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: CONNECTICUT

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.G.S.A. § 38a-477g(b)(1)(A) "Provider agrees that in no event, including, but not limited to, nonpayment by the health carrier or intermediary, the insolvency of the health carrier or intermediary, or a breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care provider who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier does not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy. "

2.2 As required by C.G.S.A. § 38a-477g(b)(1)(B), in the event of a health carrier or intermediary insolvency or other cessation of operations, the participating provider's obligation to deliver covered health care services to covered persons without requesting payment from a covered person other than a coinsurance, copayment, deductible or other out-of-pocket expense for such services will continue until the earlier of (i) the termination of the covered person's coverage under the network plan, including any extension of coverage provided under the contract terms or applicable state or federal law for covered persons who are in an active course of treatment, as set forth in § 38a-472f(2)(g), or are totally disabled, or (ii) the date the contract between the health carrier and the participating provider would have terminated if the health carrier or intermediary had remained in operation, including any extension of coverage required under applicable state or federal law for covered persons who are in an active course of treatment or are totally disabled.

2.3 As required by C.G.S.A. § 38a-477g(b)(1)(C), participating provider shall make health records available to appropriate state and federal authorities involved in assessing the quality of care provided to, or investigating grievances or complaints of, covered persons. Participating provider shall comply with applicable state and federal laws related to the confidentiality of medical and health records and a covered person's right to view, obtain copies of or amend such covered person's medical and health records.

2.4 As required by C.G.S.A. § 38a-477g(b)(1)(D), for purposes of C.G.S.A. § 38a-477g(c)(2), unless otherwise specified in the underlying Agreement

(i) Material Change shall mean any change to the Agreement (including provider documents) that have a material adverse impact on provider; and

(ii) Timely Notice shall mean at least ninety (90) days prior notice to the provider.

2.5 As required by C.G.S.A. §38a-478h,38a-472f(g)(1)(A) and Regs. Conn. State Agencies § 38a-472f-2, health carrier and participating provider shall provide at least ninety days' written notice to each other before the health carrier removes a participating provider from the network or the participating provider leaves the network. Each participating provider that receives a notice of removal or issues a departure notice shall provide to the health carrier, not later than thirty (30) days after receipt of the notice of termination, a list of such participating provider's patients who are covered persons under a network plan of such health carrier.

2.6 As required by C.G.S.A §38a-472f(g)(1)(C) if participating provider is a hospital, as defined in section 38a-493, or a parent corporation of a hospital, and the contract is not renewed or is terminated by either the health carrier or the participating provider, the health carrier and the participating provider shall continue to abide by the terms of such contract, including reimbursement terms, for a period of sixty days from the date of termination or, in the case of a nonrenewal, from the end of the contract period. Except as otherwise agreed between such health carrier and such participating provider, the reimbursement terms of any contract entered into by such health carrier and such participating provider during said sixty-day period shall be retroactive to the date of termination or, in the case of a nonrenewal, the end date of the contract period. This subparagraph shall not apply if the health carrier and participating provider agree, in writing, to the termination or nonrenewal of the contract and the health carrier and participating provider provide the notices required under subparagraphs (A) and (B) of this subdivision.

2.7 As required by CGSA § 38a-479aa(l), if the preferred provider network fails to pay for health care services as set forth in the contract, the enrollee shall not be liable to the participating provider for any sums owed by the preferred provider network or any sums owed by the managed care organization because of nonpayment by the managed care organization, insolvency of the managed care organization or breach of contract between the managed care organization and the preferred provider network.

2.8 As required by the Chairman of the Workers' Compensation Commission Pursuant to the authority granted by CGSA § 31-279(d), MPI on behalf of the medical care plan may not terminate the services of any provider without cause.

III. ACCREDITATION STANDARDS COORDINATING PROVISIONS:

There are no Accreditation Standards Coordinating Provisions at this time.

IV. GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: CONNECTICUT

4.1 Professional Liability Insurance. In the event provider is a nurse practitioner, such provider shall maintain professional liability insurance at minimum levels of $500,000 per occurrence and $1,500,000 in the aggregate.