EXHIBIT __
(Exhibit number/letter will vary in accordance with the specific provider contract)
COORDINATING PROVISIONS-STATE/FEDERAL LAW, ACCREDITATION STANDARDS AND GEOGRAPHIC EXCEPTIONS
KENTUCKY

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 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, 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

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 SLCP Exhibit or elsewhere in this Agreement.

III. STATE LAW COORDINATING PROVISIONS: KENTUCKY

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.

3.1. As required by K.R.S 304.17A-270 and K.R.S 304.17A-525(4), insurer, or its designee, may not terminate this Agreement without cause.

3.2. As required by K.R.S. §304.17A-527(1)(a) and (1)(c), provider shall not bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from the subscriber, dependent of subscriber, enrollee, or any persons acting on their behalf, with respect to services provided in accordance with this Agreement under any circumstance including, but not limited to the managed care plans nonpayment of sums due to provider, the managed care plans insolvency, or breach of this Agreement. This section shall not prohibit collection of co-payments, deductibles, and/or co-insurance, and amounts for noncovered services. This provision shall survive the termination of this Agreement.

3.3. As required by K.R.S §304.17A-527(1)(b) and (1)(c), in the event this Agreement is terminated, other than for quality of care or fraud, insurer shall continue to provide services and the plan shall continue to reimburse the provider pursuant to this Agreement until the subscriber, dependent of the subscriber, or the enrollee is discharged from an inpatient facility, or the active course of treatment is completed, whichever time period is greater; and (ii) through the end of the post-partum period if a pregnant woman is in her fourth or later month of pregnancy at the time this Agreement is terminated. This provision shall survive the termination of this Agreement.

3.4. As required by K.R.S §304A-527(1)(d), the insurer issuing the managed care plan, or its designee, will, upon request of a participating provider, will provide or make available to the participating provider, when contracting or renewing an existing Agreement with such provider, the payment or fee schedules or other information sufficient to enable the provider to determine the manner and amount of payments under the Agreement for provider's services prior to the final execution or renewal of the Agreement. The insurer issuing the managed care plan, or its designee, shall provide any change in schedules at least ninety (90) days prior to the effective date of the amendment pursuant to KRS 304.17A-577.

3.5. As required by K.R.S.§304.39-245 and Kentucky Department of Insurance Bulletin 2013-04, this Agreement applies to Kentucky no-fault benefits.

3.6. As required by K.R.S §304.17A-527(1)(e), in the event provider subcontracts with another provider to provide their licensed health care services to the subscriber, dependent of the subscriber, or enrollee of a managed care plan where the subcontracted provider will bill the managed care plan or subscriber or enrollee directly for the subcontracted services, the subcontract agreement must meet all the requirements of K.R.S §304A-527, and shall be filed with the Commissioner in accordance with K.R.S §304A-527.

3.7. In the event a client/user has been certified by the Commonwealth of Kentucky as a Workers' Compensation Managed Health Care System pursuant to K.R.S.§342.020, and as applicable to those providers that participate in the Workers' Compensation Network the provider shall:

(a) File any grievance defined by 803 KAR 25.110 Section 10 with the Managed Health Care System within thirty (30) days of the occurrence giving rise to the dispute;
(b) Such grievance shall be in writing setting forth the nature of the complaint and the remedial action requested by the provider; and;
(c) Include the provider's name and address; office contact and phone number; the Managed Health Care System and address; date of the occurrence; and employee's name and address.

Unless an alternate resolution process is provided by the Managed Health Care System, the Managed Health Care System will render a written decision within thirty (30) days of receipt by Managed Health Care System of a written grievance. It shall maintain records for two (2) years of each formal grievance which shall include the following:

(a) A description of the grievance;
(b) The employee's name and address;
(c) Names and addresses of the provider relevant to the grievance;
(d) The Managed Health Care System's and employer's name and address; and
(e) A description of the Managed Health Care System's findings, conclusions, and disposition of the grievance.

A provider dissatisfied with the Managed Health Care System's resolution of a grievance may apply for review by an administrative law judge by filing a request for resolution within thirty (30) days of the date of the Managed Health Care System's final decision. Upon review by an administrative law judge the provider shall be required to prove that the Managed Health Care System's final decision is unreasonable or otherwise fails to conform with K.R.S. Chapter 342.

3.8. In the event a client/user has been certified by the Commonwealth of Kentucky as a Workers' Compensation Managed Health Care System pursuant to K.R.S. §342.020, and as applicable to those Network Providers that participate in the Workers' Compensation Network the following shall apply:

The Workers' Compensation Managed Health Care System administrator shall provide a spreadsheet biannually by April 15 and October 15 that will state any changes in a provider's availability since the Workers' Compensation Managed Health Care System's plan/network was approved. Name, address, phone number, and disposition of the provider shall be provided. This includes any providers added or removed from the network provider directory.

IV. ACCREDITATION STANDARDS COORDINATING PROVISIONS:

There are no Accreditation Standards Coordinating Provisions at this time.

V. GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS:

There are no Geographic Exceptions Coordinating Provisions at this time.