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**EXHIBIT \_**  
**COORDINATING PROVISIONS-STATE/FEDERAL LAW, ACCREDITATION**  
**STANDARDS AND GEOGRAPHIC EXCEPTIONS**  
**NEW JERSEY**

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**I. INTRODUCTION:**

1. 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. DEFINITION:**

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 C, 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.

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: NEW JERSEY**

For any Agreement involving the delivery of health care services in the State of New Jersey, 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 N.J.A.C. 11:24B-5.2 (a)(1), this Agreement and any amendments hereto are subject to the prior approval of the New Jersey Department of Banking and Insurance (“DOBI”) and may not be effectuated without such approval. Notwithstanding the preceding, the following types of amendments do not require prior approval of DOBI:
- (i) amendments that are of a clerical nature;
  - (ii) amendments that alter numbers, be they dollar amounts, enrollment amounts or the like, without altering methodologies from which the numbers were derived; and

(iii) amendments that involve the substitution of one set of variable text for another set of variable text, if both sets of variable text were previously approved by DOBI for this Agreement.

2. As required by N.J.A.C. 11:24B-5.2 (a)(2), any provision of this Agreement that conflict with applicable federal or state laws are hereby amended to conform to such applicable federal or state law.
3. As required by N.J.A.C. 11:24B-5.2 (a)(3), MPI shall provide Network Provider with a minimum of thirty (30) calendar days notice of any amendment to this Agreement. Notwithstanding the preceding, such notice is not required in the event the amendment is required due to a change in applicable federal or state laws or regulations or such amendment does not constitute a material change. For purposes of this provision a material change is a change that substantially impacts the rights or obligations of Network Provider.
4. As required by N.J.A.C. 11:24B-5.2 (a)(7)(5), Network Provider may rely upon the written or oral authorization for Covered Services if made by Client or MPI. Covered Services shall not be retroactively denied as not medically necessary except in cases of material misrepresentation of the facts or fraud to Client or MPI.
5. As required by N.J.A.C. 11:24B-5.2 (a) (9), this Agreement is governed by New Jersey law.
6. As required by N.J.A.C. 11:24-5.2 (a)(17), Network Provider shall not be terminated or otherwise penalized because of complaints or appeals that Network Provider files on Network Provider's behalf, or on behalf of Participants, or for otherwise acting as an advocate for Participants in seeking appropriate, medically necessary Covered Services.
7. As required by N.J.A.C. 11:24B-5.2 (a)(20), Network Provider may submit and seek resolution of a complaint or grievance to MPI for review and resolution, if applicable. Such resolution shall not exceed thirty (30) calendar days. In the event Network Provider is not satisfied with the resolution of the complaint or grievance, Network Provider may submit the complaint or grievance to the New Jersey Department of Health and Senior Services, New Jersey Department of Banking and Insurance or the New Jersey Department of Human Services
8. As required by N.J.A.C. 11:24B-5.3, in the event MPI terminates this Agreement, MPI shall provide Network Provider with notice, specifying the reason(s) for such termination. Network Provider may, in writing, request a hearing to appeal the termination, except if the termination (1) occurs on the Renewal Date; or (2) is due to the Network Provider's breach or alleged fraud; or (3) in the opinion of MPI, the Network Provider poses and imminent danger to Participant(s), or the public health, safety, or welfare.
9. As required by N.J.A.C. 11:24A-4.9, in the event Network Provider requests a hearing pursuant to N.J.A.C. 11:24B-5.3, Network Provider shall request such hearing, in writing, within thirty (30) days of the date of the notice of termination. MPI shall hold such hearing within thirty (30) days following receipt of a written request for a hearing by the terminated Network Provider before a panel appointed by MPI. Such panel shall consist of at least three (3) people, one of which shall be a clinical peer in the same or substantially similar discipline and specialty as Network Provider requesting the hearing. MPI shall render a decision in writing within thirty (30) days of the close of the hearing unless MPI provides notice to Network Provider of a need for an extension of time to render its determination. The written determination notice shall set forth the relevant contract provisions and the facts upon which MPI and Network Provider have relied at the hearing and shall state whether Network Provider is terminated or reinstated and shall include MPI's reasons for such determination. In the event Network Provider is reinstated, MPI shall state the impact of the reinstatement upon the terms of the duration of the Agreement.

10. As required by N.J.A.C. 11:24B-5.3 (f), in the event this Agreement is terminated, Network Provider, if a physician, shall:
  - (i) continue to provide health care services for up to four (4) months following the effective date of such termination in cases where it is medically necessary for the Participant to continue treatment with the Network Provider;
  - (ii) in the case of pregnancy of a Participant, through postpartum evaluation of the Participant, up to six (6) months after delivery;
  - (iii) in the case of post-operative care, up to six months following the effective date of the termination;
  - (iv) in the case of oncological treatment, up to one (1) year following the effective date of the termination; or
  - (v) in the case of psychiatric treatment, up to one year following the effective date of termination.
11. As required by the Department of Banking and Insurance Bulletin No.: 06-16, in the event of an appeal of a claim determination, Client shall accept the Health Care Provider Application to Appeal a Claims Determination form and shall post such form on its website.
12. As required by N.J.S.A. § 45:1-10.1, in the event of a claim in which the Participant has assigned his /her benefits to Network Provider, the Network Provider shall submit the claim for payment within 180 days of furnishing health care services.
13. As required by N.J.A.C. 11:22-1.5(a), a Clean Claim is received on the date of actual receipt by the Client.
14. As required by N.J.S.A. §17B:27-44.2(d)(1), Client shall within thirty (30) calendar days of receipt of a Clean Claim, pay or arrange for User to pay Facility for Covered Services, as full compensation, the Contract Rate in accordance with the terms of this Agreement and the administrative handbook(s), in order to obtain the benefit of the Contract Rate.
15. As required by N.J.A.C. 11:24B-5.2(a)(19)(ii), in the event a Clean Claim is not timely paid to Network Provider, Client or User, as applicable, shall be responsible for remitting the interest payment required by New Jersey laws and regulations to Network Provider. In no event shall Network Provider be required to request payment of such interest from Client or User, as applicable, as a condition of receiving such interest payment.
16. As required by N.J.S.A §17B:27-44.2(d)(10), with the exception of claims that were submitted fraudulently or submitted by Network Provider that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, no Client or User, as applicable, shall seek reimbursement for overpayment of a claim previously paid later than 18 months after the date the first payment on the claim was made. No Client or User, as applicable, shall seek more than one (1) reimbursement for overpayment of a particular claim. At the time the reimbursement request is submitted to the Network Provider, the Client or User, as applicable, shall provide written documentation that identifies the error made by the Client or User, as applicable, in the processing or payment of the claim that justifies the reimbursement request. No Client or User, as applicable, shall base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances:
  - (i) in judicial or quasi-judicial proceedings, including arbitration;
  - (ii) in administrative proceedings;
  - (iii) in which relevant records required to be maintained by the Network Provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable; or

(iv) in which there is clear evidence of fraud by the Network Provider and the Client or User, as applicable, has investigated the claim in accordance with its fraud prevention plan and referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

**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.