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

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: TEXAS

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 Tex. Ins. Code § 1301.059(b) and 28 TAC §3.3703(15), an insurer may not engage in quality assessment except through a panel of at least three physicians selected by the insurer from among a list of physicians contracting with the insurer. The physicians contracting with the insurer in the applicable service area shall provide the list of physicians to the insurer.

3.2. As required by Tex. Ins. Code § 1301.062, for a provider that is a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners:

(a) the podiatrist may request a copy of the coding guidelines and payment schedules applicable to the compensation that the podiatrist will receive under the contract for services;
(b) the insurer shall provide a copy of the coding guidelines and payment schedules not later than the 30th day after the date of the podiatrist's request;
(c) the insurer may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules; and
(d) the podiatrist may, practicing within the scope of the law regulating podiatry, furnish x-rays and nonprefabricated orthotics covered by the health insurance policy.

3.3 As required by Tex. Ins. Code § 1301.064, subject to Subchapter C of Tex. Ins. Code § 1301, payment to a physician or health care provider for health care services and benefits provided to an insured under the contract and to which the insured is entitled under the terms of the contract shall be made not later than: (1) the 45th day after the date on which a claim for payment is received with the documentation reasonably necessary to process the claim; or (2) if applicable, within the number of calendar days specified by written agreement between the physician or health care provider and the insurer.

3.4. As required by Tex. Ins. Code § 1301.136,

(a) the preferred provider may request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures that the preferred provider will receive under the contract;

(b) the insurer or the insurer's agent will provide the coding guidelines and fee schedules not later than the 30th day after the date the insurer receives the request;
(c) the insurer or the insurer's agent will provide notice of changes to the coding guidelines and fee schedules that will result in a change of payment to the preferred provider not later than the 90th day before the date the changes take effect and will not make retroactive revisions to the coding guidelines and fee schedules; and
(d) the contract may be terminated by the preferred provider on or before the 30th day after the date the preferred provider receives information requested under this subsection without penalty or discrimination in participation in other health care products or plans.

3.5. As required by 28 TAC §3.3703(8), the dispute resolution rights are as stated in the administrative handbook and shall comply with 28 TAC § 3.3706(b)(2) as applicable.

3.6. As required by 28 TAC §3.3703(10), preferred provider agrees to bill the insured only on the discounted fee as agreed to in this Agreement and not the full charge.

3.7. As required by 28 TAC §3.3703 (11), insurer shall comply with all applicable statutes and rules pertaining to prompt payment of clean claims with respect to payment to the provider for covered services rendered to insureds.

3.8 As required by 28 TAC §3.3703(12), provider shall comply with the Insurance Code §§ 1301.152 - 1301.154, which relates to Continuity of Care. In accordance with Tex. Ins. Code § 1301.153(b) the termination of the physician's or provider's participation in a preferred provider benefit plan, except for reason of medical competence or professional behavior, shall not: (1) release the physician or health care provider from the generally recognized obligation to: (a) treat an insured whom the physician or provider is currently treating; and (b) cooperate in arranging for appropriate referrals; and (2) release the insurer from the obligation to reimburse the physician or health care provider or, if applicable, the insured, at the same preferred provider rate if, at the time a physician's or provider's participation is terminated, an insured whom the physician or provider is currently treating has special circumstances in accordance with the dictates of medical prudence.

3.9. As required by 28 TAC §3.3703(18), in the event provider voluntarily terminates the contract, provider shall provide reasonable notice to the insured, and insurer shall provide assistance to the provider as set forth in the Insurance Code § 1301.160(b).

3.10. As required by 28 TAC §3.3703(19), insurer shall provide written notice of termination of the contract to the provider, and in the case of termination of a a physician or practitioner, the notice must include the provider's right to request a review, as specified in § 3.3706(d) of this title.

3.11 As required by 28 TAC §3.3703(20), preferred provider is entitled upon request to all information necessary, in accordance with 28 TAC §3.3703(20), to determine that the preferred provider is being compensated in accordance with the contract. The insurer is required to provide the fee schedules and other required information by the 30th day after the date the insurer receives the preferred provider's request.

3.12. As required by 28 TAC §3.3703(25), preferred provider shall comply with all applicable requirements of the Insurance Code § 1661.005 (relating to refunds of overpayments from enrollees).

3.13. As required by 28 TAC §3.3703(26), a provider that is a facility shall give notice to the insurer of the termination of a contract between the facility and a facility-based physician group that is a preferred provider for the insurer as soon as reasonably practicable, but not later than the fifth business day following termination of the contract.

3.14. As required by 28 TAC §3.3703(27), except for instances of emergency care as defined under Insurance Code § 1301.155(a), a physician or provider referring an insured to a facility for surgery must: (a) notify the insured of the possibility that out-of-network providers may provide treatment and that the insured can contact the insurer for more information; (b) notify the insurer that surgery has been recommended; and (c) notify the insurer of the facility that has been recommended for the surgery.

3.15. As required by 28 TAC §3.3703(28), except for instances of emergency care as defined under Insurance Code § 1301.155(a), facility, when scheduling surgery must: (a) notify the insured of the possibility that out-of-network providers may provide treatment and that the insured can contact the insurer for more information; and (b) notify the insurer that surgery has been scheduled.

IV. ACCREDITATION STANDARDS COORDINATING PROVISIONS:

There are no Accreditation Standards Coordinating Provisions at this time.

V. GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: TEXAS

5.1 As allowed by MPI, if provider is an individual practitioner or group provider, such provider will maintain through a policy of insurance or a self-funded arrangement, coverage for professional liability insurance at minimum levels of $100,000 per occurrence and $300,000 in the aggregate.

5.2 As allowed by MPI, if provider is an urgent care center, such provider will maintain through a policy of insurance or a self-funded arrangement, coverage for professional liability at minimum levels of $200,000 per occurrence and $600,000 in the aggregate.

5.3 As allowed by Tex. Civ. Prac. & Rem. Code Ann. §101.001 et seq., if provider is governmental unit, as defined by Tex. Civ. Prac. & Rem. Code Ann. §101.001, such provider will maintain professional liability insurance and comprehensive general liability insurance in accordance with Tex. Civ. Prac. & Rem. Code Ann. §101.023. Pursuant to Tex. Civ. Prac. & Rem. Code Ann. §101.027, MPI and provider acknowledge and agree that if provider is a unit of state government, as defined by Tex. Civ. Prac. & Rem. Code Ann. §101.001, such provider may only maintain professional liability and comprehensive general liability insurance if authorized or required to do so by law. In the event such provider, who is also a unit of state government, is authorized or required by law to maintain professional liability and comprehensive general liability insurance, such provider will maintain professional liability insurance and comprehensive general liability insurance in accordance with Tex. Civ. Prac. & Rem. Code Ann. §101.023.