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: 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 subsection B 1 of Va. Code Ann. § 38.2-3407.15, a carrier shall pay any claim within forty (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 subsection B 2 of Va. Code Ann. § 38.2-3407.15, carrier shall, within thirty (30) days after receipt of a claim, notify the person submitting the claim of any defect or impropriety that prevents the carrier from deeming the claim a clean claim and request the information that will be required to process and pay the 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 Va. Code Ann. § 38.2-3407.15. 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 7 of subsection B of § 38.2-3407.15. Beginning no later than January 1, 2026, all notifications and information required under subsection B 2 of § 38.2-3407.15 shall be delivered electronically.

2.3 As required by subsection B 3 of Va. Code Ann. § 38.2-3407.15, 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 sixty (60) days thereafter.

2.4 As required by subsection B 4 a of Va. Code Ann. § 38.2-3407.15, 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 (or to the type of health care services which the provider has contracted to deliver under the provider contract) 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 or downcodes claims submitted by provider, the carrier shall clearly disclose on its website the specific bundling and downcoding policies that carrier reasonably expects to be applied to provider or provider's services 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 ten (10) business days following the date the request is received.

2.5 As required by subsection B 4 b of Va. Code Ann. § 38.2-3407.15, carrier shall make available to a provider requesting copies of policies pursuant to subsection B 4 a of Va. Code Ann. § 38.2-3407.15, within ten (10) business days of receipt of the 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 subsection B 5 of Va. Code Ann. § 38.2-3407.15, 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;
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; or,
c. During the post-service claims process, it is determined that the claim was submitted fraudulently.

2.7 As required by subsection B 6 of Va. Code Ann. § 38.2-3407.15, 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 subsection B 7 of Va. Code Ann. § 38.2-3407.15, carrier shall not impose any retroactive denial of a previously paid claim 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 carrier has provided a written explanation of why the claim is being retroactively adjusted, 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 twelve (12) months. Notwithstanding the provisions of clause (iii), a provider and a carrier may agree in writing that recoupment of overpayments by withholding or offsetting against future payments may occur after such 12-month limit for the imposition of the retroactive denial. A carrier shall notify a provider at least thirty (30) days in advance of any retroactive denial or recovery or refund of a previously paid claim.

2.9 As required by subsection B 8 of Va. Code Ann. § 38.2-3407.15, 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 (including those referred to in subsection B 4 of Va. Code Ann. § 38.2-3407.15). 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.

2.10 As required by subsection B 9 of Va. Code Ann. § 38.2-3407.15, 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 sixty (60) calendar days before the effective date and the provider has failed to notify the carrier within thirty (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.

2.11 As required by subsection B 10 of Va. Code Ann. § 38.2-3407.15., in the event that the carrier's provision of a policy required to be provided under subsection B 8 or 9 of Va. Code Ann. § 38.2-3407.15 would violate any applicable copyright law, the carrier may instead comply with Va. Code Ann. § 38.2-3407.15B. by providing a clear, written explanation of the policy as it applies to the provider.

2.12 As required by subsection B 11 of Va. Code Ann. § 38.2-3407.15., the dispute resolution process is as stated in the Agreement and/or the administrative handbook (https://www.claritev.com/healthcare-providers/). In the event the underlying Agreement does not contain a dispute resolution process, the dispute resolution process is as stated in the administrative handbook. If a carrier's claim denial is overturned following completion of a dispute review, the carrier shall, on the day the decision to overturn is made, consider the claims impacted by such decision as clean claims. All applicable laws related to the payment of a clean claim shall apply to the payments due.

2.13 As required by subsection B 12 of Va. Code Ann. § 38.2-3407.15., 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 subsection B 12 of Va. Code Ann. § 38.2-3407.15 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.

2.14 As required by subsection B 1 of VA Code Ann. § 38.2-3407.15:2, carrier, in a method of its choosing, is required to accept telephonic, facsimile, or electronic submission of prior authorization requests that are delivered from e-prescribing systems, electronic health record systems, and health information exchange platforms that utilize the National Council for Prescription Drug Programs' SCRIPT standards.

2.15 As required by subsection B 2 of VA Code Ann. § 38.2-3407.15:2, carrier is required to communicate to the prescriber or his designee within twenty-four (24) hours, including weekend hours, of submission of an urgent prior authorization request to the carrier, if submitted telephonically or in an alternate method directed by the carrier, that the request is approved, denied, or requires supplementation.

2.16 As required by subsection B 3 of VA Code Ann. § 38.2-3407.15:2, carrier is required to communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within two (2) business days of submission of a fully completed prior authorization request, that the request is approved, denied, or requires supplementation.

2.17 As required by subsection B 4 of VA Code Ann. § 38.2-3407.15:2, carrier is required to communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within two (2) business days of submission of a properly completed supplementation from the prescriber or his designee, that the request is approved or denied.

2.18 As required by subsection B 5 of VA Code Ann. § 38.2-3407.15:2, if a prior authorization request is approved for prescription drugs and such prescription drugs have been scheduled, provided, or delivered to the patient consistent with the authorization, the carrier shall not revoke, limit, condition, modify, or restrict that authorization unless (i) there is evidence that the authorization was obtained based on fraud or misrepresentation; (ii) final actions by the U.S. Food and Drug Administration, other regulatory agencies, or the manufacturer remove the drug from the market, limit its use in a manner that affects the authorization, or communicate a patient safety issue that would affect the authorization alone or in combination with other authorizations; (iii) a combination of drugs prescribed would cause a drug interaction; or (iv) a generic or biosimilar is added to the prescription drug formulary. Nothing in this section shall require a carrier to cover any benefit not otherwise covered or cover a prescription drug if the enrollee is no longer covered by a health plan on the date the prescription drug was scheduled, provided, or delivered.

2.19 As required by subsection B 6 of VA Code Ann. § 38.2-3407.15:2, if a prior authorization request is denied, the carrier shall communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within the timeframes established by subsection B 3 or 4 of VA Code Ann. § 38.2-3407.15:2, as applicable, the reasons for the denial.

2.20 As required by subsection B 7 of VA Code Ann. § 38.2-3407.15:2, prior authorization approved by another carrier is required to be honored, upon the carrier's receipt from the prescriber or his designee of a record demonstrating the previous carrier's prior authorization approval or any written or electronic evidence of the previous carrier's coverage

of such drug, at least for the initial ninety (90) days of a member's prescription drug benefit coverage under a new health plan, subject to the provisions of the new carrier's evidence of coverage and any exception listed in subsection B 5 of VA Code Ann. § 38.2-3407.15:2.

2.21 As required by subsection B 8 of VA Code Ann. § 38.2-3407.15:2, carrier is required to use a tracking system for all prior authorization requests and the identification information must be provided electronically, telephonically, or by facsimile to the prescriber or his designee, upon the carrier's response to the prior authorization request.

2.22 As required by subsection B 9 of VA Code Ann. § 38.2-3407.15:2, the carrier's prescription drug formularies, all drug benefits subject to prior authorization by the carrier, all of the carrier's prior authorization procedures, and all prior authorization request forms accepted by the carrier are required to be made available through one central location on the carrier's website and such information must be updated by the carrier within seven (7) days of approved changes.

2.23 As required by subsection B 10 of VA Code Ann. § 38.2-3407.15:2, carrier is required to honor a prior authorization issued by the carrier for a drug, other than an opioid, regardless of changes in dosages of such drug, provided such drug is prescribed consistent with U.S. Food and Drug Administration-labeled dosages.

2.24 As required by subsection B 11 of VA Code Ann. § 38.2-3407.15:2, carrier is required to honor a prior authorization issued by the carrier for a drug regardless of whether the covered person changes plans with the same carrier and the drug is a covered benefit with the current health plan.

2.25 As required by subsection B 12 of VA Code Ann. § 38.2-3407.15:2, when requiring a prescriber to provide supplemental information that is in the covered individual's health record or electronic health record, carrier shall identify the specific information required.

2.26 As required by subsection B 13 of VA Code Ann. § 38.2-3407.15:2, carrier will not require prior authorization for at least one drug prescribed for substance abuse medication-assisted treatment, provided that (i) the drug is a covered benefit, (ii) the prescription does not exceed the FDA-labeled dosages, and (iii) the drug is prescribed consistent with the regulations of the Board of Medicine.

2.27 As required by subsection B 14 of VA Code Ann. § 38.2-3407.15:2, when any carrier has previously approved prior authorization for any drug prescribed for the treatment of a mental disorder listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, no additional prior authorization shall be required by the carrier, provided that (i) the drug is a covered benefit; (ii) the prescription does not exceed the FDA-labeled dosages; (iii) the prescription has been continuously issued for no fewer than three months; and (iv) the prescriber performs an annual review of the patient to evaluate the drug's continued efficacy, changes in the patient's health status, and potential contraindications. Nothing in this subdivision shall prohibit a carrier from requiring prior authorization for any drug that is not listed on its prescription drug formulary at the time the initial prescription for the drug is issued.

2.28 As required by subsection B 15 of VA Code Ann. § 38.2-3407.15:2, carrier shall honor a prior authorization issued by the carrier for a drug regardless of whether the drug is removed from the carrier's prescription drug formulary after the initial prescription for that drug is issued, provided that the drug and prescription are consistent with the applicable provisions of subdivision 14

2.29 As required by subsection B 16 of VA Code Ann. § 38.2-3407.15:2, beginning July 1, 2025 and notwithstanding the provisions of subsection B 1 of VA Code Ann. § 38.2-3407.15:2 or any other provision of this section, carrier shall establish and maintain an online process that (i) links directly to all e-prescribing systems and electronic health record systems that utilize the National Council for Prescription Drug Programs SCRIPT standard and the National Council for Prescription Drug Programs Real Time Benefit Standard; (ii) can accept electronic prior authorization requests from a provider; (iii) can approve electronic prior authorization requests (a) for which no additional information is needed by the carrier to process the prior authorization request, (b) for which no clinical review is required, and (c) that meet the carrier's criteria for approval; and (iv) links directly to real-time patient out-of-pocket costs for the office visit, considering copayment and deductible, and (v) otherwise meets the requirements of this section. No carrier shall (a) impose a fee or charge on any person for accessing the online process as required by subsection B 16 of VA Code Ann. § 38.2-3407.15:2. or (b) access, absent provider consent, provider data via the online process other than for the enrollee. No later than July 1, 2024, a carrier, upon request from a provider, shall provide contact information of any third-party vendor or other entity the carrier will use to meet the requirements of this subdivision or the requirements of VA Code Ann. § 38.2-3407.15:7. A carrier that posts such contact information on its website shall be considered to have met this requirement.

2.30 As required by subsection B 17 of VA Code Ann. § 38.2-3407.15:2, beginning July 1, 2025, participating health care provider shall ensure that any e-prescribing system or electronic health record system owned by or contracted for the provider to maintain an enrollee's health record has the ability to access, at the point of prescribing, the electronic prior authorization process established by a carrier as required by subsection B 16 of VA Code Ann. § 38.2-3407.15:2

and the real-time patient-specific benefit information, including out-of-pocket costs and more affordable medication alternatives made available by a carrier pursuant to VA Code Ann. § 38.2-3407.15:7. A provider may request a waiver of compliance for undue hardship for a period specified by the appropriate regulatory authority with the Health and Human Resources Secretariat.

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.