EXHIBIT __
COORDINATING PROVISIONS-STATE/FEDERAL LAW, ACCREDITATION STANDARDS AND GEOGRAPHIC EXCEPTIONS
NORTH CAROLINA

I. INTRODUCTION:

1.1 Scope: To the extent of any conflict between the Agreement, including the administrative handbook as herein incorporated by reference, and this State Law Coordinating Provisions ("SLCP") Exhibit, this SLCP Exhibit shall supersede, govern and control to the extent required by federal and/or state law and to the extent that MultiPlan, Inc. on behalf of itself and its subsidiaries ("MPI"), Provider and/or Client are subject to such federal or state law.

1.2 Terms: The terms used in this exhibit are the defined terms as specified in the applicable federal and/or state law. The specific form Agreement between the parties may utilize defined terms other than those noted in the federal and/or state law(s). For purposes of this exhibit, provider means a licensed facility or licensed, registered or certified health care professional(s) contracted to provide health care services under this Agreement.

1.3 Citations: The citations are current as of the date of this SLCP. Recodification of statutory and/or regulatory citations does not nullify the intent of the provision.

II. FEDERAL LAW COORDINATING PROVISIONS:

2.1 Federal Employees Health Benefits ("FEHB"). As applicable, this Agreement is subject to the terms of the laws governing FEHB.

2.2 Federal Employees Health Benefits ("FEHB") Plan. The parties agree that any and all claims or disputes relating to such benefits under a FEHB Plan will be governed exclusively by the terms of such federal government contract and federal law, whether or not such terms and laws are specified in this SLCP Exhibit or elsewhere in this Agreement.

III. STATE LAW COORDINATING PROVISIONS: NORTH CAROLINA

Where the statutory requirement is an additional obligation not otherwise specified in the Agreement, the parties agree that the statutory requirement will be added as an obligation. Where the statutory requirement specifically conflicts with a current obligation, the statutory requirement shall take precedence and replace the existing obligation as to the statutory requirement only, and shall not void any other valid provision of this Agreement. The statutory requirements identified below are limited to only those entities specifically covered by the statute.

3.1 As required by the North Carolina Department of Insurance, Emergency Medical Condition is defined pursuant to N.C.G.S. §58-3-190(g)(1) to mean a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:
   a. Placing the health of an individual, 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.
   c. Serious dysfunction of any bodily organ or part.

3.2 As required by the North Carolina Department of Insurance, Emergency Services is defined pursuant to N.C.G.S. §58-3-190(g)(2) to mean health care items and services furnished or required to be screened for or treated an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

3.3 As required by the North Carolina Department of Insurance, medical necessity is defined pursuant to N.C.G.S. §58-3-200(b) to mean "covered services or supplies that are:
   a. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease.
   b. Not for experimental, investigational, or cosmetic purposes, except as allowed by N.C.G.S. §58-3-255.
   c. Necessary for, and appropriate to, the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.
   d. Within generally accepted standards of medical care in the community.
   e. Not solely for the convenience of the Participant, the Participant's family, or the Network Provider."

3.4 As required by N.C.G.S. §58-3-225, (b)-(d), and (f), provider shall submit claims for payment within one hundred eighty (180) calendar days of furnishing health care services. Carrier shall comply with the claim denial notice requirements in N.C.G.S. §58-3-225(c). In the event the claim is not a clean claim, carrier shall, within thirty (30)

calendar days, notify provider that such claim is incomplete. In the event carrier requires additional information to process the claim, carrier shall allow provider ninety (90) business days to submit such additional information.

3.5 As required by N.C.G.S. §58-3-225(h), provider may collect underpayments or nonpayments by carrier for a time period of up to two (2) years. Carrier may recover overpayments or offset future payments for a time period of up to two (2) years after the date of the original claim payment unless carrier has reasonable belief of fraud or other intentional misconduct by provider.

3.6 As required by N.C.G.S. §58-3-227, carrier shall make the applicable fee schedule and claims submission and reimbursement policies available to providers.

3.7 As required by N.C.G.S. §58-50-270(1) "Amendment" means any change to the terms of this Agreement, including terms incorporated by reference, that modifies fee schedules. A change required by federal or State law, rule, regulation, administrative hearing, or court order is not an Amendment.

3.8 As required by N.C.G.S. §58-50-275(b) all notices provided under this Agreement shall be one or more of the following, calculated as (i) five (5) business days following the date the notice is placed, first class postage prepaid, in the United States mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service the date of delivery. Notwithstanding the foregoing, nothing in N.C.G.S. §58-50-275(b) prohibits the use of electronic medium for a communication other than an Amendment if agreed to by the parties.

3.9 As required by N.C.G.S. §58-50-280,

(a) Any proposed contract amendment shall be sent to the notice contact of a provider pursuant to G.S. 58-50-275. The proposed amendment shall be dated, labeled "Amendment," signed by the carrier, and include an effective date for the proposed amendment.

(b) A provider receiving a proposed amendment shall be given at least 60 days from the date of receipt to object to the proposed amendment. The proposed amendment shall be effective upon the provider failing to object in writing within 60 days.

(c) If a provider objects to a proposed amendment, then the proposed amendment is not effective and the initiating carrier shall be entitled to terminate the contract upon 60 days written notice to the provider.

(d) Nothing in this section prohibits the parties from negotiating contract terms that provide for mutual consent to an amendment, a process for reaching mutual consent, or alternative notice contacts.

3.10 As required by N.C.G.S. §58-50-285, (a) carrier shall provide a copy of its policies and procedures to a health care provider prior to execution of a new or amended contract and annually to all contracted health care providers. Such policies and procedures may be provided to the health care provider in hard copy, CD, or other electronic format, and may also be provided by posting the policies and procedures on the Web site of the health plan or insurer; and (b) The policies and procedures of carrier shall not conflict with or override any term of a contract, including contract fee schedules. In the event of a conflict between a policy or procedure and the language in a contract, the contract language shall prevail.

3.11 As required by 11 N.C.A.C. 20.0202(1), this contract and any attached or incorporated amendments, exhibits, or appendices constitute the entire contract between the parties.

3.12 As required by 11 N.C.A.C. 20.0202(3), the term of the Agreement is as stated in the underlying Agreement. If the underlying Agreement does not specify a term, the Agreement is effective on the effective date and will continue in effect for a period of one (1) year. Unless otherwise terminated as specified in this Agreement, this Agreement shall renew automatically for consecutive one (1) year terms on the anniversary of the effective date.

3.13 As required by 11 N.C.A.C. 20.0202(4), the termination rights are as stated in the underlying Agreement. In the event the underlying Agreement does not include any termination rights, the termination rights are as follows:

Discretionary Termination. After the expiration of the Initial Term, this Agreement may be terminated in the sole discretion of either party, by the provision of written notice at least ninety (90) days prior to the Renewal Date, such termination to be effective on the Renewal Date.

Termination for Material Breach.

a. This Agreement may be terminated by carrier upon written notice to provider if (i) any action is taken which requires provider to provide carrier with notice; (ii) in the sole discretion of carrier, if provider fails to comply with the quality management and/or credentialing/recredentialing program(s) specified in the administrative handbook(s); or (iii) provider fails to comply with any applicable state and/or federal law related to the delivery of health care services.

b. In the event that one party commits a material breach of this Agreement (the "Breaching Party") this Agreement will terminate upon the provision of at least thirty (30) days written notice to the Breaching Party specifying the material breach. The Breaching Party may cure the breach within such thirty (30) day period, provided however, that failure to cure said breach will result in termination as of the date specified in the notice.

Network Participation Termination. Either party may terminate this Agreement as to any of the networks in which provider participates by the provision of at least ninety (90) days prior written notice to the other party provided however, provider maintains participation in at least one network. Termination of a Network will not terminate this Agreement as to any other Networks in which provider participates.

3.14 As required by 11 N.C.A.C. 20.0202 (5) (a), after termination of the provider contract or in the case of the carrier or intermediary's insolvency provider shall ensure that any administrative duties and records shall be transitioned.

3.15 As required by 11 N.C.A.C. 20.0202 (6), The provider shall maintain licensure, accreditation, and credentials sufficient to meet the carrier's credential verification program requirements and to notify the carrier of subsequent changes in status of any information relating to the provider's professional credentials.

3.16 As required by 11 N.C.A.C. 20.0202 (7), provider shall maintain professional liability insurance coverage in accordance with carrier policies and procedures and the administrative handbook. Provider shall notify the carrier of subsequent changes in status of professional liability insurance on a timely basis.

3.17 As required by 11 N.C.A.C 20.0202 (9), provider shall arrange for call coverage or other back-up to provide service in accordance with the carrier's standards for provider accessibility.

3.18 As required by 11 N.C.A.C 20.0202 (10), carrier shall provide a mechanism that allows providers to verify member eligibility, based on current information held by the carrier, before rendering health care services.

3.19 As required by 11 N.C.A.C. 20.0202 (11), provider shall:
a. Maintain confidentiality of enrollee medical records and personal information as required by G.S. 58, Article 39 and other health records as required by law.
b. Maintain adequate medical and other health records according to industry and carrier standards.
c. Make copies of such records available to the carrier and Department in conjunction with its regulation of the carrier.

3.20 As required by 11 N.C.A.C. 20.0202 (12), provider shall cooperate with members in member grievance procedures.

3.21 As required by 11 N.C.A.C. 20.0202 (13), provider shall not discriminate against members on the basis of race, color, national origin, gender, age, religion, marital status, health status, or health insurance coverage.

3.22 As required by 11 N.C.A.C. 20.0202 (15)(b), The carrier shall provide information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies. Notification of changes in these requirements shall also be provided by the carrier, allowing providers time to comply with such changes.

3.23 As required by 11 N.C.A.C. 20.0202 (16), provider shall comply with the carrier's utilization management programs, credential verification programs, quality management programs, and provider sanctions programs. None of these shall override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to their patients.

3.24 As required by 11 N.C.A.C. 20.0202 (17), provider authorizes and the carrier shall include the name of the provider or the provider group in the provider directory distributed to its members.

3.25 As required by 11 N.C.A.C. 20.0202 (18), the dispute resolution process is as stated in the underlying Agreement. In the event the underlying Agreement does not include any dispute resolution process, the dispute resolution process is as stated in the Administrative Handbook.

3.26 As required by 11 N.C.A.C. 20.0202 (19), provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the carrier. Carrier shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.

3.27 As required by 11 N.C.A.C. 20.0204,
(i) All provider contracts used by the intermediary shall comply with, and include applicable provisions of, *11 NCAC 20.0202*;
(ii) Network carrier retains its legal responsibility to monitor and oversee the offering of services to its members and financial responsibility to its members; .(iii) Intermediary may not subcontract for its services without the carrier's written permission; (iv) carrier may approve or disapprove participation of individual providers

contracting with the intermediary for inclusion in or removal from the carrier's own network plan; (v) carrier shall retain copies or the intermediary shall make available for review by the Department all provider contracts and subcontracts held by the intermediary; and.(vi) The intermediary shall comply with all applicable statutory and regulatory requirements that apply to the functions delegated by the carrier and assumed by the intermediary.

3.28 As required by the NC Department of Insurance, for the PHCS or Primary Network in North Carolina, MPI contracts on behalf of itself and its wholly owned subsidiary Private Healthcare Systems, Inc.

IV. ACCREDITATION STANDARDS COORDINATING PROVISIONS:

There are no Accreditation Standards Coordinating Provisions at this time.

V. GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS:

There are no Geographic Exceptions Coordinating Provisions at this time.