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of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402
bcbst.com

Tips for Using DocuSign to Review and Sign Your Provider Contract

We're working to make our contracting process more efficient by reducing the amount of hard-copy paperwork that's involved, which is why we have moved to DocuSign for the review and signature steps of your contract. Here are some tips to help you get enrolled quickly using DocuSign.

Video: Signing a Document

1. Sending the Contract to Someone Else for a Signature

If you're not the person authorized to sign the contract, you can send it to the proper person by following these steps:

- Click the "**OTHER ACTIONS**" drop-down menu in top right corner.
- Click "**Assign to Someone Else.**"
  Enter the person's name and email address and reason for change in **signing responsibility**.

2. Group Contracts

If you're a provider who is joining a practice with one or more providers under a group NPI number, you may receive a group contract even if the other affiliated providers have individual contracts. By consolidating the contracts of providers who practice together, our aim is to improve efficiency for your office by delivering consistent reimbursement rates and reporting requirements to each provider in the practice. It also ensures providers all participate in the same networks, which is important for your group's patients.

If you're not the Signature of Authority, please send the contract to the appropriate individual using the directions in section 1.

3. Incorrect Information OR You Decline to Sign

If the information listed on the contract is incorrect (ex. name, NPI, etc.), or if you choose not to sign it because you don't agree with the contract offer, here are the steps to take:

- Click the **"OTHER ACTIONS"** drop-down menu in top right corner.
- Click **Decline to Sign**.
- Provide the details related to your declination inside the comments section:
  - Note the exact items that are incorrect, including which pages and the correct value.
  - Add a detailed reason for not signing.

4. Process and Expected Timeline

Please sign the agreement on or before the date listed in the attached documents. Agreements not signed by that time will be cancelled. Once signed, your application will continue through the enrollment process. This process may take up to 30 days.

After 30 days, if you don't receive an email with a completed contract and acceptance letter, please contact our staff at **Contracts_Reqs_GM@bcbst.com** or call our Provider Service line at **1-800-924-7141**, Monday through Friday, from 8 a.m. to 6 p.m. (ET). Follow the prompts and select "Contracts and Credentialing" to reach us.

Please Note

This notice doesn't guarantee acceptance as a network provider. Our goal is to complete your credentialing and contracting within 30 days of receiving your completed application, but you're not considered a participating network provider until you receive an email from our Contracting Department that includes your acceptance letter and effective date.

Before BlueCross signs your contract, you must complete the network participation criteria as described in the applicable provider manual http://www.bcbst.com/providers/manuals.

Thank you for your interest in becoming a BlueCross provider.

I have read and understand the guidelines set forth above. Initial: _____

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the Blue Cross Blue Shield Association.

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BlueCross BlueShield of Tennessee
Ancillary Provider Agreement

An Independent Licensee of the
BlueCross BlueShield Association

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BLUECROSS BLUESHIELD OF TENNESSEE

ANCILLARY PROVIDER AGREEMENT

THIS ANCILLARY PROVIDER AGREEMENT (the "Agreement") is entered into by and between BlueCross BlueShield of Tennessee, Inc., for itself and on behalf of its wholly-owned subsidiaries (collectively, "BCBST"), and the entity ("Provider") that has signed the signature page attached to this Agreement (the "Signature Page"), and is effective as of the later of (i) the latest date set forth beside a Party's signature on the Signature Page, or a different date mutually agreed upon in writing by BCBST and Provider on the Signature Page or (ii) the date the Provider becomes credentialed by BCBST (the "Effective Date"). BCBST and Provider are each sometimes referred to in this Agreement as a "Party" and jointly as the "Parties".

1. RECITALS

WHEREAS, BCBST issues and administers benefit plans covering the provision of healthcare services to its Members (as such term is defined herein); and

WHEREAS, the Provider is duly licensed by the state in which the Provider is located and is provider of healthcare services; and

WHEREAS, the Parties to this Agreement desire to enter into this Agreement for Provider to provide healthcare services to the Members.

NOW, THEREFORE, in consideration of the mutual promises and covenants hereinafter contained, the Parties agree as follows:

2. DEFINITIONS

"Affiliate(s)" means any Person that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the Person specified. For purposes of this definition, "control" of a Person means the power, direct or indirect, to direct or cause the direction of the management and policies of such Person whether by contract or otherwise, and, in any event, and without limitation of the previous sentence, any Person owning fifty percent (50%) or more of the voting securities of another Person shall be deemed to control that Person. In addition to the above, each Person that has been licensed by the BCBSA to use any of the BCBS Marks shall be deemed an Affiliate of BCBST, regardless of any common control requirements or lack of control. Any licensed Person is related to BCBST as a separate and distinct licensee of Blue Cross and Blue Shield.

"Anniversary Date" means October 1, notwithstanding the Effective Date of this Agreement or the effective date of participation by Provider in any Network.

"BCBSA" means the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield licensees.

"BCBS Marks" means the trademarks, names, logos, symbols and service marks owned by the BCBSA.

"Blue Cross Benefit Plan" means an agreement entered into by BCBST or any of its Affiliates with a Person for the insurance or administration of Covered Services by BCBST or one of its Affiliates.

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"Change of Control" means the occurrence of any of the following: (a) direct or indirect sale, transfer, conveyance or other disposition (other than by way of merger, consolidation, reorganization or conversion), in one or a series of related transactions, of all or a majority of the properties or assets of Provider; (b) the consummation of any transaction (including, without limitation, any merger, consolidation, reorganization or conversion) the result of which is that a Person that is not an Affiliate prior to the transaction becomes the beneficial owner, directly or indirectly, of more than 25% of the then-outstanding number of units, interests, or shares of the Provider's voting stock (or membership interests or other equity); (c) a Person that is not an Affiliate prior to the transaction assumes substantial operational control of Provider or one or more service lines, departments, or ancillary services provided by Provider, including but not limited to operational control exercised through the entry into, or change in, an agreement for a Person that is not an Affiliate prior to the transaction to provide management or outsourcing services to Provider; or (d) there is a change to a Person that has the authority to appoint individuals to Provider's Board of Directors or equivalent governing board.

"Clean Claim" means a claim for payment of Covered Services provided to a Member by a Network Provider that requires no further information, adjustment, or alteration in order to be processed and paid by BCBST or the responsible Payor.

"Covered Service(s)" means those Medically Necessary healthcare services and supplies delivered or provided to a Member and for which benefits are available under the terms of the Member's Blue Cross Benefit Plans. In making any such determination, without limitation, BCBST may rely upon any or all of the following, in its sole discretion:

a. medical records; or

b. the protocol(s) under which proposed service or supply is to be delivered; or

c. any consent document that a Member will be asked to execute, in order to receive the proposed service or supply; or

d. the published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses; or

e. regulations and other official publications issued by the Food & Drug Administration ("FDA") and the United States Department of Health and Human Services ("HHS"); or

f. the opinions of any Person that contracts with BCBST to assess and coordinate the treatment of Members requiring non-experimental or Investigational services.

"Dispute Resolution Process" means the process set forth in the Provider Manual to resolve disputes between the Parties, including the applicable Provider Dispute Resolution Process and the Medical Management Corrective Action Plan (each as defined in the applicable Provider Manual).

"Emergency" means the definition of the term "emergency" as set forth in the applicable Provider Manual.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended, and the rules and regulations promulgated pursuant thereto.

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"Healthcare Professional(s)" means a physician, doctor of osteopathy, podiatrist, dentist, chiropractor, midwife, nurse, optometrist, or other individual licensed or certified to practice a healthcare profession by the state or states in which he or she practices such profession.

"Investigational" means the definition of the term "investigational" as set forth in the applicable Provider Manual.

"Maximum Allowable" means the amount that the Payor has determined to be the maximum amount payable for a Covered Service, which shall be the lesser of billed charges or the established fee for the services performed as set forth in the applicable Network Attachment.

"Medically Necessary" means the definition of the term "medically necessary" as set forth in the applicable Provider Manual.

"Member(s)" means an individual eligible to receive Covered Services under a Blue Cross Benefit Plan.

"Member Obligation(s)" means any and all charges that a Network Provider may collect directly from a Member as the Member's portion of payment for Covered Services, including the copayments, deductibles and coinsurance amounts described in the Member's Blue Cross Benefit Plan.

"Network" means a group of providers that has agreed to accept a pre-determined fee schedule as payment in full for Covered Services provided to select Members.

"Network Attachment" means an attachment or exhibit to this Agreement that describes the rates to be paid to Provider for provision of certain services to BCBST Members accessing a particular Network. Network Attachments may also include specific terms or conditions applicable only to Provider's participation in that Network.

"Network Provider" means a healthcare provider contracted to provide Covered Services to Members enrolled in a Blue Cross Benefit Plan.

"Network Participation Criteria" means the minimum qualifications and standards required in order to be considered and selected to participate in a Network, as described in the applicable Provider Manual.

"Non-Covered Services" means those services and supplies that are not included in Covered Services, or are specifically excluded from, or subject to a limitation of, coverage pursuant to the terms of the Provider Manual or the Member's Blue Cross Benefit Plan. Non-Covered Services are not the same as Non-Reimbursable Services, the definition of which is set forth below.

"Non-Reimbursable Services" means those services and supplies that would have been Covered Services but for the fact that Provider (i) rendered services or supplies that were not Medically Necessary; (ii) failed to comply with applicable Quality Improvement Program or Utilization Management Program requirements; or (iii) failed to submit a claim for such services or supplies within the submission deadlines established in Section 5.5 of this Agreement. "Non-Reimbursable Services" also include Non-Contracted Services as set forth in the applicable Provider Manual.

"Payor" means a person or entity that is responsible for paying for Covered Services in accordance with the terms of the Blue Cross Benefit Plan under which the Member being treated is covered.

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"Person" shall mean any natural person, corporation, general partnership, limited partnership, limited liability company, proprietorship, other business organization, trust, union, association, or governmental or regulatory authority, whether domiciled in the United States or one of its territories.

"Prior Authorization" means an authorization obtained from BCBST for the provision of Covered Services prior to the delivery of that service or period of confinement, as described in the applicable Provider Manual.

"Provider Manual" means the applicable manual(s) set forth on the BCBST website(s) that contain information, including, but not limited to, medical and operating policies and procedures established by BCBST for Network Providers.

"Quality Improvement Program" means the BCBST program which focuses on monitoring and enhancing the quality of healthcare services rendered to Members, as described in the applicable Provider Manual.

"Utilization Management Program" means the BCBST program which focuses on the medical review of healthcare services provided to Members, as described in the applicable Provider Manual.

3. RELATIONSHIP BETWEEN THE PARTIES

3.1. Independence of the Parties.

Provider expressly acknowledges its understanding that this Agreement constitutes a legally binding agreement between Provider and BCBST. BCBST and Provider are independent legal entities contracting with each other solely to carry out the terms of this Agreement for the purposes stated herein. Nothing in this Agreement shall be construed or be deemed to create a relationship other than that of independent parties. BCBST is an independent corporation operating under a license from the BCBSA, permitting BCBST to use the BCBS Marks, and that BCBST is not contracting as the agent of the BCBSA. Provider acknowledges and agrees that it has not entered into this Agreement based upon representations by any person or entity other than BCBST, and that no person, entity, employer, or organization other than BCBST shall be held accountable or liable to Provider for any of BCBST's obligations to Provider created under this Agreement.

3.2. Limitation on Provider and Third Parties.

Provider is entering into this Agreement for itself and on behalf only of its providers and locations listed on **Exhibit 1A** attached hereto. This Agreement is entered into by Provider with the understanding that the Agreement shall not constitute an agreement between Provider and other providers or locations that are parties to similar agreements or contracts. Provider agrees that this Agreement does not constitute an agreement that Provider may act as agent for any other provider that becomes party to a similar agreement or impose any liability upon any other provider by reason of any act or acts of omission or commission on its part. If Provider desires to add a new provider or location to this Agreement, Provider shall submit a request to BCBST to modify this Agreement and **Exhibit 1A**, which BCBST may accept in its sole discretion. If BCBST agrees to add a new location, the Parties shall amend **Exhibit 1A** accordingly.

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4. SERVICES AND RESPONSIBILITIES

4.1. Provision of Services.

(a) General. Under the terms and conditions of this Agreement, Provider shall provide Covered Services to Members in accordance with the provisions of this Agreement, Blue Cross Benefit Plans, and any applicable attachments or exhibits attached to this Agreement. Provider acknowledges and agrees that BCBST does not promise, warrant, or guarantee that Provider shall be permitted to participate in any particular Network, or that Provider will render any type or volume of Covered Services to Members. Provider acknowledges that BCBST does not warrant that Members will choose to utilize Provider's services.

(b) Standards. Provider shall be responsible for the medical care and treatment and the maintenance of a patient relationship with each Member that Provider treats. Provider will provide only those services that it is duly licensed, credentialed, and qualified to provide, and will otherwise abide by the terms of this Agreement, the applicable Network Attachments, and the applicable Provider Manual. Provider will use its best efforts to provide Covered Services to Members in a competent and timely manner. Provider acknowledges and agrees that any determinations made by BCBST pursuant to BCBST's Quality Improvement Program and Utilization Management Program are benefits and not treatment determinations. Provider is solely responsible for making treatment recommendations and decisions in consultation with its patients. Provider shall only provide Covered Services that are: (i) Medically Necessary; and (ii) ordered by an appropriate Healthcare Professional.

(c) Eligibility and Coverage Determinations. Either BCBST or the responsible Payor shall have full discretionary authority to make eligibility and coverage determinations concerning services rendered to Members, in accordance with ERISA, and the terms of a Member's Blue Cross Benefit Plan. Provider shall accept and abide by all such determinations, subject to its right to dispute such determinations pursuant to Section 7 of this Agreement. Provider acknowledges that it has the right to request expedited reconsideration of an adverse benefit determination if Provider reasonably believes that determination will preclude a Member from receiving urgently needed services. Provider further acknowledges that such eligibility and coverage determinations are solely benefit determinations that shall not limit or affect Provider's rights or responsibilities related to the care and treatment of its patients.

4.2. Member Protections.

(a) Nondiscrimination. Provider shall provide healthcare services to Members in accordance with recognized standards and within the same time frame as those services provided by Provider to Provider's patients that are not Members. Provider agrees not to differentiate or discriminate in the treatment of Members on the basis of race, sex, age, handicap, religion, national origin or network reimbursement, and to observe, protect and promote the rights of Members as patients. BCBST recognizes Provider's right to refuse to treat any Member for

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appropriate medical or professional reasons, in accordance with applicable state or federal law, provided that the reason for such refusal is not that the patient is a Member in a participating Blue Cross Benefit Plan.

(b) **Open Communication.** BCBST encourages open provider-patient communication regarding appropriate treatment alternatives. BCBST will not penalize Provider for discussing Medically Necessary care with Members.

(c) **Member Relations.** Each Party to this Agreement, their staff, personnel, and agents shall treat Members promptly, fairly and courteously, whether by phone, in person, or in writing. Both Parties, and their respective employees, shall endeavor to maintain a high level of customer service and satisfaction.

(d) **Disputes.** Provider shall make a good faith effort to avoid involving Members in disputes between BCBST and Provider.

(e) **Maximization of Benefits.** Provider acknowledges that BCBST may assist Members from time to time in maximizing their benefits, including through the use of care coordination activities, transparency tools and Member education.

4.3. Prior Authorization.

A Prior Authorization may be retroactively denied by BCBST if BCBST subsequently determines that (a) the healthcare services sought were not included as Covered Services under the applicable Blue Cross Benefit Plan; (b) such services were not Medically Necessary; (c) the Member was ineligible for such services at the time the services were rendered; or (d) the information submitted with the Prior Authorization request was not accurate and complete. If BCBST does not authorize a service that requires a Prior Authorization, Provider will not receive payment for such service.

4.4. Exclusivity.

This Agreement is not intended, and shall not be construed, to grant Provider an exclusive or preferential right to provide Covered Services to Members, except as expressly provided in this Agreement. Provider acknowledges that BCBST may enter into arrangements with other providers to render specified Covered Services to Members on an exclusive or preferential basis. In such circumstances, Provider shall refer Members to such providers to receive those Covered Services in accordance with the applicable Quality Improvement Program and Utilization Management Program requirements.

4.5. License Requirement.

Provider represents to BCBST that Provider possesses and shall maintain all certificates and licenses required by BCBST and state and federal law to perform its obligations pursuant to this Agreement. Provider further represents that any Healthcare Professional through whom Provider provides Covered Services shall possess and maintain all licenses and credentials required by state and federal law to perform such Covered Services.

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4.6. Insurance.

(a) **Requirements.** BCBST shall maintain such insurance coverage that BCBST reasonably believes to be appropriate. Provider maintains coverage hereunder through a self-funded insurance plan. Upon request, Provider shall provide a certificate of self-insurance, or a letter, detailing its coverage and policy amounts. Provider's insurance coverage shall provide coverage against claims for damages caused, in whole or in part, by any act or omission by Provider, Provider's employees, agents, or Affiliates. Provider shall provide evidence of any of the aforementioned insurance coverage to BCBST upon BCBST's request, and shall inform BCBST immediately of any change in such coverage.

4.7. Credentialing Requirements.

Provider acknowledges and agrees that it must be credentialed with BCBST in order to provide services under this Agreement, and must maintain all credentialing requirements in accordance with the applicable Provider Manual.

4.8. Provider Application.

Provider represents to BCBST that Provider's application for participation as a Network Provider (the "Application") has been accurately completed. Provider shall provide copies of documentation as requested by BCBST to verify all information set forth in or required by the Application. Provider agrees that it shall not represent itself as a Network Provider until it has received written confirmation from BCBST that Provider is a Network Provider.

4.9. Notification by Provider.

Provider shall immediately notify BCBST of the following:

(a) any changes of information in Provider's Application; and

(b) any action initiated against Provider, including, but not limited to, an action;

(i) for negligence; or

(ii) for a violation of law; or

(iii) resulting in a sanction or limitation upon any license or certificate issued pursuant to state or federal law or upon Provider's right or ability to participate in any state or federal program; and

(c) any other problem or situation that would materially impair the ability of Provider to carry out the duties and obligations of this Agreement.

4.10. Accessibility of Provider.

Provider shall be available to provide Covered Services to Members at all appropriate times in accordance with applicable BCBST policies and procedures and the applicable Provider Manual.

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4.11. Acceptance of Assignments.

Provider shall accept assignments for the payment of services provided to Members. Provider shall acquire and maintain all necessary evidence of assignments.

4.12. Referral to Network Providers.

In the event that Provider determines that it is necessary to refer any Member to another healthcare provider for the provision of Covered Services, Provider shall ensure that such other healthcare provider is a Network Provider.

4.13. Compliance.

The Parties agree to comply with all applicable federal and state laws, rules, and regulations related to this Agreement and the services to be provided hereunder, including, but not limited to, laws and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, privacy, self-referral, false claims, and prohibition of kickbacks. Provider represents, warrants and agrees that Provider has the requisite right and authority to submit member identifying information to BCBST for treatment, payment and health care operations purposes and has obtained, if required by applicable law, the appropriate consent or authorization to share member identifying information with BCBST for all of these purposes.

4.14. Identification Cards.

BCBST agrees to provide appropriate identification cards for BCBST Members, which may be in electronic, digital, or physical form. In order to ensure proper identification of each Member, Provider agrees to use reasonable efforts to verify the identity of the BCBST identification card-holder, including, but not necessarily limited to, checking a valid state-issued identification card, a validly-issued driver's license, or any other appropriate picture ID.

5. COMPENSATION

5.1. Reimbursement.

(a) BCBST agrees to pay Provider, via Electronic Funds Transfer ("EFT"), for Covered Services in accordance with (i) state or federal laws or regulations applicable to the Blue Cross Benefit Plan covering the Member receiving Covered Services from Provider, (ii) the terms of this Agreement, and (iii) the terms of the applicable Network Attachment. BCBST will process all Clean Claims submitted to BCBST. In the event that BCBST is unable to pay Provider via EFT, BCBST may, in its discretion, terminate this Agreement in accordance with Section 11.4.

(b) Payment to Provider of the Maximum Allowable, less Member Obligations, for Covered Services rendered to a Member shall constitute payment in full for such Covered Services. Provider agrees to accept ninety-eight percent (98%) of billed charges as a payment in full for services rendered to Members not enrolled in a

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Network. Provider shall not bill any Member for any difference between the Maximum Allowable for a Covered Service and Provider's billed charges for such Covered Service.

(c) BCBST is not obligated to pay for services provided by Provider that are not Medically Necessary (including Investigational services) or that are Non-Covered Services. However, the Parties recognize that Members might request services that are not Medically Necessary or are Non-Covered Services. Provider may bill the Member for such services, but only if, prior to performing such services, Provider notifies the Member in writing that the services will not be Covered Services and obtains the Member's informed, written consent in the form of a procedure-specific financial responsibility agreement requiring the Member to acknowledge his or her payment responsibility for such services. Any such procedure-specific financial responsibility agreement must be the same or substantially similar to the form provided in the Provider Manual and must contain the terms provided for therein.

(d) Provider agrees that in no event, including, but not limited to, non-payment by BCBST (including non-payment as a result of Provider's failure to submit claims in accordance with Section 5.5), rebundling or downcoding of charges by BCBST (as described in Section 5.5), or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation from, or have any recourse against Members for Covered Services provided pursuant to this Agreement. This provision shall not prevent Provider from charging Members for applicable Member Obligations or for Non-Covered Services in accordance with Section 5.1 and the applicable Provider Manual. Provider agrees that it will not seek payment from a Member for a Non-Reimbursable Service.

(e) Notwithstanding Provider's agreement to not seek compensation from a Member for Covered Services, if a Member is subsequently determined to have been ineligible at the time Covered Services were rendered, BCBST shall recover payments made to Provider for Covered Services rendered to that Member within ninety (90) days prior to the date that BCBST was notified or becomes aware that the Member was ineligible. Such recovery will be based upon actual claim payment date. If the applicable Blue Cross Benefit Plan contains a lesser retroactive Member termination clause or policy, such clause or policy shall apply. If a self-funded plan has a different retroactive termination clause or policy, such self-funded provisions shall prevail. Notice of recovery will be sent to Provider no more than thirty (30) days from the date BCBST was first notified of the Member ineligibility.

(f) If a Payor that has contracted with BCBST to perform administrative services for a group is responsible for reimbursing Provider for services rendered to Members covered by that Payor, BCBST's obligation pursuant to this Section 5.1 shall be limited to making a good faith effort to arrange to have the responsible Payor reimburse Provider for such services. Such services shall be deemed to be Non-Covered Services if the responsible Payor fails to reimburse Provider for otherwise Covered Services and BCBST shall have no financial liability or payment obligation to Provider for such services.

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(g) Both Parties agree that it is the intent of this Agreement that all payments and dispute resolutions shall be resolved pursuant to the terms of this Agreement and the Provider Manual.

5.2. Member Obligation.

Provider shall not waive any applicable Member Obligation without BCBST's prior written approval. Provider must bill and make a good faith effort to collect all applicable Member Obligations from Members as a condition to receiving reimbursement from BCBST for Covered Services.

5.3. Deduction of Certain Payments.

BCBST shall have the right to deduct any Member Obligations from payments due Provider. Deductions for the Member Obligations shall be determined on the basis of the applicable contracted reimbursement amounts, as set forth in applicable Network Attachments.

5.4. Overpayments or Underpayments.

(a) Claim payments made by BCBST are contingent upon the accuracy of diagnostic and other information provided by Provider to BCBST. If BCBST determines that it has made erroneous overpayments or underpayments to Provider, BCBST may recover or make additional payments to correct such errors. Reasons for overpayments include, without limitation, payments made for Non-Covered Services or Non-Reimbursable Services, duplicate payments, payment made for services rendered to ineligible individuals, payments made as the primary Payor when BCBST should be the secondary Payor, or payments for bundled or Non-Reimbursable Services in accordance with BCBST's claim coding protocols, as specified in the Provider Manual.

(b) If BCBST determines, in its sole discretion, that it has made an overpayment to Provider, Provider is obligated to and agrees to reimburse BCBST for such overpayment, subject to Provider's right to appeal in accordance with the procedures set forth in this Agreement and the Provider Manual. BCBST may recover the amount of such overpayment by offsetting the overpayment against what is owed or may become due to Provider for other claims, or at its discretion, BCBST may permit direct repayment of the overpayment by Provider.

(c) For all Networks, other than those requiring a longer period by regulation or statute, BCBST's request for recoupments shall be made no later than eighteen (18) months after the date that BCBST paid the claim submitted by Provider that has been paid in error, except in the case of Provider's fraud, in which case no time limit shall apply.

(d) Provider agrees that BCBST shall not be required to correct a payment error to Provider if the request for payment correction is made more than eighteen (18) months from the date Provider received payment or notice of non-payment for the specific claim in issue.

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(e) Notwithstanding the foregoing, BCBST's review of relevant financial and/or medical records shall not be limited to such eighteen (18) month time period, nor shall BCBST be prohibited from pursuing any other remedy available either at law or in equity.

5.5. Submission of Charges.

(a) Provider warrants that all charges submitted for Covered Services are legitimate. Provider agrees to submit all charges for services to BCBST for adjudication in accordance with the applicable Provider Manual. Provider shall submit charges for Covered Services on Clean Claims within six (6) months from the date Covered Services have been rendered to the Member or, for facilities, within six (6) months from the date of discharge of the Member. If BCBST is the secondary Payor to another commercial insurer or Medicare, claims must be submitted within sixty (60) days from the date indicated on the primary insurer's remittance advice or explanation of benefits. Failure to submit claims within the proper time period will result in denial of claims. Provider agrees to abide by recognized standards of coding, as determined by BCBST, and shall not engage in any unbundling, upcoding or any similar activities. In addition, BCBST shall have the authority, where BCBST determines that such activity has occurred, to rebundle, down code and otherwise address and correct such activities.

(b) Provider agrees to provide all administrative, clinical and support services necessary to deliver the services it is licensed, credentialed and qualified to provide. Provider also agrees that it will not engage in the unbundling of such services or permit other providers to bill for such administrative, clinical and support services.

5.6. Pass Through Charges.

(a) Provider is not permitted to submit claims to BCBST for services performed, in whole or in part, by another provider unless permitted by BCBST in writing.

(b) Where permitted by BCBST in writing, if Provider provides services under arrangement with another healthcare provider, Provider is permitted to submit claims to BCBST for those services. BCBST shall have no liability to that other healthcare provider, and Provider shall be financially liable to the other healthcare provider for those services. Provider shall advise the other healthcare provider of Provider's responsibility to pay for such services and shall not permit the other healthcare provider to bill, charge or otherwise attempt to collect from BCBST, the Member or any third party for the services. In the event that BCBST pays the other healthcare provider for such services, BCBST shall have the right to recover the amount of such payment from Provider or withhold future payments from Provider equaling the amount of the payment to the other healthcare provider as set forth in Section 5.4. Any obligation by BCBST to make payment for services is further subject to the additional terms of this Agreement, the Provider Manual, and the Member's underlying Blue Cross Benefit Plan.

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5.7. Coordination/Maintenance of Benefits.

When a Member is eligible for benefits under more than one health insurance program, policy, or other form of governmental or non-governmental health insurance coverage, the determination of primary and secondary liability ("Coordination/Maintenance of Benefits") will be made in accordance with applicable rules and established guidelines. Provider shall make a good faith effort to determine if a Member is eligible for Coordination/Maintenance of Benefits. If Provider becomes aware of the availability of other health insurance coverage, it shall promptly notify BCBST of that fact. Provider may seek payment for the provision of services rendered by Provider from multiple health benefit plans when a Member is eligible to receive benefits from other health insurers. If BCBST is the secondary Payor, then BCBST shall coordinate with the primary insurance carrier or Payor and pay up to the Maximum Allowable or will pay as set forth in the Member's Blue Cross Benefit Plan. When Provider seeks payment from another insurer, Provider is not obligated to seek payment from such insurer based on the rates in the applicable Network Attachment. BCBST and Provider shall cooperate and exchange information regarding alternative health coverage of Members and other information relative to Coordination/Maintenance of Benefits.

5.8. Subrogation and Right to Recover.

(a) Provider acknowledges and agrees that BCBST shall be subrogated to and have the right to recover amounts paid for Covered Services whenever a Member receives such Covered Services to treat illnesses or injuries caused by the Member or a third party. In such circumstances, BCBST shall have the right to recover amounts paid for Covered Services for the Member's illness or injury on a first-dollar basis, regardless of whether the Member has been made whole for his or her injuries. Provider agrees that BCBST's right to reimbursement or subrogation are net of reasonable costs and attorney's fees, such costs and fees not to exceed thirty percent (30%) of the gross amount owed to BCBST.

(b) Provider acknowledges and agrees that it shall have no right of subrogation or recovery from the Member or a third party for Covered Services rendered to a Member pursuant to this Agreement. Payment of the applicable Maximum Allowable shall be payment in full for such Covered Services.

(c) Provider agrees to notify BCBST promptly, but no later than fourteen (14) days after treatment, if it renders Covered Services to a Member to treat an illness or injury that may have been caused by the Member or by a third party. Further, Provider agrees to cooperate with BCBST and to provide any information, documentation, and assistance reasonably requested to permit BCBST to protect and enforce its rights under this section. If Provider does not notify BCBST within fourteen (14) days of treatment of a Member for an illness or injury that may have been caused by the Member or a third party, and BCBST suffers injury because of the delay, Provider agrees that BCBST shall have the right to recover any and all amounts owed from Provider.

6. QUALITY IMPROVEMENT AND UTILIZATION MANAGEMENT

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6.1. Quality Improvement and Utilization Management Programs.

BCBST, or an entity designated by BCBST, shall maintain Quality Improvement Programs and Utilization Management Programs and shall monitor the delivery of healthcare services to Members. For the purposes of providing Covered Services to Members, Provider agrees to comply with BCBST's Quality Improvement Programs and Utilization Management Programs. BCBST may monitor Provider's quality improvement activities and compliance with Quality Improvement Programs and Utilization Management Programs.

7. RESOLUTION OF DISPUTES

7.1. Disputes.

BCBST and Provider agree to meet and confer in good faith to resolve any problem, dispute, or controversy that may arise under this Agreement. Provider acknowledges and agrees to abide by the Dispute Resolution Process excluding its mandatory arbitration requirement, set forth in the Provider Manual. Provider agrees that the Dispute Resolution Process is the exclusive method for addressing or resolving any and all controversies, disputes, or claims between Provider and BCBST and its Affiliates. Provider further agrees that BCBST may amend the Dispute Resolution Process from time to time by providing thirty (30) days prior written notice in advance of the changes becoming effective. The Dispute Resolution Process is incorporated by reference into this Agreement and shall survive the termination of this Agreement. Notwithstanding the foregoing, Provider is exempt from any requirement of mandatory arbitration in the Provider Manual, this Agreement, or any other document connected to or entered into pursuant to this Agreement. The Parties acknowledge that controversies, disputes, and claims arising out of or relating to this Agreement are not subject to, and may not be adjudicated by, mandatory binding arbitration.

8. USE OF NAMES

8.1. Use of Provider's Name.

BCBST shall have the right to use the name of Provider for purposes of informing Members of the identity of Provider through written (e.g., directories) or oral means, and otherwise to carry out the terms of the Agreement.

8.2. Provider Information.

BCBST shall be permitted to collect, compile, compare, and disseminate information regarding Provider pursuant to, and in accordance with, Tennessee law.

8.3. Use of BCBST's Name.

Provider shall not use BCBST's name, symbols, trademarks, or service marks in advertising or promotional materials, or in any other way, without the prior written consent of BCBST and shall cease any such permitted usage immediately upon written

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notice from BCBST to do so, or upon termination of this Agreement, whichever occurs first.

9. RECORDS, ACCESS, INSPECTION AND CONFIDENTIALITY

9.1. Processing of Claims.

Provider will furnish to BCBST, without charge, all information reasonably required by BCBST for the proper processing and adjudication of claims, including complete and accurate descriptions of the services performed and charges made. Provider will furnish such data in an electronic format and provide all encounter data as requested by BCBST.

9.2. Maintenance of Records.

Provider shall prepare and maintain all appropriate records on Members receiving services. The records shall be maintained (i) in accordance with prudent record-keeping procedures, (ii) in a form and manner as determined by BCBST to be reasonably acceptable, and (iii) as required by law. Notwithstanding the foregoing, BCBST is not defining or prescribing the medical and clinical information and content of the records, so long as such records comply with applicable law.

9.3. Audits and Inspections.

(a) Provider agrees that BCBST, or a representative designated by BCBST, is allowed to perform audits and inspections of financial and medical records related to the performance of services under this Agreement and Utilization Management and Quality Improvement Programs covering the provision of services to any Member, pursuant to the guidelines as set forth in the Provider Manual. Such audits and inspections shall be permitted without charge to BCBST or its designated representative, who shall be provided copies of records involving the audit or inspection without charge. Except in the event of suspected fraud or other illegal activity, such inspection, audit and duplication shall occur only after reasonable notice and during regular working hours. Provider will use its best efforts to furnish records requested by BCBST promptly and in an electronic format. Audits and inspections are conducted as part of BCBST's healthcare operations in accordance with applicable federal law.

(b) **Compliance with 42 C.F.R. Part 2 (Part 2)**. If BCBST does not receive patient identifying information that is protected by Part 2 ("Part 2 Information"), the obligations in this Section will not apply. To the extent that in performing an audit or evaluation for purposes of this Agreement, BCBST receives, stores, uses, processes, discloses, maintains, transmits or otherwise deals with Part 2 Information, BCBST acknowledges and agrees to: (1) retain records in compliance with applicable federal, state, and local record retention laws; (2) maintain and destroy Part 2 Information in a manner consistent with the policies and procedures established under 42 C.F.R. § 2.16; (3) only use Part 2 Information to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by a court order entered

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under 42 C.F.R. § 2.66; and (4) only disclose Part 2 Information as permitted under Part 2, including to Provider.

9.4. Availability of Records.

Subject to all applicable privacy and confidentiality requirements as required by law, the medical records of Members shall be made available in a timely manner to Healthcare Professionals treating Members, and to BCBST, its agents and representatives, at no charge to BCBST or to Members. In the event that a Member is transferred from Provider, dis-enrolls from his or her Blue Cross Benefit Plan, or Provider no longer participates in the Member's Network, Provider shall, upon Member's request and at no cost, provide a copy of such Member's medical records to BCBST, the Member and the attending physician in a timely manner, as appropriate for the efficient provision of care to such Member.

9.5. Confidentiality.

Each Party, its Affiliates, and its and their respective officers, directors, and employees shall hold all information received or disclosed pursuant to this Agreement in strict confidence and in accordance with applicable state and federal law. The Parties agree not to reveal financial or other terms and conditions of this Agreement to any other Person or entity, except as required by law, required by a valid court order, or mutually agreed to in a writing executed by both Parties. Further, and notwithstanding the confidentiality provisions in this section, Provider authorizes BCBST to collect, compile, compare, and disseminate information concerning, without limitation, Provider's utilization of services, fees or charges, compliance with requirements for Utilization Management and Quality Improvement Programs, BCBST Member satisfaction results, and performance within the industry. BCBST may disseminate such information to Provider, other Network Providers, Payors, customers and potential customers, BCBST Members, and regulatory or accreditation agencies, provided that, in the event that BCBST provides such information directly to another Network Provider of the same type as Provider, the information provided will not identify Provider unless Provider has consented in writing. This provision will survive termination or expiration of this Agreement for any reason.

10. LIABILITY AND INDEMNIFICATION

10.1. Third Party Acts and Omissions.

Neither BCBST, Provider, nor any of their respective agents or employees shall be liable to third parties for any act or omission of the other Party.

10.2. Indemnification.

To the extent permitted under Tennessee law, each Party (the "Indemnitor") agrees to indemnify and hold the other Party (the "Indemnitee") harmless from any and all liability, loss, damage, claim, and expense of any kind, including costs and attorneys' fees which result from the negligent or willful acts or omissions of the Indemnitor, its agents or employees, regarding the duties and obligations of the Indemnitor under the Agreement, including, as applicable, the duty to maintain the legal standard of care applicable to the Indemnitor. Such indemnification and holding harmless shall not apply

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to any matters resulting in whole or in part from the negligent or willful acts or omissions of the Indemnitee, its agents or employees.

The Parties acknowledge that a governmental entity, as the same is defined in the Tenn. Code Ann. §29-20-102, may be protected by the limitation of liability imposed by the Tennessee Governmental Tort Liability Act, as defined in Tenn. Code Ann. §29-20-101 et seq. The Parties also acknowledge that any non-Tennessee governmental entity may be protected by a similar limitation of liability. If so, Provider agrees to provide the statutory reference to BCBST's legal counsel.

The above indemnification provision is not applicable to this agreement. Notwithstanding the foregoing, should Provider cease to be a governmental entity, the above provision shall apply.

11. TERM; TERMINATION

11.1. Term.

This Agreement shall be effective for a fixed period (the "Fixed Period") of three (3) years, beginning , and continuing through and including; thereafter, this Agreement shall continue in effect for successive renewal periods of one (1) year each, unless and until terminated in accordance with the terms of this Agreement, up to a total term of five (5) years. The Fixed Period and any renewal period may be referred to as the "Term" of this Agreement. Provider's participation in specific Networks shall become effective as of the date noted for the applicable Network, and shall remain in effect until terminated in accordance with the terms of this Agreement. In the event this Agreement terminates, participation in all Networks pursuant to this Agreement shall also terminate. Notwithstanding anything to the contrary contained herein, if Provider is not properly credentialed by BCBST within ninety (90) days of the date this Agreement is executed by Provider, this Agreement and participation in all Networks pursuant to this Agreement will automatically terminate and become null and void.

11.2. Without Cause Termination.

Neither Party may terminate this Agreement without cause during the Fixed Period. Thereafter, either Party may terminate this Agreement or Provider's participation in a Network by giving, via certified mail or courier service, written notice to the other Party no later than one hundred and twenty (120) days prior to the Anniversary Date with such termination to be effective on the Anniversary Date.

11.3. Material Breach.

This Agreement or participation in a specific Network may be terminated by either Party by giving, via certified mail or overnight courier service, thirty (30) days' prior written notice to the other Party if the Party to whom notice is given is in material breach of any provisions of this Agreement. The Party claiming the right to terminate will set forth in the notice, the facts underlying the claim that the other is in breach of this Agreement. Remedy of the breach to the satisfaction of the Party giving notice, within thirty (30) days of notice, will nullify the intended termination notice. However, if either Party becomes aware, in its reasonable judgment, of a pattern of activity or practice of the other Party

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that constitutes multiple material breaches under this Agreement, the non-breaching Party may terminate this Agreement. If BCBST becomes aware, in its reasonable judgement, of a pattern of activity or practice of Provider that constitutes multiple material breaches under this Agreement, BCBST may terminate Provider's participation in all Networks pursuant to this Agreement immediately by providing Provider with written notice of such termination.

11.4. BCBST Immediate Termination.

BCBST may terminate this Agreement immediately in the event that:

(a) Provider's license to provide healthcare services is suspended, terminated, revoked or limited, or if Provider is placed on probation by any applicable licensing authority;

(b) Provider, in BCBST's sole determination, provides or arranges for care in a manner that (i) jeopardizes the health or safety of a Member; or (ii) fails to meet prevailing recognized community standards of practice, standards established under law, or standards as determined by BCBST;

(c) Provider has made a material misrepresentation, in BCBST's determination, in an application or report submitted to BCBST, or any report filed with any person, corporation, partnership, association, federal or state agency, or any other entity, relating to the provision of healthcare services;

(d) A judgment of civil liability or a criminal conviction (including a plea of *nolo contendere*) for Medicare or Medicaid fraud or similar offense involving health insurance fraud, revocation or suspension of participation in Medicare or Medicaid, or conviction (including a plea of *nolo contendere*) of a felony or of a misdemeanor involving fraud or moral turpitude is rendered against Provider;

(e) Provider fails to maintain insurance in accordance with the provisions of Section 4.6 of this Agreement;

(f) Judgment in malpractice actions or settlement of malpractice claims (whether or not such claims related to care of Members) of sufficient number or seriousness as to suggest deficiencies in patient care and cause Provider to no longer meet BCBST's Network Participation Criteria;

(g) Any other behavior or circumstance that demonstrates deficiencies in Provider's competence or dedication to providing a level of care that meets prevailing recognized community standards of practice, standards established under law, or standards established by BCBST;

(h) Provider fails to maintain Network Participation Criteria or to comply with BCBST's credentialing and recredentialing guidelines as established from time to time by BCBST in the Provider Manual;

(i) Provider fails to provide BCBST notice as required under Section 4.9;

(j) Provider fails to provide prior notice to BCBST of a Change of Control as required under Section 13.1;

(k) BCBST is unable to pay Institution via EFT as required under Section 5.1(a); or

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(l) The power to direct the management of BCBST becomes controlled by an entity not controlled by BCBST, or BCBST converts to a for-profit entity.

11.5. Provider Immediate Termination.

Provider may terminate this Agreement immediately in the event that:

(a) BCBST's license to operate is suspended, revoked or limited; or

(b) A judgment of civil liability or a criminal conviction (including a plea of *nolo contendere*) for Medicare or Medicaid fraud or similar offense involving health insurance fraud, revocation or suspension of participation in Medicare and/or Medicaid, or conviction (including a plea of *nolo contendere*) of a felony or of a misdemeanor involving fraud or moral turpitude is rendered against BCBST.

11.6. Other Termination.

Either Party may terminate this Agreement in accordance with the terms of Section 13.5 below. BCBST may terminate this Agreement in accordance with the terms of Sections 12.2, 13.1, or 13.7 below.

11.7. Effects of Termination.

The termination of this Agreement shall not release Provider, except as otherwise determined by BCBST, from any obligation to provide Covered Services to a Member who is being treated by Provider until the Member is transferred to the care of another Network Provider. BCBST shall make payments to Provider for such Covered Services in accordance with the terms of this Agreement. Upon termination of this Agreement, the Parties shall cooperate with each other to effect such orderly transfer as promptly as is medically practicable and appropriate. BCBST shall, for a period of five (5) years after termination of this Agreement, or ten (10) years in the case of Members whose Blue Cross Benefit Plan was purchased through the federal health insurance exchange, or as otherwise required by law and as necessary to fulfill the terms of this Agreement and any specific terms applicable to a Network, continue to have access to records of Members. In addition, in cases of suspected fraud or abuse, BCBST shall continue to have access to records until all matters relating to such fraud and abuse have been resolved.

The Parties agree that money damages may not be a sufficient remedy for any breach of this Agreement. The non-breaching Party, at its option, shall be entitled to terminate this Agreement, to specific performance, and to injunctive relief, in addition to any other remedies available at law or in equity, upon the breach or threatened breach of this Agreement.

11.8. Cooperation Upon Termination; No Interference; Non-Disparagement.

The Parties agree to cooperate with each other to resolve promptly any outstanding financial, administrative, or patient care issues upon the termination of this Agreement. The Parties further agree to work together in good faith to provide timely and appropriate notice to Members of the anticipated termination date of this Agreement. Provider agrees to assist Members who are under the care of Provider or a Network Provider, or who

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have scheduled Covered Services to be provided after the anticipated termination date, in transitioning to another Network Provider. Provider further agrees to promptly supply all records and documents necessary for the settlement of outstanding claims for Covered Services upon the termination of the Agreement. Provider also agrees to refrain in every instance from interfering with the contractual relationship between BCBST and its Members or to discourage any person from doing business with BCBST. Finally, both Parties agree not to make any statements, written or verbal, or cause or encourage others to make any statements, written or verbal, that defame, disparage, or in any way criticize the personal or business reputation, practices, or conduct of the other Party, its employees, directors, and officers. The Parties acknowledge and agree that this prohibition extends to statements, written or verbal, made to anyone, including but not limited to, the news media, investors, potential investors, any board of directors or advisory board or directors, industry analysts, competitors, strategic partners, vendors, employees (past and present), and clients.

11.9. Survival.

It is the express intention and agreement of the Parties that Sections 5.1, 5.6, 5.7, 7, 9, 10, 11.6 and 11.7, and all other sections which by their terms are intended to survive termination, or which are necessary for the resolution of all matters unresolved, shall survive any termination of this Agreement.

12. UNFORESEEN CIRCUMSTANCES

12.1. Unforeseen Circumstances.

In the event that Provider's operations are interrupted by acts of war, fire, terrorism, insurrection, labor disputes, riots, earthquakes, or other acts of nature beyond its reasonable control, Provider shall be relieved of its obligation to perform any services that are affected, such that it could not render quality healthcare to any Member.

12.2. Right of Termination.

In the event that the Covered Services to be provided by Provider are substantially interrupted so that Provider cannot adequately render quality healthcare due to the events described in Section 12.1, for a period of sixty (60) days, BCBST shall have the right to terminate this Agreement upon thirty (30) days' prior written notice to Provider.

13. GENERAL PROVISIONS

13.1. Assignment; Change of Control.

This Agreement shall not in any manner be assigned by Provider, including to any successor-in-interest or by operation of law, without the prior written consent of BCBST, which consent may be withheld by BCBST for any reason. Provider must notify BCBST in writing at least sixty (60) days prior to the effective date of any Change of Control affecting Provider, and BCBST, at its discretion, may terminate this Agreement by providing Provider written notice no later than sixty (60) days after receiving Provider's notice of the Change of Control.

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BCBST may assign this Agreement to any of its Affiliates without Provider's prior written consent. Any assignment or attempt to do the same that is in violation of this Section 13.1 shall be void and shall have no binding effect. This Agreement shall be binding on, and inure to the benefit of, the Parties to this Agreement and their respective successors and permitted assigns.

13.2. Subcontracting.

Provider shall not subcontract this Agreement, or any portion of this Agreement, without the prior written consent of BCBST, which consent may be withheld by BCBST for any reason. Notwithstanding anything to the contrary herein, BCBST may subcontract any administrative function as it relates to this Agreement to any organization it so designates. In addition, in the absence of a separate agreement with any entity referenced in this section, the terms of this Agreement or any Network Attachment(s) shall be applicable to any services provided to individuals covered under healthcare plans insured or administered by any entity or its Affiliates that is licensed by the BCBSA to use the BCBS Marks.

13.3. Waiver of Breach.

Neither the waiver by either of the Parties of a breach of, or a default under, any of the provisions of this Agreement, nor the failure of either of the Parties, on one or more occasions, to enforce any of the provisions of this Agreement, or to exercise any right or privilege hereunder, shall be construed as a waiver of any subsequent breach or default of a similar nature, or as a waiver of any such provisions, rights, or privileges hereunder.

13.4. Notice.

Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be hand delivered (including delivery by courier), mailed by first-class or registered mail or certified mail, return receipt requested, delivered by overnight courier, or transmitted electronically or by facsimile addressed as follows:

If to BCBST:

BlueCross BlueShield of Tennessee, Inc.

Attention: Provider Contract Management

1 Cameron Hill Circle

Chattanooga, Tennessee 37402

With a copy, not constituting notice, to:

Senior Vice President and General Counsel

BlueCross BlueShield of Tennessee, Inc.

1 Cameron Hill Circle

Chattanooga, Tennessee 37402

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If to Provider:

As designated on the attached Signature Page.

Either Party may designate by notice in writing a new address to which any notice, demand, request, or communication may thereafter be so given, served, or sent. Notice is deemed effective upon the earlier to occur of (x) the date actually received and (y) when documented deposited with the appropriate third party (i.e., postmarked by the US Postal Service or accepted by overnight courier) or, if sent electronically, on the date transmitted.

13.5. Severability.

In the event that any part of any provision of this Agreement is rendered invalid or unenforceable under applicable law, or is declared null and void by any court of competent jurisdiction, such part shall be ineffective to the extent of such invalidity or unenforceability only, without in any way affecting the remaining parts of such provision or the remaining parts of this Agreement.

In such event that a provision of this Agreement is rendered invalid or unenforceable or declared null and void as provided above, and its removal has the effect of materially altering the obligations of a Party in such manner as (i) will cause serious financial hardship to such Party; or (ii) will cause such Party to act in violation of its corporate articles or bylaws, the Party so affected shall have the right to terminate this Agreement upon thirty (30) days' prior written notice to the other Party.

13.6. Entire Agreement.

This Agreement, together with the applicable Provider Manual, and other manuals provided to Provider via the BCBST website or in hard copy format, and any exhibits, schedules, and attachments, constitutes the entire Agreement between the Parties with respect to the subject matter hereof and supersedes all prior and contemporaneous agreements and undertakings, whether oral or written. In the event that an earlier executed agreement exists between the Parties regarding Provider's participation in the Networks included in this Agreement for the Covered Services eligible for payment under this Agreement, this Agreement will supersede such earlier agreement with regard to such Networks and Covered Services as of the first day of the Fixed Term, or, if different, the first day of the Network-specific Fixed Term. This Agreement shall be binding on and inure to the benefit of the Parties and their respective successors and permitted assigns. This Agreement shall remain in full force and effect with respect to all Members, unless otherwise expressly stated.

13.7. Provider Manual; Amendments.

(a) The terms and conditions of the Provider Manual are incorporated into, and made a part of, this Agreement by this reference. Unless expressly stated otherwise, if a conflict arises between this Agreement and the Provider Manual, the terms and conditions of the Provider Manual shall prevail. BCBST retains the right to

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change, revise, modify, or alter the terms of the Provider Manual upon at least thirty (30) days' prior written notice to Provider.

(b) BCBST retains the right to change, revise, modify, or alter the terms of any Blue Cross Benefit Plan issued or administered by BCBST without prior approval or notice to Provider.

(c) The removal of a Network Provider from a Network, or a change (i) to a Blue Cross Benefit Plan, (ii) to BCBST policies or procedures, or (iii) required by state or federal laws and regulations, shall be automatically incorporated herein to the extent the services rendered by Provider pursuant to this Agreement are affected by such removal or change.

(d) BCBST shall have the right to amend this Agreement in accordance with the following procedure:

(i) BCBST shall furnish Provider with the proposed amendment in writing;

(ii) Provider shall have thirty (30) days after receipt of the amendment in which to respond in writing to BCBST. If Provider either accepts such amendment or fails to respond in writing within such period, the proposed amendment shall be deemed accepted by Provider and shall become effective, and therefore binding on Provider and BCBST, upon the earlier of Provider's written acceptance or the expiration of such thirty (30) day period; and

(iii.) If Provider notifies BCBST in writing by certified mail within thirty (30) days after notice of the amendment that Provider does not accept the proposed amendment, such amendment shall not take effect and BCBST shall have the right to elect either (i) to have this Agreement remain in effect in accordance with its terms without the proposed amendment or (ii) to terminate this Agreement by giving written notice fifteen (15) days prior to the effective date of termination.

(e) Except as otherwise provided in this Section 13.7, this Agreement, or any part, article, section, exhibit, or attachment to this Agreement, may be amended, altered, or modified only in a writing duly executed by both Parties.

13.8. Headings.

The headings of articles and sections contained in this Agreement are for reference purposes only, shall not be deemed to be a part of this Agreement for any purpose, and shall not in any way define or affect the meaning, interpretation, construction, or scope of this Agreement.

13.9. Governing Law.

This Agreement shall be construed and interpreted in accordance with the laws of the State of Tennessee, without regard to any law that would render such choice of law ineffective.

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13.10. Execution of Agreement.

Each Party represents and warrants that it may lawfully execute this Agreement and perform the obligations described herein, and that the execution of this Agreement and compliance with its provisions will not in any material respect conflict with or constitute a default (immediately, with due notice, with the passage of time, or otherwise) under any agreement or instrument to which it is a party, or to the best of its knowledge, under any applicable law, rule, regulation, court order, or decree. Provider shall, from time to time upon BCBST's reasonable request, provide documentation confirming authorized signatories for purposes of this Agreement.

13.11. Counterparts and Electronic Signatures.

To facilitate execution, this Agreement may be executed in one or more counterparts, each of which shall be considered an original, and which collectively shall constitute the Agreement. BCBST may use an electronic signature system to facilitate execution of this Agreement. The terms and conditions of this Agreement and the Network Attachments may not be altered in any way after it has been transmitted for signature via the electronic signature system. Changes made to this Agreement or any of the Network Attachments prior to counter signature by BCBST will not be binding on BCBST.

14. [RESERVED]

14.1 [TO BE COMPLETED WHEN REQUIRED]

15. BLUE NETWORK P PARTICIPATION

15.1 Definitions.

(a) The "Network P Fixed Term" shall mean three (3) years beginning on the Effective Date.

(b) "Network P Members" shall mean those BCBST Members whose health benefits are delivered through BCBST's Blue Network P.

15.2 Participation. Provider agrees to participate in BCBST's Blue Network P for the purpose of providing health care Covered Services to Network P Members.

15.3 Reimbursement. For Covered Services provided to Network P Members, BCBST will pay Provider the Maximum Allowable in accordance with the attached Network Attachment P, which is incorporated by reference into this Agreement, at the time of service, less any applicable Member Obligation.

The Maximum Allowable set forth in Network Attachment P shall represent the maximum amount payable to Provider for Covered Services rendered to Network P Members.

BCBST will revise Network Attachment P pursuant to the methods and time frames established in Network Attachment P or in the applicable Provider Manual. In the event that a prior agreement established a different payment method, the date of service, or the

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admission date in the case of inpatient services, controls the payment method to be applied.

15.4 Term and Termination Provider's participation in Network P shall be effective through the Network P Fixed Term and, thereafter, this Agreement shall continue in effect for successive renewal periods of one (1) year each, unless and until terminated in accordance with the terms of this Agreement, up to a total term of five (5) years.

During the Network P Fixed Term, neither Party may terminate Provider's participation in Network P without cause pursuant to Section 11.2 but may terminate Provider's participation pursuant to any other applicable termination provision of this Agreement. Either Party may terminate Provider's participation in Network P effective after the Network P Fixed Term pursuant to Section 11.2 or any other applicable termination provision of this Agreement.

Termination of Provider's participation in Network P does not terminate this Agreement or participation in any other BCBST Network.

15.5 Network-specific Terms.

(a) [TO BE COMPLETED WHEN REQUIRED].

16. BLUE NETWORK S PARTICIPATION

16.1 Definitions.

(a) The "Network S Fixed Term" shall mean three (3) years beginning on the Effective Date.

(b) "Network S Members" shall mean those BCBST Members whose health benefits are delivered through BCBST's Blue Network S.

16.2 Participation. Provider agrees to participate in BCBST's Blue Network S for the purpose of providing health care Covered Services to Network S Members.

16.3 Reimbursement. For Covered Services provided to Network S Members, BCBST will pay Provider the Maximum Allowable in accordance with the attached Network Attachment S, which is incorporated by reference into this Agreement, at the time of service, less any applicable Member Obligation.

The Maximum Allowable set forth in Network Attachment S shall represent the maximum amount payable to Provider for Covered Services rendered to Network S Members.

BCBST will revise Network Attachment S pursuant to the methods and time frames established in Network Attachment S or in the applicable Provider Manual. In the event that a prior agreement established a different payment method, the date of service, or the admission date in the case of inpatient services, controls the payment method to be applied.

16.4 Term and Termination. Provider's participation in Network S shall be effective through the Network S Fixed Term and, thereafter, this Agreement shall continue in effect for successive renewal periods of one (1) year each, unless and until terminated in accordance with the terms of this Agreement, up to a total term of five (5) years.

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During the Network S Fixed Term, neither Party may terminate Provider's participation in Network S without cause pursuant to Section 11.2 but may terminate Provider's participation pursuant to any other applicable termination provision of this Agreement. Either Party may terminate Provider's participation in Network S effective after the Network S Fixed Term pursuant to Section 11.2 or any other applicable termination provisions of this Agreement.

Termination of Provider's participation in Network S does not terminate this Agreement or participation in any other BCBST Network.

16.5 Network-specific Terms.

(a) [TO BE COMPLETED WHEN REQUIRED]

17. [THIS SECTION INTENTIONALLY OMITTED]

18. [THIS SECTION INTENTIONALLY OMITTED]

19. [THIS SECTION INTENTIONALLY OMITTED]

20. [THIS SECTION INTENTIONALLY OMITTED]

21. [THIS SECTION INTENTIONALLY OMITTED]

22. [THIS SECTION INTENTIONALLY OMITTED]

23. [THIS SECTION INTENTIONALLY OMITTED]

24. [THIS SECTION INTENTIONALLY OMITTED]

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SIGNATURE PAGE

IN WITNESS WHEREOF, the Parties have executed this BlueCross BlueShield of Tennessee, Inc. Ancillary Agreement intending to be bound on the Effective Date.

BlueCross BlueShield of Tennessee, Inc.		**Metropolitan Government of Nashville & Davidson County**	
Signature:	Marc Barclay	Signature:	DocuSigned by: Joanna Shaw-Kaikai F0EB3ACD4AFC4C1...
Print Name:	Marc Barclay	Print Name:	Joanna Shaw-Kaikai
Title:	SVP Provider Network Management	Title:	Interim Director of Health
Date:	12/20/2024	Date:	1/15/2025
Effective Date:	*(To be completed by BCBST)*		

Address for Notice:

Street:	2500 Charlotte Avenue
City:	Nashville
State:	Tennessee
Zip Code:	37209
E-mail:	shannon.heath@nashville.gov

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IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

METROPOLITAN GOVERNMENT OF NASHVILLE AND DAVIDSON COUNTY

DocuSigned by:
Joanna Shaw-kaikai
F0EB3ACD4AFC4C1...
Interim Director, Metro Public Health Department — 1/15/2025 Date

Signed by:
Tené Hamilton Franklin
BEBF0BBF14D14B0...
Chair, Board of Health — 1/16/2025 Date

APPROVED AS TO AVAILABILITY OF FUNDS:

Signed by:
Jennean Reed/mgw
62377A2A8742469...
Initial DH DS AP
Director, Department of Finance — 1/22/2025 Date

APPROVED AS TO RISK AND INSURANCE:

DocuSigned by:
Balogun Cobb
68804BF12FD741C...
Director of Risk Management Services — 1/23/2025 Date

APPROVED AS TO FORM AND LEGALITY:

Matthew Garth
Metropolitan Attorney — 1/24/2025 Date

FILED:

Metropolitan Clerk — Date

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EXHIBIT 1A

Metropolitan Government of Nashville & Davidson County

ANCILLARY PROVIDER

Facility	Location	Provider (Internal Use Only)	Tax ID	NPI
Metro Public Health Department	2500 Charlotte Ave Nashville, TN 37209	5524866	620694743	1992185854
	1015 E Trinity Lane Nashville, TN 37216			
	224 Oriel Ave Nashville, TN 37209			

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BLUE NETWORK P

NETWORK ATTACHMENT

HEALTH DEPARTMENT

Category[1]	Fee Source	Pricing
Evaluation and Management		
E&M - Office Visits	2017 CMS RBRVS	*104%*
E&M - Neonatal	2017 CMS RBRVS	*108%*
E&M - Preventative	2017 CMS RBRVS	*108%*
E&M - Other	2017 CMS RBRVS	*104%*
Surgery - Cardiovascular System	2017 CMS RBRVS	122%
Surgery - Digestive System	2017 CMS RBRVS	118%
Surgery - Eye and Ocular Adnexa	2017 CMS RBRVS	118%
Surgery - Female Genital	2017 CMS RBRVS	122%
Surgery - Integumentary System	2017 CMS RBRVS	118%
Surgery - Maternity Delivery	2017 CMS RBRVS	122%
Surgery - Musculoskeletal System	2017 CMS RBRVS	122%
Surgery - Nervous System	2017 CMS RBRVS	122%
Surgery - Urinary System	2017 CMS RBRVS	118%
Surgery - Other	2017 CMS RBRVS	118%
Radiology - Diagnostic Imaging	2017 CMS RBRVS	98%
Radiology - Nuclear Medicine	2017 CMS RBRVS	98%
Radiology - Radiation Oncology	2017 CMS RBRVS	98%
Radiology - Other	2017 CMS RBRVS	98%
Clinical Laboratory[2]	2017 CMS Clinical Laboratory	52%
Non-Clinical Laboratory	2017 CMS RBRVS	52%
Laboratory Pathology	2017 CMS RBRVS	52%
Medicine - Allergy & Clinical Immunology	2017 CMS RBRVS	104%
Medicine - Cardiovascular	2017 CMS RBRVS	122%
Medicine - Chiropractic Manipulative Therapy[3]	2017 CMS RBRVS	98%
Medicine - Dermatology	2017 CMS RBRVS	104%
Medicine - Neurology & Neuromuscular	2017 CMS RBRVS	122%
Medicine - Ophthalmology	2017 CMS RBRVS	104%
Medicine - Physical Medicine & Rehabilitation	2017 CMS RBRVS	86%
Medicine - Pulmonary	2017 CMS RBRVS	122%
Medicine - Behavioral Health[4]	2017 CMS RBRVS	104%
Medicine-Other	2017 CMS RBRVS	104%
Immunization Administration[5]	2017 CMS RBRVS	100%
Immunizations[6]	% AWP	95%
Injectables[7]	% Base ASP	106%
Medication Administration[8]	2017 CMS RBRVS	106%
DME and Supplies	% Reg C DMEPOS Fee Schedule	75%

[1] Codes are assigned to categories based on their placement in corresponding code ranges in the Current Procedure Terminology (CPT) Manual published by the American Medical Association.
[2] Certain codes in this schedule are paid at 100% of the 2017 CMS Clinical Laboratory fee schedule. Please see the Provider Administration Manual for a listing of the codes.
[3] Pricing in this chart is not applicable to chiropractors as described herein.
[4] Includes Medicine - Psychiatry and Medicine - Biofeedback
[5] Includes Medicine – Immunization Administration for Vaccines and Toxoids
[6] Includes Medicine – Vaccines and Toxoids
[7] Includes Medicine – Immune Globulins, Serum or Recombinant Products, HCPCS for medications
[8] Includes Medicine – Therapeutic, Prophylactic, Diagnostic Injections and Infusions and Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration

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Routine Venipuncture	Set Fee	$7.00
Anesthesia Conversion Factor		$39.00
CAT III	*Based on factors for band of like service(s)*	
HCPCS	*Based on factors for band of like service(s)*	

Reimbursement Policy	The table above, in conjunction with BCBST's reimbursement policies, as fully detailed in the Provider Manual, sets forth the basis for calculating the established fee for Covered Services provided to BCBST Members who receive benefits through Network P. Any updates and/or changes to BCBST's reimbursement policies will be communicated no later than sixty (60) days prior to implementation thereof via BCBST's standard method of notice.
Code Assignment; Exceptions	The fee source for most bands on this Network Attachment is the 2017 CMS RBRVS. However, for new codes or codes for which CMS does not publish a fee or methodology (i.e., codes other than those with status code "A") that fall into those categories, reimbursement will be based on a reasonable allowable determined by BCBST, as described in the Provider Manual. In the event that CMS publishes a fee for a code for which it did not previously publish a fee, BCBST will implement such fee within a reasonable amount of time after publication.
Calculation of Established Fee	For those procedure codes that fall into bands with a fee source of 2017 CMS RBRVS, the established fee will be calculated based on the Relative Value Units (RVUs), conversion factors and Geographic Practice Cost Indices (GPCIs) in effect as of October 31, 2017. No updates will be made to these fee components, except: (1) any new procedure code added after October 31, 2017 will be added as noted above; or (2) in the event that the AMA modifies the code description, the underlying use of the code or the components that make up the code, BCBST will treat the code as a new code in order to remain consistent with recognized coding guidelines. Other fee components, which are listed in the Guidelines for Resource Based Relative Value Scale (RBRVS) Reimbursement Methodology in the Provider Manual, may be updated to ensure that reimbursement is consistent with current usage of the code. Updates to these components may result in increases or decreases to the established fee at the individual code level.
Use of Codes	The codes associated with the Agreement are subject to addition, revision, and deletion by the governing agencies or authorities in accordance with the Provider Manual. If any codes associated with the Agreement are added, revised, and/or deleted, this Agreement will be interpreted to incorporate such change, without the need for formal amendment.
Confidentiality	This Network Attachment is confidential and proprietary information of BCBST, protected under Tennessee Code Annotated § 56-7-1013. It is not to be duplicated, distributed, or revised without the written consent of BCBST.
Chiropractic Payment	BCBST shall only pay for chiropractic Covered Services when billed with the appropriate CPT codes as listed herein or described in the Provider Manual. Except for chiropractic Covered Services provided to FEP Members, all chiropractic Covered Services, excluding DME, furnished by a licensed chiropractor, as defined in Tennessee Code Annotated Section 63-4-101, ("Chiropractor") during a single office visit shall be paid at the global rate of **$60.00** per visit. Except when otherwise provided herein, the global rate in this section shall be all-inclusive and shall, in combination with any Member Obligation(s) due by the applicable Member to the Provider, compensate Provider in full for all services and supplies provided in association with Covered Services provided by a Chiropractor. All durable medical equipment ("DME") Covered Services, furnished by Chiropractor, shall be paid at **75%** of the current Medicare Region C DMEPOS Fee Schedule for Tennessee. The rates for the DME Covered Services shall be in combination with any Member Obligation(s) due by the applicable Member to the Provider. Chiropractic Covered Services provided to FEP Members shall be paid in accordance with the appropriate FEP Network pricing as set forth in the attached FEP Chiropractic Network Attachment. The Maximum Allowable for Chiropractic Covered Services provided to FEP Members will be the lesser of Provider's billed charges for Covered Services or the appropriate fee amount in the FEP Chiropractic Rate Attachment. All payment or fee amounts listed in the FEP Chiropractic Rate Attachment are subject to payment of lesser billed charges.

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Technical Component for Professional Services Provided in Facilities	For all claims with dates of service on or after January 1, 2019, and notwithstanding any other language to the contrary, Commercial DRG and outpatient case rates paid to a facility (other than free-standing ambulatory surgery centers) are all-inclusive of any technical component for professional services provided while a Member is in a facility setting. The facility shall bill for the technical component of the services, even if these services are provided under arrangements with or subcontracted out to or otherwise subject to or governed by a relationship with another entity, such as a laboratory, pathologist, or other provider. Payment shall not be made to Provider under this Network Attachment or otherwise under this Agreement for technical component services furnished to Members in facility settings (other than free-standing ambulatory surgery centers). All Providers who perform the technical component for professional services for Members must coordinate with the applicable facility (other than a free-standing ambulatory surgery center) regarding the payment of claims for such services.

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BLUE NETWORK S

NETWORK ATTACHMENT

HEALTH DEPARTMENT

Category[9]	Fee Source	Pricing
Evaluation and Management		
E&M - Office Visits	2017 CMS RBRVS	96%
E&M - Neonatal	2017 CMS RBRVS	100%
E&M - Preventative	2017 CMS RBRVS	100%
E&M - Other	2017 CMS RBRVS	96%
Surgery - Cardiovascular System	2017 CMS RBRVS	114%
Surgery - Digestive System	2017 CMS RBRVS	110%
Surgery - Eye and Ocular Adnexa	2017 CMS RBRVS	110%
Surgery - Female Genital	2017 CMS RBRVS	114%
Surgery - Integumentary System	2017 CMS RBRVS	110%
Surgery - Maternity Delivery	2017 CMS RBRVS	114%
Surgery - Musculoskeletal System	2017 CMS RBRVS	114%
Surgery - Nervous System	2017 CMS RBRVS	114%
Surgery - Urinary System	2017 CMS RBRVS	110%
Surgery - Other	2017 CMS RBRVS	110%
Radiology - Diagnostic Imaging	2017 CMS RBRVS	90%
Radiology - Nuclear Medicine	2017 CMS RBRVS	90%
Radiology - Radiation Oncology	2017 CMS RBRVS	90%
Radiology - Other	2017 CMS RBRVS	90%
Clinical Laboratory[10]	2017 CMS Clinical Laboratory	52%
Non-Clinical Laboratory	2017 CMS RBRVS	52%
Laboratory Pathology	2017 CMS RBRVS	52%
Medicine - Allergy & Clinical Immunology	2017 CMS RBRVS	96%
Medicine - Cardiovascular	2017 CMS RBRVS	114%
Medicine - Chiropractic Manipulative Therapy[11]	2017 CMS RBRVS	90%
Medicine - Dermatology	2017 CMS RBRVS	96%
Medicine - Neurology & Neuromuscular	2017 CMS RBRVS	114%
Medicine - Ophthalmology	2017 CMS RBRVS	96%
Medicine - Physical Medicine & Rehabilitation	2017 CMS RBRVS	78%
Medicine - Pulmonary	2017 CMS RBRVS	114%
Medicine - Behavioral Health[12]	2017 CMS RBRVS	96%
Medicine-Other	2017 CMS RBRVS	96%
Immunization Administration[13]	2017 CMS RBRVS	100%
Immunizations[14]	% AWP	95%
Injectables[15]	% Base ASP	106%
Medication Administration[16]	2017 CMS RBRVS	100%
DME and Supplies	% Reg C DMEPOS Fee Schedule	75%

[9] Codes are assigned to categories based on their placement in corresponding code ranges in the Current Procedure Terminology (CPT) Manual published by the American Medical Association.
[10] Certain codes in this schedule are paid at 100% of the 2017 CMS Clinical Laboratory fee schedule. Please see the Provider Administration Manual for a listing of the codes.
[11] Pricing in this chart is not applicable to chiropractors as described herein.
[12] Includes Medicine - Psychiatry and Medicine - Biofeedback
[13] Includes Medicine – Immunization Administration for Vaccines and Toxoids
[14] Includes Medicine – Vaccines and Toxoids
[15] Includes Medicine – Immune Globulins, Serum or Recombinant Products, HCPCS for medications
[16] Includes Medicine – Therapeutic, Prophylactic, Diagnostic Injections and Infusions and Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration

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Routine Venipuncture	Set Fee	$7.00
Anesthesia Conversion Factor		$37.00
CAT III	*Based on factors for band of like service(s)*	
HCPCS	*Based on factors for band of like service(s)*	

Reimbursement Policy	The table above, in conjunction with BCBST's reimbursement policies, as fully detailed in the Provider Manual, sets forth the basis for calculating the established fee for Covered Services provided to BCBST Members who receive benefits through Network S. Any updates and/or changes to BCBST's reimbursement policies will be communicated no later than sixty (60) days prior to implementation thereof via BCBST's standard method of notice.
Code Assignment; Exceptions	The fee source for most bands on this Network Attachment is the 2017 CMS RBRVS. However, for new codes or codes for which CMS does not publish a fee or methodology (i.e., codes other than those with status code "A") that fall into those categories, reimbursement will be based on a reasonable allowable determined by BCBST, as described in the Provider Manual. In the event that CMS publishes a fee for a code for which it did not previously publish a fee, BCBST will implement such fee within a reasonable amount of time after publication.
Calculation of Established Fee	For those procedure codes that fall into bands with a fee source of 2017 CMS RBRVS, the established fee will be calculated based on the Relative Value Units (RVUs), conversion factors and Geographic Practice Cost Indices (GPCIs) in effect as of October 31, 2017. No updates will be made to these fee components, except: (1) any new procedure code added after October 31, 2017 will be added as noted above; or (2) in the event that the AMA modifies the code description, the underlying use of the code or the components that make up the code, BCBST will treat the code as a new code in order to remain consistent with recognized coding guidelines. Other fee components, which are listed in the Guidelines for Resource Based Relative Value Scale (RBRVS) Reimbursement Methodology in the Provider Manual, may be updated to ensure that reimbursement is consistent with current usage of the code. Updates to these components may result in increases or decreases to the established fee at the individual code level.
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Technical Component for Professional Services Provided in Facilities	For all claims with dates of service on or after January 1, 2019, and notwithstanding any other language to the contrary, Commercial DRG and outpatient case rates paid to a facility (other than free-standing ambulatory surgery centers) are all-inclusive of any technical component for professional services provided while a Member is in a facility setting. The facility shall bill for the technical component of the services, even if these services are provided under arrangements with or subcontracted out to or otherwise subject to or governed by a relationship with another entity, such as a laboratory, pathologist, or other provider. Payment shall not be made to Provider under this Network Attachment or otherwise under this Agreement for technical component services furnished to Members in facility settings (other than free-standing ambulatory surgery centers). All Providers who perform the technical component for professional services for Members must coordinate with the applicable facility (other than a free-standing ambulatory surgery center) regarding the payment of claims for such services.

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