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., d/b/a Claritev, 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: OHIO

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 RC § 1751.13(C)(2), "Provider/Health Care Facility agrees that in no event, including but not limited to nonpayment by the health insuring corporation, insolvency of the health insuring corporation, or breach of this agreement, shall Provider/Health Care Facility bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, enrollee, person to whom health care services have been provided, or person acting on behalf of the covered enrollee, for health care services provided pursuant to this agreement. This does not prohibit Provider/Health Care Facility from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the health insuring corporation or its successor."

2.2 As required by RC § 175113(C)(3), provider or health care facility shall continue to provide covered health care services to enrollees in the event of the health insuring corporation's insolvency or discontinuance of operations. Provider or health care facility shall continue to provide covered health care services to enrollees as needed to complete any medically necessary procedures commenced but unfinished at the time of the health insuring corporation's insolvency or discontinuance of operations. The completion of a medically necessary procedure shall include the rendering of all covered health care services that constitute medically necessary follow-up care for that procedure. If an enrollee is receiving necessary inpatient care at a hospital, provision of covered health care services relating to that inpatient care may be limited in accordance with division (D)(3) of section 1751.11 of the Revised Code, and may also be limited to the period ending thirty days after the health insuring corporation's insolvency or discontinuance of operations.

2.3 As required by RC § 175113(C)(4), the rights and responsibilities of the health insuring corporation, and of the contracted providers and health care facilities, with respect to administrative policies and programs, including, but not limited to, payments systems, utilization review, quality assurance, assessment, and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs are as stated in the underlying Agreement and/or the Administrative Handbook.

2.4 As required by RC § 1751.13(C)(5), provider and health care facilities shall make available and keep confidential of those health records maintained by providers and health care facilities to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the necessity of and appropriateness of health care services provided to enrollees. Provider or health care facility shall make these health records available to appropriate state and federal authorities involved in assessing the quality of care or in investigating the grievances or complaints of enrollees, provider or health care facility shall comply with applicable state and federal laws related to the confidentiality of medical or health records.

2.5 As required by RC § 1751.13(C)(6), contractual rights and responsibilities may not be assigned or delegated by the provider or health care facility without the prior written consent of the health insuring corporation.

2.6 As required by RC § 1751.13(C)(7), provider or health care facility to maintain adequate professional liability and malpractice insurance in accordance with the underlying Agreement. Provider or health care facility shall notify the health insuring corporation not more than ten days after the provider's or health care facility's receipt of notice of any reduction or cancellation of such coverage.

2.7 As required by RC § 1751.13(C)(8), provider or health care facility shall observe, protect, and promote the rights of enrollees as patients.

2.8 As required by RC § 1751.13(C)(9), provider or health care facility shall provide health care services without discrimination on the basis of a patient's participation in the health care plan, age, sex, ethnicity, religion, sexual preference, health status, or disability, and without regard to the source of payments made for health care services rendered to a patient. This requirement shall not apply to circumstances when the provider or health care facility appropriately does not render services due to limitations arising from the provider's or health care facility's lack of training, experience, or skill, or due to licensing restrictions.

2.9 As required by RC § 1751.13(C)(10), a primary care provider shall provide, or arrange for the provision of, covered health care services twenty-four hours per day, seven days per week.

2.10 As required by RC § 1751.13(C)(11), the dispute resolution process is as stated in the underlying Agreement. In the event the underlying Agreement does not include a dispute resolution process, the dispute resolution process is as stated in the administrative handbook.

2.11 As required by RC § 1751.13(C)(12), the hold harmless provision required by RC §1751.13(C)(2) shall survive the termination of the contract with respect to services covered and provided under the contract during the time the contract was in effect, regardless of the reason for the termination, including the insolvency of the health insuring corporation.

2.12 As required by RC § 1751.13(C)(13), those terms that are used in the contract and that are defined by RC §1751.01, shall be used in the contract in a manner consistent with those definitions.

2.13 As required by RC § 1751.13 (F)(2), health insuring corporation is a third-party beneficiary to the agreement.

2.14 As required by RC § 1751.13(F)(3), health insuring corporation may approve or disapprove the participation of any provider or health care facility with which the intermediary organization contracts.

2.15 As required by RC § 1751.13(G), health insuring corporation has statutory responsibility to monitor and oversee the offering of covered health care services to its enrollees.

2.16 As required by RC § 3963.02(A)(1)(c), this Agreement applies to network rental arrangements and one purpose of the Agreement is selling, renting, or giving the contracting entity's rights to the services of the participating provider, including other preferred provider organizations, and the third party accessing the participating provider's services is any of the following:

(i) A payer or a third-party administrator or other entity responsible for administering claims on behalf of the payer;
(ii) A preferred provider organization or preferred provider network that receives access to the participating provider's services pursuant to an arrangement with the preferred provider organization or preferred provider network in a contract with the participating provider that is in compliance RC § 3963.02(A)(1)(c), and is required to comply with all of the terms, conditions, and affirmative obligations to which the originally contracted primary participating provider network is bound under its contract with the participating provider, including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement.
(iii) An entity that is engaged in the business of providing electronic claims transport between the contracting entity and the payer or third-party administrator and complies with all of the applicable terms, conditions, and affirmative obligations of the contracting entity's contract with the participating provider including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement.

2.17 As required by RC § 3961.02(B)(3), provider, participating in a discount medical plan, will not charge members more than the discounted rates agreed upon in this Agreement.

III. ACCREDITATION STANDARDS COORDINATING PROVISIONS:

There are no Accreditation Standards Coordinating Provisions at this time.

IV. GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: OHIO

There are no Geographic Exceptions Coordinating Provisions at this time.

OHIO SUMMARY DISCLOSURE FORM

IMPORTANT INFORMATION - PLEASE READ CAREFULLY

The information provided in this Summary Disclosure Form is a guide to the attached Health Care Contract as defined in section 3963.01(G) of the Ohio Revised Code. The terms and conditions of the attached Health Care Contract constitute the contract rights of the parties.

Reading this Summary Disclosure Form is not a substitute for reading the entire Health Care Contract. When you sign the Health Care Contract, you will be bound by its terms and conditions. These terms and conditions may be amended over time pursuant to section 3963.04 of the Ohio Revised Code. You are encouraged to read any proposed amendments that are sent to you after execution of the Health Care Contract.

Nothing in this Summary Disclosure Form creates any additional rights or causes of action in favor of either party.

1. Compensation terms: Article V and Contract Rate Exhibit

2. Manner of payment: Fee for Service

3. Fee Schedule Available at: 800-546-3887

4. Products or networks covered by this contract: Definition of Program

5. Term of this contract: Article II

6. Contracting entity or payer responsible for processing payment available at: 800-546-3887

7. Dispute Resolution: Article V and Article VIII

8. Subject and Order of Addenda:
   A. Amendment Exhibit (if applicable)
   B. Network Participation Requirements
   C. Coordinating Provisions State/Federal Law and Accreditation Standards
   D. Contract Rates
   E. List of Locations (if applicable)
   F. Service Requirements (if applicable)

9. Telephone number to access a readily available mechanism, such as a specific web site address, to allow a participating provider to receive the above information: 800-546-3887