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

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: NEW HAMPSHIRE

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 N.H. Rev. Stat. § 420-J:8 (I)(a):

(a) Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a covered person or a person acting on behalf of the covered person (other than the health carrier or intermediary) for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles, or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided in N.H. Stat. § 420-J:8, this agreement does not prohibit the provider from pursuing any available legal remedy.

(b) Provider further agrees that (1) this provision shall survive the termination of this agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the covered person; and (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between provider and covered person or persons acting on their behalf.

3.2 As required by N.H. Rev. Stat. § 420-J:8(X) health carrier may not remove a health care provider from its network or refuse to renew the health care provider with its network for participating in a covered person's internal grievance procedure or external review.

3.3 As required by N.H. Rev. Stat. § 420-J:8(XI) covered persons will have continued access to the provider in the event that the contract is terminated for any reason other than unprofessional behavior. The continued access to providers shall be made available for 60 days from the date of termination of the contract and shall be provided and paid for in accordance with the terms and conditions of the covered person's health benefit plan and the prior contract between a health carrier and a health care provider. Within 5 business days of the contract termination, the health carrier shall provide written notice to affected covered persons explaining their continued access rights.

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.