EXHIBIT C
COORDINATING PROVISIONS: STATE LAW,
ACCREDITATION STANDARDS AND GEOGRAPHIC EXCEPTIONS

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 Exhibit, this 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 Exhibit. Recodification of statutory and/or regulatory citations does not nullify the intent of the provision.

II. STATE LAW COORDINATING PROVISIONS: NEW JERSEY

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.

2.1 As required by N.J.A.C. 11:24B-5.2(a)(1), any provision of this Agreement that conflicts with State or Federal law is hereby amended to conform to such applicable State or Federal or law.

2.2 As required by N.J.A.C. 11:24B-5.2(a)(2), provider shall comply with the appeal rights specific to denial of additional provider compensation as stated in the underlying Agreement. In the event the underlying Agreement does not state such appeal rights, the provider may appeal a decision denying the provider additional compensation to which provider believes he or she is entitled under the terms of the provider agreement.

2.3 As required by N.J.A.C. 11:24B-5.2(a)(3), provider's activities and records relevant to the provision of health care services may be monitored from time to time either by the ODS, the carrier, or another contractor acting on behalf of the carrier in order for the ODS or the carrier to perform quality assurance and continuous quality improvement functions.

2.4 As required by N.J.A.C. 11:24B-5.2(a)(4), provider shall comply with the quality assurance program of the ODS and/or carrier, as applicable, and as stated in the underlying Agreement. In the event the underlying Agreement does not contain information regarding the quality assurance program, provider shall observe the quality assurance protocols contained in the administrative handbook. ODS shall be responsible for the day to day administration of its quality assurance program. If provider has a complaint regarding the quality assurance program, provider may follow the complaint process in the underlying Agreement. In the event the underlying Agreement does not include a mechanism to lodge a complaint, provider may contact MultiPlan's Service Operations Department.

2.5 As required by N.J.A.C. 11:24B-5.2(a)(5) & (6), provider shall comply with the carrier's utilization management ("UM") program. Carrier is responsible for the day to day operation of its UM program. Provider may contact carrier via the phone number or website indicated on covered persons identification for information regarding UM decisions, appeals and protocols as required by N.J.A.C. 11:24B-5.2 (a)(5)(ii)-(iv). Provider may rely upon the written or oral authorization for a service if made by carrier. Services shall not be retroactively denied as not medically necessary except in cases of material misrepresentation of the facts or fraud to carrier. In the event that an appeal instituted by a provider on behalf of a covered person will be entertained as a member utilization management appeal without covered person's consent, the appeal

will not be eligible for the Independent Health Care Appeals Program, established pursuant to N.J.S.A. 26:2S-11, until the covered person's specific consent to the appeal is obtained.

2.6 As required by N.J.A.C. 11:24B-5.2(a)(7), this Agreement is governed by New Jersey law with respect to health care services rendered in the State of New Jersey.

2.7 As required by N.J.A.C. 11:24B-5.2(a)(8), the term of this Agreement is as stated in the underlying Agreement. In the event the underlying Agreement does not state the term of this Agreement, then this Agreement will become effective on the effective date of the underlying Agreement and will continue in effect for a period of one (1) year ("Initial Term"). Unless otherwise terminated, this Agreement shall renew automatically for consecutive one (1) year terms ("Renewal Term") on each anniversary of the effective date ("Renewal Date").

2.8 As required by N.J.A.C. 11:24B-5.2(a)(9) and N.J.A.C. 11:24B-5.3 (a), 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 ODS upon written notice to provider if (i) any action is taken which requires provider to provide ODS with notice; (ii) in the sole discretion of ODS, 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.

2.9 As required by N.J.A.C. 11:24B-5.2(a)(10), provider shall not bill or otherwise pursue payment from a carrier's covered person for the costs of services or supplies rendered in-network that are covered, or for which benefits are payable, under the covered person's health benefits plan, except for copayment, coinsurance or deductible amounts set forth in the health benefits plan, regardless of whether the provider agrees with the amount paid or to be paid, for the services or supplies rendered.

2.10 As required by N.J.A.C. 11:24B-5.2(a)(11), provider shall cooperate and comply with the terms of the credentialing/recredentialing program(s) and otherwise be eligible to participate in various programs, as appropriate. Initial Credentialing shall be completed prior to provider's participation in a network and recredentialing shall be completed every three (3) years thereafter or as otherwise required by ODS policy.

2.11 As required by N.J.A.C. 11:24B-5.2(a)(12), provider will maintain professional liability insurance as required by the underlying Agreement, but such amount shall not be less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year.

2.12 As required by N.J.A.C. 11:24B-5.2(a)(13), provider will render medical and health care services in a manner which assures availability, adequacy, and continuity of care to covered persons. Health care services means health care treatment and supplies rendered by a provider and provided to a covered person for which a carrier is responsible for payment pursuant to the terms of a health benefits plan.

2.13 As required by N.J.A.C. 11:24B-5.2(a)(14), provider has the right and obligation to communicate openly with covered persons regarding diagnostic tests and treatment options.

2.14 As required by N.J.A.C. 11:24-5.2(a)(15), provider shall not be terminated or otherwise penalized because of complaints or appeals that the provider files on his or her own behalf, or on behalf of a covered person, or for otherwise acting as an advocate for covered persons in seeking appropriate, medically necessary health care services covered under the covered person's health benefits plan.

2.15 As required by N.J.A.C. 11:24B-5.2(a)(16), provider shall not discriminate in his or her treatment of a carrier's covered persons.

2.16 As required by N.J.A.C. 11:24B-5.2(a)(17) and N.J.A.C. 11:22-3.4, all providers shall file claims for payment unless the patient, at his or her option, files the claim directly. Where a claim is being filed by the provider on behalf of the patient without an assignment of benefits, the provider shall file the claim within 60 days of the last date of service of that course of treatment. Where the provider is filing a claim under an assignment of benefits from the patient, the provider shall file the claim within 180 days of the last date of service of the course of treatment. If the carrier or its agent fails to pay a clean claim within the time limits set forth in N.J.A.C. 11:22-1.5, the carrier shall include simple interest on the claim amount at the rate of 10 percent per year and shall either add the interest amount to the claim amount when paying the claim or issue an interest payment within 14 days of the payment of the claim. Interest shall accrue beginning 30 or 40 days, as applicable, from the date all information and documentation required to process the claim is received by the carrier. The carrier may aggregate interest amounts up to $ 25.00, with the consent of the provider. In no event shall provider be required to request payment of such interest from, as applicable, as a condition of receiving such interest payment.

2.17 As required by N.J.A.C. 11:24B-5.2(a)(17) and N.J.A.C. 11:22-3.4, in the event a provider does not file the claim within 180 days of the last date of service of a course of treatment, the carrier shall in accordance with N.J.A.C. 11:22-1.6 reserve the right to deny or dispute the claim and the provider shall be prohibited from seeking payment in whole or in part directly from the patient. Carrier shall advise provider that payment of the claim, in whole or in part, will be made based upon consideration of the following factors that shall be addressed by the provider: (i) the good faith use of information provided by the patient to the provider with respect to the identity of the patient's health benefits payer; (ii) delays encountered in filing a claim related to the coordination of benefits among third party payers; (iii) whether the provider has previously filed untimely claims or has an established pattern of untimely claim practices; (iv) any prejudice to the rights of the patient and/or the health benefits provider in determination of the medical necessity of the services and care being billed for; and (v) potential adverse impact to the public.

2.18 As required by N.J.A.C. 11:24B-5.2 (a)(17) and N.J.A.C. 11:22-3.4, providers failing to file a claim within 180 days in accordance with N.J.A.C. 11:22-3.4(d) whose claim for payment has been denied in whole or in part may, in the discretion of a Judge of the Superior Court, be permitted to refile the claim where there has not been substantial prejudice to the health benefit payer. Application to the Superior Court for permission to refile a claim shall be made within 14 days of the notification of denial of payment and shall be made upon motion based upon affidavit(s) showing sufficient reason(s) for the failure to file the claim with the third party payer within the required time.

2.19 As required by N.J.A.C. 11:24B-5.2(a)(18), the dispute resolution process is as stated in the underlying Agreement. In the event the underlying Agreement does not contain a dispute resolution process, the dispute resolution process is as stated in the administrative handbook. Provider may submit and seek resolution of a complaint or grievance, separate and apart from submitting complaints and grievances on behalf of covered person(s), and complaints addressing compensation of claims issues to ODS at MultiPlan, Inc. Service Operations Department 16 Crosby Drive Bedford, MA 01730. Such resolution shall not exceed thirty (30) calendar days following the receipt of the complaint or grievance. In the event provider is not satisfied with the resolution of the complaint or grievance, provider may submit the complaint or grievance to the New Jersey Department of Banking and Insurance or the New Jersey Department of Human Services, depending on the issue involved.

2.20 As required by N.J.A.C. 11:24B-5.2(a)(19), all information and materials provided by ODS or carrier to provider will remain proprietary to ODS or carrier, respectively. Provider will not disclose any of such information or materials or use them except as may be required to carry out its respective obligations under this Agreement. Provider shall comply with the confidentiality of medical and billing records as stated in the underlying Agreement. In the event, the underlying Agreement does not contain a provision with respect to the confidentiality of medical and billing records then provider will comply with all state and federal laws

and the requirements specified in the ODS administrative handbook(s) pertaining to the confidentiality of medical and billing records, and will keep confidential, and take all precautions to prevent the unauthorized disclosure of any and all medical and billing records.

2.21 As required by N.J.A.C. 11:24B-5.2(c)(8), nothing in this Agreement shall require provider to assure that it never charges ODS or carrier a rate that is greater than the least amount charged to another entity with which the provider contracts for similar services.

2.22 As required by N.J.A.C. 11:24B-5.3(a)(2), in the event provider believes that a carrier has repeatedly failed to comply with requirements specified in this Agreement with respect to the timely payment of claims to provider or otherwise failed to abide by the requirements for access to this Agreement, provider shall notify ODS and carrier immediately in writing and may request that such carrier be excluded from access under this Agreement. Within thirty (30) days of receipt of such notice from provider, or within such extended time period to which the parties mutually agree ("Resolution Time Period"), ODS will attempt to resolve the matter, pursuant to the Agreement, to the reasonable satisfaction of provider such that the carrier will not be excluded from access under this Agreement. At the end of the Resolution Time Period, if ODS finds that the carrier failed to adequately abide by the requirements for access to this Agreement and cannot resolve the matter to the reasonable satisfaction of provider, ODS shall exclude such carrier from access under this Agreement effective thirty (30) days after the expiration of the Resolution Time Period.

2.23 As required by N.J.A.C. 11:24B-5.3(c), if the provider is a health care professional, when the provider's status as a participating provider in a network is being terminated, written notice shall be issued to the provider no less than 90 days prior to the date of termination, except that the 90-day prior notice requirement need not apply when the contract is being terminated upon its date of renewal, or upon its anniversary date, if no annual renewal date is specified, or is being terminated because of breach, alleged fraud, or because, in the opinion of the medical director of either the ODS or the carrier, if different, the health care professional presents an imminent danger to one or more covered persons, or the public health, safety or welfare. The health care professional shall receive a written statement setting forth the reason(s) for the termination, and the procedures for obtaining such a written statement, in the event that the written notice of termination does not include a statement setting forth the reason(s) for the termination.

2.24 As required by N.J.A.C. 11:24B-5.3(d), the health care professional shall have the right to request a hearing following a notice that the health care professional's status as a participating provider with a carrier is being terminated, except that the right to a hearing may not apply when the termination occurs on the date of renewal of the contract, or upon the contract's anniversary date, if no annual renewal date is specified, or termination is based on breach or alleged fraud, or because, in the opinion of the medical director of either the ODS or the carrier, if different, the health care professional presents an imminent danger to one or more covered persons, or the public health, safety or welfare.

2.25 As required by N.J.A.C. 11:24B-5.3(e), provider may submit a request for a hearing as outlined in the letter of termination sent by ODS when a health care professional is terminated from participation in the ODS's network. The hearing procedures shall be consistent with the requirements of N.J.A.C. 11:24-3.6 or 11:24A-4.9, as appropriate.

2.26 As required by N.J.A.C. 11:24B-5.3(f) and (g), when a provider's status as a participating provider is terminated, or when the contract between the ODS and the provider terminates, regardless of the party initiating the termination, the provider, if a physician, shall remain obligated to provide services for covered persons in accordance with the following:

1. For up to four months following the effective date of the termination in cases where it is medically necessary for the covered person to continue treatment with the health care professional, except as 2 through 5 below applies;
2. In cases of the pregnancy of a covered person, through the postpartum evaluation of the covered person, up to six weeks after delivery;
3. In the case of post-operative care, up to six months following the effective date of the termination;
4. In the case of oncological treatment, up to one year following the effective date of the termination; and
5. In the case of psychiatric treatment, up to one year following the effective date of the termination.

The above referenced obligations for provider to continue to provide care, and for the carrier or its designee to pay for services rendered by the provider following the effective date of termination do not apply when

the termination is based on breach or alleged fraud, or because, in the opinion of the medical director of either the ODS or the carrier, if different, the health care professional presents an imminent danger to one or more covered persons, or the public health, safety or welfare.

2.27 As required by N.J.A.C. 11:24C-4.3(c)(5), carrier may enter into an agreement with third parties allowing the third parties to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity.

2.28 In the event that provider is offering services or supplies to a covered person for a carrier or intermediary that has been approved by the State of New Jersey as a Workers' Compensation Managed Care Organization pursuant to N.J.A.C. 11:6-2.3 then as required by N.J.A.C. 11:6-2.10(d)(4), provider shall hold such covered person harmless for the cost of any services or supplies under the carrier's or intermediary's program for workers' compensation, whether or not the provider believes its compensation for services or supplies from the carrier or intermediary is made in accordance with the reimbursement provisions of this Agreement, or is otherwise inadequate.

III. ACCREDITATION STANDARDS COORDINATING PROVISIONS:

There are no Accreditation Standards Coordinating Provisions at this time.

IV. GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: NEW JERSEY

There are no Geographic Exceptions Coordinating Provisions at this time.