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

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, participating 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: MASSACHUSETTS

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 211 CMR 52.03, Emergency Medical Condition means 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 a body organ or part, or with respect to a pregnant woman as further defined in Section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. Section 1395dd (e)(1)(B).

3.2 As required by 211 CMR 52.11(1), carrier shall not refuse to contract with or compensate for covered services an otherwise eligible health care provider solely because such provider has in good faith:

(a) communicated with or advocated on behalf of one or more of his prospective, current or former patients regarding the provisions, terms or requirements of the carrier's health benefit plans as they relate to the needs of such provider's patients; or
(b) communicated with one or more of his prospective, current or former patients with respect to the method by which such provider is compensated by the carrier for services provided to the patient

3.3 As required by 211 CMR 52.11(2), provider is not required to indemnify the carrier 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 the carrier based on the carrier's management decisions, utilization review provisions or other policies, guidelines or actions.

3.4 As required by 211CMR 52.11(6), neither the carrier nor the provider has the right to terminate the contract without cause.

3.5 As required by 211CMR 52.11(7), carrier shall provide a written statement to a provider of the reason or reasons for such provider's involuntary disenrollment.

3.6 As required by 211 CMR 52.11(8), the carrier shall notify providers in writing of modifications in payments, modifications in covered services or modifications in a carrier'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 the providers, and the effective date of the modifications. The notice shall be provided 60 days before the effective date of such modification unless such other date for notice is mutually agreed upon between the carrier and the provider.

3.7 As required by 211 CMR 52.11(9), providers shall not bill patients for charges for covered services other than for deductibles, copayments, or coinsurance.

3.8 As required by 211 CMR 52.11(10), health care providers shall not bill patients for nonpayment by the carrier of amounts owed under the contract due to the insolvency of the carrier. This requirement shall survive the termination of the contract for services rendered prior to the termination of the contract, regardless of the cause of the termination.

3.9 As required by 211 CMR 52.11(11) provider shall comply with the carrier's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.

3.10 As required by 211 CMR 52.11(15), Nurse Practitioners and Physician Assistants acting within the scope of their professional license are recognized as Participating Providers under applicable terms of this Agreement.

3.11 As required by Mass. Gen. Laws Ch.176I §2, within 45 days after the receipt by the organization of completed forms for reimbursement to the health care provider, the organization shall (i) make payments for the provision of such services, (ii) notify the provider in writing of the reason or reasons for nonpayment, or (iii) notify the provider in writing of what additional information or documentation is necessary to complete said forms for such reimbursement. If the organization fails to comply with the provisions of this paragraph for any claims related to the provision of health care services, said organization shall pay, in addition to any reimbursement for health care services provided, interest on such benefits, which shall accrue beginning 45 days after the organization's receipt of request for reimbursement at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim that the organization is investigating because of suspected fraud.

3.12 As required by the Massachusetts Division of Insurance, provider shall provide advance disclosure or notification to the carrier of any arrangements to charge an annual fee to members as a condition to continue to be a part of a providers' panel of patients.

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.