EXHIBIT C
COORDINATING PROVISIONS: FEDERAL LAW

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. 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 Exhibit or elsewhere in this Agreement.

III. MEDICARE ADVANTAGE FEDERAL LAW COORDINATING PROVISIONS:

Where a 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 a 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.

The following provisions are added to the Agreement to comply with applicable Medicare law, regulations, instructions and requirements of the Centers for Medicare and Medicaid Services ("CMS") and shall apply with respect to Covered Services rendered by Provider to Participants eligible under a Client's/User's Program that provides access to the Medicare Advantage Network.

3.1 Medicare Compliance. Provider agrees to comply with all (i) applicable Medicare laws, regulations, and CMS instructions and requirements relating to Participants, and (ii) applicable MPI and/or Client/User policies and procedures, including quality management and utilization management programs, that are required to comply with such laws, regulations, instructions, and requirements and are communicated to Provider through the Provider Manual or otherwise.

3.2 Confidentiality and Accuracy of Participant Records. Provider shall establish procedures that (i) comply with all federal and state laws regarding confidentiality and disclosure of an Participant's medical records and other health and enrollment information, (ii) safeguard the privacy of any information that identifies a particular Participant, (iii) specify for what purposes the information will be used by Provider and to whom and for what purpose Provider will disclose the information, (iv) require such records and information be maintained in an accurate and timely manner, (v) ensure that medical records are released only in accordance with applicable federal and state law or pursuant to court order or subpoena, and (vi) ensure timely access by Participants to the records and information that pertains to them.

3.3 Grievances and Appeals. Provider shall comply with the Medicare grievance and appeal procedures relating to Participants, including providing information to MPI and/or Clients/Users as necessary.

3.4 Reporting and Certification Requirements. Upon request, Provider will provide the information in Provider's possession necessary for a Client/User to comply with the reporting requirements in 42 C.F.R. 422.516 and 422.310. Provider will certify to the accuracy, completeness and truthfulness of data submitted, including, but not limited to, encounter data and other data supplied by Provider, for Participants when such certification is required by law.

3.5 Prompt Payment Provision. Unless otherwise required by law, the parties agree that any amount owing with respect to Covered Services rendered by Provider to Participants shall be paid by Clients or Users, as applicable, within sixty (60) days after receipt of a clean claim as defined by applicable federal law.

3.6 Hold Harmless. In no event, including, but not limited to, nonpayment by a Client or User, as applicable, insolvency of MPI or a Client/User, or breach of the Agreement, shall Provider or Provider's representative bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Participant (or persons having authority to act on behalf of an Participant) for Covered Services or any other fees that are the legal obligation of the Client or User, as applicable. This provision does not prohibit Provider from collecting charges for non-Covered Services or for any applicable copayments, coinsurance, deductibles, and other Participant cost-sharing amounts (collectively, "Cost Sharing Amounts") applicable under the Participant's Benefit Program. Participants that are eligible for both Medicare and Medicaid will not be held liable for Medicare Part A and B Cost Sharing Amounts when the State is responsible for paying such amounts, and, with respect to such Participants, Provider will accept the Medicare payment as payment in full or bill the appropriate State source. Information on the applicable Medicare and Medicaid benefits and rules for Participants eligible for both Medicare and Medicaid is available by contacting the User identified on the Participant identification card.

3.7 Continuation of Care. In the event of non-payment by a Client or User, as applicable, to Provider for Covered Services for any reason, including but not limited to Client's/User's insolvency or breach of the Agreement, Provider shall continue to provide Covered Services to all Participants for the duration of the contract period for which CMS payments are made to Client/User under Client's/User's contract with CMS, and for Participants who are hospitalized on the date Client's/User's contract with CMS terminates or Client/User becomes insolvent, through discharge.

3.8 Termination. Notwithstanding anything to the contrary set forth in the Agreement, each party must provide the other with at least sixty (60) days' prior written notice of termination of this Agreement without cause or termination of Provider's participation in the Medicare Advantage Network without cause. To the extent that the Agreement provides for a longer without cause termination notice period, such notice period shall apply.

3.9 Audits. Provider shall allow Clients/Users, the Department of Health and Human Services (HHS), the Comptroller General, or their designees, to evaluate, through inspection, audit or other means, any of Provider's books, contracts, records, including medical records, patient care documentation or other records pertaining to any aspect of services performed, reconciliation of benefit liabilities and determination of amounts payable for services rendered to Participants or other transactions relating to a Client's/User's contract with CMS or as the Secretary of HHS may deem necessary to enforce a Client's/User's contract with CMS. This right to inspect, evaluate or audit shall extend through ten (10) years from the end of the final contract period during which a Client/User holds a contract with CMS or the date of completion of such audit, whichever is later, unless otherwise specified by CMS.

3.10 Accountability; Delegation. To the extent that MPI delegates any activity, function or responsibility under Client's/User's contract with CMS to Provider:

(a) the delegated activities and reporting responsibilities must be specified in writing in the delegation agreement;
(b) the delegation may be revoked in instances where CMS, Client/User or MPI determines that the parties have not performed satisfactorily or if reporting and disclosure requirements are not timely;
(c) Provider's performance will be monitored by MPI or Client/User on an ongoing basis;
(d) Either the credentials of medical professionals affiliated with Provider will be reviewed by MPI, Client/User or their designee or Provider's credentialing process will be reviewed, approved, and audited on an ongoing basis by MPI, Client/User or their designee;
(e) Provider must comply with all applicable Medicare laws, regulations and CMS instructions and requirements;
(f) Any delegated service or other activity must be performed in a manner consistent with, and comply with, Client's/User's contract with CMS; and
(g) if the selection of providers, contractors or subcontractors is delegated to Provider, MPI and Clients/Users retain the right to approve, suspend, or terminate the arrangement.

If MPI has agreed that Provider may subcontract with providers or other delegatees for the provision of services to Participants or for the performance of any other activity, function or responsibility under Client's/User's contract with CMS, such subcontracts shall contain the provisions specified in this Exhibit, including those specified in Subsections (a) through (g) of this Section, and shall additionally include any other provisions mandated by Medicare laws, regulations and CMS requirements.

3.11 Medicare Participation; Program Integrity. Provider shall not employ or contract with any individual who is excluded from participation in Medicare under section 1128 or 1128A of the Social Security Act, or with any entity that employs or contracts with such a provider for the provision of health care, utilization review, medical social work, or administrative services. Provider shall immediately notify MPI in the event that Provider is excluded from

participating in Medicare under section 1128 or 1128A of the Social Security Act. Provider shall further immediately notify MPI in the event that it is criminally convicted or has a civil judgment entered against it for fraudulent activities or is sanctioned under any Federal program involving the provision of healthcare or prescription drug services.

Provider agrees to comply with MPI's compliance program or to adopt and comply with its own compliance program established in accordance with CMS requirements and reflect a commitment to detecting, preventing and correcting fraud, waste and abuse (FWA). Provider shall ensure that Provider, its employees, and subcontractors complete the requisite FWA and general compliance training, that meets CMS's requirements, within ninety (90) days of hire/contracting and annually thereafter. Provider shall maintain documentation sufficient to demonstrate its adherence to the requirements set forth in this Subsection, including but not limited to evidence of training completion, related materials, training logs and program materials, for ten (10) years and shall make such documentation available to MPI upon request.

3.12 Compliance with Other Federal Laws. Provider agrees to comply with federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et seq.), and the anti-kickback statute (section 1128B(b) of the Act), the HIPAA administrative simplification rules at 45 CFR parts 160, 162 and 164, and all laws applicable to recipients of federal funds.

3.13 Risk Adjustment Data. For purposes of this Subsection, "risk adjustment data" shall have the same meaning set forth in 42 C.F.R. Section 422.310(a), as may be amended from time to time. Client/User is required to obtain risk adjustment data from Provider for Participants, and Provider agrees to provide complete and accurate risk adjustment data to Client/User for Participants that conforms to all standards and requirements set forth in applicable laws, rules and regulations and/or CMS instructions that apply to risk adjustment data. Provider certifies, based on best knowledge, information and belief, that any risk adjustment data that Provider submits to Client/User for Participants is accurate, complete and truthful. Provider agrees to immediately notify Client/User if any risk adjustment data that was submitted to Client/User for Participants is erroneous, and follow procedures established by Client/User to correct erroneous risk adjustment data to ensure Client's/User's compliance with applicable laws, rules and regulations and CMS instructions.

Provider further agrees to maintain accurate, legible and complete medical record documentation for all risk adjustment data submitted to Client/User for Participants in a format that meets all standards and requirements set forth in applicable laws, rules, regulations and/or CMS instructions, and allows any federal governmental authorities with jurisdiction or their designees ("Government Officials") to: (i) confirm that the appropriate diagnoses codes and level of specificity are documented, (ii) verify the date of service is documented and within the risk adjustment data collection period, and (iii) confirm that the appropriate provider's signature and credentials are present.

Provider agrees to provide Client/User and Government Officials, or their designees, with medical records and any other information or documentation required by Government Officials for the validation of risk adjustment data ("Audit Data"). Provider agrees to provide Client/User with Audit Data within the timeframe established by Client/User to ensure Client's/User's compliance with deadlines imposed by Government Officials for the submission of Audit Data. In the event that CMS conducts a review that includes the validation of risk adjustment data submitted by Provider, Client/User will submit to Provider a copy of the CMS written notice of such review, along with a written request from Client/User for Audit Data.

3.14 Physician Incentive Plan. In the event the Provider participates in Client's/User's (or MPI's on behalf of Client/User) Physician Incentive Plan, as defined by CMS and/or any state or federal law, rule or regulation, the Provider agrees and acknowledges: (i) that no payments made to Provider are financial incentives or inducements to reduce, limit or withhold medically necessary services to Participants, and (ii) that any incentive plans applicable to Provider are and shall be in compliance with applicable state and federal laws, rules and regulations and in accordance with the Client's/User's contract with CMS. Upon request and as applicable, Provider agrees to disclose to MPI or Client/User the terms and conditions of any Physician Incentive Plan.

3.15 Amendment of Medicare Advantage Federal Law Coordinating Provisions. The Medicare Advantage Federal Law Coordinating Provisions provided herein may be modified or amended by MPI upon prior written or electronic notice to Provider to the extent required to comply with applicable laws, regulations, and the requirements of applicable regulatory authorities, including but not limited to CMS.