
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: VIRGINIA

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 Va. Code Ann. §38.2-3407.15 (B) (1), A carrier shall pay any claim within 40 days of receipt of the claim except where the obligation of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:
- a. The claim is determined by the carrier not to be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or
 - b. The claim was submitted fraudulently.

Carrier shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim.

- 2.2 As required by Va. Code Ann. §38.2-3407.15 (B) (2), carrier shall, within 30 days after receipt of a claim, request electronically or in writing from the person submitting the claim the information and documentation that the carrier reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information requested under this subsection necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however, nothing herein shall preclude such a carrier from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 6 of this subsection. Nothing in this subsection shall require a carrier to pay a claim which is not a clean claim.
- 2.3 As required by Va. Code Ann. §38.2-3407.15 (B) (3), any interest owing or accruing on a claim under § 38.2-3407.1 or 38.2-4306.1, under any provider contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or within 60 days thereafter.
- 2.4 As required by Va. Code Ann. §38.2-3407.15 (B) (4) (a), carrier shall establish and implement reasonable policies to permit provider (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the carrier's requirements applicable to the provider for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial

of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. If carrier routinely, as a matter of policy, bundles and/or downcodes claims submitted by provider. In the event of such practice, carrier shall disclose on its website the specific bundling and downcoding policies that carrier reasonably expects to be applied to provider on a routine basis as a matter of policy. Provider may also request the specific bundling and downcoding policies that the carrier reasonably expects to be applied to that provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a provider, carrier shall provide the requesting provider with such policies within 10 business days following the date the request is received.

- 2.5 As required by Va. Code Ann. §38.2-3407.15 (B) (4) (b), carrier shall make available to provider within 10 business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the carrier may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.
- 2.6 As required by Va. Code Ann. §38.2-3407.15 (B) (5), carrier shall pay a claim if the carrier has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:
 - a. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized; or
 - b. The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider has already been paid for the health care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person receiving the health care services was not eligible to receive them on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status.
- 2.7 As required by Va. Code Ann. §38.2-3407.15 (B) (6), in the case of an invasive or surgical procedure, if the carrier has previously authorized a health care service as medically necessary and during the procedure provider discovers clinical evidence prompting provider to perform a less or more extensive or complicated procedure than was previously authorized, then carrier shall pay the claim, provided that the additional procedures were (i) not investigative in nature, but medically necessary as a covered service under the covered person's benefit plan; (ii) appropriately coded consistent with the procedure actually performed; and (iii) compliant with a carrier's post-service claims process, including required timing for submission to carrier.
- 2.8 As required by Va. Code Ann. §38.2-3407.15 (B)(7), carrier shall not impose any retroactive denial of a previously paid claim unless the carrier has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) 12 months or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided. Carrier shall notify a provider at least 30 days in advance of any retroactive denial of a claim.
- 2.9 As required by Va. Code Ann. §38.2-3407.15 (B) (8), carrier shall not impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted.
- 2.10 As required by Va. Code Ann. §38.2-3407.15 (B) (9), this contract includes (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules and exhibits thereto and any policies applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.
- 2.11 As required by Va. Code Ann. §38.2-3407.15 (B) (10), no amendment to this contract or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and the provider has failed to

notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract.

2.12As required by Va. Code Ann. §38.2-3407.15 (B) (11), in the event that the carrier's provision of a policy required to be provided under Va. Code Ann. §38.2-3407.15 (B) (9) or (10) would violate any applicable copyright law, the carrier may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.

2.13As required by Va. Code Ann. §38.2-3407.15 (B) (12), the dispute resolution process is as stated in the Agreement and/or the administrative handbook (<http://www.multiplan.com/providers/education>). In the event the underlying Agreement does not contain a dispute resolution process, the dispute resolution process is as stated in the administrative handbook.

2.14As required by Va. Code Ann. §38.2-3407.15 (B) (13), provider shall not discriminate against any enrollee solely due to the enrollee's status as a litigant in pending litigation or a potential litigant due to being involved in a motor vehicle accident. Nothing in this subdivision shall require provider to treat an enrollee who has threatened to make or has made a professional liability claim against the provider or the provider's employer, agents, or employees or has threatened to file or has filed a complaint with a regulatory agency or board against the provider or the provider's employer, agents, or employees.

III. ACCREDITATION STANDARDS COORDINATING PROVISIONS:

There are no Accreditation Standards Coordinating Provisions at this time.

IV. GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: VIRGINIA

There are no Geographic Exceptions Coordinating Provisions at this time.