
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.

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 (A) a Clean Claim means a claim (i) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or (ii) with respect to which a Client has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with the applicable provisions of Va. Code Ann §38.2-3407.15 (B).
2. As required by Va. Code Ann. §38.2-3407.15 (B) (1), Client shall pay or arrange for User to pay any claim within forty (40) calendar days of receipt of the claim except where the obligation of the Client to pay or arrange for User 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 Client 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 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; or
 - b. The claim was submitted fraudulently.

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) calendar 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 pay or arrange for User to pay the claim in compliance with Va. Code Ann 38.203407.15 (B) (1). No Client may refuse to pay or arrange for User 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 a Client from imposing a retroactive denial of payment of such a claim if permitted by this Agreement unless such retroactive denial of payment of the claim would violate Va. Code Ann. 38.2-3407.15 (B) (6). Nothing in this Va. Code Ann. 38.2-3407.15 (B) shall require a Client to pay or arrange for User to pay a claim which is not a Clean Claim.
5. As required by Va. Code Ann. §38.2-3407.15 (B) (3), Client shall pay or arrange for User to pay any interest owing or accruing on a claim under § 38.2-3407.1 or § 38.2- 4306.1, under this Agreement or under any other applicable law without necessity of demand, at the time the claim is paid or within sixty (60) calendar days thereafter.
6. As required by Va. Code Ann. §38.2-3407.15 (B) (4) (a), Client and/or MPI, as applicable, shall establish and implement reasonable policies to permit any 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 (or to the type of health care services which the Network Provider has contracted to deliver under this Agreement) 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) Network Provider specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and (d) other Network 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. 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 either (i) disclose on its website the specific bundling and downcoding policies that Client reasonably expects to be applied to the Network Provider or Network Provider's services on a routine basis as a matter of policy or (ii) disclose a telephone or facsimile number or e-mail address that a Network Provider can use to request the specific bundling and downcoding policies that the Client reasonably expects to be applied to that Network Provider or Network Provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a Network Provider, Client shall provide the requesting Network Provider with such policies within ten (10) business days following the date the request is received.
7. As required by Va. Code Ann. §38.2-3407.15 (B) (4) (b), Client and/or MPI, as applicable, shall make available to Network Provider, within ten (10) business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the particular Network Provider or to particular health care services identified by the Network Provider. In the event the provision of the entire policy would violate any applicable copyright law, Client and/or MPI, as applicable, may instead comply with this provision by timely delivering to the Network Provider a clear explanation of the policy as it applies to the Network Provider and to any health care services identified by the Network Provider.
8. As required by Va. Code Ann. §38.2-3407.15 (B) (5), Client shall pay or arrange for User to pay a claim if the health care service has previously been authorized or if the Network Provider or Participant has been advised in advance of the provision of health care services that the health care services are medically necessary and a Covered Service, unless:
 - a. the documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized; or
 - b. the Client's refusal is because (i) another entity is responsible for the payment, (ii) the Network 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 Client by the Network Provider, Participant, or other person not related to the Client, or (iv) the person receiving the health care services was not eligible to receive them on the date of service and the Client did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status.

9. As required by Va. Code Ann. §38.2-3407.15 (B) (6), no Client may 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 the 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 the 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) 12 months or (b) the number of days under this Agreement within which a claim be submitted by the Network Provider following the date on which a health care service is provided. Client shall notify a Network Provider at least thirty (30) calendar days in advance of any retroactive denial of a claim.
10. As required by Va. Code Ann. §38.2-3407.15 (B) (7), notwithstanding Va. Code Ann. 38.2-3407.15 (6), Client shall not impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless the 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. The written communication shall also contain an explanation of why the claim is being retroactively adjusted.
11. As required by Va. Code Ann. §38.2-3407.15 (B) (8), Network Provider acknowledges that this Agreement contains (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 Network Provider or to the range of health care services reasonably expected to be delivered by that type of Network Provider on a routine basis and (ii) all material addenda, schedules and exhibits thereto and reference to any MPI policies (including those referred to in Va. Code Ann. §38.2-3407.15 (B) (4)) applicable to the Network Provider or to the range of health care services reasonably expected to be delivered by that type of Network Provider under this Agreement.
12. As required by Va. Code Ann. §38.2-3407.15 (B) (9), no amendment to this Agreement or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to the Network Provider (or to the range of health care services reasonably expected to be delivered by that type of Network Provider) shall be effective as to the Network Provider, unless the Network 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 Network Provider has failed to notify MPI in writing within thirty (30) calendar days of receipt of the documentation of the Network Provider's intention to terminate this Agreement at the earliest date thereafter permitted under this Agreement.
13. As required by Va. Code Ann. §38.2-3407.15 (B) (10), in the event that Client's and/or MPI's, as applicable, provision of a policy provided under Va. Code Ann. §38.2-3407.15 (B) (8) or Va. Code Ann. §38.2-3407.15 (B) (9) would violate any applicable copyright law, Client and/or MPI, as applicable, may instead comply with the applicable provisions of Va. Code Ann. §38.2-3407.15 (B) by providing a clear, written explanation of the policy as it applies to the Network Provider.
14. As required by Va. Code Ann. §38.2-3407.15 (B) (11), in addition to the dispute mechanisms provided under this Agreement, Client shall establish, in writing, its claims payment dispute mechanism and shall make this information available to Network Providers.

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.