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., d/b/a Claritev, Inc., on behalf of itself and its subsidiaries (collectively "Claritev"), 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: COLORADO

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 C.R.S. § 10-16-121(1)(a), neither the provider nor the carrier is prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of the carrier or provider.

2.2 As required by C.R.S. § 10-16-121(1)(b)(I), carrier may not take an adverse action against a provider because the provider expresses disagreement with a carrier's decision to deny or limit benefits to a covered person or because the provider assists the covered person to seek reconsideration of the carrier's decision or because a 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 the plan or not, policy provisions of a plan, or a provider's personal recommendation regarding selection of a health plan based on the provider's personal knowledge of the health needs of such patients.

2.3 As required by C.R.S. § 10-16-121(1)(b)(II), carrier may not take an adverse action against a provider because the provider, acting in good faith:

(A) communicates with a public official or other person concerning public policy issues related to health care items or services;

(B) files a complaint, makes a report, or comments to an appropriate governmental body regarding actions, policies, or practices of the carrier the provider believes might negatively affect the quality of, or access to, patient care;

(C) provides testimony, evidence, opinion, or any other public activity in any forum concerning a violation or possible violation of any provision of this section;

(D) reports what the provider believes to be a violation of law to an appropriate authority; or

(E) participates in any investigation into a violation or possible violation of any provision of this section.

2.4 As required by C.R.S. § 10-16-121(1)(c), carrier shall comply with § 10-16-106.5(3)-(5), as applicable.

2.5 As required by C.R.S. § 10-16-121(1)(d), provider shall not be subjected to financial disincentives based on the number of referrals made to participating providers in the health plan for covered benefits so long as the provider making the referral adheres to the carrier's or the carrier's intermediary's utilization review policies and procedures.

2.6 As required by C.R.S. § 10-16-705(3), covered persons shall, in no circumstances, be liable for money owed to participating providers by the plan and that in no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the carrier. Nothing in this section shall prohibit a participating provider from collecting coinsurance, deductibles, or copayments as specifically provided in the covered person's contract with the managed care plan.

2.7 As required by C.R.S. § 10-16-705(4), Each managed care plan shall allow covered persons to continue receiving care for sixty days from the date a participating provider is terminated by the plan without cause when proper notice

as specified in C.R.S. § 10-16-705(7) has not been provided to the covered person. In the circumstance that coverage is terminated for any reason other than nonpayment of the premium, fraud, or abuse, every managed care plan shall provide for continued care for covered persons being treated at an in-patient facility until the patient is discharged.

2.8 As required by C.R.S. § 10-16-705(9), participating providers shall not discriminate, with respect to the provision of medically necessary covered benefits, against covered persons that are participants in a publicly financed program.

2.9 As required by C.R.S. § 10-16-705(14), the sole responsibility for obtaining any necessary preauthorization rests with the participating provider that recommends or orders said services, treatments, or procedures, not with the covered person. A covered person may receive a standing referral for medically necessary treatment pursuant to C.R.S. § 10-16-705 (14)(b).

2.10 As required by C.R.S. § 25-37-108(2)(c), this Agreement applies to network rental arrangements and is for the purpose of assigning, allowing access to, selling, renting, or giving the person's or entity's rights to the health care provider's services.

2.11 As required by C.R.S. § 25-37-111(2), for a contract with a duration of less than two years each party shall have a right to terminate the contract without cause as stated in the underlying agreement, but in no event upon less than ninety days' written notice. For a contract with a duration of two or more years each party shall have the right to terminate the contract without cause as stated in the underlying agreement, but in no event upon less than sixty days' written notice as required by C.R.S. § 10-16-705(7).

III. ACCREDITATION STANDARDS COORDINATING PROVISIONS:

There are no Accreditation Standards Coordinating Provisions at this time.

IV. GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: COLORADO

4.1 Professional Liability and Comprehensive General Liability Insurance. As allowed by C.R.S. § 24-10-106, if provider is a public entity, as defined by C.R.S. § 24-10-103, and operates a public hospital, provider will maintain professional liability insurance and comprehensive general liability insurance in an amount necessary to cover its statutory liability. Provider's statutory liability is limited to the amounts set out in C.R.S. § 24-10-114.

Colorado Summary Disclosure Form

As required by C.R.S. § 25-37-103, this Summary Disclosure Form is for informational purposes only and shall not be a term or condition of the Agreement.

1. Compensation or Payment Terms: Article V and Contract Rate Exhibit

2. Category of Coverage: Definition of Program

3. Duration of the Contract: Article II

4. Contract Termination: Article II

5. Person/Entity Responsible for Processing Claims: Article V

6. Dispute Resolution: Article V and Article VIII

7. Subject and Order of Addenda:

    A. Amendment Exhibit (if applicable)
    B. Network Participation Requirements
    C. Coordinating Provisions State/Federal Law and Accreditation Standards
    D. Contract Rates
    E. List of Locations (if applicable)
    F. Service Requirements (if applicable)