
EXHIBIT __
COORDINATING PROVISIONS-STATE/FEDERAL LAW, ACCREDITATION STANDARDS AND
GEOGRAPHIC EXCEPTIONS
VIRGINIA

I. INTRODUCTION:

Scope: To the extent of any conflict between the Agreement and this State Law Coordinating Provisions (“SLCP”) Exhibit, this SLCP Exhibit shall supersede, govern and control to the extent required by federal and/or state law and to the extent that MPI, Network Provider and/or Client are subject to such federal or state law.

II. DEFINITIONS:

1. Depending upon the specific form of the Agreement, the following terms may be utilized in the Agreement and are intended to be defined as provided for in the Agreement:
 - (i) Billed Charges may be referred to as Regular Billing Rates;
 - (ii) Client may be referred to as Payor;
 - (iii) Contract Rates may be referred to as Preferred Payment Rates;
 - (iv) Covered Services may be referred to as Covered Care;
 - (v) Network Provider may be referred to as Preferred Provider;
 - (vi) Participant may be referred to as Covered Individual; and
 - (vii) Program or Benefit Program may be referred to as Contract.
2. For purposes of this Exhibit, the term Network Provider is inclusive of Participating Professional and all Network Providers.

III. FEDERAL LAW COORDINATING PROVISIONS:

Federal Employees Health Benefits (“FEHB”). As applicable, this Agreement is subject to the terms of the laws governing FEHB.

1. 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 SLCP Exhibit or elsewhere in this Agreement.

IV. STATE LAW COORDINATING PROVISIONS: VIRGINIA

For any Agreement involving the delivery of health care services in the Commonwealth of Virginia, the provisions noted below shall apply. Where the term Client is used Client shall mean only those Clients that are subject to the specific law(s) cited below:

1. As required by Va. Code Ann. §38.2-3407.15 (B) (1), In addition to the obligations set forth in the Agreement concerning payment for health care services, Client shall pay Network Provider within forty (40) days of receipt of a claim except where (1) the claim was submitted fraudulently or (2) the obligation to pay the 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 the claim is determined in good faith not to be a Clean Claim or there is a 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 entity 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.
2. As required by Va. Code Ann. §38.2-3407.15 (B) (1) (a), Clean Claim means a claim (i) that has no material defect or impropriety (including any lack of any reasonably required documentation) which substantially prevents timely payment from being made on the claim or (ii) with respect to which a Client has failed to notify the person submitting the claim of any such defect or impropriety.
3. As required by Va. Code Ann. §38.2-3407.15 (B) (1), Client 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.

4. As required by Va. Code Ann. §38.2-3407.15 (B) (2), Client shall, within thirty (30) days after receipt of a claim, request electronically or in writing from the person submitting the claim the information and documentation that Client 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 provision, necessary to make the original claim a Clean Claim, Client shall make the payment of the claim in accordance with Va. Code Ann. §38.2-3407.15(B)(1). No Client may refuse to pay a claim for health care services rendered pursuant to this Agreement, which are Covered Services if Client 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 claim(s); however, nothing herein shall preclude such Client from imposing a retroactive denial of payment of such a claim if permitted by the Agreement unless such retroactive denial of payment of the claim would violate applicable state law.
5. As required by Va. Code Ann. §38.2-3407.15 (B) (3), if applicable, Client shall pay or arrange to pay any interest owed or accrued under Va. Code Ann. §38.203407.15 (B) (1) or 38.2-3406.1, under this Agreement or under any other applicable law, without necessity of demand, at the time the claim is paid or within sixty (60) days of payment of the claim.
6. As required by Va. Code Ann. §38.2-3407.15 (B) (4) (a), Client and MPI, as applicable, shall establish and implement reasonable policies to permit Network 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 are Covered Services and (ii) to determine the Client's requirements applicable to the Network 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 this Agreement, including determining whether a claim is a Clean Claim.
7. As required by Va. Code Ann. §38.2-3407.15 (B) (4) (a). It is a general practice of some Clients to bundle and/or downcode claims for Covered Services. In the event of such practice, Client shall disclose on its website the specific bundling and downcoding policies that the Client reasonably expects to be applied to Network Provider on a routine basis as a matter of policy. In addition and in the event Network Provider requests such information from Client, Client shall provide Network Provider with such bundling and downcoding policies within ten (10) business days of receipt of the request.
8. As required by Va. Code Ann. §38.2-3407.15 (B) (4) (b), Client or MPI, as applicable, shall make available to Network Provider, within ten (10) days of a request, copies of, or reasonable electronic access to all applicable policies and procedures. In the event that the release of a policy and procedure violates any applicable copyright law, Client or MPI, as applicable, shall provide, within a reasonable amount of time, a clear explanation of the policy and procedure as it applies to Network Provider.
9. As required by Va. Code Ann. §38.2-3407.15 (B) (5), Client shall pay or arrange to pay all claims if Client has previously authorized the health care service or has advised Network Provider or Participant in advance of the provision of health care services that the health care services are medically necessary and a Covered Service unless:
 - (i) The information regarding the claim submitted by Network Provider fails to support the claim as pre-authorized; or
 - (ii) Client refuses to pay the claims for one of the following reasons:
 - (i) Client is not responsible for payment;
 - (ii) Network Provider was previously paid for the health care services identified on the claim;
 - (iii) The claim was submitted fraudulently or the pre-authorization was based in whole or material part on erroneous information provided to Client by Network Provider, the Participant, or other person not related to Client; or
 - (iv) The individual receiving health care services was not a Participant and Client did not know, and reasonably could not have known, that the individual was not a Participant.
10. As required by Va. Code Ann. §38.2-3407.15 (B) (6), Client shall not impose any retroactive denial of a previously paid claim unless the Client has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently; (ii) the original claim payment was incorrect because Network 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 Network 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) twelve (12) months or (b) the number of days within which Client requires under this Agreement that a claim be submitted by Network Provider following the date on which a health care service is provided. Client shall notify Network Provider at least thirty (30) days in advance of any retroactive denial of a claim. Network Provider shall submit claims for payment within one hundred eighty (180) days of furnishing health care services to Clients subject to Va. Code Ann. §38.2-3407.15(B)(6). For all other Clients, as defined in the Agreement, Network Provider shall comply with the submission of claims requirements contained in the base Agreement.

11. As required by Va. Code Ann. §38.2-3407.15 (B) (7), Client shall not impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless Client specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. Such written notification shall also contain an explanation of why the claim is being retroactively adjusted.
12. As required by Va. Code Ann. §38.2-3407.15 (B) (9), MPI shall provide Network Provider with at least sixty (60) calendar days prior notice of any modification of this Agreement. The modifications shall be effective on the effective date specified in the written notice unless Network Provider provides written notice to MPI, within thirty (30) calendar days of receipt of the modification, that it rejects the modification.
13. As required by Va. Code Ann. §38.2-3407.15 (B) (10), in the event Client's or MPI's, as applicable, provision of a policy required to be provided under Va. Code Ann. §38.2-3407.15 (B) (8)-(9) would violate any applicable copyright law, Client or MPI, as applicable, may comply by providing a clear, written explanation of such policy as it relates to Network Provider.

V. ACCREDITATION STANDARDS COORDINATING PROVISIONS:

There are no Accreditation Standards Coordinating Provisions at this time.

VI. GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS:

There are no Geographic Exceptions Coordinating Provisions at this time.