
EXHIBIT
COORDINATING PROVISIONS-STATE/FEDERAL LAW, ACCREDITATION STANDARDS
AND GEOGRAPHIC EXCEPTIONS
RHODE ISLAND

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 a 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: RHODE ISLAND

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 230-RICR- 20-30-9.9(A)(1)(a), beneficiary shall be held harmless from any financial liability beyond in-network cost shares attributable to the failure of a referring network provider to adhere to the referral process, including by failing to submit the required network plan’s referral documents according to the health care entity requirements when there is evidence that the beneficiary sought and received a referral from the network provider. This section is not applicable in cases where the beneficiary has self-referred.
- 3.2 As required by 230-RICR- 20-30-9.9(A)(1)(b), in no event, including but not limited to non-payment by the health care entity or intermediary, insolvency of the health care entity or one of its delegates or breach of the health care entity’s agreement with a network plan provider, shall the network plan provider bill, charge, collect a deposit from, or seek compensation, remuneration or reimbursement from a beneficiary to include but not limited to facility or administrative fees added to a beneficiary for covered services by the provider.
- 3.3 As required by 230-RICR- 20-30-9.9(A)(1)(c), no beneficiary shall be liable to any provider for charges for covered benefits, except for the amounts due for co-payments, deductibles and/or coinsurance, when provided or made available to enrolled participants by a licensed health maintenance organization, as that term is defined in R.I. Gen. Laws § 27-41-2(t), during a period in which premiums were paid by or on behalf of the enrollee.
- 3.4 As required by 230-RICR- 20-30-9.9(A)(2), in the event of a provider contract termination:
 - a. The beneficiary shall be held harmless for covered benefits except for amounts due for co-payments, coinsurance, and deductibles, for the duration of an active course of treatment or up to one year, whichever is earlier, subject to all the terms and conditions of the terminated provider contract, unless the provider is able to safely transition the patient to a network provider; and
 - b. For this period of active treatment, the beneficiary shall only be responsible for in-network cost shares provided for under the beneficiaries’ coverage documents and not otherwise prohibited by state or federal laws or regulations.

3.5 As required by 230-RICR- 20-30-9.9(B)(4), termination due to a material modification, as defined in 230-RICR- 20-30-9.3, in a professional provider contract shall not affect the method of payment or reduce the amount of reimbursement to the provider by the health care entity for any beneficiary in active treatment for an acute medical condition at the time the beneficiary's provider terminates until the active course of treatment is concluded or, if earlier, one year after the termination.

3.6 As required by 230-RICR- 20-30-9.9(G), neither party shall terminate this Agreement without cause.

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.