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.

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: _____

BlueCare Tennessee Ancillary Agreement

1 Cameron Hill Circle
Chattanooga, TN 37402

bluecare.bcbst.com

BlueCare Tennessee and BlueCare, Independent Licensees of BlueCross BlueShield Association

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BLUECARE TENNESSEE

ANCILLARY AGREEMENT

Davidson County Health Department

BCBST Tracking # 24-173

THIS ANCILLARY AGREEMENT (the "Agreement") is entered into by and between Volunteer State Health Plan, Inc. dba BlueCare Tennessee, for itself and on behalf of its Affiliates, (collectively, "BlueCare Tennessee") 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 the latest date set forth beside a Party's signature on the Signature Page, or the date the Provider becomes credentialed by BlueCare Tennessee (the "Effective Date"). BlueCare Tennessee and Provider are each sometimes referred to in this Agreement as a "Party" and jointly as the "Parties".

1. RECITALS

WHEREAS, BlueCare Tennessee is a Tennessee corporation licensed as a health maintenance organization in accordance with Tenn. Code Ann. § 56-32-101 et seq, and BlueCare Tennessee 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 a provider of healthcare services; and

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

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

2. DEFINITIONS

"Adverse Benefit Determination" means as defined at 42 C.F.R. § 438.400(b).

"Affiliate(s)" means any Person that now or in the future directly or indirectly controls or is controlled by, or is under common control with, the Person specified. 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 BlueCare Tennessee, regardless of any common control requirements or lack of control. Any licensed Person is related to BlueCare Tennessee as a separate and distinct licensee of the BCBSA.

"Anniversary Date" means **December 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.

"BCBST" means BlueCross BlueShield of Tennessee, Inc., an independent licensee of BCBSA, and the parent organization of BlueCare Tennessee.

"Benefit Appeal" As distinguished from eligibility appeal, a "Benefit Appeal" concerns an Enrollee's request to contest an MCO's Adverse Benefit Determination by receiving a SFH. CMS has determined that the provisions contained in 42 C.F.R. § 438 subpart F, which requires BlueCare Tennessee to maintain an internal appeal system, and which require Enrollees to exhaust BlueCare Tennessee's internal appeal process before being permitted to request a SFH, are satisfied by TennCare's requirement that BlueCare Tennessee comply with the "Reconsideration" phase of the SFH process. In accordance with CMS approval, BlueCare Tennessee will not have an internal appeal process that Enrollees are required to exhaust before they may request a SFH. BlueCare Tennessee's "Reconsideration" of its initial Adverse Benefit Determination during the SFH appeal process is deemed by CMS to satisfy the requirement for a MCO-level appeal.

"Benefit Appeal System" Synonymous with SFH system or SFH process. References to Benefit Appeal System or Benefit Appeal Process refers to both (1) the processes BlueCare Tennessee implements to comply with its SFH Process-related obligations (such as timely issuance of a compliant Notice of Adverse Benefit Determination, timely compliance with the Reconsideration phase of the Appeal System, timely compliance with TennCare-issued directives instructing BlueCare Tennessee to approve and arrange provision of a service in accordance with an order resulting from the Benefit Appeal System, etc.), and (2) the processes BlueCare Tennessee implements to collect, track and maintain the information gathered in accordance with the State Fair Hearing process.

"Benefit Plan" means an agreement entered into by BlueCare Tennessee or any of its Affiliates with a Person for the provision or administration of Benefits by BlueCare Tennessee or one of its Affiliates to a Person enrolled in said Benefit Plan.

"Benefits" means the package of health care services, including physical health, behavioral health, and long-term services and supports services that define the Covered Services available to Members enrolled in a Benefit Plan.

"Covered Service(s)" See Benefits.

"Dispute Resolution Procedure" means the process identified in Section 7 of this Agreement and set forth in the applicable Benefit Plan Provider Manual to resolve disputes between the Parties, including the applicable Provider Dispute Resolution Procedure and the Medical Management Corrective Action Plan (each as defined in the applicable Benefit Plan Provider Manual).

"Emergency Medical Condition" means a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part.

"Emergency Services" means covered inpatient and outpatient services that are as follows: (i) furnished by a Provider that is qualified to furnish these services; and (ii) needed to evaluate or stabilize an Emergency Medical Condition.

"Enrollee" A person who has been determined eligible for TennCare and who has been enrolled in the TennCare Program (see Member, also). Synonymous with Member. For purposes of Enrollee Benefit Appeals and the Enrollee Benefit Appeal-related provisions in Section A.2.19 of the State Contracts, "Enrollee" means (1) enrollee, (2) enrollee's parent, (3) enrollee's legal guardian or (4) Enrollee-Authorized Representative.

"Enrollee Authorized Representative" For purposes of Enrollee Benefit Appeals, and the Enrollee-Benefit Appeal-related provisions in Section A.2.19 of the State Contracts, "Enrollee Authorized Representative" means a competent adult who has the Enrollee's signed, written authorization to act on the Enrollee's behalf during the appeal process in accordance with 42 C.F.R. § 435.923. The written authority to act shall specify any limits of the representation. For example, if the Enrollee wants to authorize his treating Provider to frame the issue under dispute and file his request for a SFH, but if his treating Provider will not be receiving the Notice of Hearing and will not be representing the Enrollee during the hearing, these limitations shall be indicated on the Enrollee-Authorized Representative documentation.

"Ethical and Religious Directives" means a document that offers moral guidance on various aspects of health care delivery and is based on a religious organization's theological and moral teachings.

"Grievance" means a complaint or an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights regardless of whether remedial action is requested. Grievance includes a Member's right to dispute an extension of time proposed by BlueCare Tennessee, PHIP or PAHP to make an authorization decision. See 42 C.F.R. § 438.400(b).

"Grievance System" means the process BlueCare Tennessee implements to handle Grievances, as well as the processes to collect and track information about them. See 42 C.F.R. § 438.400(b).

"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.

"Limited English Proficient" means potential Members and Members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit or encounter. See 42 C.F.R. § 438.10(a).

"Managed Care Organization" means a Health Maintenance Organization ("HMO") that participates in the TennCare Program.

"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.

"Medical Necessity" and **"Medically Necessary"** as used in this Agreement shall have the meaning contained in Tenn. Code Ann. § 71-5-144 and Tenn. Comp. R. & Regs. 1200-13-16.

"Medical Records" means all medical, behavioral health, and long-term services and supports histories; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; X-ray and radiology interpretation; physical therapy charts and notes; lab reports; other individualized medical, behavioral health, and long-term services and supports documentation in written or electronic format; and analyses of such information.

"Member(s)" means an individual eligible to receive Covered Services under a Benefit Plan. Synonymous with Enrollee.

"Member Cost Sharing 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 Benefit Plan.

"Network" means a group of Providers that has agreed to accept a pre-determined fee schedule as payment in full for the provision of Covered Services to Members enrolled in a Benefit Plan.

"Network Attachment" means an attachment or exhibit to this Agreement that describes the rates to be paid to Provider for the provision of Covered Services to Members enrolled in a Benefit Plan. Network Attachments may also include specific terms or conditions applicable only to Provider's participation in that Network.

"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 Benefit Plan Provider Manual.

"Network Provider" means a healthcare provider contracted to provide Covered Services to Members enrolled in a Benefit Plan. Also referred to as "Contract Provider" in the State Contracts.
"Payor" means a person or entity that is responsible for paying for Covered Services in accordance with the terms of the Benefit Plan under which the Member being treated is covered.

"Person" means any natural person, firm, corporation (including, without limitation, service corporation and professional corporation), partnership (including, without limitation, general partnership, limited partnership, limited liability partnership), limited liability company, joint venture, 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 the act of authorizing specific services or activities before they are rendered or occur.

"Provider" means an institution, facility, agency, physician, health care practitioner, or other entity that is licensed or otherwise authorized to provide any of the Covered Services in the state in which they are furnished.

"Provider Manual" means the applicable Benefit Plan manuals set forth on BlueCare Tennessee's website at http://bluecare.bcbst.com which contain information, including, but not limited to, medical and operating policies and procedures established by BlueCare Tennessee for Network Providers. The applicable provisions of the Provider Manual, including but not limited to those in Section A.2.12 of the State Contracts, are incorporated herein and by reference made a part hereof.

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

"Reconsideration" mandatory component of the TennCare Appeal Process by which BlueCare Tennessee reviews and renders a decision affirming or reversing the Adverse Benefit Determination at issue in the Enrollee's request for SFH. An MCO satisfies the plan-level requirements of 42 C.F.R. § 438 Subpart F when the review includes all available, relevant, clinical documentation (including documentation which may not have been considered in the original review); is performed by a Provider other than the original reviewing Provider; and produces a timely written finding.

"Regulatory Requirements" means any requirements imposed by applicable federal, state or local laws, rules, regulations, court orders and consent decrees, a program contract, or otherwise imposed in connection with the operation of a program or the performance required by either party under an agreement.

"State" means the State of Tennessee, including, but not limited to, any entity or agency of the State, such as the Department of Finance and Administration, the Office of Inspector General, the Division of TennCare, the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU), the Department of Mental Health and Substance Abuse Services, the Department of Children's Services, the Department of Health, the Department of Commerce and Insurance, and the Office of the Attorney General.

"State Contracts" mean the Contractor Risk Agreement between the State and BlueCare Tennessee ("Contractor Risk Agreement") and the Agreement for the Administration of TennCare*Select* between the State and BlueCare Tennessee ("TennCare*Select* Agreement") which are incorporated into and made a part of this Agreement by reference. The State Contracts can be found on the BlueCare Tennessee website at http://bluecare.bcbst.com/

"State Fair Hearing" or **"SFH"** means the Benefit Appeal System set forth in subpart E of part 431 chapter IV, title 42 under which TennCare Enrollees have the right to request a SFH to contest BlueCare Tennessee's Adverse Benefit Determinations. CoverKids/CHIP program enrollees do not have the right to receive a SFH, but may receive a CoverKids "Review". 42 C.F.R. § 438.400(b). Provider may serve as an Enrollee-Authorized Representative, but may not request provision of continuation of benefits. See 42 C.F.R. § 438.402(c)(1)(i)-(ii); 42 C.F.R. § 438.408.

"TennCare" or "TennCare Program" means the program administered by the single state agency, as designated by the State and Centers for Medicare & Medicaid Services (CMS), pursuant to Title XIX of the Social Security Act and Section 1115 research and demonstration waiver granted to the State and any successor programs.

"TennCare Kids" means the State's Early and Periodic Screening, Diagnostic, and Treatment program (also referred to as "EPSDT"), which is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act requires that any medically necessary health care service listed at Section 1905(a) of the Social Security Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. The federal regulations for EPSDT are in 42 C.F.R. Part 441, Subpart B.

"Third Party Liability (TPL)" means any amount due for all or part of the cost of medical, behavioral health, or long-term care services from a third party.

"Utilization Management Program" means the BlueCare Tennessee program which focuses on the medical review of healthcare services provided to Members, as described in the applicable Benefit Plan 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 BlueCare Tennessee. BlueCare Tennessee 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. BlueCare Tennessee is an independent corporation operating under a

license from the BCBSA, permitting BlueCare Tennessee to use the BCBS Marks, and that BlueCare Tennessee 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 other than BlueCare Tennessee, and that no Person other than BlueCare Tennessee shall be held accountable or liable to Provider for any of BlueCare Tennessee's obligations to Provider created under this Agreement.

3.2. Limitation on Provider and Third Parties.

Provider is entering into this Agreement only for itself and on behalf of its locations, if any, listed on **Exhibit 1** attached hereto. This Agreement is entered into by Provider with the understanding that this Agreement shall not constitute an agreement between Provider and other providers 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 location to this Agreement, both Parties agree that **Exhibit 1** must be amended in a writing signed by both Parties.

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, Benefit Plans, and any applicable Network Attachments attached to this Agreement. Provider acknowledges and agrees that BlueCare Tennessee 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 BlueCare Tennessee does not warrant that Members will choose to utilize Provider's services.

Notwithstanding anything to the contrary, this Agreement will not be used for the provision of Covered Services to Members enrolled in CHOICES Home and Community-Based Services (HCBS) or the TennCare CHOICES in Long-Term Services and Supports (CHOICES) programs.

(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 licensed, credentialed, and qualified to provide, and will otherwise abide by the terms of this Agreement, the applicable Network Attachments, and the applicable Benefit Plan 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 BlueCare Tennessee pursuant to BlueCare Tennessee'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) **Medically Necessary Services.** Provider shall not refuse to provide covered Medically Necessary or covered preventive services to a child under the age of twenty-one (21) or a TennCare Medicaid patient under this Agreement for non-medical reasons. However, Provider shall not be required to accept or continue treatment of a patient with whom Provider feels he/she cannot establish and/or maintain a professional relationship.

(d) **Non-Covered Services.** Provider may access TennCare non-covered services as described in Section A.2.10 of the State Contracts and the TennCare rules and regulations set forth at Tenn. Comp. R. & Regs. 1200-13-13-10 for TennCare Medicaid and Tenn. Comp. R. & Regs. 1200-13-14-10 for TennCare Standard.

(e) **Notification.** For CHOICES Members, Provider shall facilitate notification of the Member's care coordinator by notifying BlueCare Tennessee, in accordance with BlueCare Tennessee's processes, as expeditiously as warranted by the Member's circumstances, of any known significant changes in the Member's condition or care, hospitalizations, or recommendations for additional services.

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 further agrees to comply with the applicable federal and State civil rights laws, including, but not limited to Section 1557 of the Patient Protection and Affordable Care Act which prohibits discrimination on the basis of race, color, national origin, sex, age or disability. In addition, Provider shall also comply with the Nondiscrimination Requirements set forth in **Exhibit 2, The Nondiscrimination Requirements Attachment** attached to this Agreement and by reference incorporated herein and made a part hereof.

(b) **Open Communication.** BlueCare Tennessee encourages open provider-patient communication regarding appropriate treatment alternatives. BlueCare Tennessee 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 BlueCare Tennessee and Provider. For the purpose of this section, the term "disputes" includes, but is not limited to, disagreements about claims or payments or any matter other than those involving Members.

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

(f) **Care to Pregnant Women.** Any unreasonable delay in providing care to a pregnant TennCare Member seeking prenatal care will be considered a material breach of this Agreement. "Unreasonable delay" in providing care for pregnant TennCare Members shall mean the following: (i) for TennCare Members in their first trimester of pregnancy, in excess of three (3) weeks from the date of the TennCare Member's request for regular appointments and forty-eight (48) hours from the date of the TennCare Member's request for urgent care; and (ii) for a TennCare Member past their first trimester of pregnancy, on the day they are determined to be eligible a first prenatal care appointment shall occur no later than fifteen (15) calendar days from the day they are determined to be eligible.

(g) **Hours of Operation.** Provider shall offer hours of operation that are no less than the hours of operation offered to commercial members.

4.3. Member Grievances/Benefit Appeals.

BlueCare Tennessee must inform Provider about Member Grievance and SFH rights as specified in 42 C.F.R Part 438 and about the attendant Member Grievance and SFH procedures and time frames. When a Grievance or SFH request is filed by or on behalf of a Member, Provider agrees to satisfy the obligations below in relation to the Member Grievance or SFH request. Provider shall also comply with applicable Member Grievance and Benefit Appeal Systems.

(a) Provider shall assist Members by providing forms and contact information including the appropriate address, telephone number and/or fax number for submitting Grievances or requests for State Fair Hearings.

(b) Provider shall comply in a timely manner with a request from Enrollee, Enrollee-Authorized Representative, TennCare or BlueCare Tennessee for information or records related to Member's Grievance or SFH request.

(c) Provider shall seek Prior Authorization in advance, when Provider feels that he/she cannot order a drug on the TennCare Preferred Drug List (PDL) as well as take the initiative to seek Prior Authorization or change or cancel the prescription when contacted by a Member or pharmacy regarding denial of a pharmacy service due to system edits (i.e., therapeutic duplication, etc.).

(d) Provider shall coordinate with the TennCare Pharmacy Benefits Manager (PBM) regarding authorization and payment for pharmacy services.

(e) Provider shall provide written certification of the emergency nature of Benefit Appeals as appropriate.

4.4. Prior Authorization.

If Prior Authorization of a service is granted by BlueCare Tennessee and the service is provided, payment for the previously authorized service may be denied by BlueCare Tennessee if BlueCare Tennessee subsequently determines that (i) the healthcare services rendered were not included as Covered Services under the applicable Benefit Plan; (ii) such services were not Medically Necessary, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were

described at the time that Prior Authorization was granted; (iii) the Member was ineligible for such services at the time the services were rendered; or (iv) the information submitted with the Prior Authorization request was inaccurate and incomplete. If BlueCare Tennessee does not authorize a service that requires a Prior Authorization, Provider will not receive payment for such service.

4.5. 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 or a Network Attachment. Provider acknowledges that BlueCare Tennessee 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.

4.6. License Requirement.

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

4.7. Insurance.

(a) **Professional Liability.** Except as otherwise provided herein, at all times during the term of this Agreement, Provider shall maintain professional liability insurance as is necessary to adequately protect BlueCare Tennessee's Members and BlueCare Tennessee under this Agreement (per Section A.2.12.9.46 of the State Contracts), including maintaining such tail or prior acts coverage necessary to avoid any gap in coverage for claims arising from incidents occurring during the term of this Agreement. Such insurance shall (i) be obtained from a carrier authorized to conduct business in the jurisdiction in which Provider operates, (ii) maintain minimum policy limits of at least $1,000,000.00 per occurrence and $3,000,000.00 in the aggregate; and (iii) include coverage for the professional acts and omissions of Provider and any employee, agent or other person for whose acts or omissions Provider is responsible.

(b) **General Liability.** Except as otherwise provided herein, at all times during the terms of this Agreement, Provider shall maintain general comprehensive liability insurance, in amounts required under Regulatory Requirements. Said insurance shall cover Provider's premises, insuring Provider against any claim of loss, liability, or damage caused by or arising out of the condition or alleged condition of said premises, or the furniture, fixtures, appliances, or equipment located therein, together with the standard liability protection against any loss, liability or damage resulting from the operation of a motor vehicle by Provider, Provider's employees or agents.

(c) **Workers' Compensation.** Provider shall maintain workers' compensation insurance for Provider's employees. Said insurance shall be obtained from a carrier authorized to conduct business in the jurisdiction in which Provider operates or through a program of self-insurance and shall provide such limits of coverage as required by Regulatory Requirements.

(d) **Evidence of Insurance.** Provider shall provide BlueCare Tennessee with evidence of Provider's compliance with the foregoing insurance requirements as reasonably requested by BlueCare Tennessee from time to time during the term of this Agreement, but in no event less than annually. Provider shall provide BlueCare Tennessee with at least thirty (30) days' prior written notice of any cancellation or non-renewal of any required coverage or any reduction in the amount of Provider's coverage, and shall secure replacement coverage meeting the requirements hereunder so as to ensure no lapse in coverage. Provider shall furnish BlueCare Tennessee with a certificate of insurance evidencing such replacement coverage. Provider shall also furnish a certificate of insurance to a requesting agency upon request. 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.

(e) **State owned and/or operated.** If Provider is State owned and/or operated, the State is prohibited by law from agreeing to provide indemnity. In addition, the General Assembly of the State does not authorize State agencies or employees to provide, carry or maintain commercial general liability insurance or medical, professional or hospital liability insurance. Claims against the State, or its employees, for injury, damages, expenses or attorney's fees are heard and determined by the Tennessee Claims Commission or the Tennessee Board of Claims in the manner prescribed by law. See Tenn. Code Ann. § § 8-42-101 et seq., 9-8-101 et seq.,9-8-301 et seq., and 9-8-401 et seq. Provider as a governmental entity is not required to provide workers' compensation insurance. It does, however, provide a fully funded injured on duty benefit program for its employees.

(f) **Local Government.** If Provider is owned and operated by a local government entity (such as county or municipality), Provider is prohibited by law from agreeing to provide indemnity. Additionally, Provider is governed by the provisions of the Tennessee Government Tort Liability Act, Tenn. Code Ann. § § 29-20-101 et seq., for causes of action sounding in tort. Further, no contract provision requiring a Tennessee political entity to indemnify or hold harmless the State beyond the liability imposed by law is enforceable because it appropriates public money and nullifies governmental immunity without the authorization of the General Assembly. Provider as a governmental entity is not required to provide workers' compensation insurance. If the Provider does not maintain workers' compensation insurance it does, however, provide a fully funded injured on duty benefit program for its employees.

(g) **BlueCare Tennessee Requirement.** During the Term (as defined herein) of this Agreement, BlueCare Tennessee shall maintain such insurance coverage that

BlueCare Tennessee reasonably believes to be appropriate and in compliance with applicable state and federal requirements.

4.8. Monitoring.

(a) BlueCare Tennessee shall have the right to monitor, whether announced or unannounced, Covered Services provided by Provider.

(b) Provider agrees that TennCare, the Department of Health and Human Services Office of Inspector General (DHHS OIG), Office of the Comptroller of the Treasury, Office of Inspector General, Tennessee Bureau of Investigation Medicaid Fraud Control Unit (TBI MFCU), and the Department of Justice (DOJ), as well as any authorized State or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means, any records pertinent to the Agreement.

(c) Said records shall be made available and furnished immediately upon request by Provider for fiscal audit, medical audit, medical review, utilization review and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of BlueCare Tennessee, TennCare or authorized federal, State and Office of the Comptroller of the Treasury personnel, including, but not limited to, the OIG, the TBI MFCU, the DHHS OIG and the DOJ. Said records are to be provided by Provider at no cost to the requesting agency.

4.9. Compliance with Regulatory Requirements.

(a) BlueCare Tennessee and Provider shall each comply with all applicable Regulatory Requirements related to this Agreement. The failure of this Agreement to expressly reference a Regulatory Requirement applicable to either Party in connection with their duties and responsibilities hereunder shall in no way limit such Party's obligation to comply with such Regulatory Requirement. Without limiting the foregoing, this Agreement incorporates by reference all applicable federal law and state laws, TennCare rules and regulations, consent decrees and court orders. Any amendments to or revisions of such laws, regulations, consent decrees or court orders shall automatically be incorporated into this Agreement, as of their respective effective dates.

(b) Provider shall comply with Section A.2.20 of the State Contracts, as applicable, regarding fraud and abuse. The TBI MFCU is the State agency responsible for the investigation of Provider fraud and abuse in the TennCare Program. The Tennessee Office of Inspector General (TN OIG) has the primary responsibility to investigate Member fraud and abuse.

(c) Provider shall comply with the requirements of prompt pay, criminal background checks and registry checks and ownership and disclosure requirements as set forth in the applicable Benefit Plan Provider Manual.

(d) BlueCare Tennessee, any subcontractor or other entity, agrees to abide by the Medicaid laws, regulations and program instructions that apply to BlueCare Tennessee. BlueCare Tennessee, any subcontractor or other entity understands that payment of a claim by TennCare or a TennCare Managed Care Contractor

and/or Organization (MCO) is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal anti-kickback statute, the Stark law, and federal requirements on disclosure, debarment and exclusion screening), and is conditioned on BlueCare Tennessee, any subcontractor or other entity's compliance with all applicable conditions of participation in Medicaid. BlueCare Tennessee, any subcontractor or other entity understands and agrees that each claim BlueCare Tennessee, any subcontractor or entity submits to TennCare or a TennCare MCO constitutes a certification that BlueCare Tennessee, any subcontractor or entity has complied with all applicable Medicaid laws, regulations, and program instructions (including, but not limited to, the federal anti-kickback statute, the Stark law and federal requirements on disclosure, debarment and exclusion screening), in connection with such claims and the Covered Services provided therein.

(e) Provider shall screen its employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, Children's Health Insurance Program (CHIP), or any federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. Provider shall be required to immediately report to BlueCare Tennessee any exclusion information discovered. Provider acknowledges that civil monetary penalties may be imposed against Providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare Members.

(f) BlueCare Tennessee reserves the right to suspend, deny, refuse to renew or terminate this Agreement in accordance with the terms of the Termination section of the State Contracts and applicable Regulatory Requirements.

4.10. Credentialing Requirements.

Provider acknowledges and agrees that it must be credentialed to provide services as a BlueCare Tennessee provider at all times throughout the Term of this Agreement, and must maintain all credentialing requirements in accordance with the applicable Benefit Plan Provider Manual. Provider shall ensure that it is credentialed in accordance with the applicable Benefit Plan Provider Manual.

4.11. Provider Application.

Provider represents to BlueCare Tennessee 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 BlueCare Tennessee 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 BlueCare Tennessee that Provider is a Network Provider.

4.12. Notification by Provider.

Provider shall immediately notify BlueCare Tennessee 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; and

(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.

4.13. Accessibility of Provider.

Provider shall be available to provide Covered Services to Members at all appropriate times in accordance with applicable BlueCare Tennessee policies and procedures and the "Member Policy" section of the applicable Benefit Plan Provider Manual.

4.14. 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.

4.15. 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 confirm that such other healthcare provider is a Network Provider.

4.16. Identification Cards.

BlueCare Tennessee agrees to provide appropriate identification cards for BlueCare Tennessee 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 BlueCare Tennessee 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.

4.17. Member Handbook.

BlueCare Tennessee is responsible for the provision of a copy of the applicable Benefit Plan member handbooks and the Provider Manuals to the Provider. The member handbooks and Provider Manuals are available via BlueCare Tennessee's website at http://bluecare.bcbst.com.

4.18. Access Requirements.

Provider shall comply with the applicable access requirements, including but not limited to, appointment and wait times as referenced in Section A.2.11 of the State Contracts.

4.19. Laboratory Services.

If Provider performs laboratory services, Provider shall meet all applicable requirements of the Clinical Laboratory Improvement Amendments of 1988.

4.20. Emergency Services.

Prior Authorization shall not be required for Emergency Services prior to stabilization.

4.21. Provider Training.

Provider agrees to participate in any required training provided by BlueCare Tennessee that is necessary to ensure satisfaction of all BlueCare Tennessee's responsibilities under the State Contracts.

5. COMPENSATION AND BILLING

5.1. Reimbursement.

(a) BlueCare Tennessee 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 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. BlueCare Tennessee will process all claims submitted to BlueCare Tennessee upon receipt of a Clean Claim. In the event that BlueCare Tennessee is unable to pay Provider via EFT, BlueCare Tennessee may, in its discretion, terminate this Agreement in accordance with Section 11.4; provided, however, that BlueCare Tennessee shall not be excused from compliance with state prompt payment requirements.

(b) BlueCare Tennessee and Members are not obligated to pay for services provided by Provider that are not Medically Necessary. However, the Parties recognize that Members might request services that are not Medically Necessary. 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 Member Policy section of the applicable Benefit Plan Provider Manual, and must contain the terms provided for therein.

(c) 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 applicable Benefit Plan Provider Manual.

(d) The Provider shall bill BlueCare Tennessee for all Covered Services provided to Members in accordance with the billing guidelines contained in the applicable Benefit Plan Provider Manual and shall be compensated based on the applicable rate schedule for each Network Attachment. These amounts will be reduced by applicable deductible, copayment and coinsurance amounts.

(e) BlueCare Tennessee will not issue any payments to Provider for any Covered Services until Provider has obtained a Tennessee Medicaid provider number and has complied with the disclosure requirements, as applicable, in accordance with 42 C.F.R. § § 455.100 - 106 and TennCare policies and procedures.

(f) Provider shall accept the amount paid by BlueCare Tennessee or appropriate denial made by BlueCare Tennessee (or if applicable, payment by BlueCare Tennessee that is supplementary to the Member's third party Payor) plus the amount of any applicable Member Cost Sharing Obligations due from the Member, as payment in full for Covered Services provided. Provider shall not solicit or accept any security or guarantee of payment from the Member in excess of the amount of applicable Member Cost Sharing Obligations. For purposes hereof, Member shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the patient being served. Further, Provider may not charge a Member for missed appointments. Provider or collection agencies acting on the Provider's behalf may not bill Members for amounts other than applicable Member Cost Sharing Obligations for Covered Services, including but not limited to, services that the State, Provider or BlueCare Tennessee have not paid for, except as permitted by any Regulatory Requirements, including, but not limited to Section A.2.6.7.5.1 of the State Contracts.

(g) BlueCare Tennessee will be responsible for the provision of notice to Provider of denied authorizations. Such notice will be provided at the time of denial.

(h) If Provider participates in the federal 340B program, Provider shall give BlueCare Tennessee the benefit of Provider's 340B pricing.

(i) If Provider becomes aware for any reason that he/she is not entitled to a capitation payment for a particular Member (a patient dies, for example), Provider shall immediately notify both BlueCare Tennessee and TennCare by certified mail, return receipt requested.

(j) Any reassignment of payment must be made in accordance with 42 C.F.R. § 447.10. All tax-reporting Provider entities shall not be permitted to assign TennCare funds/payments to billing agents or alternative payees without executing a billing agent or alternative payee assignment agreement. The billing agents and alternative payees are subject to initial and monthly federal exclusion (LEIE) and debarment (SAM) screening by the assignee if the alternative payee assignment is on-going. Further direct and indirect payments to out of country individuals and/or entities are prohibited.

(k) Provider shall comply with 42 C.F.R. Part 438, Managed Care, including but not limited to § 438.6(f)(2)(i), compliance with the requirements mandating Provider identification of Provider-preventable conditions as a condition of payment. At a minimum, this shall mean non-payment of Provider-preventable conditions as well as appropriate reporting as required by BlueCare Tennessee and TennCare.

5.2. Member Cost Sharing Obligation.

Provider shall be responsible for collecting Member Cost Sharing Obligations and agrees not to waive any applicable Member Cost Sharing Obligation in accordance with the terms of the State Contracts. Provider must bill and make a good faith effort to collect all

applicable Member Cost Sharing Obligations from Members as a condition to receiving reimbursement from BlueCare Tennessee for Covered Services. Provider shall not require any Member Cost Sharing Obligations or patient liability responsibilities for Covered Services except to the extent that Member Cost Sharing Obligations or patient liability responsibilities are required for those services by TennCare in accordance with Regulatory Requirements, including but not limited to, not holding Members liable for debt due to insolvency of BlueCare Tennessee or non-payment by the State to BlueCare Tennessee. Any Member Cost Sharing Obligations imposed on Members shall be in accordance with Medicaid fee for service requirements at 42 C.F.R. § 447.50 through 42 C.F.R. § 447.82.

5.3. Overpayments.

Provider shall comply with the Patient Protection and Affordable Care Act and TennCare policy and procedures, including written notification to BlueCare Tennessee and TennCare Office of Program Integrity ("OPI") of overpayments identified by Provider, and when applicable, returning the overpayment to BlueCare Tennessee within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may be a violation of State or federal law.

5.4. Submission of Charges.

(a) Provider warrants that all charges submitted for Covered Services are legitimate. Provider agrees to submit all charges for services to BlueCare Tennessee for adjudication in accordance with the applicable Benefit Plan Provider Manual, unless otherwise stated. Provider shall promptly submit charges for Covered Services on Clean Claims within one hundred and twenty (120) calendar days from the date of rendering Covered Services except in situations regarding coordination of benefits or subrogation, in which case the Provider is pursuing payment from a third party or if a Member is enrolled in a Benefit Plan with a retroactive eligibility date. In situations of third party benefits, the maximum time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in a Benefit Plan with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that BlueCare Tennessee receives notification from TennCare of the Member's eligibility/enrollment. 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 BlueCare Tennessee, and shall not engage in any unbundling, upcoding or any similar activities. In addition, BlueCare Tennessee shall have the authority, where BlueCare Tennessee 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.

(c) To assist Provider in submitting charges in accordance with recognized standards of coding and BlueCare Tennessee coding edits, BlueCare Tennessee represents that it will publish and make known to Provider its coding edits and reimbursement rules.

(d) **Pass-Through Charges.** Provider agrees not to pass through to BlueCare Tennessee or the Member any charges which Provider incurs as a result of providing supplies or making referrals to another Provider or entity. Examples include, but are not limited to, pass-through charges associated with laboratory services, pathology services, radiology services, and durable medical equipment.

(e) **Recoveries From Third Parties**. Provider is responsible regarding TPL, including Provider's obligation to identify TPL liability coverage, including Medicare and long-term care insurance as applicable, and except as otherwise provided in BlueCare Tennessee's agreement with TennCare, to seek such third party liability payment before submitting claims to BlueCare Tennessee.

5.5. 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 BlueCare Tennessee 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 BlueCare Tennessee is the secondary Payor, then BlueCare Tennessee (i) shall coordinate with the primary insurance carrier or Payor and pay up to the Maximum Allowable, or (ii) will pay as set forth in the Member's 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. BlueCare Tennessee and Provider shall cooperate and exchange information regarding alternative health coverage of Members and other information relative to Coordination/Maintenance of Benefits.

5.6. Subrogation and Right to Recover.

Subrogation is TennCare's right to be reimbursed any funds it has spent for medical care for a TennCare enrollee when an insurance company or another person owes money to the TennCare enrollee because of the injury or illness. The State is required by federal and State law to seek reimbursement of medical assistance funds it has paid on behalf of TennCare enrollees from responsible or liable third parties (42 USC § § 1396(a)(25) and 1396(k), and Tenn. Code Ann. § 71-5-117). State law creates an automatic assignment of third party benefits from each TennCare enrollee to the State. The law provides that the State, through the Division of TennCare or its MCOs, is "...subrogated to all rights of recovery, for the cost of care or treatment for the injury or illness for which medical assistance is provided..."

Third party resources shall include subrogation recoveries. BlueCare Tennessee is required to seek subrogation amounts regardless of the amount believed to be available as required

by federal Medicaid guidelines. The amount of any subrogation recoveries collected by BlueCare Tennessee outside of the claims processing system shall be treated by BlueCare Tennessee as offsets to medical expenses for the purposes of reporting.

6. QUALITY IMPROVEMENT AND UTILIZATION MANAGEMENT

6.1. Quality Improvement and Utilization Management Programs.

BlueCare Tennessee, or an entity designated by BlueCare Tennessee, shall maintain Quality Improvement Programs and Utilization Management Programs and shall monitor the healthcare services delivered to Members under this Agreement and initiate corrective action where necessary to improve quality of care. Provider agrees to comply with any corrective action plans initiated by BlueCare Tennessee.

For the purposes of providing Covered Services to Members, Provider agrees to comply with BlueCare Tennessee's Quality Improvement Programs and Utilization Management Programs as well as any external quality management/quality improvement programs, monitoring, utilization review, peer review and/or appeal procedures established by BlueCare Tennessee and/or TennCare. BlueCare Tennessee may monitor Provider's quality improvement activities and compliance with Quality Improvement Programs and Utilization Management Programs.

7. RESOLUTION OF DISPUTES

7.1. Meeting of Parties.

BlueCare Tennessee and Provider agree to meet and confer in good faith to resolve any problem, dispute, or controversy that may arise under this Agreement.

7.2. Disputes.

Except as set forth herein, the Parties agree to resolve all disputes in accordance with BlueCare Tennessee's Dispute Resolution Procedure as set forth in the applicable Benefit Plan Provider Manual unless otherwise agreed to in writing by the Parties. Applicable provisions of the Dispute Resolution Process are incorporated by reference into this Agreement and shall survive the termination of this Agreement. BlueCare Tennessee and Provider agree that, to the extent allowable by law, all claims against the State of Tennessee, its officers, agents, and employees arising out of or relating to this Agreement shall be adjudicated only in a proceeding before the Tennessee Claims Commission pursuant to Tenn. Code Ann. Sec. 9-8-301 et seq. Any dispute arising out of or relating to this Agreement that is not subject to adjudication by the Tennessee Court of Claims will be adjudicated as allowed by law. The Parties may, but shall not be required to, utilize non-binding alternative dispute resolution procedures to resolve any dispute arising out of or relating 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.

BlueCare Tennessee and Provider recognize that the TennCare Provider Independent Review of Disputed Claims process shall be available to BlueCare Tennessee's TennCare Providers to resolve TennCare Program (BlueCare/TennCareSelect only) claims denied

in whole or in part by BlueCare Tennessee as provided at Tenn. Code Ann. § 56-32-126(b)."

7.3. Notice and Resolution of Grievances.

If a Grievance regarding Provider is received by Provider from a Member or any other Network Provider, Provider agrees to promptly notify BlueCare Tennessee in writing and provide all details of such Grievance. Provider agrees to cooperate fully with BlueCare Tennessee in the investigation and resolution of any Grievance by a Member or any other Network Provider.

7.4. Negotiations.

The Parties agree that negotiations of rates, participation, and other terms of this Agreement are not subject to the dispute resolution procedures set forth in this section.

8. USE OF NAMES

8.1. Use of Provider's Name.

BlueCare Tennessee 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.

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

8.3. Use of BlueCare Tennessee's Name.

Provider shall not use BlueCare Tennessee's name, symbols, trademarks, or service marks in advertising or promotional materials, or in any other way, without the prior written consent of BlueCare Tennessee and shall cease any such permitted usage immediately upon written notice from BlueCare Tennessee to do so, or upon termination of this Agreement, whichever occurs first .

8.4. Use of TennCare's Name.

Provider shall not use TennCare's name or trademark for any materials intended for dissemination to their patients unless said material has been submitted to TennCare by BlueCare Tennessee for review and has been approved by TennCare in accordance with Section A.2.17 of the State Contracts. This prohibition shall not include references to whether or not the Provider accepts TennCare.

9. RECORDS, ACCESS, INSPECTION AND CONFIDENTIALITY

9.1. Records.

(a) Provider agrees to comply with specific records requirements and Availability of Records requirements by BlueCare Tennessee and the State as set forth in the applicable Benefit Plan Provider Manual.

(b) Provider shall prepare and maintain all required financial and Medical Records on Members receiving Covered Services. Such records shall include, but are not limited to Medical Records pertaining to Covered Services and changes, costs, utilization, and any other records needed to meet the requirements of governmental regulatory agencies or as may be requested by BlueCare Tennessee and the State. Such records shall be maintained in accordance with prudent record keeping procedures and as required by law.

(c) Members and their representatives shall be given access to the Member's Medical Records, to the extent and in the manner provided by Tenn. Code Ann. § § 63-2-101 and 63-2-102. When a TennCare member-provider relationship with the primary care Provider ends and the Member requests that Medical Records be sent to a second TennCare Provider, the first Provider shall not charge the Member or the second Provider for providing the Medical Records.

9.2. Processing of Claims.

Provider will furnish to BlueCare Tennessee, without charge, all information reasonably required by BlueCare Tennessee 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 BlueCare Tennessee.

9.3. 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 BlueCare Tennessee to be reasonably acceptable, and (iii) as required by law. Notwithstanding the foregoing, BlueCare Tennessee is not defining or prescribing the medical and clinical information and content of the records, so long as such records comply with applicable law.

Provider shall maintain books, records, documents and other evidence pertaining to services rendered, equipment, staff, financial records, and the administrative costs and expenses incurred pursuant to this Agreement as well as medical information relating to the individual Enrollees as required for the purposes of audit or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements set forth in Section A.2.20, Fraud and Abuse, of the State Contracts. Records other than Medical Records may be kept in an original paper state or preserved on micromedia or electronic format. Medical Records shall be maintained in their original form or may be converted to electronic format as long as the records are readable and/or legible. These records, books, documents, etc. shall be available for BlueCare Tennessee and any authorized federal or State agency, including but not limited to TennCare, TN OIG, TBI MFCU, DOJ and the DHHS OIG, and Office of the Comptroller of the Treasury personnel during the Agreement period and five (5) years thereafter, unless an audit,

administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are yet unresolved in which case records shall be kept until all tasks or proceedings are completed. During the Agreement period, these records shall be available at Provider's location in Tennessee. If the records need to be sent to BlueCare Tennessee or TennCare, Provider shall bear the expense of delivery. Prior approval of the disposition of Provider records must be requested and approved by BlueCare Tennessee in writing. Nothing in this section shall be construed to modify or change the obligations contained in Section A.2.23.2 (Data and Document Management Requirements), Section A.2.23.3 (System and Data Integration Requirements), or Section A.2.23.6 (System and Information Security and Access Management Requirements) of the State Contracts.

9.4. Audits and Inspections.

Provider agrees that BlueCare Tennessee, or a representative designated by BlueCare Tennessee, 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 applicable Benefit Plan Provider Manual. Such audits and inspections shall be permitted without charge to BlueCare Tennessee 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 BlueCare Tennessee promptly and in an electronic format. Audits and inspections are conducted as part of BlueCare Tennessee's healthcare operations in accordance with applicable federal law.

9.5. 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 Providers treating Members, and to BlueCare Tennessee, its agents and representatives, at no charge to BlueCare Tennessee or to Members. In the event that a Member is (i) transferred from Provider, (ii) disenrolls from his or her Benefit Plan, or (iii) 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 BlueCare Tennessee, the Member and the attending Provider in a timely manner, as appropriate for the efficient provision of care to such Member.

Should Provider fail or refuse to respond to BlueCare Tennessee's efforts to obtain medical information and a Benefit Appeal is decided in favor of the Member, at BlueCare Tennessee's discretion or a directive by TennCare, BlueCare Tennessee shall impose financial penalties against Provider, as appropriate.

9.6. Confidentiality.

(a) Each Party, its Affiliates, 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 (i) as required by law, (ii) required by a valid court order, or (iii) mutually agreed to in a writing executed by both Parties. Further, and notwithstanding the confidentiality provisions in this section, Provider authorizes BlueCare Tennessee 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, BlueCare Tennessee Member satisfaction results, and performance within the industry. BlueCare Tennessee may disseminate such information to Provider, other Network Providers, Payors, customers and potential customers, BlueCare Tennessee Members, and regulatory or accreditation agencies, provided that, in the event that BlueCare Tennessee 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.

(b) Provider shall safeguard all information about Members according to applicable state and federal laws and regulations and as described in the applicable Benefit Plan Provider Manual.

(c) All information as to personal facts and circumstance concerning Members or potential TennCare Members obtained by Provider shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of (i) TennCare, (ii) the Member, or (iii) BlueCare Tennessee, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning Members shall be limited to purposes directly connected with the administration of this Agreement and shall be in compliance with federal and state law.

10. LIABILITY AND INDEMNIFICATION

10.1. Third Party Acts and Omissions.

Neither BlueCare Tennessee, 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.

(a) To the extent permitted by 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 to any matters resulting in whole or in part from the negligent or willful acts or omissions of the Indemnitee, its agents or employees

(b) 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 BlueCare Tennessee's legal counsel.

(c) To the extent permitted by Tennessee law, the Provider shall indemnify and hold harmless the State as well as its officers, agents, and employees (hereinafter the "Indemnified Parties") from all claims, losses or suits incurred by or brought against the Indemnified Parties as a result of the failure of Provider to comply with the terms of this Agreement. The State shall give Provider written notice of each such claim or suit and full right and opportunity to conduct Provider's own defense thereof, together with full information and all reasonable cooperation; but the State does not hereby accord to Provider, through its attorneys, any right(s) to represent the State in any legal matter, such right being governed by Tenn. Code Ann. § 8-6-106.

(d) To the extent permitted by Tennessee law, Provider shall indemnify and hold harmless the Indemnified Parties as well as their officers, agents and employees from all claims or suits which may be brought against the Indemnified Parties for infringement of any laws regarding patents or copyrights which may arise from the Provider's or Indemnified Parties performance under the Agreement. In any such action, brought against the Indemnified Parties, Provider shall satisfy and indemnify the Indemnified Parties for the amount of any final judgment for infringement. The State shall give the Provider written notice of each such claim or suit and full right and opportunity to conduct the Provider's own defense thereof, together with full information and all reasonable cooperation; but the State does not hereby accord to Provider, through its attorneys, any right(s) to represent the State in any legal matter, such right being governed by Tenn. Code Ann. § 8-6-106.

(e) While the State or local government entity will not provide a contractual indemnification to the Provider, such shall not act as a waiver or limitation of any liability for which the State or local government entity may otherwise be legally responsible to the Provider. Provider retains all of its rights to seek legal remedies against the State or local government entity for losses the Provider may incur in connection with the furnishing of services under this Agreement or for the failure of the State or local government entity to meet its obligations under the State Contracts.

(f) If Provider is a State agency or local government entity, it may be governed by the Doctrine of Sovereign Immunity set forth in Article 1, Section 17 of the Tennessee Constitution and as codified at Tenn. Code Ann. § 20-13-102 for causes of action sounding in tort. Further, Article 2, Section 24 of the Tennessee Constitution prohibits expenditures of public monies except pursuant to appropriations authorized by law. Therefore, no contract provision requiring a State agency or local government entity to indemnify or hold harmless BlueCare Tennessee

beyond any liability imposed by law is enforceable because it appropriates public monies and nullifies the Sovereign Immunity of the State without the authorization of the General Assembly. The General Assembly has authorized pursuit of claims for tort negligence against a State agency or its agents, officers or employees in the Tennessee Claims Commission or the Tennessee Board of Claims, respectively, as described in Tenn. Code Ann. § § 9-8-307 and § 9-8-108. As provided at Tenn. Code Ann. § 9-8-407, written notice of such claims must be filed with the Division of Claims Administration.

11. TERM; TERMINATION

11.1. Term.

This Agreement shall be effective as of the Effective Date and shall continue in effect unless and until terminated in accordance with the terms of this Agreement (the "Term"). 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 BlueCare Tennessee within ninety (90) days of the Effective Date, this Agreement and participation in all Networks pursuant to this Agreement will automatically terminate and become null and void.

11.2. Without Cause Termination.

BlueCare Tennessee may terminate this Agreement or its participation in a Network by giving, via certified mail or courier service, written notice to the Provider no later than one hundred and twenty (120) days prior to the Anniversary Date.

Provider may terminate this Agreement or participation in a Network by giving written notice to BlueCare Tennessee by August 1 of the current year for termination effective January 1 of the following year.

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

11.4. BlueCare Tennessee Immediate Termination.

BlueCare Tennessee 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; or

(b) Provider, in BlueCare Tennessee'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 BlueCare Tennessee; or

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

(d) A judgment of (i) civil liability, (ii) 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 (iii) conviction (including a plea of nolo contendere) of a felony or of a misdemeanor involving fraud or moral turpitude is rendered against Provider; or

(e) Provider fails to maintain insurance in accordance with the provisions of Section 4.7 of this Agreement; or

(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 suggest deficiencies in patient care and causes Provider to no longer meet BlueCare Tennessee's Network Participation Criteria; or

(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 BlueCare Tennessee; or

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

(i) The power to direct the management of BlueCare Tennessee becomes controlled by an entity not controlled by BlueCare Tennessee or an Affiliate.

11.5. Provider Immediate Termination.

Provider may terminate this Agreement immediately in the event that:

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

(b) A judgment of (i) civil liability, (ii) 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 (iii) conviction (including a plea of *nolo contendere*) of a felony or of a misdemeanor involving fraud or moral turpitude is rendered against BlueCare Tennessee.

11.6. Other Termination.

Either Party may terminate this Agreement in accordance with the terms of Section 12.2 or 13.6 below. BlueCare Tennessee may terminate this Agreement in accordance with the terms of Section 13.1 or 13.8 below. The Parties acknowledge that TennCare reserves the right to direct BlueCare Tennessee to terminate or modify this Agreement when TennCare determines it to be in the best interest of the State.

11.7. Effects of Termination.

The termination of this Agreement shall not release Provider, except as otherwise determined by BlueCare Tennessee, 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. BlueCare Tennessee 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. BlueCare Tennessee shall, (i) for a period of five (5) years after termination of this Agreement, (ii) as otherwise required by law, and (iii) as necessary to fulfill the terms of this Agreement and any applicable Network Attachment, continue to have access to records of Members. In addition, in cases of suspected fraud or abuse, BlueCare Tennessee 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 (i) to terminate this Agreement, (ii) to specific performance, (iii) 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 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 BlueCare Tennessee and its Members or to discourage any person from doing business with BlueCare Tennessee. 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, 9, 11.7, and 11.8 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, BlueCare Tennessee 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 BlueCare Tennessee, which consent may be withheld by BlueCare Tennessee for any reason. In the event of a change of control affecting Provider, Provider shall notify BlueCare Tennessee in writing, and BlueCare Tennessee, at its discretion, may terminate this Agreement by providing Provider thirty (30) days' prior notice within the date of notice of such change of control.

BlueCare Tennessee 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. Acquisitions.

Provider may acquire or be acquired by, merge with, or otherwise become affiliated with another provider of health care services. If such other provider was already a Network

Provider, either through a direct agreement with BlueCare Tennessee or as an associated professional with another Network Provider, BlueCare Tennessee may, at its option, continue to apply the rates previously contracted by the other Network Provider and Provider to the services provided by each of them for the greatest of: (a) the remaining term of Provider's participation agreement in effect prior to the acquisition, merger or affiliation; (b) the remaining term of the other Network Provider's participation agreement in effect prior to the acquisition, merger or affiliation; or (c) one (1) year.

13.3. Subcontracting.

Provider shall not subcontract this Agreement, or any portion of this Agreement, without the prior written consent of BlueCare Tennessee, which consent may be withheld by BlueCare Tennessee for any reason. Failure by Provider to obtain written approval from BlueCare Tennessee for a subcontract that is for the purpose of providing TennCare Covered Services may lead to the contract being declared null and void. Claims submitted by the subcontractor or by the provider for services furnished by the subcontractor are considered to be improper payments and may be considered false claims. Any such improper payments may be subject to action under federal and state false clams statutes or be subject to be recouped by BlueCare Tennessee and/or TennCare as overpayment. Notwithstanding anything to the contrary herein, BlueCare Tennessee may subcontract any administrative function as it relates to this Agreement to any organization it so designates.

13.4. 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.

13.5. 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, registered, or certified mail, return receipt requested, delivered by overnight courier, or transmitted electronically or by facsimile addressed as follows:

If to BlueCare Tennessee:
BlueCare Tennessee
Attention: Provider Contract Management
1 Cameron Hill Circle
Chattanooga, Tennessee 37402

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 (i) the date actually received and (ii) 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.

13.6. Severability.

In the event that any part of any provision of this Agreement is (i) rendered invalid or unenforceable under applicable law, (ii) is declared null and void by any court of competent jurisdiction, or (iii) is determined by TennCare to conflict with the State Contracts, such part shall be null and void, 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.

13.7. Entire Agreement.

This Agreement, together with the applicable Benefit Plan Provider Manual, and other manuals provided to Provider via the BlueCare Tennessee website or in hard copy format, and 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. This Agreement shall remain in full force and effect with respect to all Members, unless otherwise expressly stated. Each Network Attachment is enforceable under the terms and conditions contained therein and, in the event of a conflict between the language of this Agreement and any Network Attachment, the language of the Network Attachment shall prevail as to participation in that particular Network.

13.8. Provider Manual; Amendments.

(a) The terms and conditions of the applicable Benefit Plan 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. BlueCare Tennessee retains the right to change, revise, modify, or alter the terms of the Provider Manual upon at least thirty (30) days' prior written notice to Provider.

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

(c) The removal of a Network Provider from a Network, or a change (i) to a Benefit Plan, (ii) to BlueCare Tennessee 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) BlueCare Tennessee shall have the right to amend this Agreement in accordance with the following procedure:

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

(ii) Provider shall have thirty (30) days after notice of the amendment in which to respond in writing to BlueCare Tennessee. 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 BlueCare Tennessee, upon the earlier of Provider's written acceptance or the expiration of such thirty (30) day period; and

(iii) If Provider notifies BlueCare Tennessee 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 BlueCare Tennessee shall have the right to elect either (A) to have this Agreement remain in effect in accordance with its terms without the proposed amendment or (B) 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 13.8, this Agreement, or any part, article, section, exhibit, or Network Attachment(s) to this Agreement, may be amended, altered, or modified only in a writing duly executed by both Parties.

13.9. 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.

13.10. 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.

13.11. Execution of Agreement.

Each Party represents and warrants that (i) it may lawfully execute this Agreement and perform the obligations described herein, and that (ii) 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 BlueCare Tennessee's reasonable request, provide documentation confirming authorized signatories for purposes of this Agreement.

13.12. 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. A scanned, imaged, electronic, photocopy or stamp of the signatures hereunder shall have the same force and effect as an originally executed signature.

13.13. Conflict of Interest.

Provider, other than a State agency provider, provides assurance that no part of the total amount received by Provider under this Agreement shall be paid directly, indirectly or through a parent organization, subsidiary or an affiliated organization to any state or federal officer or employee of the State or any immediate family member of a state or federal officer or employee of the State as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to the Provider in connection with any work contemplated or performed relative to this Agreement unless otherwise disclosed to the Commissioner, Tennessee Department of Finance and Administration. For purposes of this Section 13.13 "immediate family member" shall mean a spouse or minor child(ren) living in the household. Provider shall ensure that it maintains adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of its organization.

13.14. TennCare Kids.

As applicable, Provider shall make treatment decisions for TennCare Kids eligible children based upon the child's individual medical and behavioral health needs. Prior Authorization shall not be required for the provision of TennCare screenings by Provider.

13.15. State Custody.

Provider or Provider's staff shall not encourage or suggest, in any way, that TennCare children be placed into State custody in order to receive medical or behavioral services covered by the TennCare Program.

14. BLUECARE NETWORK PARTICIPATION

14.1. Definitions.

"BlueCare Member" means a Member enrolled in BlueCare Tennessee's MCO under the provisions of the State Contracts, and whose health benefits are delivered through the BlueCare Network.

"BlueCare Network" means the Network for the provision of Covered Services to BlueCare Members.

"BlueCare Network Fixed Term" means **December 1, 2024**, through and including **November 30, 2029**.

"Clean Claim" means a claim received by BlueCare Tennessee for adjudication that requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by BlueCare Tennessee.

14.2. Participation.

Provider agrees to participate in the BlueCare Network for the purpose of providing health care Covered Services to BlueCare Members.

14.3. Reimbursement.

Reimbursement for Clean Claims for TennCare Benefit Plans shall be in accordance with the time frames set forth in Tenn. Code Ann. § 56-32-126(b), as may be amended from time to time.

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

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

BlueCare Tennessee will revise the BlueCare Network Attachment pursuant to the methods and time frames established in the BlueCare Network Attachment or in the applicable Benefit Plan 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.

14.4. Term and Termination.

Provider's participation in the BlueCare Network shall be effective through the BlueCare Network Fixed Term and, thereafter, shall renew automatically for successive periods of one (1) year each, unless terminated in accordance with the terms of this Agreement.

Termination of participation in the BlueCare Network does not terminate this Agreement or participation in any other Network.

15. TENNCARE*SELECT* NETWORK PARTICIPATION

15.1. Definitions.

"Clean Claim" means a claim received by BlueCare Tennessee for adjudication that requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by BlueCare Tennessee.

"TennCare*Select* Member" means a Member enrolled in BlueCare Tennessee's MCO under the provisions of the State Contracts, and whose health benefits are delivered through the TennCare*Select* Network.

"TennCare*Select* Network" means the Network for the provision of Covered Services to TennCare*Select* Members.
"TennCare*Select* Network Fixed Term" shall mean **December 1, 2024**, through and including **November 30, 2029**.

15.2. Participation.

Provider agrees to participate in the TennCare*Select* Network for the purpose of providing health care Covered Services to TennCare*Select* Members.

15.3. Reimbursement.

Reimbursement for Clean Claims for TennCare Benefit Plans shall be in accordance with the time frames set forth in Tenn. Code Ann. § 56-32-126(b), as may be amended from time to time.

For Covered Services provided to TennCare*Select* Members, BlueCare Tennessee will pay Provider the Maximum Allowable in accordance with the attached TennCare*Select* Network Attachment, which is incorporated by reference into this Agreement, at the time of service, less any applicable Member Cost Sharing Obligation.

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

BlueCare Tennessee will revise the TennCare*Select* Network Attachment pursuant to the methods and time frames established in TennCare*Select* Network Attachment or in the applicable Benefit Plan 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.

15.4. Term and Termination.

Provider's participation in the TennCare*Select* Network shall be effective through the TennCare*Select* Network Fixed Term and, thereafter, shall renew automatically for successive periods of one (1) year each, unless terminated in accordance with the terms of this Agreement.

Termination of participation in the TennCare*Select* Network does not terminate this Agreement or participation in any other Network.

16. [THIS SECTION INTENTIONALLY OMITTED]

17. [THIS SECTION INTENTIONALLY OMITTED]

18. TENNESSEE HEALTH CARE INNOVATION INITIATIVE (THCII)

18.1. Definitions.

a. "**Acceptable Level**" means the maximum acceptable Average Risk-Adjusted Total Cost of Care, determined by TennCare, for each Episode-Based Model (EBM), as defined below, above which Provider may owe a Shared Risk Payment. For each EBM, the Acceptable Level will be published in the THCII BCT Statewide Initiative Model (SIM) Thresholds document, contained in the THCII Provider Guide.

b. "**Average Risk-Adjusted Total Cost of Care**" means, for each EBM, the average over a Performance Period of the Total Cost of Care for all Members for whom Provider is the Quarterback, as defined below.

c. "**Business Requirements**" mean those requirements defined and published by TennCare for each EBM and set forth at https://www.tn.gov/tenncare/health-care-innovation.html, or its successor page.

d. "**Commendable Level**" means the Average Risk-Adjusted Total Cost of Care, as determined by BCT below, which the Provider may earn a Shared Risk Payment under the THCI Initiative pursuant to Section 2.f. below. For each EBM, the Commendable Level will be published in the THCII BCT SIMS Thresholds document, contained in the THCII Provider Guide.

e. "**Episode-Based Model**" or "**EBM**" means the portion of the THCI Initiative related to a specific diagnosis, condition or procedure. EBMs are defined by TennCare at https://www.tn.gov/tenncare/health-care-innovation.html, or its successor site.

f. "**Episode of Care**" means the period of treatment provided to an individual Member related to a specific diagnosis, condition or procedure for which TennCare has directed BCT to create an EBM. The Episode of Care for each EBM is defined by TennCare and set forth at https://www.tn.gov/tenncare/health-care-innovation.html, or its successor site.

g. "**Gain-Sharing Limit**" is the Average Risk-Adjusted Total Cost of Care below which cost is considered too low for quality care to have been provided. If BCT sets a Gain-Sharing Limit for an EBM, it will be published in the THCII Provider Guide. If a Gain-Sharing Limit is not specified by BCT for a particular EBM, the Gain-Sharing Limit will be assumed to be $0 for that EBM.

h. "**Performance Period**" means a period of time for which BCT will measure performance of all providers participating in an EBM.

i. "**Performance Report**" means a report generated by BCT for a given Performance Period that shows Provider's results on Quality Metrics, Total Cost of Care, and other information related to the THCI Initiative.

j. "**Principal Accountable Provider**" or "**PAP**" means the provider that is in the best position to control cost and quality of the care provided to a Member related to the Episode of Care. The PAP for each EBM shall be determined by the Business Requirements created by TennCare for that EBM and may be a healthcare professional (primary care or specialist) or facility.
Synonymous with Quarterback

k. "**Quality Metrics**" mean the quality of care measurements related to each EBM that TennCare will set for purposes of evaluating gain-sharing eligibility and that BCT will monitor. The Quality Metrics for each EBM are set forth in the THCII Guide.

l. "**Quality Target"** means, for any Quality Metric, the minimum score that Provider must achieve in order to be eligible for a Shared Risk Payment under the THCI Initiative.

m. "**Quarterback**" See Principal Accountable Provider.

n. "**Shared Risk Payment**" means, for any given Performance Period and EBM, either: 1) the payment made by BCT to Provider in the event that Provider's Average Risk-Adjusted Total Cost of Care is below the Commendable Level and Provider has met all Quality Targets; or 2) the payment made by Provider to BCT in the event that Provider's Average Risk-Adjusted Total Cost of Care is above the Acceptable Level.

o. "**THCII Provider Guide**" means the program document for the THCI Initiative which is an attachment to the Provider Manual.

p. "**Total Cost of Care**" means the total cost of all healthcare supplies and services, including, but not limited to, medications, provided by all healthcare providers to a Member and paid for by BCT, related to an Episode of Care, plus any Member cost-sharing amounts related to such services.

18.2. THCII Program Description.

a. *Administration*. BCT will administer the THCI as directed by TennCare.

b. *THCII Provider Guide*. The THCII Provider Guide is incorporated by reference herein and made a part hereof. BCT may notify Provider of changes to the THCI Initiative through updates to the THCII Provider Guide.

c. *EBM Information*. For each EBM, BCT will publish in the THCII Provider Guide a description of the EBM, the thresholds for Acceptable and Commendable Levels, criteria for including or excluding an Episode of Care from the EBM, relevant Quality Metrics and Targets, Performance Period dates, the anticipated adjustment date, and the provider types who are designated as Quarterbacks. To the extent that any of this information is available at https://www.tn.gov/tenncare/health-care-innovation.html, or its successor site, BCT may incorporate such information into the THCII Provider Guide by reference.

BCT shall implement new EBMs as directed by TennCare, which is anticipated to occur on a semi-annual basis.

d. *Risk Adjustment*. BCT shall adjust the Total Cost of Care for each Episode of Care in accordance with the risk adjustment methodology set forth in the THCII Provider Guide.

e. *Monitoring*. For each EBM for which Provider is designated as a PAP, BCT shall measure Provider's performance on Quality Metrics and Total Cost of Care for all Episodes of Care occurring during the Performance Period and will compile them into Performance Reports. BCT shall give Provider access to its Performance Reports, so that Provider may monitor its performance.

f. *Effect on Reimbursement*. BCT will use Provider's final Performance Report for the Performance Period to determine what effect, if any, Provider performance in the THCII will have on Provider's reimbursement.

For each EBM for which Provider acts as a PAP:

1. If Provider's Average Risk-Adjusted Total Cost of Care for the Performance Period is at or below the Commendable Level, but not at or below the Gain-Sharing Limit, and Provider has met the Quality Target for each relevant Quality Metric, BCT shall pay Provider a Shared Risk Payment equal to [50%] of the difference between Provider's Commendable Level and the Average Risk-Adjusted Total Cost of Care, multiplied by the number of Provider's Episodes of Care that were included in the EBM for the Performance Period. Any such payment due to

Provider will be made in accordance with the process set forth in the THCII Provider Guide.

Shared Risk Payment = [(Commendable Level - Average Risk-Adjusted Total Cost of Care) x # of Episodes of Care] x [50%]

2. If Provider's Average Risk-Adjusted Total Cost of Care falls below the Gain-Sharing Limit, Provider's Shared Risk Payment will be limited to [50%] of the difference between the Commendable Level and the Gain-Sharing Limit, multiplied by the number of Provider's Episodes of Care that were included in the EBM for the Performance Period.

   Shared Risk Payment = [(Commendable Level – Gain-Sharing Limit) x # of Episodes of Care] x [50%]

3. If Provider's Average Risk-Adjusted Total Cost of Care for the Performance Period is at or above the Acceptable Level, the Shared Risk Payment due to BCT will be an amount equal to [50%] of the difference between Provider's Average Risk-Adjusted Total Cost of Care and the Acceptable Level, multiplied by the number of Provider's Episodes of Care that were included in the EBM for the Performance Period. BCT will offset this amount against future payments to Provider, in accordance with the process set forth in the THCII Provider Guide.

   Shared Risk Payment = [(Average Risk-Adjusted Total Cost of Care – Acceptable Level) x # of Episodes of Care] x [50%]

4. If Provider's performance Average Risk-Adjusted Total Cost of Care falls between the Acceptable Level and the Commendable Level, Provider's reimbursement shall not be affected by the THCI Initiative.

g. *Limitation on* Provider *Risk*. "BCT agrees that, in the event that Provider owes a Shared Risk Payment to BCT for any Performance Period, that Shared Risk Payment will be capped at twenty-five percent (25%) of the total of BCT's payments to Provider related to the EBM for Episodes of Care that occurred during that Performance Period.

h. *Contracting Entity Identifier*. For the purpose of the THCI Initiative, BCT will monitor and aggregate Provider's progress based on a contracting entity identifier, unless otherwise directed by TennCare. BCT will utilize the contracting entity identifier to allocate Shared Risk Payments and offsets as described in the THCII Provider Guide.

SIGNATURE PAGE

IN WITNESS WHEREOF, the Parties have executed this Provider Agreement intending to be bound on the Effective Date.

Volunteer State Health Plan, Inc. dba BlueCare Tennessee

Signature: Signed by: Casey Dungan 81F936E21B8443A...

Print Name: Casey Dungan

Title: President and CEO

Date: 12/3/2024

Davidson County Health Department

Signature: DocuSigned by: Joanna Shaw-KaiKai F0EB3ACD4AFC4C1...

Print Name: Joanna Shaw-KaiKai, M.D.

Title: Interim Director of Health

Date: 1/15/2025

Institution's Tax ID: 620694743

Address for Notice:

Street: 2500 Charlotte Avenue

City: Nashville

State: Tennessee

Zip Code: 37209

E-mail: shannon.heath@nashville.gov

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

EXHIBIT 1

Davidson County Health Department

ANCILLARY PROVIDER

Health Department Name	Provider # (Internal Use Only)	TAX ID	NPI
Metropolitan Government of Nashville & Davidson Co	5524866	620694743	1992185854

EXHIBIT 2

NONDISCRIMINATION REQUIREMENTS ATTACHMENT

1. **Nondiscrimination.** No persons on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or State laws shall be excluded from participation in, except as specified in Section A.2.3.5 of the State Contracts, or be denied benefits of, or be otherwise subjected to discrimination in the performance of the Agreement or in the employment practices of the Provider. The Provider shall upon request show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees, TennCare applicants, and enrollees.

   (a) Provider shall have written procedures for the provision of language and communication assistance services to Members and/or the Member's representative. Language and communication assistance services include interpretation and translation services and effective communication assistance in alternative formats for any Member and/or the Member's representative who needs such services, including but not limited to, LEP and individuals with disabilities. Provider shall provide information to Members regarding treatment options and alternatives in a manner appropriate to the Member's condition and ability to understand.
   (b) Provider agrees to cooperate with the Division of TennCare (includes TennCare and CoverKids) and BlueCare Tennessee during discrimination complaint investigations and to report discrimination complaints and allegations to BlueCare Tennessee including allegations of discrimination set forth in Sections A.2.12.21.1 and A.2.15.7.6.3.2.7 of the State Contracts.
   (c) Provider shall also assist Members in obtaining discrimination complaint forms and contact information for BlueCare Tennessee's Nondiscrimination Office.

2. **Corrective Action Plans to Resolve Discrimination Complaints.** If a discrimination complaint against Provider or any of Provider's providers, employees or subcontractors considered to be recipients of federal financial assistance under the terms of the State Contracts is determined by the Division of TennCare to be valid, the Division of TennCare shall, at its option and pursuant to Section A.2.25.10 of the State Contracts, either (i) provide BlueCare Tennessee with a corrective action plan to resolve the complaint, or (ii) request that BlueCare Tennessee submit a proposed corrective action plan to the Division of TennCare for review and approval that specifies what actions BlueCare Tennessee and Provider propose to take to resolve the discrimination complaint. BlueCare Tennessee may require Provider to submit a proposed corrective action plan to BlueCare Tennessee for approval. Upon provision of the corrective action plan to Provider by the Division of TennCare and BlueCare Tennessee, or approval of Provider's proposed corrective action plan by the Division of TennCare, Provider shall implement the approved corrective action plan to resolve the discrimination complaint. The Division of TennCare, in its sole discretion, shall determine when a satisfactory discrimination complaint resolution has been reached and shall notify BlueCare Tennessee of the approved resolution. BlueCare Tennessee shall notify Provider when the Division of TennCare determines that a satisfactory discrimination complaint resolution has been reached. A discrimination complaint resolution corrective action plan may consist of approved nondiscrimination training on relevant discrimination topics. Prior to use, the nondiscrimination training material shall be reviewed and approved by the Division of TennCare and BlueCare Tennessee. Time periods for the implementation of the corrective action plan nondiscrimination training shall be designated by the Division of TennCare.

3. **Electronic and Information Technology Accessibility Requirements.** To the extent that the Provider is using electronic and informational technology to fulfill its obligations under the Agreement, the Provider agrees to comply with the electronic and information technology accessibility requirements under the federal civil rights laws including Section 504 and Section 508 of the Rehabilitation Act of 1973 ("Section 508") and the Americans with Disabilities Act. To comply with the accessibility requirements for Web content and non-Web electronic documents and software, the Provider shall use W3C's Web Content Accessibility Guidelines ("WCAG") 2.0 AA (For the W3C's guidelines see: http://www.w3.org/TR/WCAG20/) (Two core linked resources are Understanding WCAG 2.0 http://www.w3.org/TR/UNDERSTANDING-WCAG20/ and Techniques for WCAG 2.0 http://www.w3.org/TR/WCAG20-TECHS/).

4. **Cultural Competency.** As required by 42 CFR 438.206, BlueCare Tennessee and its providers and subcontractors that are providing services pursuant State Contracts shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including LEP, those with disabilities and diverse cultural and ethnic backgrounds regardless of an enrollee's gender, sexual orientation, or gender identity. This includes BlueCare Tennessee emphasizing the importance of network providers to have the capabilities to ensure physical access, accommodations, and accessible equipment for the furnishing of services to enrollees with physical or mental disabilities.

5. **Ethical and Religious Directives.** In the event the Agreement includes a provision limiting the services Provider will provide, the following is applicable:

   (a) The Provider shall provide a list to BlueCare Tennessee of the services it does not deliver due to the Ethical and Religious Directives. BlueCare Tennessee shall furnish this list to the Division of TennCare, notating those services that are TennCare and CoverKids Covered Services. This list shall be used by BlueCare Tennessee and the Division of TennCare to provide information to Members about where and how the Members can obtain the services that are not being delivered by the Provider due to Ethical and Religious Directives.

   (b) At the time of service, the Provider shall inform Members of the health care options that are available to the Members, but are not being provided by the Provider due to the Ethical and Religious Directives, but the Provider is not required to make specific recommendations or referrals. In addition, the Provider shall inform Members that BlueCare Tennessee has additional information on providers and procedures that are covered by the Division of TennCare.

6. **Provider Discrimination Prohibition.** Neither BlueCare Tennessee nor Provider shall discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. Neither BlueCare Tennessee nor Provider shall discriminate against a provider for serving high-risk Members or if a provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting BlueCare Tennessee or Provider from limiting a provider's participation to the extent necessary to meet the needs of Members. This provision also is not intended and shall not interfere with measures established by BlueCare Tennessee that are designed to maintain quality of care practice standards and control costs.

EXHIBIT 3

CMS CONTRACTING REQUIRED PROVISIONS FOR MEDICARE ADVANTAGE ORGANIZATIONS

1. Record Retention.

Provider agrees that HHS, the Comptroller General or their designees have the right to audit, evaluate and inspect any pertinent information including books, contracts, records, including Medical Records, and documentation related to CMS' contract with BlueCare Tennessee, the Medicare Advantage Organizations ("MAO"), for a period of 10 years from the final date of the contract period or the completion of any audit, whichever is later. See 42 C.F.R. § § 422.504(i)(2)(i) and (ii).

2. Privacy and Accuracy of Records.

Provider agrees to safeguard beneficiary privacy and confidentiality and ensure the accuracy of beneficiary health records. See 42 C.F.R. § 422.504(a)13.

3. Hold Harmless.

Provider may not hold beneficiaries liable for payment of fees that are the legal obligation of the MAO. (Does not charge enrollees for any health care or health-care related services) See 42 C.F.R. § § 422.504(g)(1)(i) and 422.504(i)(3)(i).

4. Delegated Activities: Compliance with MAO's contractual obligations.

Provider agrees that any services performed will be consistent and comply with the MAO's contractual obligations. See 42 C.F.R. § 422.504(i)(3)(iii).

5. Delegated Activities: Selection of Providers.

If the MAO delegates the selection of Providers, written arrangements must state the MAO retains the right to approve, suspend, or terminate such arrangement. See 42 C.F.R. § 422.504(i)(5).

6. Delegated Activities: List of Delegated Activities and Reporting Responsibilities.

The contract must clearly state the delegated activities and reporting responsibilities. See 42 C.F.R. § 422.504(i)(4)(i).

7 Delegated Activities: Revocation.

Agreement provides for the revocation of the delegated activities and reporting requirements or specifies other remedies in instances when CMS or the MAO determines that such parties have not performed satisfactorily. See 42 C.F.R. § § 422.504(i)(3)(ii); 422.504(i)(4)(ii).

8. Delegated Activities: Monitoring.

Provider agrees that the performance of the parties is monitored by the MAO on an ongoing basis. See 42 C.F.R. § § 422.504(i)(3)(ii); 422.504(i)(4)(iii).

9. Delegated Activities: Credentialing.

Provider agrees that the credentials of medical professionals affiliated with the party or parties will either be reviewed by the MAO or the credentialing process will be reviewed and approved by the MAO; and the MAO must audit the credentialing process on an ongoing basis. See 42 C.F.R. § 422.504(i)(4)(iv)(A)(B).

10. Compliance with Applicable Medicare Laws and Regulations.

Provider agrees it must comply with all applicable Medicare laws, regulations, and CMS instructions. See 42 C.F.R. § 422.504(i)(4)(v).

BLUECARE NETWORK ATTACHMENT

Provider: Davidson County Health Department

Health Department

BCBST Tracking #: 20-094

This BlueCare Network Attachment ("Attachment") is incorporated by reference into the Agreement between BlueCare Tennessee and the Provider named above, and describes payment for health department professional, anesthesia, and smoking cessation Covered Services provided to BlueCare Members, as well as certain services provided to Members under 21.

This Attachment supersedes any prior BlueCare payment terms or attachments for health department professional, anesthesia, and smoking cessation Covered Services between the Parties. Should there be a conflict between the Agreement and this Attachment, this Attachment will control as to the payment for health department professional, anesthesia, and smoking cessation Covered Services.

I. Definitions.

The following terms are defined for the purposes of this Attachment. All other capitalized terms have the same meaning as in the Agreement.

"CMS" means the Centers for Medicare & Medicaid Services.

"CPT® Code" means a Current Procedural Terminology Code as created by the American Medical Association ("AMA"). CPT® is a registered trademark of the AMA.

"HCPCS Code" means Healthcare Common Procedure Coding System based on the AMA's Current Procedural Terminology ("CPT®") and updated by CMS.

II. Billing and Reimbursement Guidelines.

A. Maximum Allowable. The Maximum Allowable is the lesser of billed charges for Covered Services or the appropriate payment amount in this Attachment, less any Member Cost Sharing Obligations. Maximum Allowable will be calculated at the line level as further defined in the Provider Manual. All payments are subject to lesser of billed charges.

B. Billing Requirements. All claims related to this Attachment must be submitted on a CMS 1500 form or its current equivalent. Claims must comply with the applicable billing guidelines published in the Provider Manual.

C. Reimbursement Policies. In addition to the payment policies described herein, BlueCare Tennessee pays claims pursuant to the reimbursement guidelines and policies contained in the Provider Manual.

This Attachment does not reimburse Provider for any TennCare rates that are based on automatic escalators or linkages to other methodologies that escalate such as current Medicare rates or inflation indexes unless otherwise allowed by TennCare.

The rates in this Attachment include all rate adjustments mandated by the state of Tennessee as of the date of this Attachment. Rates included herein are subject to further adjustment by states mandate. BlueCare Tennessee will notify Provider prior to implementing any such adjustments. BlueCare Tennessee retains the right to change or modify the method of calculating payments hereunder as necessary to conduct the continued operation of the BlueCare Network or as required by state law or TennCare mandate.

Presence of a fee is not a guarantee the service will be eligible for reimbursement. Final reimbursement determinations are based on Member eligibility on the date of services, Medical Necessity, Medical Appropriateness, applicable Member Cost-Sharing Obligations, benefit plan exclusions/limitations, authorization/referral requirement, and BlueCare Tennessee Medical Policy.

D. **Use of Codes**. The codes associated with this Attachment are subject to addition, revision, and deletion by the governing agencies or authorities in accordance with the Provider Manual. If any codes associated with this Attachment are added, revised, and/or deleted, this Attachment will be interpreted to incorporate such change, without the need for formal amendment.

III. Reimbursement.

A. **Health Department Professional Services**. BlueCare Tennessee's rates for all professional services, excluding anesthesia, and certain services provided to Members under 21, are described below. The percentages shown are of the Professional Fee Schedule for the applicable provider type. An abbreviated version of the Professional Fee Schedule(s) comprised of the most commonly used CPT/HCPCS Codes is attached hereto as Exhibit A. Laboratory services will be reimbursed in accordance with the Quest Diagnostics Laboratory Billing Guidelines section of the Provider Manual and are excluded from reimbursement under this section except as expressly permitted in the Provider Manual.

Provider Type	Percentage
Primary Care Physician	**100%**
Pediatric Sub-Specialist	**Not Contracted**
Audiologist	**Not Contracted**
OB/GYN/Midwives	**Not Contracted**
All Other Specialists	**Not Contracted**

B. **Health Department Anesthesia Services**. Anesthesia services provided by an anesthesiologist or CRNA will be reimbursed based on BlueCare Tennessee's reimbursement guidelines, as contained in the Provider Manual, and the following conversion factors:

Provider Type	Conversion Factor
Anesthesiologist	**Not Contracted**
CRNA	**Not Contracted**

C. **Health Department Services Provided to Members Under 21**. Covered Services provided by a health department shall be reimbursed as described above unless otherwise specified in this section.

The rates below are limited to specified visits for Members under the age of twenty-one (21) although the CPT/HCPCS Codes in this section include preventative visits for individuals twenty- one (21) and older.

Service Description	CPT/HCPCS Code	Rate
New patient up to 1 year	99381	**$83.57**
New patient 1-4 years	99382	**$91.61**
New patient 5-11 years	99383	**$90.10**
New patient 12-17 years	99384	**$99.24**
New patient 18-39 years	99385	**$97.72**
Established patient up to 1 year	99391	**$65.59**
Established patient 1-4 years	99392	**$74.44**
Established patient 5-11 years	99393	**$73.82**
Established patient 12-17 years	99394	**$82.78**
Established patient 18-39 years	99395	**$82.17**

TENNCARE*SELECT* NETWORK ATTACHMENT

Provider: Davidson County Health Department

Health Department

BCBST Tracking #: 20-095

This TennCare*Select* Network Attachment ("Attachment") is incorporated by reference into the Agreement between BlueCare Tennessee and the Provider named above, and describes payment for health department professional, anesthesia, and smoking cessation Covered Services provided to TennCare*Select* Members, as well as certain services provided to Members under 21.

This Attachment supersedes any prior TennCare*Select* payment terms or attachments for health department professional, anesthesia, and smoking cessation Covered Services between the Parties. Should there be a conflict between the Agreement and this Attachment, this Attachment will control as to the payment for health department professional, anesthesia, and smoking cessation Covered Services.

I. Definitions.

The following terms are defined for the purposes of this Attachment. All other capitalized terms have the same meaning as in the Agreement.

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"CPT® Code" means a Current Procedural Terminology Code as created by the American Medical Association ("AMA"). CPT® is a registered trademark of the AMA.

"HCPCS Code" means Healthcare Common Procedure Coding System based on the AMA's Current Procedural Terminology ("CPT®") and updated by CMS.

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A. Maximum Allowable. The Maximum Allowable is the lesser of billed charges for Covered Services or the appropriate payment amount in this Attachment, less any Member Cost Sharing Obligations. Maximum Allowable will be calculated at the line level as further defined in the Provider Manual. All payments are subject to lesser of billed charges.

B. Billing Requirements. All claims related to this Attachment must be submitted on a CMS 1500 form or its current equivalent. Claims must comply with the applicable billing guidelines published in the Provider Manual.

C. Reimbursement Policies. In addition to the payment policies described herein, BlueCare Tennessee pays claims pursuant to the reimbursement guidelines and policies contained in the Provider Manual.

This Attachment does not reimburse Provider for any TennCare rates that are based on automatic escalators or linkages to other methodologies that escalate such as current Medicare rates or inflation indexes unless otherwise allowed by TennCare.

The rates in this Attachment include all rate adjustments mandated by the state of Tennessee as of the date of this Attachment. Rates included herein are subject to further adjustment by states mandate. BlueCare Tennessee will notify Provider prior to implementing any such adjustments. BlueCare Tennessee retains the right to change or modify the method of calculating payments hereunder as necessary to conduct the continued operation of the TennCare*Select* Network or as required by state law or TennCare mandate.

Presence of a fee is not a guarantee the service will be eligible for reimbursement. Final reimbursement determinations are based on Member eligibility on the date of services, Medical Necessity, Medical Appropriateness, applicable Member Cost-Sharing Obligations, benefit plan exclusions/limitations, authorization/referral requirement, and BlueCare Tennessee Medical Policy.

D. **Use of Codes**. The codes associated with this Attachment are subject to addition, revision, and deletion by the governing agencies or authorities in accordance with the Provider Manual. If any codes associated with this Attachment are added, revised, and/or deleted, this Attachment will be interpreted to incorporate such change, without the need for formal amendment.

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Provider Type	Percentage
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Audiologist	**Not Contracted**
OB/GYN/Midwives	**Not Contracted**
All Other Specialists	**Not Contracted**

B. **Health Department Anesthesia Services**. Anesthesia services provided by an anesthesiologist or CRNA will be reimbursed based on BlueCare Tennessee's reimbursement guidelines, as contained in the Provider Manual, and the following conversion factors:

Provider Type	Conversion Factor
Anesthesiologist	**Not Contracted**
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C. **Health Department Services Provided to Members Under 21**. Covered Services provided by a health department shall be reimbursed as described above unless otherwise specified in this section.

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New patient 18-39 years	99385	**$97.72**
Established patient up to 1 year	99391	**$65.59**
Established patient 1-4 years	99392	**$74.44**
Established patient 5-11 years	99393	**$73.82**
Established patient 12-17 years	99394	**$82.78**
Established patient 18-39 years	99395	**$82.17**