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**EXHIBIT C**  
**COORDINATING PROVISIONS: STATE LAW,**  
**ACCREDITATION STANDARDS AND GEOGRAPHIC EXCEPTIONS**

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**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., d/b/a Claritev, Inc., on behalf of itself and its subsidiaries (collectively "Claritev"), 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: OREGON**

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 O.R.S. § 743B.405(2)(a), provider shall participate in and observe the protocols of the quality management program outlined in the administrative handbook.
- 2.2 As required by O.R.S. § 743B.405(2)(b), the criteria for termination or nonrenewal are as stated in the underlying agreement. In the event the underlying agreement does not contain criteria for termination or nonrenewal, those rights are as follows:

Discretionary Termination. After the expiration of the Initial Term, this Agreement may be terminated in the sole discretion of either party, by the provision of written notice at least ninety (90) days prior to the Renewal Date, such termination to be effective on the Renewal Date.

Termination for Material Breach.

- (a) This Agreement may be terminated by insurer upon written notice to provider if (i) any action is taken which requires provider to provide insurer with notice; (ii) in the sole discretion of insurer, if provider fails to comply with the quality management and/or credentialing/recredentialing program(s) specified in the administrative handbook(s); or (iii) provider fails to comply with any applicable state and/or federal law related to the delivery of health care services.
- (b) In the event that one party commits a material breach of this Agreement (the "Breaching Party") this Agreement will terminate upon the provision of at least thirty (30) days written notice to the Breaching Party specifying the material breach. The Breaching Party may cure the breach within such thirty (30) day period, provided however, that failure to cure said breach will result in termination as of the date specified in the notice.

Network Participation Termination. Either party may terminate this Agreement as to any of the networks in which provider participates by the provision of at least ninety (90) days prior written notice to the other party provided however, provider maintains participation in at least one network. Termination of a Network will not terminate this Agreement as to any other Networks in which provider participates.

- 2.3 As required by O.R.S. § 743B.405(2)(c), provider is entitled to an annual accounting accurately summarizing the financial transactions between provider and insurer for that year.
- 2.4 As required by O.R.S. § 743B.405(2)(d), provider may withdraw from the care of a patient when, in the professional judgment of the provider, it is in the best interest of the patient to do so.
- 2.5 As required by O.R.S. § 743B.405(2)(e), a doctor of medicine or doctor of osteopathy licensed under ORS chapter 677 shall be retained by the other party to the medical services contract and shall be responsible for all final medical and mental health decisions relating to coverage or payment made pursuant to the medical services contract.

- 2.6 As required by O.R.S. § 743B.405(2)(f), a physician, as defined in ORS 677.010, who is practicing in conformity with ORS 677.095 may advocate a decision, policy or practice without being subject to termination or penalty for the sole reason of such advocacy.
- 2.7 As required by O.R.S. § 743B.405(2)(h), when continuity of care is required to be provided under a health benefit plan by ORS 743B.225, the insurer and the individual provider shall provide continuity of care to enrollees as provided in ORS 743B.225.
- 2.8 As required by O.R.S. § 742.424(2)(c), for providers offering services under a discount medical plan, provider agrees not to charge plan members more for medical and ancillary services than the amount listed in the provider's price schedule or an amount that reflects the application of the provider's discount rate.

### **III. ACCREDITATION STANDARDS COORDINATING PROVISIONS:**

There are no Accreditation Standards Coordinating Provisions at this time.

### **IV. GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: OREGON**

There are no Geographic Exceptions Coordinating Provisions at this time.