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

For any Agreement involving the delivery of health care services in the State of West 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 W. Va. Code §33-45-2 (a)(1), In addition to the obligations set forth in Section 5.2, Client shall either pay or deny a Clean Claim within forty (40) calendar days of receipt of the claim if submitted manually and within thirty (30) calendar days of receipt of the claim if submitted electronically, except in the following circumstances: (i) another entity is responsible for the claim; (ii) Client is coordinating benefits with another entity; (iii) Network Provider has already been paid for the claim; (iv) the claim was submitted fraudulently; or (v) there was a material misrepresentation in the claim.
2. As required by W. Va. Code §33-45-2 (a)(2), Client shall maintain a written or electronic record of the date of receipt of a claim. Network Provider shall be entitled to inspect the record on request and to rely on that record or on any other relevant evidence as proof of the fact of receipt of the claim. In the event Client fails to maintain an electronic or written record of the date a claim is received, the claim shall be considered received three (3) business days after the claim was submitted based upon the written or electronic record of the date of submittal by Network Provider.
3. As required by W. Va. Code §33-45-2 (a)(3), Client shall, within thirty (30) calendar days after receipt of a claim, request electronically or in writing from Network Provider any information or documentation that Client reasonably believes will be required to process and pay the claim or to determine if the claim is a Clean Claim. Client shall use

all reasonable efforts to ask for all desired information in once request, and shall, if necessary, within fifteen (15) calendar days of the receipt of the information from the first request, only request or require additional information one additional time if such additional information could not have been reasonably identified at the time of the original request or to specifically identify a material failure to provide the information requested in the initial request. Upon receipt of the additional information requested, Client shall either pay or deny the claim within thirty (30) calendar days. Client shall not refuse to pay a claim if the Client fails to timely notify Network Provider within thirty (30) calendar days of receipt of the claim of the additional information needed, unless such failure was caused in material part by Network Provider.

4. As required by W. Va. Code §33-45-2 (a)(4), in the event a Clean Claim is not paid pursuant to the timeframes provided for by W. Va. Code §33-45-2, Client shall pay interest in accordance with W. Va. Code §33-45-2 (a)(4).
5. As required by W. Va. Code §33-45-2 (a)(5), Client and MPI, as applicable, shall establish and implement reasonable policies to permit Network Provider (i) to confirm in advance during normal business hours 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, 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.
5. As required by W. Va. Code §33-45-2 (a)(5)(C), Client or MPI, as applicable, shall make available to Network Provider within twenty (20) business days of receipt or a request, reasonable access to all policies that are applicable to Network Provider. 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 narrative explanation of the policy and procedure as it applies to Network Provider.
6. As required by W. Va. Code §33-45-2 (a)(6), Client shall pay a Clean Claim if the 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 are Covered Services, unless:
 - (i) the documentation for the claim provided by Network Provider clearly fails to support the claim as originally authorized; or
 - (ii) Client's refusal is because (a) another entity is responsible for payment; (b) Network Provider has already been paid for the health care services identified on the claim; (c) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to Client by Network Provider, Participant, or other person not related to Client; (d) the person receiving the health care services was not eligible to receive them on the date of services and Client did not know, and with the exercise of reasonable care could not have known, or the person's eligibility status; (e) there is a dispute regarding the amount of charges submitted; or (f) the service provided was not a Covered Service and Client did not know, and with the exercise of reasonable care could not have been known, at the time of the certification that the service was not a Covered Service.
7. As required by W. Va. Code §33-45-2 (a)(7)(A), Client may not retroactively deny a previously paid claim unless: (i) the claim was submitted fraudulently; (ii) the claim contained material misrepresentations; (iii) the claim payment was incorrect because Network Provider was already paid for the health care services identified on the claim or the health care services were not delivered by Network Provider; (iv) Network Provider was not entitled to reimbursement; (v) the health care services were not a Covered Service; or (vi) Participant was not eligible for reimbursement.
8. As required by W. Va. Code §33-45-2 (a)(7)(B), a Network Provider to whom a previously paid claim has been denied by Client shall, upon receipt of notice of the retroactive denial, notify Client, within forty (40) calendar days of Network Provider's intent to pay or demand a written explanation of the reasons for the denial. Upon receipt of the explanation for the retroactive denial, Network Provider shall reimburse Client within thirty (30) calendar days for allowing an offset against future payments or provide written notice of the dispute. Such disputes shall be resolved within thirty (30) calendar days of receipt of the notice of dispute. Upon resolution of such dispute, Network Provider shall pay any amount due or provide a written authorization for an offset against future payments.
9. As required by W. Va. Code §33-45-2 (a)(8), Client may retroactively deny a claim only for the reasons set forth in W. Va. Code §33-45-2 (a)(7)(A) (iii)-(vi) for a period of one year from the date the claim was originally paid. There

shall be no time limitation for retroactively denying a claim for the reasons set forth in W. Va. Code §33-45-2 (a)(7)(A) (i) and (ii).

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.