendered or, if Payor is the secondary payor, within 90 days of the date of the explanation of payment from the primary payor. Claims received after this 90 day period may be denied for payment, unless Provider submits evidence of good cause for the delay. Provider shall submit all claims to the location identified by Cigna. Amounts due and owing under this Agreement with respect to Complete Claims for Covered Services will be payable within forty-five (45) working days of receipt, and interest and penalties due on any late payments will be payable in accordance with applicable law.

Amendments.

Except as provided hereafter, amendments of material terms of this Agreement shall be agreed to in advance in writing by Cigna and Provider.

Cigna shall provide at least 45 business days' notice to Provider of its intent to change a material term of this Agreement unless the parties mutually agree to waive the notice. In the event that state or federal law or regulation or any accreditation requirements of an Accreditation Organization, should change, alter or modify the present services, levels of payments to Cigna, standard of eligibility of Members, or any operations of Cigna, such that the terms, benefits and conditions of this Agreement must be changed accordingly, then upon notice from Cigna, this Agreement shall be deemed to be automatically amended to conform to the requirements (including notice requirement is less than 45 business days) of such state, federal law or regulation, and Provider shall continue to perform Ancillary Services under this Agreement as modified.

The parties acknowledge that Cigna may find it necessary to amend the Administrative Guidelines from time to time that will impact Provider. Cigna shall notify Provider in writing of material revisions to Administrative Guidelines, and such material revisions shall be deemed approved by Provider if Provider does not notify Cigna of its disapproval within 45 business days of receipt of notice of such material changes. Provider approval of such amendments shall not be unreasonably withheld, conditioned or delayed. If Provider disapproves of the change within the specified timeframe and the parties cannot reach agreement to the change in the Administrative Guidelines, Provider shall have the right to terminate the Agreement prior to the implementation of the change.

4. Provider Directory Requirements: The following provision is required by (i) CA Health and Safety Code Section 1367.27 with respect to services rendered by Provider to Participants covered by Cigna HealthCare of California, Inc. and (ii) CA Insurance Code Section 10133.15 with respect to services rendered by Provider to Participants insured by CHLIC.

(A) Provider shall inform Cigna within five business days when either of the following occurs:

(1) Provider is not accepting new Participants;

(2) If Provider had previously not accepted new Participants, Provider is currently accepting new Participants.

(B) If Provider is not accepting new Participants and is contacted by a Cigna Participant or potential customer; provider shall direct the individual to:

(1) Cigna Customer Service for assistance in finding another provider.

(2) the California Department of Managed Care or the Department of Insurance if Provider's accepting new patients status in the provider directory

is inaccurate, or does not reflect the information most recently provided to Cigna. Provider will refer the Participant or potential customer to the department with jurisdiction over the Participant's or potential customer's plan to report any inaccuracy with the provider directory or directories.

Pursuant to the obligations established by (i) CA Health and Safety Code Section 1367.27 with respect to services rendered by Provider to Participants covered by Cigna HealthCare of California, Inc. and (ii) CA Insurance Code Section 10133.15 with respect to services rendered by Provider to Participants insured by CHLIC, the following shall apply:

(A) Providers will have thirty (30) business days to respond to all notices sent to them by Cigna or a group or entity on behalf of Cigna, and either confirm their directory information is current and accurate, or otherwise, update their directory information. Provider verification may be required several times per year, depending on contracting arrangements.

(B) Providers that do not respond to directory verification notices, or providers who respond with partial or inaccurate information that cannot be verified by Cigna will receive a notice that if a response is not received within ten (10) business days, they will be suppressed from showing in on-line and printed directories at their next update.

(C) Providers shall be suppressed from the on-line and printed directories at the next required update after the ten (10) day notice period. Providers shall not be suppressed if they respond before the end of the ten (10) day notice period.

(D) Providers will be restored in the on-line and printed directories once a full and accurate response is received and verified in accordance with Cigna policies and requirements for updating directory errors and information.

(E) To the extent permitted by applicable laws, Cigna may terminate this Agreement for a pattern or repeated failure of Provider to alert Cigna to a change in the information required by applicable laws to be in the directory or directories.

ADDENDUM TO ANCILLARY AGREEMENT
FOR THE STATE OF COLORADO

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Colorado regarding provider contracts with providers rendering health care services in the State of Colorado. To the extent that such Colorado laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) The definition for Emergency Services, if any, shall comply with Colorado laws and regulations to the extent applicable.

(2) Provider shall receive payments for Covered Services as set forth in the Agreement. Colorado law prohibits the use of financial disincentives or the withholding of full compensation to Provider because of the number or type of referrals made by Provider to Participating Providers in accordance with applicable Utilization Management requirements concerning the provision of Covered Services to Participants.

(3) Pursuant to the requirements of Section 10-16-704 (4.5), Colorado Revised Statutes, to the extent applicable:

With respect to services reimbursed on a fee-for-service basis, if Provider believes Provider has been underpaid for a Covered Service Provider must submit a written request for an appeal or adjustment with Cigna or its designee within 12 months after the date of the original payment or explanation of benefits.

With respect to services reimbursed on a fee-for-service basis, Payor may only retroactively adjust reimbursement made to Provider during the 12 month period after the date of the original explanation of benefits.

Adjustments to claims related to coordination of benefits with federally funded health benefit plans, including Medicare and Medicaid, shall be made within 36 months after the date of service.

(4) Neither Provider nor Cigna is prohibited from protesting or expressing disagreement with a medical decision, medical policy or medical practice of Provider or Cigna.

(5) Cigna may not take an adverse action, as defined by applicable state laws or regulations, against Provider because: a) Provider expresses disagreement with Cigna’s decision to deny or limit benefits to a Participant or assists the Participant to seek

reconsideration of Cigna's decision; or b) Provider discusses with a current, former or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by Cigna or not, policy provisions of a plan or Provider's personal recommendation regarding selection of a health plan based on the Provider's personal knowledge of the health needs of such patients.

(5)(A) Cigna may not take an adverse action, as defined by applicable state laws or regulations, against Provider because Provider, acting on good faith: communicates with a public official or other person concerning public policy issues related to health care items or services; files a complaint, makes a report, or comments to an appropriate governmental body regarding actions, policies, or practices of Cigna Provider believes might negatively affect the quality of, or access to, patient care; provides testimony, evidence, opinion, or any other public activity in any forum concerning a violation or possible violation of any provision of C.R.S.A. § 10-16-121; reports what Provider believes to be a violation of law to an appropriate authority, or; participates in any investigation into a violation or possible violation of any provision of C.R.S.A. § 10-16- 121 .

(6) In the event of termination of the Agreement and to the extent applicable, the provisions of Section 10-16-705(4) of the Colorado Statutes shall apply.

(7) Agreements for less than 2 years in duration may be terminated without cause by Cigna or Provider with 90 days advance written notice to the other party. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider or Cigna, such longer notification period will apply.

(8) Agreements for 2 or more years in duration may be terminated without cause in accordance with the terms set forth in the Agreement.

(9) Cigna can terminate the Agreement immediately (or upon such longer notice required by applicable law, if any) if Provider no longer maintains the licenses required to perform his/her duties under the Agreement, Provider is disciplined by any licensing, regulatory, accreditation organization, or any other professional organization with jurisdiction over Provider, or if Provider no longer satisfies Cigna's credentialing requirements.

(10) Cigna or Provider can terminate the Agreement if the other becomes insolvent.

(11) Any termination notice must be in writing and sent by United States mail, postage prepaid, to Cigna at the addresses below. Cigna may also notify Provider by sending an electronic notice with automatic receipt verification to Provider's e-mail address. Either party can change the address for notices by giving written notice of the change to the other party in the manner just described.

Cigna HealthCare of Colorado, Inc.
8505 East Orchard Road
2T1
Greenwood Village, Colorado 80111
Attention: Manager of Contracting

(12) Payment terms shall not survive the termination of the Agreement except as required by law or as agreed upon by Provider.

(13) Cigna shall provide Provider with at least 90 days written notice of the effective date of a Material Change to the Agreement. Such notice will be conspicuously entitled "NOTICE OF MATERIAL CHANGE TO CONTRACT."

"Material Change" means a change to an Agreement that: a) decreases the provider's payment or compensation; b) changes the administrative procedures in a way that may reasonably be expected to significantly increase the providers administrative expense; c) replaces the maximum allowable cost list used with a new and different maximum allowable cost list by a person or entity for reimbursement of generic prescription drugs; or d) adds a new category of coverage.

A Material Change does not include: a) a decrease in payment or compensation resulting solely from a change in a published fee schedule upon which the payment or compensation is based and the date of applicability is clearly identified in the Agreement; b) a decrease in payment or compensation resulting from a change in an Agreement for pharmacy services such as a change in a fee schedule based on average wholesale price or maximum allowable cost; c) a decrease in payment or compensation that was anticipated under the terms of the Agreement, if the amount and date of applicability of the decrease is clearly identified in the Agreement; d) an administrative change that may significantly increase the provider's administrative expense, the specific applicability of which is clearly identified in the contract; e) changes to an existing prior authorization, precertification, notification or referral program that do not substantially increase the provider's administrative expense; or changes to an edit program or to specific edits.

If Provider objects in writing to the material change within 15 days and there is no resolution of the objection, Cigna or Provider may terminate the Agreement upon written notice to the other party but no later than 60 days prior to the effective date of the material change.

If Provider does not object to the material change within 15 days, the change shall be effective as specified in the notice.

If the material change is the addition of a new category of coverage and Provider objects within 15 days, the material change shall not be effective and Cigna may not terminate Provider for this reason.

Notwithstanding anything in this section, Cigna may modify the Agreement by operation of state or federal law or regulation and Cigna may make such notification to Provider by any reasonable means.

(14) Intermediary Contracts. If Provider is an Intermediary as defined by C.R.S.A. § 10-16- 102(25.5) and 3 Colo. Code of Regs. § 4.2-15(IV)(B), or any other applicable law, Provider as an Intermediary agrees to the following:

(a) If contracted to perform utilization management, utilization review, provider credentialing, administration of health insurance benefits, setting or negotiation of reimbursement rates, payment to providers, network development, disease management programs, or any other program subject to Section 10-16-705(6.5) C.R.S., Intermediary shall comply with the same standards, guidelines, medical policies, and benefit terms as Cigna.

(b) If contracted to perform utilization management, utilization review, provider credentialing, administration of health insurance benefits, setting or negotiation of reimbursement rates, payment to providers, network development, disease management programs, or any other program subject to Section 10-16-705(10.5)(a) C.R.S., Intermediary shall indicate the name of Intermediary and the company for which it is conducting the work when making any payment to a health care provider on behalf of Cigna.

(c) Intermediary will comply, and shall require Subcontracted Providers to comply, with all of the applicable requirements of Section 10-16-705, C.R.S.

(d) Cigna is responsible for ensuring that Subcontracted Providers have the capacity and legal authority to furnish Covered Services.

(e) Cigna has the right to approve or disapprove participation status of Subcontracted Providers in its own or a contracted network for the purpose of delivering Covered Services to its Participants.

(f) Intermediary shall provide Cigna with copies of Subcontracted Providers' contracts in accordance with Applicable Law and Cigna shall maintain copies of all such contracts.

(g) As applicable, Intermediary shall transmit utilization documentation and claims paid documentation to Cigna. Cigna shall monitor the timeliness and appropriateness of payments made to providers and health care services rendered to Participants.

(h) As applicable, Intermediary shall maintain books, records, financial information, and documentation of services provided to Participants at the Intermediary's place of business in the State of Colorado.

(i) Intermediary agrees to allow the Commissioner of the Division of Insurance for the State of Colorado access to the Intermediary's books, records, financial information and any documentation of services provided to Participants as necessary to determine compliance with the law.

(j) Cigna shall have the right, in the event of Intermediary's insolvency, to require the assignment to Cigna of the provisions of a Subcontracted Provider's contract addressing the provider's obligations to furnish Covered Services.

ADDENDUM TO ANCILLARY AGREEMENT FOR THE STATE OF CONNECTICUT

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Connecticut regarding provider contracts with providers rendering health care services in the State of Connecticut. To the extent that such Connecticut laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) The definition for Emergency Services, if any, shall comply with Connecticut laws and regulations to the extent applicable.

(1.1) Material Change or Material Adverse Change shall mean a change that could reasonably be expected to have a material adverse impact on the aggregate level of payment by Cigna or Payor to Provider for Covered Services under this Agreement, or on Provider's administration of their services.

(1.2) Timely Notice shall mean the timeframes established by the parties for advance written notice of a Material Change as set forth in the Material Adverse Change Amendments and All Other Amendments provisions of this Agreement.

(2) Provider, in utilizing laboratories or testing facilities for Participants, shall utilize laboratories or testing facilities covered by Cigna or notify the Participant if Provider intends to utilize a laboratory or testing facility not covered by Cigna.

(3) Termination of the Agreement by either party shall be upon at least 60 days' prior written notice by the terminating party. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement, such longer notification period will apply.

This requirement does not apply in cases involving: (a) the health or safety of the Participant; (b) any fraud or material misrepresentation by Provider when entering into the Agreement; or (c) any fraudulent activity by Provider relating to the terms of the Agreement.

(3.1) Cigna shall administer Participant requests for continuity of care in accordance with applicable state laws and regulations, including but not limited to $ 1 of Public Act 16-205.

(4) (A) Provider hereby agrees that in no event, including, but not limited to, nonpayment by Payor, Cigna or an intermediary, Cigna's insolvency or the insolvency of an intermediary, or breach of the Agreement shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Participant or person acting on the Participant's behalf, other than Payor, Cigna or an intermediary, for services provided pursuant to the Agreement. The Agreement and this provision shall not prohibit collection coinsurance, deductibles, copayments or cost-sharing amounts, or costs for noncovered services delivered on a fee-for-service basis, 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 Benefit Plan.

(A)(1) The Agreement does not prohibit Provider and a Participant from agreeing to continue services solely at the expense of Participant as long as Provider has clearly informed Participant that such services are not covered or are no longer covered.

Except as provided herein, the Agreement does not prohibit Provider from pursuing any available legal remedy.

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

(B)(1) In the event of Cigna's or an intermediary's insolvency or other cessation of operations, Provider shall deliver Covered Services to Participants without requesting payment from a Participant other than a coinsurance, copayment, deductible or other out-of-pocket expense for such services until the earlier of (i) the termination of the Participant's coverage under the network plan, including any extension of coverage provided under the contract terms or applicable state or federal law for covered persons who are in an active course of treatment, as set forth in applicable state law, or are totally disabled, or (ii) the date of the Agreement would have terminated if Cigna or an intermediary had remained in operation, including any extension of coverage required under applicable state or federal law for covered persons who are in an active course of treatment or are totally disabled.

(C) Notwithstanding any other provision in the Agreement, nothing in the Agreement shall be construed to modify the rights and benefits contained in the Participant's Benefit Plan.

(D) Provider may not bill a Participant for Covered Services, except for cost-sharing amounts, where Cigna denies payment because the Provider has failed to comply with the terms or conditions of the Agreement.

(E) Provider further agrees (i) that the provisions of paragraphs (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 the Participant, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Participant, or persons acting on Participant's behalf.

(F) If Provider contracts with other providers or facilities who agree to provide Covered Services to Participants with the expectation of receiving payment directly or indirectly from Payor, such providers or facilities shall agree to abide by the provisions of paragraphs (A), (B), (C), (D) and (E) of this section.

(5) Pursuant to Connecticut law, it is an unfair trade practice for Provider to request payment from a Participant, other than coinsurance, copayment, deductible, or other out-of-pocket expense for Covered Services or emergency services, or facility fees or surprise bills as defined by applicable state laws, or to report to a credit reporting agency a Participant's failure to pay a bill for such services when Cigna has primary responsibility for payment of such services, fees or bills.

(6) Cigna may make material changes to Provider's fee schedule once annually upon at least 90 days advance written notice. Upon receipt, Provider may accept the changes, or terminate the agreement by giving at least 60 days advance written notice. Cigna may make material changes to Provider's fee schedule at any time as permitted under applicable law subject to at least 30 days advance written notice of the changes.

(7) Cigna shall not cancel, deny or demand the return of full or partial payment for an authorized covered service due to administrative or eligibility errors more than 18 months after the receipt of a clean claim except as permitted under applicable law. Cigna shall provide at least 30 days advance written notice of any cancellation, denial or demand.

(8) If included in the Agreement, a "Most Favored Nation" provision prohibited by C.G.S.A. § 8a-479b(c) is hereby deleted in its entirety.

(9) In addition to the terms of the Agreement establishing requirements for records, Provider shall make health records available to appropriate state and federal authorities involved in assessing the quality of care provided to, or investigating grievances or complaints of, covered persons. Provider shall comply with applicable state and federal laws related to the confidentiality of medical and health records and a covered person's right to view, obtain copies of or amend such covered person's medical and health records.

(10) If Provider is an optometrist subject to C.G.S.A. $38a-472h, the following shall modify references to rates in the Agreement to the extent required by applicable laws or regulations.

Notwithstanding anything in this Agreement or in any rate exhibit to this Agreement to the contrary, the rates in this Agreement will be payment in full for all Covered Services furnished to Participants under this Agreement; the rates in this Agreement apply to all Covered Services provided to Participants in the Benefit Plan types covered by this Agreement, including services covered under a Participant's in or out-of-network benefits and whether the Payor or Participant is financially responsible for payment.

ADDENDUM TO ANCILLARY AGREEMENT FOR THE DISTRICT OF COLUMBIA

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the District of Columbia regarding provider contracts with providers rendering health care services in the District of Columbia. To the extent that such District of Columbia laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

A. (1) Payor may only retroactively deny reimbursement to Provider:

(a) For services subject to Coordination of Benefits with another health insurer during the 18-month period after the date that the Payor paid the Provider; or

(b) Except as provided in paragraph A. (1) (a) of this subsection, during the 6- month period after the date that the Payor paid the Provider.

(b) (i) A Payor that retroactively denies reimbursement to a Provider under subsection A. (1) (a) shall provide the Provider with a written statement specifying the basis for the retroactive denial. If the retroactive denial of reimbursement results from Coordination of Benefits, the written statement shall provide the name and address of the entity acknowledging responsibility for payment of the denied claim.

(2) This subsection shall not apply if a Payor retroactively denies reimbursement to a Provider because:

(a) The information submitted to the Payor was fraudulent;

(b) The information submitted to the Payor was improperly coded and the Payor has provided to the Provider sufficient information regarding the coding guidelines used by the Payor at least 30 days prior to the date the services subject to the retroactive denial were rendered; or

(c) The claim submitted to the Payor was a duplicate claim.

(3) Information submitted to the Payor may be considered to be improperly coded under paragraph A. (1) (a) of this subsection if the information submitted to the Payor by the Provider:

(a) Uses codes that do not conform with the coding guidelines used by the Payor applicable as of the date that services were rendered; or

(b) Does not otherwise conform with the contractual obligations of the Provider or the Payor applicable as of the date that services were rendered.

(c) If a Payor retroactively denies reimbursement for services as a result of Coordination of Benefits, the Provider shall have 180 days after the date of denial, unless the Payor permits a longer time period, to submit a claim for reimbursement for the service to the health insurer responsible for payment.

(d) A Payor that retroactively denies reimbursement to a Provider under this section shall provide the Provider with a written statement specifying the basis for the retroactive denial.

(e) This section shall not apply to an adjustment to reimbursement made as part of an annual contracted reconciliation of a risk-sharing the termination.

(4) In the event the Agreement is terminated by either party, Cigna shall give reasonable advance notice of such termination to those Participants whom Provider is currently treating and who are affected by the termination.

(5) Except in cases where termination of the Agreement was due to failure to meet quality standards of care or fraud, Provider shall continue to provide Covered Services for specific conditions for which a Participant was under Provider's care at the time of such termination as follows. When Medically Necessary, Participants with serious illness undergoing a course of treatment or who are in the second trimester of a pregnancy shall be permitted to continue to receive Medically Necessary Covered Services, with respect to the course of treatment or for such pregnancy, for 90 days from the date of the notice of termination. Provider shall be compensated for Covered Services provided to any such Participant in accordance with the compensation arrangements under the Agreement. Participants shall not be liable to Provider for any amounts owed for Covered Services provided during the period of continued care other than Copayments, Deductibles or Coinsurance billed in accordance with the terms of a Benefit Plan. Provider has no obligation under the Agreement to continue to provide services to individuals who cease to be Participants.

(6) To the extent required by D.C. Code § 31-3132, Cigna shall allow Provider a minimum of 180 days from the date a Covered Service is rendered or the date of inpatient discharge to submit a claim for reimbursement of services.

ADDENDUM TO ANCILLARY AGREEMENT FOR THE STATE OF DELAWARE

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Delaware regarding provider contracts with providers rendering health care services in the State of Delaware. To the extent that such Delaware laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

In the event that Cigna's final decision regarding reimbursement for an individual claim, procedure or service does not authorize reimbursement of Provider's claim in its entirety, Cigna shall give Provider written notice of Provider's right to arbitration. Provider shall attempt to resolve disputes informally with Cigna before requesting arbitration pursuant to this provision. The arbitrator may dismiss an arbitration petition without prejudice, if the arbitrator finds that Provider has not attempted to resolve the matter informally.

Petition for Arbitration: Provider or an authorized representative may request review of Cigna's final reimbursement decision through arbitration by delivering a Petition for Arbitration to the Department of Insurance so that it is received by the Department no later than 60 days after the date of mailing of Cigna's final reimbursement decision. The Department shall make available, by mail and on its web site, a standardized form for a Petition of Arbitration. Provider or an authorized representative must deliver to the Department an original and 3 copies of the Petition for Arbitration. At the time of delivering the Petition of Arbitration to the Department, Provider or an authorized representative must also: send a copy of the Petition to Cigna by certified mail, return receipt requested; deliver to the Department a Proof of Service confirming that a copy of the Petition has been sent to Cigna by certified mail, return receipt requested; and deliver to the Department a non-refundable filing fee. The fee shall be $50 for claims of $1,000 or less, in all other cases the fee shall be $100. The Department may refuse to accept any Petition that is not timely filed or does not otherwise meet the criteria for arbitration, including the disputes described in 18 Del. C. Section 333(j)(1) – (3).

Response to Petition for Arbitration: Within 20 days of receipt of the Petition, Cigna must deliver to the Department an original and 3 copies of a Response with supporting documents or other evidence attached. At the time of delivering the Response to the Department, Cigna must also: send a copy of the Response and supporting documentation to Provider or an authorized representative by first class U.S. mail, postage prepaid; and deliver to the Department a Proof of Service confirming that a copy of the Response was mailed to Provider or an authorized representative. The Department may return any non-conforming Response to Cigna. If Cigna fails to deliver a Response to the Department in a timely fashion, the Department, after verifying proper service, and with written notice to the parties, may assign the matter to the next scheduled Arbitrator for summary disposition. The Arbitrator may determine the matter in the nature of a default judgment

after establishing that the Petition is properly supported and was properly served on Cigna. The Arbitrator may allow the re-opening of the matter to prevent a manifest injustice. A request for re-opening must be made no later than 7 days after notice of the default judgment.

Summary Dismissal of Petition by the Department: If the Department determines that the subject of the Petition is not appropriate for arbitration or is meritless on its face, the Department may summarily dismiss the Petition and provide notice of such dismissal to the parties.

Appointment of Arbitrator: Upon receipt of a proper Response, the Department shall assign an Arbitrator who shall schedule the matter for a hearing so that the Arbitrator can render a written decision within 45 days of the delivery to the Department of the Petition for Arbitration. The Arbitrator shall be of suitable background and experience to decide the matter in dispute and shall not be affiliated with any of the parties or with the patient whose care is at issue in the dispute.

Arbitration Hearing: The Arbitrator shall give notice of the arbitration hearing date to the parties at least 10 days prior to the hearing. The parties are not required to appear and may rely on the papers delivered to the Department. The arbitration hearing is to be limited, to the maximum extent possible, to each party being given the opportunity to explain their view of the previously submitted evidence and to answer questions by the Arbitrator. If the Arbitrator allows any brief testimony, the Arbitrator shall allow brief cross-examination or other response by the opposing party. The Delaware Uniform Rules of Evidence will be used for general guidance but will not be strictly applied. Because the testimony may involve evidence relating to personal health information that is confidential and protected by state or federal laws from public disclosure, the arbitration hearing shall be closed. The Arbitrator may contact, with the parties' consent, individuals or entities identified in the papers by telephone in or outside of the parties' presence for information to resolve the matter. The Arbitrator is to consider the matter based on the submission of the parties and information otherwise obtained by the Arbitrator in accordance with this regulation. The Arbitrator shall not consider any matter not contained in the original or supplemental submissions of the parties that has not been provided to the opposing party with at least 5 days notice, except claims of a continuing nature that are set out in the filed papers.

Arbitrator's Written Decision: The Arbitrator shall render a decision and mail a copy of the decision to the parties within 45 days of the filing of the Petition. The Arbitrator's decision is binding upon the parties, except as provided in 18 Del. C. Section 333(f).

ADDENDUM TO ANCILLARY AGREEMENT FOR THE STATE OF FLORIDA

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Florida regarding provider contracts with providers rendering health care services in the State of Florida. To the extent that such Florida laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(A) (1) The **Dispute Resolution** provision of the Agreement is amended to add the following optional dispute resolution process for the resolution of disputes relating to the payment of provider claims:

After the exhaustion of the Agreement's internal process to resolve disputes relating to the payment of provider claims, but before the initiation of arbitration to resolve such disputes, either party may initiate the Agency for Health Care Administration dispute resolution process, to the extent that such process applies to the dispute, by providing written notice to the other party. If the Agency for Health Care Administration dispute resolution process does not apply to the dispute, and therefore such dispute resolution process does not occur, either party may initiate arbitration by providing written notice to the other party.

(2) Notwithstanding the 180 day period provided in the Underpayments provision of the Agreement, all claims for underpayment from a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 of the Florida Statutes must be submitted to Cigna or its designee within 12 months after Payor's payment of the claim.

(3) The Overpayments provision of the Agreement is amended to add the following:

(a) All claims for overpayment submitted to a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 of the Florida Statutes must be submitted within 12 months after the Payor's payment of the claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud.

(b) Notwithstanding the 12 month period provided in subsection (a) above, all claims for overpayment submitted to a provider not included in subsection (a) above must be submitted within 30 months after the Payor's payment of the claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud.

(B) With respect to Covered Services rendered to Participants covered under an HMO Benefit Plan:

(1) The definition for **Emergency Services**, if any, shall comply with Florida laws and regulations to the extent applicable.

(2) To the extent applicable and/or not otherwise preempted by federal law, the parties shall comply with Section 641.3155 of the Florida Statutes. To the extent required by Section 641.3155 of the Florida Statutes, Provider shall submit all claims for payment by mail or by electronic transfer within 6 months after the date of discharge for inpatient services or the date of service for outpatient services.

(3) Cigna or Provider may not terminate the Agreement unless the terminating party provides the other party with a written reason for such termination, which may include termination for business reasons of the terminating party. Termination of the Agreement by Provider, for any reason, shall be upon 60 days' prior written notice to Cigna and the State of Florida Office of Insurance Regulation. Nonpayment for goods or services rendered by Provider is not a valid reason for avoiding such 60 day advance notice of termination. Cigna will provide 60 days' advance written notice to Provider and the State of Florida Office of Insurance Regulation before terminating the Agreement, except in the case in which Participants' health is subject to imminent danger or the ability to practice medicine is effectively impaired by an action of the Board of Medicine or other governmental agency. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider or Cigna, such longer notification period will apply.

(4) If the Agreement is terminated for any reason other than for cause, Cigna and Provider shall allow Participants for whom treatment was active to continue coverage and care when medically necessary, through completion of treatment of a condition for which the Participant was receiving care at the time of termination so long as Participant retains eligibility under a Benefit Plan, until the Participant selects another treating provider, or during the next open enrollment period offered by the organization, whichever is longer, but not longer than 6 months after termination of the Agreement. Each party to the terminated contract shall allow a Participant who has initiated a course of

prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until completion of postpartum care. This does not prevent Provider from refusing to continue to provide care to a subscriber who is abusive, noncompliant, or in arrears in payments for services provided. For care continued under this provision, Cigna and Provider shall continue to be bound by the terms of the Agreement. Changes made within 30 days before termination of a contract are effective only if agreed to by both parties.

(5) Provider shall prominently post a consumer assistance notice to Participants in Provider's reception area. The notice must include the address and toll-free number of the Agency for Health Care Administration, the Subscriber Assistance Program, and the State of Florida Office of Insurance Regulation. The notice shall also state that the toll-free number for the applicable Member Service Center shall be provided upon request.

(C) With respect to Covered Services rendered to Participants covered under a non-HMO Benefit Plan which is insured by Cigna or a Cigna Affiliate:

To the extent applicable and/or not otherwise preempted by federal law, the parties shall comply with Section 627.6131 of the Florida Statutes.

ADDENDUM TO ANCILLARY AGREEMENT FOR THE STATE OF GEORGIA

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Georgia regarding provider contracts with providers rendering health care services in the State of Georgia. To the extent that such Georgia laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) It is the intent of the parties to this Agreement to ensure quality services that meet all uniform treatment standards required by Georgia law and any provision herein which may be inconsistent with that intent shall be void.

(2) The definition for Emergency Services, if any, shall comply with Georgia laws and regulations to the extent applicable.

(3) Pursuant to Code Section 33-20A-62 to the extent applicable and/or not otherwise preempted by federal law:

(i) Cigna, or any agent thereof, shall not conduct a post-payment audit or impose a retroactive denial of payment of any claim by Provider relating to the provision of health care services to Participants unless:

1. Cigna, or any agent thereof has provided to Provider written notice of the intent to conduct such an audit or impose such a retroactive denial of payment of such claim, or any part thereof, and has provided in such notice the specific claim and the specific reason for the audit or retroactive denial of payment;

2. Not more than 12 months have elapsed since the last date of service or discharge covered by the claim prior to the delivery to Provider of such written notice; and

3. Any such audit or retroactive denial of payment was completed and notice provided to Provider of any payment or refund due within the following time periods, whichever is applicable: (a) if the claim was submitted within 90 days of the last date of service or discharge covered by the claim, within 18 months of the last date of service or discharge covered by such claim; or (b) if the claim was submitted more than 90 days after the last date of service or discharge covered by the claim, the earlier of 18 months after Provider’s initial submission of such claim or 24 months after the date of service.

(ii) Cigna, or any agent thereof, shall not be required to respond to Provider's request for additional payment or to adjust any previously paid Provider claim or any part thereof following a final payment unless:

1. Provider makes a request in writing to Cigna, or any agent thereof, specifically identifying the previously paid claim, or any part thereof, and provides the specific reason for additional payment; and
2. the written request for additional payment or adjustment was submitted within the following time periods, whichever is applicable: (a) if the claim was submitted within 90 days of the last date of service or discharge covered by the claim, the earlier of 12 months after the date both Provider and Cigna, or any agent thereof, agree that all payments relative to the claim have been made and all appeals of such determinations have been made or waived by Provider or 24 months after the date of service or discharge; or (b) if the claim was submitted more than 90 days after the last date of service or discharge covered by the claim, the earlier of 6 months after the date both Provider and Cigna, or any agent thereof, agree that all payments relative to the claim have been made and all appeals of such determinations have been made or waived by Provider or 24 months after the date of service or discharge.

(iii) A Participant who is not billed by Provider, or agent thereof, within 45 days of the date that Provider, or agent, knew that further payment was due as a result of a post payment audit, retroactive denial, or rejected request to adjust a previously paid claim shall be relieved of any and all legal obligations to respond to a request for additional payment.

(iv) Notwithstanding any other provision to the contrary, when precertification has been obtained for a service, Cigna, or any agent thereof, shall be prohibited from contesting, requesting payment, or reopening such claim, or any portion thereof, except to the extent Cigna is not liable for the payment under Code Section 33-20A-7.1.

(4) If included in the Agreement, a "Most Favored Nation" provision or any other provision prohibited by Georgia laws and regulations is hereby deleted in its entirety.

ADDENDUM TO ANCILLARY AGREEMENT FOR THE STATE OF ILLINOIS

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Illinois regarding provider contracts with providers rendering health care services in the State of Illinois. To the extent that such Illinois laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(A) Emergency Services shall mean, unless otherwise defined by applicable state laws and regulations, transportation services, including but not limited to ambulance services, and covered inpatient and outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an emergency medical condition. Emergency medical condition shall mean, unless otherwise defined by applicable state laws and regulations, a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(B) With respect to Covered Services rendered to Participants covered under an HMO Benefit Plan:

(1) Provider shall, upon request of Participant, provide Participant the following: (a) information related to provider's educational background, experience, training, specialty, and board certification, if applicable; (b) the names of licensed facilities on the provider panel where the provider presently has privileges for the treatment, illness or procedure that is the subject of the request; and (c) information regarding provider's participation in continuing education programs and compliance with any licensure, certification, or registration requirements, if applicable.

(2) a. Cigna must give Provider at least 60 days' notice of nonrenewal or termination of the Agreement. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Cigna, the longer notification period will apply.

b. Provider must give Cigna at least 60 days' notice for termination of the Agreement for cause and at least 90 days' notice by Provider for termination of the Agreement without cause. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider, the longer notification period will apply.

(3) Cigna shall not retaliate against Provider if Provider advocates for appropriate health care services for Participants. To advocate for medically appropriate health care services means to appeal a decision to deny payment for health care services pursuant to the reasonable grievance or appeal procedure.

(4) All nurse and other ancillary and paramedic personnel shall maintain all necessary professional credentials, including but not limited to appropriate licenses, certifications, accreditations and other similar approvals required by applicable local, state and federal laws and regulations.

(5) Provider shall give Cigna at least 15 days advance written notice of cancellation, modification or termination of general or professional liability insurance.

(6) The "Limitations on Billing Participants" provision is amended to add the following Participant hold harmless requirements:

a. the provision shall also apply to Provider's assignees or subcontractors;

b. the Participant, persons acting on Participant's behalf (other than Payor) and the employer or group contract holder shall be Third Party beneficiaries of the provision; and

c. the provision supersedes any oral or written agreement now existing or hereafter entered into between Provider and Participant, person's acting on Participant's behalf (other than Payor) and the employer or group contract holder.

(7) a. Upon termination of the Agreement by Provider, or upon termination of the Agreement by Cigna, if Cigna terminates the Agreement for reason(s) other than termination in situations involving imminent harm to a patient or a final disciplinary action by a state licensing board, Provider shall, at the Participant's option, continue to provide Covered Services to the Participant for up to 90 days following the date of the written notice of Provider's termination, or if the Participant is in the third trimester of pregnancy, throughout the term of the Participant's pregnancy, including post-

partum care directly related to the pregnancy. During the transitional period under this section, Provider shall agree: (1) to continue to accept reimbursement at the rates applicable prior to the start of the transitional period; (b) to adhere to the plan's quality assurance requirements and provide the necessary medical information related to such care; and (c) to otherwise adhere to the plan's policies and procedures, including but not limited to procedures regarding referrals and obtaining preauthorizations for treatment.

b. Participants shall not be liable to Provider for any amounts owed for Covered Services provided during the period of continued care other than Copayments, Deductibles or Coinsurance billed in accordance with the terms of a Benefit Plan.

c. Provider has no obligation under the Agreement to continue to provide Covered Services to individuals who cease to be Participants.

(8) Cigna or Payor shall not request recoupment or withhold an offset from future payments eighteen months or more after the original payment was made, except in cases in which: a court, government administrative agency, other tribunal, or independent third-party arbitrator makes or has made a formal finding or fraud or material representation; Cigna or Payor is acting as a plan administrator for the Comprehensive Health Insurance Plan under the Comprehensive Health Insurance Plan Act; or, Group or Represented Provider has already been paid in full by another payor, Third Party, or worker's compensation insurer.

(9) With respect to services rendered to Participants by a dentist:

Pursuant to § 215 ILCS 5/355.3, as may be amended from time to time, the rates set forth in the Agreement are only applicable to Covered Services under the applicable insured benefit plan.

ADDENDUM TO ANCILLARY AGREEMENT FOR THE STATE OF INDIANA

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Indiana regarding provider contracts with providers rendering health care services in the State of Indiana. To the extent that such Indiana laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) If included in the Agreement, a "Most Favored Nation" provision or any other provision prohibited by Indiana Code Section 27-8-11-9 (Insurers) or Section 27-13-15-4 (Health Maintenance Organizations) is hereby deleted in its entirety.

(2) The definition for Emergency Services, if any, shall comply with Indiana laws and regulations to the extent applicable.

(3) (a) A Payor may not, more than 2 years after the date on which an overpayment on a claim was made to the Provider by the Payor:

(1) request that the Provider repay the overpayment; or

(2) adjust a subsequent claim filed by the Provider as a method of obtaining reimbursement of the overpayment from the Provider

(b) A Payor may not be required to correct a payment error to a Provider more Than 2 years after the date on which a payment on a claim was made to the Provider by the Payor

(c) This section does not apply in cases of fraud by the Provider, the Participant, or the Payor with respect to the claim on which the overpayment or underpayment was made.

(4) The Agreement may permit network rental arrangements which allow Cigna to lease, rent, or otherwise grant access to a Participating Provider's health care services to a Third Party, and the Third Party accessing the health care contract is:

(a) a payer or third-party administrator or another entity that administers claims on behalf of the payer;

(b) a preferred provider organization or preferred provider network, including a physician-hospital organization; or

(c) an entity engaged in the electronic claims transport between Cigna and the payer.

(B) With respect to Covered Services rendered to Participants covered under an HMO Benefit Plan:

(1) If Provider terminates the Agreement, Provider shall give Cigna not less than 60 days' prior written notice of the termination. If Provider renders 30 percent or more of the services required by Cigna's commercial HMO Participants, Provider shall give Cigna not less than 120 days' prior written notice of termination. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider, such longer notification period will apply.

(2) (a) Upon termination of the Agreement by Provider, or upon termination of the Agreement by Cigna, if Cigna terminates the Agreement for reason(s) other than due to a quality of care issue, Provider shall, upon the request of the Participant, continue to provide Covered Services to the Participant until the earlier of the following: (1) 60 days following the termination of the Agreement; or (2) if the Participant is in the third trimester of pregnancy, throughout the term of the Participant's pregnancy. During the continuation period under this section, Provider: (1) shall continue to accept the terms and conditions of the Agreement, together with the applicable Coinsurance, Copayments or Deductibles, as payment in full; and (2) is prohibited from billing a Participant for any amounts in excess of the Participant's applicable Coinsurance, Copayments or Deductibles.

(b) Provider has no obligation under the Agreement to provide continued services to individuals who cease to be Participants

ADDENDUM TO PROVIDER AGREEMENT FOR THE STATE OF KANSAS

The provisions set forth in this Addendum are being added to the Agreement with the provider named in the Agreement (hereafter referred as "Provider") to comply with legislative and regulatory requirements of the State of Kansas regarding provider contracts with providers rendering health care services in the State of Kansas. To the extent that such Kansas laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of the Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(A) In the event that Payor erroneously pays a claim providing payment to which Provider is not entitled, Payor shall not initiate a request for reimbursement or refund of the erroneous payment, or in any other way seek to recoup the erroneous payment, unless such action is initiated within 18 months after the end of the month in which the erroneous payment was made. In cases of fraud, such action may be initiated within the applicable statute of limitations pursuant to K.S.A. 60-513, and amendments thereto.

(B) With respect to Covered Services rendered to Participants covered under an HMO Benefit Plan:

Upon termination of the Agreement, Provider shall continue to provide Covered Services to Participants for a period of up to 90 days in those cases where the continuation of such care is medically necessary and in accordance with the dictates of medical prudence and where the Participant has special circumstances such as a disability, a life threatening illness or is in the third trimester of pregnancy. Provider shall be compensated for Covered Services provided to any such Participant in accordance with the compensation arrangements under the Agreement until 90 days following termination and thereafter compensation for continued services authorized by Cigna shall be as mutually agreed. Provider has no obligation under the Agreement to provide services to individuals who cease to be Participants.

(C) With respect to services rendered to Participants by a dentist licensed by the Kansas dental board:

Pursuant to Chapter 91 of the Laws of 2010 (Senate Bill 389), the rates set forth in the Agreement are only applicable to Covered Services under the applicable insured benefit plan.

(D) With respect to services rendered to Participants by a vision care provider as defined by the Vision Care Services Act (Chapter 73 of the Laws of 2014, Senate Bill 285) as may be amended from time to time:

(1) Nothing in the Agreement shall be construed to require Provider to provide services or materials to a Participant at a fee limited or set by the terms of the Agreement or by the Participant's Benefit Plan unless the services or materials are reimbursed as Covered Services;

(2) Nothing in the Agreement shall be construed to require Provider to participate in a vision care insurance or a vision care discount plan as a condition to participate in any other health benefit plan or vision care plan, regardless of whether such vision care plan is a plan of insurance or a vision care discount program which is not an insurance plan.

ADDENDUM TO ANCILLARY AGREEMENT
FOR THE STATE OF KENTUCKY

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Kentucky regarding provider contracts with providers rendering health care services in the State of Kentucky. To the extent that such Kentucky laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) The definition for Emergency Services, if any, shall comply with Kentucky laws and regulations to the extent applicable.

(2) If Provider enters into any subcontract agreement with another provider to provide their licensed health care services to Participants, where the subcontracted provider will bill Cigna or Participant directly for the subcontracted services, the subcontract agreement must meet all the requirements of KRS 304.17A-527 and shall be filed with the Commissioner of Insurance.

(3) (a) Cigna shall, upon request of Provider, provide or make available, when contracting or renewing an existing contract with Provider, the payment or fee schedules or other information sufficient to enable Provider to determine the manner and amount of payments under the contract for Provider's services prior to the final execution or renewal of the contract and shall provide any change in such schedules at least 90 days prior to the effective date of amendment.

(b) Any change to payment or fee schedules applicable to Provider shall be made available to Provider at least 90 days prior to the effective date of the amendment. This subsection (b) shall not apply to changes in standard codes and guidelines developed by the American Medical Association or a similar organization.

(4) Pursuant to KRS 304.17A-235 this section (4) is applicable to agreements with Participating Providers as defined below:

(a) Definitions:

"Material Change" means a change to an Agreement, the occurrence and timing of which is not clearly identified in the Agreement, that decreases the health care

provider's payment or compensation or changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expense, and includes any changes to provider network requirements, or inclusion in any new or modified insurance products.

"Participating Provider" means a Provider that has entered into an agreement with Cigna to provide health care services.

(b) Cigna shall provide Participating Provider with at least 90 days written notice of a Material Change to the Agreement. The notice shall provide the proposed effective date of the change and include a description of the Material Change and such notices and disclosures as required by applicable laws and regulations, including but not limited to KRS 304.17A-235, as may be amended from time to time, in the manner and format as prescribed by applicable laws and regulations.

For changes to an existing prior authorization, precertification, notification, or referral program, or changes to an edit program or specific edits, Cigna shall provide notice of the change to the Participating Provider at least 15 days prior to the change.

(5) Except in cases of fraud, Payor may only retroactively deny reimbursement to Provider during the 24 month period after the date Payor paid the claim submitted by Provider. Payor shall not be required to correct a claim payment error, if Provider's request for a claim payment correction is filed more than 24 months after the date that Provider received payment for the claim from Payor.

(6) (a) Pursuant to KRS 304.17A-643, if the Agreement between Cigna and Provider is terminated for reasons other than a quality of care issue or fraud, Provider may request, with the concurrence of the Participant or authorized person, to continue treatment for Participants in special circumstances. "Special circumstances" includes a circumstance in which a Participant has a disability, a congenital condition, a life-threatening illness, or is past the 24th week of pregnancy where the disruption of the Participant's continuity of care could cause medical harm. With respect to those Participants who retain eligibility under a Benefit Plan and who are in an active course of treatment for special circumstances, Provider shall continue to provide Covered Services in accordance with the terms of this Agreement: (a) for a period up to 9 months in the case of a Participant who at the time of the termination has been diagnosed with a terminal illness; (b) if a Participant is beyond the 24th week of pregnancy, for a period that extends through the delivery of the child, immediate post-partum care, and examination within the first 6 weeks following delivery; or (c) for a period up to 90 days after the effective date of

termination for all other Participants in an active course of treatment for special circumstances. Provider shall be compensated for such Covered Services in accordance with the compensation arrangements under the Agreement.

(b) Pursuant to KRS 304.17A-527 (1)(b), if the Agreement between Cigna and Provider is terminated for any reason, other than a quality of care issue or fraud, Provider shall continue to provide services and Payor shall continue to reimburse Provider in accordance with the compensation arrangements under the Agreement until Participant is discharged from an inpatient facility, or the active course of treatment is completed, whichever is greater, and in the case of a pregnant woman, services shall continue to be provided through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy at the time the Agreement is terminated.

(c) This provision survives termination of this Agreement, is intended to be for the benefit of Participants, and supersedes any oral or written agreement to the contrary now existing or hereafter entered into between you and a Participant or persons acting on the Participant's behalf.

(7) Limitations on Billing Participants. Pursuant to KRS 304.17A-527(1) (a), Provider shall not under any circumstances, including: nonpayment of moneys due Provider by Payor, insolvency of Payor, or breach of the Agreement bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Participants or any persons acting on their behalf for Covered Services or for any amounts denied or not paid under this Agreement. This provision does not prohibit collection of any applicable Copayments, Coinsurance and Deductibles. This provision survives termination of this Agreement, is intended to be for the benefit of Participants, and supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Participant or persons acting on the Participant's behalf. Modifications to this section will become effective no earlier than the date permitted by applicable law.

(8) How This Agreement Can Be Terminated. Provider can terminate this Agreement at any time by providing at least 60 days advance written notice. Either Provider or Cigna can terminate this Agreement immediately if the other becomes insolvent. Cigna can terminate this Agreement immediately (or upon such longer notice required by applicable law, if any) if Provider no longer maintains the licenses required to perform its duties under this Agreement, Provider is disciplined by any licensing, regulatory, accreditation organization, or any other professional organization with jurisdiction over Provider, or if Provider no longer satisfies Cigna's credentialing requirements. Any termination of this Agreement as a result of a professional review action will

comply with the standards of 42 U. S. C. § 11112. Upon termination of this Agreement for any reason, the rights of each party terminate, except as provided in this Agreement. Termination will not release Provider or Cigna from obligations under this Agreement prior to the effective date of termination.

(9) The section of the Agreement entitled Payments is modified as follows; the underscored language reflects the changes made to the corresponding sentence in the Agreement to conform to applicable state laws:

Notwithstanding any provision to the contrary set forth in the Compensation section of the Agreement, or any similar provision in the Agreement, or a rate exhibit, to the extent required by KRS 304.17C-085 as may be amended from time to time, the rates in the Agreement will be payment in full for all Covered Services furnished to Participants under the Agreement.

(10) The section of the Agreement entitled Applicability of the Rates is modified as follows; the underscored language reflects the changes made to the corresponding sentence in the Agreement to conform to applicable state laws:

Notwithstanding any provision to the contrary set forth in the Compensation section of the Agreement, or any similar provision in the Agreement, or a rate exhibit, to the extent required by KRS 304.17C-085 as may be amended from time to time, the rates in this Agreement apply to all Covered Services provided to Participants in the Benefit Plan types covered by this Agreement, including services covered under a Participant's in or out-of-network benefits and whether the Payor or Participant is financially responsible for payment.

ADDENDUM TO ANCILLARY AGREEMENT FOR THE STATE OF LOUISIANA

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Louisiana regarding provider contracts with providers rendering health care services in the State of Louisiana. To the extent that such Louisiana laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall apply. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

A. Upon termination of the Agreement:

1. In the event a Participant has been diagnosed as being in a high-risk pregnancy or is past the 24th week of pregnancy, the Participant shall be allowed to continue receiving Covered Services, subject to the consent of the treating Provider, through delivery and postpartum care related to the pregnancy and delivery.
2. In the event a Participant has been diagnosed with a life-threatening illness, the Participant shall be allowed to continue receiving Covered Services, subject to the consent of the treating Provider, until the course of treatment is completed, not to exceed 3 months from the effective date of such termination.
3. Provider shall be compensated for such Covered Services in accordance with the compensation arrangements under the Agreement. The contractual requirements for Provider to comply with CIGNA's utilization management and quality management policies and procedures shall remain in effect for the applicable period specified in subsections 1. and 2. above.

B. The above provisions do not apply if:

1. The reason for termination of the Agreement is due to suspension, revocation, or applicable restriction of the Provider's license to practice in Louisiana by the Louisiana State Board of Medical Examiners, or for another documents reason related to quality of care.
2. The Participant chooses to change Provider.
3. The Participant moves out of the geographic service area of the Provider.
4. The Participant requires only routine monitoring for a chronic condition but is not in an acute phase of the condition.

ADDENDUM TO ANCILLARY AGREEMENT
FOR THE STATE OF MASSACHUSETTS

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Massachusetts regarding provider contracts with providers rendering health care services in the State of Massachusetts. To the extent that such Massachusetts laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) Emergency Medical Condition is a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in § 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

(2) Medical Necessity or medically necessary is defined as, health care services that are consistent with generally accepted principles of professional medical practice as determined by whether:

(a) the service is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual;

(b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or

(c) for services and interventions not in widespread use, is based on scientific evidence.

(3) If Cigna contracts with another entity to perform some or all of the functions governed by the requirements of M.G.L. c. 176O, Cigna shall be responsible for ensuring compliance by said entity with the applicable provisions of Massachusetts law. Any failure by said entity to meet such requirements shall be the responsibility of Cigna to remedy and shall subject Cigna to any and all enforcement actions, including financial penalties authorized under M.G.L. c. 176O.

(4) Notwithstanding anything to the contrary set forth in the Agreement, the following shall be applicable to the Compensation section of the Agreement:

(a) Within 45 days after Payor's receipt of Provider's completed claim, Payor shall:

(i) pay for any fee-for-service amounts owing under this Agreement for such

health care services provided; (ii) notify Provider in writing of the reason or reasons for nonpayment or (iii) notify Provider in writing of what additional information or documentation is necessary to complete the claim for reimbursement.

(b) If Payor fails to comply with the requirements of (a) above, Payor shall pay 1½ % interest per month, not to exceed 18% per year, accruing beginning 45 days after the Payor's receipt of request for reimbursement. Interest payments shall not apply if the claim for the Covered Service was submitted fraudulently or negligently or Provider was already paid for the Covered Service.

(5) Provider shall comply with Cigna's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.

(6) Provider shall provide 90 days advance written notification to Cigna should Provider plan to implement a policy to charge a fee to Participants as a condition to be part of Provider's panel for care.

(7) Cigna shall not refuse to contract with or compensate Provider for Covered Services solely because Provider has in good faith communicated with or advocated on behalf of one or more prospective, current or former patients regarding the provisions, terms or requirements of a Benefit Plan as they relate to the needs of Provider's patients, or communicated to one or more prospective, current or former patients with respect to the method by which Provider is compensated for Covered Services. Nothing in this provision shall be construed to preclude Cigna from requiring Provider to hold confidential specific compensation terms.

(8) In the event of termination of the Agreement by either party, the written notice of termination must include the reason(s) for such termination. The parties do not have the right to terminate the Agreement without providing a reason for such termination, as neither party has the right to terminate the Agreement without cause.

(9) Pursuant to the requirements of M.G.L. c. 176O, Section 15 to the extent applicable to the Agreement:

(a) Cigna shall allow any female Participant who is in her second or third trimester of pregnancy and whose provider in connection with her pregnancy is involuntarily disenrolled, other than disenrollment for quality-related reasons, or for fraud, to continue treatment with said provider, consistent with the terms of the Benefit Plan, for the period up to and including the Participant's first postpartum visit.

(b) Cigna shall allow any Participant who is terminally ill and whose provider in connection with said illness is involuntarily disenrolled, other than disenrollment for quality-related reasons, or for fraud, to continue treatment with said provider, consistent with the terms of the Benefit Plan, until the Participant's death.

(c) During the period of continued treatment by a provider under subsections (a), (b) and (c), of this provision, provider must agree: (1) to accept reimbursement from Payor at the rates applicable prior to the notice of disenrollment as payment in full and not to impose cost sharing with respect to the Participant in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled; (2) to adhere to the quality assurance standards of Cigna and to provide Cigna with necessary medical information related to the care provided; and (3) to adhere to Cigna's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by Cigna. Nothing in this provision shall be construed to require the coverage of benefits that would not have been covered if provider remained a Participating Provider.

(10) Cigna shall notify Provider in writing of modifications in provider compensation, modifications in Covered Services, or modifications in Cigna's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of Provider, and the effective date of the modifications. The notice shall be provided 60 days before the effective date of such modification.

(11) Provider is not required to indemnify Cigna for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against Cigna based on Cigna's management decisions, utilization review provisions or other policies, guidelines or actions.

(12) In the event of Payor's insolvency, Provider shall look solely to Payor for compensation for Covered Services, except for Copayments, Deductibles or Coinsurance. Under no circumstances shall Provider directly or indirectly make any charges or claims, other than for Copayments, Deductibles or Coinsurance, against any Participants or their representatives. This provision shall survive the termination of the Agreement for services rendered prior to the termination, regardless of the cause of the termination.

(13) Pursuant to the requirements of M.G.L. c. 176O § 9A and 211 CMR 152.00 to the extent applicable to the Agreement:

(a) Provider shall have the right to opt-out of any new select network, limited, regional or tiered network health benefit plan introduced by Cigna at least sixty (60) days before the plan is submitted for regulatory approval.

(b) Nothing in the Agreement shall be construed to: guarantee Provider a right to participate in any Cigna select network or tiered network plan; require or permit either party to alter or terminate the Agreement, in whole or in part, to affect parity with an agreement with other carriers or health care providers based on Cigna's decision to introduce or modify a select network plan or tiered network plan; require Cigna to place all members in the same tier of a tiered network plan; or require Cigna to include all members in a select network plan on an all-or-nothing basis. Any supplemental payment required or permitted under the Agreement shall not be enforceable unless each payment has been publicly disclosed as a condition of state accreditation. To the extent the Agreement contains any provision prohibited by this section, the duties and obligations of the provision shall apply only to health benefit plans not subject to M.G.L. c. 176O § 9A and 211 CMR 152.00.

(c) Cigna shall notify Provider in writing at least sixty (60) days before the effective date of any modification to the process used to classify participating providers by benefit tier, the timelines used to make and implement reclassification decisions by benefit tier, the information collected from participating providers, and the criteria used to make classifications.

(d) Provider shall have the right to receive notification of classification to a benefit tier, an explanation of the past experience and other criteria used to make classification decisions, and to appeal classification decisions and receive an appeal decision prior to the new classification being made available.

(e) Cigna shall notify participating providers about health benefit plans that use networks subject to 211 CMR 152.00 as set forth in the Administrative Guidelines.

ADDENDUM TO ANCILLARY AGREEMENT FOR THE STATE OF MARYLAND

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Maryland regarding provider contracts with providers rendering health care services in the State of Maryland. To the extent that such Maryland laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) The definition for Emergency Services, if any, shall comply with Maryland laws and regulations to the extent applicable.

(2) The following definition of Experimental Medical Care is added to the Agreement:

Experimental Medical Care means medical, surgical or other health care procedures and treatments which are experimental or investigational, as determined by CIGNA's Medical Director in accordance with consensus derived from peer review medical and scientific literature and the practice of the national medical community, including (i) any procedures or treatments which are not recognized as conforming to accepted medical practice; (ii) any procedures or treatments in which the scientific assessment of the technique, or its application for a particular condition, has not been completed or its effectiveness has not been established; and (iii) any procedures or treatments for which the required approval of a governmental agency has not been granted at the time the services are rendered. Covered Services do not include Experimental Medical Care.

However, to the extent applicable under Section 15-827 of the Insurance Article, Covered Services include the patient cost to a Participant in a clinical trial, as a result of:

(a) treatment provided for a life-threatening condition; or

(b) prevention, early detection, and treatment studies on cancer.

Coverage shall be required if:

(1) The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer; or the treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV clinical trial for any other life-threatening condition.

(2) The treatment is being provided in a clinical trial approved by:

(i) one of the National Institutes of Health;

(ii) a National Institutes of Health cooperative group or a National Institutes of Health center;

(iii) the FDA in the form of an investigational new drug application;

(iv) the federal Department of Veterans Affairs; or

(v) an institutional review board of an institution in the state which has a multiple project assurance contract approved by the Office of Protection from Research Risks of the National Institutions of Health.

(3) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.

(4) There is no clearly superior noninvestigational treatment alternative.

(5) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative.

Covered Services include the patient cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the patient's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

An entity seeking coverage for treatment in a clinical trial approved by an institutional review board under subsection (2)(v) above shall post electronically and keep up-to- date a list of the clinical trials meeting the requirements of this section. The list shall include for each clinical trial: (a) the phase for which the trial is approved; (b) the entity approving the trial; (c) whether the trial is for treatment of cancer or another life- threatening disease and, if not cancer, the particular disease; and the estimated number of patients in the trial.

(3) Provider has the right to elect not to serve on a provider panel for workers' compensation services.

(4) To the extent required by § 15-1005 of the Maryland Insurance laws, Provider shall submit claims on the appropriate claim form for all Covered Services within one hundred and eighty (180) days of the date those services are rendered. Claims received after this one hundred and eighty (180) day period may be denied for payment.

Pursuant to Maryland law, to the extent applicable, within 30 days after Payor's receipt of a claim Payor shall pay any undisputed fee-for-service amounts owing under the Agreement in accordance with this provision. If Payor contests the claim, denies all or part of the claim, or needs additional information to adjudicate the claim, Payor shall send a notice of receipt and status of the claim that states: (i) that Payor refuses to reimburse all or part of the claim and the reason for the refusal; (ii) that the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be

reimbursed and what specific additional information is necessary; or (iii) that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim. Clean claim means a claim for reimbursement as defined in regulations adopted by the Commissioner under Section 15-1003 of the Annotated Code of Maryland, as may be changed from time to time.

If additional information is requested by Payor, Payor shall pay or deny the claim, or portion of the claim, within 30 days after receipt of the required additional information. If Payor fails to comply with the requirements of this provision, Payor shall pay interest on the amount of the claim that remains unpaid 30 days after the claim is received by Payor. The applicable monthly interest rate shall be: 1.5% for claims paid from the 31st through the 60th day; 2% for claims paid from the 61st through the 120th day; and 2.5% after the 120th day. Any interest owing under the Agreement shall be paid without the necessity of filing an additional claim for such interest.

(4)(A) Limitations on Billing Participants. Notwithstanding anything to the contrary set forth in the Agreement, in accordance with § 15-838 of the Maryland Insurance laws, a licensed audiologist may accept for a dispensed hearing aid the difference between the price of the hearing aid and the benefit payable under state law from a Participant who chooses a hearing aid that is priced higher than the benefit payable without financial or contractual penalty.

(5) Pursuant to Maryland law, to the extent applicable, Payor may only retroactively deny reimbursement made to Provider during the 6 month period after the date Payor paid such claim. Notwithstanding the foregoing, Payor may retroactively deny reimbursement for services that are subject to coordination of benefits with another carrier, the Maryland Medical Assistance Program, or the Medicare program during the 18 month period after the date Payor paid such claim. The term “reimbursement” includes any applicable capitation payments made to Provider.

The requirements of this provision do not apply if Payor retroactively denies reimbursement to Provider because: (1) the information submitted to the Payor was fraudulent; (2) the information submitted to Payor was improperly coded and Payor provided sufficient information regarding the coding guidelines used by Payor at least 30 days prior to the date the services subject to the retroactive denial were rendered; or (3) the claim submitted to Payor was a duplicate claim.

(6) Termination of the Agreement, by either party, shall be upon at least 90 days’ prior written notice by the terminating party, unless said termination is for reasons related to fraud, patient abuse, incompetency, or loss of licensure status. To the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement, that notification period will apply.

(7) If Provider elects to terminate the Agreement, Provider shall continue to furnish health care services to Participants for whom Provider was responsible for the delivery of health care services prior to the notice of termination for at least 90 days after the date of the notice of termination.

(8) CIGNA may not prohibit Provider from discussing with or communicating to Participant information that is necessary for the delivery of health care services, including:

(a) communications that relate to treatment alternatives:

(b) communications that are necessary or appropriate to maintain the provider- patient relationship while the patient is under Provider's care;

(c) communications that relate to Participant's right to appeal a coverage determination with which Provider or Participant does not agree; and

(d) opinions and the basis of an opinion about public policy issues.

(9) Disclosure of Carriers. Pursuant to Section 15-112.2 of the Insurance Article, a list of carriers shall be available to Provider at www.Cignaforhcp.com.

ADDENDUM TO ANCILLARY SERVICES AGREEMENT FOR THE STATE OF MAINE

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Maine regarding provider contracts with providers rendering health care services in the State of Maine. To the extent that such Maine laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) The definition for Emergency Services, if any, shall comply with Maine laws and regulations to the extent applicable.

(2) Payor may not impose on Provider any retrospective denial of a previously paid claim or any part of that previously paid claim unless:

a. Payor has provided the reason for the retrospective denial in writing to Provider; and

b. The time that has elapsed since the date of payment of the previously paid claim does not exceed 12 months. The retrospective denial of a previously paid claim may be permitted beyond 12 months from the date of payment only for the following reasons:

(1) The claim was submitted fraudulently;

(2) The claim payment was incorrect because Provider or Participant was already paid for the health care services identified in the claim;

(3) The health care services identified in the claim were not delivered by Provider;

(4) The claim payment was for services covered by Title XVIII, Title XIX or Title XXI of the Social Security Act;

(5) The claim payment is the subject of adjustment with another insurer, administrator or payor; or

(6) The claim payment is the subject of legal action.

For purposes of this provision, “retrospective denial of a previously paid claim” means any attempt by Payor to retroactively collect payments already made to Provider with respect to a claim by requiring repayment of such payments, reducing other payments currently owed to Provider, withholding or setting off against future payments or reducing or affecting the future claim payments to Provider in any other manner. Provider has 6 months from the date of notification under this provision to determine whether Participant has other appropriate insurance that was in effect on the date of service. Notwithstanding the terms of the Agreement, Cigna shall allow for the submission of a claim that was previously denied by another insurer because of Participant’s transfer or termination of coverage.

(3) a. Any modification, addition, or deletion to the provision of the Agreement relating to limitations on billing participants shall become effective upon the review and approval of the Maine Bureau of Insurance.

b. Cigna shall notify Provider of a proposed amendment to the Agreement at least 60 days prior to the amendment’s proposed effective date. If an amendment that has substantial impact on the rights and obligations of Provider is made to a manual, policy or procedure document referenced in the Agreement, such as material changes to fee schedules or material changes to procedural coding rules specified in the manual, policy or procedure document, Cigna shall give 60 days’ notice to Provider. After the 60 day notice period has expired, the amendment to a manual, policy or procedure document becomes effective and binding on both Cigna and Provider subject to any applicable termination provisions in the Agreement, except that Cigna and Provider may mutually agree to waive the 60 day notice requirement. This subsection may not be construed to limit the ability of Cigna and Provider to mutually agree to the proposed change at any time after Provider has received notice of the proposed amendment.

(4) a. Cigna may not terminate or nonrenew the Agreement unless Cigna provides Provider with a written explanation prior to the termination or nonrenewal of the reasons for the proposed termination or nonrenewal and provides an opportunity for a review or hearing. Termination or nonrenewal may not be effective earlier than 60 days from the receipt of the notice of termination or nonrenewal. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Cigna, such longer notification period will apply.

b. Notice and Hearing. If Cigna should choose to terminate the Agreement, Cigna will notify Provider of this decision in writing. The notice will include the reason(s) for the termination including reference to the evidence or documentation leading to the decision and a notice of Provider's right to request a hearing or review, at Provider's discretion. If Provider should desire a hearing with regard to the termination of the Agreement, Provider must notify Cigna in writing within 30 days of Provider's receipt of the notice of termination. A hearing will be held within 30 days after receipt of the request by Cigna. The hearing shall be conducted by a panel of at least 3 people appointed by Cigna, at least one-third of which shall be clinical peers of Provider. The panel shall render a decision in a timely manner and shall notify Provider of the decision in writing which will include one of the following resolutions: (a) unconditional reinstatement; (b) provisional reinstatement subject to certain conditions as set forth by Cigna; or (c) termination. Termination will be effective no earlier than 60 days after Provider's receipt of the panel's decision or until the termination date of the Agreement, whichever is earlier. If Provider is unsatisfied with the panel's decision, Provider may appeal the decision further pursuant to the Dispute Resolution procedures specified in the Agreement and Administrative Guidelines.

c. The requirements set forth in this provision do not apply in cases involving imminent harm to patient care, a final determination of fraud by a governmental agency or a final disciplinary action by a state licensing board or other governmental agency that impairs Provider's ability to practice.

(5) a. Upon termination of the Agreement, except in cases involving imminent harm to patient care, a final determination of fraud by a governmental agency, or a final disciplinary action by a state licensing board or other governmental agency that impairs Provider's ability to practice, Provider shall continue to provide Covered Services, for those Participants who retain eligibility under a Benefit Plan and are in active treatment under Provider's care at the time of such termination, for a transitional period of 60 days from the date of notice to the Participant of Provider's termination, or if the Participant is in the second or third trimester of pregnancy at the time of the termination of the Agreement, and Provider is treating the Participant during the pregnancy, the transitional period shall extend through the provision of postpartum care directly related to the pregnancy.

b. During the transitional period under this provision, Provider shall: (a) continue to accept reimbursement at the rates applicable prior to the start of the transitional period as payment in full and shall not impose cost-sharing with respect to the Participant in an amount that would exceed the cost-sharing that would have been imposed had the Agreement not been terminated; (b) adhere to Cigna's quality assurance requirements and provide the necessary medical information related to such care; and (c) otherwise adhere to Cigna's policies and procedures, including but not limited to procedures regarding referrals and prior authorizations and providing services pursuant to any treatment plan approved by Cigna.

c. Provider has no obligation under the Agreement to provide services to individuals who cease to be Participants.

(6) In addition to the Participant billing obligations set forth in the Agreement, in accordance with 24-A MRSA § 4303(8-A), a Participant is not liable to Provider for any sums owed by Payor, and Provider may not collect or attempt to collect any amount from Participant beyond the amount permitted by the Agreement or the managed care plan, notwithstanding Payor's failure to pay, insolvency, or any other breach of the Agreement.

(7) If included in the Agreement, a "Most Favored Nation" provision prohibited by 24-A MRSA § 4303(15) is hereby deleted in its entirety.

ADDENDUM TO ANCILLARY SERVICES AGREEMENT FOR THE STATE OF MICHIGAN

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Michigan regarding provider contracts with providers rendering health care services in the State of Michigan. To the extent that such Michigan laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

Claims for Covered Services must be submitted within 1 year of the date of service or the date of discharge from the facility.

ADDENDUM TO ANCILLARY AGREEMENT FOR THE STATE OF MISSOURI

The provisions set forth in this Addendum are being added to the Agreement to comply with of the State of Missouri Regulations and Statutes regarding provider contracts with providers rendering health care services in the State of Missouri. To the extent that such Missouri Regulations and Statutes are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

A. (1) The definitions for Emergency and Emergency Services are amended to read in their entirety as follows:

Emergency means the sudden and, at the time, unexpected onset of a health condition (emergency medical condition) that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but shall not be limited to:

1. placing the person's health in significant jeopardy;
2. serious impairment to a bodily function;
3. serious dysfunction of any bodily organ or part;
4. inadequately controlled pain; or
5. with respect to a pregnant woman who is having contractions;

a. that there is inadequate time to effect a safe transfer to another hospital before delivery; or

b. that transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

Emergency Services means health care items and services furnished or required to screen and stabilize an emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider.

(2) Provider shall be bound by and comply with the provisions of all applicable State of Missouri Regulations and Statutes (including but not limited to the credentialing and recredentialing requirements of 20 CSR 400-7.180), all applicable federal laws and regulations, and Cigna Administrative Guidelines. Provider shall comply with the requirements of and shall participate in Quality Management and Utilization Management.

(3) The Agreement shall be governed by applicable State of Missouri Regulations and Statutes and any applicable federal law.

(4) To the extent required by RSMo § 376.384, Provider shall file a claim for reimbursement for a health care service provided in this state for a period of up to six months from the date of service, unless the Agreement specifies a different standard.

B. With respect to Covered Services rendered to Participants covered under an HMO Benefit Plan:

(1) Cigna shall give Provider 30 days to review the Agreement.

(2) Pursuant to RSMo 354.603.1(3), Cigna shall monitor, on an on-going basis, the ability, clinical capacity, and legal authority of Provider to furnish all Covered Services to Participants.

(3) Throughout the term of the Agreement, Provider shall maintain general and professional liability coverage in a form and amount acceptable to Cigna ($ per occurrence and $ in the aggregate).

(4) Payor shall not request a refund or offset against a claim more than 12 months after a Payor has paid a claim except in cases of fraud or misrepresentation by Provider.

(5) Cigna will not terminate the Agreement solely because Provider has:

a. advocated on behalf of a Participant;

b. filed a complaint against Cigna;

c. appealed a decision made by Cigna;

d. provided information or filed a report with the Missouri Department of Insurance, Financial Institutions and Professional Registration; or

e. requested a hearing or review.

(6) Cigna and Provider shall provide at least 60 days written notice to each other before terminating the Agreement with notice. The written notice shall include an explanation of why the Agreement is being terminated. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with regard to termination of the Agreement by Provider or Cigna, such longer notification period will apply.

Upon termination of the Agreement, Cigna shall give written notice within 30 working days of such termination to all Participants who are seen on a regular basis by Provider. Within 15 working days of the date of termination of the Agreement, Provider shall supply Cigna with a list of Participants that must be notified of the termination.

(7) Notwithstanding anything to the contrary set forth in the Agreement, the grounds for immediate termination of the Agreement by Cigna are in cases involving imminent harm to patients, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency.

(8) a. Upon termination of the Agreement, Provider shall continue to provide Covered Services for specific conditions for which a Participant was under Provider's care at the time of such termination where the continuation of care is Medically Necessary and in accordance with the dictates of medical prudence, including circumstances such as disability, pregnancy or life- threatening illness, so long as Participant retains eligibility under a Benefit Plan, until the earlier of completion of such services, or the expiration of 90 days. Provider shall be compensated for Covered Services provided to any such Participant in accordance with the compensation arrangements under the Agreement. Participants shall not be liable to Provider for any amounts owed for Covered Services provided during such period of continued care other than Copayments, Deductibles or Coinsurance billed in accordance with the terms of a Benefit Plan.

b. Provider has no obligation under the Agreement to provide services to individuals who cease to be Participants.

(9) In the event of Cigna's insolvency or other cessation of operations, Covered Services to Participants shall continue through the period for which a premium has been paid to Cigna on behalf of the Participant or until the Participant's discharge from an inpatient facility, whichever time is greater. This provision survives termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of Participants and supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and the Participant or persons acting on the Participant's behalf.

(10) If a party initiates arbitration to resolve a dispute, the arbitrator will be instructed that, to the extent that an external review organization or the Missouri Department of Insurance, Financial Institutions and Professional Registration has rendered a final determination as permitted by RSMo 376.1350 through RSMo 376.1399 regarding coverage of a particular service rendered to a particular Participant, the arbitrator will not have authority to revise that final determination.

(11) The Limitations on Billing Participants For Your Services provision survives termination of this Agreement regardless of the cause giving rise to such termination, including Payor's insolvency.

(12) The provision of the Agreement relating to the limitation on billing participants shall also apply in the event of nonpayment by the intermediary or the intermediary's insolvency or breach of the Agreement.

(13) Any modification, addition, or deletion to the provision of the Agreement relating to the limitation on billing participants shall become effective on a date no earlier than 30 days after the applicable state regulatory agency has received written notice of such proposed changes, or the date permitted by applicable law, whichever is later.

(14) a. Cigna shall not prohibit or restrict Provider from disclosing to Participant any information that Provider deems appropriate regarding the nature of treatment, risks, or alternatives thereto, the availability of other therapy, consultation or test, the decision of any plan to authorize or deny services, or the process that the plan or any person contracting with the plan uses or proposes to use, to authorize or deny health care services. Cigna shall not prohibit any other communication expressly protected under all applicable State of Missouri Regulations and Statutes and all applicable federal laws and regulations.

b. Provider's duties to comply with Cigna's Participant Grievance procedure shall be subject to RSMo 376.1350 through RSMo 376.1399, including in particular Provider's option to appeal Cigna decisions and those provisions related to determinations to the Missouri Department of Insurance, Financial Institutions and Professional Registration or external review organizations. Cigna shall not penalize Provider because Provider, in good faith, reports to state or federal authorities any act or practice by Cigna that Provider reasonably determines may jeopardize patient health or welfare.

(15) If Provider is an optometrist subject to RSMo § 376.685, the following shall modify references to rates in the Agreement to the extent required by applicable laws or regulations.

Notwithstanding anything in this Agreement or in any rate exhibit to this Agreement to the contrary, the rates in this Agreement will be payment in full for all Covered Services furnished to Participants under this Agreement; the rates in this Agreement apply to all Covered Services provided to Participants in the Benefit Plan types covered by this Agreement, including services covered under a Participant's in or out- of-network benefits and whether the Payor or Participant is financially responsible for payment.

ADDENDUM TO PROVIDER AGREEMENT OR THE STATE OF MISSISSIPPI

The provisions set forth in this Addendum are being added to the Agreement with the provider named in the Agreement (hereafter referred as "Provider") to comply with legislative and regulatory requirements of the State of Mississippi regarding provider contracts with providers rendering health care services in the State of Mississippi. To the extent that such Mississippi laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of the Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

1. Provider shall mean "Provider," or "Group and/or Represented Provider" as named in the Agreement, or as otherwise set forth in the Agreement.

2. In addition to the negotiated terms of the Agreement establishing limits on billing participants, the following shall apply in accordance with applicable laws and regulations; in the event of a conflict between the negotiated terms and the requirements of applicable laws and regulations, the requirements of applicable laws and regulations shall control to extent applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control:

A. Provider agrees that in no event, including but not limited to nonpayment by Cigna, insolvency of Cigna, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Participant or a person (other than Cigna) acting on behalf of Participant for Covered Services provided pursuant to this Agreement. This provision does not prohibit Provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to Participants. Nor does this provision prohibit Provider and Participant from agreeing to continue services solely at the expense of the Participant, as long as Provider has clearly informed Participant that Cigna may not cover or continue to cover a specific service or services. Except as provided in the Agreement, this provision does not prohibit Provider from pursuing any available legal remedy.

B. In the event of Cigna's or Provider's insolvency or other cessation of operations, Covered Services to Participants will continue through the period for which a premium has been paid to Cigna on behalf of the Participant or

until discharge from an inpatient facility, whichever time is greater. Covered Services to Participants confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary.

C. Subsections A and B shall be construed in favor of the Participant, shall survive the termination of the contract regardless of the reason for termination, including Cigna's insolvency, and shall supersede any oral or written contrary agreement between Provider and Participant or the representative of a Participant if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions required by subsections A and B or applicable laws and regulations.

D. Provider shall ensure that all contracts entered into with participating providers contain a provision substantially similar to subsection A above, or substantially similar to the text required by applicable laws and regulations.

3. In no event shall Provider collect or attempt to collect from a Participant any money owed to Provider by Cigna.

4. Nothing in the Agreement shall be construed to offer an inducement under a managed care plan to Provider to provide less than medically necessary services to Participants. Nothing in the Agreement shall be construed to prohibit Provider from discussing treatment options with Participants irrespective of Cigna's position on the treatment options, or from advocating on behalf of Participants within the utilization review or grievance processes used by Cigna.

5. Nothing in the Agreement shall be construed to penalize Provider because Provider, in good faith, reports to state or federal authorities any act or practice by Cigna that jeopardizes patient health or welfare.

6. To the extent required by applicable law, including but not limited to Miss. Code Ann. §83-41-219, as may be amended from time to time, Cigna or Payor shall have the same time limit following payment of a claim to perform any review or audit for reconsidering the validity of the claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim as Provider has to submit a claim for payment under this Agreement. To the extent the Agreement does not limit the time in which Provider is required to submit a claim for payment, Payor shall not request reimbursement of offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than twelve months after the payment of an invalid claim or overpaid claim. Nothing in this section shall apply to claims submitted in the context of misrepresentation, omission, concealment, or fraud, or to claims submitted by Provider for reimbursement under the Mississippi Medicaid Program.

7. Cigna and Provider shall provide at least sixty (60) days written notice to each other before terminating the Agreement without cause. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider, such longer notification period will apply. Within five (5) working days of the date that Provider either gives or receives notice of termination, Provider shall supply a list of those Participants that are patients of the Provider.
8. To the extent permitted by applicable law, Cigna shall retain the right to immediately terminate the Agreement upon a valid order issued by the Mississippi Department of Insurance or other lawful authority.
9. In accordance with applicable laws and regulations, Cigna shall have the right to approve or disapprove the participation status of a participating provider in Provider's contracted network for the purpose of delivering Covered Services to Cigna's Participants.
10. Cigna's rights and responsibilities under the Agreement shall not be assigned or delegated by Provider without prior written consent. Nothing in the Agreement shall be construed to delegate or assign to Provider Cigna's statutory responsibility to monitor the offering of Covered Services to Participants.
11. In accordance with applicable laws and regulations, Cigna shall have the right, in the event of Provider's insolvency, to require the assignment to Cigna of the provisions of Provider's contract addressing the Provider's obligation to furnish covered services.
12. In addition to the negotiated terms of the Agreement, Cigna shall have access to all Provider's subcontracts, and shall have the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from Cigna.
13. In addition to the negotiated requirements of the Agreement, Provider shall maintain the books, records, financial information and documentation of services provided to Participants at its principal place of business in the state and shall preserve them in a manner that facilitates regulatory review.
14. Provider shall allow the commissioner of insurance access to Provider's books, records, financial information and any documentation of services provided to Participants, as necessary to determine compliance with applicable laws and regulations.
15. In addition to the negotiated requirements of the Agreement establishing requirements for records, 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, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

16. If applicable under the terms of the Agreement, Provider shall transmit utilization documentation and claims paid documentation to Cigna as set forth in the Agreement. Cigna shall monitor the timeliness and appropriateness of payments made to providers and health care services received by Participants.

17. Definitions or other provisions in the Agreement shall be construed to avoid conflict with the definitions or provisions contained in the managed care plan, or in applicable laws and regulations.

ADDENDUM TO ANCILLARY AGREEMENT FOR THE STATE OF MONTANA

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Montana regarding provider contracts with providers rendering health care services in the State of Montana. To the extent that such Montana laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

In the event of Cigna's insolvency or other cessation of operations, Covered Services to Participants shall continue through the period for which a premium has been paid to Cigna on behalf of the Participant, but not to exceed 30 days, or until the Participant's discharge from an acute care inpatient facility, whichever time is greater. Participants shall not be liable to Provider for any amounts owed for Covered Services provided during the period of continued care other than Copayments, Deductibles or Coinsurance billed in accordance with the terms of a Benefit Plan. Provider further agrees that this provision shall survive the termination of the Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of Participants, and that this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and the Participant or persons acting on the Participant's behalf.

ADDENDUM TO ANCILLARY AGREEMENT FOR THE STATE OF NORTH CAROLINA

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of North Carolina regarding provider contracts with providers rendering health care services in the State of North Carolina. To the extent that such North Carolina laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) The following definitions are applicable to insured Benefits Plans issued in the State of North Carolina:

(a) The definition for Emergency Services and Emergency Medical Condition shall comply with North Carolina laws and regulations to the extent applicable.

(b) Medically Necessary means those Covered Services or supplies that are:

a. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes.

b. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

c. Within generally accepted standards of medical care in the community.

d. Not solely for the convenience of the Participant, the Participant's family, or the provider.

For Medically Necessary services, Cigna is not precluded from comparing the cost- effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

(2) a. Provider shall be duly licensed by the appropriate state licensing board in North Carolina and shall be bound by and comply with the provisions of applicable local, state and federal laws and regulations. Provider shall maintain all necessary professional credentials sufficient to meet Cigna's credential verification, including but not limited to appropriate licenses, certifications, accreditations and other similar approvals required by applicable local, state, and federal laws and regulations. If applicable, Provider shall

comply with Cigna's Standards for Delegation of Credentialing, as amended from time to time. Cigna's credentialing requirements may be found in the Administrative Guidelines. Provider shall notify Cigna promptly of any subsequent changes in the status of any information relating to the provider's professional credentials. Provider shall comply with Cigna's utilization management programs, credential verification programs, quality management programs, and, if applicable, provider sanction programs with the provision that none of these shall override the professional or ethical responsibility of Provider or interfere with Provider's ability to provide information or assistance to their patients.

b. Cigna shall establish a system of Participant identification and eligibility, based on current information held by the plan, prior to Provider rendering services to Participants, communicate Administrative Guidelines to Participating Providers and identify Participating Providers to Payors and Participants. With regard to Participant identification, Participants shall be required to present a Cigna identification card at the time of service. Such identification card does not guarantee eligibility. Prior to rendering services Provider should verify Participant eligibility by calling the phone number indicated on the identification card. Mutually agreeable provisions may be made for cases where incorrect or retroactive information was submitted by employer groups.

c. Cigna shall include the name of Provider in the provider directory distributed to its members.

d. Cigna shall provide data and information to Provider, such as:

(1) Performance feedback reports or information to Provider, if compensation is related to efficiency criteria.

(2) Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and, if applicable, provider sanction policies. Notification of changes in these requirements shall also be provided by Cigna allowing Provider time to comply with such changes.

e. Provider shall:

(1) Maintain confidentiality of Participant medical records and personal information as required by G.S. 58, Article 39 and other health records as required by law.

(2) Maintain adequate medical records and other health records according to industry and Cigna's standards.

(3) Make copies of such records available to Cigna and the North Carolina Department of Insurance in conjunction with its regulation of Cigna. Provider shall provide such records to the Department of Insurance at no charge.

(3) The provision in the Agreement that applies regarding coordination of benefits does not relate to subrogation.

(4) a. For pre-paid benefit plans, Provider shall not bill any network plan Participant for Covered Services, except for any applicable Copayments, Deductibles or Coinsurance. This provision shall not prohibit Provider and Participant from agreeing to continue non-covered services, at the Participant's own expense, as long as Provider has notified the Participant in advance that Cigna may not cover or continue to cover specific services and the Participant chooses to receive the service.

b. Provider shall be responsible for collecting any applicable Participant Copayments, Deductibles or Coinsurance, and fees for non-covered services shall be specified.

c. For any Covered Services, which are reimbursed on a fee-for-service basis, Provider shall bill for Covered Services according to the following:

Claims for all Covered Services shall be submitted on the appropriate claim form within 180 days after the date of service or 180 days after the Participant's discharge from the facility. Unless otherwise agreed to by Cigna and Provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the claimant to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the Participant, later than one year from the time submittal of the claim is otherwise required.

d. Payor may recover claim overpayments made to Provider by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments that were made pursuant to the requirements of North Carolina law. Not less than 30 calendar days before Payor seeks overpayment recovery or offsets future payments, Payor shall give written notice to Provider including adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery of overpayments or offsetting of future payments shall be made within the 2 years after the date of the original claim payment unless Payor has reasonable belief of fraud or other intentional misconduct by Provider, or Provider's agents, or the claim involves a payment for the same service from a government payor.

e. Chargemaster. Cigna shall provide such notice as required by applicable law, including but not limited to NCGS § 58-3-227, when making adjustments permitted by the Chargemaster provisions of the Agreement, or when conducting an audit permitted by the Chargemaster provisions of the Agreement.

f. Sale of Business/Change in Management. Cigna shall provide such notice as required by applicable law, including but not limited to NCGS § 58-3-227 and 58-3-225, in response to a notice or failure to provide a notice required under the Agreement, when exercising rights under the Agreement to retroactively adjust reimbursements or initiate an overpayment recovery process.

(5) Provider shall cooperate with Participant and Cigna in the implementation of Cigna's Participant appeal procedure and shall assist Participant and Cigna in taking appropriate corrective action.

(6) Throughout the term of the Agreement, Provider shall maintain at Provider's expense general and professional liability coverage in a form and amount acceptable to Cigna ($$1,000,000.00 per occurrence and $$3,000,000.00 in the aggregate). Provider shall give Cigna written notice of any subsequent changes in the status of such insurance on a timely basis.

(7) Nothing in the Agreement shall limit: (a) Cigna's authority or responsibility to ensure Provider's participation and compliance with Cigna's Quality Management, Utilization Management, member grievance or other Administrative Guidelines; (b) the North Carolina Department of Insurance's authority to monitor the effectiveness of Cigna's Administrative Guidelines; (c) Cigna's authority to sanction or terminate a Provider giving inadequate or poor quality care or failing to comply with Cigna's Administrative Guidelines; or (d) Cigna's obligation to comply with applicable law.

(8) Upon termination of the Agreement or upon Cigna's insolvency or cessation of operations, Provider shall continue to provide Covered Services to Participants for the duration of the period for which premium payment has been made. For Participants who are confined in an inpatient facility, Provider shall continue to provide Covered Services until the Participant is ready for discharge. Provider shall be compensated for Covered Services provided to any such Participant in accordance with the compensation arrangements under the Agreement. Participants shall not be liable to Provider for any amounts owed for Covered Services provided during the period of continued care other than Copayments, Deductibles, or Coinsurance billed in accordance with the terms of the applicable Benefit Plan, or for non-covered services delivered on a fee-for-service basis to Participants. Provider shall also comply with all Cigna's procedures in the transfer of Participants to other providers, including without limitation the transition of administrative duties and records.

This provision shall survive the termination of the Agreement, regardless of the cause giving rise to termination and shall be construed to be for the benefit of Participants. This provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and the Participant or persons acting on the Participant's behalf insofar as such contrary agreement relates to liability for payment for services provided under the terms and conditions of the Agreement.

(9) The entire Agreement includes the Addendum to Provider Agreement for the State of North Carolina, any amendments to the Agreement and any exhibits to the Agreement.

(10) Provider's duties and obligations under the Agreement shall not be assigned, delegated or transferred without the prior written consent of Cigna. Cigna, upon prior written notice to Provider, shall be entitled, but not obligated, to assign, delegate or transfer all or any part of its rights, benefits, duties, or obligations hereunder to any of its current or future subsidiaries or affiliates, or to any entity which succeeds its business through a sale, merger, or other similar transaction.

(11) Notice Contact. Any notice required under the Agreement must be in writing and sent by United States mail, postage prepaid, to Cigna and you using the name or title and the address provided pursuant to the Notices section of the Agreement. Cigna may also notify you by sending an electronic notice with automatic receipt verification to your e-mail address if mutually agreed upon and provided pursuant to the Notices section of the Agreement. Either of us can change the name, title or address for notices by giving written notice of the change to the other in the manner just described.

(12) Administrative Guidelines. In addition to the distribution of Administrative Guidelines as set forth in the Agreement, Cigna will provide its Administrative Guidelines in hard copy, CD or other electronic format, or by web posting, prior to the execution or amendment of the Agreement, and annually.

(13) Amendments. In addition to the negotiated terms of the Material Adverse Change Amendments provision as set forth in the Agreement, Cigna shall send any contract amendment to the Notice Contact identified in the Agreement proposing to change any term of this Agreement which modifies a fee schedule, including terms incorporated by reference. No such contract amendment shall be conveyed by use of an electronic medium of communication. An amendment under this section shall be dated, labeled "Amendment," signed by Cigna, and shall include an effective date. Provider shall have at least 60 days from the date of receipt to object to the proposed amendment. The amendment shall be effective upon Provider failing to object in writing within 60 days. Should Provider object, the amendment will not be effective, and Cigna shall be entitled to terminate the Agreement upon 60 days written notice.

ADDENDUM TO ANCILLARY AGREEMENT FOR THE STATE OF NEW HAMPSHIRE

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of New Hampshire regarding provider contracts with providers rendering health care services in the State of New Hampshire. To the extent that such New Hampshire laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) Payor may not impose any retrospective denial of a previously paid claim or any part of that previously paid claim unless:

A. Payor has provided the reason for the retrospective denial in writing to Provider; and

B. The time that has elapsed since the date of payment of the previously paid claim does not exceed 18 months. The retrospective denial of a previously paid claim may be permitted beyond 18 months from the date of payment only for the following reasons:

(1) The claim was submitted fraudulently;

(2) The claim payment was incorrect because Provider or Participant was already paid for the health care services identified in the claim;

(3) The health care services identified in the claim were not delivered by Provider;

(4) The claim payment was for services covered by Title XVIII, Title XIX or Title XXI of the Social Security Act;

(5) The claim payment is the subject of adjustment with another insurer, administrator or payor; or

(6) The claim payment is the subject of legal action.

For purposes of this provision, “retrospective denial of a previously paid claim” means any attempt by Payor to retroactively collect payments already made to Provider with respect to a claim by requiring repayment of such payments, reducing other payments currently owed to Provider, withholding or setting off against future payments or reducing or affecting the future claim payments to Provider in any other manner.

Cigna shall notify Provider at least 15 days in advance of the imposition of any retroactive denials of previously paid claims. Provider has 6 months from the date of notification under this provision to determine whether Participant has other appropriate insurance that was in effect on the date of service. Notwithstanding the terms of the Agreement, Cigna shall allow for the submission of a claim that was previously denied by another insurer because of Participant's transfer or termination of coverage.

(2) Provider agrees that in no event, including but not limited to nonpayment by Payor, Payor's insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Participants or persons other than Payor for Covered Services.

(3) Cigna shall not terminate or refuse to renew the Agreement, discriminate against or penalize Provider for participating in Participant's internal grievance procedure or external review.

(4) Provider is allowed a 60 day period from the postmarked date to review any proposed Agreement and any amendment to an existing Agreement, excluding those modifications that are expressly permitted under the existing Agreement. Failure to object in writing within the 60 day period shall be deemed to constitute acceptance of the proposed Agreement or amendment to the Agreement. However, if the terms, benefits and conditions of the Agreement must be changed to comply with applicable state or federal law or regulation, Provider shall continue to perform services under the Agreement as so modified.

(5) Upon termination of the Agreement, Provider, at the option of Participant, shall continue to provide Covered Services for specific conditions for which a Participant was under Provider's care at the time of such termination so long as Participant retains eligibility under a Benefit Plan, until the earlier of completion of such services, or the expiration of 60 days. Provider shall be compensated for Covered Services provided to any such Participant in accordance with the compensation arrangements under the Agreement until 60 days following termination. Provider has no obligation under the Agreement to provide services to individuals who cease to be Participants.

(6) Nothing in the Agreement shall be construed to require or obligate a provider who is employed by a hospital or any affiliate to refer patients to providers also employed or under contract with the hospital or any affiliate.

ADDENDUM TO ANCILLARY SERVICES AGREEMENT
FOR THE STATE OF NEW JERSEY

The provisions set forth in this Addendum are being added to the Agreement to comply with 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 such New Jersey laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) The definitions for Emergency Services, Medically Necessary or Medical Necessity, Generally Accepted Standards of Medical Practice, and Utilization Management, if any, shall comply with New Jersey laws and regulations to the extent applicable.

(2) a. Cigna shall review and resolve issues raised by Provider relating to the provision of Covered Services to Participants.

b. Detailed information on Cigna's Administrative Guidelines on the following topics is found in Cigna's Hospital and Ancillary Facility Reference Guide:

Credentialing/Recredentialing
Service Standards
Provider Data Changes
Quality Management
Utilization Management
Member Rights and Responsibilities

c. If applicable, Provider shall follow clear procedures for granting admitting and attending privileges to physicians and shall notify Cigna when such procedures are no longer appropriate.

(3) a. In the event Provider does not submit a claim within the number of days specified in the Agreement, Payor, in accordance with N.J.A.C. 11:22-1.6 shall reserve the right to deny payment or dispute the claim and Provider shall be prohibited from seeking payment in whole or in part directly from Participant. Where Provider is submitting a claim under an assignment of benefits from a Participant, Provider shall, in accordance with N.J.S.A. § 45:1-10.1 and N.J.A.C. 11:22-3.6, file the claim within 180 days of the last course of treatment.

b. Any fee-for-service amounts owing under the Agreement shall be paid within 30 calendar days following receipt of a claim or no later than the time established for the payment of claims in the Medicare program pursuant to 42 U.S.C. s.1395u(c) (2) (B), whichever is earlier, if the claim is submitted by electronic means, and no later than 40 calendar days following receipt if the claim is submitted by other than electronic means, if:

(i) Provider is eligible at the date of service;

(ii) the person who received the health care service was covered on the date of service;

(iii) the claim is for a service or supply covered under the Benefit Plan;

(iv) the claim is submitted with all the information requested by the Payor on the claim form or in other instructions that were distributed in advance to Provider or Participant in accordance with the provisions of section 4 of P.L. 2005, c.352 (C.17B:30-51); and

(v) Payor has no reason to believe that the claim has been submitted fraudulently.

If all or a portion of the claim is not paid within the time frame provided in the paragraph above because:

(i) the claim submission is incomplete because the required substantiating documentation has not been submitted to Payor;

(ii) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;

(iii) Payor disputes the amount claimed; or

(iv) there is strong evidence of fraud and Payor has initiated an investigation into the suspected fraud,

Payor shall notify Provider, by electronic means and the Participant in writing within 30 days of receiving an electronic claim, or notify the Participant and Provider in writing within 40 days of receiving a claim submitted by other than electronic means that:

(i) the claim is incomplete with a statement as to what substantiating documentation is required for adjudication of the claim;

(ii) the claim contains incorrect information with a statement as to what information must be corrected for adjudication of the claim;

(iii) the Payor disputes the amount claimed in whole or in part with a statement as to the basis of that dispute; or

(iv) the Payor finds there is strong evidence of fraud and has initiated an investigation into the suspected fraud in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or referred the claim, together with supporting

documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

If all or a portion of an electronically submitted claim cannot be adjudicated because the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing, Payor shall electronically notify Provider or Provider's agent within 7 days of that determination and request any information required to complete adjudication of the claim.

Any portion of a claim that meets the criteria established in the first paragraph of this subsection b. shall be paid in accordance with the time limit established in the first paragraph of this subsection b.

Payor shall acknowledge receipt of a claim submitted by electronic means from Provider, no later than 2 working days following receipt of the transmission of the claim.

If payment is withheld on all or a portion of a claim pursuant to the reasons stated above, the claim payment shall be overdue if not remitted to Provider or Provider's agent on or before 30 calendar days or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and 40 calendar days for claims submitted by other than electronic means, following receipt by the Payor of the required documentation or information or modification of an initial submission.

If payment is withheld on all or a portion of a claim pursuant to the reasons stated above and Provider is not notified within the time frames provided, the claim shall be deemed to be overdue.

An overdue payment shall bear simple interest at the rate of 12% per annum. The interest shall be paid to Provider at the time the overdue payment is made.

c. With the exception of claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, Payor shall not seek reimbursement for overpayment of a claim previously paid pursuant to this section later than 18 months after the date the first payment on the claim was made. Payor shall not seek more than one reimbursement for overpayment of a particular claim. At the time the reimbursement request is submitted to Provider, Payor shall provide written documentation that identifies the error made by Payor in processing or payment of the claim that justifies the reimbursement request. No Payor shall base a reimbursement request for a

particular claim on extrapolation of other claims, except under the following circumstances:

(a) in judicial or quasi-judicial proceedings, including arbitration;

(b) in administrative proceedings;

(c) in which relevant records required to be maintained by Provider have been improperly altered or reconstructed, or a material number of relevant records are otherwise unavailable; or

(d) in which there is clear evidence of fraud by Provider and Payor has investigated the claim in accordance with its fraud prevention plan, and referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor.

d. Cigna will not retroactively deny reimbursement for a Covered Service provided to a Participant on grounds which contradict the written or oral authorization of Cigna or its agents to Provider reasonably relied upon by Provider prior to providing the service to the Participant, except in cases where there was material misrepresentation or fraud. Payor will be liable only for those specific services which are provided to a Participant and which were authorized and no additional services rendered without specific authorization.

e. Provider shall not seek reimbursement from Payor or Participant for underpayment of a claim submitted pursuant to this section later than 18 months from the date the first payment on the claim was made, except if the claim is the subject of an appeal submitted pursuant to section 1. of the Dispute Resolution section of the Agreement set forth in item (10) below, or the claim is subject to continual claims submission. Provider shall not seek more than one reimbursement for underpayment of a particular claim.

f. Claims will be paid in accordance with the requirements of N.J.S.A. 26:2J-8.1, N.J.S.A. 17B:26-9.1, N.J.S.A. 17B:27-44.2, and N.J.A.C. 11:4-28.7, as may be amended from time to time.

g. Cigna shall give written notice to Provider of any amount Provider inappropriately collected from Participant and Provider shall have 30 days from the date of receipt of the written notice to appeal such determination.

h. If Provider fails to reimburse Participant for any amount Provider inappropriately collected from Participant, Cigna may elect to withhold

compensation amounts from future compensation payments otherwise due to Provider. Cigna shall provide Provider with written notice and full disclosure of the funds withheld prior to such deduction.

i. To resolve disputes relating to the payment of provider claims see the Dispute Resolution section of the Agreement set forth in item (10) below.

(4) Provider and Cigna shall cooperate to facilitate timely and appropriate information and record exchanges necessary for Quality Management, Utilization Management, peer review or other programs required for Cigna's operation or in connection with the provision of health care services to Participants.

(5) In no event shall Cigna retaliate against Participants or Provider because of complaints or appeals on behalf of a Participant.

(6) Provider shall maintain professional liability coverage in an amount sufficient for Provider's anticipated risk but no less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year.

(7) a. Provider shall not be penalized or the Agreement terminated by Cigna because Provider acts as an advocate for the Participant in seeking appropriate, medically necessary health care services.

b. Provider shall not be penalized or the Agreement terminated by Cigna because Provider appeals a coverage determination or files a complaint against Cigna.

(8) Any provision of the Agreement which conflicts with state or Federal law(s) or regulation(s) is hereby amended to conform to the requirements of such law(s) or regulation(s).

(8.1) In addition to the obligations set forth in the Agreement governing amendments to the Agreement:

a. Any adverse change or amendment during the term of the Agreement shall be made in accordance with the terms of the Agreement only upon 90- days' notice prior to the effective date of the change or amendment or as otherwise specified by N.J.A.C. § 11:24C-4.3(d) as may be amended from time to time. If Provider declines to accept the amendment, Provider may terminate by providing notice in advance of the effective date.

b. If applicable, no adverse change may be made to the terms of the Agreement upon its automatic renewal. Any such change shall be made to the

Agreement as set forth above either before or after renewal. Notwithstanding any timeframe set forth in the Agreement governing amendments to the Agreement, no adverse change may be made to the Agreement without sufficient advance notice to permit Provider to terminate the Agreement in advance of the effective date of the change.

c. Adverse change or amendment shall mean any action taken by Cigna that could reasonably be expected to have a material adverse impact on either the aggregate level of payment to a health care provider or the administrative expenses incurred by the provider in complying with the change, or as otherwise defined by N.J.A.C. § 11:24C-4.2 as may be amended from time to time. Such changes attributable to a Third Party, including a health care provider, over which Cigna has no control, and such changes as identified in applicable state laws or regulations, are not adverse changes.

(9) Regardless of which party terminates the Agreement, or the reasons for the termination, Provider and Cigna shall abide by the terms of the Agreement, including reimbursement terms, for 4 months following the date of the termination. Provider has no obligation to provide, and Cigna has no obligation to reimburse at the contracted rate, services which are not Medically Necessary to be provided on and after the 31st day following the date of termination.

(10) Dispute Resolution

1. (a) To resolve disputes relating to the payment of provider claims under Health Benefit Plans as defined in N.J.S.A. 17B:30-50 but not including appeals to resolve disputes pertaining to medical necessity which are eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L. 1997, c. 192 (C.26:2S- 11):

In the event that Provider has a dispute with respect to a claim, the dispute shall be submitted for review and resolution to the Cigna designee identified by Cigna in Cigna's explanation of payment, or by calling 1.800.Cigna24. Provider must submit a written request for a review of a claim dispute within 90 calendar days of the date of the initial explanation of payment on an appeal form prescribed by the Commissioner of Banking and Insurance which shall describe the type of substantiating documentation that must be submitted with the form. The appeal form is available at: http://www.state.nj.us/dobi/chap352/352genapplication.doc

The internal review shall be conducted at no cost to Provider and Provider shall be notified of the determination on or before the 30th calendar day following receipt of the appeal form.

The written decision shall include:

(i) The names, titles and qualifying credentials of the persons participating in the internal review;

(ii) A statement of Provider's grievance;

(iii) The decision of the reviewers along with a detailed explanation of the contractual and/or medical basis for such decision;

(iv) A description of the evidence or documentation which supports the decision; and

(v) If the decision is adverse, notice of the right to have the decision submitted to arbitration as provided below.

If the appeal is resolved in favor of Provider, Payor must pay the amount owed, plus interest at 12% per year, on or before the 30th calendar day following Provider's notification of the determination on the appeal. If Provider is not notified of the determination of the appeal within 30 days, Provider may refer the dispute to arbitration as provided in this section 1.

(b) Any dispute regarding the determination of an internal appeal conducted pursuant to subsection (a) above may be referred to arbitration as provided in this section 1. The Commissioner of Banking and Insurance has contracted with MAXIMUS, Inc. to conduct the arbitration proceedings. Information is available at: http://www.state.nj.us/dobi/chap352/352implementnotice.html Any party may initiate an arbitration proceeding on or before the 90th calendar day following the receipt of the determination which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and Insurance. No dispute shall be accepted for arbitration unless the payment amount in dispute is $1,000 or more, except that Provider may aggregate disputed claim amounts for the purposes of meeting such threshold requirement. No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L. 1997, c. 192 (C.26:2S-11) shall be the subject of arbitration pursuant to this section 1.

(c) The arbitrator shall conduct the arbitration proceedings pursuant to the rules of the arbitration entity, including rules of discovery subject to confidentiality requirements established by State or federal law.

(d) An arbitrator's determination shall be:

(i) signed by the arbitrator;

(ii) issued in writing, in a form prescribed by the Commissioner of Banking and Insurance, including a statement of the issues in dispute and the findings and conclusions on which the determination is based; and

(iii) issued on or before the 30th calendar day following the receipt of the required documentation.

The arbitration shall be nonappealable and binding on all the parties to the dispute.

(e) If the arbitrator determines that Payor has withheld or denied payment in violation of the provisions of this section, the arbitrator shall order Payor to make payment of the claim, together with accrued interest, on or before the 10th business day following the issuance of the determination. If the arbitrator determines that Payor has withheld or denied payment on the basis of information submitted by Provider and Payor requested, but did not receive, this information from Provider when the claim was initially processed by Payor or reviewed under internal appeal pursuant to subsection (a) above, Payor shall not be required to pay any accrued interest.

(f) If the arbitrator determines that Provider has engaged in a pattern and practice of improper billing and a refund is due to Payor, the arbitrator may award a refund, including interest accrued at the rate of 12% per year. Interest shall begin to accrue on the day the appeal was received for resolution through the internal appeals process established pursuant to subsection (a) above.

(g) The arbitrator shall file a copy of each determination with and in the form prescribed by the Commissioner of Banking and Insurance.

2. To resolve disputes with respect to a termination and for claim disputes with respect to ASO Participants, but not including appeals to resolve disputes pertaining to medical necessity which are eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L. 1997, c. 192 (C.26:2S-11):

In the event that Provider has a dispute with respect to a claim or a termination, the dispute shall be submitted for review and resolution to the Cigna designee identified by Cigna in Cigna's explanation of payment or termination letter, as applicable (the "First Level Review"). Provider must submit a request for a First Level Review of a payment dispute within 180 days of the date of the initial explanation of payment and a request for a First Level

Review of a termination dispute within 30 days of the date of the termination letter. If Provider is not satisfied with the resolution at the First Level Review, Provider may submit the matter for a second level review to the Cigna designee identified in the First Level Review decision letter (the "Second Level Review"). Provider must submit a request for a Second Level Review within 60 days of the date of the letter communicating the First Level Review decision. The Second Level Review decision will be binding on Cigna and Provider if the resolution is accepted by Provider.

If the Second Level Review is adverse Provider may have the decision submitted to arbitration pursuant to the arbitration process set forth in the Agreement and the Administrative Guidelines. Provider must submit a request for arbitration within 12 months of the date of the letter communicating the Second Level Review decision.

3. Disputes regarding a claim or a termination that are not resolved through the process described in section 2. above and any other dispute between the parties regarding the performance or interpretation of the provider agreement may be resolved by arbitration between the parties pursuant to the arbitration process set forth in the Agreement and the Administrative Guidelines. Either party may initiate arbitration by providing written notice to the other party. If Provider initiates arbitration, Provider must submit a request for arbitration to:

Cigna HealthCare
National Appeals Unit
P.O. Box 37963
Charlotte, NC 28237

4. In addition to the above, for disputes concerning the application of Cigna's coding and payment rules and methodologies to patient specific factual situations, Provider should consult Cigna's website for details regarding a billing dispute resolution process that may be applicable and that Provider may be entitled to elect in lieu of arbitration.

(12) The Agreement may permit Cigna to enter into agreements with third parties (PPOs, ODSs, and any such other entities to which Cigna may lease its networks) that allow third parties to obtain Cigna's contracting entity rights and responsibilities under the Agreement as if the Third Party is the contracting entity. To the extent that the terms of the Agreement allow a Third Party access the Agreement, the rights of the Third Party to access discounted rates shall cease upon termination of the Agreement.

B. With respect to Covered Services rendered to Participants covered under an HMO Benefit Plan:

(1) Provider shall hold Participant harmless for the cost of Covered Services, whether or not Provider believes its compensation for such Covered Service from Payor is made in accordance with the reimbursement provisions of the Agreement, or is otherwise inadequate.

(2) In the event of Cigna's insolvency, Covered Services to Participants who are confined in an inpatient facility on the date of the declaration of insolvency shall continue until the Participant's discharge from the facility or the expiration of the Participant's benefits, whichever occurs first.

ADDENDUM TO PROVIDER AGREEMENT
FOR THE STATE OF NEW MEXICO

The provisions set forth in this Addendum are being added to the Agreement with the provider named in the Agreement (hereafter referred as the "Provider") to comply with legislative and regulatory requirements of the State of New Mexico regarding provider contracts with providers rendering health care services in the State of New Mexico. To the extent that such New Mexico laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of the Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) In addition to the requirements set forth in the Agreement, Provider agrees that in no event, including but not limited to non-payment by Cigna or Payor, insolvency of Cigna or Payor, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a Participant or covered person, or person acting on behalf of the covered person, for health care services provided pursuant to the Agreement. This does not prohibit Provider from collecting co-insurance, deductibles, or copayments as specifically provided in the benefit plan, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the Cigna or Payor or their successors. The requirements of this provision shall survive the termination of the Agreement regardless of the reason for the termination, including the insolvency of Cigna or Payor.

(2) In addition to the obligations and requirements set forth in the Agreement, Provider will comply with the Administrative Guidelines including, but not limited to, policies and programs contained therein with respect to payment systems, utilization review, quality assessment and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs.

(3) In addition to the obligations and requirements set forth in the Agreement, and in accordance with applicable state laws and regulations, Provider will notify Cigna not more than ten (10) days after the Provider's receipt of notice of any reduction or cancellation of professional liability and malpractice insurance.

(4) Provider shall, in accordance with applicable state laws and regulations, observe, protect, and promote the rights of Covered Persons as patients.

(5) In addition to the obligations and requirements set forth in the Agreement, if any, and in accordance with applicable state laws and regulations, Cigna shall provide interpreters for limited English proficient individuals and interpretive services for patients who qualify under the Americans with Disabilities Act; such interpretive services will be made available to Provider's office at no cost to Provider.

(6) Terms used in the Agreement that are defined by state statutes and division regulations will be used in the Agreement in a manner consistent with any state definitions.

(7) In addition to the obligations and requirements set forth in the Agreement, and in accordance with applicable state laws and regulations, should Payor fail to pay Provider for Covered Services within forty-five days after receipt of a clean claim, as defined by applicable laws and regulations, Payor shall be liable for the amount due and unpaid with interest on that amount at the rate established annually by the superintendent.

(8) "Clean Claim" means a manually or electronically submitted claim that contains all the required data elements necessary for accurate adjudication without the need for additional information from outside of Cigna or Payor's system and contains no deficiency or impropriety, including lack of substantiating documentation currently required by Cigna or Payor, or particular circumstances requiring special treatment that prevents timely payment from being made by Cigna or Payor.

(9) In addition to the obligations and requirements set forth in the Agreement, and in accordance with applicable state laws and regulations, Payor shall make any retroactive adjustments for overpayment within 18 months absent Provider miscoding, claim submission error, suspected fraud and abuse, or retroactive adjustments required by federal or state agencies.

(10) In addition to the obligations and requirements set forth in the Agreement, and in accordance with applicable state laws and regulations, if the Agreement is terminated without cause, Provider shall continue to provide Covered Services for a Participant to continue an ongoing course of treatment for a transitional period as set forth in the Administrative Guidelines; the transition period for a Participant who is in the third trimester of pregnancy at the time of termination shall include the provision of postpartum care directly related to the delivery. Authorization for continuing care shall be subject to Provider's agreement to accept reimbursement at the rates applicable prior to the commencement of continued care as payment in full, adherence to Cigna's policies and procedures and quality assurance program, and agreement to provide medically necessary information related to continued care.

ADDENDUM TO ANCILLARY SERVICES AGREEMENT FOR THE STATE OF NEVADA

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Nevada regarding provider contracts with providers rendering health care services in the State of Nevada. To the extent that such Nevada laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. This Addendum shall supersede any previous state mandate amendments to the Agreement.

1. Definitions. Unless otherwise defined in the Agreement, the following terms shall have the meaning set forth below.

(1.1) Material Change or Material Adverse Change shall mean a change that could reasonably be expected to have a material adverse impact on the aggregate level of payment by Cigna or Payor to Provider for Covered Services under this Agreement, or on Provider's administration of their services.

(1.2) Timely Notice shall mean the timeframe or timeframes established by the parties for prior written notice of an amendment to the agreement as set forth in the Material Adverse Change Amendments, or any other provisions of the Agreement governing changes or amendments to the Agreement.

2. In addition to the obligations set forth in the Material Adverse Change Amendments and All Other Amendments provisions of the Agreement, and to the extent permitted or required by applicable state law:

Cigna may amend this Agreement by providing 45 days' prior written notice to Provider of the modification or amendment of the schedule of payments, including any changes to the fee schedule applicable to Provider's practice. Failure of Provider to object in writing to any such proposed amendment within 45 days following receipt of notice shall constitute Provider's acceptance thereof. Timely written notification of rejection of such proposed amendment to Cigna means that this Agreement shall remain in force without the proposed amendment.

Except as provided above, Amendments to this Agreement shall be agreed to in writing by Cigna and Provider.

3. The Services Upon Termination provision of the Agreement is hereby deleted and replaced with the following:

Except in cases where termination of this Agreement was due to medical incompetence or professional misconduct, Practitioner shall, if the Practitioner and Participant agree, continue to provide Covered Services for specific conditions for which a Participant was under Practitioner's care at the time of such termination until the later of:

a) the 120th day after the date the contract is terminated; or

b) if the medical condition is pregnancy, the 45th day after:

1) the date of delivery; or

2) if the pregnancy does not end in delivery, the date of the end of the pregnancy.

During the continuation period under this section: (1) the parties shall be bound by the terms and conditions of the Agreement; (2) Provider shall be compensated for Covered Services provided to any such Participant in accordance with the compensation arrangements under the Agreement; and (3) Provider is prohibited from billing Participants for any amounts in excess of the Participant's applicable Coinsurance, Copayments or Deductibles. Provider has no obligation under the Agreement to continue to provide services to individuals who cease to be Participants.

3.1 In the event of Cigna's insolvency or the insolvency of any applicable intermediary, or in the event of any other cessation of Cigna's operations or the operations of any applicable intermediary, Provider must continue to deliver health care services covered by the network plan, as defined by applicable state law, to a Participant without billing Participant for any amount other than coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, until the earlier of: the date of the cancellation of Participant's coverage under the network plan pursuant to applicable state law, including, without limitation, any extension of coverage provided pursuant to the terms of the contract between Participant and Cigna, and applicable state continued medical treatment (continuity of care) laws, or any applicable federal law for Participants who are in an active course of treatment or totally disabled; or the date on which the contract between the Cigna and Provider would have terminated if the health carrier or intermediary, as applicable, had remained in operation, including, without limitation, any extension of coverage provided pursuant to the terms of the contract between the Participant and Cigna, and applicable state laws, or any applicable federal law for Participants who are in an active course of treatment or totally disabled.

4. The How this Agreement Can Be Terminated provision of the Agreement is amended as follows:

Either of us can terminate this Agreement at any time by providing at least 90 days advance written notice.

4.1. The How this Agreement Can Be Terminated provision of the Agreement is amended by adding the following:

Cigna shall not terminate this Agreement, refuse to contract with, or refuse to compensate you because you in good faith advocate in private or in public on behalf of a Participant, assist a Participant in seeking reconsideration of a decision to deny coverage for a health care service, or report a violation of law to an appropriate authority.

5. Disclosure of Fee Schedules.

Cigna shall provide the schedule of payments, including any changes to the fee schedule applicable to Provider's practice, if requested at the time the Agreement is executed and at any other time within 7 days upon receipt of Provider's request.

6. The following provisions shall, to the extent required by applicable law, replace and supersede the Section of the Agreement entitled Limitations on Billing Participants:

Limitations on Billing Participants. Provider agrees that in no event, including but not limited to nonpayment by Payor, Payor's insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Participants or persons other than the applicable Payor for Covered Services or for any amounts denied or not paid under this Agreement due to Provider's failure to comply with the requirements of Cigna's or its designee's Utilization Management Program or other Administrative Guidelines, or failure to file a timely claim or appeal. This provision does not prohibit collection of any applicable Copayments, Coinsurance and Deductibles, as specifically provided in the evidence of coverage. This provision survives termination of this Agreement, is intended to be for the benefit of Participants, and supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Participant or persons acting on the Participant's behalf. Modifications to this section will become effective no earlier than the date permitted by applicable law.

This provision does not prohibit collection of fees for uncovered services delivered on a fee-for-service basis to Participants.

This provision does not prohibit Provider and a Participant from agreeing to continue health care services solely at the expense of the Participant, as long as Provider has clearly informed the Participant that Cigna may not cover or continue to cover a specific health care service or health care services. Except as provided herein, this Agreement does not prohibit Provider from pursuing any available legal remedy.

7. Provisions included in this Agreement to comply with the requirements set forth in Sections 3.1 and 6 shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for the termination, including, without limitation, the insolvency of the health carrier or any applicable intermediary, and shall supersede any oral or written contrary agreement between a participating provider of health care and a covered person or the representative of a covered person if the contrary agreement is inconsistent with provisions included in the contract to comply with the requirements set forth in applicable state law.

8. Cigna will provide written notice to Provider as soon as practicable in the event that a court determines Cigna or any applicable intermediary to be insolvent, or of any other cessation of operations of Cigna or any applicable intermediary.

9. In addition to the requirements of the Agreement governing Participant health records, 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, and to comply with the applicable state and federal laws related to the confidentiality of medical and health records and Participant's right to see, obtain copies of or amend their medical and health records.

10. Neither Cigna nor Provider may assign or delegate the rights and responsibilities of either party under the contract without the prior written consent of the other party.

11. In addition to the requirements of the Agreement governing standards of care, Provider is responsible for furnishing Covered Services to all Participants without regard to the participation of the Participant in a network plan (as defined by applicable law) as a private purchaser of the network plan or as a participant in a publicly financed program of health care services.

12. In addition to the requirements of the Agreement governing Services Upon Termination, for services rendered subsequent to Provider's termination of the Agreement to a Participant who had obtained prior authorization for such services prior to the termination of the Agreement, coverage for Covered Services provided to any such Participant will be at the rate negotiated before Provider terminated the Agreement and at no additional cost to the Participant, in accordance with the terms of the Participant's Benefit Plan.

13. Cigna shall, in a timely manner, upon request from Provider or upon any change to the status or inclusion of Provider, inform Provider of the status as a provider of health care in a network plan and the status and inclusion of Provider on any list maintained by Cigna.

[ADDENDUM #2 TO ANCILLARY SERVICES AGREEMENT
FOR THE STATE OF NEVADA

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Nevada regarding arbitration provisions, including but not limited to Nev. Rev. Stat. Ann. § 597.995 (Chapter 166 of the Laws of 2013).

Provider acknowledges by the signature below that Provider has affirmatively agreed to the arbitration provisions set forth in the Agreement.

AGREED AND ACCEPTED BY:

Connecticut General Life Insurance Company:	Provider:
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date Signed: _____	Date Signed: _____]

ADDENDUM TO PROVIDER AGREEMENT FOR THE STATE OF NEW YORK

The provisions set forth in this Addendum are being added to the Agreement with the provider named in the Agreement (hereafter referred as the "Provider") 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 such New York laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of the Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) To the extent permitted by Insurance Law § 3217-b, 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.

(2) To the extent required by Insurance Law § 3224-a, the parties agree to the following. Provider shall initially submit a claim within 120 days after the date of service unless a longer time period is permitted under the Agreement and applicable law. Cigna or Payor shall permit Provider to request reconsideration of a claim that is denied exclusively because it was submitted untimely if Provider can demonstrate that non- compliance was a result of an unusual occurrence and that Provider has a pattern or practice of submitting claims in compliance with timely submission requirements. Cigna or Payor may reduce the reimbursement due for an untimely claim by an amount not to exceed twenty five percent of the amount that would have been paid had the claim been submitted in a timely manner. Cigna or Payor may deny the claim in full for a claim submitted 365 days after the date of service.

(3) To enable compliance with legislative and regulatory requirements of the State of New York regarding insurer provider network disclosures to insureds set forth by Insurance Law § 3217-a(a)(17) as may be amended from time to time, a physician will, in addition to the provider directory requirements found in the Administrative Guidelines, provide to Cigna board certifications, languages spoken and any affiliations with participating hospitals, in writing or as specified in the Administrative Guidelines. Physician will also notify Cigna in writing or as specified in the Administrative Guidelines in advance of any change in any affiliations with participating hospitals.

ADDENDUM TO ANCILLARY AGREEMENT
FOR THE STATE OF OHIO

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Ohio regarding provider contracts with providers rendering health care services in the State of Ohio. To the extent that such Ohio laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) Provider shall be duly licensed in the State of Ohio.

(2) Upon request, Cigna or its designee shall notify Provider of Covered Services, including any limitations or conditions thereon, in writing and/or telephonically.

(3) (a) Pursuant to Section 3963.03 (A)(1)(a)(ii) of the Ohio Revised Code, information pertinent to the fee schedule of procedure codes reasonably expected to be billed by Provider for services provided and the associated payment or compensation for each procedure code is available at www.Cignaforhcp.com.

(b) Pursuant to Section 3963.03 (A)(1)(a)(iii) of the Ohio Revised Code, information pertinent to the effect, if any, on payment or compensation if more than one procedure code applies to the service is available at www.Cignaforhcp.com.

(c) Pursuant to Section 3963.03 (A)(2) of the Ohio Revised Code, the identity of the contracting entity or payer responsible for the processing of Provider's compensation or payment is available at www.Cignaforhcp.com.

(4) The Agreement may permit network rental arrangements which allow the selling, renting, or giving the contracting entity's rights to the services of the Participating Provider, to a Third Party (including other preferred provider organizations), and the Third Party accessing the Participating Provider's services is any of the following:

(a) A payer or a Third-Party administrator or other entity responsible for administering claims on behalf of the payer;

(b) A preferred provider organization or preferred provider network that receives access to the Participating Provider's services pursuant to an arrangement with the preferred provider organization or preferred provider network in a contract with the Participating Provider that is in compliance with

Section 3963.02 (A)(1)(c) of the Ohio Revised Code, and is required to comply with all of the terms, conditions, and affirmative obligations to which the originally contracted primary participating provider network is bound under its contract with the Participating Provider, including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement; or

(c) An entity that is engaged in the business of providing electronic claims transport between the contracting entity and the payer or third-party administrator and complies with all of the applicable terms, conditions, and affirmative obligations of the contracting entity's contract with the Participating Provider including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement.

(5) Cigna or its designee may recover overpayments if the recovery process is initiated not later than 2 years after the payment was made to Provider. Cigna or its designee shall inform Provider of its determination of overpayment by providing notice in accordance with Section 3901.388(C) of the Ohio Revised Code. Cigna or its designee shall give Provider an opportunity to appeal the determination. If Provider fails to respond to the notice sooner than 30 days after the notice is made, elects not to appeal the determination, or appeals the determination but the appeal is not upheld, Cigna or its designee may initiate recovery of the overpayment. Such recovery may include deducting the amount of the overpayment from other payments owed to Provider or by taking action pursuant to any other remedy available under the Ohio Revised Code. Cigna shall permit Provider to repay the amount by making one or more direct payments to Cigna or its designee or by having the amount deducted from other payments owed to Provider.

(6) Provider shall give Cigna 10 days prior written notice of cancellation, reduction or termination of general and professional liability insurance.

(7) (a) Cigna shall provide Provider with at least 90 days written notice of the effective date of a Material Amendment to the Agreement.

"Material Amendment" means an amendment to an Agreement that: a) decreases the provider's payment or compensation; b) changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expense; or c) adds a new category of coverage.

A Material Amendment **does not include**: (a) a decrease in payment or compensation resulting solely from a change in a published fee schedule upon which the payment or compensation is based and the date of applicability is clearly identified in the Agreement; (b) a decrease in payment or compensation that was anticipated under the terms of the Agreement, if the amount and date

of applicability of the decrease is clearly identified in the Agreement; (c) an administrative change that may significantly increase the provider's administrative expense, the specific applicability of which is clearly identified in the Agreement; (d) changes to an existing prior authorization, precertification, notification, or referral program that do not substantially increase the provider's administrative expense; (e) changes to an edit program or to specific edits, if the provider is provided notice of the changes pursuant to division (A) (1) of Section 3963.04 of the Ohio Revised Code and the notice includes information sufficient for the provider to determine the effect of the change; or (f) changes to the Agreement described in division (B) of Section 3963.04 of the Ohio Revised Code.

If Provider objects in writing to the Material Amendment within 15 days of receipt and there is no resolution of the objection, Cigna or Provider may terminate the Agreement upon written notice to the other party but no later than 60 days prior to the effective date of the Material Amendment.

If Provider does not object to the Material Amendment within 15 days of receipt, the change shall be effective as specified in the notice.

(b) If an amendment to the Agreement is not a Material Amendment, Cigna shall provide Provider notice of the amendment at least 15 days prior to the effective date of the amendment.

(c) Subsections (a) and (b) above shall not apply if the delay caused by compliance with the requirements could result in imminent harm to a Participant, if the Material Amendment to the Agreement is required by state or federal law, rule, or regulation, or if Provider affirmatively accepts the Material Amendment in writing and agrees to an earlier effective date than otherwise required for such Material Amendment.

In addition, subsections (a) and (b) above shall not apply under any of the following circumstances:

(i) Provider's payment or compensation is based on the current Medicaid or Medicare provider fee schedule, and the change in payment or compensation results solely from a change in that provider fee schedule.

(ii) A routine change or update of the Agreement is made in response to any addition, deletion, or revision of any service code, procedure code, or reporting code, or a pricing change is made by any Third Party source.

"Service code, procedure code, or reporting code" means the current procedural terminology (CPT), current dental terminology (CDT), the

healthcare common procedure coding system (HCPCS), the international classification of diseases (ICD), or the drug topics Redbook average wholesale price (AWP).

“Third Party source” means the American Medical Association, American Dental Association, the Centers for Medicare and Medicaid Services, the National Center for Health Statistics, the Department of Health and Human Services Office of the Inspector General, the Ohio Department of Insurance, or the Ohio Department of Job and Family Services.

(d) Notwithstanding anything in this section, Cigna may modify the Agreement by operation of law as required by any applicable state or federal law, rule, or regulation.

(8) In the event of termination of the Agreement and to the extent applicable, the provisions of Section 3963.02 (E) of the Ohio Revised Code shall apply.

(9) Notwithstanding anything to the contrary set forth in the Agreement, Section 1753.09 of the Ohio Revised Code applies to the termination of a Participating Provider’s Agreement for any of the causes described in divisions (A), (D), and (F) (1) and (2) of Section 1753.09 of the Revised Code.

(10) Notices required under this Agreement shall be in writing and shall be deemed to have been duly given a) on the date of service if served personally on the party to whom notice is to be given; b) on the date of delivery if sent via overnight courier to the party to whom notice is to be given and properly addressed as specified in the Agreement; c) with respect to notifications of termination of this Agreement, on the third day after deposit in the United States mail, if mailed via certified mail, postage prepaid, and properly addressed as specified in the Agreement; d) with respect to notifications other than notifications of termination, on the third day after deposit in the United States mail, if mailed postage prepaid and properly addressed as specified in the Agreement; or e) with respect to notifications by Cigna other than notifications of termination, on the date Cigna sends an electronic notice to Provider with an automatic receipt verification to Provider’s e-mail address as specified in the Agreement.

(11)(a) When the arbitration issues are limited to issues that only concern the enforcement of the contract rights conferred by Section 3963.02, divisions (A) and (D) of Section 3963.03, and Section 3963.04 of the Ohio Revised Code, the arbitrator may award reasonable attorney’s fees and costs for arbitration relating to the enforcement of this section to the prevailing party.

(b) A party shall not simultaneously maintain an arbitration proceeding as described in division (F)(1) of Section 3963.02 of the Ohio Revised Code and

pursue a complaint with the Superintendent of Insurance to investigate the subject matter of the arbitration proceeding. However, if a complaint is filed with the Department of Insurance, the Superintendent of Insurance may choose to investigate the complaint or, after reviewing the complaint, advise the complainant to proceed with arbitration to resolve the complaint. The Superintendent of Insurance may request to receive a copy of the results of the arbitration. If the Superintendent of Insurance notifies an insurer or a health insuring corporation in writing that the superintendent has initiated a market conduct examination into the specific subject matter of the arbitration proceeding pending against that insurer or health insuring corporation, the arbitration proceeding shall be stayed at the request of the insurer or health insuring corporation pending the outcome of the market conduct investigation by the superintendent.

(B) With respect to Covered Services rendered to Participants covered under a Benefit Plan insured by a Health Insuring Corporation (as that term is defined under Ohio law), the following provisions shall apply:

(1) The definition for **Emergency Services**, if any, shall comply with Ohio laws and regulations to the extent applicable.

(2) In the event of Cigna's insolvency or discontinuance of operations: (1) Provider shall continue to provide Covered Services to Participants as needed to complete any Medically Necessary procedures commenced but unfinished at the time of such insolvency or discontinuance of operations (the completion of Medically Necessary procedures shall include the rendering of all Covered Services that constitute Medically Necessary follow-up care for that procedure); and (2) if a Participant is receiving necessary inpatient care at a hospital, Provider shall continue to provide such care until the earlier of the following: (a) the day the Participant is discharged from the hospital, (b) the day the Participant's attending physician determines that such inpatient care is no longer medically indicated, (c) the day the Participant has reached the benefit limit under the applicable Benefit Plan, (d) the effective date of Participant's new coverage; or (d) 30 days after such insolvency or discontinuance of operations.

Provider is not required to continue to provide Covered Services after the occurrence of any of the following: (a) the end of the 30 day period following the entry of a liquidation order under Chapter 3903 of the Ohio Revised Code; (b) the end of the Participant's period of coverage for a contractual prepayment or premium; (c) the Participant obtains equivalent coverage with another Health Insuring Corporation or insurer, or the Participant's employer obtains such coverage for the Participant; (d) the Participant or the Participant's employer terminates coverage under the Benefit Plan; or (e) a liquidator effects a transfer of the Health Insuring Corporation's obligations under the contract under division (A) (8) of Section 3903.21 of the Ohio Revised Code.

(3) Cigna and Provider shall observe, protect and promote the rights of Participants.

(4) Those terms used in the Agreement that are defined in Ohio Revised Code Chapter 1751 (Health Insuring Corporations) are used in the Agreement in a manner consistent with those definitions.

ADDENDUM TO ANCILLARY AGREEMENT FOR THE STATE OF OKLAHOMA

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Oklahoma regarding provider contracts with providers rendering health care services in the State of Oklahoma. To the extent that such Oklahoma laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) Payor may only retroactively deny reimbursement to Provider during the 24 month period after the date Payor paid the claim. However, this provision shall not apply: (a) if the payment was made because of fraud by provider; or (b) if Provider has otherwise agreed to make a refund to Cigna for overpayment of a claim.

(2) A. Pursuant to Oklahoma law, if Provider voluntarily chooses to terminate the Agreement, Provider shall give Cigna 90 days prior written notice of the disaffiliation.

B. In the event Cigna terminates the Agreement for reasons other than for cause, Provider shall continue to provide Covered Services under the terms of the Agreement for 90 days from the date of notice to Participant, for a Participant who is under Provider's care at the time of such termination and who has a degenerative and disabling condition or disease, or is terminally ill. With respect to a Participant who is under Provider's care at the time of such termination and who has entered the third trimester of pregnancy, additional coverage of services shall continue through at least 6 weeks of postpartum evaluation. Provider shall be compensated for continued services in accordance with the compensation arrangements under the Agreement for the 90 day period from the date of notice to Participant. Provider has no obligation under the Agreement to provide services to individuals who cease to be Participants.

C. In the event Provider voluntarily terminates the Agreement, Provider shall continue to provide Covered Services under the terms of the Agreement for a Participant who is under Provider's care at the time of such termination for 90 days from the date of Provider's notice of termination to Cigna; or for a period that includes delivery and postpartum care, if the Participant has entered the third trimester of pregnancy at the time of Provider's disaffiliation. Provider shall be compensated for continued services in accordance with the compensation arrangements under the Agreement for the 90 day period from the date of Provider's notice to Cigna. Provider has no obligation under the Agreement to provide services to individuals who cease to be Participants.

ADDENDUM TO PROVIDER AGREEMENT FOR THE STATE OF OREGON

The provisions set forth in this Addendum are being added to the Agreement with the provider named in the Agreement (hereafter referred as "Provider") to comply with legislative and regulatory requirements of the State of Oregon regarding provider contracts with providers rendering health care services in the State of Oregon. To the extent that such Oregon laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of the Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

I

1. Provider shall mean "Provider" or "Group and/or Represented Provider," as named in the Agreement, or as otherwise set forth in the Agreement.

II

(1) Cigna, upon request by Provider, shall give Provider an annual accounting accurately summarizing the financial transactions between the parties for that year.

(2) Provider may withdraw from the care of a Participant when, in the professional judgment of Provider, it is in the best interest of the Participant to do so.

(3) Except in the case of misrepresentation, precertification determinations shall be subject to the following requirements:

(1) Precertification determinations relating to benefit coverage and medical necessity shall be binding on Cigna if obtained no more than 30 days prior to the date the service is provided.

(2) Precertification determinations relating to Participant eligibility shall be binding on Cigna if obtained no more than five business days prior to the date the service is provided.

(4) Upon request by Provider, the criteria used in the Utilization Management review process and the method of development of the criteria shall be made available for review.

(5) Cigna shall employ or retain a physician licensed under ORS 677.100 to 677.228 who shall be responsible for all final medical and mental health decisions relating to coverage or payment made pursuant to the Agreement.

(6) Provider will be paid for Covered Services rendered to Participants in accordance with ORS Sec. 743B.450 and ORS Sec. 743B.452.

(7) In the event Cigna fails to pay for health care services covered by the Benefit Plan, Provider shall not bill or otherwise attempt to collect from Participants amounts owed by Cigna, and Participants shall not be liable to Provider for any sums owed by Cigna.

(8) Cigna may not terminate or otherwise financially penalize Provider for:

(1) Providing information to or communicating with a Participant in a manner that is not slanderous, defamatory or intentionally inaccurate concerning:

(a) Any aspect of the Participant's medical condition;

(b) Any proposed treatment or treatment alternatives, whether covered by the Participant's Benefit Plan or not; or

(c) Provider's general financial arrangement with Cigna.

(2) (a) Referring a Participant to another provider, whether or not that provider is under contract with Cigna. If Provider refers Participant to another provider, Provider shall:

(i) Comply with Cigna's written policies and procedures with respect to any such referrals; and

(ii) Inform the Participant that the referral services may not be covered by Cigna.

(b) Allocation of costs for referral services shall be a matter of contract between Provider and Cigna. Allocation of costs to Provider by contract shall not be considered a penalty under this section.

(9) Cigna and Provider shall provide continuity of care to Participants as provided in ORS Sec. 743B.225.

(10) Except in cases of fraud or abuse of billing, Payor may not request a refund from Provider of a payment previously made to satisfy a claim unless Payor does so in writing, specifying the reasons for the request, within 18 months after the date the payment was made. If Payor requests a refund for reasons related to coordination of benefits with another health insurer or entity responsible for payment of a claim, the request for refund must be made in writing, specifying the reasons for the request, within 30 months after the date the payment was made. If Provider fails to contest the request for a refund in writing to Cigna or Payor within thirty (30) days of receipt, the request for refund shall be deemed accepted and the refund must be paid.

(11) Except in cases of fraud, Provider may not request additional payment from Payor to satisfy a claim unless Provider does so in writing, specifying the reasons for the request, within 18 months after the date the claim was denied or the payment intended to satisfy the claim was made. If Provider requests additional payment from Payor to satisfy a claim for reasons related to coordination of benefits with another health insurer or entity responsible for payment of a claim, the request for additional payment must be made in writing, specifying the reasons for the request, within 30 months after the date the claim was denied or payment intended to satisfy the claim was made.

(12) The Agreement may permit network arrangements which grant access to Cigna's rights as a contracting entity, as defined in applicable state laws and regulations, to Provider's health care services and discounted rates to a Third Party, as defined in applicable state laws and regulations, provided that the Third Party accessing Provider's health care services and discounted rates is contractually obligated to comply with all applicable terms, limitations and conditions of the Agreement.

(13) Notwithstanding any provision to the contrary set forth in the Compensation section of the Agreement, or any similar provision in the Agreement, or a rate exhibit, the rates in the Agreement will be payment in full for all Covered Services furnished to Participants under the Agreement by a Provider who is a vision care provider as defined by applicable state laws and regulations.

ADDENDUM TO ANCILLARY AGREEMENT FOR THE STATE OF PENNSYLVANIA

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Pennsylvania regarding provider contracts with providers rendering health care services in the State of Pennsylvania. To the extent that such Pennsylvania laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) Cigna's Administrative Guidelines applicable to the Agreement are found in the provider reference manual entitled "Hospital and Ancillary Facility Reference Guide."

(2) The following definition of Emergency Services is applicable to the Agreement:

Emergency Services means any health care service provided to a Participant after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one or more of the following:

(a) placing the health of the Participant, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(b) serious impairment to bodily functions; or

(c) serious dysfunction of any bodily organ or part.

(3) Cigna acknowledges and agrees that practitioners or other individuals conducting Utilization Management are not compensated for approvals or denials of Covered Services.

(4) The Limitations on Billing Participants provision survives termination of this Agreement, regardless of the reason for termination, is intended to be for the benefit of Participants, and supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Participant or persons acting on the Participant's behalf. Provider hereby agrees that in no event, including, but not limited to non-payment by Payor, Payor's insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Participants or persons acting on the Participant's behalf (other than Payor) for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable Copayments, Deductibles or Coinsurance billed in accordance with the terms of a Benefit Plan or fees for non-Covered Services.

(5) Termination of the Agreement With Notice: Neither party to the Agreement is permitted to terminate the Agreement with notice upon less than 60 days' prior written notice to the other party. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement with notice, such longer notification period will apply.

(6) Notwithstanding anything to the contrary set forth in the Agreement:

(A) Cigna shall not penalize or restrict a health care provider from discussing:

(1) the process that Cigna or any entity contracting with Cigna uses or proposes to use to deny payment for a health care service;

(2) Medically Necessary and appropriate care with or on behalf of a Participant, including information regarding the nature of treatment; risks of treatment; alternative treatments; or the availability of alternate therapies, consultation or tests; or

(3) Cigna's decision to deny payment for a health care service.

(B) A provision to prohibit or restrict disclosure of Medically Necessary and appropriate health care information contained in a contract with a health care provider is contrary to public policy and shall be void and unenforceable.

(C) Cigna shall not terminate a contract with a health care provider for any of the following:

(1) advocating for Medically Necessary and appropriate health care consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care;

(2) filing a grievance pursuant to the procedures set forth in Pennsylvania law; or

(3) protesting a decision, policy or practice that the health care provider, consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care, reasonably believes interferes with the health care provider's ability to provide Medically Necessary and appropriate health care.

(D) Nothing in this provision shall:

(1) prohibit Cigna from making a determination not to pay for a particular medical treatment, supply or service, enforcing reasonable peer review or utilization review protocols or making a determination that a health care provider has or has not complied with appropriate protocols;

(2) be construed as requiring Cigna to provide, reimburse for or cover counseling, referral, or other health care services if Cigna: (i) objects to the provision of that service on moral or religious grounds; and (ii) makes available information on its policies regarding such health care services to Participants and prospective Participants.

(E) Nothing in this provision shall be construed to permit Cigna to sanction, terminate or fail to renew a health care provider's participation for any of the following reasons:

(1) advocating for Medically Necessary and appropriate health care services for a Participant;

(2) filing a grievance on behalf of and with the written consent of a Participant, or helping a Participant to file a grievance;

(3) protesting a Cigna decision, policy or practice the health care provider believes interferes with its ability to provide Medically Necessary and appropriate health care;

(4) the health care provider has a practice that includes a substantial number of patients with expensive medical conditions;

(5) the health care provider objects to the provision of or refuses to provide a health care service on moral or religious grounds; or

(6) taking another action specifically permitted by sections 2113, 2121, and 2171 of the act (40 P.S. sections 991.2113, 991.2121 and 991.2171).

(7) Except in the event of Cigna's termination of the Agreement for cause, including breach of the Agreement, fraud, criminal activity or posing a danger to Participants or the health, safety or welfare of the public as determined by Cigna, if Cigna initiates termination of the Agreement with Provider, a Participant may continue an ongoing course of treatment with Provider, at the Participant's option, for a transition period of up to 60 days from the date the Participant was notified by Cigna of the termination or pending termination. Cigna in consultation with Participant and Provider, may extend the transitional period if determined to be clinically appropriate. In the case of a Participant in the second or third trimester of pregnancy at the time of notice of the termination or pending termination, the transitional period shall extend through postpartum care related to the delivery. Any health care service provided under this provision shall be covered by Cigna under the same terms and conditions applicable prior to the termination of the Agreement. Nothing in this provision shall require Cigna to cover health care services that are not otherwise covered under the terms and conditions of the Benefit Plan.

(8) Cigna has 3 types of internal resolution processes to resolve the various disputes which may arise between Cigna and Provider. The Termination Dispute Resolution Process, the Act 68 Dispute Resolution Process, and the Informal Dispute Resolution Process are described in the provider reference manual entitled "Hospital and Ancillary Facility Reference Guide." The Hospital and Ancillary Facility Reference Guide contains Cigna's Administrative Guidelines applicable to the Agreement.

(9) For amendments other than those required by changes to state or federal laws or regulations, Cigna shall provide Provider with 30 days advance written notice of the amendment.

ADDENDUM TO ANCILLARY AGREEMENT FOR THE STATE OF RHODE ISLAND

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Rhode Island regarding provider contracts with providers rendering health care services in the State of Rhode Island. To the extent that such Rhode Island laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) The definition for **Emergency Services**, if any, shall comply with Rhode Island laws and regulations to the extent applicable.

(2) **Urgent Care** shall have the same meaning as the term "Urgent Health Care Services" contained in the rules and regulations promulgated pursuant to Chapter 12.3 of Title 42, as may be amended from time to time, and shall include those resources necessary to treat a symptomatic medical, mental health or substance abuse or other health care condition requiring treatment within a 24 hour period of the onset of such a condition in order that the patient's health status not decline as a consequence. This does not include those conditions considered to require **Emergency Services**.

(3) The following item is added to the list of for cause reasons for which CIGNA may terminate the Agreement:

Lack of need by CIGNA due to economic considerations.

(4) In the event of termination of the Agreement by either party, the written notice of termination must include the reason(s) for such termination.

(5) Right to a Hearing. If CIGNA proposes to terminate the Agreement, CIGNA will notify Provider of this decision in writing including the reason(s) for the proposed termination and a notice of Provider's right to request a hearing or review. The proposed termination will not be effective until the appeal process has been completed. The above rights regarding notice and hearing may be waived, in writing, by Provider. CIGNA shall not require Provider to waive notice and hearing rights as a condition of the Agreement.

Immediate Harm to Participant's Health or Safety. When CIGNA has reason to suspect there is immediate danger to Participants as a result of conduct by Provider, CIGNA shall notify the Director of Health of the State of Rhode Island Department of Health immediately and shall take appropriate action to protect Participants.

Notice to Participants. In the event the Agreement is terminated by Provider, Provider shall give reasonable advance notice of such termination to those Participants whom Provider is currently treating and who are affected by the termination.

(6) If Provider is terminated for reasons other than medical competence or professional conduct, Provider will continue to provide Covered Services for those Participants suffering from a chronic condition requiring continuity of care for whom an alternative means of receiving necessary care was not arranged at the time of such termination. Provider will continue to provide Covered Services to such Participants so long as the Participant retains eligibility under a Service Agreement, until the earlier of completion of such services or the assumption of treatment by another provider. Provider will be paid for Covered Services provided to any such Participant after termination of this Agreement in accordance with the reasonable and customary charge for such services. If, after termination of this Agreement, Provider determines that we have not used due diligence to arrange for alternative care, Provider may terminate the Provider-patient relationship. Provider has no obligation under this Agreement to provide services to individuals who cease to be Participants.

ADDENDUM TO AGREEMENT FOR THE STATE OF SOUTH CAROLINA

The provisions set forth in this Addendum are being added to the Agreement with the provider named in the Agreement (hereafter referred to as the "Provider") to comply with legislative and regulatory requirements of the State of South Carolina regarding provider contracts with providers rendering health care services in the State of South Carolina. To the extent that such South Carolina laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

1. With respect to claim payments made on or after June 11, 2009:

Cigna may not initiate overpayment recovery efforts more than 18 months after the initial claim payment was received by Provider; however, this time limit does not apply to the initiation of overpayment recovery efforts:

(1) based upon a reasonable belief of fraud or other intentional misconduct;

(2) required by a self-insured plan; or

(3) required by a state or federal government program.

2. In addition to the requirements of the Agreement and to the extent required by S.C. Code § 38-71-243, upon termination of the Agreement and upon written attestation by the treating physician, on a form prescribed by the South Carolina Department of Insurance, that a health condition or illness exists that requires medical attention where failure to provide the current course of treatment through Provider would place a Participant's health in serious jeopardy, Provider shall, if requested by a Participant, continue to provide Covered Services for ninety days or until the termination of the benefit period, whichever is greater. Provider shall accept the negotiated rate under the Agreement as payment in full for such services rendered. Except for applicable deductible, copayment or coinsurance, Provider shall not bill or otherwise hold a Participant financially responsible for Covered Services rendered by Provider in the continuation of care, unless Provider has not received payment pursuant to the Agreement and in accordance with applicable law.

ADDENDUM TO ANCILLARY AGREEMENT
FOR THE STATE OF TENNESSEE

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Tennessee regarding provider contracts with providers rendering health care services in the State of Tennessee. To the extent that such Tennessee laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

1. The definition for Emergency Services, if any, shall comply with Tennessee laws and regulations to the extent applicable.

2. (a) Within 30 calendar days after Payor's receipt of Provider's claim, if submitted by the Provider in paper form, Payor shall: (i) if the claim is a clean claim as defined below, pay for any fee-for-service amounts owing under the Agreement for such health care services provided; (ii) pay the portion of the claim that is clean and not in dispute and notify Provider in writing of the reason or reasons why the remaining portion of the claim will not be paid; or (iii) notify Provider in writing of all reasons why the claim is not a clean claim and will not be paid and what substantiating documentation and information is required to adjudicate the claim as a clean claim.

(b) Within 21 calendar days after Payor's receipt of an electronic submission of Provider's claim Payor shall: (i) if the claim is a clean claim as defined below, pay for any fee-for-service amounts owing under the Agreement for such health care services provided; (ii) pay the portion of the claim that is clean and not in dispute and notify Provider in writing of the reason or reasons why the remaining portion of the claim will not be paid; or (iii) notify Provider in writing of all reasons why the claim is not a clean claim and will not be paid and what substantiating documentation and information is required to adjudicate the claim as a clean claim.

(c) If Payor fails to comply with the applicable requirements of subsection (a) or (b) above, Payor shall pay 1% interest per month, accruing from the day after the day payment was due, on that amount of the claim that remains unpaid.

(d) As used herein clean claim means a claim received by Payor which requires no further information, adjustment or alteration by the provider of

services in order to be processed and paid by Payor. A claim is clean if it has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstances requiring special treatment that prevents timely payment from being made on Provider's claim. A clean claim does not include a duplicate claim. A duplicate claim means an original claim and its duplicate when the duplicate is filed within 30 days of the original claim. A clean claim does not include any claim submitted more than 90 days after the date of service. The definition of clean claim includes resubmitted paper form claims with previously identified deficiencies corrected.

(e) Provider shall file a claim for reimbursement for a health care service within 120 days of the date of service. Cigna or Payor may deny the claim in full for a claim submitted more than 120 days after the date of service.

3. Pursuant to the requirements of Tennessee Code Annotated Section 56-7-110:

(a) Payor shall not be required to correct a payment error to Provider, if Provider's request for a payment correction is filed more than 18 months after the date that Provider received payment for the claim from Payor.

(b) Except in cases of fraud committed by Provider, Payor may only recoup reimbursements to Provider during the 18 month period after the date that Payor paid the claim submitted by Provider.

(c) If Payor recoups reimbursement to Provider under this section, Payor shall give Provider a written or electronic statement specifying the basis for the recoupment and the statement shall contain, at a minimum, the information required by subsection (f) below.

(d) If Payor determines that payment was made for services not covered under Participant's Benefit Plan, Payor shall give written notice to Provider of its intent to recoup a previously paid claim and may:

(1) Request a refund from Provider; or

(2) Make a recoupment of the payment from Provider in accordance with subsection (f).

The notice required by this subsection may be included in the results of an audit submitted to Provider.

(e) Notwithstanding subsection (b) above, if Payor or an agent contracted to provide eligibility verification, verifies that an individual is a Participant and if Provider provides health care services to the individual in reliance on such

verification, Payor may not thereafter recoup a claim on the basis that the individual is not a Participant unless such recoupment occurs within 6 months of the date that Payor paid the claim; otherwise Payor is barred from making such recoupment unless there was fraud by Provider.

(f) If Payor chooses to recoup from Provider amounts previously paid pursuant to subsections (b) or (d), Payor shall provide Provider written documentation that specifies:

(1) The amount of the recoupment;

(2) The person's name to whom the recoupment applies;

(3) Patient identification number;

(4) Date of service;

(5) The health care service or services on which the recoupment is based; and

(6) The pending claims being recouped or that future claims will be recouped.

(g) Payor shall provide at least 30 days' notice prior to initiating recovery of any payments pursuant to this section.

4. If Provider terminates the Agreement, or Cigna terminates the Agreement without cause, then Provider and Cigna shall allow Participants who are:

(a) Under active treatment for a particular injury or sickness, to continue to receive Covered Services from Provider for such injury or sickness for a period of 120 days from the date of notice of termination,

(b) In the second trimester of pregnancy to continue care with Provider until completion of postpartum care,

(c) Being treated at an inpatient facility to remain at the facility until Participant is discharged.

The terms, conditions and compensation arrangement of the Agreement shall apply during the period of continued care.

5. Any change to the fee schedule of the Agreement shall be made available to Provider at least 30 days prior to the effective date of the amendment. However, this requirement shall not apply to changes in standard codes and guidelines developed by the American Medical Association or a similar organization.

6. The Agreement may permit network rental arrangements which allow the selling, renting, or otherwise grant access to Cigna's rights to Provider's services to a Third Party provided that the Third Party accessing Provider's services is contractually obligated to comply with all applicable terms, limitations and conditions of the Agreement, and the Third Party is any of the following:

(a) A payer, a third-party administrator, or another entity that administers or processes claims on behalf of the payer;

(b) A preferred provider organization or preferred provider network, including a physician organization or physician hospital organization; or

(c) An entity engaged in the electronic claims transport between the Cigna and the payer that does not provide access to the provider's services and a discount to any other covered entity.

ADDENDUM TO ANCILLARY AGREEMENT
FOR THE STATE OF TEXAS

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Texas regarding provider contracts with providers rendering health care services in the State of Texas. To the extent that such Texas laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) The definition for Emergency Services shall comply with Texas laws and regulations to the extent applicable.

(2) To the extent applicable, Cigna will comply with all applicable Texas statutes and rules pertaining to prompt payment of Clean Claims with respect to payment to Provider for Covered Services under the Agreement.

(3) Cigna's claims submission processes are set forth in Cigna's Provider reference manual, as amended from time to time. To the extent required by § 843.337 or § 1301.102 of the Insurance Code, Provider must submit a claim to Cigna not later than the 95th day after the date Provider provides the medical care or health care services for which the claim is made.

(4) To the extent applicable, Cigna will not refuse to process or pay an electronically submitted Clean Claim because the claim is submitted with or in a batch submission with a Clean Claim that is deficient. A "batch submission" is a group of electronic claims submitted for processing at the same time within HIPAA standard ASC X12N 837 Transaction Set and identified by a batch control number.

(5) Upon request and to the extent required by Texas law, Cigna will provide Provider with the information necessary to determine that Provider is being compensated in accordance with the Agreement.

(6) If Provider is compensated on a discounted fee basis, the Participant's financial obligation for Deductibles or Coinsurance shall be determined based upon the discounted fee and not upon the full billed charge.

(7) Provider acknowledges and agrees that the Agreement does not contain any financial incentive or make any payment that acts directly or indirectly as an inducement to

limit Medically Necessary services. This provision shall not prohibit the savings from cost effective utilization of health services by contracting physicians or health care Providers from being shared with physicians or health care Providers in the aggregate.

(8) Provider shall post a notice to Participants at the Provider's location on the process for resolving complaints with Cigna. The notice must include the Texas Department of Insurance's toll-free telephone number for filing complaints.

(9) Cigna shall not engage in any retaliatory action, including termination of or refusal to renew the Agreement, because Provider, on behalf of a Participant, reasonably filed a complaint against Cigna or has appealed a decision of Cigna.

(10) (A) Cigna will not as a condition of the Agreement or in any other manner prohibit, attempt to prohibit or discourage Provider from discussing with or communicating in good faith to a Participant who is a current, prospective or former patient or a party designated by such Participant, with respect to: a) information or opinions regarding the Participant's health care including the Participant's medical condition or treatment options; b) information or opinions regarding the provisions, terms, requirements or services of the Participant's health benefit plan as they relate to the medical needs of the Participant; c) the fact that Provider's contract with Cigna has terminated or that Provider will otherwise no longer be providing care for Cigna Participants; or d) the fact that, if medically Necessary Covered Services are not available through Participating Providers, Cigna must, upon the request of Provider, and within time appropriate to the circumstances relating to the delivery of the services and the condition of the Participant, but in no event to exceed 5 business days after receipt of reasonably requested documentation, allow referral to a non-participating Provider.

(B) Cigna will not in any way penalize or terminate Provider or refuse to compensate Provider for Covered Services for communicating with a Participant who is a current, prospective or former patient, or a party designated by Participant, in any manner protected by this provision.

(11) (A) If Cigna terminates the Agreement, Cigna shall give Provider not less than 90 days' prior written notice of the termination, except in the case of imminent harm to patient health, action against license to practice, or fraud, in which case termination may be immediate. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Cigna, such longer notification period will apply.

(B) Notice and Hearing. If Cigna should choose to terminate the Agreement, Cigna will notify Provider of this decision in writing. The notice will include

the reason(s) for the termination and a notice of Provider's right to request a hearing or review. On request and before the effective date of the termination, but within a period not to exceed 60 days, Provider shall be entitled to a review of the proposed termination by an advisory review panel.

When Cigna chooses to terminate Provider's participation with respect to its commercial HMO plans, the advisory review panel shall be composed of physicians and Providers appointed by Cigna, including at least one representative in Provider's specialty or a similar specialty, if available, who serve on a standing Quality Management committee or Utilization Management committee.

The decision of the advisory review panel must be considered but is not binding on Cigna. On request, a copy of the recommendation of the advisory review panel and Cigna's determination shall be given to Provider. If Provider is unsatisfied with the determination, Provider may appeal the decision further pursuant to the Dispute Resolution procedures specified in the Agreement and Administrative Guidelines.

(C) The requirements regarding notice and hearing set forth in subsection (B) above do not apply in the case of imminent harm to patient health, action against license to practice, or fraud.

(D) (1) In the event the Agreement is terminated by Provider, Provider shall give reasonable advance notice of such termination to those Participants whom Provider is currently treating and who are affected by the termination. Cigna will provide assistance to Provider to the extent required by Texas law.

(2) In the event the Agreement is terminated by Cigna, Cigna will notify those Participants whom Provider is currently treating and are affected by the termination at least 30 days before the effective date of such termination; provided, however, that such Participants may be notified immediately if the Agreement is terminated for reasons related to imminent harm.

(E) (1) If Provider is terminated for reasons other than medical competence or professional conduct, Provider shall continue to provide Covered Services for those Participants who retain eligibility under a Benefit Plan and whom 1) Provider has identified to Cigna as having special circumstances (i.e. persons with a disability, acute condition, life-threatening illness, past the 24th week of pregnancy or a condition such that Provider reasonably believes that discontinuing care could cause harm to the Participant); and 2) Provider has requested to continue treatment. Provider shall be compensated for Covered Services provided pursuant to this provision in accordance with the compensation arrangements under the Agreement for a period of 9 months

for those Participants diagnosed with a terminal illness at the time of termination of the Agreement, through delivery, immediate post-partum care and the follow-up checkup within the first 6 weeks of delivery for participants past the 24th week of pregnancy at the time of termination, and for a period of 90 days following termination for all others.

(2) Provider shall not seek payment from the Participant with respect to services rendered pursuant to this provision of amounts for which the Participant would not be responsible if Provider were still a Participating Provider.

(12) Nothing in the Agreement shall be construed to require Provider to indemnify Cigna for any tort liability resulting from acts or omissions of Cigna.

(13) Provider shall hold Participants harmless for payment of the cost of Covered Services in the event Payor fails to pay Provider for such Covered Services.

(14) Nothing in this Agreement shall be construed to require a referring Provider to bear the expenses of a referral for specialty care in or out of Cigna's Provider panel. Savings from cost-effective utilization of health services may, however, be shared with physicians and health care Providers in the aggregate.

(15) To the extent that Cigna conducts, uses or relies upon economic profiling to terminate the Agreement, Cigna shall make available to Provider on request the economic profile of Provider, including the written criteria by which Provider's performance was measured. An economic profile will be adjusted to recognize the characteristics of Provider's practice that may account for variations from expected costs.

(16) Quality assessment (as that term is defined under Texas law) shall be conducted through a panel of not less than 3 physicians selected by Cigna from among a list of participating physicians which list is to be provided by participating physicians in the applicable service area.

(17) Provider may be required pursuant to procedures contained in the Administrative Guidelines, when referring a Participant to another provider, to disclose to Participant that the physician, provider or facility to whom Participant is referred might not be a participating provider; and, if applicable, that the Provider has an ownership interest in the facility to which Participant is referred. Such disclosure shall not be required when referring for emergency care, and as necessary to avoid interruption or delay of medically necessary care. Nothing in this section or in the Administrative Guidelines shall be construed to limit access to non-participating providers.

(18) Provider shall, except for instances of emergency care as defined under state law,

when referring a Participant to a facility for surgery: notify Participant that out-of- network providers may provide treatment and that Participant can contact Cigna for more information; notify Cigna that surgery has been recommended; and, notify Cigna of the facility that has been recommended for the surgery.

(19) Provider shall comply with all applicable requirements of Insurance Code § 1661.005. Provider must refund the amount of an overpayment to a Participant no later than the 30th day after the date Provider determines that an overpayment has been made.

(20) To the extent applicable, Provider may request, pursuant to procedures contained in the Administrative Guidelines, a waiver of any requirement for the use of information technology established or required by Chapter 1661 of the Texas Insurance Code as may be changed from time to time. A waiver granted under this section will expire September 1, 2013, or as otherwise permitted by applicable laws and regulations.

(21) To the extent applicable, Provider may request, pursuant to procedures contained in the Administrative Guidelines, a waiver of any requirement for electronic submission established or required by Chapter 1213 of the Texas Insurance Code as may be changed from time to time.

(22) To the extent applicable, nothing in this Agreement shall be construed to permit Cigna or Payor to directly or indirectly charge or hold Provider responsible for a fee for the adjudication of a claim.

(23) The Agreement permits Cigna to contract with another party to provide access to Cigna's rights and responsibilities under this Agreement. Upon request, Cigna will provide information necessary to determine whether a particular party has been authorized to access Provider's health care services and contractual discounts under this Agreement. Any party authorized to access the health care services and contractual discounts under this Agreement must comply with all applicable terms, limitations, and conditions of the Agreement.

(24) The fee schedule for each type of Benefit Plan is included in the exhibits to this Agreement. Notwithstanding the foregoing, Cigna may at its option provide the fee schedule for any Benefit Plan to Provider electronically.

(25) Upon the request of Provider, Cigna will provide Provider with such information as is necessary to allow Provider to determine that a Payor is authorized to access the reimbursement rates under this Agreement.

(26) Cigna shall cause each Payor that accesses Provider's discounts under this Agreement to comply with all applicable terms, limitations and conditions of this Agreement.

ADDENDUM TO ANCILLARY AGREEMENT
FOR THE STATE OF TEXAS

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Texas regarding provider contracts with providers rendering health care services in the State of Texas. To the extent that such Texas laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) The definition for Emergency Services, if any, shall comply with Texas laws and regulations to the extent applicable.

(2) To the extent required by applicable Texas statutes and rules pertaining to the prompt payment of Clean Claims, the following provisions shall apply:

(A) Effect of Filing a Clean Claim.

(1) The Statutory Claims Payment Period begins to run upon receipt by Cigna of a Clean Claim from Provider as determined under Texas law. The date of claim payment is as determined under Texas law.

(2) After the receipt of a Clean Claim from Provider at the address designated by Cigna and prior to the expiration of the applicable Statutory Claims Payment Period (subject to any extensions of time permitted under Texas law):

(a) Payor shall pay the total amount of the Clean Claim in accordance with the terms of the Agreement;

(b) The Clean Claim shall be denied in its entirety after a determination that Payor is not liable for the Clean Claim and Provider shall be notified in writing why the Clean Claim will not be paid;

(c) Provider shall be notified in writing that the entire Clean Claim will be audited and Payor shall pay 100% of the Contracted Rate on the claim to Provider; or

(d) Payor shall pay the portion of the Clean Claim for which liability is acknowledged in accordance with the terms of the Agreement, and;

(i) the remainder of the Clean Claim shall be denied after a

determination that Payor is not liable for the remainder of the Clean Claim and Provider shall be notified in writing why the remainder of the Clean Claim will not be paid; or

(ii) Provider shall be notified in writing that the remainder of the Clean Claim will be audited and Payor shall pay 100% of the Contracted Rate on the unpaid portion of the Clean Claim to Provider.

(3) Requests for Additional Information From Treating Provider. If necessary to determine whether a claim is payable, Cigna may, within 30 days of receipt of a Clean Claim, request additional information from the treating provider. The time period to request additional information may be extended as allowed under Texas law. In the event that Cigna requests information under this section, Cigna shall determine whether the Clean Claim is payable and Payor shall pay or Cigna will deny the Clean Claim or audit the Clean Claim on or before the later of:

(a) the 15th day after the date Cigna receives the requested information from the treating provider along with a copy of Cigna's written request for information or with the name of the patient, patient identification number, the claim number as provided by Cigna, the date of service and the name of the treating provider (If Cigna submitted the request for additional information electronically in accordance with federal requirements concerning electronic transactions, the treating provider must submit the response in accordance with those requirements); (b) the 15th day after the date Cigna receives a written response from the treating provider that the treating provider does not possess the requested information; or (c)the latest date for determining whether the claim is payable under subsections (1) and (2) above.

(4) Requests for Additional Information From Other Sources. If Cigna requests additional information from a person other than Provider, Cigna will provide Provider with a notice containing the name of the physician, provider or other entity from whom Cigna is requesting information. Payor may not withhold payment beyond the applicable Statutory Claims Payment Period pending receipt of information under this section. If on receiving information requested under this section Cigna determines that there was an error in payment of the claim, the overpayment may be recovered pursuant to section F. below.

(5) To the extent applicable, Cigna will not refuse to process or pay an electronically submitted Clean Claim because the claim is submitted with or in a batch submission with a Clean Claim that is deficient. A "batch submission" is a group of electronic claims submitted for processing at the same time within HIPAA standard ASC X12N 837 Transaction Set and identified by a batch control number.

(B) Effect of Filing a Deficient Claim.

If a submitted claim is determined by Cigna to be deficient, Provider shall be notified that the claim is deficient within 45 calendar days of Cigna's receipt of the claim at the address designated by Cigna or within30 days of receipt by Cigna of an electronic claim. If the deficient claim is a claim for a prescription benefit, Cigna will notify Provider that the claim is deficient within 21 calendar days of receipt of the nonelectronic claim by Cigna, or within 18 days of receipt of an electronic claim. The failure to notify Provider that a claim is deficient within the timelines specified in this section shall not render a deficient claim a Clean Claim.

(C) Audit Procedures.

If Payor is unable to pay or deny a Clean Claim, in whole or in part, within the applicable Statutory Claims Payment period and intends to audit the Clean Claim to determine whether it is payable, Cigna will notify Provider that the claim is being audited and Payor shall pay 100% of the Contracted Rate within the applicable Statutory Claims Payment Period. Payment of 100% of the Contracted Rate is not an admission that liability is acknowledged on that claim. Cigna will complete the audit within 180 calendar days from receipt of the Clean Claim. Upon completion of any audit of a Clean Claim, Cigna will notify Provider of the results of the audit and:

(1) If Cigna determines that additional payment is due to Provider, such additional payment shall be paid by Payor within 30 calendar days after the completion of the audit;

(2) If Cigna determines that a refund is due from Provider, such refund shall be made by Provider within 30 calendar days of the later of notification to Provider of the results of the audit or exhaustion of any Participant appeal rights, if a Participant appeal is filed before the 30 calendar day refund period has expired, and may be made by any method, including chargeback against Provider.

(D) Failure to Meet Statutory Claims Payment Period.

(1) If Cigna determines that a Clean Claim is payable and Payor fails to pay any amount due and owing on the Clean Claim within the statutory time frames, Payor shall pay to Provider, in addition to the Contracted Rate owed, a penalty as follows:

(a) if the claim is paid on or before the 45th day after the end of the applicable Statutory Claims Payment Period, the lesser of:

(i) 50% of the difference between the Billed Charge and the Contracted Rate: or

(ii) $100,000

(b) if the claim is paid on or after the 46th day and before the 91st day after the end of the applicable Statutory Claims Payment Period, the lesser of:

(i) 100% of the difference between the Billed Charge and the Contracted Rate: or

(ii) $200,000

(c) if the claim is paid on or after the 91st day after the end of the applicable Statutory Claims Payment Period, a penalty computed under subsection (1) (b) above plus 18% annual interest on the penalty amount. Interest under this subsection accrues beginning on the date the claim was required to be paid and ending on the date the claim and the penalty are paid in full.

(d) Notwithstanding any other provision of section (2), this subsection governs the payment of a penalty under section (2)(D). For a penalty relating to a clean claim submitted by a physician or other provider other than an institutional provider, Cigna shall pay the entire penalty to the physician or provider, except any interest computed under subsection (2)(D)(1)(c) above which Cigna shall pay to the Texas Department of Insurance or as otherwise required by applicable laws or regulations.

(2) If Cigna determines that a Clean Claim is payable and Payor pays only a portion of the amount of the Clean Claim on or before the applicable Statutory Claims Payment Period and pays the balance of the Contracted Rate owed for the Clean Claim after that date, Payor shall pay to Provider, in addition to the Contracted Rate owed, a penalty as follows:

(a) if the balance of the Clean Claim is paid on or before the 45th day after the applicable Statutory Claims Payment Period, the lesser of:

(i) 50% of the underpaid amount; or

(ii) $100,000

(b) if the balance of the Clean Claim is paid on or after the 46th day and before the 91st day after the end of the applicable Statutory Claims Payment Period, the lesser of:

(i) 100% of the underpaid amount; or

(ii) $200,000

(c) if the balance of the Clean Claim is paid on or after the 91st date after the end of the applicable Statutory Claims Payment Period, a penalty computed under subsection (2)(b) above plus 18% annual interest on the penalty amount. Interest under this subsection accrues beginning on the date the claim was required to be paid and ending on the date the claim and the penalty are paid in full.

(d) For purposes of this subsection 2, the underpaid amount is calculated on the ratio of the amount underpaid on the Contracted Rate as applied to an amount equal to the Billed Charge submitted minus the Contracted Rate.

(3) No penalty shall be owed:

(a) if the failure to pay the claim in accordance with the applicable Statutory Claims Payment Period is a result of a catastrophic event that Cigna certified in accordance with Texas law; or

(b) if the claim was paid in accordance with statutory time frames but for less than the Contracted Rate, and

(i) Provider notifies Cigna of the underpayment after the 270th day after the date the underpayment was received; and

(ii) Payor pays the balance of the claim on or before the 30th day after the date Cigna received notice of the underpayment.

(4) Subsection 3 above does not relieve Payor of any obligation to pay the remaining unpaid Contracted Rate owed.

(E) Claims Filing Deadline.

Provider must submit a claim to Cigna not later than the 95th day after the date Provider providing the medical care or health care services for which the claim is made. For a claim for which coordination of benefits applies, the 95 day period does not begin for submission of the claim to the secondary payor until Provider receives notice of the payment or denial from the primary payor. If Provider fails to submit a claim in compliance with this section, Provider forfeits the right to payment unless Provider has certified in accordance with Texas law that the failure to timely submit is a result of a catastrophic event. The date of receipt of a claim and whether the method of submission of a claim is appropriate shall be determined in accordance with Texas law. Provider may not submit a duplicate claim prior to the date that the applicable Statutory Claims Payment Period has passed. If Cigna receives a duplicate claim prior to such date, such claim shall not be subject to the requirements set forth above relating to the effect of filing a Clean Claim and failure to meet the Statutory Claims Payment Period.

(F) Overpayment of Claims.

(1) A refund due to overpayment or completion of audit may be recovered if:

(a) Cigna notifies Provider of the overpayment not later than the 180th day after the date of receipt of the overpayment; or

(b) Cigna notifies Provider of the completion of an audit in accordance with section (C) above.

(2) Notification under this provision shall:

(a) be in written form and include the specific claims and amounts for which a refund is due and for each claim the basis and specific reasons for the request for refund;

(b) include notice of the Provider's right to appeal; and

(c) describe the methods by which Cigna intends to recover the refund.

(3) Provider may appeal a request for refund by providing written notice of disagreement with the refund request not later than 45 days after receipt of notice under subsection (2) above. Upon receipt of a written notice under this subsection, Cigna shall begin Cigna's internal appeal process as provided in the Administrative Guidelines to the Agreement.

(4) A refund may not be recovered under this section until:

(a) for overpayments, the later of the 45th day after notification under subsection (1) (a) of this section or the exhaustion of any Provider appeal rights under subsection (3) of this section where Provider has not made arrangements for payment with Cigna; or

(b) for audits, the later of the 30th day after notification under subsection (1) (b) of this section or the exhaustion of any Provider appeal rights under subsection (3) of this section where the Provider has not made arrangements for payment with Cigna.

(5) If Payor is a secondary payor and pays a portion of a claim that should have been paid by the primary payor and that was paid to Provider by the primary payor, Payor may recover the amount of overpayment from Provider pursuant to this section (F).

(6) This section (F) does not affect Payor's ability to recover any overpayment in the case of fraud or a material misrepresentation by Provider.

(G) Terms.

The terms Clean Claim, Statutory Claims Payment Period, Billed Charge and Contracted Rate shall have the same meaning as defined under applicable Texas law.

(3) Cigna's claims submission processes are set forth in Cigna's provider reference manual, as amended from time to time.

(4) Upon request and to the extent required by Texas law, Cigna will provide Provider with the information necessary to determine that Provider is being compensated in accordance with the Agreement.

(5) If Provider is compensated on a discounted fee basis, the Participant's financial obligation for Deductibles or Coinsurance shall be determined based upon the discounted fee and not upon the full billed charge.

(6) Provider acknowledges and agrees that the Agreement does not contain any financial incentive or make any payment that acts directly or indirectly as an inducement to

limit Medically Necessary services. This provision shall not prohibit the savings from cost effective utilization of health services by contracting physicians or health care providers from being shared with physicians or health care providers in the aggregate.

(7) Provider shall post a notice to Participants at the Provider's location on the process for resolving complaints with Cigna. The notice must include the Texas Department of Insurance's toll-free telephone number for filing complaints.

(8) Cigna shall not engage in any retaliatory action, including termination of or refusal to renew the Agreement, because Provider, on behalf of a Participant, reasonably filed a complaint against Cigna or has appealed a decision of Cigna.

(9) (A) Cigna will not as a condition of the Agreement or in any other manner prohibit, attempt to prohibit or discourage Provider from discussing with or communicating in good faith to a Participant who is a current, prospective or former patient or a party designated by such Participant, with respect to: a) information or opinions regarding the Participant's health care including the Participant's medical condition or treatment options; b) information or opinions regarding the provisions, terms, requirements or services of the Participant's health benefit plan as they relate to the medical needs of the Participant; c) the fact that Provider's contract with Cigna has terminated or that Provider will otherwise no longer be providing care for Cigna Participants; or d) the fact that, if Medically Necessary Covered Services are not available through Participating Providers, Cigna must, upon the request of Provider, and within time appropriate to the circumstances relating to the delivery of the services and the condition of the Participant, but in no event to exceed 5 business days after receipt of reasonably requested documentation, allow referral to a non-participating Provider.

(B) Cigna will not in any way penalize or terminate Provider or refuse to compensate Provider for Covered Services for communicating with a Participant who is a current, prospective or former patient, or a party designated by Participant, in any manner protected by this provision.

(10)(A) If Cigna terminates the Agreement, Cigna shall give Provider not less than 90 days' prior written notice of the termination, except in the case of imminent harm to patient health, action against license to practice, or fraud, in which case termination may be immediate. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Cigna, such longer notification period will apply.

(B) Notice and Hearing. If Cigna should choose to terminate the Agreement, Cigna will notify Provider of this decision in writing. The notice will include the reason(s) for the termination and a notice of Provider's right to request a hearing or review. On

request and before the effective date of the termination, but within a period not to exceed 60 days, Provider shall be entitled to a review of the proposed termination by an advisory review panel.

When Cigna chooses to terminate Provider's participation with respect to its commercial HMO plans, the advisory review panel shall be composed of physicians and providers appointed by Cigna, including at least one representative in Provider's specialty or a similar specialty, if available, who serve on a standing Quality Management committee or Utilization Management committee.

The decision of the advisory review panel must be considered but is not binding on Cigna. On request, a copy of the recommendation of the advisory review panel and Cigna's determination shall be given to Provider. If Provider is unsatisfied with the determination, Provider may appeal the decision further pursuant to the Dispute Resolution procedures specified in the Agreement and Administrative Guidelines.

(C) The requirements regarding notice and hearing set forth in subsection (B) above do not apply in the case of imminent harm to patient health, action against license to practice, or fraud.

(D) (1) In the event the Agreement is terminated by Provider, Provider shall give reasonable advance notice of such termination to those Participants whom Provider is currently treating and who are affected by the termination. Cigna will provide assistance to Provider to the extent required by Texas law.

(2) In the event the Agreement is terminated by Cigna, Cigna will notify those Participants whom Provider is currently treating and are affected by the termination at least 30 days before the effective date of such termination; provided, however, that such Participants may be notified immediately if the Agreement is terminated for reasons related to imminent harm.

(E) (1) If Provider is terminated for reasons other than medical competence or professional conduct, Provider shall continue to provide Covered Services for those Participants who retain eligibility under a Benefit Plan and whom 1) Provider has identified to Cigna as having special circumstances (i.e. persons with a disability, acute condition, life-threatening illness, past the 24th week of pregnancy or a condition such that Provider reasonably believes that discontinuing care could cause harm to the Participant); and 2) Provider has requested to continue treatment. Provider shall be compensated for Covered Services provided pursuant to this provision in accordance with the compensation arrangements under the Agreement for a period of 9 months for those Participants diagnosed with a terminal illness at the time of termination of the Agreement, through delivery, immediate post-partum care and the

follow-up checkup within the first 6 weeks of delivery for Participants past the 24th week of pregnancy at the time of termination, and for a period of 90 days following termination for all others.

(2) Provider shall not seek payment from the Participant with respect to services rendered pursuant to this provision of amounts for which the Participant would not be responsible if Provider were still a Participating Provider.

(11) Nothing in the Agreement shall be construed to require Provider to indemnify Cigna for any tort liability resulting from acts or omissions of Cigna.

(12) Provider shall hold Participants harmless for payment of the cost of Covered Services in the event Payor fails to pay Provider for such Covered Services.

(13) Nothing in the Agreement shall be construed to require a referring Provider to bear the expenses of a referral for specialty care in or out of Cigna's provider panel. Savings from cost-effective utilization of health services may, however, be shared with physicians and health care providers in the aggregate.

(14) To the extent that Cigna conducts, uses or relies upon economic profiling to terminate Provider, Cigna shall make available to Provider on request the economic profile of Provider, including the written criteria by which Provider's performance was measured. An economic profile will be adjusted to recognize the characteristics of Provider's practice that may account for variations from expected costs.

(15) Quality assessment (as that term is defined under Texas law) shall be conducted through a panel of not less than 3 physicians selected by Cigna from among a list of participating physicians which list is to be provided by participating physicians in the applicable service area.

(16) Provider may be required pursuant to procedures contained in the Administrative Guidelines, when referring a Participant to another provider, to disclose to Participant that the physician, provider or facility to whom Participant is referred might not be a participating provider; and, if applicable, that the Provider has an ownership interest in the facility to which Participant is referred. Such disclosure shall not be required when referring for emergency care, and as necessary to avoid interruption or delay of medically necessary care. Nothing in this section or in the Administrative Guidelines shall be construed to limit access to non-participating providers.

(17) Provider shall, except for instances of emergency care as defined under state law, when referring a Participant to a facility for surgery: notify Participant that out-of- network providers may provide treatment and that Participant can contact Cigna for more information; notify Cigna that surgery has been recommended; and, notify Cigna of the facility that has been recommended for the surgery.

(18) Provider shall comply with all applicable requirements of Insurance Code § 1661.005. Provider must refund the amount of an overpayment to a Participant no later than the 30th day after the date Provider determines that an overpayment has been made.

(19) To the extent applicable, Provider may request, pursuant to procedures contained in the Administrative Guidelines, a waiver of any requirement for the use of information technology established or required by Chapter 1661 of the Texas Insurance Code as may be changed from time to time. A waiver granted under this section will expire September 1, 2013, or as otherwise permitted by applicable laws and regulations.

(20) To the extent applicable, Provider may request, pursuant to procedures contained in the Administrative Guidelines, a waiver of any requirement for electronic submission established or required by Chapter 1213 of the Texas Insurance Code as may be changed from time to time.

(21) To the extent applicable, nothing in this Agreement shall be construed to permit Cigna or Payor to directly or indirectly charge or hold Provider responsible for a fee for the adjudication of a claim.

(22) The Agreement permits Cigna to contract with another party to provide access to Cigna's rights and responsibilities under this Agreement. Upon request, Cigna will provide information necessary to determine whether a particular party has been authorized to access Provider's health care services and contractual discounts under this Agreement. Any party authorized to access the health care services and contractual discounts under this Agreement must comply with all applicable terms, limitations, and conditions of the Agreement.

(23) The fee schedule for each type of Benefit Plan is included in the exhibits to this Agreement. Notwithstanding the foregoing, Cigna may at its option provide the fee schedule for any Benefit Plan to Provider electronically.

(24) Upon the request of Provider, Cigna will provide Provider with such information as is necessary to allow Provider to determine that a Payor is authorized to access the reimbursement rates under this Agreement.

(25) Cigna shall cause each Payor that accesses Provider's discounts under this Agreement to comply with all applicable terms, limitations and conditions of this Agreement.

ADDENDUM TO PROVIDER AGREEMENT FOR THE STATE OF UTAH

The provisions set forth in this Addendum are being added to the Agreement with the provider named in the Agreement (hereafter referred to as the "Provider") to comply with legislative and regulatory requirements of the State of Utah regarding provider contracts with providers rendering health care services in the State of Utah. To the extent that such Utah laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) The definition for Emergency Services, if any, shall comply with Utah laws and regulations to the extent applicable.

(2) Except in cases of fraud, Payor may only recover any amount improperly paid to Provider: (1) within 24 months of the amount improperly paid for a coordination of benefits error; or (2) within 12 months of the amount improperly paid for any other reason; or (3) within 36 months of the amount improperly paid when the improper payment was due to a recovery by Medicaid, Medicare, and the Children's Health Insurance Program, or any other state or federal health care program.

(3) (a) Upon Cigna's insolvency, the rehabilitator or liquidator may require Provider to continue to provide Covered Services under the Agreement between Provider and Cigna until the earlier of: (1) 90 days after the date of the filing of a petition for rehabilitation or the petition for liquidation; or (2) the date the term of the Agreement ends.

(b) The rehabilitator or liquidator may reduce the fees Provider is otherwise entitled to receive under the Agreement during the time period described above. Provider shall accept the reduced payment as payment in full and relinquish the right to collect additional amounts from the Participant. However, the rehabilitator or liquidator may not reduce a fee to less than 75% of the regular fee set forth in the Agreement and the Participant shall continue to pay the same Copayments, Deductibles, and other payments for services received from Provider that the Participant was required to pay before the filing of the petition for reorganization or petition for liquidation.

(4) Nothing in the Agreement shall be construed to require Provider to notify Cigna of a hospital in-patient emergency admission within a period of time that is less than one business day of the hospital in-patient admission, if compliance with the notification requirement would result in notification by Provider on a weekend or a federal holiday.

ADDENDUM TO ANCILLARY AGREEMENT FOR THE STATE OF VIRGINIA

The provisions set forth in this Addendum are being added to the Agreement with the provider named in the Agreement (hereafter referred as "Provider") to comply with legislative and regulatory requirements of the State of Virginia regarding provider contracts with providers rendering health care services in the State of Virginia. To the extent that such state laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of the Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

Accessing your Fee Schedule

Your fee schedule is hereby incorporated into this contract by reference and a full copy is available by visiting the Cigna HealthCare website at www.cignaforhcp.com. Additional information regarding fee schedules and other items available on the Cigna HealthCare website can be found in the Administrative Guidelines.

I

1. Provider shall mean "Provider," "Hospital," "Group and/or Represented Provider," System and/ or Represented Provider" as named in the Agreement, or as otherwise set forth in the Agreement.

II

1. The definition for Emergency Services, if any, shall comply with Virginia laws and regulations to the extent applicable.

2. Pursuant to Code of Virginia§ 38.2-3407.15, to the extent applicable and/or not otherwise preempted by federal law, Cigna shall comply with the following minimum fair business standards in the processing and payment of claims for Covered Services:

   a. Payor shall pay any claim within 40 days of receipt of the claim except where the obligation of the Payor to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

      1. The claim is determined by Cigna not to be a clean claim due to a good faith determination or dispute regarding: (a) the manner in which the claim form was completed or submitted, (b) the eligibility of a person for coverage, (c) the responsibility of another payor for all or part of the claim, (d) the amount of the claim or the amount currently due under the claim, (e) the benefits covered, or (f) the manner in which Covered Services were accessed or provided; or

      2. The claim was submitted fraudulently.

   Cigna shall maintain a written or electronic record of the date of receipt of a claim. Provider shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim.

b. Cigna shall, within 30 days after receipt of a claim, notify Provider of any defect or impropriety that prevents Cigna from deeming the claim a clean claim and request the information that will be required to process and pay the claim. Upon receipt of the additional information necessary to make the original claim a clean claim, Payor shall make the payment of the claim in compliance with subsection a. of this Addendum (above) and in accordance with Code of Virginia§ 38.2-3407.15. Payor may not refuse to pay a claim for services which are Covered Services rendered pursuant to the Agreement if Cigna fails to timely notify or attempt to notify Provider of the matters identified above unless such failure was caused in material part by Provider. However, nothing herein shall preclude a Payor from imposing a retroactive denial of payment of such a claim unless such retroactive denial of payment of the claim would violate subsection f. of this Addendum (below) and subdivision 7 of Code of Virginia § 38.2-3407.15. Beginning no later than January 1, 2026, all notifications and information required under this section b. of the Addendum and subdivision 2 of Code of Virginia§ 38.2-3407.15 shall be delivered electronically.

c. Any interest owing or accruing on a claim under Code of Virginia§ 38.2-3407.1 or 38.2- 4306.1, under the Agreement or under any other applicable law shall, if not sooner paid or required to be paid, be paid, without the necessity of demand, at the time the claim is paid or within 60 days thereafter.

d. 1. Cigna shall establish and implement reasonable policies to permit Provider: (a) to confirm in advance during normal business hours by free telephone or electronic means, if available, whether the health care services to be provided are Medically Necessary and Covered Services; and (b) to determine Cigna's requirements applicable to Provider (or to the type of health care services which Provider has contracted to deliver under the Agreement) for: (i) precertification or authorization of coverage decisions, (ii) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (iii) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and; (iv) other provider specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the Agreement, including determining whether a claim is a clean claim.

2. With respect to Agreements entered into, amended, extended or renewed on or after January 1, 2006, if Cigna routinely, as a matter of policy, bundles or downcodes claims submitted by Provider, Cigna shall clearly disclose that practice in the Agreement. Further, Cigna shall either: (i) disclose in the Agreement or on the Cigna website the specific bundling and downcoding policies that Cigna reasonably expects to be applied to Provider's services on a routine basis as a matter of policy; or (ii) disclose in the Agreement a telephone or facsimile number or e-mail address that Provider can use to request the specific bundling and downcoding policies that Cigna reasonably expects to be applied to Provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of Provider, Cigna shall provide Provider with such policies within 10 business days following the date the request is received. The paragraph below contains the disclosure of information concerning Cigna's claim bundling and downcoding practice and policies.

Payments for Covered Services under the Agreement are subject to Cigna's Payment Policies. Payment Policies are the guidelines adopted by Cigna for calculating payment of claims under the Agreement. Such guidelines include Cigna's standard claim coding and bundling methodology and claims processing policies and procedures. Cigna's Payment Policies may change from time to time. Provider may obtain up-to-date information regarding Payment Policies by visiting the Cigna HealthCare website www.cigna.com and accessing Cigna's online tool for providers including complete fee schedules for individual providers in effect by visiting the Cigna HealthCare website www.cignaforhcp.com (Cigna reserves the right to rename these website addresses and such change shall not require a modification to this addendum so long as Cigna

communicates the name of the new website address to Provider). Provider may access this secure website tool 24 hours a day, 7 days a week, by logging on through the Cigna HealthCare website. Provider may also use this website tool to e-mail Cigna HealthCare with specific questions about claim coding, fee schedules, Covered Services and coverage criteria. Provider may appeal a Payment Policy issue in accordance with the dispute resolution process described in the Agreement and the Administrative Guidelines. The Administrative Guidelines are the rules, policies and procedures adopted by Cigna or a Payor to be followed by Provider in providing services and doing business with Cigna and Payors under the Agreement.

3. Cigna shall make available to Provider within 10 business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to Provider and to the health care services identified by Provider which Provider has contracted to deliver under the Agreement. In the event that the provision of the entire policy would violate any applicable copyright law, Cigna may instead comply with Code of Virginia § 38.2-3407.15 by timely delivering to Provider a clear explanation of the policy as it applies to Provider and to those health care services identified by Provider which Provider has contracted to deliver under the Agreement.

e. Payor shall pay a claim if Cigna has previously authorized the health care service or has advised Provider or Participant in advance of the provision of health care services that the health care services are Medically Necessary and a Covered Service, unless:

1. The documentation for the claim provided by Provider clearly fails to support the claim as originally authorized; or

2. The Payor's refusal is because: (a) another payor is responsible for the payment, (b) Provider has already been paid for the health care services identified on the claim, (c) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to Cigna by Provider, Participant, or other person not related to Cigna, or (d) the individual receiving the health care services was not eligible to receive the health care services on the date the services were provided and Cigna did not know, and with the exercise of reasonable care could not have known, of the Participant's eligibility status; or

3. During the post-service claims process, it is determined that the claim was submitted fraudulently.

e.l. In the case of an invasive or surgical procedure, if Cigna has previously authorized a health care service as Medically Necessary and during the procedure Provider discovers clinical evidence prompting Provider to perform a less or more extensive or complicated procedure than was previously authorized, then Cigna shall pay the claim, provided that the additional procedures were (i) not investigative in nature, but Medically Necessary as a Covered Service under the Participant's benefit plan; (ii) appropriately coded consistent with the procedure actually performed; and (iii) compliant with Cigna's post-service claims process, including required timing for submission to Cigna.

f. Payor shall not impose any retroactive denial of a previously paid claim or in any other way seek recovery or refund of a previously paid claim unless Cigna specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought, Cigna has provided a written explanation of why the claims is being retroactively adjusted, and: (1) the original claim was submitted fraudulently, (2) the original claim payment was incorrect because Provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by Provider, or (3) the time which has elapsed since the date of the payment of the original challenged claim

does not exceed 12 months. Notwithstanding the provisions of clause (3), Provider and Cigna may agree in writing that recoupment of overpayments by withholding or offsetting against future payments may occur after such 12-month limit for the imposition of the retroactive denial. Cigna shall notify Provider at least 30 days in advance of any retroactive denial or recovery or refund of a previously paid claim. Beginning no later than January 1, 2026, all written communications, explanations, notifications, and related provider responses applicable to this section f. of the Addendum and subdivision 7 of Code of Virginia § 38.2-3407.15 shall be delivered electronically. The electronic method and location for delivery shall be agreed upon by Cigna and Provider and included in the provider contract.

g. Cigna requires that claims subject to Code of Virginia§ 38.2-3407.15 must be submitted within 12 months of the date of service and that claims received after that date may be denied for payment.

h. The Agreement shall include or attach at the time it is presented for execution: (1) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid that is applicable to Provider or to the range of health care services reasonably expected to be delivered by Provider on a routine basis under the Agreement, and (2) all material addenda, schedules and exhibits thereto and any policies (including those referred to in subsection d. of the Addendum (above) and subdivision 4 of Code of Virginia § 38.2-3407.15) applicable to Provider or to the range of health care services reasonably expected to be delivered by Provider under the Agreement.

i. No amendment to the Agreement or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to Provider (or to the range of health care services reasonably expected to be delivered by Provider under the Agreement) shall be effective as to Provider, unless Provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and Provider has failed to notify Cigna within 30 calendar days of receipt of the documentation of Provider's intention to terminate the Agreement at the earliest date thereafter permitted under the Agreement.

j. In the event that Cigna's provision of a policy required to be provided under subsections h. or i. of the Addendum (above) and subdivisions 9 or 10 of Code of Virginia§ 38.2-3407.15 would violate any applicable copyright law, Cigna may instead comply with this section by providing a clear, written explanation of the policy as it applies to Provider.

k. Cigna shall establish, in writing, its claims payment dispute mechanism and shall make this information available to Provider. If Cigna's claim denial is overturned following the completion of a dispute review, Cigna shall, on the day the decision to overturn is made, consider the claims impacted by such decision as clean claims. All applicable laws related to the payment of a clean claim shall apply to the payments due.

l. Provider is prohibited from discriminating against any Participant solely due to the Participant's status as a litigant in a pending litigation or a potential litigant due to being involved in a motor vehicle accident. (Nothing in Code of Virginia § 38.2- 3407.15 B (12) shall require a provider to treat a Participant who has threatened to make or has made a professional liability claim against the provider or the provider's employer, agents, or employees or has threated to file or has filed a complaint with a regulatory agency or board against the provider or the provider's employer, agents, or employees.)

m. Cigna shall not be in violation of the above provisions if its failure to comply is caused in material part by Provider or if Cigna's compliance is rendered impossible due to matters beyond Cigna's reasonable control (such as an act of God, insurrection, strike, fire or power outages) which are not caused in material part by Cigna.

n. Cigna shall not terminate or fail to renew the Agreement or otherwise penalize Provider for invoking any of Provider's rights under this section of the Agreement.

o. Beginning July 1, 2025, Cigna shall make available through electronic means a way for Provider to determine whether a Participant is covered by a health plan that is subject to the Commissioner's jurisdiction.

3. Nothing in the Agreement shall be construed to:

a. Require Provider to refuse to provide treatment which the Provider believes to be medically necessary and appropriate, and which is provided with respect to others with similar conditions.

b. Require that Provider indemnify Cigna for Cigna's negligence, willful misconduct or breach of contract, if any.

c. Require Provider, as a condition of participation on Cigna's panel, to waive any right to seek legal redress against Cigna.

d. Prohibit, impede or interfere in the discussion of medical treatment options between Provider and Participants. The Agreement expressly permits and requires Provider to discuss medical treatment options with Participants.

4. a. Cigna shall give Provider notice at least 90 days prior to the date of termination of Provider, except when Provider is terminated for cause. To the extent that the Agreement provides for a notification period longer than 90 days, such longer notification period will apply, except when Provider is terminated for cause.

b. Provider shall give Cigna at least 60 days' prior notice of termination of the Agreement. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider, such longer notification period will apply.

c. Provider shall be permitted to render Covered Services for a period of at least 90 days from the date of Provider's termination from a provider panel, except when the termination is for cause. Provider shall continue to render Covered Services to Participants who have an existing provider-patient relationship with Provider for a period of at least 90 days from the date of Provider's termination from a provider panel, except when the termination is for cause. Existing provider-patient relationship means the Provider has rendered Covered Services to Participant or admitted or discharged Participant in the previous 12 months.

(c)(i). Notwithstanding Section c above, Cigna shall permit Provider to continue rendering and Provider shall continue rendering Covered Services to any Participant who has an existing provider-patient relationship with Provider and who has been medically confirmed to be pregnant at the time of a Provider's termination of participation, except when Provider is terminated for cause. Such

treatment shall, at the Participant's option, continue through the provision of postpartum care directly related to the delivery.

(c)(ii). Notwithstanding Section c above, Cigna shall permit Provider to continue rendering and Provider shall continue rendering Covered Services to any Participant who has an existing provider-patient relationship with Provider and who is determined to be terminally ill (as defined under§1861(dd)(3)(A) of the Social Security Act) at the time of a Provider's termination of participation, except when Provider is terminated for cause. Such treatment shall, at the Participant's option, continue for the remainder of the Participants' life for care directly related to the treatment of the terminal illness.

(c)(iii). Notwithstanding Section c above, Cigna shall permit Provider to continue rendering and Provider shall continue rendering Covered Services to any Participant who has an existing provider-patient relationship with Provider and who has been determined by a medical professional to have a life-threatening condition at the time of Provider's termination of participation. Such treatment shall, at the Participant's option, continue for up to 180 days for care directly related to the life-threatening condition.

(c)(iv). Notwithstanding Section c above, Cigna shall permit Provider to continue rendering and Provider shall continue rendering Covered Services to any Participant who has an existing provider-patient relationship with Provider and who is admitted to and receiving treatment in any inpatient facility at the time of Provider's termination of participation. Such admission and treatment shall continue until the Participant is discharged from the inpatient facility.

d. For any Covered Services received by a Participant under Section c and Subsections (c)(i) through (c)(iv), Cigna shall reimburse Provider in accordance with the Agreement existing immediately before the Provider's termination of participation; Provider shall accept such reimbursement and any cost-sharing payment from Participant for items and services as payment in full; and, Provider shall continue to adhere to all policies and procedures and quality standards for a Participant that were required of Provider immediately before the Provider's termination of participation.

Provider has no obligation under the Agreement to provide services to individuals who cease to be Participants.

III

A. Pursuant to the prior authorization requirements for a health care provider with prescriptive authority (hereinafter "prescriber") of Code of Virginia§ 38.2-3407.15:2 to the extent applicable and/ or not otherwise preempted by federal law, Cigna shall:

1. In a method of Cigna's choosing, accept telephonic, facsimile, or electronic submission of prior authorization requests that are delivered from e-prescribing systems, electronic health record systems, and health information exchange platforms that utilize the National Council for Prescription Drug Programs' SCRIPT standards;

2. Communicate to the prescriber or his designee within 24 hours, including weekend hours, of submission of an urgent prior authorization request, if submitted telephonically or in an alternate method directed by Cigna, that the request is approved, denied, or requires supplementation;

3. Communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within two business days of submission of a fully completed prior authorization request, that the request is approved, denied, or requires supplementation;

4. Communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within two business days of submission of a properly completed supplementation from the prescriber or his designee, that the request is approved or denied;

5. Communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within the timeframes established by section 3 or 4 above, as applicable, for any prior authorization request denied, the reasons for the denial;

5.1 Not revoke, limit, condition, modify, or restrict a prior authorization request that is approved for prescription drugs and such prescription drugs have been scheduled, provided, or delivered to Participant consistent with the authorization, unless (i) there is evidence that the authorization was obtained based on fraud or misrepresentation; (ii) final actions by the U.S. Food and Drug Administration, other regulatory agencies, or the manufacturer remove the drug from the market, limit its use in a manner that affects the authorization, or communicate a patient safety issue that would affect the authorization alone or in combination with other authorizations; (iii) a combination of drugs prescribed would cause a drug interaction; or (iv) a generic or biosimilar is added to the prescription drug formulary. (Nothing in Code of Virginia § 38.2-3407.15:2 B shall require Cigna to cover any benefit not otherwise covered or cover a prescription drug if Participant is no longer covered by a health plan on the date the prescription drug was scheduled, provided, or delivered.)

6. Honor a prior authorization approved by another carrier, upon Cigna's receipt from the prescriber or his designee of a record demonstrating the previous carrier's prior authorization approval or any written or electronic evidence of the previous carrier's coverage of such drug, at least for the initial 90 days of a Participant's prescription drug benefit coverage under a new health plan, subject to the provisions of Cigna's evidence of coverage and any exception listed in Section 5.1 above;

7. Use a tracking system for all prior authorization requests; the identification information shall be provided electronically, telephonically, or by facsimile to the prescriber or his designee, upon Cigna's response to the prior authorization request;

8. Make available through one central location on Cigna's website prescription drug formularies, all drug benefits subject to prior authorization, all prior authorization procedures, and all prior authorization request forms; such information will be updated within seven days of approved changes;

9. Honor a prior authorization issued by Cigna for a drug, other than an opioid, regardless of changes in dosages of such drug, provided such drug is prescribed consistent with U.S. Food and Drug Administration-labeled dosages;

10. Honor a prior authorization issued by Cigna for a drug regardless if the covered person changes plans with the same carrier and the drug is a covered benefit with the current health plan;

11. Identify the specific information required when requiring a prescriber to provide supplemental information that is in the Participant's health record or electronic health record; and

12. Require that no prior authorization be required for at least one drug prescribed for substance abuse medication-assisted treatment, provided that (i) the drug is a covered benefit,

(ii) the prescription does not exceed the FDA-labeled dosages, and (iii) the drug is prescribed consistent with the regulations of the Board of Medicine;

13. Not require additional prior authorization when any carrier has previously approved prior authorization for any drug prescribed for the treatment of a mental disorder listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, provided that (i) the drug is a covered benefit, (ii) the prescription does not exceed the FDA-labeled dosages, (iii) the prescription has been continuously issued for no fewer than three months, and (iv) Provider performs an annual review of the patient to evaluate the drug's continued efficacy, changes in the patient's health status, and potential contraindications. (Nothing in subdivision 14 of Code of Virginia § 38.2-3407.15:2 shall prohibit a carrier from requiring prior authorization for any drug that is not listed on its prescription drug formulary at the time the initial prescription for the drug is issued.);

14. Honor a prior authorization issued by Cigna for a drug regardless if the drug is removed from Cigna's prescription drug formulary after the initial prescription for that drug is issued, provided that the drug and prescription are consistent with the applicable provisions of Section 13above.

15. Establish and maintain an online process that, beginning July 1, 2025, meets the requirements and specifications of applicable state law including Code of Virginia § 38.2- 3407.15:2 which, effective July 1, 2023 (2023 Va. Ch. 474), requires a process that: (i) links directly to all e-prescribing systems and electronic health record systems that utilize the National Council for Prescription Drug Programs SCRIPT standard and the National Council for Prescription Drug Programs Real Time Benefit Standard; (ii) can accept electronic prior authorization requests from a provider; (iii) can approve electronic prior authorization requests
(a) for which no additional information is needed by the carrier to process the prior authorization request, (b) for which no clinical review is required, and (c) that meet the carrier's criteria for approval; and (iv) links directly to real-time patient out-of-pocket costs for the office visit, considering copayment and deductible, and (v) otherwise meets the requirements of this section. Cigna shall not impose a charge or fee on any person for accessing the online process or access, absent Provider consent, provider data via the online process other than for the Participant. Cigna shall, not later than July 1, 2024, provide contact information to Provider on request for any entity Cigna will use to meet the online process requirements of§ 38.2-3407.15:2 or the benefit information requirements of§ 38.2-3407.15:7. (A carrier that posts such contact information on its website shall be considered to have met this requirement.)

Provider shall ensure that, beginning July 1, 2025, any e-prescribing system or electronic health record system owned by or contracted for Provider to maintain a Participant health record has the ability to access at the point of prescribing the electronic prior authorization process established by Cigna as required by subdivision 16 of Code of Virginia§ 38.2-3407.15:2, and the real-time patient-specific benefit information, including out-of-pocket costs and more affordable medication alternatives made available by Cigna as required by § 38.2-3407.15:7. Provider may request a waiver of compliance for undue hardship for a period specified by regulatory authority

ADDENDUM TO ANCILLARY AGREEMENT
FOR THE STATE OF VERMONT

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Vermont regarding provider contracts with providers rendering health care services in the State of Vermont. To the extent that such Vermont laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) The definition for Emergency Services, if any, shall comply with Vermont laws and regulations to the extent applicable.

(1.1) Material Change or Material Adverse Change shall mean a change that could reasonably be expected to have a material adverse impact on the aggregate level of payment by Cigna or Payor to Provider for Covered Services under this Agreement, or on Provider's administration of their services.

(1.2) Timely Notice shall mean the timeframe or timeframes established by the parties for prior written notice of an amendment to the agreement as set forth in the Material Adverse Change Amendments, or any other provisions of the Agreement governing changes or amendments to the Agreement.

(2) Cigna shall not prohibit Provider from, or penalize Provider for discussing treatment options with Participants regardless of Cigna's position on the treatment options, or advocating on behalf of Participants within the utilization review or grievance process established by Cigna, nor shall it penalize Provider because Provider in good faith reports to state or federal authorities any act or practice by Cigna that jeopardizes Participant health or welfare.

(3) Provider will comply with the Administrative Guidelines including but not limited to the rules, policies and procedures established by Cigna and required by state laws and regulations, including but not limited to the Consumer Protection and Quality Requirements for Managed Care Plans, as may be amended from time to time. Provider will comply with Administrative Guidelines governing grievance procedures and the credentialing process. Provider may give feedback to Cigna, on an ongoing basis, for Cigna's use in assessing and enhancing Cigna's Quality Management program, Utilization Management program, Participant appeal procedures, and dispute resolution process. In addition, Provider will be invited to give input annually in the form of a written survey.

(4) A. Payor shall not retrospectively deny a previously paid claim or any part of a previously paid claim, unless:

(a) Payor has provided at least 30 days' notice of any retrospective denial or overpayment recovery or both in writing to Provider. The notice must include:

(i) the patient's name;

(ii) the service date;

(iii) the payment amount;

(iv) the proposed adjustment; and

(v) a reasonably specific explanation of the proposed adjustment.

(b) the time that has elapsed since the date of payment of the previously paid claim does not exceed 12 months.

B. The retrospective denial of a previously paid claim shall be permitted beyond 12 months from the date of payment for any of the following reasons:

(a) Cigna has a reasonable belief that fraud or other intentional misconduct has occurred;

(b) the claim payment was incorrect because Provider was already paid for the health services identified in the claim;

(c) the health care services identified in the claim were not delivered by Provider;

(d) the claim payment is the subject of adjustment with another health plan; or

(e) the claim is the subject of legal action.

C. For routine recoveries as described below, retrospective denials or overpayment recovery of any or all a previously paid claim shall not require 30 days' notice before recovery may be made. A recovery shall be considered routine only if one of the following situations applies:

(a) duplicate payment to Provider for the same service;

(b) payment with respect to an individual who was not a plan participant as of the date the service was provided;

(c) payment for a noncovered, not to include services denied as not medically necessary, experimental, or investigational in nature, or services denied through a utilization review mechanism;

(d) erroneous payment for services due to a plan administrator error;

(e) erroneous payment for services where the claim was processed in a manner inconsistent with the data submitted by Provider;

(f) payment where Provider provides Cigna with new or additional information demonstrating an overpayment;

(g) payment to Provider at an incorrect rate or using an incorrect fee schedule;

(h) payment of claims for the same plan participant that are received by Cigna out of the chronological order in which services were performed;

(i) payment where Provider has received payment for the same services from another payer whose obligation is primary; or

(j) payments made in coordination with a payment by a government payer that require adjustment based on an adjustment in the government-paid portion of the claim.

D. Recoveries which, in Cigna's reasonable judgment, would be likely to affect a significant volume of claims or accumulate to a significant dollar amount shall not be deemed routine, regardless of whether one or more situations above apply.

(5) Pursuant to Vermont laws, Cigna shall, to the extent applicable, be bound by and comply with the Consumer Protection and Quality Requirements for Managed Care Plans, as may be amended from time to time.

(6) A. In the event of Cigna's insolvency or other cessation of operations, Covered Services to Participants shall continue through the contract period for which premiums have been paid on behalf of the Participant or until the Participant's discharge from an inpatient facility, whichever period is greater. Covered Services to Participants confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until the Participant's continued confinement in the facility is no longer Medically Necessary. This provision shall be construed in favor of the Participant, shall survive the termination of the Agreement regardless of the reason for termination, including the insolvency of Cigna, and shall supersede any oral or written contrary agreement between Provider and Participant or Participant's representative.

B. Upon termination of the Agreement without cause, Provider shall continue to provide Covered Services for specific conditions for which a Participant was under Provider's care at the time of such termination as follows: (a) Participants with life- threatening, disabling or degenerative conditions shall be allowed to continue undergoing a course of treatment for 60 days from the date of termination or until Cigna's provision for the assumption of such treatment by another provider, whichever is shorter; and (b) Participants who are in the second or third trimester of a pregnancy shall be permitted to continue to receive Medically Necessary Covered Services from Provider until the completion of postpartum care. The terms and conditions of the Agreement shall continue to apply. Provider shall be compensated for such continued care in accordance with the compensation arrangements that were in effect under the Agreement prior to termination. Participants shall not be liable to Provider for any amounts owed for Covered Services provided during the period of continued care other than Copayments, Deductibles or Coinsurance. Provider has no obligation under the Agreement to provide services to individuals who cease to be Participants.

C. Notwithstanding any provision in the Agreement to the contrary, within five (5) business days of the date Provider either gives or receives notice of termination of the Agreement, either with or without cause, Provider shall, in accordance with applicable laws and regulations, supply to Cigna a list of Participants seen by Provider.

D. Provider shall notify Cigna of any changes that would impact Provider's credentialing status or ongoing availability to Participants.

(7) The Agreement may permit network rental arrangements which allow the selling, renting, or otherwise grant access to Cigna's rights to Provider's services to a third party provided that the Third Party accessing Provider's services is contractually obligated to comply with all applicable terms, limitations and conditions of the Agreement, and the Third Party is any of the following:

(a) a payer, a third-party administrator, or another entity that administers or processes claims on behalf of the payer;

(b) a preferred provider organization or preferred provider network, including a physician organization or physician hospital organization; or

(c) an entity engaged in the electronic claims transport between the Cigna and the payer that does not provide access to the provider's services and a discount to any other covered entity.

(8) A. The Agreement may be amended by mutual agreement of the parties. Absent mutual agreement, Cigna shall provide Provider with a written notice of a proposed amendment and the amendment in writing not later than 60 days prior to the effective date of the amendment. The written notice shall be conspicuously entitled "Notice of Amendment to Contract," and shall contain a summary of the amendment as required by applicable law. The notice period may be extended by mutual agreement of the parties.

B. Provider shall have 60 days after receipt of the notice and amendment to object in writing to the proposed amendment. If Provider objects in writing and there is no resolution of the objection within 60 days of Cigna's receipt of the objection, Cigna or Provider may terminate the Agreement upon written notice to the other party. The terms of the Agreement shall remain in effect through the termination period and shall be unaffected by the proposed amendment.

C. If Provider does not object to the proposed amendment as specified in subsection B, the amendment shall be effective as specified in the notice.

D. Subsections A and B shall not apply under the following circumstances:

1. the delay caused by compliance with the requirements could result in imminent harm to a Participant;
2. the amendment is required by a state or federal law, rule, or regulation that includes an effective date for the amendment;
3. Provider affirmatively accepts the amendment in writing and agrees to an earlier effective date than specified in the notice;
4. Provider's payment or compensation is based on the current Medicaid or Medicare reimbursement schedule, and the change in payment or compensation results solely from a change in that reimbursement schedule;
5. the amendment is a routine change or update of the Agreement made in response to any addition, deletion, or revision of any service code, procedure code, or reporting code, or a pricing change made by a Third Party source.

(a) For purposes of this subsection, "service code, procedure code, or reporting code" means the American Medical Association's Current Procedural Terminology, the American Dental Association's Current Dental Terminology, the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System, the World Health Organization's International Classification of Diseases, or the Drug Topic Red Book average wholesale price. For purposes of this subsection, "Third Party source" means the American Medical Association, the American Society of Anesthesiologists, the American Dental Association, the Centers for Medicare and Medicaid Services, the National Center for Health Statistics, the U.S. Department of Health and Human Services Office of the Inspector General, the Vermont Department of Financial Regulation (DFR), or the Vermont Agency of Human Services.

E. Notwithstanding anything in this section, Cigna may modify the Agreement by operation of law as required by any applicable state or federal law, rule, or regulation.

(9) A. Cigna shall provide such information sufficient for Provider to determine compensation or payment terms for Covered Services. Such information shall include: the manner or payment; on request, the fee-for-service dollar amount allowable for each CPT code for those CPT codes that Provider typically uses or actually bills.

B. Cigna shall provide a readily available mechanism that includes information on the commercially available claims editing software used, standards used for claims edits, payment percentages for modifiers, and any significant edits to the claims software.

ADDENDUM TO ANCILLARY AGREEMENT FOR THE STATE OF WISCONSIN

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Wisconsin regarding provider contracts with providers rendering health care services in the State of Wisconsin. To the extent that such Wisconsin laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and shall supersede any provisions in the Agreement to the contrary. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) The definition for **Emergency Services**, if any, shall comply with Wisconsin laws and regulations to the extent applicable.

(2) With respect to a Provider who is a Participant's Primary Care Physician – Unless Provider no longer practices in the plan's service area, or the Agreement is terminated for misconduct on the part of Provider, Provider shall continue to provide Covered Services for such Participant for the following period of time: (i) for a Participant of a plan with no open enrollment period, until the end of the current plan year; or (ii) for a Participant of a plan with an open enrollment period, until the end of the plan year for which it was represented that the provider was, or would be, a Participating Provider.

With respect to a Provider who is not a Participant's Primary Care Physician - Upon termination of the Agreement, unless Provider no longer practices in the plan's service area, or the Agreement is terminated for misconduct on the part of Provider, Provider shall continue to provide Covered Services for Participants undergoing a course of treatment for the following period of time: (i) if maternity care is the course of treatment and Participant is in the second or third trimester of pregnancy when the Agreement terminates, until the completion of postpartum care for Participant and infant; or (ii) for all other courses of treatment, for the remainder of the course of treatment or for 90 days after the Agreement is terminated, whichever is shorter, except that Provider is not required to provide Covered Services beyond: (i) the end of the current plan year, for a Participant of a Benefit Plan with no open enrollment period; or (ii) the end of the plan year for which it was represented that Provider was, or would be, a Participating Provider, for a Participant of a Benefit Plan with an open enrollment period.

Provider shall be compensated for Covered Services provided to any such Participant in accordance with the compensation arrangements under the Agreement until 90 days following termination, and compensation thereafter for continued Covered Services authorized by Cigna shall be as mutually agreed.

Provider has no obligation under the Agreement to provide services to individuals who cease to be Participants.

ADDENDUM TO PROVIDER AGREEMENT FOR THE STATE OF WEST VIRGINIA

The provisions set forth in this Addendum are being added to the Agreement with the provider named in the Agreement (hereafter referred as the "Provider") to comply with legislative and regulatory requirements of the State of West Virginia regarding provider contracts with providers rendering health care services in the State of West Virginia. To the extent that such West Virginia laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of the Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

I

1. Provider shall mean "Provider," "Hospital," "Group and/or Represented Provider," or "System and/or Represented Provider" as named in the Agreement, or as otherwise set forth in the Agreement.

II

(1) The definition for Emergency Services, if any, shall comply with West Virginia laws and regulations to the extent applicable.

(2) Experimental Medical Care means medical, surgical or other health care procedures and treatments which are experimental or investigational, as determined by the Healthplan Medical Director in accordance with consensus derived from peer review medical and scientific literature and the practice of the national medical community, including (i) any procedures or treatments which are not recognized as conforming to accepted medical practice; (ii) any procedures or treatments in which the scientific assessment of the technique, or its application for a particular condition, has not been completed or its effectiveness has not been established; and (iii) any procedures or treatments for which the required approval of a governmental agency has not been granted at the time the services are rendered. Covered Services do not include Experimental Medical Care.

However, to the extent applicable, Covered Services include the patient cost to a Participant in a clinical trial, as a result of:

(a) treatment provided for a life-threatening condition; or

(b) prevention, early detection, and treatment studies on cancer.

Coverage shall be required if:

(1) The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer; or the treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV clinical trial for any other life- threatening condition.

(2) The treatment is being provided in a clinical trial approved by:

(i) one of the National Institutes of Health;

(ii) a National Institutes of Health cooperative group or a National Institutes of Health center;

(iii) the FDA in the form of an investigational new drug application;

(iv) the federal Department of Veterans Affairs; or

(v) an institutional review board of an institution in the state which has a multiple project assurance contract approved by the Office of Protection from Research Risks of the National Institutions of Health.

(3) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.

(4) There is no clearly superior noninvestigational treatment alternative.

(5) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative.

Covered Services include the patient cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the patient's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

An entity seeking coverage for treatment in a clinical trial approved by an institutional review board under subsection (2)(v) above shall post electronically and keep up-to- date a list of the clinical trials meeting the requirements of this section. The list shall include for each clinical trial: (a) the phase for which the trial is approved; (b) the entity approving the trial; (c) whether the trial is for treatment of cancer or another life- threatening disease and, if not cancer, the particular disease; and the estimated number of patients in the trial.

B. With respect to Covered Services rendered to Participants covered under an HMO Benefit Plan:

If Provider elects to terminate the Agreement for any reason, Provider must give 60 days' advance written notice to Cigna and the State of West Virginia Commissioner of Insurance before terminating the Agreement. Nonpayment for goods or services

rendered by Provider is not a valid reason for avoiding the 60 day notice period. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the agreement by Provider, the longer notification period will apply.

C. To the extent required by applicable provisions of W.Va. Code § 33-25E-5, for a Provider who is an eye care provider as defined by applicable state laws and regulations:

(1) Notwithstanding any provision to the contrary set forth in the Compensation section of the Agreement, or any similar provision in the Agreement, or a rate exhibit, the rates in the Agreement will be payment in full for all Covered Services furnished to Participants under the Agreement by a Provider who is an eye care provider as defined by applicable state laws and regulations.

(2) Notwithstanding any provision to the contrary set forth in the Compensation section of the Agreement, or any similar provision in the Agreement, or a rate exhibit, the rates in this Agreement apply to all Covered Services provided to Participants by a Provider who is an eye care provider, as defined by applicable state laws and regulations, in the Benefit Plan types covered by this Agreement, including services covered under a Participant's in or out-of-network benefits and whether the Payor or Participant is financially responsible for payment.

(3) Notwithstanding any provision to the contrary set forth in the Agreement, this Agreement shall not restrict or limit, directly or indirectly, an eye care provider's use of optical labs by the eye care provider.

(4) An eye care provider may not charge more for services and materials that are non- covered services or non-covered materials than Provider's usual and customary rate for services and materials.

ADDENDUM TO PROVIDER AGREEMENT FOR THE STATE OF WYOMING

The provisions set forth in this Addendum are being added to the Agreement with the provider named in the Agreement (hereafter referred as the "Provider") to comply with legislative and regulatory requirements of the State of Wyoming regarding provider contracts with providers rendering health care services in the State of Wyoming. To the extent that such Wyoming laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of the Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) In accordance with Wyo. Stat. § 26-22-504, Cigna shall not refuse to re-contract with, or compensate Provider for Covered Services solely because Provider in good faith communicated with a Participant regarding the provisions, terms, or requirements of the Company's products as they relate to the needs of that Participant.

(2) To the extent required by applicable law, Cigna, Payor and Provider shall comply with Wyo. Stat. § 26-15-124 and any successor provisions regarding payment of claims.

EXHIBIT A
Diabetes Prevention Program
Rate Exhibit and Reimbursement Terms
Pricing for Pre-Existing Accounts –
Phase I

This is a Rate Exhibit to an Agreement between:
Provider: Omada Health, Inc.
Cigna Party: Cigna Health Corporation on behalf of itself and its affiliates and subsidiaries
Effective Date: _____

This Rate Exhibit:
Applies to: Omada Health, Inc.
Federal Tax ID: [***]
National Provider Identifier: [***]
Effective Date: _____

I. Reimbursement Notes.

1. Provider shall accept as full and final payment for Covered Services provided to Participants the lesser of billed charges or the reimbursement specified in this Exhibit. Payor shall deduct any Copayments, Deductibles, or Coinsurance required by the Benefit Plan from payment due to Provider to the extent applicable.

2. Pricing for Pre-Existing Accounts. Fees for the Covered Services for existing Program Participants from Pre-Existing Accounts with Start Dates before the applicable Transition Date shall be as set forth below.

For the avoidance of doubt, payment shall not be required under this Agreement for any fee applicable to a Program Participant from a Pre-Existing Account that has already been paid pursuant to the Prior Agreement.

3. [***].

4. For services not included on the rate table below, no reimbursement will be made. Participants may not be billed for such services. Unless in advance, they agree in writing to be responsible for such services.

II. [***] Fees.

Fees shall include the following one-time [***] fees (i.e., fees will only be billed if [***]).

CPT Code	Modifier	[***]	Fee
[***]	[***]	[***]	[***]
[***]	[***]	[***]	[***]
[***]	[***]	[***]	[***]
[***]	[***]	[***]	[***]

III. [***] Fees.

Fees shall also include $[***] per calendar month for each month that the applicable Program Participant qualifies as a [***] (CPT Code: [***], Modifier: [***]).

IV. Additional Terms

Process Fees earned in accordance with this Rate Exhibit will be submitted by Provider to Cigna on a [***] basis by means mutually agreed by the parties, either (i) submission of claims (using codes and modifiers set forth in table above under II. [***] Fees and under III. [***] Fees) or (ii) direct invoices payable within [***] days of the date of such invoices.

EXHIBIT A-1
Diabetes Prevention Program
Rate Exhibit and Reimbursement
Terms Phase II

This is a Rate Exhibit to an Agreement between:
Provider: Omada Health, Inc.
Cigna Party: Cigna Health Corporation on behalf of itself and its affiliates and subsidiaries
Effective Date:

This Rate Exhibit:
Applies to: Omada Health, Inc.
Federal Tax ID: [***]
National Provider Identifier: [***]
Effective Date:

I. Reimbursement Notes:

1. Pricing for Pre-Existing Accounts. Fees for the Covered Services for (i) all Program Participants not associated with Pre-Existing Accounts and (ii) all Program Participants associated with Pre-Existing Accounts with Start Dates on or after the applicable Transition Date shall be as set forth below.

2. Provider shall accept as full and final payment for Covered Services provided to Participants the lesser of billed charges or the reimbursement specified in this Exhibit. Payor shall deduct any Copayments, Deductibles, or Coinsurance required by the Benefit Plan from payment due to Provider to the extent applicable.

3. Process Fees earned in accordance with this Rate Exhibit will be submitted by Provider to Cigna on a [***] basis by means mutually agreed by the parties, either (i) submission of claims (using codes and modifiers set forth in the table below or (ii) direct invoices payable within [***] days of the `date of such invoices.

4. Rate for CPT code [***], includes, but is not limited to diabetic prevention counseling, patient education and weight loss management. Cigna reserves the right to request an audit of Provider's records to validate Provider charges and reimbursement. Charges for Cigna Participants are: (i) [***] upon enrollment (i.e., at Start Date) and (ii) [***] per month per [***] in year one (1) (i.e., through the end of the calendar month that includes the one-year anniversary of Participant's Start Date)] and [***] per month per [***] in year two (2), as further described below. Subject to the [***] in the rate table below (which, for the monthly fee, is a [***]).

5. [***].

6. For services not included on the rate table, no reimbursement will be made. Participants may not be billed for such services. Unless in advance they agree in writing to be responsible for such services.

Billing CPT Code	Modifier	Service Description	Maximum Allowable Rate
[***]	[***]	[***]	[***]
[***]	[***]	[***]	[***]

EXHIBIT B
TO ANCILLARY SERVICES AGREEMENT
PERFORMANCE GUARANTEES/IT SERVICE LEVELS

ATTACHMENT C
ADDITIONAL PROVISIONS AND EXHIBITS

PART I – ADDITIONAL PROVISIONS

The following additional provisions are hereby added to the Agreement:

A. Definitions

As used in this Part I and in Exhibits 1 and 3, the following terms shall have the meanings set forth below:

1.1 “Agreement” shall mean the Agreement between Company and Supplier to which this Attachment A is attached.

1.2 “Company” or “CIP” shall mean Cigna Health Corporation.

1.3 “Supplier” shall mean Omada Health, Inc.

B. Reserved

C. Information Protection Provisions

[***]

PART II – EXHIBITS

The following Exhibits, attached hereto, are hereby added to the Agreement:

- **Exhibit 1 – Information Protection Requirements**
- **Exhibit 2 – Information Protection Service Levels**
- **Exhibit 3 – Data Privacy Provisions**

EXHIBIT 1

INFORMATION PROTECTION REQUIREMENTS

Exhibit 1 - Information Protection Requirements
CIGNA PROPRIETARY AND CONFIDENTIAL
Form Updated 1-2016

EXHIBIT 2
INFORMATION PROTECTION SERVICE LEVELS

Exhibit 2 - Information Protection Service Levels
CIGNA PROPRIETARY AND CONFIDENTIAL
Form Updated 1-2016

EXHIBIT 3
DATA PRIVACY PROVISIONS

Exhibit 3 - Data Privacy Provisions
CIGNA PROPRIETARY AND CONFIDENTIAL
Form Updated 1-2016

Exhibit 31.1

CERTIFICATION OF PRINCIPAL EXECUTIVE OFFICER PURSUANT TO RULES 13a-14(a) AND 15d-14(a) UNDER THE SECURITIES EXCHANGE ACT OF 1934, AS ADOPTED PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Sean Duffy, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Omada Health, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared; and

(b) [Reserved];

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: August 8, 2025 By: /s/ Sean Duffy

Sean Duffy

Chief Executive Officer

(Principal Executive Officer)

Exhibit 31.2

CERTIFICATION OF PRINCIPAL FINANCIAL OFFICER PURSUANT TO RULES 13a-14(a) AND 15d-14(a) UNDER THE SECURITIES EXCHANGE ACT OF 1934, AS ADOPTED PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Steve Cook, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Omada Health, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared; and

(b) [Reserved];

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: August 8, 2025 By: /s/ Steve Cook

Steve Cook

Chief Financial Officer

(Principal Financial Officer)

Exhibit 32.1

CERTIFICATION OF PRINCIPAL EXECUTIVE OFFICER PURSUANT TO
18 U.S.C. SECTION 1350, AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report on Form 10-Q of Omada Health, Inc. (the "Company") for the period ended June 30, 2025, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, as amended, that, to the best of my knowledge:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: August 8, 2025

By: /s/ Sean Duffy

Sean Duffy

Chief Executive Officer

(Principal Executive Officer)

Exhibit 32.2

CERTIFICATION OF PRINCIPAL FINANCIAL OFFICER PURSUANT TO
18 U.S.C. SECTION 1350, AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report on Form 10-Q of Omada Health, Inc. (the "Company") for the period ended June 30, 2025, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, as amended, that, to the best of my knowledge:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: August 8, 2025

By: /s/ Steve Cook

Steve Cook

Chief Financial Officer

(Principal Financial Officer)