EXHIBIT C
COORDINATING PROVISIONS-STATE/FEDERAL LAW, ACCREDITATION STANDARDS AND GEOGRAPHIC EXCEPTIONS
WASHINGTON

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: WASHINGTON

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 WAC 284-43-2050, all prior authorization requests must be submitted to the carrier or the carrier's designee. Carriers must have a current and accurate secure online prior authorization process. A participating provider or facility may appeal a prior authorization denial by contacting the carrier or the carrier's designee. Participating providers and facilities may contact the carrier for information regarding the carrier's prior authorization process and how to access the online prior authorization process, which must be consistent with WAC 284-43-2050.

3.2 As required by WAC 284-170-240(1)(a), carriers regulated by the Office of the Insurance Commissioner in Washington may not elect to use less than one hundred percent of the subcontracted network or networks in its service area.

3.3 As required by WAC 284-170-380, carriers must allow a contracted network provider to arrange for a substitute provider for at least sixty days during any calendar year. A carrier must grant an extension if a contracted network provider demonstrates that exceptional circumstances require additional time away from his or her practice.

3.4 As required by WAC 284-170-411(4), an issuer must make its selection standards for participating providers and facilities available for review upon request by the commissioner.

3.5 As required by WAC 284-170-421(1), an issuer must establish a mechanism by which participating providers and facilities can obtain timely information on patient eligibility for health care services and health plan

benefits, including any limitations or conditions on services or benefits. Participating providers and facilities may obtain patient eligibility, benefit coverage, prior authorization, and utilization management information from carrier by contacting the number patient's identification card or other identifying information provided by carrier to patient consistent with the terms of this Agreement.

3.6 As required by WAC 284-170-421(2), nothing contained in this Agreement will have the effect of modifying benefits, terms, or conditions contained in the health plan. In the event of any conflict between this Agreement and the health plan, the benefits, terms, and conditions of the health plan will govern with respect to coverage provided to enrollees.

3.7 As required by WAC 284-170-421(3)(a), "Participating provider or facility hereby agrees that in no event, including, but not limited to nonpayment by issuer, issuer's insolvency, or breach of this contract will participating provider or facility bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against an enrollee or person acting on their behalf, other issuer, for services provided pursuant to this contract. This provision does not prohibit collection of deductibles, copayments, coinsurance, and/or payment for non-covered services, which have not otherwise been paid by a primary or secondary issuer in accordance with regulatory standards for coordination of benefits, from enrollees in accordance with the terms of the enrollee's health plan."

3.8 As required by WAC 284-170-421(3)(b), "Participating provider or facility agrees, in the event of issuer's insolvency, to continue to provide the services promised in this contract to enrollees of issuer for the duration of the period for which premiums on behalf of the enrollee were paid to issuer or until the enrollee's discharge from inpatient facilities, whichever time is greater."

3.9 As required by WAC 284-170-421(3)(c), "Notwithstanding any other provision of this contract, nothing in this contract shall be construed to modify the rights and benefits contained in the enrollee's health plan."

3.10 As required by WAC 284-170-421(3)(d), "Participating provider or facility may not bill the enrollee for covered services (except for deductibles, copayments, or coinsurance) where issuer denies payments because the provider or facility has failed to comply with the terms or conditions of this contract."

3.11 As required by WAC 284-170-421(3)(e), "Participating provider or facility further agrees (i) that the provisions of (a), (b), (c), and (d) of this subsection shall survive termination of this contract regardless of the cause giving rise to termination and shall be construed to be for the benefit of issuer's enrollees, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between participating provider and enrollees or persons acting on their behalf."

3.12 As required by WAC 284-170-421(3)(f), "If participating provider or facility contracts with other providers or facilities who agree to provide covered services to enrollees of issuer with the expectation of receiving payment directly or indirectly from issuer, such providers or facilities must agree to abide by the provisions of (a), (b), (c), (d), and (e) of this subsection."

3.13 As required by WAC 284-170-421(4), willfully collecting or attempting to collect an amount from an enrollee knowing that collection to be in violation of this Agreement constitutes a class C felony under RCW 48.80.030(5).

3.14 As required by WAC 284-170-421(5), an issuer or its designee will notify participating providers and facilities of their responsibilities with respect to the health issuer's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance, appeal and adverse benefit determination procedures, data reporting requirements, pharmacy benefit substitution processes, confidentiality requirements and any applicable federal or state requirements.

3.15 As required by WAC 284-170-421(6),

(a) Participating provider and facility must be given reasonable notice of not less than sixty days of changes that affect participating provider and facility compensation or that affect health care service delivery unless changes to federal or state law or regulations make such advance notice impossible, in which case notice must be provided as soon as possible.

(b) (i) Subject to any termination and continuity of care provisions of the contract, participating provider and facility may terminate the contract without penalty if participating provider and facility does not agree

with the changes, subject to the requirements of WAC 284-170-421(9); and (ii) A material amendment to a contract may be rejected by participating provider and facility. The rejection will not affect the terms of the existing contract. A material amendment has the same meaning as in RCW 48.39.005.

(c) No change to the contract may be made retroactive without the express written consent of the participating provider and facility.

3.16 As required by WAC 284-170-421(7)(a), "No health carrier subject to the jurisdiction of the state of Washington may in any way preclude or discourage their providers from informing patients of the care they require, including various treatment options, and whether in their view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the patient's service agreement with the health carrier. No health carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of a patient with a health carrier. Nothing in this section shall be construed to authorize providers to bind health carriers to pay for any service."

3.17 As required by WAC 284-170-421(7)(b), "No health carrier may preclude or discourage patients or those paying for their coverage from discussing the comparative merits of different health carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier."

3.18 As required by WAC 284-170-421(8), subject to applicable state and federal laws related to the confidentiality of medical or health records, participating provider and facility will make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating complaints, grievances, appeals, or review of any adverse benefit determinations of enrollees. Participating provider and facility will cooperate with audit reviews of encounter data in relation to the administration of health plan risk adjustment and reinsurance programs.

3.19 As required by WAC 284-170-421(9), issuer, or its designee, and participating provider and facility must provide at least sixty days' written notice to each other before terminating the contract without cause.

3.20 As required by WAC 284-170-421(11), participating providers and facility will furnish covered services to each enrollee without regard to the enrollee's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

3.21 As required by WAC 284-170-421(13), the dispute resolution process is as stated in the Agreement and/or the administrative handbook (http://www.multiplan.com/providers/education). Except as otherwise required by a specific federal or state statute or regulation governing dispute resolution, no process for the resolution of disputes shall be considered fair under RCW 48.43.055 unless the process meets all the provisions of WAC 284-170-440.

3.22 As required by WAC 284-170-431(2)(a), for health services provided to covered persons, a carrier shall pay providers and facilities as soon as practical but subject to the following minimum standards:

(i) Ninety-five percent of the monthly volume of Clean Claims shall be paid within thirty days of receipt by the responsible carrier or agent of the carrier; and

(ii) Ninety-five percent of the monthly volume of all claims shall be paid or denied within sixty days of receipt by the responsible carrier or agent of the carrier, except as agreed to in writing by the parties on a claim-by-claim basis.

3.23 As required by WAC 284-170-431(2)(b), the receipt date of a claim is the date the responsible carrier or its agent receives either written or electronic notice of the claim.

3.24 As required by WAC 284-170-431(2)(c), carrier shall establish a reasonable method for confirming receipt of claims and responding to provider and facility inquiries about claims.

3.25 As required by WAC 284-170-431(2)(d), any carrier failing to pay claims within the standard established under WAC 284-170-431(2) shall pay interest on undenied and unpaid Clean Claims more than sixty-one days old until the carrier meets such standard. Interest shall be assessed at the rate of one percent per month, and shall be calculated monthly as simple interest prorated for any portion of a month. Carrier shall add the interest payable to the amount of the unpaid claim without the necessity of the provider or facility submitting an

additional claim. Any interest paid under this section shall not be applied by carrier to a covered person's deductible, copayment, coinsurance, or any similar obligation of the covered person.

3.26 As required by WAC 284-170-431(2)(e), when the carrier issues payment in either provider or facility and the covered person names, the carrier shall make claim checks payable in the name of the provider or facility first and the covered person second.

3.27 As required by WAC 284-170-431(3), "Clean Claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this section.

3.28 As required by WAC 284-170-431(4), denial of a claim must be communicated to provider or facility and must include the specific reason why the claim was denied. If the denial is based upon medical necessity or similar grounds, then carrier upon request of the provider or facility must also promptly disclose the supporting basis for the decision.

3.29 As required by WAC 284-170-460(1), this Agreement does not grant the carrier access to health information and other similar records unrelated to covered persons. This provision shall not limit the carrier’s right to ask for and receive information relating to the ability of the provider or facility to deliver health care services that meet the accepted standards of medical care prevalent in the community.

3.30 As required by WAC 284-170-460(2), if the Agreement grants the carrier or its designee access to medical records for audit purposes such access is limited to only that necessary to perform the audit.

3.31 As required by WAC 284-170-460(3), any billing audit standards defined in the Agreement shall be deemed mutual, giving equivalent billing audit rights to carriers and providers or facilities.

3.32 As required by WAC 284-170-470(7), issuer will authorize an emergency fill by the dispensing pharmacist and approve the claim payment.

3.33 As required by WAC 284-170-480, all participating provider and facility agreements will be filed with the commissioner for prior approval and comply with the requirements in WAC 284-170-480 and RCW 48.43.730.

3.34 As required by RCW 48.43.083, if a participating provider agreement is offered to a chiropractor within a single practice organized as a sole proprietorship, partnership, or corporation, the same participating provider agreement must be offered to any other chiropractor within that practice providing services at the same location. Either party may terminate the agreement without cause.

3.35 As required by RCW 48.43.190, a health carrier may not pay a chiropractor less for a service or procedure identified under a particular physical medicine and rehabilitation code, evaluation and management code, or spinal manipulation code, as listed in a nationally recognized services and procedures code book such as the American medical association current procedural terminology code book, than it pays any other type of provider licensed under Title 18 RCW for a service or procedure under the same or substantially similar code, except as provided in RCW 48.43.190(1)(b) of this subsection.

3.36 As required by RCW 48.43.505, health carriers and insurers shall adopt policies and procedures that conform administrative, business, and operational practices to protect an enrollee's and protected individual's right to privacy or right to confidential health care services granted under state or federal laws.

3.37 As required by RCW 48.43.515(7), each carrier must cover services of a primary care provider whose contract with the plan or whose contract with a subcontractor is being terminated by the plan or subcontractor without cause under the terms of that contract for at least sixty days following notice of termination to the enrollees or, in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period. The provider's relationship with the carrier or subcontractor must be continued on the same terms and conditions as those of the contract the plan or subcontractor is terminating, except for any provision requiring that the carrier assign new enrollees to the terminated provider.

3.38 As required by RCW 48.43.525(1), a carrier that offers a health plan shall not retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan’s written policies at the time the care was rendered.

3.39 As required by RCW 48.43.600(1) and RCW 48.43.605(1), except in the case of fraud, or as provided in Article III, sections 27 and 28 below, a carrier or a health care provider may not (a) request a refund of a payment previously made to satisfy a claim unless it does so in writing to the provider within twenty-four months after the date that the claim was denied or payment intended to satisfy the claim was made; or (b) request that a contested refund or additional payment be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier or health care provider believes the other party owes the refund or additional payment. If a provider fails to contest a request from a carrier for a refund in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

3.40 As required by RCW 48.43.600(2) and RCW 48.43.605(2), a carrier or health care provider may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim: (a) request additional payment from a health care provider or carrier to satisfy a claim unless he or she does so in writing to the health care provider or carrier within thirty months after the date the claim was denied or payment intended to satisfy the claim was made; or (b) request that the additional payment be made any sooner than six months after receipt of the request. Any such request must specify why the carrier or health care provider believes the health care provider or carrier owes the refund or additional payment, and include the name and mailing address of any entity that has primary responsibility or disclaimed responsibility for payment of the claim. If a health care provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

3.41 As required by RCW 48.43.600(3), a carrier may at any time request a refund from a health care provider of a payment previously made to satisfy a claim if: (a) A third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law, such as tort liability; and (b) the carrier is unable to recover directly from the third party because the third party has either already paid or will pay the provider for the health services covered by the claim.

3.42 As required by RCW 48.43.600(4) and RCW 48.43.605(3), if Article III, sections 26, 27, and 28 above, conflict with RCW 48.43.600 or RCW 48.43.605, RCW 48.43.600 and/or RCW 48.43.605 shall prevail. However, nothing in RCW 48.43.600 or RCW 48.43.605 prohibits a health care provider or a carrier from choosing at any time to refund a carrier or a health care provider any payment previously made to satisfy a claim.

3.43 As required by RCW 48.43.600(5), "refund" means the return, either directly or through an offset to a future claim, by a carrier, of some or all of a payment already received by a health care provider.

3.44 As required by RCW 48.43.600(6), RCW 48.43.600 neither permits nor precludes a carrier from recovering from a subscriber, enrollee, or beneficiary any amounts paid to a health care provider for benefits to which the subscriber, enrollee, or beneficiary was not entitled under the terms and conditions of the health plan, insurance policy, or other benefit agreement.

3.45 As required by WAC 284-170-433(1)(a), a health carrier shall reimburse a provider for a health care service provided to a covered person through telemedicine or store and forward technology if: (i) The plan provides coverage of the health care service when provided in person by the provider; (ii) The health care service is medically necessary; (iii) The health care service is a service recognized as an essential health benefit under section 1302(b) of the federal Patient Protection and Affordable Care Act in effect on January 1, 2015, RCW 48.43.005 and 48.43.715; (iv) The health care service is determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards, and the technology used to provide the health care service meets the standards required by state and federal laws governing the privacy and security of protected health information. Beginning January 1, 2023, for audio-only telemedicine, the covered person has an established relationship with the provider.

3.46 As required by WAC 284-170-433(2)(a) and RCW 48.43.735, except as otherwise permitted under RCW 48.43.735, a health carrier shall reimburse a provider for a health care service provided to a covered person through telemedicine the same amount of compensation the carrier would pay the provider if the health care service was provided in person by the provider.

3.47 As required by WAC 284-170-433(3)(a), provide that an originating site for a telemedicine health care service subject to subsection (1) of this section includes a: (i) Hospital; (ii) Rural health clinic; (iii) Federally qualified health center; (iv) Physician's or other provider's office; (v) Licensed or certified behavioral health agency; (vi) Skilled nursing facility; (vii) Home or any location determined by the individual receiving the service including, but not limited to, a pharmacy licensed under chapter 18.64 RCW or a school-based health center as defined in RCW 43.70.825. If the site chosen by the individual receiving service is in a state other than the state of Washington, a provider's ability to conduct a telemedicine encounter in that state is determined by the licensure status of the provider and the provider licensure laws of the other state; or (viii) Renal dialysis center, except an independent renal dialysis center.

3.48 As required by WAC 284-170-433(6)(a), if a provider intends to bill a covered person or the covered person's health plan for an audio-only telemedicine service, the provider must obtain patient consent from the covered person for the billing in advance of the service being delivered, consistent with the requirements of this subsection and state and federal laws applicable to obtaining patient consent.

3.49 As required by WAC 284-170-433(9), access to telemedicine services shall be inclusive for those patients who may have disabilities or limited-English proficiency and for whom the use of telemedicine technology may be more challenging, consistent with carriers' obligations under WAC 284-43-5940 through 284-43-5965 with respect to design and implementation of plan benefits.

3.50 As required by RCW 48.43.750, a health carrier shall make a determination approving or denying a credentialing application submitted to the carrier no later than ninety days after receiving a complete application from a health care provider. All determinations made by a health carrier in approving or denying credentialing applications must average no more than sixty days. If a carrier approves a health care provider's credentialing

application, upon completion of the credentialing process, carrier must reimburse health care provider in accordance with RCW 48.43.757.

3.51 As required by RCW 48.43.761, health plans and providers and facilities offering behavioral health and substance use disorder services must comply with the applicable requirements outlined in RCW 48.43.761 and WAC 284-43-2000.

3.52 As required by RCW 48.43.775, a carrier may not require a provider or facility participating in a qualified health plan under RCW 41.05.410 to, as a condition of participation in a qualified health plan under RCW 41.05.410, accept a reimbursement rate for other health plans offered by the carrier at the same rate as the provider or facility is reimbursed for a qualified health plan under RCW 41.05.410.

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.