Amerigroup

RFQ # 20211210

Public Copy

(Amerigroup Mississippi, Inc.)

Response Deadline: March 4, 2022 2:00 p.m. (CST)

Amerigroup Mississippi, Inc. (Amerigroup) has designated the following pages of the RFQ response as containing trade secret or confidential commercial or financial information as defined by Mississippi Code Annotated § 25-61-9. Amerigroup obtains independent actual or potential economic value from the information not being generally known to, and not being readily ascertainable by proper means, by our competitors, who may obtain economic value from its disclosure or use by providing information to them that is not generally available. Amerigroup considers this information, together with the comments and data provided to be confidential commercial and financial and Trade Secret Information, and Amerigroup has taken reasonable efforts to maintain the secrecy of this information.

Proposal Part and Section	Confidentiality Category	Page Number(s)	Statutory Reference
Transmittal Letter	Staffing characteristics and resources	2, 3	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9
Technical Qualification: 4.2.1 Executive Summary	Provider network strategies; value added benefits; investments; work plan; staffing charts; population health strategies; strategies to address SDOH challenges	1-4, 6-9	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9

Proposal Part and Section	Confidentiality Category	Page Number(s)	Statutory Reference
Technical Qualification 4.2.2.1: Member Services and Benefits	EPSDT, other screenings and immunization processes and strategies; member incentives and value-adds; personalized provider supports; partnerships; strategies, capabilities and committees to address health disparities; strategies to address substance use disorder; value based payment arrangements and other provider incentives; outcome data; strategies to promote health equity; maternal and child health strategies; telehealth strategies and solutions; approaches to close care gaps; strategies to address chronic conditions; dental health strategies; vision health initiatives; transportation solutions and innovations; member satisfaction results; care management processes;	12-15, 17-30, 32, 34-41, 45-54, 56-57, 60, 62, 65, 70, 72	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9
Technical Qualification 4.2.2.2: Provider Network and Services	Provider recruitment strategies and network development plan; incentive programs; provider support strategies; strategies to assure and asses network access; value based purchasing programs; telehealth solutions; staffing support; provider education strategies; call center statistics; provider engagement strategies; provider trainings and resources; telehealth strategies; strategies to address chronic conditions; maternal and child health strategies;	84-95, 100-104, 108, 110-111, 113-115, 117-123	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9

Proposal Part and Section	Confidentiality Category	Page Number(s)	Statutory Reference
Technical Qualification: Attachment 4.2.2.2-1	Standard Provider Contract Template	129-184	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9
Technical Qualification: 4.2.2.3 Care Management	Staffing resources; care management goals and improvement targets; health equity strategies; programs to offer supports for Members with specialized needs; Member incentives and value added benefits; population health resources and strategies; member outreach strategies; partnerships; value based contracting and provider incentives; strategies to improve transition of care processes and outcomes; care management training programs; salary information; hypotheticals	185-188, 190-191, 194-196, 198-203, 205-211, 213-228	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9

Proposal Part and Section	Confidentiality Category	Page Number(s)	Statutory Reference
Technical Qualification: Attachment 4.2.2.3-1	Mississippi Heath Risk Screening	229-233	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9
Technical Qualification: Attachment 4.2.2.3-2	Mississippi Comprehensive Health Assessment	234-238	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9

Proposal Part and Section	Confidentiality Category	Page Number(s)	Statutory Reference
Technical Qualification: Attachment 4.2.2.3-3	Proposed Mississippi Pediatric Comprehensive Health Assessment	239-245	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9
Technical Qualification: 4.2.2.4 Quality Management	Quality Management Infrastructure and staffing resources; quality strategy priorities; capabilities for identifying social risk factors; health equity strategies; strategies to promote provider adherence to clinical practice guidelines; incentive programs; training programs; analytical capabilities; predictive modeling trends; member stratification tools; reporting capabilities;	248-249, 251, 254, 257-260, 263, 265-267, 271, 274-279	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9

Proposal Part and Section	Confidentiality Category	Page Number(s)	Statutory Reference
Technical Qualification: Attachment 4.2.2.4-1	Model Annual QM Program	281-289	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9
Technical Qualification: Attachment 4.2.2.4-2	QM Report Samples and Excerpts	290-297	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9

Proposal Part and Section	Confidentiality Category	Page Number(s)	Statutory Reference
Technical Qualification: 4.2.2.5 Utilization Management	Staffing resources and committee structure; performance improvement and enhancement program; programs and technologies to ease provider burden; predictive modeling processes and capabilities; reporting capabilities; telehealth solutions; solutions to manage ER visits; provider incentives and value based payment; program savings and achievements; pharmacy clinical quality programs;	299-300, 303-305, 309-324	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9
Technical Qualification: 4.2.2.6 Information Technology	Claims payment accuracy and timeliness data; technological system descriptions and charts; innovations; digital programs; telehealth resources; education and training programs; description of comprehensive business continuity program supports emergency response;	325, 329, 332-349	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9

Proposal Part and Section	Confidentiality Category	Page Number(s)	Statutory Reference
Technical Qualification: 4.2.2.8 Financial and Data Processing	Encounter data workflow; integrated performance tools; process for reviewing and validating data generation, certification and submission	363, 365, 371	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9
Technical Qualification: 4.2.2.9 Program Integrity	Staffing resources; claim audit methodology; saving projections; provider portal details;	378-379, 385, 387-389	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9

Proposal Part and Section	Confidentiality Category	Page Number(s)	Statutory Reference
Technical Qualification: 4.2.2.10 Subrogation and Third-Party Liability	Staffing resources; overpayment and recovery best practices and savings; initiatives and innovations	395, 399, 402-404	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9
Technical Qualification: 4.2.2.11 Eligibility, Enrollment, and Disenrollment	PCMH assignment methodology; sample PCP notification alerts	410-413	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9

Proposal Part and Section	Confidentiality Category	Page Number(s)	Statutory Reference
Technical Qualification: 4.2.3.1 Value-Based Purchasing	Value-based purchasing arrangements, strategies and innovations.	425-434	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9
Technical Qualification: 4.2.3.2 Patient Centered Medical Home (PCMH)	Strategies for implementing PCMH models; staffing resources; incentives; strategies for monitoring performance.	435-439, 442	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9

Proposal Part and Section	Confidentiality Category	Page Number(s)	Statutory Reference
Technical Qualification: 4.2.3.3 Social Determinants of Health (SDOH)	Approach for addressing SDOH needs and challenges; data collection and analysis strategies; SDOH based incentive programs; SDOH driven health equity strategy; staffing resources;	444-460	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9
Technical Qualification: 4.2.3.4 Value-Added Benefits	Value-added benefit descriptions, cost, utilization projections, and staffing resources involved.	461-479	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9

Proposal Part and Section	Confidentiality Category	Page Number(s)	Statutory Reference
Technical Qualification: 4.2.3.5 Performance Improvement Projects	Descriptions of performance improvement projects, goals and strategies for implementing; staffing resources involved	480-484	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9
Technical Qualification: 4.2.3.6 Health Literacy Campaigns	Health literacy campaign goals and strategies; staffing resources	485-489	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9

Proposal Part and Section	Confidentiality Category	Page Number(s)	Statutory Reference
Technical Qualification: 4.2.3.7 Telehealth	Predictive modeling methodology; telehealth strategies and programs; staffing resources; provider incentive and value-based purchasing strategies; value-added benefits	490-497	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9
Technical Qualification: 4.2.3.8 Use of Technology	Technology innovations, solutions, and description of their capabilities	498-505	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9

Proposal Part and Section	Confidentiality Category	Page Number(s)	Statutory Reference
Technical Qualification: 4.2.3.9 Potential Partnerships	Detailed information on potential partnerships for Mississippi	506-513	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9
Management Qualification: 4.3.3.1 Corporate Background	IT solutions and capabilities; provider satisfaction data; population health goals and strategies; strategies for addressing needs of members with chronic conditions; maternal and child health strategies; strategies for addressing behavioral health and well-being; SDOH strategies; community investment programs and partnerships; value-added benefits; provider incentives and value-based purchasing; predictive algorithm methodology; telehealth strategies; staffing resources; health equity strategies	1, 8-37, 39	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9

Proposal Part and Section	Confidentiality Category	Page Number(s)	Statutory Reference
Management Qualification: 4.3.1.2 Corporate Experience	Reference contact information; detailed information on staffing resources utilized; contract values	43-75, 77, 79, 81-146	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9
Management Qualification: 4.3.2.1 Ownership and Financial Information Disclosure Information	Confidential personal information; Company information details	Cover page, 148-149, 152-162, 170-182,	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9

Proposal Part and Section	Confidentiality Category	Page Number(s)	Statutory Reference
Management Qualification: 4.3.2.6 Audited Financial Statements and Pro Forma Financial Template; Appendix G: Financial Pro Forma Template	Pro Forma Financial Template	1709-1714	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9
Management Qualification: 4.3.3.1 Organization	Detailed organizational charts and staffing levels	1715-1720	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9

Proposal Part and Section	Confidentiality Category	Page Number(s)	Statutory Reference
Management Qualification: 4.3.3.4 Staffing	Staffing ratios; staff qualification requirements; staff training requirements; shared services resources dedicated to Mississippi	1804-1806, 1808-1814, 1820-1822, 1824-1825	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9
Management Qualification: 4.3.3.5 Subcontractors, Appendix H	Detailed stuffing numbers and publicly funded contract costs	1831-1834, 1836, 1839-1887, 1889-1912, 1915, 1917-1939, 1942-1950, 1953, 1955-1957, 1960-1967, 1969-1982, 1984-1985, 1987-1989, 1992-2010, 2012-2018	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9

Proposal Part and Section	Confidentiality Category	Page Number(s)	Statutory Reference
Management Qualification: 4.3.3.6 Economic Impact	Investment strategy and programs; wage charts; staffing details and salary information	2019-2029	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9
Management Qualification: 4.3.4.1 Day-to-Day Management	Committee structure and information; schedule of major activities to support implementation; staffing ratios; reporting capabilities and report details; strategies for monitoring data and performance; sample reports	2032-2034, 2039, 2042-2043, 2046-2047	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9

Proposal Part and Section	Confidentiality Category	Page Number(s)	Statutory Reference
Management Qualification: 4.3.4.2: Problem Management	Strategies for overcoming barriers to access to care; grant information	2054-2055	Trade Secret or confidential commercial or financial information, Miss. Code Ann. § 25-61-9

Amerigroup

RFQ # 20211210

Transmittal Letter

(Amerigroup Mississippi, Inc.)

Response Deadline: March 4, 2022 2:00 p.m. (CST)

March 4, 2022

Office of Procurement
Mississippi Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

Re: Request for Qualifications Mississippi Division of Medicaid Coordinated Care, RFQ No. 20211210, RFx No. 3150003991

To whom it may concern:

Amerigroup Mississippi, Inc. (Amerigroup) is pleased to submit this proposal in response to RFQ No. 20211210, RFx No. 3150003991 for the Mississippi Coordinated Access Network (MississippiCAN) Program and the Mississippi Children's Health Insurance Program (CHIP).

Amerigroup is a wholly owned subsidiary of Anthem, Inc. (Anthem), a leading health benefits company. Anthem and its affiliate health plans have more than 31 years of experience administering Medicaid and other state-sponsored programs and currently operate Medicaid and CHIP Programs in 26 and 19 other markets, respectively. In 2021, Anthem affiliates served more than 10.6 million Medicaid and 437,000 CHIP Members nationwide and coordinated the delivery of approximately 188,000 babies across the country. ***Amerigroup will bring the breadth and depth of our affiliate health plans' experience along with our knowledgeable Mississippi-based staff to collaborate with the Mississippi Division of Medicaid (Division) to improve access to quality healthcare, improve health outcomes, inform Population Health management, reduce health disparities, and ease administrative burden for all Medicaid Providers and Members.***

In accordance with the RFQ, the Offeror, Amerigroup, is providing the following statements and certifications:

1. Amerigroup is a domestic for-profit Mississippi corporation and was incorporated on December 6, 2016.
2. Amerigroup is registered to do business and in "Good Standing" with the State of Mississippi. The corporate charter number to work in Mississippi is 1106522.
3. Amerigroup is licensed by the Mississippi Insurance Department, Health Maintenance Organization License Number 160002. A copy of the license is included as Attachment 4.1.3, Mississippi Department of Insurance License.
4. Amerigroup's federal tax identification number is 81-4626605.
5. Amerigroup confirms that it has not been sanctioned by a state or the federal government within the past 10 years. In addition, we abide by the requirement that prohibits affiliation with individuals debarred, suspended, or otherwise excluded from participation as a director, officer, partner, or person with ownership of more than 5%. Our corporate parent, or a subsidiary of our corporate parent performing managed care services in another state has not been sanctioned, as defined by 42.C.F.R. § 438.702, by a State or Federal government within the last ten (10) years.
6. Amerigroup confirms that it is not suspended or debarred under federal law and regulations or any state's laws or regulations.

7. As part of Anthem, Inc., one of the nation's largest providers of healthcare for public programs, Amerigroup has the experience needed to provide the type of contractual services described in the RFQ. As stated previously, Anthem and its affiliate health plans currently serve more than 10.6 million Members enrolled in programs offering services similar to those contemplated by this RFQ. Amerigroup will bring this deep organizational experience in providing the full continuum and type of services described in this RFQ to Mississippi. Through its 31-year history administering Medicaid and other state-sponsored programs, Anthem and its affiliate health plans have a proven record of accomplishment in delivering high-quality outcomes while effectively and efficiently managing taxpayer funds. As part of the Anthem organization, Amerigroup has the financial wherewithal to be a stable and steady partner in a time of great change in healthcare.
8. If Amerigroup is awarded the Contract, we agree that any lost or reduced federal matching money resulting from unacceptable performance of a task or responsibility, as defined in this RFQ, will be accompanied by reductions in State payments to Amerigroup under the Contract.
9. Neither Amerigroup nor any of our affiliate health plans have been subject to a termination before the end of a contract period.
10. We confirm that Amerigroup has not and will not attempt to induce any other person or firm to submit or not submit a proposal.
11. We have not violated and promise that we will not violate the prohibition against gratuities set forth in Section 6-204 of the Personal Service Contract Review Board Rules and Regulations.
12. We do not discriminate in our employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, disability, or genetic information. We are committed to diversity. Our affiliate health plans reflect the populations we serve, including a minority representation of [redacted] in leadership positions at the director and higher levels and [redacted] female representation in staff/regional vice president roles and above.
13. We agree to the language of the Division's Business Associate Agreement (BAA) and Data Use Agreement (DUA) without expectation of negotiation.
14. Amerigroup confirms the receipt of 12 amendments to this RFQ issued by the Division as of the date of response submission. The amendments are:
    - Amendment No. 1 to RFQ 20211210: Section 5, Enterprise Security Policy; issued January 21, 2022
    - Amendment No. 2 to RFQ 20211210: RFQ Mandatory Pre-Qualification Question and Answer Document; issued January 21, 2022
    - Amendment No. 3 to RFQ 20211210: RFQ Appendices D, E, F, G, and H in Microsoft Word format; issued January 21, 2022
    - Amendment No. 4 to RFQ 20211210: RFQ Questions and Answers; issued February 7, 2022
    - Amendment No. 5 to RFQ 20211210: RFQ Corrections and Clarifications; issued February 7, 2022
    - Amendment No. 6 to RFQ 20211210: Draft Contract Corrections and Clarifications; issued February 7, 2022
    - Amendment No. 7 to RFQ 20211210: Updated RFQ Appendices F and H in Word format; issued February 7, 2022
    - Amendment No. 8 to RFQ 20211210: Additional MSCAN and CHIP Rate Information in Microsoft Excel format; issued February 7, 2022

- Amendment No. 9 to RFQ 20211210: Clarification of Amendment 4 Responses; issued February 10, 2022
- Amendment No. 10 to RFQ 20211210: Summary of Pre-Qualification Conference; issued February 11, 2022
- Amendment No. 11 to RFQ 20211210: Reporting Manuals; issued February 11, 2022
- Amendment No. 12 to RFQ 20211210: Responses Regarding Amendment 9; issued February 16, 2022

15. We have read, understand, and agree to all provisions of this RFQ without reservation and without expectation of negotiation.
16. We certify that this proposal is firm and binding for 365 days from the proposal due date.
17. Amerigroup was responsible for writing the proposal but did engage outside firms for support in the writing of portions of the proposal. [redacted] This support was performed under Amerigroup's direct supervision and direction.
18. We propose contracting with 11 subcontractor partners. Pursuant to the requirements of the RFQ, we have appended a statement from each subcontractor partner signed by an individual authorized to legally bind the partner and stating the general scope of work that partner will perform. We have included signed Subcontractor Agreements in Attachment 4.1.18, Signed Subcontractor Statements.
19. We understand that all proposals submitted by corporations must contain certifications by the secretary or appropriate corporate official, other than the corporate official signing the corporate proposal, that the corporate official signing the corporate proposal has the full authority to obligate and bind the corporation to the terms, conditions, and provisions of the proposal. Our proposal is executed by our CEO, Tara Clark. We have included this certification in Attachment 4.1.19, Corporate Authority Certification.
20. We confirm that we presently have no interest and shall not acquire any interest — direct or indirect — that would conflict in any manner or degree with the performance of services under this Contract, and we shall not employ, in the performance of this Contract, any person having such interest.
21. We will make no public disclosure or news release pertaining to this procurement without prior written approval of the Division.
22. We confirm that our redacted electronic single-document qualification referenced in Section 1.4.2, Release of Public Information, does not contain trade secrets or other proprietary information.
23. We have executed and included with this Transmittal Letter the following certifications, located in Appendix D:
    a. Certifications and Assurances Regarding Contingent Fees and Gratuities — Section 4.1.23a, Appendix D: Certifications and Assurances Regarding Contingent Fees and Gratuities
    b. DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other Than Individuals (This document must be executed by the Offeror as well as any expected subcontractor partners and submitted with the Offeror's qualification) — Section 4.1.23b, Appendix D: DHHS Certification Regarding Drug-Free Workplace Requirements
    c. DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters — Section 4.1.23c, Appendix D: DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters
24. We are not requesting or proposing any deviations from the detailed specifications and requirements of the RFQ.

We greatly appreciate the opportunity to provide an overview of our qualifications and approaches toward meeting the RFQ specifications and goals of the MississippiCAN and CHIP Programs. We look forward to collaborating with the Division and other stakeholders in the State of Mississippi to carry out the admirable goals and objectives of this initiative.

If you have any questions or would like to discuss our proposal further, please feel free to contact me by phone at (601) 331-0352 or by email at tarance.clark@amerigroup.com. We look forward to collaborating with you.

Sincerely,

Tara Clark
Chief Executive Officer

Attachment 4.1: Transmittal Letter Attachments

Attachment 4.1: Transmittal Letter Attachments include the following:

- Attachment 4.1.3: Mississippi Insurance Department License
- Attachment 4.1.14-1: RFQ Amendments
- Attachment 4.1.18-1: Signed Subcontractor Statements
- Attachment 4.1.19: Corporate Authority Certification
- Appendix D: Certifications and Assurances Regarding Contingent Fees and Gratuities
- Appendix D: DHHS Certification Regarding Drug-Free Workplace Requirements
- Appendix D: DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

MISSISSIPPI
CERTIFICATE OF AUTHORITY

I, THE UNDERSIGNED COMMISSIONER OF INSURANCE, OF THE STATE OF MISSISSIPPI, DO HEREBY CERTIFY THAT

AMERIGROUP MISSISSIPPI, INC.
645 LAKELAND EAST DRIVE, SUITE 101
FLOWOOD, MS 39232

LICENSE NUMBER: 1600021

HAS COMPLIED WITH ALL THE REQUIREMENTS OF THE LAWS OF THIS STATE APPLICABLE TO SAID COMPANY AND IS AUTHORIZED TO TRANSACT THE BUSINESS OF:

HEALTH MAINTENANCE ORGANIZATION

IN ACCORDANCE WITH THE LAWS THEREOF UNTIL: **12/31/2022**

MIKE CHANEY
COMMISSIONER OF INSURANCE

Amendment #1 to RFQ 20211210: Section 5 – Enterprise Security Policy – Issued January 21, 2022

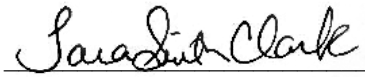
This Amendment must be signed and submitted as a part of any proposal to be considered for this procurement. The following section of RFP #20211210 is amended to correct Section 5: Authority, References, and Disclaimers in reference to accessing the State of Mississippi's Enterprise Security Policy to read as follows, with removed text stricken through and replacement text added in **RED**:

~~The Enterprise Security Policy is available to third parties on a need-to-know basis and requires the execution of a non-disclosure agreement with the Department of Informatiosn Technology Services (ITS) prior to accessing the policy. The Offeror or Contractor may request individual sections of the Enterprise Security Policy or request the entire document by contacting the Office of Procurement.~~

~~Instructions to acquire a copy of the Enterprise Security Policy can be found at the following link: http://www.its.ms.gov/Services/Pages/ENTERPRISE-SECURITY-POLICY.aspx~~

The Enterprise Security Policy can be found at the following link:
https://www.sos.ms.gov/adminsearch/ACProposed/00020006b.pdf

Receipt of Amendment Acknowledged:



(Signature)

Tara Clark

(Printed)

Chief Executive Officer

(Title)

Amerigroup Mississippi, Inc.

(Company)

Amendment #2 to RFQ 20211210: RFQ Mandatory Pre-Qualification Question and Answer Document – Issued January 21, 2022

Question #	RFQ Section #	RFQ Page #	Question	DOM Response
1	N/A	N/A	In the mandatory Pre-Qualification Conference, the Division stated that "No branding may be included in any part of the proposal." Can the Division please clarify what is considered branding (logos, colors, etc.) and confirm that this requirement applies across the entire proposal including both the Technical (unmarked) and Management (marked) components?	"Branding" includes company colors, logos, or other symbols or designs adopted by an organization to identify itself, its products, or its corporate parents or siblings. Branding must not appear in the Offeror's Technical (unmarked) proposal. Branding may appear in the Offeror's Management (marked) proposal. However, the Offeror must still use black, Times New Roman 12 pt. font for responses, and black, Times New Roman font no smaller than 9 pt. for any tables, graphics, charts, figures, footnotes, and headers/footers.
2	N/A	N/A	The Clarification of Formatting Requirements slide at the Mandatory Pre-Qualification Conference indicated that "no branding may be included in any part of the proposal." Can the Division please confirm if this is meant to include the marked section of the proposal or if this is only referring to the unmarked submission? If this requirement is inclusive of the marked section, can the Division please expand on what is included under "branding?"	"Branding" includes company colors, logos, or other symbols or designs adopted by an organization to identify itself, its products, or its corporate parents or siblings. Branding must not appear in the Offeror's Technical (unmarked) proposal. Branding may appear in the Offeror's Management (marked) proposal. However, the Offeror must still use black, Times New Roman 12 pt. font for responses, and black, Times New Roman font no smaller than 9 pt. for any tables, graphics, charts, figures, footnotes, and headers/footers.

Receipt of Amendment #2 Acknowledged:

Printed Name: Tara Clark

Signature: Tara Lin Clark

Title: Chief Executive Officer

Company: Amerigroup Mississippi, Inc.

Page 1 of 1

END OF DOCUMENT

Amendment #3 to RFQ 20211210: RFQ Appendices D, E, F, G, and H in Word Format – Issued January 21, 2022

Provided herein are Microsoft Word versions of the following Appendices included with RFQ 20211210:

- APPENDIX D: Certifications
- APPENDIX E: Innovation and Commitment
- APPENDIX F: Corporate Background and Experience
- APPENDIX G: Ownership and Financial Disclosure Information
- APPENDIX H: Organization and Staffing

Additionally, the following typographical errors were corrected in the following documents included in this Amendment:

Appendix E
Text in 4.2.3.6: Health Literacy Campaigns has been altered in the following manner, with removed text stricken through and replacement text added in **RED**:

Use the Health Literacy Campaign: Summary Chart on the following page for each ~~PIP~~ Campaign the Offeror is including in its response to this section. The Offeror must include four (4) Health Literacy Campaigns in its response.

Appendix F
Text in the header for 4.3.1.2: Corporate Experience has been altered in the following manner, with removed text stricken through and replacement text added in **RED**:

4.3.1.~~1~~2:Corporate Experience

Appendix H
The form included 4.3.3.5 Subcontractors entitled **Prior Experiences with Subcontractor** has been updated to remove one of the fields requesting Geographic and population coverage requirements. Duplication of this field was an error.

Receipt of Amendment Acknowledged:

Tara Clark
(Signature)

Tara Clark
(Printed)

Chief Executive Officer
(Title)

Amerigroup Mississippi, Inc.
(Company

Amendment #4 to RFQ 20211210: RFQ Questions and Answers

RFQ #: 20211210 / RFx#3150003991

Date: February 7, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

This document contains all questions submitted by potential offerors by the RFQ Questions Deadline of January 7, 2022. The document is split into two parts:

1. RFQ-Specific Questions and Answers (Blue Table, 120 Questions)
2. Appendix A: Draft Contract-Specific Questions and Answers (Green Table, 56 Questions)

Three additional amendments will be referenced throughout this document that will be published the same day as this Amendment 4 (February 7, 2022):

- Amendment 5: RFQ Corrections and Clarifications
- Amendment 6: Appendix A: Draft Contract Corrections and Clarifications
- Amendment 7: Updates to Certain RFQ forms from Appendix F and H in Word Format
- Amendment 8: Additional MSCAN and CHIP Rate Information in Excel Format

Receipt of Amendment 4 Acknowledged:

Tara Clark
(Signature)

Tara Clark
(Printed)

Chief Executive Officer
(Title)

Amerigroup Mississippi, Inc.
(Company)

RFQ 20211210: Amendment 5
February 7, 2022
Cover/Acknowledgment Page

Amendment #5 to RFQ 20211210: RFQ Corrections and Clarifications

RFQ #: 20211210 / RFx#3150003991

Date: February 7, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

This document contains corrections and clarifications referenced in Amendment 4: RFQ Questions and Answers as they relate to RFQ-Specific Questions and Answers.

Receipt of Amendment 5 Acknowledged:

Tara Clark
(Signature)

Tara Clark
(Printed)

Chief Executive Officer
(Title)

Amerigroup Mississippi, Inc.
(Company)

RFQ 20211210: Amendment 6
February 7, 2022
Cover/Acknowledgment Page

Amendment #6 to RFQ 20211210: Appendix A: Draft Contract Corrections and Clarifications

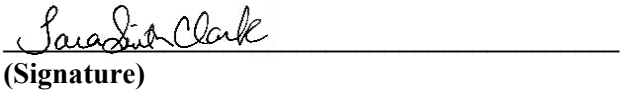
RFQ #: 20211210 / RFx#3150003991

Date: February 7, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

This document contains corrections referenced in Amendment 4: RFQ Questions and Answers as they relate to Appendix A: Draft Contract-Specific Questions and Answers.

Receipt of Amendment 6 Acknowledged:



(Signature)

Tara Clark

(Printed)

Chief Executive Officer

(Title)

Amerigroup Mississippi, Inc.

(Company)

Amendment #7 to RFQ 20211210: Updated RFQ Appendices F and H in Word Format

RFQ #: 20211210 / RFx#3150003991

Date: February 7, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

Provided herein are amended Microsoft Word versions of the following:

- APPENDIX F: Corporate Background and Experience, form 4.3.1.2: Corporate Experience
- APPENDIX H: Organization and Staffing, Attestation for 4.3.3.3 Administrative Requirements
- APPENDIX H: Organization and Staffing, first form for 4.3.3.5 Subcontractors

Typographical Errors

Additionally, the following typographical errors were corrected in the following documents included in this amendment:

APPENDIX F Amendments

Page 112 is amended in red, below:

4.3.1.2: Corporate Experience

Use the following form to provide information for any states that the Offeror is currently or has been under contract with to provide managed care services since January 1, 2018, for any market of beneficiaries totaling or exceeding 400,000.

If the Offeror has no current or recent clients, the Offeror must provide a narrative explanation, not to exceed three (3) pages. ~~an explanation. Offerors must submit appropriate documentation to support information provided.~~ Acceptance of the explanation provided is at the discretion of the Division.

Page 113 is amended as explained below:

The form for APPENDIX F: Corporate Background and Experience, form 4.3.1.2: Corporate Experience (Page 113) is amended to remove a duplicative field requesting "Geographic and population coverage requirements."

APPENDIX H Amendments

Page 132 is amended as explained below:

The header of the attestation for APPENDIX H: Organization and Staffing, 4.3.3.3 Administrative Requirements is amended to show the correct number of points available for this section as indicated in red below, in conformance with the scoring as stated in the body of the RFQ:

4.3.3.3 Administrative Requirements (Marked) – 5~~10~~ points

The body of the attestation for APPENDIX H: Organization and Staffing, 4.3.3.3 Administrative Requirements is amended as indicated in red below:

4.3.3.3 Administrative Requirements (Marked) – 5~~10~~ points

Offeror attests to the following:

1. The Offeror will have an Administrative Office within fifteen (15) miles of the Mississippi Division of Medicaid's Central Office at the Walter Sillers Building, Jackson, Mississippi 39201-1399, as required by the RFQ.

2. ~~The Offeror will Describe how and where administrative records and data will be maintained and the process and time frame for retrieving records requested by the Division or other State or external review representatives.~~

Page 133 is amended as indicated in red, below:

4.3.3.5 Subcontractors – 20 points

The Offeror must provide a narrative explanation no longer than three (3) pages giving an overview of its overall philosophy for subcontractor hiring and management.

Use the first provided form entitled "Subcontractor" to describe the any subcontractor the Offeror plans to use if chosen as a winning Contractor through this RFQ.

If the Offeror has worked with the subcontractor in the past three (3) years on a managed care contract, use the second form, "Prior Experience with Subcontractor" to give details about that experience.

Page 134 is amended as explained, below:

The first form in APPENDIX H: Organization and Staffing, 4.3.3.5 Subcontractors was amended to include an option for "Affiliate under the same common ownership" as a response to the question, "This entity is a:".

Receipt of Amendment 7 Acknowledged:

Tara Clark
(Signature)

Tara Clark
(Printed)

Chief Executive Officer
(Title)

Amerigroup Mississippi, Inc.
(Company)

RFQ 20211210: Amendment 8
February 7, 2022
Cover/Acknowledgement Page

Amendment #8 to RFQ 20211210: Additional MSCAN and CHIP Rate Information in Excel Format

RFQ #: 20211210 / RFx#3150003991

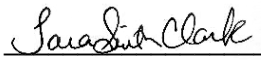
Date: February 7, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

There was request through RFQ Questions and Answers (see Amendment 4 to this RFQ) for complete tables used for rate development, as referenced in RFQ Appendix C. These tables are now available in Excel Format for both MSCAN and CHIP on the dedicated Division of Medicaid Coordinated Care Procurement website, https://medicaid.ms.gov/coordinated-care-procurement/ with the following names:

- Amendment 8: SFY 2022 Preliminary MSCAN Capitation Rates
- Amendment 8: SFY 2022 Preliminary CHIP Capitation Rates

Receipt of Amendment 8 Acknowledged:



(Signature)

Tara Clark

(Printed)

Chief Executive Officer

(Title)

Amerigroup Mississippi, Inc.

(Company)

Amendment #9 to RFQ 20211210: Clarification of Amendment 4 Responses

RFQ #: 20211210 / RFx#3150003991

Date: February 10, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

The Division has received requests to clarify certain answers given by the Division in Amendment 4: RFQ Questions and Answers. The Division is not obligated to grant this request. However, in order to ensure that the Division receives the best possible qualifications, the Division has decided to grant this request, with the following requirements:

1. Questions submitted must be about specific answers given in **Amendment 4 ONLY**. No questions outside of that scope will be accepted. The Division has sole discretion as to whether a question submitted complies with this requirement.
2. The Division is not obligated to provide an answer to a question submitted if, in the Division's judgment, there is an answer that has already been given that addresses the submitted question. The Division may respond to such a question with the previously stated answer.
3. All questions must be submitted using Appendix J, Question and Answer template. Potential Offerors should use the "Section" Column to reference the specific question the Potential Offeror is referencing in Amendment 4 and use the "Page" column to reference the page of that question.
4. Potential Offerors must submit questions under this Amendment via Email to MSCAN_CHIP@medicaid.ms.gov by no later than **Monday, February 14, 2022, 12:00 pm Central Time Zone**. Submissions made after this time will not be accepted. The Offeror bears all risk of delivery.
5. The Division will publish answers no later than Wednesday, February 16, 2022, 5:00 pm Central Time Zone.
6. Other than in response to this Amendment, Offerors may not submit any further questions, other than those necessary to ensure that the Offeror has access to the SharePoint submission site. As stated previously, those questions should be submitted to both Christopher.Shontell@medicaid.ms.gov and MSCAN_CHIP@medicaid.ms.gov. Those questions are handled on an ad hoc basis, and technical assistance given is not considered an amendment to this process.

Receipt of Amendment 9 Acknowledged:

Tara Clark
(Signature)

Tara Clark
(Printed)

Chief Executive Officer
(Title)

Amerigroup Mississippi, Inc.
(Company)

RFQ 20211210: Amendment 10
February 11, 2022
Cover/Acknowledgement Page

Amendment #10 to RFQ 20211210: Summary of Pre-Qualification Conference Held on Friday, January 14, 2022

RFQ #: 20211210 / RFx#3150003991

Date: February 11, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

The Division held a Pre-Qualification Conference on Friday, January 14, 2022. This meeting has been transcribed so that Offerors have a record to reference. Statements made in the meeting have been further clarified by Amendment 2. No part of Amendment 10 supersedes any amendment made after the date of the Pre-Qualification conference. The only additional requirement is included in 1, below.

This document contains the follow:

1. **Attendance Sheet – The Offeror's representative must sign this sheet, certifying that the Offeror attended the pre-qualification conference on Friday, January 14, 2022. This must be submitted with the Receipt of Amendment 10 Acknowledgement when the Offeror submits its qualification.**
2. Transcript of Pre-Qualification Conference
3. Slide Deck presented at the Conference

Receipt of Amendment 10 Acknowledged:

Tara Lin Clark
(Signature)

Tara Clark
(Printed)

Chief Executive Officer
(Title)

Amerigroup Mississippi, Inc.
(Company)

RFQ 20211210: Amendment 11
February 11, 2022
Cover/Acknowledgement Page

Amendment #11 to RFQ 20211210: Reporting Manuals

RFQ #: 20211210 / RFx#3150003991

Date: February 11, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

As stated in Amendment 4, issued on February 7, 2022, the Division is supplying Offerors with downloadable links for the following:

- MississippiCAN Reporting Manual
- CHIP Reporting Manual

Both are available for download on the Division's dedicated CCO Procurement website: https://medicaid.ms.gov/coordinated-care-procurement/.

Receipt of Amendment 11 Acknowledged:

Tara Clark
(Signature)

Tara Clark
(Printed)

Chief Executive Officer
(Title)

Amerigroup Mississippi, Inc.
(Company)

Amendment #12 to RFQ 20211210: Responses Regarding Amendment 9

RFQ #: 20211210 / RFx#3150003991

Date: February 16, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

This document contains all questions submitted by Potential Offerors in response to Amendment #9: Clarification of Amendment 4 Responses, issued on February 10, 2022.

As stated in Amendment #9, Potential Offerors may not submit any further questions, other than those necessary to ensure that the Offeror has access to the SharePoint submission site. Those questions should be submitted to both Christopher.Shontell@medicaid.ms.gov and MSCAN_CHIP@medicaid.ms.gov. Those questions are handled on an ad hoc basis, and technical assistance given is not considered an amendment to this process

As additionally stated in Amendment #9, the Division has sole discretion as to whether a question submitted complies with the requirements stated in Amendment #9. The Division is not obligated to provide an answer to a question submitted if, in the Division's judgment, there is an answer that has already been given through Amendment #4 that addresses the submitted question. The Division may respond to such a question with the previously stated answer.

Receipt of Amendment 12 Acknowledged:

Tara Clark
(Signature)

Tara Clark
(Printed)

Chief Executive Officer
(Title)

Amerigroup Mississippi, Inc.
(Company)

February 8, 2022

Office of Procurement
Mississippi Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

TO: Office of Procurement Mississippi Division of Medicaid

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ # 20211210 and RFx # 3150003991

Dear Office of Procurement:

This letter is to confirm that AMC Health has entered into a subcontract to provide service to Amerigroup Mississippi, Inc. ("Amerigroup") for the above referenced RFQ.

This letter, signed by the individual authorized to legally bind AMC Health, serves as a commitment to provide services to Amerigroup.

As required by Section 4 Qualification Content, 4.1 Transmittal Letter, we've provided the general scope of work to be performed by AMC Health:

Members receive an FDA-approved inhaler sensor that attaches to any prescribed medication. By assessing under or over-utilization data, case managers can inform providers of these patterns and coach members for improved health and more control over recurrent symptoms and avoid costly emergency interventions.

In addition, AMC Health has executed the DHHS Certification Regarding Drug-Free Workplace located in Appendix D.

Sincerely,

Nesim Bildirici
President and CEO

One World Trade Center, Suite 8500, New York, NY 10007 info@amchealth.com
• www.amchealth.com

DocuSign Envelope ID: 06A0CB55-079C-4336-86A3-ED114248BFFB

Anthem, Inc.
220 Virginia Ave.,
Indianapolis, IN 46204

February 11, 2022

Office of Procurement
Mississippi Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

TO: Office of Procurement, Mississippi Division of Medicaid

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ # 20211210 and RFx # 3150003991

Dear Office of Procurement:

This letter is to confirm that Anthem, Inc. has entered into an agreement to provide service to Amerigroup Mississippi, Inc. ("Amerigroup") for the above referenced RFQ.

This letter, signed by the individual authorized to legally bind Anthem, Inc., serves as a commitment to provide services to Amerigroup.

As required by Section 4 Qualification Content, 4.1 Transmittal Letter, we have provided the general scope of work to be performed by Anthem, Inc.

Anthem, Inc. will provide administrative and support services related to enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; and finance.

In addition, Anthem, Inc. has executed the DHHS Certification Regarding Drug-Free Workplace located in Appendix D.

Sincerely,

DocuSigned by:
Kathy Kiefer
34259124741844A...
Kathleen Kiefer
Corporate Secretary

February 8, 2022

Mississippi Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

TO: Mississippi Division of Medicaid

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ # 20211210 and RFx # 3150003991

To Whom It May Concern:

This letter is to confirm that Aunt Bertha has entered into a subcontract to provide service to Amerigroup Mississippi, Inc. ("Amerigroup") for the above referenced RFQ.

This letter, signed by the individual authorized to legally bind Aunt Bertha, serves as a commitment to provide services to Amerigroup.

As required by Section 4 Qualification Content, 4.1 Transmittal Letter, we've provided the general scope of work to be performed by Aunt Bertha:

Platform to connect members with local community resources, programs, and services such as food, housing, transportation, and substance abuse treatment.

In addition, Aunt Bertha has executed the DHHS Certification Regarding Drug-Free Workplace located in Appendix D.

Sincerely,

Tyler Hartung
Vice President of Finance

Proprietary
Access Limited to Company Use Only

February 8, 2022

Mississippi Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

TO: Mississippi Division of Medicaid

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ # 20211210 and RFx # 3150003991

To Whom It May Concern:

This letter is to confirm that Beacon Health Options, Inc. ("Beacon") has entered into a subcontract to provide services to Amerigroup Mississippi, Inc. ("Amerigroup") for the above referenced RFP.

This letter, signed by an individual authorized to legally bind Beacon, serves as a commitment to provide services to Amerigroup.

As required by Section 4 Qualification Content, 4.1 Transmittal Letter, we have provided the general scope of work to be performed by Beacon as follows:

Behavioral Health/Substance Use Disorder 24-hour line (member and provider); After Hours, Weekend and Holiday support for Utilization Management functions.

In addition, Beacon has executed the DHHS Certification Regarding Drug-Free Workplace located in Appendix D.

Sincerely,

Glenn A. MacFarlane
President & Chief Executive Officer

February 8, 2022

Mississippi Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

TO: Mississippi Division of Medicaid

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ # 20211210 and RFx # 3150003991

To Whom It May Concern:

This letter is to confirm that Center for the Study of Services (CSS) has entered into a subcontract to provide service to Amerigroup Mississippi, Inc. ("Amerigroup") for the above referenced RFQ.

This letter, signed by the individual authorized to legally bind CSS, serves as a commitment to provide services to Amerigroup.

As required by Section 4 Qualification Content, 4.1 Transmittal Letter, we've provided the general scope of work to be performed by CSS:

NCQA certified vendor provides surveys to assess patient experience with health care services delivered in different settings and for specific conditions.

In addition, CSS has executed the DHHS Certification Regarding Drug-Free Workplace located in Appendix D.

Sincerely,

Paul Kallaur, President
Center for the Study Services

1625 K St. NW Suite 800
Washington, DC 20006
Phone: (202) 347-9612
Fax: (202) 347-4000

February 8, 2022

Office of Procurement
Mississippi Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

TO: Office of Procurement, Mississippi Division of Medicaid

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ # 20211210 and RFx # 3150003991

Dear Office of Procurement:

This letter is to confirm that, upon award of a contract by the Mississippi Division of Medicaid Coordinated Care to Amerigroup Mississippi, Inc. ("Amerigroup") pursuant to the above-referenced RFQ (the "Contract"), DSM USA Insurance Company, Inc. ("DSM USA") intends to enter into a subcontract, on mutually agreeable terms, to provide services to Amerigroup for the Contract.

DSM USA is a wholly-owned subsidiary of DentaQuest, LLC ("DQ LLC"), which owns and manages the DentaQuest organization (collectively, "DentaQuest") comprised of companies that hold insurance, third party administrator and similar licenses in nearly every state in the country. DQ LLC provides similar administrative and management services for all of its affiliated benefits companies. Although DSM USA retains sole and ultimate responsibility for compliance with the subcontract and oversight of DQ LLC's performance of the services in connection with the subcontract, the executive leadership team and staff who are charged with fulfilling these requirements are all employed by DQ LLC.

This letter, signed by the individual authorized to legally bind DSM USA, serves as a commitment to provide services to Amerigroup, under the terms described above, upon award of the Contract to Amerigroup and execution of a mutually agreeable subcontract between Amerigroup and DSM USA.

As required by Section 4 Qualification Content, 4.1 Transmittal Letter, we've provided the general scope of work to be performed by DentaQuest:

• Full spectrum of core and Value-Added Benefit (VAB) dental benefit administration services.
• Full spectrum of core and VAB vision benefit administration services (EyeQuest product).

PO Box 2906 Milwaukee, WI 53201-2906 | www.dentaquest.com | TEL: 800.417.7140

In addition, DSM USA has executed the DHHS Certification Regarding Drug-Free Workplace located in Appendix D.

Sincerely,

Brett Bostrack
President
DSM USA Insurance Company, Inc.

IngenioRx
450 Headquarters Plaza, 4th Floor East Tower
Morristown, NJ 07960

Office of Procurement
Mississippi Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

February 4, 2022

TO: Office of Procurement, Mississippi Division of Medicaid

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ # 20211210 and RFx # 3150003991

Dear Office of Procurement:

This letter is to confirm that IngenioRx has entered into a subcontract to provide service to Amerigroup Mississippi, Inc. ("Amerigroup") for the above referenced RFQ.

This letter, signed by the individual authorized to legally bind IngenioRx, serves as a commitment to provide services to Amerigroup.

As required by Section 4 Qualification Content, 4.1 Transmittal Letter, we've provided the general scope of work to be performed by IngenioRx:

Oversee medical drug management including medical injectable drug policy/criteria development and review of medical injectable prior authorizations, as well as provide pharmacy clinical quality programs.

In addition, IngenioRx has executed the DHHS Certification Regarding Drug-Free Workplace located in Appendix D.

Sincerely,

Paul Marchetti
President

February 8, 2022

Office of Procurement
Mississippi Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

TO: Office of Procurement
Mississippi Division of Medicaid

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ # 20211210 and RFx # 3150003991

Dear Office of Procurement:

This letter is to confirm that MedAware has entered into a subcontract to provide service to Amerigroup Mississippi, Inc. ("Amerigroup") for the above referenced RFQ.

This letter, signed by the individual authorized to legally bind MedAware, serves as a commitment to provide services to Amerigroup.

As required by Section 4 Qualification Content, 4.1 Transmittal Letter, we've provided the general scope of work to be performed by MedAware:

In-home healthcare using mobile capabilities of paramedics associated with local EMS agencies to help members with complex care needs and limited access regain stability in health and reconnect with their PCP.

In addition, MedAware has executed the DHHS Certification Regarding Drug-Free Workplace located in Appendix D.

Sincerely,

Chris Cebollero, COO

Office of Procurement
Mississippi Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

TO: Office of Procurement, Mississippi Division of Medicaid

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ # 20211210 and RFx # 3150003991

Dear Office of Procurement:

This letter is to confirm that Medical Transportation Management, Inc. (MTM) has entered into a subcontract to provide service to Amerigroup Mississippi, Inc. ("Amerigroup") for the above referenced RFQ.

This letter, signed by the individual authorized to legally bind MTM, serves as a commitment to provide services to Amerigroup.

As required by Section 4 Qualification Content, 4.1 Transmittal Letter, we've provided the general scope of work to be performed by MTM:

Non-emergency transportation services for the medically fragile, disabled, underserved, elderly, and other populations.

In addition, MTM has executed the DHHS Certification Regarding Drug-Free Workplace located in Appendix D.

Sincerely,

Alaina Maciá
President and CEO
Medical Transportation Management, Inc. (MTM)

February 8, 2022

Office of Procurement
Mississippi Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

TO: Office of Procurement, Mississippi Division of Medicaid

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ # 20211210 and RFx # 3150003991

Dear Office of Procurement:

This letter is to confirm that Meridian Resource Company, LLC (Meridian) has entered into a subcontract to provide service to Amerigroup Mississippi, Inc. ("Amerigroup") for the above referenced RFQ.

This letter, signed by the individual authorized to legally bind Meridian, serves as a commitment to provide services to Amerigroup.

As required by Section 4 Qualification Content, 4.1 Transmittal Letter, we've provided the general scope of work to be performed by Meridian:

Medicaid third-party liability recovery from tort and workers' compensation losses.

In addition, Meridian has executed the DHHS Certification Regarding Drug-Free Workplace located in Appendix D.

Sincerely,

Matthew Monyhan

Matthew Monyhan
Dir Financial Ops Dept, Subrogation Support

DocuSign Envelope ID: D6269458-8A01-4634-B87B-C26ADFE02BD9

900 G Street, NW
Fourth Floor
Washington, DC 20001

truthinitiative.org
202 454 5555

February 8, 2022

Office of Procurement
Mississippi Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

TO: Office of Procurement, Mississippi Division of Medicaid

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ # 20211210 and RFx # 3150003991

Office of Procurement,

This letter is to confirm that Truth Initiative has entered into a subcontract to provide service to Amerigroup Mississippi, Inc. ("Amerigroup") for the above referenced RFQ.

This letter, signed by the individual authorized to legally bind Truth Initiative, serves as a commitment to provide services to Amerigroup.

As required by Section 4 Qualification Content, 4.1 Transmittal Letter, we've provided the general scope of work to be performed by Truth Initiative:

Customized Adult and Teen Programming: Tobacco and Vaping Cessation Program, for adults age 18 and over, offers real-time, personalized engagement with unlimited access to quit plan, peer support, live chat coaching, and text messaging; up to eight weeks of nicotine replacement therapy. This Quitting program, for teens age 13-17, offers text-based support and on-demand content to help young people quit.

In addition, Truth Initiative has executed the DHHS Certification Regarding Drug-Free Workplace located in Appendix D.

Sincerely,

DocuSigned by:
Robert Falk
4237B5A35898 4A8...
Robert Falk
Corporate Secretary

@truthinitiative
facebook.com/truthinitiative

CERTIFICATE OF SECRETARY
Amerigroup Mississippi, Inc.

I, the undersigned, certify that I am the duly elected Secretary of Amerigroup Mississippi, Inc. (the "Corporation") and in that capacity I am authorized to execute and deliver this Certification on behalf of the Corporation.

I further certify that Tarance S. Clark is the duly elected President of the Corporation and that in that capacity has signing authority on behalf of the Corporation

IN WITNESS WHEREOF, I, Kathleen S. Kiefer, have hereunto subscribed my name as Secretary of the Corporation, and affixed the corporate seal of the Corporation, this 25th day of January, 2022.

Kathleen S. Kiefer, Secretary
Amerigroup Mississippi, Inc.

Transmittal Letter: Certifications and Assurances

Certifications and Assurances Regarding Contingency Fees and Gratuities

Instructions: Mark the applicable word for each certification provided below. Failure to mark the applicable word or words and/or to sign the qualification form may result in the qualification being rejected as nonresponsive. Modifications or additions to any portion of this qualification document may be cause for rejection of the qualification.

Certifications:
I/We make the following certifications and assurances as a required element of the qualification to which it is attached, of the understanding that the truthfulness of the facts affirmed here and the continued compliance with these requirements are conditions precedent to the award or continuation of the related contract(s) by circling the applicable word or words in each paragraph below:

1. Representation Regarding Contingent Fees

The Offeror represents that it [ ] **has [X] has not** retained a person to solicit or secure a state contract upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except as disclosed in Contractor's qualification.

2. Representation Regarding Gratuities

The Offeror represents that it [ ] **has [X] has not** violated, is not violating, and promises that it will not violate the prohibition against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Public Procurement Review Board Rules and Regulations.

3. Prospective Contractor's Representation Regarding Contingent Fees

The prospective Contractor (Offeror) represents as a part of such Contractor's qualification that such Contractor [ ] **has [X] has not** retained any person or agency on a percentage, commission, or other contingent arrangement to secure this contract.

Amerigroup Mississippi, Inc.
Name of Offeror

Tara Clark
Printed name of person attesting for Offeror

President and Chief Executive Officer
Title of person attesting for Offeror

Tara Clark
Signature of person attesting for Offeror

3/2/2022
Date

[END OF RESPONSE]

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other than Individuals

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1) This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

2) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., all vehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performsers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

    a. "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

    b. "Conviction" means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

    c. “Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

    d. "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge employees unless their impact or involvement is insignificant to the performance of the grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definition does not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing an ongoing drug-free awareness program to inform employees about:

   (1) The dangers of drug abuse in the workplace;

   (2) the grantee's policy of maintaining a drug-free workplace;

   (3) any available drug counseling, rehabilitation, and employee assistance programs; and

   (4) the penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

C. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will:

   (1) Abide by the terms of the statement; and

   (2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

E. Notifying the Division in writing, within ten calendar days after receiving notice under paragraph D(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

F. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph D(2), with respect to any employee who is so convicted:

   (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

   (2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

G. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs A, B, C, D, E, and F.

G. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the table provided below):

Place of Performance					
Name of Location: Amerigroup Mississippi, Inc.					
Line 1 (Street Name and Number): 750 Woodlands Parkway					
Address Line 2 (Suite, Room, etc.):					
City: Ridgeland	State: MS	Zip Code: 39157	County: Madison		
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:	

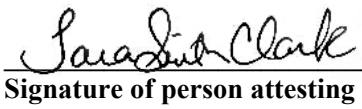
[X] Check if there are workplaces on file that are not identified here.

---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and for notification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

Amerigroup, Mississippi, Inc.
Name of Offeror

Tara Clark
Printed name of person attesting for Offeror

President and Chief Executive Officer
Title of person attesting for Offeror


Signature of person attesting for Offeror

3/2/2022
Date

[END OF RESPONSE]

Place of Performance					
Name of Location: The Wellness Center					
Line 1 (Street Name and Number): 350 Woodrow Wilson Ave.					
Address Line 2 (Suite, Room, etc.):					
City: Jackson		State: MS	Zip Code: 39213	County: Madison	
Mailing Address (P.O. Box):	City:		State:	Zip Code:	County:

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other thanIndividuals

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1) This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

2) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., allvehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

   a) "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

   b) "Conviction" means a finding of guilt (including a plea of nolo contendere) or impositionof sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

   c) “Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

   d) "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge employees unless their impact or involvement is insignificant to the performance of the

grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definitiondoes not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing an ongoing drug-free awareness program to inform employees about:

   (1) The dangers of drug abuse in the workplace;

   (2) the grantee's policy of maintaining a drug-free workplace;

   (3) any available drug counseling, rehabilitation, and employee assistance programs; and

   (4) the penalties that may be imposed upon employees for drug abuse violations occurring inthe workplace;

C. Making it a requirement that each employee to be engaged in the performance of the grant begiven a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition ofemployment under the grant, the employee will:

   (1) Abide by the terms of the statement; and

   (2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

E. Notifying the Division in writing, within ten calendar days after receiving notice under paragraphD(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agencyhas designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

F. Taking one of the following actions, within 30 calendar days of receiving notice under paragraphD(2), with respect to any employee who is so convicted:

   (1) Taking appropriate personnel action against such an employee, up to and includingtermination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health,law enforcement, or other appropriate agency;

G. Making a good faith effort to continue to maintain a drug-free workplace through implementationof paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the tableprovided below):

Place of Performance				
Name of Location: AMC Health				
Line 1 (Street Name and Number): One World Trade Center				
Address Line 2 (Suite, Room, etc.): Suite 8500				
City: New York	State: NY	Zip Code: 10007	County: Manhattan	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

✔ Check if there are workplaces on file that are not identified here.

---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and fornotification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

Advanced Monitored Caregiving,Inc. (AMC)

Name of Offeror

Nesim Bildirici

Printed name of person attesting for Offeror

President and CEO

Title of person attesting for Offeror

Nesim Bildirici (Jan 26, 2022 11:49 EST)

Signature of person attesting for Offeror

January 26, 2022

Date

[END OF RESPONSE]

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the tableprovided below):

Place of Performance				
Name of Location: AMC Health				
Line 1 (Street Name and Number): 8053 Warwick Avenue				
Address Line 2 (Suite, Room, etc.):				
City: Louisville	State: KY	Zip Code: 40222	County: Jefferson	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

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DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other thanIndividuals

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1) This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

2) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., allvehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

   a) "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

   b) "Conviction" means a finding of guilt (including a plea of nolo contendere) or impositionof sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

   c) “Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

   d) "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge employees unless their impact or involvement is insignificant to the performance of the

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grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definitiondoes not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing an ongoing drug-free awareness program to inform employees about:

   (1) The dangers of drug abuse in the workplace;

   (2) the grantee's policy of maintaining a drug-free workplace;

   (3) any available drug counseling, rehabilitation, and employee assistance programs; and

   (4) the penalties that may be imposed upon employees for drug abuse violations occurring inthe workplace;

C. Making it a requirement that each employee to be engaged in the performance of the grant begiven a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition ofemployment under the grant, the employee will:

   (1) Abide by the terms of the statement; and

   (2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

E. Notifying the Division in writing, within ten calendar days after receiving notice under paragraphD(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agencyhas designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

F. Taking one of the following actions, within 30 calendar days of receiving notice under paragraphD(2), with respect to any employee who is so convicted:

   (1) Taking appropriate personnel action against such an employee, up to and includingtermination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

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(2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health,law enforcement, or other appropriate agency;

G. Making a good faith effort to continue to maintain a drug-free workplace through implementationof paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the tableprovided below):

Place of Performance				
Name of Location: Anthem, Inc.				
Line 1 (Street Name and Number): 5800 Northampton Boulevard				
Address Line 2 (Suite, Room, etc.):				
City: Norfolk	State: VA	Zip Code: 23502	County: Norfolk	
Mailing Address (P.O. Box): same as above	City:	State:	Zip Code:	County:

✔ Check if there are workplaces on file that are not identified here.

----->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and fornotification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

Anthem, Inc.

Name of Offeror

Kathleen S Kiefer

Printed name of person attesting for Offeror

Corporate Secretary

Title of person attesting for Offeror

DocuSigned by:
Kathy Kiefer
34259124741844A...

Signature of person attesting for Offeror

February 22, 2022

Date

[END OF RESPONSE]

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the table provided below):

Place of Performance				
Name of Location: Amerigroup Mississippi, Inc.				
Line 1 (Street Name and Number): 750 Woodlands Parkway				
Address Line 2 (Suite, Room, etc.):				
City: Ridgeland	State: MS	Zip Code: 39157	County: Madison	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: National Call Center				
Line 1 (Street Name and Number): 22 Century Boulevard				
Address Line 2 (Suite, Room, etc.): Suite 220				
City: Nashville	State: TN	Zip Code: 37214	County: Davidson	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: Anthem, Inc.				
Line 1 (Street Name and Number): 22001 Loudon County Parkway				
Address Line 2 (Suite, Room, etc.):				
City: Ashburn	State: VA	Zip Code: 20147	County: Loudoun	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: Anthem, Inc.				
Line 1 (Street Name and Number): 12898 Towne Center Drive				
Address Line 2 (Suite, Room, etc.):				
City: Cerritos	State: CA	Zip Code: 90703	County: Los Angeles	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: Anthem, Inc.				
Line 1 (Street Name and Number): 1300 Amerigroup Way				
Address Line 2 (Suite, Room, etc.):				
City: Virginia Beach	State: VA	Zip Code: 23464	County: Virginia Beach	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: Anthem, Inc.				
Line 1 (Street Name and Number): 1175 North Main Street				
Address Line 2 (Suite, Room, etc.):				
City: Harrisonburg	State: VA	Zip Code: 22802	County: Harrisonburg	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

DocuSign Envelope ID: CCC5CC22-9A78-4446-9A57-4D5CBBEA14FF

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other thanIndividuals

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1) This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

2) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., allvehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

   a) "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

   b) "Conviction" means a finding of guilt (including a plea of nolo contendere) or impositionof sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

   c) “Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

   d) "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge employees unless their impact or involvement is insignificant to the performance of the

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grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definitiondoes not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing an ongoing drug-free awareness program to inform employees about:

   (1) The dangers of drug abuse in the workplace;

   (2) the grantee's policy of maintaining a drug-free workplace;

   (3) any available drug counseling, rehabilitation, and employee assistance programs; and

   (4) the penalties that may be imposed upon employees for drug abuse violations occurring inthe workplace;

C. Making it a requirement that each employee to be engaged in the performance of the grant begiven a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition ofemployment under the grant, the employee will:

   (1) Abide by the terms of the statement; and

   (2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

E. Notifying the Division in writing, within ten calendar days after receiving notice under paragraphD(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agencyhas designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

F. Taking one of the following actions, within 30 calendar days of receiving notice under paragraphD(2), with respect to any employee who is so convicted:

   (1) Taking appropriate personnel action against such an employee, up to and includingtermination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health,law enforcement, or other appropriate agency;

G. Making a good faith effort to continue to maintain a drug-free workplace through implementationof paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the tableprovided below):

Place of Performance				
Name of Location: Aunt Bertha - Austin				
Line 1 (Street Name and Number): 3429 Executive Center Drive				
Address Line 2 (Suite, Room, etc.):				
City: Austin	State: TX	Zip Code: 78731	County: Travis	
Mailing Address (P.O. Box): 3616 Far West Blvd 117454	City: Austin	State: TX	Zip Code: 78731	County: Travis

✔ Check if there are workplaces on file that are not identified here.

---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and fornotification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

Aunt Bertha, a Public Benefit Corporation

Name of Offeror

Tyler Hartung

Printed name of person attesting for Offeror

VP of Finance

Title of person attesting for Offeror

Tyler Hartung Digitally signed by Tyler Hartung Date: 2022.02.28 20:32:49 -07'00'

Signature of person attesting for Offeror

02/28/2022

Date

[END OF RESPONSE]

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the tableprovided below):

Place of Performance				
Name of Location: Denver Office – Aunt Bertha, a Public Benefit Corp				
Line 1 (Street Name and Number): 1035 Osage Street				
Address Line 2 (Suite, Room, etc.): 8th Floor				
City: Denver	State: CO	Zip Code: 80204	County: Denver	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: Madison Office – Aunt Bertha, a Public Benefit Corp				
Line 1 (Street Name and Number): 2801 Marshall Court				
Address Line 2 (Suite, Room, etc.): Office 23				
City: Madison	State: WI	Zip Code: 53705	County: Dane	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other thanIndividuals

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1) This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

2) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., allvehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

   a) "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

   b) "Conviction" means a finding of guilt (including a plea of nolo contendere) or impositionof sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

   c) “Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

   d) "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge employees unless their impact or involvement is insignificant to the performance of the

grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definitiondoes not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing an ongoing drug-free awareness program to inform employees about:

(1) The dangers of drug abuse in the workplace;

(2) the grantee's policy of maintaining a drug-free workplace;

(3) any available drug counseling, rehabilitation, and employee assistance programs; and

(4) the penalties that may be imposed upon employees for drug abuse violations occurring inthe workplace;

C. Making it a requirement that each employee to be engaged in the performance of the grant begiven a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition ofemployment under the grant, the employee will:

(1) Abide by the terms of the statement; and

(2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

E. Notifying the Division in writing, within ten calendar days after receiving notice under paragraphD(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agencyhas designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

F. Taking one of the following actions, within 30 calendar days of receiving notice under paragraphD(2), with respect to any employee who is so convicted:

(1) Taking appropriate personnel action against such an employee, up to and includingtermination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health,law enforcement, or other appropriate agency;

G. Making a good faith effort to continue to maintain a drug-free workplace through implementationof paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the tableprovided below):

Place of Performance				
Name of Location: Amerigroup Mississippi, Inc.				
Line 1 (Street Name and Number): 750 Woodlands Parkway				
Address Line 2 (Suite, Room, etc.):				
City: Ridgeland	State: MS	Zip Code: 39157	County: Madison	
Mailing Address (P.O. Box): same as above	City: N/A	State: N/A	Zip Code: N/A	County: N/A

Check if there are workplaces on file that are not identified here.

---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and fornotification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

Beacon Health Options, Inc

Name of Offeror

Glenn A MacFarlane

Printed name of person attesting for Offeror

President and Chief Executive Officer

Title of person attesting for Offeror

Glenn MacFarlane

Digitally signed by Glenn MacFarlane
DN: cn=Glenn MacFarlane, o=Beacon Health Options, ou, email=glenn.macfarlane@beaconhealthoptions.com, c=US
Date: 2022.03.01 09:57:37 -05'00'

Signature of person attesting for Offeror

03/01/22

Date

[END OF RESPONSE]

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other thanIndividuals

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1) This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

2) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., allvehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

   a) "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

   b) "Conviction" means a finding of guilt (including a plea of nolo contendere) or impositionof sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

   c) “Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

   d) "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge employees unless their impact or involvement is insignificant to the performance of the

grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definitiondoes not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing an ongoing drug-free awareness program to inform employees about:

   (1) The dangers of drug abuse in the workplace;

   (2) the grantee's policy of maintaining a drug-free workplace;

   (3) any available drug counseling, rehabilitation, and employee assistance programs; and

   (4) the penalties that may be imposed upon employees for drug abuse violations occurring inthe workplace;

C. Making it a requirement that each employee to be engaged in the performance of the grant begiven a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition ofemployment under the grant, the employee will:

   (1) Abide by the terms of the statement; and

   (2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

E. Notifying the Division in writing, within ten calendar days after receiving notice under paragraphD(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agencyhas designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

F. Taking one of the following actions, within 30 calendar days of receiving notice under paragraphD(2), with respect to any employee who is so convicted:

   (1) Taking appropriate personnel action against such an employee, up to and includingtermination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health,law enforcement, or other appropriate agency;

G. Making a good faith effort to continue to maintain a drug-free workplace through implementationof paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the tableprovided below):

Place of Performance				
Name of Location: CSS Headquarters				
Line 1 (Street Name and Number): 1625 K Street, NW Suite 800				
Address Line 2 (Suite, Room, etc.):				
City: Washington	State: DC	Zip Code: 20006	County: District of Columbia	
Mailing Address (P.O. Box): same as above	City:	State:	Zip Code:	County:

Check if there are workplaces on file that are not identified here.
---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and fornotification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

Center for the Study of Services (CSS)

Name of Offeror

Paul Kallaur

Printed name of person attesting for Offeror

President

Title of person attesting for Offeror

Paul Kallaur Digitally signed by Paul Kallaur Date: 2022.02.10 13:06:58 -05'00'

Signature of person attesting for Offeror

February 10, 2022

Date

[END OF RESPONSE]

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other thanIndividuals

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1) This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

2) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., allvehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

   a) "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

   b) "Conviction" means a finding of guilt (including a plea of nolo contendere) or impositionof sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

   c) "Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

   d) "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge employees unless their impact or involvement is insignificant to the performance of the

grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definitiondoes not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing an ongoing drug-free awareness program to inform employees about:

(1) The dangers of drug abuse in the workplace;

(2) the grantee's policy of maintaining a drug-free workplace;

(3) any available drug counseling, rehabilitation, and employee assistance programs; and

(4) the penalties that may be imposed upon employees for drug abuse violations occurring inthe workplace;

C. Making it a requirement that each employee to be engaged in the performance of the grant begiven a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition ofemployment under the grant, the employee will:

(1) Abide by the terms of the statement; and

(2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

E. Notifying the Division in writing, within ten calendar days after receiving notice under paragraphD(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agencyhas designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

F. Taking one of the following actions, within 30 calendar days of receiving notice under paragraphD(2), with respect to any employee who is so convicted:

(1) Taking appropriate personnel action against such an employee, up to and includingtermination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health,law enforcement, or other appropriate agency;

G. Making a good faith effort to continue to maintain a drug-free workplace through implementationof paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the tableprovided below):

Place of Performance				
Name of Location: DentaQuest LLC				
Line 1 (Street Name and Number): 11100 West Liberty Drive				
Address Line 2 (Suite, Room, etc.):				
City: Milwaukee	State: WI	Zip Code: 53224	County: Milwaukee	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

✓ Check if there are workplaces on file that are not identified here.
---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and fornotification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

DentaQuest LLC
Name of Offeror

ROXANNE E. MARTINEZ
Printed name of person attesting for Offeror

EVP, CHIEF HUMAN RESOURCES OFFICER
Title of person attesting for Offeror

Roxanne E M
Signature of person attesting for Offeror

1/28/22
Date

[END OF RESPONSE]

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the tableprovided below):

Place of Performance				
Name of Location: DentaQuest				
Line 1 (Street Name and Number): 465 Medford Street				
Address Line 2 (Suite, Room, etc.):				
City: Boston	State: MA	Zip Code: 02129-1454	County: Suffolk	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: DentaQuest				
Line 1 (Street Name and Number): 11044 Research Boulevard Building D				
Address Line 2 (Suite, Room, etc.): Suite 400				
City: Austin	State: TX	Zip Code: 78759	County: Travis	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other thanIndividuals

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1) This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

2) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., allvehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

    a) "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

    b) "Conviction" means a finding of guilt (including a plea of nolo contendere) or impositionof sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

    c) “Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

    d) "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge employees unless their impact or involvement is insignificant to the performance of the

grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definitiondoes not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing an ongoing drug-free awareness program to inform employees about:

   (1) The dangers of drug abuse in the workplace;

   (2) the grantee's policy of maintaining a drug-free workplace;

   (3) any available drug counseling, rehabilitation, and employee assistance programs; and

   (4) the penalties that may be imposed upon employees for drug abuse violations occurring inthe workplace;

C. Making it a requirement that each employee to be engaged in the performance of the grant begiven a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition ofemployment under the grant, the employee will:

   (1) Abide by the terms of the statement; and

   (2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

E. Notifying the Division in writing, within ten calendar days after receiving notice under paragraphD(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agencyhas designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

F. Taking one of the following actions, within 30 calendar days of receiving notice under paragraphD(2), with respect to any employee who is so convicted:

   (1) Taking appropriate personnel action against such an employee, up to and includingtermination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health,law enforcement, or other appropriate agency;

G. Making a good faith effort to continue to maintain a drug-free workplace through implementationof paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the tableprovided below):

Place of Performance				
Name of Location: IngenioRx, Inc. Corporate				
Line 1 (Street Name and Number): 450 Headquarters Plaza, East Tower				
Address Line 2 (Suite, Room, etc.): 7th Floor				
City: Morristown	State: NJ	Zip Code: 07960	County: Morris	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

✓ Check if there are workplaces on file that are not identified here.
---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and fornotification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

IngenioRx, Inc.

Name of Offeror

Paul Marchetti

Printed name of person attesting for Offeror

President, IngenioRx

Title of person attesting for Offeror

Paul L Marchetti

Signature of person attesting for Offeror

January 26, 2022

Date

[END OF RESPONSE]

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the table provided below):

Place of Performance				
Name of Location: IngenioRx, Inc – Wallingford, CT				
Line 1 (Street Name and Number): 108 Leigus Road				
Address Line 2 (Suite, Room, etc.):				
City: Wallingford	State: CT	Zip Code: 06492	County: Morris	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: IngenioRx, Inc - Atlanta, GA				
Line 1 (Street Name and Number): 740 West Peachtree Street NW				
Address Line 2 (Suite, Room, etc.):				
City: Atlanta	State: GA	Zip Code: 30308	County: Fulton	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: IngenioRx, Inc – Chicago, IL				
Line 1 (Street Name and Number): 233 S Wacker Drive				
Address Line 2 (Suite, Room, etc.):				
City: Chicago	State: IL	Zip Code: 60606	County: Cook	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: IngenioRx, Inc – Louisville, KY				
Line 1 (Street Name and Number): 13550 Triton Office Park Boulevard				
Address Line 2 (Suite, Room, etc.):				
City: Louisville	State: KY	Zip Code: 40223	County: Jefferson	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: IngenioRx, Inc – Mendota Heights, MN				
Line 1 (Street Name and Number): 1285 Northland Drive				
Address Line 2 (Suite, Room, etc.):				
City: Mendota Heights	State: MN	Zip Code: 55120	County: Dakota	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: IngenioRx, Inc - St. Louis, MO				
Line 1 (Street Name and Number): 1831 Chestnut Street				
Address Line 2 (Suite, Room, etc.):				
City: St. Louis	State: MO	Zip Code: 63103	County: St. Louis	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: IngenioRx, Inc - Las Vegas, NV				
Line 1 (Street Name and Number): 1451 Center Crossing Road				
Address Line 2 (Suite, Room, etc.):				
City: Las Vegas	State: NV	Zip Code: 89144	County: Clark	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: IngenioRx, Inc - Mason, OH				
Line 1 (Street Name and Number): 4241 Irwin Simpson Road				
Address Line 2 (Suite, Room, etc.): Building 2				
City: Mason	State: OH	Zip Code: 45040	County: Warren	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: IngenioRx, Inc - Virginia Beach, VA				
Line 1 (Street Name and Number): 1330 Amerigroup Way				
Address Line 2 (Suite, Room, etc.):				
City: Virginia Beach	State: VA	Zip Code: 23464	County: City of Virginia Beach	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other thanIndividuals

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1) This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

2) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., allvehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

   a) "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

   b) "Conviction" means a finding of guilt (including a plea of nolo contendere) or impositionof sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

   c) "Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

   d) "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge employees unless their impact or involvement is insignificant to the performance of the

grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definitiondoes not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing an ongoing drug-free awareness program to inform employees about:

   (1) The dangers of drug abuse in the workplace;

   (2) the grantee's policy of maintaining a drug-free workplace;

   (3) any available drug counseling, rehabilitation, and employee assistance programs; and

   (4) the penalties that may be imposed upon employees for drug abuse violations occurring inthe workplace;

C. Making it a requirement that each employee to be engaged in the performance of the grant begiven a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition ofemployment under the grant, the employee will:

   (1) Abide by the terms of the statement; and

   (2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

E. Notifying the Division in writing, within ten calendar days after receiving notice under paragraphD(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agencyhas designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

F. Taking one of the following actions, within 30 calendar days of receiving notice under paragraphD(2), with respect to any employee who is so convicted:

   (1) Taking appropriate personnel action against such an employee, up to and includingtermination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health,law enforcement, or other appropriate agency;

G. Making a good faith effort to continue to maintain a drug-free workplace through implementationof paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the tableprovided below):

Place of Performance				
Name of Location: MedAware Solutions				
Line 1 (Street Name and Number): 320 Brookes Drive				
Address Line 2 (Suite, Room, etc.): Suite 227-B				
City: Hazelwood	State: MO	Zip Code: 63042	County: St. Louis	
Mailing Address (P.O. Box): N/A	City: N/A	State: N/A	Zip Code: N/A	County: N/A

Check if there are workplaces on file that are not identified here.
---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and fornotification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

Chris Cebollero

Name of Offeror

Chris Cebollero

Printed name of person attesting for Offeror

COO

Title of person attesting for Offeror

Signature of person attesting for Offeror

March 1, 2022

Date

[END OF RESPONSE]

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other thanIndividuals

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1) This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

2) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., allvehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

   a) "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

   b) "Conviction" means a finding of guilt (including a plea of nolo contendere) or impositionof sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

   c) “Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

   d) "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge employees unless their impact or involvement is insignificant to the performance of the

grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definitiondoes not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing an ongoing drug-free awareness program to inform employees about:

(1) The dangers of drug abuse in the workplace;

(2) the grantee's policy of maintaining a drug-free workplace;

(3) any available drug counseling, rehabilitation, and employee assistance programs; and

(4) the penalties that may be imposed upon employees for drug abuse violations occurring inthe workplace;

C. Making it a requirement that each employee to be engaged in the performance of the grant begiven a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition ofemployment under the grant, the employee will:

(1) Abide by the terms of the statement; and

(2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

E. Notifying the Division in writing, within ten calendar days after receiving notice under paragraphD(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agencyhas designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

F. Taking one of the following actions, within 30 calendar days of receiving notice under paragraphD(2), with respect to any employee who is so convicted:

(1) Taking appropriate personnel action against such an employee, up to and includingtermination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health,law enforcement, or other appropriate agency;

G. Making a good faith effort to continue to maintain a drug-free workplace through implementationof paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the tableprovided below):

Place of Performance				
Name of Location: Medical Transportaton Management, Inc. (MTM)				
Line 1 (Street Name and Number): 16 Hawk Ridge Drive				
Address Line 2 (Suite, Room, etc.):				
City: Lake St. Louis	State: MO	Zip Code: 63367	County: St. Charles	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

Check if there are workplaces on file that are not identified here.
---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and fornotification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

MTM, Inc.

Name of Offeror

Alaina Maciá

Printed name of person attesting for Offeror

President and CEO

Title of person attesting for Offeror

Alaina Maciá

Signature of person attesting for Offeror

1/26/2022

Date

[END OF RESPONSE]

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other thanIndividuals

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1) This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

2) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., allvehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

   a) "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

   b) "Conviction" means a finding of guilt (including a plea of nolo contendere) or impositionof sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

   c) “Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

   d) "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge employees unless their impact or involvement is insignificant to the performance of the

grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definitiondoes not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing an ongoing drug-free awareness program to inform employees about:

(1) The dangers of drug abuse in the workplace;

(2) the grantee's policy of maintaining a drug-free workplace;

(3) any available drug counseling, rehabilitation, and employee assistance programs; and

(4) the penalties that may be imposed upon employees for drug abuse violations occurring inthe workplace;

C. Making it a requirement that each employee to be engaged in the performance of the grant begiven a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition ofemployment under the grant, the employee will:

(1) Abide by the terms of the statement; and

(2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

E. Notifying the Division in writing, within ten calendar days after receiving notice under paragraphD(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agencyhas designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

F. Taking one of the following actions, within 30 calendar days of receiving notice under paragraphD(2), with respect to any employee who is so convicted:

(1) Taking appropriate personnel action against such an employee, up to and includingtermination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health,law enforcement, or other appropriate agency;

G. Making a good faith effort to continue to maintain a drug-free workplace through implementationof paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the tableprovided below):

Place of Performance				
Name of Location: Merdian Resource Company, LLC				
Line 1 (Street Name and Number): N17W24340 Riverwood Drive				
Address Line 2 (Suite, Room, etc.):				
City: Waukesha	State: WI	Zip Code: 53188	County: Waukesha	
Mailing Address (P.O. Box): P.O. Box 659940	City: San Antonio	State: TX	Zip Code: 78265-9939	County: Bexar

✓ Check if there are workplaces on file that are not identified here.

---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and fornotification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

Meridian Resource Company, LLC

Name of Offeror

Matthew Monyhan

Printed name of person attesting for Offeror

Dir Financial Ops Dept - Subrogation Suppor

Title of person attesting for Offeror

Matthew Monyhan

Signature of person attesting for Offeror

02/15/2022

Date

[END OF RESPONSE]

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the tableprovided below):

Place of Performance				
Name of Location: Meridian Resource Company, LLC				
Line 1 (Street Name and Number): PO Box 659940				
Address Line 2 (Suite, Room, etc.):				
City: San Antonio	State: TX	Zip Code: 78265-9939	County: Bexar	
Mailing Address (P.O. Box): PO Box 659940	City: San Antonio	State: TX	Zip Code: 78265-9939	County: Bexar

Place of Performance				
Name of Location: Meridan Resource Company, LLC				
Line 1 (Street Name and Number): 13550 Triton Park Blvd.				
Address Line 2 (Suite, Room, etc.):				
City: Louisville	State: KY	Zip Code: 40223	County: Jefferson	
Mailing Address (P.O. Box): PO Box 659940	City: San Antonio	State: TX	Zip Code: 78265-9939	County: Bexar

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other thanIndividuals

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1) This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

2) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., allvehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

   a) "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

   b) "Conviction" means a finding of guilt (including a plea of nolo contendere) or impositionof sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

   c) “Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

   d) "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge employees unless their impact or involvement is insignificant to the performance of the

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grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definitiondoes not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing an ongoing drug-free awareness program to inform employees about:

   (1) The dangers of drug abuse in the workplace;

   (2) the grantee's policy of maintaining a drug-free workplace;

   (3) any available drug counseling, rehabilitation, and employee assistance programs; and

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C. Making it a requirement that each employee to be engaged in the performance of the grant begiven a copy of the statement required by paragraph (a);

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   (1) Abide by the terms of the statement; and

   (2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

E. Notifying the Division in writing, within ten calendar days after receiving notice under paragraphD(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agencyhas designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

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   (1) Taking appropriate personnel action against such an employee, up to and includingtermination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

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(2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health,law enforcement, or other appropriate agency;

G. Making a good faith effort to continue to maintain a drug-free workplace through implementationof paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the tableprovided below):

Place of Performance				
Name of Location: Truth Initiative Foundation d/b/a Truth Initiative				
Line 1 (Street Name and Number): 900 G St NW				
Address Line 2 (Suite, Room, etc.): 4th Floor				
City: Washington	State: DC	Zip Code: 20001	County: USA	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

✔ Check if there are workplaces on file that are not identified here.
---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and fornotification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

Truth Initiative Foundation

Name of Offeror

Robert Falk

Printed name of person attesting for Offeror

Corporate Secretary

Title of person attesting for Offeror

DocuSigned by:
Robert Falk
4237B5A3E6964A8...

Signature of person attesting for Offeror

1/24/2022

Date

[END OF RESPONSE]

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the tableprovided below):

Place of Performance				
Name of Location: Denver Office				
Line 1 (Street Name and Number): 1035 Osage Street				
Address Line 2 (Suite, Room, etc.): 8th Floor				
City: Denver	State: CO	Zip Code: 80204	County: Denver	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: Madison Office				
Line 1 (Street Name and Number): 2801 Marshall Court				
Address Line 2 (Suite, Room, etc.): Office 23				
City: Madison	State: WI	Zip Code: 53705	County: Dane	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

Transmittal Letter: DHHS Certification Regarding Drug-Free Workplace Requirements

DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

Primary Covered Transactions
45 CFR Part 76,

1. The prospective primary participant certifies to the best of its knowledge and belief that it and its principals:

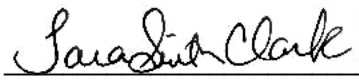
    a. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;
    b. Have not within a three-year period preceding this qualification been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    c. Are not presently indicted for or otherwise criminally or civilly charged by a government entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (1)(b) of this certification; and
    d. Have not within a three-year period preceding this qualification had one or more public transactions (Federal, State or local) terminated for cause or default.

2. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this qualification.

Amerigroup Mississippi, Inc.
Name of Offeror

Tara Clark
Printed name of person attesting for Offeror

President and Chief Executive Officer
Title of person attesting for Offeror


Signature of person attesting for Offeror

3/2/2022
Date

[END OF RESPONSE]

RFQ # 20211210

Technical Qualification (Blind Evaluation)

(Amerigroup Mississippi, Inc.)

Response Deadline: March 4, 2022 2:00 p.m. (CST)

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4.2.1 Executive Summary

4.2.1 Executive Summary

We are pleased to submit this response to the Request for Qualifications for the Mississippi Coordinated Access Network (MississippiCAN) Program and Mississippi Children's Health Insurance Program (CHIP) (RFQ# 20211210).

Our Focus Is Mississippi

We believe that healthcare is local. An informed approach to delivering healthcare services to some of the state's most vulnerable populations requires a Coordinated Care Organization (CCO) comprised of Mississippians, who live and work in the communities they serve. Our local team understand Mississippi's healthcare delivery system and its challenges and is ideally suited to help MississippiCAN and CHIP Members address the local barriers or circumstances that may keep them from accessing the care and services they need. As a future CCO we will focus on the health and wellness of our Members — improving the overall health of Mississippi, one Member at a time.

We stand ready to partner with the Division to implement this next phase of MississippiCAN and CHIP.
We are committed to providing transformative Member, Provider, and community solutions to optimize healthcare delivery in Mississippi. Our solutions will be evidence-based, creative, agile, and forward thinking — driven by our person-centered model of care. We look forward to working with the Division to drive quality improvements, address barriers to access, and facilitate collaborative innovation, providing the highest quality programs and services in the State, including the following initiatives:

Promoting Quality and advancing data-driven, evidence-based practices with an emphasis on improving outcomes:

- Using a Mississippi Performance Improvement Project (PIP) process that will leverage our organization's extensive experience selecting areas of focus and identifying impactful PIPs based on our robust Population Health strategy
- Supporting and empowering Providers with dedicated resources, technical assistance, training, and reporting tools
- Transforming care delivery through Value-Based Purchasing agreements that will tie incentive payments to improved quality performance and incentivize Member engagement and effective care coordination

Maximizing Access by tackling the root causes of health disparities and incentivizing value:

- Assuring Members in rural communities have access to care through collaboration with the Division, Rural Health Association, and rural Providers, including establishment of a quarterly Rural Provider Advisory Council to discuss access shortages and solutions
- Implementing innovative workforce development strategies that contribute directly to the Provider pipeline, including providing support for scholarships and other initiatives that reduce staffing shortages in rural clinics, hospitals, and Community Mental Health Centers (CMHCs)
- Addressing health disparities and Social Determinants of Health (SDOH) by developing specialized staff to tackle Mississippi's greatest challenges

Supporting Collaborative Innovation by simplifying Provider processes and bridging community resources to focus on the well-being of whole communities:

[redacted]

1. Proposed Work Plan

We recognize a key determination of our success is our ability to integrate and collaborate with the Division and other CCOs. We will work closely with the Division, Providers, other CCOs, and partners to tailor our programs, systems, and services to Mississippi's specific needs, concerns, and goals—finding a common path to the best approach while reducing administrative burden. To build our MississippiCAN and CHIP Programs on a strong foundation, our CCO leadership and cross-functional implementation and operational teams will collaborate with the Division, defining clear objectives and managing resources and schedules to assure we control risks and meet timelines.

Time-proven Approach

We are eager to partner with the Division to enhance services for Mississippians. Our approach to creating work plans begins with industry best practices, methodologies, and standards established by the Project Management Institute Project Management Body of Knowledge. We are fully prepared to implement MississippiCAN and CHIP Programs and have developed technology, allocated resources, and begun preparations for post-award program implementation. ***We ask the right questions at the right time to make sure we fully understand requirements and get it right the first time.*** Our work plan and organizational structure will assure we run smoothly and efficiently during implementation and throughout day-to-day operations. Our plan will include a task list, staff responsibilities, timelines, and processes to make sure services begin on the Contract effective date and Members and Providers have an excellent experience with our CCO before and after go-live.

Cross-functional Work Plan Team Led by a Local Project Manager

To build our Medicaid program on a strong foundation, our local Mississippi Project Manager, under the overall guidance and direction of our Chief Executive Officer, will collaborate to achieve successful implementation and manage resources, staffing, schedules, risks, and timelines. Employing a best practice to deploy project management principles across all work plans, we will aggressively address challenges to assure seamless transition for Members and Providers. Table 4.2.1-1 provides a high-level task schedule with major activities to support MississippiCAN and CHIP operations.

Flexible Work Plan and Resolving Issues

Our flexible work plan will allow for changes to the critical path without affecting operations. Our Mississippi leadership team will conduct regular check-in meetings with department leads to monitor progress on deliverables, identify issues that may affect timeliness, and plan resolution. The team will track, review, and report on critical dates to keep all parties informed of progress. Strategies to mitigate risks will include:

- Maintaining open channels of communication with the Division and other stakeholders
- Establishing strong implementation and project management leads
- Using agile system development methodology to incorporate process flexibility
- Fostering a "can-do" attitude within our team — doing whatever it takes in challenging situations to make things happen when we do not have additional time or resources

Culture of Continuous Improvement Drives Innovation

Our organization embraces a corporate culture of continuous improvement, encouraging employees to share ideas, innovations, and evidence-based best practices. We understand that a successful program implementation in Mississippi will require local staff expertise and constant communication with the Division and its contractors. We maintain national support teams comprised of dedicated experts who drive innovation by incorporating lessons learned and best practices from past implementations. For example, as Contract requirements are reviewed, each item will be assessed and flagged as existing functionality or a new development requirement, and we will use this list to establish implementation scope and create the Implementation Plan. This enables our experienced team to identify risks and issues quickly so each implementation project starts with a full understanding of effort.

2. Staff Organizational Structure

We understand that healthcare is personal and must be managed by a local presence, rooted in the community. Our local, Mississippi-based team will fully own program operations and all decisions regarding service delivery and support a Population Health approach to healthcare delivery, with all aspects of our organization aligned with Mississippi Population Health priorities. Local CCO leaders will work closely with Providers, community-based organizations (CBOs), State and local agencies, and other stakeholders to achieve the Division's program objectives. The Organizational Chart in Figure 4.2.1-1 highlights our local staffing model and management structure, which includes clear lines of authority that place a priority on responsiveness, flexibility, and accountability of our local key staff across all areas of operation.

[redacted]

We Are Ready to Serve Mississippians and the Division on Day One of the New Contract

Staff bring our mission, vision, and outcomes to life. Our commitment to making a healthy difference in the lives of Mississippians presents an opportunity to be bold and think big about health — that includes focusing on our staff, who are essential for achieving this. We know employees will be the heart of what we do every day for the Mississippi Members and communities we will serve. We believe in putting people first. From executive leadership to frontline staff, we are committed to every person in Mississippi, as we will be extensions of the communities we will serve. Our diverse team of Mississippi-based leaders and employees will passionately apply their energy and knowledge to address the significant health issues facing residents, focusing on the whole person and helping Members access the services and supports they need.

Our overall Population Health approach drives our efforts to design customized CM programs that prioritize Mississippi's challenges and the Division's goals as well as meet Member needs and improve health literacy. Across our organization and affiliates, we have built strong CM programs backed by highly skilled and trained CM teams — all of whom work together across local communities to reach and engage Members. We will offer similar programs tailored to support the Division's goals and to address Mississippi's challenges, such as the high rates of infant mortality and preterm births, the prevalence of chronic conditions such as diabetes, and health disparities that exist.

We are supported by the deep expertise of our parent company and its national experience in operating Medicaid and similar programs. Leveraging this extensive local and national knowledge, we understand the needs of Members, Providers, and community stakeholders throughout Mississippi and will apply our experience to support the Division's goals in continuing to transform healthcare in Mississippi.

3. Key Personnel

We select the right staff with the right skills and experience for the job. We choose local staff by carefully recruiting the most qualified individuals who understand Mississippi with a strong skill set and background to perform their roles successfully. Our executive leadership team and key personnel consist of individuals who have dedicated their careers to healthcare and government programs, including those in Table 4.2.1-2.

Table 4.2.1-2. Our tailored Staffing Plan and organizational structure positions us to achieve State goals.

Staffing	Description
Chief Executive Officer (CEO)	Our CEO will be fully accountable for all Contract requirements and serve as primary liaison between our CCO and the Division. Our CEO will build strategic partnerships with community organizations, State agencies, Providers, and Mississippi system of care stakeholders. Our CEO will serve as a thought leader at the helm of innovation and impactful changes to maximize MississippiCAN and CHIP Program efficiency and responsiveness.
Chief Operating Officer (COO)	Our COO will lead operations, developing and implementing our strategic vision, goals, objectives, policies, and decision making for MississippiCAN and CHIP Programs. Our COO will have in-depth managed care operations experience and will be responsible for all operations functions, including internal department coordination and collaboration with CCO leaders to create seamless processes between shared services and the CCO.
Chief Financial Officer (CFO)	The CFO will direct CCO preparation of overall budget, forecast, and cost allocation processes. The CFO also directs CCO preparation of annual operating/capital budget and quarterly forecasts to provide senior leadership with tools necessary to maximize investment of resources. The CFO will interact with Division staff to communicate trends and work with the Division on financial reporting.
Medical Director	Our Medical Director will spearhead the CM team, including the Mississippi-licensed Perinatal Health Director and BH Director. The Medical Director will work closely with the division on quality initiatives, aligning goals to execute our Population Health strategy, and sharing best practices and clinical expertise.
Perinatal Health Director	The Perinatal Health Director will serve as a liaison between the CCO and Providers; be available for consultation on referrals, denials, Grievances, and Appeals; review potential quality of care problems, collaborate with the Division on quality initiatives, and participate in the development and implementation of corrective action plans.

Staffing	Description
Behavioral Health (BH) Director	Our BH Director will be board-certified in adult, child/adolescent, and forensic psychiatry and will be responsible for the development and implementation of BH policy through covered services to Members. Additionally, our BH Director will work closely with the Division on BH-related initiatives.
Chief Information Officer (CIO)	The CIO will coordinate and lead multiple teams on initiating, developing, designing, and implementing new change initiatives and acts as a liaison to leverage initiatives and best practices from other areas. The CIO also will lead the identification and development of independent initiatives across the organization.
Compliance Officer	Our local Compliance Officer will have experience and knowledge of MississippiCAN and CHIP regulatory requirements and will serve as the primary point of contact for the Division. Reporting directly to our Mississippi CEO, the Compliance Officer will design and implement the Compliance Plan for Mississippi, along with related policies and procedures to work in tandem with the Program Integrity Unit.
Project Manager	The Project Manager will be responsible for overseeing the implementation of the Contract requirements and will direct and coordinate all activity concerned with implementation across all work streams.

In addition, in Table 4.2.1-3, we include select key personnel who will support our Population Health model and deliver the locally driven, person-centered model of care at the center of our overall program.

[redacted]

4. We Know Mississippi and Its MississippiCAN and CHIP Programs

We will have a CCO leadership team steeped in local Mississippi healthcare knowledge and experience. Our CCO leaders will understand the nuances of the delivery systems across the state, the community organizations that serve MississippiCAN and CHIP Members, and the disparities and barriers those Members face.

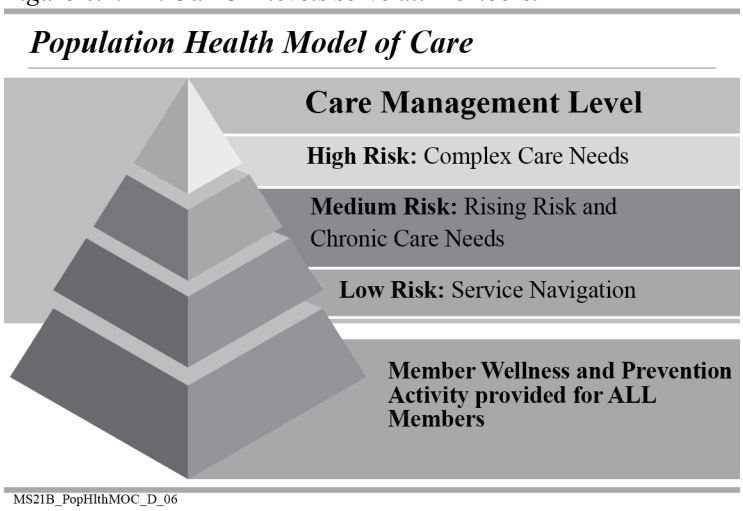
Summary of Our Proposed Approach

Our service to Members, Providers, and State partners informs our approach to everything we do and shapes our fundamental belief in the power of integrated support and healthy communities. Our Population Health management approach focuses on improving outcomes for Members and fostering healthier, more resilient communities across Mississippi, as shown in Figure 4.2.1-2. Through this model, we will support comprehensive, fully integrated, and person-centered CM to address Members' physical health (PH), BH, and SDOH needs. Our evidence-based model is compliant with NCQA's quality framework and will be ***adapted specifically with Mississippi's healthcare landscape and challenges in mind to focus our resources and programs on the unique needs of MississippiCAN and CHIP Members***.

Data-driven Population Health Approach Aligned with the Division's Goals

Our Population Health program will engage all Members in wellness and prevention activities. We will identify and prioritize specific populations and conditions for outreach and special programs using our Mississippi-based Population Health approach. [redacted]

Figure 4.2.1-2. Our CM levels serve all Members.



[redacted]

In addition to statewide priorities, we will use regional data to strengthen CM protocols in specific regional areas. For example, knowledge that certain regions, such as the Delta, have higher rates of diabetes, frequent mental distress, and higher blood pressure than the state average, will inform our CM outreach and chronic care engagement for these areas. In addition to reviewing national comparisons and state-level health and disparity data, we will organize stakeholder meetings and interviews in communities in Mississippi's Northern, Central, and Southern regions, including the Delta, to identify local challenges, barriers to care, and wellness goals and explore available community services. We will use analysis to understand root causes of disparity, inform our CM interventions and special programs, and support priority regions, subpopulations, and partnerships. For example, racial and geographic health disparities are particularly pronounced among Black Members and those in the Delta. We will partner with an outreach center in this area to provide access for Members to local health education, exercise classes, and prevention and self-management support for chronic conditions. When possible, we will align CM team staff with Members' same race or language and partner with Doulas to provide culturally competent care for Members when pregnant.

Our Population Health Approach Informs All CCO Operations and Focuses on Health Equity

With a focus on health equity and SDOH, our Population Health priorities influence and inform every aspect of how we will coordinate care for Members, including:

- Identifying SDOH and addressing barriers to access
- Delivering a comprehensive Provider Network
- Supporting Provider partners
- Providing Member-centered CM

Identifying SDOH and Addressing Barriers to Access

For the MississippiCAN and CHIP Programs, ***we will take an integrated, person-centered approach to healthcare that includes identifying and addressing the unmet social needs of our Members and their communities***. Our understanding of the greatest SDOH challenges that MississippiCAN and CHIP populations currently face is informed by research, as well as on-the-ground engagement with CBOs and social services organizations. Through this thorough investigation, we have identified the greatest needs as economic, environmental, food security, and educational. We outline our approach to address these in Table 4.2.1-5. We will address these top four challenges upon Division review and approval of our proposed SDOH initiatives and will help address the individual and specific SDOH challenges unique to each Member as well.

To make sure that our SDOH programs and initiatives address health equity among Mississippians, our Quality Management Committee will continuously review SDOH outcomes compared to local demographics and disparities using our comprehensive data analytics capabilities. Our analytics systems integrate data from external software, which expands race, ethnicity, and language projection capabilities and delivers twice the accuracy of the standard Demographics Predictive Model Report methodology. This robust data set will allow us to identify the needs of Mississippi Members using external context to pinpoint health equity and SDOH needs and map them so factors can be visualized at the county level. Maps can be easily filtered by county, Member demographics, and HEDIS® compliance status. Our HEAC will also be responsible for informing and evaluating the outcomes of our SDOH programming.

Delivering a Comprehensive Provider Network

Our established and comprehensive network development process is foundational to building and maintaining an extensive network of experienced primary and specialty care Providers to deliver the full array of MississippiCAN and CHIP services. Using the goals of the Division as our guide, we are focused on developing an adequate network of high performing, engaged Providers, and will prioritize the recruitment of key health systems, Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs), and other high-volume or high-priority Provider types. To build a Mississippi network that will provide timely access to care for all covered services for MississippiCAN and CHIP Members, we will leverage our organizations extensive experience developing and maintaining Medicaid Provider networks that exceed access and availability requirements and use insights gained from collaborating with Providers, Provider associations, community leaders, and advocacy groups; and listening to Mississippi residents and their families from the Delta to the Coast describe the challenges they face as they maneuver the healthcare system.

Supporting Our Provider Partners

Understanding challenges that exist in the Provider community today, our approach to building and maintaining a comprehensive network will be grounded in our commitment to superior Provider support. We believe our Provider Experience model is "Best in Class." Our local Provider Experience team will support Providers with ongoing education and training and resolve operational issues or concerns. Upon joining our network, every Provider will be assigned to a local Provider Experience Consultant located in their region, with dedicated representatives assigned to more complex Provider types, including a CMHC and FQHC/RHC representative. Specialized representatives will receive in-depth training on unique billing requirements and historical challenges experienced by these Providers.

Providing Member-centered CM

Providing the best possible care for Members is at the core of everything we do. We have designed our CM strategy to identify and address the unique needs of Medicaid and CHIP Members in Mississippi. Focusing on Mississippi's challenges and the Division's priorities and expectations, our comprehensive array of CM programs will meet Members' needs throughout the risk continuum and address Population Health and health equity concerns. Our Mississippi-based CM team will be comprised of: Care Managers (Nurses, Licensed Professional Counselors, Licensed Marriage and Family Therapists, and Master level Social Workers) with expertise in PH, BH, obstetrics, pediatrics, and knowledge of American Indian communities; Care Management Navigators who may be certified Peer Support Specialists, Doulas, or Health Educators; and Community Health Workers, who will link Members, particularly those who may be harder to reach, to needed services and social supports.

As Mississippi looks to the future, we are excited to support the Division's goals as a partner, collaborator, and innovator. We stand ready to prove why we want to serve Mississippians: because working to make a difference in people's lives is an honor and a privilege.

Identifying Information. To comply with the Identifying Information requirements defined in Section 1.2.3.3 of the RFQ and subsequent amendments, we removed names of federal and state agencies, Providers, and other stakeholders from our response, except where expressly permitted by the Division. If this information is needed to validate our proposed solutions or evaluate our response, we will be ready to provide it to the Division.

[END OF RESPONSE]

4.2.2 Methodology/Work Statement

4.2.2.1: Member Services and Benefits

A.1 Children

a. Ensuring All Children Receive Timely, Robust Developmental Screening and Early Intervention

We share the State's commitment to making sure children receive timely and robust developmental screenings and early intervention. Mississippi ranked 34th of 50 states for completion of developmental screenings in 2021 and 49th in the rate of Well-Child visits, but has achieved success in immunizing children, ranking 11th for childhood immunizations. We will build on this success by working collaboratively with the Division and other Coordinated Care Organization (CCOs) to implement a data-driven, evidence-based approach that includes child/family- and Provider-focused activities proven effective in improving completion of developmental screenings and connecting children to necessary services.

One of our affiliates identified low developmental screening rates during data analysis and significantly improved their rates by delivering more than 40 Provider trainings on standardized developmental screening tools, billing and coding guidelines, and early intervention programs. The affiliate provided Member developmental screening gap reports to Providers for targeted outreach, delivered educational materials and texts to parents on the importance of developmental screenings, reviewed a random sample of charts to validate adherence to billing and coding guidelines, and collaborated with early intervention programs and Providers to facilitate referrals to these programs. We will implement this type of multifaceted approach in Mississippi and expect to achieve comparable results.

Affiliate Improves Developmental Screening Rates

- **19.92** percentage points - one year olds
- **20.91** percentage points - two year olds
- **17.68** percentage points - three year olds

(MY 2020-2021)

MS21B_DevelopmentalScreeningRates_C_09

(i) Approach to Assure MississippiCAN Members Receive EPSDT Services and Immunizations

We will assure Members have access to MississippiCAN EPSDT services in accordance with the Mississippi Administrative Code, the State Plan, communication from the Division, and the Contract. We will also comply with relevant sections of the Social Security Act and federal regulations and CMS reporting requirements.

We will contract with all qualified EPSDT Providers and use the Division's monthly list of qualified EPSDT Providers to identify and then recruit newly identified EPSDT Providers for our network. Our dental/vision partner will conduct periodic dental and vision examinations of children and adolescents and provide timely access to needed services through our local Providers. They will also provide a monthly report of systemic and chronic medical conditions found during a child's vision exam, which we will share with the child's PCP/Patient-Centered Medical Home (PCMH) and our Care Management (CM) team for coordination of care. We will also increase access to timely care through innovations and partnerships described throughout this section, such as telehealth services, e-consults between PCPs/PCMHs and specialists, and provision of in-home services to close care gaps and meet urgent needs.

1. Overview of Related Policies, Procedures, and Processes

We will develop processes, policies, and procedures, drawing on our parent company's experience, that will assure MississippiCAN children and youth access and receive timely examinations and developmental screenings, including periodic examinations for vision, dental, and hearing services, mental health, substance use disorder (SUD), and other necessary services, including early intervention services. We will use Advisory Committee on Immunization Practices (ACIP) and American Academy of Pediatrics (AAP) guidelines to develop comprehensive policies and procedures for EPSDT service delivery. ***Our local EPSDT Coordinator*** will oversee our comprehensive and cross-functional approach for MississippiCAN and CHIP under the direction of our Quality Management (QM) Director, with guidance from Division staff in accordance with the Contract. We will provide our EPSDT policies and procedures to the Division for review and approval and adjust and collaborate on updates and changes from the Division, including if the Division revises the Contract

or adopts a centralized dental administrator. Figure 4.2.2.1.A.1-1 summarizes our approach for MississippiCAN Members and their families, which is informed by evidence-based practices and our affiliates' experience.

We will assure completion of initial visits for newborns, EPSDT screenings and reporting of screening results, and diagnosis, treatment, and referral. Our parent company's ***tracking system*** will support collection of information on compliance with EPSDT requirements through ongoing review of medical records, claims and encounter data, which we will evaluate through ***continuous data tracking, outcomes analysis, intervention, and outcome monitoring and reporting***. Our local QM Director will oversee our data-driven quality improvement approach that will leverage the Continued Quality Improvement (CQI) process to evaluate our Member- and Provider-focused EPSDT activities. We will evaluate our quality data, membership, service utilization patterns, and year-over-year performance measures to identify, implement, or adjust interventions.

2. Encouraging Members to Obtain Services

Our approach to encouraging Members to obtain needed services will begin with Member/family education and includes an array of outreach and engagement strategies, including personalized support from our CM team of local Community Health Workers (CHWs) and Care Management Navigators (CMNs) who share the Member's cultural and ethnic background when possible. We will communicate with local country health agencies and the Mississippi Department of Child Protection Services. We will work with the agencies and families to assure children access these screenings and services and document this in our Care Management Platform (CMP). Table 4.2.2.1.A.1-1 summarizes methods we will use to encourage Members and their families to obtain services.

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Provider Outreach, Education, and Support. Figure 4.2.2.1.A.1-2 summarizes how we will support Providers' critical role in delivering preventive care education, Well-Child Care, immunizations, developmental screenings, and referral to needed services to Members.

[redacted]

[redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

[redacted]	[redacted]

3. How Our Approach Will Improve Health Outcomes

We are confident our proposed Mississippi approach will lead to the same types of improvement in children's health outcomes as experienced by our affiliates. Table 4.2.2.1.A.1-3 provides examples of improved health outcomes as well as increases in EPSDT screening rates among affiliate plans.

Table 4.2.2.1.A.1-3. Our affiliates achieved improved health outcomes and EPSDT screening rates.

Focus	Success
Improved Immunizations for Adolescents	• Through Member outreach and curbside immunization events, one affiliate increased Immunizations for Adolescents – Human Papilloma Virus by 15.4%
Improve Depression Management	• In one affiliate, children and adolescents with major depressive disorder engaged in condition management programs experienced a 29.81% decline in emergency room (ER) visits. In a second affiliate, children and adolescents experienced a 51% decline in hospitalizations from 2018 to 2019.
Reduce Inappropriate Medication Use	• Through our parent company's medication management program, inappropriate psychotropic medication use was discontinued among 70% of children prescribed these medications in one affiliate. In a second affiliate, stimulant medications were reduced 35% among children younger than six years of age.
Increase EPSDT Screenings	• Screenings increased 7% in a single year (2020) through an affiliate's combination of a calling and texting campaign to families with children overdue for EPSDT visits, an increased Member EPSDT incentive, a new immunization incentive, and arranging access to transportation. • Screenings increased 20.31% between 2015 and 2020 using the same types of Member and Provider interventions described in this section. We propose to use these interventions for Mississippi.

4. The Process for Reminders and Follow-ups

Our process for reminders and follow-ups (summarized in Table 4.2.2.1.A.1-4) will include live calls, text messages, and mailings to parents (or young adult Members), supplemented by home visits from our CM team and in-home Provider visits, all designed to make it as easy as possible for Members to receive needed screenings, immunizations, and services.

Table 4.2.2.1.A.1-4. We will implement multiple supports to promote Members' screenings, immunizations, and access to services.

Approach	Description
Age-specific and Culturally Tailored Care Reminders	• We will deliver age-specific, culturally tailored care reminders and preventive care education through live calls, texting, Member newsletters, birthday post cards, and emails. • Upon logging in to our Member Portal, Members/families will receive targeted messages advising them of care gaps and reminding them to schedule an appointment with their Provider. • We will also implement targeted texting and calling campaigns to encourage parents' active participation in their child's care and offer assistance in closing care gaps. ***An affiliate closed 150 care gaps using a one-week, targeted calling campaign in March 2020.***
Child/Family Engagement	• Our local CM team will conduct home visits for Members with overdue screenings and immunizations, coordinate healthcare appointments, and refer families unable to take a child for a screening or immunization to a Provider for an in-home visit.

5. Informing Families/Members of Cost Sharing

We will make sure families are aware that ***we will not require cost sharing for any Medicaid services*** and are not permitted to require cost sharing for family planning or pregnancy-related assistance or for services furnished by an Indian Health Care Provider, in compliance with Contract Section 6.2.10.5. We will include this information in our Member materials and text messages and review this with Members/families during new Member welcome calls and interaction with our CM team. We will inform all Member-facing CCO staff and Providers of these requirements and of the assistance available to assist Members and families with issues regarding prohibited cost sharing through the Member services call center and our CM team.

6. Innovative Methods That Will Augment Our Approach

We will promote Members' timely access to required services, including dental services and BH/SUD services, through innovative partnerships and technology-enabled options and partnerships, described in Table 4.2.2.1.A.1-5.

[redacted]

(ii) Approach to Assure CHIP Members Receive Well-Child Visits and Immunizations, and Other Services in the CHIP State Health Plan

We share the Division's commitment to making sure all children receive timely and robust developmental screenings and early intervention, and our approach for CHIP Members will mirror our proposed approach for MississippiCAN Members, with a few modifications. We are fully committed to assuring that CHIP Members who are not eligible for Non-Emergency Transportation (NET) services are supported and assisted to navigate public transit and other transportation services. While the Mississippi Youth Programs Around the Clock (MYPAC) and Community Support programs are not CHIP-covered benefits, Members are eligible for a full range of mental health (MH) and SUD benefits, all of which will be coordinated by our CM team.

Because CHIP coverage ends when a Member is 19 years of age, our CM team will begin early and proactive transition planning with the youth and their family to assist with transition to another source of coverage, such as employment with benefits, continuing education with coverage through their parent's insurance, or other available options. We will also assist CHIP Members transitioning to the MississippiCAN eligibility category for any reason (including pregnancy) or who the Division informs us will be disenrolled, coordinating care with new Providers or resources. We will provide additional service navigation assistance to assure families' understanding of and success in accessing the covered services, Value-Adds, and services from other sources available to their child.

We will assure CHIP Members receive timely services, periodic health screenings, and appropriate and up-to-date immunizations in accordance with Title XXI of the Act, 42 C.F.R. § 457 Subpart A, the Mississippi CHIP State Health Plan, and the Division's policies, rules, and regulations, the Contract, and written communications. We will assure Members have access to covered services in compliance with Contract Section 4.2. We will recruit and contract with all qualified PCPs/PCMHs and offer an additional reimbursement amount to Providers for delivery of in-home services. Our dental/vision partner will conduct periodic dental and vision examinations of children and adolescents and provide timely access to needed services through our local Providers. They will also provide a monthly report of systemic and chronic medical conditions found during a child's vision exam, which we will share with the child's PCP/PCMH and CM team for coordination of care.

Affiliate Success

Our affiliate met the **66th NCQA National Benchmark** for CHIP (MY 2020) for:

- Well-Child Visits in the First 30 Months of Life
- Child and Adolescent Well-Care Visits 18-21
- Asthma Medication Ratio 18-21
- Follow-Up Care for Children Prescribed ADHD Medication

MS21B_66NCQANational_C_06

1. Overview of Related Policies, Procedures, and Processes

We will develop policies and procedures, drawing on the experience of our parent company and its affiliates, that describe how we will assure CHIP-covered children and youth will access and receive Well-Baby and Well-Child care services and periodic health screenings, including vision screening, laboratory tests, and hearing screenings, according to the recommendations of the U.S. Preventive Services Task Force, as well as MH and SUD and other needed screenings. We will also describe how we will assure provision of appropriate and up-to-date immunization receipt using the schedule recommended by the ACIP. Our ***Mississippi EPSDT Coordinator*** will oversee our comprehensive and cross-functional approach for CHIP (and MississippiCAN) under the direction of our QM Director, with guidance from Division staff in accordance with Contract Section 1.13.2.7. We will provide our CHIP Well-Baby, Well-Child Care, immunization services, and other related policies and procedures to the Division for review and approval. We will also adjust and collaborate in every way necessary with updates and changes from the Division, including if the Division revises the Contract or adopts a centralized dental administrator. Figure 4.2.2.1.A.1-3 summarizes our approach for children and their families (and Figure 4.2.2.1.A.1-4, our approach for Providers).

We will assure completion and reporting of screening results, and diagnosis, treatment, and referral. Our parent company's ***tracking system*** will collect information on compliance with Well-Baby and Well-Child care services, immunizations, and other items in the CMS Child Core Set and HEDIS measurement set relevant to children and adolescents under age 19. We will continuously track data, complete outcomes analyses, assess and adjust interventions, and complete outcome monitoring and reporting through ongoing review of claims and encounter data in compliance with Contract Section 4.2.3. Our local QM Director will oversee our data-driven quality improvement approach that will leverage the CQI process to evaluate our Member and Provider-focused activities. We will evaluate our quality data, membership and its characteristics, service use patterns, and year-over-year performance measures to identify, implement, or adjust interventions.

2. Encouraging Members to Obtain Services

We recognize families face many challenges in making sure their children complete timely screenings and preventive care. Our approach to encouraging children/families to obtain these important services begins with Member/family education and includes an array of outreach and engagement strategies, including personalized support, summarized in Table 4.2.2.1.A.1-6.

Provider Outreach, Education, and Support. We will support Providers' critical role in delivering preventive care education and services and connecting families to needed services through our approach summarized in Figure 4.2.2.1.A.1-4.

Our proposed Provider-focused initiatives are designed to promote Providers' completion of age-appropriate screenings, evaluations for further diagnosis, and referrals for Members needing additional treatment and services. As described previously in Table 4.2.2.1.A.1-2, and summarized next, these will include:

- Member panel care gap analytics and reporting and proactive distribution of monthly gap in care reports.
- PCP/PCMH engagement in VBP programs that reward Providers for achieving specified improvements child and adolescent screenings, immunizations, and service delivery.
- Assistance with screenings and Member appreciation days — we will help schedule Members during a designated appointment window who are due (or overdue) for screenings and immunizations.
- Provider education on Well-Baby, Well-Child Care services, including vision screenings, laboratory tests, and hearing screenings as recommended by the U.S. Preventive Services Task Force, and on the immunization schedule recommended by the ACIP. Our EPSDT Toolkit includes CHIP-specific requirements and will be available via the Provider website and discussed with Provider Experience team.

3. How Our Approach Will Improve Health Outcomes

We are confident our proposed Mississippi approach will lead to the same types of improvement in children's health outcomes as experienced by our affiliates for their Medicaid Members. (Please refer to Table 4.2.2.1.A.1-3 for improvement examples.)

4. The Process for Reminders and Follow-Ups

Our process for reminders and follow-ups (summarized previously in Table 4.2.2.1.A.1-4) will include age-specific, culturally tailored care reminders and preventive care education through live calls, texting, Member newsletters, birthday post cards, and emails. We will also deliver a care gap notification and appointment reminder when a Member/parent logs on to the Member Portal with information about access to online appointment scheduling with Providers. We will periodically implement texting campaigns and live calls to close care gaps by helping families schedule appointments, arranging home visits by our CM team to assist with care gap closure, and coordinating Provider in-home visits.

5. Informing Families/Members of Cost Sharing

We will make sure families are aware ***we will not require cost sharing for any CHIP services unless required by the State*** and may not require cost sharing for family planning or pregnancy-related assistance and services for Native Americans or Alaskan Natives in accordance with Contract Section 4.2.10. We will assure all Member-facing CCO staff and Providers are informed of these requirements. Members may contact the Member services call center or speak with the CM team to address issues regarding prohibited cost sharing. If copayments specified in Contract Section 4.2.10 are deemed required by the Division, we will educate families and Providers on these co-payment requirements and educate Providers and their staff about their responsibility to collect them.

6. Innovative Methods That Will Augment Our Approach

We will promote Members' timely access to required services, including innovative partnerships and technology-enabled options, described previously in Table 4.2.2.1.A.1-5 and summarized here in Table 4.2.2.1.A.1-7.

Table 4.2.2.1.A.1-7. Partnerships and technology-enabled services will promote access to care.

Initiative	Description
Pediatric and Dental Collaboration Will Promote Improved Child Health	• We will encourage pediatricians to use an oral health assessment tool to identify children's dental needs and a referral guide to understand when and how to refer a child to a dental Provider and engage interested FQHC Providers in delivering integrated medical and dental care to our Members in a single visit.
Innovative Health Literacy Intervention for Primary Care Practices	• We will promote and help fund an early literacy organization that delivers an evidence-based early literacy intervention for primary care settings during wellness visits with children between six months and five years of age, an approach demonstrated to be effective in increasing completion of wellness and immunization services.
Technology-enabled Services Will Provide Convenient Access to Services	• We will offer an array of telehealth options described in Section 4.2.3.7. PCPs/PCMHs will be able to consult with licensed and board-certified physicians in over 150 specialties to quickly address a child's or youth's needs identified through the developmental screening.
Mobile Dental Partnerships	• Our dental partner will contract with dental Providers who participate in health access and prevention programs at schools and use mobile dental units, including FQHC dental units, to deliver preventive dental care
[redacted]	[redacted]

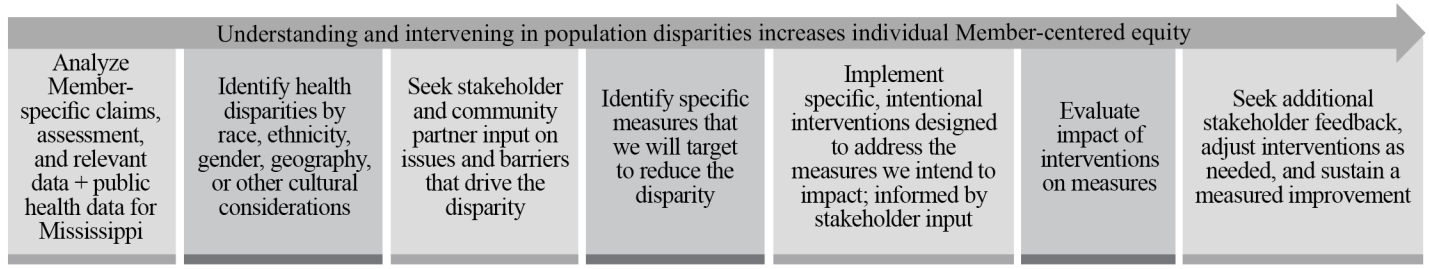
b. Approach to Addressing Racial, Ethnic, and Geographic Disparities Among Children

We are dedicated to eliminating health disparities and advancing health equity in Mississippi. Our approach to addressing racial, ethnic, and geographic disparities will be methodical, local, and data-driven. We will use the framework depicted in Figure 4.2.2.1.A.1-5 to identify gaps in services and health outcomes among MississippiCAN and CHIP-eligible children, implement solutions, and evaluate and refine our strategies.

To address disparities among children, we will analyze publicly available data sets from federal and state agencies, research organizations, and other sources, along with claims data, HEDIS data sets, screenings and assessments, and findings from stakeholder engagement to provide insight into Members' and communities' cultural and health needs. ***Our approach will include a full analysis and focus on the disparities that exist for***

children and youth ages birth to 21 in Mississippi. For example, to identify gaps we will use specific maternal and infant measures stratified by race and ethnicity, such as Prenatal and Postpartum Care and Well-Child Visits.

Figure 4.2.2.1.A.1-5. We will leverage our parent company's proven health equity framework to address disparities.



Our Population Health Director, QM Director, and Perinatal Health Director will oversee our approach locally, working with other CCO clinical and Provider services leadership (with ultimate accountability to our CEO) and the Division. [redacted] Each proposed intervention will be managed locally, with a specific owner responsible for its development, execution, and evaluation.

From our initial analysis, we know that Mississippi's American Indian teen pregnancy rate is nearly twice the national average (among teens age 15 to 19). Additionally, Black and Hispanic teens exhibit a significantly higher teen pregnancy rate (40 births per 1,000) than their White peers (28 births per 1,000). Many counties in the Delta demonstrate rates between 50 and 60 births per 1,000. To identify disparities and determine root causes, we will collaborate with key stakeholders on interventions at the CCO, Provider, and community (county and zip code) level. We will continue to collect and analyze data to evaluate focused interventions and metrics aimed to reduce identified disparities and adjust where indicated.

Based on the disparities identified, we will focus interventions and measurable outcomes in areas that include Care Management engagement rate for pregnant teens from the Choctaw Tribe and Black or Hispanic teens. We will also measure prenatal and postpartum visits in the Delta and birth weight for babies born to these teen mothers. Table 4.2.2.1.A.1-8 provides examples of our customized interventions to reduce health disparities for American Indian, Black, and Hispanic teen mothers, with a focus on the Delta.

Table 4.2.2.1.A.1-8. Our interventions will help promote health equity among Mississippi's teens.

Interventions	
Distribute Member panels with ***race and ethnicity data to Providers and have a dedicated OB Practice Consultant to focus on disparities***.	***Community Health Workers with Tribal experience*** will engage American Indian Members to inform them in a culturally appropriate way.
Refer ***Choctaw, Black, and Hispanic teen mothers to safe sleep/home visiting programs*** and other community resources.	***Expand capacity of an evidence-based group prenatal care model*** in the Delta with a focus on teen pregnancy.
Health Literacy Campaigns for maternal health including digital literacy with tailored cultural and linguistic elements.	Community events in the Delta area that are tailored to Members to include ***Baby Showers in collaboration with CBOs***.

Once interventions are implemented, we will continue to evaluate and determine impact though data collection and analysis, Provider feedback, incentive utilization, and CM engagement with a focus on our disparity targets. As we identify both successes and opportunities for improvement, we will share data on our performance with our HEAC, Member Advisory Committee, CBOs, Providers, and other stakeholders through roundtable

discussions. This information will be aggregated, evaluated, and reported up through our Population Health Council and Quality Management Committee (QMC) for necessary adjustments to improve and sustain our health equity performance.

A.2 Behavioral Health Services

We will offer the Division a well-designed BH program rooted in whole person care that incorporates the principles of trauma-informed care, recovery, and resiliency. We will provide BH/SUD services to our MississippiCAN and CHIP Members in accordance with all federal, State, and Contract requirements. This includes relevant Codes of Federal Regulation, the Mental Health Parity and Addiction Equity Act (MHPAEA), the SUD Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 (SUPPORT Act), and the Mississippi Administrative Code.

We are dedicated to helping our Members — children, adolescents, and adults — receive timely access to the services and supports they need. Through our model, we will deliver a person-centered experience that is culturally and linguistically responsive, supports Members in working toward their goals, and empowers their independence and dignity. We know the importance of forming collaborative relationships across system stakeholders, including the Division and other CCOs, to expand Provider offerings and capacity to support the delivery of BH across the State. Our local Mississippi team, led by our BH Director, will routinely hold Joint Operating Committees (JOCs) with Providers, CBOs, and stakeholders to solicit feedback, address challenges, and bring innovation that improves access for youth and adults.

a. Experience Providing Pediatric and Adolescent Behavioral Health/Substance Use Disorder Service Delivery, Payment and Compliance with the SUPPORT Act

Across our parent organization and affiliates, we have more than two decades direct experience overseeing delivery and payment of BH/SUD services for pediatric and adolescent populations. This includes children with specialized health care needs (SHCNs); TANF; CHIP; children, youth, and young adults involved with foster care and juvenile justice.

We have developed specific CM programs to enhance the services and supports children and adolescents receive. For example, through focused and collaborative CM and Provider interventions for Members in Psychiatric Residential Treatment Facilities (PRTFs), an affiliate's efforts have ***reduced the number of bed days by 18% and average length of stay by 9% over the previous year***. Through this experience, we have refined our BH/SUD service delivery model to focus on working with Members and their families to simplify how they access and engage the system of care to promote stability and normalcy. Table 4.2.2.1.A.2-1 highlights the best practices from our affiliates' experience we will customize for Mississippi.

Our Child and Adolescent BH/ SUD Experience

Experience in child and adolescent BH/SUD services in multiple markets includes:

- Members with serious emotional disturbance (SED)
- Members in the child welfare and juvenile justice system
- Members with autism

MS21B_BHSUDOutcomes_Child_C_04

Payment Experience

In providing BH/SUD services over the last two decades, our affiliates have also refined their payment models to help promote the delivery of quality care. For example, payment models include VBP programs for ABA and Provider incentives for completing tasks like ACEs screenings, closing gaps for HEDIS measures, and first-line psychosocial care for children and adolescents on antipsychotics. Our payment experience also includes incentivizing PRTF for providing quality care and services to our children and youth. Our national teams and systems have been configured and customized for each state and build on an integrated system so that one affiliate can leverage capabilities and share best practices with another.

Experience Complying with the SUPPORT Act

Together with our affiliates and parent company, we have experience complying with the SUPPORT Act since it was established in 2018. For example, our affiliates have used programming for infants at risk of NAS to incent Providers to implement a standardized screening and treatment protocol. We have also used data from Pharmacy Benefits Administrator (PBA) programs in affiliate markets to identify and address potential opioid misuse to comply with the SUPPORT Act, as seen in Table 4.2.2.1.A.2-2.

[redacted]	[redacted]

b. Experience Providing Adult Behavioral Health/Substance Use Disorder Service Delivery, Payment, and Compliance with the SUPPORT Act

Through our affiliates, we also have more than two decades of experience providing adult BH/SUD service delivery and payment experience that is rooted in bringing together a whole person program and integrated best practices. We have coordinated the delivery of BH/SUD services and supports that are localized, and proactively identified and improved health outcomes. We have experience carving in 1115 waiver expansion services such as the continuum of care for SUD, wraparound community supports, and partnering with CMHCs for innovative solutions and care delivery. We also have supported access to care and building supports by expanding specialty Providers and bringing in telehealth offerings. Some examples from our affiliates, building on those in Table 4.2.2.1.a.2-1, include:

- **SUD Community-based Care Management Outreach and Engagement.** Leveraging a predictive algorithm that is designed to identify those Members who are at critical risk of developing an alcohol or opioid negative health outcome, field-based CMs engage with Members. They address BH, SUD, physical health (PH), SDOH, and health literacy needs by working with the Member and Provider community. This program is in many affiliate markets with ***over a 60% engagement rate***.
- **Transition of Care for Individuals Leaving or Recently Discharged from an Institution for Mental Diseases (IMD).** Providing Transition of Care planning for successful treatment planning, discharge support, and fostering a collaborative relationship with residential treatment Providers, in compliance with our state partner's policy regarding IMD monitoring.

Payment Experience

We will refine our payment processes to optimize accuracy, timeliness, and satisfaction, so that our Providers can focus on delivering the best care to our Members. [redacted]

Compliance with the SUPPORT Act

Since the SUPPORT Act's inception, our affiliates have had experience complying with all related requirements; we will leverage this experience for our CCO. Organizationally, our affiliates have invested in tracking opioid prescribing; expanding access to Naloxone; encouraging Providers to offer and expand Medication-Assisted Treatment (MAT); proactively engaging women of childbearing age and pregnant women in opioid-related harm reduction; addressing health disparities that may lead to opioid misuse; and assuring that all services are delivered through a health equity lens. [redacted] Using data from the PBA,

in addition to programs discussed in Subsection a, adult focused programs from our affiliate markets that comply with the SUPPORT Act include:

- **Controlled Substance Prescription Monitoring.** Identifies Members, aged 18 and over, at risk of SUD or other harm, whether receiving multiple controlled substance medications and/or at high dosages, filling opioid prescriptions from multiple Providers/pharmacies, or receiving certain combinations of controlled substances. This program also monitors Members receiving MAT to assure compliance with therapy and follow-up.
- **Opioid Prescriber Monitoring.** The report summarizing Providers' opioid prescribing practices compares prescribers to peers in their specialty practice areas. The information is provided to prescribers in the form of a report card to educate them on their prescribing patterns and offers Providers multimodal support to reduce the opportunities for opioid misuse and abuse among their Members. We can also leverage this report to identify potential fraud and abuse of controlled substances by prescribers.

c. Approach to Delivery and Payment for Behavioral Health/Substance Use Disorder Services

We will use a comprehensive, integrated approach with our assessment tools, training, and systems to provide services that Members need to meet their goals and help them address SDOH and other barriers to health such as stable housing, educational attainment, and employment. Members will also be supported by a 24/7/365 BH/SUD line.

Our local BH Director will oversee the delivery and quality of BH/SUD services to our MississippiCAN and CHIP Members. This includes serving as liaison for Providers by providing consultation and addressing quality of care concerns, supporting CCO leadership and staff on a daily basis regarding Member care, and serving on required quality committees as needed. Our BH Director will lead our staff of specially trained clinical and non-licensed employees in BH and SUD as part of our CM team. These local staff understand the challenges impacting Mississippi and will bring firsthand experience that spans the age and disease continuums, including working with Members who have a SMI or SED, as well as SUD.

We will align each Member with a Care Manager who most closely meets their primary need and works closely with our Members, regardless of risk level, to address all their needs and goals cohesively. ***Our integrated care model is also supported by our CMP, which enables data sharing, interoperability, and full visibility of the clinical record for all medical and BH clinical review and CM activities.***

We will also build special programs for specific subpopulations for whom we have identified a need for additional CM services. Through these specialized CM programs, we will improve Member identification and engagement and uncover opportunities to improve health outcomes and patient safety, such as reducing avoidable admissions, readmissions, and low-acuity ER visits. Our team will use data and monitoring to timely engage with Members and Providers when there is a change in the Member's BH needs. Our BH approach is local, customized, and evidence-based with key components that include:

- **Comprehensive CM Services.** We will provide a continuum of supports for prevention and health education, connection to a PCP/PCMH, and interventions in support of the Member's treatment plan. This includes attention to SDOH and linkage to community resources, and specialized programs for Members with emerging risk, chronic conditions, or complex BH/SUD needs. Our CM team will complete the Comprehensive Health Assessment for Members identified as potentially having medium or high risk.

  For Members that have experienced a crisis, our CM team will increase the frequency and/or intensity of interventions in the Member's treatment plan to help transition them back to the community, with supports and services to prevent a subsequent crisis. A Care Manager may conduct an in-person visit with the Member at the inpatient setting through partnerships with large

hospitals, or they may visit with Providers, family members, or others involved in the Member's care with appropriate consents. As described more fully in Section 4.2.2.1.B, Members will also be supported by our 24-hour BH/SUD line and 24-hour nurse advice line.

- **Integrated Rounds.** Through integrated rounds, our clinical staff will meet with our Medical Director, BH Director, and Perinatal Health Director to consult on Members with comorbid conditions, including those who are currently inpatient or with the most complex BH cases. This collaborative approach provides the team with an opportunity to develop innovative strategies to determine the best path to support a Member and remove barriers. At least weekly, we will hold rounds with BH and PH Providers where Care Managers present cases and seek guidance from our medical and BH doctors on staff.
- **Integrated Care Management Platform.** Our CMP leverages predictive modeling capabilities to identify Members with the highest risk levels, so we can begin proactively coordinating the services and supports they need to achieve optimal outcomes. It also enables data sharing by housing all physical and BH information in an individual electronic record for each Member. Our clinical staff will have a complete view of all claims and utilization history, assessments (including SDOH), medication history, and treatment plans to make informed clinical decisions. We will also connect to Providers who are on aligned electronic medical record (EMR) systems to integrate the information sharing and improve clinical insight when supporting Members accessing care.
- **Integrated Training.** Our CM team staff will receive extensive cross-training in physical and BH, trauma-informed care, ACEs, suicide prevention, substance use recovery and resiliency, person-centered planning, and motivational interviewing to build trust and rapport with Members as they support them in their health journey.
- **Provider Network Enhancements.** We will work with local Providers to offer targeted interventions, such as crisis intervention, crisis stabilization, psychosocial rehabilitation, and therapeutic behavioral on-site services to reduce admissions and readmission. We will hold JOCs with hospital systems and CMHCs to develop processes that ease Provider administrative burden and increase support. Further, we will work with the Division, State agencies, Providers, academic institutions, and other CCOs to enhance existing telehealth capabilities across Mississippi, particularly in rural areas.

Our approach incorporates regular monitoring and evaluation of our processes, systems, and structure to help assure the integration of PH and BH care. This involves systematically tracking PH and BH outcomes to bring the best programs and services to Mississippi and reviewing data to identify trends and opportunities to refine our programs so that we maximize outcomes. We will collect and review data including:

- Quality improvement data and key performance indicators
- HEDIS data (including depression screening and follow-up, antidepressant medication management, depression response, follow-up after ER or inpatient admission, and use of opioid measures)
- Utilization data (including ER, inpatient, SUD, and PRTF utilization)
- SUD services and timely access to MAT and opioid services
- CAHPS surveys of Members' experience
- BH Provider Incentive Program outcomes aimed at improving follow-up care after BH hospitalizations and reducing unnecessary hospitalizations due to BH issues

Payment Approach

Our payment approach includes working with Providers to give them the support, tools, and information they need and to address issues that arise promptly. [redacted]

Our local Provider Experience team will provide frequent, ongoing outreach, and education on key topics, such as screening Members for BH needs, referral processes for additional services, critical incident reporting and management, and proper claims submission and billing practices. This team will include a dedicated, local CMHC Provider Experience Consultant, trained specifically on CMHC billing and reimbursement requirements and our Claims Administrator who will be available to assist all Provider types, including BH Providers. The Claims Administrator will be a primary contributor to the development and administration of monthly trainings on claims submission and payment processes we will offer for at least the first 12 months of the Contract, or longer if needed.

We will work in conjunction with the Division and Providers to implement the needed tools and collaboration to prevent claims payments issues. Our Member Services team will have the ability to resolve claims issues presented by Members. We will monitor for authorizations for services to assure that claims execute timely.

Our efficient, precise, and timely claims processing will enable us to achieve consistently high adjudication accuracy; Provider satisfaction through prompt claims payment and focused claims inquiries; and performance and scalability to support current volumes and future growth. ***Using our integrated payment platform, all PH and BH claims and audits will be processed on the same platform, by the same team.*** Our claims processing system supports prompt payment using automated workflows to manage the steps required to auto-adjudicate a claim. Our local COO and Claims Administrator will help oversee the timely delivery of claims payments. Further***, we will use daily check runs to expedite payments to Providers***. Prior to go-live, we will leverage integrated codes and specialty circumstances to build test scenarios and a test environment that will allow for issue resolution prior to disruption. This will assure the claims system is configured to pay specialty services, telehealth services, day treatment, HCPCs, bundled payments, and inclusive payment models.

D. Innovative Methods to Service Delivery of Behavioral Health/Substance Use Disorder Services

We will leverage local and national resources and expertise to develop innovative methods to assure Member access to BH/SUD services within required timeframes for routine, urgent, and post-discharge appointments and to offer new treatment options and modalities to Members. The Care Manager will address PH, BH, and SUD needs as well as SDOH and health literacy needs by working with the Member and Provider community. We also will have built predictive analytics that are able to understand which specific risk factors increase an individual's likelihood for attempting suicide. We will build these models to support adults (27 and older), adolescents, and young adults (ages 12 to 26) who are at high or critical risk for a first or subsequent suicide attempt over the next 12 months. To augment our integrated approach, we will offer the innovations described in Table 4.2.2.1.A.2-3.

e. Approaches to Address Racial, Ethnic, and Geographic Disparities in BH Services

Through our local, data-driven approach (illustrated in Figure 4.2.2.1.1.A.1-4), we will continuously evaluate and refine our solutions to address racial, ethnic, and geographic disparities in behavioral health service delivery. To identify gaps, we will use BH HEDIS measures stratified by race and ethnicity, including follow-up after inpatient admission, follow-up after an ER visit for mental illness, and antidepressant medication management (as a measure for suicide prevention). Through data analysis and findings from stakeholder engagement, we know Mississippi has a high prevalence of suicide for White males ages 25 to 34, exceeding the national average. Suicide is the fifth leading cause of death in the state for people ages 35 to 44, and the third leading cause of death among individual ages 10 to 34.

To identify disparities and determine root causes, we will collaborate with key stakeholders on interventions at the CCO, Provider, and community (county and zip code) level. For example, for disparities often seen in Members with BH/SUD diagnoses,

We will continue to seek feedback from our Member Advisory Committee, HEAC, CBOs, Providers, and other stakeholders through round table discussions. This information will be aggregated, evaluated, and reported up through our and Quality Management Committee for necessary adjustments to improve and sustain our health equity performance.

A.3 Perinatal and Neonatal

a. Experience with Service Delivery and Payment for Perinatal and Neonatal Services

We bring extensive organizational service delivery and payment experience focused on improving women's and infants' health and reducing disparities in prenatal and postpartum care and birth outcomes. ***In 2020, the low birth weight rate among all affiliates' Medicaid newborns was 7.93%, compared with the Centers for Disease Control and Prevention national final 2019 rate of 8.31%.*** We will leverage and customize our parent company's comprehensive maternal and child health program for Mississippi, which includes Member health education, care coordination, and OB CM, specialized programs for the highest risk women and infants, Member and Provider incentives, and Provider and community partnerships. Using a comprehensive and multifaceted approach, we will engage MississippiCAN and CHIP Members and their Providers in evidence-based preconception, perinatal, and neonatal care.

CenteringPregnancy Outcomes

An affiliate experienced the following outcomes for Members engaged in CenteringPregnancy:

- **Preterm birth rates declined 6.8%**
- **C-sections declined 6.7%**
- **NICU cost and the cost in the first year of life declined**

MS21B_CenteringPregnancy_C_07

Our parent company's VBP and medical management programs will promote Providers' adherence to clinical practice guidelines and incentivize Providers to achieve improved outcomes [redacted]

Affiliates also have experience with bundled payments and blended payment rates for maternity services. They have successfully resolved some common reimbursement challenges, such as reimbursing Providers for long-acting reversible contraception (LARC) placement immediately following delivery by unbundling the delivery fee and LARC placement fee. They have also implemented a rapid reconciliation process to make sure multiple Providers are reimbursed correctly when a woman or her infant requires transfer from the delivering facility to a specialty care facility. Affiliates typically develop these reimbursement approaches with the State Medicaid agency and often with other managed care plans. Our affiliates have also identified trends in nonindicated care (such as early elective deliveries). They have encouraged completion of appropriate prenatal and postpartum care to promote the best outcomes and reduce high-cost deliveries resulting from preterm birth. For example, our affiliates review claims for documentation of gestational age and type of pregnancy to confirm valid medically necessary reasons for early elective deliveries before processing the claim.

b. Approach to Service Delivery and Payment for Perinatal and Neonatal Services

Our approach to managing perinatal and neonatal services and payment for MississippiCAN and CHIP Members will include and will prioritize services to support a healthy pregnancy and healthy baby and to keep each woman healthy throughout her life. A healthy mother has the best chance of having a healthy child. Based on our analysis of publicly available Mississippi data, the state ranks among the lowest in the nation for key maternal and infant health outcomes. We will offer a comprehensive suite of culturally competent solutions designed to promote and support the health of pregnant Members and their babies, including support for all pregnant women and specialized interventions for those who are high risk, including pregnant teens. Our evidence-based OB CM Continuum will deliver Member and Provider interventions designed to address identified underutilization of prenatal and postpartum care that can lead to poorer maternal and child outcomes. ***This approach significantly increased the rate of timely prenatal care by 9 percentage points and postpartum care by 10 percentage points among an affiliate's Medicaid Members.***

Key Mississippi Maternal and Infant Measures Lag Behind All Other States

- **50th** for preterm birth at **14.2%** (2020)
- **50th** for infant mortality with 9.1 deaths/1,000 live births (2019)
- Highest rate for low-risk Caesarian births at **30.7%** (2019)

Source: March of Dimes 2021 Report Card

MS21B_MaternalandInfant_C_04

All pregnant Members will receive support from our local CM team that includes experienced OB Care Managers; Care Management Navigators, who may be Certified Peer Support Specialists, Doulas, or Health Educators; and Community Health Workers. Our Mississippi-licensed Perinatal Health Director will oversee our perinatal approach; liaise with Providers and assist in resolving reimbursement and quality of care concerns; and be available for consultation to Providers and our clinical team in addressing the needs of women with high-risk pregnancies, infants in the NICU, and postpartum risks.

We will provide all pregnant women with valuable, linguistically appropriate educational information about maternal health and emotional well-being; perinatal care; nutrition; physical activity; planning for infant care and safety; and family planning, including pregnancy prevention options. We will inform women of our pregnancy and condition-specific educational materials, Value-Adds, perinatal and Well-Child incentives, and self-management tools as well as the personal assistance available from the CM team. Our pregnancy guide will be available online via the Member Portal, which provides pregnant Members with information about benefits, how to stay healthy throughout their pregnancy and postpartum, and when to see their OB Provider for prenatal and postpartum care.

Identification of Pregnant Members

Because of the importance of identifying pregnancy as early as possible, we will use a variety of methods to encourage women to seek early prenatal care. Our strategy will include our health literacy and social media campaigns and distribution of important perinatal information during community events, at local libraries, and through community partners, as described in Section 4.2.3.6. To make sure that we are continuously identifying pregnant Members, we will also review Enrollment files; the results of the initial Health Risk Screening; and accept referrals, both internal and external. ***When we identify a CHIP Member with a diagnosis related to pregnancy, we will report this to the Division within seven calendar days of identification in the manner specified by the Division (Contract Section 3.3.2.1.2).*** On an ongoing basis, we will mine claims data, lab results, and inpatient census data to identify Members who may be pregnant. We will train all Member-facing staff about the importance of identifying and quickly connecting pregnant Members to our CM team and of accepting referrals for perinatal or neonatal support from any source. We will work with community partners, such as the Department of Health and faith-based organizations, to make sure they know how to refer Members who are or may be pregnant to our CM team.

Assessing Pregnant Members' Risk to Prioritize Outreach and Engagement

Regardless of how we identify a pregnant woman, we will promptly initiate risk screening. We will invite women to complete our OB Screener in person at their home; in our outreach center or other location of their choosing; or by telephone, by text, through the Member website, or by mail. The OB Screener gathers general information, determines a woman's risk of delivering an infant that may be admitted to the NICU as well as her own health risks, and assigns the Member to the most appropriate risk level based on her responses to the screening questions. It also incorporates motivational interviewing concepts. Questions include whether the woman has a history of preterm labor, early delivery, C-section, or a low birth weight infant; preexisting health conditions, recent use of the ER, or an inpatient admission for a pregnancy-related issue; current drug or tobacco use; or a history of intimate partner violence.

We will also ask women to self-identify their race so we may consider and address potential disparities in healthcare and social factors that may affect her and her baby. The more predictive questions are placed at the

beginning of the tool so we can identify high-risk pregnant Members early in the event they do not complete the screening. If a Member does not complete the OB Screener, a member of the CM team will visit her in her home or other location of her choice, evaluate any unmet social needs that may impede her ability to engage in CM, and help her complete the OB Screener.

We will also apply our parent company's predictive models, which use the OB Screener responses or risk factors identified through data science techniques to identify women at risk of specific outcomes for rapid outreach and engagement in CM. In developing our advanced analytics models, we evaluated a wealth of data sources covering claims; authorizations; Enrollment data; laboratory testing results; diagnosis history; risk scores; and demographic and SDOH information, including age and race/ethnicity. The models predict the probability of delivering an infant requiring the NICU, pregnant Members at risk for developing preeclampsia, likelihood a pregnant woman will deliver a newborn with neonatal abstinence syndrome (NAS), and likelihood that a pregnant woman with diabetes will have a C-section delivery. Pregnant Members with a history of preeclampsia or a previous preterm delivery at 35 weeks estimated gestation or less or with current hypertension are automatically identified as having urgent needs. We will assign these pregnant Members and others identified with urgent needs for immediate outreach and engagement by our CM team.

OB Care Management

We will offer all pregnant women OB CM through ***an assigned OB Care Manager,*** who will provide personalized support, including telephonic and in-home support and care coordination aligned with the woman's risk level throughout her pregnancy and postpartum. Pregnant women identified as the highest risk will receive increasing levels of care and intervention throughout their pregnancy and postpartum. We will assign OB Care Managers from the woman's local community who reflect the woman's race, ethnicity, and culture when possible. The Care Manager will offer to visit women who decline telephonic contact, prioritizing visits to women with comorbid conditions, such as SUD/OUD, obesity, or smoking.

The Care Manager will promote access to needed services, comprehensive prenatal and postpartum care, and coordination of the Member's needs. Working with other members of the CM team, the Care Manager will address the Member's unmet SDOH needs, tobacco cessation options, and BH needs, including those related to SUD/OUD, and help Members access transportation to perinatal and infant care appointments, incentives, and Value-Adds. Care Managers will connect Members to resources available through community organizations and agencies, such as local prenatal education classes; infant care classes; and support groups, including lactation support and postpartum support. They will educate expectant mothers on the importance of establishing a relationship with a pediatrician before their baby's birth and assist them if needed in locating a pediatrician with whom they are comfortable. They will also deliver specialized interventions for women with high-risk pregnancies, including pregnant teens or women with preeclampsia; SUD; preexisting or developing conditions, such as diabetes; and a prior history that places them at high risk for preterm or low birth weight babies. Our program includes specialized support for infants in the NICU and their families.

Support for Women with SUD and Infants with NAS

Intervening early and often with pregnant women who have SUD/OUD is a critical part of our approach to improving health outcomes and reducing the incidence of NAS. We know that Mississippi's rate for babies born with NAS began an upward trajectory and that the NAS rate has more than tripled over the past decade. We will implement a multi-prong, Population Health approach to address substance use, with a focus on improving Members' access to MAT and other important support to address SUD/OUD, educating Members about NAS and its prevention, and engaging pregnant Members in our OB CM program. An OB Care Manager with experience in SUD/OUD will work with pregnant women with SUD/OUD and provide individualized interventions that address all the woman's identified needs. The Care Manager will connect her to resources and services designed to mitigate the impact of SUD and help reduce the number of infants born with NAS, providing

new mothers with educational material and referrals to community resources for up to six months if an infant is born with NAS. After delivery, the Care Manager will assess both mother's and baby's health, assure appropriate pediatric appointment adherence, monitor developmental milestones, monitor MAT adherence, and provide continued education and support. ***An affiliate implemented this proven approach and by early 2021 had reduced perinatal substance misuse among Members by more than 33% from two years prior.***

Additional Support

Table 4.2.2.1.A.3-1 summarizes the additional support we will offer to promote improved outcomes for mothers and their babies.

[redacted]

Healthy Moms, Healthy Babies CM Option (7.5.4)

We will coordinate our support with that offered through the Healthy Moms, Healthy Babies program (formerly the Perinatal High-risk Management/Infant Services System program) by offering women who meet the program criteria the choice of Healthy Moms, Healthy Babies CM, or our OB CM. Through our OB assessments and direct outreach, we will identify Members who meet Healthy Moms, Healthy Babies CM eligibility criteria, inform the Member about this option, and make a warm handoff to a Healthy Moms, Healthy Babies program contact in addition to sending a list of eligible Members to the Division's agent. If the Member chooses Healthy Moms, Healthy Babies CM, our OB Care Manager will work with the agent's case managers to develop a treatment plan, documenting the plan and role of Healthy Moms, Healthy Babies in our CM platform. We will confirm that the case manager will support all of the Members' healthcare needs. Our OB Care Manager will contact the Member and the Healthy Moms, Healthy Babies program monthly and monitor the woman's service utilization (such as ER or inpatient use) to identify and coordinate access to any additional health plan resources the Member needs. If the Member declines Healthy Moms, Healthy Babies participation, we will provide our full continuum of OB CM. ***We will designate a single point of contact for State agencies and community-based organizations to establish a personal relationship, foster smooth and timely referrals, and make it easier for these organizations to reach us and address any issues that arise.*** We also recommend development of a data sharing agreement and protocol to promote close coordination of care.

Supporting Women's Transition from Medicaid Coverage

We will assist women whose Medicaid coverage ends 60 days following delivery by planning for transition as soon as we learn of the woman's eligibility status. Our CM team will coordinate with the woman and her OB with a goal of completing postpartum care visits and arranging SDOH services before transition. If the Member will be transitioning to another type of coverage, we will coordinate her care with her receiving PCP or OB-GYN. If eligibility for low-income pregnant women in Mississippi is extended to 12 months after delivery, we will provide transition support as applicable to the woman's needs, including coordination of care with her receiving PCP, before the end of her 12-month extended eligibility period.

Provider Engagement and Support

We understand the importance of data exchange and Provider communication to improve delivery of perinatal and neonatal care and will equip Providers with information and support. Our Provider Portal will provide easy access to a pregnancy notification and HEDIS attestation feature. Our OB Practice Consultant will work with OB Providers and office staff to reiterate the importance of preparing new mothers to select a pediatrician before delivery and arrange for Well-Child and preventive services for their newborn. The OB Practice Consultants will share OB Profile Reports with the delivering Provider inclusive of preterm birth rates, low birth weight rates, C-section rates, postpartum visit compliance, and timeliness of prenatal care. ***Because of the significant disparities in maternal and infant outcomes in Mississippi, we will include race and ethnicity data in these reports so that Providers can identify and address health disparities within their own practice.*** OB Providers can also participate in our OB quality incentive program (described in Section 4.2.3.1).

c. Innovative Methods Used to Augment Our Approach for Perinatal and Neonatal Services

We will use the innovative methods described in Table 4.2.2.1.A.3-2 to enhance our approach to meeting the needs of women with high-risk pregnancies and reduce disparities.

d. Our Approach to Addressing Racial, Ethnic, and Geographic Disparities in Perinatal and Neonatal Services Delivery and Outcomes

Through our local, data-driven approach (illustrated in Figure 4.2.2.1.1.A.1-4), we will continuously evaluate and refine our solutions to address racial, ethnic, and geographic disparities in perinatal and neonatal services and outcomes. To identify gaps and give us greater insight into the health needs and culture of communities and Members, our approach will include analyzing publicly available data sets combined with claims data, HEDIS data sets, health and OB screenings and assessments, and findings from stakeholder engagement.

From our initial analysis, we know that Blacks experience higher infant mortality rates (1.7 times more) and higher maternal mortality rates (nearly three times more) when compared to their White counterparts, and preterm birth rates are 44% higher for Black women than all other women in the state. In the Delta, low birth weights among all pregnant women equals or exceeds rates across the rest of the state. To determine root causes for disparities like these, we will seek stakeholder and community feedback by partnerships with local organizations that support women and infants, women's health clinics that support integrated care, and community health centers in areas of need. Our HEAC will include key public health agencies, community Doulas, and other Mississippi healthcare leaders to inform and guide our health equity work. Based on the disparities identified, we will focus on targeted interventions (Table 4.2.2.1.A.3-3) and measurable outcomes in areas that include increasing prenatal visits and Care Management engagement for all pregnant women in the Delta and reducing preterm birth rates and low birth weight for Black Members.

Once interventions are implemented, we will continue to evaluate and determine the impact via data collection and analysis (such as claims for prenatal and postpartum visits, Provider feedback, incentive utilization, and CM engagement). As we identify both successes and opportunities for improvement, we will share data on our performance with our HEAC, Member Advisory Committee, CBOs, Providers, and other stakeholders through roundtable discussions. This information will be aggregated, evaluated, and reported up through our Population Health Council and Quality Management Committee for necessary adjustments to improve and sustain our health equity performance.

A.4 Chronic Conditions

a. Approach to Implementing Innovative Programs for Members with Diabetes and Pre-diabetes

The incidence of diabetes among Mississippians (14.6%) is higher than the U.S. average rate of 10.6% and Mississippi ranks 48th out of 50 states. The state also ranks 50th for rates of obesity and 49th for rates of physical inactivity, both among the primary contributing factors to diabetes onset (America's Health Rankings 2021). We will implement innovative programs and initiatives that leverage our parent company's NCQA accredited Population Health model and affiliates' experience to improve the completion of preventive care and treatment for MississippiCAN and CHIP Members at risk of developing diabetes (pre-diabetes) and those diagnosed with diabetes. Our locally based Diabetes Educator will work with our clinical leadership, including our Population Health Director, to coordinate the diabetes-focused activities and innovative programs described in Table 4.2.2.1.A.4-1.

Affiliate Achieves Improved Outcomes Among Members with Diabetes

Member outreach and incentives helped close care gaps:

- **43%** Completion of diabetic retinal screening
- **27%** Statin therapy
- **24%** HbA1c of less than 8

(RYs 2016-2020)

MS21B_MemberOutreach3_C_08

Table 4.2.2.1.A.4-1. Our proposed diabetes-focused initiatives are designed to improve Members' health outcomes

Diabetes-focused Programs/Initiatives	Description
Early Identification of Members at Risk of Diabetes	• We will continually mine all available data to identify Members with pre-diabetes and diabetes for rapid outreach and engagement in health education and CM. We will make sure Providers understand the importance of including the ICD-10 pre-diabetes diagnosis code and other applicable coding in their claims so we can more accurately identify and engage at-risk Members. Our vision partner will provide a report of Members found to have medical conditions associated with or suggestive of diabetes during an eye exam. We will contact the Member/family to provide health education and coordinate needed care and provide the report to their PCP/PCMH for appropriate follow-up.
Diabetes Condition Management Program	• Experienced, local Care Managers assisted by other CM team members, including CMNs — who may be Certified Peer Support Specialists, Doulas, or Health Educators — and CHWs, will implement our parent company's evidence-based diabetes condition management program. They will support Members' PH, BH, and SDOH needs and deliver individualized and evidence-based services coordinated with the Member's PCP (including specialists acting as a PCP) or PCMH. Interventions will include diabetes screenings/assessments, self-management coaching, coordinating access to remote patient monitoring (RPM) and other technology-enabled supports, identification and connection to specialists, a nutritionist/dietician to support healthy eating habits, connection to community classes and resources, and Care Manager/Member interactive text messaging that includes preventive service reminders and education. Members will also have access to linguistically appropriate diabetes screenings and healthy eating guides through the Member app. • Our pharmacy partner will alert prescribers and Members when a Member's medication use does not adhere to evidence-based guidelines (for example, overutilization or polypharmacy) based on available pharmacy data.
Diabetes Health Literacy Campaign	• Our ***Making Every Step Count: Preventing and Managing Diabetes*** campaign described in Section 4.2.3.6, will increase awareness across the state and among our Members about diabetes as a preventable and manageable disease, with the goal of reducing the incidence of diabetes. The CM team will connect Members with diabetes or pre-diabetes to materials and resources available through the campaign and review these during CM as part of a Member's overall plan for self-management.

[redacted]

Diabetes-focused Programs/Initiatives	Description
[redacted]	

b. Experience in Service Delivery and Payment for Members with Chronic Conditions

Our affiliates have been delivering services to Medicaid and CHIP Members with chronic conditions for more than 20 years. From this experience, we will implement integrated approaches to proactively address payment for chronic conditions and Members' over- or under-utilization of services.

We will draw on our affiliates' approaches that include Provider collaboration and data sharing, monitoring of under- and over-utilization, and implementation of aligned VBP programs. For example, Members with asthma, serious mental illness, or SUD are among our affiliates' Members who most often visit the ER for management of conditions or needs that would be more appropriately and cost-effectively managed in outpatient settings. We will leverage our ER Avoidance (ERA) program to educate Members who frequently use the ER on their benefits and healthcare options, make sure they are connected to a local PCP/PCMH, and that Members receive appropriate assistance in resolving barriers to care. ERA will identify Members for focused outreach and education using predictive modeling around avoidable and unavoidable ER visits and Preventable ER Diagnosis groups.

Chronic Condition Management Reduces ER Visits

Affiliates' Members engaged in condition management programs had fewer visits to the ER (2019):

- **5.3% Adults** with major depressive disorder
- **4.58% Members** with SUD
- **3.8% Children** with major depressive disorder
- **2.76% Members** with bipolar disorder

MS21B_ChronicConditions_C_06

[redacted]

c. Our Approach to Delivery and Payment for Chronic Health Conditions Services

Identifying Members' chronic conditions is an important part of our overall approach to making sure each Member receives the support needed to manage and improve their health. We will identify Members with chronic conditions through screenings; comprehensive data analysis, including analysis of claims and utilization data from our dental/vision partner and the State PBA; from predictive modeling findings described in Section 4.2.2.3; and from referrals (both internal and external). Members with chronic conditions identified as having medium or high-risk will receive chronic condition management (disease management) and personalized support from a Mississippi-based Care Manager. (Contract Section 7.4.3.4) Members with diabetes, asthma, cardiovascular diseases, chronic kidney disease, SUD, serious and persistent BH conditions, or who otherwise meet the criteria specified in Contract Section 7.4.3.3.1, will be enrolled into the high-risk CM category, and

have an assigned Care Manager who will deliver chronic condition management as part of the Member's comprehensive, integrated treatment plan. Members with chronic conditions that are well controlled and not required by the Contract for higher stratification will receive assistance with service navigation and access to supports from the CM team member most qualified to help (a CHW or CMN). Interventions will be adjusted as a Member's risk level and associated needs change.

Patient-Centered Medical Homes and Members with Chronic Conditions

We will assign Members with chronic conditions identified as medium- or high-risk to a PCMH and inform PCPs, PCMHs, and specialists that are serving as a PCP, of the Member's Enrollment in condition management. We will orient the Provider to the program, provide Member stratification and assessment results and the treatment plan, and seek feedback from the Provider to enhance care planning and care coordination. We will also share condition-specific materials with Providers so they can reinforce self-management concepts with the Member during patient visits. [redacted]

Chronic Condition Management

Our chronic condition management programs encourage improved health outcomes and healthy behaviors through a combination of Member assessment, education, and care coordination, and include ongoing monitoring of measurable outcomes. We will partner with Providers and other community stakeholders to ameliorate modifiable risk factors like lack of physical activity, tobacco use, high blood pressure, and high cholesterol, to decrease poor health outcomes due to chronic disease. We will offer 17 chronic condition management programs, more than half of which hold NCQA Population Health Program accreditation. ***We also will offer tailored CM programs for Members with high-risk pregnancies*** as described in Section 4.2.2.1.A.3 and for ***Members with serious mental illness and substance use disorder (SMI/SUD)*** (in addition to the chronic condition programs we offer for Members with depression, bipolar disorder, and schizophrenia) as described in Section 4.2.2.1.A.2 and in compliance with Contract Section 7.4.3.4.

Our 17 Chronic Condition Management Programs Are Evidence-based and Person-centered

- Asthma
- ADHD
- Bipolar disorder
- Chronic kidney disease
- Chronic obstructive pulmonary disorder
- Congestive heart disease
- Coronary artery disease
- Depression (adolescent)
- Depression (adult)
- Diabetes
- Hepatitis C
- HIV/AIDS
- Hypertension
- Obesity
- Organ transplants
- Schizophrenia
- Sickle cell anemia

MS21B_CondMgmtProg_C_09

We will ***identify Members for engagement in chronic condition programs*** using a comprehensive population identification process, supported by our risk stratification model described in Section 4.2.2.3. Based on the hierarchy of the Member's condition, we will then enroll them in a single program. For example, we will enroll Members with HIV/AIDS in our HIV/AIDS condition management program, but will also include support for additional comorbidities, such as hypertension or depression, as part of our holistic chronic condition approach.

Members and Providers in Affiliate Plans Give Condition Management High Marks

4.91 out of 5: Members' rating of overall experience with their or their child's Care Manager

92.8% of Providers indicated their patients' participation in our chronic condition management programs had a positive effect

(2020)

MS21B_ConditionManagement_C_04

The Care Manager, after conducting a condition-specific screening in person or by telephone, will further stratify Members to enable more precise care planning based on the severity of the Member's condition or combination of conditions. They will use person-centered care planning to support each Member to establish personal goals and desired outcomes and connect Members to needed services and supports, working in close collaboration with the Member's PCP/PCMH. Through a review of claims data and discussion with the Member they will identify any care gaps and work closely with the Member, their PCP/PCMH, and other Providers to assure access to needed services. The Care Manager and other members of the CM team will provide in-person CM and care coordination when

indicated based on the Member's identified needs and risks. Our approach will include *Member self-management education and support*, including education on prevention, behavior modification, and the importance of the Member following their treatment plan. The Care Manager will educate Members and Providers about covered services that promote self-management, including RPM (which we will offer to Members with conditions specified in Mississippi Administrative Code, Title 23, Part 225, as well as to Members with asthma) and other tools, such as a digital app that supports recovery for Members in SUD treatment. [redacted] To make sure Members' needs are being met, a member of the CM team will contact the Member by phone or face-to-face at a frequency appropriate to their identified risk but no less than monthly in compliance with Contract Section 7.5.2. Member contact will be more frequent during initial engagement and following specific events, such as an ER visit. The Care Manager and Member, with input from the Member's Providers, will assess the Member's progress and outcomes and revise the Member's treatment plan to reflect progress, changes in the Member's condition, and updates in the Member's goals.

Provider Supports

We will make sure PCPs/PCMHs and specialty Providers have the information and support needed to address Members' chronic condition needs. Our Provider education program includes orientation to the full range of programs and supports for Members with chronic conditions, how to access valuable tools such as RPM and telehealth kits, local condition education and support programs, the process for Member referral, and adherence to condition-specific CPGs. Our web-based CMP will offer Providers real-time, Member-specific data including treatment plans, Health Risk Screenings and assessments, risk stratification data, HEDIS care alerts, and pharmacy data. Providers can filter this data by key conditions, risk factors, care gaps, and visit history to identify Members for outreach and follow-up. [redacted]

Community Partnerships

We will partner with trusted local organizations through funding, technical assistance, and collaboration to support, develop, and expand resources that address prevalent chronic conditions [redacted] We will also distribute health literacy brochures and arrange health screenings during community partners' food distribution and other community events. Our CM team will refer identified Members to these and other collaborative programs, including those focused on smoking and vaping prevention and cessation, fitness and weight loss, and condition self-management. We will provide data for shared Members to facilitate collaborative care planning with our community partners.

D. Innovative Methods That Will Augment Our Approach for Chronic Health Conditions Services

We will implement additional innovative approaches summarized in Table 4.2.2.1.A.4-2 to augment our core chronic condition program focused on improving access to and timeliness of care and care gap closure.

Table 4.2.2.1.A.4-2. Innovative approaches will help close care gaps and connect Members to additional supports.

Innovative Approach	Description
Member Appreciation Days	During Member appreciation days, we will help Providers schedule Members with care gaps for an appointment during a designated appointment window. We will help arrange transportation and make reminder calls to Members to increase the likelihood of gap closure. We will also coordinate with CBOs to bring supplies, such as nutritious food boxes, for the Members/families to take home.
Interactive Texting	We will implement interactive texting that promotes timely communication between Members, our CM team, and other clinical staff when and where the Member needs it, including when at the ER. Interactive texting focuses on closing care gaps; outreach following ER visits to connect Members to their PCP and inform them of alternatives to the ER; and timely notification of available community-based resources, such as support groups and food pantries.
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

[redacted]

e. Addressing Racial, Ethnic, and Geographic Disparities for Members with Chronic Conditions

Through our local, data-driven approach (illustrated in Figure 4.2.2.1.1.A.1-4), we will continuously evaluate and refine our solutions to address racial, ethnic, and geographic disparities for Members with chronic conditions. To identify gaps, we will analyze publicly available data sets combined with claims data, HEDIS data sets, screenings and assessments, and findings from stakeholder engagement to provide insight into Members' and communities' cultural and health needs.

[redacted]

[redacted]

Once interventions are implemented, we will continue to evaluate and determine impact though data collection and analysis (such as evaluating claims for HbA1c screenings or retinal eye exams), Provider feedback, incentive utilization, and CM engagement with a focus on our disparity targets. As we identify both successes and opportunities for improvement, we will share data on our performance with our HEAC, Member Advisory Committee, CBOs, Providers, and other stakeholders through roundtable discussions. This information will be aggregated, evaluated, and reported up through our and QMC for necessary adjustments to improve and sustain our health equity performance.

A.5 Foster Children

We understand the foster care system is unique and ever evolving and that holistic, integrated care and best practices for children in the child welfare system are continually being assessed and adapted on a local and national level to appropriately address the needs and strengths of this diverse population. We support the Division's vision of children in foster care growing up in strong families, safe from harm, and supported through partnerships to promote family stability and permanency. Our approach will be based on person-centered, trauma-informed principles that promote health, educational, and social well-being and resiliency while supporting a safe, stable, nurturing environment through wraparound services and supports across the continuum of care.

We will collaborate with appropriate State agencies the Mississippi Department of Child Protection Services (MDCPS) and local stakeholders through regular task force meetings to develop and implement a comprehensive program that uses best practices, data, and local expertise to address the unique and holistic needs of children in foster care. This will include identifying and addressing PH and BH; educational; health-related social; racial, ethnic, and geographic health disparity; and caregiver needs that are unique to each Member, family/caregiver, and the areas of the State in which they live. Our Foster Care Children CM program will comply with all federal, State, and Contract requirements.

a. Experience Managing Care for Foster Children and Developing a Responsive Continuum of Care

Our affiliate health plans have been serving children and youth involved in child welfare (foster care, adoption assistance, juvenile justice) and working with over 15 state partners in markets across the country for decades. We will leverage this experience and strong local partnerships and stakeholder input to tailor an approach that meets the specific needs of Mississippi's foster care population. Mississippi's children in foster care are more likely to be placed in traditional foster homes (51%) and with relatives (31%). Therefore, supporting Members in foster care means understanding their holistic needs and those of caregivers, biological parents, and social supports to avoid placement changes or admissions to higher levels of care.

Our locally based, designated foster care Care Managers will interact with Members, their caregivers/foster parents, Providers, and MDCPS caseworkers (caseworkers) to identify and coordinate care, services, and supports needed. Care Managers will also assess if the child/youth has an Individual Education Plan and identify points of contact at the school to assess and address educational needs. For transition age youth, Care Managers will assist with transitions to the adult system of care, including:

- Anticipating and addressing challenges and barriers with accessing services and supports
- Connecting the Member to PCPs, specialists, and BH Providers as they transition from pediatric Providers
- Assisting young adults with independent living, education, housing, and other SDOH needs
- Supporting youth and young adults in residential or inpatient facilities, as appropriate

We will monitor youth and family/caregiver progress through phone, face-to-face, and electronic communication with them, their caseworker, and their Providers. This includes monitoring care opportunities and gaps, Grievances, PCP change requests, out-of-network referrals, and ER visits, and hospitalizations as potential flags for intervention. Through motivational interviewing and person-centered planning, our Care Managers will outreach and coordinate wraparound supportive services.

We will serve Members in foster care by supporting them in their placements and during transitions between care settings, prioritizing this as one of our crucial CM functions. We will provide foster parents and kin caregivers with an informational portfolio that has several items designed for them, including access to a quick-start guide that will walk them through the most important supports and services offered by our CCO. They will also receive a success guide that includes information on parenting after trauma, the importance of medication adherence as prescribed, and CCO resources and services. Our local Care Managers will also engage and work with caregivers with them to provide the supports they need to address their needs, reduce the risk of placement disruption, and support family reunification if possible based on the MDCPS case plan.

We will use our parent company and its affiliates' experience serving Members in foster care and their caregivers to take a proactive and integrated approach to serving the foster care population. Our Utilization Management (UM) Clinicians and designated Care Managers for foster care youth will work together to quickly identify Members who are hospitalized or placed in a PRTF. Throughout the Member's stay, their Care Manager will work alongside UM and participate in MDCPS rounds and meetings with the Member's MDCPS caseworker and facility discharge planner, identifying any needed resources, and reducing barriers to a successful transition back to the community or next level of care and a stable placement.

For example, one affiliate identified that they had multiple children in out-of-state PRTF placements and that the lengths of stay in these facilities were typically nine to 12 months. ***Through the affiliate's innovative methods, they reduced the number of out-of-state placements by 86% year over year and reduced lengths of stay by three to five months.*** They achieved this by implementing bi-monthly integrated team calls with each PRTF facility, actively monitoring Member progress towards treatment goals, and conducting bi-monthly medical necessity reviews. All PRTF admissions required Medical Director approval and Care Managers monitored Member and family/caregiver progress towards their short- and long-term goals, communicated regularly with the caseworker, and conducted weekly home visits with caregivers. They also developed a

comprehensive geographic list of alternative in-home Providers and intensive in-state programs to assist the team during discussions with Providers to assure Members were accessing the most integrated level of care inclusive of community options. These are the kinds of innovations we expect to implement in Mississippi.

We will use our local knowledge of the foster care population, bolstered by the national experience of our affiliates, to build a Provider Network specific to the needs of children in foster care in Mississippi. Our network development approach will identify, engage, and elevate Providers of all sizes and geographic locations across the service continuum, including therapeutic foster homes, small rural Providers, large hospital systems, and PRTFs. Our network will include Providers with specialized training and certifications, such as trauma-informed care, adverse childhood experiences, and person-centered concepts. This will include pediatric psychologists, psychiatrists, therapists, and counselors, as well as adult specialty Providers who will assist with youth transitions to the adult system of care. We will focus on building capacity to provide trauma-informed Care, and with Providers who have experience working with victims of sexual assault, abuse, intimate partner violence, neglect, and human trafficking. We will identify the needs of Mississippi's foster care population and work to align all Members to a PCMH in their region.

We will empower Mississippi Providers by providing user-friendly, easily accessible education on best practices, evolving standards, and Contract requirements. Our ***Trauma Toolkit***, described in Subsection d of this response, is one example of our comprehensive Provider education efforts. We will offer multiple modalities, including e-learning, webinars, instructor-led, newsletters, direct mailings, and web-based. Trainings are included as part of our Provider training program and will include information on foster care resources and supports, parent and child interactions, and working within the juvenile justice system.

b. Working Collaboratively with the Mississippi Department of Child Protection Services

To promote a holistic and fully integrated system of care and avoid duplication or fragmentation of services, we will coordinate care through an integrated treatment plan that includes the Member's strengths, needs, preferences, and the services and supports for the Member's needs. We will incorporate the available to a Member, including State Plan-covered services, carved-out services, and community and natural supports. We will coordinate closely with the MDCPS and the Division through regular meetings and will meet all Contract requirements for provision of services for children and youth in foster care, including, but not limited to, collaborating with MDCPS to determine and support services that are medically necessary. ***A designated Care Manager will be assigned to each Member in foster care and work as a team with the Member, caregiver, and caseworker to collaborate on assessments, information sharing, and strategies to improve Member outcomes.*** Care Managers will also share treatment plans with caseworkers to monitor goals and services the Member is receiving through the plan.

We will work with MDCPS to build upon and tailor our established UM and CM policies, procedures, and strategies to support the care coordination and delivery of services that meet the unique and holistic needs of our Members. When reviewing referral and treatment requests for medical necessity, we will consider the Member's current clinical needs, psychosocial influences, health-related social needs, and availability of services in the Member's area. Our approach will include consistently applying UM and CM processes, clinical criteria, tools, and input from the assigned caseworker. We will make sure Members within child welfare, including those with specialized healthcare needs, disabilities or at risk of developing a disabling condition, and chronic or complex medical or BH conditions are identified, screened, and referred to specialty Providers for assessment and appropriate treatment.

c. Capacity to Provide MDCPS Access to Data and Documentation

Supported by flexible data exchange systems and procedures tailored to Mississippi and with support from our parent company's experienced data exchange team, we will collaborate with MDCPS on mechanisms to provide

data and reports required by MDCPS to assure we are achieving the Department's vision in caring for these Members. Our CCO leadership will actively participate in regular task force meetings with MDCPS to improve collaboration, provide consultation, and share de-identified clinical documentation. Our Care Managers will also work with the MDCPS caseworkers to coordinate services and support streamlined information sharing.

Our Members, caregivers, and MDCPS caregivers will have access to our Member clinical data dashboard, which provides a holistic view of each Member's treatment plan, utilization, CM services, and gaps in care. We will integrate data and information from multiple sources, including claims history, Prior Authorizations, ER visits, hospitalizations, immunization records, prescriptions from the State PBA, lab results, and when available, data from available HIEs and electronic medical record organizations. Access to the same information facilitates collaborative CM team meetings and better Member outcomes. We will also share the Member's Health Risk Screening and Comprehensive Health Assessment results, treatment plans, and other documents with their PCP/PCMH, BH Provider(s), treating Providers, case workers from MDCPS, and others participating in the Member's multidisciplinary team to the extent permissible and with appropriate Member authorization.

d. Innovative Methods to Serve the Foster Care Population

We will deploy a variety of innovative methods to assure we meet the holistic needs of children and families involved in foster care. This will include the following:

- **Training and Education.** Our CM team will be cross-trained on PH and BH and will receive comprehensive training designed specifically for the foster care population, including: understanding child welfare, trauma-informed care, and motivational interviewing techniques to engage and screen Members for BH, SUD, OUD, SDOH needs, additional training on health disparities, LGBTQ+ issues and concerns, implicit bias, and adverse childhood experiences (ACEs).
  Each Member of our CM team will also complete training on Person Centered Thinking® by the Learning Community for Person Centered Practices to strengthen our ability to understand, identify, and respond to Member personal goals and preferences and build highly tailored treatment plans. We will also train our team in Wellness Recovery Action Plans, training to understand and recognize situations involving human trafficking, and youth Mental Health First Aid that helps them assist Members experiencing a mental health or substance use-related crisis.
- **Trauma-informed Care Toolkit.** Understanding the trauma needs of children involved with child welfare is essential to providing care for this population. Our forthcoming trauma-informed care toolkit will provide a roadmap for Providers of all types and sizes to begin and continue implementing the strengths-based framework to promote responsiveness to the impact of trauma on Members. This approach emphasizes physical, psychological, and emotional safety, and includes content on cultural competency for serving African Americans, American Indian or Alaskan Native, and people of color to address inequities in care. Providers can use assessment tools to measure programs and receive ongoing support from our CCO to discuss successes and barriers to implementation.
- **Supporting Transition Age Youth.** Early planning for successful young adult transitions to the adult system of care is essential and a key strength of parent company and its affiliates' experience and approach. Our designated Care Managers will collaborate with caseworkers to begin working with youth at age 14 to begin helping them understand the services, supports, and resources that will be available to them, encourage continued education, and foster independence and self-management of their healthcare. As Members near the age of 16, we will also work with them on accessing employment-related supports, such as interviewing techniques, job search activities, self-management skills, financial literacy education, and health literacy information to achieve successful independence.
- **Using Pharmacy Benefit Claims Data for Improved Health Outcomes.** Using pharmacy claims data from the State's PBA and in collaboration with our pharmacy partner, we will provide focused pharmacy

programs that will promote prescribing best practices, prescription access and medication compliance. We will identify Members, aged 18 and over, including transition age youth who are:

- At risk of SUD, OUD, or other harmful substance use
- Receiving multiple controlled substance medications and/or at high dosages
- Filling opioid prescriptions from multiple Providers at multiple pharmacies
- Receiving certain combinations of controlled substances

We will also monitor inappropriate prescribing of antipsychotics, stimulants, and antidepressants for children under age six, as the use of such medications outside of clinical guidelines for early identification and prevention of potential complications and adverse side effects. Members and prescribers will receive coordination support by our CM team.

e. Addressing Racial, Ethnic, and Geographic Disparities for Foster Children

Through our local, data-driven approach, we will continuously evaluate and refine our solutions to address racial, ethnic, and geographic disparities for children in foster care. To identify gaps, we will analyze publicly available data sets combined with claims data, HEDIS measures (such as children and adolescents on antipsychotics), EPSDT screenings, and Well-Child visits by foster care children. We will actively engage our Members, CBOs, Providers, and other stakeholders in designing, implementing, and evaluating health equity and health disparity initiatives.

A.6 Dental Services

a. Direct Experience in Dental Service Delivery and Payment

We will be accountable to the Division for all services delivered to Members and all contractual obligations. We will leverage our parent company and its affiliates' experience in dental service delivery to maintain a robust and seamless delivery model. Our selected dental partner has extensive expertise in service delivery and payment serving more than 25 million dental Medicaid and CHIP Members. This experience includes a longstanding partnership with our parent company and its affiliates ***administrating dental and vision benefits*** for more than three million Members in shared markets across the country today. Together, we have built successful shared processes, programs with a track record of success, and innovative solutions. Our success in other markets is demonstrated by achieving an overall dental Provider satisfaction rating greater than 90% and within one of our affiliate plans, achieving the highest HEDIS rate for annual dental visits over the past three years. Our seamless delivery model includes assurance of subcontractor oversight and accountability at all operational levels.

Dental Service Delivery

Our partner's core dental benefit administration experience includes eligibility determination, claims intake, processing, and payment; encounter data submission; customer service; complaints, Grievances and Appeals; utilization review, network recruitment and retention; Provider credentialing; fraud, waste, and abuse prevention and detection; Member and Provider surveys; quality assurance; and reporting. We have extensive experience customizing programs to meet local and statewide needs. Further, we will leverage our Provider network experience in building, maintaining, supporting, and monitoring the network to assure it will meet Contract requirements and serve Member needs.

Dental Claim Payment

Our proposed solution uses a proven claims processing system specifically designed for dental programs and customizable for Division policies to assure prompt and accurate claims are paid only for medically necessary services. Our dental partner processes Medicaid claims with a financial accuracy of more than 99%. Our three Mississippi Provider Representatives are assigned by region and they will act as a main point of contact for all Provider related queries including dental claims. We will also leverage our Grievance and Appeals process to judiciously resolve Member and Provider concerns related to dental claims payment. We will closely monitor Grievance and Appeals data to help us implement strategies across functional areas and maintain high Member and Provider satisfaction.

b. Innovative Methods in Dental Care Delivery

In addition to covered services outlined in Contract Sections 4.1.3, 4.2.5, 4.2.10, 6.2.1, 6.2.2, 12.3.1 and 16.7.1, we will bring unique and innovative solutions to reach rural Members and leverage preventive services. We will invest in implementing strategies that support whole person health and complement the goals of the Division and the Mississippi State Department of Health, Office of Oral Health. We will leverage shared analytic claim data to proactively identify potential medical needs from specialized Providers and identify trends within targeted populations. We propose programs that support a culture of good oral health, such as:

[redacted]

[redacted]

[redacted]

Teledentistry

Teledentistry expands access to dental screenings and preventive care for underserved populations by helping Members who face barriers, such as lack of transportation or living in an area with limited dental Providers. Through triaging and providing early evaluations, Providers can improve outcomes, decrease the overall cost of care, and reduce ER use. For example, through a successful pilot, our dental benefit partner has reported the following improvements:

[redacted]

Additionally, contact through teledentistry has been found to help improve HEDIS scores and EPSDT screenings. We will offer preventive and urgent care consultations and 24/7 teledentistry for oral health emergencies. Following teledental visits, we will refer the Member back to their dental home to assure continuity of care. The outcome of the visit will be added to the Provider Portal the day following claim receipt.

[redacted]

Leveraging Data and Offering Incentives to Engage Members in their Dental Care

By leveraging appointment tracking data in innovative ways, we will identify Members for proactive outreach to remind them of available rewards for completing an Annual Dental Visit (ADV) and when they are due or overdue for regular dental care. Further, we will collaborate with our transportation and dental benefit Provider to share data and provide NET information to educate Providers on how we can coordinate NET services for MississippiCAN Members. We will also encourage Providers to identify Members who have missed their

[2] Crystal, Y.O. and Niederman, R., *Evidence-Based Dentistry Update on Silver Diamine Fluoride* (January 2019).
[3] March of Dimes, *Dental Health During Pregnancy* (June 2019).

dental appointment so that we may educate the Member on the importance of regular care, help them reschedule their dental appointment, and book transportation if needed. CHWs will provide these same supports to Members that need assistance accessing care.

c. Addressing Racial, Ethnic, and Geographic Disparities in Dental Care

Through our local, data-driven approach (illustrated in Figure 4.2.2.1.1.A.1-4), we will continuously evaluate and refine our solutions to address racial, ethnic, and geographic disparities for dental services and outcomes. Our strategy will include monitoring clinical performance measures such as HEDIS ADV and CMS 416 data. Tracking and analyzing data such as services for sealants, oral evaluations, topical fluoride treatments, and care continuity and utilization will allow us to monitor Members' dental health and create strategies specific to subpopulations.

Our local Population Health Director will oversee our approach, working in collaboration with our dental partner, other CCO clinical and Provider services leadership, and the Division. [redacted] Each proposed intervention will be managed locally under the new Contract, with a specific owner responsible for the development, execution, and evaluation of the initiative.

We know a variety of disparities exist in Mississippi related to dental services. For instance, only about half of Mississippi's children eligible to receive dental prevention and screenings access these services. In 2019, Mississippi ranked 41st for preventive dental visits and 47th for access to dental Providers. To address these disparities, we will work with a variety of dental Provider and community partnerships to determine root causes, including our HEAC, which will include Members from key public health agencies and other Mississippi experts focused on oral health screening and prevention.

[redacted]

Addressing Health Disparities Through Collaborative Methods

We know behaviors that affect general health such as tobacco use, excessive alcohol use, and poor dietary choices are also associated with poor oral health. Therefore, to facilitate comprehensive whole person healthcare, we will leverage relationships with Providers and community partners. We will offer oral health information to PCPs to share with patients at visits and offer them dental sealant, oral health evaluation, and fluoride varnish educational materials. To reach underserved populations, we will provide mobile dental services. For services not appropriate in a mobile setting, we will refer Members to the Providers' brick-and-mortar clinics to assure continuity in care. Further, in addition to leveraging and supporting FQHCs and Rural Health Clinics (RHC), we will use our Community Engagement team to target Members who have an ADV gap.

Based on the disparities identified, we will focus on measurable outcomes in areas such as increasing the rate of annual dental visits and increasing access to mobile dental visits. We will achieve these goals through a variety of targeted interventions included in Table 4.2.2.1.A.6-1.

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Once interventions are implemented, we will continue to evaluate and determine impact though data collection and analysis, with a focus on our disparity targets. As we identify both successes and opportunities for improvement, we will share data on our performance with our HEAC, Member Advisory Committee, CBOs, Providers, and other stakeholders through roundtable discussions. This information will be aggregated, evaluated, and reported up through our [redacted] and QMC for necessary adjustments.

A.7 Vision Services

a. Direct Experience in Vision Service Delivery and Payment

We are accountable to the Division for all services delivered to Members and all contractual obligations. We will leverage our parent company and its affiliates' experience in vision service delivery to maintain a robust and seamless delivery model. Together with our vision partner, we have built successful shared processes and innovative programs with a track record of success. We have successfully partnered with this vendor for many years across multiple states. Our seamless delivery model includes assurance of subcontractor oversight and accountability at all operational levels.

Vision Service Delivery

We will provide a full spectrum of services, tailored to specifically meet all contractual requirements including Sections 4.1.3, 4.2.3, and 4.2.6. Services will include core vision benefit administration such as eligibility, claims intake, processing, and payment; encounter data submission; customer service; complaints, Grievances and Appeals; utilization review, network recruitment and retention; Provider credentialing; fraud, waste, and abuse prevention and detection; Member and Provider surveys; quality assurance and improvement; and reporting. We will also offer services above and beyond these core functions, including benefit design for Value-Adds; innovative Population Health management programs; medical/vision/dental integration programs; and Member and Provider outreach and education services.

Vision Claim Payment

We will leverage an advanced claims processing system to assure prompt and accurate claims payment for Providers. [redacted]

Our three (3) Mississippi Provider Representatives are assigned by region and they will act as a point of contact for Provider queries related to dental and vision claims. We will also leverage our Grievance and Appeals process to judiciously resolve Member and Provider concerns. Closely monitoring Grievance and Appeals data will help us engage functional strategies and maintain high Member and Provider satisfaction.

b. Innovative Methods in Vision Care Delivery

We offer quality of care initiatives for improving overall ocular health and chronic condition management using Member and Provider communications and tools to help drive positive outcomes. Programs that we propose include:

Health Risk Disease Management Report

Recognizing that certain conditions have the potential for high morbidity and that early identification of systemic/chronic medical conditions can be identified during an eye exam, we will compile and analyze a risk chronic condition report. The monthly report will identify Members who present to the eye doctor with specific findings or diagnoses. The report will consolidate cases where certain underlying systemic conditions are present, often with a high potential for medical management costs, significant morbidity, and high incidence of multispecialty intervention or hospitalization. We will share the report with Care Managers who will work with the Member to update their treatment plan, including necessary referrals.

Wellness Events

To offer additional access for targeted Members and close specific care gaps, we will provide vision education and screenings at our CCO-sponsored health fairs and Vision Screening Days at least quarterly such as:

- Intraocular pressure testing (glaucoma) screenings for high-risk populations
- Retinal image capture and interpretation to satisfy HEDIS diabetic exam measures
- Basic visual acuity testing with referrals for a follow-up exam, as deemed necessary

c. Addressing Racial, Ethnic, and Geographic Disparities in Eye Care

In addition to chronic health conditions, risk factors for eye disease also include race and ethnicity as well as SDOH factors like education and neighborhood.[5] Using health equity analytics, we will evaluate the distribution of ocular health risk, service use, resources, and costs across racial, ethnic, and geographic population subgroups to identify and address disparities. Our local, data-driven approach (illustrated in Figure 4.2.2.1.1.A.1-4) highlights this comprehensive process.

To identify gaps, we will analyze publicly available data sets combined with claims data, HEDIS data sets, screenings and assessments, and findings from stakeholder engagement to provide insight into Members' and communities' cultural and health needs. Tracking and analyzing data, such as profiles designated as high risk for eye diseases like glaucoma, will allow us to monitor Members' ocular health and create strategies specific to subpopulations.

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[4] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Public Health Approaches to Reduce Vision Impairment and Promote Eye Health; Welp, A., Woodbury, R.B., McCoy, M.A., et al., editors, *Making Eye Health a Population Health Imperative: Vision for Tomorrow* (September 15, 2016).

[5] Centers for Disease Control and Prevention, *Social Determinants of Health, Health Equity, and Vision Loss* (June 9, 2021).

Focusing Interventions to Address Disparities in Vision Care

We know that disparities around vision care exist across the state. For example, among children with special health care needs (CSHCN), an estimated 6% have unmet vision care needs, and these rates differ significantly across racial, ethnic, and socioeconomic groups. Compared to non-Hispanic White CSHCN, non-Hispanic Black, multiracial, and Hispanic CSHCN are two to three times more likely to have unmet vision care needs. To address these disparities, we will work with a variety of vision care Providers and community partners to determine root causes, including our HEAC. Based on the disparities identified, we will focus on measurable outcomes in areas such as increasing the rate of annual vision exams, particularly for those underserved and for individuals diagnosed with diabetes and at greater risk of vision problems. We will achieve these goals through a variety of targeted interventions included in Table 4.2.2.1.A.7-1.

Once interventions are implemented, we will continue to evaluate and determine impact though data collection and analysis, Provider feedback, and CM engagement with a focus on our disparity targets. We will share data on our performance with our Member Advisory Committee, CBOs, Providers, and other stakeholders in scheduled meetings and reports. This information will be aggregated, evaluated, and reported up through our and QMC for necessary adjustments to improve health equity performance.

A.8 Additional Items

a. No Cost Sharing or Copayments Required

We will not require any cost sharing or copayments from our MississippiCAN or CHIP Members that are not required by the State. If programs such as those outlined in 4.2.10 for CHIP Members are deemed required, we

will educate Providers on how to collect this money and will process claims accordingly. Reducing barriers is one of our key priorities, and we recognize that imposing cost sharing or copayments may create access issues. Our goal is to make access to quality healthcare easy for our Members and to support Providers in delivering this care. Our approach to advancing health equity by reducing disparities, maximizing health outcomes, and addressing health-related social needs is a collaborative framework focused on ***the development of innovative solutions to address Member needs and the needs of their communities, increasing access, and improving outcomes***.

b. Ensuring Access to NET for MississippiCAN Members

Delivering NET is a vital element of healthcare delivery, especially for MississippiCAN Members living in rural areas where they often need additional transportation services to travel to and from non-emergency medical appointments and services. As part of our commitment to providing reliable and timely access to necessary services, we will contract with our vendor to provide NET benefits to assure reliable and accessible transportation delivered in a way that is responsive to our MississippiCAN Members' unique needs, promoting access to care and health equity. [redacted]

Approach for Serving Members in Rural Areas

We understand the unique challenges that delivering transportation to Members residing in rural areas poses, and we will introduce policies and practices that are responsive to these needs. Our ***Transportation Specialist*** will oversee the CCO benefits-based NET services and assist Members in finding rides to places that support their overall health, such as job interviews, grocery stores, and community events. We will collaborate with our transportation partner to provide MississippiCAN Members reliable, timely transportation with an approach that integrates the following key components:

- **Innovative Provider Rate Structure.** We will offer rates that incentivize transportation Providers to fulfill trips in rural areas.
- **Unique Partnerships.** We will work with medical facilities and Tribal health clinics that have fleets to set up unique arrangements that enable Members to receive trips to appointments or programs at their facilities.
- **Leveraging Community Drivers.** We will leverage volunteer drivers in rural areas where public transportation and traditional transportation Providers are lacking. We have identified approximately 60 volunteer drivers that will supplement our network in rural counties throughout the State.
- **Gas Mileage Reimbursement.** Members with access to a working personal vehicle can drive to their medical appointments or arrange for a friend or family member to drive them to their medical appointments and will be reimbursed accordingly, and we will help them understand how to get that reimbursement.
- **Removing Administrative Burdens.** We will enable our Members as well as their caregivers and Providers of care to schedule standing order rides. This is particularly helpful for Members with chronic conditions that require reoccurring trips. As examples: dialysis, cancer treatments, and infusion services.
- **Leveraging Telehealth.** We will track the NET utilization data, including ride trip codes, frequency of trips, and high-mileage trips, for our Members that reside in more rural counties to identify those that may benefit from telehealth services and connect them to such services. Leveraging telehealth services for Member care, where appropriate, can also help free up NET capacity in the more rural areas of the State.
- **Local Oversight Resource.** Our local Mississippi Vendor Oversight Manager will oversee our NET partners' performance, assuring compliance with all Contract requirements to best serve the Division and Members. They will work with our transportation partner to address any requirement changes or performance issues and make sure they are communicated and appropriately escalated to achieve timely resolution. When we receive a complaint, especially those for late or missed trips, we will work with our transportation partner to resolve the issue, which includes monitoring the outcome, identifying the root cause of the complaint, and putting safeguards in place to prevent like issues from reoccurring. We will work collaboratively with the Division's oversight staff to address any systemic NET issues identified.

c. Proposed Innovations to Improve Delivery of Member Services and Benefits

We are dedicated to comprehensively meeting the healthcare needs of MississippiCAN and CHIP Members in ways that ***identify and target existing needs, improve access, and reduce health disparities***. Table 4.2.2.1.A.8-1 details some proposed innovations.

d. Health Equity Focus and Commitment to Address Disparities

Through our local, data-driven approach (illustrated in Figure 4.2.2.1.1.A.1-4), we will continuously evaluate and refine our solutions to address racial, ethnic, and geographic disparities. We will partner with Members, advocates, Providers, community organizations, and the Division to inform and guide efforts to create a more equitable healthcare experience for our Members — putting our health equity framework in action.

Our local Population Health Director will oversee our approach, working in collaboration with other CCO clinical and Provider services leadership, and the Division. Each proposed intervention will be managed locally under the new Contract, with a specific owner responsible for the development, execution, and evaluation of the initiative.

We know disparities exist concerning COVID-19 and the importance of vaccinations, particularly in Black communities and in American Indian communities. For example, American Indians experience nearly double the cases of COVID-19 per 100,000 in comparison to their White counterparts and nearly four times the number of deaths. Black residents in Mississippi also experience disparities related to their White counterparts in contracting COVID-19 — 388 cases and 21 more deaths per 100,000. To address these disparities, we will work with a variety of Provider and community partners to determine root causes, including our HEAC, which will include Members from key public health agencies and other Mississippi experts focused on preventive health and screenings (including immunizations).

Based on the disparities identified, we will focus on measurable outcomes in areas such as decreasing the rate of COVID-19 cases, hospitalizations, and deaths among Black and American Indian communities. We will achieve these goals through a variety of focused interventions, outlined in Table 4.2.2.1.A.8-2, to address the disparities that exist in receiving COVID-19 vaccinations.

Table 4.2.2.1.A.8-2. Closing the gap in COVID-19 vaccination rates.

Interventions to Address COVID-19 Vaccination Rates	
• ***Care Manager with Tribal experience*** who will work with the Choctaw Tribal community to inform them about the importance of receiving COVID-19 vaccinations, including booster shots.	• ***Community Health Workers with Tribal experience*** to engage American Indian Members in culturally responsive ways about the importance of vaccines and connect them to resources for vaccination in their community.
• ***Education to Black Members*** on the importance of COVID-19 vaccinations and connect them to resources in the community to receive the vaccine.	• ***Member Health Incentive program*** for COVID-19 vaccination with culturally responsive and appropriate outreach to Black communities and to Members of the Choctaw Tribe to inform them about the incentives available.
• ***Multimodal outreach*** (in person, calls, texts, and appointment scheduling assistance) on the importance of ***COVID-19*** vaccines, resources, and sites for vaccination in local communities.	

Once interventions are implemented, we will continue to evaluate and determine impact though data collection and analysis (such as evaluating claims for service utilization), Provider feedback, incentive utilization, and CM engagement with a focus on our disparity targets. We will share data on our performance with our HEAC, Member Advisory Committee, CBOs, Providers, and other stakeholders. This information will be aggregated, evaluated, and reported up through our [redacted] and QMC to improve our health equity performance.

B. Member Services Call Center

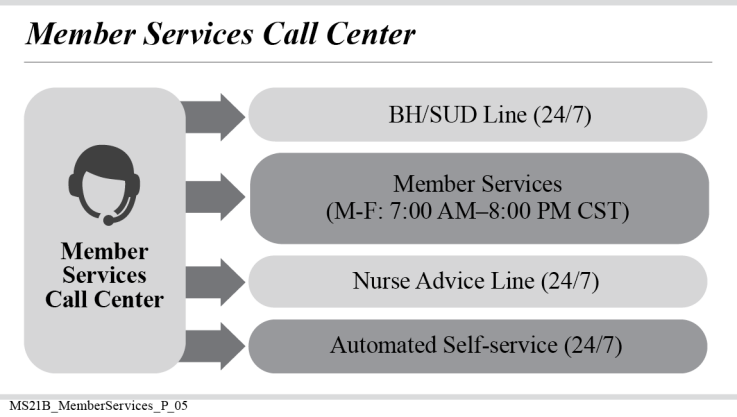
1. Our Member Services Call Center: Improving Access for Members

We understand that for many Members, our Mississippi Member services call center team will be the first point of contact when they need help and information to access needed healthcare services. To best serve our Members' varied needs, our Member services call center will use an integrated platform that seamlessly blends self-service and agent-assisted service to provide each Member with easy access to personalized support. Our team of diverse, qualified, well-trained Member Services Call Center Representatives (MSCCRs) will assist MississippiCAN and CHIP Members with any issue such as:

- Scheduling Provider appointments when needed
- Connecting MississippiCAN Members to our transportation vendor for Non-Emergency Transportation (NET) services
- Helping Members navigate their services and benefits including our Member Health Incentive program
- Resolving emergency issues
- Making referrals to the Fraud and Abuse Hotline

Our Mississippi-based Member services call center will leverage our national organization's call center technology platform to offer Members comprehensive, personalized Member services. We will use a powerful customer service application that helps our MSCCRs handle Member inquiries and requests more efficiently. This application integrates information from multiple back-end systems into a single screen view for our MSCCRs.

Figure 4.2.2.1.B.1-1. A single toll-free number.



Our Member services call center (see Figure 4.2.2.1.B.1-1) will be available Monday through Friday from 7:00 a.m. to 8:00 p.m. CST except for New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, and Christmas. Members calling outside of normal business hours will receive a message in English or Spanish depending on the language selected at the start of the call that provides the hours of operation and offers to connect them quickly if needed to the 24-hour nurse advice line or Behavioral Health (BH)/Substance Use Disorder (SUD) line. We will also offer 24/7 automated self-service through our Member services call center's toll-free number's automatic call distribution (ACD) system as well as our secure Member Portal, and mobile app. ***Members can call our toll-free number and choose options*** to:

- Connect to Member Services, where Members can check Enrollment status, find the right PCP or BH Provider, change Providers, and access assistance with making appointments. Additionally, they can update their address and phone number and request Member materials like their ID card, Member Handbook, or Provider Directory
- Connect 24/7 directly to the BH/SUD line and the nurse advice line
- Be connected by the MSCCR to Care Management (CM)
- Address Grievances and Appeals and access help making fraud and abuse referrals

Personalized and Responsive Member Services

When a Member calls in the MSCCR will use an integrated desktop to streamline access to needed information, eliminating the need for MSCCRs to spend time flipping between screens and keeping the Member waiting while they search for information during the call. The integrated desktop will display necessary information including talk tips for the MSCCRs to facilitate effective Member interactions and make sure the right key points are included in the conversation in an organized and simplified fashion. All MSCCRs will be trained to use this business rule-driven system that drives the transactional flow and enables the MSCCR to focus attention on the caller and the conversation and not be distracted wondering if they are following the correct process to optimize responsive call support. These preprogrammed rules are customized down to the product and Member level and enhance efficiency and consistency in servicing Member requests while the integrated desktop system simultaneously captures detailed call documentation. When an MSCCR is unable to resolve an inquiry during the first call, the issue will be immediately transferred to the appropriate business area for resolution and the issue status will be available for all viewers. All MSCCRs will be trained on the escalation processes and when appropriate to use the warm-transfer approach for our "no wrong door" commitment to Members. ***Our system is designed to create consistent responses for Member inquiries***, so we will always be delivering high-quality responses to all Member inquiries. Further, our system is customized based on the Member's Enrollment in MississippiCAN or CHIP. System updates will be applied immediately upon receipt to our system knowledge base and become available for the MSCCRs in real time. Our systems and processes have the flexibility to get more prescriptive with an interactive script to meet Contract requirements and exceed

the Division's expectations, including for emergency and unusual situations with a natural, personalized, and fully informed approach. We will provide each caller with a call reference number for the caller's records.

Measuring Member Satisfaction

We will use a sophisticated performance management reporting and data visualization package for telephony and voice of the customer metrics, including multiple key performance indicators that will directly measure Member satisfaction. We will also track and analyze Member feedback in our Service Quality Committee, which rolls up to the Quality Management Committee. All callers will be asked for their level of satisfaction at the end of each call and their response is stored in our system where it is used to measure trends and for reporting. MSCCRs will be well-versed in our complaint and Grievances processes. If an issue is not resolved during the initial call or within 48 hours, we will help the Member access the Grievance system. Member experience reports include those that:

- Pull all the key performance guarantee data together into a single view
- Summarize the Member email survey results for MississippiCAN
- Shows any follow-up from calls that have not yet been completed
- Provides a dashboard view specific for MississippiCAN leadership showing call metrics and results

We will also administer automated surveys for our Member services call center. A random sample of callers will receive an email or automated call with a request to complete the survey; we use email if we have the Member's email available. We will gather Member feedback on their experiences with the Member services call center. We will use this information to continually assess Member satisfaction levels and respond to emerging issues and evolving trends. [redacted] All calls will be documented, and we will measure Member satisfaction through an annual CAHPS® and analyze Grievances. We will provide a toll-free telephone number to respond to Members' inquiries, issues, or referrals, and we will text monthly to measure Member satisfaction.

a. The Location Will Be Within the State of Mississippi

Yes.

b. Call Center Response Standards and Measures

We will maintain operating protocols that promote consistent attainment of our service standards, including real-time monitoring of our call-handling performance and comply with all Division performance standards. Our Workforce Management team monitors performance metrics using a variety of technology tools and real-time reports. We encourage our MSCCRs to meet the needs of each caller and will not promote a standard for average length of call. We will never rush callers or place a maximum time limit on Member calls; our system optimizes the use of the time we do spend to promote first call resolution and provide added convenience and speed to resolution for our Members. [redacted]. We will report the findings of these audits as required to the Division, make recordings available to the Division upon request within five business days, and maintain the recordings for 10 years.

Additionally, we use reporting measures to assure telephone statistics meet national benchmarks, individual state Medicaid Contract requirements, and the Coordinated Care Organization's (CCO's) internal guidelines. The ACD and Service Level reports are downloaded on a daily, weekly, monthly, and quarterly basis from the contact management system. Results are distributed daily, weekly, monthly, and quarterly to management, including managers and above. Reports are also available at any time via self-service. The ACD is available 24/7 for Member eligibility verification, claims status, and authorization status.

c. Accommodating Non-English Speaking, Hearing Impaired, and Visually Impaired Callers

To assure all Members have access to the same call center supports and resources, we have identified Culturally and Linguistically Appropriate Services (CLAS) as a core element of our cultural competency program. CLAS will also be an important part of our quality management program to support our efforts working toward NCQA's new Health Equity distinction. We will provide access to appropriate linguistic services for all Members emphasizing services that best support Member needs based on our assessment of Mississippi Member demographics. We understand that most MississippiCAN and CHIP Members speak English or Spanish and will configure our call center platform with options that make it easy for Members to access Spanish prompts or request a live Spanish-speaking representative. We will train all our employees on how to identify the need for and initiate interpretation services for all Member calls. All other interpretive services will be provided by professional over-the-phone interpreters trained in healthcare terminology. The FCC's 7-1-1 Telecommunication Relay Service (TRS) or locally contracted interpreter service partners will be available at no charge to Members. The 7-1-1 system accommodates all types of telecommunication relay calls, including video relay where the TRS operator and the caller are signing to one another while having a voice conversation with the MSCCR.

d. Responding to and Properly Handling Calls for Immediate Medical Needs

Our menu of telephone prompts is designed so that callers with emergent or urgent needs are immediately directed to the help they need. Our welcome message will instruct Members with a medical emergency to hang up and dial 911. Members in danger of hurting themselves or others will be instructed to press a key that directly connects them a representative with our 24/7 BH/SUD line. We also train staff to recognize and respond to Member crisis calls and Members experiencing acute health symptoms. For example, when Members call the BH/SUD line, they will reach a MSCCR trained in recognizing Members in crisis. Staff listen for signs of distress, depression, anxiety, or intent to hurt self or others. If the MSCCR determines a Member is experiencing a crisis, the MSCCR will bring a BH Clinician on the call via warm-transfer to address the crisis in real time. This may include referral to emergency services, connection to the Member's local mobile crisis team, referral to outpatient Providers, and telehealth access. All calls will result in a referral to our CM team for follow-up and further assistance with connection to services and supports.

e. Training Program for Call Center Employees, Including Cultural Competency and Care Management

Our extensive Member Services training program will include curriculum specific to the MississippiCAN and CHIP Programs, including Covered Services, Member Rights, Cultural Competency, Identifying Emergency Calls, the MississippiCAN Provider Network, and NET. Our training curriculum supports MSCCRs in building the skills necessary to deliver knowledgeable and accessible assistance and services to our MississippiCAN and CHIP Members of all cultures and abilities. ***Members can be confident they will be talking to a skilled MSCCR with complete knowledge of issues and who is committed to solving the inquiry on the first call.*** All employees will attend a one-day orientation about our company and services, HIPAA privacy compliance requirements, and our customer and membership base. We will conduct our training in a controlled environment with supervision and coaching, followed by an evaluation period. The curriculum will cover a variety of topics, including Member Services core training and training specific to the MississippiCAN and CHIP Programs. [redacted] Table 4.2.2.1.B.2 details some of our specific trainings. MSCCRs and Provider Services Call Center Representatives receive the same training upon hire and to advance in levels, which is detailed more completely in Section 4.2.2.2 B of this response. ***Training includes New Hire Training, Refresher Training, Advanced Skillset Training, and Specialty Skillset Training (see Table 4.2.2.1.B.1-1).***

Table 4.2.2.1.B.1-1. Comprehensive staff training offered to maintain skills.

Topic	Training Description
Systems Training	We will introduce MSCCRs to the computer-based programs that will be used to assist Members. They will undergo extensive training on our core operations systems as well as instruction on verifying Enrollment, changing a PCP, and accurately recording all Member transactions in the contact log. We will also provide training on our CM philosophy and the role of our CM team. MSCCRs will learn to identify issues that may require the involvement of a Care Manager, such as a more complex coordination issue. Our training, and subsequent monitoring, assures that unlicensed staff never provides health-related advice.
Call Monitoring	MSCCRs will participate in call monitoring, a controlled classroom exercise in which they listen to live calls and see the systems in use. MSCCRs discuss each call and learn techniques to address Members' needs.
On-the-job Training	MSCCRs will remain in the classroom and handle live calls under close supervision from an experienced staff Member. We will provide an assessment exam after each training session to gauge their understanding of our processes and procedures.
Continuing Training	After MSCCRs receive their initial training and begin taking Member calls, they will benefit from continued training assuring their skills remain fresh and are continually engaged in personal development. When we introduce a new product or system, we will make certain that each MSCCR fully understands the product through one-on-one and/or classroom training. We will provide ongoing training at least quarterly and include education about Medicaid, the MississippiCAN and CHIP Program, transfer protocols, and customer service. We will also provide education about Medicaid changes and requirements, including "Late Breaking News" articles, Provider bulletins, State Plan Amendments, Administrative Code Filings, the Division's Provider Reference Guide, and MississippiCAN Program updates.
Cultural Competency Training	Recognizing and being sensitive to the cultural needs of a diverse population and recognizing the impact of implicit biases is a core competency for all employees, including MSCCRs. All employees must complete this training upon hire and annually thereafter and pass an exam at the end of the course to demonstrate their understanding that provision of services to people of all cultures, races, ethnicities, regional backgrounds, abilities, sexual orientation, gender identities or expression, and religions must be completed in a manner that recognizes, values, affirms, and respects the worth, and protects and preserves the dignity, of each Member.
Ethics, Compliance, and Program Integrity Training	We will require ethics and compliance training for all employees as a condition of employment. Each employee must successfully complete, at a minimum, three hours of initial compliance training within 30 days of employment and four hours annually, thereafter. Employees who fail to complete the required courses will be subject to corrective action, up to and including termination of employment.

f. Avoiding Service Interruptions and Mitigating Downtime

We will maintain operating protocols that promote consistent attainment of our service standards, including real-time monitoring of our call-handling performance. For example, if call volume increases beyond the capacity of our scheduled MSCCRs to respond, we can and will expand the call answering queue to include designated backup MSCCRs in other locations who are trained to support MississippiCAN and CHIP Members. We will also expand the queue to other call centers as part of contingency plans for facility or system outages. An added benefit of being able to move calls between call centers is our ability to react quickly during natural disasters. Because our telephone technology enables us to easily route calls to MSCCRs based in other locations, we will route a percentage of calls to these other locations on a regular basis. This assures that in the event of an interruption in local service, Member calls are serviced by MSCCRs that are both trained and current on the needs of our Mississippi Members.

We will also maintain a backup system capable of operating eight hours at full capacity. In the event, such as a fire, flood, or damage to a building, our Business Continuity Plan will be activated. Together, response teams will assess the duration of the facility outage and activate the employee call tree. If necessary, they will compile information about which employees are available to travel to other sites. The primary focus is redistribution of employees according to need and skill set, with consideration of what training, lodging, transportation, and work materials may be required at interim locations. Finally, the team will plan for return to the permanent work site at the time it is expected to be available again. Our leadership team will notify the Division immediately when employing the backup system, and we will provide a manual backup procedure in the event the system is down to remain able to take Member calls without interruption.

g. Behavioral Health and Substance Use Disorder Crisis Intervention and 24/7 Phone Access

Members experiencing a BH or SUD crisis will be able to call one number for Member Services and to be immediately connected with a BH services MSCCR. The MSCCR will screen callers for crisis and harm and promptly connect those in crisis to a licensed BH Clinician with at least five years of clinical experience, while staying on the line to make sure the connection is made. Callers will be warm connected to a BH Clinician if the caller expresses intent to harm themselves or others, mentions involvement with weapons or a history of potential for domestic violence, indicates or suggests the possibility of abuse or neglect, indicates urgent or emergent needs due to SUD, or if the caller is incoherent. In these instances, or in the event the MSCCR is not able to resolve the Member's request, the MSCCR will connect with a BH Clinician to support the Member. Our ACD will also provide an option for a Member in crisis to be connected directly with the BH/SUD line, and the BH Clinician will immediately assess each caller by gathering key information, including the reason for the call, the presence of potential threats of harm, involvement of drugs or alcohol, co-occurring medical or BH conditions, status of any current BH treatment, and adequacy of the Member's immediate support system. ***Using standardized protocols that guide case handling according to the intensity of the caller's situation, the BH Care Manager will coordinate the services necessary to evaluate and stabilize the urgent or emergent situation.*** For life-threatening emergencies, the BH Clinician will arrange for immediate evaluation of the Member and alert local emergency services, or community mobile crisis response as appropriate. If the emergency is non-life-threatening, the BH Clinician will coordinate evaluation by local resources, such as the local Community Mental Health Center or other community-based Providers. We can also warm connect the caller to their local CMHC/mobile crisis response. In all cases, our local BH Care Managers will follow up with the Member to confirm the evaluation took place and to coordinate subsequent services.

2. Multimodal Communications with Automatic Call Distribution (ACD) Capabilities

As a key component of our multimodal communication approach, and to assure responsive and consistent communication access for our Members, our ACD provides high call efficiency without delay to Members. Calls will be balanced between two data centers with full redundancy and capacity for both to accept 100% of call volume from the projected 125,000 MississippiCAN and CHIP Members. Based on decades of Medicaid experience from our affiliates, we will understand how to predict peaks in call volumes prompted by, for example, significant change in benefits or a natural disaster and can proactively adjust staffing to meet an increase in demand. As a part of standard operations, the ACD will:

- Answer all calls within one ring.
- Advise callers that calls are monitored and recorded for quality assurance.
- Ask Members if they require assistance in a language other than English.
- Ask Members if they are experiencing a mental health or BH event, giving the Member the option to be routed directly to the 24-hour BH/SUD line.
- Maintain a reporting system to record and aggregate to inform reports as required in the MississippiCAN and CHIP Reporting Manuals as well as any other report required by the Division.
- Appropriately transfer a Member to a live MSCCR with an average hold time that will not exceed two minutes, including to our 24-hour BH/SUD line, 24-hour nurse advice line, or Member services call center.
- Enable transfers to Case Management during regular business hours. Calls are triaged, and MSCCRs will help with Member needs they are able to address and provide a transfer to CM during regular business hours, if needed.

Our ACD capability supports our commitment to a "no wrong door" approach for access to healthcare services. We will use a routing decision tree to connect a Member to the right MSCCR the first time. Our approach to providing access to healthcare is intentionally flexible and proactive to include Member-initiated referrals through the Member services call center and ACD for those Members invested in addressing issues for themselves or those who need to be connected to healthcare services during off hours. Our ACD will be equipped with natural language capabilities to

make it more pleasant and efficient for Members to use. The system includes speech triggers that facilitate connection of the Member to an MSCCR trained and equipped to best handle the Member's needs quickly and efficiently. For Members who are hard of hearing or deaf, they will have an option to first dial 7-1-1 to initiate a relay call to our Member services call center. [redacted]

The Workforce Management team will meet the Division's performance standards and requirements through real-time monitoring of the Mississippi Member services call center. We will maintain real-time reports on call queues and shift resources as needed for optimal customer experiences that meet or exceed required performance standards and leverage this trend information to adjust future staffing forecasts. When call volume increases beyond the capacity of our scheduled MSCCRs, we will expand the call answering queue to temporarily include designated Mississippi-trained backup MSCCRs who may be located in other national call centers. ***All MSCCRs will be using the same integrated desktop system, knowledge management system, and workforce management system*** designed to service MississippiCAN and CHIP Members and Providers.

C. Member Handbook

We will create two distinct Member Handbooks: one for MississippiCAN Members and one for CHIP Members. Based on experience in affiliate markets, this approach will help assure that Members fully understand the benefits and services in their plan. Our Member Handbooks will be practical guides to help our Members access their benefits and services and comply with all the requirements outlined in Contract Section 5.4. The Member Handbooks will be at the third-grade reading level; culturally appropriate; available in more than 230 languages and in alternate formats, such as braille, audio, and large print; and available on our Member website in 508c-compliant PDF format for Members who are visually impaired. In addition, Members will receive a cover letter summarizing the contents of the Member Handbook as well as a quick reference guide that provides an overview of essential benefits and services.

We know that accessing care is a key component to health, so the information about access will be prominent in our Member Handbooks. Starting with a section titled ***How to Get Help,*** our Member Handbooks will provide Members with a quick introduction to accessing benefits and services, as well as information and phone numbers for contacting our Member Services department for assistance with access, including:

- Healthcare benefits
- Mental health services
- Substance use treatment
- Care Management (CM) services
- Doctors and making appointments
- Specialty, wellness, and urgent care
- Prior Authorizations
- Interpretation/translation services

1. Accessing Physical and Behavioral Health/Substance Use Disorder Services

We will prioritize creating Member Handbooks that clearly inform Members how to access their physical health (PH) services and behavioral health (BH)/substance use disorder (SUD) services. Two of the most important elements to accessing care are our help lines and our telemedicine options.

24-hour Help Lines

The ***How to Get Help*** section also includes contact phone numbers and concise information about our 24-hour nurse advice line and 24-hour Behavioral Health/Substance Use Disorder line, both of which are staffed with Mississippi-licensed clinicians and available to Members 24/7/365. We recognize that Member questions and concerns are not limited to business hours, and health crises can occur at any time. Nurse advice line nurses offer clinical advice and assistance, including self-care and helping with appointments or referrals to the emergency room or an urgent care facility. For Members who may be having a mental health or substance use crisis, BH clinicians are available to help Members maintain continuous, active engagement for de-escalation and stabilization. An important feature of our help lines is that they use the same phone number as Member Services. This is part of our "no wrong door" approach to access and is especially crucial in urgent and

emergent situations. Members will be able to use one number to speak to Member Services, choose the 24-hour nurse advice line and 24-hour Behavioral Health/Substance Use Disorder line, or be warm transferred.

Telemedicine

As telemedicine has become more sophisticated and widely used, access to care has greatly expanded, especially for those Members with special or emergent needs or who live in rural or underserved areas. Our Member Handbooks will inform Members about the telemedicine services we offer, such as the online urgent care solution, with live video for mobile device/computer for nonemergency and BH visits. The Member Handbooks will also include information on Mississippi Medicaid Providers offering a multimodal program for virtual access to SUD and Medication-Assisted Treatment and an in-school digital virtual visit platform, which provides virtual visit devices in school settings. We will also educate Members about the benefits of telemedicine, identifying Providers in the Provider Directory who offer telemedicine services and how to use the options available.

Description of Benefits

Our Member Handbooks will provide simple and clear descriptions of all covered services so that Members have the information they need to access PH and BH/SUD services. We will include descriptions of PH benefits, including primary and preventive care, dental, maternity, family planning, and pharmacy, as well as EPSDT services, nonemergency transportation, and benefits for children in foster care in the MississippiCAN Handbook and Well-Baby and Well-Child services in the CHIP Handbook. We will include descriptions of BH/SUD services and how they are coordinated with PH services as well as information about the amount, duration, scope, and any limitations on services.

Primary Care

An important avenue of healthcare access is through PCPs. For that reason, our Member Handbooks will educate Members in a clear, concise manner about primary care, emphasizing the importance for all Members of engaging with a PCP. We will also provide information about choosing a Patient-Centered Medical Home (PCMH) and the additional benefits that PCMH Providers offer Members identified with complex needs and in need of CM. Our handbooks will explain how PCPs/PCMHs not only facilitate access to PH services but how they are instrumental in the coordination of care of BH/SUD services. Additionally, we will inform Members about:

- Choosing or changing a PCP/PCMH based on needs, such as language or accessibility
- Restrictions on choosing network Providers
- How to make/cancel an appointment
- Standard wait times and how to report Providers who are not adhering to wait times
- What to bring to your appointments
- Disability access
- When Providers move or leave our network
- Getting referrals for specialists from your PCP/PCMH
- Information about family planning and the freedom to choose any family planning Provider
- Scheduling transportation for an appointment

2. Informing Members About Care Management

Members with a higher level of health literacy are more likely to be engaged and experience better healthcare outcomes, as Figure 4.2.2.1.C.2-1 shows. Therefore, connecting Members with CM services is key to assuring timely access to care and the best possible health outcomes. Our Member Handbooks will provide comprehensive information about our CM program, as outlined in Figure 4.2.2.1.C.2-1, and comply with the requirements in Contract Section 5.4.2.9.g. The Member Handbooks will cover the vital elements of the CM program, including:

- Contacting us for information and questions about CM and how to self-refer
- Assessment of the Member's healthcare needs and the level of CM needed via the initial Health Risk Screening, Comprehensive Health Assessment, and outreach from our local Care Managers
- How a Member of the CM team will collect and assess information through phone interviews or home visits

- Documenting and resolving barriers to care, such as transportation or PCP/PCMH selection
- How CM works with Members, their family, caregivers, and PCPs/PCMHs to review strengths and needs
- Development of a treatment plan based on personal needs, including wellness and prevention, care coordination, referrals to specialists, chronic condition management, and social need goals
- The Member's role in participating in the CM process and development and execution of the treatment plan
- Empowering Members through education to make informed decisions about their health and treatment plan
- Working with the Member's doctors to provide the information they need about any changes in health to help them in planning, delivering, and monitoring services
- Ongoing communications and reassessments as needed

[redacted]

D. Website and Mobile Application

1. Engaging Members with Our Member Engagement Platform and Mobile Application

We will use a ***continuum of resources based on Member's individual needs***, including virtual/video interactions, direct person to person communications (for example, with Community Health Workers [CHWs] and Care Managers), and telephone and text to engage our Members with our website, Member Portal, and mobile app. As part of our initial outreach to Members, including welcome calls and Member Information Packet, we will tell Members about the Member Portal and answer any questions they have. We will include a link to download the app, available from all major mobile device operating systems, directly from our website. Additionally, Members visiting our proposed physical location for Member outreach (outreach center) can see the Member Portal and mobile app in action and get assistance with downloads from our staff. The Member Information Packet also directs Members to our digital tools, including a sticker on the Member ID card to encourage Members to register on the Member Portal. Since launching the app in affiliate markets, Member visits are 30% to 50% higher than from a desktop, and app downloads consistently trend higher.

For many of our adult Medicaid Members, their only online connection is with their smartphone or tablets — 86% of adult Medicaid beneficiaries own smartphones and 69% own tablets, and roughly one in four lower-income adults are "smartphone only" internet users. ***Our mobile app is optimized for users with limited broadband access*** to ease access and keep our Members engaged.

Access and engagement with the Member Portal and mobile app:

- New Member welcome calls and Member Information Packet will direct MississippiCAN and CHIP Members to our online searchable tool that will allow them to easily find the care they are looking for, to select or change their PCP, and find a specialist when needed.
- Our Provider Directory will also include helpful information such as languages spoken, ADA compliance, office hours, and completion of cultural competency training to help Members make informed decisions when choosing a PCP or Patient-Centered Medical Home (PCMH).

- We will use a customized approach to engage Members with the data obtained from a Member's health history, such as claims data and self-identified interests, to proactively recommend products and programs, identify gaps in care, and help Members achieve their health goals.

Members using the Member Portal and mobile app will be able to access all required elements in Contract Sections 5.8.3 and 5.8.3.1, including:

- Member Handbook(s) and information about Member rights and responsibilities
- ID card with the option to download and an option to email a request for a physical ID card by mail
- Verify Enrollment status, update contact information, and add additional health information
- Request Member Materials and/or opt-in for paperless eDelivery
- Community-based referral platform linking Members to social services information and resources, such as housing supports and food programs to better meet their health-related social needs
- Online Provider Directory including the ability to search for Providers by location and specialty, whether they offer telehealth, and a connection to our online urgent care solution
- Complete Health Risk Screening
- Personalized consumer-friendly content that complies with Member education guidelines
- Direct connection with the 24-hour nurse advice line
- Ability to self-refer for Care Management (CM) — Members can chat live with an employee, send secure messages, request a call from Member Services at a specific day and time, and be connected to CM if needed during regular business hours
- Medical claims information such as lab and imaging results, medications provided by the State Pharmacy Benefits Administrator, and key health appointments
- Grievance and Appeal process

2. Website and Mobile Application Functions That Meet and Exceed the Contract Requirements

The website will have a secure Member Portal, requiring unique login credentials and two-factor authentication at login, and we will update the Member Portal regularly to assure it is compliant with appropriate cybersecurity standards, as approved by the Division. PHI will only be accessible through the secure Member Portal. We provide a selection of features that exceed Contract Section 5.8.3 requirements in Table 4.2.2.1.D.2-1.

Table 4.2.2.1.D.2-1. Features of the Member Portal that exceed requirements.

Features	Description

Communication Choices	• Expanded technologies will focus on Member preference for communication modalities to increase effective engagement.
	  o Members can call Member Services, chat in real time during regular business hours via live chat functionality, or send secure messages, and receive responses from us within one business day.
	  o Members can also click for call back to request Member Services to call back at a specific day and time.

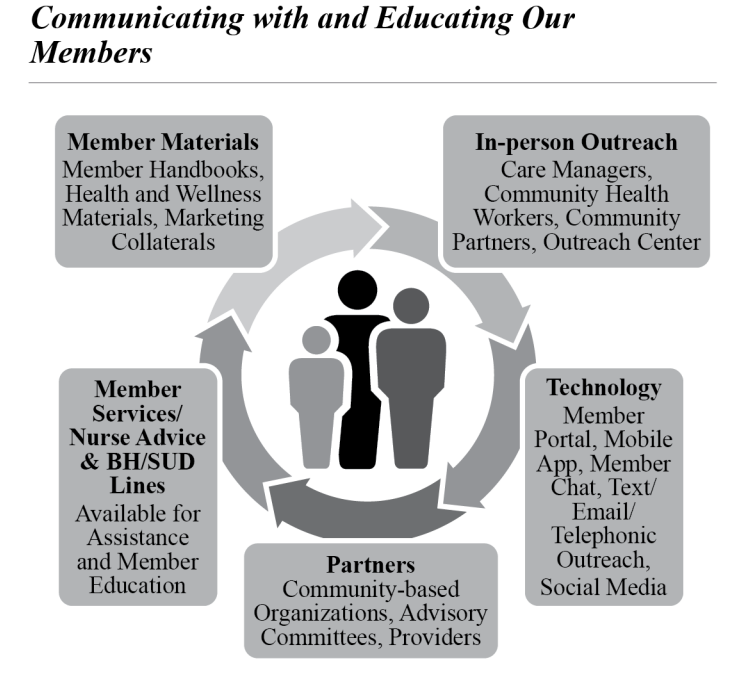
Personalized Tools	• Using claims data, Prior Authorizations, preferences and more, the Member Portal will offer an innovative, tailored, and personalized Member experience • Access to the Member Health Incentive platform, a customized and consistent resource for health education that will serve as a guide to their benefits based on their health history and interests, and to request Value-Added Benefits (Value-Adds) through the Member Portal and the mobile app using their smartphone, computer, or tablet — capabilities above and beyond a traditional Member Portal and mobile app format.
Member Supports	• Checklist of questions Members may take with them to healthcare appointments. • Better access to care with online access to treatment plans and assessments. • Access to claims and benefit information. • Tools for Members to understand their health condition(s), like diabetes risk tests and a BMI calculator. • Tools to help Members avoid risky behaviors, such as tobacco, alcohol, and substance use disorder. • Translation capability.

Features	Description
Optimized for Our Users	• Connecting those Members with limited broadband access to digital services like finding care through their smartphone; our mobile app is optimized for the user with broadband limitations. For example, the ID card can be downloaded when they have Wi-Fi available, then accessed offline from the app when needed. This increases access knowing that 86% of adult Medicaid Members own smartphones and 69% own tablets.
Telehealth	• Members can easily access telehealth services through the Member Portal or mobile app. Our online urgent care solution will offer Members 24/7/365 access to on-demand, live video visits with Mississippi-licensed, board-certified Providers through their mobile devices or computers for non-emergency health conditions. Members will have access to scheduled appointments with BH Providers, with services like psychiatry and psychology that include pediatric services.
Health Literacy	• Access to the most up-to-date healthcare information, such as: o Videos that educate Members and their families on topics such as preventive care, the role of the Care Manager, when to call the doctor, and when to use urgent care or the ER o Comprehensive library of Health Tips and educational fliers in English and Spanish o Useful programs for education on and help managing chronic conditions, such as asthma action plans
Engagement Rewards	• Member Incentives for things like preventive care and help to access Value-Adds. • Health engagement, including health challenges and a health dashboard. • Members can also earn incentives for completing their Health Risk Screening directly through the Member Portal to further increase engagement at the start of a Member's health journey with our plan. • Single-sign-on to Member incentive program for a more seamless and easier experience for the Member.

E. Member Education and Communication

Our goal as a Coordinated Care Organization (CCO) will be to improve the lives and health outcomes of vulnerable Mississippians, focus on Member-centric outreach, health equity, and align with Division goals. We will achieve this through robust communication and education, employing multiple channels to connect with Members in the most efficient way, according to their communication preferences. As outlined in Figure 4.2.2.1.E.1-1, we will combine proactive on-the-ground Member outreach through Mississippi-based staff, community and Provider collaborations with local and national resources, innovative technology solutions, data-driven digital and telephonic outreach, as well as standard communication channels.

Figure 4.2.2.1.E.1-1. Our outreach to Members is comprehensive and leverages multiple channels.



1. Informing Members About the Function of Member Services

Our Member Services department will be an important point of contact and resource for Members. We will educate our Members on how, when, and why to contact our trained, Mississippi-based Member Services Call Center Representatives (MSCCRs). We will use multiple channels and methods to make sure Members know Member Services is a valuable resource to promote access to benefits and services. Our Member Handbook, written at a third-grade reading level and in a culturally appropriate manner, will provide comprehensive information about Member Services' function in assisting Members with all of their healthcare needs, such as information about covered benefits and services, filing a Grievance, finding a Provider, CM services, and more. We will also educate Members about using Member Services in

our quick reference guide, through our welcome calls and texts, as well as on our Member website. Additionally, we will use educational and outreach events, in-person education with our CHWs and Marketing and Community Outreach Representatives as opportunities to inform Members about the function of Member Services and the resources available.

Encouraging Use of Member Services

We view every encounter with Members, whether via mail, email, phone, digital, printed collaterals, virtual or in-person interactions as an opportunity to inform Members and encourage use of Member Services. The most crucial time to encourage engagement is when a Member first enrolls. We will take a high-touch approach in our outreach to new Members by hosting monthly new Member orientation meetings. During these meetings, our Marketing and Community Outreach Representatives will inform new Members about the benefits available to them, how to access them, and how Member Services can facilitate. Our goal is to establish rapport and confidence with Members to assure a level of comfort and ease with us, not just as their CCO, but as a trusted resource for their health and well-being. It is also part of our commitment to excellence to assure Members are fully informed and understand the value of the benefits and services available to them and the part our Member Services team plays. This commitment is reflected in our Member Services post-call survey scores. [redacted]

In-person and telephone interactions with Members will offer opportunities where we encourage use of Member Services as a resource to manage and take charge of their healthcare. Our Care Management Navigators and CHWs play a significant role in informing hard-to-reach Members and Members experiencing homelessness about using Member Services to help access their benefits and social supports. Members who visit our outreach center are also encouraged to connect with Member Services.

2. Informing Members About the Function of Care Management

Information is key to assuring Members know how to use their benefits and services, especially accessing CM. Our approach will leverage all opportunities and communication channels to educate Members about CM services, the Member's role, and how to self-refer, as outlined in Contract Section 7.

Encouraging Engagement Through In-person Education

A vital aspect of our overall education strategy will be meeting Members where they are in their healthcare journey. In-person education will present valuable opportunities to inform Members about our CM services. For example, our CHWs are frontline representatives who will help facilitate needed care to our Members, especially those that are hard to reach. CHWs will educate Members about the benefits of our CM program, help them complete the Health Risk Screening (HRS) and get them connected with our Care Managers.

We will also have several other in-person venues that offer great opportunities to educate Members about CM. This will include our outreach center, quarterly advisory committees, and various workshops and forums. Our community partnerships will also be a great education resource. For example, we will work with a nonprofit that promotes public health through projects in policy evaluation, community health, data analysis, and health access, which will host our sponsored health and wellness events, extending our reach to Members and the community. We will also host events such as Member Appreciation Day in partnership with PCPs and PCMHs for dedicated appointment times for Members as well as education about CM services as well as health and wellness topics and health literacy.

We will offer specific training to our Providers upon contracting so they will be able to help their patients understand our CM program, make referrals for them, and provide in-office materials. In addition, we will provide ongoing support to help Providers connect Members with CM services, such as quarterly performance reports available through the Provider Portal, monthly touchpoints, coaching, and quarterly Provider meetings. ***We will also embed CM staff in high-volume facilities to further enhance this collaboration.***

Member Services Call Center

Our Mississippi-based Member services call center will be a valuable resource for informing Members about our CM program. Our MSCCRs will inform Members about the availability of CM services and encourage use each time a Member calls. Representatives receive specific training regarding our CM program and will be able to provide nonclinical information about CM services and self-referrals, as well as helping Members complete the HRS and warm transferring them to CM if necessary.

Member Materials

Primary among the materials we will use to inform Members about our CM services is the Member Handbook, which will provide a thorough description of our continuum of CM services, including chronic condition, behavioral health (BH), and maternity CM services. Members will be informed about the benefits of CM, care coordination, treatment plans, and self-referral, which can be done by calling Member Services, through the secure Member Portal and mobile app via live chat or a callback request, and from Providers and family members on the Member's behalf. As a companion resource to the Handbook, our quick reference guide will provide concise information about CM in an accessible format.

Our Website, Secure Member Portal, and Mobile App

Our public Member website, secure Member Portal, and mobile app also function as excellent resources to educate our Members about CM and encourage use and self-referral. Our public site, easily accessible to Members and the community, will include information about CM services, various educational materials on specific conditions, digital solutions, and apps. On our secure site and mobile app, Members can log in to learn more about all the CM services available, make self-referrals for services, as well as complete the HRS using a direct link.

3. Our Evidence-based Health Education Program

We know that health education is a crucial part of helping our Members achieve optimal health and wellness. Our approach will be informed by our Population Health strategies, using evidence-based practices and guidelines to address the healthcare needs of Members, as well as health literacy, health disparities, and Social Determinants of Health (SDOH) gaps. Our program will align with the Division's goals of improving healthcare outcomes at both the individual and population level.

a. Program Overview

Our comprehensive health education strategy starts with connecting Members with the tools and resources they need. We will create accessible and engaging resources using evidence-based health literacy principles to empower Members and encourage self-management and self-sufficiency. We will make materials available in numerous ways, including through targeted outreach, our library of health tips, self-management tools, and numerous apps on our Member website. On our mobile app and secure Member Portal, we leverage advanced analytics to provide resources based on the Member's preferences and needs, offering a personalized experience. We will also connect Members with community resources available online, such as evidence-based programs like diabetes prevention programs and smoking cessation.

b. Selecting Areas of Focus

Our health education program aligns with the Division's goals, as well as with the components of our Population Health and CM strategies. We will focus on supporting Members' physical, BH, and SDOH needs through individualized services, as well as helping Members with chronic conditions build self-management skills, while promoting adherence to evidence-based care and services. We will select topics such as chronic condition program management, tobacco cessation, and others related to healthy behaviors based on significant prevalence within the population and utilization. Additionally, based on data and Population Health analysis, we are proposing Healthy Literacy Campaigns targeting diabetes, Well-Child visits, maternal health, and mental well-being to improve health outcomes for Mississippians.

If we see that a specific condition is trending, we will create new programming to meet the needs of the Member population. For example, one of our affiliates noticed an increased prevalence in sickle cell disease. To address the needs of their Members with sickle cell disease, the affiliate engaged Providers, hospitals and organizations in the community and increased targeted educational outreach to Members diagnoses and their families. A six-month rapid cycle project resulted in a 55% decrease in overall emergency room utilization for affected adult Members.

c. Ensuring Appropriate Reading Level

Our materials will be written at the required third-grade level in compliance with Contract Section 5.6. In our development processes, we will use evidence-based health literacy principles, including the Flesch-Kincaid standard to determine reading level. To verify materials are at or below the required reading level, we will also use the Health Literacy Advisor™ software, which confirms the reading level, and assists the writer with simplifying content that is accessible and culturally appropriate for Members.

d. Available Language Alternatives

All our vital documents, such as health education materials, Member Handbooks, and our website will be automatically translated into Spanish. We will also be able to translate materials in over 230 languages. Reaching all Members in the language they speak is key to driving improved outcomes and health equity and to reach all Mississippians in the most appropriate way.

e. Accommodations for Members Who Are Visually and/or Hearing Impaired

For Members who are visually impaired, we will offer our health education and all other materials in braille, audio recording, and large print format. Our Member website will be 508c compliant, which will enable Members to hear the content. For Members who are hearing impaired, our education videos will contain closed captioning and phone numbers will list available TTY/TTD options to facilitate communication.

Speaking Our Members' Language

While **96.12%** of Mississippi residents speak only English, **3.88%** speak other languages, including Spanish, which is spoken by **2.43%** of the population.

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4. Encouraging Participation in Member Outreach and Education Activities

We will employ a number of creative ways to encourage Members to take part in outreach and education activities. Our Mississippi-based CHWs will play a significant role in outreach and encouraging engagement. They will be an integral part of the community where they live and can make meaningful connections with our Members and help connect them with benefits and services, such as CM. Our Marketing and Community Outreach Representatives will also be an integral part of the community, hosting events to educate Members about benefits and connecting them with community partners. Our outreach team will be on the ground focusing on key health disparities and cultural responsiveness according to Member needs. For example, there will be a concerted focus on food deserts in the Central Region since a greater percentage of counties in this region face this disparity. Whereas staff will emphasize interventions for substance use disorder (SUD) hospitalizations in the Southern Region, as this region has the highest number of such hospitalizations and is above the state average.

Another innovative approach will be leveraging our mobile app and secure Member Portal to encourage participation. Our platforms use advanced analytics to send content based on individual preferences and create personalized experiences for each Member. This approach will allow us to:

- Tailor content to each Member's unique needs
- Better engage Members to help them achieve goals
- Recommend products and programs and identify gaps in care
- Make it easy for Members to choose how and when they interact with us

5. Provider Directories

Our online and print Provider Directories will be designed to assure Members have convenient, accurate, information about our Provider network. To maintain our directories, we will use all Provider demographic information available to us, including information we receive from Providers and in the Division file transfer. Our Provider Contracting team will assure the data are appropriately configured in our system and monitored monthly. ***Our best-in-class searchable online directory will be updated daily, exceeding all contractual requirements.*** Providers will be able to update their practice and demographic information directly in the Provider Portal, enabling real-time updates. Our printed directory will be updated monthly and available on the Member website and mobile app in PDF format. Our directories will be fully compliant with Section 5.5, listing all required elements, including many additional features such as wheelchair accessibility, telehealth availability, and race and ethnicity. We will inform Members via the Member Handbook and quick reference guide how to request a printed copy of the Provider Directory and that the online version is updated daily; we will also send all Members an annual notice with this information.

6. Educating Members on Their Rights and Responsibilities

We know that Members who are educated about their rights and responsibilities are empowered individuals who take an active role in their own healthcare. Our written policy, "Member Rights and Responsibilities," will comply with all requirements outlined in Contract Section 5.10 as well as 42 CFR 438.100, and will be maintained in accordance with state and federal requirements and NCQA accreditation standards. It will promote and protect Member rights to assure Members are treated with respect and due consideration for dignity and privacy, and never discriminated against for exercising their rights. We will prioritize educating our Members using materials written in plain language at or below a third-grade reading level in a variety of ways:

- Member rights will be included in our Member Handbook and our website.
- Member Grievance and Appeals notices will inform Members of their rights and how to seek assistance.
- Information and printed materials about Member rights will be included in presentations and outreach events, such as our monthly new Member orientation meetings and Member Advisory Committee meetings.
- Periodic notices will be posted on our Member blog directing Members to sources that describe Member rights.
- Members in our CM program will be educated of their rights and responsibilities through engagement with our Care Managers and materials.

7. Marketing Requirements

Maintaining compliance with the marketing requirements of 42 C.F.R. § 438.104, as well as Contract Section 5.9, is not just a high priority for our company, it is central to our strategy in delivering effective, Member-centric, culturally competent healthcare. We will leverage robust oversight processes used in our affiliate markets to assure compliance with all marketing requirements and materials. In addition to established policies and procedures from our affiliates, all employees engaged in marketing functions or community events will be required to complete marketing integrity and oversight training as well as annual refresher training. Employees will be required to sign an attestation stating that they completed training and that they fully understand the rules regarding marketing activities. In addition, Compliance staff members will also attend monthly marketing meetings to confirm activities align with requirements. This will help us assure:

- Unsolicited, cold-call marketing is not conducted by any of our staff or anyone representing our company
- Only State-approved materials are distributed and to all service areas indicated in the Contract
- Compliance with 42 CFR § 438.10, Information requirements
- We do not seek to influence Enrollment in conjunction with the sale or offering of any private insurance
- Activities and materials are accurate and do not mislead, confuse, or defraud Members or the Division

Marketing Materials

Our marketing materials comprise a broad range of offerings designed to engage and empower our Members. They will include materials in print and digital formats such as the Member Handbook, quick reference guide, fliers, postcards, and brochures, covering topics such as health education, accessing benefits and services, Value-Added Benefits (Value-Adds), eligibility redetermination, community events, and more. Our materials will be compliant with all contractual, State, and federal requirements, state-approved prior to distribution, medically accurate, and written in a culturally competent manner at the third-grade reading level. We have provided samples of our Member materials from our Member Information Packet and other educational materials used in our affiliate markets in Attachment 4.2.2.1-1.

8. Informing Members About Covered Services

We place great priority on educating and informing Members about covered services to include physical and BH/substance use disorder (SUD) services, Value-Adds, treatment for chronic health conditions, CM, perinatal and neonatal care, autism, and other developmental disability services, EPSDT screening and preventive care, and pharmacy services. We will connect Members to the most relevant, up-to-date, culturally responsive, and easy-to-understand resources so they can make informed health decisions, using multiple channels to assure that Members will have the information they need, including:

- **In-person/Virtual Events.** This includes outreach events, monthly orientation meetings, and Member Advisory Committee meetings.
- **Member Services.** Our MSCCRs will receive thorough training to help inform Members about all their covered services.
- **Member Handbook and Quick Reference Guide.** Our Member Handbook will be the most comprehensive resource for educating our Members about their benefits and CM services. The quick reference guide will offer brief, high-level information in an easy, accessible format.
- **Website and Mobile App.** Our websites and mobile app will offer a convenient overview of all covered services, including descriptions of Care Management and preventive care.
- **Printed Collaterals.** We will develop a wide array of collaterals covering topics including health and wellness, self-management of chronic conditions, preventive services, and covered benefits.
- **Live Calls, Text, and Email Outreach.** Reminders for doctor and dental care, EPSDT, Well-Child visits, immunizations, post ER visits, and more.

9. Timely Disclosure of Changes Affecting Benefits and Services

We know from experience how changes to benefits and services can have an impact on the lives and health of Members. Leveraging experience of our affiliates, we will have an established process for notifying Members in a timely manner — at least 30 days in advance — of any changes that may affect their benefits and services. We will use several channels, which may include notification by letter, postcard, text, email, or outbound call, as well as our Member website. All communications will be submitted to the Division for approval at least 60 calendar days prior to distribution, as outlined in Contract Section 5.7. Our standard procedure will not typically involve notification via media release or general public announcement; however, in the event any such public announcement is made, we will notify the Division.

F. Member Satisfaction

1. Assessing Member Satisfaction

Our approach to assessing Member satisfaction will be comprehensive. We view all interactions with Members as opportunities to understand their needs and solicit their feedback and will use multiple tools to gather input and gauge Member satisfaction. As outlined in Table 4.2.2.1.F.1-1, this will include several methods such as analyzing internal data, engaging with Members and stakeholders statewide through committees, and using surveys to gather Member feedback. As part of our commitment to the principles of cultural competency and

health equity, we will gather input in a culturally responsive way to address the diversity of Mississippi communities and assure that Members' voices are heard.

Table 4.2.2.1.F.1-1. We will employ multiple methods to gather feedback from Members.

Type Survey/Feedback	Frequency	Responsible Party
Grievance and Appeals Data	Quarterly	Quality Management
Member Advisory Committee Surveys	Quarterly	Quality Management/Community Relations
Member Services Surveys	Ongoing — Post-call	Member Services Department
CAHPS®	Annually	Quality Management

Grievance and Appeals

Our Grievance and Appeals data will provide us with information to identify opportunities to impact and improve Member satisfaction. Trending data and reporting will pinpoint areas of concern, drivers of complaints or dissatisfaction, and allow us to efficiently develop refinements to our services or processes in response. Data is gathered by our Quality Management team, reported up to our Quality Management Committee (QMC), and reviewed on a quarterly basis. We will conduct follow-up outreach and create additional quality improvement initiatives to address systemic issues. Additionally, individual Member complaints related to quality of care concerns will provide an opportunity to review medical records as needed for immediate improvement to Member experience. Member Grievances that allege discrimination or culturally inappropriate care will result in working with Providers to address deficiencies, including training opportunities such as cultural competency and health equity training.

Member Advisory Committee

Our Member Advisory Committee (MAC) will provide an interactive forum in a structured format with formal agendas and meeting topics to receive Member feedback and recommendations to evaluate and improve services. Overseen by both our quality management and community relations teams with data reported up to our QMC, the Committee will meet quarterly and provide valuable input regarding such topics as healthcare needs, resource gaps, potential Value-Added Benefits (Value-Adds), barriers to care, telehealth offerings, and more. ***For example, based on input from Members in the MAC in one of our affiliates, they initiated delivery for electric breast pumps to eligible Members during the third trimester instead of post-delivery since it could take up to 30 days for Members to receive them.*** The MAC will also be helpful in the development of vital programs such as our Value-Based Purchasing program for Providers and Member materials that are user-friendly and culturally competent, such as our quick reference guide, which was developed through input from the MAC meetings in one of our affiliate markets. The MAC will also provide input regarding education and outreach programs, help inform our health literacy campaigns, and assure Grievance and Appeal resolution processes are culturally and linguistically sensitive, and capable of identifying, preventing, and resolving Grievances and Appeals.

We are also proposing a Teen Advisory Committee to hear the voice of the customer for this important demographic. This group for teen Members will promote healthy lifestyles, empower young Members with knowledge about teen health and social issues, help participants exchange ideas, and capture their perspective.

Member Services Surveys

The Member services call center is often the primary point of contact for Members. Interactions with our representatives can significantly influence Members' overall satisfaction. For this reason, as a standard practice and to gain immediate, real-time feedback, we will offer a brief post-call survey for a sample of calls to Member Services. [redacted] The survey will gauge how we are doing and identify areas requiring review. For Members who participate, this automated survey (in English or Spanish) will gather feedback on their experience with the call center, and more importantly with our CCO. If any of the survey responses are negative, we will call the Member to discuss their experience and ways we can improve. ***To understand how we can do better, we will call every***

surveyed Member who does not give us a perfect score. Additionally, in accordance with Contract Section 5.1.4, we will ask all callers if our response to their call was satisfactory. If not, we will refer the caller to the appropriate individual within our CCO for follow-up and resolution within 48 hours of the call.

We may also review a recording of the call as needed and follow up with the Member Services Call Center Representative involved if additional training or performance review is needed. We will track and trend survey results to assess satisfaction with Member Services, and if we identify recurring issues, we will adjust staffing, training, or other service operations. We will also create new Member materials, such as FAQs, and update existing materials to address misinformation or common education needs. Additionally, our Data and Analytics team will perform text mining of unstructured data and survey comments to be analyzed for trends, disparities, gaps in services and to identify other areas for improvement. Member satisfaction improvement plans will be based on the opportunities identified from comments from the customer surveys analysis.

Annual Member Satisfaction Surveys

Our quality management department will facilitate an annual CAHPS survey of a random sample of Members that measures satisfaction regarding access to care, quality of care and appointment availability. We will comply with the requirements outlined in Contract Section 8.6 by contracting with an NCQA-certified vendor to administer the survey and file the survey results and related action plans with the Division within 90 calendar days of receipt of the survey and no later than December 1 of the calendar year. We will review annual CAHPS surveys to identify potential access and availability concerns, quality of care, and Member satisfaction and incorporate the survey results into our quality assessment and performance improvement program. We will analyze each question domain area of the survey and questions in detail and will complete a root cause analysis. The baseline data will support a comprehensive Member satisfaction improvement plan, and we will analyze ongoing interventions as part of the evaluation.

Excelling in Member Satisfaction

In 2021, 5 of our affiliates had the distinction of scoring NCQA **4 STARs or above** for Patient Experience as a result of CAHPs scores.

MS21B_MemberSatisfaction_C_04

Other Feedback Tools

We will look for ways to improve Member satisfaction through Member input, including:

- On-boarding satisfaction surveys sent via text/email 60 to 90 days post-Enrollment to gauge satisfaction and improve the new Member experience
- Care Management and chronic condition management satisfaction surveys: sent via text/email from the Care Management team within 30 days after case closure to assess satisfaction and improve CM services
- Post-Provider visit surveys sent via text/email from Quality within one week of the Member receiving services to assess satisfaction with the Provider. Results are shared with Providers for identification of improvement opportunities
- Listening sessions hosted monthly by the Community Relations team for input from Members on services, Value-Adds, areas of improvement, and more
- Feedback via our website feedback form as well as via social media, virtual events, and orientations

G. Member Appeals

1. Member Grievance and Appeals Process

We will make submitting a Grievance or Appeal simple and convenient for Members. Our Grievance and Appeal processes will be fair, objective, understandable, easy to use, and clearly defined to meet the needs of Members. We will make sure Members are kept informed of their Grievance and Appeals rights throughout the entire process to provide the best possible experience. We will provide ongoing training to staff, Providers, and our subcontracted partners to make sure our processes remain compliant, focused on our Members, and

efficient. [redacted]

A. Compliance with State Requirements

Our Grievance and Appeal processes will be compliant with all the requirements listed in Contract Section 5.11, the Division's Administrative Code, CMS 42 C.F.R. Part 438, Subpart F guidelines, and the Division's Quality Strategy. To assure our compliance with these regulations, we will:

- Provide our Members with information in the Member Handbook outlining how they or their representative can file a Grievance or Appeal, the process, and the time frames for resolution
- Review our Grievance and Appeal procedures at least annually or as often as needed with changes directed by the Division
- Commit to continuous improvements including pursuing feedback from the Division to build best practices
- Make sure Members are kept informed of their Grievance and Appeal rights throughout the entire process, including the exhaustion of Appeals rights
- Designate a Grievances and Appeals Coordinator to process and resolve Grievances and Appeals, administer policies and procedures, review trends, and implement corrective action as needed

Receipt, Acknowledgment, and Resolution of Grievances

All Members, their caregivers, or a Provider authorized in writing by the Member will be able to submit a Grievance at any time. As outlined in Figure 4.2.2.1.G.1-1, Grievances can be filed orally by contacting Member Services, or in writing by email, or fax. In addition, Grievances can be submitted through our secure Member Portal or via our free mobile health app. All Grievances are entered into our Grievance and Appeals system, which is part of our Health Information Trust Alliance (HITRUST)-certified and HIPAA-compliant Management Information System (MIS). This system houses all data elements needed to record, investigate, track, trend, and report on the status of all Grievances. We will assure we have all the necessary information from the Member to initiate an investigation, send an acknowledgment letter to the Member within five days to acknowledge receipt of their Grievance, and track and report on resolution of the Grievance. Grievance cases are resolved within 30 days, or as expeditiously as possible unless an extension is approved by Member and the Division.

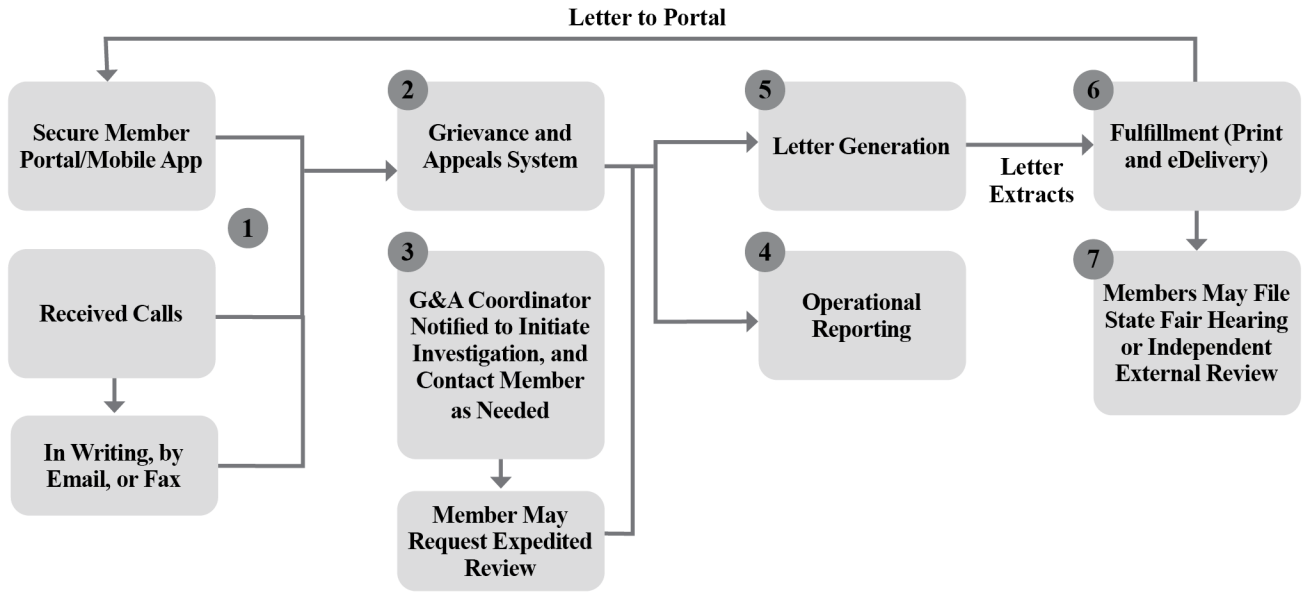
Receipt, Acknowledgment, and Resolution of Appeals

All Members, their caregivers, or a Provider authorized by the Member will be able to submit an Appeal within 60 calendar days of the date on their notice of Adverse Benefit Determination. This notice will inform the Members of the denial or limitation of service they requested and will comply with the notification requirements in Contract Section 4.4.1. Members can file Appeals using the same methods as Grievances (Figure 4.2.2.1.G.1-1). Once we receive an Appeal, we enter it into the same Grievance and Appeals system, assuring continuity to track and resolve all Appeals. This triggers an acknowledgment letter to the Member sent within five days to acknowledge receipt of their Appeal. We will then work to resolve the Appeal within 30 days.

We document all Appeals received in our system, which houses all data elements needed to investigate, track, trend, and record Appeals. Upon receipt, an Appeals team member will document all information, interactions, and decisions in our system, and maintain communication with Members about the final resolution.

Figure 4.2.2.1.G.1-1. Our Grievance and Appeals process assures our Members are heard and their needs are met.

Member Grievance and Appeals Tracking



1. Members may file issues via our secure Member Portal or by calling Member Services. Members can also file in writing, by email, or fax.
2. Grievances and Appeals received are keyed into our system, which stores the total inventory of G&A activity, manages workflow, and tracks status.
3. Grievance and Appeals Coordinator is notified and the investigation is initiated. The Coordinator will contact the Member if more information if needed. If the Appeal is a quality of care issue, the Medical Director is involved.
4. Data necessary for operational reporting is loaded to an operational data warehouse.
5. On demand and as required, letters are generated and sent to our fulfillment team.
6. The fulfillment team prints and mails letters to Members and ships letter images to our secure portals for eDelivery.
7. MississippiCAN Members may request a State Fair Hearing, and CHIP Members may request an Independent External Review.

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Member Rights After Appeals

After exhausting our Appeal process, MississippiCAN Members will have the right to file a request for a State Fair Hearing (SFH) within 120 calendar days from the date of our notice of resolution. Additionally, we will notify MississippiCAN Members of their right to file a Continuation of Benefits within 10 calendar days of the notice. CHIP Members will have the right to file an Independent External Review (IER) within 120 calendar days from the date of our notice of resolution.

b. Process for Expedited Review

We will implement a systematic approach to resolving Member Appeals and make sure Members or their designated representative have easy access to our expedited review processes to facilitate quick resolution and prompt access to time-sensitive treatment. The Member or designated representative, including a Provider or attorney, can request an expedited Appeal if the turnaround time for a standard Appeal could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. Expedited Appeals may be filed orally or in writing via fax, or email, and we do not require oral Appeal requests to be followed by written requests in such cases. We use clinical judgment in reviewing all requests for an expedited Appeal and do not take punitive action against anyone who requests an expedited resolution.

The Appeal staff will confirm that the clinician is not the same Mississippi-licensed physician, or a subordinate involved in the initial determination. All previously considered information, in addition to any new information provided, will be considered by the clinician during the review. A clinician will resolve the expedited request within 72 hours of receipt unless this time frame is extended under 42 C.F.R. 438.408. If the request for an expedited Appeal is denied, we will transfer the Appeal to the standard time frame in accordance with 42 C.F.R. §438.408(b)(2) for standard Appeals and provide the Member with prompt verbal notice of the decision, as well as written notice within two calendar days. This notice will also inform the Member of their right to file a Grievance if they disagree with the decision.

We will provide the Member with written notice of resolution and make a reasonable attempt to provide verbal notification when feasible. We will review all Appeal requests within the required time frames.

c. Member and Family Involvement in the Grievance and Appeal Process

Members can provide written consent to designate a family member, representative, or Provider to act on their behalf. The Member and their authorized representative will be involved in our Grievance and Appeals processes from beginning to end, starting with the submission of a Grievance or an Appeal. Once received, we will notify Members and their authorized caregivers in writing of the receipt of the Grievance or Appeal. The Grievances and Appeals team will respond quickly, attentively, and compassionately to Member issues and concerns.

We will also inform Members how to contact the Division to address Grievances and Appeals. Additionally, we will provide translation services for Members or representatives as needed. We will focus on responding to Members courteously and professionally and will resolve issues through a well-defined and documented process that supports the Member at every step. As a core element of our own cultural competency program, we will make sure Members and their caregivers have access to culturally and linguistically responsive services to support their involvement in the Grievance and Appeals processes.

d. Grievances Tracked and Trended for Improvements

Our Members are an important source of information regarding our performance. If they are not satisfied with their care, we want to know about it. In compliance with all the requirements in Contract Section 16.2.9, our dedicated Grievance and Appeals system within our MIS will store all data elements needed for our Grievance and Appeals processes. Our system will allow us to track the receipt and resolution of Grievances and Appeals and submit the required reports and trends to the Division per the Reporting Manuals.

In our affiliate markets, we have built visualization tools and metrics dashboards for Grievance analytics. This data is categorized using reasons for Grievances, sources of the Grievance or Appeal, and timelines of response and resolution. The analytics tools are updated daily where appropriate to assure we have a current view into the inventory. Further analysis using Grievances and Appeals data includes monthly turnaround reporting, weekly and monthly volume trends, and deep-dive analysis to identify root cause.

We will link our Grievance and Appeal system to our quality improvement (QI) plan and program evaluation that includes an analysis of Grievances and Appeals to inform continuous QI activities. We will track and trend Grievance data by type and Appeal data by service type. We will review Grievance trends at the Quality Management Committee (QMC) to identify trends and discuss proactive solutions to improve processes and reduce the overall volume of Grievances. Grievances related to quality of care will be fully investigated and referred to our Credentialing department and Medical Advisory Committee, as appropriate. If a Member filing a Grievance is determined to have a Care Management issue or an assigned Care Manager, the Care Management team will be notified and engaged as needed to resolve the Member's issue.

We will review Grievance and Appeal data by categories, such as type of care, and volume. A dedicated team of risk analysts within the Grievance and Appeals team will continuously mine data and monitor these trends weekly to be proactive in addressing Members' concerns and contribute to programmatic continuous QI efforts.

These reports and analyses will also be presented to the Medicaid Quality Improvement Committee on a quarterly basis to discuss solutions to facilitate access to clinically necessary care, reduce any unnecessary burden on Providers, and reduce the overall volume of Appeals.

e. Addressing Grievances Prior to Appeal

If our Members are dissatisfied with any aspect of their experience with us, we want to know so we can address the matter and take steps to improve. When a Member submits a Grievance, we will record it in our system to investigate, track, trend, and report on the status. We will make sure the information necessary to initiate an investigation and complete resolution of a Grievance is provided promptly and completely. Throughout the process, we will keep the Member or designated representative acting on their behalf completely informed on the status of the request. Grievance employees will be trained to make sure they are addressing the needs of the Member and resolving their concerns. For example, if the Member has an issue with their Provider, the Grievance and Appeals Coordinator will work with the Member to help choose a more appropriate Provider for them. Training will also include identifying cases that may require an Appeal to be created. In these instances, the Grievance and Appeals Coordinator will call the Member to discuss the need for Appeal and open a corresponding Appeal case. The Member will be updated on both the Grievance resolution and the Appeal resolution in writing.

f. Review of Decisions Overturned in Independent External Reviews and State Fair Hearings

We will track Grievances and Appeals by the outcome of SFHs and IERs in our Grievance and Appeals system. Upon notice of filing for a SFH or IER, we will perform an immediate review of the case with a qualified medical professional to assure that the original complaint was appropriately handled. If a case is overturned, we will update the case and pay services within three days of the decision notification.

Our Grievance and Appeals Coordinator will track and trend by type to indicate whether the service is physical health, behavioral health, dental, or other covered services. Using a series of data analytics capabilities to drive performance improvement and quality activities, we will identify potential reasons for any trends to determine whether one decision-maker is experiencing more decisions being overturned. The QMC will routinely review aggregated results for overturned decisions to identify areas for improvement. When the need for an improvement is identified based on Member safety, trends such as the number of overturned decisions by a decision-maker, or quality of care issues, we will take targeted action and apply QI techniques.

Our QM Evaluation will include sections to identify opportunities and barriers gleaned from analyses of Grievance and Appeals data. We will review data related to overall Grievances and Appeals, particularly look at those Grievances and Appeals that result in overturned decisions for needed changes.

Identifying Information. To comply with the Identifying Information requirements defined in Section 1.2.3.3 of the RFQ and subsequent amendments, we removed names of federal and state agencies, Providers, and other stakeholders from our response, except where expressly permitted by the Division. If this information is needed to validate our proposed solutions or evaluate our response, we will be ready to provide it to the Division.

Attachment 4.2.2.1-1: Marketing Samples

Attachment 4.2.2.1-1 includes the following:

- Attachment 4.2.2.1-1a: Marketing Sample Member Blogs
- Attachment 4.2.2.1-1b: Marketing Sample Well Child Website

It's Safe to Visit Your Child's Doctor During COVID-19

With a year of the COVID-19 pandemic behind us, people are adjusting to safely living life. That might include catching up on your child's wellness visits and vaccines. While it might have seemed unsafe to visit your doctor's office, many doctor offices have taken steps to keep you and your family safe during visits. It is important to attend visits because getting your child vaccinated helps their immune system fight off preventable diseases.

To find out how your child's doctor is making it safe to visit, call ahead or visit them online. Ask them if they are:

- Checking everyone's temperature.
- Checking for other symptoms of COVID-19 when you arrive.
- Requiring all visitors and staff to wear masks.
- Moving the furniture in waiting rooms six feet apart for social distancing.
- Cleaning exam rooms, equipment, and other spaces between each visit.
- Having hand sanitizer available.

For vaccine appointments, your child's doctor may:

- Schedule special kids-only hours.
- Ask you and your family to wait outside or in your car until they're ready to see your child.
- Set up a separate entrance or area for kids' well-visits.
- Offer a drive-up service for checkups and vaccines in your car.

You and your child can do your part by taking these steps:

- Wear a mask at all times.
- Stay six feet apart from others.
- Wash your hands for at least 20 seconds or use hand sanitizer before and after touching anything in public places.
- Avoid touching your face, eyes, nose, and mouth.
- Remind small children to keep their hands to themselves and in their laps.
- Cover any coughs or sneezes.

Don't let COVID-19 stop you from keeping your kids healthy. The pandemic may have changed many things, but we can't let it stop us from keeping our kids — and ourselves — healthy.

Find out more about **staying on track** [*link to* blog] with your kids' shots.

Do kids still need their shots during the pandemic?

Raising kids during the pandemic has been full of challenges. Spending more time at home, juggling home responsibilities, virtual learning, not being able to settle into routine — if any of this sounds familiar, you're not alone. Taking your kids for their regular check-ups — especially if they are healthy — might not be at the top of your to-do list. Well-visits and shots help kids fend off common illnesses and can strengthen their immune systems overall, so it's a good idea to stay on schedule. Now is a great time to check in with your child's doctor to see if they are due for any shots.

Here are some answers to common questions about child vaccines and well-visits during COVID-19.

Should my child still get their vaccines or can we wait and catch up?
Your child should still get all their vaccines on schedule. Skipping vaccines could put them at risk for diseases that vaccines can prevent, such as whooping cough and the measles. Those who aren't protected by vaccines are more likely to get sick.

Will my child get COVID-19 if I take them to the doctor's office?
Many parents are concerned about visiting the doctor's office right now. Doctors have taken steps to make sure it's safe to bring your child in for appointments. Some steps may include:

- Checking temperatures and screening for COVID-19 when patients arrive.
- Requiring visitors and staff to wear masks.
- Cleaning and sanitizing exam rooms and offices.
- Practicing safe social distancing.

If you'd like to talk with your child's doctor about safety measures, here's how you could start the conversation. *[link to Blog - **It's Safe to Visit Your Child's Doctor During COVID-19**]*

Should healthy kids still go for checkups?
Kids should continue to go for in-person checkups, even if they are healthy. During a checkup, healthy children will receive vaccines to prevent infectious diseases. Even healthy children can be admitted to the hospital for a vaccine-preventable disease. Vaccines can protect your child and keep them healthy.

What should I do if I still have questions or concerns about safely getting my kids their shots?
If you have concerns about your healthy child getting vaccinated in the doctor's office, talk to their doctor. During the pandemic, some doctors are giving vaccines to children while they stay in the car. Others are scheduling kids-only hours or providing a separate entrance or area for well-child visits. Call your child's doctor and ask about your options for a safe visit.

For more information on well check-ups and immunizations, visit *[link to website - **American Academy of Pediatrics**]*

Now is a great time to take your child for their well visits

Now is the time to visit your child's doctor.

Well visits and immunizations (shots) help keep children from getting sick. And if your child hasn't been to the doctor for a well visit recently, they aren't alone. During the pandemic, a lot of people couldn't get to the doctor for many reasons.

As schools open, your children will be in close contact with other kids again. Kids who haven't been vaccinated may get sick and spread more illnesses to other kids. By getting your child vaccinated, you are protecting both your child and other children.

You can help your child stay on track with their appointments.

Is it time for your child's well visit? Call your doctor today to get your appointment scheduled.

If you are <a/an health plan name> member, you may be eligible for rewards. You can also get help finding a doctor or a ride to the doctor's office by visiting <health plan website>.

Choosing the right doctor for your child

The doctor you choose is up to you. There are many ways to find out if a doctor is the right fit – location, the language they speak, when they are open, and more. You can find a doctor who fits both your needs *and* your child's needs.

You may have questions about how to choose a doctor for your child. Here are some tips to help you find the right pediatrician:

1. **Ask someone you trust**
   A simple first step is to talk to someone you trust about pediatricians they like. Asking family members or friends is a quick way to learn who the people that you trust, trust with their children. You can also ask your health plan for doctors they recommend for your child.

   Members can download the <health plan> mobile app to live chat with a representative or send a secure message.

2. **Look at office websites**
   Next, check out these doctors' websites. You can find useful information and get important questions answered.

   - Is the office close to where I live or work? Is it near my child's day care?
   - How flexible are the office hours? Are they open on weekends or in the evening?
   - Can I schedule same-day or last-minute appointments?
   - What languages do the doctor and staff speak?
   - What are their specialties? Can they provide care for my child's specific health needs?
   - Do they offer virtual appointments?
   - How much medical training and years of experience does the doctor have?

3. **Meet or visit the doctor**
   Once you have a list of a few doctors, schedule a call or visit to meet them. Writing down your questions before speaking with them for the first time can help you remember what to ask the doctor. And take notes during your visit. Having notes to review later can help you decide which pediatrician is the best fit.

   - Do the staff and doctors make my child and I feel comfortable?
   - Are they professional and welcoming?
   - Do I feel comfortable asking questions?
   - Are they good listeners?
   - Do they explain things clearly to me?

4. **Trust your instincts**
   You decide what is most important when choosing a pediatrician for your child. Knowing more about the doctors and their offices will help you choose the best option for your child.

You can search the large network of doctors in the <health plan> plan by visiting <health plan website> and selecting Find a Doctor.

<health plan name> members can change their child's pediatrician or PCP at any time by logging into their secure account at <health plan website>. Once you are logged in, you can chat with a Member Services representative if you need help. Or, download the <health plan> mobile app to live chat with a representative or send a secure message.

Child Wellness Website Design Layout

MODULE 1 PURPOSE: Start building awareness – engage audience attention

LOGO: <Health plan logo>

HEAD: Now is a great time to catch-up on well child visits!

SUB: Don't let life get in the way of getting your child vaccinated.

MODULE 2 PURPOSE: Offer tools to remove barriers to making the appointment

HEAD: Setting up your child's doctor visit

SUB1: Find a doctor
ACCORD: Your child's pediatrician is your choice.

- **CTA:** <Learn more/Visit the [branded provider search tool] to find one of the many providers offered to <Health plan> members. *<link to provider search page>*

SUB2: Schedule a ride

ACCORD:
Your health plan may cover rides to your child's doctor appointments.

- **CTA:** Learn more *<link to health plan transportation page>*

MODULE 2 continued

SUB3: Download the <health plan 1st> mobile app!

ACCORD: Manage your child's health on the go, with everything in one place.

- Find a doctor, hospital, pharmacy, or specialist.
- Always have your child's member ID card.
- Check your child's symptoms.
- Call a registered nurse to talk in private about your child's health, 24/7/365.
- Manage your child's prescriptions.

CTA: Learn more *<link to health plan mobile app link>*

MODULE 3 PURPOSE: Generate action/urgency by reminding parents they can earn rewards

HEAD: Get your child's checkups and money to shop.

SUB/ACCORD: For <Health plan> members, earning rewards is as easy as:

1. Enrolling in the <member incentive brand name> program.
2. Going to your child's doctor visit.

3. Getting rewarded.

CTA: <Log in to enroll/Learn more> *<link to the member website log in page>*

MODULE 4: Interactive section to depict what to expect at each age. Content changes with the child age is selected.

HEAD: What to expect at your child's well visit

SUB: Well-child visits help prevent your child from getting sick and track their growth. At these visits, your child's doctor will examine your child and give them vaccinations to protect them against infections.

Select your child's age to learn more about what to expect, like what vaccines they will receive, at each well visit.

<Note: content to be filled in according to CDC immunization schedule: link to website - ***Centers for Disease Control and Prevention, Vaccines***>

<Age: <0 to 2 years old>
When to visit the doctor: <Every 1–3 months>

Your child's doctor wants to make sure they're growing at the right pace. They will track your child's development stages, or milestones. When your child will begin to roll over, babble, and sit up are examples of milestones.

Your child will receive vaccines that teach their body to protect them against infections like chickenpox and hepatitis. **Learn more** about what vaccines your child will receive at each visit. *<link to website* - ***Centers for Disease Control and Prevention, Vaccines***>

<Age: <3–6 years old>
When to visit the doctor: <Every year>

Your child's doctor may talk about healthy behaviors like daily screen time, nutrition, allergies, and others.

Your child will receive vaccines that teach their body to protect them against infections like measles, mumps, and the flu. **Learn more** about what vaccines your child will receive at each visit. *<link to website* - ***Centers for Disease Control and Prevention, Vaccines***>

<Age: <7–13 years old>
When to visit the doctor: <Every year>

At these visits, your child's doctor will give your child vaccines, provide behavioral health screenings, and talk to your child about hygiene and healthy habits. They may also provide annual physicals for school, sports, and camps.

Your child will receive vaccines that teach their body to protect them against infections like HPV, meningitis, and the flu. **Learn more** about what vaccines your child will receive at each visit. <*link to website* - ***Centers for Disease Control and Prevention, Teen Vaccines***>

<**Age:** <14–18 years old>
When to visit the doctor: <Every year>

At these visits, your child's doctor will give your child vaccines and talk to them about reproductive health and what it means to be a healthy adult. They may also provide annual physicals for school, sports, and camps.

Your child may also begin have their own questions for the doctor.

Your child will receive vaccines that teach their body to protect them against infections like meningitis and the flu. Learn more about what vaccines your child will receive at each visit. <*link to website* - ***Centers for Disease Control and Prevention, Teen Vaccines***>

MODULE 5: Blog articles

HEAD: More information for healthy kids

ARTICLE:
<It's safe to visit your child's doctor>
<Read more>

ARTICLE:
<Kids still need their regular shots during COVID-19.>
<Read more>

ARTICLE:
<Now is a great time to take your child for their well visits.>
<Read more>

ARTICLE:
<Choosing the right doctor for your child>
<Read more>

3

[END OF RESPONSE]

4.2.2.2: Provider Network and Services

A. Provider Network

1. Plan to Develop a Comprehensive Provider Network to Deliver the Division's Access and Availability Requirements for All Covered Benefits

Access to Providers, whether that means geographic accessibility or access to timely appointments, is the cornerstone of care delivery. Our parent company and its affiliates have extensive experience developing comprehensive Medicaid Provider networks that exceed access and availability requirements. ***Across our affiliates, we have successfully built and maintained networks for more than 20 markets, including those with a predominance of rural areas.*** This experience will be enhanced by the insight we will gain being in Mississippi communities; collaborating with Providers, Provider associations, community leaders, and advocacy groups; and listening to Mississippi residents and their families from the Delta to the Coast describe the challenges they face as they maneuver the healthcare system. Building our network development strategies around this feedback creates a strong foundation for a Mississippi network that will provide timely access to care for all covered services for our MississippiCAN and CHIP Members.

a. Provider Recruitment Strategy

[redacted]

Our full network development strategy will be outlined in our ***Network Access Plan***, which will be overseen by our local Provider Services Manager, and supported by our local Provider Contracting team. This team will have extensive experience building Medicaid Provider networks and negotiating contracts with large health systems, Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs), and other high-volume or high-priority Provider types listed in Figure 4.2.2.2.A.1-1. This team will be ultimately accountable to our CEO and will hold weekly meetings to monitor network progress and assure quick decisions on contract negotiations.

[redacted]

As a part of our strategy, we will hold listening sessions with Providers and other key stakeholders, including Provider associations, Members, and community-based organizations (CBOs), to understand the local access challenges and nuances within the state. For instance, we know we must prioritize the recruitment of outpatient behavioral health (BH) Providers, CMHCs, and Certified Community Behavioral Health Clinics (CCBHCs) so that Members have appropriate access to care following their discharge from an inpatient setting or Psychiatric Residential Treatment Facilities (PRTF). We will also engage members of relevant councils, such as our Health Equity Advisory Council, to inform and guide our efforts to create a more equitable healthcare experience.

When building a network, and on an ongoing basis, we will use the information we get from engagement with these key stakeholders, as well as data from various sources like the Credentialing Verification Organization (CVO), historical claims data, and other Coordinated Care Organization (CCO) Provider directories, to build and expand our target recruitment list. We will also use available information from the Division, including the Division's monthly list of qualified EPSDT Providers, to identify and recruit Providers into our network.

Identifying Network Gaps

Our Provider Contracting team will use industry-standard geographic mapping tools to assess network adequacy using our projected membership to identify gaps in our target recruitment list. To do this, we will:

- Analyze the anticipated Enrollment and service utilization, which determines the required composition and capacity needs of our network, including PCPs, specialists, hospitals, ancillary Providers, and facilities.
- Establish target ratios of Members-to-Providers by Provider type to account for expected utilization of services. We will use NCQA Member-to-Provider ratios assuring appropriate access for services.
- Identify available Providers within the travel distance requirements established in the RFQ using our analytics software to measure the average time and distance to a Provider.
- Analyze and track the percentages of Members with access through our analytics application to various Provider types based on the Division's access standards. We will monitor these access percentages on a weekly basis during our build phase, proactively identifying potential gaps by geography or by capacity.
- Multiply the Provider counts for each Provider type by the applicable capacity ratio to determine network capacity. We will test the capacity result from the network adequacy model against our anticipated Enrollment to identify network gaps.

Our Provider Contracting team will review network adequacy reports at least weekly during the network build phase to monitor our network development progress. During the network maintenance phase, we will review these reports on at least a quarterly basis to identify any network gaps. We will also submit a Network

Geographic Access Assessment Report to the Division on a quarterly basis to demonstrate our compliance with the geographic access standards for all Members set forth in Contract Section 6.2.1.

In addition to meeting these network standards, we will seek to provide ***access beyond geography*** by assessing Provider Network elements, such as languages spoken and accessibility for Members with physical or mental disabilities. Health equity assessments will be conducted to identify any gaps in our network's ability to meet the cultural and linguistic needs of our membership. Feedback from Members, Providers, and our Care Management (CM) team will be sought and analyzed to identify potential network gaps that may not be identified through geographic analysis.

Developing a Recruitment Work Plan

Our Member-centered approach to network development will emphasize community-based, coordinated, culturally competent, and accessible care aligned to Division priorities. In order to develop the most comprehensive Provider Network for our Members, we will contract with every willing Provider. When we identify network gaps, we will leverage multiple data sources to identify eligible Providers to fill the gaps and incorporate them into our recruitment work plan. Data sources include Provider listings from the District, the CVO, current CCO Provider directories, collaboration with Provider associations or CBOs, recommendations from other Mississippi Providers, Members, or simply a Provider contacting us either in person, by telephone, or through our Provider website.

The recruitment work plan defines all key tasks, timelines, resources, and accountabilities across all phases of the development initiative, from early engagement through post-go-live implementation and assessment. This recruitment work plan is a key element of our overall ***Network Access*** strategy and will allow us to effectively manage and monitor our progress and address any issues to assure we stay on track and meet targets and deliverables. An overview of our strategy is included in Figure 4.2.2.2.A.1-2.

[redacted]

Contract Processing and Execution

Based on our identified recruitment targets, our Provider Contracting team will outreach to those Providers and invite them to join our network. We understand that the first interaction with Providers is important, and our processes have been designed to establish meaningful relationships and build trust. We want Providers to know that we are not just a payer, but a partner in their success**.** In addition to phone calls, emails, and in-person meetings, we will also mail recruitment packets that will be personalized for each Provider. In addition to including key information about program participation, the packets will also include a letter introducing them to their Provider Contracting Consultant, ***who will serve as their dedicated point of contact throughout the contracting and onboarding process***. Once Providers agree to join our network, we will request a W-9 and use this information to customize a contract for them using our approved Provider agreement template. We will also provide the option for Providers to sign these contracts electronically, expediting the contracting process and further reducing administrative burden. However, if a Provider prefers to review and sign a hard copy of the agreement, their consultant will either provide this through mail or by meeting with them in person.

In compliance with Contract Section 6.5, we will coordinate with the Division's Fiscal Agent to confirm the credentialing status of a Provider prior to executing contracts. As soon as we are notified by the Fiscal Agent that the Provider's credentialing is approved, we will initiate our contract execution process. We will quickly execute contracts for Providers who have accepted standard Medicaid rates and contract terms and will load the Provider's data into our Core Service Platform (CSP), our system of record for claims and authorization data. This will be completed within 21 calendar days from the date of notification of approved credentialing. We recognize that some Providers may request rate and/or language changes, and our skilled Provider Contracting team will work with them to come to agreeable terms. As noted previously, this team will have direct access to our CEO and other subject matter experts to assure timely decisions on contract negotiations. We understand that awaiting signature from a Provider does not count towards the 21-calendar day data load requirement, and we will keep a record of this information. Our process for collaborating with the CVO is detailed further in Questions 3 and 4.

Carrying Out Recruitment Efforts

In accordance with our recruitment work plan, we will deploy our local and community focused Provider Contracting team to meet with and contract Providers through extensive one-on-one Provider engagement. Especially important in rural areas, we will meet with Providers where they are and at times and locations convenient to them. We will track all Provider leads and outreach activities in a centralized recruitment tracking tool. During these interactions, we will also document key information, including whether Providers are certified to offer evidence-based practices (EBPs) and their willingness to participate in Value-Based Purchasing (VBP) arrangements, so we can fully assess the overall strengths and capabilities of our network.

We will also conduct webinars and "open door" meetings to explain our reimbursement policies and Provider collaboration approaches, processes for prompt and accurate payment of claims, the use and functionality of our Provider web portal to minimize administrative burden, and streamlined utilization management practices, including electronic submission of authorization requests. We will use our industry-standard network adequacy tool to monitor the composition and capacity of our network throughout the entire network development period to focus activity where it is the most critical to meet our Members' needs. Our Provider Contracting team will meet at least weekly to monitor deliverable progress. We will never close our Provider Network for any Provider type without approval from the Division.

b. Strategy for Retaining Specialists and Providing Access to Specialists Outside the Network

We make a pledge to our Providers: to deliver a best-in-class experience, to simplify administrative processes, offer accountable reimbursement, and support them so they can focus on what matters most — the health of our Members. [redacted]

[redacted]

Arranging for Out-of-network Services

To maintain continuity of care and augment any in-network service gaps, if medically necessary services are not available from an in-network Provider, we will authorize services from an out-of-network Provider and initiate a single-case agreement (SCA). When we receive an out-of-network care request, our Utilization Management (UM) team will verify Member eligibility and then confirm the Provider is licensed, not excluded from participation by the Department of Health and Human Services or Office of Inspector General (OIG), and not on the Division's list of excluded Providers. We will then review the request for medical necessity and forward the case to our local UM team to review and discuss with our Medical Director. We will document medical necessity in our CSP upon confirmation and negotiate an SCA. We will process routine non-urgent SCAs within five business days and urgent SCAs within one business day. Our Provider Contracting team will also assess SCA requests to identify Providers to join our network. In one of our affiliate markets, this SCA analysis and outreach process has resulted in more than 80% of Providers that requested SCAs being recruited into the network. Additionally, if a Member is in CM, then our CM team will coordinate out-of-network services.

c. Coordinating Subcontractor Network Development with Our Overall Recruitment Strategy and How We Will Provide Oversight and Monitoring of Network Development Activities

We will build and maintain all networks through one recruitment strategy and one contract execution process with all parties aligned. As a seamless extension of our parent company and its affiliates, our subcontractors are our valued partners in delivering the highest quality services to our Members, Providers, and the Division. We have built trusted, collaborative, long-standing relationships with our subcontractor partners that coordinate successful delivery of dental and vision services. We use a comprehensive vetting process to select qualified subcontractors and have selected one subcontractor to manage delivery of both dental and vision services in Mississippi.

To assure our Members receive timely, appropriate, and quality care and services from our partners, our local Vendor Oversight Manager and Provider Representatives will capitalize on our established, proven Subcontractor Oversight Program used and refined over more than a quarter century by our affiliates serving Medicaid Members. This program is aligned with the Division priority of seamless delivery of services to Members and will enable us to continuously monitor subcontractor performance via daily collaboration and formalized auditing processes.

Through our Subcontractor Oversight Program, our local Vendor Oversight Manager will conduct day-to-day management, as well as oversight and review of subcontractor performance. The Vendor Oversight Manager will work in conjunction with our local Provider Contracting team to monitor our subcontractor's network development and ongoing network management efforts to confirm compliance with MississippiCAN and CHIP access and availability requirements. We will meet with our subcontractor at least weekly during the network build phase, and at least quarterly thereafter to measure progress against targets.

We will work closely with our partner to develop a detailed network development plan that meets the Division's requirements for access, availability, reporting, and timelines for demonstrating network adequacy. This includes a draft contract and recruitment letters, identification of target Providers, and how they will recruit (such as telephone calls, in-person office visits, webinars, town hall meetings), as well as specific milestones. Our local Vendor Oversight Manager and team will meet weekly with our subcontractor to review progress against the plan and discuss successes, challenges, or concerns. In addition, we also work with subcontractors to create a training plan to make sure our Providers understand MississippiCAN and CHIP Program requirements. Ongoing activities to monitor subcontractor performance, including maintaining compliance with network requirements, is outlined in our response for Section 4.2.2.7.B.

d. Method for Assessing and Assuring Network Standards Are Maintained for All Provider Types, Including Using Geographical Adequacy Reports to Assure Network Adequacy

[redacted]

While we are confident in our ability to achieve and maintain network adequacy for all Provider types, we recognize the impact of the primary care shortage in Mississippi, and we will work closely with the Division to offer short-term and long-term solutions, including:

e. Continuous Network Improvement

We will monitor information obtained through our local Provider Experience, Care Coordination, QM, Population Health, and Member Services teams to identify opportunities to improve our network and address deficiencies. We will comply with Contract Section 6.2.5 and present our PCMH strategy to the Division in writing within 90 days of Contract award for review and approval, which will include our approach to promote and assure PCMHs adhere to all access and availability requirements.

Monitoring and Evaluating Compliance with Availability and Scheduling Appointment Requirements

Meeting network adequacy standards is not enough if Members still struggle to access services in a timely manner. We will educate Providers on availability and appointment scheduling requirements listed in Contract Section 6.2.2 at orientation and on an ongoing basis, through trainings or in-person meetings. Our Provider newsletters and Provider Manual supplement initial training and will serve as reminders for timely scheduling of routine appointments and triage requirement standards. Understanding the key role that PCPs/PCMHs play in coordinating Member care, we will conduct appointment access and availability reviews at least quarterly, exceeding the contractual requirement of every six months. We also will include other Provider types, including specialists, BH, dental, and transportation Providers, in these reviews to make sure Members have access to the full range of care in our network. In addition, we will monitor the following to identify noncompliance with availability and appointment standards:

- Review of Member Grievances routed to our Provider Contracting and Provider Experience teams for review, investigation, and follow-up.
- Annual CAHPS survey to obtain Member satisfaction with Provider wait times and access to care.
- Provider site visits by Provider Representatives to assure Providers are adhering to office wait times and accessibility requirements.
- Member service utilization patterns, including utilization of the emergency room (ER) and inpatient admissions and readmissions, to identify specific communities or practices with inadequate access.

If we identify a pattern of noncompliance with appointment availability or wait time through audits, site visits, or Member Grievances, we will immediately send a written notice to the Provider and:

- Investigate the issue and develop an action plan to bring them into compliance.
- Meet with the Provider to discuss the plan and standards, formalize the plan, and obtain agreement for follow-up reassessment.
- Monitor the plan to make sure the Provider completes the critical tasks according to schedule and conduct a follow-up audit three months after resolution.
- Provide guidance if they do not achieve compliance or remain non-compliant. We may also impose sanctions such as limiting the Provider's panel size. Finally, if Providers do not correct their deficiencies after our continued improvement efforts, we may terminate the Provider from our network.

Assuring Member Access to Care If We Lack an Agreement with a Key Provider Type in a Geographic Area
As described earlier, we have a comprehensive approach to make sure we build a network that meets or exceeds the Division's access and availability requirements. However, in the event that we lack an agreement with a specialist or key Provider in a given geographic area, we will maintain continuity of care and augment any in-network service gaps by coordinating care with an out-of-network Provider through an SCA, including Providers located in bordering states, involving our CM team as appropriate. We will also offer impacted Members access to telehealth services or other innovative solutions that meet their health needs.

f. Assuring Appointment Access When Members Cannot Access Care Within Our Network
As discussed previously, if a Member does not have access to needed care within our network, we will initiate our SCA process. Our SCAs specify mutually agreed reimbursement terms and conditions, including quality and accessibility standards and requirements related to professionally recognized standards of care. On a daily basis, our Utilization Management Clinician will review open case out-of-network reports for care coordination and resolve potential barriers to timely services, including any issues related to SCAs. If the out-of-network Provider is not providing the care or services needed by a Member, such as timely appointments, we will meet with the Member and Provider. If issues cannot be resolved, we will work with the Member to find another Provider able to address the Member's needs. If we find the issue to be a quality of care concern, we may refer the case to our legal counsel for peer review and appropriate State reporting.

If we identify that a Member is having issues accessing care within the appointment standards with one Provider, our team will work with the Member to identify an alternate Provider with a proven history of adhering to required appointment requirements within their specified geographic area. We will work to assure that Members have adequate access to timely appointments. If access to timely appointments is not available within the Member's geographic access area, we will arrange to transport the Member to an out-of-network Provider or to another in-network Provider outside of the Member's geographic area. We will also work to expand the availability of telemedicine and mobile services as described earlier. Our value-based incentive programs, described in response to Section 4.2.2.2.A.7, also incent participating in-network Providers to expand access and availability.

g. Role of Our Provider Representatives, How We Recruit and Maintain Them, and How We Assure They Stay Current on Medicaid Policy
Our dedicated Provider Representatives will be local, Mississippi-based employees trained to support Providers on everything from claims submission to clinical practice transformation. In accordance with Contract Section 6.9.3.3, we will retain a proportional number of Provider Representatives to adequately assist Providers, which will not be fewer than 30. These Representatives will live in the same communities as our Providers and understand the nuances of the local landscape. [redacted]

[redacted]

Recruiting and Maintaining Provider Representatives

Our overall staffing model embraces our belief that healthcare is best delivered locally. Our local, hands-on approach draws on a variety of recruitment sources and activities to attract qualified candidates with requisite skills to recruit Provider Representatives including referrals, job search networks, and social media campaigns; we will also partner with our Providers, key stakeholders, including Provider associations, and community-based organizations to help source and secure qualified candidates. Our team will know Mississippi, and they will understand the labor market and work with local organizations to make sure we recruit Provider Representatives who will excel in this role.

Our overall staffing approach also focuses on supporting and retaining our staff, championing professional development, and providing comprehensive training to retain diverse, inclusive, and culturally competent Provider Representatives. Our approach looks towards the future, with strategies that promote innovation, address the changing Medicaid landscape, and strengthen community ties.

Through our staffing plan, we will monitor and maintain staffing levels to deliver an effective system of care using multi-pronged processes to foster team stability, consistency, and continuity — essential components to assure we provide the best services and supports to our Provider and Members. Our focus on retention and training will help reduce turnover and assure stability of our Provider Representatives. Further, we will routinely evaluate and adjust our team based on the needs of our Providers, our communities, cultural and geographic nuances, needs, or requests by the Division, and when changes in volume, service delivery, or programs occur. Annually, our Provider Services Manager will conduct an analysis to determine whether current staffing levels are adequate to meet Provider needs. If the analysis indicates that we have staffing opportunities, we have processes in place to quickly recruit, hire, and train qualified professionals. For example, based on feedback from our Providers related to increased training needs.

Assuring Provider Representatives Remain Current on Medicaid Policy

Our Provider Representative training approach incorporates initial, ongoing, and advanced training curricula. We will deliver MississippiCAN and CHIP-specific training to our Provider Representatives and we will assure they stay up to date on Medicaid policy with ongoing training by working closely with our Compliance team and Division staff. As soon as our Compliance team receives a notification on updated Medicaid policy, they will send an immediate alert to the Provider Services Manager, who will communicate the update to all Provider staff within one business day. This will make sure Provider Representatives are able to answer any questions from Providers quickly and accurately.

As Medicaid policy changes, we will adapt our systems and communicate this information through notifications and additional training. Our Provider Representatives will receive MississippiCAN and CHIP updates on policies, procedures, and workflows. We will also update our knowledge management system with any new requirements and notify Provider Representatives via memo, assuring timely and correct information is given with every Provider interaction. If additional training is needed, training platforms will alert, track, and make sure our representatives complete required courses in advance of the effective date of change. We will also schedule training sessions to assure there is no impact on supporting our Providers.

2. Developing and Maintaining Collaborative Relationships with Low, Medium, and High Intensity Residential Treatment Facilities and Medically Monitored Inpatient Treatment Facilities

We recognize the importance of a robust continuum of care and access to all levels of residential treatment facilities (RTFs) within our network to meet the needs of MississippiCAN and CHIP Members with mental health and SUD. Our parent company and its affiliates have extensive experience developing collaborative

relationships with low-, medium-, and high-intensity RTFs encompassing the continuum from clinically managed to medically monitored inpatient service facilities as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA); and providing Medicaid SUD services to help Members transition out of residential treatment programs. We will collaborate with our Provider Network, Community Mental Health Centers (CMHCs), CCBHCs, outreach programs, and social and housing support Providers to increase access to and support successful care post residential treatment.

Our primary goal in collaborating and contracting with all levels of RTFs is to provide our Members with the intensity of services they need to support resiliency and recovery, and to facilitate transition to a lower level of care or back into the community. We understand that this requires relationships with CBOs and Providers across the continuum of care to assure our Members get the support and services they need.

Our strategy of fostering collaborative relationships and supporting RTFs across Mississippi will begin with a focused approach by our designated BH Provider Experience Consultants. We will foster and develop collaborative relationships with Mississippi's RTFs, including the 13 regional CMHCs, which are certified for primary residential services by the Mississippi Department of Mental Health. For the seven freestanding Mississippi Medicaid PRTFs, we will work to establish strong relationships. We will also include in our contracting Institutions for Mental Disease, as certified by the Division, to provide support and payment for Members between the ages of 21 through 64 who may need substance use disorder (SUD) treatment for a short-term stay. We will also work with Mississippi Youth Programs Around the Clock (MYPAC) Providers and develop strong working relationships with key BH stakeholders across the state including key Provider associations.

Our locally based BH Provider Experience Consultants will conduct in-person visits to RTFs for support and continuing education. Through ongoing support, education, and the sharing of actionable data, our Representatives will help facilitate operational efficiencies. As they identify training needs, they can refer Providers to our robust array of educational resources available on our Provider website, or request in-person training with our national SUD or serious mental illness (SMI) residential subject matter experts. Over the course of the Contract, our Provider incentive programs may be leveraged to reward facilities that deliver higher quality of care and achieve positive Member outcomes. Additionally, we will maintain sound reimbursement practices, including prompt and accurate claims payment, and use person-centered VBP arrangements to support Member recovery and facilitate transition to a lower level of care or back to the community.

Understanding the need for and establishing collaborative relationships is the cornerstone of our utilization and CM process. When a Member is admitted to a SUD or psychiatric facility for residential treatment, our UM staff will work with the facility's utilization reviewers and discharge planners to develop a discharge plan that includes the holistic needs of the Member, and family if appropriate. Throughout the duration of treatment in the facility, our UM clinicians will maintain regular contact with the facility discharge planners, internal utilization review staff and the primary Provider of services. We will also offer support from expert Addictionologists who are available to provide consultation on SUD issues, and we will offer training and coaching on level of care guidelines or treatment protocols.

Our CM team will work alongside our UM clinicians to support successful discharge planning and coordinate services within the community. All Members who receive care from a PRTF will be assigned to a Care Manager. Through this approach, we will assure:

- All necessary post-discharge treatment authorizations and other support services are in place
- Any additional support needed will be available until the transition has been successfully negotiated

Additionally, our interdisciplinary, Mississippi-based Transition of Care (TOC) team, Care Managers, CHWs, Care Management Navigators (CMNs), and a certified Diabetes Educator, will work closely with our UM staff and Medical Directors to thoroughly monitor care for Members as they transition. Understanding the unique needs of Members who experience SMI, specialized healthcare needs, and SUDs, we will give particular

attention to the transition process to assure that the discharge plan will maintain continuity of existing therapeutic relationships desired by the Member, including:

- Collaboration with medical and BH Providers as appropriate
- Support systems and transportation needs are outlined and incorporated into the plan as appropriate
- Input from the Member, and family or caregiver if applicable, is outlined and incorporated into the plan as appropriate

In addition to coordinating with BH Providers to facilitate access to outpatient services, we will link our Members to CBOs that support their resiliency and recovery. We will cultivate relationships with Mississippi-based recovery-focused organizations, and to help Members access 12-step and recovery programs, we will provide community transportation, through our Non-Emergency Transportation vendor, as an ***enhanced benefit***, which provides rides to and from these types of organizations. Our goal is to support our Members through every step of treatment and recovery, and we view collaboration with RTFs as essential to meeting this goal.

3. Working with Providers and the CVO to Educate and Assist Providers in Completing the Credentialing and Recredentialing Process with the CVO

We appreciate the Division's commitment to simplifying the Provider Enrollment process and reducing administrative burden through a CVO program. In compliance with Contract Section 6.5, we will work collaboratively with the CVO and Providers to complete the credentialing and recredentialing process required to participate in the MississippiCAN and CHIP Programs. We will also participate on the Credentialing Committee and collaborate with other CCOs to streamline communications and outreach, using best practices from our affiliate markets that already use a CVO.

Educating and Assisting Providers with the CVO Process

We will partner with the CVO and Providers to make sure Providers are properly educated and assisted in completing the credentialing and recredentialing process with the CVO. For our internal leads and referrals, we will direct all Providers who are interested in joining our network to the CVO's website to enroll in Medicaid (if not already enrolled) and to complete the credentialing process prior to enrolling with us. Our Provider website will also include a link to the CVO website, where they will complete credentialing, recredentialing, and Provider data maintenance processes.

Our Provider Services Call Center Representatives will also be trained on the CVO requirements so they can appropriately respond to questions and direct callers to the appropriate resources. Information on the CVO will be added to our online knowledge management application, a database of program requirements and covered services, providing call center staff with real-time access to information on the CVO to accurately relay information and respond to questions from Providers and their staff.

Our team will inform Providers of the requirement to submit an electronic application or complete a Council for Affordable Quality Healthcare (CAQH) profile. We will also inform Providers that the Division's Fiscal Agent and CVO will create a credentialing portfolio for review by the Credentialing Committee and process the Provider credentialing and recredentialing information to apply to Fee-for-Service, MississippiCAN, and CHIP delivery systems. We will never require Providers to submit supplemental or additional information for purposes of conducting a second credentialing process for Medicaid lines of business, and we will assure Providers know they may appeal the CVO's credentialing decision to the Division.

We will work closely and remain actively engaged with the CVO, Providers, and other CCOs to make sure the Provider community is properly informed. In addition to educating Providers on the CVO requirements during initial contracting discussions and ongoing trainings, we will use various print and electronic materials to educate Providers on the CVO, including:

- **Provider Updates and Frequently Asked Questions.** We will use these user-friendly tools to explain new programs or procedures to Providers. To convey important information or updates to Providers, we will post

Division-approved bulletins to our Provider website and send email notifications and fax blasts to Provider offices. We will also include information on the CVO in our quarterly Provider newsletters.

- **Provider Manual.** Our Provider Manual will be a comprehensive document designed to inform Providers of our guidelines and requirements and assist them with caring for MississippiCAN and CHIP Members. We will incorporate information about the CVO's role and processes for initial credentialing and re-credentialing into our Provider Manual, which will be accessible through our Provider Portal.
- **Provider Portal.** In addition to bulletins, our Provider Portal will also contain information about our network and links to important Mississippi resources, including the CVO website.

4. Timely Contracting of Providers upon Receipt of CVO Notification That Credentialing Is Complete

We will coordinate with the CVO to confirm the status of Providers who are requesting to enroll in our network. Once we receive notification from the CVO that the Provider's credentialing is complete, we will comply with all requirements in Contract Section 6.5, including outreaching to all Providers within 7 days of the file interface exchange. Our Network/Contracting Manager will review the file to identify which Providers are currently engaged in our contracting process, as well as new Providers that are not engaged in our contracting process and require outreach from our Provider Contracting team.

- For newly credentialed Providers that have already signed a contract, we will immediately execute the contract once we receive the CVO notification and initiate Provider loading.
- For newly credentialed Providers that are still going through our contracting process, we will notify them of the approved credentialing status and the need to execute the contract expeditiously. We understand awaiting contract signature from a Provider does not count as part of the required 21 calendar day load time.
- For newly credentialed Providers not currently engaged in our contracting process, we will outreach within 48 hours of receipt of the file from the CVO to initiate contracting discussions and provide them with our standard contract template for signature.

Upon receiving the Division file transfer, we will incorporate all required information, including the completed Provider application, current license, and proof of malpractice insurance, into the Provider's file. We will not take longer than 21 calendar days from the date of notification of credentialing to load the Provider information into our CSP, which is our system of record for claims and authorization data. Our Provider Contracting team will make sure Providers are accurately configured in the CSP and can also help facilitate claims testing at the Provider's request. All Providers will be sent a welcome letter once they are fully credentialed and contracted. We will also promptly update our online Provider Directory to promote Member choice and assure that Members have access to our most current Provider information. We will also submit the reports required in Contract Section 16.2.1.

5. Standard Provider Contract Template

Please refer to Attachment 4.2.2.2-1: Standard Provider Contract Template.

6. Proposed Policies and Procedures for Addressing a Large Provider Group or Health System Loss

We understand that the loss of a large Provider group or health system from a Provider Network is a significant event for Members, and can also significantly affect the Division, other stakeholders, and our CCO if not managed in an effective manner. With this in mind, we will work to avoid such circumstances. Our Provider Network management and servicing approach, which includes our local Provider Representative team, has been developed on the principles of maintaining strong and long-lasting Provider relationships. In the rare event of a large Provider termination, we will execute established formal policies and procedures that address Member notification, State agency communication, and continuity of care, including systems to identify and notify affected Members, and the supports needed to assist Members with continuity of care and transitions. We will comply with all requirements in Contract Section 6.4 when addressing Provider terminations.

Using a Comprehensive Work Plan to Assure Seamless Continuity of Care During Transitions

We pride ourselves in our ability to seamlessly support continuity of care during Member and Provider transitions and we will comply with all applicable contractual, State, and federal requirements. In the event of a large Provider group termination, our process begins by notifying the Division, assigning a project manager, and establishing a Provider Termination Work Plan. Our local Provider Representative team, in collaboration with other internal stakeholders, will have oversight of the work plan that will be developed as soon as we become aware of the termination or potential termination.

Our Provider Termination Work Plan will include all 13 elements listed in Contract Section 6.4.1, define the tasks to be completed, business owners for each task, start and finish dates, and a monitoring mechanism to keep each task on track. Upon creation of our work plan, the project manager will schedule mandatory internal transition meetings; coordinate drafting and finalizing of applicable communications through internal communication management processes; and help assure staff are notified, trained, and available to support the work plan. We will submit our work plan and supporting documentation to the Division within 10 business days of notifying the Division of a Provider's termination and we will provide weekly status updates. Additionally, we will provide any supplementary information on the termination requested by the Division within two business days of the request.

a. System Used to Identify and Notify Affected Members

As soon as we become aware of an anticipated termination, we will immediately focus on Member notification and work to assure continuity and coordination of care for affected Members. We will identify all Members assigned to Providers within the exiting group or health system, pulling recent utilization data to determine Members and services being provided by the terminating Provider that need to be transitioned to an alternate in-network Provider to assure continuity of care. The assigned project manager will obtain listings of Members assigned to each terminating Provider and coordinate Member notification via first-class mail within 15 days of notice or issuance of termination. We will supplement these letters with Member portal and mobile app notices, FAQs, automated outbound calls, and live outreach. Our notifications will include information on how to select a new Provider, as well as dates after which the Member may no longer use the Provider. Our PCP auto-assignment algorithm and Member default optimization processes, described in our response for Section 4.2.2.11.B.1, may also be used to help assure affected Members who have not selected a new PCP have access to in-network primary care services. Additionally, if Members are not engaged in CM, they will be contacted for engagement with our TOC team to make sure the Member has a positive transition process and a coordinated transition plan. Members engaged in CM will receive direct communication from their Care Manager and will be assisted with finding a new Provider, developing a plan for the transition, and alleviating any concerns of the Member.

b. Automated Systems and Membership Supports to Assist Affected Members with Provider Transitions

Our team will be available throughout the Provider transition process to personally assist affected Members in their selection of a new PCP or transition to new Providers. We will use live outreach, Member portal and mobile app notices, automated outbound calls, and our Member services call center to assist Members during transitions. As discussed in our response for Section 4.2.2.1.B, our diverse, well-qualified Member Services team will be well-trained to support and assist our Members during transitions. We will offer comprehensive, personalized Member service through a fully integrated call center. The strategic design of our Member services call center will enable our Member Services Call Center Representatives to provide callers the accurate information they need. Additionally, our interdisciplinary, Mississippi-based TOC team, Care Managers, CHWs, CMNs, and a certified Diabetes Educator, will work closely with our UM staff and Medical Directors to thoroughly monitor care for Members as they transition.

c. Systems and Policies to Maintain Continuity of Care of Members Experiencing a Provider Transition

We will allow Members to continue an ongoing course of treatment (as defined by the five elements of Contract Section 6.4.2) from their Provider for the greater of 60 calendar days from the date the Member is notified of the termination or pending termination, or 60 calendar days from the date of the termination unless the Provider is being terminated for cause, in which case we will transition the Member immediately to another Provider for services. We will also extend this transition period if we determine the extension is clinically appropriate, and we consult with the Member and Provider in making these determinations. We will continue the ongoing course of treatment while making the determination, and we will notify the Member as expeditiously as the Member's health condition requires, but no later than two business days. If we determine that what the Member is requesting is not an ongoing course of treatment, we will issue the Member an adverse benefit determination notice with information on the Appeal process.

For any affected Member, including Members undergoing an ongoing course of treatment, our CM team will contact them directly by phone and in writing to facilitate continuity of care and help them find a new Provider.

We will facilitate the confidential exchange of information between PCPs/PCMHs and specialty Providers, specifically BH, and our CM team reviews Member and Provider requests for continuity of care and facilitate continuation with the current Provider until a short-term regimen of care is completed or the Member transitions to a new Provider. Our Care Managers will coordinate with applicable Providers and make sure all care is coordinated and documented in our clinical system as part of our interdisciplinary treatment team process. If the termination is a hospital or a facility, we will conduct a review of surgeons and other Providers who maintain privileges only at the terminated hospital or facility and make appropriate arrangements to maintain hospital coverage or obtain privileges at another in-network hospital.

d. Covering Membership Needs with Existing Network Resources

In the rare event of a large Provider group or health system termination, we will run updated network adequacy reports, analyzing the impact to accessibility to verify we continue to meet the care and service needs of our Members. If we identify any adverse impacts or gaps to our network, our local Provider Representative team will develop strategic plans to remediate those barriers, either by supplementing access with alternative Providers or through other means, including telehealth, as necessary. We will carefully review our existing network Providers to help assure their access and availability remains within the requirements with the potential addition of new patients. Additionally, our local Provider Representatives will meet with terminated Provider group representatives to set expectations for post-termination continuity of care based on Provider contract provisions and Division requirements.

As discussed previously, our Member Services Call Center Representatives, as part of our Member services call center, will be trained to provide information about transitioning from one Provider to another. With a focus on medium or high-risk Members assigned to a PCMH, our staff will help Members find the right Provider to best meet their needs and understand their services and benefits. Member Services Call Center Representatives will also help schedule Provider appointments when needed. Our online Provider Directory (updated nightly five days per week) will enable Members to select the most appropriate Provider based on detailed information, including office locations, office hours, specialties, board certifications, accessibility for those with a disability, age or gender served, and languages spoken.

[redacted]

[redacted]

8. Process for Maintaining Provider File with Information Sufficient to Support Provider Payment

We will partner with the Division and the CVO to obtain all the required data for the Provider file from the Division. The design of our system will not allow us to move a Provider to active without having all the necessary data to pay claims and produce 1099s. Our process and system will successfully manage the initial load and ongoing maintenance.

For the initial load, our system will merge two sets of data: the majority coming from the CVO when credentialing is complete and the data is sent to us; the remaining data coming as a result of our contracting process (for example, contract rates). Once we receive all required data for the Provider file via file transfer from the Division, we will maintain a file for each Provider with a complete Provider application, including:

- Signed attestation statement
- Copy of the Provider's current license issued by the State

- Valid DEA or Controlled Dangerous Substances certificate
- Proof or cover page of malpractice insurance (copy of certificate or cover page)
- Additional information specified by the Division

Ongoing maintenance will occur every day through a combination of confirming demographic data when the Provider calls our call center, meets with our team, and requests updates, or updates data directly through our Provider Portal. We fully understand that the Division will not reimburse for services rendered by any Provider that is excluded or debarred from participation by Medicare, Medicaid, or OIG, including any other states' Medicaid program, or CHIP program, except for emergency services. We assure all of our Providers and subcontractors screen their employees for excluded persons, and we will re-communicate this obligation to all Providers and subcontractors upon any contract renewals.

a. Issue IRS 1099 Forms

We will use a centralized tax information reporting solution that will handle the complete compliance process of up to millions of forms; proactively validate information accuracy; and will react to IRS changes almost instantaneously. Our solution will provide an on-demand, centralized platform, where organizational units, tax forms and corrections will all be managed in one place. We will issue IRS 1099 forms for reportable payments made to payees that generally exceed $600 in a calendar year. We will mail the payee a recipient copy of the 1099 form by January 31st of each year and provide an electronic filing with the IRS by March 31st of each year. We will also issue the appropriate type of 1099 form for each payee where backup withholding tax was imposed even if the reportable payments were less than $600 in a calendar year.

b. Meet All Federal and Division Reporting Requirements

We will comply with all federal and Division reporting requirements when maintaining Provider files to support Provider payment. We will comply with Contract Section 16 and follow the specific requirements provided in Contract Section 16.2. Our MIS and reporting processes will support seamless operation of all managed care functions and to produce timely and accurate regulatory and ad hoc reports in the formats required by the Division.

Data flows to our data warehouse where it readily supports Division and internal reporting needs and requirements. Our data warehouse is optimized to support data analytics and regulatory reporting as required by CMS and the Division and can easily be modified and expanded to meet new reporting requirements.

c. Cross-reference to State and Federal Identification Numbers to Identify and Report Excluded Providers

We will conduct a monthly comparison of our Provider files against the Social Security Master Death File, the General Services Administration System for Award Management (SAM) and the HHS-OIG List of Excluded Individuals/Entities (LEIE) and provide a report of the result of comparison to the Division each month. Our monitoring also includes reviewing Medicaid Sanction Exclusions and Reinstatement reports.

Specifically, we will comply with 42 C.F.R. § 455.436 requiring performance of the following:

- Confirming the identity and determining the exclusion status of Providers and subcontractors and any person with an ownership or control interest or who is an agent or managing employee of the Provider, our organization, or subcontractor through routine checks of federal databases
- Checking the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any such other databases as the Secretary may prescribe
- Consulting appropriate databases to confirm identity upon Enrollment and reenrollment
- Checking the LEIE and EPLS no less frequently than monthly

Pursuant to 42 CFR §438.610(d)(2), we will not employ or contract with Providers excluded from participation in federal healthcare programs under either Section 1128 or Section 1128A of the Social Security Act. We will not employ or contract with a Provider that has been excluded by the Division, other state Medicaid agencies, or

other state CHIP. Additionally, at the direction of the Division, we will provide information to allow the Division to monitor our compliance with these terms as well as our Providers' and subcontractors' compliance with these terms.

We will establish an electronic database to capture identifiable information on the owners, agents, and managing employees listed on Providers' disclosure information as provided by the Division. We will also perform a monthly check for exclusions of their owners, agents and managing employees, and establish an electronic database to capture identifiable information on its owners, agents, and managing employees and perform monthly exclusion checking. We will provide the Division with the database and a monthly report of the exclusion check.

B. Provider Services Call Center

1. Provider Services Call Center Operations — Enhanced Support for Providers

Clear and consistent communications are central to our partnership with Providers. The Provider services call center is a critical component of those communications and our partnership with all Providers, to best meet Members' needs and streamline Provider interactions. Accordingly, we will offer comprehensive, personalized customer service to Providers via our Provider services call center. For maximum efficiency, Provider calls will be routed to Provider Services Call Center Representatives (PSCCRs) specifically trained to support MississippiCAN and CHIP Providers. Most calls will be routed to PSCCRs in Mississippi, but some will be routed to other states to facilitate readiness for call routing changes during emergencies or when service demands are higher than expected. Our PSCCRs handle multiple levels of service items:

- General administration Provider calls will be handled by Level 1 staff
- Prior Authorizations and notifications not requiring clinical review will be handled by Level 2 staff
- Web Support calls will be handled by level 2 staff
- Claims issues, including telephonic adjustments, will be handled by Level 3 staff
- Prior Authorizations requiring clinical reviews will be handled by Utilization Management (UM) Clinicians

PSCCRs will be trained to:

- Assist Providers with questions concerning Member eligibility status
- Assist Providers with Prior Authorizations and referral procedures
- Assist Providers with claims payment procedures, billing, disputes, Grievances, and other issues
  - Providers can be directed to claims processing PSCCRs quickly, where specially trained staff will be able to expedite and resolve claims concerns on the first call
- Facilitate transfer of medical records among Providers
- Educate Providers on Member covered services and benefit limits
- Refer Providers to the Fraud, Waste and Abuse Hotline
- Respond to Provider inquiries regarding current Enrollment and panel
- Coordinate the administration of out-of-network services
- Assist with all escalating issues or concerns and be connected to staff trained to resolve issues and concerns on the first call

When Providers (or Provider staff) contact the call center, they will be prompted to enter the Provider's National Provider Identifier (NPI). Callers that do not have the NPI will be routed to a Level 1 PSCCR who will attempt to qualify the caller. All other calls will proceed to the main menu, which includes options for routing the call to the person most likely to be able to resolve the issue identified by the Provider or the nature of the inquiry as quickly as possible. For example, a claims question would go to a Level 3 PSCCRs with the required claims training. Callers who choose not to self-service and have questions related to Member status, Prior Authorizations, claims, case management, website support, or pharmacy services will be directly transfer to a PSCCR. As an added enhancement, when any caller (Member or Provider) authenticates in the automated call

distribution (ACD) system, they will be automatically provided the Member's eligibility information preventing them from having to request something that almost every caller requires.

PSCCRs will have access to the latest information, both data and processes, via a knowledge base that is updated in real time. Our call systems and processes have the flexibility to get more prescriptive with an interactive script to meet Contract requirements and exceed the Division's expectations when responding to or making outbound calls to Providers. Our PSCCRs will also promote the use of our web-based Provider Portal.

The Provider Portal will offer the ability to:

- Submit inquiries and receive response with chat feature
- Access the Provider Manual
- Access newsletters, updates, and Provider notices
- Access a searchable Provider Directory
- Link to the State Preferred Drug List (PDL)
- Submit and view status of PA requests
- Initiate and track status for claims adjudication and reconsideration
- Link Members to Care Management (CM) services
- Provide training support, toolkits and access to clinical practice and medical necessity guidelines

a. Provider Services Call Center Hours of Operation

The Provider services call center will be accessed via a toll-free line for questions, concerns, and complaints. It will be open 7:30 a.m. through 5:30 p.m. CT, Monday through Friday, consistent with contract requirements. We will be accessible to our Providers after hours through a variety of mechanisms including our ACD that can self-service or route calls to physical health (PH) or behavioral health (BH) UM Clinicians that are available 24/7. As an additional option for Providers, our Provider Portal will be available 24/7 to verify eligibility and request authorizations. During regular business hours, ***Providers with questions will be able to opt out of the ACD at any time to connect directly with a live representative***.

b. Cultural Competency Training

Upon hire and annually thereafter, 100% of our employees complete cultural competency education and training to address cultural and linguistic differences with sensitivity. This training will include a review of case studies that detail medical services, treatments, medication needs, and other ancillary services, equipping PSCCRs with knowledge to connect Members to necessary and appropriate services including Providers that share their cultural experiences and backgrounds. We will conduct post-testing to measure for competency with the training and conduct ongoing and annual refresher training. Cultural competency is an ongoing focus for our PSCCRs, and we will include this in our call audit process to be sure our Providers and Members are received and supported respectfully and knowledgeably, so they will be confident their concerns and questions are being capably and fully addressed.

c. Rates of Response and Measures to Assure Standards Are Met

Our Provider services call center will:

- Maintain a monthly average speed to answer calls of 120 seconds or less
- Maintain a monthly abandonment rate of no more than 4%
- Maintain a backup system capable of operating eight hours at full capacity and will notify the Division immediately when deploying the backup system

We will use the daily, weekly, monthly, and quarterly reports to predict call volumes and establish initial staffing levels. We will then use more frequent data (as often as every 15 minutes) to adjust the number of staff taking calls. If volume is higher than projected, we will put more staff on the phone. When volume is lower, we may pull one or more PSCCRs off the phone to receive additional training. Our workforce management (WFM)

team will monitor the call center's telephony metrics to identify if call volume increases beyond the capacity of our scheduled PSCCRs to respond. We can and will expand the call answering queue to include designated backup PSCCRs in other locations. PSCCRs in any of our call centers have access to a full knowledge library with resource tools including material specific to the program to answer any questions from our MississippiCAN and CHIP Providers. [redacted]

d. Training for Call Center Employees

Our call center employees will be trained on all MississippiCAN and CHIP Programs to be a one-stop service to assist Providers with services, eligibility, or claims related to benefits. Beginning with new hire training, we educate PSCCRs on our Member-centered approach to care, best practices, and strategies for engaging customers. Throughout their employment, we will provide continuous training, coaching, and supervision that support employees' consistent application of these principles when serving our Members and Providers. We will conduct training in controlled environments with supervision and coaching, followed by evaluation. Our curriculum will cover a variety of topics, including Member Services core training, Provider Services training, and training specific to the Program.

Our PSCCR training includes:

- **New Hire Training.** All new hires receive 18 days of training and two weeks of nesting (close supervision while taking calls) prior to taking Member/Provider General calls.
- **Refresher Training.** Three to four months after nesting, PSCCR1s will receive four to eight hours of Refresher Training.
- **Advanced Skillset Training.** Progression to PSCCR2 promotion and Advanced Skillset training is dependent upon manager assessment and employee performance. Advanced Skillset training is 12 days of training and two weeks of nesting. Topics include Billing, Grievance and Appeals, Claims Research.
- **Specialty Skills.** Web Support (must be claims-trained) is four days training and PAA/Auth Intake/ Notifications is five days training.
- **Promotion to PSCCR3.** Promotion is based on employee performance and manager assessment. No additional training will be required.

Our extensive Provider and Member services call center training program will include curriculum specific to the MississippiCAN and CHIP Programs, including Covered Services, Member Rights, Cultural Competency, Identifying Emergency Calls, the MississippiCAN Provider Network, and Non-Emergency Transportation. Our training curriculum will support PSCCRs in building the skills necessary to deliver knowledgeable assistance and services for our Members of all cultures and abilities. ***Providers can be confident they will be talking to a skilled PSCCR with complete knowledge of issues who is committed to solving the inquiry on the first call.***

Ongoing Training. Our PSCCRs will benefit from ongoing training to keep their skills fresh, and they will be continuously engaged in professional development. We will provide education at least quarterly, focused on Medicaid, MississippiCAN, and CHIP, including changes and requirements via "Late Breaking News" articles; Provider Bulletins; State Plan amendments; CHIP State Health Plan Amendments and Administrative Code Filings; the Division's Provider Billing Handbook; and MississippiCAN and CHIP Program updates.

Tracking and Reporting Training Completion. We will submit reports detailing our PSCCR education activities that adhere to Division requirements. We will track and document all employee training within ourHuman Resources application. When any newly hired employee does not complete the required training, we will send a report to the supervisor for corrective action to, as a minimum, remove them from the phones until the required training is complete.

e. Call Center Electronic Communications

Our powerful customer service platform will enable our PSCCRs to respond efficiently and effectively to inquiries and requests by integrating information from multiple back-end systems onto a single-screen view. The integrated desktop rapidly accesses and displays all data related to the Member's benefits, assigned PCP, service utilization, claims history, Enrollment, authorizations, other health insurance coverage, and will be tailored to specific local, community-based support programs and service areas. The PSCCR will also be able to view a list of a Provider's Appeals by Member and the processing status of each Appeal. When Providers call the Provider services call center, they will be prompted to enter their NPI. The call then enters the main menu, which includes the following options: Member status, precertification, claims, Care Management, website support, pharmacy services, or direct transfer to a PSCCR. Claims-related calls will be transferred directly to a Level 3 PSCCRs with the training and skills to adjust claims over the phone.

2. Assessing Quality and Efficiency

We will use PSCCR call monitoring and documentation review to evaluate the quality of service and accuracy of information delivered to Providers. All callers will be informed that their call may be monitored for quality control purposes. We will use the recordings to assess the accuracy of information provided, to evaluate the quality of the interaction between a PSCCR and a Provider, and to provide feedback and coaching to individual employees to improve performance. Call monitoring will include silent monitoring, recorded calls, and side-by-side monitoring. We will monitor calls randomly throughout the month for experienced PSCCRs. Monitoring for newly hired employees completing training will occur more frequently, and results will be used immediately as coaching opportunities. A quality audit will evaluate PSCCR performance in multiple areas related to program knowledge and a services-oriented approach to call handling. We will tabulate aggregate and individual performance metrics monthly for our quality and call center management team for oversight. Our call metrics in all markets meet or exceed the Division requirements, and

- We will submit the necessary reports to verify compliance with Division standards including for staffing.
- We will record 100% of our Provider service calls.
- We will randomly select for audit no less than 3% of those calls for compliance with customer care guidelines and then report findings to the Division quarterly as required.
- We will maintain the recordings for 10 years and provide recordings to the Division within five days of request.
- We will provide real-time chat capability with the opportunity for immediate post chat feedback, and our results are consistently very good in that feedback across markets.

C. Provider Education and Communication

1. Educating PCPs/Patient-Centered Medical Homes (PCMHs) About Care Management

We understand that Care Management (CM) services are vital to making sure our Members achieve optimal health outcomes, especially those Members with the greatest needs. CM services are also a crucial part of aligning with the Division's goals to improve access to healthcare, specifically to facilitate access to maternity and behavioral health (BH) services. To make sure our Providers have all the information they need to encourage their patients to take full advantage of our CM program, we will leverage many channels to educate our Providers on the critical nature of CM services and collaborative care planning to achieve positive Member outcomes.

Initial Training

Provider orientation will be the foundation for long-term collaboration with our Providers, and education and training about our CM program is a central part of our onboarding for PCPs and PCMHs. Upon joining our network, every Provider will be assigned to a Mississippi-based Provider Experience Consultant located in their respective region to facilitate initial orientation training within 30 days of becoming a participating Provider. In accordance with Contract Section 6.9.3.1, we will help make sure they understand the benefits of our CM

services for our Members, the role and responsibilities of the Care Manager, and how they can make referrals to CM on the Member's behalf. We will educate them on how we identify Members for CM as well as how they can proactively identify Members and refer them to CM. Providers are often well equipped to identify Members for CM because of the relationship they have with their patients and can have a significant impact on early identification to avoid downstream impacts. We will also include training on our interdisciplinary team process, development of treatment plans, the importance of meeting Social Determinants of Health (SDOH) needs, and when to outreach to the CM team for assistance to help manage Member care. We will also give an overview of the tools available to them, including how they can access our Provider-facing Care Management Platform for Member CM information, including assessments, treatment plans, and gaps in care.

In-person Support

Our team will work hand in hand with Providers to make sure they are educated on program requirements and have the support they need as well as the methods to facilitate referrals to our CM program, which will include a secure email inbox and a fax form located on the Provider website. Additionally, when Members are enrolled into CM, a Care Manager will outreach directly to their assigned PCP/PCMH to discuss the role of the Care Manager, our expectations about their collaboration and involvement, and how we will facilitate this through data sharing and direct interaction. ***We will also embed CM staff in high-volume facilities to further enhance this collaboration.***

Materials and Resources

We will provide many materials to educate our Providers about our CM programs, including our monthly digital Provider newsletters. Our newsletters streamline communications for Providers and contain relevant and helpful information designed to educate our entire Provider Network on program updates, Member needs, and best practices as well. In addition, our Care Managers will provide numerous educational materials such as fliers and brochures about various chronic conditions to help Providers engage with and educate Members and provide continuity with the Care Managers. In addition to these resources, our Provider Manual will serve as a comprehensive resource about our CM services. Providers will have 24/7 digital access to our manual on our Provider website and can contact our Provider services call center for any questions or further information regarding CM.

Encouraging and Measuring Engagement

[redacted]

[redacted]

2. Educating PCPs/PCMHs on Referrals for BH/SUD Treatment

We recognize PCPs/PCMHs are often an early identifier of Members with BH and substance use disorder (SUD) and facilitating mental health treatment. We will provide comprehensive training for Providers in our network on best practices for identifying, treating, and referring Members with BH/SUD needs. These training and online resources are designed to educate Providers on how and when to screen Members and the process for making referrals to a specialist.

[redacted]

We will provide information to PCPs/PCMHs on effectively identifying Members with co-occurring BH and SUD and the importance of addressing both concurrently. Our training will includes a broad array of course topics related to integration of physical health (PH) and BH/SUD care, such as SBIRT, trauma-informed care, Medication-Assisted Treatment (MAT), and ADHD, incorporating multi-modal delivery (in person, online courses, tailored webinars, written materials) and mechanisms to track, monitor, alert, and report compliance and completion. The goal is to effectively deliver information needed to allow PH and BH Providers to engage Members, improve outcomes, and simplify practice management. This will include training on identifying Members with SUD through the SBIRT process, an evidence-based approach to the delivery of early intervention and treatment for people with SUD and those at risk of developing these disorders. Once the Contract begins, we will be contacting Providers and suppling education to promote SBIRT screening and referrals. We will also be developing plan-specific Provider training tools to promote awareness of SBIRT as a covered benefit as well as the positive Member outcomes from SBIRT encounters. [redacted] We will also educate Providers on the importance of sharing all relevant information, including the results of the SBIRT screening, with BH Providers so that their Members can receive the best care. We also promote integration and data sharing from BH Providers back to the PCP/PCMH Providers through various mechanisms, including VBP programs.

[redacted]

3. Development of the Provider Manual

Our Provider Manual will be developed as a comprehensive and user-friendly resource to inform our network Providers of program guidelines and requirements, covered services for Members, Provider roles and responsibilities, contractual information, and various requirements under state and federal law. Our Provider Manuals will be tailored to the needs of Mississippi Providers, contractual requirements, and will incorporate Division priorities and feedback from our local stakeholders. We will use established policies and procedures to develop and maintain medically accurate, compliant Provider Manuals, which includes a rigorous internal review. Through this process, relevant subject matter experts, including members of our Quality, Clinical, Operations, Provider Services, and Compliance teams, will review the content and provide feedback and suggestions. Once the review is complete and approved by all internal reviewers, we will submit the Provider Manual to the Division for review, at least 90 calendar days prior to distribution. We will also use this process to review and update the Provider Manual on at least an annual basis.

As a companion to the Provider Manual, we will also offer a quick reference guide for Providers. A condensed version of the manual, this guide provides the most vital and frequently used information Providers need in a user-friendly, accessible format. Once approved by the Division, both documents will be available on our Provider website. We propose a combined MississippiCAN/CHIP Provider Manual that will meet all requirements as outlined in Section 6.9.2. Core sections to be included are listed in Table 4.2.2.2.C.3-1.

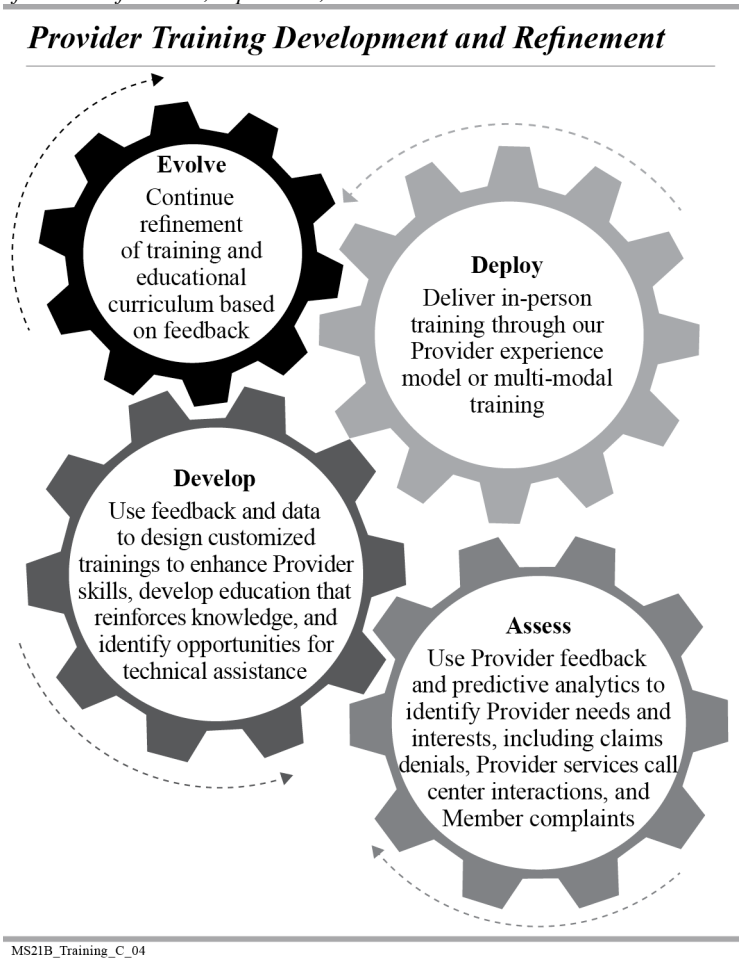
Table 4.2.2.2.C.3-1. Sections to be included in our combined MississippiCAN/CHIP Provider Manual.

Provider Manual Section	Sample Topics
Contact Information	• Provides phone numbers, emails, fax numbers for key Coordinated Care Organization (CCO) contacts and subcontractors as well as state and local agencies
Benefits and Services	• Description of covered services, scope, and limitations to include PH and BH, dental, vision, and pharmacy
PCP/PCMH Responsibilities	• Role and requirements of PCP/PCMH, including collaboration with CM, new Member outreach, required availability, panel limits, Member assignment, referrals, NCQA and PCMH recognition
Pharmacy	• Covered and non-covered medications, preferred drug lists, medication therapy management, coordination with Pharmacy Benefits Administrator
Behavioral Health Care	• Coordination of BH/PH, substance use services, Applied Behavioral Analysis, SUPPORT Act compliance, clinical practice guidelines, psychotropic medications, screenings, treatment referrals
Preventive Care/EPSDT	• Screening requirements, maternal health services, immunizations, responsibility to follow up with Members not in compliance
Care/Chronic Condition Management	• Support services, chronic condition management, referrals, incentives for engagement, Health Literacy Campaigns
Claims and Billing	• Billing instructions, submitting clean claims, filing limits, disputes, rejected/returned claims, invoice pricing requirements
Prior Authorization (PA)	• Clinical and technical criteria guidelines, processes for review and reconsideration
Quality Management	• Quality improvement, HEDIS® measures, medical record documentation, Provider performance expectations
Utilization Management	• Service reviews, referrals, PA, admissions, ER utilization (appropriate and non-appropriate use)
Grievance and Appeals	• Grievance and Appeals processes, time frames, External Independent Reviews, State Fair Hearings
Credentialing	• Description of criteria, requirements, Provider responsibilities, coordination with the Division's Credentialing Verification Organization
Fraud, Waste, and Abuse	• Reporting, investigative process, False Claims Act
Cultural Competency	• Importance of health equity, addressing implicit bias, and requirement to complete cultural competency training, access to written translation, and verbal interpretation services for Members
Provider Supports	• Access to Provider Representatives, Provider services call center, and services available on the Provider Portal
CHIP Requirements	• Covered services for CHIP Members, Well-Baby and Well-Child care services, including Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule, copayments, trauma-informed care, and valid developmental screening instruments

4. Provider Trainings and Workshops

Our Provider trainings and workshops will be conducted by our Provider Experience team. We understand the importance of educating and training our network Providers and will develop programs in compliance with Section 6.9.3. We will leverage experience and best practices in our affiliate markets to create best-in-class training and education and will work collaboratively with all Mississippi CCOs and the Division in planning and executing conferences, workshops, and webinars. As Figure 4.2.2.2.C.4-1 demonstrates, we will take an organic, closed-loop approach in the development of our training to support our collaboration and partnership with our Providers. We will incorporate Provider feedback via post-training surveys, data, and industry experience to develop and refine our training materials. After deployment of the materials through multiple channels, whether in person, virtual, or digital, we will further refine and develop materials to identify needs and gaps and improve quality and the Provider experience. The needs of Members and Providers are always changing, so we understand the need for continual enhancements. We view Provider training as a continuous, evolving process and a foundational element of our strategy to assure equitable, whole person care to our Members.

Figure 4.2.2.2.C.4-1. Our Provider training strategy is based on a closed loop of Provider feedback, experience, and data.



Because we understand that training needed by Providers is often related to claims and billing, our Provider Experience Consultants will meet regularly with our Claims Administrator to make sure they are proactively identifying and addressing any issues with claims submissions and any process updates to Providers. Our Claims Administrator will also be a primary contributor to the development and administration of the monthly claims training we will offer to Providers in the first 12 months of the contract. [redacted] In addition to the initial and ongoing training we are required to offer per the contract, we propose the six additional trainings listed in Table 4.2.2.2.C.4-2. These trainings will be incorporated into our prospective training plan and submitted to the Division no later than 60 days prior to the initial education and training for Providers.

[redacted]

5. Cultural Competency Training

Providers are key allies in reducing health disparities and promoting a culture of health equity. Our adherence to the highest standards of cultural competency and health equity starts with our recruitment strategy, assuring we have a diverse network to meet our Members' cultural and linguistic needs. We will also provide cultural competency training in our initial and ongoing Provider orientations and will promote cultural competency during regular interactions with our Providers, including in-person meetings, monthly newsletters, and through our Provider Manual. We will provide toolkits, direct access to relevant training, and racial equity Provider forums that promote cultural competency, described next.

Caring for Diverse Populations Toolkit

We will offer Providers a toolkit that helps identify the best way to communicate with diverse patients, find information on providing culturally competent care and services, how they can engage key community-based organizations to address social needs, and use interpreters for Members with limited-English proficiency. This toolkit will assist network Providers and their office staff while also serving as a resource to help reach national goals for reducing health disparities caused by lack of culturally or linguistically appropriate care. In addition to the toolkit, we will also provide a customized SDOH hot spotting platform to help Providers identify specific population conditions that may be affected by social barriers. The tool is updated monthly to aggregate Member data, including geographical density, claims data, chronic or BH conditions, maternal health statuses, admission rates, and utilization rates to trend Member experience.

Disability Accessibility and Equity

Partnering with leading advocacy voices from across the state and nation, we will offer resources and information about making service delivery settings accessible for people with disabilities. Recommended practices include setting up separate waiting rooms or quiet spaces for people to prevent sensory overload, assuring physical accessibility including exam tables and scales, allowing support workers or caregivers to accompany patients into the exam room, assuring that instructions are written in plain language and are clear, providing interpretation supports if necessary, using visual aids or communication boards for people who are non-verbal, and training office staff to be accommodating and welcoming.

6. Assessing Provider Satisfaction

We value the role Providers play in the lives of their patients and are committed to collaborating to create solutions to improve access, coordinate services across the delivery system, and improve quality outcomes for Members. Understanding that satisfaction is key to our partnership with Providers, our Provider Services and Quality Management teams will collaborate to employ several methods to gauge Provider satisfaction with the services and support that we provide. We will leverage the input we receive, whether through surveys, feedback, or data analysis, to enhance or improve existing processes, training, and engagement activities

- **Annual Provider Satisfaction Surveys.** In accordance with Contract Section 8.7, we will conduct an annual Provider Satisfaction Survey and will submit a draft survey to the Division by March 1 of each calendar year. Based on the experience of our parent company and its affiliates, the survey should gauge satisfaction on topics including claims processing, our utilization management program, chronic condition management, information exchange, trainings, and Provider Network adequacy. The survey will be conducted by an external vendor and respondents will be given a month to complete the survey either online

or by requesting a paper copy. Results from the survey will be reported out through the Quality Management Committee (QMC), who will track and trend data and identify areas of opportunity and solution development. We will report findings from this survey to the Division, outlining how the results will inform our quality improvement work plan.

- **Post-interaction Surveys.** In addition to annual surveys, we will also offer Providers the opportunity to fill out a satisfaction survey after each web-based, telephonic, or in-person interaction with one of our Provider Experience Consultants. We also survey our Providers directly after they complete training activities.
- **Provider Advisory Committees.** We will obtain regular Provider feedback on our processes and procedures through various committee meetings and interactions, including our Medicaid Provider Advisory Committee (MPAC) meetings, which are hosted by our Provider Experience team on a quarterly basis. Providers are also invited along with Members and community-based organizations to participate in the quarterly Member Advisory Committee meetings to provide feedback. Additionally, we will hold quarterly peer-to-peer discussions between Providers and our Medical Directors. All of this feedback and input will be reported up through the QMC.
- **Complaints, Grievances, and Appeals.** We will routinely monitor complaint, Grievance, and Appeals data to help us gauge satisfaction with our service delivery, as well as monitor and resolve issues. This data will also help us support access to efficient and evidence-based care, detect underutilization, identify unnecessary, wasteful, or fraudulent practices, and implement and evaluate improvements. We use this information to identify Providers for additional education as well as areas in which we may consider modifying policies based on feedback.

7. Educating Providers About EPSDT Services and Well-Baby and Well-Child Services

We will provide comprehensive education and training to our Providers about Well-Baby and Well-Child services (for the MississippiCAN and CHIP Programs respectively) in several formats and venues. Preventive care is fundamental to our overall strategy to improve and maintain health and well-being of our Members. The care provided through EPSDT services represents the entry point of wellness for our youngest Members and is therefore of the highest priority.

Initial and Ongoing Training

To augment the EPSDT Well-Baby and Well-Child information in our Provider Manual and available on our Provider website, we will also offer training for our Providers to assure they are equipped with the latest evidence-based information and any changes in policy. We are also proposing to conduct quarterly EPSDT coding workgroups and ongoing education to include coding and updates from the American Academy of Pediatrics regarding immunizations and new best practices. This training will also allow Providers to earn CMEs upon completion.

Personalized Outreach

Our CDT Consultants will provide consultations with our Providers who treat children to provide enhanced education on EPSDT, including improved practice processes, quality, and clinical guidelines. During their regular meetings with Providers, our CDT Consultants will share updates and changes to EPSDT best practices and reinforce current EPSDT information, as well as provide materials such as our EPSDT toolkit. Our CDT Consultants will work with Providers by:

- Assessing current practice patterns, assets, and challenges
- Providing a vehicle for rapid implementation of best practices
- Outlining and defining competencies required for serving this population
- Translating research into practice
- Improving communication among service Providers

Additionally, we will have an EPSDT Coordinator who can provide further EPSDT training as needed in person, virtually, or telephonically.

Provider Manual

Our Provider Manual will be designed as a thorough resource to educate our Providers about all benefits, and information about EPSDT will be the most prominent. Our manual will assure Providers have all the information they need regarding EPSDT services, information about the appropriate age for certain screenings such lead-blood level and dental screenings, and an immunization schedule to assure children get the appropriate vaccination at the right age. We also will include information about the identification and referral of children with developmental delays and the benefits of CM.

8. Educating Providers About Specific Member Needs

We will provide education, resources, and training to our Providers about specific conditions and circumstances to assure we are able to meet the specialized needs of our Members. Understanding the health disparities that exist in maternal health outcomes and various chronic conditions, we will make cultural competency the foundation of our training approach. Additionally, Members with these chronic conditions or health circumstances will be aligned with appropriate CM team resources who will offer Member-specific education and support to Providers and share monthly stratification so Providers are aware of changes in the Member's condition to guide appropriate engagement. Care Managers will also share assessment results, treatment plan components, and referrals made on behalf of a Member to keep Providers informed about the services and supports the Member is receiving. Care Managers will share condition-specific materials with Providers so they can reiterate self-management concepts with Members. Care Managers will also educate Providers on the programs and services available that may supplement their efforts to improve Member outcomes, including digital solutions, Value-Adds, and telehealth kits for chronic condition management.

In addition to this CM support, all Providers will also have a designated Mississippi-based Provider Experience Consultant who will provide customized trainings based on the needs of each Provider practice. They will also connect Providers to a variety of resources, including evidence-based strategies, care protocols, and Population Health management interventions that help support our Members with these conditions. We will also include relevant education in our monthly electronic newsletters, bulletins, web-based trainings, and our Provider Manual. We also have more than 40 clinical practice guidelines on our Provider website that provide condition-specific evidence-based approaches to support Member treatment. Additional resources that will supplement this approach to Provider education are listed in Table 4.2.2.2.C.8-3.

D. Collaboration with Providers

1. Collaborating with PCPs/PCMHs Regarding the Care of Members with Chronic Illnesses

[redacted]	[redacted]	[redacted]
[redacted]		[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	

Caring for Members with Diabetes

In collaborating with Providers, we will combine efforts to make sure Members receive necessary screenings and preventive care, such as HbA1c screenings, to better manage Member diabetes. [redacted]. Our CDT Consultants, who are part of our Provider Relations team, will provide face-to-face quarterly analysis of PCP/PCMH-identified diabetes gaps in HEDIS compliance, and will address gaps and educate on HEDIS as well as adherence to clinical practice guidelines (CPGs). Our Clinical Quality Auditor will conduct CPG audits to review and confirm PCPs/PCMHs are adhering to diabetes CPGs; for those with substandard performance, our CDT Consultants will educate and provide resources and tools. CDT Consultants will work with our Diabetes Educator and provide targeted diabetes education and training to PCPs/PCMHs with diabetic patients who had recent ER visits, hospitalizations, or diabetes medication adherence issues. Our CDTs will also collaborate with PCPs/PCMHs participating in VBP programs and help deploy targeted diabetes strategies and action plans. We will focus on identifying Providers across the state for PCMH designation to focus on areas with high rates of diabetes.

[redacted]

Caring for Members with Asthma

We understand the importance of asthma control in Mississippi. Our goal is to make sure that every Member diagnosed with asthma receives and uses the proper medication to control and manage their asthma, and we will set interim targets to assure we continually make progress towards this goal. Understanding that Mississippi ranks 48th in pediatric asthma and 28th in adult asthma nationally, our Population Health strategy includes a variety of Member- and Provider-directed strategies and tactics addressing the four pillars of asthma management: self-management, risk assessment, medical home, and asthma-ready schools. The plan also addresses the underlying issues associated with medication adherence.

We have developed a Provider survey to identify whether PCPs/PCMHs have an asthma action plan in place for each Member diagnosed with asthma and will use this survey to track Provider participation in asthma action plans, driving awareness about their importance. When responses indicate a Provider is not completing asthma action plans, we will collaborate with them and their Members to develop action plans.

We will use tools, such as our HEDIS Toolkit, to educate Providers, including PCPs/PCMHs, about the asthma medication ratio, how to use our gaps in care reports to contact Members, and how to use available data to outreach to Members. Our Provider-facing Care Management Platform will share gaps in care, authorizations, claims, and CM information with our Providers. Our platform also includes a missed opportunity list, which will give PCPs/PCMHs a list of Members with asthma care gaps and medication noncompliance based on Pharmacy Benefits Administrator data file.

Caring for Members with Obesity

We will partner with Providers and other community stakeholders to ameliorate modifiable risk factors like obesity, tobacco use, high blood pressure, and high cholesterol to decrease poor health outcomes due to chronic disease.

We will also collaborate with Providers regarding the care of our Members with obesity by providing the following:

- An introductory conversation via video conference to introduce our local Care Manager and provide overview of our CM program.
- Hard copies of obesity-related collaterals, including our Healthy Weight booklet and a quick fact sheet on obesity-related resources and programs for Member distribution and review.
- Care Management Navigator and Diabetes Educator support and collaboration with Providers regarding Member-specific needs related to obesity, weight management, and nutrition.
- Collaborative community health education/wellness exercise and nutrition class coordination opportunities via virtual or in-person options once COVID-19 restrictions are lifted, with a focus of providing at our proposed physical location for Member outreach.

2. Collaborating with PCPs/PCMHs to Reduce Preterm Births and Improve Perinatal Care

Our Population Health approach to perinatal health will provide a comprehensive suite of culturally competent solutions, including prenatal and postpartum Provider incentive programs, dedicated to promoting and supporting the health of women and babies in Mississippi. Our Perinatal Health Director, who will serve on Quality Workgroups as required by the Division, will drive our perinatal health strategy, and serve as a liaison between our Provider Experience team and Providers. Our Provider Experience team will consult with our Perinatal Health Director to review referrals, denials, Grievances and Appeals, potential quality of care problems, and participate in the development and implementation of corrective action plans. Our Perinatal Health Director and Provider Experience team will partner with PCPs/PCMHs to improve health outcomes, address Member SDOH needs, and reduce disparities through our perinatal program, Provider initiatives, BH and substance use disorder screening, and community-based solutions. We will leverage our national evidence-based perinatal programs and include customized approaches for Mississippi Members. We will also

educate Providers regarding the Mississippi Healthy Moms, Healthy Babies (formerly Perinatal High Risk Management/Infant Services System [PHRM/ISS]) program, making sure they know to submit the Infant or Maternity Screening Form to their local Healthy Moms, Healthy Babies case management agency for positive risk screens. Additionally, we use the Provider collaboration strategies outlined in Table 4.2.2.2.D.1-1 (care of Members with chronic illnesses, including diabetes, asthma, and obesity) to collaborate with all Providers, including PCPs/PCMHs, to reduce preterm births and improve perinatal care.

Our OB Practice Consultant will be a registered nurse with maternal/child expertise whose sole focus is Provider collaboration. The OB Practice Consultant will help Providers and their staff address Members' gaps in care and educate Providers on HEDIS measures, coding, and adherence to CPGs. [redacted] To promote the provision of timely and high-quality perinatal care, our OB Practice Consultant will visit all high-volume OB Providers (and will be available to any OB Provider, including PCPs/PCMHs, upon request) to orient Providers to the OB profile, provide technical assistance around interpreting and improving results, consult on best practices, participate in rounds with the Provider, and educate them about our CM supports for pregnant Members. We describe our OB CM program in detail in our response to Section 4.2.2.1.A, Question 3.

Our OB Care Managers will support Members throughout their pregnancy and during the initial postpartum period and coordinate care with OB Providers, PCPs, PCMHs, and other specialty Providers. They will make sure Providers are aware of covered benefits like OB CM, 17P if clinically indicated, our prenatal ultrasound policy, and more. Providers enrolled in our OB quality improvement program and those that meet the desired targets for preterm birth rates and compliance with timeliness of prenatal care will be eligible for enhanced reimbursement for assuring this high level of quality care for our Members. [redacted]

Consistent with guidelines from the American College of Obstetricians and Gynecologists, we will also inform Providers, including PCPs/PCMHs, of risk factors for perinatal depression and best practices in screening Members during pregnancy and postpartum, including the use of the Edinburgh Postnatal Depression Scale and Patient Health Questionnaire 9. We will educate PCPs/PCMHs how to refer women who screen positive (including through our multi-modal program that provides outpatient services and support to individuals diagnosed with mental health conditions) to BH Providers and the assistance available from the CM team.

[redacted]

[redacted]

3. Collaborating with Providers on Other Conditions to Improve Care for Members

Our collaboration and partnership with Mississippi Providers will be a foundational element of our strategy to assure equitable, whole person care to our Members and improve Population Health. We understand that the role of the PCP or PCMH is to provide comprehensive care meeting both the Member's physical health and BH needs, including prevention and wellness, acute care, and chronic care. Our collaboration will include coordinating care with regional Community Mental Health Centers and across the broader healthcare system. We will collaborate with PCPs/PCMHs on a range of initiatives designed to educate and support them in delivering care to our Members, leveraging their expertise of Mississippi to guide priority conditions. For example, through our proposed VBP programs, we have prioritized cardiovascular disease and death, including high blood pressure, to align with the State's health priorities and develop actions that will improve Mississippi's ranking of 50th in the nation for cardiovascular deaths. A complete list and description of our VBP programs for all years of the Contract are provided in our response to Section 4.2.3.1. Additionally, we will use the Provider collaboration strategies outlined in Table 4.2.2.2.D.1-1 to collaborate with all Providers to improve care for Members with other conditions.

We will partner and collaborate with Providers to ameliorate modifiable risk factors like physical activity, tobacco use, high blood pressure, and high cholesterol to decrease poor health outcomes due to chronic disease. [redacted] We will offer 17 chronic condition management programs that provide person-centered, collaborative practice models that will include both the Member PCP/PCMH and other Providers to integrate care for Members and help Members build their self-management skills. We discuss our chronic condition management programs in detail in our response to Section 4.2.2.1.A, Question 4. We will partner with PCPs/PCMHs to increase access to care, provide holistic care, promote healthy lifestyles for our Members, and increase Member engagement while taking care to minimize necessary Provider administrative effort. Our strategy includes giving Providers the tools, resources, and support needed to serve our Members and drive improvement in quality performance measures.

[redacted]

E. Provider Payment

1. Proposed Process to Ensure Timely Payment to Non-participating Emergency Service Providers

We agree to pay claims for emergency services provided to Members at the applicable Medicaid Fee-for-Service rate in the absence of a Provider agreement. In accordance with Contract Section 9.1.1.2 for out-of-network (OON) Providers, we will submit to the Division our criteria for authorization or denial of payment for services rendered by OON Providers for review and approval 60 calendar days prior to use. We will keep all criteria current and distribute criteria for approval or denial of OON services to all non-participating Providers to whom Members are referred. We will employ payment protocols for OON Providers in accordance with Contract Sections 9.2.1 and 9.2.3. Our Core Service Platform (CSP) is configured so that codes for emergency services are paid to all Providers. Our CSP will not apply the edit for Provider Network status when

adjudicating a claim submitted for emergency services. The CSP will also apply other appropriate edits such as confirming a patient was a Member on the date of service. As a result of this standard system configuration to pay emergency claims, in 2021, across affiliate markets, our OON Providers were paid an average of 8% faster than our average for in-network Providers despite the extra time required to configure our CSP for OON Providers' billing use for the first time.

We do not require authorization for an emergency service. However, a payment may be delayed if a Provider is not credentialed in Mississippi. In that instance, our credentialing team would work with the Provider and the Division's Credentialing Verification Organization (CVO) to assist with the credentialing process to expedite payment. Our process for submitting all Provider claims, including OON Providers, will be available on our public website. Any Provider may call our Provider services call center with claims submission or other questions.

2. Paying Claims with Dates of Services on and After the Date of Credentialing Irrespective of the Date the Credentialed Provider Is Loaded into Claims Processing System

We will pay claims for dates of service(s) on or after the date of credentialing, irrespective of the date the Provider is loaded into our CSP, unless the Provider has been notified in writing that we do not wish to contract with them. A Provider's participating date will be the date they are credentialed with the State CVO. Most Providers that enter the credentialing process and name us as one of the companies they wish to contract with will begin the contracting process with us prior to the State CVO completing credentialing. We will fully educate Providers on how and when to submit claims.

3. Subcontractor Claims Processing

We will contract with a single vision and dental subcontractor to process claims. We have included a system diagram detailing the claims process that enables us to provide seamless payments to Providers. Please see Figure 4.2.2.2.E.3-1 for a Subcontractor Claims Processing system diagram.

Auditing Subcontractor Claims. Our Mississippi Operations team and local Claims team will track results and report anomalies to the Subcontractor Management team, which will be led by our local Vendor Oversight Manager. All entities to which we delegate claims payment must comply with statutory claims processing requirements, as well as the Mississippi Medicaid Coordinated Care Contract. We will maintain responsibility for assuring claims processing is conducted in compliance with all contractual and performance requirements, including claim payment timeliness and accuracy.

F. Provider Grievances and Appeals

1. Proposed Provider Grievance and Appeal Process

a. Compliance with State Requirements

We will distribute to Providers and applicable subcontractors, a Division-approved system and procedure for the receipt and adjudication of Provider Grievances and Appeals in accordance with Contract Section 6. We will maintain Grievances and Appeals policies and procedures in accordance with the Division's Comprehensive Quality Strategy, with the modifications that are incorporated in the Contract. We will not modify the Grievances and Appeals procedure without the prior approval of the Division and will provide the Division with a copy of the modification for review and approval at least 60 days before we plan to implement the modification. We will review the Grievances and Appeals procedure at least annually, with the prior written approval of the Division, in order to improve our systems and procedures in accordance with Contract Section 6.10. In our Provider Manual and on our secure Provider Portal, we will offer Providers information on how and when to file a Grievance or Appeal, and the resolution process. We will advise Providers of their right to file a request for a State Administrative Hearing with the Division of Medicaid, upon notification of our decision, which is after an Appeal to the Coordinated Care Organization (CCO) in accordance with Contract Sections 6.10 and 5.8.2.

Provider Discrimination. Pursuant to 42 C.F.R. § 438.12 and Contract Section 6.12, we will not discriminate against Providers with respect to participation, reimbursement, or indemnification for any Provider acting within the scope of that Provider's license or certification under applicable State law or regulation based solely on the Provider's license or certification. Nor will we discriminate against Providers that serve high-risk populations or specialize in conditions that require costly treatment.

b. Process for Elevating Provider Grievances

We understand that complicated billing rules and regulations can lead to disagreements. Therefore, we will maintain a Grievance process that reviews and investigates issues in a fair, unbiased, and comprehensive manner. We will perform Provider Grievance activities in compliance with State and federal requirements. Our teams will include highly trained and experienced Provider Representatives, Claims Analysts, and clinical experts (for example, MDs) who will work together quickly and efficiently to resolve Provider disputes. Consistent with 42 CFR § 438.66(3), we will submit quarterly reports on all Grievances received and processed, including the total number and type of Grievance requests filed, outcomes, and average time to resolution.

Minimizing Provider Complaints and Escalations to the Division. We will use our no-wrong-door approach to minimize the escalation of complaints to the Division by capturing Provider concerns, monitoring, tracking, addressing, and resolving issues. We will address all Provider complaints using feedback to improve the experience for Providers. If we receive Provider inquiries, we will identify the root cause to address the issue, whether it is an isolated Provider concern or a trended issue, to resolve the complaint, Grievance, and minimize escalations to the Division.

Filing Grievances. A Provider may file a complaint or Grievance with our Provider Experience team, through our Mississippi Provider services call center, or through our Provider Portal, and we will accept Provider Grievances referred to us from the Division. We will document the nature and cause of the dissatisfaction and log the case in our system for investigation, tracking, and trending. A complete description of our Grievance policies and procedures will be available in our Provider Manual and we will offer reminders on the Grievance process in our monthly Provider Newsletter. Our Provider Grievance and Appeals Coordinator will assist Providers by facilitating the timely resolution of Grievances and Appeals, regardless of entry point. This approach will improve consistency in the Provider experience, establish Providers' trust with us and the Mississippi Medicaid managed care program, and result in Member satisfaction, so the Provider can focus on delivering high-quality, person-centered care instead of managing administrative concerns.

Resolving Grievances. Our procedures define how to handle Grievances, including receipt and tracking methods; escalation processes; resolution timeframe requirements; follow-up responsibilities and closure processes. Our process will track all Grievances received from Network Providers, with their resolution, in accordance with requirements described in the Contract, 42 CFR 438.10(g)(2)(xi), and other applicable State and federal requirements. We will fully respond to each Grievance and have multiple status documentation points, including final disposition and closure, in accordance with Section 6.10.

c. Identifying, Tracking, and Trending Grievances, Using Data to Make Program Improvements, and Sharing Data with the Division

We will track and monitor every contact point where we receive Provider inquiries and complaints, in accordance with Contract Section 16.2.9. A dedicated team of risk analysts within the Grievance and Appeals team will continuously mine data and monitor trends and commonalities weekly so that we can quickly identify issues and implement solutions to address the trends. We will use these reports to spot trends and patterns that could indicate something is potentially wrong with our claims system, with our Provider reimbursement, or other policies and procedures. The information received from Provider inquiries and complaints will help identify opportunities for increased Provider communication and engagement. We will take Provider inquiries

and complaints very seriously, as it is critical to make sure there are no systematic errors that could lead to a larger scale payment issue, network disruption, or unnecessary administrative burden for the Division.

Using Data to Make Program Improvements. When we identify a claims or Grievance pattern or trend across multiple Providers that may indicate the presence of a systemic issue, our local Mississippi Operations team will work to identify the reason for the increase in Provider inquiries or complaints. We will use root cause analysis techniques to get to the source of the concern quickly. We use several tools and reports to detect system issues or errors. Examples of affiliate enhancements resulting from identified system issues include:

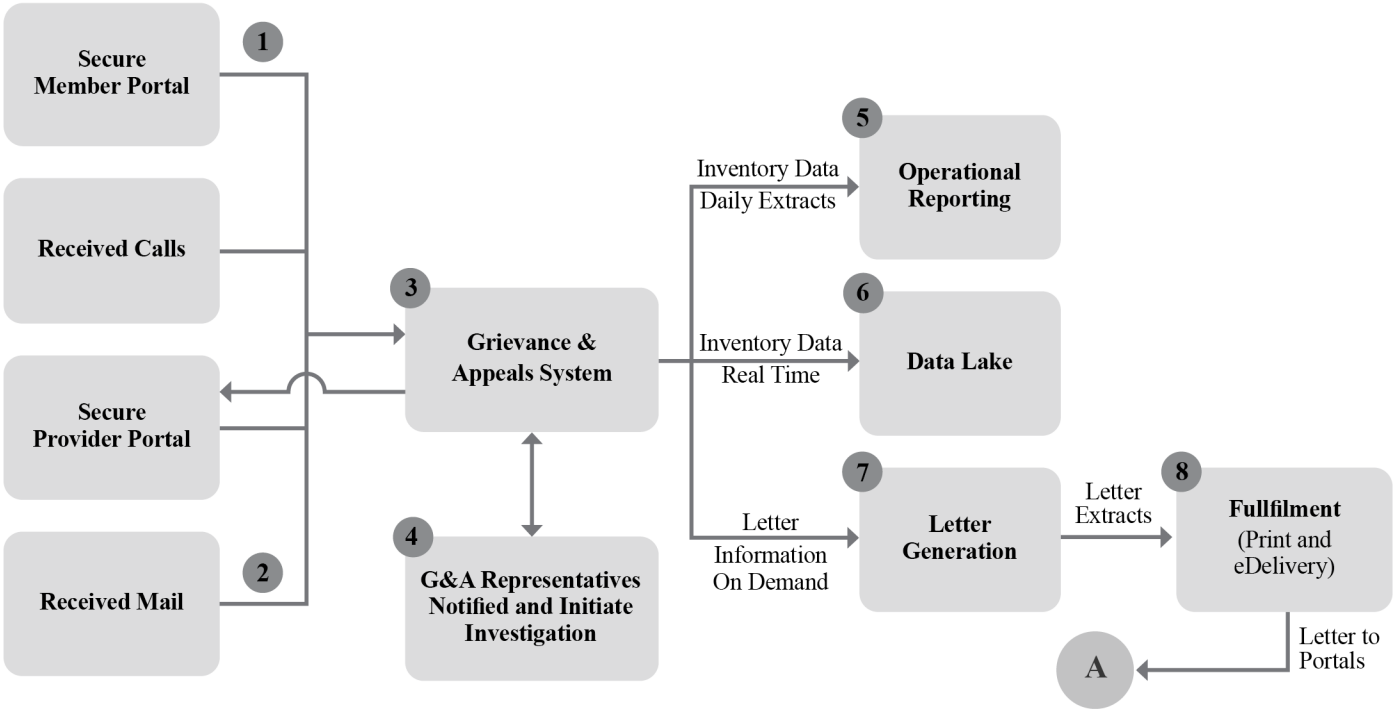
- Implementation of our ***Provider Collaborative Resolution Model***, which partners members of our Operational Excellence team with the Provider Experience team to conduct on-site visits to address outstanding Provider questions and/or concerns around claims issues
- Integration of our ***Provider Reconciliation Score Card*** to support the resolution model to provide collaborative feedback quickly and consistently to Providers when claims issues arise
- ***Optimization of our encounter data submissions*** including performance improvement to 99.8% Accuracy of monthly claims submissions

If we identify a system error that affects Provider claims payment, we will immediately implement a system update to correct the error while concurrently running an analysis to identify all impacted claims. Once this analysis is complete, we will immediately develop and implement corrective action to reconcile the claims of impacted Providers. Running in parallel to our root cause analytics, we will provide local Provider Representatives with a comprehensive overview of the issue so they can outreach to impacted Providers and inform them of our plan of action. We will make every effort to minimize the impact to our Provider's administrative responsibilities and have a process in place to proactively perform claim adjustments without the Provider having to refile claims. We will target a 30-day completion time for all claim adjustment projects. Figure 4.2.2.2.F.1-1 provides an overview of the systems that enable tracking, trending, and sharing Grievance data and highlights how our system manages medical necessity and Provider Grievances and Appeals.

Sharing Data with the Division. We will capture information related to Provider Grievances and Appeals in our Core Service Platform (CSP) and incorporate this data into the required Provider Services Reports we will submit to the Division in accordance with Contract Section 16.2.1. We will also track and trend receipt and resolution of verbal, in-person, and written Provider Grievances and Appeals in our CSP. Our Quality Management Committee will review and monitor these trends and work closely with our Mississippi Operations teams to track any remediation activities. We will provide a summary of these trends and action we have taken to address these issues in the quarterly logs we submit to the Division (Contract Section 16.2.9).

Figure 4.2.2.2.F.1-1. Provider Grievance and Appeals process.

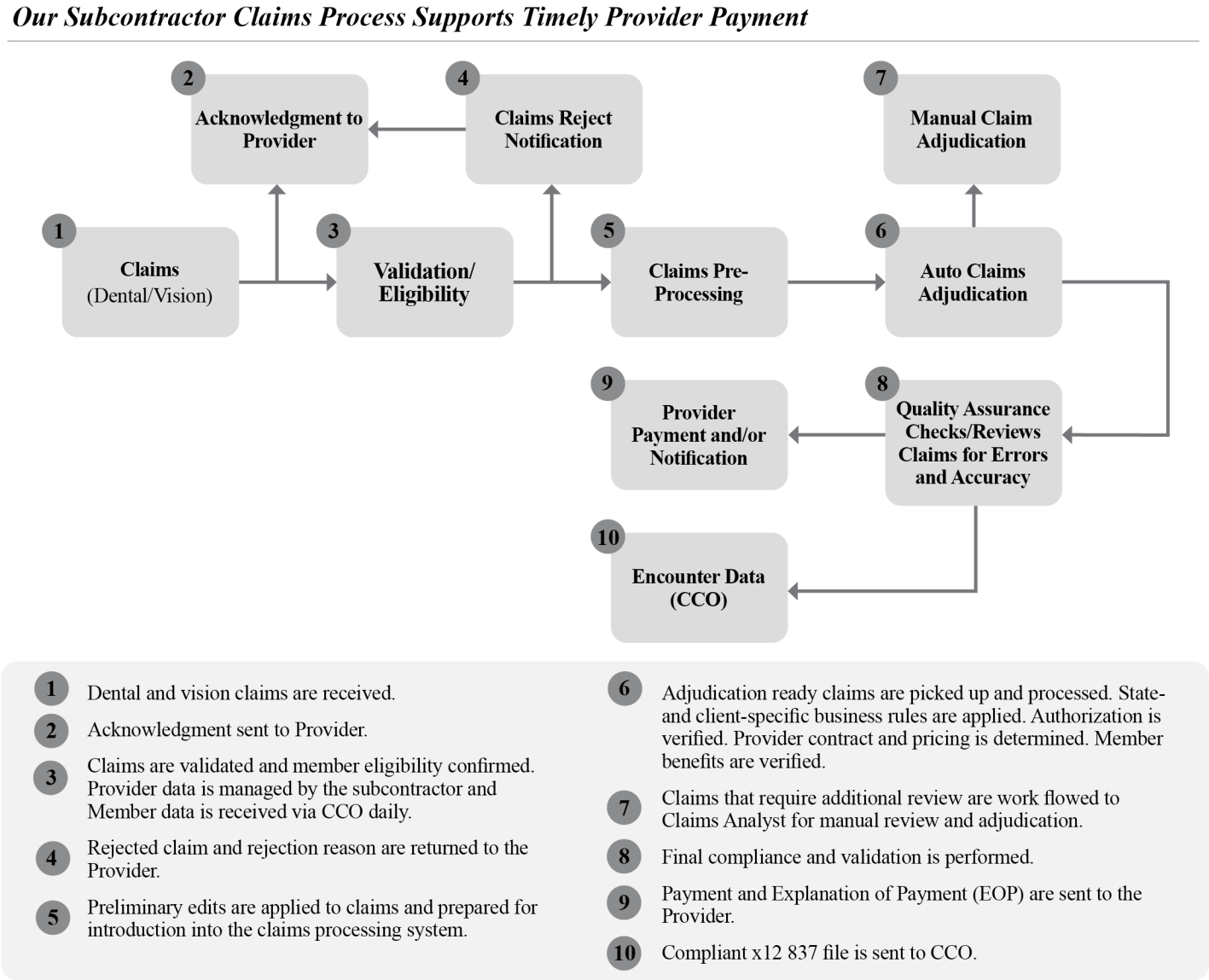
Provider Grievance and Appeals Process Flow



1. Members may file issues via our secure Member Portal or call our Member services call center.
2. Providers may file issues via fax, mail, or our secure Provider Portal, and view status of Appeal/reconsideration request. They may also mail it in.
3. Grievances and Appeals received are keyed into our Grievance and Appeals system, which contains the total inventory of G&A activity, manages workflow, and tracks status.
4. Grievance and Appeals Representative is notified and initiates investigation. If the Appeal is a quality of care issue, the Medical Director is involved.
5. Data necessary for operational reporting is loaded to an operational data warehouse.
6. Data necessary for reporting is also pushed to our Data Lake for use as we develop new capabilities.
7. On demand and as required, letters are generated and sent to our fulfillment vendor.
8. The fulfillment vendor either prints and mails letters, or for high-volume and priority letters, ships letter images to our secure portals for eDelivery.

MS21B_ProviderGrievAppeal_P_04

Figure 4.2.2.2.E.3-1. Subcontractor claims processing system diagram.



Identifying Information. To comply with the Identifying Information requirements defined in Section 1.2.3.3 of the RFQ and subsequent amendments, we removed names of federal and state agencies, Providers, and other stakeholders from our response, except where expressly permitted by the Division. If this information is needed to validate our proposed solutions or evaluate our response, we will be ready to provide it to the Division.

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4.2.2.3: Care Management

A. Care Management Proposal

1. Care Management Strategy Overview

Care Management (CM) is a key component of our overall Population Health approach to improve access and quality of healthcare delivery. We will tailor our CM strategy to Mississippi to assure all MississippiCAN and CHIP Members receive needed services effectively, efficiently, and in a timely and Member-centered way. Prioritizing Mississippi's challenges and the Division's goals, our comprehensive array of CM programs will meet Members' needs throughout the risk continuum and address health equity concerns. We will comply with all parts of Contract Section A.7, present our CM Program to the Division in writing within 60 calendar days of Contract award, and submit requested changes at least 60 days prior to implementation of the change.

[redacted]

Process. Our CM team will carry out activities consistent with the CM process defined by current *Standards of Practice for Case Management* (published by the Case Management Society of America), as well as with the standards of our NCQA accreditation. Table 4.2.2.3.A.1-1 summarizes our CM strategy.

Table 4.2.2.3.A.1-1. Our CM approach is composed of Member-centered processes.

Overview of CM Strategy	
Identification and Assessment	• Our Health Risk Screening (HRS) and Comprehensive Health Assessment (CHA) tools (detailed in Section 4.2.2.3.B) will identify Members needing outreach and CM services.
Stratification and Assignment to a Risk Level	• Results of the HRS, CHA, predictive modeling and analytics, combined with the clinical team's judgement, will be used to assign the appropriate level of CM associated with an array of care coordination and CM programs (detailed in Section 4.2.2.3.B).
Engagement and Development of Treatment Plan	• Using face-to-face, telephonic, and digital outreach strategies, our CM team will engage Members in care coordination or CM programs (detailed in Sections 4.2.2.3.A and C) and in developing Member-centered treatment plans as appropriate (detailed in Section 4.2.2.3.C).
Coordinate Care and Transitions, and Facilitate Closed-loop Referrals	• Our CM team will coordinate covered and non-covered services addressing PH, BH, and Social Determinants of Health (SDOH) needs, partnering with Providers, community-based organizations (CBOs), and State agencies, and closing the loop on referrals (described later in Section 4.2.2.3.A). Our Transition of Care (TOC) team will assure safe Member transitions across care settings, Providers, and health plans (detailed in Section 4.2.2.3.D).
Monitoring and Reassessment	• In coordination with the utilization management (UM) team, Care Managers will work with Members/caregivers to assess progress toward treatment plan goals, re-evaluate Member needs, adjust the treatment plan as needed, and communicate with Providers (detailed in Section 4.2.2.3.C).
Ongoing Engagement	• The CM team will continue to work collaboratively with the Member, their Authorized Representative, and Providers to help the Member meet their goals and achieve stabilization and improvement.

Criteria. While all Members will have access to CM services, we will use screening, comprehensive assessment, and stratification processes to assign CM levels based on risk and need. Members considered Low risk generally have at least one manageable condition but are unlikely to incur large medical costs. Table 4.2.2.3.A.1-2 presents criteria for Medium or High Risk level CM.

Table 4.2.2.3.A.1-2. Members with a variety of conditions are eligible for Medium or High Risk CM.

Condition-related Criteria for Medium and High Risk CM	
• Persistent and/or preventable inpatient readmissions	• Children in foster care
• High costs or potentially high costs	• Infants and toddlers with established risk for developmental delays
• Pregnancy (including all pregnant Members)	• Members requiring an organ transplant
• Diabetes, prediabetes, asthma, cardiovascular disease, hypertension, chronic kidney disease, obesity, attention deficit disorder, congestive heart disease, HIV/AIDS, sickle cell anemia	• Members being discharged from an acute inpatient psychiatric stay/Psychiatric Residential Treatment Facility (PRTF)
• Serious and persistent BH conditions, substance use disorder (SUD), ADHD, severe emotional disturbance	• Persistent and/or preventable emergency room (ER) readmissions
• Significant SDOH needs	• Members with catastrophic illnesses and injuries

In addition to these criteria, we use a ***"no wrong door"*** policy, whereby we will accept self-referrals and referrals for CM from Members' families, Providers, external case managers, hospital discharge planners, community partners, and others providing services to Members. We will also use clinical judgement (from the CM team, UM, and our Medical Directors) and a systematic data approach to identify Members who may need additional supports (detailed in Section 4.2.2.3.B).

Performance Measures. To assess our CM program's achievement of quality outcomes, we will continually collect, analyze, and act on multiple data sources including all required measures described in the Contract. We will integrate adjustments to interventions, processes, and engagement tools to improve performance, and incorporate industry and our affiliates' best practices, tailored to Mississippi through collaboration with the Division. An annual evaluation, shared with the Division, will measure efficiency and effectiveness, monitoring year-over-year performance and outcomes metrics that include but are not limited to CM identification and engagement rates, participation rates, Member and Provider satisfaction (to make sure our services bring value and that our CM team members are respectful, inclusive, and culturally competent), and CM program clinical measures. Table 4.2.2.3.A.1-3 presents some but not all CM performance goals, measures, and targets.

CM Goal	Proposed Measures (Subset)	Proposed Targets
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

a. Unique Mississippi Challenges

CM will incorporate a Mississippi-based Population Health approach to identify and prioritize certain populations, conditions, and regions for outreach and special programs. We will compare national and state-level health and disparity data, and we will organize stakeholder meetings and interviews across communities in Mississippi's Northern, Central, and Southern regions, including the Mississippi Delta, to identify local challenges, barriers to care, and wellness goals, and to explore available community services. We engaged an independent consultant to complete a qualitative analysis of Mississippi Medicaid consumer needs and resources across five urban and 15 rural/suburban areas.

Figure 4.2.2.3.A.1-1. Our CM program will prioritize challenges for MississippiCAN and CHIP Members.

Data Drives the Identification of Population Health Priorities

Chronic Conditions

Mississippi is among 10 states with the highest rates of diabetes, cardiovascular disease, and chronic obstructive pulmonary disease

Women's and Maternal Health

Mississippi's infant mortality (8.4 per 1k), maternal morbidity (20.8 per 100k), low birth weight (12.1%), and pre-term birth rate (14.6%) are all greater than the national average and all show significantly higher rates in Black women

Child and Adolescent Health

Mississippi is among states with the highest rates of children with special health care needs (23%), childhood adverse experiences (18.2%), childhood asthma (11%), childhood poverty (27.8%), and developmental screening rates (>20%)

Health Equity

- Mississippi has significant health disparities for Black residents in diabetes, hypertension, obesity, infant mortality, maternal morbidity, and pre-term births
- Mississippi has significant health disparities for those residents that have lower education and income levels related to COPD, cardiovascular, multiple chronic conditions, and depression

Behavioral Health

- Twenty-five counties in Mississippi have suicide rates above the national average
- Fewer than a fifth of Mississippi children ages 6 and younger are screened for developmental and behavioral disorders, the lowest rate in the nation

MS21B_DataIdentifiedPrior_C_06

Through this multi-faceted approach, aligned with the Division's priorities and Comprehensive Quality Strategy, we identified priority areas and subpopulations (displayed in Figure 4.2.2.3.A.1-1) that inform our CM strategies. For example:

- With Mississippi ranking 50th (highest rates) in infant mortality and low birthweight, and 49th in teen pregnancy[1] and preterm birth,[2] we will support State and local maternal health programs and tailor CM programs and campaigns to Members who are pregnant or are of childbearing age (detailed in Section 4.2.2.1.A.3).
- To address high rates of diabetes, adult obesity, and food insecurity in Warren County, we will partner with local Providers to screen for these conditions and will collaborate with local food banks and libraries to connect Members to CBOs to address SDOH needs.
- In two of the most populous Mississippi counties without a hospital, Amite and Itawamba, we will enhance community outreach by partnering with local paramedics – providing Members with proactive stabilization care and help reconnect them to their PCP/PCMHs for ongoing care.

[1] America's Health Rankings, United Health Foundation, accessed 2022.
[2] Kids Count Data Source, Annie E. Casey Foundation, accessed 2022.

b. Closed-loop Referrals and Warm Handoff

The CM team will directly connect Members to referred Providers, state agencies, and CBOs, using a warm handoff when possible, and will follow up as per Contract Sections A.7.4.1 and A.7.7. Referrals will be entered into our Care Management Platform (CMP), which will then prompt the CM team to close the loop. The CM team will reach out to the Member within seven calendar days of the referral to confirm and record that the Member received the service or determine the reasons if it was not received. The CM team will engage the Member, Provider, CBO, Community Mental Health Centers (CMHCs), and other supports as needed to address barriers and continue to engage to make sure the referral is completed. During Member transitions following inpatient discharges, we will follow up within 48 hours of the referral (detailed in 4.2.2.3.D). Our CMP will be designed to create reports for tracking referrals and completion rates to assess our processes and for reporting to the Division.

To facilitate community-based service referrals, all CM staff will use the ***community-based referral platform tool that is integrated with our CMP*** to track referrals for housing, food, employment, transportation, independent living, and other social services. This tool will enable real-time communication between CBOs, Members, and the CM team. Care Managers, Providers, and other users will update the referral status to "Got Help" indicating that the Member received the designated services. The tool will be available for all Members so they can identify and locate community-based programs, benefits, and services. Members can request assistance accessing community resources at any time by contacting our Member services call center or by visiting our proposed physical location for Member outreach (outreach center). With alerts from our CMP, our CM team will also follow up with Members to make sure they are receiving needed services and supports after the Member calls the 24-hour nurse advice line and 24-hour BH/SUD line, when the UM team indicates need for additional CM support, or when a Member has visited the ER.

c. CM as a Tool to Address Health Equity Concerns

We will design our CM strategy to help address Mississippi-specific health equity concerns on both individual and Population Health levels. On an individual Member level, our CM program will use assessments and myriad information sources to identify SDOH and other barriers to care that contribute to disparities (SDOH and health equity are discussed in detail in Section 4.2.3.3).

Our Population Health approach will identify geographic, racial, and other factors contributing to inequities in access and outcomes at the ZIP Code, county, region, and statewide level. We build from that analysis to understand root causes to inform our CM interventions, special programs, priority regions and subpopulations, and partnerships. For example, health disparities are particularly pronounced among Black residents and those in the Delta. We will partner with a comprehensive community health and wellness center in the Delta to support local health education, exercise classes, and prevention and self-management of chronic conditions (detailed in Section 4.2.3.9). We will also align Members with CM team staff with the same race or language when possible, and partner with Doulas to provide culturally competent care for Members when pregnant.

d. Engaging Hard-to-reach Members in CM

We will proactively validate Members' addresses, phone numbers, and preferred method of contact, recording this information in the Member's personal health record maintained in our CMP. Despite these efforts,

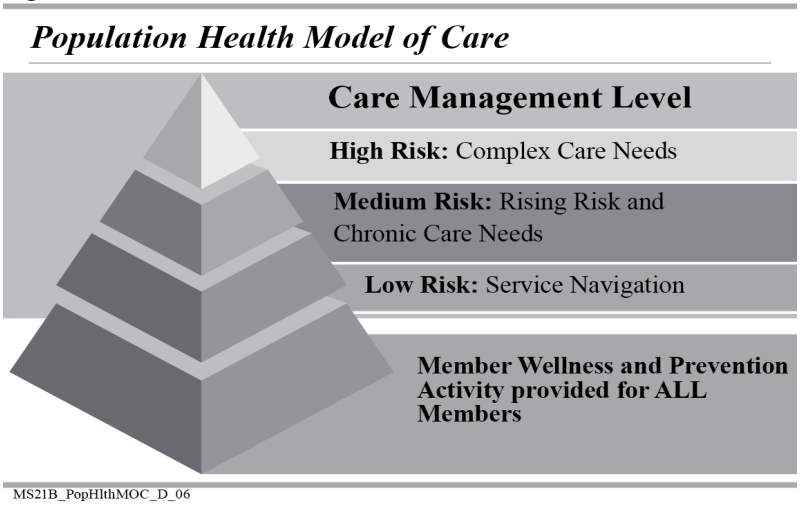
sometimes a Member is difficult to reach or engage in HRS screening, CHA, or CM through telephone or digital means. When this occurs, we will implement our ***locate and engage*** process. For example, if the Care Manager is unable to contact the Member to complete the CHA, a CMN or CHW will go into the community to locate the Member. The Care Manager will then reach out, establish rapport, and complete the assessment in person, telephonically, or through a virtual visit. If we are still unable to locate or engage the Member, the CM team will contact the Member's Providers, including current and recent pharmacies and CBOs the Member has been engaged with, to gather any updated contact information and any changes to the Member's status. They will also determine if an assessment might be feasible at a Provider location when a Member seeks services. The CM team will also monitor the Member's service authorizations and claims data to identify opportunities to connect with the Member around specific needs, such as following an ER visit or inpatient admission. We will work with CMHCs that provide comprehensive BH programs and intensive community supports and can help us engage with Members regardless of risk level. Further, partnering with Mississippi's network of homelessness assistance organizations, we will have access to the homelessness data collection system to help us to locate homeless Members.

All outreach attempts and contacts, as well as the plan for ongoing outreach and engagement, will be documented in the Member's treatment plan in our CMP. When the Care Manager is unable to engage the Member (for example, when the Member declines CM), the CM team will continue outreach at least every 90 days to check-in with the Member and assure their immediate service and support needs are being met.

e. CM Services by Risk Level

We will implement a CM model that includes interventions specific to Members' acuity levels, in compliance with Contract Section A.7.5 and Table 7.1. Drawing on data from our predictive analytics, results of screenings and assessments, referrals, and applying clinical judgement, we will match all Members to one of four levels, illustrated in Figure 4.2.2.3.A.1-2. Each risk level includes all interventions described for the prior risk levels (that is, High Risk CM includes Medium and Low Risk interventions), then adding other interventions according to the Member's individualized needs.

Figure 4.2.2.3.A.1-2. Our CM levels serve all Members.



Member Wellness and Prevention focuses on self-care strategies, illness prevention, and wellness activities ***for all Members***, including those who do not need or decline to enroll in CM. Our new Member Welcome Calls, Member materials, Member services call center, 24-hour nurse advice line and BH/SUD line, online resources, text message disease-specific education and preventive care reminders, telehealth services, health education programs, and Member Value-Added Benefits (Value-Adds) will all support self-management, help Members engage with their Patient-Centered Medical Home (PCMH) and specialty Providers (including identifying participating Providers and help scheduling appointments when needed), and complete timely immunizations and preventive care (detailed in Section 4.2.3.4). Our mobile health app will connect Members to local community resources, peer-to-peer digital communities, and educational health content and tools; and deliver personalized, data-driven recommendations to address SDOH needs. Our Health Literacy Campaigns will focus

on healthy pregnancy, diabetes prevention and management, mental health, EPSDT screenings, and other priority areas. Member health incentives will encourage screenings and preventive care.

All Members will be able to access basic care coordination and TOC planning after inpatient discharge, and all Members will be assigned a local CM team member as a point of contact to encourage communication when questions or issues arise and for following up with Members and their Providers, as appropriate.

Low Risk. These Members tend to be healthy or have chronic conditions (not required by the Contract for higher stratification) that are well-controlled. They will receive assistance, as needed, from the Mississippi-based CM team member most qualified to help (a CHW or CMN). In addition to Wellness and Prevention activities, this CM level includes locating specialists and specialty services acceptable to the Member, confirming receipt of pharmacy refill reminders, and connecting to public healthcare and SDOH resources such as employment, education, and food supports, Early Intervention services, and tobacco cessation supports.

Medium Risk. This level is designed for Members with specific conditions or episodes of care requiring management. Members may be over-utilizing services such as the ER, or under-utilizing services, placing them at ***rising risk***. Members with rising risk include those who consistently lack timely preventive care and immunizations or who do not complete follow-up care, whether for a newly identified or chronic condition. We will identify and develop targeted outreach to these Members focused on preventive care, self-management education, and connection to a PCMH or CMHC/BH Provider.

Medium Risk level will also include Members who are experiencing SUD or housing instability but do not have complex healthcare needs. These Members will be matched with a Care Manager to jointly develop an individualized treatment plan addressing PH, BH, and SDOH needs using our fully integrated model. In addition to Wellness and Prevention and Low-Risk interventions, Members may be engaged in episodic CM programs, such as OB CM, group pregnancy supports, HIV CM, TOC support, face-to-face or telephonic health coaching and follow-up, enhanced PCP/PCMH engagement, interactive texting, and medication adherence support. A CM team member with recovery support experience will engage with Members while in SUD treatment and become part of their recovery after treatment to avoid relapse.

High Risk. The most intensive level is our complex CM for all Members with special healthcare needs and conditions consistent with Contract Section 7.4.3.3.1. These Members will be matched with a qualified local Care Manager who will address PH, BH, and SDOH needs through an integrated approach. The Care Manager will work in partnership with the Member, family/caregiver, and other interdisciplinary team (IDT) participants authorized by the Member, such as the Member's PCMH, CMHC, specialist, and external case managers to develop and implement Member-centered treatment plans. The Care Manager will reach out face-to-face or by telephone monthly or more as needed, and connect the Member to appropriate, intensive programs such as high-risk maternity, NICU supports, and others summarized in Table 4.2.2.3.A.1-4.

[redacted]

[redacted]

B. Stratification and Assignment

1. Health Risk Screening

Our established screening, assessment, and stratification processes will be tailored to make sure MississippiCAN and CHIP Members receive appropriate, person-centered supports and services, and will comply with the Contract Section A.7.4.3. We will conduct an initial Health Risk Screening (HRS) to assess each Member's physical health (PH), behavioral health (BH), and Social Determinants of Health (SDOH) needs within 90 calendar days of the effective date of the Contract, and within 30 calendar days from Enrollment for newly enrolled Members or a self-referral or Provider referral. We will identify Members with immediate needs and assign a "rush" designation, prioritizing them for additional screening and assessment. This includes Members who are: hospitalized at the time of Enrollment; experiencing homelessness or housing instability; pregnant; awaiting an organ transplant; experiencing specific conditions such as HIV, hepatitis C, serious mental illness, or SUD; identified as having gaps in care (such as overdue for a flu vaccine, A1C screening, annual wellness exam, or prenatal visit); or in a course of treatment (such as cancer treatment or maternity care). In addition, we will prioritize Members referred by another case manager from Mississippi state maternal health programs, community organizations serving mothers and children, Provider partners such as Community Mental Health Centers (CMHCs), or the Mississippi Department of Child Protection Services (MDCPS). Our HRS is presented in Attachment 4.2.2.3-1.

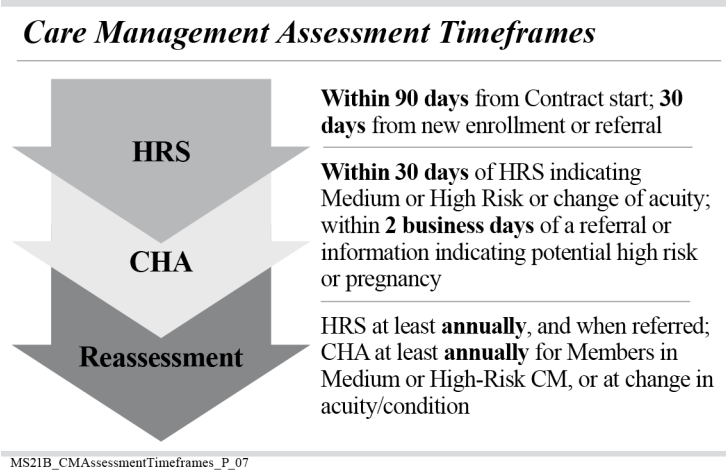
To determine and prioritize a Member's specific needs, we will take a proactive approach to obtain HRS responses through a variety of methods. [redacted] If requested, we will also send a hard copy of the HRS for Members to complete and return through the mail. When the HRS is not completed, Member services call center staff or the local Care Management (CM) team will email the HRS link to Members and offer to assist Members with completion. Additional methods supporting HRS completion will include:

- Live assistance during the initial Member outreach and welcome call
- Text alerts with a link to the HRS online and the number to call for assistance; these messages will continue every 15 days until the 90th day of Enrollment
- Live outbound calls offering assistance to Members who have not completed the HRS

- In-person visits from Community Health Workers (CHWs) and Care Management Navigators (CMNs) who will help the Member complete the HRS
- The option to complete the HRS with in-person assistance at our future outreach center

The answers to the HRS questions will be used for stratification by integrating responses into our predictive modeling tools and our Care Management Platform (CMP), triggering additional follow-up from the CM team based on Members' needs. If a Member is identified as Low risk or Wellness and Prevention level, they will be assigned to a Mississippi-based CM team that will provide outreach and engagement for their needs described in Section 4.2.2.3.A. For Members who may require assignment into Medium or High Risk levels for CM, our system alerts the CM team to initiate outreach for a CHA, as well as an OB Screener for Members who are pregnant. The HRS tool has automatic prompts in the CMP for additional outreach if a response indicates chronic or priority condition. Figure 4.2.2.3.B.1-1 summarizes the assessment timeframes.

Figure 4.2.2.3.B.1-1. Assessment of Members' needs is ongoing.



2. Comprehensive Health Assessment

Care Managers will complete a pediatric or adult CHA via face-to-face (when Member prefers), virtual, or telephone for Members identified as Medium or High Risk, including Members with special healthcare needs, to confirm the Member's need for higher levels of CM. (We include the proposed adult version in Attachment 4.2.2.3-2.) Additionally, we will use a ***no wrong door*** approach, accepting referrals for CM assessment from Members' families, Providers, external case managers, hospital discharge planners, and others providing services and supports to Members or knowledgeable of a Member. Information shared during a referral will be integrated into the Member's record in the CMP.

We will conduct the CHA within 30 calendar days of completion of the HRS indicating Medium or High Risk, or after receiving information that a Member's acuity level may have changed. We will outreach as soon as possible, but no later than two business days, to initiate a CHA and prioritize outreach following a HRS or referral identifying a Member with a potentially high-risk condition, BH condition, pregnancy, serious SDOH challenges, or other urgent need. Using motivational interviewing principles to assure full understanding of the questions, Care Managers will complete the CHA with the Member and family/caregiver to determine if additional assessments are needed to fully identify the Member's needs and CM service level.

Our CHA tools assess a full array of PH, BH, cognitive, functional, and SDOH needs. The CHA responses will be combined with our predictive modeling tools for stratification into CM levels, and into our CMP to inform the CM team. The CHA will use branching logic that probes more than 20 potential clinical areas and addresses:

- Severity of PH and chronic condition; mental health and SUDs; co-morbidities; SDOH; cognitive functioning (the ability to communicate needs, understand instructions and process information about their illness or condition); developmental level; and history of Adverse Child Events
- Clinical and treatment history including medications and therapies; current Providers and treatment plan
- Demographics including cultural, linguistic, and communication needs, preferences, and health literacy
- Caregiver resources; self-management capabilities, challenges, and barriers to accessing services

The CHA responses will inform CM follow-up. For example, the question: *Would you like to become pregnant in the next year? (check one): Yes, No, I am not sure (doesn't know), Refuses to answer*. The Care Manager is prompted as follows:

- If Yes, direct Member to primary or women's health Provider for preconception healthcare
- If No, direct Member to primary or women's health Provider for contraception/family planning purpose
- If response is "I am not sure/doesn't know," direct Member to primary or women's health Provider for interconception healthcare including contraception advice
- If Member refuses to answer, remind her that she has family planning coverage if this becomes important to her later

The Care Manager will complete supplemental assessments for specific health conditions, such as asthma, depression, diabetes, and SDOH, as well as for Members with priority needs, such as Members with high-risk pregnancies, HIV, or a BH condition. Our BH assessment reviews the Member's history of and current BH treatment, their strengths, housing and community living status, family status, legal issues, tobacco use, substance use, prior hospitalizations and ER visits, diagnoses, and onset dates. Care Managers will complete a BH assessment with every Member engaged in High Risk CM with a primary BH diagnosis at 30, 60, and 90 days after CM Enrollment. Using branching logic, the BH assessment prompts the Care Manager to ask additional questions based on the Member's responses, while avoiding unnecessary questions to promote efficient completion of the tool. Care Managers will complete our OB risk screener for pregnant Members that will help us identify pregnant Members with high-risk conditions and/or urgent needs and incorporates five predictive models. (Assessment of pregnant Members is described in detail in Section 4.2.2.1.3.)

The CM team will gather all available data and establish a comprehensive picture of the Member's needs and challenges, storing applicable documents in the CMP. Additional data sources will include:

- Members' diagnostic information, current gaps in care, and utilization data pulled from available admission, discharge, and transfer (ADT) data; we will contract with available Health Information Exchanges (HIEs), and will encourage Providers to share data through electronic health record (EHR) systems
- Information we receive from other Coordinated Care Organizations (CCOs), fee-for-service programs, or Providers such as existing treatment plans, service authorizations, screenings and assessments completed by PCPs/PCMHs and BH Providers
- Individualized Family Service Plans for children birth to age three
- For children in foster care, relevant information from MDCPS
- For school age youth with disabilities, the Individual Education Plan (IEP) or 504 Plan

3. Reassessment

Understanding that Members conditions and circumstances change over time, ***we will reassess Members on a systematic basis, as well as ad hoc basis as needed***, consistent with Contract Section A.7.4.2 and A.7.4.3. At a minimum, we will complete a HRS annually for all Members, and a CHA annually for Members in Medium and High Risk CM (though our goal for CM completion is within six months in most cases). We use these timeframes because our affiliates found annual reassessments allow identification of progress and acuity changes, while avoiding Member dissatisfaction from being "over-assessed." We will also complete a new HRS when there is self or Provider referral. We will conduct a new or initial CHA when there is a change in the Member's risk or condition (based on monthly predictive modeling renewals, claims, Care Manager visits, and other sources), a new diagnosis, or the Member experiences a transition to a different care setting. The Care Manager will also complete a comprehensive treatment plan review at least annually for Members engaged in Medium or High Risk CM. We will maintain all treatment plan updates and reassessments in the CMP, available to Members' PCP/PCMHs, CMHC/BH Provider, or the MDCPS.

4. Additional Assessment Tools for Identifying Member Acuity Levels

Our Member-centered approach to determine the appropriate risk level recognizes that Member needs can be fluid and influenced by many factors — diagnosis, treatment history, family and extended supports, and social risk factors. We will blend rigorous and refined predictive modeling tools with a thorough analysis of diverse sets of demographics, claims data, Member engagement and Member utilization patterns, available pharmacy data, laboratory results, community and Member-level social risk factor data, ADT, and EHR data.

Using tools that predict risk of readmission, emerging risk, and potential for ER utilization, our algorithms will identify Members with Low, Medium, or High Risk. Additional predictive modeling tools will help us generate risk scores for subpopulations, such as our various OB or BH tools, to further refine Member risk level, prioritize outreach and assessment activities, and determine the scope and level of needed interventions. This process is summarized in Figure 4.2.2.3.B.4-1.

Continuous case identification, whereby paid claims and encounter data – reflecting diagnoses and utilization— are incorporated into the clinical algorithm to identify Members newly eligible for outreach services and CM, prioritizing Members based on their level of risk. Results are produced within 30 days of incorporating new or updated information.

Following completion of the assessments, predictive modeling, review by a qualified professional of our local CM team, and based on the team's clinician's judgement, we will enroll the Member into the appropriate CM level, ***which may differ from their initial service level***. The clinician may place a Member in a higher CM service level based on the review of all available information but does not place a Member in a lower level. The Care Manager will complete a treatment plan with the Member within 30 calendar days of the completion of the CHA, if appropriate.

5. Integrating SDOH, Health Equity Evaluations, and Non-medical Risk Factors into HRS and CHA

If SDOH needs are identified in the HRS, our CMP will prompt the CM team to complete the evidence-based normed social risk factor screening tool (as part of the CHA or separately for Members who do not require a full CHA). We will include questions across 13 SDOH domains such as housing, employment, education, food security, and interpersonal safety. Responses will be captured and prioritized in Members' treatment plans, as applicable, and the CM team will help the Member address the needs and inform them about related Value-Added Benefits.

In addition, demographics collected in our HRS and CHA will help us identify Members who are part of subpopulations that may experience health disparities. As part of our overall Member assessment, our Health Indexing Report takes into account social, community, and clinical health quality drivers to develop a Member score. Social drivers measured at the neighborhood level include socio-economic status, vulnerable populations, minority composition, language, transportation, housing, and food insecurity. When reviewed on a community level, the index will provide a "summary" of the overall health of our Members across communities and regions. This standardized information allows us to develop community-specific strategies that address key areas of need with the overarching goal to help improve overall Member health.

C. Care Management (CM) Services

1. Outreach to Ensure Preventive and Medically Necessary Follow-up Treatment and Medications

Our array of Member and Provider outreach strategies, development and monitoring of Member-centered treatment plans, and partnerships with community-based organizations (CBOs), state agencies, and Providers will help assure that MississippiCAN and CHIP Members receive recommended preventive, chronic care, and follow-up treatment and medications, including during and after transitions. These Care Management (CM) services are in compliance with Contract Section A.7 and will be maintained in our policies and procedures.

Multiple Outreach Modalities. All Members will receive Wellness and Prevention communications and resources to help them engage with their Patient-Centered Medical Home (PCMH) and other Providers, and complete timely immunizations and preventive care. Members may receive additional, personal outreach and follow-up from the CM team, as needed, to close care gaps. Table 4.2.2.3.C.1-1 summarizes key outreach methods.

Follow-up to Promote Preventive Care and Close Care Gaps. Identifying prevention opportunities and care gaps, and helping to close those gaps, are integral components of CM. Extensive analytic capabilities and our HRS and CHA results enable us to recognize potential underutilization, missed prescriptions, and Member-specific gaps. We also invest in technologies and systems that allow us to target care gap reporting and closure, such as broad based and condition-specific texting programs. Our CMP flags upcoming as well as overdue and missed appointments that prompt the CM team to follow up. On a broader scale, we will use heat maps to identify clusters of care gaps (for example, lack of prenatal visits or Medication-Assisted Treatment (MAT) in a specific ZIP Code) and target interventions and improvement activities to that region and those specific Providers and Members.

When care gaps are identified, the CM team will reach out to Members to learn and address the root causes. For example, when a Member has not accessed preventive care or referrals, the CM will assist the Member in setting up appointments or securing wraparound and SDOH services such as transportation, food, and safe housing through warm handoffs to CBOs and agencies when possible. The Care Manager will also reach out to the Provider to detail all identified care gaps so they can be closed at the Member's next appointment.

Our closed-loop referral process (described in Section 4.2.2.3.A) leverages our CMP prompts and integrated community-based referral platform to make sure that referrals for medical services and community-based services are completed. Similarly, our TOC processes include proactively arranging follow-up appointments,

home care, and supplies to make sure Members leaving inpatient facilities have what they need to avoid readmissions (detailed in Section 4.2.2.3.C and in Section 4.2.2.3.D).

Our parent company and its affiliates' experience shows ***the most effective way to address Members who have used the ER for non-emergent conditions is to contact them as quickly as possible after the visit to review the reasons for the visit, educate them on alternatives, and help them schedule a follow-up visit with their PCP/PCMH or behavioral health (BH)/Community Mental Health Center (CMHC) Providers***. Our CM team will:

- Make sure the Member received the care to address the Member's health need
- Support the Member and Provider in the provision of post-stabilization services needed to make sure that the Member's health remains stable
- Make sure Members who require admissions are in the most appropriate care setting
- Provide ongoing care coordination and discharge planning with the Member or their caregivers, facility, and treating Providers, communicating with the Member's PCP/PCMH concerning the Member's ER visit
- Work with the Member or their caregiver to educate and connect them to resources and supports to promote appropriate use of the ER going forward

When we are unable, by phone or text, to reach a Member (or their caregiver) experiencing care gaps, we will alert our CHWs who will go into communities to locate the Member and offer community-based assistance. Our Care Management Navigators (CMNs) and CHWs will help the Member resolve unmet SDOH needs that may impede the Member's ability or willingness to obtain timely care or participate in CM. Using these outreach and follow-up strategies, our affiliates have significantly improved preventive care rates and outcomes (as displayed in Figure 4.2.2.3.C.1-1).

Figure 4.2.2.3.C.1-1. Our CM approach has improved engagement and outcomes.

Outreach Improves Prevention and Follow-up (Affiliate, Reporting Year 2020)

Chronic Conditions	Maternal and Women's Health	SUD/OUD	Healthy Behaviors
↑ **35%:** Corticosteroid therapy for management of COPD – Total 69.21%	↓ **48%*:** Non-recommended Cervical cancer screening in adolescent females – Total 0.75%	↑ **100%:** Follow-up care after ER visit for alcohol/other drug use or dependence – 18+, 7 days 5.70%	↑ **12%:** Immunizations for Adolescents – Combo 1 total 75.91% and Combo 2 total 30.66%
↑ **11%:** Statin therapy for patients with cardiovascular disease – Received 74.35%	↑ **21%:** Postpartum care – Total 72.99%	↑ **52%:** Engagement of members with opioid abuse or dependence – Total 40.08%	↑ **5.5%:** Rating of All Health Care – Adult 8 + 9 + 10, 75.55%

**Decrease for this metric indicates improvement, based on changes in screening criteria*

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a. Facilitating and Monitoring Member Compliance with Treatment Plan

Supported by CMP capabilities, our person-centered processes for facilitating, developing, and monitoring adherence to treatment plans will enable us to identify and address barriers to service provision and goal completion, consistent with Contract Section A.7.4.3.2.

Treatment Plan Development. The Care Manager will support Members in Medium and High Risk CM in developing a treatment plan and identifying IDT participants of the Member's choosing such as a family member/caregiver, Providers, peer supports, teacher, or case managers from other programs or representatives from other social service agencies. The Care Manager will review:

- The Member's clinical information, SDOH needs, and living environment to identify hazards, safety concerns, needed adaptations, or other environmental concerns

- The types of care, services, and supports available, including currently received services, additional covered services, services funded by other programs, community resources, and Value-Added Benefits (Value-Adds) that support the Member's access to care or community resources
- The Member's plans for self-management and wellness

Working with the Member and their authorized representative, the Care Manager will develop an initial interdisciplinary treatment plan ***within 30 days of CHA completion that***:

- Reflects the Member's cultural values and priorities, strengths, preferences, needs, and desired outcomes
- Documents a prioritized list of Member's needs and interventions designed to meet the Member's PH, BH, SDOH, and educational complexities
- Documents the Member's personal and prioritized short- and long-term goals with achievable timeframes, including self-management activities
- Supports the Member to build resiliency and recovery, as appropriate
- Includes services to be delivered, the frequency and expected duration and, if known, service Providers
- Documents any identified barriers along with interventions to minimize the effects of each barrier
- Includes linkages to community resources
- Includes a ***BH crisis prevention plan*** that identifies crisis triggers and strategies to deal with the crisis
- Documents the frequency and method of contact with the Care Manager

Facilitating Adherence to the Treatment Plan. Our Care Managers will incorporate evidence-based strategies such as person-centered planning and motivational interviewing to help Members identify their goals and understand their role in the treatment plan, promoting Member ownership, engagement, and adherence. [redacted]

The Care Manager will reach out to the Member at least monthly through face-to-face, telephone, or digital outreach to assess progress and identify barriers the Member may be facing in adhering to their treatment plan. The Care Manager will help address obstacles to achieving Member goals.

Monitoring and Updating the Treatment Plan. The treatment plan is a living document that our Care Managers implement, monitor, and update with the Member. Care Managers will document progress toward goals in the CMP at least monthly. Care Managers will also review the Member's treatment plan when there is a change in the Member's risk status, a triggering event such as ER use or hospitalization, and during outreach to Providers. To support this process, our CMP alerts Care Managers of upcoming reassessment and treatment plan due dates, expected goal completions, and follow-up through weekly update reports. The Care Manager will complete a comprehensive treatment plan review and update at least annually.

The Care Manager will also gather information from the Member's PCP/PCMH, other Providers, Mississippi Department of Child Protection Services (MDCPS), and other members of the IDT (as applicable) and document recommendations for follow-up in our CMP. Care Managers will participate in internal clinical rounds with our Care Management Director, Population Health Director, Medical Director, Behavioral Health Director, Perinatal Health Director, and UM staff, who will provide consultation on individual cases as needed. Any adjustments suggested to the treatment plan through rounds or Member/Provider collaboration will be discussed and approved by the Member and when applicable, family or caregiver.

b. Partnerships with CBOs and State Agencies

As part of our Population Health approach, and consistent with Contract Sections A.7.2 and A.7.8.2, our overall CM processes will assure effective coordination with federal and state public programs and state agencies that serve

mothers and children. For example, through our OB assessments and direct outreach, we will identify Members meeting State eligibility criteria for perinatal high risk management and infant services, inform the Member about the program, and make a warm handoff in addition to sending a list of eligible Members to the State's agent. If the Member chooses case management through this State program, our Care Manager will work with the agent's case managers to develop a treatment plan, documenting the plan and the role of this State program in our CMP. We will monitor utilization that would prompt outreach, such as ER use, and continue to outreach to the Member (and the program's case manager) to determine if we can assist with meeting any unmet needs. If the Member declines participation in this State program, we will provide our full continuum of needed OB CM. ***We will designate a CM team member as a single point of contact for State agencies and CBOs, to establish a personal relationship, foster smooth and timely referrals, and make it easier for these organizations to reach us and address any issues that arise. We additionally suggest data-sharing arrangements whenever possible to enhance coordination and improve communication with partner organizations.***

We pursue community partnerships strategically, considering geographic and racial disparities in Mississippi. Our initial CM partners (detailed in Section 4.2.3.6), with whom we will arrange direct communication and referral processes and provide funding, include (detailed in Section 4.2.3.9):

c. Coordination with Providers

Our innovative, established processes for engagement, collaboration, and coordination with Providers will make sure that Members receive all recommended preventive and medically necessary follow-up treatment and medications. For all Members, we will inform their PCP or PCMH of referrals made and changes in acuity level through the Provider Portal, CM engagement with Providers, and monthly reporting. We will align Members at Medium and High Risk with a PCMH, determining if their current PCP is a PCMH, educating them about why this alignment would be beneficial, but ultimately adhering to the Member's preference. If a Member chooses to stay with their PCP who is not a PCMH, the CM team will inform our locally based Additionally, the CM team will work collaboratively with the PCP in engaging other Providers for collaborative care planning. The CM team will also educate the Member annually regarding the PCMH model and confirm their choice of alignment with a PCMH.

will coordinate care with PCPs, PCMHs, BH Providers, CMHCs, Obstetricians and other specialty Providers, ancillary Providers, and community resources to address gaps in care and remove access barriers. Recognizing the power of one-to-one communication, our experienced Care Managers will reach out directly to Providers, pharmacists,

therapists, and hospital discharge planners in situations such as: to obtain a letter of necessity or authorization for services needed by the Member (for example, personal care services, home health); to inform the Provider of a Member's new diagnosis; to help a Member refill a prescription; or discuss a Member that has become hard to reach.

Recognizing the importance of medication adherence, we will integrate available Pharmacy Benefits Administrator (PBA) data to support Member medication needs. We will identify and work with Provider practices having higher medication adherence rates and other favorable trends to learn about their best practices and educate other practices.

We will also work with pharmacists to make sure Members can access prescribed medications and help remove barriers, for example through home delivery, or transportation to the pharmacy (for MississippiCAN Members).

2. Coordination Across Care Continuum for Members with Specialized Needs

While we will provide coordination to all Members, we understand Members with special healthcare needs, including individuals in foster care, often require more active CM as they often engage with specialists and other agencies, programs, and community resources providing non-covered services. We will implement enhanced support to proactively connect Members with specialized needs to the full range of services and supports necessary to meet their needs, and to support continuity of care. ***We will make a live initial phone outreach to all new Members identified with special healthcare needs or their designated caregiver as soon as possible, but not later than within five business days of Enrollment.*** During this outreach we will attempt to complete the initial HRS to identify any urgent needs and make sure services that are in place will continue. If we are unable to reach a Member with special healthcare needs by phone after multiple attempts, our CHWs and CMNs will go into the community to help locate and connect with them. They will provide as needed care coordination that addresses immediate services and supports needs and connect the Member to an assigned Care Manager. We will also partner with CBOs to help us locate Members with special healthcare needs we are otherwise unable to reach.

Our comprehensive, full range of CM services, including integrated High Risk level, offer a proven approach to supporting Members with special healthcare needs to assure ongoing coordination across the care continuum. This involves assigning a Care Manager with experience serving Members with specialized needs, establishing partnerships and communication channels with other programs and organizations (such as MDCPS), and using IDT meetings to make sure our treatment plans include all necessary specialty and ancillary services and supports. We will educate and inform Members of their ability to directly access a specialist for a course of

treatment or to serve as their PCP for regular monitoring, as well as a PCMH that offers additional CM supports.

We will prioritize partnering and coordinating with CMHCs to make sure Members with BH needs do not experience gaps in services. Recognizing that some Members with special healthcare needs are receiving State waiver services and engaged in special mental health initiatives such as the home and community-based Medicaid program that provides wraparound services for children and youth with Serious Emotional Disturbance (SED), our CM team will collaborate with these programs and other specialized Providers, and use closed-loop referrals and warm handoffs, to make sure the Member's needs are met.

For children with special healthcare needs, including those involved in the child welfare system, the Care Manager provides additional resources and supports for the Member and authorized representatives and works collaboratively with any external case managers to address the Member's needs. For example, we confirm if the child has an Individual Education Plan (IEP) or a 504 plan for accommodations and the child's contact person at the school. The Care Manager will seek the Member's or family's agreement to gather medical and educational information to promote development of a comprehensive treatment plan. We review this information upon receipt, incorporate the information into the Member's CM record and the Member's treatment plan.

3. Communication with Provider, Follow-up with PCP/PCMH and Members

Using established policies and procedures that will be tailored to Mississippi, we will use multiple tools and strategies to communicate with and support Providers, hospitals and facilities, CBOs, and state agencies to coordinate care for Members (consistent with Contract Section A.7.2). Section 4.2.2.3.D details communication with inpatient facilities and follow-up service Providers during and after transitions.

a. Our Role and PCP/PCMH Role

We will work to align each Member with a primary Provider that they are comfortable with, is accessible to them, and is able to meet the Member's needs. We will provide PCPs/PCMHs with information regarding a Member's care including assessments, treatment plans, stratification, referrals made, outcomes, and medication adherence information. The PCP/PCMH then uses that information to enhance their engagement with the Member, working to address the Member's specific needs.

b. Examples of Information We Provide to Providers

Our measurement and reporting platform will be available on our Provider Portal and will deliver Member-level reporting and aggregated Population Health performance and quality results to PCPs/PCMHs and CMHCs/BH Providers. PCMHs will have access to their attributed Members' diagnoses, gaps in care, claims history, procedure codes, and available prescription data in our Provider-facing CMP. This tool will aid in care coordination activities, so that our CM team and PCMH staff have access to the same information. We will deliver aggregated quality results, gaps in care reporting, and Member panels to our PCMH practices through our Provider Portal and Provider website, and we will continually look for ways to provide enhanced information to Providers engaged in VBP. Figure 4.2.2.3.C.3-1 presents a sample screenshot from our Provider Portal that all network Providers will be able to access 24/7.

c. Care Manager Interaction with Members, PCP/PCMH, Family, Other Physicians, and Relevant Parties

For Members in Medium (including Rising) and High Risk CM, the Care Manager will reach out to the Member at least monthly through face-to-face, telephone, or digital outreach. For Members in Low Risk CM, the CM team will reach out quarterly, supported by digital connections for all Members.

The Care Manager will ask questions to discern the Member's adherence to their treatment plan including scheduling and attending medical appointments and preventive screenings, and completing self-management activities such as maintaining a prescribed diet and exercising, taking medications, charting daily blood sugar readings, or engaging in smoking cessation. The ***Care Manager will engage the Member and family*** to identify barriers such as health literacy challenges, inability to secure an appointment with a Provider or reach a CBO for services, or lack of transportation to appointments or the pharmacy. The Care Manager will help to develop solutions such as educating the Member and family about the treatment plan, assisting with making appointments, arranging warm handoffs to specialists and contacts at CBOs when possible, or arranging transportation or pharmacy delivery. If a Member has clinical questions regarding new or acute symptoms, test results, procedures, or questions outside the scope of the program, the Care Manager will engage the Provider regarding the need to educate and make sure the Member understands the information.

Through phone call, letter, or verified fax, the Care Manager will notify the physician directing the Member's care that the Member is engaged in the CM program. This communication, documented in the CMP, will:

- Specify that the Member has agreed to participate in the CM program
- Describe the Care Manager's role (such as assisting the Member better understand their condition; identify and overcome barriers to adherence; develop a goal directed treatment plan to support physician's prescribed treatment plans; and work with physician to coordinate requested services using patient's available benefits and resources)
- Provide a high-level overview of the treatment plan, describing the significant issue(s), goal(s), and intervention(s) that the Member has agreed to
- Invite the physician to contact them with any concerns or updates

Recognizing that regular and routine communication between our CM team and our Members' Providers assures continuity and coordination, we will provide Members' Providers with clinical information, education, and expectations on engaging Members on an ongoing basis. Using the Provider Portal (as well as secure fax), our CMP shares Members' assessments, treatment plans, and health milestones.

For Members with Medium and High Risk, Care Managers will reach out to the Member's PCP at least twice per year, plus as needed, to discuss the Member's treatment plan, progress and challenges, new needs, coordination with and information from other Providers, and ways to close any care gaps. [redacted]

In addition, Care Managers will convene an IDT in partnership with the Member and, as applicable, family or caregiver as needed to promote communication, collaboration, and engagement among the Member's CM team. The IDT may include the ***Member's PCP and specialty Providers, external case managers, and others involved in the Member's care (with the Member's authorization)***. The Care Manager will review the treatment plan, address gaps or barriers, and make sure the participants are on the same page. Our clinical staff such as a Psychologist, Pharmacist, Nutritionist, Housing Specialist and others will be available to the IDT to provide consultation.

d. Transition Planning for Covered Services from Out-of-network Providers at Contract Implementation

As detailed in Section 4.2.2.3.D.3, for Members receiving covered services from non-contracted Providers at Contract Implementation, we will honor existing authorizations for up to 90 calendar days, consistent with Contract Section A.7.8. Our Provider Contracting team will invite qualified non-contracted Providers to join our network and help onboard and support them throughout the contracting process. If we are unable to contract with the Provider, we will work closely with the Member to choose an appropriate network Provider; or we will work with the Provider to establish a single case agreement for ongoing care. Our procedures allow for exceptions that may require continuity of care beyond the 90 days, such as BH services, pregnancy, chemotherapy, hospice, transplants, or a Provider's unique expertise with the Member's condition or diagnosis. When exceptions occur, we extend authorization beyond the transition period until the treatment may safely be transitioned to a contracted Provider. We will reach out to non-contracted Providers to transfer applicable clinical and CM information to our system.

In addition to honoring authorizations for new Members, we design our systems to prevent claims denials for these existing services. Our CM team will support Members through these transitions by making sure they receive services as authorized, connecting them with New Member Services, educating them on their benefits and Value-Adds, expediting screenings and assessments, and engaging them in CM as appropriate.

e. Processes and Communication Steps with Hospitals on Post-discharge Care and Readmission Reduction

Post-discharge Processes. As detailed in Section 4.2.2.3.D.2, we will tailor our processes for TOC and CM teams to communicate and coordinate with Mississippi hospital discharge staff. Transition planning starts at the

time of admission to identify and address potential challenges as early as possible. This would be a joint UM/CM collaboration as UM will be conducting continued stay reviews based on the Member's needs. UM staff are aligned to facilities and will bring in the TOC team to work with facility discharge planners, case managers, or social workers to clarify roles and responsibilities (to avoid transition activities being duplicated or falling through the cracks), develop the Member's discharge or transition plan, and work through any barriers to discharge. Direct communication with facility staff provides our TOC team firsthand knowledge of the treatment provided in the hospital and post-discharge recommendations. Discussions include discharge instructions, the home environment, supports available to the Member, medications, and follow-up appointments. Prior to the Member's discharge, we will attempt to perform a discharge risk assessment, with a hospital visit as needed, to fully understand the Member's clinical and SDOH needs and goals for transition.

We will use available admission, discharge, and transfer (ADT) and Health Information Exchange (HIE) data to promote coordination and consistent communication, and to reduce the burden on Providers and hospital staff. The TOC team will escalate challenging situations for case rounds to identify needed solutions. To further enhance our TOC process, we will pursue co-location through an on-site TOC team member with high-volume facilities representing different regions of the State.

Readmission Reduction. In addition to using these post-discharge processes to reduce readmissions, we will proactively identify trends and opportunities for intervention to reduce avoidable admissions through continuous case finding, Member utilization data monitoring, and predictive modeling. We will conduct complex case rounds and educate and engage Members at high-risk of ER use through our ER Avoidance Program and ER Educational Outreach Program (detailed in Section 4.2.2.5.B). Further, we will coordinate with hospitals and other facilities, PCP/PCMHs, specialists, and CMHCs to reduce readmissions as follows:

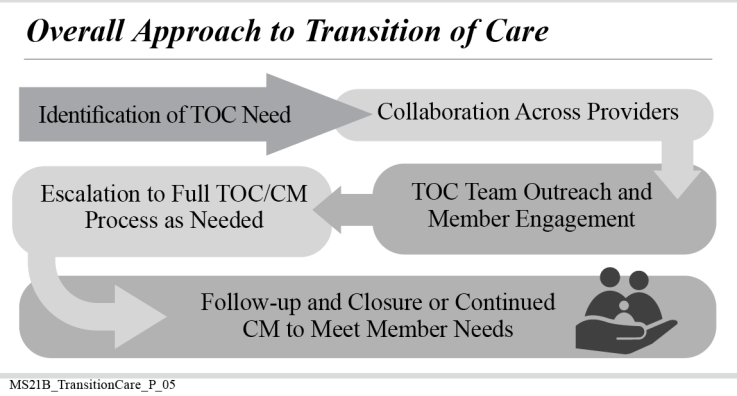
- We will review hospital census data daily to identify Members admitted for ambulatory sensitive conditions and refer to CM. We will monitor Members' diagnoses and frequency of admissions and readmissions over a rolling 12-month period and reach out to their PCP/PCMH to engage in efforts to reduce avoidable admissions and readmissions.
- We will examine long-term regional and facility trends in readmissions and will increase coordination efforts with high readmission facilities — for example, through an on-site Care Manager or TOC team member. Given the high proportion of 30-day readmissions related to BH, we will build relationships and enhance coordination with BH specialists and CMHCs in Mississippi.
- We will consistently review available data in our CMP to identify Members with gaps in care and share this information with Members' PCP/PCMHs so there can be coordinated outreach to the Member. Our ***Care Delivery Transformation (CDT) Consultants*** will work with Provider offices to educate them on gaps in care for their attributed Members and the importance of closing those gaps, which can help reduce avoidable admissions and readmissions. If we identify unexpected variation in readmissions by Provider, we will drill down to identify Providers with higher-than-expected readmissions to discuss placement of a community-based Care Manager to support discharge coordination and follow-up appointments.
- Under our local Medical Director's direction, our clinical team will meet weekly to evaluate demographic information, medical information, and social determinants that can influence a Member's pattern of care. The team designs interventions specific to individual Members to avoid admissions and readmissions and works with the PCP/PCMH, BH specialists and other CM team members to implement them.
- Through our Provider Portal, network PCP/PCMHs will have access to a holistic view of Members' treatment plans, assessments, and utilization history, including authorization determinations to assist with discharge planning, transitions of care, and supporting Members in the most integrated setting possible.

D. Transition of Care (TOC)

1. Overall Approach to Transition of Care

Our approach to Members' Transition of Care (TOC) will be based on coordination with Mississippi hospitals, community Providers including CMHCs, other CCOs, the Division, and other State agencies; and working with Members and their caregivers to understand how to manage conditions, access follow-up services, and assure continuity of care. Summarized in Figure 4.2.2.3.D.1-1, our process will assure safe and effective transitions across care settings, CCOs, Providers, and placements within the timeframes and requirements outlined in the Contract Section A.7.5-8. We will submit our Transition of Care System proposal (including Transition of Care Partnership and Referral Report) for Division review and approval within 60 calendar days after Contract award.

Figure 4.2.2.3.D.1-1. Our TOC process ensures safe Member-centered transitions across care settings.



[redacted]

Members experiencing a critical transition require careful, proactive, and supportive planning that promotes continuity of care and timely access to needed services and supports. Our approach is ***based on the Care Transitions Intervention® developed by Eric Coleman, MD, MPH*** from the University of Colorado. Using best practices described in this Section, we will engage with each person individually to reduce medical and social barriers. We promote personal choice in helping our Members, families, and caregivers prepare for transitions before they occur, supporting seamless transitions in care.

Identification. We will proactively identify Members experiencing or soon to experience a transition through:

- Enrollment data (834 files securely received from the Division) and communication from the Member's prior CCO indicating a new Member requires coordination with the former CCO; similarly, the 834 file would indicate if a new Member is coming from fee-for-service coverage, with information necessary for transition activities
- Data in our Core Service Platform indicating that a Member is disenrolling; we will then send the Division a TOC plan with the Member's CM history, six months of claims history, and information about specialized needs as well as proposed quarterly aggregate reporting of the volume of transitions conducted; if the Member is going to another CCO, we proactively contact the new CCO, Member, and Member's Providers to make sure existing care is continued without disruption
- Communication with the CM team indicating changes in a Member's Providers, whereby the CM team will assist with transfer of records to the new Provider, share the Member's treatment plan with Member consent and as applicable, and assist with appointment scheduling and other supports as needed

- Notification from the Mississippi Department of Child Protection Services (MDCPS) of placement changes for children in foster care; we will prioritize CM outreach (within 48 hours of notification) and support to avoid disruptions in services that could affect the child's physical, behavioral, and emotional health
- Daily review of hospital census data and UM team collaboration to identify Members for proactive engagement in discharge and transition planning; we are also developing admission, discharge, and transfer (ADT) feeds, and to promote information sharing, we will provide grants to Provider practices to connect to a Mississippi Health Information Exchange (HIE) or adopt an electronic health record

Criteria. Our TOC team will reach out to Members identified for TOC with basic transition assistance such as referrals and scheduling of follow-up appointments. Members meeting any of the following criteria are engaged for a higher level of TOC interventions (detailed later in this Section):

- Members with chronic conditions, and/or those who are already in Medium or High Risk CM
- Members who are admitted to a hospital and projected by our predictive modeling tool as High Risk for readmission, and Members discharging from a PRTF
- Members referred for intense transition support by partner hospitals, Providers, or other programs, or at Member or caregiver request
- Members determined by our initial TOC team outreach as requiring more intense engagement due to complexity of clinical or SDOH needs or barriers

CM Approach Shows Results

Our Care Management reduces high-cost ER and inpatient use and increases Members' use of outpatient services. In 2020, across our affiliates, members engaged in our post-discharge management resulted in:

- **11% decline** in inpatient days/1000
- **33% decline** in inpatient non-acute days/1000
- **25% increase** in outpatient home and community-based services

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Performance Measures. To evaluate our TOC processes and outcomes, we will track multiple metrics related to reducing potentially preventable readmissions and ER visits. Table 4.2.2.3.D.1-1 presents key HEDIS® and other measures that we review to identify opportunities for improvement. For example, we will identify and partner with hospitals with high readmissions to enhance coordination through data sharing or co-location of Care Managers. Our transition efforts have shown significant results across our affiliates.

[redacted]	[redacted]

2. Transition of Care After Discharge from an Institutional Clinic or Inpatient Facility

Our affiliates' experience shows that a Member's highest risk of readmission is within the first week following an inpatient discharge. In response, we will use a collaborative process, consistent with Contract Sections 7.4.5 and 7.8.5, that coordinates post-discharge services across Providers and CBOs and removes barriers to needed care. Upon identification of an admission, a TOC team member will engage the Member, discharge planner, and our UM team during the stay to begin discharge planning and initiate our TOC process. For all Members in Low risk or Wellness and Prevention levels, a TOC team members will reach out by telephone as soon as possible (not to exceed 72 hours of discharge) to make sure they understand their post-discharge instructions and assist as needed with referrals, accessing medications, and scheduling of follow-up appointments and transportation (for MississippiCAN Members).

For the higher TOC level (based on criteria described), a local Care Manager will contact the Member/caregiver prior to or within 72 hours of discharge from a hospital or other inpatient facility. For Members who had already been engaged in Medium or High Risk CM, their assigned Care Manager will continue to coordinate the transition. The Care Manager will conduct a hospital visit, as needed, to complete an assessment. Working with the inpatient facility discharge planner (or hospital case manager or social worker), Member, and their Providers, our TOC team will review SDOH needs and caregiver supports, assess the home environment and arrange home modifications as needed, assist with referrals, confirm Members' follow-up appointment(s) are scheduled and transportation is available, and conduct activities displayed in Figure 4.2.2.3.D.2-1. This may involve coordinating access to high-quality, in-network secondary levels of care such as acute inpatient rehab, long-term acute care hospitals, skilled nursing facilities, PRTFs, and BH services. ***At the core of our approach are daily multidisciplinary rounds to discuss the Member's treatment, identify supports, and resolve gaps or barriers to achieve a safe transition plan.***

Figure 4.2.2.3.D.2-1. Our TOC processes will result in smooth transitions after discharge.

Post-Discharge Management

Prior to Discharge Call
Discuss discharge with Member.

Follow-up Care
Verify that scheduled services and follow-up appointments are made with PCPs, specialists, and BH Providers.

Post-discharge Check-in
Follow up to ensure that proper services are in place and plan is being completed.

Medication Reconciliation
Verify that member has all medications prescribed and resolves problems by contacting outpatient provider.

"Red Flag" Education
Create potential problem list and educates Member/caregivers about how to address complications.

Disease-specific intervention
Educate Member about specific condition and encourages self-care responsibility.

Discharge Plan Reminders
Contact Member for reminders/assistance concerning future needs.

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Post-discharge, the Care Manager will engage the Member/caregiver in weekly calls at a minimum for the first 30 days and conduct a home visit as needed. The TOC team will conduct a second assessment at the end of 30 days to determine need for ongoing supports, whereby the Member may continue CM in the appropriate CM level and programs.

a. Scheduling Follow-up Prior to Discharge

Through joint UM/CM collaboration, we will engage hospital discharge staff within 48 hours of the admission notice to begin discharge planning. Our UM staff who are conducting concurrent review and considering the needs of the Member in UM decisions, will work closely with hospital staff and the TOC team to review and authorize services and continued stays as appropriate. The TOC team will verify that any needed Prior Authorizations are approved, and help the Member in transferring medical records, medication information, and other pertinent information to their PCP/PCMH, CMHC/BH Provider, or specialist upon discharge. For Members accessing an

ER, our ER surveillance reporting will trigger early outreach, when possible, prior to the Members release or transfer from the ER.

We will perform a discharge assessment prior to the Member's discharge. The TOC team will assist in scheduling follow-up appointments within 30 days of a hospital discharge, and within seven days following an inpatient psychiatric discharge. [redacted] Understanding the importance of wraparound services and continuing care after BH inpatient stays, we will work closely with the Member's BH/SUD Providers and establish relationships with CMHCs; before discharge we will arrange follow-up services and housing and will follow up to confirm completion. Our strategies have been successful. ***Based on our TOC process, an affiliate achieved HEDIS rates for both the seven day and 30-day follow-up after hospitalization for mental illness exceeding the 90th percentile (Reporting Year 2019).***

The TOC team will also help arrange regular preventive appointments with the PCP/PCMH or specialists (and connect the Member with an appropriate Provider if they do not have one) and remove any barriers to confirm services identified on the discharge plan are in place.

Closed-loop Referrals and Warm Handoffs. To make sure Members receive needed services and supports after a transition, a TOC team member will engage with the Member/caregiver to assess and address potential barriers to completing each referral. The TOC team will make warm handoffs when possible, including the Member/caregiver on the phone when contacting a practitioner's office or CBO to make appointments or arrange post-discharge services. Supported by the Care Management Platform (CMP) that tracks and flags referrals, the TOC team will contact the Member (or Provider as necessary) within 48 hours of the referral to determine whether the referral was completed, and work to resolve any challenges. For example, the TOC team will follow up with the Provider to confirm the Member's attendance at post-discharge appointments. If the Provider indicates that the Member did not attend, the TOC team will contact the Member within three days of the missed appointment to identify the reasons and assist the Member in rescheduling the appointment. Members who face difficulties following through with an appointment will be referred to the CM team for additional assistance. We will report on referrals as required in the Contract Section 7.8.4.

b. Coordinating with Hospital Discharge Planners, PCP/PCMHs, and BH Staff

We know from our affiliates' experience that the most efficient and effective way to coordinate discharge planning for Members is for our TOC team to collaborate with hospital discharge planners, case managers, or social workers. Through this partnership, our TOC team gains direct knowledge of the treatment provided in the hospital and post-discharge recommendations, can access the medical team serving the Member, and benefits from near real-time information from the medical record. We will access available ADT and HIE data to promote coordination and consistent communication, as well as to reduce the burden on Providers and hospital staff. The TOC team will work with hospital discharge staff to clarify roles and responsibilities (to avoid transition activities being duplicated or Members falling into gaps in care), and to develop the Member's transition plan. For Members engaged in Medium and High Risk CM, the transition plan will be incorporated into the Member's CM treatment plan. Recognizing that Members with BH needs often have greater post-discharge challenges, our integrated transition plan will incorporate BH as well as physical and SDOH needs.

Based on our affiliates' experience, co-location of a TOC team in a facility builds close working relationships with discharge planners and other facility staff, enabling our TOC team to become an extension of their discharge team, coordinate authorization reviews, share information, and avoid duplication of services. [redacted]

Our TOC process includes communication and coordination with PCP/PCMH and CMHCs/BH Providers, and we will provide training to Providers about TOC requirements and resources at least twice a year. We will notify the Member's PCP/PCMH, BH Provider, or other specialists via the Provider Portal and direct calling within seven calendar days of the Member's discharge to confirm or arrange follow-up appointments.

c. Arranging Timely Home-based Services

For many individuals transitioning home or with complex needs, quality home-based services and equipment can help stabilize the Member in the community and avoid exacerbation of conditions and readmissions. For children with specialized needs, such as those in child welfare and those with chronic, serious, and complex conditions, home-based care supports optimal health and development. As part of our TOC process, we will identify and coordinate medically necessary ***in-home supports such as home health, nursing care, and durable medical equipment (DME)***.

We will monitor initiation and utilization of home-based services to assess whether the Member is receiving timely care, assuring we close the loop on referrals within 48 hours. For example, the CM team will identify where Members are not receiving the level of home and community-based services they need. When our reviews indicate the need for increased services due to a change in the Member's condition, our TOC team will reach out to the ordering physician to discuss and develop a plan for increasing services to avoid negative outcomes. Preventing underutilization of home and community-based services protects the health and wellness of Members and mitigates the need for higher levels of care, including hospitalization and institutional care. Further, we will build relationships with home health agencies and other vendors and work with them to resolve issues and delays, such as identifying alternative vendors until the service is received.

d. Medication Reconciliation to Assure Continuation of Therapy

A critical component of our transition process and our broader CM program is medication education, reconciliation, and adherence. In addition to UM processes that review medication for clinical appropriateness (detailed in Section 4.2.2.5), our TOC team will educate the Member/caregiver about prescribed medications. The TOC team will also reach out to prescribers and make sure the PCP/PCMH and BH Providers are aware of changes in medications, providing them with a medication list through secure fax or the Provider Portal. Our Clinical Pharmacist will provide expertise related to a Member's medications during multidisciplinary rounds, and act as a liaison with the PBA for medication coverage or filling issues. Utilizing available data from the PBA, we will implement pharmacy clinical quality programs through our pharmacy partner that address polypharmacy and other issues.

We will also work with pharmacists to make sure Members can access prescribed medications, for example through home delivery or transportation to the pharmacy for MississippiCAN Members.

[redacted]

3. Transitions from Non-contracted Out-of-network Providers and Continuity of Care

Our policies regarding all transitions emphasize continuity of care and Member-centered planning.

Care from Non-contracted Providers. For Members receiving treatment at Contract implementation, or at Enrollment after the implementation period, we will honor existing authorizations — regardless of the Providers' contract status with us –for up to 90 calendar days consistent with Contract Section 7.8.7. We will also coordinate continuation of previously ordered DME and other supplies. Our procedures address ***exceptions that may require continuity of care beyond the 90 days***, such as BH services, pregnancy, chemotherapy, hospice, transplants, or a Provider's unique expertise with the Member's condition or diagnosis. For example, we may extend outpatient BH services provided by an out-of-network Provider beyond the transition period until we can contract with the Provider, or the treatment may safely be transitioned to a contracted Provider. We will reach out to non-contracted Providers to transfer applicable clinical and CM information to our CMP.

We will identify new Members receiving care from non-contracted Providers through claims, CM and UM staff review of information from Division Enrollment files, the transferring CCO, our HRS, and New Member Calls. Our CM and TOC teams will coordinate with our Provider Services representatives who invite qualified non-contracted Providers to join our network. If we are unable to contract with the Provider or the Member seeks treatment elsewhere, we will work closely with the Member to choose an appropriate network Provider; or we will work with the Provider to establish a single case agreement for ongoing care. The CM team will follow up on single case agreements to make sure care is continued and to support the Provider. Our payments to contracted or non-contracted Providers will be based on their contracted rate of current Medicaid fee schedule and in accordance with Division payment timeliness standards.

Smooth Transitions for All New Members. Our CMP signals Members transitioning into our plan, tracks completion of transition processes, and alerts us to outstanding screenings and assessments. In addition to our outreach and assessments (detailed in Sections 4.2.2.3.A and B), our CM team will thoroughly review all the information received from the Division or a prior CCO, and reach out to Providers or CCOs as necessary, to assure a complete understanding of existing needs, Prior Authorizations, and treatment plans. The CM team will facilitate the transfer of applicable clinical and CM information, including authorizations and identification of the Member's current Providers. The CM team will coordinate with the prior CCO and current Providers so that services are not interrupted, active referrals are completed, and Members receive information and instructions for continuing services. ***The CM team will identify and contact Members with urgent needs and time sensitive issues that require immediate outreach, such as a recent inpatient admission, planned discharge, or other transition, for coordination of care.***

The CM team also will verify whether services continue to be received and contact Providers if the Member or caregiver report any disruptions. If we identify services, medical equipment, or supplies that were ordered prior to the Member's Enrollment, the CM team will coordinate with the appropriate vendor (for example, DME or home health agency) to make sure the Member continues to receive them.

E. Staff

1. Care Management Staff Requirements

To best serve Mississippians, we will bring a local Care Management (CM) team with specialized expertise in areas such as physical health, behavioral health, substance use, obstetrics, and pediatrics. Equally important, we will make sure our CM staff understand local nuances, culture, language, and norms. Backed by a highly skilled

and trained CM team, we will offer CM programs tailored to support the Division's goals and to address Mississippi's challenges, such as the high rates of infant mortality and preterm births, the prevalence of chronic conditions, and the need to enhance EPSDT screenings and services.

A. Education and Training Required for Care Managers and Other CM Team Staff

Our CM team includes the following roles, all working together in collaboration with Providers, community-based organizations, state agencies, and wraparound resources to address Members' needs and increase health literacy. For each role, we require the following minimum education and training:

[redacted]

Once we identify qualified individuals to hire, we will provide the CM team with training that includes a 90-day orientation to learn basic job functions, policies, and procedures. This includes skills practice sessions throughout to reinforce information taught. Following these sessions, they will receive on-the-job training for at least the remainder of the 90-day training period, which includes partnering with a preceptor who provides coaching and support as they begin their new roles. Through training on motivational interviewing, we enhance our CM team's skills to engage Members, build rapport, and support a Member's ideas, concerns, and ability to make their own choices. ***Following orientation, our CM staff will receive two full-day trainings on Person Centered***

Thinking© by the Learning Community for Person Centered Practices, an interactive course that teaches skills to better assist Members in living the life they want in their communities (see Table 4.2.2.3.E.1-1).

Table 4.2.2.3.E.1-1. Examples of our training topics help prepare our CM team for success.

Care Management Training Topics		
MississippiCAN and CHIP Benefits	Division Contract Requirements	Cultural Competency, Health Literacy,
Motivational Interviewing	Trauma-informed Care	Adverse Childhood Experiences
Integrated Care Approach	UM Principles, Protocols, and Tools	Care Coordination Processes
Recovery and Resiliency	BH, Including Co-occurring Disorders, Harm Reduction, and Suicide Prevention	Social Risk Factors That Impact Care
Transition of Care Processes	Quality Management Program	Pharmacy Benefit and Med Management
Fraud, Waste, and Abuse	Legal and Ethical Issues in CM	Incident and Reporting of Adverse Events

To increase our community reach and engagement, we will also provide a four-day training on CHW core skills and capacity, led by a local expert associated with a Mississippi university. The training has been designated as a best practice CHW model for rural health and addresses key topics for building rapport and engaging Members, such as cultural competency, implicit bias, health literacy, and motivational interviewing.

b. CM Team Hiring Process, Including Recruitment and Retention

Through our multi-pronged hiring process, we will recruit CM team staff with diverse backgrounds and deep roots in Mississippi. Our process uses traditional advertising media, social media, marketing strategies, association outreach, job fairs in the local community, colleges and universities, and staff and community referrals to attract the best candidates. We will prioritize candidates who meet our education and experience requirements, but also those who show aptitude in providing compassionate service. To help reach candidates across Mississippi with the right blend of qualifications and experience, we will incorporate local strategies and partnerships to help us recruit, such as local universities and local professional associations.

Our recruiting, interviewing, and hiring decisions focus on vetting candidates to make sure they have the credentials, education, and experience to fulfill the requirements of their position. Our Human Resources team will conduct employment verification and background investigation through reference checks, confirmation of academic credentials and licensures, Social Security number trace, and investigation of criminal histories, which includes reviewing information from the Office of the Inspector General's exclusion database and national sex offender's registry check. We will perform the screening after an offer of employment is accepted but prior to employment, and periodically thereafter.

Once we recruit and hire our CM team, we will take a thoughtful approach to retaining them using the same type of "whole person" philosophy we bring to the Members we serve. Our workplace culture helps assure staff are comfortable, welcomed, and engaged in their work environment. Setting employees up for success begins with furnishing them with the resources they need to achieve their professional goals. Providing benefits that enable staff to take time off, spend time caring for a loved one, welcome a new family member, or simply enjoy a day volunteering for an organization that is personally important to them are all part of our benefits program. We will offer CM staff a rich blend of work-life balance offerings, financial compensation, health and wellness programs, and opportunities for professional development, further described in our response to Section 4.3.3.4.

c. Making Sure Our CM Team Stays Culturally Competent and Aware of Implicit Biases

Our CM team will receive cultural competency training during initial onboarding and annually thereafter. This comprehensive training includes applicable laws (such as the Civil Rights Act and ADA), cultural competency, healthcare literacy, and the language interpretation and translation services we offer. New staff must complete this training within 30 days of hire. In addition, the training covers implicit bias as well as the development of disability-related cultural competency skills so that our CM team can better understand the perspectives of people who rely on supports — including the creativity and resiliency of individuals and families in their local

communities and knowledge related to improving SDOH. Our Compliance Officer will monitor attendance, and we will submit a quarterly report to the Division listing employee completion in accordance with Contract Section 5.1.5.

In addition, CM staff will have access to a Diversity and Inclusion Toolbox, which offers an all-in-one training resource that combines research-based strategies and tools to help develop inclusive leadership skills and promote behaviors that are the foundation of an inclusive culture. The toolbox includes a comprehensive, searchable database that helps staff understand the influence of culture on one's beliefs, values, and behaviors in general and specifically, in a healthcare environment. The toolbox provides information on more than 50 different cultural groups, with topics such as communication, family patterns, nutrition, treatment protocols, and ethno-pharmacological issues. It also features material on unconscious bias, inclusion of people with disabilities, and religious diversity at work.

d. Continuing Education and Training Plan

After orientation, our CM team will receive monthly quality assurance audits and feedback on their performance as well as ongoing specialized training and annual refresher courses on Contract requirements, cultural competency, compliance, ethics, and HIPAA, for example. Our CM team audits include reviewing Care Managers' cases to evaluate timeliness of Member engagement and interventions, completeness of assessments and treatment plans, and identifying Member opportunities for improvement. We build training into annual performance goals and our clinical leadership will work with each Care Manager to identify, plan, and meet individual training needs. ***Further, we will offer tuition reimbursement and paid time off to attend training that will fulfill continuing education needs for our licensed Care Managers.*** CM staff will also have access to an online catalog of resources on the company intranet to further hone their skills. Our approach streamlines developing, delivering, and reporting on training into one system, which makes it easy for staff to complete training and obtain the latest evidence-based best practices. Our staff can also access trainers certified in professional development courses, such as Meyers-Briggs, Unconscious Bias, and Discovery Insights.

We Support Continuing Education and Development for Care Managers

From the moment our employees join our team, they have access to resources to support their professional development. Employees will have access to more than **10,000** development resources to support their career aspirations, and this includes the courses required to prepare for over **100 certifications**, as well as courses that qualify for continuing education credits to support various licenses — all free of charge.

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e. Expected Wages for Care Managers

[redacted]

F. Hypotheticals

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Identifying Information. To comply with the Identifying Information requirements defined in Section 1.2.3.3 of the RFQ and subsequent amendments, we removed names of federal and state agencies, Providers, and other stakeholders from our response, except where expressly permitted by the Division. If this information is needed to validate our proposed solutions or evaluate our response, we will be ready to provide it to the Division.

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4.2.2.4: Quality Management

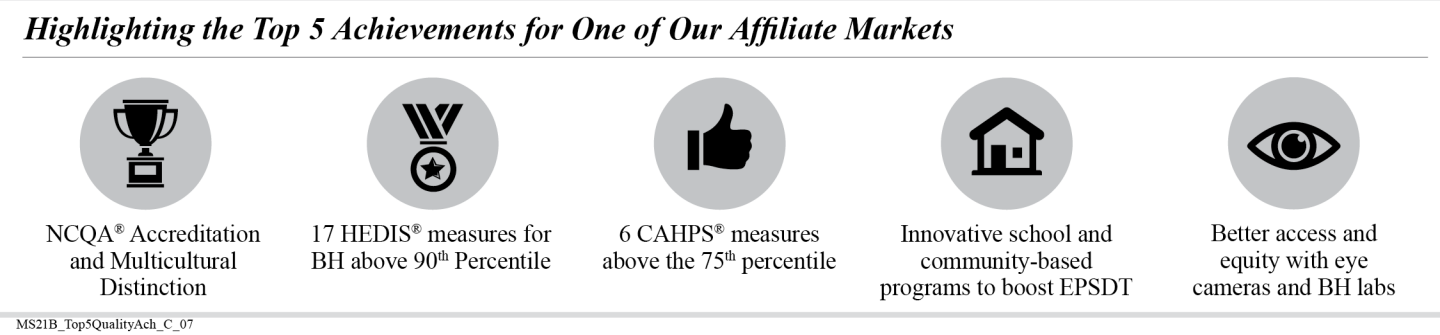
A. Quality Management Program

We will bring a deep understanding of and commitment to the State of Mississippi, the needs of its people, and innovative, evidence-based strategies to advance health equity and quality results. To meet the evolving healthcare needs of MississippiCAN and CHIP Members, we will develop and implement solutions that support continuous quality improvement (CQI) and advance State goals and priorities. Our comprehensive quality management and quality improvement (QM/QI) program will blend our local expertise, resources, and community relationships with the experience and best practices of our parent company and its affiliates to meet the needs of our Members, Providers, and community partners. Our program will adhere to all federal, State, and Contract requirements and comply with the Mississippi Division of Medicaid (Division's) QM goals and requirements to improve the health outcomes for all Members.

We will align our QM/QI program and QM Work Plan with the Division as outlined in Exhibit F: Quality Management and with the Mississippi Comprehensive Quality Strategy in collaboration with the Division and other Coordinated Care Organizations (CCOs). Our written policies and procedures (P&Ps) for our Quality Management program will meet the requirements outlined in the Contract and guide monitoring of our compliance. To resolve any performance or quality of care deficiencies identified by the Division, we will submit an improvement plan to the Division, within established time frames, for approval.

1. Our Proposed Quality Management Program and Outcomes-based Approach to Quality Improvement
Quality is embedded in our organizational mission and approach, embraced within our workplace culture, and is at the heart of everything we do. Every employee in our organization is a quality champion, practicing CQI and supporting innovation for quality excellence. We will train all employees on quality and assure our training addresses the unique needs of the MississippiCAN and CHIP Programs. We will listen to the voice of the community and our QI programs will achieve results that are important to Mississippi Members. Our commitment to quality is evidenced by the capabilities and results of our national organization and affiliates — Figure 4.2.2.4.A.1-1 illustrates one of our affiliate's commitment to quality.

Figure 4.2.2.4.A.1-1. Quality achievements from an affiliate provides a strong foundation for our Quality Management Program.



Our QM/QI program will be an integral part of our Population Health approach and will promote coordinated services that meet Members' physical health (PH) and behavioral health (BH) needs, while assuring that improvements in Member health and well-being support health equity and reduced disparities in Mississippi. Our Population Health priorities shown in Figure 4.2.2.4.A.1-2 will be supported across our organization to advance the vision and mission of the Division and reduce disparities, maximize health, increase health literacy, and address Social Determinants of Health (SDOH) needs. We will approach QI and Population Health management cross-functionally by engaging our entire organization to support these intertwined efforts.

We will refine our data-driven, Member-centered, Provider-supportive, and locally focused strategies in collaboration with community stakeholders, other CCO's, and the Division. These strategies will inform our targeted interventions and Performance Improvement Projects (PIPs) that will comply with the Division's Contract requirements, State and federal laws and regulations, and industry standards, including measures and standards defined by NCQA.

Figure 4.2.2.4 A.1-2. Our Mississippi priorities are grounded in our QM and Population Health approach.

Our QM/QI strategies will leverage many years of affiliate Medicaid managed care experience, with a commitment to QM/QI that is evidenced by an extensive list of recognitions and accreditations held across our organization. ***All our established affiliate plans have NCQA accreditation and our newer affiliate plans are working towards accreditation.*** We also demonstrate our commitment to recognizing the value of cultural competency as reflected in the fact that many of our affiliate markets have Multicultural Health Care Distinction.

These accreditations and distinctions drive industry best practices and provide structure to make sure we incorporate culturally and linguistically sensitive physical, behavioral, and social risk factors throughout our quality infrastructure. Our continued dedication to enhancing cultural competency is also demonstrated through our current collaboration with NCQA in an affiliate market on the new Health Equity Distinction, which will replace Multicultural Health Care Distinction through a pilot partnership.

In accordance with Contract Section 8.4, we will participate in meetings with the Division of Medicaid Quality Leadership Team as directed by the Division and at the Division's discretion. We will continuously assess quality data, including claims data, Member demographics, Member satisfaction, Provider surveys, utilization patterns, and year-over-year quality measure performance to develop innovative strategies that will improve health outcomes for Members and support network Providers with delivering quality care. Our Population Health and QM data analytics will quickly identify disparities and high-risk Members through a comprehensive view of service utilization, SDOH, and stratified demographic data which we will share openly and routinely with the Division. We will use the results of this data to:

- Drive and inform initiatives such as providing support through field-based Community Health Workers (CHWs) and Care Management Navigators (CMNs)
- Coordinate targeted community health events
- Promote wellness and prevention campaigns through text messaging
- Execute health literacy strategies
- Design incentive programs for Providers to promote better health outcomes

Advancing Health Equity Through Cultural Competency

Our QM program will incorporate cultural competency throughout all our QM/QI initiatives. We will train our staff to be culturally sensitive, focusing on prevalent Mississippi cultural distinctions, such as Black, Tribal, and Spanish-speaking Members, as we recognize that there are common disparities within these cultures throughout the State as evidenced by data reviewed.

We will also look at demographic, geographic, and other factors contributing to inequities in access and outcomes, assessing disparities throughout Mississippi, at the demographic level, including ZIP Code, county, region, and statewide level. We will then partner with Providers and community-based organizations (CBOs) who serve these areas to develop and implement interventions that target closing identified disparity gaps.

We will also offer cultural competency training on demand to our Providers through our Provider website and will promote this training as part of our orientation program. These online courses are designed to offer interactive training and resources for Providers to help support the diverse needs of the Members they serve. Our local Provider Services team will also educate Providers on cultural competency during their one-on-one engagements as well as through monthly newsletters and our Provider Manual. As part of our training, ***we will offer Provider evidence-based toolkits on caring for Members with diverse needs, including information on treating ADHD, asthma medication adherence, and tips for improving the patient experience and reducing healthcare stereotypes.***

a. Quality Management Infrastructure

Subcontractor Partners

To assure that Members receive timely, appropriate, and quality services from our subcontractor partners, we will leverage our robust Subcontractor Oversight program, led by a local Mississippi Vendor Oversight Manager. Our collaborative, agile, and transparent oversight processes will deliver operational excellence. Our oversight teams, tools, and protocols will enable us to continuously monitor partner performance via daily collaboration and formalized auditing processes. We have detailed QM approaches to subcontractor oversight in our response to Section 4.2.2.7.B.

In addition, our local Compliance Officer, Vendor Oversight Manager, and Compliance Committee will verify that subcontractor partners comply with all applicable requirements and expectations to meet our quality standards. Our Compliance Committee will meet quarterly with key partners to monitor performance against goals, objectives, and contractual requirements, as well as engage them in QI initiatives when appropriate. The Compliance Committee will report up to the Quality Management Committee (QMC) for additional oversight and monitoring.

Our Vendor Oversight Manager will have primary responsibility for subcontractor partner compliance with State requirements. Examples of affiliate subcontractor partners our Vendor Oversight Manager oversees include, Dental Benefit Management, Non-Emergency Transportation (NET) Benefit Management, and Survey Administration. The Vendor Oversight Manager will work with our national Delegate/Vendor Oversight and

Management Committee (DVOMC) to oversee compliance with all State, federal, NCQA, and CMS program requirements, standards, and expectation, as well as and any other applicable regulatory and accreditation standards. Through annual assessments, we will review and evaluate each partner's performance, including compliance with standards and initiate a Corrective Action Plan if we identify deficiencies or gaps. The DVOMC reports quarterly to our national Quality Improvement Committee (QIC) and national Operational Compliance Committee.

b. Quality Management Program Lines of Accountability

Our local QMC, comprised of executive leaders including our CEO, Medical Director, Behavioral Health Director, Perinatal Health Director and QM Director, as well as leaders from the Provider Services, Compliance, and Operations departments, will serve as the hub for all QI/QM activities and collaborative efforts including various subcommittees and taskforces as shown in Figure 4.2.2.4.A.1-4. Our Medical Director and QM Director will oversee the QMC, which meets quarterly and provides multidisciplinary and cross-functional direction and oversight of all QM and Population Health strategies to assure the quality, safety, accessibility, and availability of care and services.

The QMC and QM/QI staff will work collaboratively with the Division to assure that we meet their quality goals. The QMC will be accountable to Mississippi-based Board of Directors and executive management team. Our QMC will also have responsibility for organizational governance, annually approving the QM Program Description, Work Plan, and Program Evaluation. Additionally, our QM program will monitor outcomes and maintain responsibility and accountability for oversight of all activities including delegated activities, ongoing monitoring, evaluation, and actions to improve identified opportunities. QM coordinates with other departments for oversight monitoring and determination that appropriate actions have occurred as outlined in accreditation, State and federal standards.

Complementing our local QM program, our national Medicaid division will support us through the national QIC, promoting adoption of best practices from affiliates, such as boosting access through telemedicine in rural communities. The QIC is our national organization's governing body that reviews and approves all NCQA-required quality reports, including clinical practice guidelines (CPGs), utilization management (UM), credentialing, chronic condition management, BH, healthcare disparities, access and availability, and Member and Provider satisfaction. The QIC will provide oversight of QM programs, approves templates for required accreditation reports, and assures that NCQA standards and guidelines are met. Our CCO's senior leaders will also serve as members of the QIC.

[redacted]

assuring each is compliant with all Contract requirements to best serve the Division and Mississippi Members. They will serve as a liaison between the Division and our partners to assure any requirement changes or performance issues are directly communicated and appropriately escalated to the partner to achieve resolution, assuring Contract compliance and delivery of quality services to MississippiCAN and CHIP Members.

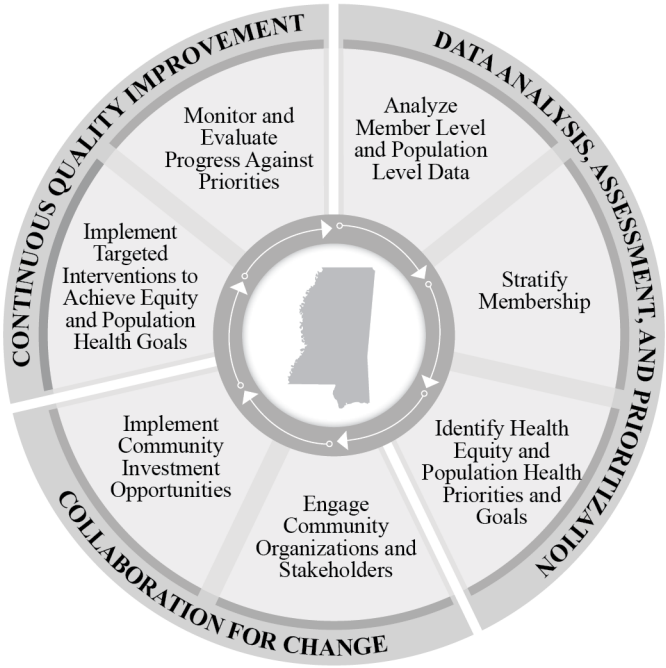
Our Compliance Officer will have primary accountability to maintain oversight of day-to-day compliance activities for our organization The Compliance Officer will work with our CEO and functional areas to identify and assist in the mitigation of potential risks. The Compliance Officer will lead our Compliance Committee and assist in the tracking and reporting of risks, facilitate audit coordination/responses, monitor the implementation and effectiveness of integrity programs, and track and assure timely responses to regulatory amendments.

c. Process for Selecting Areas of Focus

As illustrated in Figure 4.2.2.4.A.1-5, our quality program will take a data-driven Population Health approach to identify areas of focus to tackle Mississippi's greatest challenges. We will use comprehensive data analytics to continuously assess opportunities and identify specific groups with disproportionate disparities, including people with severe and persistent mental illness,

F*igure 4.2.2.4.A.1-5. Our data-driven Population Health approach will help the Division tackle Mississippi's greatest challenges.*

Comprehensive Population Health Approach



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high-risk chronic conditions, and specific life challenges (such as homelessness, lack of employment, and food insecurity).

In addition to identified statewide priorities, we will use regional hot spot data to identify populations with poor outcomes for developing QM initiatives in specific areas. For example, knowledge that certain regions, such as the Delta, and specific cities — including Gulfport and Jackson, have worse rates of diabetes, frequent mental distress, and high blood pressure than the State average, will inform enhanced Care Management (CM) outreach and chronic care engagement for these areas. In addition to reviewing national comparisons and State-level health and disparity data, we will also organize stakeholder meetings and interviews in communities in Mississippi's Northern, Central, and Southern regions, including the Mississippi Delta, to identify local challenges, barriers to care, wellness goals, and to explore available community services.

We will build from that analysis to understand the root causes of the disparity to inform our CM interventions, special programs, priority regions and subpopulations, and partnerships. For example, racial and geographic health disparities are particularly pronounced among Black Members and those in the Delta. We will partner with a comprehensive community health and wellness center located in the Delta to provide our Members access to local health education, exercise classes, and support in prevention and self-management of chronic conditions. We will also align Members with CM team staff with the same race or language, when possible, and partner with doulas to provide culturally competent care for Members when pregnant.

We will use data analysis, assessment, and prioritization of population data to identify Member risk and drive our targeted areas of focus such as health equity. We will also engage community stakeholders for feedback in addition to collaboration with the Division and other CCOs to make sure our areas of focus align with Mississippi's priorities and goals.

Based on our initial analysis aligned with the Division's priorities and Comprehensive Quality Strategy, we have identified our Population Health priority areas and subpopulations, displayed in Figure 4.2.2.4.A.1-6 that will inform our QI program and PIPs.

Our Mississippi PIP process will leverage our organization's extensive experience selecting areas of focus and identifying impactful PIPs. As we develop and execute our PIPs and other internal QI projects, we will apply rigorous quality principles that include the Plan-Do-Study-Act (PDSA) approach as described later in this section. Additionally, we will use an end-to-end quality approach to assure improved health outcomes and efficiency including the following functions:

- Document current status
- Identify quantitative and qualitative gaps and trends
- Set goals, objectives, and indicators
- Develop QI Plan

Figure 4.2.2.4.A.1-6. We base our Population Health priorities on Mississippi health data and the Division's Comprehensive Quality Strategy.

Data Drives the Identification of Population Health Priorities

Chronic Conditions
Mississippi is among 10 states with the highest rates of diabetes, cardiovascular disease, and chronic obstructive pulmonary disease

Women's and Maternal Health
Mississippi's infant mortality (8.4 per 1k), maternal morbidity (20.8 per 100k), low birth weight (12.1%), and pre-term birth rate (14.6%) are all greater than the national average and all show significantly higher rates in Black women

Child and Adolescent Health
Mississippi is among states with the highest rates of children with special health care needs (23%), childhood adverse experiences (18.2%), childhood asthma (11%), childhood poverty (27.8%), and developmental screening rates (>20%)

Health Equity
- Mississippi has significant health disparities for Black residents in diabetes, hypertension, obesity, infant mortality, maternal morbidity, and pre-term births
- Mississippi has significant health disparities for those residents that have lower education and income levels related to COPD, cardiovascular, multiple chronic conditions, and depression

Behavioral Health
- Twenty-five counties in Mississippi have suicide rates above the national average
- Fewer than a fifth of Mississippi children ages 6 and younger are screened for developmental and behavioral disorders, the lowest rate in the nation

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- Monitor and analyze
- Conduct rapid-cycle improvement
- Evaluate continuity and effectiveness
- Share best practices with the Division, CCO partners, Providers, and stakeholders

Our goal is to deliver measurable improvements through Member-centered, individual solutions that support the population-driven outcomes throughout the healthcare continuum. Through our QM program, we will measure the success of interventions from initiation through implementation. We will identify health outcome trends in need of improvement, specific subpopulations most affected by disparate health outcomes, and key determinants impacting health among those specific subpopulations, such as health literacy. By combining measurement with our understanding of State, Provider, and Member needs, we will identify opportunities to bring proven solutions forward and improve health equity.

d. Process for Using Evidence-based Practices

We will work with the Division, Providers, and other CCOs to drive innovation through evidence-based practices (EBPs), interventions, and strategies that improve the delivery of EBPs and outcomes. We will use evidence-based, Member-centered models that address Members' social barriers to care and improve their health outcomes and overall well-being. We will have clinicians with the expertise to evaluate data on Member's values, and preferences to determine the most effective EBPs that align with their clinical needs. Our CCO will leverage every opportunity to include evidence-based curriculum in Provider trainings.

For example, we will offer a foster care training for Providers in partnership with Mississippi Department of Child Protection Services (MDCPS). We will train Providers about different EBP options (such as our Parent-Child Interaction Therapy curriculum) and offer programs that support and incentivize Providers to become credentialed in emerging EBPs. As described in detail in Section 4.2.2.4.B, we propose a CCO Collaborative Workgroup to discuss policies and procedures related to CPGs and EBPs that promote better health outcomes for Mississippians.

Our affiliates' experience has shown that Provider participation in EBPs can be quite effective. ***For example, through outreach campaigns and PCP engagement regarding EBPs, one of our affiliates decreased non-emergent emergency room (ER) visits by 23% and visits per 1,000 Members by 27%.*** Another affiliate used EBPs to identify a need to reduce ER use for low-acuity conditions and minimize adverse incidents such as acute care readmissions.

We will use predictive modeling algorithms to proactively identify Members that may have poor outcomes in the future, and identify Members with high risk of ER visit, hospitalization, and readmission. We will recommend tracking outcomes related to EBPs for Mississippi, including:

- **Family Functional Therapy.** Using a Youth Outcome Questionnaire (both parent and self-report) to measure behavior change before and after therapy.
- **Multi-systemic Therapy for Juveniles.** Review outcomes based on percentage of Members remaining at home, in school, and having no arrests.

e. Complying With and Supporting the Mississippi Managed Care Quality Strategy

We are committed to executing on the Division's Comprehensive Quality Strategy. Our affiliates have extensive experience driving state-specific quality strategies through a robust QM program structure and we will leverage this experience for our local program. We will build strong ties to local communities so that we can meet Members where they are and drive meaningful change for Members and the communities in which they live.

We will align our Quality Strategy goals with the priorities proactively identified by our Population Health Council and with the Division's Comprehensive Quality Strategy and Population Health and SDOH initiatives.

We will continuously assess quality data, membership, utilization patterns, and year-over-year performance measures to develop innovative strategies that improve health outcomes for MississippiCAN and CHIP Members, designing interventions specifically to address these key Population Health priorities. Figure 4.2.2.4.A.1-7 shows these key Population Health priority areas along with our proposed QM interventions.

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f. Using Data to Design, Implement, and Evaluate the Effectiveness of the Quality Management Program

Our CCO will collect, aggregate, and analyze data to transform and evaluate the effectiveness of our QM program. We will collect this data from multiple internal and external sources. We will share the data in the

form of graphics and tables that will help the Division easily view the effectiveness of the QM program as described in Section 4.3.4.1. We will develop and implement quality initiatives and process improvements driven by data analysis. We will reassess initiatives monthly through our quality committee structure, including HEDIS Task Force meetings, and will perform more formal evaluations quarterly and annually to evaluate intervention effectiveness and compare year-to-year performance through our committee structure.

We will conduct data analytics in the planning stages to define the scope of the program and confirm that appropriate goals and objectives are set, as well as throughout the proposed project to adjust as needed to achieve the desired outcomes. Baseline data is key, and analytics will assure that the right metrics are selected for the proposed project. Once interventions have been implemented, our analytics team will work with the program to assure data collection and ongoing performance measurement are completed. These performance measurements will summarize performance, trends, disparities, and outliers. Data analytics will also be completed as part of program outcome evaluation to determine any differences between the stated goals and the program results.

Sharing Data with the Division

We are committed to working collaboratively with the Division to create customized processes and information exchanges. Upon Contract award and based on our organization's experience with successfully administering capabilities in affiliate markets, we propose, with the Division's approval, developing a comprehensive set of QM metrics made available to the Division with visualization of key MississippiCAN and CHIP statistics and trends. These metrics will evolve to support the needs of the Division.

We will provide a comprehensive set of custom reports for the Division at least quarterly and more frequently if desired. Reports will include any combination of administrative, survey, or medical record data, and will include Enrollment information, claims, encounters, authorizations, Appeals, complaints, CM documentation, access and availability survey findings, and CAHPS® and HEDIS results. The suite of QM data will allow for customized visualizations and reporting to help the Division better understand, visualize, and report on Medicaid and CHIP initiatives and programs.

We will provide the QM data to the Division as part of a proposed quarterly business review in which our CCO will review the findings, identify areas of opportunity, and develop solutions in collaboration with the Division. During these QM quarterly business reviews, we will address any questions Division leadership may have about the timeliness of the data and the data collection methodologies, as well as provide insights into how we are using the data to inform CCO operations and strategies.

Data Sources

Data sources may consist of any combination of administrative, survey, or medical record data, internally collected, or provided by our subcontractor partners or the State's Pharmacy Benefits Administrator (PBA) that may help us identify opportunities for improvement, disparities, and effectiveness. Additional data sets may include, without limitation: Enrollment information, claims, encounters, authorizations, Appeals, complaints, CM documentation, access and availability survey findings, Member medical records within Provider offices and facilities, immunization registry information, surveys by external bodies such as accreditation entities or CMS, QI studies, State data files, CAHPS, and HEDIS results.

Data Collection Methodology

Our QM program will leverage our quality analytics capabilities and HEDIS data warehouse. We will generate information on utilization, clinical indicators, and trended, segmented, and comparable data from this robust quality data infrastructure. These reports will provide information on access to care, demand for services, and quality to design and implement targeted interventions and improve Member outcomes and efficiency. Our

affiliates have used comprehensive reports to understand outcomes and trends in other markets and to refine interventions.

Our analytics platform will deliver the flexibility to support rapid development and deployment of any new data exchange through secure data transfer. It will collect and aggregate data into a comprehensive source of health information about our Members — including types of encounter data, lab results, and immunizations including electronic health record (EHR) and Health Information Exchange (HIE) data. The data warehouse will support access to Member data through the Care Management Platform (CMP). The data warehouse performs advanced data analytics, including predictive modeling, and will identify Members for CM and support operational, management, regulatory, and ad hoc reporting. We will leverage our experience in other markets where our affiliates utilized expanded data assets and reports to better address health outcomes.

Sampling Methodology

We will select samples based on the indicator or measure being evaluated and identified in the written documentation of monitoring activities. Statistically valid sampling will be used for data collection when appropriate, including HEDIS specifications, as applicable. Additionally, we will determine sample size to select a target variance derived from the sample that is obtained. For example, when data is collected for our PIPs, we will determine if the random statistically significant sample with a confidence interval of 95% or -5.

Frequency of Data Collection

We will continuously collect data, as well as at systematically specified intervals such as daily, weekly, monthly, quarterly, and annually. Data collection and reporting frequency will be included in the QM Work Plan for each measure or activity. Data results will be reported on a comprehensive dashboard and presented to the relevant quality committee and task force for review and analysis.

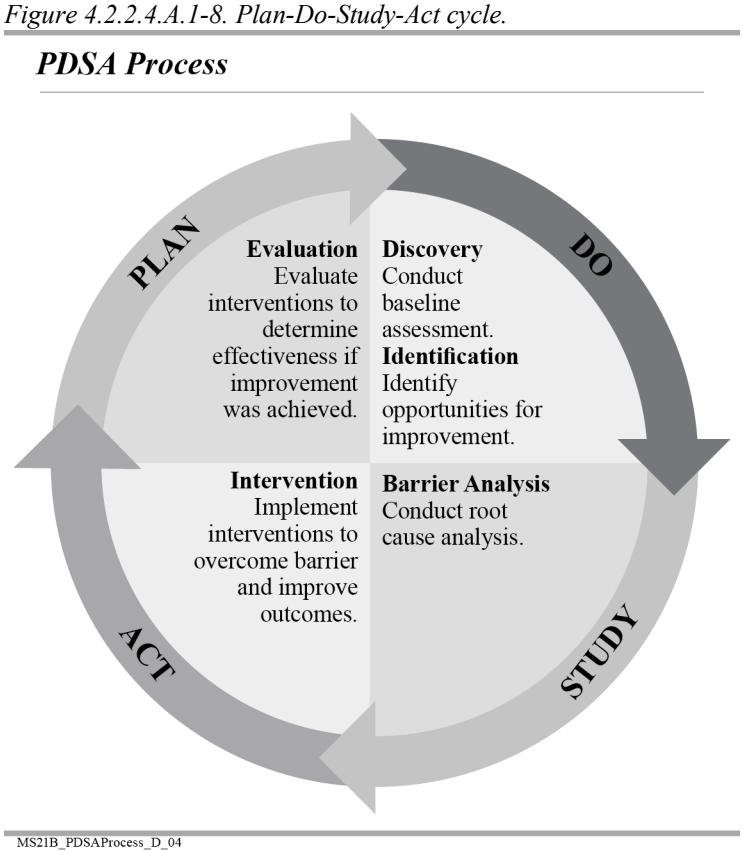
Data Analysis and Evaluation

Quantitative and qualitative analyses will be conducted to evaluate the effectiveness of activities in achieving our CCO's clinical and service performance goals. These analyses consider, among other things, potential barriers for achieving desired outcomes and interventions or recommended strategies. Revisions to the QM Work Plan may be initiated in collaboration with the Division in response to findings or reprioritization of projects and new events.

Analyses and QM program reports will be communicated to the relevant quality committees. Summary reports will be presented to the Board or its designee. At least semi-annually, our CCO will disseminate information about the QI program and progress toward goals to Members. We will also share data and reporting to the Division on a routine basis.

Our QM program also will include rigorous clinical initiatives that use the PDSA process (shown in Figure 4.2.2.4.A.1-8) and includes the following functions:

Figure 4.2.2.4.A.1-8. Plan-Do-Study-Act cycle.



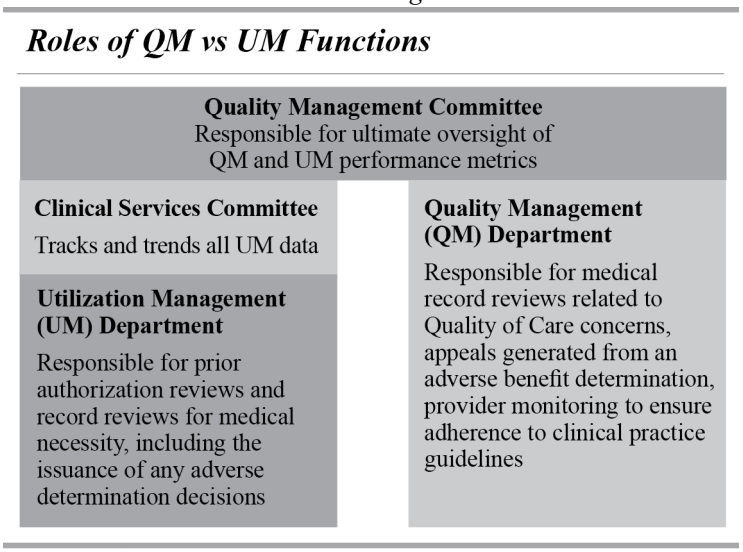
- Analyzing gaps in service delivery and quality of care
- Identifying underlying reasons for variations in provision of care (root cause analysis)
- Implementing improvement strategies based on findings from root cause analysis

We will follow a seasoned PDSA process to tailor our QI strategies to specifically impact each HEDIS measure in response to our data analysis findings. We will synthesize and analyze our data to inform baseline measures and realistic goals for our Population Health programs.

g. Separating Responsibilities Between Utilization Management and Quality Assurance Staff

We will employ dedicated QM staff and provide the resources necessary to support the day-to-day operations of the QM program. Our dedicated, local, QM team, supported by a QM Director and sufficient QM staff will deliver the Mississippi QM program. QM staff will have unique QM roles, separate from UM. Our UM staff will be led by a UM Coordinator and a Medical Director who oversee day-to-day UM functions and conduct ongoing monitoring and evaluations of UM staff.

Figure 4.2.2.4.A.1-9. Our UM and QM functions are independent but coordinated under common oversight.



As shown in Figure 4.2.2.4.A.1-9, our UM team will be responsible for medical necessity record reviews to make determination decisions, including adverse determinations. In contrast, the QM team will be responsible for review of medical records related to quality of care concerns, Appeals based on adverse determinations, and Provider monitoring for adherence to CPGs. Our UM and QM departments will be managed independently by two distinct leadership teams. Additionally, all work completed by the UM team will be tracked and trended through the Clinical Services Committee, which reports into the QMC for ultimate oversight.

h. Assuring Health Access and Equity Through Our Quality Management Program

We will target our interventions to improve individual and community health access and equity. Local, community-based solutions can advance health equity by working towards a shared vision and values, increasing the community's capacity to shape outcomes. We will identify communities and populations experiencing disparities and collaborate with key stakeholders and CBOs to develop interventions at the CCO, Provider, and community level that can improve both health access and equity, including:

[redacted]

- **Mobile Screenings.** We will partner with Providers in the community to expand access to care through compliant mobile solutions. Our partners have committed to conduct screenings, including vision and dental, at youth organizations and back-to-school events.
- **Community Outreach Vehicle.** This mobile care unit will bring health screenings for conditions such as diabetes, obesity, and high blood pressure. We are also committed to working with the Division to develop innovative strategies that will address health disparities in our rural communities using our community outreach vehicle. For example, we will monitor utilization and gap in care reports to identify potential counties for outreach, focusing on counties like Tunica and Quitman where there is no access to a hospital.

We could then partner with local physicians in those areas and facilitate home visits using our community outreach vehicle. These home visits could include various screenings, including BH and SDOH.

Assuring Access

Heat maps and GeoAccess reports indicate Mississippi Members struggle to access pediatricians, geriatricians, OB-GYNs, BH Providers, and other specialists. In response to these gaps in access, our CCO will implement strategies, such as telehealth solutions and training to increase Provider capacity, Value-Based Purchasing (VBP) programs that attract provider types hesitant to participate in Medicaid, and tuition incentives for medical school graduates to stay within rural areas of the State. Additional strategies are described in detail in Section 4.2.2.2.

[redacted]

We will also monitor access and availability at least quarterly and as needed to verify adequate Provider Network access for both current membership and anticipated new Enrollment. We will use GeoAccess reports to evaluate Member driving distance to PCPs or Patient-Centered Medical Homes (PCMHs), specialists, ancillary Providers, and hospitals. Access to practitioners is also monitored through Member to practitioner ratio reports. We will conduct quarterly Provider audits to measure appointment wait time for specific types of visits and Provider types. In addition, the Member services call center will monitor average speed of answer, hold times, and call abandonment rates on an ongoing basis to assess adequate access to CCO personnel for Members and Providers. We also will monitor access and availability monthly via a Member satisfaction survey distributed through text and annually via the CAHPS Member satisfaction survey, in addition to monitoring of Grievances.

Our QM Program Description, Annual Work Plan, and Evaluation will comply with the requirements as outlined in Contract Exhibit F: Quality Management. Our local QM Director will produce an annual QM Program Description, as well as QM Work Plan and QM Program Evaluation in accordance with Contract Section 8.4.1 and 8.11.1. We have attached Model Annual QM Program documents in Attachment 4.2.2.4.A-1, and we provide a description of these documents here.

Annual Quality Management Program Description

We will produce an annual QM Program Description in compliance with all Contract requirements, specifically Exhibit F, Section B.1.5. The QM Program Description will include CCO Background, Purpose, Vision, and Values; QM Program Purpose, Goals, Scope, and Objective; QM Structure and Accountability; QM Program Dedicated Resources; Program Methodology; Program Initiatives; HIPAA, State, and Federal Compliance; Contractually Required Activities and Initiatives; and QM Annual Evaluation Methodology.

Additionally, it will include standards and mechanisms to monitor Members' timely accessibility of primary care, and specialty care, in accordance with timeframes outlined in Contract Section 6.2, Provider Network, as well as mechanisms for assessment, analysis, and reporting for all requirements in Exhibit F.B.1.5, including

assessments of timely, accurate, complete collection, and analysis of Member and Provider surveys and assessments of partnerships with CBOs.

Our QM program will promote the accountability of all CCO staff and partners to be responsible for the quality of care and services provided to our Members and to address the clinical care and service needs of Members. We will continually strive for industry best practice and use NCQA's Quality Compass National percentiles as goals for HEDIS and CAHPS. Additionally, our QM program will have:

- Mechanisms and processes that assure related and relevant operational components, activities, and initiatives from the QM program are communicated and integrated into activities and initiatives undertaken by other departments within our CCO, delegated subcontractors, and CM programs
- Procedures for informing Providers about the written QM program, and for securing cooperation with the QM program with all PCPs, PCMHs, and community-based services
- Procedures for feedback and interpretation of findings from analysis of quality data to PCPs and PCMHs, CM staff, CBOs, and Members and their family members
- Mechanisms and processes that allow for the development and implementation of specific improvement actions in response to identified barriers and quality of care concerns within the QM program or the communication of the findings to the Division
- Cooperation with State initiatives, including Provider and Member outreach and education, quality studies, and participation in workgroups

We have provided the table of contents from a model Annual QM Program Description in Attachment 4.2.2.4.A-1a, Model Annual Program Description.

Annual Quality Management Work Plan

We will produce an Annual QM Work Plan to accompany the QM Program Description, which includes a framework for monitoring of the QM program structure as described in Contract Exhibit F, Section B.1.6. The Work Plan will include a timetable, individuals accountable for each task, target dates for start dates, target dates for completion of all QM activities, updates, quarterly PDSA assessments, data collection methods, and analysis target dates. We will submit this evaluation and reporting of findings to the Division annually.

We have included excerpts of activities and dashboards from a model Annual QM Work Plan in Attachment 4.2.2.4.A-1b, Model Annual QM Work Plan.

Annual Quality Management Program Evaluation

Our QM Program Evaluation will provide a formal process to monitor and evaluate the quality, appropriateness, efficiency, safety, and effectiveness of care and service objectively and systematically. Our QM assessment will focus on studies and activities undertaken, rationales and methodologies for activities and studies undertaken, results of activities, subsequent improvement actions, analysis of claims data, Member demographic information, Member and Provider surveys, and other data as applicable. Our QM assessment will also focus on quarterly analysis and re-measurement of barriers to care and the quality of care provided to Members.

The QM program will promote the accountability of all CCO staff and partners to be responsible for the quality of care and services provided to our Members and to address their clinical care and service needs. We will continually strive for industry best practice and use NCQA's Quality Compass National percentiles as goals for HEDIS and CAHPS.

We have included a sample table of contents and excerpts of an introduction and executive summary from a model QM Program Evaluation in Attachment 4.2.2.4.A-1c, Model Annual QM Program Evaluation.

B. Clinical Guidelines and Compliance

Clinical Guidelines keep Providers informed about scientific advances, bring rigor to consistent care delivery, and positively impact health outcomes. Leveraging the work of our national committee on medical policy, a multidisciplinary group that includes practicing physicians and academics from various specialties, clinical practices, and geographies, we will identify clinical practice guidelines (CPGs) based on the Mississippi healthcare landscape and the specific needs of MississippiCAN and CHIP Members. Our local approach to developing, reviewing, and approving CPGs for Mississippi will include input from our Provider Advisory Committee (PAC), Coordinated Care Organization (CCO) collaboration, and the Division's guidance. Mississippi-specific CPGs will be reviewed by our CPG Workgroup, which includes our Medical Director, Perinatal Director and Behavioral Health Director (BH Director), and then presented to our local Medical Advisory Committee (MAC) for final review and approval.

Our QM Director will coordinate with our local MAC to review and approve newly adopted and revised CPGs and will make sure they are consistent with the Division's priorities and appropriate for MississippiCAN and CHIP Members. Our locally based Medical Director and BH Director will review all guidelines annually. Our Medical Director, Perinatal Health Director, and BH Director will also request specific guidelines or topics to be considered for approval on the CPG list. In addition, network Providers can request that a guideline be considered, such as in MAC or PAC meetings.

To assure consistency, the MAC and national committee on medical policy will review Provider and Member education materials, benefit plans, and coverage parameters annually against guidelines.

1. Notifying Providers and Monitoring Implementation of New Practice Guidelines

Our CCO will promote the use of our comprehensive portfolio of evidence-based clinical guidelines which spans over 49 conditions and diseases. We will communicate new and existing CPGs and notice of changes to Providers through multiple channels, including in person during face-to-face Provider engagement visits, and through our Provider Manual, newsletters, website, fax blasts, and special mailings. We will also submit our proposed CPGs to the Division by January 1st of each year for review and approval prior to Provider distribution and notification.

We will introduce Providers to our CPGs through our comprehensive Provider orientation process and during initial and ongoing training, including through our PAC. Local Providers on our MAC will also review, provide input, and approve CPGs before use. We will post new or revised CPGs to the Provider website within 30 days of adoption or revision, where Providers will also have access to other relevant resources. Additionally, on a continuing basis, we will proactively engage Providers identified through quality audit reviews, claims analysis, and utilization data to provide them with enhanced CPG education tailored to the clinical services they provide to our MississippiCAN and CHIP Members.

When initiating a substantial CPG change, we will make it publicly available for a 45-day review and commenting period. We will place a notice on our Provider website, include an article in our Provider newsletter about the new CPG, and encourage Providers to contact our Provider Services team with questions, comments, or concerns. We will also offer in-network Providers and experts an opportunity to share feedback and opinions on CPGs through our MAC and PAC or when our staff are on-site for medical record reviews. To support ongoing refinement of our CPGs, we will engage Mississippi-based clinical thought leaders with Medicaid expertise in CPG development and will continue to encourage out-of-network Providers and experts to share their opinions in this area.

Monitoring Implementation of Guidelines

We will use HEDIS® information, missed opportunity (gaps in care) data, and medical record reviews to monitor Providers' implementation of and adherence to new and existing CPGs, including BH and PH CPGs.

Annually, we will assess compliance with a sample of at least four guidelines that apply to various segments of our Member population. In year one of the contract, we propose assessing compliance with six CPGs, exceeding the requirements in Contract Section 8.15. We will select at least two CPGs for acute and chronic care, two BH guidelines (one of which addresses children and adolescents), and two preventive health guidelines. We will also review Member education material, benefit plans, and coverage parameters against the guidelines annually to verify consistency. We will share the results of our annual evaluation, including a summary of any Corrective Action Plans (CAPs), with the Division in accordance with Contract requirements.

Promoting Provider Adherence to CPGs

Our QM team and Clinical Auditor will analyze and monitor CPG adherence and continuously provide feedback and education on best practices to Providers We will routinely track and trend quality indicators, such as HEDIS measures, quality of care concerns and performance indicators that align with our CPGs. For example, our diabetes CPGs support the receipt of an annual eye exam for individuals with diabetes. We will monitor adherence to these CPGs through the associated HEDIS measure. We will stratify aggregated data by Provider so we can identify those who are not complying with CPGs and reach out to educate them about improving compliance.

We will use our UM over- and under-utilization review processes to determine cause for trend with Provider and identify target education related to CPG adherence. We will also support Providers by delivering actionable information to them about gaps in recommended care through our various Provider profile and communication tools, described in response to 4.2.2.4.B.5, later in this section, as well as in Section 4.2.2.2. Some of our strategies for promoting Provider adherence to CPGs are described in Table 4.2.2.4.B.1-1.

Understanding Root Causes Drives Recommendations

To drive improvement in clinical services provided, EBPs, and health outcomes, we will identify root causes for why Providers do not adhere to CPGs. Root cause analysis (RCA) is a foundational and best practice quality approach adopted throughout our organization. An example of applying RCA to identify and solve a CPG adherence issue would be one of our Medicaid affiliates who identified specific causes for non-compliance with diabetes CPGs, which included Providers' attitudes, beliefs, and knowledge about testing for blood sugar levels and retinal eye exams for Members with diabetes. After analyzing the data and root causes, our affiliate implemented interventions to address those causes. Interventions included continued Provider education on current guidelines as well as continued Member-oriented interventions, such as distribution of an Adult Personalized Healthy Checklist. As a result of these efforts, our affiliate's HEDIS measure rate for Comprehensive Diabetes Care: Eye Exam has exceeded the national average for the most recent two years.

Fostering Collaboration

To identify discrepancies and build consensus and alignment across CCOs, we will examine proposed CPGs in concert with those promoted by the Division and other MississippiCAN and CHIP CCOs. We will foster partnership with other CCOs and the Division to confirm consistent application of CPGs, including through a proposed CCO Collaborative Workgroup. This workgroup, comprised of CCO Medical Directors and Division and CCO leaders, will discuss policies and procedures related to CPGs and EBPs that promote better health outcomes for Mississippians.

We also will propose the development of a collaborative Provider monitoring strategy to assure consistent implementation of guidelines, which would include a consistent monitoring tool, sample selection methodology, and Provider education resources. We are strong proponents of this type of collaboration and the positive health outcomes that result. For example, one our Medicaid affiliates had a positive result from a recent EBP collaboration with other CCO's in that state regarding Vitamin D deficiency screening. Participating CCOs compared all current policies and arrived at a consensus to adopt a common CMS guideline and issue a joint policy to streamline the process and ease administrative burden for Providers.

2. Listing of Behavioral Health and Substance Use Disorder Guidelines

We will promote consistent CPG practices for both PH and BH. To improve BH outcomes and improve substance SUD diagnosis and treatment, we will foster adoption of EBPs and maintain a comprehensive array of BH CPGs that incorporate recommendations and guidelines from nationally recognized professional organizations, including the American Psychiatric Association (APA) and Substance Abuse and Mental Health Services Administration (SAMHSA). We have provided several examples in Table 4.2.2.4.B.1-2.

Table 4.2.2.4.B.1-2. Sample listing of our behavioral health clinical practice guidelines.

CPG Description	Recognized Source
Depression	
Depression in Adults: Screening (January 2016)	U.S. Preventive Services Task Force (USPSTF)
Depression in Adults: Recognition and Management Clinical Guideline CG90 (Updated April 2018)	National Collaborating Centre for Mental Health commissioned by the National Institute for Health & Clinical Excellence
Depression in Children and Adolescents: Screening (February 2016)	USPSTF
Depression in children and Young People: Identification and Management (updated September 2017)	National Institute for Health and Care Excellence (NICE)
Substance Use Disorders	
Medication-Assisted Treatment of Adolescents with Opioid Use Disorders (September 2016)	American Academy of Pediatrics (AAP)
CDC Guideline for Prescribing Opioids for Chronic Pain – United States (March 2016)	Centers for Disease Control and Prevention (CDC)
American Society of Addiction Medicine Clinical Practice Guideline on Alcohol Withdrawal Management (2020)	American Society of Addiction Medicine
APA Practice Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder (Reviewed 2020)	APA
Medication-Assisted Treatment (MAT) (Last Updated February 2018)	SAMHSA
Suicide and Trauma	
SAFE-T: Suicide Assessment Five Step Evaluation and Triage	Suicide Prevention Resource Center (SPRC)
Assessment and Management of Patients at Risk for Suicide (2019)	Veterans Administration/Department of Defense (VA/DoD)
A Treatment Improvement Protocol: Trauma-informed Care in Behavioral Health Services (2014)	SAMHSA
Psychosis	
APA Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia (July 2018)	APA

CPG Description	Recognized Source
Overall BH	
The APA Practice Guidelines for the Psychiatric Evaluation of Adults 3rd Edition (August 2015)	APA
Childhood Diagnoses	
Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents (October 2019)	AAP
Practice Parameter: Screening and Diagnosis of Autism (Reaffirmed August 2014)	American Academy of Neurology (AAN) and the Child Neurology Society (CNS)
Identification Evaluation and Management of Children with Autism Spectrum Disorder (January 2020)	AAP

Monitoring Provider Adherence to Guidelines

The process for monitoring adherence to BH CPGs mirrors the process described earlier in this section, including using HEDIS information, gaps in care data, and medical record reviews to monitor Providers' implementation of and compliance with CPGs. Annually, we will measure Provider performance for two BH CPGs, including one that addresses children and adolescents. We will also employ monitoring of EBP outcomes. We will use our auditing tools to monitor priority CPGs, such as BH, SUD, and inpatient discharge planning. Our Clinical Quality Auditor will perform Provider adherence audits, provide important feedback and education to Providers based on findings, and collaborate with our Medical Director, Perinatal Health Director, and BH Director to follow up on any identified need for CAPs. Corrective Action Plans will be closely monitored until resolved.

3. Complying with the SUPPORT Act

We understand the importance of advancing efforts to stop the circulation of illegal and unsafe drugs, while preventing SUD and promoting opioid recovery and treatment. We will leverage our affiliates experience in supporting the continuum of services for Members with SUD, carving in Institutions for Mental Disease (IMDs), promoting quality MAT, and developing Member and Provider pharmacy oversight and monitoring. Our affiliates have participated in the Alliance for Addiction Payment Reform, [redacted] We will have Care Management (CM) programs that specialize in supporting neonatal abstinence syndrome (NAS) and SUD, and leverage our data science platforms to proactively identify affected Members and provide education material, referrals, access, and support for treatment. We will comply with the SUPPORT Act through initiatives that encourage SUD treatment and recovery, including:

[redacted]

[redacted]

[redacted]

In addition to our clinical pharmacy programs that aid in SUPPORT Act compliance, our Clinical Pharmacist will partner with the PBA to assure all prospective claim review requirements for opioids and benzodiazepines and opioids and antipsychotics are met. We will also implement an anti-fraud plan that identifies fraud and abuse of controlled substances by Members, Providers, and pharmacies.

4. Listing of Physical Health Guidelines

Our CPGs are best practice, evidence-based resources that we will review, revise, and approve annually. We will monitor and address updates that come from the Division and Administrative Code, and from nationally recognized organizations, such as the US Preventive Services Task Force and medical specialty societies that produce evidence-based guidelines using medical literature, professional standards, and expert opinions. We will encourage Providers to offer recommendations for new guidelines for inclusion in our CPG registry and provide comments on existing ones. Ultimately, active Mississippi CPGs and EBPs will reflect that Provider feedback. We will include CPGs for:

- Adult preventive care
- Pediatric and adolescent preventive care with a focus on EPSDT for MississippiCAN
- Well-Baby and Well-Child for CHIP
- Division-defined clinical areas
- CM-related clinical outcomes and performance
- BH and SUD integration
- Maternity and perinatal care
- Inpatient discharge planning
- Provider preventable conditions

We provide some examples of PH CPGs that will be considered for inclusion in our clinical quality program in Table 4.2.2.4.B.1-3.

Table 4.2.2.4.B.1-3. Sample listing of our physical health clinical practice guidelines.

CPG Description	Recognized Source
Adult Preventive Care and Chronic Condition Management	
Guidelines for the Diagnosis and Management of Asthma (EPR-3) (August 2007)	National Heart, Lung and Blood Institute (NHLBI)
AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease (November 2011 Update)	American Heart Association (AHA)/American College of Cardiology Foundation (AHA/ACCF)
Treatment of Hypertension in Patients with Coronary Artery Disease (March 2015)	American Heart Association, American College of Cardiology, and American Society of Hypertension
Effectiveness-based Guidelines for the Prevention of Cardiovascular Disease in Women (February 2011)	AHA
ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease (2019)	American College of Cardiology (ACC)/ AHA
Chronic Kidney Disease: Detection and Evaluation (2017)	American Academy of Family Physicians (AAFP)
Infectious Disease	
Sexually Transmitted Diseases Treatment Guidelines (June 2015)	Center for Disease Control and Prevention (CDC)
AASLD Guidelines for Treatment of Chronic Hepatitis B (August 2015)	American Association for the Study of Liver Diseases (AASLD)
Update on Prevention, Diagnosis, and Treatment of Chronic Hepatitis B: AASLD 2018 Hepatitis B Guidance (January 2018)	AASLD
HCV Guidance: Recommendations for Testing, Managing and Treating Hepatitis C	Infectious Diseases Society of America (IDSA)/AASLD
Primary Care Guidelines for the Management of Persons Infected With HIV: 2013 Update by the HIV Medicine Association of the Infectious Diseases Society of America (November 2013)	HIV Medicine Association of the (IDSA)
Pediatric/Adolescent Health	
Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report (December 2007)	American Academy of Pediatrics (AAP)
Clinical Report: The Role of the Pediatrician in Primary Prevention of Obesity (July 2015)	AAP
Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents (September 2017)	AAP
Women's Health	
Women's Preventive Services Guidelines. (Last Reviewed 2017)	Health Resources and Services Administration (HRSA)
Women's Health Care Physicians: Cervical Cancer FAQs (December 2015)	American Congress of Obstetrics and Gynecology (ACOG)
Gestational Diabetes	ACOG
Postpartum Screening for Abnormal Glucose Tolerance in Women Who Had Gestational Diabetes Mellitus	ACOG

When initiating a substantial CPG change, we will communicate directly with Providers and the Division to inform them of the 45-day review and commenting period. We also will offer in-network Providers and experts an opportunity to share feedback and opinions on CPGs through our PAC or when our staff are on-site for medical record reviews. We will engage Mississippi-based clinical thought leaders with Medicaid expertise in CPG development and ongoing refinement and will continue to encourage out-of-network Providers and experts to share their opinions in this area.

Monitoring Provider Adherence to Guidelines

Our Provider agreements will require compliance with CPGs, which we will reinforce through ongoing monitoring, educational outreach, and incentives for Providers who meet quality goals and improved outcomes. Our Provider-centric approach will feature local PH and BH Clinical Quality Audit Analysts, who will provide education on CPG adherence, and review medical records to assure accurate evidence of compliance. We will provide feedback and education to Providers based on findings, and we will collaborate with our Medical Director and Perinatal Health Director to follow up on any identified CAPs. CAPs will be closely monitored until resolved. We monitor Providers across all levels of care, including on-site reviews to assure adherence to EBPs and CPGs. This includes monitoring for the following CPGs: EPSDT, developmental screening, SBIRT screenings, autism spectrum disorder (ASD), and ADHD. We will also determine the frequency of review, sampling approach, data sources and tools, data collection and validation methods, and site visits that will work best for these programs and for Mississippi Providers.

5. Conducting Provider Profiling to Assess Quality of Care

We will implement policies and procedures regarding Provider profiling activities to assess quality of care delivered to Mississippians. With the goal of reducing variation in performance and improving health outcomes, we will use quality profiling and utilization pattern profiling among our Providers to analyze patterns in care and provide meaningful feedback to Providers about their performance to help them improve the quality of care they provide to MississippiCAN and CHIP Members. We will use several Provider profiling tools including Provider scorecards and reconciliation reports, which are outlined in Section 4.2.3.1. These tools will include reports that compare a Provider's performance to peers and established benchmarks and help Providers improve performance and manage care more effectively.

For example, our OB Profile report will allow OB Providers to compare key clinical metrics, such as preterm birth rate, C-section rate, and timeliness of prenatal and postpartum care to benchmarks and performance of all Providers in Mississippi and nationally within their specialty and panel peer groups. ***Due to the significant disparities in maternal outcomes, we also include race and ethnicity data in these reports so that Providers can identify and address health disparities within their own practice.***

6. Ensuring Quality of Care Among Non-contracted Providers

We are committed to proactively ensuring quality of care for our Members whether that care is delivered by a network or non-contracted Provider. To support our commitment to quality, we will engage non-contracted Providers in single-case agreements (SCAs) that include a clause allowing our CCO to monitor the quality of care provided to our Members for the duration of the SCA. This means that Members will be able to complete their care with non-contracted Providers while still receiving our quality oversight, including ongoing analysis to identify areas of opportunity to address quality of care concerns. For example, employing similar oversight for non-contracted Providers, one of our Medicaid affiliates identified quality of care issues related to irregular opioid prescriptions patterns. As a result of this identification, the affiliate put safety edits in place to block opioid prescription refills from non-network Providers after working with the CM team to transition affected Members to quality network Providers to assure ability for oversight and monitoring of the care received. When possible, we will make every attempt to transfer the Member to an in-network Provider or recruit the non-contracted Provider to join our network.

We will monitor our out-of-network providers for utilization trends and if providers are identified to frequently provide services to recruit them into our network. Our affiliates' experience has shown that quality-of-care concerns are frequently identified for non-contracted Providers through the Grievance and Appeals process. For MississippiCAN and CHIP Members, we will follow best practice Grievance and Appeals processes to investigate each quality concern, develop a solution, and implement it. We will also identify quality of care

concerns among non-contracted Providers during CM case rounds, as our clinical staff discuss Member cases and evaluate their treatment plans.

As with our Grievance and Appeals process, we will develop and implement solutions to identified quality concerns. For example, when a newly enrolled Member is receiving services at a non-contracted facility or with a non-contracted Provider, our goal is to ensure the Member receives consistent, uninterrupted care. In this example, we will assist the Member by signing an SCA with the facility, while locating an in-network facility that the Member could be safely transferred to when appropriate.

Additionally, when we receive an out-of-network care request, our Utilization Management team will verify Member eligibility and then confirm the Provider is licensed, not excluded from participation by the Department of Health and Human Services or Office of Inspector General (OIG), and not on the Division's list of excluded Providers.

If a comparable network facility could not be located, we will monitor the status of the SCA to make sure it does not lapse and attempt to recruit facilities that offer these services into our network. The CM team will follow up on SCAs to make sure care is continued and to support the Provider. One possible scenario to address access gaps in rural areas may involve recruiting inpatient BH facilities that serve Members who are facing mental health challenges and are a danger to themselves or their families.

7. Reducing Provider Preventable Conditions

Our strategy for reducing potentially preventable conditions (PPCs) will include support for Providers and Members. We will work with the Division, Providers, and other CCOs to drive innovation through evidence-based interventions and strategies that reduce PPCs and address super-utilizers.

We are dedicated to identifying patients at risk for and diagnosed with complex conditions to assign them to a PCMH. PCMH assignment will be the foundation to our approach to preventing PPC. PCMH Providers are proven to provide better primary care and care coordination, which reduces the likelihood of PPCs. This approach helps ensure that discharged Members are immediately engaged with their PCMH Provider for timely, appropriate follow up care and decreases the chance of post discharge complications that could lead to a readmission Our VBP program will incentivize Providers to engage in activities, such as follow-up after discharge that will ultimately reduce PPCs.

We will use person-centered models that address MississippiCAN and CHIP Members' social barriers to care, reduce ER use for low-acuity conditions, and minimize PPCs, including acute care readmissions. We will use predictive modeling algorithms to identify Members with high risk of ER visit, hospitalization, and readmission. We will also promote the use of the Choosing Wisely platform, an initiative of the American Board of Internal Medicine. The mission of Choosing Wisely is to promote conversations between clinicians and patients by helping patients choose care that is:

- Supported by evidence
- Not duplicative of other tests or procedures already received
- Free from harm
- Truly necessary

Never Events

Our CCO supports CMS' adoption of the non-reimbursement policy for certain Never Events — defined as "non-reimbursable serious hospital-acquired conditions" — to motivate hospitals to accelerate improvement of patient safety by implementation of standardized protocols. We propose the following strategies to impact "Never Events:"

- Offering comprehensive Provider education
- Assuring appropriate documentation of services
- Taking appropriate action once we identify hospitals where Never Events are occurring

- Employ a local Transition of Care team that proactively works with Members, Providers, and community resources to make sure that a Member has a smooth transition when leaving an inpatient setting
- Review quality of care concerns through our formal QM process to identify root causes and develop interventions to address them

Through continuous case finding, predictive modeling, and monitoring of Member utilization data, we will proactively identify trends and opportunities for intervention through oversight and monitoring of our quality program structure and targeted Member and Provider solutions. To minimize the occurrence of Never Events, we also employ the following strategies to reduce unnecessary use of the ER and avoid hospital readmissions:

- Hospitalization Risk-assessing Predictive Modeling
- ER Low- and High-risk Predictive Modeling Tool
- ER Triage Tool
- Real-time Admission, Discharge, Transfer (ADT) Alerts

Each of these solutions/tools is described further in our response to Section 4.2.2.5.B.1.

Precluding Payments to Providers

We maintain policies and procedures based on CMS guidance that support both appropriate claim payment, as well as the prevention of inappropriate claim payments, including a policy to stop payment on PPC and adverse events. This policy establishes specific claim edits to assure we do not reimburse for PPC and Never Events unless Provider, State, federal, or CMS contracts and requirements indicate otherwise. We agree to not make payments for PPCs as defined by the federal regulations and the Mississippi State Plan, in accordance with 42 CFR § 438.3(g). We will track all identified and denied "Never Events" — which are a type of PPC — and provide a quarterly report, in the format specified by the Division. We will also report encounter data to the Division in accordance with 42 CFR § 438.3.

8. Encouraging Provider Use of Electronic Health Records and e-Prescribing

Our team of Provider Experience Consultants provides tools, resources, and support needed to encourage Provider use of EHRs and e-prescribing. We offer Provider education and training on e-prescribing and integrate EHR into our supplemental data feeds to improve outcomes.

Value-Based Purchasing Contracts

With a reimbursement policy tied to the Division's goals, our VBP arrangements will reduce inappropriate care and improve health and health equity for MississippiCAN and CHIP Members.

We will assign all Providers contracted through a VBP arrangement to a Mississippi-based Care Delivery Transformation (CDT) Consultant. Our CDT Consultants will coach Providers on ways to effectively leverage HIE and their systems to achieve better health outcomes. We will educate Providers on the advantages of using EHRs, such as the ability to coordinate their patients' care more effectively. We will also educate Providers on the values of e-prescribing, including:

- **Member Information-sharing.** Supplies Provider EHR systems with information about Member eligibility and history
- **Prescription Benefit.** Delivers Member-specific eligibility, prescription benefit and Preferred Drug List information, giving prescribers this information up front to assist in prescribing

- **Prescription History.** Delivers a Member's prescription history, regardless of prescriber, to Providers during a Member's office visit–to better prevent overutilization and dangerous combinations

Section 4.2.3.1 provides complete information about our VBP incentive programs.

C. Quality Measurement

Working in collaboration with the Division, we will apply best practices in Medicaid data management to measure, evaluate, and refine our MississippiCAN and CHIP Programs and identify areas for quality improvement (QI) and enhanced quality management (QM) activities. Our data-driven QM program and strategies will use a proven quality measurement approach verified by national audit firms and based on the extensive experience of our national organization and Medicaid affiliates.

1. Data Analytics and Informatics Drive Performance Improvement and QM Activities

Built on a HITRUST-certified and HIPAA-compliant Management Information System (MIS) and data infrastructure, our interactive quality analytics platform analyzes data at State, population, and Member levels by integrating public and internal data sets with individual Member information. This multi-dimensional data infrastructure will be fully integrated with our operational data and includes a robust suite of automated and dynamic reporting. With dedicated, local data analytic support, we will continuously assess quality data, Population Health trends, utilization patterns, and year-over-year performance measures to develop innovative strategies that support network Providers in delivering quality care and improve health outcomes for MississippiCAN and CHIP Members.

Guided by strategic direction from the Division's Quality Strategy and our QM Work Plan, we will enact internal quality control and ongoing monitoring, using comprehensive data analytics and data informatics capabilities that drive performance improvement and QM activities, including:

- Monitoring overall quality metric performance against benchmarks and targets
- Driving evidence-based decision-making through review of utilization trends, such as access to care, demand for services, and quality of care to inform our QM and Population Health strategies
- Using performance metric trends to identify opportunities for QI
- Conducting in-depth barrier and root cause analysis to identify unhealthy behaviors and their determinants
- Building out reporting capabilities to meet all MississippiCAN and CHIP reporting requirements

Monitoring Overall CCO Performance Against Quality Measures

Our QM team and CCO leadership will have on-demand access to a wealth of data to assess utilization and pinpoint improvements, including:

- Demographic data, including geographic location, age, ethnicity, race, language, disability status, and income level
- Claims and encounters
- Authorizations and Appeals
- Chronic condition/Care Management (CM) documentation
- State data files
- Community-based organization information
- Member medical records
- Predictive modeling for Member risk stratification
- CAHPS® and HEDIS® results
- Public health information
- Access and availability survey findings
- QI studies/Performance Improvement Plans

Our data infrastructure will drive consistent, timely, evidence-based decision-making. The near real-time data warehouse is an integrated repository that will receive data directly from the system of record to promote quality, control, and consistency. Collecting and aggregating multiple data sources into a comprehensive source of health information about Members, our local QM data analyst and CM team will have 24/7/365 access to critical insights, enabling innovative solutions and promoting high quality of care for our Members.

Quality Improvement Activities

Quantitative and qualitative data collection and data-driven decision-making are central to our QM/QI program. We will apply valid and reliable methods, such as our advanced data analytic tools, to continuously measure and re-measure the effectiveness of clinical and non-clinical initiatives, quality of care, access, safety, and more, including the following benchmarking activities.

We will continually monitor clinical and non-clinical data including HEDIS results. We will use NCQA's Quality Compass tool to determine national benchmarks and State-specific performance targets to compare our MississippiCAN and CHIP performance with the overall goal of exceeding national averages for the NCQA Medicaid HMO Quality Compass Percentiles.

Our QM/QI team will track and trend our measures through bi-weekly and monthly reports, which we share with our internal departments, taskforces and quality committees. To identify areas for improvement in health disparities, we will routinely stratify more than 20 HEDIS clinical performance measures by race and ethnicity. We will use these findings to implement interventions that will target disadvantaged populations and enhance health equity.

Comprehensive Quality Management Reporting Suite

Through our quality analytics platform, we will integrate and transform data from multiple sources into actionable information that provides in-depth insight on overall performance against quality goals identified in our QM Work Plan. With the following list as a starting point, we will develop a comprehensive QM Reporting Suite that gives our QM team and CCO leadership the information they need to monitor performance and identify opportunities for QI initiatives:

- **HEDIS Performance Rates.** The QM team and the HEDIS Task Force will use this report to Analyze monthly HEDIS rates and identify trends year over year. Additionally, data will be analyzed against national benchmarks and State performance goals to identify opportunities to improve clinical care and service. These performance rates will also be used to develop and monitor tailored interventions to support Providers and engage Members. Sample provided in Attachment 4.2.2.4-2, Figure 4.2.2.4-2a.
- **CAHPS Trending.** The QM team will use the CAHPS Survey to analyze annual Member experience with clinical care and services and compare performance against national benchmarks and State performance goals to identify improvement opportunities and take action. Sample provided in Attachment 4.2.2.4-2, Figure 4.2.2.4-2b.
- **Annual Performance Improvement Project (PIP) Summary.** We will apply rapid-cycle improvement methodology to design and evaluate QM program interventions, including clinical and non-clinical PIPs required by the Division on a bi-monthly basis through the work of our PIP Task force. A summary of our annual PIPs selected is based on identified areas of opportunity or improvement to better services or outcomes and prevent or decrease the likelihood of problems. This includes details of testing new approaches to fix underlying causes of persistent, systemic problems, or barriers to improvement. [Sample provided in Attachment 4.2.2.4-2, Figure 4.2.2.4-2c].
- **Grievance and Appeals Data.** We will use this data to identify and monitor complaints, Grievances, Appeals and reported quality of care and service issues monthly. This data will also support analysis of issues related to quality of care and patient safety and will be used to initiate peer review processes [Sample provided in Attachment 4.2.2.4-2, Figure 4.2.2.4-2d].
- **Annual Cultural Linguistics and Appropriate Services (CLAS) Evaluation Report.** This report is an annual written evaluation of the CLAS Program which includes assessment that helps ensure the implementation of culturally and linguistically appropriate healthcare related services to Members with diverse health beliefs and practices, limited English proficiency (LEP) and variable literacy levels. The annual evaluation will also include a description of completed and ongoing activities for CLAS and health disparity identification, trending of measures to assess performance, analysis of results and initiatives —

including barrier analysis, evaluation of overall effectiveness of the program and of the interventions to address CLAS and health disparities. [Sample provided in Attachment 4.2.2.4-2, Figure 4.2.2.4-2e].

We provide a sample screen from our Interactive Quality Analytics Report in Figure 4.2.2.4-2f of Attachment 4.2.2.4-2.

We provide a Population Health Analytics report sample in Figure 4.2.2.4-2g of Attachment 4.2.2.4.C.

We provide sample segmentation analysis results in Figure 4.2.2.4-2h of Attachment 4.2.2.4-2.

Care Management Trends. We will collect and use a range of Member-, Provider-, and community-level data to inform our QM and Population Health strategies and establish priorities for interventions. Our analytics engine will aggregate data from multiple sources, so we have in-depth insight into all aspects of Population Health to take steps proactively. We leverage qualitative and quantitative data, using internal sources including claims, utilization, demographic, and data from external sources including:

- Published, peer-reviewed research
- Mississippi-specific public health data
- Any available data from the Division
- Integrated EHR data from Providers (as available)
- Data from national and local organizations, such our community-based referral platforms and a local nonprofit that promotes public health through projects in policy evaluation, community health, data analysis, and health access

We provide a sample of the Care Management Trends report in Figure 4.2.2.4-2i of Attachment 4.2.2.4-2.

This data analytics enhancement will improve our longitudinal view of Members, their clinical history, and their communication preferences. The tool analyzes metrics and recommends Member engagement strategies most likely to resonate with targeted populations or individuals. Our QM, Care Management, BH, and Provider Experience teams will use this data to infuse quality improvement approaches in closing care gaps across all functional areas.

We provide a sample of the tool used for Predictive Modeling for Optimal Outreach Trends in Figure 4.2.2.4-2j of Attachment 4.2.2.4-2.

Member Segmentation Trends and Equity Assessments. The goal of Member segmentation is to identify and classify Members who will most likely go into care on their own versus those who may need additional support to go into care. To predict Member behavior and assess equity by NCQA domains and HEDIS measure, we will use statistical algorithms that combine closely determined variables of interest spanning socio-demographic variables and clinical information, among other factors.

Through this data-based approach, our CCO will direct resources to getting Members into appropriate care, thereby improving HEDIS rates. We will also use this data to provide Member outreach through the various modalities that match their preference and likelihood of compliance.

We provide sample Member Segmentation Trends and Equity Assessments in Figures 4.2.2.4-2k and 4.2.2.4-2l of Attachment 4.2.2.4-2.

Using Benchmarking and Performance Metrics to Identify Opportunities for Quality Improvement

As discussed in Section 4.2.2.4.B.8, reimbursement policy for Providers with VBP arrangements will be tied to State goals, including reducing inappropriate care and improving health and health equity for MississippiCAN

and CHIP Members. Through enhanced data sharing, we will identify critical points of intervention and optimize Provider resources that directly improve HEDIS and quality scores, medication adherence, admission rates, and gap closures.

Tools and Data to Support Providers in Value-Based Purchasing Arrangements

[redacted]

We provide sample VBP Performance Reports in Figures 4.2.2.4-2m of Attachment 4.2.2.4-2.

Conducting In-depth Barrier Analysis to Identify Unhealthy Behaviors and Their Determinants

We will collect, track, and trend Member data to identify healthcare disparities, barriers to treatment, areas of dissatisfaction, and gaps in Provider coverage related to cultural or linguistic representation. We will use demographic data on location, age, ethnicity, race, primary language, disability status, and income level, as well as Member self-reported demographics, SDOH risks, and assessment data to educate Providers on culturally competent communication and interactions. We will compare this data against prior year performance and against regional and national benchmarks, making sure all potential disparities are identified and addressed in our annual QM Work Plan.

We provide a sample of our Health Indexing Report in Figure 4.2.2.4-2n of Attachment 4.2.2.4-2, Sample QM Reports.

We provide screen captures from the SDOH hot spotting tool in Figure 4.2.2.4-2o of Attachment 4.2.2.4-2.

We provide a sample dashboard view of Demographic Predictive Model Trends in Figure 4.2.2.4-2p of Attachment 4.2.2.4-2.

a. Building Reporting Capabilities That Meet MississippiCAN and CHIP Reporting Requirements

We will establish an infrastructure and systems to streamline data analytics and report development to meet Division requirements for the MississippiCAN and CHIP Programs, including the suite of QM reports and tools described in this section. This core set of tools and reports will serve as a starting point for development of the Mississippi-specific capabilities that will enable us not only to meet Contract requirements but exceed them.

Our local leadership will maintain ownership and oversight of all reporting that supports the MississippiCAN and CHIP Programs, implementing a specific local policy and procedure for the development, review, and submission of all Mississippi regulatory reporting. This procedure will assure consistency and accountability in the development and submission of Division required reports by establishing appropriate mechanisms,

processes, methods, and submission practices that will enable us to maintain the appropriate and necessary standards to meet contractual and regulatory obligations.

Our well-established reporting framework will support report accuracy and completeness and include:

- Leadership accountability and oversight of required reporting
- A system that collects, captures, and maintains a comprehensive set of data necessary for report generation and analysis
- A Mississippi Compliance Officer who will manage and monitor the generation, review, and submission of all deliverables and reports to the Division
- The Regulatory Reporting Center of Excellence (COE) that will develop and maintain a regulatory reporting database that captures comprehensive documentation of the contractual and regulatory reporting obligations for the MississippiCAN and CHIP Programs
- Through this Reporting COE, we will have the capability to produce ad hoc, customized reporting to meet the needs of the Division

2. Innovative Approaches to Quality Measurement

A strong data foundation is essential to a successful QM/QI program and the qualitative measurement that underpins it. Based on our affiliates' experience, we will leverage a well-established and technologically advanced data infrastructure that integrates data from internal and external sources across our healthcare ecosystem. Coupled with robust analytics and data science solutions across our organization, we will have advantages that are unique and innovative in the industry. Additionally, our dedicated Mississippi Data Analyst will oversee and drive data-driven decisions that improve our ability to exceed the Division's expectations.

Rather than having a fully centralized analytics organization, with rigidity and uniform perspective, or a decentralized analytics model where efficiency, scale, and coordination are difficult to achieve, we will have access to a hub-and-spoke model that combines the best of each to achieve a proper balance, and to support effective and accurate execution. To support best in class analytics oversight, we will use a uniform data management strategy that consolidates various types of data (such as Member, Provider, claims, and CM) from their source systems to facilitate comparative analytics to be performed across functional areas and by all levels of CCO leadership and staff — making it easy for qualitative measures to be used to identify new initiatives and support innovation. One example of this is the creation of a C-section optimization analytic dashboard implemented across all our affiliates, which has led to the identification of more than 30 potential interventions with a cost of care savings of more than $30 million dollars.

Ensuring Accuracy and Evidence of Program Efficacy

[redacted]

Some affiliate examples of QM program efficacy and resulting improvements include:

- Using text messages, outreach, mailings, telephone contact, and PCP engagement, an ER initiative for an affiliate decreased non-emergent visits by 23% across all ER levels and decreased visits per 1,000 Members by 27%. Visits per 1,000 have continued to decrease during the COVID-19 pandemic.
- Another affiliate used qualitative data analytics, including Population Health analytics and SVI information to identify that Black Members who have diabetes have lower rates of retinal exams, and the SDOH hot spotting tool showed that there were also SDOH barriers. As result of these findings, the affiliate implemented a Diabetic Retinal Exam DRE pilot that combined resources to address both the lack of exam compliance and the transportation disparity resulting in 100% of Providers participating in the pilot program meeting equity goals.

Table 4.2.2.4.C.2-1. lists the attachments included as part of our response to Section 4.2.2.4 Quality Management.

Table 4.2.2.4.C.2-1. Quality Management attachment tracking.

Attachment Number	Title
Attachment 4.2.2.4.A-1	Model Annual QM Program documents
Attachment 4.2.2.4.A-1a	Model Annual Program Description
Attachment 4.2.2.4.A-1b	Model Annual QM Work Plan
Attachment 4.2.2.4.A-1c	Model Annual QM Program Evaluation
Attachment 4.2.2.4-2 (Figure a)	Sample HEDIS Performance Rates
Attachment 4.2.2.4-2 (Figure b)	Sample and CAHPS Results
Attachment 4.2.2.4-2 (Figure c)	Annual Performance Improvement Project Summary
Attachment 4.2.2.4-2 (Figure d)	Grievance and Appeals Data
Attachment 4.2.2.4-2 (Figure e)	Annual Cultural Linguistics and Appropriate Services Evaluation Report
Attachment 4.2.2.4-2 (Figure f)	Interactive Quality Analytics Report
Attachment 4.2.2.4-2 (Figure g)	Sample Population Health Analytics Report
Attachment 4.2.2.4-2 (Figure h)	Sample Segmentation Analysis Results
Attachment 4.2.2.4-2 (Figure i)	Care Management Trends Report
Attachment 4.2.2.4-2 (Figure j)	Sample Predictive Modeling for Optimal Outreach Trends Tool
Attachment 4.2.2.4-2 (Figure k-l)	Sample Member Segmentation Trends and Equity Assessments
Attachment 4.2.2.4-2 (Figure m)	Sample VBP Performance Reports
Attachment 4.2.2.4-2 (Figure n)	Excerpt of Health Indexing Report – Sample QM Reports
Attachment 4.2.2.4-2 (Figure o)	Screen Captures from SDOH Hot Spotting Tool
Attachment 4.2.2.4-2 (Figure p)	Sample Dashboard View of Demographic Predictive Model Trends

Identifying Information. To comply with the Identifying Information requirements defined in Section 1.2.3.3 of the RFQ and subsequent amendments, we removed names of federal and state agencies, Providers, and other stakeholders from our response, except where expressly permitted by the Division. If this information is needed to validate our proposed solutions or evaluate our response, we will be ready to provide it to the Division.

Attachment 4.2.2.4: Quality Management

Attachment 4.2.2.4-1: Model Annual QM Program include the following:

- Attachment 4.2.2.4-1a: Model Annual QM Program Description
- Attachment 4.2.2.4-1b: Model Annual QM Program Workplan
- Attachment 4.2.2.4-1c: Model Annual QM Program Evaluation

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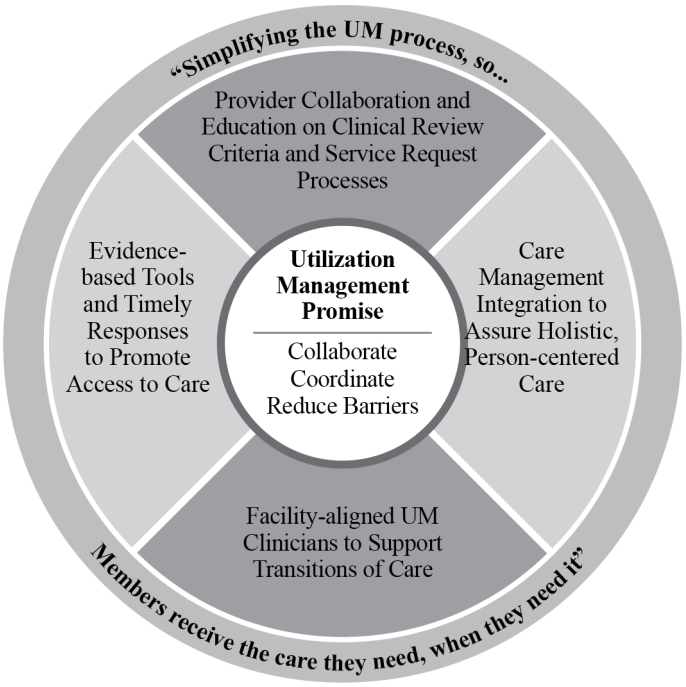
4.2.2.5 Utilization Management

A. Approach

1. Proposed Approach to Utilization Management

As a Coordinated Care Organization (CCO), our local utilization management (UM) program will support timely access to appropriate care, connect MississippiCAN and CHIP Members to Care Management (CM) programs, and encourage health literacy and informed medical decision-making. Figure 4.2.2.5.A.1-1 depicts our promise to simplify UM processes while making sure Members receive the care they need when they need it, through collaboration, coordination, and reducing barriers. Our UM program will be local and tailored to the uniqueness of Mississippi Medicaid and CHIP. With our affiliates combined experience, we bring decades of experience serving millions of Medicaid and CHIP Members, that will be leveraged to help the Division of Medicaid (the Division) build on its vision to improve health outcomes and quality of life for Members while improving cost outcomes for the State. We look forward to collaborating with Providers, the Division, and other CCOs to standardize certain Prior Authorization (PA) requirements, notifications, and clinical documentation as part of our UM program. We will collaborate with and receive feedback on our PA processes and determinations from Providers and bring this feedback to our UM leadership and committees to continually improve our UM program.

Figure 4.2.2.5.A.1-1. Our CCO will implement a UM program that promotes and supports the Division's vision to continue to evolve the CCO program to improve health outcomes and quality of life for Members.



a. Utilization Management Program Description

Our UM program will use PA processes as a tool to remove barriers and facilitate access to coordinated care that is safe, effective, cost efficient, and consistent with medical evidence. The UM Coordinator will use UM program data, trends, and findings to inform our Population Health and quality management (QM) and quality improvement strategies. The UM Coordinator will assure we meet all Division UM contractual requirements outlined in Contract Sections 4.3 and 8.16. We will design our UM program in alignment with our Population Health, Quality, and health equity priorities, which include:

- Prevent and control chronic conditions and improve self-management
- Improve women's access to quality healthcare
- Improve specialty and preventive care for Mississippi children
- Improve health equity by addressing racial and geographic disparities
- Enhance integrated behavioral health (BH) delivery and access across the state

These Population Health priorities support the goals we share with the Division to improve health outcomes and quality of life for Members and lower costs for the State.

Our UM program will incorporate policies, procedures, and processes to meet the UM functions and requirements in Contract Section 4.3. Our UM Program Description will outline the program structure and accountability and include required elements per Contract Section 8.16. We will establish a Work Plan annually specifying our UM program objectives, required internal and external reporting, responsible staff, activities, status, and outcomes. We will conduct an annual UM evaluation that meets NCQA/Managed Behavioral Healthcare Organization (MBHO) requirements, reviewed by our Quality Management Committee (QMC). UM evaluation will include review of our UM Program Description and Work Plan, which we will submit to the Division annually for approval.

[redacted]

Through UM activities, we will connect Members to services that address individualized needs in a timely manner and the most appropriate setting. Our NCQA- and MBHO-accredited UM program will be guided by Mississippi Division-specific policies and nationally recognized medical policies and clinical guidelines, including nationally recognized care guideline criteria for inpatient services, and consolidated in our UM Program Description. Our UM program will be tailored to the uniqueness of Mississippi Medicaid and CHIP and based on decades of experience serving Medicaid Members.

We put Members at the center of all we do. We will partner with treating Providers, considering Members' needs to make sure requested care is timely and appropriate, especially for expedited PA requests. We will review each request individually, connecting Members to our integrated CM program when the information UM Clinicians receive indicates a need for support. These connections are often initiated by clinical information received either in writing or during peer-to-peer conversations with treating Providers. When making medical necessity determinations, we continually consider Members' physical health (PH) and BH conditions, home environments, family and caregiver support and resources, and social challenges, as well as each Member's unique healthcare community.

Whole Person Utilization Management Determinations

We apply person-centered, integrated, and evidence-based principles to our UM approach. ***Our UM team goes beyond traditional UM activities and is woven into the mesh of our Population Health program.*** Population Health is the foundation of our whole person approach in all processes and programs. We support and address Members' diversity, social needs, and individual learning and linguistic needs.

Our UM program considers multiple complex factors when authorizing services, while keeping Members at the center of every UM decision. We will deliver a flexible, Provider-friendly, efficient, and fiscally responsible program. We will consider the Member's home situation and inquire about transfer to lower levels of care, including services in the home and based upon clinical need, to assure safety and support for the Member. When Members are hospitalized, our UM Clinicians will collaborate closely with the Member's Care Manager, with support from the Transition of Care (TOC) team, to increase integration of care. This will be reflected in the Member's treatment plan and aligned with appropriate programs and interventions. Whenever possible and

in collaboration with the applicable facility, the CM team will conduct a face-to-face visit ***in the inpatient setting*** with the Member, their Provider, family, or others involved in the Member's care and support system. In all circumstances, we will consider the Member's home and social supports, particularly during a TOC, to assure safety and necessary supports are in place.

[redacted]

Integrating Our UM Program with Other Functional Units

Our UM program will be an integral part of Population Health and assure Members get the right care, at the right place and time, in the right amount. Our UM team will interact daily with other functional teams who directly support UM activities, such as Claims, CM, Provider Services, Quality, and Member Services. Our teams will come together to drive Population Health in many forums and through ongoing collaborative activities, such as the QMC, Population Health Committee, Clinical Services Committee, Medical Advisory Committee (MAC), and clinical care rounds. Frequent consultation and collaboration with the Division is why our approach to Population Health will work — many team players with diverse roles, backgrounds, and lived experience focused on innovative strategies to support Members while driving healthy behaviors and healthcare resources that add value.

Our UM team will have unlimited access to our local and national Medical Directors for consultation and clinical supervision, as well as "no wrong door to consultations," to enable issue resolution and efficiently get Members the right care. As illustrated in Figure 4.2.2.5.A.1-2, we will integrate our UM program across key departments within our affiliates to make sure all Members receive high-quality care and services that are medically necessary, timely, and based upon individual needs, circumstances, and preferences.

Figure 4.2.2.5.A.1-2. Our UM program includes input from key departments across our CCO for an integrated approach to UM policies and processes.

Integration Across Key Departments and Collaboration with the Division to Assure Delivery of Holistic, Timely, and Quality Care

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- **Care Management.** Our integrated CM team will execute our chronic condition management, CM, and TOC approach. Members may request services requiring authorization through this team, who will route requests to our UM department. UM Clinicians will work closely on PA determinations that need additional clarification, discuss CM needs and gaps, and review alternative services, if appropriate. UM Clinicians will proactively identify Members for CM services, such as those with high service utilization, including ER and pharmacy, and educate and refer Members as appropriate. For example, upon identification that a Member receives a denial of service for inpatient substance use disorder (SUD) benefits, our UM Clinicians will refer to the CM team. We will collaborate to identify gaps in CM programming, based on review of available utilization data, including development of other chronic condition management programs as necessary. Our clinical teams will partner closely with hospital discharge planners and Providers for step-down care and discharge planning.
- **Provider Services.** Our UM Clinicians will work directly with Providers to discuss the PA process, and UM support will be available to Providers 24/7. This regular interaction will allow us to gather valuable Provider feedback for training opportunities, revise our processes to reduce administrative effort, and improve overall Provider experience. We will share data with Providers specific to their PAs and provide technical assistance, such as enhanced training for Providers with high denial rates. Our Provider Experience Consultants will collaborate with UM leadership and will be in the community to support Providers with PA, clinical review guidelines, training, and value-based partnerships. Our UM leadership will collaborate with the Provider Services department when UM processes identify potential network deficiencies or gaps to inform network development strategies.

- **Member Services.** We will provide information to Members on services that require authorization and processes for requesting them through our Member Handbook and website. To assure responsiveness through our Member services call center, we will train our Member Services team on services that require PA. Member Services Call Center Representatives who receive service requests through the Member services call center will route requests to the UM department for processing and document the request in our Core Service Platform (CSP).
- **Grievance and Appeals.** Our Clinical Services Committee will regularly review our UM Appeals report, with details of pharmacy, outpatient, and inpatient authorization denials. The Clinical Services Committee discusses trends, and the Grievance and Appeals Coordinator provides ongoing feedback to the UM team to correct processing errors. If necessary, we will complete root cause analysis for persistent negative trends.

We will obtain Member and Provider feedback through Grievance and Appeals, as well as annual satisfaction surveys, and use this feedback to inform needed changes to our UM processes.

- **Quality Management.** Our Medical Director will co-chair the QMC with the QM Director and assist in identifying gaps in HEDIS® care, mismatches of PA and claims, ER utilization, and readmissions or potentially avoidable hospitalizations in specific geographic areas. We will reduce burden for Members and Providers through policy changes based on authorization trends reported by QM staff to local UM leadership. The QMC will review key topics and data in our QM dashboard, including over- and under-utilization, aberrant Provider practices, Member and Provider satisfaction, and Grievance and Appeals data, as well as develop performance improvement projects to address issues.
- **Claims.** The UM Coordinator and Claims Administrator will work together to audit claims data, assuring Provider payment for services approved through our authorization processes. We will routinely monitor authorizations to identify issues that could lead to a delay or denial in payment, proactively correct issues, and provide training to prevent recurrence. This collaboration is key as it allows end-to-end review of Provider PA requests.
- **Compliance.** Our UM leadership will be part of the local Mississippi Regulatory Compliance Committee and will meet regularly with our Compliance Officer, in accordance with Contract Section 10.2.2. Our UM Coordinator will be responsible for identifying and reporting potential over-utilization of services that may indicate fraud, waste, and abuse (FWA) during daily functioning of the UM department. Our Clinical Services Committee includes participation of our Compliance Officer and Program Integrity Manager, to assure we identify and address utilization that may indicate inappropriate use of services and potential FWA.

We will promote fully integrated and collaborative processes through our Care Management Platform (CMP), which captures service requests and provides UM Clinicians with near real-time information and actionable data critical to making authorization determinations. Member utilization data, such as claims history, authorizations, immunization records, lab results, and care and condition management, are readily available in our CMP, delivering a holistic picture of the individual's service utilization, treatment plan, and gaps in care. Through this system, our CM team and in-network Providers will have the same access and holistic view of Members' electronic medical records, including authorization determinations, to assist with discharge planning, TOC, and supporting Members in the most integrated setting possible.

b. Developing, Implementing, and Monitoring Compliance with Utilization Management Policies and Procedures

Our UM policies, procedures, and review practices will affirm that covered services are medically necessary and not arbitrarily or inappropriately approved, denied, or reduced in number, duration, or scope due to diagnosis, illness, or condition. We will not provide incentives for entities that conduct UM activities to deny, limit, or discontinue medically necessary services. We will require all staff involved in utilization or service authorization decisions to sign an Affirmative Statement regarding compensation, annually.

Developing UM Policies and Procedures

Our process for developing appropriate UM policies and procedures will involve two layers of review and approval. The first layer of review occurs at the national level. Our parent organization adopts and annually updates medical policy, as well as clinical guidelines, with input and approval by all affiliated Medicaid health plans. We will then review and revise these policies and guidelines at the CCO level through our committee structure, which includes practicing licensed clinicians, to assure a flexible, local approach that accommodates our care delivery system, Division requirements, and Members' needs. Both national and local layers of review involve significant input from the Provider community through committee participation, Provider complaints, and interactions with our Provider Services team.

Our UM policies and clinical guidelines will be based on national criteria adopted by our national committee on medical policy each year and undergo a rigorous review process to assure appropriateness in administering MississippiCAN and CHIP benefits. Our Medical Director will oversee development and review of all UM and medical policies and clinical guidelines, and local Providers on our MAC will review, provide input, and approve them before use. We will include adopted medical policies and clinical guidelines in our network Providers' toolkits, which define appropriate treatment and setting and assure consistency of care. In review of medical policies and clinical guidelines through our MAC, we will gather feedback from network Providers and consider individual Member needs as well as clinical and environmental factors.

We will have access to additional resources across the country through our parent organization, including committees that assure our UM program aligns with nationally recognized best practices, as described in Table 4.2.2.5.A.1-1. Our Mississippi Medical Director, BH Director, and Perinatal Health Director will be involved in the activities of these committees, either through direct membership, reporting through other committees, or at the regional or CCO level. The purpose of their involvement in these committees is to incorporate Mississippi specific recommendations and address concerns regarding proposed policy changes. Collaboration of these committees will help us design, inform, and evaluate our overall UM program policies and procedures. The Clinical Services Committee also has alignment and accountability within these committee structures.

[redacted]

Implementing UM Policies and Procedures

Assuring consistent UM policies and procedures implementation and review criteria application begins with our robust UM Clinician training program. UM Clinician training is a continuous process that begins the moment a clinician joins our team. We will leverage a variety of training methods to meet the needs of diverse learning styles and make sure staff can interpret and apply UM guidelines appropriately and consistently. Our licensed UM Clinicians complete a three-week classroom curriculum and two-week preceptor training using relevant modules and in-depth, micro-learning exercises. This includes skill practice scenarios with checkpoints, quick reference guides, identification of available tools and resources, and error and warning messages. This is followed by one to two weeks of on-the-job training under careful guidance of preceptors, managers, and team leads, with Medical Directors available to answer questions. We assure thorough understanding of UM policies and procedures through an additional 90 days of close monitoring. We will provide continuous education for seasoned staff through refresher courses and ongoing review of unique cases.

In addition to specific UM clinical training, we will train all UM Clinicians on whole person health (for example, PH, BH, cultural competency, social determinants, and trauma-informed care). We outline a sample of

training opportunities provided to staff in Table 4.2.2.5.A.1-2. We will assign trainings at regular intervals throughout the year via our internal Learning and Development platform and provide a written training plan to the Division upon request, including dates, subject matter, and training materials.

Table 4.2.2.5.A.1-2. Preparing our UM Clinicians to meet the individual needs of Members.

General Topic	In-depth, Micro-learning Exercises	Specialized Training
• Overview of the Division, Medicaid, MississippiCAN, CHIP, and populations served • Benefits and eligibility • Legal and ethical issues • NCQA and MBHO standards • Medical policies, procedures, and clinical UM guidelines, including making appropriate clinical decisions • PA processes • MHPAEA compliance • Day in the life of a UM Clinician	• System training (CM, PA) • Inpatient daily census • Emergent and planned inpatient admissions • Level of care • Initial length of stay • Continuing and retrospective reviews • Authorization timeframes, based on State and NCQA requirements • TOC planning	• Treating the whole person (PH, BH, pharmacy, dental, Social Determinants of Health [SDOH]) • CM levels • Integrated case rounds • Provider network • Community-based resources, TOC partnerships, and referral reporting • Person-centered care • Trauma-informed care • SUD, including opioid use disorder (OUD) • SDOH, including housing, food security, transportation, and employment; closed-loop referrals and warm hand-off process • Clinical updates • Cultural competency • Health equity in UM

Monitoring Compliance with UM Policies and Procedures

UM performance monitoring is a formalized function within our CCO and will be facilitated through our Clinical Services Committee. UM policies and procedures compliance monitoring will include our annual UM evaluation, Performance Improvement and Enhancement (PIE) program, and External Quality Review Organization (EQRO) evaluations and assessments. Monitoring UM activities will help us identify opportunities for improvement that lead to higher quality services, more efficient operations, and improved Member and Provider satisfaction.

[redacted]

Annual UM Program Evaluation

We will conduct an annual UM evaluation that meets NCQA and MBHO requirements, which our QMC will review and approve. This includes review of our UM Program Description and Work Plan. Our QMC will assess recommendations for policy changes and refer to the national committee on medical policy for consideration.

Performance Improvement and Enhancement Program. [redacted]

[redacted]

EQRO and NCQA Audits Demonstrate Efficient UM Processes

EQRO and NCQA Audit findings demonstrate our affiliates' experience in meeting and exceeding UM turnaround time metrics quarter over quarter for many years. Our UM Clinicians have electronic medical record access to the majority of health systems where we serve Medicaid and CHIP Members, reducing the burden on hospital staff and helping to expedite UM authorizations as well as Care Management engagement in effective discharge planning. In Mississippi, our UM Clinicians will have electronic medical record access for participating Providers.

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[redacted]

c. Services Requiring Prior Authorization

PA is one tool we will use to assure Members receive the most appropriate and highest quality care. We will continually monitor the need to remove or add services to the PA list, to achieve our goal of covering timely and effective services in the most efficient manner. We will follow the Division's Administrative Code for MississippiCAN and CHIP Programs.

Data and Processes

Using our health informatics platform, we will examine claims and utilization trend data, such as top 100 procedures, top 50 denied procedures, and modified requests, along with Grievance and Appeals data and Provider feedback, and will recommend adding or removing services from the PA list to the Division. Our goal is to prevent service delays for Members, promote cost-effective care, and reduce administrative burden for Providers by ***removing PA requirements for services we consistently approve*** that have not been associated with the need for CM or quality of care monitoring. Examples of services that typically require PA are inpatient, transplant, and elective hospitalizations.

We will summarize the number of reviews, approvals, denials, and costs for each service, tracking whether PA is effective, efficient, and economical, and adjust our PA requirements accordingly. We will obtain Provider feedback — through our MAC, peer-to-peer discussions between Providers and Medical Directors, and Provider satisfaction surveys — to improve authorization processes and identify burdensome or unnecessary PA service request requirements. The MAC will consider nationally recognized best practices, as well as Mental Health Parity implications, when determining appropriate PAs.

To assure safety and quality outcomes for Members, ***we may recommend adding services to our PA list that have potential for over-utilization or require referral to CM and care planning***. We will assess trends in utilization patterns of services not currently requiring PA, to identify those that may require further assessment and coordination, reviewing this data with our MAC to determine whether to incorporate them into our PA list or

leverage QM or other interventions. For example, as part of UM oversight and reporting, our parent company evaluated use of presumptive versus definitive drug screens. As a result, our affiliates implemented appropriate UM processes, such as PA for definitive screens, to decrease likelihood of excessive testing. As another example, similar analyses identified some Providers were billing for breathalyzer testing at every visit. After raising this issue, other health plans reported similar trends. Our affiliate approached their state partner, and the code is no longer covered without PA.

Re-evaluation

Quarterly, or more frequently in response to trends or feedback, our Mississippi-based MAC will review processes for handling service requests, accuracy of UM Clinician determinations, data used to assess our PA list as described previously, and Provider feedback to identify opportunities to improve the list of services requiring PA.

d. Developing Utilization Review Criteria

While our utilization review clinical criteria are objective and provide a rules-based system for determining medical necessity (prospectively, concurrently, and retrospectively), our UM Clinicians understand that unique, person-centered circumstances factor into our decisions. ***We will evaluate application of our criteria based on individual Member needs and preferences, assessment of service availability within the local delivery system, and the treating Provider's request.*** We will also consider community-based supports and services to make sure we do not duplicate services.

We will review and update utilization review clinical criteria annually, or more often based on Division requirements or utilization trends. Maximizing appropriate service delivery and minimizing over- and under-utilization is a primary function of our UM program. We will adjust utilization review clinical criteria and clinical practice guidelines (CPGs) upon review of clinical indications for new medical services or procedures and new uses of existing services or procedures. Through a formally scheduled process, we will review and develop medical policy and UM guidelines as necessary.

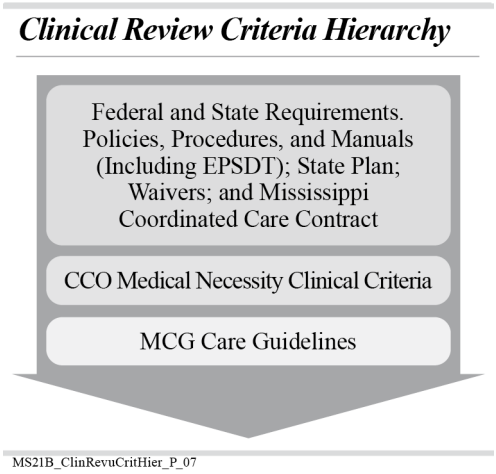
We apply rigorous processes to make sure utilization review criteria are current, best practice, and locally pertinent. As part of our UM clinical hierarchy, we will leverage State and federal guidelines, nationally recognized and evidence-based criteria, best practices, and other decision-making tools to inform our decision-making processes. ***MCG Care Guidelines***® provide nationally recognized, evidence-based, clinical guidelines that support CM across the continuum of care, such as inpatient and outpatient service authorizations, concurrent reviews, and rehabilitation. For specialty services, we will use clinical appropriateness guidelines, supplemented with clinically sound, peer-reviewed, and reputable CPGs developed by organizations such as SAMHSA, American Heart Association, American College of Obstetricians and Gynecologists, and American Academy of Pediatrics. We will use non-customized MCG Care Guidelines uniformly for all populations, in particular acute inpatient, skilled nursing facility, acute inpatient rehabilitation, long-term acute care facility, and BH inpatient.

If medical necessity criteria are not available or not specifically addressed for a service or particular population, we will submit proposed criteria to the Division for approval. We will disseminate changes in authorization requirements in alignment with contractual requirements by delivering Provider notifications, posting changes on the Provider Portal and Member website, and updating Member Handbooks and Provider Manuals. Our Provider Services team will also update Providers through ongoing touchpoints in person or over the phone. In the event a Provider feels clinical criteria used are not current or has additional evidence-based criteria for consideration, they can submit this to our clinical reviewers and Chief Medical Officer. Providers may also submit evidence-based data for our consideration if they disagree with our clinical guidelines.

e. Prior Authorization Clinical Criteria

Ongoing review by our Clinical Services Committee will make sure clinical criteria and guidelines ***are not more restrictive than those of the Division***, and we will only use guidelines approved by the Division. In accordance with 42 CFR 438.210(b), we will actively engage in-network Providers in developing, adopting, and reviewing clinical criteria and CPGs. This includes adherence to requirements set forth in the MHPAEA.

Figure 4.2.2.5.A.1-3. Our clinical review criteria hierarchy guides consistent UM Clinician decision making.



As part of our UM clinical hierarchy in Figure 4.2.2.5.A.1-3, we will rank State and federal guidelines, nationally recognized and evidence-based criteria, best practices, and other decision-making tools to inform our decision-making processes.

- **Mississippi Division and CMS Requirements.** These include, for example, use of a Division-approved, NCQA-compliant Health Risk Screening (HRS) tool, per Contract Section 7.4.3.1.
- **CCO Medical Necessity Clinical Criteria.** These are internally developed guidelines based on national Medicaid guidelines and best practices, local practices, and clinical tools for inpatient, outpatient, and specialty service reviews. Our UM Clinicians apply Mississippi specific policy and community practice guidelines to inpatient and outpatient authorization requests. For example, we will train UM Clinicians who work with SUD admissions on American Society of Addiction Medicine (ASAM) level of care assessments.
- **MCG Care Guidelines.** These guidelines include nationally recognized, evidence-based clinical guidelines that support CM across the continuum of care, such as inpatient and outpatient reviews, concurrent reviews, and rehabilitation, in accordance with Contract Section 4.3.1.1. We will use non-customized MCG guidelines uniformly for all populations, in particular acute inpatient, skilled nursing facility, acute inpatient rehabilitation, long-term acute care facility, and BH inpatient. When population-specific recommendations are warranted, those are detailed in clinical indications and often accompanied by informative descriptions of evidentiary support in the Evidence Summary. Examples include recommendations for certain age groups (for example, pediatric guidelines or BH).
  - **MCG Health, LLC.** We will continue to collaborate with MCG Health, LLC to customize guidelines for Members by integrating MCG guidelines with our medical policies and other evidence-based criteria. Today, we have more than 20 customized guidelines in areas such as general recovery care, BH, inpatient, and surgical care. Each guideline undergoes external review by clinically active experts (board-certified specialist physicians who affirm no financial conflicts of interest) to confirm relevancy and clinical appropriateness, in accordance with the selected evidence and real-world clinical practice.

We will review national utilization reports when available, such as data published by CMS and the Centers for Disease Control and Prevention (CDC), as well as changes in nationally recognized medical necessity criteria. We believe scientific evidence is essential to informed decision-making, and we adopt the best evidence-based practices and criteria. We will provide physician reviewers with online access to a valuable, evidence-based resource used widely in clinicians' day-to-day practice. This resource is especially useful in peer-to-peer conversations as "real-life" applications of reasoning that support our medical necessity decisions.

f. Prior Authorization Requirements Review to Assess Effectiveness and Need for Updates

We will collaborate with the Division and other CCOs toward standardizing certain PA requirements, notifications, and clinical documentation. We will solicit regular Provider feedback to improve our PA processes and identify service request requirements that are inefficient or unnecessary during peer-to-peer discussions. We will formally collect Provider satisfaction data regarding our UM processes, PA, and responsiveness quarterly and annually to inform opportunities for improvement. We will partner with Providers on authorization requirements, recognizing the Provider's vantage point when evaluating Member needs. During interactions with Providers, we will collaborate, solicit feedback on PA processes and determinations, and bring this to our UM leadership and committees. MAC will review PA requirements through our annual UM program evaluation and approve changes, as needed.

Using Admission, Discharge, and Transfer (ADT) Data to Streamline PA

As a CCO, we will integrate real-time ADT data into our system, allowing us to proactively reach out to facilities and populate authorization information upon notification of admission before the facility reaches out to us.

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We will streamline administrative PA requirements where possible, to reduce Provider burden and administrative costs. We will pay careful attention to Provider input about necessity and effectiveness of PA requirements, and systematically track Provider complaints by subject every month as part of our QM program. When there are denials, it is often due to a lack of information, so we will guide Providers to give us all necessary data for approval. QM staff will report trends to CCO leadership on common Provider or service type denials. To the extent there are negative trends (for example, related to volume of denials by service type, Provider complaints by service, or overturned Appeals), we will develop interventions or policy changes to address them.

g. Prior Authorization for Non-participating Providers and Expedited Prior Authorization

PA for Non-participating Providers

We will implement timely UM processes to assure timely Member access to appropriate care, even when provided by a non-participating Provider. A Member may be referred to or receive care from a non-participating Provider if they need medical care only available from a doctor not in our network, or if they are in active treatment with a Provider not in our network when they transition to our CCO. Referring Providers must obtain PA from our CCO before sending Members to non-participating Providers. Non-participating Providers will have access to our UM team for assistance with PA and claims payment processes through our Provider services call center and Provider Services team, who will assist with executing a single-case agreement. We will submit our criteria for authorization and denial of payment to non-participating Providers to the Division for approval per Contract Section 9.1.1.2.

All Providers (referring, treating, non-participating) must enroll with the Division as a Medicaid-enrolled Provider to receive payment for services rendered to a MississippiCAN or CHIP Member. When the treating Provider is not in our network, we will confirm licensure and lack of sanctions, and enter into a single-case agreement. We may recruit the Provider to join our network to improve access, and guarantee the historical rate for at least 30 days, unless the Provider agrees to an alternative arrangement.

When Members transition between Providers, we will facilitate sharing existing treatment plans between Providers. We contractually require network Providers to share treatment plans when they are transferring or coordinating care, to support continuity of care per Contract Section 7.6.

Expedited PA

For situations in which a Provider indicates, or our team determines, that following the standard timeframe could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function, our team will make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires, ***no later than 24 hours after receipt of the request for service***. We will increase the 24 hours

by up to 14 calendar days if the Member or Provider requests an extension, or the team justifies a need for additional information or that extension is in the Member's best interest. We will provide justification for extension to the Division for approval after we have received all medical information to render a decision per Contract Section 4.3.3.

We have experience exceeding state turnaround time (TAT) performance standards for expedited authorizations within 24 hours. ***Across our Medicaid affiliates, our average TAT rate for Emergent and Urgent (expedited) Pre-service authorization determinations is 97.3%.*** The UM team will review our authorization TAT Compliance Report monthly to make sure we meet the Division's required TATs and take quick action when needed.

h. Reducing Prior Authorizations Required

In addition to our annual UM review and evaluation process, we will review PA approval rates to identify opportunities to update our list of services that require PA. Quarterly, we will review PA requirements, trends in approvals and denials, and trends in utilization patterns not currently on our list of services that require PA and incorporate them into our UM program. We will use a variety of mechanisms to identify services we believe no longer require inclusion on the standard PA list for medical necessity determination, including:

- **Provider Feedback.** We will obtain regular Provider feedback through our MAC, peer-to-peer discussions between Providers and Medical Directors, as well as quarterly and annual Provider satisfaction surveys. For delegated UM, we will monitor Provider and Member Grievance and Appeals and UM trends through regular delegation oversight meetings.
- **Data Mining.** We will review PA requirements, trends in approvals and denials of services, and trends in utilization patterns not currently on our list of services that require PA.

INNOVATION

i. Timely Prior Authorization in an Emergency

UM clinical reviewers will be available 24/7 to make determinations for emergency admission reviews post-admission, within 24 hours of request per Contract Section 4.3.2.1. Providers can submit requests 24/7 through our Provider Portal, as well as by phone or fax. Members can call our 24-hour nurse advice line and 24-hour BH/SUD line for urgent consultation. Referral to emergency care will not require authorization.

In an emergency, it is not necessary for the Member or Provider to contact us ***prior to treatment***. While we do not deny claims based on failure to receive notification of emergency services, we encourage Members and Providers to contact us within 24 hours of treatment, so we can support CM and facilitate necessary authorizations for ongoing service or transfers to network Providers. Follow-up activity is based on severity of the Member's health issue.

j. Consistent Application of Clinical Criteria by Reviewers

We will use a tiered approach to confirm consistent application of clinical criteria through our local, highly qualified team of UM leaders and clinical reviewers, and validation of application through IRR audits. Our PIE program audits, integrated case rounds, and comprehensive UM staff training, as described in Section A.1.b of this response, guide consistent application of clinical criteria.

UM Team

Highly qualified healthcare staff with appropriate experience and expertise will conduct our UM program operations and activities. Mississippi-licensed professionals will make clinical determinations on medical necessity and benefit coverage, with physicians involved in any adverse medical necessity determination, per Contract Section 4.3.1.6.

Inter-Rater Reliability Audits

We will conduct NCQA-approved annual IRR audits of all Medical Directors and UM Clinicians to evaluate consistency and accuracy in applying UM criteria and assure we treat Members and Providers fairly and consistently in service delivery. Our audit program will use hypothetical UM test cases or a sample of UM determination files, along with an NCQA-approved auditing method, to evaluate consistent criteria application. Medical Directors and UM Clinicians who do not meet the identified standard will be subject to a Corrective Action Plan (CAP) to bring performance up to plan expectations. Goals of our IRR program will be to:

- Measure knowledge and appropriate decisions based on federal- or State-specified criteria and CCO medical policies
- Minimize variation in application of criteria

- Enhance staff recognition of potentially avoidable or inappropriate utilization
- Identify staff who need additional training
- Identify potential risks resulting from inconsistent application of guidelines
- Identify potentially avoidable or inappropriate utilization, including potentially preventable admissions, readmissions, and ER visits

We will report individual performance and overall UM department IRR results to our Medical Director, UM Coordinator, Clinical Services Committee, and QMC annually. Audits will identify staff who need additional training, as well as opportunities for new training modules or refreshers that would benefit the entire UM team. For example, IRR results clearly identify areas of inconsistent criteria application that require action plans and future training focus. If a clinician falls below our IRR compliance threshold of 90%, we will require additional training and develop an individual CAP to address the deficiency. ***Across our Medicaid affiliates, overall PH and BH UM Clinicians scored an average of 95.5% compliance on 2021 IRR reviews.***

We will also use results from these evaluations to identify opportunities for improvement to our UM processes and workflows, such as developing new training modules or requiring more frequent refresher training. We will communicate process changes to our UM team through the UM Coordinator during clinical supervision, intra-net communications, and ongoing and annual training.

B. Methods

1. Managing Unnecessary Emergency Room Use, Avoidable Hospitalizations, and Readmissions

Our Mississippi-focused UM program will use a tiered approach to manage unnecessary ER utilization, avoidable hospitalization, and readmissions. Through continuous Member utilization data monitoring and predictive modeling, as well as identifying avoidable admissions and readmissions, we will proactively identify trends and opportunities for intervention through our ER Avoidance program and targeted Member and Provider solutions. Our broad array of tools and resources will identify, predict, and track ER utilization and admissions/readmissions, and our CM team will engage Members with education and supportive relationships.

Utilization Data Monitoring and Predictive Modeling

As a CCO, we will use a suite of robust and timely reporting tools to continually monitor utilization ER use, hospitalizations, and readmissions data. We will identify individuals with emerging or high risk of an ER visit or hospital admission with proven predictive modeling tools, and proactively coordinate their services and supports to achieve optimal outcomes. Our ***data mining and profiling*** comprises a comprehensive suite of reports to track and trend utilization, which our ***UM Trends Workgroup***, a multidisciplinary clinical team, will review at least monthly to gauge the impact of our strategies. ***Data mining and profiling*** includes data on ER visits; inpatient admissions and readmissions; medical and pharmacy utilization; follow-up after hospitalization for mental health conditions; and follow-up after ER visits for alcohol or other substance use or dependence. Through ***data mining and profiling*** and the ***UM Trends Workgroup***, we will identify Members with emerging or high risk of an ER visit, avoidable hospitalization, or readmission. Tools we will use in Mississippi include:

[redacted]

- **Real-time ADT Alerts.** We will work to make sure we have access to real-time ADT data to quickly identify ER visits and initiate discharge planning. Our network Providers will have access to ***real-time ADT data through our secure Provider Portal, with accompanying email alerts*** to support coordination of care and authorizations, as needed.

Our clinical teams (UM, CM team, and Medical Directors) can nimbly develop interventions and action plans, collaborating with hospital staff on the Member's care. While continuing UM and CM activities, prioritizing identified outliers can drive better outcomes, such as decreased lengths of stay or a reduced level of medically necessary care that results in lower costs.

Our suite of utilization reporting tools will help us monitor ER use, avoidable hospitalizations, and readmissions; identify opportunities to educate Members; connect them with the appropriate PCP, Patient-Centered Medical Home (PCMH), or Community Mental Health Center (CMHC) region to coordinate care; identify gaps in our network that support the continuum of care (for example, urgent care centers); and pinpoint opportunities to improve communication with Providers. When we identify a significant ER, inpatient, or readmission trend, UM staff will have reporting capabilities to ***drill down to Member-, Provider-, group-, geographic-, service-, and diagnosis-specific utilization***. We will review daily, monthly, and quarterly reports to identify variations by service, Provider type, facility, or conditions and implement interventions to address them.

Identifying Avoidable Admission and Readmission Trends

We will leverage our CMP and proven data-driven analytics and reporting to understand Members' care opportunities and intervene early to identify and reduce the likelihood of inappropriate hospital admissions and readmissions. We recognize early identification of risks due to diagnosis, health conditions, social factors, and historical utilization through timely and actionable data monitoring helps to prevent inappropriate hospital admissions and readmission. PCPs/PCMHs are in an optimal position to use this information, along with their knowledge of Members' care needs and circumstances.

[redacted]

ER Avoidance Program

The goal of the ER Avoidance (ERA) program is to educate Members who frequently use the ER on benefits and healthcare options and make sure they are connected to a PCP/PCMH and receive appropriate assistance in resolving barriers to care. ERA will use predictive modeling around avoidable and unavoidable ER visits and leverage Preventable ER Diagnosis groups to optimize focused CM outreach and education. The outreach strategy may include SMS/text, email, and/or other digital means initially or throughout the program to increase the likelihood of initial and continued engagement. Our ERA program will include targeted educational outreach, complex case rounds, telehealth, TOC program, and numerous Member- and Provider-targeted solutions.

ER Educational Outreach Program

One of our affiliates identified and conducted educational outreach to Members who have not had contact with their PCP or have a PCP but may be at risk for frequent emergencies. Education included reminders to visit their PCP, kinds of conditions typical for urgent care versus emergent care, and where to go for urgent care in their area. We will deploy this successful outreach strategy in Mississippi, using multiple tools to remind Members of our non-emergency resources in Mississippi, such as the ***24-hour nurse advice line, 24-hour BH/SUD line, and urgent care centers***.

Educational Outreach Reduces ER Visits

From 2019 to the second quarter of 2021, our affiliate successfully reached approximately **70,000 Members** and decreased PMPM spend for non-emergent visits by **23%** across all ER levels. Prior to COVID-19, we had seen visits per 1,000 decrease by **27%**, and visits per 1,000 decreased another **27%** after COVID-19.

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Connecting Members to Their PCP/PCMH

Through annual program reassessment, our affiliates have found that Members with 2 to 15 ER visits per year often decrease ER use if given specific prompts to keep them engaged with their PCP and treating Providers. For these Members, we will send reminders for well-visits, flu shots, and text messages about how a PCP/PCMH can help them (for example, allergies or earaches).

Complex Case Rounds

Our multidisciplinary team will analyze Members identified through predictive modeling with emerging risks. Care Managers solicit feedback and expertise through routine meetings with experts from a variety of disciplines, including our Medical Director, BH Director, Perinatal Health Director, and UM Clinicians. Care Managers will discuss Member needs, seek guidance to resolve challenging coordination of care issues, and break down barriers across systems of care. The team will meet biweekly and review identified Members with the task of assuring Members receive the right level of care, in the right setting. For example, Members identified as high risk for potentially preventable events due to BH and SUD conditions, or multiple psychiatric admissions in the month prior, will be reviewed in our biweekly integrated multidisciplinary rounds. [redacted]

Telehealth

Our telehealth policy and solutions will support Members to better manage care by meeting them where they are. This improves access to preventive care for all Members and reduces the need for emergent care and likelihood of readmissions. Our telehealth policy, which we will submit within 60 days of award, will address Contract requirements, such as allowable billing practices and how our Member and Provider education approach supports telehealth service delivery. Our telehealth policy and solutions will address health disparities, especially those in rural areas, through improving access to preventive care for all Members. We will empower Members to access care in the form most convenient for them. We will educate Members on the availability of telehealth through their PCP/PCMHs and other Providers, while equipping Providers with tools to successfully offer virtual visits. [redacted]

Transition of Care

Our UM Clinicians will work closely with hospital staff and Care Managers to review and authorize continued stay reviews within 24 hours, per Contract Section 4.3.2.4. We recognize one key to reducing readmission and continued inpatient services is coordinated transition management and follow-up. We will connect Members to care, support, and needed resources, and make sure they clearly understand their discharge plan, risks, and

medication directions to prevent a return to the hospital, so Members can recover at home in their own communities.

Through a joint UM/CM collaboration, we will engage hospital discharge staff within 48 hours of admission (or our notice of admission) to begin discharge planning discussions. Our fully integrated ***TOC program*** will be available for Members in an inpatient setting, in accordance with Contract Section 7.8.5. A Care Manager will contact the Member prior to discharge, or within 72 hours following discharge, and engage them in a minimum of weekly calls for the first 30 days. Where applicable, our on-site Care Manager will meet face-to-face with the Member while they are inpatient to start discharge planning and connect them with the TOC management program. Our interdisciplinary TOC team, comprised of Care Managers, CHWs, CMNs, and a Diabetes Educator, will work closely with our UM staff and Medical Directors to thoroughly monitor care for Members as they transition between care settings. UM Clinicians will conduct continued stay reviews, considering Members' needs and working closely with hospital staff and the TOC team. They will verify needed authorizations are in place and help the Member transfer medical records, medication information, and other pertinent data to their PCP/PCMH or specialist, upon discharge.

Member-targeted Solutions

We will use multiple Member-targeted solutions to manage unnecessary ER utilization, avoidable hospitalization, and readmissions, as described in Table 4.2.2.5.B.1-1.

Provider-targeted Solutions
We will use multiple Provider-targeted solutions to manage unnecessary ER utilization, avoidable hospitalization, and readmissions, as described in Table 4.2.2.5.B.1-2.

We look forward to bringing our ERA program, with meaningful, targeted Member and Provider solutions to Mississippi, to address inappropriate and high ER utilization, avoidable admissions, and readmissions and improve the health and well-being of Mississippians.

2. Cooperating with Hospitals Post-discharge

Our ***CDT Consultants*** will collaborate with hospitals to develop their capabilities and improve program performance, facilitating progress along the VBP continuum to help hospitals prepare for risk, per Contract Section 8.8. Through our dedicated CDT approach, we will offer resources, tools, and supports that enable hospitals to advance along the VBP continuum as they mature and build appropriate capabilities. We can design our VBP arrangements with hospitals to include metrics that further incentivize and fund efforts to reduce PPHRs, enabling hospitals to meet their QIPP metrics.

Our CDT approach will support our hospital partners through technical assistance, practice transformation consultation, and interpretation of regular hospital-specific cost and quality data and reports for cost of care and quality opportunities. CDT will also help Providers understand how they are performing in their respective VBP program and how process improvements could help them achieve additional incentives. We can share this data with the Division to inform and support the QIPP. CDT supports implementation of Population Health and CM strategies and identifies action plans for hospitals to improve cost, quality, and patient experience. CDT Consultants will also lead design and development of community learning forums, so hospitals can learn from one another and national experts.

TOC Team Collaborates with Hospital Discharge Planners

We know from decades of affiliate experience serving Medicaid Members that the most efficient and effective way to coordinate discharge planning for Members is for Care Managers ***to partner with hospitals and facilities***. By working with hospital staff and discharge planners, our fully integrated ***TOC team*** will gain direct knowledge of treatment provided in the hospital and post-discharge recommendations, access the medical team serving the Member, and benefit from near real-time information from the medical record. The TOC team will engage with the Member and family, achieving a deep understanding of issues that may affect a successful transition home or to another setting. By building close working relationships with discharge planners and other hospital facility staff, our TOC team will become an extension of their discharge team, reduce duplication, and contribute to an environment of collaboration. The team will participate in discharge planning, make recommendations for appropriate services upon discharge, coordinate authorization reviews, share information with hospital staff, and arrange for Members to receive follow-up services and supports post-discharge.

Supporting Members Post-discharge

Upon admission or notification, and for at least 30 days following inpatient admission, our TOC team will provide additional support for Members identified through daily review of hospital census data, ADT data, discharge risk assessment, or a BH inpatient admission who has recently left the hospital or rehabilitation facility. Our established practices, developed through our affiliates' Medicaid managed care experience in several states, will help minimize Member readmissions. The TOC team will help the Member and family, or caregiver, understand discharge plans, current medication lists, transfer plans, and

instructions. TOC team members will reach out by telephone to all Members in Low-Risk or Wellness/Prevention levels within 72 hours of discharge to make sure they understand post-discharge instructions and assist with referrals, follow-up appointments, and accessing medications and transportation. For the higher TOC level, a local Care Manager will contact the Member/caregiver prior to or within 72 hours of discharge from a hospital or other inpatient facility. Following discharge, the team will contact the Member to confirm safe transition, verify that in-home services are in place and satisfactory, remind of upcoming appointments, and address attendance barriers.

[redacted] Following discharge from an inpatient setting, the TOC team will continue close communication with the Member and family or caregivers at a level based on the Member's needs to identify and address any barriers they may face in engaging and participating in services and supports identified in the discharge plan. They will also identify opportunities to use telehealth as part of the discharge plan, which is often more convenient for Members, and may decrease readmissions.

3. Identifying and Addressing Over-and Under-Utilization

We will use data analytics through our health informatics platform, tools, training, and innovative initiatives to identify and address under- and over-utilization of services and assure Members get the right care. Daily and ad hoc multidisciplinary rounds, including CM, UM, dental, and regional coordinators, will discuss and address individual Members' circumstances. As described in detail in Question 1 of this section, we use predictive modeling to proactively identify likely inpatient cost outliers early, allowing us to address potential barriers and improve Member outcomes. We enhance our collaboration with the identified facility to avoid poor Member outcomes and reduce length of stay.

Our Data Analytics and Tools Inform Appropriate Use of Services

We will use data to support our complete operation and business approach. We will bring data to life through analysis and acting on findings. Data and analytics are key to identifying over- and under-utilization, as well as potential FWA related to over-utilization. We will gather utilization data in our CSP, which contains all Provider, Member, claims, and authorization data that enables us to stratify utilization by subpopulation demographics, service types, geographies, and priority areas. Our integrated data warehouse stores this information, as well as utilization data from our subcontractors, to support data control and consistency. We will incorporate this into our CMP within Members' personal health records. This will provide a complete and holistic view of Member and Provider trends that support comprehensive analysis and review.

Our [redacted] will review the internal UM daily report with our UM Clinicians and Medical Directors. The UM daily report aggregates and displays utilization data from the data warehouse in easy-to-read visual displays and enables UM staff to pull utilization variables into standard and ad hoc reports that facilitate close analysis. Through this daily UM activity, we will identify trends to detect and correct potential under- and over-utilization of services and refer cases of suspected inappropriate utilization to our ***Special Investigation Unit (SIU)*** for further investigation of potential FWA. We will use the Division's PBA claims data, in addition to other available resources, to monitor Member utilization and Provider prescribing patterns of controlled substances and other drugs. Through our annual UM evaluation and ongoing UM monitoring, including review of codes for PA, we will identify Provider trends indicative of potential over- and under-utilization for intervention.

Our suite of utilization reporting tools will help us look for opportunities to direct Members to appropriate utilization, identify network gaps, and pinpoint opportunities to improve communication with Providers. If we identify any significant over- and under-utilization trend, UM staff will have additional reporting capabilities to

drill down to Member-, Provider-, group-, geographic-, service-, and diagnosis-specific utilization. We will review our daily, monthly, and quarterly reports for variations by service, Provider type, facility, or conditions, and trigger interventions.

For example, we will use a readmissions report to identify trends in readmission rates. If we identify unexpected variation, such as an increase from the prior month, we drill down to identify Providers with higher-than-expected readmissions and may discuss placement of a Care Guide to support discharge coordination and follow-up appointments. For example, our affiliate placed Care Managers in a hospital NICU to offer CM for parents, assist with discharge planning, link to resources, and reduce readmission rates. [redacted]

Incorporating UM into Quality Improvement

Our UM program informs our Population Health and QM strategies. When aggregate patterns of over- or under-utilization present, the Clinical Services Committee will report results to the cross-functional QMC. The QMC will review inpatient bed day trends; outpatient utilization; PIE audit results; CM outreach and enrollment; ER utilization for preventable conditions; and the number of Members admitted to or discharged from the Coordinated Services program. Representatives from our clinical, CM, and QM areas will work with our Medical Director and discuss intervention strategies to reduce over-utilization and improve under-utilization, consistent with clinical and quality indicators.

Helping Providers Operating Outside Peer Norms

We will monitor Providers' compliance with our UM clinical review criteria and CPGs by reviewing and trending performance over a six-month or shorter period. We will assist Providers identified with utilization patterns, prescribing patterns, and quality or safety of care outside peer norms through training and technical assistance, in addition to reporting these Providers to the Division. Our Medical Director and Provider Services Manager will review identified cases with the QMC and, if appropriate, develop an action plan with the Provider, referring to our SIU if we identify possible FWA. The action plan will begin with a peer-to-peer discussion between the Provider and a Medical Director. They will discuss pertinent medical policy and clinical guidelines in the context of case examples where we have concerns about potential over- or under-utilization. We give Providers an opportunity to explain circumstances that may be unique to their practice or the geographic area they serve. We will share information with the Division and Credentialing Verification Organization as requested, related to Provider performance and progress reports for consideration in the recredentialing process. We will consider this information to determine if the Provider should remain in our network.

Member Interventions to Address Under-utilization

Members may be at risk for or currently not getting the care they need, such as service needs identified through EPSDT and early childhood intervention screenings. When our health informatics platform identifies Members with gaps in care, we will connect them to resources across our parent company and its affiliates, including their PCPs, PCMHs, and appropriate supportive services to help Members overcome social and functional barriers that impact their health. Through our CM model, we will provide assessment, care planning, and Member education, or other specialized clinical programs tailored to their individual needs. We will proactively identify trends of under-utilization of services in aggregate, by service type or geographic location that may indicate systemic access to care barriers or Provider and Member education needs. Once identified, our UM Manager and QMC will assess root cause of under-utilization and develop proactive interventions to make sure Members access necessary care, such as our Immunization Strategy discussed later in this section.

[redacted]

Our multi-faceted Immunization Strategy is another example of how we will identify and address under-utilization of needed services for Members. During the COVID-19 pandemic, Well-Child and Well-Adolescent visits and immunizations declined dramatically, increasing the risk of developing preventable diseases. Our affiliates quickly mobilized to increase outreach efforts and assisted with getting Members into care to receive vaccinations.

Member Interventions to Address Over-utilization

We understand Medicaid Members may have significant barriers to care that can lead to inappropriate or overuse of services. For example, Members with avoidable ER use for dental issues will receive text messages discussing appropriate use of the ER and whom to contact for help with their dental care needs. Pregnant Members who are high risk will have access to a digital program that connects them with their OB Care Manager for as-needed support.

We take a data-driven and community-based approach to identifying and addressing Mississippi specific health needs and disparities. We will identify and engage Members indicating inappropriate utilization with a multipronged approach focused on prevention, identification, and intervention combined with Provider engagement and a wide variety of accessible alternatives to emergency care. We track progress in holistically addressing Members' needs, reducing under- and over-utilization of services, and improving Members' experience of care. Our suite of utilization reporting tools supports ongoing monitoring and evaluation of ER and hospital use. We will identify individuals with high ER and hospital use through the following:

- Review of HRS, CHA, and other assessment tools results to identify Members with special healthcare needs and frequent ER visits
- Review of our CMP, which provides service utilization history in an easy to view format that includes ER utilization
- Review of our daily census, which includes ADT data and direct inpatient feed information regarding hospitalizations and ER visits
- CM staff who have frequent contact with Members and are often contacted first by the Member, family, or caregiver
- Notifications of ER use from our 24-hour nurse advice line and 24-hour BH/SUD line clinicians
- We will train Providers and provide methods to notify us when Members on their panel use the ER

- Continuous claims data monitoring for ER visits

When we identify a Member with over-utilization of ER services, our CM team will conduct outreach to the Member to discuss precipitating circumstances and complete an HRS or other condition-specific assessment, if necessary. The CM team will talk with the Member about alternative options in their area, such as urgent care or telemedicine, and share information on the benefits of our CM model to address SDOH and other factors contributing to ER use. Our mobile health app digital health home will provide Members with interactive resources that help them make appropriate decisions about the need for ER services. Members will also receive interactive text messages about appropriate ER use, including specific texts for follow-up after alcohol-, SUD-, or mental illness-related visits.

4. Analyzing Pharmacy Utilization Patterns

We understand the Division will use a PBA to administer covered outpatient drug benefits for Members. We will fully cooperate with the PBA for pharmacy administration as directed by the Division per Contract Section 4.4.4, including PBA payment, use of claims data in our CM program, and provision of Physician-Administered Drugs and Implantable Drug Systems to Members. We will employ a Mississippi-licensed Clinical Pharmacist to coordinate with the PBA and oversee our pharmacy clinical quality programs.

Pharmacy Clinical Quality Programs

[redacted]

5. Medication Continuity of Care

Ensuring Medication Continuity of Care Upon Enrollment

Upon notification of initial and ongoing enrollment of new Members, the CCO will coordinate with the transferring CCO to obtain pertinent information to assure continuity of care, per Contract Sections 4.3.1.3 and 7.6. Our CM team, in collaboration with our Clinical Pharmacist, will coordinate with the PBA to make sure there is no disruption to Members' medications when transitioning from another CCO.

We will engage Members and encourage them to complete their HRS upon initial enrollment in our CCO, per our Division-approved script and in accordance with Contract Section 5.1.4. We will send each Member or caregiver a printed copy of the HRS in our Member Information Packet, sent within 14 days of notice of enrollment, per Contract Section 3.2.6. Our trained, culturally competent call center staff will make at least three attempts to contact Members telephonically to welcome them to our CCO and assist them with completing the HRS. Members can also access the HRS "on demand" via our secure Member Portal, as well as a link in Member written materials. Our team will also email Members a link to the HRS based on their preference. Through the HRS, we can quickly identify Members with chronic conditions and/or ongoing medication needs and refer them to our CM program. The CM team will work with Members to address barriers and make sure they do not experience disruption in medications. [redacted]

We will incorporate all existing pharmacy information provided by the Division, PBA, or the Member's previous CCO into our integrated CMP, so we are able to support Members at enrollment and throughout their participation in our CCO. Our CM team will review existing PAs and treatment plans to identify and honor existing authorizations, in accordance with the Division's requirements. We will communicate this to Members through the Member Handbook, Member Portal, and Care Managers in our CM program.

Ensuring Ongoing Medication Continuity of Care

As described in our response to Question 4, we will implement multiple pharmacy clinical quality programs to promote the best health outcomes for Members using medications. Timely pharmacy claims data from the PBA will be critical for helping Members adhere to prescribed medication regimes and manage chronic conditions. We will feed received pharmacy claims data into our predictive modeling, risk stratification, and HRS processes to identify Members with complex needs who require ongoing medications.

Our CM team will be available to assist Members to coordinate with the PBA, their prescribers, and chosen pharmacy for all medication authorizations. Our CM team will assist with medication reconciliation as needed during implementation and transition, complex case rounds, and discharge planning for Members at higher levels of care. Our coordinated discharge planning and post-discharge supports make sure Members' prescriptions are in place prior to discharge and address barriers to care, such as transportation to the pharmacy.

Procedure for Formulary/Preferred Drug List Changes

We understand the Division may make periodic changes to the Division's Preferred Drug List (PDL). Our Clinical Pharmacist will monitor the Division's PDL, to which we will provide a link on our Provider Portal, per Contract Section 5.8.4. Our Clinical Pharmacist will work with Providers and our CM team regarding changes to the PDL that may impact Members' prescribed medications.

Identifying Information. To comply with the Identifying Information requirements defined in Section 1.2.3.3 of the RFQ and subsequent amendments, we removed names of federal and state agencies, Providers, and other stakeholders from our response, except where expressly permitted by the Division. If this information is needed to validate our proposed solutions or evaluate our response, we will be ready to provide it to the Division.

[END OF RESPONSE]

4.2.2.6: Information Technology

A. Claims Processing

1. Claims Processing System Overview

Our Coordinated Care Organization (CCO) will use best-in-class technology and skilled employees who specialize in Medicaid managed care to deliver prompt and accurate claims payment. Timely and accurate claims adjudication is critical to Provider financial stability, particularly for smaller Providers, such as Rural Health Clinics, Federally Qualified Health Centers, and all Providers serving the MississippiCAN and CHIP Programs. Our claims system will pay Providers timely and support the high standards established by the Division for claims processing.

a. Systems Diagram Describing Components of the Claims Processing System

Our claims adjudication system will be configured to support the high standards established by the Division for claims processing in accordance with Contract Section 9. In 2021, our parent company's system processed more than [redacted] Medicaid physical health (PH) and behavioral health (BH) claims across the country. We closely monitor the claims payment lifecycle, paying claims for covered services quickly and correctly. As required under 42 CFR § 447.46, we will pay at least 90% of all clean claims, as defined by 42 CFR § 447.45, for covered services within 30 calendar days of receipt. We will pay at least 99% of all clean claims within 90 calendar days of receipt, except to the extent an alternative payment schedule has been agreed to in the Contract.

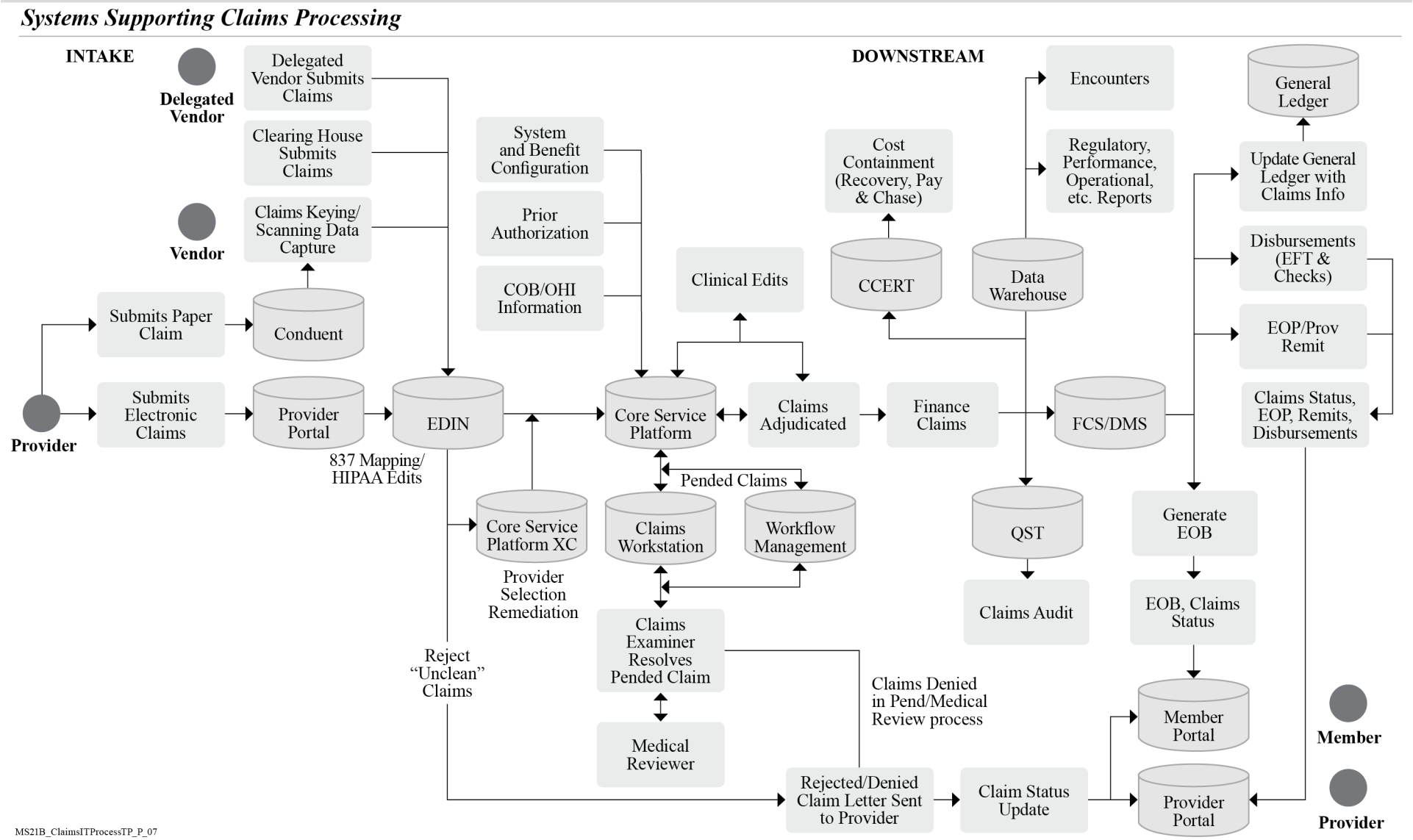
This record reflects that we have the capabilities to maintain high standards in claims processing. Our affiliates' quick turnaround time for claims payment (eight-day average for the last four quarters) and their longstanding history of claims adjudication accuracy [redacted] supports our capability to meet our obligations under Contract Sections 9.1.1 and 16.11. In accordance with Contract Section 9.1.3, we will follow all Division guidelines for payment of inpatient hospital services for all enrolled Members using the same mapper and grouper version, healthcare-acquired condition utility, Never Events, and inpatient payment parameters as used by the Division for other Medicaid Members.

We will notify Providers of claim status (for example, pend, deny, or other reason), and if applicable, an explanation of payment with a reason the claim cannot be paid within 30 calendar days of the adjudication of the claim. We will pay all other claims, except those from Providers under investigation for fraud and abuse, within 120 calendar days of the date of receipt.

We will process claims in our Core Service Platform (CSP), a key component of our HITRUST-certified and HIPAA-compliant Medicaid Management Information System (MIS), which seamlessly integrates with other components, including the Member Portal, Provider Portal, our Care Management Platform, and reporting data warehouses. We will perform updates to this data through the user interface or application-specific data loads, such as ANSI X12 837 (837) claims transactions and processing X12 834 Enrollment and eligibility files received. We will apply extensive edits and validations to verify data entering the system is complete and accurate to assure reliable information for use in Division and other processes and reports, especially encounter data management.

In addition, our ***Claims Administrator***, will be a primary contributor to the development and administration of monthly education and training regarding claims submission and payment processes we will offer to Providers in the first 12 months of the Contract. Figure 4.2.2.6.A.1-1 highlights each component of the claims processing system and the interfacing or supporting systems we use to assure compliance with Contract requirements.

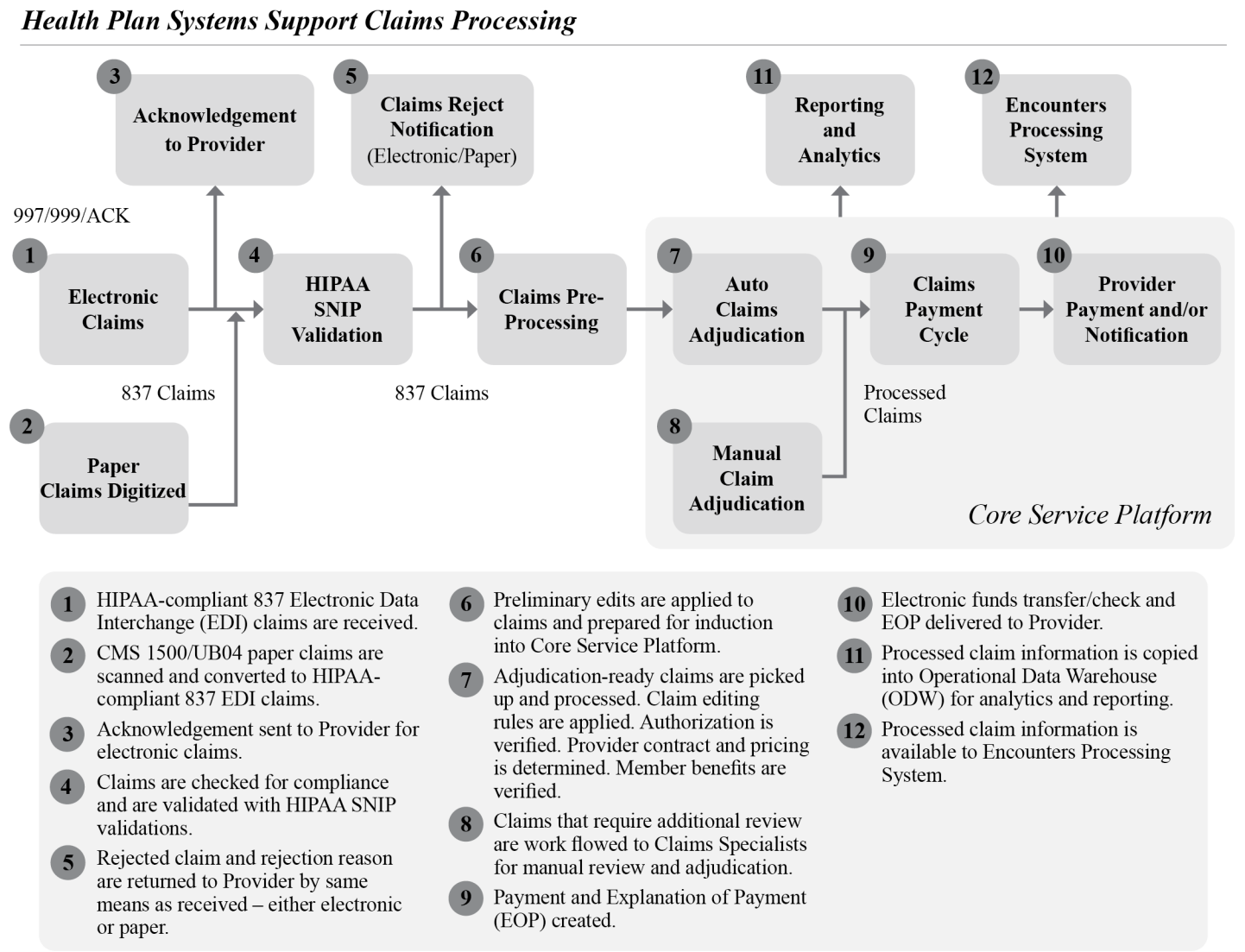
Figure 4.2.2.6.A.1-1. Key systems that support claims processing.



b. How Claims Processing Components Support Program Functional Areas

Our claims processing system collects, processes, integrates, and stores data on all health services delivered (including PH, BH, and medical supplies) using standard HCPCS, ICD-10-CM, and revenue codes. Our claims process, from claims intake through payment, includes controls that validate and account for all claims submitted to support all major functional areas of the Mississippi Medicaid Coordinated Care program. The information we collect, process, and store is available to call center reps in real-time and available for enterprise reporting. Figure 4.2.2.6.A.1-2 depicts our overall claims process flow.

Figure 4.2.2.6.A.1-2. Claims processing flow supports all functional areas of the MississippiCAN and CHIP programs.



Processing Claims. We will adjudicate claims to final status (payment or denial) within timeframes specified by the Division and provide daily updates on claims activity. We respond to 276 Electronic Data Interchange (EDI) transactions with a complete HIPAA-compliant 277 transaction. This provides claim status information (paid, denied, or pended) or remittance advice to the Fiscal Agent (FA) within 30 calendar days of receipt.

Comprehensive Claims Edits. Our claims processing system supports comprehensive claim edits, including enhanced clinical edits and National Correct Coding Initiative (NCCI) edits. This checks each claim for codes

subject to unbundling or Medically Unlikely Edits, identifying codes that may be incompatible with these standards. We incorporate edits that support MississippiCAN and CHIP Program requirements, including edits that verify timely, accurate, and complete encounter records. The system validates that required data elements are present and match allowable values. It verifies Member eligibility, service coverage, required attachments, and Prior Authorization.

Subcontractor Claims Processing. We will delegate claims processing for dental and vision services to our Division-approved subcontractors. We will require all entities to which we delegate claim payment to comply with statutory claims processing and Mississippi Medicaid Contract requirements and timeframes for processing clean claims. When we delegate claims payment to Subcontractors, we will maintain the same commitment to quality as if we processed the claims in-house. For this reason, we will require that all entities to which we have delegated claims payments:

- Submit all adjudicated claims (encounter) data weekly to allow for review before being included with the claims from our CSP on the next encounters submission to the Division.
- Submit monthly encounter data and claims processing performance metrics that demonstrate compliance with all CCO, State, and federal requirements.

Claim Payment Disputes. While we will focus on proactively identifying and correcting issues before they affect claim payment, we maintain a robust Provider dispute process available to all Providers when they believe we have incorrectly processed their claim. Our claims dispute process is the same for in- and out-of-network Providers. We will provide detailed information on our claims dispute process in our Provider Manual, posted on public pages of our Provider website. Our remittance advice will available to Providers electronically (via our Provider Portal or their clearinghouse) or on paper and includes instructions on how to file a claims dispute within the designated timeframe.

We will provide an electronic copy of an Explanation of Payment (EOP) letter to each Provider for which we have denied the coverage of a procedure that was ordered or requested by the Provider on behalf of a Member. The EOP explains the reasons for the denial of coverage of the procedure and the name and the credentials of the person who denied the coverage. After we have denied coverage for a claim submitted by a Provider, within 60 days, we will issue to the Provider a final ruling of denial of the claim that allows the Provider to have a State Fair Hearing and/or agency Appeal with the Division.

2. Modifications or Updates to Claims Processing System to Meet Program Requirements

Our Mississippi CCO will assess the benefit configuration requirements versus our current configuration and update the system as needed to meet the requirements of this program and the Division. Our claims processing system will be ready on day one of this Contract to support MississippiCAN and CHIP operations to process claims consistent with timeliness and accuracy requirements identified in this Contract. System updates will be completed within 60 calendar days of notice by the Division. Our claims processing and information retrieval systems will comply with all components of 42 CFR § 433.116.

3. Claims Processing Operations

a. Claims Processing Systems That Will Support the Program

Our CSP will collect data on all services furnished to Mississippi Members. We will capture and adjudicate medical claims by integrating CSP data with electronic document imaging, a workflow management system, and electronic claims solutions. This leads to higher rates of auto-adjudication and faster, more accurate claims turnaround and Provider payment. For paper claims, our Document Services team batches, scans, and exports the files for data entry each production day. After we perform quality checks, we create 837 claims data files for processing. We will report these as encounter data to the Division following the 837 post-adjudicated claims data reporting standards for encounter data submissions. Our systems will combine all claims and adjustment data processed, including claim data from subcontractors. We use control totals to validate that CSP and

subcontractor claim records load properly for processing. Our local Member Encounters Data Manager will oversee the entire encounter process lifecycle, from data collection to the creation of an encounter submission and receipt of encounter status.

Coordination of Benefits with Third-Party Liability (TPL). We will actively seek and identify third-party resources, including Medicare coverage, other health insurance (OHI) coverage, and other liable third parties. We will identify Medicare and OHI coverage through multiple avenues, including:

- TPL information maintained by the Division's FA
- Providers indicating this information on or with claims submissions
- Vendor partnerships for acquisition of Medicare and OHI information
- Claims data mining processes performed on all inbound claims
- Daily Medicare, OHI, and TPL leads received throughout the company from Members, Providers, and internal Member Services and Care Coordination staff

Integrating Cost Avoidance with Claims Adjudication. Our claims processing system is fully integrated with our TPL process to capture OHI information contained on the claim and evaluate OHI information stored in the Member's electronic record. Our claims process effectively supports cost avoidance by automatically applying edits during adjudication to identify potential overpayments, based on current alternate insurance information on file. We will provide the Division with TPL information weekly, including a change file based on reconciliation with the Division's data.

b. Standards for Speed and Accuracy of Processing

Our claims processing system complies with all components of 42 CFR § 433.116 and has the capability to accept claims history data from the Division or its Agent. Our claims processing system uses automated workflows to manage the steps required to auto-adjudicate a claim. Auto-adjudication leads to faster and more accurate Provider payment and supports complete and accurate encounters reporting.

We quickly capture and adjudicate claims with minimum manual intervention by combining our core claims transaction platform with electronic document imaging and a workflow management system that includes an integrated rules engine. This additional layer of processing expands capabilities of our core claims system and increases volume of claims processed through automation. Our process includes initial HIPAA compliance and completeness validation and validation software that automatically and comprehensively audits codes before each claim is paid. We maintain an image of each electronic claim in our document management system; this facilitates adjudication and research tasks.

Claims Payment and Prompt Payment Guidelines. We will configure our claims adjudication system to support the high standards established by the Division. [redacted] Our claims processing system supports prompt payment using automated workflows to manage the steps required to auto-adjudicate a claim. This maximizes speed and efficiency of the claims process. Under the new Contract, we will implement daily payments Monday through Friday, which will further maximize speed and efficiency.

A claim moves automatically through the system based on status at points in the process, minimizing manual work. When manual intervention is required, workflows automatically route claims to queues and analysts skilled in addressing the specific edit. Our local, dedicated Claims Administrator and Member Services Manager will closely monitor the process to assure we are adjudicating and paying claims in a timely manner. There are several checkpoints with service level agreement reporting throughout the claims workflow to provide insight into process timeliness. The system sends immediate feedback on EDI claims that have successfully

loaded into the CSP and can track claim movement from adjudication to payment through reporting and workflow queues.

On a quarterly basis and according to timelines established by the Division, we will submit prompt pay reports. In accordance with Contract Section 9.1.1 and 42 CFR § 447.46, we will measure and comply with prompt payment standards by claim types and pay or deny all submitted clean claims for both in-and out-of-network Providers — at least 90% within 30 calendar days of receipt and 99% within 90 calendar days of receipt.

c. Process for Dealing with Discovered Compliance Issues

Our process for managing compliance issues in an expedited manner includes routing claims that meet the criteria of the issue for manual review prior to payment. This minimizes the impact of the issue while we work quickly to correct it and often helps to identify the root cause of the problem, accelerating resolution timeline.

When we identify a systemic issue within our own processes, we will implement a fix, identify, and reprocess affected claims. We will alert the Provider Experience team so they can inform Providers that a remedy is forthcoming and that they do not need to file disputes. In addition to contacting individual Providers or facilities, the Provider Experience team will leverage relationships with Provider associations to quickly disseminate information on an issue that might impact a specific Provider type.

If the Division applies billing changes, we will work to update our claims processing system to meet the effective date. If the changes are retroactive, we will perform a mass adjustment of impacted claims back to the effective date. We will process them as an adjustment to the existing claim with the Provider receiving (or owing) the incremental change in rate. We will follow all State and federal laws, rules, and regulations regarding reimbursement and in accordance with Contract Section 9.2.

Our local team will collaborate with the national Internal Resolution Unit (IRU) to identify configuration and process issues that may impact claims processing accuracy. IRU staff will determine if we paid a claim appropriately based on business rules, Provider contract, plan benefits, and federal and State regulations. When the IRU identifies a potential Provider- or system-level claims issue, they will route the information to the appropriate department (such as pricing configuration or front-end claims editing) and track the issue to resolution.

Our Claims Operations team will monitor claims processing accuracy daily using a variety of processes, including:

- Claim audits with an emphasis on hot spots
- Tracking key performance indicators (KPIs)
- Monitoring scheduled and ad hoc reports

We will use established systems and tools to monitor KPIs — including claim aging, denial rates, and other trend data. Claim aging and denial reports are a standard part of our claim operations. Our Operations team will monitor daily claims processing metrics using these reports and drill down to individual claim detail to identify and address issues that are slowing down claim processing or increasing denials.

We maintain written policies and procedures for Providers to Appeal claims denials. We will provide specific reasons for a claims denial so that the Provider may address all known issues with the claim at one time. For example, “The submitted procedure is disallowed because CMS indicates that this procedure is always bundled when billed with any other procedure.” This includes nearly 500 edits and denial codes that affect Provider claim denials.

If a claim is partially or totally denied on the basis the Provider did not submit the required information or documentation with the claim, then our Denial Notification will specifically identify this information and documentation. Providers will receive an acknowledgment letter to let them know their dispute was successfully submitted, and they are provided with the turnaround time the Provider should allow for a response. We will

respond to Provider inquiries promptly and resolve Provider claims within a 30-calendar day period for incorrectly paid or incorrectly denied claims.

d. Process and Timeframe to Correct Programming Errors

Our process begins with pre-payment audits on a sample of claims that allow us to catch the highest impact issues before they leave our doors. We also observe claims trending data and act upon that information to identify errors as early as possible and provide an estimated time for resolution. Our CSP supports financial functions required for managed care service delivery, including tracking all financial transactions by program, source, and fiscal year. This verifies appropriate disbursement of funds for claim payments and accurate application of all post-payment transactions.

Adjustments, Corrections, and Voids. Our claim system assigns each claim a unique internal control number (ICN) to track progress from initial system entry to final adjudication. It can differentiate an adjusted claim from the previously adjudicated claim. The system maintains details for each claim transaction at the time it occurs and records date of receipt. The claims system tracks all changes or corrections in corresponding audit tables. We use the ICN to access claims and their attachments, as well as audit trail information within our system. We can generate trail reports to facilitate auditing of individual claim records as well as batch audits. For integrity purposes, the system keeps transaction logs (used for commit and rollback of transactions) and error logs (recording failed operations). All logs enable comprehensive system and user activity reporting.

Our claims and financial systems support recouping payments for voided or adjusted claims, as well as processing manual or reissued checks and will comply with Contract Section 9.1.6. We will handle settlements outside of the claims system and mark them so the claims process will not process payment. When applicable, we will void or adjust claims to reflect identified Provider overpayments. We will not employ off-system adjustments when processing corrections to payment errors unless it requests and receives prior written authorization from the Division.

We will make changes or corrections to any systems, processes, or data transmission formats as needed to comply with the Division's data quality standards as originally defined, or subsequently amended. We will maintain controls to track all financial functions, including batch balancing, audit trails, and claims history.

e. Process for Identifying and Addressing Deficiencies or Variances from Claims Processing Standards

Our fully automated tools will identify variances or deficiencies from claims processing standards in accordance with Contract Section 9. These tools offer drill-down capability to the claim level, which accelerates research for root cause analysis. We refresh data in these tools at least weekly. We closely monitor a number of factors: claims/reconsideration inventory, denial rates, call volume, auto-adjudication rates, and other metrics to see when we have outliers that could be indicative of a problem.

For example, for one affiliate health plan, we recently noticed a spike in our long-term care pend volume. Upon further investigation, we identified that the increase was due to an edit in the system that was being applied incorrectly. Rather than stop at that one health plan, we began to investigate across other markets and identified this as a global issue. Within days, the edit was removed, the impacted claims were identified, and a project was kicked off to adjust 155,000 claims. We partnered with our Provider Experience team to message to Providers about the issue, trained our Provider services call center on the issue so they could respond to questions, and conducted a root cause analysis. This led to process improvement around code edit governance.

Innovation in Identifying Claims Variances. Our parent company is investing in an innovative predictive analytics pilot that will change the way we approach Provider training and communication. Through this pilot, we will apply a combination of algorithms to diverse sets of data to analyze claims payment patterns to identify potential outliers.

Using machine learning, these algorithms will be refined over time, continuously analyzing additional datasets, including trends across claims, disputes, Provider calls, system updates, and more. This early warning system will enable us to both proactively adjust claims if the anomaly is due to a system configuration issue or identify Providers that need additional education on claims and billing.

For example, if we see an abnormal spike in denials around a specific procedure code for Prior Authorization, we will analyze the issue. After completing our research, if we determine a denial is accurate, but the Prior Authorization requirement for the particular service was new in the market, this would indicate that our communication strategy could be enhanced. We would then proactively reach out to the Providers commonly billing for the service to further educate them on the new Prior Authorization requirement and provide helpful tips on how they can request Prior Authorization in the future.

B. Technological Systems

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Text Reminders Help Close Care Gaps

In 2020, our affiliate sent 1.6 million texts to Members, and **62.9%** of the Members engaged in their text campaigns.

MS21B_TextReminders_C_04

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Identifying Information. To comply with the Identifying Information requirements defined in Section 1.2.3.3 of the RFQ and subsequent amendments, we removed names of federal and state agencies, Providers, and other stakeholders from our response, except where expressly permitted by the Division. If this information is needed to validate our proposed solutions or evaluate our response, we will be ready to provide it to the Division.

[END OF RESPONSE]

4.2.2.7: Subcontractual Relationships and Delegation

A. Services to Be Subcontracted

1. Selecting Services to Be Subcontracted

Our selection of subcontractors is informed by our experienced Coordinated Care Organization (CCO) Leadership team and their knowledge of the Mississippi landscape. We propose to use services from our parent and affiliated companies as well as non-affiliated subcontractors. We will leverage the expertise of our partners to bring their specialized capabilities to the needs of Members in alignment with Contract Section 13. To assure success and seamless delivery of services, we will perform oversight of our subcontractors with a local ***Mississippi Vendor Oversight Manager*** along with the Mississippi CCO Leadership team.

Our subcontractor approach aligns with our whole health Member goals. By selecting the best partners to augment our services, we will successfully combine a variety of services and supports to best meet Member needs. See Table 4.2.2.7.A.1-1 for the services we propose to subcontract.

Table 4.2.2.7.A.1-1. Description of proposed services to delegate to subcontractors.

Proposed Subcontracted Service	Description
Administrative Support	Administrative and support services related to enrollment; claims processing; third-party liability; fraud, waste, and abuse; call center services; utilization management (UM); information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance. (Please note: our parent company and its affiliates provide administrative support to our utilization management process for functions such as intake and initial screening. However, all UM decisions to reduce or deny, in whole or in part, will ultimately be made by local CCO licensed clinical staff.) These shared and support services will be tailored specifically to Mississippi's needs and will be provided upon direction of the CCO leadership. While we will make use of support services from our parent organization, the subcontract allows us flexibility in how we apply those resources. Our CEO will be responsible and accountable for all functional areas, with Mississippi-based key personnel overseeing all operations.
Asthma Support	Quantitative and qualitative usage data using an internet-based asthma monitoring tool (FDA-approved inhaler sensor attaches to prescribed medication to assess under or over-utilization).
Behavioral Health Services	24-hour Behavioral Health (BH)/Substance Use Disorder (SUD) line (Member and Provider); after-hours, weekend, and holiday support for UM functions. (Please note: our parent company and its affiliates provide administrative support to our UM process for functions such as intake and initial screening. However, all UM decisions to reduce or deny, in whole or in part, will ultimately be made by local CCO licensed clinical staff.)
Community Outreach (Using Paramedics)	In-home healthcare using mobile capabilities of paramedics associated with local EMS agencies to help Members with complex care needs and limited access regain stability in health.
Dental Benefit Management	Full spectrum of core and Value-Added Benefit (Value-Add) dental administration services.
Community-based Referral Platform	Platform to connect Members with local community resources, programs, and services such as food, housing, transportation, and SUD treatment.
Medical Drug Management and Pharmacy Clinical Quality Programs	Oversight of medical drug management including medical injectable drug policy/criteria development and review of medical injectable Prior Authorizations, as well as provide pharmacy clinical quality programs if pharmacy data files are received from the State.
Non-Emergency Transportation (NET) Benefit Management	Non-Emergency Transportation services.

Proposed Subcontracted Service	Description
Smoking Cessation Program	Customized adult and teen tobacco and vaping cessation programs. For adults age 18 and over, the program offers real-time, personalized engagement with unlimited access to quit plan, peer support, live chat coaching, and text messaging and includes up to eight weeks of nicotine replacement therapy. For teens age 13 to 17, the program offers text-based support and on-demand content to help young people quit.
Subrogation	Medicaid third-party liability recovery from tort and workers' compensation losses.
Survey Administration	Administer Provider satisfaction surveys as well as Member satisfaction surveys to assess Member experience with healthcare services delivered in different settings for specific conditions in addition to CCO satisfaction, such as Member CAHPS® surveys and Member BH surveys.
Vision Benefit Management	Full spectrum of core and Value-Add vision benefit administration services.

2. Relationship to Proposed Subcontractors

We view our subcontractors as an integral extension of our affiliate's experience assisting in the delivery of meaningful services to Members. We build trusted, collaborative, long-standing relationships with our subcontractors to coordinate seamless delivery of services. See a description of our relationship with proposed subcontractors outlined in Table 4.2.2.7.A.1-2.

Table 4.2.2.7.A.1-2. Description of relationship with subcontractor.

Proposed Subcontracted Service	Relationship Experience
Administrative Support	Since our inception, we have leveraged our ***parent organization*** for their three decades of experience performing similar services and support for our affiliate plans nationally.
Asthma Support	Our affiliates have leveraged this ***subcontractor***'s internet-based asthma monitoring tool and data across multiple shared markets for nearly five years.
Behavioral Health Services	This ***subcontractor*** has provided BH services for our shared markets for nearly 10 years.
Community Outreach (Using Paramedics)	We have used this ***subcontractor*** to provide community outreach using paramedics for more than one year across multiple shared markets.
Community-based Referral Platform	We have leveraged the platform of this ***subcontractor*** across affiliate markets for more than five years.
Dental Benefit Management	For more than 10 years, we have partnered with this ***subcontractor*** as a dental benefit manager across multiple shared markets.
Medical Drug Management and Pharmacy Clinical Quality Programs	For several years, our parent company has used our ***subcontractor*** to provide medical drug management and pharmacy clinical quality programs.
NET Benefit Administration	This ***subcontractor*** has provided NET benefit administration for more than five years across affiliate markets.
Smoking Cessation Program	Our affiliates have leveraged the smoking cessation support services of this ***subcontractor*** for more than one year across multiple markets.
Subrogation	This affiliate has provided third-party liability recovery services for nearly two decades across multiple markets.
Survey Administration	This ***subcontractor*** has provided survey administration services for nearly three years across our affiliate markets.
Vision Benefit Management	For more than 10 years, our affiliates have partnered with this ***subcontractor*** as a vision benefit manager across multiple markets.

B. Subcontractor Oversight

1. Subcontractor Oversight Program

We will meticulously screen potential subcontracting partners and provide continuous oversight to assure that Members receive timely, appropriate, and quality care and services. To do so, we will leverage our robust Subcontractor Oversight program, led by a local Mississippi ***Vendor Oversight Manager***. This dedicated role will specifically oversee subcontractors to align with both the Division of Medicaid (the Division) and CCO requirements.

a. Providing Ongoing Subcontractor Oversight

Oversight Activities

Championed by our top-tier managed care leaders who live in Mississippi, our oversight activities will deliver operational excellence that are collaborative, agile, and transparent. We will continuously monitor subcontracting partner performance via daily collaboration and formalized auditing with activities such as:

- Answering questions, collaborating on problem solving, discussing opportunities for improvement, and escalating urgent performance concerns with partners as frequently as daily as needed
- Obtaining and reviewing monthly scorecards with key metrics specific to functions delegated
- Conducting Joint Operations Committee meetings
- Performing analysis on transactional data to identify potential anomalies that may trigger a focused review
- Issuing formal Corrective Action Plans (CAPs) when instances of non-compliance are identified and performing follow-up to help ensure remediation
- Reviewing and analyzing complaints and Grievances and Appeals to identify trends
- Reporting monitoring activities to Compliance Committee and Proactively reviewing and analyzing data to identify potential compliance issue and address them immediately
- Performing an annual audit using tools specific to the function delegated and mapped to contractual requirements and accreditation standards
- Ensuring accurate and timely submission of the Annual Quality Management Program report to the Division

Furthermore, our vendor management structure will be responsive and responsible for the day-to-day operations and oversight of our subcontractors. As part of our process, we will ensure our COO leadership team is continually informed of monitoring and oversight activities across each subcontractor.

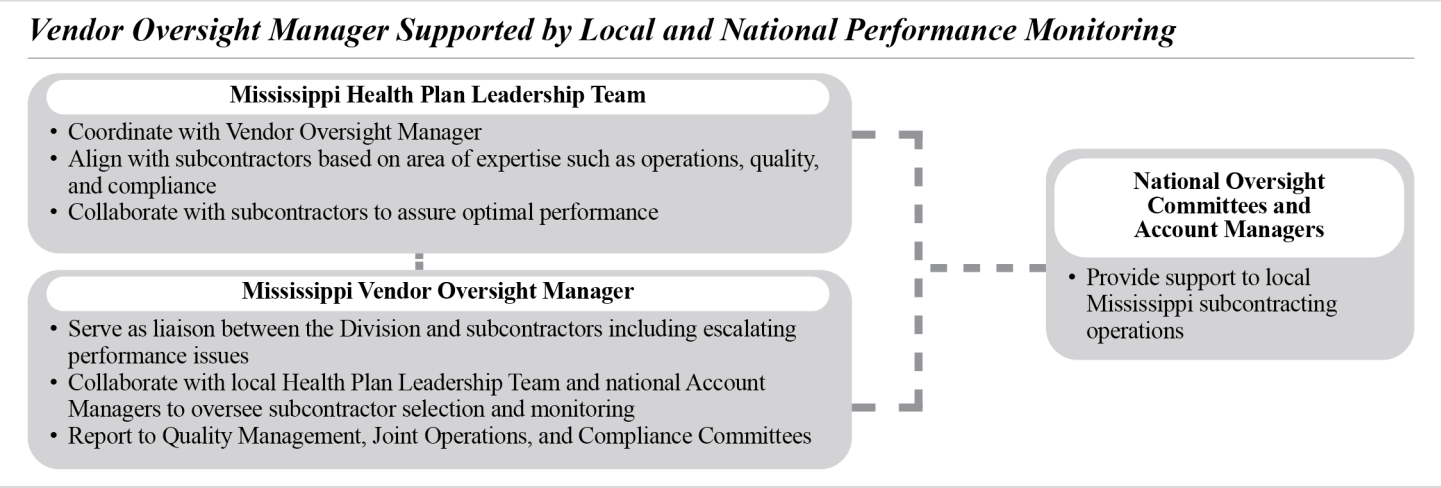
Organizational Structure

We will leverage our Mississippi CCO Leadership team that will include staff from our local operations, quality, and compliance departments as well as the ***Vendor Oversight Manager***. The Vendor Oversight Manager will serve as the single point of contact for the Division and will oversee the subcontractor's performance. To monitor and manage the subcontractor while assuring a seamless experience for Members, Providers, and the Division, the Vendor Oversight Manager will:

- Cultivate a strong relationship with the subcontractor
- Identify, implement, and manage service quality and operational improvement projects
- Collaborate with, and oversee activities performed by, our departments such as Procurement, Quality, and Claims
- Facilitate subcontractor performance reviews and review audit results
- Oversee complaints, Grievances and Appeals, and service level agreement (SLA) adherence
- Help ensure receipt and reconciliation of all required reporting data
- Escalate contract changes or performance issues and provide support through resolution

The ***Vendor Oversight Manager*** and CCO Leadership team will also receive support from national organizational resources that add an additional layer of performance monitoring. This approach allows for the leverage and exchange of best practices as well as cross market communication to more quickly identify and address immerging issues that could impact compliance to the Division contract requirements. Collaborative monitoring will provide accountability and transparency between our affiliates and subcontracting partners and help prevent compliance and quality issues. This structure, outlined in Figure 4.2.2.7-B.1-1, maximizes effectiveness in monitoring performance, enhancing accountability, and avoiding compliance issues. Our vendor management structure will be responsive and responsible for the day-to-day operations and oversight of our subcontractors and will be tailored to specifically meet all contractual requirements in Contract Section 13.5.

Figure 4.2.2.7-B.1-1. Subcontractor Management team structure.



Types of Reports Required from Subcontractors

After fully vetting subcontractors through a rigorous pre-delegation evaluation, we will continue oversight through mandatory reporting. Our partners will submit reports to the ***Vendor Oversight Manager*** based on an internal due date (prior to the Division's deadline as applicable) to provide time for a thorough quality review. We will require applicable reports from different partners depending on the service they provide as outlined in Table 4.2.2.7.B.1-1. They will submit reports that:

- Fulfill regulatory reporting requirements
- Fulfill ad hoc regulatory report requests
- Substantiate/validate their ability to perform contractually required services
- Monitor performance against contractual service levels

Table 4.2.2.7.B.1-1. Types of reports maintained by the Vendor Oversight Manager.

	Encounter/ Claims Data	Call Center SLAs	Network Adequacy	Grievance and Appeals	Administration and Medical Expense	FWA Monitoring	Service Utilization	Remediation such as CAP Reporting
Direct Services Subcontractor	✓	✓	✓	✓	✓	✓	✓	✓
Non-Member Facing Subcontractor						✓	✓	✓

b. Ensuring Receipt and Reconciliation of All Required Data

Including being fully integrated with our affiliates, we will oversee and validate subcontractor Encounter Data using an automated process that minimizes manual checks. Upon receipt, Encounter files received from subcontractors will undergo a series of automated edits that check for a range of completeness and accuracy. These will include automated edits such as Duplicate Encounter submissions, HIPAA format errors, Missing/Invalid Claim Receipt Date, and Invalid Member Eligibility on Date of Service. If errors are found, we will notify the subcontractor and specify the Encounter(s) that contained the errors. Each Encounters process will include rigorous validation of data accuracy from claim adjudication through Encounter file creation and comply with all Division requirements including Contract, Section 16.7.

Front-end Claim Validation
Starting with claims processing, we will subject submitted claims to extensive front-end edits during processing, denying those submitted without the data required by the Division to support accurate encounter submissions. These automated validation edits will verify the claims are relevant, complete, and contextually appropriate.

Encounter Quality Checks
To prevent Encounter Data submission problems, we will have several checkpoints such as:

- Log details of each submission and capture source claim information such as claim number, type (original, adjustment, void), file name, path, and creation date
- Check for and remove duplicate records
- Reconcile queued Encounter Data to claims processed for eligible services during the matching time period (including paid, denied, and voided claims)
- Verify HIPAA compliance

We will apply business rules based on Division submission requirements. Validation edits confirm that National Provider Identifiers and atypical Providers will follow encounter rules and format dates and occurrence spans correctly. Records that fail edits will pend for review, investigation, and remediation. We will promptly coordinate corrections and include the corrected encounter in a subsequent submission. Prior to submission, we will perform quality checks on all encounter files to assure compliance with Division standards. With support from the Account Managers our ***Vendor Oversight Manager*** will also be informed of any Subcontractor compliance issues prior to submission.

Continuous Monitoring
Using key performance metrics and dashboards, will allow our ***Vendor Oversight Manager*** to continuously monitor and assess our encounter performance. Seeing the summary statistics on encounters processed, submitted, internally pended, and rejected for all encounter types, will help us evaluate the overall health of our encounter submissions. Additional details will support the repair, remediation, and resubmission of rejected and internally pended encounters. If we identify gaps or errors, we will use a systematic approach to investigate and resolve them. Depending on the nature of the issue, resolution may include business process improvements, claims processing procedure or configuration changes, Provider data collection enhancements, and/or staffing changes.

c. Ensuring Appropriate Utilization of Healthcare Services
Employing a multi-prong approach will help ensure appropriate utilization. From our prior athorization checkpoints to our fraud, waste, and abuse training and clinical practice guidelines that transcend to subcontractors, we will leverage advanced technology and practices to optimize patient care. Further, in collaboration with our Quality Management Committee, we will monitor over- and under-utilization of partner services and adherence to regulatory compliance. We will adapt the scope and frequency of our oversight activities to reflect the nature of each delegated activity and the nuances of services provided, using our contractual obligations to the Division as the foundation of our program. If at any time our ***Vendor Oversight Manager*** determines performance does not meet our subcontractual agreement requirements or our performance expectations, we will take corrective action, up to and including termination.

d. Ensuring Delivery of Administrative and Healthcare Services Meet All RFQ Standards
We view our subcontracting partners as an integral extension of our affiliates assisting in the delivery of meaningful services to Members. With support from the Account Managers, the ***Vendor Oversight Manager*** we ensure our agreements will outline specific service level agreements that will align with Division requirements for each function we delegate. Our CCO will retain sole responsibility for ensuring our partners fulfill all contractual and performance requirements, as outlined in Contract Section 13.2.1.

e. Ensuring Adherence to Required Grievance Policies and Procedures

The local ***Vendor Oversight Manager*** will oversee our partners' performance including all related complaints, Grievances, and Appeals which will be routinely reported to our Quality Management Committee. The CCO and our partners will use quality assurance (QA) to evaluate adherence to and effectiveness of established procedures. For example, subcontractors review calls placed to their call centers to assess whether Appeals and Grievances are identified and classified appropriately. We will then perform call calibration by reviewing a subset of these calls to check whether the subcontractor's classification and handling align with established procedures. This QA will provide valuable information for oversight purposes and help us to identify trends. Other QA activities may include a random sample review of call notes and cases. The ***Vendor Oversight Manager*** will communicate errors and improvement opportunities to our partners and work collaboratively with them and the CCO Leadership team to quickly resolve any complaints/Grievances, identify actions needed to remediate issues and prevent reoccurrence.

We will track and trend Grievance and Appeals data to address common issues and identify opportunities for continuous improvement. In accordance with Contract Section 16.2.9, we will review data to identify volume changes, timeliness, trends, and key metrics such as the date the Grievance Appeal was received, incoming urgency, date the acknowledgement letter was sent, reason for the Grievance or Appeal, date of resolution, and outcome. We will use this data, and request additional documentation, when necessary, to assure accuracy and understand and address the root cause of trends. Our ***Vendor Oversight Manager*** will meet with the subcontractor to discuss monitoring results such as trends, remediation efforts, policy and procedure revisions, training opportunities, and recommended operational improvements.

Auditing

Our assessments will include a review of policies and procedures as well as an evaluation of files for adherence to regulatory and contractual requirements. For each audit or assessment, the subcontractor being audited will provide a list of all Grievances and Appeals handled during the audit period. From that list, the auditor will select a random sample for review. The subcontractor then provides the auditor all case file documentation. They will note areas that do not meet the requirement and details about the failures and provide to the subcontractor. Once the review is complete, an audit report will be issued that outlines the scope of the audit and findings that require correction. Partners must then submit a CAP that includes a root cause analysis, impact analysis, remediation actions, corrective actions, and expected timeline for completion. Before closure, we will validate the CAP to assure the issues are corrected. We will also leverage analytics to validate overall processes and program effectiveness including trends, volumes, significance testing, metrics dashboards, and reports.

Reporting

The ***Vendor Oversight Manager*** will share results of monitoring and auditing with the CCO Leadership team and the subcontractor performing the function. The Vendor Oversight Manager will provide updates on their performance through monthly meetings and in writing, which includes information on Grievances and Appeals. The Vendor Oversight Manager will also provide Grievance and Appeal data, trends, and audit reports to the Compliance Committee. This will help assure leadership will be aware of the overall performance of our Grievance and Appeals System and engaged to help resolve issues. The Vendor Oversight Manager will inform the Division by providing the audit reports quarterly upon request and submitting the Annual Quality Management Program report.

f. Addressing Deficiencies or Contractual Variances with our Subcontractors

The ***Vendor Oversight Manager*** will work daily to identify and discuss resolution of performance issues early — before they become a problem. We supplement our proactive vendor management structure with robust monitoring, including monthly performance reporting, quarterly reviews, and annual audits. When we identify subcontractor deficiencies, risk due to non-compliance, or an increase in volume of complaints, Grievances, or

Appeals, we will initiate a CAP and notify the Division if the subcontractor has been placed on corrective action as outlined in Contract Section 13.5.

If it becomes apparent that CAP implementation is not addressing areas of concern as expected, our Legal and Compliance departments may also become involved. If the subcontractor is unable to resolve the issue or comply with contract provisions, we will invoke the subcontractor contingency plan, which addresses de-delegation of subcontracted functions and possible contract termination.

For example, through our Joint Operating Committee meetings and review of required reports for one of our affiliate plans, we identified a subcontractor was falling short of the required staffing levels for a call center. The staffing deficiency affected their ability to meet other performance standards, including timely completion of Member outreach through call campaigns. To support the subcontractor and identify root causes that affected the subcontractor's performance, we:

- Initiated a CAP and worked with the subcontractor to acknowledge their understanding of the steps forward
- Notified the State of the deficiency and actions taken
- Facilitated weekly check-in calls with the subcontractor to confirm progress until they met contractual staffing requirements for three months
- Reported performance improvement progress to the State

Staffing levels for this partner continue to be monitored through reporting and monthly Joint Operations Committee meetings. The previously deficient subcontractor has consistently met all performance standards. Continuous monitoring and regular, open communication with our subcontractors prevents small performance anomalies from becoming larger problems that affect Member and Provider satisfaction. We build upon lessons learned and cooperatively employ strategies to prevent problems from reoccurring.

g. Performing Annual Quality Review of Subcontractors

Working closely with our subcontractors will allow our ***Vendor Oversight Manager*** to address meaningful performance improvement initiatives aimed at improving results, quality of care, and Member satisfaction. The Division can expect our CCO to perform an annual quality review of subcontractors, ***which will be included in the Annual Quality Management Program report to the Division***. Reporting of the audit results will be made available upon request.

h. Ensuring the Proper Classification of All Subcontractor Expenses

In accordance with the Division's policies, with support from the Account Managers, we will ensure the proper classification of all subcontractor expenses between administrative and medical. We will also contractually require subcontractors to report administrative and medical expenses and validate the accuracy of what they report. All contracts with third-party subcontractors or vendors providing claims adjudication services will contain language in line with CMS 42 CFR § 438.8(k)(3). This will require those entities to submit the underlying data to break down amounts paid to vendor between claims, activities to improve healthcare quality, and non-claims costs. This will be required within 180 days of the end of the administrative and medical expense reporting period or within 30 calendar days upon request.

Identifying Information. To comply with the Identifying Information requirements defined in Section 1.2.3.3 of the RFQ and subsequent amendments, we removed names of federal and state agencies, Providers, and other stakeholders from our response, except where expressly permitted by the Division. If this information is needed to validate our proposed solutions or evaluate our response, we will be ready to provide it to the Division.

[END OF RESPONSE]

4.2.2.8: Financial and Data Reporting

A. Financial Reporting

Our parent company and its affiliates have decades of experience in providing financial reports tailored to our state partners' needs or existing reporting practices. As a Coordinated Care Organization (CCO), we will provide reporting at different frequencies and levels of granularity based on the Division's needs, with the shared goal of providing meaningful data and insights to assist state partners or rating actuaries in developing capitation rates.

1. Approach for Supplying Data to Develop Actuarially Sound Capitation Rates

We will prepare the MississippiCAN and CHIP financial reports and applicable schedules using generally accepted accounting principles (GAAP) to satisfy the requirements for base data needed to develop actuarially sound capitation rates, as defined in 42 C.F.R. § 438.5 (c) and as stated in Contract Section 16.2.3. Our approach is collaborative, working closely with the Division during implementation to make sure we fully understand all financial reporting requirements. Combined with data validation and quality controls, this will limit the need to submit adjusted reports. We offer subcontractor controls to make sure our partners provide timely and accurate data to our CCO so that we, in turn, can meet the Division's requirements. Most importantly, transparency in financial reporting is the foundation of our approach. We will promptly provide the Division with financial data as contractually required and additional information as requested for capitation rate development.

Preparing Accurate, Complete, and Timely Data for Capitation Rate Development

The Division requires validated encounter data, fee-for-service (FFS) data, as appropriate, and audited financial reports for the three most recent and complete years to develop sound capitation rates.

Encounter Data

As described in detail in Section 4.2.2.8.B, we will provide complete and accurate encounter data to the Division that meets all required timelines. Our local Mississippi Member Encounters Data Analyst, along with national encounters resources, is responsible for managing the comprehensive encounter data process. We will submit encounter data through SFTP on a weekly basis, and our local, dedicated Mississippi Chief Financial Officer (CFO) or an individual with delegated authority then reviews the submission for accuracy and completeness prior to submission.

Audited Financial Reports

Our national external financial reporting team will engage an external independent auditing firm to conduct the annual audit requirement after the close of the calendar year. The audit will be conducted in accordance with GAAP and generally accepted auditing standards. The external financial reporting team will coordinate requests for information to supply the auditors with the data to complete the exam. Once the exam is complete, we will obtain the auditor's report providing the opinion that the financials present fairly, in all material aspects, the financial positions of the company for the date reviewed. The external financial reporting team will then file the audited statement with both the Department of Insurance and the Division of Medicaid by June 1. The annual audited financial statements will also be provided to the State actuaries for rate development purposes. Our national Actuarial Data and Reporting (ADR) team, in conjunction with our Medicaid Financial Accounting and Reporting team, will collaborate with the State actuaries to complete any reconciliation between these audited financials and other annual financial templates required.

Annual Financial Template

In accordance with Contract Section 16.2.3, our annual financial templates will include medical expenditures by rate cell and region, administrative expenses, and other required supplemental expenditure data. Payroll and fringe benefit information for staff or contractors dedicated to the MississippiCAN and CHIP Contracts will be

provided. Capital improvement, real property acquisition or lease information, and any other data associated with service delivery will be reported.

Once the medical values are completed and checked for reasonableness, we will add membership, revenue, and administrative expenses into the template. The reports are reviewed internally by our parent company's CPAs and an employee belonging to the American Academy of Actuaries. Additionally, the final report will be checked for reasonableness against internal analytics. Further extensive reviews will be held with our Mississippi CCO leadership, before submission.

Data Submission Management and Oversight Will Result in Accurate Financial Reporting for the Division
Our dedicated Mississippi Compliance Officer will manage and monitor submission requirements and schedules. The Financial Accounting and Reporting team will perform the following activities to deliver timely and accurate financial reports to the Division:

- Maintain current understanding of the Division's report template and instructions
- Create reports in the current templates, reviewing data to make sure numbers are complete, accurate, and tie back to the General Ledger
- Conduct the internal quality control review process
- Review reports with the local CCO leadership team and revise as needed
- Submit approved report to the Regulatory Oversight Manager for review and certification from the CEO or CFO, as required in Contract Section 16.10, for addition of required certifications and timely submission to the Division

2. Approach for the Timely Completion and Reporting of Medical Loss Ratio Reporting Requirements
We understand the requirement to maintain financial sustainability of the program. In doing so, we also confirm the understanding that, at a minimum, 87.5% of the capitated payments to CCOs should be directed to services and activities that improve health in alignment with the Division's program goals and objectives. We will comply with any minimum Medical Loss Ratio (MLR) requirement or risk-sharing agreement specified in the MississippiCAN and CHIP Contracts. As such, we will meet all contractual requirements outlined in Contract Section 11.4 and Exhibit C, and in accordance with 42 C.F.R. § 438.8 and 438.74. This will be accomplished by following the methodology specified in the Contract and complying with GAAP, Securities and Exchange Commission guidance, and all federal rules and regulations, as applicable. Transparency is the cornerstone of our values, and we commit to submitting timely, accurate, and complete MLR reporting to the Division.

Expertise in Preparing and Delivering Timely and Accurate MLR Reports
Our parent company and its affiliates have extensive experience in evaluating the program policies and procedures of MLR requirements. Currently, our affiliate health plans comply with and provide timely and accurate MLR reporting that may include rebate policies for more than two dozen state Medicaid departments. Of those Medicaid states, nearly half follow CMS-defined language on calculation standards as in in 42 CFR § 438.8, and the remainder follow State-defined MLR requirements. Our local Mississippi CCO will have as an established alliance with our parent organization that will combine the CCO's extensive local knowledge and Provider relationships with our parent's national Medicaid managed care expertise. We will leverage specific systems and processes, including validating CCO and subcontractor data, attestation, and data retention procedures. We will customize these systems and processes to meet the needs of the Division and the MississippiCAN Program and CHIP. Our local CCO will maintain ultimate responsibility for all contractual requirements, including reporting.

Approach to Meeting Requirements for MLR Reporting

We will submit MLR reports in a format and manner determined by the Division. Each report will comply with the requirements concerning capitation payments received and expenses related to MississippiCAN and CHIP Members. Per Contract Sections A.1 and A.2, quarterly reports will be submitted to the Division no later than the 60th calendar day following the end of the MLR reporting quarter, and a 30-day run-out period will be used. Annual reports will be submitted no later than April 1st of the year following the end of the MLR reporting year. The final annual MLR report will include a run-out period of 180 days. Any time the Division makes a retroactive change to the capitation payments for an MLR reporting year for which the MLR report has already been submitted, we will recalculate the MLR for all reporting years affected by the change, as required in Contract Section A.6. We will submit a new MLR report that meets the applicable requirements no later than 60 days after Division notification of the change. We commit to providing all additional reports listed in Contract Section A.4 during each MLR reporting quarter and year.

Quarterly and Annual MLR Reporting Process

We have a dedicated ADR team that will compile and validate the incurred claims data. ADR will use the Data Warehouse for retrieving paid incurred claims data. The Data Warehouse will be used to extract FFS medical and ancillary medical claims, as well as capitation payments at the Member level. Member eligibility, sourced from the 834 Enrollment files, is utilized to track eligibility at the time of claim adjudication. Within the database, each claim is run against the restated Member eligibility tables to identify the population and rate cell and/or benefit plan. The data is then summarized by elements such as product, region, category of service, and date of service. The summarized form of the data is then used to populate the report. We load in the non-system transactions (NSTs) that are recorded by the financial and accounting reporting team. Only NSTs with a date of service in the current calendar year will be included. Incurred but not paid (IBNP) values are extracted from the reserve schedule, then a weighting methodology is used to place the IBNP values to a category of service. As required in Contract Section 11.4, the medical data will also include all Mississippi Hospital Access Program and Mississippi Medicaid Access to Physician Services-directed payments received by the CCO for the service dates of the reporting period. Once the medical values are completed and checked for reasonableness, the medical data will be provided to our Financial Accounting and Reporting group to be included in the report. This team will populate the Member months and premium by using restated data sourced from 820 payment data files. The data will be calculated at the contract, product, and month-of-service level, and it will be produced and reconciled by our dedicated premium reconciliation team.

The Financial Accounting and Reporting team uses the PeopleSoft General Ledger financial system to capture non-claims cost for the reporting. This financial system allows us to record journal entries for premium and medical related to each state contract in the normal course of business. The General Ledger financial system also accounts for the taxes, licensing, and regulatory fees at the state contract level. The company also maintains databases to capture and segregate data for activities that improve healthcare quality that meet the definitions put forth by the National Association of Insurance Commissioners (NAIC) and 45 C.F.R. 158.150. We can also capture fraud-reduction recoveries and fraud-reduction expenses that meet the definitions put forth by the NAIC and 45 C.F.R. 158. In addition, the system captures non-claims costs such as cost containment activities, loss adjustment expenses, workforce salaries and benefits, and community benefit expenditures that either directly support the contract or are allocated costs for national shared services. All administrative expenses will be recorded to specific General Ledger accounts that will allow us to identify exclusions as required under the MLR reporting requirements. These systems and other databases will allow for timely reporting at a detailed level by either date of service or financial reporting month. The previous items will be loaded into the MLR reporting template, and a calculation will be made based on the requirements of the Contract. If it is determined that a rebate is required for the reporting year, we will submit such rebate no later than the 10th business day of May following the MLR reporting year.

On a monthly basis, the Financial Accounting and Reporting team, in collaboration with the ADR team, will develop an accrual for the annual Contract based on the CMS-defined MLR model. The MLR model will be updated monthly with the most current actual results. The actual results for the MLR reporting period will be restated for prior period medical adjustments. In addition, other inclusions and exclusions will be made to premium and medical as required by the Division-defined MLR requirements and in conjunction with 42 C.F.R. § 438.8. The balance of months in the Contract year will use approved forecasted values. Once the calculation is completed, the model will determine if the MLR is below the required threshold. At this time, an independent review of the calculation will be conducted by a manager with licensure as a CPA. The calculation will also be reviewed with the local Mississippi finance team. An external independent auditor will review the MLR calculations quarterly. A reconciliation of the balance sheet accounts will be conducted on a monthly and quarterly basis in conjunction with the approval process. Once review is completed and approved, an accrual will be made by the Financial Accounting and Reporting team for the rebate in the General Ledger financial system. This will be done in connection with the month-end financial close process.

Receiving and Validating Third-party Subcontractor Data

Our MLR calculation will include all claims that are adjudicated by our subcontractor partners. Our delegated dental and vision partner contract will contain language that requires the partner to submit the underlying data to validate the breakdown of amounts paid between incurred claims, healthcare quality activities, and non-claims cost. Our dental and vision partner will be required to submit this data to us within 180 days of the end of the MLR reporting period or within 30 calendar days upon request. Please refer to our response to Section 4.2.2.8.B, Data Reporting, for details regarding partner data reporting compliance and our approach to managing data completeness and validation.

Allocation of Expenses

Expense allocation will follow the requirements outlined in Contract Sections H and I. Each expense will be reported under only one type of expense or prorated between types of expenses, if applicable. The MLR report will include a detailed description of the methods used to allocate expenses. Descriptions will include how the expense meets the criteria for its determined category and the method by which it was aggregated.

Attestation and Record Retention

We will complete an attestation statement with each MLR report, as required in Contract Section A.5, signed by the CCO's CEO, CFO, or an individual with delegated signing authority who reports to one of these staff. The certification will attest — based on our best knowledge, information, and belief — to the accuracy, completeness, and truthfulness of the MLR calculation that we submit to the Division. Following submission, we will meet with the Division regularly to discuss the experience reports, financial templates, and encounters for use in the rate-setting base period. Our CCO and partner data used to allocate reported expenses and all supporting information will be maintained and retained for no less than 10 years. This information will be made available to the Division upon request to assist with evaluating the accuracy of our MLR report.

Computation of Medical Claims and Non-claims Cost

As a CCO, we will adhere to the Division's method for determining medical claims and non-medical claims cost, as described in Contract Sections B and F. The MLR report will include direct claims paid to or received by our capitated Providers for clinical services as defined in Appendix A. Incurred claims for capitated payments to any subcontracted vendor will reflect all adjustments noted in Exhibit C, Section J. Incurred claims amounts will include:

- Unpaid claims liabilities for the MLR reporting year
- Withholds from payments made to network Providers
- Recoverable claims for coordination of benefits or recovered from subrogation and fraud-reduction efforts
- Incurred but not reported claims based on past experience

- Changes in other claims-related reserves
- Reserves for contingent benefits and medial claim portion of lawsuits
- Incentive and bonus payments made, or expected to be made, to network Providers
- Net payments related to state-mandated solvency funds

Administrative (non-claims) costs will be computed based on our expenses related to:

- Cost containment activities not related to a qualifying quality activity
- Loss adjustment expenses not classified as cost containment
- Workforce salaries and benefits
- General administrative expenses and community benefit expenditures

Expenses not allowed will be excluded from the non-claims costs and capitation rate-setting purposes. Any administrative expense amounts that exceed a third party's costs will be justified and consistent with fiscal soundness requirements as detailed in 42 C.F.R. § 422.516(b).

B. Data Reporting

Our integrated HITRUST-certified and HIPAA-compliant Management Information System (MIS) supports streamlined, coordinated, and automated reporting processes that will give our Mississippi CCO the flexibility to meet contractual reporting requirements and respond to changing Division needs. We will configure our MIS to support and comply with the Division's reporting requirements.

1. Approach for Collecting, Validating, and Submitting Complete and Accurate Encounter Data

We affirm that our CCO and its subcontractors will follow all encounter data submission requirements contained within the Contract. In accordance with Contract Section 16.7, and federal statutes 42 C.F.R. § 438.242 and 42 C.F.R. § 438.818, our CCO will collect required data and submit complete, accurate, and timely Member encounter data on a weekly basis to the Division. We acknowledge all Member encounter data are the property of the Division, and as such, we are prohibited from releasing any data without written approval of the Division, as required in Contract Section 16.7.8.

a. Team Based Approach and Expertise Drives Accuracy, Completeness, and Timeliness

We recognize the critical value that accurate claims and encounter data bring to effective management of clinical and healthcare services information — and the systems, processes, and staffing necessary to maintain high standards. Our local Mississippi Member Encounters Data Analyst will be accountable for overall encounter data compliance. This staff person will be supported by our national Encounters team providing resources and infrastructure to maintain comprehensive end-to-end encounter data management operations. Our Medicaid affiliates have vast experience processing encounter transactions that cover large amounts of paid claims. Through this extensive experience, we have a deep understanding of the level of collaboration needed between the Division, Providers, subcontractors, and External Quality Review (EQR) vendors to ***"get encounters data submission right the first time."*** We recognize the importance of complete, accurate, and timely encounter records to the Division, and the data will demonstrate our ability to meet the Division's quality standards.

Our CCO's Chief Information Officer will be responsible for assuring the timely and accurate submission of encounter data, as defined in Contract Section 16.7. This individual will work in collaboration with our Mississippi Claims Administrator and Data and Analytics Manager to assure the encounter data system is configured appropriately to generate submissions that meet contractual requirements for completeness and accuracy. They, along with our Mississippi Member Encounters Data Analyst, will receive support from experienced staff within our national encounter team. Collectively, these staff will be responsible for building and submitting encounter data files, performing analyses related to encounter data quality, developing reports, formulating recommendations, and providing guidance for business units related to encounter metrics. The

Encounters team will develop and analyze encounter data performance reports for example, timeliness, accuracy, and duplication, and will provide notations of performance deviations and outliers, as required by Contract Section 16.7.3. The Encounters staff will provide consultation to other business areas, leadership, and any delegated subcontractor partners.

Overview of Encounter Processing

The encounters workflow outlines the journey from data receipt through submission, as depicted in Figure 4.2.2.8.B.1-1. It begins with the Provider submitting claims for services delivered to MississippiCAN and CHIP Members. The process will include our dental/vision and transportation partner data integrations, validation checkpoints, and issue-resolution stages. It also outlines the process for validation and delivery of all encounter data in the required ASC X12N and NCPDP formats, as required in Contract Section 16.7.1. The Member encounter file will include the Provider's National Provider Identifier (NPI) and all data the Division is required to report to CMS under 42 C.F.R.§ 438.818.

We will process encounters on a weekly basis and submit through SFTP. All Member encounter data, including settled claims and claim adjustments, zero-dollar amounts, voids, denials, and capitated Provider encounters, will be submitted no later than the 30th calendar day after the date of adjudication. Within two business days of the end of a payment cycle, we will generate Member encounter data files for that cycle and transmit them to the Division each week through SFTP. If there is more than one payment cycle within the same calendar week, the files will be merged within two business days following the last cycle.

[redacted]

Encounter Data Collection

The encounter collection process selects newly adjudicated, voided, and adjusted claims processed since the last submission and loads the data into our encounter staging area. The number of claims is verified against the source data. If counts do not match, we identify and resolve the issue and rerun the process. We acknowledge that the standards, file structure, and content definitions in the Companion Guides may be amended and will fully comply with any future changes. Our Member encounter data will comply with industry-accepted clean claim standards to support proper claim adjudication. Our Core Service Platform (CSP) and those of our subcontractors are fully 5010 and ICD-10 compliant. We support the most recent versions of the electronic data interchange (EDI) transactions and the national reference data code sets, as required in Contract Section 16.7.1.

Data Validation and Correction

We will create HIPAA-compliant ASC X12N 837 formats for the submission of institutional and professional encounters. Our CCO will comply with all requirements outlined in Contract Section 16.7.3 and in accordance with the Division's Encounter Companion Guides for professional, institutional, and dental encounter claims. Changes to the Member encounter data transaction requirements will be communicated to our subcontractors to make sure timely submission of this data to the Division occurs. We will adhere to file size, format specifications, and schedule, as directed by the Division, in accordance with Contract Section 16.7.4.

File Approval and Submission

In accordance with Contract Section 16.7.3, we will design our submission schedule to meet the Division submission requirements, with additional time allowed for review and remediation of any errors. The Encounters Submission Analyst will complete a checklist and request approval from the local Encounters Manager to submit the file. Once approved, the file is submitted and the attestation is sent to the Division.

State Response/Error Remediation

On a weekly basis, our Encounters team will review details from the Division's pre-cycle edits, research errors, update the encounter's status within our encounters system, and track error correction and resubmission. This team will hold weekly meetings to review submission reports, work through identified errors, and monitor compliance with the Division's encounter reporting requirements. If the Encounters team has questions or issues that they cannot resolve without input from the Division or the State's agent, the Encounters Manager will address those during the weekly sessions or reach out directly for an urgent issue that requires immediate attention. We will correct and resubmit identified encounter errors within 30 calendar days of the date the reject file was received.

We are dedicated to meeting the Member encounter data processing and submission requirements outlined in the Contract and the Division's Companion Guides. We will comply with the encounter data performance standards as documented in Attachment A, Exhibit G, and understand that we may need to submit a Corrective Action Plan for failure to comply with these requirements, as outlined in Contract Section 14.1.3.

Encounter Data Retention

We will maintain comprehensive information on each encounter submission, including claim ID, line number, payment status, type (original, adjustment, void), file, path, and creation data. Our file-retention policy exceeds the Division's 10-year requirement, as specified in Contract Exhibit C, Section K.

Monitoring Member Encounter Data System to Ensure Data Completeness

Our successful encounter submission process will be guided by written policies and procedures that document a comprehensive schedule of system processes, review tasks, and submission dates that allow us to deliver timely and complete encounter data to the Division, as required in Contract Sections 16.7.5 and 16.7.6. This will result in the highest-quality Member encounter reporting to the Division. Following a comprehensive schedule of system processes, review tasks, and submission dates, our Encounters team will closely monitor the entire

encounter process lifecycle, starting with the encounter extract process and ending with acceptance of encounter data by the Division. The Encounters team will use a suite of self-service reporting tools to measure performance and track trends, as shown in Figure 4.2.2.8.B.1-2.

[redacted]

Our tools are fully automated and designed to easily identify variances in financial completeness, accuracy, and timeliness. They also offer drill-down capability to the claim level, which accelerates research for root cause analysis. We will refresh the data in these tools at a least once each week, load encounter response files from the Division's fiscal agent, and work on rejections with the appropriate department or subcontractor. We will monitor rejected encounters using aging reports, managing correction and resubmission of all encounters for which errors can be remediated by the Provider who submitted the claim.

Innovative Technology Systems and Governance to Support Member Encounter Performance

Encounter data submission is a plan-wide priority. Our Encounters Processing System offers process checkpoints, combined with detailed online dashboards and status reports, to monitor and assess our encounter performance locally and across affiliates. All affiliates use this technology, giving our Mississippi CCO greater capacity and outstanding day-one performance.

Innovative Technology Drives Encounters Accuracy and Completeness

Since employing our Encounters Management System, our affiliates have seen:

- **99% completeness** on a claim count basis
- **98% completeness** based on financial data
- **99% accuracy** and acceptance on a claim count level on average
- Majority of claims submitted within two to three days of adjudication
- Submissions move from one to two batches per week (where supported by state processing)

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Recurring governance forums will be in place to prioritize encounter-related issues and verify accountability for issue remediation by the Mississippi CCO staff, supported by the appropriate functional team(s), including EDI, subcontractors, IT, and claims. As part of our culture of continuous improvement, our parent organization regularly reviews encounter policies, procedures, and systems to identify ways to streamline operations, increase efficiency, and improve overall performance. Our Encounters governance team will include our Mississippi-based CEO, CFO, COO, and Claims Administrator, along with our national Operations team and the Encounters team. Biweekly meetings will provide a regular opportunity to review encounter performance and discuss any issues or concerns. This shared responsibility and oversight of encounter data allow us to combine local expertise with best practices gleaned from affiliate health plans. We will make program changes to enhance encounter processing and reporting,

incorporating additional front-end edits and prioritizing compliance changes to make sure we are meeting the Division's requirements.

Managing Non-submission of Encounter Data by a Provider or Subcontractor

We understand that it is the CCO's responsibility to assure timely receipt of Provider and subcontractor data to comply with the Division's Member encounter data reporting requirements as outlined in Contract Section 16.7. As a CCO, we will maintain explicit policies and procedures that govern how claims and encounter data are received and processed from Providers and our subcontractor partners. We will employ monitoring procedures to make sure that data is secure, accurate, complete, and timely and in accordance with contractual requirements.

Provider Non-submission of Encounter Data

Our Provider Services staff will monitor electronic submission rates and proactively conduct Provider outreach regarding late or missing files. All new Providers will receive training on the importance of encounter data. We will encourage Providers to submit claims soon after service delivery — but no more than 180 calendar days following the date of service and resubmissions for reconsiderations within 90 calendar days from date of denial, in accordance with Contract Exhibit C, Section J. Outreach may include virtual or face-to-face Provider staff training on electronic claim tools.

Subcontractor Non-submission of Encounter Data

Contractual language will require our dental/vision subcontractor and transportation partner to submit encounter data and will specify the penalties for non-compliance. Our processes will closely monitor the encounter submission schedule for each partner, and if we do not receive their file by close of business on the due date, the Vendor Load Management team will send an email alert that prompts outreach to the subcontractor to check the submission status and reason for the delay. Vendor Load Management will track the receipt date and status (accepted or rejected, and the reason) of each partner submission and will send a daily email to business owners showing the status of all files. Late and rejected files will remain on the daily broadcast until resolved. We will review subcontractor encounter data against the same comprehensive edit routines as internally processed claims. Through reporting, Vendor Management and our local Mississippi CCO will be notified and outreach will be conducted, holding our partners accountable for correctly submitting all required and key field combinations.

Key Components of Encounter Completeness Plan

We are committed to meeting all requirements and will work diligently to avoid incurring penalties for non-submission, non-compliant formats, or failure to correct and resubmit returned files, as outlined in Exhibit G, Liquidated Damages. To make sure we meet all deliverables and timelines, in collaboration with our EQR partner, our CCO will develop a Data Completeness Plan with all Division-required elements as specified in Contract Section 16.7.5. We will submit the plan to the Division for review and approval. We will submit findings from our annual data completeness internal audits to the Division at least annually or upon the request of the Division.

Key components of our Encounter Completeness Plan will include:

- Procedures to make sure that timely and accurate claims and encounter data are sent to the CCO by Providers and subcontractors
- Provider and subcontractor contractual reporting compliance evaluation methods
- Corrective action procedures to assure full compliance with encounter data reporting
- Independent third-party encounter data auditor program

Internal Evaluation and Monitoring for Data Completeness

Our Encounters team will closely monitor the entire encounter process lifecycle. Using comprehensive reporting tools, the team can easily identify variances in financial completeness, accuracy, and timeliness.

Data Verification. To support clean encounter data, we will apply front-end edits on claims in accordance with the Division's requirements. This will result in the pending of claims that need to be reviewed and worked by market analysts, claims teams, or other support teams, to be resolved, corrected, and submitted.

Data Accuracy. If a claim or encounter fails one or more edits, we will return it to the submitter for correction and resubmission. To support the Division's validation and reconciliation process, we will work to assure that 99% of all submitted Member encounter data is in a Division-validated format for original, adjustment, and void encounters. Our processes will also make certain that 99% of encounter batch submission will successfully pass X12 EDI compliance edits and the Mississippi Medicaid MES/MMIS threshold and repairable compliance edits, as required in Contract Section 16.7.6.

We will leverage our proven systems, controls, operational processes, and experience to assure the accuracy of data processed and submitted. Our Program Integrity organization will employ a variety of tools and processes to substantiate that the services delivered to eligible Members are effective, efficient, and provided by (and associated payments made to) legitimate Providers. As a part of our national Program Integrity organization, the Special Investigation Unit (SIU) will closely monitor claims to make sure Providers are not billing for services that are not rendered, as well as provide fraud and abuse reporting as specified in Contract Section 16.12.

Data Completeness. Our weekly encounter process will retrieve claims records for every service rendered to a Member for which the CCO either paid or denied reimbursement. We will run incoming claims and encounters against edits that check for the presence and validity of required FFS equivalent detail, including:

- Member data, including State-assigned ID
- Diagnosis codes and service diagnosis pointers
- Date of service
- DRG
- Procedures/revenue codes
- NDC
- Place of service
- Units of service
- Billed amount
- Billing Provider taxonomy, NPI, and physical location address
- Rendering Provider taxonomy and NPI
- Coordination of benefits payer paid amount
- Date of adjudication
- Date of payment/check date
- Adjustment information

Our Encounters team will also review the monthly Top 10 Denial reports released by the fiscal agent, engaging tactical workgroups for analysis and remediation of these issues as needed. Affiliate solutions have included enhancements to front-end Provider validation logic to more closely align with state-specific pre-cycle edits, data-mapping changes to address billing and rendering NPI issues, and review of procedure-code edits to confirm accuracy of claims adjudication and appropriate Provider education. As a CCO, we will configure the system to support all Division requirements.

Provider and Subcontractor Compliance and Corrective Action Procedures

As a part of our annual encounters work plan, we will perform our own completeness validation using an internal reconciliation tool that compares financial paid claims to accepted encounters. Consistently reconciling back to financial paid claims leverages the rigor employed by our accounting, actuarial, and third-party audit teams as another check against encounter submission health and completeness. We will update claims and encounter data within the tool on a daily basis. When the completeness measure for encounter data falls below our internal standard of 99%, the Encounters governance team will perform a root cause analysis and create a remediation plan. This information will be shared with the Division if requested. Our parent company will work

closely with our local, Mississippi-based Vendor Oversight Manager to address subcontractor submission issues and hold all partners to the same completeness standard.

Through our encounters reporting dashboards, we can filter results to focus on capitation type submissions/performance. The system's filtering and drill-down capabilities help us pinpoint non-compliant Providers and develop the necessary interventions to help improve Provider compliance. We recognize that vendor oversight and monitoring requires a flexible approach tailored to the specific functions and services each partner provides. Our program will enable us to monitor partner performance, including claims processing, billing and collections, and encounter data validation. We will adapt the scope and frequency of our oversight activities to reflect the nature of any delegated activities and the nuances of services provided, using our contractual obligations to the Division as the foundation of our program. As a part of subcontractor oversight, our partners will submit audit results to the national Encounters team, which will validate that the audits are being performed appropriately and the results meet the required standards. If at any time a vendor's performance does not meet contractual requirements or our CCO's performance expectations, we will take corrective action — up to and including termination.

Independent, Third-party Encounter Data Auditor Program
Our CCO's EQR will be responsible for developing the monitoring strategy for assessing the quality of encounter data. In accordance with contractual requirements, we will meet with our EQR auditor to review the Encounter Data Quality Report and create action plans to resolve any variances.

Support for Division Chart Audits
We understand that the Division will conduct chart reviews of sample enrollees against our CCO's monthly Member encounter data. We will assist the Division in its validation of Member encounter data and will provide requested medical records and claims data as outlined in Contract Section 16.7.7.

2. Approach to Maintaining Our Health Information System
Our MIS provides us with flexibility to configure the system to meet current requirements and respond to changing Division needs. The MIS contains built-in controls to promote the accuracy of data feeds and has eliminated many manual processes in reporting, thereby reducing the administrative burden of collecting, analyzing, and producing actionable information and reducing the risk of manual error. Our reporting process will support the collection and reporting of relevant data to the State through both regulatory/contractual and ad hoc reports. Our CCO and its subcontractors will maintain detailed records as required by 42 C.F.R. § 438.3(u) and detailed in Contract Section 16.1. This includes report and documentation regarding services delivered, Enrollment, expense allocation, Grievance and Appeal records, training records, and quality management activities.

a. Approach to Maintaining a Health Information System That Collects, Analyzes, Integrates, Validates, and Reports Data
We will maintain a health information system that collects, analyzes, integrates, and reports data for a variety of reporting needs in accordance with Contract Section 16.5. Clinical, encounter, and Care Management (CM) data will be sent at a minimum frequency of once per day in a format that meets State and federal government standards, including HL7-FHIR, API, or USCDI. We will use the processes and tools detailed in Table 4.2.2.8.B.2-1 to comply with the data requirements of the MississippiCAN and CHIP Programs and deliver high-quality, accurate results.

Table 4.2.2.8.B.2-1. We offer a robust set of processes and tools to meet and exceed reporting requirements.

Process/Tools	Summary Description	Benefits to the Division
Information Management Data Governance Process	Set of formal management processes that include accountability, risk management, and quality control to assure important data assets are managed in accordance with best practices	• Assures consistency and quality of all data source information • Supports continuous enhanced resources with additional value-added data
Business Intelligence Competency Center (BICC)	Supports the information management data governance process, providing training, help desk, and real-time staff support	• Provides consistent training in reporting tools and techniques to assure accuracy in reports and data
Formal Software Development Life Cycle (SDLC)	Standardized tools and techniques to make sure each report is developed through a consistent process that includes capture and validation of all report requirements, quality testing, and business review and validation	• Supports both routine and additional reports, promoting accuracy • Uses a streamlined process to reduce development time and assure high-quality data
Regulatory Reporting Tracking Database	Tracks reports, data owners, due dates, and record of submissions	• Managed and updated by the specialized Regulatory Reporting Center of Excellence (COE) to be sure we meet our contractual requirements • Tracks thousands of reports across our affiliates' state-sponsored programs • Generates reminders for business owners and responsible managers to facilitate timeliness of submission and provides scorecards for monitoring and tracking performance
Data Warehouse	We focus on providing quality data that is refreshed daily and housed in our Data Warehouse as the core foundation of reporting and analytics	• Facilitates consistency and quality of information of all data sources • Does not burden online transactional systems with queries to maintain its performance
Advanced Reporting	Gaps in care, primary medical physician data-sharing, and other performance-based reports	• Improves Member care by encouraging behavior changes and reduces costs
Variance Analysis Tools and Dashboards	Tools to enable the business owners and leadership team to assess the performance of an area quickly and easily against requirements in the scope of work or the accuracy of the reports being submitted	• Provides the Division confidence in the integrity of the data being submitted, as well as the demonstration that key performance metrics are being met

The MIS will run reports more frequently than required for submission so we can monitor real-time performance of our operations. For example, encounters operational reports are run daily, rather than within two business days of the end of a payment cycle as required by Contract Section 16.7.3. By generating reports more frequently, we can more closely monitor submission accuracy, timeliness, and remit status. These tools enable improvements in performance measurement, monitoring, and the ability to track changes. Our quality controls also include variance reporting at the individual metric level and a summary dashboard of performance. Our CCO will run reports on a regular basis, using them for management purposes. We will also use the reports to verify that our data integrity is precise and that we are meeting performance metrics.

We will work collaboratively with the Division as we strive to continuously enhance our reporting systems to meet the State's needs for timely and accurate reporting. This includes implementing changes per Division direction as the Medicaid environment changes. We understand that, in an effort to evaluate the CCO program, the Division may change the frequency of reports and may require additional reports at any time. In these situations, we appreciate the Division providing at least 60 calendar days' notice before changing reporting requirements and recognize that ad hoc reports may be requested at any time, per Contract Section 16.

Operational Structure to Support Compilation of Data and Reporting Processes

Our report generation environment integrates:

- Subject matter experts who understand the content and meaning of reports
- Information technology experts who maintain and manage our systems
- Analysts who know how to retrieve, associate, and process data to produce accurate, timely reports that meet the State requirements

A specialized Regulatory Reporting COE and Compliance team will work diligently with business teams to determine how to prevent issues before they occur and address risks in a timely manner. We will also respond quickly to any issues identified by the Division or its partners, working to respond quickly to requests, perform root cause analyses on defects, and verify adherence to the standard process to prevent the defect from recurring. Our Data and Analytics Manager will make sure our data conforms to the Division's data standards and policies. This staff will be responsible for data quality and verification, data delivery, change management processes used for data extract corrections, and modification and enforcement of data standards and policies for data exchanges to the Division as defined by the Contract.

We use our reporting and development life cycle to plan and implement all aspects of automated reporting, from intake to production — a sophisticated and formal process that standardizes our work. The reporting process begins with each business owner submitting reporting intake forms, using them to create Business Requirements Documents for review and approval. Using verified Business Requirements Documents, we assign developers and sets milestones to provide estimated timelines for complete programming. During the development phase, developers work collaboratively with Business Analysts and business owners to create reports according to the approved specifications. Both Business Analysts and business owners work together to test and validate the files at each step of development. Once completed and approved, the reports are considered live. We will have well-developed policies and procedures that complement our reporting and MIS platform, enhancing the quality of financial and non-financial performance data submitted to the Division, and in accordance with 42 C.F.R. 438.604. We will seek the Division's written approval of all deliverables 60 calendar days prior to the operational date of the initial term and throughout the term of the Contract, and we will meet required timeframes for all deliverables in accordance with Contract Section 16.14.

Data and Report Generation, Validation, Review, and Certification

Our quality process means that all plans, reports, and data extracts are reviewed and verified by business process owners and the Regulatory Reporting COE before they are submitted. We subject each plan, report, or data submission to extensive review and validation before certifying it for submission, as shown in our submission process flow (Figure 4.2.2.8.B.2-1).

[redacted]

The process calls for the use of variance analysis at the individual metric level and highlights elements that have changed by 5% or more. Highlighting these movements affords management the opportunity to recognize changes or possible inaccuracies and catch them well before submission. Business owners consider events that have occurred during the reporting period that could affect the data, documenting the potential rationale for observed variances.

Following this review and validation, business owners will submit reports to senior-level directors for an additional quality review and verification of accuracy. The reports are also reviewed by the Compliance Officer to verify compliance with the Division's requirements. Our local Mississippi Vendor Oversight Manager will work closely with our Vendor Load Management team in the event of late or rejected partner data files. This staff will make sure that performance issues are directly communicated and appropriately escalated to the partners to achieve resolution. Our CFO or an individual with delegated authority then reviews the submission for accuracy and completeness prior to submission and provides written certification that attests — based on their best knowledge, information, and belief — to the accuracy, completeness, and truthfulness of the data and/or documents, as required in Contract Section 16.10. This process will ascertain that accountability for timely and accurate report submission remains at the senior level of the organization.

After submission, the Regulatory Reporting COE updates the database to indicate that the report has been submitted, along with the date of submission. The database automatically generates the due date for the next monthly, quarterly, or annual report. Our reporting process and structure of quality control have advanced the accuracy and timeliness of our ongoing and additional reports. Our integrated system will generate reports in advance of the Division's submission deadline to allow adequate time for thorough review. Business owners, the compliance and specialized Regulatory Reporting COE, and our CCO's leadership team will review reports for completeness and accuracy prior to submission to the Division. Business owners will use various methods to confirm the quality of reports.

Compliance with the Division's Reporting Requirements

We will comply with all reporting requirements, including required submission timelines, formats, and performance metrics, as stated in the MississippiCAN and CHIP reporting manuals; Contract Section 16, Reporting; and Exhibit G, Liquidated Damages. In addition, we will supply any and all reporting and information need to prepare the Division's Annual Managed Care Program Report as defined under 42 C.F.R. §438.66(e). We acknowledge the Division's right to perform audits and make operational reports, data, and information public. We will provide a website for MississippiCAN and CHIP Members with CCO-certified information required by the federal statutes listed, in accordance with Contract Section 16.15. We will provide URLs to the Division for posting to the State's website as required by 42 C.F.R. § 438.10(c)(3).

We have policies, processes, and infrastructure to continually comply with 42 C.F.R. 438.224, the HIPAA Privacy Rule, and State and federal privacy and confidentiality requirements (Contract Section 16.3). We understand the sensitive nature of medical records and any other health and Enrollment information we collect and maintain to conduct our business. We are committed to securing this information to protect the privacy of our Members and Providers. Our CCO will fully comply with the provisions of the HIPAA Privacy Rule. Established policies, processes, infrastructure, and annual staff training comprise our privacy program and support our continued compliance with the requirements of the HIPAA Privacy Rule and State and federal privacy and confidentiality requirements. We will make sure that Mississippi Member medical records and other health Enrollment information containing protected health information and personally identifiable information are used and disclosed in accordance with HIPAA Privacy Rule requirements. All vendors and subcontractors will execute a Business Associate Agreement that holds them to the same standards.

In accordance with the federal requirements outlined in Contract Section 16.4, we acknowledge and support the Division's right to access CCO and our Providers, and subcontractor books, documents, papers, medical and financial records, data, surveys and computer databases (collectively referred to as records) available for examination and audit by the Division, the State attorney general, authorized federal or State personnel or the authorized representatives of these parties including, without limitation, any employee, agent, or contractor of the Division, CMS, and the Division's agent.

(i) Utilization Reports

Utilization reports are vital in assessing utilization trends, performance, and progress toward performance targets. Our integrated CSP includes regulatory reporting capabilities to support required clinical and administrative regulatory reporting. Our Utilization Management Coordinator and SIU Manager (for the Program Integrity Plan) are accountable for the development and accuracy of our utilization reports. Utilization reports will include:

- Hospice reports (Contract Section 16.2.6)
- Drug utilization data for any pharmacy or drug delivery services directed to deliver (Contract Section 16.8)
- Psychiatric Hospital Services Utilization Report (Contract Section 9.2.7)
- Provider Statistical and Summary Reporting for Outpatient Hospital and Inpatient Claims (Contract Section 16.2.5)

(ii) Claims, Grievances, and Appeals Reports

Our CSP is fully integrated into our claims processing system to assure claims are managed in a timely and accurate manner. Please refer to our responses to Section 4.2.2.6 for additional details on our claims processing features and functions. Our information retrieval system can accept claims history data from the Division or its agent in accordance with Contract Section 16.11. Our claims reports will provide a transparent view of our claims processing activities to assure appropriate Member access to services and payments to Providers. Our CSP is the central repository for inquiry, Grievance, and Appeals information. The CSP will generate data that allows us to measure, monitor, and report our processing timeliness.

We will track and trend Grievance data by type and Appeal data by service type. We will review Grievance trends through the Quality Management Committee to identify trends and discuss proactive solutions to improve processes and reduce the overall volume of Grievances. A dedicated team of risk analysts within the Grievance and Appeals team will continuously mine data and monitor these trends weekly to be proactive in addressing Members' concerns and contribute to programmatic continuous quality improvement efforts. We will provide required claims and Grievance and Appeals reports, including:

- Claims Denial Report, including explanations for denials in excess of 2.0% (Contract Section 16.2.4)
- Quarterly Grievance and Appeals Logs (Contract Section 16.2.9)

(iii) Disenrollment (For Other than Loss of Medicaid Eligibility)

Member demographic data is derived from the daily Enrollment reports consolidated monthly. The state 834 file report (Member Listing Report) is used to notify the CCO of Enrollment, disenrollment, or any changes in a participant's eligibility or benefits. In accordance with Contract Section 3.6 and the reporting manuals, we will submit monthly Enrollment reports in a submission format approved by the Division. We will report any adjustments to the Member Listing Report, including disenrollment for voluntary or involuntary disenrollment for cause, and submit corrections to the Division for review and approval on or before the 15th day of the month for which the Member Listing Report was issued.

(iv) Member Characteristics

Our MIS collects volumes of data on Member characteristics, including trimester of Enrollment, medical appointments kept or missed, number of Members with a Patient-Centered Medical Home as their primary care,

assessment information, other health insurance, and much more. Our system can capture multiple Member addresses, including the Division's official address, and transmit that information back to the Division. All collected Member characteristic data will be made available to the Division, CMS, Mississippi Department of Insurance, or any other agency upon the Division's request.

(v) Provider Characteristics

Provider characteristics and various other attributes are collected, stored, and available for reporting. These include Provider type, specialty, location, gender, language spoken, ethnicity, and much more. Provider characteristics are important in assisting Members to choose the right Provider, and this information is included in Provider directories. The tracking of Provider ethnicity is critical, as studies have shown that Member health is positively impacted when helping Members to connect with a Provider of shared background.

(vi) Care Management Utilization

Our CSP includes regulatory reporting capabilities to support required clinical and administrative regulatory reporting as well as ad hoc requests made by the Division, including Member encounter data, Member utilization of prescription drugs and services, and others. The CM reports will offer transparency into the effectiveness of our CM intervention activities. As required in Contract Section 7.7, our Mississippi-based Care Management Director will be accountable for the development and accuracy of our CM reports as required in Attachment A. Reports will include:

- Demographics such as:
  - Number of Members by Acuity Level
  - Number of Members Unable to Contact in 60 days
  - Number of New, Completed/closed, Unable to Complete/close Referrals
  - Number of Members in Medication Management Therapy
  - Number of Members Consenting to Case Management
  - Number of Emergency Room (ER) Visits Per Month
- Services Rendered to Members
- Outreach Reporting
- Closed-loop Referrals
- Warm Handoffs Completed
- Referral Completion Rate
- Health Risk Screening Status and Completion Rate
- Barriers to Referral Completion
- Comprehensive Health Assessment Completion Rate
- Month-over-month HEDIS® trends
- EPSDT Reporting
- ER Utilization and Unplanned Hospital Readmissions
- Other data as requested

Our local, Mississippi-based EPSDT Coordinator has oversight over the EPSDT program, including reporting. In accordance with CMS, NCQA, and the Division's requirements, we will report all EPSDT-related HEDIS measures to monitor the success of our program and track EPSDT rates through our annual CMS416 reporting, as well as rates by Provider group, in accordance with Contract Section 16.2.2. Several data sources will inform our performance metrics and are linked to our Provider incentive programs to promote whole person-centered care. For example, certain data sources will help us monitor compliance with the EPSDT periodicity schedule. Measurement sources will include HEDIS, our EPSDT Data Warehouse, medical records, and key performance indicator reports, as needed. HEDIS benchmarks and quality coding guidelines will be made available on our Provider Portal and offered to Providers as needed. For instance, our Clinical Quality Auditor will visit Provider

offices to review medical record documentation compliance, including compliance with HEDIS measures of EPSDT. They will check to see if hearing and vision screenings, wellness visits, lead screens, and other EPSDT requirements were completed according to EPSDT guidance. Our performance-based Provider incentive programs will reward Providers for closing HEDIS care gaps and correlate with HEDIS measures.

(vii) Clinical Data

Aggregated clinical data will include Member-specific information in accordance with Contract Section 16.5.1. We will comply with Section 6504(a) of the Patient Protection and Affordable Care Act to support the Division's claims processing and retrieval systems ability to collect required data elements for claims processing and information retrieval systems. Our CCO will maintain a wealth of data and information about its Members. We will augment our claims data with clinical data, including lab results and Provider electronic medical record data, offering even greater utility to healthcare Providers and our CCO. We will use our clinical and administrative data to produce reports and analytics to monitor and manage the delivery of quality care. Better data allows us to derive more value from our analytical tools and processes, enables better care coordination and management, and helps us drive better decision-making. Data sets such as clinical, CM plans, SDOH, and encounter data will be made available to the Division in both structured and unstructured formats. We will work with the Division's Systems Workgroup to define a statement of work that will detail all data-routing requirements in accordance with State and federal standards, as required in Contract Section 16.5.

(viii) Population Health Data and Reporting

In accordance with Contract Sections 16.5.2 and 8.10.1, we will submit raw data pertaining to the quality of our Population Health program, as requested by the Division. Our Population Health Director serves as a liaison to the Division. This staff will work collaboratively with the Division's Population Health leadership to assure we are meeting the Division's population reporting needs throughout the Contract period. Our analytics system will offer the Division modern data analytic capabilities to evaluate our CCO's Population Health performance. Our analytics platform will help us to target our interventions to specific populations, support Providers in the delivery of care, measure our progress, and create program improvements to best support Members, Providers, and our CCO leadership team.

As a CCO, we will provide reports to the Division and PCPs/Patient-Centered Medical Homes that identify changes in health disparities, targeted health outcomes, Member participation in health promotion and disease-prevention initiatives, percent of Members in each risk-stratification level, and Member utilization of inpatient and emergency departments, in accordance with Contract Section 16.6. Member information, including treatment plans, will be available to our network Providers through our secure portion of the Provider website. This tool will enable Providers who are treating our Members to see the full picture, including treatment plans and assessment information, enhancing their ability to reduce duplication, fill in gaps in care, and verify that their patients are getting the services they need. Our systems will also support clinical information sharing between physical and behavioral health Providers, with Member authorization as necessary — promoting integration of care.

Additional Reporting Requirements

As described in our responses to Sections 4.2.2.8.A.1, 4.2.2.8.B.1.a, and 4.2.2.10.A.1, we will provide financial, encounter, and third-party liability reporting. In addition, we will submit to the Division copies of reports that our CCO has submitted to the Mississippi Insurance Department, as required in Contract Section 16.2.10.

Provider Services Reports. Provider Services Reports that include information and reporting on our Provider services operations, Provider Enrollment, training, and Grievance and Appeals will be submitted to the Division in accordance with Contract Section 16.2.1. We will continually monitor information from our Provider

Services, CM, Quality Management (QM), and Grievance and Appeals departments to identify opportunities to improve the network and address any deficiencies.

Quality Management System Reports. Our QM program will provide a formal process to monitor and evaluate the quality, appropriateness, efficiency, safety, and effectiveness of care and service objectively and systematically. We will focus on operational processes as well as health outcomes and satisfaction of Members and practitioners. The QM program will promote the accountability of all employees and affiliated health personal to be responsible for the quality of care and services provided to our Members and to address the clinical care and service needs of Members. As a CCO, we will continually strive for industry best practices and use NCQA's Quality Compass Medicaid All Lines of Business National percentiles as goals for HEDIS and CAHPS®, as outlined in Contract Section 8.18. Internal audit reports detailing the annual review, quality of care trends, adverse incident trends, completed performance improvement projects and quality improvement initiatives, proposed system or policy and procedure modifications, and audit review trends and recommended corrective actions will be submitted to the Division, as required in Contract Section 16.2.8.

Subcontractor Disclosures. Our subcontractor partners are an extension of us, and their involvement enables us to perform a variety of Contract requirements in a way that is most responsive to local needs. We will retain sole responsibility for fulfilling Contract requirements and complete accountability for our partners' performance. In accordance with 42 C.F.R. § 455.104(b), 42 C.F.R § 438.608(c), and 42 C.F.R. § 455.106, we will obtain and report disclosure information from all subcontractors, managing employees, and agent's employees to the Division.

Identifying Information. To comply with the Identifying Information requirements defined in Section 1.2.3.3 of the RFQ and subsequent amendments, we removed names of federal and state agencies, Providers, and other stakeholders from our response, except where expressly permitted by the Division. If this information is needed to validate our proposed solutions or evaluate our response, we will be ready to provide it to the Division.

[END OF RESPONSE]

4.2.2.9: Program Integrity

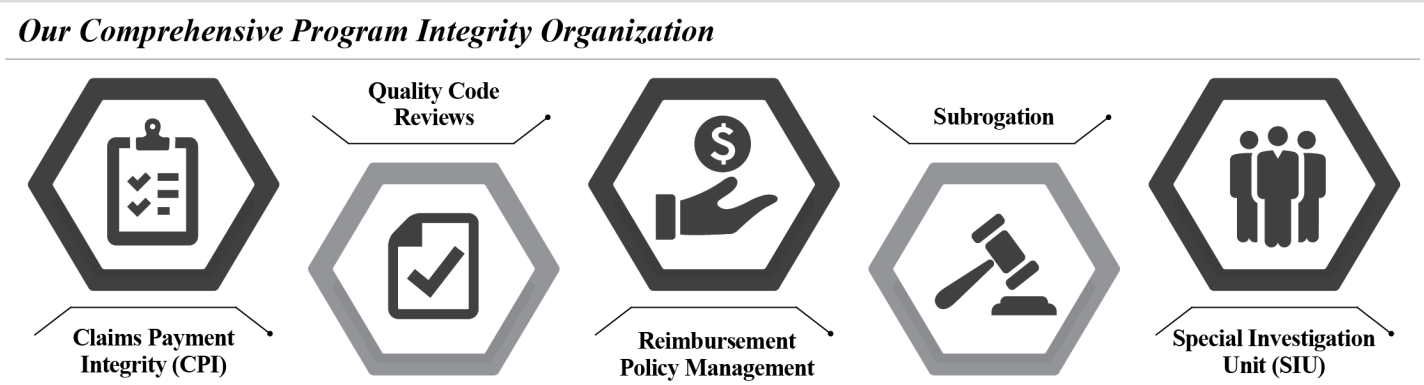
A. Fraud, Waste, and Abuse

1. An Organizational Commitment to Detecting and Addressing Fraud, Waste, and Abuse
Our Coordinated Care Organization (CCO) is committed to optimal stewardship of MississippiCAN and CHIP program funds, and we will engage in active, transparent collaboration with the Division of Medicaid (Division) and the Medicaid Fraud Control Unit (MFCU) to prevent, detect, and correct fraud, waste, and abuse (FWA).

Coordinated Action Across the Entire CCO. Assuring program integrity and minimizing FWA will require coordinated and integrated action across our entire organization. For this reason, our Program Integrity Unit will be composed of multiple teams across our Mississippi CCO, performing a variety of functions to prevent, detect, and correct FWA (see Figure 4.2.2.9.A.1-1). The following teams of highly trained, experienced individuals will work in concert to execute our Fraud and Abuse Compliance Plan, as outlined in Contract Section 10.2:

- The ***Claims Payment Integrity team*** will be responsible for two major areas, Coordination of Benefits (COB) and data mining. COB functions include identifying and validating other coverage and identification of recovery and prevention savings. Data mining functions (pre- and post-payment) include applying claim guidelines and detecting potential FWA.
- The ***Quality Code Reviews team*** will be responsible for two major areas, Provider education and Provider audit. We will educate Providers on appropriate coding practices for frequently misused codes, documentation requirements for each CPT® code, and how to bill correctly for services rendered. We will also conduct complex Provider audits and review medical charts for correct coding and documentation.
- The ***Reimbursement Policy Management team*** will develop and maintain reimbursement policies and define code editing procedures. In addition to industry-standard claims coding logic, such as administrative edits and correct coding, we will also apply clinical edits and customized edits for waste, fraud, and abuse. With Medical Director guidance, this team will go beyond the application of billing rules to also focus on clinical concerns that address Members' health interests.
- The ***Subrogation team*** will recover expenses when a claim results from accident or injury and another party is liable.
- Our ***Special Investigation Unit (SIU)*** will bear primary responsibility for the FWA investigative process. SIU staff, including Mississippi-based Investigators, will conduct proactive and reactive FWA detection methods (described in detail in this section) and investigate suspicious behavior or patterns.

Figure 4.2.2.9.A.1-1. An organizational commitment to program integrity.



Local Leadership. Our program integrity and FWA activities will be overseen by our Mississippi-based Program Integrity Manager, who is accountable to our locally based Compliance Officer. The Program Integrity Manager will coordinate the development and implementation of our CCO's Fraud and Compliance Plan and serve as a key point of contact to the Division's Office of Program Integrity on matters related to compliance, program integrity, and FWA. In addition, they will work closely with our parent company's national Compliance and Program Integrity units, leveraging their substantial FWA expertise and analytic resources to amplify and optimize our efforts to detect, prevent, and mitigate FWA in Mississippi.

"Fraud Team" Builds FWA Prevention and Detection Capacity

In 2021, an affiliate health plan's, SIU team launched a fraud team that included Member- and Provider-facing staff from across the organization. Quarterly workgroup meetings focus on new and emerging FWA issues and offer training on detecting and referring potential FWA. Workgroup members serve as liaisons and report back to their departments. In this manner, departments across the organization are continuously engaged and mindful of FWA. We will be developing a Fraud Team in Mississippi.

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National Support. Our local FWA efforts, led by our Mississippi-based Program Integrity Manager will be fully supported by the expertise and resources of our national Compliance and Program Integrity units. For instance, a team of registered nurses, certified professional coders, and employees with investigative experience will routinely examine MississippiCAN and CHIP claims data using analytic models to generate Provider and concept-based leads to forward to the SIU. Similarly, an audit team will review claims data to identify Providers with unusual billing trends and areas of over- and under-utilization. Pertinent data and leads will be forwarded to the Mississippi team for investigation and/or Provider education follow-up.

Compliance with State and Federal Requirements. In all FWA activities, we will comply with all federal and state requirements, including but not limited to 42 CFR Part 455, Section 1902 (a)(68) of the Social Security Act, and 42 CFR § 438.608. In addition, we will comply with all written direction by the Division's Office of Program Integrity regarding FWA investigations, overpayments, and any other program integrity related activities and reporting.

We have already gathered a collection of cornerstone documents that detail program integrity policies and procedures; standards of conduct; proactive and reactive FWA detection methods; types and frequency of FWA training and education for staff, Providers, and subcontractors; provisions for internal monitoring and auditing; and guidance for the prompt assessment and investigation of suspected fraud and abuse. We will submit all FWA documentation to the Division's Office of Program Integrity for written approval within 90 calendar days of execution of this Contract and annually thereafter.

a. Proactive and Reactive FWA Detection Methods

FWA can manifest in multiple ways in a Medicaid program: billing for services not rendered, billing for medically unnecessary services, unbundling, upcoding, altered claims, excessive services, among many others. For this reason, effectively detecting FWA requires a multi-faceted approach involving diverse proactive and reactive detection methods, including but not limited to claims examination and adjudication, predictive analysis and data mining, desk audits, on-site reviews, and investigating allegations of fraud.

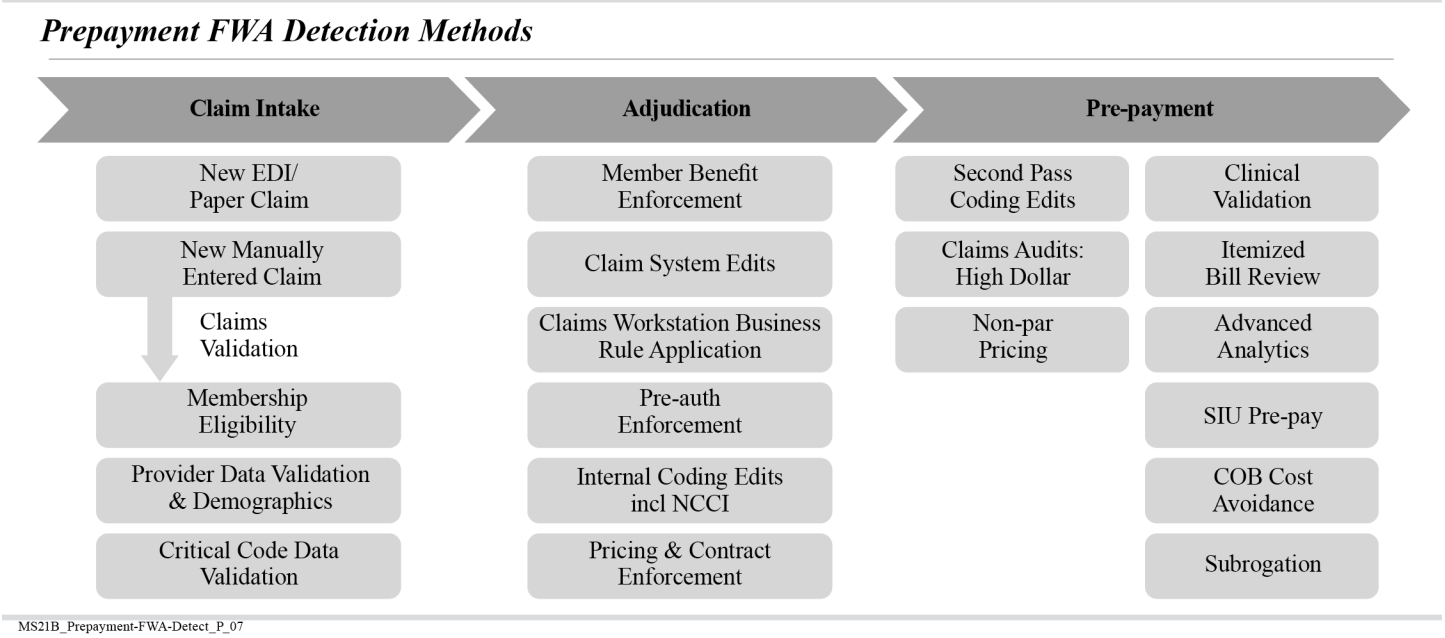
Dollar Thresholds for Initiating a Review. To reduce the likelihood of fraud at any dollar level, our SIU will ***not*** place a minimum dollar threshold for reviewing fraud allegations. [redacted]

Proactive (Prepayment) Detection Methods

By conducting multiple reviews of all submitted claims, we will assure accurate reimbursements based on medical policy, coding accuracy, and contract adherence, making sure we make proper payments to legitimate Providers for reasonable services provided to eligible Members. We will apply an initial set of edits for prepayment analysis, then an electronic comparison against local and national edits in a secondary system before releasing claims for payment. Prepayment prevention and post-payment audit reviews will address improper coding and billing errors. Figure 4.2.2.9.A.1-2 provides an overview of the various methods we will use to detect FWA prior to payment of claims. Prepayment detection methods will include:

- Claims system edits to verify Member eligibility at date of service, Provider participation, timely filing, Prior Authorization, and benefit determination
- Comparison of claims against industry coding standards to identify fraud triggers like unbundling, mutually exclusive codes, procedure frequency by day, and age/gender discrepancies
- Advanced analytics facilitating the identification of discrepancies such as inappropriate modifiers, medically unlikely procedures, and duplicate billing
- COB cost avoidance and subrogation
- High dollar claims audits

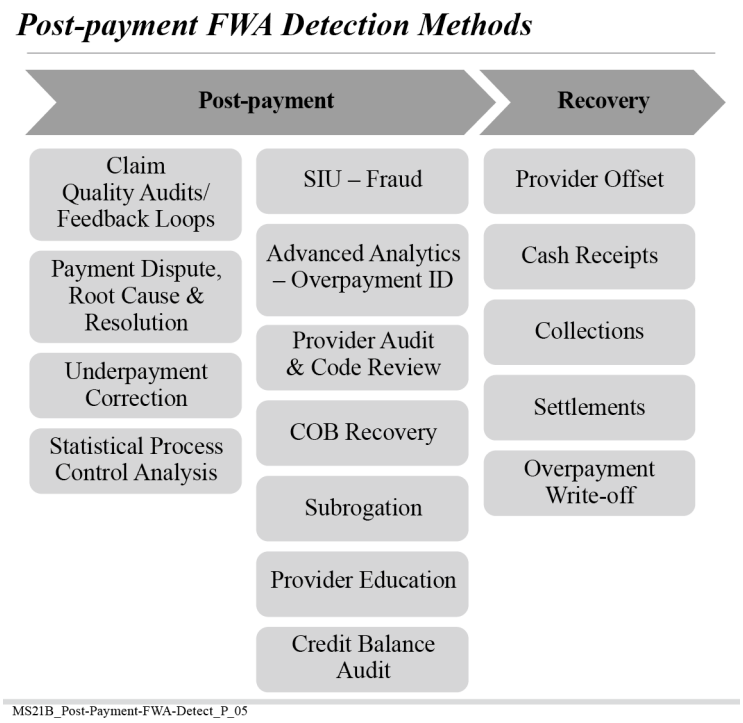
Figure 4.2.2.9.A.1-2. We implement comprehensive methods to detect FWA upon claims submission.



Reactive (Post-payment) Detection Methods

While we will focus heavily on prevention methods, such as prepayment detection, our SIU will also use reactive, analysis-driven, post-payment review to identify claim aberrancies (Figure 4.2.2.9.A.1-3). Our post-payment data mining tools and methods will facilitate discovery of payment integrity issues, investigative leads, and new research areas through statistical and machine learning models. Predictive modeling tools will be used to compare Provider claims and billing practices against their peers and detect instances not specifically restricted to CPT codes. Additionally, our post-payment reviews will assure claims have been paid in

Figure 4.2.2.9.A.1-3. We conduct extensive post-payment review and recovery.



accordance with Contract terms and applicable laws. Investigative actions will also help identify trends and schemes that aid in system configurations improvements.

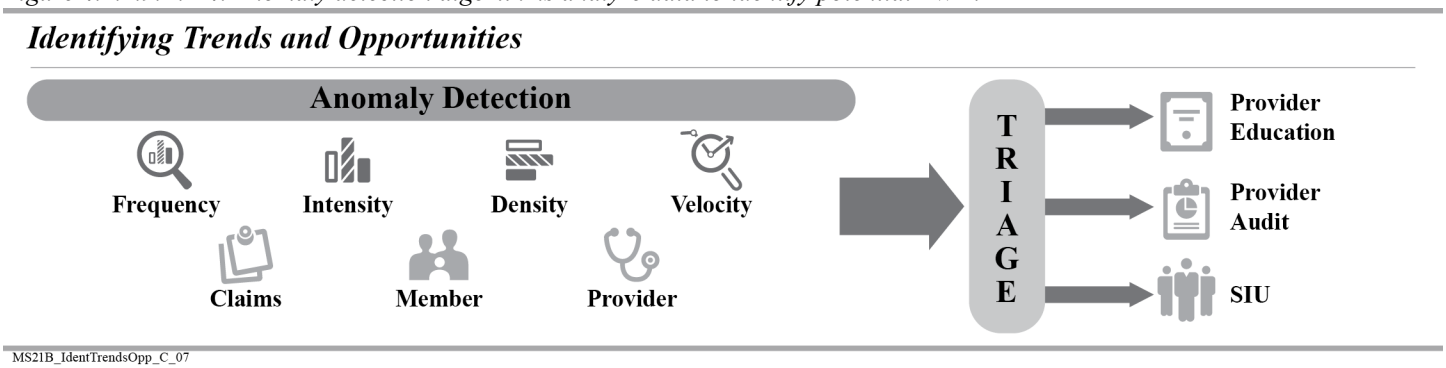
Further, we will use a suite of advanced models that predict and flag suspicious trends in Provider billing patterns. These models are tools used to review and analyze data to identify previously undetected high-risk areas.

For example, a multidisciplinary team will use anomaly detection models along with other sources to generate Provider and concept-based leads to the SIU. Similarly, our auditing team will use anomaly detection models to identify Providers with unusual billing trends and areas of over- and under-utilization. This information will guide Provider education efforts regarding correct usage of coding guidelines, billing policies, and contract adherence. In addition, through our utilization management (UM) dashboard, our UM team will be able to identify trends to detect and correct potential overutilization of services and refer cases of suspected inappropriate utilization to the SIU for further investigation.

These models (see Figure 4.2.2.9.A.1-4) identify atypical patterns of behavior through peer comparison and historical trend analysis using data analytic algorithms that analyze risk populations (Provider, Member, procedure, and diagnosis) against risk dimensions:

- **Frequency.** Identifies spikes and trends of a particular behavior that can be watched and tracked against norms for that behavior, such as when a Provider bills a type of service more than their peers
- **Intensity.** Calculates a score based on overall measurement of an aberrant behavior; for example, a Provider that classifies a greater percentage of high-level Evaluation and Management (E&M) services than their peers
- **Density.** Identifies outlier Providers/Members whose behavior is flagged by multiple identification algorithms, indicating predictability for aberrant behavior

Figure 4.2.2.9.A.1-4. Anomaly detection algorithms analyze data to identify potential FWA.



Velocity. Qualifies spikes in identified behavior across a timeline, indicating the speed at which the aberrant behavior takes place

For example, we can identify Providers in need of billing education and training based upon frequency or intensity measures generated through anomaly detection. In this circumstance, a local Provider Relations team member will reach out to the identified Provider to offer education and training to correct the billing problem. As another example, an anomalous spike from a Provider in a particular billing code may lead to a referral to our SIU for investigation.

Monthly reporting and analysis will also support the generation and verification of leads related to potential Provider fraud and abuse. A dashboard for the investigation team will display a rolling 13 months of data and support sorting, filtering, and drill-down analysis on several elements, including county or city, Provider tax ID, and top procedure codes. The ability to view a summary of any Provider's billing history, including changes and peer comparisons will be a key part of the investigative process and strategy to detect and prevent Provider fraud and abuse.

Effective Fraud Detection Methods

During a vendor audit, one of our affiliate health plans identified significant red flags in documentation provided by a behavioral health Provider, including cloned records and documents lacking Member and Provider signatures. Our SIU subsequently confirmed, through Member interviews, the Provider had been submitting claims for services not rendered. We referred the Provider to the State Medicaid program. In 2021, the Provider pled guilty to healthcare fraud in federal court, was sentenced to two years of supervised probation, and was ordered to pay restitution of nearly **$150,000** to the Medicaid program and **$40,000** to Medicare.

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Desk Audits. We will perform desk audits on a post-processing claims review basis. Desk audits will include a review of medical records and supporting documentation for accuracy, appropriateness of codes billed, and standard documentation rules. This review also includes claims evaluation for upcoding, unbundling, inappropriate use of modifiers, and billing for services not performed. The SIU will use rules-based fraud detection tools and report findings via our data mining tools, as well as Medicaid schemes and trends across all lines of business.

On-site Review. The SIU may conduct announced and unannounced site visits on Providers who are under investigation as directed by the Division's Office of Program Integrity. In ***announced visits***, the Provider will receive notification of a visit and a list of dates of service and medical records that will be reviewed. Announced visits may be indicated if the SIU has been openly working with the Provider on claims errors, ongoing Provider education, or as a follow-up to corrective action.

We will conduct ***unannounced on-site reviews*** based on the need to maintain the integrity of the investigation, depending on the egregiousness of the allegation. For example, when a Provider is suspected of billing for services not rendered, an unannounced visit may be appropriate. On-site visits allow the investigative team to interview Providers and/or their staff and collect medical records during the visit. On-site appraisals also allow for observations of the overall office location, condition, and environment and provide opportunities to meet directly with Providers.

Our SIU will frequently coordinate with other CCO departments, including Care Management and Provider Services, to make certain we have all necessary information to properly conduct the visit. During the on-site review, all HIPAA and privacy rules will be followed. Our Clinical Fraud Investigators will review medical records collected from on-site visits. A detailed report will be completed after every on-site visit and stored within the official case file.

Member Verification of Receipt of Service. To make certain that submitted claims are for services rendered, the CCO will send Explanation of Benefits (EOBs) to a sample of Members with an accompanying letter asking

them to verify receipt of the listed service. To increase our Member response rate, we will call and text Members, reminding them to complete the form.

Reporting of Suspected Waste, Fraud, and Abuse. Our SIU will conduct fraud and abuse investigations based upon referrals of suspected fraud and abuse from internal and external sources, including but not limited to staff, Members, Providers, Subcontractors, and law enforcement. We will encourage individuals to report FWA suspicions and provide multiple channels to make it as easy as possible — especially for those who wish to remain anonymous. Anyone will be able to report FWA via mail, in person, customer service, the toll-free national hotline, or reporting links on our website. Members, Providers, community members, and internal staff will be able to report suspicions directly through a website specifically developed for this purpose. The FWA reporting website and fraud referral form will be published on our website and in Member and Provider handbooks. We will also use newsletters to remind Members and Providers how to report FWA suspicions.

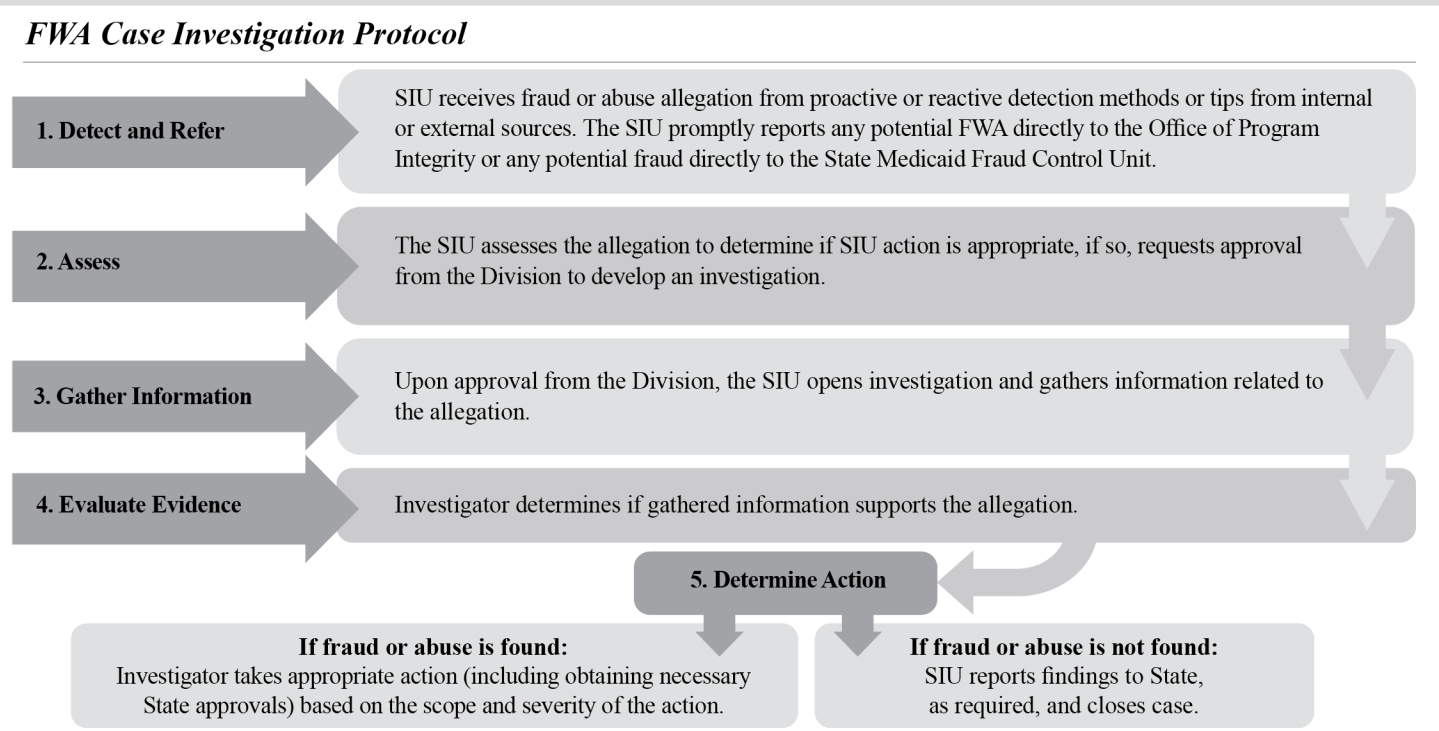
In addition, employees will have several options available to promptly report any suspected or identified issues:

- Calling the SIU Fraud Hotline for confidential and anonymous reporting of allegations
- Completing an online fraud and abuse referral form located on our intranet website
- Reporting allegations or concerns directly through our national FWA website

b. Process for Acting upon Suspected FWA Cases

As noted in the previous section, suspected FWA cases are identified primarily through data mining activities but can include referrals from the Division and tips from staff — such as other departments in our Program Integrity Unit as well as UM, Claims, and Operations. When we identify a subcontractor, Member, or Provider that we suspect of committing fraud and/or abuse, we will notify the Office of Program Integrity in writing immediately upon discovery. Our SIU staff members will follow established protocols throughout the case investigation (Figure 4.2.2.9.A.1-5).

Figure 4.2.2.9.A.1-5. SIU's formal process for FWA investigation.



Our FWA documentation will provide guidance for the prompt assessment and investigation of detected offenses, ranging from mild offenses calling for Provider education to more egregious offenses potentially requiring a complex SIU investigation. The SIU will promptly conduct a thorough review of all tips and leads received and thoroughly vet every allegation to determine credibility. All referrals will be handled as new allegations, even if a similar complaint has been previously received. The allegation will be reviewed to determine if it is actionable by the SIU, and not an erroneous referral (for example, a billing error). Our leads are triaged by our Investigative Assistants, and if found to be credible, management reviews and the lead is transferred to a SIU Investigator further assessment.

Our SIU will promptly conduct a preliminary investigation of all allegations of fraud and abuse in accordance with the Contract Section 10.3. The primary goal will be to firmly establish predication and the need for additional SIU action. This preliminary investigation will give our team the opportunity to collect evidence that validates the allegation to the point we could classify it as a case. The SIU will have access to a variety of useful public and restricted access databases. They include:

- LexisNexis®: Accurint for Insurance (Public Records)
- Encoder Pro®
- NHCAA's Special Investigations Resource and Intelligence System (SIRIS)
- U.S. HHS Sanctions Database
- State Licensing and Sanctions websites

These resources can be used during the assessment process and are an integral part of the investigative process.

Once a fraud or abuse referral is made, and if a Credible Allegation of Fraud is determined, the SIU will await permission from the Division's Office of Program Integrity or MFCU to pursue any action with the Provider, specifically related to MississippiCAN and CHIP claims, such as:

- Contact the subject of the investigation about any matters related to the investigation
- Enter into or attempt to negotiate any settlement or agreement regarding the incident
- Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident

Our SIU will be committed to full transparency about our investigations from the point the allegations are received through proposed resolutions. We will fully cooperate with all requests for additional information on Providers under review by the Office of Program Integrity or MFCU, and we will make sure that we do not take any steps that would potentially jeopardize a criminal or civil investigation.

Generally, leads referred to the SIU will include:

- Claims containing red flag indicators, or other objective evidence of FWA regardless of the number of indicators
- Any allegation that involves a direct contact with or by an informant
- Information obtained through third-party sources such as police reports or regulatory inquiries
- All accusations in which there has been a law enforcement contact regarding the possibility of FWA

The SIU will stay current with industry schemes and issues and contributes to national initiatives, such as the Federal Healthcare Fraud Prevention Partnership and the National Healthcare Anti-Fraud Association. We will interact regularly with Mississippi regulators and law enforcement, participating in or hosting task forces with various law enforcement and prosecuting agencies.

The SIU management meets monthly with each assigned investigator to review their cases and confirm that cases are updated at least every 45 days. This will help facilitate timely processing of cases. The SIU team will also host a regular SIU/CCO meeting, in which we will present details of cases, data mining projects, trends, and schemes. During that meeting, the team will review a report that includes details on open, closed,

conditionally cleared cases as well as all leads and requests for information. Additionally, SIU leadership will participate as directed by the Division in conference calls to review aged cases, volume of external requests, volume of tips/leads received, and overall caseloads by investigator.

The SIU documents all allegations that require SIU action in our case tracking system and those that rise to the level of a case will be included on our monthly reporting to the Office of Program Integrity.

As the review moves from a lead (referral) to the investigation and information gathering stages, our Mississippi-based Investigators will apply their skills and experience to obtain, process, and report information derived from a variety of methods, such as interviews, medical record reviews, on-site visits, and other sources of investigative information. There is no predetermined point in time at which the information gathering stage of the investigation is complete. Additional evidence may surface at any time; however, at some point, the investigator must determine the appropriate time to move from information gathering to evaluation and action.

Data Mining Leads to $1 Million Overpayment Recovery

An affiliate health plan, through data mining performed by an SIU investigator, identified a circumstance in which the health plan was charged more than $1 million for a dental procedure CPT® code (41899) during a two-year period. Upon investigation, it was found that the Provider, a large urban medical center, had mistakenly invoiced the health plan for these services — instead of its dental vendor. The SIU sent a referral and a request to recover to the MFCU. After some delays due to the pandemic, our SIU was given approval to seek overpayment of slightly more than $1 million from the Provider, to which the Provider agreed. The overpayment was resolved in April 2021, and the case was closed.

MS21B_DataMining_C_04

Our SIU FWA Plan will detail our investigative process, which incorporates:

- **Information Gathering.** Data mining, data review, interviews, and medical record reviews. Specific information gathering activities may include:
  - Performing claims data analysis to assure coding guidelines are followed
  - Reviewing medical records from the suspect Provider's universe directly, which may involve sampling
  - Reviewing other medical records, logs, or service orders from other Providers who may be involved with suspected claim(s)
  - Conducting announced and unannounced site visits to the Provider location(s)
  - Conducting telephone interviews of the Provider or staff
  - Performing Member interviews via telephone or in person
- **Evaluation of Investigative Findings.** Cross-departmental collaboration and engagement of CCO partners (Care Management, Provider Services, Compliance, UM, Quality), implementation of prepayment review
- **Formal Notification.** Refer to the Office of Program Integrity, obtain permission to share SIU findings, educate and collect overpayment, establish other corrective actions
- **Case Resolution.** Collection of overpayments, administration of corrective action and educational follow-up, close case

c. Process for Complying with Federal Regulations Related to Disclosures and Exclusion of Debarred or Suspended Providers

To comply with applicable federal regulations, we will secure completed Disclosure of Ownership and Control Interest Statement forms from network Providers via the following process:

- **Mail Forms to Providers.** We will mail forms during initial contracting, upon request from the Division, or when notified of a change in ownership.
- **Upon Receipt, Review Completed Provider Forms.** We will review forms for accuracy and completeness and check information against the Office of the Inspector General and Excluded Parties List Systems. Those identified as excluded will not be allowed to join the Provider network.
- **Report Exclusion to the State.** We will report exclusions to the State in a timely manner, according to Division and state regulations.

In accordance with Contract Section 10.2.2.8, the Program Integrity team will review the Mississippi Sanctioned Provider List at least monthly and immediately terminate and/or exclude from participation the Enrollment of any Provider that is terminated under Medicaid, Medicare, or CHIP Programs. In addition, we will conduct a monthly comparison of our Provider files against the following databases: Social Security Master Death File, HHS-OIG's List of Excluded Individuals and Entities (LEIE); General Services Administration Excluded Parties List Service; CMS' Medicare Exclusion Databank; State Board of Examiners; National Practitioner Data Bank; Health Integrity and Protection Databank; and State listings of excluded Providers. Our Compliance Officer will report any Providers showing on any of the lists to the Division immediately, as well as provide a report to the Division of the result of the comparison. We will establish an electronic database to capture identifiable information on the owners, agents, and managing employees listed on the Provider's Disclosure information as provided by the Division. We will also review inactive Providers and terminate them due to inactivity for 12 months, unless otherwise approved by the Division.

In addition, we will require network Providers to comply with all federal requirements (42 CFR 1002) on exclusion and debarment screening. This process will include coordinating with the Division's contracted Fiscal Agent to confirm the status of Providers who are requesting to enroll with our CCO and to confirm recredentialing status.

d. Process for Interacting with the Division, Including the Office of Program Integrity

We understand the importance of a building a strong working relationship with the Division and the Office of Program Integrity in addressing FWA in the MississippiCAN and CHIP Programs. To do this, we will develop internal systems, controls, and processes that facilitate routine and ad hoc communication, timely reporting, and joint investigation in accordance with Contract Section 10.0. Specifically, we will:

- Meet at least quarterly with the Office of Program Integrity and more frequently as needed, via phone, teleconference, video conference, or in person to discuss past current, and future investigations and to improve the effectiveness of FWA oversight activities [redacted]
- Develop cross-departmental systems and controls to assure timely routine and ad hoc reporting within Contract timeframes regarding activities such as overpayments identified or recovered, changes in Member residence or death of a Member, changes in Provider circumstances that may influence ongoing participation in the MississippiCAN or CHIP Program, and referral of any potential FWA
- Submit to on-site reviews and respond to requests from the Division to supply documentation and records
- Cooperate with all appropriate state and federal agencies, including the Mississippi Attorney General's MFCU in investigating FWA
- Seek prior Division approval for specified activities, such as retrospective reviews and prepayment reviews
- Cooperate with the Division when the Office of Program Integrity imposes payment suspensions or lifts a payment suspension

In addition, we will share FWA trends with the Division and other CCOs in a collective effort to combat FWA.

e. Other Components of Our Fraud, Waste, and Abuse Program

While we pursue recovery of overpayments that stem from FWA, we have found it more efficient and cost-effective to stop erroneous payments before they are made. Our focus on prevention includes working closely with Providers to facilitate behavior change prior to claims submission and payment. [redacted]

Provider Education

Our Provider education approach acknowledges the complexity of coding rules for Providers and individuals who conduct their coding. The goal of the Provider billing and claims education program is to elicit change in behavior from the Provider and their staff members by using a comprehensive, progressive approach through written correspondence and educational telephone calls conducted coder to coder, coder to biller, or coder to Provider. Our CPT correct coding policies and monitoring of coding practices are discussed, offering the Provider an opportunity to ask questions and gain clarification, if needed, on the American Medical Association CPT coding guidelines and our CCO policies. To monitor and identify potential billing concerns, Providers are compared to their peers in the same medical specialty, as defined by National Provider Identifier (NPI) classification. Peer groups are determined by geography, and they are based on the distribution of claims billed by visit type as compared to the specialty average for that visit type. Each Provider's data is analyzed to identify aberrant billing trends. If billing trends fall outside the norm, the Provider is assigned an outlier status and a Provider Relations representative is tasked with contacting the Provider to provide information and education, as indicated.

Our Provider education approach involves:

- **Identifying Opportunities.** A team of certified professional coders will be dedicated to researching CMS and federal and state regulations, meeting with CCO staff, participating in cost of care workgroups, and using analytical tools made available to them to maintain the pipeline of concepts. The pipeline allows Provider Education to continually launch new initiatives rather than one or two a year.
- **Analyze.** Provider Education will have a dedicated team of data analysts and certified professional coders. Together, they customize the analytics to specific diagnosis and CPT codes, date ranges, and state contracts and regulations to develop the initiatives and appropriate lists of Providers for education.
- **Execute.** Provider Education has a proven process:
  - **Concept Development.** Research medical trends, state and Provider contracts, CMS guidelines, CPT codes, etc. Leverage the power of advanced analytics using the anomaly detection tool to detect potential abnormal billing practices.
  - **Data Mining.** Validate and value concept and identify aberrant Providers for education.
  - **Presentation.** Present concept overview, scope, and objectives to CCOs; provide list of identified Providers for education for review and approval.
  - **Provider Education.** Generate and mail letters.
  - **Provider Inquiries.** Dedicated staff of Certified Professional Coders and direct "hotline" number, fax, and email provided in letters.
  - **Follow-up.** Calculate savings at the line of business, market, concept, and Provider level using cost avoidance methodology; other potential actions include referral of non-responsive Providers for possible medical record request and review, referral to SIU, or referral to additional training videos and, potentially, to CCOs.

B. Claims Denial

1. Denials Review and Reporting Program

a. Description of Denials Management Program

We understand that accurate claims processing is critical to the success of the MississippiCAN and CHIP Programs. As a partner to the Division, we will assemble a Claims Operations team with oversight from local Mississippi CCO leadership and experience in multiple Medicaid markets, including Mississippi, to process Medicaid claims and configuring systems to specific State requirements. Through this collaboration, we will establish formal processes and tools to monitor claims operations, improve accuracy, and decrease risk to comply with Contract Sections 9.1.4, 4.3.1.10 and 16.7.2. We maintain policies and procedures for claims

adjudication accuracy, and we will submit them to the Division for review and approval before implementation. These policies and procedures provide a mechanism for Providers to Appeal a denial of claims.

Using Administrative Processes to Reduce Prior Authorization and Claim Denials

Our reporting and monitoring processes help us understand whether Prior Authorization (PA) or claim denial issues are the result of processes or education. We will use this information to inform our targeted strategies to address outliers and help Providers submit claims successfully.

Depending on the trends we see, we may modify our review process to better align with clinical practice patterns so that Providers see fewer upfront PA denials and subsequent claim denials in the future. We will pay careful attention to Provider input about whether a PA requirement is administratively burdensome or unnecessary and systematically track Provider complaints associated with PA by subject every month as part of our Payment Integrity program oversight.

We will keep Providers up to date and incorporate their input into our procedures. Our affiliates have implemented PA process changes and technologies to eliminate abrasion, reduce Provider burden, and reduce the number of PA denials that result from common Provider administrative error or mistakes. Following this model, our innovative Prior Authorization pass program will reduce administrative burden for Mississippi Providers who consistently demonstrate excellence in PA performance and meeting coverage criteria. Our Provider Experience team will educate Providers on specific outpatient codes for which they can bypass the PA process. In addition, we will work with Providers to whom we delegate UM functions to establish flexible UM criteria and processes specific to their needs.

We will address every part of a Denial Notification, with specific detail about every reason a claim is or may be denied so that the Provider can address all issues with the claim at one time. If a claim is denied because the Provider did not submit required information or documentation with the claim, then the Denial Notification will specifically identify all such information and documentation. We will respond to Provider inquiries promptly and resolve Provider claims within a 30-calendar day period for incorrectly paid or incorrectly denied claims.

Investing in Process and System Enhancements. As part of our continuing efforts toward administrative simplification, we have moved to a standard process across our affiliates. Our parent company and its affiliates base the process design on national experience and resources and best practices from Medicaid with the goal of establishing consistency for Providers.

We will offer Providers an electronic method for submitting claim payment dispute requests through the Provider Portal. The electronic method allows Providers to file claim payment disputes with the following:

[redacted]

b. Summary of Denials Criteria and Protocols

We have a catalog of nearly 500 Medicaid claims processing edits based on our affiliates' extensive experience in Medicaid managed care. Table 4.2.2.9.B.1-1 highlights examples of 50 to 60 common types of edits that

capture a range of the variations of our overall suite of edits. We will continually update our core denial edits tailored to our future experience in Mississippi.

[redacted]

[redacted]

c. Process for Identifying Claims or Claim Lines That Meet Denial Criteria

Before we accept a claim, we will apply a variety of automated preprocessing edits to validate the quality of the data submitted and verify that they are relevant, complete, and contextually appropriate, including:

- Validation of data through HIPAA Level 6 in accordance with the Workgroup for Electronic Data Interchange's Strategic National Implementation Process standards
- Professional (X12 837P) and institutional (X12 837I) claim edits
- Institutional (X12 837I) claim validations
- Checks for data accuracy and completeness, including verifying that the Member ID matches a valid health plan Member record and State-specific editing

We will reject claims that fail these initial edits. If we receive a claim electronically, we will notify the Provider within 24 hours of receipt in our system from the claim entry source. For paper claims, receipt will be available on our Provider Portal within two days. We will load claims that pass front-end validation into the adjudication system and subject them to a series of processes that will include:

- Edits based on eligibility; Provider status; medical necessity; qualified benefits; valid dates of service; pricing; PA; Third-Party Liability (TPL); and FWA detection
- Verifying that the Provider is not excluded by Medicare or Medicaid
- Identifying duplicate claims
- Applying enhanced clinical and NCCI edits to check each claim for codes subject to unbundling or Medically Unlikely Edits for codes that may be incompatible
- Evaluating claims for Never Events, Provider-preventable, and hospital-acquired conditions

We will process claims that pass all claims edits during the next payment cycle. The system will deny claims that fail claims edits and immediately generate a remittance advice, available online or on paper, to notify the Provider of the reason for the denial. ***If one claim line fails, it will not cause the other correct claim lines to be denied.*** Remittance advice will include the level of payment or denial reason for each claim using standard procedures, codes, and definitions as well as instructions on how to file a claims Appeal.

d. Reconsideration Process as It Relates to Claims Denials

As shown in Figure 4.2.2.9.B.1-1, if a Provider is dissatisfied with the outcome of a claim payment, the Provider may request an investigation into the claim payment decision, called Reconsideration. The Provider

may request a Reconsideration from the date of the claim Explanation of Payment (EOP). The Provider may submit a Reconsideration in writing, verbally, or through the Provider Portal.

Upon receipt of the request from the Provider, we will send an Acknowledgment Letter to the Provider. This response will occur within five calendar days of receipt of the Provider's Grievance. We will then conduct an internal review, which will include a thorough investigation by a trained claims analyst using all applicable statutory, regulatory, contractual, and Provider subcontract provisions; CCO policies and procedures; State policies; and all pertinent facts submitted from all parties. We will communicate the results through a written determination letter to the Provider in accordance with the Contract, Summary of Provider Grievances, and Appeals Requirements.

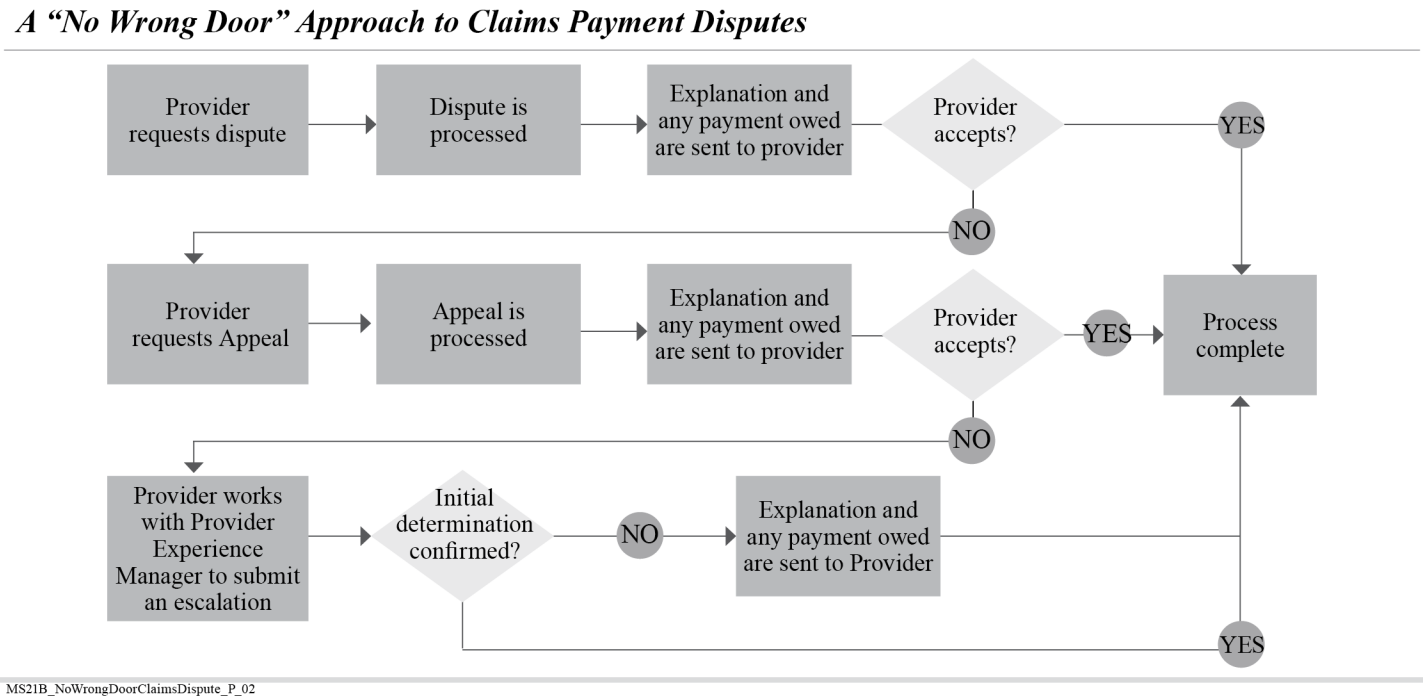
If the determination results in a claim adjustment, we will send the payment and EOP separately. If the Determination of the Reconsideration requires additional information to resolve, the determination may be extended according to the Contract. We will send a written extension letter to the Provider before the expiration of the initial determination period. If the determination requires clinical expertise, appropriate clinical CCO professionals will review it.

The determination letter will include:

- Date of notice
- A statement of the Provider's Reconsideration request
- A statement of the action the CCO intends or has to take
- The reason for the action
- Support for the action, including applicable statutes, regulations, or policies and claims, codes, or Provider Manual references
- An explanation of the Provider's right to request a Claim Payment Appeal
- Address to which to submit the Claim Payment Appeal
- The Provider's right to represent him- or herself or be represented by legal counsel or another spokesperson when requesting an Appeal

Reconsideration Resolution letters will be sent at the time of the Reconsideration decision. Claims filed within the appropriate time frame but denied may be resubmitted for Reconsideration within 90 calendar days from the date of denial. We will process claims in accordance with 42 CFR § 447.46 and Contract Section 9.1.

Figure 4.2.2.9.B.1-1. We offer a "no wrong door" approach to claims payment disputes.



e. Process for Notifying and Educating Providers of Claims Denials

Our Claims Operations team will monitor claims denials closely to identify claims denial trends that indicate the need for Provider education beyond initial orientation and training. The team will also monitor claims processing accuracy daily, including:

- Tracking key performance indicators (KPIs)
- Scheduled and ad hoc reports
- Claim audits

We will also establish a ***Mississippi Rapid Resolution*** team comprising local and parent company Claims Analysts; Appeals Specialists; Internal Resolution Analysts; and Credentialing, Pricing and Configuration, and other operational units dedicated to assuring that network Providers receive timely claims payment and identify the primary cause for denials. Our national Internal Resolution Unit (IRU) will help this team identify configuration and process issues that could affect claims processing accuracy. The IRU will consist of highly trained and experienced claims research analysts focused on resolving complex Provider claims issues. IRU staff will determine whether a claim was paid appropriately based on the configuration of the system, including business rules, Provider contract, plan benefits, and federal and State regulations. When the IRU identifies a potential Provider- or system-level claims issue, it will route the information to the appropriate department (such as Pricing Configuration or Front-end Claims editing) and track the issue to resolution.

We will use established systems and tools to monitor KPIs, including claim aging, denial, and other trend data. Claim aging and denial reports are a standard part of our claim operations. Our local Operations team will monitor daily claims processing metrics using these reports and drill down to individual claim detail to identify and address issues that are slowing down claim processing or increasing denials.

Rapid Resolution Team Provides Local Support for Providers. Timely review of denial rates and trends minimizes the occurrence of inappropriate claim denials and any undue administrative burden on Providers. Our Rapid Resolution team is one example of the accuracy-assurance efforts that we have put in place. As trends or outliers emerge, the team conducts a root cause analysis and promptly engages the appropriate stakeholders to

resolve. This process could include updating configuration or reaching out to a Provider to assure proper billing techniques. Weekly, our Rapid Resolution team will review trends for several operational metrics, including:

- Top denial reasons (split by professional and institutional claim types)
- Denials by procedure code
- Top Providers by denial reason (critical when mitigating an issue or assuring successful configuration)

Notifying Providers of Submission Issues. We will provide timely notification to Providers for any deficiencies identified on the claims they have submitted during claim adjudication. Notifications will include details on the information needed to establish a clean claim. When we identify a systemic issue, the Provider Experience team determines the appropriate type of Provider education, presenting the information in a user-friendly manner and letting Providers know they can reach out for assistance.

In addition to the claim-specific denial notice that is sent back to the Provider, our Rapid Resolution team and national IRU work to identify systematic issues that might be leading to incorrect payments or denials. These teams review accuracy for claim samples to identify recurring issues with processing or billing. We pay close attention to manually processed claims, especially those with complicated billing rules. When we identify issues, our Provider Experience team proactively reaches out to Providers, offers assistance with reprocessing claims, and offers training and educational materials.

Provider Billing Education. We will work proactively with Providers to make sure that they understand our claims processing and payment system and know how to prepare and submit clean claims. Provider orientation includes training on claims submission and payment requirements. Our Provider Experience team will provide continuous billing education and training through in-person meetings with Providers, webinars, conference calls, mail, email, and Provider newsletters, in accordance with Contract Section 6.9.3. Providers also have access to ongoing training through our Provider Portal. We will tailor both our Provider orientation and ongoing Provider education to address the denial issues most prevalent among Mississippi Providers.

Our local Provider Experience team will conduct monthly education and training for Providers on claims submission and payment processes. These training sessions will include an overview of claims processes and an explanation of common claims submission errors and how to avoid them. We will conduct these training sessions for at least 12 months following implementation and continue them as needed or requested. Our Provider Manual will include a detailed section on claims submission and payments. We also maintain electronic data interchange companion guides: one for professional and one for institutional claims. Both include detailed information about electronic claims submission.

To identify the most common denial reasons, we will regularly review detailed Provider claims data, such as totals and trends; rejections and denials; Appeals; and claims issues related to specific areas. When we identify a trend in denials, we provide clarification to our Providers through our Medicaid Provider bulletins (which we incorporate into the Provider Manual) and webinars.

For example, in recent years and across multiple affiliate health plans, we found that a major reason why claims were denied was that the Provider's rendering and billing Provider taxonomy codes were either missing or inaccurate. In response, we issued three Medicaid Provider bulletins that included detailed information and instructions about how to avoid denials for this reason. We offer updates on claims payment topics in periodic webinars.

Our Provider Experience team will offer targeted Provider education. When our Operational Excellence team finds a Provider who frequently appears on the Denied Claims Report, they will notify our Provider Experience team. A Provider Experience representative meets with the Provider one on one and works with the Provider and their billing office to understand the reasons for the Provider's claims denials. If applicable, a Provider Experience Consultant provides instruction on how to resubmit the claims for payment. Our team understands

that Providers have diverse levels of experience with billing processes, and we believe that it is important to provide the right assistance at the right time.

Strategies for Addressing Potential Provider Payment Issues. Our Operations team including our Claims Processing staff analyze claims reports for issues such as possible Provider submission problems, system problems, or other areas of improvement. For example, if we see a high number of claims pending for a specific reason, we will analyze the claims to determine whether there is an appropriate intervention, such as modifying a system edit. A high volume of claims pending or denied for a specific Provider will prompt our team to conduct additional review and proactive outreach to the Provider.

Our Provider Experience team is dedicated to supporting our network Providers with complaints resolution, contracting issues, and concerns related to PAs and claims. Our Provider Experience team is the local touchpoint for technical support; Provider Services Call Center Representatives are available to meet face-to-face with Providers and offer immediate support. They also help educate Providers on the resources available through our Provider website that promote communication and convenience and support the complaint and resolution process. This support includes links to online training, our Provider Manual, Provider bulletins, and network updates that include important information about claims submission processes, BH, and the PA process. Providers also have access to our toll-free Provider services call center for any help they need, questions, or concerns. The general Provider services call center hours of operation are 7:30 a.m. to 5:30 p.m. CT Monday through Friday, including federal holidays, with self-service available 24/7. Providers can also contact us using the email address in our Provider Portal.

Digital Support Tools to Track Claims Status in Real Time. Providers can submit their claims through our Provider Portal and track their claims status in real time. Our Provider Experience team will offer Providers on-demand support, including support for claims and payment issues. Providers can call our Provider services call center or use live chat through the Provider Portal for support. This unique offering makes claims and billing processes easier by giving Providers access to the information and features important to their day-to-day operations, such as Member management, claim functionality, and authorization management.

C. National Correct Coding Initiative (MississippiCAN)

1. Process to Comply with Medicaid National Correct Coding Initiative for MississippiCAN, Including Timeline for Pulling Medicaid National Correct Coding Initiative Files, Testing, and Implementation

National Correct Coding Initiative Compliance and Timeline

Our highly configurable Core Service Platform (CSP), part of our HITRUST-certified and HIPAA-complaint Management Information System, supports comprehensive claim edits for both paper and electronic claims in accordance with Contract Sections 10 and 4.1. This platform supports enhanced clinical, duplicate, unbundling, and NCCI edits as well as edits based on Mississippi Medicaid requirements. Using the same system for eligibility, service authorizations, TPL, and Provider data, the CSP will have all the data needed to apply the appropriate edits and make accurate, timely payments.

We understand the value of NCCI edits to Medicaid program integrity and being good stewards of taxpayers' dollars. As such, our affiliates comply with state specific NCCI policies in every state with which we partner. We understand that states have CMS approval to turn off some standard NCCI edits, and states add their own edits. We will partner with Mississippi Medicaid to assure that we comply with Mississippi policy to meet policy and business objectives.

Where MississippiCAN or CHIP policy differs from NCCI edits (for example, for some applied behavior analysis services and prenatal lab tests), we will configure claim edits based on Division guidance.

National Correct Coding Initiative Edits Process and Timeline

According to CMS instructions, NCCI updates must be in at the beginning of each quarter. Our Rapid Response team will receive NCCI edits from the state approximately 45 days from the start of the quarter and supply them to the Reimbursement Policy Management (RPM) team. The RPM team's policy will require implementing NCCI edits into production by the start of the new quarter dependent on timing of receipt of the new file. The RPM team will load these updates into our development and quality assurance (QA) environments for testing.

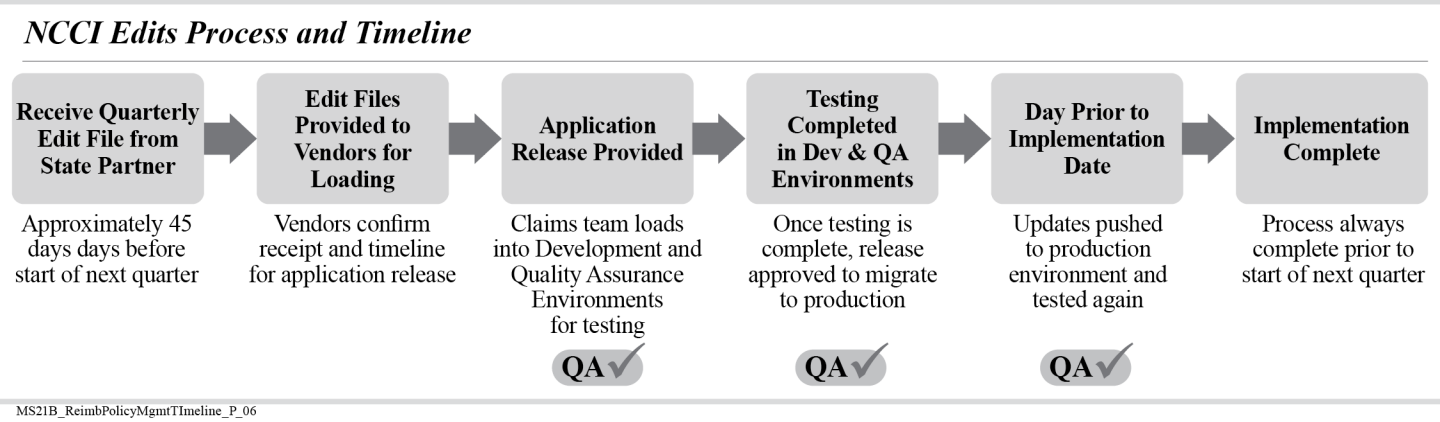
After our RPM team completes testing, we will approve the release to migrate to our production environment on the next scheduled implementation date.

For new implementations, we will provide edit files to our vendor, and then conduct joint test cases with the vendor. We will receive a file that goes into our core claims platform to perform the following activities:

1. Establish a validation testing environment (FAC3D).
2. Establish a development database in which to conduct regression testing (test deck) to double-check past edits (FAC7D).
3. Submit to the QA test environment (FAC8D).
4. Submit for user acceptance testing (FAC8Q).
5. Move to production and validate.

On the evening of the implementation, our system will push the updates to our production environment and the release will be retested. Implementation dates may vary based on information technology scheduling, but we will load updates into the system before the start of the quarter. We highlight this process and timeline in the process flow in Figure 4.2.2.9.C.1-1.

Figure 4.2.2.9.C.1-1. NCCI updates will follow a detailed edit process and timeline that aligns with CMS and Division requirements.



Identifying Information. To comply with the Identifying Information requirements defined in Section 1.2.3.3 of the RFQ and subsequent amendments, we removed names of federal and state agencies, Providers, and other stakeholders from our response, except where expressly permitted by the Division. If this information is needed to validate our proposed solutions or evaluate our response, we will be ready to provide it to the Division.

[END OF RESPONSE]

4.2.2.10: Subrogation and Third-Party Liability

A. Approach

We recognize the importance of a strong Third-Party Liability (TPL) cost avoidance and recovery program in lowering costs of care delivered to Medicaid Members. Our TPL program will operate in accordance with the State Plan and applicable federal and State laws and regulations, including Section 1902(a)(25) of the Social Security Act and 42 CFR § 433 Subpart D, as specified in Contract Section 12. Prioritizing the identification of other health insurance (OHI), coordination of benefits (COB), and collection of overpayments and subrogation, we will leverage experienced financial personnel, technology and automated applications, and consistent, replicable processes throughout our cost avoidance and recovery program. Our guiding principle is that Member access to medically necessary services is paramount. As good stewards of State funds, our cost avoidance and recovery strategies must prudently manage healthcare costs with the least impact on Providers and Members. We work with in- and out-of-network Providers to identify and resolve root causes of inappropriate billing.

1. Approach to Conducting Subrogation and Third-Party Liability Activities

As a Coordinated Care Organization (CCO), we will emphasize prospective cost avoidance versus retrospective pay-and-chase methods whenever possible. We will employ several cost avoidance strategies, including capturing third-party coverage data from all available sources; validating third-party coverage leads; applying extensive edits in our Core Service Platform (CSP), which is part of our HITRUST-certified and HIPAA-compliant Management Information System; and storing third-party coverage information in Members' electronic records in our CSP. When we identify TPL post-payment, we will act immediately to recover funds and report all TPL, COB, and subrogation activity monthly, in a format determined by the Division.

Our cost containment program will use experienced staff and documented policies and procedures to maximize the identification and recovery of MississippiCAN and CHIP funds. Our Cost Containment department will be responsible for:

- **Identification.** Identifies third-party coverage through a variety of sources and employs telephonic and online verification tools to facilitate prompt confirmation.
- **TPL Recovery.** Recovers payments associated with COB from the Provider or directly from the primary carrier. Recovery efforts bill liable third parties following claim payment. We apply recovered funds to claim records and reflect these in encounter files submitted to the Division.
- **Subrogation.** Works on TPL subrogation cases, including initial identification of liable third parties, such as auto carriers, through final payment recovery/reimbursement and case closure.
- **Credit Balance Recovery.** Conducts ongoing audits across our Provider Network to identify credit balances on Providers' accounts receivable.

Using an integrated operational approach including claims adjudication, Provider education, and system configuration, we will proactively identify third-party coverage and coordinate benefits. Our local Mississippi team will maintain ultimate accountability and oversight of our TPL program, supported by our national Cost Containment department. [redacted] This team specializes in a variety of programs, including identification of third-party coverage, cost avoidance through COB, overpayment/collections, and subrogation. Our executive leadership will hold twice-monthly TPL meetings to discuss current numbers and year-over-year comparisons, as well as issues, concerns, or areas for improvement. This strategic approach layers multiple recovery efforts to maximize TPL/COB payment correction. Our first approach will be to attempt recovery using internal resources before allowing a vendor to perform recovery. This will allow Providers the opportunity to bill the other carrier under the appropriate contract, minimizing our recovery cost by avoiding vendor fees. TPL recovery activities will cease 180 days after the payment date of a claim that is eligible for recovery, as required in Contract Section 12.4.

a. Process for Capturing Third-Party Resource and Payment Information for Use in Reporting Cost-avoided Dollars and Provider-reported Savings

We will use multiple methods to determine if a Member has other insurance throughout their relationship with our CCO. It is our fiduciary responsibility to make sure Medicaid is the payer of last resort. We will accomplish this through the following strategies:

- **TPL File from the Division.** We will process the monthly TPL file we receive and load Member third-party coverage information into our CSP. We acknowledge that failure to do so will result in liquidated damages, as defined in Contract Exhibit G.
- **Provider Claims.** We may discover third-party coverage when a Provider submits a claim that lists other insurance information or indicates payment from another insurer.
- **Member Contact.** During regular contact with Members, we will ask about other insurance coverage or if any insurance coverage has changed:
  - Care Managers ask Members about other coverage during routine communications
  - Our Member services call center is configured to prompt representatives to ask about third-party coverage every six months during Member inbound calls.

By leveraging experience, best practice systems, and proven processes of the national Cost Containment department that supports our affiliate state-sponsored health plans, we will deliver more value and better results for the Mississippi TPL program.

We acknowledge that we must use the State's daily TPL file, which will be shared with our delegated subcontractor partners, as required in Contract Section 12.3.1. We will report identified discrepancies to the Division. Our CCO will store available data regarding alternate insurance carriers in each Member's electronic record, such as a commercial healthcare insurer or health maintenance organization (HMO); TRICARE (the healthcare program for active duty service members, National Guard and Reserve members, retirees, their families and others); or an employer-administered Employee Retirement Income Security Act of 1974 (ERISA) plan. We will submit all potential OHI leads to our dedicated unit for validation. This staff will conduct daily review of all potential OHI and TPL leads received throughout the company from Members, Providers, and others. Information will be validated with the primary carrier, if appropriate, and added to a separate COB tab in the Member's data record maintained in our CSP. The COB tab will include the policy issuer and number, effective and termination dates, and last date verified. The tab will also identify the policy holder, which is important if the Member is a child and insurance coverage is through an absent parent. For Members with such information noted in their record, we will automatically incorporate COB into the claim adjudication process. We will report findings at least monthly to the Cost Containment Unit for validation and addition to the COB tab on the Member's record.

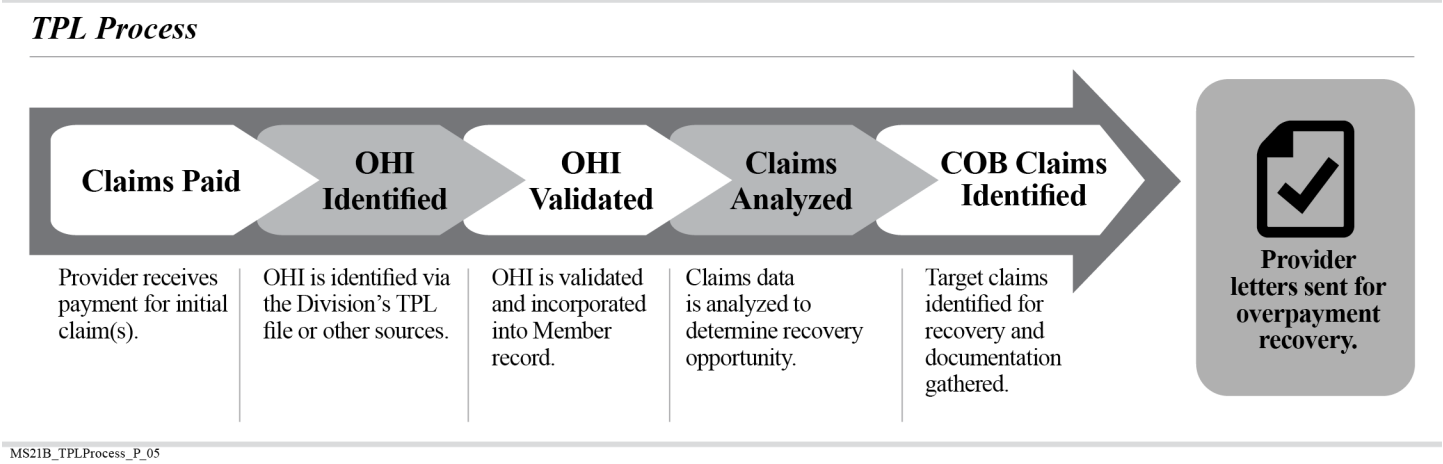
Transparency via Third-Party Liability Reporting

As a CCO, we will comply with all TPL reporting requirements, including preparing a monthly Third-Party Subrogation report to the Division, as required by Contract Section 16.2.7. We will submit monthly Third-Party Resources reports that detail newly identified health insurance leads, total amount of denied claims due to TPL, total amount recovered from other insurance companies, and total amount recovered from Providers due to audits, reviews, or disallowances following payment. We will submit a report reconciling recovery amounts annually.

b. Process for Retrospective Post-payment Recoveries of Health-related Insurance

We have documented procedures in place to support post-payment recovery and recoupment efforts to maximize Medicaid program funding, as defined in Contract Section 12.3.2. Figure 4.2.2.10.A.1-1 summarizes our TPL process.

Figure 4.2.2.10.A.1-1. We offer a streamlined TPL process results in swift overpayment recovery.



After claims adjudicate and payments are disbursed, we will analyze data to retrospectively identify opportunities for COB or TPL recoveries. We will use a multi-pass approach to make sure we review claims impacted by Member OHI changes for potential recovery. The first pass will leverage validated OHI associated with the Member's record. When we identify overpayments, the team will gather all claims documentation and send written notification to the Provider, furnishing supporting documentation including other carrier information. We will offer Providers the option of refunding the overpayment directly or offsetting future payments by the overpayment amount. We will wait a minimum of 45-days for Providers to respond to written requests. Once we receive confirmation, we will adjust the individual claim record and configure to either accept a refund or withhold future payments up to the overpayment amount.

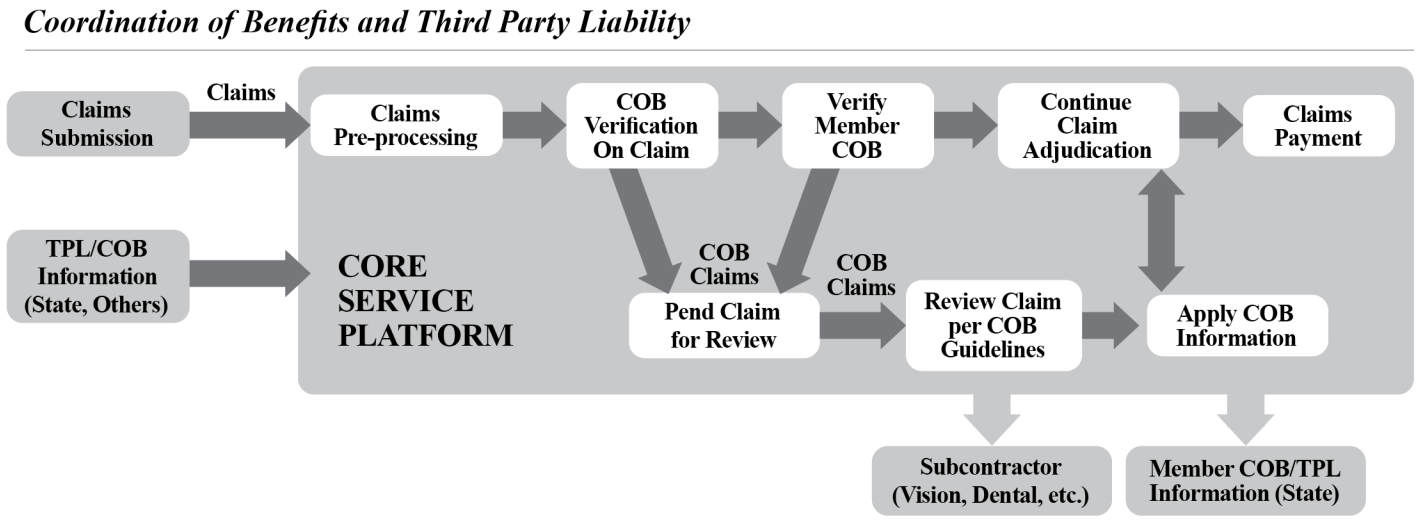
For the second pass, we will compare claims information against a second data repository that contains health information from more than 150 health insurance organizations. Through this process, we will obtain a monthly data file of all processed claims with associated Member and Provider data. We will then compare our file against this data repository to identify the appropriate primary carrier and bill for payment. This second pass will assure valid recovery opportunities have not been missed due to lags in OHI visibility. All reimbursements will be directed to our CCO and recoveries noted in the claims record for reporting to our State partners. When we identify new OHI information, we will incorporate it into Member records to facilitate COB for future claims.

c. Process for Adjudicating Claims Involving Third-Party Coverage

Our claims processing system (see Figure 4.2.2.10.A.1-2) is fully integrated with our TPL process to:

- Capture OHI information contained on the claim
- Evaluate OHI information stored in the Member's electronic record
- Suspend claims where OHI or TPL is indicated, unless the service is designated pay-and-chase

Figure 4.2.2.10.A.1-2. We effectively support cost avoidance through proactive identification of OHI.



During adjudication, our CSP will compare submitted dates of service to OHI coverage effective and termination dates in the Member record. If dates of service are within OHI effective and termination dates, the claim will be suspended for additional analyst review. If the analyst determines the claim is eligible for cost avoidance, they will coordinate the claim based on our COB guidelines. For example, if an OHI source is identified and the required Explanation of Benefits is not attached, our CCO will notify the Provider that it must be submitted to the appropriate third party for a determination of the OHI amount. If the required information is attached to the claim, the claim is suspended for additional analyst review prior to final adjudication. We will use this information to assure total benefits issued by the primary carrier and our CCO do not exceed contractually allowed amounts. In certain circumstances, such as claims for EPSDT/preventive services or when primary coverage is held by an absent parent, our CCO will pay the claim first and then pursue recovery.

Processing Subrogation Claims

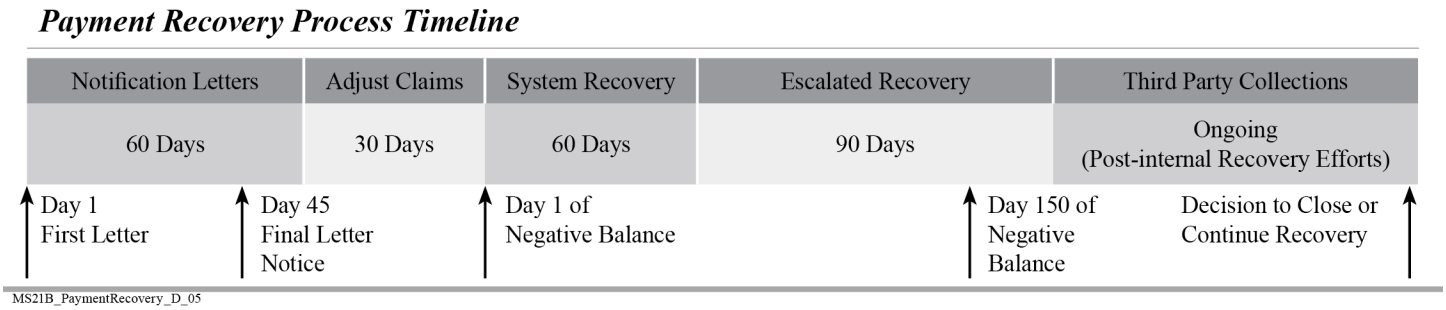
Claims submitted to our CCO for payment with indicators suggesting the service rendered is the result of an automobile, liability, or workers' compensation injury or illness may mean that another entity has primary responsibility for the cost of healthcare services. We will pay the Provider for the service rendered and then evaluate claims data, in accordance with diagnosis and trauma codes designated in the Code of Federal Regulations. Specifically, we will use the diagnosis codes identifying accident or injury. If we determine pursuit of payment by another entity may be appropriate, we will establish a case for further investigation and recovery of payments made.

d. Process for Identifying, Recouping, and Releasing Claims

When alternate insurance is noted with the claim or there is alternate coverage information on file, this will be included on the COB tab of the Member record. The record will note the policy issuer and number (group, policy, and/or social security number); type of coverage; carrier information (full name, address, telephone and/or web/email contacts, etc.); policy effective and termination dates; and last date verified. If OHI exists in the Member record, we will automatically evaluate COB during claims adjudication.

We will monitor Provider recoveries through tracking databases, regular reporting, and a structured recovery process. Our recovery system will track Provider overpayments through the life cycle of recovery, including validation, Provider notification, claim adjustment, and collection. As shown in Figure 4.2.2.10.A.1-3, our Provider recovery process timeline documents required activities at specified intervals after overpayment identification.

Figure 4.2.2.10.A.1-3. COB/TPL recovery activities are ongoing throughout the 180-day recovery period.



Regardless of overpayment type, our process will include the following standard steps:

- Log the overpayment
- Notify the Provider, including specific instructions and timelines, with a detailed listing of claims or encounters affected, education or citation supporting findings, amount of overpayment, options for repayment, and Provider Appeal rights, including the right to an Administrative Fair Hearing through the State, following direct Appeal to the CCO
- Take appropriate action based on Provider response or lack of response
- Adjust the claim record(s)
- Submit adjusted or voided encounters to the Division within 60 days of identification, regardless of payment recovery status

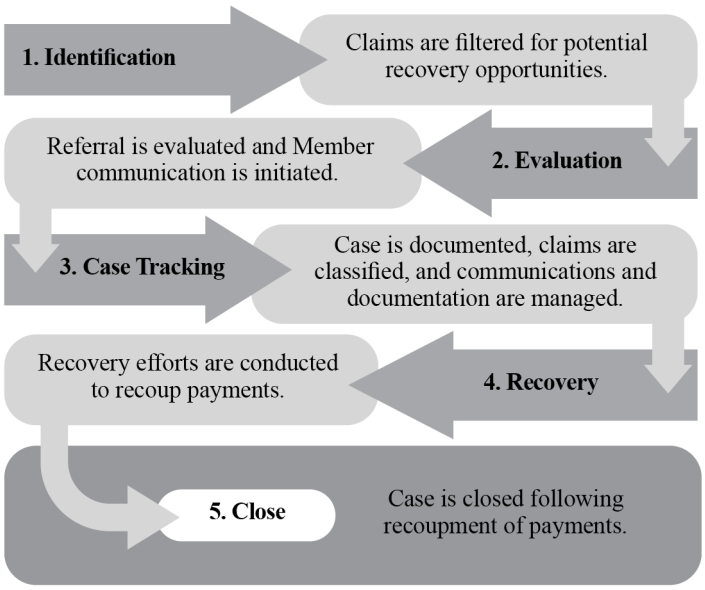
If the Provider responds with payment or requests future payments be offset, we will record details and update claims records accordingly to reflect payment amount changes in encounter filings. If the Provider does not respond within the required time (including a grace period to allow mail delivery), we will adjust claim record(s) in our system to offset future payments to the Provider by the overpayment amount, effectively releasing the claim.

Through regular reports and monthly meetings, we will monitor the status of Provider overpayment recovery efforts, including prior month and year-to-date dollars recovered, as well as pipeline information on cases at each phase of the overpayment recovery life cycle. We will review Providers and associated claims identified for recovery before Provider notification. This review step confirms overpayment accuracy and keeps leadership and Provider Services informed.

Our parent company's Subrogation department is a dedicated unit of more than [redacted] experienced employees committed to providing dependable and high-value cost containment services. Their mission is to aggressively pursue TPL to assure the appropriate party assumes responsibility for paying medical bills, reducing healthcare costs. The Subrogation department's key function is to recover expenses when a claim is due to accident or injury or another party is liable for services provided, as required in Contract Section 12.3.4. This is in support of the legal right of a CCO to recover sums paid for a Member's healthcare from a legally liable third party, the third party's insurer, or a workers' compensation insurer or program. Figure 4.2.2.10.A.1-4 summarizes the subrogation process.

Claims data is mined to identify opportunities by filtering for specific diagnosis and procedure. The subrogation system uses more than 40,000 different diagnosis and procedure codes to trigger potential investigation. Using monthly paid claims data, our staff will look for codes indicating claims due to a motor vehicle accident, premise liability, medical malpractice, workers' compensation, product liability, or other torts. Claims identified for subrogation will be accumulated for up to 90 days until a $750 threshold is reached. Once an opportunity is validated, written notification, including a Medicaid-specific questionnaire, will be sent to the Member. Members can respond via phone, mail, or web. The case will be documented in the designated tracking system, to record case activities and communications. We will then engage in recovery activities, including generating standard and non-standard correspondence, from a portfolio of templates to the insurer and/or attorney representing the case. Our system automatically schedules, tracks, and maintains subrogation case records and communications. Received payments and recouped funds go through a formal documentation process that includes the vendor's claims and finance departments.

Figure 4.2.2.10.A.1-4. Our CCO will carefully manage the subrogation process to maximize recoveries.



Cases will be closed upon recoupment of all or partial overpayments. Cases may also be closed should one of the following conditions be met:

- Case escalated to litigation
- Case reached contractual timeframes without recoupment (180 days from payment date)
- Case closed without recovery (for example, no rights to recover, workers' compensation/TPL carrier denied the claim, or settlement funds were dispersed prior to CCO involvement)

e. Process for Conducting Education for Offeror's Attorneys and Insurers About MississippiCAN and CHIP

For each market, supporting legal counsel for our Subrogation department reviews applicable statutes, regulations, and agency contract terms to prepare a presentation and training materials regarding applicable laws and best practices specific to the new market. As a component of this implementation, legal counsel will draft a set of form letters specific to the market for outreach to attorneys and insurers regarding the Medicaid managed care organizations' TPL recovery rights and relation to a state Medicaid agency. These letters are configurable and will provide an additional opportunity to direct attorneys and insurers to MississippiCAN and CHIP educational resources or publicly available information via insertion of a link. Our parent organization's Compliance department reviews all form letters to assure they meet State-specific requirements. We will send all form letters to the Division for review and approval. A call center will be available for Members, attorneys, and insurers should they have questions. Once a file is opened, the adjuster's contact information will be included in all communications, allowing callers to connect directly with the adjuster.

When TPL or subrogation issues arise during operations, our Provider Education team, an area within Program Integrity, will support additional Provider educational opportunities. For any overpayment reason, including OHI, we will initiate outreach to the Provider with a letter detailing our findings and reason for overpayment to

assure accuracy in future billing. The letter will encourage Providers to contact our Provider Services team with questions or for more information and will provide the direct hotline number, email, fax number, and mailing address. Our Provider orientation will include education regarding claims submission and payment requirements. We will highlight COB during orientation and include more detailed information on TPL and subrogation in our Provider Manual. Our Mississippi Provider Manual will describe how claims are handled when TPL resources are available to cover costs of trauma-related claims and medical services provided to Medicaid Members. It will also detail the criteria for pay-and-chase situations and provide COB claims scenarios to help Providers glean an understanding of how their claims will be processed.

f. Data Analytics and Informatics Used to Support the Process

We will use data analytics and informatics to mine data; identify and define overpayments; manage and expand recurring recovery concepts; validate and internalize vendor identified overpayments; and support COB efforts. The Claims department will evaluate overpayments, analyze claims data, and review issues related to retroactive COB identification. Post-payment analysis may lead to claim adjustments and recovery of overpayments, as well as Provider education and fraud investigations. Our national Program Integrity team will work closely with Provider Education and the Special Investigation Unit (SIU) to address issues identified through post-payment review.

In addition to data mining algorithms, we will conduct retrospective clinical reviews during the claims process and post-payment audits. On a post-payment basis, the SIU will also audit claims and medical records to assure we make payments in accordance with Provider contracts, medical and reimbursement policies, Member benefits, and industry standards. Post-payment audits may result in claim adjustments and recovery of overpayments. We will submit a schedule of all Provider TPL audits prior to audit initiation and report all findings and recoveries to the Division.

Our subrogation team will use an automated online case handling system for subrogation claims. The subrogation application is maintained by IT and Business Analyst resources who continuously monitor technological and industry advances to assure our subrogation system is cutting edge and customers receive the most efficient and cost-effective service. The subrogation management system will give our staff the ability to:

- Incorporate predictive analytics modeling into potential cases
- Generate standard and non-standard correspondence from a portfolio of templates
- Produce up-to-date listing of injury claims paid
- Automatically schedule, track, and maintain records of each subrogation case
- Prioritize high-dollar value recoveries for attentive specialist follow-up
- Track workloads and recoveries
- Generate reports

The system electronically screens paid claims to determine questionnaire eligibility daily. We will compare claims data against thousands of trauma-related diagnosis codes and other criteria, incorporating predictive analytics to identify potential subrogation or workers' compensation cases and produce system-generated questionnaires. Follow-up procedures achieve a consistently high rate of questionnaire responses.

g. Process for Providing Supplemental Third-Party Data and Files to the Division

We will transmit updates to COB information to the Division via a Secure File Transfer Protocol (SFTP) connection. As a CCO, we will maintain complete records regarding TPL collections and report this information to the Division in the requested format and timeframe. We are aware that TPL information impacts capitation rate development. We will work with the Division and their actuary during rate development to assure TPL is accurately captured.

h. Process for Reconciling Third-Party Liability Payments Received for Submission to the Division's Actuaries for Rate Setting Purposes

We will submit an annual regulatory report reconciling recovery amounts to the Division. This reporting will reflect updates to our claims systems when solicited and unsolicited cash is received. We recognize that the Division or its designated agent may conduct a TPL audit of our CCO, as specified in Contract Section 12.5. We are committed to delivering operational excellence through collaboration and transparency and will provide additional TPL/COB data and documentation to the Division, upon request.

2. Internal Process for Benchmarking TPL Collections Against Best Practices to Assure Optimization for the Division

We have an internal process for benchmarking TPL collections. Our ability to accurately assess TPL and subrogation opportunities for Mississippi leverages decades of best practice experience and evolution across our affiliates. Our parent company works closely with our Program Integrity Strategy team to review recent TPL collection benchmarks against historical performance and monitor against each state's contractually required metrics. Metrics used to benchmark TPL collection performance include:

- Year-over-year Total TPL Savings Growth
- Year-over-year Incremental TPL Savings Growth
- Previous Year TPL Post-payment Recovery Savings
- Previous Year TPL Prepayment (Cost Avoidance) Savings
- Age of Inventory/Turn Around Times with 90 to 95% Completed within Service Level Agreements

The Subrogation team measures performance monthly against nearly 50 key performance indicators (KPIs), including recoveries, open files, number of calls handled, and cases for Analysts and Examiners. We monitor KPIs for all lines of business; individual state performance can be benchmarked against aggregate results.

B. Effectiveness

We embrace a culture of continuous improvement and modernization for early identification of OHI prior to claims payment and increase post-payment recoveries to preserve valuable Medicaid funds.

1. Innovative Approaches to Ensure Third-Party Liability Program Is Effective

As a CCO, our objectives will be to sustainably achieve the Division's program goals through purposeful actions that maximize the value of delivering care to Members and report total program savings demonstrating the value of our TPL and subrogation activities. We will achieve the Division's goals by using qualified teams that efficiently and effectively manage prevention and recovery processes; engaging technology systems that support TPL activities; providing program oversight that closely monitors progress against benchmarks; and developing innovative initiatives that drive value for our Medicaid programs.

Innovative Initiatives to Maximize Medicaid Savings

Our approach is to apply continuous quality improvements, regardless of performance status. We will continuously source new ideas from affiliate plans, industry best practices, and shared services. We will vet local applications and work with our Operations team to implement quickly to provide further savings opportunities. Over the past two years, our affiliates have implemented 12 technology-driven improvements. Projects span from expanding staff capacity, to identifying new prevention and recovery opportunities, to fully automating our letter generation processes. Table 4.2.2.10.B.1-1 highlights key initiatives implemented in 2021 and expected savings in 2022.

[redacted]

As a CCO, we will commit to being good stewards of Mississippi public funding. Through these projects and other future roadmap initiatives, we will harness a culture of continuous improvement for Members, Providers, and Mississippians.

Effective Approach to Prevention and Recovery

Staff will use a series of Prevention Reports to proactively identify OHI opportunities before they become a recovery situation. We will use these reports, along with edits, inquiries, and claims requests to identify additional Member leads for staff to initiate action. Our TPL team will leverage best practices from partner engagements, adopting them internally to achieve additional savings. For example, in 2020, our parent company and its affiliates transitioned to a fully insourced TPL/COB program. Benefits of bringing this program in house were realized in 2021, as illustrated in Table 4.2.2.10.B.1-2, with significant year-over-year savings.

[redacted]

Technology Systems that Drive TPL Processes

Our team's use of innovative technology to support TPL data mining will swiftly identify OHI and manage recovery activities for the MississippiCAN and CHIP Programs. Our Inventory Management System automatically tracks TPL inventory, eliminating the need for manual management. These systems will also allow us to reduce the number of Member touch points. For example, if we receive claims from multiple Providers for a Member identified with OHI, we will assign a single employee to manage the case, so the Member is not contacted more than once, reducing Member abrasion.

Program Oversight

Our parent company's TPL program is led by a Program Manager who is responsible for monitoring day-to-day processes and overall program performance. This staff works with process experts to respond to escalation requests, addressing legal issues as needed. The Workforce Management team assigns cases to staff, monitoring daily

Medicaid dashboards to make sure inventory is progressed in a timely manner, compliant with contractual requirements, in line with or ahead of prior year performance, and in accordance with national standards, where appropriate.

2. Additional Measurements to Measure the Efficacy of Our Third-Party Liability Program

Our CCO will measure success against various internal TPL/COB metrics to gauge performance. These measurements are in excess of those typically required for State and regulatory reporting and will include:

- Average time to initiate and average speed to recovery
- Percentage of Provider audits that generate TPL recovery
- Monitoring number of TPL-related Provider/Member complaints
- Subrogation department call center metrics
- Quantitative results of specific Performance Improvement Projects

Our Proven Recovery Practices Deliver Medicaid Savings

Our health plan will produce results for the Division as:

- **80%** of our Provider audits generate a TPL recovery
- Our average speed to recovery is just **60 days**

MS21B_RecoveryPractices_C_03

Monitoring Efficacy Through Achieved Medicaid Savings

Our primary measure of program effectiveness is Medicaid savings. As it relates to TPL/COB prevention, our parent company monitors year-to-date savings and projections against expected savings for the year. We work with our actuarial team annually to benchmark expected savings per Member per year (PMPY). For 2021, the expected average was [redacted] for our parent company, which was exceeded. Multi-year trends are examined to evaluate per Member per month and return on investment, applying expected membership and budget for the following year. Incremental work will be considered when creating a total program goal.

We will conduct "Path to Green" calls with our Program Integrity staff to assess our path toward annual savings goals for each Medicaid market we serve. If original projections are not met, TPL/COB leadership will meet with the appropriate functional areas to determine a Path to Green or root cause for underperformance. This will be done through discussions with the local leadership team. We will evaluate our recovery efforts using monthly TPL/COB reporting to monitor projections against market-level goals and work on levers to alleviate/solve underperformance, as necessary. Recovery team leadership participates in Path to Green meetings to share recovery performance information, allowing cross-functional team transparency and creative solutions.

Identifying Information. To comply with the Identifying Information requirements defined in Section 1.2.3.3 of the RFQ and subsequent amendments, we removed names of federal and state agencies, Providers, and other stakeholders from our response, except where expressly permitted by the Division. If this information is needed to validate our proposed solutions or evaluate our response, we will be ready to provide it to the Division.

[END OF RESPONSE]

4.2.2.11: Eligibility, Enrollment, and Disenrollment

A. File Management

1. Using the Division's Eligibility and Enrollment Files to Manage Membership

We recognize complete, accurate, and timely Member Enrollment data loads will be critical to our operational functions and vital to supporting MississippiCAN and CHIP Members. ***In 2021, across our Medicaid affiliates, we processed 99.9% of Medicaid Member Enrollment records within 24 hours of receipt without any manual intervention.*** As a Mississippi Coordinated Care Organization (CCO), we will process daily 834 Medicaid Enrollment files, securely transferred, typically within six hours of receipt. We will also process monthly files and reconcile our Core Service Platform (CSP) to the Mississippi Medicaid Audit file as part of our quality process to verify that all membership is aligned accurately between our systems. Our processes will comply with the Companion Guide for the 834 transaction, and we acknowledge that all Enrollments and Disenrollments will become effective on the dates specified on the 834 eligibility file and serve as the basis for our capitated payments.

Accepting and Processing Member Enrollment Data

When we are notified of new Members through receipt of an 834 eligibility file securely transferred from the Division, we will assign each a unique number to track and manage the individual throughout all systems, including those of our subcontractor partners. This number will stay with the Members even as they move between Mississippi Programs.

We will mail confirmation letters and new Member Information Packets daily within five business days after notification of new Member Enrollment. Our confirmation letter will include the effective date of Enrollment, PCP address and contact information (if selected during Enrollment process), how to obtain referrals, our role as the CCO, the benefits of preventive healthcare, an overview of the Population Health management program, a copy of the Member Handbook, and a list of Covered Services. We will send the Member identification card with instructions for changing PCPs within two business days after notification of new Member Enrollment. If a Member Information Packet is returned to us due to an incorrect address, we will mine claims data for address information provided on recent claims for that Member. If we find claims data showing an alternative address, we will update our system and send the Member Information Packet to the new address.

In addition to the mailed materials, we will outreach with welcome calls, help the Member complete a Health Risk Assessment, and help connect the Member to a PCP or Patient-Centered Medical Home (PCMH). Loading these records promptly and accurately assures that Members also receive immediate access to their benefits and services.

We maintain a sophisticated analytics strategy to monitor membership Enrollment at an aggregate level as well as at a detailed eligibility category or Member demographics level. This will enable us to tailor our operational strategy based upon current Enrollment geographic dispersion and Member profiles.

Our Enrollment load process will support the Division's Enrollment processes and requirements. As necessary, we will add or update Member demographic and eligibility information using data from daily and monthly 834 files and monthly 820 capitation files, according to Division timelines. We will maintain complete eligibility history for all Members using uniquely dated spans to manage variation in benefit category and product — maintaining a complete timeline of participation in the MississippiCAN and CHIP Programs.

We will receive, maintain, and use data extracts from the Division and its agents and update our database within five calendar days of receipt of the files. We will make sure our subcontractors also update within five calendar days of receipt of the files, unless otherwise directed by the Division to update more frequently, in accordance with Contract Section 1.12.

Process for Resolving Discrepancies

We will retrieve all 834 eligibility files from the Division using a secure FTP site and subject all files from the Division to HIPAA compliance edits before processing. If the file passes those checks, we will perform additional edits against Division-specific criteria, such as field length, field type, and required data elements. We will evaluate each record on the daily 834 eligibility file and execute appropriate business rule checks, whether it is an addition, termination, change, or void, and update our CSP accordingly. Our process will include logic to compare Member demographic data on the incoming 834 eligibility file against our data to make sure that we record the most current Member information. The Enrollment file load process will establish "begin" and "end" dates for Members under their current Program eligibility category. Members' eligibility information may change periodically, and we will capture those changes promptly and accurately while maintaining historical data. This level of detail will enable us to provide appropriate services and accurately process all claims, even when the Member's eligibility changes after the claim date of service. Our daily process will generate reports that list Member-level activity and identifies any errors. Our Mississippi Operations team will review the reports and investigate errors. The investigation may involve correcting data in our CSP, checking the Division's Portal for Member information, and sending a secure email message to the Division for clarification.

Addressing Differences in Member Addresses

We recognize that 834 data is the source of truth for Members' addresses, and we will capture address information from the Division's Enrollment file in Members' eligibility records within our systems. As Members move and addresses change, they may not report these changes in a timely manner to the State, creating a gap between the current address and what is being sent on the 834 files. Because up-to-date contact information is critical to our ability to reach and engage Members, we will take proactive steps to identify inaccurate or outdated addresses and track down current address information, including:

- We will verify Member contact information, including email address, during welcome calls to Members within 30 days of Enrollment.
- If an ID card is returned for an incorrect address, we will start looking for claims over the next 90 days that will provide another address where we can send the card.
- Every time a Member calls the Member services call center, we will verify and update their address.

Enrollment Verification

We will assure that out-of-network (OON) Providers can verify Member Enrollment in our CCO prior to treating a patient for non-emergency services; Providers also have the option to use the Department of Medicaid's eligibility site to confirm Member eligibility. Within five business days of the date on which we receive the Member Listing Report from the Division, we will provide network Providers and OON Providers the ability to verify Enrollment by telephone or by another timely mechanism in accordance with Contract Section 3.2.9.

Member Reconciliation

We will perform several reconciliations each month for MississippiCAN and CHIP Member eligibility using daily and monthly 834 files and monthly 820 files. Our process will reconcile daily 834C files to monthly 834F files and we will report discrepancies between daily and monthly Enrollment files in the format specified by the Division — and within one business day for discrepancies that would negatively affect Member access to care. We will compare the State's 834 and 820 files to data in our system to identify Members on the 834 or 820 file who are not in our system and Members in our system who are not included in 834 or 820 files. We will use Enrollment data to make important linkages and close gaps in care.

Our reconciliation process will generate discrepancy reports, which our Enrollment and Billing teams carefully review. They will add Members on the 834 or 820 files who are not already in our system and initiate new Member processes. For those in our system but not on 834 or 820 files, we will review all Enrollment data previously

received to confirm we did not receive a termination record. We will submit discrepancies and reconciliation requests to the Division no later than 60 calendar days after receiving the monthly 820 remittance advice.

We will submit to the Division information about all new Enrollments, Disenrollments, reinstatements, and circumstances affecting a Member's Enrollment status in a format approved by the Division. We will review each Member Listing Report upon receipt and submit corrections to the Division on or before the 15th day of the month for which the Member Listing Report is issued. Adjustments will be made to the next Member Listing Report to reflect corrections, and the Enrollment or Disenrollment of Members reported to the Division (and approved by the Division in the case of voluntary or involuntary Disenrollment for cause) on or before the 15th calendar day of each month to comply with Contract Section 3.6.

2. Engaging Members to Stay Enrolled

a. Our Process for Outreach and Engagement of Members Who Request Disenrollment

We understand Members can have the option to disenroll with or without cause, as well as the circumstances for Disenrollment to occur, as outlined in the Contract Section 3.3. For Members who request to disenroll from our CCO, we will take steps to identify and quickly address the reason whenever possible. We will document all requests for Disenrollment, send this to the Division in compliance with Contract Section 3.3.3, and then leverage this information to identify opportunities for improvement. In addition, we will focus on proactive steps to prevent Members from disenrolling for cause, including:

- Throughout their membership, we will focus on engaging Members to make sure we are addressing their needs and preferences and preventing issues before they arise.
- During the redetermination period, we will engage Members so they are aware of actions they may need to take.

We understand that, in accordance with Contract Section 3.2.5.1, Members in specific eligibility categories may voluntarily participate in MississippiCAN. Members will have the option to disenroll from MississippiCAN without cause or change their CCO without cause during the 90-calendar day period following the date the Division sends the Member notice of Enrollment or the date of the Member's initial Enrollment, whichever is later. Disenrollment may occur during the Annual Open Enrollment period; upon automatic reenrollment if the temporary loss of Medicaid eligibility has caused the Member to miss the annual Disenrollment opportunity; or when the Division imposes an intermediate sanction on a CCO as specified in Contract Section 14.

Further, Members who are mandated into MississippiCAN may change CCOs without cause during the 90-calendar day period following the date the Division sends the Member notice of Enrollment or the date of the Member's initial Enrollment, whichever is later. After the Member's initial Enrollment, the Member may change CCOs without cause during the Annual Open Enrollment period.

Reenrollment and Redetermination

We will reach out to Members who are close to their redetermination period to support them throughout the process and make sure they do not lose their benefits. We understand that Members previously enrolled with us will be automatically re-enrolled if their eligibility is re-established within two months, and we will provide a new Enrollment date when Members are reinstated. We will treat reenrollment more than two months after losing eligibility as a new Enrollment. Our philosophy of achieving "no gaps in coverage" is at the heart of our redetermination activities. Some Members need assistance navigating the healthcare system, including completing the redetermination process. We will provide redetermination assistance equally and consistently to all Members who are not automatically re-enrolled in Medicaid, per our redetermination policy and procedure.

We will make sure Members are aware of redetermination actions they may be required to take and will conduct multiple forms of outreach, described in further detail throughout this section, to Members who require Medicaid redetermination. Proactive outreach will include the following activities:

- **Text and Email Reminders.** We will send a "Happy Anniversary" text and email approximately 60 days prior to the Member's anniversary/effective date to Members eligible for redetermination activities. The text and email will notify Members about the need to renew eligibility and will explain that they will receive a benefits renewal notice from the Division. In our notification, we will also provide our Member Services number and encourage Members to call us for questions or assistance with their redetermination process. This message will also remind Members how to make the most of their benefits.
- **Postcard Mailings.** If we receive undeliverable notifications for the text messages and emails, we will mail a "Happy Anniversary" postcard reminder to the Member's home address. The postcard will provide Members with information similar to our text and email reminders and encourage them to reach out to us if they have any questions or need assistance with their redetermination process.
- **Connecting Members to Support.** We will provide all Members with our Member Services contact information and encourage them to contact us to receive assistance with their Medicaid redetermination process. Our Member Services staff connect Members who call to request assistance with redetermination and help Members through the redetermination process. We accomplish this by asking questions such as:
  - Did you receive a letter from the Division of Medicaid?
  - Did you receive a letter from the Social Security Administration?
  - What does your letter tell you to do?
  - When is this information due back to the sender?
  - Do you need assistance to complete the required tasks in the letter?

Disenrollment

We will work to assure the continuity of a Member's care upon Disenrollment, whether transferring to another CCO or fee-for-service; this includes assisting in the selection of a new PCP, cooperating with the new PCP in transitioning the Member's care, and making medical records available to the new PCP in accordance with the Division and federal law. We also follow Transition and Coordination of Care Plan guidelines whenever a Member is transferred to another CCO. As previously noted, we recognize that Members may request Disenrollment in accordance with the Contract Section 3.3.3 with or without cause, and we will direct any Member requests for Disenrollment to the Division either orally or in writing.

If the Division sends us a Member Disenrollment for cause request, it will go to our Regulatory team for review. Following review, our Regulatory team will send the request to CCO leadership, including the Grievance and Appeals Coordinator who will contact the Member upon receipt of request. The Grievance and Appeals Coordinator will then ask the Member if they would be open to resolving the issues, they are having with the CCO prior to Disenrollment. If the Member agrees, the Grievance and Appeals Coordinator will help resolve the issue that prompted the request for Disenrollment.

For example, if a Member needs help finding a Provider, the Grievance and Appeals Coordinator assists with scheduling an appointment. The Grievance and Appeals Coordinator may also provide education on services that will help meet the Member's needs, such as our Value-Added Benefits, any pertinent quality programs, and our 24/7 nurse hotline. Afterwards, the Grievance and Appeals Coordinator asks the Member if they wish to stay with the CCO or would still like to disenroll.

We will then send an update on the Member's Disenrollment status to the Division with the exact information we provided to the Member and the outcome. We will transmit Member requests for Disenrollment to the Division Contract Compliance Officer, and our requests for Disenrollment (pursuant to 42 CFR 438.56) will be provided to the Division in writing with the reason for our request.

b. Conducting Disenrollment Surveys with Members to Determine Reasons for Disenrollment

We treat every Disenrollment as an opportunity for improvement. We will contact Members who disenroll from our CCO to determine the reason and administer a Disenrollment survey to Members via phone or mail within five business days of the Member disenrolling. We will track these survey results to identify trends at least monthly, and report through our Quality Management Committee and our Service Quality Committee quarterly. We will also analyze survey results against any Grievances and Appeals or quality concerns to further pinpoint trends and address opportunities to improve Members' experience with our CCO. For any trends or results we identify, our COO will oversee improvement activities in conjunction with department leadership to make changes in programs and operations, as needed.

We will submit survey questions along with our methodology to the Division for review and approval. We will also report findings from the Disenrollment survey and a work plan for addressing results of the Disenrollment survey to the Division on a quarterly basis in accordance with Contract Section 8.12.

c. Draft Disenrollment Survey

We have provided a copy of the Draft Disenrollment Survey we plan to use for the MississippiCAN and CHIP Programs as Attachment 4.2.2.11-1.

B. Assignment of Members to a Primary Care Physician

1. Proposed Process to Assign Members to a Primary Care Physician Within 60 Days of Enrollment

a. Provider Selection and Assignment

At Enrollment, we will offer each Member the opportunity to choose from at least two PCPs. If the Member does not voluntarily choose a PCP when signing up, they will be assigned a PCP using our Smart Assignment process, which we describe throughout our response. We will assign the Member to a PCP within 60 calendar days of Enrollment, in accordance with Contract Section 6.3.1.1.

Assisting Members in PCP Selection

Our staff will work with Members and caregivers to help them understand how to select a PCP. To assist with this process, our Member Services Call Center Representatives (MSCCRs) will be available to Members and authorized caregivers through our Member services call center, which is available Monday through Friday from 7:00 a.m. to 8:00 p.m. CST except for New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, and Christmas. Members also have access to the online directory for self-service or choose a new PCP 24/7/365.

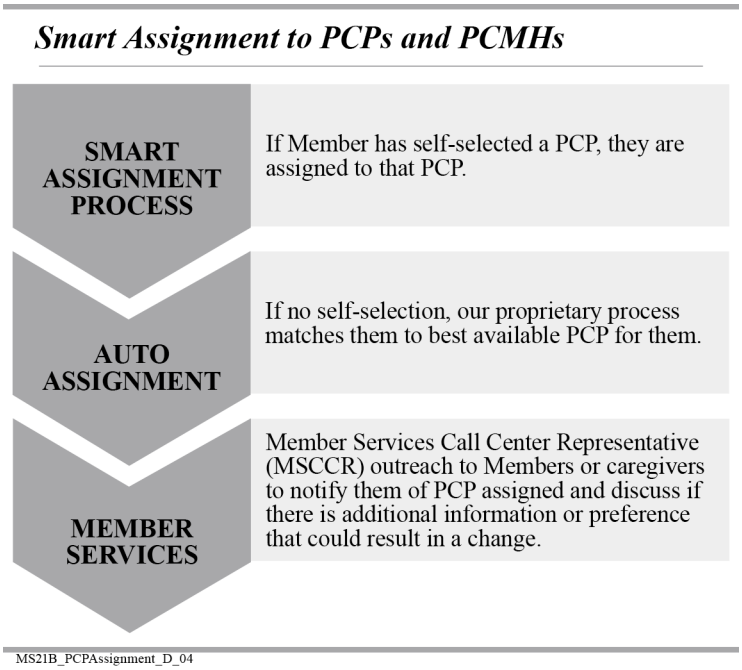
Our MSCCRs can provide callers with detailed information regarding PCP options. PCP-specific information will include physician specialty designation, Patient-Centered Medical Home (PCMH) designation, hospital affiliation(s), office locations, and languages spoken. Different Provider types may serve as PCPs to accommodate the Members' needs.

For example, with the assistance of our Case Managers, individuals who have chronic, disabling, life-threatening conditions, or children with special healthcare needs, may choose an appropriate specialist as the PCP (provided the specialist agrees to perform the duties of the PCP), in accordance with Contract Section 6.3.1.1.

Default Assignment of PCP

Any Member that does not self-select will have a PCP assigned to them using our ***Smart Assignment*** process at the time we process their Enrollment. We will employ continuity of care and quality of care logic in each auto-assignment. We will factor each Member's current Provider relationships, language needs (to the extent they are known), age and sex, Enrollment of family members (for example, siblings), and distance from area of residence to the PCP in this process. We will also analyze any previous claims data we may have to identify treating Providers to whom the Member may be matched as a PCP.

We recognize that Members enrolled in the MississippiCAN and CHIP Programs often have unique circumstances that must be considered when linking them with a PCP. For example, whether a Member is eligible for assignment to a PCMH, if they are indicated as potentially having medium or high risks. We will also confirm age ranges served when assigning Members to a PCP.



We will identify Providers who best meet the Members' needs by examining metrics related to continuity of care, quality of care, and convenient location using our Smart Assignment process to assign PCPs once we gather data about Provider quality and efficiency. This assignment will incorporate the following components:

- Quality rating (for example, HEDIS® scores)
- Efficiency rating
- Geographic proximity (within 30 miles or 30 minutes of the Member's residence, residential facility, or case worker)
- Provider specialty and language
- Access to transportation

In compliance with Contract Section 3.2.4, Members can request to change their PCP at any time through our Member Portal, which they can access via computer or mobile app, or by calling our Member services call center.

We will notify PCPs via U.S. Mail, Provider Portal, or by telephone of the Members assigned to them within five business days of the date on which the Contractor receives the Member Listing Report from the Division. If we notify PCPs via the Provider Portal, we will confirm that the PCP acknowledges receipt of the list of Members assigned to them. We will also send written notification to the Member of the PCP assignment.

Assigning Members to PCPs and PCMHs. A Member who has received Prior Authorization for referral to a specialist or from the Division's vendor for inpatient care may choose from among all the available specialists and hospitals within our Provider network. When we identify mandatory populations for medium and high risk, we will align them with a geographically available PCMH through our ***Smart Assignment*** process. We will assign Members to PCMHs in accordance with Contract Sections 6.2.5 and 6.3.1.1. We highlight the conditions for PCMH assignment in Table 4.2.2.11.B.1-1.

[redacted]

We will maintain written policies and procedures for assigning Members to PCPs/PCMHs according to their stratification level and we will submit our PCP/PCMH assignment policies and procedures to the Division for review and approval within 90 days of Contract award. Our policies and procedures will include a documented process for assuring that PCPs are willing to accept assignment of a Member prior to assigning the Member to the PCP. We will monitor PCPs/PCMHs to confirm that they have open panels. Providers may log into the Provider Portal at any time to review their Member attribution and dispute any Member assignments.

We understand that we must submit any changes or modifications to these policies and procedures to the Division for approval at least 30 calendar days prior to implementation.

Collaborating to Assign PCPs. Continuity of care is a critical factor in the selection of a PCP. We will work with relevant stakeholders, especially those for children and youth in foster care, in a collaborative and flexible way to make sure Members are connected to the best possible PCP or PCMH to meet their individual needs. Our MSCCRs will assist all authorized callers with the selection of a PCP based on the Member's needs. They will be able to assist both during the Enrollment process and after, when authorized callers request a PCP change.

Placement Changes. We will work closely with the Division, providing support for changes and tracking those changes closely. If the PCP no longer meets access standards due to a change in location, we will monitor claims and move the Member to the new PCP they select. We will then update the PCP roster on our Provider Portal. Even if a PCP still meets access standards, a change in placement would trigger our Member Services team to contact the new caregiver and discuss whether they want to continue with this PCP.

b. Tracking Data to Confirm Member Assignments

We will comply with all requirements related to the assignment of Members to PCPs and PCMHs in the MississippiCAN and CHIP Programs, and we will have the processes and systems in place to meet the PCP assignment requirements on day one. We will maintain all PCP and PCMH assignments in our Core Service Platform (CSP) and can run Provider management reports in a specified time frame (daily, weekly, etc.) as well as on an ad hoc basis. Our processes to load the 834 includes PCP assignment for every Member. If for any reason an error occurs and a PCP is not assigned, the record will be routed for manual correction. As a safeguard, any claim that we receive for a Member that does not identify a PCP will pend to draw attention to it so that we can get it corrected. Finally, we run Quality Assurance reports weekly and we will identify if there are any Members without an assigned PCP.

As part of our process to confirm that all Members in the MississippiCAN or CHIP Program are assigned to a PCP and/or PCMH, we will run a daily report identifying any not assigned to a PCP. Member Services will use the report to reach out to these Members or their authorized caregivers to assist them with selection of a PCP.

Our CSP will serve as the system of record for all Member data, including current and historical demographic and eligibility information. The CSP will also be the system of record for Provider, claims, and authorization data. We will control updates via role-based access to the user interface or application-specific data loads, such as the Division's 834 Enrollment files. We will maintain an audit trail of all changes made to each Member record. Applications interfacing with our CSP will map to data structures for consistency in naming, formatting, validation, data quality, and reliability.

c. Timely PCP/PCMH Notification
We will provide PCPs with timely notifications of new MississippiCAN and CHIP Members assigned to their practices. PCP assignments automatically update network Provider panel rosters daily and are available to Providers through our secure Provider Portal. Providers can generate a PCP panel report at any time.

We will also notify PCPs, via U.S. Mail or by telephone, of the Members assigned to them within five business days of the date we receive the Member Listing Report from the Division. For notifications to PCPs via our Provider Portal, we will confirm that the PCP acknowledges receipt of the list of Members assigned to them. We will track which Providers have not acknowledged receipt and use our dedicated Provider Experience team to follow up and work with PCPs to verify that they have complete and accurate information about Members assigned to their panels.

We will also send written notification to the Member of the PCP assignment. We will also notify individual Providers monthly through a push notification listing new Members assigned to their panels.

d. PCP/PCMH Confirmation of Assigned Members
We will educate Providers on how to access updated panel rosters on our secure Provider Portal and the importance of doing so routinely. PCPs will be able to access and manage their Member rosters online through our secure Provider Portal 24/7. We can track whether Providers access our PCP panel roster notifications. Following initial assignment notification, ***we will track which Providers pull their new panels and our Provider Experience team will follow up with any PCPs who have not accessed their panel roster within the first 30 days of assignment***.

In addition to the assistance provided by our Care Managers, we will review claims data, identifying PCPs who have not yet submitted claims for new Members' well visits and send a report to each Provider, requesting a status update.

The PCP-Member relationship is crucial to the health, well-being, and comfort level of our Members, so we will urge Providers to develop a solid relationship with new Members as soon as possible. During periodic visits to Providers' offices, our Provider Experience team will refer to this report and ask Providers to present updates on their new Members.

2. PCP Assigned Members Report
Please see Figures 4.2.2.11.B.1-1 and 4.2.2.11.B.1-2 for a Sample PCP Notification Report that we will create and use to notify PCPs of their assigned MississippiCAN and CHIP Members. This report will be available via our secure Provider Portal.

[redacted]

[redacted]

3. Assisting with Making and Keeping PCP Appointments

We will use multiple supportive tools and processes to help Members and caregivers make and keep appointments with Providers and for other services. We will make sure Members have an appointment scheduled within 90 days of Enrollment.

Tools for Scheduling PCP Appointments

Members may call our Member services call center or they can schedule directly through our Member Portal using our online Provider directory and appointment scheduling functionality. Our Care Management (CM) model will also include regular contacts with Members. During these regular contacts, our CM team will help Members schedule and reschedule appointments with easy and convenient tools, such as our online scheduling tool. Members or caregivers can also use our mobile app to schedule appointments.

Member Resources for Appointment Reminders

- Welcome Call
- New Member Information Packet
- Care Management Team
- Reminder Texts, Calls, and Emails
- Mobile App
- Coordinating with Caregivers as Permitted

MS21B_KeepingAppointments_C_05

PCPs are responsible for contacting new Members identified in the quarterly encounter lists we send them to identify whether they have had an encounter with the Member during the first six months of Enrollment. We will require PCPs to:

- Contact Members identified in the quarterly Encounter lists as not complying with Well-Baby, Well-Child Care, and immunization schedules for Children
- Identify any Members who are not in compliance with Well-Baby, Well-Child Care, and immunization schedules within one month of such notification
- Document the reasons for noncompliance, where possible, and document efforts to bring the Member's care into compliance with the standards

4. Proposed Policies and Procedures for Designating a Specialist as a PCP/PCMH

We will establish procedures for assuring access to needed services for Members with disabling conditions, chronic illnesses, or child(ren) with special health care needs. We understand that Members may request that their PCP be a specialist in accordance with Contract Section 6.3.1.1. We understand the Division will indicate on the 834 those Members who require a specialist. We will grant requests for a specialist as PCP when it is in the best interest of the Member and to the extent reasonably feasible.

A Member's Care Manager may request that a Member's PCP be a specialist, based on the Care Manager's assessment. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by the CM

team, in consultation with the PCP to which the Member is currently assigned, the Member and, as appropriate, the specialist. When possible, the specialist must be a Provider participating in our network.

Our policies and procedures will assure access to needed services for these Members. We can designate specialists as PCPs/PCMHs in the system without restrictions.

- Our Provider Experience team can determine if certain Specialists have agreed to be PCPs and that they are willing to perform primary care functions
- Members will have the option to switch to a Specialist designated as PCP and may inform us at any time if that is their preference (assuming this has not already been determined by a Care Manager)
- If a Member is flagged on the 834 as needing a Specialist, the Member would also be flagged for CM and our Care Manager could help determine the most appropriate Specialist for the Member
- Specialists may also function as PCPs

5. Communicating with Members About Their PCP/PCMH Assignment

We will use various communication methods to collaborate with Members on PCP assignments and upcoming appointments. We will also take the time to understand the barriers, concerns, and logistical issues around keeping appointments, and our team will work diligently to resolve them.

We will remind Members about appointments via phone calls and contacts from our MSCCRs and Care Managers, and digitally. We will use a text-based application designed to inform Members and caregivers about gaps in care and how they can close them as well as inform them of any available incentives. This will be a vital tool to alert Members to needed appointments and provide reminders to encourage Members to use their assigned PCP/PCMH and keep scheduled appointments. We also perform live call campaigns to offer scheduling assistance.

Incentivizing Providers for Completing Appointments

We will encourage Providers to make personalized reminder calls, sending emails and "e-blast" messages with information about Members who are due to make or keep an appointment, and encouraging them to contact Members in advance of the scheduled appointment.

We will pay earned incentives quarterly at enhanced rates for eligible claims for specified CPT® and diagnosis codes.

6. Communicating with Members About PCP/PCMH Assignment and PCP/PCMH Utilization

We will reinforce the importance of preventive care and regular visits to PCPs for MississippiCAN and CHIP Members by providing information in our Member Information Packet and Member Handbook, on our Member Portal and mobile app, and during our welcome calls, as well as through community events, social media, text messages, and face-to-face visits.

We will also reinforce the need for establishing and maintaining good relationships with PCPs through direct interaction with our CM team. All communications will reflect our staff training in cultural competency, trauma-informed care, and adverse childhood experiences. Translation services will be available, and we will be prepared to respond to special communication needs of Members and caregivers who are disabled, blind, deaf, and aged.

Monitoring Barriers to Care

Initial assessments and regular medical care are vital to the health and well-being of MississippiCAN and CHIP Members. We will engage Providers in helping to verify prompt appointment scheduling and adherence, and monitor compliance through claims data and Provider reports.

When we receive notification that a Member has missed an appointment, a Care Manager will personally reach out to the Member or caregiver. The CM team will help remove barriers to care, such as coordinating in-home care, using telehealth options, or talking with the caregiver about any fears or concerns.

Identifying and Resolving Member Barriers to Using Assigned PCP/PCMHs

We understand that multiple factors can make it difficult for a Member or caregiver to keep appointments, such as transportation, convenience of appointment times, and multiple children in the home needing care. Our goal is to remove barriers and make it easier for Members get access to the care they need in the manner and location that works for them. To address this access gap, we will work closely with Providers with mobile clinics and explore telehealth options and various on-site opportunities.

We will use certified Community Health Workers and Care Management Navigators to identify and remove barriers to keeping appointments, such as transportation. Our Care Management Navigators, who are in a unique position to develop a relationship of trust, will assist caregivers and Members in making and keeping appointments. This is particularly helpful for appointments with behavioral health practitioners.

C. Member Information

We know it is crucial to begin engaging with Members and welcoming them to our CCO as soon as possible. To make sure Members are educated about our CCO and have the information they need to make informed decisions about their healthcare, we will send Members our new Member Information Packet and Member ID card upon Enrollment. Created to welcome and engage our Members in a Member-centric and culturally appropriate format, the materials provided in the packet will use simple, easy-to-understand language, in compliance with the third-grade reading level requirement in Contract Section 5.9.1. Each Member will also receive an automated call from us to welcome them to our CCO and to confirm they have received their Member Information Packet and ID card.

1. Providing Member Information Packets

To send out the Member Information Packets as quickly and efficiently as possible, our process will begin immediately upon receipt of the 834 Enrollment file from the Division. Through an automated process, we will create a new Member mailing file containing the names and addresses of the new Members, as well as indicators that may include plan, product, language, and any other information required to assure Members get the packet in a timely manner. The mailing file will then be sent to a fulfillment vendor for Member Information Packet distribution.

We will use a similar process to distribute ID cards to our Members. An ID card application batch process will run nightly and create a file containing the names and addresses of the newly enrolled Members based on information received from the 834 file. This new Member mail file is automatically transferred via secure FTP to the ID card vendor for distribution.

a. Language Alternatives

Understanding that our Members have a wide range of reading and language capabilities, we will develop the Member Information Packets as well as all our materials, in a culturally and linguistically competent way, specifically using accessible formats and simple language. We will also have a Spanish-language version of the Member Information Packet that will be sent out if the language indicator on the 834 Enrollment informs us the Member's preferred language is Spanish. We also have the capability to translate materials and offer in-person or telephone language interpretation in more than 230 languages. We will make other formats available as well. For Members who are blind or have low vision, we will offer our materials in braille, audio recording, and large print format. For Members who are deaf or hard of hearing, our education videos will contain closed captioning.

b. Compliance with Information Requirements

Our Member Information Packets and ID cards will comply with all the requirements listed in Contract Section 3.2.6. We understand the importance the packet plays in the education and outreach process for Members. Because of this, per an established best practice among our affiliates we will deliver the Member Information Packet to new Members within five business days, surpassing the 14 days required per Contract Section 3.2.6 and Section 5.4.1.

The packet will contain the essential information to start Members on their new healthcare journey with us. In developing our materials, we will leverage the best practices of our affiliates and feedback from their Members. Among the materials to be included in the packet are:

- **Quick Reference Guide.** Provides a brief overview of benefits and services in an easy-to-read, accessible format
- **Welcome/Introduction Letter.** Welcomes the Member to our plan and provides a summary of the Member Handbook contents and key phone numbers
- **Provider Information Flier.** Informs Members how to request a printed Provider Directory and access our directory online

We will produce two separate Member Handbooks — one version for MississippiCAN Members and one for CHIP Members. The Handbooks will be comprehensive resources to inform Members about their physical health and behavioral health/SUD benefits, Care Management services, pharmacy, Value-Added Benefits, and more. The Handbooks will be available electronically on our Member website and will be mailed to Members within five business days upon request.

We will provide the Division with a copy of our packet on an annual basis for review and approval. If at any point we make changes to it, we will submit it for review and approval at that time. As with all our materials, Members can request the complete packet at any time.

The ID cards, which indicate the Member's first effective date of Enrollment, will be accompanied by a welcome letter to the Member in envelopes marked with "Return Services Requested" and will also be sent to Members within five days of receipt of the Enrollment file. Members will have an electronic version of the ID card on our secure Member Portal and mobile app. Upon logging in, Members will be able to download their ID card from an easily identifiable link on the home page.

c. Obtaining Correct Member Addresses

Correct contact information is critical to our ability to engage and educate our Members and assure they can access their benefits and services. We will employ several proactive methods and creative approaches, listed in Table 4.2.2.11.C.1-1, to help assure we have the most up-to-date Member address and other contact information. In addition, we will update our system regularly with new contact information from the daily 834 files and check the National Change of Address registry before any Member mailings.

Address Update Campaign

One of our most successful and proactive approaches is our parent organization's campaign to update addresses. This campaign approach was developed to address increased Member transience during the COVID-19 pandemic. Deployed across our affiliates in May 2021, the campaign resulted in 31,000 Members updating their contact information. It was redeployed again in November 2021 resulting in an additional 15,000 Members updating their information.

We will use this same approach using automated calls to outreach to MississippiCAN and CHIP Members to verify and correct the contact information we have on file, along with several other methods we have described in Table 4.2.2.11.C-1.

Table 4.2.2.11.C-1. Methods to obtain correct addresses.

Method	Description
Address Update Campaign	• Automated call campaign to verify and correct Member contact information
Member ID Cards	• Cards will have a QR code sticker encouraging Members to enroll on our mobile app helping capture email address and updated mailing address and phone numbers
Member Services	• Member contact information will be verified with each call and updated as needed.
Community Health Workers (CHWs)	• Our CHWs reflect the population they serve and will be able to develop relationships in the community and meet Members where they are, such as homeless shelters, to verify and update Member contact information as needed.
Care Managers	• Care Managers will be in frequent contact with Members and can update information as it changes.
Community and Provider Partnerships	• We will receive information on our transient, hard-to-reach Members through partnerships with: o Community-based Organizations o Providers, CMHCs o Local pharmacies
Claims Reports	• Claims data will be scanned and can be used to assure we have the most up-to-date Member contact information on file.
Proposed Physical Location for Member Outreach	• Our outreach center will offer a great opportunity to verify and update contact information in-person and on the spot.
Member Portal/Mobile App	• Messaging on our portal and app prompts Members to update their contact information if it changes.

d. Returned Member Information Packets or Identification Cards

We will also take a proactive approach when the Member Information Packets or ID cards are returned to us. If these returned materials are marked as undeliverable by the Postal Service, a call to those Members will be triggered to prompt them to validate or update their address. Members will be able to update their address and contact information in several ways such as calling Member Services and via the secure Member Portal or mobile app. Returned packets or ID cards will also trigger another process to obtain updated contact information by searching claims for that Member over the following 90 days.

We will also develop communications and collaterals to raise awareness to membership that if they have not received their Member Information Packet or Member ID Card, they should contact us to update their contact information. Printed materials will also have QR codes linking to our Member website and can be distributed in multiple ways, such as including them in information packets for schools and providing them to social services offices for foster care families. Additionally, we will forge partnerships with community-based organizations who will be able to assist us in locating hard-to-reach Members and assure we have updated contact information to deliver the Member Information Packets and ID cards to the Member.

Identifying Information. To comply with the Identifying Information requirements defined in Section 1.2.3.3 of the RFQ and subsequent amendments, we removed names of federal and state agencies, Providers, and other stakeholders from our response, except where expressly permitted by the Division. If this information is needed to validate our proposed solutions or evaluate our response, we will be ready to provide it to the Division.

<Logo>

JOB #/NAME: MEMCOM-1138-19 Lost Member Survey
CLIENT: John Smith
DATE: 1/23/22
GRADE: Flesch-Kincaid 3.6 without proper nouns, numbers, variable fields
AUDIENCE: Members in MS who lost coverage or are in enrolled in another health plan.
PURPOSE: To get feedback on why they lost coverage and how we can improve our service.

<Date>

<Member Name>
<Member Address>
<City, State ZIP>

Dear Member,

We're sorry to lose you!

You or someone in your family is no longer enrolled in <Health Pan> as of <the first of this month> <date>. If you think this is a mistake, call the Mississippi Division of Medicaid **at < 1-800-884-3222 >** and say you want to stay with < Health Plan >

Remember — if you lost your benefits, you need to reapply for < Mississippi Division of Medicaid > now! Visit <MississippiCAN enrollment website URL> or call < 1-800-884-3222 > < Monday-Friday, 8 AM – 5 PM > to get started.

Please answer the questions below to let us know why you're leaving and how we can make our services better. When you're done, mail them back in the prepaid envelope we included. Thank you!

Sincerely,

<Health Plan>

Enclosures: <Nondiscrimination notice>
<Get help in another language>

<Health Plan Member Website>

<Disclaimers>

1. **[Why are you leaving <** Health Plan**>?]**
   - I recently moved and didn't get my renewal packet. *If you've moved, please contact <your local Department of Social Services (DSS)/Applicable Agency> to update your address and reapply.*
   - I didn't turn in my Social Services or renewal paperwork on time.
   - My income status has changed and I'm no longer eligible.
   - Other reason. *Please explain:*

     _____
     _____
     _____
     _____
   - **I did not know I lost my <** Health Plan**> benefits**. *If you think this is a mistake, please call* < Mississippi Division of Medicaid > *and say you want to stay with us.*
   - Other: _____

2. **How would you rate our service on a scale of 1 to 5?** *(5 being the highest)*

   _____

3. **Would you choose <** Health Plan**> again? If no, why not?**

   _____

   _____

   _____

4. **How can we improve our service to our members?**

_____

_____

_____

New Member Quick Reference Guide

COVER PAGE

IMAGE: Mother and child embracing or adults engaging in healthy activities or similar
TITLE: **Your <Product name(s) plan quick reference guide>**
SUB: All you need to know, all in one place
LOGO(S): <Plan logo(s)>
WEB: <Plan member website URL>
PHONE: <Member Services/CCC number (TTY 711); information on translation/alternate formats>

INSIDE PAGE 1

IMAGE: Mother and child embracing or adults engaging in healthy activities or similar
HEAD: **Hi, we're <Plan name – 1st ref>, your new health plan.**
COPY: Welcome. Thank you for letting us support your health and well-being. We've put together this quick reference guide to help you get the most out of your benefits.
CALLOUT: Only have <2> minutes? Watch our welcome video: <**Plan member websiteURL**>

INSIDE PAGES 2-4

HEAD: **Key things to do now**..... [page #]
COPY: We know you want to use your plan benefits and services. And we know you're short on time. Here are some key things to do now to get started with your health plan. Each one takes no more than <#–##> minutes, so you'll be on your health journey in no time.

Your pharmacy benefits..... [page #]
Find out where and how to get your prescription drugs and OTC items.
Your extra benefits ..... [page #]
Learn about the plan benefits you get beyond the basics.
Where to go for care ..... [page #]
Find out when to visit your doctor, urgent care, or the ER.

SUB: **Let's get started**
ICON: [Design: Insert topic-related icon]
COPY: **1. Know the basics about your health plan**
We're a health plan offering benefits to individuals and families in <state name>. For more than <#> years, our goal has been to improve the care of our neighbors in under-resourced communities. How exactly do we do that? We have <case managers> who help you find the doctors and specialists you need. Doctors who provide services that support your whole health, not just treat your symptoms. And nurses ready to answer your questions 24/7. We're all about you living your best life.

If you want a full list of your benefits and services:

- Find them on the member website, **<Plan member website URL>**. You can also view your member handbook or find health articles, useful apps, your rights, and much more.

CALLOUT: We'll be calling you soon to say hello and answer any questions you have.

ICON: [Design: Insert topic-related icon]
COPY: **2. Review your member ID card**
Your plan member ID card is where you'll find important numbers you and doctors will need. And to get health benefits and services, you'll need to show your card. The name, phone number, and address of your <PCP 1st ref>, your main healthcare provider, is on your card, too. Keep it in a safe place, like your wallet.

ICON: [Design: Insert topic-related icon]
COPY: **3. Schedule your wellness visit**
Having a longer, healthier life starts with a wellness visit. This yearly exam can help your <PCP 2nd ref> learn about your health history and find any concerns before they become problems. Your <PCP 2nd ref> is your main source for most of your care. Think of them as your healthcare BFF. Their prime goal is ensuring you get the care you need when you need it. Call your <PCP 2nd ref> today to set up a wellness checkup.

If you need help making an appointment, call our <Member Services/Customer Care Center> team. If you want to change your <PCP 2nd ref>, visit the member website to find one in our plan.

ICON: [Design: Insert topic-related icon]
COPY: **4. Create your online account**
You can find all you need to know about your benefits, all in one place, with an online account. Visit the member website (<**Plan member website URL**>) <and go to the Login page> today to register. Have your ID card handy. [After creating your account, log in to member website, or the <Plan app name> mobile app].

CALLOUT: **Download our free app.** Go to <**plan URL**> or scan this code with your smartphone camera. [Design: Add QR code to <plan URL>]

ICON: [Design: Insert topic-related icon]
COPY: **5. Complete your Health Risk Assessment**
When you know more about your health needs, your doctors can, too. By completing this survey, we can learn more about your needs than we do from a doctor visit. This in turn helps us improve your benefits and services. [**All but CA:** You can complete it online at **<Plan member website URL>.**

ICON: [Design: Insert topic-related icon]
HEAD: **6. Tell us about any changes**
COPY: If you have you moved or changed your phone number, let us know right away. Log in to your secure account on our website or call <Member Services/Customer Call Center> at <**Member Services/CCC number**> to update your information with us so you get important plan materials. [Also, make sure you tell <your local Department of Social Services office> about any changes.]

INSIDE PAGES 5-7

ICON: [Design: Insert pharmacy-related icon]
HEAD: **Let's talk about your pharmacy benefits**
COPY: We cover your prescription drugs, some over-the-counter items, and certain medical supplies so you can feel your best. There's no copay for generic drugs <or if you are under 21 years old, pregnant, or in long-term care>, and your copay for brand-name prescription drugs is <$>.

How to get your prescriptions
[You can either pick up your prescription in a retail pharmacy or have your drugs mailed to you:

- **In store.** Take your written prescription and member ID card to a network pharmacy or ask your doctor to call it in. On the member website, use the <Find a Doctor> tool or view the provider directory for a plan pharmacy near you.
- **By mail.** Log in to your online account and request home delivery for your prescription refills.]

For more information about your pharmacy benefits, visit the <**Pharmacy**> page on the member website, <**Plan Member Site URL**> or check out your member handbook. For questions, call the <Pharmacy> number on your ID card.

ICON: [Design: Insert topic-related icon]
HEAD: **And now for your extra benefits**
COPY: With us, you get all your standard <Product name(s)> benefits, plus some extra ones — all [free/at no cost] to eligible members.

- <Insert bulleted list of 5-10 highest priority plan VABs>

For a full list of your benefits, check out your member handbook or go online to **<Plan member website URL>**. If you want a printed copy of your member handbook, call us and we'll mail one.

ICON: [Design: Insert topic-related icon]
HEAD: **Where to go for care**
COPY: If you need care right away, the emergency room (ER) is not always your best option. You have other choices for getting care quicker when your life is not in danger:

1. **Call your** <**PCP 1st ref**> **first** and ask to be seen at once. Sometimes an opening in their schedule happens or their office has a different doctor who can see you. If it's after hours or on weekends, leave a voicemail so someone can call you back soon.
2. **Visit an urgent care center**. Not only do they have skilled providers on hand, but you also don't need an appointment. And many are open late and on weekends. Find one near you by using the <Find a Doctor> tool on the member website, <**Plan Member Site URL**>.
3. [**Video chat with a doctor** through <telehealth branded name. from the comfort of your home by visiting <**website**>.]
4. **Talk to a nurse 24/7** if you're not sure where to go or have health questions. Call <Nurse line name> at <the number on your ID card>.

If you feel your health concern is life-threatening, then go to the ER or call 911.

Sample Member ID Card Welcome Letter

LOGO: <Plan logo(s)>

HEAD: **Here's your new member ID card**

SUB: **Start using your benefits today**

DESIGN: Add icons for each bulleted copy point as you see fit, like an ID card, cellphone, doctor, etc.

COPY: Hi <First name>,

Welcome to <Plan Name – 1st Ref>. We're here to support your health and wellbeing. Now that your health plan benefits are ready to use, we want to help you make the most of them. Here are some key things to know and do to help you get started:

- **Keep your member ID card close.** You will need to show it when you receive care. It includes important phone numbers you and providers will need to access your benefits.
- **Access your benefits any time or place.** When you create an online account, you can find a doctor, [order prescriptions,] pull up your digital ID card, view benefit details, and more. If you have questions or need help, you can live chat with us or send us a message anytime. [OA CTA Test A: Visit <Plan Member Site URL> or download the <Branded Name> mobile app to register and log in today.] [OA CTA Test B: Visit <Plan Member Site URL> to register and log in today.]
- **Visit your <PCP 1st ref>**. Listed on your ID card, you should see this doctor for most of your healthcare needs. We have assigned one for you to help you get started. Call and set up your first visit soon. All new members should see their <PCP 2nd ref> within 90 days of joining.
    - **If you want to change your <PCP 2nd ref>**, you can. Visit <Plan Member Site URL> and either use the <Branded Name> tool or provider directory to view and choose from providers in your plan. Change your <PCP 2nd ref> [anytime] by [logging into <Plan Member Site URL> or the <Branded Name> app.] [You can] [also] call[ing] the <Member Services/Customer Call Center> number on your ID card <Monday to Friday> from <X> a.m. to <X> p.m. [<Central/Eastern/local/Mountain/Pacific>] time.
- **Tell us about your health.** You have healthcare needs that are specific to you. Fill out the Health Risk Assessment <form you got in the mail/online at [URL]> to let us know more about them. Your answers help us learn about your health so we can connect you to better care. [Plus, you will get <incentive> for completing it.]

Sample Member ID Card

Front of ID Card
Across top **–** <Plan Logo> (top left)

Upper left quadrant

Member Name
Member ID #

Upper right quadrant

Primary Care Provider (PCP):
Telephone #:
Address:

Lower left quadrant

Effective Date:
Date of Birth:

Lower right quadrant

RXBIN:
RXPCN:
RXGRP:

Back of ID Card

Upper left quadrant
<Plan Logo>

Members: Please carry this card at all times. Show this card before you get medical care (except emergencies). If you have an emergency, call 911 or go to the nearest emergency room.

Providers/hospitals: For preapproval/billing information, call <phone number>. For emergency admissions, notify <plan> within 24 hours after treatment.

Bottom left quadrant:
Pharmacies: Submit claims using RXBIN: <#>; RXPCN: <state>; RXGRP: <#>.
Submit medical claims to:
<Plan>
<Address>

Upper right quadrant
<Plan Website>

Member Services: <phone number>
Provider Services: <phone number>
Pharmacy Member Services: <phone number>
Help for Pharmacists: <phone number>
24/7 NurseLine: <phone number>
24/7 Behavioral Health Crisis: <phone number>
TTY: 711
Use of this card by any person other than the member is fraud. If you suspect a doctor, clinic, hospital, home health service or any other kind of medical provider is committing Medicaid fraud, report it. Call <phone number>.

Bottom right quadrant:
<Plan Name>
<Address>

Certain services are covered directly by <Medicaid Agency>. For a list of carved-out services, see your member handbook.

<Plan legal tagline>

[END OF RESPONSE]

4.2.3 Innovation and Commitment

4.2.3 Innovation and Commitment

4.2.3.1: Value-Based Purchasing

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[END OF RESPONSE]

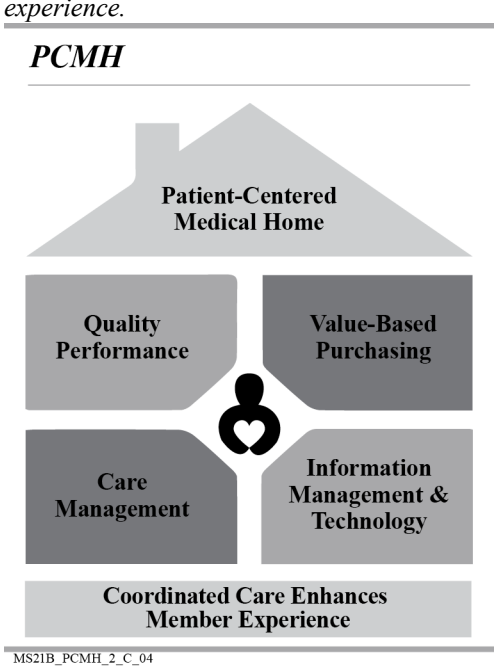
4.2.3.2: Patient-Centered Medical Home (PCMH)

We have developed a comprehensive Patient-Centered Medical Home Model (PCMH) model that will improve the capabilities and practice standards of PCPs, reduce health disparities, and increase the overall value of healthcare delivered to Mississippians. We will include NCQA-recognized PCMHs and the joint principles of the PCMH developed by the American Academy of Family Physicians, American College of Physicians, and American Osteopathic Association into our model. We will also bring best practices and lessons learned from successful PCMH model development that have helped us achieve improved quality outcomes across our parent organization and affiliates to Mississippi. ***For instance, the PCMH model in one of our affiliate markets has resulted in significant quality improvements, including a 158% increase in adolescent immunizations, and a 17% reduction in emergency room (ER) utilization over a four-year period.*** To achieve the same success in Mississippi, we will align medium- and high-risk Members with the existing accredited PCMHs and focus on building PCMH capacity across the State.

Our Proposed PCMH Approach

PCMHs are an integral component of our Population Health approach, which will use continuous quality improvement and comprehensive data analytics to assess and adjust strategies to drive improved health for all Mississippians. Our PCMH model, as seen in Figure 4.2.3.2-1, promotes health equity and minimizes racial disparities through whole person, coordinated care. ***We will collaborate with the Division to implement an approach that will support and empower Providers with dedicated resources, technical assistance, training, and reporting tools to help them fulfill PCMH program goals and work with PCPs to expand PCMH offerings across the State.***

Figure 4.2.3.2-1. Our PCMH strategy coordinates care to enhance the Member experience.



Experience with Implementing and Supporting PCMH Models

[redacted]

Through this organizational experience, we have gained valuable insight about the best ways to support practice transformation as well as the barriers that exist. For many Provider practices, the prospect of transitioning to a PCMH model can be daunting due to a lack of staffing, time, or financial means. As a result, we know we must work with Providers to establish the infrastructure and provide the clinical and administrative support they need to be successful. [redacted]

Our approach to sustain and grow this PCMH model within Mississippi includes effectively supporting the practices that have already achieved PCMH recognition and identifying new Provider practices that would be good candidates for transformation. We have identified more than 150 Providers throughout Mississippi who are certified as a PCMH and will prioritize the recruitment of these practices into our Provider network. We will

also identify new candidates for PCMH Transformation by identifying practices with superior quality performance, prioritizing geographic areas where PCMH practices do not exist.

How PCMHs Will Interact with Other Programs to Benefit Members

We know that effective collaboration with our programs is essential to making sure that PCMH Providers can complete essential tasks and provide quality care. We also know the first step in making sure that PCMHs interact with our programs is educating them on the programs we offer and how they will benefit their patients. [redacted] Descriptions of these programs are included next.

Care Management (CM) Program

CM services are vital to making sure our Members achieve optimal health outcomes, especially medium- and high-risk Members with the greatest needs. To make sure our Providers have all the information they need to encourage their patients to take full advantage of our CM program, we will leverage many channels to educate our Providers on the critical nature of CM services and collaborative care planning to achieve positive Member outcomes. We will help make sure they understand the benefits of our CM services for our Members and the role and responsibilities of the Care Manager. Understanding Providers are well equipped to identify Members for CM because of the relationship they have with their patients, we will also educate them on how they can make referrals to CM.

Along with outreach, coordination, and support to Members, Care Managers will offer training and support to PCMH Providers in accessing services, Member incentives, Value-Added Benefits, and community-based resources. Care Managers will also share monthly stratification so that the PCMH is aware of changes in the Member's risk level to guide appropriate engagement. In addition to providing risk stratification information and treatment plans, Care Managers will coordinate with the PCMH as needed, but at least twice per year, to discuss each attributed Member's treatment plans, progress and challenges, barriers to care, new needs, coordination with other Providers, and ways to close any care gaps. We will invite PCMH Providers to these conferences by mail, offer the option to choose an on-site visit or teleconference, and offer to reimburse them for their time to incentivize attendance. We will work closely with PCMHs, review Member readmissions with them to assure they are managed, conduct rounds for high-risk Members, and look for opportunities to provide additional support. For example, through our Population Health Program, we will target PCMHs that have pediatric Members with asthma for support.

Utilization Management Program

We will provide data regarding utilization patterns of attributed Members so that Providers can understand the full picture of their membership. The Utilization Management/Care Management (CM) teams will make sure that the PCMH is aware of when a Member accesses the ER and inpatient care. The Utilization Management team will engage the PCMH when care decisions are being made to attain a holistic picture of the Member and make sure that services address that Member's need.

Telehealth Program

The main goal of our telehealth program will ***be supplying local Providers with the tools they need to offer effectively manage the care of their existing patients***. In addition to reducing inappropriate ER utilization, telehealth can also help address barriers to care, such as long transportation distances, which is especially important in states like Mississippi where there is a predominance of rural areas. It also increases the likelihood that Members with co-occurring behavioral health (BH)/substance use disorder (SUD) conditions will seek treatment. We will conduct ongoing assessments of Provider capabilities and identify opportunities to use our telehealth solutions that will help them more effectively manage Member care in more convenient and cost-

effective ways. Our response to Section 4.2.3.7 includes the full description of our telehealth offerings.

PCMH Transformation Consultants

PCMH Transformation Consultants will hold a **NCQA PCMH Content Expert** Certification.

MS21B_PCMHTransformation_C_03

The CDT team will also educate Providers on evidence-based practices related to BH screenings, including the tools they can use to identify Members with co-occurring BH and SUD conditions and the importance of addressing both concurrently.

Supporting PCMH Activities

Members benefit from having a PCP who has earned the PCMH designation and work with the Members not just to treat symptoms but also to look at overall health needs. This approach includes identifying social risk factors and more proactively engaging in specialist referrals and care coordination. As described previously, we will offer PCMHs the right level of support to successfully perform specific tasks related to Members' care that include, but are not limited to:

- **Care Management Support.** PCMHs will deliver CM solutions customized to the populations, health conditions, and locations served, with data and support provided through our CDT Consultants. Providing medium- and high-risk patients with CM and treatment plans, with self-care support recommendations, and working collaboratively with Coordinated Care Organizations (CCOs) and external partners.
- **Care Coordination and Transitions.** Referral tracking, follow-up, and coordinating care transitions help assure that primary, behavioral health (BH), and specialty care clinicians are effectively sharing information and managing patient referrals to minimize cost, confusion, and inappropriate care.

- **Performance Measurement and Quality Improvement.** Ongoing analysis to measure and track performance on quality and efficiency measures helps practices develop ways to measure performance, set goals, and develop activities that will improve performance.
- **Addressing Disparities.** Identifying and mitigating patient health disparities through CCO-supplied data and Provider profiles, assuring delivery of culturally competent care.
- **Education.** Providing ongoing education to patients increases health literacy. We will offer online Health Literacy training for Providers to enhance their ability to understand and improve Health Literacy status in rural populations.
- **Patient-centered Access.** Providing same-day appointments for routine and urgent care guides practices, facilitates convenient access to clinical advice, reduces avoidable ER visits and hospital admissions, and promotes continuity of care. We will continuously educate PCMHs on access and availability requirements and monitor compliance.
- **Team-based Care.** Holding scheduled patient CM team meetings or a structured communication process focused on individual patient care helps structure a practice's leadership and CM team responsibilities and determines how the practice works with patients, families, and caregivers.
- **Population Health Management.** Using data for population management to address chronic and acute care services.
- **Knowing and Managing Patients.** Setting standards for data collection, medication reconciliation, evidence-based clinical decision support, and other activities.
- **Member Engagement.** Actively engaging Members in their healthcare decision-making and solicit ongoing feedback from Members on whether their goals are being met.

Identifying New Candidates for PCMH Recognition

To identify priority PCMH recruitment areas, we will assess geographic need, considering both the concentration of PCMHs in the area and the number of Members with complex needs. Once we identify these areas of need, we will

assess quality performance for Providers to identify potential PCMH candidates. All PCP practices will be supported by CDT Consultants, who will work closely with these Providers and identify practices that may be good PCMH candidates based on superior quality performance. These Provider groups will be referred to our local PCMH Transformation Consultants, who will conduct initial assessments to determine the level of participating practices' knowledge of PCMH principles and whether the practice has adequate processes, workflows, and data-sharing capabilities in place to be successful.

Coaching Sessions

We will provide PCMH NCQA coaching sessions for all practices at any point during the performance year. Coaching sessions will occur on-site or virtually. On-site coaching will occur with office staff, which may include one-on-one coaching with physicians, office managers, care coordinators, and more. Coaching plans will be individualized and may include the tasks in Table 4.2.3.2-1.

Table 4.2.3.2-1. Coaching plans will address Providers' individual needs.

Coaching Plan Tasks	
• Completion of initial outreach assessment, annual review, coaching plans, and coaching notes	• Reviewing strategies that practices have in place to identify current enhancement opportunities
• Educating on best practice guidelines and how to incorporate them in their procedures and systems	• Encouraging/suggesting strategies for care coordination specifically around Member engagement that include outreach to ER and specialists for updated Member contact information
• Coordinating mentoring/coaching sessions between high- and low-performing Providers to encourage best practices and operations discussion	• Encouraging Providers to download and review quarterly reports to help track and trend progress on existing quality and efficiency measures
• Encouraging the use of data tools available to improve coordination of care as part of the quality and efficiency improvement and Member engagement	• Providing quality and supplemental data reports to improve performance rates, such as Gaps in Care, ER Utilization, Claims, EPSDT data, Monthly Payment Details, and Last Member Visit
• Promoting the importance of Population Health management strategies as part of the transformation process	• Fostering collaboration in conjunction with the CCO to improve care integration, collaboration strategies, and process improvement
• Driving collaboration between PCMH groups to create a more integrated relationship	• Assisting with creating and documenting best practices for team-based care and CM at the practice level
• Keeping practices abreast of all NCQA and State updates and potential changes that could affect the certification process	• Assuring that PCMHs are assessing, tracking, and addressing Member health disparities

Assuring All Medium- and High-risk Members Are Attributed to a PCMH

Our PCP auto-assignment algorithm is designed to incorporate PCMH recognition and quality performance into the assignment process. We will use our risk stratification software to identify medium- and high-risk Members and, where possible and geographically appropriate, will assign these Members to PCMH Providers in collaboration with the Member. We will also be targeting geographic areas in which a PCMH practice does not exist and prioritizing identification of PCMH candidates in those areas. This will help ensure every Member in our CCO has access to high-performing Providers.

Further, when Members are newly stratified as medium- or high-risk, they are aligned with a single Care Manager. This Care Manager will determine identify the Member is current PCP assignment and whether the Provider has achieved PCMH recognition. If not, the Care Manager will educate the Member about the benefits of working with a PCMH and offer to align the Member with a PCMH that is close to them. If accepted, the Care Manager will make sure that the attribution is changed, that the Member has an appointment set up with the PCMH, and that the PCMH has all the data needed to provide whole person care for the Member. If the Member's PCP does not have PCMH recognition, and the Member does not wish to be re-assigned, the Care Manager will note this in the Member's record and will work with the current PCP to coordinate care. Additionally, our PCMH Transformation team will educate the PCP on the benefits of becoming a PCMH and offer to assist their PCP in achieving this recognition. The Care Manager will periodically remind and educate the Member of the PCMH option, documenting the conversation in their treatment plan.

Supporting Providers in Delivery System Transformation Through Actionable Data

PCMH Providers will benefit from our custom data analytics capabilities, data sharing, reporting, and performance management tools. Our report structure will facilitate program success by delivering timely, actionable, and relevant information. Providers will be able to examine current performance and quickly

identify opportunities for improvement. When necessary, we will help Providers develop action plans, processes, and workflows to improve quality and cost outcomes. Our PCMH Providers will receive customized quarterly interim performance reports that compare their performance with that of their peers and against established benchmarks. As part of our coaching process, they will also receive an annual final performance report each year. We will share data with our PCMH Providers regularly to help them monitor their program performance. Table 4.2.3.2-2 details our proposed listing of reporting for PCMH Providers.

Table 4.2.3.2-2. Our proposed reporting makes sure that Providers have meaningful data to inform their PCMH approach.

Report	Description	Frequency
Care Management Platform (CMP)	Provides access to Member data in an easy-to-navigate dashboard available to all network Providers through our Provider Portal. Data includes HEDIS care alerts, authorizations, prescriptions, and claims organized by type (inpatient, ER, and office visits). Our CMP also serves as our primary method for sharing Member CM information, including Health Risk Screenings and treatment plans.	Daily
CM Reports	Allows Providers participating in more advanced VBP programs to see actionable data and identify Members needing outreach and engagement, including: • **Care Opportunities.** Identifies Members with existing/pending care gaps and due date for next clinical intervention. • **Hot Spotter.** Identifies high-risk Member clinical opportunities and Members at increased risk for hospital readmission. • **ER Visits.** Identifies ER utilization, including avoidable visits.	Daily
Missed Opportunity List	Provides PCPs a list of Members with care gaps, such as missed preventive health services, and targets need for HEDIS-measured procedures and visits. Includes Member contact information so Providers can easily conduct outreach.	Monthly
Member Panel Report	Details all Members attributed to the PCMH Provider; panel review be incorporated into the quarterly meetings to address assignment errors	Quarterly
Performance Report	Details PCMH progress toward meeting program goals, relative to quality and cost measures and targets	Quarterly
Member Last Visit Report	Details the percentage of assigned Members seen that year; helps Providers monitor their engagement level and opportunities for improvement	Annually, more frequently upon request
ER Utilization Summary	Details ER utilization for Members the Provider has treated within the last year	Annually, more frequently upon request

When we identify practices that are underperforming, we will incorporate a more robust, team-based, targeted approach to underperforming practices that will involve increased coaching hours, action plans, increased clinical support, and program reassessment. Practice performance will also be evaluated through quarterly performance reports available through our Provider-facing Care Management Platform (CMP) on the Provider Portal, monthly touchpoints, coaching, and quarterly Provider meetings. Practices triggered for remediation will be shared with the Division via quarterly email.

For those practices that have been in the program for at least two years, the following will trigger performance remediation:

- Organizations that do not earn an annual outcome payment for two consecutive years and do not show improvement in quality or efficiency/cost of care will be targeted for remediation
- We will work with these groups to develop a Corrective Action Plan to identify gaps in care targets and set benchmarks for the group in the following calendar year after the final report is received. The Provider will be given six months to achieve these benchmarks:
  - Corrective action plans will be individualized and evaluated on a case-by-case basis annually. If the practice is not already receiving coaching, coaching/monthly meetings will be required

- After six months, groups not achieving their benchmarks will be targeted for removal from the program indefinitely at the end of the year and will be reevaluated for other performance incentive programs if applicable. Final removal from the program will be at our discretion.

Maintaining a Robust Measurement and Reporting Platform

Our measurement and reporting platform will be available on our Provider Portal and will include our Provider CM system, which will deliver Member-level reporting and aggregated Population Health performance and quality results to participating PCMH Providers and practices. PCMHs will have access to their attributed Members' diagnoses, claims history, procedure codes, and prescriptions in our Provider-facing CMP. This tool aids in care coordination activities so that our CM team and PCMH staff have access to the same information. We will also deliver aggregated quality results, gaps in care, and SDOH reporting as well as Member panels to our PCMH practices through our Provider Portal and our Provider website.

Using a Shared Tool

Based on the experience of our parent company and its affiliates, the use of a shared tool or data aggregator has been beneficial in further enhancing coordination across the CCOs and PCMH practices. For instance, in one affiliate market, we collaborated with the State and other entities to develop a collaborative data exchange tool that includes Member information, such as admission, discharge, transfer from a hospital, and ER visits. It also identifies and tracks the closure of gaps in care linked to quality measures and allows Providers to view their Member panels and Members' risk scores to facilitate Member outreach. Using a web-based application allows PCMHs to identify gaps in care linked to quality measures and coordinate and track the closure of those gaps. It also makes it easier for PCMHs because they have one consistent application across all CCOs, which reduces

administrative burden. We would like to work with the Division and the other CCOs to consider such a tool to move the Mississippi PCMH initiative along the continuum and promote optimal success.

Collaboration Efforts with Other CCOs

We also propose collaborating with the Division and other CCOs through quarterly meetings dedicated to improving existing programs, discussing barriers to Provider success, developing data-driven ideas for improvement within this program, and assuring no duplication of efforts with Providers.

Collaborating with the Division

As noted in this section, we will collaborate with the Division through quarterly meetings, regularly regarding program development, Provider identification, notification of Provider NCQA recognition, and when remediation is necessary. We will submit our PCMH Program Description to the Division 90 days prior to go-live date.

Identifying Information. To comply with the Identifying Information requirements defined in Section 1.2.3.3 of the RFQ and subsequent amendments, we removed names of federal and State agencies, Providers, and other stakeholders from our response, except where expressly permitted by the Division. If this information is needed to validate our proposed solutions or evaluate our response, we will be ready to provide it to the Division.

[END OF RESPONSE]

4.2.3.3: Social Determinants of Health (SDOH)

We Will Proactively Address Our Members' Social Determinants of Health Needs

For the MississippiCAN and CHIP Programs, ***we will take an integrated, person-centered approach to healthcare that includes identifying and addressing the unmet social needs of our Members and their communities*** in compliance with Contract Sections 7, 8, 8.9, and Exhibit E. Our methods of administering programs to address Members' Social Determinants of Health (SDOH) needs will be an integral component of our Quality Management (QM) and Population Health approaches.

Our approach will provide an operational foundation and structured framework to support Member health and well-being. As depicted in Figure 4.2.3.3-1, we will incorporate individual and population data analyzed through our Population Health program with information gleaned from Member, Provider, and community engagement to inform, develop, and deliver SDOH programs, services, and community investments. This approach supports the continuous monitoring of Member outcomes and external environment. We will measure and share the effectiveness of our SDOH solutions, compare outcomes with program goals across our teams and with the Division, make adjustments as appropriate, and continually develop new social interventions that focus on improved outcomes. ***This integrated approach builds on analysis, evaluation, and lessons learned to quickly remove barriers to care and expand access to services and supports in the communities where people live, work, and play.***

1. Our Approach and Experience Collecting Data on Non-medical Risk Factors

Aligned with our Population Health and QM approaches, our ***SDOH strategy*** will focus on analyzing multiple types of data to identify and address complex and often hard-to-see social and medical needs.

Domains and Metrics Collected That Inform Our SDOH Programming

Our health informatics platform brings together internal and external data to provide insight into the prevalence and impact of SDOH.

Standardized Screening Tools to Identify SDOH Needs

Our initial ***Health Risk Screening*** (HRS) will help identify each Member's physical conditions, mental health, and SUD needs (detailed in Section 4.2.2.3.B.5), and will include questions to help determine any SDOH challenges as described in Contract Section 7.4.

We will offer Providers training, education, and resources to help them identify Members' social needs and raise their awareness of population-specific health disparities. We will continuously monitor and capture this information and will submit reports to the Division as required.

Analyzing and Acting on Data

Our CMP will be the primary storage and access site for an individual Member's clinical information. When a screening is completed for a Member, this information will be readily available in our CMP, putting actionable data in the hands of our CM team.

Beyond our CMP, we will use many tools to help capture, monitor, and evaluate social risk factors.

As described in detail in this section, these data analytic tools enable us to develop and implement specific interventions for key populations, such as chronic condition management programs, Value-Added Benefits (Value-Adds), health promotion campaigns, and community investments and partnership projects that address SDOH needs. Our Population Health team will continuously assess and reevaluate the effectiveness of our interventions in achieving improved health outcomes.

[1] U.S. Census Bureau, *American Community Survey* (2019).
[2] U.S. Department of Agriculture, *Economic Research Service* (2019).
[3] U.S. Bureau of Labor Statistics, *Labor Force* (November 2021).

[redacted]

[4] Mississippi State University™ Extension, *Rural Health* (accessed February 2022).
[5] Broadband Now Research, *Best and Worst States for Internet Coverage, Prices and Speeds, 2021* (September 16, 2021).
[6] Federal Communications Commission, *Broadband Map* (accessed February 2022).
[7] U.S. Census Bureau, *American Community Survey* (2019).

[8] US Department of Agriculture, *Economic Research Service* (2019).

[9] Gucciardi, E., Vahabi, M., Norris, N., Del Monte, J., and Farnum, C., *The Intersection between Food Insecurity and Diabetes: A Review* (October 2, 2014).

[redacted]

[10] Feeding America, Food Insecurity in Mississippi Before COVID-19 (2018).
[11] The Nation's Report Card, 2019
[12] US Census Bureau, American Community Survey 2019
[13] Zajacova, A. and Lawrence, E., The relationship between education and health: reducing disparities through a contextual approach (January 12, 2018).

[redacted]

5. Integrating SDOH Evaluation into QM, CM, and Other Programs

Driven by our Population Health approach, we will continually analyze and evaluate our SDOH programs to assure that they are improving the health of our Members and communities.

Identifying Information. To comply with the Identifying Information requirements defined in Section 1.2.3.3 of the RFQ and subsequent amendments, we removed names of federal and State agencies, Providers, and other stakeholders from our response, except where expressly permitted by the Division. If this information is needed to validate our proposed solutions or evaluate our response, we will be ready to provide it to the Division.

Technical Qualification: 4.2.3.3: Social Determinants of Health (SDOH) (Unmarked)

[redacted]

Technical Qualification: 4.2.3.3: Social Determinants of Health (SDOH) (Unmarked)

[redacted]

Technical Qualification: 4.2.3.3: Social Determinants of Health (SDOH) (Unmarked)

[redacted]

Technical Qualification: 4.2.3.3: Social Determinants of Health (SDOH) (Unmarked)

[redacted]

Technical Qualification: 4.2.3.3: Social Determinants of Health (SDOH) (Unmarked)

[redacted]

Technical Qualification: 4.2.3.3: Social Determinants of Health (SDOH) (Unmarked)

[redacted]

[redacted]

[END OF RESPONSE]

[redacted]

[1] Centering Healthcare Institute, *Analysis Finds Evidence-based CenteringPregnancy® Model Reduces Racial and Social Disparities Across Maternal Child Health* (October 2, 2019).

Technical Qualification: 4.2.3.4: Value-Added Benefits (Value-Adds) (Unmarked)

[redacted]

[redacted]

[2] March of Dimes, *Dental Health During Pregnancy* (June 2019).

Technical Qualification: 4.2.3.4: Value-Added Benefits (Value-Adds) (Unmarked)

[redacted]

[redacted]

[3] Centers for Disease Control and Prevention, *Measuring the Impact of Hearing Loss on Quality of Life* (April 27, 2016).

[redacted]

[4] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Public Health Approaches to Reduce Vision Impairment and Promote Eye Health; Welp, A., Woodbury, R.B., McCoy, M.A., et al., editors, *Making Eye Health a Population Health Imperative: Vision for Tomorrow* (September 15, 2016).

[redacted]

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[redacted]

[6] Carnemolla, P. and Bridge, C., *Housing Design and Community Care: How Home Modifications Reduce Care Needs of Older People and People with Disability* (June 1, 2019).

Technical Qualification: 4.2.3.4: Value-Added Benefits (Value-Adds) (Unmarked)

[redacted]

Technical Qualification: 4.2.3.4: Value-Added Benefits (Value-Adds) (Unmarked)

[redacted]

[redacted]

[7] Centers for Disease Control and Prevention, *Map: Overall Obesity* (2020).

[redacted]

[8] Mayo Clinic, *Sudden Infant Death Syndrome (SIDS)* (accessed February 2020).

[9] United States Environmental Protection Agency, *Bed Bugs: A Public Health Issue* (March 23, 2021).
[10] American Lung Association, *Cockroaches* (March 16, 2020).

[redacted]

[11] Mississippi State Department of Health, *Teen Pregnancy Prevention* (June 14, 2018).

Technical Qualification: 4.2.3.4: Value-Added Benefits (Value-Adds) (Unmarked)

[redacted]

Technical Qualification: 4.2.3.4: Value-Added Benefits (Value-Adds) (Unmarked)

[redacted]

Technical Qualification: 4.2.3.4: Value-Added Benefits (Value-Adds) (Unmarked)

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[redacted]

[END OF RESPONSE]

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Technical Qualification: 4.2.3.5: Performance Improvement Projects

[redacted]

Technical Qualification: 4.2.3.5: Performance Improvement Projects

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[END OF RESPONSE]

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Technical Qualification: 4.2.3.6: Health Literacy Campaigns

[redacted]

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Technical Qualification: 4.2.3.6: Health Literacy Campaigns

[redacted]

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Technical Qualification: 4.2.3.6: Health Literacy Campaigns

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Technical Qualification: 4.2.3.6: Health Literacy Campaigns

[redacted]

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Technical Qualification: 4.2.3.6: Health Literacy Campaigns

[END OF RESPONSE]

4.2.3.7: Telehealth

Meeting Member Needs Through Telehealth

We recognize that the effective use of telehealth services is vital to increasing access and treatment options to best meet Member healthcare needs. While telehealth usage has grown in Mississippi, with nearly 300% growth during the pandemic, we recognize there is much more potential to expand telehealth adoption in comparison to other states. Our affiliate markets have significant experience implementing telehealth solutions and we will leverage this experience to create robust telehealth offerings to expand Provider capabilities and supplement traditional service methods. We will collaborate with the Division to obtain the appropriate approvals prior to making these offerings available in Mississippi.

Mississippi Telehealth Usage Growth

According to Trilliant Health's 2021 Health Trends Report, Mississippi has seen a **293% growth in telehealth** use during the pandemic.

MS21B_ MississippiTelehealthUsage _C_04

While the COVID-19 pandemic presented many challenges to the healthcare system, it also underscored the valuable role that telehealth can play in increasing access to care and addressing geographic health disparities. This is particularly important in Mississippi, where there is a predominance of rural areas that lack convenient access to a doctor or clinic. Mississippi also has a significant shortage of Providers, ranking 33rd for Primary Care Providers, 46th for pediatricians, and 41st for mental health Providers across the county. Many of the services offered by these Providers, such as mental health therapy and the management of chronic conditions, can be just as effective when conducted virtually. Telehealth also provides many benefits to Members that can improve engagement and satisfaction, including reduced travel and wait times and decreased time away from home and work. Further, it increases the likelihood that Members who may be uncomfortable accessing services due to perceived stigma will seek care for important services, such as behavioral health (BH)/substance use disorder (SUD) treatment.

Telehealth also supports the Division's goal to manage costs more effectively by reducing inappropriate ER utilization and preventing avoidable inpatient re-admissions, and helping Members more effectively manage their chronic conditions. We will conduct regular monitoring of network adequacy and service utilization patterns to identify gaps and opportunities to improve access to care through telehealth. For instance, [redacted] This analysis will allow us to develop targeted solutions to expand Provider capacity and Members' access to timely and quality care.

We will also work with key stakeholders, including schools and community-based organizations, to promote telehealth and help overcome any hesitancy or other barriers to adoption that exist in the community. For example, through a State-funded grant, Mississippi public schools will have access to telehealth and teletherapy services for students for free in 2022. We are in full support of this expansion of telehealth services, and we will assist our school and Provider partners to maximize this opportunity to increase access to care for students [redacted]

Supporting Local Provider Efforts

The primary goal of our telehealth strategy will ***be supplying local Providers with the tools they need to offer telehealth to their existing patients***. We will comply with all reimbursement requirements for telehealth

services and pay according to Medicaid rates. [redacted]

The full range of supports that we will offer to Providers includes: [redacted]

Technical Assistance for Providers

Comprehensive Provider Training

During both initial orientation training and ongoing training, we will provide a comprehensive overview of our telehealth offerings and resources available to our Providers. We will also train Providers on Mississippi requirements related to the provision of telehealth services, such as the requirement that telehealth services be live, interactive, and audiovisual and on proper billing procedures. ***Our Telehealth Program Manager will closely monitor all Mississippi telehealth statutes, contractual requirements and the Division's SPAs and Administrative Code, and make sure Providers receive timely, Division-approved notifications of any updates.*** Our Provider Portal will also offer telehealth resources, links, training modules, and timely notifications of updates to Mississippi telehealth policy. For instance, we will notify Providers to telehealth policy that will extend beyond the emergency order, including allowing telehealth sessions to take place in a Member's home.

In addition to the initial and ongoing training we are required to offer per the contract, we have also proposed that telehealth be one of the primary trainings that we offer to Providers in the first year of the contract. Topics would include:

- Overview of telehealth in Mississippi, including utilization, relevant statutes, and contractual requirements
- Telehealth benefits, including improving access to care, reducing health disparities, and reducing stigma
- Proper telehealth etiquette and HIPAA guidelines, such as conducting sessions in a private space
- Telehealth billing guidance and how to prevent fraud and abuse

This training will be incorporated into our prospective training plan and submitted to the Division no later than 60 days prior to the initial education and training for Providers.

Supporting Members with Telehealth Options

We recognize the importance of expanding traditional Provider offerings through telehealth, particularly in rural communities like the Delta. Our proposed telemedicine solutions prioritize incorporating local, Mississippi Providers. We will work to make sure the implementation of these services does not supplant local, Mississippi Providers, but instead fills gaps where no Mississippi Providers exist. All Providers of telehealth will be Medicaid enrolled and licensed in Mississippi. The telehealth options that will be available to Members include:

Online Urgent Care

Across our markets, nearly **one in five** Members indicated they would have gone to the ER if the online urgent care solution had not been available.

MS21B_OnlineUrgentCare_C_03

[redacted]

Additional Telehealth Supports

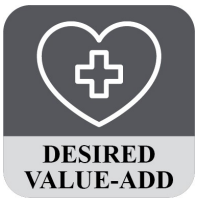
We will offer additional mobile supports that will supplement our telehealth offerings and help Members more effectively manage their care. These supports include:

Informing Members of Telehealth Options

We will also provide comprehensive education to Members on the availability of telehealth options and how utilizing these services can improve their health and decrease healthcare costs. This education will be included in the Member handbook, in Division-approved Member communications, on our Member portal, on our mobile app, via texts, at community events, and meetings with Care Managers. Members can easily access telehealth services through our mobile Member portal, accessible from either a computer or mobile app. We will also collaborate with CBOs and other organizations to develop targeted educational resources and support programs for anyone who may be hesitant to use telehealth, including older adults and people with intellectual disabilities. Members will also be able to ask questions about how to access telehealth services by calling our Member services line. We will also have information about our range of services, including telehealth that will be available at our proposed physical location for Member services. Finally, Members will also be able to identify Providers with telehealth capabilities through a designation in the Provider Directory.

For Members in low, medium, or high risk levels, the CM team will provide education about telehealth through ongoing CM contacts. Telehealth options will also be identified and included in Member's treatment plans and as part of their discharge and treatment plans in conjunction and collaboration with a Member's PCP/PCMH. Following discharge from an inpatient setting, our Transition of Care (TOC) team will continue close communication with the Member and family or caregivers at a level based on the Member's needs to identify and address any barriers they may face in engaging and participating in services and supports identified in the discharge plan. They will also identify opportunities to use telehealth as part of the discharge plan, which is

often more convenient for Members, and may decrease re-admissions. [redacted]



Identifying Information. To comply with the Identifying Information requirements defined in Section 1.2.3.3 of the RFQ and subsequent amendments, we removed names of federal and State agencies, Providers, and other stakeholders from our response, except where expressly permitted by the Division. If this information is needed to validate our proposed solutions or evaluate our response, we will be ready to provide it to the Division.

[END OF RESPONSE]

4.2.3.8 Use of Technology

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Identifying Information. To comply with the Identifying Information requirements defined in Section 1.2.3.3 of the RFQ and subsequent amendments, we removed names of federal and state agencies, Providers, and other stakeholders from our response, except where expressly permitted by the Division. If this information is needed to validate our proposed solutions or evaluate our response, we will be ready to provide it to the Division.

[END OF RESPONSE]

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Technical Qualification: 4.2.3.9: Potential Partnerships (Unmarked)

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Technical Qualification: 4.2.3.9: Potential Partnerships (Unmarked)

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Technical Qualification: 4.2.3.9: Potential Partnerships (Unmarked)

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Technical Qualification: 4.2.3.9: Potential Partnerships (Unmarked)

[END OF RESPONSE]

Amerigroup

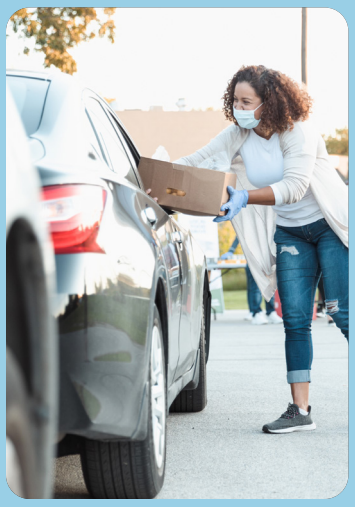
RFQ # 20211210

Management Qualification

(Amerigroup Mississippi, Inc.)

Response Deadline: March 4, 2022 2:00 p.m. (CST)

Amerigroup



Mississippi Food Network Partnership

Amerigroup's Plan President and Community Relations Representative worked with Mississippi Food Network CEO and staff to fund 1,612 food boxes. The boxes went to food banks around the state to continue the drive-thru food pantries. In 2021, Amerigroup provided funding for two vans for Mississippi Food Network — one to transport incarcerated individuals who work in the warehouse and the other for perishable donations to food-insecure communities throughout the state.

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Amerigroup

Girl Scouts of Greater Mississippi

With the support of Amerigroup, Girl Scouts of Greater Mississippi has developed a new badge program promoting healthy behaviors for girls ages 5 to 18. The program focuses on healthy mind, healthy body, and healthy eating initiatives Girl Scouts can learn about and complete to earn a newly unveiled health badge. Mississippi First Lady Elee Reeves attended the event to unveil the new badge.

4.3.1 Corporate Background and Experience

Management Qualification: 4.3.1.1 Corporate Background

Biographical Information	
General Background Information	
Date Business was Established: Amerigroup Mississippi, Inc. (Amerigroup) was established on December 6, 2016.	
Legal Business Name as Reported to the Internal Revenue Service: Amerigroup Mississippi, Inc.	
Doing Business As Name (if applicable): Not applicable.	**Tax Identification Number (required):** The tax identification number for Amerigroup Mississippi, Inc. is 81-4626605.
Ownership Type (public company, partnership, subsidiary, etc.): Amerigroup Mississippi, Inc. is a Mississippi-based corporation. Amerigroup Mississippi, Inc. is a wholly owned direct subsidiary of Anthem Partnership Holding Company, LLC. Anthem Partnership Holding Company, LLC is a wholly owned direct subsidiary of Anthem, Inc., a for-profit, publicly traded corporation on the New York Stock Exchange.	
Number of Personnel Currently Engaged in Operations: Currently, [redacted]	**Total Number of Employees:** Nationally, Amerigroup's parent organization, Anthem, Inc. (Anthem) has more than 71,000 employees. [redacted]

Management Qualification: 4.3.1.1 Corporate Background

Professional accreditations pertinent to the services provided by this RFQ:
Amerigroup Mississippi, Inc. has been licensed by the Mississippi Department of Insurance as an HMO since 2016.

All clinical personnel serving Members will be licensed and accredited and follow all requirements contained within the Contract regardless of geographic location.

NCQA Accreditation
As a member of the Anthem, Inc. (Anthem) family of health plans, Amerigroup Mississippi, Inc. also benefits from the expertise, proven industry-leading experts, and tools of our parent organization, Anthem, and its subsidiaries. Our Medicaid affiliates in 21 states hold Health Plan Accreditation – Accredited Status from NCQA. From our parent company to our affiliates, we have a 100% success rate on accreditation applications and meeting required timeframes to achieve this. As a whole, we have not had any unsuccessful submissions for NCQA Health Plan Accreditation. Anthem holds NCQA Population Health Program Accreditation, which is awarded to organizations that align their operations to manage different Population Health needs efficiently and work to reduce duplicated efforts and healthcare waste associated with misaligned goals.[1]

Our organization also holds full Managed Behavioral Health Organization (MBHO) Accreditation, achieving a near-perfect score for all MBHO UM program and policy elements and a "High" on all file review elements.[2] This accreditation reflects our organization's commitment to evidence-based practices for the provision of high-quality care, access, Member protections, and integration of physical health and behavioral health. ***We will leverage this NCQA-accredited BH and Population Health approach, driven by our Mississippi-based leadership and local care and UM teams to provide seamless, integrated services to MississippiCAN and CHIP Members.***

Our organization's dedication to providing culturally competent services is demonstrated by the NCQA Multicultural Health Care Distinction, currently awarded to 18 of our affiliate health plans. As NCQA is transitioning its historical Multicultural Health Care Distinction to a newly developed and defined Health Equity Accreditation program, ***our Florida affiliate is one of nine organizations nationally participating in NCQA's Health Equity Plus pilot,*** further signaling our organization-wide commitment to advancing health equity through Member-centric practices. ***Amerigroup Mississippi, Inc. will pursue Health Equity Accreditation when the program is launched at full scale.***

Location of the Principal Place of Business				
Address Line 1 (Street Name and Number): 750 Woodlands Parkway				
Address Line 2 (Suite, Room, etc.):				
City: Ridgeland	**State:** MS	**Zip Code:** 39157	**County:** Madison	
Mailing Address (P.O. Box): P.O. Box 3306	**City:** Ridgeland	**State:** MS	**Zip Code:** 39158	**County:** Madison
Location of place of performance of the proposed Contract				
Address Line 1: 750 Woodlands Parkway				
Address Line 2:				
City: Ridgeland	**State:** MS	**Zip Code:** 39157	**County:** Madison	

[1] The accreditation is maintained through an Anthem, Inc. subsidiary corporation, State Sponsored Services, Inc.
[2] The MBHO Accreditation is maintained through an Anthem, Inc. subsidiary corporation, Anthem GBD Behavioral Health.

Management Qualification: 4.3.1.1 Corporate Background

Contractual Termination
Has the Offeror been a party to any contractual termination within the past five (5) years? [ ] Yes [x **] No** **If yes, attach a narrative explanation for each termination including date, market, population covered, circumstances of termination, and contact information for the state entity that was party to the contract.**

[REST OF PAGE INTENTIONALLY LEFT BLANK]

[END OF RESPONSE]

4.3.1.1: Corporate Background

4.3.1.1.2 Corporate Resources

Amerigroup Mississippi, Inc. (Amerigroup) proudly brings an array of transformative health solutions to serve Mississippi that are evidence-based, creative, and rooted in collaborative partnerships. Over the last 18 months, our local leadership team has traveled across the state to listen and learn from those who know Mississippi best: the individuals and families who live here, Providers, advocates, community-based organizations (CBOs), Provider associations, state agencies, and other stakeholders. Across the state, in the most rural counties like Issaquena to the metropolitan Hinds and Harrison counties, we are building our person-centered delivery model with local communities, local Providers, and local organizations to address health disparities and achieve the best outcomes for Members. Led by our Chief Executive Officer, we will offer customized resources, products, and services aligned with what matters most to Division of Medicaid (the Division) by focusing on:

- Promoting ***Quality*** and advancing data-driven, evidence-based practices with an emphasis on improving outcomes
- Supporting ***Collaborative Innovation*** by simplifying Provider processes and bridging community resources to focus on the well-being of whole communities
- Maximizing ***Access*** by offering Provider incentives that promote increased participation, and reward Providers for adopting evidence-based practices and achieving health equity
- Exemplifying a ***Commitment*** to continuous process improvement, transparency, and a steadfast dedication to the Members and communities we serve

The following sections highlight examples of what we can offer to help achieve the Division's goals, advance health equity, and improve health outcomes for Mississippians — from digital services such as telehealth and specialized Care Management (CM) programs that help reduce health disparities to community investments and partnerships that build capacity across the state.

Computer and Technological Resources

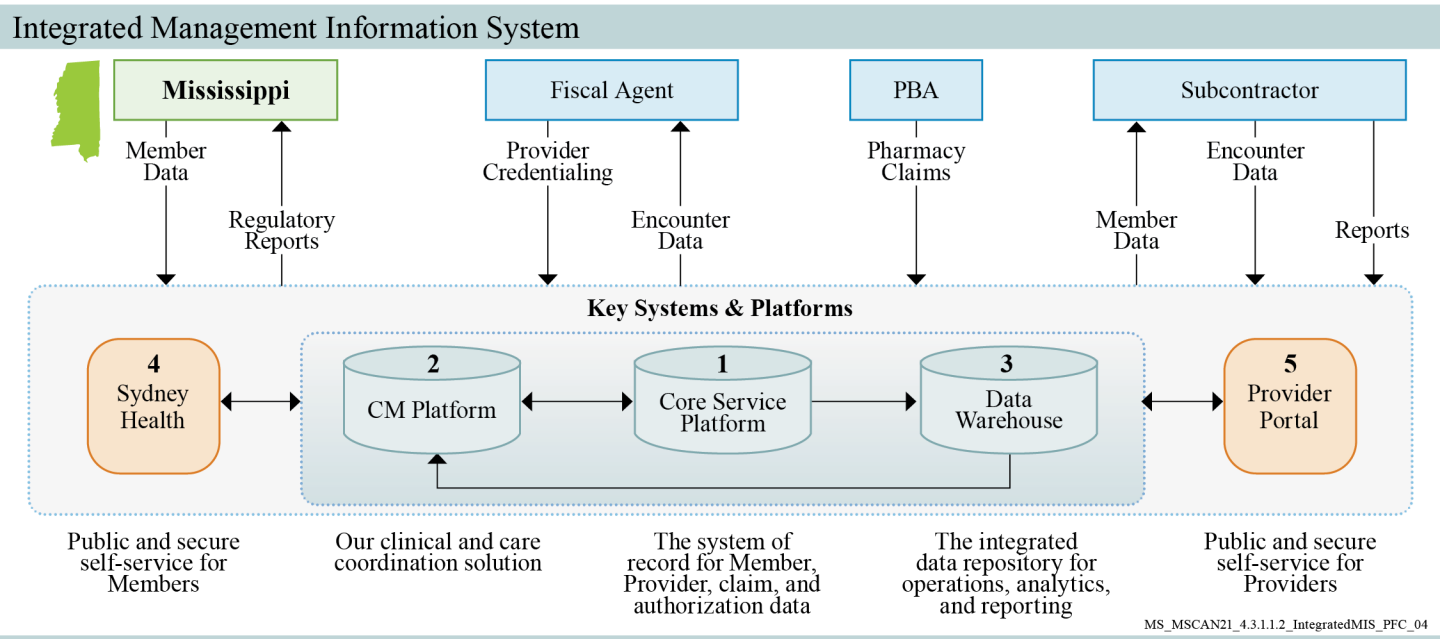
Across Amerigroup and our affiliates, continued investment in IT is a priority so that we can bring the best care and services to Members. ***Leveraging a service-oriented architecture, our customized Management Information System (MIS) for the MississippiCAN and CHIP Programs will give us the foundation to deliver on the products and services we will offer Mississippi.***

Central to our daily Mississippi operations, we will use our HITRUST-certified and HIPAA-compliant MIS that is configurable and customizable, so that we can meet all MississippiCAN and CHIP Program requirements now and in the future. It is designed on the principle that all data originates from a single system of record, with all changes being made within the system, then replicated to surrounding systems and applications. This integrated system is built on a managed Medicaid model with a design and configuration based on our affiliates' experience supporting managed care programs in 26 markets nationwide. The system will accommodate state-specific needs and innovations, enabling unique capabilities implemented for one affiliate to be leveraged for another. ***This ability to customize allows us to remain agile and efficiently implement innovative functionality that meets the specific needs of Mississippi.***

Figure 4.3.1.1.2-1 illustrates our overarching technology with its five integrated components that will support our cross-functional operations, and we describe these components in more detail next. The components interoperate where needed but are independent enough to provide specialized functionality to fulfill Contract requirements. This approach protects data integrity and prevents inconsistencies between systems. Further, timely exchange of accurate information is essential to assuring our Members receive the right care based on

their needs and preferences. ***Our MIS enables us to collect and process data from all relevant sources and share it with all stakeholders so that together, we can take action to achieve the Division's goals and improve outcomes for Mississippi Members.***

Figure 4.3.1.1.2-1. Computer and technological resources include five primary system components.



1. Core Service Platform

Our Core Service Platform (CSP) serves as the authoritative host, or system of record, for data about Providers, Members (including demographics, Enrollment, and other insurance coverage), claims and encounters, and service authorizations. It collects and tracks data on utilization, Grievances and Appeals, Provider contracts, Member benefits, finance, and more in support of program operations and quality assessment and improvement activities. We maintain data quality through interfacing applications that apply rules-based standardization, verification, and validation logic to data elements. For example, the platform will:

- Use Provider data across multiple functions, including network development and management, PCP or Patient-Centered Medical Home (PCMH) assignment, claims, utilization, quality management (QM), and care coordination and management
- Store Provider data including Provider type, specialty, payment information, contract status, affiliations, and exclusion status as well as Provider capacity, locations, specialties, hours, accessibility, languages, age/gender, cultural competency training completion, and web address
- Maintain and track information and claims and encounters for covered services processed on behalf of our Providers
- Allow us to combine claims we process with encounters received from our subcontractors into a complete submission.

2. Care Management Platform to Coordinate Care and Data Sharing

Our fully integrated Care Management Platform (CMP) shares and aggregates actionable data across systems and organizations, promoting effective, efficient, and collaborative care coordination — particularly for complex, high-risk individuals. This system fully integrates with our CSP for Member, Provider, and claims data. It also provides tools for the CM team, Utilization Management (UM) Clinicians, and other functional teams, such as our Provider Experience and Quality teams.

The CMP makes data readily available in an organized format to deliver a holistic picture of each individual's treatment plan, service use, and gaps in care. It captures Member utilization data, such as claims history, authorizations, immunization records, lab results, and care and chronic condition management. It connects the team of preferred support facilitating communication, collaboration, and information sharing among those involved in a Member's care. Through this platform, the CM team and Providers can easily identify and address Members' needs and support the development, management, coordination, and communication of the person-centered treatment plan.

3. Data Warehouse

Our data warehouse platform uses the SQL server and supports operational processes, analytics, and reporting. Fed directly from the system of record to promote data quality, control, and consistency, the data warehouse delivers a comprehensive source of health information about our Members and includes encounter claims data for medical, behavioral, pharmacy, dental, vision, and transportation services they receive. We integrate additional information into the data warehouse to support other processes, including lab results, immunization data, clinical data, and pharmacy data from the Pharmacy Benefits Administrator (PBA) for our Members to be used for UM and CM. The data warehouse supports access to integrated Member health information through our CMP; advanced analytics, including our predictive modeling system to identify Members for CM; and our operational, management, and regulatory reporting process information.

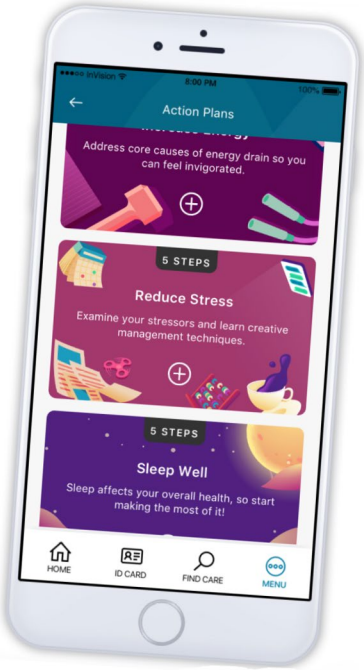
We apply rigorous edits and controls to preserve the integrity of all data, knowing that accurate operational systems provide a solid foundation for accurate reporting. Our integrated data warehouse consolidates data from internal and external sources to support the ongoing requirement for scheduled reports and specialized ad hoc reporting. Internal data include claims, Member, Provider, CM, and authorization information. Data from external sources include items such as historical claims data, lab results, and subcontractor encounters. The data warehouse is fed directly from source systems to drive data accuracy. Within our MIS, we electronically update data between components on a schedule designed to preserve consistency across systems and support business needs. ***The integration of data into our data warehouse supports holistic care for the Member, closes gaps in care when shared with Providers, and eliminates care silos that can occur if our CM team were unable to access all Member-related data.***

4. Member Engagement Platform: Website and App (Sydney Health)

Members will also have 24/7/365 access to our website and Sydney Health (Sydney), our secure Member Portal and digital app, which offers personalized content and access to resources at their fingertips. Our public Member website will offer a convenient overview of all covered services, including descriptions of CM and preventive care. Our secure Member website and mobile app offer our Members targeted information specific to their healthcare needs. Sydney is our next-generation Member engagement platform that supports a Member's health journey without requiring multiple calls, apps, or internet searches. ***Going beyond the traditional website or app format, Sydney provides Members with tools and resources customized to their health history and interests.*** It offers answers to questions that matter most to Members and directs them to the right care resources in real time. Using data science to personalize each Members' experience, Sydney increases engagement and makes healthcare smarter, easier, and more accessible than ever before by:

- Integrating benefits, claims, and health and wellness
- Tailoring to each Member's unique needs
- Making it easy for Members to choose how and when they interact with us (telephone, chat, text, email)
- Delivering an integrated, seamless experience regardless of whether the Member uses the website or the mobile app
- Recommending products and programs and identifying gaps in care to deliver better outcomes and lower costs

Amerigroup's Sydney Application Has Stress Reduction Action Plan



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With Sydney, Members can seamlessly move from one valuable resource to another and check symptoms, visit with a Provider in real time, or send needed prescriptions straight to their pharmacy of choice. Sydney delivers an unparalleled, convenient, personalized experience that removes barriers to care.

Figure 4.3.1.1.2-2 illustrates an example of Sydney's functionality in helping a Member who is expecting her first child find the services and information she needs to support a health pregnancy. As the app illustrates, the Member can quickly connect to an assigned OB screener and access incentives, including Healthy Rewards (a program we will offer to encourage Members to adopt and sustain healthy behaviors the improve well-being). The Member can also receive information on community services and important reminders about her health.

[redacted]

5. Provider Portal and Website

Our secure 24/7/365 Provider Portal and website offers the latest communication and toolkits to make Providers' jobs easier. The public website delivers timely and relevant information, announcements, alerts, forms, and a list of Provider Representatives by region for Providers, staff, and stakeholders. The Provider Portal and the public website include evidence-based trainings and tools, such as clinical practice guidelines, Member eligibility, and medical policies.

Fully compliant with Contract Section 5.8.4, Providers use a single point of access to the portal to check eligibility, request Prior Authorizations (PAs), manage patient care, submit claims, and access online functionality for claim inquiry, including access to Grievances and Appeals, Provider remittance advice, denial descriptions, disputes, and tracking. They can access our dashboard with information about care gaps, CM communications, utilization, and documents such as assessments, treatment plans, and referrals for their patients. They can screen for social risk factors, find community resources, and communicate closed-loop referrals back to the Care Manager. Providers will also be able to use the Provider Portal to access information about MississippiCAN and CHIP Programs, link to trainings, and submit inquiries to our team. ***Through our Provider Chat, available through our Provider Portal, Providers can connect in real time with staff and get immediate answers to questions about claims submission, PA, and Appeals.*** [redacted]

Our Provider Portal also houses several digital tools that help Providers streamline their efforts, reducing administrative burden. Our Clear Claim Connection™ tool helps Providers determine if procedure codes and modifiers are likely to pay based on a Member's diagnosis. Our tool to look up PA helps Providers easily identify whether a specific code requires it and helps prevent denials. This tool streamlines the authorization process by giving Providers a central location where they can check if an authorization is needed, submit the authorization with required documentation, and manage it all through a user-friendly dashboard. It also:

- Checks service codes against a payer database, reducing calls and unnecessary paperwork
- Guides Providers through creating an authorization using our portal's intuitive user interface
- Offers a dashboard to review status of previously submitted authorizations from all payers
- Supports the submission of documents electronically

Our innovative PA Pass program will reduce administrative burden for select Providers who consistently demonstrate excellence in PA performance and meet coverage criteria, enabling these Providers to bypass the PA process on specific outpatient codes.

Technology Resources That Enhance Visibility and Transparency into Our Performance

We are committed to working with the Division on providing the data they need when they need it. Through data sharing, we can give the Division and our own leadership line of sight into our operations and how we perform so we can make collaborative decisions. Our local leadership will work hand-in-hand with our national shared service partners to collect, integrate, and maintain a comprehensive set of data to generate the necessary reports. This will allow real-time data sharing with the Division and enable us to comprehensively review, monitor, and analyze trends to inform the way we deliver products and services to our Members, Providers, and stakeholders. ***We will implement a Quarterly Business Review, in which our Coordinated Care Organization (CCO) leadership team will review findings, identify areas of opportunity, and develop solutions in collaboration with the Division. We are committed to working with the Division to continuously revise our reports and data submissions to meet the Division's custom needs. Additionally, we will have a local and dedicated QM Analyst to support this work.***

Our Current Products and Services to Support Mississippi's Needs and Program Goals

Amerigroup was formed for one purpose: creating a CCO to serve MississippiCAN and CHIP Members. Our entire Amerigroup operations will focus on meeting the Division's requirements and goals and providing the best services and programs to Members, Providers, and our stakeholders in Mississippi.

With a focus on health equity, our overall Population Health approach centers on a cycle of continuous quality improvement, so that we can continually refine the services we offer as Members' needs evolve over time and as we form new partnerships and develop initiatives to best serve Mississippi. Through our Population Health strategy, we bring all CCO functions together to deliver solutions that foster healthier, more resilient communities and increase health literacy, including:

[redacted]

The following provides examples of the products and services we will offer to support the Division's goals.

Products and Services That Prioritize Quality

We recognize the Division's emphasis on quality-based improvements — our quality programs and initiatives are data-driven and rooted in Population Health, with emphasis on improving the health and well-being of our Members. Based on our initial analysis and the Division's Comprehensive Quality Strategy, we identified five Population Health priority areas that inform our CM products and services as well as the Value-Adds we will offer, described next. Our priority areas include:

- Chronic Conditions
- Women's and Maternal Health
- Child and Adolescent Health
- Behavioral Health (BH)
- Health Equity

These CM products and services help our Members and their families along their health and wellness journey by breaking down barriers and driving more accessible, equitable care. With a range of customized interventions, our Members can access the extra assistance they may need to help them manage their health. Along with the support and assistance from our skilled CM team (including Care Managers, Care Management Navigators, and Community Health Workers), these products and services can help make accessing healthcare easier, engaging, and less overwhelming for our Members.

Products and Services to Support Members in Managing Their Chronic Conditions

Identifying Members' chronic conditions is an important part of our overall approach to making sure each Member receives the support needed to manage and improve their health. Our chronic condition management programs encourage improved health outcomes and healthy behaviors through a combination of Member assessment, education, care coordination, and ongoing monitoring of measurable outcomes.

We will offer 17 chronic condition management programs, nine of which hold NCQA Population Health Program Accreditation (Figure 4.3.1.1.2-3). We will identify Members for engagement in chronic condition programs using a comprehensive population identification process, supported by our risk stratification model described in Section 4.2.2.3.

Figure 4.3.1.1.2-3. We support Members with chronic conditions.

Chronic Condition Management Programs	
We will offer **17 chronic condition management programs**	
• Diabetes*	• Asthma*
• ADHD	• Congestive heart failure*
• Hepatitis C	• Organ Transplants
• Bipolar disorder	• Coronary artery disease*
• HIV/AIDS	• Schizophrenia*
• Chronic kidney disease	• Sickle cell anemia
• Hypertension*	• Major depressive disorder – adult*
• Chronic obstructive pulmonary disease*	• Major depressive disorder – child and adolescent*
• Obesity	** Denotes NCQA accredited program*

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Based on the hierarchy of the Member's condition, we will then enroll them in a single program. For example, we will enroll Members with HIV/AIDS in our HIV/AIDS condition management program, but will also include support for additional comorbidities, such as hypertension or depression, as part of our holistic chronic condition approach. To augment these core chronic condition services, we also provide the following services described in Table 4.3.1.1.2-1.

[redacted]

[redacted]	
	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

[redacted]	
	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Women's and Maternal Health Products and Services

We recognize that Mississippi's infant mortality, maternal morbidity, and preterm birth rates are greater than the national average and are significantly higher in Black women. Using a comprehensive and multifaceted approach, we will engage MississippiCAN and CHIP Members and their Providers in evidence-based preconception, perinatal, and neonatal care to support a healthy pregnancy and baby and to keep each woman healthy throughout her life. We will offer evidence-based products and services (shown in Table 4.3.1.1.2-2) to help assure all pregnant women have information, services, and supports they need to improve maternal and child health outcomes.

[redacted]

[redacted]	
[redacted]	[redacted]
[redacted]	[redacted]

[redacted]	
	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
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[redacted]	[redacted]
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[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Quality Priority: Helping Children and Adolescents Stay Healthy Through Early Interventions

Recognizing that Mississippi is among states with the highest rates of children with special health care needs (23%), adverse childhood experiences (18.2%), childhood asthma (11%), childhood poverty (27.8%), and development screening rates (>20%), we are bringing an array of products and services to help promote early interventions, screenings, and improved outcomes so that our young Members stay healthy and can thrive in

their homes and at school. We are committed to helping children have healthier lives by engaging with parents, guardians, young adult Members, and Providers early and often. Examples of our products and services to support our child and adolescent Members are highlighted in Table 4.3.1.1.2-3.

Quality Priority: Providing Behavioral Health Services to Support Recovery and Resiliency

Our products and services focused on BH are designed to help our Members — children, adolescents, and adult — receive services they need to support recovery and resiliency. Table 4.3.1.1.2-4 outlines examples of our BH products and services we will offer to our MississippiCAN and CHIP Members.

[redacted]	
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

[redacted]	
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

[redacted]	
	[redacted]

Products and Services That Support Health Equity

Every Mississippian should have the opportunity to reach their full health and well-being potential, without disadvantage because of social position or other socially determined circumstances. We will use individual- and community-level data to proactively identify the health equity issues facing our Members. Equipped with this information, we will work with our Providers, community partners, and other stakeholders to determine root causes and implement effective interventions to address disparities.

[redacted]

[redacted]

[redacted]

[redacted] We will provide financial support and program management and work collaboratively with a variety of organizations to improve the life of Mississippians (See Table 4.3.1.1.2-5).

[redacted]

[redacted]

** Provided as part of our overall CM strategies, rather than as a Value-Add.*

Products and Services That Support Collaborative Innovation

Amerigroup's collaborative approach fuels program-specific solutions and allows us to deliver results that will address the priorities of the Division, meet the diverse needs of Members, and minimize administrative burdens on Providers. Rooted in a local model and our belief in the power of people working together, we welcome collaboration across all of our system stakeholders — the Division, other CCOs, Providers, and community organizations. The following are a few examples of the ways we will support and encourage this collaboration.

[redacted]

[redacted]

VBP Advancement

Using pay-for-quality as a basis of the program will allow Providers an opportunity to get comfortable with the concepts of quality-based payments prior to engaging in more advanced models. Under this proposed program, CCOs would have the flexibility to move PCPs and PCMHs along the HCP-LAN Alternative Payment Model (APM) continuum into more advanced programs at their own pace. To assure continued alignment with the Division's goals, the quality metrics and targets in these more advanced programs would still align with the Division's Quality Withhold, but would offer opportunities to increase the level of rewards for Providers who assume greater responsibility for managing and improving overall Population Health outcomes and cost of care.

[redacted]

[redacted]

Specialty VBP Programs

[redacted]

[redacted]

Collaborations That Improve Access

As we describe in more detail next, we are bringing a wealth of telehealth solutions to expand access, particularly in rural areas where specialty and BH services may be more challenging to obtain. [redacted]

Products and Services That Address Barriers to Access

We are investing in robust telehealth capabilities to expand access to high-demand specialties, including various pediatric sub-specialties, and BH services, such as child psychology and child psychiatry, throughout Mississippi. A significant component of our telehealth strategy will be supplying local Providers with the tools they need to offer telehealth to their existing patients. [redacted] By providing training, resources, and supports, Providers can continue to meet the needs of their current Members through virtual platforms. We will also identify shortages of Provider types in Mississippi through network adequacy monitoring to identify opportunities to improve access to care through telehealth. When we identify Provider type/service shortages, we will target outreach to Providers who offer these services to see how we can support them in expanding access to services through telehealth.

Telehealth also supports the Division's goal to manage costs more effectively by reducing inappropriate ER utilization and preventing avoidable inpatient readmissions, and helping Members more effectively manage their chronic conditions. [redacted]

Our telehealth solutions combine state-of-the-art audio/video technology along with our collaborative relationships with Providers to expand options for accessible care for Members across the state, particularly those in rural and underserved areas. For example, Table 4.3.1.1.2-8 outlines our telehealth services we will offer.

[redacted]

[redacted]

We will also partner with Providers in the community to expand access to care through compliant mobile solutions. We will conduct screenings, including vision and dental, at youth organizations and back-to-school events. We will work with the Division to identify opportunities to address health disparities in our rural communities using our community outreach vehicle. For example, we will monitor utilization and gaps in care reports to identify potential counties for outreach that we identify with poor outcomes and access limitations, focusing on counties like Tunica and Quitman where there is no access to a hospital. We would then partner with local physicians in those areas and facilitate home visits using our community outreach vehicle. These home visits could include various screenings, including BH and SDOH.

Community Outreach Vehicle

We are committed to working with the Division to develop innovative strategies that will address health disparities in our rural communities using our community outreach vehicle.

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[redacted]

[redacted] We will also collaborate with stakeholders, including the Division and Rural Health Association, to develop strategies to help retain staff and reduce staffing shortages in rural clinics, hospitals, and CMHCs to help improve access.

Products and Services That Demonstrate Our Commitment and Investment in Mississippi

We are building relationships with local partners, asking questions, and actively listening to understand local needs throughout the state's 82 counties. We know that by partnering with communities, Providers that serve Members, and the state, we can make a difference — together. ***In 2020 and 2021, Amerigroup invested more than [redacted] in Mississippi. We have also committed [redacted] for 2022.*** The following represents a few examples of the products and services we will deliver to local communities and families because of our commitment and investment to Mississippi:

- **Food Boxes.** Amerigroup will provide funding to Mississippi Food Network (MFN) to supply food boxes for food banks around the state and support efforts to continue drive-thru food pantries. Through our partnership and financial commitment, MFN will provide nearly 1,500 additional food boxes in currently underserved counties, like Lincoln, LeFlore, Franklin, and Claiborne — counties that have high unemployment rates and food deserts. Through our partnership with MFN, we will also collaborate on Member Appreciation Days at Provider offices and provide health education and screening focused on diabetes and hypertension, two chronic health conditions that also affect communities impacted by high rates of food insecurity.
- **Enhanced Access to Behavioral Health Services for Youth.** We will partner with UMMC's Center for the Advancement of Youth (CAY) to incorporate training, expanded access to telehealth services, and recruitment of more BH clinicians across the state. These efforts will aim to improve overall BH services for children and adolescents with additional focus on children and youth with co-occurring serious mental illness and autism spectrum disorder. CAY combines telehealth technology, multidisciplinary health expertise, and the support of statewide agencies to serve children and youth and their families. CAY's goal is to make sure that no child or youth suffers from lack of access to appropriate behavioral or developmental care and treatment. Through our partnership, our Members will have access to CAY's Multidisciplinary Evaluations team, which includes a developmental and behavioral pediatrician and licensed clinical psychologist and can receive services that include:
  - Medical management/developmental evaluations
  - Psychological and psychoeducational evaluations
  - Behavioral therapy
  - ABA therapy
  - Speech therapy
  - Occupational therapy
  - Physical therapy
- **EVERFI: Mental Wellness Basics Education and Health Literacy in Schools.** We partnered with EVERFI in the spring of 2021 to bring EVERFI's Mental Wellness Basics course (created by a team of counselors, psychiatrists, and public health professionals) to middle and high schools across the state of Mississippi at no cost to them, impacting 1,686 students across 19 schools to date. Students have completed more than 2,000 hours of education, focused on increasing education and awareness of mental health issues, reducing the stigma around mental health disorders, and promoting students' self-efficacy. We will also use ***EVERFI, an inclusive, interactive learning experience to engage students and improve health literacy in at least 10 schools***.

- **The Diaper Bank of the Delta.** Mississippi's first nationally recognized diaper bank helps lighten the burden of parenting for families with young children living in the Delta by providing supplies and assisting women living in poverty. Through our partnership, we will help the Diaper Bank expand their reach to the Southern and Central regions of the state. We will also hold community events as opportunities to provide Members with additional supports, supplies, and essential health information. Our collaboration will also include drive-thru baby showers to provide Members and the community diapers, baby supplies, and maternal health information including safe sleep practices, breastfeeding resources, and materials related to our Health Literacy Campaign: Building Blocks for a Healthy Pregnancy (described in Section 4.2.3.6). We will also help establish brick-and-mortar distribution sites in the Delta, Central, and Southern Mississippi to provide diapers and maternal health and child safety information.

> *Our organization has worked and collaborated with Amerigroup for about a year to meet the basic need of families in Mississippi. We appreciate the service and care they provide.*
>
> **Chelesa Presley**
> Co-Founder/Executive Director,
> The Diaper Bank of the Delta
>
> MS_MSCAN_2021_CPresley_TST_02

- **Girl Scouts of Greater Mississippi.** Obesity among Mississippi children has historically been among the highest in the nation. Mississippi children eat less nutritious meals and get less physical activity today than in the past, and it is creating a future of chronic disease and shorter life. Through a partnership with Girls Scouts of Greater Mississippi, we will work to increase access to programming that promotes healthy behaviors among girls and lays the foundation for a healthier generation. For example, we will invest in new Girl Scout badge programs (that promote healthy behaviors), summer camp scholarships, and scholarships to help 150 girls from across the state join Girl Scouts (whose families may not otherwise be able to cover the costs).
- **University of Mississippi Medical Center.** With high rates of diabetes prevalent in Mississippi, we will partner with the Department of Preventive Medicine at UMMC to deliver the National Diabetes Prevention Program, an evidence-based lifestyle change program designed to prevent or delay type 2 diabetes for individuals at risk for the disease. Because DPP is not currently covered by Medicaid, we will cover the cost of this service for our Members, as we believe in the promise of mitigating diabetes risks early. We will evaluate the ***reach, effectiveness, adoption, implementation, and maintenance*** of the Medicaid DPP at UMMC and share utilization data with the Division in compliance with the Contract. Our Diabetes Educator will follow up with UMMC's Lifestyle Coaches to assure Member participation in DPP and determine if any additional wraparound services may be needed for the Member and their family.

In addition, many of the products and services we describe throughout this section are the result of collaborative partnerships. For example, [redacted] described earlier in this section, demonstrate services we will bring to children and adolescents to help them thrive in their homes and at school based on collaboration with our community partners and stakeholders.

Amerigroup's Intangible Assets

In addition to the resources, products, and services previously described, we recognize and nurture the intangible assets (as seen in Figure 4.3.1.1.2-8) that are indispensable to our delivery model — our inclusive culture and the talented staff who make up our Mississippi team, the valuable relationships we have built with Providers and CBOs throughout the state, and the stability and efficiencies we bring as part of a larger family of affiliates and our parent company, Anthem, Inc. (Anthem).

[redacted]

Culture, Talent, and Experience

As an organization, we are dedicated to excellence and embrace a culture of inclusivity and continuous improvement across the entire organization, encouraging employees to share ideas, innovations, and evidence-based best practices. While it may be one of the least tangible parts of our organization, our culture is one of the key drivers to our success in serving Members and supporting Providers. Our inclusive culture not only makes us a stronger organization, but enables us to fulfill our mission. ***Employees bring our mission, vision, and outcomes to life — they are the heart of what we do and are essential to making a difference in the lives of Mississippians.***

One way we facilitate this culture is through our ***Employee Engagement Groups***, which offer a formalized opportunity for employees to share ideas and perspectives, build relationships, and discuss issues relevant to their common interests, culture, and values. For example, the PRIDE resource group is currently providing input around LGBTQ+ experiences as part of cultural competency training. Another initiative designed to strengthen company culture is ***Culture Conversations***, discussions designed to engage every employee in meaningful conversations to bring our culture to life. We will introduce a new topic each month for our Mississippi staff and provide managers with a detailed toolkit to help them facilitate conversations with their teams. Leaders will share feedback with their managers, who will then share pertinent information with our executive leadership team. We will use this feedback to prioritize programs and resources that help to address the needs of our employees professionally, personally, and socially.

Building on our culture, we will use a multi-pronged hiring process to recruit staff with diverse backgrounds and deep roots in Mississippi. Our process combines traditional advertising, social media, marketing strategies, local job fairs, and partnerships to help in customized recruitment, such as colleges and universities (Jackson State, Delta State, Alcorn State, and Mississippi University for Women) and professional associations (Mississippi Nurses Association) along with community referrals to attract the best candidates reflective of the communities. ***We prioritize candidates who meet our education and experience requirements, but also those who show aptitude in providing compassionate service.***

From executive leadership to frontline staff, our employees live and work in the same communities we serve and are committed to every person in Mississippi. We have chosen a leadership team steeped in local Mississippi experience, knowledge, and culture. These leaders understand the nuances of the state's delivery system, the community organizations and Providers who serve MississippiCAN and CHIP Members, and the health disparities and barriers Members face across the state. These individuals have dedicated their careers to

healthcare and government programs and will be integral to delivering our locally driven, person-centered model of care at the center of our overall program.

In addition to local leadership, we created several positions beyond the Contract requirements to support our Members and Providers in their communities, such as (but not limited to):

- **Care Management Team.** Our CM team structure facilitates localized CM at the site of care, in the home, or in the community, while also equipping our system partners (Providers or CBOs) with tools, analytics, and support to address the physical health, BH, and social needs of Members. As a single, fully integrated unit, our CM team includes ***Care Managers, Care Management Navigators, and Community Health Workers*** who will closely mirror the communities they serve by bringing knowledge of local resources, nuances, culture, language, and norms. With a strong understanding of the community, they will also help drive the development of partnerships and initiatives with CBOs, state agencies, and wraparound resources available in the state. In addition, our CM team includes ***Transitional Care Nurses***, who coordinate continuity of care for Members and make sure their transition from one level of care to another is seamless.
- **SDOH Team.** We will employ a diverse team of locally based clinical and non-clinical support staff to identify unmet SDOH needs, administer, and evaluate holistic SDOH programs and initiatives for MississippiCAN and CHIP beneficiaries. Our ***SDOH Training Specialist*** will make sure we meet all contractual requirements of specialized training, including cultural competency and SDOH. Our ***Housing Specialist*** will address housing stability and connect Members experiencing or at risk of homelessness with housing resources. Our ***Employment Specialist*** will link Members with career development and employment opportunities. Our ***Transportation Specialist*** will oversee the benefits-based Non-Emergency Transportation services and assist Members in finding rides to places that support their overall health, such as job interviews, grocery stores, and community events. Finally, we will have a ***Foster Care Specialist***, who will support the unique social needs of foster care Members as well as their families and caregivers, and a ***SDOH Specialist***, who will collaborate with CBOs to address the varied social needs of Mississippians.
- **Diabetes Educator.** This position will reach out to Members to provide information on managing diabetes and to offer diabetic nutritional classes. The Diabetes Educator will also work with Providers and community stakeholders on best practices for closing diabetes gaps.
- **EPSDT Coordinator.** The EPSDT Coordinator will oversee the EPSDT program including strategy, data analysis, and development of quality improvement activities. This position will track outcomes and use the Plan-Do-Study-Act model for continued quality improvement.
- **Provider Representatives.** Our collaboration and partnership with Mississippi Providers is a foundational element in our strategy to promote equitable, high-quality care. Upon joining our network, every Provider will be assigned a ***Provider Experience Consultant***, who will serve as their primary point of contact to foster strong relationships and provide support, tools, and assistance. (For complex Provider types, such as CMHCs, FQHCs, or Rural Health Clinics, we will assign a more seasoned Consultant). Our Providers will also have access to ***Care Delivery Transformation Consultants***, who will meet with Providers at least quarterly to provide tailored practice transformation guidance, including an analysis of performance based on quality metrics, cost data and utilization trends, and Provider profiles to identify practice-centric solutions and improvement opportunities. [redacted]

Training That Supports Diversity and Inclusion

We will support our staff with the training, resources, and tools they need to be successful — this includes making sure they are aware of implicit bias and provide culturally and linguistically responsive service that respects the diversity of Members, their values, beliefs, and preferences. As part of our overall training approach, all staff who interact with Members will receive cultural competency training during initial onboarding and annually thereafter. This comprehensive training includes applicable laws (such as the Civil Rights Act and ADA), cultural competency, healthcare literacy, and the language interpretation and translation services we offer. New staff must complete this training within 30 days of hire. In addition, the training covers implicit bias as well as the development of disability-related cultural competency skills so that our CM team and other staff who directly assist Members have a better understanding of the perspectives of people who rely on supports — including the creativity and resiliency of individuals and families in their local communities and knowledge related to improving SDOH.

In addition, staff will have access to a Diversity and Inclusion Toolbox, which offers an all-in-one training resource that combines research-based strategies and practical tools to help develop inclusive leadership skills and promote behaviors that are the foundation of an inclusive culture. The toolbox includes a comprehensive, searchable database that helps staff understand the influence of culture on one's beliefs, values, and behaviors in general and specifically, in a healthcare environment. The toolbox provides information on more than 50 different cultural groups on such topics as communication, family patterns, nutrition, treatment protocols, and ethno-pharmacological issues. It also features material on mitigating unconscious bias, inclusion of people with disabilities, and religious diversity in the workplace.

A Commitment to Health Equity Across Our Organization

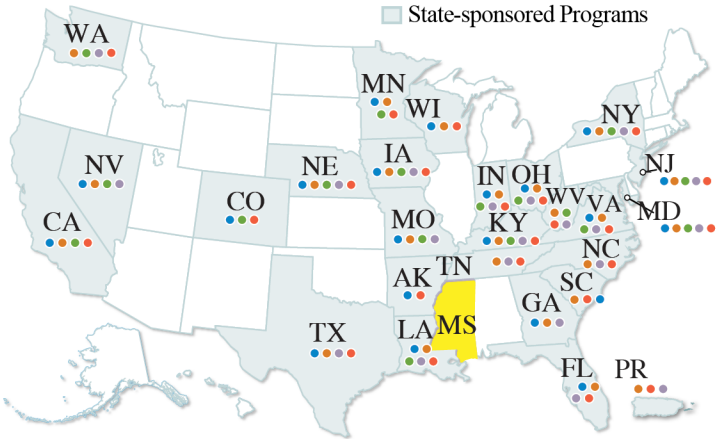
[redacted]

National Experience to Help Keep Mississippi at the Forefront of Best Practices

To augment our local solutions, we draw on the expansive experience of our affiliates and our parent company, Anthem, currently serving 10.6 million Members through state-sponsored programs across 26 markets. With more than 30 years of experience, we benefit from their deep and varied knowledge, lessons learned, and best practices, including more than 270 successful implementations and readiness reviews.

Our Affiliate Health Plans Coordinate Care for More Than 10.6 Million Medicaid Members in 26 Markets

- Serve more than **8.4 million TANF** Members in **24 markets**
- Coordinate care for more than **437,000 CHIP** Members
- Provide services for **121,000 child welfare (Foster Care)** members in **19 markets**
- In 2021, coordinated Well-Child visits for more than **5.1 million** children and adult wellness visits for more than **1.5 million members**
- In 2021, coordinated more than **6.3 million** vaccinations for children and nearly **670,000** for adults
- Coordinate care for more than **5.62 million** Members under the age of 19
- **929,000** SSI-ABD Members in **23 markets**
- Manage integrated BH services for **9.8 million** Members in **24 markets**



In 2021, we coordinated the delivery of more than 188,000 babies for Medicaid Members

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A Culture of Continuous Quality Improvement — NCQA Accreditations

As part of our commitment to continuous quality improvement, Amerigroup and all of our affiliates prioritize NCQA accreditation so that our Members receive the highest quality of care. Our Medicaid affiliates in 21 states hold Health Plan Accreditation – Accredited Status from NCQA, while the remaining markets are newer and in process of obtaining this status. ***From our parent company to our affiliates, we have a 100% success rate on accreditation applications, a testament to our commitment to quality.*** Our organization and affiliates are bolstered by additional NCQA accreditations and distinctions — all of which will help support our Mississippi operations in bringing best practices and accredited-programs to Members from Day One.

As a member of the Anthem family of health plans, Amerigroup also benefits from the expertise, proven industry leading experts, and tools of our parent organization, Anthem, and its subsidiaries. Anthem holds NCQA Population Health Program Accreditation,[1] which is awarded to organizations that align operations to manage different Population Health needs efficiently and work to reduce duplicated efforts and healthcare waste associated with misaligned goals.

[1] The accreditation is maintained through an Anthem, Inc. subsidiary corporation, State Sponsored Services, Inc.

Our National Medical Management department has held NCQA Population Health Accreditation (formerly known as Disease Management Accreditation) for the following disease management programs: chronic obstructive pulmonary disorder, coronary artery disease, congestive heart failure, depression, diabetes, asthma, HIV/AIDS, and schizophrenia. In 2018, the department was also accredited in child/adolescent depression. NCQA awards this status to organizations that meet or exceed its accreditation standards and report results for a specified number of disease management performance measures. We will make these programs available to Members in the MississippiCAN and CHIP Programs, which will help empower Members to self-manage their chronic conditions and complex needs.

Our organization also holds full Managed Behavioral Health Organization (MBHO) Accreditation,[2] achieving a near perfect score for all MBHO UM program and policy elements. This accreditation reflects our organization's commitment to evidence-based practices for the provision of high-quality care, access, Member protections, and integration of physical health and BH. ***We will leverage this NCQA-accredited BH and Population Health approach, driven by our Mississippi-based leadership and local care and UM teams to provide seamless, integrated services to MississippiCAN and CHIP Members.***

Further, 18 of our affiliates hold Multicultural Health Care Distinction, demonstrating our overall commitment to culturally and linguistically responsive programs and services. In addition, our Florida Medicaid affiliate is one of nine organizations nationally participating in the Health Equity Accreditation Plus pilot with NCQA, and we will adopt best practices from this affiliate to implement in Mississippi.

Invaluable Relationships with Providers and Community Stakeholders

Another intangible asset that impacts our service delivery is the ability to build strong, long-standing relationships. We focus on partnerships at all levels. We will be a collaborative partner to the Division, a strong partner to community organizations to coordinate services and supports, to our Providers by offering them the tools and supports to improve Member outcomes, and finally, a partner to the Members and families we serve to work collaboratively in achieving health and wellness.

We do more than invest dollars — we stay connected and involved, working side-by-side with our partners to make sure Members and families have the care, education, and supports they need. With [redacted] letters of support from CBOs and Providers in Mississippi, we are continuing to build relationships that will benefit our Members.

Our affiliates have successfully built comprehensive Provider Networks for more than 60 managed care contracts that include rural markets, and we will do the same in Mississippi. We have been engaging with the Provider community over the last 18 months, holding listening sessions with Providers and other key stakeholders, including Provider associations, Members, and CBOs, to understand the local access challenges and nuances within the state. ***We have made more than 2,000 contacts with Providers and received 92 letters of intent to contract (LOIs) that represent more than 7,000 Providers with coverage in all 82 counties.*** These LOIs include key hospitals, FQHCS/RHCs, Provider groups, and women and minority-owned practices who are ready to support our entry into the market. During this outreach, we are also documenting each Provider's willingness to participate in VBP programs.

Upon award, we will leverage these existing relationships and our organization's proven network development processes to rapidly build our contracted Provider Network. For example, in Iowa, our affiliate successfully

[2] The MBHO Accreditation is maintained through an Anthem, Inc. subsidiary corporation, Anthem GBD Behavioral Health.

built a complete Medicaid Provider Network of 40,000 contracted Providers within seven months in 2015 and early 2016, where our organization had no previous footprint. The Iowa network build required our affiliate to rapidly establish relationships with potential Providers, engage in contracting negotiations and subsequent contract execution, complete new credentialing for all Providers, configure all new Providers to our system, and deliver new Provider orientation to the entire state prior to readiness review. Upon award of the Iowa Medicaid contract in 2015, our Network Development team secured contracts with 95% of Providers needed to establish adequacy contracted with a fully developed network in advance of readiness review in 2016.

Financial Stability and Resources

Amerigroup is well positioned to become a long-standing and reliable partner to the Division for years to come. We are well capitalized, and in addition, if ever needed, have access to the vast financial resources of our parent organization, Anthem. As of September 30, 2021, Anthem held $1.4 billion in cash and investments and maintained revolving credit lines of $3.5 billion that could be used if necessary. Beyond financial stability, the shared and support services we can leverage from our national organization, to be tailored specifically to the needs of Mississippi, will allow Amerigroup to achieve operational efficiencies and thus achieve program savings for the Division.

In recent years, multiple states including Iowa, Kentucky, Indiana, and Texas experienced managed care organizations (MCOs) exiting their markets before the expiration of their contracts for financial and other

reasons. In several of those markets, our organization was able to step in and support their state partners and Members who were facing the loss of their MCO, by seamlessly transitioning those Members and assuring no disruption in their care occurred. ***Our organization's commitment to our state partners and the Members we serve, coupled with the financial stability and strength alone, are important intangible assets we are excited to bring to Mississippi.***

For example, in July 2019, following the exit of a competitor MCO from the Iowa Medicaid program, our Iowa affiliate successfully transitioned approximately 200,000 additional Members, including those with disabilities, long-term care needs, or special health care needs. As a trusted partner to the state partner, our Iowa affiliate worked very closely to make sure continuity of care of their new Members remained intact. To support the transition, our Iowa affiliate took deliberate action by:

- Executing a business associate agreement to allow open communication directly with the exiting MCO to help with the transition of high-risk Members
- Working with the state on a plan to waive PA on certain services to smooth the transition for all involved, including Providers, Members, and our Iowa affiliate
- Collaborating with Iowa Medicaid to put together public notices and FAQs
- Submitting daily updates that monitored call center metrics, PA turn-around-times, claims turnaround times, claims denial reasons, and pharmacy call and claim statistics

It was the strong partnership between our affiliate and the Iowa state Medicaid agency, as well as their commitment and ability to effectively work together to avoid disruption for the Members, that made the transition successful.

Unique and Innovative Resources

We will leverage the important lessons learned and the innovations from our affiliates' in other states to share best practices and collaborate with the Division. We will continue to design and implement innovative resources that increase access to care, improve quality outcomes, and maximize cost-effectiveness. Our national experience gives us a strong foundation for innovation and best practices so that Mississippians can receive the very best care.

Innovation That Supports Our Members

Our Amerigroup Wellness Center, located in Jackson, will provide our Members with a convenient plan to receive in-person services and supports, such as:

- **Self-care, Illness Prevention, and Wellness Support.** We will offer a host of health and wellness activities, programs and supports, including fitness, nutrition, and cooking, as well as access to a community garden. During these events, we also educate Members about available Value-Adds.
- **Assistance Accessing Benefits and Services.** The Wellness Center staff will help Members navigate the healthcare system, including providing group and individual training on the benefits and services available to MississippiCAN and CHIP Members and how to access services appropriately (for example, when to seek outpatient care instead of the ER). They will also assist in scheduling appointments and show Members how to use our website. We will have portable and secure, encrypted Digital Solutions Kiosks available at our

Amerigroup's Wellness Center

Amerigroup's Wellness Center will serve as our member-facing space where we support Members' wellness goals and encourage self-management and new healthy behaviors. Our Wellness Center will be open to Members and the community at-large. We will offer a variety of benefits, including member support hours, fitness classes, non-invasive screenings, cooking and nutrition classes, maternal health education, baby showers, CPR classes, parent training classes, and food distributions.

MS_MSCAN21_Wellnesscenters_COB_02

Wellness Centers and other locations, such as homeless shelters and other community-based settings, to expand access and increase engagement. Our centers will also have on-site and virtual CM resources for Members who need face-to-face support.

- **Connection to Social Supports.** The Wellness Center staff are available to help Members access community social services such as education, employment, housing, and transportation. We also will hold community events at the Wellness Center, such as Community Baby Showers, to engage and increase Member understanding of prenatal care and engage with other Members to promote a network of supports. For the new Center, one of our priorities will be offering access to on-site showers and laundry facilities for those experiencing homelessness or housing instability.

Innovation That Supports Our Providers

Technology is a powerful tool that supports delivery of integrated care and eases the administrative burden on Providers. We will invest in advanced digital solutions to support our Provider relationships and will work collaboratively with our network and technology solution companies to build and refine digital data solutions. We will also provide trainings and resources to make sure our Providers understand how to use these digital tools. A local Provider Experience Consultant, and Telehealth Program Manager, will support Providers virtually and through in-person events like our proposed Telehealth Summit, described earlier in this section.

Strategies to Address Interoperability and Bi-directional Health Information Exchange

We will work collaboratively with our network Providers and technology solution companies for several widely used electronic medical record (EMR) systems to build digital data bridges. [redacted]

Our platform leverages innovative technology to streamline administrative processes by using real-time, bi-directional information exchange and workflow improvements. We integrate clinical information maintained in the Provider's EMR with other sources of valuable clinical insights captured through claims, HIEs, and labs. This interoperability promotes open communication and transparency, supports streamlined administrative processes, and gives Providers more real-time data on Member behaviors such as ER visits. Real-time access allows our review team to proactively review clinical information to continuously monitor services for medical necessity, reducing Provider administrative burden and the likelihood of a subsequent PA denial.

Telehealth Resources Support Alternative Ways for Providers to Deliver Services

We will give network Providers an easy-to-use HIPAA-compliant two-way video ***telehealth platform***, at no cost and payer agnostic, designed to improve access to care for urban and rural Providers seeking to create, replace, or supplement their existing telehealth strategy. Through ***Provider electronic consultations (e-consults)***, Mississippi PCPs will be able to consult with a variety of licensed and board-certified specialty and subspecialty specialists, helping them manage their patients within their practice without needing to send the patient for a face-to-face visit with a specialist.

Innovative Approaches for Training and Education

In addition to in-person training delivered by our Provider Services team, we will implement digital training solutions that facilitate on-demand access to our curriculum at Providers' convenience. We will also offer digital training and continuing medical education units to help Providers support the needs of diverse patients through our online Provider education portal and toolkits. Topics include healthcare stereotypes, LGBTQ+-friendly practices, and birth equity. Our digital Provider orientation provides a self-paced, on-demand education resource option that allows Providers and their staff to select from various training paths and determine their

own training pace. Training available via our Provider website will enable us to host on-demand videos on timely topics specific to Mississippi needs. Users will be able to register for live trainings on the website, and trainings completed by Provider will be tracked, giving us valuable insight into Provider training history and resources they find most valuable.

Our organization is also investing in an innovative predictive analytics pilot that allows us to identify potential outliers, which will change the way we approach Provider training and communication. Through this pilot, we will apply a combination of algorithms to diverse sets of data to analyze claims payment patterns. Using advanced analytics and data science, these algorithms will be refined over time, continuously analyzing additional datasets, including trends across claims, disputes, Provider calls, system updates, and more. This early warning system will enable us to both proactively adjust claims if the anomaly is due to a system configuration issue or identify Providers that need additional education on claims and billing.

Additional Resources

Throughout this section, we described the many resources, products, and services that we will offer to help drive and support the best outcomes for Members, assist Providers in delivering optimal care, and support the Division's goals. In addition, we understand that data is a critical component of everything we do — it will shape how we identify, monitor, and evaluate the needs, trends, and health outcomes of our Members and inform meaningful interventions, including support of targeted local and community partnerships, to equip us with concrete information. For Members with complex needs, medical, behavioral, and social data is imperative to delivering on our promise of integrated, whole person care. Our local leadership will work hand-in-hand with our national shared service partners to collect, integrate, and maintain a comprehensive set of data to generate the necessary reports to allow us to comprehensively review, monitor and analyze trends, and inform the way we deliver products and services to our Members, Providers, and stakeholders. Our parent company's Analytics Center of Excellence established a Delivery System Transformation Insights and Analytics team — which will support our local team in providing customized analytics along with real-time analysis directly to Mississippi to more effectively identify trends and generate granular analytics that help inform our initiatives to improve healthcare delivery.

[END OF RESPONSE]

Management Qualification: 4.3.1.2 Corporate Experience

4.3.1.2: Corporate Experience

Use the following form to provide information for any states that the Offeror is currently or has been under contract with to provide managed care services since January 1, 2018, for any market of beneficiaries totaling or exceeding 400,000.

If the Offeror has no current or recent clients, the Offeror must provide an explanation. Offerors must submit appropriate documentation to support information provided. Acceptance of the explanation provided is at the discretion of the Division.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Management Qualification: 4.3.1.2 Corporate Experience

In some markets, our affiliates hold multiple contracts in the market, each covering different service areas or populations. Our California affiliate, for example, holds 14 different publicly funded managed care contracts. For ease of review, we segmented these affiliates into two groups:

- **Single Contract from Each Market.** In this group, we provide information for one contract in each state (alphabetically, by market)
- **Additional Contracts.** In this group, we include the additional managed care contracts in each state (alphabetically, by market)

Corporate Experience: Current and/or Recent Client

Client's Name: L.A. Care Health Plan
Affiliate: Blue Cross of California dba Anthem Blue Cross
Program: California Medicaid — Los Angeles Service Area (L.A. Care)

Client Location

Address Line 1: 1055 West 7th Street, 10th Floor

Address Line 2:

City: Los Angeles	**State:** CA	**Zip Code:** 90017	**County:** Los Angeles

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 489,994 (as of 12/31/2021)

Time period of contract:
Original start: 4/1/1997
Current contract: 10/1/2009–9/30/2025

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Anthem Blue Cross' staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Anthem Blue Cross has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Anthem Blue Cross' operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Compliance Officer, Full-Time Health Educator, MCP/MEDS/834 Management Information System (MIS) Coordinator, Contractor's Representative, Security Officer. As discussed above, Anthem Blue Cross is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Regional, Los Angeles service area

Publicly funded contract cost: [redacted]
Description of work performed under this contract
Regional contract to provide PH, BH, long-term care (LTC), LTSS, pharmacy, vision, and transportation to TANF, aged, blind, and disabled (ABD), Medicaid Expansion, Dual Eligibles, and Child Welfare/Foster Care populations.

Corporate Experience: Current and/or Recent Client

Client's Name: Colorado Department of Health Care Policy & Financing
Affiliate: CCHA, LLC dba Colorado Community Health Alliance
Program: Colorado Medicaid — Accountable Care Collaborative Delivery Model, Regions 6 and 7

Client Location

Address Line 1: 1570 Grant Street

Address Line 2:

City: Denver	**State:** CO	**Zip Code:** 80203	**County:** Denver

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 400,218 (as of 12/31/2021)

Time period of contract:
Original start: 04/30/2018
Current contract: 1/1/2014–12/31/2022; awarded new contract, contract execution pending

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Colorado Community Health Alliance's staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Colorado Community Health Alliance has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Colorado Community Health Alliance's operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Program Officer, CFO, COO, Quality Improvement Director, Health IT and Data Director, UM Director, Regional Contract Manager. As discussed above, Colorado Community Health Alliance is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Regions 6 and 7; ABD, Medicaid Expansion, Dual Eligibles, and Child Welfare/Foster Care
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Regional contract to provide BH services.

Corporate Experience: Current and/or Recent Client

Client's Name: Florida Agency for Health Care Administration
Affiliate: Simply Healthcare Plans, Inc.
Program: Florida Medicaid — Managed Medical Assistance, LTC, HIV/AIDS Specialty

Client Location

Address Line 1: 2727 Mahan Drive

Address Line 2: Building 3, Room 2217B

City: Tallahassee	**State:** FL	**Zip Code:** 32308	**County:** Leon

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 669,361 (as of 12/31/2021)

Time period of contract:
Original start: 1/1/2003
Current contract: 12/1/2018–12/31/2023

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Simply Healthcare Plans, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Simply Healthcare Plans, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Simply Healthcare Plans, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Contract Manager, Medical Director, Compliance Officer, Fraud Investigative Unit Manager. As discussed above, Simply Healthcare Plans, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Statewide; Families and Children, including Pregnant Women (TANF), ABD with Medicare, Dual Eligibles, service coordination.

Publicly funded contract cost: [redacted]
Description of work performed under this contract
Statewide contract to provide PH, BH, LTC, LTSS, pharmacy, vision, and transportation.

Corporate Experience: Current and/or Recent Client

Client's Name: Georgia Department of Community Health
Affiliate: AMGP Georgia Managed Care Company, Inc.
Program: Georgia Medicaid — Georgia Families

Client Location

Address Line 1: 2 Peachtree Street

Address Line 2: 36th Floor

City: Atlanta	**State:** GA	**Zip Code:** 30303	**County:** Fulton

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 542,565 (as of 12/31/2021)

Time period of contract:
Original start: 7/18/2005
Current contract: 7/1/2020–6/30/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of AMGP Georgia Managed Care Company, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, AMGP Georgia Managed Care Company, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support AMGP Georgia Managed Care Company, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Chief Executive Officer, Member Services Director, Provider Services Director, Utilization Management Director, Medical Director, Quality Management Director, Health Services Director and the Program Implementation Manager. As discussed above, AMGP Georgia Managed Care Company, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Statewide; TANF, CHIP, and family planning waiver service membership.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Statewide contract to provide PH, BH, LTC, pharmacy, dental, and vision.

Corporate Experience: Current and/or Recent Client

Client's Name: Indiana Family and Social Services Administration
Affiliate: Anthem Insurance Companies, Inc.
Program: Indiana Medicaid — Hoosier Healthwise

Client Location

Address Line 1: 402 West Washington Street

Address Line 2: Room W374, MS07

City: Indianapolis	**State:** IN	**Zip Code:** 46204	**County:** Marion

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 310,475 (as of 12/31/2021)

Time period of contract:
Original start: 1/1/2017
Current contract: 1/1/2020–12/31/2021 Extended to 12/31/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Anthem Insurance Companies, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Anthem Insurance Companies, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Anthem Insurance Companies, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Chief Executive Officer, CFO, Compliance Officer, Chief Information Officer, Medical Director (licensed Indiana Health Care Provider), Member Services Manager, Provider Services Manager, Quality Management Manager, Special Investigation Unit Manager, Utilization Management Manager, BH Manager, Data Compliance Manager, Pharmacy Director, Grievance and Appeals Manager, and Claims Manager. As discussed above, Anthem Insurance Companies, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Statewide; TANF and CHIP.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Statewide contract to provide PH, BH, pharmacy, dental, vision, and transportation for pregnant women and children up to age 19.

Corporate Experience: Current and/or Recent Client

Client's Name: Iowa Medicaid — Iowa Health Link
Affiliate: Amerigroup Iowa, Inc.
Program: Iowa Medicaid — Iowa Health Link

Client Location

Address Line 1: 1305 East Walnut Street

Address Line 2:

City: Des Moines	**State:** IA	**Zip Code:** 50319	**County:** Polk

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 445,885 (as of 12/31/2021)

Time period of contract:
Original start: 4/1/2016
Current contract: 4/1/2020–6/30/2023

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Amerigroup Iowa, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Amerigroup Iowa, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Amerigroup Iowa, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Contract Administrator/CEO/Chief Operating Officer (COO), Medical Director (Iowa licensed physician), CFO, Compliance Officer (full-time dedication; closely aligns with Regulatory manager accountabilities), Pharmacy Director (Iowa licensed pharmacist), Grievance and Appeals Manager, Quality Management Manager (Iowa licensed), Utilization Management Manager (Iowa licensed), BH Manager (Iowa licensed), Member Services Manager, Provider Services Manager, Information Services Manager, Claims Administrator, Care Coordination Manager, Program Integrity Manager (located in Iowa office and dedicated 90% of the time), Long Term Care Manager, Government Relations Director Ombudsman. As discussed above, Amerigroup Iowa, Inc. is currently supported by a total of [redacted] FTEs

dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.
Geographic and population coverage requirements: Statewide; TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Statewide contract to provide PH, BH, LTC, LTSS, pharmacy, vision, and transportation.

Corporate Experience: Current and/or Recent Client

Client's Name: Kentucky Department for Medicaid Services
Affiliate: Anthem Kentucky Managed Care Plan, Inc.
Program: Kentucky Medicaid

Client Location

Address Line 1: 275 East Main Street

Address Line 2:

City: Frankfort	**State:** KY	**Zip Code:** 40601	**County:** Frankfort

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 168,124 (as of 12/31/2021)

Time period of contract:
Original start: 1/1/2014
Current contract: 1/1/2021–12/31/2024

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Anthem Kentucky Managed Care Plan, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Anthem Kentucky Managed Care Plan, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Anthem Kentucky Managed Care Plan, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Medical Director, Dental Director, Finance Officer, Enrollee Services function, Provider Services function, Quality Improvement Director, BH Director, Case Management Coordinator, EPSDT Coordinator, Foster Care and Subsidized Adoption Liaison, Guardianship Liaison, MIS Director, Claims Processing function, Program Integrity Coordinator, Pharmacy Director, Compliance Director. As discussed above, Anthem Kentucky Managed Care Plan, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Statewide; TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Statewide contract to provide PH, BH, dental, pharmacy, dental, and vision.

Corporate Experience: Current and/or Recent Client

Client's Name: Louisiana Department of Health
Affiliate: Community Care Health Plan of Louisiana, Inc. dba Healthy Blue
Program: Louisiana Medicaid — Healthy Louisiana

Client Location

Address Line 1: 628 North 4th Street

Address Line 2:

City: Baton Rouge	**State:** LA	**Zip Code:** 70802	**County:** East Baton Rouge Parish

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 355,069 (as of 12/31/2021)

Time period of contract:
Original start: 2/1/2012
Current contract: 1/1/2020–12/31/2021 Extended to 12/31/22

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Healthy Blue's staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Healthy Blue has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Healthy Blue's operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Administrator/CEO, Medical Director/CMO, BH Medical Director, CFO, COO, Program Integrity Officer, Grievance System Manager, Business Continuity Planning and Emergency Coordinator, Contract Compliance Officer, Quality Management Coordinator, Performance/Quality Improvement Coordinator, Maternal Child Health/EPSDT Coordinator, Medical Management Coordinator, Provider Services Manager, Member Services Manager, Claims Administrator, Provider Claims Educator, Case Management Administrator/Manager, Information Management and Systems Director, Encounter Data Quality Coordinator, BH Coordinator, BH Children's System Administrator, Addictionologist or an Addiction Services Manager (ASM), BH Case Management Supervisor. As discussed above, Healthy Blue is

currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.
Geographic and population coverage requirements: Statewide; TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Statewide contract to provide PH, pharmacy, vision, and transportation.

Corporate Experience: Current and/or Recent Client

Client's Name: Maryland Department of Health
Affiliate: AMERIGROUP Maryland, Inc.
Program: Maryland Medicaid — HealthChoice

Client Location

Address Line 1: 201 West Preston Street

Address Line 2:

City: Baltimore	**State:** MD	**Zip Code:** 21201	**County:** Baltimore City

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 320,013 (as of 12/31/2021)

Time period of contract:
Original start: 6/1/1999
Current contract: 1/1/2022–12/31/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of AMERIGROUP Maryland, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, AMERIGROUP Maryland, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support AMERIGROUP Maryland, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Plan Administrator, Medical Director, Medical Records Director, Enrollment/Disenrollment Director, QA Director, Case Management Director, UM Director, Grievance Director, Marketing Director. As discussed above, AMERIGROUP Maryland, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Statewide; TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Statewide contract to provide PH, pharmacy, and vision.

Corporate Experience: Current and/or Recent Client

Client's Name: HMO Minnesota dba Blue Plus (an affiliate of Blue Cross Blue Shield of Minnesota)
Affiliate: Amerigroup Partnership Plan, LLC
Program: Minnesota Medicaid — Prepaid Medical Assistance and MinnesotaCare

Client Location

Address Line 1: 3400 Yankee Drive

Address Line 2:

City: Eagan	**State:** MN	**Zip Code:** 55121	**County:** Dakota

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 427,883 (as of 12/31/2021)

Time period of contract:
Original start: 1/1/2019
Current contract: 1/1/2022–12/31/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Amerigroup Partnership Plan, LLC's staffing plan for its subcontract with HMO Minnesota is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to its partner, and to the Members and Providers they serve. Amerigroup Partnership Plan's supplements these local resourceswith designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Amerigroup Partnership Plan, LLC has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Amerigroup Partnership Plan, LLC's operations. They continually review their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to HMO Minnesota and to the Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: As discussed above, Amerigroup Partnership Plan, LLC is currently supported by a total of [redacted] FTEs dedicated to the performance of its services for the subcontract with HMO Minnesota. Amerigroup Partnership Plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Regional; TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.

Publicly funded contract cost: [redacted]
Description of work performed under this contract
Alliance subcontract under HMO Minnesota dba Blue Plus (an affiliate of Blue Cross Blue Shield of Minnesota) contract to provide PH, BH, LTC, LTSS, pharmacy, dental, vision, and transportation.

Corporate Experience: Current and/or Recent Client

Client's Name: Missouri Department of Social Services
Affiliate: Missouri Care, Incorporated
Program: Missouri Medicaid — MO HealthNet

Client Location

Address Line 1: 615 Howerton Court

Address Line 2:

City: Jefferson City	**State:** MO	**Zip Code:** 65109	**County:** Cole

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 340,487 (as of 12/31/2021)

Time period of contract:
Original start: 1999
Current contract: 6/30/2021–7/1/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Missouri Care, Incorporated's staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Missouri Care, Incorporated has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Missouri Care, Incorporated's operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Health Plan Administrator, Clerical and support staff, Medical Director, Dental Consultant, CFO, Quality Assessment and Improvement Coordinator, Utilization Management Coordinator, Special Programs Coordinator, Care Management Supervisors, BH Coordinator, Prior Authorization Staff, Inpatient Certification Review Staff, Member Services Staff, Provider Services Staff, Compliant, Grievance, and Appeal Coordinator, Claims Administrator/MIS Director, Compliance Officer, and Fraud, Waste, and Abuse investigator (per 100,000 Members). As discussed above, Missouri Care, Incorporated is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their

staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.
Geographic and population coverage requirements: Statewide; TANF, CHIP, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Statewide contract to provide PH, BH, dental, vision, and transportation.

Corporate Experience: Current and/or Recent Client

Client's Name: Nebraska Division of Medicaid & Long-Term Care
Affiliate: Community Care Health Plan of Nebraska, Inc. dba Healthy Blue Nebraska
Program: Nebraska Medicaid — Heritage Health

Client Location

Address Line 1: 301 Centennial Mall South

Address Line 2:

City: Lincoln	**State:** NE	**Zip Code:** 68509	**County:** Lancaster

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted]	**Email Address:** [redacted]

Work Details

Number of covered lives: 110,488 (as of 12/31/2021)

Time period of contract:
Original start: 1/1/2017
Current contract: 1/1/2017–12/31/2021 Renewed an addition (1) year period, January 1, 2022-December 31, 2022.

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Healthy Blue Nebraska's staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Healthy Blue Nebraska has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Healthy Blue Nebraska's operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: CEO, Medical Officer, BH Clinical Director, BH Manager, COO, CFO, Program Integrity Officer, Grievance System Manager, Business Continuity Planning and Emergency Coordinator, Contract Compliance Coordinator, Quality Coordinator, Performance and Quality Improvement Coordinator, Maternal Child/EPSDT Coordinator, Medical Management Coordinator, Provider Services Manager, Member Services Manager, Claims Administrator, Provider Claims Educator, Case Management Administrator, Information Management and Systems Director, Encounter Data Quality Coordinator, Tribal Network Liaison, and Pharmacist/Pharmacy Director. As discussed above, Healthy Blue Nebraska is

currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.
Geographic and population coverage requirements: Statewide; TANF, CHIP, ABD, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Statewide contract to provide PH, BH, pharmacy, vision, and transportation.

Corporate Experience: Current and/or Recent Client

Client's Name: Nevada Division of Health Care Financing and Policy
Affiliate: Community Care Health Plan of Nevada, Inc. dba Anthem Blue Cross and Blue Shield Healthcare Solutions
Program: Nevada Medicaid — Medicaid and Nevada Check Up

Client Location

Address Line 1: 1210 South Valley View Boulevard

Address Line 2: Suite 104

City: Las Vegas	**State:** NV	**Zip Code:** 89102	**County:** Clark

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 274,479 (as of 12/31/2021)

Time period of contract:
Original start: 2/1/2009
Current contract: 1/1/2022–12/31/2025

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Anthem Blue Cross and Blue Shield Healthcare Solutions' staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Anthem Blue Cross and Blue Shield Healthcare Solutions has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Anthem Blue Cross and Blue Shield Healthcare Solutions operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: CEO, CFO, Chief Medical Director, Medical Director of BH, Compliance Officer, Member Services Manager, Provider Services Manager, Grievance and Appeals Coordinator, Claims Administrator, Nevada Medicaid/CHIP Operations Manager, Quality Manager/Cultural Competency, Program Integrity/SIU Manager, Nevada Department of Corrections Manager, Population Health Manager, and Utilization Manager. As discussed above, Anthem Blue Cross and Blue Shield Healthcare Solutions is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews

their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.
Geographic and population coverage requirements: Regional; TANF, CHIP, Medicaid Expansion, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Full-risk contract to provide PH, BH, LTC, pharmacy, and vision services in urban Clark and Washoe counties.

Corporate Experience: Current and/or Recent Client

Client's Name: New Jersey Office of Managed Health Care, Division of Medical Assistance and Health Services
Affiliate: AMERIGROUP New Jersey, Inc.
Program: New Jersey Medicaid — NJ FamilyCare

Client Location

Address Line 1: New Jersey Department of Human Services

Address Line 2: Division of Medical Assistance and Health Services (DMAHS)

City: Trenton	**State:** NJ	**Zip Code:** 08625	**County:** Mercer

Mailing Address (P.O. Box): P.O. Box 712	**City:** Trenton	**State:** NJ	**Zip Code:** 08625	**County:** Mercer

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 242,977 (as of 12/31/2021)

Time period of contract:
Original start: 2/1/1996
Current contract: 7/1/2020–6/30/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of AMERIGROUP New Jersey, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, AMERIGROUP New Jersey, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support AMERIGROUP New Jersey, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Medical Director, MLTSS Manager, Dental Director, BH Administrator, Financial Officer, QM/UR Coordinator, Care Management Supervisor, Medicaid Care Manager, Member Services Unit Head, Provider Services Unit Head, Provider Services Liaison, Encounter Reporting Staff/Claims Processor Supervisor, Grievance Coordinator, MLTSS Member Representative, Nursing Facility Transition/Money Follows the Person Program Staff Person, Participant Direction Liaison, Compliance Officer, Housing Specialist, Pharmacy Director. As discussed above, AMERIGROUP New Jersey, Inc. is currently supported

by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.
Geographic and population coverage requirements: Statewide; TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Statewide contract to provide PH, BH, LTC, LTSS, pharmacy, dental, vision, and transportation.

Corporate Experience: Current and/or Recent Client

Client's Name: New York State Department of Health
Affiliate: HealthPlus HP, LLC dba Empire BlueCross BlueShield HealthPlus
Program: New York Medicaid — Medicaid Participating Managed Care Plan Agreement

Client Location

Address Line 1: Corning Tower, OCP

Address Line 2: Room 1609

City: Albany	**State:** NY	**Zip Code:** 12237	**County:** Albany

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 381,042 (as of 12/31/2021)

Time period of contract:
Original start: 1/1/2005
Current contract: 3/1/2019–2/29/2024

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Empire BlueCross BlueShield HealthPlus' staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Empire BlueCross BlueShield HealthPlus has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Empire BlueCross BlueShield HealthPlus operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Utilization management staff, Case Managers, Member Services Staff, Medical Director, HIV Education Staff, behavioral health Director, HARP staff, Provider Services Staff, Compliance Officer, SIU Director. As discussed above, Empire BlueCross BlueShield HealthPlus is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Regional, Kings, Bronx, New York, Queens, Nassau, Putnam, and Richmond counties; TANF, CHIP, and Medicaid Expansion.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Regional contract to provide PH, BH, LTC, LTSS, pharmacy, dental, and vision.

Corporate Experience: Current and/or Recent Client

Client's Name: Blue Cross and Blue Shield of North Carolina
Affiliate: Amerigroup Partnership Plan, LLC
Program: North Carolina Medicaid — Medicaid Managed Care

Client Location

Address Line 1: 4615 University Drive

Address Line 2:

City: Durham	**State:** NC	**Zip Code:** 27707	**County:** Durham

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 438,229 (as of 12/31/2021)

Time period of contract:
Original start: 7/1/2021
Current contract: 7/1/2021–6/30/2025

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Amerigroup Partnership Plan, LLC's staffing plan for its subcontract with Blue Cross and Blue Shield of North Carolina is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services its partner, and to the to Members and Providers they serve. Amerigroup Partnership Plan supplements these local resources with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Amerigroup Partnership Plan, LLC has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Amerigroup Partnership Plan, LLC's operations. They continually review their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Blue Cross and Blue Shield of North Carolina and the Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: As discussed above, Amerigroup Partnership Plan is currently supported by a total of [redacted] FTEs dedicated to the performance of its services for the subcontract with Blue Cross and Blue Shield of North Carolina. Amerigroup Partnership Plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Statewide; TANF, CHIP, and ABD.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Alliance subcontract under Blue Cross and Blue Shield of North Carolina contract to provide PH, BH, LTC, LTSS, pharmacy, vision, and transportation.

Corporate Experience: Current and/or Recent Client

Client's Name: Ohio Department of Medicaid
Affiliate: Community Insurance Company dba Anthem Blue Cross and Blue Shield
Program: Ohio Medicaid Managed Care Program

Client Location

Address Line 1: 50 West Town Street

Address Line 2:

City: Columbus	**State:** OH	**Zip Code:** 43215	**County:** Franklin

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted]

Email Address: [redacted]

Work Details

Number of covered lives: 257,000

Time period of contract:

2/11/2022* – 6/30/2022
* Effective 2/11/2022, Community Insurance Company dba Anthem Blue Cross and Blue Shield completed the acquisition of the contract held by Paramount Advantage to serve Ohio Medicaid members and began administering benefits for these members immediately upon close. Beginning July 1, 2022, Community Insurance Company will begin serving Ohio members on state-wide basis pursuant to a contract awarded during a most recent procurement.

Total number of staff hours expended during time period of contract: This information is not yet available. Community Insurance Company began serving members on 2/11/2022. However, an integral part of Community Insurance Company's staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through our parent company Anthem, Inc., to leverage national best practices and economies of scale. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to the Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing is adjusted whenever necessary.

Personnel requirements: CEO, CFO, Chief Medical Director, Medical Director of BH, Compliance Officer, Member Services Manager, Provider Services Manager, Grievance and Appeals Coordinator, Claims Administrator, Nevada Medicaid/CHIP Operations Manager, Quality Manager/Cultural Competency,

Program Integrity/SIU Manager, Nevada Department of Corrections Manager, Population Health Manager, and Utilization Manager.
Geographic and population coverage requirements: Currently, Northeast and West Regions. On 7/1/2022, Community Insurance Company will begin serving TANF, CHIP, Medicaid Expansion, ABD, and Child Welfare members on state-wide basis.
Publicly funded contract cost: This information is not yet available. Community Insurance Company began serving members on 2/11/2022.
Description of work performed under this contract
Regional contract to provide PH, BH, LTC, pharmacy, dental, vision, and transportation.

Corporate Experience: Current and/or Recent Client

Client's Name: Puerto Rico Health Insurance Administration
Affiliate: MMM Multi Health, LLC
Program: Puerto Rico Medicaid — Government Health Plan Program (Vital Program)

Client Location

Address Line 1: Urb. Caribe Calle Alda 1549

Address Line 2:

City: San Juan	**State:** PR	**Zip Code:** 00926-2712	**County:**

Mailing Address (P.O. Box): P.O. Box 195661	**City:** San Juan	**State:** PR	**Zip Code:** 00919-5661	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 316,653

Time period of contract:
Original start: 4/1/2015
Current contract: 11/1/2018–9/30/2022

Total number of staff hours expended during time period of contract: An integral part of MMM Multi Health, LLC's staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, MMM Multi Health, LLC has [redacted] associates available to support their performance of their contracts. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: CEO, CFO, Case Managers, Care Manager, Marketing Coordinator, UM Coordinator, Grievance & Appeal staff, Medical Director, Claims and Encounter Manager/Administrator

Geographic and population coverage requirements: Islandwide; TANF, CHIP, and Child Welfare/Foster Care

Publicly funded contract cost: [redacted]

Description of work performed under this contract
Full-risk, island-wide contract to provide PH, BH, pharmacy, dental, vision and transportation for individuals eligible for the Government Health Program.

Corporate Experience: Current and/or Recent Client

Client's Name: BlueChoice Health Plan of South Carolina, Inc.
Affiliate: Amerigroup Partnership Plan, LLC
Program: South Carolina Medicaid — Healthy Connections

Client Location

Address Line 1: 4101 Percival Road

Address Line 2: AX-E13

City: Columbia	**State:** SC	**Zip Code:** 29219	**County:** Richland

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 180,229 (as of 12/31/2021)

Time period of contract:
Original start: 6/1/2008
Current contract: 7/1/2021–6/30/2024

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Amerigroup Partnership Plan, LLC's staffing plan for its subcontract with BlueChoice is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services its partner, and to the to Members and Providers they serve. Amerigroup Partnership Plan supplements these local resources with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Amerigroup Partnership Plan, LLC has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Amerigroup Partnership Plan, LLC's operations. They continually review their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to BlueChoice and the Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: As discussed above, Amerigroup Partnership Plan, LLC is currently supported by a total of [redacted] FTEs dedicated to the subcontract with BlueChoice. Amerigroup Partnership Plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Statewide; TANF and ABD.

Publicly funded contract cost: [redacted]

Description of work performed under this contract
Alliance subcontract under BlueChoice Health Plan of South Carolina, Inc. statewide contract to provide PH, BH, LTC, pharmacy, and vision.

Corporate Experience: Current and/or Recent Client

Client's Name: Department of Finance and Administration, Division of TennCare
Affiliate: AMERIGROUP Tennessee, Inc.
Program: Tennessee Medicaid Managed Care Contract

Client Location

Address Line 1: 310 Great Circle Road

Address Line 2:

City: Nashville	**State:** TN	**Zip Code:** 37243	**County:** Davidson

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 501,138 (as of 12/31/2021)

Time period of contract:
Original start: 8/1/2006
Current contract: 1/1/2014–12/31/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of AMERIGROUP Tennessee, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, AMERIGROUP Tennessee, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support AMERIGROUP Tennessee, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Administrator/project director, Transition/Implementation Lead, Medical Director, Medical Director for LTSS programs, Board-Certified Psychiatrist, BH Program Director, CHOICES Program Director, ECF CHOICES Program Director, CFO, Information Systems Lead, After hours "on-call" person for TennCare Solutions, Non-discrimination Compliance Coordinator, Member Services Lead, Provider Services Lead, Dedicated CHOICES Lead trainer, Dedicated ECF CHOICES Lead trainer, CHOICES Provider Services and FEA Lead, PCMH/THL Trainers and Coaches, Fraud and Abuse Detection Lead, UM Lead, QM Lead, Appeal System Resolution Lead, Claims Management Lead, Court-ordered Services Lead, Litigation Hold Contact, Population Health Lead, CHOICES Care Coordination Lead, ECF

CHOICES Person-Centered Support Coordination Lead, CHOICES care coordinators, ECF CHOICES support coordinators, Allied health professionals, Consumer Advocate for BH services, Specialized Member Advocate for intellectual and developmental disabilities in each Region, CHOICES Consumer Advocate in each Region, TennCare Kids Services Lead, Department of Children's Services Coordinator, Senior Executive responsible for oversight of subcontractor activities, NEMT Program Coordinator, Dental Benefits Manager Coordinator, PBM Coordinator, TDMHSAS Planning and Policy Councils Coordinator, Employment Services Director, Housing Specialist. As discussed above, AMERIGROUP Tennessee, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.
Geographic and population coverage requirements: Statewide; TANF, CHIP, ABD, and Uninsured Adults.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Statewide contract to provide PH, BH, LTSS, vision, and transportation services.

Corporate Experience: Current and/or Recent Client

Client's Name: Texas Health and Human Services Commission
Affiliate: AMERIGROUP Texas, Inc.
Program: Texas Medicaid — STAR, CHIP, and STAR+PLUS, Joint Procurement

Client Location

Address Line 1: 4601 West Guadalupe Street

Address Line 2:

City: Austin	**State:** TX	**Zip Code:** 78751	**County:** Travis

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted]

Email Address: [redacted]

Work Details

Number of covered lives: 762,460 (as of 12/31/2021)

Time period of contract:
Original start: 9/1/1996
Current contract: 9/1/2015–8/31/2023

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of AMERIGROUP Texas, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, AMERIGROUP Texas, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support AMERIGROUP Texas, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Executive Director (CEO/COO), Medical Director, Member Services Manager, Management Information Systems Manager, Claims Processing Manager, Provider Network Development and Management Manager, Benefit Administration and Utilization and Care Management Manager, Quality Improvement Manager, BH Services Manager, Financial Functions Manager, Reporting Manager, STAR+PLUS Service Coordinators, SIU. As discussed above, AMERIGROUP Texas, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their

staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.
Geographic and population coverage requirements: Regional; TANF, CHIP, ABD, and Child Welfare.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Regional contract to provide PH, BH, LTC, LTSS, pharmacy, dental, vision, and transportation.

Corporate Experience: Current and/or Recent Client

Client's Name: Virginia Department of Medical Assistance Services
Affiliate: HealthKeepers, Inc.
Program: Virginia Medicaid — Medallion 4.0

Client Location

Address Line 1: 600 East Broad Street

Address Line 2:

City: Richmond	**State:** VA	**Zip Code:** 23219	**County:** Richmond City

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 453,627 (as of 12/31/2021)

Time period of contract:
Original start: 7/1/1996
Current contract: 7/1/2020–6/30/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of HealthKeepers, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, HealthKeepers, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support epers, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Positions are listed as examples of key staff positions, but no concrete list is given: CEO, President, Contract Administrator, CFO, Chief Medical Director/Officer, Pharmacy Director, Medical Management Director, Member Services/Operations Manager, Information Technology Staff, Quality Improvement Manager, Project Executive, Compliance Manager/Director, Compliance Officer, Program Integrity Lead, Encounter Data Manager, anyone key to the Contractor's operations. As discussed above, Anthem HealthKeepers Plus is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine

whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.
Geographic and population coverage requirements: Statewide; TANF, CHIP, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Statewide contract to provide PH, BH, pharmacy, vision, dental, and transportation.

Corporate Experience: Current and/or Recent Client

Client's Name: Washington Health Care Authority
Affiliate: AMERIGROUP Washington, Inc.
Program: Washington Medicaid — Apple Health Integrated Managed Care

Client Location

Address Line 1: 626 8th Avenue Southeast

Address Line 2:

City: Olympia	**State:** WA	**Zip Code:** 98501	**County:** Thurston

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 254,500 (as of 12/31/2021)

Time period of contract:
Original start: 11/1/2018
Current contract: 1/1/2022–12/31/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of AMERIGROUP Washington, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, AMERIGROUP Washington, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support AMERIGROUP Washington, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: CEO, CFO, HCA government relations contact, HCA Account Executive, Compliance Officer, Medical Director, BH Medical Director, BH Clinical Director, Tribal Liaison. As discussed above, AMERIGROUP Washington, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Statewide; TANF, CHIP, ABD, and Medicaid Expansion.

Publicly funded contract cost: [redacted]
Description of work performed under this contract
Statewide contract to provide PH, BH, LTC, pharmacy, and vision.

Corporate Experience: Current and/or Recent Client

Client's Name: West Virginia Bureau for Medical Services
Affiliate: UNICARE Health Plan of West Virginia, Inc.
Program: West Virginia Medicaid — Mountain Health Trust, West Virginia Health Bridge

Client Location

Address Line 1: 350 Capitol Street

Address Line 2: Room 251

City: Charleston	**State:** WV	**Zip Code:** 25301	**County:** Kanawha

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted]	**Email Address:** [redacted]

Work Details

Number of covered lives: 188,505 (as of 12/31/2021)

Time period of contract:
Original start: 1/1/2003
Current contract: 7/1/2021–6/30/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of UNICARE Health Plan of West Virginia, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, UNICARE Health Plan of West Virginia, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support UNICARE Health Plan of West Virginia, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: CEO/COO, Contract Liaison/MHT Administrator, Medical Management Director, BH Medical Director, Member Services Director, Network Development Director, Program Integrity Lead, Community Engagement Director, MHT Member Advocate, CFO, Medical Director, Care Management Director, Quality Director, Claims Payment Director, Provider Relations Director, IT Director, Encounter Data Integrity Manager, Dental Director. As discussed above, UNICARE Health Plan of West Virginia, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional

employees, including additional shared services resources, to provide excellent services to members they serve.
Geographic and population coverage requirements: Statewide; TANF, ABD, and Medicaid Expansion.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Full-risk contract to provide PH, BH, dental, and vision.

Corporate Experience: Current and/or Recent Client

Client's Name: Wisconsin Department of Health Services
Affiliate: Compcare Health Services Insurance Corporation dba Anthem Blue Cross and Blue Shield
Program: Wisconsin Medicaid — BadgerCare Plus and Medicaid SSI

Client Location

Address Line 1: 1 West Wilson Street

Address Line 2: Suite 650

City: Madison	**State:** WI	**Zip Code:** 53703	**County:** Dane

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 150,636 (as of 12/31/2021)

Time period of contract:
Original start (BadgerCare Plus): 9/1/2010
Original start (SSI): 8/1/2015
Current contracts (BadgerCare Plus and SSI): 1/1/2022–12/31/2023

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Anthem Anthem Blue Cross and Blue Shield's staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Anthem Blue Cross and Blue Shield has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Anthem Blue Cross and Blue Shield's operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Contract Representative, Care Coordination Staff, Case Management Staff, HMO Representative. As discussed above, Anthem Blue Cross and Blue Shield is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Statewide; TANF, ABD, and Uninsured Adults.

Publicly funded contract cost: [redacted]
Description of work performed under this contract
Statewide contract to provide PH, BH, LTC, dental, and vision.

Corporate Experience: Current and/or Recent Client

Client's Name: California Department of Health Care Services
Affiliate: Blue Cross of California Partnership Plan, Inc.
Program: California Medicaid — Medi-Cal, Central Valley/Bay Area (Primary Contract)

Client Location

Address Line 1: 1501 Capitol Avenue

Address Line 2:

City: Sacramento	**State:** CA	**Zip Code:** 95814	**County:** Sacramento

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted]	**Email Address:** [redacted]

Work Details

Number of covered lives: 199,488 (as of 12/31/2021)

Time period of contract:
Original start: 9/1/1996
Current contract: 12/1/2003–12/31/2021, contract extended through 12/21/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Blue Cross of California Partnership Plan, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Blue Cross of California Partnership Plan, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Blue Cross of California Partnership Plan, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Compliance Officer, Full-Time Health Educator, MCP/MEDS/834 MIS Coordinator, Contractor's Representative, Security Officer. As discussed above, Blue Cross of California Partnership Plan, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Regional, Central Valley/Bay Area; TANF, ABD, Medicaid Expansion, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Regional contract to provide PH, BH, LTC, LTSS, pharmacy, vision, and transportation.

Corporate Experience: Current and/or Recent Client				
Client's Name: California Department of Health Care Services Affiliate: Blue Cross of California Partnership Plan, Inc. Program: California Medicaid — Medi-Cal, Central Valley/Bay Area (HYDE Amendment Services)				
Client Location				
Address Line 1: 1501 Capitol Avenue				
Address Line 2:				
City: Sacramento	**State:** CA	**Zip Code:** 95814		**County:** Sacramento
Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: [redacted]				
Title: [redacted]				
Phone Number: [redacted]		**Email Address:** [redacted]		
Work Details				
Number of covered lives: Membership provided in Primary Contract for Central Valley/Bay Area				
Time period of contract: Original start: 12/1/2003 Current contract: 12/1/2003–12/31/2021, contract extended through 12/21/2022				
Total number of staff hours expended during time period of contract: Provided in Primary Contract for Central Valley/Bay Area.				
Personnel requirements: Provided in Primary Contract for Central Valley/Bay Area.				
Geographic and population coverage requirements: Regional, Central Valley/Bay Area; TANF, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: Contract cost provided in Primary Contract for Central Valley/Bay Area.				
Description of work performed under this contract				
Amendment to provide family planning services to the primary Medi-Cal contract.				

Corporate Experience: Current and/or Recent Client

Client's Name: California Department of Health Care Services
Affiliate: Blue Cross of California Partnership Plan, Inc.
Program: California Medicaid — Medi-Cal, Sacramento County (Primary Contract)

Client Location

Address Line 1: 1501 Capitol Avenue

Address Line 2:

City: Sacramento	**State:** CA	**Zip Code:** 95814	**County:** Sacramento

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: ([redacted]

Email Address: [redacted]

Work Details

Number of covered lives: 201,053 (as of 12/31/2021)

Time period of contract:
Original start: 9/1/1996
Current contract: 12/1/2003–12/31/2021, contract extended through 12/21/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Blue Cross of California Partnership Plan, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Blue Cross of California Partnership Plan, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Blue Cross of California Partnership Plan, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Compliance Officer, Full-Time Health Educator, MCP/MEDS/834 MIS Coordinator, Contractor's Representative, Security Officer. As discussed above, Blue Cross of California Partnership Plan, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Regional, Sacramento County; TANF, ABD, Medicaid Expansion, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Regional contract to provide PH, BH, LTC, LTSS, pharmacy, vision, and transportation.

Corporate Experience: Current and/or Recent Client				
Client's Name: California Department of Health Care Services Affiliate: Blue Cross of California Partnership Plan, Inc. Program: California Medicaid — Medi-Cal, Sacramento County (HYDE Amendment Services)				
Client Location				
Address Line 1: 1501 Capitol Avenue				
Address Line 2:				
City: Sacramento	**State:** CA	**Zip Code:** 95814		**County:** Sacramento
Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: [redacted]				
Title: [redacted]				
Phone Number: [redacted]		**Email Address:** [redacted]		
Work Details				
Number of covered lives: Membership provided in Primary Contract for Sacramento County				
Time period of contract: Original start: 6/30/2005 Current contract: 1/1/2008–12/31/2021, contract extended through 12/21/2022				
Total number of staff hours expended during time period of contract: Provided in Primary Contract for Sacramento County.				
Personnel requirements: Provided in Primary Contract for Sacramento County.				
Geographic and population coverage requirements: Regional, Sacramento County; TANF, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: Contract cost provided in Primary Contract for Sacramento County.				
Description of work performed under this contract				
Amendment to provide family planning services to the primary Medi-Cal contract.				

Corporate Experience: Current and/or Recent Client

Client's Name: California Department of Health Care Services
Affiliate: Blue Cross of California Partnership Plan, Inc.
Program: California Medicaid — Medi-Cal, Tulare County (Primary Contract)

Client Location

Address Line 1: 1501 Capitol Avenue

Address Line 2:

City: Sacramento	**State:** CA	**Zip Code:** 95814	**County:** Sacramento

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 112,144 (as of 12/31/2021)

Time period of contract:
Original start: 2/1/1999
Current contract: 4/1/2005–12/31/2021, contract extended through 12/21/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Blue Cross of California Partnership Plan, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Blue Cross of California Partnership Plan, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Blue Cross of California Partnership Plan, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Compliance Officer, Full-Time Health Educator, MCP/MEDS/834 MIS Coordinator, Contractor's Representative, Security Officer. As discussed above, Blue Cross of California Partnership Plan, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Regional, Tulare County; TANF, ABD, Medicaid Expansion, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Regional contract to provide PH, BH, LTC, pharmacy, vision, and transportation.

Corporate Experience: Current and/or Recent Client				
Client's Name: California Department of Health Care Services Affiliate: Blue Cross of California Partnership Plan, Inc. Program: California Medicaid — Medi-Cal, Tulare County (HYDE Amendment Services)				
Client Location				
Address Line 1: 1501 Capitol Avenue				
Address Line 2:				
City: Sacramento	**State:** CA	**Zip Code:** 95814		**County:** Sacramento
Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: [redacted]				
Title: [redacted]				
Phone Number: [redacted]		**Email Address:** [redacted]		
Work Details				
Number of covered lives: Membership provided in Primary Contract for Tulare County				
Time period of contract: Original start: 2/1/1999 Current contract: 4/1/2005–12/31/2021, contract extended through 12/21/2022				
Total number of staff hours expended during time period of contract: Provided in Primary Contract for Tulare County.				
Personnel requirements: Provided in Primary Contract for Tulare County.				
Geographic and population coverage requirements: Regional, Tulare County; TANF, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: Contract cost provided in Primary Contract for Tulare County.				
Description of work performed under this contract				
Amendment to provide family planning services to the primary Medi-Cal contract.				

Corporate Experience: Current and/or Recent Client

Client's Name: California Department of Health Care Services
Affiliate: Blue Cross of California Partnership Plan, Inc.
Program: California Medicaid — Medi-Cal, Rural Expansion (Primary Contract)

Client Location

Address Line 1: 1501 Capitol Avenue

Address Line 2:

City: Sacramento	**State:** CA	**Zip Code:** 95814	**County:** Sacramento

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 174,945 (as of 12/31/2021)

Time period of contract:
Original start: 11/1/2013
Current contract: 11/1/2013–10/31/2023

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Blue Cross of California Partnership Plan, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Blue Cross of California Partnership Plan, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Blue Cross of California Partnership Plan, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Compliance Officer, Full-Time Health Educator, MCP/MEDS/834 MIS Coordinator, Contractor's Representative, Security Officer. As discussed above, Blue Cross of California Partnership Plan, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Regional; TANF, ABD, Medicaid Expansion, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Regional contract to provide PH, BH, LTC, pharmacy, vision, and transportation.

Corporate Experience: Current and/or Recent Client				
Client's Name: California Department of Health Care Services Affiliate: Blue Cross of California Partnership Plan, Inc. Program: California Medicaid — Medi-Cal, Rural Expansion (HYDE Amendment Services)				
Client Location				
Address Line 1: 1501 Capitol Avenue				
Address Line 2:				
City: Sacramento	**State:** CA	**Zip Code:** 95814		**County:** Sacramento
Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: [redacted]				
Title: [redacted]				
Phone Number: [redacted]		**Email Address:** [redacted]		
Work Details				
Number of covered lives: Membership provided in Primary Contract for Rural Expansion				
Time period of contract: Original start: 11/1/2013 Current contract: 11/1/2013–10/31/2023				
Total number of staff hours expended during time period of contract: Provided in Primary Contract for Rural Expansion.				
Personnel requirements: Provided in Primary Contract for Rural Expansion.				
Geographic and population coverage requirements: Regional; TANF, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: Contract cost provided in Primary Contract for Rural Expansion.				
Description of work performed under this contract				
Amendment to provide family planning services to the primary Medi-Cal contract.				

Corporate Experience: Current and/or Recent Client

Client's Name: California Department of Health Care Services
Affiliate: Blue Cross of California Partnership Plan, Inc.
Program: California Medicaid — Medi-Cal, San Benito County (Primary Contract)

Client Location

Address Line 1: 1501 Capitol Avenue

Address Line 2:

City: Sacramento	**State:** CA	**Zip Code:** 95814	**County:** Sacramento

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 9,940 (as of 12/31/2021)

Time period of contract:
Original start: 11/1/2013
Current contract: 11/1/2013–10/31/2023

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Blue Cross of California Partnership Plan, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Blue Cross of California Partnership Plan, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Blue Cross of California Partnership Plan, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Compliance Officer, Full-Time Health Educator, MCP/MEDS/834 MIS Coordinator, Contractor's Representative, Security Officer. As discussed above, Blue Cross of California Partnership Plan, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Regional, San Benito County; TANF, ABD, Medicaid Expansion, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Full-risk contract to provide PH, BH, LTC, pharmacy, vision, and transportation.

Corporate Experience: Current and/or Recent Client				
Client's Name: California Department of Health Care Services Affiliate: Blue Cross of California Partnership Plan, Inc. Program: California Medicaid — Medi-Cal, San Benito County (HYDE Amendment Services)				
Client Location				
Address Line 1: 1501 Capitol Avenue				
Address Line 2:				
City: Sacramento	**State:** CA	**Zip Code:** 95814		**County:** Sacramento
Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: [redacted]				
Title: [redacted]				
Phone Number: [redacted]		**Email Address:** [redacted]		
Work Details				
Number of covered lives: Membership provided in Primary Contract for San Benito County				
Time period of contract: Original start: 11/1/2013 Current contract: 11/1/2013–10/31/2023				
Total number of staff hours expended during time period of contract: Provided in Primary Contract for San Benito County.				
Personnel requirements: Provided in Primary Contract for San Benito County.				
Geographic and population coverage requirements: Regional, San Benito County; TANF, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: Contract cost provided in Primary Contract for San Benito County.				
Description of work performed under this contract				
Amendment to provide family planning services to the primary Medi-Cal contract.				

Corporate Experience: Current and/or Recent Client

Client's Name: California Department of Health Care Services
Affiliate: Blue Cross of California Partnership Plan, Inc.
Program: California Medicaid — Medi-Cal, Tri-County (Primary Contract)

Client Location

Address Line 1: 1501 Capitol Avenue

Address Line 2:

City: Sacramento	**State:** CA	**Zip Code:** 95814	**County:** Sacramento

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: ([redacted]

Email Address: [redacted]

Work Details

Number of covered lives: 175,004 (as of 12/31/2021)

Time period of contract:
Original start: 3/1/2011
Current contract: 3/1/2011–12/31/2021, contract extended through 12/21/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Blue Cross of California Partnership Plan, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Blue Cross of California Partnership Plan, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Blue Cross of California Partnership Plan, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Compliance Officer, Full-Time Health Educator, MCP/MEDS/834 MIS Coordinator, Contractor's Representative, Security Officer. As discussed above, Blue Cross of California Partnership Plan, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Regional; TANF, ABD, Medicaid Expansion, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Full-risk contract to provide PH, BH, LTC, pharmacy, vision, and transportation.

Corporate Experience: Current and/or Recent Client				
Client's Name: California Department of Health Care Services Affiliate: Blue Cross of California Partnership Plan, Inc. Program: California Medicaid — Medi-Cal, Tri-County (HYDE Amendment Services)				
Client Location				
Address Line 1: 1501 Capitol Avenue				
Address Line 2:				
City: Sacramento	**State:** CA	**Zip Code:** 95814		**County:** Sacramento
Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: [redacted]				
Title: [redacted]				
Phone Number: [redacted]		**Email Address:** [redacted]		
Work Details				
Number of covered lives: Membership provided in Primary Contract for Tri-County				
Time period of contract: Original start: 3/1/2011 Current contract: 3/1/2011–12/31/2021, contract extended through 12/21/2022				
Total number of staff hours expended during time period of contract: Provided in Primary Contract for Tri-County.				
Personnel requirements: Provided in Primary Contract for Tri-County.				
Geographic and population coverage requirements: Regional; TANF, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: Contract cost provided in Primary Contract for Tri-County.				
Description of work performed under this contract				
Amendment to provide family planning services to the primary Medi-Cal contract.				

Corporate Experience: Current and/or Recent Client

Client's Name: California Department of Health Care Services and CMS
Affiliate: Blue Cross of California Partnership Plan, Inc.
Program: Capitated Financial Alignment Model Demonstration (Dual Demonstration)

Client Location

Address Line 1: 1501 Capitol Avenue

Address Line 2:

City: Sacramento	**State:** CA	**Zip Code:** 95814	**County:** Sacramento

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted]	**Email Address:** [redacted]

Work Details

Number of covered lives: 3,747

Time period of contract:
Current contract (Los Angeles): 7/1/2014–12/31/2022
Current contract (Santa Clara): 1/1/2015–12/31/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Blue Cross of California Partnership Plan, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Blue Cross of California Partnership Plan, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Blue Cross of California Partnership Plan, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Compliance Officer, Full-Time Health Educator, MCP/MEDS/834 MIS Coordinator, Contractor's Representative, and Security Officer. As discussed above, for this contract Blue Cross of California Partnership Plan. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Regional, Los Angeles and Santa Clara counties; Dual Eligibles.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Regional contract to provide PH, BH, LTC, LTSS, pharmacy, vision, and transportation in Los Angeles and Santa Clara counties.

Corporate Experience: Current and/or Recent Client

Client's Name: Florida Healthy Kids Corporation
Affiliate: Simply Healthcare Plans, Inc.
Program: Florida Medicaid — Florida Healthy Kids

Client Location

Address Line 1: 1203 Governors Square Boulevard

Address Line 2: Suite 400

City: Tallahassee	**State:** FL	**Zip Code:** 32301	**County:** Leon

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 61,164 (as of 12/31/2021)

Time period of contract:
Original start: 1/1/2003
Current contract: 1/1/2020–12/31/2023

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Simply Healthcare Plans, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Simply Healthcare Plans, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Simply Healthcare Plans, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Executive Sponsor, Contract Manager, Member Services Manager, Clinical Specialist, Clinical Manager, or Medical Director, Compliance Manager, Finance Officer. As discussed above, Simply Healthcare Plans, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Statewide; CHIP.

Publicly funded contract cost: [redacted]
Description of work performed under this contract
Statewide contract to provide PH, BH, pharmacy, and vision.

Corporate Experience: Current and/or Recent Client

Client's Name: Georgia Department of Community Health
Affiliate: AMGP Georgia Managed Care Company, Inc.
Program: Georgia Medicaid — Georgia Families 360°SM

Client Location

Address Line 1: 2 Peachtree Street

Address Line 2: 36th Floor

City: Atlanta	**State:** GA	**Zip Code:** 30303	**County:** Fulton

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 30,283 (as of 12/31/2021)

Time period of contract:
Original start: 7/1/2017
Current contract: 7/1/2021–6/30/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of AMGP Georgia Managed Care Company, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, AMGP Georgia Managed Care Company, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support AMGP Georgia Managed Care Company, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: CEO, Member Services Director, Provider Services Director, Utilization Management Director, Medical Director, Quality Management Director, Health Services Director, and the Program Implementation Manager. As discussed above, AMGP Georgia Managed Care Company, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Statewide; Child Welfare/Foster Care.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Statewide single MCO contract to provide PH, BH, LTC, pharmacy, dental, and vision for children, youth, and young adults in foster care, children and youth receiving adoption assistance, and select youth involved in the juvenile justice system.

Corporate Experience: Current and/or Recent Client

Client's Name: Indiana Family and Social Services Administration
Affiliate: Anthem Insurance Companies, Inc.
Program: Indiana Medicaid — Healthy Indiana Plan

Client Location

Address Line 1: 402 West Washington Street

Address Line 2: Room W374, MS07

City: Indianapolis	**State:** IN	**Zip Code:** 46204	**County:** Marion

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 332,841 (as of 12/31/2021)

Time period of contract:
Original start: 1/1/2017
Current contract: 1/1/2022–12/31/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Anthem Insurance Companies, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Anthem Insurance Companies, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Anthem Insurance Companies, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: CEO, CFO, Compliance Officer, Systems (IS) Coordinator, Director (licensed Indiana Health Care Provider), Member Services Manager, Provider Services Manager, Quality Management Manager, Special Investigation Unit Manager, Utilization Management Manager, BH Manager, Data Compliance Manager, Pharmacy Director, Grievance and Appeals Manager, Claims Manager, POWER Account Operations Manager, and Transition Coordination Manager. As discussed above, Anthem Insurance Companies, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they

need additional employees, including additional shared services resources, to provide excellent services to members they serve.
Geographic and population coverage requirements: Statewide; TANF and Medicaid Expansion.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Statewide contract to provide PH, BH, pharmacy, dental, vision, and transportation to provide healthcare to low-income adults, ages 19 to 64.

Corporate Experience: Current and/or Recent Client

Client's Name: Indiana Family and Social Services Administration
Affiliate: Anthem Insurance Companies, Inc.
Program: Indiana Medicaid — Hoosier Care Connect

Client Location

Address Line 1: 402 West Washington Street

Address Line 2: Room W374, MS07

City: Indianapolis	**State:** IN	**Zip Code:** 46204	**County:** Marion

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 62,071 (as of 12/31/2021)

Time period of contract:
Original start: 4/1/2015
Current contract: **4/1/2021–3/1/2025**

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Anthem Insurance Companies, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Anthem Insurance Companies, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Anthem Insurance Companies, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: CEO, CFO, Compliance Officer, Systems (IS) Coordinator, Director (licensed Indiana Health Care Provider), Member Services Manager, Provider Services Manager, Quality Improvement Management Manager, Special Investigation Unit Manager, Utilization Management Manager, BH Manager, Data Compliance Manager, Pharmacy Director, Grievance and Appeals Manager, Claims Manager, Care Management Manager, Member Advocate/Non-Discrimination Coordinator, DCS Liaison. As discussed above, Anthem Insurance Companies, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to

determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.
Geographic and population coverage requirements: Statewide; ABD and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Statewide contract to provide PH, BH, pharmacy, dental, vision, and transportation for individuals who are aged 65 years and older, blind, or disabled and not eligible for Medicare.

Corporate Experience: Current and/or Recent Client

Client's Name: New York State Department of Health
Affiliate: HealthPlus HP, LLC dba Empire BlueCross BlueShield HealthPlus
Program: New York Medicaid — Child Health Plus

Client Location

Address Line 1: Corning Tower, OCP 826

Address Line 2:

City: Albany	**State:** NY	**Zip Code:** 12237	**County:** Albany

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 36,054 (as 12/31/2021)

Time period of contract:
Original start: 1/1/2005
Current contract: 4/1/2019–9/30/2024

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Empire BlueCross BlueShield Health Plus's staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Empire BlueCross BlueShield HealthPlus has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Empire BlueCross BlueShield HealthPlus' operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Utilization management staff, Case Managers, Member Services Staff, Medical Director, behavioral health Director, HARP staff, Provider Services Staff, Compliance Officer, SIU Director. As discussed above, Empire BlueCross BlueShield HealthPlus is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Regional; CHIP.

Publicly funded contract cost: [redacted]
Description of work performed under this contract
Regional contract to provide PH, BH, pharmacy, dental, and vision.

Corporate Experience: Current and/or Recent Client

Client's Name: New York State Department of Health
Affiliate: HealthPlus HP, LLC dba Empire BlueCross BlueShield HealthPlus
Program: New York Medicaid — Medicaid Advantage Plus

Client Location

Address Line 1: One Commerce Plaza

Address Line 2: Room 1620

City: Albany	**State:** NY	**Zip Code:** 12210	**County:** Albany

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 133

Time period of contract:
Original start: 4/1/2010
Current contract: 1/1/2017–12/31/2021 Received amendment from the State, new extension date awaiting approval.

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually.

Personnel requirements: Utilization management staff, Case Managers, Member Services Staff, Medical Director, Behavioral health Director, HARP staff, Provider Services Staff, Compliance Officer, and SIU Director. As discussed above, Empire BlueCross BlueShield HealthPlus is currently supported by a total of approximately [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Regional; Dual Eligibles.

Publicly funded contract cost: [redacted]

Description of work performed under this contract

Regional contract to provide PH, BH, pharmacy, dental, vision, and transportation.

Corporate Experience: Current and/or Recent Client

Client's Name: New York State Department of Health
Affiliate: HealthPlus HP, LLC dba Empire BlueCross BlueShield HealthPlus
Program: New York Medicaid — Managed Long-Term Care

Client Location

Address Line 1: One Commerce Plaza

Address Line 2: Room 1620

City: Albany	**State:** NY	**Zip Code:** 12210	**County:** Albany

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 4,929 (as of 12/31/2021)

Time period of contract:
Original start: 12/1/2005
Current contract: 1/1/2017–12/31/2021

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Empire BlueCross BlueShield HealthPlus' staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Empire BlueCross BlueShield HealthPlus has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Empire BlueCross BlueShield HealthPlus's operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Utilization management staff, Case Managers, Member Services Staff, Medical Director, behavioral health Director, HARP staff, Provider Services Staff, Compliance Officer, SIU Director. As discussed above, Empire BlueCross BlueShield HealthPlus is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Regional; ABD.

Publicly funded contract cost: [redacted]
Description of work performed under this contract
Regional contract to provide PH, LTC, LTSS, pharmacy, dental, vision, and transportation.

Corporate Experience: Current and/or Recent Client

Client's Name: New York State Department of Health
Affiliate: HealthPlus HP, LLC dba Empire BlueCross BlueShield HealthPlus
Program: New York Medicaid — Essential Plan

Client Location

Address Line 1: Corning Tower, OCP

Address Line 2: Room 2378

City: Albany	**State:** NY	**Zip Code:** 12237	**County:** Albany

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 69,980 (as of 12/31/2021)

Time period of contract:
Original start: 11/1/2015
Current contract: 1/1/2021–12/31/2025

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Empire BlueCross BlueShield HealthPlus's staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Empire BlueCross BlueShield HealthPlus has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Empire BlueCross BlueShield HealthPlus's operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Utilization management staff, Case Managers, Member Services Staff, Medical Director, HIV Education Staff, behavioral health Director, HARP staff, Provider Services Staff, Compliance Officer, SIU Director. As discussed above, Empire BlueCross BlueShield HealthPlus is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Regional; Uninsured Adults.

Publicly funded contract cost: [redacted]
Description of work performed under this contract
Regional contract to provide PH, pharmacy, dental, vision, and transportation individuals ineligible for Medicaid and do not have access to affordable employer coverage.

Corporate Experience: Current and/or Recent Client

Client's Name: Highmark Western and Northeastern New York Inc. dba Highmark Blue Cross Blue Shield of Western New York
Affiliate: Amerigroup Partnership Plan, LLC
Program: Western New York Medicaid — Family Health Plus and Child Health Plus

Client Location

Address Line 1: 120 Fifth Avenue

Address Line 2:

City: Pittsburgh	**State:** PA	**Zip Code:** 15222	**County:** Allegheny

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 56,145 (as of 12/31/2021)

Time period of contract:
Current contract: 11/1/2021–10/31/2023

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Amerigroup Partnership Plan, LLC's staffing plan for its subcontract with Highmark Blue Cross Blue Shield of Western New York is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services its partner, and to the to Members and Providers they serve. Amerigroup Partnership Plan supplements these local resources with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Amerigroup Partnership Plan, LLC has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Amerigroup Partnership Plan, LLC's operations. They continually review their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Highmark Blue Cross Blue Shield of Western New York and the Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements:
As discussed above, Amerigroup Partnership Plan, LLC is currently supported by a total of [redacted] FTEs dedicated to the contract. Amerigroup Partnership Plan, LLC continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Regional; TANF, CHIP, and ABD.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Alliance subcontract under Highmark Blue Cross Blue Shield of Western New York regional contract to provide PH, BH, LTC, LTSS, pharmacy, dental, and vision.

Corporate Experience: Current and/or Recent Client

Client's Name: Texas Health and Human Services Commission
Affiliate: Amerigroup Insurance Company
Program: Texas Medicaid — STAR, Medicaid Rural Service Area

Client Location

Address Line 1: 4601 West Guadalupe Street

Address Line 2:

City: Austin	**State:** TX	**Zip Code:** 78751	**County:** Travis

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted]

Email Address: [redacted]

Work Details

Number of covered lives: 167,340 (as of 12/31/2021)

Time period of contract:
Original start: 9/1/2011
Current contract: 9/1/2015–8/31/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Amerigroup Insurance Company's staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Amerigroup Insurance Company has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Amerigroup Insurance Company's operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Executive Director (CEO/COO), Medical Director, Member Services Manager, Management Information Systems Manager, Claims Processing Manager, Provider Network Development and Management Manager, Benefit Administration and Utilization and Care Management Manager, Quality Improvement Manager, BH Services Manager, Financial Functions Manager, Reporting Manager, STAR+PLUS Service Coordinators, SIU. As discussed above, Amerigroup Insurance Company is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their

staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.
Geographic and population coverage requirements: Regional; TANF and Child Welfare.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Regional contract to provide PH, BH, pharmacy, dental, vision, and transportation.

Corporate Experience: Current and/or Recent Client

Client's Name: Texas Health and Human Services Commission
Affiliate: Amerigroup Insurance Company
Program: Texas Medicaid — STAR+PLUS, Medicaid Rural Service Area West

Client Location

Address Line 1: 4601 West Guadalupe Street

Address Line 2:

City: Austin	**State:** TX	**Zip Code:** 78751	**County:** Travis

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted]

Email Address: [redacted]

Work Details

Number of covered lives: 15,730 (as of 12/31/2021)

Time period of contract:
Original start: 9/1/2014
Current contract: 9/1/2017–8/31/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Amerigroup Insurance Company's staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Amerigroup Insurance Company has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Amerigroup Insurance Company's operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Executive Director (CEO/COO), Medical Director, Member Services Manager, Management Information Systems Manager, Claims Processing Manager, Provider Network Development and Management Manager, Benefit Administration and Utilization and Care Management Manager, Quality Improvement Manager, BH Services Manager, Financial Functions Manager, Reporting Manager, STAR+PLUS Service Coordinators, SIU. As discussed above, Amerigroup Insurance Company is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their

staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.
Geographic and population coverage requirements: Regional; ABD.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Regional contract to provide PH, BH, LTC, LTSS, pharmacy, dental, vision, and transportation for individuals age 65 or older who have disabilities.

Corporate Experience: Current and/or Recent Client

Client's Name: Texas Health and Human Services Commission
Affiliate: AMERIGROUP Texas, Inc.
Program: Texas Medicaid — STAR+PLUS, Tarrant Service Area

Client Location

Address Line 1: 4601 West Guadalupe Street

Address Line 2:

City: Austin	**State:** TX	**Zip Code:** 78751	**County:** Travis

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted]

Email Address: [redacted]s

Work Details

Number of covered lives: 32,139 (as of 12/31/2021)

Time period of contract:
Original start: 9/1/2011
Current contract: 9/1/2015–8/31/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of AMERIGROUP Texas, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, AMERIGROUP Texas, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support AMERIGROUP Texas, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Executive Director (CEO/COO), Medical Director, Member Services Manager, Management Information Systems Manager, Claims Processing Manager, Provider Network Development and Management Manager, Benefit Administration and Utilization and Care Management Manager, Quality Improvement Manager, BH Services Manager, Financial Functions Manager, Reporting Manager, STAR+PLUS Service Coordinators, SIU. As discussed above, AMERIGROUP Texas, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their

staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.
Geographic and population coverage requirements: Regional; ABD.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Regional contract to provide PH, BH, LTC, LTSS, pharmacy, dental, vision, and transportation for individuals age 65 or older who have disabilities.

Corporate Experience: Current and/or Recent Client

Client's Name: Texas Health and Human Services Commission
Affiliate: Amerigroup Insurance Company
Program: Texas Medicaid — STAR Kids (Multiple Service Areas)

Client Location

Address Line 1: 4601 West Guadalupe Street

Address Line 2:

City: Austin	**State:** TX	**Zip Code:** 78751	**County:** Travis

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted]

Email Address: [redacted]

Work Details

Number of covered lives: 28,865 (as of 12/31/2021)

Time period of contract:
Original start: 11/1/2016
Current contract: 10/1/2015–8/31/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Amerigroup Insurance Company's staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Amerigroup Insurance Company has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Amerigroup Insurance Company's operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Executive Director (CEO/COO), Medical Director, Member Services Manager, Management Information Systems Manager, Claims Processing Manager, Provider Network Development and Management Manager, Benefit Administration and Utilization and Care Management Manager, Quality Improvement Manager, BH Services Manager, Financial Functions Manager, Reporting Manager, SIU. As discussed above, Amerigroup Insurance Company is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Regional; ABD, Child Welfare.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Regional contract to provide PH, BH, LTSS, pharmacy, dental, vision, and transportation to individuals 20 and younger who have disabilities.

Corporate Experience: Current and/or Recent Client

Client's Name: Seton Health Plan, Inc. (Dell Children's Health Plan)
Affiliate: Amerigroup Partnership Plan, LLC
Program: Texas Medicaid — STAR and CHIP, Travis Service Area

Client Location

Address Line 1: 4601 West Guadalupe Street

Address Line 2:

City: Austin	**State:** TX	**Zip Code:** 78751	**County:** Travis

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted]

Email Address: [redacted]

Work Details

Number of covered lives: 42,274

Time period of contract:
Original start: 12/1/2016
Current contract: 12/1/2016–8/31/2023

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Amerigroup Partnership Plan, LLC's staffing plan for its subcontract with Dell Children's Health Plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to its partner, and to the Members and Providers they serve. Amerigroup Partnership Plan's supplements these local resources with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, Amerigroup Partnership Plan, LLC has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support Amerigroup Partnership Plan, LLC's operations. They continually review their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Dell Children's Health Plan and to the Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.**30,00**

Personnel requirements: As discussed above, Amerigroup Partnership Plan, LLC is currently supported by a total of [redacted] FTEs dedicated to the contract. Amerigroup Partnership Plan, LLC continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Regional, Travis Service Area; TANF and CHIP.

Publicly funded contract cost: [redacted]
Description of work performed under this contract
Alliance subcontract under Dell Children's Health Plan's regional contract to provide PH, BH, pharmacy, vision, and transportation.

Corporate Experience: Current and/or Recent Client

Client's Name: Virginia Department of Medical Assistance Services
Affiliate: HealthKeepers, Inc.
Program: Virginia Medicaid — Commonwealth Coordinated Care Plus

Client Location

Address Line 1: 600 E Broad Street

Address Line 2:

City: Richmond	**State:** VA	**Zip Code:** 23219	**County:** Richmond City

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 80,705 (as of 12/31/2021)

Time period of contract:
Original start: 8/1/2017
Current contract: 7/1/2021–6/30/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of HealthKeepers, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, HealthKeepers, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support HealthKeepers, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Project Director, Project Manager, Chief Medical Officer/Medical Director, Pharmacy Director, BH Director, Director of Long Term Services and Support, CFO, COO or Director of Operations, Quality Director, Senior Manager of Clinical Services, Claims Director, IT Director, Compliance Officer, ADA Compliance Director. As discussed above, HealthKeepers, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Statewide; ABD, Dual Eligibles, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Statewide contract to provide PH, BH, LTC, LTSS, pharmacy, dental, vision, and transportation.

Corporate Experience: Current and/or Recent Client				
Client's Name: Washington Health Care Authority Affiliate: Amerigroup Washington, Inc. Program: Washington Medicaid — BH Wraparound for Apple Health				
Client Location				
Address Line 1: 626 8th Avenue Southeast				
Address Line 2:				
City: Olympia	**State:** WA	**Zip Code:** 98501		**County:** Thurston
Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: [redacted]				
Title: [redacted]				
Phone Number: [redacted]		**Email Address:** [redacted]		
Work Details				
Number of covered lives: N/A, contract provides wraparound services for the Apple Health contract's 254,500 Members (as of 12/31/2021)				
Time period of contract: Original start: 7/1/2020 Current contract: 7/1/2020–12/31/2021 Extended 12/31/2022				
Total number of staff hours expended during time period of contract: Provided in Apple Health Integrated Managed Care Contract.				
Personnel requirements: Provided in Apple Health Integrated Managed Care Contract.				
Geographic and population coverage requirements: Statewide; TANF, CHIP, ABD, and Medicaid Expansion.				
Publicly funded contract cost: [redacted]				
Description of work performed under this contract				
Statewide contract to provide BH and LTC to Members in the Apple Health program.				

Corporate Experience: Current and/or Recent Client

Client's Name: Washington Health Care Authority
Affiliate: Amerigroup Washington, Inc.
Program: Washington Medicaid — Foundational Community Supports

Client Location

Address Line 1: 626 8th Avenue Southeast

Address Line 2:

City: Olympia	**State:** WA	**Zip Code:** 98501	**County:** Thurston

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: N/A, contract is support services for all MCOs

Time period of contract:
Original start: 1/1/2017
Current contract: 1/1/2017–12/31/2021 Extended 12/31/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of AMERIGROUP Washington, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, AMERIGROUP Washington, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support AMERIGROUP Washington, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Executive Sponsors, FCS Director (Contract Manager), FCS Process Improvement Director, Business Information Analyst, FCS Housing and Employment Manager, CEO, COO, CFO, Director State Operations, Director Quality Management, Compliance Director, IT Account Manager. As discussed above, Amerigroup Washington, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to members they serve.

Geographic and population coverage requirements: Statewide; Medicaid eligible individuals.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Third Party Administrator of Foundational Community Supports program, facilitating supported employment and housing for Medicaid Members of all contracted MCOs in Washington.

Corporate Experience: Current and/or Recent Client

Client's Name: West Virginia Children's Health Insurance Program
Affiliate: UNICARE Health Plan of West Virginia, Inc.
Program: West Virginia Medicaid — West Virginia CHIP

Client Location

Address Line 1: 350 Capitol Street

Address Line 2: Room 251

City: Charleston	**State:** WV	**Zip Code:** 25301	**County:** Kanawha

Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**

Direct Contact for Client

Name: [redacted]

Title: [redacted]

Phone Number: [redacted] **Email Address:** [redacted]

Work Details

Number of covered lives: 7,286 (as of 12/31/2021)

Time period of contract:
Original start: 1/1/2021
Current contract: 7/1/2021–6/30/2022

Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of UNICARE Health Plan of West Virginia, Inc.'s staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, UNICARE Health Plan of West Virginia, Inc. has [redacted] FTEs engaged in performance of the contract. Additionally, [redacted] national shared services FTEs support UNICARE Health Plan of West Virginia, Inc.'s operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Personnel requirements: Chief Executive Officer/Chief Operating Officer (CEO/COO), Chief Financial Officer , Compliance Officer, Contract Liaison/MHT Administrator, Medical Director, Medical Management Director, Care Management Director, Behavioral Health Medical Director, Quality Director, Member Services Director, Claims Payment Director, Network Development Director, Provider Relations Director, Program Integrity Lead, Information Technology Director, Community Engagement Director, Encounter Data Integrity Manager, MHT Member Advocate, Dental Director As discussed above, UNICARE Health Plan of West Virginia, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether

they need additional employees, including additional shared services resources, to provide excellent services to members they serve.
Geographic and population coverage requirements: Statewide; CHIP.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Full-risk contract to provide medical, BH, dental, and vision.

[END OF RESPONSE]

Amerigroup

Amerigroup Rural Medicine Scholarship

[redacted]

4.3.2 Ownership and Financial Disclosure Information

4.3.2.1 Information to Be Disclosed

4.3.2.1 Appendix G Information to Be Disclosed attachments include the following:

- Appendix G: Information to Be Disclosed
- Appendix G: Disclosure of Subcontractor Information
- Appendix G: Other Disclosing Entities

CONFIDENTIAL

Management Qualification: 4.3.2.1 Information to Be Disclosed

Management Qualification: 4.3.2.1 Information to Be Disclosed

CONFIDENTIAL

[redacted]

Management Qualification: 4.3.2.1 Information to Be Disclosed

We are providing the following list of subsidiaries that Anthem, Inc., the ultimate parent company of Amerigroup Mississippi, Inc., also beneficially owns and that operate under Medicaid contracts similar to this one, as well as the locations of those subsidiaries:

Amerigroup Insurance Company	2505 N. Highway 360, Suite 300 Grand Prairie, TX 75050
Amerigroup Iowa, Inc.	4800 Westown Parkway, Suite 200 West Des Moines, IA 50266
AMERIGROUP Maryland, Inc.	7550 Teague Road, Suite 500 Hanover, MD 21076
AMERIGROUP New Jersey, Inc.	101 Wood Avenue South, Suite 800 Iselin, NJ 08830
AMERIGROUP Tennessee, Inc.	22 Century Boulevard, Suite 220 Nashville, TN 37214
AMERIGROUP Texas, Inc.	2505 N. Highway 360, Suite 300 Grand Prairie, TX 75050
AMERIGROUP Washington, Inc.	705 5th Avenue South, Suite 300 Seattle, WA 98104
AMGP Georgia Managed Care Company, Inc.	740 W. Peachtree Street Atlanta, GA 30308
Anthem Insurance Companies, Inc.	220 Virginia Avenue Indianapolis, IN 46204
Anthem Kentucky Managed Care Plan, Inc.	13550 Triton Boulevard Louisville, KY 40223
APC PASSE, LLC	650 S. Shackleford Road, Suite 440 Little Rock, AR 72211
Blue Cross of California	425 E. Colorado Street, Suite 600 Glendale, CA 91205
Blue Cross of California Partnership Plan, Inc.	425 E. Colorado Street, Suite 600 Glendale, CA 91205
CCHA, LLC	1125 17th Street, Suite 1000 Denver, CO 80202
Community Care Health Plan of Louisiana, Inc.	10000 Perkins Rowe, Suite G-510 Baton Rouge, LA 70810
Community Care Health Plan of Nebraska, Inc.	8055 O Street, Suite 300 Lincoln, NE 68510
Community Care Health Plan of Nevada, Inc.	9133 West Russell Road Las Vegas, NV 89148
Community Insurance Company	4361 Irwin-Simpson Road Mason, OH 45040
Compcare Health Services Insurance Corporation	N17 W24340 Riverwood Waukesha, WI 53188
HealthKeepers, Inc.	2015 Staples Mill Road Richmond, VA 23230
HealthPlus HP, LLC	9 Pine Street, 14th Floor New York, NY 10005

Management Qualification: 4.3.2.1 Information to Be Disclosed

Missouri Care, Incorporated	1831 Chestnut Street St. Louis, MO 63103
MMM Multi Health, LLC	350 Chardon Avenue, Suite 500 Torre Chardon San Juan, PR 00918
Simply Healthcare Plans, Inc.	9250 West Flagler Street Miami, FL 33174
UNICARE Health Plan of West Virginia, Inc.	200 Association Drive, Suite 200 Charleston, WV 25311

CONFIDENTIAL

[redacted]

Management Qualification: 4.3.2.1 Information to Be Disclosed

CONFIDENTIAL

[redacted]

CONFIDENTIAL

Management Qualification: 4.3.2.1 Information to Be Disclosed

[redacted]

Management Qualification: 4.3.2.1 Information to Be Disclosed

CONFIDENTIAL

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Management Qualification: 4.3.2.1 Information to Be Disclosed

CONFIDENTIAL

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Management Qualification: 4.3.2.1 Information to Be Disclosed

CONFIDENTIAL

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Management Qualification: 4.3.2.1 Information to Be Disclosed

CONFIDENTIAL

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Management Qualification: 4.3.2.1 Information to Be Disclosed

CONFIDENTIAL

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Management Qualification: 4.3.2.1 Information to Be Disclosed

CONFIDENTIAL

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Amerigroup Mississippi, Inc.

Management Qualification: 4.3.2.1 Information to Be Disclosed

CONFIDENTIAL

[REST OF PAGE INTENTIONALLY LEFT BLANK]

CONFIDENTIAL

Management Qualification: 4.3.2.1 Information to Be Disclosed

[redacted]

Section 2: Disclosure of Subcontractor Information

Disclosure of Subcontractor Information				
Include information about subcontractors of the Offeror in which the Offeror or owner of the Offeror has a more than 5%ownership interest and/or a management control interest. Use a new form for each subcontractor and/or ownership interest. Use a copy of this page for each subcontractor subject to disclosure.				
This response applies to: ☐ The Offeror ☒ An Owner of the Offeror				
If this applies to an owner of the offeror, name that owner (as already disclosed in Section 1, above): Anthem, Inc.				
The person or entity named as an: ☒ Ownership Interest ☐ Management Control Interest				
If there is an ownership interest, what is the ownership percentage? 100% Indirect				
If there is a management control interest, describe that interest: N/A				
Effective Date of Ownership and/or Management Control:				
Legal Business Name of Subcontractor as Reported to the Internal Revenue Service: Beacon Health Options, Inc.				
Doing Business as Name (if applicable): N/A	Tax Identification Number (required): 54-1414194			
Primary Business Address				
Line 1 (Street Name and Number): 200 State Street				
Address Line 2 (Suite, Room, etc.): Suite 302				
City: Boston	State: MA	Zip Code: 02109	County: Suffolk	
Mailing Address (P.O. Box): Same as above	City: N/A	State: N/A	Zip Code: N/A	County: N/A
Additional Business Location(s): Duplicate this page to provide all locations if necessary.				
Address Line 1: 750 Woodlands Parkway				
Address Line 2:				
City: Ridgeland	State: MS	Zip Code: 39157	County: Madison	
Business Location				
Address Line 1: N/A				
Address Line 2:				
City:	State:	Zip Code:	County:	
Business Location				
Address Line 1: N/A				
Address Line 2:				
City:	State:	Zip Code:	County:	

Disclosure of Subcontractor Information (cont.)		
Are any individuals disclosed in Section 1 or 2 related to the subcontractor or an owner of the subcontractor as aspouse, parent, child, or sibling? ☐ Yes ☒ No **If yes, provide the following information for each.**		
Name of Subcontractor/ Subcontractor's Owner	**Name of Offeror's Owner**	**Relationship**

Section 2: Disclosure of Subcontractor Information

Disclosure of Subcontractor Information				
Include information about subcontractors of the Offeror in which the Offeror or owner of the Offeror has a more than 5%ownership interest and/or a management control interest. Use a new form for each subcontractor and/or ownership interest. Use a copy of this page for each subcontractor subject to disclosure.				
This response applies to: ☐ The Offeror ☒ An Owner of the Offeror				
If this applies to an owner of the offeror, name that owner (as already disclosed in Section 1, above): Anthem, Inc.				
The person or entity named as an: ☒ Ownership Interest ☐ Management Control Interest				
If there is an ownership interest, what is the ownership percentage? 100% Indirect				
If there is a management control interest, describe that interest:				
Effective Date of Ownership and/or Management Control:				
Legal Business Name of Subcontractor as Reported to the Internal Revenue Service: IngenioRx, Inc.				
Doing Business as Name (if applicable): N/A	Tax Identification Number (required): 82-3062245			
Primary Business Address				
Line 1 (Street Name and Number): 450 Headquarters Plaza				
Address Line 2 (Suite, Room, etc.): East Tower, 7th Floor				
City: Morristown	State: NJ	Zip Code: 07960	County: Morris	
Mailing Address (P.O. Box): 450 Headquarters Plaza	City: Morristown	State: NJ	Zip Code: 07960	County: Morris
Additional Business Location(s): Duplicate this page to provide all locations if necessary.				
Address Line 1: 108 Leigus Road				
Address Line 2:				
City: Wallingford	State: CT	Zip Code: 06492	County: New Haven	
Business Location				
Address Line 1: 740 West Peachtree Street NW				
Address Line 2:				
City: Atlanta	State: GA	Zip Code: 30308	County: Fulton	
Business Location				
Address Line 1: 233 S Wacker Drive				
Address Line 2:				
City: Chicago	State: IL	Zip Code: 60606	County: Cook	
Business Location				
Address Line 1: 13550 Triton Office Park Boulevard				
Address Line 2:				

City: Louisville	State: KY	Zip Code: 40223	County: Jefferson
Business Location			
Address Line 1: 4241 Irwin Simpson Road			
Address Line 2: Building 2			
City: Mason	State: OH	Zip Code: 45040	County: Warren
Business Location			
Address Line 1: 1285 Northland Drive			
Address Line 2:			
City: Mendota Heights	State: MN	Zip Code: 55120	County: Dakota
Business Location			
Address Line 1: 1831 Chestnut Street			
Address Line 2:			
City: St. Louis	State: MO	Zip Code: 63103	County: St. Louis
Business Location			
Address Line 1: 1451 Center Crossing Road			
Address Line 2:			
City: Las Vegas	State: NV	Zip Code: 89144	County: Clark
Business Location			
Address Line 1: 1330 Amerigroup Way			
Address Line 2:			
City: Virginia Beach	State: VA	Zip Code: 23464	County: City of Virginia Beach

Disclosure of Subcontractor Information (cont.)		
Are any individuals disclosed in Section 1 or 2 related to the subcontractor or an owner of the subcontractor as aspouse, parent, child, or sibling? ☐ Yes ☒ No **If yes, provide the following information for each.**		
Name of Subcontractor/ Subcontractor's Owner	**Name of Offeror's Owner**	**Relationship**

Section 2: Disclosure of Subcontractor Information

Disclosure of Subcontractor Information				
Include information about subcontractors of the Offeror in which the Offeror or owner of the Offeror has a more than 5%ownership interest and/or a management control interest. Use a new form for each subcontractor and/or ownership interest. Use a copy of this page for each subcontractor subject to disclosure.				
This response applies to: ☐ The Offeror ☒ An Owner of the Offeror				
If this applies to an owner of the offeror, name that owner (as already disclosed in Section 1, above): Anthem, Inc.				
The person or entity named as an: ☒ Ownership Interest ☐ Management Control Interest				
If there is an ownership interest, what is the ownership percentage? 100% Indirect				
If there is a management control interest, describe that interest:				
Effective Date of Ownership and/or Management Control:				
Legal Business Name of Subcontractor as Reported to the Internal Revenue Service: Meridian Resource Company, LLC				
Doing Business as Name (if applicable): N/A		Tax Identification Number (required): 39-2013971		
Primary Business Address				
Line 1 (Street Name and Number): N17W24340 Riverwood Drive				
Address Line 2 (Suite, Room, etc.):				
City: Waukesha	State: WI	Zip Code: 53188	County: Waukesha	
Mailing Address (P.O. Box): N17W24340 Riverwood Dr	City: Waukesha	State: WI	Zip Code: 53188	County: Waukesha
Additional Business Location(s): Duplicate this page to provide all locations if necessary.				
Address Line 1: P.O. Box 659940				
Address Line 2:				
City: San Antonio	State: TX	Zip Code: 78265	County: Bexar	
Business Location				
Address Line 1: 13550 Triton Park Blvd.				
Address Line 2:				
City: Louisville	State: KY	Zip Code: 40223	County: Jefferson	
Business Location				
Address Line 1:				
Address Line 2:				
City:	State:	Zip Code:	County:	

Disclosure of Subcontractor Information (cont.)		
Are any individuals disclosed in Section 1 or 2 related to the subcontractor or an owner of the subcontractor as aspouse, parent, child, or sibling? ☐ Yes ☒ No **If yes, provide the following information for each.**		
Name of Subcontractor/ Subcontractor's Owner	**Name of Offeror's Owner**	**Relationship**
N/A		

CONFIDENTIAL

Management Qualification: 4.3.2.1 Information to Be Disclosed

Management Qualification: 4.3.2.1 Information to Be Disclosed

[redacted]

Management Qualification: 4.3.2.1 Information to Be Disclosed

[redacted]

Management Qualification: 4.3.2.1 Information to Be Disclosed

[redacted]

[redacted]

Management Qualification: 4.3.2.1 Information to Be Disclosed

[redacted]

Management Qualification: 4.3.2.1 Information to Be Disclosed

[redacted]

Management Qualification: 4.3.2.1 Information to Be Disclosed

[redacted]

Management Qualification: 4.3.2.1 Information to Be Disclosed

[redacted]

Management Qualification: 4.3.2.1 Information to Be Disclosed

[redacted]

[redacted]

CONFIDENTIAL

Management Qualification: 4.3.2.1 Information to Be Disclosed

[END OF RESPONSE]

Management Qualification: 4.3.2.2 When and to Whom Information Will Be Disclosed

Response to 4.3.2.2 When and to Whom Information Will Be Disclosed (Marked) – Pass/Fail

The Offeror attests to and affirms the following:

In accordance with 42 C.F.R. § 455.104(c), disclosures from the Offeror/winning Contractor are due at any of the following times:

1. Upon the Contractor submitting a qualification in accordance with the State's procurement process;
2. Annually, including upon the execution, renewal, and extension of the contract with the State; and,
3. Within thirty-five (35) days after any change in ownership of the Contractor.

In accordance with 42 C.F.R. § 455.104(d), all disclosures shall be provided to the Division, the State's designated Medicaid agency.

The Offeror attests that the disclosures made as part of this application are true and correct, and the Offeror will make required disclosures as necessary for this RFQ. If the Offeror is chosen as a Contractor, the Offeror will comply with all disclosure requirements.

Amerigroup Mississippi, Inc.
Name of Offeror

Tara Clark
Printed name of person attesting for Offeror

President and Chief Executive Officer
Title of person attesting for Offeror

Signature of person attesting for Offeror

3/2/2022
Date

Management Qualification: 4.3.2.3 Information Related to Business Transactions

Response to 4.3.2.3 Information Related to Business Transactions (Marked) – Pass/Fail

In accordance with 42 C.F.R. § 455.105, the Offeror shall fully disclose all information related to business transactions. The Contractor shall submit full and complete information about:

1. The ownership of any subcontractor with whom the Offeror has had business transactions totaling more than twenty-five thousand dollars and zero cents ($25,000.00) during the twelve (12)-month period ending on the date of the request and,

2. Any significant business transactions between the Offeror and any wholly owned supplier, or between the Contractor and any subcontractor, during the five (5)-year period ending on the date of the request.

The date of the request is the issue date of the RFQ.

If the Offeror has information responsive to this request, use the forms in the following pages of this Attachment to respond to this request.

If the Offeror does not have information responsive to one or both of these requests, attest to that by signing below and submitting this page as the response to this request. If the Offeror has information responsive to one of these requests and not the other, use the following attestation as applicable as well as the applicable form to respond.

The Offeror does not have:

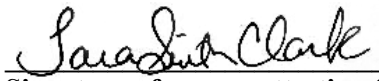
[x] The ownership of any subcontractor with whom the Offeror has had business transactions totaling more than twenty-five thousand dollars and zero cents ($25,000.00) during the twelve (12)-month period ending on the date of the request.

[x] Any significant business transactions between the Offeror and any wholly owned supplier, or between the Contractor and any subcontractor, during the five (5)-year period ending on the date of the request.

Amerigroup Mississippi, Inc.
Name of Offeror

Tara Clark
Printed name of person attesting for Offeror

President and Chief Executive Officer
Title of person attesting for Offeror


Signature of person attesting for Offeror

3/2/2022
Date

4.3.2.4 Change of Ownership

Change of Ownership

Amerigroup Mississippi, Inc. (Amerigroup) acknowledges that a change of ownership of the Offeror includes, but is not limited to, inter vivo gifts, purchases, transfers, lease arrangements, case and/or stock transactions, or other comparable arrangements whenever the person or entity acquires a majority interest (50.1%) of the Offeror. We understand that the change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer-seller relationship.

We acknowledge and will comply with all laws of the State of Mississippi and the Mississippi Department of Insurance requirements regarding change of ownership of the Contractor.

We will notify the Division of Medicaid (the Division) in writing prior to the effective date of the sale should it undergo a change of direct ownership. We acknowledge that any new owner must complete a new Contract with the Division, Members will be notified, and that any change of ownership does not relieve the previous owner of liability under the previous Contract.

Because our parent company, Anthem, Inc., is publicly traded on the New York Stock Exchange, we acknowledge that changes in beneficial ownership will be reported to the Division in writing within sixty (60) calendar days of the end of each quarter.

Disclosures

We do not have a disclosure to make that is responsive to this section; therefore, no explanation of the circumstances surrounding the change of ownership is needed or included.

Attestation

Should we be a winning Contractor, we will comply with the duty to disclose any change(s) of ownership during the life of the Contract.

Appendix G

As required, we provide a completed and signed attestation in our response to Section 4.3.2.4, Change of Ownership, of Appendix G: Ownership and Financial Disclosure Information.

Management Qualification: 4.3.2.4 Change of Ownership

Response to 4.3.2.4 Change of Ownership (Marked) – Pass/Fail

If the Offeror has a disclosure to make that is responsive to this section, the Offeror must include an explanation of the circumstances surrounding the Change of Ownership. The Offeror must also include in its response an attestation that, should the Offeror be a winning Contractor, it will comply with the duty to disclose any Change(s) of Ownership during the life of the Contract.

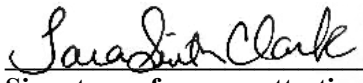
If the Offeror does not have a disclosure to make that is responsive to this request, the offeror must sign below, attesting to the following:

- The Offeror does not have a disclosure that is responsive to this request.
- Should the Offeror be chosen as a winning Contractor, the Offeror will comply with the requirement to disclose any and all changes of ownership in the time and manner required by the C.F.R. and the Division.

Amerigroup Mississippi, Inc.
Name of Offeror

Tara Clark
Printed name of person attesting for Offeror

President and Chief Executive Officer
Title of person attesting for Offeror


Signature of person attesting for Offeror

3/2/2022
Date

[END OF RESPONSE]

4.3.2.5 Disclosure of Identity of Any Person Convicted of a Criminal Offense

Disclosure of Identity of Any Person Convicted of a Criminal Offense

Amerigroup Mississippi, Inc. (Amerigroup) attests that no person or entity with ownership or control interest in Amerigroup, or who is an agent or managing employee of Amerigroup, has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Titles XIX or XXI services program since the inception of those programs. As such, we do not have a disclosure to make that is responsive to this request.

We have completed the attestation included in Appendix G as our response to this section.

In accordance with 42 C.F.R. § 455.106(a), Amerigroup agrees that if it is selected as a winning Contractor through this Request for Qualifications, it will disclose (in the time and manner required by the C.F.R. and the Division of Medicaid) the identity of any person who:

1. Has ownership or control interest in Amerigroup, or is an agent or managing employee of Amerigroup; and,
2. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Titles XIX or XXI services program since the inception of those programs.

Management Qualification: 4.3.2.5 Disclosure of Identity of Any Person Convicted of a Criminal Offense (Marked) – Pass/Fail

Response to 4.3.2.5 Disclosure of Identity of Any Person Convicted of a Criminal Offense (Marked) – Pass/Fail

If the Offeror has information responsive to this request, provide that information using the form on the following page. The Offeror must also include in its response an attestation that, should the Offeror be a winning Contractor, it will comply with the duty to disclose make disclosures regarding this issue during the life of the Contract.

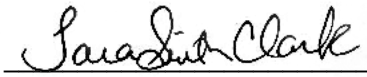
If the Offeror does not have a disclosure to make that is responsive to this request, the offeror must sign below, attesting to the following:

- The Offeror does not have a disclosure that is responsive to this request.
- Should the Offeror be chosen as a winning Contractor, the Offeror will comply with the requirement to make disclosures regarding this issue in the time and manner required by the C.F.R. and the Division.

Amerigroup Mississippi, Inc.
Name of Offeror

Tara Clark
Printed name of person attesting for Offeror

President and Chief Executive Officer
Title of person attesting for Offeror


Signature of person attesting for Offeror

3/2/2022
Date

4.3.2.6 Audited Financial Statements and Pro Forma Financial Template

Financial Statements for Past Three Years

As the contracting entity, Amerigroup Mississippi, Inc. (Amerigroup) has provided annual filed financial statements. Each statement details required elements, including our health plan's statement of income, balance sheet, statement of changes in financial position during the past three years, statement of cash flow, notes to financial statements, and summary of significant accounting policies.

Amerigroup does not currently write any risk business; therefore, we have provided unaudited financial statements along with written proof of exemption from the Mississippi Insurance Department. Per Mississippi Code ANN 83-5-104, insurers having direct premiums written of less than $1 million ($1,000,000.00) in any calendar year, and fewer than 1,000 policyholders or certificate holders of directly written policies nationwide at the end of such calendar year shall be exempt from Sections 83-5-101 through 83-5-113 for such year.

We have provided Amerigroup's annual financial statements in Attachment 4.3.2.6-1 including:

- Attachment 4.3.2.6-1a. 2018, Amerigroup Mississippi, Inc. Annual Financial Statements
- Attachment 4.3.2.6-1b. 2019, Amerigroup Mississippi, Inc. Annual Financial Statements
- Attachment 4.3.2.6-1c. 2020, Amerigroup Mississippi, Inc. Annual Financial Statements

Please refer to Attachment 4.2.3.6-2 for our audited financial statement exemption letters, including:

- Attachment 4.3.2.6-2a. 2018, Audited Financial Statement Exemption for Amerigroup Mississippi, Inc.
- Attachment 4.3.2.6-2b. 2019, Audited Financial Statement Exemption for Amerigroup Mississippi, Inc.
- Attachment 4.3.2.6-2c. 2020, Audited Financial Statement Exemption for Amerigroup Mississippi, Inc.

Although Amerigroup is well funded and financially stable, our parent company, Anthem, Inc., provides us with the ability to obtain any necessary financial support. Amerigroup is the wholly owned subsidiary of Anthem, Inc. (New York Stock Exchange ticker: ANTM), which has access to revolving credit facilities totaling $3.5 billion. As evidence of our parent company's financial strength, we have provided Anthem Inc.'s audited financial statements for the past three years in Attachment 4.3.2.6-3, including:

- Attachment 4.3.2.6-3a. Anthem, Inc. Form 10-K-2018
- Attachment 4.3.2.6-3b. Anthem, Inc. Form 10-K-2019
- Attachment 4.3.2.6-3c. Anthem, Inc. Form 10-K-2020

1. Documentation of Available Lines of Credit

As of September 30, 2021, Anthem, Inc. held $1.4 billion in cash and investments and maintained revolving credit lines of $3.5 billion that could be used if necessary. We have provided Anthem Inc.'s most recent 10-Q filed for September 30, 2021, as Attachment 4.3.2.6-4, Anthem Inc. Form 10-Q-2021. These statements include information about our parent company's maximum credit lines and amounts available before submission. Page 28 of the 10-Q states that Anthem, Inc. has a senior revolving credit facility (the "5-Year Facility") with a group of lenders for general corporate purposes. The 5-Year Facility provides credit up to $2.5 billion and matures in June 2024. On June 3, 2021, we terminated our 364-day senior revolving credit facility, which was scheduled to mature in June 2021 (the "prior 364-Day Facility"), and entered into a new 364-day senior revolving credit facility (the "new 364-Day Facility" and together with the 5-Year Facility, the "Credit Facilities") with a group of lenders for general corporate purposes. The new 364-Day Facility provides for credit in the amount of $1 billion and matures in June 2022. Our ability to borrow under these Credit Facilities is subject to compliance with certain covenants, including covenants requiring us to maintain a defined debt-to-capital ratio of not more than 60%, subject to increase in certain circumstances set forth in the applicable credit agreement. As of September 30, 2021, our debt-to-capital ratio, as defined and calculated under the Credit Facilities, was 38.9%. We do not believe the restrictions contained in any of our Credit Facility covenants materially affect our

financial or operating flexibility. As of September 30, 2021, we were in compliance with all the debt covenants under these Credit Facilities. No amounts were outstanding under the prior 364-Day Facility or the new 364-Day Facility at any time during the nine months ending September 30, 2021, or the year ending December 31, 2020. On September 30, 2021, and December 31, 2020, no amounts were outstanding under our 5-Year Facility.

2. Three-Year Financial Pro Forma

Please refer to Appendix G: Financial Pro Forma Template for our completed three-year pro forma template.

4.3.2.6 Audited Financial Statements and Pro Forma Financial Template

4.3.2.6 Audited Financial Statements and Pro Forma Financial Template attachments include the following:

- Attachment 4.3.2.6-1: Amerigroup Mississippi, Inc., Annual Financial Statements
  - Attachment 4.3.2.6-1a: 2018 Amerigroup Mississippi, Inc., Annual Financial Statements
  - Attachment 4.3.2.6-1b: 2019 Amerigroup Mississippi, Inc., Annual Financial Statements
  - Attachment 4.3.2.6-1c: 2020 Amerigroup Mississippi, Inc., Annual Financial Statements
- Attachment 4.3.2.6-2: Audited Financial Statement Exemption for Amerigroup Mississippi, Inc.
  - Attachment 4.3.2.6-2a: 2018 Audited Financial Statement Exemption for Amerigroup Mississippi, Inc
  - Attachment 4.3.2.6-2b: 2019 Audited Financial Statement Exemption for Amerigroup Mississippi, Inc.
  - Attachment 4.3.2.6-2c: 2020 Audited Financial Statement Exemption for Amerigroup Mississippi, Inc.
- Attachment 4.3.2.6-3: Anthem, Inc. Financials
  - Attachment 4.3.2.6-3a: Anthem, Inc. Form 10-K-2018
  - Attachment 4.3.2.6-3b: Anthem, Inc. Form 10-K-2019
  - Attachment 4.3.2.6-3c: Anthem, Inc. Form 10-K-2020
- Attachment 4.3.2.6-4: Anthem, Inc. Form 10-Q-2021
- Appendix G: Financial Pro Forma Template

ANNUAL STATEMENT

OF THE

Amerigroup Mississippi, Inc.

TO THE

Insurance Department

OF THE

STATE OF

FOR THE YEAR ENDED
DECEMBER 31, 2018

HEALTH

2018

1 6 1 4 5 2 0 1 8 2 0 1 0 0 1 0 0

HEALTH ANNUAL STATEMENT

FOR THE YEAR ENDED DECEMBER 31, 2018
OF THE CONDITION AND AFFAIRS OF THE

Amerigroup Mississippi, Inc.

NAIC Group Code 0671 (Current) 0671 (Prior) NAIC Company Code 16145 Employer's ID Number 81-4626605

Organized under the Laws of Mississippi, State of Domicile or Port of Entry MS

Country of Domicile United States of America

Licensed as business type: Health Maintenance Organization

Is HMO Federally Qualified? Yes [ ] No [X]

Incorporated/Organized 12/06/2016 Commenced Business

Statutory Home Office 645 Lakeland East Drive-Suite 101 (Street and Number), Flowwood, MS, US 39232 (City or Town, State, Country and Zip Code)

Main Administrative Office 220 Virginia Avenue (Street and Number)
Indianapolis, IN, US 46204 (City or Town, State, Country and Zip Code), (Area Code) (Telephone Number)

Mail Address 220 Virginia Avenue (Street and Number or P.O. Box), Indianapolis, IN, US 46204 (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 220 Virginia Avenue (Street and Number)
Indianapolis, IN, US 46204 (City or Town, State, Country and Zip Code), (Area Code) (Telephone Number)

Internet Website Address www.amerigroup.com

Statutory Statement Contact Tim Niccum (Name), 317-488-6716 (Area Code) (Telephone Number)
tim.niccum@anthem.com (E-mail Address), 317-488-6523 (FAX Number)

OFFICERS

President Francesca Deborah Gary # Treasurer Vincent Edward Scher #
Secretary Kathleen Susan Kieler Assistant Secretary Jack Louis Young

OTHER

Eric (Rick) Kenneth Noble, Assistent Treasurer

DIRECTORS OR TRUSTEES

Jack Louis Young, Catherine Irene Kelaghan, Francesca Deborah Gary #

State of Indiana
County of Marion SS:

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Francesca Deborah Gary President/Chairperson	Kathleen Susan Kieler Secretary	Vincent Edward Scher Treasurer

Subscribed and sworn to before me this 30th day of April 2019

a. Is this an original filing? Yes [ ] No [X]
b. If no,
1. State the amendment number
2. Date filed
3. Number of pages attached

Rita F. Gentry
Executive Admin Assistant I
January 17, 2021

Rita F. Gentry
Notary Public
Seal
Marion County, State of Indiana
Commission Expires January 17, 2021
Commission No 641321

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

ASSETS

	Current Year 1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	Prior Year 4 Net Admitted Assets
1. Bonds (Schedule D)	575,461		575,461	586,623
2. Stocks (Schedule D):				
2.1 Preferred stocks			0	
2.2 Common stocks			0	
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens			0	
3.2 Other than first liens			0	
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less $ ..... encumbrances)			0	
4.2 Properties held for the production of income (less $ ..... encumbrances)			0	
4.3 Properties held for sale (less $ ..... encumbrances)			0	
5. Cash ($ 3,442,636 , Schedule E - Part 1), cash equivalents ($ 0 , Schedule E - Part 2) and short-term investments ($ ..... , Schedule DA)	3,442,636		3,442,636	3,428,630
6. Contract loans, (including $ ..... premium notes)			0	
7. Derivatives (Schedule DB)			0	0
8. Other invested assets (Schedule BA)			0	
9. Receivables for securities			0	0
10. Securities lending reinvested collateral assets (Schedule DL)			0	0
11. Aggregate write-ins for invested assets	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	4,018,097	0	4,018,097	4,015,253
13. Title plants less $ ..... charged off (for Title insurers only)		0	0	
14. Investment income due and accrued	7,361	0	7,361	7,361
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection		0	0	0
15.2 Deferred premiums and agents' balances and installments booked but deferred and not yet due (including $ ..... earned but unbilled premiums)		0	0	
15.3 Accrued retrospective premiums ($ .....) and contracts subject to redetermination ($ .....)		0	0	0
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers		0	0	
16.2 Funds held by or deposited with reinsured companies		0	0	
16.3 Other amounts receivable under reinsurance contracts		0	0	
17. Amounts receivable relating to uninsured plans		0	0	0
18.1 Current federal and foreign income tax recoverable and interest thereon	1,622	0	1,622	0
18.2 Net deferred tax asset		0	0	0
19. Guaranty funds receivable or on deposit		0	0	
20. Electronic data processing equipment and software		0	0	
21. Furniture and equipment, including health care delivery assets ($ .....)		0	0	0
22. Net adjustment in assets and liabilities due to foreign exchange rates		0	0	
23. Receivables from parent, subsidiaries and affiliates	8,781	0	8,781	0
24. Health care ($ .....) and other amounts receivable		0	0	0
25. Aggregate write-ins for other than invested assets	0	0	0	0
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	4,035,861	0	4,035,861	4,022,614
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0	
28. Total (Lines 26 and 27)	4,035,861	0	4,035,861	4,022,614
DETAILS OF WRITE-INS				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199. Totals (Lines 1101 thru 1103 plus 1198)(Line 11 above)	0	0	0	0
2501.				
2502.				
2503.				
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	0	0	0	0

LIABILITIES, CAPITAL AND SURPLUS

	Current Year 1 Covered	2 Uncovered	3 Total	Prior Year 4 Total
1. Claims unpaid (less $ ..... reinsurance ceded)		0	0	0
2. Accrued medical incentive pool and bonus amounts		0	0	0
3. Unpaid claims adjustment expenses		0	0	0
4. Aggregate health policy reserves, including the liability of $ ..... for medical loss ratio rebate per the Public Health Service Act		0	0	0
5. Aggregate life policy reserves		0	0	
6. Property/casualty unearned premium reserves		0	0	
7. Aggregate health claim reserves		0	0	
8. Premiums received in advance		0	0	
9. General expenses due or accrued	1,280	0	1,280	963
10.1 Current federal and foreign income tax payable and interest thereon (including $ ..... on realized capital gains (losses))		0	0	543
10.2 Net deferred tax liability	9	0	9	9
11. Ceded reinsurance premiums payable		0	0	
12. Amounts withheld or retained for the account of others		0	0	
13. Remittances and items not allocated		0	0	
14. Borrowed money (including $ ..... current) and interest thereon $ ..... (including $ ..... current)		0	0	
15. Amounts due to parent, subsidiaries and affiliates		0	0	7,109
16. Derivatives		0	0	
17. Payable for securities		0	0	0
18. Payable for securities lending		0	0	0
19. Funds held under reinsurance treaties (with $ ..... authorized reinsurers, $ .....0 unauthorized reinsurers and $ .....0 certified reinsurers)		0	0	
20. Reinsurance in unauthorized and certified ($ .....) companies		0	0	
21. Net adjustments in assets and liabilities due to foreign exchange rates		0	0	
22. Liability for amounts held under uninsured plans		0	0	0
23. Aggregate write-ins for other liabilities (including $ ..... current)	0	0	0	0
24. Total liabilities (Lines 1 to 23)	1,289	0	1,289	8,624
25. Aggregate write-ins for special surplus funds	XXX	XXX	0	0
26. Common capital stock	XXX	XXX	1,000	1,000
27. Preferred capital stock	XXX	XXX		
28. Gross paid in and contributed surplus	XXX	XXX	3,999,000	3,999,000
29. Surplus notes	XXX	XXX		
30. Aggregate write-ins for other than special surplus funds	XXX	XXX	0	0
31. Unassigned funds (surplus)	XXX	XXX	34,572	13,990
32. Less treasury stock, at cost:				
32.1 ..... shares common (value included in Line 26 $ .....)	XXX	XXX		
32.2 ..... shares preferred (value included in Line 27 $ .....)	XXX	XXX		
33. Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	4,034,572	4,013,990
34. Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	4,035,861	4,022,614
DETAILS OF WRITE-INS				
2301.				
2302.				
2303.				
2398. Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399. Totals (Lines 2301 thru 2303 plus 2398)(Line 23 above)	0	0	0	0
2501.	XXX	XXX		
2502.	XXX	XXX		
2503.	XXX	XXX		
2598. Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	XXX	XXX	0	0
3001.	XXX	XXX		
3002.	XXX	XXX		
3003.	XXX	XXX		
3098. Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099. Totals (Lines 3001 thru 3003 plus 3098)(Line 30 above)	XXX	XXX	0	0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

STATEMENT OF REVENUE AND EXPENSES

		Current Year 1 Uncovered	Current Year 2 Total	Prior Year 3 Total
1.	Member Months	XXX		
2.	Net premium income (including $ non-health premium income)	XXX	0	
3.	Change in unearned premium reserves and reserve for rate credits	XXX	0	
4.	Fee-for-service (net of $ medical expenses)	XXX	0	
5.	Risk revenue	XXX	0	
6.	Aggregate write-ins for other health care related revenues	XXX	0	0
7.	Aggregate write-ins for other non-health revenues	XXX	0	0
8.	Total revenues (Lines 2 to 7)	XXX	0	0
	Hospital and Medical:			
9.	Hospital/medical benefits		0	
10.	Other professional services		0	
11.	Outside referrals		0	
12.	Emergency room and out-of-area		0	
13.	Prescription drugs		0	
14.	Aggregate write-ins for other hospital and medical	0	0	0
15.	Incentive pool, withhold adjustments and bonus amounts		0	
16.	Subtotal (Lines 9 to 15)	0	0	0
	Less:			
17.	Net reinsurance recoveries		0	
18.	Total hospital and medical (Lines 16 minus 17)	0	0	0
19.	Non-health claims (net)			
20.	Claims adjustment expenses, including $ 0 cost containment expenses		0	0
21.	General administrative expenses		2,341	0
22.	Increase in reserves for life and accident and health contracts (including $ increase in reserves for life only)		0	0
23.	Total underwriting deductions (Lines 18 through 22)	0	2,341	0
24.	Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	(2,341)	0
25.	Net investment income earned (Exhibit of Net Investment Income, Line 17)		23,955	16,276
26.	Net realized capital gains (losses) less capital gains tax of $			0
27.	Net investment gains (losses) (Lines 25 plus 26)	0	23,955	16,276
28.	Net gain or (loss) from agents' or premium balances charged off [(amount recovered $) (amount charged off $)]			0
29.	Aggregate write-ins for other income or expenses	0	0	0
30.	Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	21,614	16,276
31.	Federal and foreign income taxes incurred	XXX	1,032	2,277
32.	Net income (loss) (Lines 30 minus 31)	XXX	20,582	13,999
	DETAILS OF WRITE-INS			
0601.		XXX		
0602.		XXX		
0603		XXX		
0698.	Summary of remaining write-ins for Line 6 from overflow page	XXX	0	0
0699.	Totals (Lines 0601 thru 0603 plus 0698)(Line 6 above)	XXX	0	0
0701.		XXX		
0702.		XXX		
0703		XXX		
0798.	Summary of remaining write-ins for Line 7 from overflow page	XXX	0	0
0799.	Totals (Lines 0701 thru 0703 plus 0798)(Line 7 above)	XXX	0	0
1401.				
1402.				
1403.				
1498.	Summary of remaining write-ins for Line 14 from overflow page	0	0	0
1499.	Totals (Lines 1401 thru 1403 plus 1498)(Line 14 above)	0	0	0
2901.				
2902.				
2903				
2998.	Summary of remaining write-ins for Line 29 from overflow page	0	0	0
2999.	Totals (Lines 2901 thru 2903 plus 2998)(Line 29 above)	0	0	0

STATEMENT OF REVENUE AND EXPENSES (Continued)

		1 Current Year	2 Prior Year
	CAPITAL AND SURPLUS ACCOUNT		
33.	Capital and surplus prior reporting year	4,013,990	0
34.	Net income or (loss) from Line 32	20,582	13,999
35.	Change in valuation basis of aggregate policy and claim reserves		
36.	Change in net unrealized capital gains (losses) less capital gains tax of $		
37.	Change in net unrealized foreign exchange capital gain or (loss)		
38.	Change in net deferred income tax		(9)
39.	Change in nonadmitted assets		0
40	Change in unauthorized and certified reinsurance	0	
41.	Change in treasury stock	0	
42.	Change in surplus notes	0	
43.	Cumulative effect of changes in accounting principles		
44.	Capital Changes:		
	44.1 Paid in	0	1,000
	44.2 Transferred from surplus (Stock Dividend)	0	
	44.3 Transferred to surplus		
45.	Surplus adjustments:		
	45.1 Paid in	0	3,999,000
	45.2 Transferred to capital (Stock Dividend)		
	45.3 Transferred from capital		
46.	Dividends to stockholders		
47.	Aggregate write-ins for gains or (losses) in surplus	0	0
48.	Net change in capital and surplus (Lines 34 to 47)	20,582	4,013,990
49.	Capital and surplus end of reporting period (Line 33 plus 48)	4,034,572	4,013,990
	DETAILS OF WRITE-INS		
4701.			
4702.			
4703.			
4798.	Summary of remaining write-ins for Line 47 from overflow page	0	0
4799.	Totals (Lines 4701 thru 4703 plus 4798)(Line 47 above)	0	0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

CASH FLOW

		1 Current Year	2 Prior Year
	Cash from Operations		
1.	Premiums collected net of reinsurance	0	0
2.	Net investment income	35,117	17,842
3.	Miscellaneous income	0	
4.	Total (Lines 1 through 3)	35,117	17,842
5.	Benefit and loss related payments	0	0
6.	Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts		
7.	Commissions, expenses paid and aggregate write-ins for deductions	2,023	(963)
8.	Dividends paid to policyholders		
9.	Federal and foreign income taxes paid (recovered) net of $ tax on capital gains (losses)	3,197	1,734
10.	Total (Lines 5 through 9)	5,220	771
11.	Net cash from operations (Line 4 minus Line 10)	29,897	17,071
	Cash from Investments		
12.	Proceeds from investments sold, matured or repaid:		
	12.1 Bonds	0	0
	12.2 Stocks	0	
	12.3 Mortgage loans	0	
	12.4 Real estate	0	
	12.5 Other invested assets	0	
	12.6 Net gains or (losses) on cash, cash equivalents and short-term investments	0	0
	12.7 Miscellaneous proceeds	0	0
	12.8 Total investment proceeds (Lines 12.1 to 12.7)	0	0
13.	Cost of investments acquired (long-term only):		
	13.1 Bonds	0	595,550
	13.2 Stocks	0	
	13.3 Mortgage loans	0	
	13.4 Real estate	0	
	13.5 Other invested assets	0	
	13.6 Miscellaneous applications	0	0
	13.7 Total investments acquired (Lines 13.1 to 13.6)	0	595,550
14.	Net increase (decrease) in contract loans and premium notes	0	
15.	Net cash from investments (Line 12.8 minus Line 13.7 minus Line 14)	0	(595,550)
	Cash from Financing and Miscellaneous Sources		
16.	Cash provided (applied):		
	16.1 Surplus notes, capital notes	0	
	16.2 Capital and paid in surplus, less treasury stock	0	4,000,000
	16.3 Borrowed funds	0	
	16.4 Net deposits on deposit-type contracts and other insurance liabilities	0	
	16.5 Dividends to stockholders	0	
	16.6 Other cash provided (applied)	(15,891)	7,109
17.	Net cash from financing and miscellaneous sources (Lines 16.1 to 16.4 minus Line 16.5 plus Line 16.6)	(15,891)	4,007,109
	RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS		
18.	Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	14,006	3,428,630
19.	Cash, cash equivalents and short-term investments:		
	19.1 Beginning of year	3,428,630	0
	19.2 End of year (Line 18 plus Line 19.1)	3,442,636	3,428,630

Note: Supplemental disclosures of cash flow information for non-cash transactions:

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

ANALYSIS OF OPERATIONS BY LINES OF BUSINESS

	1 Total	2 Comprehensive (Hospital & Medical)	3 Medicare Supplement	4 Dental Only	5 Vision Only	6 Federal Employees Health Benefits Plan	7 Title XVIII Medicare	8 Title XIX Medicaid	9 Other Health	10 Other Non-Health
1. Net premium income	0									
2. Change in unearned premium reserves and reserve for rate credit	0									
3. Fee-for-service (net of $ ..... medical expenses)	0									XXX
4. Risk revenue	0									XXX
5. Aggregate write-ins for other health care related revenues	0	0	0	0	0	0	0	0	0	XXX
6. Aggregate write-ins for other non-health care related revenues	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
7. Total revenues (Lines 1 to 6)	0	0	0	0	0	0	0	0	0	0
8. Hospital/medical benefits	0									XXX
9. Other professional services	0									XXX
10. Outside referrals	0									XXX
11. Emergency room and out-of-area	0									XXX
12. Prescription drugs	0									XXX
13. Aggregate write-ins for other hospital and medical	0	0	0	0	0	0	0	0	0	XXX
14. Incentive pool, withhold adjustments and bonus amounts	0									XXX
15. Subtotal (Lines 8 to 14)	0	0	0	0	0	0	0	0	0	XXX
16. Net reinsurance recoveries	0									XXX
17. Total medical and hospital (Lines 15 minus 16)	0	0	0	0	0	0	0	0	0	XXX
18. Non-health claims (net)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
19. Claims adjustment expenses including $ ..... cost containment expenses	0									
20. General administrative expenses	2,341								2,341	
21. Increase in reserves for accident and health contracts	0									XXX
22. Increase in reserves for life contracts	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
23. Total underwriting deductions (Lines 17 to 22)	2,341	0	0	0	0	0	0	0	2,341	0
24. Total underwriting gain or (loss) (Line 7 minus Line 23)	(2,341)	0	0	0	0	0	0	0	(2,341)	0
DETAILS OF WRITE-INS										
0501.										XXX
0502.										XXX
0503.										XXX
0598. Summary of remaining write-ins for Line 5 from overflow page	0	0	0	0	0	0	0	0	0	XXX
0599. Totals (Lines 0501 thru 0503 plus 0598) (Line 5 above)	0	0	0	0	0	0	0	0	0	XXX
0601.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0602.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0603.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0698. Summary of remaining write-ins for Line 6 from overflow page	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
0699. Totals (Lines 0601 thru 0603 plus 0698) (Line 6 above)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
1301.										XXX
1302.										XXX
1303.										XXX
1398. Summary of remaining write-ins for Line 13 from overflow page	0	0	0	0	0	0	0	0	0	XXX
1399. Totals (Lines 1301 thru 1303 plus 1398) (Line 13 above)	0	0	0	0	0	0	0	0	0	XXX

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Underwriting and Investment Exhibit - Part 1 - Premiums

N O N E

Underwriting and Investment Exhibit - Part 2 - Claims Incurred

N O N E

Underwriting and Investment Exhibit - Part 2A - Claims Liability

N O N E

Underwriting and Investment Exhibit - Part 2B - Analysis of Claims

N O N E

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
($000 Omitted)

Section A - Paid Health Claims -

NONE

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2014	2 2015	3 2016	4 2017	5 2018
1. Prior					
2. 2014					
3. 2015	XXX				
4. 2016	XXX	XXX			
5. 2017	XXX	XXX	XXX		
6. 2018	XXX	XXX	XXX	XXX	

Section B - Incurred Health Claims -

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2014	2 2015	3 2016	4 2017	5 2018
1. Prior					
2. 2014					
3. 2015	XXX				
4. 2016	XXX	XXX			
5. 2017	XXX	XXX	XXX		
6. 2018	XXX	XXX	XXX	XXX	

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio -

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2014										
2. 2015										
3. 2016										
4. 2017										
5. 2018										

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ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2D - AGGREGATE RESERVE FOR ACCIDENT AND HEALTH CONTRACTS ONLY

	1 Total	2 Comprehensive (Hospital & Medical)	3 Medicare Supplement	4 Dental Only	5 Vision Only	6 Federal Employees Health Benefits Plan	7 Title XVIII Medicare	8 Title XIX Medicaid	9 Other
1. Unearned premium reserves									
2. Additional policy reserves (a)									
3. Reserve for future contingent benefits									
4. Reserve for rate credits or experience rating refunds (including $ .....) for investment income									
5. Aggregate write-ins for other policy reserves									
6. Totals (gross)									
7. Reinsurance ceded									
8. Totals (Net)(Page 3, Line 4)									
9. Present value of amounts not yet due on claims									
10. Reserve for future contingent benefits									
11. Aggregate write-ins for other claim reserves									
12. Totals (gross)									
13. Reinsurance ceded									
14. Totals (Net)(Page 3, Line 7)									
DETAILS OF WRITE-INS									
0501.									
0502.									
0503.									
0598. Summary of remaining write-ins for Line 5 from overflow page									
0599. Totals (Lines 0501 thru 0503 plus 0598) (Line 5 above)									
1101.									
1102.									
1103.									
1198. Summary of remaining write-ins for Line 11 from overflow page									
1199. Totals (Lines 1101 thru 1103 plus 1198) (Line 11 above)									

NONE

(a) Includes $ ..... premium deficiency reserve.

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ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 3 - ANALYSIS OF EXPENSES

	Claim Adjustment Expenses		3	4	5
	1 Cost Containment Expenses	2 Other Claim Adjustment Expenses	General Administrative Expenses	Investment Expenses	Total
1. Rent ($ ..... for occupancy of own building)					0
2. Salary, wages and other benefits					0
3. Commissions (less $ ..... ceded plus $ ..... assumed)					0
4. Legal fees and expenses					0
5. Certifications and accreditation fees					0
6. Auditing, actuarial and other consulting services					0
7. Traveling expenses					0
8. Marketing and advertising					0
9. Postage, express and telephone					0
10. Printing and office supplies					0
11. Occupancy, depreciation and amortization					0
12. Equipment					0
13. Cost or depreciation of EDP equipment and software					0
14. Outsourced services including EDP, claims, and other services					0
15. Boards, bureaus and association fees					0
16. Insurance, except on real estate					0
17. Collection and bank service charges					0
18. Group service and administration fees					0
19. Reimbursements by uninsured plans					0
20. Reimbursements from fiscal intermediaries					0
21. Real estate expenses					0
22. Real estate taxes					0
23. Taxes, licenses and fees:					
23.1 State and local insurance taxes					0
23.2 State premium taxes					0
23.3 Regulatory authority licenses and fees					0
23.4 Payroll taxes					0
23.5 Other (excluding federal income and real estate taxes)					0
24. Investment expenses not included elsewhere					0
25. Aggregate write-ins for expenses	0	0	2,341	8,346	10,687
26. Total expenses incurred (Lines 1 to 25)	0	0	2,341	8,346	(a) 10,687
27. Less expenses unpaid December 31, current year			1,281		1,281
28. Add expenses unpaid December 31, prior year			963		963
29. Amounts receivable relating to uninsured plans, prior year					0
30. Amounts receivable relating to uninsured plans, current year					0
31. Total expenses paid (Lines 26 minus 27 plus 28 minus 29 plus 30)	0	0	2,023	8,346	10,369
DETAILS OF WRITE-INS					
2501. Miscellaneous Expenses			2,341	8,346	10,687
2502.					
2503.					
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	0	0	2,341	8,346	10,687

(a) Includes management fees of $ 0 to affiliates and $ 0 to non-affiliates.

EXHIBIT OF NET INVESTMENT INCOME

		1 Collected During Year	2 Earned During Year
1.	U.S. government bonds	(a) 0	0
1.1	Bonds exempt from U.S. tax	(a)	
1.2	Other bonds (unaffiliated)	(a) 13,838	13,838
1.3	Bonds of affiliates	(a) 0	0
2.1	Preferred stocks (unaffiliated)	(b) 0	0
2.11	Preferred stocks of affiliates	(b) 0	0
2.2	Common stocks (unaffiliated)	0	0
2.21	Common stocks of affiliates	0	0
3.	Mortgage loans	(c) 0	0
4.	Real estate	(d) 0	0
5	Contract Loans	0	0
6	Cash, cash equivalents and short-term investments	(e) 18,463	18,463
7	Derivative instruments	(f) 0	0
8.	Other invested assets	0	0
9.	Aggregate write-ins for investment income	0	0
10.	Total gross investment income	32,301	32,301
11.	Investment expenses		(g) 8,346
12.	Investment taxes, licenses and fees, excluding federal income taxes		(g) 0
13.	Interest expense		(h)
14.	Depreciation on real estate and other invested assets		(i)
15.	Aggregate write-ins for deductions from investment income		0
16.	Total deductions (Lines 11 through 15)		8,346
17.	Net investment income (Line 10 minus Line 16)		23,955
	DETAILS OF WRITE-INS		
0901.			
0902.			
0903.			
0998.	Summary of remaining write-ins for Line 9 from overflow page	0	0
0999.	Totals (Lines 0901 thru 0903 plus 0998) (Line 9, above)	0	0
1501.			
1502.			
1503.			
1598.	Summary of remaining write-ins for Line 15 from overflow page		0
1599.	Totals (Lines 1501 thru 1503 plus 1598) (Line 15, above)		0

(a) Includes $ 0 accrual of discount less $ 11,162 amortization of premium and less $ ..... paid for accrued interest on purchases.

(b) Includes $ ..... accrual of discount less $ ..... amortization of premium and less $ ..... paid for accrued dividends on purchases.

(c) Includes $ ..... accrual of discount less $ ..... amortization of premium and less $ ..... paid for accrued interest on purchases.

(d) Includes $ ..... for company's occupancy of its own buildings; and excludes $ ..... interest on encumbrances.

(e) Includes $ ..... accrual of discount less $ ..... amortization of premium and less $ ..... paid for accrued interest on purchases.

(f) Includes $ ..... accrual of discount less $ ..... amortization of premium.

(g) Includes $. ..... investment expenses and $ ..... investment taxes, licenses and fees, excluding federal income taxes, attributable to segregated and Separate Accounts.

(h) Includes $ ..... interest on surplus notes and $ ..... interest on capital notes.

(i) Includes $ ..... depreciation on real estate and $ ..... depreciation on other invested assets.

EXHIBIT OF CAPITAL GAINS (LOSSES)

		1 Realized Gain (Loss) On Sales or Maturity	2 Other Realized Adjustments	3 Total Realized Capital Gain (Loss) (Columns 1 + 2)	4 Change in Unrealized Capital Gain (Loss)	5 Change in Unrealized Foreign Exchange Capital Gain (Loss)
1.	U.S. Government bonds					
1.1	Bonds exempt from U.S. tax					
1.2	Other bonds (unaffiliated)					
1.3	Bonds of affiliates					
2.1	Preferred stocks (unaffiliated)					
2.11	Preferred stocks of affiliates					
2.2	Common stocks (unaffiliated)					
2.21	Common stocks of affiliates					
3.	Mortgage loans					
4.	Real estate					
5.	Contract loans					
6.	Cash, cash equivalents and short-term investme					
7.	Derivative instruments					
8.	Other invested assets					
9.	Aggregate write-ins for capital gains (losses)					
10.	Total capital gains (losses)					
	DETAILS OF WRITE-INS					
0901.						
0902.						
0903.						
0998.	Summary of remaining write-ins for Line 9 from overflow page					
0999.	Totals (Lines 0901 thru 0903 plus 0998) (Line 9, above)					

NONE

Exhibit of Nonadmitted Assets

N O N E

Exhibit 1 - Enrollment by Product Type for Health Business Only

N O N E

Exhibit 2 - A&H Premiums Due and Unpaid

N O N E

Exhibit 3 - Health Care Receivables

N O N E

Exhibit 3A - Health Care Receivables Collected and Accrued

N O N E

Exhibit 4 - Claims Unpaid and Incentive Pool, Withhold and Bonus

N O N E

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

EXHIBIT 5 - AMOUNTS DUE FROM PARENT, SUBSIDIARIES AND AFFILIATES

1	2	3	4	5	6	Admitted	
						7	8
Name of Affiliate	1 - 30 Days	31 - 60 Days	61 - 90 Days	Over 90 Days	Nonadmitted	Current	Non-Current
Anthem, Inc.	8,781					8,781	
0199999. Individually listed receivables	8,781	0	0	0	0	8,781	0
0299999. Receivables not individually listed							
0399999 Total gross amounts receivable	8,781	0	0	0	0	8,781	0

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Exhibit 6 - Amounts Due To Parent, Subsidiaries and Affiliates

N O N E

Exhibit 7 - Part 1 - Summary of Transactions with Providers

N O N E

Exhibit 7 - Part 2

N O N E

Exhibit 8 - Furniture and Equipment Owned

N O N E

ANNUAL STATEMENT FOR THE YEAR 2018 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies and Going Concern

A. Accounting Practices

The accompanying financial statements of AMERIGROUP Mississippi, Inc. (the "Company") have been prepared in conformity with the National Association of Insurance Commissioners' ("NAIC") *Annual Statement Instructions* and in accordance with accounting practices prescribed by the NAIC *Accounting Practices and Procedures Manual* ("NAIC SAP"), subject to any deviations prescribed or permitted by the Mississippi Insurance Department (the "Department").

A reconciliation of the Company's net income (loss) and capital and surplus between NAIC SAP and practices prescribed and permitted by the MID is shown below:

	SSAP #	F/S Page	F/S Line #	2018	2017
Net Income					
(1) AMERIGROUP Mississippi, Inc. state basis (Page 4, Line 32, Columns 2 & 4)	XXX	XXX	XXX	$ 20,582	$ 13,999
(2) State Prescribed Practices that is an increase/(decrease) from NAIC SAP:				—	—
(3) State Permitted Practices that is an increase/(decrease) from NAIC SAP:				—	—
(4) NAIC SAP (1-2-3=4)	XXX	XXX	XXX	$ 20,582	$ 13,999
Surplus					
(5) AMERIGROUP Mississippi, Inc. state basis (Page 3, Line 33, Columns 3 & 4)	XXX	XXX	XXX	$ 4,034,572	$ 4,013,990
(6) State Prescribed Practices that is an increase/(decrease) from NAIC SAP:				—	—
(7) State Permitted Practices that is an increase/(decrease) from NAIC SAP:				—	—
(8) NAIC SAP (5-6-7=8)	XXX	XXX	XXX	$ 4,034,572	$ 4,013,990

B. Use of Estimates in the Preparation of the Financial Statements

Preparation of financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

C. Accounting Policies

Health premiums are earned over the term of the related insurance policies. Premiums written are reported net of experience rating refunds. Premiums paid prior to the effective date are recorded on the balance sheet as premiums received in advance and are subsequently credited to income as earned during the coverage period. Premium rates are subject to approval by

ANNUAL STATEMENT FOR THE YEAR 2018 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

the Centers for Medicare and Medicaid Services. Expenses are charged to operations as incurred.

In addition, the Company uses the following accounting policies:

(1) Short-term investments include investments with maturities of less than one year and more than three months at the date of acquisition and are reported at amortized cost, which approximates fair value. Non-investment grade short-term investments are stated at the lower of amortized cost or fair value.
(2) Investment grade bonds not backed by other loans are stated at amortized cost, with amortization calculated based on the modified scientific method, using lower of yield to call or yield to maturity. Non-investment grade bonds are stated at the lower of amortized cost or fair value as determined by various third-party pricing sources.
(3) The Company has no investments in common stocks of unaffiliated companies.
(4) The Company has no investments in preferred stocks.
(5) The Company has no mortgage loans - real estate.
(6) The Company has no loan-backed securities.
(7) The Company has no investments in subsidiaries, controlled and affiliated companies.
(8) The Company has no investments in joint ventures, partnerships or limited liability companies.
(9) The Company has no derivative instruments.
(10) The Company does not anticipate investment income as a factor in premium deficiency calculations.
(11) Unpaid claims and claims adjustment expenses include management's best estimate of amounts based on historical claim development patterns and certain individual case estimates. The established liability considers health benefit provisions, business practices, economic conditions and other factors that may materially affect the cost, frequency and severity of claims. Liabilities for unpaid claims and claim adjustment expenses are based on assumptions and estimates, and while management believes such estimates are reasonable, the ultimate liability may be in excess of or less than the amount provided. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed and changes in estimates are incorporated into current period estimates.
(12) The Company has not modified its capitalization policy from the prior period.
(13) The Company recognizes losses from other-than-temporary impairment ("OTTI") of investments in accordance with Statements of Standard Accounting Practice ("SSAP") No. 26R, *Bonds*.

D. Going Concern

Not applicable.

2. Accounting Changes and Corrections of Errors

There were no accounting changes or corrections of errors during the years ended December 31, 2018 and 2017.

3. Business Combinations and Goodwill

A. Statutory Purchase Method	Not applicable.
B. Statutory Merger	Not applicable.
C. Assumption Reinsurance	Not applicable.
D. Impairment Loss	Not applicable.

4. Discontinued Operations

The Company had no operations that were discontinued during 2018 or 2017.

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NOTES TO FINANCIAL STATEMENTS

5. Investments

A. Mortgage Loans, including Mezzanine Real Estate Loans

The Company did not have investments in mortgage loans at December 31, 2018 or 2017.

B. Debt Restructuring

The Company did not have invested assets that were restructured debt at December 31, 2018 or 2017.

C. Reverse Mortgages

The Company did not have investments in reverse mortgages at December 31, 2018 or 2017.

D. Loan-Backed Securities

(1) The Company did not have loan-backed securities at December 31, 2018 and 2017.
(2) The Company did not recognize OTTI on its loan-backed securities during the years ended December 31, 2018 and 2017.
(3) The Company did not hold OTTI on its loan-backed securities at December 31, 2018 and 2017.
(4) The Company had no impaired securities for which an OTTI had not been recognized in earnings as a realized loss at December 31, 2018 and 2017.
(5) The Company had no impaired loan-backed securities at December 31, 2018 and 2017.

E. Dollar Repurchase Agreements and/or Securities Lending Transactions

The Company did not enter into repurchase agreements or securities lending transactions at December 31, 2018 or 2017.

F. Repurchase Agreements Transactions Accounted for as Secured Borrowing

The Company did not enter into repurchase agreement transactions accounted for as secured borrowing at December 31, 2018 or 2017.

G. Reverse Repurchase Agreements Transactions Accounted for as Secured Borrowing

The Company did not enter into reverse repurchase agreement transactions accounted for as a secured borrowing at December 31, 2018 or 2017.

H. Repurchase Agreements Transactions Accounted for as a Sale

The Company did not enter into repurchase agreement transactions accounted for as a sale at December 31, 2018 or 2017.

I. Reverse Repurchase Agreements Transactions Accounted for as a Sale

The Company did not enter into reverse repurchase agreement transactions accounted for as a secured borrowing at December 31, 2018 or 2017.

J. Real Estate

The Company did not have investments in real estate and did not engage in retail land sales operations during 2018 and 2017.

ANNUAL STATEMENT FOR THE YEAR 2018 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

K. Investments in Low-Income Housing Tax Credits

The Company did not invest in properties generating low-income housing tax credits during 2018 or 2017.

L. Restricted Assets

(1) Restricted assets (including pledged)

Restricted Asset Category	1 Total Gross (Admitted & Nonadmitted) Restricted from Current Year	2 Total Gross (Admitted & Nonadmitted) Restricted from Prior Year	3 Increase/ (Decrease) (1 minus 2)	4 Total Current Year Nonadmitted Restricted	5 Total Current Year Admitted Restricted (1 minus 4)	6 Gross Admitted and Nonadmitted Restricted to Total Assets (a)	7 Admitted Restricted to Total Admitted Assets (b)
a. Subject to contractual obligation for which liability is not shown		$ —	$ —	$ —	$ —	0.00%	0.00%
b. Collateral held under security lending agreements	—	—	—	—	—	0.00%	0.00%
c. Subject to repurchase agreements	—	—	—	—	—	0.00%	0.00%
d. Subject to reverse repurchase agreements	—	—	—	—	—	0.00%	0.00%
e. Subject to dollar repurchase agreements	—	—	—	—	—	0.00%	0.00%
f. Subject to dollar reverse repurchase agreements	—	—	—	—	—	0.00%	0.00%
g. Placed under option contracts	—	—	—	—	—	0.00%	0.00%
h. Letter stock or securities restricted as to sale-excluding FHLB capital stock	—	—	—	—	—	0.00%	0.00%
i. FHLB capital stock	—	—	—	—	—	0.00%	0.00%
j. On deposit with states	575,461	586,623	(11,162)	—	575,461	14.50%	0.00%
k. On deposit with other regulatory bodies	—	—	—	—	—	0.00%	0.00%
l. Pledged as collateral to FHLB (including assets backing funding agreements)	—	—	—	—	—	0.00%	0.00%
m. Pledged as collateral not captured in other categories	—	—	—	—	—	0.00%	0.00%
n. Other restricted assets	—	—	—	—	—	0.00%	0.00%
o. Total Restricted Assets	$ 575,461	$ 586,623	$ (11,162)	$ —	$ 575,461	14.50%	0.00%

(a) Column 1 divided by Asset Page, Column 1, Line 28

(b) Column 5 divided by Asset Page, Column 3, Line 28

(2) Not applicable.
(3) Not applicable.
(4) Not applicable.

M. Working Capital Finance Investments

The Company did not have any working capital finance investments at December 31, 2018 and 2017.

N. Offsetting and Netting of Assets and Liabilities

The Company did not have any offsetting or netting of assets and liabilities at December 31, 2018 and 2017.

O. Structured Notes

The Company did not have any structured notes at December 31, 2018 and 2017.

ANNUAL STATEMENT FOR THE YEAR 2018 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

P. 5GI Securities

The Company has no 5GI Securities as of December 31, 2018 and 2017.

Q. Short Sales

The Company did not have any short sales at December 31, 2018 and 2017.

R. Prepayment Penalty and Acceleration Fees

The Company did not have any prepayment penalty or acceleration fees at December 31, 2018 and 2017.

6. Joint Ventures, Partnerships and Limited Liability Companies

A. The Company has no investments in joint ventures, partnerships or LLCs.

B. Not applicable.

7. Investment Income

A. All investment income due and accrued with amounts that are over 90 days past due is non-admitted.

B. At December 31, 2018 and 2017 there was no nonadmitted accrued investment income.

8. Derivative Instruments

The Company has no derivative instruments.

ANNUAL STATEMENT FOR THE YEAR 2018 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

9. Income Taxes

A. The components of net deferred tax assets (liabilities):

(1) The components of net deferred tax asset (liabilities) are as follows:

		12/31/2018		
		(1) Ordinary	(2) Capital	(3) (Col 1+2) Total
(a)	Gross Deferred Tax Assets	$ —	$ —	$ —
(b)	Statutory Valuation Allowance Adjustments	—	—	—
(c)	Adjusted Gross Deferred Tax Assets (1a - 1b)	—	—	—
(d)	Deferred Tax Assets Nonadmitted	—	—	—
(e)	Subtotal Net Admitted Deferred Tax Asset (1c - 1d)	—	—	—
(f)	Deferred Tax Liabilities	—	9	9
(g)	Net Admitted Deferred Tax Asset/(Net Deferred Tax Liability) (1e - 1f)	$ —	$ (9)	$ (9)

		12/31/2017		
		(4) Ordinary	(5) Capital	(6) (Col 4+5) Total
(a)	Gross Deferred Tax Assets	$ —	$ —	$ —
(b)	Statutory Valuation Allowance Adjustments	—	—	—
(c)	Adjusted Gross Deferred Tax Assets (1a - 1b)	—	—	—
(d)	Deferred Tax Assets Nonadmitted	—	—	—
(e)	Subtotal Net Admitted Deferred Tax Asset (1c - 1d)	—	—	—
(f)	Deferred Tax Liabilities	—	9	9
(g)	Net Admitted Deferred Tax Asset/(Net Deferred Tax Liability) (1e - 1f)	$ —	$ (9)	$ (9)

		Change		
		(7) (Col 1-4) Ordinary	(8) (Col 2-5) Capital	(9) (Col 7+8) Total
(a)	Gross Deferred Tax Assets	$ —	$ —	$ —
(b)	Statutory Valuation Allowance Adjustments	—	—	—
(c)	Adjusted Gross Deferred Tax Assets (1a - 1b)	—	—	—
(d)	Deferred Tax Assets Nonadmitted	—	—	—
(e)	Subtotal Net Admitted Deferred Tax Asset (1c - 1d)	—	—	—
(f)	Deferred Tax Liabilities	—	—	—
(g)	Net Admitted Deferred Tax Asset/(Net Deferred Tax Liability) (1e - 1f)	$ —	$ —	$ —

ANNUAL STATEMENT FOR THE YEAR 2018 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

(2) The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101, *Income Taxes* ("SSAP No. 101") are as follows:

	12/31/2018		
	(1) Ordinary	(2) Capital	(3) (Col 1+2) Total
Admission Calculation Components SSAP No. 101			
(a) Federal Income Taxes Paid in Prior Years Recoverable Through Loss Carrybacks.	$ —	$ —	$ —
(b) Adjusted Gross Deferred Tax Assets Expected To Be Realized (Excluding The Amount Of Deferred Tax Assets From 2(a) above) After Application of the Threshold Limitation. (The Lesser of 2(b)1 and 2(b)2 Below)	—	—	—
1. Adjusted Gross Deferred Tax Assets Expected To Be Realized Following the Balance Sheet Date.	—	—	—
2. Adjusted Gross Deferred Tax Assets Allowed per Limitation Threshold.	XXX	XXX	605,187
(c) Adjusted Gross Deferred Tax Assets (Excluding The Amount Of Deferred Tax Assets From 2(a) and 2(b) above) Offset by Gross Deferred Tax Liabilities.	—	—	—
(d) Deferred Tax Assets Admitted as the result of application of SSAP No. 101. Total (2(a) + 2(b) + 2(c))	$ —	$ —	$ —

	12/31/2017		
	(4) Ordinary	(5) Capital	(6) (Col 4+5) Total
Admission Calculation Components SSAP No. 101			
(a) Federal Income Taxes Paid in Prior Years Recoverable Through Loss Carrybacks.	$ —	$ —	$ —
(b) Adjusted Gross Deferred Tax Assets Expected To Be Realized (Excluding The Amount Of Deferred Tax Assets From 2(a) above) After Application of the Threshold Limitation. (The Lesser of 2(b)1 and 2(b)2 Below)	—	—	—
1. Adjusted Gross Deferred Tax Assets Expected To Be Realized Following the Balance Sheet Date.	—	—	—
2. Adjusted Gross Deferred Tax Assets Allowed per Limitation Threshold.	XXX	XXX	602,100
(c) Adjusted Gross Deferred Tax Assets (Excluding The Amount Of Deferred Tax Assets From 2(a) and 2(b) above) Offset by Gross Deferred Tax Liabilities.	—	—	—
(d) Deferred Tax Assets Admitted as the result of application of SSAP No. 101. Total (2(a) + 2(b) + 2(c))	$ —	$ —	$ —

	Change		
	(7) (Col 1-4) Ordinary	(8) (Col 2-5) Capital	(9) (Col 7+8) Total
Admission Calculation Components SSAP No. 101			
(a) Federal Income Taxes Paid in Prior Years Recoverable Through Loss Carrybacks.	$ —	$ —	$ —
(b) Adjusted Gross Deferred Tax Assets Expected To Be Realized (Excluding The Amount Of Deferred Tax Assets From 2(a) above) After Application of the Threshold Limitation. (The Lesser of 2(b)1 and 2(b)2 Below)	—	—	—
1. Adjusted Gross Deferred Tax Assets Expected To Be Realized Following the Balance Sheet Date.	—	—	—
2. Adjusted Gross Deferred Tax Assets Allowed per Limitation Threshold.	XXX	XXX	3,087
(c) Adjusted Gross Deferred Tax Assets (Excluding The Amount Of Deferred Tax Assets From 2(a) and 2(b) above) Offset by Gross Deferred Tax Liabilities.	—	—	—
(d) Deferred Tax Assets Admitted as the result of application of SSAP No. 101. Total (2(a) + 2(b) + 2(c))	$ —	$ —	$ —

ANNUAL STATEMENT FOR THE YEAR 2018 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

(3)

	2018	2017
(a) Ratio Percentage Used To Determine Recovery Period And Threshold Limitation Amount.	43,959.16%	19,153.00%
(b) Amount Of Adjusted Capital And Surplus Used To Determine Recovery Period And Threshold Limitation In 2 (b)2 Above.	$ 4,034,572	$ 4,013,999

(4)

	12/31/2018		12/31/2017		Change	
	(1) Ordinary	(2) Capital	(3) Ordinary	(4) Capital	(5) (Col 1-3) Ordinary	(6) (Col 2-4) Capital
Impact of Tax-Planning Strategies						
(a) Determination of Adjusted Gross Deferred Tax Assets and Net Admitted Deferred Tax Assets, By Tax Character As A Percentage.						
1. Adjusted Gross DTAs Amount From Note 9A1(c)	$ —	$ —	$ —	$ —	$ —	$ —
2. Percentage of Adjusted Gross DTAs By Tax Character Attributable To The Impact Of Tax Planning Strategies	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
3. Net Admitted Adjusted Gross DTAs Amount From Note 9A1(e)	$ —	$ —	$ —	$ —	$ —	$ —
4. Percentage of Net Admitted Adjusted Gross DTAs By Tax Character Admitted Because Of The Impact Of Tax Planning Strategies	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

(b) Does the Company's tax-planning strategies include the use of reinsurance? Yes _____ No X

B. The Company has no unrecognized deferred tax liabilities at December 31, 2018 and 2017.

C. Current income taxes incurred consist of the following major components:

	(1) 12/31/2018	(2) 12/31/2017	(3) (Col 1-2) Change
(1) Current Income Tax			
(a) Federal	$ 1,032	$ 2,277	$ (1,245)
(b) Foreign	—	—	—
(c) Subtotal	1,032	2,277	(1,245)
(d) Federal income tax expense on net capital gains	—	—	—
(e) Utilization of capital loss carry-forwards	—	—	—
(f) Other	—	—	—
(g) Federal and foreign income taxes incurred	$ 1,032	$ 2,277	$ (1,245)
(2) Deferred Tax Assets:			
(a) Ordinary			
(1) Discounting of unpaid losses	$ —	$ —	$ —
(2) Unearned premium reserve	—	—	—
(3) Policyholder reserves	—	—	—
(4) Investments	—	—	—
(5) Deferred acquisition costs	—	—	—
(6) Policyholder dividends accrual	—	—	—

ANNUAL STATEMENT FOR THE YEAR 2018 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

(7)	Fixed assets	—	—	—
(8)	Compensation and benefits accrual	—	—	—
(9)	Pension accrual	—	—	—
(10)	Receivables - nonadmitted	—	—	—
(11)	Net operating loss carry-forward	—	—	—
(12)	Tax credit carry-forward	—	—	—
(13)	Other (including items <5% of total ordinary tax assets)	—	—	—
(14)	Accrued future expenses	—	—	—
(15)	Amortization	—	—	—
(16)	Partnership income	—	—	—
(17)	Premium deficiency reserves	—	—	—
(18)	Prepaid expenses	—	—	—
(19)	Section 467 lease expense	—	—	—
(20)	Personal property tax accrual	—	—	—
(21)	Deferred gain on sale of building	—	—	—
(22)	State income tax liability	—	—	—
(23)	Income from reinsurance contract	—	—	—
(24)	Revenue agent's report adjustment	—	—	—
	(99) Subtotal	—	—	—
(b)	Statutory valuation allowance adjustment	—	—	—
(c)	Nonadmitted	—	—	—
(d)	Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	—	—	—
(e)	Capital:			
(1)	Investments	—	—	—
(2)	Net capital loss carry-forward	—	—	—
(3)	Real estate	—	—	—
(4)	Other (including items <5% of total capital tax assets)	—	—	—
(5)	Partnership investment	—	—	—
(6)	Affiliated investment write-downs	—	—	—
(7)	Bonds	—	—	—
	(99) Subtotal	—	—	—
(f)	Statutory valuation allowance adjustment	—	—	—
(g)	Nonadmitted	—	—	—
(h)	Admitted capital deferred tax assets (2e99 - 2f - 2g)	—	—	—
(i)	Admitted deferred tax assets (2d + 2h)	$ —	$ —	$ —

		(1) 12/31/2018	(2) 12/31/2017	(3) (Col 1-2) Change
(3)	Deferred Tax Liabilities:			
(a)	Ordinary			
(1)	Investments	$ —	$ —	$ —
(2)	Fixed assets	—	—	—
(3)	Deferred and uncollected premium	—	—	—
(4)	Policyholder reserves	—	—	—
(5)	Other (including items <5% of total ordinary tax liabilities)	—	—	—
(6)	Amortization	—	—	—
(7)	Discount of coordination of benefits	—	—	—
(8)	Guaranty fund assessment	—	—	—
(9)	Business partnership	—	—	—
(10)	Tax reserves per Tax Reform over 8 years	—	—	—
(11)	Oil and gas depletion deduction	—	—	—
(12)	Deferred cost - surplus note	—	—	—
	(99) Subtotal	—	—	—
(b)	Capital:			
(1)	Investments	9	9	—
(2)	Real estate	—	—	—
(3)	Other (including items <5% of total capital tax liabilities)	—	—	—

ANNUAL STATEMENT FOR THE YEAR 2018 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

(4) Section 166 partial worthlessness	—	—	—
(5) Investment partnership income	—	—	—
(99) Subtotal	9	9	—
(c) Deferred tax liabilities (3a99 + 3b99)	$ 9	$ 9	$ —
(4) Net deferred tax assets/liabilities (2i - 3c)	$ (9)	$ (9)	$ —

Preparation of financial statements require management to make estimates and assumptions that affect the amount reported in the financial statements and accompanying notes. Actual results could differ from those estimates. As of December 31, 2017, the Company remeasured certain deferred tax assets and liabilities based on the rates at which they were expected to reverse in the future, which was generally 21%, by recording a provisional net increase to deferred tax assets and liabilities of ($6). Upon further analysis of the Tax Cuts and Jobs Act and refinement of calculations during the twelve months ended December 31, 2018, the Company adjusted the provisional amount by $0 to ($6), which is included as a component of statutory surplus.

D. The Company's income tax expense and change in deferred income taxes differs from the amount obtained by applying the federal statutory income tax rate of 21% for the year ended December 31, 2018, and 35% for the year ended December 31, 2017 as follows:

	2018	2017
Tax expense computed using federal statutory rate	$ 4,539	$ 5,697
ACA health insurer fee	—	—
Change in nonadmitted assets	—	—
Tax exempt income and dividend received deduction net of proration	(2,179)	(3,405)
Tax exempt income received net of proration	—	—
Prior year true-up and adjustments	(601)	—
Interest (federal and state income tax)	—	—
Tax settlements and contingencies	—	—
Intercompany transfers and adjustments	—	—
IMR/AVR tax	—	—
Intercompany dividends	—	—
Valuation allowance	—	—
Tax Cuts and Jobs Act	—	(6)
Deferred transfers	—	—
Partnership tax credits	—	—
Equities investment tax true-up	—	—
Mark to market and impairments	—	—
Low income housing tax credits	—	—
National Government Services	—	—
Other, net	(727)	—
Total	$ 1,032	$ 2,286
Federal income taxes incurred	$ 1,032	$ 2,277
Change in net deferred income taxes	—	9
Total statutory income taxes	$ 1,032	$ 2,286

E. Operating loss carryforwards:

(1) The Company has no operating loss carryforwards and no tax credit carryforwards as of December 31, 2018 or 2017.

(2) The following are income taxes incurred in the current and prior year(s) that will be available for recoupment in the event of future net losses:

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NOTES TO FINANCIAL STATEMENTS

	Ordinary	Capital	Total
2018	$ 1,633	$ —	$ 1,633
2017	1,675	—	1,675
2016	—	—	—

(3) The Company has no protective tax deposits reported as admitted assets under Section 6603 of the Internal Revenue Service Code as of December 31, 2018 and 2017.

F. The following companies will be included in the consolidated federal income tax return with their parent Anthem, Inc. ("Anthem") as of December 31, 2018 and either are current members of the consolidated tax sharing agreement or are in the process of being added to the consolidated tax sharing agreement. Allocation of federal income taxes with affiliates subject to the tax sharing agreement is based upon separate income tax return calculations with credit for net losses that can be used on a consolidated basis. Pursuant to this agreement, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes. Intercompany income tax balances are settled based on the Internal Revenue Service due dates.

American Imaging Management, Inc.
America's 1st Choice of South Carolina, Inc.
America's Health Management Services, Inc.
AMERIGROUP Community Care of New Mexico, Inc.
AMERIGROUP Corporation
Amerigroup Delaware, Inc.
AMERIGROUP District of Columbia, Inc.
Amerigroup Health Plan of Louisiana, Inc.
Amerigroup Health Plan of Oregon, Inc.
Amerigroup Insurance Company
AMERIGROUP Iowa, Inc.
Amerigroup Kansas, Inc.
AMERIGROUP Maryland, Inc.
Amerigroup Michigan, Inc.
AMERIGROUP Mississippi, Inc.
AMERIGROUP New Jersey, Inc.
AMERIGROUP Ohio, Inc.
AMERIGROUP Oklahoma, Inc.
Amerigroup Pennsylvania, Inc.
AMERIGROUP Tennessee, Inc.
AMERIGROUP Texas, Inc.
Amerigroup Utah, Inc.
AMERIGROUP Washington, Inc.
AMGP Georgia Managed Care Company, Inc.
Anthem Blue Cross Life and Health Insurance Company
Anthem Financial, Inc.
Anthem Health Insurance Company of Nevada
Anthem Health Plans of Kentucky, Inc.
Anthem Health Plans of Maine, Inc.
Anthem Health Plans of New Hampshire, Inc.
Anthem Health Plans of Virginia, Inc.
Anthem Health Plans, Inc.
Anthem Holding Corp.
Anthem Insurance Companies, Inc.
Anthem Kentucky Managed Care Plan, Inc.
Anthem Life & Disability Insurance Company
Anthem Southeast, Inc.
Anthem UM Services, Inc.
DeCare Dental Networks, LLC
DeCare Dental, LLC
Designated Agent Company, Inc.
EHC Benefits Agency, Inc.
Empire HealthChoice Assurance, Inc.
Empire HealthChoice HMO, Inc.
Federal Government Solutions, LLC
Freedom Health, Inc.
Golden West Health Plan, Inc.
Greater Georgia Life Insurance Company
Health Core, Inc.
Health Management Corporation
HealthKeepers, Inc.
HealthLink HMO, Inc.
HealthLink, Inc.
HealthLink Insurance Company
HealthPlus HP, LLC
HealthSun Blocker Corp. I
HealthSun Blocker Corp. II
Healthy Alliance Life Insurance Company
HEP AP Holdings, Inc.
Highland Holdco, Inc.
HMO Colorado, Inc.
HMO Missouri, Inc.
Imaging Management Holdings, LLC
IngenioRx, Inc.
Legato Holdings I, Inc.
Living Complete Technologies, Inc.
Matthew Thornton Health Plan, Inc.
National Government Services, Inc.
New England Research Institutes, Inc.
Newco Holdings, Inc.
Optimum Healthcare, Inc.
Park Square Holdings, Inc.
Park Square I, Inc.
Park Square II, Inc.
Resolution Health, Inc.
RightCHOICE Managed Care, Inc.

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NOTES TO FINANCIAL STATEMENTS

Anthem, Inc.
Arcus Enterprises, Inc.
Aspire Health, Inc.
Associated Group, Inc.
Blue Cross and Blue Shield of Georgia, Inc.
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.
Blue Cross Blue Shield of Wisconsin
Blue Cross of California
Blue Cross of California Partnership Plan, Inc.
CareMore Health Plan
CareMore Health Plan of Arizona, Inc.
CareMore Health Plan of Nevada, Inc.
CareMore Health Plan of Texas, Inc.
CareMore Health System
Cerulean Companies, Inc.
Claim Management Services, Inc.
Community Care Health Plan of Louisiana, Inc.
Community Care Health Plan of Nevada, Inc.
Community Insurance Company
Compcare Health Services Insurance Corporation
Crossroads Acquisition Corp
DeCare Analytics, LLC
DeCare Dental Health International, LLC
Rocky Mountain Hospital and Medical Service, Inc.
SellCore, Inc.
Simply Healthcare Plans, Inc.
Southeast Services, Inc.
State Sponsored DM Services, Inc.
The Anthem Companies of California, Inc.
The Anthem Companies, Inc.
TrustSolutions, LLC
UNICARE Health Plan of West Virginia, Inc.
UNICARE Illinois Services, Inc.
UNICARE Life & Health Insurance Company
UNICARE National Services, Inc.
UNICARE Specialty Services, Inc.
Valus, Inc.
WellPoint Behavioral Health, Inc.
WellPoint California Services, Inc.
WellPoint Dental Services, Inc.
WellPoint Health Solutions, Inc.
WellPoint Holding Corporation
WellPoint Information Technology Services, Inc.
WellPoint Insurance Services, Inc.
WellPoint Military Care Corporation

G. Not applicable.

H. Repatriation Transition Tax (RTT)

Not applicable.

I. Alternative Minimum Tax (AMT) Credit

Not applicable.

10. Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

A. Nature of the Relationship

The Company is a Mississippi domiciled stock insurance company and is a wholly-owned subsidiary of Anthem Partnership Holding Company, LLC, which is a direct wholly-owned subsidiary of Anthem, Inc. ("Anthem"), a publicly traded company.

B. Significant Transactions for Each Period

There were no significant transactions during the years ended December 31, 2018 and 2017.

C. Intercompany Management and Service Arrangements

There were no changes to the intercompany management and service arrangements, and there were no additional arrangements entered into during 2018 or 2017. The amounts of transactions under such agreements are presented in Schedule Y, Part 2.

D. Amounts Due to or from Related Parties

At December 31, 2018 and 2017, the Company reported $8,781 and $0 due from affiliates, and $0, and $7,109 due to affiliates respectively. The receivable and payable balances represent intercompany transactions that will be settled in accordance with the settlement terms of the intercompany agreement.

ANNUAL STATEMENT FOR THE YEAR 2018 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

E. Guarantees or Contingencies for Related Parties

The Company did not enter into guarantees or undertakings for the benefit of an affiliate which would result in a material contingent exposure of the Company's or any affiliated insurer's assets or liabilities.

F. Management and Service Contracts and Cost Sharing Arrangements

The Company has entered into administrative services agreements with its affiliated companies. Pursuant to these agreements, various administrative, management and support services are provided to or provided by the Company. The costs and expenses related to these administrative management and support services are allocated to or allocated by the Company in an amount equal to the direct and indirect costs and expenses incurred in providing these services. Costs include expenses such as salaries, employee benefits, communications, advertising, consulting services, rent, utilities, billing, accounting, underwriting, and product development, which support the Company's operations. These costs are allocated based on various utilization statistics.

G. Nature of Control Relationships that Could Affect Operations or Financial Position

Anthem Partnership owns all outstanding shares of the Company. The Company's ultimate parent is Anthem, Inc.

H. Amount Deducted for Investment in Upstream Company

The Company does not own shares of upstream intermediate entities or Anthem.

I. Detail of Investments in Affiliates Greater than 10% of Admitted Assets

The Company does not have investments in affiliates greater than 10% of admitted assets.

J. Write-down for Impairments of Investments in Subsidiaries, Controlled or Affiliated ("SCA") Companies

Not applicable.

K. Investment in a Foreign Insurance Subsidiary

The Company does not have investments in foreign insurance subsidiaries.

L. Investment in Downstream Non-insurance Holding Companies

The Company does not have investments in downstream non-insurance holding companies.

M. All SCA Investments

The Company has no SCA Investments.

N. Investment in Insurance SCAs

The Company does not have investments in Insurance SCAs.

O. SCA Loss Tracking

The Company does not have losses on investments in Insurance SCAs and/or joint ventures, partnerships or LLCs.

ANNUAL STATEMENT FOR THE YEAR 2018 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

11. Debt

A. Capital Notes and Other Debt

The Company had no capital notes or other debt outstanding at December 31, 2018 and 2017.

B. FHLB (Federal Home Loan Bank) Agreements

The Company had no FHLB agreements outstanding at December 31, 2018 and 2017.

C. All Other Debt

The Company had no other debt outstanding at December 31, 2018 and 2017.

12. Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans

A. Defined Benefit Plan

Not applicable.

B. Not applicable.

C. Not applicable.

D. Not applicable.

E. Defined Contribution Plans

Not applicable.

F. Multiemployer Plans

The Company does not participate in a multiemployer plan.

G. Consolidated/Holding Company Plans

Not applicable.

H. Post Employment Benefits and Compensated Absences

Not applicable.

I. Impact of Medicare Modernization Act on Postretirement Benefits (INT 04-17)

Not applicable.

13. Capital and Surplus, Shareholders' Dividend Restrictions and Quasi-Reorganizations

(1) Outstanding Shares

As of December 31, 2018, the Company has 1000 shares of $1 par value common stock authorized, issued and outstanding.

(2) Preferred Stock

The Company has no preferred stock outstanding.

ANNUAL STATEMENT FOR THE YEAR 2018 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

(3) Dividend Restrictions

Under Mississippi law, he amount of ordinary dividends a domestic insurer is permitted to pay is limited to an amount not exceeding the greater of net income or 10% of statutory surplus at the end of the preceding year as long as the Company's unassigned surplus is positive.

(4) Dividends Paid

See Footnote 10B.

(5) Maximum Ordinary Dividend During 2019

Within the limitations of (3) above, the Company may not pay dividends during 2019 without prior approval.

(6) Unassigned Surplus Restrictions

Unassigned surplus funds are not restricted at December 31, 2018.

(7) Mutual Surplus Advances

Not applicable.

(8) Company Stock Held for Special Purpose

There are no shares of stock held for special purposes at December 31, 2018.

(9) Changes in Special Surplus Funds

There are no special surplus funds at December 31, 2018.

(10) Changes in Unassigned Funds

There was no portion of unassigned funds represented by cumulative unrealized gains and losses at December 31, 2018.

(11) Surplus Notes

The Company has not issued any surplus notes or debentures or similar obligations.

(12) Restatement due to Prior Quasi-reorganizations

The Company had no restatements due to prior quasi-reorganizations.

(13) Quasi-reorganizations over Prior 10 Years

The Company has not been involved in a quasi-reorganization during the past 10 years.

14. Liabilities, Contingencies and Assessments

A. Contingent Commitments

The Company had no contingent commitments at December 31, 2018 or 2017.

ANNUAL STATEMENT FOR THE YEAR 2018 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

B. Assessments

(1) The Company is subject to guaranty fund and other assessments by the state(s) in which it writes business. Guaranty fund assessments are accrued at the time of insolvencies. Other assessments are accrued either at the time of the assessment or at the time the losses are incurred.

(2) Not applicable.

C. Gain Contingencies

The Company has no gain contingencies at December 31, 2018 or 2017.

D. Claims-Related Extra Contractual Obligation and the Bad Faith Losses Stemming From Lawsuits

Not applicable.

E. Joint and Several Liabilities

Not applicable.

F. All Other Contingencies

The Company is involved in pending and threatened litigation of the character incidental to the business transacted, arising out of its operations and is from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits and reviews and administrative proceedings include routine and special investigations by state insurance departments, state attorneys general, the U.S. Attorney General and subcommittees of the U.S. Congress. Such investigations, audits, reviews and administrative proceedings could result in the imposition of civil or criminal fines, penalties, other sanctions and additional rules, regulations or other restrictions on the Company's business operations. The Company believes that any liability that may result from any one of these actions, or in the aggregate, could have a material adverse effect on the Company's financial position or results of operations.

15. Leases

A. Lessee Operating Lease

The Company has no lessee leasing arrangements.

B. Lessor Leases

(1) The Company has not entered into any operating leases.

(2) The Company has not entered into any leveraged leases.

16. Information About Financial Instruments With Off-Balance Sheet Risk and Financial Instruments With Concentrations of Credit Risk

The Company has no significant financial instruments with off-balance sheet risk.

Financial instruments that potentially subject the Company to concentrations of credit risk consist primarily of investment securities. All investment securities are managed by professional investment managers within policies authorized by the board of directors. Such policies limit the amounts that may be invested in any one issuer and prescribe certain investee company criteria. As of December 31, 2018, there were no significant concentrations.

ANNUAL STATEMENT FOR THE YEAR 2018 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

A. Transfers of Receivables Reported as Sales

Not applicable at December 31, 2018 and 2017.

B. Transfer and Servicing of Financial Assets

(2) - (7) Not applicable.

C. Wash Sales

(1) In the course of the Company's asset management, securities may be sold and reacquired within 30 days of the sale date to enhance the yield on the investments.

(2) At December 31, 2018 and 2017, there were no wash sales involving securities with an NAIC designation of 3 or below or unrated.

18. Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans

A. Administrative Services Only ("ASO") Plans

Not applicable at December 31, 2018

B. Administrative Services Contract ("ASC") Plans

Not applicable at December 31, 2018.

C. Medicare or Other Similarly Structured Cost-Based Reimbursement Contract

Not applicable at December 31, 2018 and 2017.

19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

No premiums were written by managing general agents or third party administrators during the years ended December 31, 2018 and 2017.

20. Fair Value Measurements

A. There are no assets or liabilities measured at fair value as of December 31, 2018 and 2017.

B. Fair Value Measurements Under Other Accounting Pronouncements

Not applicable at December 31, 2018 and 2017.

C. Financial Instruments

Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
Bonds	$ 581,970	$ 575,461	$ —	$ 581,970	$ —	$ —	$ —

D. Not Practicable to Estimate Fair Value

There are no financial instruments that were not practicable to estimate fair value.

ANNUAL STATEMENT FOR THE YEAR 2018 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

E. Investments Measured at Net Asset Value

The Company has no investments measured at net asset value.

21. Other Items

A. Unusual or Infrequent Items

Not applicable at December 31, 2018 and 2017.

B. Troubled Debt Restructuring: Debtors

Not applicable at December 31, 2018 and 2017.

C. Other Disclosures

Assets in the amount of $574,461 and $586,623 at December 31, 2018 and 2017, respectively, were on deposit with government authorities or trustees as required by law.

D. Business Interruption Insurance Recoveries

The Company has reported no recoveries for business interruption for the years ended December 31, 2018 and 2017.

E. State Transferable and Non-Transferable Tax Credits

The Company did not have state transferable or non-transferable tax credits at December 31, 2018 and 2017.

F. Subprime Mortgage-Related Risk Exposure

(1) The Company's investment strategy of providing safety and preservation of capital, sufficient liquidity to meet cash flow requirements and the attainment of a competitive after-tax investment return is supported by a well diversified portfolio consisting of many different types of investments. The portion of the Company's investment portfolio with subprime mortgage-related risk exposure is relatively small in comparison to the overall investment portfolio, and consists mainly of investment grade securities with no exposure to collateralized debt obligations. All mortgage related investments are monitored closely as part of the quarterly investment review performed by the Anthem Investment Impairment Review Committee.

(2) The Company did not carry investments in subprime mortgage loans in its portfolio at December 31, 2018 or 2017.

(3) The Company did not have subprime mortgage-related risk exposure at December 31, 2018 or 2017.

(4) The Company did not underwrite Mortgage Guaranty or Financial Guaranty insurance coverage at December 31, 2018 or 2017.

G. Retained Assets

The Company does not have retained assets at December 31, 2018 and 2017.

H. Insurance-Linked Securities Contracts

Not applicable.

ANNUAL STATEMENT FOR THE YEAR 2018 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

22. Events Subsequent

The Company did not have any Affordable Care Act ("ACA") assessable premium in 2018 and 2017.

Subsequent events have been considered through February 26, 2019 for the statutory statement issued on February 26, 2019. There were no events occurring subsequent to December 31, 2018 requiring recognition or disclosure.

23. Reinsurance

A. Ceded Reinsurance Report

Section 1 - General Interrogatories

a. Are any of the reinsurers that are listed in Schedule S as non-affiliated owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?

Yes ( ) No (X)

If yes, give full details.

b. Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. Branches of such companies) that is owned in excess of 10% or controlled, directly or indirectly, by an insured, a beneficiary, a creditor or an insured or any other person not primarily engaged in the insurance business?

Yes ( ) No (X)

If yes, give full details.

Section 2 - Ceded Reinsurance Report - Part A

(1) Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credits?

Yes ( ) No (X)

If yes, give full details.

(2) Does the reporting entity have any reinsurance agreements in effect such that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premium collected under the reinsured policies?

Yes ( ) No (X)

If yes, give full details.

Section 3 - Ceded Reinsurance Report - Part B

(1) What is the estimated amount of the aggregate reduction in surplus, (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2 above) of termination of ALL reinsurance agreements, by either party, as of the date of this

ANNUAL STATEMENT FOR THE YEAR 2018 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

$0

(2) Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had existing reserves established by the Company as of the effective date of the agreement?

Yes ( ) No (X)

If yes, give full details.

B. Uncollectible Reinsurance

The Company has no uncollectible reinsurance at December 31, 2018 and 2017.

C. Commutation of Ceded Reinsurance

The Company has not commuted ceded reinsurance during 2018 and 2017.

D. Certified Reinsurer Rating Downgraded or Status Subject Revocation

The Company has no downgraded certified reinsurer ratings or status subject to revocations during 2018 and 2017.

24. Retrospectively Rated Contracts & Contracts Subject to Redetermination

A. Not applicable.

B. Not applicable.

C. Not applicable.

D. Not applicable.

E. Risk-Sharing Provisions of the ACA

(1) Did the reporting entity write accident and health insurance premium that is subject to the Affordable Care Act risk-sharing provisions (YES/NO)? No

(2) Impact of Risk-Sharing Provisions of the Affordable Care Act on Admitted Assets, Liabilities and Revenue for the Current Year

Not applicable.

(3) Roll-forward of prior year ACA risk-sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reasons for adjustments to prior year balance.

Not applicable.

(4) Roll-forward of Risk Corridors Asset and Liability Balances by Program Benefit Year.

Not applicable.

(5) ACA Risk Corridors Receivable as of Reporting Date.

ANNUAL STATEMENT FOR THE YEAR 2018 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

Not applicable.

25. Change in Incurred Claims and Claim Adjustment Expenses

Not applicable at December 31, 2018 and 2017.

26. Intercompany Pooling Arrangements

Not applicable at December 31, 2018 and 2017.

27. Structured Settlements

Not applicable at December 31, 2018 and 2017.

28. Health Care Receivables

A. Pharmaceutical Rebate Receivables

Not applicable at December 31, 2018 and 2017.

B. Risk Sharing Receivables

Not applicable at December 31, 2018 and 2017.

29. Participating Policies

Not applicable at December 31, 2018 and 2017.

30. Premium Deficiency Reserves

The Company had no liabilities related to premium deficiency reserves as of December 31, 2018 and 2017.

31. Anticipated Salvage and Subrogation

Not applicable at December 31, 2018 and 2017.

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES
GENERAL

1.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? ..... Yes [X] No [ ]
If yes, complete Schedule Y, Parts 1, 1A and 2

1.2 If yes, did the reporting entity register and file with its domiciliary State Insurance Commissioner, Director or Superintendent, or with such regulatory official of the state of domicile of the principal insurer in the Holding Company System, a registration statement providing disclosure substantially similar to the standards adopted by the National Association of Insurance Commissioners (NAIC) in its Model Insurance Holding Company System Regulatory Act and model regulations pertaining thereto, or is the reporting entity subject to standards and disclosure requirements substantially similar to those required by such Act and regulations? ..... Yes [X] No [ ] N/A [ ]

1.3 State Regulating? ..... Mississippi

1.4 Is the reporting entity publicly traded or a member of a publicly traded group? ..... Yes [X] No [ ]

1.5 If the response to 1.4 is yes, provide the CIK (Central Index Key) code issued by the SEC for the entity/group. 0001156039

2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? ..... Yes [ ] No [X]

2.2 If yes, date of change: .....

3.1 State as of what date the latest financial examination of the reporting entity was made or is being made. 12/31/2017

3.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released. .....

3.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date). .....

3.4 By what department or departments?
Mississippi Department of Insurance .....

3.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with Departments? ..... Yes [ ] No [ ] N/A [X]

3.6 Have all of the recommendations within the latest financial examination report been complied with? ..... Yes [ ] No [ ] N/A [X]

4.1 During the period covered by this statement, did any agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the reporting entity), receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
4.11 sales of new business? ..... Yes [ ] No [X]
4.12 renewals? ..... Yes [ ] No [X]

4.2 During the period covered by this statement, did any sales/service organization owned in whole or in part by the reporting entity or an affiliate, receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
4.21 sales of new business? ..... Yes [ ] No [X]
4.22 renewals? ..... Yes [ ] No [X]

5.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? ..... Yes [ ] No [X]
If yes, complete and file the merger history data file with the NAIC.

5.2 If yes, provide the name of the entity, NAIC Company Code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1 Name of Entity	2 NAIC Company Code	3 State of Domicile

6.1 Has the reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? ..... Yes [ ] No [X]

6.2 If yes, give full information:
.....

7.1 Does any foreign (non-United States) person or entity directly or indirectly control 10% or more of the reporting entity? ..... Yes [ ] No [X]

7.2 If yes,
7.21 State the percentage of foreign control; ..... %
7.22 State the nationality(s) of the foreign person(s) or entity(s) or if the entity is a mutual or reciprocal, the nationality of its manager or attorney-in-fact; and identify the type of entity(s) (e.g., individual, corporation or government, manager or attorney in fact).

1 Nationality	2 Type of Entity

GENERAL INTERROGATORIES

8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board? Yes [ ] No [X]

8.2 If response to 8.1 is yes, please identify the name of the bank holding company.

8.3 Is the company affiliated with one or more banks, thrifts or securities firms? Yes [ ] No [X]

8.4 If response to 8.3 is yes, please provide below the names and location (city and state of the main office) of any affiliates regulated by a federal regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 FDIC	6 SEC

9. What is the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit?
N/A - The Company has received an exemption by the Mississippi Department of Insurance from filing the Audited Financial Statement for the year ended December 31, 2018.

10.1 Has the insurer been granted any exemptions to the prohibited non-audit services provided by the certified independent public accountant requirements as allowed in Section 7H of the Annual Financial Reporting Model Regulation (Model Audit Rule), or substantially similar state law or regulation? Yes [ ] No [X]

10.2 If the response to 10.1 is yes, provide information related to this exemption:

10.3 Has the insurer been granted any exemptions related to the other requirements of the Annual Financial Reporting Model Regulation as allowed for in Section 18A of the Model Regulation, or substantially similar state law or regulation? Yes [ ] No [X]

10.4 If the response to 10.3 is yes, provide information related to this exemption:

10.5 Has the reporting entity established an Audit Committee in compliance with the domiciliary state insurance laws? Yes [X] No [ ] N/A [ ]

10.6 If the response to 10.5 is no or n/a, please explain

11. What is the name, address and affiliation (officer/employee of the reporting entity or actuary/consultant associated with an actuarial consulting firm) of the individual providing the statement of actuarial opinion/certification?
N/A - The Company has received an exemption by the Mississippi Department of Insurance from filing the Actuarial Opinion for the year ended December 31, 2018.

12.1 Does the reporting entity own any securities of a real estate holding company or otherwise hold real estate indirectly? Yes [ ] No [X]

12.11 Name of real estate holding company

12.12 Number of parcels involved

12.13 Total book/adjusted carrying value $

12.2 If, yes provide explanation:

13. **FOR UNITED STATES BRANCHES OF ALIEN REPORTING ENTITIES ONLY:**

13.1 What changes have been made during the year in the United States manager or the United States trustees of the reporting entity?

13.2 Does this statement contain all business transacted for the reporting entity through its United States Branch on risks wherever located? Yes [ ] No [ ]

13.3 Have there been any changes made to any of the trust indentures during the year? Yes [ ] No [ ]

13.4 If answer to (13.3) is yes, has the domiciliary or entry state approved the changes? Yes [ ] No [ ] N/A [ ]

14.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards? Yes [X] No [ ]
(a) Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
(b) Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;
(c) Compliance with applicable governmental laws, rules and regulations;
(d) The prompt internal reporting of violations to an appropriate person or persons identified in the code; and
(e) Accountability for adherence to the code.

14.11 If the response to 14.1 is No, please explain:

14.2 Has the code of ethics for senior managers been amended? Yes [X] No [ ]

14.21 If the response to 14.2 is yes, provide information related to amendment(s).
Administrative changes were made in February 2018 to update the President & CEO letter, and to clarify our sexual harassment policy. In November 2018, the CCO letter was updated to reflect a change in the Chief Compliance Officer.

14.3 Have any provisions of the code of ethics been waived for any of the specified officers? Yes [ ] No [X]

14.31 If the response to 14.3 is yes, provide the nature of any waiver(s).

GENERAL INTERROGATORIES

15.1 Is the reporting entity the beneficiary of a Letter of Credit that is unrelated to reinsurance where the issuing or confirming bank is not on the SVO Bank List? Yes [ ] No [X]

15.2 If the response to 15.1 is yes, indicate the American Bankers Association (ABA) Routing Number and the name of the issuing or confirming bank of the Letter of Credit and describe the circumstances in which the Letter of Credit is triggered.

1 American Bankers Association (ABA) Routing Number	2 Issuing or Confirming Bank Name	3 Circumstances That Can Trigger the Letter of Credit	4 Amount

BOARD OF DIRECTORS

16. Is the purchase or sale of all investments of the reporting entity passed upon either by the board of directors or a subordinate committee thereof? Yes [X] No [ ]

17. Does the reporting entity keep a complete permanent record of the proceedings of its board of directors and all subordinate committees thereof? Yes [X] No [ ]

18. Has the reporting entity an established procedure for disclosure to its board of directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict with the official duties of such person? Yes [X] No [ ]

FINANCIAL

19. Has this statement been prepared using a basis of accounting other than Statutory Accounting Principles (e.g., Generally Accepted Accounting Principles)? Yes [ ] No [X]

20.1 Total amount loaned during the year (inclusive of Separate Accounts, exclusive of policy loans):
- 20.11 To directors or other officers $ 0
- 20.12 To stockholders not officers $ 0
- 20.13 Trustees, supreme or grand (Fraternal Only) $ 0

20.2 Total amount of loans outstanding at the end of year (inclusive of Separate Accounts, exclusive of policy loans):
- 20.21 To directors or other officers $ 0
- 20.22 To stockholders not officers $ 0
- 20.23 Trustees, supreme or grand (Fraternal Only) $ 0

21.1 Were any assets reported in this statement subject to a contractual obligation to transfer to another party without the liability for such obligation being reported in the statement? Yes [ ] No [X]

21.2 If yes, state the amount thereof at December 31 of the current year:
- 21.21 Rented from others $
- 21.22 Borrowed from others $ 0
- 21.23 Leased from others $ 0
- 21.24 Other $ 0

22.1 Does this statement include payments for assessments as described in the Annual Statement Instructions other than guaranty fund or guaranty association assessments? Yes [ ] No [X]

22.2 If answer is yes:
- 22.21 Amount paid as losses or risk adjustment $
- 22.22 Amount paid as expenses $ 0
- 23.23 Other amounts paid $ 0

23.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? Yes [X] No [ ]

23.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: $ 8,781

INVESTMENT

24.01 Were all the stocks, bonds and other securities owned December 31 of current year, over which the reporting entity has exclusive control, in the actual possession of the reporting entity on said date? (other than securities lending programs addressed in 24.03) Yes [X] No [ ]

24.02 If no, give full and complete information relating thereto

24.03 For security lending programs, provide a description of the program including value for collateral and amount of loaned securities, and whether collateral is carried on or off-balance sheet. (an alternative is to reference Note 17 where this information is also provided)

24.04 Does the Company's security lending program meet the requirements for a conforming program as outlined in the Risk-Based Capital Instructions? Yes [ ] No [ ] N/A [X]

24.05 If answer to 24.04 is yes, report amount of collateral for conforming programs. $

24.06 If answer to 24.04 is no, report amount of collateral for other programs. $

24.07 Does your securities lending program require 102% (domestic securities) and 105% (foreign securities) from the counterparty at the outset of the contract? Yes [ ] No [ ] N/A [ ]

24.08 Does the reporting entity non-admit when the collateral received from the counterparty falls below 100%? Yes [ ] No [ ] N/A [ ]

24.09 Does the reporting entity or the reporting entity 's securities lending agent utilize the Master Securities lending Agreement (MSLA) to conduct securities lending? Yes [ ] No [ ] N/A [ ]

GENERAL INTERROGATORIES

24.10 For the reporting entity's security lending program state the amount of the following as December 31 of the current year:

24.101 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2. $ 0
24.102 Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2 $ 0
24.103 Total payable for securities lending reported on the liability page. $ 0

25.1 Were any of the stocks, bonds or other assets of the reporting entity owned at December 31 of the current year not exclusively under the control of the reporting entity, or has the reporting entity sold or transferred any assets subject to a put option contract that is currently in force? (Exclude securities subject to Interrogatory 21.1 and 24.03). Yes [X] No [ ]

25.2 If yes, state the amount thereof at December 31 of the current year:

25.21 Subject to repurchase agreements $
25.22 Subject to reverse repurchase agreements $
25.23 Subject to dollar repurchase agreements $
25.24 Subject to reverse dollar repurchase agreements $
25.25 Placed under option agreements $
25.26 Letter stock or securities restricted as to sale - excluding FHLB Capital Stock $
25.27 FHLB Capital Stock $
25.28 On deposit with states $ 575,461
25.29 On deposit with other regulatory bodies $
25.30 Pledged as collateral - excluding collateral pledged to an FHLB $
25.31 Pledged as collateral to FHLB - including assets backing funding agreements $
25.32 Other $

25.3 For category (25.26) provide the following:

1 Nature of Restriction	2 Description	3 Amount

26.1 Does the reporting entity have any hedging transactions reported on Schedule DB? Yes [ ] No [X]

26.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? Yes [ ] No [ ] N/A [X]
If no, attach a description with this statement.

27.1 Were any preferred stocks or bonds owned as of December 31 of the current year mandatorily convertible into equity, or, at the option of the issuer, convertible into equity? Yes [ ] No [X]

27.2 If yes, state the amount thereof at December 31 of the current year. $

28. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook? Yes [X] No [ ]

28.01 For agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1 Name of Custodian(s)	2 Custodian's Address
JP Morgan Chase Bank, N.A	383 Madison Ave, New York, NY 10179

28.02 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)

28.03 Have there been any changes, including name changes, in the custodian(s) identified in 28.01 during the current year? Yes [X] No [ ]
28.04 If yes, give full and complete information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason
Bank of New York Mellon Corporation	JP Morgan Chase Bank, N.A	02/01/2018	Operational decision to change custodian

GENERAL INTERROGATORIES

28.05 Investment management – Identify all investment advisors, investment managers, broker/dealers, including individuals that have the authority to make investment decisions on behalf of the reporting entity. For assets that are managed internally by employees of the reporting entity, note as such. ["…that have access to the investment accounts"; "…handle securities"]

1 Name of Firm or Individual	2 Affiliation
McDonnell Investment Management, LLC	U

28.0597 For those firms/individuals listed in the table for Question 28.05, do any firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") manage more than 10% of the reporting entity's assets? Yes [X] No [ ]

28.0598 For firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") listed in the table for Question 28.05, does the total assets under management aggregate to more than 50% of the reporting entity's assets? Yes [ ] No [X]

28.06 For those firms or individuals listed in the table for 28.05 with an affiliation code of "A" (affiliated) or "U" (unaffiliated), provide the information for the table below.

1 Central Registration Depository Number	2 Name of Firm or Individual	3 Legal Entity Identifier (LEI)	4 Registered With	5 Investment Management Agreement (IMA) Filed
113878	McDonnell Investment Management, LLC		Securities Exchange Commission	NO

29.1 Does the reporting entity have any diversified mutual funds reported in Schedule D, Part 2 (diversified according to the Securities and Exchange Commission (SEC) in the Investment Company Act of 1940 [Section 5(b)(1)])? Yes [ ] No [X]

29.2 If yes, complete the following schedule:

1 CUSIP #	2 Name of Mutual Fund	3 Book/Adjusted Carrying Value
29.2999 - Total		0

29.3 For each mutual fund listed in the table above, complete the following schedule:

1 Name of Mutual Fund (from above table)	2 Name of Significant Holding of the Mutual Fund	3 Amount of Mutual Fund's Book/Adjusted Carrying Value Attributable to the Holding	4 Date of Valuation

30. Provide the following information for all short-term and long-term bonds and all preferred stocks. Do not substitute amortized value or statement value for fair value.

	1 Statement (Admitted) Value	2 Fair Value	3 Excess of Statement over Fair Value (-), or Fair Value over Statement (+)
30.1 Bonds	575,461	581,970	6,509
30.2 Preferred stocks	0		0
30.3 Totals	575,461	581,970	6,509

30.4 Describe the sources or methods utilized in determining the fair values:
Fair values were obtained from third-party pricing sources. If a security was not priced by a third-party pricing source, internal analytical systems or broker quotes were utilized.

31.1 Was the rate used to calculate fair value determined by a broker or custodian for any of the securities in Schedule D? Yes [ ] No [X]

31.2 If the answer to 31.1 is yes, does the reporting entity have a copy of the broker's or custodian's pricing policy (hard copy or electronic copy) for all brokers or custodians used as a pricing source? Yes [ ] No [ ]

31.3 If the answer to 31.2 is no, describe the reporting entity's process for determining a reliable pricing source for purposes of disclosure of fair value for Schedule D:
N/A

32.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed? Yes [X] No [ ]

32.2 If no, list exceptions:
N/A

GENERAL INTERROGATORIES

33. By self-designating 5GI securities, the reporting entity is certifying the following elements of each self-designated 5GI security:
    a. Documentation necessary to permit a full credit analysis of the security does not exist or an NAIC CRP credit rating for an FE or PL security is not available.
    b. Issuer or obligor is current on all contracted interest and principal payments.
    c. The insurer has an actual expectation of ultimate payment of all contracted interest and principal.

    Has the reporting entity self-designated 5GI securities? ..... Yes [ ] No [X]

34. By self-designating PLGI securities, the reporting entity is certifying the following elements of each self-designated PLGI security:
    a. The security was purchased prior to January 1, 2018.
    b. The reporting entity is holding capital commensurate with the NAIC Designation reported for the security.
    c. The NAIC Designation was derived from the credit rating assigned by an NAIC CRP in its legal capacity as a NRSRO which is shown on a current private letter rating held by the insurer and available for examination by state insurance regulators.
    d. The reporting entity is not permitted to share this credit rating of the PL security with the SVO.

    Has the reporting entity self-designated PLGI securities? ..... Yes [ ] No [X]

OTHER

35.1 Amount of payments to trade associations, service organizations and statistical or rating bureaus, if any? ..... $ .....

35.2 List the name of the organization and the amount paid if any such payment represented 25% or more of the total payments to trade associations, service organizations and statistical or rating bureaus during the period covered by this statement.

1 Name	2 Amount Paid

36.1 Amount of payments for legal expenses, if any? ..... $ .....

36.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payments for legal expenses during the period covered by this statement.

1 Name	2 Amount Paid

37.1 Amount of payments for expenditures in connection with matters before legislative bodies, officers or departments of government, if any? ..... $ .....

37.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payment expenditures in connection with matters before legislative bodies, officers or departments of government during the period covered by this statement.

1 Name	2 Amount Paid

GENERAL INTERROGATORIES

PART 2 - HEALTH INTERROGATORIES

1.1 Does the reporting entity have any direct Medicare Supplement Insurance in force? Yes [ ] No [X]

1.2 If yes, indicate premium earned on U.S. business only. $

1.3 What portion of Item (1.2) is not reported on the Medicare Supplement Insurance Experience Exhibit? $

1.31 Reason for excluding

1.4 Indicate amount of earned premium attributable to Canadian and/or Other Alien not included in Item (1.2) above $

1.5 Indicate total incurred claims on all Medicare Supplement Insurance. $ 0

1.6 Individual policies:

Most current three years:
1.61 Total premium earned $ 0
1.62 Total incurred claims $ 0
1.63 Number of covered lives 0
All years prior to most current three years:
1.64 Total premium earned $ 0
1.65 Total incurred claims $ 0
1.66 Number of covered lives 0

1.7 Group policies:

Most current three years:
1.71 Total premium earned $ 0
1.72 Total incurred claims $ 0
1.73 Number of covered lives 0
All years prior to most current three years:
1.74 Total premium earned $ 0
1.75 Total incurred claims $ 0
1.76 Number of covered lives 0

2. Health Test:

		1 Current Year	2 Prior Year
2.1	Premium Numerator	0	0
2.2	Premium Denominator	0	
2.3	Premium Ratio (2.1/2.2)	0.000	0.000
2.4	Reserve Numerator	0	0
2.5	Reserve Denominator	0	0
2.6	Reserve Ratio (2.4/2.5)	0.000	0.000

3.1 Has the reporting entity received any endowment or gift from contracting hospitals, physicians, dentists, or others that is agreed will be returned when, as and if the earnings of the reporting entity permits? Yes [ ] No [X]

3.2 If yes, give particulars:

4.1 Have copies of all agreements stating the period and nature of hospitals', physicians', and dentists' care offered to subscribers and dependents been filed with the appropriate regulatory agency? Yes [ ] No [X]

4.2 If not previously filed, furnish herewith a copy(ies) of such agreement(s). Do these agreements include additional benefits offered? Yes [ ] No [X]

5.1 Does the reporting entity have stop-loss reinsurance? Yes [ ] No [X]

5.2 If no, explain:
Currently, there are no insurance operations for this Company.

5.3 Maximum retained risk (see instructions)

5.31 Comprehensive Medical $
5.32 Medical Only $
5.33 Medicare Supplement $
5.34 Dental & Vision $
5.35 Other Limited Benefit Plan $
5.36 Other $

6. Describe arrangement which the reporting entity may have to protect subscribers and their dependents against the risk of insolvency including hold harmless provisions, conversion privileges with other carriers, agreements with providers to continue rendering services, and any other agreements:
N/A.

7.1 Does the reporting entity set up its claim liability for provider services on a service date basis? Yes [ ] No [X]

7.2 If no, give details
Currently, there are no insurance operations for this Company.

8. Provide the following information regarding participating providers:

8.1 Number of providers at start of reporting year 0
8.2 Number of providers at end of reporting year 0

9.1 Does the reporting entity have business subject to premium rate guarantees? Yes [ ] No [X]

9.2 If yes, direct premium earned:

9.21 Business with rate guarantees between 15-36 months $
9.22 Business with rate guarantees over 36 months $

GENERAL INTERROGATORIES

10.1 Does the reporting entity have Incentive Pool, Withhold or Bonus Arrangements in its provider contracts? Yes [ ] No [X]

10.2 If yes:

10.21 Maximum amount payable bonuses $
10.22 Amount actually paid for year bonuses $
10.23 Maximum amount payable withholds $
10.24 Amount actually paid for year withholds $

11.1 Is the reporting entity organized as:

11.12 A Medical Group/Staff Model, Yes [ ] No [X]
11.13 An Individual Practice Association (IPA), or, Yes [ ] No [X]
11.14 A Mixed Model (combination of above)? Yes [ ] No [X]

11.2 Is the reporting entity subject to Statutory Minimum Capital and Surplus Requirements? Yes [X] No [ ]
11.3 If yes, show the name of the state requiring such minimum capital and surplus. Mississippi
11.4 If yes, show the amount required. $ 1,000,000
11.5 Is this amount included as part of a contingency reserve in stockholder's equity? Yes [ ] No [X]
11.6 If the amount is calculated, show the calculation

12. List service areas in which reporting entity is licensed to operate:

1 Name of Service Area

13.1 Do you act as a custodian for health savings accounts? Yes [ ] No [X]

13.2 If yes, please provide the amount of custodial funds held as of the reporting date. $

13.3 Do you act as an administrator for health savings accounts? Yes [ ] No [X]

13.4 If yes, please provide the balance of funds administered as of the reporting date. $

14.1 Are any of the captive affiliates reported on Schedule S, Part 3, authorized reinsurers? Yes [ ] No [ ] N/A [X]
14.2 If the answer to 14.1 is yes, please provide the following:

1 Company Name	2 NAIC Company Code	3 Domiciliary Jurisdiction	4 Reserve Credit	Assets Supporting Reserve Credit		
				5 Letters of Credit	6 Trust Agreements	7 Other

15. Provide the following for individual ordinary life insurance* policies (U.S. business only) for the current year (prior to reinsurance assumed or ceded):

15.1 Direct Premium Written $
15.2 Total Incurred Claims $ 0
15.3 Number of Covered Lives 0

*Ordinary Life Insurance Includes
Term(whether full underwriting, limited underwriting, jet issue, "short form app")
Whole Life (whether full underwriting, limited underwriting, jet issue, "short form app")
Variable Life (with or without secondary gurarantee)
Universal Life (with or without secondary gurarantee)
Variable Universal Life (with or without secondary gurarantee)

16. Is the reporting entity licensed or chartered, registered, qualified, eligible or writing business in at least two states? Yes [ ] No [X]

16.1 If no, does the reporting entity assume reinsurance business that covers risks residing in at least one state other than the state of domicile of the reporting entity? Yes [ ] No [ ]

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

FIVE-YEAR HISTORICAL DATA

		1 2018	2 2017	3 2016	4 2015	5 2014
	Balance Sheet (Pages 2 and 3)					
1.	Total admitted assets (Page 2, Line 28)	4,035,861	4,022,614			
2.	Total liabilities (Page 3, Line 24)	1,289	8,624			
3.	Statutory minimum capital and surplus requirement	1,000,000	1,500,000			
4.	Total capital and surplus (Page 3, Line 33)	4,034,572	4,013,990			
	Income Statement (Page 4)					
5.	Total revenues (Line 8)	0	0			
6.	Total medical and hospital expenses (Line 18)	0	0			
7.	Claims adjustment expenses (Line 20)	0	0			
8.	Total administrative expenses (Line 21)	2,341	0			
9.	Net underwriting gain (loss) (Line 24)	(2,341)	0			
10.	Net investment gain (loss) (Line 27)	23,955	16,276			
11.	Total other income (Lines 28 plus 29)	0	0			
12.	Net income or (loss) (Line 32)	20,582	13,999			
	Cash Flow (Page 6)					
13.	Net cash from operations (Line 11)	29,897	17,071			
	Risk-Based Capital Analysis					
14.	Total adjusted capital	4,034,572	4,013,990			
15.	Authorized control level risk-based capital	9,178	20,958			
	Enrollment (Exhibit 1)					
16.	Total members at end of period (Column 5, Line 7)					
17.	Total members months (Column 6, Line 7)					
	Operating Percentage (Page 4) (Item divided by Page 4, sum of Lines 2, 3 and 5) x 100.0					
18.	Premiums earned plus risk revenue (Line 2 plus Lines 3 and 5)	100.0	100.0	100.0	100.0	100.0
19.	Total hospital and medical plus other non-health (Lines 18 plus Line 19)	0.0	0.0			
20.	Cost containment expenses	0.0	0.0			
21.	Other claims adjustment expenses	0.0	0.0			
22.	Total underwriting deductions (Line 23)	0.0	0.0			
23.	Total underwriting gain (loss) (Line 24)	0.0	0.0			
	Unpaid Claims Analysis (U&I Exhibit, Part 2B)					
24.	Total claims incurred for prior years (Line 13, Col. 5)					
25.	Estimated liability of unpaid claims-[prior year (Line 13, Col. 6)]					
	Investments In Parent, Subsidiaries and Affiliates					
26.	Affiliated bonds (Sch. D Summary, Line 12, Col. 1)					
27.	Affiliated preferred stocks (Sch. D Summary, Line 18, Col. 1)					
28.	Affiliated common stocks (Sch. D Summary, Line 24, Col. 1)					
29.	Affiliated short-term investments (subtotal included in Schedule DA Verification, Col. 5, Line 10)		0			
30.	Affiliated mortgage loans on real estate					
31.	All other affiliated					
32.	Total of above Lines 26 to 31	0	0	0	0	0
33.	Total investment in parent included in Lines 26 to 31 above.					

NOTE: If a party to a merger, have the two most recent years of this exhibit been restated due to a merger in compliance with the disclosure requirements of SSAP No. 3, Accounting Changes and Correction of Errors? Yes [ ] No [ ]

If no, please explain:

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION _____ 2. _____ (LOCATION)

NAIC Group Code BUSINESS IN THE STATE OF DURING THE YEAR 2018 NAIC Company Code

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3							
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other
Total Members at end of:										
1. Prior Year										
2. First Quarter										
3. Second Quarter										
4. Third Quarter										
5. Current Year										
6. Current Year Member Months										
Total Member Ambulatory Encounters for Year:										
7 Physician										
8. Non-Physician										
9. Total										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b)										
13. Life Premiums Direct										
14. Property/Casualty Premiums Written										
15. Health Premiums Earned										
16. Property/Casualty Premiums Earned										
17. Amount Paid for Provision of Health Care Services										
18 Amount Incurred for Provision of Health Care Services										

NONE

(a) For health business: number of persons insured under PPO managed care products ..... and number of persons insured under indemnity only products ..... .
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $ .....

30

Schedule S - Part 1 - Section 2

N O N E

Schedule S - Part 2

N O N E

Schedule S - Part 3 - Section 2

N O N E

Schedule S - Part 4

N O N E

Schedule S - Part 4 - Bank Footnote

N O N E

Schedule S - Part 5

N O N E

Schedule S - Part 5 - Bank Footnote

N O N E

Schedule S - Part 6

N O N E

Schedule S - Part 7

N O N E

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE T PREMIUMS AND OTHER CONSIDERATIONS

Allocated by States and Territories

	1	Direct Business Only							
		2	3	4	5	6	7	8	9
States, etc.	Active Status (a)	Accident & Health Premiums	Medicare Title XVIII	Medicaid Title XIX	Federal Employees Health Benefits Plan Premiums	Life & Annuity Premiums & Other Considerations	Property/ Casualty Premiums	Total Columns 2 Through 7	Deposit-Type Contracts
1. Alabama AL	N							0	
2. Alaska AK	N							0	
3. Arizona AZ	N							0	
4. Arkansas AR	N							0	
5. California CA	N							0	
6. Colorado CO	N							0	
7. Connecticut CT	N							0	
8. Delaware DE	N							0	
9. District of Columbia DC	N							0	
10. Florida FL	N							0	
11. Georgia GA	N							0	
12. Hawaii HI	N							0	
13. Idaho ID	N							0	
14. Illinois IL	N							0	
15. Indiana IN	N							0	
16. Iowa IA	N							0	
17. Kansas KS	N							0	
18. Kentucky KY	N							0	
19. Louisiana LA	N							0	
20. Maine ME	N							0	
21. Maryland MD	N							0	
22. Massachusetts MA	N							0	
23. Michigan MI	N							0	
24. Minnesota MN	N							0	
25. Mississippi MS	L							0	
26. Missouri MO	N							0	
27. Montana MT	N							0	
28. Nebraska NE	N							0	
29. Nevada NV	N							0	
30. New Hampshire NH	N							0	
31. New Jersey NJ	N							0	
32. New Mexico NM	N							0	
33. New York NY	N							0	
34. North Carolina NC	N							0	
35. North Dakota ND	N							0	
36. Ohio OH	N							0	
37. Oklahoma OK	N							0	
38. Oregon OR	N							0	
39. Pennsylvania PA	N							0	
40. Rhode Island RI	N							0	
41. South Carolina SC	N							0	
42. South Dakota SD	N							0	
43. Tennessee TN	N							0	
44. Texas TX	N							0	
45. Utah UT	N							0	
46. Vermont VT	N							0	
47. Virginia VA	N							0	
48. Washington WA	N							0	
49. West Virginia WV	N							0	
50. Wisconsin WI	N							0	
51. Wyoming WY	N							0	
52. American Samoa AS	N							0	
53. Guam GU	N							0	
54. Puerto Rico PR	N							0	
55. U.S. Virgin Islands VI	N							0	
56. Northern Mariana Islands MP	N							0	
57. Canada CAN	N							0	
58. Aggregate other alien OT	XXX	0	0	0	0	0	0	0	0
59. Subtotal	XXX	0	0	0	0	0	0	0	0
60. Reporting entity contributions for Employee Benefit Plans	XXX							0	
61. Total (Direct Business)	XXX	0	0	0	0	0	0	0	0
DETAILS OF WRITE-INS									
58001.	XXX								
58002.	XXX								
58003.	XXX								
58998. Summary of remaining write-ins for Line 58 from overflow page	XXX	0	0	0	0	0	0	0	0
58999. Totals (Lines 58001 through 58003 plus 58998)(Line 58 above)	XXX	0	0	0	0	0	0	0	0

(a) Active Status Counts:

L - Licensed or Chartered - Licensed insurance carrier or domiciled RRG 1
R - Registered - Non-domiciled RRGs 0
E - Eligible - Reporting entities eligible or approved to write surplus lines in the state 0
Q - Qualified - Qualified or accredited reinsurer. 0
N - None of the above - Not allowed to write business in the state 56

(b) Explanation of basis of allocation by states, premiums by state, etc.
Based on Membership

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE T - PART 2

INTERSTATE COMPACT - EXHIBIT OF PREMIUMS WRITTEN

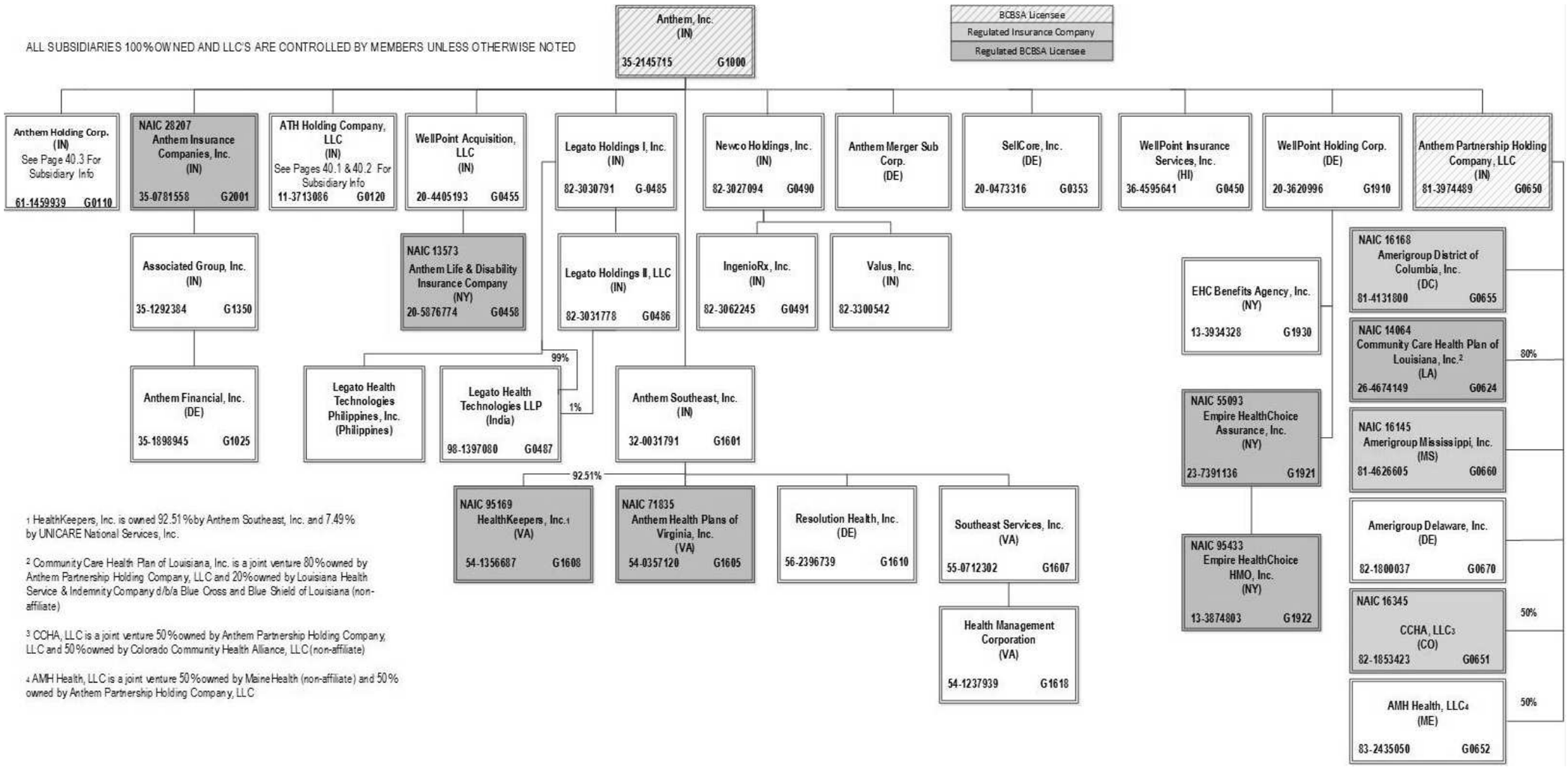
Allocated by States and Territories

		Direct Business Only					
		1	2	3	4	5	6
States, Etc.		Life (Group and Individual)	Annuities (Group and Individual)	Disability Income (Group and Individual)	Long-Term Care (Group and Individual)	Deposit-Type Contracts	Totals
1. Alabama	AL						
2. Alaska	AK						
3. Arizona	AZ						
4. Arkansas	AR						
5. California	CA						
6. Colorado	CO						
7. Connecticut	CT						
8. Delaware	DE						
9. District of Columbia	DC						
10. Florida	FL						
11. Georgia	GA						
12. Hawaii	HI						
13. Idaho	ID						
14. Illinois	IL						
15. Indiana	IN						
16. Iowa	IA						
17. Kansas	KS						
18. Kentucky	KY						
19. Louisiana	LA						
20. Maine	ME						
21. Maryland	MD						
22. Massachusetts	MA						
23. Michigan	MI						
24. Minnesota	MN						
25. Mississippi	MS						
26. Missouri	MO						
27. Montana	MT						
28. Nebraska	NE						
29. Nevada	NV						
30. New Hampshire	NH						
31. New Jersey	NJ						
32. New Mexico	NM						
33. New York	NY						
34. North Carolina	NC						
35. North Dakota	ND						
36. Ohio	OH						
37. Oklahoma	OK						
38. Oregon	OR						
39. Pennsylvania	PA						
40. Rhode Island	RI						
41. South Carolina	SC						
42. South Dakota	SD						
43. Tennessee	TN						
44. Texas	TX						
45. Utah	UT						
46. Vermont	VT						
47. Virginia	VA						
48. Washington	WA						
49. West Virginia	WV						
50. Wisconsin	WI						
51. Wyoming	WY						
52. American Samoa	AS						
53. Guam	GU						
54. Puerto Rico	PR						
55. U.S. Virgin Islands	VI						
56. Northern Mariana Islands	MP						
57. Canada	CAN						
58. Aggregate Other Alien	OT						
59. Total							

NONE

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



1 HealthKeepers, Inc. is owned 92.51% by Anthem Southeast, Inc. and 7.49% by UNICARE National Services, Inc.

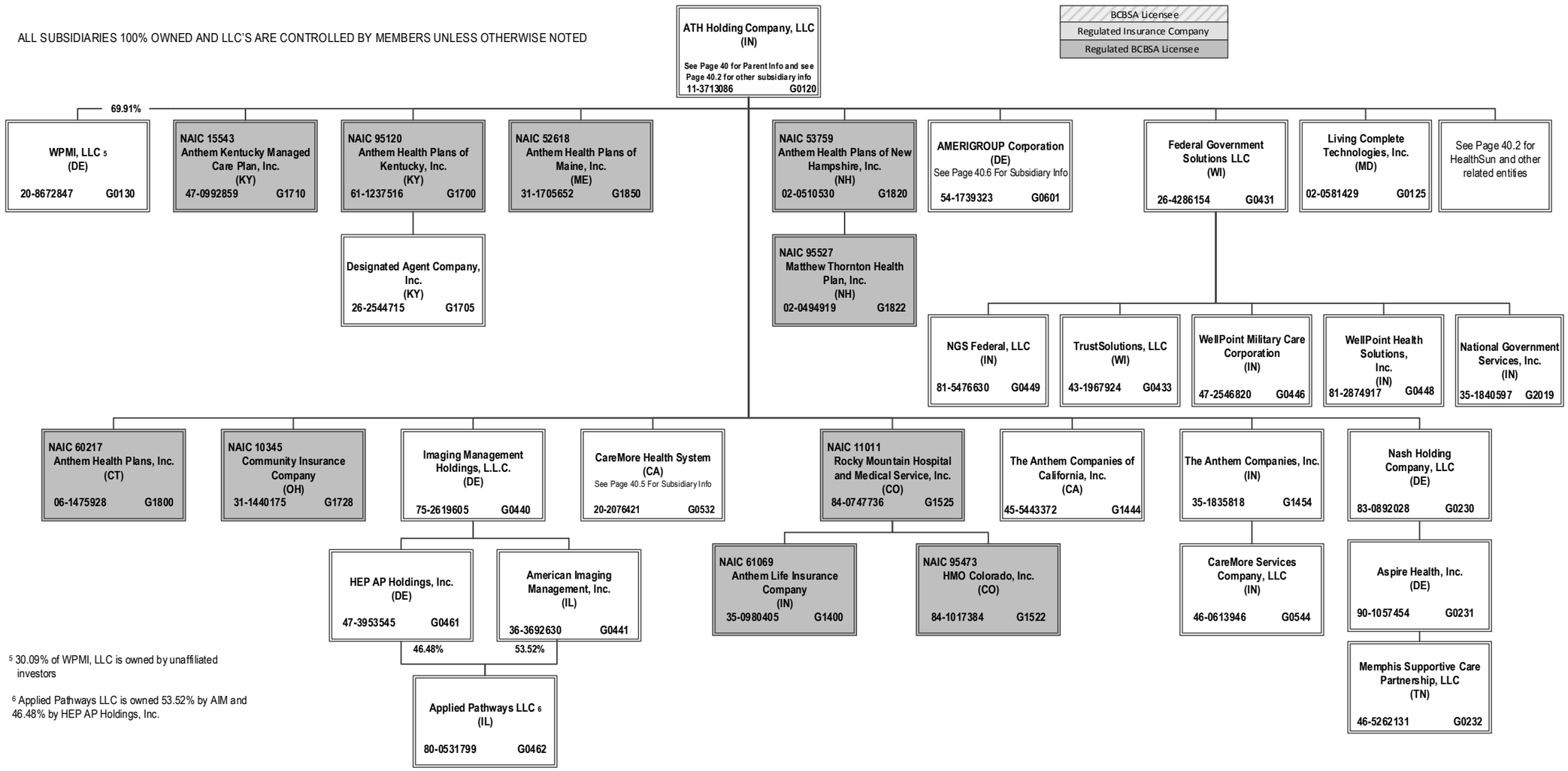
2 Community Care Health Plan of Louisiana, Inc. is a joint venture 80% owned by Anthem Partnership Holding Company, LLC and 20% owned by Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana (non-affiliate)

3 CCHA, LLC is a joint venture 50% owned by Anthem Partnership Holding Company, LLC and 50% owned by Colorado Community Health Alliance, LLC (non-affiliate)

4 AMH Health, LLC is a joint venture 50% owned by Maine Health (non-affiliate) and 50% owned by Anthem Partnership Holding Company, LLC

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART

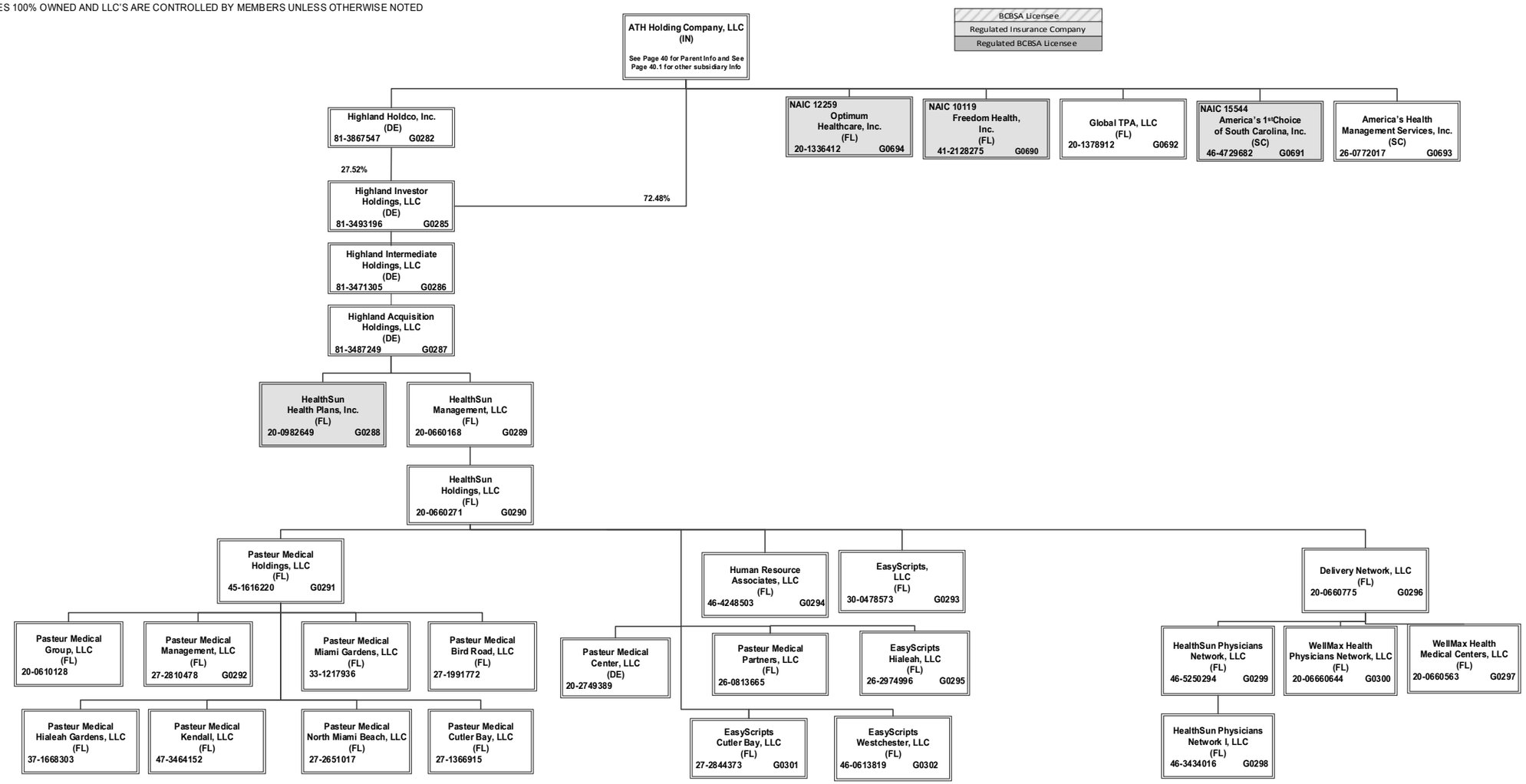


40.1

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART

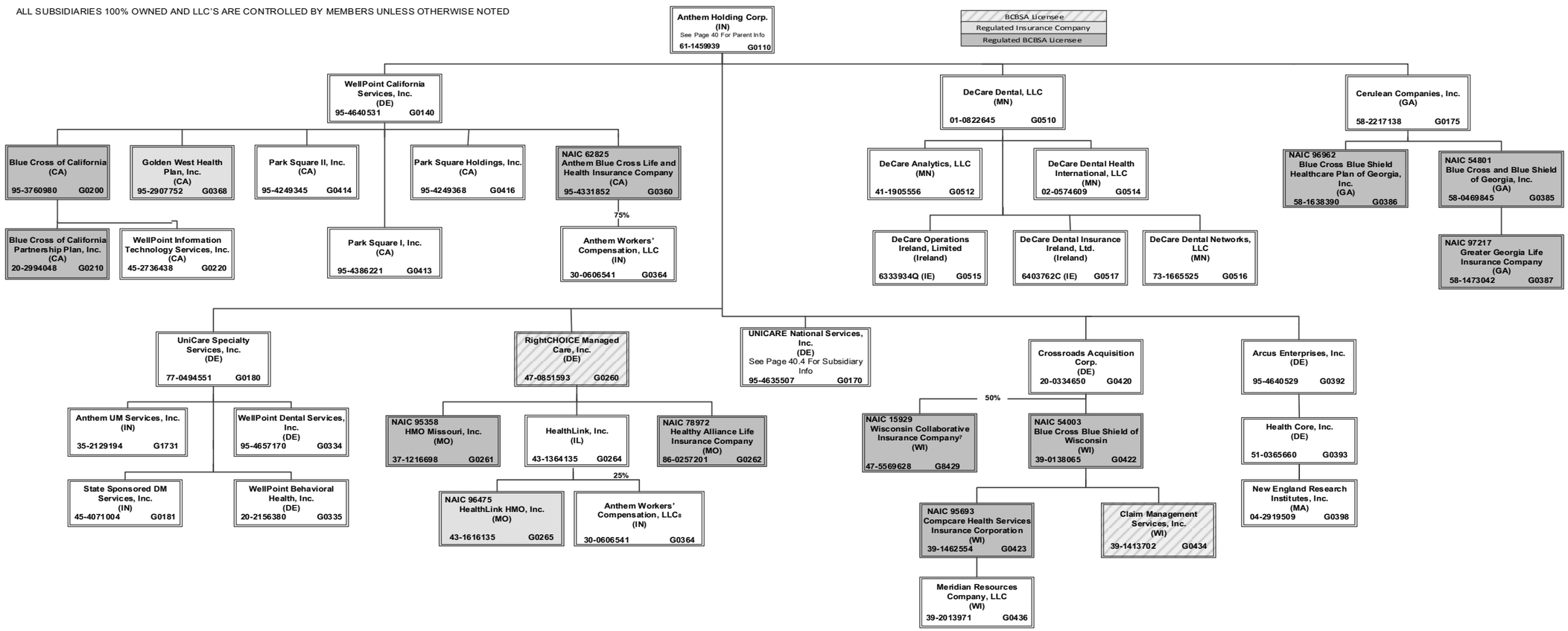
ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED



40.2

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



40.3

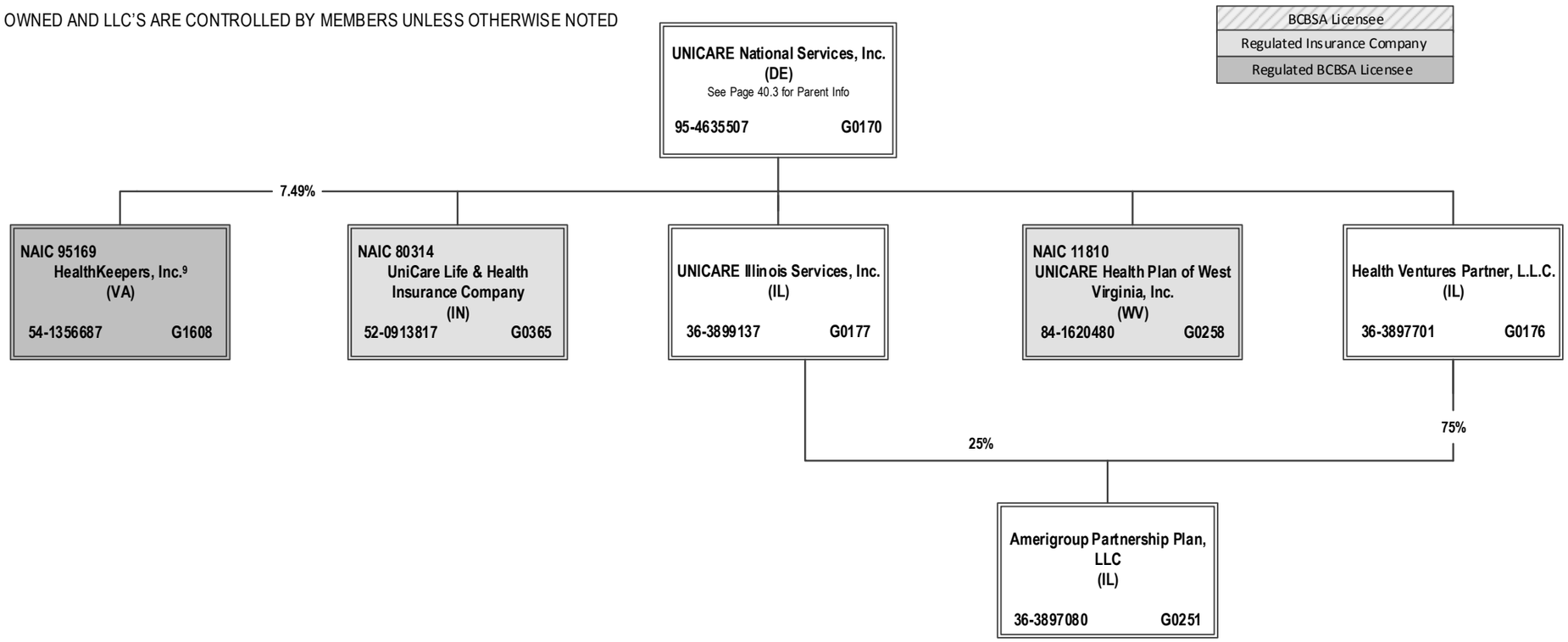
[7] 50% of WCIC is owned by Aurora Health Care, Inc. (non-affiliate). Not consolidated for accounting purposes.

[8] Anthem Workers' Compensation LLC is owned 75% by Anthem Blue Cross Life and Health Insurance Company and 25% by HealthLink, Inc.

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED



[9] HealthKeepers, Inc. is owned 92.51% by Anthem Southeast, Inc. and 7.49% by UNICARE National Services, Inc.

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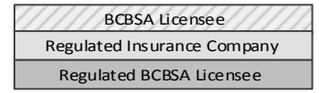
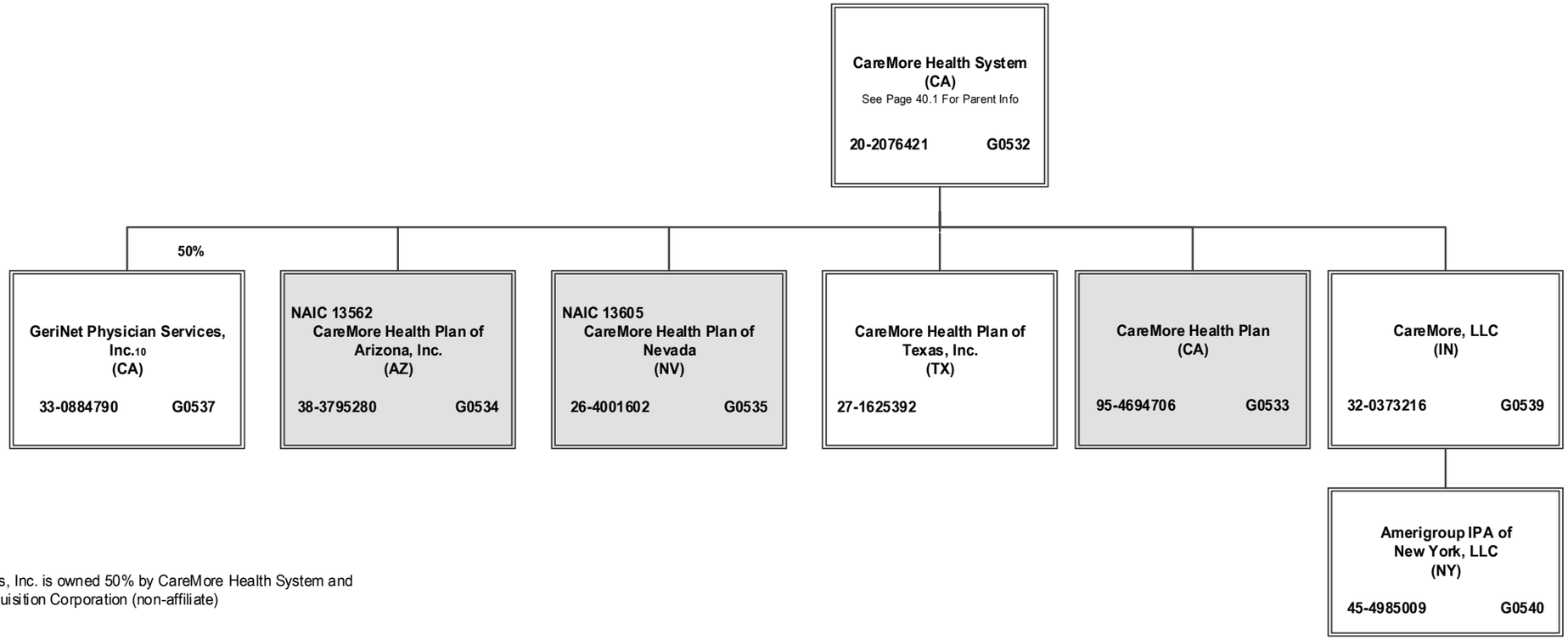
ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED



[10] GeriNet Physician Services, Inc. is owned 50% by CareMore Health System and 50% by Health Essentials Acquisition Corporation (non-affiliate)

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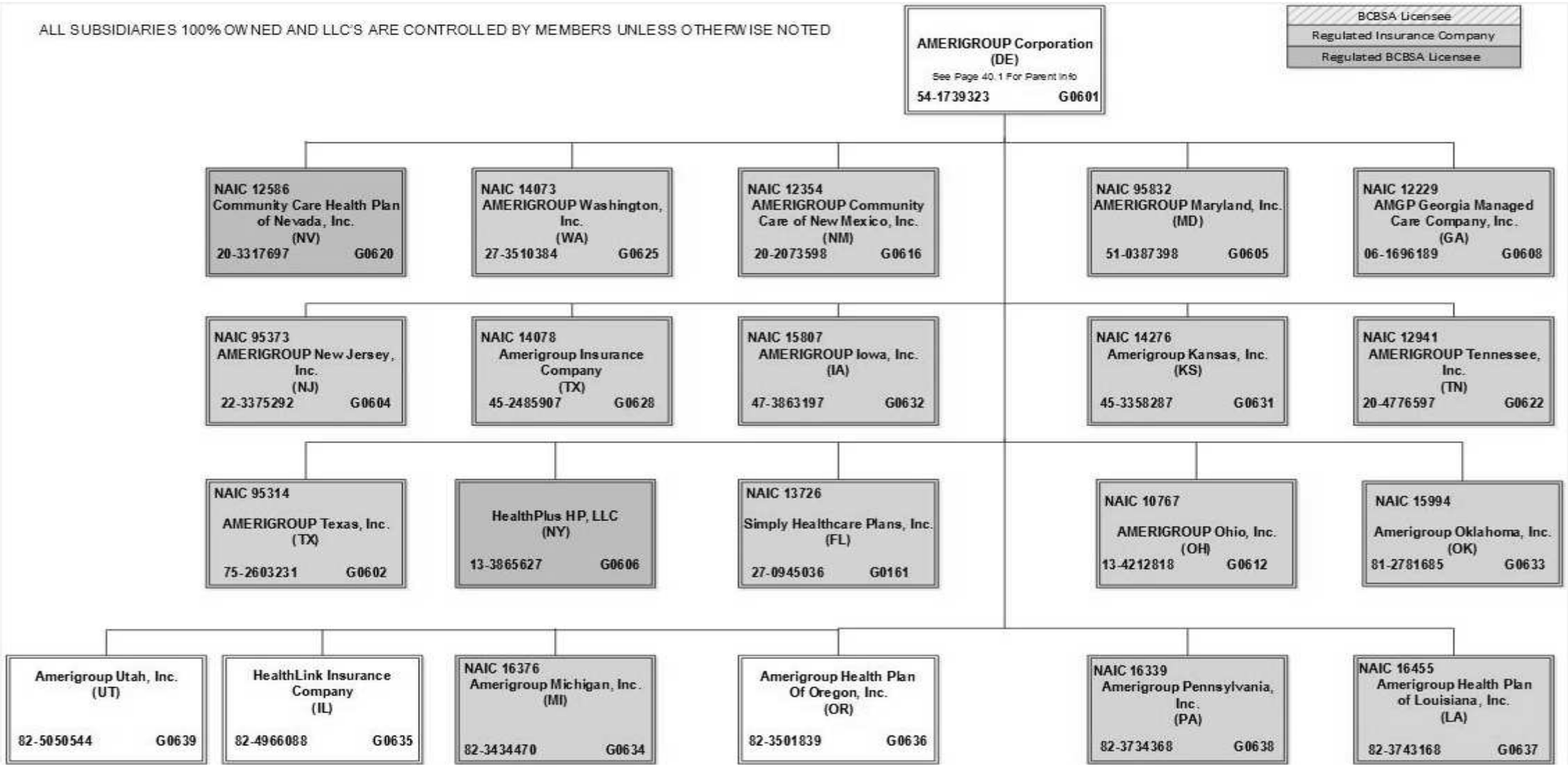
ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



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ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0671	Anthem, Inc.		36-3692630		0001156039		American Imaging Management, Inc.	IL	NIA	Imaging Management Holdings, L.L.C.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	15544	46-4729682		0001156039		America's 1st Choice of South Carolina, Inc.	SC	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		26-0772017		0001156039		America's Health Management Services, Inc.	SC	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	12354	20-2073598		0001156039		AMERIGROUP Community Care of New Mexico, Inc.	NM	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		54-1739323		0001156039		AMERIGROUP Corporation	DE	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-1800037		0001156039		AMERIGROUP Delaware, Inc.	DE	NIA	Anthem Partnership Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	16168	81-4131800		0001156039		Amerigroup District of Columbia, Inc.	DC	IA	Anthem Partnership Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	16455	82-3743168		0001156039		Amerigroup Health Plan of Louisiana, Inc.	LA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-3501839		0001156039		Amerigroup Health Plan of Oregon, Inc.	OR	NIA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	14078	45-2485907		0001156039		Amerigroup Insurance Company	TX	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	15807	47-3863197		0001156039		AMERIGROUP Iowa, Inc.	IA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		45-4985009		0001156039		Amerigroup IPA of New York, LLC	NY	NIA	CareMore, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	14276	45-3358287		0001156039		Amerigroup Kansas, Inc.	KS	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95832	51-0387398		0001156039		AMERIGROUP Maryland, Inc.	MD	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	16376	82-3434470		0001156039		Amerigroup Michigan, Inc.	MI	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	16145	81-4626605		0001156039		Amerigroup Mississippi, Inc.	MS	RE	Anthem Partnership Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95373	22-3375292		0001156039		AMERIGROUP New Jersey, Inc.	NJ	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	10767	13-4212818		0001156039		AMERIGROUP Ohio, Inc.	OH	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	15994	81-2781685		0001156039		AMERIGROUP Oklahoma, Inc.	OK	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		36-3897080		0001156039		Amerigroup Partnership Plan, LLC	IL	NIA	Health Ventures Partner, L.L.C.	Ownership	75.000	Anthem, Inc.	N	
0671	Anthem, Inc.		36-3897080		0001156039		Amerigroup Partnership Plan, LLC	IL	NIA	UNICARE Illinois Services, Inc.	Ownership	25.000	Anthem, Inc.	N	
0671	Anthem, Inc.	16339	82-3734368		0001156039		Amerigroup Pennsylvania, Inc.	PA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	12941	20-4776597		0001156039		AMERIGROUP Tennessee, Inc.	TN	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95314	75-2603231		0001156039		AMERIGROUP Texas, Inc.	TX	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	14073	27-3510384		0001156039		AMERIGROUP Washington, Inc.	WA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-5050544		0001156039		AMERIGROUP Utah, Inc.	UT	NIA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	12229	06-1696189		0001156039		AMGP Georgia Managed Care Company, Inc.	GA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		83-2435050		0001156039		AMH Health, LLC	ME	NIA	Anthem Partnership Holding Company, LLC	Ownership	50.000	Anthem, Inc.	N	0102
0671	Anthem, Inc.	62825	95-4331852		0001156039		Anthem Blue Cross Life and Health Insurance Company	CA	IA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		35-1898945		0001156039		Anthem Financial, Inc.	DE	NIA	Associated Group, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95120	61-1237516		0001156039		Anthem Health Plans of Kentucky, Inc.	KY	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	52618	31-1705652		0001156039		Anthem Health Plans of Maine, Inc.	ME	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	53759	02-0510530		0001156039		Anthem Health Plans of New Hampshire, Inc.	NH	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	71835	54-0357120	40003317	0001156039		Anthem Health Plans of Virginia, Inc.	VA	IA	Anthem Southeast, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	60217	06-1475928		0001156039		Anthem Health Plans, Inc.	CT	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		61-1459939		0001156039		Anthem Holding Corp.	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		35-2145715		0001156039	New York Stock Exchange (NYSE)	Anthem, Inc.	IN	UIP				Anthem, Inc.	N	
0671	Anthem, Inc.	28207	35-0781558		0001156039		Anthem Insurance Companies, Inc.	IN	IA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	15543	47-0992859		0001156039		Anthem Kentucky Managed Care Plan, Inc.	KY	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	13573	20-5876774		0001156039		Anthem Life & Disability Insurance Company	NY	IA	WellPoint Acquisition, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	61069	35-0980405		0001156039		Anthem Life Insurance Company	IN	IA	Rocky Mountain Hospital and Medical Service, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.				0001156039		Anthem Merger Sub Corp.	DE	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		81-3974489		0001156039		Anthem Partnership Holding Company, LLC	DE	UDP	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		32-0031791		0001156039		Anthem Southeast, Inc.	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		35-2129194		0001156039		Anthem UM Services, Inc.	IN	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		30-0606541		0001156039		Anthem Workers' Compensation, LLC	IN	NIA	Anthem Blue Cross Life and Health Insurance Company	Ownership	75.000	Anthem, Inc.	N	
0671	Anthem, Inc.		30-0606541		0001156039		Anthem Workers' Compensation, LLC	IN	NIA	HealthLink, Inc.	Ownership	25.000	Anthem, Inc.	N	
0671	Anthem, Inc.		80-0531799		0001156039		Applied Pathways, LLC	IL	NIA	American Imaging Management, Inc.	Ownership	53.520	Anthem, Inc.	N	0108

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

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0671	Anthem, Inc.		80-0531799		0001156039		Applied Pathways, LLC	IL	NIA	HEP AP Holdings, Inc.	Ownership	46.480	Anthem, Inc.	N	0108
0671	Anthem, Inc.		95-4640529		0001156039		Arcus Enterprises, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		90-1057454		0001156039		Aspire Health, Inc.	DE	NIA	Nash Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		35-1292384		0001156039		Associated Group, Inc.	IN	NIA	Anthem Insurance Companies, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		11-3713086		0001156039		ATH Holding Company, LLC	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	54801	58-0469845		0001156039		Blue Cross and Blue Shield of Georgia, Inc.	GA	IA	Cerulean Companies, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	96962	58-1638390		0001156039		Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	GA	IA	Cerulean Companies, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	54003	39-0138065		0001156039		Blue Cross Blue Shield of Wisconsin	WI	IA	Crossroads Acquisition Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-3760980		0001156039		Blue Cross of California	CA	IA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	0101
0671	Anthem, Inc.		20-2994048		0001156039		Blue Cross of California Partnership Plan, Inc.	CA	IA	Blue Cross of California	Ownership	100.000	Anthem, Inc.	N	0101
0671	Anthem, Inc.		95-4694706		0001156039		CareMore Health Plan	CA	IA	CareMore Health System	Ownership	100.000	Anthem, Inc.	N	0101
0671	Anthem, Inc.	13562	38-3795280		0001156039		CareMore Health Plan of Arizona, Inc.	AZ	IA	CareMore Health System	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	13605	26-4001602		0001156039		CareMore Health Plan of Nevada	NV	IA	CareMore Health System	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		27-1625392		0001156039		CareMore Health Plan of Texas, Inc.	TX	NIA	CareMore Health System	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		32-0373216		0001156039		CareMore, LLC	IN	NIA	CareMore Health System	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-2076421		0001156039		CareMore Health System	CA	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		46-0613946		0001156039		CareMore Services Company, LLC	IN	NIA	The Anthem Companies, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		58-2217138		0001156039		Cerulean Companies, Inc.	GA	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		39-1413702		0001156039		Claim Management Services, Inc.	WI	NIA	Blue Cross Blue Shield of Wisconsin	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	16345	82-1853423		0001156039		CCHA, LLC	CO	IA	Anthem Partnership Holding Company, LLC	Ownership	50.000	Anthem, Inc.	N	0102
0671	Anthem, Inc.	14064	26-4674149		0001156039		Community Care Health Plan of Louisiana, Inc.	LA	IA	Anthem Partnership Holding Company, LLC	Ownership	80.000	Anthem, Inc.	N	0104
0671	Anthem, Inc.	12586	20-3317697		0001156039		Community Care Health Plan of Nevada, Inc.	NV	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	10345	31-1440175		0001156039		Community Insurance Company	OH	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95693	39-1462554		0001156039		Compcare Health Services Insurance Corporation	WI	IA	Blue Cross Blue Shield of Wisconsin	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0334650		0001156039		Crossroads Acquisition Corp.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		41-1905556		0001156039		DeCare Analytics, LLC	MN	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		02-0574609		0001156039		DeCare Dental Health International, LLC	MN	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.				0001156039		DeCare Dental Insurance Ireland, Ltd.	IRL	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		73-1665525		0001156039		DeCare Dental Networks, LLC	MN	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		01-0822645		0001156039		DeCare Dental, LLC	MN	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.				0001156039		DeCare Operations Ireland, Limited	IRL	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0660775		0001156039		Delivery Network, LLC	FL	NIA	HealthSun Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		26-2544715		0001156039		Designated Agent Company, Inc.	KY	NIA	Anthem Health Plans of Kentucky, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		27-2844373		0001156039		EasyScripts Cutler Bay, LLC	FL	NIA	HealthSun Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		26-2974996		0001156039		EasyScripts Hialeah, LLC	FL	NIA	HealthSun Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		30-0478573		0001156039		EasyScripts LLC	FL	NIA	HealthSun Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		46-0613819		0001156039		EasyScripts Westchester, LLC	FL	NIA	HealthSun Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		13-3934328		0001156039		EHC Benefits Agency, Inc.	NY	NIA	WellPoint Holding Corp	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	55093	23-7391136		0001156039		Empire HealthChoice Assurance, Inc.	NY	IA	WellPoint Holding Corp	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95433	13-3874803		0001156039		Empire HealthChoice HMO, Inc.	NY	IA	Empire HealthChoice Assurance, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		26-4286154		0001156039		Federal Government Solutions, LLC	WI	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	10119	41-2128275		0001156039		Freedom Health, Inc.	FL	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		33-0884790		0001156039		GeriNet Physician Services, Inc.	CA	NIA	CareMore Health System	Ownership	50.000	Anthem, Inc.	N	0102
0671	Anthem, Inc.		20-1378912		0001156039		Global TPA, LLC	FL	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-2907752		0001156039		Golden West Health Plan, Inc.	CA	IA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	0101
0671	Anthem, Inc.	97217	58-1473042		0001156039		Greater Georgia Life Insurance Company	GA	IA	Blue Cross and Blue Shield of Georgia, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		51-0365660		0001156039		Health Core, Inc.	DE	NIA	Arcus Enterprises, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		54-1237939		0001156039		Health Management Corporation	VA	NIA	Southeast Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		36-3897701		0001156039		Health Ventures Partner, L.L.C.	IL	NIA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	N	

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ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0671	Anthem, Inc.	95169	54-1356687		0001156039		HealthKeepers, Inc.	VA	IA	Anthem Southeast, Inc.	Ownership	92.510	Anthem, Inc.	N	
0671	Anthem, Inc.	95169	54-1356687		0001156039		HealthKeepers, Inc.	VA	IA	UNICARE National Services, Inc.	Ownership	7.490	Anthem, Inc.	N	
0671	Anthem, Inc.	96475	43-1616135		0001156039		HealthLink HMO, Inc.	MO	IA	HealthLink, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		43-1364135		0001156039		HealthLink, Inc.	IL	NIA	RightCHOICE Managed Care, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-4966088		0001156039		HealthLink Insurance Company	IL	NIA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		13-3865627		0001156039		HealthPlus HP, LLC	NY	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	0100
0671	Anthem, Inc.	10122	20-0982649		0001156039		HealthSun Health Plans, Inc.	FL	IA	Highland Acquisition Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0660271		0001156039		HealthSun Holdings, LLC	FL	NIA	HealthSun Management, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0660168		0001156039		HealthSun Management, LLC	FL	NIA	Highland Acquisition Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		46-5250294		0001156039		HealthSun Physicians Network, LLC	FL	NIA	Delivery Network, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		46-3434016		0001156039		HealthSun Physicians Network I, LLC	FL	NIA	HealthSun Physicians Network, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	78972	86-0257201		0001156039		Healthy Alliance Life Insurance Company	MO	IA	RightCHOICE Managed Care, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		47-3953545		0001156039		HEP AP Holdings, Inc.	DE	NIA	Imaging Management Holdings, L.L.C.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		81-3867547		0001156039		Highland Holdco, Inc.	DE	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		81-3487249		0001156039		Highland Acquisition Holdings, LLC	DE	NIA	Highland Intermediate Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		81-3471305		0001156039		Highland Intermediate Holdings, LLC	DE	NIA	Highland Investor Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		81-3493196		0001156039		Highland Investor Holdings, LLC	DE	NIA	ATH Holding Company, LLC	Ownership	72.480	Anthem, Inc.	N	0107
0671	Anthem, Inc.		81-3493196		0001156039		Highland Investor Holdings, LLC	DE	NIA	Highland Holdco, Inc.	Ownership	27.520	Anthem, Inc.	N	0107
0671	Anthem, Inc.	95473	84-1017384		0001156039		HMO Colorado, Inc.	CO	IA	Rocky Mountain Hospital and Medical Service, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95358	37-1216698		0001156039		HMO Missouri, Inc.	MO	IA	RightCHOICE Managed Care, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.				0001156039		Human Resource Associates, LLC	FL	NIA	HealthSun Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		75-2619605		0001156039		Imaging Management Holdings, L.L.C.	DE	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-3062245		0001156039		IngenioRX, Inc.	IN	NIA	Newco Holdings, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		98-1397080		0001156039		Legato Health Technologies LLC	IN	NIA	Legato Holdings I, Inc.	Ownership	100.000	Anthem, Inc.	N	0105
0671	Anthem, Inc.				0001156039		Legato Health Technologies Philippines, Inc.	PHL	NIA	Legato Holdings I, Inc.	Ownership	100.000	Anthem, Inc.	N	0106
0671	Anthem, Inc.		82-3030791		0001156039		Legato Holdings I, Inc.	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-3031178		0001156039		Legato Holdings II, Inc.	IN	NIA	Legato Holdings I, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		02-0581429		0001156039		Living Complete Technologies, Inc.	MD	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95527	02-0494919		0001156039		Matthew Thornton Health Plan, Inc.	NH	IA	Anthem Health Plans of New Hampshire, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		46-5262131		0001156039		Memphis Supportive Care Partnership, LLC	TN	NIA	Nash Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		39-2013971		0001156039		Meridian Resource Company, LLC	WI	NIA	Compcare Health Services Insurance Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		83-0892028		0001156039		Nash Holding Company, LLC	DE	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		35-1840597		0001156039		National Government Services, Inc.	IN	NIA	Federal Government Solutions, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		04-2919509		0001156039		New England Research Institute, Inc.	MA	NIA	Health Core, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-3027094		0001156039		Newco Holdings, Inc.	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		81-5476630		0001156039		NGS Federal, LLC	IN	NIA	Federal Government Solutions, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	12259	20-1336412		0001156039		Optimum Healthcare, Inc.	FL	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4249368		0001156039		Park Square Holdings, Inc.	CA	NIA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4386221		0001156039		Park Square I, Inc.	CA	NIA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4249345		0001156039		Park Square II, Inc.	CA	NIA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		27-1991772		0001156039		Pasteur Medical Birds Road, LLC	FL	NIA	Pasteur Medical Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-2749389		0001156039		Pasteur Medical Center, LLC	DE	NIA	HealthSun Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		27-1366915		0001156039		Pasteur Medical Cutler Bay, LLC	FL	NIA	Pasteur Medical Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0610128		0001156039		Pasteur Medical Group, LLC	FL	NIA	Pasteur Medical Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		37-1668303		0001156039		Pasteur Medical Hialeah Gardens, LLC	FL	NIA	Pasteur Medical Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		45-1616220		0001156039		Pasteur Medical Holdings, LLC	FL	NIA	HealthSun Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		47-3464152		0001156039		Pasteur Medical Kendall, LLC	FL	NIA	Pasteur Medical Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		27-2810478		0001156039		Pasteur Medical Management, LLC	FL	NIA	Pasteur Medical Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		33-1217936		0001156039		Pasteur Medical Miami Gardens, LLC	FL	NIA	Pasteur Medical Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		27-2651017		0001156039		Pasteur Medical North Miami Beach, LLC	FL	NIA	Pasteur Medical Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	

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ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0671	Anthem, Inc.		26-0813665		0001156039		Pasteur Medical Partners, LLC	FL	NIA	HealthSun Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		56-2396739		0001156039		Resolution Health, Inc.	DE	NIA	Anthem Southeast, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		47-0851593		0001156039		RightCHOICE Managed Care, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	11011	84-0747736		0001156039		Rocky Mountain Hospital and Medical Service, Inc.	CO	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0473316		0001156039		SellCore, Inc.	DE	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	13726	27-0945036		0001156039		Simply Healthcare Plans, Inc.	FL	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		55-0712302		0001156039		Southeast Services, Inc.	VA	NIA	Anthem Southeast, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		45-4071004		0001156039		State Sponsored DM Services, Inc.	IN	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		35-1835818		0001156039		The Anthem Companies, Inc.	IN	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		45-5443372		0001156039		The Anthem Companies of California, Inc.	CA	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		43-1967924		0001156039		TrustSolutions, LLC	WI	NIA	Federal Government Solutions, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	11810	84-1620480		0001156039		UNICARE Health Plan of West Virginia, Inc.	WV	IA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		36-3899137		0001156039		UNICARE Illinois Services, Inc.	IL	NIA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	80314	52-0913817		0001156039		UNICARE Life & Health Insurance Company	IN	IA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4635507		0001156039		UNICARE National Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		77-0494551		0001156039		UNICARE Specialty Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-3300542		0001156039		Valus, Inc.	IN	NIA	IngenioRX, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0660644		0001156039		WellMax Health Medical Centers, LLC	FL	NIA	Delivery Network, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		36-4014617		0001156039		WellMax Health Physicians Network, LLC	FL	NIA	Delivery Network, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-4405193		0001156039		WellPoint Acquisition, LLC	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-2156380		0001156039		WellPoint Behavioral Health, Inc.	DE	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4640531		0001156039		WellPoint California Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4657170		0001156039		WellPoint Dental Services, Inc.	DE	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		81-2874917		0001156039		WellPoint Health Solutions, Inc.	DE	NIA	Federal Government Solutions, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-3620996		0001156039		WellPoint Holding Corp	DE	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		45-2736438		0001156039		WellPoint Information Technology Services, Inc.	CA	NIA	Blue Cross of California	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		36-4595641		0001156039		WellPoint Insurance Services, Inc.	HI	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		47-2546820		0001156039		WellPoint Military Care Corporation	IN	NIA	Federal Government Solutions, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	15929	47-5569628		0001156039		Wisconsin Collaborative Insurance Company	WI	IA	Crossroads Acquisition Corp.	Ownership	50.000	Anthem, Inc.	N	0102
0671	Anthem, Inc.		20-8672847		0001156039		WPMI, LLC	DE	NIA	ATH Holding Company, LLC	Ownership	69.910	Anthem, Inc.	N	0103

Asterisk	Explanation
0100	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the New York State Department of Health.
0101	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0102	50% owned by unaffiliated investors
0103	30.09% owned by unaffiliated investors
0104	20% owned by an unaffiliated investor
0105	Legato Health Technologies LLP is a Limited Liability Partnership formed under the laws of India, and is 99% owned by Legato Holdings I, Inc. an Indiana corporation, and 1% owned by Legato Holdings II, LLC, an Indiana Limited Liability company.
0106	Legato Health Technologies Philippines, Inc. was incorporated under with the Republic of the Philippines, and is 100% owned by Legato Holdings I, Inc. an Indiana corporation.
0107	Highland Investor Holding LLC is a Limited Liability Company formed under the laws of Delaware, and is 72.48% owned by Anthem Holding Company, LLC. an Indiana limited liability company, and 27.52% owned by Highland Holdco, Inc., a Delaware corporation.
0108	Applied Pathways, LLC is a Limited Liability Company formed under the laws of Illinois, and is 53.52% owned by American Imaging Management, Inc. an Illinois limited liability company, and 46.48% owned by HEP AP Holdings, Inc., a Delaware corporation.

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1 NAIC Company Code	2 ID Number	3 Names of Insurers and Parent, Subsidiaries or Affiliates	4 Shareholder Dividends	5 Capital Contributions	6 Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	7 Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	8 Management Agreements and Service Contracts	9 Income/ (Disbursements) Incurred Under Reinsurance Agreements	10 *	11 Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	12 Totals	13 Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
	36-3692630	American Imaging Management, Inc.					(109,017,782)				(109,017,782)	
15544	46-4729682	America's 1st Choice of South Carolina, Inc.		1,500,000			(995,497)				504,503	
	26-0772017	America's Health Management Services, Inc.					810,941				810,941	
12354	20-2073598	AMERIGROUP Community Care of New Mexico, Inc.					(2,737,305)				(2,737,305)	
	54-1739323	AMERIGROUP Corporation					99,361,113				99,361,113	
16168	81-4131800	AMERIGROUP District of Columbia, Inc.	(25,000,000)	20,000,000			(28,453,424)				(33,453,424)	
14078	45-2485907	AMERIGROUP Insurance Company					(126,821,389)				(126,821,389)	
15807	47-3863197	AMERIGROUP Iowa, Inc.		15,000,000			(70,492,263)				(55,492,263)	
14276	45-3358287	AMERIGROUP Kansas, Inc.					(70,930,126)				(70,930,126)	
95832	51-0387398	AMERIGROUP Maryland, Inc.	(70,000,000)				(138,996,806)				(208,996,806)	
16376	82-3434470	Amerigroup Michigan, Inc.		2,525,000							2,525,000	
16145	81-4626605	AMERIGROUP Mississippi, Inc.									0	
95373	22-3375292	AMERIGROUP New Jersey, Inc.	(41,100,000)				(136,960,942)				(178,060,942)	
10767	13-4212818	AMERIGROUP Ohio, Inc.					18,570				18,570	
15994	81-2781685	AMERIGROUP Oklahoma, Inc.					433				433	
	36-3897080	Amerigroup Partnership Plan, LLC					(55,876,250)				(55,876,250)	
16339	82-3734368	Amerigroup Pennsylvania, Inc.		6,500,000							6,500,000	
12941	20-4776597	AMERIGROUP Tennessee, Inc.	(55,600,000)				(209,590,024)				(265,190,024)	
95314	75-2603231	AMERIGROUP Texas, Inc.	(20,000,000)				(425,939,887)				(445,939,887)	
14073	27-3510384	AMERIGROUP Washington, Inc.	(14,600,000)				(67,521,981)				(82,121,981)	
12229	06-1696189	AMGP Georgia Managed Care Company, Inc.	(26,800,000)				(197,062,484)				(223,862,484)	
62825	95-4331852	Anthem Blue Cross Life and Health Insurance Company, Inc.	(151,900,000)				(981,978,783)	(24,264,593)			(1,158,143,376)	36,781,726
95120	61-1237516	Anthem Health Plans of Kentucky, Inc.	(160,000,000)				(426,362,603)	(10,418,343)			(596,780,946)	16,518,427
52618	31-1705652	Anthem Health Plans of Maine, Inc.	(37,700,000)				(103,716,716)	(57,484)			(141,474,200)	
53759	02-0510530	Anthem Health Plans of New Hampshire, Inc.	(10,000,000)				(87,407,739)				(97,407,739)	
71835	54-0357120	Anthem Health Plans of Virginia, Inc.	(300,000,000)				(598,889,640)	(29,436,643)			(928,326,283)	66,928,552
60217	06-1475928	Anthem Health Plans, Inc.	(42,300,000)				(343,430,476)				(385,730,476)	
28207	35-0781558	Anthem Insurance Companies, Inc.	(490,000,000)				(1,393,869,102)	(84,247,077)			(1,968,116,179)	(48,641,479)
15543	47-0992859	Anthem Kentucky Managed Care Plan, Inc.					(77,063,283)				(77,063,283)	
13573	20-5876774	Anthem Life and Disability Insurance Company					(2,081,909)				(2,081,909)	
61069	35-0980405	Anthem Life Insurance Company	(12,500,000)				(41,930,064)	35,755,952			(18,674,112)	(75,644,050)
	81-3974489	Anthem Partnership Holding Company, LLC									0	
	35-2145715	Anthem, Inc.	3,647,100,000	(117,766,951)			6,313,861,562				9,843,194,611	
15544	46-4729682	APC Passe, LLC		862,745							862,745	
	11-3713086	ATH Holding Company, LLC					1,434,940				1,434,940	
54801	58-0469845	Blue Cross and Blue Shield of Georgia, Inc.	(31,900,000)				(357,624,214)				(389,524,214)	

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1 NAIC Company Code	2 ID Number	3 Names of Insurers and Parent, Subsidiaries or Affiliates	4 Shareholder Dividends	5 Capital Contributions	6 Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	7 Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	8 Management Agreements and Service Contracts	9 Income/ (Disbursements) Incurred Under Reinsurance Agreements	10 *	11 Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	12 Totals	13 Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
96962	58-1638390	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	(103,800,000)				(527,376,338)				(631,176,338)	
54003	39-0138065	Blue Cross Blue Shield of Wisconsin	(70,000,000)				(146,490,315)	(25,451,644)			(241,941,959)	20,140,470
	95-3760980	Blue Cross of California	(400,000,000)	(380,000,000)			(2,200,914,232)				(2,980,914,232)	
	20-2994048	Blue Cross of California Partnership Plan, Inc.	(100,000,000)				(422,852,904)				(522,852,904)	
	95-4694706	Caremore Health Plan	(30,000,000)				812,135,218				782,135,218	
13562	38-3975280	Caremore Health Plan of Arizona, Inc.					(53,721,171)				(53,721,171)	
13605	26-4001602	Caremore Health Plan of Nevada					79,592,087				79,592,087	
16345	82-1853423	CCHA, LLC		3,000,500				(716,063)			2,284,437	25,500,260
14064	26-4674149	Community Care Health Plan of Louisiana, Inc.		52,000,000			(102,454,994)				(50,454,994)	
12586	20-3317697	Community Care Health Plan of Nevada, Inc.					(94,001,461)				(94,001,461)	
10345	31-1440175	Community Insurance Company	(348,500,000)				(1,018,946,924)	(19,020,011)			(1,386,466,935)	45,230,805
95693	39-1462554	Compcare Health Services Insurance Corporation	(29,000,000)				(122,111,536)				(151,111,536)	
	01-0822645	DeCare Dental, LLC					(49,230,575)				(49,230,575)	
	30-0478573	EasyScripts LLC					15,555,437				15,555,437	
55093	23-7391136	Empire HealthChoice Assurance, Inc.	(250,000,000)				(613,755,584)				(863,755,584)	
95433	13-3874803	Empire HealthChoice HMO, Inc.					(72,010,478)				(72,010,478)	
10119	41-2128275	Freedom Health, Inc.		9,111,028			(148,515,455)				(139,404,427)	
	20-1378912	Global TPA, LLC					216,505,663				216,505,663	
	95-2907752	Golden West Health Plan, Inc.					(464,335)				(464,335)	
97217	58-1473042	Greater Georgia Life Insurance Company					(8,719,700)				(8,719,700)	
	51-0365660	Health Core, Inc.					(28,583,837)				(28,583,837)	
	54-1237939	Health Management Corporation					(13,098,242)				(13,098,242)	
95169	54-1356687	HealthKeepers, Inc.	(183,400,000)				(423,188,078)	(4,513,023)			(611,101,101)	104,760
96475	43-1616135	HealthLink HMO, Inc.					5,236,022				5,236,022	
	43-1364135	HealthLink, Inc.					(49,925,006)				(49,925,006)	
	13-3865627	HealthPlus LLC					(271,251,937)				(271,251,937)	
10122	20-0982649	HealthSun Health Plans, Inc	(18,600,000)	50,904,906			(379,715,056)				(347,410,150)	
78972	86-0257201	Healthy Alliance Life Insurance Company	(343,400,000)				(353,359,994)				(696,759,994)	
	81-3471305	Highland Acquisition Holdings LLC		(50,904,906)			(18,545,466)				(69,450,372)	
95473	84-1017384	HMO Colorado, Inc.	(7,000,000)				(207,102,762)				(214,102,762)	
95358	37-1216698	HMO Missouri, Inc.					(27,868,903)				(27,868,903)	
	46-4248503	Human Resource Associates, LLC					446,050				446,050	
95527	02-0494919	Matthew Thornton Health Plan, Inc.	(40,000,000)				(117,383,160)				(157,383,160)	
	39-2013971	Meridian Resource Company, LLC	(11,000,000)				(949,823)				(11,949,823)	
12259	20-1336412	Optimum Healthcare, Inc.		1,045,028			(108,902,212)				(107,857,184)	
	27-2810478	Pasteur Medical Management LLC (Centers)					219,536,011				219,536,011	
	47-0851593	RightCHOICE Managed Care, Inc.					(21,087,100)				(21,087,100)	
11011	84-0747736	Rocky Mountain Hospital and Medical Service, Inc.	(100,500,000)				(284,252,997)	(35,839,182)			(420,592,179)	32,627,969

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ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1 NAIC Company Code	2 ID Number	3 Names of Insurers and Parent, Subsidiaries or Affiliates	4 Shareholder Dividends	5 Capital Contributions	6 Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	7 Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	8 Management Agreements and Service Contracts	9 Income/ (Disbursements) Incurred Under Reinsurance Agreements	10 *	11 Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	12 Totals	13 Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
13726	27-0945036	Simply Healthcare Plans, Inc.	(115,400,000)				(365,221,237)				(480,621,237)	
	45-5443372	The Anthem Companies of California, Inc.					148,219,517				148,219,517	
	35-1835818	The Anthem Companies, Inc.					5,966,202,946				5,966,202,946	
	45-2541383	The Medical City LLC					826,419				826,419	
11810	84-1620480	UNICARE Health Plan of West Virginia, Inc.	(7,100,000)				(58,938,884)				(66,038,884)	
80314	52-0913817	UNICARE Life & Health Insurance Company					(64,307,365)	(45,406,458)			(109,713,823)	(3,717,626)
	20-0660775	WellMax Health Delivery Network, LLC					143,387,395				143,387,395	
	45-2736438	WellPoint Information Technology Services		380,000,000			429,830,045				809,830,045	
	36-4595641	WellPoint Insurance Services, Inc.					(3,473,983)	243,614,569			240,140,586	(115,829,814)
15929	47-5569628	Wisconsin Collaborative Insurance Company		6,222,650			(18,487,636)				(12,264,986)	
9999999 Control Totals			0	0	0	0	0	0	XXX	0	0	0

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ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

		Responses
	MARCH FILING	
1.	Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?	YES
2.	Will an actuarial opinion be filed by March 1?	WAIVED
3.	Will the confidential Risk-based Capital Report be filed with the NAIC by March 1?	YES
4.	Will the confidential Risk-based Capital Report be filed with the state of domicile, if required, by March 1?	YES
	APRIL FILING	
5.	Will Management's Discussion and Analysis be filed by April 1?	YES
6.	Will the Supplemental Investment Risks Interrogatories be filed by April 1?	YES
7.	Will the Accident and Health Policy Experience Exhibit be filed by April 1?	YES
	JUNE FILING	
8.	Will an audited financial report be filed by June 1?	WAIVED
9.	Will Accountant's Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1?	WAIVED
	AUGUST FILING	
10.	Will the regulator-only (non-public) Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile and electronically with the NAIC (as a regulator-only non-public document) by August 1?	WAIVED

The following supplemental reports are required to be filed as part of your annual statement filing **if your company is engaged in the type of business covered by the supplement. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below.** If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

	MARCH FILING	
11.	Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1?	NO
12.	Will the Supplemental Life data due March 1 be filed with the state of domicile and the NAIC?	NO
13.	Will Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1?	NO
14.	Will the actuarial opinion on participating and non-participating policies as required in Interrogatories 1 and 2 on Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	NO
15.	Will the actuarial opinion on non-guaranteed elements as required in Interrogatory 3 to Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	NO
16.	Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC by March 1?	NO
17.	Will an approval from the reporting entity's state of domicile for relief related to the five-year rotation requirement for lead audit partner be filed electronically with the NAIC by March 1?	NO
18.	Will an approval from the reporting entity's state of domicile for relief related to the one-year cooling off period for independent CPA be filed electronically with the NAIC by March 1?	NO
19.	Will an approval from the reporting entity's state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1?	NO
	APRIL FILING	
20.	Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?	NO
21.	Will the Supplemental Life data due April 1 be filed with the state of domicile and the NAIC?	NO
22.	Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?	NO
23.	Will the regulator only (non-public) Supplemental Health Care Exhibit's Expense Allocation Report be filed with the state of domicile and the NAIC by April 1?	NO
24.	Will the Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit be filed with the state of domicile and the NAIC by April 1?	NO
25.	Will the Adjustments to the Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit (if required) be filed with the state of domicile and the NAIC by April 1?	NO
	AUGUST FILING	
26.	Will Management's Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?	NO

Explanations:

11.
12.
13.
14.
15.
16.
17.
18.
19.
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21.
22.
23.
24.
25.
26.

Bar Codes:

2. Actuarial Opinion [Document Identifier 440] 1 6 1 4 5 2 0 1 8 4 4 0 0 0 0 0 0
8. Audited Financial Report [Document Identifier 220] 1 6 1 4 5 2 0 1 8 2 2 0 0 0 0 0 0
9. Accountants Letter of Qualifications [Document Identifier 221] 1 6 1 4 5 2 0 1 8 2 2 1 0 0 0 0 0
10. Communication of Internal Control Related Matters Noted in Audit [Document Identifier 222] 1 6 1 4 5 2 0 1 8 2 2 2 0 0 0 0 0
11. Medicare Supplement Insurance Experience Exhibit [Document Identifier 360] 1 6 1 4 5 2 0 1 8 3 6 0 0 0 0 0 0
12. Life Supplement [Document Identifier 205] 1 6 1 4 5 2 0 1 8 2 0 5 0 0 0 0 0
13. SIS Stockholder Information Supplement [Document Identifier 420] 1 6 1 4 5 2 0 1 8 4 2 0 0 0 0 0 0

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

14. Participating Opinion for Exhibit 5 [Document Identifier 371]
15. Non-Guaranteed Opinion for Exhibit 5 [Document Identifier 370]
16. Medicare Part D Coverage Supplement [Document Identifier 365]
17. Relief from the five-year rotation requirement for lead audit partner [Document Identifier 224]
18. Relief from the one-year cooling off period for independent CPA [Document Identifier 225]
19. Relief from the Requirements for Audit Committees [Document Identifier 226]
20. Long-Term Care Experience Reporting Forms [Document Identifier 306]
21. Life Supplement [Document Identifier 211]
22. Supplemental Health Care Exhibit (Parts 1, 2 and 3) [Document Identifier 216]
23. Supplemental Health Care Exhibit's Expense Allocation Report [Document Identifier 217]
24. Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit [Document Identifier 290]
25 Adjustments to the Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit [Document Identifier 300]
26 Management's Report of Internal Control Over Financial Reporting [Document Identifier 223]

OVERFLOW PAGE FOR WRITE-INS

NONE

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SUMMARY INVESTMENT SCHEDULE

	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
	1	2	3	4	5	6
Investment Categories	Amount	Percentage	Amount	Securities Lending Reinvested Collateral Amount	Total (Col. 3 + 4) Amount	Percentage
1. Bonds:						
1.1 U.S. treasury securities		0.000			0	0.000
1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
1.21 Issued by U.S. government agencies		0.000			0	0.000
1.22 Issued by U.S. government sponsored agencies		0.000			0	0.000
1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)		0.000			0	0.000
1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S. :						
1.41 States, territories and possessions general obligations		0.000			0	0.000
1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations		0.000			0	0.000
1.43 Revenue and assessment obligations	575,461	14.322	575,461	0	575,461	14.322
1.44 Industrial development and similar obligations		0.000			0	0.000
1.5 Mortgage-backed securities (includes residential and commercial MBS):						
1.51 Pass-through securities:						
1.511 Issued or guaranteed by GNMA		0.000			0	0.000
1.512 Issued or guaranteed by FNMA and FHLMC		0.000			0	0.000
1.513 All other		0.000			0	0.000
1.52 CMOs and REMICs:						
1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA		0.000			0	0.000
1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521		0.000			0	0.000
1.523 All other		0.000			0	0.000
2. Other debt and other fixed income securities (excluding short-term):						
2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)		0.000			0	0.000
2.2 Unaffiliated non-U.S. securities (including Canada)		0.000			0	0.000
2.3 Affiliated securities		0.000			0	0.000
3. Equity interests:						
3.1 Investments in mutual funds		0.000			0	0.000
3.2 Preferred stocks:						
3.21 Affiliated		0.000			0	0.000
3.22 Unaffiliated		0.000			0	0.000
3.3 Publicly traded equity securities (excluding preferred stocks):						
3.31 Affiliated		0.000			0	0.000
3.32 Unaffiliated		0.000			0	0.000
3.4 Other equity securities:						
3.41 Affiliated		0.000			0	0.000
3.42 Unaffiliated		0.000			0	0.000
3.5 Other equity interests including tangible personal property under lease:						
3.51 Affiliated		0.000			0	0.000
3.52 Unaffiliated		0.000			0	0.000
4. Mortgage loans:						
4.1 Construction and land development		0.000			0	0.000
4.2 Agricultural		0.000			0	0.000
4.3 Single family residential properties		0.000			0	0.000
4.4 Multifamily residential properties		0.000			0	0.000
4.5 Commercial loans		0.000			0	0.000
4.6 Mezzanine real estate loans		0.000			0	0.000
5. Real estate investments:						
5.1 Property occupied by company		0.000	0		0	0.000
5.2 Property held for production of income (including $ 0 of property acquired in satisfaction of debt)		0.000	0		0	0.000
5.3 Property held for sale (including $ 0 property acquired in satisfaction of debt)		0.000	0		0	0.000
6. Contract loans		0.000	0		0	0.000
7. Derivatives		0.000	0		0	0.000
8. Receivables for securities		0.000	0		0	0.000
9. Securities Lending (Line 10, Asset Page reinvested collateral)		0.000	0	XXX	XXX	XXX
10. Cash, cash equivalents and short-term investments	3,442,636	85.678	3,442,636		3,442,636	85.678
11. Other invested assets		0.000			0	0.000
12. Total invested assets	4,018,097	100.000	4,018,097	0	4,018,097	100.000

Schedule A - Verification - Real Estate

N O N E

Schedule B - Verification - Mortgage Loans

N O N E

SCHEDULE BA - VERIFICATION BETWEEN YEARS

Other Long-Term Invested Assets

NONE

1.	Book/adjusted carrying value, December 31 of prior year	
2.	Cost of acquired:	
	2.1 Actual cost at time of acquisition (Part 2, Column 8)	
	2.2 Additional investment made after acquisition (Part 2, Column 9)	
3.	Capitalized deferred interest and other:	
	3.1 Totals, Part 1, Column 16	
	3.2 Totals, Part 3, Column 12	
4.	Accrual of discount	
5.	Unrealized valuation increase (decrease):	
	5.1 Totals, Part 1, Column 13	
	5.2 Totals, Part 3, Column 9	
6.	Total gain (loss) on disposals, Part 3, Column 19	
7.	Deduct amounts received on disposals, Part 3, Column 16	
8.	Deduct amortization of premium and depreciation	
9.	Total foreign exchange change in book/adjusted carrying value:	
	9.1 Totals, Part 1, Column 17	
	9.2 Totals, Part 3, Column 14	
10.	Deduct current year's other than temporary impairment recognized:	
	10.1 Totals, Part 1, Column 15	
	10.2 Totals, Part 3, Column 11	
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)	
12.	Deduct total nonadmitted amounts	
13.	Statement value at end of current period (Line 11 minus Line 12)	

SCHEDULE D - VERIFICATION BETWEEN YEARS

Bonds and Stocks

1.	Book/adjusted carrying value, December 31 of prior year		586,623
2.	Cost of bonds and stocks acquired, Part 3, Column 7		
3.	Accrual of discount		0
4.	Unrealized valuation increase (decrease):		
	4.1. Part 1, Column 12	0	
	4.2. Part 2, Section 1, Column 15		
	4.3. Part 2, Section 2, Column 13		
	4.4. Part 4, Column 11		0
5.	Total gain (loss) on disposals, Part 4, Column 19		
6.	Deduction consideration for bonds and stocks disposed of, Part 4, Column 7		
7.	Deduct amortization of premium		11,162
8.	Total foreign exchange change in book/adjusted carrying value:		
	8.1. Part 1, Column 15	0	
	8.2. Part 2, Section 1, Column 19		
	8.3. Part 2, Section 2, Column 16		
	8.4. Part 4, Column 15		0
9.	Deduct current year's other than temporary impairment recognized:		
	9.1. Part 1, Column 14	0	
	9.2. Part 2, Section 1, Column 17		
	9.3. Part 2, Section 2, Column 14		
	9.4. Part 4, Column 13		0
10.	Total investment income recognized as a result of prepayment penalties and/or acceleration fees, Notes 5R, Line 5R(2)		0
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9+10)		575,461
12.	Deduct total nonadmitted amounts		0
13.	Statement value at end of current period (Line 11 minus Line 12)		575,461

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - SUMMARY BY COUNTRY

Long-Term Bonds and Stocks OWNED December 31 of Current Year

Description			1 Book/Adjusted Carrying Value	2 Fair Value	3 Actual Cost	4 Par Value of Bonds
BONDS	1.	United States				
Governments	2.	Canada				
(Including all obligations guaranteed by governments)	3.	Other Countries				
	4.	Totals	0	0	0	0
U.S. States, Territories and Possessions (Direct and guaranteed)	5.	Totals				
U.S. Political Subdivisions of States, Territories and Possessions (Direct and guaranteed)	6.	Totals				
U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and their Political Subdivisions	7.	Totals	575,461	581,970	595,550	500,000
Industrial and Miscellaneous, SVO Identified Funds, Bank Loans and Hybrid Securities (unaffiliated)	8.	United States				
	9.	Canada				
	10.	Other Countries				
	11.	Totals	0	0	0	0
Parent, Subsidiaries and Affiliates	12.	Totals				
	13.	Total Bonds	575,461	581,970	595,550	500,000
PREFERRED STOCKS	14.	United States				
Industrial and Miscellaneous (unaffiliated)	15.	Canada				
	16.	Other Countries				
	17.	Totals	0	0	0	
Parent, Subsidiaries and Affiliates	18.	Totals				
	19.	Total Preferred Stocks	0	0	0	
COMMON STOCKS	20.	United States				
Industrial and Miscellaneous (unaffiliated)	21.	Canada				
	22.	Other Countries				
	23.	Totals	0	0	0	
Parent, Subsidiaries and Affiliates	24.	Totals				
	25.	Total Common Stocks	0	0	0	
	26.	Total Stocks	0	0	0	
	27.	Total Bonds and Stocks	575,461	581,970	595,550	

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - PART 1A - SECTION 1

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 11.7	9 Total from Col. 7 Prior Year	10 % From Col. 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed (a)
1. U.S. Governments												
1.1 NAIC 1						XXX	0	0.0		0.0		0
1.2 NAIC 2						XXX	0	0.0		0.0		0
1.3 NAIC 3						XXX	0	0.0		0.0		0
1.4 NAIC 4						XXX	0	0.0		0.0		0
1.5 NAIC 5						XXX	0	0.0		0.0		0
1.6 NAIC 6						XXX	0	0.0		0.0		0
1.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
2. All Other Governments												
2.1 NAIC 1						XXX	0	0.0		0.0		0
2.2 NAIC 2						XXX	0	0.0		0.0		0
2.3 NAIC 3						XXX	0	0.0		0.0		0
2.4 NAIC 4						XXX	0	0.0		0.0		0
2.5 NAIC 5						XXX	0	0.0		0.0		0
2.6 NAIC 6						XXX	0	0.0		0.0		0
2.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
3. U.S. States, Territories and Possessions etc., Guaranteed												
3.1 NAIC 1						XXX	0	0.0		0.0		0
3.2 NAIC 2						XXX	0	0.0		0.0		0
3.3 NAIC 3						XXX	0	0.0		0.0		0
3.4 NAIC 4						XXX	0	0.0		0.0		0
3.5 NAIC 5						XXX	0	0.0		0.0		0
3.6 NAIC 6						XXX	0	0.0		0.0		0
3.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
4. U.S. Political Subdivisions of States, Territories and Possessions , Guaranteed												
4.1 NAIC 1						XXX	0	0.0		0.0		0
4.2 NAIC 2						XXX	0	0.0		0.0		0
4.3 NAIC 3						XXX	0	0.0		0.0		0
4.4 NAIC 4						XXX	0	0.0		0.0		0
4.5 NAIC 5						XXX	0	0.0		0.0		0
4.6 NAIC 6						XXX	0	0.0		0.0		0
4.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
5. U.S. Special Revenue & Special Assessment Obligations, etc., Non-Guaranteed												
5.1 NAIC 1	0	0	575,461	0	0	XXX	575,461	100.0	586,623	100.0	575,461	0
5.2 NAIC 2						XXX	0	0.0		0.0		0
5.3 NAIC 3						XXX	0	0.0		0.0		0
5.4 NAIC 4						XXX	0	0.0		0.0		0
5.5 NAIC 5						XXX	0	0.0		0.0		0
5.6 NAIC 6						XXX	0	0.0		0.0		0
5.7 Totals	0	0	575,461	0	0	XXX	575,461	100.0	586,623	100.0	575,461	0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - PART 1A - SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 11.7	9 Total from Col. 7 Prior Year	10 % From Col. 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed (a)
6. Industrial & Miscellaneous (Unaffiliated)												
6.1 NAIC 1						XXX	0	0.0		0.0		0
6.2 NAIC 2						XXX	0	0.0		0.0		0
6.3 NAIC 3						XXX	0	0.0		0.0		0
6.4 NAIC 4						XXX	0	0.0		0.0		0
6.5 NAIC 5						XXX	0	0.0		0.0		0
6.6 NAIC 6						XXX	0	0.0		0.0		0
6.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7. Hybrid Securities												
7.1 NAIC 1						XXX	0	0.0		0.0		0
7.2 NAIC 2						XXX	0	0.0		0.0		0
7.3 NAIC 3						XXX	0	0.0		0.0		0
7.4 NAIC 4						XXX	0	0.0		0.0		0
7.5 NAIC 5						XXX	0	0.0		0.0		0
7.6 NAIC 6						XXX	0	0.0		0.0		0
7.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8. Parent, Subsidiaries and Affiliates												
8.1 NAIC 1						XXX	0	0.0		0.0		0
8.2 NAIC 2						XXX	0	0.0		0.0		0
8.3 NAIC 3						XXX	0	0.0		0.0		0
8.4 NAIC 4						XXX	0	0.0		0.0		0
8.5 NAIC 5						XXX	0	0.0		0.0		0
8.6 NAIC 6						XXX	0	0.0		0.0		0
8.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
9. SVO Identified Funds												
9.1 NAIC 1	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.2 NAIC 2	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.3 NAIC 3	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.4 NAIC 4	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.5 NAIC 5	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.6 NAIC 6	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.7 Totals	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	0	0
10. Bank Loans												
10.1 NAIC 1						XXX	0	0.0	XXX	XXX		0
10.2 NAIC 2						XXX	0	0.0	XXX	XXX		0
10.3 NAIC 3						XXX	0	0.0	XXX	XXX		0
10.4 NAIC 4						XXX	0	0.0	XXX	XXX		0
10.5 NAIC 5						XXX	0	0.0	XXX	XXX		0
10.6 NAIC 6						XXX	0	0.0	XXX	XXX		0
10.7 Totals	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - PART 1A - SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 11.7	9 Total from Col. 7 Prior Year	10 % From Col. 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed (a)
11. Total Bonds Current Year												
11.1 NAIC 1	(d) 0	0	575,461	0	0	0	575,461	100.0	XXX	XXX	575,461	0
11.2 NAIC 2	(d) 0	0	0	0	0	0	0	0.0	XXX	XXX	0	0
11.3 NAIC 3	(d) 0	0	0	0	0	0	0	0.0	XXX	XXX	0	0
11.4 NAIC 4	(d) 0	0	0	0	0	0	0	0.0	XXX	XXX	0	0
11.5 NAIC 5	(d) 0	0	0	0	0	0	(c) 0	0.0	XXX	XXX	0	0
11.6 NAIC 6	(d) 0	0	0	0	0	0	(c) 0	0.0	XXX	XXX	0	0
11.7 Totals	0	0	575,461	0	0	0	(b) 575,461	100.0	XXX	XXX	575,461	0
11.8 Line 11.7 as a % of Col. 7	0.0	0.0	100.0	0.0	0.0	0.0	100.0	XXX	XXX	XXX	100.0	0.0
12. Total Bonds Prior Year												
12.1 NAIC 1	0	0	586,623	0	0	0	XXX	XXX	586,623	100.0	586,623	0
12.2 NAIC 2							XXX	XXX	0	0.0		0
12.3 NAIC 3							XXX	XXX	0	0.0		0
12.4 NAIC 4							XXX	XXX	0	0.0		0
12.5 NAIC 5							XXX	XXX	(c) 0	0.0		0
12.6 NAIC 6							XXX	XXX	(c) 0	0.0		0
12.7 Totals	0	0	586,623	0	0	0	XXX	XXX	(b) 586,623	100.0	586,623	0
12.8 Line 12.7 as a % of Col. 9	0.0	0.0	100.0	0.0	0.0	0.0	XXX	XXX	100.0	XXX	100.0	0.0
13. Total Publicly Traded Bonds												
13.1 NAIC 1	0	0	575,461	0	0	0	575,461	100.0	586,623	100.0	575,461	XXX
13.2 NAIC 2							0	0.0	0	0.0	0	XXX
13.3 NAIC 3							0	0.0	0	0.0	0	XXX
13.4 NAIC 4							0	0.0	0	0.0	0	XXX
13.5 NAIC 5							0	0.0	0	0.0	0	XXX
13.6 NAIC 6							0	0.0	0	0.0	0	XXX
13.7 Totals	0	0	575,461	0	0	0	575,461	100.0	586,623	100.0	575,461	XXX
13.8 Line 13.7 as a % of Col. 7	0.0	0.0	100.0	0.0	0.0	0.0	100.0	XXX	XXX	XXX	100.0	XXX
13.9 Line 13.7 as a % of Line 11.7, Col. 7, Section 11	0.0	0.0	100.0	0.0	0.0	0.0	100.0	XXX	XXX	XXX	100.0	XXX
14. Total Privately Placed Bonds												
14.1 NAIC 1	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.2 NAIC 2	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.3 NAIC 3	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.4 NAIC 4	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.5 NAIC 5	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.6 NAIC 6	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.7 Totals	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.8 Line 14.7 as a % of Col. 7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	XXX	XXX	XXX	XXX	0.0
14.9 Line 14.7 as a % of Line 11.7, Col. 7, Section 11	0.0	0.0	0.0	0.0	0.0	0.0	0.0	XXX	XXX	XXX	XXX	0.0

(a) Includes $ ..... freely tradable under SEC Rule 144 or qualified for resale under SEC Rule 144A.

(b) Includes $ ..... current year of bonds with Z designations, $ ..... prior year of bonds with Z designations and $ ..... prior year of bonds with Z* designations. The letter "Z" means the NAIC designation was not assigned by the Securities Valuation Office (SVO) at the date of the statement. "Z*" means the SVO could not evaluate the obligation because valuation procedures for the security class are under regulatory review.

(c) Includes $ ..... current year of bonds with 5GI designations, $ ..... prior year of bonds with 5* or 5GI designations and $ ..... current year, $ ..... prior year of bonds with 6* designations. "5GI" means the NAIC designation was assigned by the (SVO) in reliance on the insurer's certification that the issuer is current in all principal and interest payments. "6*" means the NAIC designation was assigned by the SVO due to inadequate certification of principal and interest payments.

(d) Includes the following amount of short-term and cash equivalent bonds by NAIC designation: NAIC 1 $ ..... ; NAIC 2 $ ..... ; NAIC 3 $..... ; NAIC 4 $..... ; NAIC 5 $..... ; NAIC 6 $.....

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - PART 1A - SECTION 2

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 11.7	9 Total from Col. 7 Prior Year	10 % From Col. 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed
1. U.S. Governments												
1.1 Issuer Obligations						XXX	0	0.0		0.0		0
1.2 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
1.3 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
1.4 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
1.5 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
2. All Other Governments												
2.1 Issuer Obligations						XXX	0	0.0		0.0		0
2.2 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
2.3 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
2.4 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
2.5 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
3. U.S. States, Territories and Possessions, Guaranteed												
3.1 Issuer Obligations						XXX	0	0.0		0.0		0
3.2 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
3.3 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
3.4 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
3.5 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
4. U.S. Political Subdivisions of States, Territories and Possessions, Guaranteed												
4.1 Issuer Obligations						XXX	0	0.0		0.0		0
4.2 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
4.3 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
4.4 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
4.5 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
5. U.S. Special Revenue & Special Assessment Obligations etc., Non-Guaranteed												
5.1 Issuer Obligations	0	0	575,461	0	0	XXX	575,461	100.0	586,623	100.0	575,461	0
5.2 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
5.3 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
5.4 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
5.5 Totals	0	0	575,461	0	0	XXX	575,461	100.0	586,623	100.0	575,461	0
6. Industrial and Miscellaneous												
6.1 Issuer Obligations						XXX	0	0.0		0.0		0
6.2 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
6.3 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
6.4 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
6.5 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7. Hybrid Securities												
7.1 Issuer Obligations						XXX	0	0.0		0.0		0
7.2 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
7.3 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
7.4 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
7.5 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8. Parent, Subsidiaries and Affiliates												
8.1 Issuer Obligations						XXX	0	0.0		0.0		0
8.2 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
8.3 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
8.4 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
8.5 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - PART 1A - SECTION 2 (Continued)

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 11.7	9 Total from Col. 7 Prior Year	10 % From Col. 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed
9. SVO Identified Funds												
9.1 Exchange Traded Funds Identified by the SVO	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.2 Bond Mutual Funds Identified by the SVO	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.3 Totals	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	0	0
10. Bank Loans												
10.1 Bank Loans - Issued						XXX	0	0.0	XXX	XXX		0
10.2 Bank Loans - Acquired						XXX	0	0.0	XXX	XXX		0
10.3 Totals	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
11. Total Bonds Current Year												
11.1 Issuer Obligations	0	0	575,461	0	0	XXX	575,461	100.0	XXX	XXX	575,461	0
11.2 Residential Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
11.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
11.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
11.5 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX	0	0	0.0	XXX	XXX	0	0
11.6 Bank Loans	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
11.7 Totals	0	0	575,461	0	0	0	575,461	100.0	XXX	XXX	575,461	0
11.8 Line 11.7 as a % of Col. 7	0.0	0.0	100.0	0.0	0.0	0.0	100.0	XXX	XXX	XXX	100.0	0.0
12. Total Bonds Prior Year												
12.1 Issuer Obligations	0	0	586,623	0	0	XXX	XXX	XXX	586,623	100.0	586,623	0
12.2 Residential Mortgage-Backed Securities						XXX	XXX	XXX	0	0.0		0
12.3 Commercial Mortgage-Backed Securities						XXX	XXX	XXX	0	0.0		0
12.4 Other Loan-Backed and Structured Securities						XXX	XXX	XXX	0	0.0		0
12.5 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX		XXX	XXX	0	0.0		0
12.6 Bank Loans	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
12.7 Totals	0	0	586,623	0	0	0	XXX	XXX	586,623	100.0	586,623	0
12.8 Line 12.7 as a % of Col. 9	0.0	0.0	100.0	0.0	0.0	0.0	XXX	XXX	100.0	XXX	100.0	0.0
13. Total Publicly Traded Bonds												
13.1 Issuer Obligations	0	0	575,461	0	0	XXX	575,461	100.0	586,623	100.0	575,461	XXX
13.2 Residential Mortgage-Backed Securities						XXX	0	0.0	0	0.0	0	XXX
13.3 Commercial Mortgage-Backed Securities						XXX	0	0.0	0	0.0	0	XXX
13.4 Other Loan-Backed and Structured Securities						XXX	0	0.0	0	0.0	0	XXX
13.5 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX		0	0.0	0	0.0	0	XXX
13.6 Bank Loans						XXX	0	0.0	XXX	XXX	0	XXX
13.7 Totals	0	0	575,461	0	0	0	575,461	100.0	586,623	100.0	575,461	XXX
13.8 Line 13.7 as a % of Col. 7	0.0	0.0	100.0	0.0	0.0	0.0	100.0	XXX	XXX	XXX	100.0	XXX
13.9 Line 13.7 as a % of Line 11.7, Col. 7, Section 11	0.0	0.0	100.0	0.0	0.0	0.0	100.0	XXX	XXX	XXX	100.0	XXX
14. Total Privately Placed Bonds												
14.1 Issuer Obligations	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
14.2 Residential Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
14.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
14.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
14.5 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	XXX	0
14.6 Bank Loans	0	0	0	0	0	XXX	0	0.0	XXX	XXX	XXX	0
14.7 Totals	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.8 Line 14.7 as a % of Col. 7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	XXX	XXX	XXX	XXX	0.0
14.9 Line 14.7 as a % of Line 11.7, Col. 7, Section 11	0.0	0.0	0.0	0.0	0.0	0.0	0.0	XXX	XXX	XXX	XXX	0.0

Schedule DA - Verification - Short-Term Investments

N O N E

Schedule DB - Part A - Verification - Options, Caps, Floors, Collars, Swaps and Forwards

N O N E

Schedule DB - Part B - Verification - Futures Contracts

N O N E

Schedule DB - Part C - Section 1 - Replication (Synthetic Asset) Transactions (RSATs) Open

N O N E

Schedule DB-Part C-Section 2-Reconciliation of Replication (Synthetic Asset) Transactions Open

N O N E

Schedule DB - Verification - Book/Adjusted Carrying Value, Fair Value and Potential Exposure of Derivatives

N O N E

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE E - PART 2 - VERIFICATION BETWEEN YEARS

(Cash Equivalents)

	1 Total	2 Bonds	3 Money Market Mutual funds	4 Other (a)
1. Book/adjusted carrying value, December 31 of prior year	3,428,630	0	3,428,630	0
2. Cost of cash equivalents acquired	3,125	0	3,125	0
3. Accrual of discount	0			
4. Unrealized valuation increase (decrease)	0			
5. Total gain (loss) on disposals	0			
6. Deduct consideration received on disposals	3,431,755	0	3,431,755	0
7. Deduct amortization of premium	0			
8. Total foreign exchange change in book/adjusted carrying value	0			
9. Deduct current year's other than temporary impairment recognized	0			
10. Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9)	0	0	0	0
11. Deduct total nonadmitted amounts	0			
12. Statement value at end of current period (Line 10 minus Line 11)	0	0	0	0

(a) Indicate the category of such investments, for example, joint ventures, transportation equipment:

Schedule A - Part 1 - Real Estate Owned

N O N E

Schedule A - Part 2 - Real Estate Acquired and Additions Made

N O N E

Schedule A - Part 3 - Real Estate Disposed

N O N E

Schedule B - Part 1 - Mortgage Loans Owned

N O N E

Schedule B - Part 2 - Mortgage Loans Acquired and Additions Made

N O N E

Schedule B - Part 3 - Mortgage Loans Disposed, Transferred or Repaid

N O N E

Schedule BA - Part 1 - Other Long-Term Invested Assets Owned

N O N E

Schedule BA - Part 2 - Other Long-Term Invested Assets Acquired and Additions Made

N O N E

Schedule BA - Part 3 - Other Long-Term Invested Assets Disposed, Transferred or Repaid

N O N E

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book/Adjusted Carrying Value				Interest					Dates	
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	Code	Foreign	Bond Char	NAIC Designation and Administrative Symbol	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization) Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Rate of	Effective Rate of	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
0599999. Total - U.S. Government Bonds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
1099999. Total - All Other Government Bonds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
1799999. Total - U.S. States, Territories and Possessions Bonds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
2499999. Total - U.S. Political Subdivisions Bonds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
650035-W8-7	NEW YORK ST URBAN DEV CORP REV SERIES A				1FE	595,550	116.3940	581,970	500,000	575,461	0	(11,162)	0	0	5.000	2.370	MS	7,361	25,000	03/02/2017	03/15/2025
2599999. Subtotal - Bonds - U.S. Special Revenues - Issuer Obligations						595,550	XXX	581,970	500,000	575,461	0	(11,162)	0	0	XXX	XXX	XXX	7,361	25,000	XXX	XXX
3199999. Total - U.S. Special Revenues Bonds						595,550	XXX	581,970	500,000	575,461	0	(11,162)	0	0	XXX	XXX	XXX	7,361	25,000	XXX	XXX
3899999. Total - Industrial and Miscellaneous (Unaffiliated) Bonds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
4899999. Total - Hybrid Securities						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
5599999. Total - Parent, Subsidiaries and Affiliates Bonds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
6099999. Subtotal - SVO Identified Funds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
6599999. Subtotal -Bank Loans						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
7799999. Total - Issuer Obligations						595,550	XXX	581,970	500,000	575,461	0	(11,162)	0	0	XXX	XXX	XXX	7,361	25,000	XXX	XXX
7899999. Total - Residential Mortgage-Backed Securities						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
7999999. Total - Commercial Mortgage-Backed Securities						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
8099999. Total - Other Loan-Backed and Structured Securities						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
8199999. Total - SVO Identified Funds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
8299999. Total - Bank Loans						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
8399999 - Total Bonds						595,550	XXX	581,970	500,000	575,461	0	(11,162)	0	0	XXX	XXX	XXX	7,361	25,000	XXX	XXX

Schedule D - Part 2 - Section 1 - Preferred Stocks Owned

N O N E

Schedule D - Part 2 - Section 2 - Common Stocks Owned

N O N E

Schedule D - Part 3 - Long-Term Bonds and Stocks Acquired

N O N E

Schedule D - Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed Of

N O N E

Schedule D - Part 5 - Long Term Bonds and Stocks Acquired and Fully Disposed Of

N O N E

Schedule D-Part 6-Section 1-Valuation of Shares of Subsidiary, Controlled or Affiliated Companies

N O N E

Schedule D - Part 6 - Section 2

N O N E

Schedule DA - Part 1 - Short-Term Investments Owned

N O N E

Schedule DB - Part A - Section 1 - Options, Caps, Floors, Collars, Swaps and Forwards Open

N O N E

Schedule DB - Part A - Section 2 - Options, Caps, Floors, Collars, Swaps and Forwards Terminated

N O N E

Schedule DB - Part B - Section 1 - Futures Contracts Open

N O N E

Schedule DB - Part B - Section 1B - Brokers with whom cash deposits have been made

N O N E

Schedule DB - Part B - Section 2 - Futures Contracts Terminated

N O N E

Schedule DB - Part D - Section 1 - Counterparty Exposure for Derivative Instruments Open

N O N E

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged By

N O N E

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged To

N O N E

Schedule DL - Part 1 - Reinvested Collateral Assets Owned

N O N E

Schedule DL - Part 2 - Reinvested Collateral Assets Owned

N O N E

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE E - PART 1 - CASH

1 Depository	2 Code	3 Rate of Interest	4 Amount of Interest Received During Year	5 Amount of Interest Accrued December 31 of Current Year	6 Balance	7 *
Bank of America 101 S. Tryon Street, 19th Floor, Charlotte, NC 28255		0.000	0	0	3,442,636	XXX
0199998 Deposits in ... depositories which do not exceed the allowable limit in any one depository (See instructions) - open depositories	XXX	XXX				XXX
0199999. Totals - Open Depositories	XXX	XXX	0	0	3,442,636	XXX
0299998 Deposits in ... depositories which do not exceed the allowable limit in any one depository (See instructions) - suspended depositories	XXX	XXX				XXX
0299999. Totals - Suspended Depositories	XXX	XXX	0	0	0	XXX
0399999. Total Cash on Deposit	XXX	XXX	0	0	3,442,636	XXX
0499999. Cash in Company's Office	XXX	XXX	XXX	XXX		XXX
0599999 Total - Cash	XXX	XXX	0	0	3,442,636	XXX

TOTALS OF DEPOSITORY BALANCES ON THE LAST DAY OF EACH MONTH DURING THE CURRENT YEAR

1. January	0	4. April	0	7. July	0	10. October	3,442,636
2. February	3,435,269	5. May	0	8. August	3,442,636	11. November	3,442,636
3. March	3,451,458	6. June	0	9. September	3,442,636	12. December	3,442,636

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE E - PART 2 - CASH EQUIVALENTS

Show Investments Owned December 31 of Current Year

1 CUSIP	2 Description	3 Code	4 Date Acquired	5 Rate of Interest	6 Maturity Date	7 Book/Adjusted Carrying Value	8 Amount of Interest Due and Accrued	9 Amount Received During Year
8899999 - Total Cash Equivalents								

NONE

E27

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

SCHEDULE E - PART 3 - SPECIAL DEPOSITS

		1	2	Deposits For the Benefit of All Policyholders		All Other Special Deposits	
				3	4	5	6
	States, Etc.	Type of Deposit	Purpose of Deposit	Book/Adjusted Carrying Value	Fair Value	Book/Adjusted Carrying Value	Fair Value
1.	Alabama AL						
2.	Alaska AK						
3.	Arizona AZ						
4.	Arkansas AR						
5.	California CA						
6.	Colorado CO						
7.	Connecticut CT						
8.	Delaware DE						
9.	District of Columbia DC						
10.	Florida FL						
11.	Georgia GA						
12.	Hawaii HI						
13.	Idaho ID						
14.	Illinois IL						
15.	Indiana IN						
16.	Iowa IA						
17.	Kansas KS						
18.	Kentucky KY						
19.	Louisiana LA						
20.	Maine ME						
21.	Maryland MD						
22.	Massachusetts MA						
23.	Michigan MI						
24.	Minnesota MN						
25.	Mississippi MS	ST	Required by Mississippi statue	575,461	581,970		
26.	Missouri MO						
27.	Montana MT						
28.	Nebraska NE						
29.	Nevada NV						
30.	New Hampshire NH						
31.	New Jersey NJ						
32.	New Mexico NM						
33.	New York NY						
34.	North Carolina NC						
35.	North Dakota ND						
36.	Ohio OH						
37.	Oklahoma OK						
38.	Oregon OR						
39.	Pennsylvania PA						
40.	Rhode Island RI						
41.	South Carolina SC						
42.	South Dakota SD						
43.	Tennessee TN						
44.	Texas TX						
45.	Utah UT						
46.	Vermont VT						
47.	Virginia VA						
48.	Washington WA						
49.	West Virginia WV						
50.	Wisconsin WI						
51.	Wyoming WY						
52.	American Samoa AS						
53.	Guam GU						
54.	Puerto Rico PR						
55.	U.S. Virgin Islands VI						
56.	Northern Mariana Islands MP						
57.	Canada CAN						
58.	Aggregate Alien and Other OT	XXX	XXX	0	0	0	0
59.	Subtotal	XXX	XXX	575,461	581,970	0	0
	DETAILS OF WRITE-INS						
5801.							
5802.							
5803.							
5898.	Summary of remaining write-ins for Line 58 from overflow page	XXX	XXX	0	0	0	0
5899.	Totals (Lines 5801 thru 5803 plus 5898)(Line 58 above)	XXX	XXX	0	0	0	0

1 6 1 4 5 2 0 1 8 3 6 0 0 0 0 0 0

SUPPLEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For The Year Ended December 31, 2018
(To Be Filed by March 1)

FOR THE STATE OF .....
NAIC Group Code ..... NAIC Company Code .....
ADDRESS (City, State and Zip Code) , ...
Person Completing This Exhibit .....
Title ..... Telephone Number .....

NONE

1	2	3	4	5	6	7	8	9	10	11	Policies Issued Through 2015			Policies Issued in 2016; 2017; 2018			
											Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Character-istics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

NONE

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details .....
2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(b)(3)(A) for this state.
   2.1 Address: , ...
   2.2 Contact Person and Phone Number: .....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address: , ...
   3.2 Contact Person and Phone Number: .....
4. Explain any policies identified above as policy type "O". .....

360

1 6 1 4 5 2 0 1 8 3 6 5 0 0 0 0 0

SUPPLEMENT FOR THE YEAR 2018 OF THE Amerigroup Mississippi, Inc.

MEDICARE PART D COVERAGE SUPPLEMENT

(Net of Reinsurance)

NAIC Group Code 0671 (To Be Filed by March 1) NAIC Company Code 16145

	Individual Coverage		Group Coverage		5
	1 Insured	2 Uninsured	3 Insured	4 Uninsured	Total Cash
1. Premiums Collected					
1.1 Standard Coverage					
1.11 With Reinsurance Coverage		XXX		XXX	
1.12 Without Reinsurance Coverage		XXX		XXX	
1.13 Risk-Corridor Payment Adjustments		XXX		XXX	
1.2 Supplemental Benefits		XXX		XXX	
2. Premiums Due and Uncollected-change					
2.1 Standard Coverage					
2.11 With Reinsurance Coverage		XXX		XXX	XXX
2.12 Without Reinsurance Coverage		XXX		XXX	XXX
2.2 Supplemental Benefits		XXX		XXX	XXX
3. Unearned Premium and Advance Premium-change					
3.1 Standard Coverage					
3.11 With Reinsurance Coverage		XXX		XXX	XXX
3.12 Without Reinsurance Coverage		XXX		XXX	XXX
3.2 Supplemental Benefits		XXX		XXX	XXX
4. Risk-Corridor Payment Adjustments-change					
4.1 Receivable		XXX		XXX	XXX
4.2 Payable		XXX		XXX	XXX
5. Earned Premiums					
5.1 Standard Coverage					
5.11 With Reinsurance Coverage		XXX		XXX	XXX
5.12 Without Reinsurance Coverage		XXX		XXX	XXX
5.13 Risk-Corridor Payment Adjustments		XXX		XXX	XXX
5.2 Supplemental Benefits		XXX		XXX	XXX
6. Total Premiums		XXX		XXX	
7. Claims Paid					
7.1 Standard Coverage					
7.11 With Reinsurance Coverage		XXX		XXX	
7.12 Without Reinsurance Coverage		XXX		XXX	
7.2 Supplemental Benefits		XXX		XXX	
8. Claim Reserves and Liabilities-change					
8.1 Standard Coverage					
8.11 With Reinsurance Coverage		XXX		XXX	XXX
8.12 Without Reinsurance Coverage		XXX		XXX	XXX
8.2 Supplemental Benefits		XXX		XXX	XXX
9. Health Care Receivables-change					
9.1 Standard Coverage					
9.11 With Reinsurance Coverage		XXX		XXX	XXX
9.12 Without Reinsurance Coverage		XXX		XXX	XXX
9.2 Supplemental Benefits		XXX		XXX	XXX
10. Claims Incurred					
10.1 Standard Coverage					
10.11 With Reinsurance Coverage		XXX		XXX	XXX
10.12 Without Reinsurance Coverage		XXX		XXX	XXX
10.2 Supplemental Benefits		XXX		XXX	XXX
11. Total Claims		XXX		XXX	
12. Reinsurance Coverage and Low Income Cost Sharing					
12.1 Claims Paid - Net of Reimbursements Applied	XXX		XXX		
12.2 Reimbursements Received but Not Applied-change	XXX		XXX		
12.3 Reimbursements Receivable-change	XXX		XXX		XXX
12.4 Health Care Receivables-change	XXX		XXX		XXX
13. Aggregate Policy Reserves-change					XXX
14. Expenses Paid		XXX		XXX	
15. Expenses Incurred		XXX		XXX	XXX
16. Underwriting Gain/Loss		XXX		XXX	XXX
17. Cash Flow Results	XXX	XXX	XXX	XXX	

NONE

ANNUAL STATEMENT

OF THE

Amerigroup Mississippi, Inc.

TO THE

Insurance Department

OF THE

STATE OF

Mississippi

FOR THE YEAR ENDED
DECEMBER 31, 2019

HEALTH

2019

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1 6 1 4 5 2 0 1 9 2 0 1 0 0 1 0 0

HEALTH ANNUAL STATEMENT

FOR THE YEAR ENDED DECEMBER 31, 2019
OF THE CONDITION AND AFFAIRS OF THE

Amerigroup Mississippi, Inc.

NAIC Group Code 0671 (Current) 0671 (Prior) NAIC Company Code 16145 Employer's ID Number 81-4626605

Organized under the Laws of Mississippi, State of Domicile or Port of Entry MS

Country of Domicile United States of America

Licensed as business type: Health Maintenance Organization

Is HMO Federally Qualified? Yes [ ] No [X]

Incorporated/Organized 12/06/2016 Commenced Business

Statutory Home Office 645 Lakeland East Drive-Suite 101 (Street and Number), Flowwood, MS, US 39232 (City or Town, State, Country and Zip Code)

Main Administrative Office 220 Virginia Avenue (Street and Number)
Indianapolis, IN, US 46204 (City or Town, State, Country and Zip Code), (Area Code) (Telephone Number)

Mail Address 220 Virginia Avenue (Street and Number or P.O. Box), Indianapolis, IN, US 46204 (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 220 Virginia Avenue (Street and Number)
Indianapolis, IN, US 46204 (City or Town, State, Country and Zip Code), (Area Code) (Telephone Number)

Internet Website Address www.amerigroup.com

Statutory Statement Contact Tim Niccum (Name), 317-488-6716 (Area Code) (Telephone Number)
tim.niccum@anthem.com (E-mail Address), 317-488-6200 (FAX Number)

OFFICERS

President Francesca Deborah Gary
Treasurer Vincent Edward Scher
Secretary Kathleen Susan Kiefer
Assistant Secretary Jack Louis Young

OTHER

Eric (Rick) Kenneth Noble, Assistent Treasurer

DIRECTORS OR TRUSTEES

Jack Louis Young
Ronald William Penczek
Francesca Deborah Gary

State of Indiana
County of Marion SS:

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Francesca Deborah Gary
President/Chairperson

Kathleen Susan Kiefer
Secretary

Vincent Edward Scher
Treasurer

Subscribed and sworn to before me this 10th day of February 2020

a. Is this an original filing? Yes [X] No [ ]
b. If no,
1. State the amendment number
2. Date filed
3. Number of pages attached

Rita F. Gentry
Executive Admin Assistant I
January 17, 2021

Rita F. Gentry
Notary Public
Seal
Marion County, State of Indiana
My Commission Expires January 17, 2021
Commission No 641321

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

ASSETS

		Current Year 1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	Prior Year 4 Net Admitted Assets
1.	Bonds (Schedule D)	564,032		564,032	575,461
2.	Stocks (Schedule D):				
	2.1 Preferred stocks			0	0
	2.2 Common stocks			0	0
3.	Mortgage loans on real estate (Schedule B):				
	3.1 First liens			0	0
	3.2 Other than first liens			0	0
4.	Real estate (Schedule A):				
	4.1 Properties occupied by the company (less $ ..... encumbrances)			0	0
	4.2 Properties held for the production of income (less $ ..... encumbrances)			0	0
	4.3 Properties held for sale (less $ ..... encumbrances)			0	0
5.	Cash ($ 3,442,636 , Schedule E - Part 1), cash equivalents ($ ..... , Schedule E - Part 2) and short-term investments ($ ..... , Schedule DA)	3,442,636		3,442,636	3,442,636
6.	Contract loans, (including $ ..... premium notes)			0	0
7.	Derivatives (Schedule DB)			0	0
8.	Other invested assets (Schedule BA)			0	0
9.	Receivables for securities			0	0
10.	Securities lending reinvested collateral assets (Schedule DL)			0	0
11.	Aggregate write-ins for invested assets	0	0	0	0
12.	Subtotals, cash and invested assets (Lines 1 to 11)	4,006,668	0	4,006,668	4,018,097
13.	Title plants less $ ..... charged off (for Title insurers only)			0	0
14.	Investment income due and accrued	7,361	0	7,361	7,361
15.	Premiums and considerations:				
	15.1 Uncollected premiums and agents' balances in the course of collection		0	0	0
	15.2 Deferred premiums and agents' balances and installments booked but deferred and not yet due (including $ ..... earned but unbilled premiums)		0	0	0
	15.3 Accrued retrospective premiums ($ .....) and contracts subject to redetermination ($ .....)		0	0	0
16.	Reinsurance:				
	16.1 Amounts recoverable from reinsurers		0	0	0
	16.2 Funds held by or deposited with reinsured companies		0	0	0
	16.3 Other amounts receivable under reinsurance contracts		0	0	0
17.	Amounts receivable relating to uninsured plans		0	0	0
18.1	Current federal and foreign income tax recoverable and interest thereon	1,253	0	1,253	1,622
18.2	Net deferred tax asset	4,525	0	4,525	0
19.	Guaranty funds receivable or on deposit		0	0	0
20.	Electronic data processing equipment and software		0	0	0
21.	Furniture and equipment, including health care delivery assets ($ .....)		0	0	0
22.	Net adjustment in assets and liabilities due to foreign exchange rates		0	0	0
23.	Receivables from parent, subsidiaries and affiliates	21,576	21,576	0	8,781
24.	Health care ($ .....) and other amounts receivable		0	0	0
25.	Aggregate write-ins for other than invested assets	3,328	0	3,328	0
26.	Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	4,044,711	21,576	4,023,135	4,035,861
27.	From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0	0
28.	Total (Lines 26 and 27)	4,044,711	21,576	4,023,135	4,035,861
	DETAILS OF WRITE-INS				
1101.					
1102.					
1103.					
1198.	Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199.	Totals (Lines 1101 thru 1103 plus 1198)(Line 11 above)	0	0	0	0
2501.	State income tax recoverable	3,328	0	3,328	0
2502.					
2503.					
2598.	Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599.	Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	3,328	0	3,328	0

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

LIABILITIES, CAPITAL AND SURPLUS

	Current Year 1 Covered	Current Year 2 Uncovered	Current Year 3 Total	Prior Year 4 Total
1. Claims unpaid (less $ ..... reinsurance ceded)			0	0
2. Accrued medical incentive pool and bonus amounts			0	0
3. Unpaid claims adjustment expenses			0	0
4. Aggregate health policy reserves, including the liability of $ ..... for medical loss ratio rebate per the Public Health Service Act			0	0
5. Aggregate life policy reserves			0	0
6. Property/casualty unearned premium reserves			0	0
7. Aggregate health claim reserves			0	0
8. Premiums received in advance			0	0
9. General expenses due or accrued	143		143	1,280
10.1 Current federal and foreign income tax payable and interest thereon (including $ ..... on realized capital gains (losses))			0	0
10.2 Net deferred tax liability			0	9
11. Ceded reinsurance premiums payable			0	0
12. Amounts withheld or retained for the account of others			0	0
13. Remittances and items not allocated			0	0
14. Borrowed money (including $ ..... current) and interest thereon $ ..... (including $ ..... current)			0	0
15. Amounts due to parent, subsidiaries and affiliates			0	0
16. Derivatives			0	0
17. Payable for securities			0	0
18. Payable for securities lending			0	0
19. Funds held under reinsurance treaties (with $ ..... authorized reinsurers, $ .....0 unauthorized reinsurers and $ .....0 certified reinsurers)			0	0
20. Reinsurance in unauthorized and certified ($ .....) companies			0	0
21. Net adjustments in assets and liabilities due to foreign exchange rates			0	0
22. Liability for amounts held under uninsured plans			0	0
23. Aggregate write-ins for other liabilities (including $ ..... current)	0	0	0	0
24. Total liabilities (Lines 1 to 23)	143	0	143	1,289
25. Aggregate write-ins for special surplus funds	XXX	XXX	0	0
26. Common capital stock	XXX	XXX	1,000	1,000
27. Preferred capital stock	XXX	XXX		
28. Gross paid in and contributed surplus	XXX	XXX	3,999,000	3,999,000
29. Surplus notes	XXX	XXX		
30. Aggregate write-ins for other than special surplus funds	XXX	XXX	0	0
31. Unassigned funds (surplus)	XXX	XXX	22,992	34,572
32. Less treasury stock, at cost:				
32.1 ..... shares common (value included in Line 26 $ .....)	XXX	XXX		
32.2 ..... shares preferred (value included in Line 27 $ .....)	XXX	XXX		
33. Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	4,022,992	4,034,572
34. Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	4,023,135	4,035,861
DETAILS OF WRITE-INS				
2301.				
2302.				
2303.				
2398. Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399. Totals (Lines 2301 thru 2303 plus 2398)(Line 23 above)	0	0	0	0
2501.	XXX	XXX		
2502.	XXX	XXX		
2503.	XXX	XXX		
2598. Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	XXX	XXX	0	0
3001.	XXX	XXX		
3002.	XXX	XXX		
3003.	XXX	XXX		
3098. Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099. Totals (Lines 3001 thru 3003 plus 3098)(Line 30 above)	XXX	XXX	0	0

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

STATEMENT OF REVENUE AND EXPENSES

		Current Year 1 Uncovered	Current Year 2 Total	Prior Year 3 Total
1.	Member Months	XXX		
2.	Net premium income (including $ non-health premium income)	XXX	0	
3.	Change in unearned premium reserves and reserve for rate credits	XXX	0	
4.	Fee-for-service (net of $ medical expenses)	XXX	0	
5.	Risk revenue	XXX	0	
6.	Aggregate write-ins for other health care related revenues	XXX	0	0
7.	Aggregate write-ins for other non-health revenues	XXX	0	0
8.	Total revenues (Lines 2 to 7)	XXX	0	0
	Hospital and Medical:			
9.	Hospital/medical benefits		0	
10.	Other professional services		0	
11.	Outside referrals		0	
12.	Emergency room and out-of-area		0	
13.	Prescription drugs		0	
14.	Aggregate write-ins for other hospital and medical	0	0	0
15.	Incentive pool, withhold adjustments and bonus amounts		0	
16.	Subtotal (Lines 9 to 15)	0	0	0
	Less:			
17.	Net reinsurance recoveries		0	
18.	Total hospital and medical (Lines 16 minus 17)	0	0	0
19.	Non-health claims (net)			
20.	Claims adjustment expenses, including $ 0 cost containment expenses		0	0
21.	General administrative expenses		532	2,341
22.	Increase in reserves for life and accident and health contracts (including $ increase in reserves for life only)		0	0
23.	Total underwriting deductions (Lines 18 through 22)	0	532	2,341
24.	Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	(532)	(2,341)
25.	Net investment income earned (Exhibit of Net Investment Income, Line 17)		4,740	23,955
26.	Net realized capital gains (losses) less capital gains tax of $			
27.	Net investment gains (losses) (Lines 25 plus 26)	0	4,740	23,955
28.	Net gain or (loss) from agents' or premium balances charged off [(amount recovered $) (amount charged off $)]			
29.	Aggregate write-ins for other income or expenses	0	0	0
30.	Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	4,208	21,614
31.	Federal and foreign income taxes incurred	XXX	(1,254)	1,032
32.	Net income (loss) (Lines 30 minus 31)	XXX	5,462	20,582
	DETAILS OF WRITE-INS			
0601.		XXX		
0602.		XXX		
0603		XXX		
0698.	Summary of remaining write-ins for Line 6 from overflow page	XXX	0	0
0699.	Totals (Lines 0601 thru 0603 plus 0698)(Line 6 above)	XXX	0	0
0701.		XXX		
0702.		XXX		
0703		XXX		
0798.	Summary of remaining write-ins for Line 7 from overflow page	XXX	0	0
0799.	Totals (Lines 0701 thru 0703 plus 0798)(Line 7 above)	XXX	0	0
1401.				
1402.				
1403.				
1498.	Summary of remaining write-ins for Line 14 from overflow page	0	0	0
1499.	Totals (Lines 1401 thru 1403 plus 1498)(Line 14 above)	0	0	0
2901.				
2902.				
2903				
2998.	Summary of remaining write-ins for Line 29 from overflow page	0	0	0
2999.	Totals (Lines 2901 thru 2903 plus 2998)(Line 29 above)	0	0	0

STATEMENT OF REVENUE AND EXPENSES (Continued)

		1 Current Year	2 Prior Year
	CAPITAL AND SURPLUS ACCOUNT		
33.	Capital and surplus prior reporting year	4,034,572	4,013,990
34.	Net income or (loss) from Line 32	5,462	20,582
35.	Change in valuation basis of aggregate policy and claim reserves		
36.	Change in net unrealized capital gains (losses) less capital gains tax of $		
37.	Change in net unrealized foreign exchange capital gain or (loss)		
38.	Change in net deferred income tax	4,534	
39.	Change in nonadmitted assets	(21,576)	0
40	Change in unauthorized and certified reinsurance	0	0
41.	Change in treasury stock	0	0
42.	Change in surplus notes	0	0
43.	Cumulative effect of changes in accounting principles		
44.	Capital Changes:		
	44.1 Paid in	0	0
	44.2 Transferred from surplus (Stock Dividend)	0	0
	44.3 Transferred to surplus		
45.	Surplus adjustments:		
	45.1 Paid in	0	0
	45.2 Transferred to capital (Stock Dividend)		
	45.3 Transferred from capital		
46.	Dividends to stockholders		
47.	Aggregate write-ins for gains or (losses) in surplus	0	0
48.	Net change in capital and surplus (Lines 34 to 47)	(11,580)	20,582
49.	Capital and surplus end of reporting period (Line 33 plus 48)	4,022,992	4,034,572
	DETAILS OF WRITE-INS		
4701.			
4702.			
4703.			
4798.	Summary of remaining write-ins for Line 47 from overflow page	0	0
4799.	Totals (Lines 4701 thru 4703 plus 4798)(Line 47 above)	0	0

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

CASH FLOW

		1 Current Year	2 Prior Year
	Cash from Operations		
1.	Premiums collected net of reinsurance	0	0
2.	Net investment income	16,169	35,117
3.	Miscellaneous income	0	0
4.	Total (Lines 1 through 3)	16,169	35,117
5.	Benefit and loss related payments	0	0
6.	Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts		
7.	Commissions, expenses paid and aggregate write-ins for deductions	1,670	2,023
8.	Dividends paid to policyholders		
9.	Federal and foreign income taxes paid (recovered) net of $ ..... tax on capital gains (losses)	(1,623)	3,197
10.	Total (Lines 5 through 9)	47	5,220
11.	Net cash from operations (Line 4 minus Line 10)	16,122	29,897
	Cash from Investments		
12.	Proceeds from investments sold, matured or repaid:		
	12.1 Bonds	0	0
	12.2 Stocks	0	0
	12.3 Mortgage loans	0	0
	12.4 Real estate	0	0
	12.5 Other invested assets	0	0
	12.6 Net gains or (losses) on cash, cash equivalents and short-term investments	0	0
	12.7 Miscellaneous proceeds	0	0
	12.8 Total investment proceeds (Lines 12.1 to 12.7)	0	0
13.	Cost of investments acquired (long-term only):		
	13.1 Bonds	0	0
	13.2 Stocks	0	0
	13.3 Mortgage loans	0	0
	13.4 Real estate	0	0
	13.5 Other invested assets	0	0
	13.6 Miscellaneous applications	0	0
	13.7 Total investments acquired (Lines 13.1 to 13.6)	0	0
14.	Net increase (decrease) in contract loans and premium notes	0	0
15.	Net cash from investments (Line 12.8 minus Line 13.7 minus Line 14)	0	0
	Cash from Financing and Miscellaneous Sources		
16.	Cash provided (applied):		
	16.1 Surplus notes, capital notes	0	0
	16.2 Capital and paid in surplus, less treasury stock	0	0
	16.3 Borrowed funds	0	0
	16.4 Net deposits on deposit-type contracts and other insurance liabilities	0	0
	16.5 Dividends to stockholders	0	0
	16.6 Other cash provided (applied)	(16,122)	(15,891)
17.	Net cash from financing and miscellaneous sources (Lines 16.1 to 16.4 minus Line 16.5 plus Line 16.6)	(16,122)	(15,891)
	RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS		
18.	Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	0	14,006
19.	Cash, cash equivalents and short-term investments:		
	19.1 Beginning of year	3,442,636	3,428,630
	19.2 End of year (Line 18 plus Line 19.1)	3,442,636	3,442,636

Note: Supplemental disclosures of cash flow information for non-cash transactions:

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

ANALYSIS OF OPERATIONS BY LINES OF BUSINESS

	1 Total	2 Comprehensive (Hospital & Medical)	3 Medicare Supplement	4 Dental Only	5 Vision Only	6 Federal Employees Health Benefits Plan	7 Title XVIII Medicare	8 Title XIX Medicaid	9 Other Health	10 Other Non-Health
1. Net premium income	0									
2. Change in unearned premium reserves and reserve for rate credit	0									
3. Fee-for-service (net of $ ..... medical expenses)	0									XXX
4. Risk revenue	0									XXX
5. Aggregate write-ins for other health care related revenues	0	0	0	0	0	0	0	0	0	XXX
6. Aggregate write-ins for other non-health care related revenues	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
7. Total revenues (Lines 1 to 6)	0	0	0	0	0	0	0	0	0	0
8. Hospital/medical benefits	0									XXX
9. Other professional services	0									XXX
10. Outside referrals	0									XXX
11. Emergency room and out-of-area	0									XXX
12. Prescription drugs	0									XXX
13. Aggregate write-ins for other hospital and medical	0	0	0	0	0	0	0	0	0	XXX
14. Incentive pool, withhold adjustments and bonus amounts	0									XXX
15. Subtotal (Lines 8 to 14)	0	0	0	0	0	0	0	0	0	XXX
16. Net reinsurance recoveries	0									XXX
17. Total medical and hospital (Lines 15 minus 16)	0	0	0	0	0	0	0	0	0	XXX
18. Non-health claims (net)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
19. Claims adjustment expenses including $ ..... cost containment expenses	0									
20. General administrative expenses	532								532	
21. Increase in reserves for accident and health contracts	0									XXX
22. Increase in reserves for life contracts	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
23. Total underwriting deductions (Lines 17 to 22)	532	0	0	0	0	0	0	0	532	0
24. Total underwriting gain or (loss) (Line 7 minus Line 23)	(532)	0	0	0	0	0	0	0	(532)	0
DETAILS OF WRITE-INS										
0501.										XXX
0502.										XXX
0503.										XXX
0598. Summary of remaining write-ins for Line 5 from overflow page	0	0	0	0	0	0	0	0	0	XXX
0599. Totals (Lines 0501 thru 0503 plus 0598) (Line 5 above)	0	0	0	0	0	0	0	0	0	XXX
0601.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0602.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0603.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0698. Summary of remaining write-ins for Line 6 from overflow page	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
0699. Totals (Lines 0601 thru 0603 plus 0698) (Line 6 above)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
1301.										XXX
1302.										XXX
1303.										XXX
1398. Summary of remaining write-ins for Line 13 from overflow page	0	0	0	0	0	0	0	0	0	XXX
1399. Totals (Lines 1301 thru 1303 plus 1398) (Line 13 above)	0	0	0	0	0	0	0	0	0	XXX

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Underwriting and Investment Exhibit - Part 1 - Premiums

N O N E

Underwriting and Investment Exhibit - Part 2 - Claims Incurred

N O N E

Underwriting and Investment Exhibit - Part 2A - Claims Liability

N O N E

Underwriting and Investment Exhibit - Part 2B - Analysis of Claims

N O N E

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
($000 Omitted)
Section A - Paid Health Claims -

NONE

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2015	2 2016	3 2017	4 2018	5 2019
1. Prior					
2. 2015					
3. 2016	XXX				
4. 2017	XXX	XXX			
5. 2018	XXX	XXX	XXX		
6. 2019	XXX	XXX	XXX	XXX	

Section B - Incurred Health Claims -

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2015	2 2016	3 2017	4 2018	5 2019
1. Prior					
2. 2015					
3. 2016	XXX				
4. 2017	XXX	XXX			
5. 2018	XXX	XXX	XXX		
6. 2019	XXX	XXX	XXX	XXX	

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio -

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2015										
2. 2016										
3. 2017										
4. 2018										
5. 2019										

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ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2D - AGGREGATE RESERVE FOR ACCIDENT AND HEALTH CONTRACTS ONLY

	1 Total	2 Comprehensive (Hospital & Medical)	3 Medicare Supplement	4 Dental Only	5 Vision Only	6 Federal Employees Health Benefits Plan	7 Title XVIII Medicare	8 Title XIX Medicaid	9 Other
1. Unearned premium reserves									
2. Additional policy reserves (a)									
3. Reserve for future contingent benefits									
4. Reserve for rate credits or experience rating refunds (including $ .....) for investment income									
5. Aggregate write-ins for other policy reserves									
6. Totals (gross)									
7. Reinsurance ceded									
8. Totals (Net)(Page 3, Line 4)									
9. Present value of amounts not yet due on claims									
10. Reserve for future contingent benefits									
11. Aggregate write-ins for other claim reserves									
12. Totals (gross)									
13. Reinsurance ceded									
14. Totals (Net)(Page 3, Line 7)									
DETAILS OF WRITE-INS									
0501.									
0502.									
0503.									
0598. Summary of remaining write-ins for Line 5 from overflow page									
0599. Totals (Lines 0501 thru 0503 plus 0598) (Line 5 above)									
1101.									
1102.									
1103.									
1198. Summary of remaining write-ins for Line 11 from overflow page									
1199. Totals (Lines 1101 thru 1103 plus 1198) (Line 11 above)									

NONE

(a) Includes $ ..... premium deficiency reserve.

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ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 3 - ANALYSIS OF EXPENSES

	Claim Adjustment Expenses		3	4	5
	1 Cost Containment Expenses	2 Other Claim Adjustment Expenses	General Administrative Expenses	Investment Expenses	Total
1. Rent ($ ..... for occupancy of own building)	0	0	0	0	0
2. Salary, wages and other benefits	0	0	0	0	0
3. Commissions (less $ ..... ceded plus $ ..... assumed)	0	0	0	0	0
4. Legal fees and expenses	0	0	0	0	0
5. Certifications and accreditation fees	0	0	0	0	0
6. Auditing, actuarial and other consulting services	0	0	0	0	0
7. Traveling expenses	0	0	0	0	0
8. Marketing and advertising	0	0	0	0	0
9. Postage, express and telephone	0	0	0	0	0
10. Printing and office supplies	0	0	0	0	0
11. Occupancy, depreciation and amortization	0	0	0	0	0
12. Equipment	0	0	0	0	0
13. Cost or depreciation of EDP equipment and software	0	0	0	0	0
14. Outsourced services including EDP, claims, and other services	0	0	0	0	0
15. Boards, bureaus and association fees	0	0	0	0	0
16. Insurance, except on real estate	0	0	0	0	0
17. Collection and bank service charges	0	0	0	0	0
18. Group service and administration fees	0	0	0	0	0
19. Reimbursements by uninsured plans	0	0	0	0	0
20. Reimbursements from fiscal intermediaries	0	0	0	0	0
21. Real estate expenses	0	0	0	0	0
22. Real estate taxes	0	0	0	0	0
23. Taxes, licenses and fees:					
23.1 State and local insurance taxes	0	0	532	0	532
23.2 State premium taxes	0	0	0	0	0
23.3 Regulatory authority licenses and fees	0	0	0	0	0
23.4 Payroll taxes	0	0	0	0	0
23.5 Other (excluding federal income and real estate taxes)	0	0	0	0	0
24. Investment expenses not included elsewhere	0	0	0	8,832	8,832
25. Aggregate write-ins for expenses	0	0	0	0	0
26. Total expenses incurred (Lines 1 to 25)	0	0	532	8,832	(a) 9,364
27. Less expenses unpaid December 31, current year	0	0	0	143	143
28. Add expenses unpaid December 31, prior year			1,142	139	1,281
29. Amounts receivable relating to uninsured plans, prior year					0
30. Amounts receivable relating to uninsured plans, current year			0		0
31. Total expenses paid (Lines 26 minus 27 plus 28 minus 29 plus 30)	0	0	1,674	8,828	10,502
DETAILS OF WRITE-INS					
2501.					
2502.					
2503.					
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	0	0	0	0	0

(a) Includes management fees of $ 0 to affiliates and $ 0 to non-affiliates.

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

EXHIBIT OF NET INVESTMENT INCOME

		1 Collected During Year	2 Earned During Year
1.	U.S. government bonds	(a) 0	0
1.1	Bonds exempt from U.S. tax	(a)	
1.2	Other bonds (unaffiliated)	(a) 13,572	13,572
1.3	Bonds of affiliates	(a) 0	0
2.1	Preferred stocks (unaffiliated)	(b) 0	0
2.11	Preferred stocks of affiliates	(b) 0	0
2.2	Common stocks (unaffiliated)	0	0
2.21	Common stocks of affiliates	0	0
3.	Mortgage loans	(c) 0	0
4.	Real estate	(d) 0	0
5	Contract Loans	0	0
6	Cash, cash equivalents and short-term investments	(e) 0	0
7	Derivative instruments	(f) 0	0
8.	Other invested assets	0	0
9.	Aggregate write-ins for investment income	0	0
10.	Total gross investment income	13,572	13,572
11.	Investment expenses		(g) 8,832
12.	Investment taxes, licenses and fees, excluding federal income taxes		(g) 0
13.	Interest expense		(h)
14.	Depreciation on real estate and other invested assets		(i)
15.	Aggregate write-ins for deductions from investment income		0
16.	Total deductions (Lines 11 through 15)		8,832
17.	Net investment income (Line 10 minus Line 16)		4,740
	DETAILS OF WRITE-INS		
0901.			
0902.			
0903.			
0998.	Summary of remaining write-ins for Line 9 from overflow page	0	0
0999.	Totals (Lines 0901 thru 0903 plus 0998) (Line 9, above)	0	0
1501.			
1502.			
1503.			
1598.	Summary of remaining write-ins for Line 15 from overflow page		0
1599.	Totals (Lines 1501 thru 1503 plus 1598) (Line 15, above)		0

(a) Includes $ ..... accrual of discount less $ 11,429 amortization of premium and less $ ..... paid for accrued interest on purchases.

(b) Includes $ ..... accrual of discount less $ ..... amortization of premium and less $ ..... paid for accrued dividends on purchases.

(c) Includes $ ..... accrual of discount less $ ..... amortization of premium and less $ ..... paid for accrued interest on purchases.

(d) Includes $ ..... for company's occupancy of its own buildings; and excludes $ ..... interest on encumbrances.

(e) Includes $ ..... accrual of discount less $ ..... amortization of premium and less $ ..... paid for accrued interest on purchases.

(f) Includes $ ..... accrual of discount less $ ..... amortization of premium.

(g) Includes $. ..... investment expenses and $ ..... investment taxes, licenses and fees, excluding federal income taxes, attributable to segregated and Separate Accounts.

(h) Includes $ ..... interest on surplus notes and $ ..... interest on capital notes.

(i) Includes $ ..... depreciation on real estate and $ ..... depreciation on other invested assets.

EXHIBIT OF CAPITAL GAINS (LOSSES)

		1 Realized Gain (Loss) On Sales or Maturity	2 Other Realized Adjustments	3 Total Realized Capital Gain (Loss) (Columns 1 + 2)	4 Change in Unrealized Capital Gain (Loss)	5 Change in Unrealized Foreign Exchange Capital Gain (Loss)
1.	U.S. Government bonds					
1.1	Bonds exempt from U.S. tax					
1.2	Other bonds (unaffiliated)					
1.3	Bonds of affiliates					
2.1	Preferred stocks (unaffiliated)					
2.11	Preferred stocks of affiliates					
2.2	Common stocks (unaffiliated)					
2.21	Common stocks of affiliates					
3.	Mortgage loans					
4.	Real estate					
5.	Contract loans					
6.	Cash, cash equivalents and short-term investme					
7.	Derivative instruments					
8.	Other invested assets					
9.	Aggregate write-ins for capital gains (losses)					
10.	Total capital gains (losses)					
	DETAILS OF WRITE-INS					
0901.						
0902.						
0903.						
0998.	Summary of remaining write-ins for Line 9 from overflow page					
0999.	Totals (Lines 0901 thru 0903 plus 0998) (Line 9, above)					

NONE

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

EXHIBIT OF NON-ADMITTED ASSETS

		1 Current Year Total Nonadmitted Assets	2 Prior Year Total Nonadmitted Assets	3 Change in Total Nonadmitted Assets (Col. 2 - Col. 1)
1.	Bonds (Schedule D)			0
2.	Stocks (Schedule D):			
	2.1 Preferred stocks			0
	2.2 Common stocks			0
3.	Mortgage loans on real estate (Schedule B):			
	3.1 First liens			0
	3.2 Other than first liens			0
4.	Real estate (Schedule A):			
	4.1 Properties occupied by the company			0
	4.2 Properties held for the production of income			0
	4.3 Properties held for sale			0
5.	Cash (Schedule E - Part 1), cash equivalents (Schedule E - Part 2) and short-term investments (Schedule DA)			0
6.	Contract loans			0
7.	Derivatives (Schedule DB)			0
8.	Other invested assets (Schedule BA)			0
9.	Receivables for securities			0
10.	Securities lending reinvested collateral assets (Schedule DL)			0
11.	Aggregate write-ins for invested assets	0	0	0
12.	Subtotals, cash and invested assets (Lines 1 to 11)	0	0	0
13.	Title plants (for Title insurers only)			0
14.	Investment income due and accrued	0		0
15.	Premiums and considerations:			
	15.1 Uncollected premiums and agents' balances in the course of collection	0		0
	15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due	0		0
	15.3 Accrued retrospective premiums and contracts subject to redetermination	0		0
16.	Reinsurance:			
	16.1 Amounts recoverable from reinsurers	0		0
	16.2 Funds held by or deposited with reinsured companies	0		0
	16.3 Other amounts receivable under reinsurance contracts	0		0
17.	Amounts receivable relating to uninsured plans	0		0
18.1	Current federal and foreign income tax recoverable and interest thereon	0		0
18.2	Net deferred tax asset	0		0
19.	Guaranty funds receivable or on deposit	0		0
20.	Electronic data processing equipment and software	0		0
21.	Furniture and equipment, including health care delivery assets	0		0
22.	Net adjustment in assets and liabilities due to foreign exchange rates	0		0
23.	Receivable from parent, subsidiaries and affiliates	21,576		(21,576)
24.	Health care and other amounts receivable	0		0
25.	Aggregate write-ins for other than invested assets	0	0	0
26.	Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	21,576	0	(21,576)
27.	From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0
28.	Total (Lines 26 and 27)	21,576	0	(21,576)
	DETAILS OF WRITE-INS			
1101.				
1102.				
1103.				
1198.	Summary of remaining write-ins for Line 11 from overflow page	0	0	0
1199.	Totals (Lines 1101 thru 1103 plus 1198)(Line 11 above)	0	0	0
2501.				
2502.				
2503.				
2598.	Summary of remaining write-ins for Line 25 from overflow page	0	0	0
2599.	Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	0	0	0

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

EXHIBIT 1 - ENROLLMENT BY PRODUCT TYPE FOR HEALTH BUSINESS ONLY

Source of Enrollment	Total Members at End of					6
	1 Prior Year	2 First Quarter	3 Second Quarter	4 Third Quarter	5 Current Year	Current Year Member Months
1. Health Maintenance Organizations						
2. Provider Service Organizations						
3. Preferred Provider Organizations						
4. Point of Service						
5. Indemnity Only						
6. Aggregate write-ins for other lines of business						
7. Total						
DETAILS OF WRITE-INS						
0601.						
0602.						
0603.						
0698. Summary of remaining write-ins for Line 6 from overflow page						
0699. Totals (Lines 0601 thru 0603 plus 0698) (Line 6 above)						

NONE

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Exhibit 2 - A&H Premiums Due and Unpaid

N O N E

Exhibit 3 - Health Care Receivables

N O N E

Exhibit 3A - Health Care Receivables Collected and Accrued

N O N E

Exhibit 4 - Claims Unpaid and Incentive Pool, Withhold and Bonus

N O N E

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

EXHIBIT 5 - AMOUNTS DUE FROM PARENT, SUBSIDIARIES AND AFFILIATES

1	2	3	4	5	6	Admitted	
						7	8
Name of Affiliate	1 - 30 Days	31 - 60 Days	61 - 90 Days	Over 90 Days	Nonadmitted	Current	Non-Current
Anthem, Inc.				21,576	21,576		
0199999. Individually listed receivables	0	0	0	21,576	21,576	0	0
0299999. Receivables not individually listed							
0399999 Total gross amounts receivable	0	0	0	21,576	21,576	0	0

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Exhibit 6 - Amounts Due To Parent, Subsidiaries and Affiliates

N O N E

Exhibit 7 - Part 1 - Summary of Transactions with Providers

N O N E

Exhibit 7 - Part 2

N O N E

Exhibit 8 - Furniture and Equipment Owned

N O N E

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies and Going Concern

A. Accounting Practices

The accompanying financial statements of AMERIGROUP Mississippi, Inc. (the "Company") have been prepared in conformity with the National Association of Insurance Commissioners' ("NAIC") *Annual Statement Instructions* and in accordance with accounting practices prescribed by the NAIC *Accounting Practices and Procedures Manual* ("NAIC SAP"), subject to any deviations prescribed or permitted by the Mississippi Insurance Department (the "Department").

A reconciliation of the Company's net income (loss) and capital and surplus between NAIC SAP and practices prescribed and permitted by the MID is shown below:

	SSAP #	F/S Page	F/S Line #	2019	2018
Net Income					
(1) AMERIGROUP.Mississippi,.Inc. state basis (Page 4, Line 32, Columns 2 & 3)	XXX	XXX	XXX	$ 5,462	$ 20,582
(2) State Prescribed Practices that is an increase/(decrease) from NAIC SAP:				—	—
(3) State Permitted Practices that is an increase/(decrease) from NAIC SAP:				—	—
(4) NAIC SAP (1-2-3=4)	XXX	XXX	XXX	$ 5,462	$ 20,582
Surplus					
(5) AMERIGROUP.Mississippi,.Inc. state basis (Page 3, Line 33, Columns 3 & 4)	XXX	XXX	XXX	$ 4,022,992	$ 4,034,572
(6) State Prescribed Practices that is an increase/(decrease) from NAIC SAP:				—	—
(7) State Permitted Practices that is an increase/(decrease) from NAIC SAP:				—	—
(8) NAIC SAP (5-6-7=8)	XXX	XXX	XXX	$ 4,022,992	$ 4,034,572

B. Use of Estimates in the Preparation of the Financial Statements

Preparation of financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

C. Accounting Policies

Health premiums are earned over the term of the related insurance policies. Premiums written are reported net of experience rating refunds. Premiums paid prior to the effective date are recorded on the balance sheet as premiums received in advance and are subsequently credited to income as earned during the coverage period. Premium rates are subject to approval by

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

the Centers for Medicare and Medicaid Services. Expenses are charged to operations as incurred.

In addition, the Company uses the following accounting policies:

(1) Short-term investments include investments with maturities of less than one year and more than three months at the date of acquisition and are reported at amortized cost, which approximates fair value. Non-investment grade short-term investments are stated at the lower of amortized cost or fair value.
(2) Investment grade bonds not backed by other loans are stated at amortized cost, with amortization calculated based on the modified scientific method, using lower of yield to call or yield to maturity. Non-investment grade bonds are stated at the lower of amortized cost or fair value as determined by various third-party pricing sources.
(3) The Company has no investments in common stocks of unaffiliated companies.
(4) The Company has no investments in preferred stocks.
(5) The Company has no mortgage loans - real estate.
(6) The Company has no loan-backed securities.
(7) The Company has no investments in subsidiaries, controlled and affiliated companies.
(8) The Company has no investments in joint ventures, partnerships or limited liability companies.
(9) The Company has no derivative instruments.
(10) The Company recognizes losses from other-than-temporary impairments ("OTTI") of investments in accordance with Statements of Standard Accounting Practice ("SSAP") No. 26R, *Bonds*; and SSAP No. 30R, *Common Stock*; and SSAP No. 32, *Preferred Stock*.
(11) The Company does not anticipate investment income as a factor in premium deficiency calculations.
(12) Unpaid claims and claims adjustment expenses include management's best estimate of amounts based on historical claim development patterns and certain individual case estimates. The established liability considers health benefit provisions, business practices, economic conditions and other factors that may materially affect the cost, frequency and severity of claims. Liabilities for unpaid claims and claim adjustment expenses are based on assumptions and estimates, and while management believes such estimates are reasonable, the ultimate liability may be in excess of or less than the amount provided. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed and changes in estimates are incorporated into current period estimates.
(13) The Company has not modified its capitalization policy from the prior period.

D. Going Concern

Not applicable.

2. Accounting Changes and Corrections of Errors

There were no accounting changes or corrections of errors during the years ended December 31, 2019 and 2018.

3. Business Combinations and Goodwill

A. Statutory Purchase Method	Not applicable.
B. Statutory Merger	Not applicable.
C. Assumption Reinsurance	Not applicable.
D. Impairment Loss	Not applicable.

4. Discontinued Operations

The Company had no operations that were discontinued during 2019 or 2018.

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

5. Investments

A. Mortgage Loans, including Mezzanine Real Estate Loans

The Company did not have investments in mortgage loans at December 31, 2019 or 2018.

B. Debt Restructuring

The Company did not have invested assets that were restructured debt at December 31, 2019 or 2018.

C. Reverse Mortgages

The Company did not have investments in reverse mortgages at December 31, 2019 or 2018.

D. Loan-Backed Securities

(1) The Company did not have loan-backed securities at December 31, 2019 and 2018.
(2) The Company did not recognize OTTI on its loan-backed securities during the years ended December 31, 2019 and 2018.
(3) The Company did not hold OTTI on its loan-backed securities at December 31, 2019 and 2018.
(4) The Company had no impaired loan-backed securities for which an OTTI had not been recognized in earnings at December 31, 2019 and 2018.
(5) The Company had no impaired loan-backed securities at December 31, 2019 and 2018.

E. Dollar Repurchase Agreements and/or Securities Lending Transactions

The Company did not enter into repurchase agreements or securities lending transactions at December 31, 2019 or 2018.

F. Repurchase Agreements Transactions Accounted for as Secured Borrowing

The Company did not enter into repurchase agreement transactions accounted for as secured borrowing at December 31, 2019 or 2018.

G. Reverse Repurchase Agreements Transactions Accounted for as Secured Borrowing

The Company did not enter into reverse repurchase agreement transactions accounted for as a secured borrowing at December 31, 2019 or 2018.

H. Repurchase Agreements Transactions Accounted for as a Sale

The Company did not enter into repurchase agreement transactions accounted for as a sale at December 31, 2019 or 2018.

I. Reverse Repurchase Agreements Transactions Accounted for as a Sale

The Company did not enter into reverse repurchase agreement transactions accounted for as a secured borrowing at December 31, 2019 or 2018.

J. Real Estate

The Company did not have investments in real estate and did not engage in retail land sales operations during 2019 and 2018.

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

K. Investments in Low-Income Housing Tax Credits

The Company did not invest in properties generating low-income housing tax credits during 2019 or 2018.

L. Restricted Assets

(1) Restricted assets (including pledged)

Restricted Asset Category	1 Total Gross (Admitted & Nonadmitted) Restricted from Current Year	2 Total Gross (Admitted & Nonadmitted) Restricted from Prior Year	3 Increase/ (Decrease) (1 minus 2)	4 Total Current Year Nonadmitted Restricted	5 Total Current Year Admitted Restricted (1 minus 4)	6 Gross Admitted and Nonadmitted Restricted to Total Assets (a)	7 Admitted Restricted to Total Admitted Assets (b)
a. Subject to contractual obligation for which liability is not shown	$ —	$ —	$ —	$ —	$ —	0.00%	0.00%
b. Collateral held under security lending agreements	—	—	—	—	—	0.00%	0.00%
c. Subject to repurchase agreements	—	—	—	—	—	0.00%	0.00%
d. Subject to reverse repurchase agreements	—	—	—	—	—	0.00%	0.00%
e. Subject to dollar repurchase agreements	—	—	—	—	—	0.00%	0.00%
f. Subject to dollar reverse repurchase agreements	—	—	—	—	—	0.00%	0.00%
g. Placed under option contracts	—	—	—	—	—	0.00%	0.00%
h. Letter stock or securities restricted as to sale-excluding FHLB capital stock	—	—	—	—	—	0.00%	0.00%
i. FHLB capital stock	—	—	—	—	—	0.00%	0.00%
j. On deposit with states	564,032	575,461	(11,428)	—	564,032	13.94%	14.02%
k. On deposit with other regulatory bodies	—	—	—	—	—	0.00%	0.00%
l. Pledged as collateral to FHLB (including assets backing funding agreements)	—	—	—	—	—	0.00%	0.00%
m. Pledged as collateral not captured in other categories	—	—	—	—	—	0.00%	0.00%
n. Other restricted assets	—	—	—	—	—	0.00%	0.00%
o. Total Restricted Assets	$ 564,032	$ 575,461	$ (11,428)	$ —	$ 564,032	13.94%	14.02%

(a) Column 1 divided by Asset Page, Column 1, Line 28

(b) Column 5 divided by Asset Page, Column 3, Line 28

(2) Not applicable.
(3) Not applicable.
(4) Not applicable.

M. Working Capital Finance Investments

The Company did not have any working capital finance investments at December 31, 2019 and 2018.

N. Offsetting and Netting of Assets and Liabilities

The Company did not have any offsetting or netting of assets and liabilities at December 31, 2019 and 2018.

O. 5GI Securities

The Company has no 5GI Securities as of December 31, 2019 and 2018.

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

P. Short Sales

The Company did not have any short sales at December 31, 2019 and 2018.

Q. Prepayment Penalty and Acceleration Fees

The Company did not have any prepayment penalty or acceleration fees at December 31, 2019 and 2018.

6. Joint Ventures, Partnerships and Limited Liability Companies

A. The Company has no investments in joint ventures, partnerships or LLCs.

B. Not applicable.

7. Investment Income

A. All investment income due and accrued with amounts that are over 90 days past due is non-admitted.

B. At December 31, 2019 and 2018 there was no nonadmitted accrued investment income.

8. Derivative Instruments

The Company has no derivative instruments.

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

9. Income Taxes

A. The components of net deferred tax assets (liabilities):

(1) The components of net deferred tax asset (liabilities) are as follows:

		12/31/2019		
		(1) Ordinary	(2) Capital	(3) (Col 1+2) Total
(a)	Gross Deferred Tax Assets	$ 4,531	$ —	$ 4,531
(b)	Statutory Valuation Allowance Adjustments	—	—	—
(c)	Adjusted Gross Deferred Tax Assets (1a - 1b)	4,531	—	4,531
(d)	Deferred Tax Assets Nonadmitted	—	—	—
(e)	Subtotal Net Admitted Deferred Tax Asset (1c - 1d)	4,531	—	4,531
(f)	Deferred Tax Liabilities	—	6	6
(g)	Net Admitted Deferred Tax Asset/(Net Deferred Tax Liability) (1e - 1f)	$ 4,531	$ (6)	$ 4,525

		12/31/2018		
		(4) Ordinary	(5) Capital	(6) (Col 4+5) Total
(a)	Gross Deferred Tax Assets	$ —	$ —	$ —
(b)	Statutory Valuation Allowance Adjustments	—	—	—
(c)	Adjusted Gross Deferred Tax Assets (1a - 1b)	—	—	—
(d)	Deferred Tax Assets Nonadmitted	—	—	—
(e)	Subtotal Net Admitted Deferred Tax Asset (1c - 1d)	—	—	—
(f)	Deferred Tax Liabilities	—	9	9
(g)	Net Admitted Deferred Tax Asset/(Net Deferred Tax Liability) (1e - 1f)	$ —	$ (9)	$ (9)

		Change		
		(7) (Col 1-4) Ordinary	(8) (Col 2-5) Capital	(9) (Col 7+8) Total
(a)	Gross Deferred Tax Assets	$ 4,531	$ —	$ 4,531
(b)	Statutory Valuation Allowance Adjustments	—	—	—
(c)	Adjusted Gross Deferred Tax Assets (1a - 1b)	4,531	—	4,531
(d)	Deferred Tax Assets Nonadmitted	—	—	—
(e)	Subtotal Net Admitted Deferred Tax Asset (1c - 1d)	4,531	—	4,531
(f)	Deferred Tax Liabilities	—	(3)	(3)
(g)	Net Admitted Deferred Tax Asset/(Net Deferred Tax Liability) (1e - 1f)	$ 4,531	$ 3	$ 4,534

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

(2) The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101, *Income Taxes* ("SSAP No. 101") are as follows:

	12/31/2019		
	(1) Ordinary	(2) Capital	(3) (Col 1+2) Total
Admission Calculation Components SSAP No. 101			
(a) Federal Income Taxes Paid in Prior Years Recoverable Through Loss Carrybacks.	$ 1,633	$ —	$ 1,633
(b) Adjusted Gross Deferred Tax Assets Expected To Be Realized (Excluding The Amount Of Deferred Tax Assets From 2(a) above) After Application of the Threshold Limitation. (The Lesser of 2(b)1 and 2(b)2 Below)	2,898	—	2,898
1. Adjusted Gross Deferred Tax Assets Expected To Be Realized Following the Balance Sheet Date.	2,898	—	2,898
2. Adjusted Gross Deferred Tax Assets Allowed per Limitation Threshold.	XXX	XXX	602,770
(c) Adjusted Gross Deferred Tax Assets (Excluding The Amount Of Deferred Tax Assets From 2(a) and 2(b) above) Offset by Gross Deferred Tax Liabilities.	—	—	—
(d) Deferred Tax Assets Admitted as the result of application of SSAP No. 101. Total (2(a) + 2(b) + 2(c))	$ 4,531	$ —	$ 4,531

	12/31/2018		
	(4) Ordinary	(5) Capital	(6) (Col 4+5) Total
Admission Calculation Components SSAP No. 101			
(a) Federal Income Taxes Paid in Prior Years Recoverable Through Loss Carrybacks.	$ —	$ —	$ —
(b) Adjusted Gross Deferred Tax Assets Expected To Be Realized (Excluding The Amount Of Deferred Tax Assets From 2(a) above) After Application of the Threshold Limitation. (The Lesser of 2(b)1 and 2(b)2 Below)	—	—	—
1. Adjusted Gross Deferred Tax Assets Expected To Be Realized Following the Balance Sheet Date.	—	—	—
2. Adjusted Gross Deferred Tax Assets Allowed per Limitation Threshold.	XXX	XXX	605,187
(c) Adjusted Gross Deferred Tax Assets (Excluding The Amount Of Deferred Tax Assets From 2(a) and 2(b) above) Offset by Gross Deferred Tax Liabilities.	—	—	—
(d) Deferred Tax Assets Admitted as the result of application of SSAP No. 101. Total (2(a) + 2(b) + 2(c))	$ —	$ —	$ —

	Change		
	(7) (Col 1-4) Ordinary	(8) (Col 2-5) Capital	(9) (Col 7+8) Total
Admission Calculation Components SSAP No. 101			
(a) Federal Income Taxes Paid in Prior Years Recoverable Through Loss Carrybacks.	$ 1,633	$ —	$ 1,633
(b) Adjusted Gross Deferred Tax Assets Expected To Be Realized (Excluding The Amount Of Deferred Tax Assets From 2(a) above) After Application of the Threshold Limitation. (The Lesser of 2(b)1 and 2(b)2 Below)	2,898	—	2,898
1. Adjusted Gross Deferred Tax Assets Expected To Be Realized Following the Balance Sheet Date.	2,898	—	2,898
2. Adjusted Gross Deferred Tax Assets Allowed per Limitation Threshold.	XXX	XXX	(2,417)
(c) Adjusted Gross Deferred Tax Assets (Excluding The Amount Of Deferred Tax Assets From 2(a) and 2(b) above) Offset by Gross Deferred Tax Liabilities.	—	—	—
(d) Deferred Tax Assets Admitted as the result of application of SSAP No. 101. Total (2(a) + 2(b) + 2(c))	$ 4,531	$ —	$ 4,531

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

(3)

	2019	2018
(a) Ratio Percentage Used To Determine Recovery Period And Threshold Limitation Amount.	44,066.97%	43,959.16%
(b) Amount Of Adjusted Capital And Surplus Used To Determine Recovery Period And Threshold Limitation In 2 (b)2 Above.	$ 4,018,467	$ 4,034,572

(4)

	12/31/2019		12/31/2018		Change	
	(1) Ordinary	(2) Capital	(3) Ordinary	(4) Capital	(5) (Col 1-3) Ordinary	(6) (Col 2-4) Capital
Impact of Tax-Planning Strategies						
(a) Determination of Adjusted Gross Deferred Tax Assets and Net Admitted Deferred Tax Assets, By Tax Character As A Percentage.						
1. Adjusted Gross DTAs Amount From Note 9A1(c)	$ 4,531	$ —	$ —	$ —	$ 4,531	$ —
2. Percentage of Adjusted Gross DTAs By Tax Character Attributable To The Impact Of Tax Planning Strategies	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
3. Net Admitted Adjusted Gross DTAs Amount From Note 9A1(e)	$ 4,531	$ —	$ —	$ —	$ 4,531	$ —
4. Percentage of Net Admitted Adjusted Gross DTAs By Tax Character Admitted Because Of The Impact Of Tax Planning Strategies	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

(b) Does the Company's tax-planning strategies include the use of reinsurance? Yes _____ No X

B. The Company has no unrecognized deferred tax liabilities at December 31, 2019 and 2018.

C. Current income taxes incurred consist of the following major components:

	(1) 12/31/2019	(2) 12/31/2018	(3) (Col 1-2) Change
(1) Current Income Tax			
(a) Federal	$ (1,254)	$ 1,032	$ (2,286)
(b) Foreign	—	—	—
(c) Subtotal	(1,254)	1,032	(2,286)
(d) Federal income tax expense on net capital gains	—	—	—
(e) Utilization of capital loss carry-forwards	—	—	—
(f) Other	—	—	—
(g) Federal and foreign income taxes incurred	$ (1,254)	$ 1,032	$ (2,286)
(2) Deferred Tax Assets:			
(a) Ordinary			
(1) Discounting of unpaid losses	$ —	$ —	$ —
(2) Unearned premium reserve	—	—	—
(3) Policyholder reserves	—	—	—

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

(4)	Investments	—	—	—
(5)	Deferred acquisition costs	—	—	—
(6)	Policyholder dividends accrual	—	—	—
(7)	Fixed assets	—	—	—
(8)	Compensation and benefits accrual	—	—	—
(9)	Pension accrual	—	—	—
(10)	Receivables - nonadmitted	4,531	—	4,531
(11)	Net operating loss carry-forward	—	—	—
(12)	Tax credit carry-forward	—	—	—
(13)	Other (including items <5% of total ordinary tax assets)	—	—	—
(14)	Accrued future expenses	—	—	—
(15)	Amortization	—	—	—
(16)	Partnership income	—	—	—
(17)	Premium deficiency reserves	—	—	—
(18)	Prepaid expenses	—	—	—
(19)	Section 467 lease expense	—	—	—
(20)	Personal property tax accrual	—	—	—
(21)	Deferred gain on sale of building	—	—	—
(22)	State income tax liability	—	—	—
(23)	Income from reinsurance contract	—	—	—
(24)	Revenue agent's report adjustment	—	—	—
	(99) Subtotal	4,531	—	4,531
(b)	Statutory valuation allowance adjustment	—	—	—
(c)	Nonadmitted	—	—	—
(d)	Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	4,531	—	4,531
(e)	Capital:			
(1)	Investments	—	—	—
(2)	Net capital loss carry-forward	—	—	—
(3)	Real estate	—	—	—
(4)	Other (including items <5% of total capital tax assets)	—	—	—
(5)	Partnership investment	—	—	—
(6)	State low income housing credits	—	—	—
(7)	Affiliated investment write-down	—	—	—
	(99) Subtotal	—	—	—
(f)	Statutory valuation allowance adjustment	—	—	—
(g)	Nonadmitted	—	—	—
(h)	Admitted capital deferred tax assets (2e99 - 2f - 2g)	—	—	—
(i)	Admitted deferred tax assets (2d + 2h)	$ 4,531	$ —	$ 4,531

		(1) 12/31/2019	(2) 12/31/2018	(3) (Col 1-2) Change
(3)	Deferred Tax Liabilities:			
(a)	Ordinary			
(1)	Investments	$ —	$ —	$ —
(2)	Fixed assets	—	—	—
(3)	Deferred and uncollected premium	—	—	—
(4)	Policyholder reserves	—	—	—
(5)	Other (including items <5% of total ordinary tax liabilities)	—	—	—
(6)	Amortization	—	—	—
(7)	Discount of coordination of benefits	—	—	—
(8)	Guaranty fund assessment	—	—	—
(9)	Business partnership	—	—	—
(10)	Tax reserves per Tax Reform over 8 years	—	—	—
(11)	Oil and gas depletion deduction	—	—	—
(12)	Deferred cost - surplus note	—	—	—
	(99) Subtotal	—	—	—
(b)	Capital:			
(1)	Investments	6	9	(3)

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

(2) Real estate	—	—	—
(3) Other (including items <5% of total capital tax liabilities)	—	—	—
(4) Section 166 partial worthlessness	—	—	—
(5) Investment partnership income	—	—	—
(99) Subtotal	6	9	(3)
(c) Deferred tax liabilities (3a99 + 3b99)	$ 6	$ 9	$ (3)
(4) Net deferred tax assets/liabilities (2i - 3c)	$ 4,525	$ (9)	$ 4,534

D. The Company's income tax expense and change in deferred income taxes differs from the amount obtained by applying the federal statutory income tax rate of 21% for the year ended December 31 as follows:

	2019	2018
Tax expense computed using federal statutory rate	$ 884	$ 4,539
ACA health insurer fee	—	—
Change in nonadmitted assets	(4,531)	—
Tax exempt income and dividend received deduction net of proration	(2,140)	(2,179)
Tax exempt income received net of proration	—	—
Prior year true-up and adjustments	—	(601)
Interest (federal and state income tax)	—	—
Tax settlements and contingencies	—	—
Intercompany transfers and adjustments	—	—
IMR/AVR tax	—	—
Intercompany dividends	—	—
Valuation allowance	—	—
Tax Cuts and Jobs Act	—	—
Deferred transfers	—	—
Partnership tax credits	—	—
Equities investment tax true-up	—	—
Mark to market and impairments	—	—
Low income housing tax credits	—	—
National Government Services	—	—
Other, net	(1)	(727)
Total	$ (5,788)	$ 1,032
Federal income taxes incurred	$ (1,254)	$ 1,032
Change in net deferred income taxes	(4,534)	—
Total statutory income taxes	$ (5,788)	$ 1,032

E. Operating loss carryforwards:

(1) The Company has no operating loss carryforwards and no tax credit carryforwards as of December 31, 2019 or 2018.

(2) The following are income taxes incurred in the current and prior year(s) that will be available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2019	$ —	$ —	$ —
2018	1,633	—	1.633
2017	N/A	—	—

(3) The Company has no protective tax deposits reported as admitted assets under Section 6603 of the Internal Revenue Service Code as of December 31, 2019 and 2018.

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

F. The following companies will be included in the consolidated federal income tax return with their parent Anthem, Inc. ("Anthem") as of December 31, 2019 and either are current members of the consolidated tax sharing agreement or are in the process of being added to the consolidated tax sharing agreement. Allocation of federal income taxes with affiliates subject to the tax sharing agreement is based upon separate income tax return calculations with credit for net losses that can be used on a consolidated basis. Pursuant to this agreement, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes. Intercompany income tax balances are settled based on the Internal Revenue Service due dates.

American Imaging Management, Inc.
America's 1st Choice of South Carolina, Inc.
America's Health Management Services, Inc.
AMERIGROUP Community Care of New Mexico, Inc.
AMERIGROUP Corporation
Amerigroup Delaware, Inc.
AMERIGROUP District of Columbia, Inc.
Amerigroup Health Plan of Louisiana, Inc.
Amerigroup Health Plan of Oregon, Inc.
Amerigroup Insurance Company
AMERIGROUP Iowa, Inc.
Amerigroup Kansas, Inc.
AMERIGROUP Maryland, Inc.
Amerigroup Michigan, Inc.
AMERIGROUP Mississippi, Inc.
AMERIGROUP New Jersey, Inc.
AMERIGROUP Ohio, Inc.
AMERIGROUP Oklahoma, Inc.
Amerigroup Pennsylvania, Inc.
AMERIGROUP Tennessee, Inc.
AMERIGROUP Texas, Inc.
Amerigroup Utah, Inc.
AMERIGROUP Washington, Inc.
AMGP Georgia Managed Care Company, Inc.
Anthem Blue Cross Life and Health Insurance Company
Anthem Financial, Inc.
Anthem Health Plans of Kentucky, Inc.
Anthem Health Plans of Maine, Inc.
Anthem Health Plans of New Hampshire, Inc.
Anthem Health Plans of Virginia, Inc.
Anthem Health Plans, Inc.
Anthem Holding Corp.
Anthem Insurance Companies, Inc.
Anthem Kentucky Managed Care Plan, Inc.
Anthem Life & Disability Insurance Company
Anthem Southeast, Inc.
Anthem UM Services, Inc.
Anthem, Inc.
Arcus Enterprises, Inc.
Aspire Health, Inc.
Associated Group, Inc.
Blue Cross and Blue Shield of Georgia, Inc.
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.
Blue Cross Blue Shield of Wisconsin
Blue Cross of California
DeCare Analytics, LLC
DeCare Dental Health International, LLC
DeCare Dental Networks, LLC
DeCare Dental, LLC
Designated Agent Company, Inc.
EHC Benefits Agency, Inc.
Empire HealthChoice Assurance, Inc.
Empire HealthChoice HMO, Inc.
Federal Government Solutions, LLC
Freedom Health, Inc.
Golden West Health Plan, Inc.
Greater Georgia Life Insurance Company
Health Core, Inc.
Health Management Corporation
HealthKeepers, Inc.
HealthLink HMO, Inc.
HealthLink, Inc.
HealthLink Insurance Company
HealthPlus HP, LLC
Healthy Alliance Life Insurance Company
HEP AP Holdings, Inc.
Highland Holdco, Inc.
HMO Colorado, Inc.
HMO Missouri, Inc.
Imaging Management Holdings, LLC
IngenioRx, Inc.
Legato Holdings I, Inc.
Living Complete Technologies, Inc.
Matthew Thornton Health Plan, Inc.
Nash Holding Company, LLC
National Government Services, Inc.
New England Research Institutes, Inc.
Optimum Healthcare, Inc.
Park Square Holdings, Inc.
Park Square I, Inc.
Park Square II, Inc.
Resolution Health, Inc.
RightCHOICE Managed Care, Inc.
Rocky Mountain Hospital and Medical Service, Inc.
SellCore, Inc.
Simply Healthcare Plans, Inc.
Southeast Services, Inc.
State Sponsored Services, Inc.
The Anthem Companies of California, Inc.
The Anthem Companies, Inc.

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

Blue Cross of California Partnership Plan, Inc.	TrustSolutions, LLC
CareMarket, Inc.	UNICARE Health Plan of West Virginia, Inc.
CareMore Health Plan	UNICARE Illinois Services, Inc.
CareMore Health Plan of Arizona, Inc.	UNICARE Life & Health Insurance Company
CareMore Health Plan of Nevada	UNICARE National Services, Inc.
CareMore Health Plan of Texas, Inc.	UNICARE Specialty Services, Inc.
CareMore Health System	Valus, Inc.
Cerulean Companies, Inc.	WellPoint Behavioral Health, Inc.
Claim Management Services, Inc.	WellPoint California Services, Inc.
Community Care Health Plan of Louisiana, Inc.	WellPoint Dental Services, Inc.
Community Care Health Plan of Nevada, Inc.	WellPoint Health Solutions, Inc.
Community Insurance Company	WellPoint Holding Corporation
Compcare Health Services Insurance Corporation	WellPoint Information Technology Services, Inc.
Crossroads Acquisition Corp	WellPoint Insurance Services, Inc.
DBG Holdings, Inc. (fka Newco Holdings, Inc.)	WellPoint Military Care Corporation

G. Not applicable.

H. Repatriation Transition Tax (RTT)

Not applicable.

I. Alternative Minimum Tax (AMT) Credit

Not applicable.

10. Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

A. Nature of the Relationship

The Company is a Mississippi domiciled stock insurance company and is a wholly-owned subsidiary of Anthem Partnership Holding Company, LLC (“Anthem Partnership”), which is a direct wholly-owned subsidiary of Anthem, Inc. ("Anthem"), a publicly traded company.

B. Significant Transactions for Each Period

There were no significant transactions during the years ended December 31, 2019 and 2018.

C. Intercompany Management and Service Arrangements

There were no changes to the intercompany management and service arrangements, and there were no additional arrangements entered into during 2019 or 2018. The amounts of transactions under such agreements are presented in Schedule Y, Part 2.

D. Amounts Due to or from Related Parties

At December 31, 2019 and 2018, the Company reported $0 and $8,781 due from affiliates, respectively. At December 31, 2019 and 2018, the Company reported no amounts due to affiliates. The receivable and payable balances represent intercompany transactions that will be settled in accordance with the settlement terms of the intercompany agreement.

E. Guarantees or Contingencies for Related Parties

The Company did not enter into guarantees or undertakings for the benefit of an affiliate which would result in a material contingent exposure of the Company’s or any affiliated insurer’s assets or liabilities.

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

F. Management and Service Contracts and Cost Sharing Arrangements

The Company has entered into administrative services agreements with its affiliated companies. Pursuant to these agreements, various administrative, management and support services are provided to or provided by the Company. The costs and expenses related to these administrative management and support services are allocated to or allocated by the Company in an amount equal to the direct and indirect costs and expenses incurred in providing these services. Costs include expenses such as salaries, employee benefits, information technology, pharmacy benefits administration, communications, advertising, consulting services, rent, utilities, billing, accounting, underwriting, and product development, which support the Company's operations. These costs are allocated based on various utilization statistics.

G. Nature of Control Relationships that Could Affect Operations or Financial Position

Anthem Partnership owns all outstanding shares of the Company. The Company's ultimate parent is Anthem.

H. Amount Deducted for Investment in Upstream Company

The Company does not own shares of upstream intermediate entities or Anthem.

I. Detail of Investments in Affiliates Greater than 10% of Admitted Assets

The Company does not have investments in affiliates greater than 10% of admitted assets.

J. Write-down for Impairments of Investments in Subsidiaries, Controlled or Affiliated ("SCA") Companies

Not applicable.

K. Investment in a Foreign Insurance Subsidiary

The Company does not have investments in foreign insurance subsidiaries.

L. Investment in Downstream Non-insurance Holding Companies

The Company does not have investments in downstream non-insurance holding companies.

M. All SCA Investments

The Company has no SCA Investments.

N. Investment in Insurance SCAs

The Company does not have investments in Insurance SCAs.

O. SCA or SSAP 48 Entity Loss Tracking

The Company does not have losses on investments in Insurance SCAs and/or joint ventures, partnerships or LLCs.

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

11. Debt

A. Capital Notes and Other Debt

The Company had no capital notes or other debt outstanding at December 31, 2019 and 2018.

B. FHLB (Federal Home Loan Bank) Agreements

The Company had no FHLB agreements outstanding at December 31, 2019 and 2018.

C. All Other Debt

The Company had no other debt outstanding at December 31, 2019 and 2018.

12. Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans

A. Defined Benefit Plan

Not applicable.

B. Not applicable.

C. Not applicable.

D. Not applicable.

E. Defined Contribution Plans

Not applicable.

F. Multiemployer Plans

The Company does not participate in a multiemployer plan.

G. Consolidated/Holding Company Plans

Not applicable.

H. Post Employment Benefits and Compensated Absences

Not applicable.

I. Impact of Medicare Modernization Act on Postretirement Benefits (INT 04-17)

Not applicable.

13. Capital and Surplus, Shareholders' Dividend Restrictions and Quasi-Reorganizations

(1) Outstanding Shares

As of December 31, 2019, the Company has 1000 shares of $1 par value common stock authorized, issued and outstanding.

(2) Preferred Stock

The Company has no preferred stock outstanding.

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

(3) Dividend Restrictions

Under Mississippi law, the amount of ordinary dividends a domestic insurer is permitted to pay is limited to an amount not exceeding the greater of net income or 10% of statutory surplus at the end of the preceding year as long as the Company's unassigned surplus is positive.

(4) Dividends Paid

See Footnote 10B.

(5) Maximum Ordinary Dividend During 2020

Within the limitations of (3) above, the Company may pay dividends of $22,992 during 2020 without prior approval.

(6) Unassigned Surplus Restrictions

Unassigned surplus funds are not restricted at December 31, 2019.

(7) Mutual Surplus Advances

Not applicable.

(8) Company Stock Held for Special Purpose

There are no shares of stock held for special purposes at December 31, 2019.

(9) Changes in Special Surplus Funds

There are no special surplus funds at December 31, 2019.

(10) Changes in Unassigned Funds

There was no portion of unassigned funds represented by cumulative unrealized gains and losses at December 31, 2019.

(11) Surplus Notes

The Company has not issued any surplus notes or debentures or similar obligations.

(12) Restatement due to Prior Quasi-reorganizations

The Company had no restatements due to prior quasi-reorganizations.

(13) Quasi-reorganizations over Prior 10 Years

The Company has not been involved in a quasi-reorganization during the past 10 years.

14. Liabilities, Contingencies and Assessments

A. Contingent Commitments

The Company had no contingent commitments at December 31, 2019 or 2018.

B. Assessments

(1) The Company is subject to guaranty fund and other assessments by the state in which it writes business. Guaranty fund assessments are accrued at the time of insolvencies.

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

Other assessments are accrued either at the time of the assessment or at the time the losses are incurred.

(2) Not applicable.

(3) Not applicable.

C. Gain Contingencies

The Company has no gain contingencies at December 31, 2019 or 2018.

D. Claims-Related Extra Contractual Obligation and the Bad Faith Losses Stemming From Lawsuits

Not applicable.

E. Joint and Several Liabilities

Not applicable.

F. All Other Contingencies

The Company is involved in pending and threatened litigation of the character incidental to the business transacted, arising out of its operations and is from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits and reviews and administrative proceedings include routine and special investigations by state insurance departments, state attorneys general, the U.S. Attorney General and subcommittees of the U.S. Congress. Such investigations, audits, reviews and administrative proceedings could result in the imposition of civil or criminal fines, penalties, other sanctions and additional rules, regulations or other restrictions on the Company's business operations. The Company believes that any liability that may result from any one of these actions, or in the aggregate, could have a material adverse effect on the Company's financial position or results of operations.

15. Leases

A. Lessee Operating Lease

The Company has no lessee leasing arrangements.

B. Lessor Leases

(1) The Company has not entered into any operating leases.

(2) The Company has not entered into any leveraged leases.

16. Information About Financial Instruments With Off-Balance Sheet Risk and Financial Instruments With Concentrations of Credit Risk

The Company has no significant financial instruments with off-balance sheet risk.

Financial instruments that potentially subject the Company to concentrations of credit risk consist primarily of investment securities. All investment securities are managed by professional investment managers within policies authorized by the board of directors. Such policies limit the amounts that may be invested in any one issuer and prescribe certain investee company criteria. As of December 31, 2019, there were no significant concentrations.

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

A. Transfers of Receivables Reported as Sales

Not applicable at December 31, 2019 and 2018.

B. Transfer and Servicing of Financial Assets

Not applicable at December 31, 2019 and 2018.

C. Wash Sales

(1) In the course of the Company's asset management, securities may be sold and reacquired within 30 days of the sale date to enhance the yield on the investments.

(2) At December 31, 2019 and 2018, there were no wash sales involving securities with an NAIC designation of 3 or below or unrated.

18. Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans

A. Administrative Services Only ("ASO") Plans

Not applicable at December 31, 2019

B. Administrative Services Contract ("ASC") Plans

Not applicable at December 31, 2019.

C. Medicare or Other Similarly Structured Cost-Based Reimbursement Contract

Not applicable at December 31, 2019 and 2018.

19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

No premiums were written by managing general agents or third party administrators during the years ended December 31, 2019 and 2018.

20. Fair Value Measurements

A. There are no assets or liabilities measured at fair value as of December 31, 2019 and 2018.

B. Fair Value Measurements Under Other Accounting Pronouncements

Not applicable at December 31, 2019 and 2018.

C. Financial Instruments

Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
Bonds	$ 595,940	$ 564,032	$ —	$ 595,940	$ —	$ —	$ —

D. Not Practicable to Estimate Fair Value

There are no financial instruments that were not practicable to estimate fair value.

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

E. Investments Measured at Net Asset Value

The Company has no investments measured at net asset value.

21. Other Items

A. Unusual or Infrequent Items

Not applicable at December 31, 2019 and 2018.

B. Troubled Debt Restructuring: Debtors

Not applicable at December 31, 2019 and 2018.

C. Other Disclosures

Assets in the amount of $564,032 and $575,461 at December 31, 2019 and 2018, respectively, were on deposit with government authorities or trustees as required by law.

D. Business Interruption Insurance Recoveries

The Company has reported no recoveries for business interruption for the years ended December 31, 2019 and 2018.

E. State Transferable and Non-Transferable Tax Credits

The Company did not have state transferable or non-transferable tax credits at December 31, 2019 and 2018.

F. Subprime Mortgage-Related Risk Exposure

(1) The Company's investment strategy of providing safety and preservation of capital, sufficient liquidity to meet cash flow requirements and the attainment of a competitive after-tax investment return is supported by a well diversified portfolio consisting of many different types of investments. The portion of the Company's investment portfolio with subprime mortgage-related risk exposure is relatively small in comparison to the overall investment portfolio, and consists mainly of investment grade securities with no exposure to collateralized debt obligations. All mortgage related investments are monitored closely as part of the quarterly investment review performed by the Anthem Investment Impairment Review Committee.

(2) The Company did not carry investments in subprime mortgage loans in its portfolio at December 31, 2019 or 2018.

(3) The Company did not have subprime mortgage-related risk exposure at December 31, 2019 or 2018.

(4) The Company did not underwrite Mortgage Guaranty or Financial Guaranty insurance coverage at December 31, 2019 or 2018.

G. Retained Assets

The Company does not have retained assets at December 31, 2019 and 2018.

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

H. Insurance-Linked Securities Contracts

Not applicable.

I. The Amount That Could Be Realized on Life Insurance Where the Reporting Entity is Owner and Beneficiary or Has Otherwise Obtained Rights to Control the Policy

Not applicable.

22. Events Subsequent

The Company did not have any Affordable Care Act ("ACA") assessable premium in 2019 and 2018.

Subsequent events have been considered through February 26, 2020 for the statutory statement issued on February 26, 2020. There were no events occurring subsequent to December 31, 2019 requiring recognition or disclosure.

23. Reinsurance

A. Ceded Reinsurance Report

Section 1 - General Interrogatories

a. Are any of the reinsurers that are listed in Schedule S as non-affiliated owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?

Yes ( ) No (X)

If yes, give full details.

b. Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. Branches of such companies) that is owned in excess of 10% or controlled, directly or indirectly, by an insured, a beneficiary, a creditor or an insured or any other person not primarily engaged in the insurance business?

Yes ( ) No (X)

If yes, give full details.

Section 2 - Ceded Reinsurance Report - Part A

(1) Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credits?

Yes ( ) No (X)

If yes, give full details.

(2) Does the reporting entity have any reinsurance agreements in effect such that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premium collected under the reinsured policies?

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

Yes ( ) No (X)

If yes, give full details.

Section 3 - Ceded Reinsurance Report - Part B

(1) What is the estimated amount of the aggregate reduction in surplus, (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2 above) of termination of ALL reinsurance agreements, by either party, as of the date of this statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

$0

(2) Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had existing reserves established by the Company as of the effective date of the agreement?

Yes ( ) No (X)

If yes, give full details.

B. Uncollectible Reinsurance

The Company has no uncollectible reinsurance at December 31, 2019 and 2018.

C. Commutation of Ceded Reinsurance

The Company has not commuted ceded reinsurance during 2019 and 2018.

D. Certified Reinsurer Rating Downgraded or Status Subject Revocation

The Company has no downgraded certified reinsurer ratings or status subject to revocations during 2019 and 2018.

24. Retrospectively Rated Contracts & Contracts Subject to Redetermination

A. Not applicable.

B. Not applicable.

C. Not applicable.

D. Not applicable.

E. Risk-Sharing Provisions of the ACA

(1) Did the reporting entity write accident and health insurance premium that is subject to the Affordable Care Act risk-sharing provisions (YES/NO)? No

(2) Impact of Risk-Sharing Provisions of the Affordable Care Act on Admitted Assets, Liabilities and Revenue for the Current Year

Not applicable.

ANNUAL STATEMENT FOR THE YEAR 2019 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

(3) Roll-forward of prior year ACA risk-sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reasons for adjustments to prior year balance.

Not applicable.

(4) Roll-forward of Risk Corridors Asset and Liability Balances by Program Benefit Year.

Not applicable.

(5) ACA Risk Corridors Receivable as of Reporting Date.

Not applicable.

25. Change in Incurred Claims and Claim Adjustment Expenses

Not applicable at December 31, 2019 and 2018.

26. Intercompany Pooling Arrangements

Not applicable at December 31, 2019 and 2018.

27. Structured Settlements

Not applicable at December 31, 2019 and 2018.

28. Health Care Receivables

A. Pharmaceutical Rebate Receivables

Not applicable at December 31, 2019 and 2018.

B. Risk Sharing Receivables

Not applicable at December 31, 2019 and 2018.

29. Participating Policies

Not applicable at December 31, 2019 and 2018.

30. Premium Deficiency Reserves

1. Liability carried for premium deficiency reserves	$		—
2. Date of the most recent evaluation of this liability		December 31, 2019	
3. Was anticipated investment income utilized in the calculation?	Yes ____	No	X

The Company had no liabilities related to premium deficiency reserves as of December 31, 2019 and 2018.

31. Anticipated Salvage and Subrogation

Not applicable at December 31, 2019 and 2018.

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES
GENERAL

1.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? ..... Yes [X] No [ ]
If yes, complete Schedule Y, Parts 1, 1A and 2

1.2 If yes, did the reporting entity register and file with its domiciliary State Insurance Commissioner, Director or Superintendent, or with such regulatory official of the state of domicile of the principal insurer in the Holding Company System, a registration statement providing disclosure substantially similar to the standards adopted by the National Association of Insurance Commissioners (NAIC) in its Model Insurance Holding Company System Regulatory Act and model regulations pertaining thereto, or is the reporting entity subject to standards and disclosure requirements substantially similar to those required by such Act and regulations? ..... Yes [X] No [ ] N/A [ ]

1.3 State Regulating? ..... Mississippi

1.4 Is the reporting entity publicly traded or a member of a publicly traded group? ..... Yes [X] No [ ]

1.5 If the response to 1.4 is yes, provide the CIK (Central Index Key) code issued by the SEC for the entity/group. 0001156039

2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? ..... Yes [ ] No [X]

2.2 If yes, date of change: .....

3.1 State as of what date the latest financial examination of the reporting entity was made or is being made. 12/31/2017

3.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released. 12/31/2017

3.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date). 06/20/2019

3.4 By what department or departments?
Mississippi Department of Insurance .....

3.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with Departments? ..... Yes [ ] No [ ] N/A [X]

3.6 Have all of the recommendations within the latest financial examination report been complied with? ..... Yes [ ] No [ ] N/A [X]

4.1 During the period covered by this statement, did any agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the reporting entity), receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
4.11 sales of new business? ..... Yes [ ] No [X]
4.12 renewals? ..... Yes [ ] No [X]

4.2 During the period covered by this statement, did any sales/service organization owned in whole or in part by the reporting entity or an affiliate, receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
4.21 sales of new business? ..... Yes [ ] No [X]
4.22 renewals? ..... Yes [ ] No [X]

5.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? ..... Yes [ ] No [X]
If yes, complete and file the merger history data file with the NAIC.

5.2 If yes, provide the name of the entity, NAIC Company Code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1 Name of Entity	2 NAIC Company Code	3 State of Domicile

6.1 Has the reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? ..... Yes [ ] No [X]

6.2 If yes, give full information:
.....

7.1 Does any foreign (non-United States) person or entity directly or indirectly control 10% or more of the reporting entity? ..... Yes [ ] No [X]

7.2 If yes,
7.21 State the percentage of foreign control; ..... %
7.22 State the nationality(s) of the foreign person(s) or entity(s) or if the entity is a mutual or reciprocal, the nationality of its manager or attorney-in-fact; and identify the type of entity(s) (e.g., individual, corporation or government, manager or attorney in fact).

1 Nationality	2 Type of Entity

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

GENERAL INTERROGATORIES

8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board? Yes [ ] No [X]

8.2 If response to 8.1 is yes, please identify the name of the bank holding company.

8.3 Is the company affiliated with one or more banks, thrifts or securities firms? Yes [ ] No [X]

8.4 If response to 8.3 is yes, please provide below the names and location (city and state of the main office) of any affiliates regulated by a federal regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 FDIC	6 SEC

9. What is the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit?
N/A - The Company has received an exemption by the Mississippi Department of Insurance from filing the Audited Financial Statement for the year ended December 31, 2019.

10.1 Has the insurer been granted any exemptions to the prohibited non-audit services provided by the certified independent public accountant requirements as allowed in Section 7H of the Annual Financial Reporting Model Regulation (Model Audit Rule), or substantially similar state law or regulation? Yes [ ] No [X]

10.2 If the response to 10.1 is yes, provide information related to this exemption:

10.3 Has the insurer been granted any exemptions related to the other requirements of the Annual Financial Reporting Model Regulation as allowed for in Section 18A of the Model Regulation, or substantially similar state law or regulation? Yes [ ] No [X]

10.4 If the response to 10.3 is yes, provide information related to this exemption:

10.5 Has the reporting entity established an Audit Committee in compliance with the domiciliary state insurance laws? Yes [X] No [ ] N/A [ ]

10.6 If the response to 10.5 is no or n/a, please explain

11. What is the name, address and affiliation (officer/employee of the reporting entity or actuary/consultant associated with an actuarial consulting firm) of the individual providing the statement of actuarial opinion/certification?
N/A - The Company has received an exemption by the Mississippi Department of Insurance from filing the Actuarial Opinion for the year ended December 31, 2019.

12.1 Does the reporting entity own any securities of a real estate holding company or otherwise hold real estate indirectly? Yes [ ] No [X]

12.11 Name of real estate holding company

12.12 Number of parcels involved

12.13 Total book/adjusted carrying value $

12.2 If, yes provide explanation:

13. **FOR UNITED STATES BRANCHES OF ALIEN REPORTING ENTITIES ONLY:**

13.1 What changes have been made during the year in the United States manager or the United States trustees of the reporting entity?

13.2 Does this statement contain all business transacted for the reporting entity through its United States Branch on risks wherever located? Yes [ ] No [ ]

13.3 Have there been any changes made to any of the trust indentures during the year? Yes [ ] No [ ]

13.4 If answer to (13.3) is yes, has the domiciliary or entry state approved the changes? Yes [ ] No [ ] N/A [ ]

14.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards? Yes [X] No [ ]
a. Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
b. Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;
c. Compliance with applicable governmental laws, rules and regulations;
d. The prompt internal reporting of violations to an appropriate person or persons identified in the code; and
e. Accountability for adherence to the code.

14.11 If the response to 14.1 is No, please explain:

14.2 Has the code of ethics for senior managers been amended? Yes [ ] No [X]

14.21 If the response to 14.2 is yes, provide information related to amendment(s).

14.3 Have any provisions of the code of ethics been waived for any of the specified officers? Yes [ ] No [X]

14.31 If the response to 14.3 is yes, provide the nature of any waiver(s).

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

GENERAL INTERROGATORIES

15.1 Is the reporting entity the beneficiary of a Letter of Credit that is unrelated to reinsurance where the issuing or confirming bank is not on the SVO Bank List? Yes [ ] No [X]

15.2 If the response to 15.1 is yes, indicate the American Bankers Association (ABA) Routing Number and the name of the issuing or confirming bank of the Letter of Credit and describe the circumstances in which the Letter of Credit is triggered.

1 American Bankers Association (ABA) Routing Number	2 Issuing or Confirming Bank Name	3 Circumstances That Can Trigger the Letter of Credit	4 Amount

BOARD OF DIRECTORS

16. Is the purchase or sale of all investments of the reporting entity passed upon either by the board of directors or a subordinate committee thereof? Yes [X] No [ ]

17. Does the reporting entity keep a complete permanent record of the proceedings of its board of directors and all subordinate committees thereof? Yes [X] No [ ]

18. Has the reporting entity an established procedure for disclosure to its board of directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict with the official duties of such person? Yes [X] No [ ]

FINANCIAL

19. Has this statement been prepared using a basis of accounting other than Statutory Accounting Principles (e.g., Generally Accepted Accounting Principles)? Yes [ ] No [X]

20.1 Total amount loaned during the year (inclusive of Separate Accounts, exclusive of policy loans):
20.11 To directors or other officers $
20.12 To stockholders not officers $
20.13 Trustees, supreme or grand (Fraternal Only) $

20.2 Total amount of loans outstanding at the end of year (inclusive of Separate Accounts, exclusive of policy loans):
20.21 To directors or other officers $
20.22 To stockholders not officers $
20.23 Trustees, supreme or grand (Fraternal Only) $

21.1 Were any assets reported in this statement subject to a contractual obligation to transfer to another party without the liability for such obligation being reported in the statement? Yes [ ] No [X]

21.2 If yes, state the amount thereof at December 31 of the current year:
21.21 Rented from others $
21.22 Borrowed from others $
21.23 Leased from others $
21.24 Other $

22.1 Does this statement include payments for assessments as described in the Annual Statement Instructions other than guaranty fund or guaranty association assessments? Yes [ ] No [X]

22.2 If answer is yes:
22.21 Amount paid as losses or risk adjustment $
22.22 Amount paid as expenses $
22.23 Other amounts paid $

23.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? Yes [ ] No [X]

23.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: $

INVESTMENT

24.01 Were all the stocks, bonds and other securities owned December 31 of current year, over which the reporting entity has exclusive control, in the actual possession of the reporting entity on said date? (other than securities lending programs addressed in 24.03) Yes [X] No [ ]

24.02 If no, give full and complete information relating thereto

24.03 For security lending programs, provide a description of the program including value for collateral and amount of loaned securities, and whether collateral is carried on or off-balance sheet. (an alternative is to reference Note 17 where this information is also provided)

24.04 Does the Company's security lending program meet the requirements for a conforming program as outlined in the Risk-Based Capital Instructions? Yes [ ] No [ ] N/A [X]

24.05 If answer to 24.04 is yes, report amount of collateral for conforming programs. $

24.06 If answer to 24.04 is no, report amount of collateral for other programs. $

24.07 Does your securities lending program require 102% (domestic securities) and 105% (foreign securities) from the counterparty at the outset of the contract? Yes [ ] No [ ] N/A [ ]

24.08 Does the reporting entity non-admit when the collateral received from the counterparty falls below 100%? Yes [ ] No [ ] N/A [ ]

24.09 Does the reporting entity or the reporting entity 's securities lending agent utilize the Master Securities lending Agreement (MSLA) to conduct securities lending? Yes [ ] No [ ] N/A [ ]

GENERAL INTERROGATORIES

24.10 For the reporting entity's security lending program state the amount of the following as December 31 of the current year:

24.101 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2. $ 0
24.102 Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2 $ 0
24.103 Total payable for securities lending reported on the liability page. $ 0

25.1 Were any of the stocks, bonds or other assets of the reporting entity owned at December 31 of the current year not exclusively under the control of the reporting entity, or has the reporting entity sold or transferred any assets subject to a put option contract that is currently in force? (Exclude securities subject to Interrogatory 21.1 and 24.03). Yes [X] No [ ]

25.2 If yes, state the amount thereof at December 31 of the current year:

25.21 Subject to repurchase agreements $
25.22 Subject to reverse repurchase agreements $
25.23 Subject to dollar repurchase agreements $
25.24 Subject to reverse dollar repurchase agreements $
25.25 Placed under option agreements $
25.26 Letter stock or securities restricted as to sale - excluding FHLB Capital Stock $
25.27 FHLB Capital Stock $
25.28 On deposit with states $ 564,032
25.29 On deposit with other regulatory bodies $
25.30 Pledged as collateral - excluding collateral pledged to an FHLB $
25.31 Pledged as collateral to FHLB - including assets backing funding agreements $
25.32 Other $

25.3 For category (25.26) provide the following:

1 Nature of Restriction	2 Description	3 Amount

26.1 Does the reporting entity have any hedging transactions reported on Schedule DB? Yes [ ] No [X]

26.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? Yes [ ] No [ ] N/A [X]
If no, attach a description with this statement.

LINES 26.3 through 26.5: FOR LIFE/FRATERNAL REPORTING ENTITIES ONLY:

26.3 Does the reporting entity utilize derivatives to hedge variable annuity guarantees subject to fluctuations as a result of interest rate sensitivity? Yes [ ] No [X]

26.4 If the response to 26.3 is YES, does the reporting entity utilize:
26.41 Special accounting provision of SSAP No. 108 Yes [ ] No [ ]
26.42 Permitted accounting practice Yes [ ] No [ ]
26.43 Other accounting guidance Yes [ ] No [ ]

26.5 By responding YES to 26.41 regarding utilizing the special accounting provisions of SSAP No. 108, the reporting entity attests to the following: Yes [ ] No [ ]

- The reporting entity has obtained explicit approval from the domiciliary state.
- Hedging strategy subject to the special accounting provisions is consistent with the requirements of VM-21.
- Actuarial certification has been obtained which indicates that the hedging strategy is incorporated within the establishment of VM-21 reserves and provides the impact of the hedging strategy within the Actuarial Guideline Conditional Tail Expectation Amount.
- Financial Officer Certification has been obtained which indicates that the hedging strategy meets the definition of a Clearly Defined Hedging Strategy within VM-21 and that the Clearly Defined Hedging Strategy is the hedging strategy being used by the company in its actual day-to-day risk mitigation efforts.

27.1 Were any preferred stocks or bonds owned as of December 31 of the current year mandatorily convertible into equity, or, at the option of the issuer, convertible into equity? Yes [ ] No [X]

27.2 If yes, state the amount thereof at December 31 of the current year. $

28. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook? Yes [X] No [ ]

28.01 For agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1 Name of Custodian(s)	2 Custodian's Address
JP Morgan Chase Bank, N.A	383 Madison Ave, New York, NY 10179

GENERAL INTERROGATORIES

28.02 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)

28.03 Have there been any changes, including name changes, in the custodian(s) identified in 28.01 during the current year? Yes [ ] No [X]

28.04 If yes, give full and complete information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

28.05 Investment management – Identify all investment advisors, investment managers, broker/dealers, including individuals that have the authority to make investment decisions on behalf of the reporting entity. For assets that are managed internally by employees of the reporting entity, note as such. ["…that have access to the investment accounts"; "…handle securities"]

1 Name of Firm or Individual	2 Affiliation
Loomis, Sayles & Company, LP	U

28.0597 For those firms/individuals listed in the table for Question 28.05, do any firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") manage more than 10% of the reporting entity's invested assets? Yes [X] No [ ]

28.0598 For firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") listed in the table for Question 28.05, does the total assets under management aggregate to more than 50% of the reporting entity's invested assets? Yes [ ] No [X]

28.06 For those firms or individuals listed in the table for 28.05 with an affiliation code of "A" (affiliated) or "U" (unaffiliated), provide the information for the table below.

1 Central Registration Depository Number	2 Name of Firm or Individual	3 Legal Entity Identifier (LEI)	4 Registered With	5 Investment Management Agreement (IMA) Filed
105377	Loomis, Sayles & Company, LP	JIZPN2RX3UMNOYIDI313	Securities Exchange Commission	NO

29.1 Does the reporting entity have any diversified mutual funds reported in Schedule D, Part 2 (diversified according to the Securities and Exchange Commission (SEC) in the Investment Company Act of 1940 [Section 5(b)(1)])? Yes [ ] No [X]

29.2 If yes, complete the following schedule:

1 CUSIP #	2 Name of Mutual Fund	3 Book/Adjusted Carrying Value
29.2999 - Total		0

29.3 For each mutual fund listed in the table above, complete the following schedule:

1 Name of Mutual Fund (from above table)	2 Name of Significant Holding of the Mutual Fund	3 Amount of Mutual Fund's Book/Adjusted Carrying Value Attributable to the Holding	4 Date of Valuation

GENERAL INTERROGATORIES

30. Provide the following information for all short-term and long-term bonds and all preferred stocks. Do not substitute amortized value or statement value for fair value.

	1 Statement (Admitted) Value	2 Fair Value	3 Excess of Statement over Fair Value (-), or Fair Value over Statement (+)
30.1 Bonds	564,032	595,940	31,908
30.2 Preferred stocks	0		0
30.3 Totals	564,032	595,940	31,908

30.4 Describe the sources or methods utilized in determining the fair values:
Fair values were obtained from third-party pricing sources. If a security was not priced by a third-party pricing source, internal analytical systems or broker quotes were utilized.

31.1 Was the rate used to calculate fair value determined by a broker or custodian for any of the securities in Schedule D? Yes [ ] No [X]

31.2 If the answer to 31.1 is yes, does the reporting entity have a copy of the broker's or custodian's pricing policy (hard copy or electronic copy) for all brokers or custodians used as a pricing source? Yes [ ] No [ ]

31.3 If the answer to 31.2 is no, describe the reporting entity's process for determining a reliable pricing source for purposes of disclosure of fair value for Schedule D:
N/A

32.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed? Yes [X] No [ ]
32.2 If no, list exceptions:

33. By self-designating 5GI securities, the reporting entity is certifying the following elements of each self-designated 5GI security:
a. Documentation necessary to permit a full credit analysis of the security does not exist or an NAIC CRP credit rating for an FE or PL security is not available.
b. Issuer or obligor is current on all contracted interest and principal payments.
c. The insurer has an actual expectation of ultimate payment of all contracted interest and principal.
Has the reporting entity self-designated 5GI securities? Yes [ ] No [X]

34. By self-designating PLGI securities, the reporting entity is certifying the following elements of each self-designated PLGI security:
a. The security was purchased prior to January 1, 2018.
b. The reporting entity is holding capital commensurate with the NAIC Designation reported for the security.
c. The NAIC Designation was derived from the credit rating assigned by an NAIC CRP in its legal capacity as a NRSRO which is shown on a current private letter rating held by the insurer and available for examination by state insurance regulators.
d. The reporting entity is not permitted to share this credit rating of the PL security with the SVO.
Has the reporting entity self-designated PLGI securities? Yes [ ] No [X]

35. By assigning FE to a Schedule BA non-registered private fund, the reporting entity is certifying the following elements of each self-designated FE fund:
a. The shares were purchased prior to January 1, 2019.
b. The reporting entity is holding capital commensurate with the NAIC Designation reported for the security.
c. The security had a public credit rating(s) with annual surveillance assigned by an NAIC CRP in its legal capacity as an NRSRO prior to January 1, 2019.
d. The fund only or predominantly holds bonds in its portfolio.
e. The current reported NAIC Designation was derived from the public credit rating(s) with annual surveillance assigned by an NAIC CRP in its legal capacity as an NRSRO.
f. The public credit rating(s) with annual surveillance assigned by an NAIC CRP has not lapsed.
Has the reporting entity assigned FE to Schedule BA non-registered private funds that complied with the above criteria? Yes [ ] No [X]

OTHER

36.1 Amount of payments to trade associations, service organizations and statistical or rating bureaus, if any? $ 0

36.2 List the name of the organization and the amount paid if any such payment represented 25% or more of the total payments to trade associations, service organizations and statistical or rating bureaus during the period covered by this statement.

1 Name	2 Amount Paid

GENERAL INTERROGATORIES

37.1 Amount of payments for legal expenses, if any? $ 838,859

37.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payments for legal expenses during the period covered by this statement.

1 Name	2 Amount Paid
OMELVENY & MYERS Total	514,724

38.1 Amount of payments for expenditures in connection with matters before legislative bodies, officers or departments of government, if any? $ 0

38.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payment expenditures in connection with matters before legislative bodies, officers or departments of government during the period covered by this statement.

1 Name	2 Amount Paid

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

GENERAL INTERROGATORIES

PART 2 - HEALTH INTERROGATORIES

1.1 Does the reporting entity have any direct Medicare Supplement Insurance in force? Yes [ ] No [X]
1.2 If yes, indicate premium earned on U.S. business only. $
1.3 What portion of Item (1.2) is not reported on the Medicare Supplement Insurance Experience Exhibit? $
1.31 Reason for excluding

1.4 Indicate amount of earned premium attributable to Canadian and/or Other Alien not included in Item (1.2) above $
1.5 Indicate total incurred claims on all Medicare Supplement Insurance. $ 0
1.6 Individual policies:

Most current three years:
1.61 Total premium earned $ 0
1.62 Total incurred claims $ 0
1.63 Number of covered lives 0
All years prior to most current three years:
1.64 Total premium earned $ 0
1.65 Total incurred claims $ 0
1.66 Number of covered lives 0

1.7 Group policies:

Most current three years:
1.71 Total premium earned $ 0
1.72 Total incurred claims $ 0
1.73 Number of covered lives 0
All years prior to most current three years:
1.74 Total premium earned $ 0
1.75 Total incurred claims $ 0
1.76 Number of covered lives 0

2. Health Test:

		1 Current Year	2 Prior Year
2.1	Premium Numerator		0
2.2	Premium Denominator	0	
2.3	Premium Ratio (2.1/2.2)	0.000	0.000
2.4	Reserve Numerator		0
2.5	Reserve Denominator	0	0
2.6	Reserve Ratio (2.4/2.5)	0.000	0.000

3.1 Has the reporting entity received any endowment or gift from contracting hospitals, physicians, dentists, or others that is agreed will be returned when, as and if the earnings of the reporting entity permits? Yes [ ] No [X]

3.2 If yes, give particulars:

4.1 Have copies of all agreements stating the period and nature of hospitals', physicians', and dentists' care offered to subscribers and dependents been filed with the appropriate regulatory agency? Yes [ ] No [X]

4.2 If not previously filed, furnish herewith a copy(ies) of such agreement(s). Do these agreements include additional benefits offered? Yes [ ] No [X]

5.1 Does the reporting entity have stop-loss reinsurance? Yes [ ] No [X]

5.2 If no, explain:
Currently, there are no insurance operations for this Company.

5.3 Maximum retained risk (see instructions)

5.31 Comprehensive Medical $
5.32 Medical Only $
5.33 Medicare Supplement $
5.34 Dental & Vision $
5.35 Other Limited Benefit Plan $
5.36 Other $

6. Describe arrangement which the reporting entity may have to protect subscribers and their dependents against the risk of insolvency including hold harmless provisions, conversion privileges with other carriers, agreements with providers to continue rendering services, and any other agreements:
N/A.

7.1 Does the reporting entity set up its claim liability for provider services on a service date basis? Yes [ ] No [X]

7.2 If no, give details
Currently, there are no insurance operations for this Company.

8. Provide the following information regarding participating providers:

8.1 Number of providers at start of reporting year
8.2 Number of providers at end of reporting year

9.1 Does the reporting entity have business subject to premium rate guarantees? Yes [ ] No [X]

9.2 If yes, direct premium earned:

9.21 Business with rate guarantees between 15-36 months $
9.22 Business with rate guarantees over 36 months $

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

GENERAL INTERROGATORIES

10.1 Does the reporting entity have Incentive Pool, Withhold or Bonus Arrangements in its provider contracts? Yes [ ] No [X]

10.2 If yes:

10.21 Maximum amount payable bonuses $
10.22 Amount actually paid for year bonuses $
10.23 Maximum amount payable withholds $
10.24 Amount actually paid for year withholds $

11.1 Is the reporting entity organized as:

11.12 A Medical Group/Staff Model, Yes [ ] No [X]
11.13 An Individual Practice Association (IPA), or, Yes [ ] No [X]
11.14 A Mixed Model (combination of above)? Yes [ ] No [X]

11.2 Is the reporting entity subject to Statutory Minimum Capital and Surplus Requirements? Yes [X] No [ ]
11.3 If yes, show the name of the state requiring such minimum capital and surplus. Mississippi
11.4 If yes, show the amount required. $ 1,000,000
11.5 Is this amount included as part of a contingency reserve in stockholder's equity? Yes [ ] No [X]
11.6 If the amount is calculated, show the calculation

12. List service areas in which reporting entity is licensed to operate:

1 Name of Service Area

13.1 Do you act as a custodian for health savings accounts? Yes [ ] No [X]

13.2 If yes, please provide the amount of custodial funds held as of the reporting date. $

13.3 Do you act as an administrator for health savings accounts? Yes [ ] No [X]

13.4 If yes, please provide the balance of funds administered as of the reporting date. $

14.1 Are any of the captive affiliates reported on Schedule S, Part 3, authorized reinsurers? Yes [ ] No [ ] N/A [X]
14.2 If the answer to 14.1 is yes, please provide the following:

1 Company Name	2 NAIC Company Code	3 Domiciliary Jurisdiction	4 Reserve Credit	Assets Supporting Reserve Credit		
				5 Letters of Credit	6 Trust Agreements	7 Other

15. Provide the following for individual ordinary life insurance* policies (U.S. business only) for the current year (prior to reinsurance assumed or ceded):

15.1 Direct Premium Written $
15.2 Total Incurred Claims $
15.3 Number of Covered Lives

*Ordinary Life Insurance Includes
Term(whether full underwriting, limited underwriting, jet issue, "short form app")
Whole Life (whether full underwriting, limited underwriting, jet issue, "short form app")
Variable Life (with or without secondary gurarantee)
Universal Life (with or without secondary gurarantee)
Variable Universal Life (with or without secondary gurarantee)

16. Is the reporting entity licensed or chartered, registered, qualified, eligible or writing business in at least two states? Yes [ ] No [X]

16.1 If no, does the reporting entity assume reinsurance business that covers risks residing in at least one state other than the state of domicile of the reporting entity? Yes [ ] No [X]

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

FIVE-YEAR HISTORICAL DATA

	1 2019	2 2018	3 2017	4 2016	5 2015
Balance Sheet (Pages 2 and 3)					
1. Total admitted assets (Page 2, Line 28)	4,023,135	4,035,861	4,022,614		
2. Total liabilities (Page 3, Line 24)	143	1,289	8,624		
3. Statutory minimum capital and surplus requirement	1,000,000	1,000,000	1,500,000		
4. Total capital and surplus (Page 3, Line 33)	4,022,992	4,034,572	4,013,990		
Income Statement (Page 4)					
5. Total revenues (Line 8)	0	0	0		
6. Total medical and hospital expenses (Line 18)	0	0	0		
7. Claims adjustment expenses (Line 20)	0	0	0		
8. Total administrative expenses (Line 21)	532	2,341	0		
9. Net underwriting gain (loss) (Line 24)	(532)	(2,341)	0		
10. Net investment gain (loss) (Line 27)	4,740	23,955	16,276		
11. Total other income (Lines 28 plus 29)	0	0	0		
12. Net income or (loss) (Line 32)	5,462	20,582	13,999		
Cash Flow (Page 6)					
13. Net cash from operations (Line 11)	16,122	29,897	17,071		
Risk-Based Capital Analysis					
14. Total adjusted capital	4,022,992	4,034,572	4,013,990		
15. Authorized control level risk-based capital	9,119	9,178	20,958		
Enrollment (Exhibit 1)					
16. Total members at end of period (Column 5, Line 7)					
17. Total members months (Column 6, Line 7)					
Operating Percentage (Page 4) (Item divided by Page 4, sum of Lines 2, 3 and 5) x 100.0					
18. Premiums earned plus risk revenue (Line 2 plus Lines 3 and 5)	100.0	100.0	100.0	100.0	100.0
19. Total hospital and medical plus other non-health (Lines 18 plus Line 19)	0.0	0.0	0.0		
20. Cost containment expenses	0.0	0.0	0.0		
21. Other claims adjustment expenses	0.0	0.0	0.0		
22. Total underwriting deductions (Line 23)	0.0	0.0	0.0		
23. Total underwriting gain (loss) (Line 24)	0.0	0.0	0.0		
Unpaid Claims Analysis (U&I Exhibit, Part 2B)					
24. Total claims incurred for prior years (Line 13, Col. 5)					
25. Estimated liability of unpaid claims-[prior year (Line 13, Col. 6)]					
Investments In Parent, Subsidiaries and Affiliates					
26. Affiliated bonds (Sch. D Summary, Line 12, Col. 1)					
27. Affiliated preferred stocks (Sch. D Summary, Line 18, Col. 1)	0				
28. Affiliated common stocks (Sch. D Summary, Line 24, Col. 1)	0				
29. Affiliated short-term investments (subtotal included in Schedule DA Verification, Col. 5, Line 10)			0		
30. Affiliated mortgage loans on real estate					
31. All other affiliated					
32. Total of above Lines 26 to 31	0	0	0	0	0
33. Total investment in parent included in Lines 26 to 31 above.					

NOTE: If a party to a merger, have the two most recent years of this exhibit been restated due to a merger in compliance with the disclosure requirements of SSAP No. 3, Accounting Changes and Correction of Errors? Yes [ ] No [ ]

If no, please explain:

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION _____ 2. _____

(LOCATION)

NAIC Group Code BUSINESS IN THE STATE OF DURING THE YEAR 2019 NAIC Company Code

	1	Comprehensive (Hospital & Medical) 2	3	4	5	6	7	8	9	10
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other
Total Members at end of:										
1. Prior Year										
2. First Quarter										
3. Second Quarter										
4. Third Quarter										
5. Current Year										
6. Current Year Member Months										
Total Member Ambulatory Encounters for Year:										
7 Physician										
8. Non-Physician										
9. Total										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b)										
13. Life Premiums Direct										
14. Property/Casualty Premiums Written										
15. Health Premiums Earned										
16. Property/Casualty Premiums Earned										
17. Amount Paid for Provision of Health Care Services										
18 Amount Incurred for Provision of Health Care Services										

NONE

(a) For health business: number of persons insured under PPO managed care products ..... and number of persons insured under indemnity only products ..... .
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $ .....

30

Schedule S - Part 1 - Section 2

N O N E

Schedule S - Part 2

N O N E

Schedule S - Part 3 - Section 2

N O N E

Schedule S - Part 4

N O N E

Schedule S - Part 4 - Bank Footnote

N O N E

Schedule S - Part 5

N O N E

Schedule S - Part 5 - Bank Footnote

N O N E

Schedule S - Part 6

N O N E

Schedule S - Part 7

N O N E

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE T PREMIUMS AND OTHER CONSIDERATIONS

Allocated by States and Territories

States, etc.		1 Active Status (a)	Direct Business Only 2 Accident & Health Premiums	3 Medicare Title XVIII	4 Medicaid Title XIX	5 Federal Employees Health Benefits Plan Premiums	6 Life & Annuity Premiums & Other Considerations	7 Property/ Casualty Premiums	8 Total Columns 2 Through 7	9 Deposit-Type Contracts
1. Alabama	AL	N							0	
2. Alaska	AK	N							0	
3. Arizona	AZ	N							0	
4. Arkansas	AR	N							0	
5. California	CA	N							0	
6. Colorado	CO	N							0	
7. Connecticut	CT	N							0	
8. Delaware	DE	N							0	
9. District of Columbia	DC	N							0	
10. Florida	FL	N							0	
11. Georgia	GA	N							0	
12. Hawaii	HI	N							0	
13. Idaho	ID	N							0	
14. Illinois	IL	N							0	
15. Indiana	IN	N							0	
16. Iowa	IA	N							0	
17. Kansas	KS	N							0	
18. Kentucky	KY	N							0	
19. Louisiana	LA	N							0	
20. Maine	ME	N							0	
21. Maryland	MD	N							0	
22. Massachusetts	MA	N							0	
23. Michigan	MI	N							0	
24. Minnesota	MN	N							0	
25. Mississippi	MS	L							0	
26. Missouri	MO	N							0	
27. Montana	MT	N							0	
28. Nebraska	NE	N							0	
29. Nevada	NV	N							0	
30. New Hampshire	NH	N							0	
31. New Jersey	NJ	N							0	
32. New Mexico	NM	N							0	
33. New York	NY	N							0	
34. North Carolina	NC	N							0	
35. North Dakota	ND	N							0	
36. Ohio	OH	N							0	
37. Oklahoma	OK	N							0	
38. Oregon	OR	N							0	
39. Pennsylvania	PA	N							0	
40. Rhode Island	RI	N							0	
41. South Carolina	SC	N							0	
42. South Dakota	SD	N							0	
43. Tennessee	TN	N							0	
44. Texas	TX	N							0	
45. Utah	UT	N							0	
46. Vermont	VT	N							0	
47. Virginia	VA	N							0	
48. Washington	WA	N							0	
49. West Virginia	WV	N							0	
50. Wisconsin	WI	N							0	
51. Wyoming	WY	N							0	
52. American Samoa	AS	N							0	
53. Guam	GU	N							0	
54. Puerto Rico	PR	N							0	
55. U.S. Virgin Islands	VI	N							0	
56. Northern Mariana Islands	MP	N							0	
57. Canada	CAN	N							0	
58. Aggregate other alien	OT	XXX	0	0	0	0	0	0	0	0
59. Subtotal		XXX	0	0	0	0	0	0	0	0
60. Reporting entity contributions for Employee Benefit Plans		XXX							0	
61. Total (Direct Business)		XXX	0	0	0	0	0	0	0	0
DETAILS OF WRITE-INS										
58001.		XXX								
58002.		XXX								
58003.		XXX								
58998. Summary of remaining write-ins for Line 58 from overflow page		XXX	0	0	0	0	0	0	0	0
58999. Totals (Lines 58001 through 58003 plus 58998)(Line 58 above)		XXX	0	0	0	0	0	0	0	0

(a) Active Status Counts:

L - Licensed or Chartered - Licensed insurance carrier or domiciled RRG 1
R - Registered - Non-domiciled RRGs 0
E - Eligible - Reporting entities eligible or approved to write surplus lines in the state 0
Q - Qualified - Qualified or accredited reinsurer 0
N - None of the above - Not allowed to write business in the state 56

(b) Explanation of basis of allocation by states, premiums by state, etc.
Situs of contract

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE T - PART 2

INTERSTATE COMPACT - EXHIBIT OF PREMIUMS WRITTEN

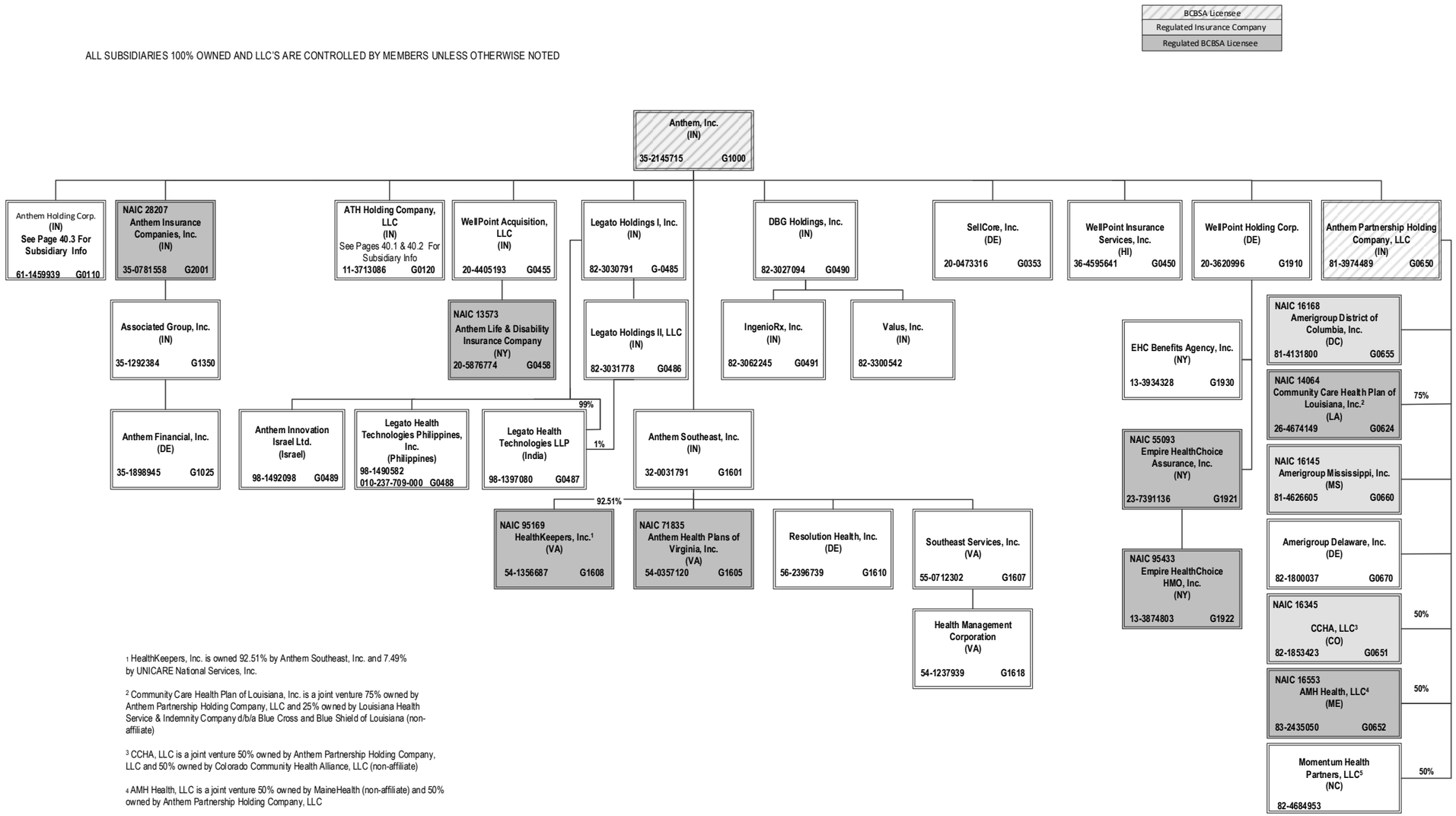
Allocated by States and Territories

		Direct Business Only					
		1	2	3	4	5	6
States, Etc.		Life (Group and Individual)	Annuities (Group and Individual)	Disability Income (Group and Individual)	Long-Term Care (Group and Individual)	Deposit-Type Contracts	Totals
1. Alabama	AL						
2. Alaska	AK						
3. Arizona	AZ						
4. Arkansas	AR						
5. California	CA						
6. Colorado	CO						
7. Connecticut	CT						
8. Delaware	DE						
9. District of Columbia	DC						
10. Florida	FL						
11. Georgia	GA						
12. Hawaii	HI						
13. Idaho	ID						
14. Illinois	IL						
15. Indiana	IN						
16. Iowa	IA						
17. Kansas	KS						
18. Kentucky	KY						
19. Louisiana	LA						
20. Maine	ME						
21. Maryland	MD						
22. Massachusetts	MA						
23. Michigan	MI						
24. Minnesota	MN						
25. Mississippi	MS						
26. Missouri	MO						
27. Montana	MT						
28. Nebraska	NE						
29. Nevada	NV						
30. New Hampshire	NH						
31. New Jersey	NJ						
32. New Mexico	NM						
33. New York	NY						
34. North Carolina	NC						
35. North Dakota	ND						
36. Ohio	OH						
37. Oklahoma	OK						
38. Oregon	OR						
39. Pennsylvania	PA						
40. Rhode Island	RI						
41. South Carolina	SC						
42. South Dakota	SD						
43. Tennessee	TN						
44. Texas	TX						
45. Utah	UT						
46. Vermont	VT						
47. Virginia	VA						
48. Washington	WA						
49. West Virginia	WV						
50. Wisconsin	WI						
51. Wyoming	WY						
52. American Samoa	AS						
53. Guam	GU						
54. Puerto Rico	PR						
55. U.S. Virgin Islands	VI						
56. Northern Mariana Islands	MP						
57. Canada	CAN						
58. Aggregate Other Alien	OT						
59. Total							

NONE

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



1 HealthKeepers, Inc. is owned 92.51% by Anthem Southeast, Inc. and 7.49% by UNICARE National Services, Inc.

2 Community Care Health Plan of Louisiana, Inc. is a joint venture 75% owned by Anthem Partnership Holding Company, LLC and 25% owned by Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana (non-affiliate)

3 CCHA, LLC is a joint venture 50% owned by Anthem Partnership Holding Company, LLC and 50% owned by Colorado Community Health Alliance, LLC (non-affiliate)

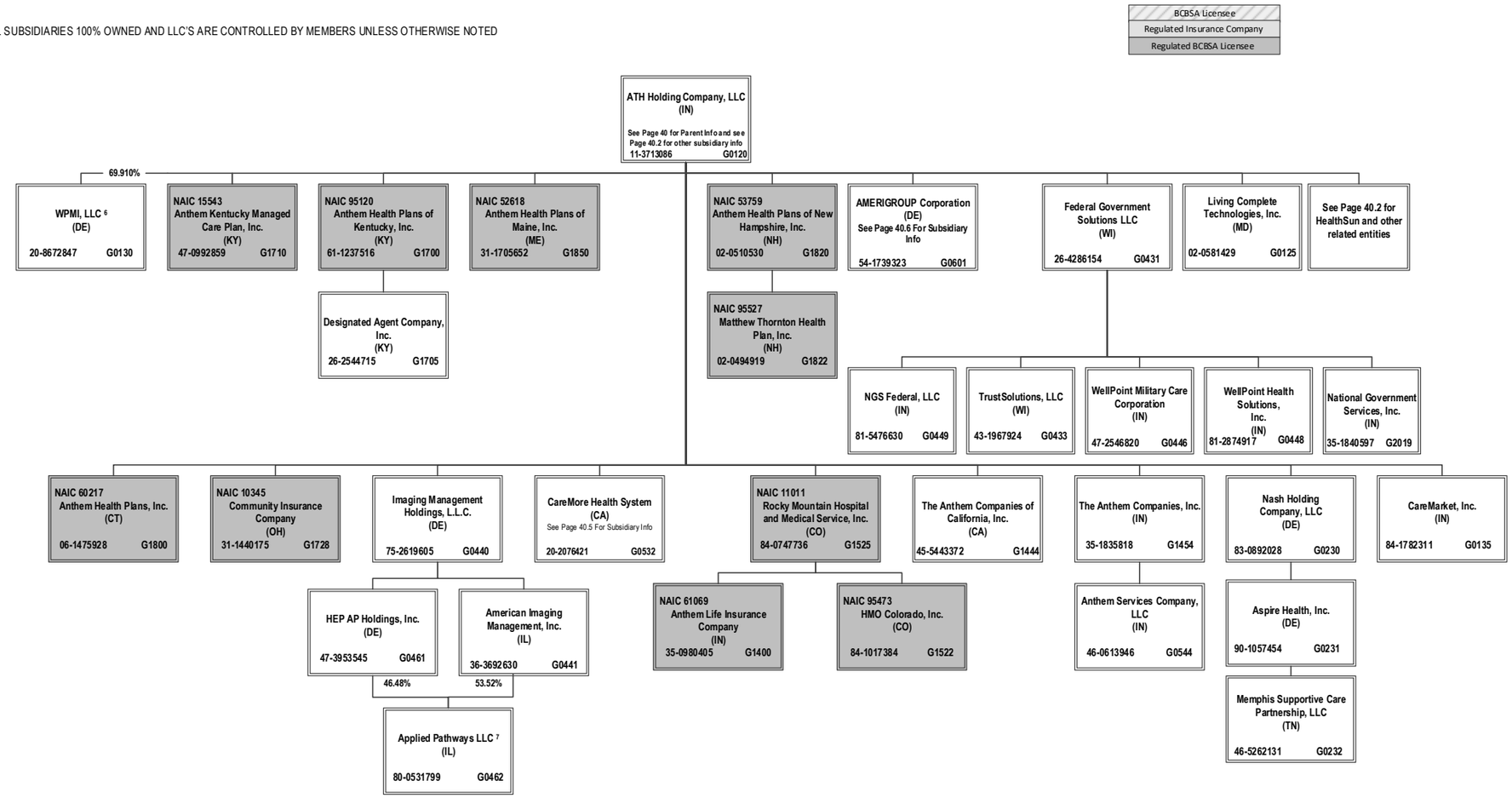
4 AMH Health, LLC is a joint venture 50% owned by MaineHealth (non-affiliate) and 50% owned by Anthem Partnership Holding Company, LLC

5 Momentum Health Partners, LLC is a joint venture 50% owned by Anthem Partnership Holding Company, LLC and 50% owned by Blue Cross and Blue Shield of North Carolina (non-affiliate)

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED



[6] 30.09% of WPMI, LLC is owned by unaffiliated investors

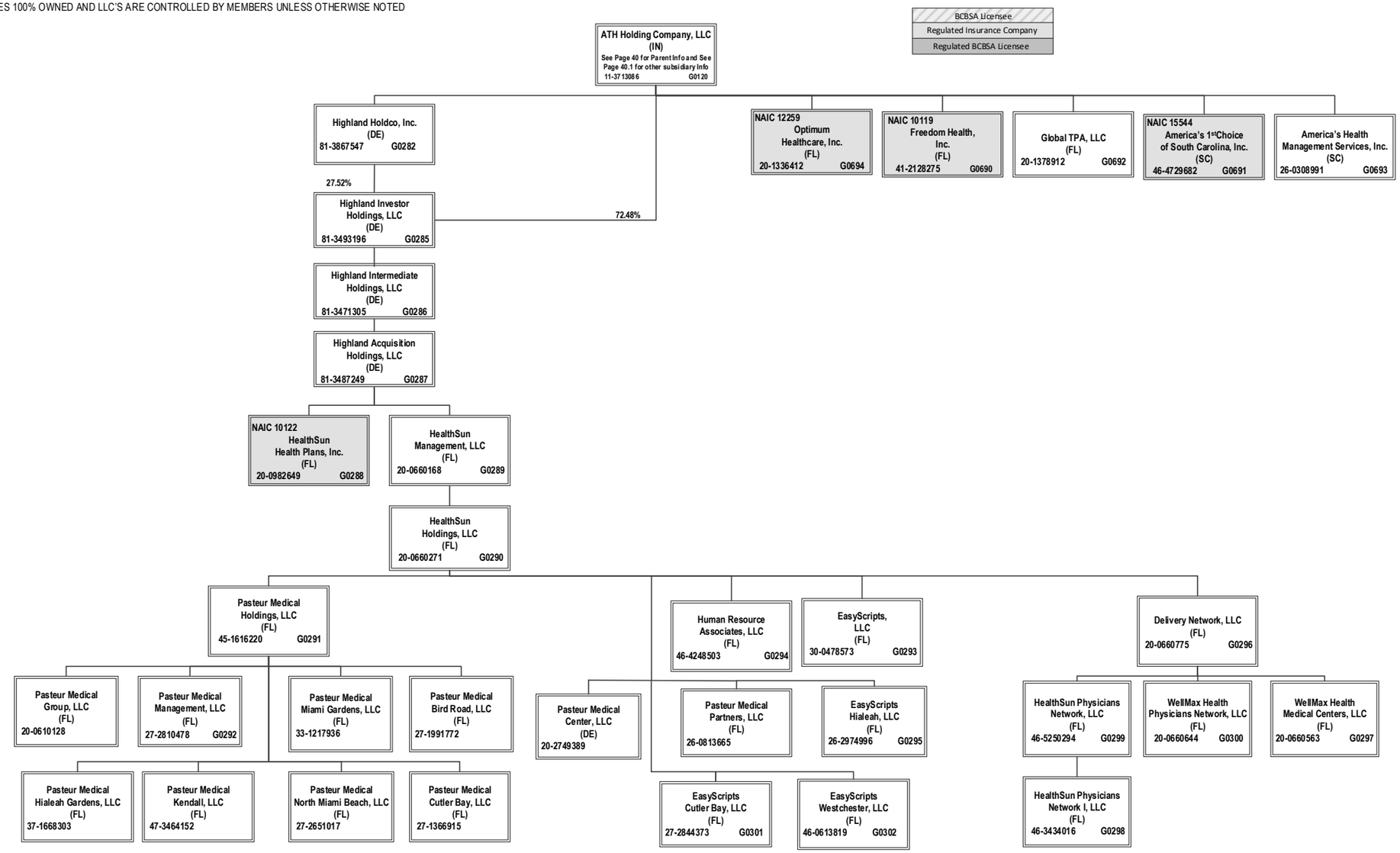
[7] Applied Pathways LLC is owned 53.52% by AIM and 46.48% by HEP AP Holdings, Inc.

40.1

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART

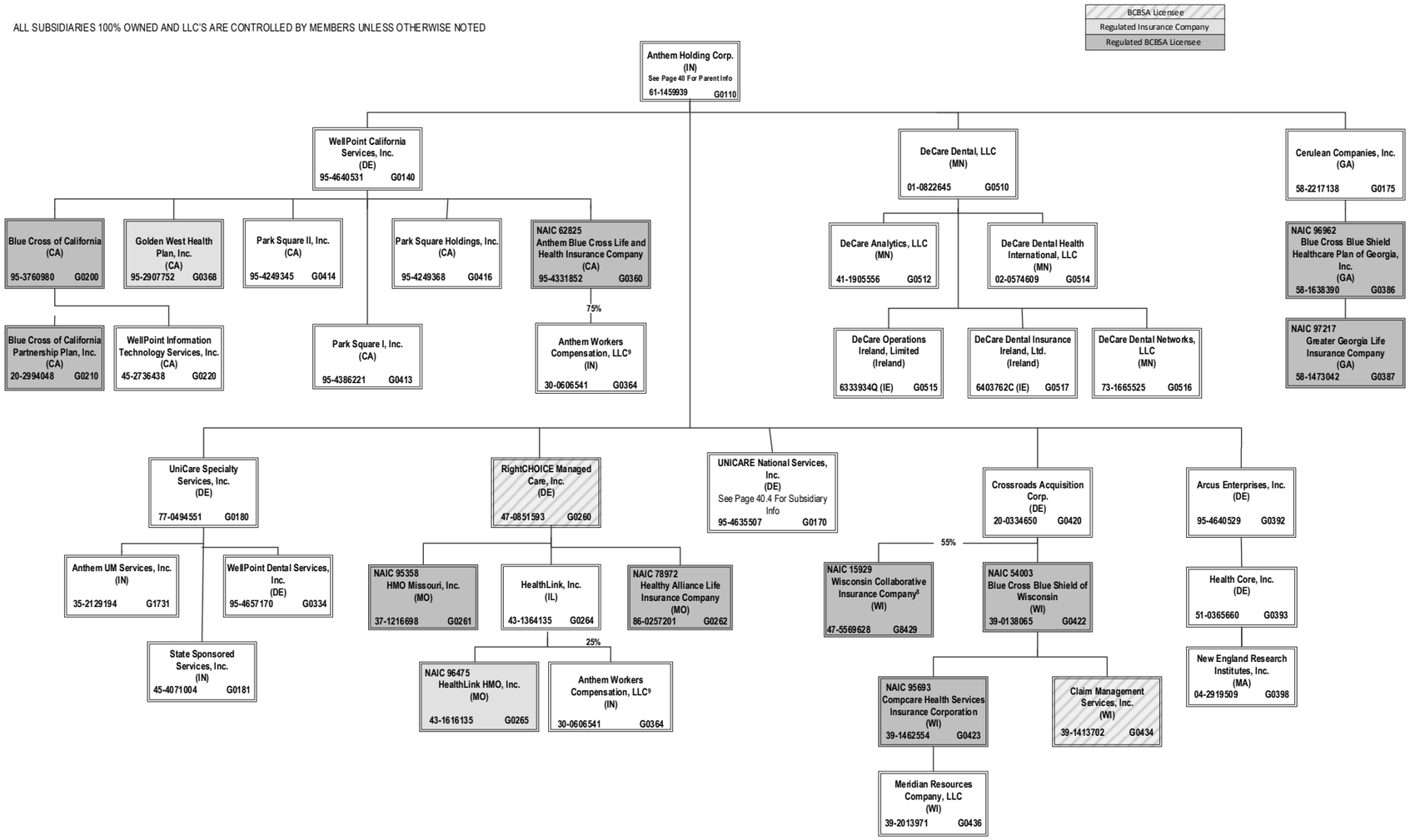
ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED



40.2

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



[8] 45% of WCIC is owned by Aurora Health Care, Inc. (non-affiliate). Not consolidated for accounting purposes.

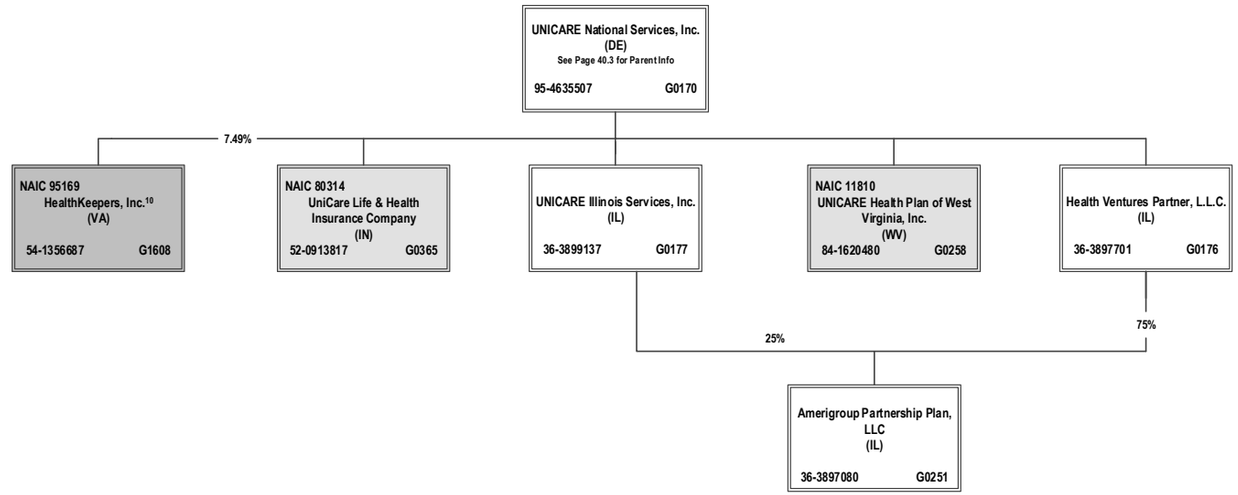
[9] Anthem Workers' Compensation LLC is owned 75% by Anthem Blue Cross Life and Health Insurance Company and 25% by HealthLink, Inc.

40.3

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED

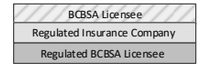


[10] HealthKeepers, Inc. is owned 92.51% by Anthem Southeast, Inc. and 7.49% by UNICARE National Services, Inc.

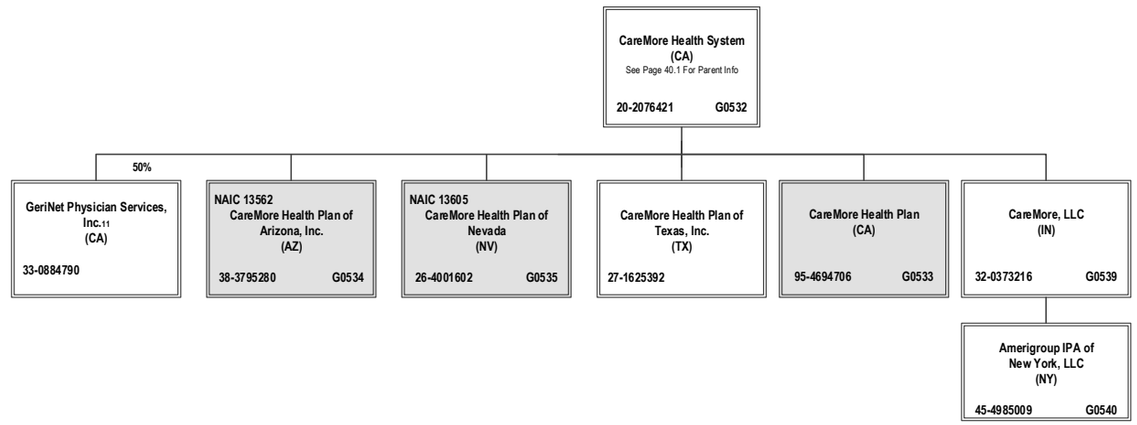
40.4

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED



[11] GeriNet Physician Services, Inc. is owned 50% by CareMore Health System and 50% by Health Essentials Acquisition Corporation (non-affiliate)

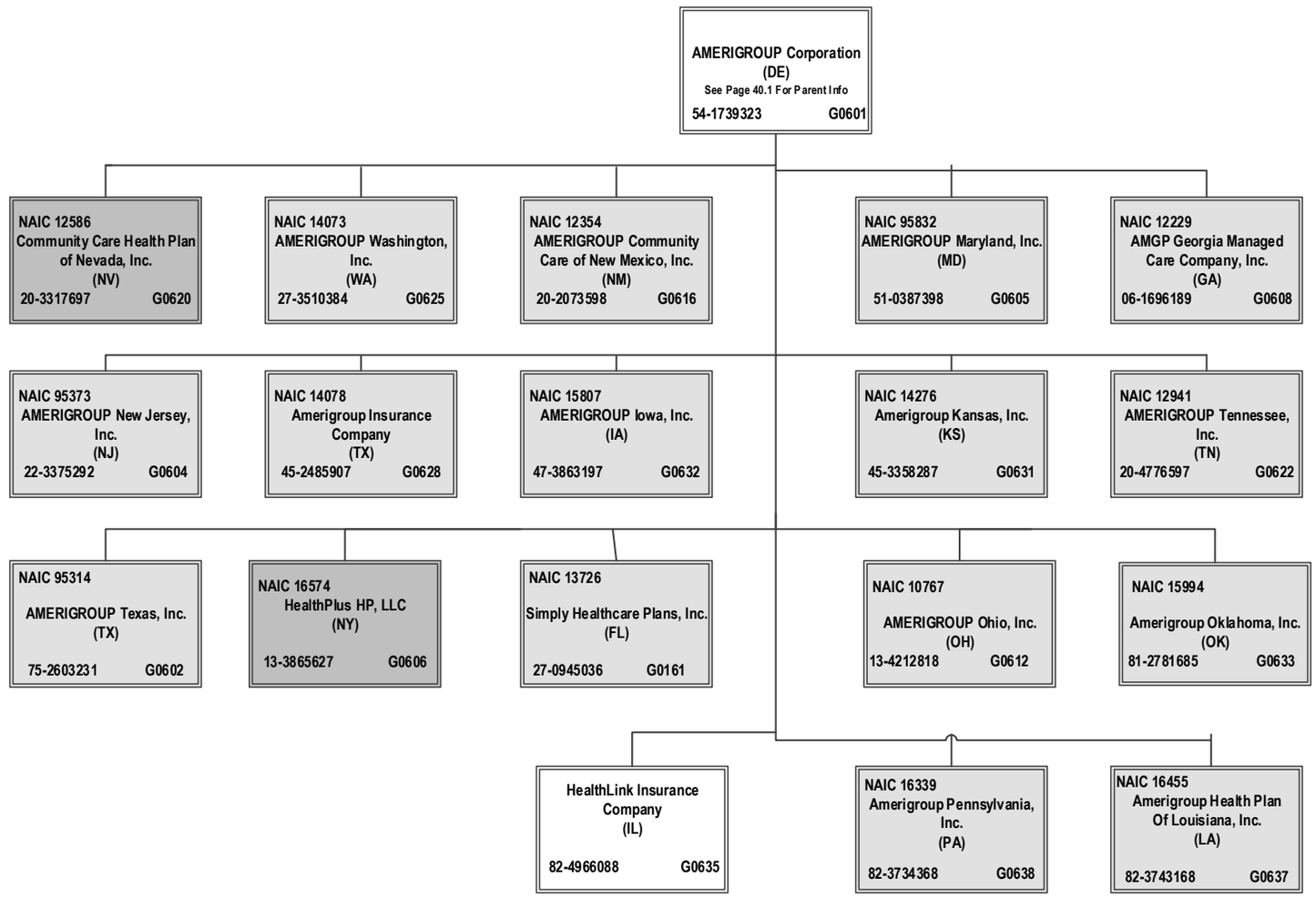
40.5

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART

BCBSA Licensee
Regulated Insurance Company
Regulated BCBSA Licensee

ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED



40.6

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	Is an SCA Filing Required? (Y/N)	*
0671	Anthem, Inc.		36-3692630		0001156039		American Imaging Management, Inc.	IL	NIA	Imaging Management Holdings, L.L.C.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	15544	46-4729682		0001156039		America's 1st Choice of South Carolina, Inc.	SC	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		26-0308991		0001156039		America's Health Management Services, Inc.	SC	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	12354	20-2073598		0001156039		AMERIGROUP Community Care of New Mexico, Inc.	NM	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		54-1739323		0001156039		AMERIGROUP Corporation	DE	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-1800037		0001156039		AMERIGROUP Delaware, Inc.	DE	NIA	Anthem Partnership Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	16168	81-4131800		0001156039		Amerigroup District of Columbia, Inc.	DC	IA	Anthem Partnership Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	16455	82-3743168		0001156039		Amerigroup Health Plan of Louisiana, Inc.	LA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	14078	45-2485907		0001156039		Amerigroup Insurance Company	TX	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	15807	47-3863197		0001156039		AMERIGROUP Iowa, Inc.	IA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		45-4985009		0001156039		Amerigroup IPA of New York, LLC	NY	NIA	CareMore, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	14276	45-3358287		0001156039		Amerigroup Kansas, Inc.	KS	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95832	51-0387398		0001156039		AMERIGROUP Maryland, Inc.	MD	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	16145	81-4626605		0001156039		Amerigroup Mississippi, Inc.	MS	RE	Anthem Partnership Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95373	22-3375292		0001156039		AMERIGROUP New Jersey, Inc.	NJ	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	10767	13-4212818		0001156039		AMERIGROUP Ohio, Inc.	OH	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	15994	81-2781685		0001156039		AMERIGROUP Oklahoma, Inc.	OK	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		36-3897080		0001156039		Amerigroup Partnership Plan, LLC	IL	NIA	Health Ventures Partner, L.L.C.	Ownership	75.000	Anthem, Inc.	N	
0671	Anthem, Inc.		36-3897080		0001156039		Amerigroup Partnership Plan, LLC	IL	NIA	UNICARE Illinois Services, Inc.	Ownership	25.000	Anthem, Inc.	N	
0671	Anthem, Inc.	16339	82-3734368		0001156039		Amerigroup Pennsylvania, Inc.	PA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	12941	20-4776597		0001156039		AMERIGROUP Tennessee, Inc.	TN	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95314	75-2603231		0001156039		AMERIGROUP Texas, Inc.	TX	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	14073	27-3510384		0001156039		AMERIGROUP Washington, Inc.	WA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	12229	06-1696189		0001156039		AMGP Georgia Managed Care Company, Inc.	GA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	16553	83-2435050		0001156039		AMH Health, LLC	ME	IA	Anthem Partnership Holding Company, LLC	Ownership	50.000	Anthem, Inc.	N	0102
0671	Anthem, Inc.	62825	95-4331852		0001156039		Anthem Blue Cross Life and Health Insurance Company	CA	IA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		35-1898945		0001156039		Anthem Financial, Inc.	DE	NIA	Associated Group, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95120	61-1237516		0001156039		Anthem Health Plans of Kentucky, Inc.	KY	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	52618	31-1705652		0001156039		Anthem Health Plans of Maine, Inc.	ME	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	53759	02-0510530		0001156039		Anthem Health Plans of New Hampshire, Inc.	NH	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	71835	54-0357120	40003317	0001156039		Anthem Health Plans of Virginia, Inc.	VA	IA	Anthem Southeast, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	60217	06-1475928		0001156039		Anthem Health Plans, Inc.	CT	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		61-1459939		0001156039		Anthem Holding Corp.	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		35-2145715		0001156039	New York Stock Exchange (NYSE)	Anthem, Inc.	IN	UIP				Anthem, Inc.	N	
0671	Anthem, Inc.		98-1492098		0001156039		Anthem Innovation Israel Ltd	ISR	NIA	Legato Holdings I, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	28207	35-0781558		0001156039		Anthem Insurance Companies, Inc.	IN	IA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	15543	47-0992859		0001156039		Anthem Kentucky Managed Care Plan, Inc.	KY	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	13573	20-5876774		0001156039		Anthem Life & Disability Insurance Company	NY	IA	WellPoint Acquisition, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	61069	35-0980405		0001156039		Anthem Life Insurance Company	IN	IA	Rocky Mountain Hospital and Medical Service, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		81-3974489		0001156039		Anthem Partnership Holding Company, LLC	DE	UDP	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		46-0613946		0001156039		Anthem Services Company, LLC	IN	NIA	The Anthem Companies, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		32-0031791		0001156039		Anthem Southeast, Inc.	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		35-2129194		0001156039		Anthem UM Services, Inc.	IN	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		30-0606541		0001156039		Anthem Workers' Compensation, LLC	IN	NIA	Anthem Blue Cross Life and Health Insurance Company	Ownership	75.000	Anthem, Inc.	N	0109
0671	Anthem, Inc.		30-0606541		0001156039		Anthem Workers' Compensation, LLC	IN	NIA	HealthLink, Inc.	Ownership	25.000	Anthem, Inc.	N	0109
0671	Anthem, Inc.		80-0531799		0001156039		Applied Pathways, LLC	IL	NIA	American Imaging Management, Inc.	Ownership	53.520	Anthem, Inc.	N	0108
0671	Anthem, Inc.		80-0531799		0001156039		Applied Pathways, LLC	IL	NIA	HEP AP Holdings, Inc.	Ownership	46.480	Anthem, Inc.	N	0108
0671	Anthem, Inc.		95-4640529		0001156039		Arcus Enterprises, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0671	Anthem, Inc.		90-1057454		0001156039		Aspire Health, Inc.	DE	NIA	Nash Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		35-1292384		0001156039		Associated Group, Inc.	IN	NIA	Anthem Insurance Companies, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		11-3713086		0001156039		ATH Holding Company, LLC	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	96962	58-1638390		0001156039		Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	GA	IA	Cerulean Companies, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	54003	39-0138065		0001156039		Blue Cross Blue Shield of Wisconsin	WI	IA	Crossroads Acquisition Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-3760980		0001156039		Blue Cross of California	CA	IA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	0101
0671	Anthem, Inc.		20-2994048		0001156039		Blue Cross of California Partnership Plan, Inc.	CA	IA	Blue Cross of California	Ownership	100.000	Anthem, Inc.	N	0101
0671	Anthem, Inc.		84-1782311		0001156039		CareMarket, Inc.	IN	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4694706		0001156039		CareMore Health Plan	CA	IA	CareMore Health System	Ownership	100.000	Anthem, Inc.	N	0101
0671	Anthem, Inc.	13562	38-3795280		0001156039		CareMore Health Plan of Arizona, Inc.	AZ	IA	CareMore Health System	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	13605	26-4001602		0001156039		CareMore Health Plan of Nevada	NV	IA	CareMore Health System	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		27-1625392		0001156039		CareMore Health Plan of Texas, Inc.	TX	NIA	CareMore Health System	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		32-0373216		0001156039		CareMore, LLC	IN	NIA	CareMore Health System	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-2076421		0001156039		CareMore Health System	CA	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		58-2217138		0001156039		Cerulean Companies, Inc.	GA	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		39-1413702		0001156039		Claim Management Services, Inc.	WI	NIA	Blue Cross Blue Shield of Wisconsin	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	16345	82-1853423		0001156039		CCHA, LLC	CO	IA	Anthem Partnership Holding Company, LLC	Ownership	50.000	Anthem, Inc.	N	0102
0671	Anthem, Inc.	14064	26-4674149		0001156039		Community Care Health Plan of Louisiana, Inc.	LA	IA	Anthem Partnership Holding Company, LLC	Ownership	75.000	Anthem, Inc.	N	0104
0671	Anthem, Inc.	12586	20-3317697		0001156039		Community Care Health Plan of Nevada, Inc.	NV	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	10345	31-1440175		0001156039		Community Insurance Company	OH	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95693	39-1462554		0001156039		Compcare Health Services Insurance Corporation	WI	IA	Blue Cross Blue Shield of Wisconsin	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0334650		0001156039		Crossroads Acquisition Corp.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-3027094		0001156039		DBG Holdings, Inc.	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		41-1905556		0001156039		DeCare Analytics, LLC	MN	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		02-0574609		0001156039		DeCare Dental Health International, LLC	MN	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.				0001156039		DeCare Dental Insurance Ireland, Ltd.	IRL	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		73-1665525		0001156039		DeCare Dental Networks, LLC	MN	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		01-0822645		0001156039		DeCare Dental, LLC	MN	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.				0001156039		DeCare Operations Ireland, Limited	IRL	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0660775		0001156039		Delivery Network, LLC	FL	NIA	HealthSun Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		26-2544715		0001156039		Designated Agent Company, Inc.	KY	NIA	Anthem Health Plans of Kentucky, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		27-2844373		0001156039		EasyScripts Cutler Bay, LLC	FL	NIA	HealthSun Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		26-2974996		0001156039		EasyScripts Hialeah, LLC	FL	NIA	HealthSun Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		30-0478573		0001156039		EasyScripts LLC	FL	NIA	HealthSun Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		46-0613819		0001156039		EasyScripts Westchester, LLC	FL	NIA	HealthSun Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		13-3934328		0001156039		EHC Benefits Agency, Inc.	NY	NIA	WellPoint Holding Corp	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	55093	23-7391136		0001156039		Empire HealthChoice Assurance, Inc.	NY	IA	WellPoint Holding Corp	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95433	13-3874803		0001156039		Empire HealthChoice HMO, Inc.	NY	IA	Empire HealthChoice Assurance, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		26-4286154		0001156039		Federal Government Solutions, LLC	WI	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	10119	41-2128275		0001156039		Freedom Health, Inc.	FL	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		33-0884790		0001156039		GeriNet Physician Services, Inc.	CA	NIA	CareMore Health System	Ownership	50.000	Anthem, Inc.	N	0102
0671	Anthem, Inc.		20-1378912		0001156039		Global TPA, LLC	FL	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-2907752		0001156039		Golden West Health Plan, Inc.	CA	IA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	0101
0671	Anthem, Inc.	97217	58-1473042		0001156039		Greater Georgia Life Insurance Company	GA	IA	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		51-0365660		0001156039		Health Core, Inc.	DE	NIA	Arcus Enterprises, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		54-1237939		0001156039		Health Management Corporation	VA	NIA	Southeast Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		36-3897701		0001156039		Health Ventures Partner, L.L.C.	IL	NIA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95169	54-1356687		0001156039		HealthKeepers, Inc.	VA	IA	Anthem Southeast, Inc.	Ownership	92.510	Anthem, Inc.	N	
0671	Anthem, Inc.	95169	54-1356687		0001156039		HealthKeepers, Inc.	VA	IA	UNICARE National Services, Inc.	Ownership	7.490	Anthem, Inc.	N	

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ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0671	Anthem, Inc.	96475	43-1616135		0001156039		HealthLink HMO, Inc.	MO	IA	HealthLink, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		43-1364135		0001156039		HealthLink, Inc.	IL	NIA	RightCHOICE Managed Care, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-4966088		0001156039		HealthLink Insurance Company	IL	NIA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		13-3865627		0001156039		HealthPlus HP, LLC	NY	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	0100
0671	Anthem, Inc.	10122	20-0982649		0001156039		HealthSun Health Plans, Inc.	FL	IA	Highland Acquisition Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0660271		0001156039		HealthSun Holdings, LLC	FL	NIA	HealthSun Management, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0660168		0001156039		HealthSun Management, LLC	FL	NIA	Highland Acquisition Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		46-5250294		0001156039		HealthSun Physicians Network, LLC	FL	NIA	Delivery Network, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		46-3434016		0001156039		HealthSun Physicians Network I, LLC	FL	NIA	HealthSun Physicians Network, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	78972	86-0257201		0001156039		Healthy Alliance Life Insurance Company	MO	IA	RightCHOICE Managed Care, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		47-3953545		0001156039		HEP AP Holdings, Inc.	DE	NIA	Imaging Management Holdings, L.L.C.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		81-3867547		0001156039		Highland Holdco, Inc.	DE	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		81-3487249		0001156039		Highland Acquisition Holdings, LLC	DE	NIA	Highland Intermediate Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		81-3471305		0001156039		Highland Intermediate Holdings, LLC	DE	NIA	Highland Investor Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		81-3493196		0001156039		Highland Investor Holdings, LLC	DE	NIA	ATH Holding Company, LLC	Ownership	72.480	Anthem, Inc.	N	0107
0671	Anthem, Inc.		81-3493196		0001156039		Highland Investor Holdings, LLC	DE	NIA	Highland Holdco, Inc.	Ownership	27.520	Anthem, Inc.	N	0107
0671	Anthem, Inc.	95473	84-1017384		0001156039		HMO Colorado, Inc.	CO	IA	Rocky Mountain Hospital and Medical Service, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95358	37-1216698		0001156039		HMO Missouri, Inc.	MO	IA	RightCHOICE Managed Care, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.				0001156039		Human Resource Associates, LLC	FL	NIA	HealthSun Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		75-2619605		0001156039		Imaging Management Holdings, L.L.C.	DE	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-3062245		0001156039		IngenioRX, Inc.	IN	NIA	DBG Holdings, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		98-1397080		0001156039		Legato Health Technologies LLP	IN	NIA	Legato Holdings I, Inc.	Ownership	100.000	Anthem, Inc.	N	0105
0671	Anthem, Inc.		98-1490582		0001156039		Legato Health Technologies Philippines, Inc.	PHL	NIA	Legato Holdings I, Inc.	Ownership	100.000	Anthem, Inc.	N	0106
0671	Anthem, Inc.		82-3030791		0001156039		Legato Holdings I, Inc.	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-3031178		0001156039		Legato Holdings II, LLC	IN	NIA	Legato Holdings I, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		02-0581429		0001156039		Living Complete Technologies, Inc.	MD	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95527	02-0494919		0001156039		Matthew Thornton Health Plan, Inc.	NH	IA	Anthem Health Plans of New Hampshire, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		46-5262131		0001156039		Memphis Supportive Care Partnership, LLC	TN	NIA	Nash Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		39-2013971		0001156039		Meridian Resource Company, LLC	WI	NIA	Compcare Health Services Insurance Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-4684953		0001156039		Momentum Health Partners, LLC	NC	NIA	Anthem Partnership Holding Company, LLC	Ownership	50.000	Anthem, Inc.	N	0102
0671	Anthem, Inc.		83-0892028		0001156039		Nash Holding Company, LLC	DE	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		35-1840597		0001156039		National Government Services, Inc.	IN	NIA	Federal Government Solutions, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		04-2919509		0001156039		New England Research Institute, Inc.	MA	NIA	Health Core, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		81-5476630		0001156039		NGS Federal, LLC	IN	NIA	Federal Government Solutions, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	12259	20-1336412		0001156039		Optimum Healthcare, Inc.	FL	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4249368		0001156039		Park Square Holdings, Inc.	CA	NIA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4386221		0001156039		Park Square I, Inc.	CA	NIA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4249345		0001156039		Park Square II, Inc.	CA	NIA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		27-1991772		0001156039		Pasteur Medical Birds Road, LLC	FL	NIA	Pasteur Medical Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-2749389		0001156039		Pasteur Medical Center, LLC	DE	NIA	HealthSun Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		27-1366915		0001156039		Pasteur Medical Cutler Bay, LLC	FL	NIA	Pasteur Medical Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0610128		0001156039		Pasteur Medical Group, LLC	FL	NIA	Pasteur Medical Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		37-1668303		0001156039		Pasteur Medical Hialeah Gardens, LLC	FL	NIA	Pasteur Medical Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		45-1616220		0001156039		Pasteur Medical Holdings, LLC	FL	NIA	HealthSun Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		47-3464152		0001156039		Pasteur Medical Kendall, LLC	FL	NIA	Pasteur Medical Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		27-2810478		0001156039		Pasteur Medical Management, LLC	FL	NIA	Pasteur Medical Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		33-1217936		0001156039		Pasteur Medical Miami Gardens, LLC	FL	NIA	Pasteur Medical Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		27-2651017		0001156039		Pasteur Medical North Miami Beach, LLC	FL	NIA	Pasteur Medical Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		26-0813665		0001156039		Pasteur Medical Partners, LLC	FL	NIA	HealthSun Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		56-2396739		0001156039		Resolution Health, Inc.	DE	NIA	Anthem Southeast, Inc.	Ownership	100.000	Anthem, Inc.	N	

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	Is an SCA Filing Required? (Y/N)	*
0671	Anthem, Inc.		47-0851593		0001156039		RightCHOICE Managed Care, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	11011	84-0747736		0001156039		Rocky Mountain Hospital and Medical Service, Inc.	CO	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0473316		0001156039		SelfCore, Inc.	DE	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	13726	27-0945036		0001156039		Simply Healthcare Plans, Inc.	FL	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		55-0712302		0001156039		Southeast Services, Inc.	VA	NIA	Anthem Southeast, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		45-4071004		0001156039		State Sponsored Services, Inc.	IN	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		35-1835818		0001156039		The Anthem Companies, Inc.	IN	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		45-5443372		0001156039		The Anthem Companies of California, Inc.	CA	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		43-1967924		0001156039		TrustSolutions, LLC	WI	NIA	Federal Government Solutions, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	11810	84-1620480		0001156039		UNICARE Health Plan of West Virginia, Inc.	WV	IA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		36-3899137		0001156039		UNICARE Illinois Services, Inc.	IL	NIA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	80314	52-0913817		0001156039		UNICARE Life & Health Insurance Company	IN	IA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4635507		0001156039		UNICARE National Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		77-0494551		0001156039		UNICARE Specialty Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-3300542		0001156039		Valus, Inc.	IN	NIA	DBG Holdings, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0660563		0001156039		WellMax Health Medical Centers, LLC	FL	NIA	Delivery Network, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0660644		0001156039		WellMax Health Physicians Network, LLC	FL	NIA	Delivery Network, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-4405193		0001156039		WellPoint Acquisition, LLC	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4640531		0001156039		WellPoint California Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4657170		0001156039		WellPoint Dental Services, Inc.	DE	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		81-2874917		0001156039		WellPoint Health Solutions, Inc.	DE	NIA	Federal Government Solutions, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-3620996		0001156039		WellPoint Holding Corp	DE	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		45-2736438		0001156039		WellPoint Information Technology Services, Inc.	CA	NIA	Blue Cross of California	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		36-4595641		0001156039		WellPoint Insurance Services, Inc.	HI	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		47-2546820		0001156039		WellPoint Military Care Corporation	IN	NIA	Federal Government Solutions, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	15929	47-5569628		0001156039		Wisconsin Collaborative Insurance Company	WI	IA	Crossroads Acquisition Corp.	Ownership	55.000	Anthem, Inc.	N	0110
0671	Anthem, Inc.		20-8672847		0001156039		WPMI, LLC	DE	NIA	ATH Holding Company, LLC	Ownership	69.910	Anthem, Inc.	N	0103

Asterisk	Explanation
0100	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the New York State Department of Health.
0101	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0102	50% owned by unaffiliated investors
0103	30.09% owned by unaffiliated investors
0104	25% owned by an unaffiliated investor
0105	Legato Health Technologies LLP is a Limited Liability Partnership formed under the laws of India, and is 99% owned by Legato Holdings I, Inc. an Indiana corporation, and 1% owned by Legato Holdings II, LLC, an Indiana Limited Liability company.
0106	Legato Health Technologies Philippines, Inc. was incorporated under with the Republic of the Philippines, and is 100% owned by Legato Holdings I, Inc. an Indiana corporation.
0107	Highland Investor Holding LLC is a Limited Liability Company formed under the laws of Delaware, and is 72.48% owned by Anthem Holding Company, LLC. an Indiana limited liability company, and 27.52% owned by Highland Holdco, Inc., a Delaware corporation.
0108	Applied Pathways, LLC is a Limited Liability Company formed under the laws of Illinois, and is 53.52% owned by American Imaging Management, Inc. an Illinois limited liability company, and 46.48% owned by HEP AP Holdings, Inc., a Delaware corporation.
0109	Anthem Worker's Compensation, LLC is owned 75% by Anthem Blue Cross Life and Health Insurance Company and 25% by HealthLink, Inc.
0110	45% of WCIC is owned by Aurora Health Care, Inc. (non-affiliate) and 55% by Crossroads Acquisition Corp

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1 NAIC Company Code	2 ID Number	3 Names of Insurers and Parent, Subsidiaries or Affiliates	4 Shareholder Dividends	5 Capital Contributions	6 Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	7 Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	8 Management Agreements and Service Contracts	9 Income/ (Disbursements) Incurred Under Reinsurance Agreements	10 *	11 Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	12 Totals	13 Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
	36-3692630	American Imaging Management, Inc.					(340,361,720)				(340,361,720)	
15544	46-4729682	America's 1st Choice of South Carolina, Inc.					(303,992)				(303,992)	
12354	20-2073598	AMERIGROUP Community Care of New Mexico, Inc.		(54,976,214)			(2,336,204)				(57,312,418)	
	54-1739323	AMERIGROUP Corporation					58,616,140				58,616,140	
16168	81-4131800	AMERIGROUP District of Columbia, Inc.					(29,262,222)				(29,262,222)	
16455	82-3743168	Amerigroup Health Plan of Louisiana, Inc.					(815)				(815)	
14078	45-2485907	AMERIGROUP Insurance Company					(74,490,686)				(74,490,686)	
	45-4985009	Amerigroup IPA of New York, LLC					(20,029,433)				(20,029,433)	
15807	47-3863197	AMERIGROUP Iowa, Inc.		55,000,000			(121,902,155)				(66,902,155)	
14276	45-3358287	AMERIGROUP Kansas, Inc.		(150,000,000)			(2,892,704)				(152,892,704)	
95832	51-0387398	AMERIGROUP Maryland, Inc.	(90,000,000)				(119,448,085)				(209,448,085)	
16145	81-4626605	AMERIGROUP Mississippi, Inc.					1,622				1,622	
95373	22-3375292	AMERIGROUP New Jersey, Inc.					(114,962,141)				(114,962,141)	
10767	13-4212818	AMERIGROUP Ohio, Inc.	(1,251,968)	(7,248,032)			(30,872)				(8,530,872)	
15994	81-2781685	AMERIGROUP Oklahoma, Inc.					(10,784)				(10,784)	
	36-3897080	Amerigroup Partnership Plan, LLC					(151,572,896)				(151,572,896)	
16339	82-3734368	AMERIGROUP Pennsylvania, Inc.					511				511	
12941	20-4776597	AMERIGROUP Tennessee, Inc.					(146,168,275)				(146,168,275)	
95314	75-2603231	AMERIGROUP Texas, Inc.		25,000,000			(573,506,837)				(548,506,837)	
14073	27-3510384	AMERIGROUP Washington, Inc.	(15,100,000)				(71,153,850)				(86,253,850)	
12229	06-1696189	AMGP Georgia Managed Care Company, Inc.	(15,300,000)				(163,354,941)				(178,654,941)	
16553	83-2435050	AMH Health, LLC		6,500,000			(177,344)				6,322,656	
62825	95-4331852	Anthem Blue Cross Life and Health Insurance Company, Inc.	(180,100,000)				(1,033,705,467)	52,186,143			(1,161,619,324)	220,141,017
95120	61-1237516	Anthem Health Plans of Kentucky, Inc.	(190,000,000)				(393,954,739)	(9,361,065)			(593,315,804)	25,847,747
52618	31-1705652	Anthem Health Plans of Maine, Inc.	(58,600,000)				(118,993,095)				(177,593,095)	
53759	02-0510530	Anthem Health Plans of New Hampshire, Inc.					(88,170,097)				(88,170,097)	
71835	54-0357120	Anthem Health Plans of Virginia, Inc.	(350,000,000)				(556,933,088)	(27,798,003)			(934,731,091)	109,950,079
60217	06-1475928	Anthem Health Plans, Inc.	(79,700,000)				(288,375,996)				(368,075,996)	
28207	35-0781558	Anthem Insurance Companies, Inc.	(425,000,000)				(1,352,367,602)	(2,639,172)			(1,780,006,774)	(102,424,008)
15543	47-0992859	Anthem Kentucky Managed Care Plan, Inc.					(59,615,003)				(59,615,003)	
13573	20-5876774	Anthem Life and Disability Insurance Company					(3,001,752)				(3,001,752)	
61069	35-0980405	Anthem Life Insurance Company	0				(41,325,404)	31,032,881			(10,292,523)	(142,812,135)
	81-3974489	Anthem Partnership Holding Company, LLC	0				(19,841,956)				(19,841,956)	
	46-0613946	Anthem Services Company, LLC.					50,295,416				50,295,416	
	35-2145715	Anthem, Inc.	3,595,051,968	(19,275,754)			6,006,236,160				9,582,012,374	
15544	46-4729682	APC Passe, LLC						(181,235,982)			(181,235,982)	189,070,842
	90-1057454	Aspire Health, Inc.	0				(70,607,205)				(70,607,205)	
	11-3713086	ATH Holding Company, LLC					(46,293,396)				(46,293,396)	

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1 NAIC Company Code	2 ID Number	3 Names of Insurers and Parent, Subsidiaries or Affiliates	4 Shareholder Dividends	5 Capital Contributions	6 Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	7 Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	8 Management Agreements and Service Contracts	9 Income/ (Disbursements) Incurred Under Reinsurance Agreements	10 *	11 Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	12 Totals	13 Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
96962	58-1638390	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	(241,700,000)				(875,259,237)				(1,116,959,237)	
54003	39-0138065	Blue Cross Blue Shield of Wisconsin	(110,000,000)				(128,448,232)	(7,269,339)			(245,717,571)	33,349,826
	95-3760980	Blue Cross of California	(450,000,000)				(2,051,273,729)				(2,501,273,729)	
	20-2994048	Blue Cross of California Partnership Plan, Inc.	(250,000,000)				(324,300,331)				(574,300,331)	
	95-4694706	Caremore Health Plan	(20,000,000)				842,178,067				822,178,067	
13562	38-3975280	Caremore Health Plan of Arizona, Inc.					114,349,659				114,349,659	
13605	26-4001602	Caremore Health Plan of Nevada					80,400,533				80,400,533	
16345	82-1853423	CCHA, LLC					(7,373)	(4,377,672)			(4,385,045)	30,037,985
14064	26-4674149	Community Care Health Plan of Louisiana, Inc.					(82,616,318)				(82,616,318)	
12586	20-3317697	Community Care Health Plan of Nevada, Inc.					(78,522,461)				(78,522,461)	
10345	31-1440175	Community Insurance Company	(386,600,000)				(992,659,788)	(20,767,702)			(1,400,027,490)	66,564,801
95693	39-1462554	Compcare Health Services Insurance Corporation	(24,000,000)				(144,626,584)				(168,626,584)	
	01-0822645	DeCare Dental, LLC					(44,481,913)				(44,481,913)	
55093	23-7391136	Empire HealthChoice Assurance, Inc.	(80,000,000)	(15,000,000)			(558,951,472)				(653,951,472)	
95433	13-3874803	Empire HealthChoice HMO, Inc.		15,000,000			(96,242,446)				(81,242,446)	
10119	41-2128275	Freedom Health, Inc.	(6,600,000)				(89,884,486)				(96,484,486)	
	95-2907752	Golden West Health Plan, Inc.					(826,876)				(826,876)	
97217	58-1473042	Greater Georgia Life Insurance Company					(9,903,337)				(9,903,337)	
	51-0365660	Health Core, Inc.					(26,801,381)				(26,801,381)	
	54-1237939	Health Management Corporation					(240,846,223)				(240,846,223)	
95169	54-1356687	HealthKeepers, Inc.	(75,000,000)				(518,708,076)	(8,968,740)			(602,676,816)	
96475	43-1616135	HealthLink HMO, Inc.					4,171,276				4,171,276	
	43-1364135	HealthLink, Inc.					(45,731,260)				(45,731,260)	
	13-3865627	HealthPlus LLC					(224,762,586)				(224,762,586)	
10122	20-0982649	HealthSun Health Plans, Inc	(44,000,000)				(75,779,865)				(119,779,865)	
	20-0660168	HealthSun Management, LLC					(50,680,602)				(50,680,602)	
78972	86-0257201	Healthy Alliance Life Insurance Company	(200,200,000)				(285,898,278)				(486,098,278)	
95473	84-1017384	HMO Colorado, Inc.	(80,000,000)				(198,196,328)				(278,196,328)	
95358	37-1216698	HMO Missouri, Inc.	(18,000,000)				(4,949,464)				(22,949,464)	
	82-3062245	IngenioRx, Inc.					(195,947,061)				(195,947,061)	
	98-1397080	Legato Health Technologies LLC					99,420,232				99,420,232	
95527	02-0494919	Matthew Thornton Health Plan, Inc.	(50,000,000)				(86,033,164)				(136,033,164)	
	39-2013971	Meridian Resource Company, LLC	(16,000,000)				(29,321,873)				(45,321,873)	
12259	20-1336412	Optimum Healthcare, Inc.	(12,800,000)				(59,401,638)				(72,201,638)	
	47-0851593	RightCHOICE Managed Care, Inc.					(24,229,799)				(24,229,799)	
11011	84-0747736	Rocky Mountain Hospital and Medical Service, Inc.	(70,000,000)				(272,229,111)	(14,629,215)			(356,858,326)	52,766,767
13726	27-0945036	Simply Healthcare Plans, Inc.	(46,600,000)				(321,465,982)				(368,065,982)	
	45-5443372	The Anthem Companies of California, Inc.					143,211,586				143,211,586	

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1 NAIC Company Code	2 ID Number	3 Names of Insurers and Parent, Subsidiaries or Affiliates	4 Shareholder Dividends	5 Capital Contributions	6 Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	7 Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	8 Management Agreements and Service Contracts	9 Income/ (Disbursements) Incurred Under Reinsurance Agreements	10 *	11 Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	12 Totals	13 Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
	35-1835818	The Anthem Companies, Inc.					6,463,929,276				6,463,929,276	
11810	84-1620480	UNICARE Health Plan of West Virginia, Inc.	(8,500,000)				(50,613,422)				(59,113,422)	
80314	52-0913817	UNICARE Life & Health Insurance Company		145,000,000			(72,505,355)	93,930,815			166,425,460	(301,644,703)
	45-2736438	WellPoint Information Technology Services					430,674,292				430,674,292	
	36-4595641	WellPoint Insurance Services, Inc.					(8,429,366)	99,897,051			91,467,685	(180,848,218)
15929	47-5569628	Wisconsin Collaborative Insurance Company					(17,798,597)				(17,798,597)	
9999999 Control Totals			0	0	0	0	0	0	XXX	0	0	0

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ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

		Responses
	MARCH FILING	
1.	Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?	YES
2.	Will an actuarial opinion be filed by March 1?	WAIVED
3.	Will the confidential Risk-based Capital Report be filed with the NAIC by March 1?	YES
4.	Will the confidential Risk-based Capital Report be filed with the state of domicile, if required, by March 1?	YES
	APRIL FILING	
5.	Will Management's Discussion and Analysis be filed by April 1?	YES
6.	Will the Supplemental Investment Risks Interrogatories be filed by April 1?	YES
7.	Will the Accident and Health Policy Experience Exhibit be filed by April 1?	YES
	JUNE FILING	
8.	Will an audited financial report be filed by June 1?	WAIVED
9.	Will Accountant's Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1?	WAIVED
	AUGUST FILING	
10.	Will the regulator-only (non-public) Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile and electronically with the NAIC (as a regulator-only non-public document) by August 1?	WAIVED

The following supplemental reports are required to be filed as part of your annual statement filing **if your company is engaged in the type of business covered by the supplement. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below.** If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

	MARCH FILING	
11.	Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1?	NO
12.	Will the Supplemental Life data due March 1 be filed with the state of domicile and the NAIC?	NO
13.	Will Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1?	NO
14.	Will the actuarial opinion on participating and non-participating policies as required in Interrogatories 1 and 2 on Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	NO
15.	Will the actuarial opinion on non-guaranteed elements as required in Interrogatory 3 to Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	NO
16.	Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC by March 1?	NO
17.	Will an approval from the reporting entity's state of domicile for relief related to the five-year rotation requirement for lead audit partner be filed electronically with the NAIC by March 1?	NO
18.	Will an approval from the reporting entity's state of domicile for relief related to the one-year cooling off period for independent CPA be filed electronically with the NAIC by March 1?	NO
19.	Will an approval from the reporting entity's state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1?	NO
	APRIL FILING	
20.	Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?	NO
21.	Will the Supplemental Life data due April 1 be filed with the state of domicile and the NAIC?	NO
22.	Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?	NO
23.	Will the regulator only (non-public) Supplemental Health Care Exhibit's Expense Allocation Report be filed with the state of domicile and the NAIC by April 1?	NO
24.	Will the Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit be filed with the state of domicile and the NAIC by April 1?	NO
25.	Will the Adjustments to the Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit (if required) be filed with the state of domicile and the NAIC by April 1?	NO
	AUGUST FILING	
26.	Will Management's Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?	NO

Explanations:

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Bar Codes:

2. Actuarial Opinion [Document Identifier 440]
8. Audited Financial Report [Document Identifier 220]
9. Accountants Letter of Qualifications [Document Identifier 221]
10. Communication of Internal Control Related Matters Noted in Audit [Document Identifier 222]
11. Medicare Supplement Insurance Experience Exhibit [Document Identifier 360]
12. Life Supplement [Document Identifier 205]
13. SIS Stockholder Information Supplement [Document Identifier 420]

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

14. Participating Opinion for Exhibit 5 [Document Identifier 371]
15. Non-Guaranteed Opinion for Exhibit 5 [Document Identifier 370]
16. Medicare Part D Coverage Supplement [Document Identifier 365]
17. Relief from the five-year rotation requirement for lead audit partner [Document Identifier 224]
18. Relief from the one-year cooling off period for independent CPA [Document Identifier 225]
19. Relief from the Requirements for Audit Committees [Document Identifier 226]
20. Long-Term Care Experience Reporting Forms [Document Identifier 306]
21. Life Supplement [Document Identifier 211]
22. Supplemental Health Care Exhibit (Parts 1, 2 and 3) [Document Identifier 216]
23. Supplemental Health Care Exhibit's Expense Allocation Report [Document Identifier 217]
24. Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit [Document Identifier 290]
25 Adjustments to the Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit [Document Identifier 300]
26 Management's Report of Internal Control Over Financial Reporting [Document Identifier 223]

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

OVERFLOW PAGE FOR WRITE-INS

NONE

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SUMMARY INVESTMENT SCHEDULE

	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
	1	2	3	4	5	6
Investment Categories	Amount	Percentage of Column 1 Line 13	Amount	Securities Lending Reinvested Collateral Amount	Total (Col. 3 + 4) Amount	Percentage of Column 5 Line 13
1. Long-Term Bonds (Schedule D, Part 1):						
1.01 U.S. governments		0.000			0	0.000
1.02 All other governments		0.000			0	0.000
1.03 U.S. states, territories and possessions, etc. guaranteed		0.000			0	0.000
1.04 U.S. political subdivisions of states, territories, and possessions, guaranteed		0.000			0	0.000
1.05 U.S. special revenue and special assessment obligations, etc. non-guaranteed	564,032	14.077	564,032	0	564,032	14.077
1.06 Industrial and miscellaneous		0.000			0	0.000
1.07 Hybrid securities		0.000			0	0.000
1.08 Parent, subsidiaries and affiliates		0.000			0	0.000
1.09 SVO identified funds		0.000			0	0.000
1.10 Unaffiliated Bank loans		0.000			0	0.000
1.11 Total long-term bonds	564,032	14.077	564,032	0	564,032	14.077
2. Preferred stocks (Schedule D, Part 2, Section 1):						
2.01 Industrial and miscellaneous (Unaffiliated)	0	0.000			0	0.000
2.02 Parent, subsidiaries and affiliates	0	0.000			0	0.000
2.03 Total preferred stocks	0	0.000	0	0	0	0.000
3. Common stocks (Schedule D, Part 2, Section 2):						
3.01 Industrial and miscellaneous Publicly traded (Unaffiliated)		0.000			0	0.000
3.02 Industrial and miscellaneous Other (Unaffiliated)		0.000			0	0.000
3.03 Parent, subsidiaries and affiliates Publicly traded		0.000			0	0.000
3.04 Parent, subsidiaries and affiliates Other		0.000			0	0.000
3.05 Mutual funds		0.000			0	0.000
3.06 Unit investment trusts		0.000			0	0.000
3.07 Closed-end funds		0.000			0	0.000
3.08 Total common stocks	0	0.000	0	0	0	0.000
4. Mortgage loans (Schedule B):						
4.01 Farm mortgages	0	0.000			0	0.000
4.02 Residential mortgages	0	0.000			0	0.000
4.03 Commercial mortgages	0	0.000			0	0.000
4.04 Mezzanine real estate loans	0	0.000			0	0.000
4.05 Total mortgage loans	0	0.000	0	0	0	0.000
5. Real estate (Schedule A):						
5.01 Properties occupied by company		0.000	0		0	0.000
5.02 Properties held for production of income		0.000	0		0	0.000
5.03 Properties held for sale		0.000	0		0	0.000
5.04 Total real estate	0	0.000	0	0	0	0.000
6. Cash, cash equivalents and short-term investments:						
6.01 Cash (Schedule E, Part 1)	3,442,636	85.923	3,442,636		3,442,636	85.923
6.02 Cash equivalents (Schedule E, Part 2)		0.000	0		0	0.000
6.03 Short-term investments (Schedule DA)		0.000	0		0	0.000
6.04 Total cash, cash equivalents and short-term investments	3,442,636	85.923	3,442,636	0	3,442,636	85.923
7. Contract loans	0	0.000	0		0	0.000
8. Derivatives (Schedule DB)	0	0.000	0		0	0.000
9. Other invested assets (Schedule BA)	0	0.000	0		0	0.000
10. Receivables for securities	0	0.000	0		0	0.000
11. Securities Lending (Schedule DL, Part 1)	0	0.000	0	XXX	XXX	XXX
12. Other invested assets (Page 2, Line 11)	0	0.000	0		0	0.000
13. Total invested assets	4,006,668	100.000	4,006,668	0	4,006,668	100.000

Schedule A - Verification - Real Estate

N O N E

Schedule B - Verification - Mortgage Loans

N O N E

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE BA - VERIFICATION BETWEEN YEARS

Other Long-Term Invested Assets

NONE

1.	Book/adjusted carrying value, December 31 of prior year	
2.	Cost of acquired:	
	2.1 Actual cost at time of acquisition (Part 2, Column 8)	
	2.2 Additional investment made after acquisition (Part 2, Column 9)	
3.	Capitalized deferred interest and other:	
	3.1 Totals, Part 1, Column 16	
	3.2 Totals, Part 3, Column 12	
4.	Accrual of discount	
5.	Unrealized valuation increase (decrease):	
	5.1 Totals, Part 1, Column 13	
	5.2 Totals, Part 3, Column 9	
6.	Total gain (loss) on disposals, Part 3, Column 19	
7.	Deduct amounts received on disposals, Part 3, Column 16	
8.	Deduct amortization of premium and depreciation	
9.	Total foreign exchange change in book/adjusted carrying value:	
	9.1 Totals, Part 1, Column 17	
	9.2 Totals, Part 3, Column 14	
10.	Deduct current year's other than temporary impairment recognized:	
	10.1 Totals, Part 1, Column 15	
	10.2 Totals, Part 3, Column 11	
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)	
12.	Deduct total nonadmitted amounts	
13.	Statement value at end of current period (Line 11 minus Line 12)	

SCHEDULE D - VERIFICATION BETWEEN YEARS

Bonds and Stocks

1.	Book/adjusted carrying value, December 31 of prior year		575,461
2.	Cost of bonds and stocks acquired, Part 3, Column 7		
3.	Accrual of discount		0
4.	Unrealized valuation increase (decrease):		
	4.1. Part 1, Column 12	0	
	4.2. Part 2, Section 1, Column 15		
	4.3. Part 2, Section 2, Column 13		
	4.4. Part 4, Column 11		0
5.	Total gain (loss) on disposals, Part 4, Column 19		
6.	Deduction consideration for bonds and stocks disposed of, Part 4, Column 7		
7.	Deduct amortization of premium		11,429
8.	Total foreign exchange change in book/adjusted carrying value:		
	8.1. Part 1, Column 15	0	
	8.2. Part 2, Section 1, Column 19		
	8.3. Part 2, Section 2, Column 16		
	8.4. Part 4, Column 15		0
9.	Deduct current year's other than temporary impairment recognized:		
	9.1. Part 1, Column 14	0	
	9.2. Part 2, Section 1, Column 17		
	9.3. Part 2, Section 2, Column 14		
	9.4. Part 4, Column 13		0
10.	Total investment income recognized as a result of prepayment penalties and/or acceleration fees, Note 5Q, Line 2		0
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9+10)		564,032
12.	Deduct total nonadmitted amounts		0
13.	Statement value at end of current period (Line 11 minus Line 12)		564,032

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - SUMMARY BY COUNTRY

Long-Term Bonds and Stocks OWNED December 31 of Current Year

Description		1 Book/Adjusted Carrying Value	2 Fair Value	3 Actual Cost	4 Par Value of Bonds
BONDS	1. United States				
Governments	2. Canada				
(Including all obligations guaranteed by governments)	3. Other Countries				
	4. Totals	0	0	0	0
U.S. States, Territories and Possessions (Direct and guaranteed)	5. Totals				
U.S. Political Subdivisions of States, Territories and Possessions (Direct and guaranteed)	6. Totals				
U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and their Political Subdivisions	7. Totals	564,032	595,940	595,550	500,000
Industrial and Miscellaneous, SVO Identified Funds, Unaffiliated Bank Loans and Hybrid Securities (unaffiliated)	8. United States				
	9. Canada				
	10. Other Countries				
	11. Totals	0	0	0	0
Parent, Subsidiaries and Affiliates	12. Totals				
	13. Total Bonds	564,032	595,940	595,550	500,000
PREFERRED STOCKS	14. United States				
Industrial and Miscellaneous (unaffiliated)	15. Canada				
	16. Other Countries				
	17. Totals	0	0	0	
Parent, Subsidiaries and Affiliates	18. Totals	0	0	0	
	19. Total Preferred Stocks	0	0	0	
COMMON STOCKS	20. United States				
Industrial and Miscellaneous (unaffiliated)	21. Canada				
	22. Other Countries				
	23. Totals	0	0	0	
Parent, Subsidiaries and Affiliates	24. Totals	0	0	0	
	25. Total Common Stocks	0	0	0	
	26. Total Stocks	0	0	0	
	27. Total Bonds and Stocks	564,032	595,940	595,550	

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - PART 1A - SECTION 1

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 11.7	9 Total from Col. 7 Prior Year	10 % From Col. 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed (a)
1. U.S. Governments												
1.1 NAIC 1						XXX	0	0.0		0.0		0
1.2 NAIC 2						XXX	0	0.0		0.0		0
1.3 NAIC 3						XXX	0	0.0		0.0		0
1.4 NAIC 4						XXX	0	0.0		0.0		0
1.5 NAIC 5						XXX	0	0.0		0.0		0
1.6 NAIC 6						XXX	0	0.0		0.0		0
1.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
2. All Other Governments												
2.1 NAIC 1						XXX	0	0.0		0.0		0
2.2 NAIC 2						XXX	0	0.0		0.0		0
2.3 NAIC 3						XXX	0	0.0		0.0		0
2.4 NAIC 4						XXX	0	0.0		0.0		0
2.5 NAIC 5						XXX	0	0.0		0.0		0
2.6 NAIC 6						XXX	0	0.0		0.0		0
2.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
3. U.S. States, Territories and Possessions etc., Guaranteed												
3.1 NAIC 1						XXX	0	0.0		0.0		0
3.2 NAIC 2						XXX	0	0.0		0.0		0
3.3 NAIC 3						XXX	0	0.0		0.0		0
3.4 NAIC 4						XXX	0	0.0		0.0		0
3.5 NAIC 5						XXX	0	0.0		0.0		0
3.6 NAIC 6						XXX	0	0.0		0.0		0
3.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
4. U.S. Political Subdivisions of States, Territories and Possessions , Guaranteed												
4.1 NAIC 1						XXX	0	0.0		0.0		0
4.2 NAIC 2						XXX	0	0.0		0.0		0
4.3 NAIC 3						XXX	0	0.0		0.0		0
4.4 NAIC 4						XXX	0	0.0		0.0		0
4.5 NAIC 5						XXX	0	0.0		0.0		0
4.6 NAIC 6						XXX	0	0.0		0.0		0
4.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
5. U.S. Special Revenue & Special Assessment Obligations, etc., Non-Guaranteed												
5.1 NAIC 1	0	0	564,032	0	0	XXX	564,032	100.0	575,461	100.0	564,032	0
5.2 NAIC 2						XXX	0	0.0		0.0		0
5.3 NAIC 3						XXX	0	0.0		0.0		0
5.4 NAIC 4						XXX	0	0.0		0.0		0
5.5 NAIC 5						XXX	0	0.0		0.0		0
5.6 NAIC 6						XXX	0	0.0		0.0		0
5.7 Totals	0	0	564,032	0	0	XXX	564,032	100.0	575,461	100.0	564,032	0

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - PART 1A - SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 11.7	9 Total from Col. 7 Prior Year	10 % From Col. 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed (a)
6. Industrial & Miscellaneous (Unaffiliated)												
6.1 NAIC 1						XXX	0	0.0		0.0		0
6.2 NAIC 2						XXX	0	0.0		0.0		0
6.3 NAIC 3						XXX	0	0.0		0.0		0
6.4 NAIC 4						XXX	0	0.0		0.0		0
6.5 NAIC 5						XXX	0	0.0		0.0		0
6.6 NAIC 6						XXX	0	0.0		0.0		0
6.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7. Hybrid Securities												
7.1 NAIC 1						XXX	0	0.0		0.0		0
7.2 NAIC 2						XXX	0	0.0		0.0		0
7.3 NAIC 3						XXX	0	0.0		0.0		0
7.4 NAIC 4						XXX	0	0.0		0.0		0
7.5 NAIC 5						XXX	0	0.0		0.0		0
7.6 NAIC 6						XXX	0	0.0		0.0		0
7.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8. Parent, Subsidiaries and Affiliates												
8.1 NAIC 1						XXX	0	0.0		0.0		0
8.2 NAIC 2						XXX	0	0.0		0.0		0
8.3 NAIC 3						XXX	0	0.0		0.0		0
8.4 NAIC 4						XXX	0	0.0		0.0		0
8.5 NAIC 5						XXX	0	0.0		0.0		0
8.6 NAIC 6						XXX	0	0.0		0.0		0
8.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
9. SVO Identified Funds												
9.1 NAIC 1	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.2 NAIC 2	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.3 NAIC 3	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.4 NAIC 4	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.5 NAIC 5	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.6 NAIC 6	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.7 Totals	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	0	0
10. Unaffiliated Bank Loans												
10.1 NAIC 1						XXX	0	0.0		0.0		0
10.2 NAIC 2						XXX	0	0.0		0.0		0
10.3 NAIC 3						XXX	0	0.0		0.0		0
10.4 NAIC 4						XXX	0	0.0		0.0		0
10.5 NAIC 5						XXX	0	0.0		0.0		0
10.6 NAIC 6						XXX	0	0.0		0.0		0
10.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - PART 1A - SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 11.7	9 Total from Col. 7 Prior Year	10 % From Col. 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed (a)
11. Total Bonds Current Year												
11.1 NAIC 1	(d) 0	0	564,032	0	0	0	564,032	100.0	XXX	XXX	564,032	0
11.2 NAIC 2	(d) 0	0	0	0	0	0	0	0.0	XXX	XXX	0	0
11.3 NAIC 3	(d) 0	0	0	0	0	0	0	0.0	XXX	XXX	0	0
11.4 NAIC 4	(d) 0	0	0	0	0	0	0	0.0	XXX	XXX	0	0
11.5 NAIC 5	(d) 0	0	0	0	0	0	(c) 0	0.0	XXX	XXX	0	0
11.6 NAIC 6	(d) 0	0	0	0	0	0	(c) 0	0.0	XXX	XXX	0	0
11.7 Totals	0	0	564,032	0	0	0	(b) 564,032	100.0	XXX	XXX	564,032	0
11.8 Line 11.7 as a % of Col. 7	0.0	0.0	100.0	0.0	0.0	0.0	100.0	XXX	XXX	XXX	100.0	0.0
12. Total Bonds Prior Year												
12.1 NAIC 1	0	0	575,461	0	0	0	XXX	XXX	575,461	100.0	575,461	0
12.2 NAIC 2							XXX	XXX	0	0.0		0
12.3 NAIC 3							XXX	XXX	0	0.0		0
12.4 NAIC 4							XXX	XXX	0	0.0		0
12.5 NAIC 5							XXX	XXX	(c) 0	0.0		0
12.6 NAIC 6							XXX	XXX	(c) 0	0.0		0
12.7 Totals	0	0	575,461	0	0	0	XXX	XXX	(b) 575,461	100.0	575,461	0
12.8 Line 12.7 as a % of Col. 9	0.0	0.0	100.0	0.0	0.0	0.0	XXX	XXX	100.0	XXX	100.0	0.0
13. Total Publicly Traded Bonds												
13.1 NAIC 1	0	0	564,032	0	0	0	564,032	100.0	575,461	100.0	564,032	XXX
13.2 NAIC 2							0	0.0	0	0.0	0	XXX
13.3 NAIC 3							0	0.0	0	0.0	0	XXX
13.4 NAIC 4							0	0.0	0	0.0	0	XXX
13.5 NAIC 5							0	0.0	0	0.0	0	XXX
13.6 NAIC 6							0	0.0	0	0.0	0	XXX
13.7 Totals	0	0	564,032	0	0	0	564,032	100.0	575,461	100.0	564,032	XXX
13.8 Line 13.7 as a % of Col. 7	0.0	0.0	100.0	0.0	0.0	0.0	100.0	XXX	XXX	XXX	100.0	XXX
13.9 Line 13.7 as a % of Line 11.7, Col. 7, Section 11	0.0	0.0	100.0	0.0	0.0	0.0	100.0	XXX	XXX	XXX	100.0	XXX
14. Total Privately Placed Bonds												
14.1 NAIC 1	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.2 NAIC 2	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.3 NAIC 3	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.4 NAIC 4	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.5 NAIC 5	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.6 NAIC 6	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.7 Totals	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.8 Line 14.7 as a % of Col. 7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	XXX	XXX	XXX	XXX	0.0
14.9 Line 14.7 as a % of Line 11.7, Col. 7, Section 11	0.0	0.0	0.0	0.0	0.0	0.0	0.0	XXX	XXX	XXX	XXX	0.0

(a) Includes $ ..... freely tradable under SEC Rule 144 or qualified for resale under SEC Rule 144A.
(b) Includes $ ..... current year of bonds with Z designations and $ ..... prior year of bonds with Z designations. The letter "Z" means the NAIC designation was not assigned by the Securities Valuation Office (SVO) at the date of the statement.
(c) Includes $ ..... current year, $ ..... prior year of bonds with 5GI designations and $ ..... current year, $ ..... prior year of bonds with 6* designations. "5GI" means the NAIC designation was assigned by the (SVO) in reliance on the insurer's certification that the issuer is current in all principal and interest payments. "6*" means the NAIC designation was assigned by the SVO due to inadequate certification of principal and interest payments.
(d) Includes the following amount of short-term and cash equivalent bonds by NAIC designation: NAIC 1 $ ..... ; NAIC 2 $ ..... ; NAIC 3 $ ..... ; NAIC 4 $ ..... ; NAIC 5 $ ..... ; NAIC 6 $ .....

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - PART 1A - SECTION 2

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 11.08	9 Total from Col. 7 Prior Year	10 % From Col. 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed
1. U.S. Governments												
1.01 Issuer Obligations						XXX	0	0.0		0.0		0
1.02 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
1.03 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
1.04 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
1.05 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
2. All Other Governments												
2.01 Issuer Obligations						XXX	0	0.0		0.0		0
2.02 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
2.03 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
2.04 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
2.05 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
3. U.S. States, Territories and Possessions, Guaranteed												
3.01 Issuer Obligations						XXX	0	0.0		0.0		0
3.02 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
3.03 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
3.04 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
3.05 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
4. U.S. Political Subdivisions of States, Territories and Possessions, Guaranteed												
4.01 Issuer Obligations						XXX	0	0.0		0.0		0
4.02 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
4.03 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
4.04 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
4.05 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
5. U.S. Special Revenue & Special Assessment Obligations etc., Non-Guaranteed												
5.01 Issuer Obligations	0	0	564,032	0	0	XXX	564,032	100.0	575,461	100.0	564,032	0
5.02 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
5.03 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
5.04 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
5.05 Totals	0	0	564,032	0	0	XXX	564,032	100.0	575,461	100.0	564,032	0
6. Industrial and Miscellaneous												
6.01 Issuer Obligations						XXX	0	0.0		0.0		0
6.02 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
6.03 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
6.04 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
6.05 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7. Hybrid Securities												
7.01 Issuer Obligations						XXX	0	0.0		0.0		0
7.02 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
7.03 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
7.04 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
7.05 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8. Parent, Subsidiaries and Affiliates												
8.01 Issuer Obligations						XXX	0	0.0		0.0		0
8.02 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
8.03 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
8.04 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
8.05 Affiliated Bank Loans - Issued						XXX	0	0.0		0.0		0
8.06 Affiliated Bank Loans - Acquired						XXX	0	0.0		0.0		0
8.07 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0

SI08

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - PART 1A - SECTION 2 (Continued)

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 11.08	9 Total from Col. 7 Prior Year	10 % From Col. 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed
9. SVO Identified Funds												
9.01 Exchange Traded Funds Identified by the SVO	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.02 Bond Mutual Funds Identified by the SVO	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.03 Totals	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	0	0
10. Unaffiliated Bank Loans												
10.01 Unaffiliated Bank Loans - Issued						XXX	0	0.0		0.0		0
10.02 Unaffiliated Bank Loans - Acquired						XXX	0	0.0		0.0		0
10.03 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
11. Total Bonds Current Year												
11.01 Issuer Obligations	0	0	564,032	0	0	XXX	564,032	100.0	XXX	XXX	564,032	0
11.02 Residential Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
11.03 Commercial Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
11.04 Other Loan-Backed and Structured Securities	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
11.05 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX	0	0	0.0	XXX	XXX	0	0
11.06 Affiliated Bank Loans	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
11.07 Unaffiliated Bank Loans	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
11.08 Totals	0	0	564,032	0	0	0	564,032	100.0	XXX	XXX	564,032	0
11.09 Line 11.08 as a % of Col. 7	0.0	0.0	100.0	0.0	0.0	0.0	100.0	XXX	XXX	XXX	100.0	0.0
12. Total Bonds Prior Year												
12.01 Issuer Obligations	0	0	575,461	0	0	XXX	XXX	XXX	575,461	100.0	575,461	0
12.02 Residential Mortgage-Backed Securities						XXX	XXX	XXX	0	0.0		0
12.03 Commercial Mortgage-Backed Securities						XXX	XXX	XXX	0	0.0		0
12.04 Other Loan-Backed and Structured Securities						XXX	XXX	XXX	0	0.0		0
12.05 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX		XXX	XXX	0	0.0		0
12.06 Affiliated Bank Loans						XXX	XXX	XXX	0	0.0		0
12.07 Unaffiliated Bank Loans						XXX	XXX	XXX	0	0.0		0
12.08 Totals	0	0	575,461	0	0	0	XXX	XXX	575,461	100.0	575,461	0
12.09 Line 12.08 as a % of Col. 9	0.0	0.0	100.0	0.0	0.0	0.0	XXX	XXX	100	XXX	100.0	0.0
13. Total Publicly Traded Bonds												
13.01 Issuer Obligations	0	0	564,032	0	0	XXX	564,032	100.0	575,461	100.0	564,032	XXX
13.02 Residential Mortgage-Backed Securities						XXX	0	0.0	0	0.0	0	XXX
13.03 Commercial Mortgage-Backed Securities						XXX	0	0.0	0	0.0	0	XXX
13.04 Other Loan-Backed and Structured Securities						XXX	0	0.0	0	0.0	0	XXX
13.05 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX		0	0.0	0	0.0	0	XXX
13.06 Affiliated Bank Loans						XXX	0	0.0	0	0.0	0	XXX
13.07 Unaffiliated Bank Loans						XXX	0	0.0	0	0.0	0	XXX
13.08 Totals	0	0	564,032	0	0	0	564,032	100.0	575,461	100.0	564,032	XXX
13.09 Line 13.08 as a % of Col. 7	0.0	0.0	100.0	0.0	0.0	0.0	100.0	XXX	XXX	XXX	100.0	XXX
13.10 Line 13.08 as a % of Line 11.08, Col. 7, Section 11	0.0	0.0	100.0	0.0	0.0	0.0	100.0	XXX	XXX	XXX	100.0	XXX
14. Total Privately Placed Bonds												
14.01 Issuer Obligations	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
14.02 Residential Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
14.03 Commercial Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
14.04 Other Loan-Backed and Structured Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
14.05 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	XXX	0
14.06 Affiliated Bank Loans	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
14.07 Unaffiliated Bank Loans	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
14.08 Totals	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.09 Line 14.08 as a % of Col. 7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	XXX	XXX	XXX	XXX	0.0
14.10 Line 14.08 as a % of Line 11.08, Col. 7, Section 11	0.0	0.0	0.0	0.0	0.0	0.0	0.0	XXX	XXX	XXX	XXX	0.0

Schedule DA - Verification - Short-Term Investments

N O N E

Schedule DB - Part A - Verification - Options, Caps, Floors, Collars, Swaps and Forwards

N O N E

Schedule DB - Part B - Verification - Futures Contracts

N O N E

Schedule DB - Part C - Section 1 - Replication (Synthetic Asset) Transactions (RSATs) Open

N O N E

Schedule DB-Part C-Section 2-Reconciliation of Replication (Synthetic Asset) Transactions Open

N O N E

Schedule DB - Verification - Book/Adjusted Carrying Value, Fair Value and Potential Exposure of Derivatives

N O N E

Schedule E - Part 2 - Verification - Cash Equivalents

N O N E

Schedule A - Part 1 - Real Estate Owned

N O N E

Schedule A - Part 2 - Real Estate Acquired and Additions Made

N O N E

Schedule A - Part 3 - Real Estate Disposed

N O N E

Schedule B - Part 1 - Mortgage Loans Owned

N O N E

Schedule B - Part 2 - Mortgage Loans Acquired and Additions Made

N O N E

Schedule B - Part 3 - Mortgage Loans Disposed, Transferred or Repaid

N O N E

Schedule BA - Part 1 - Other Long-Term Invested Assets Owned

N O N E

Schedule BA - Part 2 - Other Long-Term Invested Assets Acquired and Additions Made

N O N E

Schedule BA - Part 3 - Other Long-Term Invested Assets Disposed, Transferred or Repaid

N O N E

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book/Adjusted Carrying Value				Interest					Dates	
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	Code	Foreign	Bond Char	NAIC Designation and Administrative Symbol	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization) Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Rate of	Effective Rate of	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
0599999. Total - U.S. Government Bonds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
1099999. Total - All Other Government Bonds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
1799999. Total - U.S. States, Territories and Possessions Bonds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
2499999. Total - U.S. Political Subdivisions Bonds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
650035-W8-7	NEW YORK ST URBAN DEV CORP REV SERIES A	SD			1FE	595,550	119.1880	595,940	500,000	564,032	0	(11,429)	0	0	5.000	2.370	MS	7,361	25,000	03/02/2017	03/15/2025
2599999. Subtotal - Bonds - U.S. Special Revenues - Issuer Obligations						595,550	XXX	595,940	500,000	564,032	0	(11,429)	0	0	XXX	XXX	XXX	7,361	25,000	XXX	XXX
3199999. Total - U.S. Special Revenues Bonds						595,550	XXX	595,940	500,000	564,032	0	(11,429)	0	0	XXX	XXX	XXX	7,361	25,000	XXX	XXX
3899999. Total - Industrial and Miscellaneous (Unaffiliated) Bonds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
4899999. Total - Hybrid Securities						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
5599999. Total - Parent, Subsidiaries and Affiliates Bonds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
6099999. Subtotal - SVO Identified Funds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
6599999. Subtotal - Unaffiliated Bank Loans						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
7699999. Total - Issuer Obligations						595,550	XXX	595,940	500,000	564,032	0	(11,429)	0	0	XXX	XXX	XXX	7,361	25,000	XXX	XXX
7799999. Total - Residential Mortgage-Backed Securities						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
7899999. Total - Commercial Mortgage-Backed Securities						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
7999999. Total - Other Loan-Backed and Structured Securities						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
8099999. Total - SVO Identified Funds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
8199999. Total - Affiliated Bank Loans						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
8299999. Total - Unaffiliated Bank Loans						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
8399999 - Total Bonds						595,550	XXX	595,940	500,000	564,032	0	(11,429)	0	0	XXX	XXX	XXX	7,361	25,000	XXX	XXX

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Schedule D - Part 2 - Section 1 - Preferred Stocks Owned

N O N E

Schedule D - Part 2 - Section 2 - Common Stocks Owned

N O N E

Schedule D - Part 3 - Long-Term Bonds and Stocks Acquired

N O N E

Schedule D - Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed Of

N O N E

Schedule D - Part 5 - Long Term Bonds and Stocks Acquired and Fully Disposed Of

N O N E

Schedule D-Part 6-Section 1-Valuation of Shares of Subsidiary, Controlled or Affiliated Companies

N O N E

Schedule D - Part 6 - Section 2

N O N E

Schedule DA - Part 1 - Short-Term Investments Owned

N O N E

Schedule DB - Part A - Section 1 - Options, Caps, Floors, Collars, Swaps and Forwards Open

N O N E

Schedule DB - Part A - Section 2 - Options, Caps, Floors, Collars, Swaps and Forwards Terminated

N O N E

Schedule DB - Part B - Section 1 - Futures Contracts Open

N O N E

Schedule DB - Part B - Section 1B - Brokers with whom cash deposits have been made

N O N E

Schedule DB - Part B - Section 2 - Futures Contracts Terminated

N O N E

Schedule DB - Part D - Section 1 - Counterparty Exposure for Derivative Instruments Open

N O N E

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged By

N O N E

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged To

N O N E

Schedule DB - Part E - Derivatives Hedging Variable Annuity Guarantees as of December 31 of Current Year

N O N E

Schedule DL - Part 1 - Reinvested Collateral Assets Owned

N O N E

Schedule DL - Part 2 - Reinvested Collateral Assets Owned

N O N E

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE E - PART 1 - CASH

1 Depository	2 Code	3 Rate of Interest	4 Amount of Interest Received During Year	5 Amount of Interest Accrued December 31 of Current Year	6 Balance	7 *
Bank of America 101 S. Tryon Street, 19th Floor, Charlotte, NC 28255		0.000	0	0	3,442,636	XXX
0199998 Deposits in ... depositories which do not exceed the allowable limit in any one depository (See instructions) - open depositories	XXX	XXX				XXX
0199999. Totals - Open Depositories	XXX	XXX	0	0	3,442,636	XXX
0299998 Deposits in ... depositories which do not exceed the allowable limit in any one depository (See instructions) - suspended depositories	XXX	XXX				XXX
0299999. Totals - Suspended Depositories	XXX	XXX	0	0	0	XXX
0399999. Total Cash on Deposit	XXX	XXX	0	0	3,442,636	XXX
0499999. Cash in Company's Office	XXX	XXX	XXX	XXX		XXX
0599999 Total - Cash	XXX	XXX	0	0	3,442,636	XXX

TOTALS OF DEPOSITORY BALANCES ON THE LAST DAY OF EACH MONTH DURING THE CURRENT YEAR

1. January	3,442,636	4. April	3,442,636	7. July	3,442,636	10. October	3,442,636
2. February	3,442,636	5. May	3,442,636	8. August	3,442,636	11. November	3,442,636
3. March	3,442,636	6. June	3,442,636	9. September	3,442,636	12. December	3,442,636

ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE E - PART 2 - CASH EQUIVALENTS

Show Investments Owned December 31 of Current Year

1 CUSIP	2 Description	3 Code	4 Date Acquired	5 Rate of Interest	6 Maturity Date	7 Book/Adjusted Carrying Value	8 Amount of Interest Due and Accrued	9 Amount Received During Year
8899999 - Total Cash Equivalents								

NONE

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ANNUAL STATEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

SCHEDULE E - PART 3 - SPECIAL DEPOSITS

	1	2	Deposits For the Benefit of All Policyholders		All Other Special Deposits	
			3	4	5	6
States, Etc.	Type of Deposit	Purpose of Deposit	Book/Adjusted Carrying Value	Fair Value	Book/Adjusted Carrying Value	Fair Value
1. Alabama AL						
2. Alaska AK						
3. Arizona AZ						
4. Arkansas AR						
5. California CA						
6. Colorado CO						
7. Connecticut CT						
8. Delaware DE						
9. District of Columbia DC						
10. Florida FL						
11. Georgia GA						
12. Hawaii HI						
13. Idaho ID						
14. Illinois IL						
15. Indiana IN						
16. Iowa IA						
17. Kansas KS						
18. Kentucky KY						
19. Louisiana LA						
20. Maine ME						
21. Maryland MD						
22. Massachusetts MA						
23. Michigan MI						
24. Minnesota MN						
25. Mississippi MS	B	Required by Mississippi statue	564,032	595,940		
26. Missouri MO						
27. Montana MT						
28. Nebraska NE						
29. Nevada NV						
30. New Hampshire NH						
31. New Jersey NJ						
32. New Mexico NM						
33. New York NY						
34. North Carolina NC						
35. North Dakota ND						
36. Ohio OH						
37. Oklahoma OK						
38. Oregon OR						
39. Pennsylvania PA						
40. Rhode Island RI						
41. South Carolina SC						
42. South Dakota SD						
43. Tennessee TN						
44. Texas TX						
45. Utah UT						
46. Vermont VT						
47. Virginia VA						
48. Washington WA						
49. West Virginia WV						
50. Wisconsin WI						
51. Wyoming WY						
52. American Samoa AS						
53. Guam GU						
54. Puerto Rico PR						
55. U.S. Virgin Islands VI						
56. Northern Mariana Islands MP						
57. Canada CAN						
58. Aggregate Alien and Other OT	XXX	XXX	0	0	0	0
59. Subtotal	XXX	XXX	564,032	595,940	0	0
DETAILS OF WRITE-INS						
5801.						
5802.						
5803.						
5898. Summary of remaining write-ins for Line 58 from overflow page	XXX	XXX	0	0	0	0
5899. Totals (Lines 5801 thru 5803 plus 5898)(Line 58 above)	XXX	XXX	0	0	0	0

1 6 1 4 5 2 0 1 9 3 6 0 0 0 0 0 0

SUPPLEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For The Year Ended December 31, 2019
(To Be Filed by March 1)

FOR THE STATE OF .....
NAIC Group Code ..... NAIC Company Code .....
ADDRESS (City, State and Zip Code) , ...
Person Completing This Exhibit .....
Title ..... Telephone Number .....

NONE

1	2	3	4	5	6	7	8	9	10	11	Policies Issued Through 2016			Policies Issued in 2017; 2018; 2019			
											Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Character-istics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

NONE

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details
2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(a)(3)(A) for this state.
   2.1 Address: , ...
   2.2 Contact Person and Phone Number: .....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address: , ...
   3.2 Contact Person and Phone Number: .....
4. Explain any policies identified above as policy type "O". .....

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1 6 1 4 5 2 0 1 9 3 6 5 0 0 0 0 0

SUPPLEMENT FOR THE YEAR 2019 OF THE Amerigroup Mississippi, Inc.

MEDICARE PART D COVERAGE SUPPLEMENT

(Net of Reinsurance)

NAIC Group Code 0671 (To Be Filed by March 1) NAIC Company Code 16145

	Individual Coverage		Group Coverage		5
	1 Insured	2 Uninsured	3 Insured	4 Uninsured	Total Cash
1. Premiums Collected					
1.1 Standard Coverage					
1.11 With Reinsurance Coverage		XXX		XXX	
1.12 Without Reinsurance Coverage		XXX		XXX	
1.13 Risk-Corridor Payment Adjustments		XXX		XXX	
1.2 Supplemental Benefits		XXX		XXX	
2. Premiums Due and Uncollected-change					
2.1 Standard Coverage					
2.11 With Reinsurance Coverage		XXX		XXX	XXX
2.12 Without Reinsurance Coverage		XXX		XXX	XXX
2.2 Supplemental Benefits		XXX		XXX	XXX
3. Unearned Premium and Advance Premium-change					
3.1 Standard Coverage					
3.11 With Reinsurance Coverage		XXX		XXX	XXX
3.12 Without Reinsurance Coverage		XXX		XXX	XXX
3.2 Supplemental Benefits		XXX		XXX	XXX
4. Risk-Corridor Payment Adjustments-change					
4.1 Receivable		XXX		XXX	XXX
4.2 Payable		XXX		XXX	XXX
5. Earned Premiums					
5.1 Standard Coverage					
5.11 With Reinsurance Coverage		XXX		XXX	XXX
5.12 Without Reinsurance Coverage		XXX		XXX	XXX
5.13 Risk-Corridor Payment Adjustments		XXX		XXX	XXX
5.2 Supplemental Benefits		XXX		XXX	XXX
6. Total Premiums		XXX		XXX	
7. Claims Paid					
7.1 Standard Coverage					
7.11 With Reinsurance Coverage		XXX		XXX	
7.12 Without Reinsurance Coverage		XXX		XXX	
7.2 Supplemental Benefits		XXX		XXX	
8. Claim Reserves and Liabilities-change					
8.1 Standard Coverage					
8.11 With Reinsurance Coverage		XXX		XXX	XXX
8.12 Without Reinsurance Coverage		XXX		XXX	XXX
8.2 Supplemental Benefits		XXX		XXX	XXX
9. Health Care Receivables-change					
9.1 Standard Coverage					
9.11 With Reinsurance Coverage		XXX		XXX	XXX
9.12 Without Reinsurance Coverage		XXX		XXX	XXX
9.2 Supplemental Benefits		XXX		XXX	XXX
10. Claims Incurred					
10.1 Standard Coverage					
10.11 With Reinsurance Coverage		XXX		XXX	XXX
10.12 Without Reinsurance Coverage		XXX		XXX	XXX
10.2 Supplemental Benefits		XXX		XXX	XXX
11. Total Claims		XXX		XXX	
12. Reinsurance Coverage and Low Income Cost Sharing					
12.1 Claims Paid - Net of Reimbursements Applied	XXX		XXX		
12.2 Reimbursements Received but Not Applied-change	XXX		XXX		
12.3 Reimbursements Receivable-change	XXX		XXX		XXX
12.4 Health Care Receivables-change	XXX		XXX		XXX
13. Aggregate Policy Reserves-change					XXX
14. Expenses Paid		XXX		XXX	
15. Expenses Incurred		XXX		XXX	XXX
16. Underwriting Gain/Loss		XXX		XXX	XXX
17. Cash Flow Results	XXX	XXX	XXX	XXX	

NONE

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ANNUAL STATEMENT

OF THE

Amerigroup Mississippi, Inc.

TO THE

Insurance Department

OF THE

STATE OF

Mississippi

FOR THE YEAR ENDED
DECEMBER 31, 2020

HEALTH

2020

.MS

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HEALTH ANNUAL STATEMENT

FOR THE YEAR ENDED DECEMBER 31, 2020
OF THE CONDITION AND AFFAIRS OF THE

Amerigroup Mississippi, Inc.

NAIC Group Code 0671 (Current) 0671 (Prior) NAIC Company Code 16145 Employer's ID Number 81-4626605

Organized under the Laws of Mississippi, State of Domicile or Port of Entry MS

Country of Domicile United States of America

Licensed as business type: Health Maintenance Organization

Is HMO Federally Qualified? Yes [ ] No [X]

Incorporated/Organized 12/06/2016 Commenced Business

Statutory Home Office 645 Lakeland East Drive-Suite 101 (Street and Number), Flowwood, MS, US 39232 (City or Town, State, Country and Zip Code)

Main Administrative Office 220 Virginia Avenue (Street and Number)
Indianapolis, IN, US 46204 (City or Town, State, Country and Zip Code), (Area Code) (Telephone Number)

Mail Address 220 Virginia Avenue (Street and Number or P.O. Box), Indianapolis, IN, US 46204 (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 220 Virginia Avenue (Street and Number)
Indianapolis, IN, US 46204 (City or Town, State, Country and Zip Code), (Area Code) (Telephone Number)

Internet Website Address www.amerigroup.com

Statutory Statement Contact Tim Niccum (Name), 317-488-6716 (Area Code) (Telephone Number)
tim.niccum@anthem.com (E-mail Address), 317-488-6200 (FAX Number)

OFFICERS

President Tarance Smith Clark # Treasurer Vincent Edward Scher
Secretary Kathleen Susan Kiefer Assistant Secretary Jack Louis Young

OTHER

Eric (Rick) Kenneth Noble, Assistent Treasurer

DIRECTORS OR TRUSTEES

Jack Louis Young Ronald William Penczek Tarance Smith Clark #

State of
County of SS:

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

DocuSigned by:	DocuSigned by:	DocuSigned by:
Tarance Smith Clark	Kathleen Susan Kiefer	Vincent Edward Scher
President	Secretary	Treasurer

Subscribed and sworn to before me this
day of

a. Is this an original filing? ..... Yes [X] No [ ]
b. If no,
1. State the amendment number.....
2. Date filed .....
3. Number of pages attached.....

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

ASSETS

		Current Year 1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	Prior Year 4 Net Admitted Assets
1.	Bonds (Schedule D)	552,332		552,332	564,032
2.	Stocks (Schedule D):				
	2.1 Preferred stocks			0	0
	2.2 Common stocks			0	0
3.	Mortgage loans on real estate (Schedule B):				
	3.1 First liens			0	0
	3.2 Other than first liens			0	0
4.	Real estate (Schedule A):				
	4.1 Properties occupied by the company (less $ ..... encumbrances)			0	0
	4.2 Properties held for the production of income (less $ ..... encumbrances)			0	0
	4.3 Properties held for sale (less $ ..... encumbrances)			0	0
5.	Cash ($ 3,482,936 , Schedule E - Part 1), cash equivalents ($ ..... , Schedule E - Part 2) and short-term investments ($ ..... , Schedule DA)	3,482,936		3,482,936	3,442,636
6.	Contract loans, (including $ ..... premium notes)			0	0
7.	Derivatives (Schedule DB)			0	0
8.	Other invested assets (Schedule BA)			0	0
9.	Receivables for securities			0	0
10.	Securities lending reinvested collateral assets (Schedule DL)			0	0
11.	Aggregate write-ins for invested assets	0	0	0	0
12.	Subtotals, cash and invested assets (Lines 1 to 11)	4,035,268	0	4,035,268	4,006,668
13.	Title plants less $ ..... charged off (for Title insurers only)			0	0
14.	Investment income due and accrued	7,361		7,361	7,361
15.	Premiums and considerations:				
	15.1 Uncollected premiums and agents' balances in the course of collection			0	0
	15.2 Deferred premiums and agents' balances and installments booked but deferred and not yet due (including $ ..... earned but unbilled premiums)			0	0
	15.3 Accrued retrospective premiums ($ .....) and contracts subject to redetermination ($ .....)			0	0
16.	Reinsurance:				
	16.1 Amounts recoverable from reinsurers			0	0
	16.2 Funds held by or deposited with reinsured companies			0	0
	16.3 Other amounts receivable under reinsurance contracts			0	0
17.	Amounts receivable relating to uninsured plans			0	0
18.1	Current federal and foreign income tax recoverable and interest thereon	1,178		1,178	1,253
18.2	Net deferred tax asset			0	4,525
19.	Guaranty funds receivable or on deposit			0	0
20.	Electronic data processing equipment and software			0	0
21.	Furniture and equipment, including health care delivery assets ($ .....)			0	0
22.	Net adjustment in assets and liabilities due to foreign exchange rates			0	0
23.	Receivables from parent, subsidiaries and affiliates			0	0
24.	Health care ($ .....) and other amounts receivable			0	0
25.	Aggregate write-ins for other than invested assets	3,370	0	3,370	3,328
26.	Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	4,047,177	0	4,047,177	4,023,135
27.	From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0	0
28.	Total (Lines 26 and 27)	4,047,177	0	4,047,177	4,023,135
	DETAILS OF WRITE-INS				
1101.					
1102.					
1103.					
1198.	Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199.	Totals (Lines 1101 thru 1103 plus 1198)(Line 11 above)	0	0	0	0
2501.	State income tax recoverable	3,370		3,370	3,328
2502.					
2503.					
2598.	Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599.	Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	3,370	0	3,370	3,328

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

LIABILITIES, CAPITAL AND SURPLUS

	Current Year 1 Covered	Current Year 2 Uncovered	Current Year 3 Total	Prior Year 4 Total
1. Claims unpaid (less $ ..... reinsurance ceded)			0	0
2. Accrued medical incentive pool and bonus amounts			0	0
3. Unpaid claims adjustment expenses			0	0
4. Aggregate health policy reserves, including the liability of $ ..... for medical loss ratio rebate per the Public Health Service Act			0	0
5. Aggregate life policy reserves			0	0
6. Property/casualty unearned premium reserves			0	0
7. Aggregate health claim reserves			0	0
8. Premiums received in advance			0	0
9. General expenses due or accrued	143		143	143
10.1 Current federal and foreign income tax payable and interest thereon (including $ ..... on realized capital gains (losses))			0	0
10.2 Net deferred tax liability	10		10	0
11. Ceded reinsurance premiums payable			0	0
12. Amounts withheld or retained for the account of others			0	0
13. Remittances and items not allocated			0	0
14. Borrowed money (including $ ..... current) and interest thereon $ ..... (including $ ..... current)			0	0
15. Amounts due to parent, subsidiaries and affiliates	730		730	0
16. Derivatives			0	0
17. Payable for securities			0	0
18. Payable for securities lending			0	0
19. Funds held under reinsurance treaties (with $ ..... authorized reinsurers, $ .....0 unauthorized reinsurers and $ .....0 certified reinsurers)			0	0
20. Reinsurance in unauthorized and certified ($ .....) companies			0	0
21. Net adjustments in assets and liabilities due to foreign exchange rates			0	0
22. Liability for amounts held under uninsured plans			0	0
23. Aggregate write-ins for other liabilities (including $ ..... current)	0	0	0	0
24. Total liabilities (Lines 1 to 23)	883	0	883	143
25. Aggregate write-ins for special surplus funds	XXX	XXX	0	0
26. Common capital stock	XXX	XXX	1,000	1,000
27. Preferred capital stock	XXX	XXX	0	
28. Gross paid in and contributed surplus	XXX	XXX	3,999,000	3,999,000
29. Surplus notes	XXX	XXX		
30. Aggregate write-ins for other than special surplus funds	XXX	XXX	0	0
31. Unassigned funds (surplus)	XXX	XXX	46,294	22,992
32. Less treasury stock, at cost:				
32.1 ..... shares common (value included in Line 26 $ .....)	XXX	XXX		
32.2 ..... shares preferred (value included in Line 27 $ .....)	XXX	XXX		
33. Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	4,046,294	4,022,992
34. Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	4,047,177	4,023,135
DETAILS OF WRITE-INS				
2301.				
2302.				
2303.				
2398. Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399. Totals (Lines 2301 thru 2303 plus 2398)(Line 23 above)	0	0	0	0
2501.	XXX	XXX		
2502.	XXX	XXX		
2503.	XXX	XXX		
2598. Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	XXX	XXX	0	0
3001.	XXX	XXX		
3002.	XXX	XXX		
3003.	XXX	XXX		
3098. Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099. Totals (Lines 3001 thru 3003 plus 3098)(Line 30 above)	XXX	XXX	0	0

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

STATEMENT OF REVENUE AND EXPENSES

		Current Year 1 Uncovered	Current Year 2 Total	Prior Year 3 Total
1.	Member Months	XXX		
2.	Net premium income (including $ non-health premium income)	XXX	0	
3.	Change in unearned premium reserves and reserve for rate credits	XXX	0	
4.	Fee-for-service (net of $ medical expenses)	XXX	0	
5.	Risk revenue	XXX	0	
6.	Aggregate write-ins for other health care related revenues	XXX	0	0
7.	Aggregate write-ins for other non-health revenues	XXX	0	0
8.	Total revenues (Lines 2 to 7)	XXX	0	0
	Hospital and Medical:			
9.	Hospital/medical benefits		0	
10.	Other professional services		0	
11.	Outside referrals		0	
12.	Emergency room and out-of-area		0	
13.	Prescription drugs		0	
14.	Aggregate write-ins for other hospital and medical	0	0	0
15.	Incentive pool, withhold adjustments and bonus amounts		0	
16.	Subtotal (Lines 9 to 15)	0	0	0
	Less:			
17.	Net reinsurance recoveries		0	
18.	Total hospital and medical (Lines 16 minus 17)	0	0	0
19.	Non-health claims (net)			
20.	Claims adjustment expenses, including $ 0 cost containment expenses		0	0
21.	General administrative expenses		132	532
22.	Increase in reserves for life and accident and health contracts (including $ increase in reserves for life only)		0	0
23.	Total underwriting deductions (Lines 18 through 22)	0	132	532
24.	Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	(132)	(532)
25.	Net investment income earned (Exhibit of Net Investment Income, Line 17)		4,501	4,740
26.	Net realized capital gains (losses) less capital gains tax of $			
27.	Net investment gains (losses) (Lines 25 plus 26)	0	4,501	4,740
28.	Net gain or (loss) from agents' or premium balances charged off [(amount recovered $) (amount charged off $)]			
29.	Aggregate write-ins for other income or expenses	0	0	0
30.	Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	4,369	4,208
31.	Federal and foreign income taxes incurred	XXX	(1,892)	(1,254)
32.	Net income (loss) (Lines 30 minus 31)	XXX	6,261	5,462
	DETAILS OF WRITE-INS			
0601.		XXX		
0602.		XXX		
0603		XXX		
0698.	Summary of remaining write-ins for Line 6 from overflow page	XXX	0	0
0699.	Totals (Lines 0601 thru 0603 plus 0698)(Line 6 above)	XXX	0	0
0701.		XXX		
0702.		XXX		
0703		XXX		
0798.	Summary of remaining write-ins for Line 7 from overflow page	XXX	0	0
0799.	Totals (Lines 0701 thru 0703 plus 0798)(Line 7 above)	XXX	0	0
1401.				
1402.				
1403.				
1498.	Summary of remaining write-ins for Line 14 from overflow page	0	0	0
1499.	Totals (Lines 1401 thru 1403 plus 1498)(Line 14 above)	0	0	0
2901.				
2902.				
2903				
2998.	Summary of remaining write-ins for Line 29 from overflow page	0	0	0
2999.	Totals (Lines 2901 thru 2903 plus 2998)(Line 29 above)	0	0	0

STATEMENT OF REVENUE AND EXPENSES (Continued)

		1 Current Year	2 Prior Year
	CAPITAL AND SURPLUS ACCOUNT		
33.	Capital and surplus prior reporting year	4,022,992	4,034,572
34.	Net income or (loss) from Line 32	6,261	5,462
35.	Change in valuation basis of aggregate policy and claim reserves		
36.	Change in net unrealized capital gains (losses) less capital gains tax of $		
37.	Change in net unrealized foreign exchange capital gain or (loss)		
38.	Change in net deferred income tax	(4,535)	4,534
39.	Change in nonadmitted assets	21,576	(21,576)
40	Change in unauthorized and certified reinsurance	0	0
41.	Change in treasury stock	0	0
42.	Change in surplus notes	0	0
43.	Cumulative effect of changes in accounting principles		
44.	Capital Changes:		
	44.1 Paid in	0	0
	44.2 Transferred from surplus (Stock Dividend)	0	0
	44.3 Transferred to surplus		
45.	Surplus adjustments:		
	45.1 Paid in	0	0
	45.2 Transferred to capital (Stock Dividend)		
	45.3 Transferred from capital		
46.	Dividends to stockholders		
47.	Aggregate write-ins for gains or (losses) in surplus	0	0
48.	Net change in capital and surplus (Lines 34 to 47)	23,302	(11,580)
49.	Capital and surplus end of reporting period (Line 33 plus 48)	4,046,294	4,022,992
	DETAILS OF WRITE-INS		
4701.			
4702.			
4703.			
4798.	Summary of remaining write-ins for Line 47 from overflow page	0	0
4799.	Totals (Lines 4701 thru 4703 plus 4798)(Line 47 above)	0	0

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

CASH FLOW

		1 Current Year	2 Prior Year
	Cash from Operations		
1.	Premiums collected net of reinsurance	0	0
2.	Net investment income	16,344	16,169
3.	Miscellaneous income	0	0
4.	Total (Lines 1 through 3)	16,344	16,169
5.	Benefit and loss related payments	0	0
6.	Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts		
7.	Commissions, expenses paid and aggregate write-ins for deductions	275	1,670
8.	Dividends paid to policyholders		
9.	Federal and foreign income taxes paid (recovered) net of $ ..... tax on capital gains (losses)	(1,967)	(1,623)
10.	Total (Lines 5 through 9)	(1,692)	47
11.	Net cash from operations (Line 4 minus Line 10)	18,036	16,122
	Cash from Investments		
12.	Proceeds from investments sold, matured or repaid:		
	12.1 Bonds	0	0
	12.2 Stocks	0	0
	12.3 Mortgage loans	0	0
	12.4 Real estate	0	0
	12.5 Other invested assets	0	0
	12.6 Net gains or (losses) on cash, cash equivalents and short-term investments	0	0
	12.7 Miscellaneous proceeds	0	0
	12.8 Total investment proceeds (Lines 12.1 to 12.7)	0	0
13.	Cost of investments acquired (long-term only):		
	13.1 Bonds	0	0
	13.2 Stocks	0	0
	13.3 Mortgage loans	0	0
	13.4 Real estate	0	0
	13.5 Other invested assets	0	0
	13.6 Miscellaneous applications	0	0
	13.7 Total investments acquired (Lines 13.1 to 13.6)	0	0
14.	Net increase (decrease) in contract loans and premium notes	0	0
15.	Net cash from investments (Line 12.8 minus Line 13.7 minus Line 14)	0	0
	Cash from Financing and Miscellaneous Sources		
16.	Cash provided (applied):		
	16.1 Surplus notes, capital notes	0	0
	16.2 Capital and paid in surplus, less treasury stock	0	0
	16.3 Borrowed funds	0	0
	16.4 Net deposits on deposit-type contracts and other insurance liabilities	0	0
	16.5 Dividends to stockholders	0	0
	16.6 Other cash provided (applied)	22,264	(16,122)
17.	Net cash from financing and miscellaneous sources (Lines 16.1 to 16.4 minus Line 16.5 plus Line 16.6)	22,264	(16,122)
	RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS		
18.	Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	40,300	0
19.	Cash, cash equivalents and short-term investments:		
	19.1 Beginning of year	3,442,636	3,442,636
	19.2 End of year (Line 18 plus Line 19.1)	3,482,936	3,442,636

Note: Supplemental disclosures of cash flow information for non-cash transactions:

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

ANALYSIS OF OPERATIONS BY LINES OF BUSINESS

	1 Total	2 Comprehensive (Hospital & Medical)	3 Medicare Supplement	4 Dental Only	5 Vision Only	6 Federal Employees Health Benefits Plan	7 Title XVIII Medicare	8 Title XIX Medicaid	9 Other Health	10 Other Non-Health
1. Net premium income	0									
2. Change in unearned premium reserves and reserve for rate credit	0									
3. Fee-for-service (net of $ ..... medical expenses)	0									XXX
4. Risk revenue	0									XXX
5. Aggregate write-ins for other health care related revenues	0	0	0	0	0	0	0	0	0	XXX
6. Aggregate write-ins for other non-health care related revenues	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
7. Total revenues (Lines 1 to 6)	0	0	0	0	0	0	0	0	0	0
8. Hospital/medical benefits	0									XXX
9. Other professional services	0									XXX
10. Outside referrals	0									XXX
11. Emergency room and out-of-area	0									XXX
12. Prescription drugs	0									XXX
13. Aggregate write-ins for other hospital and medical	0	0	0	0	0	0	0	0	0	XXX
14. Incentive pool, withhold adjustments and bonus amounts	0									XXX
15. Subtotal (Lines 8 to 14)	0	0	0	0	0	0	0	0	0	XXX
16. Net reinsurance recoveries	0									XXX
17. Total medical and hospital (Lines 15 minus 16)	0	0	0	0	0	0	0	0	0	XXX
18. Non-health claims (net)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
19. Claims adjustment expenses including $ ..... cost containment expenses	0									
20. General administrative expenses	132								132	
21. Increase in reserves for accident and health contracts	0									XXX
22. Increase in reserves for life contracts	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
23. Total underwriting deductions (Lines 17 to 22)	132	0	0	0	0	0	0	0	132	0
24. Total underwriting gain or (loss) (Line 7 minus Line 23)	(132)	0	0	0	0	0	0	0	(132)	0
DETAILS OF WRITE-INS										
0501.										XXX
0502.										XXX
0503.										XXX
0598. Summary of remaining write-ins for Line 5 from overflow page	0	0	0	0	0	0	0	0	0	XXX
0599. Totals (Lines 0501 thru 0503 plus 0598) (Line 5 above)	0	0	0	0	0	0	0	0	0	XXX
0601.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0602.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0603.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0698. Summary of remaining write-ins for Line 6 from overflow page	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
0699. Totals (Lines 0601 thru 0603 plus 0698) (Line 6 above)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
1301.										XXX
1302.										XXX
1303.										XXX
1398. Summary of remaining write-ins for Line 13 from overflow page	0	0	0	0	0	0	0	0	0	XXX
1399. Totals (Lines 1301 thru 1303 plus 1398) (Line 13 above)	0	0	0	0	0	0	0	0	0	XXX

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Underwriting and Investment Exhibit - Part 1 - Premiums

N O N E

Underwriting and Investment Exhibit - Part 2 - Claims Incurred

N O N E

Underwriting and Investment Exhibit - Part 2A - Claims Liability

N O N E

Underwriting and Investment Exhibit - Part 2B - Analysis of Claims

N O N E

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
($000 Omitted)
Section A - Paid Health Claims -

NONE

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2016	2 2017	3 2018	4 2019	5 2020
1. Prior					
2. 2016					
3. 2017	XXX				
4. 2018	XXX	XXX			
5. 2019	XXX	XXX	XXX		
6. 2020	XXX	XXX	XXX	XXX	

Section B - Incurred Health Claims -

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2016	2 2017	3 2018	4 2019	5 2020
1. Prior					
2. 2016					
3. 2017	XXX				
4. 2018	XXX	XXX			
5. 2019	XXX	XXX	XXX		
6. 2020	XXX	XXX	XXX	XXX	

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio -

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2016										
2. 2017										
3. 2018										
4. 2019										
5. 2020										

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ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2D - AGGREGATE RESERVE FOR ACCIDENT AND HEALTH CONTRACTS ONLY

	1 Total	2 Comprehensive (Hospital & Medical)	3 Medicare Supplement	4 Dental Only	5 Vision Only	6 Federal Employees Health Benefits Plan	7 Title XVIII Medicare	8 Title XIX Medicaid	9 Other
1. Unearned premium reserves									
2. Additional policy reserves (a)									
3. Reserve for future contingent benefits									
4. Reserve for rate credits or experience rating refunds (including $ .....) for investment income									
5. Aggregate write-ins for other policy reserves									
6. Totals (gross)									
7. Reinsurance ceded									
8. Totals (Net)(Page 3, Line 4)									
9. Present value of amounts not yet due on claims									
10. Reserve for future contingent benefits									
11. Aggregate write-ins for other claim reserves									
12. Totals (gross)									
13. Reinsurance ceded									
14. Totals (Net)(Page 3, Line 7)									
DETAILS OF WRITE-INS									
0501.									
0502.									
0503.									
0598. Summary of remaining write-ins for Line 5 from overflow page									
0599. Totals (Lines 0501 thru 0503 plus 0598) (Line 5 above)									
1101.									
1102.									
1103.									
1198. Summary of remaining write-ins for Line 11 from overflow page									
1199. Totals (Lines 1101 thru 1103 plus 1198) (Line 11 above)									

NONE

(a) Includes $ ..... premium deficiency reserve.

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ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 3 - ANALYSIS OF EXPENSES

	Claim Adjustment Expenses		3	4	5
	1 Cost Containment Expenses	2 Other Claim Adjustment Expenses	General Administrative Expenses	Investment Expenses	Total
1. Rent ($ ..... for occupancy of own building)					0
2. Salary, wages and other benefits					0
3. Commissions (less $ ..... ceded plus $ ..... assumed)					0
4. Legal fees and expenses					0
5. Certifications and accreditation fees					0
6. Auditing, actuarial and other consulting services					0
7. Traveling expenses					0
8. Marketing and advertising					0
9. Postage, express and telephone					0
10. Printing and office supplies					0
11. Occupancy, depreciation and amortization					0
12. Equipment					0
13. Cost or depreciation of EDP equipment and software					0
14. Outsourced services including EDP, claims, and other services					0
15. Boards, bureaus and association fees					0
16. Insurance, except on real estate					0
17. Collection and bank service charges					0
18. Group service and administration fees					0
19. Reimbursements by uninsured plans					0
20. Reimbursements from fiscal intermediaries					0
21. Real estate expenses					0
22. Real estate taxes					0
23. Taxes, licenses and fees:					
23.1 State and local insurance taxes			132		132
23.2 State premium taxes					0
23.3 Regulatory authority licenses and fees					0
23.4 Payroll taxes					0
23.5 Other (excluding federal income and real estate taxes)					0
24. Investment expenses not included elsewhere				8,798	8,798
25. Aggregate write-ins for expenses	0	0	0	0	0
26. Total expenses incurred (Lines 1 to 25)	0	0	132	8,798	(a) 8,930
27. Less expenses unpaid December 31, current year				143	143
28. Add expenses unpaid December 31, prior year	0	0	0	143	143
29. Amounts receivable relating to uninsured plans, prior year			0		0
30. Amounts receivable relating to uninsured plans, current year					0
31. Total expenses paid (Lines 26 minus 27 plus 28 minus 29 plus 30)	0	0	132	8,798	8,930
DETAILS OF WRITE-INS					
2501.					
2502.					
2503.					
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	0	0	0	0	0

(a) Includes management fees of $ 0 to affiliates and $ ..... to non-affiliates.

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

EXHIBIT OF NET INVESTMENT INCOME

		1 Collected During Year	2 Earned During Year
1.	U.S. government bonds	(a) 0	0
1.1	Bonds exempt from U.S. tax	(a)	
1.2	Other bonds (unaffiliated)	(a) 13,299	13,299
1.3	Bonds of affiliates	(a) 0	0
2.1	Preferred stocks (unaffiliated)	(b) 0	0
2.11	Preferred stocks of affiliates	(b) 0	0
2.2	Common stocks (unaffiliated)	0	0
2.21	Common stocks of affiliates	0	0
3.	Mortgage loans	(c) 0	0
4.	Real estate	(d) 0	0
5	Contract Loans	0	0
6	Cash, cash equivalents and short-term investments	(e) 0	0
7	Derivative instruments	(f) 0	0
8.	Other invested assets	0	0
9.	Aggregate write-ins for investment income	0	0
10.	Total gross investment income	13,299	13,299
11.	Investment expenses		(g) 8,798
12.	Investment taxes, licenses and fees, excluding federal income taxes		(g) 0
13.	Interest expense		(h)
14.	Depreciation on real estate and other invested assets		(i)
15.	Aggregate write-ins for deductions from investment income		0
16.	Total deductions (Lines 11 through 15)		8,798
17.	Net investment income (Line 10 minus Line 16)		4,501
	DETAILS OF WRITE-INS		
0901.			
0902.			
0903.			
0998.	Summary of remaining write-ins for Line 9 from overflow page	0	0
0999.	Totals (Lines 0901 thru 0903 plus 0998) (Line 9, above)	0	0
1501.			
1502.			
1503.			
1598.	Summary of remaining write-ins for Line 15 from overflow page		0
1599.	Totals (Lines 1501 thru 1503 plus 1598) (Line 15, above)		0

(a) Includes $ 0 accrual of discount less $ 11,700 amortization of premium and less $ 0 paid for accrued interest on purchases.

(b) Includes $ accrual of discount less $ amortization of premium and less $ paid for accrued dividends on purchases.

(c) Includes $ accrual of discount less $ amortization of premium and less $ paid for accrued interest on purchases.

(d) Includes $ for company's occupancy of its own buildings; and excludes $ interest on encumbrances.

(e) Includes $ accrual of discount less $ amortization of premium and less $ paid for accrued interest on purchases.

(f) Includes $ accrual of discount less $ amortization of premium.

(g) Includes $. investment expenses and $ investment taxes, licenses and fees, excluding federal income taxes, attributable to segregated and Separate Accounts.

(h) Includes $ interest on surplus notes and $ interest on capital notes.

(i) Includes $ depreciation on real estate and $ depreciation on other invested assets.

EXHIBIT OF CAPITAL GAINS (LOSSES)

		1 Realized Gain (Loss) On Sales or Maturity	2 Other Realized Adjustments	3 Total Realized Capital Gain (Loss) (Columns 1 + 2)	4 Change in Unrealized Capital Gain (Loss)	5 Change in Unrealized Foreign Exchange Capital Gain (Loss)
1.	U.S. Government bonds					
1.1	Bonds exempt from U.S. tax					
1.2	Other bonds (unaffiliated)					
1.3	Bonds of affiliates					
2.1	Preferred stocks (unaffiliated)					
2.11	Preferred stocks of affiliates					
2.2	Common stocks (unaffiliated)					
2.21	Common stocks of affiliates					
3.	Mortgage loans					
4.	Real estate					
5.	Contract loans					
6.	Cash, cash equivalents and short-term investme					
7.	Derivative instruments					
8.	Other invested assets					
9.	Aggregate write-ins for capital gains (losses)					
10.	Total capital gains (losses)					
	DETAILS OF WRITE-INS					
0901.						
0902.						
0903.						
0998.	Summary of remaining write-ins for Line 9 from overflow page					
0999.	Totals (Lines 0901 thru 0903 plus 0998) (Line 9, above)					

NONE

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

EXHIBIT OF NON-ADMITTED ASSETS

		1 Current Year Total Nonadmitted Assets	2 Prior Year Total Nonadmitted Assets	3 Change in Total Nonadmitted Assets (Col. 2 - Col. 1)
1.	Bonds (Schedule D)			0
2.	Stocks (Schedule D):			
	2.1 Preferred stocks			0
	2.2 Common stocks			0
3.	Mortgage loans on real estate (Schedule B):			
	3.1 First liens			0
	3.2 Other than first liens			0
4.	Real estate (Schedule A):			
	4.1 Properties occupied by the company			0
	4.2 Properties held for the production of income			0
	4.3 Properties held for sale			0
5.	Cash (Schedule E - Part 1), cash equivalents (Schedule E - Part 2) and short-term investments (Schedule DA)			0
6.	Contract loans			0
7.	Derivatives (Schedule DB)			0
8.	Other invested assets (Schedule BA)			0
9.	Receivables for securities			0
10.	Securities lending reinvested collateral assets (Schedule DL)			0
11.	Aggregate write-ins for invested assets	0	0	0
12.	Subtotals, cash and invested assets (Lines 1 to 11)	0	0	0
13.	Title plants (for Title insurers only)			0
14.	Investment income due and accrued		0	0
15.	Premiums and considerations:			
	15.1 Uncollected premiums and agents' balances in the course of collection		0	0
	15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due		0	0
	15.3 Accrued retrospective premiums and contracts subject to redetermination		0	0
16.	Reinsurance:			
	16.1 Amounts recoverable from reinsurers		0	0
	16.2 Funds held by or deposited with reinsured companies		0	0
	16.3 Other amounts receivable under reinsurance contracts		0	0
17.	Amounts receivable relating to uninsured plans		0	0
18.1	Current federal and foreign income tax recoverable and interest thereon		0	0
18.2	Net deferred tax asset		0	0
19.	Guaranty funds receivable or on deposit		0	0
20.	Electronic data processing equipment and software		0	0
21.	Furniture and equipment, including health care delivery assets		0	0
22.	Net adjustment in assets and liabilities due to foreign exchange rates		0	0
23.	Receivable from parent, subsidiaries and affiliates		21,576	21,576
24.	Health care and other amounts receivable		0	0
25.	Aggregate write-ins for other than invested assets	0	0	0
26.	Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	0	21,576	21,576
27.	From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0
28.	Total (Lines 26 and 27)	0	21,576	21,576
	DETAILS OF WRITE-INS			
1101.				
1102.				
1103.				
1198.	Summary of remaining write-ins for Line 11 from overflow page	0	0	0
1199.	Totals (Lines 1101 thru 1103 plus 1198)(Line 11 above)	0	0	0
2501.				
2502.				
2503.				
2598.	Summary of remaining write-ins for Line 25 from overflow page	0	0	0
2599.	Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	0	0	0

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

EXHIBIT 1 - ENROLLMENT BY PRODUCT TYPE FOR HEALTH BUSINESS ONLY

Source of Enrollment	Total Members at End of					6
	1 Prior Year	2 First Quarter	3 Second Quarter	4 Third Quarter	5 Current Year	Current Year Member Months
1. Health Maintenance Organizations						
2. Provider Service Organizations						
3. Preferred Provider Organizations						
4. Point of Service						
5. Indemnity Only						
6. Aggregate write-ins for other lines of business						
7. Total						
DETAILS OF WRITE-INS						
0601.						
0602.						
0603.						
0698. Summary of remaining write-ins for Line 6 from overflow page						
0699. Totals (Lines 0601 thru 0603 plus 0698) (Line 6 above)						

NONE

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Exhibit 2 - A&H Premiums Due and Unpaid

N O N E

Exhibit 3 - Health Care Receivables

N O N E

Exhibit 3A - Health Care Receivables Collected and Accrued

N O N E

Exhibit 4 - Claims Unpaid and Incentive Pool, Withhold and Bonus

N O N E

Exhibit 5 - Amounts Due From Parent, Subsidiaries and Affiliates

N O N E

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

EXHIBIT 6 - AMOUNTS DUE TO PARENT, SUBSIDIARIES AND AFFILIATES

1 Affiliate	2 Description	3 Amount	4 Current	5 Non-Current
Anthem, Inc.	Corporate Services	730	730	
0199999. Individually listed payables		730	730	0
0299999. Payables not individually listed		0		
0399999 Total gross payables		730	730	0

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Exhibit 7 - Part 1 - Summary of Transactions with Providers

N O N E

Exhibit 7 - Part 2

N O N E

Exhibit 8 - Furniture and Equipment Owned

N O N E

ANNUAL STATEMENT FOR THE YEAR 2020 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies and Going Concern

A. Accounting Practices

The accompanying financial statements of AMERIGROUP Mississippi, Inc. (the "Company") have been prepared in conformity with the National Association of Insurance Commissioners' ("NAIC") *Annual Statement Instructions* and in accordance with accounting practices prescribed by the NAIC *Accounting Practices and Procedures Manual* ("NAIC SAP"), subject to any deviations prescribed or permitted by the Mississippi Insurance Department (the "Department").

A reconciliation of the Company's net income (loss) and capital and surplus between NAIC SAP and practices prescribed and permitted by the MID is shown below:

		SSAP #	F/S Page	F/S Line #	2020	2019
	Net Income					
(1)	AMERIGROUP Mississippi, Inc. state basis (Page 4, Line 32, Columns 2 & 3)	XXX	XXX	XXX	$ 6,261	$ 5,462
(2)	State Prescribed Practices that is an increase/(decrease) from NAIC SAP:				—	—
(3)	State Permitted Practices that is an increase/(decrease) from NAIC SAP:				—	—
(4)	NAIC SAP (1-2-3=4)	XXX	XXX	XXX	$ 6,261	$ 5,462
	Surplus					
(5)	AMERIGROUP Mississippi, Inc. state basis (Page 3, Line 33, Columns 3 & 4)	XXX	XXX	XXX	$ 4,046,294	$ 4,022,992
(6)	State Prescribed Practices that is an increase/(decrease) from NAIC SAP:				—	—
(7)	State Permitted Practices that is an increase/(decrease) from NAIC SAP:				—	—
(8)	NAIC SAP (5-6-7=8)	XXX	XXX	XXX	$ 4,046,294	$ 4,022,992

A. Use of Estimates in the Preparation of the Financial Statements

Preparation of financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

B. Accounting Policies

Health premiums are earned over the term of the related insurance policies. Premiums written are reported net of experience rating refunds. Premiums paid prior to the effective date are recorded on the balance sheet as premiums received in advance and are subsequently credited to income as earned during the coverage period. Premium rates are

ANNUAL STATEMENT FOR THE YEAR 2020 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

subject to approval by the Centers for Medicare and Medicaid Services. Expenses are charged to operations as incurred.

In addition, the Company uses the following accounting policies:

(1) Short-term investments include investments with maturities of less than one year and more than three months at the date of acquisition and are reported at amortized cost, which approximates fair value. Non-investment grade short-term investments are stated at the lower of amortized cost or fair value.
(2) Investment grade bonds not backed by other loans are stated at amortized cost, with amortization calculated based on the modified scientific method, using lower of yield to call or yield to maturity. Non-investment grade bonds are stated at the lower of amortized cost or fair value as determined by various third-party pricing sources.
(3) The Company has no investments in common stocks of unaffiliated companies.
(4) The Company has no investments in preferred stocks.
(5) The Company has no mortgage loans - real estate.
(6) The Company has no loan-backed securities.
(7) The Company has no investments in subsidiaries, controlled and affiliated companies.
(8) The Company has no investments in joint ventures, partnerships or limited liability companies.
(9) The Company has no derivative instruments.
(10) The Company recognizes losses from other-than-temporary impairments ("OTTI") of investments in accordance with Statements of Standard Accounting Practice ("SSAP") No. 26R, *Bonds*; and SSAP No. 30, *Common Stock*; and SSAP No. 32, *Preferred Stock*.
(11) The Company does not anticipate investment income as a factor in premium deficiency calculations.
(12) Unpaid claims and claims adjustment expenses include management's best estimate of amounts based on historical claim development patterns and certain individual case estimates. The established liability considers health benefit provisions, business practices, economic conditions and other factors that may materially affect the cost, frequency and severity of claims. Liabilities for unpaid claims and claim adjustment expenses are based on assumptions and estimates, and while management believes such estimates are reasonable, the ultimate liability may be in excess of or less than the amount provided. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed and changes in estimates are incorporated into current period estimates.
(13) The Company has not modified its capitalization policy from the prior period.

C. Going Concern

Not applicable.

2. Accounting Changes and Corrections of Errors

There were no accounting changes or corrections of errors during the years ended December 31, 2020 and 2019.

3. Business Combinations and Goodwill

A. Statutory Purchase Method

Not applicable.

B. Statutory Merger

Not applicable.

ANNUAL STATEMENT FOR THE YEAR 2020 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

C. Assumption Reinsurance

Not applicable.

D. Impairment Loss

Not applicable.

4. Discontinued Operations

The Company had no operations that were discontinued during 2020 or 2019.

5. Investments

A. Mortgage Loans, including Mezzanine Real Estate Loans

The Company did not have investments in mortgage loans at December 31, 2020 or 2019.

B. Debt Restructuring

The Company did not have invested assets that were restructured debt at December 31, 2020 or 2019.

C. Reverse Mortgages

The Company did not have investments in reverse mortgages at December 31, 2020 or 2019.

D. Loan-Backed Securities

(1) The Company did not have loan-backed securities at December 31, 2020 and 2019.
(2) The Company did not recognize OTTI on its loan-backed securities during the years ended December 31, 2020 and 2019.
(3) The Company did not hold OTTI on its loan-backed securities at December 31, 2020 and 2019.
(4) The Company had no impaired loan-backed securities for which an OTTI had not been recognized in earnings at December 31, 2020 and 2019.
(5) The Company had no impaired loan-backed securities at December 31, 2020 and 2019.

E. Dollar Repurchase Agreements and/or Securities Lending Transactions

The Company did not enter into repurchase agreements or securities lending transactions at December 31, 2020 or 2019.

F. Repurchase Agreements Transactions Accounted for as Secured Borrowing

The Company did not enter into repurchase agreement transactions accounted for as secured borrowing at December 31, 2020 or 2019.

G. Reverse Repurchase Agreements Transactions Accounted for as Secured Borrowing

The Company did not enter into reverse repurchase agreement transactions accounted for as a secured borrowing at December 31, 2020 or 2019.

ANNUAL STATEMENT FOR THE YEAR 2020 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

H. Repurchase Agreements Transactions Accounted for as a Sale

The Company did not enter into repurchase agreement transactions accounted for as a sale at December 31, 2020 or 2019.

I. Reverse Repurchase Agreements Transactions Accounted for as a Sale

The Company did not enter into reverse repurchase agreement transactions accounted for as a sale at December 31, 2020 or 2019.

J. Real Estate

The Company did not have investments in real estate and did not engage in retail land sales operations during 2020 or 2019.

K. Investments in Low-Income Housing Tax Credits

The Company did not invest in properties generating low-income housing tax credits during 2020 or 2019.

L. Restricted Assets

(1) Restricted assets (including pledged)

	1	2	3	4	5	6	7
Restricted Asset Category	Total Gross (Admitted & Nonadmitted) Restricted from Current Year	Total Gross (Admitted & Nonadmitted) Restricted from Prior Year	Increase/ (Decrease) (1 minus 2)	Total Current Year Nonadmitted Restricted	Total Current Year Admitted Restricted (1 minus 4)	Gross Admitted and Nonadmitted Restricted to Total Assets (a)	Admitted Restricted to Total Admitted Assets (b)
a. Subject to contractual obligation for which liability is not shown	$ —	$ —	$ —	$ —	$ —	0.00 %	0.00 %
b. Collateral held under security lending agreements	—	—	—	—	—	0.00 %	0.00 %
c. Subject to repurchase agreements	—	—	—	—	—	0.00 %	0.00 %
d. Subject to reverse repurchase agreements	—	—	—	—	—	0.00 %	0.00 %
e. Subject to dollar repurchase agreements	—	—	—	—	—	0.00 %	0.00 %
f. Subject to dollar reverse repurchase agreements	—	—	—	—	—	0.00 %	0.00 %
g. Placed under option contracts	—	—	—	—	—	0.00 %	0.00 %
h. Letter stock or securities restricted as to sale-excluding FHLB capital stock	—	—	—	—	—	0.00 %	0.00 %
i. FHLB capital stock	—	—	—	—	—	0.00 %	0.00 %
j. On deposit with states	552,331	564,032	(11,701)	—	552,331	13.65 %	13.65 %
k. On deposit with other regulatory bodies	—	—	—	—	—	0.00 %	0.00 %
l. Pledged as collateral to FHLB (including assets backing funding agreements)	—	—	—	—	—	0.00 %	0.00 %
m. Pledged as collateral not captured in other categories	—	—	—	—	—	0.00 %	0.00 %
n. Other restricted assets	—	—	—	—	—	0.00 %	0.00 %
o. Total Restricted Assets	$ 552,331	$ 564,032	$ (11,701)	$ —	$ 552,331	13.65 %	13.65 %

(a) Column 1 divided by Asset Page, Column 1, Line 28

(b) Column 5 divided by Asset Page, Column 3, Line 28

(2) Not applicable.
(3) Not applicable.
(4) Not applicable.

ANNUAL STATEMENT FOR THE YEAR 2020 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

M. Working Capital Finance Investments

The Company did not have any working capital finance investments at December 31, 2020 and 2019.

N. Offsetting and Netting of Assets and Liabilities

The Company did not have any offsetting or netting of assets and liabilities at December 31, 2020 and 2019.

O. 5GI Securities

The Company has no 5GI Securities as of December 31, 2020 and 2019.

P. Short Sales

The Company did not have any short sales at December 31, 2020 and 2019.

Q. Prepayment Penalty and Acceleration Fees

The Company did not have any prepayment penalty or acceleration fees at December 31, 2020 and 2019.

6. Joint Ventures, Partnerships and Limited Liability Companies

A. The Company has no investments in joint ventures, partnerships or LLCs.

B. Not applicable.

7. Investment Income

A. All investment income due and accrued with amounts that are over 90 days past due is non-admitted.

B. At December 31, 2020 and 2019 there was no nonadmitted accrued investment income.

8. Derivative Instruments

The Company has no derivative instruments.

ANNUAL STATEMENT FOR THE YEAR 2020 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

9. Income Taxes

A. The components of net deferred tax assets (liabilities):

(1) The components of net deferred tax asset (liabilities) are as follows:

		12/31/2020		
		(1) Ordinary	(2) Capital	(3) (Col 1+2) Total
(a)	Gross Deferred Tax Assets	$ —	$ —	$ —
(b)	Statutory Valuation Allowance Adjustments	—	—	—
(c)	Adjusted Gross Deferred Tax Assets (1a - 1b)	—	—	—
(d)	Deferred Tax Assets Nonadmitted	—	—	—
(e)	Subtotal Net Admitted Deferred Tax Asset (1c - 1d)	—	—	—
(f)	Deferred Tax Liabilities	—	10	10
(g)	Net Admitted Deferred Tax Asset/(Net Deferred Tax Liability) (1e - 1f)	$ —	$ (10)	$ (10)

		12/31/2019		
		(4) Ordinary	(5) Capital	(6) (Col 4+5) Total
(a)	Gross Deferred Tax Assets	$ 4,531	$ —	$ 4,531
(b)	Statutory Valuation Allowance Adjustments	—	—	—
(c)	Adjusted Gross Deferred Tax Assets (1a - 1b)	4,531	—	4,531
(d)	Deferred Tax Assets Nonadmitted	—	—	—
(e)	Subtotal Net Admitted Deferred Tax Asset (1c - 1d)	4,531	—	4,531
(f)	Deferred Tax Liabilities	—	6	6
(g)	Net Admitted Deferred Tax Asset/(Net Deferred Tax Liability) (1e - 1f)	$ 4,531	$ (6)	$ 4,525

		Change		
		(7) (Col 1-4) Ordinary	(8) (Col 2-5) Capital	(9) (Col 7+8) Total
(a)	Gross Deferred Tax Assets	$ (4,531)	$ —	$ (4,531)
(b)	Statutory Valuation Allowance Adjustments	—	—	—
(c)	Adjusted Gross Deferred Tax Assets (1a - 1b)	(4,531)	—	(4,531)
(d)	Deferred Tax Assets Nonadmitted	—	—	—
(e)	Subtotal Net Admitted Deferred Tax Asset (1c - 1d)	(4,531)	—	(4,531)
(f)	Deferred Tax Liabilities	—	4	4
(g)	Net Admitted Deferred Tax Asset/(Net Deferred Tax Liability) (1e - 1f)	$ (4,531)	$ (4)	$ (4,535)

ANNUAL STATEMENT FOR THE YEAR 2020 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

(2) The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101, *Income Taxes* ("SSAP No. 101") are as follows:

	12/31/2020		
	(1) Ordinary	(2) Capital	(3) (Col 1+2) Total
Admission Calculation Components SSAP No. 101			
(a) Federal Income Taxes Paid in Prior Years Recoverable Through Loss Carrybacks.	$ —	$ —	$ —
(b) Adjusted Gross Deferred Tax Assets Expected To Be Realized (Excluding The Amount Of Deferred Tax Assets From 2(a) above) After Application of the Threshold Limitation. (The Lesser of 2(b)1 and 2(b)2 Below)	—	—	—
1. Adjusted Gross Deferred Tax Assets Expected To Be Realized Following the Balance Sheet Date.	—	—	—
2. Adjusted Gross Deferred Tax Assets Allowed per Limitation Threshold.	XXX	XXX	606,944
(c) Adjusted Gross Deferred Tax Assets (Excluding The Amount Of Deferred Tax Assets From 2(a) and 2(b) above) Offset by Gross Deferred Tax Liabilities.	—	—	—
(d) Deferred Tax Assets Admitted as the result of application of SSAP No. 101. Total (2(a) + 2(b) + 2(c))	$ —	$ —	$ —

	12/31/2019		
	(4) Ordinary	(5) Capital	(6) (Col 4+5) Total
Admission Calculation Components SSAP No. 101			
(a) Federal Income Taxes Paid in Prior Years Recoverable Through Loss Carrybacks.	$ 1,633	$ —	$ 1,633
(b) Adjusted Gross Deferred Tax Assets Expected To Be Realized (Excluding The Amount Of Deferred Tax Assets From 2(a) above) After Application of the Threshold Limitation. (The Lesser of 2(b)1 and 2(b)2 Below)	2,898	—	2,898
1. Adjusted Gross Deferred Tax Assets Expected To Be Realized Following the Balance Sheet Date.	2,898	—	2,898
2. Adjusted Gross Deferred Tax Assets Allowed per Limitation Threshold.	XXX	XXX	602,770
(c) Adjusted Gross Deferred Tax Assets (Excluding The Amount Of Deferred Tax Assets From 2(a) and 2(b) above) Offset by Gross Deferred Tax Liabilities.	—	—	—
(d) Deferred Tax Assets Admitted as the result of application of SSAP No. 101. Total (2(a) + 2(b) + 2(c))	$ 4,531	$ —	$ 4,531

	Change		
	(7) (Col 1-4) Ordinary	(8) (Col 2-5) Capital	(9) (Col 7+8) Total
Admission Calculation Components SSAP No. 101			
(a) Federal Income Taxes Paid in Prior Years Recoverable Through Loss Carrybacks.	$ (1,633)	$ —	$ (1,633)
(b) Adjusted Gross Deferred Tax Assets Expected To Be Realized (Excluding The Amount Of Deferred Tax Assets From 2(a) above) After Application of the Threshold Limitation. (The Lesser of 2(b)1 and 2(b)2 Below)	(2,898)	—	(2,898)
1. Adjusted Gross Deferred Tax Assets Expected To Be Realized Following the Balance Sheet Date.	(2,898)	—	(2,898)
2. Adjusted Gross Deferred Tax Assets Allowed per Limitation Threshold.	XXX	XXX	4,174
(c) Adjusted Gross Deferred Tax Assets (Excluding The Amount Of Deferred Tax Assets From 2(a) and 2(b) above) Offset by Gross Deferred Tax Liabilities.	—	—	—
(d) Deferred Tax Assets Admitted as the result of application of SSAP No. 101. Total (2(a) + 2(b) + 2(c))	$ (4,531)	$ —	$ (4,531)

ANNUAL STATEMENT FOR THE YEAR 2020 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

(3)

	2020	2019
(a) Ratio Percentage Used To Determine Recovery Period And Threshold Limitation Amount.	44,562.71 %	44,066.97 %
(b) Amount Of Adjusted Capital And Surplus Used To Determine Recovery Period And Threshold Limitation In 2(b)2 Above.	$ 4,046,294	$ 4,018,467

(4)

	12/31/2020		12/31/2019		Change	
	(1) Ordinary	(2) Capital	(3) Ordinary	(4) Capital	(5) (Col 1-3) Ordinary	(6) (Col 2-4) Capital
Impact of Tax-Planning Strategies						
(a) Determination of Adjusted Gross Deferred Tax Assets and Net Admitted Deferred Tax Assets, By Tax Character As A Percentage.						
1. Adjusted Gross DTAs Amount From Note 9A1(c)	$ —	$ —	$ 4,531	$ —	$ (4,531)	$ —
2. Percentage of Adjusted Gross DTAs By Tax Character Attributable To The Impact Of Tax Planning Strategies	0.00 %	0.00 %	0.00 %	0.00 %	0.00 %	0.00 %
3. Net Admitted Adjusted Gross DTAs Amount From Note 9A1(e)	$ —	$ —	$ 4,531	$ —	$ (4,531)	$ —
4. Admitted Adjusted Gross DTAs By Tax Character Admitted Because Of The Impact Of Tax Planning Strategies	0.00 %	0.00 %	0.00 %	0.00 %	0.00 %	0.00 %

(b) Does the Company's tax-planning strategies include the use of reinsurance? Yes _____ No X

B. The Company has no unrecognized deferred tax liabilities at December 31, 2020 and 2019.

C. Current income taxes incurred consist of the following major components:

	(1) 12/31/2020	(2) 12/31/2019	(3) (Col 1-2) Change
(1) Current Income Tax			
(a) Federal	$ (1,892)	$ (1,254)	$ (638)
(b) Foreign	—	—	—
(c) Subtotal	(1,892)	(1,254)	(638)
(d) Federal income tax expense on net capital gains	—	—	—
(e) Utilization of capital loss carry-forwards	—	—	—
(f) Other	—	—	—
(g) Federal and foreign income taxes incurred	$ (1,892)	$ (1,254)	$ (638)
(2) Deferred Tax Assets:			
(a) Ordinary			
(1) Discounting of unpaid losses	$ —	$ —	$ —
(2) Unearned premium reserve	—	—	—
(3) Policyholder reserves	—	—	—
(4) Investments	—	—	—

ANNUAL STATEMENT FOR THE YEAR 2020 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

	(5) Deferred acquisition costs	—	—	—
	(6) Policyholder dividends accrual	—	—	—
	(7) Fixed assets	—	—	—
	(8) Compensation and benefits accrual	—	—	—
	(9) Pension accrual	—	—	—
	(10) Receivables - nonadmitted	—	4,531	(4,531)
	(11) Net operating loss carry-forward	—	—	—
	(12) Tax credit carry-forward	—	—	—
	(13) Other (including items <5% of total ordinary tax assets)	—	—	—
	(14) Accrued future expenses	—	—	—
	(15) Amortization	—	—	—
	(16) Partnership income	—	—	—
	(17) Premium deficiency reserves	—	—	—
	(18) Prepaid expenses	—	—	—
	(19) Section 467 lease expense	—	—	—
	(20) Personal property tax accrual	—	—	—
	(21) Deferred gain on sale of building	—	—	—
	(22) State income tax liability	—	—	—
	(23) Income from reinsurance contract	—	—	—
	(24) Revenue agent's report adjustment	—	—	—
	(99) Subtotal	—	4,531	(4,531)
(b)	Statutory valuation allowance adjustment	—	—	—
(c)	Nonadmitted	—	—	—
(d)	Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	—	4,531	(4,531)
(e)	Capital			
	(1) Investments	—	—	—
	(2) Net capital loss carry-forward	—	—	—
	(3) Real estate	—	—	—
	(4) Other (including items <5% of total capital tax assets)	—	—	—
	(5) Partnership investment	—	—	—
	(6) State low income housing tax credits	—	—	—
	(7) Affiliated investment write-down	—	—	—
	(99) Subtotal	—	—	—
(f)	Statutory valuation allowance adjustment	—	—	—
(g)	Nonadmitted	—	—	—
(h)	Admitted capital deferred tax assets (2e99 - 2f - 2g)	—	—	—
(i)	Admitted deferred tax assets (2d + 2h)	$ —	$ 4,531	$ (4,531)

		(1) 12/31/2020	(2) 12/31/2019	(3) (Col 1-2) Change
(3)	Deferred Tax Liabilities:			
(a)	Ordinary			
	(1) Investments	$ —	$ —	$ —
	(2) Fixed assets	—	—	—
	(3) Deferred and uncollected premium	—	—	—
	(4) Policyholder reserves	—	—	—
	(5) Other (including items <5% of total ordinary tax liabilities)	—	—	—
	(6) Amortization	—	—	—
	(7) Discount of coordination of benefits	—	—	—
	(8) Guaranty fund assessment	—	—	—
	(9) Business partnership	—	—	—
	(10) Tax reserves per Tax Reform over 8 years	—	—	—
	(11) Oil and gas depletion deduction	—	—	—
	(12) Deferred cost - surplus note	—	—	—
	(99) Subtotal	—	—	—
(b)	Capital			
	(1) Investments	10	6	4

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NOTES TO FINANCIAL STATEMENTS

(2) Real estate	—	—	—
(3) Other (including items <5% of total capital tax liabilities)	—	—	—
(4) Section 166 partial worthlessness	—	—	—
(5) Investment partnership income	—	—	—
(99) Subtotal	10	6	4
(c) Deferred tax liabilities (3a99 + 3b99)	$ 10	$ 6	$ 4
(4) Net deferred tax assets/liabilities (2i - 3c)	$ (10)	$ 4,525	$ (4,535)

D. The Company's income tax expense and change in deferred income taxes differs from the amount obtained by applying the federal statutory income tax rate of 21% for the year ended December 31 as follows:

		2020	2019
	Tax expense computed using federal statutory rate	$ 918	$ 884
	ACA health insurer fee	—	—
	Change in nonadmitted assets	4,531	(4,531)
a	Tax exempt income and dividend received deduction net of proration	(2,091)	(2,140)
a	Tax exempt income received net of proration	—	—
	Prior year true-up and adjustments	(715)	—
	Interest (federal and state income tax)	—	—
	Tax settlements and contingencies	—	—
	Intercompany transfers and adjustments	—	—
	IMR/AVR tax	—	—
	Intercompany dividends	—	—
	Valuation allowance	—	—
	Other, net	—	(1)
	Total	$ 2,643	$ (5,788)
	Federal income taxes incurred	$ (1,892)	$ (1,254)
	Change in net deferred income taxes	4,535	(4,534)
	Total statutory income taxes	$ 2,643	$ (5,788)

E. Operating loss carryforwards:

(1) The Company has no operating loss carryforwards and no tax credit carryforwards as of December 31, 2020 or 2019.

(2) The Company has no federal income taxes available for recoupment.

(3) The Company has no protective tax deposits reported as admitted assets under Section 6603 of the Internal Revenue Service Code as of December 31, 2020 and 2019.

F. The following companies will be included in the consolidated federal income tax return with their parent Anthem, Inc. ("Anthem") as of December 31, 2020 and either are current members of the consolidated tax sharing agreement or are in the process of being added to the consolidated tax sharing agreement. Allocation of federal income taxes with affiliates subject to the tax sharing agreement is based upon separate income tax return calculations with credit for net losses that can be used on a consolidated basis. Pursuant to this agreement, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes. Intercompany income tax balances are settled based on the Internal Revenue Service due dates.

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NOTES TO FINANCIAL STATEMENTS

American Imaging Management, Inc.
America's 1st Choice of South Carolina, Inc.
America's Health Management Services, Inc.
AMERIGROUP Community Care of New Mexico, Inc.
AMERIGROUP Corporation
Amerigroup Delaware, Inc.
AMERIGROUP District of Columbia, Inc.
Amerigroup Health Plan of Louisiana, Inc.
Amerigroup Insurance Company
AMERIGROUP Iowa, Inc.
Amerigroup Kansas, Inc.
AMERIGROUP Maryland, Inc.
AMERIGROUP Mississippi, Inc.
AMERIGROUP New Jersey, Inc.
AMERIGROUP Ohio, Inc.
AMERIGROUP Oklahoma, Inc.
Amerigroup Pennsylvania, Inc.
AMERIGROUP Tennessee, Inc.
AMERIGROUP Texas, Inc.
AMERIGROUP Washington, Inc.
AMGP Georgia Managed Care Company, Inc.
Anthem Blue Cross Life and Health Insurance Company
Anthem Financial, Inc.
Anthem Health Plans of Kentucky, Inc.
Anthem Health Plans of Maine, Inc.
Anthem Health Plans of New Hampshire, Inc.
Anthem Health Plans of Virginia, Inc.
Anthem Health Plans, Inc.
Anthem Holding Corp.
Anthem Insurance Companies, Inc.
Anthem Kentucky Managed Care Plan, Inc.
Anthem Southeast, Inc.
Anthem UM Services, Inc.
Anthem, Inc.
Arcus Enterprises, Inc.
Aspire Health, Inc.
Associated Group, Inc.
Beacon Health Financing, LLC
Beacon Health Options Care Services, Inc.
Beacon Health Options Holdco, Inc.
Beacon Health Options, Inc.
Beacon Health Options of California, Inc.
Beacon Health Options of Ohio, Inc.
Beacon Health Options of Pennsylvania, Inc.
Beacon Health Vista Parent, Inc.
BHS IPA, LLC
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.
Blue Cross Blue Shield of Wisconsin
Blue Cross of California
Blue Cross of California Partnership Plan, Inc.
CareMarket, Inc.
CareMore Health Plan
CareMore Health Plan of Arizona, Inc.
CareMore Health Plan of Nevada, Inc.
CareMore Health Plan of Texas, Inc.
CareMore Health System
Cerulean Companies, Inc.
CHCS IPA, Inc.
Claim Management Services, Inc.
Community Care Health Plan of Nebraska, Inc. fka WellCare of Nebraska, Inc.
Designated Agent Company, Inc.
EHC Benefits Agency, Inc.
Empire HealthChoice Assurance, Inc.
Empire HealthChoice HMO, Inc.
Federal Government Solutions, LLC
FHC Health Systems, Inc.
Freedom Health, Inc.
Golden West Health Plan, Inc.
Health Core, Inc.
Health Management Corporation
HealthKeepers, Inc.
HealthLink HMO, Inc.
HealthLink Insurance Company
HealthLink, Inc.
HealthPlus HP, LLC
HealthSun Health Plan, Inc.
Healthy Alliance Life Insurance Company
HEP AP Holdings, Inc.
Highland Holdco, Inc.
HMO Colorado, Inc.
HMO Missouri, Inc.
IEC Group Holdings, Inc.
IEC Group, Inc. d/b/a AmeriBen
Imaging Management Holdings, LLC
IngenioRx, Inc.
Legato Holdings I, Inc.
Living Complete Technologies, Inc.
Massachusetts Behavioral Health Partnership
Matthew Thornton Health Plan, Inc.
Missouri Care, Incorporated
Nash Holding Company, LLC
National Government Services, Inc.
New England Research Institutes, Inc.
Optimum Healthcare, Inc.
OPTIONS Health Care, Inc.
Park Square Holdings, Inc.
Park Square I, Inc.
Park Square II, Inc.
Resolution Health, Inc.
RightCHOICE Managed Care, Inc.
Rocky Mountain Hospital and Medical Service, Inc.
SellCore, Inc.
Simply Healthcare Plans, Inc.
Southeast Services, Inc.
State Sponsored Services, Inc.
The Anthem Companies of California, Inc.
The Anthem Companies, Inc.
TrustSolutions, LLC
UNICARE Health Plan of West Virginia, Inc.
UNICARE Illinois Services, Inc.
UNICARE Life & Health Insurance Company
UNICARE National Services, Inc.
UNICARE Specialty Services, Inc.
Value Health Reinsurance, Inc.
ValueOptions Federal Services, Inc.
ValueOptions New Mexico, Inc.
ValueOptions of Kansas, Inc.
ValueOptions of New Jersey, Inc.
ValueOptions Texas, Inc.
Valus, Inc.

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NOTES TO FINANCIAL STATEMENTS

Community Care Health Plan of Nevada, Inc.
Community Insurance Company
Compcare Health Services Insurance Corporation
Crossroads Acquisition Corp.
DBG Holdings, Inc.
DeCare Analytics, LLC
DeCare Dental Health International, LLC
DeCare Dental Networks, LLC
DeCare Dental, LLC
WellPoint California Services, Inc.
WellPoint Dental Services, Inc.
WellPoint Health Solutions, Inc.
WellPoint Holding Corporation
WellPoint Information Technology Services, Inc.
WellPoint Insurance Services, Inc.
WellPoint Military Care Corporation
ZipDrug, Inc.

G. Not applicable.

H. Repatriation Transition Tax (RTT)

Not applicable.

I. Alternative Minimum Tax (AMT) Credit

Not applicable

10. Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

A. Nature of the Relationship

The Company is a Mississippi domiciled stock insurance company and is a wholly-owned subsidiary of Anthem Partnership Holding Company, LLC (“Anthem Partnership”),which is a direct wholly-owned subsidiary of Anthem, Inc. ("Anthem"), a publicly traded company.

B. Significant Transactions for Each Period

The Company became party to the Fair Market Value (“FMV”) Services Attachment discussed in Note 10E. There were no additional arrangements entered into as of December 31, 2020.

C. Transactions with Related Parties who are not Reported on Schedule Y

The Company has no transactions with related parties who are not reported on Schedule Y.

D. Amounts Due to or from Related Parties

At December 31, 2020, the Company reported no amounts due from affiliates. At December 31, 2020, the Company reported $730 due to affiliates. At December 31, 2019, the Company reported $21,576 due from affiliates. At December 31, 2019, the Company reported no amounts due to affiliates. The receivable and payable balances represent intercompany transactions that will be settled in accordance with the settlement terms of the intercompany agreement.

E. Management and Service Contracts and Cost Sharing Arrangements

The Company has entered into administrative services agreements with its affiliated companies. Pursuant to these agreements, various administrative, management and support services are provided to or provided by the Company. The costs and expenses related to these administrative management and support services are allocated to or allocated by the Company in an amount equal to the direct and indirect costs and expenses incurred in providing these services. Costs include expenses such as salaries, employee benefits, information technology, pharmacy benefits administration, communications, advertising, consulting services, rent, utilities, billing, accounting,

ANNUAL STATEMENT FOR THE YEAR 2020 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

underwriting, and product development, which support the Company's operations. These costs are allocated based on various utilization statistics.

In addition, the Company is party to the Fair Market Value ("FMV") Services Attachment, starting January 1, 2020, the costs and expenses related to certain care management and other services are allocated to or allocated by the Company in an amount equal to the fair market value of the services provided. These costs are allocated based on various utilization statistics.

F. Guarantees or Contingencies for Related Parties

The Company did not enter into guarantees or undertakings for the benefit of an affiliate which would result in a material contingent exposure of the Company's or any affiliated insurer's assets or liabilities.

G. Nature of Control Relationships that Could Affect Operations or Financial Position

Anthem Partnership owns all outstanding shares of the Company. The Company's ultimate parent is Anthem.

H. Amount Deducted for Investment in Upstream Company

The Company does not own shares of upstream intermediate entities or Anthem.

I. Detail of Investments in Affiliates Greater than 10% of Admitted Assets

The Company does not have investments in affiliates greater than 10% of admitted assets.

J. Write-down for Impairments of Investments in Subsidiaries, Controlled or Affiliated ("SCA") Companies

Not applicable.

K. Investment in a Foreign Insurance Subsidiary

The Company does not have investments in foreign insurance subsidiaries.

L. Investment in Downstream Non-insurance Holding Companies

The Company does not have investments in downstream non-insurance holding companies.

M. All SCA Investments

The Company has no SCA Investments.

N. Investment in Insurance SCAs

The Company does not have investments in Insurance SCAs.

O. SCA or SSAP 48 Entity Loss Tracking

The Company does not have losses on investments in Insurance SCAs and/or joint ventures, partnerships or LLCs.

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NOTES TO FINANCIAL STATEMENTS

11. Debt

A. Capital Notes and Other Debt

The Company had no capital notes or other debt outstanding at December 31, 2020 and 2019.

B. FHLB (Federal Home Loan Bank) Agreements

The Company had no FHLB agreements outstanding at December 31, 2020 and 2019.

C. All Other Debt

The Company had no other debt outstanding at December 31, 2020 and 2019.

12. Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans

A. Defined Benefit Plan

Not applicable - See Note 12G.

B. Not applicable - See Note 12G.

C. Not applicable - See Note 12G.

D. Not applicable - See Note 12G.

E. Defined Contribution Plans

Not applicable - See Note 12G..

F. Multiemployer Plans

The Company does not participate in a multiemployer plan.

G. Consolidated/Holding Company Plans

Not applicable.

H. Post Employment Benefits and Compensated Absences

Not applicable..

I. Impact of Medicare Modernization Act on Postretirement Benefits (INT 04-17)

Not applicable.

13. Capital and Surplus, Shareholders' Dividend Restrictions and Quasi-Reorganizations

A. Outstanding Shares

As of December 31, 2020, the Company has 1000 shares of $1 par value common stock authorized, issued and outstanding.

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NOTES TO FINANCIAL STATEMENTS

B. Preferred Stock

The Company has no preferred stock outstanding.

C. Dividend Restrictions

Under Mississippi law, the amount of ordinary dividends a domestic insurer is permitted to pay is limited to an amount not exceeding the greater of net income or 10% of statutory surplus at the end of the preceding year as long as the Company's unassigned surplus is positive.

D. Dividends Paid

See Footnote 10B.

E. Maximum Ordinary Dividend During 2021

Within the limitations of (3) above, the Company may pay dividends of $46,294 during 2021 without prior approval.

F. Unassigned Surplus Restrictions

Unassigned surplus funds are not restricted at December 31, 2019.

G. Mutual Surplus Advances

Not applicable.

H. Company Stock Held for Special Purpose

There are no shares of stock held for special purposes at December 31, 2020.

I. Changes in Special Surplus Funds

There are no special surplus funds at December 31, 2020.

J. Changes in Unassigned Funds

There was no portion of unassigned funds represented by cumulative unrealized investment gains and losses at December 31, 2020.

K. Surplus Notes

The Company has not issued any surplus notes or debentures or similar obligations.

L. Restatement due to Prior Quasi-reorganizations

The Company had no restatements due to prior quasi-reorganizations.

M. Quasi-reorganizations over Prior 10 Years

The Company has not been involved in a quasi-reorganization during the past 10 years.

14. Liabilities, Contingencies and Assessments

A. Contingent Commitments

The Company had no contingent commitments at December 31, 2020 or 2019.

ANNUAL STATEMENT FOR THE YEAR 2020 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

B. Assessments

(1) The Company is subject to guaranty fund and other assessments by the state in which it writes business. Guaranty fund assessments are accrued at the time of insolvencies. Other assessments are accrued either at the time of the assessment or at the time the losses are incurred.

(2) Not applicable.

(3) Not applicable.

C. Gain Contingencies

The Company has no gain contingencies at December 31, 2020 or 2019.

D. Claims-Related Extra Contractual Obligation and the Bad Faith Losses Stemming From Lawsuits

Not applicable.

E. Joint and Several Liabilities

Not applicable.

F. All Other Contingencies

From time to time, the Company is party to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. The Company, like HMOs and health insurers generally, excludes certain healthcare and other services from coverage under our HMO, PPO, and other plans. The Company is, in the ordinary course of business, subject to the claims of our enrollees arising out of decisions to restrict or deny reimbursement for uncovered services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on the Company. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable reimbursement of coverage claims.

The Company is involved in pending and threatened litigation of the character incidental to the business transacted, arising out of its operations and is from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits and reviews and administrative proceedings include routine and special investigations by state insurance departments, state attorneys general, the U.S. Attorney General and subcommittees of the U.S. Congress. Such investigations, audits, reviews and administrative proceedings could result in the imposition of civil or criminal fines, penalties, other sanctions and additional rules, regulations or other restrictions on the Company's business operations. Any liability that may result from any one of these actions, or in the aggregate, could have a material adverse effect on the Company's financial position or results of operations.

The Company has no other known material contingencies.

15. Leases

A. Lessee Operating Lease

The Company has no lessee leasing arrangements.

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B. Lessor Leases

(1) The Company has not entered into any operating leases.

(2) The Company has not entered into any leveraged leases.

16. Information About Financial Instruments With Off-Balance Sheet Risk and Financial Instruments With Concentrations of Credit Risk

The Company has no significant financial instruments with off-balance sheet risk.

Financial instruments that potentially subject the Company to concentrations of credit risk consist primarily of investment securities. All investment securities are managed by professional investment managers within policies authorized by the board of directors. Such policies limit the amounts that may be invested in any one issuer and prescribe certain investee company criteria. As of December 31, 2020, there were no significant concentrations.

17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

A. Transfers of Receivables Reported as Sales

Not applicable at December 31, 2020 and 2019.

B. Transfer and Servicing of Financial Assets

Not applicable at December 31, 2020 and 2019.

C. Wash Sales

(1) In the course of the Company's asset management, securities may be sold and reacquired within 30 days of the sale date to enhance the yield on the investments.

(2) At December 31, 2020 and 2019, there were no wash sales involving securities with an NAIC designation of 3 or below or unrated.

18. Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans

A. Administrative Services Only ("ASO") Plans

Not applicable at December 31, 2020.

B. Administrative Services Contract ("ASC") Plans

Not applicable at December 31, 2020.

C. Medicare or Other Similarly Structured Cost-Based Reimbursement Contract

Not applicable at December 31, 2020 and 2019.

19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

No premiums were written by managing general agents or third party administrators during the years ended December 31, 2020 and 2019.

ANNUAL STATEMENT FOR THE YEAR 2020 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

20. Fair Value Measurements

A. There are no assets or liabilities measured at fair value as of December 31, 2020 and 2019.

B. Fair Value Measurements Under Other Accounting Pronouncements

Not applicable at December 31, 2020 and 2019.

C. Financial Instruments

Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
Bonds	$ 598,270	$ 552,332	$ —	$ 598,270	$ —	$ —	$ —

D. Not Practicable to Estimate Fair Value

There are no financial instruments that were not practicable to estimate fair value.

E. Investments Measured at Net Asset Value

The Company has no investments measured at net asset value.

21. Other Items

A. Unusual or Infrequent Items

The spread of the COVID-19 virus caused significant financial market volatility, economic uncertainty, and interruptions to normal business activities. The ultimate impact to the Company is unknown, but management expects continued interruptions to day-to-day business activities, impacts to claim and premium activity, investment values, as well as possible impacts to liquidity.

B. Troubled Debt Restructuring: Debtors

Not applicable at December 31, 2020 and 2019.

C. Other Disclosures

Assets in the amount of $552,332 and $564,032 at December 31, 2020 and 2019, respectively, were on deposit with government authorities or trustees as required by law.

D. Business Interruption Insurance Recoveries

The Company has reported no recoveries for business interruption for the years ended December 31, 2020 and 2019.

E. State Transferable and Non-Transferable Tax Credits

The Company did not have state transferable or non-transferable tax credits at December 31, 2020 and 2019.

ANNUAL STATEMENT FOR THE YEAR 2020 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

F. Subprime Mortgage-Related Risk Exposure

(1) The Company's investment strategy of providing safety and preservation of capital, sufficient liquidity to meet cash flow requirements and the attainment of a competitive after-tax investment return is supported by a well diversified portfolio consisting of many different types of investments. The portion of the Company's investment portfolio with subprime mortgage-related risk exposure is relatively small in comparison to the overall investment portfolio, and consists mainly of investment grade securities with no exposure to collateralized debt obligations. All mortgage related investments are monitored closely as part of the quarterly investment review performed by the Anthem Investment Impairment Review Committee.

(2) The Company did not carry investments in subprime mortgage loans in its portfolio at December 31, 2020 or 2019.

(3) The Company did not have subprime mortgage-related risk exposure at December 31, 2020 or 2019.

(4) The Company did not underwrite Mortgage Guaranty or Financial Guaranty insurance coverage at December 31, 2020 or 2019.

G. Retained Assets

The Company does not have retained assets at December 31, 2020 and 2019.

H. Insurance-Linked Securities Contracts

Not applicable.

I. The Amount That Could Be Realized on Life Insurance Where the Reporting Entity is Owner and Beneficiary or Has Otherwise Obtained Rights to Control the Policy

Not applicable.

22. Events Subsequent

The Company did not have any ACA health insurer fee assessable premium in 2020 and 2019.

Subsequent events have been considered through February 26, 2021 for the statutory statement issued on February 26, 2021. There were no events occurring subsequent to December 31, 2020 requiring recognition or disclosure.

23. Reinsurance

A. Ceded Reinsurance Report

Section 1 - General Interrogatories

(A) Are any of the reinsurers that are listed in Schedule S as non-affiliated owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?

Yes ( ) No (X)

If yes, give full details.

ANNUAL STATEMENT FOR THE YEAR 2020 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

(B) Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. Branches of such companies) that is owned in excess of 10% or controlled, directly or indirectly, by an insured, a beneficiary, a creditor or an insured or any other person not primarily engaged in the insurance business?

Yes ( ) No (X)

If yes, give full details.

Section 2 - Ceded Reinsurance Report - Part A

(A) Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credits?

Yes ( ) No (X)

If yes, give full details.

(B) Does the reporting entity have any reinsurance agreements in effect such that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premium collected under the reinsured policies?

Yes ( ) No (X)

If yes, give full details.

Section 3 - Ceded Reinsurance Report - Part B

(A) What is the estimated amount of the aggregate reduction in surplus, (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2 above) of termination of ALL reinsurance agreements, by either party, as of the date of this statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

$0

(B) Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had existing reserves established by the Company as of the effective date of the agreement?

Yes ( ) No (X)

If yes, give full details.

B. Uncollectible Reinsurance

The Company has no uncollectible reinsurance at December 31, 2020 and 2019.

C. Commutation of Ceded Reinsurance

The Company has not commuted ceded reinsurance during 2020 and 2019.

ANNUAL STATEMENT FOR THE YEAR 2020 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

D. Certified Reinsurer Rating Downgraded or Status Subject Revocation

The Company has no downgraded certified reinsurer ratings or status subject to revocations during 2020 and 2019.

E. Reinsurance Credit

(1) Not applicable.

(2) Not applicable.

(3) Not applicable.

(4) Not applicable.

(5) Not applicable.

(6) Not applicable.

24. Retrospectively Rated Contracts & Contracts Subject to Redetermination

A. Not applicable.

B. Not applicable.

C. Not applicable.

D. Not applicable**.**

E. Risk-Sharing Provisions of the ACA

(1) Did the reporting entity write accident and health insurance premium that is subject to the Affordable Care Act risk-sharing provisions (YES/NO)? ___No__

(2) Impact of Risk-Sharing Provisions of the Affordable Care Act on Admitted Assets, Liabilities and Revenue for the Current Year

Not applicable.

(3) Roll-forward of prior year ACA risk-sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reasons for adjustments to prior year balance.

Not applicable.

(4) Roll-forward of Risk Corridors Asset and Liability Balances by Program Benefit Year.

Not applicable.

(5) ACA Risk Corridors Receivable as of Reporting Date.

Not applicable.

25. Change in Incurred Claims and Claim Adjustment Expenses

Not applicable at December 31, 2020 and 2019.

ANNUAL STATEMENT FOR THE YEAR 2020 OF AMERIGROUP MISSISSIPPI, INC.

NOTES TO FINANCIAL STATEMENTS

26. Intercompany Pooling Arrangements

Not applicable at December 31, 2020 and 2019.

27. Structured Settlements

Not applicable at December 31, 2020 and 2019.

28. Health Care Receivables

A. Pharmaceutical Rebate Receivables

Not applicable at December 31, 2019 and 2018.

B. Risk Sharing Receivables

Not applicable at December 31, 2020 and 2019.

29. Participating Policies

Not applicable at December 31, 2020 and 2019.

30. Premium Deficiency Reserves

1. Liability carried for premium deficiency reserves	$		—
2. Date of the most recent evaluation of this liability			December 31, 2020
3. Was anticipated investment income utilized in the calculation?	Yes	No	X

The Company had no liabilities related to premium deficiency reserves as of December 31, 2020 and 2019.

31. Anticipated Salvage and Subrogation

Not applicable at December 31, 2020 and 2019.

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES
GENERAL

1.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? ..... Yes [X] No [ ]
If yes, complete Schedule Y, Parts 1, 1A and 2

1.2 If yes, did the reporting entity register and file with its domiciliary State Insurance Commissioner, Director or Superintendent, or with such regulatory official of the state of domicile of the principal insurer in the Holding Company System, a registration statement providing disclosure substantially similar to the standards adopted by the National Association of Insurance Commissioners (NAIC) in its Model Insurance Holding Company System Regulatory Act and model regulations pertaining thereto, or is the reporting entity subject to standards and disclosure requirements substantially similar to those required by such Act and regulations? ..... Yes [X] No [ ] N/A [ ]

1.3 State Regulating? ..... Mississippi

1.4 Is the reporting entity publicly traded or a member of a publicly traded group? ..... Yes [X] No [ ]

1.5 If the response to 1.4 is yes, provide the CIK (Central Index Key) code issued by the SEC for the entity/group. 0001156039

2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? ..... Yes [ ] No [X]

2.2 If yes, date of change: .....

3.1 State as of what date the latest financial examination of the reporting entity was made or is being made. 12/31/2017

3.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released. 12/31/2017

3.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date). 06/20/2019

3.4 By what department or departments?
Mississippi Department of Insurance .....

3.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with Departments? ..... Yes [ ] No [ ] N/A [X]

3.6 Have all of the recommendations within the latest financial examination report been complied with? ..... Yes [ ] No [ ] N/A [X]

4.1 During the period covered by this statement, did any agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the reporting entity), receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
4.11 sales of new business? ..... Yes [ ] No [X]
4.12 renewals? ..... Yes [ ] No [X]

4.2 During the period covered by this statement, did any sales/service organization owned in whole or in part by the reporting entity or an affiliate, receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
4.21 sales of new business? ..... Yes [ ] No [X]
4.22 renewals? ..... Yes [ ] No [X]

5.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? ..... Yes [ ] No [X]
If yes, complete and file the merger history data file with the NAIC.

5.2 If yes, provide the name of the entity, NAIC Company Code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1 Name of Entity	2 NAIC Company Code	3 State of Domicile

6.1 Has the reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? ..... Yes [ ] No [X]

6.2 If yes, give full information:
.....

7.1 Does any foreign (non-United States) person or entity directly or indirectly control 10% or more of the reporting entity? ..... Yes [ ] No [X]

7.2 If yes,
7.21 State the percentage of foreign control; ..... %
7.22 State the nationality(s) of the foreign person(s) or entity(s) or if the entity is a mutual or reciprocal, the nationality of its manager or attorney-in-fact; and identify the type of entity(s) (e.g., individual, corporation or government, manager or attorney in fact).

1 Nationality	2 Type of Entity

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

GENERAL INTERROGATORIES

8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board? Yes [ ] No [X]

8.2 If response to 8.1 is yes, please identify the name of the bank holding company.

8.3 Is the company affiliated with one or more banks, thrifts or securities firms? Yes [ ] No [X]

8.4 If response to 8.3 is yes, please provide below the names and location (city and state of the main office) of any affiliates regulated by a federal regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 FDIC	6 SEC

9. What is the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit?
N/A - The Company has received an exemption by the Mississippi Department of Insurance from filing the Audited Financial Statement for the year ended December 31, 2020.

10.1 Has the insurer been granted any exemptions to the prohibited non-audit services provided by the certified independent public accountant requirements as allowed in Section 7H of the Annual Financial Reporting Model Regulation (Model Audit Rule), or substantially similar state law or regulation? Yes [ ] No [X]

10.2 If the response to 10.1 is yes, provide information related to this exemption:

10.3 Has the insurer been granted any exemptions related to the other requirements of the Annual Financial Reporting Model Regulation as allowed for in Section 18A of the Model Regulation, or substantially similar state law or regulation? Yes [ ] No [X]

10.4 If the response to 10.3 is yes, provide information related to this exemption:

10.5 Has the reporting entity established an Audit Committee in compliance with the domiciliary state insurance laws? Yes [X] No [ ] N/A [ ]

10.6 If the response to 10.5 is no or n/a, please explain

11. What is the name, address and affiliation (officer/employee of the reporting entity or actuary/consultant associated with an actuarial consulting firm) of the individual providing the statement of actuarial opinion/certification?
N/A - The Company has received an exemption by the Mississippi Department of Insurance from filing the Actuarial Opinion for the year ended December 31, 2020.

12.1 Does the reporting entity own any securities of a real estate holding company or otherwise hold real estate indirectly? Yes [ ] No [X]

12.11 Name of real estate holding company

12.12 Number of parcels involved

12.13 Total book/adjusted carrying value $

12.2 If, yes provide explanation:

13. **FOR UNITED STATES BRANCHES OF ALIEN REPORTING ENTITIES ONLY:**

13.1 What changes have been made during the year in the United States manager or the United States trustees of the reporting entity?

13.2 Does this statement contain all business transacted for the reporting entity through its United States Branch on risks wherever located? Yes [ ] No [ ]

13.3 Have there been any changes made to any of the trust indentures during the year? Yes [ ] No [ ]

13.4 If answer to (13.3) is yes, has the domiciliary or entry state approved the changes? Yes [ ] No [ ] N/A [ ]

14.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards? Yes [X] No [ ]
a. Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
b. Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;
c. Compliance with applicable governmental laws, rules and regulations;
d. The prompt internal reporting of violations to an appropriate person or persons identified in the code; and
e. Accountability for adherence to the code.

14.11 If the response to 14.1 is No, please explain:

14.2 Has the code of ethics for senior managers been amended? Yes [ ] No [X]

14.21 If the response to 14.2 is yes, provide information related to amendment(s).

14.3 Have any provisions of the code of ethics been waived for any of the specified officers? Yes [ ] No [X]

14.31 If the response to 14.3 is yes, provide the nature of any waiver(s).

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

GENERAL INTERROGATORIES

15.1 Is the reporting entity the beneficiary of a Letter of Credit that is unrelated to reinsurance where the issuing or confirming bank is not on the SVO Bank List? Yes [ ] No [X]

15.2 If the response to 15.1 is yes, indicate the American Bankers Association (ABA) Routing Number and the name of the issuing or confirming bank of the Letter of Credit and describe the circumstances in which the Letter of Credit is triggered.

1 American Bankers Association (ABA) Routing Number	2 Issuing or Confirming Bank Name	3 Circumstances That Can Trigger the Letter of Credit	4 Amount

BOARD OF DIRECTORS

16. Is the purchase or sale of all investments of the reporting entity passed upon either by the board of directors or a subordinate committee thereof? Yes [X] No [ ]

17. Does the reporting entity keep a complete permanent record of the proceedings of its board of directors and all subordinate committees thereof? Yes [X] No [ ]

18. Has the reporting entity an established procedure for disclosure to its board of directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict with the official duties of such person? Yes [X] No [ ]

FINANCIAL

19. Has this statement been prepared using a basis of accounting other than Statutory Accounting Principles (e.g., Generally Accepted Accounting Principles)? Yes [ ] No [X]

20.1 Total amount loaned during the year (inclusive of Separate Accounts, exclusive of policy loans):
- 20.11 To directors or other officers $ 0
- 20.12 To stockholders not officers $ 0
- 20.13 Trustees, supreme or grand (Fraternal Only) $ 0

20.2 Total amount of loans outstanding at the end of year (inclusive of Separate Accounts, exclusive of policy loans):
- 20.21 To directors or other officers $ 0
- 20.22 To stockholders not officers $ 0
- 20.23 Trustees, supreme or grand (Fraternal Only) $ 0

21.1 Were any assets reported in this statement subject to a contractual obligation to transfer to another party without the liability for such obligation being reported in the statement? Yes [ ] No [X]

21.2 If yes, state the amount thereof at December 31 of the current year:
- 21.21 Rented from others $ 0
- 21.22 Borrowed from others $ 0
- 21.23 Leased from others $ 0
- 21.24 Other $ 0

22.1 Does this statement include payments for assessments as described in the Annual Statement Instructions other than guaranty fund or guaranty association assessments? Yes [ ] No [X]

22.2 If answer is yes:
- 22.21 Amount paid as losses or risk adjustment $ 0
- 22.22 Amount paid as expenses $ 0
- 22.23 Other amounts paid $ 0

23.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? Yes [ ] No [X]

23.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: $

INVESTMENT

24.01 Were all the stocks, bonds and other securities owned December 31 of current year, over which the reporting entity has exclusive control, in the actual possession of the reporting entity on said date? (other than securities lending programs addressed in 24.03) Yes [X] No [ ]

24.02 If no, give full and complete information relating thereto

24.03 For securities lending programs, provide a description of the program including value for collateral and amount of loaned securities, and whether collateral is carried on or off-balance sheet. (an alternative is to reference Note 17 where this information is also provided)

24.04 For the reporting entity's securities lending program, report amount of collateral for conforming programs as outlined in the Risk-Based Capital Instructions. $

24.05 For the reporting entity's securities lending program, report amount of collateral for other programs. $

24.06 Does your securities lending program require 102% (domestic securities) and 105% (foreign securities) from the counterparty at the outset of the contract? Yes [ ] No [ ] N/A [X]

24.07 Does the reporting entity non-admit when the collateral received from the counterparty falls below 100%? Yes [ ] No [ ] N/A [X]

24.08 Does the reporting entity or the reporting entity 's securities lending agent utilize the Master Securities lending Agreement (MSLA) to conduct securities lending? Yes [ ] No [ ] N/A [X]

GENERAL INTERROGATORIES

24.09 For the reporting entity's securities lending program state the amount of the following as of December 31 of the current year:

24.091 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2. $ 0
24.092 Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2 $ 0
24.093 Total payable for securities lending reported on the liability page. $ 0

25.1 Were any of the stocks, bonds or other assets of the reporting entity owned at December 31 of the current year not exclusively under the control of the reporting entity, or has the reporting entity sold or transferred any assets subject to a put option contract that is currently in force? (Exclude securities subject to Interrogatory 21.1 and 24.03). Yes [X] No [ ]

25.2 If yes, state the amount thereof at December 31 of the current year:

25.21 Subject to repurchase agreements $
25.22 Subject to reverse repurchase agreements $
25.23 Subject to dollar repurchase agreements $
25.24 Subject to reverse dollar repurchase agreements $
25.25 Placed under option agreements $
25.26 Letter stock or securities restricted as to sale - excluding FHLB Capital Stock $
25.27 FHLB Capital Stock $
25.28 On deposit with states $ 552,332
25.29 On deposit with other regulatory bodies $
25.30 Pledged as collateral - excluding collateral pledged to an FHLB $
25.31 Pledged as collateral to FHLB - including assets backing funding agreements $
25.32 Other $

25.3 For category (25.26) provide the following:

1 Nature of Restriction	2 Description	3 Amount

26.1 Does the reporting entity have any hedging transactions reported on Schedule DB? Yes [ ] No [X]

26.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? Yes [ ] No [ ] N/A [ ]
If no, attach a description with this statement.

LINES 26.3 through 26.5: FOR LIFE/FRATERNAL REPORTING ENTITIES ONLY:

26.3 Does the reporting entity utilize derivatives to hedge variable annuity guarantees subject to fluctuations as a result of interest rate sensitivity? Yes [ ] No [X]

26.4 If the response to 26.3 is YES, does the reporting entity utilize:
26.41 Special accounting provision of SSAP No. 108 Yes [ ] No [ ]
26.42 Permitted accounting practice Yes [ ] No [ ]
26.43 Other accounting guidance Yes [ ] No [ ]

26.5 By responding YES to 26.41 regarding utilizing the special accounting provisions of SSAP No. 108, the reporting entity attests to the following: Yes [ ] No [ ]

- The reporting entity has obtained explicit approval from the domiciliary state.
- Hedging strategy subject to the special accounting provisions is consistent with the requirements of VM-21.
- Actuarial certification has been obtained which indicates that the hedging strategy is incorporated within the establishment of VM-21 reserves and provides the impact of the hedging strategy within the Actuarial Guideline Conditional Tail Expectation Amount.
- Financial Officer Certification has been obtained which indicates that the hedging strategy meets the definition of a Clearly Defined Hedging Strategy within VM-21 and that the Clearly Defined Hedging Strategy is the hedging strategy being used by the company in its actual day-to-day risk mitigation efforts.

27.1 Were any preferred stocks or bonds owned as of December 31 of the current year mandatorily convertible into equity, or, at the option of the issuer, convertible into equity? Yes [ ] No [X]

27.2 If yes, state the amount thereof at December 31 of the current year. $

28. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook? Yes [X] No [ ]

28.01 For agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1 Name of Custodian(s)	2 Custodian's Address
JP Morgan Chase Bank, N.A	383 Madison Ave, New York, NY 10179

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

GENERAL INTERROGATORIES

28.02 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)

28.03 Have there been any changes, including name changes, in the custodian(s) identified in 28.01 during the current year? Yes [ ] No [X]

28.04 If yes, give full and complete information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

28.05 Investment management – Identify all investment advisors, investment managers, broker/dealers, including individuals that have the authority to make investment decisions on behalf of the reporting entity. For assets that are managed internally by employees of the reporting entity, note as such. ["…that have access to the investment accounts"; "…handle securities"]

1 Name of Firm or Individual	2 Affiliation
Loomis, Sayles & Company, LP	U

28.0597 For those firms/individuals listed in the table for Question 28.05, do any firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") manage more than 10% of the reporting entity's invested assets? Yes [X] No [ ]

28.0598 For firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") listed in the table for Question 28.05, does the total assets under management aggregate to more than 50% of the reporting entity's invested assets? Yes [ ] No [X]

28.06 For those firms or individuals listed in the table for 28.05 with an affiliation code of "A" (affiliated) or "U" (unaffiliated), provide the information for the table below.

1 Central Registration Depository Number	2 Name of Firm or Individual	3 Legal Entity Identifier (LEI)	4 Registered With	5 Investment Management Agreement (IMA) Filed
105377	Loomis, Sayles & Company, LP	JIZPN2RX3UMN0YIDI313	Securities Exchange Commission	NO

29.1 Does the reporting entity have any diversified mutual funds reported in Schedule D, Part 2 (diversified according to the Securities and Exchange Commission (SEC) in the Investment Company Act of 1940 [Section 5(b)(1)])? Yes [ ] No [X]

29.2 If yes, complete the following schedule:

1 CUSIP #	2 Name of Mutual Fund	3 Book/Adjusted Carrying Value
29.2999 - Total		0

29.3 For each mutual fund listed in the table above, complete the following schedule:

1 Name of Mutual Fund (from above table)	2 Name of Significant Holding of the Mutual Fund	3 Amount of Mutual Fund's Book/Adjusted Carrying Value Attributable to the Holding	4 Date of Valuation

GENERAL INTERROGATORIES

30. Provide the following information for all short-term and long-term bonds and all preferred stocks. Do not substitute amortized value or statement value for fair value.

	1 Statement (Admitted) Value	2 Fair Value	3 Excess of Statement over Fair Value (-), or Fair Value over Statement (+)
30.1 Bonds	552,332	598,270	45,938
30.2 Preferred stocks	0		0
30.3 Totals	552,332	598,270	45,938

30.4 Describe the sources or methods utilized in determining the fair values:
Fair values were obtained from third-party pricing sources. If a security was not priced by a third-party pricing source, internal analytical systems or broker quotes were utilized.

31.1 Was the rate used to calculate fair value determined by a broker or custodian for any of the securities in Schedule D? Yes [ ] No [X]

31.2 If the answer to 31.1 is yes, does the reporting entity have a copy of the broker's or custodian's pricing policy (hard copy or electronic copy) for all brokers or custodians used as a pricing source? Yes [ ] No [ ]

31.3 If the answer to 31.2 is no, describe the reporting entity's process for determining a reliable pricing source for purposes of disclosure of fair value for Schedule D:
N/A

32.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed? Yes [X] No [ ]
32.2 If no, list exceptions:

33. By self-designating 5GI securities, the reporting entity is certifying the following elements of each self-designated 5GI security:
a. Documentation necessary to permit a full credit analysis of the security does not exist or an NAIC CRP credit rating for an FE or PL security is not available.
b. Issuer or obligor is current on all contracted interest and principal payments.
c. The insurer has an actual expectation of ultimate payment of all contracted interest and principal.
Has the reporting entity self-designated 5GI securities? Yes [ ] No [X]

34. By self-designating PLGI securities, the reporting entity is certifying the following elements of each self-designated PLGI security:
a. The security was purchased prior to January 1, 2018.
b. The reporting entity is holding capital commensurate with the NAIC Designation reported for the security.
c. The NAIC Designation was derived from the credit rating assigned by an NAIC CRP in its legal capacity as a NRSRO which is shown on a current private letter rating held by the insurer and available for examination by state insurance regulators.
d. The reporting entity is not permitted to share this credit rating of the PL security with the SVO.
Has the reporting entity self-designated PLGI securities? Yes [ ] No [X]

35. By assigning FE to a Schedule BA non-registered private fund, the reporting entity is certifying the following elements of each self-designated FE fund:
a. The shares were purchased prior to January 1, 2019.
b. The reporting entity is holding capital commensurate with the NAIC Designation reported for the security.
c. The security had a public credit rating(s) with annual surveillance assigned by an NAIC CRP in its legal capacity as an NRSRO prior to January 1, 2019.
d. The fund only or predominantly holds bonds in its portfolio.
e. The current reported NAIC Designation was derived from the public credit rating(s) with annual surveillance assigned by an NAIC CRP in its legal capacity as an NRSRO.
f. The public credit rating(s) with annual surveillance assigned by an NAIC CRP has not lapsed.
Has the reporting entity assigned FE to Schedule BA non-registered private funds that complied with the above criteria? Yes [ ] No [X]

36. By rolling/renewing short-term or cash equivalent investments with continued reporting on Schedule DA, Part 1 or Schedule E Part 2 (identified through a code (%) in those investment schedules), the reporting entity is certifying to the following:
a. The investment is a liquid asset that can be terminated by the reporting entity on the current maturity date.
b. If the investment is with a nonrelated party or nonaffiliate, then it reflects an arms-length transaction with renewal completed at the discretion of all involved parties.
c. If the investment is with a related party or affiliate, then the reporting entity has completed robust re-underwriting of the transaction for which documentation is available for regulator review.
d. Short-term and cash equivalent investments that have been renewed/rolled from the prior period that do not meet the criteria in 36.a - 36.c are reported as long-term investments.
Has the reporting entity rolled/renewed short-term or cash equivalent investments in accordance with these criteria? Yes [ ] No [X] N/A [ ]

GENERAL INTERROGATORIES

OTHER

37.1 Amount of payments to trade associations, service organizations and statistical or rating bureaus, if any? $ 0

37.2 List the name of the organization and the amount paid if any such payment represented 25% or more of the total payments to trade associations, service organizations and statistical or rating bureaus during the period covered by this statement.

1 Name	2 Amount Paid

38.1 Amount of payments for legal expenses, if any? $ 0

38.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payments for legal expenses during the period covered by this statement.

1 Name	2 Amount Paid

39.1 Amount of payments for expenditures in connection with matters before legislative bodies, officers or departments of government, if any? $ 0

39.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payment expenditures in connection with matters before legislative bodies, officers or departments of government during the period covered by this statement.

1 Name	2 Amount Paid

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

GENERAL INTERROGATORIES

PART 2 - HEALTH INTERROGATORIES

1.1 Does the reporting entity have any direct Medicare Supplement Insurance in force? Yes [ ] No [X]
1.2 If yes, indicate premium earned on U.S. business only. $
1.3 What portion of Item (1.2) is not reported on the Medicare Supplement Insurance Experience Exhibit? $
1.31 Reason for excluding

1.4 Indicate amount of earned premium attributable to Canadian and/or Other Alien not included in Item (1.2) above $
1.5 Indicate total incurred claims on all Medicare Supplement Insurance. $ 0
1.6 Individual policies:

Most current three years:
1.61 Total premium earned $ 0
1.62 Total incurred claims $ 0
1.63 Number of covered lives 0
All years prior to most current three years:
1.64 Total premium earned $ 0
1.65 Total incurred claims $ 0
1.66 Number of covered lives 0

1.7 Group policies:

Most current three years:
1.71 Total premium earned $ 0
1.72 Total incurred claims $ 0
1.73 Number of covered lives 0
All years prior to most current three years:
1.74 Total premium earned $ 0
1.75 Total incurred claims $ 0
1.76 Number of covered lives 0

2. Health Test:

		1 Current Year	2 Prior Year
2.1	Premium Numerator		
2.2	Premium Denominator	0	
2.3	Premium Ratio (2.1/2.2)	0.000	0.000
2.4	Reserve Numerator		
2.5	Reserve Denominator	0	0
2.6	Reserve Ratio (2.4/2.5)	0.000	0.000

3.1 Has the reporting entity received any endowment or gift from contracting hospitals, physicians, dentists, or others that is agreed will be returned when, as and if the earnings of the reporting entity permits? Yes [ ] No [X]

3.2 If yes, give particulars:

4.1 Have copies of all agreements stating the period and nature of hospitals', physicians', and dentists' care offered to subscribers and dependents been filed with the appropriate regulatory agency? Yes [ ] No [X]

4.2 If not previously filed, furnish herewith a copy(ies) of such agreement(s). Do these agreements include additional benefits offered? Yes [ ] No [X]

5.1 Does the reporting entity have stop-loss reinsurance? Yes [ ] No [X]

5.2 If no, explain:
Currently, there are no insurance operations for this Company.

5.3 Maximum retained risk (see instructions)

5.31 Comprehensive Medical $
5.32 Medical Only $
5.33 Medicare Supplement $
5.34 Dental & Vision $
5.35 Other Limited Benefit Plan $
5.36 Other $

6. Describe arrangement which the reporting entity may have to protect subscribers and their dependents against the risk of insolvency including hold harmless provisions, conversion privileges with other carriers, agreements with providers to continue rendering services, and any other agreements:
N/A.

7.1 Does the reporting entity set up its claim liability for provider services on a service date basis? Yes [ ] No [X]

7.2 If no, give details
Currently, there are no insurance operations for this Company.

8. Provide the following information regarding participating providers:

8.1 Number of providers at start of reporting year
8.2 Number of providers at end of reporting year

9.1 Does the reporting entity have business subject to premium rate guarantees? Yes [ ] No [X]

9.2 If yes, direct premium earned:

9.21 Business with rate guarantees between 15-36 months $
9.22 Business with rate guarantees over 36 months $

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

GENERAL INTERROGATORIES

10.1 Does the reporting entity have Incentive Pool, Withhold or Bonus Arrangements in its provider contracts? Yes [ ] No [X]

10.2 If yes:

10.21 Maximum amount payable bonuses $
10.22 Amount actually paid for year bonuses $
10.23 Maximum amount payable withholds $
10.24 Amount actually paid for year withholds $

11.1 Is the reporting entity organized as:

11.12 A Medical Group/Staff Model, Yes [ ] No [X]
11.13 An Individual Practice Association (IPA), or, Yes [ ] No [X]
11.14 A Mixed Model (combination of above)? Yes [ ] No [X]

11.2 Is the reporting entity subject to Statutory Minimum Capital and Surplus Requirements? Yes [X] No [ ]
11.3 If yes, show the name of the state requiring such minimum capital and surplus. Mississippi
11.4 If yes, show the amount required. $ 1,000,000
11.5 Is this amount included as part of a contingency reserve in stockholder's equity? Yes [ ] No [X]
11.6 If the amount is calculated, show the calculation

12. List service areas in which reporting entity is licensed to operate:

1 Name of Service Area

13.1 Do you act as a custodian for health savings accounts? Yes [ ] No [X]

13.2 If yes, please provide the amount of custodial funds held as of the reporting date. $

13.3 Do you act as an administrator for health savings accounts? Yes [ ] No [X]

13.4 If yes, please provide the balance of funds administered as of the reporting date. $

14.1 Are any of the captive affiliates reported on Schedule S, Part 3, authorized reinsurers? Yes [ ] No [ ] N/A [X]
14.2 If the answer to 14.1 is yes, please provide the following:

1 Company Name	2 NAIC Company Code	3 Domiciliary Jurisdiction	4 Reserve Credit	Assets Supporting Reserve Credit		
				5 Letters of Credit	6 Trust Agreements	7 Other

15. Provide the following for individual ordinary life insurance* policies (U.S. business only) for the current year (prior to reinsurance assumed or ceded):

15.1 Direct Premium Written $
15.2 Total Incurred Claims $
15.3 Number of Covered Lives

*Ordinary Life Insurance Includes
Term(whether full underwriting, limited underwriting, jet issue, "short form app")
Whole Life (whether full underwriting, limited underwriting, jet issue, "short form app")
Variable Life (with or without secondary gurarantee)
Universal Life (with or without secondary gurarantee)
Variable Universal Life (with or without secondary gurarantee)

16. Is the reporting entity licensed or chartered, registered, qualified, eligible or writing business in at least two states? Yes [ ] No [X]

16.1 If no, does the reporting entity assume reinsurance business that covers risks residing in at least one state other than the state of domicile of the reporting entity? Yes [ ] No [X]

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

FIVE-YEAR HISTORICAL DATA

	1 2020	2 2019	3 2018	4 2017	5 2016
Balance Sheet (Pages 2 and 3)					
1. Total admitted assets (Page 2, Line 28)	4,047,177	4,023,135	4,035,861	4,022,614	
2. Total liabilities (Page 3, Line 24)	883	143	1,289	8,624	
3. Statutory minimum capital and surplus requirement	1,000,000	1,000,000	1,000,000	1,500,000	
4. Total capital and surplus (Page 3, Line 33)	4,046,294	4,022,992	4,034,572	4,013,990	
Income Statement (Page 4)					
5. Total revenues (Line 8)	0	0	0	0	
6. Total medical and hospital expenses (Line 18)	0	0	0	0	
7. Claims adjustment expenses (Line 20)	0	0	0	0	
8. Total administrative expenses (Line 21)	132	532	2,341	0	
9. Net underwriting gain (loss) (Line 24)	(132)	(532)	(2,341)	0	
10. Net investment gain (loss) (Line 27)	4,501	4,740	23,955	16,276	
11. Total other income (Lines 28 plus 29)	0	0	0	0	
12. Net income or (loss) (Line 32)	6,261	5,462	20,582	13,999	
Cash Flow (Page 6)					
13. Net cash from operations (Line 11)	18,036	16,122	29,897	17,071	
Risk-Based Capital Analysis					
14. Total adjusted capital	4,046,294	4,022,992	4,034,572	4,013,990	
15. Authorized control level risk-based capital	9,080	9,119	9,178	20,958	
Enrollment (Exhibit 1)					
16. Total members at end of period (Column 5, Line 7)					
17. Total members months (Column 6, Line 7)					
Operating Percentage (Page 4) (Item divided by Page 4, sum of Lines 2, 3 and 5) x 100.0					
18. Premiums earned plus risk revenue (Line 2 plus Lines 3 and 5)	100.0	100.0	100.0	100.0	100.0
19. Total hospital and medical plus other non-health (Lines 18 plus Line 19)	0.0	0.0	0.0	0.0	
20. Cost containment expenses	0.0	0.0	0.0	0.0	
21. Other claims adjustment expenses	0.0	0.0	0.0	0.0	
22. Total underwriting deductions (Line 23)	0.0	0.0	0.0	0.0	
23. Total underwriting gain (loss) (Line 24)	0.0	0.0	0.0	0.0	
Unpaid Claims Analysis (U&I Exhibit, Part 2B)					
24. Total claims incurred for prior years (Line 13, Col. 5)					
25. Estimated liability of unpaid claims-[prior year (Line 13, Col. 6)]					
Investments In Parent, Subsidiaries and Affiliates					
26. Affiliated bonds (Sch. D Summary, Line 12, Col. 1)					
27. Affiliated preferred stocks (Sch. D Summary, Line 18, Col. 1)	0	0			
28. Affiliated common stocks (Sch. D Summary, Line 24, Col. 1)	0	0			
29. Affiliated short-term investments (subtotal included in Schedule DA Verification, Col. 5, Line 10)				0	
30. Affiliated mortgage loans on real estate					
31. All other affiliated					
32. Total of above Lines 26 to 31	0	0	0	0	0
33. Total investment in parent included in Lines 26 to 31 above.					

NOTE: If a party to a merger, have the two most recent years of this exhibit been restated due to a merger in compliance with the disclosure requirements of SSAP No. 3, Accounting Changes and Correction of Errors? Yes [ ] No [ ]

If no, please explain:

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION _____ 2. _____

(LOCATION)

NAIC Group Code BUSINESS IN THE STATE OF DURING THE YEAR 2020 NAIC Company Code

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3							
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other
Total Members at end of:										
1. Prior Year										
2. First Quarter										
3. Second Quarter										
4. Third Quarter										
5. Current Year										
6. Current Year Member Months										
Total Member Ambulatory Encounters for Year:										
7 Physician										
8. Non-Physician										
9. Total										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b)										
13. Life Premiums Direct										
14. Property/Casualty Premiums Written										
15. Health Premiums Earned										
16. Property/Casualty Premiums Earned										
17. Amount Paid for Provision of Health Care Services										
18 Amount Incurred for Provision of Health Care Services										

NONE

(a) For health business: number of persons insured under PPO managed care products ..... and number of persons insured under indemnity only products ..... .
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $ .....

30

Schedule S - Part 1 - Section 2

N O N E

Schedule S - Part 2

N O N E

Schedule S - Part 3 - Section 2

N O N E

Schedule S - Part 4

N O N E

Schedule S - Part 4 - Bank Footnote

N O N E

Schedule S - Part 5

N O N E

Schedule S - Part 5 - Bank Footnote

N O N E

Schedule S - Part 6

N O N E

Schedule S - Part 7

N O N E

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE T PREMIUMS AND OTHER CONSIDERATIONS

Allocated by States and Territories

		1	Direct Business Only							
			2	3	4	5	6	7	8	9
States, etc.		Active Status (a)	Accident & Health Premiums	Medicare Title XVIII	Medicaid Title XIX	Federal Employees Health Benefits Plan Premiums	Life & Annuity Premiums & Other Considerations	Property/ Casualty Premiums	Total Columns 2 Through 7	Deposit-Type Contracts
1. Alabama	AL	N							0	
2. Alaska	AK	N							0	
3. Arizona	AZ	N							0	
4. Arkansas	AR	N							0	
5. California	CA	N							0	
6. Colorado	CO	N							0	
7. Connecticut	CT	N							0	
8. Delaware	DE	N							0	
9. District of Columbia	DC	N							0	
10. Florida	FL	N							0	
11. Georgia	GA	N							0	
12. Hawaii	HI	N							0	
13. Idaho	ID	N							0	
14. Illinois	IL	N							0	
15. Indiana	IN	N							0	
16. Iowa	IA	N							0	
17. Kansas	KS	N							0	
18. Kentucky	KY	N							0	
19. Louisiana	LA	N							0	
20. Maine	ME	N							0	
21. Maryland	MD	N							0	
22. Massachusetts	MA	N							0	
23. Michigan	MI	N							0	
24. Minnesota	MN	N							0	
25. Mississippi	MS	L							0	
26. Missouri	MO	N							0	
27. Montana	MT	N							0	
28. Nebraska	NE	N							0	
29. Nevada	NV	N							0	
30. New Hampshire	NH	N							0	
31. New Jersey	NJ	N							0	
32. New Mexico	NM	N							0	
33. New York	NY	N							0	
34. North Carolina	NC	N							0	
35. North Dakota	ND	N							0	
36. Ohio	OH	N							0	
37. Oklahoma	OK	N							0	
38. Oregon	OR	N							0	
39. Pennsylvania	PA	N							0	
40. Rhode Island	RI	N							0	
41. South Carolina	SC	N							0	
42. South Dakota	SD	N							0	
43. Tennessee	TN	N							0	
44. Texas	TX	N							0	
45. Utah	UT	N							0	
46. Vermont	VT	N							0	
47. Virginia	VA	N							0	
48. Washington	WA	N							0	
49. West Virginia	WV	N							0	
50. Wisconsin	WI	N							0	
51. Wyoming	WY	N							0	
52. American Samoa	AS	N							0	
53. Guam	GU	N							0	
54. Puerto Rico	PR	N							0	
55. U.S. Virgin Islands	VI	N							0	
56. Northern Mariana Islands	MP	N							0	
57. Canada	CAN	N							0	
58. Aggregate other alien	OT	XXX	0	0	0	0	0	0	0	0
59. Subtotal		XXX	0	0	0	0	0	0	0	0
60. Reporting entity contributions for Employee Benefit Plans		XXX							0	
61. Total (Direct Business)		XXX	0	0	0	0	0	0	0	0
DETAILS OF WRITE-INS										
58001.		XXX								
58002.		XXX								
58003.		XXX								
58998. Summary of remaining write-ins for Line 58 from overflow page		XXX	0	0	0	0	0	0	0	0
58999. Totals (Lines 58001 through 58003 plus 58998)(Line 58 above)		XXX	0	0	0	0	0	0	0	0

(a) Active Status Counts:

L - Licensed or Chartered - Licensed insurance carrier or domiciled RRG 1
R - Registered - Non-domiciled RRGs 0
E - Eligible - Reporting entities eligible or approved to write surplus lines in the state 0
Q - Qualified - Qualified or accredited reinsurer 0
N - None of the above - Not allowed to write business in the state 56

(b) Explanation of basis of allocation by states, premiums by state, etc.
Situs of contract

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE T - PART 2

INTERSTATE COMPACT - EXHIBIT OF PREMIUMS WRITTEN

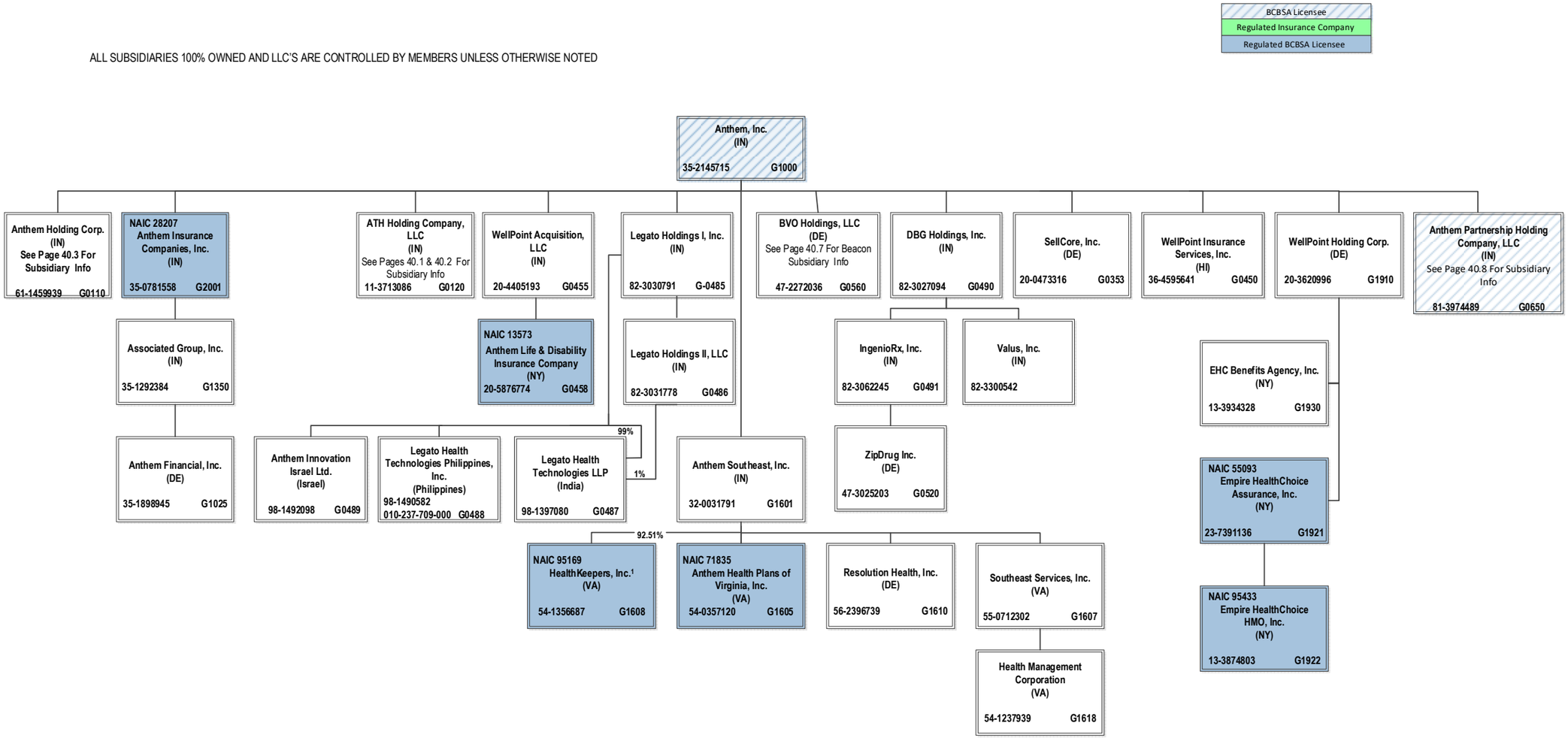
Allocated by States and Territories

		Direct Business Only					
	States, Etc.	1 Life (Group and Individual)	2 Annuities (Group and Individual)	3 Disability Income (Group and Individual)	4 Long-Term Care (Group and Individual)	5 Deposit-Type Contracts	6 Totals
1.	Alabama AL						
2.	Alaska AK						
3.	Arizona AZ						
4.	Arkansas AR						
5.	California CA						
6.	Colorado CO						
7.	Connecticut CT						
8.	Delaware DE						
9.	District of Columbia DC						
10.	Florida FL						
11.	Georgia GA						
12.	Hawaii HI						
13.	Idaho ID						
14.	Illinois IL						
15.	Indiana IN						
16.	Iowa IA						
17.	Kansas KS						
18.	Kentucky KY						
19.	Louisiana LA						
20.	Maine ME						
21.	Maryland MD						
22.	Massachusetts MA						
23.	Michigan MI						
24.	Minnesota MN						
25.	Mississippi MS						
26.	Missouri MO						
27.	Montana MT						
28.	Nebraska NE						
29.	Nevada NV						
30.	New Hampshire NH						
31.	New Jersey NJ						
32.	New Mexico NM						
33.	New York NY						
34.	North Carolina NC						
35.	North Dakota ND						
36.	Ohio OH						
37.	Oklahoma OK						
38.	Oregon OR						
39.	Pennsylvania PA						
40.	Rhode Island RI						
41.	South Carolina SC						
42.	South Dakota SD						
43.	Tennessee TN						
44.	Texas TX						
45.	Utah UT						
46.	Vermont VT						
47.	Virginia VA						
48.	Washington WA						
49.	West Virginia WV						
50.	Wisconsin WI						
51.	Wyoming WY						
52.	American Samoa AS						
53.	Guam GU						
54.	Puerto Rico PR						
55.	U.S. Virgin Islands VI						
56.	Northern Mariana Islands MP						
57.	Canada CAN						
58.	Aggregate Other Alien OT						
59.	Total						

NONE

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



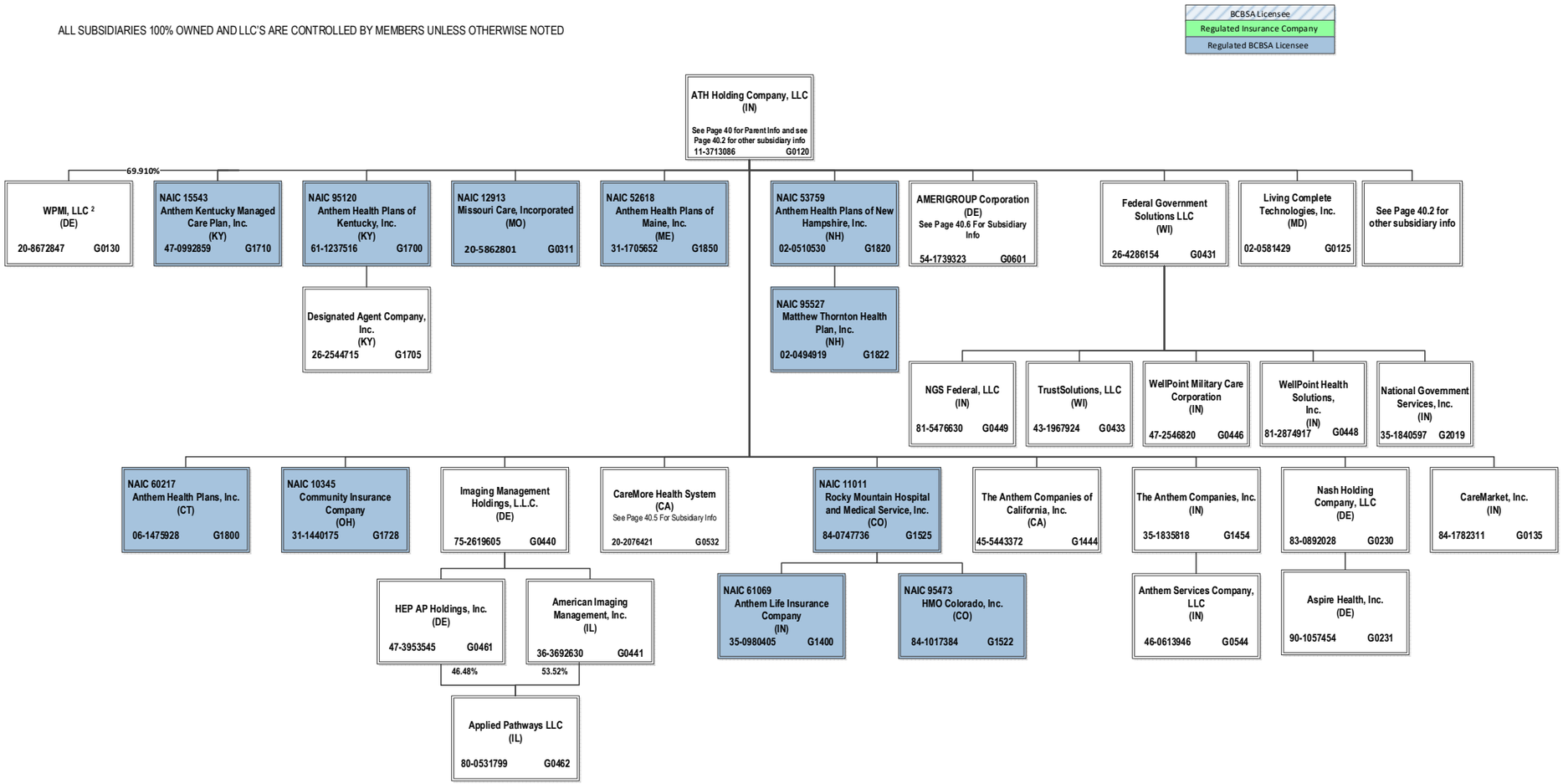
1 HealthKeepers, Inc. is owned 92.51% by Anthem Southeast, Inc. and 7.49% by UNICARE National Services, Inc.

40

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED



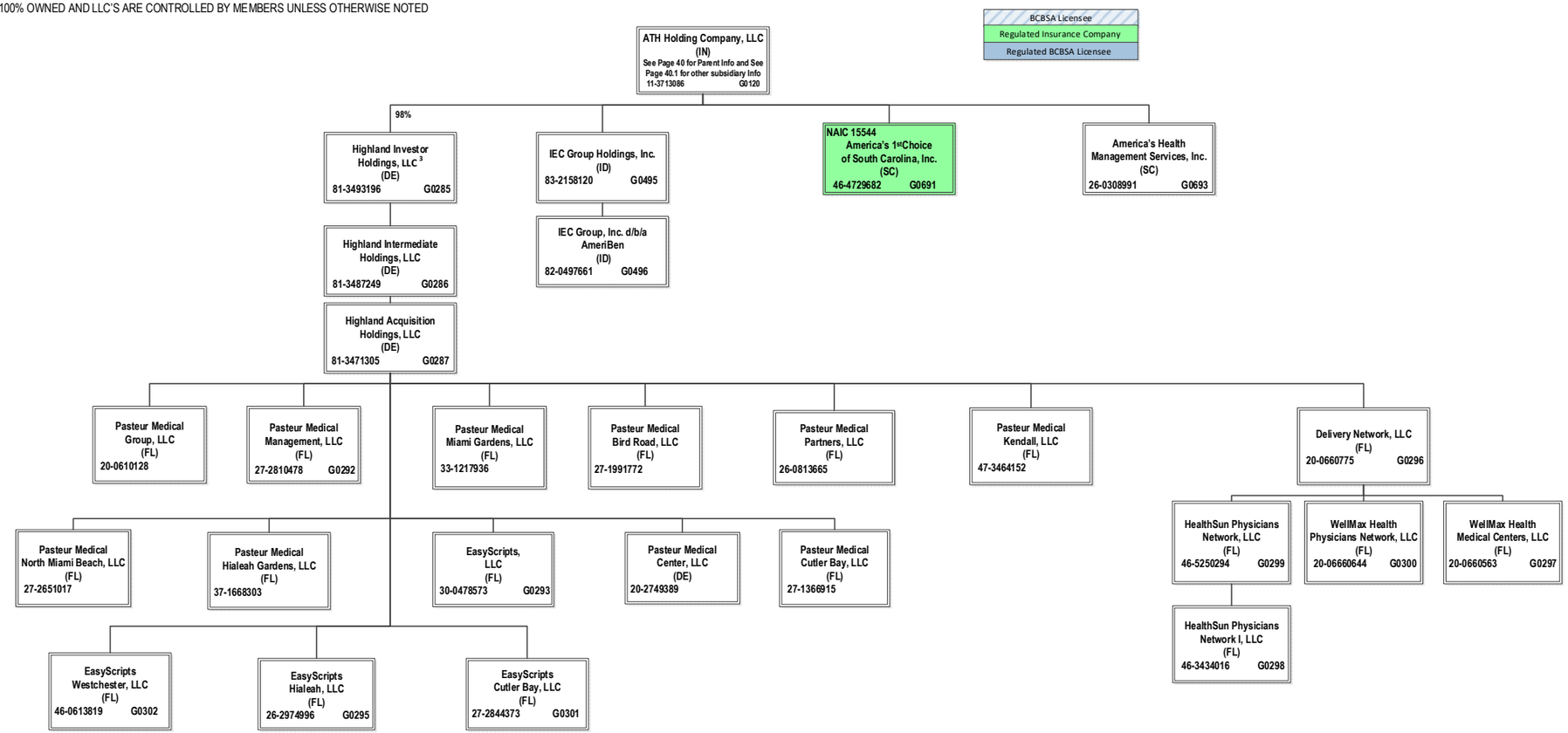
[2] 30.09% of WPMI, LLC is owned by unaffiliated investors

40.1

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED

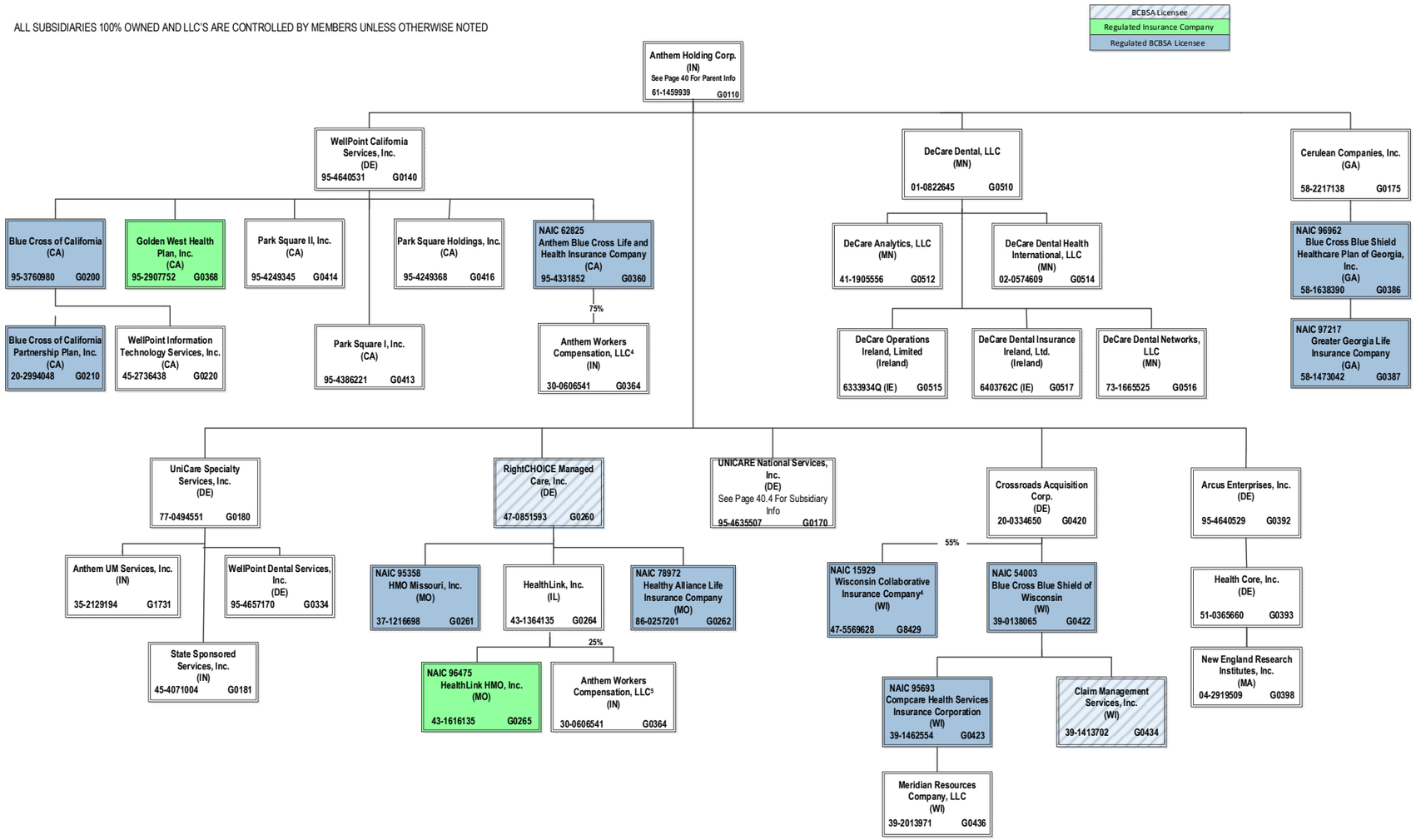


40.2

[3] ATH Holding Company, LLC holds a 98% interest in Highland Investor Holdings, LLC, and Amerigroup Corporation holds the remaining 2% interest.

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



[4] 45% of WCIC is owned by Aurora Health Care, Inc. (non-affiliate). Not consolidated for accounting purposes.

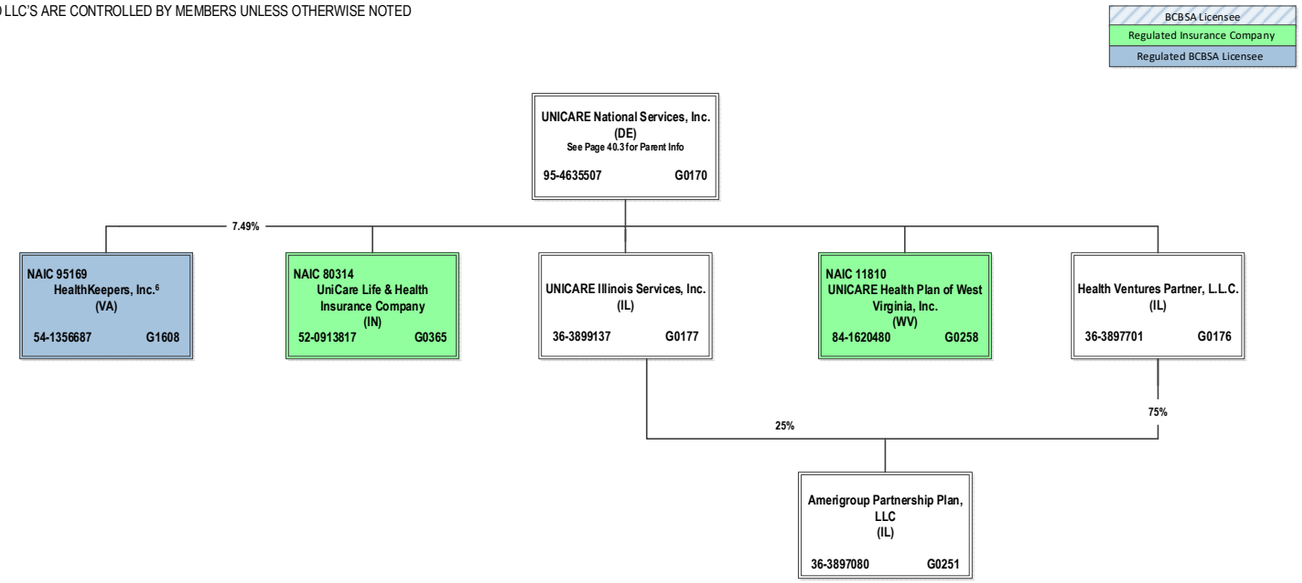
[5] Anthem Workers' Compensation LLC is owned 75% by Anthem Blue Cross Life and Health Insurance Company and 25% by HealthLink, Inc.

40.3

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED



40.4

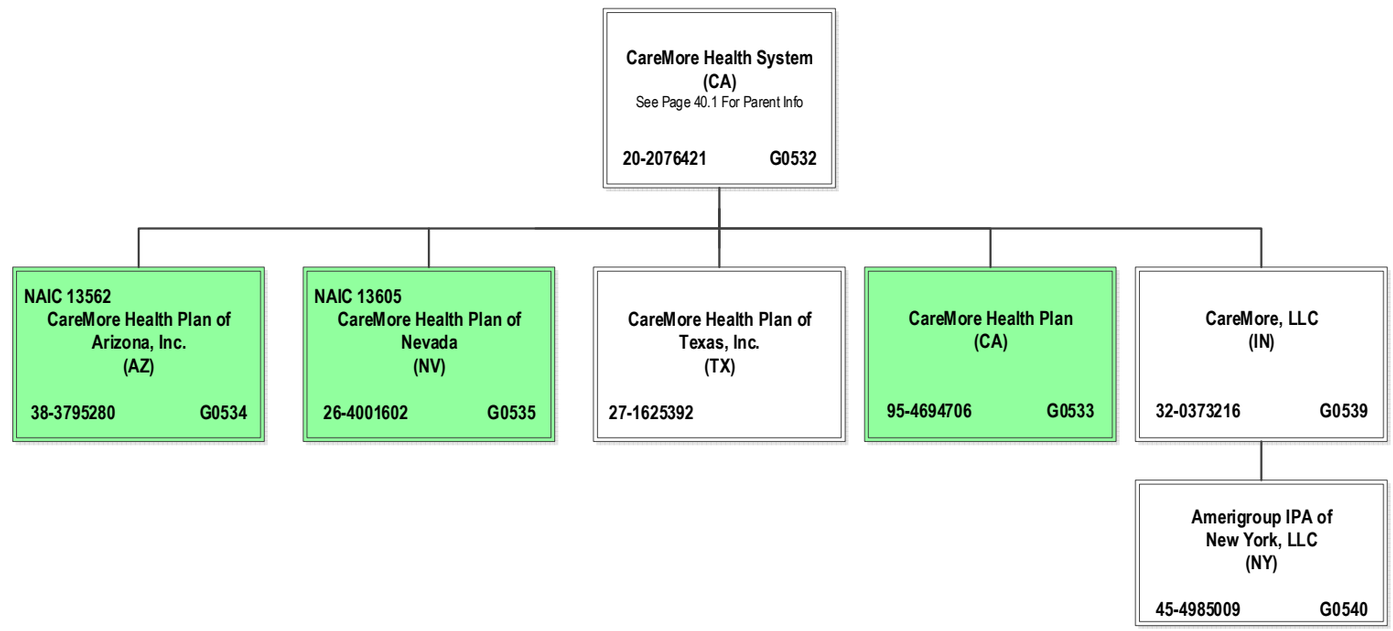
[6] HealthKeepers, Inc. is owned 92.51% by Anthem Southeast, Inc. and 7.49% by UNICARE National Services, Inc.

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART

BCBSA Licensee
Regulated Insurance Company
Regulated BCBSA Licensee

ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED

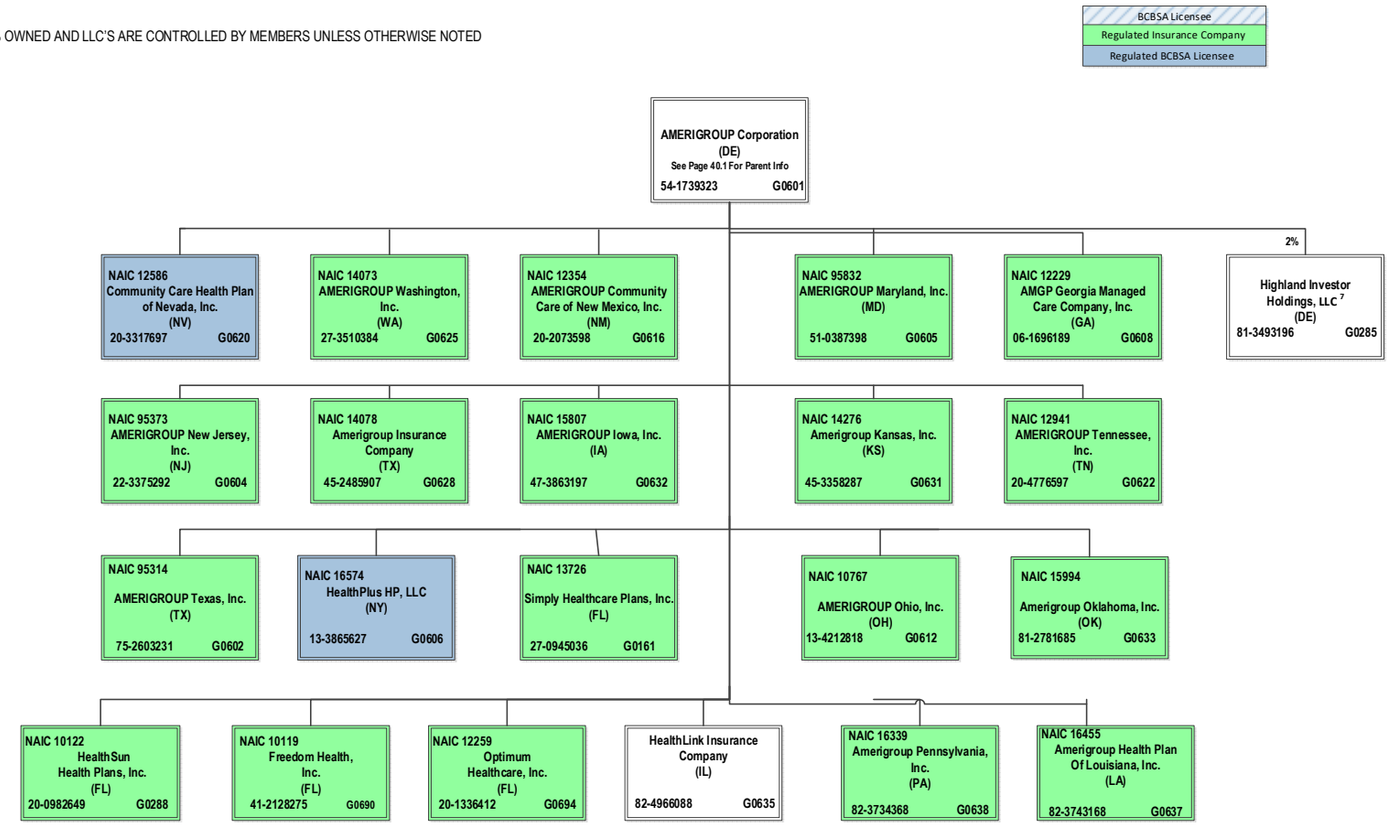


40.5

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART

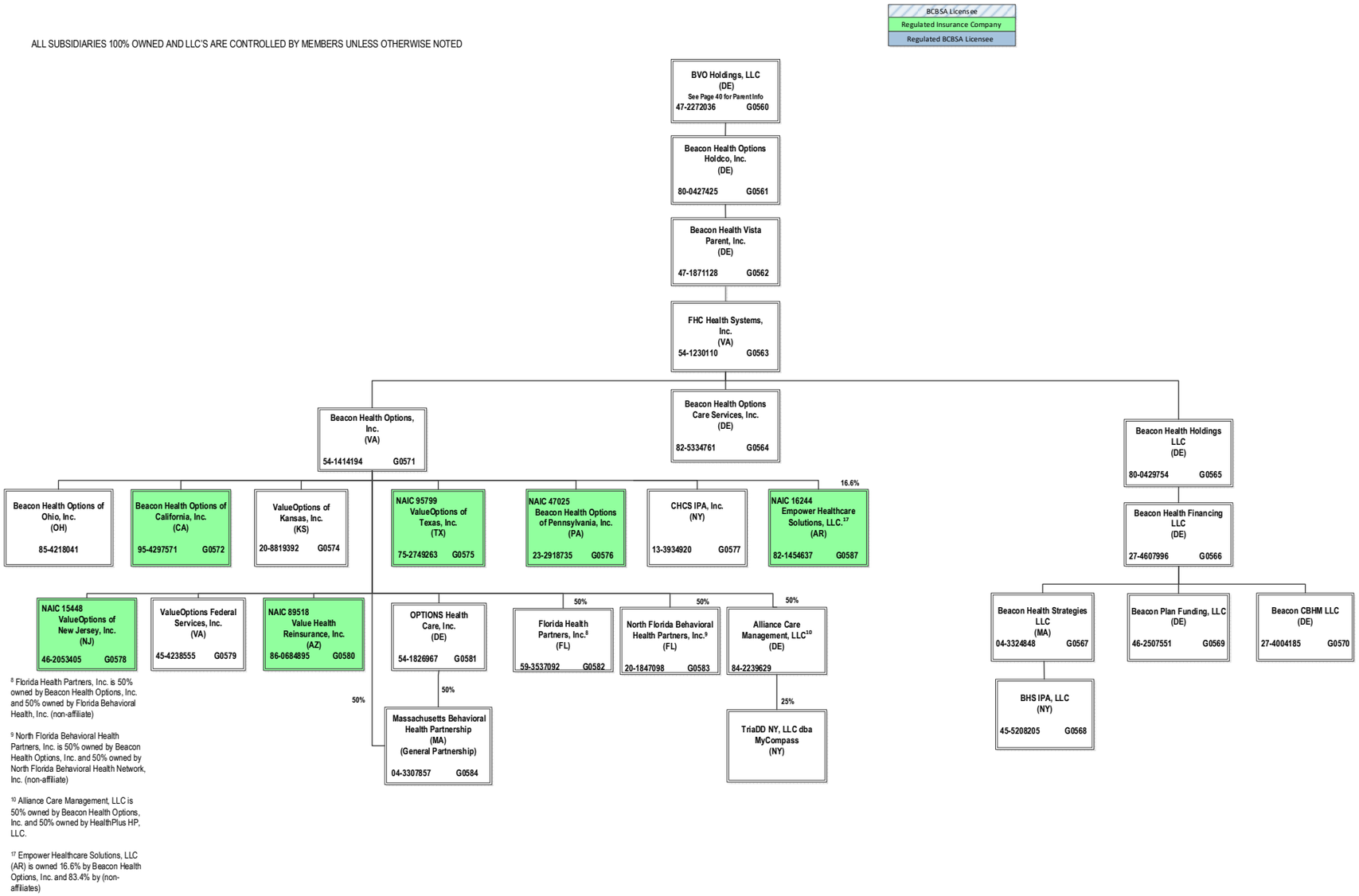
ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED



[7] Amerigroup Corporation holds a 2% interest in Highland Investor Holdings, LLC, and ATH Holding Company, LLC holds the remaining 98% interest.

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



[8] Florida Health Partners, Inc. is 50% owned by Beacon Health Options, Inc. and 50% owned by Florida Behavioral Health, Inc. (non-affiliate)

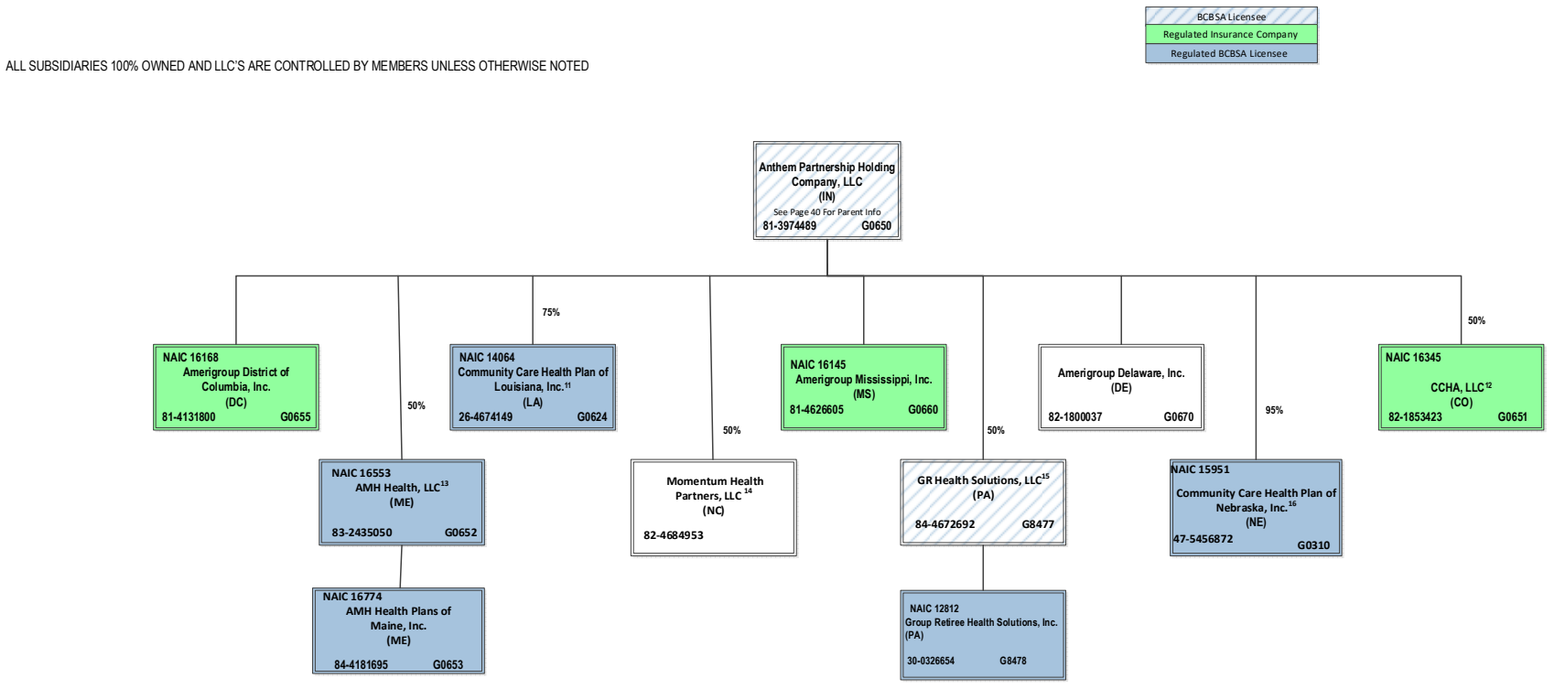
[9] North Florida Behavioral Health Partners, Inc. is 50% owned by Beacon Health Options, Inc. and 50% owned by North Florida Behavioral Health Network, Inc. (non-affiliate)

[10] Alliance Care Management, LLC is 50% owned by Beacon Health Options, Inc. and 50% owned by HealthPlus HP, LLC.

[17] Empower Healthcare Solutions, LLC (AR) is owned 16.6% by Beacon Health Options, Inc. and 83.4% by (non-affiliates)

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



[11] Community Care Health Plan of Louisiana, Inc. is a joint venture 75% owned by Anthem Partnership Holding Company, LLC and 25% owned by Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana (non-affiliate)

[12] CCHA, LLC is a joint venture 50% owned by Anthem Partnership Holding Company, LLC and 50% owned by Colorado Community Health Alliance, LLC (non-affiliate)

[13] AMH Health, LLC is a joint venture 50% owned by MaineHealth (non-affiliate) and 50% owned by Anthem Partnership Holding Company, LLC

[14] Momentum Health Partners, LLC is a joint venture 50% owned by Anthem Partnership Holding Company, LLC and 50% owned by Blue Cross and Blue Shield of North Carolina (non-affiliate)

[15] GR Health Solutions, LLC is a joint venture 50% owned by Anthem Partnership Holding Company, LLC and 50% owned by Independence Blue Cross, LLC (non-affiliate)

[16] Anthem Partnership Holding Company, LLC holds a 95% interest in Community Care Health Plan of Nebraska, Inc., and Blue Cross and Blue Shield of Nebraska, Inc. (non-affiliate) holds the remaining 5%

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0671	Anthem, Inc.		84-2239629		0001156039		Alliance Care Management, LLC	DE	NIA	Beacon Health Options, Inc.	Ownership	50.000	Anthem, Inc.	N	
0671	Anthem, Inc.		84-2239629		0001156039		Alliance Care Management, LLC	DE	NIA	HealthPlus HP, LLC	Ownership	50.000	Anthem, Inc.	N	
0671	Anthem, Inc.		36-3692630		0001156039		American Imaging Management, Inc.	IL	NIA	Imaging Management Holdings, L.L.C.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	15544	46-4729682		0001156039		America's 1st Choice of South Carolina, Inc.	SC	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		26-0308991		0001156039		America's Health Management Services, Inc.	SC	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	12354	20-2073598		0001156039		AMERIGROUP Community Care of New Mexico, Inc.	NM	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		54-1739323		0001156039		AMERIGROUP Corporation	DE	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-1800037		0001156039		AMERIGROUP Delaware, Inc.	DE	NIA	Anthem Partnership Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	16168	81-4131800		0001156039		Amerigroup District of Columbia, Inc.	DC	IA	Anthem Partnership Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	16455	82-3743168		0001156039		Amerigroup Health Plan of Louisiana, Inc.	LA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	14078	45-2485907		0001156039		Amerigroup Insurance Company	TX	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	15807	47-3863197		0001156039		AMERIGROUP Iowa, Inc.	IA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		45-4985009		0001156039		Amerigroup IPA of New York, LLC	NY	NIA	CareMore, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	14276	45-3358287		0001156039		Amerigroup Kansas, Inc.	KS	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95832	51-0387398		0001156039		AMERIGROUP Maryland, Inc.	MD	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	16145	81-4626605		0001156039		Amerigroup Mississippi, Inc.	MS	RE	Anthem Partnership Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95373	22-3375292		0001156039		AMERIGROUP New Jersey, Inc.	NJ	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	10767	13-4212818		0001156039		AMERIGROUP Ohio, Inc.	OH	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	15994	81-2781685		0001156039		AMERIGROUP Oklahoma, Inc.	OK	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		36-3897080		0001156039		Amerigroup Partnership Plan, LLC	IL	NIA	Health Ventures Partner, L.L.C.	Ownership	75.000	Anthem, Inc.	N	
0671	Anthem, Inc.		36-3897080		0001156039		Amerigroup Partnership Plan, LLC	IL	NIA	UNICARE Illinois Services, Inc.	Ownership	25.000	Anthem, Inc.	N	
0671	Anthem, Inc.	16339	82-3734368		0001156039		Amerigroup Pennsylvania, Inc.	PA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	12941	20-4776597		0001156039		AMERIGROUP Tennessee, Inc.	TN	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95314	75-2603231		0001156039		AMERIGROUP Texas, Inc.	TX	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	14073	27-3510384		0001156039		AMERIGROUP Washington, Inc.	WA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	12229	06-1696189		0001156039		AMGP Georgia Managed Care Company, Inc.	GA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	16553	83-2435050		0001156039		AMH Health, LLC	ME	IA	Anthem Partnership Holding Company, LLC	Ownership	50.000	Anthem, Inc.	N	0102
0671	Anthem, Inc.	16774	84-4181695		0001156039		AMH Health Plans of Maine, Inc.	ME	IA	AMH Health, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	62825	95-4331852		0001156039		Anthem Blue Cross Life and Health Insurance Company	CA	IA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		35-1898945		0001156039		Anthem Financial, Inc.	DE	NIA	Associated Group, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95120	61-1237516		0001156039		Anthem Health Plans of Kentucky, Inc.	KY	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	52618	31-1705652		0001156039		Anthem Health Plans of Maine, Inc.	ME	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	53759	02-0510530		0001156039		Anthem Health Plans of New Hampshire, Inc.	NH	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	71835	54-0357120	40003317	0001156039		Anthem Health Plans of Virginia, Inc.	VA	IA	Anthem Southeast, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	60217	06-1475928		0001156039		Anthem Health Plans, Inc.	CT	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		61-1459939		0001156039		Anthem Holding Corp.	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		35-2145715		0001156039	New York Stock Exchange (NYSE)	Anthem, Inc.	IN	UIP				Anthem, Inc.	N	
0671	Anthem, Inc.		98-1492098		0001156039		Anthem Innovation Israel Ltd	ISR	NIA	Legato Holdings I, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	28207	35-0781558		0001156039		Anthem Insurance Companies, Inc.	IN	IA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	15543	47-0992859		0001156039		Anthem Kentucky Managed Care Plan, Inc.	KY	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	13573	20-5876774		0001156039		Anthem Life & Disability Insurance Company	NY	IA	WellPoint Acquisition, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	61069	35-0980405		0001156039		Anthem Life Insurance Company	IN	IA	Rocky Mountain Hospital and Medical Service, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		81-3974489		0001156039		Anthem Partnership Holding Company, LLC	DE	UDP	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		46-0613946		0001156039		Anthem Services Company, LLC	IN	NIA	The Anthem Companies, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		32-0031791		0001156039		Anthem Southeast, Inc.	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		35-2129194		0001156039		Anthem UM Services, Inc.	IN	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		30-0606541		0001156039		Anthem Workers' Compensation, LLC	IN	NIA	Anthem Blue Cross Life and Health Insurance Company	Ownership	75.000	Anthem, Inc.	N	0109
0671	Anthem, Inc.		30-0606541		0001156039		Anthem Workers' Compensation, LLC	IN	NIA	HealthLink, Inc.	Ownership	25.000	Anthem, Inc.	N	0109

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0671	Anthem, Inc.		80-0531799		0001156039		Applied Pathways, LLC	IL	NIA	American Imaging Management, Inc.	Ownership	53.520	Anthem, Inc.	N	0108
0671	Anthem, Inc.		80-0531799		0001156039		Applied Pathways, LLC	IL	NIA	HEP AP Holdings, Inc.	Ownership	46.480	Anthem, Inc.	N	0108
0671	Anthem, Inc.		95-4640529		0001156039		Arcus Enterprises, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		90-1057454		0001156039		Aspire Health, Inc.	DE	NIA	Nash Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		35-1292384		0001156039		Associated Group, Inc.	IN	NIA	Anthem Insurance Companies, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		11-3713086		0001156039		ATH Holding Company, LLC	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		27-4004185		0001156039		Beacon CBHM LLC	DE	NIA	Beacon Health Financing LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		27-4607996		0001156039		Beacon Health Financing LLC	DE	NIA	Beacon Health Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		80-0427425		0001156039		Beacon Health Holdings, LLC	DE	NIA	FHC Health Systems, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-5334761		0001156039		Beacon Health Options Care Services, Inc.	DE	NIA	FHC Health Systems, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4297571		0001156039		Beacon Health Options of California, Inc.	CA	IA	Beacon Health Options, Inc.	Ownership	100.000	Anthem, Inc.	N	0101
0671	Anthem, Inc.	47025	23-2918735		0001156039		Beacon Health Options of Pennsylvania, Inc.	PA	IA	Beacon Health Options, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		80-0427425		0001156039		Beacon Health Options Holdco, Inc.	DE	NIA	BVO Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		85-4218041		0001156039		Beacon Health Options of Ohio, Inc.	OH	NIA	Beacon Health Options, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		54-1414194		0001156039		Beacon Health Options, Inc.	VA	NIA	FHC Health Systems, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		04-3324848		0001156039		Beacon Health Strategies LLC	MA	NIA	Beacon Health Financing LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		47-1871128		0001156039		Beacon Health Vista Parent, Inc.	DE	NIA	Beacon Health Options Holdco, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		46-2507551		0001156039		Beacon Plan Funding, LLC	DE	NIA	Beacon Health Financing LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		45-5208205		0001156039		BHS IPA, LLC	NY	NIA	Beacon Health Strategies LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	96962	58-1638390		0001156039		Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	GA	IA	Cerulean Companies, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	54003	39-0138065		0001156039		Blue Cross Blue Shield of Wisconsin	WI	IA	Crossroads Acquisition Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-3760980		0001156039		Blue Cross of California	CA	IA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	0101
0671	Anthem, Inc.		20-2994048		0001156039		Blue Cross of California Partnership Plan, Inc.	CA	IA	Blue Cross of California	Ownership	100.000	Anthem, Inc.	N	0101
0671	Anthem, Inc.		47-2272036		0001156039		BVO Holdings, LLC	DE	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		84-1782311		0001156039		CareMarket, Inc.	IN	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4694706		0001156039		CareMore Health Plan	CA	IA	CareMore Health System	Ownership	100.000	Anthem, Inc.	N	0101
0671	Anthem, Inc.	13562	38-3795280		0001156039		CareMore Health Plan of Arizona, Inc.	AZ	IA	CareMore Health System	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	13605	26-4001602		0001156039		CareMore Health Plan of Nevada	NV	IA	CareMore Health System	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		27-1625392		0001156039		CareMore Health Plan of Texas, Inc.	TX	NIA	CareMore Health System	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		32-0373216		0001156039		CareMore, LLC	IN	NIA	CareMore Health System	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-2076421		0001156039		CareMore Health System	CA	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		58-2217138		0001156039		Cerulean Companies, Inc.	GA	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		39-1413702		0001156039		Claim Management Services, Inc.	WI	NIA	Blue Cross Blue Shield of Wisconsin	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	16345	82-1853423		0001156039		CCHA, LLC	CO	IA	Anthem Partnership Holding Company, LLC	Ownership	50.000	Anthem, Inc.	N	0102
0671	Anthem, Inc.				0001156039		CHCS IPA, Inc.	NY	NIA	Beacon Health Options, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	14064	26-4674149		0001156039		Community Care Health Plan of Louisiana, Inc.	LA	IA	Anthem Partnership Holding Company, LLC	Ownership	75.000	Anthem, Inc.	N	0104
0671	Anthem, Inc.	15951	47-5456872		0001156039		Community Care Health Plan of Nebraska, Inc	NE	IA	Anthem Partnership Holding Company, LLC	Ownership	95.000	Anthem, Inc.	N	0116
0671	Anthem, Inc.	12586	20-3317697		0001156039		Community Care Health Plan of Nevada, Inc.	NV	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	10345	31-1440175		0001156039		Community Insurance Company	OH	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95693	39-1462554		0001156039		Compcare Health Services Insurance Corporation	WI	IA	Blue Cross Blue Shield of Wisconsin	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0334650		0001156039		Crossroads Acquisition Corp.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-3027094		0001156039		DBG Holdings, Inc.	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		41-1905556		0001156039		DeCare Analytics, LLC	MN	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		02-0574609		0001156039		DeCare Dental Health International, LLC	MN	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.				0001156039		DeCare Dental Insurance Ireland, Ltd.	IRL	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		73-1665525		0001156039		DeCare Dental Networks, LLC	MN	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		01-0822645		0001156039		DeCare Dental, LLC	MN	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.				0001156039		DeCare Operations Ireland, Limited	IRL	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0660775		0001156039		Delivery Network, LLC	FL	NIA	Highland Acquisition Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		26-2544715		0001156039		Designated Agent Company, Inc.	KY	NIA	Anthem Health Plans of Kentucky, Inc.	Ownership	100.000	Anthem, Inc.	N	

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ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	Is an SCA Filing Required? (Y/N)	*
0671	Anthem, Inc.		27-2844373		0001156039		EasyScripts Cutler Bay, LLC	FL	NIA	Highland Acquisition Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		26-2974996		0001156039		EasyScripts Hialeah, LLC	FL	NIA	Highland Acquisition Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		30-0478573		0001156039		EasyScripts LLC	FL	NIA	Highland Acquisition Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		46-0613819		0001156039		EasyScripts Westchester, LLC	FL	NIA	Highland Acquisition Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		13-3934328		0001156039		EHC Benefits Agency, Inc.	NY	NIA	WellPoint Holding Corp	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	55093	23-7391136		0001156039		Empire HealthChoice Assurance, Inc.	NY	IA	WellPoint Holding Corp	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95433	13-3874803		0001156039		Empire HealthChoice HMO, Inc.	NY	IA	Empire HealthChoice Assurance, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	16244	82-1454637		0001156039		Empower Healthcare Solutions, LLC	AR	IA	Beacon Health Options, Inc.	Ownership	16.600	Anthem, Inc.	N	0115
0671	Anthem, Inc.		26-4286154		0001156039		Federal Government Solutions, LLC	WI	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		54-1230110		0001156039		FHC Health Systems, Inc.	VA	NIA	Beacon Health Vista Parent, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		59-3537092		0001156039		Florida Health Partners, Inc.	FL	NIA	Beacon Health Options, Inc.	Ownership	50.000	Anthem, Inc.	N	0112
0671	Anthem, Inc.	10119	41-2128275		0001156039		Freedom Health, Inc.	FL	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		33-0884790		0001156039		GeriNet Physician Services, Inc.	CA	NIA	CareMore Health System	Ownership	50.000	Anthem, Inc.	N	0102
0671	Anthem, Inc.		95-2907752		0001156039		Golden West Health Plan, Inc.	CA	IA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	0101
0671	Anthem, Inc.		84-4672692		0001156039		GR Health Solutions LLC	PA	NIA	Anthem Partnership Holding Company, LLC	Ownership	50.000	Anthem, Inc.	N	0102
0671	Anthem, Inc.	97217	58-1473042		0001156039		Greater Georgia Life Insurance Company	GA	IA	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	12812	30-0326654		0001156039		Group Retiree Health Solutions, Inc.	PA	IA	GR Health Solutions LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		51-0365660		0001156039		Health Core, Inc.	DE	NIA	Arcus Enterprises, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		54-1237939		0001156039		Health Management Corporation	VA	NIA	Southeast Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		36-3897701		0001156039		Health Ventures Partner, L.L.C.	IL	NIA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95169	54-1356687		0001156039		HealthKeepers, Inc.	VA	IA	Anthem Southeast, Inc.	Ownership	92.510	Anthem, Inc.	N	
0671	Anthem, Inc.	95169	54-1356687		0001156039		HealthKeepers, Inc.	VA	IA	UNICARE National Services, Inc.	Ownership	7.490	Anthem, Inc.	N	
0671	Anthem, Inc.	96475	43-1616135		0001156039		HealthLink HMO, Inc.	MO	IA	HealthLink, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		43-1364135		0001156039		HealthLink, Inc.	IL	NIA	RightCHOICE Managed Care, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-4966088		0001156039		HealthLink Insurance Company	IL	NIA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	16574	13-3865627		0001156039		HealthPlus HP, LLC	NY	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	0100
0671	Anthem, Inc.	10122	20-0982649		0001156039		HealthSun Health Plans, Inc.	FL	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		46-5250294		0001156039		HealthSun Physicians Network, LLC	FL	NIA	Delivery Network, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		46-3434016		0001156039		HealthSun Physicians Network I, LLC	FL	NIA	HealthSun Physicians Network, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	78972	86-0257201		0001156039		Healthy Alliance Life Insurance Company	MO	IA	RightCHOICE Managed Care, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		47-3953545		0001156039		HEP AP Holdings, Inc.	DE	NIA	Imaging Management Holdings, L.L.C.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		81-3487249		0001156039		Highland Acquisition Holdings, LLC	DE	NIA	Highland Intermediate Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		81-3471305		0001156039		Highland Intermediate Holdings, LLC	DE	NIA	Highland Investor Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		81-3493196		0001156039		Highland Investor Holdings, LLC	DE	NIA	ATH Holding Company, LLC	Ownership	98.000	Anthem, Inc.	N	0107
0671	Anthem, Inc.		81-3493196		0001156039		Highland Investor Holdings, LLC	DE	NIA	AMERIGROUP Corporation	Ownership	2.000	Anthem, Inc.	N	0107
0671	Anthem, Inc.	95473	84-1017384		0001156039		HMO Colorado, Inc.	CO	IA	Rocky Mountain Hospital and Medical Service, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95358	37-1216698		0001156039		HMO Missouri, Inc.	MO	IA	RightCHOICE Managed Care, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-2157122		0001156039		IEC Group Holdings, Inc.	ID	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-0497661		0001156039		IEC Group, Inc. d/b/a AmeriBen	ID	NIA	IEC Group Holdings, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		75-2619605		0001156039		Imaging Management Holdings, L.L.C.	DE	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-3062245		0001156039		IngenioRX, Inc.	IN	NIA	DBG Holdings, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		98-1397080		0001156039		Legato Health Technologies LLP	IN	NIA	Legato Holdings I, Inc.	Ownership	100.000	Anthem, Inc.	N	0105
0671	Anthem, Inc.		98-1490582		0001156039		Legato Health Technologies Philippines, Inc.	PHL	NIA	Legato Holdings I, Inc.	Ownership	100.000	Anthem, Inc.	N	0106
0671	Anthem, Inc.		82-3030791		0001156039		Legato Holdings I, Inc.	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-3031178		0001156039		Legato Holdings II, LLC	IN	NIA	Legato Holdings I, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		02-0581429		0001156039		Living Complete Technologies, Inc.	MD	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		04-3307857		0001156039		Massachusetts Behavioral Health Partnership	MA	NIA	Beacon Health Options, Inc.	Ownership	50.000	Anthem, Inc.	N	0111
0671	Anthem, Inc.		04-3307857		0001156039		Massachusetts Behavioral Health Partnership	MA	NIA	OPTIONS Health Care, Inc.	Ownership	50.000	Anthem, Inc.	N	0111
0671	Anthem, Inc.	95527	02-0494919		0001156039		Matthew Thornton Health Plan, Inc.	NH	IA	Anthem Health Plans of New Hampshire, Inc.	Ownership	100.000	Anthem, Inc.	N	

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ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0671	Anthem, Inc.		39-2013971		0001156039		Meridian Resource Company, LLC	WI	NIA	Compcare Health Services Insurance Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	12913	20-5862801		0001156039		Missouri Care, Incorporated	MO	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-4684953		0001156039		Momentum Health Partners, LLC	NC	NIA	Anthem Partnership Holding Company, LLC	Ownership	50.000	Anthem, Inc.	N	0102
0671	Anthem, Inc.		83-0892028		0001156039		Nash Holding Company, LLC	DE	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		35-1840597		0001156039		National Government Services, Inc.	IN	NIA	Federal Government Solutions, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		04-2919509		0001156039		New England Research Institute, Inc.	MA	NIA	Health Core, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		81-5476630		0001156039		NGS Federal, LLC	IN	NIA	Federal Government Solutions, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-1847098		0001156039		North Florida Behavioral Health Partners, Inc.	FL	NIA	Beacon Health Options, Inc.	Ownership	50.000	Anthem, Inc.	N	0113
0671	Anthem, Inc.	12259	20-1336412		0001156039		Optimum Healthcare, Inc.	FL	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		54-1826967		0001156039		OPTIONS Health Care, Inc.	DE	NIA	Beacon Health Options, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4249368		0001156039		Park Square Holdings, Inc.	CA	NIA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4386221		0001156039		Park Square I, Inc.	CA	NIA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4249345		0001156039		Park Square II, Inc.	CA	NIA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		27-1991772		0001156039		Pasteur Medical Bird Road, LLC	FL	NIA	Highland Acquisition Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-2749389		0001156039		Pasteur Medical Center, LLC	DE	NIA	Highland Acquisition Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		27-1366915		0001156039		Pasteur Medical Cutler Bay, LLC	FL	NIA	Highland Acquisition Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0610128		0001156039		Pasteur Medical Group, LLC	FL	NIA	Highland Acquisition Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		37-1668303		0001156039		Pasteur Medical Hialeah Gardens, LLC	FL	NIA	Highland Acquisition Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		47-3464152		0001156039		Pasteur Medical Kendall, LLC	FL	NIA	Highland Acquisition Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		27-2810478		0001156039		Pasteur Medical Management, LLC	FL	NIA	Highland Acquisition Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		33-1217936		0001156039		Pasteur Medical Miami Gardens, LLC	FL	NIA	Highland Acquisition Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		27-2651017		0001156039		Pasteur Medical North Miami Beach, LLC	FL	NIA	Highland Acquisition Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		26-0813665		0001156039		Pasteur Medical Partners, LLC	FL	NIA	Highland Acquisition Holdings, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		56-2396739		0001156039		Resolution Health, Inc.	DE	NIA	Anthem Southeast, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		47-0851593		0001156039		RightCHOICE Managed Care, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	11011	84-0747736		0001156039		Rocky Mountain Hospital and Medical Service, Inc.	CO	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0473316		0001156039		SellCore, Inc.	DE	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	13726	27-0945036		0001156039		Simply Healthcare Plans, Inc.	FL	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		55-0712302		0001156039		Southeast Services, Inc.	VA	NIA	Anthem Southeast, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		45-4071004		0001156039		State Sponsored Services, Inc.	IN	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		35-1835818		0001156039		The Anthem Companies, Inc.	IN	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		45-5443372		0001156039		The Anthem Companies of California, Inc.	CA	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.				0001156039		TriaDD NY, LLC dba MyCompass	NY	NIA	Alliance Care Management, LLC	Ownership	25.000	Anthem, Inc.	N	0114
0671	Anthem, Inc.		43-1967924		0001156039		TrustSolutions, LLC	WI	NIA	Federal Government Solutions, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	11810	84-1620480		0001156039		UNICARE Health Plan of West Virginia, Inc.	WV	IA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		36-3899137		0001156039		UNICARE Illinois Services, Inc.	IL	NIA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	80314	52-0913817		0001156039		UNICARE Life & Health Insurance Company	IN	IA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4635507		0001156039		UNICARE National Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		77-0494551		0001156039		UNICARE Specialty Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	89518	86-0684895		0001156039		Value Health Reinsurance, Inc.	AZ	IA	Beacon Health Options, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		45-4238555		0001156039		ValueOptions Federal Services, Inc.	VA	NIA	Beacon Health Options, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-8819392		0001156039		ValueOptions of Kansas, Inc.	KS	NIA	Beacon Health Options, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	15448	46-2053405		0001156039		ValueOptions of New Jersey, Inc.	NJ	IA	Beacon Health Options, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	95799	75-2749263		0001156039		ValueOptions of Texas, Inc.	TX	IA	Beacon Health Options, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		82-3300542		0001156039		Valus, Inc.	IN	NIA	DBG Holdings, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0660563		0001156039		WellMax Health Medical Centers, LLC	FL	NIA	Delivery Network, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-0660644		0001156039		WellMax Health Physicians Network, LLC	FL	NIA	Delivery Network, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		20-4405193		0001156039		WellPoint Acquisition, LLC	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4640531		0001156039		WellPoint California Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		95-4657170		0001156039		WellPoint Dental Services, Inc.	DE	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		81-2874917		0001156039		WellPoint Health Solutions, Inc.	DE	NIA	Federal Government Solutions, LLC	Ownership	100.000	Anthem, Inc.	N	

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	Is an SCA Filing Required? (Y/N)	*
0671	Anthem, Inc.		20-3620996		0001156039		WellPoint Holding Corp	DE	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		45-2736438		0001156039		WellPoint Information Technology Services, Inc.	CA	NIA	Blue Cross of California	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		36-4595641		0001156039		WellPoint Insurance Services, Inc.	HI	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.		47-2546820		0001156039		WellPoint Military Care Corporation	IN	NIA	Federal Government Solutions, LLC	Ownership	100.000	Anthem, Inc.	N	
0671	Anthem, Inc.	15929	47-5569628		0001156039		Wisconsin Collaborative Insurance Company	WI	IA	Crossroads Acquisition Corp.	Ownership	55.000	Anthem, Inc.	N	0110
0671	Anthem, Inc.		20-8672847		0001156039		WPMI, LLC	DE	NIA	ATH Holding Company, LLC	Ownership	69.910	Anthem, Inc.	N	0103
0671	Anthem, Inc.		47-3025203		0001156039		ZipDrug Inc.	DE	NIA	IngenioRx, Inc.	Ownership	100.000	Anthem, Inc.	N	

Asterisk	Explanation
0100	Insurer is deemed to be an insurance affiliate in column 10 and has an NAIC Company Code in column 3. However, it does not file an NAIC statutory statement because it is regulated by the New York State Department of Health.
0101	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0102	50% owned by unaffiliated investors
0103	30.09% owned by unaffiliated investors
0104	25% owned by an unaffiliated investor
0105	Legato Health Technologies LLP is a Limited Liability Partnership formed under the laws of India, and is 99% owned by Legato Holdings I, Inc. an Indiana corporation, and 1% owned by Legato Holdings II, LLC, an Indiana Limited Liability company.
0106	Legato Health Technologies Philippines, Inc. was incorporated under with the Republic of the Philippines, and is 100% owned by Legato Holdings I, Inc. an Indiana corporation.
0107	Highland Investor Holding LLC is a Limited Liability Company formed under the laws of Delaware, and is 98% owned by ATH Holding Company, LLC. an Indiana limited liability company, and Amerigroup Corporation holds the remaining 2% interest..
0108	Applied Pathways, LLC is a Limited Liability Company formed under the laws of Illinois, and is 53.52% owned by American Imaging Management, Inc. an Illinois limited liability company, and 46.48% owned by HEP AP Holdings, Inc., a Delaware corporation.
0109	Anthem Worker's Compensation, LLC is owned 75% by Anthem Blue Cross Life and Health Insurance Company and 25% by HealthLink, Inc.
0110	45% of WCIC is owned by Aurora Health Care, Inc. (non-affiliate) and 55% by Crossroads Acquisition Corp
0111	Massachusetts Behavioral Health Partnership is a General Partnership formed under the laws of Massachusetts, and is 50% owned by Beacon Health Options, Inc., a Virginia corporation, and 50% owned by OPTIONS Health Care, Inc., a Delaware corporation.
0112	Florida Health Partners, Inc. is 50% owned by Beacon Health Options, Inc. and 50% owned by Florida Behavioral Health, Inc. (non-affiliate)
0113	North Florida Behavioral Health Partners, Inc. is 50% owned by Beacon Health Options, Inc. and 50% owned by North Florida Behavioral Health Network, Inc. (non-affiliate)
0114	75% owned by an unaffiliated investor
0115	83.4% owned by unaffiliated investors
0116	(BCBSNE) purchased 5% of the common stock of Community Care Health Plan of Nebraska, Inc. (CCHPNE). With this purchase, BCBSNE now owns 5% of CCHPNE and Anthem Partnership Holding Company, LLC owns the remaining 95%.

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1 NAIC Company Code	2 ID Number	3 Names of Insurers and Parent, Subsidiaries or Affiliates	4 Shareholder Dividends	5 Capital Contributions	6 Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	7 Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	8 Management Agreements and Service Contracts	9 Income/ (Disbursements) Incurred Under Reinsurance Agreements	10 *	11 Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	12 Totals	13 Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
	36-3692630	American Imaging Management, Inc.					(320,933,939)				(320,933,939)	
15544	46-4729682	America's 1st Choice of South Carolina, Inc.		1,500,000			590,647				2,090,647	
12354	20-2073598	AMERIGROUP Community Care of New Mexico, Inc.	(1,700,000)				(3,561,645)				(5,261,645)	
	54-1739323	AMERIGROUP Corporation	18,700,000				79,759,611				98,459,611	
16168	81-4131800	Amerigroup District of Columbia, Inc.	(10,300,000)				(22,288,625)				(32,588,625)	
16455	82-3743168	Amerigroup Health Plan of Louisiana, Inc.					818				818	
14078	45-2485907	Amerigroup Insurance Company		10,000,000			(126,680,505)				(116,680,505)	
15807	47-3863197	AMERIGROUP Iowa, Inc.					(262,534,064)				(262,534,064)	
14276	45-3358287	Amerigroup Kansas, Inc.					5,005,030				5,005,030	
95832	51-0387398	AMERIGROUP Maryland, Inc.	(70,000,000)				(137,828,540)				(207,828,540)	
16145	81-4626605	Amerigroup Mississippi, Inc.					1,966				1,966	
95373	22-3375292	AMERIGROUP New Jersey, Inc.	(18,700,000)				(163,439,174)				(182,139,174)	
10767	13-4212818	AMERIGROUP Ohio, Inc.					(41,514)				(41,514)	
15994	81-2781685	AMERIGROUP Oklahoma, Inc.					(4,795)				(4,795)	
	36-3897080	Amerigroup Partnership Plan, LLC					(127,088,014)				(127,088,014)	
16339	82-3734368	Amerigroup Pennsylvania, Inc.					1,844				1,844	
12941	20-4776597	AMERIGROUP Tennessee, Inc.					(202,884,259)				(202,884,259)	
95314	75-2603231	AMERIGROUP Texas, Inc.					(842,437,724)				(842,437,724)	
14073	27-3510384	AMERIGROUP Washington, Inc.	(17,400,000)				(86,337,675)				(103,737,675)	
12229	06-1696189	AMGP Georgia Managed Care Company, Inc.	(27,800,000)				(195,930,963)				(223,730,963)	
16553	83-2435050	AMH Health, LLC		9,100,000			(9,307,621)				(207,621)	
16774	84-4181695	AMH Health Plans of Maine, Inc.		2,400,000							2,400,000	
62825	95-4331852	Anthem Blue Cross Life and Health Insurance Company	(259,800,000)				(1,128,793,830)	609,553,336			(779,040,494)	(66,836,081)
95120	61-1237516	Anthem Health Plans of Kentucky, Inc.	(24,800,000)				(425,367,054)	(12,144,836)			(462,311,890)	35,053,934
52618	31-1705652	Anthem Health Plans of Maine, Inc.	(71,900,000)				(126,165,917)				(198,065,917)	
53759	02-0510530	Anthem Health Plans of New Hampshire, Inc.					(113,823,407)				(113,823,407)	
71835	54-0357120	Anthem Health Plans of Virginia, Inc.	(370,000,000)				(591,128,292)	(42,736,438)			(1,003,864,730)	214,460,343
60217	06-1475928	Anthem Health Plans, Inc.	(70,000,000)				(347,749,490)				(417,749,490)	
28207	35-0781558	Anthem Insurance Companies, Inc.	(250,000,000)				(1,514,930,101)	9,308,919			(1,755,621,182)	(12,379,593)
15543	47-0992859	Anthem Kentucky Managed Care Plan, Inc.					(85,810,404)				(85,810,404)	
13573	20-5876774	Anthem Life & Disability Insurance Company		4,500,000			(1,975,248)				2,524,752	
61069	35-0980405	Anthem Life Insurance Company	(23,200,000)	30,000,000			(43,274,183)	21,514,349			(14,959,834)	(156,650,533)
	81-3974489	Anthem Partnership Holding Company, LLC					(23,483,306)				(23,483,306)	
	46-0613946	Anthem Services Company, LLC					54,868,466				54,868,466	
	35-2129194	Anthem UM Services					(83,370,775)				(83,370,775)	
	35-2145715	Anthem, Inc.	3,617,500,000	(30,000,000)			7,753,571,849				11,341,071,849	
16298	82-3062789	APC Passe, LLC						(84,643,749)			(84,643,749)	123,221,255
	90-1057454	Aspire Health, Inc.					(71,399,880)				(71,399,880)	

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1 NAIC Company Code	2 ID Number	3 Names of Insurers and Parent, Subsidiaries or Affiliates	4 Shareholder Dividends	5 Capital Contributions	6 Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	7 Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	8 Management Agreements and Service Contracts	9 Income/ (Disbursements) Incurred Under Reinsurance Agreements	10 *	11 Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	12 Totals	13 Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
	11-3713086	ATH Holding Company, LLC					(46,915,268)				(46,915,268)	
	54-1414194	Beacon Health Options, Inc.	4,500,000	(300,000)			64,758,324				68,958,324	
	95-4297571	Beacon Health Options of California, Inc.	(1,500,000)				(1,525,500)				(3,025,500)	
47025	23-2918735	Beacon Health Options of Pennsylvania, Inc.					(4,733,805)				(4,733,805)	
96962	58-1638390	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	(328,300,000)	(10,000,000)	(72,000,000)		(857,704,518)				(1,268,004,518)	
54003	39-0138065	Blue Cross Blue Shield of Wisconsin	(75,900,000)				(137,773,812)	(7,814,568)			(221,488,380)	63,144,726
	95-3760980	Blue Cross of California	(625,000,000)	(320,000,000)			(2,242,526,843)				(3,187,526,843)	
	20-2994048	Blue Cross of California Partnership Plan, Inc.	(75,000,000)		72,000,000		(304,253,852)				(307,253,852)	
	95-4694706	CareMore Health Plan					791,075,680				791,075,680	
13562	38-3795280	CareMore Health Plan of Arizona, Inc.					118,429,576				118,429,576	
13605	26-4001602	CareMore Health Plan of Nevada					81,651,684				81,651,684	
16345	82-1853423	CCHA, LLC					(3,230,264)	(186,762,691)			(189,992,955)	30,886,713
14064	26-4674149	Community Care Health Plan of Louisiana, Inc.					(140,916,438)				(140,916,438)	
15951	47-5456872	Community Care Health Plan of Nebraska, Inc	(15,000,000)	2,500,000			(18,574,858)				(31,074,858)	
12586	20-3317697	Community Care Health Plan of Nevada, Inc.					(81,255,150)	16,111			(81,239,039)	274,225
10345	31-1440175	Community Insurance Company	(165,000,000)				(1,105,118,481)	(32,550,690)			(1,302,669,171)	70,057,233
95693	39-1462554	Compcare Health Services Insurance Corporation	(2,100,000)				(218,626,165)				(220,726,165)	
	20-0660775	Delivery Network, LLC					(30,067,290)				(30,067,290)	
55093	23-7391136	Empire HealthChoice Assurance, Inc.	(32,000,000)				(552,263,658)				(584,263,658)	
95433	13-3874803	Empire HealthChoice HMO, Inc.					(121,895,267)				(121,895,267)	
16244	82-1454637	Empower Healthcare Solutions, LLC		300,000			(57,578,802)				(57,278,802)	
10119	41-2128275	Freedom Health, Inc.	(61,500,000)				(127,263,533)				(188,763,533)	
	95-2907752	Golden West Health Plan, Inc.	(10,000,000)				(770,929)				(10,770,929)	
97217	58-1473042	Greater Georgia Life Insurance Company		10,000,000			(9,527,340)				472,660	
12812	30-0326654	Group Retiree Health Solutions, Inc.		4,082,993							4,082,993	
	84-4672692	GR Health Solutions LLC		(4,082,993)							(4,082,993)	
	51-0365660	Health Core, Inc.					(28,816,778)				(28,816,778)	
	54-1237939	Health Management Corporation					(303,978,149)				(303,978,149)	
95169	54-1356687	HealthKeepers, Inc.	(350,000,000)				(721,424,139)	(10,892,830)			(1,082,316,969)	1,769,906
96475	43-1616135	HealthLink HMO, Inc.	(7,000,000)				4,505,076				(2,494,924)	
	43-1364135	HealthLink, Inc.					(39,719,797)				(39,719,797)	
16574	13-3865627	HealthPlus HP, LLC	(75,000,000)				(255,549,594)	(159,986)			(330,709,580)	
10122	20-0982649	HealthSun Health Plans, Inc.	(80,000,000)				(346,675,197)				(426,675,197)	
78972	86-0257201	Healthy Alliance Life Insurance Company	(181,100,000)				(330,951,926)				(512,051,926)	
95473	84-1017384	HMO Colorado, Inc.	(70,000,000)				(219,178,570)	(3,519,722)			(292,698,292)	4,897,559
95358	37-1216698	HMO Missouri, Inc.	(1,900,000)				(8,967,005)				(10,867,005)	

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1 NAIC Company Code	2 ID Number	3 Names of Insurers and Parent, Subsidiaries or Affiliates	4 Shareholder Dividends	5 Capital Contributions	6 Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	7 Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	8 Management Agreements and Service Contracts	9 Income/ (Disbursements) Incurred Under Reinsurance Agreements	10 *	11 Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	12 Totals	13 Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
	82-3062245	IngenioRX, Inc.					(329,831,019)				(329,831,019)	
	98-1397080	Legato Health Technologies LLP					180,970,464				180,970,464	
	98-1490582	Legato Health Technologies Philippines, Inc.					47,380,440				47,380,440	
95527	02-0494919	Matthew Thornton Health Plan, Inc.	(60,000,000)				(92,746,168)				(152,746,168)	
	39-2013971	Meridian Resource Company, LLC	(17,000,000)				(31,693,432)				(48,693,432)	
12913	20-5862801	Missouri Care, Incorporated					(31,277,213)				(31,277,213)	
12259	20-1336412	Optimum Healthcare, Inc.	(45,600,000)				(85,618,589)				(131,218,589)	
	27-2810478	Pasteur Medical Management, LLC					166,922,955				166,922,955	
	47-0851593	RightCHOICE Managed Care, Inc.					8,279,804				8,279,804	
11011	84-0747736	Rocky Mountain Hospital and Medical Service, Inc.	(56,800,000)	(30,000,000)			(273,316,491)	(6,798,624)			(366,915,115)	104,629,238
13726	27-0945036	Simply Healthcare Plans, Inc.	(76,800,000)				(420,104,173)				(496,904,173)	
	45-5443372	The Anthem Companies of California, Inc.					139,245,491				139,245,491	
	35-1835818	The Anthem Companies, Inc.					6,983,351,930				6,983,351,930	
11810	84-1620480	UNICARE Health Plan of West Virginia, Inc.	(9,600,000)				(69,959,919)				(79,559,919)	
80314	52-0913817	UNICARE Life & Health Insurance Company					(75,931,929)	(362,697,412)			(438,629,341)	70,155,666
89518	86-0684895	Value Health Reinsurance, Inc.									0	
15448	46-2053405	ValueOptions of New Jersey, Inc.	(3,000,000)				(9,052,705)				(12,052,705)	
95799	75-2749263	ValueOptions of Texas, Inc.					(2,979)				(2,979)	
	20-0660563	WellMax Health Medical Centers, LLC					48,823,918				48,823,918	
	45-2736438	WellPoint Information Technology Services, Inc.		320,000,000			286,724,347				606,724,347	
	36-4595641	WellPoint Insurance Services, Inc.					(1,129,675)	110,328,831			109,199,156	(482,684,591)
15929	47-5569628	Wisconsin Collaborative Insurance Company					(18,901,756)				(18,901,756)	
9999999 Control Totals			0	0	0	0	0	0	XXX	0	0	0

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ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

		Responses
	MARCH FILING	
1.	Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?	YES
2.	Will an actuarial opinion be filed by March 1?	WAIVED
3.	Will the confidential Risk-based Capital Report be filed with the NAIC by March 1?	YES
4.	Will the confidential Risk-based Capital Report be filed with the state of domicile, if required, by March 1?	YES
	APRIL FILING	
5.	Will Management's Discussion and Analysis be filed by April 1?	YES
6.	Will the Supplemental Investment Risks Interrogatories be filed by April 1?	YES
7.	Will the Accident and Health Policy Experience Exhibit be filed by April 1?	YES
	JUNE FILING	
8.	Will an audited financial report be filed by June 1?	WAIVED
9.	Will Accountant's Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1?	WAIVED
	AUGUST FILING	
10.	Will the regulator-only (non-public) Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile and electronically with the NAIC (as a regulator-only non-public document) by August 1?	WAIVED

The following supplemental reports are required to be filed as part of your annual statement filing **if your company is engaged in the type of business covered by the supplement. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below.** If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

	MARCH FILING	
11.	Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1?	NO
12.	Will the Supplemental Life data due March 1 be filed with the state of domicile and the NAIC?	NO
13.	Will Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1?	NO
14.	Will the actuarial opinion on participating and non-participating policies as required in Interrogatories 1 and 2 on Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	NO
15.	Will the actuarial opinion on non-guaranteed elements as required in Interrogatory 3 to Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	NO
16.	Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC by March 1?	NO
17.	Will an approval from the reporting entity's state of domicile for relief related to the five-year rotation requirement for lead audit partner be filed electronically with the NAIC by March 1?	NO
18.	Will an approval from the reporting entity's state of domicile for relief related to the one-year cooling off period for independent CPA be filed electronically with the NAIC by March 1?	NO
19.	Will an approval from the reporting entity's state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1?	NO
	APRIL FILING	
20.	Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?	NO
21.	Will the Supplemental Life data due April 1 be filed with the state of domicile and the NAIC?	NO
22.	Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?	NO
23.	Will the regulator only (non-public) Supplemental Health Care Exhibit's Expense Allocation Report be filed with the state of domicile and the NAIC by April 1?	NO
24.	Will the Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit be filed with the state of domicile and the NAIC by April 1?	NO
25.	Will the Adjustments to the Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit (if required) be filed with the state of domicile and the NAIC by April 1?	NO
	AUGUST FILING	
26.	Will Management's Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?	NO

Explanations:

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Bar Codes:

2. Actuarial Opinion [Document Identifier 440]
8. Audited Financial Report [Document Identifier 220]
9. Accountants Letter of Qualifications [Document Identifier 221]
10. Communication of Internal Control Related Matters Noted in Audit [Document Identifier 222]
11. Medicare Supplement Insurance Experience Exhibit [Document Identifier 360]
12. Life Supplement [Document Identifier 205]
13. SIS Stockholder Information Supplement [Document Identifier 420]

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

14. Participating Opinion for Exhibit 5 [Document Identifier 371]
15. Non-Guaranteed Opinion for Exhibit 5 [Document Identifier 370]
16. Medicare Part D Coverage Supplement [Document Identifier 365]
17. Relief from the five-year rotation requirement for lead audit partner [Document Identifier 224]
18. Relief from the one-year cooling off period for independent CPA [Document Identifier 225]
19. Relief from the Requirements for Audit Committees [Document Identifier 226]
20. Long-Term Care Experience Reporting Forms [Document Identifier 306]
21. Life Supplement [Document Identifier 211]
22. Supplemental Health Care Exhibit (Parts 1, 2 and 3) [Document Identifier 216]
23. Supplemental Health Care Exhibit's Expense Allocation Report [Document Identifier 217]
24. Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit [Document Identifier 290]
25 Adjustments to the Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit [Document Identifier 300]
26 Management's Report of Internal Control Over Financial Reporting [Document Identifier 223]

OVERFLOW PAGE FOR WRITE-INS

NONE

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SUMMARY INVESTMENT SCHEDULE

	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
	1	2	3	4	5	6
Investment Categories	Amount	Percentage of Column 1 Line 13	Amount	Securities Lending Reinvested Collateral Amount	Total (Col. 3 + 4) Amount	Percentage of Column 5 Line 13
1. Long-Term Bonds (Schedule D, Part 1):						
1.01 U.S. governments		0.000			0	0.000
1.02 All other governments		0.000			0	0.000
1.03 U.S. states, territories and possessions, etc. guaranteed		0.000			0	0.000
1.04 U.S. political subdivisions of states, territories, and possessions, guaranteed		0.000			0	0.000
1.05 U.S. special revenue and special assessment obligations, etc. non-guaranteed	552,332	13.688	552,332	0	552,332	13.688
1.06 Industrial and miscellaneous		0.000			0	0.000
1.07 Hybrid securities		0.000			0	0.000
1.08 Parent, subsidiaries and affiliates		0.000			0	0.000
1.09 SVO identified funds		0.000			0	0.000
1.10 Unaffiliated Bank loans		0.000			0	0.000
1.11 Total long-term bonds	552,332	13.688	552,332	0	552,332	13.688
2. Preferred stocks (Schedule D, Part 2, Section 1):						
2.01 Industrial and miscellaneous (Unaffiliated)	0	0.000			0	0.000
2.02 Parent, subsidiaries and affiliates	0	0.000			0	0.000
2.03 Total preferred stocks	0	0.000	0	0	0	0.000
3. Common stocks (Schedule D, Part 2, Section 2):						
3.01 Industrial and miscellaneous Publicly traded (Unaffiliated)		0.000			0	0.000
3.02 Industrial and miscellaneous Other (Unaffiliated)		0.000			0	0.000
3.03 Parent, subsidiaries and affiliates Publicly traded		0.000			0	0.000
3.04 Parent, subsidiaries and affiliates Other		0.000			0	0.000
3.05 Mutual funds		0.000			0	0.000
3.06 Unit investment trusts		0.000			0	0.000
3.07 Closed-end funds		0.000			0	0.000
3.08 Total common stocks	0	0.000	0	0	0	0.000
4. Mortgage loans (Schedule B):						
4.01 Farm mortgages	0	0.000			0	0.000
4.02 Residential mortgages	0	0.000			0	0.000
4.03 Commercial mortgages	0	0.000			0	0.000
4.04 Mezzanine real estate loans	0	0.000			0	0.000
4.05 Total valuation allowance		0.000			0	0.000
4.06 Total mortgage loans	0	0.000	0	0	0	0.000
5. Real estate (Schedule A):						
5.01 Properties occupied by company		0.000	0		0	0.000
5.02 Properties held for production of income		0.000	0		0	0.000
5.03 Properties held for sale		0.000	0		0	0.000
5.04 Total real estate	0	0.000	0	0	0	0.000
6. Cash, cash equivalents and short-term investments:						
6.01 Cash (Schedule E, Part 1)	3,482,936	86.312	3,482,936		3,482,936	86.312
6.02 Cash equivalents (Schedule E, Part 2)		0.000	0		0	0.000
6.03 Short-term investments (Schedule DA)		0.000	0		0	0.000
6.04 Total cash, cash equivalents and short-term investments	3,482,936	86.312	3,482,936	0	3,482,936	86.312
7. Contract loans	0	0.000	0		0	0.000
8. Derivatives (Schedule DB)	0	0.000	0		0	0.000
9. Other invested assets (Schedule BA)	0	0.000	0		0	0.000
10. Receivables for securities	0	0.000	0		0	0.000
11. Securities Lending (Schedule DL, Part 1)	0	0.000	0	XXX	XXX	XXX
12. Other invested assets (Page 2, Line 11)	0	0.000	0		0	0.000
13. Total invested assets	4,035,268	100.000	4,035,268	0	4,035,268	100.000

Schedule A - Verification - Real Estate

N O N E

Schedule B - Verification - Mortgage Loans

N O N E

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE BA - VERIFICATION BETWEEN YEARS

Other Long-Term Invested Assets

NONE

1.	Book/adjusted carrying value, December 31 of prior year	
2.	Cost of acquired:	
	2.1 Actual cost at time of acquisition (Part 2, Column 8)	
	2.2 Additional investment made after acquisition (Part 2, Column 9)	
3.	Capitalized deferred interest and other:	
	3.1 Totals, Part 1, Column 16	
	3.2 Totals, Part 3, Column 12	
4.	Accrual of discount	
5.	Unrealized valuation increase (decrease):	
	5.1 Totals, Part 1, Column 13	
	5.2 Totals, Part 3, Column 9	
6.	Total gain (loss) on disposals, Part 3, Column 19	
7.	Deduct amounts received on disposals, Part 3, Column 16	
8.	Deduct amortization of premium and depreciation	
9.	Total foreign exchange change in book/adjusted carrying value:	
	9.1 Totals, Part 1, Column 17	
	9.2 Totals, Part 3, Column 14	
10.	Deduct current year's other than temporary impairment recognized:	
	10.1 Totals, Part 1, Column 15	
	10.2 Totals, Part 3, Column 11	
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)	
12.	Deduct total nonadmitted amounts	
13.	Statement value at end of current period (Line 11 minus Line 12)	

SCHEDULE D - VERIFICATION BETWEEN YEARS

Bonds and Stocks

1.	Book/adjusted carrying value, December 31 of prior year		564,032
2.	Cost of bonds and stocks acquired, Part 3, Column 7		
3.	Accrual of discount		0
4.	Unrealized valuation increase (decrease):		
	4.1. Part 1, Column 12	0	
	4.2. Part 2, Section 1, Column 15		
	4.3. Part 2, Section 2, Column 13		
	4.4. Part 4, Column 11		0
5.	Total gain (loss) on disposals, Part 4, Column 19		
6.	Deduction consideration for bonds and stocks disposed of, Part 4, Column 7		
7.	Deduct amortization of premium		11,700
8.	Total foreign exchange change in book/adjusted carrying value:		
	8.1. Part 1, Column 15	0	
	8.2. Part 2, Section 1, Column 19		
	8.3. Part 2, Section 2, Column 16		
	8.4. Part 4, Column 15		0
9.	Deduct current year's other than temporary impairment recognized:		
	9.1. Part 1, Column 14	0	
	9.2. Part 2, Section 1, Column 17		
	9.3. Part 2, Section 2, Column 14		
	9.4. Part 4, Column 13		0
10.	Total investment income recognized as a result of prepayment penalties and/or acceleration fees, Note 5Q, Line 2		0
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9+10)		552,332
12.	Deduct total nonadmitted amounts		0
13.	Statement value at end of current period (Line 11 minus Line 12)		552,332

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - SUMMARY BY COUNTRY

Long-Term Bonds and Stocks OWNED December 31 of Current Year

Description		1 Book/Adjusted Carrying Value	2 Fair Value	3 Actual Cost	4 Par Value of Bonds
BONDS	1. United States				
Governments	2. Canada				
(Including all obligations guaranteed by governments)	3. Other Countries				
	4. Totals	0	0	0	0
U.S. States, Territories and Possessions (Direct and guaranteed)	5. Totals				
U.S. Political Subdivisions of States, Territories and Possessions (Direct and guaranteed)	6. Totals				
U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and their Political Subdivisions	7. Totals	552,332	598,270	595,550	500,000
Industrial and Miscellaneous, SVO Identified Funds, Unaffiliated Bank Loans and Hybrid Securities (unaffiliated)	8. United States				
	9. Canada				
	10. Other Countries				
	11. Totals	0	0	0	0
Parent, Subsidiaries and Affiliates	12. Totals				
	13. Total Bonds	552,332	598,270	595,550	500,000
PREFERRED STOCKS	14. United States				
Industrial and Miscellaneous (unaffiliated)	15. Canada				
	16. Other Countries				
	17. Totals	0	0	0	
Parent, Subsidiaries and Affiliates	18. Totals	0	0	0	
	19. Total Preferred Stocks	0	0	0	
COMMON STOCKS	20. United States				
Industrial and Miscellaneous (unaffiliated)	21. Canada				
	22. Other Countries				
	23. Totals	0	0	0	
Parent, Subsidiaries and Affiliates	24. Totals	0	0	0	
	25. Total Common Stocks	0	0	0	
	26. Total Stocks	0	0	0	
	27. Total Bonds and Stocks	552,332	598,270	595,550	

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - PART 1A - SECTION 1

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 11.7	9 Total from Col. 7 Prior Year	10 % From Col. 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed (a)
1. U.S. Governments												
1.1 NAIC 1						XXX	0	0.0		0.0		0
1.2 NAIC 2						XXX	0	0.0		0.0		0
1.3 NAIC 3						XXX	0	0.0		0.0		0
1.4 NAIC 4						XXX	0	0.0		0.0		0
1.5 NAIC 5						XXX	0	0.0		0.0		0
1.6 NAIC 6						XXX	0	0.0		0.0		0
1.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
2. All Other Governments												
2.1 NAIC 1						XXX	0	0.0		0.0		0
2.2 NAIC 2						XXX	0	0.0		0.0		0
2.3 NAIC 3						XXX	0	0.0		0.0		0
2.4 NAIC 4						XXX	0	0.0		0.0		0
2.5 NAIC 5						XXX	0	0.0		0.0		0
2.6 NAIC 6						XXX	0	0.0		0.0		0
2.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
3. U.S. States, Territories and Possessions etc., Guaranteed												
3.1 NAIC 1						XXX	0	0.0		0.0		0
3.2 NAIC 2						XXX	0	0.0		0.0		0
3.3 NAIC 3						XXX	0	0.0		0.0		0
3.4 NAIC 4						XXX	0	0.0		0.0		0
3.5 NAIC 5						XXX	0	0.0		0.0		0
3.6 NAIC 6						XXX	0	0.0		0.0		0
3.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
4. U.S. Political Subdivisions of States, Territories and Possessions , Guaranteed												
4.1 NAIC 1						XXX	0	0.0		0.0		0
4.2 NAIC 2						XXX	0	0.0		0.0		0
4.3 NAIC 3						XXX	0	0.0		0.0		0
4.4 NAIC 4						XXX	0	0.0		0.0		0
4.5 NAIC 5						XXX	0	0.0		0.0		0
4.6 NAIC 6						XXX	0	0.0		0.0		0
4.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
5. U.S. Special Revenue & Special Assessment Obligations, etc., Non-Guaranteed												
5.1 NAIC 1	0	552,332	0	0	0	XXX	552,332	100.0	564,032	100.0	552,332	0
5.2 NAIC 2						XXX	0	0.0		0.0		0
5.3 NAIC 3						XXX	0	0.0		0.0		0
5.4 NAIC 4						XXX	0	0.0		0.0		0
5.5 NAIC 5						XXX	0	0.0		0.0		0
5.6 NAIC 6						XXX	0	0.0		0.0		0
5.7 Totals	0	552,332	0	0	0	XXX	552,332	100.0	564,032	100.0	552,332	0

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ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - PART 1A - SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 11.7	9 Total from Col. 7 Prior Year	10 % From Col. 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed (a)
6. Industrial & Miscellaneous (Unaffiliated)												
6.1 NAIC 1						XXX	0	0.0		0.0		0
6.2 NAIC 2						XXX	0	0.0		0.0		0
6.3 NAIC 3						XXX	0	0.0		0.0		0
6.4 NAIC 4						XXX	0	0.0		0.0		0
6.5 NAIC 5						XXX	0	0.0		0.0		0
6.6 NAIC 6						XXX	0	0.0		0.0		0
6.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7. Hybrid Securities												
7.1 NAIC 1						XXX	0	0.0		0.0		0
7.2 NAIC 2						XXX	0	0.0		0.0		0
7.3 NAIC 3						XXX	0	0.0		0.0		0
7.4 NAIC 4						XXX	0	0.0		0.0		0
7.5 NAIC 5						XXX	0	0.0		0.0		0
7.6 NAIC 6						XXX	0	0.0		0.0		0
7.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8. Parent, Subsidiaries and Affiliates												
8.1 NAIC 1						XXX	0	0.0		0.0		0
8.2 NAIC 2						XXX	0	0.0		0.0		0
8.3 NAIC 3						XXX	0	0.0		0.0		0
8.4 NAIC 4						XXX	0	0.0		0.0		0
8.5 NAIC 5						XXX	0	0.0		0.0		0
8.6 NAIC 6						XXX	0	0.0		0.0		0
8.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
9. SVO Identified Funds												
9.1 NAIC 1	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.2 NAIC 2	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.3 NAIC 3	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.4 NAIC 4	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.5 NAIC 5	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.6 NAIC 6	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.7 Totals	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	0	0
10. Unaffiliated Bank Loans												
10.1 NAIC 1						XXX	0	0.0		0.0		0
10.2 NAIC 2						XXX	0	0.0		0.0		0
10.3 NAIC 3						XXX	0	0.0		0.0		0
10.4 NAIC 4						XXX	0	0.0		0.0		0
10.5 NAIC 5						XXX	0	0.0		0.0		0
10.6 NAIC 6						XXX	0	0.0		0.0		0
10.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - PART 1A - SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 11.7	9 Total from Col. 7 Prior Year	10 % From Col. 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed (a)
11. Total Bonds Current Year												
11.1 NAIC 1	(d) 0	552,332	0	0	0	0	552,332	100.0	XXX	XXX	552,332	0
11.2 NAIC 2	(d) 0	0	0	0	0	0	0	0.0	XXX	XXX	0	0
11.3 NAIC 3	(d) 0	0	0	0	0	0	0	0.0	XXX	XXX	0	0
11.4 NAIC 4	(d) 0	0	0	0	0	0	0	0.0	XXX	XXX	0	0
11.5 NAIC 5	(d) 0	0	0	0	0	0	(c) 0	0.0	XXX	XXX	0	0
11.6 NAIC 6	(d) 0	0	0	0	0	0	(c) 0	0.0	XXX	XXX	0	0
11.7 Totals	0	552,332	0	0	0	0	(b) 552,332	100.0	XXX	XXX	552,332	0
11.8 Line 11.7 as a % of Col. 7	0.0	100.0	0.0	0.0	0.0	0.0	100.0	XXX	XXX	XXX	100.0	0.0
12. Total Bonds Prior Year												
12.1 NAIC 1	0	0	564,032	0	0	0	XXX	XXX	564,032	100.0	564,032	0
12.2 NAIC 2							XXX	XXX	0	0.0		0
12.3 NAIC 3							XXX	XXX	0	0.0		0
12.4 NAIC 4							XXX	XXX	0	0.0		0
12.5 NAIC 5							XXX	XXX	(c) 0	0.0		0
12.6 NAIC 6							XXX	XXX	(c) 0	0.0		0
12.7 Totals	0	0	564,032	0	0	0	XXX	XXX	(b) 564,032	100.0	564,032	0
12.8 Line 12.7 as a % of Col. 9	0.0	0.0	100.0	0.0	0.0	0.0	XXX	XXX	100.0	XXX	100.0	0.0
13. Total Publicly Traded Bonds												
13.1 NAIC 1	0	552,332	0	0	0	0	552,332	100.0	564,032	100.0	552,332	XXX
13.2 NAIC 2							0	0.0	0	0.0	0	XXX
13.3 NAIC 3							0	0.0	0	0.0	0	XXX
13.4 NAIC 4							0	0.0	0	0.0	0	XXX
13.5 NAIC 5							0	0.0	0	0.0	0	XXX
13.6 NAIC 6							0	0.0	0	0.0	0	XXX
13.7 Totals	0	552,332	0	0	0	0	552,332	100.0	564,032	100.0	552,332	XXX
13.8 Line 13.7 as a % of Col. 7	0.0	100.0	0.0	0.0	0.0	0.0	100.0	XXX	XXX	XXX	100.0	XXX
13.9 Line 13.7 as a % of Line 11.7, Col. 7, Section 11	0.0	100.0	0.0	0.0	0.0	0.0	100.0	XXX	XXX	XXX	100.0	XXX
14. Total Privately Placed Bonds												
14.1 NAIC 1	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.2 NAIC 2	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.3 NAIC 3	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.4 NAIC 4	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.5 NAIC 5	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.6 NAIC 6	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.7 Totals	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.8 Line 14.7 as a % of Col. 7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	XXX	XXX	XXX	XXX	0.0
14.9 Line 14.7 as a % of Line 11.7, Col. 7, Section 11	0.0	0.0	0.0	0.0	0.0	0.0	0.0	XXX	XXX	XXX	XXX	0.0

(a) Includes $ ..... freely tradable under SEC Rule 144 or qualified for resale under SEC Rule 144A.
(b) Includes $ ..... current year of bonds with Z designations and $ ..... prior year of bonds with Z designations. The letter "Z" means the NAIC designation was not assigned by the Securities Valuation Office (SVO) at the date of the statement.
(c) Includes $ ..... current year, $ ..... prior year of bonds with 5GI designations and $ ..... current year, $ ..... prior year of bonds with 6* designations. "5GI" means the NAIC designation was assigned by the (SVO) in reliance on the insurer's certification that the issuer is current in all principal and interest payments. "6*" means the NAIC designation was assigned by the SVO due to inadequate certification of principal and interest payments.
(d) Includes the following amount of short-term and cash equivalent bonds by NAIC designation: NAIC 1 $ ..... ; NAIC 2 $ ..... ; NAIC 3 $ ..... ; NAIC 4 $ ..... ; NAIC 5 $ ..... ; NAIC 6 $ .....

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - PART 1A - SECTION 2

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 11.08	9 Total from Col. 7 Prior Year	10 % From Col. 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed
1. U.S. Governments												
1.01 Issuer Obligations						XXX	0	0.0		0.0		0
1.02 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
1.03 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
1.04 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
1.05 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
2. All Other Governments												
2.01 Issuer Obligations						XXX	0	0.0		0.0		0
2.02 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
2.03 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
2.04 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
2.05 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
3. U.S. States, Territories and Possessions, Guaranteed												
3.01 Issuer Obligations						XXX	0	0.0		0.0		0
3.02 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
3.03 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
3.04 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
3.05 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
4. U.S. Political Subdivisions of States, Territories and Possessions, Guaranteed												
4.01 Issuer Obligations						XXX	0	0.0		0.0		0
4.02 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
4.03 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
4.04 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
4.05 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
5. U.S. Special Revenue & Special Assessment Obligations etc., Non-Guaranteed												
5.01 Issuer Obligations	0	552,332	0	0	0	XXX	552,332	100.0	564,032	100.0	552,332	0
5.02 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
5.03 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
5.04 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
5.05 Totals	0	552,332	0	0	0	XXX	552,332	100.0	564,032	100.0	552,332	0
6. Industrial and Miscellaneous												
6.01 Issuer Obligations						XXX	0	0.0		0.0		0
6.02 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
6.03 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
6.04 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
6.05 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7. Hybrid Securities												
7.01 Issuer Obligations						XXX	0	0.0		0.0		0
7.02 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
7.03 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
7.04 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
7.05 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8. Parent, Subsidiaries and Affiliates												
8.01 Issuer Obligations						XXX	0	0.0		0.0		0
8.02 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
8.03 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
8.04 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
8.05 Affiliated Bank Loans - Issued						XXX	0	0.0		0.0		0
8.06 Affiliated Bank Loans - Acquired						XXX	0	0.0		0.0		0
8.07 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - PART 1A - SECTION 2 (Continued)

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 11.08	9 Total from Col. 7 Prior Year	10 % From Col. 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed
9. SVO Identified Funds												
9.01 Exchange Traded Funds Identified by the SVO	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.02 Bond Mutual Funds Identified by the SVO	XXX	XXX	XXX	XXX	XXX		0	0.0		0.0		0
9.03 Totals	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	0	0
10. Unaffiliated Bank Loans												
10.01 Unaffiliated Bank Loans - Issued						XXX	0	0.0		0.0		0
10.02 Unaffiliated Bank Loans - Acquired						XXX	0	0.0		0.0		0
10.03 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
11. Total Bonds Current Year												
11.01 Issuer Obligations	0	552,332	0	0	0	XXX	552,332	100.0	XXX	XXX	552,332	0
11.02 Residential Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
11.03 Commercial Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
11.04 Other Loan-Backed and Structured Securities	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
11.05 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX	0	0	0.0	XXX	XXX	0	0
11.06 Affiliated Bank Loans	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
11.07 Unaffiliated Bank Loans	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
11.08 Totals	0	552,332	0	0	0	0	552,332	100.0	XXX	XXX	552,332	0
11.09 Line 11.08 as a % of Col. 7	0.0	100.0	0.0	0.0	0.0	0.0	100.0	XXX	XXX	XXX	100.0	0.0
12. Total Bonds Prior Year												
12.01 Issuer Obligations	0	0	564,032	0	0	XXX	XXX	XXX	564,032	100.0	564,032	0
12.02 Residential Mortgage-Backed Securities						XXX	XXX	XXX	0	0.0		0
12.03 Commercial Mortgage-Backed Securities						XXX	XXX	XXX	0	0.0		0
12.04 Other Loan-Backed and Structured Securities						XXX	XXX	XXX	0	0.0		0
12.05 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX		XXX	XXX	0	0.0		0
12.06 Affiliated Bank Loans						XXX	XXX	XXX	0	0.0		0
12.07 Unaffiliated Bank Loans						XXX	XXX	XXX	0	0.0		0
12.08 Totals	0	0	564,032	0	0	0	XXX	XXX	564,032	100.0	564,032	0
12.09 Line 12.08 as a % of Col. 9	0.0	0.0	100.0	0.0	0.0	0.0	XXX	XXX	100.0	XXX	100.0	0.0
13. Total Publicly Traded Bonds												
13.01 Issuer Obligations	0	552,332	0	0	0	XXX	552,332	100.0	564,032	100.0	552,332	XXX
13.02 Residential Mortgage-Backed Securities						XXX	0	0.0	0	0.0	0	XXX
13.03 Commercial Mortgage-Backed Securities						XXX	0	0.0	0	0.0	0	XXX
13.04 Other Loan-Backed and Structured Securities						XXX	0	0.0	0	0.0	0	XXX
13.05 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX		0	0.0	0	0.0	0	XXX
13.06 Affiliated Bank Loans						XXX	0	0.0	0	0.0	0	XXX
13.07 Unaffiliated Bank Loans						XXX	0	0.0	0	0.0	0	XXX
13.08 Totals	0	552,332	0	0	0	0	552,332	100.0	564,032	100.0	552,332	XXX
13.09 Line 13.08 as a % of Col. 7	0.0	100.0	0.0	0.0	0.0	0.0	100.0	XXX	XXX	XXX	100.0	XXX
13.10 Line 13.08 as a % of Line 11.08, Col. 7, Section 11	0.0	100.0	0.0	0.0	0.0	0.0	100.0	XXX	XXX	XXX	100.0	XXX
14. Total Privately Placed Bonds												
14.01 Issuer Obligations	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
14.02 Residential Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
14.03 Commercial Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
14.04 Other Loan-Backed and Structured Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
14.05 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	XXX	0
14.06 Affiliated Bank Loans	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
14.07 Unaffiliated Bank Loans	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
14.08 Totals	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.09 Line 14.08 as a % of Col. 7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	XXX	XXX	XXX	XXX	0.0
14.10 Line 14.08 as a % of Line 11.08, Col. 7, Section 11	0.0	0.0	0.0	0.0	0.0	0.0	0.0	XXX	XXX	XXX	XXX	0.0

Schedule DA - Verification - Short-Term Investments

N O N E

Schedule DB - Part A - Verification - Options, Caps, Floors, Collars, Swaps and Forwards

N O N E

Schedule DB - Part B - Verification - Futures Contracts

N O N E

Schedule DB - Part C - Section 1 - Replication (Synthetic Asset) Transactions (RSATs) Open

N O N E

Schedule DB-Part C-Section 2-Reconciliation of Replication (Synthetic Asset) Transactions Open

N O N E

Schedule DB - Verification - Book/Adjusted Carrying Value, Fair Value and Potential Exposure of Derivatives

N O N E

Schedule E - Part 2 - Verification - Cash Equivalents

N O N E

Schedule A - Part 1 - Real Estate Owned

N O N E

Schedule A - Part 2 - Real Estate Acquired and Additions Made

N O N E

Schedule A - Part 3 - Real Estate Disposed

N O N E

Schedule B - Part 1 - Mortgage Loans Owned

N O N E

Schedule B - Part 2 - Mortgage Loans Acquired and Additions Made

N O N E

Schedule B - Part 3 - Mortgage Loans Disposed, Transferred or Repaid

N O N E

Schedule BA - Part 1 - Other Long-Term Invested Assets Owned

N O N E

Schedule BA - Part 2 - Other Long-Term Invested Assets Acquired and Additions Made

N O N E

Schedule BA - Part 3 - Other Long-Term Invested Assets Disposed, Transferred or Repaid

N O N E

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book/Adjusted Carrying Value				Interest					Dates	
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	Code	Foreign	Bond Char	NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization) Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Rate of	Effective Rate of	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
0599999. Total - U.S. Government Bonds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
1099999. Total - All Other Government Bonds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
1799999. Total - U.S. States, Territories and Possessions Bonds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
2499999. Total - U.S. Political Subdivisions Bonds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
650035-W8-7	NEW YORK ST URBAN DEV CORP REV SERIES A		SD		1.B FE	595,550	119.6540	598,270	500,000	552,332	0	(11,701)	0	0	5.000	2.370	MS	7,361	25,000	03/02/2017	03/15/2025
2599999. Subtotal - Bonds - U.S. Special Revenues - Issuer Obligations						595,550	XXX	598,270	500,000	552,332	0	(11,701)	0	0	XXX	XXX	XXX	7,361	25,000	XXX	XXX
3199999. Total - U.S. Special Revenues Bonds						595,550	XXX	598,270	500,000	552,332	0	(11,701)	0	0	XXX	XXX	XXX	7,361	25,000	XXX	XXX
3899999. Total - Industrial and Miscellaneous (Unaffiliated) Bonds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
4899999. Total - Hybrid Securities						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
5599999. Total - Parent, Subsidiaries and Affiliates Bonds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
6099999. Subtotal - SVO Identified Funds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
6599999. Subtotal - Unaffiliated Bank Loans						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
7699999. Total - Issuer Obligations						595,550	XXX	598,270	500,000	552,332	0	(11,701)	0	0	XXX	XXX	XXX	7,361	25,000	XXX	XXX
7799999. Total - Residential Mortgage-Backed Securities						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
7899999. Total - Commercial Mortgage-Backed Securities						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
7999999. Total - Other Loan-Backed and Structured Securities						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
8099999. Total - SVO Identified Funds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
8199999. Total - Affiliated Bank Loans						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
8299999. Total - Unaffiliated Bank Loans						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
8399999 - Total Bonds						595,550	XXX	598,270	500,000	552,332	0	(11,701)	0	0	XXX	XXX	XXX	7,361	25,000	XXX	XXX

Book/Adjusted Carrying Value by NAIC Designation Category Footnote:

1A ..$ 0 1B ...$ 552,332 1C ...$ 0 1D ...$ 0 1E ...$ 0 1F ...$ 0 1G ..$ 0
2A ..$ 0 2B ...$ 0 2C ...$ 0
3A ..$ 0 3B ...$ 0 3C ...$ 0
4A ..$ 0 4B ...$ 0 4C ...$ 0
5A ..$ 0 5B ...$ 0 5C ...$ 0
6 ....$ 0

Schedule D - Part 2 - Section 1 - Preferred Stocks Owned

N O N E

Schedule D - Part 2 - Section 2 - Common Stocks Owned

N O N E

Schedule D - Part 3 - Long-Term Bonds and Stocks Acquired

N O N E

Schedule D - Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed Of

N O N E

Schedule D - Part 5 - Long Term Bonds and Stocks Acquired and Fully Disposed Of

N O N E

Schedule D-Part 6-Section 1-Valuation of Shares of Subsidiary, Controlled or Affiliated Companies

N O N E

Schedule D - Part 6 - Section 2

N O N E

Schedule DA - Part 1 - Short-Term Investments Owned

N O N E

Schedule DB - Part A - Section 1 - Options, Caps, Floors, Collars, Swaps and Forwards Open

N O N E

Schedule DB - Part A - Section 2 - Options, Caps, Floors, Collars, Swaps and Forwards Terminated

N O N E

Schedule DB - Part B - Section 1 - Futures Contracts Open

N O N E

Schedule DB - Part B - Section 1B - Brokers with whom cash deposits have been made

N O N E

Schedule DB - Part B - Section 2 - Futures Contracts Terminated

N O N E

Schedule DB - Part D - Section 1 - Counterparty Exposure for Derivative Instruments Open

N O N E

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged By

N O N E

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged To

N O N E

Schedule DB - Part E - Derivatives Hedging Variable Annuity Guarantees as of December 31 of Current Year

N O N E

Schedule DL - Part 1 - Reinvested Collateral Assets Owned

N O N E

Schedule DL - Part 2 - Reinvested Collateral Assets Owned

N O N E

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE E - PART 1 - CASH

1 Depository	2 Code	3 Rate of Interest	4 Amount of Interest Received During Year	5 Amount of Interest Accrued December 31 of Current Year	6 Balance	7 *
Bank of America 101 S. Tryon Street, 19th Floor, Charlotte, NC 28255		0.000	0	0	3,482,936	XXX
0199998 Deposits in ... depositories which do not exceed the allowable limit in any one depository (See instructions) - open depositories	XXX	XXX				XXX
0199999. Totals - Open Depositories	XXX	XXX	0	0	3,482,936	XXX
0299998 Deposits in ... depositories which do not exceed the allowable limit in any one depository (See instructions) - suspended depositories	XXX	XXX				XXX
0299999. Totals - Suspended Depositories	XXX	XXX	0	0	0	XXX
0399999. Total Cash on Deposit	XXX	XXX	0	0	3,482,936	XXX
0499999. Cash in Company's Office	XXX	XXX	XXX	XXX		XXX
0599999 Total - Cash	XXX	XXX	0	0	3,482,936	XXX

TOTALS OF DEPOSITORY BALANCES ON THE LAST DAY OF EACH MONTH DURING THE CURRENT YEAR

1. January	3,442,636	4. April	3,474,506	7. July	3,472,300	10. October	3,484,570
2. February	3,442,636	5. May	3,473,771	8. August	3,471,567	11. November	3,483,841
3. March	3,442,636	6. June	3,473,036	9. September	3,470,834	12. December	3,482,936

ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE E - PART 2 - CASH EQUIVALENTS

Show Investments Owned December 31 of Current Year

1 CUSIP	2 Description	3 Code	4 Date Acquired	5 Rate of Interest	6 Maturity Date	7 Book/Adjusted Carrying Value	8 Amount of Interest Due and Accrued	9 Amount Received During Year
8899999 - Total Cash Equivalents								

NONE

Book/Adjusted Carrying Value by NAIC Designation Category Footnote:
1A ..$ ..... 1B ...$ ..... 1C ..$ ..... 1D ..$ ..... 1E ...$ ..... 1F ...$ ..... 1G ..$ .....
2A ..$ ..... 2B ...$ ..... 2C ..$ .....
3A ..$ ..... 3B ...$ ..... 3C ..$ .....
4A ..$ ..... 4B ...$ ..... 4C ..$ .....
5A ..$ ..... 5B ...$ ..... 5C ..$ .....
6 ....$ .....

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ANNUAL STATEMENT FOR THE YEAR 2020 OF THE Amerigroup Mississippi, Inc.

SCHEDULE E - PART 3 - SPECIAL DEPOSITS

	1	2	Deposits For the Benefit of All Policyholders		All Other Special Deposits	
			3	4	5	6
States, Etc.	Type of Deposit	Purpose of Deposit	Book/Adjusted Carrying Value	Fair Value	Book/Adjusted Carrying Value	Fair Value
1. Alabama AL						
2. Alaska AK						
3. Arizona AZ						
4. Arkansas AR						
5. California CA						
6. Colorado CO						
7. Connecticut CT						
8. Delaware DE						
9. District of Columbia DC						
10. Florida FL						
11. Georgia GA						
12. Hawaii HI						
13. Idaho ID						
14. Illinois IL						
15. Indiana IN						
16. Iowa IA						
17. Kansas KS						
18. Kentucky KY						
19. Louisiana LA						
20. Maine ME						
21. Maryland MD						
22. Massachusetts MA						
23. Michigan MI						
24. Minnesota MN						
25. Mississippi MS	B	Required by Mississippi statue	552,331	598,270		
26. Missouri MO						
27. Montana MT						
28. Nebraska NE						
29. Nevada NV						
30. New Hampshire NH						
31. New Jersey NJ						
32. New Mexico NM						
33. New York NY						
34. North Carolina NC						
35. North Dakota ND						
36. Ohio OH						
37. Oklahoma OK						
38. Oregon OR						
39. Pennsylvania PA						
40. Rhode Island RI						
41. South Carolina SC						
42. South Dakota SD						
43. Tennessee TN						
44. Texas TX						
45. Utah UT						
46. Vermont VT						
47. Virginia VA						
48. Washington WA						
49. West Virginia WV						
50. Wisconsin WI						
51. Wyoming WY						
52. American Samoa AS						
53. Guam GU						
54. Puerto Rico PR						
55. U.S. Virgin Islands VI						
56. Northern Mariana Islands MP						
57. Canada CAN						
58. Aggregate Alien and Other OT	XXX	XXX	0	0	0	0
59. Subtotal	XXX	XXX	552,331	598,270	0	0
DETAILS OF WRITE-INS						
5801.						
5802.						
5803.						
5898. Summary of remaining write-ins for Line 58 from overflow page	XXX	XXX	0	0	0	0
5899. Totals (Lines 5801 thru 5803 plus 5898)(Line 58 above)	XXX	XXX	0	0	0	0

MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

MARK HAIRE
Deputy Commissioner of Insurance

MISSISSIPPI INSURANCE DEPARTMENT
501 N. WEST STREET, SUITE 1001
WOOLFOLK BUILDING
JACKSON, MISSISSIPPI 39201
www.mid.ms.gov

MAILING ADDRESS
Post Office Box 79
Jackson, MS 39205-0079
TELEPHONE: (601) 359-3569
FAX: (601) 576-2568

Delivered Via Email
Tim.niccum@anthem.com

February 21, 2019

Timothy R. Niccum
Director II, External Financial Reporting
Anthem, Inc.

Re: Request for Exemption

Dear Timothy R. Niccum:

The exemption requested in your letter dated January 10, 2019 for filing the 2018 Audited Annual Financial Statements, per the Miss Code Ann 83-5-104 has been approved for Amerigroup Mississippi, Inc.

Please note this exemption is only for the year ending December 31, 2018. Unless an exemption is requested and approved, the Audited Annual Financial Statements will be required by the Company for year ending December 31, 2019 commencing with the 2019 Annual Statement. The filing submission will be due to the Department by June 1, 2020.

Please let us know if we can be of further assistance.

Respectfully,

MIKE CHANEY
COMMISSIONER OF INSURANCE

BY Lauren Williams
Lauren Williams, CFE
Insurance Examiner

LW/CTB

MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

MARK HAIRE
Deputy Commissioner of Insurance

MISSISSIPPI INSURANCE DEPARTMENT

501 N. WEST STREET, SUITE 1001
WOOLFOLK BUILDING
JACKSON, MISSISSIPPI 39201
www.mid.ms.gov

MAILING ADDRESS
Post Office Box 79
Jackson, MS 39205-0079
TELEPHONE: (601) 359-3569
FAX: (601) 576-2568

Delivered Via Email
Tim.niccum@anthem.com

February 26, 2020

Timothy R. Niccum
Director II, External Financial Reporting
Anthem, Inc.

Re: Request for Exemption

Dear Timothy R. Niccum:

The exemption requested in your letter dated December 2, 2019 for filing the 2019 Audited Annual Financial Statements, per the Miss Code Ann 83-5-104 has been approved for Amerigroup Mississippi, Inc.

Please note this exemption is only for the year ending December 31, 2019. Unless an exemption is requested and approved, the Audited Annual Financial Statements will be required by the Company for year ending December 31, 2020 commencing with the 2020 Annual Statement. The filing submission will be due to the Department by June 1, 2021.

Please let us know if we can be of further assistance.

Respectfully,

MIKE CHANEY
COMMISSIONER OF INSURANCE

BY Lauren Williams
Lauren Williams, CFE
Insurance Examiner

LW/CTB

MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

MARK HAIRE
Deputy Commissioner of Insurance

MISSISSIPPI INSURANCE DEPARTMENT
501 N. WEST STREET, SUITE 1001
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JACKSON, MISSISSIPPI 39201
www.mid.ms.gov

MAILING ADDRESS
Post Office Box 79
Jackson, MS 39205-0079
TELEPHONE: (601) 359-3569
FAX: (601) 576-2568

Delivered Via Email
Tim.niccum@anthem.com

February 4, 2021

Timothy R. Niccum
Director II, External Financial Reporting
Anthem, Inc.

Re: Request for Exemption

Dear Timothy R. Niccum:

The exemption requested in your letter dated December 2, 2020 for filing the 2020 Audited Annual Financial Statements, per the Miss Code Ann 83-5-104 has been approved for Amerigroup Mississippi, Inc.

Please note this exemption is only for the year ending December 31, 2020. Unless an exemption is requested and approved, the Audited Annual Financial Statements will be required by the Company for year ending December 31, 2021 commencing with the 2021 Annual Statement. The filing submission will be due to the Department by June 1, 2022.

Please let us know if we can be of further assistance.

Respectfully,

MIKE CHANEY
COMMISSIONER OF INSURANCE

BY Lauren Williams
Lauren Williams, CFE
Insurance Examiner

LW/CTB

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)

x **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2018
OR

o **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from to
Commission file number: 001-16751

ANTHEM, INC.
(Exact name of registrant as specified in its charter)

INDIANA **(State or other jurisdiction of incorporation or organization)**	**35-2145715** **(I.R.S. Employer Identification Number)**
220 VIRGINIA AVENUE **INDIANAPOLIS, INDIANA** **(Address of principal executive offices)**	**46204** **(Zip Code)**

Registrant's telephone number, including area code: **(800) 331-1476**
Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock, Par Value $0.01	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes x No ☐

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No x

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes x No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes x No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. x

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer	x	Accelerated filer	☐
Non-accelerated filer	☐	Smaller reporting company	☐
Emerging growth company	☐		

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No x

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant (assuming solely for the purposes of this calculation that all Directors and executive officers of the registrant are "affiliates") as of June 29, 2018 was approximately $61,871,738,688.

As of February 7, 2019, 257,011,928 shares of the Registrant's Common Stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Annual Report on Form 10-K incorporates by reference information from the registrant's Definitive Proxy Statement for the Annual Meeting of Shareholders to be held May 15, 2019.

Anthem, Inc.

Annual Report on Form 10-K
For the Year Ended December 31, 2018

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References in this Annual Report on Form 10-K to the terms "we," "our," "us," "Anthem" or the "Company" refer to Anthem, Inc., an Indiana corporation, and, unless the context otherwise requires, its direct and indirect subsidiaries. References to the term "states" include the District of Columbia, unless the context otherwise requires.

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K, including Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations," contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements reflect our views about future events and financial performance and are generally not historical facts. Words such as "expect," "feel," "believe," "will," "may," "should," "anticipate," "intend," "estimate," "project," "forecast," "plan" and similar expressions are intended to identify forward-looking statements. These statements include, but are not limited to: financial projections and estimates and their underlying assumptions; statements regarding plans, objectives and expectations with respect to future operations, products and services; and statements regarding future performance. Such statements are subject to certain risks and uncertainties, many of which are difficult to predict and generally beyond our control, that could cause actual results to differ materially from those expressed in, or implied or projected by, the forward-looking statements. You are cautioned not to place undue reliance on these forward-looking statements that speak only as of the date hereof. You are also urged to carefully review and consider the various risks and other disclosures discussed in our reports filed with the U.S. Securities and Exchange Commission from time to time, which attempt to advise interested parties of the factors that affect our business. Except to the extent otherwise required by federal securities laws, we do not undertake any obligation to republish revised forward-looking statements to reflect events or circumstances after the date hereof. These risks and uncertainties include, but are not limited to: the impact of federal and state regulation, including ongoing changes in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended, or collectively, the ACA, and the ultimate outcome of legal challenges to the ACA; trends in healthcare costs and utilization rates; our ability to contract with providers on cost-effective and competitive terms; our ability to secure sufficient premium rates, including regulatory approval for and implementation of such rates; competitive pressures and our ability to adapt to changes in the industry and develop and implement strategic growth opportunities; reduced enrollment; unauthorized disclosure of member or employee sensitive or confidential information, including the impact and outcome of any investigations, inquiries, claims and litigation related thereto; risks and uncertainties regarding Medicare and Medicaid programs, including those related to non-compliance with the complex regulations imposed thereon; our ability to maintain and achieve improvement in Centers for Medicare and Medicaid Services, or CMS, Star ratings and other quality scores and funding risks with respect to revenue received from participation therein; a negative change in our healthcare product mix; costs and other liabilities associated with litigation, government investigations, audits or reviews; the ultimate outcome of litigation between Cigna Corporation, or Cigna, and us related to the merger agreement between the parties, including our claim for damages against Cigna, Cigna's claim for payment of a termination fee and other damages against us, and the potential for such litigation to cause us to incur substantial costs, materially distract management and negatively impact our reputation and financial condition; non-compliance by any party with the pharmacy benefit management services agreement between Express Scripts, Inc., or Express Scripts, and us, as well as any agreements governing the transition of pharmacy benefit management services provided to us from Express Scripts to CaremarkPCS Health, L.L.C., a subsidiary of CVS Health Corporation, which could result in financial penalties, our inability to meet customer demands, and sanctions imposed by governmental entities, including CMS; medical malpractice or professional liability claims or other risks related to healthcare services and pharmacy benefit management services provided by our subsidiaries; possible restrictions in the payment of dividends from our subsidiaries and increases in required minimum levels of capital; the potential negative effect from our substantial amount of outstanding indebtedness; a downgrade in our financial strength ratings; the effects of any negative publicity related to the health benefits industry in general or us in particular; failure to effectively maintain and modernize our information systems; events that may negatively affect our licenses with the Blue Cross and Blue Shield Association; large scale medical emergencies, such as future public health epidemics and catastrophes; general risks associated with mergers, acquisitions, joint ventures and strategic alliances; possible impairment of the value of our intangible assets if future results do not adequately support goodwill and other intangible assets; changes in economic and market conditions, as well as regulations that may negatively affect our liquidity and investment portfolios; changes in U.S. tax laws; intense competition to attract and retain employees; and, various laws and provisions in our governing documents that may prevent or discourage takeovers and business combinations.

PART I

ITEM 1. BUSINESS.

General

We are one of the largest health benefits companies in the United States in terms of medical membership, serving approximately 40 million medical members through our affiliated health plans as of December 31, 2018. We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (in the New York City metropolitan area and upstate New York), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas, we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia, and Empire Blue Cross Blue Shield or Empire Blue Cross. We also conduct business through arrangements with other BCBS licensees in Louisiana, South Carolina and western New York. Through our subsidiaries, we also serve customers in over 25 states across the country as America's 1st Choice, Amerigroup, Aspire Health, CareMore, Freedom Health, HealthLink, HealthSun, Optimum HealthCare, Simply Healthcare, and/or UniCare. We are licensed to conduct insurance operations in all 50 states and the District of Columbia through our subsidiaries.

On February 15, 2018, we completed our acquisition of Freedom Health, Inc., Optimum HealthCare, Inc., America's 1st Choice of South Carolina, Inc. and related entities, or collectively, America's 1st Choice, a Medicare Advantage organization that offers health maintenance organization, or HMO, products, including Chronic Special Needs Plans and Dual-Eligible Special Needs Plans under its Freedom Health and Optimum HealthCare brands in Florida and its America's 1st Choice of South Carolina brand in South Carolina. At the time of acquisition, through its Medicare Advantage Plans, America's 1st Choice served approximately one hundred and thirty-five thousand members in 25 Florida and 3 South Carolina counties. This acquisition aligned with our plans for continued growth in the Medicare Advantage and Special Needs populations.

In October 2017, we established a new pharmacy benefits manager, or PBM, called IngenioRx, and entered into a five-year agreement with CaremarkPCS Health, L.L.C., or CVS Health, which is a subsidiary of CVS Health Corporation, to begin offering PBM solutions (the "CVS PBM Agreement"), which coincides with the conclusion of our current PBM agreement with Express Scripts, Inc. or Express Scripts, (the "ESI PBM Agreement"). In January 2019, we exercised our contractual right to terminate the ESI PBM Agreement earlier than the original expiration date of December 31, 2019 due to the recent acquisition of Express Scripts by Cigna Corporation, or Cigna. As a result of exercising our early termination right, the ESI PBM Agreement will now terminate on March 1, 2019, and the twelve-month transition period to migrate the business begins on March 2, 2019. At that time CVS Health is able to begin providing certain PBM services to IngenioRx pursuant to the CVS PBM Agreement. Notwithstanding our termination of the ESI PBM Agreement, the litigation between us and Express Scripts regarding the ESI PBM Agreement continues. In March 2016, we filed a lawsuit against Express Scripts seeking to recover damages for pharmacy pricing that is higher than competitive benchmark pricing and damages related to operational breaches. Express Scripts filed an answer to the lawsuit disputing our contractual claims and alleging various defenses and counterclaims. For additional information regarding this lawsuit, see Note 13, "Commitments and Contingencies - *Litigation and Regulatory Proceedings - Express Scripts, Inc. Pharmacy Benefit Management Litigation*," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

In May 2017, we announced that we were terminating the Agreement and Plan of Merger, or Cigna Merger Agreement, between us and Cigna. Both we and Cigna have commenced litigation against the other seeking various actions and damages, including Cigna's damage claim for a $1.850 billion termination fee pursuant to the terms of the Cigna Merger Agreement. For additional information about the ongoing litigation related to the Cigna Merger Agreement, see Note 13, "Commitments and Contingencies - *Litigation and Regulatory Proceedings - Cigna Corporation Merger Litigation,*" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

At Anthem, we believe in working together to achieve our mission of improving lives and communities, simplifying healthcare and expecting more. As we seek to accomplish these goals through a collaborative focus on execution and delivering for those we serve, our vision is to be the most innovative, valuable and inclusive health partner. We focus on ensuring quality products and services that give members access to the care they need. With an unyielding commitment to meeting the needs of our diverse customers, we are guided by the following values:

- Leadership – Redefine what is possible
- Community – Committed, connected, invested
- Integrity – Do the right thing, with a spirit of excellence
- Agility – Delivery today, transform tomorrow
- Diversity – Open your hearts and minds

By striving to live our values each day and in every interaction, we are committed to simplifying as well as radically reinventing the healthcare experience for all Americans.

We offer a broad spectrum of network-based managed care plans to Large Group, Small Group, Individual, Medicaid and Medicare markets. Our managed care plans include: Preferred Provider Organizations, or PPOs; HMOs; Point-of-Service, or POS, plans; traditional indemnity plans and other hybrid plans, including Consumer-Driven Health Plans, or CDHPs; and hospital only and limited benefit products. In addition, we provide a broad array of managed care services to self-funded customers, including claims processing, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services. We provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal healthcare. We also provide services to the federal government in connection with the Federal Employee Program®, or FEP®.

The increased focus on healthcare costs by employers, the government and consumers has continued to drive the growth of alternatives to traditional indemnity health insurance. HMO, PPO and hybrid plans are among the various forms of managed care products that have been developed. Through these types of products, insurers attempt to contain the cost of healthcare by negotiating contracts with hospitals, physicians and other providers to deliver high-quality healthcare to members at favorable rates. These products usually feature medical management and other quality and cost optimization measures such as pre-admission review and approval for certain non-emergency services, pre-authorization of outpatient surgical procedures, network credentialing to determine that network physicians and hospitals have the required certifications and expertise, and various levels of care management programs to help members better understand and navigate the healthcare system. In addition, providers may have incentives to achieve certain quality measures, may share medical cost risk or may have other incentives to deliver quality medical services in a cost-effective manner. Also, certain plans offer members incentives for healthy behaviors, such as smoking cessation and weight management. Members are charged periodic, prepaid premiums and generally pay co-payments, coinsurance and/or deductibles when they receive services. While the distinctions between the various types of plans have lessened over recent years, PPO, POS and CDHP products generally provide reduced benefits for out-of-network services, while traditional HMO products generally provide little to no reimbursement for non-emergency out-of-network utilization, but often offer more generous benefit coverage. An HMO plan may also require members to select one of the network primary care physicians, or PCPs, to coordinate their care and approve any specialist or other services.

Economic factors, greater consumer and employer sophistication and accountability have resulted in an increased demand for choice in both product/benefit designs and provider network configurations. As a result we continue to offer our broad access PPO networks with multiple benefit designs, but are also focused on leveraging our provider collaboration initiatives with our Accountable Care Organization, or ACO, partnerships to develop both narrow and tiered network offerings. This array of network and product configurations allows both the employer and the employee to design and select the combination of benefit designs (e.g., traditional PPOs, high deductibles, health reimbursement accounts, health savings accounts, PCP based products, tiered copays) and networks (e.g., broad, narrow, tiered, closed or exclusive provider, and open) that optimize choice, quality and price at the consumer, employer and market level. We believe we are well-positioned in each of our states to respond to these market preferences.

For our fully-insured products, we charge a premium and assume the risk for the cost of covered healthcare services. Under self-funded products, we charge a fee for services and the employer or plan sponsor reimburses us for the healthcare costs. In addition, we charge a premium to underwrite stop loss insurance for Local Group and National Account employers that maintain self-funded health plans.

Our medical membership includes seven different customer types: Local Group, Individual, National Accounts, BlueCard®, Medicare, Medicaid and FEP®. BCBS-branded business generally refers to members in our service areas licensed by the BCBSA. Non-BCBS-branded business refers to members in our non-BCBS-branded America's 1st Choice, Amerigroup, CareMore, HealthSun, and Simply Healthcare plans, as well as HealthLink and UniCare members. In addition to the above medical membership, we also serve customers who purchase one or more of our other products or services that are often ancillary to our health business.

Our products are generally developed and marketed with an emphasis on the differing needs of our customers. In particular, our product development and marketing efforts take into account the differing characteristics between the various customers served by us, as well as the unique needs of educational and public entities, labor groups, federal employee health and benefit programs, national employers and state-run programs servicing low-income, high-risk and underserved markets. Overall, we seek to establish pricing and product designs to provide value for our customers while achieving an appropriate level of profitability for each of our customer categories balanced with the competitive objective to grow market share. We believe that one of the keys to our success has been our focus on these distinct customer types, which better enables us to develop benefit plans and services that meet our customers' unique needs.

We market our products through direct marketing activities and an extensive network of independent agents, brokers and retail partnerships for Individual and Medicare customers, and for certain Local Group customers with a smaller employee base. Products for National Accounts and Local Group customers with a larger employee base are generally sold through independent brokers or consultants retained by the customer and working with industry specialists from our in-house sales force. In the Individual and Small Group markets, we offer on-exchange products through state- or federally-facilitated marketplaces, referred to as public exchanges, and off-exchange products. Federal subsidies are available for certain members, subject to income and family size, who purchase public exchange products.

Being a licensee of the BCBS association of companies, of which there were 36 independent primary licensees as of December 31, 2018, provides significant market value, especially when competing for very large multi-state employer groups. For example, each BCBS member company is able to utilize other BCBS licensees' substantial provider networks and discounts when any BCBS member works or travels outside of the state in which their policy is written. This program is referred to as BlueCard® and is a source of revenue when we provide member services in the states where we are the BCBS licensee to individuals who are customers of BCBS plans not affiliated with us. This program also provides a national provider network for our members when they travel to other states.

For additional information describing each of our customer types, detailed marketing efforts and changes in medical membership over the last three years, see "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in Part II, Item 7 of this Annual Report on Form 10-K.

Our results of operations depend in large part on accurately predicting healthcare costs and our ability to manage future healthcare costs through adequate product pricing, medical management, product design and negotiation of favorable provider contracts.

Advances in medical technology, increases in specialty drug costs, increases in hospital expenditures and other provider costs, the aging of the population and other demographic characteristics continue to contribute to rising healthcare costs. Our managed care plans and products are designed to encourage providers and members to participate in quality, cost-effective health benefit programs by using the full range of our innovative medical management services, quality initiatives and financial incentives. Our market share and high business retention rates enable us to realize the long-term benefits of investing in preventive and early detection programs. Our ability to provide cost-effective health benefits products and services is enhanced through a disciplined approach to internal cost containment, prudent management of our risk exposure and successful integration of acquired businesses. In addition, our ability to manage selling, general and administrative costs continues to be a driver of our overall profitability.

The future results of our operations will also be impacted by certain external forces and resulting changes in our business model and strategy. The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended, or collectively, the ACA, has changed and may continue to make broad-based changes to the U.S. healthcare system. The ACA presented us with new growth opportunities, but also introduced new risks, regulatory challenges and uncertainties, and required changes in the way products are designed, underwritten, priced, distributed and administered. Changes to our business environment are likely to continue for the next several years as elected officials at the national and state levels continue to propose and enact significant modifications to existing laws and regulations, including the reduction of the individual mandate penalty to zero effective January 1, 2019, elimination of funding for cost-sharing subsidies made available for qualified individuals, and changes to taxes and fees. In addition, the legal challenges regarding the ACA, including the December 2018 decision of the U.S. District Court for the Northern District of Texas, Fort Worth Division invalidating the ACA (the “2018 Texas District Court ACA Decision”), which judgment has been stayed pending appeal, continue to contribute to this uncertainty. We will continue to evaluate the impact of the ACA as additional guidance is made available and any further developments or judicial rulings occur. For additional discussion, see “Regulation,” herein and Part I, Item 1A “Risk Factors” in this Annual Report on Form 10-K.

In addition to the external forces discussed in the preceding paragraph, our results of operations are impacted by levels and mix of membership which can change as a result of the quality and pricing of our health benefits products and services, economic conditions, changes in unemployment, acquisitions, entry into new markets and expansions in or exits from existing markets. Our reduced participation in the Individual ACA-compliant market in 2018 led to a decrease in our fully-insured membership which was partially offset by an increase in our self-funded membership. We believe the self-funded portion of our group membership base will continue to increase as a percentage of total group membership. These membership trends could be negatively impacted by various factors that could have a material adverse effect on our future results of operations such as general economic downturns that result in business failures, failure to obtain new customers or retain existing customers, premium increases, benefit changes or our exit from a specific market. See Part I, Item 1A “Risk Factors” and Part II, Item 7 “Management’s Discussion and Analysis of Financial Condition and Results of Operations” included in this Annual Report on Form 10-K.

Private exchanges have gained visibility in the market based on the promise of helping employers reduce costs, increase consumer engagement and manage the complexities created by the ACA and other market forces. While private exchanges have been a distribution channel in the Medicare and Individual markets for some time, in more recent years the Commercial market has received an increased level of attention from the consulting and broker communities as well as health insurance carriers. In response, we have continued our broad-based strategy of offering our own private exchange, Anthem Health Marketplace, a consumer experience platform, to groups, while also participating in four large national consultant-led exchanges, several regional broker-led exchanges and various Individual, Commercial and Medicare exchanges. To date, adoption levels in the Commercial market overall have been lower than analyst predictions. While the ultimate volume, pace of growth and winning business models remain highly uncertain in this space, we continue to believe we are well positioned to adapt with the market as it evolves.

During 2018, we strategically reduced our participation in the Individual ACA-compliant market. Our strategy has been, and will continue to be, to only participate in rating regions where we have an appropriate level of confidence that these markets are on a path toward sustainability, including, but not limited to, factors such as expected financial performance, regulatory environment, and underlying market characteristics. We currently offer Individual ACA-compliant products in 73 of the 143 rating regions in which we operate.

We believe healthcare is local and that we have the strong local presence required to understand and meet local customer needs. Further, we believe we are well-positioned to deliver what customers want: innovative, choice-based and affordable products; distinctive service; simplified transactions; and better access to information for quality care. Our local presence, combined with our national expertise, has created opportunities for collaborative programs that reward physicians and hospitals for clinical quality and excellence. We feel that our commitment to health improvement and care management provides added value to customers and healthcare professionals. Ultimately, we believe that practical and sustainable improvements in healthcare must focus on improving healthcare quality while managing costs for total affordability. We have implemented initiatives driving payment innovation and partnering with providers to lower cost and improve the quality of healthcare for our members and we continue to develop new and innovative ways to effectively manage risk and engage our members. In addition, we are focused on achieving efficiencies from our national scale while optimizing service performance for our customers. Finally, we expect to continue to rationalize our portfolio of businesses and products and align our

investments to capitalize on new opportunities to drive growth in our existing markets and expand into new markets in the future.

We continue to enhance interactions with customers, providers, brokers, agents, employees and other stakeholders through web-enabled technology and improving internal operations. Our approach includes not only sales and distribution of health benefits products on the Internet, but also implementing advanced capabilities that improve services benefiting customers, agents, brokers, and providers while optimizing administrative costs. These enhancements can also help improve the quality, coordination and safety of healthcare through increased communications between patients and their physicians.

In pursuing our vision of being the most innovative, valuable and inclusive partner, we intend to transform healthcare by providing trusted and caring solutions and delivering quality products and services that give customers access to the care they need. At the same time, we will focus on earnings, organic membership growth, improvements in our operating cost structure, strategic acquisitions and the efficient use of capital.

Significant Transactions

The significant transactions that have occurred over the last five years that have impacted or will impact our capital structure or that have influenced or will influence how we conduct our business operations include:

- Acquisition of America's 1st Choice (2018);
- Acquisition of HealthSun Health Plans, Inc., or HealthSun (2017);
- Acquisition of Simply Healthcare Holdings, Inc., or Simply Healthcare (2015);
- Use of Capital—Board of Directors declarations of dividends on our common stock (2013 through January 2019); repurchases of our common stock (2019 and prior); and debt repurchases and new debt issuances (2018 and prior); and
- Divestiture of 1-800 CONTACTS, Inc. (2014).

For additional information regarding certain of these transactions, see Note 3, "Business Acquisitions," Note 12, "Debt," and Note 14, "Capital Stock," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Competition

The managed care industry is highly competitive, both nationally and in our local markets. Competition continues to be intense due to aggressive marketing and pricing, business consolidations, new competitors in the market, a proliferation of new products, the impact of the ACA, and increased quality awareness and price sensitivity among customers.

We believe that participants in the managed care industry compete for customers based on quality of service, price, access to provider networks, access to care management and wellness programs (including health information), innovation, breadth and flexibility of products and benefits, reputation (including National Committee on Quality Assurance, or NCQA, accreditation status), brand recognition and financial stability. Our ability to attract and retain customers is substantially tied to our ability to distinguish ourselves from our competitors in these areas.

Also, a health plan's ability to interact with employers, customers and other third parties (including healthcare professionals) through electronic data transfer has become a more important competitive factor, and we have made significant investments in technology to enhance our electronic interaction with providers, employers, customers and third parties.

We believe our exclusive right to market products under the most recognized brand in the industry, BCBS, in our most significant markets provides us with greater brand recognition over competitive product offerings. Our provider networks in our markets enable us to achieve efficiencies and distinctive service levels by allowing us to offer a broad range of health benefits to our customers on a more cost-effective basis than many of our competitors. We strive to distinguish our products through provider access, service, care management, product value and brand recognition.

Product pricing remains competitive and we strive to price our healthcare benefit products consistent with anticipated underlying medical trends. We believe our pricing strategy, based on predictive modeling, proprietary research and data-driven processes has positioned us to benefit from the potential growth opportunities available through entry into new markets, expansions in existing markets and as a result of any subsequent changes to the current regulatory scheme. We believe that our pricing strategy, brand name and network quality will provide a strong foundation for membership growth opportunities in the future.

To build our provider networks, we compete with other health benefits plans for the best contracts with hospitals, physicians and other providers. We believe that physicians and other providers primarily consider customer volume, reimbursement rates, timeliness of reimbursement and administrative service capabilities along with the reduction of non-value added administrative tasks when deciding whether to contract with a health benefits plan.

At the sales and distribution level, we compete for qualified agents and brokers to recommend and distribute our products. Strong competition exists among insurance companies and health benefits plans for agents and brokers with demonstrated ability to secure new business and maintain existing accounts. We believe that the quality and price of our products, support services, reputation and prior relationships, along with a reasonable commission structure are the factors agents and brokers consider in choosing whether to market our products. We believe that we have good relationships with our agents and brokers, and that our products, support services and commission structure compare favorably to those of our competitors in all of our markets. Typically, we are the largest competitor in each of our BCBS branded markets and, thus, are a closely-watched target by other insurance competitors.

Reportable Segments

We manage our operations through three reportable segments: Commercial & Specialty Business, Government Business and Other. We regularly evaluate the appropriateness of our reportable segments, particularly in light of organizational changes, merger and acquisition activity and changing laws and regulations. During the fourth quarter of 2018, we reclassified certain ancillary businesses to align how our segments are currently being managed. Prior year amounts have been reclassified for comparability. Current reportable segments may change in the future.

Our Commercial & Specialty Business and Government Business segments both offer a diversified mix of managed care products, including PPOs, HMOs, traditional indemnity benefits and POS plans, as well as a variety of hybrid benefit plans including CDHPs, hospital only and limited benefit products.

Our Commercial & Specialty Business segment includes our Local Group, National Accounts, Individual and Specialty businesses. Business units in the Commercial & Specialty Business segment offer fully-insured health products; provide a broad array of managed care services to self-funded customers including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services; and provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits.

Our Government Business segment includes our Medicare and Medicaid businesses, National Government Services, or NGS, and services provided to the federal government in connection with FEP®. Medicaid makes federal matching funds available to all states for the delivery of healthcare benefits to eligible individuals, principally those with incomes below specified levels who meet other state-specified requirements. Medicaid is structured to allow each state to establish its own eligibility standards, benefits package, payment rates and program administration under broad federal guidelines. Our Medicare customers are Medicare-eligible individual members age 65 and over who have enrolled in Medicare Advantage, a managed care alternative for the Medicare program, or who have purchased Medicare Supplement benefit coverage, some disabled members under age 65, or members of all ages with end stage renal disease. Medicare Supplement policies are sold to Medicare recipients as supplements to the benefits they receive from the Medicare program. Rates are filed with, and in some cases approved by, state insurance departments. Most of the premium for Medicare Advantage is paid directly by the federal government on behalf of the participant who may also be charged a small premium. Additionally, through our alliance partnership engagements with larger provider groups and BCBS plans, we offer a variety of Medicaid services that include joint ventures, administrative service offerings, and full-risk arrangements. NGS acts as a Medicare contractor for the federal government in several regions across the nation.

Our Other segment includes certain eliminations and corporate expenses not allocated to either of our other reportable segments.

Through our participation in various federal government programs, we generated approximately 19.8%, 17.8% and 18.2% of our total consolidated revenues from agencies of the U.S. government for the years ended December 31, 2018, 2017 and 2016, respectively. These revenues are contained in the Government Business segment. An immaterial amount of our total consolidated revenues is derived from activities outside of the U.S.

Products and Services

A general description of our products and services is provided below:

Preferred Provider Organization: PPO products offer the member an option to select any healthcare provider, with benefits reimbursed by us at a higher level when care is received from a participating network provider. Increasingly, customers are choosing our PPO products offered with an exclusive provider organization which eliminates coverage out of network. Coverage is subject to co-payments or deductibles and coinsurance, with member cost sharing usually limited by out-of-pocket maximums.

Consumer-Driven Health Plans: CDHPs provide consumers with increased financial responsibility, choice and control regarding how their healthcare dollars are spent. Generally, CDHPs combine a high-deductible PPO plan with an employer-funded and/or employee-funded personal care account, which may result in tax benefits to the employee. Some or all of the dollars remaining in the personal care account at year-end can be rolled over to the next year for future healthcare needs.

Traditional Indemnity: Indemnity products offer the member an option to select any healthcare provider for covered services. Coverage is subject to deductibles and coinsurance, with member cost sharing usually limited by out-of-pocket maximums.

Health Maintenance Organization: HMO products include comprehensive managed care benefits, generally through a participating network of physicians, hospitals and other providers. A member in one of our HMOs must typically select a PCP from our network. PCPs generally are family practitioners, internists or pediatricians who provide necessary preventive and primary medical care, and are generally responsible for coordinating other necessary healthcare services. We offer HMO plans with varying levels of co-payments, which result in different levels of premium rates.

Point-of-Service: POS products blend the characteristics of HMO, PPO and indemnity plans. Members can have comprehensive HMO-style benefits through participating network providers with minimum out-of-pocket expenses (co-payments) and also can go directly, without a referral, to any provider they choose, subject to, among other things, certain deductibles and coinsurance. Member cost sharing is limited by out-of-pocket maximums.

ACA Public Exchange and Off-Exchange Products: The ACA required the modification of existing products and development of new products to meet the requirements of the legislation, subject to certain transitional relief. Individual and Small Group products cover essential health benefits as defined in the ACA along with many other requirements and cost sharing features. Individual and Small Group products offered on and off the public exchanges meet the definition of the “metal” product requirements (bronze, silver, gold and platinum) and each metal product must satisfy a specific actuarial value. Health insurers participating on the public exchanges must offer at least one silver and one gold product.

Administrative Services: In addition to fully-insured products, we provide administrative services to Large Group, Small Group and National Account employers that maintain self-funded health plans. These administrative services include underwriting, actuarial services, medical cost management, disease management, wellness programs, claims processing and other administrative services for self-funded employers. Self-funded health plans are also able to use our provider networks and to realize savings through our negotiated provider arrangements, while allowing employers the ability to design certain health benefit plans in accordance with their own requirements and objectives. We also underwrite stop loss insurance for self-funded plans.

BlueCard®: BlueCard® is a national program that links participating healthcare providers and independent BCBS plans. BlueCard® host members are generally members who reside in or travel to a state in which an Anthem subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer sponsored health plan serviced by a non-Anthem controlled BCBS licensee, which is the “home” plan. We perform certain administrative functions for BlueCard®

host members, for which we receive administrative fees from the BlueCard® members' home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan.

Medicare Plans: We offer a wide variety of plans, products and options to individuals age 65 and older such as Medicare Supplement plans; Medicare Advantage, including Special Needs Plans; Medicare Part D Prescription Drug Plans, or Medicare Part D; and dual-eligible programs through Medicare-Medicaid Plans, or MMPs. Medicare Supplement plans typically pay the difference between healthcare costs incurred by a beneficiary and amounts paid by Medicare. Medicare Advantage plans provide Medicare beneficiaries with a managed care alternative to traditional Medicare and often include a Medicare Part D benefit. In addition, our Medicare Advantage Special Needs Plans provide tailored benefits to Medicare beneficiaries who have chronic diseases and also cover certain dual-eligible customers, who are low-income seniors and persons under age 65 with disabilities. Medicare Part D offers a prescription drug plan to Medicare and MMP beneficiaries. MMP is a demonstration program focused on serving members who are dually eligible for Medicaid and Medicare, which was established as a result of the passage of the ACA. We offer these plans to customers through our health benefit subsidiaries throughout the country, including America's 1st Choice, Amerigroup, CareMore, HealthSun and Simply Healthcare.

Individual Plans: We offer a full range of health insurance plans with a variety of options and deductibles for individuals who are not covered by employer-sponsored coverage and are not eligible for government sponsored plans, such as Medicare and/or Medicaid. Individual policies are generally sold through independent agents and brokers, retail partnerships, our in-house sales force or via the exchanges. Individual business is sold on a fully-insured basis. We offer on-exchange products through public exchanges and off-exchange products. Federal premium subsidies are available only for certain public exchange Individual products. Unsubsidized Individual customers are generally more sensitive to product pricing and, to a lesser extent, the configuration of the network and the efficiency of administration. Instability in the Individual market has resulted in a targeted approach where we offer products in select geographies.

Medicaid Plans and Other State-Sponsored Programs: We have contracts to serve members enrolled in publicly funded healthcare programs, including Medicaid; ACA-related Medicaid expansion programs; Temporary Assistance for Needy Families, or TANF; programs for seniors and people with disabilities, or SPD; Children's Health Insurance Programs, or CHIP; and specialty programs such as those focused on long-term services and support, or LTSS, HIV/AIDS, children living in foster care, behavioral health and/or substance abuse disorders, and intellectual disabilities and/or developmental disabilities, or ID/DD programs. The Medicaid program makes federal matching funds available to all states for the delivery of healthcare benefits for low income and/or high medical risk individuals. These programs are managed by the individual states based on broad federal guidelines. TANF is a state and federally funded program designed for the population consisting primarily of low-income children and their guardians. SPD is a federal income supplement program designed for Supplemental Security Income recipients; however, states can broaden eligibility criteria. This population consists of low-income seniors and people with disabilities. CHIP is a state and federally funded program that provides healthcare coverage to children not otherwise covered by Medicaid or other insurance programs. LTSS is a state and federally funded program that offers states a broad and flexible set of program design options and refers to the delivery of long-term services and support for our members who receive home and community- or institution-based services for long-term care. Our HIV/AIDS program is a state and federally sponsored program that provides services to those living with HIV/AIDS. Our Foster Care program is a state and federally sponsored program serving children with complex needs within the foster care system. Our Behavioral Health program is a state and federally sponsored program providing services to those with mental health and/or substance abuse disorders. ID/DD is a state and federally sponsored program serving those living with limitations in intellectual functioning and adaptive behavior learning disabilities. Our Medicaid plans also cover certain dual-eligible customers, as previously described above, who also receive Medicare benefits. We provide Medicaid and other state sponsored services, such as administrative services, in Arkansas, California, Colorado, Florida, Georgia, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Nevada, New Jersey, New York, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia, Wisconsin and Washington D.C.

Pharmacy Products: We market and sell an integrated prescription drug product to both fully-insured and self-funded customers through our health benefit subsidiaries throughout the country. This comprehensive product includes features such as drug formularies, a pharmacy network, prescription drug database and mail order capabilities. Since December 1, 2009, we have delegated certain functions and administrative services related to our integrated prescription drug products to Express Scripts under a ten-year contract, excluding our HealthSun and America's 1st Choice subsidiaries, our CareMore operations in the state of Arizona and certain self-insured members who have exclusive agreements with different PBM service

providers. Express Scripts manages the network of pharmacy providers, operates mail order pharmacies and processes prescription drug claims on our behalf, while we sell and support the product for clients, make formulary decisions, set drug benefit design strategy and provide front line member support. In October 2017, we established a new PBM, called IngenioRx, and entered into a five-year agreement with CVS Health to begin offering PBM solutions upon the conclusion of the current ESI PBM Agreement. As part of the CVS PBM Agreement, and consistent with our strong reputation as a leader in healthcare delivery, we will drive clinical and formulary strategy and development, member and employer experiences, operations, sales, marketing, account management, and retail network strategy. We will delegate certain administrative services, including claims processing and prescription fulfillment, to CVS Health. Our current ESI PBM Agreement will terminate on March 1, 2019, and the twelve-month transition provided for in the ESI PBM Agreement to migrate the services begins on March 2, 2019. At that time CVS Health is able to begin providing certain PBM services to IngenioRx. Notwithstanding our termination of the ESI PBM Agreement, the litigation between us and Express Scripts regarding the ESI PBM Agreement continues. In March 2016, we filed a lawsuit against Express Scripts seeking to recover damages for pharmacy pricing that is higher than competitive benchmark pricing. For additional information, see Note 13, “Commitments and Contingencies - *Litigation and Regulatory Proceedings - Express Scripts, Inc. Pharmacy Benefit Management Litigation*,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Life Insurance: We offer an array of competitive individual and group life insurance benefit products to both Large Group and Small Group customers in conjunction with our health plans. The life products include term life and accidental death and dismemberment.

Disability: We offer short-term and long-term disability products, usually in conjunction with our health plans.

Radiology Benefit Management: We offer outpatient diagnostic imaging management services to health plans which promote the most appropriate use of clinical services to improve the quality of care delivered to members. These services include utilization management for advanced diagnostic imaging procedures, network development and optimization, patient safety, claims adjudication and provider payment.

Personal Health Care Guidance: We offer evidence-based and analytics-driven personal healthcare guidance. These services help improve the quality, coordination and safety of healthcare, enhance communications between patients and their physicians, and reduce medical costs.

Dental: Our dental plans include networks in certain states in which we operate. Many of the dental benefits are provided to customers enrolled in our health plans and are offered on both a fully-insured and self-funded basis. Our members also have access to additional dental providers through our participation in the National Dental GRID, a national dental network developed by and for BCBS plans. The National Dental GRID includes dentists in all 50 states and the District of Columbia and provides multi-state customers with a national solution providing in-network discounts across the country. Additionally, we offer managed dental services to other healthcare plans to assist those plans in providing dental benefits to their customers.

Vision Services and Products: Our vision plans include networks within the states in which we operate. Many of the vision benefits are provided to customers enrolled in our health plans and are offered on both a fully-insured and self-funded basis.

Medicare Administrative Operations: Through our subsidiary, NGS, we serve as a fiscal intermediary, carrier and Medicare administrative contractor for the federal government providing administrative services for the Medicare program, Parts A and B, which generally provides coverage for persons who are 65 or older and for persons who are under 65 and disabled or with end-stage renal disease. Part A of the Medicare program provides coverage for services provided by hospitals, skilled nursing facilities and other healthcare facilities. Part B of the Medicare program provides coverage for services provided by physicians, physical and occupational therapists and other professional providers, as well as certain durable medical equipment and medical supplies.

Networks and Provider Relations

Our relationships with physicians, hospitals and professionals that render healthcare services to our members are guided by local, regional and national standards for network development, reimbursement and contract methodologies. While

following industry standards, we are simultaneously seeking to lead transformation efforts within our healthcare system, moving from a fragmented model premised on episodic intervention to one based on proactive, coordinated care built around the needs of the patient. A key element of this transformation involves a transition from traditional fee-for-service payment models to models where providers are paid based on the value, both in quality and affordability, of the care they deliver.

We establish “market-based” hospital reimbursement payments that we believe are fair, but aggressive, and among the most competitive in the market. We also seek to ensure that physicians in our network are paid in a timely manner at appropriate rates. In many instances, we deploy multi-year contracting strategies, including case rates or fixed rates, to limit our exposure to medical cost inflation and to increase cost predictability. We maintain both broad and narrow provider networks to ensure member choice, based on both price and access needs, while implementing programs designed to improve the quality of care our members receive. Increasingly, we are supplementing our broad-based networks with smaller or more cost-effective networks that are designed to be attractive to a more price-sensitive customer segment, such as public exchange customers.

Our reimbursement strategies vary across markets and depend on the degree of consolidation and integration of physician groups and hospitals. Under a fee-for-service reimbursement methodology for physicians, fee schedules are developed at the state level based on an assessment of several factors and conditions, including the CMS resource-based relative value system, or RBRVS, medical practice cost inflation and physician supply. We utilize CMS RBRVS fee schedules as a reference point for fee schedule development and analysis. The RBRVS structure was developed, maintained, and updated by CMS and is used by the Medicare program and other major payers. In addition, we have implemented and continue to expand physician incentive contracting, or “pay-for-performance,” which ties physician payment levels to performance on clinical measures.

While we generally do not delegate full financial responsibility to our physician providers in the form of capitation-based reimbursement, we maintain capitation-based arrangements in certain markets where we determine that market dynamics result in it being a useful method to lower costs and reduce underwriting risk.

Our hospital contracts provide for a variety of reimbursement arrangements depending on local market dynamics and current hospital utilization efficiency. Most hospitals are reimbursed a fixed amount per day or reimbursed a per-case amount, per admission, for inpatient covered services. A small percentage of hospitals, primarily rural, sole community hospitals, are reimbursed on a discount from approved charge basis for covered services. Our “per-case” reimbursement methods utilize many of the same attributes contained in Medicare’s Diagnosis Related Groups, or DRG, methodology. Hospital outpatient services are reimbursed by fixed case rates, fee schedules or percent of approved charges. Our hospital contracts recognize unique hospital attributes, such as academic medical centers or community hospitals, and the volume of care performed for our members. To improve predictability of expected costs, we frequently use a multi-year contracting approach with providers. In addition, the majority of our hospital contracts include a pay-for-performance component where reimbursement levels are linked to improved clinical performance, patient safety and medical error reduction.

Our provider engagement and contracting strategies are moving away from “unit price” or volume-based payment models to payment models that align compensation with the value delivered as measured by healthcare outcomes, quality and cost. Our Enhanced Personal Health Care program augments traditional fee-for-service with shared savings opportunities for providers when actual healthcare costs are below projected costs, and providers meet specific quality measures. The quality measures are based on nationally accepted, credible standards (e.g., NCQA, the American Diabetes Association and the American Academy of Pediatrics) and span preventive, acute and chronic care. We understand, however, that payment incentives alone are insufficient to create the large-scale, system-wide transformation required to achieve meaningful impacts on cost, quality and member experience. Accordingly, we invested in care delivery transformation and population health management support structures to help providers succeed under value-based payment models. This support includes our web-based population health management technology and teams of dedicated practice consultants who work alongside providers, sharing best practices, and helping them leverage our data to the benefit of their patients. In some of these arrangements, participating physician practices receive a per-member, per-month clinical coordination fee to compensate them for important care management activities that occur outside of the patient visit (e.g., purchasing an electronic health record or hiring care management nurses), all of which have been shown to reduce healthcare costs and improve care outcomes. Since the launch of Enhanced Personal Health Care, we now have arrangements with provider organizations covering 52% of our PCPs and have rolled this program out in each of the fourteen states where we operate as a licensee of the BCBSA.

Medical Management Programs

Our medical management programs include a broad array of activities that facilitate improvements in the quality of care provided to our members and promote cost-effective medical care. These medical management activities and programs are administered and directed by physicians and nurses. The goals of our medical management strategies are to ensure that the care delivered to our members is supported by appropriate medical and scientific evidence, is received on a timely basis and occurs in the most appropriate setting. The following is a general description of our medical management programs, which are available to our members depending on the particular plan or product in which they participate:

Precertification: A traditional medical management program involves assessment of the appropriateness of certain hospitalizations and other medical services prior to the services being rendered. For example, precertification is used to determine whether a set of hospital and medical services is being appropriately applied to the member's clinical condition, in accordance with criteria for medical necessity as that term is defined in the member's benefits contract. All of our health plans have implemented precertification programs for common high-tech radiology studies, including cardiac diagnostic testing, addressing an area of historically significant cost trends. Through our American Imaging Management, Inc. subsidiary, doing business as AIM Specialty Health, or AIM, we promote appropriate, safe and affordable member care in imaging, as well as oncology and sleep management. These expanded specialty benefit management solutions leverage clinical expertise and technology to engage our provider communities and members in more effective and efficient use of outpatient services.

Care Coordination: Another traditional medical management strategy we use is care coordination, which is based on nationally recognized criteria developed by third-party medical specialists. With inpatient care coordination, the requirements and intensity of services during a patient's hospital stay are reviewed, at times by an onsite skilled nurse professional in collaboration with the hospital's medical and nursing staff, in order to coordinate care and determine the most effective transition of care from the hospital setting. In addition, guidance for many continued stay cases is reviewed with physician medical directors to ensure appropriate utilization of medical services. We also coordinate care for outpatient services to help ensure that patients with chronic conditions who receive care from multiple physicians are able to manage the exchange of information between physicians and coordinate office visits to their physicians.

Case Management: We have implemented a medical management strategy focused on identifying the small percentage of the membership that will require a high level of intervention to manage their healthcare needs. The registered nurses and medical directors focus on members likely to be readmitted to the hospital and help them coordinate their care through pharmacy compliance, post-hospital care, follow-up visits to see their physician and support in their home. We are also working to move increasing aspects of this work to the providers we work with via our provider collaboration efforts, a set of capabilities, offerings, programs and products that help us partner with providers to leverage data, insights and technology to deliver the right care, at the right time, in the right place.

Formulary management: We have developed formularies, which are selections of drugs based on clinical quality and effectiveness. A pharmacy and therapeutics committee of physicians uses scientific and clinical evidence to ensure that our members have access to the appropriate drug therapies.

Medical policy: A medical policy group determines our national policy for the application of new medical technologies and treatments. This group is comprised of internal and external physician leaders from various specialties and areas of the country, working in cooperation with academic medical centers, practicing community physicians and medical specialty organizations such as the American College of Radiology and national organizations such as the Centers for Disease Control and Prevention and the American Cancer Society.

Quality programs: We are actively engaged with our hospital and physician networks to enable them to improve medical and surgical care and achieve better outcomes for our members. We endorse, encourage and incentivize hospitals and physicians to support national initiatives to improve the quality of clinical care and patient outcomes and to reduce medication errors and hospital infections.

External review procedures: We work with outside experts through a process of external review to provide our members scientifically and clinically, evidence-based medical care. When we receive member concerns, we have formal appeals procedures that ultimately allow coverage disputes related to medical necessity decisions under the benefits contract to be settled by independent expert physicians.

Service management: In HMO and POS networks, PCPs serve as the overall coordinators of members' healthcare needs by providing an array of preventive health services and overseeing referrals to specialists for appropriate medical care. In PPO networks, members have access to network physicians without a PCP serving as the coordinator of care.

Provider Cost Comparison Tools: Through Estimate Your Cost, Anthem Care Comparison and other tools, our members can compare cost estimates and quality data for common services at contracted providers, with cost estimates for facility, professional and ancillary services. These cost estimates bundle related services typically performed at the time of the procedure, not just for the procedure itself. Users can review cost data for over 400 procedures in 50 states. Members can also estimate out-of-pocket costs based on a member's own benefit coverage, deductible, and out-of-pocket maximum. We also offer information on overall facility ratings and patient experience using trusted third-party data. We continue to work on enhancing and evolving our tools to assist members in making informed and value-based healthcare decisions. In addition, we collaborate with an external independent vendor to support employers wanting to purchase a consumer engagement web solution with certain additional functionality.

Personal Health Care Guidance: These services help improve the quality, coordination and safety of healthcare, enhance communications between patients and their physicians, and reduce medical costs. Examples of services include member and physician messaging, providing access to evidence-based medical guidelines, physician quality assessment, and other consulting services.

Anthem Health Guide: Anthem Health Guide integrates customer service with clinical and wellness coaching to provide easier navigation of healthcare services for our members. Members are supported by a team of nurses, coaches, educators, and social workers using voice, click-to-chat, secure email and mobile technology. Our Smart Engagement Platform supports this integrated team using our smart engagement triggers for speech recognition, preventative and clinical gaps in care and highlighting when we have members who are identified for current healthcare support. Anthem Health Guide is fully integrated with our specialty products, such as dental, vision and other supplemental products, to ensure members can optimize their benefits.

Anthem Whole Health Connection: Anthem Whole Health Connection is focused on whole person health and connects medical, pharmacy, dental, vision, disability and supplemental health clinical and claims data to proactively identify health issues and engage our members with their health providers in new ways to deliver better healthcare experience and lower cost. Anthem Whole Health Connection is included with Anthem health benefits and one or more of the pharmacy, dental, vision, life, disability or supplemental health coverage plans.

Care Management Programs

We continue to expand our *360º Health* suite of integrated care management programs and tools. *360º Health* offers the following programs, among others, which are available to our members depending on the particular plan or product in which they participate, and have been proven to increase quality and reduce medical costs for our members:

ConditionCare and *FutureMoms* are care management and maternity management programs that serve as adjuncts to physician care. Skilled nurse professionals with added support from our team of dietitians, social workers, pharmacists, health educators and other health professionals help participants understand their condition, their doctor's orders and how to become a better self-manager of their condition. We also offer members infertility consultation through our SpecialOffers@Anthem program, a comprehensive and integrated assembly of discounted health and wellness products and services from a variety of the nation's leading retailers.

24/7 NurseLine offers access to qualified, registered nurses anytime. This allows our members to make informed decisions about the appropriate level of care and avoid unnecessary worry. This program also includes a referral process to the nearest urgent care facility, a robust audio library, accessible by phone, with more than 600 health and wellness topics, as well as on-line health education topics designed to educate members about symptoms and treatment of many common health concerns.

Case Management is an advanced care management program that reaches out to participants with multiple healthcare issues who are at risk for frequent and high levels of medical care in order to offer support and assistance in managing their healthcare needs. *Case Management* identifies candidates through claims analysis using predictive modeling techniques, the

use of health risk assessment data, utilization management reports and referrals from a physician or one of our other programs, such as the *24/7 NurseLine*.

MyHealth Advantage utilizes integrated information systems and sophisticated data analytics to help our members improve their compliance with evidence-based care guidelines, providing personal care notes that alert members to potential gaps in care, enable more prudent healthcare choices, and assist in the realization of member out-of-pocket cost savings. Key opportunities are also shared with physicians through Availity® at the time of membership eligibility verification. Availity® is an electronic data interchange system that allows for the exchange of health information among providers over a secure network.

MyHealth Coach provides our members with a professional guide who helps them navigate the healthcare system and make better decisions about their well-being. *MyHealth Coach* proactively reaches out to people who are at risk for potentially serious health issues or have complex healthcare needs. Our health coaches help participants understand and manage chronic conditions, handle any health and wellness related services they need and make smart lifestyle choices.

HealthyLifestyles helps employees transform unhealthy habits into positive ones by focusing on behaviors that can have a positive effect on their health and their employer's financial well-being. *HealthyLifestyles* programs include smoking cessation, weight management, stress management, physical activity, and diet and nutrition.

Behavioral Health Case Management is an integrated component of the health plan, supporting a wide range of members who are impacted by their behavioral health condition including specialty areas such as eating disorders, anxiety, depression and substance use. The program assists members and their families with obtaining appropriate behavioral health treatment, offering community resources, providing education and telephonic support, and promoting provider collaboration.

Autism Spectrum Disorder is a specialized case management program staffed by a dedicated team of clinicians who have been trained on the unique challenges and needs of families with a member who has a diagnosis of autism spectrum disorder. These clinicians provide education, information on community resources to help with care and support, guidance on the appropriate usage of benefits, and assistance in exploring effective treatments, such as medical services, that may help the member and their families.

Employee Assistance Programs provide 24/7 telephonic support for personal and crisis events. Members also gain access to many resources that allow support within work and personal life by providing quick and easy access to confidential resources to help meet the challenges of daily life. Examples of services available include counseling, referral assistance with child care, health and wellness, financial issues, legal issues, adoption and daily living.

Healthcare Quality Initiatives

Increasingly, the healthcare industry is able to define quality healthcare based on preventive health measurements, outcomes of care and optimal care management for chronic disease. A key to our success has been our ability to work with our network physicians and hospitals to improve the quality and outcomes of the healthcare services provided to our members. Our ability to promote quality medical care has been recognized by NCQA, the largest and most respected national accreditation program for managed care health plans.

Several quality healthcare measures, including the Healthcare Effectiveness Data and Information Set, or HEDIS®, have been incorporated into NCQA's accreditation processes. HEDIS® measures range from preventive services, such as screening mammography and pediatric immunization, to elements of care, including decreasing the complications of diabetes and improving treatment for patients with heart disease. For health plans, NCQA's highest accreditation status of Excellent is granted only to those plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. Plans earning this accreditation level must also achieve HEDIS® results that are in the highest range of national or regional performance. Details for each of our plans' accreditation levels can be found at www.ncqa.org.

Our wholly-owned health outcomes research subsidiary, HealthCore, Inc., or HealthCore, generates consistent and actionable evidence to support decision making while helping to guide fresh initiatives for a range of stakeholders in the healthcare industry. By leveraging a rich array of medical and pharmacy utilization data queried from administrative claims, patient surveys, medical charts and laboratory diagnostics, among other health records, HealthCore's multi-disciplinary

research teams uncover a broad spectrum of safety, effectiveness, pharmacoepidemiology, and health economics evidence. HealthCore's real world evidence and comparative effectiveness research, among other data, has played roles in the product planning and development campaigns of biotechnology and pharmaceutical companies and today it lists most of the leading biologics and drug manufacturers as clients or alliance partners. Its health plan research has led to better insights into evidence-based treatment approaches, the development of value-based initiatives to drive access and adherence to treatment, and the crafting of incentives to modify patient and provider behavior. One of HealthCore's predominant initiatives is its governmental and academic collaborations that include cooperation with some of the country's top institutions and federal agencies, including the Food and Drug Administration, or FDA, Patient-Centered Outcomes Research Institute and the National Institutes of Health. HealthCore is also an active contributor to the FDA's medical product safety surveillance Sentinel program. Additionally, HealthCore has taken a thought-leadership position in the development of pragmatic clinical trials. As a notable contributor to the health outcomes evidence base, HealthCore's research findings are broadly disseminated during presentations at national and international medical meetings and are published in a variety of respected peer-reviewed medical and health services journals.

Our AIM subsidiary supports quality by implementing clinical appropriateness and patient safety solutions for advanced imaging procedures, cardiology, sleep medicine, specialty pharmaceuticals, medical oncology, radiation therapy and musculoskeletal services. These programs, based on widely accepted and evidence-based clinical guidelines, promote the most appropriate use of clinical services to improve the quality of overall healthcare delivered to our members and members of other health plans that are covered under AIM's programs. To provide additional impact to its clinical appropriateness program, AIM has also implemented a provider assessment program, OptiNet®, which promotes more informed selection of diagnostic imaging and testing facilities by providing cost and facility information to physician offices at the point that a procedure is ordered. We have also leveraged AIM's provider network assessment information to proactively engage and educate our members about imaging providers and sleep testing choices based on site capabilities and cost differences. This program is another example of how we facilitate improvements in the quality of care provided to our members and promote cost-effective medical care.

Pricing and Underwriting of Our Products

We price our products based on our assessment of current healthcare claim costs and emerging healthcare cost trends, combined with charges for administrative expenses, risk and profit, including charges for the ACA taxes and fees, where applicable. We continually review our product designs and pricing guidelines on a national and regional basis so that our products remain competitive and consistent with our profitability goals and strategies.

In applying our pricing to each employer group and customer, we maintain consistent, competitive, disciplined underwriting standards. We employ our proprietary accumulated actuarial and financial data in determining underwriting and pricing parameters for both our fully-insured and self-funded businesses.

In most circumstances, our pricing and underwriting decisions follow a prospective rating process in which a fixed premium is determined at the beginning of the contract period. For fully-insured business, any deviation, favorable or unfavorable, from the medical costs assumed in determining the premium is our responsibility. Some of our larger groups employ retrospective rating reviews, where positive experience is partially refunded to the group, and negative experience is charged against a rate stabilization fund established from the group's favorable experience or charged against future favorable experience.

BCBSA Licenses

We are a party to license agreements with the BCBSA that entitle us to the exclusive, and in certain areas, non-exclusive use of the Blue Cross and Blue Shield names and marks in assigned geographic territories. BCBSA is a national trade association of Blue Cross and Blue Shield licensees, the primary function of which is to promote and preserve the integrity of the BCBS names and marks, as well as provide certain coordination among the member companies. Each BCBSA licensee is an independent legal organization and is not responsible for obligations of other BCBSA member organizations. We have no right to market products and services using the BCBS names and marks outside of the states in which we are licensed to sell BCBS products. We are required to pay an annual license fee to the BCBSA based on enrollment and also to comply with various operational, governance and financial standards set forth in the licenses.

We believe that we and our licensed affiliates are currently in compliance with these standards. The standards under the license agreements may be modified in certain instances by the BCBSA. See Part I, Item 1A “Risk Factors” in this Annual Report on Form 10-K for additional details of our licensing requirements and the impact if we were not to comply with these license agreements.

Regulation

General

Our operations are subject to comprehensive and detailed state, federal and international regulation throughout the jurisdictions in which we do business. As discussed below, the regulatory aspects of the U.S. healthcare system have been and will continue to be significantly affected by the ACA and subsequent legislative and regulatory changes at the federal and state levels. Supervisory agencies, including state health, insurance and corporation departments, have broad authority to:

- grant, suspend and revoke licenses to transact business;
- regulate our products and services in great detail;
- regulate, limit, or suspend our ability to market products, including the exclusion of our plans from participating on public exchanges;
- retroactively adjust premium rates;
- monitor our solvency and reserve adequacy;
- scrutinize our investment activities on the basis of quality, diversification and other quantitative criteria; and
- impose monetary and criminal sanctions for non-compliance with regulatory requirements.

To carry out these tasks, these regulators periodically examine our operations and accounts.

Regulation of Insurance Company and HMO Business Activity

The governments of the states in which we conduct business, as well as the federal government, have adopted laws and regulations that govern our business activities in various ways. Further, the ACA has resulted in increased federal regulation that significantly impacts our business. These laws and regulations, which vary significantly from state to state, restrict how we conduct our businesses and result in additional burdens and costs to us. These federal and state laws and regulations are subject to amendments and changing interpretations in each jurisdiction.

States generally require health insurers and HMOs to obtain a certificate of authority prior to commencing operations. If we were to establish a health insurance company or an HMO in any jurisdiction, we generally would have to obtain such a certificate or authorization to expand the operations permitted under an existing certificate if we already operate in the state. The time necessary to obtain such a certificate varies from jurisdiction to jurisdiction. Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. The health benefits business also may be adversely impacted by court and regulatory decisions that expand or invalidate the interpretations of existing statutes and regulations. It is uncertain whether we can recoup, through higher premiums or other measures, the increased costs of mandated benefits or other increased costs caused by potential legislation, regulation or court rulings. See Part I, Item 1A “Risk Factors” in this Annual Report on Form 10-K.

Ongoing Requirements and Changes Stemming from the ACA

The ACA significantly changed health insurance markets by prohibiting lifetime limits, certain annual limits, member cost-sharing on specified preventive benefits and pre-existing condition exclusions. Further, the ACA implemented certain requirements for insurers, including changes to Medicare Advantage payments and the minimum medical loss ratio, or MLR, provision that requires insurers to pay rebates to customers when insurers do not meet or exceed the specified MLR thresholds. In addition, the ACA also required a number of other changes with significant effects on both federal and state health insurance markets, including strict rules on how health insurance is rated, what benefits must be offered, the assessment of new taxes and fees (including annual fees on health insurance companies), the creation of public exchanges for

Individuals and Small Groups, the availability of premium and cost-sharing subsidies for qualified individuals, and expansions in eligibility for Medicaid. Changes to our business environment are likely to continue for the next several years as elected officials at the national and state levels continue to propose and enact significant modifications to existing laws and regulations, including the reduction of the individual mandate penalty to zero effective January 1, 2019, elimination of funding for cost-sharing subsidies made available for qualified individuals, and changes to taxes and fees. Also, the legal challenges regarding the ACA, including the ultimate outcome of the 2018 Texas District Court ACA Decision, could have a material adverse effect on our business, cash flows, financial condition and results of operations.

In general, the Individual market risk pool that includes public exchange markets has become less healthy since its inception in 2014. The reduction of the individual mandate penalty to zero, effective in 2019, is also expected to result in further deterioration of the overall Individual market risk pool. In June 2018, the U.S. Department of Labor, or DOL, released a final rule on association health plans, and in August 2018, the DOL, the U.S. Department of Treasury, or TRE, and the U.S. Department of Health and Human Services, or HHS, issued a final rule on short-term limited duration insurance. In October 2018, the DOL, TRE and HHS issued a proposed rule on health reimbursement accounts, and in January 2019, HHS issued a proposed rule for the Notice of Benefit and Payment Parameters for 2020. Additionally, in October 2018 HHS issued guidance on waivers pursuant to Section 1332 of the ACA, which aims to allow states to create waiver programs allowing premium subsidies to be used for non-ACA products. These regulations and guidance may provide additional opportunities for individuals, sole proprietors and small employers to access more affordable health coverage options, but may also result in additional adverse risk selection. Based on our experience in public exchange markets to date, we have made adjustments to our premium rates and strategically reduced our participation footprint, and we will continue to evaluate the performance of our public exchange plans going forward. In addition, insurers have faced uncertainties related to federal government funding for various ACA programs. These factors may have a material adverse effect on our results of operations if premiums are not adequate or do not appropriately reflect the acuity of these individuals. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions utilized in setting premium rates could have a material adverse effect on our results of operations, financial position, and cash flows.

Further, implementation of the ACA brings with it significant oversight responsibilities by health insurers that may result in increased governmental audits, increased assertions of False Claims Act violations, and an increased risk of other litigation.

Federal regulatory agencies continue to modify regulations and guidance related to the ACA and markets more broadly. Some of the more significant ACA rules are described below:

- The minimum MLR thresholds by line of business for the Commercial market, as defined by HHS, are as follows:

Line of Business	%
Large Group	85
Small Group	80
Individual	80

New York state regulations require us to meet a more restrictive MLR threshold of 82% for both Small Group and Individual lines of business. The minimum MLR thresholds disclosed above are based on definitions of an MLR calculation provided by HHS, or specific states, as applicable, and differ from our calculation of “benefit expense ratio” based on premium revenue and benefit expense as reported in accordance with U.S. generally accepted accounting principles, or GAAP. Furthermore, the definitions of the lines of business differ under the various federal and state regulations and may not correspond to our lines of business. Definitions under the MLR regulation also impact insurers differently depending upon their organizational structure or tax status, which could result in a competitive advantage to some insurance providers that may not be available to us, resulting in an uneven playing field in the industry.

The ACA also imposed a separate minimum MLR threshold of 85% for Medicare Advantage and Medicare Part D prescription drug plans or Medicare Part D plans. Medicare Advantage or Medicare Part D plans that do not meet this threshold will have to pay a minimum MLR rebate. If a plan’s MLR is below 85% for three consecutive years beginning with 2014, enrollment will be restricted. A Medicare Advantage or Medicare Part D plan contract will be terminated if the plan’s MLR is below 85% for five consecutive years.

HHS also finalized a rule in April 2016 that requires state Medicaid programs to set managed care capitation rates such that a minimum 85% MLR is projected to be achieved. However, this rule does not require states to collect remittances if the minimum MLR is not achieved.

Approximately 58.7% and 22.0% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2018. Approximately 61.3% and 21.5% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2017.

- The ACA created an incentive payment program for Medicare Advantage plans. CMS developed the Medicare Advantage Star Ratings System, which awards between 1.0 and 5.0 stars to Medicare Advantage plans based on performance in several categories, including quality of care and customer service. The star ratings are used by CMS to award quality-based bonus payments to plans that receive a rating of 4.0 or higher. The methodology and measures included in the star ratings system can be modified by CMS annually. As of December 31, 2018, all of our Medicare Advantage plans have received a rating of 3.0 or higher.

- Regulations require premium rate increases to be reviewed for Small Group and Individual products above specified thresholds, 10% for 2018 and 15% for 2019, and may be adjusted from time to time. The regulations provide for state insurance regulators to conduct the reviews, except for cases where a state does not have an “effective” rate review program or in federal enforcement states, in which cases HHS will conduct the reviews for any rate increase.

- Prior to the implementation of the ACA, health insurers were permitted to use differential pricing, commonly referred to as “rating bands,” based on factors such as health status, gender and age. The ACA precludes health insurers from using health status and gender in the determination of the insurance premium. In addition, rating bands for age cannot vary by more than 3 to 1 and rating bands for tobacco use cannot vary by more than 1.5 to 1. The ongoing use of the 3 to 1 rating bands may have a significant impact on the majority of Individual and Small Group customers and could lead to adverse selection in the market as well as increased variability in projecting future premiums for those customer markets.

- In 2014 significant new taxes and fees became effective for health insurers, some of which may or may not be passed through to customers. The most significant of the taxes and fees is the annual Health Insurance Provider Fee, or HIP Fee, on health insurers that write certain types of health insurance on U.S. risks. The annual HIP Fee is allocated to health insurers based on the ratio of the amount of an insurer’s net premium revenues written during the preceding calendar year to the amount of health insurance premium for all U.S. health risk for those certain lines of business written during the preceding calendar year. We record our estimated liability for the HIP Fee in full at the beginning of the year with a corresponding deferred asset that is amortized on a straight-line basis to selling, general and administrative expense. The final calculation and payment of the annual HIP Fee is due by September 30th of each fee year. The HIP Fee is non-deductible for federal income tax purposes. We price our affected products to cover the increased selling, general and administrative and income tax expenses associated with the HIP Fee. The total amount due from allocations to health insurers was $11.3 billion for 2016, was suspended for 2017, had resumed and increased to $14.3 billion for 2018 and is suspended for 2019. The HIP Fee is scheduled to go back into effect for 2020.

- Medicare Advantage reimbursement rates will not increase as much as they would otherwise due to the payment formula promulgated by the ACA that continues to impact reimbursements. We also expect further and ongoing regulatory guidance on a number of issues related to Medicare, including evolving methodology for ratings and quality bonus payments. CMS is also proposing changes to its program that audits data submitted under the risk adjustment programs in a way that could increase financial recoveries from plans.

Pharmacy Benefit Manager Regulation

A number of proposals are being considered at the federal and state levels that would increase regulation of pharmacy benefit managers. Such proposals under consideration include (1) proposed federal regulation of drug rebates that would narrow the types of rebates that are allowed in public programs and require rebates to be reflected at the point-of-sale, (2) proposed federal regulation that would tie Medicare reimbursement for physician-administered drugs to prices paid in other countries, and (3) proposed reforms to the Medicare drug benefit, such as reducing the number of drugs that must be covered

in protected classes and beneficiary cost-sharing changes that aim to lower out-of-pocket costs. These reforms have the potential to have broad impacts on our pharmacy benefit business.

Dodd-Frank Wall Street Reform and Consumer Protection Act

The Dodd-Frank Wall Street Reform and Consumer Protection Act, or the Dodd-Frank Act, includes a number of financial reforms and regulations that affect our business and financial reporting, including margin requirements and reporting and clearing transactions for our investments in derivative instruments. In addition, the Dodd-Frank Act creates a Federal Insurance Office with limited powers that include information-gathering and subpoena authority for certain parts of our business, including life insurance, but excluding health insurance. There remains uncertainty surrounding the manner in which the provisions of the Dodd-Frank Act will ultimately be implemented by the various regulatory agencies, and the full extent of the impact of the requirements on our operations is unclear, especially in light of the Trump administration's January 2017 executive order calling for a full review of the Dodd-Frank Act and the regulations promulgated thereunder.

HIPAA and Gramm-Leach-Bliley Act

The federal Health Insurance Portability and Accountability Act of 1996, or HIPAA, imposes obligations for issuers of health insurance coverage and health benefit plan sponsors. This law requires guaranteed renewability of healthcare coverage for most group health plans and certain individuals. Also, the law limited exclusions based on preexisting medical conditions.

The administrative simplification provisions of HIPAA imposed a number of requirements on covered entities (including insurers, HMOs, group health plans, providers and clearinghouses). These requirements include uniform standards of common electronic healthcare transactions; privacy and security regulations; and unique identifier rules for employers, health plans and providers. Additional federal privacy and security requirements, including breach notification, improved enforcement, and additional limitations on use and disclosure of protected health information were passed through the Health Information Technology for Economic and Clinical Health, or HITECH, Act provisions of the American Recovery and Reinvestment Act of 2009 and corresponding implementing regulations. States are also passing privacy and security requirements, such as the California Consumer Privacy Act, which may limit our use and disclosure of member data and impose additional breach notification requirements.

The federal Gramm-Leach-Bliley Act generally places restrictions on the disclosure of non-public information to non-affiliated third parties, and requires financial institutions, including insurers, to provide customers with notice regarding how their non-public personal information is used, including an opportunity to "opt out" of certain disclosures. State departments of insurance and certain federal agencies adopted implementing regulations as required by federal law. In addition, a number of states have adopted data security laws and/or regulations governing data security and/or requiring security breach notification, which may apply to us in certain circumstances.

Employee Retirement Income Security Act of 1974

The provision of services to certain employee welfare benefit plans is subject to the Employee Retirement Income Security Act of 1974, as amended, or ERISA, a complex set of laws and regulations subject to interpretation and enforcement by the Internal Revenue Service and the DOL. ERISA regulates certain aspects of the relationships between us, the employers that maintain employee welfare benefit plans subject to ERISA and participants in such plans. Some of our administrative services and other activities may also be subject to regulation under ERISA. In addition, certain states require licensure or registration of companies providing third-party claims administration services for benefit plans. We provide a variety of products and services to employee welfare benefit plans that are covered by ERISA. Plans subject to ERISA can also be subject to state laws and the question of whether and to what extent ERISA preempts a state law has been, and will continue to be, interpreted by many courts.

HMO and Insurance Holding Company Laws, including Risk-Based Capital Requirements

We are regulated as an insurance holding company and are subject to the insurance holding company acts of the states in which our insurance company and HMO subsidiaries are domiciled. These acts contain certain reporting requirements as well as restrictions on transactions between an insurer or HMO and its affiliates. These holding company laws and regulations generally require insurance companies and HMOs within an insurance holding company system to register with the insurance

department of each state where they are domiciled and to file with those states' insurance departments certain reports describing capital structure, ownership, financial condition, certain intercompany transactions, enterprise risks, corporate governance and general business operations. In addition, various notice and reporting requirements generally apply to transactions between insurance companies and HMOs and their affiliates within an insurance holding company system, depending on the size and nature of the transactions. Some insurance holding company laws and regulations require prior regulatory approval or, in certain circumstances, prior notice of certain material intercompany transfers of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies and affiliates. Among other provisions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends.

Additionally, the holding company acts of the states in which our subsidiaries are domiciled restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval (or an exemption), no person may acquire any voting security of an insurance holding company, which controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would "control" the insurance holding company. "Control" is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person. Dispositions of control generally are also regulated under the state holding company acts.

The states of domicile of our regulated subsidiaries have statutory risk-based capital, or RBC, requirements for health and other insurance companies and HMOs based on the Risk-Based Capital (RBC) For Health Organizations Model Act, or RBC Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company's investments and products. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year. The law requires increasing degrees of regulatory oversight and intervention as a company's RBC declines. As of December 31, 2018, the RBC levels of our insurance and HMO subsidiaries exceeded all RBC requirements.

Guaranty Fund Assessments

Under insolvency or guaranty association laws in most states, insurance companies can be assessed for amounts paid by guaranty funds for policyholder losses incurred when an insurance company becomes insolvent. Most state insolvency or guaranty association laws currently provide for assessments based upon the amount of premiums received on insurance underwritten within such state (with a minimum amount payable even if no premium is received). Under many of these guaranty association laws, assessments against insurance companies that issue policies of accident or sickness insurance are made retrospectively. Some states permit insurers to recover assessments paid through full or partial premium tax offsets or through future policyholder surcharges. The amount and timing of any future assessments cannot be predicted with certainty; however, future assessments are likely to occur.

Employees

At December 31, 2018, we had approximately 63,900 full-time employees. Our employees are an important asset, and we seek to develop them to their full potential. We believe that our relationship with our employees is good.

Available Information

We are a large accelerated filer (as defined in Rule 12b-2 of the Securities Exchange Act of 1934, as amended, or the Exchange Act) and are required, pursuant to Item 101 of Regulation S-K, to provide certain information regarding our website and the availability of certain documents filed with or furnished to the U.S. Securities and Exchange Commission, or SEC. Our Internet website is www.antheminc.com. We have included our Internet website address throughout this Annual Report on Form 10-K as a textual reference only. The information contained on, or accessible through, our Internet website is not incorporated into this Annual Report on Form 10-K. We make available, free of charge, by mail or through our Internet website, our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act as soon as reasonably practicable after we electronically file such material with or furnish it to the SEC. We also include on our Internet website our Corporate Governance Guidelines, our Standards of Ethical Business Conduct and the charter of each standing committee of our Board

of Directors. In addition, we intend to disclose on our Internet website any amendments to, or waivers from, our Standards of Ethical Business Conduct that are required to be publicly disclosed pursuant to rules of the SEC and the New York Stock Exchange, or NYSE. Anthem, Inc. is an Indiana corporation incorporated on July 17, 2001.

ITEM 1A. RISK FACTORS.

The following is a description of significant factors that could cause our actual results to differ materially from those contained in forward-looking statements made in this Annual Report on Form 10-K and presented elsewhere by management from time to time. Such factors may have a material adverse effect on our business, financial condition, and results of operations, and you should carefully consider them and not place undue reliance on any forward-looking statements. It is not possible to predict or identify all such factors. Consequently, you should not consider any such list to be a complete statement of all our potential risks or uncertainties. Because of these and other factors, past performance should not be considered an indication of future performance.

If we fail to appropriately predict, price for and manage healthcare costs, the profitability of our products could decline, which could materially adversely affect our business, cash flows, financial condition and results of operations.

Our profitability depends in large part on accurately predicting healthcare costs and on our ability to manage future healthcare costs through medical management, product design, negotiation of favorable provider contracts and underwriting criteria. Government-imposed limitations on Medicare and Medicaid reimbursement have also caused the private sector to bear a greater share of increasing healthcare costs. Changes in healthcare practices, demographic characteristics including the aging population, inflation, new technologies and therapies, increases in the cost and number of prescription drugs, clusters of high cost cases, changes in the regulatory environment and numerous other factors affecting the cost of healthcare may adversely affect our ability to predict and manage healthcare costs, as well as our business, cash flows, financial condition and results of operations. Future modifications to, or enactment of, laws and regulations that impact our product pricing and required product benefits may also impact our profitability in future periods.

Relatively small differences between predicted and actual healthcare costs as a percentage of premium revenues can result in significant changes in our results of operations. In general, healthcare benefit costs in excess of our cost projections reflected in our fully insured product pricing cannot be recovered in the current premium period through higher premiums. Although federal and state premium and risk adjustment mechanisms could help offset healthcare benefit costs in excess of our projections if our assumptions (including assumptions for government premium and risk adjustment payments) utilized in setting our premium rates are significantly different than actual results, our income statement and financial condition could still be adversely affected.

In addition to the challenge of managing healthcare costs, we face pressure to contain premium rates. Our customers may renegotiate their contracts to seek to contain their costs or may move to a competitor to obtain more favorable premiums. Further, federal and state regulatory agencies may restrict our ability to implement changes in premium rates. For example, we must submit data on all proposed rate increases to HHS for monitoring purposes on many of our products. In addition, the ACA includes an annual rate review requirement to prohibit unreasonable rate increases, and our plans may be excluded from participating in the public exchanges if they are deemed to have a history of “unreasonable” rate increases. Fiscal concerns regarding the continued viability of programs such as Medicare and Medicaid may cause decreasing reimbursement rates, including retroactive decreases in Medicaid reimbursement rates, delays in premium payments or reimbursement rate increases for government-sponsored programs that are lower than the increase in cost of care trends. A limitation on our ability to increase or maintain our premium or reimbursement levels or a significant loss of membership resulting from our need to increase or maintain premium or reimbursement levels could adversely affect our business, cash flows, financial condition and results of operations.

The reserves that we establish for health insurance policy benefits and other contractual rights and benefits are based upon assumptions concerning a number of factors, including trends in healthcare costs, expenses, general economic conditions and other factors. To the extent the actual claims experience is unfavorable as compared to our underlying assumptions, our incurred losses would increase and future earnings could be adversely affected.

Our profitability is also dependent in part upon our ability to contract on favorable terms with hospitals, physicians, PBM service providers and other healthcare providers. Physicians, hospitals and other healthcare providers may elect not to

contract with us, and the failure to secure or maintain cost-effective healthcare provider contracts on competitive terms may result in a loss of membership or higher medical costs, which could adversely affect our business. In addition, consolidation among healthcare providers, ACO practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, and other organizational structures that physicians, hospitals and other care providers choose, as well as the ability of larger employers to contract directly with providers, may change the way that these providers interact with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which may impact our relationship with these providers or affect the way that we price our products and estimate our costs and may require us to incur costs to change our operations, which could adversely affect our business, cash flows, financial condition and results of operations.

Our inability to contract with providers, or if providers attempt to use their market position to negotiate more favorable contracts or place us at a competitive disadvantage, or the inability of providers to provide adequate care, could adversely affect our business. In addition, we do not have contracts with all providers that render services to our members and, as a result, may not have a pre-established agreement about the amount of compensation those out-of-network providers will accept for the services they render, which can result in significant litigation or arbitration proceedings, or provider attempts to obtain payment from our members for the difference between the amount we have paid and the amount they have charged.

The ongoing changes to the ACA and related laws and regulations could adversely affect our business, cash flows, financial condition and results of operations.

The ongoing changes in federal and state laws and regulations stemming from the ACA, including the steps that have been taken to amend, repeal and limit the scope and application of the ACA, continue to represent significant challenges to the U.S. healthcare system. We are unable to predict how these events will ultimately be resolved and what the potential impact may be on our business, including, but not limited to, our products, services, processes and technology, and on our relationships with current and future customers and healthcare providers. The legal challenges regarding the ACA, including the 2018 Texas District Court ACA Decision invalidating the ACA, which judgment has been stayed pending appeals, continue to contribute to this uncertainty, which could significantly impact the market for our products, the regulations applicable to us and the fees and taxes payable by us. In addition, the ACA imposes significant fees, assessments and taxes on us and other health insurers, health plans and other industry participants, including the annual non-tax deductible HIP Fee. Further regulations and modifications to the ACA at the federal or state level, including a judicial invalidation of the ACA, will likely have significant effects on our business and future operations, some of which may adversely affect our results of operations and financial condition.

In general, the risk pool for the Individual market, which includes public exchange markets, has become less healthy since its inception in 2014. The reduction of the individual mandate penalty to zero, effective in 2019, is also expected to result in further deterioration of the overall Individual market risk pool. Based on our experience in public exchange markets to date, we have made adjustments to our premium rates and geographic participation, and we will continue to evaluate the performance of our public exchange plans, the future viability of the public exchanges and availability of federal subsidies, and may make further adjustments to our rates and participation going forward. In addition, insurers have faced uncertainties related to federal government funding for various ACA programs. These factors may have a material adverse effect on our results of operations if premiums are not adequate or do not appropriately reflect the acuity of these individuals. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions utilized in setting premium rates could have a material adverse effect on our results of operations, financial position, and cash flows.

For additional information related to the ACA, see Part I, Item 1 “Business” and Part II, Item 7 “Management’s Discussion and Analysis of Financial Condition and Results of Operations” of this Annual Report on Form 10-K.

We are subject to significant government regulation, and changes in the regulation of our business by federal and state regulators may adversely affect our business, cash flows, financial condition and results of operations.

In addition to the ACA and efforts to modify the ACA, we face state and federal regulation associated with many aspects of our business, including, but not limited to, licensing, premiums, marketing activities, provider contracting, access and payment standards, and corporate governance and financial reporting matters. In addition, our PBM is also subject to an increasing number of licensure, registration and other laws and accreditation standards that impact the business practices of a pharmacy benefit manager. We must identify, assess and respond to new laws and regulations, as well as comply with the

various existing laws and regulations applicable to our business. Changes in existing laws, rules and regulatory interpretation or future laws, rules, regulatory interpretations or judgments could force us to change how we conduct our business, affect the products we offer, restrict revenue and enrollment growth, increase our costs, including operating, healthcare technology and administrative costs, restrict our ability to obtain new product approvals and implement changes in premium rates and require enhancements to our compliance infrastructure and internal controls environment.

Our insurance, managed healthcare and HMO subsidiaries are subject to extensive regulation and supervision by regulatory authorities in each state in which they are licensed or authorized to do business, in addition to regulation by federal agencies. Future regulatory action by state or federal authorities could have a material adverse effect on the profitability or marketability of our health benefits or managed care products or on our business, financial condition and results of operations. In addition, because of our participation in government-sponsored programs such as Medicare and Medicaid, a number of our subsidiaries are also subject to regulation by CMS and state Medicaid agencies, and to changes in government regulations or policy with respect to, among other things, reimbursement levels, eligibility requirements, benefit coverage requirements and additional governmental participation, which could also adversely affect our business, cash flows, financial condition and results of operations.

In addition, under insolvency or guaranty association laws in most states, insurance companies can be assessed for certain obligations to policyholders and claimants of impaired or insolvent insurance companies. Some states have similar laws relating to HMOs and other payers such as consumer operated and oriented plans (co-ops) established under the ACA. We may experience assessments in the future if, for example, premiums established by other companies for their health insurance products, including certain long-term care products, are inadequate to cover the cost of care. Any such assessment could expose us to the risk of paying a portion of an impaired or insolvent insurance company's claims through state guaranty associations. We are not currently able to estimate our potential financial obligations, losses, or the availability of potential offsets associated with potential guaranty association assessments; however, any significant increase in guaranty association assessments could have a material adverse effect on our business, cash flows, financial condition and results of operations.

State legislatures will continue to focus on healthcare delivery and financing issues. State ballot initiatives can also be put to voters that would substantially impair our operating environment. Most states are very focused on how to manage and reduce their budgets and are exploring ways to mitigate cost increases. As such, some states have acted to reduce or limit increases to premium payments. Others have enacted, or are contemplating, significant reform of their health insurance markets to include provisions affecting both public programs and privately-financed health insurance arrangements. If enacted into law, these state proposals could have a material adverse impact on our business, cash flows, operations or financial condition.

A number of states in which we offer Medicaid products have not opted for Medicaid expansion under the ACA, at least for the present time. Where states allow certain programs to expire or have not opted for Medicaid expansion, we could experience reduced Medicaid enrollment and reduced growth opportunities. If future modifications to laws and regulations significantly reduce Medicaid enrollment, this will negatively impact our Medicaid business.

Additionally, from time to time, Congress has considered, and may consider in the future, various forms of managed care reform legislation which, if adopted, could fundamentally alter the treatment of coverage decisions under ERISA. There have been legislative attempts to limit ERISA's preemptive effect on state laws and litigants' ability to seek damages beyond the benefits offered under their plans. If adopted, such limitations could increase our liability exposure, could permit greater state regulation of our operations, and could expand the scope of damages, including punitive damages, litigants could be awarded. While we cannot predict if any of these initiatives will ultimately become effective or, if enacted, what their terms will be, their enactment could increase our costs, expose us to expanded liability or require us to revise the ways in which we conduct business.

We face competition in many of our markets, and if we fail to adequately adapt to changes in our industry and develop and implement strategic growth opportunities, our ability to compete and grow may be adversely affected.

As a health benefits company, we operate in a highly competitive environment and in an industry that is subject to significant changes from legislative reform, business consolidations, new strategic alliances, new market entrants, aggressive marketing practices by other health benefits organizations, technological advancements and market pressures brought about by an informed and organized customer base, particularly among large employers, which may increasingly have the ability to contract directly with providers. In addition, the PBM industry is highly competitive, and our PBM business will be subject to competition from owned drugstores, retail drugstore chains, supermarkets, discount retailers, membership clubs, internet companies and other mail-order and long-term care pharmacies. These factors have produced and will likely continue to produce significant pressures on our profitability.

In addition, as a result of changes to traditional health insurance over the past several years, the health insurance industry has experienced a significant shift in membership to insurance products with lower margins. In order to profitably grow our business in the future, we need to not only grow our profitable medical membership, but also continue to diversify our sources of revenue and earnings, including through the increased sale of our specialty products, such as dental, vision and other supplemental products, expansion of non-ACA medical products, expansion of our non-insurance assets and establishment of new cost of care solutions, including innovations in PBM services. If we are unable to acquire or develop and successfully manage new opportunities that further our strategic objectives and differentiate our products from our competitors, our ability to profitably grow our business could be adversely affected.

We also will have to respond to pricing and other actions taken by existing competitors and potentially disruptive new entrants. Due to the price transparency provided by public exchanges and new market entrants, we face competitive pressures from new and existing competitors in the market for Individual health insurance. These risks may be enhanced if employers shift to defined contribution healthcare benefits plans and make greater utilization of private insurance exchanges or encourage their employees to purchase health insurance on the public exchanges. We can provide no assurance that we will be able to compete successfully on these exchanges or that we will be able to benefit from any opportunities presented by such exchanges. The elimination of the individual mandate penalty in the ACA, effective January 1, 2019, may further disrupt the public exchange markets. If we are not competitive on these exchanges or are unsuccessful in reducing our cost structure, our future growth and profitability may be adversely impacted.

We are currently dependent on the non-exclusive services of independent agents and brokers in the marketing of our healthcare products, particularly with respect to individuals, seniors and small employer group customers. We face intense competition for the services and allegiance of these independent agents and brokers, who may also market the products of our competitors. Our relationship with our brokers and independent agents could be adversely impacted by changes in our business practices to address legislative changes, including potential reductions in commissions and consulting fees paid to agents and brokers. We cannot ensure that we will be able to compete successfully against current and future competitors for these services or that competitive pressures faced by us will not materially and adversely affect our business, cash flows, financial condition and results of operations.

A significant reduction in the enrollment in our health benefits programs, particularly in states where we have large regional concentrations, could have an adverse effect on our business, cash flows, financial condition and results of operations.

A significant reduction in the number of enrollees in our health benefits programs could adversely affect our business, cash flows, financial condition and results of operations. Factors that could contribute to a reduction in enrollment include: reductions in workforce by existing customers; a general economic upturn that results in fewer individuals being eligible for Medicaid programs; a general economic downturn that results in business failures and high unemployment rates; employers no longer offering certain healthcare coverage as an employee benefit or electing to offer coverage on a voluntary, employee-funded basis; participation on public exchanges; federal and state regulatory changes, including the elimination of the individual mandate penalty in the ACA effective January 1, 2019; failure to obtain new customers or retain existing customers; premium increases and benefit changes; our exit from a specific market; negative publicity and news coverage; and failure to attain or maintain nationally recognized accreditations.

The states in which we operate that have the largest concentrations of revenues include California, Florida, Georgia, Indiana, New York, Ohio, Texas and Virginia. Due to this concentration of business in these states, we are exposed to potential losses resulting from the risk of state-specific or regional economic downturns impacting these states. If any such negative economic conditions do not improve, we may experience a reduction in existing and new business, which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

A cyber attack or other privacy or data security incident could result in an unauthorized disclosure of sensitive or confidential information, cause a loss of data, disrupt a large amount of our operations, give rise to remediation or other expenses, expose us to liability under federal and state laws, and subject us to litigation and investigations, which could have an adverse effect on our business, cash flows, financial condition and results of operations.

As part of our normal operations, we collect, process and retain certain sensitive and confidential information. We are subject to various federal, state and international laws and rules regarding the use and disclosure of certain sensitive or confidential information, including HIPAA, the HITECH Act, the Gramm-Leach-Bliley Act and numerous state laws governing personal information. Our facilities and systems, and those of our third-party service providers, are regularly the target of, and may be vulnerable to, cyber attacks, security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other threats.

We have been, and will likely continue to be, the target of attempted cyber attacks and other security threats. In February 2015, we reported the discovery that certain of our information technology systems had been the target of an external cyber attack, as more fully described under Note 13, “Commitments and Contingencies - *Litigation and Regulatory Proceedings – Cyber Attack Regulatory Proceedings and Litigation*,” of the Notes to our Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K. The attackers gained unauthorized access to certain of our information technology systems and obtained personal information related to many individuals and employees. We have incurred expenses to investigate and remediate this matter and expect to continue to incur expenses of this nature in the foreseeable future. Although the consolidated civil actions, state court cases and investigation by the Office of Civil Rights related to this cyber attack have been settled and dismissed, respectively, an ongoing investigation by a multi-state group of Attorneys General remains outstanding. We also may be subject to additional litigation and governmental investigations which could divert the attention of management from the operation of our business, result in reputational damage and have a material adverse impact on our business, cash flows, financial condition and results of operations. While we have contingency plans and insurance coverage for potential liabilities of this nature, they may not be sufficient to cover all claims and liabilities.

We cannot ensure that we will be able to identify, prevent or contain the effects of additional cyber attacks or other cybersecurity risks in the future that bypass our security measures or disrupt our information technology systems or business. We have security technologies, processes and procedures in place to protect against cybersecurity risks and security breaches. However, hardware, software or applications we develop or procure from third parties may contain defects in design, manufacturer defects or other problems that could unexpectedly compromise information security. In addition, because the techniques used to obtain unauthorized access, disable or degrade service or sabotage systems change frequently and may not immediately produce signs of intrusion, we may be unable to anticipate these techniques, timely discover or counter them or implement adequate preventative measures. Viruses, worms or other malicious software programs may be used to attack our systems or otherwise exploit any security vulnerabilities, and such security attacks may cause system disruptions or shutdowns, or may cause personal information or proprietary or confidential information to be misappropriated or compromised. As a result, cybersecurity and the continued development and enhancement of our controls, processes and practices designed to protect our systems, computers, software, data and networks from attack, damage and unauthorized access remain a priority for us.

In addition, we use third-party technology, systems and services for a variety of reasons, including, without limitation, encryption and authentication technology, employee email, content delivery to customers, back-office support, and other functions. Although we have developed systems and processes that are designed to reduce the impact of a security breach at a third-party vendor, such measures cannot provide absolute security, and these third-party providers may also experience security breaches or interruptions to their information technology hardware and software infrastructure and communications systems that could adversely impact us.

Noncompliance with any privacy or security laws and regulations, or any security breach, cyber attack or cybersecurity breach, and any incident involving the misappropriation, loss or other unauthorized disclosure or use of, or access to,

sensitive or confidential member information, whether by us or by one of our third-party service providers, could require us to expend significant resources to continue to modify or enhance our protective measures and to remediate any damage. In addition, this could result in interruptions to our operations, damage our reputation and cause membership losses, and could also result in regulatory enforcement actions, material fines and penalties, litigation or other actions that could have a material adverse effect on our business, cash flows, financial condition and results of operations.

There are various risks associated with participating in Medicaid and Medicare programs, including dependence upon government funding and the timing of payments, compliance with government contracts and increased regulatory oversight.

We contract with various federal and state agencies, including CMS, to provide managed healthcare services, such as Medicare Advantage, Medicare Part D, Medicare Supplement, Medicaid, TANF, SPD, LTSS, CHIP, ACA-related Medicaid expansion programs and various specialty programs. We also provide various administrative services for several other entities offering medical and/or prescription drug plans to their Medicaid or Medicare eligible members through our affiliated companies, and we offer employer group waiver plans which provide medical and/or prescription drug coverage to retirees. We are also participating in MMPs in several states. These programs in our Government Business segment have been the subject of recent regulatory reform initiatives, including the ACA. It is difficult to predict the future impact of the ACA or other regulatory reforms on our Government Business segment due to the potential for further ACA modifications and other reforms. Regulatory reform initiatives or additional changes in existing laws or regulations, or their interpretations, could have a material adverse effect on our business, cash flows, financial condition and results of operations.

Revenues from the Medicare and Medicaid programs are dependent, in whole or in part, upon annual funding from the federal government and/or applicable state governments. The base premium rate paid by each state or federal agency differs depending upon a combination of various factors such as defined upper payment limits, a member's health status, age, gender, county or region, benefit mix, member eligibility category and risk scores. Future Medicare and Medicaid rates may be affected by continued government efforts to contain costs as well as federal and state budgetary constraints. If the federal government or any state in which we operate were to decrease rates paid to us, pay us less than the amount necessary to keep pace with our cost trends or seek an adjustment to previously negotiated rates, it could have a material adverse effect on our business, cash flows, financial condition and results of operations. Further, certain state contracts are subject to cancellation in the event of the unavailability of state funds. In addition, various states' MMPs are still subject to uncertainty surrounding payment rates and other requirements, which could affect where we seek to participate in these programs. An unexpected reduction, inadequate government funding or significantly delayed payments for these programs may adversely affect our business, cash flows, financial condition and results of operations.

In addition, Medicare and Medicaid are subject to various MLR rules. Other potential risks associated with the Medicare Advantage and Medicare Part D plans include increased medical or pharmaceutical costs, overpayments identified as a result of ongoing auditing and monitoring activities, potential uncollectability of receivables resulting from processing and/or verifying enrollment, inadequacy of underwriting assumptions, inability to receive and process correct information (including inability due to systems issues by the federal government, the applicable state government or us), uncollectability of premiums from members, and limited enrollment periods. While we believe we have adequately reviewed our assumptions and estimates regarding these complex and wide-ranging programs under Medicare Advantage and Medicare Part D, including those related to collectability of receivables and establishment of liabilities, actual results may be materially different than our assumptions and estimates and could have a material adverse effect on our business, financial condition and results of operations. Finally, there is the possibility that the Medicare Advantage program could be significantly impacted by any future modification, repeal or replacement of the ACA.

Our revenue on Medicare policies is based on bids submitted to CMS in June the year before the contract year. Although we base the commercial and Medicaid premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period, many factors may cause actual costs to exceed those estimated and reflected in premiums or bids. These factors may include medical cost inflation, increased use of services, increased cost of individual services, natural catastrophes or other large-scale medical emergencies, epidemics, the introduction of new or costly drugs, treatments and technologies, new treatment guidelines, new mandated benefits (such as the expansion of essential benefits coverage) or changes to other regulations and insured population characteristics. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results.

Our contracts with CMS and state governmental agencies contain certain provisions regarding data submission, provider network maintenance, quality measures, claims payment, encounter data, continuity of care, call center performance and other requirements specific to federal and state program regulations. If we fail to comply with these requirements, we may be subject to fines, penalties, liquidated damages and retrospective adjustments in payments made to our health plans that could impact our profitability. In addition, we could be required to file a corrective plan of action with additional penalties for noncompliance, including a negative impact on future membership enrollment levels. Further, certain of our CMS and state Medicaid contracts are subject to a competitive procurement process. If our existing contracts are not renewed, if we are not awarded new contracts as a result of the competitive procurement process, or if we lose members under an existing contract as a result of a post-award challenge, it could have a material adverse effect on our business, cash flows, financial condition and results of operations.

Further, the Medicare Advantage Star Rating System utilized by CMS to evaluate Medicare Advantage Plans may have a significant effect on our results of operations, as higher-rated plans tend to experience increased enrollment and plans with a star rating of 4.0 or higher are eligible for quality-based bonus payments. Our star ratings may be negatively impacted if we fail to meet the quality, performance and regulatory compliance criteria established by CMS. Furthermore, the star rating system is subject to change annually by CMS, which may make it more difficult to achieve four stars or greater. If we do not maintain or continue to improve our star ratings, fail to meet or exceed our competitors' ratings, or if quality-based bonus payments are reduced or eliminated, we may experience a negative impact on our revenues and the benefits that our plans can offer, which could materially and adversely affect the marketability of our plans, our membership levels, results of operations, financial condition and cash flows. Similarly, a number of state Medicaid programs in which we participate have implemented performance standards, and if we fail to meet or exceed those standards, we may not receive performance-based bonus payments or may incur performance-based penalties.

In addition to the contractual requirements affecting our participation in Medicaid and Medicare programs, we are also subject to various federal and state healthcare laws and regulations, including those directed at preventing fraud, abuse and discrimination in government-funded programs. Failure to comply with these laws and regulations could result in investigations, litigation, fines, restrictions on, or exclusions from, program participation, or the imposition of corporate integrity agreements or other agreements with a federal or state governmental agency, any of which could adversely impact our business, cash flows, financial condition and results of operations.

We are periodically subject to CMS audits of our Medicare Advantage Plans to validate the diagnostic data and patient claims, as well as audits of our Medicare Part D plans by the Medicare Part D Recovery Audit Contractor, or RAC. CMS has recently proposed changing these audits in a way that could increase financial recoveries from health plans. These audits could result in significant adjustments in payments made to our health plans. In addition to these federal programs, a number of states have implemented Medicaid RAC programs which were authorized by the ACA. State RAC programs could increase the number of audits and any subsequent recoupment by the federal and state governments, which could adversely affect our financial condition and results of operations. If we fail to report and correct errors discovered through our own auditing procedures or during a CMS or RAC audit, or otherwise fail to comply with applicable laws and regulations, we could be subject to fines, civil penalties or other sanctions which could have a material adverse effect on our ability to participate in these programs, and on our financial condition, cash flows and results of operations.

Our Medicare and Medicaid contracts are also subject to minimum MLR audits. If a Medicare Advantage, MMP or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to participate in open enrollment. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS.

In addition, there are an increasing number of investigations regarding compliance with various provisions of the ACA. These investigations are being conducted by CMS and other federal authorities as well as state regulators. As a result, we could be subject to multiple investigations of the same issue. These investigations, and any possible enforcement actions, could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

A change in our healthcare product mix may impact our profitability.

Our healthcare products that involve greater potential risk generally tend to be more profitable than administrative services products and those healthcare products where the employer groups assume the underwriting risks. Individuals and small employer groups are more likely to purchase our higher-risk healthcare products because such purchasers are generally unable or unwilling to bear greater liability for healthcare expenditures. Typically, government-sponsored programs also involve our higher-risk healthcare products. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on our cash flows, financial condition and results of operations.

We face risks related to litigation.

We are, or may in the future, be a party to a variety of legal actions that may affect our business, such as employment and employment discrimination-related suits, administrative charges before government agencies, employee benefit claims, breach of contract actions, tort claims and intellectual property-related litigation. In addition, because of the nature of our business, we are subject to a variety of legal actions relating to our business operations, including the design, administration and offering of our products and services. These could include claims relating to the denial or limitation of healthcare benefits; development or application of medical policies and coverage and clinical guidelines; medical malpractice actions; product liability claims; allegations of anti-competitive and unfair business activities; provider disputes over reimbursement; provider tiering programs; narrow networks; termination of provider contracts; the recovery of overpayments from providers; self-funded business; disputes over co-payment calculations; reimbursement of out-of-network claims; the failure to disclose certain business practices; the failure to comply with various state or federal laws, including but not limited to, ERISA and the Mental Health Parity Act; and customer audits and contract performance, including government contracts. These actions or proceedings could have a material adverse effect on our business, cash flows, financial condition and results of operations.

In addition, we are also involved in, or may in the future be party to, pending or threatened litigation of the character incidental to the business transacted or arising out of our operations, including, but not limited to, breaches of security and violations of privacy requirements, shareholder actions, compliance with federal and state laws and regulations (including *qui tam* or “whistleblower” actions), or sales and acquisitions of businesses or assets (including as a result of the terminated Cigna Merger Agreement, or as more fully described under Note 13, “Commitments and Contingencies - *Litigation and Regulatory Proceedings - Cigna Corporation Merger Litigation*,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K). From time to time, we are involved as a party in various governmental investigations, audits, reviews and administrative proceedings, including challenges to the award of government contracts by disappointed bidders. These investigations, audits and reviews include routine and special investigations by various state insurance departments, various federal regulators including CMS and the Department of Health and Human Services Office of Inspector General (HHS-OIG), state attorneys general, the Department of Justice (DOJ), and various offices of the U.S. Attorney General. Following an investigation, we may be subject to civil or criminal fines, penalties and other sanctions if we are determined to be in violation of applicable laws or regulations. Liabilities that may result from these actions could have a material adverse effect on our cash flows, results of operations and financial condition.

Recent court decisions and legislative activity may increase our exposure for any of these types of claims. In some cases, substantial non-economic (including injunctive relief), treble or punitive damages may be sought. Although we maintain insurance coverage for some of these potential liabilities, some liabilities and damages may not be covered by insurance, insurers may dispute coverage or the amount of insurance may not be enough to cover the damages awarded. In addition, insurance coverage for all or certain forms of liability may become unavailable or prohibitively expensive in the future. Any adverse judgment against us resulting in such damage awards could result in negative publicity and have an adverse effect on our cash flows, results of operations and financial condition.

Further, litigation brought against the federal and some state governments over the ACA, including the 2018 Texas District Court ACA Decision, could have a material adverse effect on our business, cash flows, financial condition and results of operations as changes to, or the invalidation of, the ACA resulting from such litigation may be unfavorable to our business or may create uncertainty over the applicability and enforceability of portions of the law and related regulations, which impacts our strategy and could negatively impact our future growth opportunities.

Cigna's pursuit of litigation in connection with the Cigna Merger Agreement, together with our own litigation against Cigna, could cause us to incur substantial costs, may present material distractions and, if decided adverse to Anthem, could negatively impact our financial condition.

As described in Note 13, "Commitments and Contingencies - *Litigation and Regulatory Proceedings - Cigna Corporation Merger Litigation*," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K, in February 2017, Cigna commenced litigation against us in the Delaware Court of Chancery, or the Delaware Court, for a declaratory judgment that its purported termination of the Cigna Merger Agreement was lawful and seeking damages against us. We promptly filed our own litigation against Cigna seeking to compel Cigna's specific performance of the Cigna Merger Agreement and damages against Cigna. In May 2017, after the Delaware Court denied our motion to enjoin Cigna from terminating the Cigna Merger Agreement, we delivered to Cigna a notice terminating the Cigna Merger Agreement. The litigation in Delaware continues. These lawsuits could result in substantial costs to us, including litigation costs and potential settlement and judgment costs. Further, due to the potential significance of the allegations and damages claimed by Cigna, we expect that our officers will continue to spend substantial time focused on the litigation. Our defense against Cigna's claims, the pursuit of our claims or the settlement, or failure to reach a settlement, for any claims may result in negative media attention, and may adversely affect our business, reputation, financial condition, results of operations and cash flows.

We are dependent on the success of our relationships with third parties for various services and functions, including PBM services.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Certain of these third parties provide us with significant portions of our business infrastructure and operating requirements, and we could become overly dependent on key vendors, which could cause us to lose core competencies. A termination of our agreements with, or disruption in the performance of, one or more of these service providers could result in service disruptions or unavailability, reduced service quality and effectiveness, increased or duplicative costs or an inability to meet our obligations to our customers. In addition, we may also have to seek alternative service providers, which may be unavailable or only available on less favorable contract terms. Any of these outcomes could adversely affect our business, reputation, cash flows, financial condition and operating results.

In particular, we are a party to agreements with each of Express Scripts and CVS Health for the provision of certain PBM services to our plans. In January 2019, we provided notice to Express Scripts terminating the ESI PBM Agreement effective March 1, 2019, with the twelve-month transition period provided for in the ESI Agreement to migrate the services beginning on March 2, 2019. The litigation between us and Express Scripts regarding the ESI PBM Agreement continues, as more fully described under Note 13, "Commitments and Contingencies - *Litigation and Regulatory Proceedings - Express Scripts, Inc. Pharmacy Benefit Management Litigation*," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Beginning March 2, 2019, CVS Health may begin providing certain PBM services to IngenioRx pursuant to the CVS PBM Agreement. In connection with the transition of PBM services to CVS Health, if either Express Scripts or CVS Health fails to provide adequate transition and PBM services as contractually required, we may not be able to meet the full demands of our customers, which could have a material adverse effect on our business, reputation and results of operations. For additional information on the agreement with CVS Health, see "Business - General," in Part I, Item 1 of this Annual Report on Form 10-K.

There are various risks associated with providing healthcare services.

The direct provision of healthcare services by certain of our subsidiaries involves risks of additional litigation arising from medical malpractice actions based on our treatment decisions or brought against us or our physician associates for alleged malpractice or professional liability claims arising out of the delivery of healthcare and related services. In addition, liability may arise from maintaining healthcare premises that serve the public. If we fail to maintain adequate insurance coverage for these liabilities, or if such insurance is not available, the resulting costs could adversely affect our business, cash flows, financial condition and results of operations.

Additionally, many states in which certain of our subsidiaries operate limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals. Business corporations generally may not exercise control over the medical decisions of physicians and we are not licensed to practice medicine. Rules and regulations relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary from state to state. Further, certain federal and state laws, including those covering our Medicare and Medicaid plans, prohibit the offer, payment, solicitation, or receipt of any form of remuneration to induce, or in return for, the referral of patient care opportunities, including, but not limited to, Medicare patients, and also generally prohibit physicians from making referrals to any entity providing certain designated health services if the referring physician or related person has an ownership or financial interest in the entity. Any enforcement actions by governmental officials alleging non-compliance with these rules and regulations could adversely affect our business, cash flows, financial condition and results of operations.

Our PBM business and related operations are subject to a number of risks and uncertainties that are in addition to those we face in our core healthcare business.

Notwithstanding our arrangements with Express Scripts and CVS Health, we remain responsible to regulators and our customers for the delivery of those PBM services that we contract to provide. Our PBM business is subject to the risks inherent in the dispensing, packaging and distribution of pharmaceuticals and other healthcare products, including claims related to purported dispensing and other operational errors. Any failure by us or one of our PBM services suppliers to adhere to the laws and regulations applicable to the dispensing of pharmaceuticals could subject our PBM business to civil and criminal penalties.

Our PBM business is subject to federal and state laws and regulations that govern its relationships with pharmaceutical manufacturers, physicians, pharmacies and customers, including without limitation, federal and state anti-kickback laws, consumer protection laws, ERISA, HIPAA and laws related to the operation of internet and mail-service pharmacies, as well as an increasing number of licensure, registration and other laws and accreditation standards that impact the business practices of a PBM. In addition, the practice of pharmacy is subject to federal and state laws and regulation, including those of state boards of pharmacy, individual state-controlled substance authorities, the U.S. Drug Enforcement Agency and the FDA, and we and our third-party vendors are subject to registration requirements and state and federal laws concerning labeling, packaging, advertising, handling and adulteration of prescription drugs and dispensing of controlled substances. Noncompliance with applicable laws and regulations by us or our third-party vendors could have material adverse effects on our business, results of operations, financial condition, liquidity and reputation and could expose us to civil and criminal penalties.

Our PBM business also would be adversely affected if we are unable to contract on favorable terms with pharmaceutical manufacturers, and we could suffer exposure to liabilities and reputational harm in connection with purported errors by mail order or retail pharmacy businesses.

As a holding company, we are dependent on dividends from our subsidiaries. These dividends are necessary to pay our outstanding indebtedness. Our regulated subsidiaries are subject to state regulations, including restrictions on the payment of dividends, maintenance of minimum levels of capital and restrictions on investment portfolios.

We are a holding company whose assets include the outstanding shares of common stock (or other ownership interest) of our subsidiaries including our intermediate holding companies and regulated insurance and HMO subsidiaries. Our subsidiaries are separate legal entities. As a holding company, we depend on dividends and administrative expense reimbursements from our subsidiaries. Furthermore, our subsidiaries are not obligated to make funds available to us, and creditors of our subsidiaries will have a superior claim to certain of our subsidiaries' assets. Among other restrictions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends. In some states, we have made special undertakings that may limit the ability of our regulated subsidiaries to pay dividends. In addition, our subsidiaries' ability to make any payments to us will also depend on their earnings, the terms of their indebtedness, business and tax considerations and other legal restrictions. Our ability to repurchase shares or pay dividends in the future to our shareholders and meet our obligations, including paying operating expenses and debt service on our outstanding and future indebtedness, will depend upon the receipt of dividends from our subsidiaries. An inability of our subsidiaries to pay dividends in the future in an amount sufficient for us to meet our financial obligations may materially adversely affect our business, cash flows, financial condition and results of operations.

Most of our regulated subsidiaries are subject to RBC standards imposed by their states of domicile. These laws are based on the RBC Model Act adopted by the National Association of Insurance Commissioners, or NAIC, and require our regulated subsidiaries to report their results of risk-based capital calculations to the departments of insurance and the NAIC. Failure to maintain the minimum RBC standards could subject our regulated subsidiaries to corrective action, including state supervision or liquidation. Changes to the existing RBC standards or the adoption of an RBC requirement at the holding company level, which is currently being considered by the NAIC, could further restrict our or our regulated subsidiaries' ability to pay dividends and adversely affect our business. In addition, as discussed in more detail below, we are a party to license agreements with the BCBSA which contain certain requirements and restrictions regarding our operations, including minimum capital and liquidity requirements, which could restrict the ability of our regulated subsidiaries to pay dividends.

Our regulated subsidiaries are subject to state laws and regulations that require diversification of their investment portfolios and limit the amount of investments in certain riskier investment categories, such as below-investment-grade fixed maturity securities, mortgage loans, real estate and equity investments, which could generate higher returns on their investments. Failure to comply with these laws and regulations might cause investments exceeding regulatory limitations to be treated as non-admitted assets for purposes of measuring statutory surplus and risk-based capital, and, in some instances, require the sale of those investments.

We have substantial indebtedness outstanding and may incur additional indebtedness in the future in connection with acquisitions or otherwise. Such indebtedness could adversely affect our ability to pursue desirable business opportunities and to react to changes in the economy or our industry, and exposes us to interest rate risk to the extent of our variable rate indebtedness.

Our debt service obligations require us to use a portion of our cash flow to pay interest and principal on debt instead of for other corporate purposes, including funding future expansion. If our cash flow and capital resources are insufficient to service our debt obligations, we may be forced to seek extraordinary dividends from our subsidiaries, sell assets, seek additional equity or debt capital or restructure our debt. However, these measures might be unsuccessful or inadequate to meet scheduled debt service obligations, or may not be available on commercially reasonable terms.

We may also incur future debt obligations, in connection with acquisitions or otherwise, that might subject us to restrictive covenants that could affect our financial and operational flexibility. Our breach or failure to comply with any of these covenants could result in a default under our credit facilities or other indebtedness. If we default under our credit agreement, the lenders could cease to make further extensions of credit or cause all of our outstanding debt obligations under our credit agreement to become immediately due and payable, together with accrued and unpaid interest. If the indebtedness under our notes or our credit agreement or our other indebtedness is accelerated, we may be unable to repay or finance the amounts due, on commercially reasonable terms, or at all.

Further, a substantial portion of our indebtedness bears interest at fluctuating interest rates, primarily based on the London Interbank Offered Rate ("LIBOR"). In July 2017, the Financial Conduct Authority, a regulator of financial services firms in the United Kingdom, announced that it intends to stop persuading or compelling banks to submit LIBOR rates after 2021. We are unable to predict the effect of any changes, any establishment of alternative reference rates or any other reforms to LIBOR or any replacement of LIBOR that may be enacted in the United Kingdom or elsewhere. Such changes, reforms or replacements relating to LIBOR could have an adverse impact on the market for or value of any LIBOR-linked securities, loans, derivatives and other financial obligations or extensions of credit held by us or on our overall financial condition or results of operations.

A downgrade in our credit ratings could have an adverse effect on our business, cash flows, financial condition and results of operations.

Claims-paying ability and financial strength and debt ratings by nationally recognized statistical rating organizations are an important factor in establishing the competitive position of insurance companies and health benefits companies. We believe our strong credit ratings are an important factor in marketing our products to customers, since credit ratings information is broadly disseminated and generally used by customers and creditors. In addition, if our credit ratings are downgraded or placed under review, our business, cash flows, financial condition and results of operations could be adversely impacted by limitations on future borrowings and a potential increase in our borrowing costs. Our ratings reflect each rating agency's opinion of our financial strength, operating performance and ability to meet our obligations to policyholders and

creditors, and are not evaluations directed toward the protection of investors in our common stock. Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future.

The health benefits industry is subject to negative publicity, which could adversely affect our business, cash flows, financial condition and results of operations.

The health benefits industry is subject to negative publicity, which can arise from, among other things, increases in premium rates, industry consolidation, cost of care initiatives and the ongoing debate over the ACA. Negative publicity may result in increased regulation and legislative review of industry practices, which may further increase our costs of doing business and adversely affect our profitability by limiting our ability to market or provide our products and services, requiring us to change our products and services, or increasing the regulatory oversight under which we operate. In addition, as long as we use the BCBS names and marks in marketing our health benefits products and services, any negative publicity concerning the BCBSA or other BCBSA licensees may adversely affect us and the sale of our health benefits products and services. Negative public perception or publicity of the health benefits industry in general, the BCBSA, other BCBSA licensees, or us or our key vendors in particular, could adversely affect our business, cash flows, financial condition and results of operations.

The failure to effectively maintain and upgrade our information systems could adversely affect our business.

Our business depends significantly on effective information systems, and we have many different information systems for our various businesses. As a result of our merger and acquisition activities, we have acquired additional systems. Our information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and develop new systems in order to keep pace with continuing changes in information processing technology, emerging cybersecurity risks and threats, evolving industry and regulatory standards including public exchanges and other aspects of the ACA, compliance with legal requirements, private insurance exchanges and changing customer preferences. In addition, we may from time to time obtain significant portions of our systems-related or other services or facilities from independent third parties, which may make our operations vulnerable if such third parties fail to perform adequately.

Failure to adequately implement and maintain effective and efficient information systems with sufficiently advanced technological capabilities, or our failure to efficiently and effectively consolidate our information systems to eliminate redundant or obsolete applications, could result in competitive and cost disadvantages to us compared to our competitors, a diversion of management’s time and could have a material adverse effect on our business, financial condition and results of operations. If the information we rely upon to run our business were found to be inaccurate or unreliable or if we fail to adequately maintain our information systems and data integrity effectively, we could experience problems in determining medical cost estimates and establishing appropriate pricing and reserves, have disputes with customers and providers, face regulatory problems, including sanctions and penalties, incur increases in operating expenses or suffer other adverse consequences, including a decrease in membership.

We are a party to license agreements with the BCBSA that entitle us to the exclusive and, in certain areas, non-exclusive use of the BCBS names and marks in our geographic territories. The termination of these license agreements or changes in the terms and conditions of these license agreements could adversely affect our business, cash flows, financial condition and results of operations.

We use the BCBS names and marks as identifiers for our products and services under licenses from the BCBSA. Our license agreements with the BCBSA contain certain requirements and restrictions regarding our operations and our use of the BCBS names and marks, including: minimum capital and liquidity requirements; enrollment and customer service performance requirements; participation in programs that provide portability of membership between plans; disclosures to the BCBSA relating to enrollment and financial conditions; disclosures as to the structure of the BCBS system in contracts with third parties and in public statements; plan governance requirements; cybersecurity requirements; a requirement that at least 80% (or, in the case of Blue Cross of California, substantially all) of a licensee’s annual combined local net revenue, as defined by the BCBSA, attributable to healthcare plans and related services within its service areas must be sold, marketed, administered or underwritten under the BCBS names and marks; a requirement that at least two-thirds of a licensee’s annual combined national net revenue, as defined by the BCBSA, attributable to healthcare plans and related services must be sold, marketed, administered or underwritten under the BCBS names and marks; a requirement that neither a plan nor any of its licensed affiliates may permit an entity other than a plan or a licensed affiliate to obtain control of the plan or the licensed

affiliate or to acquire a substantial portion of its assets related to licensable services; a requirement that we divide our Board of Directors into three classes serving staggered three-year terms; a requirement that we guarantee certain contractual and financial obligations of our licensed affiliates; and a requirement that we indemnify the BCBSA against any claims asserted against it resulting from the contractual and financial obligations of any subsidiary that serves as a fiscal intermediary providing administrative services for Medicare Parts A and B. Failure to comply with the foregoing requirements could result in a termination of the license agreements.

The license agreements may be modified by the BCBSA. To the extent that such amendments to the license agreements are adopted in the future, they could have a material adverse effect on our future expansion plans or results of operations. Further, BCBS licensees have certain requirements to perform administrative services for members of other BCBS licensees. As of December 31, 2018, we provided services to approximately 30 million Blue Cross and/or Blue Shield enrollees. If we or another BCBS licensee are not in compliance with all legal requirements or are unable to perform administrative services as required, this could have an adverse effect on our members and our ability to maintain our licenses, which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

Upon the occurrence of an event causing termination of the license agreements, we would no longer have the right to use the BCBS names and marks or to sell BCBS health insurance products and services in one or more of our service areas. Furthermore, the BCBSA would be free to issue a license to use the BCBS names and marks in these service areas to another entity. Our existing BCBS members would be provided with instructions for obtaining alternative products and services licensed by the BCBSA. Events that could cause the termination of a license agreement with the BCBSA include, without limitation, failure to comply with minimum capital requirements imposed by the BCBSA, failure to comply with governance requirements such as maintaining a classified board structure, a change of control or violation of the BCBSA ownership limitations on our capital stock, impending financial insolvency and the appointment of a trustee or receiver or the commencement of any action against a licensee seeking its dissolution. We believe that the BCBS names and marks are valuable identifiers of our products and services in the marketplace.

Upon termination of a license agreement, the BCBSA would have the right to impose a “Re-establishment Fee” upon us, which would be used in part to fund the establishment of a replacement Blue Cross and/or Blue Shield licensee in the vacated service area. The fee is set at $98.33 per licensed enrollee. If the Re-establishment Fee was applied to our total Blue Cross and/or Blue Shield enrollees of approximately 30 million as of December 31, 2018, we would be assessed approximately $3 billion by the BCBSA. As a result, termination of the license agreements would have a material adverse effect on our business, cash flows, financial condition and results of operations.

Large-scale medical emergencies may have a material adverse effect on our business, cash flows, financial condition and results of operations.

Large-scale medical emergencies can take many forms and can cause widespread illness and death. For example, federal and state law enforcement officials have issued warnings about potential terrorist activity involving biological and other weapons. In addition, natural disasters such as hurricanes and the potential for a widespread pandemic of influenza coupled with the lack of availability of appropriate preventative medicines can have a significant impact on the health of the population of widespread areas. If the United States were to experience widespread bioterrorism or other attacks, large-scale natural disasters in our concentrated coverage areas or a large-scale pandemic or epidemic, our covered medical expenses could rise and we could experience a material adverse effect on our business, cash flows, financial condition and results of operations or, in the event of extreme circumstances, our viability could be threatened.

We have built a significant portion of our current business through mergers and acquisitions, joint ventures and strategic alliances and we expect to pursue such opportunities in the future.

The following are some of the risks associated with mergers, acquisitions, joint ventures and strategic alliances, referred to collectively as business combinations, that could have a material adverse effect on our business, cash flows, financial condition and results of operations:

- some of the business combinations may not achieve anticipated revenues, earnings or cash flow, business opportunities, synergies, growth prospects and other anticipated benefits;

- the goodwill or other intangible assets established as a result of our business combinations may be incorrectly valued or become non-recoverable;
- we may assume liabilities that were not disclosed to us or which were underestimated;
- we may experience difficulties in integrating business combinations, be unable to integrate business combinations successfully or as quickly as expected, and be unable to realize anticipated economic, operational and other benefits in a timely manner, which could result in substantial costs and delays or other operational, technical or financial problems;
- business combinations, and proposed business combinations that are not completed, could disrupt our ongoing business, lead to the incurrence of significant fees, distract management, result in the loss of key employees, divert resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies and procedures;
- we may finance future business combinations by issuing common stock for some or all of the purchase price, which could dilute the ownership interests of our shareholders;
- we may also incur additional debt related to future business combinations;
- we would be competing with other firms, some of which may have greater financial and other resources, to acquire attractive companies; and
- future business combinations may make it difficult to comply with the requirements of the BCBSA and lead to an increased risk that our BCBSA license agreements may be terminated.

The value of our intangible assets may become impaired.

Due largely to our past mergers, acquisitions and divestitures, goodwill and other intangible assets represent a substantial portion of our assets. If we make additional acquisitions, it is likely that we will record additional intangible assets on our consolidated balance sheets. The value we place on intangible assets may be adversely impacted if business combinations fail to perform in a manner consistent with our assumptions.

In accordance with applicable accounting standards, we periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may no longer be recoverable, in which case a charge to income may be necessary. This impairment testing requires us to make assumptions and judgments regarding the estimated fair value of our reporting units, including goodwill and other intangible assets. In addition, certain other intangible assets with indefinite lives, such as trademarks, are also tested separately. Estimated fair values developed based on our assumptions and judgments might be significantly different if other reasonable assumptions and estimates were to be used. If estimated fair values are less than the carrying values of goodwill and other intangible assets with indefinite lives in future impairment tests, or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially affect our results of operations and shareholders' equity in the period in which the impairment occurs. A material decrease in shareholders' equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

In addition, the estimated value of our reporting units may be impacted as a result of business decisions we make associated with any future changes to laws and regulations. Such decisions, which could unfavorably affect our ability to support the carrying value of certain goodwill and other intangible assets, could result in impairment charges in future periods.

Adverse securities and credit market conditions may significantly affect our ability to meet liquidity needs.

During periods of increased volatility, adverse securities and credit markets may exert downward pressure on the availability of liquidity and credit capacity for certain issuers. We need liquidity to pay our operating expenses, make payments on our indebtedness and pay capital expenditures. The principal sources of our cash receipts are premiums,

administrative fees, investment income, other revenue, proceeds from the sale or maturity of our investment securities, proceeds from borrowings and proceeds from the issuance of common stock under our employee stock plans.

Our access to additional financing will depend on a variety of factors such as market conditions, the general availability of credit, the volume of trading activities, the availability of credit to our industry, our credit ratings and credit capacity, as well as the possibility that customers or lenders could develop a negative perception of our long- or short-term financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If one or a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain additional financing on favorable terms, or at all.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value may result in a loss charged to income.

The market values of our investments vary from time to time depending on economic and market conditions. For various reasons, we may sell certain of our investments at prices that are less than the carrying value of the investments. During periods in which interest rates are relatively low, as in recent years, our investment income could be adversely impacted. In addition, in periods of declining interest rates, bond calls and mortgage loan prepayments generally increase, resulting in the reinvestment of these funds at the then lower market rates. In periods of rising interest rates, the market values of our fixed maturity securities will generally decrease, which could result in material losses on investments in future periods. In addition, defaults by issuers, primarily from investments in corporate and municipal bonds, who fail to pay or perform their obligations, could reduce net investment income, which would adversely affect our profitability. We cannot assure you that our investment portfolios will produce positive returns or maintain their present values.

In accordance with FASB guidance for investments, we classify fixed maturity securities in our investment portfolio as “available-for-sale” or “trading” and report those securities at fair value. Current and long-term available-for-sale investment securities represented a significant percentage of our total consolidated assets at December 31, 2018.

Changes in the economic environment, including periods of increased volatility in the securities markets, can increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. Over time, the economic and market environment may provide additional insight into the value of our investment securities, which could change our judgment regarding the fair value of certain securities and/or impairment. Given the sometimes rapidly changing market conditions and the significant judgments involved, there is continuing risk that future declines in fair value may occur and material other-than-temporary impairments may be charged to income in future periods, resulting in realized losses.

Changes in U.S. tax laws and regulations could have a material adverse effect on our business, cash flow, financial condition and results of operations. In addition, we may not be able to realize the value of our deferred tax assets.

Changes in tax laws and regulations, including with respect to corporate tax rates and the deductibility of expenses, or changes in the interpretation of tax laws and regulations by federal and/or state authorities, could have a material impact on the future value of our deferred tax assets and deferred tax liabilities, could result in significant one-time charges in the current or future taxable years and could increase our future U.S. tax expense. These changes could have a material adverse effect on our business, cash flow, financial condition and results of operations.

In accordance with applicable accounting standards, we separately recognize deferred tax assets and deferred tax liabilities. Such deferred tax assets and deferred tax liabilities represent the tax effect of temporary differences between financial reporting and tax reporting measured at tax rates enacted at the time the deferred tax asset or liability is recorded. At each financial reporting date, we evaluate our deferred tax assets to determine the likely realization of the benefit of the temporary differences. Our evaluation includes a review of the types of temporary differences that created the deferred tax asset; the amount of taxes paid on both capital gains and ordinary income in prior periods and available for a carry-back claim; the forecasted future taxable income, and therefore, the likely future deduction of the deferred tax item; and any other significant issues that might impact the realization of the deferred tax asset. If it is more likely than not that all or a portion of the deferred tax asset may not be realized, we establish a valuation allowance. Significant judgment is required in determining an appropriate valuation allowance.

Any future increase in our valuation allowance would result in additional income tax expense and a decrease in shareholders' equity, which could materially affect our financial position and results of operations in the period in which the increase occurs. A material decrease in shareholders' equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

We face intense competition to attract and retain employees. Further, managing key executive transition, succession and retention is critical to our success.

Our success depends on our ability to attract and retain qualified employees to meet current and future needs, and to integrate and engage employees who have joined us through acquisitions. We face intense competition for qualified employees, and there can be no assurance that we will be able to attract and retain such employees or that such competition among potential employers will not result in increasing salaries. An inability to retain existing employees or attract additional employees could have a material adverse effect on our business, cash flows, financial condition and results of operations.

We would be adversely affected if we fail to adequately plan for the succession of our President and Chief Executive Officer and other senior management and retention of key executives. While we have succession plans in place for members of our senior management, and employment arrangements with certain key executives, these plans and arrangements do not guarantee that the services of our senior executives will continue to be available to us or that we will be able to attract, transition and retain suitable successors.

Indiana law, other applicable laws, our articles of incorporation and bylaws, and provisions of our BCBSA license agreements may prevent or discourage takeovers and business combinations that our shareholders might consider to be in their best interest.

Indiana law and our articles of incorporation and bylaws may delay, defer, prevent or render more difficult a takeover attempt that our shareholders might consider to be in their best interests. For instance, they may prevent our shareholders from receiving the benefit from any premium to the market price of our common stock offered by a bidder in a takeover context. Even in the absence of a takeover attempt, the existence of these provisions may adversely affect the prevailing market price of our common stock if they are viewed as discouraging takeover attempts in the future.

We are regulated as an insurance holding company and subject to the insurance holding company acts of the states in which our insurance company subsidiaries are domiciled, as well as similar provisions included in the health statutes and regulations of certain states where these subsidiaries are regulated as managed care companies or HMOs. The insurance holding company acts and regulations and these similar provisions restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes and regulations, without such approval or an exemption, no person may acquire any voting security of a domestic insurance company or HMO, or an insurance holding company which controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would "control" the insurance holding company, insurance company or HMO. "Control" is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person. Further, the Indiana Business Corporation Law contains business combination provisions that, in general, prohibit for five years any business combination with a beneficial owner of 10% or more of our common stock unless the holder's acquisition of the stock was approved in advance by our Board of Directors.

Our articles of incorporation restrict the beneficial ownership of our capital stock in excess of specific ownership limits. The ownership limits restrict beneficial ownership of our voting capital stock to less than 10% for institutional investors and less than 5% for non-institutional investors, both as defined in our articles of incorporation. Additionally, no person may beneficially own shares of our common stock representing a 20% or more ownership interest in us. These restrictions are intended to ensure our compliance with the terms of our licenses with the BCBSA. Our articles of incorporation prohibit ownership of our capital stock beyond these ownership limits without prior approval of a majority of our continuing directors (as defined in our articles of incorporation). In addition, as discussed above in the risk factor describing our license agreements with the BCBSA, such license agreements are subject to termination upon a change of control and a re-establishment fee would be imposed upon termination of the license agreements.

Certain other provisions included in our articles of incorporation and bylaws may also have anti-takeover effects and may delay, defer or prevent a takeover attempt that our shareholders might consider to be in their best interests. In particular, our articles of incorporation and bylaws: divide our Board of Directors into three classes serving staggered three-year terms (which is required by our license agreement with the BCBSA); permit our Board of Directors to determine the terms of and issue one or more series of preferred stock without further action by shareholders; restrict the maximum number of directors; limit the ability of shareholders to remove directors; impose restrictions on shareholders' ability to fill vacancies on our Board of Directors; impose advance notice requirements for shareholder proposals and nominations of directors to be considered at meetings of shareholders; and prohibit shareholders from amending certain provisions of our bylaws.

We also face other risks that could adversely affect our business, financial condition or results of operations, which include:

- any requirement to restate financial results in the event of inappropriate application of accounting principles;
- a significant failure of our internal control over financial reporting;
- failure of our prevention and control systems related to employee compliance with internal policies, including data security;
- provider fraud that is not prevented or detected and impacts our medical costs or those of self-insured customers;
- failure to protect our proprietary information; and
- failure of our corporate governance policies or procedures.

ITEM 1B. UNRESOLVED SEC STAFF COMMENTS.

None.

ITEM 2. PROPERTIES.

We lease our principal executive offices located at 220 Virginia Avenue, Indianapolis, Indiana. In addition to this location, we have operating facilities located in each state where we operate as licensees of the BCBSA, in each state where Amerigroup conducts business and in certain other states where our other subsidiaries operate. A majority of these locations are also leased properties. Our facilities support our various business segments. We believe that our properties are adequate and suitable for our business as presently conducted as well as for the foreseeable future.

ITEM 3. LEGAL PROCEEDINGS.

For information regarding our legal proceedings, see Note 13, "Commitments and Contingencies - *Litigation and Regulatory Proceedings*," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

ITEM 4. MINE SAFETY DISCLOSURES.

Not applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES.

Market Information

Our common stock, par value $0.01 per share, is listed on the NYSE under the symbol "ANTM."

Holders

As of February 7, 2019, there were 60,778 shareholders of record of our common stock.

Securities Authorized for Issuance under Equity Compensation Plans

The information required by this Item concerning securities authorized for issuance under our equity compensation plans is set forth in or incorporated by reference into Part III, Item 12 "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters" in this Annual Report on Form 10-K.

Issuer Purchases of Equity Securities

The following table presents information related to our repurchases of common stock for the periods indicated:

Period	Total Number of Shares Purchased[1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Programs[2]	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Programs
(In millions, except share and per share data)				
October 1, 2018 to October 31, 2018	618,636	$ 273.13	612,200	$ 5,819
November 1, 2018 to November 30, 2018	443,657	277.54	438,100	5,697
December 1, 2018 to December 31, 2018	772,820	264.85	770,300	5,493
	1,835,113		1,820,600	

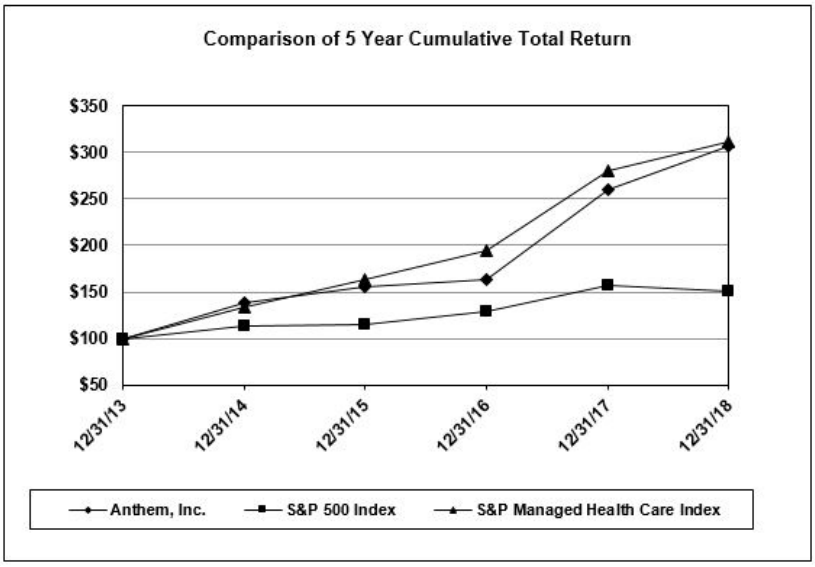
1 Total number of shares purchased includes 14,513 shares delivered to or withheld by us in connection with employee payroll tax withholding upon exercise or vesting of stock awards. Stock grants to employees and directors and stock issued for stock option plans and stock purchase plans in the consolidated statements of shareholders' equity are shown net of these shares purchased.

2 Represents the number of shares repurchased through the common stock repurchase program authorized by our Board of Directors, which the Board evaluates periodically. During the year ended December 31, 2018, we repurchased 6,783,692 shares at a cost of $1,685 under the program, including the cost of options to purchase shares. The Board of Directors has authorized our common stock repurchase program since 2003. The Board's most recent authorized increase to the program was $5,000 on December 7, 2017. Between January 1, 2019 and February 7, 2019, we repurchased 631,943 shares at a cost of $165, bringing our current availability to $5,328 at February 7, 2019. No duration has been placed on our common stock repurchase program and we reserve the right to discontinue the program at any time.

Performance Graph

The following Performance Graph and related information compares the cumulative total return to shareholders of our common stock for the period from December 31, 2013 through December 31, 2018, with the cumulative total return over such period of (i) the Standard & Poor's 500 Stock Index (the "S&P 500 Index") and (ii) the Standard & Poor's Managed Health Care Index (the "S&P Managed Health Care Index"). The graph assumes an investment of $100 on December 31, 2013 in each of our common stock, the S&P 500 Index and the S&P Managed Health Care Index (and the reinvestment of all dividends).

The comparisons shown in the graph below are based on historical data and we caution that the stock price performance shown in the graph below is not indicative of, and is not intended to forecast, the potential future performance of our common stock. Information used in the graph was obtained from S&P Global Market Intelligence, a source believed to be reliable, but we are not responsible for any errors or omissions in such information. The following graph and related information shall not be deemed "soliciting materials" or to be "filed" with the SEC, nor shall such information be incorporated by reference into any future filing under the Exchange Act, except to the extent that we specifically incorporate it by reference into such filing.



	December 31,					
	2013	2014	2015	2016	2017	2018
Anthem, Inc.	$ 100	$ 138	$ 156	$ 164	$ 260	$ 307
S&P 500 Index	100	114	115	129	157	150
S&P Managed Health Care Index	100	134	163	195	280	311

Based upon an initial investment of $100 on December 31, 2013 with dividends reinvested.

ITEM 6. SELECTED FINANCIAL DATA.

The table below provides selected consolidated financial data of Anthem. The information has been derived from our consolidated financial statements for each of the years in the five-year period ended December 31, 2018. You should read this selected consolidated financial data in conjunction with the audited consolidated financial statements and notes as of and for the year ended December 31, 2018 included in Part II, Item 8 "Financial Statements and Supplementary Data," and Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K.

	As of and for the Years Ended December 31				
	2018 [1]	2017 [1]	2016	2015 [1]	2014 [2]
(in millions, except where indicated and except per share data)					
Income Statement Data					
Total operating revenue[3]	$ 91,341	$ 89,061	$ 84,194	$ 78,405	$ 73,022
Total revenues	92,105	90,040	84,863	79,157	73,874
Income from continuing operations	3,750	3,843	2,470	2,560	2,560
Net income	3,750	3,843	2,470	2,560	2,570
Per Share Data					
Basic net income per share - continuing operations	$ 14.53	$ 14.70	$ 9.39	$ 9.73	$ 9.28
Diluted net income per share - continuing operations	14.19	14.35	9.21	9.38	8.96
Dividends per share	3.00	2.70	2.60	2.50	1.75
Other Data (unaudited)					
Benefit expense ratio[4]	84.2%	86.4%	84.8%	83.3%	83.1%
Selling, general and administrative expense ratio[5]	15.3%	14.2%	14.9%	16.0%	16.1%
Income from continuing operations before income tax expense as a percentage of total revenues	5.5%	4.4%	5.4%	5.9%	5.9%
Net income as a percentage of total revenues	4.1%	4.3%	2.9%	3.2%	3.5%
Medical membership (*in thousands*)	39,938	40,299	39,940	38,599	37,499
Balance Sheet Data					
Cash and investments[6]	$ 22,639	$ 25,179	$ 23,263	$ 21,065	$ 22,062
Total assets	71,571	70,540	65,083	61,718	61,676
Long-term debt, less current portion	17,217	17,382	14,359	15,325	14,020
Total liabilities	43,030	44,037	39,982	38,673	37,425
Total shareholders' equity	28,541	26,503	25,101	23,045	24,251

1 The net assets of and results of operations for America's 1st Choice, HealthSun and Simply Healthcare are included from their respective acquisition dates of February 15, 2018, December 21, 2017 and February 17, 2015, respectively.
2 The operating results of 1-800 CONTACTS, Inc. are reported as discontinued operations at December 31, 2014 as a result of the divestiture completed on January 31, 2014. Included in net income for the year ended December 31, 2014 is income from discontinued operations, net of tax, of $10.
3 Operating revenue is obtained by adding premiums and administrative fees and other revenue.
4 The benefit expense ratio represents benefit expenses as a percentage of premium revenue.
5 The selling, general and administrative expense ratio represents selling, general and administrative expenses as a percentage of total operating revenue.
6 Cash and investments is obtained by adding cash and cash equivalents, current and long-term fixed maturity securities and current and long-term equity securities.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS.

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

This Management's Discussion and Analysis of Financial Condition and Results of Operations, or MD&A, should be read in conjunction with our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K. References to the terms "we," "our," "us," "Anthem" or the "Company" used throughout this MD&A refer to Anthem, Inc., an Indiana corporation, and, unless the context otherwise requires, its direct and indirect subsidiaries. References to the "states" include the District of Columbia, unless the context otherwise requires.

Overview

We are one of the largest health benefits companies in the United States in terms of medical membership, serving approximately 40 medical members through our affiliated health plans as of December 31, 2018. We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (in the New York City metropolitan area and upstate New York), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas, we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia, and Empire Blue Cross Blue Shield or Empire Blue Cross. We also conduct business through arrangements with other BCBS licensees in Louisiana, South Carolina and western New York. Through our subsidiaries, we also serve customers in over 25 states across the country as America's 1st Choice, Amerigroup, Aspire Health, CareMore, Freedom Health, HealthLink, HealthSun, Optimum HealthCare, Simply Healthcare, and/or UniCare. We are licensed to conduct insurance operations in all 50 states and the District of Columbia through our subsidiaries.

We manage our operations through three reportable segments: Commercial & Specialty Business, Government Business and Other. During the fourth quarter of 2018, we reclassified certain ancillary businesses to align how our segments are currently being managed. Prior year amounts have been reclassified for comparability.

Our operating revenue consists of premiums and administrative fees and other revenue. Premium revenue comes from fully-insured contracts where we indemnify our policyholders against costs for covered health and life benefits. Administrative fees come from contracts where our customers are self-insured, or where the fee is based on either processing of transactions or a percent of network discount savings realized. Additionally, we earn administrative fee revenues from our Medicare processing business and from other health-related businesses including disease management programs. Other revenue includes miscellaneous income other than premium revenue and administrative fees.

Our benefit expense primarily includes costs of care for health services consumed by our fully-insured members, such as outpatient care, inpatient hospital care, professional services (primarily physician care) and pharmacy benefit costs. All four components are affected both by unit costs and utilization rates. Unit costs include the cost of outpatient medical procedures per visit, inpatient hospital care per admission, physician fees per office visit and prescription drug prices. Utilization rates represent the volume of consumption of health services and typically vary with the age and health status of our members and their social and lifestyle choices, along with clinical protocols and medical practice patterns in each of our markets. A portion of benefit expense recognized in each reporting period consists of actuarial estimates of claims incurred but not yet paid by us. Any changes in these estimates are recorded in the period the need for such an adjustment arises. While we offer a diversified mix of managed care products and services through our managed care plans, our aggregate cost of care can fluctuate based on a change in the overall mix of these products and services. Our managed care plans include: Preferred Provider Organizations, or PPOs; Health Maintenance Organizations, or HMOs; Point-of-Service plans, or POS plans; traditional indemnity plans and other hybrid plans, including Consumer-Driven Health Plans, or CDHPs; and hospital only and limited benefit products.

We classify certain claims-related costs as benefit expense to reflect costs incurred for our members' traditional medical care, as well as those expenses which improve our members' health and medical outcomes. These claims-related costs may be comprised of expenses incurred for: (i) medical management, including case and prospective utilization management; (ii) health and wellness, including disease management services for such conditions as diabetes, high-risk pregnancies,

congestive heart failure and asthma management and wellness initiatives like weight-loss programs and smoking cessation treatments; and (iii) clinical health policy such as identification and use of best clinical practices to avoid harm, identifying clinical errors and safety concerns, and identifying potential adverse drug interactions. These types of claims-related costs are designed to ultimately lower our members' cost of care.

Our selling, general and administrative expenses consist of fixed and variable costs. Examples of fixed costs are depreciation, amortization and certain facilities expenses. Certain variable costs, such as premium taxes, vary directly with premium volume. Commission expense generally varies with premium or membership volume. Other variable costs, such as salaries and benefits, do not vary directly with changes in premium but are more aligned with changes in membership. The acquisition or loss of a significant block of business would likely impact staffing levels and thus, associated compensation expense. Other variable costs include professional and consulting expenses and advertising. Other factors can impact our administrative cost structure, including systems efficiencies, inflation and changes in productivity.

Our results of operations depend in large part on our ability to accurately predict and effectively manage healthcare costs through effective contracting with providers of care to our members and our medical management and health and wellness programs. Several economic factors related to healthcare costs, such as regulatory mandates of coverage as well as direct-to-consumer advertising by providers and pharmaceutical companies, have a direct impact on the volume of care consumed by our members. The potential effect of escalating healthcare costs, any changes in our ability to negotiate competitive rates with our providers and any regulatory or market-driven restrictions on our ability to obtain adequate premium rates to offset overall inflation in healthcare costs, including increases in unit costs and utilization resulting from the aging of the population and other demographics, as well as advances in medical technology, may impose further risks to our ability to profitably underwrite our business, and may have a material adverse impact on our results of operations.

For additional information about our business and reportable segments, see Part I, Item 1, "Business" and in Note 19, "Segment Information" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Business Trends

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended, or collectively, the ACA, has changed and may continue to make broad-based changes to the U.S. healthcare system, which we expect will continue to impact our business model and strategy. Also, the legal challenges regarding the ACA, including the ultimate outcome of the December 2018 decision of the U.S. District Court for the Northern District of Texas, Fort Worth Division invalidating the ACA (the "2018 Texas District Court ACA Decision"), which judgment has been stayed pending appeal, could significantly disrupt our business. During 2018, we strategically reduced our participation in the Individual ACA-compliant market. Our strategy has been, and will continue to be, to only participate in rating regions where we have an appropriate level of confidence that these markets are on a path toward sustainability, including, but not limited to, factors such as expected financial performance, regulatory environment, and underlying market characteristics. We currently offer Individual ACA-compliant products in 73 of the 143 rating regions in which we operate.

In October 2017, we established a new pharmacy benefits manager, or PBM, called IngenioRx, and entered into a five-year agreement with CaremarkPCS Health, L.L.C., or CVS Health, which is a subsidiary of CVS Health Corporation, to begin offering PBM solutions upon the conclusion of our current PBM Agreement with Express Scripts Inc., or Express Scripts. The twelve-month transition period to migrate the services from Express Scripts begins March 2, 2019, at which time CVS Health can begin providing certain PBM services to IngenioRx. We expect IngenioRx to provide our members with more cost-effective solutions and improve our ability to integrate pharmacy benefits within our already strong medical and specialty platform.

Pricing Trends: We strive to price our healthcare benefit products consistent with anticipated underlying medical trends. We frequently make adjustments to respond to legislative and regulatory changes as well as pricing and other actions taken by existing competitors and new market entrants. Product pricing in our Commercial & Specialty Business segment, including our Individual and Small Group lines of business, remains competitive. The ACA imposed an annual Health Insurance Provider Fee, or HIP Fee, on health insurers that write certain types of health insurance on U.S. risks. We price our affected products to cover the impact of the HIP Fee. The HIP Fee was suspended for 2019 and is scheduled to resume for 2020.

Revenues from the Medicare and Medicaid programs are dependent, in whole or in part, upon annual funding from the federal government and/or applicable state governments.

Medical Cost Trends: Our medical cost trends are primarily driven by increases in the utilization of services across all provider types and the unit cost increases of these services. We work to mitigate these trends through various medical management programs such as utilization management, condition management, program integrity and specialty pharmacy management, as well as benefit design changes. There are many drivers of medical cost trends that can cause variance from our estimates, such as changes in the level and mix of services utilized, regulatory changes, aging of the population, health status and other demographic characteristics of our members, epidemics, advances in medical technology, new high cost prescription drugs, and healthcare provider or member fraud. Our underlying Local Group medical cost trends reflect the “allowed amount,” or contractual rate, paid to providers. We estimate that our aggregate cost of care trend was slightly below the midpoint of our 5.5% to 6.5% range for the full year of 2018. We anticipate the Local Group medical cost trend will be in the range of 5.5% to 6.5% in 2019.

For additional discussion regarding business trends, see Part I, Item 1 “Business” of this Annual Report on Form 10-K.

Regulatory Trends and Uncertainties

The ACA presented us with new growth opportunities, but also introduced new risks, regulatory challenges and uncertainties, and required changes in the way products are designed, underwritten, priced, distributed and administered. Changes to our business environment are likely to continue for the next several years as elected officials at the national and state levels continue to propose and enact significant modifications to existing laws and regulations, including the reduction of the individual mandate penalty to zero effective January 1, 2019, elimination of funding for cost-sharing subsidies made available for qualified individuals, and changes to taxes and fees. In addition, the legal challenges regarding the ACA, including the ultimate outcome of the 2018 Texas District Court ACA Decision, continue to contribute to this uncertainty. We will continue to evaluate the impact of the ACA as additional guidance is made available and any further developments or judicial rulings occur.

The annual HIP Fee is allocated to health insurers based on the ratio of the amount of an insurer’s net premium revenues written during the preceding calendar year to the amount of health insurance premium for all U.S. health risk for those certain lines of business written during the preceding calendar year. We record our estimated liability for the HIP Fee in full at the beginning of the year with a corresponding deferred asset that is amortized on a straight-line basis to selling, general and administrative expense. The final calculation and payment of the annual HIP Fee is due by September 30th of each fee year. The HIP Fee is non-deductible for federal income tax purposes. We price our affected products to cover the increased selling, general and administrative and income tax expenses associated with the HIP Fee. The total amount due from allocations to health insurers was $14,300 for 2018, and we recognized $1,544 as selling, general and administrative expense related to the HIP Fee. There was no corresponding expense for 2017 due to the suspension of the HIP Fee for 2017. The HIP Fee is suspended for 2019 and scheduled to resume for 2020.

As a result of the ACA, the U.S. Department of Health and Human Services, or HHS, issued Medical Loss Ratio, or MLR, regulations that require us to meet minimum MLR thresholds of 85% for Large Group and 80% for Small Group and Individual lines of business. Plans that do not meet the minimum thresholds have to pay a MLR rebate. For purposes of determining MLR rebates, HHS has defined the types of costs that should be included in the MLR rebate calculation. However, certain components of the MLR calculation as defined by HHS cannot be classified consistently under U.S. generally accepted accounting principles, or GAAP. While considered benefit expense or a reduction of premium revenue by HHS, certain of these costs are classified as other types of expense, such as selling, general and administrative expense or income tax expense, in our GAAP basis financial statements. Accordingly, the benefit expense ratio determined using our consolidated GAAP operating results is not comparable to the MLR calculated under HHS regulations.

The ACA also imposed a separate minimum MLR threshold of 85% for Medicare Advantage and Medicare Part D prescription drug plans, or Medicare Part D. Medicare Advantage or Medicare Part D plans that do not meet this threshold have to pay an MLR rebate. If a plan’s MLR is below 85% for three consecutive years beginning with 2014, enrollment is restricted. A Medicare Advantage or Medicare Part D plan contract will be terminated if the plan’s MLR is below 85% for five consecutive years.

For additional discussion regarding regulatory trends and uncertainties, and risk factors that could cause actual results to differ materially from those contained in forward-looking statements made in this Annual Report on Form 10-K, see Part I, Item 1 “Business - Regulation” and Part I, Item 1A “Risk Factors.”

Other Significant Items or Transactions

In October 2017, we established IngenioRx and entered into a five-year agreement with CVS Health to begin offering PBM solutions (the “CVS PBM Agreement”), which coincides with the conclusion of our current PBM agreement with Express Scripts (the “ESI PBM Agreement”). In January 2019, we exercised our contractual right to terminate the ESI PBM Agreement earlier than the original expiration date of December 31, 2019 due to the recent acquisition of Express Scripts by Cigna Corporation, or Cigna. As a result of exercising our early termination right, the ESI PBM Agreement will now terminate on March 1, 2019, and the twelve-month transition period to migrate the services begins on March 2, 2019. At that time CVS Health is able to begin providing certain PBM services to IngenioRx pursuant to the CVS PBM Agreement. Notwithstanding our termination of the ESI PBM Agreement, the litigation between us and Express Scripts regarding the ESI PBM Agreement continues. In March 2016, we filed a lawsuit against Express Scripts seeking to recover damages for pharmacy pricing that is higher than competitive benchmark pricing and damages related to operational breaches. Express Scripts filed an answer to the lawsuit disputing our contractual claims and alleging various defenses and counterclaims. For additional information regarding this lawsuit, see Note 13, “Commitments and Contingencies - *Litigation and Regulatory Proceedings - Express Scripts, Inc. Pharmacy Benefit Management Litigation*,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

On February 15, 2018, we completed our acquisition of Freedom Health, Inc., Optimum HealthCare, Inc., America’s 1st Choice of South Carolina, Inc. and related entities, or collectively, America’s 1st Choice, a Medicare Advantage organization that offers HMO products, including Chronic Special Needs Plans and Dual-Eligible Special Needs Plans under its Freedom Health and Optimum HealthCare brands in Florida and its America’s 1st Choice of South Carolina brand in South Carolina. At the time of acquisition, through its Medicare Advantage Plans, America’s 1st Choice served approximately one hundred and thirty-five thousand members in 25 Florida and 3 South Carolina counties. This acquisition aligned with our plans for continued growth in the Medicare Advantage and Special Needs populations.

In December 2017, we acquired HealthSun Health Plans, Inc., or HealthSun, which at the time of acquisition served approximately forty thousand members in the state of Florida through its Medicare Advantage plans, and which received a five-star rating from the Centers for Medicare & Medicaid Services. This acquisition aligned with our plans for continued growth in the Medicare Advantage and dual-eligible populations.

For additional information related to the acquisitions of America’s 1st Choice and HealthSun, see Note 3, “Business Acquisitions,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

In May 2017, we announced that we were terminating the Agreement and Plan of Merger, or Cigna Merger Agreement, between us and Cigna. Both we and Cigna have commenced litigation against the other seeking various actions and damages, including Cigna’s damage claim for a $1,850 termination fee pursuant to the terms of the Cigna Merger Agreement. For additional information about the ongoing litigation related to the Cigna Merger Agreement, see Note 13, “Commitments and Contingencies - *Litigation and Regulatory Proceedings - Cigna Corporation Merger Litigation*,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Other significant transactions in recent years that have impacted or will impact our capital structure or that have influenced or will influence how we conduct our business operations include our Board of Directors’ declarations of dividends on our common stock (2013 through January 2019), repurchases of our common stock (2019 and prior), and debt repurchases and new debt issuances (2018 and prior). For additional information regarding these transactions, see Note 12, “Debt” and Note 14, “Capital Stock,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Operating Performance

Operating revenue for the year ended December 31, 2018 was $91,341, an increase of $2,280, or 2.6%, from the year ended December 31, 2017. The increase in operating revenue was primarily a result of higher premium revenue in our

Government Business segment, and, to a lesser extent, increased administrative fees and other revenue in our Commercial & Specialty Business segment. These increases were partially offset by a decrease in premium revenue in our Commercial & Specialty Business segment.

Net income for the year ended December 31, 2018 was $3,750, a decrease of $93, or 2.4%, from the year ended December 31, 2017. The decrease in net income was primarily a result of higher income tax expense, net realized losses on investments and increased amortization of other intangible assets. The decrease in net income was partially offset by higher operating results in both our Commercial & Specialty Business and Government Business segments, lower realized losses on extinguishment of debt and an increase in net earnings from investment activities.

Our fully-diluted earnings per share, or EPS, for the year ended December 31, 2018 was $14.19, a decrease of $0.16, or 1.1%, from the year ended December 31, 2017. Our diluted shares for the year ended December 31, 2018 were 264.2, a decrease of 3.6, or 1.3% compared to the year ended December 31, 2017. The decrease in EPS resulted from the decrease in net income, partially offset by the lower number of shares outstanding in 2018.

Operating cash flow for the year ended December 31, 2018 was $3,827, or 1.0 times net income. Operating cash flow for the year ended December 31, 2017 was $4,185, or 1.1 times net income. The decrease in operating cash flow from 2017 of $358 was primarily due to increased spend to support growth initiatives and the impact of membership declines due to our reduced participation in ACA-compliant Individual marketplaces, and to a lesser extent, membership declines in our fully-insured Local Group business. The decrease in cash provided by operating activities was partially offset by cash receipts related to rate increases across our businesses designed to cover overall cost trends. The decrease was further offset by lower income taxes paid in 2018 as a result of the tax bill, H.R.1, *An Act to provide for reconciliation pursuant to titles II and V of the concurrent resolution on the budget for fiscal year 2018*, or the Tax Cuts and Jobs Act, enacted by the federal government on December 22, 2017. The Tax Cuts and Jobs Act reduced the U.S. federal corporate income tax rate from 35% to 21% effective January 1, 2018.

Our results of operations discussed throughout this MD&A are determined in accordance with GAAP. We also calculate operating gain, a non-GAAP measure, to further aid investors in understanding and analyzing our core operating results. We define operating revenue as premium income and administrative fees and other revenues. Operating gain is calculated as total operating revenue less benefit expense and selling, general and administrative expense. We use these measures as a basis for evaluating segment performance, allocating resources, forecasting future operating periods and setting incentive compensation targets. This information is not intended to be considered in isolation or as a substitute for income before income tax expense, net income or EPS prepared in accordance with GAAP, and may not be comparable to similarly titled measures reported by other companies. For additional details on operating gain, see our “Reportable Segments Results of Operations” discussion included in this MD&A. For a reconciliation of reportable segment operating revenue to the amounts of total revenue included in the consolidated statements of income and a reconciliation of reportable segment operating gain to income before income tax expense, see Note 19, “Segment Information,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We intend to expand through a combination of organic growth, strategic acquisitions and efficient use of capital in both existing and new markets. Our growth strategy is designed to enable us to take advantage of additional economies of scale, as well as providing us access to new and evolving technologies and products. In addition, we believe geographic and product diversity reduces our exposure to local or regional regulatory, economic and competitive pressures and provides us with increased opportunities for growth. In 2018, we reduced our participation in the Individual ACA-compliant market. In all other markets, we have maintained our position or achieved growth as a result of strategic mergers and acquisitions, as well as organic growth resulting from delivering excellent service, offering competitively priced products, providing access to high-quality provider networks and effectively capitalizing on the brand strength of the Blue Cross and Blue Shield names and marks.

Membership

Our medical membership includes seven different customer types: Local Group, Individual, National Accounts, BlueCard®, Medicare, Medicaid and FEP®. BCBS-branded business generally refers to members in our service areas licensed by the BCBSA. Non-BCBS-branded business refers to members in our non-BCBS-branded America's 1st Choice, Amerigroup, CareMore, HealthSun, and Simply Healthcare plans, as well as HealthLink and UniCare members. In addition to the above medical membership, we also serve customers who purchase one or more of our other products or services that are often ancillary to our health business.

- Local Group consists of those employer customers with less than 5% of eligible employees located outside of the headquarter state, as well as customers with more than 5% of eligible employees located outside of the headquarter state with up to 5,000 eligible employees. In addition, Local Group includes UniCare members. Local Group accounts are generally sold through brokers or consultants working with industry specialists from our in-house sales force and are offered both on and off the public exchanges. Local Group insurance premiums may be based on claims incurred by the group or sold on a self-insured basis. The customer's buying decision is typically based upon the size and breadth of our networks, customer service, the quality of our medical management services, the administrative cost included in our quoted price, our financial stability, our reputation and our ability to effectively service large complex accounts. Local Group accounted for 39.4%, 39.4% and 38.6% of our medical members at December 31, 2018, 2017 and 2016, respectively.
- Individual consists of individual customers under age 65 and their covered dependents. Individual policies are generally sold through independent agents and brokers, retail partnerships, our in-house sales force or via the exchanges. Individual business is sold on a fully-insured basis. We offer on-exchange products through public exchanges and off-exchange products. Federal premium subsidies are available only for certain public exchange Individual products. Unsubsidized Individual customers are generally more sensitive to product pricing and, to a lesser extent, the configuration of the network and the efficiency of administration. Customer turnover is generally higher with Individual as compared to Local Group. Individual business accounted for 1.6%, 3.9% and 4.2% of our medical members at December 31, 2018, 2017 and 2016, respectively.
- National Accounts generally consist of multi-state employer groups primarily headquartered in an Anthem service area with at least 5% of the eligible employees located outside of the headquarter state and with more than 5,000 eligible employees. Some exceptions are allowed based on broker and consultant relationships. Service area is defined as the geographic area in which we are licensed to sell BCBS products. National Accounts are generally sold through independent brokers or consultants retained by the customer working with our in-house sales force. We believe we have an advantage when competing for very large National Accounts due to the size and breadth of our networks and our ability to access the national provider networks of BCBS companies at their competitive local market rates. National Accounts represented 19.0%, 18.5% and 18.8% of our medical members at December 31, 2018, 2017 and 2016, respectively.
- BlueCard® host customers represent enrollees of Blue Cross and/or Blue Shield plans not owned by Anthem who receive healthcare services in our BCBSA licensed markets. BlueCard® membership consists of estimated host members using the national BlueCard® program. Host members are generally members who reside in or travel to a state in which an Anthem subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer-sponsored health plan issued by a non-Anthem controlled BCBSA licensee (i.e., the "home plan"). We perform certain administrative functions for BlueCard® members, for which we receive administrative fees from the BlueCard® members' home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan. Host members are computed using, among other things, the average number of BlueCard® claims received per month. BlueCard® host membership accounted for 14.6%, 14.2% and 14.5% of our medical members at December 31, 2018, 2017 and 2016, respectively.
- Medicare customers are Medicare-eligible individual members age 65 and over who have enrolled in Medicare Supplement plans; Medicare Advantage, including Special Needs Plans; Medicare Part D; and dual-eligible programs through Medicare-Medicaid Plans, or MMPs. Medicare Supplement plans typically pay the difference between healthcare costs incurred by a beneficiary and amounts paid by Medicare. Medicare Advantage plans provide Medicare beneficiaries with a managed care alternative to traditional Medicare and often include a Medicare Part D benefit. In addition, our Medicare Advantage Special Needs Plans provide tailored benefits to Medicare beneficiaries who have chronic diseases and also cover certain dual-eligible customers, who are low-income seniors

and persons under age 65 with disabilities. Medicare Advantage membership also includes Employer Group Medicare Advantage members who are related to National Accounts or retired members of Local Group accounts who have selected a Medicare Advantage product. Medicare Part D offers a prescription drug plan to Medicare and MMP beneficiaries. MMP, which was established as a result of the passage of the ACA, is a demonstration program focused on serving members who are dually eligible for Medicaid and Medicare. Medicare Supplement and Medicare Advantage products are marketed in the same manner, primarily through independent agents and brokers. Medicare business accounted for 4.6%, 3.9% and 3.6% of our medical members at December 31, 2018, 2017 and 2016, respectively.

- Medicaid membership represents eligible members who receive healthcare benefits through publicly funded healthcare programs, including Medicaid, ACA-related Medicaid expansion programs, Temporary Assistance for Needy Families, programs for seniors and people with disabilities, Children's Health Insurance Programs, and specialty programs such as those focused on long-term services and support, HIV/AIDS, foster care, behavioral health and/or substance abuse disorders, and intellectual disabilities or developmental disabilities, among others. Total Medicaid program business accounted for 16.8%, 16.1% and 16.4% of our medical members at December 31, 2018, 2017 and 2016, respectively.
- FEP® members consist of United States government employees and their dependents within our geographic markets through our participation in the national contract between the BCBSA and the U.S. Office of Personnel Management. FEP® business accounted for 3.9% of our medical members at each of December 31, 2018, 2017 and 2016.

In addition to reporting our medical membership by customer type, we report by funding arrangement according to the level of risk that we assume in the product contract. Our two principal funding arrangement categories are fully-insured and self-funded. Fully-insured products are products in which we indemnify our policyholders against costs for health benefits. Self-funded products are offered to customers, generally larger employers, who elect to retain most or all of the financial risk associated with their employees' healthcare costs. Some self-funded customers choose to purchase stop loss coverage to limit their retained risk.

During the fourth quarter of 2018 we made a number of changes to our membership reporting to better align our reported membership to the appropriate type, funding arrangement and segment, including movement of our Employer Group Medicare Advantage members from National Accounts to Medicare Advantage, reclassification of these Employer Group members from the Commercial & Specialty Business segment to our Government Business segment, and other marginal changes.

The following table presents our medical membership by customer type, funding arrangement and reportable segment as of December 31, 2018, 2017 and 2016. Also included below is other membership by product. The medical membership and other membership presented are unaudited and in certain instances include estimates of the number of members represented by each contract at the end of the period.

	December 31			2018 vs. 2017		2017 vs. 2016	
(In thousands)	**2018**	**2017 [1]**	**2016 [1]**	**Change**	**% Change**	**Change**	**% Change**
Medical Membership							
Customer Type							
Local Group	15,733	15,888	15,417	(155)	(1.0)%	471	3.1 %
Individual	655	1,588	1,664	(933)	(58.8)%	(76)	(4.6)%
National:							
National Accounts	7,588	7,463	7,510	125	1.7 %	(47)	(0.6)%
BlueCard®	5,838	5,733	5,774	105	1.8 %	(41)	(0.7)%
Total National	13,426	13,196	13,284	230	1.7 %	(88)	(0.7)%
Medicare:							
Medicare Advantage	1,006	746	629	260	34.9 %	117	18.6 %
Medicare Supplement	846	823	828	23	2.8 %	(5)	(0.6)%
Total Medicare	1,852	1,569	1,457	283	18.0 %	112	7.7 %
Medicaid	6,716	6,496	6,548	220	3.4 %	(52)	(0.8)%
Federal Employee Program®	1,556	1,562	1,570	(6)	(0.4)%	(8)	(0.5)%
Total Medical Membership by Customer Type	39,938	40,299	39,940	(361)	(0.9)%	359	0.9 %
Funding Arrangement							
Self-Funded	25,287	24,862	24,563	425	1.7 %	299	1.2 %
Fully-Insured	14,651	15,437	15,377	(786)	(5.1)%	60	0.4 %
Total Medical Membership by Funding Arrangement	39,938	40,299	39,940	(361)	(0.9)%	359	0.9 %
Reportable Segment							
Commercial & Specialty Business	29,814	30,672	30,365	(858)	(2.8)%	307	1.0 %
Government Business	10,124	9,627	9,575	497	5.2 %	52	0.5 %
Total Medical Membership by Reportable Segment	39,938	40,299	39,940	(361)	(0.9)%	359	0.9 %
Other Membership							
Life and Disability Members	4,795	4,700	4,732	95	2.0 %	(32)	(0.7)%
Dental Members	5,807	5,864	5,486	(57)	(1.0)%	378	6.9 %
Dental Administration Members	5,327	5,342	5,294	(15)	(0.3)%	48	0.9 %
Vision Members	6,946	6,867	6,388	79	1.2 %	479	7.5 %
Medicare Part D Standalone Members	309	318	350	(9)	(2.8)%	(32)	(9.1)%

1 Certain types of membership have been reclassified to conform to the current year presentation, as described above.

December 31, 2018 Compared to December 31, 2017

Medical Membership

Total medical membership decreased primarily due to decreases in our Individual, Local Group and FEP membership, partially offset by increases in our Medicare, Medicaid, National Accounts and BlueCard® membership. Our reduced participation in ACA-compliant marketplaces led to the decreases in our Individual and fully-insured memberships. This decrease in fully-insured membership was partially offset by an increase in Medicare membership as a result of our America's 1st Choice acquisition and higher sales during open enrollment. Self-funded medical membership increased due to

increases in our National Accounts and Large Group businesses and higher activity from BlueCard® membership. Local Group membership decreased as a result of competitive pressures in fully-insured membership, partially offset by new sales and growth in our existing self-funded business. National Accounts membership increased primarily due to new sales and growth from existing contracts exceeding lapses. BlueCard® membership increased primarily due to higher membership activity at other BCBSA plans whose members reside in or travel to our licensed areas. Medicare Advantage membership increased primarily due to membership acquired through the acquisition of America's 1st Choice and organic growth in existing markets. Medicaid membership increased primarily due to new business, partially offset by certain state market contractions and membership reverification processes.

Other Membership

Growth in our other membership can be impacted by changes in our medical membership, as our medical members often purchase our other products that are ancillary to our health business. We have experienced growth in our life and disability and vision memberships primarily due to higher sales in our Large Group business. Dental membership decreased primarily due to our reduced participation in ACA-compliant marketplaces, partially offset by higher sales in our Local Group and National Accounts businesses. Dental administration membership decreased primarily due to the loss of a large managed dental contract, partially offset by membership expansion under current contracts.

December 31, 2017 Compared to December 31, 2016

Medical Membership

Total medical membership increased primarily due to increases in our Local Group and Medicare membership, partially offset by decreases in our Individual, National Accounts, Medicaid, and BlueCard® membership. Self-funded medical membership increased primarily due to new sales and growth in our existing Large Group accounts, partially offset by lower activity from BlueCard® membership and the loss of a large multi-state employer group contract in our National Accounts. Fully-insured membership increased primarily due to higher sales during Medicare open enrollment, new sales in Large Group accounts and Medicare membership acquired through the acquisition of HealthSun. These increases in fully-insured membership were partially offset by attrition in both our non-ACA-compliant and ACA-compliant off-exchange Individual product offerings. Local Group membership increased primarily due to new sales and growth in our existing Large Group accounts. Individual membership decreased primarily due to attrition in both our non-ACA-compliant and ACA-compliant off-exchange product offerings, partially offset by growth in ACA-compliant on-exchange product offerings. National Accounts membership decreased primarily due to the loss of a large multi-state employer group, partially offset by new sales. BlueCard® membership decreased primarily due to lower membership activity at other BCBSA plans whose members reside in or travel to our licensed areas. Medicare membership increased primarily due to higher sales during open enrollment, membership acquired through the acquisition of HealthSun and growth in certain existing Medicare Advantage markets. Medicaid membership decreased primarily due to membership reverification processes and the impact of a new entrant in one of our existing markets, partially offset by new business expansions.

Other Membership

Life and disability membership decreased primarily due to higher lapses in our fully-insured Local Group business. Dental membership increased primarily due to new sales and increased penetration in our Local Group and National Accounts businesses. Dental administration membership increased primarily due to membership expansion under current contracts. Vision membership increased primarily due to new sales and increased penetration in our National Accounts, Local Group and Medicare product offerings. Medicare Part D standalone membership decreased primarily due to our product repositioning strategies in certain markets.

Consolidated Results of Operations

Our consolidated summarized results of operations for the years ended December 31, 2018, 2017 and 2016 are discussed in the following section.

	Years Ended December 31			Change			
				2018 vs. 2017		2017 vs. 2016	
	2018	2017	2016	$	%	$	%
Total operating revenue	$ 91,341	$ 89,061	$ 84,194	$ 2,280	2.6 %	$ 4,867	5.8 %
Net investment income	970	867	779	103	11.9 %	88	11.3 %
Net realized (losses) gains on financial instruments	(180)	145	5	(325)	(224.1)%	140	2,800.0 %
Other-than-temporary impairment losses recognized in income	(26)	(33)	(115)	7	21.2 %	82	71.3 %
Total revenues	92,105	90,040	84,863	2,065	2.3 %	5,177	6.1 %
Benefit expense	71,895	72,236	66,834	(341)	(0.5)%	5,402	8.1 %
Selling, general and administrative expense	14,020	12,650	12,559	1,370	10.8 %	91	0.7 %
Other expense[1]	1,122	1,190	915	(68)	(5.7)%	275	30.1 %
Total expenses	87,037	86,076	80,308	961	1.1 %	5,768	7.2 %
Income before income tax expense	5,068	3,964	4,555	1,104	27.9 %	(591)	(13.0)%
Income tax expense	1,318	121	2,085	1,197	989.3 %	(1,964)	(94.2)%
Net income	$ 3,750	$ 3,843	$ 2,470	$ (93)	(2.4)%	$ 1,373	55.6 %
Average diluted shares outstanding	264.2	267.8	268.1	(3.6)	(1.3)%	(0.3)	(0.1)%
Diluted net income per share	$ 14.19	$ 14.35	$ 9.21	$ (0.16)	(1.1)%	$ 5.14	55.8 %
Effective Tax Rate	26.0%	3.1%	45.8%		2,290bp[3]		(4,270)bp[3]
Benefit expense ratio[2]	84.2%	86.4%	84.8%		(220)bp[3]		160bp[3]
Selling, general and administrative expense ratio[4]	15.3%	14.2%	14.9%		110bp[3]		(70)bp[3]
Income before income tax expense as a percentage of total revenues	5.5%	4.4%	5.4%		110bp[3]		(100)bp[3]
Net income as a percentage of total revenues	4.1%	4.3%	2.9%		(20)bp[3]		140bp[3]

Certain of the following definitions are also applicable to all other results of operations tables in this discussion:

1 Includes interest expense, amortization of other intangible assets and loss on extinguishment of debt.
2 Benefit expense ratio represents benefit expense as a percentage of premium revenue. Premiums for the years ended December 31, 2018, 2017 and 2016 were $85,421, $83,648 and $78,860, respectively. Premiums are included in total operating revenue presented above.
3 bp = basis point; one hundred basis points = 1%.
4 Selling, general and administrative expense ratio represents selling, general and administrative expense as a percentage of total operating revenue.

Year Ended December 31, 2018 Compared to the Year Ended December 31, 2017

Total operating revenue increased primarily from higher premiums, and, to a lesser extent, increased administrative fees and other revenue. Higher premiums were primarily due to rate increases designed to cover overall cost trends and the HIP Fee reinstatement for 2018, as well as membership growth in our Medicare business as a result of our acquisitions of America's 1st Choice and HealthSun and organic growth in existing markets. These increases in premiums were partially offset by a premium revenue decrease resulting from our reduced participation in ACA-compliant Individual markets in various states and a membership decline in our fully-insured Local Group business. The increase in administrative fees and other revenue primarily resulted from rate increases and membership growth in our self-funded Local Group and National Accounts businesses.

Net investment income increased primarily due to higher dividend yields on equity securities and higher income from alternative investments.

We recognized net realized losses on financial instruments in 2018 compared to net realized gains on financial instruments in 2017. This change was primarily due to the recognition of changes in the fair values of equity securities from the adoption of Accounting Standards Update No. 2016-01, *Financial Instruments - Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities*, or ASU 2016-01. For additional information related to the adoption of ASU 2016-01, see Note 2, "Basis of Presentation and Significant Accounting Policies - *Recently Adopted Accounting Guidance*," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K. The change was further due to an increase in net realized losses on sales of fixed maturity securities, partially offset by increases in net realized gains on sales of equity securities and net realized gains on derivative financial instruments.

Benefit expense decreased primarily due to our reduced participation in ACA-compliant Individual marketplaces in various states. The decrease was partially offset by increased expenses related to membership growth in our Medicare business primarily as a result of our America's 1st Choice and HealthSun acquisitions and organic growth in existing markets. The decrease was further offset by higher medical costs in our Medicaid business.

Our benefit expense ratio decreased primarily due to the increase in premiums to cover the HIP Fee reinstatement for 2018 and, to a lesser extent, improved medical cost performance in our Commercial & Specialty Business segment. The decrease was partially offset by higher medical costs in our Medicaid business.

Selling, general and administrative expense increased primarily due to the reinstatement of the HIP Fee for 2018. The increase was further attributable to an increase in spend to drive future growth. These increases were partially offset by the recognition of a guaranty fund assessment during 2017 related to the liquidation order of Penn Treaty Network American Insurance Company and its subsidiary American Network Insurance Company, or collectively Penn Treaty, and a decrease in performance-based incentive compensation.

Our selling, general and administrative expense ratio increased primarily due to the reinstatement of the HIP Fee for 2018. The increase in the ratio was further attributable to an increase in spend to drive future growth. These increases were partially offset by the growth in operating revenue, the impact of the Penn Treaty guaranty fund assessment in 2017 and a decrease in performance-based incentive compensation.

Other expense decreased primarily due to lower debt extinguishment losses. For more information on our debt, see Note 12, "Debt" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K. The decrease was partially offset by increased amortization of intangible assets acquired with the HealthSun and America's 1st Choice acquisitions.

Our income tax expense and effective tax rate increased primarily due to the non-recurring income tax benefit we recognized in 2017 related to the remeasurement of our deferred tax balance pursuant to the Tax Cuts and Jobs Act and the reinstatement of the non-tax deductible HIP Fee for 2018. This increase was partially offset by a decrease in income tax expense due to the effect of the Tax Cuts and Jobs Act, which reduced the U.S. federal corporate income tax rate from 35% to 21% effective January 1, 2018.

Our net income as a percentage of total revenue decreased as a result of all factors discussed above.

Year Ended December 31, 2017 Compared to the Year Ended December 31, 2016

Total operating revenue increased, resulting primarily from higher premiums, and, to a lesser extent, increased administrative fees and other revenue. Higher premiums were due, in part, to rate increases across our businesses designed to cover overall cost trends. The increase was further attributable to membership growth in our Medicare Advantage and Large Group product offerings. The increase in premiums was partially offset by the impact of the HIP Fee suspension for 2017, as we did not price affected products to cover any HIP Fee related expense in 2017. Additionally declines in both our non-ACA-compliant and ACA-compliant off-exchange Individual businesses, lower favorable adjustments to prior year estimates for the ACA risk adjustment premium stabilization program and declines in our National Accounts business partially offset the overall increase in premiums. The increase in administrative fees and other revenue primarily resulted from membership growth in our self-funded Large Group business.

Net investment income increased primarily due to higher income from alternative investments and higher investment yields on fixed maturity securities, partially offset by lower dividend yields on equity securities.

Net realized gains on financial instruments increased primarily due to a decrease in net realized losses on derivative financial instruments and an increase in net realized gains on sales of fixed maturity securities, partially offset by a decrease in net realized gains on sales of equity securities.

Other-than-temporary impairment losses on investments decreased primarily due to a decrease in impairment losses on fixed maturity securities.

Benefit expense increased primarily due to increased costs as a result of overall cost trends across our businesses. The increase was further attributable to membership growth in our Medicare Advantage and Large Group business product offerings. These increases were partially offset by the impact of membership declines in both our non-ACA-compliant and ACA-compliant off-exchange Individual product offerings.

Our benefit expense ratio increased in 2017. The increase in the ratio was largely driven by the loss of revenue associated with the HIP Fee suspension for 2017, higher medical cost experience in our Medicare business and adjustments to prior year estimates for the ACA risk adjustment premium stabilization program. The increase in the ratio was partially offset by improved medical cost experience in our Individual business.

Our selling, general and administrative expense increased due, in part, to an increase in spend to support our growth initiatives, the recognition of a guaranty fund assessment related to the liquidation order of Penn Treaty, an increase in performance-based incentive compensation and a legal settlement accrual related to settlement of the 2015 cyber attack class action litigation. For additional information regarding the cyber attack and related settlement, see Note 13, “Commitments and Contingencies - *Litigation and Regulatory Proceedings - Cyber Attack Regulatory Proceedings and Litigation,*” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K. These increases were partially offset by lower ACA fees, primarily as a result of the suspension of the HIP Fee for 2017 and, to a lesser extent, the expiration of the fees for the ACA temporary reinsurance premium stabilization program that ended on December 31, 2016. The increases were further offset by lower selling, general and administrative costs related to expense efficiency initiatives and lower transaction costs related to the terminated Cigna Merger Agreement.

Our selling, general and administrative expense ratio decreased due, in part, to the lower ACA fees discussed above, lower selling, general and administrative costs related to expense efficiency initiatives and growth in operating revenue. These decreases were partially offset by an increase in spend to support our growth initiatives, the impact of the Penn Treaty guaranty fund assessment, an increase in performance-based incentive compensation and the accrual related to the settlement of the 2015 cyber attack class action litigation.

Other expense increased primarily due to losses on extinguishment of debt. For more information on our debt, see Note 12, “Debt” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Income tax expense decreased primarily due to the effect of the Tax Cuts and Jobs Act, the suspension of the non-tax deductible HIP Fee for 2017 and the favorable impact of our recognition of tax benefits for prior acquisition costs incurred related to the terminated Cigna Merger Agreement. For the year ended December 31, 2017, we recognized a non-recurring income tax benefit related to the remeasurement of our deferred tax balance pursuant to the Tax Cuts and Jobs Act. For the year ended December 31, 2016, we recognized additional income tax expense related to the HIP Fee. The decrease in income tax expense was further due to the recognition of excess tax benefits during the year ended December 31, 2017 from the adoption of Accounting Standards Update No. 2016-09, *Compensation - Stock Compensation (Topic 718): Improvements to Employee Share-Based Payment Accounting,* or ASU 2016-09. For additional information related to the adoption of ASU 2016-09, see Note 2, “Basis of Presentation of Significant Accounting Policies - *Recently Adopted Accounting Guidance*” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K. Additionally, during the year ended December 31, 2016, we recognized additional California deferred state tax expense resulting from specific California legislation related to Managed Care Organizations that did not recur in 2017.

Our effective tax rate decreased primarily due to the effect of the Tax Cuts and Jobs Act, the suspension of the HIP Fee in 2017, the deduction of the prior acquisition costs incurred related to the terminated Cigna Merger Agreement, the excess tax benefits from the adoption of ASU 2016-09 and the additional 2016 California deferred state tax expense, discussed above.

Our net income as a percentage of total revenue increased as a result of all factors discussed above.

Reportable Segments Results of Operations

We use operating gain to evaluate the performance of our reportable segments, which are Commercial & Specialty Business, Government Business, and Other. Operating gain, which is a non-GAAP measure, is calculated as total operating revenue less benefit expense and selling, general and administrative expense. It does not include net investment income, net realized (losses) gains on financial instruments, other-than-temporary impairment losses recognized in income, interest expense, amortization of other intangible assets, loss (gain) on extinguishment of debt or income taxes, as these items are managed in a corporate shared service environment and are not the responsibility of operating segment management.

The discussion of segment results for the years ended December 31, 2018, 2017 and 2016 presented below are based on operating gain, as described above, and operating margin, which is calculated as operating gain divided by operating revenue. Our definitions of operating gain and operating margin may not be comparable to similarly titled measures reported by other companies. For additional information, including a reconciliation of non-GAAP financial measures, see Note 19, "Segment Information," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Our Commercial & Specialty Business, Government Business, and Other segments' summarized results of operations for the years ended December 31, 2018, 2017 and 2016 are as follows:

				Change			
	Years Ended December 31			2018 vs. 2017		2017 vs. 2016	
	2018	2017 [2]	2016 [2]	$	%	$	%
Commercial & Specialty Business							
Operating revenue	$ 35,782	$ 40,363	$ 38,347	$ (4,581)	(11.3)%	$ 2,016	5.3 %
Operating gain	$ 3,629	$ 2,847	$ 3,148	$ 782	27.5 %	$ (301)	(9.6)%
Operating margin	10.1%	7.1%	8.2%		300bp		(110)bp
Government Business							
Operating revenue	$ 55,567	$ 48,702	$ 45,850	$ 6,865	14.1 %	$ 2,852	6.2 %
Operating gain	$ 1,895	$ 1,445	$ 1,827	$ 450	31.1 %	$ (382)	(20.9)%
Operating margin	3.4%	3.0%	4.0%		40bp		(100)bp
Other							
Operating revenue	$ (8)	$ (4)	$ (3)	$ (4)	100.0 %	$ (1)	33.3 %
Operating loss[1]	$ (98)	$ (117)	$ (174)	$ 19	(16.2)%	$ 57	(32.8)%

1 Primarily a result of changes in unallocated corporate expenses.
2 Certain amounts have been reclassified to conform to the current year presentation.

Year Ended December 31, 2018 Compared to the Year Ended December 31, 2017

Commercial & Specialty Business

Operating revenue decreased primarily due to a decrease in our Individual business membership resulting from our reduced participation in ACA-compliant marketplaces in various states and, to a lesser extent, membership declines in our Local Group fully-insured products. The decrease was partially offset by premium rate increases designed to cover overall cost trends and the impact of the HIP Fee reinstatement for 2018. The decrease was further offset by an increase in administrative fees and other revenue due to rate increases and membership growth in our self-funded Large Group and National Accounts businesses.

Operating gain increased due to improved medical cost performance, the impact of the recognition of the Penn Treaty guaranty fund assessment in 2017, and a decrease in certain selling, general and administrative expenses.

Government Business

Operating revenue increased primarily due to membership growth in our Medicare business as a result of our acquisitions of America's 1st Choice and HealthSun and organic growth in existing markets. The increase was further due to premium rate increases designed to cover overall cost trends and the HIP Fee reinstatement for 2018.

Operating gain increased primarily due to the membership growth in our Medicare business described in the preceding paragraph. The increase was further due to retroactive premium adjustments recognized in various Medicaid markets and the impact of the HIP Fee reinstatement. These increases were partially offset by higher medical costs in our Medicaid business.

Year Ended December 31, 2017 Compared to the Year Ended December 31, 2016

Commercial & Specialty Business

Operating revenue increased primarily due to premium rate increases designed to cover overall cost trends in our Individual and Local Group businesses. The increase was further attributable to membership growth in our fully-insured Large Group business and an increase in administrative fees and other revenue. The increase in administrative fees and other revenue was primarily due to membership growth in our self-insured Large Group business. The increase in operating revenue was partially offset by the impact of the HIP Fee suspension for 2017, declines in membership in our non-ACA-compliant and ACA-compliant off-exchange Individual businesses, lower favorable adjustments to prior year estimates for the ACA risk adjustment premium stabilization program and declines in membership in our National Accounts business.

Operating gain decreased primarily due to the recognition of the guaranty fund assessment related to the Penn Treaty liquidation, an increase in spend to support our growth initiatives and adjustments to prior year estimates for the ACA risk adjustment premium stabilization program. The decrease in operating gain was further due to an increase in performance-based incentive compensation and the settlement accrual for the class action litigation related to the 2015 cyber attack. The decrease in operating gain was partially offset by lower selling, general and administrative costs related to expense efficiency initiatives and fixed costs leverage from higher operating revenue. The decrease in operating gain was further offset by improved medical cost experience in our Individual businesses.

Government Business

Operating revenue increased primarily due to premium rate increases designed to cover overall cost trends in our Medicaid and Medicare business. The increase was further due to new Medicaid business expansions and membership growth in our Medicare Advantage business. These increases were partially offset by the impact of the HIP Fee suspension for 2017 and Medicaid membership declines resulting from membership reverification processes and the impact of a new entrant in an existing market.

Operating gain decreased primarily due to the impact of the HIP Fee suspension for 2017 and higher medical cost experience in our Medicare business. The decrease was further due to an increase in performance-based incentive compensation and an increase in spend to support our growth initiatives. These decreases were partially offset by lower selling, general and administrative costs related to expense efficiency initiatives and fixed costs leverage from higher operating revenue.

Critical Accounting Policies and Estimates

We prepare our consolidated financial statements in conformity with GAAP. Application of GAAP requires management to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes and within this MD&A. We consider our most important accounting policies that require significant estimates and management judgment to be those policies with respect to liabilities for medical claims payable, income taxes, goodwill and other intangible assets, investments and retirement benefits, which are discussed below. Our other significant accounting policies are summarized in Note 2, "Basis of Presentation and Significant Accounting Policies," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We continually evaluate the accounting policies and estimates used to prepare the consolidated financial statements. In general, our estimates are based on historical experience, evaluation of current trends, information from third-party

professionals and various other assumptions that we believe to be reasonable under the known facts and circumstances. Estimates can require a significant amount of judgment and a different set of assumptions could result in material changes to our reported results.

Medical Claims Payable

The most subjective accounting estimate in our consolidated financial statements is our liability for medical claims payable. At December 31, 2018, this liability was $7,454 and represented 17% of our total consolidated liabilities. We record this liability and the corresponding benefit expense for incurred but not paid claims, including the estimated costs of processing such claims. Incurred but not paid claims include (1) an estimate for claims that are incurred but not reported, as well as claims reported to us but not yet processed through our systems, which approximated 98%, or $7,300, of our total medical claims liability as of December 31, 2018; and (2) claims reported to us and processed through our systems but not yet paid, which approximated 2%, or $154, of the total medical claims payable as of December 31, 2018. The level of claims payable processed through our systems but not yet paid may fluctuate from one period-end to the next, from approximately 1% to 5% of our total medical claims liability, due to timing of when claim payments are made.

Liabilities for both claims incurred but not reported and reported but not yet processed through our systems are determined in the aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Actuarial Standards of Practice require that the claim liabilities be appropriate under moderately adverse circumstances. We determine the amount of the liability for incurred but not paid claims by following a detailed actuarial process that uses both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities. Under this process, historical paid claims data is formatted into “claim triangles,” which compare claim incurred dates to the dates of claim payments. This information is analyzed to create “completion factors” that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the period-end date to estimate the ultimate claim expense incurred for the period. Actuarial estimates of incurred but not paid claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims.

For the most recent incurred months (typically the most recent two months), the percentage of claims paid for claims incurred in those months is generally low. This makes the completion factor methodology less reliable for such months. Therefore, incurred claims for recent months are not projected from historical completion and payment patterns; rather, they are projected by estimating the claims expense for those months based on recent claims expense levels and healthcare trend levels, or “trend factors.”

Because the reserve methodology is based upon historical information, it must be adjusted for known or suspected operational and environmental changes. These adjustments are made by our actuaries based on their knowledge and their estimate of emerging impacts to benefit costs and payment speed. Circumstances to be considered in developing our best estimate of reserves include changes in utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations. A comparison of prior period liabilities to re-estimated claim liabilities based on subsequent claims development is also considered in making the liability determination. In our comparison to prior periods, the methods and assumptions are not changed as reserves are recalculated; rather, the availability of additional paid claims information drives changes in the re-estimate of the unpaid claim liability. To the extent appropriate, changes in such development are recorded as a change to current period benefit expense.

We regularly review and set assumptions regarding cost trends and utilization when initially establishing claim liabilities. We continually monitor and adjust the claims liability and benefit expense based on subsequent paid claims activity. If it is determined that our assumptions regarding cost trends and utilization are materially different than actual results, our income statement and financial position could be impacted in future periods. Adjustments of prior year estimates may result in additional benefit expense or a reduction of benefit expense in the period an adjustment is made. Further, due to the considerable variability of healthcare costs, adjustments to claim liabilities occur each period and are sometimes significant as compared to the net income recorded in that period. Prior period development is recognized immediately upon the actuary’s judgment that a portion of the prior period liability is no longer needed or that an additional liability should have been accrued. That determination is made when sufficient information is available to ascertain that the re-estimate of the liability is reasonable.

While there are many factors that are used as a part of the estimation of our medical claims payable liability, the two key assumptions having the most significant impact on our incurred but not paid claims liability as of December 31, 2018 were the completion and trend factors. As discussed above, these two key assumptions can be influenced by utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations.

There is variation in the reasonable choice of completion factors by duration for durations of three months through twelve months where the completion factors have the most significant impact. As previously discussed, completion factors tend to be less reliable for the most recent months and therefore are not specifically utilized for months one and two. In our analysis for the claim liabilities at December 31, 2018, the variability in months three to five was estimated to be between 40 and 90 basis points, while months six through twelve have much lower estimated variability ranging from 0 to 30 basis points.

The difference in completion factor assumptions, assuming moderately adverse experience, results in variability of 3%, or approximately $213, in the December 31, 2018 incurred but not paid claims liability, depending on the completion factors chosen. It is important to note that the completion factor methodology inherently assumes that historical completion rates will be reflective of the current period. However, it is possible that the actual completion rates for the current period will develop differently from historical patterns and therefore could fall outside the possible variations described herein.

The other major assumption used in the establishment of the December 31, 2018 incurred but not paid claim liability was the trend factors. In our analysis for the period ended December 31, 2018, there was a 300 basis point differential in the high and low trend factors assuming moderately adverse experience. This range of trend factors would imply variability of 5%, or approximately $408, in the incurred but not paid claims liability, depending upon the trend factors used. Because historical trend factors are often not representative of current claim trends, the trend experience for the most recent six to nine months, plus knowledge of recent events likely affecting current trends, have been taken into consideration in establishing the incurred but not paid claims liability at December 31, 2018.

See Note 11, “Medical Claims Payable,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K, for a reconciliation of the beginning and ending balance for medical claims payable for the years ended December 31, 2018, 2017 and 2016. Components of the total incurred claims for each year include amounts accrued for current year estimated claims expense as well as adjustments to prior year estimated accruals. In Note 11, “Medical Claims Payable,” the line labeled “Net incurred medical claims: Prior years redundancies” accounts for those adjustments made to prior year estimates. The impact of any reduction of “Net incurred medical claims: Prior years redundancies” may be offset as we establish the estimate of “Net incurred medical claims: Current year.” Our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for our claims. When we recognize a release of the redundancy, we disclose the amount that is not in the ordinary course of business, if material.

The ratio of current year medical claims paid as a percent of current year net medical claims incurred was 90.2% for 2018, 89.4% for 2017 and 89.2% for 2016. This ratio serves as an indicator of claims processing speed whereby claims were processed slightly faster during 2018 than in both 2017 and 2016.

We calculate the percentage of prior year redundancies in the current year as a percent of prior year net incurred claims payable less prior year redundancies in the current year in order to demonstrate the development of the prior year reserves. For the year ended December 31, 2018, this metric was 13.7%, largely driven by favorable trend factor development at the end of 2017 as well as favorable completion factor development from 2017. For the year ended December 31, 2017, this metric was 18.9%, largely driven by favorable trend factor development at the end of 2016 as well as favorable completion factor development from 2016. For the year ended December 31, 2016, this metric was 14.2%, largely driven by favorable trend factor development at the end of 2015.

We calculate the percentage of prior year redundancies in the current year as a percent of prior year net incurred medical claims to indicate the percentage of redundancy included in the preceding year calculation of current year net incurred medical claims. We believe this calculation supports the reasonableness of our prior year estimate of incurred medical claims and the consistency in our methodology. For the year ended December 31, 2018, this metric was 1.3%, which was calculated using the redundancy of $930. This metric was 1.8% for 2017 and 1.4% for 2016. These metrics demonstrate a generally consistent level of reserve conservatism.

The following table shows the variance between total net incurred medical claims as reported in Note 11, “Medical Claims Payable,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K, for each of 2017 and 2016 and the incurred claims for such years had it been determined retrospectively (computed as the difference between “net incurred medical claims – current year” for the year shown and “net incurred medical claims – prior years redundancies” for the immediately following year):

	Years Ended December 31	
	2017	2016
Total net incurred medical claims, as reported	$ 69,244	$ 64,033
Retrospective basis, as described above	69,447	63,735
Variance	$ (203)	$ 298
Variance to total net incurred medical claims, as reported	(0.3)%	0.5%

Given that our business is primarily short tailed (which means that medical claims are generally paid within twelve months of the member receiving service from the provider), the variance to total net incurred medical claims, as reported above, is used to assess the reasonableness of our estimate of ultimate incurred medical claims for a given calendar year with the benefit of one year of experience. We expect that substantially all of the development of the 2018 estimate of medical claims payable will be known during 2019.

The 2017 variance to total net incurred medical claims, as reported of (0.3)% was less than the 2016 percentage of 0.5%. The higher 2016 variance was driven by a similar level of prior year redundancies in 2017 associated with 2016 claim payments to the prior year redundancies in 2016 associated with 2015 claims payments. Prior year redundancies in 2018 associated with 2017 claim payments were lower by comparison to the previous year, thus creating a smaller 2017 variance.

Income Taxes

We account for income taxes in accordance with FASB guidance, which requires, among other things, the separate recognition of deferred tax assets and deferred tax liabilities. Such deferred tax assets and deferred tax liabilities represent the tax effect of temporary differences between financial reporting and tax reporting measured at tax rates enacted at the time the deferred tax asset or liability is recorded. A valuation allowance must be established for deferred tax assets if it is “more likely than not” that all or a portion may be unrealized. Our judgment is required in determining an appropriate valuation allowance.

At each financial reporting date, we assess the adequacy of the valuation allowance by evaluating each of our deferred tax assets based on the following:

- the types of temporary differences that created the deferred tax asset;
- the amount of taxes paid in prior periods and available for a carry-back claim;
- the tax rate at which the deferred tax assets will likely be utilized at in the future;
- the forecasted future taxable income, and therefore, likely future deduction of the deferred tax item; and
- any significant other issues impacting the likely realization of the benefit of the temporary differences.

We, like other companies, frequently face challenges from tax authorities regarding the amount of taxes due. These challenges include questions regarding the timing and amount of deductions that we have taken on our tax returns. In evaluating any additional tax liability associated with various positions taken in our tax return filings, we record additional liabilities for potential adverse tax outcomes. Based on our evaluation of our tax positions, we believe we have appropriately accrued for uncertain tax benefits, as required by the guidance. To the extent we prevail in matters we have accrued for, our future effective tax rate would be reduced and net income would increase. If we are required to pay more than accrued, our future effective tax rate would increase and net income would decrease. Our effective tax rate and net income in any given future period could be materially impacted.

In the ordinary course of business, we are regularly audited by federal and other tax authorities, and from time to time, these audits result in proposed assessments. We believe our tax positions comply with applicable tax law and we intend to defend our positions vigorously through the federal, state and local appeals processes. We believe we have adequately provided for any reasonably foreseeable outcome related to these matters. Accordingly, although their ultimate resolution may require additional tax payments, we do not anticipate any material impact on our results of operations or financial condition from these matters.

For additional information, see Note 7, “Income Taxes,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Goodwill and Other Intangible Assets

Our consolidated goodwill at December 31, 2018 was $20,504 and other intangible assets were $9,007. The sum of goodwill and other intangible assets represented 41.2% of our total consolidated assets and 103.4% of our consolidated shareholders’ equity at December 31, 2018.

We follow FASB guidance for business combinations and goodwill and other intangible assets, which specifies the types of acquired intangible assets that are required to be recognized and reported separately from goodwill. Under the guidance, goodwill and other intangible assets (with indefinite lives) are not amortized but are tested for impairment at least annually. Furthermore, goodwill and other intangible assets are allocated to reporting units for purposes of the annual impairment test. Our impairment tests require us to make assumptions and judgments regarding the estimated fair value of our reporting units, which include goodwill and other intangible assets. In addition, certain other intangible assets with indefinite lives, such as trademarks, are also tested separately.

We complete our annual impairment tests of existing goodwill and other intangible assets with indefinite lives during the fourth quarter of each year. These tests involve the use of estimates related to the fair value of goodwill at the reporting unit level and other intangible assets with indefinite lives, and require a significant degree of management judgment and the use of subjective assumptions. Certain interim impairment tests are also performed when potential impairment indicators exist or changes in our business or other triggering events occur. We have the option of first performing a qualitative assessment for each reporting unit to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount which is an indication that our goodwill may be impaired. These qualitative impairment tests include assessing events and factors that could affect the fair value of the indefinite-lived intangible assets. Our procedures include assessing our financial performance, macroeconomic conditions, industry and market considerations, various asset specific factors and entity specific events. If we determine that a reporting unit’s goodwill may be impaired after utilizing these qualitative impairment analysis procedures, we are required to perform a quantitative impairment test.

Our quantitative impairment test utilizes the projected income and market valuation approaches for goodwill and the projected income approach for our indefinite lived intangible assets. Use of the projected income and market valuation approaches for our goodwill impairment test reflects our view that both valuation methodologies provide a reasonable estimate of fair value. The projected income approach is developed using assumptions about future revenue, expenses and net income derived from our internal planning process. These estimated future cash flows are then discounted. Our assumed discount rate is based on our industry’s weighted-average cost of capital. Market valuations are based on observed multiples of certain measures including revenue, EBITDA, and book value of invested capital (debt and equity) and include market comparisons to publicly traded companies in our industry.

We did not incur any impairment losses as a result of our 2018 annual impairment tests, as the estimated fair values of our reporting units were substantially in excess of the carrying values as of December 31, 2018. Additionally, we do not believe that the estimated fair values of our reporting units are at risk of becoming impaired in the next twelve months.

While we believe we have appropriately allocated the purchase price of our acquisitions, this allocation requires many assumptions to be made regarding the fair value of assets and liabilities acquired. In addition, estimated fair values developed based on our assumptions and judgments might be significantly different if other reasonable assumptions and estimates were to be used. If estimated fair values are less than the carrying values of goodwill and other intangibles with indefinite lives in future annual impairment tests, or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

For additional information, see Note 3, “Business Acquisitions” and Note 9, “Goodwill and Other Intangible Assets,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Investments

Current and long-term marketable investment securities were $18,705 at December 31, 2018 and represented 26.1% of our total consolidated assets at December 31, 2018. We classify fixed maturity securities in our investment portfolio as “available-for-sale” or “trading” and report those securities at fair value. Certain fixed maturity securities are available to support current operations and, accordingly, we classify such investments as current assets without regard to their contractual maturity. Investments used to satisfy contractual, regulatory or other requirements are classified as long-term, without regard to contractual maturity.

We review fixed maturity investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis, using both qualitative and quantitative factors, to determine whether a decline in value is other-than-temporary. Such factors considered include the length of time and the extent to which a security’s market value has been less than its cost, the reasons for the decline in value (i.e., credit event compared to liquidity, general credit spread widening, currency exchange rate or interest rate factors), financial condition and near term prospects of the issuer, including the credit ratings and changes in the credit ratings of the issuer, recommendations of investment advisors, and forecasts of economic, market or industry trends.

FASB other-than-temporary impairment, or OTTI, guidance applies to fixed maturity securities and provides guidance on the recognition, presentation of, and disclosures for OTTIs. If a fixed maturity security is in an unrealized loss position and we have the intent to sell the fixed maturity security, or it is more likely than not that we will have to sell the fixed maturity security before recovery of its amortized cost basis, the decline in value is deemed to be other-than-temporary and is presented within the other-than-temporary impairment losses recognized in the income line item on our consolidated statements of income. For impaired fixed maturity securities that we do not intend to sell or it is more likely than not that we will not have to sell such securities, but we expect that we will not fully recover the amortized cost basis, the credit component of the OTTI is presented within the other-than-temporary impairment losses recognized in the income line item on our consolidated statements of income and the non-credit component of the OTTI is recognized in other comprehensive income. Furthermore, unrealized losses entirely caused by non-credit related factors related to fixed maturity securities for which we expect to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive loss.

The credit component of an OTTI is determined primarily by comparing the net present value of projected future cash flows with the amortized cost basis of the fixed maturity security. The net present value is calculated by discounting our best estimate of projected future cash flows at the effective interest rate implicit in the fixed maturity security at the date of acquisition. For mortgage-backed and asset-backed securities, cash flow estimates are based on assumptions regarding the underlying collateral, including prepayment speeds, vintage, type of underlying asset, geographic concentrations, default rates, recoveries and changes in value. For all other securities, cash flow estimates are driven by assumptions regarding probability of default, including changes in credit ratings and estimates regarding timing and amount of recoveries associated with a default.

We have a committee of accounting and investment associates and management that is responsible for managing the impairment review process. We believe we have adequately reviewed our investment securities for impairment and that our investment securities are carried at fair value. However, over time, the economic and market environment may provide additional insight regarding the fair value of certain securities, which could change our judgment regarding impairment. This could result in OTTI losses on investments being charged against future income. Given the uncertainty of future market conditions, as well as the significant judgments involved, there is continuing risk that declines in fair value may occur and material OTTI losses on investments may be recorded in future periods.

In addition to marketable investment securities, we held additional long-term investments of $3,726, or 5.2% of total consolidated assets, at December 31, 2018. These long-term investments consisted primarily of certain other equity investments, the cash surrender value of corporate-owned life insurance policies and real estate. Due to their less liquid nature, these investments are classified as long-term.

Through our investing activities, we are exposed to financial market risks, including those resulting from changes in interest rates and changes in equity market valuations. We manage market risks through our investment policy, which establishes credit quality limits and limits on investments in individual issuers. Ineffective management of these risks could have an impact on our future results of operations and financial condition. Our investment portfolio includes fixed maturity securities with a fair value of $17,179 at December 31, 2018. The weighted-average credit rating of these securities was “A” as of December 31, 2018. Included in this balance are investments in fixed maturity securities of states, municipalities and political subdivisions of $947 that are guaranteed by third parties. With the exception of seven securities with a fair value of $16, these securities are all investment-grade and carry a weighted-average credit rating of “A” as of December 31, 2018. The securities are guaranteed by a number of different guarantors, and we do not have any material exposure to any single guarantor, neither indirectly through the guarantees, nor directly through investment in the guarantor. Further, due to the high underlying credit rating of the issuers, the weighted-average credit rating of the fixed maturity securities without a guarantee, for which such information is available, was “A” as of December 31, 2018.

Fair values of fixed maturity and equity securities are based on quoted market prices, where available. These fair values are obtained primarily from third-party pricing services, which generally use Level I or Level II inputs for the determination of fair value in accordance with FASB guidance for fair value measurements and disclosures. We have controls in place to review the pricing services’ qualifications and procedures used to determine fair values. In addition, we periodically review the pricing services’ pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable.

We obtain quoted market prices for each security from the pricing services, which are derived through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available market observable information. For securities not actively traded, the pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in these valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. As we are responsible for the determination of fair value, we perform analysis on the prices received from the pricing services to determine whether the prices are reasonable estimates of fair value. Our analysis includes procedures such as a review of month-to-month price fluctuations and price comparisons to secondary pricing services. There were no adjustments to quoted market prices obtained from the pricing services during the years ended December 31, 2018 and 2017.

In certain circumstances, it may not be possible to derive pricing model inputs from observable market activity, and therefore, such inputs are estimated internally. Such securities are designated Level III in accordance with FASB guidance. Securities designated Level III at December 31, 2018 totaled $623 and represented approximately 2.9% of our total assets measured at fair value on a recurring basis. Our Level III securities primarily consisted of certain corporate securities and equity securities for which observable inputs were not always available and the fair values of these securities were estimated using internal estimates for inputs including, but not limited to, prepayment speeds, credit spreads, default rates and benchmark yields.

For additional information, see Part II, Item 7A “Quantitative and Qualitative Disclosures about Market Risk,” and Note 2, “Basis of Presentation and Significant Accounting Policies,” Note 4, “Investments,” and Note 6, “Fair Value,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Retirement Benefits

Pension Benefits

We sponsor defined benefit pension plans for some of our employees. These plans are accounted for in accordance with FASB guidance for retirement benefits, which requires that amounts recognized in financial statements be determined on an actuarial basis. As permitted by the guidance, we calculate the value of plan assets as described below. Further, the difference between our expected rate of return and the actual performance of plan assets, as well as certain changes in pension liabilities, are amortized over future periods.

An important factor in determining our pension expense is the assumption for expected long-term return on plan assets. As of our December 31, 2018 measurement date, we selected a weighted-average long-term rate of return on plan assets of 7.44%. We use a total portfolio return analysis in the development of our assumption. Factors such as past market performance, the long-term relationship between fixed maturity and equity securities, interest rates, inflation and asset

allocations are considered in the assumption. The assumption includes an estimate of the additional return expected from active management of the investment portfolio. Peer data and an average of historical returns are also reviewed for appropriateness of the selected assumption. We believe our assumption of future returns is reasonable. However, if we lower our expected long-term return on plan assets, future contributions to the pension plan and pension expense would likely increase.

This assumed long-term rate of return on assets is applied to a calculated value of plan assets, which recognizes changes in the fair value of plan assets in a systematic manner over three years, producing the expected return on plan assets that is included in the determination of pension expense. We apply a corridor approach to amortize unrecognized actuarial gains or losses. Under this approach, only accumulated net actuarial gains or losses in excess of 10% of the greater of the projected benefit obligation or the fair value of plan assets are amortized over the average remaining service or lifetime of the workforce as a component of pension expense. The net deferral of past asset gains or losses affects the calculated value of plan assets and, ultimately, future pension expense.

The discount rate reflects the current rate at which the pension liabilities could be effectively settled at the end of the year based on our most recent measurement date. At the December 31, 2017 measurement date, we changed the discount rate setting methodology from the single equivalent discount rate to the annual spot rate approach. Under the spot rate approach, individual spot rates from a full yield curve of published rates are used to discount each plan's cash flows to determine the plan's obligation. The spot rate approach produces a more precise measure of service and interest cost, and results in obligations that are equal at the measurement date under both methods. At the December 31, 2018 measurement date, the weighted-average discount rate under the annual spot rate approach was 4.15%, compared to 3.44% at the December 31, 2017 measurement date. The net effect of changes in the discount rate, as well as the net effect of other changes in actuarial assumptions and experience, have been deferred and amortized as a component of pension expense in accordance with FASB guidance.

In managing the plan assets, our objective is to be a responsible fiduciary while minimizing financial risk. Plan assets include a diversified mix of investment grade fixed maturity securities, equity securities and alternative investments across a range of sectors and levels of capitalization to maximize the long-term return for a prudent level of risk. In addition to producing a reasonable return, the investment strategy seeks to minimize the volatility in our expense and cash flow.

Effective January 1, 2019, we curtailed the benefits under the Anthem Cash Balance Plan B pension plan. All grandfathered participants will no longer have pay credits added to their accounts, but will continue to earn interest on existing account balances. Participants will continue to earn years of pension service for vesting purposes.

Other Postretirement Benefits

We provide most associates with certain medical, vision and dental benefits upon retirement. We use various actuarial assumptions, including a discount rate and the expected trend in healthcare costs, to estimate the costs and benefit obligations for our retiree benefits.

At our December 31, 2018 measurement date, the selected discount rate for all plans was 4.04%, compared to a discount rate of 3.42% at the December 31, 2017 measurement rate. We developed this rate using the annual spot rate approach as described above.

The assumed healthcare cost trend rates used to measure the expected cost of pre-Medicare (those who are not currently eligible for Medicare benefits) other benefits at our December 31, 2018 measurement date was 7.50% for 2019 with a gradual decline to 4.50% by the year 2028. The assumed healthcare cost trend rates used to measure the expected cost of post-Medicare (those who are currently eligible for Medicare benefits) other benefits at our December 31, 2018 measurement date was 6.00% for 2019 with a gradual decline to 4.50% by the year 2028. These estimated trend rates are subject to change in the future. The healthcare cost trend rate assumption affects the amounts reported. For example, an increase in the assumed healthcare cost trend rate of one percentage point would increase the postretirement benefit obligation as of December 31, 2018 by $24 and would increase service and interest costs by $1. Conversely, a decrease in the assumed healthcare cost trend rate of one percentage point would decrease the postretirement benefit obligation as of December 31, 2018 by $21 and would decrease service and interest costs by $1.

For additional information regarding our retirement benefits, see Note 10, “Retirement Benefits,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

New Accounting Pronouncements

For information regarding new accounting pronouncements that were issued or became effective during the year ended December 31, 2018 that had, or are expected to have, a material impact on our financial position, results of operations or financial statement disclosures, see the “*Recently Adopted Accounting Guidance*” and “*Recent Accounting Guidance Not Yet Adopted*” sections of Note 2, “Basis of Presentation and Significant Accounting Policies,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Liquidity and Capital Resources

Introduction

Our cash receipts result primarily from premiums, administrative fees and other revenue, investment income, proceeds from the sale or maturity of our investment securities, proceeds from borrowings, and proceeds from the issuance of common stock under our employee stock plans. Cash disbursements result mainly from claims payments, administrative expenses, taxes, purchases of investment securities, interest expense, payments on borrowings, acquisitions, capital expenditures, repurchases of our debt securities and common stock and the payment of cash dividends. Cash outflows fluctuate with the amount and timing of settlement of these transactions. Any future decline in our profitability would likely have an unfavorable impact on our liquidity.

We manage our cash, investments and capital structure so we are able to meet the short-term and long-term obligations of our business while maintaining financial flexibility and liquidity. We forecast, analyze and monitor our cash flows to enable investment and financing within the overall constraints of our financial strategy.

A substantial portion of the assets held by our regulated subsidiaries are in the form of cash and cash equivalents and investments. After considering expected cash flows from operating activities, we generally invest cash that exceeds our near term obligations in longer term marketable fixed maturity securities to improve our overall investment income returns. Our investment strategy is to make investments consistent with insurance statutes and other regulatory requirements, while preserving our asset base. Our investments are generally available-for-sale to meet liquidity and other needs. Our subsidiaries pay out excess capital annually in the form of dividends to their respective parent companies for general corporate use, as permitted by applicable regulations.

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, debt ratings, contractual restrictions, regulatory requirements and market conditions. The securities and credit markets have in the past experienced higher than normal volatility, although current market conditions are more stable. During recent years, the federal government and various governmental agencies have taken a number of steps to improve liquidity in the financial markets and strengthen the regulation of the financial services market. In addition, governments around the world have developed their own plans to provide liquidity and security in the credit markets and to ensure adequate capital in certain financial institutions.

We have a $2,500 commercial paper program. Should commercial paper issuance be unavailable, we have the ability to use a combination of cash on hand and/or our $3,500 senior revolving credit facility to redeem any outstanding commercial paper upon maturity. Additionally, we believe the lenders participating in our credit facility would be willing and able to provide financing in accordance with their legal obligations. In addition to the $3,500 senior revolving credit facility, we estimate that we expect to receive approximately $2,680 of dividends from our subsidiaries during 2019, which also provides further operating and financial flexibility.

A summary of our major sources and uses of cash and cash equivalents for the years ended December 31, 2018, 2017 and 2016 is as follows:

	Years Ended December 31			$ Change	
	2018	2017	2016	2018 vs. 2017	2017 vs. 2016
Sources of Cash					
Net cash provided by operating activities	$ 3,827	$ 4,185	$ 3,270	$ (358)	$ 915
Proceeds from sales, maturities, calls and redemptions of investments, net of purchases	1,929	—	—	1,929	—
Issuance of common stock under Equity Units stock purchase contracts	1,250	—	—	1,250	—
Issuances of commercial paper and short- and long-term debt, net of repayments	—	3,653	—	(3,653)	3,653
Issuances of common stock under employee stock plans	173	225	120	(52)	105
Changes in bank overdrafts	—	71	513	(71)	(442)
Other sources of cash, net	174	712	276	(538)	436
Total sources of cash	7,353	8,846	4,179	(1,493)	4,667
Uses of Cash:					
Purchases of investments, net of proceeds from sales, maturities, calls and redemptions	—	(2,913)	(114)	2,913	(2,799)
Purchases of subsidiaries, net of cash acquired	(1,760)	(2,080)	—	320	(2,080)
Repurchase and retirement of common stock	(1,685)	(1,998)	—	313	(1,998)
Purchases of property and equipment	(1,208)	(800)	(584)	(408)	(216)
Repayments of commercial paper and short- and long-term debt, net of issuances	(1,086)	—	(153)	(1,086)	153
Cash dividends	(776)	(705)	(684)	(71)	(21)
Changes in bank overdrafts	(210)	—	—	(210)	—
Other uses of cash, net	(301)	(820)	(687)	519	(133)
Total uses of cash	(7,026)	(9,316)	(2,222)	2,290	(7,094)
Effect of foreign exchange rates on cash and cash equivalents	(2)	4	5	(6)	(1)
Net increase (decrease) in cash and cash equivalents	$ 325	$ (466)	$ 1,962	$ 791	$ (2,428)

Liquidity—Year Ended December 31, 2018 Compared to Year Ended December 31, 2017

The decrease in cash provided by operating activities was primarily due to increased spend to support growth initiatives and the impact of membership declines due to our reduced participation in ACA-compliant Individual marketplaces, and to a lesser extent, membership declines in our fully-insured Local Group business. The decrease in cash provided by operating activities was partially offset by cash receipts related to rate increases across our businesses designed to cover overall cost trends. The decrease was further offset by lower income taxes paid in 2018 as a result of the Tax Cuts and Jobs Act.

Other significant changes in sources and uses of cash year-over-year included an increase in net proceeds from sales of investments and the issuance of common stock under our Equity Units stock purchase contracts in 2018. These increases in cash were partially offset by an increase in net repayments of commercial paper and short- and long-term debt and increased purchases of property and equipment.

Liquidity— Year Ended December 31, 2017 Compared to Year Ended December 31, 2016

The increase in cash provided by operating activities was primarily attributable to an increase in premium receipts as a result of both rate increases across our businesses designed to cover overall cost trends and growth in membership. The increase in cash flow was partially offset by an increase in claims payments due to higher medical cost experience and

growth in membership. The increase was further offset by an increase in spend to support our growth initiatives, the timing of provider capitation payments for pass-through funding under the California Medicaid contract and the timing of certain state Medicaid payments.

Other significant changes in sources and uses of cash year-over-year included an increase in net purchases of investments, cash paid for acquisitions in 2017 and repurchases and retirement of common stock in 2017. These decreases in cash were partially offset by the cash received from the issuances of commercial paper and short- and long-term debt, net of repayments.

Financial Condition

We maintained a strong financial condition and liquidity position, with consolidated cash, cash equivalents and investments in fixed maturity and equity securities of $22,639 at December 31, 2018. Since December 31, 2017, total cash, cash equivalents and investments in fixed maturity and equity securities decreased by $2,540 primarily due to cash used for acquisitions, purchases of property and equipment, repurchases of our common stock, net repayments of commercial paper and short- and long-term debt and cash dividends paid to shareholders. These decreases were partially offset by cash generated from operations and the proceeds received from the issuance of our common stock under Equity Units stock purchase contracts.

Many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid to their respective parent companies. Certain accounting practices prescribed by insurance regulatory authorities, or statutory accounting practices, differ from GAAP. Changes that occur in statutory accounting practices, if any, could impact our subsidiaries' future dividend capacity. In addition, we have agreed to certain undertakings to regulatory authorities, including the requirement to maintain certain capital levels in certain of our subsidiaries.

At December 31, 2018, we held $1,949 of cash, cash equivalents and investments at the parent company, which are available for general corporate use, including investment in our businesses, acquisitions, potential future common stock repurchases and dividends to shareholders, repurchases of debt securities and debt and interest payments.

Debt

Periodically, we access capital markets and issue debt, or Notes, for long-term borrowing purposes, for example, to refinance debt, to finance acquisitions or for share repurchases. Certain of these Notes may have a call feature that allows us to redeem the Notes at any time at our option and/or a put feature that allows a Note holder to redeem the Notes upon the occurrence of both a change in control event and a downgrade of the Notes below an investment grade rating. For more information on our debt, including redemptions and issuances, see Note 12, "Debt" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We calculate our consolidated debt-to-capital ratio, a non-GAAP measure, from the amounts presented on our audited consolidated balance sheets included in Part II, Item 8 of this Annual Report on Form 10-K. Our debt-to-capital ratio is calculated as total debt divided by total debt plus total shareholders' equity. Total debt is the sum of short-term borrowings, current portion of long-term debt, and long-term debt, less current portion. We believe our debt-to-capital ratio assists investors and rating agencies in measuring our overall leverage and additional borrowing capacity. In addition, our bank covenants include a maximum debt-to-capital ratio that we cannot and did not exceed. Our debt-to-capital ratio may not be comparable to similarly titled measures reported by other companies. Our consolidated debt-to-capital ratio was 40.2% and 42.9% as of December 31, 2018 and 2017, respectively.

Our senior debt is rated "A" by S&P Global, "BBB" by Fitch Ratings, Inc., "Baa2" by Moody's Investor Service, Inc. and "bbb+" by AM Best Company, Inc. We intend to maintain our senior debt investment grade ratings. If our credit ratings are downgraded, our business, financial condition and results of operations could be adversely impacted by limitations on future borrowings and a potential increase in our borrowing costs.

Future Sources and Uses of Liquidity

We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansions.

We have a senior revolving credit facility, or the Facility, with a group of lenders for general corporate purposes. The Facility provides credit up to $3,500 and matures on August 25, 2020. Our ability to borrow under the Facility is subject to compliance with certain covenants. There were no amounts outstanding under the Facility at December 31, 2018.

We have an authorized commercial paper program of up to $2,500, the proceeds of which may be used for general corporate purposes. At December 31, 2018, we had $697 outstanding under our commercial paper program.

We are a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati and the Federal Home Loan Bank of Atlanta, or collectively, the FHLBs. As a member we have the ability to obtain short-term cash advances, subject to certain minimum collateral requirements. At December 31, 2018, we had $645 outstanding under our short-term FHLB borrowings.

Through certain subsidiaries, we have entered into multiple 364-day lines of credit with separate lenders for general corporate purposes. These lines of credit provide combined credit up to $600. Our ability to borrow under the lines of credit is subject to compliance with certain covenants. At December 31, 2018 we had $500 outstanding under our 364-day lines of credit.

As discussed in "*Financial Condition*" above, many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid. Based upon these requirements, we currently estimate that approximately $2,680 of dividends will be paid to the parent company during 2019. During 2018, we received $3,606 of dividends from our subsidiaries.

We regularly review the appropriate use of capital, including acquisitions, common stock and debt security repurchases and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors.

On January 29, 2019, our Audit Committee declared a quarterly cash dividend to shareholders of $0.80 per share on the outstanding shares of our common stock. This quarterly dividend is payable on March 29, 2019 to the shareholders of record as of March 18, 2019.

Under our Board of Directors' authorization, we maintain a common stock repurchase program. As of December 31, 2018, we had Board authorization of $5,493 to repurchase our common stock.

For additional information regarding our sources and uses of capital, see Note 4, "Investments," Note 5 "Derivative Financial Instruments," Note 12 "Debt" and Note 14 "Capital Stock-*Use of Capital-Dividends and Stock Repurchase Program*" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Contractual Obligations and Commitments

Our estimated contractual obligations and commitments as of December 31, 2018 are as follows:

		Payments Due by Period			
	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
On-Balance Sheet:					
Debt[1]	$ 29,640	$ 3,379	$ 3,568	$ 3,695	$ 18,998
Other long-term liabilities[2]	1,374	30	574	472	298
Off-Balance Sheet:					
Purchase obligations[3]	3,849	1,261	1,151	1,345	92
Operating lease commitments	1,117	192	304	236	385
Investment commitments[4]	873	263	281	35	294
Total contractual obligations and commitments	$ 36,853	$ 5,125	$ 5,878	$ 5,783	$ 20,067

1 Includes estimated interest expense.
2 Primarily consists of reserves for future policy benefits, projected other postretirement benefits, deferred compensation, supplemental executive retirement plan liabilities and certain other miscellaneous long-term obligations. Estimated future payments for funded pension benefits have been excluded from this table as we had no funding requirements under ERISA at December 31, 2018 as a result of the value of the assets in the plans.
3 Includes estimated payments for future services under contractual arrangements from third-party service contracts.
4 Includes unfunded capital commitments for alternative investments.

The above table does not contain $278 of gross liabilities for uncertain tax positions and interest for which we cannot reasonably estimate the timing of the resolutions with the respective taxing authorities. For further information, see Note 7, “Income Taxes,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

In addition to the contractual obligations and commitments discussed above, we have a variety of other contractual agreements related to acquiring materials and services used in our operations. However, we do not believe these other agreements contain material noncancelable commitments.

We believe that funds from future operating cash flows, cash and investments and funds available under our Facility and/or from public or private financing sources, will be sufficient for future operations and commitments, and for capital acquisitions and other strategic transactions.

Off-Balance Sheet Arrangements

We do not have any off-balance sheet derivative instruments, guarantee transactions, agreements or other contractual arrangements or any indemnification agreements that will require funding in future periods. We have not transferred assets to an unconsolidated entity that serves as credit, liquidity or market risk support to such entity. We do not hold any variable interest in an unconsolidated entity where such entity provides us with financing, liquidity, market risk or credit risk support.

Risk-Based Capital

Our regulated subsidiaries’ states of domicile have statutory risk-based capital, or RBC, requirements for health and other insurance companies and HMOs largely based on the National Association of Insurance Commissioners, or NAIC, Risk-Based Capital (RBC) For Health Organizations Model Act, or RBC Model Act. These RBC requirements are intended to measure capital adequacy, taking into account the risk characteristics of an insurer’s investments and products. The NAIC sets forth the formula for calculating the RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual insurance company’s business. In general, under the RBC Model Act, an insurance company must submit a report of its RBC level to the state insurance department or insurance commissioner, as appropriate, at the end of each calendar year. Our regulated subsidiaries’ respective RBC levels as

of December 31, 2018, which was the most recent date for which reporting was required, were in excess of all mandatory RBC requirements. In addition to exceeding the RBC requirements, we are in compliance with the liquidity and capital requirements for a licensee of the BCBSA and with the tangible net worth requirements applicable to certain of our California subsidiaries.

For additional information, see Note 21, “Statutory Information,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK.

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

As a result of our investing and borrowing activities, we are exposed to financial market risks, including those resulting from changes in interest rates and changes in market valuations. Potential impacts discussed below are based upon sensitivity analyses performed on our financial position as of December 31, 2018. Actual results could vary from these estimates. Our primary objectives with our investment portfolio are to provide safety and preservation of capital, sufficient liquidity to meet cash flow requirements, the integration of investment strategy with the business operations and an attainment of a competitive after-tax total return.

Investments

Our investment portfolio is exposed to three primary sources of risk: credit quality risk, interest rate risk and market valuation risk.

The primary risks associated with our fixed maturity securities, which are classified as available-for-sale, are credit quality risk and interest rate risk. Credit quality risk is defined as the risk of a credit event, such as a ratings downgrade or default, to an individual fixed maturity security and the potential loss attributable to that event. Credit quality risk is managed through our investment policy, which establishes credit quality limitations on the overall portfolio as well as diversification and percentage limits on securities of individual issuers. The result is a well-diversified portfolio of fixed maturity securities, with an average credit rating of approximately “A.” Interest rate risk is defined as the potential for economic losses on fixed maturity securities due to a change in market interest rates. Our fixed maturity portfolio is invested primarily in U.S. government securities, corporate bonds, asset-backed bonds, mortgage-related securities and municipal bonds, all of which have exposure to changes in the level of market interest rates. Interest rate risk is managed by maintaining asset duration within a band based upon our liabilities, operating performance and liquidity needs. Additionally, we have the capability of holding any security to maturity, which would allow us to realize full par value.

Investments in fixed maturity securities include corporate securities which account for 46.2% of the total fixed maturity securities at December 31, 2018 and are subject to credit/default risk. In a declining economic environment, corporate yields will usually increase prompted by concern over the ability of corporations to make interest payments, thus causing a decrease in the price of corporate securities, and the decline in value of the corporate fixed maturity portfolio. We manage this risk through fundamental credit analysis, diversification of issuers and industries and an average credit rating of our corporate fixed maturity portfolio of approximately “BBB.”

Market risk for fixed maturity securities is addressed by actively managing the duration, allocation and diversification of our investment portfolio. We have evaluated the impact on the fixed maturity portfolio’s fair value considering an immediate 100 basis point change in interest rates. A 100 basis point increase in interest rates would result in an approximate $733 decrease in fair value, whereas a 100 basis point decrease in interest rates would result in an approximate $723 increase in fair value. While we classify our fixed maturity securities as “available-for-sale” for accounting purposes, we believe our cash flows and the duration of our portfolio should allow us to hold securities to maturity, thereby avoiding the recognition of losses should interest rates rise significantly.

Our equity portfolio is comprised of large capitalization and small capitalization domestic equities, foreign equities, exchange-traded funds and index mutual funds. Our equity portfolio is subject to the volatility inherent in the stock market, driven by concerns over economic conditions, earnings and sales growth, inflation, and consumer confidence. These systemic risks cannot be managed through diversification alone. However, more routine risks, such as stock/industry specific risks, are managed by investing in a diversified equity portfolio.

As of December 31, 2018, 8.2% of our investments were equity securities. An immediate 10% decrease in each equity investment's value, arising from market movement, would result in a fair value decrease of $153. Alternatively, an immediate 10% increase in each equity investment's value, attributable to the same factor, would result in a fair value increase of $153.

For additional information regarding our investments, see Note 4, "*Investments*," of the Notes to Consolidated Financial Statements included in Part II, Item 8 and "Critical Accounting Policies and Estimates - *Investments*" within Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K.

Long-Term Debt

Our total long-term debt at December 31, 2018 consists of senior unsecured notes, convertible debentures, commercial paper and subordinated surplus notes by one of our insurance subsidiaries. At December 31, 2018, the carrying value and estimated fair value of our long-term debt was $18,066 and $18,872, respectively. This debt is subject to interest rate risk as these instruments have fixed interest rates and the fair value is affected by changes in market interest rates. Should interest rates increase or decrease in the future, the estimated fair value of our fixed rate debt would decrease or increase accordingly.

For additional information regarding our long-term debt, see Note 6, "Fair Value" and Note 12, "Debt" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Derivatives

We have exposure to economic losses due to interest rate risk arising from changes in the level or volatility of interest rates. We attempt to mitigate our exposure to interest rate risk through the use of derivative financial instruments. These strategies include the use of interest rate swaps and forward contracts, which are used to lock-in interest rates or to hedge (on an economic basis) interest rate risks associated with variable rate debt. We have used these types of instruments as designated hedges against specific liabilities.

Changes in interest rates will affect the estimated fair value of these derivatives. As of December 31, 2018, we recorded a net liability of $4, the estimated fair value of the swaps at that date. We have evaluated the impact on the interest rate swaps' fair value considering an immediate 100 basis point change in interest rates. A 100 basis point increase in interest rates would result in an approximate $27 decrease in fair value, whereas a 100 basis point decrease in interest rates would result in an approximate $27 increase in fair value.

For additional information regarding our derivatives, see Note 5, "Derivative Financial Instruments" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA.

ANTHEM, INC.

CONSOLIDATED FINANCIAL STATEMENTS

Years ended December 31, 2018, 2017 and 2016

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Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of Anthem, Inc.

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Anthem, Inc. (the Company) as of December 31, 2018 and 2017, the related consolidated statements of income, comprehensive income, shareholders' equity, and cash flows for each of the three years in the period ended December 31, 2018, and the related notes and financial statement schedule listed in the Index at Item 15(c) (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated February 20, 2019 expressed an unqualified opinion thereon.

Adoption of New Accounting Standard

As discussed in Note 2 to the consolidated financial statements, the Company changed its method of accounting for non-consolidated equity investments not accounted for under the equity method of accounting by requiring changes in fair value to be recognized in income for the year ended December 31, 2018.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ ERNST & YOUNG LLP

We have served as the Company's auditor since 1944.

Indianapolis, Indiana
February 20, 2019

Anthem, Inc.
Consolidated Balance Sheets

	December 31, 2018	December 31, 2017
(In millions, except share data)		
Assets		
Current assets:		
Cash and cash equivalents	$ 3,934	$ 3,609
Fixed maturity securities, current (amortized cost of $16,894 and $17,055)	16,692	17,377
Equity securities, current	1,493	3,599
Other invested assets, current	21	17
Accrued investment income	162	163
Premium receivables	4,465	3,605
Self-funded receivables	2,278	2,580
Other receivables	2,558	2,267
Income taxes receivable	10	342
Securities lending collateral	604	455
Other current assets	2,104	2,249
Total current assets	34,321	36,263
Long-term investments:		
Fixed maturity securities (amortized cost of $486 and $555)	487	561
Equity securities	33	33
Other invested assets	3,726	3,344
Property and equipment, net	2,735	2,175
Goodwill	20,504	19,231
Other intangible assets	9,007	8,368
Other noncurrent assets	758	565
Total assets	$ 71,571	$ 70,540
Liabilities and shareholders' equity		
Liabilities		
Current liabilities:		
Policy liabilities:		
Medical claims payable	$ 7,454	$ 7,992
Reserves for future policy benefits	75	70
Other policyholder liabilities	2,590	2,950
Total policy liabilities	10,119	11,012
Unearned income	902	860
Accounts payable and accrued expenses	4,959	5,024
Security trades pending payable	197	113
Securities lending payable	604	454
Short-term borrowings	1,145	1,275
Current portion of long-term debt	849	1,275
Other current liabilities	3,190	3,343
Total current liabilities	21,965	23,356
Long-term debt, less current portion	17,217	17,382
Reserves for future policy benefits, noncurrent	706	647
Deferred tax liabilities, net	1,960	1,727
Other noncurrent liabilities	1,182	925
Total liabilities	43,030	44,037
Commitments and contingencies—Note 13		
Shareholders' equity		
Preferred stock, without par value, shares authorized - 100,000,000; shares issued and outstanding - none	—	—
Common stock, par value $0.01, shares authorized - 900,000,000; shares issued and outstanding - 257,395,577 and 256,084,913	3	3
Additional paid-in capital	9,536	8,547
Retained earnings	19,988	18,054
Accumulated other comprehensive loss	(986)	(101)
Total shareholders' equity	28,541	26,503
Total liabilities and shareholders' equity	$ 71,571	$ 70,540

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Income

(In millions, except per share data)	Years Ended December 31 2018	2017	2016
Revenues			
Premiums	$ 85,421	$ 83,648	$ 78,860
Administrative fees and other revenue	5,920	5,413	5,334
Total operating revenue	91,341	89,061	84,194
Net investment income	970	867	779
Net realized (losses) gains on financial instruments	(180)	145	5
Other-than-temporary impairment losses on investments:			
Total other-than-temporary impairment losses on investments	(29)	(35)	(147)
Portion of other-than-temporary impairment losses recognized in other comprehensive (loss) income	3	2	32
Other-than-temporary impairment losses recognized in income	(26)	(33)	(115)
Total revenues	92,105	90,040	84,863
Expenses			
Benefit expense	71,895	72,236	66,834
Selling, general and administrative expense	14,020	12,650	12,559
Interest expense	753	739	723
Amortization of other intangible assets	358	169	192
Loss on extinguishment of debt	11	282	—
Total expenses	87,037	86,076	80,308
Income before income tax expense	5,068	3,964	4,555
Income tax expense	1,318	121	2,085
Net income	$ 3,750	$ 3,843	$ 2,470
Net income per share			
Basic	$ 14.53	$ 14.70	$ 9.39
Diluted	$ 14.19	$ 14.35	$ 9.21
Dividends per share	$ 3.00	$ 2.70	$ 2.60

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Comprehensive Income

(In millions)	Years Ended December 31 2018	2017	2016
Net income	$ 3,750	$ 3,843	$ 2,470
Other comprehensive (loss) income, net of tax:			
Change in net unrealized gains/losses on investments	(418)	173	118
Change in non-credit component of other-than-temporary impairment losses on investments	(2)	4	5
Change in net unrealized gains/losses on cash flow hedges	37	(65)	(87)
Change in net periodic pension and postretirement costs	(90)	51	(13)
Foreign currency translation adjustments	(1)	3	2
Other comprehensive (loss) income	(474)	166	25
Total comprehensive income	$ 3,276	$ 4,009	$ 2,495

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Cash Flows

	Years Ended December 31		
(In millions)	**2018**	**2017**	**2016**
Operating activities			
Net income	$ 3,750	$ 3,843	$ 2,470
Adjustments to reconcile net income to net cash provided by operating activities:			
Net realized losses (gains) on financial instruments	180	(145)	(5)
Other-than-temporary impairment losses recognized in income	26	33	115
Loss on extinguishment of debt	11	282	—
Loss on disposal of assets	8	13	5
Deferred income taxes	91	(1,272)	127
Amortization, net of accretion	1,008	780	808
Depreciation expense	124	111	104
Impairment of property and equipment	5	2	45
Share-based compensation	226	170	165
Excess tax benefits from share-based compensation	—	—	(54)
Changes in operating assets and liabilities:			
Receivables, net	(695)	(22)	(1,381)
Other invested assets	(1)	(36)	(19)
Other assets	(26)	(629)	(128)
Policy liabilities	(1,059)	732	322
Unearned income	(36)	(120)	(174)
Accounts payable and accrued expenses	122	922	182
Other liabilities	(25)	(120)	606
Income taxes	323	(194)	179
Other, net	(205)	(165)	(97)
Net cash provided by operating activities	3,827	4,185	3,270
Investing activities			
Purchases of fixed maturity securities	(8,244)	(9,795)	(10,158)
Proceeds from fixed maturity securities:			
Sales	6,442	7,932	8,636
Maturities, calls and redemptions	1,938	1,848	1,419
Purchases of equity securities	(896)	(5,416)	(1,476)
Proceeds from sales of equity securities	2,809	3,463	1,593
Purchases of other invested assets	(531)	(1,164)	(433)
Proceeds from sales of other invested assets	411	219	305
Changes in collateral and settlement of non-hedging derivatives	—	65	(35)
Changes in securities lending collateral	(149)	625	222
Purchases of subsidiaries, net of cash acquired	(1,760)	(2,080)	—
Purchases of property and equipment	(1,208)	(800)	(584)
Proceeds from sales of property and equipment	—	9	—
Other, net	(71)	12	(3)
Net cash used in investing activities	(1,259)	(5,082)	(514)
Financing activities			
Net (repayments of) proceeds from commercial paper borrowings	(107)	175	(53)
Proceeds from long-term borrowings	835	5,458	—
Repayments of long-term borrowings	(1,684)	(2,815)	—
Proceeds from short-term borrowings	9,120	5,835	2,400
Repayments of short-term borrowings	(9,250)	(5,000)	(2,500)
Changes in securities lending payable	150	(625)	(222)
Changes in bank overdrafts	(210)	71	513
Proceeds from sale of put options	1	1	—
Proceeds from issuance of common stock under Equity Units stock purchase contracts	1,250	—	—
Repurchase and retirement of common stock	(1,685)	(1,998)	—
Change in collateral and settlements of debt-related derivatives	23	(149)	(360)
Cash dividends	(776)	(705)	(684)
Proceeds from issuance of common stock under employee stock plans	173	225	120
Taxes paid through withholding of common stock under employee stock plans	(81)	(46)	(67)
Excess tax benefits from share-based compensation	—	—	54

Net cash (used in) provided by financing activities	(2,241)	427	(799)
Effect of foreign exchange rates on cash and cash equivalents	(2)	4	5
Change in cash and cash equivalents	325	(466)	1,962
Cash and cash equivalents at beginning of year	3,609	4,075	2,113
Cash and cash equivalents at end of year	$ 3,934	$ 3,609	$ 4,075

See accompanying notes.

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Anthem, Inc.
Consolidated Statements of Shareholders' Equity

(In millions)	Common Stock Number of Shares	Common Stock Par Value	Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive Loss	Total Shareholders' Equity
January 1, 2016	261.2	$ 3	$ 8,556	$ 14,778	$ (292)	$ 23,045
Net income	—	—	—	2,470	—	2,470
Other comprehensive income	—	—	—	—	25	25
Dividends and dividend equivalents	—	—	—	(688)	—	(688)
Issuance of common stock under employee stock plans, net of related tax benefits	2.5	—	249	—	—	249
December 31, 2016	263.7	3	8,805	16,560	(267)	25,101
Net income	—	—	—	3,843	—	3,843
Other comprehensive income	—	—	—	—	166	166
Premiums for and settlement of equity options	—	—	1	—	—	1
Repurchase and retirement of common stock	(10.5)	—	(356)	(1,642)	—	(1,998)
Dividends and dividend equivalents	—	—	—	(707)	—	(707)
Issuance of common stock under employee stock plans, net of related tax benefits	2.9	—	342	—	—	342
Convertible debenture conversions	—	—	(245)	—	—	(245)
December 31, 2017	256.1	3	8,547	18,054	(101)	26,503
Adoption of Accounting Standards Update No. 2016-01 (Note 2)	—	—	—	320	(320)	—
January 1, 2018	256.1	3	8,547	18,374	(421)	26,503
Net income	—	—	—	3,750	—	3,750
Other comprehensive loss	—	—	—	—	(474)	(474)
Issuance of common stock under Equity Units stock purchase contracts	6.0	—	1,250	—	—	1,250
Premiums for and settlement of equity options	—	—	1	—	—	1
Repurchase and retirement of common stock	(6.8)	—	(243)	(1,442)	—	(1,685)
Dividends and dividend equivalents	—	—	—	(785)	—	(785)
Issuance of common stock under employee stock plans, net of related tax benefits	2.1	—	318	—	—	318
Convertible debenture conversions	—	—	(337)	—	—	(337)
Adoption of Accounting Standards Update No. 2018-02 (Note 2)	—	—	—	91	(91)	—
December 31, 2018	257.4	$ 3	$ 9,536	$ 19,988	$ (986)	$ 28,541

See accompanying notes.

Anthem, Inc.

Notes to Consolidated Financial Statements

December 31, 2018

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

1. Organization

References to the terms “we,” “our,” “us” or “Anthem” used throughout these Notes to Consolidated Financial Statements refer to Anthem, Inc., an Indiana corporation, and unless the context otherwise requires, its direct and indirect subsidiaries.

We are one of the largest health benefits companies in the United States in terms of medical membership, serving approximately 40 medical members through our affiliated health plans as of December 31, 2018. We offer a broad spectrum of network-based managed care plans to Large Group, Small Group, Individual, Medicaid and Medicare markets. Our managed care plans include: Preferred Provider Organizations, or PPOs; Health Maintenance Organizations, or HMOs; Point-of-Service, or POS, plans; traditional indemnity plans and other hybrid plans, including Consumer-Driven Health Plans, or CDHPs; and hospital only and limited benefit products. In addition, we provide a broad array of managed care services to self-funded customers, including claims processing, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services. We provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal healthcare. We also provide services to the federal government in connection with the Federal Employee Program®, or FEP®.

We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (in the New York City metropolitan area and upstate New York), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas, we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia, and Empire Blue Cross Blue Shield or Empire Blue Cross. We also conduct business through arrangements with other BCBS licensees in Louisiana, South Carolina and western New York. Through our subsidiaries, we also serve customers in over 25 states across the country as America’s 1st Choice, Amerigroup, Aspire Health, CareMore, Freedom Health, HealthLink, HealthSun, Optimum HealthCare, Simply Healthcare, and/or UniCare. We are licensed to conduct insurance operations in all 50 states and the District of Columbia through our subsidiaries.

2. Basis of Presentation and Significant Accounting Policies

Basis of Presentation: The accompanying consolidated financial statements include the accounts of Anthem and its subsidiaries and have been prepared in conformity with U.S. generally accepted accounting principles, or GAAP. All significant intercompany accounts and transactions have been eliminated in consolidation.

Certain of our subsidiaries operate outside of the United States and have functional currencies other than the U.S. dollar, or USD. We translate the assets and liabilities of those subsidiaries to USD using the exchange rate in effect at the end of the period. We translate the revenues and expenses of those subsidiaries to USD using the average exchange rates in effect during the period. The net effect of these translation adjustments is included in “Foreign currency translation adjustments” in our consolidated statements of comprehensive income.

Reclassifications: Certain prior year amounts have been reclassified to conform to the current year presentation or adjusted to conform to the current year rounding convention of reporting financial data in whole millions of dollars, except as otherwise noted.

Use of Estimates: The preparation of consolidated financial statements in conformity with GAAP requires us to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and Cash Equivalents: Cash and cash equivalents includes available cash and all highly liquid investments with maturities of three months or less when purchased. We control a number of bank accounts that are used exclusively to hold customer funds for the administration of customer benefits, and we have cash and cash equivalents on deposit to meet certain regulatory requirements. These amounts totaled $222 and $182 at December 31, 2018 and 2017, respectively, and are included in the cash and cash equivalents line on our consolidated balance sheets.

Investments: Financial Accounting Standards Board, or FASB, other-than-temporary impairment, or OTTI, guidance applies to fixed maturity securities and provides guidance on the recognition, presentation of, and disclosures for OTTIs. If a fixed maturity security is in an unrealized loss position and we have the intent to sell the fixed maturity security, or it is more likely than not that we will have to sell the fixed maturity security before recovery of its amortized cost basis, the decline in value is deemed to be other-than-temporary and is presented within the other-than-temporary impairment losses recognized in the income line item on our consolidated statements of income. For impaired fixed maturity securities that we do not intend to sell or it is more likely than not that we will not have to sell such securities, but we expect that we will not fully recover the amortized cost basis, the credit component of the OTTI is presented within the other-than-temporary impairment losses recognized in the income line item on our consolidated statements of income and the non-credit component of the OTTI is recognized in other comprehensive income. Furthermore, unrealized losses entirely caused by non-credit related factors related to fixed maturity securities for which we expect to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive loss.

The credit component of an OTTI is determined primarily by comparing the net present value of projected future cash flows with the amortized cost basis of the fixed maturity security. The net present value is calculated by discounting our best estimate of projected future cash flows at the effective interest rate implicit in the fixed maturity security at the date of acquisition. For mortgage-backed and asset-backed securities, cash flow estimates are based on assumptions regarding the underlying collateral, including prepayment speeds, vintage, type of underlying asset, geographic concentrations, default rates, recoveries and changes in value. For all other securities, cash flow estimates are driven by assumptions regarding probability of default, including changes in credit ratings and estimates regarding timing and amount of recoveries associated with a default.

For asset-backed securities included in fixed maturity securities, we recognize income using an effective yield based on anticipated prepayments and the estimated economic life of the securities. When estimates of prepayments change, the effective yield is recalculated to reflect actual payments to date and anticipated future payments. The net investment in the securities is adjusted to the amount that would have existed had the new effective yield been applied since the acquisition of the securities. Such adjustments are reported within net investment income.

Effective January 1, 2018 and in accordance with the FASB guidance, the changes in fair value of our marketable equity securities are recognized in our results of operations within the net realized gains and losses on financial instruments. Prior to 2018, the unrealized gains or losses on our equity securities previously classified as available-for-sale were included in accumulated other comprehensive loss as a separate component of shareholders' equity, unless the decline in value was deemed to be other-than-temporary and we did not have the intent and ability to hold such equity securities until their full cost can be recovered, in which case such equity securities were written down to fair value and the loss was charged to other-than-temporary impairment losses recognized in income.

We maintain various rabbi trusts to account for the assets and liabilities under certain deferred compensation plans. Under these plans, the participants can defer certain types of compensation and elect to receive a return on the deferred amounts based on the changes in fair value of various investment options, primarily a variety of mutual funds. We have corporate-owned life insurance policies on certain participants in our deferred compensation plans. The cash surrender value of the corporate-owned life insurance policies is reported in other invested assets, long-term, in the consolidated balance sheets. The remaining rabbi trust assets are generally invested according to the participant's investment election and are classified as trading, which are reported in other invested assets, current, in the consolidated balance sheets.

We use the equity method of accounting for investments in companies in which our ownership interest enables us to influence the operating or financial decisions of the investee company. Our proportionate share of equity in net income of these unconsolidated affiliates is reported within net investment income.

Investment income is recorded when earned. All securities sold resulting in investment gains and losses are recorded on the trade date. Realized gains and losses are determined on the basis of the cost or amortized cost of the specific securities sold.

We participate in securities lending programs whereby marketable securities in our investment portfolio are transferred to independent brokers or dealers in exchange for cash and securities collateral. Under FASB guidance related to accounting for transfers and servicing of financial assets and extinguishments of liabilities, we recognize the collateral as an asset, which is reported as securities lending collateral on our consolidated balance sheets, and we record a corresponding liability for the obligation to return the collateral to the borrower, which is reported as securities lending payable. The securities on loan are reported in the applicable investment category on our consolidated balance sheets. Unrealized gains or losses on securities lending collateral are included in accumulated other comprehensive loss as a separate component of shareholders' equity. The market value of loaned securities and that of the collateral pledged can fluctuate in non-synchronized fashions. To the extent the loaned securities' value appreciates faster or depreciates slower than the value of the collateral pledged, we are exposed to the risk of the shortfall. As a primary mitigating mechanism, the loaned securities and collateral pledged are marked to market on a daily basis and the shortfall, if any, is collected accordingly. Secondarily, the collateral level is set at 102% of the value of the loaned securities, which provides a cushion before any shortfall arises. The investment of the cash collateral is subject to market risk, which is managed by limiting the investments to higher quality and shorter duration instruments.

Receivables: Premium receivables include the uncollected amounts from insured groups, individuals and government programs. Premium receivables are reported net of an allowance for doubtful accounts of $278 and $302 at December 31, 2018 and 2017, respectively. Self-funded receivables include administrative fees, claims and other amounts due from self-funded customers. Self-funded receivables are reported net of an allowance for doubtful accounts of $47 and $153 at December 31, 2018 and 2017, respectively. The allowance for doubtful accounts is based on historical collection trends and our judgment regarding the ability to collect specific accounts.

Other receivables include pharmacy rebates, provider advances, claims recoveries, reinsurance receivables, proceeds due from brokers on investment trades, other government receivables and other miscellaneous amounts due to us. These receivables are reported net of an allowance for doubtful accounts of $280 and $306 at December 31, 2018 and 2017, respectively, which is based on historical collection trends and our judgment regarding the ability to collect specific accounts.

Income Taxes: We file a consolidated income tax return. Deferred income tax assets and liabilities are recognized for temporary differences between the financial statement and tax return basis of assets and liabilities based on enacted tax rates and laws. The deferred tax benefits of the deferred tax assets are recognized to the extent realization of such benefits is more likely than not. Deferred income tax expense or benefit generally represents the net change in deferred income tax assets and liabilities during the year, excluding the impact from amounts initially recorded for business combinations, if any, and amounts recorded to accumulated other comprehensive loss. Current income tax expense represents the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported.

We account for income tax contingencies in accordance with FASB guidance that contains a model to address uncertainty in tax positions and clarifies the accounting for income taxes by prescribing a minimum recognition threshold, which all income tax positions must achieve before being recognized in the financial statements.

Property and Equipment: Property and equipment is recorded at cost, net of accumulated depreciation. Depreciation is computed principally by the straight-line method over estimated useful lives ranging from fifteen to thirty-nine years for buildings and improvements, three to five years for computer equipment and software, and the lesser of the remaining life of the building lease, if any, or seven years for furniture and other equipment. Leasehold improvements are depreciated over the term of the related lease. Certain costs related to the development or purchase of internal-use software are capitalized and amortized over five years.

Goodwill and Other Intangible Assets: FASB guidance requires business combinations to be accounted for using the acquisition method of accounting and it also specifies the types of acquired intangible assets that are required to be recognized and reported separately from goodwill. Goodwill represents the excess of the cost of acquisition over the fair

value of net assets acquired. Other intangible assets represent the values assigned to customer relationships, provider and hospital networks, Blue Cross and Blue Shield and other trademarks, licenses, non-compete and other agreements. Goodwill and other intangible assets are allocated to reportable segments based on the relative fair value of the components of the businesses acquired.

Goodwill and other intangible assets with indefinite lives are not amortized but are tested for impairment at least annually. We complete our annual impairment tests of existing goodwill and other intangible assets with indefinite lives during the fourth quarter of each year. Certain interim impairment tests are also performed when potential impairment indicators exist or changes in our business or other triggering events occur. Goodwill and other intangible assets are allocated to reporting units for purposes of the annual goodwill impairment test. Other intangible assets with indefinite lives, such as trademarks, are tested for impairment separately.

FASB guidance allows for qualitative assessments of whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount for purposes of a goodwill impairment analysis and whether it is more likely than not that an indefinite-lived intangible asset is impaired for purposes of an indefinite-lived intangible asset impairment analysis. Quantitative analysis must be performed if qualitative analyses are not conclusive. Entities also have the option to bypass the assessment of qualitative factors and proceed directly to performing quantitative analyses. Our impairment tests require us to make assumptions and judgments regarding the estimated fair value of our reporting units, including goodwill and other intangible assets with indefinite lives. Estimated fair values developed based on our assumptions and judgments might be significantly different if other reasonable assumptions and estimates were to be used. We began our 2018 annual test with qualitative analyses.

Qualitative analysis involves assessing situations and developments that could affect key drivers used to evaluate whether the fair value of our goodwill and indefinite-lived intangible assets are impaired. Our procedures include assessing our financial performance, macroeconomic conditions, industry and market considerations, various asset specific factors, and entity specific events.

Fair value for purposes of a quantitative goodwill impairment test is calculated using a blend of the projected income and market valuation approaches. The projected income approach is developed using assumptions about future revenue, expenses and net income derived from our internal planning process. Our assumed discount rate is based on our industry's weighted-average cost of capital and reflects volatility associated with the cost of equity capital. Market valuations include market comparisons to publicly traded companies in our industry and are based on observed multiples of certain measures including revenue; earnings before interest, taxes, depreciation and amortization, or EBITDA; and book value of invested capital. A goodwill impairment loss is recognized to the extent that the carrying amount exceeds the asset's fair value. This determination is made at the reporting unit level and consists of two steps. First, the fair value of a reporting unit is determined and compared to its carrying amount. Second, if the carrying amount of a reporting unit exceeds its fair value, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation on a business acquisition, at the impairment test date.

Fair value for purposes of a quantitative impairment test for indefinite-lived intangible assets is estimated using a projected income approach. We recognize an impairment loss when the estimated fair value of indefinite-lived intangible assets is less than the carrying value. If significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

Derivative Financial Instruments: We primarily invest in the following types of derivative financial instruments: interest rate swaps, futures, forward contracts, put and call options, swaptions, embedded derivatives and warrants. Derivatives embedded within non-derivative instruments, such as options embedded in convertible fixed maturity securities, are bifurcated from the host instrument when the embedded derivative is not clearly and closely related to the host instrument. Our use of derivatives is limited by statutes and regulations promulgated by the various regulatory bodies to which we are subject, and by our own derivative policy. Our derivative use is generally limited to hedging purposes, on an economic basis, and we generally do not use derivative instruments for speculative purposes.

We have exposure to economic losses due to interest rate risk arising from changes in the level or volatility of interest rates. We attempt to mitigate our exposure to interest rate risk through active portfolio management, including rebalancing

our existing portfolios of assets and liabilities, as well as changing the characteristics of investments to be purchased or sold in the future. In addition, derivative financial instruments are used to modify the interest rate exposure of certain liabilities or forecasted transactions. These strategies include the use of interest rate swaps and forward contracts, which are used to lock-in interest rates or to hedge, on an economic basis, interest rate risks associated with variable rate debt. We have used these types of instruments as designated hedges against specific liabilities.

All investments in derivatives are recorded as assets or liabilities at fair value. If certain correlation, hedge effectiveness and risk reduction criteria are met, a derivative may be specifically designated as a hedge of exposure to changes in fair value or cash flow. The accounting for changes in the fair value of a derivative depends on the intended use of the derivative and the nature of any hedge designation thereon. Amounts excluded from the assessment of hedge effectiveness, if any, as well as the ineffective portion of the gain or loss, are reported in results of operations immediately. If the derivative is not designated as a hedge, the gain or loss resulting from the change in the fair value of the derivative is recognized in results of operations in the period of change. Cash flows associated with the settlement of non-designated derivatives are shown on a net basis in investing activity in our consolidated statements of cash flow.

From time to time, we may also purchase derivatives to hedge, on an economic basis, our exposure to foreign currency exchange fluctuations associated with the operations of certain of our subsidiaries. We generally use futures or forward contracts for these transactions. We generally do not designate these contracts as hedges and, accordingly, the changes in fair value of these derivatives are recognized in results of operations immediately.

Credit exposure associated with non-performance by the counterparties to derivative instruments is generally limited to the uncollateralized fair value of the asset related to instruments recognized in the consolidated balance sheets. We attempt to mitigate the risk of non-performance by selecting counterparties with high credit ratings and monitoring their creditworthiness and by diversifying derivatives among multiple counterparties. At December 31, 2018, we believe there were no material concentrations of credit risk with any individual counterparty.

We generally enter into master netting agreements, which reduce credit risk by permitting net settlement of transactions with the same counterparty. Certain of our derivative agreements also contain credit support provisions that require us or the counterparty to post collateral if there are declines in the derivative fair value or our credit rating. The derivative assets and derivative liabilities are reported at their fair values net of collateral and netting by the counterparty.

Retirement Benefits: We recognize the funded status of pension and other postretirement benefit plans on the consolidated balance sheets based on fiscal-year-end measurements of plan assets and benefit obligations. Prepaid pension benefits represent prepaid costs related to defined benefit pension plans and are reported with other noncurrent assets. Postretirement benefits represent outstanding obligations for retiree medical, life, vision and dental benefits. Liabilities for pension and other postretirement benefits are reported with current and noncurrent liabilities based on the amount by which the actuarial present value of benefits payable in the next twelve months included in the benefit obligation exceeds the fair value of plan assets.

We determine the expected return on plan assets using the calculated value of plan assets, which recognizes changes in the fair value of plan assets in a systematic manner over three years. We apply a corridor approach to amortize unrecognized actuarial gains or losses. Under this approach, only accumulated net actuarial gains or losses in excess of 10% of the greater of the projected benefit obligation or the fair value of plan assets are amortized over the average remaining service or lifetime of the workforce as a component of net periodic benefit cost.

The discount rate reflects the current rate at which the pension liabilities could be effectively settled at the end of the year based on our most recent measurement date. At the December 31, 2017 measurement date, we changed the discount rate setting methodology from the single equivalent discount rate to the annual spot rate approach. Under the spot rate approach, individual spot rates from a full yield curve of published rates are used to discount each plan’s cash flows to determine the plan’s obligations. The spot rate approach produces a more precise measure of service and interest cost, and results in obligations that are equal at the measurement date under both methods.

The assumed healthcare cost trend rates used to measure the expected cost of other postretirement benefits are based on an initial assumed healthcare cost trend rate declining to an ultimate healthcare cost trend rate over a select number of years.

Medical Claims Payable: Liabilities for medical claims payable include estimated provisions for incurred but not paid claims on an undiscounted basis, as well as estimated provisions for expenses related to the processing of claims. Incurred but not paid claims include (1) an estimate for claims that are incurred but not reported, as well as claims reported to us but not yet processed through our systems; and (2) claims reported to us and processed through our systems but not yet paid.

Liabilities for both claims incurred but not reported and reported but not yet processed through our systems are determined in the aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Actuarial Standards of Practice require that the claim liabilities be appropriate under moderately adverse circumstances. We determine the amount of the liability for incurred but not paid claims by following a detailed actuarial process that uses both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities. Under this process, historical paid claims data is formatted into “claim triangles,” which compare claim incurred dates to the dates of claim payments. This information is analyzed to create “completion factors” that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the period-end date to estimate the ultimate claim expense incurred for the period. Actuarial estimates of incurred but not paid claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims.

For the most recent incurred months (typically the most recent two months), the percentage of claims paid for claims incurred in those months is generally low. This makes the completion factor methodology less reliable for such months. Therefore, incurred claims for recent months are not projected from historical completion and payment patterns; rather, they are projected by estimating the claims expense for those months based on recent claims expense levels and healthcare trend levels, or “trend factors.”

We regularly review and set assumptions regarding cost trends and utilization when initially establishing claim liabilities. We continually monitor and adjust the claims liability and benefit expense based on subsequent paid claims activity. If it is determined that our assumptions regarding cost trends and utilization are materially different than actual results, our income statement and financial position could be impacted in future periods.

Premium deficiencies are recognized when it is probable that expected claims and administrative expenses will exceed future premiums on existing medical insurance contracts without consideration of investment income. Determination of premium deficiencies for longer duration life and disability contracts includes consideration of investment income. For purposes of premium deficiencies, contracts are deemed to be either short or long duration and are grouped in a manner consistent with our method of acquiring, servicing and measuring the profitability of such contracts. Once established, premium deficiencies are released commensurate with actual claims experience over the remaining life of the contract. No premium deficiencies were established at December 31, 2018 or 2017.

Benefit expense includes incurred medical claims as well as quality improvement expenses for our fully-insured members. Quality improvement activities are those designed to improve member health outcomes, prevent hospital readmissions and improve patient safety. They also include expenses for wellness and health promotion provided to our members.

Reserves for Future Policy Benefits: Reserves for future policy benefits include liabilities for life and long-term disability insurance policy benefits based upon interest, mortality and morbidity assumptions from published actuarial tables, modified based upon our experience. Future policy benefits also include liabilities for insurance policies for which some of the premiums received in earlier years are intended to pay anticipated benefits to be incurred in future years. Future policy benefits are continually monitored and reviewed, and when reserves are adjusted, differences are reflected in benefit expense.

The current portion of reserves for future policy benefits relates to the portion of such reserves that we expect to pay within one year. We believe that our liabilities for future policy benefits, along with future premiums received, are adequate to satisfy our ultimate benefit liability; however, these estimates are inherently subject to a number of variable circumstances. Consequently, the actual results could differ materially from the amounts recorded in our consolidated financial statements.

Other Policyholder Liabilities: Other policyholder liabilities include rate stabilization reserves associated with retrospectively rated insurance contracts and certain case-specific reserves. Other policyholder liabilities also includes liabilities for premium refunds based upon the minimum medical loss ratio, or MLR, the relative health risk of members, or other contractual or regulatory requirements. Rate stabilization reserves represent accumulated premiums that exceed what

customers owe us based on actual claim experience. The timing of payment of these retrospectively rated refunds is based on the contractual terms with our customers and can vary from period to period based on the specific contractual requirements.

We are required to meet certain minimum MLR thresholds prescribed by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended, or collectively, the ACA. If we do not meet or exceed the minimum MLR thresholds specified by the ACA, we are required to pay rebates to certain customers. Minimum MLR rebates are calculated by subsidiary, state and applicable line of business (Large Group, Small Group, Individual and Medicare) in accordance with regulations issued by the Department of Health and Human Services, or HHS. Such calculations are made using estimated calendar year medical loss expense and premiums, as defined by HHS.

We follow HHS guidelines for determining the types of expenses that may be included in our minimum MLR rebate calculations, which differ from benefit expense and premiums as reported in our consolidated financial statements prepared in conformity with GAAP. Certain amounts reported as expense in our GAAP basis consolidated financial statements may be reported as a reduction of premiums in accordance with HHS regulations. In addition, profit amounts included in our payments to third-party administrative service providers are recorded as benefit expense in our consolidated GAAP financial statements while HHS does not allow for the inclusion of these expenses within the medical loss expense for purposes of calculating minimum MLR.

Revenue Recognition: Premiums for fully-insured contracts are recognized as revenue over the period insurance coverage is provided, and, if applicable, net of amounts recognized for the ACA MLR rebates, risk adjustment, reinsurance and risk corridor or contractual premium stabilization programs. Premium payments from contracted government agencies are based on eligibility lists produced by the government agencies. Premiums related to the unexpired contractual coverage periods are reflected in the accompanying consolidated balance sheets as unearned income. Premiums include revenue adjustments for retrospectively rated contracts where revenue is based on the estimated loss experience of the contract. Premium rates for certain lines of business are subject to approval by the Department of Insurance of each respective state. Additionally, delays in annual premium rate changes from contracted government agencies require that we defer the recognition of any increases to the period in which the premium rates become final. The value of the impact can be significant in the period in which it is recognized depending on the magnitude of the premium rate increase, the membership to which it applies and the length of the delay between the effective date of the rate increase and the final contract date. Premium rate decreases are recognized in the period the change in premium rate becomes effective and the change in the rate is known, which may be prior to the period when the contract amendment affecting the rate is finalized.

Administrative fees and other revenues include revenue from certain group contracts that provide for the group to be at risk for all, or with supplemental insurance arrangements, a portion of their claims experience. We charge these self-funded groups an administrative fee, which is based on the number of members in a group or the group’s claim experience. In addition, administrative fees and other revenues include amounts received for the administration of Medicare or certain other government programs. Under our self-funded arrangements, revenue is recognized as administrative services are performed. All benefit payments under these programs are excluded from benefit expense.

For our non-fully-insured contracts, we had no material contract assets, contract liabilities or deferred contract costs recorded on our consolidated balance sheet at December 31, 2018. Revenue recognized in 2018 from performance obligations related to prior years, such as due to changes in transaction price, was not material. For contracts that have an original expected duration of greater than one year, revenue expected to be recognized in future periods related to unfulfilled contractual performance obligations and contracts with variable consideration related to undelivered performance obligations is not material.

Share-Based Compensation: Our current compensation philosophy provides for share-based compensation, including stock options, restricted stock awards and an employee stock purchase plan. Stock options are granted for a fixed number of shares with an exercise price at least equal to the fair value of the shares at the date of the grant. Restricted stock awards are issued at the fair value of the stock on the grant date. The employee stock purchase plan allows for a purchase price per share which is 95% of the fair value of a share of common stock on the last trading day of the plan quarter. The employee stock purchase plan discount is not recognized as compensation expense based on GAAP guidance. All other share-based payments to employees are recognized as compensation expense in the income statement based on their fair values. Additionally, excess tax benefits, which result from actual tax benefits realized when awards vest or options are exercised exceeding deferred tax benefits previously recognized based on grant date fair value, are recognized as tax benefits in the income statement. Our

share-based employee compensation plans and assumptions are described in Note 14, "Capital Stock." Also see "*Recently Adopted Accounting Guidance*" within this Note 2 for reference to accounting changes adopted related to share-based compensation.

***Advertising and Marketing Costs*:** We use print, broadcast and other advertising to promote our products and to develop our corporate image. We market our products through direct marketing activities and an extensive network of independent agents, brokers and retail partnerships for Individual and Medicare customers, and for certain Local Group customers with a smaller employee base. Products for National Accounts and Local Group customers with a larger employee base are generally sold through independent brokers or consultants retained by the customer and working with industry specialists from our in-house sales force. In the Individual and Small Group markets we offer products through state or federally facilitated marketplaces, or public exchanges, and off-exchange products. The cost of advertising and marketing for product promotion is expensed as incurred while advertising and marketing costs associated with our corporate image is expensed when first aired. Total advertising and marketing expense was $385, $338 and $246 for the years ended December 31, 2018, 2017 and 2016, respectively.

***Health Insurance Provider Fee*:** The ACA imposed an annual Health Insurance Provider Fee, or HIP Fee, on health insurers that write certain types of health insurance on U.S. risks. The annual HIP Fee is allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to the amount of health insurance premium for all U.S. health risk for those certain lines of business written during the preceding calendar year. We record our estimated liability for the HIP Fee in full at the beginning of the year with a corresponding deferred asset that is amortized on a straight-line basis to selling, general and administrative expense. The final calculation and payment of the annual HIP Fee is due by September 30th of each fee year. The HIP Fee is non-deductible for federal income tax purposes. We price our affected products to cover the increased selling, general and administrative and income tax expenses associated with the HIP Fee. The total amount due from allocations to health insurers was $11,300 for 2016, was suspended for 2017, had resumed and increased to $14,300 for 2018 and is suspended for 2019. The HIP Fee is scheduled to go back into effect for 2020. For the years ended December 31, 2018 and 2016, we recognized $1,544 and $1,176, respectively, as selling, general and administrative expense related to the HIP Fee. There was no corresponding expense for 2017 due to the suspension of the HIP Fee for 2017.

Earnings per Share: Earnings per share amounts, on a basic and diluted basis, have been calculated based upon the weighted-average common shares outstanding for the period.

Basic earnings per share excludes dilution and is computed by dividing income available to common shareholders by the weighted-average number of common shares outstanding for the period. Diluted earnings per share may include the dilutive effect of stock options, restricted stock, convertible debentures and Equity Units, using the treasury stock method. See Note 12, "Debt," for a description of our Equity Units. The treasury stock method assumes exercise of stock options and vesting of restricted stock, with the assumed proceeds used to purchase common stock at the average market price for the period. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Recently Adopted Accounting Guidance: In February 2018, the FASB issued Accounting Standards Update No. 2018-02, *Income Statement—Reporting Comprehensive Income (Topic 220)*: *Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income*, or ASU 2018-02. On December 22, 2017, the federal government enacted a tax bill, H.R.1, *An act to provide for reconciliation pursuant to titles II and V of the concurrent resolution on the budget for fiscal year 2018*, or the Tax Cuts and Jobs Act. The Tax Cuts and Jobs Act contains significant changes to corporate taxation, including, but not limited to, reducing the U.S. federal corporate income tax rate from 35% to 21% and modifying or limiting many business deductions. Current FASB guidance requires adjustments of deferred taxes due to a change in the federal corporate income tax rate to be included in income from operations. As a result, the tax effects of items within accumulated other comprehensive loss did not reflect the appropriate tax rate. The amendments in ASU 2018-02 allow a reclassification from accumulated other comprehensive loss to retained earnings for stranded tax effects resulting from the change in the federal corporate income tax rate. We adopted the amendments in ASU 2018-02 for our interim and annual reporting periods beginning on January 1, 2018 and reclassified $91 of stranded tax effects from accumulated other comprehensive loss to retained earnings on our consolidated balance sheets. The adoption of ASU 2018-02 did not have any impact on our results of operations or cash flows.

In August 2017, the FASB issued Accounting Standards Update No. 2017-12, *Derivatives and Hedging (Topic 815): Targeted Improvements to Accounting for Hedging Activities*, or ASU 2017-12. This update amends the hedge accounting recognition and presentation requirements in Topic 815 with the objective of improving the financial reporting of hedging relationships to better portray the economic results of an entity's risk management activities in its financial statements. The update also makes certain targeted improvements to simplify the application of the hedge accounting guidance and provides several transition elections. We adopted ASU 2017-12 on October 1, 2017. The adoption of ASU 2017-12 did not have a material impact on our consolidated financial position, results of operations or cash flows.

In May 2017, the FASB issued Accounting Standards Update No. 2017-09, *Compensation - Stock Compensation (Topic 718): Scope of Modification Accounting*, or ASU 2017-09. This update provides guidance about which changes to the terms or conditions of a share-based payment award require an entity to apply modification accounting in Topic 718. We adopted ASU 2017-09 on January 1, 2018. The guidance has been and will be applied prospectively to awards modified on or after the adoption date. The adoption of ASU 2017-09 did not have any impact on our consolidated financial position, results of operations or cash flows.

In March 2017, the FASB issued Accounting Standards Update No. 2017-07, *Compensation - Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*, or ASU 2017-07. This amendment requires entities to disaggregate the service cost component from the other components of the benefit cost and present the service cost component in the same income statement line item as other employee compensation costs arising from services rendered by the pertinent employees during the period. The other components of net benefit cost are required to be presented in the income statement separately from the service cost component and outside a subtotal of income from operations. Certain of our defined benefit plans have previously been frozen, resulting in no annual service costs, and the remaining service costs for our non-frozen plan are not material. We adopted ASU 2017-07 on January 1, 2018 and it did not have a material impact on our results of operations, cash flows or consolidated financial position.

In December 2016, the FASB issued Accounting Standards Update No. 2016-20, *Technical Corrections and Improvements to Topic 606, Revenue from Contracts with Customers*. In May 2016, the FASB issued Accounting Standards Update No. 2016-12, *Revenue from Contracts with Customers (Topic 606): Narrow-Scope Improvements and Practical Expedients*. In April 2016, the FASB issued Accounting Standards Update No. 2016-10, *Revenue from Contracts with Customers (Topic 606): Identifying Performance Obligations and Licensing*, or ASU 2016-10. In March 2016, the FASB issued Accounting Standards Update No. 2016-08, *Revenue from Contracts with Customers (Topic 606): Principal versus Agent Considerations (Reporting Revenue Gross verses Net)*. These updates provide additional clarification and implementation guidance on the previously issued Accounting Standards Update No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*. Collectively, these updates require a company to recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods or services. These updates supersede almost all existing revenue recognition guidance under GAAP, with certain exceptions, including an exception for our premium revenues, which are recorded on the Premiums line item on our consolidated statements of income and will continue to be accounted for in accordance with the provisions of Accounting Standards Codification, or ASC, Topic 944, *Financial Services - Insurance*. Our administrative service and other contracts that are subject to these Accounting Standards Updates are recorded in the Administrative fees and other revenue line item on our consolidated statements of income and represents approximately 6% of our consolidated total operating revenue. We adopted these standards on January 1, 2018 using the modified retrospective approach. The adoption of these standards did not have a material impact on our beginning retained earnings, results of operations, cash flows or consolidated financial position.

In November 2016, the FASB issued Accounting Standards Update No. 2016-18, *Statement of Cash Flows (Topic 230): Restricted Cash*, or ASU 2016-18. This update amends ASC Topic 230 to add and clarify guidance on the classification and presentation of restricted cash in the statement of cash flows. The guidance requires entities to show the changes in the total of cash, cash equivalents, restricted cash and restricted cash equivalents in the statement of cash flows. We adopted ASU 2016-18 on January 1, 2018 using a retrospective approach. The adoption of ASU 2016-18 did not have a material impact on our consolidated statements of cash flows and did not impact our results of operations or consolidated financial position.

In August 2016, the FASB issued Accounting Standards Update No. 2016-15, *Statement of Cash Flows (Topic 230): Classification of Certain Cash Receipts and Cash Payments*, or ASU 2016-15. This update addresses the presentation and classification on the statement of cash flows for eight specific items, with the objective of reducing existing diversity in

practice in how certain cash receipts and cash payments are presented and classified. We adopted ASU 2016-15 on January 1, 2018. The adoption of ASU 2016-15 did not have a material impact on our consolidated statements of cash flows, results of operations or consolidated financial position.

In March 2016, the FASB issued Accounting Standards Update No. 2016-09, *Compensation - Stock Compensation (Topic 718): Improvements to Employee Share-Based Payment Accounting*, or ASU 2016-09. The amendments in this update simplify several aspects of accounting for and reporting on share-based payment transactions, including the income tax consequences, classification of awards as either equity or liabilities, and classification on the statement of cash flows. We adopted the amendments in ASU 2016-09 on January 1, 2017. We continue to estimate forfeitures expected to occur in determining stock compensation recognized in each period. We prospectively recognized tax benefits of $36, or $0.13 per diluted share, for the year ended December 31, 2017 in our consolidated statements of income, which previously would have been recorded to additional paid-in capital. In addition, we prospectively recognized excess tax benefits as an operating activity within our consolidated statement of cash flows for the year ended December 31, 2017. Finally, we retrospectively recognized taxes paid on our employees' behalf through the withholding of common stock as a financing activity within our consolidated statements of cash flows for the years ended December 31, 2017 and 2016.

In January 2016, the FASB issued Accounting Standards Update No. 2016-01, *Financial Instruments - Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities*, or ASU 2016-01. The amendments in ASU 2016-01 change the accounting for non-consolidated equity investments that are not accounted for under the equity method of accounting by requiring changes in fair value to be recognized in income. Additionally, ASU 2016-01 simplifies the impairment assessment of equity investments without readily determinable fair values; requires entities to use the exit price when estimating the fair value of financial instruments; and modifies various presentation disclosure requirements for financial instruments. We adopted ASU 2016-01 on January 1, 2018 as a cumulative-effect adjustment and reclassified $320 of unrealized gains on equity investments, net of tax, from accumulated other comprehensive loss to retained earnings on our consolidated balance sheet. Effective January 1, 2018, our results of operations include the changes in fair value of these financial instruments.

In April 2015, the FASB issued Accounting Standards Update No. 2015-05, *Intangibles - Goodwill and Other - Internal-Use Software (Subtopic 350-40): Customer's Accounting for Fees Paid in a Cloud Computing Arrangement*, or ASU 2015-05. This update provides guidance to help entities determine whether a cloud computing arrangement contains a software license that should be accounted for as internal-use software or as a service contract. ASU 2015-05 became effective January 1, 2016 and we elected to adopt the provisions of the new guidance prospectively to all arrangements entered into or materially modified on or after January 1, 2016. The adoption of ASU 2015-05 did not have an impact on our consolidated financial position, results of operations or cash flows.

In February 2015, the FASB issued Accounting Standards Update No. 2015-02, *Consolidation (Topic 810): Amendments to the Consolidation Analysis*, or ASU 2015-02. This update amended the consolidation guidance by modifying the evaluation criteria for whether limited partnerships and similar legal entities are variable interest entities or voting interest entities, eliminating the presumption that a general partner should consolidate a limited partnership, and affecting the consolidation analysis of reporting entities that are involved with variable interest entities. We adopted the provisions of ASU 2015-02 effective January 1, 2016, and re-evaluated all legal entity investments under the revised consolidation model. The adoption of ASU 2015-02 did not have a material impact on our consolidated financial position, results of operations or cash flows.

Recent Accounting Guidance Not Yet Adopted: In November 2018, the FASB issued Accounting Standards Update No. 2018-19, *Codification Improvements to Topic 326, Financial Instruments - Credit Losses*, or ASU 2018-19. The amendments in ASU 2018-19 provide additional clarification and implementation guidance on certain aspects of the previously issued Accounting Standards Update No. 2016-13, *Financial Instruments - Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments*, or ASU 2016-13, and have the same effective date and transition requirements as ASU 2016-13. ASU 2016-13 introduces a current expected credit loss model for measuring expected credit losses for certain types of financial instruments held at the reporting date based on historical experience, current conditions and reasonable supportable forecasts. ASU 2016-13 replaces the current incurred loss model for measuring expected credit losses, requires expected losses on available-for-sale debt securities to be recognized through an allowance for credit losses rather than as reductions in the amortized cost of the securities and provides for additional disclosure requirements. ASU 2016-13 is effective for interim and annual reporting periods beginning after December 15, 2019, with early adoption permitted for

interim and annual reporting periods beginning after December 15, 2018. We are currently evaluating the effects the adoption of ASU 2016-13 will have on our consolidated financial statements, results of operations and cash flows.

In August 2018, the FASB issued Accounting Standards Update No. 2018-15, *Intangibles—Goodwill and Other—Internal-Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract*, or ASU 2018-15. The amendments in ASU 2018-15 require implementation costs incurred by customers in cloud computing arrangements to be deferred and recognized over the term of the arrangement, if those costs would be capitalized by the customer in a software licensing arrangement under the internal-use software guidance. The amendments also require an entity to disclose the nature of its hosting arrangements and adhere to certain presentation requirements in its balance sheet, income statement and statement of cash flows. ASU 2018-15 is effective for us on January 1, 2020, with early adoption permitted. The guidance can be applied either prospectively to all implementation costs incurred after the date of adoption or retrospectively. We are currently evaluating the effects the adoption of ASU 2018-15 will have on our consolidated financial position, results of operations and cash flows.

In August 2018, the FASB issued Accounting Standards Update No. 2018-14, *Compensation—Retirement Benefits—Defined Benefit Plans—General (Subtopic 715-20): Disclosure Framework—Changes to the Disclosure Requirements for Defined Benefit Plans*, or ASU 2018-14. The amendments in ASU 2018-14 eliminate, add and modify certain disclosure requirements for employers that sponsor defined benefit pension or other postretirement plans. The amendments are effective for our annual reporting periods beginning after December 15, 2020, with early adoption permitted. The guidance is to be applied on a retrospective basis to all periods presented. We are currently evaluating the effects the adoption of ASU 2018-14 will have on our disclosures.

In August 2018, the FASB issued Accounting Standards Update No. 2018-13, *Fair Value Measurement (Topic 820): Disclosure Framework—Changes to the Disclosure Requirements for Fair Value Measurement*, or ASU 2018-13. The amendments in ASU 2018-13 eliminate, add and modify certain disclosure requirements for fair value measurements. The amendments are effective for our interim and annual reporting periods beginning after December 15, 2019, with early adoption permitted for either the entire ASU or only the provisions that eliminate or modify disclosure requirements. We early adopted the provisions that eliminate and modify disclosure requirements on a retrospective basis effective in this Annual Report on Form 10-K and we adopted the new disclosure requirements on a prospective basis effective January 1, 2019.

In August 2018, the FASB issued Accounting Standards Update No. 2018-12, *Financial Services Insurance (Topic 944): Targeted Improvements to the Accounting for Long-Duration Contracts*, or ASU 2018-12. The amendments in ASU 2018-12 make changes to a variety of areas to simplify or improve the existing recognition, measurement, presentation and disclosure requirements for long-duration contracts issued by an insurance entity. The amendments require insurers to annually review the assumptions they make about their policyholders and update the liabilities for future policy benefits if the assumptions change. The amendments also simplify the amortization of deferred contract acquisition costs and add new disclosure requirements about the assumptions insurers use to measure their liabilities and how they may affect future cash flows. The amendments in ASU 2018-12 will be effective for our interim and annual reporting periods beginning after December 15, 2020. The amendments related to the liability for future policy benefits for traditional and limited-payment contracts and deferred acquisition costs are to be applied to contracts in force as of the beginning of the earliest period presented, with an option to apply such amendments retrospectively with a cumulative-effect adjustment to the opening balance of retained earnings as of the earliest period presented. The amendments for market risk benefits are to be applied retrospectively. We are currently evaluating the effects the adoption of ASU 2018-12 will have on our consolidated financial position, results of operations, cash flows, and related disclosures.

In July 2018, the FASB issued Accounting Standards Update No. 2018-11, *Leases* (Topic 842): *Targeted Improvements*, or ASU 2018-11, and Accounting Standards Update No. 2018-10, *Codification Improvements to Topic 842, Leases*, or ASU 2018-10. The amendments in ASU 2018-11 provide for an additional and optional transition method that allows an entity to initially apply ASC Topic 842 at the adoption date and recognize a cumulative effect adjustment to its opening balance of retained earnings in the period of adoption and continue its reporting for the comparative periods presented in accordance with the current lease guidance in ASC Topic 840. The amendments in ASU 2018-11 also provide lessors with a practical expedient, by class of underlying asset, to not separate nonlease components from the associated lease component and, instead, to account for those components as a single component if the nonlease components otherwise would be accounted for under the new revenue guidance in ASC Topic 606 and if certain conditions are met. The amendments in ASU 2018-10

provide additional clarification and implementation guidance on certain aspects of the previously issued Accounting Standards Update No. 2016-02, *Leases (Topic 842)*, or ASU 2016-02, and have the same effective and transition requirements as ASU 2016-02. Upon the effective date, ASU 2016-02 will supersede the current lease guidance in ASC Topic 840. Under the new guidance, lessees will be required to recognize for all leases, with the exception of short-term leases, a lease liability, which is a lessee's obligation to make lease payments arising from a lease, measured on a discounted basis. Concurrently, lessees will be required to recognize a right-of-use asset, which is an asset that represents the lessee's right to use, or control the use of, a specified asset for the lease term. ASU 2016-02 became effective for us on January 1, 2019. ASU 2016-02 requires a modified retrospective transition approach for leases existing at, or entered into after, the beginning of the earliest comparative periods presented in the financial statements. As noted above, ASU 2018-11 provides for an additional and optional transition method. We applied the optional transition method upon adoption and have elected the package of practical expedients permitted, which among other things, allows us to carry forward lease classification for our existing leases. In preparation for the adoption of this standard and to enable the preparation of the required financial information, we implemented a new lease accounting software solution as well as new internal controls. The adoption of this standard impacted our consolidated balance sheet in January 2019, as we recorded lease assets and liabilities of approximately $700 for our operating leases. The adoption of this standard did not have an impact on our consolidated statements of income or cash flows. We also do not believe the new standard will have an impact on our liquidity or debt-covenant compliance under our current agreements.

In March 2017, the FASB issued Accounting Standards Update No. 2017-08, *Receivables—Nonrefundable Fees and Other Costs (Subtopic 310-20): Premium Amortization on Purchased Callable Debt Securities*, or ASU 2017-08. This update changes the amortization period for certain purchased callable debt securities held at a premium by shortening the amortization period for the premium to the earliest call date. Under current guidance, the premium is generally amortized over the contractual life of the instrument. The amendments are to be applied on a modified retrospective basis through a cumulative-effect adjustment directly to retained earnings as of the beginning of the period of adoption. We adopted ASU 2017-08 on January 1, 2019 and the adoption of this standard did not have a material impact on our beginning retained earnings or upon our consolidated financial position, results of operations or cash flows.

In January 2017, the FASB issued Accounting Standards Update No. 2017-04, *Intangibles - Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment*, or ASU 2017-04. This update removes Step 2 of the goodwill impairment test under current guidance, which requires a hypothetical purchase price allocation. The new guidance requires an impairment charge to be recognized for the amount by which the carrying amount exceeds the reporting unit's fair value. Upon adoption, the guidance is to be applied prospectively. ASU 2017-04 is effective for us on January 1, 2020, with early adoption permitted. The adoption of ASU 2017-04 is not expected to have a material impact on our consolidated financial position, results of operations or cash flows.

There were no other new accounting pronouncements that were issued or became effective during the year ended December 31, 2018 that had, or are expected to have, a material impact on our financial position, results of operations, cash flows or financial statement disclosures.

3. Business Acquisitions

Acquisition of America's 1st Choice

On February 15, 2018, we completed our acquisition of Freedom Health, Inc., Optimum HealthCare, Inc., America's 1st Choice of South Carolina, Inc. and related entities, or collectively, America's 1st Choice, a Medicare Advantage organization that offers HMO products, including Chronic Special Needs Plans and Dual-Eligible Special Needs Plans under its Freedom Health and Optimum HealthCare brands in Florida and its America's 1st Choice of South Carolina brand in South Carolina. At the time of acquisition, through its Medicare Advantage Plans, America's 1st Choice served approximately one hundred and thirty-five thousand members in twenty-five Florida and three South Carolina counties. This acquisition aligns with our plans for continued growth in the Medicare Advantage and Special Needs populations.

In accordance with FASB accounting guidance for business combinations, the consideration transferred was allocated to the fair value of America's 1st Choice's assets acquired and liabilities assumed, including identifiable intangible assets. The excess of the consideration transferred over the fair value of net assets acquired resulted in goodwill of $1,029 at December 31, 2018, of which $295 was tax deductible. All of the goodwill was allocated to our Government Business segment.

Goodwill recognized from the acquisition of America's 1st Choice primarily relates to the future economic benefits arising from the assets acquired and is consistent with our stated intentions to strengthen our position and expand operations in the government sector to service Medicare Advantage and Special Needs populations.

The fair value of the net assets acquired from America's 1st Choice includes $711 of other intangible assets at December 31, 2018, which primarily consist of finite-lived customer relationships with amortization periods ranging from 7 to 13 years. The results of operations of America's 1st Choice are included in our consolidated financial statements within our Government Business segment for the periods following February 15, 2018. The pro forma effects of this acquisition for prior periods were not material to our consolidated results of operations.

Acquisition of HealthSun

On December 21, 2017, we completed our acquisition of HealthSun Health Plans, Inc., or HealthSun, which at the time of acquisition served approximately forty thousand members in the state of Florida through its Medicare Advantage Plans, and which received a five-star rating from the Centers for Medicare & Medicaid Services. This acquisition aligns with our plans for continued growth in the Medicare Advantage and dual-eligible populations.

In accordance with FASB accounting guidance for business combinations, the consideration transferred was allocated to the fair value of HealthSun's assets acquired and liabilities assumed, including identifiable intangible assets. The excess of the consideration transferred over the fair value of net assets acquired resulted in goodwill of $1,631, at December 31, 2018, of which $956 was tax deductible. All of the goodwill was allocated to our Government Business segment. Goodwill recognized from the acquisition of HealthSun primarily relates to the future economic benefits arising from the assets acquired and is consistent with our stated intentions to strengthen our position and expand operations in the government sector to service Medicare Advantage and dual-eligible enrollees. Subsequent to the acquisition date, we recognized a $12 decrease to goodwill primarily related to adjustments to provisional amounts of intangible assets recorded on the acquisition date.

The fair value of the net assets acquired from HealthSun includes $637 of other intangible assets at December 31, 2018, which primarily consist of finite-lived customer relationships with amortization periods ranging from 7 to 11 years. The results of operations of HealthSun are included in our consolidated financial statements within our Government Business segment for the periods following December 21, 2017. The pro forma effects of this acquisition for prior periods were not material to our consolidated results of operations.

Termination of Agreement and Plan of Merger with Cigna Corporation

On July 24, 2015, we and Cigna Corporation, or Cigna, announced that we entered into an Agreement and Plan of Merger, or Cigna Merger Agreement, dated as of July 23, 2015, to acquire all outstanding shares of Cigna. On May 12, 2017, we delivered to Cigna a notice terminating the Cigna Merger Agreement. Both we and Cigna have commenced litigation against the other seeking various actions and damages, including Cigna's damage claim for a $1,850 termination fee pursuant to the terms of the Cigna Merger Agreement. For additional information, see Note 13, "Commitments and Contingencies - *Litigation and Regulatory Proceedings - Cigna Corporation Merger Litigation.*"

4. Investments

A summary of current and long-term fixed maturity securities, available-for-sale, at December 31, 2018 and 2017 is as follows:

	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses		Estimated Fair Value	Non-Credit Component of OTTIs Recognized in Accumulated Other Comprehensive Loss
			Less than 12 Months	12 Months or Greater		
December 31, 2018						
Fixed maturity securities:						
United States Government securities	$ 414	$ 3	$ —	$ (1)	$ 416	$ —
Government sponsored securities	108	1	—	(1)	108	—
States, municipalities and political subdivisions, tax-exempt	4,716	91	(3)	(19)	4,785	—
Corporate securities	8,189	33	(170)	(115)	7,937	(3)
Residential mortgage-backed securities	2,769	31	(3)	(47)	2,750	—
Commercial mortgage-backed securities	69	—	—	(2)	67	—
Other securities	1,115	14	(8)	(5)	1,116	—
Total fixed maturity securities	$ 17,380	$ 173	$ (184)	$ (190)	$ 17,179	$ (3)
December 31, 2017						
Fixed maturity securities:						
United States Government securities	$ 649	$ 2	$ (5)	$ (1)	$ 645	$ —
Government sponsored securities	90	—	—	—	90	—
States, municipalities and political subdivisions, tax-exempt	5,854	193	(5)	(7)	6,035	—
Corporate securities	7,363	166	(30)	(13)	7,486	—
Residential mortgage-backed securities	2,520	39	(8)	(12)	2,539	—
Commercial mortgage-backed securities	80	1	—	(2)	79	—
Other securities	1,054	14	(3)	(1)	1,064	—
Total fixed maturity securities	$ 17,610	$ 415	$ (51)	$ (36)	$ 17,938	$ —

For fixed maturity securities in an unrealized loss position at December 31, 2018 and 2017, the following table summarizes the aggregate fair values and gross unrealized losses by length of time those securities have continuously been in an unrealized loss position.

	Less than 12 Months			12 Months or Greater		
	Number of Securities	Estimated Fair Value	Gross Unrealized Loss	Number of Securities	Estimated Fair Value	Gross Unrealized Loss
(Securities are whole amounts)						
December 31, 2018						
Fixed maturity securities:						
United States Government securities	5	$ 47	$ —	25	$ 79	$ (1)
Government sponsored securities	8	11	—	24	31	(1)
States, municipalities and political subdivisions, tax-exempt	177	295	(3)	604	1,032	(19)
Corporate securities	2,185	4,503	(170)	1,220	2,072	(115)
Residential mortgage-backed securities	259	383	(3)	816	1,458	(47)
Commercial mortgage-backed securities	6	11	—	19	37	(2)
Other securities	193	599	(8)	93	237	(5)
Total fixed maturity securities	2,833	$ 5,849	$ (184)	2,801	$ 4,946	$ (190)
December 31, 2017						
Fixed maturity securities:						
United States Government securities	36	$ 450	$ (5)	11	$ 56	$ (1)
Government sponsored securities	12	16	—	16	15	—
States, municipalities and political subdivisions, tax-exempt	414	641	(5)	189	356	(7)
Corporate securities	1,081	2,200	(30)	279	330	(13)
Residential mortgage-backed securities	445	1,050	(8)	287	478	(12)
Commercial mortgage-backed securities	7	14	—	12	27	(2)
Other securities	132	406	(3)	20	36	(1)
Total fixed maturity securities	2,127	$ 4,777	$ (51)	814	$ 1,298	$ (36)

The amortized cost and fair value of fixed maturity securities at December 31, 2018, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because the issuers of the securities may have the right to prepay obligations.

	Amortized Cost	Estimated Fair Value
Due in one year or less	$ 543	$ 544
Due after one year through five years	5,174	5,105
Due after five years through ten years	4,956	4,857
Due after ten years	3,869	3,856
Mortgage-backed securities	2,838	2,817
Total fixed maturity securities	$ 17,380	$ 17,179

Equity Securities

A summary of current and long-term marketable equity securities at December 31, 2018 and 2017 is as follows:

	December 31, 2018	December 31, 2017
Equity Securities:		
Exchange traded funds	$ 2	$ 1,300
Fixed maturity mutual funds	557	791
Common equity securities	654	1,254
Private equity securities	313	287
Total	$ 1,526	$ 3,632

Investment Income

The major categories of net investment income for the years ended December 31, 2018, 2017 and 2016 are as follows:

	2018	2017	2016
Fixed maturity securities	$ 681	$ 614	$ 673
Equity securities	86	116	62
Cash equivalents	51	25	3
Other	193	153	85
Investment income	1,011	908	823
Investment expense	(41)	(41)	(44)
Net investment income	$ 970	$ 867	$ 779

Investment Gains

Net realized investment gains/losses and the net change in unrealized appreciation/depreciation on investments for the years ended December 31, 2018, 2017 and 2016 are as follows:

	2018	2017	2016
Net realized gains (losses):			
Fixed maturity securities:			
Gross realized gains from sales	$ 85	$ 137	$ 210
Gross realized losses from sales	(116)	(55)	(152)
Net realized (losses) gains from sales of fixed maturity securities	(31)	82	58
Equity securities:			
Gross realized gains	77	140	205
Gross realized losses	(276)	(17)	(50)
Net realized (losses) gains on equity securities	(199)	123	155
Other investments:			
Gross realized gains from sales	27	—	7
Gross realized losses from sales	—	(5)	—
Net realized gains (losses) from sales of other investments	27	(5)	7
Net realized (losses) gains on investments	(203)	200	220
Other-than-temporary impairment losses recognized in income:			
Fixed maturity securities	(9)	(4)	(75)
Equity securities	—	(15)	(22)
Other investments	(17)	(14)	(18)
Other-than-temporary impairment losses recognized in income	(26)	(33)	(115)
Change in net unrealized (losses) gains on investments:			
Fixed maturity securities	(529)	156	193
Equity securities	—	111	7
Other investments	5	(10)	(2)
Total change in net unrealized (losses) gains on investments	(524)	257	198
Deferred income tax benefit (expense)	106	(84)	(80)
Change in net unrealized (losses) gains on investments	(418)	173	118
Net realized (losses) gains on investments, other-than-temporary impairment losses recognized in income and change in net unrealized (losses) gains on investments	$ (647)	$ 340	$ 223

The gains and losses related to equity securities for the year ended December 31, 2018 are as follows:

	2018
Net realized losses recognized on equity securities	$ (199)
Less: Net realized losses recognized on equity securities sold during the period	57
Unrealized losses recognized in income on equity securities still held at December 31	$ (142)

A primary objective in the management of our fixed maturity and equity portfolios is to maximize total return relative to underlying liabilities and respective liquidity needs. In achieving this goal, assets may be sold to take advantage of market conditions or other investment opportunities as well as tax considerations. Sales will generally produce realized gains and losses. In the ordinary course of business, we may sell securities at a loss for a number of reasons, including, but not limited to: (i) changes in the investment environment; (ii) expectations that the fair value could deteriorate further; (iii) desire to reduce exposure to an issuer or an industry; (iv) changes in credit quality; or (v) changes in expected cash flow.

Proceeds from sales, maturities, calls or redemptions of fixed maturity securities and the related gross realized gains and gross realized losses for the years ended December 31 are as follows:

	2018	2017	2016
Proceeds	$ 8,380	$ 9,780	$ 10,055
Gross realized gains	85	137	210
Gross realized losses	(116)	(55)	(152)

A significant judgment in the valuation of investments is the determination of when an other-than-temporary decline in value has occurred. We follow a consistent and systematic process for recognizing impairments on securities that sustain other-than-temporary declines in value. We have established a committee responsible for the impairment review process. The decision to impair a security incorporates both quantitative criteria and qualitative information. The impairment review process considers a number of factors including, but not limited to: (i) the length of time and the extent to which the fair value has been less than book value, (ii) the financial condition and near term prospects of the issuer, (iii) our intent and ability to retain impaired investments for a period of time sufficient to allow for any anticipated recovery in fair value, (iv) our intent to sell or the likelihood that we will need to sell a fixed maturity security before recovery of its amortized cost basis, (v) whether the debtor is current on interest and principal payments, (vi) the reasons for the decline in value (i.e., credit event compared to liquidity, general credit spread widening, currency exchange rate or interest rate factors) and (vii) general market conditions and industry or sector specific factors. For securities that are deemed to be other-than-temporarily impaired, the security is adjusted to fair value and the resulting losses are recognized in the consolidated statements of income. The new cost basis of the impaired securities is not increased for future recoveries in fair value.

Other-than-temporary impairments recorded in 2018, 2017 and 2016 were primarily the result of the continued credit deterioration on specific issuers in the bond markets. There were no individually significant OTTI losses on investments by issuer during 2018, 2017 or 2016.

Investment securities are exposed to various risks, such as interest rate, market and credit. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is possible that changes in these risk factors in the near term could have an adverse material impact on our results of operations or shareholders' equity.

The changes in the amount of the credit component of OTTI losses on fixed maturity securities recognized in income, for which a portion of the OTTI losses was recognized in other comprehensive income, was not material for the years ended December 31, 2018, 2017 or 2016.

At December 31, 2018 and 2017, no investments exceeded 10% of shareholders' equity.

At December 31, 2018 and 2017, the carrying value of fixed maturity investments that did not produce income during the years then ended were $0 and $9, respectively.

As of December 31, 2018 and 2017, we had committed approximately $873 and $824, respectively, to future capital calls from various third-party investments in exchange for an ownership interest in the related entities.

At December 31, 2018 and 2017, securities with carrying values of approximately $487 and $561, respectively, were deposited by our insurance subsidiaries under requirements of regulatory authorities.

Securities Lending Programs

The fair value of the collateral received at the time of the securities lending transactions amounted to $604 and $454 at December 31, 2018 and 2017, respectively. The value of the collateral represented 102% and 104% of the market value of the securities on loan at December 31, 2018 and 2017, respectively.

The remaining contractual maturity of our securities lending agreements at December 31, 2018 is as follows:

	Overnight and Continuous	Less than 30 days	30-90 days	Greater Than 90 days	Total
Securities lending transactions					
United States Government securities	$ 169	$ —	$ —	$ —	$ 169
Corporate securities	396	—	—	—	396
Equity securities	39	—	—	—	39
Total	$ 604	$ —	$ —	$ —	$ 604

5. Derivative Financial Instruments

We primarily invest in the following types of derivative financial instruments: interest rate swaps, futures, forward contracts, put and call options, swaptions, embedded derivatives and warrants. We also enter into master netting agreements which reduce credit risk by permitting net settlement of transactions. We had posted collateral of $1 and $12 related to our derivative financial instruments at December 31, 2018 and 2017, respectively.

A summary of the aggregate contractual or notional amounts and estimated fair values related to derivative financial instruments at December 31, 2018 and 2017 is as follows:

	Contractual/ Notional Amount	Balance Sheet Location	Estimated Fair Value	
			Asset	(Liability)
December 31, 2018				
Hedging instruments				
Interest rate swaps - fixed to floating	$ 1,200	Other assets/other liabilities	$ 7	$ (11)
Non-hedging instruments				
Interest rate swaps	164	Equity securities	4	(1)
Options	100	Other assets/other liabilities	—	—
Futures	415	Equity securities	5	(5)
Subtotal non-hedging	679	Subtotal non-hedging	9	(6)
Total derivatives	$ 1,879	Total derivatives	16	(17)
		Amounts netted	(14)	14
		Net derivatives	$ 2	$ (3)
December 31, 2017				
Hedging instruments				
Interest rate swaps - fixed to floating	$ 1,235	Other assets/other liabilities	$ 2	$ (5)
Interest rate swaps - forward starting pay fixed	425	Other assets/other liabilities	—	$ (9)
Subtotal hedging	1,660	Subtotal hedging	2	(14)
Non-hedging instruments				
Interest rate swaps	171	Equity securities	1	(5)
Options	100	Other assets/other liabilities	—	—
Futures	117	Equity securities	—	(2)
Subtotal non-hedging	388	Subtotal non-hedging	1	(7)
Total derivatives	$ 2,048	Total derivatives	3	(21)
		Amounts netted	(1)	1
		Net derivatives	$ 2	$ (20)

Fair Value Hedges

We have entered into various interest rate swap contracts to convert a portion of our interest rate exposure on our long-term debt from fixed rates to floating rates. The floating rates payable on all of our fair value hedges are benchmarked to the London Interbank Offered Rate, or LIBOR. A summary of our outstanding fair value hedges at December 31, 2018 and 2017 is as follows:

Type of Fair Value Hedges	Year Entered Into	Outstanding Notional Amount		Interest Rate Received	Expiration Date
		2018	2017		
Interest rate swap	2018	$ 50	$ —	4.101 %	September 1, 2027
Interest rate swap	2018	450	—	3.300	January 15, 2023
Interest rate swap	2018	90	—	4.350	August 15, 2020
Interest rate swap	2017	50	50	4.350	August 15, 2020
Interest rate swap	2015	200	200	4.350	August 15, 2020
Interest rate swap	2014	150	150	4.350	August 15, 2020
Interest rate swap	2013	10	10	4.350	August 15, 2020
Interest rate swap	2012	200	200	4.350	August 15, 2020
Interest rate swap	2012	—	625	1.875	January 15, 2018
Total notional amount outstanding		$ 1,200	$ 1,235		

The following amounts were recorded on our consolidated balance sheets related to cumulative basis adjustments for fair value hedges at December 31, 2018 and 2017:

Balance Sheet Classification in Which Hedged Item is Included	Carrying Amount of Hedged Liability		Cumulative Amount of Fair Value Hedging Adjustment Included in the Carrying Amount of the Hedged Liability	
	2018	2017	2018	2017
Current portion of long term-debt	$ 849	$ 1,275	$ 7	$ 2
Long-term debt	17,217	17,382	(11)	(5)

Cash Flow Hedges

We have entered into a series of forward starting pay fixed interest rate swaps with the objective of eliminating the variability of cash flows in the interest payments on anticipated future financings. During 2018, swaps in the notional amount of $425 were terminated. We received an aggregate of $24 from the swap counter parties upon termination.

The unrecognized loss for all outstanding, expired and terminated cash flow hedges included in accumulated other comprehensive loss, net of tax, was $246 and $233 at December 31, 2018 and 2017, respectively. As of December 31, 2018, the total amount of amortization over the next twelve months for all cash flow hedges is estimated to increase interest expense by approximately $14. No amounts were excluded from effectiveness testing.

Anthem, Inc.

Notes to Consolidated Financial Statements (continued)

A summary of the effect of cash flow hedges in accumulated other comprehensive loss for the years ended December 31, 2018 and 2017 is as follows:

Type of Cash Flow Hedge	Hedge Loss Recognized in Other Comprehensive Income (Loss)	Income Statement Location of Loss Reclassification from Accumulated Other Comprehensive Loss	Hedge Loss Reclassified from Accumulated Other Comprehensive Loss
Year ended December 31, 2018			
Forward starting pay fixed swaps	$ (33)	Interest expense	$ (14)
Year ended December 31, 2017			
Forward starting pay fixed swaps	$ (112)	Interest expense	$ (7)
Forward starting pay fixed swaps		Net realized (losses) gains on financial instruments	$ (7)

A summary of the effect of cash flow hedges in accumulated other comprehensive loss for the year ended December 31, 2016 is as follows:

	Effective Portion			Ineffective Portion	
Type of Cash Flow Hedge	Hedge Loss Recognized in Other Comprehensive Income (Loss)	Income Statement Location of Loss Reclassification from Accumulated Other Comprehensive Loss	Hedge Loss Reclassified from Accumulated Other Comprehensive Loss	Income Statement Location of Loss Recognized	Hedge Loss Recognized
Year ended December 31, 2016					
Forward starting pay fixed swaps	$ (140)	Interest expense	$ (6)	Net realized (losses) gains on financial instruments	$ (8)

Income Statement Relationship of Fair Value and Cash Flow Hedging

A summary of the relationship between the effects of fair value and cash flow hedges on the total amount of income and expense presented in our consolidated statements of income for the years ended December 31, 2018, 2017 and 2016 is as follows:

	Classification and Amount of Gain (Loss) Recognized in Income on Fair Value and Cash Flow Hedging Relationships					
	2018		2017		2016	
	Net Realized (Losses) Gains on Financial Instruments	Interest Expense	Net Realized (Losses) Gains on Financial Instruments	Interest Expense	Net Realized (Losses) Gains on Financial Instruments	Interest Expense
Total amount of income or expense in the income statement in which the effects of fair value or cash flow hedges are recorded	$ (180)	$ (753)	$ 145	$ (739)	$ 5	$ (723)
Gain (loss) on fair value hedging relationships:						
Interest rate swaps:						
Hedged items	—	—	—	—	—	(8)
Derivatives designated as hedging instruments	—	—	—	—	—	8
Loss on cash flow hedging relationships:						
Forward starting pay fixed swaps:						
Amount of loss reclassified from accumulated other comprehensive loss into net income	—	(14)	—	(7)	—	(6)
Amount of loss reclassified from accumulated other comprehensive loss into net income due to ineffectiveness and missed forecasted transactions	—	—	(7)	—	(8)	—

Non-Hedging Derivatives

A summary of the effect of non-hedging derivatives on our consolidated statements of income for the years ended December 31, 2018, 2017 and 2016 is as follows:

Type of Non-hedging Derivatives	Income Statement Location of Gain (Loss) Recognized	Derivative Gain (Loss) Recognized
Year ended December 31, 2018		
Interest rate swaps	Net realized (losses) gains on financial instruments	$ 14
Options	Net realized (losses) gains on financial instruments	1
Futures	Net realized (losses) gains on financial instruments	8
Total		$ 23
Year ended December 31, 2017		
Interest rate swaps	Net realized (losses) gains on financial instruments	$ (9)
Options	Net realized (losses) gains on financial instruments	(36)
Futures	Net realized (losses) gains on financial instruments	(3)
Total		$ (48)
Year ended December 31, 2016		
Interest rate swaps	Net realized (losses) gains on financial instruments	$ 1
Options	Net realized (losses) gains on financial instruments	(209)
Futures	Net realized (losses) gains on financial instruments	1
Total		$ (207)

6. Fair Value

Assets and liabilities recorded at fair value in the consolidated balance sheets are categorized based upon the level of judgment associated with the inputs used to measure their fair value. Level inputs, as defined by FASB guidance for fair value measurements and disclosures, are as follows:

Level Input:	Input Definition:
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.
Level III	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date.

The following methods, assumptions and inputs were used to determine the fair value of each class of the following assets and liabilities recorded at fair value in the consolidated balance sheets:

Cash equivalents: Cash equivalents primarily consist of highly rated money market funds with maturities of three months or less, and are purchased daily at par value with specified yield rates. Due to the high ratings and short-term nature of the funds, we designate all cash equivalents as Level I.

Fixed maturity securities, available-for-sale: Fair values of available-for-sale fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third-party pricing services, which generally use Level I or Level II inputs for the determination of fair value to facilitate fair value measurements and disclosures. Level II securities primarily include corporate securities, securities from states, municipalities and political subdivisions, mortgage-backed securities, United States Government securities and certain other asset-backed securities. For securities not actively traded, the pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. We have controls

in place to review the pricing services' qualifications and procedures used to determine fair values. In addition, we periodically review the pricing services' pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. We also have certain fixed maturity securities, primarily corporate debt securities, that are designated Level III securities. For these securities, the valuation methodologies may incorporate broker quotes or discounted cash flow analyses using assumptions for inputs such as expected cash flows, benchmark yields, credit spreads, default rates and prepayment speeds that are not observable in the markets.

Equity securities: Fair values of equity securities are generally designated as Level I and are based on quoted market prices. For certain equity securities, quoted market prices for the identical security are not always available and the fair value is estimated by reference to similar securities for which quoted prices are available. These securities are designated Level II. We also have certain equity securities, including private equity securities, for which the fair value is estimated based on each security's current condition and future cash flow projections. Such securities are designated Level III. The fair values of these private equity securities are generally based on either broker quotes or discounted cash flow projections using assumptions for inputs such as the weighted-average cost of capital, long-term revenue growth rates and earnings before interest, taxes, depreciation and amortization, and/or revenue multiples that are not observable in the markets.

Other invested assets, current: Other invested assets, current include securities held in rabbi trusts that are classified as trading. These securities are designated Level I securities as fair values are based on quoted market prices.

Securities lending collateral: Fair values of securities lending collateral are based on quoted market prices, where available. These fair values are obtained primarily from third-party pricing services, which generally use Level I or Level II inputs for the determination of fair value, to facilitate fair value measurements and disclosures.

Derivatives: Fair values are based on the quoted market prices by the financial institution that is the counterparty to the derivative transaction. We independently verify prices provided by the counterparties using valuation models that incorporate market observable inputs for similar derivative transactions. Derivatives are designated as Level II securities.

In addition, the following methods and assumptions were used to determine the fair value of each class of pension benefit plan assets and other benefit plan assets not defined above (see Note 10, "Retirement Benefits," for fair values of benefit plan assets):

Mutual funds: Fair values are based on quoted market prices, which represent the net asset value, or NAV, of the shares held.

Common and collective trusts: Fair values of common/collective trusts that replicate traded money market funds are based on cost, which approximates fair value. Fair values of common/collective trusts that invest in securities are valued at the NAV of the shares held, where the trust applies fair value measurements to the underlying investments to determine the NAV.

Partnership interests: Fair values are estimated based on the plan's proportionate share of the undistributed partners' capital as reported in audited financial statements of the partnership.

Contract with insurance company: Fair value of the contract in the insurance company general investment account is determined by the insurance company based on the fair value of the underlying investments of the account.

Investment in DOL 103-12 trust: Fair value is based on the plan's proportionate share of the fair value of investments held by the trust, qualified as a Department of Labor Regulation 2520.103-12 entity, or DOL 103-12 trust, as reported in the audited financial statements of the trust, where the trustee applies fair value measurements to the underlying investments of the trust.

Life insurance contracts: Fair value is based on the cash surrender value of the policies as reported by the insurer.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

A summary of fair value measurements by level for assets and liabilities measured at fair value on a recurring basis at December 31, 2018 and 2017 is as follows:

	Level I	Level II	Level III	Total
December 31, 2018				
Assets:				
Cash equivalents	$ 1,815	$ —	$ —	$ 1,815
Fixed maturity securities, available-for-sale:				
United States Government securities	—	416	—	416
Government sponsored securities	—	108	—	108
States, municipalities and political subdivisions, tax-exempt	—	4,785	—	4,785
Corporate securities	2	7,648	287	7,937
Residential mortgage-backed securities	—	2,744	6	2,750
Commercial mortgage-backed securities	—	67	—	67
Other securities	—	1,099	17	1,116
Total fixed maturity securities, available-for-sale	2	16,867	310	17,179
Equity securities:				
Exchange traded funds	2	—	—	2
Fixed maturity mutual funds	—	557	—	557
Common equity securities	601	53	—	654
Private equity securities	—	—	313	313
Total equity securities	603	610	313	1,526
Other invested assets, current	21	—	—	21
Securities lending collateral	314	290	—	604
Derivatives	—	16	—	16
Total assets	$ 2,755	$ 17,783	$ 623	$ 21,161
Liabilities:				
Derivatives	$ —	$ (17)	$ —	$ (17)
Total liabilities	$ —	$ (17)	$ —	$ (17)
December 31, 2017				
Assets:				
Cash equivalents	$ 1,956	$ —	$ —	$ 1,956
Fixed maturity securities, available-for-sale:				
United States Government securities	—	645	—	645
Government sponsored securities	—	90	—	90
States, municipalities and political subdivisions, tax-exempt	—	6,035	—	6,035
Corporate securities	25	7,232	229	7,486
Residential mortgage-backed securities	—	2,534	5	2,539
Commercial mortgage-backed securities	—	79	—	79
Other securities	75	973	16	1,064
Total fixed maturity securities, available-for-sale	100	17,588	250	17,938
Equity securities:				
Exchange traded funds	1,300	—	—	1,300
Fixed maturity mutual funds	—	791	—	791
Common equity securities	1,147	107	—	1,254
Private equity securities	—	—	287	287
Total equity securities	2,447	898	287	3,632
Other invested assets, current	17	—	—	17
Securities lending collateral	214	241	—	455
Derivatives	—	3	—	3
Total assets	$ 4,734	$ 18,730	$ 537	$ 24,001
Liabilities:				
Derivatives	$ —	$ (21)	$ —	$ (21)
Total liabilities	$ —	$ (21)	$ —	$ (21)

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level III inputs for the years ended December 31, 2018, 2017 and 2016 is as follows:

	Corporate Securities	Residential Mortgage-backed Securities	Commercial Mortgage-backed Securities	Other Securities	Equity Securities	Total
Year ended December 31, 2018						
Beginning balance at January 1, 2018	$ 229	$ 5	$ —	$ 16	$ 287	$ 537
Total gains (losses):						
Recognized in net income	1	—	—	—	(229)	(228)
Recognized in accumulated other comprehensive loss	(5)	—	—	—	—	(5)
Purchases	120	2	—	18	290	430
Sales	(33)	—	—	(1)	(35)	(69)
Settlements	(88)	(1)	—	(10)	—	(99)
Transfers into Level III	65	—	—	9	—	74
Transfers out of Level III	(2)	—	—	(15)	—	(17)
Ending balance at December 31, 2018	$ 287	$ 6	$ —	$ 17	$ 313	$ 623
Change in unrealized losses included in net income related to assets still held at December 31, 2018	$ —	$ —	$ —	$ —	$ 30	$ 30
Year ended December 31, 2017						
Beginning balance at January 1, 2017	$ 239	$ 11	$ —	$ 43	$ 188	$ 481
Total (losses) gains:						
Recognized in net income	(1)	—	—	—	—	(1)
Recognized in accumulated other comprehensive loss	3	—	—	—	11	14
Purchases	88	4	—	36	89	217
Sales	(48)	(5)	—	(1)	(1)	(55)
Settlements	(64)	(2)	—	(7)	—	(73)
Transfers into Level III	15	3	—	15	—	33
Transfers out of Level III	(3)	(6)	—	(70)	—	(79)
Ending balance at December 31, 2017	$ 229	$ 5	$ —	$ 16	$ 287	$ 537
Change in unrealized losses included in net income related to assets still held at December 31, 2017	$ (3)	$ —	$ —	$ —	$ —	$ (3)
Year ended December 31, 2016						
Beginning balance at January 1, 2016	$ 186	$ —	$ 2	$ 26	$ 102	$ 316
Total (losses) gains:						
Recognized in net income	(3)	—	—	—	1	(2)
Recognized in accumulated other comprehensive loss	(2)	—	—	(1)	(1)	(4)
Purchases	170	4	—	—	223	397
Sales	(5)	—	—	—	(137)	(142)
Settlements	(57)	—	—	(1)	—	(58)
Transfers into Level III	7	9	—	29	—	45
Transfers out of Level III	(57)	(2)	(2)	(10)	—	(71)
Ending balance at December 31, 2016	$ 239	$ 11	$ —	$ 43	$ 188	$ 481
Change in unrealized losses included in net income related to assets still held at December 31, 2016	$ (2)	$ —	$ —	$ —	$ —	$ (2)

There were no individually material transfers into or out of Level III during the years ended December 31, 2018, 2017 or 2016.

Our valuation policy is determined by members of our treasury and accounting departments. Whenever possible, our policy is to obtain quoted market prices in active markets to estimate fair values for recognition and disclosure purposes. Where quoted market prices in active markets are not available, fair values are estimated using discounted cash flow analyses, broker quotes or other valuation techniques. These techniques are significantly affected by our assumptions,

including discount rates and estimates of future cash flows. Potential taxes and other transaction costs are not considered in estimating fair values. Our valuation policy is generally to obtain quoted prices for each security from third-party pricing services, which are derived through recently reported trades for identical or similar securities making adjustments through the reporting date based upon available market observable information. As we are responsible for the determination of fair value, we perform analysis on the prices received from the pricing services to determine whether the prices are reasonable estimates of fair value. This analysis is performed by our internal treasury personnel who are familiar with our investment portfolios, the pricing services engaged and the valuation techniques and inputs used. Our analysis includes procedures such as a review of month-to-month price fluctuations and price comparisons to secondary pricing services. There were no adjustments to quoted market prices obtained from the pricing services during the years ended December 31, 2018, 2017 or 2016.

Certain assets and liabilities are measured at fair value on a nonrecurring basis; that is, the instruments are not measured at fair value on an ongoing basis but are subject to fair value adjustments only in certain circumstances. As disclosed in Note 3, “Business Acquisitions,” we completed our acquisition of America’s 1st Choice on February 15, 2018. The net assets acquired in our acquisition of America’s 1st Choice and resulting goodwill and other intangible assets were recorded at fair value primarily using Level III inputs. The majority of America’s 1st Choice assets acquired and liabilities assumed were recorded at their carrying values as of the respective date of acquisition, as their carrying values approximated their fair values due to their short-term nature. The fair values of goodwill and other intangible assets acquired in our acquisition of America’s 1st Choice were internally estimated based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets could be expected to generate in the future. We developed internal estimates for the expected cash flows and discount rate in the present value calculation. Other than the assets acquired and liabilities assumed in our acquisition of America’s 1st Choice described above, there were no other material assets or liabilities measured at fair value on a nonrecurring basis during the years ended December 31, 2018 or 2017.

In addition to the preceding disclosures on assets recorded at fair value in the consolidated balance sheets, FASB guidance also requires the disclosure of fair values for certain other financial instruments for which it is practicable to estimate fair value, whether or not such values are recognized in the consolidated balance sheets.

Non-financial instruments such as real estate, property and equipment, other current assets, deferred income taxes, intangible assets and certain financial instruments, such as policy liabilities, are excluded from the fair value disclosures. Therefore, the fair value amounts cannot be aggregated to determine our underlying economic value.

The carrying amounts reported in the consolidated balance sheets for cash, accrued investment income, premium receivables, self-funded receivables, other receivables, income taxes receivable, unearned income, accounts payable and accrued expenses, security trades pending payable, securities lending payable and certain other current liabilities approximate fair value because of the short-term nature of these items. These assets and liabilities are not listed in the table below.

The following methods and assumptions were used to estimate the fair value of each class of financial instrument that is recorded at its carrying value on the consolidated balance sheets:

Other invested assets, long-term: Other invested assets, long-term primarily include our investments in limited partnerships, joint ventures and other non-controlled corporations, as well as the cash surrender value of corporate-owned life insurance policies. Investments in limited partnerships, joint ventures and other non-controlled corporations are carried at our share in the entities’ undistributed earnings, which approximates fair value. The carrying value of corporate-owned life insurance policies represents the cash surrender value as reported by the respective insurer, which approximates fair value.

Short-term borrowings: The fair value of our short-term borrowings is based on quoted market prices for the same or similar debt, or if no quoted market prices were available, on the current market interest rates estimated to be available to us for debt of similar terms and remaining maturities.

Long-term debt - commercial paper: The carrying amount for commercial paper approximates fair value, as the underlying instruments have variable interest rates at market value.

Long-term debt - senior unsecured notes and surplus notes: The fair values of our notes are based on quoted market prices in active markets for the same or similar debt, or, if no quoted market prices are available, on the current market observable rates estimated to be available to us for debt of similar terms and remaining maturities.

Long-term debt—convertible debentures: The fair value of our convertible debentures is based on the quoted market price in the active private market in which the convertible debentures trade.

A summary of the estimated fair values by level of each class of financial instrument that is recorded at its carrying value on our consolidated balance sheets at December 31, 2018 and 2017 are as follows:

	Carrying Value	Estimated Fair Value			
		Level I	Level II	Level III	Total
December 31, 2018					
Assets:					
Other invested assets, long-term	$ 3,726	$ —	$ —	$ 3,726	$ 3,726
Liabilities:					
Debt:					
Short-term borrowings	1,145	—	1,145	—	1,145
Commercial paper	697	—	697	—	697
Notes	17,178	—	17,145	—	17,145
Convertible debentures	191	—	1,030	—	1,030
December 31, 2017					
Assets:					
Other invested assets, long-term	$ 3,344	$ —	$ —	$ 3,344	$ 3,344
Liabilities:					
Debt:					
Short-term borrowings	1,275	—	1,275	—	1,275
Commercial paper	804	—	804	—	804
Notes	17,593	—	18,815	—	18,815
Convertible debentures	260	—	1,216	—	1,216

7. Income Taxes

The components of deferred income taxes at December 31, 2018 and 2017 are as follows:

	2018	2017
Deferred tax assets relating to:		
Retirement benefits	$ 226	$ 211
Accrued expenses	301	279
Insurance reserves	96	136
Net operating loss carryforwards	7	4
Bad debt reserves	104	128
State income tax	32	33
Deferred compensation	20	24
Investment basis difference	—	24
Unrealized losses on securities	41	—
Other	72	81
Total deferred tax assets	899	920
Deferred tax liabilities relating to:		
Investment basis difference	52	—
Unrealized gains on securities	—	175
Intangible assets:		
Trademarks and state Medicaid licenses	1,529	1,529
Customer, provider and hospital relationships	290	186
Internally developed software and other amortization differences	461	324
Retirement benefits	183	170
Debt discount	27	28
State deferred tax	105	105
Depreciation and amortization	47	41
Other	165	89
Total deferred tax liabilities	2,859	2,647
Net deferred tax liability	$ 1,960	$ 1,727

Significant components of the provision for income taxes for the years ended December 31, 2018, 2017 and 2016 consist of the following:

	2018	2017	2016
Current tax expense:			
Federal	$ 1,128	$ 1,356	$ 1,862
State and local	78	39	94
Total current tax expense	1,206	1,395	1,956
Deferred tax expense (benefit)	112	(1,274)	129
Total income tax expense	$ 1,318	$ 121	$ 2,085

State and local current tax expense is reported gross of federal benefit, and includes amounts related to audit settlements, uncertain tax positions, state tax credits and true up of prior years' tax. Such items are included in multiple lines in the following rate reconciliation table on a net of federal tax basis.

A reconciliation of income tax expense recorded in the consolidated statements of income and amounts computed at the statutory federal income tax rate for the years ended December 31, 2018, 2017 and 2016 is as follows:

	2018		2017		2016	
	Amount	Percent	Amount	Percent	Amount	Percent
Amount at statutory rate	$ 1,064	21.0 %	$ 1,387	35.0 %	$ 1,594	35.0 %
State and local income taxes net of federal tax expense/benefit	63	1.2	(2)	(0.1)	62	1.4
Tax exempt interest and dividends received deduction	(27)	(0.5)	(58)	(1.4)	(62)	(1.4)
HIP Fee	324	6.4	—	—	412	9.0
Tax Cuts and Jobs Act	(28)	(0.6)	(1,108)	(27.9)	—	—
Other, net	(78)	(1.5)	(98)	(2.5)	79	1.8
Total income tax expense	$ 1,318	26.0 %	$ 121	3.1 %	$ 2,085	45.8 %

During the year ended December 31, 2018, we recognized income tax expense of $324, or $1.23 per diluted share, as a result of the non-tax deductibility of the HIP Fee payment. On December 22, 2017, the federal government enacted the Tax Cuts and Jobs Act, which contains significant changes to corporate taxation, including, but not limited to, reducing the U.S. federal corporate income tax rate from 35% to 21% and modifying or limiting many business deductions. At December 31, 2018, we have completed our accounting for the tax effects of enactment of the Tax Cuts and Jobs Act. There was no material change to our 2017 provisional amount. In addition we reclassified, for our interim and annual reporting periods beginning on January 1, 2018, $91 of stranded tax effects from accumulated other comprehensive loss to retained earnings on our consolidated balance sheet.

During the year ended December 31, 2017, we recognized an income tax benefit of $1,108, or $4.14 per diluted share, as a result of the provisional amount recorded related to the remeasurement of our deferred tax balance as a result of the enactment of the Tax Cuts and Jobs Act. The HIP Fee payment was suspended for 2017.

During the year ended December 31, 2016, we recognized income tax expense of $412, or $1.54 per diluted share, as a result of the non-tax deductibility of the HIP Fee payments.

The change in the carrying amount of gross unrecognized tax benefits from uncertain tax positions for the years ended December 31, 2018 and 2017 is as follows:

	2018	2017
Balance at January 1	$ 190	$ 131
Additions based on:		
Tax positions related to current year	35	3
Tax positions related to prior years	50	83
Reductions based on:		
Tax positions related to prior years	(31)	(18)
Settlements with taxing authorities	(3)	(9)
Balance at December 31	$ 241	$ 190

The table above excludes interest, net of related tax benefits, which is treated as income tax expense (benefit) under our accounting policy. The interest is included in the amounts described in the following paragraph.

The amount of unrecognized tax benefits that would impact our effective tax rate in future periods, if recognized, was $237 and $175 at December 31, 2018 and 2017, respectively. Also included in the table above, at December 31, 2018, is $2 that would be recognized as an adjustment to additional paid-in capital, which would not affect our effective tax rate. In

addition to the contingent liabilities included in the table above, during 2017 we filed protective state income tax refund claims of approximately $310. There were no equivalent protective state income tax refund claims filed in 2018.

For the years ended December 31, 2018, 2017 and 2016, we recognized net interest expense of $15, $3 and $7, respectively. We had accrued approximately $37 and $22 for the payment of interest at December 31, 2018 and 2017, respectively.

As of December 31, 2018, as further described below, certain tax years remain open to examination by the Internal Revenue Service, or IRS, and various state and local authorities. In addition, we continue to discuss certain industry issues with the IRS. As a result of these examinations and discussions, we have recorded amounts for uncertain tax positions. It is anticipated that the amount of unrecognized tax benefits will change in the next twelve months due to possible settlements of audits and changes in temporary items. However, the ultimate resolution of these items is dependent on the completion of negotiations with various taxing authorities. While it is difficult to determine when other tax settlements will actually occur, it is reasonably possible that one could occur in the next twelve months and our unrecognized tax benefits could change within a range of approximately $(54) to $(158).

We are a member of the IRS Compliance Assurance Process, or CAP. The objective of CAP is to reduce taxpayer burden and uncertainty while assuring the IRS of the accuracy of tax returns prior to filing, thereby reducing or eliminating the need for post-filing examinations.

As of December 31, 2018, the IRS examination of our 2018 and 2017 tax years continues to be in process.

In certain states, we pay premium taxes in lieu of state income taxes. Premium taxes are reported with selling, general and administrative expense.

At December 31, 2018, we had unused federal tax net operating loss carryforwards of approximately $20 to offset future taxable income. The loss carryforwards expire in the years 2032 through 2037. During 2018, 2017 and 2016, federal income taxes paid totaled $738, $1,503 and $1,665, respectively.

8. Property and Equipment

A summary of property and equipment at December 31, 2018 and 2017 is as follows:

	2018	2017
Computer software, purchased and internally developed	$ 3,532	$ 2,613
Computer equipment, furniture and other equipment	1,266	1,080
Leasehold improvements	563	494
Building and improvements	169	168
Land and improvements	18	18
Property and equipment, gross	5,548	4,373
Accumulated depreciation and amortization	(2,813)	(2,198)
Property and equipment, net	$ 2,735	$ 2,175

Depreciation expense for 2018, 2017 and 2016 was $124, $111 and $104, respectively. Amortization expense on computer software and leasehold improvements for 2018, 2017 and 2016 was $528, $490 and $472, respectively, which includes amortization expense on computer software, both purchased and internally developed, for 2018, 2017 and 2016 of $465, $435 and $412, respectively. Capitalized costs related to the internal development of software of $3,226 and $2,373 at December 31, 2018 and 2017, respectively, are reported with computer software.

During the years ended December 31, 2018, 2017 and 2016, we recognized $5, $2 and $25, respectively, of impairments related to computer software, primarily internally developed. We also recognized $20 of impairments related to computer equipment in 2016. These impairments were due to project cancellation or asset replacement, some of which resulted from a change in strategic focus needed to effectively manage business operations in a post-ACA environment.

9. Goodwill and Other Intangible Assets

A summary of the change in the carrying amount of goodwill for our segments (see Note 19, “Segment Information”) for 2018 and 2017 is as follows:

	Commercial and Specialty Business	Government Business	Other	Total
Balance as of January 1, 2017	$ 11,818	$ 5,743	$ —	$ 17,561
Acquisitions	—	1,659	11	1,670
Balance as of December 31, 2017	11,818	7,402	11	19,231
Acquisitions	—	1,285	—	1,285
Adjustments	(267)	266	(11)	(12)
Balance as of December 31, 2018	$ 11,551	$ 8,953	$ —	$ 20,504
Accumulated impairment as of December 31, 2018	$ (41)	$ —	$ —	$ (41)

The increase in goodwill in 2018 was primarily due to the acquisition of America's 1st Choice in February 2018. The increase in goodwill in 2017 was primarily due to the acquisition of HealthSun in December 2017. For additional information regarding these acquisitions, see Note 3, “Business Acquisitions”.

The adjustments in 2018 include measurement period adjustments for HealthSun as well as certain reclassifications made for segment reporting. For additional information, see Note 19, “Segment Information”.

As required by FASB guidance, we completed annual impairment tests of existing goodwill and other intangible assets with indefinite lives during 2018, 2017 and 2016. We perform these annual impairment tests during the fourth quarter. FASB guidance also requires interim impairment testing to be performed when potential impairment indicators exist. These tests involve the use of estimates related to the fair value of goodwill and intangible assets with indefinite lives and require a significant degree of management judgment and the use of subjective assumptions. Qualitative testing procedures include assessing our financial performance, macroeconomic conditions, industry and market considerations, various asset specific factors and entity specific events. For quantitative testing, the fair values are estimated using the projected income and market valuation approaches, incorporating Level III internal estimates for inputs, including, but not limited to, revenue projections, income projections, cash flows and discount rates. We did not incur any impairment losses in 2018, 2017 or 2016, as the estimated fair values of our reporting units were substantially in excess of their carrying values.

The components of other intangible assets as of December 31, 2018 and 2017 are as follows:

	2018			2017		
	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
Intangible assets with finite lives:						
Customer relationships	$ 4,495	$ (3,185)	$ 1,310	$ 3,725	$ (2,878)	$ 847
Provider and hospital relationships	228	(85)	143	187	(73)	114
Other	352	(88)	264	184	(67)	117
Total	5,075	(3,358)	1,717	4,096	(3,018)	1,078
Intangible assets with indefinite lives:						
Blue Cross and Blue Shield and other trademarks	6,299	—	6,299	6,299	—	6,299
State Medicaid licenses	991	—	991	991	—	991
Total	7,290	—	7,290	7,290	—	7,290
Other intangible assets	$ 12,365	$ (3,358)	$ 9,007	$ 11,386	$ (3,018)	$ 8,368

As of December 31, 2018, the estimated amortization expense for each of the five succeeding years is as follows: 2019, $337; 2020, $289; 2021, $243; 2022, $195; and 2023, $161.

10. Retirement Benefits

We sponsor various non-contributory employee defined benefit plans through certain subsidiaries.

The Anthem Cash Balance Plan A and the Anthem Cash Balance Plan B are cash balance pension plans covering certain eligible employees of the affiliated companies that participate in these plans. Effective January 1, 2006, benefits were curtailed, with the result that most participants stopped accruing benefits but continue to earn interest on benefits accrued prior to the curtailment. Certain participants subject to collective bargaining and certain other participants who met grandfathering rules continued to accrue benefits. Participants who did not receive credits and/or benefit accruals are included in the Anthem Cash Balance Plan A, while employees who were still receiving credits and/or benefits participate in the Anthem Cash Balance Plan B. Effective January 1, 2019, benefits under the Anthem Cash Balance Plan B were curtailed. All grandfathered participants will no longer have pay credits added to their accounts but will continue to earn interest on existing account balances. Participants will continue to earn years of pension service for vesting purposes. Several pension plans acquired through various corporate mergers and acquisitions have been merged into these plans in prior years.

The UGS Pension Plan is a defined benefit pension plan with a cash balance component. The UGS Pension Plan covers eligible employees of the affiliated companies that participate in the UGS Pension Plan. Effective January 1, 2004, benefits were curtailed, with the result that most participants stopped accruing benefits but continue to earn interest on benefits previously accrued. Certain employees subject to collective bargaining agreements and certain other employees who met grandfathering rules continue to accrue benefits. Effective December 31, 2017, the UGS Pension Plan was merged into the Anthem Cash Balance Plan B.

The Employees' Retirement Plan of Blue Cross of California, or the BCC Plan, is a defined benefit pension plan that covers eligible employees of Blue Cross of California who are covered by a collective bargaining agreement. Effective January 1, 2007, benefits were curtailed under the BCC Plan with the result that no Blue Cross of California employees hired or rehired after December 31, 2006 are eligible to participate in the BCC Plan.

All of the plans' assets consist primarily of common stocks, fixed maturity securities, investment funds and short-term investments. The funding policies for all plans are to contribute amounts at least sufficient to meet the minimum funding requirements set forth in the Employee Retirement Income Security Act of 1974, as amended, or ERISA, including amendments by the Pension Protection Act of 2006, and in accordance with income tax regulations, plus such additional amounts as are necessary to provide assets sufficient to meet the benefits to be paid to plan participants.

We use a December 31 measurement date for determining benefit obligations and fair value of plan assets.

The following tables disclose consolidated "pension benefits," which include the defined benefit pension plans described above, and consolidated "other benefits," which include postretirement health and welfare benefits including medical, vision and dental benefits offered to certain employees. Calculations were computed using assumptions at the December 31 measurement dates.

The reconciliation of the benefit obligation is as follows:

	Pension Benefits		Other Benefits	
	2018	2017	2018	2017
Benefit obligation at beginning of year	$ 1,872	$ 1,825	$ 524	$ 565
Service cost	8	10	1	1
Interest cost	55	66	15	21
Actuarial (gain) loss	(70)	104	(57)	(39)
Benefits paid	(122)	(133)	(52)	(24)
Benefit obligation at end of year	$ 1,743	$ 1,872	$ 431	$ 524

The changes in the fair value of plan assets are as follows:

	Pension Benefits		Other Benefits	
	2018	2017	2018	2017
Fair value of plan assets at beginning of year	$ 2,012	$ 1,888	$ 356	$ 332
Actual return on plan assets	(76)	253	(17)	41
Employer contributions	4	4	49	7
Benefits paid	(122)	(133)	(52)	(24)
Fair value of plan assets at end of year	$ 1,818	$ 2,012	$ 336	$ 356

The net amount included in the consolidated balance sheets is as follows:

	Pension Benefits		Other Benefits	
	2018	2017	2018	2017
Noncurrent assets	$ 134	$ 202	$ —	$ —
Current liabilities	(6)	(5)	—	—
Noncurrent liabilities	(53)	(57)	(95)	(168)
Net amount at December 31	$ 75	$ 140	$ (95)	$ (168)

The net amounts included in accumulated other comprehensive loss that have not been recognized as components of net periodic benefit costs are as follows:

	Pension Benefits		Other Benefits	
	2018	2017	2018	2017
Net actuarial loss	$ 751	$ 625	$ 58	$ 77
Prior service cost (credit)	1	1	(34)	(46)
Net amount before tax at December 31	$ 752	$ 626	$ 24	$ 31

The estimated net actuarial loss and prior service cost for the defined benefit pension plans that will be reclassified from accumulated other comprehensive loss into net periodic benefit costs over the next year are $16 and $0, respectively. The estimated net actuarial loss and prior service credit for postretirement benefit plans that will be reclassified from accumulated other comprehensive loss into net periodic benefit costs over the next year are $2 and $12, respectively.

The accumulated benefit obligation for the defined benefit pension plans was $1,742 and $1,869 at December 31, 2018 and 2017, respectively.

As of December 31, 2018, certain pension plans had accumulated benefit obligations in excess of plan assets. For those same plans, the projected benefit obligation was also in excess of plan assets. Such plans had a combined projected benefit obligation, accumulated benefit obligation and fair value of plan assets of $94, $93 and $36, respectively.

The weighted-average assumptions used in calculating the benefit obligations for all plans are as follows:

	Pension Benefits		Other Benefits	
	2018	2017	2018	2017
Discount rate	4.15%	3.44%	4.04%	3.42%
Rate of compensation increase	3.00%	3.00%	3.00%	3.00%
Expected rate of return on plan assets	7.44%	7.83%	7.00%	7.00%

The components of net periodic benefit credit included in the consolidated statements of income are as follows:

	2018	2017	2016
Pension Benefits			
Service cost	$ 8	$ 10	$ 12
Interest cost	55	66	69
Expected return on assets	(147)	(147)	(147)
Recognized actuarial loss	22	22	19
Amortization of prior service credit	—	—	(1)
Settlement loss	5	7	7
Net periodic benefit credit	$ (57)	$ (42)	$ (41)
Other Benefits			
Service cost	$ 1	$ 1	$ 2
Interest cost	15	21	22
Expected return on assets	(24)	(23)	(22)
Recognized actuarial loss	3	11	12
Amortization of prior service credit	(12)	(13)	(14)
Net periodic benefit credit	$ (17)	$ (3)	$ —

During the years ended December 31, 2018, 2017 and 2016 we incurred total settlement losses of $5, $7 and $7, respectively, as lump-sum payments exceeded the service cost and interest cost components of net periodic benefit cost for certain of our plans.

The weighted-average assumptions used in calculating the net periodic benefit cost for all plans are as follows:

	2018	2017	2016
Pension Benefits			
Discount rate	3.44%	3.77%	3.92%
Rate of compensation increase	3.00%	3.00%	3.00%
Expected rate of return on plan assets	7.83%	7.95%	7.84%
Other Benefits			
Discount rate	3.42%	3.82%	4.01%
Rate of compensation increase	3.00%	3.00%	3.00%
Expected rate of return on plan assets	7.00%	7.00%	7.00%

The assumed healthcare cost trend rates used to measure the expected cost of pre-Medicare (those who are not currently eligible for Medicare benefits) other benefits at our December 31, 2018 measurement date was 7.50% for 2019 with a gradual decline to 4.50% by the year 2028. The assumed healthcare cost trend rates used to measure the expected cost of post-Medicare (those who are currently eligible for Medicare benefits) other benefits at our December 31, 2018 measurement date was 6.00% for 2019 with a gradual decline to 4.50% by the year 2028. These estimated trend rates are subject to change in the future. The healthcare cost trend rate assumption affects the amounts reported. For example, an increase in the assumed healthcare cost trend rate of one percentage point would increase the postretirement benefit obligation as of December 31, 2018 by $24 and would increase service and interest costs by $1. Conversely, a decrease in the assumed healthcare cost trend rate of one percentage point would decrease the postretirement benefit obligation as of December 31, 2018 by $21 and would decrease service and interest costs by $1.

Plan assets include a diversified mix of investment grade fixed maturity securities, equity securities and alternative investments across a range of sectors and levels of capitalization to maximize the long-term return for a prudent level of risk. The weighted-average target allocation for pension benefit plan assets is 44% equity securities, 47% fixed maturity securities, and 9% to all other types of investments. Equity securities primarily include a mix of domestic securities, foreign securities and mutual funds invested in equities. Fixed maturity securities primarily include treasury securities, corporate bonds and asset-backed investments issued by corporations and the U.S. government. Other types of investments primarily include partnership interests, collective trusts that replicate money market funds and insurance contracts designed specifically for employee benefit plans. As of December 31, 2018, there were no significant concentrations of investments in the pension benefit assets or other benefit assets. No plan assets were invested in Anthem common stock.

Pension benefit assets and other benefit assets recorded at fair value are categorized based upon the level of judgment associated with the inputs used to measure their fair value.

The fair values of our pension benefit assets and other benefit assets by asset category and level inputs at December 31, 2018, excluding cash, investment income receivable and amounts due to/from brokers, resulting in a net asset of $69, are as follows (see Note 6, “Fair Value,” for additional information regarding the definition of level inputs):

	Level I	Level II	Level III	Total
December 31, 2018				
Pension Benefit Assets:				
Equity securities:				
U.S. securities	$ 488	$ —	$ —	$ 488
Foreign securities	147	—	—	147
Mutual funds	36	—	—	36
Fixed maturity securities:				
Government securities	—	248	—	248
Corporate securities	—	347	—	347
Asset-backed securities	—	153	—	153
Other types of investments:				
Partnership interests	—	—	187	187
Insurance company contracts	—	—	166	166
Total pension benefit assets	$ 671	$ 748	$ 353	$ 1,772
Other Benefit Assets:				
Equity securities:				
U.S. securities	$ 9	$ —	$ —	$ 9
Foreign securities	3	—	—	3
Mutual funds	27	—	—	27
Fixed maturity securities:				
Government securities	—	3	—	3
Corporate securities	—	5	—	5
Asset-backed securities	—	5	—	5
Other types of investments:				
Partnership interests	—	—	2	2
Life insurance contracts	—	—	249	249
Investment in DOL 103-12 trust	—	10	—	10
Total other benefit assets	$ 39	$ 23	$ 251	$ 313

The fair values of our pension benefit assets and other benefit assets by asset category and level inputs at December 31, 2017, excluding cash, investment income receivable and amounts due to/from brokers, resulting in a net asset of $14, are as follows:

	Level I	Level II	Level III	Total
December 31, 2017				
Pension Benefit Assets:				
Equity securities:				
U.S. securities	$ 584	$ 5	$ —	$ 589
Foreign securities	179	—	—	179
Mutual funds	39	—	—	39
Fixed maturity securities:				
Government securities	227	—	—	227
Corporate securities	—	377	—	377
Asset-backed securities	—	140	—	140
Other types of investments:				
Common and collective trusts	—	54	—	54
Partnership interests	—	—	221	221
Insurance company contracts	—	—	173	173
Total pension benefit assets	$ 1,029	$ 576	$ 394	$ 1,999
Other Benefit Assets:				
Equity securities:				
U.S. securities	$ 10	$ —	$ —	$ 10
Foreign securities	3	—	—	3
Mutual funds	48	—	—	48
Fixed maturity securities:				
Government securities	3	—	—	3
Corporate securities	—	5	—	5
Asset-backed securities	—	5	—	5
Other types of investments:				
Common and collective trusts	—	1	—	1
Life insurance contracts	—	—	269	269
Investment in DOL 103-12 trust	—	11	—	11
Total other benefit assets	$ 64	$ 22	$ 269	$ 355

A reconciliation of the beginning and ending balances of plan assets measured at fair value using Level III inputs for the years ended December 31, 2018, 2017 and 2016 is as follows:

	Partnership Interests	Insurance Company Contracts	Life Insurance Contracts	Total
Year ended December 31, 2018				
Beginning balance at January 1, 2018	$ 221	$ 173	$ 269	$ 663
Actual return on plan assets relating to assets still held at the reporting date	(10)	(7)	(15)	(32)
Purchases	—	8	—	8
Sales	(22)	(8)	(5)	(35)
Ending balance at December 31, 2018	$ 189	$ 166	$ 249	$ 604
Year ended December 31, 2017				
Beginning balance at January 1, 2017	$ 114	$ 173	$ 238	$ 525
Actual return on plan assets relating to assets still held at the reporting date	20	(1)	31	50
Purchases	126	10	—	136
Sales	(39)	(9)	—	(48)
Ending balance at December 31, 2017	$ 221	$ 173	$ 269	$ 663
Year ended December 31, 2016				
Beginning balance at January 1, 2016	$ 119	$ 174	$ 230	$ 523
Actual return on plan assets relating to assets still held at the reporting date	(4)	(3)	11	4
Purchases	18	9	—	27
Sales	(19)	(7)	(3)	(29)
Ending balance at December 31, 2016	$ 114	$ 173	$ 238	$ 525

During 2018, we transferred our United States Government securities from Level I to Level II based on the inputs used to measure fair value. There were no transfers into or out of Level III during the years ended December 31, 2018, 2017 or 2016.

Our current funding strategy is to fund an amount at least equal to the minimum required funding as determined under ERISA with consideration of maximum tax deductible amounts. We may elect to make discretionary contributions up to the maximum amount deductible for income tax purposes. For the years ended December 31, 2018, 2017 and 2016, no material contributions were necessary to meet ERISA required funding levels. However, during the years ended December 31, 2018, 2017 and 2016, we made tax deductible discretionary contributions to the pension benefit plans of $4, $4 and $11, respectively. Employer contributions to other benefit plans represent discretionary contributions and do not include payments to retirees for current benefits.

Our estimated future payments for pension benefits and postretirement benefits, which reflect expected future service, as appropriate, are as follows:

	Pension Benefits	Other Benefits
2019	$ 124	$ 37
2020	121	37
2021	123	37
2022	123	37
2023	121	36
2024 - 2028	575	159

In addition to the defined benefit plans, we maintain the Anthem 401(k) Plan which is a qualified defined contribution plan covering substantially all employees. Voluntary employee contributions are matched by us subject to certain limitations. Contributions made by us totaled $211, $142 and $132 during 2018, 2017 and 2016, respectively. Contributions in 2018 include approximately $58 for a one time contribution made to employees following the enactment of the Tax Cuts and Jobs Act.

11. Medical Claims Payable

A reconciliation of the beginning and ending balances for medical claims payable, by segment (see Note 19, “Segment Information”), for the year ended December 31, 2018 is as follows:

	Commercial & Specialty Business	Government Business	Total
Gross medical claims payable, beginning of year	$ 3,383	$ 4,431	$ 7,814
Ceded medical claims payable, beginning of year	(78)	(27)	(105)
Net medical claims payable, beginning of year	3,305	4,404	7,709
Business combinations and purchase adjustments	—	199	199
Net incurred medical claims:			
Current year	24,094	45,487	69,581
Prior years redundancies	(456)	(474)	(930)
Total net incurred medical claims	23,638	45,013	68,651
Net payments attributable to:			
Current year medical claims	21,633	41,115	62,748
Prior years medical claims	2,734	3,845	6,579
Total net payments	24,367	44,960	69,327
Net medical claims payable, end of year	2,576	4,656	7,232
Ceded medical claims payable, end of year	10	24	34
Gross medical claims payable, end of year	$ 2,586	$ 4,680	$ 7,266

A reconciliation of the beginning and ending balances for medical claims payable, by segment, for the year ended December 31, 2017 is as follows:

	Commercial & Specialty Business	Government Business	Total
Gross medical claims payable, beginning of year	$ 3,247	$ 4,409	$ 7,656
Ceded medical claims payable, beginning of year	(521)	(18)	(539)
Net medical claims payable, beginning of year	2,726	4,391	7,117
Business combinations and purchase adjustments	—	76	76
Net incurred medical claims:			
Current year	29,467	40,910	70,377
Prior years redundancies	(462)	(671)	(1,133)
Total net incurred medical claims	29,005	40,239	69,244
Net payments attributable to:			
Current year medical claims	26,250	36,673	62,923
Prior years medical claims	2,176	3,629	5,805
Total net payments	28,426	40,302	68,728
Net medical claims payable, end of year	3,305	4,404	7,709
Ceded medical claims payable, end of year	78	27	105
Gross medical claims payable, end of year	$ 3,383	$ 4,431	$ 7,814

A reconciliation of the beginning and ending balances for medical claims payable, by segment, for the year ended December 31, 2016 is as follows:

	Commercial & Specialty Business	Government Business	Total
Gross medical claims payable, beginning of year	$ 3,371	$ 3,989	$ 7,360
Ceded medical claims payable, beginning of year	(636)	(10)	(646)
Net medical claims payable, beginning of year	2,735	3,979	6,714
Net incurred medical claims:			
Current year	27,588	37,280	64,868
Prior years redundancies	(463)	(372)	(835)
Total net incurred medical claims	27,125	36,908	64,033
Net payments attributable to:			
Current year medical claims	24,928	32,951	57,879
Prior years medical claims	2,206	3,545	5,751
Total net payments	27,134	36,496	63,630
Net medical claims payable, end of year	2,726	4,391	7,117
Ceded medical claims payable, end of year	521	18	539
Gross medical claims payable, end of year	$ 3,247	$ 4,409	$ 7,656

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any period-end are continually reviewed and re-estimated as information regarding actual claims payments, or runout, becomes known. This information is compared to the originally established year end liability. Negative amounts reported for incurred medical claims related to prior years result from claims being settled for amounts less than originally estimated. The prior year redundancy of $930 shown above for the year ended December 31, 2018 represents an estimate

based on paid claim activity from January 1, 2018 to December 31, 2018. Medical claim liabilities are usually described as having a "short tail," which means that they are generally paid within twelve months of the member receiving service from the provider. Accordingly, the majority of the $930 redundancy relates to claims incurred in calendar year 2017.

The following table provides a summary of the two key assumptions having the most significant impact on our incurred but not paid liability estimates for the years ended December 31, 2018, 2017 and 2016, which are the completion and trend factors. These two key assumptions can be influenced by utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations.

	Favorable Developments by Changes in Key Assumptions		
	2018	2017	2016
Assumed trend factors	$ (515)	$ (631)	$ (578)
Assumed completion factors	(415)	(502)	(257)
Total	$ (930)	$ (1,133)	$ (835)

The favorable development recognized in 2018 and 2017 resulted from trend and completion factors developing more favorably than originally expected. The favorable development recognized in 2016 resulted primarily from trend factors in late 2015 developing more favorably than originally expected as well as a smaller but significant contribution from completion factor development.

The reconciliation of net incurred medical claims to benefit expense included in the consolidated statements of income is as follows:

	Years Ended December 31		
	2018	2017	2016
Net incurred medical claims:			
Commercial & Specialty Business	$ 23,638	$ 29,005	$ 27,125
Government Business	45,013	40,239	36,908
Total net incurred medical claims	68,651	69,244	64,033
Quality improvement and other claims expense	3,244	2,992	2,801
Benefit expense	$ 71,895	$ 72,236	$ 66,834

Incurred claims development, net of reinsurance, for the Commercial & Specialty Business for the years ended December 31, 2018, 2017 and 2016 is as follows:

Commercial & Specialty Business	Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Years	2016 (Unaudited)	2017 (Unaudited)	2018
2016 & Prior	$ 29,861	$ 29,399	$ 29,298
2017		29,467	29,112
2018			24,094
Total			$ 82,504

Paid claims development, net of reinsurance, for the Commercial & Specialty Business for the years ended December 31, 2018, 2017 and 2016 is as follows:

Commercial & Specialty Business	Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Years	**2016 (Unaudited)**	**2017 (Unaudited)**	**2018**
2016 & Prior	$ 27,135	$ 29,311	$ 29,289
2017		26,250	29,006
2018			21,633
Total			$ 79,928

At December 31, 2018, the total of incurred but not reported liabilities plus expected development on reported claims for the Commercial & Specialty Business was $9, $106 and $2,461 for the claim years 2016 and prior, 2017 and 2018, respectively.

At December 31, 2018, the cumulative number of reported claims for the Commercial & Specialty Business was 120, 117 and 85 for the claim years 2016 and prior, 2017 and 2018, respectively.

Incurred claims development, net of reinsurance, for the Government Business as of and for the years ended December 31, 2018, 2017 and 2016 is as follows:

Government Business	Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Years	**2016 (Unaudited)**	**2017 (Unaudited)**	**2018**
2016 & Prior	$ 40,888	$ 40,217	$ 40,133
2017		40,986	40,596
2018			45,686
Total			$ 126,415

Paid claims development, net of reinsurance, for the Government Business as of and for the years ended December 31, 2018, 2017 and 2016 is as follows:

Government Business	Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Years	**2016 (Unaudited)**	**2017 (Unaudited)**	**2018**
2016 & Prior	$ 36,497	$ 40,126	$ 40,103
2017		36,673	40,541
2018			41,115
Total			$ 121,759

At December 31, 2018, the total of incurred but not reported liabilities plus expected development on reported claims for the Government Business was $30, $55 and $4,571 for the claim years 2016 and prior, 2017 and 2018, respectively.

At December 31, 2018, the cumulative number of reported claims for the Government Business was 209, 211 and 205 for the claim years 2016 and prior, 2017 and 2018, respectively.

The information about incurred claims development, paid claims development and cumulative number of reported claims for the years ended December 31, 2016 and 2017, for both the Commercial & Specialty Business and Government Business, is unaudited and presented as supplementary information.

The cumulative number of reported claims for each claim year, for both the Commercial & Specialty Business and Government Business, have been developed using historical data captured by our claim payment systems. The provided claim amounts are not a precise tool for understanding utilization of medical services. They could be impacted by a variety of factors including changes in provider billing practices, provider reimbursement arrangements, mix of services, benefit design or processing systems. The cumulative number of reported claims has been provided to comply with FASB accounting standards and is not used by management in its claims analysis. Our cumulative number of reported claims may not be comparable to similar measures reported by other health benefits companies.

The reconciliation of the Commercial & Specialty Business and Government Business incurred and paid claims development information for the three years ended December 31, 2018, reflected in the tables above, to the consolidated ending balance for medical claims payable included in the consolidated balance sheet, as of December 31, 2018, is as follows:

	Commercial & Specialty Business	Government Business	Total
Cumulative incurred claims and allocated claim adjustment expenses, net of reinsurance	$ 82,504	$ 126,415	$ 208,919
Less: Cumulative paid claims and allocated claim adjustment expenses, net of reinsurance	79,928	121,759	201,687
Net medical claims payable, end of year	2,576	4,656	7,232
Ceded medical claims payable, end of year	10	24	34
Insurance lines other than short duration	—	188	188
Gross medical claims payable, end of year	$ 2,586	$ 4,868	$ 7,454

12. Debt

Short-term Borrowings

We are a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati and the Federal Home Loan Bank of Atlanta, or collectively, the FHLBs. As a member we have the ability to obtain short-term cash advances, subject to certain minimum collateral requirements. At December 31, 2018 and 2017, $645 and $825, respectively, were outstanding under our short-term FHLB borrowings. These outstanding short-term FHLB borrowings at December 31, 2018 and 2017 had fixed interest rates of 2.458% and 1.386%, respectively.

Through certain subsidiaries, we have entered into multiple 364-day lines of credit with separate lenders for general corporate purposes. In 2018, we increased the combined borrowing capacity on these line of credit from $450 to $600. The interest rate on each line of credit is based on the LIBOR rate plus a predetermined rate. Our ability to borrow under the lines of credit is subject to compliance with certain covenants. At December 31, 2018 and 2017, $500 and $450, respectively, were outstanding under our 364-day lines of credit.

Long-term Debt

The carrying value of long-term debt at December 31, 2018 and 2017 consists of the following:

	2018	2017
Senior unsecured notes:		
1.875%, due 2018	$ —	$ 625
2.300%, due 2018	—	649
2.250%, due 2019	849	847
2.500%, due 2020	897	895
4.350%, due 2020	688	693
3.700%, due 2021	698	698
2.950%, due 2022	747	746
3.125%, due 2022	846	845
3.300%, due 2023	1,000	994
3.350%, due 2024	846	845
3.500%, due 2024	794	793
3.650%, due 2027	1,589	1,589
4.101%, due 2028	1,250	—
5.950%, due 2034	334	334
5.850%, due 2036	396	396
6.375%, due 2037	366	366
5.800%, due 2040	124	123
4.625%, due 2042	887	887
4.650%, due 2043	986	986
4.650%, due 2044	791	791
5.100%, due 2044	594	594
4.375%, due 2047	1,386	1,386
4.550%, due 2048	838	—
4.850%, due 2054	247	247
Remarketable subordinated notes:		
1.900%, due 2028	—	1,239
Surplus note:		
9.000%, due 2027	25	25
Senior convertible debentures:		
2.750%, due 2042	191	260
Variable rate debt:		
Commercial paper program	697	804
Total long-term debt	18,066	18,657
Current portion of long-term debt	(849)	(1,275)
Long-term debt, less current portion	$ 17,217	$ 17,382

All debt is a direct obligation of Anthem, Inc., except for the surplus note, the FHLB borrowings and the lines of credit.

We generally issue senior unsecured notes, or Notes, for long-term borrowing purposes. Certain of these Notes may have a call feature that allows us to redeem the Notes at any time at our option and/or a put feature that allows a Note holder to redeem the Notes upon the occurrence of both a change in control event and a downgrade of the Notes below an investment grade rating.

On July 16, 2018, we repaid, at maturity, the $650 outstanding balance of our 2.300% senior unsecured notes. On January 15, 2018, we repaid, at maturity, the $625 outstanding balance of our 1.875% senior unsecured notes.

On May 1, 2018, we settled our Equity Units stock purchase contracts at a settlement rate of 0.2412 shares of our common stock, using a market value formula set forth in the Equity Units purchase contracts. This resulted in the issuance of approximately 6 shares. We had issued 25 Equity Units on May 12, 2015, pursuant to an underwriting agreement dated May 6, 2015, in an aggregate principal amount of $1,250. Each Equity Unit had a stated amount of $50 (whole dollars) and consisted of a purchase contract obligating the holder to purchase a certain number of shares of our common stock on May 1, 2018, subject to earlier termination or settlement, for a price in cash of $50 (whole dollars); and a 5% undivided beneficial ownership interest in $1,000 (whole dollars) principal amount of our 1.900% remarketable subordinated notes, or RSNs, due 2028. At December 31, 2017, the stock purchase contract liability was $21 and was included in other current liabilities and other noncurrent liabilities with a corresponding offset to additional paid-in capital in our consolidated balance sheet. Contract adjustment payments commenced on August 1, 2015 at a rate of 3.350% per annum on the stated amount per Equity Unit. The RSNs were pledged as collateral to secure the purchase of common stock under the related stock purchase contracts. Quarterly interest payments on the RSNs commenced on August 1, 2015. On March 2, 2018, we remarketed the RSNs and used the proceeds to purchase U.S. Treasury securities that were pledged to secure the stock purchase obligations of the holders of the Equity Units. The purchasers of the RSNs transferred the RSNs to us in exchange for $1,250 principal amount of our 4.101% senior notes due 2028, or the 2028 Notes, and a cash payment of $4. We cancelled the RSNs upon receipt and recognized a loss on extinguishment of debt of $18. At the remarketing, we also issued $850 aggregate principal amount of 4.550% notes due 2048, or the 2048 Notes, under our shelf registration statement. We used the proceeds from the 2048 Notes for working capital and general corporate purposes. Interest on the 2028 Notes and the 2048 Notes is payable semi-annually in arrears on March 1 and September 1 of each year, commencing on September 1, 2018.

On November 21, 2017, we issued $900 aggregate principal amount of 2.500% Notes due 2020, $750 aggregate principal amount of 2.950% Notes due 2022, $850 aggregate principal amount of 3.350% Notes due 2024, $1,600 aggregate principal amount of 3.650% Notes due 2027 and $1,400 aggregate principal amount of 4.375% Notes due 2047 under our shelf registration statement. Interest on the 2020 Notes is payable semi-annually in arrears on May 21 and November 21 of each year, commencing on May 21, 2018. Interest on the 2022 Notes, the 2024 Notes, the 2027 Notes and the 2047 Notes is payable semi-annually in arrears on June 1 and December 1 of each year, commencing on June 1, 2018. The net proceeds were used to fund the acquisitions of HealthSun and America’s 1st Choice; redemption of the 7.000% Notes due 2019, discussed below; and redemption of the Tender Notes, discussed below.

On November 14, 2017, we initiated a cash tender offer to purchase any and all of our 7.000% Notes due 2019, or the Any and All Notes, and certain of our 5.950% Notes due 2034, 5.850% Notes due 2036, 6.375% Notes due 2037, 5.800% Notes due 2040 and 5.100% Notes due 2044, or the Maximum Tender Offer Notes, and collectively with the Any and All Notes, the Tender Notes. On November 21, 2017, we repurchased $185 aggregate principal amount of the Any and All Notes, plus applicable premium and accrued and unpaid interest, for cash totaling $199. On November 30, 2017, we repurchased $836 aggregate principal amount of the Maximum Tender Offer Notes, plus applicable premium and accrued and unpaid interest, for cash totaling $1,095. We recognized a loss on extinguishment of debt of $266 for the repurchase of the Tender Notes.

On December 14, 2017, we redeemed the $255 remaining outstanding principal balance of our 7.000% Notes due 2019, plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling $275. We recognized a loss on extinguishment of debt of $14 for the repurchase of these Notes.

On June 15, 2017 and February 15, 2017, we repaid, upon maturity, the $529 outstanding balance of our 5.875% Notes and the $400 outstanding balance of our 2.375% Notes, respectively.

The surplus note is an unsecured obligation of Anthem Insurance Companies, Inc., or Anthem Insurance, a wholly owned subsidiary, and is subordinate in right of payment to all of Anthem Insurance’s existing and future indebtedness. Any payment of interest or principal on the surplus note may be made only with the prior approval of the Indiana Department of Insurance,

or IDOI, and only out of capital and surplus funds of Anthem Insurance that the IDOI determines to be available for the payment under Indiana insurance laws.

We have a senior revolving credit facility, or the Facility, with a group of lenders for general corporate purposes. The Facility provides credit up to $3,500 and matures on August 25, 2020. The interest rate on the Facility is based on either the LIBOR rate or a base rate plus a predetermined rate based on our public debt rating at the date of utilization. Our ability to borrow under the Facility is subject to compliance with certain covenants. There were no amounts outstanding under the Facility at December 31, 2018 or 2017.

We have an authorized commercial paper program of up to $2,500, the proceeds of which may be used for general corporate purposes. At December 31, 2018, we had $697 outstanding under our commercial paper program with a weighted-average interest rate of 2.8270%. At December 31, 2017, we had $804 outstanding under our commercial paper program with a weighted-average interest rate of 1.8247%. Commercial paper borrowings have been classified as long-term debt at December 31, 2018 and 2017, as our general practice and intent is to replace short-term commercial paper outstanding at expiration with additional short-term commercial paper for an uninterrupted period extending for more than one year, and we have the ability to redeem our commercial paper with borrowings under the Facility described above.

During the year ended December 31, 2015, we entered into a bridge facility commitment letter and a joinder agreement, and a term loan facility, to finance a portion of the consideration under the now terminated Cigna Merger Agreement. In January 2017, we reduced the size of the bridge facility from $22,500 to $19,500 and extended the termination date under the Cigna Merger Agreement, as well as the availability of commitments under the bridge facility and term loan facility, to April 30, 2017. We recorded $108 and $104 of interest expense related to the amortization of the bridge loan facility and other related fees during the years ended December 31, 2017 and 2016, respectively. The commitment of the lenders to provide the bridge facility and term loan facility expired on April 30, 2017.

Convertible Debentures

On October 9, 2012, we issued $1,500 of senior convertible debentures, or the Debentures, in a private offering to qualified institutional buyers pursuant to Rule 144A under the Securities Act of 1933, as amended, or the Securities Act. The Debentures are governed by an indenture dated as of October 9, 2012 between us and The Bank of New York Mellon Trust Company, N.A., as trustee, or the Indenture. The Debentures bear interest at a rate of 2.750% per year, payable semi-annually in arrears in cash on April 15 and October 15 of each year, and mature on October 15, 2042, unless earlier redeemed, repurchased or converted into shares of common stock at the applicable conversion rate. The Debentures also have a contingent interest feature that will require us to pay additional interest based on certain thresholds and for certain events, as defined in the Indenture, beginning on October 15, 2022.

Holders may convert their Debentures at their option prior to the close of business on the business day immediately preceding April 15, 2042, only under the following circumstances: (1) during any fiscal quarter if the last reported sale price of our common stock for at least 20 trading days during a period of 30 consecutive trading days ending on the last trading day of the preceding fiscal quarter is greater than or equal to 130% of the applicable conversion price on each applicable trading day; (2) during the five business day period after any 10 consecutive trading day period, or the measurement period, in which the trading price per $1,000 (whole dollars) principal amount of Debentures for each trading day of that measurement period was less than 98% of the product of the last reported sale price of our common stock and the applicable conversion rate on each such day; (3) if we call any or all of the Debentures for redemption, at any time prior to the close of business on the third scheduled trading day prior to the redemption date; or (4) upon the occurrence of specified corporate events, as defined in the Indenture. On and after April 15, 2042 and until the close of business on the third scheduled trading day immediately preceding the Debentures' maturity date of October 15, 2042, holders may convert their Debentures into common stock at any time irrespective of the preceding circumstances. The Debentures are redeemable at our option at any time on or after October 20, 2022, upon the occurrence of certain events, as defined in the Indenture.

Upon conversion of the Debentures, we will deliver cash up to the aggregate principal amount of the Debentures converted. With respect to any conversion obligation in excess of the aggregate principal amount of the Debentures converted, we have the option to settle the excess with cash, shares of our common stock or a combination thereof based on a daily conversion value, determined in accordance with the Indenture. The initial conversion rate for the Debentures was 13.2319 shares of our common stock per Debenture, which represented a 25% conversion premium based on the closing

price of $60.46 per share of our common stock on October 2, 2012 (the date the Debentures' terms were finalized) and is equivalent to an initial conversion price of $75.575 per share of our common stock.

During the year ended December 31, 2018, $109 aggregate principal amount of the Debentures were surrendered for conversion by certain holders in accordance with the terms and provisions of the Indenture. We elected to settle the excess of the principal amount of the conversions with cash for total payments of $402. We recognized a gain on the extinguishment of debt related to the Debentures of $7, based on the fair values of the debt on the conversion settlement dates. During the year ended December 31, 2017, $117 aggregate principal amount of the Debentures was surrendered for conversion. We elected to settle the excess of the principal amount of the conversions with cash for total payments of $345 and recognized a loss on the extinguishment of debt of $2. There were no repurchases or material conversions during the year ended December 31, 2016.

As of December 31, 2018, our common stock was last traded at a price of $262.63 per share. If the remaining Debentures had been converted or matured at December 31, 2018, we would have been obligated to pay the principal of the Debentures plus an amount in cash or shares equal to $757. The Debentures and underlying shares of our common stock have not been and will not be registered under the Securities Act, or any state securities laws, and may not be offered or sold in the United States absent registration or an applicable exemption from registration requirements.

We have accounted for the Debentures in accordance with the cash conversion guidance in FASB guidance for debt with conversion and other options. As a result, the value of the embedded conversion option, net of deferred taxes and equity issuance costs, has been bifurcated from its debt host and recorded as a component of additional paid-in capital in our consolidated balance sheets.

The following table summarizes, at December 31, 2018, the related balances, conversion rate and conversion price of the Debentures:

Outstanding principal amount	$	287
Unamortized debt discount	$	93
Net debt carrying amount	$	191
Equity component carrying amount	$	104
Conversion rate (shares of common stock per $1,000 of principal amount)		13.8474
Effective conversion price (per $1,000 of principal amount)	$	72.2151

The remaining amortization period of the unamortized debt discount as of December 31, 2018 is approximately 24 years. The unamortized discount will be amortized into interest expense using the effective interest method based on an effective interest rate of 5.130%, which represents the market interest rate for a comparable debt instrument that does not have a conversion feature. During the years ended December 31, 2018, 2017 and 2016, we recognized $12, $17 and $17, respectively, of interest expense related to the Debentures, of which $10, $14 and $14, respectively, represented interest expense recognized at the stated interest rate of 2.750% and $2, $3 and $3, respectively, represented interest expense resulting from amortization of the debt discount.

Total interest paid during 2018, 2017 and 2016 was $728, $778, and $595, respectively.

We were in compliance with all applicable covenants under all of our outstanding debt agreements at December 31, 2018 and 2017.

Future maturities of all long-term debt outstanding at December 31, 2018 are as follows: 2019, $1,546; 2020, $1,585; 2021, $698; 2022, $1,593; 2023, $1,000 and thereafter, $11,644.

13. Commitments and Contingencies

Litigation and Regulatory Proceedings

In the ordinary course of business, we are defendants in, or parties to, a number of pending or threatened legal actions or proceedings. To the extent a plaintiff or plaintiffs in the following cases have specified in their complaint or in other court filings the amount of damages being sought, we have noted those alleged damages in the descriptions below. With respect to

the cases described below, we contest liability and/or the amount of damages in each matter and believe we have meritorious defenses.

Where available information indicates that it is probable that a loss has been incurred as of the date of the consolidated financial statements and we can reasonably estimate the amount of that loss, we accrue the estimated loss by a charge to income. In many proceedings, however, it is difficult to determine whether any loss is probable or reasonably possible. In addition, even where loss is possible or an exposure to loss exists in excess of the liability already accrued with respect to a previously identified loss contingency, it is not always possible to reasonably estimate the amount of the possible loss or range of loss.

With respect to many of the proceedings to which we are a party, we cannot provide an estimate of the possible losses, or the range of possible losses in excess of the amount, if any, accrued, for various reasons, including but not limited to some or all of the following: (i) there are novel or unsettled legal issues presented, (ii) the proceedings are in early stages, (iii) there is uncertainty as to the likelihood of a class being certified or decertified or the ultimate size and scope of the class, (iv) there is uncertainty as to the outcome of pending appeals or motions, (v) there are significant factual issues to be resolved, and/or (vi) in many cases, the plaintiffs have not specified damages in their complaint or in court filings. For those legal proceedings where a loss is probable, or reasonably possible, and for which it is possible to reasonably estimate the amount of the possible loss or range of losses, we currently believe that the range of possible losses, in excess of established reserves is, in the aggregate, from $0 to approximately $250 at December 31, 2018. This estimated aggregate range of reasonably possible losses is based upon currently available information taking into account our best estimate of such losses for which such an estimate can be made.

Blue Cross Blue Shield Antitrust Litigation

We are a defendant in multiple lawsuits that were initially filed in 2012 against the BCBSA and Blue Cross and/or Blue Shield licensees, or Blue plans, across the country. The cases were consolidated into a single multi-district proceeding captioned *In re Blue Cross Blue Shield Antitrust Litigation* that is pending in the United States District Court for the Northern District of Alabama, or the Court. Generally, the suits allege that the BCBSA and the Blue plans have conspired to horizontally allocate geographic markets through license agreements, best efforts rules that limit the percentage of non-Blue revenue of each plan, restrictions on acquisitions rules governing the BlueCard and National Accounts programs and other arrangements in violation of the Sherman Antitrust Act, or Sherman Act, and related state laws. The cases were brought by two putative nationwide classes of plaintiffs, health plan subscribers and providers, and actions filed in Alabama, Arkansas, California, Florida, Hawaii, Illinois, Indiana, Kansas, Kansas City, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Dakota, Rhode Island, South Carolina, Tennessee, Texas, Vermont and Virginia have been consolidated into the multi-district proceeding.

In response to cross motions for partial summary judgment by plaintiffs and defendants, the Court issued an order in April 2018 determining that the defendants' aggregation of geographic market allocations and output restrictions are to be analyzed under a per se standard of review, and the BlueCard program and other alleged Section 1 Sherman Act violations are to be analyzed under the rule of reason standard of review. The Court also found that there remain genuine issues of material fact as to whether defendants operate as a single entity with regard to the enforcement of the Blue Cross Blue Shield trademarks. In June 2018, in response to a motion filed by the defendants, the Court certified its April order for interlocutory appeal to the United States Court of Appeals for the Eleventh Circuit, or the Eleventh Circuit. Also in June 2018, the defendants filed, with the Eleventh Circuit Court of Appeals, a petition for permission to appeal the April order, which Plaintiffs opposed. In December 2018, the Eleventh Circuit denied the petition. No dates have been set for either the final pretrial conferences or trials in these actions. We intend to vigorously defend these suits; however, their ultimate outcome cannot be presently determined.

Blue Cross of California Taxation Litigation

In July 2013, our California affiliate Blue Cross of California (doing business as Anthem Blue Cross), or BCC, was named as a defendant in a California taxpayer action filed in Los Angeles County Superior Court, captioned *Michael D. Myers v. State Board of Equalization, et al.* This action was brought under a California statute that permits an individual taxpayer to sue a governmental agency when the taxpayer believes the agency has failed to enforce governing law. Plaintiff contends that BCC, a licensed Health Care Service Plan, or HCSP, is an "insurer" for purposes of taxation despite acknowledging it is not an "insurer" under regulatory law. At the time, under California law, "insurers" were required to pay

a gross premiums tax, or GPT, calculated as 2.35% on gross premiums. As a licensed HCSP, BCC has paid the California Corporate Franchise Tax, or CFT, the tax paid by California businesses generally. Plaintiff contends that BCC must pay the GPT rather than the CFT, and seeks a writ of mandate directing the taxing agencies to collect the GPT and an order requiring BCC to pay GPT back taxes, interest, and penalties, for the eight-year period prior to the filing of the complaint.

In March 2018, the Court denied BCC's motion for judgment on the pleadings and similar motions brought by other entities. We filed a writ of mandate in the California Court of Appeal. The Court of Appeal accepted our writ, and we anticipate that a hearing on our writ will occur in mid-2019. Because GPT is constitutionally imposed in lieu of certain other taxes, BCC has filed protective tax refund claims with the City of Los Angeles, the California Department of Health Care Services and the Franchise Tax Board to protect its rights to recover certain taxes previously paid should BCC eventually be determined to be subject to the GPT for the tax periods at issue in the litigation. BCC intends to vigorously defend this suit; however, its ultimate outcome cannot be presently determined.

Express Scripts, Inc. Pharmacy Benefit Management Litigation

In March 2016, we filed a lawsuit against Express Scripts, Inc., or Express Scripts, our vendor for pharmacy benefit management, or PBM, services, captioned *Anthem, Inc. v. Express Scripts, Inc.*, in the U.S. District Court for the Southern District of New York. The lawsuit seeks to recover over $14,800 in damages for pharmacy pricing that is higher than competitive benchmark pricing under the agreement between the parties, or ESI PBM Agreement, over $158 in damages related to operational breaches, as well as various declarations under the ESI PBM Agreement between the parties, including that Express Scripts: (i) breached its obligation to negotiate in good faith and to agree in writing to new pricing terms; (ii) is required to provide competitive benchmark pricing to us through the term of the ESI PBM Agreement; (iii) has breached the ESI PBM Agreement and that we can terminate the ESI PBM Agreement; and (iv) is required under the PBM Agreement to provide post-termination services, at competitive benchmark pricing, for one year following any termination.

Express Scripts has disputed our contractual claims and is seeking declaratory judgments: (i) regarding the timing of the periodic pricing review under the ESI PBM Agreement; (ii) that it has no obligation to ensure that we receive any specific level of pricing, that we have no contractual right to any change in pricing under the ESI PBM Agreement and that its sole obligation is to negotiate proposed pricing terms in good faith; and (iii) that we do not have the right to terminate the ESI PBM Agreement. In the alternative, Express Scripts claims that we have been unjustly enriched by its payment of $4,675 at the time of the ESI PBM Agreement. In March 2017, the court granted our motion to dismiss Express Scripts' counterclaims for (i) breach of the implied covenant of good faith and fair dealing, and (ii) unjust enrichment with prejudice. The only remaining claims are for breach of contract and declaratory relief. We intend to vigorously pursue our claims and defend against any counterclaims, which we believe are without merit; however, the ultimate outcome cannot be presently determined.

ERISA Litigation

We are a defendant in a class action lawsuit that was initially filed in June 2016 against Anthem, Inc. and Express Scripts, which has been consolidated into a single multi-district lawsuit captioned *In Re Express Scripts/Anthem ERISA Litigation*, in the U.S. District Court for the Southern District of New York. The consolidated complaint was filed by plaintiffs against Express Scripts and us on behalf of all persons who are participants in or beneficiaries of any ERISA or non-ERISA healthcare plan from December 1, 2009 to the present in which we provided prescription drug benefits through the ESI PBM Agreement and paid a percentage based co-insurance payment in the course of using that prescription drug benefit. The plaintiffs allege that we breached our duties, either under ERISA or with respect to the implied covenant of good faith and fair dealing implied in the health plans, (i) by failing to adequately monitor Express Scripts' pricing under the ESI PBM Agreement and (ii) by placing our own pecuniary interest above the best interests of our insureds by allegedly agreeing to higher pricing in the ESI PBM Agreement in exchange for the purchase price for our NextRx PBM business, and (iii) with respect to the non-ERISA members, by negotiating and entering into the ESI PBM Agreement that was allegedly detrimental to the interests of such non-ERISA members. Plaintiffs seek to hold us and Express Scripts jointly and severally liable and to recover all losses suffered by the proposed class, equitable relief, disgorgement of alleged ill-gotten gains, injunctive relief, attorney's fees and costs and interest.

In April 2017, we filed a motion to dismiss the claims brought against us, and it was granted, without prejudice, in January 2018. Plaintiffs filed a notice of appeal with the United States Court of Appeals for the Second Circuit, which was

heard in October 2018. We intend to vigorously defend this suit; however, its ultimate outcome cannot be presently determined.

Cigna Corporation Merger Litigation

In July 2015, we and Cigna announced that we entered into the Cigna Merger Agreement, pursuant to which we would acquire all outstanding shares of Cigna. In July 2016, the U.S. Department of Justice, or DOJ, along with certain state attorneys general, filed a civil antitrust lawsuit in the U.S. District Court for the District of Columbia, or District Court, seeking to block the merger. In February 2017, Cigna purported to terminate the Cigna Merger Agreement and commenced litigation against us in the Delaware Court of Chancery, or Delaware Court, seeking damages, including the $1,850 termination fee pursuant to the terms of the Cigna Merger Agreement, and a declaratory judgment that its purported termination of the Cigna Merger Agreement was lawful, among other claims, which is captioned *Cigna Corp. v. Anthem Inc.*

Also in February 2017, we initiated our own litigation against Cigna in the Delaware Court seeking a temporary restraining order to enjoin Cigna from terminating the Cigna Merger Agreement, specific performance compelling Cigna to comply with the Cigna Merger Agreement and damages, which is captioned *Anthem Inc. v. Cigna Corp*. In April 2017, the U.S. Circuit Court of Appeals for the District of Columbia affirmed the ruling of the District Court, which blocked the merger. In May 2017, after the Delaware Court denied our motion to enjoin Cigna from terminating the Cigna Merger Agreement, we delivered to Cigna a notice terminating the Cigna Merger Agreement.

The litigation in Delaware is ongoing with trial scheduled to commence in late February 2019. We believe Cigna's allegations are without merit and we intend to vigorously pursue our claims and defend against Cigna's allegations; however, the ultimate outcome of our litigation with Cigna cannot be presently determined.

In October 2018, a shareholder filed a derivative lawsuit in the State of Indiana Marion County Superior Court, captioned *Henry Bittmann, Derivatively, et al. v. Joseph R Swedish, et al.*, purportedly on behalf of Anthem and its shareholders against certain current and former directors and officers alleging breaches of fiduciary duties, unjust enrichment and corporate waste associated with the Cigna Merger Agreement. This case has been stayed at the request of the parties pending the outcome of our litigation with Cigna in the Delaware Court. This lawsuit's ultimate outcome cannot be presently determined.

U.S. Department of Justice (DOJ) Civil Investigative Demands

Beginning in December 2016, the DOJ has issued civil investigative demands to us to discover information about our chart review and risk adjustment programs under Parts C and D of the Medicare Program. We understand the DOJ is investigating the programs of other Medicare Advantage health plans, along with providers and vendors. We continue to cooperate with the DOJ's investigation, and the ultimate outcome cannot presently be determined.

Cyber Attack Regulatory Proceedings and Litigation

In February 2015, we reported that we were the target of a sophisticated external cyber attack. The attackers gained unauthorized access to certain of our information technology systems and obtained personal information related to many individuals and employees, such as names, birth dates, healthcare identification/social security numbers, street addresses, email addresses, phone numbers and employment information, including income data. To date, there is no evidence that credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be given that we will not identify additional information that was accessed or obtained.

Upon discovery of the cyber attack, we took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate our systems and identify solutions based on the evolving landscape. We have provided credit monitoring and identity protection services to those who have been affected by this cyber attack. We have continued to implement security enhancements since this incident. We have incurred expenses subsequent to the cyber attack to investigate and remediate this matter and expect to continue to incur expenses of this nature in the foreseeable future. We recognize these expenses in the periods in which they are incurred.

Federal and state agencies, including state insurance regulators, state attorneys general, the HHS Office of Civil Rights and the Federal Bureau of Investigation, are investigating, or have investigated, events related to the cyber attack, including how it occurred, its consequences and our responses. In connection with the resolution of the National Association of

Insurance Commissioners' multistate targeted market conduct and financial exam in December 2016, we agreed to provide a customized credit protection program, equivalent to a credit freeze, for our members who were under the age of eighteen on January 27, 2015. No fines or penalties were imposed on us. In October 2018, we resolved the investigation by the HHS Office of Civil Rights. The resolution included a monetary settlement along with an agreement to a two-year Corrective Action Plan. Additionally, an ongoing investigation by a multi-state group of Attorneys General remains outstanding. Although we are cooperating in this investigation, we may be subject to additional fines or other obligations, which may have an adverse effect on how we operate our business and an adverse effect on our results of operations and financial condition.

Civil class actions were filed in various federal and state courts by current or former members and others seeking damages that they alleged arose from the cyber attack. In June 2015, the Judicial Panel on Multidistrict Litigation entered an order transferring the consolidated civil actions to the U.S. District Court for the Northern District of California, or the U.S. District Court, in a matter captioned *In Re Anthem, Inc. Data Breach Litigation*. The parties agreed to settle plaintiffs' claims on a class-wide basis for a total settlement payment of $115. In August 2017, the U.S. District Court issued an order of preliminary approval of the settlement. The U.S. District Court held hearings on plaintiffs' motion for final approval and class counsel's fee petition in February and June 2018 and appointed a special master to review class counsel's fee petition. Final approval of the settlement was granted by the U.S. District Court in August 2018. All appeals that were filed with the Ninth Circuit Court of Appeals by class-member objections challenging approval of the settlement have been resolved. This matter is now closed. The three state court cases related to the cyber attack that were proceeding outside of this multidistrict litigation have been resolved and dismissed with prejudice.

We have contingency plans and insurance coverage for certain expenses and potential liabilities of this nature and will pursue coverage for all applicable losses; however, the ultimate outcome of our pursuit of insurance coverage cannot be presently determined. We intend to vigorously defend the remaining regulatory actions related to the cyber attack; however, their ultimate outcome cannot be presently determined.

Other Contingencies

From time to time, we and certain of our subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. We, like HMOs and health insurers generally, exclude certain healthcare and other services from coverage under our HMO, PPO and other plans. We are, in the ordinary course of business, subject to the claims of our enrollees arising out of decisions to restrict or deny reimbursement for uncovered services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on us. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable settlements of coverage claims.

In addition to the lawsuits described above, we are also involved in other pending and threatened litigation of the character incidental to our business, and are from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits, reviews and administrative proceedings include routine and special inquiries by state insurance departments, state attorneys general, the U.S. Attorney General and subcommittees of the U.S. Congress. Such investigations, audits, reviews and administrative proceedings could result in the imposition of civil or criminal fines, penalties, other sanctions and additional rules, regulations or other restrictions on our business operations. Any liability that may result from any one of these actions, or in the aggregate, could have a material adverse effect on our consolidated financial position or results of operations.

Contractual Obligations and Commitments

Express Scripts, through our ESI PBM Agreement, is the provider of certain PBM services to our plans. In October 2017, we established a new pharmacy benefits manager, called IngenioRx, and entered into a five-year agreement with CaremarkPCS Health, L.L.C., or CVS Health, which is a subsidiary of CVS Health Corporation, to begin offering PBM solutions, or the CVS PBM Agreement. In January 2019, we exercised our contractual right to terminate the ESI PBM Agreement earlier than the original expiration date of December 31, 2019 due to the recent acquisition of Express Scripts by Cigna. As a result of exercising our early termination right, the ESI PBM Agreement will now terminate on March 1, 2019, and the twelve-month transition period provided for in the ESI PBM Agreement to migrate the services begins on March 2, 2019. At that time CVS Health is able to begin providing certain PBM services to IngenioRx, pursuant to the CVS PBM Agreement. Notwithstanding our termination of the ESI PBM Agreement, the litigation between us and Express Scripts

regarding the ESI PBM Agreement continues. In March 2016, we filed a lawsuit against Express Scripts seeking to recover damages for pharmacy pricing that is higher than competitive benchmark pricing, damages related to operational breaches, as well as various declarations under the ESI PBM Agreement between the parties. For additional information regarding this lawsuit, refer to the *Litigation and Regulatory Proceedings-Express Scripts, Inc. Pharmacy Benefit Management Litigation* section above. We believe we have appropriately recognized all rights and obligations under the ESI PBM Agreement as of December 31, 2018.

Vulnerability from Concentrations

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash equivalents, investment securities, premium receivables and instruments held through hedging activities. All investment securities are managed by professional investment managers within policies authorized by our Board of Directors. Such policies limit the amounts that may be invested in any one issuer and prescribe certain investee company criteria. Concentrations of credit risk with respect to premium receivables are limited due to the large number of employer groups that constitute our customer base in the states in which we conduct business. As of December 31, 2018, there were no significant concentrations of financial instruments in a single investee, industry or geographic location.

14. Capital Stock

***Stock Incentive Plan*s**

Our Board of Directors has adopted the 2017 Anthem Incentive Compensation Plan, or 2017 Incentive Plan, which has been approved by our shareholders. The term of the 2017 Incentive Plan is such that no awards may be granted on or after May 18, 2027. The 2017 Incentive Plan gives authority to the Compensation Committee of the Board of Directors to make incentive awards to our non-employee directors, employees and consultants, consisting of stock options, stock, restricted stock, restricted stock units, cash-based awards, stock appreciation rights, performance shares and performance units. The 2017 Incentive Plan limits the number of available shares for issuance to 37.5 shares, subject to adjustment as set forth in the 2017 Incentive Plan.

Stock options are granted for a fixed number of shares with an exercise price at least equal to the fair value of the shares at the grant date. Historically, stock options have vested over three years in equal semi-annual installments and generally have a term of ten years from the grant date. Amendments to the 2017 Incentive Plan, effective July 1, 2018, require future grants of stock options to vest in three equal annual installments.

Certain option grants contain provisions whereby the employee continues to vest in the award subsequent to termination due to retirement. Our attribution method for newly granted awards considers all vesting and other provisions, including retirement eligibility, in determining the requisite service period over which the fair value of the awards will be recognized.

Awards of restricted stock or restricted stock units are issued at the fair value of the stock on the grant date and may also include one or more performance measures that must be met for the award to vest. The restrictions lapse in three equal annual installments. Performance units issued in 2018 will vest in 2021, based on earnings targets over the three year period of 2018 to 2020. Performance units issued in 2017 will vest in 2020, based on earnings targets over the three year period of 2017 to 2019. Performance units issued in 2016 will vest in 2019, based on earnings targets over the three year period of 2016 to 2018.

For the years ended December 31, 2018, 2017 and 2016, we recognized share-based compensation expense of $226, $170 and $165, respectively, as well as related tax benefits of $61, $68 and $61, respectively.

A summary of stock option activity for the year ended December 31, 2018 is as follows:

	Number of Shares	Weighted-Average Option Price per Share	Weighted-Average Remaining Contractual Life (Years)	Aggregate Intrinsic Value
Outstanding at January 1, 2018	4.3	$ 124.31		
Granted	0.9	232.79		
Exercised	(1.3)	112.72		
Forfeited or expired	(0.2)	189.52		
Outstanding at December 31, 2018	3.7	149.65	6.15	$ 416
Exercisable at December 31, 2018	2.4	125.88	5.00	$ 331

The intrinsic value of options exercised during the years ended December 31, 2018, 2017 and 2016 amounted to $172, $192 and $103, respectively. We recognized tax benefits of $47, $76 and $38 in 2018, 2017 and 2016, respectively, from option exercises and disqualifying dispositions. During the years ended December 31, 2018, 2017 and 2016, we received cash of $141, $200 and $95, respectively, from exercises of stock options.

The total fair value of restricted stock awards that vested during the years ended December 31, 2018, 2017 and 2016 was $237, $127 and $185, respectively.

A summary of the status of nonvested restricted stock activity, including restricted stock units, for the year ended December 31, 2018 is as follows:

	Restricted Stock Shares and Units	Weighted-Average Grant Date Fair Value per Share
Nonvested at January 1, 2018	2.0	$ 152.20
Granted	0.9	233.73
Vested	(1.0)	147.93
Forfeited	(0.2)	188.06
Nonvested at December 31, 2018	1.7	183.32

During the year ended December 31, 2018, we granted approximately 0.3 restricted stock units that are contingent upon us achieving earning targets over the three year period of 2018 to 2020. These grants have been included in the activity shown above, but will be subject to adjustment at the end of 2020, based on results in the three year period.

During the year ended December 31, 2018, we granted an additional 0.2 restricted stock units, associated with our 2015 grants, that were earned as a result of satisfactory completion of performance measures between 2015 and 2017. These grants and vested shares have been included in the activity shown above.

As of December 31, 2018, the total remaining unrecognized compensation expense related to nonvested stock options and restricted stock, including restricted stock units, amounted to $22 and $136, respectively, which will be amortized over the weighted-average remaining requisite service periods of 11 months and 12 months, respectively.

As of December 31, 2018, there were approximately 26.9 shares of common stock available for future grants under the 2017 Incentive Plan.

Fair Value

We use a binomial lattice valuation model to estimate the fair value of all stock options granted. Expected volatility assumptions used in the binomial lattice model are based on an analysis of implied volatilities of publicly traded options on our stock and historical volatility of our stock price. The risk-free interest rate is derived from the U.S. Treasury strip rates at the time of the grant. The expected term of the options was derived from the outputs of the binomial lattice model, which

incorporates post-vesting forfeiture assumptions based on an analysis of historical data. The dividend yield was based on our estimate of future dividend yields. Similar groups of employees that have dissimilar exercise behavior are considered separately for valuation purposes. We utilize the multiple-grant approach for recognizing compensation expense associated with each separately vesting portion of the share-based award.

The following weighted-average assumptions were used to estimate the fair values of options granted during the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
Risk-free interest rate	2.90%	2.31%	1.76%
Volatility factor	30.00%	32.00%	32.00%
Dividend yield (annual)	1.30%	1.60%	2.00%
Weighted-average expected life (years)	3.70	4.00	4.10

The following weighted-average fair values were determined for the years ending December 31, 2018, 2017 and 2016:

	2018	2017	2016
Options granted during the year	$ 55.48	$ 40.88	$ 30.56
Restricted stock awards granted during the year	233.73	174.44	131.81

The binomial lattice option-pricing model requires the input of highly subjective assumptions including the expected stock price volatility. Because our stock option grants have characteristics significantly different from those of traded options, and because changes in the subjective input assumptions can materially affect the fair value estimate, in our opinion, existing models do not necessarily provide a reliable single measure of the fair value of our stock option grants.

Employee Stock Purchase Plan

We have registered 14.0 shares of common stock for the Employee Stock Purchase Plan, or the Stock Purchase Plan, which is intended to provide a means to encourage and assist employees in acquiring a stock ownership interest in Anthem. Pursuant to the terms of the Stock Purchase Plan, an employee is permitted to purchase no more than $25,000 (actual dollars) worth of stock in any calendar year, based on the fair value of the stock at the end of each plan quarter. Employees become participants by electing payroll deductions from 1% to 15% of gross compensation. Once purchased, the stock is accumulated in the employee's investment account. The Stock Purchase Plan allows participants to purchase shares of our common stock at a price per share of 95% of the fair value of a share of common stock on the last trading day of the plan quarter. The employee stock purchase plan discount is not recognized as compensation expense based on GAAP guidance. There were 0.2 shares issued during the year ended December 31, 2018. As of December 31, 2018, 5.0 shares were available for issuance under the Stock Purchase Plan.

Effective January 1, 2019, the price per share for the shares purchased under the Stock Purchase Plan will be 90% of the fair value of a share of common stock on the lower of the first or last trading day of the plan quarter. This additional discount will result in compensation expense beginning in the first quarter of 2019. Participants will be required to hold shares purchased under the Stock Purchase Plan for at least one year from the purchase date.

Use of Capital and Stock Repurchase Program

We regularly review the appropriate use of capital, including acquisitions, common stock and debt security repurchases and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors.

A summary of the cash dividend activity for the years ended December 31, 2018 and 2017 is as follows:

Declaration Date	Record Date	Payment Date	Cash Dividend per Share	Total
Year ended December 31, 2018				
January 30, 2018	March 9, 2018	March 23, 2018	$ 0.75	$ 192
April 24, 2018	June 8, 2018	June 25, 2018	0.75	196
July 24, 2018	September 10, 2018	September 25, 2018	0.75	195
October 30, 2018	December 5, 2018	December 21, 2018	0.75	193
Year ended December 31, 2017				
February 22, 2017	March 10, 2017	March 24, 2017	$ 0.65	$ 172
April 27, 2017	June 9, 2017	June 23, 2017	0.65	172
July 25, 2017	September 8, 2017	September 25, 2017	0.70	181
October 24, 2017	December 5, 2017	December 21, 2017	0.70	180

On January 29, 2019, our Audit Committee declared a quarterly cash dividend to shareholders of $0.80 per share on the outstanding shares of our common stock. This quarterly dividend is payable on March 29, 2019 to the shareholders of record as of March 18, 2019.

Under our Board of Directors' authorization, we maintain a common stock repurchase program. On December 7, 2017, the Board of Directors authorized a $5,000 increase to the common stock repurchase program. Repurchases may be made from time to time at prevailing market prices, subject to certain restrictions on volume, pricing and timing. The repurchases are effected from time to time in the open market, through negotiated transactions, including accelerated share repurchase agreements, and through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. Our stock repurchase program is discretionary as we are under no obligation to repurchase shares. We repurchase shares under the program when we believe it is a prudent use of capital. The excess cost of the repurchased shares over par value is charged on a pro rata basis to additional paid-in capital and retained earnings.

A summary of common stock repurchases for the period January 1, 2019 through February 7, 2019 (subsequent to December 31, 2018) and for the years ended December 31, 2018 and 2017 is as follows:

	January 1, 2019 through February 7, 2019	Years Ended December 31	
		2018	2017
Shares repurchased	0.6	6.8	10.5
Average price per share	$ 261.26	$ 248.34	$ 189.93
Aggregate cost	$ 165	$ 1,685	$ 1,998
Authorization remaining at end of year	$ 5,328	$ 5,493	$ 7,178

We expect to utilize the remaining authorized amount over a multi-year period, subject to market and industry conditions.

For additional information regarding the use of capital for debt security repurchases, see Note 12, "Debt."

15. Accumulated Other Comprehensive Loss

A reconciliation of the components of accumulated other comprehensive loss at December 31, 2018 and 2017 is as follows:

	2018	2017
Investments:		
Gross unrealized gains	$ 173	$ 940
Gross unrealized losses	(371)	(105)
Net pretax unrealized (losses) gains	(198)	835
Deferred tax asset (liability)	39	(301)
Net unrealized (losses) gains on investments	(159)	534
Non-credit components of OTTI on investments:		
Gross unrealized losses	(3)	—
Deferred tax asset	1	—
Net unrealized non-credit component of OTTI on investments	(2)	—
Cash flow hedges:		
Gross unrealized losses	(311)	(359)
Deferred tax asset	65	126
Net unrealized losses on cash flow hedges	(246)	(233)
Defined benefit pension plans:		
Deferred net actuarial loss	(751)	(625)
Deferred prior service cost	(1)	(1)
Deferred tax asset	193	244
Net unrecognized periodic benefit costs for defined benefit pension plans	(559)	(382)
Postretirement benefit plans:		
Deferred net actuarial loss	(58)	(77)
Deferred prior service credits	34	46
Deferred tax asset	6	12
Net unrecognized periodic benefit costs for postretirement benefit plans	(18)	(19)
Foreign currency translation adjustments:		
Gross unrealized losses	(3)	(2)
Deferred tax asset	1	1
Net unrealized losses on foreign currency translation adjustments	(2)	(1)
Accumulated other comprehensive loss	$ (986)	$ (101)

We adopted the FASB standard on accounting for non-consolidated equity investments (ASU 2016-01) on January 1, 2018 as a cumulative-effect adjustment and reclassified $320 of unrealized gains on equity investments, net of tax, from accumulated other comprehensive loss to retained earnings on our consolidated balance sheet. We also adopted the FASB standard on reclassification of certain tax effects from accumulated other comprehensive income (ASU 2018-02) on January 1, 2018 and reclassified $91 of stranded tax effects from accumulated other comprehensive loss to retained earnings on our consolidated balance sheet. See Note 2, “Basis of Presentation and Significant Accounting Policies – *Recently Adopted Accounting Guidance*” for further information on these standards.

Other comprehensive income (loss) reclassification adjustments for the years ended December 31, 2018, 2017 and 2016 are as follows:

	2018	2017	2016
Investments:			
Net holding (loss) gain on investment securities arising during the period, net of tax benefit (expense) of $133, ($153), and ($119), respectively	$ (465)	$ 280	$ 186
Reclassification adjustment for net realized loss (gain) on investment securities, net of tax (benefit) expense of $(13), $58, and $37, respectively	47	(107)	(68)
Total reclassification adjustment on investments	(418)	173	118
Non-credit component of OTTI on investments:			
Non-credit component of OTTI on investments, net of tax benefit (expense) of $1, ($3), and ($3), respectively	(2)	4	5
Cash flow hedges:			
Holding gain (loss), net of tax (expense) benefit of $(10), $35, and $47, respectively	37	(65)	(87)
Other:			
Net change in unrecognized periodic benefit costs for defined benefit pension and postretirement benefit plans, net of tax benefit (expense) of $29, $(35), and $5, respectively	(90)	51	(13)
Foreign currency translation adjustment, net of tax expense of $0, ($1), and ($1), respectively	(1)	3	2
Net (loss) gain recognized in other comprehensive loss, net of tax benefit (expense) of $140, ($99), and ($34), respectively	$ (474)	$ 166	$ 25

16. Reinsurance

We reinsure certain risks with other companies and assume risk from other companies. We remain primarily liable to policyholders under ceded insurance contracts and are contingently liable for amounts recoverable from reinsurers in the event that such reinsurers do not meet their contractual obligations. In conjunction with the ACA temporary reinsurance premium stabilization program that was effective for 2014 through 2016, we recognized assessments upon our fully-insured non-grandfathered individual market plans that were eligible for reinsurance recoveries as ceded premiums and estimated reinsurance recoveries as a reduction to benefit expense. Assessments upon all other lines of business that were not eligible for reinsurance recoveries were recognized in selling, general and administrative expense.

A summary of direct, assumed and ceded premiums written and earned for the years ended December 31, 2018, 2017 and 2016 is as follows:

	2018		2017		2016	
	Written	Earned	Written	Earned	Written	Earned
Direct	$ 84,835	$ 85,213	$ 83,974	$ 83,418	$ 78,200	$ 78,726
Assumed	264	259	275	275	217	217
Ceded	(51)	(51)	(44)	(45)	(80)	(83)
Net premiums	$ 85,048	$ 85,421	$ 84,205	$ 83,648	$ 78,337	$ 78,860
Percentage—assumed to net premiums	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%

A summary of net premiums written and earned by segment (see Note 19, "Segment Information") for the years ended December 31, 2018, 2017 and 2016 is as follows:

	2018		2017		2016	
	Written	Earned	Written	Earned	Written	Earned
Reportable segments:						
Commercial & Specialty Business	$ 30,661	$ 30,532	$ 35,382	$ 35,503	$ 33,101	$ 33,577
Government Business	54,387	54,889	48,823	48,145	45,236	45,283
Net premiums	$ 85,048	$ 85,421	$ 84,205	$ 83,648	$ 78,337	$ 78,860

The effect of reinsurance on benefit expense for the years ended December 31, 2018, 2017 and 2016 is as follows:

	2018	2017	2016
Direct	$ 71,749	$ 72,135	$ 67,222
Assumed	219	217	184
Ceded	(73)	(116)	(572)
Net benefit expense	$ 71,895	$ 72,236	$ 66,834

The effect of reinsurance on certain assets and liabilities at December 31, 2018 and 2017 is as follows:

	2018	2017
Policy liabilities, assumed	$ 50	$ 54
Unearned income, assumed	6	1
Premiums payable, ceded	17	9
Premiums receivable, assumed	37	33

17. Leases

We lease office space and certain computer and related equipment using noncancelable operating leases. At December 31, 2018, future lease payments for operating leases with initial or remaining noncancelable terms of one year or more consisted of the following:

2019	$ 192
2020	165
2021	139
2022	127
2023	109
Thereafter	385
Total minimum payments required	$ 1,117

We have certain lease agreements that contain contingent payment provisions. Under these provisions, we pay contingent amounts in addition to base rent, primarily based upon annual changes in the consumer price index. The schedule above contains estimated amounts for potential future increases in lease payments based on the contingent payment provisions.

Lease expense for 2018, 2017 and 2016 was $207, $205 and $207, respectively.

18. Earnings per Share

The denominator for basic and diluted earnings per share at December 31, 2018, 2017 and 2016 is as follows:

	2018	2017	2016
Denominator for basic earnings per share—weighted-average shares	258.1	261.5	262.9
Effect of dilutive securities—employee stock options, non-vested restricted stock awards, convertible debentures and equity units	6.1	6.3	5.2
Denominator for diluted earnings per share	264.2	267.8	268.1

During the years ended December 31, 2018, 2017 and 2016, weighted-average shares related to certain stock options of 0.3, 0.4 and 2.2, respectively, were excluded from the denominator for diluted earnings per share because the stock options were anti-dilutive. The Equity Unit purchase contracts were settled in May 2018, and approximately 6.0 shares of our common stock were issued and included in the basic earnings per share calculation.

During the years ended December 31, 2018, 2017 and 2016, we issued approximately 0.3, 0.4 and 0.5 restricted stock units, respectively, of which vesting was contingent upon us meeting certain earnings targets. Contingent restricted stock units are excluded from the denominator for diluted earnings per share and are included only if and when the contingency is met. The 2018 contingent restricted stock units are being measured over the three year period of 2018 through 2020, the 2017 contingent restricted stock units are being measured over the three year period of 2017 through 2019 and the 2016 contingent restricted stock units are being measured over the three year period of 2016 through 2018. Contingent restricted stock units vest in March of the year following each measurement period.

19. Segment Information

Our organizational structure is comprised of three reportable segments: Commercial & Specialty Business; Government Business; and Other.

Our Commercial & Specialty Business segment includes our Local Group, National Accounts, Individual and Specialty businesses. Business units in the Commercial & Specialty Business segment offer fully-insured health products; provide a broad array of managed care services to self-funded customers including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services; and provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits.

Our Government Business segment includes our Medicare and Medicaid businesses, National Government Services, or NGS, and services provided to the federal government in connection with FEP®. Our Medicare business includes services such as Medicare Supplement plans; Medicare Advantage, including Special Needs Plans; Medicare Part D; and dual-eligible programs through Medicare-Medicaid Plans. Our Medicaid business includes our managed care alternatives through publicly funded healthcare programs, including Medicaid, ACA-related Medicaid expansion programs, Temporary Assistance for Needy Families programs, programs for seniors and people with disabilities, Children's Health Insurance Programs, and specialty programs such as those focused on long-term services and support, HIV/AIDS, foster care, behavioral health and/or substance abuse disorders, and intellectual disabilities or developmental disabilities. NGS acts as a Medicare contractor for the federal government in several regions across the nation.

Our Other segment includes certain eliminations and corporate expenses not allocated to either of our other reportable segments.

We define operating revenues to include premium income and administrative fees and other revenues. Operating revenues are derived from premiums and fees received, primarily from the sale and administration of health benefit products. Operating gain, a non-GAAP measure, is calculated as total operating revenue less benefit expense and selling, general and administrative expense.

Through our participation in various federal government programs, we generated approximately 19.8%, 17.8% and 18.2% of our total consolidated revenues from agencies of the U.S. government for the years ended December 31, 2018, 2017, and 2016, respectively. These revenues are contained in the Government Business segment.

The accounting policies of the segments are consistent with those described in the summary of significant accounting policies in Note 2, "Basis of Presentation and Significant Accounting Policies," except that certain shared administrative expenses for each segment are recognized on a pro rata allocated basis, which in the aggregate approximates the consolidated expense. Any difference between the allocated expenses and actual consolidated expense is included in other expenses not allocated to reportable segments. Intersegment sales and expenses are recorded at cost and eliminated in the consolidated financial statements. We evaluate performance of the reportable segments based on operating gain or loss as defined above. We evaluate net investment income, net realized gains on financial instruments, OTTI losses recognized in income, interest expense, amortization expense, gain or loss on extinguishment of debt, income taxes, assets and liabilities on a consolidated basis as these items are managed in a corporate shared service environment and are not the responsibility of segment operating management.

During the fourth quarter of 2018, we reclassified certain ancillary businesses to align how our segments are currently being managed. Prior year amounts have been reclassified for comparability.

Financial data by reportable segment for the years ended December 31, 2018, 2017 and 2016 is as follows:

	Commercial & Specialty Business	Government Business	Other	Total
Year ended December 31, 2018				
Operating revenue	$ 35,782	$ 55,567	$ (8)	$ 91,341
Operating gain (loss)	3,629	1,895	(98)	5,426
Depreciation and amortization of property and equipment	—	—	652	652
Year ended December 31, 2017				
Operating revenue	$ 40,363	$ 48,702	$ (4)	$ 89,061
Operating gain (loss)	2,847	1,445	(117)	4,175
Depreciation and amortization of property and equipment	—	—	601	601
Year ended December 31, 2016				
Operating revenue	$ 38,347	$ 45,850	$ (3)	$ 84,194
Operating gain (loss)	3,148	1,827	(174)	4,801
Depreciation and amortization of property and equipment	—	—	576	576

The major product revenues for each of the reportable segments for the years ended December 31, 2018, 2017 and 2016 are as follows:

	2018	2017	2016
Commercial & Specialty Business			
Managed care products	$ 29,013	$ 33,971	$ 32,134
Managed care services	5,115	4,732	4,616
Dental/Vision products and services	1,220	1,218	1,182
Other	434	442	415
Total Commercial & Specialty Business	35,782	40,363	38,347
Government Business			
Managed care products	54,889	48,145	45,283
Managed care services	678	557	567
Total Government Business	55,567	48,702	45,850
Other			
Other	(8)	(4)	(3)
Total product revenues	$ 91,341	$ 89,061	$ 84,194

The classification between managed care products and managed care services in the above table primarily distinguishes between the levels of risk assumed. Managed care products represent insurance products where we bear the insurance risk, whereas managed care services represent product offerings where we provide claims adjudication and other administrative services to the customer, but the customer principally bears the insurance risk.

Asset, liability and equity details by reportable segment have not been disclosed, as we do not internally report such information.

A reconciliation of reportable segment operating revenues to the amounts of total revenues included in the consolidated statements of income for the years ended December 31, 2018, 2017 and 2016 is as follows:

	2018	2017	2016
Reportable segments operating revenues	$ 91,341	$ 89,061	$ 84,194
Net investment income	970	867	779
Net realized (losses) gains on financial instruments	(180)	145	5
Other-than-temporary impairment losses recognized in income	(26)	(33)	(115)
Total revenues	$ 92,105	$ 90,040	$ 84,863

A reconciliation of reportable segment operating gain to income before income tax expense included in the consolidated statements of income for the years ended December 31, 2018, 2017 and 2016 is as follows:

	2018	2017	2016
Reportable segments operating gain	$ 5,426	$ 4,175	$ 4,801
Net investment income	970	867	779
Net realized (losses) gains on financial instruments	(180)	145	5
Other-than-temporary impairment losses recognized in income	(26)	(33)	(115)
Interest expense	(753)	(739)	(723)
Amortization of other intangible assets	(358)	(169)	(192)
Loss on extinguishment of debt	(11)	(282)	—
Income before income tax expense	$ 5,068	$ 3,964	$ 4,555

20. Related Party Transactions

We have a 19.50% equity investment in National Accounts Service Company, LLC, or NASCO, which processes National Accounts claims and provides other administrative services for us and certain other Blue Cross Blue Shield plans. Administrative expenses incurred related to NASCO services totaled $79, $73 and $80, for the years ended December 31, 2018, 2017 and 2016, respectively. Amounts due to NASCO were $5 and $6 at December 31, 2018 and 2017, respectively.

21. Statutory Information

The majority of our insurance and HMO subsidiaries report their accounts in conformity with accounting practices prescribed or permitted by state insurance regulatory authorities, commonly referred to as statutory accounting, which vary in certain respects from GAAP. However, certain of our insurance and HMO subsidiaries, including BCC, Blue Cross of California Partnership Plan, Inc., Golden West Health Plan, Inc. and CareMore Health Plan are regulated by the California Department of Managed Health Care, or DMHC, and report their accounts in conformity with GAAP (these entities are collectively referred to as the “DMHC regulated entities”). Typical differences of GAAP reporting as compared to statutory reporting are the inclusion of unrealized gains or losses relating to fixed maturity securities in shareholders’ equity, recognition of all assets including those that are non-admitted for statutory purposes and recognition of all deferred tax assets without regard to statutory limits. The National Association of Insurance Commissioners, or NAIC, developed a codified version of the statutory accounting principles, designed to foster more consistency among the states for accounting guidelines and reporting. Prescribed statutory accounting practices are set forth in a variety of publications of the NAIC as well as state laws, regulations and general administrative rules.

Our ability to pay dividends and credit obligations is significantly dependent on receipt of dividends from our subsidiaries. The payment of dividends to us by our insurance and HMO subsidiaries without prior approval of the insurance departments of each subsidiary's domiciliary jurisdiction is limited by formula. Dividends in excess of these amounts are subject to prior approval by the respective state insurance departments or the DMHC.

Our statutory basis insurance and HMO subsidiaries are subject to risk-based capital, or RBC, requirements. RBC is a method developed by the NAIC to determine the minimum amount of statutory capital appropriate for an insurance company or HMO to support its overall business operations in consideration of its size and risk profile. The formula for determining the amount of RBC specifies various factors, weighted based on the perceived degree of risk, which are applied to certain financial balances and financial activity. Below minimum RBC requirements are classified within certain levels, each of which requires specified corrective action. Additionally, the DMHC regulated entities are subject to capital and solvency requirements as prescribed by the DMHC. As of December 31, 2018 and 2017, all of our regulated subsidiaries exceeded the minimum RBC requirements and/or capital and solvency requirements of their applicable governmental regulator. The statutory RBC necessary to satisfy regulatory requirements of our statutory basis insurance and HMO subsidiaries was approximately $4,800 and $4,700 as of December 31, 2018 and 2017, respectively. The tangible net equity required for the DMHC regulated entities was approximately $570 and $670 as of December 31, 2018 and 2017, respectively.

Statutory-basis capital and surplus of our insurance and HMO subsidiaries and capital and surplus of our other regulated subsidiaries, excluding the DMHC regulated entities, was $12,038 and $11,666 at December 31, 2018 and 2017, respectively. Statutory-basis net income of our insurance and HMO subsidiaries and net income of our other regulated subsidiaries, excluding the DMHC regulated entities, was $3,412, $2,674 and $2,613 for 2018, 2017 and 2016, respectively. GAAP equity of the DMHC regulated entities was $3,125 and $2,917 at December 31, 2018 and 2017, respectively. GAAP net income of the DMHC regulated entities was $789, $1,047 and $775 for the years ended December 31, 2018, 2017 and 2016, respectively.

22. Selected Quarterly Financial Data (Unaudited)

Selected quarterly financial data is as follows:

	For the Quarter Ended			
	March 31	June 30	September 30	December 31
2018				
Total revenues	$ 22,537	$ 22,944	$ 23,251	$ 23,373
Income before income tax expense	1,780	1,504	1,242	542
Net income	1,312	1,054	960	424
Basic net income per share	$ 5.13	$ 4.07	$ 3.70	$ 1.64
Diluted net income per share	4.99	3.98	3.62	1.61
2017				
Total revenues	$ 22,525	$ 22,407	$ 22,426	$ 22,682
Income before income tax expense	1,514	1,205	1,119	126
Net income	1,009	855	747	1,232
Basic net income per share	$ 3.82	$ 3.23	$ 2.87	$ 4.80
Diluted net income per share	3.73	3.16	2.80	4.67

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE.

There have been no changes in or disagreements with our independent registered public accounting firm on accounting or financial disclosures.

ITEM 9A. CONTROLS AND PROCEDURES.

Evaluation of Disclosure Controls and Procedures

We carried out an evaluation as of December 31, 2018, under the supervision and with the participation of our management, including our Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures as defined in Rule 13a-15(e) of the Exchange Act. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures are effective in timely alerting them to material information relating to us (including our consolidated subsidiaries) required to be disclosed in our reports under the Exchange Act. In addition, based on that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective in ensuring that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosures.

Management’s Report on Internal Control over Financial Reporting

Management, under the supervision and with the participation of the principal executive officer and principal financial officer, of Anthem, Inc., or the Company, is responsible for establishing and maintaining effective internal control over financial reporting, or Internal Control, as such term is defined in the Exchange Act. The Company’s Internal Control is designed to provide reasonable assurance regarding the reliability of the Company’s financial reporting and the preparation of financial statements for external reporting purposes in accordance with U.S. generally accepted accounting principles, or GAAP. The Company’s Internal Control includes those policies and procedures that (i) pertain to the maintenance of records that in reasonable detail accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with GAAP, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company’s assets that could have a material effect on the financial statements.

Because of inherent limitations in any Internal Control, no matter how well designed, misstatements due to error or fraud may occur and not be detected. Accordingly, even effective Internal Control can provide only reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with GAAP.

Management, under the supervision and with the participation of the principal executive officer and principal financial officer, assessed the effectiveness of the Company’s Internal Control as of December 31, 2018. Management’s assessment was based on criteria established in Internal Control—Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission.

The Company completed its acquisition of America's 1st Choice on February 15, 2018. As permitted by the U.S. Securities and Exchange Commission, management's assessment as of December 31, 2018 did not include the Internal Control of America's 1st Choice, which is included in the Company's consolidated financial statements as of December 31, 2018. Such operations of America's 1st Choice constituted 0.5% and 0.6% of the Company's total assets and net assets, respectively, as of December 31, 2018, and 1.9% and 1.9% of the Company's total revenue and net income for the year then ended.

Based on management’s assessment, which excluded an assessment of Internal Control of America's 1st Choice, management has concluded that the Company’s Internal Control was effective as of December 31, 2018 to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external reporting purposes in accordance with GAAP.

Ernst & Young LLP, the Company's independent registered public accounting firm, has audited the consolidated financial statements of the Company for the year ended December 31, 2018, and has also issued an audit report dated February 20, 2019, on the effectiveness of the Company's Internal Control as of December 31, 2018, which is included in this Annual Report on Form 10-K.

/s/ GAIL K. BOUDREAUX	/s/ JOHN E. GALLINA
President and Chief Executive Officer	Executive Vice President and Chief Financial Officer

Changes in Internal Control over Financial Reporting

There have been no changes in our internal control over financial reporting that occurred during the three months ended December 31, 2018 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of Anthem, Inc.

Opinion on Internal Control over Financial Reporting

We have audited Anthem, Inc.'s internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control–Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, Anthem, Inc. (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on the COSO criteria.

As indicated in the accompanying Management's Report on Internal Control Over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of America's 1st Choice, which is included in the 2018 consolidated financial statements of the Company and constituted 0.5% and 0.6% of total and net assets, respectively, as of December 31, 2018, and 1.9% and 1.9% of revenues and net income, respectively, for the year then ended. Our audit of internal control over financial reporting of the Company also did not include an evaluation of the internal control over financial reporting of America's 1st Choice.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of Anthem, Inc. as of December 31, 2018 and 2017, the related consolidated statements of income, comprehensive income, shareholders' equity, and cash flows for each of the three years in the period ended December 31, 2018, and the related notes and financial statement schedule listed in the Index at Item 15(c) and our report dated February 20, 2019 expressed an unqualified opinion thereon.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ ERNST & YOUNG LLP

Indianapolis, Indiana
February 20, 2019

ITEM 9B. OTHER INFORMATION.

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE.

The information required by this Item concerning our Executive Officers, Directors and nominees for Director, Audit Committee members and financial expert(s) and concerning disclosure of delinquent filers under Section 16(a) of the Exchange Act and our Standards of Ethical Business Conduct is incorporated herein by reference from our definitive Proxy Statement for our 2019 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 11. EXECUTIVE COMPENSATION.

The information required by this Item concerning remuneration of our Executive Officers and Directors, material transactions involving such Executive Officers and Directors and Compensation Committee interlocks, as well as the Compensation Committee Report and Pay Ratio Disclosure are incorporated herein by reference from our definitive Proxy Statement for our 2019 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS.

The information required by this Item concerning the stock ownership of management and five percent beneficial owners and securities authorized for issuance under equity compensation plans is incorporated herein by reference from our definitive Proxy Statement for our 2019 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE.

The information required by this Item concerning certain relationships and related person transactions and director independence is incorporated herein by reference from our definitive Proxy Statement for our 2019 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES.

The information required by this Item concerning principal accountant fees and services is incorporated herein by reference from our definitive Proxy Statement for our 2019 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES.

(a) 1. Financial Statements:

The following consolidated financial statements of the Company are set forth in Part II, Item 8:

Report of Independent Registered Public Accounting Firm

Consolidated Balance Sheets as of December 31, 2018 and 2017

Consolidated Statements of Income for the years ended December 31, 2018, 2017, and 2016

Consolidated Statements of Comprehensive Income for the years ended December 31, 2018, 2017, and 2016

Consolidated Statements of Shareholders' Equity for the years ended December 31, 2018, 2017 and 2016

Consolidated Statements of Cash Flows for the years ended December 31, 2018, 2017 and 2016

Notes to Consolidated Financial Statements

2. Financial Statement Schedule:

The following financial statement schedule of the Company is included in Item 15(c):

Schedule II—Condensed Financial Information of Registrant (Parent Company Only).

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore, have been omitted.

3. Exhibits required to be filed as part of this report:

Exhibit Number	Exhibit
2.1	Agreement and Plan of Merger, dated as of July 23, 2015 among Anthem, Inc., Anthem Merger Sub. Corp. and Cigna Corporation, incorporated by reference to Exhibit 2.1 to the Company's Current Report on Form 8-K filed on July 27, 2015.
3.1	Amended and Restated Articles of Incorporation of the Company, as amended and restated effective May 16, 2018, incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on May 16, 2018.
3.2	Bylaws of the Company, as amended and restated effective May 16, 2018, incorporated by reference to Exhibit 3.2 to the Company's Current Report on Form 8-K filed on May 16, 2018.
4.1	Form of Specimen Certificate of the Company's common stock, $0.01 par value per share, incorporated by reference to Exhibit 4.3 to the Company's Post-Effective Amendment No.1 to Form S-8 Registration Statement filed on May 23, 2017.
4.2	Indenture, dated as of December 9, 2004, between the Company and The Bank of New York Trust Company, N.A., as trustee, including the Form of the Company's 5.950% Notes due 2034, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on December 15, 2004, SEC File No. 001-16751.
4.3	Indenture, dated as of January 10, 2006, between the Company and The Bank of New York Mellon Trust Company, N.A. (formerly known as The Bank of New York Trust Company, N.A.), as trustee, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on January 11, 2006, SEC File No. 001-16751.
(a)	Form of 5.85% Notes due 2036, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on January 11, 2006, SEC File No. 001-16751.

Exhibit Number	Exhibit
(b)	Form of 6.375% Notes due 2037, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on June 8, 2007, SEC File No. 001-16751.
(c)	Form of 4.350% Notes due 2020, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on August 12, 2010, SEC File No. 001-16751.
(d)	Form of 5.800% Notes due 2040, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on August 12, 2010, SEC File No. 001-16751.
(e)	Form of 3.700% Notes due 2021, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on August 15, 2011, SEC File No. 001-16751.
(f)	Form of 3.125% Notes due 2022, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on May 7, 2012, SEC File No. 001-16751.
(g)	Form of 4.625% Notes due 2042, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on May 7, 2012, SEC File No. 001-16751.
(h)	Form of 3.300% Notes due 2023, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on September 10, 2012, SEC File No. 001-16751.
(i)	Form of 4.650% Notes due 2043, incorporated by reference to Exhibit 4.5 to the Company's Current Report on Form 8-K filed on September 10, 2012, SEC File No. 001-16751.
(j)	Form of 5.100% Notes due 2044, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on July 31, 2013, SEC File No. 001-16751.
(k)	Form of 2.250% Notes due 2019, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on August 12, 2014.
(l)	Form of 3.500% Notes due 2024, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on August 12, 2014.
(m)	Form of 4.650% Notes due 2044, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on August 12, 2014.
(n)	Form of 4.850% Notes due 2054, incorporated by reference to Exhibit 4.5 to the Company's Current Report on Form 8-K filed on August 12, 2014.
4.4	Indenture dated as of October 9, 2012 between the Company and The Bank of New York Mellon Trust Company, N.A. as trustee, including the Form of the 2.750% Senior Convertible Debentures due 2042, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on October 9, 2012, SEC File No. 001-16751.
4.5	Subordinated Indenture, dated as of May 12, 2015, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on May 12, 2015.
(a)	First Supplemental Indenture to the Subordinated Indenture, dated as of May 12, 2015, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee, including the Form of 1.90% Remarketable Subordinated Notes due 2028, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on May 12, 2015.
4.6	Indenture dated as of November 21, 2017 between the Company and The Bank of New York Mellon Trust Company, N.A. as trustee, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on November 21, 2017.
(a)	Form of 2.500% Notes due 2020, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on November 21, 2017.
(b)	Form of 2.950% Notes due 2022, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on November 21, 2017.
(c)	Form of 3.350% Notes due 2024, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on November 21, 2017.
(d)	Form of 3.650% Notes due 2027, incorporated by reference to Exhibit 4.5 to the Company's Current Report on Form 8-K filed on November 21, 2017.

Exhibit Number		Exhibit
	(e)	Form of 4.375% Notes due 2047, incorporated by reference to Exhibit 4.6 to the Company's Current Report on Form 8-K filed on November 21, 2017.
	(f)	Form of 4.101% Notes due 2028, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on March 2, 2018.
	(g)	Form of 4.550% Notes due 2048, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on March 2, 2018.
4.7		Upon the request of the Securities and Exchange Commission, the Company will furnish copies of any other instruments defining the rights of holders of long-term debt of the Company or its subsidiaries.
10.1	*	Anthem Incentive Compensation Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed on December 2, 2014.
	(a)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2013, incorporated by reference to Exhibit 10.2(s) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, SEC File No. 001-76751.
	(b)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2014, incorporated by reference to Exhibit 10.2(p) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014.
	(c)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2015, incorporated by reference to Exhibit 10.2(n) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015.
	(d)	Form of Amendment, dated March 9, 2016, to Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2014, incorporated by reference to Exhibit 10.2(m) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
	(e)	Form of Amendment, dated March 9, 2016, to Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2015, incorporated by reference to Exhibit 10.2(p) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
	(f)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2016 and 2017, incorporated by reference to Exhibit 10.2(s) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
	(g)	Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2016 and 2017, incorporated by reference to Exhibit 10.2(t) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
	(h)	Form of Incentive Compensation Plan Performance Stock Unit Award Agreement for 2016, incorporated by reference to Exhibit 10.2(u) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
10.2	*	2017 Anthem Incentive Compensation Plan, effective May 18, 2017, incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on May 18, 2017.
	(a)	Form of Incentive Compensation Plan Performance Stock Unit Award Agreement for 2017, incorporated by reference to Exhibit 10.1(r) to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2017.
	(b)	Form of Incentive Compensation Plan Performance Stock Unit Award Agreement for the Chief Executive Officer for 2017, incorporated by reference to Exhibit 10.2(b) to the Company's Annual Report on Form 10-K for the year ended December 31, 2017.
	(c)	First Amendment, effective January 1, 2018, to 2017 Anthem Incentive Compensation Plan, incorporated by reference to Exhibit 10.2(c) to the Company's Annual Report on Form 10-K for the year ended December 31, 2017.
	(d)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2018, incorporated by reference to Exhibit 10.2(d) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2018.
	(e)	Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2018, incorporated by reference to Exhibit 10.2(e) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2018.

Exhibit Number		Exhibit
	(f)	Form of Incentive Compensation Plan Performance Stock Unit Award Agreement for 2018, incorporated by reference to Exhibit 10.2(f) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2018.
	(g)	Form of Incentive Compensation Plan Performance Stock Unit Award Agreement for Executive Vice President and CEO of IngenioRx, incorporated by reference to Exhibit 10.2(g) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2018.
	(h)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement commencing July 2018, incorporated by reference to Exhibit 10.2(h) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2018.
	(i)	Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement commencing July 2018, incorporated by reference to Exhibit 10.2(i) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2018.
	(j)	Form of Incentive Compensation Plan Performance Stock Unit Award Agreement commencing July 2018, incorporated by reference to Exhibit 10.2(j) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2018.
	(k)	Second Amendment, effective August 6, 2018, to 2017 Anthem Incentive Compensation Plan incorporated by reference to Exhibit 10.2(k) to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2018.
10.3	*	Anthem, Inc. Comprehensive Nonqualified Deferred Compensation Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.3 to the Company's Annual Report on Form 10-K for the year ended December 31, 2014.
10.4	*	Anthem, Inc. Executive Agreement Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.4 to the Company's Annual Report on Form 10-K for the year ended December 31, 2014.
	(a)	First Amendment, dated March 9, 2016, to Executive Agreement Plan, incorporated by reference to Exhibit 10.4(a) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
	(b)	Second Amendment, dated January 6, 2017, to Executive Agreement Plan, incorporated by reference to Exhibit 10.3(b) to the Company's Annual Report on Form 10-K for the year ended December 31, 2016.
	(c)	Third Amendment, dated August 27, 2018, to Executive Agreement Plan, incorporated by reference to Exhibit 10.4(c) to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2018.
10.5	*	Anthem, Inc. Executive Salary Continuation Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.5 to the Company's Annual Report on Form 10-K for the year ended December 31, 2015.
10.6	*	Anthem, Inc. Directed Executive Compensation Plan amended effective January 1, 2019.
10.7	*	Anthem, Inc. Board of Directors Compensation Program, as amended effective May 18, 2017, incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2017.
10.8	*	Anthem Board of Directors' Deferred Compensation Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.8 to the Company's Annual Report on Form 10-K for the year ended December 31, 2014.
10.9	*	(a) Form of Employment Agreement between the Company and each of the following: John E. Gallina, Brian T. Griffin, Peter D. Haytaian, Gloria McCarthy and Thomas C. Zielinski, incorporated by reference to Exhibit A to Exhibit 10.41 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2007, SEC File No. 001-16751.
		(b) Form of Employment Agreement between the Company and Gail Boudreaux, incorporated by reference to Exhibit A to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on November 6, 2017.
		(c) Form of Employment Agreement between the Company and each of the following: Felicia F. Norwood, Prakash Patel and Leah Stark incorporated by reference to Exhibit 10.9(d) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2018.

Exhibit Number		Exhibit
10.10	*	Offer Letter, by and between the Company and Gail Boudreaux, dated as of November 5, 2017, incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on November 6, 2017.
10.11	*	Transition Letter Agreement between the Company and Joseph R. Swedish, dated as of November 5, 2017, incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed on November 6, 2017.
10.12		Blue Cross License Agreement by and between Blue Cross Blue Shield Association and the Company, including revisions, if any, adopted by the Member Plans through September 27, 2018.
10.13		Blue Shield License Agreement by and between Blue Cross Blue Shield Association and the Company, including revisions, if any, adopted by the Member Plans through September 27, 2018.
21		Subsidiaries of the Company.
23		Consent of Independent Registered Public Accounting Firm.
31.1		Certification of Chief Executive Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Exchange Act Rules, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2		Certification of Chief Financial Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Exchange Act Rules, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1		Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2		Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101		The following materials from Anthem, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2018, formatted in XBRL (Extensible Business Reporting Language): (i) the Consolidated Balance Sheets; (ii) the Consolidated Statements of Income; (iii) the Consolidated Statements of Comprehensive Income; (iv) the Consolidated Statements of Cash Flows; (v) the Consolidated Statements of Shareholders' Equity; (vi) the Notes to Consolidated Financial Statements and (vii) Financial Statement Schedule II.

* Indicates management contracts or compensatory plans or arrangements.

(b) Exhibits

The response to this portion of Item 15 is set forth in paragraph (a) 3 above.

(c) Financial Statement Schedule

Schedule II—Condensed Financial Information of Registrant (Parent Company Only).

ITEM 16. FORM 10-K SUMMARY.

None.

Schedule II—Condensed Financial Information of Registrant

Anthem, Inc. (Parent Company Only)
Balance Sheets

(In millions, except share data)	December 31, 2018	December 31, 2017
Assets		
Current assets:		
Cash and cash equivalents	$ 1,290	$ 956
Fixed maturity securities, current (amortized cost of $589 and $342)	573	346
Equity securities, current	86	1,458
Other invested assets, current	10	5
Other receivables	131	61
Income taxes receivable	—	75
Net due from subsidiaries	170	2,428
Securities lending collateral	35	15
Other current assets	320	228
Total current assets	2,615	5,572
Long-term investments:		
Equity securities	6	6
Other invested assets, long-term	616	644
Property and equipment, net	186	118
Deferred tax assets, net	209	162
Investments in subsidiaries	44,877	40,211
Other noncurrent assets	225	89
Total assets	$ 48,734	$ 46,802
Liabilities and shareholders' equity		
Liabilities		
Current liabilities:		
Accounts payable and accrued expenses	$ 1,429	$ 1,232
Security trades pending payable	—	11
Securities lending payable	35	14
Income taxes payable	112	—
Current portion of long-term debt	849	1,275
Other current liabilities	235	219
Total current liabilities	2,660	2,751
Long-term debt, less current portion	17,192	17,357
Other noncurrent liabilities	341	191
Total liabilities	20,193	20,299
Commitments and contingencies—Note 5		
Shareholders' equity		
Preferred stock, without par value, shares authorized - 100,000,000; shares issued and outstanding - none	—	—
Common stock, par value $0.01, shares authorized - 900,000,000; shares issued and outstanding - 257,395,577 and 256,084,913	3	3
Additional paid-in capital	9,536	8,547
Retained earnings	19,988	18,054
Accumulated other comprehensive loss	(986)	(101)
Total shareholders' equity	28,541	26,503
Total liabilities and shareholders' equity	$ 48,734	$ 46,802

See accompanying notes.

Anthem, Inc. (Parent Company Only)
Statements of Income

(In millions)	Years ended December 31 2018	2017	2016
Revenues			
Net investment income	$ 39	$ 64	$ 75
Net realized losses on financial instruments	(46)	(18)	(195)
Other-than-temporary impairment losses on investments:			
Total other-than-temporary impairment losses on investments	(15)	(7)	(65)
Portion of other-than-temporary impairment losses recognized in other comprehensive (loss) income	—	—	17
Other-than-temporary impairment losses recognized in income	(15)	(7)	(48)
Other revenue	2	—	—
Total (losses) revenues	(20)	39	(168)
Expenses			
General and administrative expense	86	437	270
Interest expense	723	727	719
Loss on extinguishment of debt	11	283	—
Total expenses	820	1,447	989
Loss before income tax credits and equity in net income of subsidiaries	(840)	(1,408)	(1,157)
Income tax credits	(238)	(216)	(439)
Equity in net income of subsidiaries	4,352	5,035	3,188
Net income	$ 3,750	$ 3,843	$ 2,470

See accompanying notes.

Anthem, Inc. (Parent Company Only)
Statements of Comprehensive Income

(in millions)	Years ended December 31		
	2018	2017	2016
Net income	$ 3,750	$ 3,843	$ 2,470
Other comprehensive income, net of tax:			
Change in net unrealized gains/losses on investments	(418)	173	118
Change in non-credit component of other-than-temporary impairment losses on investments	(2)	4	5
Change in net unrealized gains/losses on cash flow hedges	37	(65)	(87)
Change in net periodic pension and postretirement costs	(90)	51	(13)
Foreign currency translation adjustments	(1)	3	2
Other comprehensive (loss) income	(474)	166	25
Total comprehensive income	$ 3,276	$ 4,009	$ 2,495

See accompanying notes.

Anthem, Inc. (Parent Company Only)
Statements of Cash Flows

(In millions)	Years ended December 31 2018	2017	2016
Operating activities			
Net income	$ 3,750	$ 3,843	$ 2,470
Adjustments to reconcile net income to net cash provided by operating activities:			
Undistributed earnings of subsidiaries	(744)	(2,437)	(502)
Net realized losses on financial instruments	46	18	195
Other-than-temporary impairment losses recognized in income	15	7	48
Loss on extinguishment of debt	11	283	—
Loss on disposal of assets	—	—	2
Deferred income taxes	(43)	(33)	(7)
Amortization, net of accretion	43	25	34
Depreciation expense	70	69	70
Share-based compensation	226	170	165
Excess tax benefits from share-based compensation	—	—	(54)
Changes in operating assets and liabilities:			
Receivables, net	(73)	(17)	18
Other invested assets, current	(5)	(1)	1
Other assets	(225)	(102)	213
Amounts due to/from subsidiaries	2,259	(1,034)	(1,488)
Accounts payable and accrued expenses	303	491	44
Other liabilities	154	(61)	(31)
Income taxes	187	(6)	198
Other, net	1	(2)	5
Net cash provided by operating activities	5,975	1,213	1,381
Investing activities			
Purchases of investments	(800)	(3,814)	(2,875)
Proceeds from sales, maturities, calls and redemptions of investments	1,865	2,595	3,310
Changes in collateral and settlement of non-hedging derivatives	—	65	(34)
Capitalization of subsidiaries	(4,379)	(124)	(295)
Changes in securities lending collateral	(21)	25	92
Purchases of property and equipment, net of sales	(137)	(44)	(99)
Other, net	4	18	(8)
Net cash (used in) provided by investing activities	(3,468)	(1,279)	91
Financing activities			
Net (repayments of) proceeds from commercial paper borrowings	(107)	175	(53)
Proceeds from long-term borrowings	835	5,458	—
Repayments of long-term borrowings	(1,684)	(2,815)	—
Changes in securities lending payable	21	(25)	(91)
Changes in bank overdrafts	(107)	51	30
Proceeds from sale of put options	1	1	—
Proceeds from issuance of common stock under Equity Units stock purchase contracts	1,250	—	—
Repurchase and retirement of common stock	(1,685)	(1,998)	—
Change in collateral and settlements of debt-related derivatives	23	(149)	(360)
Cash dividends	(812)	(737)	(715)
Proceeds from issuance of common stock under employee stock plans	173	225	120
Taxes paid through withholding of common stock under employee stock plans	(81)	(47)	(67)
Excess tax benefits from share-based compensation	—	—	54
Net cash (used in) provided by financing activities	(2,173)	139	(1,082)
Change in cash and cash equivalents	334	73	390
Cash and cash equivalents at beginning of year	956	883	493
Cash and cash equivalents at end of year	$ 1,290	$ 956	$ 883

See accompanying notes.

Anthem, Inc.
(Parent Company Only)
Notes to Condensed Financial Statements

December 31, 2018
(In Millions, Except Per Share Data)

1. Basis of Presentation and Significant Accounting Policies

In the parent company only financial statements of Anthem, Inc., or Anthem, Anthem's investment in subsidiaries is stated at cost plus equity in undistributed earnings of the subsidiaries. Anthem's share of net income of its unconsolidated subsidiaries is included in income using the equity method of accounting.

Certain amounts presented in the parent company only financial statements are eliminated in the consolidated financial statements of Anthem.

Certain prior year amounts have been adjusted to conform to the current year rounding convention of reporting financial data in whole millions of dollars, except as otherwise noted.

Anthem's parent company only financial statements should be read in conjunction with Anthem's audited consolidated financial statements and the accompanying notes included in Part II, Item 8 of this Annual Report on Form 10-K.

2. Subsidiary Transactions

Dividends from Subsidiaries

Anthem received cash dividends from subsidiaries of $3,606, $2,268 and $2,689 during 2018, 2017 and 2016, respectively.

Dividends to Subsidiaries

Certain subsidiaries of Anthem own shares of Anthem common stock. Anthem paid cash dividends to subsidiaries related to these shares of common stock in the amount of $36, $32 and $31 during 2018, 2017 and 2016, respectively.

Investments in Subsidiaries

Capital contributions to subsidiaries were $4,379, $124 and $295 during 2018, 2017 and 2016, respectively.

Amounts Due to and From Subsidiaries

At December 31, 2018 and 2017, Anthem reported amounts due from subsidiaries of $170 and $2,428, respectively. The amounts due from subsidiaries primarily include amounts for allocated administrative expenses or cash held overnight at the parent level resulting from daily cash management activities. These items are routinely settled, and as such, are classified as current assets or liabilities.

Guarantees on Behalf of Subsidiaries

Anthem guarantees contractual or financial obligations or solvency requirements for certain of its subsidiaries. These guarantees approximated $580 at December 31, 2018. There were no payments made on these guarantees in 2018.

3. Derivative Financial Instruments

The information regarding derivative financial instruments contained in Note 5, "Derivative Financial Instruments," of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K, is incorporated herein by reference.

4. Long-Term Debt

The information regarding long-term debt contained in Note 12, “Debt,” of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K, is incorporated herein by reference.

5. Commitments and Contingencies

The information regarding commitments and contingencies contained in Note 13, “Commitments and Contingencies,” of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K, is incorporated herein by reference.

6. Capital Stock

The information regarding capital stock contained in Note 14, “Capital Stock,” of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K, is incorporated herein by reference.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

ANTHEM, INC.

By: /s/ GAIL K. BOUDREAUX

Gail K. Boudreaux
President and Chief Executive Officer

Dated: February 20, 2019

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ GAIL K. BOUDREAUX **Gail K. Boudreaux**	President and Chief Executive Officer, Director (Principal Executive Officer)	February 20, 2019
/s/ JOHN E. GALLINA **John E. Gallina**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 20, 2019
/s/ RONALD W. PENCZEK **Ronald W. Penczek**	Senior Vice President and Chief Accounting Officer (Principal Accounting Officer)	February 20, 2019
/s/ ELIZABETH E. TALLETT **Elizabeth E. Tallett**	Chair of the Board	February 20, 2019
/s/ R. KERRY CLARK **R. Kerry Clark**	Director	February 20, 2019
/s/ ROBERT L. DIXON, JR. **Robert L. Dixon, Jr.**	Director	February 20, 2019
/s/ LEWIS HAY III **Lewis Hay III**	Director	February 20, 2019
/s/ JULIE A. HILL **Julie A. Hill**	Director	February 20, 2019
/s/ BAHIJA JALLAL **Bahija Jallal**	Director	February 20, 2019
/s/ ANTONIO F. NERI **Antonio F. Neri**	Director	February 20, 2019
/s/ RAMIRO G. PERU **Ramiro G. Peru**	Director	February 20, 2019
/s/ GEORGE A. SCHAEFER, JR. **George A. Schaefer, Jr.**	Director	February 20, 2019

Exhibit 10.6

Summary of the Anthem, Inc. Directed Executive Compensation (DEC) Program (effective January 1, 2019)

The Directed Executive Compensation (DEC) program is an executive perquisite plan that provides officers of Anthem, Inc. (the "Company") with flexibility to tailor certain benefits to meet their needs with Credits.

Credits can be used to reimburse the following expenses:

- Investment Advisor Fees
- Investment Management Fees
- Financial Counseling Fees
- Retirement Planning and Advice
- Tax Preparation and Advice Fees
- Estate Planning Fees
- Legal Fees associated with:
  - Anthem compensation and/or benefits program review
  - Tax Preparation issues
  - Estate Planning issues
  - Financial Counseling issues
- Tax and Investment Software
- Tax, Investment and Financial Subscriptions

The amount of Credits the executive receives is based upon his or her position.

Corporate Title	Credits
Chief Executive Officer	$54,000 per year
Executive Vice President	$30,000 per year
Senior Vice President	$12,000 per year
Vice President	$12,000 per year

Those newly hired or promoted into an executive position will participate in the program at the beginning of the month following date of hire or promotion and will receive prorated credits for the year based on the number of full months in the position.

BLUE CROSS LICENSE AGREEMENT
(Includes revisions, if any, adopted by Member Plans through their September 27, 2018 meeting)

This agreement by and between Blue Cross and Blue Shield Association ("BCBSA") and The Blue Cross Plan, known as _____ (the "Plan").

Preamble

WHEREAS, the Plan and/or its predecessor(s) in interest (collectively the "Plan") had the right to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") for health care plans in its service area, which was essentially local in nature;

WHEREAS, the Plan was desirous of assuring nationwide protection of the Licensed Marks, maintaining uniform quality controls among Plans, facilitating the provision of cost effective health care services to the public and otherwise benefiting the public;

WHEREAS, to better attain such ends, the Plan and the predecessor of BCBSA in 1972 simultaneously executed the BCA License Agreement (s) and the Ownership Agreement; and

WHEREAS, BCBSA and the Plan desire to supercede said Agreement(s) and to revise certain provisions of the Ownership Agreement to reflect their current practices and to assure the continued integrity of the Licensed Marks and of the BLUE CROSS system;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

Agreement

1. BCBSA hereby grants to the Plan, upon the terms and conditions of this License Agreement ("Agreement" or "Primary License Agreement", the right to use BLUE CROSS in its trade and/or corporate name (the "Licensed Name"), and the right to use the Licensed Marks, in the sale, marketing and administration of health care plans and related services in the Service Area set forth and defined in paragraph 5 below. As used herein, health care plans and related services shall include acting as a nonprofit health care plan, a for-profit health care plan, or mutual health insurer operating on a not-for-profit or for-profit basis, under state law; financing access to health care services; when working with a bank that holds the relevant license to use the Licensed Name and Marks, offering: (i) tax-favored savings accounts for medical expenses and means for accessing such accounts, such as debit cards or checks, that are provided solely to support access to such tax-favored savings accounts, all pursuant to such license, or (ii) prepaid rewards cards that are provided for completion of a wellness program, all pursuant to such license; providing health care management and administration; administering, but not underwriting, non-health portions of Worker's Compensation insurance; delivering health care services, except hospital services (as defined in the Guidelines to Membership Standards Applicable to Regular Members); and performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by a group account to its members, including benefit plans not provided by the Plan, provided that the Plan has contracted to provide Health Coverage under the Licensed Marks to the account (as the terms "Health Coverage," "Eligibility" and "Enrollment" are defined in Exhibit 4, Paragraph 2.t.).

2. The Plan may use the Licensed Marks and Name in connection with the offering of: i) health care plans and related services in the Service Area through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the "Controlled Affiliate License Agreement"); and: ii) insurance coverages offered by life insurers under the applicable law in the Service Area, other than those which the Plan may offer in its own name, provided through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1A hereto (the "Controlled Affiliate License Agreement Applicable to Life Insurance Companies") or the Agreement attached as Exhibit 1A1 hereto (the "Controlled Affiliate Trademark License Agreement for Life and Disability Insurance Products") and further provided that the offering of such services does not and will not dilute or tarnish the unique value of the Licensed Marks and Name; and iii)administration and underwriting of Workers' Compensation Insurance Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the "Controlled Affiliate License."); and iv) regional Medicare Advantage PPO products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1B hereto (the "Controlled Affiliate License Agreement Applicable to Regional Medicare Advantage PPO Products"); and v) regional Medicare Part D Prescription Drug Plan products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1C hereto (the "Controlled Affiliate License Agreement Applicable to Regional Medicare Part D Prescription Drug Plan Products"). As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans and, if the entity meets the standards of Paragraph 2a.B but not Paragraph2a.A, the entity, its owners, and persons

Amended as of September 19, 2014

with authority to select or appoint members or board members, other than a Plan or Plans, have received written approval of BCBSA. Absent written approval by BCBSA of an alternative method of control, bona fide control shall have the meaning set forth in Paragraphs 2a. and 2b.

2a. With respect to the Controlled Affiliate Licenses authorized in clauses i) through iii) of Paragraph 2, bona fide control shall mean that a Plan (the "Sponsoring Plan") authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to this Primary License Agreement with BCBSA must have:

B. The legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; (b) to exercise control over the policy and operations of the Controlled Affiliate; (c) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control more than 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee; or

C. The legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; (c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan. Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

1. Change its legal and/or trade name;

2. Change the geographic area in which it operates;

3. Change any of the types of businesses in which it engages;

4. Create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

5. Sell any assets, except for sales in the ordinary course of busines or sales of equipment no longer useful or being replaced;

6. Make any loans or advances except in the ordinary course of business;

Amended as of March 26, 2015

7. Enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners of the Controlled Affiliate or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

8. Conduct any business other than under the Licensed Marks and Name;

9. Take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks or Names.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control at least 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee; or

C. With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid products and services, the legal authority together with such other Plans (a) to select all members of the Controlled Affiliate's governing body; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; (c) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the "Addendum to Controlled Affiliate License" attached as Exhibit B-1 to Exhibit 1 attached hereto; or

D. With respect to a Controlled Affiliate that is 100% controlled by a Sponsoring Plan which on a Blue-branded basis offers solely a Basic Medicare Part D Prescription Drug product, the legal authority (a) to select all members of the Controlled Affiliate's governing body; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; (c) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by the Plan shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and Participating Plan as defined on the Controlled Affiliate License Agreement shall execute the "Addendum to Controlled Affiliate License" attached as Exhibit B-2 to Exhibit 1 attached hereto.

2b. With respect to the Controlled Affiliate License Agreements authorized in clauses iv) and v) of Paragraph 2, bona fide control shall mean that the Controlled Affiliate is organized and operated in such a manner that it meets the following requirements:

A. The Controlled Affiliate is owned or controlled by two or more Plans authorized to use the Licensed Marks pursuant to this License Agreement with BCBSA (for purposes of this subparagraph A. through subparagraph C., the "Controlling Plans"); and

Amended as of March 17, 2016

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B. Each Controlling Plan is authorized pursuant to this Agreement to use the Licensed Marks in a geographic area in the Region (as that term is defined in such Controlled Affiliate License Agreements) and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

C. The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur; and (c) to exercise control over the policy and operations of the Controlled Affiliate. Notwithstanding anything to the contrary in (a) through (c) of this subparagraph E., the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

1. Change its legal and/or trade names;

2. Change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

3. Change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

4. Take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Amended as of June 19, 2014

(The next page is page 3)

3. With respect to a Controlled Affiliate that is not licensed to use the Licensed Marks and Name, the Plan may, in communications that contain the Licensed Marks or Name, indicate its corporate relationship to the Affiliate and permit such Affiliate to indicate its corporate relationship to the Plan, solely in the circumstances, style and manner specified by BCBSA from time-to-time in regulations of general application consistent with the avoidance of confusion or mistake or the dilution or tarnishment of the Licensed Marks and Name. No rights are hereby created in any Controlled Affiliate to use the Licensed Marks or Name in its own name or otherwise.

4. The Plan recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Plan further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide. The Plan agrees (a) to maintain in good standing its membership in BCBSA; (b) promptly to pay its dues to BCBSA, said dues to represent the royalties for this License Agreement; (c) materially to comply with all applicable laws; (d) to comply with the Membership Standards Applicable to Regular Members of BCBSA, a current copy of which is attached as Exhibit 2 hereto; and (e) reasonably to permit BCBSA, upon a written, good faith request and during reasonable business hours, to inspect the Plan's books and records necessary to ascertain compliance herewith. As to other Plans and third parties, BCBSA shall maintain the confidentiality of all documents and information furnished by the Plan pursuant hereto, or pursuant to the Membership Standards, and clearly designated by the Plan as containing proprietary information of the Plan.

5. The rights hereby granted are exclusive to the Plan within the geographical area(s) served by the Plan on June 30, 1972, and/or as to which the Plan has been granted a subsequent license, which is hereby defined as the "Service Area," except that BCBSA reserves the right to use the Licensed Marks in said Service Area, and except to the extent that said Service Area may overlap areas served by one or more other licensed Blue Cross Plans as of said date or subsequent license, as to which overlapping areas the rights hereby granted are nonexclusive as to such other Plan or Plans only.

Amended as of June 19, 2014

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6. Except as expressly provided by BCBSA with respect to National Accounts, Government Programs and certain other necessary and collateral uses, the current rules and regulations governing which are attached as Exhibit 3 and Exhibit 4 hereto, and are contained in other documents referenced herein, or as expressly provided herein, the Plan may not use the Licensed Marks and Name outside the Service Area or in connection with other goods and services, nor may the Plan use the Licensed Marks or Name in a manner which is intended to transfer in the Service Area the goodwill associated therewith to another mark or name. Nothing herein shall be construed to prevent the Plan from engaging in lawful activity anywhere under other marks and names not confusingly similar to the Licensed Marks and Name, provided that engaging in such activity does and will not dilute or tarnish the unique value of the Licensed Marks and Name. In addition to any and all remedies available hereunder, BCBSA may impose monetary fines on the Plan for the Plan's use of the Licensed Marks and Names outside the Service Area, and provided that the procedure used in imposing a fine is consistent with procedures specifically prescribed by BCBSA from time to time in regulations of general application. In the case of regional Medicare Advantage PPO and regional Medicare Part D Prescription Drug Plan products offered by consenting and participating Plans in a region that includes the Service Areas, or portions thereof, of more than one Plan, such fine may be imposed jointly on the consenting and participating Plans for use of the Licensed Marks and Name in any geographic area of the region in which a Plan having exclusive rights to the Licensed Marks and Name does not consent to and participate in such offering, provided that the basis for imposition of such fine is consistent with rules specifically prescribed by BCBSA from time to time in regulations of general application.

7. The Plan agrees that it will display the Licensed Marks and Name only in such form, style and manner as shall be specifically prescribed by BCBSA from time-to-time in regulations of general application in order to prevent impairment of the distinctiveness of the Licensed Marks and Name and the goodwill pertaining thereto. The Plan shall cause to appear on all materials on or in connection with which the Licensed Marks or Name are used such legends, markings and notices as BCBSA may reasonably request in order to give appropriate notice of service mark or other proprietary rights therein or pertaining thereto.

8. BCBSA agrees that: (a) it will not grant any other license effective during the term of this License Agreement for the use of the Licensed Marks or Name which is inconsistent with the rights granted to the Plan hereunder; and (b) it will not itself use the Licensed Marks in derogation of the rights of the Plan or in a manner to deprive the Plan of the full benefits of this License Agreement, provided that BCBSA shall have the right to use the Licensed Marks in conjunction with any national offering under the Federal Employees Health Benefits Program in the manner set forth in Exhibit 4, Paragraph 4 (including subparagraphs) to this License Agreement. The Plan agrees that it will not attack the title of BCBSA in and to the Licensed Marks or Name or attack the validity of the Licensed Marks or of this License Agreement. The Plan further agrees that all use by it of the Licensed Marks and Name or any similar mark or name shall inure to the benefit of BCBSA, and the Plan shall cooperate with BCBSA in effectuating the assignment to BCBSA of any service mark or trademark registrations of the Licensed Marks or any similar mark or name held by the Plan or a Controlled Affiliate of the Plan, all or any portion of which registration consists of the Licensed Marks.

Amended as of November 16, 2006

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9. (a). Should the Plan fail to comply with the provisions of paragraphs 2-4, 6, 7 and/or 12, and not cure such failure within thirty (30) days of receiving written notice thereof (or commence curing such failure within such thirty day period and continue diligent efforts to complete the curing of such failure if such curing cannot reasonably be completed within such thirty day period), BCBSA shall have the right to issue a notice that the Plan is in a state of noncompliance. Except as to the termination of a Plan's License Agreement or the merger of two or more Plans, disputes as to noncompliance, and all other disputes between or among BCBSA, the Plan, other Plans and/or Controlled Affiliates, shall be submitted promptly to mediation and mandatory dispute resolution pursuant to the rules and regulations of BCBSA, a current copy of which is attached as Exhibit 5 hereto, and shall be timely presented and resolved. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. If a state of noncompliance as aforesaid is undisputed by the Plan or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the License Agreement. Except, however, as provided in paragraphs 9(d)(iii), 15(a)(i)-(viii), and 15(a)(x) below, no Plan's license to use the Licensed Marks and Name may be finally terminated for any reason without the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

(b). Notwithstanding any other provision of this License Agreement, a Plan's license to use the Licensed Marks and Name may be forthwith terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to Member Plans for: (i) failure to comply with any minimum capital or liquidity requirement under the Membership Standard on Financial Responsibility; or (ii) impending financial insolvency; or (iii) the pendency of any action instituted against the Plan seeking its dissolution or liquidation or its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property of business, unless this License Agreement has been earlier terminated under paragraph 15(a); or (iv) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans and/or the Licensed Marks.

Amended as of March 16, 2006

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(c). To the extent not otherwise provided therein, neither: (i) the Membership Standards Applicable to Regular Members of BCBSA; nor (ii) the rules and regulations governing Government Programs and certain other uses; nor (iii) the rules and regulations governing mediation and mandatory dispute resolution, may be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans. The rules and regulations governing National Accounts and other national programs required by the Membership Standards Applicable to Regular Members of BCBSA (Exhibit 2) are contained, in addition to those set forth in Exhibit 3, in the following documents, as amended from time to time: (1) the Inter-Plan Programs Policies and Provisions; (2) Inter-Plan Medicare Advantage Program Policies and Provisions. The voting requirements specified in rules and regulations governing such national programs may not be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans.

Amended as of November 21, 2014

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(d). The Plan may operate as a for-profit company on the following conditions:

(i) The Plan shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement and the Plan's membership in BCBSA.

(ii) The Plan shall not use the licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Plan in any securities market. The Plan shall use the licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(iii) Plan's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Plan knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Plan (“Excess Institutional Voter”), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Plan knows, or there is an SEC filing indicating that, any Noninstitutional Investor has become the Beneficial Owner of securities representing 5% or more of the voting power of the Plan (“Excess Noninstitutional Voter”) unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Plan knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner of 20% or more of the Plan’s then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 9(d)(iv) below (“Excess Owner”), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Plan went public constituted the Board of Directors of the Plan (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Plan went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Plan consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Plan in a writing received by BCBSA prior to such automatic termination becoming effective, the provisions of this paragraph 9(d)(iii) may be waived, in whole or in part,

Amended as of September 17, 1997

upon the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 9(d)(iii)(a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Plan's license to use the Licensed Marks and Name is terminated pursuant to this Paragraph 9(d)(iii), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Plan demonstrates that the Person referred to in clause (a), (b) or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(iv) The Plan shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities or (iii) such other securities as the Plan may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(v) For purposes of paragraph 9(d)(iii), the following definitions shall apply:

(a) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(b) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

(i) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

Amended as of September 17, 1997

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(ii) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(iii) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (b)(ii)(B) above) or disposing of any securities of the Plan.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding," when used with reference to a Person's Beneficial Ownership of securities of the Plan, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(c) A Person shall be deemed an “Institutional Investor” if (but only if) such Person (i) is an entity or group identified in the SEC’s Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person’s Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 10 of SEC Schedule 13G as constituted on June 1, 1997.

(d) “Noninstitutional Investor” means any Person who is not an Institutional Investor.

(e) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

Amended as of September 17, 1997

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10. This License Agreement shall remain in effect: (a) until terminated as provided herein; or (b) until this and all such other License Agreements are terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans; or (c) until termination of aforesaid Ownership Agreement; or (d) until terminated by the Plan upon eighteen (18) months written notice to BCBSA or upon a shorter notice period approved by BCBSA in writing at its sole discretion.

11. Except as otherwise provided in paragraph 15 below or by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans, or unless this and all such other License Agreements are simultaneously terminated by force of law, the termination of this License Agreement for any reason whatsoever shall cause the reversion to BCBSA of all rights in and to the Licensed Marks and Name, and the Plan agrees that it will promptly discontinue all use of the Licensed Marks and Name, will not use them thereafter, and will promptly, upon written notice from BCBSA, change its corporate name so as to eliminate the Licensed Name therefrom.

12. The license hereby granted to Plan to use the Licensed Marks and Name is and shall be personal to the Plan so licensed and shall not be assignable by any act of the Plan, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Plan mortgage or part with possession or control of this license or any right hereunder, and the Plan shall have no right to grant any sublicense to use the Licensed Marks and Name.

13. BCBSA shall maintain appropriate service mark registrations of the Licensed Marks and BCBSA shall take such lawful steps and proceedings as may be necessary or proper to prevent use of the Licensed Marks by any person who is not authorized to use the same. Any actions or proceedings undertaken by BCBSA under the provisions of this paragraph shall be at BCBSA's sole cost and expense. BCBSA shall have the sole right to determine whether or not any legal action shall be taken on account of unauthorized use of the Licensed Marks, such right not to be unreasonably exercised. The Plan shall report any unlawful usage of the Licensed Marks to BCBSA in writing and agrees, free of charge, to cooperate fully with BCBSA's program of enforcing and protecting the service mark rights, trade name rights and other rights in the Licensed Marks.

14. The Plan hereby agrees to save, defend, indemnify and hold BCBSA and any other Plan(s) harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of the activities of the Plan or of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan. BCBSA hereby agrees to save, defend, indemnify and hold the Plan and any other Plan(s) harmless from and against all claims, damages, liabilities And costs of every kind, nature and description which may arise exclusively and directly as a result of the activities of BCBSA.

Amended as of June 21, 2012

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15. (a). This Agreement shall automatically terminate upon the occurrence of any of the following events: (i) a voluntary petition shall be filed by the Plan or by BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against the Plan or BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Plan or BCBSA respectively, or (iii) an order for relief is entered against the Plan or BCBSA in any case under the bankruptcy laws of the United States, or the Plan or BCBSA is adjudged bankrupt or insolvent (as that term is defined in the Uniform Commercial Code as enacted in the state of Illinois) by any court of competent jurisdiction, or (iv) the Plan or BCBSA makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of the Plan or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Plan or BCBSA respectively, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association’s Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of the Plan's or BCBSA's property or business is appointed, or the Plan or BCBSA is ordered dissolved or liquidated, or (ix) the Plan shall fail to pay its dues and shall not cure such failure within thirty (30) days of receiving written notice thereof, or (x) if, due to regulatory action, the Plan together with any applicable Controlled Affiliate becomes unable to do business using the Names and Marks in any State or portion thereof included in its Service Area, provided that: (i) automatic termination shall not occur prior to the exhaustion by any such Plan of its rights to appeal or challenge such regulatory action; and (ii) in the event the Plan is licensed to do business using the Names and Marks in multiple States or portions of States, the termination of its License Agreement shall be solely limited to the State(s) or portions thereof in which the regulatory action applies. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

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Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Plan's or BCBSA's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 15(a)(vii) and (viii) of this Agreement.

Amended as of March 26, 2015

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(b). BCBSA, or the Plans (as provided and in addition to the rights conferred in Paragraph 10(b) above), may terminate this Agreement immediately upon written notice upon the occurrence of either of the following events: (a) the Plan or BCBSA becomes insolvent (as that term is defined in the Uniform Commercial Code enacted in the state of Illinois), or (b) any final judgment against the Plan or BCBSA remains unsatisfied or unbonded of record for a period of sixty (60) days or longer.

(c). If this License Agreement is terminated as to BCBSA for any reason stated in subparagraphs 15(a) and (b) above, the ownership of the Licensed Marks shall revert to each of the Plans as provided in the Ownership Agreement.

(d). Upon termination of this License Agreement or any Controlled Affiliate License Agreement of a Larger Controlled Affiliate, as defined in Exhibit 1 to this License Agreement, the following conditions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 15 (a)(x)(ii) of this Agreement, the notices, national account listing, payment and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated:

(i) The terminated entity shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the terminated entity or its Controlled Affiliates under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination or, if termination is pursuant to paragraph 10(d) of this Agreement, within 15 days after the written notice to BCBSA described in paragraph 10(d).

(ii) The terminated entity shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the terminated entity is involved (in a Control, Participating or Servicing capacity), identifying the national account and the terminated entity's role therein. For those accounts where the terminated entity is the Control Plan, the Plan must also indicate the Participating and Servicing Plans in the national account syndicate.

Amended as of June 16, 2005

(iii) Unless the cause of termination is an event stated in paragraph 15(a) or (b) above respecting BCBSA, the Plan and its Licensed Controlled Affiliates shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re-Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. The Re-Establishment Fee shall be indexed to a base fee of $80. The Re-Establishment Fee through December 31, 2005 shall be $80. The Re-Establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was $278.60, $285.00 and $290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be $83.27 (100% of the base fee plus $1.84 for calendar year 2005 and $1.43 for calendar year 2006). Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (a) the end of the last fiscal year of the terminated entity which ended prior to termination or (b) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph (d)(iii) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Plan to fall below 100% of the Health Risk-Based Capital formula or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and

Amended as of June 16, 2005

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three-fourths of the total then current weighted vote of all the Plans), measured as of the date of termination and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plan or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Plan (and/or its Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph only to the extent that such payments exceed the amounts due to BCBSA pursuant to subparagraph 15(d)(vi) and any costs associated with reestablishing the Service Area, including any payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the terminated entity.

(iv) The terminated entity shall comply with all financial settlement procedures set forth in BCBSA's License Termination Contingency Plan, as amended from time to time and shall work diligently and in good faith with BCBSA, any Alternative Control Licensee or Replacement Licensee and any existing or potential new account for Blue-branded products and services to minimize the disruption of termination, and honor, to the fullest extent possible, the desire of accounts to continue to receive or obtain Blue-branded products and services through a new Licensee ("Transition"). Such diligence and good faith on the part of the terminated entity shall include, but not be limited to: (a) working cooperatively with BCBSA to protect the Names and Marks from potential harm; (b) cooperating with BCBSA's use of the Names and Marks in the terminated entity's former service area during the termination and Transition; (c) transmitting, upon the request of an

Amended as of June 16, 2005

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existing Blue account or of BCBSA with consent and on behalf of an existing Blue account, all member and account-data relating to the
Federal Employee Program to BCBSA, and all member and account data relating to other programs to an Alternative Control Licensee or Replacement Licensee; (d) working with BCBSA and the Alternative Control or Replacement Licensee with respect to potential new Blue accounts headquartered in the terminated entity's former service area; (e) continuing to service Blue accounts during the Transition; (f) continuing to comply with National Programs, Federal Employee Program and NASCO policies and procedures and all voluntary BCBSA programs, policies and performance standards, such as Away From Home Care, including being responsible for payment of all penalties for non-compliance duly levied in conformity with the License Agreements, Membership Standards, or the Federal Employee Program agreements, that may arise during the Transition; (g) maintaining and providing access to its provider networks, as defined by Federal Employee Program agreements and National Account Program Policies and Provisions, and Inter-Plan Programs Policies and Provisions, and making those networks and discounts available to members and providers who participate in National Programs and the Federal Employee Program during the Transition; (h) maintaining its technical connections and processing capabilities during the Transition; and (i) working diligently to conclude all financial settlements and account reconciliations as negotiated in the termination transition agreement.

(v) Notwithstanding any other provision in this Agreement, BCBSA shall have the right, with the approval of its Board of Directors, to assess additional fines against the terminated entity during the Transition in the event it fails to maintain and provide access to provider networks as defined by Federal Employee Program agreements, National Account Program Policies and Provisions, and Inter-Plan Programs Policies and Provisions, and/or pass on applicable discounts. Such fines shall be in addition to any other assessments, fees or liquidated damages payable herein, or under existing policies and programs and shall be imposed to make whole BCBSA and/or the Plans. Terminated entity shall pay any such fines to BCBSA no later than 30 days after they are approved by the Board of Directors.

(vi) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third-party auditor to examine and audit the books and records of the terminated entity and its Licensed Controlled Affiliates to verify compliance with the terms and requirements this paragraph 15(d).

Amended as of November 16, 2006

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(vii) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.

(viii) As to a breach of 15 (d) (i), (ii), (iii), (iv), (vi), or (vii) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 15 (d) (i), (ii), (iv), (vi), or (vii) by the Plan, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

(ix) In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Plan and its Licensed Controlled Affiliates shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

(e). BCBSA shall be entitled to enjoin the Plan or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this License Agreement unless the License Agreement has been terminated pursuant to paragraph 10 (d) of this Agreement upon the required six (6) month written notice.

(f). BCBSA acknowledges that it is not the owner of assets of the Plan.

Amended as of June 16, 2005

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16. This Agreement supersedes any and all other agreements between the parties with respect to the subject matter herein, and contains all of the covenants and agreements of the parties as to the licensing of the Licensed Marks and Name. This Agreement may be amended only by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

17. If any provision or any part of any provision of this Agreement is judicially declared unlawful, each and every other provision, or any part of any provision, shall continue in full force and effect notwithstanding such judicial declaration.

18. No waiver by BCBSA or the Plan of any breach or default in performance on the part of BCBSA or the Plan or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

19a. All notices provided for hereunder shall be in writing and shall be sent in duplicate by regular mail to BCBSA or the Plan at the address currently published for each by BCBSA and shall be marked respectively to the attention of the President and, if any, the General Counsel, of BCBSA or the Plan.

19b. Except as provided in paragraphs 9(b), 9(d)(iii), 15(a), and 15(b) above, this Agreement may be terminated for a breach only upon at least 30 days' written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Member Plans.

19c. For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

Amended as of June 16, 2006
(The next page is page 9)

20. Nothing herein contained shall be construed to constitute the parties hereto as partners or joint venturers, or either as the agent of the other, and Plan shall have no right to bind or obligate BCBSA in any way, nor shall it represent that it has any right to do so. BCBSA shall have no liability to third parties with respect to any aspect of the business, activities, operations, products, or services of the Plan.

21. This Agreement shall be governed, construed and interpreted in accordance with the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By

Title

Date

PLAN:

By

Title

Date

-9-

EXHIBIT 1

BLUE CROSS
CONTROLLED AFFILIATE LICENSE AGREEMENT
(**Includes revisions adopted by Member Plans through their September 27, 2018 meeting**)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan, known as _____ ("Plan" or "Sponsoring Plan"), which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, Plan and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name");

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with: (i) health care plans and related services, as defined in BCBSA's License Agreement with Plan, and administering the non-health portion of workers' compensation insurance, and (ii) underwriting the indemnity portion of workers' compensation insurance, provided that Controlled Affiliate's total premium revenue comprises less than 15 percent of the Sponsoring Plan's net subscription revenue.

This grant of rights is non-exclusive and is limited to the Service Area served by the Plan. Subject to paragraph 3A(3) of this Agreement, Controlled Affiliate may use the Licensed Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Service Area under any name or mark; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market, unless such Controlled Affiliate is a not-for-profit company which may use the Licensed Marks and Name, or an approved derivative therefor, to identify itself in debt securities markets. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

Amended as of March 26, 2015

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report or reports to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that the Sponsoring Plan has:

(1) The legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate’s governing body having not less than 50% voting control thereof; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and

(c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate’s establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates;

Amended as of September 19, 2014

(iii) change any of the type(s) of businesses in which it engages;

(iv) create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

(v) sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;

(vi) make any loans or advances except in the ordinary course of business;

(vii) enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

(viii) conduct any business other than under the Licensed Marks and Name;

(ix) take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control at least 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee.

Or

(2) the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof and to:

Amended as of March 26, 2015

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and

(c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control more than 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee.

Or

(3) With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services, the legal authority together with such other Plans:

(a) to select all members of the Controlled Affiliate's governing body; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and

(c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate with the Sponsoring Plan and such other Plans each having an ownership interest. Such control and ownership by Plans must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute a separate Addendum to Controlled Affiliate License Agreement attached hereto as Exhibit B-1 for each product noted in Paragraph 2E(3) that is licensed to use the Marks.

Or

(4) With respect to a Controlled Affiliate that is 100% controlled by a Sponsoring Plan which on a Blue-branded basis offers solely a Basic Medicare Part D Prescription Drug product, the legal authority:

(a) to select all members of the Controlled Affiliate's governing body; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and

(c) to exercise control over the policy and operations of the Controlled Affiliate.

Amended September 27, 2018

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In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by Sponsoring Plan must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Participating Plan as defined in Exhibit B-2 and the Sponsoring Plan shall execute the Addendum to Controlled Affiliate License Agreement attached hereto as Exhibit B-2.

3. **FOR-PROFIT, PUBLICLY TRADED LICENSEES**

A. The Controlled Affiliate may operate as a for-profit publicly traded company on the following conditions:

(1) The Controlled Affiliate shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement.

(2) The Controlled Affiliate shall provide 90 days advance written notice to BCBSA prior to the initial filing with the SEC.

(3) The Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Controlled Affiliate in any securities market. The Controlled Affiliate shall use the Licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(4) The Controlled Affiliate's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Controlled Affiliate ("Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Noninstituional Investor, other than a Plan or Plans or Controlled Affiliate Licensee or Licensees has become the Beneficial Owner of securities representing 5% or more of the voting power of the Controlled Affiliate ("Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner, other than a Plan or Plans or Controlled Affiliate Licensee or Licensees, of 20% or more of the Controlled Affiliate's then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 3A(4) below ("Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Controlled Affiliate went public constituted the Board of Directors of the

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Controlled Affiliate (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the
time the Controlled Affiliate went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Controlled Affiliate consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Sponsoring Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Controlled Affiliate in a writing received by BCBSA prior to such automatic termination becoming effective, the provisions of this paragraph 3A(4) may be waived, in whole or in part, upon the affirmative vote of a majority of the disinterested Plans and majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by
the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 3A(4) (a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Controlled Affiliate's license, or any other license, to use the Licensed Marks and Name is terminated pursuant to Paragraph 3A(4), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Controlled Affiliate demonstrates that the Person referred to in clause (a), (b), or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(5) The Controlled Affiliate shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities or (iii) such other securities as the Controlled Affiliate may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(6) For purposes of paragraph 3A(4) above, the following definitions shall apply:

(i) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

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(ii) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

(1) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

(2) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to
beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(3) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (ii)2(B) above) or disposing of any securities of the Controlled Affiliate.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding," when used with reference to a Person's Beneficial Ownership of securities of the Controlled Affiliate, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(iii) A Person shall be deemed an "Institutional Investor" if (but only if) such Person (i) is an entity or group identified in the SEC's Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person's Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 10 of SEC Schedule 13G as constituted on June 1, 1997.

(iv) "Noninstitutional Investor" means any Person who is not an Institutional Investor.

(v) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

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4. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Service Area the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. If Controlled Affiliate meets the standards of 2E(1) but not 2E(2) above and any of Controlled Affiliate's advertising or promotional material is reasonably determined by BCBSA and/or the Plan to be in contravention of rules and regulations governing the use of the Licensed Marks and Name, Controlled Affiliate shall for ninety (90) days thereafter obtain prior approval from BCBSA of advertising and promotional efforts using the Licensed Marks and Name, approval or disapproval thereof to be forthcoming within five (5) business days of receipt of same by BCBSA or its designee. In all advertising and promotional efforts, Controlled Affiliate shall observe the Service Area limitations applicable to Plan.

E. Notwithstanding any other provision in the Plan's License Agreement with BCBSA or in this Agreement, Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name.

5. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

6. INFRINGEMENT

Controlled Affiliate shall promptly notify Plan and Plan shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement,

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unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

7. LIABILITY INDEMNIFICATION

Controlled Affiliate and Plan hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to: (i) Controlled Affiliate's rendering of services under the Licensed Marks and Name; or (ii) the activities of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan or Controlled Affiliate.

8. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) the Plan ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement the Plan ceases to be authorized to use the Licensed Names and Marks in the geographic area served by the Controlled Affiliate provided, however, that if the Controlled Affiliate is serving more than one State or portions thereof, the termination of this Agreement shall be limited to the State(s) or portions thereof in which the Plan's license to use the Licensed Marks and Names is terminated. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) for a Smaller Controlled Affiliate (as defined in Exhibit A), failure to comply with any of the applicable requirements of Standards 2, 3, 4, 5 or 7 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless

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this Controlled Affiliate License Agreement has been earlier terminated under paragraph 8(E); or (6) failure by a Controlled Affiliate that meets the standards of 2E(1) but not 2E(2) above to obtain BCBSA's written consent to a change in the identity of any owner, in the extent of ownership, or in the identity of any person or entity with the authority to select or appoint members or board members, provided that as to publicly traded Controlled Affiliates this provision shall apply only if the change affects a person or entity that owns at least 5% of the Controlled Affiliate's stock before or after the change; or (7) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans, any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 8(B), 8(C) or 8(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Plan shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 8(B), 8(C) or 8(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between BCBSA, the Plan and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 8(B) and 8(E) of this Agreement, this license to use the Licensed
Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled
Affiliate pursuant to paragraph 10 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled

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Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 8(E)(3)(vii) and (viii) of this Agreement.

(4) The for-profit, publicly traded Controlled Affiliate is terminated pursuant to Paragraph 3A(4) of this Agreement. In which case, the licenses of any Controlled Affiliates directly or indirectly owned by the terminated for-profit, publicly traded Controlled Affiliate also shall immediately terminate as provided for in paragraph 3A(4) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name.

Amended as of March 26, 2015

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 8(B) hereof, or in the event the Controlled Affiliate is a Larger Controlled Affiliate (as defined in Exhibit A), upon termination of this Agreement, the provisions of Paragraph 8.G. shall not apply and the following provisions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 8(B)(ii) of this Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated.

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re-Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area.

Amended as of March 26, 2015

The Re-Establishment Fee shall be indexed to a base fee of $80. The Re-Establishment Fee through December 31, 2005 shall be $80. The Re-establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was $278.60, $285.00 and $290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be $83.27 (100% of base fee plus $1.84 for calendar year 2005 and $1.43 for calendar year 2006). Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H.(3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Plan or any other Licensed Controlled Affiliates of the Plan to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re-Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Plan or its other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 8.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 8.M. and any costs associated with reestablishing the Service Area, including payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the Controlled Affiliate.

Amended as of March 26, 2015

(4) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third party auditor to examine and audit the books and records of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan to verify compliance with this paragraph 8.H.

(5) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.

(6) As to a breach of 8.H.(1), (2), (3), (4) or (5) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 8.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. This Agreement shall remain in effect until terminated by the Controlled Affiliate or the Plan upon not less than eighteen (18) months written notice to the Association or upon a shorter notice period approved by BCBSA in writing at its sole discretion, or until terminated as otherwise provided herein. The Plan's right to terminate without cause upon such notice is unfettered and may be exercised in the Plan's sole discretion.

J. In the event the Controlled Affiliate is a Smaller Controlled Affiliate (as defined in Exhibit A), the Controlled Affiliate agrees to be jointly liable for the amount described in H.3. and M. hereof upon termination of the BCBSA license agreement of any Larger Controlled Affiliate of the Plan.

K. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless the Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of the Plan's license agreement upon the required 18 months written notice.

L. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

M. In the event that the Plan has more than 50 percent voting control of the Controlled Affiliate under Paragraph 2(E)(2) above and is a Larger Controlled Affiliate (as defined in Exhibit A), then the vote called for in Paragraphs 8(C) and 8(D) above shall require the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

Amended as of March 26, 2015

N. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

9. DISPUTE RESOLUTION

The parties agree that any disputes between them or between or among either of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

10. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit C.

11. JOINT VENTURE

Nothing contained in the Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

12. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

13. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

Amended as of March 26, 2015

14. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

15. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of
this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question.

Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

Amended as of March 26, 2015

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16. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

17. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By:

Date:_____

Plan:

By:

Date:_____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____

Date:_____

Amended as of March 26, 2015

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EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS
September 2018
PREAMBLE

For purposes of definition:

A "smaller Controlled Affiliate:" (1) comprises less than fifteen percent (15%) of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed);* or (2) underwrites the indemnity portion of workers' compensation insurance and has total premium revenue less than 15 percent of the Sponsoring Plan's net subscription revenue.

A "larger Controlled Affiliate" comprises fifteen percent (15%) or more of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed.)*

Changes in Controlled Affiliate status:

If **any** Controlled Affiliate's status changes regarding: its Plan ownership level, its risk acceptance or direct delivery of medical care, the Controlled Affiliate shall notify BCBSA within thirty (30) days of such occurrence in writing and come into compliance with the applicable standards within six (6) months.

If a smaller Controlled Affiliate's health and workers' compensation administration business reaches or surpasses fifteen percent (15%) of the total member enrollment of the Sponsoring Plan and licensed Controlled Affiliates, the Controlled Affiliate shall:

Amended as of September 19, 2014

EXHIBIT A (continued)

1. Within thirty (30) days, notify BCBSA of this fact in writing, including evidence that the Controlled Affiliate meets the minimum liquidity and capital (BCBSA "Health Risk-Based Capital (HRBC)" as defined by the NAIC and state-established minimum reserve) requirements of the larger Controlled Affiliate Financial Responsibility standard; and

2. Within six (6) months after reaching or surpassing the fifteen percent (15%) threshold, demonstrate compliance with all license requirements for a larger Controlled Affiliate.

If a Controlled Affiliate that underwrites the indemnity portion of workers' compensation insurance receives a change in rating or proposed change in rating, the Controlled Affiliate shall notify BCBSA within 30 days of notification by the external rating agency.

*For purposes of this calculation,

The numerator equals:

Applicant Controlled Affiliate's member enrollment, as defined in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

The denominator equals:

Numerator PLUS Sponsoring Plan and all other licensed Controlled Affiliates' member enrollment, as reported in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

Amended as of September 19, 2002

EXHIBIT A (continued)

STANDARDS FOR LICENSED CONTROLLED AFFILIATES

Each licensed controlled affiliate shall be subject to certain standards as determined below:

1. What percent of the licensed controlled affiliate is controlled by the Sponsoring Plan and other Plans?

More than 50% by Sponsoring Plan	50% by Sponsoring Plan	100% Plan Control but less than 50% Sponsoring Plan Control and it offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services	100% Sponsoring Plan control and on a Blue-branded basis, it only offers a Basic Medicare Part D Prescription Drug Plan product
ò Standard 1A, 4	ò Standard 1B, 4	ò Standard 1C, 4	ò Standard 1D, 4

IN ADDITION,

2. Is risk being assumed?

Yes			No	
÷ Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance ò Standards 7A-7E, 11	ò Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance ò Standard 2 (Guidelines 1.1,1.2) and Standard 11	ø Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance ò Standard 6H	÷ Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates ò Standard 2 (Guidelines 1.1,1.3) and Standard 11	ò Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates Standard 6H

IN ADDITION,

3. Is medical care being directly provided?

Yes	No
ò Standard 3A	ò Standard 3B

IN ADDITION,

4. If the controlled affiliate has health or workers' compensation administration business, does such business comprise 15% or more of the total member enrollment of Plan and its licensed Controlled Affiliates?

Yes	No			
ò Standards 6A-6J	Controlled Affiliate is not a former primary licensee and is not subject to Standard 1(C) ò Standards 5,8,9B,10,11	÷ Controlled Affiliate is a former primary licensee ò Standards 5,8,9A,10,11	÷	ø Controlled Affiliate is not a former primary licensee and is subject to Standard 1(C) ò Standards 5,8,9B,11

Amended September 27, 2018

EXHIBIT A (continued)

Standard 1 - Organization and Governance

1A.) The Standard for more than 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA, has the legal authority, directly or indirectly through wholly-owned subsidiaries: 1) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; and 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and 3) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate.

1B.) The Standard for 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA, has the legal authority, directly or indirectly through wholly-owned subsidiaries:

1) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; and

2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and

3) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan.

Amended as of March 17, 2016

EXHIBIT A (continued)

Notwithstanding anything to the contrary in 1) through 3) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by Sponsoring Plan before the Controlled Affiliate can:

- change the geographic area in which it operates
- change its legal and/or trade names
- change any of the types of businesses in which it engages
- create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business
- sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced
- make any loans or advances except in the ordinary course of business
- enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate)
- conduct any business other than under the Licensed Marks and Name
- take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate.

Amended September 19, 2014

1C.) The Standard for a Controlled Affiliate that offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and service and has 100% Plan control but less than 50% Sponsoring Plan Control:

A Controlled Affiliate shall be organized and operated in such a manner that (i) it offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services; and (ii) a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA (the "Sponsoring Plan,) has the legal authority together with Other Plans:

1) to select all members of the Controlled Affiliate's governing body; and

2) to prevent any change in the articles of incorporation, bylaws, or other establishing or governing documents of the Controlled Affiliate; and

3) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the Addendum to Controlled Affiliate License.

1D.) The Standard for a Controlled Affiliate that on a Blue-branded basis, only offers a Basic Medicare Part D Prescription Drug product and has 100% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that (i) it offers solely a Basic Medicare PDP product; and (ii) the Sponsoring Plan has the legal authority:

1) to select all members of the Controlled Affiliate's governing body; and

2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and

3) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by Sponsoring Plan must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA.

Further, the Sponsoring Plan and Participating Plan shall execute the Addendum to Controlled Affiliate License.

Amended September 27, 2018

EXHIBIT A (continued)

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. If a risk-assuming Controlled Affiliate ceases operations for any reason, Blue Cross and/or Blue Cross Plan coverage will be offered to all Controlled Affiliate subscribers without exclusions, limitations or conditions based on health status. If a nonrisk-assuming Controlled Affiliate ceases operations for any reason, Sponsoring Plan will provide for services to its customers. The requirements of the preceding two sentences shall apply to all lines of business unless a line of business is specially exempted from the requirement(s) by the BCBSA Board of Directors.

Standard 3 - State Licensure/Certification

3A.) The Standard for a Controlled Affiliate that employs, owns or contracts on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification for its medical care providers to operate under applicable state laws.

3B.) The Standard for a Controlled Affiliate that does not employ, own or contract on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification to operate under applicable state laws.

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of 1) the structure of the Blue Cross and Blue Shield System; and 2) the independent nature of every licensee; and 3) the Controlled Affiliate's financial condition.

Amended as of September 19, 2014

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EXHIBIT A (continued)

Standard 5 - Reports and Records for Certain Smaller Controlled Affiliates

For a smaller Controlled Affiliate that does not underwrite the indemnity portion of workers' compensation insurance, the Standard is:

A Controlled Affiliate and/or its Sponsoring licensed Plan shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Other Standards for Larger Controlled Affiliates

Standards 6(A) - (I) that follow apply to larger Controlled Affiliates.

Standard 6(A): Board of Directors

A Controlled Affiliate Governing Board shall act in the interest of its Corporation in providing cost-effective health care services to its customers. A Controlled Affiliate shall maintain a governing Board, which shall control the Controlled Affiliate, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 6(B): Responsiveness to Customers

A Controlled Affiliate shall be operated in a manner responsive to customer needs and requirements.

Standard 6(C): Participation in National Programs

A Controlled Affiliate shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the licensees and ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's Service Area.

Amended as of September 19, 2014

EXHIBIT A (continued)

Such programs are applicable to licensees, and include:

1. BlueCard Program;
2. Inter-Plan Teleprocessing System (ITS);
3. National Account Programs;
4. Business Associate Agreement for Blue Cross and Blue Shield Licensees, effective April 14, 2003; and
5. Inter-Plan Medicare Advantage Program.

Standard 6(D): Financial Performance Requirements

In addition to requirements under the national programs listed in
Standard 6C: Participation in National Programs, a Controlled Affiliate shall take such action as required to ensure its financial performance in programs and contracts of an inter-licensee nature or where BCBSA is a party.

Standard 6(E): Cooperation with Plan Performance Response Process

A Controlled Affiliate shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Plan Performance Response Process and in addressing Controlled Affiliate performance problems identified thereunder.

Standard 6(F): Independent Financial Rating

A Controlled Affiliate shall obtain a rating of its financial strength from an independent rating agency approved by BCBSA's Board of Directors for such purpose.

Standard 6(G): Local and National Best Efforts

Notwithstanding any other provision in the Plan’s License Agreement with BCBSA or in this License Agreement, during each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Cross Mark.

Amended as of November 21, 2014

EXHIBIT A (continued)

Standard 6(H): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 6(I): Reports and Records

A Controlled Affiliate shall furnish to BCBSA on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between BCBSA and Controlled Affiliate. Such reports and records are the following:

A) BCBSA Controlled Affiliate Licensure Information Request; and

B) Triennial trade name and service mark usage material, including disclosure material; and

C) Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, or changes in the identity of the Controlled Affiliate's Principal Officers, and changes in risk acceptance, contract growth, or direct delivery of medical care; and

D) Semi-annual “Health Risk-Based Capital (HRBC) Report”as defined by the NAIC, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), and

Amended as of November 17, 2011

EXHIBIT A (continued)

Standard 6(J): Control by Unlicensed Entities Prohibited

No Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Standard 7 - Other Standards for Risk-Assuming Workers' Compensation Controlled Affiliates

Standards 7(A) - (E) that follow apply to Controlled Affiliates that underwrite the indemnity portion of workers' compensation insurance.

Standard 7 (A): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 7(B): Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Controlled Affiliate Licensure Information Request; and

B. Triennial trade name and service mark usage materials, including disclosure materials; and

C. Annual Certified Audit Report, Annual Statement as filed with the State Insurance Department (with all attachments), Annual NAIC's Risk-Based Capital Worksheets for Property and Casualty Insurers; and

D. Quarterly Estimated Risk-Based Capital for Property and Casualty Insurers, Insurance Department Examination Report; and

Amended as of November 17, 2011

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EXHIBIT A (continued)

A. Notification of all changes and proposed changes to independent ratings within 30 days of receipt and submission of a copy of all rating reports; and

B. Changes in the ownership and governance of the Controlled Affiliate including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 7(C): Loss Prevention

A Controlled Affiliate shall apply loss prevention protocol to both new and existing business.

Standard 7(D): Claims Administration

A Controlled Affiliate shall maintain an effective claims administration process that includes all the necessary functions to assure prompt and proper resolution of medical and indemnity claims.

Standard 7(E): Disability and Provider Management

A Controlled Affiliate shall arrange for the provision of appropriate and necessary medical and rehabilitative services to facilitate early intervention by medical professionals and timely and appropriate return to work.

Amended as of November 16, 2000

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EXHIBIT A (continued)

Standard 8 - Cooperation with Controlled Affiliate License Performance Response Process Protocol

A Controlled Affiliate and its Sponsoring Plan shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Controlled Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing Controlled Affiliate compliance problems identified thereunder.

Standard 9(A) - Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees

A smaller controlled affiliate that formerly was a Primary Licensee shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:
- BlueCard Program;
- Inter-Plan Teleprocessing System (ITS);
- National Account Programs.

B. Financial Requirements include:
- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Amended as of November 21, 2014

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EXHIBIT A (continued)

Standard 9(A) - Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees

C. Reporting requirements include:
- The Semi-annual Health Risk-Based Capital (HRBC) Report.

Amended as of June 13, 2002

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EXHIBIT A (continued)

Standard 9(B) - Participation in National Programs by Smaller Controlled Affiliates

A smaller controlled affiliate shall participate in national programs in accordance with BlueCard and other relevant Policies and Provisions shall effectively and efficiently participate in national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:
- BlueCard Program;
- Inter-Plan Teleprocessing System (ITS);
- National Account Programs.

B. Financial Requirements include:
- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Amended as of June 20, 2013

EXHIBIT A (continued)

Standard 10 - Participation in Inter-Plan Medicare Advantage Program

A smaller controlled affiliate for which this standard applies pursuant to the Preamble section of Exhibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area.

National program requirements include:

A. Inter-Plan Medicare Advantage Program.

Standard 11: Participation in Master Business Associate Agreement by Smaller Controlled Affiliate Licensees

Effective April 14, 2003, all smaller controlled affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of September 19, 2014

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EXHIBIT B-1

ADDENDUM TO CONTROLLED AFFILIATE LICENSE TO BE EXECUTED BY CONTROLLED AFFILIATES LICENSED UNDER CONTROLLED AFFILIATE LICENSE STANDARD 1C.

ADDENDUM TO CONTROLLED AFFILIATE LICENSE

This Addendum is made to that certain Blue Cross Controlled Affiliate License Agreement executed by and among Blue Cross and Blue Shield Association ("Licensor"), _____ ("Controlled Affiliate Licensee") and _____("Sponsoring Plan") dated the _____ day of _____ , _____ ("Agreement"). The parties to this Addendum are Licensor, Controlled Affiliate Licensee, Sponsoring Plan, and the undersigned other Plans ('Other Plans"). This Addendum is made and shall be deemed effective as of the date of the Agreement.

WHEREAS, the Sponsoring Plan asserts that it can serve the Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans market in its Service Area more efficiently and with less risk through an enterprise jointly owned and controlled with other Plans than through a wholly owned and Controlled Affiliate Licensee;

WHEREAS, in such circumstance Controlled Affiliate License Standard 1C permits the licensing of a Controlled Affiliate that is less than 50% owned and controlled by the Sponsoring Plan but which is 100% owned and controlled by Plans including the Sponsoring Plan, subject to certain conditions;

WHEREAS, one such condition is that the Sponsoring Plan and all such other owning and controlling Plans enter into this Addendum;

NOW THEREFORE, for good and valuable consideration, including the promises and covenants set forth herein, the parties agree as follows:

1. This Addendum is limited to [identify product name].

2. The Sponsoring Plan shall participate operationally in Controlled Affiliate's business that is conducted under the Licensed Marks. The parties understand that participation may take many forms, one of which should be providing a network of providers in the Service Area of the Controlled Affiliate for the Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans services being offered under the Agreement and being involved in network development and provider engagement functions.

3. Each of the Other Plans agrees that (i) it will cooperate fully with the Sponsoring Plan and BCBSA as needed to enable Sponsoring Plan and

Amended September 27, 2018

Controlled Affiliate Licensee to meet their obligations to Licensor under the Agreement and all associated rules and regulations of Licensor, including the Brand Regulations, (ii) it will not take any action, either individually or jointly with any of the Other Plans, that would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement, and (iii) it will not fail to take any action, either individually or jointly with any of the Other Plans, where such failure would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement.

4. Each of the Other Plans acknowledges that it has reviewed the Agreement and understands that Sponsoring Plan has the right to terminate the Agreement without cause upon notice as provided in Paragraph 8 of the Agreement, and that such right is unfettered and may be exercised by Sponsoring Plan in its sole discretion.

WHEREFORE, by signing below the parties agree to be bound to the terms stated herein.

BLUE CROSS BLUE SHIELD ASSOCIATION

By: _____

[Controlled Affiliate Licensee]

By: _____

[Sponsoring Plan]

By: _____

[Other Plan 1]

By: _____

[Other Plan 2]

By: _____

Amended September 27, 2018

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EXHIBIT B-2

ADDENDUM TO CONTROLLED AFFILIATE LICENSE TO BE EXECUTED BY CONTROLLED AFFILIATES LICENSED UNDER CONTROLLED AFFILIATE LICENSE STANDARD 1D.

ADDENDUM TO CONTROLLED AFFILIATE LICENSE

This Addendum is made to that certain Blue Cross Controlled Affiliate License Agreement executed by and among Blue Cross and Blue Shield Association ("Licensor"), _____ ("Controlled Affiliate Licensee"), _____("Sponsoring Plan") and _____ ("Participating Plan") dated the _____ day of _____ , _____ ("Agreement").

WHEREAS, the Participating Plan is defined as the Plan that holds the Primary License with BCBSA to use the Service Marks in the Service Area where the Controlled Affiliate will use the Service Marks;

WHEREAS, the Participating Plan asserts that it can offer a lower cost Basic Medicare Part D Prescription Drug Plan product more efficiently in the Participating Plan's Service Area through the Controlled Affiliate Licensee;

WHEREAS, the Controlled Affiliate shall only use the Service Marks inside of the Participating Plan(s) Service Area subject to each Participating Plan signing a separate Addendum;

WHEREAS, in such circumstance Controlled Affiliate License Standard 1D permits the licensing of a Controlled Affiliate that is 100% owned and controlled by a Sponsoring Plan, subject to certain conditions;

WHEREAS, one such condition is that the Sponsoring Plan, Controlled Affiliate and the Participating Plan enter into this Addendum;

NOW THEREFORE, for good and valuable consideration, including the promises and covenants set forth herein, the parties agree as follows:

1. The Participating Plan shall participate in Controlled Affiliate's business that is conducted under the Licensed Marks. The parties understand that the Participating Plan shall conduct sales support and marketing of the Controlled Affiliate's Basic Medicare Part D Prescription Drug Plan product offered in the Participating Plan's Service Area. Any other form of participation shall require BCBSA's written approval.

2. Participating Plan agrees that (i) it will cooperate fully with the Sponsoring Plan and BCBSA as needed to enable Sponsoring Plan and

Controlled Affiliate Licensee to meet their obligations to Licensor under the Agreement and all associated rules and regulations of Licensor, including the Brand Regulations, (ii) it will not take any action that would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement, and (iii) it will not fail to take any action, either individually or jointly with the Sponsoring Plan or Controlled Affiliate Licensee, where such failure would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement.

3. The Controlled Affiliate Licensee shall only use the Licensed Marks authorized by the Participating Plan in connection with the Basic Medicare Part D Prescription Drug Plan product offered in the Participating Plan's Service Area.

4. The Sponsoring Plan and Controlled Affiliate acknowledge that it has reviewed the Agreement and understands that Participating Plan has the right to terminate this Agreement: (i) immediately upon the expiration or termination of the Plan Participation Agreement by and between Participating Plan and Controlled Affiliate upon written notice to the Sponsoring Plan, Controlled Affiliate Licensee and Licensor, or (ii) without cause upon 18 months written notice to the Sponsoring Plan, Controlled Affiliate Licensee and Licensor, and that such right is unfettered and may be exercised by Participating Plan in its sole discretion. In the event that Participating Plan and Controlled Affiliate fail to execute the Plan Participation Agreement by _____(Date), Participating Plan may terminate this Agreement immediately upon notice to Sponsoring Plan, Controlled Affiliate Licensee and Licensor.

5. This Agreement and all of Controlled Affiliate Licensee's rights hereunder shall immediately terminate without any further action by any party or entity in the event that the Sponsoring Plan or Participating Plan ceases to be authorized to use the Licensed Marks and Name.

WHEREFORE, by signing below the parties agree to be bound to the terms stated herein.

BLUE CROSS BLUE SHIELD ASSOCIATION

By: _____

[Controlled Affiliate Licensee]

By: _____

[Sponsoring Plan]

By: _____

[Participating Plan]

By: _____

Amended March 17, 2016

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EXHIBIT C
ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENT

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

FOR RISK PRODUCTS:

For Controlled Affiliates not underwriting the indemnity portion of workers' compensation insurance:

An amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For Controlled Affiliates underwriting the indemnity portion of workers' compensation insurance:

An amount equal to 0.35 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus, an annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 7.

Amended as of September 19, 2014

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EXHIBIT C (continued)

FOR NONRISK PRODUCTS:

For third-party administrative business, an amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For non-third party administrative business (e.g., case management, provider networks, etc.), an amount equal to 0.24 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus:

1) An annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 6 D.

2) An annual fee of $2,000 per license for all other Controlled Affiliates.

The foregoing shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® License are issued to the same Controlled Affiliate. In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Amended as of September 19, 2014

EXHIBIT 1A

CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO LIFE INSURANCE COMPANIES
(Includes revisions adopted by Member Plans through their September 27, 2018 meeting)

This agreement by and among Blue Cross and Blue Shield Association ("BCBSA") _____("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____("Plan").

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, the Plan and the Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name");

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Controlled Affiliate the exclusive right to use the licensed Marks and Names in connection with and only in connection with those life insurance and related services authorized by applicable state law, other than health care plans and related services (as defined in the Plan's License Agreements with BCBSA) which services are not separately licensed to Controlled Affiliate by BCBSA, in the Service Area served by the Plan, except that BCBSA reserves the right to use the Licensed Marks and Name in said Service Area, and except to the extent that said Service Area may overlap the area or areas served by one or more other licensed Blue Cross Plans as of the date of this License as to which overlapping areas the rights hereby granted are non-exclusive as to such other Plan or Plans and their respective Licensed Controlled Affiliates only. Controlled Affiliate cannot use the Licensed Marks or Name outside the Service Area or in its legal or trade name; provided, however, that if and only for so long as Controlled Affiliate also holds a Blue Cross Controlled Affiliate License Agreement applicable to health care plans and related services, Controlled Affiliate may use the Licensed Marks and Name in its legal and trade name according to the terms of such license agreement.

Amended as of June 12, 2003

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in relation to the sale, marketing and rendering of authorized products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A as it may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans. Absent written approval by BCBSA of an alternative method of control, bona fide control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having not less than 51% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Plan or Plans shall own at least 51% of any for-profit Controlled Affiliate. If the Controlled Affiliate is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items (a) and (c) above, proxies representing 51% of the votes at any meeting of the policyholders and shall demonstrate that there is no reason to believe this such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

3. SERVICE MARK USE

Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks, and shall comply with such rules (applicable to all Controlled Affiliates licensed to use the Marks) relative to service mark use, as are issued from time-to-time by BCBSA. If there is any public reference to the affiliation between the Plan and the Controlled Affiliate, all of the Controlled Affiliate's licensed services in the Service Area of the Plan shall be rendered under the Licensed Marks. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted
hereunder and any such act shall be voidable at the option of Plan or BCBSA.
This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENTS

Controlled Affiliate shall promptly notify Plan and BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate hereby agrees to save, defend, indemnify and hold Plan and BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Controlled Affiliate's rendering of health care services under the Licensed Marks.

7. LICENSE TERM

The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods upon evidence satisfactory to the Plan and BCBSA that Controlled Affiliate meets the then applicable quality control standards, unless one of the parties hereto notifies the other party of the termination hereof at least sixty (60) days prior to expiration of any license period.

This Agreement may be terminated by the Plan or by BCBSA for cause at any time provided that Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Controlled Affiliate's failure to abide by the quality control provisions of Paragraph 2, above, shall be considered a proper ground for cancellation of this Agreement.

This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

A. Controlled Affiliate shall no longer comply with Standard No. 1 (Organization and Governance) of Exhibit A or, following an opportunity to cure, with the remaining quality control provisions of Exhibit A, as it may be amended from time-to-time; or

B. Plan ceases to be authorized to use the Licensed Marks; or

C. Appropriate dues for Controlled Affiliate pursuant to item 8 hereof, which are the royalties for this License Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks including any use in its trade name.

In the event of any disagreement between Plan and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of the Blue Cross and Blue Shield Association and provide instruction on how the customer can contact the Blue Cross and Blue Shield Association or a designated licensee to obtain further information on securing coverage. The written notification required by this paragraph shall be in writing and in a form approved by the Association. The Association shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. DUES

Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

An annual fee of five thousand dollars ($5,000) per license, plus

.05% of gross revenue per year from branded group products, plus

.5% of gross revenue per year from branded individual products plus

.14% of gross revenue per year from branded individual annuity products.

The foregoing percentages shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® license are issued to the same entity. In the event that any License period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Plan will promptly and timely transmit to BCBSA all dues owed by Controlled Affiliate as determined by the above formula and if Plan shall fail to do so, Controlled Affiliate shall pay such dues directly.

Amended as of November 20, 1997

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9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

9A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

10. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

Amended as of June 16, 2005

(The next page is page 5)

11. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by a writing executed by all parties.

12. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way effect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

13. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: _

Date: _

Controlled Affiliate:

By: _

Date: _

Plan:

By: ___

Date: _

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EXHIBIT A
CONTROLLED AFFILIATE LICENSE STANDARDS
LIFE INSURANCE COMPANIES
Page 1 of 2

PREAMBLE

The standards for licensing Life Insurance Companies (Life and Health Insurance companies, as defined by state statute) are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote of all Plans. Each Licensed Plan is required to use a standard controlled affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Life Insurance Company maintains compliance with the license standards.

An organization meeting the following standards shall be eligible for a license to use the Licensed Marks within the service area of its sponsoring Licensed Plan to the extent and the manner authorized under the Controlled Affiliate License applicable to Life Insurance Companies and the principal license to the Plan.

Standard 1 - Organization and Governance

The LIC shall be organized and operated in such a manner that it is controlled by a licensed Plan or Plans which have, directly or indirectly: 1) not less than 51% of the voting control of the LIC; and 2) the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the LIC with which it does not concur; and 3) operational control of the LIC.

If the LIC is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items 1 and 2 above, proxies representing at least 51% of the votes at any policyholder meeting and shall demonstrate that there is no reason to believe such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

Standard 2 - State Licensure

The LIC must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life and health insurance company in each state in which the LIC does business.

EXHIBIT A
CONTROLLED AFFILIATE LICENSE STANDARDS
LIFE INSURANCE COMPANIES
Page 2 of 2

Standard 3 - Records and Examination

The LIC and its sponsoring licensed Plan(s) shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the LIC as may be required in order to establish compliance with the license agreement. The LIC and its sponsoring licensed Plan(s) shall permit BCBSA to examine the affairs of the LIC and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the sponsoring Plan(s).

Standard 4 - Mediation

The LIC and its sponsoring Plan(s) shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed controlled affiliate, a licensed Plan or BCBSA.

Standard 5 - Financial Responsibility

The LIC shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with Affiliate License Performance Response Process Protocol

The LIC and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing LIC compliance problems identified thereunder.

Exhibit 1A1

CONTROLLED AFFILIATE
TRADEMARK LICENSE AGREEMENT
FOR LIFE AND DISABILTY INSURANCE PRODUCTS

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____, (“Life and Disability Controlled Affiliate”) which is a company offering life and disability insurance products owned and controlled by _____, _____, _____ (individually, “Sponsoring Plan” and when referred to collectively, “Sponsoring Plans”).

Whereas, BCBSA is the owner of the BLUE CROSS and BLUE SHIELD word and design service marks and any derivatives thereof (“Licensed Marks”);

Whereas, each Sponsoring Plan is licensed separately by BCBSA to use one or more of the Licensed Marks in a particular Service Area;

Whereas, the Sponsoring Plans and the Life and Disability Controlled Affiliate desire that the latter be entitled to use the appropriate Licensed Marks in connection with life and disability insurance products in some or all of such Sponsoring Plans’ Service Areas and in the Service Areas of other Regular Member Plans, as defined in the BCBSA By-laws, (“Blue Plans”) consistent with the terms of this Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. <u>GRANT OF LICENSE</u>

A. Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Life and Disability Controlled Affiliate the limited right to use the Licensed Marks in connection with and only in connection with the following life and disability insurance products authorized by state law: (1) Group: Term Life, Long Term Disability, Whole Life, Benefit Life, Universal Life; (2) Individual: Term Life, Whole Life, Dependent Life, Spouse Life; (3) Other: Disability Income, Short Term Disability, Long Term Disability, Income Replacement; and (4) such other life and disability products approved by BCBSA in writing (“Licensed Products”) in the Service Areas served by the Sponsoring Plans or in the Service Area or Areas of one or more other licensed Blue Plans, provided that such Blue Plans have consented to such use as authorized by this Agreement. Life and Disability Controlled Affiliate may not use the Licensed Marks in its legal or trade name.

B. Notwithstanding that the license granted to Life and Disability Controlled Affiliate is a license to use all of the Licensed Marks, Life and Disability Controlled Affiliate may only use those of the Licensed Marks in

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the Service Area of a Sponsoring Plan or other consenting Blue Plan as described below that such Plan is authorized to use as a Blue Plan pursuant to its separate license agreements with BCBSA.

C. Life and Disability Controlled Affiliate may use the Licensed Marks in the Service Areas of Sponsoring Plans or in the Service Area of a Blue Plan that is not a signatory to this Agreement only after such Sponsoring Plan(s) or non-signatory Blue Plan consents to such use by executing a written consent in substantially the same form as the Consent Agreement attached as Exhibit B.

D. The following provisions apply with respect to Consent Agreements once such agreements have been fully and properly executed:

(1) All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in the Service Area of Sponsoring Plan or consenting Blue Plan (hereinafter, such consenting Sponsoring Plan or consenting Blue Plan collectively referred to “Consenting Plan(s)”) must clearly identify the Consenting Plan (for example, a statement on such materials that reads “This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]”);

(2) To the extent the Consenting Plan has separate divisions or other Affiliates that use the Licensed Marks in distinct geographic areas within its Service Area, consent obtained under this Agreement may be limited to one or more of such specific geographic areas as specified by the Consenting Plan in its signed Consent Agreement. For purposes of this entire Agreement, all references to the Service Area of a Sponsoring Plan, Blue Plan or Consenting Plan may include the entire Service Area or a distinct geographic area within such Service Area as specified in this Section 1 D (2);

(3) Where BCBSA has licensed two or more Blue Plans to use the same Licensed Marks in the same Service Area, in addition to the requirements set forth in Section D (1) above, the sales, marketing and advertising materials referenced in such section above must be communicated to the Consenting Plan’s existing and prospective accounts through or with the approval of such Consenting Plan, and the personnel of such Consenting Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the Consenting Plan;

(4) Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the Consenting Plan has been granted by BCBSA the license to use under its Blue Plan license

(5) agreements (for example, if a Consenting Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).

(6) If a Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless BCBSA and the Consenting Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.

2. QUALITY CONTROL

A. Life and Disability Controlled Affiliate agrees to use the Licensed Marks only in relation to the sale, marketing and administration of the Licensed Products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A and the Guidelines to Administer the Standards for Trademark License Agreement for Life and Disability Insurance Products attached thereto.

B. Life and Disability Controlled Affiliate agrees that BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Life and Disability Controlled Affiliate's rendering of service and use of the Licensed Marks.

C. Life and Disability Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by BCBSA) a report to BCBSA demonstrating Life and Disability Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Life and Disability Controlled Affiliate is defined as: An entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

3. SERVICE MARK USE

Life and Disability Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and shall ensure all uses of the Licensed Marks comply with the BCBSA Brand Regulations, as amended by BCBSA from time to time. Life and Disability Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Life and Disability Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

The license hereby granted to Life and Disability Controlled Affiliate to use the Licensed Marks is and shall be personal to Life and Disability Controlled Affiliate and shall not be assignable by any act of the Life and Disability Controlled Affiliate, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Life and Disability Controlled Affiliate mortgage or part with possession or control of this license or any right hereunder, and the Life and Disability Controlled Affiliate shall have no right to grant any sublicense to use the Licensed Marks.

5. INFRINGEMENTS

Life and Disability Controlled Affiliate shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Life and Disability Controlled Affiliate shall not be entitled to require BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Life and Disability Controlled Affiliate agrees to render to BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA. BCBSA shall have sole control of the defense and resolution of any claim of infringement brought or threatened by others.

6. LIABILITY INDEMNIFICATION

Life and Disability Controlled Affiliate hereby agrees to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Life and Disability Controlled Affiliate's conduct.

7. LICENSE TERM

A. The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods, unless either BCBSA or Life and Disability Controlled Affiliate notifies the other party in writing of the termination hereof at least sixty (60) days prior to expiration of any license period.

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B. This Agreement may be terminated by BCBSA for cause at any time provided that Life and Disability Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Life and Disability Controlled Affiliate's failure to abide by the conditions regarding use of the Licensed Marks set forth in Section 1 of this Agreement or the quality control provisions of Section 2 (other than with respect to Section 2 D which is subject to immediate termination as stated in Section 7 C (1) below) shall be considered proper grounds for termination of this Agreement.

C. This Agreement and all of Life and Disability Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Life and Disability Controlled Affiliate shall no longer comply with Section 2 D (or Standard No. 1 (Organization and Governance) of Exhibit A); or

(2) Any Sponsoring Plan ceases to be authorized to use the Licensed Marks; or

(3) Appropriate fees for Life and Disability Controlled Affiliate pursuant to Section 8 of this Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Life and Disability Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks.

In the event of any disagreement between Life and Disability Controlled Affiliate and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Life and Disability Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. ROYALTIES

Life and Disability Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

- An annual fee of five thousand dollars ($5,000) per license, plus
- .05% of gross revenue per year from group products sold under the Licensed Marks, plus
- .5% of gross revenue per year from individual products sold under the Licensed Marks

In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Life and Disability Controlled Affiliate will promptly and timely transmit to BCBSA all fees owed by Life and Disability Controlled Affiliate as determined by the above formula.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between any Sponsoring Plan and Life and Disability Controlled Affiliate or between among them and/or BCBSA.

10. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by: (a) a writing signed by all parties; or (b) a writing approved by the affirmative vote of three-fourths of the Blue Plans and three-fourths of the total then current weighted vote of all the Blue Plans as officially recorded by the BCBSA Corporate Secretary. Upon such adoption by the Blue Plans, this Agreement and all other Trademark License Agreements for Life and Disability Insurance Products then in effect shall simultaneously be amended.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Life and Disability Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: _

Date: _

Life and Disability Controlled Affiliate:

By: _

Date: _

Sponsoring Plan:

By: ___

Date: _

Name:_____

Sponsoring Plan:

By: ___

Date: _

Name:_____

[Add other Sponsoring Plans as necessary]

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EXHIBIT A

LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS
Page 1 of 2

Standard 1 - Organization and Governance

Any Life and Disability Controlled Affiliate licensed under the Trademark License Agreement for Life and Disability Insurance Products ("licensee") shall be organized and operated in such a manner that it is an entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

Standard 2 - State Licensure

The licensee must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life company in each state in which the licensee does business.

Standard 3 - Records and Examination

The licensee shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the licensee as may be required in order to establish compliance with the Agreement. The licensee shall permit BCBSA to examine the affairs of the licensee and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the Sponsoring Plan(s).

Standard 4 - Mediation

The licensee, its Sponsoring Plan(s) and all consenting Blue Plans shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed Life and Disability Controlled Affiliate, a Sponsoring Plan and or consenting Blue Plan or BCBSA.

EXHIBIT A

LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS
Page 2 of 2

Standard 5 - Financial Responsibility

The licensee shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with BCBSA Governance

The licensee shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of and in addressing licensee compliance problems that may be identified in connection with the operation or administration of the Trademark License Agreement for Life and Disability Insurance Products.

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EXHIBIT B
CONSENT AGREEMENT

This Consent Agreement is made and entered into by and among the undersigned Blue Plan, and _____ ("Life and Disability Controlled Affiliate"), and the Blue Cross and Blue Shield Association ("BCBSA") and shall be deemed effective on _____ ("Effective Date").

Whereas, BCBSA owns the Blue Cross and Blue Shield word and design service marks and any derivative mark thereof (the "Brands");

Whereas, the undersigned Blue Plan is licensed to use one or more of the Brands within a specific geographic area ("Service Area");

Whereas Life and Disability Controlled Affiliate is licensed by BCBSA to use one or more of the Brands to offer life and disability insurance products ("Products") as defined and authorized in the Trademark License Agreement for Life and Disability Insurance Products ("Life and Disability License Agreement");

Whereas neither the Blue Plan nor its affiliates offer the Products under any of the Brands in such Blue Plan's Service Area or portion thereof where Blue Plan has consented to sale of the Products by Life and Disability Controlled Affiliate; and

Whereas BCBSA and the undersigned Blue Plan desire to consent to Life and Disability Controlled Affiliate's use of the Brands in Blue Plan's Service Area consistent with the terms of the Life and Disability License Agreement and this Consent Agreement.

Now, therefore, in consideration of the obligations and conditions stated in this Agreement, Blue Plan, Life and Disability Controlled Affiliate and BCBSA agree as follows:

1. Life and Disability Controlled Affiliate may market, sell, administer and underwrite the Products in Blue Plan's Service Area under the Brands licensed to Blue Plan in such Service Area subject to the terms of this Consent Agreement, the Life and Disability License Agreement and Blue Plan's license agreement(s) with BCBSA. Life and Disability Controlled Affiliate's rights under the Brands to offer the Products under the Brands are limited to offering the Products only under the Brand(s) licensed to the consenting Blue Plan.

2. Life and Disability Controlled Affiliate shall work with the undersigned Blue Plan to develop a written sales and marketing agreement that identifies the relationship between it and Blue Plan for the sales, marketing and customer service for the Products. The term of the sales and marketing agreement shall be the same as the term of this Consent Agreement.

3. All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in a consenting Blue Plan's Service Area must clearly identify the consenting Blue Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");

4. Life and Disability Controlled Affiliate may use the Brands to sell the Products in the following Service Area or portion thereof as designated by Blue Plan:

   _____

5. If two or more Blue Plans to use the same Licensed Marks in the same Service Area, Life and Disability Controlled Affiliate shall work with the consenting Blue Plan in the following manner: (a) the sales, marketing and advertising materials must be communicated to the consenting Blue Plan's existing and prospective accounts through or with the approval of such Blue Plan, and (b) the personnel of such Blue Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the consenting Blue Plan;

6. Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the consenting Blue Plan has been granted by BCBSA the license to use under its license agreement (for example, if a consenting Blue Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).

7. If this Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless each BCBSA and the Blue Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.

8. The term of this Consent Agreement shall be one year from the Effective Date. Unless either Blue Plan or Life and Disability Controlled Affiliate provides the other party with written notice of its desire not to renew this Consent Agreement at least 60 days prior to expiration of the term or any extended term or unless terminated as provided in Paragraph 9 below, this Consent Agreement shall automatically renew for subsequent one year periods.

9. This Consent Agreement may be terminated as follows:

   A. Upon mutual written consent of Life and Disability Controlled Affiliate and Blue Plan;

   B. By Blue Plan or Life and Disability Controlled Affiliate upon 60 days advance written notice to the non-terminating party and BCBSA; or

   C. By Blue Plan immediately if Life and Disability Controlled Affiliate does not comply with this Consent Agreement or the sales protocol agreement.

10. This Consent Agreement shall automatically terminate if Blue Plan's primary licensee agreement terminates for any reason or if the Life and Disability License Agreement terminates for any reason.

Agreed and Accepted by:

[Blue Plan]:

By:_____

Title:_____

BLUE CROSS AND BLUE SHIELD ASSOCIATION:

By:_____

Title:_____

LIFE AND DISABILITY CONTROLLED AFFILIATE:

By:_____

Title:_____

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Exhibit 1B

BLUE CROSS
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS
(Adopted by Member Plans at their September 27, 2018 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ (“Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services (“CMS”) to offer Medicare Advantage PPO products in geographic regions designated by CMS (hereafter “regional MAPPO products”).

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name") to offer regional MAPPO products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. <u>GRANT OF LICENSE</u>

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional MAPPO products and related services.

This grant of rights is non-exclusive and is limited to the following states: _____ (the “Region”). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

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In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional MAPPO products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this

Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or
(4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled
Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

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(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x)(ii) of the Blue Cross License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and

any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would
result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last

known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with
0.5 or multiples thereof being rounded to the next higher whole number) fail to cast
weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By:_____

Date:_____

Controlling Plan:

By: _____

Date:_____

Controlling Plan:

By: _____

Date:_____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____

Date:_____

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EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS
September 2018

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Advantage PPO Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

(b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) exercise control over the policy and operations of the Controlled Affiliate; and

EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

a. the structure of the Blue Cross and Blue Shield System; and
b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Cross Marks.

Standard 7 - Participation in Certain National Programs

A Controlled Affiliate shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area.

National program requirements include:

a. Inter-Plan Teleprocessing System (ITS); and

b. Inter-Plan Medicare Advantage Program.

Standard 8 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of November 15, 2007

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EXHIBIT B

**ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS**

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional MAPPO products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

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Exhibit 1C

BLUE CROSS
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS
(Adopted by Member Plans at their September 27, 2018 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Part D Prescription Drug Plan products in geographic regions designated by CMS (hereafter "regional PDP products)."

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name") to offer regional PDP products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. <u>GRANT OF LICENSE</u>

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional PDP products and related services.

This grant of rights is non-exclusive and is limited to the following states: _____ (the "Region"). Controlled Affiliate may use the Licensed

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Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing Body having not less than 100% voting control thereof;

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii)change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. <u>SERVICE MARK USE</u>

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional PDP products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely

as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or
(4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that

the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its

dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x)(ii) of the Blue Cross

License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths

of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the

termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with
0.5 or multiples thereof being rounded to the next higher whole number) fail to cast
weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By:_____

Date:_____

Controlling Plan:

By: _____

Date:_____

Controlling Plan:

By: _____

Date:_____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____

Date:_____

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EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS
APPLICABLE TO REGIONAL MEDICARE
PART D PRESCRIPTION DRUG PLAN PRODUCTS
September 2018

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Part D Prescription Drug Plan Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

(b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) exercise control over the policy and operations of the Controlled Affiliate; and

EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

a. the structure of the Blue Cross and Blue Shield System; and
b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Cross Marks.

Standard 7 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

EXHIBIT B

**ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS**

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional PDP products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

EXHIBIT 2

Membership Standards
Page 1 of 5

Preamble

The Membership Standards apply to all organizations seeking to become or to continue as Regular Members of the Blue Cross and Blue Shield Association. Any organization seeking to become a Regular Member must be found to be in substantial compliance with all Membership Standards at the time membership is granted and the organization must be found to be in substantial compliance with all Membership Standards for a period of two (2) years preceding the date of its application. If Membership is sought by an entity which controls or is controlled by one or more Plans, such compliance shall be determined on the basis of compliance by such Plan or Plans.

The Regular Member Plans shall have authority to interpret these Standards.

A Regular Member Plan that operates as a “Shell Holding Company” is defined as an entity that assumes no underwriting risk and has less than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) and less than 5% of the consolidated enterprise net general and administrative expenses.

A Regular Member Plan that operates as a “Hybrid Holding Company” is defined as an entity that assumes no underwriting risk and has either more than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) or more than 5% of the consolidated enterprise net general and administrative expenses.

Standard 1: A Plan shall maintain a governing Board, which shall control the Plan and ensure that the Plan follows appropriate practices of corporate governance. A Plan's Board shall not be controlled by any special interest group, shall make an annual determination that a majority of its directors are independent, and shall act in the best interest of its Corporation and its customers. The Board shall be composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Amended as of March 15, 2007

EXHIBIT 2

Membership Standards
Page 2 of 5

Standard 2: A Plan shall furnish to the Association on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between the Association and the Plans. Such reports and records are the following:

A. BCBSA Membership Information Request;

B. Triennial trade name and service mark usage material, including disclosure material under Standard 7;

C. Changes in the governance of the Plan, including changes in a Plan's Charter, Articles of Incorporation, or Bylaws, changes in a Plan's Board composition, or changes in the identity of the Plan's Principal Officers;

D. Quarterly Financial Report, Semi-annual “Health Risk-Based Capital (HRBC) Report” as defined by the NAIC, Annual Budget, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), Plan, Subsidiary and Affiliate Report; and

* Plans that are a Shell Holding Company as defined in the Preamble hereto are required to furnish only a calendar year-end “Health Risk-Based Capital (HRBC) Report” as defined by the NAIC.

Amended as of November 17, 2011

EXHIBIT 2

Membership Standards
Page 3 of 5

E. Quarterly Enrollment Report, Quarterly Member Touchpoint Measures Index (MTM) through 12/31/2011, and Semi-annual MTM Index starting 1/1/2012 and thereafter.

* For purposes of MTM reporting only, a Plan shall file a separate MTM report for each Geographic Market.

Standard 3: A Plan shall be operated in a manner that provides reasonable financial assurance that it can fulfill its contractual obligations to its customers.

Standard 4: A Plan shall be operated in a manner responsive to customer needs and requirements.

Standard 5: A Plan shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the Plans and ease of claims processing for customers receiving benefits outside of the Plan's Service Area.

Such programs are applicable to Blue Cross and Blue Shield Plans, and include:

A. Inter-Plan Teleprocessing System (ITS);
B. BlueCard Program;
C. National Account Programs;
D. Business Associate Agreement for Blue Cross and Blue Shield Licensees, effective April 14, 2003; and
E. Inter-Plan Medicare Advantage Program.

Amended as of November 21, 2014

EXHIBIT 2

Membership Standards
Page 4 of 5

Standard 6:	In addition to requirements under the national programs listed in Standard 5: Participation in National Programs, a Plan shall take such action as required to ensure its financial performance in programs and contracts of an inter-Plan nature or where the Association is a party.
Standard 7:	A Plan shall make adequate disclosure in contracting with third parties and in disseminating public statements of (i) the structure of the Blue Cross and Blue Shield System, (ii) the independent nature of every Plan, and (iii) the Plan's financial condition.
Standard 8:	A Plan shall cooperate with the Association's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Plan Performance Response Process and in addressing Plan performance problems identified thereunder.
Standard 9:	A Plan shall obtain a rating of its financial strength from an independent rating agency approved by the Association's Board of Directors for such purpose.
Standard 10:	Notwithstanding any other provision in this License Agreement, during each year, a Plan and its Controlled Affiliate(s) engaged in providing licensable services (excluding Life Insurance and Charitable Foundation Services) shall use their best efforts to promote and build the value of the Blue Cross Marks.
Standard 11:	Neither a Plan nor any Larger Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Plan or Larger Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Amended as of June 16, 2005

EXHIBIT 2

Membership Standards
Page 5 of 5

Standard 12: No provider network, or portion thereof, shall be rented or otherwise made available to a National Competitor if the Licensed Marks or Names are used in any way with such network.

A provider network may be rented or otherwise made available, provided there is no use of the Licensed Marks or Names with respect to the network being rented.

Standard 13: Each Plan shall operate in a manner to reasonably: 1) protect the security and confidentiality of Personally Identifiable Information (PII) and Protected Health Information (PHI); 2) protect the Brands from reputational damage; and 3) cooperate with BCBSA and other Plans if a data security incident or data breach occurs.

Amended as of June 18, 2015

EXHIBIT 3

**GUIDELINES WITH RESPECT TO USE OF
LICENSED NAME AND MARKS IN CONNECTION WITH NATIONAL ACCOUNTS**

Page 1 of 3

1. The strength of the Blue Cross/Blue Cross National Accounts mechanism, and the continued provision of cost effective, quality health care benefits to National Accounts, are predicated on locally managed provider networks coordinated on a national scale in a manner consistent with effective service to National Account customers and consistent with the preservation of the integrity of the Blue Cross/Blue Shield system and the Licensed Marks. These guidelines shall be interpreted in keeping with such ends.

2. A National Account is an entity with employee and/or retiree locations in more than one Plan's Service Area. Unless otherwise agreed, a National Account is deemed located in the Service Area in which the corporate headquarters of the National Account is located. A local plant, office or division headquarters of an entity may be deemed a separate National Account when that local plant, office or division headquarters 1) has employee locations in more than one Service Area, and 2) has independent health benefit decision-making authority for the employees working at such local plant, office or division headquarters and for employees working at other locations outside the Service Area. In such a case, the local plant, office or division headquarters is a National Account that is deemed located in the Service Area in which such local plant, office or division headquarters is located. The Control Plan of a National Account is the Plan in whose Service Area the National Account is located. A participating ("Par") Plan is a Plan in whose Service Area the National Account has employee and/or retiree locations, but in which the National Account is not located. In the event that a National Account parent company consolidates health benefit-decision making for itself and its wholly-owned subsidiary companies, the parent company and the subsidiary companies shall be considered one National Account. The Control Plan for such a National Account shall be the Plan in whose Service Area the parent company headquarters is located.

3. The National Account Guidelines enunciated herein below shall be applicable only with respect to the business of new National Accounts acquired after January 1, 1991.

4. Control Plans shall utilize National Account identification cards complying with then currently effective BCBSA graphic standards in connection with all National Accounts business to facilitate administration thereof, to minimize subscriber and provider confusion, and to reflect a commitment to cooperation among Plans.

Amended as of June 12, 2003

EXHIBIT 3

Page 2 of 3

5. Disputes among Plans and/or BCBSA as to the interpretation or implementation of these Guidelines or as to other National Accounts issues shall be submitted to mediation and mandatory dispute resolution as provided in the License Agreement. For two years from the effective date of the License Agreement, however, such disputes shall be subject to mediation only, with the results of such mediation to be collected and reported in order to establish more definitive operating parameters for National Accounts business and to serve as ground rules for future binding dispute resolution.

6. The Control Plan may use the BlueCard Program (as defined by IPPC) to deliver benefits to employees and non-Medicare eligible retirees in a Participating Plan's service area if an alternative arrangement with the Participating Plan cannot be negotiated. The Participating Plan's minimum servicing requirement for those employees and non-Medicare retirees in its service area is to deliver benefits using the BlueCard Program. Account delivery is subject to the policies, provisions and procedures of the BlueCard Program.

7. For provider payments in a Participating Plan's area (on non-BlueCard claims), payment to the provider may be made by the Participating Plan or the Control Plan at the Participating Plan's option. If the Participating Plan elects to pay the provider, it may not withhold payment of a claim verified by the Control Plan or its designated processor, and payment must be in conformity with service criteria established by the Board of Directors of BCBSA (or an authorized committee thereof) to assure prompt payment, good service and minimum confusion with providers and subscribers. The Control Plan, at the Participating Plan's request, will also assure that measures are taken to protect the confidentiality of the data pertaining to provider reimbursement levels and profiles.

Amended as of June 14, 1996

EXHIBIT 3

Page 3 of 3

8. The Control Plan, in its financial agreements with a National Account, is expected to reasonably reflect the aggregate amount of differentials passed along to the Control Plan by all Participating Plans in a National Account.

9. Other than in contracting with health care providers or soliciting such contracts in areas contiguous to a Plan's Service Area in order to serve its subscribers or those of its licensed Controlled Affiliate residing or working in its Service Area, a Control Plan may not use the Licensed Marks and/or Name, as a tag line or otherwise, to negotiate directly with providers outside its Service Area.

Amended as of March 13, 2003

EXHIBIT 4

GOVERNMENT PROGRAMS AND CERTAIN OTHER USES

1. A Plan and its licensed Controlled Affiliate may use the Licensed Marks and Name in bidding on and executing a contract to serve a Government Program, and in thereafter communicating with the Government concerning the Program. With respect, however, to such contracts entered into after the 1st day of January, 1991, the Licensed Marks and Name will not be used in communications or transactions with beneficiaries or providers in the Government Program located outside a Plan's Service Area, unless the Plan can demonstrate to the satisfaction of BCBSA's governing body that such a restriction on use of the Licensed Marks and Name will jeopardize its ability to procure the contract for the Government Program. As to both existing and future contracts for Government Programs, Plans will discontinue use of the Licensed Marks and Name as to beneficiaries and Providers outside their Service Area as expeditiously as circumstances reasonably permit. Effective January 1, 1995, except as provided in the first sentence above, all use by a Plan of the Licensed Marks and Name in Government Programs outside of the Plan's Service Area shall be discontinued. Incidental communications outside a Plan's Service Area with resident or former resident beneficiaries of the Plan, and other categories of necessary incidental communications approved by BCBSA, are not prohibited. For purposes of this Paragraph 1, the term “Government Programs” shall mean Medicare Part A, Medicare Part B and other non-risk government programs.

2. In connection with activity otherwise in furtherance of the License Agreement, a Plan and its Controlled Affiliates that are licensed to use the Licensed Marks and Name in its Service Area pursuant to the Controlled Affiliate License Agreements authorized in clauses a) through c) of Paragraph 2 of the Plan’s License Agreement with BCBSA may use the Licensed Marks and Name outside the Plan’s Service Area in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

2.1 Common Business Communications

a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);

b. distributing business cards other than in marketing and selling;

c. advertising in publications or electronic media solely to persons for employment;

Amended as of June 19, 2014

EXHIBIT 4

2.2 Marketing Spillover

a. advertising in print, electronic or other media which serve, as a substantial market, the Service Area of the Plan or licensed Controlled Affiliate, provided that no Plan or Controlled Affiliate may advertise outside its Service Area on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Service Area;

b. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Plan's Service Area or that of a licensed Controlled Affiliate;

2.3 Provider Contracting

a. contracting with health care providers or soliciting such contracts in areas contiguous to the Plan's Service Area in order to serve its subscribers or those of such licensed Controlled Affiliates residing or working in its service area;

b. issuing a small sign containing the legal name or trade name of the Plan or such licensed Controlled Affiliates for display by a provider to identify the latter as a participating provider of the Plan or Controlled Affiliate;

c. negotiating rates with a health care provider for services to a specific member, provided that all of the following conditions are met:

(1) the health care provider does not have a contract, applicable to the services rendered or to be rendered, with the Licensee (or any of the Licensees in the case of overlapping Service Areas) in whose Service Area the health care provider is located; and

(2) the Plan or Controlled Affiliate reasonably determines that the member did/does not have a reasonable opportunity to access a participating provider whose contract applies to the services rendered or to be rendered; and

(3) at least one of the following circumstances exists:

Amended as of June 19, 2014

EXHIBIT 4

(i) the member received emergency services and the Plan or Controlled Affiliate knows or reasonably anticipates that the charges on the claim will meet or exceed $5,000; or

(ii) a provider, in consultation pre- or post- treatment with the Plan or Controlled Affiliate, makes/made a treatment recommendation or referral to a non-par provider or to a par provider whose contract does not apply to the services to be rendered; or

(iii) the member inadvertently accessed a non-par provider or non-contracted services in the course of receiving services from a par provider (e.g., the member sees a non-par consulting specialist in a participating hospital); and

(4) the Licensee (and in the case of overlapping Service Areas, all of the Licensees) in whose Service Area the health care provider is located consent(s) in advance.

d. contracting with a pharmacy management organization ("Pharmacy Intermediary") to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;

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e. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided that (1) the Plan and the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Plan's Service Area, and (2) neither the Plan's or the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Plan's Service Area;

f. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;

g. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;

h. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Plan's Service Area;

i. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Plan's Service Area;

j. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Plan's Service Area;

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k. contracting with a company that operates provider sites in the Plan's Service Area, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Plan's Service Area;

l. contracting with a company that makes health care professionals available in the Plan's Service Area (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Plan's Service Area.

2.4 Services to National Accounts

a. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee (as those terms are defined in the Inter-Plan Programs Policies and Provisions ("IP Policies")) to offer Blue-branded Health Coverage to the National Account, offering Blue-branded Health and Wellness Programs to all members of the National Account, including members who have not enrolled in the Blue-branded Health Coverage ("non-Blue Health Coverage members"), provided that:

(i) the Plan and/or licensed Controlled Affiliate has no contact or interaction with providers outside of the Plan's Service Area, except as specifically provided in the IP Policies and in 2.4 (b); and

(ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Brands a local plant, office or division of the account that is outside of the Plan's Service Area, the Plan and/or licensed Controlled Affiliate may not offer Blue-branded Health and Wellness Programs to any employees working at such local plant, office or division without the consent of such other Licensee; and

(iii) if the Plan and/or licensed Controlled Affiliate provides an information card to the non-Blue Health Coverage members, the card may not display the Symbols in the masthead, must contain a prominent disclosure conveying that it is not a health insurance card, and otherwise must be designed so that it is dissimilar to a Blue member identification card.

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2.4 Services to National Accounts (continued)

For purposes of this subparagraph a, the following definitions apply:

"Health and Wellness Program" shall mean a program that includes at least one of the following elements or a related element:

- Health Risk Assessment and/or Preventive Screenings
- Exercise and Fitness Programs
- Health and Wellness Events (e.g., attendance at a health fair, a 5K walk)
- Nutrition and Weight Management
- Health Education (e.g., smoking cessation classes)
- Prenatal and Parenting Education
- Disease or Chronic Condition Management

The above listing is intended to represent examples of the types of programs that may be offered, and other programs, including those offered through different media such as the internet or telephonically, may also be deemed Health and Wellness programs.

"Health Coverage" shall mean providing or administering medical, surgical, hospital, major medical, or catastrophic coverage, or any HMO, PPO, POS or other managed care plan for the foregoing services.

b. as part of a Health and Wellness Program that is otherwise compliant with Brand Regulation 4.11.4(a), contracting with a health and wellness organization to gain access to providers to deliver a discrete health and wellness event ("Event") held at a National Account's worksite outside of the Licensee's Service Area, provided that:

(i) the services delivered at the Event are limited to fingerstick screenings for cholesterol and glucose, seasonal flu immunizations, blood pressure measurements, body mass index measurements, and other routine screenings, immunizations and measurements; and

(ii) neither such services nor their costs are applied as claims against any benefit plan; and

(iii) the Event is presented during one or more limited periods during a benefit year and is available to all employees at the worksite. **Amended as of June 19, 2014**

EXHIBIT 4

c. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee to offer Blue-branded Health Coverage to the National Account, performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by the National Account to its members, including benefit plans that are not underwritten or administered by the Plan, provided that:

(i) in performing such functions, the Plan and/or licensed Controlled Affiliate does not use the Brands in any communications with health care providers outside of the Plan's Service Area, and otherwise limits its use of the Brands outside of the Service Area to communications with the account's members, the other benefit plan providers with which the account has contracted and other reasonably necessary communications to perform such functions; and

(ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Brands a local plant, office or division of the account that is outside of the Plan's Service Area, the Plan and/or licensed Controlled Affiliate may not perform Eligibility and Enrollment functions for employees working at such local plant, office or division without the consent of such other Licensee;

d. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee to perform or investigate fraud, waste and abuse investigation activities for a non-participating provider in a Par/Host Plan's service area, as long as the Control/Home Plan is given permission to do so by the Par/Host Plan and specific conditions are met in accordance with Inter-Plan Programs and Inter-Plan Medicare Advantage Program policies.

For purposes of this subparagraph b, the following definitions apply:

"Health Coverage" has the meaning set forth in subparagraph 2.4.a.

Amended September 27, 2018

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"Eligibility" means services that manage the account's eligibility data and determine or process determinations relating to eligibility for benefit plans offered by the account to its employees, including such services as:

- monitoring and auditing data to ensure that only entitled individuals are enrolled in each such benefit plan;
- review of eligibility documentation (e.g. marriage licenses, birth certificates, student status verification letters, employment records);
- identification of key member segments such as over-age dependents, part-time employees, employees reaching certain milestones (e.g. Medicare-eligible, retirees);
- termination of coverage for those individuals found to be ineligible for coverage under a benefit plan, and, if applicable, generation of a COBRA event; and
- management of "hour-banking" for union environments in which union members can bank hours to remain eligible for benefits.

"Enrollment" means services that enroll eligible individuals and their spouses/dependents or terminate or change their enrollment in the account's benefit plans on an ongoing basis and during open enrollment periods, including such services as:

- the coordination of each step in open enrollment process from project planning and system set-up to the generation of confirmation statements;
- ongoing enrollment support for new hires and changes due to life events and work status adjustments;
- evidence of insurability (EOI) administration for life and disability coverage;
- transmission of eligibility/enrollment information to the account's benefit plan providers;
- review and reconciliation of error reports received from the account's benefit plan providers; and
- transmission of information to the account's payroll system (e.g., benefit deductions, employee demographic data).

Amended as of November 18, 2010

EXHIBIT 4

2.5 Knowledge Sharing

a. submitting scholarly articles authored or co-authored by the Plan or Controlled Affiliate or its respective employees for publication in peer-reviewed journals;

b. permitting an internal representative of the Licensee (e.g., officer, employee) to speak or present at a conference or symposium outside of the Licensee's Service Area regarding either (i) healthcare financing, administration, delivery or policy, or (ii) topics within the representative's functional discipline or expertise at the Licensee, for which the event sponsor will issue communications to promote, administer, and/or recap the event that will identify the Licensee's representative as a participant. The communications outside of the Licensee's Service Area that mention the Licensee's representative shall be limited to materials and digital media provided to attendees, on-site signage, advertising in relevant trade publications, direct mail and email to attendees and prospective attendees, and the sponsor's website. Participation in any conference or symposium outside of the Licensee's Service Area may not be for the purpose of marketing or selling products or services.

If the Licensee's representative wishes to use the Brands in any manner, including use in his/her title, when participating as a speaker or presenter outside of the Licensee's Service Area about a topic that is not related to healthcare financing, administration, delivery, or policy, or to topics within the representative's functional discipline or expertise at the Licensee, the Licensee must notify BCBSA and receive prior approval from BCBSA before participating;

Amended as of March 26, 2015

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2.6 Other Uses

a. entering into a license agreement between and among BCBSA, the Plan and a debit card issuer located outside the Plan's Service Area, and entering into a corresponding operating agreement or agreements, in order to offer a debit card bearing the Licensed Marks and Name to eligible persons as defined by the aforementioned license agreement;

b. appearing in communications issued by an independent third party to recognize outstanding performance of the Plan or Controlled Affiliate or a member of the Plan's or Controlled Affiliate's senior management as part of an established program of the third party for which the Plan has provided information to be considered for the recognition, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;

c. to identify itself as being a joint sponsor of an event, program or activity along with other Plans or such Plans' licensed Controlled Affiliates, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;

d. hosting meetings or events (collectively, "events") in Washington, D.C. related to policy and business issues in the Licensee's Service Area, or hosting events in conjunction with the assemblies or conventions of national political parties. Such events may not involve marketing or selling products or services. Use of the Brands outside the Licensee's Service Area in connection with such events shall be limited to materials and digital media provided to attendees and prospective attendees and onsite signage. For any such events in Washington, D.C. that are open to attendees other than government officials or their staffs, or are briefings open to all Congressional staff, or are otherwise likely to receive media coverage, the Licensee is required to provide advance notice to BCBSA. For events hosted outside of Washington, D.C. in conjunction with the assemblies or conventions of national political parties, the Licensee is required to provide advance notice to BCBSA and to the local Plan;

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e. permitting an affiliate that is not licensed to use the Licensed Marks to identify its corporate relationship with the Plan, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time.

3. In connection with activity otherwise in furtherance of the License Agreement, a Controlled Affiliate that is licensed to use the Licensed Marks and Name pursuant to a Controlled Affiliate License Agreement authorized in clauses d) or e) of Paragraph 2 of the Plan's License Agreement with BCBSA may use the Licensed Marks and Name outside the Region (as that term is defined in such respective Controlled Affiliate License Agreements) in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);

b. distributing business cards other than in marketing and selling;

c. contracting with health care providers or soliciting such contracts in areas contiguous to the Region in order to serve its subscribers residing in the Region, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans in connection with such contracting unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;

d. issuing a small sign containing the legal name or trade name of the Controlled Affiliate for display by a provider to identify the latter as a participating provider of the Controlled Affiliate, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans on such signs unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;

e. advertising in publications or electronic media solely to persons for employment;

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f. advertising in print, electronic or other media which serve, as a substantial market, the Region, provided that the Controlled Affiliate may not advertise outside its Region on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Region, and provided further that any such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to advertise in such media;

g. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Region, provided that such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to send direct mail to such zip code plus 4.

h. [Intentionally left blank, pending review by the Inter-Plan Programs Committee of the applicability of the case management rule to such Controlled Affiliates.]

i. contracting with a pharmacy management organization (“Pharmacy Intermediary”) to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for the Controlled Affiliate’s regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective Controlled Affiliate License Agreements, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;

j. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit to the Controlled Affiliate’s regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective

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Controlled Affiliate License Agreements, provided that (1) the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Region, and (2) neither the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Region;

k. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for the Controlled Affiliate's regional Medicare Advantage PPO members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;

l. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for the Controlled Affiliate's regional Medicare Advantage members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;

m. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Controlled Affiliate's Region;

n. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Controlled Affiliate's Region;

o. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Region;

p. contracting with a company that operates provider sites in the Region, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Region;

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q. contracting with a company that makes health care professionals available in the Region (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Region.

4. BCBSA shall retain the right to use the Licensed Marks in conjunction with the Federal Employee Program and with any other national offering made to federal employees pursuant to the Federal Employees Health Benefits Program (FEHBP), including the right to license such use to its vendors, but only in the following manner.

   a. the Licensed Marks may only be used by BCBSA with the term “Federal Employee Program”, “Federal”, “FEP”, or similar language identifying the program as a benefit program for federal employees;

   b. the Licensed Marks may not be used by BCBSA with the name(s) of a specific Plan or Plans and;

   c. any use by BCBSA in conjunction with a new national FEHBP program proposed after the enactment of this amendment will require the approval of the BCBSA Board of Directors.

5. Where required by applicable state or local law or regulation, a Plan or its licensed Controlled Affiliate may submit documents that contain the Brands to, and file forms that contain the Brands with, state or local regulators in a state not included in its Service Area, provided that it gives reasonable advance notice to the local Plan of its intent to submit such documents or file such forms. Notwithstanding, in no event may a Plan or its licensed Controlled Affiliate use the Brands to register, or to obtain or maintain a license, a certificate of authority, or an equivalent document authorizing it to act as a risk-bearing entity or third party administrator in a state not included in its Service Area. If the local Plan advises BCBSA that it believes its License Agreement has been or would be violated by any submission or filing, BCBSA shall determine whether such submission or filing is required by state or local law or regulation and violates the License Agreement, subject to the Plan’s or licensed Controlled Affiliate’s rights to obtain an independent review of such determination under Paragraph 9(a) and Exhibit 5 of its License Agreement or Paragraph 8 of the Controlled Affiliate License. For purposes of this paragraph, “local Plan” is defined as each Plan whose Service Area includes all or part of the state in which the foregoing applicable state or local law or regulation has been enacted.

Amended as of March 26, 2015

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MEDIATION AND MANDATORY DISPUTE RESOLUTION (MMDR) RULES

The Blue Cross and Blue Shield Plans ("Plans") and the Blue Cross Blue Shield Association ("BCBSA") recognize and acknowledge that the Blue Cross and Blue Shield system is a unique nonprofit and for-profit system offering cost effective health care financing and services. The Plans and BCBSA desire to utilize Mediation and Mandatory Dispute Resolution ("MMDR") to avoid expensive and time-consuming litigation that may otherwise occur in the federal and state judicial systems. Even MMDR should be viewed, however, as methods of last resort, all other procedures for dispute resolution having failed. Except as otherwise provided in the License Agreements, the Plans, their Controlled Affiliates and BCBSA agree to submit all disputes to MMDR pursuant to these Rules and in lieu of litigation.

1. Initiation of Proceedings

A. Pre-MMDR Efforts

Before filing a Complaint to invoke the MMDR process, the CEO of a complaining party, or his/her designated representative, shall undertake good faith efforts with the other side(s) to try to resolve any dispute.

B. Complaint

To commence a proceeding, the complaining party (or parties) shall provide by certified mail, return receipt requested, a written Complaint to the BCBSA Corporate Secretary (which shall also constitute service on BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) named therein. The Complaint shall contain:

i. identification of the complaining party (or parties) requesting the proceeding;

ii. identification of the respondent(s);

iii. identification of any other persons or entities who are interested in a resolution of the dispute;

iv. a full statement describing the nature of the dispute;

v. identification of all of the issues that are being submitted for resolution;

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vi. the remedy sought;

vii. a statement as to whether the complaining party (or parties) elect(s) first to pursue Mediation;

viii. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor; and

ix. a statement signed by the CEO of the complaining party affirming that the CEO has undertaken efforts, or has directed efforts to be undertaken, to resolve the dispute before resorting to the MMDR process.

The complaining party (or parties) shall file and serve with the Complaint copies of all documents which the party (or parties) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

C. Answer

Within twenty (20) days after receipt of the Complaint, each respondent shall serve on BCBSA and on the complaining party (or parties);

i. a full Answer to the aforesaid Complaint;

ii. a statement of any Counterclaims against the complaining party (or parties), providing with respect thereto the information specified in Paragraph 1.B., above;

iii. a statement as to whether the respondent elects to first pursue Mediation; and

iv. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor.

The respondent(s) shall file and serve with the Answer or by the date of the Initial Conference set forth in Paragraph 3.C., below, copies of all documents which the respondent(s) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

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D. Reply To Counterclaim

Within ten (10) days after receipt of any Counterclaim, the complaining party (or parties) shall serve on BCBSA and on the responding party (or parties), a Reply to the Counterclaim. Such Reply must provide the same information required by Paragraph 1.C., above.

2. Mediation

To facilitate the mediation of disputes between or among BCBSA, the Plans and/or their Controlled Affiliates, the BCBSA Board has provided for Mediation under these Rules. Mediation may be pursued in lieu of or in an effort to obviate the Mandatory Dispute Resolution process, and all parties are strongly urged, but not required, to exhaust the mediation procedure provided for herein. In the event any party refuses to proceed with Mediation, the parties shall proceed immediately to Mandatory Dispute Resolution, as provided in Section 3.

A. Selection of Mediators

If all parties agree to pursue Mediation, they shall promptly attempt to agree upon: (i) the number of mediators desired, not to exceed three mediators; and (ii) the selection of experienced mediator(s) from an independent entity to mediate all disputes set forth in the Complaint and Answer (and Counterclaim and Reply, if any). In the event the parties are unable to agree upon the selection or number of mediators, both within five (5) days of the service of the Answer or Reply to Counterclaim, whichever is later, the BCBSA Corporate Secretary shall immediately refer the matter to a nationally recognized professional ADR organization (such as CPR or JAMS) for mediation by a single mediator to be selected by the ADR organization.

B. Binding Decision

Before the Mediation Hearing described below, the BCBSA Corporate Secretary shall contact the parties to determine whether they wish to be bound by any recommendation of the selected mediator(s) for resolution of the disputes. If all wish to be bound, the Corporate Secretary will send appropriate documentation to them for their signatures before the Mediation Hearing begins.

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C. Mediation Procedure

The Mediator(s) shall apply the mediation procedures and processes provided for herein (not the rules of the ADR organization with which they are affiliated) and shall promptly advise the parties of a scheduled Mediation Hearing date. Unless a party requests an expedited procedure, or unless all parties to the proceeding agree to one or more extensions of time, the Mediation Hearing set forth below shall be completed within forty (40) days of BCBSA's receipt of the Complaint. The selected mediator(s), unless the parties otherwise agree, shall adhere to the following procedure:

i. Each party must be represented by its CEO or other representative who has been delegated full authority to resolve the dispute. However, parties may send additional representatives as they see fit.

ii. Each party will be given one-half hour to present its case, beginning with the complaining party (or parties), followed by the other party or parties. The parties are free to structure their presentations as they see fit, using oral statements or direct examination of witnesses. However, neither cross-examination nor questioning of opposing representatives will be permitted. At the close of each presentation, the selected mediator(s) will be given an opportunity to ask questions of the presenters and witnesses. All parties must be present throughout the Mediation Hearing. The selected mediator(s) may extend the time allowed for each party's presentation at the Mediation Hearing. The selected mediator(s) may meet in executive session, outside the presence of the parties, or may meet with the parties separately, to discuss the controversy.

iii. After the close of the presentations, the parties will attempt to negotiate a settlement of the dispute. If the parties desire, the selected mediator(s), or any one or more of the selected mediators, will sit in on the negotiations.

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iv. After the close of the presentations, the selected mediator(s) may meet privately to agree upon a recommendation for resolution of the dispute which would be submitted to the parties for their consideration and approval. If the parties have previously agreed to be bound by the results of this procedure, this recommendation shall be binding upon the parties.

v. The purpose of the Mediation Hearing is to assist the parties to settle their grievances short of mandatory dispute resolution. As a result, the Mediation Hearing has been designed to be as informal as possible. Rules of evidence shall not apply. There will be no transcript of the proceedings, and no party may make a tape recording of the Mediation Hearing.

vi. In order to facilitate a free and open discussion, the Mediation proceeding shall remain confidential. A "Stipulation to Confidentiality" which prohibits future use of settlement offers, all position papers or other statements furnished to the selected mediator(s), and decisions or recommendations in any Mediation proceeding shall be executed by each party.

vii. Upon request of the selected mediator(s), or one of the parties, BCBSA staff may also submit documentation at any time during the proceedings.

D. Notice of Termination of Mediation

If the Mediation cannot be completed within the prescribed or agreed time period due to the lack of cooperation of any party, as determined by the selected mediator(s), or if the Mediation does not result in a final resolution of all disputes at the Mediation Hearing or within ten (10) days after the Mediation Hearing, any party or any one of the selected mediators shall so notify the BCBSA Corporate Secretary, who shall promptly issue a Notice of Termination of Mediation to all parties, to the selected mediator(s), and to the MDR Administrator. Such notice shall serve to bring the Mediation to an end and to initiate Mandatory Dispute Resolution. Upon agreement of all parties and the mediator(s), the Mediation process may continue at the same time the MDR process is invoked. In such case, the Notice of Termination of Mediation described above serves to initiate the MDR proceeding, but does not terminate mediation proceedings, which may proceed simultaneous with the MDR proceeding.

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3. Mandatory Dispute Resolution (MDR)

If any party elects not to first pursue Mediation, or if a Notice of Termination of Mediation is issued as set forth in Paragraph 2.D., above, then the unresolved disputes set forth in any Complaint and Answer (and Counterclaim and Reply, if any) shall be subject to mandatory binding arbitration (herein referred to as "MDR").

A. MDR Administrator

The Administrator for purposes of Mandatory Arbitration shall be an independent nationally recognized entity such as CPR or JAMS, specializing in alternative dispute resolution. In the event the parties pursued Mediation with CPR, JAMS or a similar organization, that organization also shall serve as the MDR Administrator, unless all parties notify the BCBSA Corporate Secretary in writing within two (2) days of receiving the Notice of Termination of Mediation that they wish to pursue MDR with another nationally recognized organization serving as MDR Administrator.

In the event the parties (i) did not pursue Mediation, (ii) pursued mediation with a Mediator not affiliated with an ADR organization that offers a panel of arbitrators, or (iii) all parties that pursued Mediation notified the BCBSA Corporate Secretary that they wish to have an MDR Administrator that is different from the organization with which their mediator was affiliated, they shall promptly attempt to agree on a nationally recognized ADR entity that supplies a panel of arbitrators. If they reach such agreement within five (5) days of the Notice of Termination of Mediation or receipt of the Answer or Reply to Counterclaim (whichever is later), the parties shall promptly inform the BCBSA Corporate Secretary of their agreed upon ADR organization. In the event the parties are unable to reach agreement on an MDR Administrator within that timeframe, the BCBSA Corporate Secretary shall immediately refer the matter to CPR, JAMS or a similar organization for MDR.

Any person who served as a Mediator shall not serve as an arbitrator for the same or similar dispute for purposes of MDR.

B. Rules for MDR

The rules controlling all aspects of MDR shall be exclusively those provided for herein. The rules promulgated or otherwise used by the MDR Administrator organization shall not apply.

Amended as of September 20, 2007

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C. Initial Conference

Within seven (7) days after a Notice of Termination has issued or the matter has otherwise been referred to an MDR Administrator, or within five (5) days after the time for filing and serving the Answer or Reply to any Counterclaim (whichever is later) if the parties elect first not to mediate, the parties shall confer with the Administrator to discuss selecting a dispute resolution panel ("the Panel"). This conference (the “Initial Conference”) may be by telephone. The parties are encouraged to agree to the composition of the Panel and to present that agreement to the Administrator at the Initial Conference. If the parties do not agree on the composition of the Panel by the time of the Initial Conference, or by any extension thereof agreed to by all parties and the Administrator, then the Panel Selection Process set forth in subparagraph D, below, shall be followed.

D. Panel Selection Process

The Administrator shall designate, prior to the Initial Conference, at least seven potential arbitrators. Each party shall be permitted to strike any designee for cause and the Administrator shall determine the sufficiency thereof in its sole discretion. The Administrator will designate a replacement for any designee so stricken. Each party shall then be permitted one peremptory strike from the list of designees. The Administrator shall set the dates for exercising all strikes, which shall be set to encourage the prompt selection of arbitrators.

After the parties exercise any designee strikes for cause and their peremptory strike against any designee of their choice, the parties shall each rank the remaining panel members in order of preference and provide the Administrator, without serving on any other party, their ranked list. The Administrator shall not disclose any party’s ranked list to members of the panel or to other parties.

From the remaining designees, and after considering opportunities to maximize, so far as possible, the collectively stated arbitrator preferences provided by the parties on their ranked lists, the Administrator shall select a three member Panel. The Panel Selection Process shall be completed no later than ten (10) days after the Initial Conference.

Each Arbitrator shall be compensated at his or her normal hourly rate or, in the absence of an established rate, at a reasonable hourly rate to be promptly fixed by the Administrator for all time spent in connection with the proceedings and shall be reimbursed for any travel and other reasonable expenses.

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E. Duties Of The Arbitrators

The Panel shall promptly designate a Presiding Arbitrator for the purposes reflected below, but shall retain the power to review and modify any ruling or other action of said Presiding Arbitrator. Each Arbitrator shall be an independent Arbitrator, shall be governed by the Code of Ethics for Arbitrators in Commercial Disputes and shall at or prior to the commencement of any Arbitration Hearing take an oath to that effect. Each Arbitrator shall promptly disclose in writing to the Panel and to the parties any circumstances, whenever arising, that might cause doubt as to such Arbitrator's compliance, or ability to comply, with said Code of Ethics, and, absent resignation by such Arbitrator, the remaining Arbitrators shall determine in their sole discretion whether the circumstances so disclosed constitute grounds for disqualification and for replacement. With respect to such circumstances arising or coming to the attention of a party after an Arbitrator's selection, a party may likewise request the Arbitrator's resignation or a determination as to disqualification by the remaining Arbitrators. With respect to a sole Arbitrator, the determination as to disqualification shall be made by the Administrator.

There shall be no ex parte communication between the parties or their counsel and any member of the Panel.

F. Panel's Jurisdiction And Authority

The Panel's jurisdiction and authority shall extend to all disputes between or among the Plans, their Controlled Affiliates, and/or BCBSA, except for those disputes excepted from these MMDR procedures as set forth in the License Agreements.

With the exception of punitive or treble damages, the Panel shall have full authority to award the relief it deems appropriate to resolve the parties' disputes, including monetary awards and injunctions, mandatory or prohibitory. The Panel has no authority to award punitive or treble damages except that the Panel may allocate or assess responsibility for punitive or treble damages assessed by another tribunal. Subject to the above limitations, the Panel may, by way of example, but not of limitation:

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i. interpret or construe the meaning of any terms, phrase or provision in any license between BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.

ii. determine whether BCBSA, a Plan or a Controlled Affiliate has violated the terms or conditions of any license between the BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.

iii. decide challenges as to its own jurisdiction.

iv. issue such orders for interim relief as it deems appropriate pending Hearing and Award in any Arbitration.

It is understood that the Panel is expected to resolve issues based on governing principles of law, preserving to the maximum extent legally possible the continued integrity of the Licensed Marks and the BLUE CROSS/BLUE SHIELD system. The Panel shall apply federal law to all issues which, if asserted in the United States District Court, would give rise to federal question jurisdiction, 28 U.S.C. § 1331. The Panel shall apply Illinois law to all issues involving interpretation, performance or construction of any License Agreement or Controlled Affiliate License Agreement unless the agreement otherwise provides. As to other issues, the Panel shall choose the applicable law based on conflicts of law principles of the State of Illinois.

G. Administrative Conference

Within five (5) days of the Panel being selected, the Presiding Arbitrator shall confer with the parties and the other members of the Panel and shall schedule, in writing, a conference in which the parties and the Panel shall participate (the "Administrative Conference"). The Administrative Conference shall take place no later than fifteen (15) days after the Panel is selected. At the Administrative Conference the parties and the Panel shall discuss the scheduling of the Arbitration Hearing and any other matter appropriate to be considered, including but not limited to: any written discovery in the form of requests for production of documents or requests to admit facts; the identity of any witness whose deposition a party may desire and a showing of exceptional good cause for the taking of any such deposition; the desirability of bifurcation or other separation of the issues; the need for and the type of record of conferences and hearings, including the need for transcripts; the need for expert witnesses and

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how expert testimony should be presented; the appropriateness of motions to dismiss and/or for full or partial summary judgment; consideration of stipulations; the desirability of presenting any direct testimony in writing; and the necessity for any on-site inspection by the Panel. If the parties agree, the Administrative Conference may be by telephone.

H. Discovery

i. ***Requests for Production of Documents***: All requests for the production of documents must be served no later than five (5) days after the date of the Initial Conference. Within twenty (20) days after receipt of a request for production of documents, a party shall (a) serve responses and objections to the request, (b) produce all responsive, non-privileged documents to the requesting party, and (c) to the extent any responsive documents are withheld on the grounds of attorney-client privilege or work product, produce a log identifying such documents in the manner specified in Fed. R. Civ. P. 26(b)(5). If, after reviewing a privilege log, the requesting party believes attorney-client privilege or work product protection was improperly claimed by the producing party with respect to any document, the requesting party may ask the Presiding Arbitrator to conduct an in-camera inspection of the same. With respect to documentary and other discovery produced in any MDR proceeding by BCBSA, the fact that a party's CEO or other senior officers may serve on the BCBSA Board of Directors, BCBSA Board Committees or other BCBSA work groups, task forces and the like, shall not be a basis for defeating an otherwise valid claim of attorney-client privilege or work product protection over such documentary or other discovery materials by BCBSA.

ii. ***Requests for Admissions***: Requests for Admissions may be served up to twenty-one (21) days prior to the discovery cut-off set by the Presiding Arbitrator. A party served with Requests For Admissions must respond within twenty (20) days of receipt of said request. The good faith use of and response to Requests for Admissions is encouraged, and the Panel shall have full discretion, with reference to the Federal Rules of Civil Procedure, in awarding appropriate sanctions with respect to abuse of the procedure.

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iii. ***Depositions****:* As a general rule, the parties will not be permitted to take party or non-party deposition testimony for discovery purposes. The Presiding Arbitrator, in his or her sole discretion, shall have the authority to permit a party to take such deposition testimony upon a showing of exceptional good cause. The parties will be permitted to take de bene esse deposition[1] testimony to the fullest extent permitted by law of any witness who cannot be compelled to testify at the Arbitration Hearing. No deposition, for discovery purposes or otherwise, shall exceed three (3) hours, excluding objections and colloquy of counsel. Depositions may be recorded in any manner recognized by the Federal Rules of Civil Procedure and the parties shall specify in each notice of deposition or request for permission to take deposition testimony the manner in which such deposition shall be recorded.

iv. ***Expert witness(es)***: If a party intends to present the testimony of an expert witness during the oral hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2)
(B) ten (10) days prior to the discovery cut-off set by the Presiding Arbitrator. If a party intends to present the testimony of a rebuttal expert witness during the Arbitration Hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2)(B) within twenty (20) days after the date on which the written statement of the expert witness whose testimony is to be rebutted was produced.

v. ***Discovery cut-off****:* The Presiding Arbitrator shall determine the date on which the discovery period will end, but the discovery period shall not exceed thirty (30) days from the date of the Administrative Conference without the agreement of all parties.

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[1] As used in these Rules, "de bene esse deposition" means a deposition that is not taken for discovery purposes, but is taken for the purpose of reading part or all of the deposition transcript into the record at the Arbitration Hearing, to the extent permitted by the Panel, because the witness cannot be compelled to testify at the Arbitration Hearing or has exercised a right provided under these Rules to provide deposition testimony in lieu of testimony at the Arbitration Hearing.

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vi. ***Additional discovery***: Any additional discovery will be at the discretion of the Presiding Arbitrator.

vii. ***Discovery Disputes****:* Any discovery disputes shall be raised by motion to the Presiding Arbitrator, who is authorized to resolve all such disputes, and whose resolution will be binding on the parties unless modified by the Arbitration Panel. Prior to raising any discovery dispute with the Presiding Arbitrator, the parties shall meet and confer, telephonically or in person, in an attempt to resolve or narrow the dispute. If a party refuses to comply with a decision resolving a discovery dispute, the Panel, in keeping with Fed. R. Civ. P. 37, may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for resolution adversely to that party.

viii. ***Extensions****:* The time for responding to discovery requests may be extended by the Presiding Arbitrator for good and sufficient cause shown. Any request for such an extension shall be made in writing.

I. Panel Suggested Settlement/Mediation

At any point during the proceedings, the Panel at the request of any party or on its own initiative, may suggest that the parties explore settlement and that they do so at or before the conclusion of the Arbitration Hearing, and the Panel shall give such assistance in settlement negotiations as the parties may request and the Panel may deem appropriate. Alternatively, the Panel may direct the parties to endeavor to mediate their disputes as provided above, or to explore a mini-trial proceeding, or to have an independent party render a neutral evaluation of the parties' respective positions. The Panel shall enter such sanctions as it deems appropriate with respect to any party failing to pursue in good faith such Mediation or other alternate dispute resolution methods.

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J. Subpoenas on Third Parties

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq*., and subject to Paragraph 3.G(iii) above, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan or any officer, employee or director of a third party Blue Plan, to compel deposition testimony or the production of documents, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena.

K. Arbitration Hearing

An Arbitration Hearing will be held within thirty (30) days after the Administrative Conference if no discovery is taken, or within thirty (30) days after the close of discovery, unless all parties and the Panel agree to extend the Arbitration Hearing date, or unless the parties agree in writing to waive the Arbitration Hearing. The parties may mutually agree on the location of the Arbitration Hearing. If the parties fail to agree, the Arbitration Hearing shall be held in Chicago, Illinois, or at such other location determined by the Presiding Arbitrator to be most convenient to the participants. The Panel will determine the date(s) and time(s) of the Arbitration Hearing(s) after consultation with all parties and shall provide reasonable notice thereof to all parties or their representatives.

L. Arbitration Hearing Memoranda

Twenty (20) days prior to the Arbitration Hearing, each party shall submit to the other party (or parties) and to the Panel an Arbitration Hearing Memorandum which sets forth the applicable law and any argument as to any relevant issue. The Arbitration Hearing Memorandum will supplement, and not repeat, the allegations, information and documents contained in or with the Complaint, Answer, Counterclaim and Reply, if any. Ten (10) days prior to the Arbitration Hearing, each party shall submit to each other party a list of all expert and fact witnesses (but not including rebuttal fact witness) that such party intends to have testify at the Arbitration Hearing and a brief summary of the testimony each such witness is expected to give. In addition, no later than five (5) days prior to the Arbitration, each party may submit to each other party and to the Panel a Response Arbitration Hearing Memorandum which sets forth any response to another party's Arbitration Hearing Memorandum.

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M. Notice For Testimony

Ten (10) days prior to the Arbitration Hearing, any party may serve a Notice on any other party (or parties) requesting the attendance at the Arbitration Hearing of any officer, employee or director of the other party (or parties) for the purpose of providing noncumulative testimony. If a party fails to produce one of its officers, employees or directors whose noncumulative testimony during the Arbitration Hearing is reasonably requested by an adverse party, the Panel may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for mandatory dispute resolution adversely to that party; provided, however, that a party may refuse to produce a director to testify if, within two (2) days of receiving a notice requesting the attendance of such director at the Arbitration Hearing, the party agrees to make the director available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. This Rule may not be used for the purpose of burdening or harassing any party, and the Presiding Arbitrator may impose such orders as are appropriate so as to prevent or remedy any such burden or harassment.

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq.*, twenty (20) days or more prior to the Arbitration Hearing, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan, BCBSA or any officer, employee or director of a third party Blue Plan or BCBSA for the purpose of providing noncummulative testimony at the Arbitration Hearing, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena; provided however, that a director of a third party Blue Plan or BCBSA may refuse to testify if, within two (2) days of receiving a subpoena requesting the attendance of such director at the Arbitration Hearing, the director agrees to make him/herself available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. Each Blue Plan agrees to waive, on its own behalf and on behalf of its directors and officers, any objection it otherwise might have to any such subpoena based on service, venue or extraterritoriality.

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N. Arbitration Hearing Procedures

i. ***Attendance at Arbitration Hearing***: Any person having a direct interest in the proceeding is entitled to attend the Arbitration Hearing. The Presiding Arbitrator shall otherwise have the power to require the exclusion of any witness, other than a party or other essential person, during the testimony of any other witness. It shall be discretionary with the Presiding Arbitrator to determine the propriety of the attendance of any other person.

i. ***Confidentiality***: The Panel and all parties shall maintain the privacy of the Arbitration Proceeding. The parties and the Panel shall treat the Arbitration Hearing and any discovery or other proceedings or events related thereto, including any award resulting therefrom, as confidential except as otherwise necessary in connection with a judicial challenge to or enforcement of an award or unless otherwise required by law.

i. ***Stenographic Record***: Any party, or if the parties do not object, the Panel, may request that a stenographic or other record be made of any Arbitration Hearing or portion thereof. The costs of the recording and/or of preparing the transcript shall be borne by the requesting party and by any party who receives a copy thereof. If the Panel requests a recording and/or a transcript, the costs thereof shall be borne equally by the parties.

iv. ***Oaths***: The Panel may require witnesses to testify under oath or affirmation administered by any duly qualified person and, if requested by any party, shall do so.

v. ***Order of Arbitration Hearing***: An Arbitration Hearing shall be opened by the recording of the date, time, and place of the Arbitration Hearing, and the presence of the Panel, the parties, and their representatives, if any. The Panel may, at the beginning of the Arbitration Hearing, ask for statements clarifying the issues involved.

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Unless otherwise agreed, the complaining party (or parties) shall then present evidence to support their claim(s). The respondent(s) shall then present evidence supporting their defenses and Counterclaims, if any. The complaining party (or parties) shall then present evidence supporting defenses to the Counterclaims, if any, and rebuttal.

Witnesses for each party shall submit to questions by adverse parties and/or the Panel.

The Panel has the discretion to vary these procedures, but shall afford a full and equal opportunity to all parties for the presentation of any material and relevant evidence.

vi. ***Evidence***: The parties may offer such evidence as is relevant and material to the dispute and shall produce such evidence as the Panel may deem necessary to an understanding and resolution of the dispute. Unless good cause is shown, as determined by the Panel or agreed to by all other parties, no party shall be permitted to offer evidence at the Arbitration Hearing which was not disclosed prior to the Arbitration Hearing by that party. The Panel may receive and consider the evidence of witnesses by affidavit upon such terms as the Panel deems appropriate.

The Panel shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence, other than enforcement of the attorney-client privilege and the work product protection, shall not be necessary. The Federal Rules of Evidence shall be considered by the Panel in conducting the Arbitration Hearing but those rules shall not be controlling. All evidence shall be taken in the presence of the Panel and all of the parties, except where any party is in default or has waived the right to be present.

Settlement offers by any party in connection with Mediation or MDR proceedings, decisions or recommendations of the selected mediators, and a party's position papers or statements furnished to the selected mediators shall not be admissible evidence or considered by the Panel without the consent of all parties.

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vii. ***Closing of Arbitration Hearing***: The Presiding Arbitrator shall specifically inquire of all parties whether they have any further proofs to offer or witnesses to be heard. Upon receiving negative replies or if he or she is satisfied that the record is complete, the Presiding Arbitrator shall declare the Arbitration Hearing closed with an appropriate notation made on the record. Subject to being reopened as provided below, the time within which the Panel is required to make the award shall commence to run, in the absence of contrary agreement by the parties, upon the closing of the Arbitration Hearing.

With respect to complex disputes, the Panel may, in its sole discretion, defer the closing of the Arbitration Hearing for a period of up to thirty (30) days after the presentation of proofs in order to permit the parties to submit post-hearing briefs and argument, as the Panel deems appropriate, prior to making an award.

For good cause, the Arbitration Hearing may be reopened for up to thirty (30) days on the Panel's initiative, or upon application of a party, at any time before the award is made

O. Awards

An Award must be in writing and shall be made promptly by the Panel and, unless otherwise agreed by the parties or specified by law, no later than thirty (30) days from the date of closing the Arbitration Hearing. If all parties so request, the Award shall contain findings of fact and conclusions of law. The Award, and all other rulings and determinations by the Panel, may be by a majority vote.

Parties shall accept as legal delivery of the Award the placing of the Award or a true copy thereof in the mail addressed to a party or its representative at its last known address or personal service of the Award on a party or its representative.

Awards are binding only on the parties to the Arbitration and are not binding on any non-parties to the Arbitration and may not be used or cited as precedent in any other proceeding.

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After the expiration of twenty (20) days from initial delivery, the Award (with corrections, if any) shall be final and binding on the parties, and the parties shall undertake to carry out the Award without delay.

Proceedings to confirm, modify or vacate an Award shall be conducted in conformity with and controlled by the Federal Arbitration Act. 9 U.S.C. § 1, *et seq*.

P. Return of Documents

Within sixty (60) days after the Award and the conclusion of any judicial proceedings with respect thereto, each party and the Panel shall return any documents produced by any other party, including all copies thereof. If a party receives a discovery request in any other proceeding which would require it to produce any documents produced to it by any other party in a proceeding hereunder, it shall not produce such documents without first notifying the producing party and giving said party reasonable time to respond, if appropriate, to the discovery request.

4. Miscellaneous

A. Expedited Procedures

Any party to a Mediation may direct a request for an expedited Mediation Hearing to the Chairman of the Mediation Committee, to the selected Mediators, and to all other parties at any time. The Chairman of the Mediation Committee, or at his or her direction, the then selected Mediators, shall grant any request which is supported by good and sufficient reasons. If such a request is granted, the Mediation shall be completed within as short a period as practicable, as determined by the Chairman of the Mediation Committee or, at his or her direction, the then selected Mediators.

Any party to an Arbitration may direct a request for expedited proceedings to the Administrator, to the Panel, and to all other parties at any time. The Administrator, or the Presiding Arbitrator if the Panel has been selected, shall grant any such request which is supported by good and sufficient reasons. If such a request is granted, the Arbitration shall be completed within as short a time as practicable, as determined by the Administrator and/or the Presiding Arbitrator.

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B. Temporary or Preliminary Injunctive Relief

Any party may seek temporary or preliminary injunctive relief with the filing of a Complaint or at any time thereafter. If such relief is sought prior to the time that an Arbitration Panel has been selected, then the Administrator shall select a single Arbitrator who is a lawyer who has no interest in the subject matter of the dispute, and no connection to any of the parties, to hear and determine the request for temporary or preliminary injunction. If such relief is sought after the time that an Arbitration Panel has been selected, then the Arbitration Panel will hear and determine the request. The request for temporary or preliminary injunctive relief will be determined with reference to the temporary or preliminary injunction standards set forth in Fed. R. Civ. P. 65.

C. Defaults and Proceedings in the Absence of a Party

Whenever a party fails to comply with the MDR Rules in a manner deemed material by the Panel, the Panel shall fix a reasonable time for compliance and, if the party does not comply within said period, the Panel may enter an Order of default or afford such other relief as it deems appropriate. Arbitration may proceed in the event of a default or in the absence of any party who, after due notice, fails to be present or fails to obtain an extension. An Award shall not be made solely on the default or absence of a party, but the Panel shall require the party who is present to submit such evidence as the Panel may require for the making of findings, determinations, conclusions, and Awards.

D. Notice

Each party shall be deemed to have consented that any papers, notices, or process necessary or proper for the initiation or continuation of a proceeding under these rules or for any court action in connection therewith may be served on a party by mail addressed to the party or its representative at its last known address or by personal service, in or outside the state where the MDR proceeding is to be held.

The Corporate Secretary and the parties may also use facsimile transmission, telex, telegram, or other written forms of electronic communication to give the notices required by these rules.

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E. Expenses

The expenses of witnesses shall be paid by the party causing or requesting the appearance of such witnesses. All expenses of the MDR proceeding, including compensation, required travel and other reasonable expenses of the Panel, and the cost of any proof produced at the direct request of the Panel, shall be borne equally by the parties and shall be paid periodically on a timely basis, unless they agree otherwise or unless the Panel in the Award assesses such expenses, or any part thereof against any party (or parties). In exceptional cases, the Panel may award reasonable attorneys' fees as an item of expense, and the Panel shall promptly determine the amount of such fees based on affidavits or such other proofs as the Panel deems sufficient.

F. Disqualification or Disability of A Panel Member

In the event that any Arbitrator of a Panel with more than one Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the remaining Panel member(s):

i. shall designate a replacement, subject to the right of any party to challenge such replacement for cause.

ii. shall decide the extent to which previously held hearings shall be repeated.

If the remaining Panel members consider the proceedings to have progressed to a stage as to make replacement impracticable, the parties may agree, as an alternative to the recommencement of the Mandatory Dispute Resolution process, to resolution of the dispute by the remaining Panel members.

In the event that a single Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the Administrator shall appoint a successor, subject to the right of any party to challenge such successor for cause, and the successor shall decide the extent to which previously held proceedings shall be repeated.

EXHIBIT 5

G. Extensions of Time

Subject to the provisions of Paragraph 3.H.(viii.), any time limit set forth in these Rules may be extended upon agreement of the parties and approval of: (1) the Mediator if the proceeding is then in Mediation; (2) the Administrator if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (3) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected.

H. Intervention

The Plans, their Controlled Affiliates, and BCBSA, to the extent subject to MMDR pursuant to their License Agreements, shall have the right to move to intervene in any pending Arbitration. A written motion for intervention shall be made to: (1) the Administrator, if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (2) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected. The written motion for intervention shall be delivered to the BCBSA Corporate Secretary (which shall also constitute service on the BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) which are parties to the proceeding. Any party to the proceeding can submit written objections to the motion to intervene. The motion for intervention shall be granted upon good cause shown. Intervention also may be allowed by stipulation of the parties to the Arbitration proceeding. Intervention shall be allowed upon such terms as the Arbitration Panel decides.

I. BCBSA Assistance in Resolution of Disputes

The resources and personnel of the BCBSA may be requested by any member Plan at any time to try to resolve disputes with another Plan.

J. Neutral Evaluation

The parties can voluntarily agree at any time to have an independent party render a neutral evaluation of the parties' respective positions.

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K. Recovery of Attorney Fees and Expenses

i. Motions to Compel

Nothwithstanding any other provisions of these Rules, any Party subject to the License Agreements (for purposes of this Section K and all of its sub-sections only hereinafter referred to collectively and individually as a “Party”) that initiates a court action or administrative proceeding solely to compel adherence to these Rules shall not be determined to have violated these Rules by initiating such action or proceeding.

ii Recovery of Fees, Expenses and Costs

The Arbitration Panel may, in its sole discretion, award a Party its reasonable attorneys’ fees, expenses and costs associated with a filing to compel adherence to these Rules and/or reasonable attorneys’ fees, expenses and costs incurred in responding to an action filed in violation of these Rules; provided, however, that neither fees, expenses, nor costs shall be awarded by the Arbitration Panel if the Party from which the award is sought can demonstrate to the Arbitration panel, in its sole discretion, that it did not violate these Rules or that it had reasonable grounds for believing that its action did not violate these Rules.

iii Requests for Reimbursement

For purposes of this Section K, any Party may request reimbursement of fees, expenses and/or costs by submitting said request in writing to the Arbitration Panel at any time before an award is delivered pursuant Paragraph to 3.O above with a copy to the Party from which reimbursement is sought, explaining why it is entitled to such reimbursement. The Party from which reimbursement is sought shall have twenty (20) days to submit a response to such request to the Arbitration Panel with a copy to the Party seeking reimbursement.

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L. Calculation of Time and Deadlines

In computing any period of time prescribed or allowed under these rules, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not one of the aforementioned days. When the period of time prescribed is less than six (6) days, intermediate Saturdays, Sundays and legal holidays shall be excluded in the computation. As used in this rule, “legal holiday” includes New Year’s Day, Martin Luther King, Jr. Day, Washington’s Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day and any other day appointed as a holiday by the President or the Congress of the United States.

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Exhibit 10.13

BLUE SHIELD LICENSE AGREEMENT
(Includes revisions, if any, adopted by Member Plans through their September 27, 2018 meeting)

This agreement by and between Blue Cross and Blue Shield Association ("BCBSA") and The Blue Shield Plan, known as _____ (the "Plan").

Preamble

WHEREAS, the Plan and/or its predecessor(s) in interest (collectively the "Plan") had the right to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") for health care plans in its service area, which was essentially local in nature;

WHEREAS, the Plan was desirous of assuring nationwide protection of the Licensed Marks, maintaining uniform quality controls among Plans, facilitating the provision of cost effective health care services to the public and otherwise benefiting the public;

WHEREAS, to better attain such ends, the Plan and the predecessor of BCBSA executed the Agreement(s) Relating to the Collective Service Mark "Blue Shield"; and

WHEREAS, BCBSA and the Plan desire to supercede said Agreement(s) to reflect their current practices and to assure the continued integrity of the Licensed Marks and of the BLUE SHIELD system;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

Exhibit 10.13

Agreement

1. BCBSA hereby grants to the Plan, upon the terms and conditions of this License Agreement ("Agreement" or "Primary License Agreement", the right to use BLUE SHIELD in its trade and/or corporate name (the "Licensed Name"), and the right to use the Licensed Marks, in the sale, marketing and administration of health care plans and related services in the Service Area set forth and defined in paragraph 5 below. As used herein, health care plans and related services shall include acting as a nonprofit health care plan, a for-profit health care plan, or mutual health insurer operating on a not-for-profit or for-profit basis, under state law; financing access to health care services; when working with a bank that holds the relevant license to use the Licensed Name and Marks, offering: (i) tax-favored savings accounts for medical expenses and means for accessing such accounts, such as debit cards or checks, that are provided solely to support access to such tax-favored savings accounts, all pursuant to such license, or (ii) prepaid rewards cards that are provided for completion of a wellness program, all pursuant to such license; providing health care management and administration; administering, but not underwriting, non-health portions of Worker's Compensation insurance; delivering health care services, except hospital services (as defined in the Guidelines to Membership Standards Applicable to Regular Members); and performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by a group account to its members, including benefit plans not provided by the Plan, provided that the Plan has contracted to provide Health Coverage under the Licensed Marks to the account (as the terms "Health Coverage," "Eligibility" and "Enrollment" are defined in Exhibit 4, Paragraph 2.t.).

2. The Plan may use the Licensed Marks and Name in connection with the offering of: i) health care plans and related services in the Service Area through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the "Controlled Affiliate License Agreement"); and ii) insurance coverages offered by life insurers under the applicable law in the Service Area, other than those which the Plan may offer in its own name, provided through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1A hereto (the "Controlled Affiliate License Agreement Applicable to Life Insurance Companies") or the Agreement attached as Exhibit 1A1 hereto (the "Controlled Affiliate Trademark License Agreement for Life and Disability Insurance Products") and further provided that the offering of such services does not and will not dilute or tarnish the unique value of the Licensed Marks and Name; and iii) administration and underwriting of Workers' Compensation Insurance Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the "Controlled Affiliate License."); and iv) regional Medicare Advantage PPO Products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1B hereto (the "Controlled Affiliate License Agreement Applicable to Regional Medicare Advantage PPO Products"); and v) regional Medicare Part D Prescription Drug Plan products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1C hereto (the "Controlled Affiliate License Agreement Applicable to Regional Medicare Part D Prescription Drug Plan Products"). As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans and, if the entity meets the standards of Paragraph 2a.B but not Paragraph 2a.A, the entity, its owners, and persons authority to select or appoint members or board members, other than a Plan or Plans, have received written approval of BCBSA. Absent written approval by BCBSA of an alternative method of control, bona fide control shall have the meaning set forth in Paragraphs 2a. and 2b.

2a. With respect to the Controlled Affiliate Licenses authorized in clauses i) through iii) of Paragraph 2, bona fide control shall mean that a Plan (the "Sponsoring Plan") authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to this Primary License Agreement with BCBSA must have:

A. The legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; (b) to exercise control over the policy and operations of the Controlled Affiliate; (c) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control more than 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee; or

B. The legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; (c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan. Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

1. Change its legal and/or trade name;

2. Change the geographic area in which it operates;

3. Change any of the types of businesses in which it engages;
4. Create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;
5. Sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;
6. Make any loans or advances except in the ordinary course of business;

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7. Enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners of the Controlled Affiliate or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

8. Conduct any business other than under the Licensed Marks and Name;

9. Take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks or Names.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control at least 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee; or

C. With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid products and services, the legal authority together with such other Plans (a) to select all members of the Controlled Affiliate's governing body; (b) to prevent any change in the articles of incorporation, bylaws, or other establishing or governing documents of the Controlled Affiliate; (c) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the "Addendum to Controlled Affiliate License" attached as Exhibit B-1 to Exhibit 1 attached hereto; or

D. With respect to a Controlled Affiliate that is 100% controlled by a Sponsoring Plan which on a Blue-branded basis, offers solely a Basic Medicare Part D Prescription Drug product, the legal authority (a) to select all members of the Controlled Affiliate's governing body; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of

Amended as of March 17, 2016

the Controlled Affiliate; (c) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by the Plan shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and Participating Plan as defined on the Controlled Affiliate License Agreement shall execute the "Addendum to Controlled Affiliate License" attached as Exhibit B-2 to Exhibit 1 attached hereto.

2b. With respect to the Controlled Affiliate License Agreements authorized in clauses iv) and v) of Paragraph 2, bona fide control shall mean that the Controlled Affiliate is organized and operated in such a manner that it meets the following requirements:

A. The Controlled Affiliate is owned or controlled by two or more Plans authorized to use the Licensed Marks pursuant to this License Agreement with BCBSA (for purposes of this subparagraph A. through subparagraph C., the "Controlling Plans"); and

B. Each Controlling Plan is authorized pursuant to this Agreement to use the Licensed Marks in a geographic area in the Region (as that term is defined in such Controlled Affiliate License Agreements) and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

C. The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur; and (c) to exercise control over the policy and operations of the Controlled Affiliate. Notwithstanding anything to the contrary in (a) through (c) of this subparagraph E., the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

1. Change its legal and/or trade names;

2. Change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

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3. Change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

4. Take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly- owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. With respect to a Controlled Affiliate that is not licensed to use the Licensed Marks and Name, the Plan may, in communications that contain the Licensed Marks or Name, indicate its corporate relationship to the Affiliate and permit such Affiliate to indicate its corporate relationship to the Plan, solely in the circumstances, style and manner specified by BCBSA from time-to-time in regulations of general application consistent with the avoidance of confusion or mistake or the dilution or tarnishment of the Licensed Marks and Name. No rights are hereby created in any Controlled Affiliate to use the Licensed Marks or Name in its own name or otherwise.

4. The Plan recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Plan further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide. The Plan agrees (a) to maintain in good standing its membership in BCBSA; (b) promptly to pay its dues to BCBSA, said dues to represent the royalties for this License Agreement; (c) materially to comply with all applicable laws; (d) to comply with the Membership Standards Applicable to Regular Members of BCBSA, a current copy of which is attached as Exhibit 2 hereto; and (e) reasonably to permit BCBSA, upon a written, good faith request and during reasonable business hours, to inspect the Plan's books and records necessary to ascertain compliance herewith. As to other Plans and third parties, BCBSA shall maintain the confidentiality of all documents and information furnished by the Plan pursuant hereto, or pursuant to the Membership Standards, and clearly designated by the Plan as containing proprietary information of the Plan.

5. The rights hereby granted are exclusive to the Plan within the geographical area(s) served by the Plan on June 30, 1972, and/or as to which the Plan has been granted a subsequent license, which is hereby defined as the "Service Area," except that BCBSA reserves the right to use the Licensed Marks in said Service Area, and except to the extent that said Service Area may overlap areas served by one or more other licensed Blue Shield Plans as of said date or subsequent license, as to which overlapping areas the rights hereby granted are nonexclusive as to such other Plan or Plans only.

Amended as of June 19, 2014

6. Except as expressly provided by BCBSA with respect to National Accounts, Government Programs and certain other necessary and collateral uses, the current rules and regulations governing which are attached as Exhibit 3 and Exhibit 4 hereto, and are contained in other documents referenced herein, or as expressly provided herein, the Plan may not use the Licensed Marks and Name outside the Service Area or in connection with other goods and services, nor may the Plan use the Licensed Marks or Name in a manner which is intended to transfer in the Service Area the goodwill associated therewith to another mark or name. Nothing herein shall be construed to prevent the Plan from engaging in lawful activity anywhere under other marks and names not confusingly similar to the Licensed Marks and Name, provided that engaging in such activity does and will not dilute or tarnish the unique value of the Licensed Marks and Name. In addition to any and all remedies available hereunder, BCBSA may impose monetary fines on the Plan for the Plan's use of the Licensed Marks and Names outside the Service Area, and provided that the procedure used in imposing a fine is consistent with procedures specifically prescribed by BCBSA from time to time in regulations of general application. In the case of regional Medicare Advantage PPO and regional Medicare Part D Prescription Drug Plan products offered by consenting and participating Plans in a region that includes the Service Areas, or portions thereof, of more than one Plan, such fine may be imposed jointly on the consenting and participating Plans for use of the Licensed Marks and Name in any geographic area of the region in which a Plan having exclusive rights to the Licensed Marks and Name does not consent to and participate in such offering, provided that the basis for imposition of such fine is consistent with rules specifically prescribed by BCBSA from time to time in regulations of general application.

7. The Plan agrees that it will display the Licensed Marks and Name only in such form, style and manner as shall be specifically prescribed by BCBSA from time-to-time in regulations of general application in order to prevent impairment of the distinctiveness of the Licensed Marks and Name and the goodwill pertaining thereto. The Plan shall cause to appear on all materials on or in connection with which the Licensed Marks or Name are used such legends, markings and notices as BCBSA may reasonably request in order to give appropriate notice of service mark or other proprietary rights therein or pertaining thereto.

8. BCBSA agrees that: (a) it will not grant any other license effective during the term of this License Agreement for the use of the Licensed Marks or Name which is inconsistent with the rights granted to the Plan hereunder; and (b) it will not itself use the Licensed Marks in derogation of the rights of the Plan or in a manner to deprive the Plan of the full benefits of this License Agreement, provided that BCBSA shall have the right to use the Licensed Marks in conjunction with any national offering under the Federal Employees Health Benefits Program in the manner set forth in Exhibit 4, Paragraph 4 (including subparagraphs) to this License Agreement. The Plan agrees that it will not attack the title of BCBSA in and to the Licensed Marks or Name or attack the validity of the Licensed Marks or of this License Agreement. The Plan further agrees that all use by it of the Licensed Marks and Name or any similar mark or name shall inure to the benefit of BCBSA, and the Plan shall cooperate with BCBSA in effectuating the assignment to BCBSA of any service mark or trademark registrations of the Licensed Marks or any similar mark or name held by the Plan or a Controlled Affiliate of the Plan, all or any portion of which registration consists of the Licensed Marks.

Amended as of November 16, 2006

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9. (a). Should the Plan fail to comply with the provisions of paragraphs 2-4, 6, 7 and/or 12, and not cure such failure within thirty (30) days of receiving written notice thereof (or commence curing such failure within such thirty day period and continue diligent efforts to complete the curing of such failure if such curing cannot reasonably be completed within such thirty day period), BCBSA shall have the right to issue a notice that the Plan is in a state of noncompliance. Except as to the termination of a Plan's License Agreement or the merger of two or more Plans, disputes as to noncompliance, and all other disputes between or among BCBSA, the Plan, other Plans and/or Controlled Affiliates, shall be submitted promptly to mediation and mandatory dispute resolution pursuant to the rules and regulations of BCBSA, a current copy of which is attached as Exhibit 5 hereto, and shall be timely presented and resolved. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. If a state of noncompliance as aforesaid is undisputed by the Plan or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the License Agreement. Except, however, as provided in paragraphs 9(d)(iii), 15(a)(i)-(viii), and 15(a)(x) below, no Plan's license to use the Licensed Marks and Name may be finally terminated for any reason without the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.
(b). Notwithstanding any other provision of this License Agreement, a Plan's license to use the Licensed Marks and Name may be forthwith terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to Member Plans for: (i) failure to comply with any minimum capital or liquidity requirement under the Membership Standard on Financial Responsibility; or (ii) impending financial insolvency; or (iii) the pendency of any action instituted against the Plan seeking its dissolution or liquidation or its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property of business, unless this License Agreement has been earlier terminated under paragraph 15(a); or (iv) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans and/or the Licensed Marks.

Amended as of March 16, 2006

(c). To the extent not otherwise provided therein, neither: (i) the Membership Standards Applicable to Regular Members of BCBSA; nor (ii) the rules and regulations governing Government Programs and certain other uses; nor (iii) the rules and regulations governing mediation and mandatory dispute resolution, may be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans. The rules and regulations governing National Accounts and other national programs required by the Membership Standards Applicable to Regular Members of BCBSA (Exhibit 2) are contained, in addition to those set forth in Exhibit 3, in the following documents, as amended from time to time: (1) the Inter-Plan Programs Policies and Provisions; (2) Inter-Plan Medicare Advantage Program Policies and Provisions. The voting requirements specified in rules and regulations governing such national programs may not be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans.

Amended as of November 21, 2014

Exhibit 10.13

(d). The Plan may operate as a for-profit company on the following conditions:

(i) The Plan shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement and the Plan's membership in BCBSA.

(ii) The Plan shall not use the licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Plan in any securities market. The Plan shall use the Licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(iii) The Plan's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Plan knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Plan (“Excess Institutional Voter”), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Plan knows, or there is an SEC filing indicating that, any Noninstitutional Investor has become the Beneficial Owner of securities representing 5% or more of the voting power of the Plan (“Excess Noninstitutional Voter”) unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Plan knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner of 20% or more of the Plan’s then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 9(d)(iv) below (“Excess Owner”), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Plan went public constituted the Board of Directors of the Plan (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Plan went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Plan consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Plan in a writing received by BCBSA prior to such automatic termination

Amended as of September 17, 1997

Exhibit 10.13

becoming effective, the provisions of this paragraph 9(d)(iii) may be waived, in whole or in part, upon the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 9(d)(iii)(a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Plan's license to use the Licensed Marks and Name is terminated pursuant to this Paragraph 9(d)(iii), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Plan demonstrates that the Person referred to in clause (a), (b) or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(iv) The Plan shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities or (iii) such other securities as the Plan may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(v) For purposes of paragraph 9(d)(iii), the following definitions shall apply:

(a) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(b) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

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(i) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

(ii) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(iii) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (b)(ii)(B) above) or disposing of any securities of the Plan.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding," when used with reference to a Person's Beneficial Ownership of securities of the Plan, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(c) A Person shall be deemed an “Institutional Investor” if (but only if) such Person (i) is an entity or group identified in the SEC’s Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person’s Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 10 of SEC Schedule 13G as constituted on June 1, 1997.

(d) “Noninstitutional Investor” means any Person who is not an Institutional Investor.

(e) Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

Amended as of September 17, 1997

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10. This License Agreement shall remain in effect: (a) until terminated as provided herein; or (b) until this and all such other License Agreements are terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans; (c) until terminated by the Plan upon eighteen (18) months written notice to BCBSA or upon a shorter notice period approved by BCBSA in writing at its sole discretion.

11. Except as otherwise provided in paragraph 15 below or by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans, or unless this and all such other License Agreements are simultaneously terminated by force of law, the termination of this License Agreement for any reason whatsoever shall cause the reversion to BCBSA of all rights in and to the Licensed Marks and Name, and the Plan agrees that it will promptly discontinue all use of the Licensed Marks and Name, will not use them thereafter, and will promptly, upon written notice from BCBSA, change its corporate name so as to eliminate the Licensed Name therefrom.

12. The license hereby granted to Plan to use the Licensed Marks and Name is and shall be personal to the Plan so licensed and shall not be assignable by any act of the Plan, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Plan mortgage or part with possession or control of this license or any right hereunder, and the Plan shall have no right to grant any sublicense to use the Licensed Marks and Name.

13. BCBSA shall maintain appropriate service mark registrations of the Licensed Marks and BCBSA shall take such lawful steps and proceedings as may be necessary or proper to prevent use of the Licensed Marks by any person who is not authorized to use the same. Any actions or proceedings undertaken by BCBSA under the provisions of this paragraph shall be at BCBSA's sole cost and expense. BCBSA shall have the sole right to determine whether or not any legal action shall be taken on account of unauthorized use of the Licensed Marks, such right not to be unreasonably exercised. The Plan shall report any unlawful usage of the Licensed Marks to BCBSA in writing and agrees, free of charge, to cooperate fully with BCBSA's program of enforcing and protecting the service mark rights, trade name rights and other rights in the Licensed Marks.

14. The Plan hereby agrees to save, defend, indemnify and hold BCBSA And any other Plan(s) harmless from and against all claims, damages, liabilities and Costs of every kind, nature and description which may arise as a result of the activitie of the Plan or of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan. BCBSA hereby agrees tosave, defend, indemnify and hold the Plan and any other Plan(s) harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise exclusively and directly as a result of the activities of BCBSA.

Amended as of June 21, 2012

Exhibit 10.13

15. (a). This Agreement shall automatically terminate upon the occurrence of any of the following events: (i) a voluntary petition shall be filed by the Plan or by BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against the Plan or BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Plan or BCBSA respectively, or (iii) an order for relief is entered against the Plan or BCBSA in any case under the bankruptcy laws of the United States, or the Plan or BCBSA is adjudged bankrupt or insolvent (as that term is defined in the Uniform Commercial Code as enacted in the state of Illinois) by any court of competent jurisdiction, or (iv) the Plan or BCBSA makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of the Plan or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Plan or BCBSA respectively, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association’s Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of the Plan's or BCBSA's property or business is appointed, or the Plan or BCBSA is ordered dissolved or liquidated, or (ix) the Plan shall fail to pay its dues and shall not cure such failure within thirty (30) days of receiving written notice thereof, or (x) if, due to regulatory action, the Plan together with any applicable Controlled Affiliate becomes unable to do business using the Names and Marks in any State or portion thereof included in its Service Area, provided that: (i) automatic termination shall not occur prior to the exhaustion by any such Plan of its rights to appeal or challenge such regulatory action; and (ii) in the event the Plan is licensed to do business using the Names and Marks in multiple States or portions of States, the termination of its License Agreement shall be solely limited to the State(s) or portions thereof in which the regulatory action applies. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Plan's or BCBSA's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 15(a)(vii) and (viii) of this Agreement.

Amended as of September 14, 2004

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(b). BCBSA, or the Plans (as provided and in addition to the rights conferred in Paragraph 10(b) above), may terminate this Agreement immediately upon written notice upon the occurrence of either of the following events: (a) the Plan or BCBSA becomes insolvent (as that term is defined in the Uniform Commercial Code enacted in the state of Illinois), or (b) any final judgment against the Plan or BCBSA remains unsatisfied or unbonded of record for a period of sixty (60) days or longer.

(c). If this License Agreement is terminated as to BCBSA for any reason stated in subparagraphs 15(a) and (b) above, the ownership of the Licensed Marks shall revert to each of the Plans.

(d). Upon termination of this License Agreement or any Controlled Affiliate License Agreement of a Larger Controlled Affiliate, as defined in Exhibit 1 to this License Agreement, the following conditions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 15 (a)(x)(ii) of this Agreement, the notices, national account listing, payment and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated:

(i) The terminated entity shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the terminated entity or its Controlled Affiliates under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination or, if termination is pursuant to paragraph 10(d) of this Agreement, within 15 days after the written notice to BCBSA described in paragraph 10(d).

(ii) The terminated entity shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the terminated entity is involved (in a Control, Participating or Servicing capacity), identifying the national account and the terminated entity's role therein. For those accounts where the terminated entity is the Control Plan, the Plan must also indicate the Participating and Servicing Plans in the national account syndicate.

Amended as of June 16, 2005

(iii) Unless the cause of termination is an event stated in paragraph 15(a) or (b) above respecting BCBSA, the Plan and its Licensed Controlled Affiliates shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re-Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. The Re-Establishment Fee shall be indexed to a base fee of $80. The Re-Establishment Fee through December 31, 2005 shall be $80. The Re-Establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was$278.60, $285.00 and $290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be $83.27 (100% of the base fee plus $1.84 for calendar year 2005 and $1.43 for calendar year 2006). Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (a) the end of the last fiscal year of the terminated entity which ended prior to termination or (b) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph (d)(iii) shall be due only

Amended as of June 16, 2005

to the extent that, in BCBSA's opinion, it does not cause the net worth of the Plan to fall below 100% of the Health Risk-Based Capital formula or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans), measured as of the date of termination and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plan or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re-Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Plan (and/or its Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph only to the extent that such payments exceed the amounts due to BCBSA pursuant to subparagraph 15(d)(vi) and any costs associated with reestablishing the Service Area, including any payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the terminated entity.

(iv) The terminated entity shall comply with all financial settlement procedures set forth in BCBSA's License Termination Contingency Plan, as amended from time to time and shall work diligently and in good faith with

Amended as of June 16, 2005

BCBSA, any Alternative Control Licensee or Replacement Licensee and any existing or potential new account for Blue-branded products and services to minimize the disruption of termination, and honor, to the fullest extent possible, the desire of accounts to continue to receive or obtain Blue-branded products and services through a new Licensee ("Transition"). Such diligence and good faith on the part of the terminated entity shall include, but not be limited to: (a) working cooperatively with BCBSA to protect the Names and Marks from potential harm; (b) cooperating with BCBSA's use of the Names and Marks in the terminated entity's former service area during the termination and Transition; (c) transmitting, upon the request of an existing Blue account or of BCBSA with consent and on behalf of an existing Blue account, all member and account-data relating to the Federal Employee Program to BCBSA, and all member and account data relating to other programs to an Alternative Control Licensee or Replacement Licensee; (d) working with BCBSA and the Alternative Control or Replacement Licensee with respect to potential new Blue accounts headquartered in the terminated entity's former service area; (e) continuing to service Blue accounts during the Transition; (f) continuing to comply with National Programs, Federal Employee Program and NASCO policies and procedures and all voluntary BCBSA programs, policies and performance standards, such as Away From Home Care, including being responsible for payment of all penalties for non-compliance duly levied in conformity with the License Agreements, Membership Standards, or the Federal Employee Program agreements, that may arise during the Transition; (g) maintaining and providing access to its provider networks, as defined by Federal Employee Program agreements and National Account Program Policies and Provisions, and Inter-Plan Programs Policies and Provisions, and making those networks and discounts available to members and providers who participate in National Programs and the Federal Employee Program during the Transition; (h) maintaining its technical connections and processing capabilities during the Transition; and (i) working diligently to conclude all financial settlements and account reconciliations as negotiated in the termination transition agreement.

Amended as of November 16, 2006

(v) Notwithstanding any other provision in this Agreement, BCBSA shall have the right, with the approval of its Board of Directors, to assess additional fines against the terminated entity during the Transition in the event it fails to maintain and provide access to provider networks as defined by Federal Employee Program agreements, National Account Program Policies and Provisions, and Inter-Plans Programs Policies and Provisions, and/or pass on applicable discounts. Such fines shall be in addition to any other assessments, fees or liquidated damages payable herein, or under existing policies and programs and shall be imposed to make whole BCBSA and/or the Plans. Terminated entity shall pay any such fines to BCBSA no later than 30 days after they are approved by the Board of Directors.

(vi) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third-party auditor to examine and audit the books and records of the terminated entity and its Licensed Controlled Affiliates to verify compliance with the terms and requirements of this paragraph 15(d).

(vii) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.

(viii) As to a breach of 15 (d) (i), (ii), (iii), (iv), (vi), or (vii) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 15 (d) (i), (ii), (iv), (vi), or (vii) by the Plan, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

Amended as of November 16, 2006

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(ix) In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Plan and its Licensed Controlled Affiliates shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

(e). BCBSA shall be entitled to enjoin the Plan or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this License Agreement unless the License Agreement has been terminated pursuant to paragraph 10 (d) of this Agreement upon the required six (6) month written notice.

(f). BCBSA acknowledges that it is not the owner of assets of the Plan.

Amended as of June 16, 2006

16. This Agreement supersedes any and all other agreements between the parties with respect to the subject matter herein, and contains all of the covenants and agreements of the parties as to the licensing of the Licensed Marks and Name. This Agreement may be amended only by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

17. If any provision or any part of any provision of this Agreement is judicially declared unlawful, each and every other provision, or any part of any provision, shall continue in full force and effect notwithstanding such judicial declaration.

18. No waiver by BCBSA or the Plan of any breach or default in performance on the part of BCBSA or the Plan or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

19a. All notices provided for hereunder shall be in writing and shall be sent in duplicate by regular mail to BCBSA or the Plan at the address currently published for each by BCBSA and shall be marked respectively to the attention of the President and, if any, the General Counsel, of BCBSA or the Plan.

Amended as of November 20, 1997

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19b. Except as provided in paragraphs 9(b), 9(d)(iii), 15(a), and 15(b) above, this Agreement may be terminated for a breach only upon at least 30 days' written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Member Plans.

19c. For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans
(rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

Amended as of June 16, 2006

(The next page is page 9)

20. Nothing herein contained shall be construed to constitute the parties hereto as partners or joint venturers, or either as the agent of the other, and Plan shall have no right to bind or obligate BCBSA in any way, nor shall it represent that it has any right to do so. BCBSA shall have no liability to third parties with respect to any aspect of the business, activities, operations, products, or services of the Plan.

21. This Agreement shall be governed, construed and interpreted in accordance with the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By_____

Title_____

Date_____

Plan:

By_____

Title_____

Date_____

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EXHIBIT 1

BLUE SHIELD
CONTROLLED AFFILIATE LICENSE AGREEMENT
(Includes revisions adopted by Member Plans through their September 27, 2018 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Shield Plan, known as _____ ("Plan" or "Sponsoring Plan"), which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, Plan and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name");

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with: (i) health care plans and related services, as defined in BCBSA's License Agreement with Plan, and administering the non-health portion of workers' compensation insurance, and (ii) underwriting the indemnity portion of workers' compensation insurance, provided that Controlled Affiliate's total premium revenue comprises less than 15 percent of the Sponsoring Plan's net subscription revenue.

This grant of rights is non-exclusive and is limited to the Service Area served by the Plan. Subject to Paragraph 3A(3) of this Agreement, Controlled Affiliate may use the Licensed Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Service Area under any name or mark; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market, unless such Controlled Affiliate is a not-for-profit company which may use the Licensed Marks and Name, or an approved derivative therefor, to identify itself in debt securities markets. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

Amended as of March 26, 2015

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report or reports to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that the Sponsoring Plan has:

(1) The legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate’s governing body having not less than 50% voting control thereof; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and

(c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate’s establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates;

(iii) change any of the type(s) of businesses in which it engages;

Amended as of September 19, 2014

(iv) create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

(v) sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;

(vi) make any loans or advances except in the ordinary course of business;

(vii) enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

(viii) conduct any business other than under the Licensed Marks and Name;

(ix) take any action that Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control at least 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee.

Or

(2) The legal authority directly or indirectly through wholly-owned subsidiaries;

(a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof and to:

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; and

c) to exercise control over the policy and operations of the Controlled Affiliate.

Amended as of March 26, 2015

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In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control more than 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee.

Or

(3) With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services, the legal authority together with such other Plans:

(a) to select all members of the Controlled Affiliate's governing body; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and

(c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such control and ownership by Plans must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute a separate Addendum to Controlled Affiliate License Agreement attached hereto as Exhibit B-1 for each product noted in Paragraph 2E(3) that is licensed to use the Marks.

Or

(4) With respect to a Controlled Affiliate that is 100% controlled by a Sponsoring Plan which on a Blue-branded basis offers solely a Basic Medicare Part D Prescription Drug product, the legal authority:

(a) to select all members of the Controlled Affiliate's governing body; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and

(c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by Sponsoring Plan must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA, Further, the Participating Plan as defined in Exhibit B-2 and the Sponsoring Plan shall execute the Addendum to Controlled Affiliate License Agreement attached hereto as Exhibit B-2.

Amended September 27, 2018

3. FOR-PROFIT, PUBLICLY TRADED LICENSEES

A. The Controlled Affiliate may operate as a for-profit publicly traded company on the following conditions:

(1) The Controlled Affiliate shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement.

(2) The Controlled Affiliate shall provide 90 days advance written notice to BCBSA prior to the initial filing with the SEC.

(3) The Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Controlled Affiliate in any securities market. The Controlled Affiliate shall use the Licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(4) The Controlled Affiliate's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Controlled Affiliate ("Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Noninstitutional Investor, other than a Plan or Plans or Controlled Affiliate licensee or licensees has become the Beneficial Owner of securities representing 5% or more of the voting power of the Controlled Affiliate ("Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner, other than a Plan or Plans or Controlled Affiliate licensee or licensees, of 20% or more of the Controlled Affiliate's then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under Paragraph 3A(4) below ("Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Controlled Affiliate went public constituted the Board of Directors of the Controlled Affiliate (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Controlled Affiliate went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors;

Amended as of March 26, 2015

or (e) ten business days after the Controlled Affiliate consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Sponsoring Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Controlled Affiliate in a writing received by BCBSA prior to such automatic termination becoming effective, the provision of this paragraph 3A(4) may be waived, in whole or in part, upon the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 3A(4)(a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Controlled Affiliate's license, or any other license, to use the Licensed Marks and Name is terminated pursuant to Paragraph 3A(4), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Controlled Affiliate demonstrates that the Person referred to in clause (a), (b) or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(5) The Controlled Affiliate shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities, or (iii) such other securities as the Controlled Affiliate may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(6) For purposes of paragraph 3(A) above, the following definitions shall apply:

(i) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(ii) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

Amended as of March 26, 2015

(1) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

(2) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(3) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (ii)2(B) above) or disposing of any securities of the Controlled Affiliate.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding", when used with reference to a Person's Beneficial Ownership of securities of the Controlled Affiliate, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(iii) A Person shall be deemed an "Institutional Investor" if (but only if) such Person (i) is an entity or group identified in the SEC's Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person's Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 1 of SEC Schedule 13G as constituted on June 1, 1997.

(iv) "Noninstitutional Investor" means any Person who is not an Institutional Investor.

(v) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

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4. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Service Area the goodwill associated therewith to another mark or name, nor may Controlled Affiliate
engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. If Controlled Affiliate meets the standards of 2E(1) but not 2E(2) above and any of Controlled Affiliate's advertising or promotional material is reasonably determined by BCBSA and/or the Plan to be in contravention of rules and regulations governing the use of the Licensed Marks and Name, Controlled Affiliate shall for ninety (90) days thereafter obtain prior approval from BCBSA of advertising and promotional efforts using the Licensed Marks and Name, approval or disapproval thereof to be forthcoming within five (5) business days of receipt of same by BCBSA or its designee. In all advertising and promotional efforts, Controlled Affiliate shall observe the Service Area limitations applicable to Plan.

E. Notwithstanding any other provision in the Plan's License Agreement with BCBSA or in this Agreement, Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name.

5. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

6. INFRINGEMENT

Controlled Affiliate shall promptly notify Plan and Plan shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that

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may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

7. LIABILITY INDEMNIFICATION

Controlled Affiliate and Plan hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to: (i) Controlled Affiliate's rendering of services under the Licensed Marks and Name; or (ii) the activities of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan or Controlled Affiliate.

8. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) the Plan ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement the Plan ceases to be authorized to use the Licensed Names and Marks in the geographic area served by the Controlled Affiliate provided, however, that if the Controlled Affiliate is serving more than one State or portions thereof, the termination of this Agreement shall be limited to the State(s) or portions thereof in which the Plan’s license to use the Licensed Marks and Names is terminated. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial

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insolvency; or (4) for a Smaller Controlled Affiliate (as defined in Exhibit A), failure to comply with any of the applicable requirements of Standards 2, 3, 4, 5 or 7 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph
8(E); or (6) failure by a Controlled Affiliate that meets the standards of 2E(1) but not 2E(2) above to obtain BCBSA's written consent to a change in the identity of any owner, in the extent of ownership, or in the identity of any person or entity with the authority to select or appoint members or board members, provided that as to publicly traded Controlled Affiliates this provision shall apply only if the change affects a person or entity that owns at least 5% of the Controlled Affiliate's stock before or after the change; or (7) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans, any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 8(B), 8(C) or 8(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Plan shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 8(B), 8(C) or 8(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between BCBSA, the Plan and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 8(B) and 8(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 10 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

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(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 8(E)(3)(vii) and (viii) of this Agreement.

(4) The for-profit, publicly traded Controlled Affiliate is terminated pursuant to Paragraph 3A(4) of this Agreement. In which case, the licenses of any controlled Affiliates directly or indirectly owned by the terminated for profit, publicly traded Controlled Affiliate also shall immediately terminate as provided for in paragraph 3A(4) of this Agreement

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name.

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G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 8(b) hereof, or in the event the Controlled Affiliate is a Larger Controlled Affiliate (as defined in Exhibit A), upon termination of this Agreement, the provisions of Paragraph 8.G. shall not apply and the following provisions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 8(B)(ii) of this Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re-Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area.

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The Re-Establishment Fee shall be indexed to a base fee of $80. The Re-Establishment Fee through December 31, 2005 shall be $80. The Re-Establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was $278.60, $285.00 and $290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be $83.27 (100% of base fee plus $1.84 for calendar year 2005 and $1.43 for calendar year 2006. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Plan or any other Licensed Controlled Affiliates of the Plan to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re-Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided
further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Plan or its other Licensed Controlled Affiliates, as the
case may be) for payments made under this subparagraph 8.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 8.M. and any cost associated with reestablishing the Service Area, including any payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the Controlled Affiliate.

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(4) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third party auditor to examine and audit the books and records of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan to verify compliance with this paragraph 8.H.

(5) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.

(6) As to a breach of 8.H.(1), (2), (3), (4) or (5) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 8.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. This Agreement shall remain in effect until terminated by the Controlled Affiliate or the Plan upon not less than eighteen (18) months written notice to the Association or upon a shorter notice period approved by BCBSA in writing at its sole discretion, or until terminated as otherwise provided herein. The Plan's right to terminate without cause upon such notice is unfettered and may be exercised in the Plan's sole discretion.

J. In the event the Controlled Affiliate is a Smaller Controlled Affiliate (as defined in Exhibit A), the Controlled Affiliate agrees to be jointly liable for the amount described in H.3.and M. hereof upon termination of the BCBSA license agreement of any Larger Controlled Affiliate of the Plan.

K. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless the Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of the Plan's license agreement upon the required 18 months written notice.

L. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

M. In the event that the Plan has more than 50 percent voting control of the Controlled Affiliate under Paragraph 2(E)(2) above and is a Larger Controlled Affiliate (as defined in Exhibit A), then the vote called for in Paragraphs 8(C) and 8(D)
above shall require the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

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N. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

9. DISPUTE RESOLUTION

The parties agree that any disputes between them or between or among either of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

10. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit C.

11. JOINT VENTURE

Nothing contained in the Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

12. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

13. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

14. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

15. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

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16. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

17. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By:_____

Date:_____

Plan:

By:_____

Date:_____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____

Date:_____

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EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS
September 2018
PREAMBLE

For purposes of definition:

A "smaller Controlled Affiliate:" (1) comprises less than fifteen percent (15%) of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed);* or (2) underwrites the indemnity portion of workers' compensation insurance and has total premium revenue less than 15 percent of the Sponsoring Plan's net subscription revenue.

A "larger Controlled Affiliate" comprises fifteen percent (15%) or more of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed.)*

Changes in Controlled Affiliate status:

If **any** Controlled Affiliate's status changes regarding: its Plan ownership level, its risk acceptance or direct delivery of medical care, the Controlled Affiliate shall notify BCBSA within thirty (30) days of such occurrence in writing and come into compliance with the applicable standards within six (6) months.

If a smaller Controlled Affiliate's health and workers' compensation administration business reaches or surpasses fifteen percent (15%) of the total member enrollment of the Sponsoring Plan and licensed Controlled Affiliates, the Controlled Affiliate shall:

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EXHIBIT A (continued)

1. Within thirty (30) days, notify BCBSA of this fact in writing, including evidence that the Controlled Affiliate meets the minimum liquidity and capital (BCBSA “Health Risk-Based Capital (HRBC)” as defined by the NAIC and state-established minimum reserve) requirements of the larger Controlled Affiliate Financial Responsibility standard; and

2. Within six (6) months after reaching or surpassing the fifteen percent (15%) threshold, demonstrate compliance with all license requirements for a larger Controlled Affiliate.

If a Controlled Affiliate that underwrites the indemnity portion of workers’ compensation insurance receives a change in rating or proposed change in rating, the Controlled Affiliate shall notify BCBSA within 30 days of notification by the external rating agency.

*For purposes of this calculation,

The numerator equals:

Applicant Controlled Affiliate's member enrollment, as defined in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

The denominator equals:

Numerator PLUS Sponsoring Plan and all other licensed Controlled Affiliates' member enrollment, as reported in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

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EXHIBIT A (continued)

STANDARDS FOR LICENSED CONTROLLED AFFILIATES

Each licensed controlled affiliate shall be subject to certain standards as determined below:

1. What percent of the licensed controlled affiliate is controlled by the Sponsoring Plan and other Plans?

More than 50% by Sponsoring Plan ò Standard 1A, 4	50% by Sponsoring Plan ò Standard 1B, 4	100% Plan Control but less than 50% Sponsoring Plan Control and it offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services ò Standard 1C, 4	100% Sponsoring Plan control and on a Blue-branded basis, it only offers Basic Medicare Part D Prescription Drug Plan product ò Standard 1D, 4

IN ADDITION,

2. Is risk being assumed?

Yes			No	
÷	ò	ø	÷	ò
Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance ò Standards 7A-7E, 11	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance ò Standard 2 (Guidelines 1.1,1.2) and Standard 11	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance ò Standard 6H	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates ò Standard 2 (Guidelines 1.1,1.3) and Standard 11	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates ò Standard 6H

IN ADDITION,

3. Is medical care being directly provided?

Yes ò Standard 3A	No ò Standard 3B

IN ADDITION,

4. If the controlled affiliate has health or workers' compensation administration business, does such business comprise 15% or more of the total member enrollment of Plan and its licensed Controlled Affiliates?

Yes	No		
ò	÷	÷	ø
Standards 6A-6J	Controlled Affiliate is not a former primary licensee and is not subject to Standard 1(C) ò Standards 5,8,9B,10,11	Controlled Affiliate is a former primary licensee ò Standards 5,8,9A,10,11	Controlled Affiliate is not a former primary licensee and is subject to Standard 1(C) ò Standards 5,8,9B,11

Amended September 27, 2018

EXHIBIT A (continued)

Standard 1 - Organization and Governance

1A.) The Standard for more than 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA has the legal authority, directly or indirectly through wholly-owned subsidiaries: 1) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; and 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; and 3) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate.

1B.)The Standard for 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA has the legal authority, directly or indirectly through wholly-owned subsidiaries:

1)to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; and

2)to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; and

3)to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan.

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EXHIBIT A (continued)

Notwithstanding anything to the contrary in 1) through 3) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

- change the geographic area in which it operates
- change its legal and/or trade names
- change any of the types of businesses in which it engages
- create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business
- sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced
- make any loans or advances except in the ordinary course of business
- enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate)
- conduct any business other than under the Licensed Marks and Name
- take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate.

1C.) The Standard for a Controlled Affiliate that offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and service and has100% Plan control but less than 50% Sponsoring Plan Control:

A Controlled Affiliate shall be organized and operated in such a manner that (i) it offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services; and (ii) a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA (the "Sponsoring Plan,) has the legal authority together with Other Plans:

Amended September 27, 2018

1) to select all members of the Controlled Affiliate's governing body; and

2) to prevent any change in the articles of incorporation, bylaws, or other establishing or governing documents of the Controlled Affiliate; and

3) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the Addendum to Controlled Affiliate License.

1D). The Standard for a Controlled Affiliate that on a Blue-branded basis, only offers a Basic Medicare Part D Prescription Drug product and has 100% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that (i) on a Blue-branded basis, it only offers a Basic Medicare Part D Prescription Drug product; and (ii) the Sponsoring Plan has the legal authority:

1) to select all members of the Controlled Affiliate's governing body; and

2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and

3) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by Sponsoring Plan must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA.

Further, the Sponsoring Plan and Participating Plan shall execute the Addendum to Controlled Affiliate License.

Amended March 17, 2016

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EXHIBIT A (continued)

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. If a risk-assuming Controlled Affiliate ceases operations for any reason, Blue Cross and/or Blue Cross Plan coverage will be offered to all Controlled Affiliate subscribers without exclusions, limitations or conditions based on health status. If a nonrisk-assuming Controlled Affiliate ceases operations for any reason, Sponsoring Plan will provide for services to its customers. The requirements of the preceding two sentences shall apply to all lines of business unless a line of business is specially exempted from the requirement(s) by the BCBSA Board of Directors.

Standard 3 - State Licensure/Certification

3A.) The Standard for a Controlled Affiliate that employs, owns or contracts on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification for its medical care providers to operate under applicable state laws.

3B.) The Standard for a Controlled Affiliate that does not employ, own or contract on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification to operate under applicable state laws.

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of 1) the structure of the Blue Cross and Blue Shield System; and 2) the independent nature of every licensee; and 3) the Controlled Affiliate's financial condition.

Amended as of September 19, 2014

EXHIBIT A (continued)

Standard 5 - Reports and Records for Certain Smaller Controlled Affiliates

For a smaller Controlled Affiliate that does not underwrite the indemnity portion of workers' compensation insurance, the Standard is:

A Controlled Affiliate and/or its Sponsoring licensed Plan shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Other Standards for Larger Controlled Affiliates

Standards 6(A) - (I) that follow apply to larger Controlled Affiliates.

Standard 6(A): Board of Directors

A Controlled Affiliate Governing Board shall act in the interest of its Corporation in providing cost-effective health care services to its customers. A Controlled Affiliate shall maintain a governing Board, which shall control the Controlled Affiliate, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 6(B): Responsiveness to Customers

A Controlled Affiliate shall be operated in a manner responsive to customer needs and requirements.

Standard 6(C): Participation in National Programs

A Controlled Affiliate shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the licensees and ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's Service Area.

Amended as of September 19, 2014

EXHIBIT A (continued)

Such programs are applicable to licensees, and include:

1. BlueCard Program;
2. Inter-Plan Teleprocessing System (ITS);
3. National Account Programs;
4. Business Associate Agreement for Blue Cross and Blue Shield Licensees, effective April 14, 2003; and
5. Inter-Plan Medicare Advantage Program.

Standard 6(D): Financial Performance Requirements

In addition to requirements under the national programs listed in
Standard 6C: Participation in National Programs, a Controlled Affiliate shall take such action as required to ensure its financial performance in programs and contracts of an inter-licensee nature or where BCBSA is a party.

Standard 6(E): Cooperation with Plan Performance Response Process

A Controlled Affiliate shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Plan Performance Response Process and in addressing Controlled Affiliate performance problems identified thereunder.

Standard 6(F): Independent Financial Rating

A Controlled Affiliate shall obtain a rating of its financial strength from an independent rating agency approved by BCBSA's Board of Directors for such purpose.

Standard 6(G): Local and National Best Efforts

Notwithstanding any other provision in the Plan’s License Agreement with BCBSA or in this License Agreement, during each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Shield Mark.

Standard 6(H): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Amended as of November 21, 2014

EXHIBIT A (continued)

Standard 6(I): Reports and Records

A Controlled Affiliate shall furnish to BCBSA on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between BCBSA and Controlled Affiliate. Such reports and records are the following:

A) BCBSA Controlled Affiliate Licensure Information Request; and

B) Triennial trade name and service mark usage material, including disclosure material; and

C) Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, or changes in the identity of the Controlled Affiliate's Principal Officers, and changes in risk acceptance, contract growth, or direct delivery of medical care; and

D) Semi-annual “Health Risk-Based Capital (HRBC) Report” as defined by the NAIC, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), and

Amended as of November 17, 2011

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EXHIBIT A (continued)

Standard 6(J): Control by Unlicensed Entities Prohibited

No Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Standard 7 - Other Standards for Risk-Assuming Workers' Compensation Controlled Affiliates

Standards 7(A) - (E) that follow apply to Controlled Affiliates that underwrite the indemnity portion of workers' compensation insurance.

Standard 7 (A): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 7(B): Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Controlled Affiliate Licensure Information Request; and

B. Triennial trade name and service mark usage materials, including disclosure materials; and
C. Annual Certified Audit Report, Annual Statement as filed with the State Insurance Department (with all attachments), Annual NAIC's Risk-Based Capital Worksheets for Property and Casualty Insurers; and

D. Quarterly Estimated Risk-Based Capital for Property and Casualty Insurers, Insurance Department Examination Report; and

Amended as of November 17, 2011

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EXHIBIT A (continued)

E. Notification of all changes and proposed changes to independent ratings within 30 days of receipt and submission of a copy of all rating reports; and
F. Changes in the ownership and governance of the Controlled Affiliate including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 7(C): Loss Prevention

A Controlled Affiliate shall apply loss prevention protocol to both new and existing business.

Standard 7(D): Claims Administration

A Controlled Affiliate shall maintain an effective claims administration process that includes all the necessary functions to assure prompt and proper resolution of medical and indemnity claims.

Standard 7(E): Disability and Provider Management

A Controlled Affiliate shall arrange for the provision of appropriate and necessary medical and rehabilitative services to facilitate early intervention by medical professionals and timely and appropriate return to work.

Amended as of November 16, 2000

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EXHIBIT A (continued)

Standard 8 - Cooperation with Controlled Affiliate License Performance Response Process Protocol

A Controlled Affiliate and its Sponsoring Plan shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Controlled Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing Controlled Affiliate compliance problems identified thereunder.

Standard 9(A) - Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees

A smaller controlled affiliate that formerly was a Primary Licensee shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter-Plan Teleprocessing System (ITS);
- National Account Programs.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Amended as of November 21, 2014

EXHIBIT A (continued)

Standard 9(A) - Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees

C. Reporting requirements include:

- The Semi-annual Health Risk-Based Capital (HRBC) Report.

Amended as of June 13, 2002

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Exhibit A (continued)

Standard 9(B) - Participation in National Programs by Smaller Controlled Affiliates

A smaller controlled affiliate shall participate in national programs in accordance with BlueCard and other relevant Policies and Provisions shall effectively and efficiently participate in national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter-Plan Teleprocessing System (ITS);
- National Account Programs.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Amended as of June 20, 2013

EXHIBIT A (continued)

Standard 10 - Participation in Inter-Plan Medicare Advantage Program

A smaller controlled affiliate for which this standard applies pursuant to the Preamble section of Exhibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area.

National program requirements include:

A. Inter-Plan Medicare Advantage Program.

Standard 11: Participation in Master Business Associate Agreement by Smaller Controlled Affiliate Licensees

Effective April 14, 2003, all smaller controlled affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of September 19, 2014

EXHIBIT B-1
ADDENDUM TO CONTROLLED AFFILIATE LICENSE TO BE EXECUTED BY CONTROLLED AFFILIATES LICENSED UNDER CONTROLLED AFFILIATE LICENSE STANDARD 1C.

ADDENDUM TO CONTROLLED AFFILIATE LICENSE

This Addendum is made to that certain Blue Shield Controlled Affiliate License Agreement executed by and among Blue Cross and Blue Shield Association ("Licensor"), _____ ("Controlled Affiliate Licensee") and _____("Sponsoring Plan") dated the _____ day of _____ , _____ ("Agreement"). The parties to this Addendum are Licensor, Controlled Affiliate Licensee, Sponsoring Plan, and the undersigned other Plans ('Other Plans"). This Addendum is made and shall be deemed effective as of the date of the Agreement.

WHEREAS, the Sponsoring Plan asserts that it can serve the Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans market in its Service Area more efficiently and with less risk through an enterprise jointly owned and controlled with other Plans than through a wholly owned and Controlled Affiliate Licensee;

WHEREAS, in such circumstance Controlled Affiliate License Standard 1C permits the licensing of a Controlled Affiliate that is less than 50% owned and controlled by the Sponsoring Plan but which is 100% owned and controlled by Plans including the Sponsoring Plan, subject to certain conditions;

WHEREAS, one such condition is that the Sponsoring Plan and all such other owning and controlling Plans enter into this Addendum;

NOW THEREFORE, for good and valuable consideration, including the promises and covenants set forth herein, the parties agree as follows:

1. This Addendum is limited to [identify product name].

2. The Sponsoring Plan shall participate operationally in Controlled Affiliate's business that is conducted under the Licensed Marks. The parties understand that participation may take many forms, one of which should be providing a network of providers in the Service Area of the Controlled Affiliate for the Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans services being offered under the Agreement and being involved in network development and provider engagement functions.

3. Each of the Other Plans agrees that (i) it will cooperate fully with the Sponsoring Plan and BCBSA as needed to enable Sponsoring Plan and Controlled Affiliate Licensee to meet their obligations to Licensor under the Agreement and all associated rules and regulations of Licensor, including the Brand Regulations, (ii) it

Amended September 27, 2018

will not take any action, either individually or jointly with any of the Other Plans, that would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement, and (iii) it will not fail to take any action, either individually or jointly with any of the Other Plans, where such failure would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement.

4. Each of the Other Plans acknowledges that it has reviewed the Agreement and understands that Sponsoring Plan has the right to terminate the Agreement without cause upon notice as provided in Paragraph 8 of the Agreement, and that such right is unfettered and may be exercised by Sponsoring Plan in its sole discretion.

WHEREFORE, by signing below the parties agree to be bound to the terms stated herein.

BLUE CROSS BLUE SHIELD ASSOCIATION

By: _____

[Controlled Affiliate Licensee]

By: _____

[Sponsoring Plan]

By: _____

[Other Plan 1]

By: _____

[Other Plan 2]

By: _____

Amended as of September 19, 2014

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EXHIBIT B-2

ADDENDUM TO CONTROLLED AFFILIATE LICENSE TO BE EXECUTED BY CONTROLLED AFFILIATES LICENSED UNDER CONTROLLED AFFILIATE LICENSE STANDARD 1D.

ADDENDUM TO CONTROLLED AFFILIATE LICENSE

This Addendum is made to that certain Blue Shield Controlled Affiliate License Agreement executed by and among Blue Cross and Blue Shield Association ("Licensor"), _____ ("Controlled Affiliate Licensee"), _____("Sponsoring Plan") and _____ ("Participating Plan") dated the _____ day of _____ , _____ ("Agreement").

WHEREAS, the Participating Plan is defined as the Plan that holds the Primary License with BCBSA to use the Service Marks in the Service Area where the Controlled Affiliate will use the Service Marks;

WHEREAS, the Participating Plan asserts that it can offer a lower cost Basic Medicare Part D Prescription Drug Plan product more efficiently in the Participating Plan's Service Area through the Controlled Affiliate Licensee;

WHEREAS, the Controlled Affiliate shall only use the Service Marks inside of the Participating Plan(s) Service Area subject to each Participating Plan signing a separate Addendum;

WHEREAS, in such circumstance Controlled Affiliate License Standard 1D permits the licensing of a Controlled Affiliate that is 100% owned and controlled by a Sponsoring Plan, subject to certain conditions;

WHEREAS, one such condition is that the Sponsoring Plan, Controlled Affiliate and the Participating Plan enter into this Addendum;

NOW THEREFORE, for good and valuable consideration, including the promises and covenants set forth herein, the parties agree as follows:

1. The Participating Plan shall participate in Controlled Affiliate's business that is conducted under the Licensed Marks. The parties understand that the Participating Plan shall conduct sales support and marketing of the Controlled Affiliate's Basic Medicare Part D Prescription Drug Plan product offered in the Participating Plan's Service Area. Any other form of participation shall require BCBSA's written approval.
2. Participating Plan agrees that (i) it will cooperate fully with the Sponsoring Plan and BCBSA as needed to enable Sponsoring Plan and

Controlled Affiliate Licensee to meet their obligations to Licensor under the Agreement and all associated rules and regulations of Licensor, including the Brand Regulations, (ii) it will not take any action that would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement, and (iii) it will not fail to take any action, either individually or jointly with the Sponsoring Plan or Controlled Affiliate Licensee, where such failure would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement.

3. The Controlled Affiliate Licensee shall only use the Licensed Marks authorized by the Participating Plan in connection with the Basic Medicare Part D Prescription Drug Plan product offered in the Participating Plan's Service Area.

4. The Sponsoring Plan and Controlled Affiliate acknowledge that it has reviewed the Agreement and understands that Participating Plan has the right to terminate this Agreement: (i) immediately upon the expiration or termination of the Plan Participation Agreement by and between Participating Plan and Controlled Affiliate upon written notice to the Sponsoring Plan, Controlled Affiliate Licensee and Licensor, or (ii) without cause upon 18 months written notice to the Sponsoring Plan, Controlled Affiliate Licensee and Licensor, and that such right is unfettered and may be exercised by Participating Plan in its sole discretion. In the event that Participating Plan and Controlled Affiliate fail to execute the Plan Participation Agreement by _____(Date), Participating Plan may terminate this Agreement immediately upon notice to Sponsoring Plan, Controlled Affiliate Licensee and Licensor.

5. This Agreement and all of Controlled Affiliate Licensee's rights hereunder shall immediately terminate without any further action by any party or entity in the event that the Sponsoring Plan or Participating Plan ceases to be authorized to use the Licensed Marks and Name.

WHEREFORE, by signing below the parties agree to be bound to the terms stated herein.

BLUE CROSS BLUE SHIELD ASSOCIATION

By: _____

[Controlled Affiliate Licensee]

By: _____

[Sponsoring Plan]

By: _____

[Participating Plan]

By: _____

Amended March 17, 2016

EXHIBIT C
ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENT

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

FOR RISK PRODUCTS:

For Controlled Affiliates not underwriting the indemnity portion of workers' compensation insurance:

An amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For Controlled Affiliates underwriting the indemnity portion of workers' compensation insurance:

An amount equal to 0.35 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus, an annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 7.

Amended as of September, 19, 2014

EXHIBIT C (continued)

FOR NONRISK PRODUCTS:

For third-party administrative business, an amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For non-third party administrative business (e.g., case management, provider networks, etc.), an amount equal to 0.24 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus:

1) An annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 6 D.

2) An annual fee of $2,000 per license for all other Controlled Affiliates.

The foregoing shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® License are issued to the same Controlled Affiliate. In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Amended as of September 19, 2014

EXHIBIT 1A

CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO LIFE INSURANCE COMPANIES
(Includes revisions adopted by Member Plans through their September 27, 2018 meeting)

This agreement by and among Blue Cross and Blue Shield Association ("BCBSA") _____("Controlled Affiliate"), a Controlled Affiliate of the Blue Shield Plan(s), known as _____("Plan").

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, the Plan and the Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name");

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Controlled Affiliate the exclusive right to use the licensed Marks and Names in connection with and only in connection with those life insurance and related services authorized by applicable state law, other than health care plans and related services (as defined in the Plan's License Agreements with BCBSA) which services are not separately licensed to Controlled Affiliate by BCBSA, in the Service Area served by the Plan, except that BCBSA reserves the right to use the Licensed Marks and Name in said Service Area, and except to the extent that said Service Area may overlap the area or areas served by one or more other licensed Blue Shield Plans as of the date of this License as to which overlapping areas the rights hereby granted are non-exclusive as to such other Plan or Plans and their respective Licensed Controlled Affiliates only. Controlled Affiliate cannot use the Licensed Marks or Name outside the Service Area or in its legal or trade name; provided, however, that if and only for so long as Controlled Affiliate also holds a Blue Shield Affiliate License Agreement applicable to health care plans and related services, Controlled Affiliate may use the Licensed Marks and Name in its legal and trade name according to the terms of such license agreement.

Amended as of June 12, 2003

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in relation to the sale, marketing and rendering of authorized products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A as it may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans. Absent written approval by BCBSA of an alternative method of control, bona fide control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having not less than 51% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Plan or Plans shall own at least 51% of any for-profit Controlled Affiliate. If the Controlled Affiliate is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items (a) and (c) above, proxies representing 51% of the votes at any meeting of the policyholders and shall demonstrate that there is no reason to believe this such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

3. SERVICE MARK USE

Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks, and shall comply with such rules (applicable to all Controlled Affiliates licensed to use the Marks) relative to service mark use, as are issued from time-to-time by BCBSA. If there is any public reference to the affiliation between the Plan and the Controlled Affiliate, all of the Controlled Affiliate's licensed services in the Service Area of the Plan shall be rendered under the Licensed Marks. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENTS

Controlled Affiliate shall promptly notify Plan and BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate hereby agrees to save, defend, indemnify and hold Plan and BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Controlled Affiliate's rendering of health care services under the Licensed Marks.

7. LICENSE TERM

The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods upon evidence satisfactory to the Plan and BCBSA that Controlled Affiliate meets the then applicable quality control standards, unless one of the parties hereto notifies the other party of the termination hereof at least sixty (60) days prior to expiration of any license period.

This Agreement may be terminated by the Plan or by BCBSA for cause at any time provided that Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Controlled Affiliate's failure to abide by the quality control provisions of Paragraph 2, above, shall be considered a proper ground for cancellation of this Agreement.

This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

A. Controlled Affiliate shall no longer comply with Standard No. 1 (Organization and Governance) of Exhibit A or, following an opportunity to cure, with the remaining quality control provisions of Exhibit A, as it may be amended from time-to-time; or

B. Plan ceases to be authorized to use the Licensed Marks; or

C. Appropriate dues for Controlled Affiliate pursuant to item 8 hereof, which are the royalties for this License Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks including any use in its trade name.

In the event of any disagreement between Plan and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of the Blue Cross and Blue Shield Association and provide instruction on how the customer can contact the Blue Cross and Blue Shield Association or a designated licensee to obtain further information on securing coverage. The written notification required by this paragraph shall be in writing and in a form approved by the Association. The Association shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. <u>DUES</u>

Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

Ÿ An annual fee of five thousand dollars ($5,000) per license, plus

Ÿ.05% of gross revenue per year from branded group products, plus

Ÿ.5% of gross revenue per year from branded individual products plus

Ÿ.14% of gross revenue per year from branded individual annuity products.

The foregoing percentages shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® license are issued to the same entity. In the event that any License period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Plan will promptly and timely transmit to BCBSA all dues owed by Controlled Affiliate as determined by the above formula and if Plan shall fail to do so, Controlled Affiliate shall pay such dues directly.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

9A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

10. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

Amended as of November 20, 1997

11. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by a writing executed by all parties.

12. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way effect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

13. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

Amended as of June 16, 2005

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IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: _

Date: _

Controlled Affiliate

By: _

Date: _

Plan

By: _

Date: _

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EXHIBIT A
CONTROLLED AFFILIATE LICENSE STANDARDS
LIFE INSURANCE COMPANIES
Page 1 of 2

PREAMBLE

The standards for licensing Life Insurance Companies (Life and Health Insurance companies, as defined by state statute) are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote of all Plans. Each Licensed Plan is required to use a standard controlled affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Life Insurance Company maintains compliance with the license standards.

An organization meeting the following standards shall be eligible for a license to use the Licensed Marks within the service area of its sponsoring Licensed Plan to the extent and the manner authorized under the Controlled Affiliate License applicable to Life Insurance Companies and the principal license to the Plan.

Standard 1 - Organization and Governance

The LIC shall be organized and operated in such a manner that it is controlled by a licensed Plan or Plans which have, directly or indirectly: 1) not less than 51% of the voting control of the LIC; and 2) the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the LIC with which it does not concur; and 3) operational control of the LIC.

If the LIC is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items 1 and 2 above, proxies representing at least 51% of the votes at any policyholder meeting and shall demonstrate that there is no reason to believe such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

Standard 2 - State Licensure

The LIC must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life and health insurance company in each state in which the LIC does business.

Standard 3 - Records and Examination

The LIC and its sponsoring licensed Plan(s) shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the LIC as may be required in order to establish compliance with the license agreement.

EXHIBIT A
CONTROLLED AFFILIATE LICENSE STANDARDS
LIFE INSURANCE COMPANIES
Page 2 of 2

LIC and its sponsoring licensed Plan(s) shall permit BCBSA to examine the affairs of the LIC and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the sponsoring Plan(s).

Standard 4 - Mediation

The LIC and its sponsoring Plan(s) shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed controlled affiliate, a licensed Plan or BCBSA.

Standard 5 - Financial Responsibility

The LIC shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with Affiliate License Performance Response Process Protocol

The LIC and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing LIC compliance problems identified thereunder.

Exhibit 10.13

CONTROLLED AFFILIATE
TRADEMARK LICENSE AGREEMENT
FOR LIFE AND DISABILTY INSURANCE PRODUCTS

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____, (“Life and Disability Controlled Affiliate”) which is a company offering life and disability insurance products owned and controlled by _____, _____, _____ (individually, “Sponsoring Plan” and when referred to collectively, “Sponsoring Plans”).

Whereas, BCBSA is the owner of the BLUE CROSS and BLUE SHIELD word and design service marks and any derivatives thereof (“Licensed Marks”);

Whereas, each Sponsoring Plan is licensed separately by BCBSA to use one or more of the Licensed Marks in a particular Service Area;

Whereas, the Sponsoring Plans and the Life and Disability Controlled Affiliate desire that the latter be entitled to use the appropriate Licensed Marks in connection with life and disability insurance products in some or all of such Sponsoring Plans’ Service Areas and in the Service Areas of other Regular Member Plans, as defined in the BCBSA By-laws, (“Blue Plans”) consistent with the terms of this Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. <u>GRANT OF LICENSE</u>

A. Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Life and Disability Controlled Affiliate the limited right to use the Licensed Marks in connection with and only in connection with the following life and disability insurance products authorized by state law: (1) Group: Term Life, Long Term Disability, Whole Life, Benefit Life, Universal Life; (2) Individual: Term Life, Whole Life, Dependent Life, Spouse Life; (3) Other: Disability Income, Short Term Disability, Long Term Disability, Income Replacement; and (4) such other life and disability products approved by BCBSA in writing (“Licensed Products”) in the Service Areas served by the Sponsoring Plans or in the Service Area or Areas of one or more other licensed Blue Plans, provided that such Blue Plans have consented to such use as authorized by this Agreement. Life and Disability Controlled Affiliate may not use the Licensed Marks in its legal or trade name.

B. Notwithstanding that the license granted to Life and Disability Controlled Affiliate is a license to use all of the Licensed Marks, Life and Disability Controlled Affiliate may only use those of the Licensed Marks in the Service Area of a Sponsoring Plan or other consenting Blue Plan as described below that such Plan is authorized to use as a Blue Plan pursuant to its separate license agreements with BCBSA.

C. Life and Disability Controlled Affiliate may use the Licensed Marks in the Service Areas of Sponsoring Plans or in the Service Area of a Blue Plan that is not a signatory to this Agreement only after such Sponsoring Plan(s) or non-signatory Blue Plan consents to such use by executing a written consent in substantially the same form as the Consent Agreement attached as Exhibit B.

D. The following provisions apply with respect to Consent Agreements once such agreements have been fully and properly executed:

(1) All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in the Service Area of Sponsoring Plan or consenting Blue Plan (hereinafter, such consenting Sponsoring Plan or consenting Blue Plan collectively referred to “Consenting Plan(s)”) must clearly identify the Consenting Plan (for example, a statement on such materials that reads “This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]”);

(2) To the extent the Consenting Plan has separate divisions or other Affiliates that use the Licensed Marks in distinct geographic areas within its Service Area, consent obtained under this Agreement may be limited to one or more of such specific geographic areas as specified by the Consenting Plan in its signed Consent Agreement. For purposes of this entire Agreement, all references to the Service Area of a Sponsoring Plan, Blue Plan or Consenting Plan may include the entire Service Area or a distinct geographic area within such Service Area as specified in this Section 1 D (2);

(3) Where BCBSA has licensed two or more Blue Plans to use the same Licensed Marks in the same Service Area, in addition to the requirements set forth in Section D (1) above, the sales, marketing and advertising materials referenced in such section above must be communicated to the Consenting Plan’s existing and prospective accounts through or with the approval of such Consenting Plan, and the personnel of such Consenting Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the Consenting Plan;

(4) Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the Consenting Plan has been granted by BCBSA the license to use under its Blue Plan license agreements (for example, if a Consenting Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).

(5) If a Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless BCBSA and the Consenting Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.

2. QUALITY CONTROL

A. Life and Disability Controlled Affiliate agrees to use the Licensed Marks only in relation to the sale, marketing and administration of the Licensed Products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A and the Guidelines to Administer the Standards for Trademark License Agreement for Life and Disability Insurance Products attached thereto.

B. Life and Disability Controlled Affiliate agrees that BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Life and Disability Controlled Affiliate's rendering of service and use of the Licensed Marks.

C. Life and Disability Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by BCBSA) a report to BCBSA demonstrating Life and Disability Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Life and Disability Controlled Affiliate is defined as: An entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance

thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

3. SERVICE MARK USE

Life and Disability Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and shall ensure all uses of the Licensed Marks comply with the BCBSA Brand Regulations, as amended by BCBSA from time to time. Life and Disability Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Life and Disability Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

The license hereby granted to Life and Disability Controlled Affiliate to use the Licensed Marks is and shall be personal to Life and Disability Controlled Affiliate and shall not be assignable by any act of the Life and Disability Controlled Affiliate, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Life and Disability Controlled Affiliate mortgage or part with possession or control of this license or any right hereunder, and the Life and Disability Controlled Affiliate shall have no right to grant any sublicense to use the Licensed Marks.

5. INFRINGEMENTS

Life and Disability Controlled Affiliate shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Life and Disability Controlled Affiliate shall not be entitled to require BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Life and Disability Controlled Affiliate agrees to render to BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA. BCBSA shall have sole control of the defense and resolution of any claim of infringement brought or threatened by others.

6. LIABILITY INDEMNIFICATION

Life and Disability Controlled Affiliate hereby agrees to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Life and Disability Controlled Affiliate's conduct.

7. LICENSE TERM

A. The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods, unless either BCBSA or Life and Disability Controlled Affiliate notifies the other party in writing of the termination hereof at least sixty (60) days prior to expiration of any license period.

B. This Agreement may be terminated by BCBSA for cause at any time provided that Life and Disability Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Life and Disability Controlled Affiliate's failure to abide by the conditions regarding use of the Licensed Marks set forth in Section 1 of this Agreement or the quality control provisions of Section 2 (other than with respect to Section 2 D which is subject to immediate termination as stated in Section 7 C (1) below) shall be considered proper grounds for termination of this Agreement.

C. This Agreement and all of Life and Disability Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Life and Disability Controlled Affiliate shall no longer comply with Section 2 D (or Standard No. 1 (Organization and Governance) of Exhibit A); or

(2) Any Sponsoring Plan ceases to be authorized to use the Licensed Marks; or

(3) Appropriate fees for Life and Disability Controlled Affiliate pursuant to Section 8 of this Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Life and Disability Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks.

In the event of any disagreement between Life and Disability Controlled Affiliate and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Life and Disability Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. ROYALTIES

Life and Disability Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

- An annual fee of five thousand dollars ($5,000) per license, plus
- .05% of gross revenue per year from group products sold under the Licensed Marks, plus
- .5% of gross revenue per year from individual products sold under the Licensed Marks

In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Life and Disability Controlled Affiliate will promptly and timely transmit to BCBSA all fees owed by Life and Disability Controlled Affiliate as determined by the above formula.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between any Sponsoring Plan and Life and Disability Controlled Affiliate or between among them and/or BCBSA.

10. VOTING

For all provisions of this Agreement referring to voting, the term ‘Plans’ shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the

Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by: (a) a writing signed by all parties; or (b) a writing approved by the affirmative vote of three-fourths of the Blue Plans and three-fourths of the total then current weighted vote of all the Blue Plans as officially recorded by the BCBSA Corporate Secretary. Upon such adoption by the Blue Plans, this Agreement and all other Trademark License Agreements for Life and Disability Insurance Products then in effect shall simultaneously be amended.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Life and Disability Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

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IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: _

Date: _

Life and Disability Controlled Affiliate:

By: _

Date: _

Sponsoring Plan:

By: ___

Date: _

Name:_____

Sponsoring Plan:

By: ___

Date: _

Name:_____

[Add other Sponsoring Plans as necessary]

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EXHIBIT A

LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS
Page 1 of 2

Standard 1 - Organization and Governance

Any Life and Disability Controlled Affiliate licensed under the Trademark License Agreement for Life and Disability Insurance Products ("licensee") shall be organized and operated in such a manner that it is an entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

Standard 2 - State Licensure

The licensee must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life company in each state in which the licensee does business.

Standard 3 - Records and Examination

The licensee shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the licensee as may be required in order to establish compliance with the Agreement. The licensee shall permit BCBSA to examine the affairs of the licensee and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the Sponsoring Plan(s).

Standard 4 - Mediation

The licensee, its Sponsoring Plan(s) and all consenting Blue Plans shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed Life and Disability Controlled Affiliate, a Sponsoring Plan and or consenting Blue Plan or BCBSA.

EXHIBIT A
LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS
Page 2 of 2

Standard 5 - Financial Responsibility

The licensee shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with BCBSA Governance

The licensee shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of and in addressing licensee compliance problems that may be identified in connection with the operation or administration of the Trademark License Agreement for Life and Disability Insurance Products.

EXHIBIT B

CONSENT AGREEMENT

This Consent Agreement is made and entered into by and among the undersigned Blue Plan, and _____ ("Life and Disability Controlled Affiliate"), and the Blue Cross and Blue Shield Association ("BCBSA") and shall be deemed effective on _____ ("Effective Date").

Whereas, BCBSA owns the Blue Cross and Blue Shield word and design service marks and any derivative mark thereof (the "Brands");

Whereas, the undersigned Blue Plan is licensed to use one or more of the Brands within a specific geographic area ("Service Area");

Whereas Life and Disability Controlled Affiliate is licensed by BCBSA to use one or more of the Brands to offer life and disability insurance products ("Products") as defined and authorized in the Trademark License Agreement for Life and Disability Insurance Products ("Life and Disability License Agreement");

Whereas neither the Blue Plan nor its affiliates offer the Products under any of the Brands in such Blue Plan's Service Area or portion thereof where Blue Plan has consented to sale of the Products by Life and Disability Controlled Affiliate; and

Whereas BCBSA and the undersigned Blue Plan desire to consent to Life and Disability Controlled Affiliate's use of the Brands in Blue Plan's Service Area consistent with the terms of the Life and Disability License Agreement and this Consent Agreement.

Now, therefore, in consideration of the obligations and conditions stated in this Agreement, Blue Plan, Life and Disability Controlled Affiliate and BCBSA agree as follows:

1. Life and Disability Controlled Affiliate may market, sell, administer and underwrite the Products in Blue Plan's Service Area under the Brands licensed to Blue Plan in such Service Area subject to the terms of this Consent Agreement, the Life and Disability License Agreement and Blue Plan's license agreement(s) with BCBSA. Life and Disability Controlled Affiliate's rights under the Brands to offer the Products under the Brands are limited to offering the Products only under the Brand(s) licensed to the consenting Blue Plan.

2. Life and Disability Controlled Affiliate shall work with the undersigned Blue Plan to develop a written sales and marketing agreement that
identifies the relationship between it and Blue Plan for the sales,

marketing and customer service for the Products. The term of the sales and marketing agreement shall be the same as the term of this Consent Agreement.

3. All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in a consenting Blue Plan's Service Area must clearly identify the consenting Blue Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");

4. Life and Disability Controlled Affiliate may use the Brands to sell the Products in the following Service Area or portion thereof as designated by Blue Plan:

_____

5. If two or more Blue Plans to use the same Licensed Marks in the same Service Area, Life and Disability Controlled Affiliate shall work with the consenting Blue Plan in the following manner: (a) the sales, marketing and advertising materials must be communicated to the consenting Blue Plan's existing and prospective accounts through or with the approval of such Blue Plan, and (b) the personnel of such Blue Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the consenting Blue Plan;

6. Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the consenting Blue Plan has been granted by BCBSA the license to use under its license agreement (for example, if a consenting Blue Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).

7. If this Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless each BCBSA and the Blue Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.

8. The term of this Consent Agreement shall be one year from the Effective Date. Unless either Blue Plan or Life and Disability Controlled Affiliate provides the other party with written notice of its desire not to renew this Consent Agreement at least 60 days prior to expiration of the term or any extended term or unless terminated as provided in Paragraph 9 below, this Consent Agreement shall automatically renew for subsequent one year periods.

9. This Consent Agreement may be terminated as follows:

   A. Upon mutual written consent of Life and Disability Controlled Affiliate and Blue Plan;

   B. By Blue Plan or Life and Disability Controlled Affiliate upon 60 days advance written notice to the non-terminating party and BCBSA; or

   C. By Blue Plan immediately if Life and Disability Controlled Affiliate does not comply with this Consent Agreement or the sales protocol agreement.

10. This Consent Agreement shall automatically terminate if Blue Plan's primary licensee agreement terminates for any reason or if the Life and Disability License Agreement terminates for any reason.

Agreed and Accepted by:

[Blue Plan]:

By:_____

Title:_____

BLUE CROSS AND BLUE SHIELD ASSOCIATION:

By:_____

Title:_____

LIFE AND DISABILITY CONTROLLED AFFILIATE:

By:_____

Title:_____

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Exhibit 1B

BLUE SHIELD
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS
(Adopted by Member Plans at their September 27, 2018)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Advantage PPO products in geographic regions designated by CMS (hereafter "regional MAPPO products").

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name") to offer regional MAPPO products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. <u>GRANT OF LICENSE</u>

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional MAPPO products and related services.

This grant of rights is non-exclusive and is limited to the following states: _____ (the "Region"). Controlled Affiliate may use the Licensed

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Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) to exercise control over the policy and operations of the Controlled Affiliate; and Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional MAPPO products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Shield License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking

appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or

proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this
paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall

have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x)(ii) of the Blue Shield License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the

foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other

Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the
Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By:_____

Date:_____

Controlling Plan:

By: _____

Date:_____

Controlling Plan:

By: _____

Date:_____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____

Date:_____

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EXHIBIT A

**CONTROLLED AFFILIATE LICENSE STANDARDS
APPLICABLE TO REGIONAL MEDICARE
ADVANTAGE PPO PRODUCTS
September 2018**

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Advantage PPO Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

(b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) exercise control over the policy and operations of the Controlled Affiliate; and

EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

a. the structure of the Blue Cross and Blue Shield System; and
b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Shield Marks.

Standard 7 - Participation in Certain National Programs

A Controlled Affiliate shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area.

National program requirements include:

a. Inter-Plan Teleprocessing System (ITS); and

b. Inter-Plan Medicare Advantage Program.

Standard 8 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of November 15, 2007

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EXHIBIT B

**ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS**

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional MAPPO products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

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Exhibit 1C

BLUE SHIELD
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS
(Adopted by Member Plans at their September 27, 2018 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Part D Prescription Drug Plan products in geographic regions designated by CMS (hereafter "regional PDP products").

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name") to offer regional PDP products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. <u>GRANT OF LICENSE</u>

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional PDP products and related services.

This grant of rights is non-exclusive and is limited to the following states: _____ (the "Region"). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional PDP products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Shield License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to

complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim

trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x)(ii) of the Blue Shield License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license

termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By:_____

Date:_____

Controlling Plan:

By: _____

Date:_____

Controlling Plan:

By: _____

Date:_____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____

Date:_____

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EXHIBIT A

**CONTROLLED AFFILIATE LICENSE STANDARDS
APPLICABLE TO REGIONAL MEDICARE
PART D PRESCRIPTION DRUG PLAN PRODUCTS
September 2018**

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Part D Prescription Drug Plan Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

(b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) exercise control over the policy and operations of the Controlled Affiliate; and

EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

a. the structure of the Blue Cross and Blue Shield System; and
b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Shield Marks.

Standard 7 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

EXHIBIT B

**ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS**

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional PDP products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

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EXHIBIT 2

Membership Standards
Page 1 of 5

Preamble

The Membership Standards apply to all organizations seeking to become or to continue as Regular Members of the Blue Cross and Blue Shield Association. Any organization seeking to become a Regular Member must be found to be in substantial compliance with all Membership Standards at the time membership is granted and the organization must be found to be in substantial compliance with all Membership Standards for a period of two (2) years preceding the date of its application. If Membership is sought by an entity which controls or is controlled by one or more Plans, such compliance shall be determined on the basis of compliance by such Plan or Plans.

The Regular Member Plans shall have authority to interpret these Standards.

A Regular Member Plan that operates as a “Shell Holding Company” is defined as an entity that assumes no underwriting risk and has less than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) and less than 5% of the consolidated enterprise net general and administrative expenses.

A Regular Member Plan that operates as a “Hybrid Holding Company” is defined as an entity that assumes no underwriting risk and has either more than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) or more than 5% of the consolidated enterprise net general and administrative expenses.

Standard 1:	A Plan shall maintain a governing Board, which shall control the Plan and ensure that the Plan follows appropriate practices of corporate governance. A Plan's Board shall not be controlled by any special interest group, shall make an annual determination that a majority of its directors are independent, and shall act in the best interest of its Corporation and its customers. The Board shall be composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Amended as of March 15, 2007

EXHIBIT 2
Membership Standards
Page 2 of 5

Standard 2: A Plan shall furnish to the Association on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between the Association and the Plans. Such reports and records are the following:

A. BCBSA Membership Information Request;

B. Triennial trade name and service mark usage material, including disclosure material under Standard 7;

C. Changes in the governance of the Plan, including changes in a Plan's Charter, Articles of Incorporation, or Bylaws, changes in a Plan's Board composition, or changes in the identity of the Plan's Principal Officers;

D. Quarterly Financial Report, Semi-annual “Health Risk-Based Capital (HRBC) Report” as defined by the NAIC, Annual Budget, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), Plan, Subsidiary and Affiliate Report; and

•Plans that are a Shell Holding Company as defined in the Preamble hereto are required to furnish only a calendar year-end “Health Risk-Based Capital (HRBC) Report” as defined by the NAIC.

Amended as of November 17, 2011

EXHIBIT 2

Membership Standards
Page 3 of 5

E. Quarterly Enrollment Report, Quarterly Member Touchpoint Measures Index (MTM) through 12/31/2011, and Semi-annual MTM Index starting 1/1/2012 and thereafter.

•For purposes of MTM reporting only, a Plan shall file a separate MTM report for each Geographic Market.

Standard 3: A Plan shall be operated in a manner that provides reasonable financial assurance that it can fulfill its contractual obligations to its customers.

Standard 4: A Plan shall be operated in a manner responsive to customer needs and requirements.

Standard 5: A Plan shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the Plans and ease of claims processing for customers receiving benefits outside of the Plan's Service Area.

Such programs are applicable to Blue Cross and Blue Shield Plans, and include:

A. Inter-Plan Teleprocessing System (ITS);
B. BlueCard Program;
C. National Account Programs;
D. Business Associate Agreement for Blue Cross and Blue Shield Licensees, effective April 14, 2003; and
E. Inter-Plan Medicare Advantage Program.

Amended as of November 21, 2014

EXHIBIT 2

Membership Standards
Page 4 of 5

Standard 6: In addition to requirements under the national programs listed in Standard 5: Participation in National Programs, a Plan shall take such action as required to ensure its financial performance in programs and contracts of an inter-Plan nature or where the Association is a party.

Standard 7: A Plan shall make adequate disclosure in contracting with third parties and in disseminating public statements of (i) the structure of the Blue Cross and Blue Shield System, (ii) the independent nature of every Plan, and (iii) the Plan's financial condition.

Standard 8: A Plan shall cooperate with the Association's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Plan Performance Response Process and in addressing Plan performance problems identified thereunder.

Standard 9: A Plan shall obtain a rating of its financial strength from an independent rating agency approved by the Association's Board of Directors for such purpose.

Standard 10: Notwithstanding any other provision in this License Agreement, during each year, a Plan and its Controlled Affiliate(s) engaged in providing licensable services (excluding Life Insurance and Charitable Foundation Services) shall use their best efforts to promote and build the value of the Blue Shield Marks.

Standard 11: Neither a Plan nor any Larger Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Plan or Larger Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Amended as of June 16, 2005

EXHIBIT 2

Membership Standards
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StandardNo provider network, or portion thereof, shall be rented or otherwise made available to a National Competitor 12:	if the Licensed Marks or Names are used in any way with such network. A provider network may be rented or otherwise made available, provided there is no use of the Licensed Marks or Names with respect to the network being rented.
StandardEach Plan shall operate in a manner to reasonably: 1) protect the security and confidentiality of Personally 13:	Identifiable Information (PII) and Protected Health Information (PHI); 2) protect the Brands from reputational damage; and 3) cooperate with BCBSA and other Plans if a data security incident or data breach occurs.

Amended as of June 18, 2015

EXHIBIT 3

**GUIDELINES WITH RESPECT TO USE OF
LICENSED NAME AND MARKS IN CONNECTION WITH NATIONAL ACCOUNTS**

Page 1 of 3

1. The strength of the Blue Cross/Blue Shield National Accounts mechanism, and the continued provision of cost effective, quality health care benefits to National Accounts, are predicated on locally managed provider networks coordinated on a national scale in a manner consistent with effective service to National Account customers and consistent with the preservation of the integrity of the Blue Cross/Blue Shield system and the Licensed Marks. These guidelines shall be interpreted in keeping with such ends.

2. A National Account is an entity with employee and/or retiree locations in more than one Plan's Service Area. Unless otherwise agreed, a National Account is deemed located in the Service Area in which the corporate headquarters of the National Account is located. A local plant, office or division headquarters of an entity may be deemed a separate National Account when that local plant, office or division headquarters 1) has employee locations in more than one Service Area, and 2) has independent health benefit decision-making authority for the employees working at such local plant, office or division headquarters and for employees working at other locations outside the Service Area. In such a case, the local plant, office or division headquarters is a National Account that is deemed located in the Service Area in which such local plant, office or division headquarters is located. The Control Plan of a National Account is the Plan in whose Service Area the National Account is located. A participating ("Par") Plan is a Plan in whose Service Area the National Account has employee and/or retiree locations, but in which the National Account is not located. In the event that a National Account parent company consolidates health benefit-decision making for itself and its wholly-owned subsidiary companies, the parent company and the subsidiary companies shall be considered one National Account. The Control Plan for such a National Account shall be the Plan in whose Service Area the parent company headquarters is located.

3. The National Account Guidelines enunciated herein below shall be applicable only with respect to the business of new National Accounts acquired after January 1, 1991.

4. Control Plans shall utilize National Account identification cards complying with then currently effective BCBSA graphic standards in connection with all National Accounts business to facilitate administration thereof, to minimize subscriber and provider confusion, and to reflect a commitment to cooperation among Plans.

Amended as of June 12, 2003

Exhibit 3

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5. Disputes among Plans and/or BCBSA as to the interpretation or implementation of these Guidelines or as to other National Accounts issues shall be submitted to mediation and mandatory dispute resolution as provided in the License Agreement. For two years from the effective date of the License Agreement, however, such disputes shall be subject to mediation only, with the results of such mediation to be collected and reported in order to establish more definitive operating parameters for National Accounts business and to serve as ground rules for future binding dispute resolution.

6. The Control Plan may use the BlueCard Program (as defined by IPPC) to deliver benefits to employees and non-Medicare eligible retirees in a Participating Plan's service area if an alternative arrangement with the Participating Plan cannot be negotiated. The Participating Plan's minimum servicing requirement for those employees and non-Medicare retirees in its service area is to deliver benefits using the BlueCard Program. Account delivery is subject to the policies, provisions and procedures of the BlueCard Program.

7. For provider payments in a Participating Plan's area (on non-BlueCard claims), payment to the provider may be made by the Participating Plan or the Control Plan at the Participating Plan's option. If the Participating Plan elects to pay the provider, it may not withhold payment of a claim verified by the Control Plan or its designated processor, and payment must be in conformity with service criteria established by the Board of Directors of BCBSA (or an authorized committee thereof) to assure prompt payment, good service and minimum confusion with providers and subscribers. The Control Plan, at the Participating Plan's request, will also assure that measures are taken to protect the confidentiality of the data pertaining to provider reimbursement levels and profiles.

Amended as of June 14, 1996

Exhibit 3

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8. The Control Plan, in its financial agreements with a National Account, is expected to reasonably reflect the aggregate amount of differentials passed along to the Control Plan by all Participating Plans in a National Account.

9. Other than in contracting with health care providers or soliciting such contracts in areas contiguous to a Plan's Service Area in order to serve its subscribers or those of its licensed Controlled Affiliate residing or working in its Service Area, a Control Plan may not use the Licensed Marks and/or Name, as a tag line or otherwise, to negotiate directly with providers outside its Service Area.

Amended as of March 13, 2003

EXHIBIT 4

GOVERNMENT PROGRAMS AND CERTAIN OTHER USES

Page 1 of 14

1. A Plan and its licensed Controlled Affiliate may use the Licensed Marks and Name in bidding on and executing a contract to serve a Government Program, and in thereafter communicating with the Government concerning the Program. With respect, however, to such contracts entered into after the 1st day of January, 1991, the Licensed Marks and Name will not be used in communications or transactions with beneficiaries or providers in the Government Program located outside a Plan's Service Area, unless the Plan can demonstrate to the satisfaction of BCBSA's governing body that such a restriction on use of the Licensed Marks and Name will jeopardize its ability to procure the contract for the Government Program. As to both existing and future contracts for Government Programs, Plans will discontinue use of the Licensed Marks and Name as to beneficiaries and Providers outside their Service Area as expeditiously as circumstances reasonably permit. Effective January 1, 1995, except as provided in the first sentence above, all use by a Plan of the Licensed Marks and Name in Government Programs outside of the Plan's Service Area shall be discontinued. Incidental communications outside a Plan's Service Area with resident or former resident beneficiaries of the Plan, and other categories of necessary incidental communications approved by BCBSA, are not prohibited. For purposes of this Paragraph 1, the term “Government Programs” shall mean Medicare Part A, Medicare Part B and other non-risk government programs.

2. In connection with activity otherwise in furtherance of the License Agreement, a Plan and its Controlled Affiliates that are licensed to use the Licensed Marks and Name in its Service Area pursuant to the Controlled Affiliate License Agreements authorized in clauses a) through c) of Paragraph 2 of the Plan’s License Agreement with BCBSA may use the Licensed Marks and Name outside the Plan’s Service Area in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

2.1 Common Business Communications

a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);

b. distributing business cards other than in marketing and selling;

c. advertising in publications or electronic media solely to persons for employment;

Amended as of June 19, 2014

EXHIBIT 4

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2.2 Marketing Spillover

a. advertising in print, electronic or other media which serve, as a substantial market, the Service Area of the Plan or licensed Controlled Affiliate, provided that no Plan or Controlled Affiliate may advertise outside its Service Area on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Service Area;

b. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Plan's Service Area or that of a licensed Controlled Affiliate;

2.3 Provider Contracting

a. contracting with health care providers or soliciting such contracts in areas contiguous to the Plan's Service Area in order to serve its subscribers or those of such licensed Controlled Affiliates residing or working in its service area;

b. issuing a small sign containing the legal name or trade name of the Plan or such licensed Controlled Affiliates for display by a provider to identify the latter as a participating provider of the Plan or Controlled Affiliate;

c. negotiating rates with a health care provider for services to a specific member, provided that all of the following conditions are met:

(1) the health care provider does not have a contract, applicable to the services rendered or to be rendered, with the Licensee (or any of the Licensees in the case of overlapping Service Areas) in whose Service Area the health care provider is located; and

(2) the Plan or Controlled Affiliate reasonably determines that the member did/does not have a reasonable opportunity to access a participating provider whose contract applies to the services rendered or to be rendered; and

(3) at least one of the following circumstances exists:

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EXHIBIT 4

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(i) the member received emergency services and the Plan or Controlled Affiliate knows or reasonably anticipates that the charges on the claim will meet or exceed $5,000; or

(ii) a provider, in consultation pre- or post- treatment with the Plan or Controlled Affiliate, makes/made a treatment recommendation or referral to a non-par provider or to a par provider whose contract does not apply to the services to be rendered; or

(iii) the member inadvertently accessed a non-par provider or non-contracted services in the course of receiving services from a par provider (e.g., the member sees a non-par consulting specialist in a participating hospital); and

(4) the Licensee (and in the case of overlapping Service Areas, all of the Licensees) in whose Service Area the health care provider is located consent(s) in advance.

d. contracting with a pharmacy management organization ("Pharmacy Intermediary") to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;

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EXHIBIT 4

e. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided that (1) the Plan and the Controlled Affiliate may
not contract directly with pharmacists or pharmacy stores outside the Plan's Service Area, and (2) neither the Plan's or the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Plan's Service Area;

f. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;

g. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;

h. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Plan's Service Area;

i. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Plan's Service Area;

j. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Plan's Service Area;

EXHIBIT 4

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k. contracting with a company that operates provider sites in the Plan's Service Area, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Plan's Service Area;

l. contracting with a company that makes health care professionals available in the Plan's Service Area (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Plan's Service Area.

2.4 Services to National Accounts

a. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee (as those terms are defined in the Inter-Plan Programs Policies and Provisions ("IP Policies")) to offer Blue-branded Health Coverage to the National Account, offering Blue-branded Health and Wellness Programs to all members of the National Account, including members who have not enrolled in the Blue-branded Health Coverage ("non-Blue Health Coverage members"), provided that:

(i) the Plan and/or Licensed Controlled Affiliate has no contact or interaction with providers outside of the Plan's Service Area, except as specifically provided in the IP Policies and in 2.4(b); and

(ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Brands a local plant, office or division of the account that is outside of the Plan's Service Area, the Plan and/or licensed Controlled Affiliate may not offer Blue-branded Health and Wellness Programs to any employees working at such local plant, office or division without the consent of such other Licensee; and

(iii) if the Plan and/or licensed Controlled Affiliate provides an information card to the non-Blue Health Coverage members, the card may not display the Symbols in the masthead, must contain a prominent disclosure conveying that it is not a health insurance card, and otherwise must be designed so that it is dissimilar to a Blue member identification card.

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2.4 Services to National Accounts (continued)

For purposes of this subparagraph a, the following definitions apply:

"Health and Wellness Program" shall mean a program that includes at least one of the following elements or a related element:

- Health Risk Assessment and/or Preventive Screenings
- Exercise and Fitness Programs
- Health and Wellness Events (e.g., attendance at a health fair, a 5K walk)
- Nutrition and Weight Management
- Health Education (e.g., smoking cessation classes)
- Prenatal and Parenting Education
- Disease or Chronic Condition Management

The above listing is intended to represent examples of the types of programs that may be offered, and other programs, including those offered through different media such as the internet or telephonically, may also be deemed Health and Wellness programs.

"Health Coverage" shall mean providing or administering medical, surgical, hospital, major medical, or catastrophic coverage, or any HMO, PPO, POS or other managed care plan for the foregoing services.

b. as part of a Health and Wellness Program that is otherwise compliant with Brand Regulation 4.11.4(a), contracting with a health and wellness organization to gain access to providers to deliver a discrete health and wellness event ("Event") held at a National Account's worksite outside of the Licensee's Service Area, provided that:

(i) the services delivered at the Event are limited to fingerstick screenings for cholesterol and glucose, seasonal flu immunizations, blood pressure measurements, body mass index measurements, and other routine screenings, immunizations and measurements; and

(ii) neither such services nor their costs are applied as claims against any benefit plan; and

(iii) the Event is presented during one or more limited periods during a benefit year and is available to all employees at the worksite.

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c. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee to offer Blue-branded Health Coverage to the National Account, performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by the National Account to its members, including benefit plans that are not underwritten or administered by the Plan, provided that:
   (i) in performing such functions, the Plan and/or licensed Controlled Affiliate does not use the Brands in any communications with health care providers outside of the Plan's Service Area, and otherwise limits its use of the Brands outside of the Service Area to communications with the account's members, the other benefit plan providers with which the account has contracted and other reasonably necessary communications to perform such functions; and
   (ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Brands a local plant, office or division of the account that is outside of the Plan's Service Area, the Plan and/or licensed Controlled Affiliate may not perform Eligibility and Enrollment functions for employees working at such local plant, office or division without the consent of such other Licensee;

d. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee to perform or investigate fraud, waste and abuse investigation activities for a non-participating provider in a Par/Host Plan's service area, as long as the Control/Home Plan is given permission to do so by the Par/Host Plan and specific conditions are met in accordance with Inter-Plan Programs and Inter-Plan Medicare Advantage Program policies.

For purposes of this subparagraph b, the following definitions apply:

"Health Coverage" has the meaning set forth in subparagraph 2.4.a.

Amended as of September 27, 2018

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"Eligibility" means services that manage the account's eligibility data and determine or process determinations relating to eligibility for benefit plans offered by the account to its employees, including such services as:

- monitoring and auditing data to ensure that only entitled individuals are enrolled in each such benefit plan;
- review of eligibility documentation (e.g. marriage licenses, birth certificates, student status verification letters, employment records);
- identification of key member segments such as over-age dependents, part-time employees, employees reaching certain milestones (e.g. Medicare-eligible, retirees);
- termination of coverage for those individuals found to be ineligible for coverage under a benefit plan, and, if applicable, generation of a COBRA event; and
- management of "hour-banking" for union environments in which union members can bank hours to remain eligible for benefits.

"Enrollment" means services that enroll eligible individuals and their spouses/dependents or terminate or change their enrollment in the account's benefit plans on an ongoing basis and during open enrollment periods, including such services as:

- the coordination of each step in open enrollment process from project planning and system set-up to the generation of confirmation statements;
- ongoing enrollment support for new hires and changes due to life events and work status adjustments;
- evidence of insurability (EOI) administration for life and disability coverage;
- transmission of eligibility/enrollment information to the account's benefit plan providers;
- review and reconciliation of error reports received from the account's benefit plan providers; and
- transmission of information to the account's payroll system (e.g., benefit deductions, employee demographic data).

Amended as of March 26, 2015

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2.5 Knowledge Sharing

a. submitting scholarly articles authored or co-authored by the Plan or Controlled Affiliate or its respective employees for publication in peer-reviewed journals;

b. permitting an internal representative of the Licensee (e.g., officer, employee) to speak or present at a conference or symposium outside of the Licensee's Service Area regarding either (i) healthcare financing, administration, delivery or policy, or (ii) topics within the representative's functional discipline or expertise at the Licensee, for which the event sponsor will issue communications to promote, administer, and/or recap the event that will identify the Licensee's representative as a participant. The communications outside of the Licensee's Service Area that mention the Licensee's representative shall be limited to materials and digital media provided to attendees, on-site signage, advertising in relevant trade publications, direct mail and email to attendees and prospective attendees, and the sponsor's website, Participation in any conference or symposium outside of the Licensee's Service Area may not be for the purpose of marketing or selling products or services.

If the Licensee's representative wishes to use the Brands in any manner, including use in his/her title, when participating as a speaker or presenter outside of the Licensee's Service Area about a topic that is not related to healthcare financing, administration, delivery, or policy, or to topics within the representative's functional discipline or expertise at the Licensee, the Licensee must notify BCBSA and receive prior approval from BCBSA before participating.

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2.6 Other Uses

a. entering into a license agreement between and among BCBSA, the Plan and a debit card issuer located outside the Plan's Service Area, and entering into a corresponding operating agreement or agreements, in order to offer a debit card bearing the Licensed Marks and Name to eligible persons as defined by the aforementioned license agreement;

b. appearing in communications issued by an independent third party to recognize outstanding performance of the Plan or Controlled Affiliate or a member of the Plan's or Controlled Affiliate's senior management as part of an established program of the third party for which the Plan has provided information to be considered for the recognition, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;

c. to identify itself as being a joint sponsor of an event, program or activity along with other Plans or such Plans' licensed Controlled Affiliates, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;

d. hosting meetings or events (collectively, "events") in Washington, D.C. related to policy and business issues in the Licensee's Service Area, or hosting events in conjunction with the assemblies or conventions of national political parties. Such events may not involve marketing or selling products or services. Use of the Brands outside the Licensee's Service Area in connection with such events shall be limited to materials and digital media provided to attendees and prospective attendees and onsite signage. For any such events in Washington, D.C. that are open to attendees other than government officials or their staffs, or are briefings open to all Congressional staff, or are otherwise likely to receive media coverage, the Licensee is required to provide advance notice to BCBSA. For events hosted outside of Washington, D.C. in conjunction with the assemblies or conventions of national political parties, the Licensee is required to provide advance notice to BCGSA and to the local Plan;

Amended as of March 26, 2015

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e. permitting an affiliate that is not licensed to use the Licensed Marks to identify its corporate relationship with the Plan, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time.

3. In connection with activity otherwise in furtherance of the License Agreement, a Controlled Affiliate that is licensed to use the Licensed Marks and Name pursuant to a Controlled Affiliate License Agreement authorized in clauses d) or e) of Paragraph 2 of the Plan's License Agreement with BCBSA may use the Licensed Marks and Name outside the Region (as that term is defined in such respective Controlled Affiliate License Agreements) in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);

b. distributing business cards other than in marketing and selling;

c. contracting with health care providers or soliciting such contracts in areas contiguous to the Region in order to serve its subscribers residing in the Region, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans in connection with such contracting unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;

d. issuing a small sign containing the legal name or trade name of the Controlled Affiliate for display by a provider to identify the latter as a participating provider of the Controlled Affiliate, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans on such signs unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;

e. advertising in publications or electronic media solely to persons for employment;

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f. advertising in print, electronic or other media which serve, as a substantial market, the Region, provided that the Controlled Affiliate may not advertise outside its Region on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Region, and provided further that any such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to advertise in such media;

g. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Region, provided that such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to send direct mail to such zip code plus 4.

h. [Intentionally left blank, pending review by the Inter-Plan Programs Committee of the applicability of the case management rule to such Controlled Affiliates.]

i. contracting with a pharmacy management organization (“Pharmacy Intermediary”) to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for the Controlled Affiliate’s regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective Controlled Affiliate License Agreements, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;

j. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit to the Controlled Affiliate’s regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective

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Controlled Affiliate License Agreements, provided that (1) the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Region, and (2) neither the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Region;

k. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for the Controlled Affiliate's regional Medicare Advantage PPO members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;

l. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for the Controlled Affiliate's regional Medicare Advantage members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;

m. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Controlled Affiliate's Region;

n. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Controlled Affiliate's Region;

o. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Region;

p. contracting with a company that operates provider sites in the Region, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Region;

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q. contracting with a company that makes health care professionals available in the Region (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Region.

4. BCBSA shall retain the right to use the Licensed Marks in conjunction with the Federal Employee Program and with any other national offering made to federal employees pursuant to the Federal Employees Health Benefits Program (FEHBP), including the right to license such use to its vendors, but only in the following manner.

a. the Licensed Marks may only be used by BCBSA with the term “Federal Employee Program”, “Federal”, “FEP”, or similar language identifying the program as a benefit program for federal employees;

b. the Licensed Marks may not be used by BCBSA with the name(s) of a specific Plan or Plans and;

c. any use by BCBSA in conjunction with a new national FEHBP program proposed after the enactment of this amendment will require the approval of the BCBSA Board of Directors.

5. Where required by applicable state or local law or regulation, a Plan or its licensed Controlled Affiliate may submit documents that contain the Brands to, and file forms that contain the Brands with, state or local regulators in a state not included in its Service Area, provided that it gives reasonable advance notice to the local Plan of its intent to submit such documents or file such forms. Notwithstanding, in no event may a Plan or its licensed Controlled Affiliate use the Brands to register, or to obtain or maintain a license, a certificate of authority, or an equivalent document authorizing it to act as a risk-bearing entity or third party administrator in a state not included in its Service Area. If the local Plan advises BCBSA that it believes its License Agreement has been or would be violated by any submission or filing, BCBSA shall determine whether such submission or filing is required by state or local law or regulation and violates the License Agreement, subject to the Plan’s or licensed Controlled Affiliate’s rights to obtain an independent review of such determination under Paragraph 9(a) and Exhibit 5 of its License Agreement or Paragraph 8 of the Controlled Affiliate License. For purposes of this paragraph, “local Plan” is defined as each Plan whose Service Area includes all or part of the state in which the foregoing applicable state or local law or regulation has been enacted.

Amended as of March 26, 2015

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MEDIATION AND MANDATORY DISPUTE RESOLUTION (MMDR) RULES

The Blue Cross and Blue Shield Plans ("Plans") and the Blue Cross Blue Shield Association ("BCBSA") recognize and acknowledge that the Blue Cross and Blue Shield system is a unique nonprofit and for-profit system offering cost effective health care financing and services. The Plans and BCBSA desire to utilize Mediation and Mandatory Dispute Resolution ("MMDR") to avoid expensive and time-consuming litigation that may otherwise occur in the federal and state judicial systems. Even MMDR should be viewed, however, as methods of last resort, all other procedures for dispute resolution having failed. Except as otherwise provided in the License Agreements, the Plans, their Controlled Affiliates and BCBSA agree to submit all disputes to MMDR pursuant to these Rules and in lieu of litigation.

1. Initiation of Proceedings

A. Pre-MMDR Efforts

Before filing a Complaint to invoke the MMDR process, the CEO of a complaining party, or his/her designated representative, shall undertake good faith efforts with the other side(s) to try to resolve any dispute.

B. Complaint

To commence a proceeding, the complaining party (or parties) shall provide by certified mail, return receipt requested, a written Complaint to the BCBSA Corporate Secretary (which shall also constitute service on BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) named therein. The Complaint shall contain:

i. identification of the complaining party (or parties) requesting the proceeding;

ii. identification of the respondent(s);

iii. identification of any other persons or entities who are interested in a resolution of the dispute;

iv. a full statement describing the nature of the dispute;

v. identification of all of the issues that are being submitted for resolution;

Amended as of November 21, 1996

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vi. the remedy sought;

vii. a statement as to whether the complaining party (or parties) elect(s) first to pursue Mediation;

viii. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor; and

ix. a statement signed by the CEO of the complaining party affirming that the CEO has undertaken efforts, or has directed efforts to be undertaken, to resolve the dispute before resorting to the MMDR process.

The complaining party (or parties) shall file and serve with the Complaint copies of all documents which the party (or parties) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

C. Answer

Within twenty (20) days after receipt of the Complaint, each respondent shall serve on BCBSA and on the complaining party (or parties):

i. a full Answer to the aforesaid Complaint;

ii. a statement of any Counterclaims against the complaining party (or parties), providing with respect thereto the information specified in Paragraph 1.B., above;

iii. a statement as to whether the respondent elects to first pursue Mediation; and

iv. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor.

The respondent(s) shall file and serve with the Answer or by the date of the Initial Conference set forth in Paragraph 3.C., below, copies of all documents which the respondent(s) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

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D. Reply To Counterclaim

Within ten (10) days after receipt of any Counterclaim, the complaining party (or parties) shall serve on BCBSA and on the responding party (or parties) a Reply to the Counterclaim. Such Reply must provide the same information required by Paragraph 1.C., above.

2. Mediation

To facilitate the mediation of disputes between or among BCBSA, the Plans and/or their Controlled Affiliates, the BCBSA Board has provided for Mediation under these Rules. Mediation may be pursued in lieu of or in an effort to obviate the Mandatory Dispute Resolution process, and all parties are strongly urged, but not required, to exhaust the mediation procedure provided for herein. In the event any party refuses to proceed with Mediation, the parties shall proceed immediately to Mandatory Dispute Resolution, as provided in Section 3.

A. Selection of Mediators

If all parties agree to pursue Mediation, they shall promptly attempt to agree upon: (i) the number of mediators desired, not to exceed three mediators; and (ii) the selection of experienced mediator(s) from an independent entity to mediate all disputes set forth in the Complaint and Answer (and Counterclaim and Reply, if any). In the event the parties are unable to agree upon the selection or number of mediators, both within five (5) days of the service of the Answer or Reply to Counterclaim, whichever is later, the BCBSA Corporate Secretary shall immediately refer the matter to a nationally recognized professional ADR organization (such as CPR or JAMS) for mediation by a single mediator to be selected by the ADR organization.

B. Binding Decision

Before the Mediation Hearing described below, the BCBSA Corporate Secretary shall contact the parties to determine whether they wish to be bound by any recommendation of the selected mediator(s) for resolution of the disputes. If all wish to be bound, the Corporate Secretary will send appropriate documentation to them for their signatures before the Mediation Hearing begins.

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C. Mediation Procedure

The Mediator(s) shall apply the mediation procedures and processes provided for herein (not the rules of the ADR organization with which they are affiliated) and shall promptly advise the parties of a scheduled Mediation Hearing date. Unless a party requests an expedited procedure, or unless all parties to the proceeding agree to one or more extensions of time, the Mediation Hearing set forth below shall be completed within forty (40) days of BCBSA's receipt of the Complaint. The selected mediator(s), unless the parties otherwise agree, shall adhere to the following procedure:

i. Each party must be represented by its CEO or other representative who has been delegated full authority to resolve the dispute. However, parties may send additional representatives as they see fit.

ii. Each party will be given one-half hour to present its case, beginning with the complaining party (or parties), followed by the other party or parties. The parties are free to structure their presentations as they see fit, using oral statements or direct examination of witnesses. However, neither cross-examination nor questioning of opposing representatives will be permitted. At the close of each presentation, the selected mediator(s) will be given an opportunity to ask questions of the presenters and witnesses. All parties must be present throughout the Mediation Hearing. The selected mediator(s) may extend the time allowed for each party's presentation at the Mediation Hearing. The selected mediator(s) may meet in executive session, outside the presence of the parties, or may meet with the parties separately, to discuss the controversy.

iii. After the close of the presentations, the parties will attempt to negotiate a settlement of the dispute. If the parties desire, the selected mediators, or any one or more of the selected mediator(s), will sit in on the negotiations.

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iv. After the close of the presentations, the selected mediator(s) may meet privately to agree upon a recommendation for resolution of the dispute which would be submitted to the parties for their consideration and approval. If the parties have previously agreed to be bound by the results of this procedure, this recommendation shall be binding upon the parties.

v. The purpose of the Mediation Hearing is to assist the parties to settle their grievances short of mandatory dispute resolution. As a result, the Mediation Hearing has been designed to be as informal as possible. Rules of evidence shall not apply. There will be no transcript of the proceedings, and no party may make a tape recording of the Mediation Hearing.

vi. In order to facilitate a free and open discussion, the Mediation proceeding shall remain confidential. A "Stipulation to Confidentiality" which prohibits future use of settlement offers, all position papers or other statements furnished to the selected mediator(s), and decisions or recommendations in any Mediation proceeding shall be executed by each party.

vii. Upon request of the selected mediator(s), or one of the parties, BCBSA staff may also submit documentation at any time during the proceedings.

D. Notice of Termination of Mediation

If the Mediation cannot be completed within the prescribed or agreed time period due to the lack of cooperation of any party, as determined by the selected mediator(s), or if the Mediation does not result in a final resolution of all disputes at the Mediation Hearing or within ten (10) days after the Mediation Hearing, any party or any one of the selected mediator(s) shall so notify the BCBSA Corporate Secretary, who shall promptly issue a Notice of Termination of Mediation to all parties, to the selected mediator(s), and to the MDR Administrator. Such notice shall serve to bring the Mediation to an end and to initiate Mandatory Dispute Resolution. Upon agreement of all parties and the mediator(s), the Mediation process may continue at the same time the MDR process is invoked. In such case, the Notice of Termination of Mediation described above serves to initiate the MDR proceeding, but does not terminate mediation proceedings, which may proceed simultaneous with the MDR proceeding.

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3. Mandatory Dispute Resolution (MDR)

If any party elects not to first pursue Mediation, or if a Notice of Termination of Mediation is issued as set forth in Paragraph 2.D., above, then the unresolved disputes set forth in any Complaint and Answer (and Counterclaim and Reply, if any) shall be subject to mandatory binding arbitration (herein referred to as “MDR”).

A. MDR Administrator

The Administrator for purposes of Mandatory Arbitration shall be an independent nationally recognized entity such as CPR or JAMS, specializing in alternative dispute resolution. In the event the parties pursued Mediation with CPR, JAMS or a similar organization, that organization also shall serve as the MDR Administrator, unless all parties notify the BCBSA Corporate Secretary in writing within two (2) days of receiving the Notice of Termination of Mediation that they wish to pursue MDR with another nationally recognized organization serving as MDR Administrator.

In the event the parties (i) did not pursue Mediation, (ii) pursued mediation with a Mediator not affiliated with an ADR organization that offers a panel of arbitrators, or (iii) all parties that pursued Mediation notified the BCBSA Corporate Secretary that they wish to have an MDR Administrator that is different from the organization with which their mediator was affiliated, they shall promptly attempt to agree on a nationally recognized ADR entity that supplies a panel of arbitrators. If they reach such agreement within five (5) days of the Notice of Termination of Mediation or receipt of the Answer or Reply to Counterclaim (whichever is later), the parties shall promptly inform the BCBSA Corporate Secretary of their agreed upon ADR organization. In the event the parties are unable to reach agreement on an MDR Administrator within that timeframe, the BCBSA Corporate Secretary shall immediately refer the matter to CPR, JAMS or a similar organization for MDR.

Any person who served as a Mediator shall not serve as an arbitrator for the same or similar dispute for purposes of MDR.

B. Rules for MDR

The rules controlling all aspects of MDR shall be exclusively those provided for herein. The rules promulgated or otherwise used by the MDR Administrator organization shall not apply.

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C. Initial Conference

Within seven (7) days after a Notice of Termination has issued, or the matter has otherwise been referred to an MDR Administrator, or within five (5) days after the time for filing and serving the Answer or Reply to any Counterclaim (whichever is later) if the parties elect first not to mediate, the parties shall confer with the Administrator to discuss selecting a dispute resolution panel ("the Panel"). This conference (the “Initial Conference”) may be by telephone. The parties are encouraged to agree to the composition of the Panel and to present that agreement to the Administrator at the Initial Conference. If the parties do not agree on the composition of the Panel by the time of the Initial Conference, or by any extension thereof agreed to by all parties and the Administrator, then the Panel Selection Process set forth in subparagraph D, below, shall be followed.

D. Panel Selection Process

The Administrator shall designate, prior to the Initial Conference, at least seven potential arbitrators. Each party shall be permitted to strike any designee for cause and the Administrator shall determine the sufficiency thereof in its sole discretion. The Administrator will designate a replacement for any designee so stricken. Each party shall then be permitted one peremptory strike from the list of designees. The Administrator shall set the dates for exercising all strikes, which shall be set to encourage the prompt selection of arbitrators.

After the parties exercise any designee strikes for cause and their peremptory strike against any designee of their choice, the parties shall each rank the remaining panel members in order of preference and provide the Administrator, without serving on any other party, their ranked list. The Administrator shall not disclose any party’s ranked list to members of the panel or to other parties.

From the remaining designees, and after considering opportunities to maximize, so far as possible, the collectively stated arbitrator preferences provided by the parties on their ranked lists, the Administrator shall select a three member Panel. The Panel Selection Process shall be completed no later than ten (10) days after the Initial Conference.

Each Arbitrator shall be compensated at his or her normal hourly rate or, in the absence of an established rate, at a reasonable hourly rate to be promptly fixed by the Administrator for all time spent in connection with the proceedings and shall be reimbursed for any travel and other reasonable expenses.

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E. Duties Of The Arbitrators

The Panel shall promptly designate a Presiding Arbitrator for the purposes reflected below, but shall retain the power to review and modify any ruling or other action of said Presiding Arbitrator. Each Arbitrator shall be an independent Arbitrator, shall be governed by the Code of Ethics for Arbitrators in Commercial Disputes, and shall at or prior to the commencement of any Arbitration Hearing take an oath to that effect. Each Arbitrator shall promptly disclose in writing to the Panel and to the parties any circumstances, whenever arising, that might cause doubt as to such Arbitrator's compliance, or ability to comply, with said Code of Ethics, and, absent resignation by such Arbitrator, the remaining Arbitrators shall determine in their sole discretion whether the circumstances so disclosed constitute grounds for disqualification and for replacement. With respect to such circumstances arising or coming to the attention of a party after an Arbitrator's selection, a party may likewise request the Arbitrator's resignation or a determination as to disqualification by the remaining Arbitrators. With respect to a sole Arbitrator, the determination as to disqualification shall be made by the Administrator.

There shall be no ex parte communication between the parties or their counsel and any member of the Panel.

F. Panel's Jurisdiction And Authority

The Panel's jurisdiction and authority shall extend to all disputes between or among the Plans, their Controlled Affiliates, and/or BCBSA, except for those disputes excepted from these MMDR procedures as set forth in the License Agreements.

With the exception of punitive or treble damages, the Panel shall have full authority to award the relief it deems appropriate to resolve the parties' disputes, including monetary awards and injunctions, mandatory or prohibitory. The Panel has no authority to award punitive or treble damages except that the Panel may allocate or assess responsibility for punitive or treble damages assessed by another tribunal. Subject to the above limitations, the Panel may, by way of example, but not of limitation:

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i. interpret or construe the meaning of any terms, phrase or provision in any license between BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.

ii. determine whether BCBSA, a Plan or a Controlled Affiliate has violated the terms or conditions of any license between the BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.

iii. decide challenges as to its own jurisdiction.

iv. issue such orders for interim relief as it deems appropriate pending Hearing and Award in any Arbitration.

It is understood that the Panel is expected to resolve issues based on governing principles of law, preserving to the maximum extent legally possible the continued integrity of the Licensed Marks and the BLUE CROSS/BLUE SHIELD system. The Panel shall apply federal law to all issues which, if asserted in the United States District Court, would give rise to federal question jurisdiction, 28 U.S.C. § 1331. The Panel shall apply Illinois law to all issues involving interpretation, performance or construction of any License Agreement or Controlled Affiliate License Agreement unless the agreement otherwise provides. As to other issues, the Panel shall choose the applicable law based on conflicts of law principles of the State of Illinois.

G. Administrative Conference

Within five (5) days of the Panel being selected, the Presiding Arbitrator shall confer with the parties and the other members of the Panel and shall schedule, in writing, a conference in which the parties and the Panel shall participate (the “Administrative Conference”). The Administrative Conference shall take place no later than fifteen (15) days after the Panel is selected. At the Administrative Conference the parties and the Panel shall discuss the scheduling of the Arbitration Hearing and any other matter appropriate to be considered, including but not limited to: any written discovery in the form of requests for production of documents or requests to admit facts; the identity of any witness whose deposition a party may desire and a showing of exceptional good cause for the taking

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of any such deposition; the desirability of bifurcation or other separation of the issues; the need for and the type of record of conferences and hearings, including the need for transcripts; the need for expert witnesses and how expert testimony should be presented; the appropriateness of motions to dismiss and/or for full or partial summary judgment; consideration of stipulations; the desirability of presenting any direct testimony in writing; and the necessity for any on-site inspection by the Panel. If the parties agree, the Administrative Conference may be by telephone.

H. Discovery

i. ***Requests for Production of Documents***: All requests for the production of documents must be served no later than five (5) days after the date of the Initial Conference. Within twenty (20) days after receipt of a request for production of documents, a party shall (a) serve responses and objections to the request, (b) produce all responsive, non-privileged documents to the requesting party, and (c) to the extent any responsive documents are withheld on the grounds of attorney-client privilege or work product, produce a log identifying such documents in the manner specified in Fed. R. Civ. P. 26(b)(5). If, after reviewing a privilege log, the requesting party believes attorney-client privilege or work product protection was improperly claimed by the producing party with respect to any document, the requesting party may ask the Presiding Arbitrator to conduct an in-camera inspection of the same. With respect to documentary and other discovery produced in any MDR proceeding by BCBSA, the fact that a party's CEO or other senior officers may serve on the BCBSA Board of Directors, BCBSA Board Committees or other BCBSA work groups, task forces and the like, shall not be a basis for defeating an otherwise valid claim of attorney-client privilege or work product protection over such documentary or other discovery materials by BCBSA.

ii. ***Requests for Admissions***: Requests for Admissions may be served up to twenty-one (21) days prior to the discovery cut-off set by the Presiding Arbitrator. A party served with Requests For Admissions must respond within twenty (20) days of receipt of said request. The good faith use of and response to Requests for Admissions is encouraged, and the Panel shall have full discretion, with reference to the Federal Rules of Civil Procedure, in awarding appropriate sanctions with respect to abuse of the procedure.

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iii. ***Depositions:*** As a general rule, the parties will not be permitted to take party or non-party deposition testimony for discovery purposes. The Presiding Arbitrator, in his or her sole discretion, shall have the authority to permit a party to take such deposition testimony upon a showing of exceptional good cause. The parties will be permitted to take de bene esse deposition testimony to the fullest extent permitted by law of any witness who cannot be compelled to testify at the Arbitration Hearing. No deposition, for discovery purposes or otherwise, shall exceed three (3) hours, excluding objections and colloquy of counsel. Depositions may be recorded in any manner recognized by the Federal Rules of Civil Procedure and the parties shall specify in each notice of deposition or request for permission to take deposition testimony the manner in which such deposition shall be recorded.

iv. ***Expert witness(es)***: If a party intends to present the testimony of an expert witness during the oral hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2)(B) ten (10) days prior to the discovery cut-off set by the Presiding Arbitrator. If a party intends to present the testimony of a rebuttal expert witness during the Arbitration Hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2)(B) within twenty (20) days after the date on which the written statement of the expert witness whose testimony is to be rebutted was produced.

v. ***Discovery cut-off****:* The Presiding Arbitrator shall determine the date on which the discovery period will end, but the discovery period shall not exceed thirty (30) days from the date of the Administrative Conference without the agreement of all parties.

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vi. ***Additional discovery***: Any additional discovery will be at the discretion of the Presiding Arbitrator.

vii. ***Discovery Disputes:*** Any discovery disputes shall be raised by motion to the Presiding Arbitrator, who is authorized to resolve all such disputes, and whose resolution will be binding on the parties unless modified by the Arbitration Panel. Prior to raising any discovery dispute with the Presiding Arbitrator, the parties shall meet and confer, telephonically or in person, in an attempt to resolve or narrow the dispute. If a party refuses to comply with a decision resolving a discovery dispute, the Panel, in keeping with Fed. R. Civ. P. 37, may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for resolution adversely to that party.

viii. ***Extensions:*** The time for responding to discovery requests may be extended by the Presiding Arbitrator for good and sufficient cause shown. Any request for such an extension shall be made in writing.

I. Panel Suggested Settlement/Mediation

At any point during the proceedings, the Panel at the request of any party or on its own initiative, may suggest that the parties explore settlement and that they do so at or before the conclusion of the Arbitration Hearing, and the Panel shall give such assistance in settlement negotiations as the parties may request and the Panel may deem appropriate. Alternatively, the Panel may direct the parties to endeavor to mediate their disputes as provided above, or to explore a mini-trial proceeding, or to have an independent party render a neutral evaluation of the parties' respective positions. The Panel shall enter such sanctions as it deems appropriate with respect to any party failing to pursue in good faith such Mediation or other alternate dispute resolution methods.

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J. Subpoenas on Third Parties

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq*., and subject to Paragraph 3.G(iii) above, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan or any officer, employee or director of a third party Blue Plan, to compel deposition testimony or the production of documents, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena.

K. Arbitration Hearing

An Arbitration Hearing will be held within thirty (30) days after the Administrative Conference if no discovery is taken, or within thirty (30) days after the close of discovery, unless all parties and the Panel agree to extend the Arbitration Hearing date, or unless the parties agree in writing to waive the Arbitration Hearing. The parties may mutually agree on the location of the Arbitration Hearing. If the parties fail to agree, the Arbitration Hearing shall be held in Chicago, Illinois, or at such other location determined by the Presiding Arbitrator to be most convenient to the participants. The Panel will determine the date(s) and time(s) of the Arbitration Hearing(s) after consultation with all parties and shall provide reasonable notice thereof to all parties or their representatives.

L. Arbitration Hearing Memoranda

Twenty (20) days prior to the Arbitration Hearing, each party shall submit to the other party (or parties) and to the Panel an Arbitration Hearing Memorandum which sets forth the applicable law and any argument as to any relevant issue. The Arbitration Hearing Memorandum will supplement, and not repeat, the allegations, information and documents contained in or with the Complaint, Answer, Counterclaim and Reply, if any. Ten (10) days prior to the Arbitration Hearing, each party shall submit to each other party a list of all expert and fact witnesses (but not including rebuttal fact witness) that such party intends to have testify at the Arbitration Hearing and a brief summary of the testimony each such witness is expected to give. In addition, no later than five (5) days prior to the Arbitration, each party may submit to each other party and to the Panel a Response Arbitration Hearing Memorandum which sets forth any response to another party's Arbitration Hearing Memorandum.

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M. Notice For Testimony

Ten (10) days prior to the Arbitration Hearing, any party may serve a Notice on any other party (or parties) requesting the attendance at the Arbitration Hearing of any officer, employee or director of the other party (or parties) for the purpose of providing noncumulative testimony. If a party fails to produce one of its officers, employees or directors whose noncumulative testimony during the Arbitration Hearing is reasonably requested by an adverse party, the Panel may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for mandatory dispute resolution adversely to that party; provided, however, that a party may refuse to produce a director to testify if, within two (2) days of receiving a notice requesting the attendance of such director at the Arbitration Hearing, the party agrees to make the director available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. This Rule may not be used for the purpose of burdening or harassing any party, and the Presiding Arbitrator may impose such orders as are appropriate so as to prevent or remedy any such burden or harassment.

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq.*, twenty (20) days or more prior to the Arbitration Hearing, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan, BCBSA or any officer, employee or director of a third party Blue Plan or BCBSA for the purpose of providing noncumulative testimony at the Arbitration Hearing, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena; provided however, that a director of a third party Blue Plan or BCBSA may refuse to testify if, within two (2) days of receiving a subpoena requesting the attendance of such director at the Arbitration Hearing, the director agrees to make him/herself available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. Each Blue Plan agrees to waive, on its own behalf and on behalf of its directors and officers, any objection it otherwise might have to any such subpoena based on service, venue or extraterritoriality.

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N. Arbitration Hearing Procedures

i. ***Attendance at Arbitration Hearing***: Any person having a direct interest in the proceeding is entitled to attend the Arbitration Hearing. The Presiding Arbitrator shall otherwise have the power to require the exclusion of any witness, other than a party or other essential person, during the testimony of any other witness. It shall be discretionary with the Presiding Arbitrator to determine the propriety of the attendance of any other person.

ii. ***Confidentiality***: The Panel and all parties shall maintain the privacy of the Arbitration Proceeding. The parties and the Panel shall treat the Arbitration Hearing and any discovery or other proceedings or events related thereto, including any award resulting therefrom, as confidential except as otherwise necessary in connection with a judicial challenge to or enforcement of an award or unless otherwise required by law.

iii. ***Stenographic Record***: Any party, or if the parties do not object, the Panel, may request that a stenographic or other record be made of any Arbitration Hearing or portion thereof. The costs of the recording and/or of preparing the transcript shall be borne by the requesting party and by any party who receives a copy thereof. If the Panel requests a recording and/or a transcript, the costs thereof shall be borne equally by the parties.

iv. ***Oaths***: The Panel may require witnesses to testify under oath or affirmation administered by any duly qualified person and, if requested by any party, shall do so.

v. ***Order of Arbitration Hearing***: An Arbitration Hearing shall be opened by the recording of the date, time, and place of the Arbitration Hearing, and the presence of the Panel, the parties, and their representatives, if any. The Panel may, at the beginning of the Arbitration Hearing, ask for statements clarifying the issues involved.

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Unless otherwise agreed, the complaining party (or parties) shall then present evidence to support their claim(s). The respondent(s) shall then present evidence supporting their defenses and Counterclaims, if any. The complaining party (or parties) shall then present evidence supporting defenses to the Counterclaims, if any, and rebuttal.

Witnesses for each party shall submit to questions by adverse parties and/or the Panel.

The Panel has the discretion to vary these procedures, but shall afford a full and equal opportunity to all parties for the presentation of any material and relevant evidence.

vi. ***Evidence***: The parties may offer such evidence as is relevant and material to the dispute and shall produce such evidence as the Panel may deem necessary to an understanding and resolution of the dispute. Unless good cause is shown, as determined by the Panel or agreed to by all other parties, no party shall be permitted to offer evidence at the Arbitration Hearing which was not disclosed prior to the Arbitration Hearing by that party. The Panel may receive and consider the evidence of witnesses by affidavit upon such terms as the Panel deems appropriate.

The Panel shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence, other than enforcement of the attorney-client privilege and the work product protection, shall not be necessary. The Federal Rules of Evidence shall be considered by the Panel in conducting the Arbitration Hearing but those rules shall not be controlling. All evidence shall be taken in the presence of the Panel and all of the parties, except where any party is in default or has waived the right to be present.

Settlement offers by any party in connection with Mediation or MDR proceedings, decisions or recommendations of the selected mediators, and a party's position papers or statements furnished to the selected mediators shall not be admissible evidence or considered by the Panel without the consent of all parties.

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vii. ***Closing of Arbitration Hearing***: The Presiding Arbitrator shall specifically inquire of all parties whether they have any further proofs to offer or witnesses to be heard. Upon receiving negative replies or if he or she is satisfied that the record is complete, the Presiding Arbitrator shall declare the Arbitration Hearing closed with an appropriate notation made on the record. Subject to being reopened as provided below, the time within which the Panel is required to make the award shall commence to run, in the absence of contrary agreement by the parties, upon the closing of the Arbitration Hearing.

With respect to complex disputes, the Panel may, in its sole discretion, defer the closing of the Arbitration Hearing for a period of up to thirty (30) days after the presentation of proofs in order to permit the parties to submit post-hearing briefs and argument, as the Panel deems appropriate, prior to making an award.

For good cause, the Arbitration Hearing may be reopened for up to thirty (30) days on the Panel's initiative, or upon application of a party, at any time before the award is made

O. Awards

An Award must be in writing and shall be made promptly by the Panel and, unless otherwise agreed by the parties or specified by law, no later than thirty (30) days from the date of closing the Arbitration Hearing. If all parties so request, the Award shall contain findings of fact and conclusions of law. The Award, and all other rulings and determinations by the Panel, may be by a majority vote.

Parties shall accept as legal delivery of the Award the placing of the Award or a true copy thereof in the mail addressed to a party or its representative at its last known address or personal service of the Award on a party or its representative.

Awards are binding only on the parties to the Arbitration and are not binding on any non-parties to the Arbitration and may not be used or cited as precedent in any other proceeding.

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After the expiration of twenty (20) days from initial delivery, the Award (with corrections, if any) shall be final and binding on the parties, and the parties shall undertake to carry out the Award without delay.

Proceedings to confirm, modify or vacate an Award shall be conducted in conformity with and controlled by the Federal Arbitration Act. 9 U.S.C. § 1, *et seq*.

P. Return of Documents

Within sixty (60) days after the Award and the conclusion of any judicial proceedings with respect thereto, each party and the Panel shall return any documents produced by any other party, including all copies thereof. If a party receives a discovery request in any other proceeding which would require it to produce any documents produced to it by any other party in a proceeding hereunder, it shall not produce such documents without first notifying the producing party and giving said party reasonable time to respond, if appropriate, to the discovery request.

4. Miscellaneous

A. Expedited Procedures

Any party to a Mediation may direct a request for an expedited Mediation Hearing to the Chairman of the Mediation Committee, to the selected Mediators, and to all other parties at any time. The Chairman of the Mediation Committee, or at his or her direction, the then selected Mediators, shall grant any request which is supported by good and sufficient reasons. If such a request is granted, the Mediation shall be completed within as short a period as practicable, as determined by the Chairman of the Mediation Committee or, at his or her direction, the then selected Mediators.

Any party to an Arbitration may direct a request for expedited proceedings to the Administrator, to the Panel, and to all other parties at any time. The Administrator, or the Presiding Arbitrator if the Panel has been selected, shall grant any such request which is supported by good and sufficient reasons. If such a request is granted, the Arbitration shall be completed within as short a time as practicable, as determined by the Administrator and/or the Presiding Arbitrator.

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B. Temporary or Preliminary Injunctive Relief

Any party may seek temporary or preliminary injunctive relief with the filing of a Complaint or at any time thereafter. If such relief is sought prior to the time that an Arbitration Panel has been selected, then the Administrator shall select a single Arbitrator who is a lawyer who has no interest in the subject matter of the dispute, and no connection to any of the parties, to hear and determine the request for temporary or preliminary injunction. If such relief is sought after the time that an Arbitration Panel has been selected, then the Arbitration Panel will hear and determine the request. The request for temporary or preliminary injunctive relief will be determined with reference to the temporary or preliminary injunction standards set forth in Fed. R. Civ. P. 65.

C. Defaults and Proceedings in the Absence of a Party

Whenever a party fails to comply with the MDR Rules in a manner deemed material by the Panel, the Panel shall fix a reasonable time for compliance and, if the party does not comply within said period, the Panel may enter an Order of default or afford such other relief as it deems appropriate. Arbitration may proceed in the event of a default or in the absence of any party who, after due notice, fails to be present or fails to obtain an extension. An Award shall not be made solely on the default or absence of a party, but the Panel shall require the party who is present to submit such evidence as the Panel may require for the making of findings, determinations, conclusions, and Awards.

D. Notice

Each party shall be deemed to have consented that any papers, notices, or process necessary or proper for the initiation or continuation of a proceeding under these rules or for any court action in connection therewith may be served on a party by mail addressed to the party or its representative at its last known address or by personal service, in or outside the state where the MDR proceeding is to be held.

The Corporate Secretary and the parties may also use facsimile transmission, telex, telegram, or other written forms of electronic communication to give the notices required by these rules.

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E. Expenses

The expenses of witnesses shall be paid by the party causing or requesting the appearance of such witnesses. All expenses of the MDR proceeding, including compensation, required travel and other reasonable expenses of the Panel, and the cost of any proof produced at the direct request of the Panel, shall be borne equally by the parties and shall be paid periodically on a timely basis, unless they agree otherwise or unless the Panel in the Award assesses such expenses, or any part thereof against any party (or parties). In exceptional cases, the Panel may award reasonable attorneys' fees as an item of expense, and the Panel shall promptly determine the amount of such fees based on affidavits or such other proofs as the Panel deems sufficient.

F. Disqualification or Disability of A Panel Member

In the event that any Arbitrator of a Panel with more than one Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the remaining Panel member(s):

i. shall designate a replacement, subject to the right of any party to challenge such replacement for cause.

ii. shall decide the extent to which previously held hearings shall be repeated.

If the remaining Panel members consider the proceedings to have progressed to a stage as to make replacement impracticable, the parties may agree, as an alternative to the recommencement of the Mandatory Dispute Resolution process, to resolution of the dispute by the remaining Panel members.

In the event that a single Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the Administrator shall appoint a successor, subject to the right of any party to challenge such successor for cause, and the successor shall decide the extent to which previously held proceedings shall be repeated.

EXHIBIT 5

Page 21 of 23

G. Extensions of Time

Subject to the provisions of Paragraph 3.H.(viii), any time limit set forth in these Rules may be extended upon agreement of the parties and approval of: (1) the Mediator if the proceeding is then in Mediation; (2) the Administrator if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (3) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected.

H. Intervention

The Plans, their Controlled Affiliates, and BCBSA, to the extent subject to MMDR pursuant to their License Agreements, shall have the right to move to intervene in any pending Arbitration. A written motion for intervention shall be made to: (1) the Administrator, if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (2) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected. The written motion for intervention shall be delivered to the BCBSA Corporate Secretary (which shall also constitute service on the BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) which are parties to the proceeding. Any party to the proceeding can submit written objections to the motion to intervene. The motion for intervention shall be granted upon good cause shown. Intervention also may be allowed by stipulation of the parties to the Arbitration proceeding. Intervention shall be allowed upon such terms as the Arbitration Panel decides.

I. BCBSA Assistance In Resolution of Disputes

The resources and personnel of the BCBSA may be requested by any member Plan at any time to try to resolve disputes with another Plan.

J. Neutral Evaluation

The parties can voluntarily agree at any time to have an independent party render a neutral evaluation of the parties' respective positions.

Amended as of September 20, 2007

EXHIBIT 5

Page 22 of 23

K. Recovery of Attorney Fees and Expenses

i.Motions to Compel

Nothwithstanding any other provisions of these Rules, any Party subject to the License Agreements (for purposes of this Section K and all of its sub-sections only hereinafter referred to collectively and individually as a "Party") that initiates a court action or administrative proceeding solely to compel adherence to these Rules shall not be determined to have violated these Rules by initiating such action or proceeding.

iiRecovery of Fees, Expenses and Costs

The Arbitration Panel may, in its sole discretion, award a Party its reasonable attorneys' fees, expenses and costs associated with a filing to compel adherence to these Rules and/or reasonable attorneys' fees, expenses and costs incurred in responding to an action filed in violation of these Rules; provided, however, that neither fees, expenses, nor costs shall be awarded by the Arbitration Panel if the Party from which the award is sought can demonstrate to the Arbitration panel, in its sole discretion, that it did not violate these Rules or that it had reasonable grounds for believing that its action did not violate these Rules.

iiiRequests for Reimbursement

For purposes of this Section K, any Party may request reimbursement of fees, expenses and/or costs by submitting said request in writing to the Arbitration Panel at any time before an award is delivered pursuant to Paragraph 3.O above, with a copy to the Party from which reimbursement is sought, explaining why it is entitled to such reimbursement. The Party from which reimbursement is sought shall have twenty (20) days to submit a response to such request to the Arbitration Panel with a copy to the Party seeking reimbursement.

Amended as of September 20, 2007

EXHIBIT 5

L. Calculation of Time and Deadlines

In computing any period of time prescribed or allowed under these rules, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not one of the aforementioned days. When the period of time prescribed is less than six (6) days, intermediate Saturdays, Sundays and legal holidays shall be excluded in the computation. As used in this rule, “legal holiday” includes New Year’s Day, Martin Luther King, Jr. Day, Washington’s Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day and any other day appointed as a holiday by the President or the Congress of the United States.

Amended as of September 20, 2007

Exhibit 21

SUBSIDIARIES OF THE COMPANY

Legal Name	*State or Country*
American Imaging Management, Inc.	Illinois
America's 1st Choice of South Carolina, Inc.	South Carolina
America's Health Management Services, Inc.	South Carolina
AMERIGROUP Community Care of New Mexico, Inc.	New Mexico
AMERIGROUP Corporation	Delaware
Amerigroup Delaware, Inc.	Delaware
Amerigroup District of Columbia, Inc.	District of Columbia
Amerigroup Health Plan of Louisiana, Inc.	Louisiana
Amerigroup Health Plan of Oregon, Inc.	Oregon
Amerigroup Insurance Company	Texas
Amerigroup Iowa, Inc.	Iowa
Amerigroup IPA of New York, LLC	New York
Amerigroup Kansas, Inc.	Kansas
AMERIGROUP Maryland, Inc.	Maryland
Amerigroup Michigan, Inc.	Michigan
Amerigroup Mississippi, Inc.	Mississippi
AMERIGROUP New Jersey, Inc.	New Jersey
AMERIGROUP Ohio, Inc.	Ohio
Amerigroup Oklahoma Inc.	Oklahoma
Amerigroup Partnership Plan, LLC	Illinois
Amerigroup Pennsylvania, Inc.	Pennsylvania
AMERIGROUP Tennessee, Inc.	Tennessee
AMERIGROUP Texas, Inc.	Texas
Amerigroup Utah, Inc.	Utah
AMERIGROUP Washington, Inc.	Washington
AMGP Georgia Managed Care Company, Inc.	Georgia
Anthem Blue Cross Life and Health Insurance Company	California
Anthem Financial, Inc.	Delaware
Anthem Health Plans of Kentucky, Inc.	Kentucky
Anthem Health Plans of Maine, Inc.	Maine
Anthem Health Plans of New Hampshire, Inc.	New Hampshire
Anthem Health Plans of Virginia, Inc.	Virginia
Anthem Health Plans, Inc.	Connecticut
Anthem Holding Corp.	Indiana
Anthem Insurance Companies, Inc.	Indiana
Anthem Kentucky Managed Care Plan, Inc.	Kentucky
Anthem Life & Disability Insurance Company	New York
Anthem Life Insurance Company	Indiana
Anthem Partnership Holding Company, LLC	Indiana
Anthem Southeast, Inc.	Indiana
Anthem UM Services, Inc.	Indiana

Anthem Workers' Compensation, LLC	Indiana
APPLIED PATHWAYS LLC	Illinois
Arcus Enterprises, Inc.	Delaware
Aspire Health, Inc.	Delaware
Associated Group, Inc.	Indiana
ATH Holding Company, LLC	Indiana
Blue Cross and Blue Shield of Georgia, Inc.	Georgia
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	Georgia
Blue Cross Blue Shield of Wisconsin	Wisconsin
Blue Cross of California	California
Blue Cross of California Partnership Plan, Inc.	California
CareMore Health Plan	California
CareMore Health Plan of Arizona, Inc.	Arizona
CareMore Health Plan of Nevada	Nevada
CareMore Health Plan of Texas, Inc.	Texas
CareMore Health System	California
CareMore Services Company, LLC	Indiana
CareMore, LLC	Indiana
Cerulean Companies, Inc.	Georgia
Claim Management Services, Inc.	Wisconsin
Community Care Health Plan of Louisiana, Inc.	Louisiana
Community Care Health Plan of Nevada, Inc.	Nevada
Community Insurance Company	Ohio
Compcare Health Services Insurance Corporation	Wisconsin
Crossroads Acquisition Corp.	Delaware
DeCare Analytics, LLC	Minnesota
DeCare Dental Health International, LLC	Minnesota
DeCare Dental Insurance Ireland, Ltd.	Ireland
DeCare Dental Networks, LLC	Minnesota
DeCare Dental, LLC	Minnesota
DeCare Operations Ireland, Limited	Ireland
Delivery Network, LLC	Florida
Designated Agent Company, Inc.	Kentucky
EasyScripts, LLC	Florida
EasyScripts Cutler Bay, LLC	Florida
EasyScripts Hialeah, LLC	Florida
EasyScripts Westchester, LLC	Florida
EHC Benefits Agency, Inc.	New York
Empire HealthChoice Assurance, Inc.	New York
Empire HealthChoice HMO, Inc.	New York
Federal Government Solutions, LLC	Wisconsin
Freedom Health, Inc.	Florida
Global TPA, LLC	Florida

Golden West Health Plan, Inc.	California
Greater Georgia Life Insurance Company	Georgia
Health Core, Inc.	Delaware
Health Management Corporation	Virginia
Health Ventures Partner, L.L.C.	Illinois
HealthKeepers, Inc.	Virginia
HealthLink HMO, Inc.	Missouri
HealthLink, Inc.	Illinois
HealthLink Insurance Company	Illinois
HealthPlus HP, LLC	New York
HealthSun Health Plans, Inc.	Florida
HealthSun Holdings, LLC	Florida
HealthSun Management, LLC	Florida
HealthSun Physicians Network I, LLC	Florida
HealthSun Physicians Network, LLC	Florida
Healthy Alliance Life Insurance Company	Missouri
HEP AP Holdings, Inc.	Delaware
Highland Acquisition Holdings, LLC	Delaware
Highland Holdco, Inc.	Delaware
Highland Intermediate Holdings, LLC	Delaware
Highland Investor Holdings, LLC	Delaware
HMO Colorado, Inc.	Colorado
HMO Missouri, Inc.	Missouri
Human Resource Associates, LLC	Florida
Imaging Management Holdings, LLC	Delaware
IngenioRx, Inc.	Indiana
Legato Health Technologies, LLP	India
Legato Health Technologies Philippines, Inc.	Philippines
Legato Holdings I, Inc.	Indiana
Legato Holdings II, LLC	Indiana
Living Complete Technologies, Inc.	Maryland
Matthew Thornton Health Plan, Inc.	New Hampshire
Memphis Supportive Care Partnership, LLC	Tennessee
Meridian Resource Company, LLC	Wisconsin
Nash Holding Company, LLC	Delaware
National Government Services, Inc.	Indiana
New England Research Institutes, Inc.	Massachusetts
Newco Holdings, Inc.	Indiana
NGS Federal, LLC	Indiana
OPTIMUM HEALTHCARE, INC.	Florida
Park Square Holdings, Inc.	California
Park Square I, Inc.	California
Park Square II, Inc.	California

Pasteur Medical Bird Road, LLC	Florida
Pasteur Medical Center, LLC	Delaware
Pasteur Medical Cutler Bay, LLC	Florida
Pasteur Medical Group, LLC	Florida
Pasteur Medical Hialeah Gardens, LLC	Florida
Pasteur Medical Holdings, LLC	Florida
Pasteur Medical Kendall, LLC	Florida
Pasteur Medical Management, LLC	Florida
Pasteur Medical Miami Gardens, LLC	Florida
Pasteur Medical North Miami Beach, LLC	Florida
Pasteur Medical Partners, LLC	Florida
Resolution Health, Inc.	Delaware
RightCHOICE Managed Care, Inc.	Delaware
Rocky Mountain Hospital and Medical Service, Inc.	Colorado
SellCore, Inc.	Delaware
Simply Healthcare Plans, Inc.	Florida
Southeast Services, Inc.	Virginia
State Sponsored DM Services, Inc.	Indiana
The Anthem Companies of California, Inc.	California
The Anthem Companies, Inc.	Indiana
TrustSolutions, LLC	Wisconsin
UNICARE Health Plan of West Virginia, Inc.	West Virginia
UNICARE Illinois Services, Inc.	Illinois
UniCare Life & Health Insurance Company	Indiana
UNICARE National Services, Inc.	Delaware
UniCare Specialty Services, Inc.	Delaware
Valus, Inc.	Indiana
Wellmax Health Medical Centers, LLC	Florida
Wellmax Health Physicians Network, LLC	Florida
WellPoint Acquisition, LLC	Indiana
WellPoint Behavioral Health, Inc.	Delaware
WellPoint California Services, Inc.	Delaware
WellPoint Dental Services, Inc.	Delaware
WellPoint Health Solutions, Inc.	Indiana
WellPoint Holding Corp.	Delaware
WellPoint Information Technology Services, Inc.	California
WellPoint Insurance Services, Inc.	Hawaii
WellPoint Military Care Corporation	Indiana
WPMI, LLC	Delaware

Exhibit 23

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in the following Registration Statements:

- Form S-8 No. 333-84906 and Form S-8 No. 333-129334 pertaining to the Anthem 401(k) Plan;
- Form S-8 No. 333-156099 pertaining to the Anthem, Inc. Employee Stock Purchase Plan;
- Form S-8 No. 333-159830 pertaining to the Anthem Incentive Compensation Plan;
- Form S-8 No. 333-218190 pertaining to the 2017 Anthem Incentive Compensation Plan; and
- Form S-3 No. 333-221824 pertaining to the Anthem, Inc. registration of senior debt securities, subordinated debt securities, preferred stock, common stock, depositary shares, warrants, rights, stock purchase contracts and stock purchase units

of our reports dated February 20, 2019, with respect to the consolidated financial statements and financial statement schedule listed in the Index at Item 15(c) of Anthem, Inc., and the effectiveness of internal control over financial reporting of Anthem, Inc., included in its Annual Report (Form 10-K) for the year ended December 31, 2018.

/S/ ERNST & YOUNG LLP
Indianapolis, Indiana
February 20, 2019

1

Exhibit 31.1

CERTIFICATION PURSUANT TO
RULE 13a-14(a) AND RULE 15d-14(a) OF THE EXCHANGE ACT RULES,
AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Gail K. Boudreaux, certify that:

1. I have reviewed this report on Form 10-K of Anthem, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):

   a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 20, 2019

/s/ GAIL K. BOUDREAUX
President and Chief Executive Officer

Exhibit 31.2

CERTIFICATION PURSUANT TO
RULE 13a-14(a) AND RULE 15d-14(a) OF THE EXCHANGE ACT RULES,
AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, John E. Gallina, certify that:

1. I have reviewed this report on Form 10-K of Anthem, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):

   a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 20, 2019

/s/ JOHN E. GALLINA
Executive Vice President and
Chief Financial Officer

Exhibit 32.1

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of Anthem, Inc. (the "Company") on Form 10-K for the period ended December 31, 2018 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Gail K. Boudreaux, President and Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ GAIL K. BOUDREAUX

Gail K. Boudreaux
President and Chief Executive Officer
February 20, 2019

Exhibit 32.2

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of Anthem, Inc. (the "Company") on Form 10-K for the period ended December 31, 2018 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, John E. Gallina, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to
§ 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ JOHN E. GALLINA

John E. Gallina
Executive Vice President and Chief Financial Officer
February 20, 2019

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2019

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number: 001-16751

ANTHEM, INC.
(Exact name of registrant as specified in its charter)

Indiana	**35-2145715**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification Number)**

220 Virginia Avenue
Indianapolis, Indiana 46204
(Address of principal executive offices) (Zip Code)

Registrant's telephone number, including area code: (800) 331-1476

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading symbol(s)	Name of each exchange on which registered
Common Stock, Par Value $0.01	ANTM	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.:

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐	Smaller reporting company	☐
Emerging growth company	☐		

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant (assuming solely for the purposes of this calculation that all Directors and executive officers of the registrant are "affiliates") as of June 28, 2019 was approximately $72,160,040,688.

As of February 6, 2020, 252,329,919 shares of the Registrant's Common Stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Annual Report on Form 10-K incorporates by reference information from the registrant's Definitive Proxy Statement for the Annual Meeting of Shareholders to be held May 21, 2020.

Anthem, Inc.

Annual Report on Form 10-K
For the Year Ended December 31, 2019

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References in this Annual Report on Form 10-K to the terms "we," "our," "us," "Anthem" or the "Company" refer to Anthem, Inc., an Indiana corporation, and, unless the context otherwise requires, its direct and indirect subsidiaries. References to the term "states" include the District of Columbia, unless the context otherwise requires.

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K, including Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations," contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements reflect our views about future events and financial performance and are generally not historical facts. Words such as "expect," "feel," "believe," "will," "may," "should," "anticipate," "intend," "estimate," "project," "forecast," "plan" and similar expressions are intended to identify forward-looking statements. These statements include, but are not limited to: financial projections and estimates and their underlying assumptions; statements regarding plans, objectives and expectations with respect to future operations, products and services; and statements regarding future performance. Such statements are subject to certain risks and uncertainties, many of which are difficult to predict and generally beyond our control, that could cause actual results to differ materially from those expressed in, or implied or projected by, the forward-looking statements. You are cautioned not to place undue reliance on these forward-looking statements that speak only as of the date hereof. You are also urged to carefully review and consider the various risks and other disclosures discussed in our reports filed with the U.S. Securities and Exchange Commission from time to time, which attempt to advise interested parties of the factors that affect our business. Except to the extent otherwise required by federal securities laws, we do not undertake any obligation to republish revised forward-looking statements to reflect events or circumstances after the date hereof. These risks and uncertainties include, but are not limited to: trends in healthcare costs and utilization rates; our ability to secure sufficient premium rates, including regulatory approval for and implementation of such rates; the impact of federal and state regulation, including ongoing changes in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended, or collectively, the ACA, and the ultimate outcome of legal challenges to the ACA; our ability to contract with providers on cost-effective and competitive terms; competitive pressures and our ability to adapt to changes in the industry and develop and implement strategic growth opportunities; reduced enrollment; unauthorized disclosure of member or employee sensitive or confidential information, including the impact and outcome of any investigations, inquiries, claims and litigation related thereto; risks and uncertainties regarding Medicare and Medicaid programs, including those related to non-compliance with the complex regulations imposed thereon; our ability to maintain and achieve improvement in Centers for Medicare and Medicaid Services, or CMS, Star ratings and other quality scores and funding risks with respect to revenue received from participation therein; a negative change in our healthcare product mix; costs and other liabilities associated with litigation, government investigations, audits or reviews; the ultimate outcome of litigation between Cigna Corporation, or Cigna, and us related to the merger agreement between the parties and the potential for such litigation to cause us to incur substantial additional costs, including potential settlement and judgment costs; risks and uncertainties related to our pharmacy benefit management, or PBM, business, including non-compliance by any party with the PBM services agreements between us and each of Express Scripts, Inc., or Express Scripts, and CaremarkPCS Health, L.L.C., or CVS Health, as well as agreements governing the transition of pharmacy benefit management services provided to us from Express Scripts to CVS Health Corporation; medical malpractice or professional liability claims or other risks related to healthcare services and PBM services provided by our subsidiaries; general risks associated with mergers, acquisitions, joint ventures and strategic alliances; possible impairment of the value of our intangible assets if future results do not adequately support goodwill and other intangible assets; possible restrictions in the payment of dividends from our subsidiaries and increases in required minimum levels of capital; our ability to repurchase shares of our common stock and pay dividends on our common stock due to the adequacy of our cash flow and earnings and other considerations; the potential negative effect from our substantial amount of outstanding indebtedness; a downgrade in our financial strength ratings; the effects of any negative publicity related to the health benefits industry in general or us in particular; failure to effectively maintain and modernize our information systems; events that may negatively affect our licenses with the Blue Cross and Blue Shield Association; large scale medical emergencies, such as future public health epidemics and catastrophes; changes in economic and market conditions, as well as regulations that may negatively affect our liquidity and investment portfolios; the impact of international laws and regulations; changes in U.S. tax laws; intense competition to attract and retain employees; and various laws and provisions in our governing documents that may prevent or discourage takeovers and business combinations.

PART I

ITEM 1. BUSINESS.

General

We are one of the largest health benefits companies in the United States in terms of medical membership, serving approximately 41 million medical members through our affiliated health plans as of December 31, 2019. We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (in the New York City metropolitan area and upstate New York), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas, we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, and Empire Blue Cross Blue Shield or Empire Blue Cross. We also conduct business through arrangements with other BCBS licensees as well as other strategic partners. Through our subsidiaries, we also serve customers in numerous states across the country as Aim Specialty Health, Amerigroup, Aspire Health, CareMore, Freedom Health, HealthLink, HealthSun, Optimum HealthCare, Simply Healthcare, and/or UniCare. Also, in the second quarter of 2019, we began providing pharmacy benefits management, or PBM, services through our IngenioRx subsidiary. We are licensed to conduct insurance operations in all 50 states and the District of Columbia through our subsidiaries.

In the second quarter of 2019, we began using our new pharmacy benefits manager called IngenioRx to market and sell a PBM product to fully-insured and self-funded Anthem health plan customers throughout the country, as well as to customers outside of the health plans we own. This comprehensive product portfolio includes features such as drug formularies, a pharmacy network, prescription drug database, member services and mail order capabilities. In July 2019, we announced our first contract win with a third-party health insurer, Blue Cross of Idaho, and we began providing PBM services under that contract beginning on January 1, 2020. Also beginning in the second quarter of 2019, we began delegating certain PBM administrative functions, such as claims processing and prescription fulfillment, to CaremarkPCS Health, L.L.C., or CVS Health, which is a subsidiary of CVS Health Corporation, pursuant to a five-year agreement with CVS Health, or the CVS PBM Agreement. We intend to retain the responsibilities for IngenioRx's clinical and formulary strategy and development, member and employer experiences, operations, sales, marketing, account management and retail network strategy. From December 2009 through December 2019, we delegated certain PBM functions and administrative services to Express Scripts, Inc., or Express Scripts, pursuant our PBM agreement with Express Scripts, or the ESI PBM Agreement. In January 2019, we exercised our contractual right to terminate the ESI PBM Agreement earlier than the original expiration date of December 31, 2019, due to the acquisition of Express Scripts by Cigna Corporation, or Cigna. We began transitioning existing members from Express Scripts to IngenioRx in the second quarter of 2019, and completed the transition of all of our members on January 1, 2020. Prior to the termination of the ESI PBM Agreement, Express Scripts managed the network of pharmacy providers, operated mail order pharmacies and processed prescription drug claims on our behalf, while we sold and supported the product for our members, made formulary decisions, sold drug benefit design strategy and provided front line member support. We expect IngenioRx to provide our members with more cost-effective solutions and improve our ability to integrate pharmacy benefits within our medical and specialty platform. Notwithstanding our termination of the ESI PBM Agreement, the litigation between us and Express Scripts regarding the ESI PBM Agreement continues. In March 2016, we filed a lawsuit against Express Scripts seeking to recover damages for pharmacy pricing that is higher than competitive benchmark pricing and damages related to operational breaches. Express Scripts filed an answer to the lawsuit disputing our contractual claims and alleging various defenses and counterclaims. For additional information regarding this lawsuit, see Note 13, "Commitments and Contingencies - *Litigation and Regulatory Proceedings - Express Scripts, Inc. Pharmacy Benefit Management Litigation,*" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

On June 6, 2019, we announced our entrance into an agreement to acquire Beacon Health Options, Inc., or Beacon, the largest independently held behavioral health organization in the country. Beacon serves approximately 40 million individuals across all 50 states. This acquisition aligns with our strategy to diversify into health services and deliver both integrated solutions and care delivery models that personalize care for people with complex and chronic conditions. The acquisition is expected to close in the first quarter of 2020 and is subject to standard closing conditions and customary approvals.

In May 2017, we announced that we were terminating the Agreement and Plan of Merger, or Cigna Merger Agreement, between us and Cigna. Both we and Cigna have commenced litigation against the other seeking various actions and damages, including Cigna's damage claim for a $1.850 billion termination fee pursuant to the terms of the Cigna Merger Agreement. For additional information about the ongoing litigation related to the Cigna Merger Agreement, see Note 13, "Commitments and Contingencies - *Litigation and Regulatory Proceedings - Cigna Corporation Merger Litigation,*" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

At Anthem, we believe in working together to achieve our mission of improving lives and communities, simplifying healthcare and expecting more. As we seek to accomplish these goals through a collaborative focus on execution and delivering for those we serve, our vision is to be the most innovative, valuable and inclusive health partner. We focus on ensuring quality products and services that give members access to the care they need. With an unyielding commitment to meeting the needs of our diverse customers, we are guided by the following values:

- Leadership – Redefine what is possible
- Community – Committed, connected, invested
- Integrity – Do the right thing, with a spirit of excellence
- Agility – Delivery today, transform tomorrow
- Diversity – Open your hearts and minds

By striving to live our values each day and in every interaction, we are committed to simplifying as well as radically reinventing the healthcare experience for all Americans.

We offer a broad spectrum of network-based managed care plans to Large Group, Small Group, Individual, Medicaid and Medicare markets. Our managed care plans include: Preferred Provider Organizations, or PPOs; Health Maintenance Organizations, or HMOs; Point-of-Service, or POS, plans; traditional indemnity plans and other hybrid plans, including Consumer-Driven Health Plans, or CDHPs; and hospital only and limited benefit products. In addition, we provide a broad array of managed care services to self-funded customers, including claims processing, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services. We provide an array of specialty and other insurance products and services such as PBM services, dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal healthcare. We also provide services to the federal government in connection with our Federal Health Products & Services business, or FHPS, which administers the Federal Employees Health Benefits, or FEHB, Program.

An ongoing focus on healthcare costs by employers, the government and consumers has continued to drive the growth of alternatives to traditional indemnity health insurance. HMO, PPO and hybrid plans are among the various forms of managed care products that have been developed. Through these types of products, insurers attempt to contain the cost of healthcare by negotiating contracts with hospitals, physicians and other providers to deliver high-quality healthcare to members at favorable rates. These products usually feature medical management and other quality and cost optimization measures such as pre-admission review and approval for certain non-emergency services, pre-authorization of outpatient surgical procedures, network credentialing to determine that network physicians and hospitals have the required certifications and expertise, and various levels of care management programs to help members better understand and navigate the healthcare system. In addition, providers may have incentives to achieve certain quality measures, may share medical cost risk or may have other incentives to deliver quality medical services in a cost-effective manner. Also, certain plans offer members incentives for healthy behaviors, such as smoking cessation and weight management. Members are charged periodic, prepaid premiums and generally pay co-payments, coinsurance and/or deductibles when they receive services. While the distinctions between the various types of plans have lessened over recent years, PPO, POS and CDHP products generally provide reduced benefits for out-of-network services, while traditional HMO products generally provide little to no reimbursement for non-emergency out-of-network utilization, but often offer more generous benefit coverage. An HMO plan may also require members to select one of the network primary care physicians, or PCPs, to coordinate their care and approve any specialist or other services.

Economic factors, greater consumer and employer sophistication and accountability have resulted in an increased demand for choice in both product/benefit designs and provider network configurations. As a result, we continue to offer our broad access PPO networks with multiple benefit designs, but are also focused on leveraging our provider collaboration

initiatives with our Accountable Care Organization, or ACO, partnerships to develop both narrow and tiered network offerings. This array of network and product configurations allows both the employer and the employee to design and select the combination of benefit designs (e.g., traditional PPOs, high deductibles, health reimbursement accounts, health savings accounts, PCP based products, tiered copays) and networks (e.g., broad, narrow, tiered, closed or exclusive provider, and open) that optimize choice, quality and price at the consumer, employer and market level. We believe we are well-positioned in each of our states to respond to these market preferences.

For our fully-insured products, we charge a premium and assume the risk for the cost of covered healthcare services. Under self-funded products, we charge a fee for services and the employer or plan sponsor funds or reimburses us for the healthcare costs. In addition, we charge a premium to underwrite stop loss insurance for Local Group and National Account employers that maintain self-funded health plans.

Our medical membership includes seven different customer types: Local Group, Individual, National Accounts, BlueCard®, Medicare, Medicaid and FEHB. BCBS-branded business generally refers to members in our service areas licensed by the BCBSA. Non-BCBS-branded business refers to members in our non-BCBS-branded Amerigroup, Freedom Health, HealthSun, Optimum HealthCare and Simply Healthcare plans, as well as HealthLink and UniCare members. In addition to the above medical membership, we also serve customers who purchase one or more of our other products or services that are often ancillary to our health business.

Our products are generally developed and marketed with an emphasis on the differing needs of our customers. In particular, our product development and marketing efforts take into account the differing characteristics between the various customers served by us, as well as the unique needs of educational and public entities, labor groups, federal employee health and benefit programs, national employers and state-run programs servicing low-income, high-risk and underserved markets. Overall, we seek to establish pricing and product designs to provide value for our customers while achieving an appropriate level of profitability for each of our customer categories balanced with the competitive objective to grow market share. We believe that one of the keys to our success has been our focus on these distinct customer types, which better enables us to develop benefit plans and services that meet our customers' unique needs. Further, IngenioRx was built to simplify pharmacy care and focus on the whole person, and we expect it will make it easier for our customers to achieve the best possible health outcomes at the lowest possible total cost of care.

We market our Individual, Medicare and certain Local Group products through direct marketing activities and an extensive network of independent agents, brokers and retail partnerships. Products for National Accounts and Local Group customers with a larger employee base are generally sold through independent brokers or consultants retained by the customer who work with industry specialists from our in-house sales force. In the Individual and Small Group markets, we offer on-exchange products through state- or federally-facilitated marketplaces, referred to as public exchanges, and off-exchange products. Federal subsidies are available for certain members, subject to income and family size, who purchase public exchange products.

Being a licensee of the BCBS association of companies, of which there were 36 independent primary licensees including us as of December 31, 2019, provides significant market value, especially when competing for very large multi-state employer groups. For example, each BCBS member company is able to utilize other BCBS licensees' substantial provider networks and discounts when any BCBS member works or travels outside of the state in which their policy is written. This program is referred to as BlueCard® and is a source of revenue when we provide member services in the states where we are the BCBS licensee to individuals who are customers of BCBS plans not affiliated with us. This program also provides a national provider network for our members when they travel to other states.

For additional information describing each of our customer types, detailed marketing efforts and changes in medical membership over the last three years, see "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in Part II, Item 7 of this Annual Report on Form 10-K.

Our results of operations depend in large part on our ability to accurately predict and effectively manage healthcare costs through effective contracting with providers of care to our members, product pricing, medical management and health and wellness programs, including service coordination and case management for addressing complex and specialized health care needs, innovative product design and our ability to maintain or achieve improvement in our CMS Star ratings. CMS Star ratings affect Medicare Advantage plan reimbursements as well as our eligibility to earn quality-based bonus payments for those plans. See "Regulation" herein for additional information on our CMS Star ratings.

Advances in medical technology, increases in specialty drug costs, increases in hospital expenditures and other provider costs, the aging of the population and other demographic characteristics continue to contribute to rising healthcare costs. Our managed care plans and products are designed to encourage providers and members to participate in quality, cost-effective health benefit programs by using the full range of our innovative medical management services, quality initiatives and financial incentives. Our market share and high business retention rates enable us to realize the long-term benefits of investing in preventive and early detection programs. Our ability to provide cost-effective health benefits products and services is enhanced through a disciplined approach to internal cost containment, prudent management of our risk exposure and successful integration of acquired businesses. In addition, our ability to manage selling, general and administrative costs continues to be a driver of our overall profitability.

The future results of our operations will also be impacted by certain external forces and resulting changes in our business model and strategy. The continuing growth in our government-sponsored business exposes us to increased regulatory oversight. The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended, or collectively, the ACA, has changed and may continue to make broad-based changes to the U.S. healthcare system. The ACA presented us with new growth opportunities, but also introduced new risks, regulatory challenges and uncertainties, and required changes in the way products are designed, underwritten, priced, distributed and administered. Changes to our business environment are likely to continue as elected officials at the national and state levels continue to enact, and both elected officials and candidates for election continue to propose, significant modifications to existing laws and regulations, including changes to taxes and fees. In addition, the legal challenges regarding the ACA, including a federal district court decision invalidating the ACA, or the "2018 ACA Decision", which judgment has been stayed pending appeal, continue to contribute to this uncertainty. We will continue to evaluate the impact of the ACA as additional guidance is made available and any further developments or judicial rulings occur. For additional discussion, see "Regulation" herein and Part I, Item 1A "Risk Factors" in this Annual Report on Form 10-K.

In addition to the external forces discussed in the preceding paragraph, our results of operations are impacted by levels and mix of membership which can change as a result of the quality and pricing of our health benefits products and services, aging population, economic conditions, changes in unemployment, acquisitions, entry into new markets and expansions in or exits from existing markets. These membership trends could be negatively impacted by various factors that could have a material adverse effect on our future results of operations such as general economic downturns that result in business failures, failure to obtain new customers or retain existing customers, premium increases, benefit changes or our exit from a specific market. See Part I, Item 1A "Risk Factors" and Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K.

During 2019, we modestly expanded our participation in the Individual ACA-compliant market. Our strategy has been, and will continue to be, to only participate in rating regions where we have an appropriate level of confidence that these markets are on a path toward sustainability, including, but not limited to, factors such as expected financial performance, regulatory environment, and underlying market characteristics. We currently offer Individual ACA-compliant products in 91 of the 143 rating regions in which we operate.

We believe healthcare is local and that we have the strong local presence required to understand and meet local customer needs with regard to any product they are enrolled in with us. Further, we believe we are well-positioned to deliver what customers want: innovative, choice-based and affordable products; distinctive service; simplified transactions; and better access to information for quality care. Our local presence, combined with our national expertise, has created opportunities for collaborative programs that reward physicians and hospitals for clinical quality and excellence. We feel that our commitment to health improvement and care management provides added value to customers and healthcare professionals. Ultimately, we believe that practical and sustainable improvements in healthcare must focus on improving healthcare quality while managing costs for total affordability. We have implemented initiatives driving payment innovation and partnering with providers to lower cost and improve the quality of healthcare for our members, and we continue to develop new and innovative ways to effectively manage risk and engage our members. Further, we are expanding our financial arrangements with providers to include payment models that encourage value-based care. We believe focusing on quality of care rather than volume of care is the foundation for improving patient outcomes. Our value-based payment model supports patient-centered care by improving collaboration between providers and health partners and delivering to our patients the right care, at the right time, in the right place. In addition, we are focused on achieving efficiencies from our national scale while optimizing service performance for our customers. Finally, we expect to continue to rationalize our portfolio of businesses and products

and align our investments to capitalize on new opportunities to drive growth in our existing markets and expand into new markets in the future.

We continue to enhance interactions with customers, providers, brokers, agents, employees and other stakeholders through web-enabled technology and improving internal operations. Our approach includes not only the sales and distribution of health benefits products on the Internet, but also implementing advanced capabilities that improve services benefiting customers, agents, brokers, and providers while optimizing administrative costs. These enhancements can also help improve the quality, coordination and safety of healthcare through increased communications between patients and their physicians.

In pursuing our vision of being the most innovative, valuable and inclusive partner, we intend to transform healthcare by providing trusted and caring solutions and delivering quality products and services that give customers access to the care they need. At the same time, we will focus on earnings, organic membership growth, improvements in our operating cost structure, strategic acquisitions and the efficient use of capital.

Significant Transactions

The significant transactions that have occurred over the last five years that have impacted or will impact our capital structure or that have influenced or will influence how we conduct our business operations include:

- Launch of IngenioRx (2019);
- Acquisition of America's 1st Choice (2018);
- Acquisition of HealthSun Health Plans, Inc., or HealthSun (2017);
- Acquisition of Simply Healthcare Holdings, Inc., or Simply Healthcare (2015); and
- Use of Capital—Board of Directors declarations of dividends on our common stock; repurchases of our common stock; and debt repurchases and new debt issuances (2019 and prior).

For additional information regarding certain of these transactions, see Note 3, "Business Acquisitions," Note 12, "Debt," and Note 14, "Capital Stock," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Competition

The managed care industry is highly competitive, both nationally and in our local markets. Competition continues to be intense due to aggressive marketing, pricing, government-sponsored programs bid activity, business consolidations, new strategic alliances, new competitors in the market, a proliferation of new products, technological advancements, the impact of legislative reform, and increased quality awareness and price sensitivity among customers.

We believe that participants in the managed care industry compete for customers based on quality of service, price, access to provider networks, access to care management and wellness programs (including health information), innovation, breadth and flexibility of products and benefits, expertise and reputation (including National Committee on Quality Assurance, or NCQA, accreditation status), brand recognition and financial stability. Our ability to attract and retain customers is substantially tied to our ability to distinguish ourselves from our competitors in these areas.

Also, a health plan's ability to interact with employers, customers and other third parties (including healthcare professionals) through electronic data transfer has become a more important competitive factor, and we have made significant investments in technology to enhance our electronic interaction with providers, employers, customers and third parties.

We believe our exclusive right to market products under the most recognized brand in the industry, BCBS, in our most significant markets provides us with greater brand recognition over competitive product offerings. Our provider networks in our markets enable us to achieve efficiencies and distinctive service levels by allowing us to offer a broad range of health benefits to our customers on a more cost-effective basis than many of our competitors. We strive to distinguish our products through provider access, service, care management, product value and brand recognition.

Product pricing remains competitive and we strive to price our healthcare benefit products and design our Medicare and Medicaid bids consistent with anticipated underlying medical trends. We believe our pricing and bid strategy, based on

predictive modeling, proprietary research and data-driven processes, has positioned us to benefit from the potential growth opportunities available through entry into new markets, expansions in existing markets and as a result of any future changes to the current regulatory scheme. We believe that our pricing and bid strategy, brand name and network quality will provide a strong foundation for membership growth opportunities in the future.

To build our provider networks, we compete with other health benefits plans for the best contracts with hospitals, physicians and other providers. We believe that physicians and other providers primarily consider customer volume, reimbursement rates, timeliness of reimbursement and administrative service capabilities along with the reduction of non-value added administrative tasks when deciding whether to contract with a health benefits plan.

At the sales and distribution level, we compete for qualified agents and brokers to recommend and distribute our products. Strong competition exists among insurance companies and health benefits plans for agents and brokers with demonstrated ability to secure new business and maintain existing accounts. We believe that the quality and price of our products, support services, reputation and prior relationships, along with a reasonable commission structure, are the factors agents and brokers consider in choosing whether to market our products. We believe that we have good relationships with our agents and brokers, and that our products, support services and commission structure compare favorably to those of our competitors in all of our markets. Typically, we are the largest competitor in each of our BCBS branded markets and, thus, are a closely-watched target by other insurance competitors.

In addition, the PBM industry is highly competitive, and IngenioRx is subject to competition from national, regional and local PBMs, insurers, health plans, large retail pharmacy chains, large retail stores, supermarkets, other mail order pharmacies, web pharmacies and specialty pharmacies.

Reportable Segments

We manage our operations through three reportable segments: Commercial & Specialty Business, Government Business and Other. We regularly evaluate the appropriateness of our reportable segments, particularly in light of organizational changes, merger and acquisition activity and changing laws and regulations. Prior to the second quarter of 2019, our Other segment included certain eliminations and corporate expenses not allocated to either of our other reportable segments. Beginning with the second quarter of 2019, our Other segment also includes IngenioRx, our pharmacy benefits manager, which began operations during the second quarter of 2019. In addition, during the second quarter of 2019, we reclassified our integrated health services business, our Diversified Business Group, or DBG, from our Government Business segment to the Other segment to reflect changes in how our segments are being managed. Amounts for prior years have been reclassified to conform to the current year presentation for comparability. Based on the Financial Accounting Standards Board, or FASB, guidance, as of December 31, 2019, IngenioRx and DBG did not collectively meet the quantitative thresholds for a reportable segment. Current reportable segments may change in the future.

Our Commercial & Specialty Business and Government Business segments both offer a diversified mix of managed care products, including PPOs, HMOs, traditional indemnity benefits and POS plans, as well as a variety of hybrid benefit plans including CDHPs, hospital only and limited benefit products.

Our Commercial & Specialty Business segment includes our Local Group, National Accounts, Individual and Specialty businesses. Business units in the Commercial & Specialty Business segment offer fully-insured health products; provide a broad array of managed care services to self-funded customers including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services; and provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits.

Our Government Business segment includes our Medicare and Medicaid businesses, National Government Services, or NGS, and services provided to the federal government in connection with our FHPS business. Medicaid makes federal matching funds available to all states for the delivery of healthcare benefits to eligible individuals, principally those with incomes below specified levels who meet other state-specified requirements. Medicaid is structured to allow each state to establish its own eligibility standards, benefits package, payment rates and program administration under broad federal guidelines. Our Medicare customers are Medicare-eligible individual members age 65 and over who have enrolled in Medicare Advantage, a managed care alternative for the Medicare program, or who have purchased Medicare Supplement benefit coverage, some disabled members under age 65, or members of all ages with end stage renal disease. Medicare

Supplement policies are sold to Medicare recipients as supplements to the benefits they receive from the Medicare program. Medicare Supplement policy rates are filed with, and in some cases approved by, state insurance departments. Most of the premium for Medicare Advantage is based on bids submitted to CMS and paid directly by the federal government on behalf of the participant who may also be charged a small premium. Additionally, through our alliance partnership engagements with larger provider groups and BCBS plans, we offer a variety of Medicaid services that include joint ventures, administrative service offerings, and full-risk arrangements. NGS acts as a Medicare contractor for the federal government in several regions across the nation.

Our Other segment includes our PBM business (IngenioRx), our integrated health services business (DBG) and corporate expenses not allocated to either of our other reportable segments.

Through our participation in various federal government programs, we generated approximately 20.7%, 19.8% and 17.8% of our total consolidated revenues from agencies of the U.S. government for the years ended December 31, 2019, 2018 and 2017, respectively. These revenues are contained in the Government Business segment. An immaterial amount of our total consolidated revenues is derived from activities outside of the U.S.

Products and Services

A general description of our products and services is provided below:

Preferred Provider Organization: PPO products offer the member an option to select any healthcare provider, with benefits reimbursed by us at a higher level when care is received from a participating network provider. Increasingly, customers are choosing our PPO products offered with an exclusive provider organization, which eliminates coverage out of network. Coverage is subject to co-payments or deductibles and coinsurance, with member cost sharing usually limited by out-of-pocket maximums.

Consumer-Driven Health Plans: CDHPs provide consumers with increased financial responsibility, choice and control regarding how their healthcare dollars are spent. Generally, CDHPs combine a high-deductible PPO plan with an employer-funded and/or employee-funded personal care account, which may result in tax benefits to the employee. Some or all of the dollars remaining in the personal care account at year-end can be rolled over to the next year for future healthcare needs.

Traditional Indemnity: Indemnity products offer the member an option to select any healthcare provider for covered services. Coverage is subject to deductibles and coinsurance, with member cost sharing usually limited by out-of-pocket maximums.

Health Maintenance Organization: HMO products include comprehensive managed care benefits, generally through a participating network of physicians, hospitals and other providers. A member in one of our HMOs must typically select a PCP from our network. PCPs generally are family practitioners, internists or pediatricians who provide necessary preventive and primary medical care, and are generally responsible for coordinating other necessary healthcare services. We offer HMO plans with varying levels of co-payments, which result in different levels of premium rates.

Point-of-Service: POS products blend the characteristics of HMO, PPO and indemnity plans. Members can have comprehensive HMO-style benefits through participating network providers with minimum out-of-pocket expenses (co-payments) and also can go directly, without a referral, to any provider they choose, subject to, among other things, certain deductibles and coinsurance. Member cost sharing is limited by out-of-pocket maximums.

Public Exchange and Off-Exchange Products: Individual and Small Group products cover essential health benefits as defined in the ACA along with many other requirements and cost sharing features. Individual and Small Group products offered on and off the public exchanges meet the definition of the “metal” product requirements (bronze, silver, gold and platinum) and each metal product must satisfy a specific actuarial value. Health insurers participating on the public exchanges must offer at least one silver and one gold product.

Administrative Services: In addition to fully-insured products, we provide administrative services to Large Group, Small Group and National Account employers that maintain self-funded health plans. These administrative services include underwriting, actuarial services, medical cost management, disease management, wellness programs, claims processing and other administrative services for self-funded employers. Self-funded health plans are also able to use our provider networks and to realize savings through our negotiated provider arrangements, while allowing employers the ability to design certain

health benefit plans in accordance with their own requirements and objectives. We also underwrite stop loss insurance for self-funded plans.

BlueCard®: BlueCard® is a national program that links participating healthcare providers and independent BCBS plans. BlueCard® host members are generally members who reside in or travel to a state in which an Anthem subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer-sponsored health plan serviced by a non-Anthem controlled BCBS licensee, which is the "home" plan. We perform certain administrative functions for BlueCard® host members, for which we receive administrative fees from the BlueCard® members' home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan.

Medicare Plans: We offer a wide variety of plans, products and options to individuals age 65 and older such as Medicare Supplement plans; Medicare Advantage, including Special Needs Plans or SNPs, also known as Medicare Advantage SNPs; Medicare Part D Prescription Drug Plans, or Medicare Part D; and dual-eligible programs through Medicare-Medicaid Plans, or MMPs. Medicare Supplement plans typically pay the difference between healthcare costs incurred by a beneficiary and amounts paid by Medicare. Medicare Advantage plans provide Medicare beneficiaries with a managed care alternative to traditional Medicare and often include a Medicare Part D benefit. In addition, our Medicare Advantage SNPs provide tailored benefits to special needs individuals who are institutionalized or have severe or disabling chronic conditions and to dual-eligible customers, who are low-income seniors and persons under age 65 with disabilities. Medicare Advantage SNPs are coordinated care plans specifically designed to provide targeted care, covering all the health care services considered medically necessary for members and often providing professional care coordination services, with personal guidance and programs that help members maintain their health. Medicare Part D offers a prescription drug plan to Medicare and MMP beneficiaries. MMP is a demonstration program focused on serving members who are dually eligible for Medicaid and Medicare, which was established as a result of the passage of the ACA. We offer these plans to customers through our health benefit subsidiaries throughout the country, including America's 1st Choice, Amerigroup, CareMore, HealthSun and Simply Healthcare.

Individual Plans: We offer a full range of health insurance plans with a variety of options and deductibles for individuals who are not covered by employer-sponsored coverage and are not eligible for government sponsored plans, such as Medicare and/or Medicaid. Individual policies are generally sold through independent agents and brokers, retail partnerships, our in-house sales force or via the exchanges. Individual business is sold on a fully-insured basis. We offer on-exchange products through public exchanges and off-exchange products. Federal premium subsidies are available only for certain public exchange Individual products. Unsubsidized Individual customers are generally more sensitive to product pricing and, to a lesser extent, the configuration of the network and the efficiency of administration. Instability in the Individual market has resulted in a targeted approach where we offer products in select geographies.

Medicaid Plans and Other State-Sponsored Programs: We have state contracts to serve members enrolled in publicly funded healthcare programs, including Medicaid; ACA-related Medicaid expansion programs; Temporary Assistance for Needy Families, or TANF; programs for seniors and people with disabilities, or SPD; Children's Health Insurance Programs, or CHIP; and specialty programs such as those focused on long-term services and support, or LTSS, HIV/AIDS, children living in foster care, behavioral health and/or substance abuse disorders, and intellectual disabilities and/or developmental disabilities, or ID/DD programs. The Medicaid program makes federal matching funds available to all states for the delivery of healthcare benefits for low income and/or high medical risk individuals. These programs are managed by the individual states based on broad federal guidelines. TANF is a state and federally funded program designed for the population consisting primarily of low-income children and their guardians. SPD is a federal income supplement program designed for Supplemental Security Income recipients; however, states can broaden eligibility criteria. This population consists of low-income seniors and people with disabilities. CHIP is a state and federally funded program that provides healthcare coverage to children not otherwise covered by Medicaid or other insurance programs. LTSS is a state and federally funded program that offers states a broad and flexible set of program design options and refers to the delivery of long-term services and support for our members who receive home and community- or institution-based services for long-term care. Our HIV/AIDS program is a state and federally sponsored program that provides services to those living with HIV/AIDS. Our foster care program is a state and federally sponsored program serving children with complex needs within the foster care system. Our behavioral health program is a state and federally sponsored program providing services to those with mental health and/or substance abuse disorders. ID/DD is a state and federally sponsored program serving those living with limitations in intellectual functioning and adaptive behavior learning disabilities. Our Medicaid plans also cover certain dual-eligible customers, as previously described above, who also receive Medicare benefits. We provide Medicaid and other state

sponsored services, such as administrative services, in Arkansas, California, Colorado, Florida, Georgia, Indiana, Iowa, Kentucky, Louisiana, Maryland, Minnesota, Missouri, Nebraska, Nevada, New Jersey, New York, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia, Wisconsin and Washington D.C.

Pharmacy Products: In the second quarter of 2019, we began using IngenioRx to market and sell a PBM product to fully-insured and self-funded Anthem health plan customers throughout the country, as well as to customers outside of the health plans we own. This comprehensive product portfolio includes features such as drug formularies, a pharmacy network, prescription drug database, member services, and mail order capabilities. In July 2019, we announced our first contract win with a third-party health insurer, Blue Cross of Idaho, and we began providing PBM services under that contract beginning on January 1, 2020. Also beginning in the second quarter of 2019, we began delegating certain PBM administrative functions, such as claims processing and prescription fulfillment, to CVS Health pursuant to the CVS PBM Agreement. We intend to retain the responsibilities for IngenioRx's clinical and formulary strategy and development, member and employer experiences, operations, sales, marketing, account management and retail network strategy. From December 2009 through December 2019, we delegated certain PBM functions and administrative services to Express Scripts pursuant to the ESI PBM Agreement, excluding certain health plans and self-insured members who have exclusive agreements with different PBM service providers. We began transitioning existing members from Express Scripts to IngenioRx in the second quarter of 2019 and completed the transition of all of our members on January 1, 2020. Express Scripts managed the network of pharmacy providers, operated mail order pharmacies and processed prescription drug claims on our behalf, while we sold and supported the product for our members, made formulary decisions, sold drug benefit design strategy and provided front line member support.

Life Insurance: We offer an array of competitive individual and group life insurance benefit products to both Large Group and Small Group customers in conjunction with our health plans. The life products include term life and accidental death and dismemberment.

Disability: We offer short-term and long-term disability products, usually in conjunction with our health plans.

Radiology Benefit Management: We offer outpatient diagnostic imaging management services to health plans, which promote the most appropriate use of clinical services to improve the quality of care delivered to members. These services include utilization management for advanced diagnostic imaging procedures, network development and optimization, patient safety, claims adjudication and provider payment.

Personal Health Care Guidance: We offer evidence-based and analytics-driven personal healthcare guidance. These services help improve the quality, coordination and safety of healthcare, enhance communications between patients and their physicians, and reduce medical costs.

Dental: Our dental plans include networks in certain states in which we operate. Many of the dental benefits are provided to customers enrolled in our health plans and are offered on both a fully-insured and self-funded basis. Our members also have access to additional dental providers through our participation in the National Dental GRID, a national dental network developed by and for BCBS plans. The National Dental GRID includes dentists in all 50 states and the District of Columbia and provides multi-state customers with a national solution that offers in-network discounts across the country. Additionally, we offer managed dental services to other healthcare plans to assist those plans in providing dental benefits to their customers.

Vision Services and Products: Our vision plans include networks within the states in which we operate. Many of the vision benefits are provided to customers enrolled in our health plans and are offered on both a fully-insured and self-funded basis.

Medicare Administrative Operations: Through our subsidiary, NGS, we serve as a fiscal intermediary, carrier and Medicare administrative contractor for the federal government by providing administrative services for the Medicare program, Parts A and B, which generally provides coverage for persons who are 65 or older and for persons who are under 65 and disabled or with end-stage renal disease. Part A of the Medicare program provides coverage for services provided by hospitals, skilled nursing facilities and other healthcare facilities. Part B of the Medicare program provides coverage for services provided by physicians, physical and occupational therapists and other professional providers, as well as certain durable medical equipment and medical supplies.

Networks and Provider Relations

Our relationships with physicians, hospitals and professionals that render healthcare services to our members are guided by local, regional and national standards for network development, reimbursement and contract methodologies. While following industry standards, we are simultaneously seeking to lead transformation efforts within our healthcare system, moving from a fragmented model premised on episodic intervention to one based on proactive, coordinated care built around the needs of the patient. A key element of this transformation involves a transition from traditional fee-for-service payment models to models where providers are paid based on the value, both in quality and affordability, of the care they deliver.

We establish "market-based" hospital reimbursement payments that we believe are fair, but aggressive, and among the most competitive in the market. We also seek to ensure that physicians in our network are paid in a timely manner at appropriate rates. In many instances, we deploy multi-year contracting strategies, including case rates or fixed rates, to limit our exposure to medical cost inflation and to increase cost predictability. We maintain both broad and narrow provider networks to ensure member choice, based on both price and access needs, while implementing programs designed to improve the quality of care our members receive. Increasingly, we are supplementing our broad-based networks with smaller or more cost-effective networks that are designed to be attractive to a more price-sensitive customer segment, such as public exchange customers.

Our reimbursement strategies vary across markets and depend on the degree of consolidation and integration of physician groups and hospitals. Under a fee-for-service reimbursement methodology for physicians, fee schedules are developed at the state level based on an assessment of several factors and conditions, including the CMS resource-based relative value system, or RBRVS, medical practice cost inflation and physician supply. We utilize CMS RBRVS fee schedules as a reference point for fee schedule development and analysis. The RBRVS structure was developed, maintained, and updated by CMS and is used by the Medicare program and other major payers. In addition, we have implemented and continue to expand physician incentive contracting, or "pay-for-performance," which ties physician payment levels to performance on clinical measures.

While we generally do not delegate full financial responsibility to our physician providers in the form of capitation-based reimbursement, we maintain capitation-based arrangements in certain markets where we determine that market dynamics result in it being a useful method to lower costs and reduce underwriting risk.

Our hospital contracts provide for a variety of reimbursement arrangements depending on local market dynamics and current hospital utilization efficiency. Most hospitals are reimbursed a fixed amount per day or reimbursed a per-case amount, per admission, for inpatient covered services. A small percentage of hospitals, primarily rural, sole community hospitals, are reimbursed on a discount from approved charge basis for covered services. Our "per-case" reimbursement methods utilize many of the same attributes contained in Medicare's Diagnosis Related Groups methodology. Hospital outpatient services are reimbursed by fixed case rates, fee schedules or percent of approved charges. Our hospital contracts recognize unique hospital attributes, such as academic medical centers or community hospitals, and the volume of care performed for our members. To improve predictability of expected costs, we frequently use a multi-year contracting approach with providers. In addition, the majority of our hospital contracts include a pay-for-performance component where reimbursement levels are linked to improved clinical performance, patient safety and medical error reduction.

Our provider engagement and contracting strategies are moving away from "unit price" or volume-based payment models to payment models that align compensation with the value delivered as measured by healthcare outcomes, quality and cost. Our Enhanced Personal Health Care program augments traditional fee-for-service with shared savings opportunities for providers when actual healthcare costs are below projected costs and providers meet specific quality measures. The quality measures are based on nationally accepted, credible standards (e.g., NCQA, the American Diabetes Association and the American Academy of Pediatrics) and span preventive, acute and chronic care. We understand, however, that payment incentives alone are insufficient to create the large-scale, system-wide transformation required to achieve meaningful impacts on cost, quality and member experience. Accordingly, we are investing in care delivery transformation and population health management support structures to help providers succeed under value-based payment models. This support includes our web-based population health management technology and teams of dedicated practice consultants who work alongside providers, sharing best practices, and helping them leverage our data to the benefit of their patients. In some of these arrangements, participating physician practices receive a per-member, per-month clinical coordination fee to compensate them for important care management activities that occur outside of the patient visit (e.g., purchasing an electronic health record or hiring care

management nurses), all of which have been shown to reduce healthcare costs and improve care outcomes. Since the launch of our Enhanced Personal Health Care program, we now have arrangements with provider organizations covering 52% of our PCPs and have rolled this program out in each of the 14 states where we operate as a licensee of the BCBSA.

Medical Management Programs

Our medical management programs include a broad array of activities that facilitate improvements in the quality of care provided to our members and promote cost-effective medical care. These medical management activities and programs are administered and directed by physicians and nurses. The goals of our medical management strategies are to ensure that the care delivered to our members is supported by appropriate medical and scientific evidence, is received on a timely basis and occurs in the most appropriate setting. The following is a general description of our medical management programs, which are available to our members depending on the particular plan or product in which they participate:

Precertification: A traditional medical management program involves assessment of the appropriateness of certain hospitalizations and other medical services prior to the services being rendered. For example, precertification is used to determine whether a set of hospital and medical services is being appropriately applied to the member's clinical condition, in accordance with criteria for medical necessity as that term is defined in the member's benefits contract. All of our health plans have implemented precertification programs for selected medical services including surgeries, major diagnostic procedures, devices, drugs and other services to help members maximize benefits and avoid unnecessary charges or penalties. Through our American Imaging Management, Inc. subsidiary, doing business as AIM Specialty Health, or AIM, we promote appropriate, safe and affordable member care in the areas of imaging, sleep disorders, cardiac testing, oncology drugs and musculoskeletal procedures. These expanded specialty benefit management solutions leverage clinical expertise and technology to engage our provider communities and members in more effective and efficient use of outpatient services.

Care coordination: Another traditional medical management strategy we use is care coordination, which is based on nationally recognized criteria developed by third-party medical specialists. With inpatient care coordination, the requirements and intensity of services during a patient's hospital stay are reviewed, at times by an onsite, skilled nurse professional in collaboration with the hospital's medical and nursing staff, in order to coordinate care and determine the most effective transition of care from the hospital setting. In addition, continued stay cases are reviewed with physician medical directors to ensure appropriate utilization of medical services. We also coordinate care for outpatient services to help ensure that patients with chronic conditions who receive care from multiple physicians are able to manage the exchange of information between physicians and coordinate office visits to their physicians.

Case management: We have implemented a medical management strategy focused on identifying the small percentage of the membership that will require a high level of intervention and assistance to manage their healthcare needs. Case Management identifies members who are likely to be re-admitted to the hospital through claims analysis using predictive modeling techniques, the use of health risk assessment data, utilization management reports and referrals from a physician or one of our other programs, such as the 24/7 NurseLine. Registered nurses, medical directors, behavioral health experts, pharmacists and other clinicians focus on these members and help them coordinate their care through pharmacy compliance, post-hospital care, follow-up visits to see their physician and support in their home. Increasingly, we collaborate with our providers and key health partners within the member's provider care team by providing actionable patient data insights, practice-coaching capabilities, technology and programs and products that help our providers and health partners to successfully deliver the right care, at the right time, in the right place.

Formulary management: We have developed formularies, which are selections of drugs based on clinical quality and effectiveness. A pharmacy and therapeutics committee of physicians uses scientific and clinical evidence to ensure that our members have access to the appropriate drug therapies and receive these therapies through proper settings.

Medical policy: A medical policy committee determines our national policies and guidelines for the application of medical technologies, procedures and services. This committee is comprised of internal and external physician leaders from various specialties and areas of the country. We also work in cooperation with academic medical centers, practicing community physicians and medical specialty organizations. All guidelines and policies are reviewed at least once a year or as new published clinical evidence becomes available.

Quality programs: We are actively engaged with our hospital and physician networks to enable them to improve medical and surgical care and achieve better outcomes for our members. We endorse, encourage and incentivize hospitals and

physicians to support national initiatives to improve the quality of clinical care and patient outcomes and to reduce medication errors and hospital infections.

External review procedures: We work with outside experts through a process of external review to provide our members scientifically and clinically, evidence-based medical care. When we receive member concerns, we have formal appeals procedures that ultimately allow coverage disputes related to medical necessity decisions under the benefits contract to be settled by independent expert physicians.

Provider cost comparison tools: Through Estimate Your Cost, Care & Cost Finder, and other web-based tools, our members can compare cost estimates, quality accreditation data and patient reviews for common services at contracted providers, with cost estimates for facility, professional and ancillary services. These cost estimates bundle related services typically performed at the time of the procedure, not just for the procedure itself. Users can review cost data for over 400 common, shop-able medical procedures in all states. Members can also estimate out-of-pocket costs based on a member's own benefit coverage, deductible, and out-of-pocket maximum. We also offer information on overall facility ratings and patient experience using trusted third-party data. We continue to work on enhancing and evolving our tools to assist members in making informed and value-based healthcare decisions. In addition, we collaborate with an external independent vendor to support employers wanting to purchase a consumer engagement solution with certain additional functionality.

Anthem Health Guide: Anthem Health Guide integrates the customer service experience with clinical and wellness coaching to provide easier navigation of healthcare services for our members. Anthem Health Guide provides members with education on benefit options and digital opportunities that fit member references, and makes recommendations for eligible clinical programs to ensure members are connected to the most appropriate care and clinical resources. By allowing members to connect with us using voice, click-to-chat, secure email and mobile technology, we enhance our ability to engage with our members.

Anthem Whole Health Connection: Anthem Whole Health Connection is a differentiated approach to whole person health that uniquely connects medical, pharmacy, dental, vision, disability and supplemental health clinical and claims data to proactively identify health issues earlier and engage our members with their health providers in new ways to support health, lower costs and deliver better healthcare experience. Anthem Whole Health Connection is included when Anthem health benefits are combined with one or more of the Anthem pharmacy, dental, vision, life, disability or supplemental health coverage plans.

Care Management Programs

We continue to expand our *360º Health* suite of integrated care management programs and tools. *360º Health* offers the following programs, among others, which are available to our members depending on the particular plan or product in which they participate, and have been proven to increase quality and reduce medical costs for our members:

ConditionCare and *FutureMoms* are care management and maternity management programs that serve as adjuncts to physician care. Skilled nurse professionals, with added support from our team of dietitians, social workers, pharmacists, health educators and other health professionals, help participants understand their condition, their doctor's orders and how to become a better self-manager of their condition. We also offer members infertility consultation through our SpecialOffers@Anthem program, a comprehensive and integrated assembly of discounted health and wellness products and services from a variety of the nation's leading retailers.

24/7 NurseLine offers access to qualified, registered nurses anytime. This allows our members to make informed decisions about the appropriate level of care and avoid unnecessary worry. This program also includes a referral process to the nearest urgent care facility, a robust audio library, accessible by phone, with more than 600 health and wellness topics, as well as on-line health education topics designed to educate members about symptoms and treatment of many common health concerns.

MyHealth Advantage utilizes integrated information systems and sophisticated data analytics to help our members improve their compliance with evidence-based care guidelines, providing personal care notes that alert members to potential gaps in care, enable more prudent healthcare choices, and assist in the realization of member out-of-pocket cost savings. Key opportunities are also shared with physicians through Availity® at the time of membership eligibility verification. Availity® is

an electronic data interchange system that allows for the exchange of health information among providers over a secure network.

MyHealth Coach provides our members with a professional guide who helps them navigate the healthcare system and make better decisions about their well-being. *MyHealth Coach* proactively reaches out to people who are at risk for potentially serious health issues or have complex healthcare needs. Our health coaches help participants understand and manage chronic conditions, handle any health and wellness related services they need and make smart lifestyle choices.

HealthyLifestyles helps employees transform unhealthy habits into positive ones by focusing on behaviors that can have a positive effect on their health and their employer's financial well-being. *HealthyLifestyles* programs include smoking cessation, weight management, stress management, physical activity, and diet and nutrition.

Behavioral Health Case Management is a comprehensive program supporting a wide range of members who are impacted by their behavioral health condition, including specialty areas such as eating disorders, anxiety, depression and substance abuse. The program assists members and their families with obtaining appropriate behavioral health treatment, offering community resources, providing education and telephonic support, and promoting provider collaboration.

Autism Spectrum Disorder Program is a specialized case management program staffed by a dedicated team of clinicians who have been trained on the unique challenges and needs of families with a member who has a diagnosis of autism spectrum disorder. These clinicians provide education, information on community resources to help with care and support, guidance on the appropriate usage of benefits, and assistance in exploring effective treatments, such as medical services, that may help the member and their families.

Employee Assistance Programs provide 24/7 telephonic support for personal and crisis events. Members also gain access to many resources that allow support within work and personal life by providing quick and easy access to confidential resources to help meet the challenges of daily life. Examples of services available include counseling, referral assistance with child care, health and wellness, financial issues, legal issues, adoption and daily living.

Healthcare Quality Initiatives

Increasingly, the healthcare industry is able to define quality healthcare based on preventive health measurements, outcomes of care and optimal care management for chronic disease. A key to our success has been our ability to work with our network physicians and hospitals to improve the quality and outcomes of the healthcare services provided to our members. Our ability to promote quality medical care has been recognized by NCQA, the largest and most respected national accreditation program for managed care health plans.

Several quality healthcare measures, including the Healthcare Effectiveness Data and Information Set, or HEDIS®, have been incorporated into NCQA's accreditation processes. HEDIS® measures range from preventive services, such as screening mammography and pediatric immunization, to elements of care, including decreasing the complications of diabetes and improving treatment for patients with heart disease. For health plans, NCQA's highest accreditation status of Excellent is granted only to those plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. Plans earning this accreditation level must also achieve HEDIS® results that are in the highest range of national or regional performance. Details for each of our plans' accreditation levels can be found at www.ncqa.org.

Our wholly-owned health outcomes research subsidiary, HealthCore, Inc., or HealthCore, generates consistent and actionable evidence to support decision making while helping to guide fresh initiatives for a range of stakeholders in the healthcare industry. By leveraging a rich array of medical and pharmacy utilization data queried from administrative claims, patient surveys, medical charts and laboratory diagnostics, among other health records, HealthCore's multi-disciplinary research teams uncover a broad spectrum of safety, effectiveness, pharmacoepidemiology, and health economics evidence. HealthCore's real world evidence and comparative effectiveness research, among other data, has played roles in the product planning and development campaigns of biotechnology and pharmaceutical companies and today it lists most of the leading biologics and drug manufacturers as clients or alliance partners. Its health plan research has led to better insights into evidence-based treatment approaches, the development of value-based initiatives to drive access and adherence to treatment, and the crafting of incentives to modify patient and provider behavior. One of HealthCore's predominant initiatives is its governmental and academic collaborations that include cooperation with some of the country's top institutions and federal

agencies, including the Food and Drug Administration, or FDA, Patient-Centered Outcomes Research Institute and the National Institutes of Health. HealthCore is also an active contributor to the FDA's medical product safety surveillance Sentinel program. HealthCore serves as the coordinating center for the National Heart, Lung, and Blood Institute's Pediatric Heart Network, a collaboration among 40 of the nation's top pediatric hospitals. Additionally, HealthCore has taken a thought-leadership position in the development of pragmatic clinical trials. As a notable contributor to the health outcomes evidence base, HealthCore's research findings are broadly disseminated during presentations at national and international medical meetings and are published in a variety of respected peer-reviewed medical and health services journals.

Our AIM subsidiary supports quality by implementing clinical appropriateness and patient safety solutions for advanced imaging procedures, cardiology, sleep medicine, medical oncology, radiation therapy, rehabilitative, certain outpatient surgical and musculoskeletal services. These programs, based on widely accepted and evidence-based clinical guidelines, promote the most appropriate use of clinical services to improve the quality of overall healthcare delivered to our members and members of other health plans that are covered under AIM's programs. To provide additional impact to its clinical appropriateness program, AIM has also implemented a provider assessment program, OptiNet®, which promotes more informed selection of diagnostic imaging and testing facilities by providing cost and facility information to physician offices at the point that a procedure is ordered. We have also leveraged AIM's provider network assessment information to proactively engage and educate our members about imaging providers and sleep testing choices based on site capabilities and cost differences. This program is another example of how we facilitate improvements in the quality of care provided to our members and promote cost-effective medical care.

Pricing and Underwriting of Our Products

We price our products based on our assessment of current healthcare claim costs and emerging healthcare cost trends, combined with charges for administrative expenses, risk and profit, including charges for the ACA taxes and fees, where applicable. We continually review our product designs and pricing guidelines on a national and regional basis so that our products remain competitive and consistent with our profitability goals and strategies.

Our revenue on Medicare policies is based on annual bids submitted to CMS. We base the commercial and Medicaid premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period. In applying our pricing to each employer group and customer, we aim to maintain consistent, competitive, disciplined underwriting standards. We employ our proprietary accumulated actuarial and financial data to determine underwriting and pricing parameters for both our fully-insured and self-funded businesses.

In most circumstances, our pricing and underwriting decisions follow a prospective rating process in which a fixed premium is determined at the beginning of the contract period. For our fully-insured business, any deviation, favorable or unfavorable, from the medical costs assumed in determining the premium is our responsibility. Some of our larger groups employ retrospective rating reviews, where positive experience is partially refunded to the group, and negative experience is charged against a rate stabilization fund established from the group's favorable experience or charged against future favorable experience.

BCBSA Licenses

We are a party to license agreements with the BCBSA that entitle us to the exclusive, and in certain areas, non-exclusive use of the Blue Cross and Blue Shield names and marks in assigned geographic territories. BCBSA is a national trade association of Blue Cross and Blue Shield licensees, the primary function of which is to promote and preserve the integrity of the BCBS names and marks, as well as provide certain coordination among the member companies. Each BCBSA licensee is an independent legal organization and is not responsible for obligations of other BCBSA member organizations. We have no right to market products and services using the BCBS names and marks outside of the states in which we are licensed to sell BCBS products. We are required to pay an annual license fee to the BCBSA based on enrollment and also to comply with various operational, governance and financial standards set forth in the licenses.

We believe that we and our licensed affiliates are currently in compliance with these standards. The standards under the license agreements may be modified in certain instances by the BCBSA. See Part I, Item 1A "Risk Factors" in this Annual Report on Form 10-K for additional details of our licensing requirements and the impact if we were not to comply with these license agreements.

Regulation

General

Our operations are subject to comprehensive and detailed state, federal and international regulation throughout the jurisdictions in which we do business. These laws and regulations, which can vary significantly from jurisdiction to jurisdiction, restrict how we conduct our businesses and result in additional burdens and costs to us. Further, federal and state laws and regulations are subject to amendments and changing interpretations in each jurisdiction. The application of these complex legal and regulatory requirements to the detailed operation of our businesses creates areas of uncertainty. In addition, there are numerous proposed healthcare laws and regulations at the federal and state levels, including single payer, Medicare for All and public option proposals, some of which could materially adversely affect our businesses if they were to be enacted.

Supervisory agencies, including federal and state regulators and departments of health, insurance and corporation, have broad authority to:

- grant, suspend and revoke licenses to transact business;
- regulate our products and services in great detail;
- regulate, limit, or suspend our ability to market products, including the exclusion of our plans from participating on public exchanges;
- retroactively adjust premium rates;
- monitor our solvency and reserve adequacy;
- scrutinize our investment activities on the basis of quality, diversification and other quantitative criteria; and
- impose monetary and criminal sanctions for non-compliance with regulatory requirements.

To carry out these tasks, these government entities periodically examine our operations and accounts.

The health benefits business also may be adversely impacted by court and regulatory decisions that expand or invalidate the interpretations of existing statutes and regulations. It is uncertain whether we can recoup, through higher premiums or other measures, the increased costs of mandated benefits or other increased costs caused by potential legislation, regulation or court rulings. See Part I, Item 1A “Risk Factors” in this Annual Report on Form 10-K.

State Regulation of Insurance Companies and HMOs

Our insurance and HMO subsidiaries must obtain a certificate of authority and maintain that license in the jurisdictions in which they conduct business. The National Association of Insurance Commissioners, or NAIC, has adopted model regulations that, where adopted by states, require expanded governance practices, risk and solvency assessment reporting and the filing of periodic financial and operating reports. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. Health insurers and HMOs are subject to state examination and periodic license renewal.

In addition, we are regulated as an insurance holding company and are subject to the insurance holding company acts of the states in which our insurance company and HMO subsidiaries are domiciled. These acts contain certain reporting requirements, as well as restrictions on transactions between an insurer or HMO and its affiliates, and may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies. These holding company laws and regulations generally require registration with applicable state departments of insurance and the filing of reports describing capital structure, ownership, financial condition, certain intercompany transactions, enterprise risks, corporate governance and general business operations. In addition, state insurance holding company laws and regulations require notice or prior regulatory approval of transactions including acquisitions, material intercompany transfers of assets, guarantees and other transactions between the regulated companies and their affiliates, including parent holding companies. Applicable state insurance holding company acts also restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. “Control” is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or

controls 10% or more of the voting securities of another person. Dispositions of control generally are also regulated under the state insurance holding company acts.

The states of domicile of our regulated subsidiaries have statutory risk-based capital, or RBC, requirements for health and other insurance companies and HMOs based on the Risk-Based Capital (RBC) For Health Organizations Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company's investments and products. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year. The law requires increasing degrees of regulatory oversight and intervention as a company's RBC declines. As of December 31, 2019, the RBC levels of our insurance and HMO subsidiaries exceeded all applicable mandatory RBC requirements. For more information on RBC capital and additional liquidity and capital requirements for a licensee of the BCBSA, see "Management's Discussion and Analysis of Financial Condition and Results of Operations–Liquidity and Capital Resources–*Risk-Based Capital*," included in Part II, Item 7 of this Annual Report on Form 10-K.

Ongoing Requirements and Changes Stemming from the ACA

The ACA significantly changed the United States healthcare system. While we anticipate continued efforts to invalidate, modify, repeal or replace the ACA, either through Congress or court challenges, we expect the major portions of the ACA to remain in place and continue to significantly impact our business operations and results of operations, including pricing, minimum medical loss ratios, or MLRs, and the geographies in which our products are available.

The ACA prohibits lifetime limits, certain annual limits, member cost-sharing on specified preventive benefits and pre-existing condition exclusions. Further, the ACA implemented certain requirements for insurers, including changes to Medicare Advantage payments and the minimum MLR provision that requires insurers to pay rebates to customers when insurers do not meet or exceed the specified MLR thresholds. In addition, the ACA also required a number of other changes with significant effects on both federal and state health insurance markets, including strict rules on how health insurance is rated, what benefits must be offered, the assessment of new taxes and fees (including annual fees on health insurance companies), the creation of public exchanges for Individuals and Small Groups, the availability of premium subsidies for qualified individuals, and expansions in eligibility for Medicaid. Changes to our business environment are likely to continue as elected officials at the national and state levels continue to enact, and both elected officials and candidates for election continue to propose, significant modifications to existing laws and regulations, including changes to taxes and fees. Also, the legal challenges regarding the ACA, including the 2018 ACA Decision, which judgment has been stayed pending appeal, could have a material adverse effect on our business, cash flows, financial condition and results of operations.

In general, the Individual market risk pool that includes public exchange markets has become less healthy since its inception in 2014 and continues to exhibit risk volatility. Based on our experience in public exchange markets to date, we have made adjustments to our premium rates and participation footprint, and we will continue to evaluate the performance of our public exchange plans going forward. In addition, insurers have faced uncertainties related to federal government funding for various ACA programs. These factors may have a material adverse effect on our results of operations if premiums are not adequate or do not appropriately reflect the acuity of these individuals. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions utilized in setting premium rates could have a material adverse effect on our results of operations, financial position, and cash flows.

Further, implementation of the ACA brings with it significant oversight responsibilities by health insurers that may result in increased governmental audits, increased assertions of False Claims Act violations, and an increased risk of other litigation.

Federal regulatory agencies continue to modify regulations and guidance related to the ACA and markets more broadly. Some of the more significant ACA rules are described below:

- The minimum MLR thresholds by line of business for the Commercial market, as defined by HHS, are as follows:

Line of Business	%
Large Group	85
Small Group	80
Individual	80

New York state regulations require us to meet a more restrictive MLR threshold of 82% for both Small Group and Individual lines of business. The minimum MLR thresholds disclosed above are based on definitions of an MLR calculation provided by HHS, or specific states, as applicable, and differ from our calculation of "benefit expense ratio" based on premium revenue and benefit expense as reported in accordance with U.S. generally accepted accounting principles, or GAAP. Furthermore, the definitions of the lines of business differ under the various federal and state regulations and may not correspond to our lines of business. Definitions under the MLR regulation also impact insurers differently depending upon their organizational structure or tax status, which could result in a competitive advantage to some insurance providers that may not be available to us, resulting in an uneven playing field in the industry.

The ACA also imposed a separate minimum MLR threshold of 85% for Medicare Advantage and Medicare Part D prescription drug plans, or Medicare Part D plans. Medicare Advantage or Medicare Part D plans that do not meet this threshold will have to pay a minimum MLR rebate. If a plan's MLR is below 85% for three consecutive years beginning with 2014, enrollment will be restricted. A Medicare Advantage or Medicare Part D plan contract will be terminated if the plan's MLR is below 85% for five consecutive years.

In addition, state Medicaid programs are required to set managed care capitation rates such that a minimum 85% MLR is projected to be achieved; however, states are not required to collect remittances if the minimum MLR is not achieved.

Approximately 58.9% and 20.8% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2019. Approximately 58.7% and 22.0% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2018.

- The ACA created an incentive payment program for Medicare Advantage plans. CMS developed the Medicare Advantage Star ratings system, which awards between 1.0 and 5.0 stars to Medicare Advantage plans based on performance in several categories, including quality of care and customer service. The Star ratings are used by CMS to award quality-based bonus payments to plans that receive a rating of 4.0 or higher. The methodology and measures included in the Star ratings system can be modified by CMS annually. As of December 31, 2019, all of our Medicare Advantage plans have received a rating of 3.0 or higher.

- Regulations require premium rate increases to be reviewed for Small Group and Individual products above specified thresholds, 15% for 2019 and 2020, and may be adjusted from time to time. The regulations provide for state insurance regulators to conduct the reviews, except for cases where a state does not have an "effective" rate review program or in federal enforcement states, in which cases HHS will conduct the reviews for any rate increase.

- Prior to the implementation of the ACA, health insurers were permitted to use differential pricing, commonly referred to as "rating bands," based on factors such as health status, gender and age. The ACA precludes health insurers from using health status and gender in the determination of the insurance premium. In addition, rating bands for age cannot vary by more than 3 to 1, and rating bands for tobacco use cannot vary by more than 1.5 to 1. The ongoing use of the 3 to 1 rating bands may have a significant impact on the majority of Individual and Small Group customers and could lead to adverse selection in the market as well as increased variability in projecting future premiums for those customer markets.

- The ACA imposed an annual Health Insurance Provider Fee, or HIP Fee, on health insurers that write certain types of health insurance on U.S. risks, which has been permanently repealed effective January 1, 2021. The annual HIP Fee is allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to the amount of health insurance premium for all U.S. health risk for those certain lines of business written during the preceding calendar year. We record our estimated liability for the HIP Fee in full at the beginning of the year with a corresponding deferred asset that is amortized on a straight-line basis to selling, general and administrative expense. The final calculation and payment of the annual HIP Fee is due by September 30th of each fee year. The HIP Fee is non-deductible for federal income tax purposes. Our affected products are priced to cover the increased selling, general and administrative and income tax expenses associated with the HIP Fee. The total amount due from allocations to health insurers was $14.3 billion for 2018 and was suspended for 2019. The HIP Fee has resumed and increased to $15.5 billion for 2020 and has been permanently eliminated beginning in 2021.

- Medicare Advantage reimbursement rates will not increase as much as they would otherwise due to the payment formula promulgated by the ACA that continues to impact reimbursements. We also expect further and ongoing regulatory guidance on a number of issues related to Medicare, including evolving methodology for ratings and quality bonus payments. CMS is also proposing changes to its program that audits data submitted under the risk adjustment programs in a way that would increase financial recoveries from plans.

Drug Benefit and Pharmacy Benefit Manager Regulation

Pharmacy benefit managers are regulated at both the federal and state levels and must comply with federal and state statutes and regulations governing labeling, packaging, advertising and adulteration of prescription drugs, dispensing of controlled substances, and licensing. In recent years the federal government has banned certain business practices, including "gag clauses," which prohibited pharmacists from informing patients when a lower cost drug was available as a substitute, and "clawbacks," which occurred when pharmacy benefit managers sought to recoup the difference between the reimbursed cost of the drug and the patient's copay and the drug itself was less expensive than the copay paid by the patient. Regulation in the states varies dramatically and ranges from licensure of PBMs as third-party administrators, licensure specifically as a pharmacy benefit manager, and licensure accompanied by additional disclosures and limitations of business practices to varying degrees. The NAIC is working on a PBM model law that, if adopted widely, could result in a more standardized approach to PBM regulation in the states in the future.

A number of proposals are being considered at the federal and state levels that would increase regulation of drug benefits and pharmacy benefit managers. Such proposals under consideration include (1) regulation of rebates from drug manufacturers that would require rebate dollars to be applied at the point-of-sale, (2) federal policy changes to set the prices for a subset of drugs covered under the Medicare program, (3) reforms to the Medicare drug benefit, such as beneficiary cost-sharing changes that aim to lower consumer costs, and (4) attempts at both the federal and state levels to ban the use of spread pricing contracts in both the Commercial and Medicaid markets. These reforms have the potential to have broad impacts on our PBM business and could materially adversely affect our business if they are enacted.

Privacy, Confidentiality and Data Standards Regulation

The federal Health Insurance Portability and Accountability Act of 1996, or HIPAA, and the administrative simplification provisions of HIPAA impose a number of requirements on covered entities (including insurers, HMOs, group health plans, providers and clearinghouses) and their business associates relating to the use, disclosure and safeguarding of protected health information. These requirements include uniform standards of common electronic healthcare transactions; privacy and security regulations; and unique identifier rules for employers, health plans and providers.

Also, the Health Information Technology for Economic and Clinical Health, or HITECH, Act provisions of the American Recovery and Reinvestment Act of 2009 and corresponding implementing regulations have imposed additional requirements on the use and disclosure of protected health information such as additional breach notification and reporting requirements, contracting requirements for HIPAA business associate agreements, strengthened enforcement mechanisms and increased penalties for HIPAA violations. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

The federal Gramm-Leach-Bliley Act generally places restrictions on the disclosure of non-public information to non-affiliated third parties, and requires financial institutions, including insurers, to provide customers with notice regarding how their non-public personal information is used, including an opportunity to "opt out" of certain disclosures. State departments of insurance and certain federal agencies adopted implementing regulations as required by federal law.

The Cybersecurity Information Sharing Act of 2015 encourages organizations to share cyber threat indicators with the federal government and, among other things, directed HHS to develop a set of voluntary cybersecurity best practices for organizations in the health care industry.

In addition, public exchanges are required to adhere to privacy and security standards with respect to personally identifiable information and to impose privacy and security standards that are at least as protective as those the public exchange has implemented for itself on insurers offering plans through the public exchanges and their designated downstream entities, including pharmacy benefit mangers and other business associates. These standards may differ from, and be more stringent than, HIPAA.

Furthermore, states have begun enacting more comprehensive privacy laws and regulations addressing consumer rights to data protection or transparency that may affect our privacy and security practices, such as state laws like the California Consumer Privacy Act that govern the use, disclosure and protection of member data and impose additional breach notification requirements. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Complying with conflicting cybersecurity regulations and varying enforcement philosophies, which may differ from state to state, requires significant resources and may materially and adversely affect our ability to standardize our products and services across state lines.

Federal regulation has also been proposed in the following areas that could materially impact our operations if finalized:

- Federal regulations on data interoperability that would require claims data to be made available to third parties unaffiliated with Anthem; and
- Federal regulations requiring hospitals and health insurers to publish negotiated prices for services.

Employee Retirement Income Security Act of 1974

The provision of services to certain employee welfare benefit plans is subject to the Employee Retirement Income Security Act of 1974, as amended, or ERISA, a complex set of laws and regulations subject to interpretation and enforcement by the Internal Revenue Service and the Department of Labor. ERISA regulates certain aspects of the relationships between us, the employers that maintain employee welfare benefit plans subject to ERISA and participants in such plans. Some of our administrative services and other activities may also be subject to regulation under ERISA. In addition, certain states require licensure or registration of companies providing third-party claims administration services for benefit plans. We provide a variety of products and services to employee welfare benefit plans that are covered by ERISA. Plans subject to ERISA can also be subject to state laws, and the question of whether and to what extent ERISA preempts a state law has been, and will continue to be, interpreted by many courts.

Guaranty Fund Assessments

Under insolvency or guaranty association laws in most states, insurance companies and HMOs can be assessed for amounts paid by guaranty funds for policyholder losses incurred when an insurance company or HMO becomes insolvent. Most state insolvency or guaranty association laws currently provide for assessments based upon the amount of premiums received on insurance underwritten within such state (with a minimum amount payable even if no premium is received). Under many of these guaranty association laws, assessments are made retrospectively. Some states permit insurers or HMOs to recover assessments paid through full or partial premium tax offsets or through future policyholder surcharges. The amount and timing of any future assessments cannot be predicted with certainty; however, future assessments are likely to occur.

Employees

At December 31, 2019, we had approximately 70,600 employees. Our employees are an important asset, and we seek to develop them to their full potential. We believe that our relationship with our employees is good.

Available Information

We are a large accelerated filer (as defined in Rule 12b-2 of the Securities Exchange Act of 1934, as amended, or the Exchange Act) and are required, pursuant to Item 101 of Regulation S-K, to provide certain information regarding our website and the availability of certain documents filed with or furnished to the U.S. Securities and Exchange Commission, or SEC. Our website is www.antheminc.com. We have included our website address throughout this Annual Report on Form 10-K as a textual reference only. The information contained on, or accessible through, our website is not incorporated into this Annual Report on Form 10-K. We make available, free of charge, by mail or through our website, our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act as soon as reasonably practicable after we electronically file such material with or furnish it to the SEC. We also include on our website our Corporate Governance Guidelines, our Code of Conduct and the charter of each standing committee of our Board of Directors. In addition, we intend to disclose on our website any amendments to, or waivers from, our Code of Conduct that are required to be publicly disclosed pursuant to rules of the SEC and the New York Stock Exchange, or NYSE. Anthem, Inc. is an Indiana corporation incorporated on July 17, 2001.

ITEM 1A. RISK FACTORS.

The following is a description of significant factors that could cause our actual results to differ materially from those contained in forward-looking statements made in this Annual Report on Form 10-K and presented elsewhere by management from time to time. Such factors may have a material adverse effect on our business, financial condition, and results of operations, and you should carefully consider them and not place undue reliance on any forward-looking statements. It is not possible to predict or identify all such factors. Consequently, you should not consider any such list to be a complete statement of all our potential risks or uncertainties. Because of these and other factors, past performance should not be considered an indication of future performance.

If we fail to appropriately predict, price for and manage healthcare costs, the profitability of our products could decline, which could materially adversely affect our business, cash flows, financial condition and results of operations.

Our profitability depends in large part on accurately predicting and pricing healthcare costs and on our ability to manage future healthcare costs through medical management, product design, negotiation of favorable provider contracts and underwriting criteria. Total healthcare costs are affected by the number of individual services rendered, the cost of each service and the type of service rendered. Numerous factors affecting the cost of healthcare may adversely affect our ability to predict and manage healthcare costs, as well as our business, cash flows, financial condition and results of operations. These factors include, among others, changes in healthcare practices, demographic characteristics including the aging population, medical cost inflation, the introduction of new technologies, drugs and treatments, increased cost of individual services, increases in the cost and number of prescription drugs, clusters of high cost cases, increased use of services, including due to natural catastrophes or other large-scale medical emergencies or epidemics, and new treatment guidelines, new mandated benefits (such as the expansion of essential benefits coverage) or changes to other regulations impacting our business. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results.

Generally, our premiums on Commercial policies and Medicaid contracts are fixed for a 12-month period and are determined several months prior to the commencement of the premium period. Our revenue on Medicare policies is based on bids submitted to CMS six months prior to the start of the contract year. Accordingly, the costs we incur in excess of our benefit cost projections generally are not recovered in the contract year through higher premiums. Existing Medicaid contract rates are often established by the applicable state, and our actual costs may exceed those rates. Although we base our Commercial premiums and our Medicare and Medicaid bids, and our acceptance of state-established Medicaid rates on our estimates of future medical costs over the fixed contract period, many factors, including those discussed above, may cause actual costs to exceed those estimated and reflected in premiums and bids.

Relatively small differences between predicted and actual healthcare costs as a percentage of premium revenues can result in significant changes in our results of operations. Although federal and state premium and risk adjustment mechanisms could help offset healthcare benefit costs in excess of our projections if our assumptions (including assumptions for

government premium and risk adjustment payments) utilized in setting our premium rates are significantly different than actual results, our income statement and financial condition could still be adversely affected.

In addition to the challenge of managing healthcare costs, we face pressure to contain premium rates. Our customers may renegotiate their contracts to seek to contain their costs or may move to a competitor to obtain more favorable premiums. Further, federal and state regulatory agencies may restrict or prevent entirely our ability to implement changes in premium rates. For example, we must submit data on all proposed rate increases to HHS for monitoring purposes on many of our products. In addition, the ACA includes an annual rate review requirement to prohibit unreasonable rate increases, and our plans may be excluded from participating in the public exchanges if they are deemed to have a history of "unreasonable" rate increases. A limitation on our ability to increase or maintain our premium or reimbursement levels or a significant loss of membership resulting from our need to increase or maintain premium or reimbursement levels could adversely affect our business, cash flows, financial condition and results of operations.

In addition, the reserves that we establish for health insurance policy benefits and other contractual rights and benefits are based upon assumptions concerning a number of factors, including trends in healthcare costs, expenses, general economic conditions and other factors. To the extent the actual claims experience is unfavorable as compared to our underlying assumptions, our incurred losses would increase and future earnings could be adversely affected.

We are subject to significant government regulation, and changes or proposed changes in the regulation of our business by federal and state regulators may adversely affect our business, cash flows, financial condition, results of operations and the market price of our securities.

We are subject to significant state and federal regulation associated with many aspects of our business, including, but not limited to, licensing, premiums, marketing activities, provider contracting, access and payment standards, and corporate governance and financial reporting matters. In addition, IngenioRx is also subject to an increasing number of licensure, registration and other laws and accreditation standards that impact the business practices of a pharmacy benefit manager. We must identify, assess and respond to new laws and regulations, as well as comply with the various existing laws and regulations applicable to our business. Further, the integration into our business of entities that we acquire, or the expansion of our business into new areas, may affect the way in which existing laws and rules apply to us, including by subjecting us to laws and rules that did not previously apply to us.

Changes in existing laws, rules and regulatory interpretation or future laws, rules, regulatory interpretations or judgments could force us to change how we conduct our business, affect the products we offer (and where we offer them), restrict revenue and enrollment growth, increase our costs, including operating, healthcare technology and administrative costs, restrict our ability to obtain new product approvals and implement changes in premium rates and require enhancements to our compliance infrastructure and internal controls environment, which could adversely impact our business and results of operations. In addition, legislative and/or regulatory policies or proposals that seek to manage the healthcare industry or otherwise impact our business may cause the market price of our securities to decrease, even if such policies or proposals never become effective.

Our insurance, managed healthcare and HMO subsidiaries are subject to extensive regulation and supervision by regulatory authorities and agencies in each state in which they are licensed or authorized to do business, in addition to regulation by federal agencies. We are required to obtain and maintain insurance and other regulatory approvals to market certain of our products, to increase prices for certain regulated products and to consummate some of our acquisitions and dispositions. Delays in obtaining or failure to obtain or maintain these approvals, as well as future regulatory action by state or federal authorities could have a material adverse effect on the profitability or marketability of our health benefits or managed care products or on our business, financial condition and results of operations.

In addition, because of our participation in government-sponsored programs such as Medicare and Medicaid, many of our subsidiaries are also subject to regulation by CMS and state Medicaid agencies, and to changes in government regulations or policy with respect to, among other things, reimbursement levels, eligibility requirements, benefit coverage requirements and additional governmental participation, which could also adversely affect our business, cash flows, financial condition and results of operations.

In addition, under insolvency or guaranty association laws in most states, insurance companies can be assessed for certain obligations to policyholders and claimants of impaired or insolvent insurance companies. Some states have similar

laws relating to HMOs and other payers such as consumer operated and oriented plans (co-ops) established under the ACA. The NAIC has amended the Life and Health Insurance Guaranty Association Model Act, or NAIC Model Act, to expand the assessment base for long-term care products and to add HMOs as members. We have experienced assessments in the past, and may experience assessments in the future as a result of other companies that fail to establish premiums sufficient to cover their costs. If the amended NAIC Model Act is adopted by the states, these changes could impact our assessments. Any such assessment could expose us to the risk of paying a portion of an impaired or insolvent insurance company's claims through state guaranty associations. We are not currently able to estimate our potential financial obligations, losses, or the availability of potential offsets associated with potential guaranty association assessments; however, any significant increase in guaranty association assessments could have a material adverse effect on our business, cash flows, financial condition and results of operations.

We expect state legislatures will continue to focus on healthcare delivery and financing issues. State ballot initiatives can also be put to voters that would substantially impair our operating environment. Most states are very focused on how to manage and reduce their budgets and are exploring ways to mitigate cost increases. As such, some states have acted to reduce or limit increases to premium payments. Others have enacted, or are contemplating, significant reform of their health insurance markets to include provisions affecting both public programs and privately-financed health insurance arrangements. If enacted into law, these state proposals could have a material adverse impact on our business, cash flows, operations or financial condition.

A number of states in which we offer Medicaid products have not opted for Medicaid expansion under the ACA, at least for the present time, and states frequently review public program eligibility. Where states make changes to reduce eligibility, we could experience reduced Medicaid enrollment and reduced growth opportunities. If future modifications to laws and regulations at the federal or state level result in reduced public enrollment, this could negatively impact our Medicaid business.

Additionally, from time to time, Congress has considered, and may consider in the future, various forms of managed care reform legislation which, if adopted, could fundamentally alter the treatment of coverage decisions under ERISA. There have been legislative attempts to limit ERISA's preemptive effect on state laws and litigants' ability to seek damages beyond the benefits offered under their plans. If adopted, such limitations could increase our liability exposure, could permit greater state regulation of our operations, and could expand the scope of damages, including punitive damages, litigants could be awarded. While we cannot predict if any of these initiatives will ultimately become effective or, if enacted, what their terms will be, their enactment could increase our costs, expose us to expanded liability or require us to revise the ways in which we conduct business.

The ongoing changes to the ACA and related laws and regulations could adversely affect our business, cash flows, financial condition and results of operations.

The ongoing changes in federal and state laws and regulations stemming from the ACA, including the steps that have been taken to amend, repeal and limit the scope and application of the ACA, continue to represent significant challenges to the U.S. healthcare system. We are unable to predict how these events will ultimately be resolved and what the potential impact may be on our business, including, but not limited to, our products, services, processes and technology, and on our relationships with current and future customers and healthcare providers. The legal challenges regarding the ACA, including a federal district court decision invalidating the ACA in its entirety, which judgment has been stayed pending appeal, continue to contribute to this uncertainty, which could significantly impact the market for our products, the regulations applicable to us and the fees and taxes payable by us. In addition, the ACA imposes significant fees, assessments and taxes on us and other health insurers, health plans and other industry participants, including the annual non-tax deductible HIP Fee; however, the HIP Fee has been permanently repealed beginning January 1, 2021. Further regulations and modifications to the ACA at the federal or state level, including any judicial invalidation of the ACA, could have significant effects on our business and future operations, some of which may adversely affect our results of operations and financial condition.

In general, the risk pool for the Individual market, which includes public exchange markets, has become less healthy since its inception in 2014. In addition, insurers have faced uncertainties related to federal government funding for various ACA programs. Based on our experience in public exchange markets to date, we have made adjustments to our premium rates and geographic participation, and will continue to evaluate the performance of our public exchange plans, the future viability of the public exchanges and availability of federal subsidies, and may make further adjustments to our rates and

participation going forward. These factors may have a material adverse effect on our results of operations if premiums are not adequate or do not appropriately reflect the acuity of these individuals. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions utilized in setting premium rates could have a material adverse effect on our results of operations, financial position, and cash flows.

For additional information related to the ACA, see Part I, Item 1 "Business" and Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" of this Annual Report on Form 10-K.

If we fail to develop and maintain satisfactory relationships with hospitals, physicians, pharmacy benefit service providers and other healthcare providers, our business, cash flows, financial condition and results of operations may be adversely affected.

Our profitability is also dependent in part upon our ability to contract on favorable terms with hospitals, physicians, PBM service providers and other healthcare providers. Physicians, hospitals and other healthcare providers may elect not to contract with us, and the failure to secure or maintain cost-effective healthcare provider contracts on competitive terms may result in a loss of membership or higher medical costs, which could adversely affect our business. In addition, consolidation among healthcare providers, ACO practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, and other organizational structures that physicians, hospitals and other care providers choose, as well as the ability of larger employers to contract directly with providers, may change the way that these providers interact with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which may impact our relationship with these providers or affect the way that we price our products and estimate our costs and may require us to incur costs to change our operations, which could adversely affect our business, cash flows, financial condition and results of operations.

Our inability to contract with providers, or if providers attempt to use their market position to negotiate more favorable contracts or place us at a competitive disadvantage, or the inability of providers to provide adequate care, could adversely affect our business. In addition, we do not have contracts with all providers that render services to our members and, as a result, may not have a pre-established agreement about the amount of compensation those out-of-network providers will accept for the services they render, which can result in significant litigation or arbitration proceedings, or provider attempts to obtain payment from our members for the difference between the amount we have paid and the amount they have charged.

We face competition in many of our markets, and if we fail to adequately adapt to changes in our industry and develop and implement strategic growth opportunities, our ability to compete and grow may be adversely affected.

As a health benefits company, we operate in a highly competitive environment and in an industry that is subject to significant changes from legislative reform, business consolidations, new strategic alliances, new market entrants, aggressive marketing practices by other health benefits organizations and technological advancements. These factors have produced and will likely continue to produce, significant pressures on our profitability. Furthermore, decisions to buy our products and services are increasingly made or influenced by consumers, through means such as direct purchasing (for example, Medicare Advantage plans) and insurance exchanges that allow individual choice, or by large employers that may increasingly have the ability to contract directly with providers. This creates unique market pressures, and in order to compete effectively in the consumer-driven marketplace, we will be required to develop and deliver innovative and potentially disruptive products and services to satisfy evolving market demands.

In addition, the PBM industry is highly competitive, and IngenioRx is subject to competition from national, regional and local PBMs, insurers, health plans, large retail pharmacy chains, large retail stores, supermarkets, other mail order pharmacies, web pharmacies and specialty pharmacies. Strong competition within the pharmacy benefit business has generated greater demand for lower product and service pricing, increased revenue sharing and enhanced product and service offerings. Our inability to maintain positive trends, contract on favorable terms with pharmaceutical manufacturers for, among other things, rebates, discounts and administrative fees or a failure to identify and implement new ways to mitigate pricing pressures, could negatively impact our ability to attract or retain customers, negatively impact our margins and have a material adverse effect on our business and results of operations.

Furthermore, as a result of changes to traditional health insurance over the past several years, the health insurance industry has experienced a significant shift in membership to products with lower margins. In order to profitably grow our

business in the future, we need to not only grow our profitable medical membership, but also continue to diversify our sources of revenue and earnings, including through the increased sale of our specialty products, such as dental, vision and other supplemental products, expansion of our non-insurance assets and establishment of new cost of care solutions, including innovations in PBM services. If we are unable to acquire or develop and successfully manage new opportunities that further our strategic objectives and differentiate our products from our competitors, our ability to profitably grow our business could be adversely affected.

We also will have to respond to pricing and other actions taken by existing competitors and potentially disruptive new entrants. Also, due to the price transparency provided by public exchanges and new market entrants, we face competitive pressures from new and existing competitors in the market for Individual health insurance. These risks may be enhanced if employers shift to defined contribution healthcare benefits plans and make greater utilization of private insurance exchanges or encourage their employees to purchase health insurance on the public exchanges. We can provide no assurance that we will be able to compete successfully on these exchanges or that we will be able to benefit from any opportunities presented by such exchanges. If we are not competitive on these exchanges or are unsuccessful in reducing our cost structure, our future growth and profitability may be adversely impacted.

We are currently dependent on the non-exclusive services of independent agents and brokers in the marketing of our healthcare products, particularly with respect to individuals, seniors and small employer group customers. We face intense competition for the services and allegiance of these independent agents and brokers, who may also market the products of our competitors. Our relationship with our brokers and independent agents could be adversely impacted by changes in our business practices to address legislative changes, including potential reductions in commissions and consulting fees paid to agents and brokers. We cannot ensure that we will be able to compete successfully against current and future competitors for these services or that competitive pressures faced by us will not materially and adversely affect our business, cash flows, financial condition and results of operations.

A significant reduction in the enrollment in our health benefits or PBM products or services, particularly in states where we have large regional concentrations, could have an adverse effect on our business, cash flows, financial condition and results of operations.

A significant reduction in the number of enrollees in our health benefits or PBM products or services could adversely affect our business, cash flows, financial condition and results of operations. Factors that could contribute to a reduction in enrollment include: reductions in workforce by existing customers; a general economic upturn that results in fewer individuals being eligible for Medicaid programs; a general economic downturn that results in business failures and high unemployment rates; employers no longer offering certain healthcare coverage as an employee benefit or electing to offer coverage on a voluntary, employee-funded basis; participation on public exchanges; federal and state regulatory changes, including the elimination of the individual mandate penalty in the ACA; failure to obtain new customers or retain existing customers; premium increases and benefit changes; our exit from a specific market; negative publicity and news coverage; and failure to attain or maintain nationally recognized accreditations.

The states in which we operate that have the largest concentrations of revenues include California, Florida, Georgia, Indiana, New York, Ohio, Texas and Virginia. Due to this concentration of business in these states, we are exposed to potential losses resulting from the risk of state-specific or regional economic downturns impacting these states. If any such negative economic conditions do not improve, we may experience a reduction in existing and new business, which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

A cyber attack or other privacy or data security incident could result in an unauthorized disclosure of sensitive or confidential information, cause a loss of data, disrupt a large amount of our operations, give rise to remediation or other expenses, expose us to liability under federal and state laws, and subject us to litigation and investigations, which could have an adverse effect on our business, cash flows, financial condition and results of operations.

As part of our normal operations, we collect, process and retain certain sensitive and confidential information. We are subject to various federal, state and international laws and rules regarding the use and disclosure of certain sensitive or confidential information, including HIPAA, the HITECH Act, the Gramm-Leach-Bliley Act and numerous state laws governing personal information, including the California Consumer Privacy Act. Our facilities and systems, and those of our

third-party service providers, are regularly the target of, and may be vulnerable to, cyber attacks, security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other threats.

We were the target of an external cyber attack in 2015 and have been, and will likely continue to be, the target of other attempted cyber attacks and security threats. In the event of such a cyber attack in the future, we may be subject to litigation and governmental investigations which could divert the attention of management from the operation of our business, result in reputational damage and have a material adverse impact on our business, cash flows, financial condition and results of operations. While we have contingency plans and insurance coverage for potential liabilities of this nature, they may not be sufficient to cover all claims and liabilities.

We cannot ensure that we will be able to identify, prevent or contain the effects of cyber attacks or other cybersecurity risks that bypass our security measures or disrupt our information technology systems or business. We have security technologies, processes and procedures in place to protect against cybersecurity risks and security breaches. However, hardware, software or applications we develop or procure from third parties may contain defects in design, manufacturer defects or other problems that could unexpectedly compromise information security. In addition, because the techniques used to obtain unauthorized access, disable or degrade service or sabotage systems change frequently, are becoming increasingly sophisticated, and may not immediately produce signs of intrusion, we may be unable to anticipate these techniques, timely discover or counter them or implement adequate preventative measures. Viruses, worms or other malicious software programs may be used to attack our systems or otherwise exploit any security vulnerabilities, and such security attacks may cause system disruptions or shutdowns, or may cause personal information or proprietary or confidential information to be misappropriated or compromised. As a result, cybersecurity and the continued development and enhancement of our controls, processes and practices designed to protect our systems, computers, software, data and networks from attack, damage and unauthorized access remain a priority for us.

In addition, we use third-party technology, systems and services for a variety of reasons, including, without limitation, encryption and authentication technology, employee email, content delivery to customers, back-office support, and other functions that in some cases involve processing, storing and transmitting large amounts of data for our business. Although we have developed systems and processes that are designed to reduce the impact of a security breach at a third-party vendor, such measures cannot provide absolute security, and these third-party providers may also experience security breaches or interruptions to their information technology hardware and software infrastructure and communications systems that could adversely impact us.

Noncompliance with any privacy or security laws and regulations, or any security breach, cyber attack or cybersecurity breach, and any incident involving the misappropriation, loss or other unauthorized disclosure or use of, or access to, sensitive or confidential member information, whether by us or by one of our third-party service providers, could require us to expend significant resources to continue to modify or enhance our protective measures and to remediate any damage. In addition, this could negatively affect our operations, cause system disruptions, damage our reputation, cause membership losses and contract breaches, and could also result in regulatory enforcement actions, material fines and penalties, litigation or other actions that could have a material adverse effect on our business, cash flows, financial condition and results of operations.

There are various risks associated with participating in Medicaid and Medicare programs, including dependence upon government funding and the timing of payments, compliance with government contracts and increased regulatory oversight.

We contract with various federal and state agencies, including CMS, to provide managed healthcare services, such as Medicare Advantage, Medicare Part D, Medicare Supplement, Medicaid, TANF, SPD, LTSS, CHIP, ACA-related Medicaid expansion programs and various specialty programs. We also provide various administrative services for several other entities offering medical and/or prescription drug plans to their Medicaid or Medicare eligible members through our affiliated companies, and we offer employer group waiver plans which provide medical and/or prescription drug coverage to retirees. We are also participating in programs in several states for the care of dual-eligible members. These programs have been the subject of ongoing regulatory reform initiatives, and it is difficult to predict the impact of these and potential future regulatory reforms on our Government Business segment. Regulatory reform initiatives or additional changes in existing laws or regulations, or their interpretations, could have a material adverse effect on our business, cash flows, financial condition and results of operations.

Revenues from the Medicare and Medicaid programs are dependent, in whole or in part, upon annual funding from the federal government and/or applicable state governments. The base premium rate paid by each state or federal agency differs depending upon a combination of various factors such as defined upper payment limits, a member's health status, age, gender, county or region, benefit mix, member eligibility category and risk scores. Future Medicare and Medicaid rates may be affected by continued government efforts to contain costs as well as federal and state budgetary constraints. Additionally, ongoing CMS system changes related to the data it uses to calculate risk scores in the Medicare Advantage program may impact our federal funding. If the federal government or any state in which we operate were to decrease rates paid to us, pay us less than the amount necessary to keep pace with our cost trends or seek an adjustment to previously negotiated rates, it could have a material adverse effect on our business, cash flows, financial condition and results of operations. Further, certain state contracts are subject to cancellation in the event of the unavailability of state funds. In addition, various states' MMPs are still subject to uncertainty surrounding payment rates and other requirements, which could affect where we seek to participate in these programs. An unexpected reduction in payments, inadequate government funding or significantly delayed payments for these programs may adversely affect our business, cash flows, financial condition and results of operations.

Other potential risks associated with Medicare Advantage and Medicare Part D plans include increased medical or pharmaceutical costs, data corrections identified as a result of ongoing auditing and monitoring activities, potential uncollectability of receivables resulting from processing and/or verifying enrollment, inadequacy of underwriting assumptions, inability to receive and process correct information (including inability due to systems issues by the federal government, the applicable state government or us), uncollectability of premiums from members, and limited enrollment periods. While we believe we have adequately reviewed our assumptions and estimates regarding these complex and wide-ranging programs under Medicare Advantage and Medicare Part D, including those related to collectability of receivables and establishment of liabilities, actual results may be materially different than our assumptions and estimates and could have a material adverse effect on our business, financial condition and results of operations. Finally, there is the possibility that the Medicare Advantage program could be significantly impacted by any future modification, repeal or replacement of the ACA.

Our contracts with CMS and state governmental agencies contain certain provisions regarding data submission, risk adjustment, provider network maintenance, quality measures, claims payment, encounter data, continuity of care, call center performance and other requirements specific to federal and state program regulations. We have been subject in the past, and may again be in the future, to administrative actions, fines, penalties, liquidated damages or retrospective adjustments in payments made to our health plans as a result of a failure to comply with those requirements, which has impacted and in the future could impact our profitability. In addition, we could be required to file a corrective plan of action with additional penalties for noncompliance, including a negative impact on future membership enrollment levels. Further, the majority of our CMS and state Medicaid contracts are subject to a competitive procurement process. Our existing contracts have not always been renewed, we have not always been awarded new contracts as a result of the competitive procurement process, and in some cases, we have lost members under existing contracts as a result of a post-award challenge, each of which could take place again in the future and have a material adverse effect on our business, cash flows, financial condition and results of operations.

Further, the Medicare Advantage Star rating system utilized by CMS to evaluate Medicare Advantage Plans may have a significant effect on our revenue, as higher-rated plans tend to experience increased enrollment and plans with a Star rating of 4.0 or higher are eligible for quality-based bonus payments and can market to and enroll members year-round. Our Star ratings may be negatively impacted if we fail to meet the quality, performance and regulatory compliance criteria established by CMS. Furthermore, the Star rating system is subject to change annually by CMS, which may make it more difficult to achieve four stars or greater. If we do not maintain or continue to improve our Star ratings, fail to meet or exceed our competitors' ratings, or if quality-based bonus payments are reduced or eliminated, we may experience a negative impact on our revenues and the benefits that our plans can offer, which could materially and adversely affect the marketability of our plans, our membership levels, results of operations, financial condition and cash flows. Similarly, a number of state Medicaid programs in which we participate have implemented performance standards, and if we fail to meet or exceed those standards, we may not receive performance-based bonus payments or may incur performance-based penalties.

In addition to the contractual requirements affecting our participation in Medicaid and Medicare programs, we are also subject to various federal and state healthcare laws and regulations, including those directed at preventing fraud, abuse and discrimination in government-funded programs. Failure to comply with these laws and regulations could result in investigations, litigation, fines, restrictions on, or exclusions from, program participation, or the imposition of corporate

integrity agreements or other agreements with a federal or state governmental agency, any of which could adversely impact our business, cash flows, financial condition and results of operations.

We are periodically subject to government audits, including CMS Risk Adjustment Data Validation, or RADV audits, of our Medicare Advantage Plans to validate diagnostic data, patient claims and financial reporting, as well as audits by the Medicare Part D Recovery Audit Contractor, or RAC. CMS has recently proposed changing its audits in a way that could increase financial recoveries from health plans. These audits could result in significant adjustments in payments made to our health plans. In addition to these federal programs, the states in which we operate Medicaid plans conduct audits, and a number of states have implemented Medicaid RAC programs which were authorized by the ACA. State RAC programs could increase the number of audits and any subsequent recoupment by the federal and state governments, which could adversely affect our financial condition and results of operations. If we fail to report and correct errors discovered through our own auditing procedures or during a CMS, state or RAC audit, or otherwise fail to comply with applicable laws and regulations, we could be subject to fines, civil penalties or other sanctions which could have a material adverse effect on our ability to participate in these programs, and on our financial condition, cash flows and results of operations.

On November 1, 2018, CMS released a proposed rule that would revise its RADV methodology by, among other things, excluding an adjustment for underlying fee-for-service data errors and extrapolating RADV results at the contract level. If adopted in its current form, the rule could have a detrimental impact on all Medicare Advantage insurers. While it is uncertain whether CMS will issue the rule as proposed, if adopted, it could have a material adverse impact on our Medicare business and future results of operations. In addition to the proposed rule, there has been increased government scrutiny and civil litigation under the False Claims Act related to risk adjustment practices under the Medicare Advantage program. Government investigations, any enforcement actions and civil litigation could result in monetary damages, penalties and business practice changes that could have a material adverse effect on our financial condition, cash flows and results of operations.

Our Medicare and Medicaid contracts are also subject to various MLR rules, including minimum MLR thresholds, rebate requirements and audits, which could adversely affect our membership and revenues if any of our state Medicare or Medicaid plans do not meet an applicable minimum MLR thresholds. If a Medicare Advantage, MMP or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to participate in open enrollment. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS.

A change in our healthcare product mix may impact our profitability.

Our healthcare products that involve greater potential risk generally tend to be more profitable than administrative services products and those healthcare products where the employer groups assume the underwriting risks. Individuals and small employer groups are more likely to purchase our higher-risk healthcare products because such purchasers are generally unable or unwilling to bear greater liability for healthcare expenditures. Typically, government-sponsored programs also involve our higher-risk healthcare products. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on our cash flows, financial condition and results of operations.

We face risks related to litigation.

We are, or may in the future be, a party to a variety of legal actions that may affect our business, such as employment and employment discrimination-related suits, administrative charges before government agencies, employee benefit claims, breach of contract actions, tort claims and intellectual property-related litigation. In addition, because of the nature of our business, we are subject to a variety of legal actions relating to our business operations, including the design, administration and offering of our products and services. These could include claims relating to the denial or limitation of healthcare benefits; federal and state false claims act laws; dispensing of drugs associated with our PBM business; professional liability claims arising out of the delivery of healthcare and related services to the public; development or application of medical policies and coverage and clinical guidelines; medical malpractice actions; product liability claims; allegations of anti-competitive and unfair business activities; provider disputes over reimbursement and contracts; provider tiering programs; narrow networks; termination of provider contracts; the recovery of overpayments from providers; self-funded business; disputes over co-payment calculations; reimbursement of out-of-network claims; the failure to disclose certain business practices; the failure to comply with various state or federal laws, including but not limited to, ERISA and the Mental Health

Parity Act; and customer audits and contract performance, including government contracts. These actions or proceedings could have a material adverse effect on our business, cash flows, financial condition and results of operations.

We are also involved in, or may in the future be party to, pending or threatened litigation of the character incidental to the business we transact or arising out of our operations, including, but not limited to, breaches of security and violations of privacy requirements, shareholder actions, compliance with federal and state laws and regulations (including *qui tam* or "whistleblower" actions), or sales and acquisitions of businesses or assets (including as a result of the terminated Cigna Merger Agreement, or as more fully described under Note 13, "Commitments and Contingencies - *Litigation and Regulatory Proceedings - Cigna Corporation Merger Litigation*," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K). From time to time, we are involved as a party in various governmental investigations, audits, reviews and administrative proceedings, including challenges relating to the award of government contracts. These investigations, audits and reviews include routine and special investigations by various state insurance departments, various federal regulators including CMS and the Department of Health and Human Services Office of Inspector General (HHS-OIG), state attorneys general, the Department of Justice (DOJ), and various offices of the U.S. Attorney General. Following an investigation, we may be subject to civil or criminal fines, penalties and other sanctions if we are determined to be in violation of applicable laws or regulations. Liabilities that may result from these actions could have a material adverse effect on our cash flows, results of operations and financial condition.

Recent court decisions and legislative activity may increase our exposure for any of these types of claims. In some cases, substantial non-economic (including injunctive relief), treble or punitive damages may be sought. Although we maintain insurance coverage for some of these potential liabilities, some liabilities and damages may not be covered by insurance, insurers may dispute coverage or the amount of insurance may not be enough to cover the damages awarded. In addition, insurance coverage for all or certain forms of liability may become unavailable or prohibitively expensive in the future. Any adverse judgment against us resulting in such damage awards could result in negative publicity and have an adverse effect on our cash flows, results of operations and financial condition.

Further, litigation brought against the federal and some state governments over the ACA, including the 2018 ACA Decision, could have a material adverse effect on our business, cash flows, financial condition and results of operations as changes to, or the invalidation of, the ACA resulting from such litigation may be unfavorable to our business or may create uncertainty over the applicability and enforceability of portions of the law and related regulations, which impacts our strategy and could negatively impact our future growth opportunities.

Cigna's pursuit of litigation in connection with the Cigna Merger Agreement, together with our own litigation against Cigna, could cause us to incur substantial costs, may present material distractions and, if decided adverse to Anthem, could negatively impact our financial condition.

As described in Note 13, "Commitments and Contingencies - *Litigation and Regulatory Proceedings - Cigna Corporation Merger Litigation*," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K, in February 2017, Cigna commenced litigation against us in the Delaware Court of Chancery, or the Delaware Court, for a declaratory judgment that its purported termination of the Cigna Merger Agreement was lawful and seeking damages against us. We promptly filed our own litigation against Cigna seeking to compel Cigna's specific performance of the Cigna Merger Agreement and damages against Cigna. In May 2017, after the Delaware Court denied our motion to enjoin Cigna from terminating the Cigna Merger Agreement, we delivered to Cigna a notice terminating the Cigna Merger Agreement. In the Delaware Court litigation, trial commenced in late February 2019 and concluded in March 2019, and closing arguments were held in November 2019. We have incurred, and likely will continue to incur, substantial litigation costs related to these lawsuits, and may incur substantial additional cost, including potential settlement and judgment costs. Our defense against Cigna's claims, the pursuit of our claims or the settlement, or failure to reach a settlement, for any claims may result in negative media attention, and may adversely affect our business, reputation, financial condition, results of operations and cash flows.

Our PBM business and related operations are subject to a number of risks and uncertainties that are in addition to those we face in our core healthcare business.

We provide PBM services through our IngenioRx business, and we are responsible to regulators and our customers for the delivery of those PBM services that we contract to provide. Our PBM business is subject to the risks inherent in the

dispensing, packaging, fulfillment and distribution of pharmaceuticals and other healthcare products, including claims related to dispensing and other operational errors. Any failure by us or one of our PBM services suppliers to adhere to the laws and regulations applicable to the dispensing of pharmaceuticals could subject our PBM business to civil and criminal penalties.

Our PBM business is subject to federal and state laws and regulations that govern its relationships with pharmaceutical manufacturers, physicians, pharmacies and customers, including without limitation, federal and state anti-kickback laws, beneficiary inducement laws, consumer protection laws, ERISA, HIPAA and laws related to the operation of internet and mail-service pharmacies, as well as an increasing number of licensure, registration and other laws and accreditation standards that impact the business practices of a PBM business. In addition, the practice of pharmacy is subject to federal and state laws and regulation, including those of state boards of pharmacy, individual state-controlled substance authorities, the U.S. Drug Enforcement Agency and the FDA. Also, we and our third-party vendors are subject to registration requirements and state and federal laws concerning labeling, packaging, advertising, handling and adulteration of prescription drugs and dispensing of controlled substances. Federal and state legislatures also regularly consider new regulations for the industry that could materially affect current industry practices, including potential new legislation and regulations regarding the receipt or disclosure of rebates, discounts and other fees from pharmaceutical companies, the development and use of formularies and other utilization management tools, the use of average wholesale prices or other pricing benchmarks, pricing for specialty pharmaceuticals, limited access to networks and pharmacy network reimbursement methodologies. Noncompliance with applicable laws and regulations by us or our third-party vendors could have a material adverse effect on our business, results of operations, financial condition, liquidity and reputation and could expose us to civil and criminal penalties.

Our PBM business would be adversely affected if we are unable to contract on favorable terms with pharmaceutical manufacturers for, among other things, rebates, discounts and administrative fees.

We are dependent on the success of our relationships with third parties for various services and functions, including PBM services.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Certain of these third parties provide us with significant portions of our business infrastructure and operating requirements, and we could become overly dependent on key vendors, which could cause us to lose core competencies. A termination of our agreements with, or disruption in the performance of, one or more of these service providers could result in service disruptions or unavailability, reduced service quality and effectiveness, increased or duplicative costs or an inability to meet our obligations to our customers. In addition, we may also have to seek alternative service providers, which may be unavailable or only available on less favorable contract terms. Any of these outcomes could adversely affect our business, reputation, cash flows, financial condition and operating results.

In particular, beginning in the second quarter of 2019, we began delegating certain PBM administrative functions, such as claims processing and prescription fulfillment, to CVS Health pursuant to the CVS PBM Agreement. In addition, although we completed the transition of our members from Express Scripts to IngenioRx on January 1, 2020, Express Scripts continues to provide certain audit and various run-out transition services related to our PBM business pursuant to the ESI PBM Agreement. CVS Health began providing certain PBM administrative functions to IngenioRx pursuant to the CVS PBM Agreement beginning in the second quarter of 2019. In connection with the transition of PBM administrative functions to CVS Health, if CVS Health fails to provide PBM services as contractually required, we may not be able to meet the full demands of our customers, which could have a material adverse effect on our business, reputation and results of operations. For additional information on the agreement with CVS Health, see “Business - General,” in Part I, Item 1 of this Annual Report on Form 10-K. In addition, the litigation between us and Express Scripts regarding the ESI PBM Agreement continues, as more fully described under Note 13, “Commitments and Contingencies - *Litigation and Regulatory Proceedings - Express Scripts, Inc. Pharmacy Benefit Management Litigation,*” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

There are various risks associated with providing healthcare services.

The direct provision of healthcare services by certain of our subsidiaries involves risks of additional litigation arising from medical malpractice actions based on our treatment decisions or brought against us or our associates for alleged malpractice or professional liability claims arising out of the delivery of healthcare and related services. In addition, liability may arise from maintaining healthcare premises that serve the public. The defense of any actions may result in significant

expenses, and if we fail to maintain adequate insurance coverage for these liabilities, or if such insurance is not available, the resulting costs could adversely affect our business, cash flows, financial condition and results of operations.

Additionally, many states in which certain of our subsidiaries operate limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals. Business corporations generally may not exercise control over the medical decisions of physicians, and we are not licensed to practice medicine. Rules and regulations relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary from state to state. Further, certain federal and state laws, including those covering our Medicare and Medicaid plans, prohibit the offer, payment, solicitation, or receipt of any form of remuneration to induce, or in return for, the referral of patient care opportunities, including, but not limited to, Medicare patients, and also generally prohibit physicians from making referrals to any entity providing certain designated health services if the referring physician or related person has an ownership or financial interest in the entity. Any enforcement actions by governmental officials alleging non-compliance with these rules and regulations could adversely affect our business, cash flows, financial condition and results of operations.

Mergers, acquisitions, joint ventures, strategic partnerships and other business combinations involve risks that could have a material adverse effect on our business, cash flows, financial condition and results of operation.

The following are some of the risks associated with mergers, acquisitions, joint ventures and strategic alliances, referred to collectively as business combinations, that could have a material adverse effect on our business, cash flows, financial condition and results of operations:

- some of the business combinations may not achieve anticipated revenues, earnings or cash flow, business opportunities, synergies, growth prospects and other anticipated benefits;
- the goodwill or other intangible assets established as a result of our business combinations may be incorrectly valued or become non-recoverable;
- we may assume liabilities that were not disclosed to us or which were underestimated;
- we may experience difficulties in integrating business combinations, be unable to integrate business combinations successfully or as quickly as expected, and be unable to realize anticipated economic, operational and other benefits in a timely manner, which could result in substantial costs and delays or other operational, technical or financial problems;
- business combinations, and proposed business combinations that are not completed, could disrupt our ongoing business, lead to the incurrence of significant fees, distract management, result in the loss of key employees, divert resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies and procedures;
- we may finance future business combinations by issuing common stock for some or all of the purchase price, which could dilute the ownership interests of our shareholders;
- we may also incur additional debt related to future business combinations;
- we would be competing with other firms, some of which may have greater financial and other resources, to acquire attractive companies;
- we may experience disputes with our partners in our strategic alliances and joint ventures, which could result in litigation or a loss of business; and
- future business combinations may make it difficult to comply with the requirements of the BCBSA and lead to an increased risk that our BCBSA license agreements may be terminated.

The value of our intangible assets may become impaired.

Due largely to our past mergers and acquisitions, goodwill and other intangible assets represent a substantial portion of our assets. If we make additional acquisitions, it is likely that we will record additional intangible assets on our consolidated balance sheets. The value we place on intangible assets may be adversely impacted if business combinations fail to perform in a manner consistent with our assumptions.

In accordance with applicable accounting standards, we periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may no longer be recoverable, in which case a charge to income may be necessary. This impairment testing requires us to make assumptions and judgments regarding the estimated fair value of our reporting units, including goodwill and other intangible assets. In addition, certain other intangible assets with indefinite lives, such as trademarks, are also tested separately. Estimated fair values developed based on our assumptions and judgments might be significantly different if other reasonable assumptions and estimates were to be used. If estimated fair values are less than the carrying values of goodwill and other intangible assets with indefinite lives in future impairment tests, or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially affect our results of operations and shareholders' equity in the period in which the impairment occurs. A material decrease in shareholders' equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

In addition, the estimated fair value of our reporting units may be impacted as a result of business decisions we make associated with any future changes to laws and regulations. Such decisions, which could unfavorably affect our ability to support the carrying value of certain goodwill and other intangible assets, could result in impairment charges in future periods.

As a holding company, we are dependent on dividends from our subsidiaries. These dividends are necessary to pay our outstanding indebtedness. Our regulated subsidiaries are subject to state regulations, including restrictions on the payment of dividends, maintenance of minimum levels of capital and restrictions on investment portfolios.

We are a holding company whose assets include the outstanding shares of common stock (or other ownership interest) of our subsidiaries including our intermediate holding companies and regulated insurance and HMO subsidiaries. Our subsidiaries are separate legal entities. As a holding company, we depend on dividends and administrative expense reimbursements from our subsidiaries. Furthermore, our subsidiaries are not obligated to make funds available to us, and creditors of our subsidiaries will have a superior claim to certain of our subsidiaries' assets. Among other restrictions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends. In some states, we have made special undertakings that may limit the ability of our regulated subsidiaries to pay dividends. In addition, our subsidiaries' ability to make any payments to us will also depend on their earnings, the terms of their indebtedness, business and tax considerations and other legal restrictions. Our ability to repurchase shares or pay dividends in the future to our shareholders and meet our obligations, including paying operating expenses and debt service on our outstanding and future indebtedness, will depend upon the receipt of dividends from our subsidiaries. An inability of our subsidiaries to pay dividends in the future in an amount sufficient for us to meet our financial obligations may materially adversely affect our business, cash flows, financial condition and results of operations.

Most of our regulated subsidiaries are subject to RBC standards or other forms of minimum capital requirements imposed by their states of domicile, which require our regulated subsidiaries to report their results of risk-based capital calculations to the departments of insurance and the NAIC. Failure to maintain the minimum RBC standards could subject our regulated subsidiaries to corrective action, including state supervision or liquidation. Changes to the existing RBC standards or the adoption of an RBC requirement at the holding company level, which is currently being considered and developed by the NAIC and various states, could further restrict our or our regulated subsidiaries' ability to pay dividends and adversely affect our business. In addition, as discussed in more detail below, we are a party to license agreements with the BCBSA which contain certain requirements and restrictions regarding our operations, including minimum capital and liquidity requirements, which could restrict the ability of our regulated subsidiaries to pay dividends.

Our regulated subsidiaries are subject to state laws and regulations that require diversification of their investment portfolios and limit the amount of investments in certain riskier investment categories, such as below-investment-grade fixed maturity securities, mortgage loans, real estate and equity investments, which could generate higher returns on their investments. Failure to comply with these laws and regulations might cause investments exceeding regulatory limitations to be treated as non-admitted assets for purposes of measuring statutory surplus and risk-based capital, and, in some instances, require the sale of those investments.

We have substantial indebtedness outstanding and may incur additional indebtedness in the future in connection with acquisitions or otherwise. Such indebtedness could adversely affect our ability to pursue desirable business opportunities and to react to changes in the economy or our industry, and exposes us to interest rate risk to the extent of our variable rate indebtedness.

Our debt service obligations require us to use a portion of our cash flow to pay interest and principal on debt instead of for other corporate purposes, including funding future expansion. If our cash flow and capital resources are insufficient to service our debt obligations, we may be forced to seek extraordinary dividends from our subsidiaries, sell assets, seek additional equity or debt capital or restructure our debt. However, these measures might be unsuccessful or inadequate to meet scheduled debt service obligations, or may not be available on commercially reasonable terms.

We may also incur future debt obligations, in connection with acquisitions or otherwise, that might subject us to restrictive covenants that could affect our financial and operational flexibility. Our breach or failure to comply with any of these covenants could result in a default under our credit facilities or other indebtedness. If we default under our credit agreement, the lenders could cease to make further extensions of credit or cause all of our outstanding debt obligations under our credit agreement to become immediately due and payable, together with accrued and unpaid interest. If the indebtedness under our notes or our credit agreement or our other indebtedness is accelerated, we may be unable to repay or finance the amounts due, on commercially reasonable terms, or at all.

Changes in the method of determining the London Interbank Offered Rate, or LIBOR, or the replacement of LIBOR with an alternative reference rate, may adversely affect the market for or value of our outstanding debt and the interest rate, return, value and liquidity of certain of our investments.

A portion of our indebtedness bears interest at fluctuating interest rates, primarily based on LIBOR, and our investment portfolio also includes some LIBOR-based, floating rate debt investments. In July 2017, the Financial Conduct Authority, a regulator of financial services firms in the United Kingdom, announced that it intends to stop persuading or compelling banks to submit LIBOR rates after 2021. In response to concerns regarding the future of LIBOR, the Board of Governors of the Federal Reserve System and the Federal Reserve Bank of New York convened the Alternative Reference Rates Committee ("ARRC") to identify alternatives to LIBOR. The ARRC has recommended a benchmark replacement waterfall to assist issuers in continued capital market entry while safeguarding against LIBOR's discontinuation. The initial steps in the ARRC's recommended provision reference variations of the Secured Overnight Financing Rate ("SOFR"). At this time, it is not possible to predict whether SOFR will attain market traction as a LIBOR replacement.

We are unable to predict whether LIBOR will cease to exist after calendar year 2021, the effect of any changes, any establishment of alternative reference rates or any other reforms to LIBOR or any replacement of LIBOR that may be enacted in the United Kingdom or elsewhere. Such changes, reforms or replacements relating to LIBOR could have an adverse impact on the market for or value of any LIBOR-linked securities, loans, derivatives or other financial obligations or extensions of credit entered into by us, as well as the interest rate, return, value, and liquidity of any LIBOR-based securities held in our investment portfolios, and could adversely impact our cost of capital, overall financial condition or results of operations.

A downgrade in our credit ratings could have an adverse effect on our business, cash flows, financial condition and results of operations.

Claims-paying ability as well as financial strength ratings and debt ratings by nationally recognized statistical rating organizations are an important factor in establishing the competitive position of insurance companies and health benefits companies. We believe our strong credit ratings are an important factor in marketing our products to customers, since credit ratings information is broadly disseminated and generally used by customers and creditors. In addition, if our credit ratings are downgraded or placed under review, our business, cash flows, financial condition and results of operations could be adversely impacted by limitations on future borrowings and a potential increase in our borrowing costs. Our ratings reflect each rating agency's opinion of our financial strength, operating performance and ability to meet our obligations to policyholders and creditors, and are not evaluations directed toward the protection of investors in our common stock. Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future.

The health benefits industry is subject to negative publicity, which could adversely affect our business, cash flows, financial condition and results of operations.

The health benefits industry is subject to negative publicity, which can arise from, among other things, increases in premium rates, industry consolidation, cost of care initiatives and the ongoing debate over laws and regulations impacting the U.S. healthcare system. Negative publicity may result in increased regulation and legislative review of industry practices, which may further increase our costs of doing business and adversely affect our profitability by limiting our ability to market or provide our products and services, requiring us to change our products and services, or increasing the regulatory oversight under which we operate. In addition, as long as we use the BCBS names and marks in marketing our health benefits products and services, any negative publicity concerning the BCBSA or other BCBSA licensees may adversely affect us and the sale of our health benefits products and services. Negative public perception or publicity of the health benefits industry in general, the BCBSA, other BCBSA licensees, or us or our key vendors in particular, could adversely affect our business, cash flows, financial condition and results of operations.

The failure to effectively maintain and upgrade our information systems could adversely affect our business.

Our business depends significantly on effective information systems, and we have many different information systems for our various businesses. As a result of our merger and acquisition activities, we have acquired and expect to acquire additional systems. Our information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and develop new systems in order to keep pace with continuing changes in information processing technology, emerging cybersecurity risks and threats, evolving industry and regulatory standards including public exchanges and other aspects of the ACA, compliance with legal requirements, private insurance exchanges and changing customer preferences. In addition, we may from time to time obtain significant portions of our systems-related or other services or facilities from independent third parties, which may make our operations vulnerable if such third parties fail to perform adequately.

Failure to adequately implement and maintain effective and efficient information systems with sufficiently advanced technological capabilities, or our failure to efficiently and effectively consolidate our information systems to eliminate redundant or obsolete applications, could result in competitive and cost disadvantages to us compared to our competitors, a diversion of management's time and could have a material adverse effect on our business, financial condition and results of operations. If the information we rely upon to run our business were found to be inaccurate or unreliable or if we fail to adequately maintain our information systems and data integrity effectively, we could experience problems in determining medical cost estimates and establishing appropriate pricing and reserves, have disputes with customers and providers, face regulatory problems, including sanctions and penalties, incur increases in operating expenses or suffer other adverse consequences, including a decrease in membership.

We are a party to license agreements with the BCBSA that entitle us to the exclusive and, in certain areas, non-exclusive use of the BCBS names and marks in our geographic territories. The termination of these license agreements or changes in the terms and conditions of these license agreements could adversely affect our business, cash flows, financial condition and results of operations.

We use the BCBS names and marks as identifiers for our products and services under licenses from the BCBSA. Our license agreements with the BCBSA contain certain requirements and restrictions regarding our operations and our use of the BCBS names and marks, including: minimum capital and liquidity requirements; enrollment and customer service performance requirements; participation in programs that provide portability of membership between plans; disclosures to the BCBSA relating to enrollment and financial conditions; disclosures as to the structure of the BCBS system in contracts with third parties and in public statements; plan governance requirements; cybersecurity requirements; a requirement that at least 80% (or, in the case of Blue Cross of California, substantially all) of a licensee's annual combined local net revenue, as defined by the BCBSA, attributable to healthcare plans and related services within its service areas must be sold, marketed, administered or underwritten under the BCBS names and marks; a requirement that at least two-thirds of a licensee's annual combined national net revenue, as defined by the BCBSA, attributable to healthcare plans and related services must be sold, marketed, administered or underwritten under the BCBS names and marks; a requirement that neither a plan nor any of its licensed affiliates may permit an entity other than a plan or a licensed affiliate to obtain control of the plan or the licensed affiliate or to acquire a substantial portion of its assets related to licensable services; a requirement that we divide our Board of Directors into three classes serving staggered three-year terms; a requirement that we guarantee certain contractual and

financial obligations of our licensed affiliates; and a requirement that we indemnify the BCBSA against any claims asserted against it resulting from the contractual and financial obligations of any subsidiary that serves as a fiscal intermediary providing administrative services for Medicare Parts A and B. Failure to comply with the foregoing requirements could result in a termination of the license agreements.

The license agreements may be modified by the BCBSA. To the extent that such amendments to the license agreements are adopted in the future, they could have a material adverse effect on our future expansion plans or results of operations. Further, BCBS licensees have certain requirements to perform administrative services for members of other BCBS licensees. As of December 31, 2019, we provided services to approximately 30 million Blue Cross and/or Blue Shield enrollees. If we or another BCBS licensee are not in compliance with all legal requirements or are unable to perform administrative services as required, this could have an adverse effect on our members and our ability to maintain our licenses, which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

Upon the occurrence of an event causing termination of the license agreements, we would no longer have the right to use the BCBS names and marks or to sell BCBS health insurance products and services in one or more of our service areas. Furthermore, the BCBSA would be free to issue a license to use the BCBS names and marks in these service areas to another entity. Our existing BCBS members would be provided with instructions for obtaining alternative products and services licensed by the BCBSA. Events that could cause the termination of a license agreement with the BCBSA include, without limitation, failure to comply with minimum capital requirements imposed by the BCBSA, failure to comply with governance requirements such as maintaining a classified board structure, a change of control or violation of the BCBSA ownership limitations on our capital stock, impending financial insolvency and the appointment of a trustee or receiver or the commencement of any action against a licensee seeking its dissolution. We believe that the BCBS names and marks are valuable identifiers of our products and services in the marketplace.

Upon termination of a license agreement, the BCBSA would have the right to impose a “Re-establishment Fee” upon us, which would be used in part to fund the establishment of a replacement Blue Cross and/or Blue Shield licensee in the vacated service area. The fee is set at $98.33 per licensed enrollee. If the Re-establishment Fee was applied to our total Blue Cross and/or Blue Shield enrollees of approximately 30 million as of December 31, 2019, we would be assessed approximately $3 billion by the BCBSA. As a result, termination of the license agreements would have a material adverse effect on our business, cash flows, financial condition and results of operations.

Our business may be impacted by natural disasters, war, terrorism, political events, global climate change and other occurrences that could create large-scale medical emergencies or otherwise have a material adverse effect on our business, cash flows, financial condition and results of operations.

Natural disasters, war, terrorism, political events, global climate change and other similar occurrences could create large-scale medical emergencies or otherwise have a material adverse effect on our business, cash flows, financial condition and results of operations. Large-scale medical emergencies can take many forms and can cause widespread illness and death. For example, federal and state law enforcement officials have issued warnings about potential terrorist activity involving biological and other weapons. In addition, natural disasters such as hurricanes and the potential for a widespread pandemic of influenza or other illness and the lack of availability of appropriate preventative medicines can have a significant impact on the health of the population of widespread areas. If the United States were to experience widespread bioterrorism or other attacks, large-scale natural disasters in our concentrated coverage areas or a large-scale pandemic or epidemic, our covered medical expenses could rise, our operations could be interrupted and we could experience a material adverse effect on our business, cash flows, financial condition and results of operations or, in the event of extreme circumstances, our viability could be threatened. Furthermore, global climate change could result in certain types of natural disasters occurring more frequently or with more intense effects, and may have a long-term effect on general economic conditions and the healthcare or pharmacy industry in particular, which could adversely affect our business and financial results.

Adverse securities and credit market conditions may significantly affect our ability to meet liquidity needs.

During periods of increased volatility, adverse securities and credit markets may exert downward pressure on the availability of liquidity and credit capacity for certain issuers. We need liquidity to pay our operating expenses, make payments on our indebtedness and pay capital expenditures. The principal sources of our cash receipts are premiums, administrative fees, investment income, revenue received from IngenioRx and DBG, proceeds from the sale or maturity of

our investment securities, proceeds from borrowings and proceeds from the issuance of common stock under our employee stock plans.

Our access to additional financing will depend on a variety of factors such as market conditions, the general availability of credit, the volume of trading activities, the availability of credit to our industry, our credit ratings and credit capacity, as well as the possibility that customers or lenders could develop a negative perception of our long- or short-term financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If one or a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain additional financing on favorable terms, or at all.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value may result in a loss charged to income.

The market values of our investments vary from time to time depending on economic and market conditions. For various reasons, we may sell certain of our investments at prices that are less than the carrying value of the investments. During periods in which interest rates are relatively low, as in recent years, our investment income could be adversely impacted. In addition, in periods of declining interest rates, bond calls and mortgage loan prepayments generally increase, resulting in the reinvestment of these funds at the then lower market rates. In periods of rising interest rates, the market values of our fixed maturity securities will generally decrease, which could result in material losses on investments in future periods. In addition, defaults by issuers, primarily from investments in corporate and municipal bonds, who fail to pay or perform their obligations, could reduce net investment income, which would adversely affect our profitability. We cannot assure you that our investment portfolios will produce positive returns or maintain their present values.

In accordance with FASB guidance for investments, we classify fixed maturity securities in our investment portfolio as “available-for-sale” or “trading” and report those securities at fair value. Current and long-term available-for-sale investment securities represented a significant percentage of our total consolidated assets at December 31, 2019.

Changes in the economic environment, including periods of increased volatility in the securities markets, can increase the difficulty of assessing investment impairment, and the same influences tend to increase the risk of potential impairment of these assets. Over time, the economic and market environment may provide additional insight into the value of our investment securities, which could change our judgment regarding the fair value of certain securities and/or impairment. Given the sometimes rapidly changing market conditions and the significant judgments involved, there is continuing risk that future declines in fair value may occur and material other-than-temporary impairments may be charged to income in future periods, resulting in realized losses.

We face intense competition to attract and retain employees. Further, managing key executive transition, succession and retention is critical to our success.

Our success depends on our ability to attract and retain qualified employees to meet current and future needs, and to integrate and engage employees who have joined us through acquisitions. We face intense competition for qualified employees, and there can be no assurance that we will be able to attract and retain such employees or that such competition among potential employers will not result in increasing salaries. An inability to retain existing employees or attract additional employees could have a material adverse effect on our business, cash flows, financial condition and results of operations.

We would be adversely affected if we fail to adequately plan for the succession of our President and Chief Executive Officer and other senior management and retention of key executives. While we have succession plans in place for members of our senior management, and employment arrangements with certain key executives, these plans and arrangements do not guarantee that the services of our senior executives will continue to be available to us or that we will be able to attract, transition and retain suitable successors.

We are subject to various risks associated with our international operations.

Certain of our subsidiaries that provide services to some of our health plans operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business, which requires us to devote resources to implement controls and systems in new foreign jurisdictions to comply with, and to ensure that our vendors and partners comply with, U.S. and foreign laws and regulations. These regulatory regimes encompass, among other matters, local and cross-border taxation, licensing, tariffs, intellectual property, investment, capital (including minimum solvency margin and reserve requirements), management control, labor, anti-fraud, anti-corruption and privacy and data protection regulations (including requirements for cross-border data transfers), which vary by jurisdiction. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business and significant reputational harm.

Changes in U.S. tax laws and regulations could have a material adverse effect on our business, cash flow, financial condition and results of operations. In addition, we may not be able to realize the value of our deferred tax assets.

Changes in tax laws and regulations, including with respect to corporate tax rates and the deductibility of expenses, or changes in the interpretation of tax laws and regulations by federal and/or state authorities, could have a material impact on the future value of our deferred tax assets and deferred tax liabilities, could result in significant one-time charges in the current or future taxable years and could increase our future U.S. tax expense. These changes could have a material adverse effect on our business, cash flow, financial condition and results of operations.

In accordance with applicable accounting standards, we separately recognize deferred tax assets and deferred tax liabilities. Such deferred tax assets and deferred tax liabilities represent the tax effect of temporary differences between financial reporting and tax reporting measured at tax rates enacted at the time the deferred tax asset or liability is recorded. At each financial reporting date, we evaluate our deferred tax assets to determine the likely realization of the benefit of the temporary differences. Our evaluation includes a review of the types of temporary differences that created the deferred tax asset; the amount of taxes paid on both capital gains and ordinary income in prior periods and available for a carry-back claim; the forecasted future taxable income, and therefore, the likely future deduction of the deferred tax item; and any other significant issues that might impact the realization of the deferred tax asset. If it is more likely than not that all or a portion of the deferred tax asset may not be realized, we establish a valuation allowance. Significant judgment is required in determining an appropriate valuation allowance.

Any future increase in our valuation allowance would result in additional income tax expense and a decrease in shareholders' equity, which could materially affect our financial position and results of operations in the period in which the increase occurs. A material decrease in shareholders' equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

Indiana law, other applicable laws, our articles of incorporation and bylaws, and provisions of our BCBSA license agreements may prevent or discourage takeovers and business combinations that our shareholders might consider to be in their best interest.

Indiana law and our articles of incorporation and bylaws may delay, defer, prevent or render more difficult a takeover attempt that our shareholders might consider to be in their best interests. For instance, they may prevent our shareholders from receiving the benefit from any premium to the market price of our common stock offered by a bidder in a takeover context. Even in the absence of a takeover attempt, the existence of these provisions may adversely affect the prevailing market price of our common stock if they are viewed as discouraging takeover attempts in the future.

We are regulated as an insurance holding company and subject to the insurance holding company acts of the states in which our insurance company subsidiaries are domiciled, as well as similar provisions included in the health statutes and regulations of certain states where these subsidiaries are regulated as managed care companies or HMOs. The insurance

holding company acts and regulations and these similar provisions restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes and regulations, without such approval or an exemption, no person may acquire any voting security of a domestic insurance company or HMO, or an insurance holding company which controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would "control" the insurance holding company, insurance company or HMO. "Control" is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person. Further, the Indiana Business Corporation Law contains business combination provisions that, in general, prohibit for five years any business combination with a beneficial owner of 10% or more of our common stock unless the holder's acquisition of the stock was approved in advance by our Board of Directors.

Our articles of incorporation restrict the beneficial ownership of our capital stock in excess of specific ownership limits. The ownership limits restrict beneficial ownership of our voting capital stock to less than 10% for institutional investors and less than 5% for non-institutional investors, both as defined in our articles of incorporation. Additionally, no person may beneficially own shares of our common stock representing a 20% or more ownership interest in us. These restrictions are intended to ensure our compliance with the terms of our licenses with the BCBSA. Our articles of incorporation prohibit ownership of our capital stock beyond these ownership limits without prior approval of a majority of our continuing directors (as defined in our articles of incorporation). In addition, as discussed above in the risk factor describing our license agreements with the BCBSA, such license agreements are subject to termination upon a change of control and a re-establishment fee would be imposed upon termination of the license agreements.

Certain other provisions included in our articles of incorporation and bylaws may also have anti-takeover effects and may delay, defer or prevent a takeover attempt that our shareholders might consider to be in their best interests. In particular, our articles of incorporation and bylaws: divide our Board of Directors into three classes serving staggered three-year terms (which is required by our license agreement with the BCBSA); permit our Board of Directors to determine the terms of and issue one or more series of preferred stock without further action by shareholders; restrict the maximum number of directors; limit the ability of shareholders to remove directors; impose restrictions on shareholders' ability to fill vacancies on our Board of Directors; impose advance notice requirements for shareholder proposals and nominations of directors to be considered at meetings of shareholders; and prohibit shareholders from amending certain provisions of our bylaws.

We also face other risks that could adversely affect our business, financial condition or results of operations, which include:

- any requirement to restate financial results in the event of inappropriate application of accounting principles;
- a significant failure of our internal control over financial reporting;
- failure of our prevention and control systems related to employee compliance with internal policies, including data security;
- healthcare benefits fraud by providers, members and/or brokers that is not prevented or detected and impacts our medical costs or those of self-insured customers;
- failure to protect our proprietary information; and
- failure of our corporate governance policies or procedures.

ITEM 1B. UNRESOLVED SEC STAFF COMMENTS.

None.

ITEM 2. PROPERTIES.

We lease our principal executive offices located at 220 Virginia Avenue, Indianapolis, Indiana. In addition to this location, we have operating facilities located in each state where we operate as licensees of the BCBSA, in each state where Amerigroup conducts business and in certain other states and countries where our other subsidiaries operate. A majority of these locations are also leased properties. Our facilities support our various business segments. We believe that our properties are adequate and suitable for our business as presently conducted as well as for the foreseeable future.

ITEM 3. LEGAL PROCEEDINGS.

For information regarding our legal proceedings, see Note 13, "Commitments and Contingencies - *Litigation and Regulatory Proceedings,*" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

ITEM 4. MINE SAFETY DISCLOSURES.

Not applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES.

Market Information

Our common stock, par value $0.01 per share, is listed on the NYSE under the symbol "ANTM."

Holders

As of February 6, 2020, there were 57,967 shareholders of record of our common stock.

Securities Authorized for Issuance under Equity Compensation Plans

The information required by this Item concerning securities authorized for issuance under our equity compensation plans is set forth in Part III, Item 12 "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters" in this Annual Report on Form 10-K.

Issuer Purchases of Equity Securities

The following table presents information related to our repurchases of common stock for the periods indicated:

Period	Total Number of Shares Purchased[1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Programs[2]	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Programs
(In millions, except share and per share data)				
October 1, 2019 to October 31, 2019	672,357	$ 244.58	670,000	$ 3,934
November 1, 2019 to November 30, 2019	282,903	276.20	279,500	3,857
December 1, 2019 to December 31, 2019	222,613	290.75	222,294	3,792
	1,177,873		1,171,794	

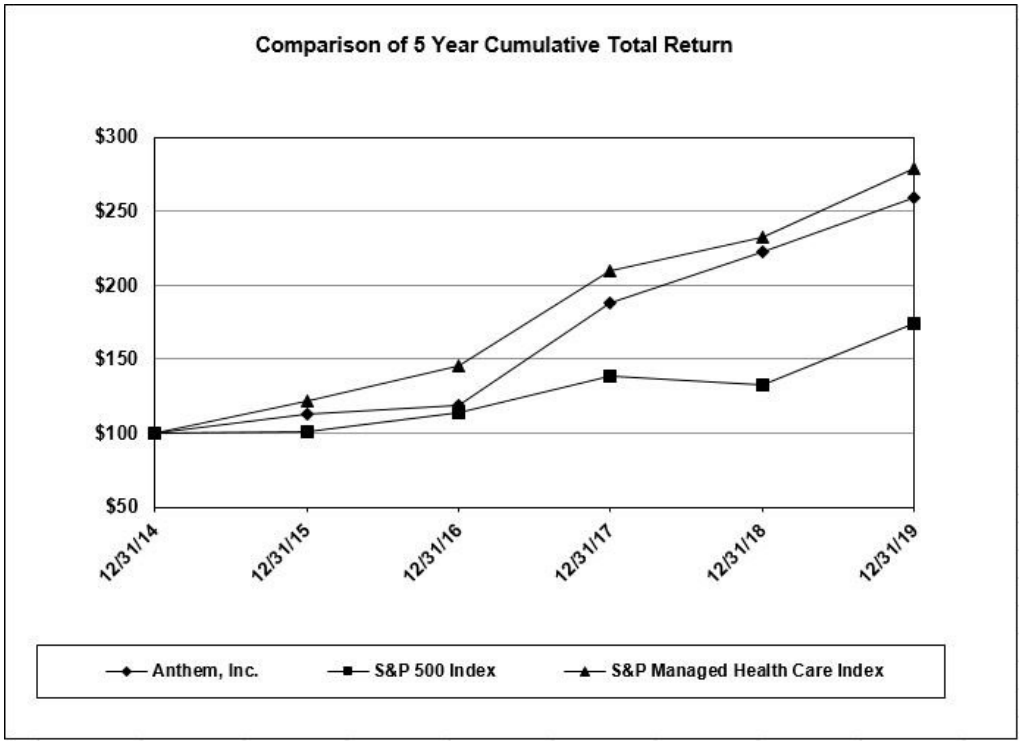
1 Total number of shares purchased includes 6,079 shares delivered to or withheld by us in connection with employee payroll tax withholding upon exercise or vesting of stock awards. Stock grants to employees and directors and stock issued for stock option plans and stock purchase plans in the consolidated statements of shareholders' equity are shown net of these shares purchased.

2 Represents the number of shares repurchased through the common stock repurchase program authorized by our Board of Directors, which the Board evaluates periodically. During the year ended December 31, 2019, we repurchased 6,332,989 shares at a cost of $1,701 under the program, including the cost of options to purchase shares. The Board of Directors has authorized our common stock repurchase program since 2003. The Board's most recent authorized increase to the program was $5,000 on December 7, 2017. No duration has been placed on our common stock repurchase program, and we reserve the right to discontinue the program at any time.

Performance Graph

The following Performance Graph and related information compares the cumulative total return to shareholders of our common stock for the period from December 31, 2014 through December 31, 2019, with the cumulative total return over such period of (i) the Standard & Poor's 500 Stock Index (the "S&P 500 Index") and (ii) the Standard & Poor's Managed Health Care Index (the "S&P Managed Health Care Index"). The graph assumes an investment of $100 on December 31, 2014 in each of our common stock, the S&P 500 Index and the S&P Managed Health Care Index (and the reinvestment of all dividends).

The comparisons shown in the graph below are based on historical data, and we caution that the stock price performance shown in the graph below is not indicative of, and is not intended to forecast, the potential future performance of our common stock. Information used in the graph was obtained from S&P Global Market Intelligence, a source believed to be reliable, but we are not responsible for any errors or omissions in such information. The following graph and related information shall not be deemed "soliciting materials" or to be "filed" with the SEC, nor shall such information be incorporated by reference into any future filing under the Exchange Act, except to the extent that we specifically incorporate it by reference into such filing.



	December 31,					
	2014	2015	2016	2017	2018	2019
Anthem, Inc.	$ 100	$ 113	$ 119	$ 188	$ 222	$ 259
S&P 500 Index	100	101	114	138	132	174
S&P Managed Health Care Index	100	122	146	210	232	279

Based upon an initial investment of $100 on December 31, 2014 with dividends reinvested.

ITEM 6. SELECTED FINANCIAL DATA.

The table below provides selected consolidated financial data of Anthem. The information has been derived from our consolidated financial statements for each of the years in the five-year period ended December 31, 2019. You should read this selected consolidated financial data in conjunction with the audited consolidated financial statements and notes as of and for the year ended December 31, 2019 included in Part II, Item 8 "Financial Statements and Supplementary Data," and Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K.

	As of and for the Years Ended December 31				
	2019	2018 [1]	2017 [1]	2016	2015 [1]
(in millions, except where indicated and except per share data)					
Income Statement Data					
Total operating revenue[2]	$ 103,141	$ 91,341	$ 89,061	$ 84,194	$ 78,405
Total revenues	104,213	92,105	90,040	84,863	79,157
Net income	4,807	3,750	3,843	2,470	2,560
Per Share Data					
Basic net income per share	$ 18.81	$ 14.53	$ 14.70	$ 9.39	$ 9.73
Diluted net income per share	18.47	14.19	14.35	9.21	9.38
Dividends per share	3.20	3.00	2.70	2.60	2.50
Other Data (unaudited)					
Benefit expense ratio[3]	86.8%	84.2%	86.4%	84.8%	83.3%
Selling, general and administrative expense ratio[4]	13.0%	15.3%	14.2%	14.9%	16.0%
Income before income tax expense as a percentage of total revenues	5.7%	5.5%	4.4%	5.4%	5.9%
Net income as a percentage of total revenues	4.6%	4.1%	4.3%	2.9%	3.2%
Medical membership (*in thousands*)	41,000	39,938	40,299	39,940	38,599
Balance Sheet Data					
Cash and investments[5]	$ 26,157	$ 22,639	$ 25,179	$ 23,263	$ 21,065
Total assets	77,453	71,571	70,540	65,083	61,718
Long-term debt, less current portion	17,787	17,217	17,382	14,359	15,325
Total liabilities	45,725	43,030	44,037	39,982	38,673
Total shareholders' equity	31,728	28,541	26,503	25,101	23,045

1 The net assets of and results of operations for America's 1st Choice, HealthSun and Simply Healthcare are included from their respective acquisition dates of February 15, 2018, December 21, 2017 and February 17, 2015, respectively.
2 Operating revenue is obtained by adding premiums and administrative fees and other revenue.
3 The benefit expense ratio represents benefit expenses as a percentage of premium revenue.
4 The selling, general and administrative expense ratio represents selling, general and administrative expenses as a percentage of total operating revenue.
5 Cash and investments is obtained by adding cash and cash equivalents, current and long-term fixed maturity securities and current and long-term equity securities.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS.

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

This Management's Discussion and Analysis of Financial Condition and Results of Operations, or MD&A, should be read in conjunction with our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K. References to the terms "we," "our," "us," "Anthem" or the "Company" used throughout this MD&A refer to Anthem, Inc., an Indiana corporation, and, unless the context otherwise requires, its direct and indirect subsidiaries. References to the "states" include the District of Columbia, unless the context otherwise requires.

This section of this Annual Report on Form 10-K generally discusses 2019 and 2018 items and year-over-year comparisons between 2019 and 2018. A detailed discussion of 2017 items and year-over-year comparisons between 2018 and 2017 that are not included in this Annual Report on Form 10-K can be found in "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2018.

Overview

We are one of the largest health benefits companies in the United States in terms of medical membership, serving approximately 41 medical members through our affiliated health plans as of December 31, 2019. We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (in the New York City metropolitan area and upstate New York), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas, we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, and Empire Blue Cross Blue Shield or Empire Blue Cross. We also conduct business through arrangements with other BCBS licensees as well as other strategic partners. Through our subsidiaries, we also serve customers in numerous states across the country as Aim Specialty Health, Amerigroup, Aspire Health, CareMore, Freedom Health, HealthLink, HealthSun, Optimum HealthCare, Simply Healthcare, and/or UniCare. Also, in the second quarter of 2019, we began providing pharmacy benefits management, or PBM, services through our IngenioRx subsidiary. We are licensed to conduct insurance operations in all 50 states and the District of Columbia through our subsidiaries.

We manage our operations through three reportable segments: Commercial & Specialty Business, Government Business and Other. Prior to the second quarter of 2019, our Other segment included certain eliminations and corporate expenses not allocated to either of our other reportable segments. Beginning with the second quarter of 2019, our Other segment also includes IngenioRx, our pharmacy benefits manager, which began operations during the second quarter of 2019. In addition, during the second quarter of 2019, we reclassified our Diversified Business Group, or DBG, our integrated health services business, from our Government Business segment to the Other segment to reflect changes in how our segments are being managed. Amounts for prior years have been reclassified through this MD&A to conform to the current year presentation for comparability. Based on the Financial Accounting Standards Board, or FASB, guidance, as of December 31, 2019, IngenioRx and DBG did not collectively meet the quantitative thresholds for a reportable segment.

Our operating revenue consists of premiums and administrative fees and other revenue. Premium revenue comes from fully-insured contracts where we indemnify our policyholders against costs for covered health and life benefits. Administrative fees and other revenue come from contracts where our customers are self-insured, or where the fee is based on either the processing of transactions or a percent of network discount savings realized, revenues from our Medicare processing business and from other health-related businesses, including disease management programs and miscellaneous other income. Administrative fees and other revenue also include product revenue for PBM services performed by IngenioRx to unaffiliated PBM customers, including our self-funded groups that have contracted with IngenioRx for PBM services, and beginning in 2020, to third-party health plans.

Our benefit expense primarily includes costs of care for health services consumed by our fully-insured members, such as outpatient care, inpatient hospital care, professional services (primarily physician care) and pharmacy benefit costs. All four components are affected both by unit costs and utilization rates. Unit costs include the cost of outpatient medical procedures

per visit, inpatient hospital care per admission, physician fees per office visit and prescription drug prices. Utilization rates represent the volume of consumption of health services and typically vary with the age and health status of our members and their social and lifestyle choices, along with clinical protocols and medical practice patterns in each of our markets. A portion of benefit expense recognized in each reporting period consists of actuarial estimates of claims incurred but not yet paid by us. Any changes in these estimates are recorded in the period the need for such an adjustment arises. While we offer a diversified mix of managed care products and services through our managed care plans, our aggregate cost of care can fluctuate based on a change in the overall mix of these products and services. Our managed care plans include: Preferred Provider Organizations; Health Maintenance Organizations, or HMOs; Point-of-Service plans; traditional indemnity plans and other hybrid plans, including Consumer-Driven Health Plans; and hospital only and limited benefit products.

We classify certain claims-related costs as benefit expense to reflect costs incurred for our members' traditional medical care, as well as those expenses which improve our members' health and medical outcomes. These claims-related costs may be comprised of expenses incurred for: (i) medical management, including case and prospective utilization management; (ii) health and wellness, including disease management services for such conditions as diabetes, high-risk pregnancies, congestive heart failure and asthma management and wellness initiatives like weight-loss programs and smoking cessation treatments; and (iii) clinical health policy, such as identification and use of best clinical practices to avoid harm, identifying clinical errors and safety concerns, and identifying potential adverse drug interactions. These types of claims-related costs are designed to ultimately lower our members' cost of care.

Our cost of products sold represents the cost of prescription drugs dispensed by IngenioRx to unaffiliated PBM customers (net of rebates or discounts), including any co-payments made by or on behalf of the customer, per-claim administrative fees for prescription fulfillment and certain direct costs related to sales and administration of customer contracts.

Our selling, general and administrative expenses consist of fixed and variable costs. Examples of fixed costs are depreciation, amortization and certain facilities expenses. Certain variable costs, such as premium taxes, vary directly with premium volume. Commission expense generally varies with premium or membership volume. Other variable costs, such as salaries and benefits, do not vary directly with changes in premium but are more aligned with changes in membership. The acquisition or loss of a significant block of business would likely impact staffing levels and thus, associated compensation expense. Other variable costs include professional and consulting expenses and advertising. Other factors can impact our administrative cost structure, including systems efficiencies, inflation and changes in productivity.

Our results of operations depend in large part on our ability to accurately predict and effectively manage healthcare costs through effective contracting with providers of care to our members and our medical management and health and wellness programs. Several economic factors related to healthcare costs, such as regulatory mandates of coverage as well as direct-to-consumer advertising by providers and pharmaceutical companies, have a direct impact on the volume of care consumed by our members. The potential effect of escalating healthcare costs, any changes in our ability to negotiate competitive rates with our providers and any regulatory or market-driven restrictions on our ability to obtain adequate premium rates to offset overall inflation in healthcare costs, including increases in unit costs and utilization resulting from the aging of the population and other demographics, as well as advances in medical technology, may impose further risks to our ability to profitably underwrite our business, and may have a material adverse impact on our results of operations.

For additional information about our business and reportable segments, see Part I, Item 1, "Business" and Note 19, "Segment Information" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Business Trends

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended, or collectively, the ACA, has changed and may continue to make broad-based changes to the U.S. healthcare system. We expect the ACA will continue to impact our business model and strategy. Also, the legal challenges regarding the ACA, including a federal district court decision invalidating the ACA, or the "2018 ACA Decision", which judgment has been stayed pending appeal, could significantly disrupt our business. During 2019, we modestly expanded our participation in the Individual ACA-compliant market. Our strategy has been, and will continue to be, to only participate in rating regions where we have an appropriate level of confidence that these markets are on a path toward sustainability, including, but not limited to, factors such as expected financial performance, regulatory environment, and underlying market characteristics. We

currently offer Individual ACA-compliant products in 91 of the 143 rating regions in which we operate. In addition, the continuing growth in our government-sponsored business exposes us to increased regulatory oversight.

In the second quarter of 2019, we began using our new pharmacy benefits manager called IngenioRx to market and sell a PBM product to fully-insured and self-funded Anthem health plan customers throughout the country, as well as to customers outside of the health plans we own. This comprehensive product portfolio includes features such as drug formularies, a pharmacy network, prescription drug database, member services and mail order capabilities. In July 2019, we announced our first contract win with a third-party health insurer, Blue Cross of Idaho, and we began providing PBM services under that contract beginning on January 1, 2020. Also beginning in the second quarter of 2019, we began delegating certain PBM administrative functions, such as claims processing and prescription fulfillment, to CaremarkPCS Health, L.L.C., or CVS Health, which is a subsidiary of CVS Health Corporation, pursuant to a five-year agreement with CVS Health, or the CVS PBM Agreement. We intend to retain the responsibilities for IngenioRx's clinical and formulary strategy and development, member and employer experiences, operations, sales, marketing, account management and retail network strategy. From December 2009 through December 2019, we delegated certain PBM functions and administrative services to Express Scripts, Inc., or Express Scripts, pursuant to our PBM agreement with Express Scripts, or the ESI PBM Agreement. In January 2019, we exercised our contractual right to terminate the ESI PBM Agreement earlier than the original expiration date of December 31, 2019 due to the acquisition of Express Scripts by Cigna Corporation, or Cigna. We began transitioning existing members from Express Scripts to IngenioRx in the second quarter of 2019, and completed the transition of all of our members on January 1, 2020. Prior to the termination of the ESI PBM Agreement, Express Scripts managed the network of pharmacy providers, operated mail order pharmacies and processed prescription drug claims on our behalf, while we sold and supported the product for our members, made formulary decisions, sold drug benefit design strategy and provided front line members support. We expect IngenioRx to provide our members with more cost-effective solutions and improve our ability to integrate pharmacy benefits within our medical and specialty platform.

Pricing Trends: We strive to price our healthcare benefit products consistent with anticipated underlying medical trends. We frequently make adjustments to respond to legislative and regulatory changes as well as pricing and other actions taken by existing competitors and new market entrants. Product pricing in our Commercial & Specialty Business segment, including our Individual and Small Group lines of business, remains competitive. Revenues from the Medicare and Medicaid programs are dependent, in whole or in part, upon annual funding from the federal government and/or applicable state governments. The ACA imposed an annual Health Insurance Provider Fee, or HIP Fee, on health insurers that write certain types of health insurance on U.S. risks. We price our affected products to cover the impact of the HIP Fee when applicable. The HIP Fee was suspended for 2019, has resumed for 2020 and has been permanently repealed beginning in 2021.

Medical Cost Trends: Our medical cost trends are primarily driven by increases in the utilization of services across all provider types and the unit cost increases of these services. We work to mitigate these trends through various medical management programs such as utilization management, condition management, program integrity and specialty pharmacy management, as well as benefit design changes. There are many drivers of medical cost trends that can cause variance from our estimates, such as changes in the level and mix of services utilized, regulatory changes, aging of the population, health status and other demographic characteristics of our members, epidemics, advances in medical technology, new high cost prescription drugs, and healthcare provider or member fraud. Our underlying Local Group medical cost trends reflect the "allowed amount," or contractual rate, paid to providers. We estimate that our aggregate cost of care trend for the full year of 2019 was approximately 6.0%, at the midpoint of our 5.5% to 6.5% estimated range for the year. We anticipate the Local Group medical cost trend in 2020 will be in the range of 3.5% to 4.5%, including the benefit of lower pharmacy cost from the launch of IngenioRx and other medical cost management initiatives.

For additional discussion regarding business trends, see Part I, Item 1 "Business" of this Annual Report on Form 10-K.

Regulatory Trends and Uncertainties

The ACA presented us with new growth opportunities, but also introduced new risks, regulatory challenges and uncertainties, and required changes in the way products are designed, underwritten, priced, distributed and administered. Changes to our business environment are likely to continue as elected officials at the national and state levels continue to enact, and both elected officials and candidates for election continue to propose, significant modifications to existing laws and regulations, including changes to taxes and fees. In addition, the legal challenges regarding the ACA, including the 2018

ACA Decision, which judgment has been stayed pending appeal, continue to contribute to this uncertainty. We will continue to evaluate the impact of the ACA as any further developments or judicial rulings occur.

The annual HIP Fee is allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to the amount of health insurance premium for all U.S. health risk for those certain lines of business written during the preceding calendar year. We record our estimated liability for the HIP Fee in full at the beginning of the year with a corresponding deferred asset that is amortized on a straight-line basis to selling, general and administrative expense. The final calculation and payment of the annual HIP Fee is due by September 30th of each fee year. The HIP Fee is non-deductible for federal income tax purposes. Our affected products are priced to cover the increased selling, general and administrative and income tax expenses associated with the HIP Fee. The total amount due from allocations to health insurers was $14,300 for 2018, and we recognized $1,544 as selling, general and administrative expense related to the HIP Fee. There was no corresponding expense for 2019 due to the suspension of the HIP Fee for 2019. The HIP Fee has resumed and increased to $15,523 for 2020 and has been permanently eliminated beginning in 2021.

As a result of the ACA, the U.S. Department of Health and Human Services, or HHS, issued Medical Loss Ratio, or MLR, regulations that require us to meet minimum MLR thresholds of 85% for Large Group and 80% for Small Group and Individual lines of business. Plans that do not meet the minimum thresholds have to pay a MLR rebate. For purposes of determining MLR rebates, HHS has defined the types of costs that should be included in the MLR rebate calculation. However, certain components of the MLR calculation as defined by HHS cannot be classified consistently under U.S. generally accepted accounting principles, or GAAP. While considered benefit expense or a reduction of premium revenue by HHS, certain of these costs are classified as other types of expense, such as selling, general and administrative expense or income tax expense, in our GAAP basis financial statements. Accordingly, the benefit expense ratio determined using our consolidated GAAP operating results is not comparable to the MLR calculated under HHS regulations.

The ACA also imposed a separate minimum MLR threshold of 85% for Medicare Advantage and Medicare Part D prescription drug plans, or Medicare Part D. Medicare Advantage or Medicare Part D plans that do not meet this threshold have to pay an MLR rebate. If a plan's MLR is below 85% for three consecutive years beginning with 2014, enrollment is restricted. A Medicare Advantage or Medicare Part D plan contract will be terminated if the plan's MLR is below 85% for five consecutive years.

For additional discussion regarding regulatory trends and uncertainties, and risk factors that could cause actual results to differ materially from those contained in forward-looking statements made in this Annual Report on Form 10-K, see Part I, Item 1 "Business - Regulation" and Part I, Item 1A "Risk Factors."

Other Significant Items or Transactions

In January 2019, we exercised our contractual right to terminate the ESI PBM Agreement, and we completed the transition of our members from Express Scripts to IngenioRx on January 1, 2020. Notwithstanding our termination of the ESI PBM Agreement, the litigation between us and Express Scripts regarding the ESI PBM Agreement continues. In March 2016, we filed a lawsuit against Express Scripts seeking to recover damages for pharmacy pricing that is higher than competitive benchmark pricing and damages related to operational breaches. Express Scripts filed an answer to the lawsuit disputing our contractual claims and alleging various defenses and counterclaims. For additional information regarding this lawsuit, see Note 13, "Commitments and Contingencies - *Litigation and Regulatory Proceedings - Express Scripts, Inc. Pharmacy Benefit Management Litigation,*" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

In February 2018, we completed our acquisition of Freedom Health, Inc., Optimum HealthCare, Inc., America's 1st Choice of South Carolina, Inc. and related entities, or collectively, America's 1st Choice, a Medicare Advantage organization that offers HMO products, including Chronic Special Needs Plans and Dual-Eligible Special Needs Plans under its Freedom Health and Optimum HealthCare brands in Florida and its America's 1st Choice of South Carolina brand in South Carolina. At the time of acquisition, through its Medicare Advantage Plans, America's 1st Choice served approximately one hundred and thirty-five thousand members in 25 Florida and 3 South Carolina counties. This acquisition aligned with our plans for continued growth in the Medicare Advantage and Special Needs populations.

In December 2017, we acquired HealthSun Health Plans, Inc., or HealthSun, which at the time of acquisition served approximately forty thousand members in the state of Florida through its Medicare Advantage plans, and which received a

five-star rating from the Centers for Medicare & Medicaid Services. This acquisition aligned with our plans for continued growth in the Medicare Advantage and dual-eligible populations.

For additional information related to the acquisitions of America's 1st Choice and HealthSun, see Note 3, "Business Acquisitions," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

In May 2017, we announced that we were terminating the Agreement and Plan of Merger, or Cigna Merger Agreement, between us and Cigna. Both we and Cigna have commenced litigation against the other seeking various actions and damages, including Cigna's damage claim for a $1,850 termination fee pursuant to the terms of the Cigna Merger Agreement. For additional information about the ongoing litigation related to the Cigna Merger Agreement, see Note 13, "Commitments and Contingencies - *Litigation and Regulatory Proceedings - Cigna Corporation Merger Litigation,*" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Other significant transactions in recent years that have impacted or will impact our capital structure or that have influenced or will influence how we conduct our business operations include our Board of Directors' declarations of dividends on our common stock, repurchases of our common stock, and debt repurchases and new debt issuances (2019 and prior). For additional information regarding these transactions, see Note 12, "Debt" and Note 14, "Capital Stock," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Selected Operating Performance

During the year ended December 31, 2019, total medical membership increased by 1.1, or 2.7%, and this increase was driven primarily by growth in our fully-insured businesses.

Operating revenue for the year ended December 31, 2019 was $103,141, an increase of $11,800, or 12.9%, from the year ended December 31, 2018. The increase in operating revenue was primarily from higher premiums, and, to a lesser extent, increased administrative fees and other revenue.

Net income for the year ended December 31, 2019 was $4,807, an increase of $1,057, or 28.2%, from the year ended December 31, 2018. The increase in net income was due to higher operating results in both our Commercial & Specialty Business and Government Business segments, in part due to the benefits realized from the launch of IngenioRx in 2019, net realized gains on financial instruments and lower income tax expense.

Our fully-diluted earnings per share, or EPS, for the year ended December 31, 2019 were $18.47, an increase of $4.28, or 30.2%, from the year ended December 31, 2018. Our diluted shares for the year ended December 31, 2019 were 260.3, a decrease of 3.9, or 1.5%, compared to the year ended December 31, 2018. The increase in EPS resulted primarily from the increase in net income in 2019.

Operating cash flow for the year ended December 31, 2019 was $6,061, or approximately 1.3 times net income. Operating cash flow for the year ended December 31, 2018 was $3,827, or approximately 1.0 times net income. The increase in operating cash flow was primarily due to the impact of membership growth in our Government Business segment as well as higher net income in 2019. These increases were partially offset by the impact of the timing of working capital changes.

Our results of operations discussed throughout this MD&A are determined in accordance with GAAP. We also calculate operating gain to further aid investors in understanding and analyzing our core operating results. We define operating revenue as premium income and administrative fees and other revenue. Operating gain is calculated as total operating revenue less benefit expense, cost of products sold and selling, general and administrative expense. We use these measures as a basis for evaluating segment performance, allocating resources, forecasting future operating periods and setting incentive compensation targets. This information is not intended to be considered in isolation or as a substitute for income before income tax expense, net income or EPS prepared in accordance with GAAP, and may not be comparable to similarly titled measures reported by other companies. For additional details on operating gain, see our "Reportable Segments Results of Operations" discussion included in this MD&A. For a reconciliation of reportable segment operating revenue to the amounts of total revenue included in the consolidated statements of income and a reconciliation of reportable segment operating gain to income before income tax expense, see Note 19, "Segment Information," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We intend to expand through a combination of organic growth, strategic acquisitions and efficient use of capital in both existing and new markets. Our growth strategy is designed to enable us to take advantage of additional economies of scale, as well as providing us access to new and evolving technologies and products. In addition, we believe geographic and product diversity reduces our exposure to local or regional regulatory, economic and competitive pressures and provides us with increased opportunities for growth. In 2019, we continued growing our government-sponsored business and modestly increased our participation in the Individual ACA-compliant market. In all other markets, we intend to maintain our position by delivering excellent service, offering competitively priced products, providing access to high-quality provider networks and effectively capitalizing on the brand strength of the Blue Cross and Blue Shield names and marks.

Membership

Our medical membership includes seven different customer types: Local Group, Individual, National Accounts, BlueCard®, Medicare, Medicaid and our Federal Employees Health Benefits, or FEHB, Program. BCBS-branded business generally refers to members in our service areas licensed by the BCBSA. Non-BCBS-branded business refers to members in our non-BCBS-branded Amerigroup, Freedom Health, HealthSun, Optimum HealthCare and Simply Healthcare plans, as well as HealthLink and UniCare members. In addition to the above medical membership, we also serve customers who purchase one or more of our other products or services that are often ancillary to our health business.

- Local Group consists of those employer customers with less than 5% of eligible employees located outside of the headquarter state, as well as customers with more than 5% of eligible employees located outside of the headquarter state with up to 5,000 eligible employees. In addition, Local Group includes UniCare members. Local Group accounts are generally sold through brokers or consultants who work with industry specialists from our in-house sales force and are offered both on and off the public exchanges. Local Group insurance premiums may be based on claims incurred by the group or sold on a self-insured basis. The customer's buying decision is typically based upon the size and breadth of our networks, customer service, the quality of our medical management services, the administrative cost included in our quoted price, our financial stability, our reputation and our ability to effectively service large complex accounts. Local Group accounted for 38.2%, 39.4% and 39.4% of our medical members at December 31, 2019, 2018 and 2017, respectively.
- Individual consists of individual customers under age 65 and their covered dependents. Individual policies are generally sold through independent agents and brokers, retail partnerships, our in-house sales force or via the exchanges. Individual business is sold on a fully-insured basis. We offer on-exchange products through public exchanges and off-exchange products. Federal premium subsidies are available only for certain public exchange Individual products. Unsubsidized Individual customers are generally more sensitive to product pricing and, to a lesser extent, the configuration of the network and the efficiency of administration. Customer turnover is generally higher with Individual as compared to Local Group. Individual business accounted for 1.7%, 1.6% and 3.9% of our medical members at December 31, 2019, 2018 and 2017, respectively.
- National Accounts generally consist of multi-state employer groups primarily headquartered in an Anthem service area with at least 5% of the eligible employees located outside of the headquarter state and with more than 5,000 eligible employees. Some exceptions are allowed based on broker and consultant relationships. Service area is defined as the geographic area in which we are licensed to sell BCBS products. National Accounts are generally sold through independent brokers or consultants retained by the customer working with our in-house sales force. We believe we have an advantage when competing for very large National Accounts due to the size and breadth of our networks and our ability to access the national provider networks of BCBS companies at their competitive local market rates. National Accounts represented 18.5%, 19.0% and 18.5% of our medical members at December 31, 2019, 2018 and 2017, respectively.
- BlueCard® host customers represent enrollees of Blue Cross and/or Blue Shield plans not owned by Anthem who receive healthcare services in our BCBSA licensed markets. BlueCard® membership consists of estimated host members using the national BlueCard® program. Host members are generally members who reside in or travel to a state in which an Anthem subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer-sponsored health plan issued by a non-Anthem controlled BCBSA licensee (i.e., the "home plan"). We perform certain administrative functions for BlueCard® members, for which we receive administrative fees from the BlueCard® members' home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan. Host members are computed using, among other things, the

average number of BlueCard® claims received per month. BlueCard® host membership accounted for 14.8%, 14.6% and 14.2% of our medical members at December 31, 2019, 2018 and 2017, respectively.

- Medicare customers are Medicare-eligible individual members age 65 and over who have enrolled in Medicare Supplement plans; Medicare Advantage, including Special Needs Plans or SNPs, also known as Medicare Advantage SNPs; Medicare Part D; and dual-eligible programs through Medicare-Medicaid Plans, or MMPs. Medicare Supplement plans typically pay the difference between healthcare costs incurred by a beneficiary and amounts paid by Medicare. Medicare Advantage plans provide Medicare beneficiaries with a managed care alternative to traditional Medicare and often include a Medicare Part D benefit. In addition, our Medicare Advantage SNPs provide tailored benefits to special needs individuals who are institutionalized or have severe or disabling chronic conditions and to dual-eligible customers, who are low-income seniors and persons under age 65 with disabilities. Medicare Advantage SNPs are coordinated care plans specifically designed to provide targeted care, covering all the health care services considered medically necessary for members and often providing professional care coordination services, with personal guidance and programs that help members maintain their health. Medicare Advantage membership also includes Employer Group Medicare Advantage members who are related to National Accounts or retired members of Local Group accounts who have selected a Medicare Advantage product. Medicare Part D offers a prescription drug plan to Medicare and MMP beneficiaries. MMP, which was established as a result of the passage of the ACA, is a demonstration program focused on serving members who are dually eligible for Medicaid and Medicare. Medicare Supplement and Medicare Advantage products are marketed in the same manner, primarily through independent agents and brokers. Medicare business accounted for 5.2%, 4.6% and 3.9% of our medical members at December 31, 2019, 2018 and 2017, respectively.
- Medicaid membership represents eligible members who receive healthcare benefits through publicly funded healthcare programs, including Medicaid, ACA-related Medicaid expansion programs, Temporary Assistance for Needy Families, programs for seniors and people with disabilities, Children's Health Insurance Programs, and specialty programs such as those focused on long-term services and support, HIV/AIDS, foster care, behavioral health and/or substance abuse disorders, and intellectual disabilities or developmental disabilities, among others. Total Medicaid program business accounted for 17.7%, 16.8% and 16.1% of our medical members at December 31, 2019, 2018 and 2017, respectively.
- FEHB members consist of United States government employees and their dependents within our geographic markets through our participation in the national contract between the BCBSA and the U.S. Office of Personnel Management. FEHB business accounted for 3.9% of our medical members at each of December 31, 2019, 2018 and 2017.

In addition to reporting our medical membership by customer type, we report by funding arrangement according to the level of risk that we assume in the product contract. Our two principal funding arrangement categories are fully-insured and self-funded. Fully-insured products are products in which we indemnify our policyholders against costs for health benefits. Self-funded products are offered to customers, generally larger employers, who elect to retain most or all of the financial risk associated with their employees' healthcare costs. Some self-funded customers choose to purchase stop loss coverage to limit their retained risk.

The following table presents our medical membership by customer type, funding arrangement and reportable segment as of December 31, 2019, 2018 and 2017. Also included below is other membership by product. The medical membership and other membership presented are unaudited and in certain instances include estimates of the number of members represented by each contract at the end of the period.

	December 31			2019 vs. 2018		2018 vs. 2017	
(In thousands)	**2019**	**2018**	**2017**	**Change**	**% Change**	**Change**	**% Change**
Medical Membership							
Customer Type							
Local Group	15,682	15,733	15,888	(51)	(0.3)%	(155)	(1.0)%
Individual	684	655	1,588	29	4.4 %	(933)	(58.8)%
National:							
National Accounts	7,596	7,588	7,463	8	0.1 %	125	1.7 %
BlueCard®	6,060	5,838	5,733	222	3.8 %	105	1.8 %
Total National	13,656	13,426	13,196	230	1.7 %	230	1.7 %
Medicare:							
Medicare Advantage	1,214	1,006	746	208	20.7 %	260	34.9 %
Medicare Supplement	905	846	823	59	7.0 %	23	2.8 %
Total Medicare	2,119	1,852	1,569	267	14.4 %	283	18.0 %
Medicaid	7,265	6,716	6,496	549	8.2 %	220	3.4 %
FEHB	1,594	1,556	1,562	38	2.4 %	(6)	(0.4)%
Total Medical Membership by Customer Type	41,000	39,938	40,299	1,062	2.7 %	(361)	(0.9)%
Funding Arrangement							
Self-Funded	25,418	25,287	24,862	131	0.5 %	425	1.7 %
Fully-Insured	15,582	14,651	15,437	931	6.4 %	(786)	(5.1)%
Total Medical Membership by Funding Arrangement	41,000	39,938	40,299	1,062	2.7 %	(361)	(0.9)%
Reportable Segment							
Commercial & Specialty Business	30,022	29,814	30,672	208	0.7 %	(858)	(2.8)%
Government Business	10,978	10,124	9,627	854	8.4 %	497	5.2 %
Total Medical Membership by Reportable Segment	41,000	39,938	40,299	1,062	2.7 %	(361)	(0.9)%
Other Membership							
Life and Disability Members	5,259	4,795	4,700	464	9.7 %	95	2.0 %
Dental Members	5,962	5,807	5,864	155	2.7 %	(57)	(1.0)%
Dental Administration Members	5,516	5,327	5,342	189	3.5 %	(15)	(0.3)%
Vision Members	7,261	6,946	6,867	315	4.5 %	79	1.2 %
Medicare Part D Standalone Members	283	309	318	(26)	(8.4)%	(9)	(2.8)%

December 31, 2019 Compared to December 31, 2018

Medical Membership

Total medical membership increased across our reportable business segments, and the increase was driven primarily by growth in our fully-insured businesses. Fully-insured membership increased primarily due to growth in our Medicaid and Medicare businesses. Self-funded medical membership increased primarily due to higher activity from BlueCard® membership, partially offset by the decrease in our Large Group self-funded membership, which declined as a result of competitive pressures. Medicaid membership increased primarily due to expansions in new and existing markets, partially offset by the membership decrease resulting from the loss of a contract. Medicare membership increased primarily due to

higher sales during open enrollment exceeding lapses. BlueCard® membership increased due to higher activity by members of other BCBSA plans who reside in or travel to our licensed areas.

Other Membership

Growth in our other membership can be impacted by changes in our medical membership, as our medical members often purchase our other products that are ancillary to our health business. We have experienced growth in our life and disability and dental memberships primarily due to higher sales in our Large Group business. Vision membership increased primarily due to higher sales in our Medicare Advantage plans and Large Group business. Dental administration membership increased primarily due to growth in our FEHB program.

Consolidated Results of Operations

Our consolidated summarized results of operations and other information for the years ended December 31, 2019, 2018 and 2017 are as follows:

	Years Ended December 31			Change			
				2019 vs. 2018		2018 vs. 2017	
	2019	2018	2017	$	%	$	%
Total operating revenue	$ 103,141	$ 91,341	$ 89,061	$ 11,800	12.9 %	$ 2,280	2.6 %
Net investment income	1,005	970	867	35	3.6 %	103	11.9 %
Net realized gains (losses) on financial instruments	114	(180)	145	294	163.3 %	(325)	(224.1)%
Other-than-temporary impairment losses recognized in income	(47)	(26)	(33)	(21)	(80.8)%	7	21.2 %
Total revenues	104,213	92,105	90,040	12,108	13.1 %	2,065	2.3 %
Benefit expense	81,786	71,895	72,236	9,891	13.8 %	(341)	(0.5)%
Cost of products sold	1,992	—	—	1,992	NM	—	—
Selling, general and administrative expense	13,364	14,020	12,650	(656)	(4.7)%	1,370	10.8 %
Other expense[1]	1,086	1,122	1,190	(36)	(3.2)%	(68)	(5.7)%
Total expenses	98,228	87,037	86,076	11,191	12.9 %	961	1.1 %
Income before income tax expense	5,985	5,068	3,964	917	18.1 %	1,104	27.9 %
Income tax expense	1,178	1,318	121	(140)	(10.6)%	1,197	989.3 %
Net income	$ 4,807	$ 3,750	$ 3,843	$ 1,057	28.2 %	$ (93)	(2.4)%
Average diluted shares outstanding	260.3	264.2	267.8	(3.9)	(1.5)%	(3.6)	(1.3)%
Diluted net income per share	$ 18.47	$ 14.19	$ 14.35	$ 4.28	30.2 %	$ (0.16)	(1.1)%
Effective tax rate	19.7%	26.0%	3.1%		(630)bp[3]		2,290bp[3]
Benefit expense ratio[2]	86.8%	84.2%	86.4%		260bp[3]		(220)bp[3]
Selling, general and administrative expense ratio[4]	13.0%	15.3%	14.2%		(230)bp[3]		110bp[3]
Income before income tax expense as a percentage of total revenues	5.7%	5.5%	4.4%		20bp[3]		110bp[3]
Net income as a percentage of total revenues	4.6%	4.1%	4.3%		50bp[3]		(20)bp[3]

Certain of the following definitions are also applicable to all other results of operations tables in this discussion:

NM Not meaningful.

1 Includes interest expense, amortization of other intangible assets and loss on extinguishment of debt.

2 Benefit expense ratio represents benefit expense as a percentage of premium revenue. Premiums for the years ended December 31, 2019, 2018 and 2017 were $94,173, $85,421 and $83,648, respectively. Premiums are included in total operating revenue presented above.

3 bp = basis point; one hundred basis points = 1%.

4 Selling, general and administrative expense ratio represents selling, general and administrative expense as a percentage of total operating revenue.

Year Ended December 31, 2019 Compared to the Year Ended December 31, 2018

The increase in total operating revenue was primarily from higher premiums, and, to a lesser extent, increased administrative fees and other revenue. The higher premiums were largely due to Medicaid expansions in new and existing markets and membership growth in our Medicare business. The increase in premiums was further attributable to rate increases across our businesses designed to cover overall cost trends. These increases in premiums were partially offset by the impact of the HIP Fee suspension for 2019. The increase in administrative fees and other revenue was primarily driven by IngenioRx, our PBM, which began its operations during the second quarter of 2019.

We recognized net realized gains on financial instruments in 2019 compared to net realized losses on financial instruments in 2018. This change was primarily due to a decrease in the net losses recognized for changes in the fair values of our equity securities.

Benefit expense increased primarily due to membership growth across our reportable business segments and higher medical cost experience in our Medicaid business.

Our benefit expense ratio increased largely due to the loss of revenue associated with the HIP Fee suspension for 2019, and, to a lesser extent, less favorable prior year reserve development in our Commercial & Specialty business segment during 2019 and margin normalization in our Individual business.

Cost of products sold reflects the cost of pharmaceuticals dispensed by IngenioRx for our self-funded customers. IngenioRx began operations during the second quarter of 2019, so there was no cost of products sold recognized in 2018.

Selling, general and administrative expense decreased primarily due to the suspension of the HIP Fee for 2019. This decrease was partially offset by a net increase in spend to support growth in our businesses.

Our selling, general and administrative expense ratio decreased due to the growth in total operating revenue and the suspension of the HIP Fee for 2019.

Our effective tax rate decreased primarily due to the suspension of the non-tax deductible HIP Fee for 2019.

Our net income as a percentage of total revenue increased as a result of all factors discussed above.

Reportable Segments Results of Operations

We use operating gain to evaluate the performance of our reportable segments, which are Commercial & Specialty Business, Government Business, and Other. Operating gain is calculated as total operating revenue less benefit expense, cost of products sold and selling, general and administrative expense. It does not include net investment income, net realized gains (losses) on financial instruments, other-than-temporary impairment losses recognized in income, interest expense, amortization of other intangible assets, loss (gain) on extinguishment of debt or income taxes, as these items are managed in a corporate shared service environment and are not the responsibility of operating segment management.

The discussion of segment results presented below are based on operating gain, as described above, and operating margin, which is calculated as operating gain divided by operating revenue. Our definitions of operating gain and operating margin may not be comparable to similarly titled measures reported by other companies. For additional information, see Note 19, “Segment Information,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

The following table presents a summary of our reportable segment financial information for the years ended December 31, 2019, 2018 and 2017:

	Years Ended December 31			Change			
				2019 vs. 2018		2018 vs. 2017	
	2019	2018	2017	$	%	$	%
Operating Revenue							
Commercial & Specialty Business	$ 37,421	$ 35,782	$ 40,363	1,639	4.6%	(4,581)	(11.3)%
Government Business	62,632	55,348	48,587	7,284	13.2%	6,761	13.9%
Other	7,695	1,519	127	6,176	406.6%	1,392	NM
Eliminations	(4,607)	(1,308)	(16)	(3,299)	NM	(1,292)	NM
Total operating revenue	$ 103,141	$ 91,341	$ 89,061	$ 11,800	12.9%	$ 2,280	2.6%
Operating Gain (Loss)							
Commercial & Specialty Business	$ 4,046	$ 3,600	$ 2,847	446	12.4%	753	26.4%
Government Business	2,054	1,928	1,442	126	6.5%	486	33.7%
Other	(101)	(102)	(114)	1	(1.0)%	12	(10.5)%
Operating Margin							
Commercial & Specialty Business	10.8%	10.1%	7.1%		70bp[1]		300bp[1]
Government Business	3.3%	3.5%	3.0%		(20)bp[1]		50bp[1]

NM Not meaningful.
1 bp = basis point; one hundred basis points = 1%.

Year Ended December 31, 2019 Compared to the Year Ended December 31, 2018

Commercial & Specialty Business

Operating revenue increased primarily due to higher premium revenue and, to a lesser extent, increased administrative fees and other revenue. Premium revenue was higher as a result of rate increases in our Local Group business designed to cover overall cost trends and membership increases in our fully-insured businesses. These increases in premium revenue were partially offset by the impact of the HIP Fee suspension for 2019. The increase in administrative fees and other revenue was due to higher penetration of value-added services for self-funded members in our Large Group and National Accounts businesses.

The increase in operating gain was primarily driven by the benefits realized in pharmacy cost as a result of the launch of IngenioRx in 2019 and greater penetration of value-added services and integrated health offerings. These increases were partially offset by less favorable prior year reserve development during 2019 and margin normalization in our Individual business.

Government Business

Operating revenue increased primarily due to higher premium revenue as a result of Medicaid expansions in new and existing markets, including specialized service populations, and membership growth in our Medicare business. The increase in premium revenue was further attributable to rate increases designed to cover overall cost trends in our Medicare and Medicaid businesses as well as increased reimbursed benefit utilization in our Federal Health Products & Services business. These increases were partially offset by the impact of the HIP Fee suspension for 2019.

The increase in operating gain was primarily driven by the impact of premium increases due to rate adjustments and membership growth in our Medicaid business. This increase was partially offset by the impact of the HIP Fee suspension for 2019 and an increase in selling, general and administrative spend to support growth in our businesses.

Other

Operating revenue increased due to higher administrative fees and other revenue from IngenioRx and DBG. The increase was primarily driven by growth in our pharmacy services provided by IngenioRx, which commenced operations and began transitioning existing clients from Express Scripts to IngenioRx in the second quarter of 2019.

Operating loss remained steady, as there were no substantial changes in unallocated corporate expenses. For our segment reporting, operating gains (losses) generated from IngenioRx and DBG affiliated activity have been included in our Commercial & Specialty Business and Government Business based upon their utilization of services from IngenioRx and DBG.

Critical Accounting Policies and Estimates

We prepare our consolidated financial statements in conformity with GAAP. Application of GAAP requires management to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes and within this MD&A. We consider our most important accounting policies that require significant estimates and management judgment to be those policies with respect to liabilities for medical claims payable, income taxes, goodwill and other intangible assets, investments and retirement benefits, which are discussed below. Our other significant accounting policies are summarized in Note 2, "Basis of Presentation and Significant Accounting Policies," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We continually evaluate the accounting policies and estimates used to prepare the consolidated financial statements. In general, our estimates are based on historical experience, evaluation of current trends, information from third-party professionals and various other assumptions that we believe to be reasonable under the known facts and circumstances. Estimates can require a significant amount of judgment and a different set of assumptions could result in material changes to our reported results.

Medical Claims Payable

The most subjective accounting estimate in our consolidated financial statements is our liability for medical claims payable. At December 31, 2019, this liability was $8,842 and represented 19% of our total consolidated liabilities. We record this liability and the corresponding benefit expense for incurred but not paid claims, including the estimated costs of processing such claims. Incurred but not paid claims include (1) an estimate for claims that are incurred but not reported, as well as claims reported to us but not yet processed through our systems, which approximated 98%, or $8,633, of our total medical claims liability as of December 31, 2019; and (2) claims reported to us and processed through our systems but not yet paid, which approximated 2%, or $209, of the total medical claims payable as of December 31, 2019. The level of claims payable processed through our systems but not yet paid may fluctuate from one period-end to the next, from approximately 1% to 5% of our total medical claims liability, due to timing of when claim payments are made.

Liabilities for both claims incurred but not reported and reported but not yet processed through our systems are determined in the aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Actuarial Standards of Practice require that the claim liabilities be appropriate under moderately adverse circumstances. We determine the amount of the liability for incurred but not paid claims by following a detailed actuarial process that uses both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities. Under this process, historical paid claims data is formatted into "claim triangles," which compare claim incurred dates to the dates of claim payments. This information is analyzed to create "completion factors" that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the period-end date to estimate the ultimate claim expense incurred for the period. Actuarial estimates of incurred but not paid claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims.

For the most recent incurred months (typically the most recent two months), the percentage of claims paid for claims incurred in those months is generally low. This makes the completion factor methodology less reliable for such months. Therefore, incurred claims for recent months are not projected from historical completion and payment patterns; rather, they are projected by estimating the claims expense for those months based on recent claims expense levels and healthcare trend levels, or "trend factors."

Because the reserve methodology is based upon historical information, it must be adjusted for known or suspected operational and environmental changes. These adjustments are made by our actuaries based on their knowledge and their estimate of emerging impacts to benefit costs and payment speed. Circumstances to be considered in developing our best estimate of reserves include changes in utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations. A comparison of prior period liabilities to re-estimated claim liabilities based on subsequent claims development is also considered in making the liability determination. In our comparison to prior periods, the methods and assumptions are not changed as reserves are recalculated; rather, the availability of additional paid claims information drives changes in the re-estimate of the unpaid claim liability. To the extent appropriate, changes in such development are recorded as a change to current period benefit expense.

We regularly review and set assumptions regarding cost trends and utilization when initially establishing claim liabilities. We continually monitor and adjust the claims liability and benefit expense based on subsequent paid claims activity. If it is determined that our assumptions regarding cost trends and utilization are materially different than actual results, our income statement and financial position could be impacted in future periods. Adjustments of prior year estimates may result in additional benefit expense or a reduction of benefit expense in the period an adjustment is made. Further, due to the considerable variability of healthcare costs, adjustments to claim liabilities occur each period and are sometimes significant as compared to the net income recorded in that period. Prior period development is recognized immediately upon the actuary's judgment that a portion of the prior period liability is no longer needed or that an additional liability should have been accrued. That determination is made when sufficient information is available to ascertain that the re-estimate of the liability is reasonable.

While there are many factors that are used as a part of the estimation of our medical claims payable liability, the two key assumptions having the most significant impact on our incurred but not paid claims liability as of December 31, 2019 were the completion and trend factors. As discussed above, these two key assumptions can be influenced by utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations.

There is variation in the reasonable choice of completion factors by duration for durations of three months through twelve months where the completion factors have the most significant impact. As previously discussed, completion factors tend to be less reliable for the most recent months and therefore are not specifically utilized for months one and two. In our analysis for the claim liabilities at December 31, 2019, the variability in months three to five was estimated to be between 40 and 90 basis points, while months six through twelve have much lower estimated variability ranging from 0 to 30 basis points.

The difference in completion factor assumptions, assuming moderately adverse experience, results in variability of 3%, or approximately $241, in the December 31, 2019 incurred but not paid claims liability, depending on the completion factors chosen. It is important to note that the completion factor methodology inherently assumes that historical completion rates will be reflective of the current period. However, it is possible that the actual completion rates for the current period will develop differently from historical patterns and therefore could fall outside the possible variations described herein.

The other major assumption used in the establishment of the December 31, 2019 incurred but not paid claim liability was the trend factors. In our analysis for the period ended December 31, 2019, there was a 320 basis point differential in the high and low trend factors assuming moderately adverse experience. This range of trend factors would imply variability of 5%, or approximately $468, in the incurred but not paid claims liability, depending upon the trend factors used. Because historical trend factors are often not representative of current claim trends, the trend experience for the most recent six to nine months, plus knowledge of recent events likely affecting current trends, have been taken into consideration in establishing the incurred but not paid claims liability at December 31, 2019.

See Note 11, "Medical Claims Payable," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K, for a reconciliation of the beginning and ending balance for medical claims payable for the years ended December 31, 2019, 2018 and 2017. Components of the total incurred claims for each year include amounts accrued for current year estimated claims expense as well as adjustments to prior year estimated accruals. In Note 11, "Medical Claims Payable," the line labeled "Net incurred medical claims: Prior years redundancies" accounts for those

adjustments made to prior year estimates. The impact of any reduction of "Net incurred medical claims: Prior years redundancies" may be offset as we establish the estimate of "Net incurred medical claims: Current year." Our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for our claims. When we recognize a release of the redundancy, we disclose the amount that is not in the ordinary course of business, if material.

The ratio of current year medical claims paid as a percent of current year net medical claims incurred was 89.3% for 2019, 90.2% for 2018 and 89.4% for 2017. This ratio serves as an indicator of claims processing speed whereby claims were processed slightly slower during 2019 than in 2018 and close to the same speed as in 2017.

We calculate the percentage of prior year redundancies in the current year as a percent of prior year net incurred claims payable less prior year redundancies in the current year in order to demonstrate the development of the prior year reserves. For the year ended December 31, 2019, this metric was 7.4%, largely driven by favorable trend factor development at the end of 2018 as well as favorable completion factor development from 2018. For the year ended December 31, 2018, this metric was 13.7%, largely driven by favorable trend factor development at the end of 2017 as well as favorable completion factor development from 2017. For the year ended December 31, 2017, this metric was 18.9%, largely driven by favorable trend factor development at the end of 2016.

We calculate the percentage of prior year redundancies in the current year as a percent of prior year net incurred medical claims to indicate the percentage of redundancy included in the preceding year calculation of current year net incurred medical claims. We believe this calculation supports the reasonableness of our prior year estimate of incurred medical claims and the consistency in our methodology. For the year ended December 31, 2019, this metric was 0.7%, which was calculated using the redundancy of $500. This metric was 1.3% for 2018 and 1.8% for 2017. These metrics demonstrate a generally consistent level of reserve conservatism.

The following table shows the variance between total net incurred medical claims as reported in Note 11, "Medical Claims Payable," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K, for each of 2018 and 2017 and the incurred claims for such years had it been determined retrospectively (computed as the difference between "net incurred medical claims – current year" for the year shown and "net incurred medical claims – prior years redundancies" for the immediately following year):

	Years Ended December 31	
	2018	2017
Total net incurred medical claims, as reported	$ 68,651	$ 69,244
Retrospective basis, as described above	69,081	69,447
Variance	$ (430)	$ (203)
Variance to total net incurred medical claims, as reported	(0.6)%	(0.3)%

Given that our business is primarily short tailed (which means that medical claims are generally paid within twelve months of the member receiving service from the provider), the variance to total net incurred medical claims, as reported above, is used to assess the reasonableness of our estimate of ultimate incurred medical claims for a given calendar year with the benefit of one year of experience. We expect that substantially all of the development of the 2019 estimate of medical claims payable will be known during 2020.

The 2018 variance to total net incurred medical claims, as reported of (0.6)% was higher than the 2017 percentage of (0.3)%. This was driven by the fact that the change in the prior year redundancy reported for 2019 as compared to 2018 was greater than the change in the prior year redundancy reported for 2018 as compared to 2017.

Income Taxes

We account for income taxes in accordance with FASB guidance, which requires, among other things, the separate recognition of deferred tax assets and deferred tax liabilities. Such deferred tax assets and deferred tax liabilities represent the tax effect of temporary differences between financial reporting and tax reporting measured at tax rates enacted at the time the deferred tax asset or liability is recorded. A valuation allowance must be established for deferred tax assets if it is "more

likely than not" that all or a portion may be unrealized. Our judgment is required in determining an appropriate valuation allowance.

At each financial reporting date, we assess the adequacy of the valuation allowance by evaluating each of our deferred tax assets based on the following:

- the types of temporary differences that created the deferred tax asset;
- the amount of taxes paid in prior periods and available for a carry-back claim;
- the tax rate at which the deferred tax assets will likely be utilized in the future;
- the forecasted future taxable income, and therefore, likely future deduction of the deferred tax item; and
- any significant other issues impacting the likely realization of the benefit of the temporary differences.

We, like other companies, frequently face challenges from tax authorities regarding the amount of taxes due. These challenges include questions regarding the timing and amount of deductions that we have taken on our tax returns. In evaluating any additional tax liability associated with various positions taken in our tax return filings, we record additional liabilities for potential adverse tax outcomes. Based on our evaluation of our tax positions, we believe we have appropriately accrued for uncertain tax benefits, as required by the applicable guidance. To the extent we prevail in matters we have accrued for, our future effective tax rate would be reduced and net income would increase. If we are required to pay more than accrued, our future effective tax rate would increase and net income would decrease. Our effective tax rate and net income in any given future period could be materially impacted.

In the ordinary course of business, we are regularly audited by federal and other tax authorities, and from time to time, these audits result in proposed assessments. We believe our tax positions comply with applicable tax law, and we intend to defend our positions vigorously through the federal, state and local appeals processes. We believe we have adequately provided for any reasonably foreseeable outcome related to these matters. Accordingly, although their ultimate resolution may require additional tax payments, we do not anticipate any material impact on our results of operations or financial condition from these matters.

For additional information, see Note 7, "Income Taxes," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Goodwill and Other Intangible Assets

Our consolidated goodwill at December 31, 2019 was $20,500 and other intangible assets were $8,674. The sum of goodwill and other intangible assets represented 37.7% of our total consolidated assets and 92.0% of our consolidated shareholders' equity at December 31, 2019.

We follow FASB guidance for business combinations and goodwill and other intangible assets, which specifies the types of acquired intangible assets that are required to be recognized and reported separately from goodwill. Under the guidance, goodwill and other intangible assets (with indefinite lives) are not amortized but are tested for impairment at least annually. Furthermore, goodwill and other intangible assets are allocated to reporting units for purposes of the annual impairment test. Our impairment tests require us to make assumptions and judgments regarding the estimated fair value of our reporting units, which include goodwill and other intangible assets. In addition, certain other intangible assets with indefinite lives, such as trademarks, are also tested separately.

We complete our annual impairment tests of existing goodwill and other intangible assets with indefinite lives during the fourth quarter of each year. These tests involve the use of estimates related to the fair value of goodwill at the reporting unit level and other intangible assets with indefinite lives, and require a significant degree of management judgment and the use of subjective assumptions. Certain interim impairment tests are also performed when potential impairment indicators exist or changes in our business or other triggering events occur. We have the option of first performing a qualitative assessment for each reporting unit to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount, which is an indication that our goodwill may be impaired. These qualitative impairment tests include assessing events and factors that could affect the fair value of the indefinite-lived intangible assets. Our procedures include assessing our financial performance, macroeconomic conditions, industry and market considerations, various asset specific

factors and entity specific events. If we determine that a reporting unit's goodwill may be impaired after utilizing these qualitative impairment analysis procedures, we are required to perform a quantitative impairment test.

Our quantitative impairment test utilizes the projected income and market valuation approaches for goodwill and the projected income approach for our indefinite lived intangible assets. Use of the projected income and market valuation approaches for our goodwill impairment test reflects our view that both valuation methodologies provide a reasonable estimate of fair value. The projected income approach is developed using assumptions about future revenue, expenses and net income derived from our internal planning process. These estimated future cash flows are then discounted. Our assumed discount rate is based on our industry's weighted-average cost of capital. Market valuations are based on observed multiples of certain measures including revenue; earnings before interest, taxes, depreciation and amortization; and book value of invested capital (debt and equity) and include market comparisons to publicly traded companies in our industry.

We did not incur any impairment losses as a result of our 2019 annual impairment tests, as it was determined that it is more likely than not that the estimated fair values of our reporting units were substantially in excess of the carrying values as of December 31, 2019. Additionally, we do not believe that the estimated fair values of our reporting units are at risk of becoming impaired in the next twelve months.

If estimated fair values are less than the carrying values of goodwill and other intangibles with indefinite lives in future annual impairment tests, or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

For additional information, see Note 3, "Business Acquisitions" and Note 9, "Goodwill and Other Intangible Assets," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Investments

Current and long-term marketable investment securities were $21,220 at December 31, 2019 and represented 27.4% of our total consolidated assets at December 31, 2019. We classify fixed maturity securities in our investment portfolio as "available-for-sale" or "trading" and report those securities at fair value. Certain fixed maturity securities are available to support current operations and, accordingly, we classify such investments as current assets without regard to their contractual maturity. Investments used to satisfy contractual, regulatory or other requirements are classified as long-term, without regard to contractual maturity.

We review fixed maturity investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis, using both qualitative and quantitative factors, to determine whether a decline in value is other-than-temporary. Such factors considered include the extent to which a security's market value has been less than its cost, the reasons for the decline in value (i.e., credit event compared to liquidity, general credit spread widening, currency exchange rate or interest rate factors), financial condition and near term prospects of the issuer, including the credit ratings and changes in the credit ratings of the issuer, recommendations of investment advisors, and forecasts of economic, market or industry trends.

FASB other-than-temporary impairment, or OTTI, guidance applies to fixed maturity securities and provides guidance on the recognition, presentation of, and disclosures for OTTIs. If a fixed maturity security is in an unrealized loss position and we have the intent to sell the fixed maturity security, or it is more likely than not that we will have to sell the fixed maturity security before recovery of its amortized cost basis, the decline in value is deemed to be other-than-temporary and is presented within the other-than-temporary impairment losses recognized in our consolidated statements of income. For impaired fixed maturity securities that we do not intend to sell or it is more likely than not that we will not have to sell such securities, but we expect that we will not fully recover the amortized cost basis, the credit component of the OTTI is presented within the other-than-temporary impairment losses recognized in our consolidated statements of income and the non-credit component of the OTTI is recognized in accumulated other comprehensive loss in our consolidated balance sheets. Furthermore, unrealized losses entirely caused by non-credit related factors related to fixed maturity securities for which we expect to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive loss.

The credit component of an OTTI is determined primarily by comparing the net present value of projected future cash flows with the amortized cost basis of the fixed maturity security. The net present value is calculated by discounting our best estimate of projected future cash flows at the effective interest rate implicit in the fixed maturity security at the date of

acquisition. For mortgage-backed and asset-backed securities, cash flow estimates are based on assumptions regarding the underlying collateral, including prepayment speeds, vintage, type of underlying asset, geographic concentrations, default rates, recoveries and changes in value. For all other securities, cash flow estimates are driven by assumptions regarding probability of default, including changes in credit ratings and estimates regarding timing and amount of recoveries associated with a default.

We have a committee of accounting and investment associates and management that is responsible for managing the impairment review process. We believe we have adequately reviewed our investment securities for impairment and that our investment securities are carried at fair value. However, over time, the economic and market environment may provide additional insight regarding the fair value of certain securities, which could change our judgment regarding impairment. This could result in OTTI losses on investments being charged against future income. Given the uncertainty of future market conditions, as well as the significant judgments involved, there is continuing risk that declines in fair value may occur and material OTTI losses on investments may be recorded in future periods.

In addition to marketable investment securities, we held additional long-term investments of $4,228, or 5.5% of total consolidated assets, at December 31, 2019. These long-term investments consisted primarily of certain other equity investments, the cash surrender value of corporate-owned life insurance policies and real estate. Due to their less liquid nature, these investments are classified as long-term.

Through our investing activities, we are exposed to financial market risks, including those resulting from changes in interest rates and changes in equity market valuations. We manage market risks through our investment policy, which establishes credit quality limits and limits on investments in individual issuers. Ineffective management of these risks could have an impact on our future results of operations and financial condition. Our investment portfolio includes fixed maturity securities with a fair value of $20,181 at December 31, 2019. The weighted-average credit rating of these securities was “A” as of December 31, 2019. Included in this balance are investments in fixed maturity securities of states, municipalities and political subdivisions of $900 that are guaranteed by third parties. With the exception of four securities with a fair value of $12, these securities are all investment-grade and carry a weighted-average credit rating of “A” as of December 31, 2019. The securities are guaranteed by a number of different guarantors, and we do not have any material exposure to any single guarantor, neither indirectly through the guarantees, nor directly through investment in the guarantor. Further, due to the high underlying credit rating of the issuers, the weighted-average credit rating of the fixed maturity securities without a guarantee, for which such information is available, was “A” as of December 31, 2019.

Fair values of fixed maturity and equity securities are based on quoted market prices, where available. These fair values are obtained primarily from third-party pricing services, which generally use Level I or Level II inputs for the determination of fair value in accordance with FASB guidance for fair value measurements and disclosures. We have controls in place to review the pricing services’ qualifications and procedures used to determine fair values. In addition, we periodically review the pricing services’ pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable.

We obtain quoted market prices for each security from the pricing services, which are derived through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available market observable information. For securities not actively traded, the pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in these valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. As we are responsible for the determination of fair value, we perform analysis on the prices received from the pricing services to determine whether the prices are reasonable estimates of fair value. Our analysis includes procedures such as a review of month-to-month price fluctuations and price comparisons to secondary pricing services. There were no adjustments to quoted market prices obtained from the pricing services during the years ended December 31, 2019 and 2018.

In certain circumstances, it may not be possible to derive pricing model inputs from observable market activity, and therefore, such inputs are estimated internally. Such securities are designated Level III in accordance with FASB guidance. Securities designated Level III at December 31, 2019 totaled $397 and represented approximately 1.7% of our total assets measured at fair value on a recurring basis. Our Level III securities primarily consisted of certain corporate securities and equity securities for which observable inputs were not always available and the fair values of these securities were estimated using inputs including, but not limited to, prepayment speeds, credit spreads, default rates and benchmark yields.

For additional information, see Part II, Item 7A "Quantitative and Qualitative Disclosures about Market Risk," and Note 2, "Basis of Presentation and Significant Accounting Policies," Note 4, "Investments," and Note 6, "Fair Value," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Retirement Benefits

Pension Benefits

We sponsor defined benefit pension plans for some of our employees. These plans are accounted for in accordance with FASB guidance for retirement benefits, which requires that amounts recognized in financial statements be determined on an actuarial basis. As permitted by the guidance, we calculate the value of plan assets as described below. Further, the difference between our expected rate of return and the actual performance of plan assets, as well as certain changes in pension liabilities, are amortized over future periods.

An important factor in determining our pension expense is the assumption for expected long-term return on plan assets. As of our December 31, 2019 measurement date, we selected a weighted-average long-term rate of return on plan assets of 7.33%. We use a total portfolio return analysis in the development of our assumption. Factors such as past market performance, the long-term relationship between fixed maturity and equity securities, interest rates, inflation and asset allocations are considered in the assumption. The assumption includes an estimate of the additional return expected from active management of the investment portfolio. Peer data and an average of historical returns are also reviewed for appropriateness of the selected assumption. We believe our assumption of future returns is reasonable. However, if we lower our expected long-term return on plan assets, future contributions to the pension plan and pension expense would likely increase.

This assumed long-term rate of return on assets is applied to a calculated value of plan assets, which recognizes changes in the fair value of plan assets in a systematic manner over three years, producing the expected return on plan assets that is included in the determination of pension expense. We apply a corridor approach to amortize unrecognized actuarial gains or losses. Under this approach, only accumulated net actuarial gains or losses in excess of 10% of the greater of the projected benefit obligation or the fair value of plan assets are amortized over the average remaining service or lifetime of the workforce as a component of pension expense. The net deferral of past asset gains or losses affects the calculated value of plan assets and, ultimately, future pension expense.

The discount rate reflects the current rate at which the pension liabilities could be effectively settled at the end of the year based on our most recent measurement date. We use the annual spot rate approach for setting our discount rate. Under the spot rate approach, individual spot rates from a full yield curve of published rates are used to discount each plan's cash flows to determine the plan's obligation. At the December 31, 2019 measurement date, the weighted-average discount rate under the annual spot rate approach was 3.11%, compared to 4.15% at the December 31, 2018 measurement date. The net effect of changes in the discount rate, as well as the net effect of other changes in actuarial assumptions and experience, have been deferred and amortized as a component of pension expense in accordance with FASB guidance.

In managing the plan assets, our objective is to be a responsible fiduciary while minimizing financial risk. Plan assets include a diversified mix of equity securities, investment grade fixed maturity securities and other types of investments across a range of sectors and levels of capitalization to maximize long-term return for a prudent level of risk. In addition to producing a reasonable return, the investment strategy seeks to minimize the volatility in our expense and cash flow.

Effective January 1, 2019, we curtailed the benefits under the Anthem Cash Balance Plan B pension plan. All grandfathered participants no longer have pay credits added to their accounts, but continue to earn interest on existing account balances. Participants continue to earn years of pension service for vesting purposes.

Other Postretirement Benefits

We provide most associates with certain medical, vision and dental benefits upon retirement. We use various actuarial assumptions, including a discount rate and the expected trend in healthcare costs, to estimate the costs and benefit obligations for our retiree benefits.

At our December 31, 2019 measurement date, the selected discount rate for all plans was 2.93%, compared to a discount rate of 4.04% at the December 31, 2018 measurement rate. We developed this rate using the annual spot rate approach as described above.

The assumed healthcare cost trend rates used to measure the expected cost of pre-Medicare (those who are not currently eligible for Medicare benefits) other benefits at our December 31, 2019 measurement date was 7.00% for 2020 with a gradual decline to 4.50% by the year 2028. The assumed healthcare cost trend rates used to measure the expected cost of post-Medicare (those who are currently eligible for Medicare benefits) other benefits at our December 31, 2019 measurement date was 6.00% for 2020 with a gradual decline to 4.50% by the year 2028. These estimated trend rates are subject to change in the future. The healthcare cost trend rate assumption affects the amounts reported. For example, an increase in the assumed healthcare cost trend rate of one percentage point would increase the postretirement benefit obligation as of December 31, 2019 by $23 and would increase service and interest costs by $1. Conversely, a decrease in the assumed healthcare cost trend rate of one percentage point would decrease the postretirement benefit obligation as of December 31, 2019 by $20 and would decrease service and interest costs by $1.

For additional information regarding our retirement benefits, see Note 10, “Retirement Benefits,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

New Accounting Pronouncements

For information regarding new accounting pronouncements that were issued or became effective during the year ended December 31, 2019 that had, or are expected to have, a material impact on our financial position, results of operations or financial statement disclosures, see the “*Recently Adopted Accounting Guidance*” and “*Recent Accounting Guidance Not Yet Adopted*” sections of Note 2, “Basis of Presentation and Significant Accounting Policies,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Liquidity and Capital Resources

Introduction

Our cash receipts result primarily from premiums, administrative fees and other revenue, investment income, proceeds from the sale or maturity of our investment securities, proceeds from borrowings, and proceeds from the issuance of common stock under our employee stock plans. Cash disbursements result mainly from claims payments, administrative expenses, taxes, purchases of investment securities, interest expense, payments on borrowings, acquisitions, capital expenditures, repurchases of our debt securities and common stock and the payment of cash dividends. Cash outflows fluctuate with the amount and timing of settlement of these transactions. Any future decline in our profitability would likely have an unfavorable impact on our liquidity.

We manage our cash, investments and capital structure so we are able to meet the short-term and long-term obligations of our business while maintaining financial flexibility and liquidity. We forecast, analyze and monitor our cash flows to enable investment and financing within the overall constraints of our financial strategy.

A substantial portion of the assets held by our regulated subsidiaries are in the form of cash and cash equivalents and investments. After considering expected cash flows from operating activities, we generally invest cash that exceeds our near term obligations in longer term marketable fixed maturity securities to improve our overall investment income returns. Our investment strategy is to make investments consistent with insurance statutes and other regulatory requirements, while preserving our asset base. Our investments are generally available-for-sale to meet liquidity and other needs. Our subsidiaries pay out excess capital annually in the form of dividends to their respective parent companies for general corporate use, as permitted by applicable regulations.

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, debt ratings, contractual restrictions, regulatory requirements and market conditions. The securities and credit markets have in the past experienced higher than normal volatility, although current market conditions are more stable. During recent years, the federal government and various governmental agencies have taken a number of steps to improve liquidity in the financial markets and strengthen the regulation of the financial services market. In addition,

governments around the world have developed their own plans to provide liquidity and security in the credit markets and to ensure adequate capital in certain financial institutions.

We have a $3,500 commercial paper program. Should commercial paper issuance be unavailable, we have the ability to use a combination of cash on hand and/or our two senior revolving credit facilities, which provide for combined credit in the amount of $3,500, to redeem any outstanding commercial paper upon maturity. Additionally, we believe the lenders participating in our credit facilities would be willing and able to provide financing in accordance with their legal obligations. In addition to the senior revolving credit facilities, we estimate that we expect to receive approximately $3,035 of dividends from our subsidiaries during 2020, which also provides further operating and financial flexibility.

A summary of our major sources and uses of cash and cash equivalents for the years ended December 31, 2019, 2018 and 2017 is as follows:

	Years Ended December 31			$ Change	
	2019	2018	2017	2019 vs. 2018	2018 vs. 2017
Sources of Cash:					
Net cash provided by operating activities	$ 6,061	$ 3,827	$ 4,185	$ 2,234	$ (358)
Proceeds from sales, maturities, calls and redemptions of investments, net of purchases	—	1,929	—	(1,929)	1,929
Issuance of common stock under Equity Units stock purchase contracts	—	1,250	—	(1,250)	1,250
Issuances of commercial paper and short- and long-term debt, net of repayments	608	—	3,653	608	(3,653)
Issuances of common stock under employee stock plans	187	173	225	14	(52)
Changes in bank overdrafts	—	—	71	—	(71)
Other sources of cash, net	254	174	703	80	(529)
Total sources of cash	7,110	7,353	8,837	(243)	(1,484)
Uses of Cash:					
Purchases of investments, net of proceeds from sales, maturities, calls and redemptions	(1,919)	—	(2,913)	(1,919)	2,913
Purchases of subsidiaries, net of cash acquired	—	(1,760)	(2,080)	1,760	320
Repurchase and retirement of common stock	(1,701)	(1,685)	(1,998)	(16)	313
Purchases of property and equipment	(1,077)	(1,208)	(791)	131	(417)
Repayments of commercial paper and short- and long-term debt, net of issuances	—	(1,086)	—	1,086	(1,086)
Cash dividends	(818)	(776)	(705)	(42)	(71)
Changes in bank overdrafts	(169)	(210)	—	41	(210)
Other uses of cash, net	(423)	(301)	(820)	(122)	519
Total uses of cash	(6,107)	(7,026)	(9,307)	919	2,281
Effect of foreign exchange rates on cash and cash equivalents	—	(2)	4	2	(6)
Net increase (decrease) in cash and cash equivalents	$ 1,003	$ 325	$ (466)	$ 678	$ 791

Liquidity—Year Ended December 31, 2019 Compared to Year Ended December 31, 2018

The increase in cash provided by operating activities was primarily due to the impact of membership growth in our Medicaid and Medicare businesses as well as higher net income in 2019. These increases in operating cash flow were partially offset by the impact of the timing of working capital changes.

Other significant changes in sources and uses of cash year-over-year included an increase in net purchases of investments in 2019 compared to net proceeds received from sales, maturities, calls and redemptions of investments in 2018, a decrease in cash paid for acquisitions, an increase in net proceeds from the issuance of commercial paper and short- and long-term debt

in 2019 compared to net repayments in 2018 and cash received from the issuance of common stock under our Equity Units stock purchase contracts in 2018 that did not recur in 2019.

Financial Condition

We maintained a strong financial condition and liquidity position, with consolidated cash, cash equivalents and investments in fixed maturity and equity securities of $26,157 at December 31, 2019. Since December 31, 2018, total cash, cash equivalents and investments in fixed maturity and equity securities increased by $3,518, primarily due to cash generated from operations and issuances of commercial paper and short- and long-term debt, net of repayments. These increases were partially offset by cash used for repurchases of our common stock, purchases of property and equipment and cash dividends paid to shareholders.

Many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid to their respective parent companies. Certain accounting practices prescribed by insurance regulatory authorities, or statutory accounting practices, differ from GAAP. Changes that occur in statutory accounting practices, if any, could impact our subsidiaries' future dividend capacity. In addition, we have agreed to certain undertakings to regulatory authorities, including the requirement to maintain certain capital levels in certain of our subsidiaries.

At December 31, 2019, we held $2,673 of cash, cash equivalents and investments at the parent company, which are available for general corporate use, including investment in our businesses, acquisitions, potential future common stock repurchases and dividends to shareholders, repurchases of debt securities and debt and interest payments.

Debt

Periodically, we access capital markets and issue debt, or Notes, for long-term borrowing purposes, for example, to refinance debt, to finance acquisitions or for share repurchases. Certain of these Notes may have a call feature that allows us to redeem the Notes at any time at our option and/or a put feature that allows a Note holder to redeem the Notes upon the occurrence of both a change in control event and a downgrade of the Notes below an investment grade rating. For more information on our debt, including redemptions and issuances, see Note 12, "Debt" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We calculate our consolidated debt-to-capital ratio, a non-GAAP measure, from the amounts presented on our audited consolidated balance sheets included in Part II, Item 8 of this Annual Report on Form 10-K. Our debt-to-capital ratio is calculated as total debt divided by total debt plus total shareholders' equity. Total debt is the sum of short-term borrowings, current portion of long-term debt, and long-term debt, less current portion. We believe our debt-to-capital ratio assists investors and rating agencies in measuring our overall leverage and additional borrowing capacity. In addition, our bank covenants include a maximum debt-to-capital ratio that we cannot and did not exceed. Our debt-to-capital ratio may not be comparable to similarly titled measures reported by other companies. Our consolidated debt-to-capital ratio was 39.5% and 40.2% as of December 31, 2019 and 2018, respectively.

Our senior debt is rated "A" by S&P Global, "BBB" by Fitch Ratings, Inc., "Baa2" by Moody's Investor Service, Inc. and "bbb+" by AM Best Company, Inc. We intend to maintain our senior debt investment grade ratings. If our credit ratings are downgraded, our business, financial condition and results of operations could be adversely impacted by limitations on future borrowings and a potential increase in our borrowing costs.

Future Sources and Uses of Liquidity

We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansions.

We have a senior revolving credit facility, or the 5-Year Facility, with a group of lenders for general corporate purposes. In June 2019, we amended and restated the credit agreement for the 5-Year Facility to, among other things, extend the

maturity date from August 2020 to June 2024 and decrease the amount of credit available from $3,500 to $2,500. In June 2019, we also entered into a 364-day senior revolving credit facility, or the 364-Day Facility, with a group of lenders for general corporate purposes, which provides for credit in the amount of $1,000 and matures in June 2020. Our ability to borrow under these credit facilities is subject to compliance with certain covenants. We do not believe the restrictions contained in these covenants materially affect our financial or operating flexibility. As of December 31, 2019, we were in compliance with all of our debt covenants. There were no amounts outstanding under the 5-Year Facility or the 364-Day Facility at December 31, 2019.

Through certain subsidiaries, we have entered into multiple 364-day lines of credit, or the Subsidiary Credit Facilities, with separate lenders for general corporate purposes. The Subsidiary Credit Facilities provide combined credit up to $600. Our ability to borrow under the Subsidiary Credit Facilities is subject to compliance with certain covenants. At December 31, 2019, we had $50 outstanding under the Subsidiary Credit Facilities.

We have an authorized commercial paper program, the proceeds of which may be used for general corporate purposes. In August 2019, we increased the amount available under the commercial paper program from $2,500 to $3,500. At December 31, 2019, we had $400 outstanding under our commercial paper program.

We are a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati and the Federal Home Loan Bank of Atlanta, or collectively, the FHLBs. As a member, we have the ability to obtain short-term cash advances, subject to certain minimum collateral requirements. At December 31, 2019, we had $650 in outstanding short-term borrowings from FHLBs.

As discussed in "*Financial Condition*" above, many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid. Based upon these requirements, we currently estimate that approximately $3,035 of dividends will be paid to the parent company during 2020. During 2019, we received $3,790 of dividends from our subsidiaries.

We regularly review the appropriate use of capital, including acquisitions, common stock and debt security repurchases and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors.

On January 28, 2020, our Audit Committee declared a quarterly cash dividend to shareholders of $0.95 per share on the outstanding shares of our common stock. This quarterly dividend is payable on March 27, 2020 to the shareholders of record as of March 16, 2020.

Under our Board of Directors' authorization, we maintain a common stock repurchase program. As of December 31, 2019, we had Board authorization of $3,792 to repurchase our common stock.

For additional information regarding our sources and uses of capital, see Note 4, "Investments," Note 5 "Derivative Financial Instruments," Note 12 "Debt" and Note 14 "Capital Stock–*Use of Capital–Dividends and Stock Repurchase Program*" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Contractual Obligations and Commitments

Our estimated contractual obligations and commitments as of December 31, 2019 are as follows:

		Payments Due by Period			
	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
On-Balance Sheet:					
Debt[1]	$ 31,249	$ 3,447	$ 3,653	$ 3,853	$ 20,296
Operating leases, including imputed interest[2]	795	172	285	203	135
Investment commitments[3]	28	11	16	—	1
Other long-term liabilities[4]	752	9	295	293	155
Off-Balance Sheet:					
Purchase obligations[5]	3,531	1,236	630	1,076	589
Operating leases, including imputed interest[2]	394	13	60	66	255
Investment commitments[6]	971	287	378	106	200
Total contractual obligations and commitments	$ 37,720	$ 5,175	$ 5,317	$ 5,597	$ 21,631

1 Includes estimated interest expense.
2 See Note 17, "Leases," of the Notes to Consolidated Financial Statements, included in Part II, Item 8 of this Annual Report on Form 10-K.
3 Represents low income housing tax credits.
4 Primarily consists of reserves for future policy benefits, projected other postretirement benefits, deferred compensation, supplemental executive retirement plan liabilities and certain other miscellaneous long-term obligations. Estimated future payments for funded pension benefits have been excluded from this table, as we had no funding requirements under ERISA at December 31, 2019 as a result of the value of the assets in the plans.
5 Includes estimated payments for future services under contractual arrangements from third-party service contracts.
6 Includes unfunded capital commitments for alternative investments.

The above table does not contain $172 of gross liabilities for uncertain tax positions and interest for which we cannot reasonably estimate the timing of the resolutions with the respective taxing authorities. For further information, see Note 7, "Income Taxes," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

In addition to the contractual obligations and commitments discussed above, we have a variety of other contractual agreements related to acquiring materials and services used in our operations. However, we do not believe these other agreements contain material noncancelable commitments.

We believe that funds from future operating cash flows, cash and investments and funds available under our senior revolving credit facilities and/or from public or private financing sources will be sufficient for future operations and commitments, and for capital acquisitions and other strategic transactions.

Off-Balance Sheet Arrangements

We do not have any off-balance sheet derivative instruments, guarantee transactions, agreements or other contractual arrangements or any indemnification agreements that will require funding in future periods. We have not transferred assets to an unconsolidated entity that serves as credit, liquidity or market risk support to such entity. We do not hold any variable interest in an unconsolidated entity where such entity provides us with financing, liquidity, market risk or credit risk support.

Risk-Based Capital

Our regulated subsidiaries' states of domicile have statutory risk-based capital, or RBC, requirements for health and other insurance companies and HMOs largely based on the National Association of Insurance Commissioners, or NAIC,

Risk-Based Capital (RBC) For Health Organizations Model Act, or RBC Model Act. These RBC requirements are intended to measure capital adequacy, taking into account the risk characteristics of an insurer's investments and products. The NAIC sets forth the formula for calculating the RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual insurance company's business. In general, under the RBC Model Act, an insurance company must submit a report of its RBC level to the state insurance department or insurance commissioner, as appropriate, at the end of each calendar year. Our regulated subsidiaries' respective RBC levels as of December 31, 2019, which was the most recent date for which reporting was required, were in excess of all applicable mandatory RBC requirements. In addition to exceeding these RBC requirements, we are in compliance with the liquidity and capital requirements for a licensee of the BCBSA and with the tangible net worth requirements applicable to certain of our California subsidiaries.

For additional information, see Note 21, "Statutory Information," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK.

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

As a result of our investing and borrowing activities, we are exposed to financial market risks, including those resulting from changes in interest rates and changes in market valuations. Potential impacts discussed below are based upon sensitivity analyses performed on our financial position as of December 31, 2019. Actual results could vary from these estimates. Our primary objectives with our investment portfolio are to provide safety and preservation of capital, sufficient liquidity to meet cash flow requirements, the integration of investment strategy with the business operations and an attainment of a competitive after-tax total return.

Investments

Our investment portfolio is exposed to three primary sources of risk: credit quality risk, interest rate risk and market valuation risk.

The primary risks associated with our fixed maturity securities, which are classified as available-for-sale, are credit quality risk and interest rate risk. Credit quality risk is defined as the risk of a credit event, such as a ratings downgrade or default, to an individual fixed maturity security and the potential loss attributable to that event. Credit quality risk is managed through our investment policy, which establishes credit quality limitations on the overall portfolio as well as diversification and percentage limits on securities of individual issuers. The result is a well-diversified portfolio of fixed maturity securities, with an average credit rating of approximately "A." Interest rate risk is defined as the potential for economic losses on fixed maturity securities due to a change in market interest rates. Our fixed maturity portfolio is invested primarily in U.S. government securities, corporate bonds, asset-backed bonds, mortgage-related securities and municipal bonds, all of which have exposure to changes in the level of market interest rates. Interest rate risk is managed by maintaining asset duration within a band based upon our liabilities, operating performance and liquidity needs. Additionally, we have the capability of holding any security to maturity, which would allow us to realize full par value.

Investments in fixed maturity securities include corporate securities, which account for 45.5% of our total fixed maturity securities at December 31, 2019 and are subject to credit/default risk. In a declining economic environment, corporate yields will usually increase, prompted by concern over the ability of corporations to make interest payments, thus causing a decrease in the price of corporate securities, and the decline in value of the corporate fixed maturity portfolio. We manage this risk through fundamental credit analysis, diversification of issuers and industries and an average credit rating of our corporate fixed maturity portfolio of approximately "BBB."

Market risk for fixed maturity securities is addressed by actively managing the duration, allocation and diversification of our investment portfolio. We have evaluated the impact on the fixed maturity portfolio's fair value considering an immediate 100 basis point change in interest rates. A 100 basis point increase in interest rates would result in an approximate $860 decrease in fair value, whereas a 100 basis point decrease in interest rates would result in an approximate $871 increase in fair value. While we classify our fixed maturity securities as "available-for-sale" for accounting purposes, we believe our cash flows and the duration of our portfolio should allow us to hold securities to maturity, thereby avoiding the recognition of losses should interest rates rise significantly.

Our equity portfolio is comprised of large capitalization and small capitalization domestic equities, foreign equities, exchange-traded funds and index mutual funds. Our equity portfolio is subject to the volatility inherent in the stock market, driven by concerns over economic conditions, earnings and sales growth, inflation, and consumer confidence. These systemic risks cannot be managed through diversification alone. However, more routine risks, such as stock/industry specific risks, are managed by investing in a diversified equity portfolio.

As of December 31, 2019, 4.9% of our investments were equity securities. An immediate 10% decrease in each equity investment's value, arising from market movement, would result in a fair value decrease of $104. Alternatively, an immediate 10% increase in each equity investment's value, attributable to the same factor, would result in a fair value increase of $104.

For additional information regarding our investments, see Note 4, "Investments," of the Notes to Consolidated Financial Statements included in Part II, Item 8 and "Critical Accounting Policies and Estimates - *Investments*" within Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K.

Long-Term Debt

Our total long-term debt at December 31, 2019 consists of senior unsecured notes, convertible debentures, commercial paper and subordinated surplus notes by one of our insurance subsidiaries. At December 31, 2019, the carrying value and estimated fair value of our long-term debt was $19,385 and $21,774, respectively. This debt is subject to interest rate risk, as these instruments have fixed interest rates and the fair value is affected by changes in market interest rates. Should interest rates increase or decrease in the future, the estimated fair value of our fixed rate debt would decrease or increase accordingly.

For additional information regarding our long-term debt, see Note 6, "Fair Value" and Note 12, "Debt," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Derivatives

We have exposure to economic losses due to interest rate risk arising from changes in the level or volatility of interest rates. We attempt to mitigate our exposure to interest rate risk through the use of derivative financial instruments. These strategies include the use of interest rate swaps and forward contracts, which are used to lock-in interest rates or to hedge (on an economic basis) interest rate risks associated with variable rate debt. We have used these types of instruments as designated hedges against specific liabilities.

Changes in interest rates will affect the estimated fair value of these derivatives. As of December 31, 2019, we recorded a net asset of $21, the estimated fair value of the swaps at that date. We have evaluated the impact on the interest rate swaps' fair value considering an immediate 100 basis point change in interest rates. A 100 basis point increase in interest rates would result in an approximate $20 decrease in fair value, whereas a 100 basis point decrease in interest rates would result in an approximate $20 increase in fair value.

For additional information regarding our derivatives, see Note 5, "Derivative Financial Instruments" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA.

ANTHEM, INC.

CONSOLIDATED FINANCIAL STATEMENTS

Years ended December 31, 2019, 2018 and 2017

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Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of Anthem, Inc.

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Anthem, Inc. (the Company) as of December 31, 2019 and 2018, the related consolidated statements of income, comprehensive income, shareholders' equity, and cash flows for each of the three years in the period ended December 31, 2019, and the related notes and financial statement schedule listed in the Index at Item 15(c) (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2019 and 2018, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2019, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2019, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework), and our report dated February 19, 2020 expressed an unqualified opinion thereon.

Adoption of New Accounting Standards

As discussed in Note 2 to the consolidated financial statements, on January 1, 2018, the Company changed its method of accounting for non-consolidated equity investments that are not accounted for under the equity method of accounting.

As discussed in Note 2 to the consolidated financial statements, on January 1, 2019, the Company changed its method of accounting for leases.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current period audit of the financial statements that were communicated or required to be communicated to the audit committee and that: (1) relate to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Valuation of Incurred but Not Paid Claims

Description of the Matter	Medical claims payable was $8,842 million at December 31, 2019, a significant portion of which related to the Company's estimate for claims that are incurred but not paid. As discussed in Note 2 to the consolidated financial statements, the Company's liability for incurred but not paid claims is determined using actuarial methods that include a number of factors and assumptions, including completion factors, which represent the average percentage of total incurred claims that have been paid through a given date after being incurred based on historical paid claims data, and trend factors, which represent an estimate of claims expense based on recent claims expense levels and healthcare cost levels. There is significant uncertainty inherent in determining management's best estimate of completion and trend factors, which are used to calculate actuarial estimates of incurred but not paid claims. Auditing management's estimate of incurred but not paid claims was complex and required the involvement of our actuarial specialists due to the highly judgmental nature of the completion and trend factor assumptions used in the valuation process. The significant judgment was primarily due to the sensitivity of management's best estimate of completion and trend factor assumptions, which have a significant impact on the valuation of incurred but not paid claims.
How We Addressed the Matter in Our Audit	We obtained an understanding, evaluated the design and tested the operating effectiveness of controls over the Company's actuarial process for estimating the liability for incurred but not paid claims. These audit procedures included among others, testing management review controls over completion and trend factor assumptions and the review and approval processes that management has in place for estimating the liability for incurred but not paid claims. To test the Company's liability for incurred but not paid claims, our audit procedures included, among others, testing the completeness and accuracy of the underlying claims and membership data recorded in the source claims processing and disbursement systems to the data used by management in developing completion and trend factor assumptions and comparing a sample of incurred and paid claims to source documentation. With the support of actuarial specialists, we analyzed the Company's completion and trend factor assumptions based on historical claim experience and emerging cost trends, and independently calculated a range of reasonable reserve estimates for comparison to management's best estimate of the liability for incurred but not paid claims. Additionally, we performed a review of the prior period liabilities for incurred but not paid claims to subsequent claims development.

Revenue Recognition for New Pharmacy Benefits Manager Business

Description of the Matter	Beginning in the second quarter of 2019, the Company commenced operations of its new pharmacy benefits manager (PBM), IngenioRx. Administrative fees and other revenue of $8,968 million for the year ended December 31, 2019 included product revenue for services performed by IngenioRx to unaffiliated PBM customers. As discussed in Note 2 to the consolidated financial statements, product revenue for PBM services to unaffiliated PBM customers is recognized using the gross method at the negotiated contract price when IngenioRx has concluded it is the principal and it controls the PBM services before prescription drugs are transferred to the customer. There is significant judgment in determining whether IngenioRx is the principal of the PBM services, which requires the identification of PBM activities relevant to evaluating control and an assessment of IngenioRx's ability to direct the identified activities. In particular, the PBM activities that determine control include formulary management, network management and pricing discretion. Auditing management's revenue recognition for PBM services to unaffiliated PBM customers required a high degree of auditor judgment due to the subjectivity in determining whether IngenioRx is the principal in the performance of PBM services. These judgments have a significant impact on the presentation and disclosure of product revenue for services performed by IngenioRx to unaffiliated PBM customers.
How We Addressed the Matter in Our Audit	We obtained an understanding, evaluated the design and tested the operating effectiveness of controls over the Company's evaluation of revenue recognition for PBM services performed by IngenioRx to unaffiliated PBM customers. These audit procedures included among others, testing management review controls over the identification of PBM activities relevant to evaluating control and the evaluation performed to assess IngenioRx's ability to direct the identified activities. To test the Company's revenue recognition for PBM services to unaffiliated PBM customers, our audit procedures included, among others, assessing the PBM activities provided by IngenioRx to the customer and analyzing the contractual rights and obligations contained in its PBM services agreement with CaremarkPCS Health, L.L.C. Further, we evaluated IngenioRx's ability to direct the identified PBM activities determined to be significant in fulfilling the promise to provide PBM services to its customers by evaluating evidence of management's control over such activities. In addition, we inspected the terms and conditions of a sample of unaffiliated PBM customer contracts to evaluate IngenioRx's assertion of control.

/s/ ERNST & YOUNG LLP

We have served as the Company's auditor since 1944.

Indianapolis, Indiana
February 19, 2020

Anthem, Inc.
Consolidated Balance Sheets

	December 31, 2019	December 31, 2018
(In millions, except share data)		
Assets		
Current assets:		
Cash and cash equivalents	$ 4,937	$ 3,934
Fixed maturity securities, current (amortized cost of $19,021 and $16,894)	19,676	16,692
Equity securities, current	1,009	1,493
Other invested assets, current	13	21
Accrued investment income	173	162
Premium receivables	5,173	4,465
Self-funded receivables	2,411	2,278
Other receivables	2,634	2,558
Income taxes receivable	335	10
Securities lending collateral	353	604
Other current assets	2,319	2,104
Total current assets	39,033	34,321
Long-term investments:		
Fixed maturity securities (amortized cost of $487 and $486)	505	487
Equity securities	30	33
Other invested assets	4,228	3,726
Property and equipment, net	3,133	2,735
Goodwill	20,500	20,504
Other intangible assets	8,674	9,007
Other noncurrent assets	1,350	758
Total assets	$ 77,453	$ 71,571
Liabilities and shareholders' equity		
Liabilities		
Current liabilities:		
Policy liabilities:		
Medical claims payable	$ 8,842	$ 7,454
Reserves for future policy benefits	85	75
Other policyholder liabilities	3,050	2,590
Total policy liabilities	11,977	10,119
Unearned income	1,017	902
Accounts payable and accrued expenses	4,198	4,959
Security trades pending payable	84	197
Securities lending payable	351	604
Short-term borrowings	700	1,145
Current portion of long-term debt	1,598	849
Other current liabilities	3,692	3,190
Total current liabilities	23,617	21,965
Long-term debt, less current portion	17,787	17,217
Reserves for future policy benefits, noncurrent	674	706
Deferred tax liabilities, net	2,227	1,960
Other noncurrent liabilities	1,420	1,182
Total liabilities	45,725	43,030
Commitments and contingencies—Note 13		
Shareholders' equity		
Preferred stock, without par value, shares authorized - 100,000,000; shares issued and outstanding - none	—	—
Common stock, par value $0.01, shares authorized - 900,000,000; shares issued and outstanding - 252,922,161 and 257,395,577	3	3
Additional paid-in capital	9,448	9,536
Retained earnings	22,573	19,988
Accumulated other comprehensive loss	(296)	(986)
Total shareholders' equity	31,728	28,541
Total liabilities and shareholders' equity	$ 77,453	$ 71,571

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Income

(In millions, except per share data)	Years Ended December 31 2019	2018	2017
Revenues			
Premiums	$ 94,173	$ 85,421	$ 83,648
Administrative fees and other revenue	8,968	5,920	5,413
Total operating revenue	103,141	91,341	89,061
Net investment income	1,005	970	867
Net realized gains (losses) on financial instruments	114	(180)	145
Other-than-temporary impairment losses on investments:			
Total other-than-temporary impairment losses on investments	(53)	(29)	(35)
Portion of other-than-temporary impairment losses recognized in other comprehensive income (loss)	6	3	2
Other-than-temporary impairment losses recognized in income	(47)	(26)	(33)
Total revenues	104,213	92,105	90,040
Expenses			
Benefit expense	81,786	71,895	72,236
Cost of products sold	1,992	—	—
Selling, general and administrative expense	13,364	14,020	12,650
Interest expense	746	753	739
Amortization of other intangible assets	338	358	169
Loss on extinguishment of debt	2	11	282
Total expenses	98,228	87,037	86,076
Income before income tax expense	5,985	5,068	3,964
Income tax expense	1,178	1,318	121
Net income	$ 4,807	$ 3,750	$ 3,843
Net income per share			
Basic	$ 18.81	$ 14.53	$ 14.70
Diluted	$ 18.47	$ 14.19	$ 14.35
Dividends per share	$ 3.20	$ 3.00	$ 2.70

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Comprehensive Income

(In millions)	Years Ended December 31		
	2019	2018	2017
Net income	$ 4,807	$ 3,750	$ 3,843
Other comprehensive income (loss), net of tax:			
Change in net unrealized gains/losses on investments	680	(418)	173
Change in non-credit component of other-than-temporary impairment losses on investments	—	(2)	4
Change in net unrealized gains/losses on cash flow hedges	(16)	37	(65)
Change in net periodic pension and postretirement costs	26	(90)	51
Foreign currency translation adjustments	—	(1)	3
Other comprehensive income (loss)	690	(474)	166
Total comprehensive income	$ 5,497	$ 3,276	$ 4,009

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Cash Flows

(In millions)	Years Ended December 31 2019	2018	2017
Operating activities			
Net income	$ 4,807	$ 3,750	$ 3,843
Adjustments to reconcile net income to net cash provided by operating activities:			
Net realized (gains) losses on financial instruments	(114)	180	(145)
Other-than-temporary impairment losses recognized in income	47	26	33
Loss on extinguishment of debt	2	11	282
Loss on disposal of assets	3	13	15
Deferred income taxes	81	91	(1,272)
Amortization, net of accretion	986	1,008	780
Depreciation expense	147	124	111
Share-based compensation	294	226	170
Changes in operating assets and liabilities:			
Receivables, net	(1,053)	(695)	(22)
Other invested assets	(48)	(1)	(36)
Other assets	(170)	(26)	(629)
Policy liabilities	1,826	(1,059)	732
Unearned income	115	(36)	(120)
Accounts payable and accrued expenses	(593)	122	922
Other liabilities	148	(25)	(120)
Income taxes	(325)	323	(194)
Other, net	(92)	(205)	(165)
Net cash provided by operating activities	6,061	3,827	4,185
Investing activities			
Purchases of fixed maturity securities	(10,487)	(8,244)	(9,795)
Proceeds from fixed maturity securities:			
Sales	5,914	6,442	7,932
Maturities, calls and redemptions	2,437	1,938	1,848
Purchases of equity securities	(11,825)	(896)	(5,416)
Proceeds from sales of equity securities	12,364	2,809	3,463
Purchases of other invested assets	(642)	(531)	(1,164)
Proceeds from sales of other invested assets	320	411	219
Changes in collateral and settlement of non-hedging derivatives	—	—	65
Changes in securities lending collateral	254	(149)	625
Purchases of subsidiaries, net of cash acquired	—	(1,760)	(2,080)
Purchases of property and equipment	(1,077)	(1,208)	(791)
Other, net	(50)	(71)	12
Net cash used in investing activities	(2,792)	(1,259)	(5,082)
Financing activities			
Net (repayments of) proceeds from commercial paper borrowings	(297)	(107)	175
Proceeds from long-term borrowings	2,473	835	5,458
Repayments of long-term borrowings	(1,123)	(1,684)	(2,815)
Proceeds from short-term borrowings	7,590	9,120	5,835
Repayments of short-term borrowings	(8,035)	(9,250)	(5,000)
Changes in securities lending payable	(254)	150	(625)
Changes in bank overdrafts	(169)	(210)	71
Premiums paid on equity call options	(1)	—	—
Proceeds from sale of put options	—	1	1
Proceeds from issuance of common stock under Equity Units stock purchase contracts	—	1,250	—
Repurchase and retirement of common stock	(1,701)	(1,685)	(1,998)
Change in collateral and settlements of debt-related derivatives	(34)	23	(149)
Cash dividends	(818)	(776)	(705)
Proceeds from issuance of common stock under employee stock plans	187	173	225
Taxes paid through withholding of common stock under employee stock plans	(84)	(81)	(46)
Net cash (used in) provided by financing activities	(2,266)	(2,241)	427
Effect of foreign exchange rates on cash and cash equivalents	—	(2)	4
Change in cash and cash equivalents	1,003	325	(466)
Cash and cash equivalents at beginning of year	3,934	3,609	4,075
Cash and cash equivalents at end of year	$ 4,937	$ 3,934	$ 3,609

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Shareholders' Equity

(In millions)	Common Stock Number of Shares	Common Stock Par Value	Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive Loss	Total Shareholders' Equity
January 1, 2017	263.7	$ 3	$ 8,805	$ 16,560	$ (267)	$ 25,101
Net income	—	—	—	3,843	—	3,843
Other comprehensive income	—	—	—	—	166	166
Premiums for and settlement of equity options	—	—	1	—	—	1
Repurchase and retirement of common stock	(10.5)	—	(356)	(1,642)	—	(1,998)
Dividends and dividend equivalents	—	—	—	(707)	—	(707)
Issuance of common stock under employee stock plans, net of related tax benefits	2.9	—	342	—	—	342
Convertible debenture conversions	—	—	(245)	—	—	(245)
December 31, 2017	256.1	3	8,547	18,054	(101)	26,503
Adoption of Accounting Standards Update No. 2016-01 (Note 2)	—	—	—	320	(320)	—
January 1, 2018	256.1	3	8,547	18,374	(421)	26,503
Net income	—	—	—	3,750	—	3,750
Other comprehensive loss	—	—	—	—	(474)	(474)
Issuance of common stock under Equity Units stock purchase contracts	6.0	—	1,250	—	—	1,250
Premiums for and settlement of equity options	—	—	1	—	—	1
Repurchase and retirement of common stock	(6.8)	—	(243)	(1,442)	—	(1,685)
Dividends and dividend equivalents	—	—	—	(785)	—	(785)
Issuance of common stock under employee stock plans, net of related tax benefits	2.1	—	318	—	—	318
Convertible debenture conversions	—	—	(337)	—	—	(337)
Adoption of Accounting Standards Update No. 2018-02 (Note 2)	—	—	—	91	(91)	—
December 31, 2018	257.4	3	9,536	19,988	(986)	28,541
Adoption of Accounting Standards Update No. 2016-02 (Note 2)	—	—	—	26	—	26
January 1, 2019	257.4	3	9,536	20,014	(986)	28,567
Net income	—	—	—	4,807	—	4,807
Other comprehensive income	—	—	—	—	690	690
Repurchase and retirement of common stock	(6.3)	—	(275)	(1,426)	—	(1,701)
Dividends and dividend equivalents	—	—	—	(822)	—	(822)
Issuance of common stock under employee stock plans, net of related tax benefits	1.8	—	396	—	—	396
Convertible debenture repurchases and conversions	—	—	(209)	—	—	(209)
December 31, 2019	252.9	$ 3	$ 9,448	$ 22,573	$ (296)	$ 31,728

See accompanying notes.

Anthem, Inc.

Notes to Consolidated Financial Statements

December 31, 2019

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

1. Organization

References to the terms "we," "our," "us" or "Anthem" used throughout these Notes to Consolidated Financial Statements refer to Anthem, Inc., an Indiana corporation, and unless the context otherwise requires, its direct and indirect subsidiaries.

We are one of the largest health benefits companies in the United States in terms of medical membership, serving approximately 41 medical members through our affiliated health plans as of December 31, 2019. We offer a broad spectrum of network-based managed care plans to Large Group, Small Group, Individual, Medicaid and Medicare markets. Our managed care plans include: Preferred Provider Organizations, or PPOs; Health Maintenance Organizations, or HMOs; Point-of-Service plans; traditional indemnity plans and other hybrid plans, including Consumer-Driven Health Plans; and hospital only and limited benefit products. In addition, we provide a broad array of managed care services to self-funded customers, including claims processing, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services. We provide an array of specialty and other insurance products and services such as pharmacy benefits management, or PBM, dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal healthcare. We also provide services to the federal government in connection with our Federal Health Products & Services business, which administers the Federal Employees Health Benefits, or FEHB, Program.

We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (in the New York City metropolitan area and upstate New York), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas, we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, and Empire Blue Cross Blue Shield or Empire Blue Cross. We also conduct business through arrangements with other BCBS licensees as well as other strategic partners. Through our subsidiaries, we also serve customers in numerous states across the country as Aim Specialty Health, Amerigroup, Aspire Health, CareMore, Freedom Health, HealthLink, HealthSun, Optimum HealthCare, Simply Healthcare, and/or UniCare. Also, in the second quarter of 2019, we began providing PBM services through our IngenioRx subsidiary. We are licensed to conduct insurance operations in all 50 states and the District of Columbia through our subsidiaries.

2. Basis of Presentation and Significant Accounting Policies

Basis of Presentation: The accompanying consolidated financial statements include the accounts of Anthem and its subsidiaries and have been prepared in conformity with U.S. generally accepted accounting principles, or GAAP. All significant intercompany accounts and transactions have been eliminated in consolidation.

Certain of our subsidiaries operate outside of the United States and have functional currencies other than the U.S. dollar, or USD. We translate the assets and liabilities of those subsidiaries to USD using the exchange rate in effect at the end of the period. We translate the revenues and expenses of those subsidiaries to USD using the average exchange rates in effect during the period. The net effect of these translation adjustments is included in "Foreign currency translation adjustments" in our consolidated statements of comprehensive income.

Reclassifications: Certain prior year amounts have been reclassified to conform to the current year presentation.

Use of Estimates: The preparation of consolidated financial statements in conformity with GAAP requires us to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

Cash and Cash Equivalents: Cash and cash equivalents includes available cash and all highly liquid investments with maturities of three months or less when purchased. We control a number of bank accounts that are used exclusively to hold customer funds for the administration of customer benefits, and we have cash and cash equivalents on deposit to meet certain regulatory requirements. These amounts totaled $215 and $222 at December 31, 2019 and 2018, respectively, and are included in the cash and cash equivalents line on our consolidated balance sheets.

Investments: Financial Accounting Standards Board, or FASB, other-than-temporary impairment, or OTTI, guidance applies to fixed maturity securities and provides guidance on the recognition, presentation of, and disclosures for OTTIs. If a fixed maturity security is in an unrealized loss position and we have the intent to sell the fixed maturity security, or it is more likely than not that we will have to sell the fixed maturity security before recovery of its amortized cost basis, the decline in value is deemed to be other-than-temporary and is presented within the other-than-temporary impairment losses recognized in our consolidated statements of income. For impaired fixed maturity securities that we do not intend to sell or it is more likely than not that we will not have to sell such securities, but we expect that we will not fully recover the amortized cost basis, the credit component of the OTTI is presented within the other-than-temporary impairment losses recognized in our consolidated statements of income and the non-credit component of the OTTI is recognized in accumulated other comprehensive loss in our consolidated balance sheets. Furthermore, unrealized losses entirely caused by non-credit related factors related to fixed maturity securities for which we expect to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive loss.

The credit component of an OTTI is determined primarily by comparing the net present value of projected future cash flows with the amortized cost basis of the fixed maturity security. The net present value is calculated by discounting our best estimate of projected future cash flows at the effective interest rate implicit in the fixed maturity security at the date of acquisition. For mortgage-backed and asset-backed securities, cash flow estimates are based on assumptions regarding the underlying collateral, including prepayment speeds, vintage, type of underlying asset, geographic concentrations, default rates, recoveries and changes in value. For all other securities, cash flow estimates are driven by assumptions regarding probability of default, including changes in credit ratings and estimates regarding timing and amount of recoveries associated with a default.

For asset-backed securities included in fixed maturity securities, we recognize income using an effective yield based on anticipated prepayments and the estimated economic life of the securities. When estimates of prepayments change, the effective yield is recalculated to reflect actual payments to date and anticipated future payments. The net investment in the securities is adjusted to the amount that would have existed had the new effective yield been applied since the acquisition of the securities. Such adjustments are reported within net investment income.

Effective January 1, 2018 and in accordance with the FASB guidance, the changes in fair value of our marketable equity securities are recognized in our results of operations within net realized gains and losses on financial instruments. Prior to 2018, the unrealized gains or losses on our equity securities previously classified as available-for-sale were included in accumulated other comprehensive loss as a separate component of shareholders' equity, unless the decline in value was deemed to be other-than-temporary and we did not have the intent and ability to hold such equity securities until their full cost could be recovered, in which case such equity securities were written down to fair value and the loss was charged to other-than-temporary impairment losses recognized in income.

We maintain various rabbi trusts to account for the assets and liabilities under certain deferred compensation plans. Under these plans, the participants can defer certain types of compensation and elect to receive a return on the deferred amounts based on the changes in fair value of various investment options, primarily a variety of mutual funds. We have corporate-owned life insurance policies on certain participants in our deferred compensation plans. The cash surrender value of the corporate-owned life insurance policies is reported in other invested assets, long-term, in the consolidated balance sheets. The remaining rabbi trust assets are generally invested according to the participant's investment election and are classified as trading, which are reported in other invested assets, current, in the consolidated balance sheets.

We use the equity method of accounting for investments in companies in which our ownership interest enables us to influence the operating or financial decisions of the investee company. Our proportionate share of equity in net income of these unconsolidated affiliates is reported within net investment income.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

Investment income is recorded when earned. All securities sold resulting in investment gains and losses are recorded on the trade date. Realized gains and losses are determined on the basis of the cost or amortized cost of the specific securities sold.

We participate in securities lending programs whereby marketable securities in our investment portfolio are transferred to independent brokers or dealers in exchange for cash and securities collateral. Under FASB guidance related to accounting for transfers and servicing of financial assets and extinguishments of liabilities, we recognize the collateral as an asset, which is reported as securities lending collateral on our consolidated balance sheets, and we record a corresponding liability for the obligation to return the collateral to the borrower, which is reported as securities lending payable. The securities on loan are reported in the applicable investment category on our consolidated balance sheets. Unrealized gains or losses on securities lending collateral are included in accumulated other comprehensive loss as a separate component of shareholders' equity. The market value of loaned securities and that of the collateral pledged can fluctuate in non-synchronized fashions. To the extent the loaned securities' value appreciates faster or depreciates slower than the value of the collateral pledged, we are exposed to the risk of the shortfall. As a primary mitigating mechanism, the loaned securities and collateral pledged are marked to market on a daily basis and the shortfall, if any, is collected accordingly. Secondarily, the collateral level is set at 102% of the value of the loaned securities, which provides a cushion before any shortfall arises. The investment of the cash collateral is subject to market risk, which is managed by limiting the investments to higher quality and shorter duration instruments.

Receivables: Premium receivables include the uncollected amounts from insured groups, individuals and government programs. Premium receivables are reported net of an allowance for doubtful accounts of $237 and $278 at December 31, 2019 and 2018, respectively. Self-funded receivables include administrative fees, claims and other amounts due from self-funded customers. Self-funded receivables are reported net of an allowance for doubtful accounts of $46 and $47 at December 31, 2019 and 2018, respectively. The allowance for doubtful accounts is based on historical collection trends and our judgment regarding the ability to collect specific accounts.

Other receivables include pharmacy rebates, provider advances, claims recoveries, reinsurance receivables, proceeds due from brokers on investment trades, other government receivables and other miscellaneous amounts due to us. These receivables are reported net of an allowance for doubtful accounts of $242 and $280 at December 31, 2019 and 2018, respectively, which is based on historical collection trends and our judgment regarding the ability to collect specific accounts.

Income Taxes: We file a consolidated income tax return. Deferred income tax assets and liabilities are recognized for temporary differences between the financial statement and tax return basis of assets and liabilities based on enacted tax rates and laws. The deferred tax benefits of the deferred tax assets are recognized to the extent realization of such benefits is more likely than not. Deferred income tax expense or benefit generally represents the net change in deferred income tax assets and liabilities during the year, excluding the impact from amounts initially recorded for business combinations, if any, and amounts recorded to accumulated other comprehensive loss. Current income tax expense represents the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported.

We account for income tax contingencies in accordance with FASB guidance that contains a model to address uncertainty in tax positions and clarifies the accounting for income taxes by prescribing a minimum recognition threshold, which all income tax positions must achieve before being recognized in the financial statements.

Property and Equipment: Property and equipment is recorded at cost, net of accumulated depreciation. Depreciation is computed principally by the straight-line method over estimated useful lives ranging from fifteen to thirty-nine years for buildings and improvements, three to five years for computer equipment and software, and the lesser of the remaining life of the building lease, if any, or seven years for furniture and other equipment. Leasehold improvements are depreciated over the term of the related lease. Certain costs related to the development or purchase of internal-use software are capitalized and amortized over estimated useful lives ranging from five to ten years.

Goodwill and Other Intangible Assets: FASB guidance requires business combinations to be accounted for using the acquisition method of accounting, and it also specifies the types of acquired intangible assets that are required to be recognized and reported separately from goodwill. Goodwill represents the excess of the cost of acquisition over the fair value of net assets acquired. Other intangible assets represent the values assigned to customer relationships, provider and hospital networks, Blue Cross and Blue Shield and other trademarks, licenses and other agreements, such as non-compete. Goodwill and other intangible assets are allocated to reportable segments based on the relative fair value of the components of the businesses acquired.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

Goodwill and other intangible assets with indefinite lives are not amortized but are tested for impairment at least annually. We complete our annual impairment tests of existing goodwill and other intangible assets with indefinite lives during the fourth quarter of each year. Certain interim impairment tests are also performed when potential impairment indicators exist or changes in our business or other triggering events occur. Goodwill and other intangible assets are allocated to reporting units for purposes of the annual goodwill impairment test. Other intangible assets with indefinite lives, such as trademarks, are tested for impairment separately.

FASB guidance allows for qualitative assessments of whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount for purposes of a goodwill impairment analysis and whether it is more likely than not that an indefinite-lived intangible asset is impaired for purposes of an indefinite-lived intangible asset impairment analysis. Quantitative analysis must be performed if qualitative analyses are not conclusive. Entities also have the option to bypass the assessment of qualitative factors and proceed directly to performing quantitative analyses. Our impairment tests require us to make assumptions and judgments regarding the estimated fair value of our reporting units, including goodwill and other intangible assets with indefinite lives. Estimated fair values developed based on our assumptions and judgments might be significantly different if other reasonable assumptions and estimates were to be used.

Qualitative analysis involves assessing situations and developments that could affect key drivers used to evaluate whether the fair value of our goodwill and indefinite-lived intangible assets are impaired. Our procedures include assessing our financial performance, macroeconomic conditions, industry and market considerations, various asset specific factors, and entity specific events.

Fair value for purposes of a quantitative goodwill impairment test is calculated using a blend of the projected income and market valuation approaches. The projected income approach is developed using assumptions about future revenue, expenses and net income derived from our internal planning process. Our assumed discount rate is based on our industry's weighted-average cost of capital and reflects volatility associated with the cost of equity capital. Market valuations include market comparisons to publicly traded companies in our industry and are based on observed multiples of certain measures including revenue; earnings before interest, taxes, depreciation and amortization, or EBITDA; and book value of invested capital. A goodwill impairment loss is recognized to the extent that the carrying amount exceeds the asset's fair value. This determination is made at the reporting unit level and consists of two steps. First, the fair value of a reporting unit is determined and compared to its carrying amount. Second, if the carrying amount of a reporting unit exceeds its fair value, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation on a business acquisition, at the impairment test date.

Fair value for purposes of a quantitative impairment test for indefinite-lived intangible assets is estimated using a projected income approach. We recognize an impairment loss when the estimated fair value of indefinite-lived intangible assets is less than the carrying value. If significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

Derivative Financial Instruments: We primarily invest in the following types of derivative financial instruments: interest rate swaps, futures, forward contracts, put and call options, swaptions, embedded derivatives and warrants. Derivatives embedded within non-derivative instruments, such as options embedded in convertible fixed maturity securities, are bifurcated from the host instrument when the embedded derivative is not clearly and closely related to the host instrument. Our use of derivatives is limited by statutes and regulations promulgated by the various regulatory bodies to which we are subject, and by our own derivative policy. Our derivative use is generally limited to hedging purposes, on an economic basis, and we generally do not use derivative instruments for speculative purposes.

We have exposure to economic losses due to interest rate risk arising from changes in the level or volatility of interest rates. We attempt to mitigate our exposure to interest rate risk through active portfolio management, including rebalancing our existing portfolios of assets and liabilities, as well as changing the characteristics of investments to be purchased or sold in the future. In addition, derivative financial instruments are used to modify the interest rate exposure of certain liabilities or forecasted transactions. These strategies include the use of interest rate swaps and forward contracts, which are used to lock-in interest rates or to hedge, on an economic basis, interest rate risks associated with variable rate debt. We have used these types of instruments as designated hedges against specific liabilities.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

All investments in derivatives are recorded as assets or liabilities at fair value. If certain correlation, hedge effectiveness and risk reduction criteria are met, a derivative may be specifically designated as a hedge of exposure to changes in fair value or cash flow. The accounting for changes in the fair value of a derivative depends on the intended use of the derivative and the nature of any hedge designation thereon. Amounts excluded from the assessment of hedge effectiveness, if any, as well as the ineffective portion of the gain or loss, are reported in results of operations immediately. If the derivative is not designated as a hedge, the gain or loss resulting from the change in the fair value of the derivative is recognized in results of operations in the period of change. Cash flows associated with the settlement of non-designated derivatives are shown on a net basis in investing activity in our consolidated statements of cash flow.

From time to time, we may also purchase derivatives to hedge, on an economic basis, our exposure to foreign currency exchange fluctuations associated with the operations of certain of our subsidiaries. We generally use futures or forward contracts for these transactions. We generally do not designate these contracts as hedges and, accordingly, the changes in fair value of these derivatives are recognized in results of operations immediately.

Credit exposure associated with non-performance by the counterparties to derivative instruments is generally limited to the uncollateralized fair value of the asset related to instruments recognized in the consolidated balance sheets. We attempt to mitigate the risk of non-performance by selecting counterparties with high credit ratings and monitoring their creditworthiness and by diversifying derivatives among multiple counterparties. At December 31, 2019, we believe there were no material concentrations of credit risk with any individual counterparty.

We generally enter into master netting agreements, which reduce credit risk by permitting net settlement of transactions with the same counterparty. Certain of our derivative agreements also contain credit support provisions that require us or the counterparty to post collateral if there are declines in the derivative fair value or our credit rating. The derivative assets and derivative liabilities are reported at their fair values net of collateral and netting by the counterparty.

Retirement Benefits: We recognize the funded status of pension and other postretirement benefit plans on the consolidated balance sheets based on fiscal-year-end measurements of plan assets and benefit obligations. Prepaid pension benefits represent prepaid costs related to defined benefit pension plans and are reported with other noncurrent assets. Postretirement benefits represent outstanding obligations for retiree medical, life, vision and dental benefits. Liabilities for pension and other postretirement benefits are reported with current and noncurrent liabilities based on the amount by which the actuarial present value of benefits payable in the next twelve months included in the benefit obligation exceeds the fair value of plan assets.

We determine the expected return on plan assets using the calculated value of plan assets, which recognizes changes in the fair value of plan assets in a systematic manner over three years. We apply a corridor approach to amortize unrecognized actuarial gains or losses. Under this approach, only accumulated net actuarial gains or losses in excess of 10% of the greater of the projected benefit obligation or the fair value of plan assets are amortized over the average remaining service or lifetime of the workforce as a component of net periodic benefit cost.

The discount rate reflects the current rate at which the pension liabilities could be effectively settled at the end of the year based on our most recent measurement date. We use the annual spot rate approach for setting our discount rate. Under the spot rate approach, individual spot rates from a full yield curve of published rates are used to discount each plan's cash flows to determine the plan's obligations.

The assumed healthcare cost trend rates used to measure the expected cost of other postretirement benefits are based on an initial assumed healthcare cost trend rate declining to an ultimate healthcare cost trend rate over a select number of years.

Medical Claims Payable: Liabilities for medical claims payable include estimated provisions for incurred but not paid claims on an undiscounted basis, as well as estimated provisions for expenses related to the processing of claims. Incurred but not paid claims include (1) an estimate for claims that are incurred but not reported, as well as claims reported to us but not yet processed through our systems; and (2) claims reported to us and processed through our systems but not yet paid.

Liabilities for both claims incurred but not reported and reported but not yet processed through our systems are determined in the aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Actuarial Standards of Practice require that the claim liabilities be appropriate under moderately adverse circumstances. We determine the amount of the liability for incurred but not paid claims by following a

detailed actuarial process that uses both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities. Under this process, historical paid claims data is formatted into "claim triangles," which compare claim incurred dates to the dates of claim payments. This information is analyzed to create "completion factors" that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the period-end date to estimate the ultimate claim expense incurred for the period. Actuarial estimates of incurred but not paid claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims.

For the most recent incurred months (typically the most recent two months), the percentage of claims paid for claims incurred in those months is generally low. This makes the completion factor methodology less reliable for such months. Therefore, incurred claims for recent months are not projected from historical completion and payment patterns; rather, they are projected by estimating the claims expense for those months based on recent claims expense levels and healthcare trend levels, or "trend factors."

We regularly review and set assumptions regarding cost trends and utilization when initially establishing claim liabilities. We continually monitor and adjust the claims liability and benefit expense based on subsequent paid claims activity. If it is determined that our assumptions regarding cost trends and utilization are materially different than actual results, our income statement and financial position could be impacted in future periods.

Premium deficiencies are recognized when it is probable that expected claims and administrative expenses will exceed future premiums on existing medical insurance contracts without consideration of investment income. Determination of premium deficiencies for longer duration life and disability contracts includes consideration of investment income. For purposes of premium deficiencies, contracts are deemed to be either short or long duration and are grouped in a manner consistent with our method of acquiring, servicing and measuring the profitability of such contracts. Once established, premium deficiencies are released commensurate with actual claims experience over the remaining life of the contract. No premium deficiencies were established at December 31, 2019 or 2018.

Benefit expense includes incurred medical claims as well as quality improvement expenses for our fully-insured members. Quality improvement activities are those designed to improve member health outcomes, prevent hospital readmissions and improve patient safety. They also include expenses for wellness and health promotion provided to our members.

Reserves for Future Policy Benefits: Reserves for future policy benefits include liabilities for life and long-term disability insurance policy benefits based upon interest, mortality and morbidity assumptions from published actuarial tables, modified based upon our experience. Future policy benefits also include liabilities for insurance policies for which some of the premiums received in earlier years are intended to pay anticipated benefits to be incurred in future years. Future policy benefits are continually monitored and reviewed, and when reserves are adjusted, differences are reflected in benefit expense.

The current portion of reserves for future policy benefits relates to the portion of such reserves that we expect to pay within one year. We believe that our liabilities for future policy benefits, along with future premiums received, are adequate to satisfy our ultimate benefit liability; however, these estimates are inherently subject to a number of variable circumstances. Consequently, the actual results could differ materially from the amounts recorded in our consolidated financial statements.

Other Policyholder Liabilities: Other policyholder liabilities include rate stabilization reserves associated with retrospectively rated insurance contracts and certain case-specific reserves. Other policyholder liabilities also includes liabilities for premium refunds based upon the minimum medical loss ratio, or MLR, the relative health risk of members, or other contractual or regulatory requirements. Rate stabilization reserves represent accumulated premiums that exceed what customers owe us based on actual claim experience. The timing of payment of these retrospectively rated refunds is based on the contractual terms with our customers and can vary from period to period based on the specific contractual requirements.

We are required to meet certain minimum MLR thresholds prescribed by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended, or collectively, the ACA. If we do not meet or exceed the minimum MLR thresholds specified by the ACA, we are required to pay rebates to certain customers. Minimum MLR rebates are calculated by subsidiary, state and applicable line of business (Large Group, Small Group, Individual, Student Health and Medicare) in accordance with regulations issued by the Department of Health and Human Services, or HHS. Such calculations are made using estimated calendar year medical loss expense and premiums, as defined by HHS.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

We follow HHS guidelines for determining the types of expenses that may be included in our minimum MLR rebate calculations, which differ from benefit expense and premiums as reported in our consolidated financial statements prepared in conformity with GAAP. Certain amounts reported as expense in our consolidated GAAP financial statements may be reported as a reduction of premiums in accordance with HHS regulations. In addition, profit amounts included in our payments to third-party administrative service providers are recorded as benefit expense in our consolidated GAAP financial statements while HHS does not allow for the inclusion of these expenses within the medical loss expense for purposes of calculating minimum MLR.

Revenue Recognition: Premiums for fully-insured contracts are recognized as revenue over the period insurance coverage is provided, and, if applicable, net of amounts recognized for MLR rebates, risk adjustment, reinsurance and risk corridor under contractual premium stabilization arrangements, the ACA or other regulatory requirements. Premium payments from contracted government agencies are based on eligibility lists produced by the government agencies. Premiums related to the unexpired contractual coverage periods are reflected in the accompanying consolidated balance sheets as unearned income. Premiums include revenue adjustments for retrospectively rated contracts where revenue is based on the estimated loss experience of the contract. Premium rates for certain lines of business are subject to approval by the Department of Insurance of each respective state. Additionally, delays in annual premium rate changes from contracted government agencies require that we defer the recognition of any increases to the period in which the premium rates become final. The value of the impact can be significant in the period in which it is recognized depending on the magnitude of the premium rate increase, the membership to which it applies and the length of the delay between the effective date of the rate increase and the final contract date. Premium rate decreases are recognized in the period the change in premium rate becomes effective and the change in the rate is known, which may be prior to the period when the contract amendment affecting the rate is finalized.

Administrative fees and other revenue include revenue from certain group contracts that provide for the group to be at risk for all, or with supplemental insurance arrangements, a portion, of their claims experience. We charge these self-funded groups an administrative fee, which is based on the number of members in a group or the group's claim experience. In addition, administrative fees and other revenue include amounts received for the administration of Medicare or certain other government programs. Under our self-funded arrangements, revenue is recognized as administrative services are performed. All benefit payments under these programs are excluded from benefit expense.

Administrative fees and other revenue also include product revenue for services performed by our IngenioRx pharmacy benefit manager, or PBM, for unaffiliated PBM customers. Unaffiliated PBM customers include our self-funded groups that have contracted with IngenioRx for PBM services and, beginning on January 1, 2020, third-party health plans. Product revenues and costs of goods sold for Anthem health plans are eliminated in consolidation. Product revenue for PBM services is recognized using the gross method at the negotiated contract price when IngenioRx has concluded that it is the principal and it controls the services before prescription drugs are transferred to the customer. IngenioRx determined it is the principal due to its contractual rights to design and develop a listing of prescription drugs offered to the customer (formulary management); its control over establishing the pharmacy network available to the customer to have its prescription fulfilled (network management); and its discretion over establishing the pricing for prescription drugs. Overall, control over these activities indicate IngenioRx is primarily responsible for fulfilling the promise to provide PBM services. Product revenues include ingredient costs (net of any rebates or discounts), including any co-payments made by or on behalf of the customer, and administrative fees. IngenioRx recognizes revenue when control of the prescription drugs is transferred to customers, in an amount it expects to be entitled to in exchange for the services provided.

For our non-fully-insured contracts, we had no material contract assets, contract liabilities or deferred contract costs recorded on our consolidated balance sheet at December 31, 2019. Revenue recognized in 2019 and 2018 from performance obligations related to prior years, such as due to changes in transaction price, was not material. For contracts that have an original expected duration of greater than one year, revenue expected to be recognized in future periods related to unfulfilled contractual performance obligations and contracts with variable consideration related to undelivered performance obligations is not material.

Cost of Products Sold: IngenioRx's cost of products sold includes the cost of prescription drugs dispensed to unaffiliated PBM customers (net of rebates or discounts). This cost includes any co-payments made by or on behalf of the customer. Cost of products sold also includes per-claim administrative fees for prescription fulfillment by its vendor and certain IngenioRx direct costs related to sales and administration of customer contracts.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

Share-Based Compensation: Our current compensation philosophy provides for share-based compensation, including stock options, restricted stock awards and an employee stock purchase plan. Stock options are granted for a fixed number of shares with an exercise price at least equal to the fair value of the shares at the date of the grant. Restricted stock awards are issued at the fair value of the stock on the grant date. The employee stock purchase plan allows for a purchase price per share which is 90% of the fair value of a share of common stock on the lower of the first or last trading day of the plan quarter. The employee stock purchase plan discount is recognized as compensation expense based on GAAP guidance. All other share-based payments to employees are recognized as compensation expense in our consolidated statements of income based on their fair values. Additionally, excess tax benefits, which result from actual tax benefits realized when awards vest or options are exercised exceeding deferred tax benefits previously recognized based on grant date fair value, are recognized as tax benefits in the income statement. Our share-based employee compensation plans and assumptions are described in Note 14, "Capital Stock." Also see "*Recently Adopted Accounting Guidance*" within this Note 2 for reference to accounting changes adopted related to share-based compensation.

***Advertising and Marketing Costs*:** We use print, broadcast and other advertising to promote our products and to develop our corporate image. We market our products through direct marketing activities and an extensive network of independent agents, brokers and retail partnerships for Individual and Medicare customers, and for certain Local Group customers with a smaller employee base. Products for National Accounts and Local Group customers with a larger employee base are generally sold through independent brokers or consultants retained by the customer who work with industry specialists from our in-house sales force. In the Individual and Small Group markets, we offer products through state or federally facilitated marketplaces, or public exchanges, and off-exchange products. The cost of advertising and marketing for product promotion is expensed as incurred, while advertising and marketing costs associated with our corporate image is expensed when first aired. Total advertising and marketing expense was $467, $385 and $338 for the years ended December 31, 2019, 2018 and 2017, respectively.

***Health Insurance Provider Fee*:** The ACA imposed an annual Health Insurance Provider Fee, or HIP Fee, on health insurers that write certain types of health insurance on U.S. risks, which has been permanently repealed effective January 1, 2021. The annual HIP Fee is allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to the amount of health insurance premium for all U.S. health risk for those certain lines of business written during the preceding calendar year. We record our estimated liability for the HIP Fee in full at the beginning of the year with a corresponding deferred asset that is amortized on a straight-line basis to selling, general and administrative expense. The final calculation and payment of the annual HIP Fee is due by September 30th of each fee year. The HIP Fee is non-deductible for federal income tax purposes. Our affected products are priced to cover the increased selling, general and administrative and income tax expenses associated with the HIP Fee. The total amount due from allocations to health insurers was $14,300 for 2018. The HIP Fee was suspended for 2017 and 2019, has resumed and increased to $15,523 for 2020 and has been permanently eliminated beginning in 2021. For the year ended December 31, 2018, we recognized $1,544 as selling, general and administrative expense related to the HIP Fee. There was no corresponding expense for 2019 or 2017 due to the suspension of the HIP Fee for 2019 and 2017.

Leases: We lease office space and certain computer and related equipment under noncancelable operating leases. We determine whether an arrangement is or contains a lease at its inception. We recognize lease liabilities based on the present value of the minimum lease payments not yet paid by using the lease term, any amounts probable of being owed under any residual value guarantees and the discount rate determined at lease commencement. As our leases do not generally provide an implicit rate, we use our incremental secured borrowing rate commensurate with the underlying lease terms to determine the present value of our lease payments. Our lease liabilities may include amounts for options to extend or terminate a lease when it is reasonably certain that we will exercise that option. We recognize operating right-of-use, or ROU, assets at an amount equal to the lease liability adjusted for prepaid or accrued rent, the remaining balance of any lease incentives and unamortized initial direct costs.

The operating lease liabilities are reported in other current liabilities and other noncurrent liabilities and the related ROU assets are reported in other noncurrent assets on our consolidated balance sheet as of December 31, 2019. Lease expense for our operating leases is calculated on a straight-line basis over the lease term and is reported in selling, general and administrative expense on our consolidated statements of income. For our office space leases, we account for the lease and non-lease components (such as common area maintenance) as a single lease component. We also do not recognize a lease liability or ROU asset for our office space leases whose lease terms, at commencement, are twelve months or less and that do not include a purchase option or option to extend that we are reasonably certain to exercise.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

Earnings per Share: Earnings per share amounts, on a basic and diluted basis, have been calculated based upon the weighted-average common shares outstanding for the period.

Basic earnings per share excludes dilution and is computed by dividing income available to common shareholders by the weighted-average number of common shares outstanding for the period. Diluted earnings per share may include the dilutive effect of stock options, restricted stock, convertible debentures and Equity Units, using the treasury stock method. See Note 12, "Debt," for a description of our Equity Units. The treasury stock method assumes exercise of stock options and vesting of restricted stock, with the assumed proceeds used to purchase common stock at the average market price for the period. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Recently Adopted Accounting Guidance: In March 2019, the FASB issued Accounting Standards Update No. 2019-01, *Leases (Topic 842): Codification Improvements*. In July 2018, the FASB issued Accounting Standards Update No. 2018-11, *Leases (Topic 842): Targeted Improvements* and Accounting Standards Update No. 2018-10, *Codification Improvements to Topic 842, Leases*. These updates provide additional clarification, an optional transition method, a practical expedient and implementation guidance on the previously issued Accounting Standards Update No. 2016-02, *Leases (Topic 842)*. Collectively, these updates supersede the lease guidance in Accounting Standards Codification, or ASC, Topic 840 and require lessees to recognize for all leases, with the exception of short-term leases, a lease liability, which is a lessee's obligation to make lease payments arising from a lease, measured on a discounted basis. Concurrently, lessees are required to recognize an ROU asset, which is an asset that represents the lessee's right to use, or control the use of, a specified asset for the lease term. We adopted this standard on January 1, 2019 by applying the optional transition method on the adoption date and did not adjust comparative periods. We also elected the package of practical expedients permitted, which, among other things, allowed us to carry forward the lease classification for our existing leases. In preparation for the adoption of this standard and to enable preparation of the required financial information, we implemented a new lease accounting software solution as well as new internal controls. The adoption of this standard impacted our 2019 opening consolidated balance sheet, as we recorded operating lease liabilities of $728 and ROU assets of $637, which equals the lease liabilities net of accrued rent, lease incentives and the carrying amount of ceased-use liabilities previously recorded on our consolidated balance sheet under the prior guidance. We also recognized a cumulative-effect adjustment of $26 to our opening retained earnings for deferred gains on our previous sale-leaseback transactions. The adoption of this standard did not have an impact on our consolidated statements of income or cash flows.

In August 2018, the FASB issued Accounting Standards Update No. 2018-13, *Fair Value Measurement (Topic 820): Disclosure Framework—Changes to the Disclosure Requirements for Fair Value Measurement,* or ASU 2018-13. The amendments in ASU 2018-13 eliminate, add, and modify certain disclosure requirements for fair value measurements. The amendments are effective for interim and annual periods beginning after December 15, 2019, with early adoption permitted for either the entirety of ASU 2018-13 or only the provisions that eliminate or modify disclosure requirements. We early adopted the provisions that eliminate and modify disclosure requirements, on a retrospective basis, effective in our 2018 Annual Report on Form 10-K. We adopted the new disclosure requirements on January 1, 2020, on a prospective basis. The new disclosure requirements are effective for our interim and annual reporting periods beginning on or after the adoption date.

In February 2018, the FASB issued Accounting Standards Update No. 2018-02, *Income Statement—Reporting Comprehensive Income (Topic 220)*: *Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income*, or ASU 2018-02. On December 22, 2017, the federal government enacted a tax bill, H.R.1, *An act to provide for reconciliation pursuant to titles II and V of the concurrent resolution on the budget for fiscal year 2018*, or the Tax Cuts and Jobs Act. The Tax Cuts and Jobs Act contains significant changes to corporate taxation, including, but not limited to, reducing the U.S. federal corporate income tax rate from 35% to 21% and modifying or limiting many business deductions. Current FASB guidance requires adjustments of deferred taxes due to a change in the federal corporate income tax rate to be included in income from operations. As a result, the tax effects of items within accumulated other comprehensive loss did not reflect the appropriate tax rate. The amendments in ASU 2018-02 allow a reclassification from accumulated other comprehensive loss to retained earnings for stranded tax effects resulting from the change in the federal corporate income tax rate. We adopted the amendments in ASU 2018-02 for our interim and annual reporting periods beginning on January 1, 2018 and reclassified $91 of stranded tax effects from accumulated other comprehensive loss to retained earnings on our consolidated balance sheets. The adoption of ASU 2018-02 did not have any impact on our consolidated results of operations or cash flows.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

In August 2017, the FASB issued Accounting Standards Update No. 2017-12, *Derivatives and Hedging (Topic 815): Targeted Improvements to Accounting for Hedging Activities*, or ASU 2017-12. This update amends the hedge accounting recognition and presentation requirements in ASC Topic 815 with the objective of improving the financial reporting of hedging relationships to better portray the economic results of an entity's risk management activities in its financial statements. The update also makes certain targeted improvements to simplify the application of the hedge accounting guidance and provides several transition elections. We adopted ASU 2017-12 on October 1, 2017. The adoption of ASU 2017-12 did not have a material impact on our consolidated financial position, results of operations or cash flows.

In May 2017, the FASB issued Accounting Standards Update No. 2017-09, *Compensation - Stock Compensation (Topic 718): Scope of Modification Accounting*, or ASU 2017-09. This update provides guidance about which changes to the terms or conditions of a share-based payment award require an entity to apply modification accounting in ASC Topic 718. We adopted ASU 2017-09 on January 1, 2018. The guidance has been and will be applied prospectively to awards modified on or after the adoption date. The adoption of ASU 2017-09 did not have any impact on our consolidated financial position, results of operations or cash flows.

In March 2017, the FASB issued Accounting Standards Update No. 2017-08, *Receivables—Nonrefundable Fees and Other Costs (Subtopic 310-20): Premium Amortization on Purchased Callable Debt Securities*, or ASU 2017-08. This update changes the amortization period for certain purchased callable debt securities held at a premium by shortening the amortization period for the premium to the earliest call date. Under current guidance, the premium is generally amortized over the contractual life of the instrument. The amendments are to be applied on a modified retrospective basis through a cumulative-effect adjustment directly to retained earnings as of the beginning of the period of adoption. We adopted ASU 2017-08 on January 1, 2019, and the adoption of this standard did not have a material impact on our beginning retained earnings or on our consolidated financial position, results of operations or cash flows.

In March 2017, the FASB issued Accounting Standards Update No. 2017-07, *Compensation - Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*, or ASU 2017-07. This amendment requires entities to disaggregate the service cost component from the other components of the benefit cost and present the service cost component in the same income statement line item as other employee compensation costs arising from services rendered by the pertinent employees during the period. The other components of net benefit cost are required to be presented in the income statement separately from the service cost component and outside a subtotal of income from operations. Certain of our defined benefit plans have previously been frozen, resulting in no annual service costs, and the remaining service costs for our non-frozen plan are not material. We adopted ASU 2017-07 on January 1, 2018 and it did not have a material impact on our results of operations, cash flows or consolidated financial position.

In December 2016, the FASB issued Accounting Standards Update No. 2016-20, *Technical Corrections and Improvements to Topic 606, Revenue from Contracts with Customers*. In May 2016, the FASB issued Accounting Standards Update No. 2016-12, *Revenue from Contracts with Customers (Topic 606): Narrow-Scope Improvements and Practical Expedients*. In April 2016, the FASB issued Accounting Standards Update No. 2016-10, *Revenue from Contracts with Customers (Topic 606): Identifying Performance Obligations and Licensing,* or ASU 2016-10. In March 2016, the FASB issued Accounting Standards Update No. 2016-08, *Revenue from Contracts with Customers (Topic 606): Principal versus Agent Considerations (Reporting Revenue Gross verses Net)*. These updates provide additional clarification and implementation guidance on the previously issued Accounting Standards Update No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*. Collectively, these updates require a company to recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods or services. These updates supersede almost all existing revenue recognition guidance under GAAP, with certain exceptions, including an exception for our premium revenues, which are recorded on the Premiums line item on our consolidated statements of income and will continue to be accounted for in accordance with the provisions of ASC Topic 944, *Financial Services - Insurance*. Our administrative service and other contracts that are subject to these Accounting Standards Updates are recorded in the Administrative fees and other revenue line item on our consolidated statements of income and were immaterial to our consolidated total operating revenue at the time of adoption. We adopted these standards on January 1, 2018 using the modified retrospective approach. The adoption of these standards did not have a material impact on our beginning retained earnings, results of operations, cash flows or consolidated financial position.

In November 2016, the FASB issued Accounting Standards Update No. 2016-18, *Statement of Cash Flows (Topic 230): Restricted Cash,* or ASU 2016-18. This update amends ASC Topic 230 to add and clarify guidance on the classification and

presentation of restricted cash in the statement of cash flows. The guidance requires entities to show the changes in the total of cash, cash equivalents, restricted cash and restricted cash equivalents in the statement of cash flows. We adopted ASU 2016-18 on January 1, 2018 using a retrospective approach. The adoption of ASU 2016-18 did not have a material impact on our consolidated statements of cash flows and did not impact our results of operations or consolidated financial position.

In August 2016, the FASB issued Accounting Standards Update No. 2016-15, *Statement of Cash Flows (Topic 230): Classification of Certain Cash Receipts and Cash Payments,* or ASU 2016-15. This update addresses the presentation and classification on the statement of cash flows for eight specific items, with the objective of reducing existing diversity in practice in how certain cash receipts and cash payments are presented and classified. We adopted ASU 2016-15 on January 1, 2018. The adoption of ASU 2016-15 did not have a material impact on our consolidated statements of cash flows, results of operations or consolidated financial position.

In March 2016, the FASB issued Accounting Standards Update No. 2016-09, *Compensation - Stock Compensation (Topic 718): Improvements to Employee Share-Based Payment Accounting*, or ASU 2016-09. The amendments in this update simplify several aspects of accounting for and reporting on share-based payment transactions, including the income tax consequences, classification of awards as either equity or liabilities, and classification on the statement of cash flows. We adopted the amendments in ASU 2016-09 on January 1, 2017. We continue to estimate forfeitures expected to occur in determining stock compensation recognized in each period. We prospectively recognized tax benefits of $36, or $0.13 per diluted share, for the year ended December 31, 2017 in our consolidated statements of income, which previously would have been recorded to additional paid-in capital. In addition, we prospectively recognized excess tax benefits as an operating activity within our consolidated statement of cash flows for the year ended December 31, 2017. Finally, we retrospectively recognized taxes paid on our employees' behalf through the withholding of common stock as a financing activity within our consolidated statements of cash flows for the years ended December 31, 2017 and 2016.

In January 2016, the FASB issued Accounting Standards Update No. 2016-01, *Financial Instruments - Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities*, or ASU 2016-01. The amendments in ASU 2016-01 change the accounting for non-consolidated equity investments that are not accounted for under the equity method of accounting by requiring changes in fair value to be recognized in income. Additionally, ASU 2016-01 simplifies the impairment assessment of equity investments without readily determinable fair values; requires entities to use the exit price when estimating the fair value of financial instruments; and modifies various presentation disclosure requirements for financial instruments. We adopted ASU 2016-01 on January 1, 2018 as a cumulative-effect adjustment and reclassified $320 of unrealized gains on equity investments, net of tax, from accumulated other comprehensive loss to retained earnings on our consolidated balance sheet. Effective January 1, 2018, our results of operations include the changes in fair value of these financial instruments.

Recent Accounting Guidance Not Yet Adopted: In December 2019, the FASB issued Accounting Standards Update No. 2019-12, *Income Taxes (Topic 740): Simplifying the Accounting for Income Taxes,* or ASU 2019-12. The amendments in ASU 2019-12 remove certain exceptions to the general principles in ASC Topic 740. The amendments also clarify and amend existing guidance to improve consistent application. The amendments are effective for our annual reporting periods beginning after December 15, 2020, with early adoption permitted. The transition method (retrospective, modified retrospective, or prospective basis) related to the amendments depends on the applicable guidance, and all amendments for which there is no transition guidance specified are to be applied on a prospective basis. We are currently evaluating the effects the adoption of ASU 2019-12 will have on our consolidated financial statements.

In November 2019, the FASB issued Accounting Standards Update No. 2019-11, *Codification Improvements to Topic 326, Financial Instruments - Credit Losses*. In May 2019, the FASB issued Accounting Standards Update No. 2019-05, *Financial Instruments - Credit Losses (Topic 326): Targeted Transition Relief*. In April 2019, the FASB issued Accounting Standards Update No. 2019-04, *Codification Improvements to Topic 326, Financial Instruments - Credit Losses, Topic 815, Derivatives and Hedging, and Topic 825, Financial Instruments*. In November 2018, the FASB issued Accounting Standards Update No. 2018-19, *Codification Improvements to Topic 326, Financial Instruments - Credit Losses*. These updates provide an option to irrevocably elect to measure certain individual financial assets at fair value instead of amortized cost and provide additional clarification and implementation guidance on certain aspects of the previously issued Accounting Standards Update No. 2016-13, *Financial Instruments - Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments,* or ASU 2016-13, and have the same effective date and transition requirements as ASU 2016-13. ASU 2016-13 introduces a current expected credit loss model for measuring expected credit losses for certain types of financial instruments

held at the reporting date based on historical experience, current conditions and reasonable supportable forecasts. ASU 2016-13 replaces the current incurred loss model for measuring expected credit losses, requires expected losses on available-for-sale debt securities to be recognized through an allowance for credit losses rather than as reductions in the amortized cost of the securities and provides for additional disclosure requirements. ASU 2016-13 requires a cumulative-effect adjustment to the opening balance of retained earnings on the statement of financial position at the date of adoption and a prospective transition approach for debt securities for which an OTTI had been recognized before the adoption date. The effect of a prospective transition approach is to maintain the same amortized cost basis before and after the date of adoption. We adopted ASU 2016-13 on January 1, 2020, and the adoption did not have a material impact on our beginning retained earnings or on our consolidated financial position, results of operations or cash flows.

In August 2018, the FASB issued Accounting Standards Update No. 2018-15, *Intangibles—Goodwill and Other—Internal-Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract*, or ASU 2018-15. The amendments in ASU 2018-15 require implementation costs incurred by customers in cloud computing arrangements to be deferred and recognized over the term of the arrangement, if those costs would be capitalized by the customer in a software licensing arrangement under the internal-use software guidance. The amendments also require an entity to disclose the nature of its hosting arrangements and adhere to certain presentation requirements in its balance sheet, income statement and statement of cash flows. We adopted ASU 2018-15 on January 1, 2020 using a prospective approach for all implementation costs incurred after the date of adoption, and the adoption did not have an impact on our consolidated financial position, results of operations or cash flows.

In August 2018, the FASB issued Accounting Standards Update No. 2018-14, *Compensation—Retirement Benefits—Defined Benefit Plans—General (Subtopic 715-20): Disclosure Framework—Changes to the Disclosure Requirements for Defined Benefit Plans*, or ASU 2018-14. The amendments in ASU 2018-14 eliminate, add and modify certain disclosure requirements for employers that sponsor defined benefit pension or other postretirement plans. The amendments are effective for our annual reporting periods beginning after December 15, 2020, with early adoption permitted. The guidance is to be applied on a retrospective basis to all periods presented. We are currently evaluating the effects the adoption of ASU 2018-14 will have on our disclosures.

In August 2018, the FASB issued Accounting Standards Update No. 2018-12, *Financial Services Insurance (Topic 944): Targeted Improvements to the Accounting for Long-Duration Contracts,* or ASU 2018-12. The amendments in ASU 2018-12 make changes to a variety of areas to simplify or improve the existing recognition, measurement, presentation and disclosure requirements for long-duration contracts issued by an insurance entity. The amendments require insurers to annually review the assumptions they make about their policyholders and update the liabilities for future policy benefits if the assumptions change. The amendments also simplify the amortization of deferred contract acquisition costs and add new disclosure requirements about the assumptions insurers use to measure their liabilities and how they may affect future cash flows. The amendments in ASU 2018-12 will be effective for our interim and annual reporting periods beginning after December 15, 2021. The amendments related to the liability for future policy benefits for traditional and limited-payment contracts and deferred acquisition costs are to be applied to contracts in force as of the beginning of the earliest period presented, with an option to apply such amendments retrospectively with a cumulative-effect adjustment to the opening balance of retained earnings as of the earliest period presented. The amendments for market risk benefits are to be applied retrospectively. We are currently evaluating the effects the adoption of ASU 2018-12 will have on our consolidated financial position, results of operations, cash flows, and related disclosures.

In January 2017, the FASB issued Accounting Standards Update No. 2017-04, *Intangibles - Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment*, or ASU 2017-04. This update removes Step 2 of the goodwill impairment test under current guidance, which requires a hypothetical purchase price allocation. The new guidance requires an impairment charge to be recognized for the amount by which the carrying amount exceeds the reporting unit's fair value. Upon adoption, the guidance is to be applied prospectively. We adopted ASU 2017-04 on January 1, 2020, and the adoption did not have an impact on our consolidated financial position, results of operations or cash flows.

There were no other new accounting pronouncements that were issued or became effective during the year ended December 31, 2019 that had, or are expected to have, a material impact on our financial position, results of operations, cash flows or financial statement disclosures.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

3. Business Acquisitions

Pending Acquisition of Beacon

On June 6, 2019, we announced our entrance into an agreement to acquire Beacon Health Options, Inc., or Beacon, the largest independently held behavioral health organization in the country. Beacon services approximately forty million individuals across all fifty states. This acquisition aligns with our strategy to diversify into health services and deliver both integrated solutions and care delivery models that personalize care for people with complex and chronic conditions. The acquisition is expected to close during the first quarter of 2020 and is subject to standard closing conditions and customary approvals.

Acquisition of America's 1st Choice

On February 15, 2018, we completed our acquisition of Freedom Health, Inc., Optimum HealthCare, Inc., America's 1st Choice of South Carolina, Inc. and related entities, or collectively, America's 1st Choice, a Medicare Advantage organization that offers HMO products, including Chronic Special Needs Plans and Dual-Eligible Special Needs Plans under its Freedom Health and Optimum HealthCare brands in Florida and its America's 1st Choice of South Carolina brand in South Carolina. At the time of acquisition, through its Medicare Advantage Plans, America's 1st Choice served approximately one hundred and thirty-five thousand members in twenty-five Florida and three South Carolina counties. This acquisition aligns with our plans for continued growth in the Medicare Advantage and Special Needs populations.

In accordance with FASB accounting guidance for business combinations, the consideration transferred was allocated to the fair value of America's 1st Choice's assets acquired and liabilities assumed, including identifiable intangible assets. The excess of the consideration transferred over the fair value of net assets acquired resulted in goodwill of $1,029 at December 31, 2018, of which $333 was tax deductible. All of the goodwill was allocated to our Government Business segment. Goodwill recognized from the acquisition of America's 1st Choice primarily relates to the future economic benefits arising from the assets acquired and is consistent with our stated intentions to strengthen our position and expand operations in the government sector to service Medicare Advantage and Special Needs populations.

The fair value of the net assets acquired from America's 1st Choice includes $711 of other intangible assets at December 31, 2018, which primarily consist of finite-lived customer relationships with amortization periods ranging from 7 to 13 years. The results of operations of America's 1st Choice are included in our consolidated financial statements within our Government Business segment for the periods following February 15, 2018. The pro forma effects of this acquisition for prior periods were not material to our consolidated results of operations.

Acquisition of HealthSun

On December 21, 2017, we completed our acquisition of HealthSun Health Plans, Inc., or HealthSun, which at the time of acquisition served approximately forty thousand members in the state of Florida through its Medicare Advantage Plans, and which received a five-star rating from the Centers for Medicare & Medicaid Services. This acquisition aligns with our plans for continued growth in the Medicare Advantage and dual-eligible populations. The results of operations of HealthSun are included in our consolidated financial statements within our Government Business segment for the periods following December 21, 2017. The pro forma effects of this acquisition for prior periods were not material to our consolidated results of operations.

Termination of Agreement and Plan of Merger with Cigna Corporation

On July 24, 2015, we and Cigna Corporation, or Cigna, announced that we entered into an Agreement and Plan of Merger, or Cigna Merger Agreement, dated as of July 23, 2015, to acquire all outstanding shares of Cigna. On May 12, 2017, we delivered to Cigna a notice terminating the Cigna Merger Agreement. Both we and Cigna have commenced litigation against the other seeking various actions and damages, including Cigna's damage claim for a $1,850 termination fee pursuant to the terms of the Cigna Merger Agreement. For additional information, see Note 13, "Commitments and Contingencies - *Litigation and Regulatory Proceedings - Cigna Corporation Merger Litigation.*"

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

4. Investments

A summary of current and long-term fixed maturity securities, available-for-sale, at December 31, 2019 and 2018 is as follows:

	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses		Estimated Fair Value	Non-Credit Component of OTTIs Recognized in Accumulated Other Comprehensive Loss
			Less than 12 Months	12 Months or Greater		
December 31, 2019						
Fixed maturity securities:						
United States Government securities	$ 524	$ 4	$ (3)	$ —	$ 525	$ —
Government sponsored securities	136	5	—	—	141	—
States, municipalities and political subdivisions, tax-exempt	4,592	262	(3)	—	4,851	—
Corporate securities	8,870	339	(9)	(15)	9,185	(3)
Residential mortgage-backed securities	3,654	87	(6)	(3)	3,732	—
Commercial mortgage-backed securities	84	2	—	—	86	—
Other securities	1,648	21	(3)	(5)	1,661	—
Total fixed maturity securities	$ 19,508	$ 720	$ (24)	$ (23)	$ 20,181	$ (3)
December 31, 2018						
Fixed maturity securities:						
United States Government securities	$ 414	$ 3	$ —	$ (1)	$ 416	$ —
Government sponsored securities	108	1	—	(1)	108	—
States, municipalities and political subdivisions, tax-exempt	4,716	91	(3)	(19)	4,785	—
Corporate securities	8,189	33	(170)	(115)	7,937	(3)
Residential mortgage-backed securities	2,769	31	(3)	(47)	2,750	—
Commercial mortgage-backed securities	69	—	—	(2)	67	—
Other securities	1,115	14	(8)	(5)	1,116	—
Total fixed maturity securities	$ 17,380	$ 173	$ (184)	$ (190)	$ 17,179	$ (3)

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

For fixed maturity securities in an unrealized loss position at December 31, 2019 and 2018, the following table summarizes the aggregate fair values and gross unrealized losses by length of time those securities have continuously been in an unrealized loss position.

	Less than 12 Months			12 Months or Greater		
	Number of Securities	Estimated Fair Value	Gross Unrealized Loss	Number of Securities	Estimated Fair Value	Gross Unrealized Loss
(Securities are whole amounts)						
December 31, 2019						
Fixed maturity securities:						
United States Government securities	27	$ 250	$ (3)	2	$ 1	$ —
Government sponsored securities	14	12	—	3	1	—
States, municipalities and political subdivisions, tax-exempt	114	306	(3)	14	11	—
Corporate securities	386	558	(9)	224	286	(15)
Residential mortgage-backed securities	321	635	(6)	189	237	(3)
Commercial mortgage-backed securities	1	3	—	4	8	—
Other securities	166	415	(3)	113	358	(5)
Total fixed maturity securities	1,029	$ 2,179	$ (24)	549	$ 902	$ (23)
December 31, 2018						
Fixed maturity securities:						
United States Government securities	5	$ 47	$ —	25	$ 79	$ (1)
Government sponsored securities	8	11	—	24	31	(1)
States, municipalities and political subdivisions, tax-exempt	177	295	(3)	604	1,032	(19)
Corporate securities	2,185	4,503	(170)	1,220	2,072	(115)
Residential mortgage-backed securities	259	383	(3)	816	1,458	(47)
Commercial mortgage-backed securities	6	11	—	19	37	(2)
Other securities	193	599	(8)	93	237	(5)
Total fixed maturity securities	2,833	$ 5,849	$ (184)	2,801	$ 4,946	$ (190)

The amortized cost and fair value of fixed maturity securities at December 31, 2019, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because the issuers of the securities may have the right to prepay obligations.

	Amortized Cost	Estimated Fair Value
Due in one year or less	$ 532	$ 534
Due after one year through five years	5,367	5,503
Due after five years through ten years	5,633	5,864
Due after ten years	4,238	4,462
Mortgage-backed securities	3,738	3,818
Total fixed maturity securities	$ 19,508	$ 20,181

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

Equity Securities

A summary of current and long-term marketable equity securities at December 31, 2019 and 2018 is as follows:

	December 31, 2019	December 31, 2018
Equity Securities:		
Exchange traded funds	$ 44	$ 2
Fixed maturity mutual funds	643	557
Common equity securities	267	654
Private equity securities	85	313
Total	$ 1,039	$ 1,526

Investment Income

The major categories of net investment income for the years ended December 31, 2019, 2018 and 2017 are as follows:

	2019	2018	2017
Fixed maturity securities	$ 721	$ 681	$ 614
Equity securities	100	86	116
Cash equivalents	64	51	25
Other	149	193	153
Investment income	1,034	1,011	908
Investment expense	(29)	(41)	(41)
Net investment income	$ 1,005	$ 970	$ 867

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

Investment Gains

Net realized investment gains/losses and the net change in unrealized appreciation/depreciation on investments for the years ended December 31, 2019, 2018 and 2017 are as follows:

	2019	2018	2017
Net realized gains (losses):			
Fixed maturity securities:			
Gross realized gains from sales	$ 125	$ 85	$ 137
Gross realized losses from sales	(59)	(116)	(55)
Net realized gains (losses) from sales of fixed maturity securities	66	(31)	82
Equity securities:			
Gross realized gains	147	77	140
Gross realized losses	(84)	(276)	(17)
Net realized gains (losses) on equity securities	63	(199)	123
Other investments:			
Gross realized gains from sales	3	27	—
Gross realized losses from sales	(1)	—	(5)
Net realized gains (losses) from sales of other investments	2	27	(5)
Net realized gains (losses) on investments	131	(203)	200
Other-than-temporary impairment losses recognized in income:			
Fixed maturity securities	(13)	(9)	(4)
Equity securities	—	—	(15)
Other investments	(34)	(17)	(14)
Other-than-temporary impairment losses recognized in income	(47)	(26)	(33)
Change in net unrealized gains (losses) on investments:			
Fixed maturity securities	874	(529)	156
Equity securities	—	—	111
Other investments	—	5	(10)
Total change in net unrealized gains (losses) on investments	874	(524)	257
Deferred income tax (expense) benefit	(194)	106	(84)
Change in net unrealized gains (losses) on investments	680	(418)	173
Net realized gains (losses) on investments, other-than-temporary impairment losses recognized in income and change in net unrealized gains (losses) on investments	$ 764	$ (647)	$ 340

The gains and losses related to equity securities for the years ended December 31, 2019 and 2018 are as follows:

	2019	2018
Net realized gains (losses) recognized on equity securities	$ 63	$ (199)
Less: Net realized (gains) losses recognized on equity securities sold during the period	(39)	57
Unrealized gains (losses) recognized in income on equity securities still held at December 31	$ 24	$ (142)

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

A primary objective in the management of our fixed maturity and equity portfolios is to maximize total return relative to underlying liabilities and respective liquidity needs. In achieving this goal, assets may be sold to take advantage of market conditions or other investment opportunities as well as tax considerations. Sales will generally produce realized gains and losses. In the ordinary course of business, we may sell securities at a loss for a number of reasons, including, but not limited to: (i) changes in the investment environment; (ii) expectations that the fair value could deteriorate further; (iii) desire to reduce exposure to an issuer or an industry; (iv) changes in credit quality; or (v) changes in expected cash flow.

Proceeds from sales, maturities, calls or redemptions of fixed maturity securities and the related gross realized gains and gross realized losses for the years ended December 31 are as follows:

	2019	2018	2017
Proceeds	$ 8,351	$ 8,380	$ 9,780
Gross realized gains	125	85	137
Gross realized losses	(59)	(116)	(55)

A significant judgment in the valuation of investments is the determination of when an other-than-temporary decline in value has occurred. We follow a consistent and systematic process for recognizing impairments on securities that sustain other-than-temporary declines in value. We have established a committee responsible for the impairment review process. The decision to impair a security incorporates both quantitative criteria and qualitative information. The impairment review process considers a number of factors including, but not limited to: (i) the extent to which the fair value is less than book value, (ii) the financial condition and near term prospects of the issuer, (iii) our intent and ability to retain impaired investments for a period of time sufficient to allow for any anticipated recovery in fair value, (iv) our intent to sell or the likelihood that we will need to sell a fixed maturity security before recovery of its amortized cost basis, (v) whether the debtor is current on interest and principal payments, (vi) the reasons for the decline in value (i.e., credit event compared to liquidity, general credit spread widening, currency exchange rate or interest rate factors) and (vii) general market conditions and industry or sector specific factors. For securities that are deemed to be other-than-temporarily impaired, the security is adjusted to fair value and the resulting losses are recognized in the consolidated statements of income. The new cost basis of the impaired security is not increased for future recoveries in fair value.

Other-than-temporary impairments recorded in 2019, 2018 and 2017 were primarily the result of the continued credit deterioration on specific issuers in the bond markets. There were no individually material OTTI losses on investments by issuer during 2019, 2018 or 2017.

Investment securities are exposed to various risks, such as interest rate, market and credit. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is possible that changes in these risk factors in the near term could have a material adverse impact on our results of operations or shareholders' equity.

The changes in the amount of the credit component of OTTI losses on fixed maturity securities recognized in income, for which a portion of the OTTI losses was recognized in other comprehensive income, was not material for the years ended December 31, 2019, 2018 or 2017.

At December 31, 2019 and 2018, there were no investments that exceeded 10% of shareholders' equity and no fixed maturity investments that did not produce income during the years then ended.

As of December 31, 2019 and 2018, we had committed approximately $999 and $873, respectively, to future capital calls from various third-party investments in exchange for an ownership interest in the related entities.

At December 31, 2019 and 2018, securities with carrying values of approximately $505 and $487, respectively, were deposited by our insurance subsidiaries under requirements of regulatory authorities.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

Securities Lending Programs

The fair value of the collateral received at the time of the securities lending transactions amounted to $351 and $604 at December 31, 2019 and 2018, respectively. The value of the collateral represented 103% and 102% of the market value of the securities on loan at December 31, 2019 and 2018, respectively.

The remaining contractual maturities of our securities lending transactions at December 31, 2019 is as follows:

	Overnight and Continuous
Securities lending transactions	
Cash	$ 291
United States Government securities	59
Other securities	1
Total	$ 351

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

5. Derivative Financial Instruments

We primarily invest in the following types of derivative financial instruments: interest rate swaps, futures, forward contracts, put and call options, swaptions, embedded derivatives and warrants. We also enter into master netting agreements which reduce credit risk by permitting net settlement of transactions. At December 31, 2019 we had received collateral of $22 related to our derivative financial instruments. As of December 31, 2018 we had posted collateral of $1 related to our derivative financial instruments.

A summary of the aggregate contractual or notional amounts and estimated fair values related to derivative financial instruments at December 31, 2019 and 2018 is as follows:

	Contractual/ Notional Amount	Balance Sheet Location	Estimated Fair Value	
			Asset	(Liability)
December 31, 2019				
Hedging instruments				
Interest rate swaps - fixed to floating	$ 1,200	Other assets/other liabilities	$ 22	$ (1)
Non-hedging instruments				
Interest rate swaps	1	Equity securities	—	—
Futures	134	Equity securities	1	—
Subtotal non-hedging	135	Subtotal non-hedging	1	—
Total derivatives	$ 1,335	Total derivatives	23	(1)
		Amounts netted	(1)	1
		Net derivatives	$ 22	$ —
December 31, 2018				
Hedging instruments				
Interest rate swaps - fixed to floating	$ 1,200	Other assets/other liabilities	$ 7	$ (11)
Non-hedging instruments				
Interest rate swaps	164	Equity securities	4	(1)
Options	100	Other assets/other liabilities	—	—
Futures	415	Equity securities	5	(5)
Subtotal non-hedging	679	Subtotal non-hedging	9	(6)
Total derivatives	$ 1,879	Total derivatives	16	(17)
		Amounts netted	(14)	14
		Net derivatives	$ 2	$ (3)

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

Fair Value Hedges

We have entered into various interest rate swap contracts to convert a portion of our interest rate exposure on our long-term debt from fixed rates to floating rates. The floating rates payable on all of our fair value hedges are benchmarked to the London Interbank Offered Rate, or LIBOR. A summary of our outstanding fair value hedges at December 31, 2019 and 2018 is as follows:

Type of Fair Value Hedges	Year Entered Into	Outstanding Notional Amount		Interest Rate Received	Expiration Date
		2019	2018		
Interest rate swap	2018	$ 50	$ 50	4.101 %	September 1, 2027
Interest rate swap	2018	450	450	3.300	January 15, 2023
Interest rate swap	2018	90	90	4.350	August 15, 2020
Interest rate swap	2017	50	50	4.350	August 15, 2020
Interest rate swap	2015	200	200	4.350	August 15, 2020
Interest rate swap	2014	150	150	4.350	August 15, 2020
Interest rate swap	2013	10	10	4.350	August 15, 2020
Interest rate swap	2012	200	200	4.350	August 15, 2020
Total notional amount outstanding		$ 1,200	$ 1,200		

The following amounts were recorded on our consolidated balance sheets related to cumulative basis adjustments for fair value hedges at December 31, 2019 and 2018:

Balance Sheet Classification in Which Hedged Item is Included	Carrying Amount of Hedged Liability		Cumulative Amount of Fair Value Hedging Adjustment Included in the Carrying Amount of the Hedged Liability	
	2019	2018	2019	2018
Current portion of long term-debt	$ 1,598	$ 849	$ 22	$ 7
Long-term debt	17,787	17,217	(1)	(11)

Cash Flow Hedges

We have entered into a series of forward starting pay fixed interest rate swaps with the objective of eliminating the variability of cash flows in the interest payments on anticipated future financings. During 2019, swaps in the notional amount of $425 were terminated. We paid an aggregate of $35 to the swap counter parties upon termination.

The unrecognized loss for all expired and terminated cash flow hedges included in accumulated other comprehensive loss, net of tax, was $262 and $246 at December 31, 2019 and 2018, respectively. As of December 31, 2019, the total amount of amortization over the next twelve months for all cash flow hedges is estimated to increase interest expense by approximately $15. No amounts were excluded from effectiveness testing.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

A summary of the effect of cash flow hedges in accumulated other comprehensive loss for the years ended December 31, 2019, 2018 and 2017 is as follows:

Type of Cash Flow Hedge	Hedge Loss Recognized in Other Comprehensive Income (Loss)	Income Statement Location of Loss Reclassification from Accumulated Other Comprehensive Loss	Hedge Loss Reclassified from Accumulated Other Comprehensive Loss
Year ended December 31, 2019			
Forward starting pay fixed swaps	$ (35)	Interest expense	$ (15)
Year ended December 31, 2018			
Forward starting pay fixed swaps	(33)	Interest expense	(14)
Year ended December 31, 2017			
Forward starting pay fixed swaps	(112)	Interest expense	(7)
Forward starting pay fixed swaps		Net realized gains (losses) on financial instruments	(7)

Income Statement Relationship of Fair Value and Cash Flow Hedging

A summary of the relationship between the effects of fair value and cash flow hedges on the total amount of income and expense presented in our consolidated statements of income for the years ended December 31, 2019, 2018 and 2017 is as follows:

	Classification and Amount of Gain (Loss) Recognized in Income on Fair Value and Cash Flow Hedging Relationships					
	2019		2018		2017	
	Net Realized Gains (Losses) on Financial Instruments	Interest Expense	Net Realized Gains (Losses) on Financial Instruments	Interest Expense	Net Realized Gains (Losses) on Financial Instruments	Interest Expense
Total amount of income or expense in the income statement in which the effects of fair value or cash flow hedges are recorded	$ 114	$ (746)	$ (180)	$ (753)	$ 145	$ (739)
Gain (loss) on fair value hedging relationships:						
Interest rate swaps:						
Hedged items	—	2	—	—	—	—
Derivatives designated as hedging instruments	—	(2)	—	—	—	—
Loss on cash flow hedging relationships:						
Forward starting pay fixed swaps:						
Amount of loss reclassified from accumulated other comprehensive loss into net income	—	(15)	—	(14)	—	(7)
Amount of loss reclassified from accumulated other comprehensive loss into net income due to ineffectiveness and missed forecasted transactions	—	—	—	—	(7)	—

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

Non-Hedging Derivatives

A summary of the effect of non-hedging derivatives on our consolidated statements of income for the years ended December 31, 2019, 2018 and 2017 is as follows:

Type of Non-hedging Derivatives	Income Statement Location of Gain (Loss) Recognized	Derivative Gain (Loss) Recognized
Year ended December 31, 2019		
Interest rate swaps	Net realized gains (losses) on financial instruments	$ 1
Options	Net realized gains (losses) on financial instruments	(8)
Futures	Net realized gains (losses) on financial instruments	(10)
Total		$ (17)
Year ended December 31, 2018		
Interest rate swaps	Net realized gains (losses) on financial instruments	$ 14
Options	Net realized gains (losses) on financial instruments	1
Futures	Net realized gains (losses) on financial instruments	8
Total		$ 23
Year ended December 31, 2017		
Interest rate swaps	Net realized gains (losses) on financial instruments	$ (9)
Options	Net realized gains (losses) on financial instruments	(36)
Futures	Net realized gains (losses) on financial instruments	(3)
Total		$ (48)

6. Fair Value

Assets and liabilities recorded at fair value in the consolidated balance sheets are categorized based upon the level of judgment associated with the inputs used to measure their fair value. Level inputs, as defined by FASB guidance for fair value measurements and disclosures, are as follows:

Level Input:	Input Definition:
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.
Level III	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date.

The following methods, assumptions and inputs were used to determine the fair value of each class of the following assets and liabilities recorded at fair value in the consolidated balance sheets:

Cash equivalents: Cash equivalents primarily consist of highly rated money market funds with maturities of three months or less, and are purchased daily at par value with specified yield rates. Due to the high ratings and short-term nature of the funds, we designate all cash equivalents as Level I.

Fixed maturity securities, available-for-sale: Fair values of available-for-sale fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third-party pricing services, which generally use Level I or Level II inputs for the determination of fair value to facilitate fair value measurements and disclosures. Level II securities primarily include corporate securities, securities from states, municipalities and political subdivisions, mortgage-backed securities, United States Government securities and certain other asset-backed securities. For securities not actively traded, the pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. We have controls

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

in place to review the pricing services' qualifications and procedures used to determine fair values. In addition, we periodically review the pricing services' pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. We also have certain fixed maturity securities, primarily corporate debt securities, that are designated Level III securities. For these securities, the valuation methodologies may incorporate broker quotes or discounted cash flow analyses using assumptions for inputs such as expected cash flows, benchmark yields, credit spreads, default rates and prepayment speeds that are not observable in the markets.

Equity securities: Fair values of equity securities are generally designated as Level I and are based on quoted market prices. For certain equity securities, quoted market prices for the identical security are not always available, and the fair value is estimated by reference to similar securities for which quoted prices are available. These securities are designated Level II. We also have certain equity securities, including private equity securities, for which the fair value is estimated based on each security's current condition and future cash flow projections. Such securities are designated Level III. The fair values of these private equity securities are generally based on either broker quotes or discounted cash flow projections using assumptions for inputs such as the weighted-average cost of capital, long-term revenue growth rates and earnings before interest, taxes, depreciation and amortization, and/or revenue multiples that are not observable in the markets.

Other invested assets, current: Other invested assets, current include securities held in rabbi trusts that are classified as trading. These securities are designated Level I securities, as fair values are based on quoted market prices.

Securities lending collateral: Fair values of securities lending collateral are based on quoted market prices, where available. These fair values are obtained primarily from third-party pricing services, which generally use Level I or Level II inputs for the determination of fair value, to facilitate fair value measurements and disclosures.

Derivatives: Fair values are based on the quoted market prices by the financial institution that is the counterparty to the derivative transaction. We independently verify prices provided by the counterparties using valuation models that incorporate market observable inputs for similar derivative transactions. Derivatives are designated as Level II securities.

In addition, the following methods and assumptions were used to determine the fair value of each class of pension benefit plan assets and other benefit plan assets not defined above (see Note 10, "Retirement Benefits," for fair values of benefit plan assets):

Mutual funds: Fair values are based on quoted market prices, which represent the net asset value, or NAV, of the shares held.

Common and collective trusts: Fair values of common/collective trusts that replicate traded money market funds are based on cost, which approximates fair value. Fair values of common/collective trusts that invest in securities are valued at the NAV of the shares held, where the trust applies fair value measurements to the underlying investments to determine the NAV.

Alternative investments: Fair values are estimated based on the plan's proportionate share of the undistributed partners' capital as reported in audited financial statements of the partnership.

Contract with insurance company: Fair value of the contract in the insurance company general investment account is determined by the insurance company based on the fair value of the underlying investments of the account.

Investment in DOL 103-12 trust: Fair value is based on the plan's proportionate share of the fair value of investments held by the trust, qualified as a Department of Labor Regulation 2520.103-12 entity, or DOL 103-12 trust, as reported in the audited financial statements of the trust, where the trustee applies fair value measurements to the underlying investments of the trust.

Life insurance contracts: Fair value is based on the cash surrender value of the policies as reported by the insurer.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

A summary of fair value measurements by level for assets and liabilities measured at fair value on a recurring basis at December 31, 2019 and 2018 is as follows:

	Level I	Level II	Level III	Total
December 31, 2019				
Assets:				
Cash equivalents	$ 2,015	$ —	$ —	$ 2,015
Fixed maturity securities, available-for-sale:				
United States Government securities	—	525	—	525
Government sponsored securities	—	141	—	141
States, municipalities and political subdivisions, tax-exempt	—	4,851	—	4,851
Corporate securities	—	8,882	303	9,185
Residential mortgage-backed securities	—	3,730	2	3,732
Commercial mortgage-backed securities	—	86	—	86
Other securities	—	1,654	7	1,661
Total fixed maturity securities, available-for-sale	—	19,869	312	20,181
Equity securities:				
Exchange traded funds	44	—	—	44
Fixed maturity mutual funds	—	643	—	643
Common equity securities	236	31	—	267
Private equity securities	—	—	85	85
Total equity securities	280	674	85	1,039
Other invested assets, current	13	—	—	13
Securities lending collateral	—	353	—	353
Derivatives	—	23	—	23
Total assets	$ 2,308	$ 20,919	$ 397	$ 23,624
Liabilities:				
Derivatives	$ —	$ (1)	$ —	$ (1)
Total liabilities	$ —	$ (1)	$ —	$ (1)
December 31, 2018				
Assets:				
Cash equivalents	$ 1,815	$ —	$ —	$ 1,815
Fixed maturity securities, available-for-sale:				
United States Government securities	—	416	—	416
Government sponsored securities	—	108	—	108
States, municipalities and political subdivisions, tax-exempt	—	4,785	—	4,785
Corporate securities	2	7,648	287	7,937
Residential mortgage-backed securities	—	2,744	6	2,750
Commercial mortgage-backed securities	—	67	—	67
Other securities	—	1,099	17	1,116
Total fixed maturity securities, available-for-sale	2	16,867	310	17,179
Equity securities:				
Exchange traded funds	2	—	—	2
Fixed maturity mutual funds	—	557	—	557
Common equity securities	601	53	—	654
Private equity securities	—	—	313	313
Total equity securities	603	610	313	1,526
Other invested assets, current	21	—	—	21
Securities lending collateral	314	290	—	604
Derivatives	—	16	—	16
Total assets	$ 2,755	$ 17,783	$ 623	$ 21,161
Liabilities:				
Derivatives	$ —	$ (17)	$ —	$ (17)
Total liabilities	$ —	$ (17)	$ —	$ (17)

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level III inputs for the years ended December 31, 2019, 2018 and 2017 is as follows:

	Corporate Securities	Residential Mortgage-backed Securities	Other Securities	Equity Securities	Total
Year ended December 31, 2019					
Beginning balance at January 1, 2019	$ 287	$ 6	$ 17	$ 313	$ 623
Total gains (losses):					
Recognized in net income	(7)	—	—	(6)	(13)
Recognized in accumulated other comprehensive loss	3	—	—	—	3
Purchases	122	—	2	65	189
Sales	(22)	—	—	(79)	(101)
Settlements	(71)	(2)	(6)	—	(79)
Transfers into Level III	—	—	3	2	5
Transfers out of Level III	(9)	(2)	(9)	(210)	(230)
Ending balance at December 31, 2019	$ 303	$ 2	$ 7	$ 85	$ 397
Change in unrealized losses included in net income related to assets still held at December 31, 2019	$ —	$ —	$ —	$ 6	$ 6
Year ended December 31, 2018					
Beginning balance at January 1, 2018	$ 229	$ 5	$ 16	$ 287	$ 537
Total (losses) gains:					
Recognized in net income	1	—	—	(229)	(228)
Recognized in accumulated other comprehensive loss	(5)	—	—	—	(5)
Purchases	120	2	18	290	430
Sales	(33)	—	(1)	(35)	(69)
Settlements	(88)	(1)	(10)	—	(99)
Transfers into Level III	65	—	9	—	74
Transfers out of Level III	(2)	—	(15)	—	(17)
Ending balance at December 31, 2018	$ 287	$ 6	$ 17	$ 313	$ 623
Change in unrealized losses included in net income related to assets still held at December 31, 2018	$ —	$ —	$ —	$ 30	$ 30
Year ended December 31, 2017					
Beginning balance at January 1, 2017	$ 239	$ 11	$ 43	$ 188	$ 481
Total (losses) gains:					
Recognized in net income	(1)	—	—	—	(1)
Recognized in accumulated other comprehensive loss	3	—	—	11	14
Purchases	88	4	36	89	217
Sales	(48)	(5)	(1)	(1)	(55)
Settlements	(64)	(2)	(7)	—	(73)
Transfers into Level III	15	3	15	—	33
Transfers out of Level III	(3)	(6)	(70)	—	(79)
Ending balance at December 31, 2017	$ 229	$ 5	$ 16	$ 287	$ 537
Change in unrealized losses included in net income related to assets still held at December 31, 2017	$ (3)	$ —	$ —	$ —	$ (3)

There were no individually material transfers into or out of Level III during the years ended December 31, 2019, 2018 or 2017.

Our valuation policy is determined by members of our treasury and accounting departments. Whenever possible, our policy is to obtain quoted market prices in active markets to estimate fair values for recognition and disclosure purposes. Where quoted market prices in active markets are not available, fair values are estimated using discounted cash flow analyses, broker quotes or other valuation techniques. These techniques are significantly affected by our assumptions,

including discount rates and estimates of future cash flows. Potential taxes and other transaction costs are not considered in estimating fair values. Our valuation policy is generally to obtain quoted prices for each security from third-party pricing services, which are derived through recently reported trades for identical or similar securities making adjustments through the reporting date based upon available market observable information. As we are responsible for the determination of fair value, we perform analysis on the prices received from the pricing services to determine whether the prices are reasonable estimates of fair value. This analysis is performed by our internal treasury personnel who are familiar with our investment portfolios, the pricing services engaged and the valuation techniques and inputs used. Our analysis includes procedures such as a review of month-to-month price fluctuations and price comparisons to secondary pricing services. There were no adjustments to quoted market prices obtained from the pricing services during the years ended December 31, 2019, 2018 or 2017.

Certain assets and liabilities are measured at fair value on a nonrecurring basis; that is, the instruments are not measured at fair value on an ongoing basis but are subject to fair value adjustments only in certain circumstances. As disclosed in Note 3, "Business Acquisitions," we completed our acquisition of America's 1st Choice on February 15, 2018. The net assets acquired in our acquisition of America's 1st Choice and resulting goodwill and other intangible assets were recorded at fair value primarily using Level III inputs. The majority of America's 1st Choice assets acquired and liabilities assumed were recorded at their carrying values as of the respective date of acquisition, as their carrying values approximated their fair values due to their short-term nature. The fair values of goodwill and other intangible assets acquired in our acquisition of America's 1st Choice were internally estimated based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets could be expected to generate in the future. We developed internal estimates for the expected cash flows and discount rate in the present value calculation. Other than the assets acquired and liabilities assumed in our acquisition of America's 1st Choice described above, there were no other material assets or liabilities measured at fair value on a nonrecurring basis during the years ended December 31, 2019 or 2018.

In addition to the preceding disclosures on assets recorded at fair value in the consolidated balance sheets, FASB guidance also requires the disclosure of fair values for certain other financial instruments for which it is practicable to estimate fair value, whether or not such values are recognized in the consolidated balance sheets.

Non-financial instruments such as real estate, property and equipment, other current assets, deferred income taxes, intangible assets and certain financial instruments, such as policy liabilities, are excluded from the fair value disclosures. Therefore, the fair value amounts cannot be aggregated to determine our underlying economic value.

The carrying amounts reported in the consolidated balance sheets for cash, accrued investment income, premium receivables, self-funded receivables, other receivables, income taxes receivable, unearned income, accounts payable and accrued expenses, security trades pending payable, securities lending payable and certain other current liabilities approximate fair value because of the short-term nature of these items. These assets and liabilities are not listed in the table below.

The following methods and assumptions were used to estimate the fair value of each class of financial instrument that is recorded at its carrying value on the consolidated balance sheets:

Other invested assets, long-term: Other invested assets, long-term primarily include our investments in limited partnerships, joint ventures and other non-controlled corporations, as well as the cash surrender value of corporate-owned life insurance policies. Investments in limited partnerships, joint ventures and other non-controlled corporations are carried at our share in the entities' undistributed earnings, which approximates fair value. The carrying value of corporate-owned life insurance policies represents the cash surrender value as reported by the respective insurer, which approximates fair value.

Short-term borrowings: The fair value of our short-term borrowings is based on quoted market prices for the same or similar debt, or if no quoted market prices were available, on the current market interest rates estimated to be available to us for debt of similar terms and remaining maturities.

Long-term debt - commercial paper: The carrying amount for commercial paper approximates fair value, as the underlying instruments have variable interest rates at market value.

Long-term debt - senior unsecured notes and surplus notes: The fair values of our notes are based on quoted market prices in active markets for the same or similar debt, or, if no quoted market prices are available, on the current market observable rates estimated to be available to us for debt of similar terms and remaining maturities.

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Notes to Consolidated Financial Statements (continued)

Long-term debt—convertible debentures: The fair value of our convertible debentures is based on the quoted market price in the active private market in which the convertible debentures trade.

A summary of the estimated fair values by level of each class of financial instrument that is recorded at its carrying value on our consolidated balance sheets at December 31, 2019 and 2018 is as follows:

	Carrying Value	Estimated Fair Value			
		Level I	Level II	Level III	Total
December 31, 2019					
Assets:					
Other invested assets, long-term	$ 4,228	$ —	$ —	$ 4,228	$ 4,228
Liabilities:					
Debt:					
Short-term borrowings	700	—	700	—	700
Commercial paper	400	—	400	—	400
Notes	18,840	—	20,470	—	20,470
Convertible debentures	145	—	904	—	904
December 31, 2018					
Assets:					
Other invested assets, long-term	$ 3,726	$ —	$ —	$ 3,726	$ 3,726
Liabilities:					
Debt:					
Short-term borrowings	1,145	—	1,145	—	1,145
Commercial paper	697	—	697	—	697
Notes	17,178	—	17,145	—	17,145
Convertible debentures	191	—	1,030	—	1,030

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Notes to Consolidated Financial Statements (continued)

7. Income Taxes

The components of deferred income taxes at December 31, 2019 and 2018 are as follows:

	2019	2018
Deferred tax assets relating to:		
Retirement benefits	$ 211	$ 226
Accrued expenses	280	301
Insurance reserves	114	96
Net operating loss carryforwards	4	7
Bad debt reserves	82	104
State income tax	11	32
Deferred compensation	22	20
Unrealized losses on securities	—	41
Other	77	72
Total deferred tax assets	801	899
Deferred tax liabilities relating to:		
Investment basis difference	78	52
Unrealized gains on securities	153	—
Intangible assets:		
Trademarks and state Medicaid licenses	1,529	1,529
Customer, provider and hospital relationships	239	290
Internally developed software and other amortization differences	528	461
Retirement benefits	194	183
Debt discount	19	27
State deferred tax	77	105
Depreciation and amortization	48	47
Other	163	165
Total deferred tax liabilities	3,028	2,859
Net deferred tax liability	$ 2,227	$ 1,960

Included as a component of the state deferred tax liabilities above is a net valuation allowance for states net operating losses of $45 and $95, respectively, at December 31, 2019 and 2018.

Significant components of the provision for income taxes for the years ended December 31, 2019, 2018 and 2017 consist of the following:

	2019	2018	2017
Current tax expense:			
Federal	$ 1,019	$ 1,128	$ 1,356
State and local	84	78	39
Total current tax expense	1,103	1,206	1,395
Deferred tax expense (benefit)	75	112	(1,274)
Total income tax expense	$ 1,178	$ 1,318	$ 121

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

State and local current tax expense is reported gross of federal benefit, and includes amounts related to audit settlements, uncertain tax positions, state tax credits and true up of prior years' tax. Such items are included in multiple lines in the following rate reconciliation table on a net of federal tax basis.

A reconciliation of income tax expense recorded in the consolidated statements of income and amounts computed at the statutory federal income tax rate for the years ended December 31, 2019, 2018 and 2017 is as follows:

	2019		2018		2017	
	Amount	Percent	Amount	Percent	Amount	Percent
Amount at statutory rate	$ 1,257	21.0%	$ 1,064	21.0%	$ 1,387	35.0%
State and local income taxes net of federal tax expense/benefit	138	2.3	63	1.2	(2)	(0.1)
Tax exempt interest and dividends received deduction	(24)	(0.4)	(27)	(0.5)	(58)	(1.4)
HIP Fee	—	—	324	6.4	—	—
Tax Cuts and Jobs Act	—	—	(28)	(0.6)	(1,108)	(27.9)
Other, net	(193)	(3.2)	(78)	(1.5)	(98)	(2.5)
Total income tax expense	$ 1,178	19.7%	$ 1,318	26.0%	$ 121	3.1%

During the year ended December 31, 2018, we recognized income tax expense of $324, or $1.23 per diluted share, as a result of the non-tax deductibility of the HIP Fee payment. On December 22, 2017, the federal government enacted the Tax Cuts and Jobs Act, which contains significant changes to corporate taxation, including, but not limited to, reducing the U.S. federal corporate income tax rate from 35% to 21% and modifying or limiting many business deductions. At December 31, 2018, we completed our accounting for the tax effects of enactment of the Tax Cuts and Jobs Act and there was no material change to our 2017 provisional amount. In addition we reclassified, for our interim and annual reporting periods beginning on January 1, 2018, $91 of stranded tax effects from accumulated other comprehensive loss to retained earnings on our consolidated balance sheets.

During the year ended December 31, 2017, we recognized an income tax benefit of $1,108, or $4.14 per diluted share, as a result of the provisional amount recorded related to the remeasurement of our deferred tax balance as a result of the enactment of the Tax Cuts and Jobs Act. The HIP Fee payment was suspended for 2017.

The change in the carrying amount of gross unrecognized tax benefits from uncertain tax positions for the years ended December 31, 2019 and 2018 is as follows:

	2019	2018
Balance at January 1	$ 241	$ 190
Additions based on:		
Tax positions related to current year	1	35
Tax positions related to prior years	—	50
Reductions based on:		
Tax positions related to prior years	(63)	(31)
Settlements with taxing authorities	(33)	(3)
Balance at December 31	$ 146	$ 241

The table above excludes interest, net of related tax benefits, which is treated as income tax expense (benefit) under our accounting policy. The interest is included in the amounts described in the following paragraph.

The amount of unrecognized tax benefits that would impact our effective tax rate in future periods, if recognized, was $140 and $237 at December 31, 2019 and 2018, respectively. Also included in the table above, at December 31, 2019, is $2 that would be recognized as an adjustment to additional paid-in capital, which would not affect our effective tax rate. In

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

addition to the contingent liabilities included in the table above, during 2017 we filed protective state income tax refund claims of approximately $310. There were no equivalent protective state income tax refund claims filed in 2019 or 2018.

For the year ended December 31, 2019, tax loss contingencies recorded in a prior year were released; therefore, we recognized a net interest benefit of $11. For the years ended December 31, 2018 and 2017, we recognized a net interest expense of $15 and $3, respectively. We had accrued approximately $26 and $37 for the payment of interest at December 31, 2019 and 2018, respectively.

As of December 31, 2019, as further described below, certain tax years remain open to examination by the Internal Revenue Service, or IRS, and various state and local authorities. In addition, we continue to discuss certain industry issues with the IRS. As a result of these examinations and discussions, we have recorded amounts for uncertain tax positions. It is anticipated that the amount of unrecognized tax benefits will change in the next twelve months due to possible settlements of audits and changes in temporary items. However, the ultimate resolution of these items is dependent on the completion of negotiations with various taxing authorities. While it is difficult to determine when other tax settlements will actually occur, it is reasonably possible that one could occur in the next twelve months and our unrecognized tax benefits could change within a range of approximately $(9) to $(102).

We are a member of the IRS Compliance Assurance Process, or CAP. The objective of CAP is to reduce taxpayer burden and uncertainty while assuring the IRS of the accuracy of tax returns prior to filing, thereby reducing or eliminating the need for post-filing examinations.

As of December 31, 2019, the IRS examination of our 2019 and 2017 tax years continues to be in process.

In certain states, we pay premium taxes in lieu of state income taxes. Premium taxes are reported in selling, general and administrative expense.

At December 31, 2019, we had unused federal tax net operating loss carryforwards of approximately $8 to offset future taxable income. The loss carryforwards expire in the years 2032 through 2037. During 2019, 2018 and 2017, federal income taxes paid totaled $1,403, $738 and $1,503, respectively.

8. Property and Equipment

A summary of property and equipment at December 31, 2019 and 2018 is as follows:

	2019	2018
Computer software, purchased and internally developed	$ 4,314	$ 3,532
Computer equipment, furniture and other equipment	1,264	1,266
Leasehold improvements	715	563
Building and improvements	169	169
Land and improvements	17	18
Property and equipment, gross	6,479	5,548
Accumulated depreciation and amortization	(3,346)	(2,813)
Property and equipment, net	$ 3,133	$ 2,735

Depreciation expense for 2019, 2018 and 2017 was $147, $124 and $111, respectively. Amortization expense on computer software and leasehold improvements for 2019, 2018 and 2017 was $528, $528 and $490, respectively, which includes amortization expense on computer software, both purchased and internally developed, for 2019, 2018 and 2017 of $450, $465 and $435, respectively. Capitalized costs related to the internal development of software of $3,939 and $3,226 at December 31, 2019 and 2018, respectively, are reported with computer software.

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Notes to Consolidated Financial Statements (continued)

9. Goodwill and Other Intangible Assets

A summary of the change in the carrying amount of goodwill for our segments (see Note 19, "Segment Information") for 2019 and 2018 is as follows:

	Commercial and Specialty Business	Government Business	Other	Total
Balance as of January 1, 2018	$ 11,818	$ 7,402	$ 11	$ 19,231
Acquisitions	—	1,285	—	1,285
Adjustments	(267)	266	(11)	(12)
Balance as of December 31, 2018	11,551	8,953	—	20,504
Adjustments	—	(674)	670	(4)
Balance as of December 31, 2019	$ 11,551	$ 8,279	$ 670	$ 20,500
Accumulated impairment as of December 31, 2019	$ (41)	$ —	$ —	$ (41)

The increase in goodwill in 2018 was primarily due to the acquisition of America's 1st Choice in February 2018. For additional information regarding this acquisition, see Note 3, "Business Acquisitions".

Goodwill adjustments in 2019 include certain reclassifications made for changes in segment reporting. The adjustments in 2018 include measurement period adjustments for HealthSun as well as certain reclassifications made for changes in segment reporting. For additional information, see Note 19, "Segment Information".

As required by FASB guidance, we completed annual impairment tests of existing goodwill and other intangible assets with indefinite lives during 2019, 2018 and 2017. We perform these annual impairment tests during the fourth quarter. FASB guidance also requires interim impairment testing to be performed when potential impairment indicators exist. These tests involve the use of estimates related to the fair value of goodwill and intangible assets with indefinite lives and require a significant degree of management judgment and the use of subjective assumptions. Qualitative testing procedures include assessing our financial performance, macroeconomic conditions, industry and market considerations, various asset specific factors and entity specific events. For quantitative testing, the fair values are estimated using the projected income and market valuation approaches, incorporating Level III internal estimates for inputs, including, but not limited to, revenue projections, income projections, cash flows and discount rates. We did not incur any impairment losses in 2019, 2018 or 2017, as the estimated fair values of our reporting units were substantially in excess of their carrying values.

The components of other intangible assets as of December 31, 2019 and 2018 are as follows:

	2019			2018		
	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
Intangible assets with finite lives:						
Customer relationships	$ 4,500	$ (3,469)	$ 1,031	$ 4,495	$ (3,185)	$ 1,310
Provider and hospital relationships	228	(98)	130	228	(85)	143
Other	352	(129)	223	352	(88)	264
Total	5,080	(3,696)	1,384	5,075	(3,358)	1,717
Intangible assets with indefinite lives:						
Blue Cross and Blue Shield and other trademarks	6,299	—	6,299	6,299	—	6,299
State Medicaid licenses	991	—	991	991	—	991
Total	7,290	—	7,290	7,290	—	7,290
Other intangible assets	$ 12,370	$ (3,696)	$ 8,674	$ 12,365	$ (3,358)	$ 9,007

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Notes to Consolidated Financial Statements (continued)

As of December 31, 2019, the estimated amortization expense for each of the five succeeding years is as follows: 2020, $290; 2021, $244; 2022, $195; 2023, $162; and 2024, $85.

10. Retirement Benefits

We sponsor various non-contributory employee defined benefit plans through certain subsidiaries.

The Anthem Cash Balance Plan A and the Anthem Cash Balance Plan B are cash balance pension plans covering certain eligible employees of the affiliated companies that participate in these plans. Effective January 1, 2006, benefits were curtailed, with the result that most participants stopped accruing benefits but continue to earn interest on benefits accrued prior to the curtailment. Certain participants subject to collective bargaining and certain other participants who met grandfathering rules continued to accrue benefits. Participants who did not receive credits and/or benefit accruals were included in the Anthem Cash Balance Plan A, while employees who were still receiving credits and/or benefits participated in the Anthem Cash Balance Plan B. Effective January 1, 2019, benefits under the Anthem Cash Balance Plan B were curtailed. All grandfathered participants no longer have pay credits added to their accounts but continue to earn interest on existing account balances. Participants continue to earn years of pension service for vesting purposes. Several pension plans acquired through various corporate mergers and acquisitions were merged into these plans in prior years.

The Employees' Retirement Plan of Blue Cross of California, or the BCC Plan, is a defined benefit pension plan that covers eligible employees of Blue Cross of California who are covered by a collective bargaining agreement. Effective January 1, 2007, benefits were curtailed under the BCC Plan with the result that no Blue Cross of California employees hired or rehired after December 31, 2006 are eligible to participate in the BCC Plan.

All of the plans' assets consist primarily of equity securities, fixed maturity securities, investment funds and cash. The funding policies for all plans are to contribute amounts at least sufficient to meet the minimum funding requirements set forth in the Employee Retirement Income Security Act of 1974, as amended, or ERISA, as amended by the Pension Protection Act of 2006, and in accordance with income tax regulations, plus such additional amounts as are necessary to provide assets sufficient to meet the benefits to be paid to plan participants.

We use a December 31 measurement date for determining benefit obligations and the fair value of plan assets.

The following tables disclose consolidated "pension benefits," which include the defined benefit pension plans described above, and consolidated "other benefits," which include postretirement health and welfare benefits including medical, vision and dental benefits offered to certain employees. Calculations were computed using assumptions at the December 31 measurement dates.

The reconciliation of the benefit obligation is as follows:

	Pension Benefits		Other Benefits	
	2019	2018	2019	2018
Benefit obligation at beginning of year	$ 1,743	$ 1,872	$ 431	$ 524
Service cost	—	8	1	1
Interest cost	62	55	15	15
Actuarial loss (gain)	200	(70)	5	(57)
Benefits paid	(125)	(122)	(29)	(52)
Benefit obligation at end of year	$ 1,880	$ 1,743	$ 423	$ 431

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Notes to Consolidated Financial Statements (continued)

The changes in the fair value of plan assets are as follows:

	Pension Benefits		Other Benefits	
	2019	2018	2019	2018
Fair value of plan assets at beginning of year	$ 1,818	$ 2,012	$ 336	$ 356
Actual return on plan assets	329	(76)	55	(17)
Employer contributions	4	4	5	49
Benefits paid	(125)	(122)	(29)	(52)
Fair value of plan assets at end of year	$ 2,026	$ 1,818	$ 367	$ 336

The net amount included in the consolidated balance sheets is as follows:

	Pension Benefits		Other Benefits	
	2019	2018	2019	2018
Noncurrent assets	$ 212	$ 134	$ —	$ —
Current liabilities	(6)	(6)	—	—
Noncurrent liabilities	(60)	(53)	(56)	(95)
Net amount at December 31	$ 146	$ 75	$ (56)	$ (95)

The net amounts included in accumulated other comprehensive loss that have not been recognized as components of net periodic benefit costs are as follows:

	Pension Benefits		Other Benefits	
	2019	2018	2019	2018
Net actuarial loss	$ 734	$ 751	$ 25	$ 58
Prior service cost (credit)	1	1	(19)	(34)
Net amount before tax at December 31	$ 735	$ 752	$ 6	$ 24

The estimated net actuarial loss and prior service cost for the defined benefit pension plans that will be reclassified from accumulated other comprehensive loss into net periodic benefit costs over the next year are $22 and $0, respectively. The estimated net actuarial loss and prior service credit for postretirement benefit plans that will be reclassified from accumulated other comprehensive loss into net periodic benefit costs over the next year are $0 and $7, respectively.

The accumulated benefit obligation for the defined benefit pension plans was $1,878 and $1,742 at December 31, 2019 and 2018, respectively.

As of December 31, 2019, certain pension plans had accumulated benefit obligations in excess of plan assets. For those same plans, the projected benefit obligation was also in excess of plan assets. Such plans had a combined projected benefit obligation, accumulated benefit obligation and fair value of plan assets of $104, $102 and $39, respectively.

The weighted-average assumptions used in calculating the benefit obligations for all plans are as follows:

	Pension Benefits		Other Benefits	
	2019	2018	2019	2018
Discount rate	3.11%	4.15%	2.93%	4.04%
Rate of compensation increase	3.00%	3.00%	3.00%	3.00%
Expected rate of return on plan assets	7.33%	7.44%	7.00%	7.00%

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Notes to Consolidated Financial Statements (continued)

The components of net periodic benefit credit included in the consolidated statements of income are as follows:

	2019	2018	2017
Pension Benefits			
Service cost	$ —	$ 8	$ 10
Interest cost	62	55	66
Expected return on assets	(138)	(147)	(147)
Recognized actuarial loss	17	22	22
Settlement loss	9	5	7
Net periodic benefit credit	$ (50)	$ (57)	$ (42)
Other Benefits			
Service cost	$ 1	$ 1	$ 1
Interest cost	15	15	21
Expected return on assets	(22)	(24)	(23)
Recognized actuarial loss	2	3	11
Amortization of prior service credit	(12)	(12)	(13)
Net periodic benefit credit	$ (16)	$ (17)	$ (3)

During the years ended December 31, 2019, 2018 and 2017, we incurred total settlement losses of $9, $5 and $7, respectively, as lump-sum payments exceeded the service cost and interest cost components of net periodic benefit cost for certain of our plans.

The weighted-average assumptions used in calculating the net periodic benefit cost for all plans are as follows:

	2019	2018	2017
Pension Benefits			
Discount rate	4.15%	3.44%	3.77%
Rate of compensation increase	3.00%	3.00%	3.00%
Expected rate of return on plan assets	7.44%	7.83%	7.95%
Other Benefits			
Discount rate	4.04%	3.42%	3.82%
Rate of compensation increase	3.00%	3.00%	3.00%
Expected rate of return on plan assets	7.00%	7.00%	7.00%

The assumed healthcare cost trend rates used to measure the expected cost of pre-Medicare (those who are not currently eligible for Medicare benefits) other benefits at our December 31, 2019 measurement date was 7.00% for 2020 with a gradual decline to 4.50% by the year 2028. The assumed healthcare cost trend rates used to measure the expected cost of post-Medicare (those who are currently eligible for Medicare benefits) other benefits at our December 31, 2019 measurement date was 6.00% for 2020 with a gradual decline to 4.50% by the year 2028. These estimated trend rates are subject to change in the future. The healthcare cost trend rate assumption affects the amounts reported. For example, an increase in the assumed healthcare cost trend rate of one percentage point would increase the postretirement benefit obligation as of December 31, 2019 by $23 and would increase service and interest costs by $1. Conversely, a decrease in the assumed healthcare cost trend rate of one percentage point would decrease the postretirement benefit obligation as of December 31, 2019 by $20 and would decrease service and interest costs by $1.

Plan assets include a diversified mix of equity securities, investment grade fixed maturity securities and other types of investments across a range of sectors and levels of capitalization to maximize long-term return for a prudent level of risk. The

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Notes to Consolidated Financial Statements (continued)

weighted-average target allocation for pension benefit plan assets is 44% equity securities, 48% fixed maturity securities, and 8% to all other types of investments. Equity securities primarily include a mix of domestic securities, foreign securities and mutual funds invested in equities. Fixed maturity securities primarily include treasury securities, corporate bonds and asset-backed investments issued by corporations and the U.S. government. Other types of investments primarily include insurance contracts designed specifically for employee benefit plans and partnership interests, collective trusts that replicate money market funds and insurance contracts designed specifically for employee benefit plans. As of December 31, 2019, there were no significant concentrations of investments in the pension benefit assets or other benefit assets. No plan assets were invested in Anthem common stock.

Pension benefit assets and other benefit assets recorded at fair value are categorized based upon the level of judgment associated with the inputs used to measure their fair value.

The fair values of our pension benefit assets and other benefit assets by asset category and level inputs at December 31, 2019, excluding cash, investment income receivable and amounts due to/from brokers, resulting in a net asset of $64, are as follows (see Note 6, "Fair Value," for additional information regarding the definition of level inputs):

	Level I	Level II	Level III	Total
December 31, 2019				
Pension Benefit Assets:				
Equity securities:				
U.S. securities	$ 626	$ —	$ —	$ 626
Foreign securities	197	—	—	197
Mutual funds	38	—	—	38
Fixed maturity securities:				
Government securities	—	252	—	252
Corporate securities	—	339	—	339
Asset-backed securities	—	163	—	163
Other types of investments:				
Alternative investments	—	136	52	188
Insurance company contracts	—	—	175	175
Total pension benefit assets	$ 861	$ 890	$ 227	$ 1,978
Other Benefit Assets:				
Equity securities:				
U.S. securities	$ 8	$ —	$ —	$ 8
Foreign securities	2	—	—	2
Mutual funds	25	—	—	25
Fixed maturity securities:				
Government securities	—	2	—	2
Corporate securities	—	4	—	4
Asset-backed securities	—	3	—	3
Other types of investments:				
Alternative investments	—	1	—	1
Life insurance contracts	—	—	294	294
Investment in DOL 103-12 trust	—	12	—	12
Total other benefit assets	$ 35	$ 22	$ 294	$ 351

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Notes to Consolidated Financial Statements (continued)

The fair values of our pension benefit assets and other benefit assets by asset category and level inputs at December 31, 2018, excluding cash, investment income receivable and amounts due to/from brokers, resulting in a net asset of $69, are as follows:

	Level I	Level II	Level III	Total
December 31, 2018				
Pension Benefit Assets:				
Equity securities:				
U.S. securities	$ 488	$ —	$ —	$ 488
Foreign securities	147	—	—	147
Mutual funds	36	—	—	36
Fixed maturity securities:				
Government securities	—	248	—	248
Corporate securities	—	347	—	347
Asset-backed securities	—	153	—	153
Other types of investments:				
Alternative investments	—	—	187	187
Insurance company contracts	—	—	166	166
Total pension benefit assets	$ 671	$ 748	$ 353	$ 1,772
Other Benefit Assets:				
Equity securities:				
U.S. securities	$ 9	$ —	$ —	$ 9
Foreign securities	3	—	—	3
Mutual funds	27	—	—	27
Fixed maturity securities:				
Government securities	—	3	—	3
Corporate securities	—	5	—	5
Asset-backed securities	—	5	—	5
Other types of investments:				
Alternative investments	—	—	2	2
Life insurance contracts	—	—	249	249
Investment in DOL 103-12 trust	—	10	—	10
Total other benefit assets	$ 39	$ 23	$ 251	$ 313

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Notes to Consolidated Financial Statements (continued)

A reconciliation of the beginning and ending balances of plan assets measured at fair value using Level III inputs for the years ended December 31, 2019, 2018 and 2017 is as follows:

	Alternative Investments	Insurance Company Contracts	Life Insurance Contracts	Total
Year ended December 31, 2019				
Beginning balance at January 1, 2019	$ 189	$ 166	$ 249	$ 604
Actual return on plan assets relating to assets still held at the reporting date	28	12	45	85
Purchases	24	6	—	30
Sales	(52)	(9)	—	(61)
Transfers out of Level III	(137)	—	—	(137)
Ending balance at December 31, 2019	$ 52	$ 175	$ 294	$ 521
Year ended December 31, 2018				
Beginning balance at January 1, 2018	$ 221	$ 173	$ 269	$ 663
Actual return on plan assets relating to assets still held at the reporting date	(10)	(7)	(15)	(32)
Purchases	—	8	—	8
Sales	(22)	(8)	(5)	(35)
Ending balance at December 31, 2018	$ 189	$ 166	$ 249	$ 604
Year ended December 31, 2017				
Beginning balance at January 1, 2017	$ 114	$ 173	$ 238	$ 525
Actual return on plan assets relating to assets still held at the reporting date	20	(1)	31	50
Purchases	126	10	—	136
Sales	(39)	(9)	—	(48)
Ending balance at December 31, 2017	$ 221	$ 173	$ 269	$ 663

During 2019, we transferred one of our alternative investments from Level III to Level II based on the inputs used to measure fair value. There were no other transfers into or out of Level III during the years ended December 31, 2019, 2018 or 2017.

Our current funding strategy is to fund an amount at least equal to the minimum required funding as determined under ERISA with consideration of maximum tax deductible amounts. We may elect to make discretionary contributions up to the maximum amount deductible for income tax purposes. For the years ended December 31, 2019, 2018 and 2017, no material contributions were necessary to meet ERISA required funding levels. However, during each of the years ended December 31, 2019, 2018 and 2017, we made tax deductible discretionary contributions to the pension benefit plans of $4. Employer contributions to other benefit plans represent discretionary contributions and do not include payments to retirees for current benefits.

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Notes to Consolidated Financial Statements (continued)

Our estimated future payments for pension benefits and postretirement benefits, which reflect expected future service, as appropriate, are as follows:

	Pension Benefits	Other Benefits
2020	$ 126	$ 37
2021	126	36
2022	127	35
2023	124	34
2024	120	33
2025 - 2029	567	140

In addition to the defined benefit plans, we maintain the Anthem 401(k) Plan, which is a qualified defined contribution plan covering substantially all employees. Voluntary employee contributions are matched by us subject to certain limitations. Contributions made by us totaled $201, $211 and $142 during 2019, 2018 and 2017, respectively. Contributions in 2018 include approximately $58 for a one time contribution made to employees following the enactment of the Tax Cuts and Jobs Act.

11. Medical Claims Payable

A reconciliation of the beginning and ending balances for medical claims payable, by segment (see Note 19, “Segment Information”), for the year ended December 31, 2019 is as follows:

	Commercial & Specialty Business	Government Business	Total
Gross medical claims payable, beginning of year	$ 2,586	$ 4,680	$ 7,266
Ceded medical claims payable, beginning of year	(10)	(24)	(34)
Net medical claims payable, beginning of year	2,576	4,656	7,232
Net incurred medical claims:			
Current year	25,942	52,753	78,695
Prior years redundancies	(190)	(310)	(500)
Total net incurred medical claims	25,752	52,443	78,195
Net payments attributable to:			
Current year medical claims	23,026	47,268	70,294
Prior years medical claims	2,277	4,242	6,519
Total net payments	25,303	51,510	76,813
Net medical claims payable, end of year	3,025	5,589	8,614
Ceded medical claims payable, end of year	14	19	33
Gross medical claims payable, end of year	$ 3,039	$ 5,608	$ 8,647

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Notes to Consolidated Financial Statements (continued)

A reconciliation of the beginning and ending balances for medical claims payable, by segment, for the year ended December 31, 2018 is as follows:

	Commercial & Specialty Business	Government Business	Total
Gross medical claims payable, beginning of year	$ 3,383	$ 4,431	$ 7,814
Ceded medical claims payable, beginning of year	(78)	(27)	(105)
Net medical claims payable, beginning of year	3,305	4,404	7,709
Business combinations and purchase adjustments	—	199	199
Net incurred medical claims:			
Current year	24,094	45,487	69,581
Prior years redundancies	(456)	(474)	(930)
Total net incurred medical claims	23,638	45,013	68,651
Net payments attributable to:			
Current year medical claims	21,633	41,115	62,748
Prior years medical claims	2,734	3,845	6,579
Total net payments	24,367	44,960	69,327
Net medical claims payable, end of year	2,576	4,656	7,232
Ceded medical claims payable, end of year	10	24	34
Gross medical claims payable, end of year	$ 2,586	$ 4,680	$ 7,266

A reconciliation of the beginning and ending balances for medical claims payable, by segment, for the year ended December 31, 2017 is as follows:

	Commercial & Specialty Business	Government Business	Total
Gross medical claims payable, beginning of year	$ 3,247	$ 4,409	$ 7,656
Ceded medical claims payable, beginning of year	(521)	(18)	(539)
Net medical claims payable, beginning of year	2,726	4,391	7,117
Business combinations and purchase adjustments	—	76	76
Net incurred medical claims:			
Current year	29,467	40,910	70,377
Prior years redundancies	(462)	(671)	(1,133)
Total net incurred medical claims	29,005	40,239	69,244
Net payments attributable to:			
Current year medical claims	26,250	36,673	62,923
Prior years medical claims	2,176	3,629	5,805
Total net payments	28,426	40,302	68,728
Net medical claims payable, end of year	3,305	4,404	7,709
Ceded medical claims payable, end of year	78	27	105
Gross medical claims payable, end of year	$ 3,383	$ 4,431	$ 7,814

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any period-end are continually reviewed and re-estimated as information regarding actual claims payments, or runout, becomes known. This information is compared to the originally established year end liability. Negative amounts reported for incurred medical claims related to prior years result from claims being settled for amounts less than originally

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

estimated. The prior year redundancy of $500 shown above for the year ended December 31, 2019 represents an estimate based on paid claim activity from January 1, 2019 to December 31, 2019. Medical claim liabilities are usually described as having a "short tail," which means that they are generally paid within twelve months of the member receiving service from the provider. Accordingly, the majority of the $500 redundancy relates to claims incurred in calendar year 2018.

The following table provides a summary of the two key assumptions having the most significant impact on our incurred but not paid liability estimates for the years ended December 31, 2019, 2018 and 2017, which are the completion and trend factors. These two key assumptions can be influenced by utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations.

	Favorable Developments by Changes in Key Assumptions		
	2019	2018	2017
Assumed trend factors	$ (325)	$ (515)	$ (631)
Assumed completion factors	(175)	(415)	(502)
Total	$ (500)	$ (930)	$ (1,133)

The favorable development recognized in 2019 resulted primarily from trend factors in late 2018 developing more favorably than originally expected as well as a smaller but significant contribution from completion factor development.

The favorable development recognized in 2018 and 2017 resulted from trend and completion factors developing more favorably than originally expected.

The reconciliation of net incurred medical claims to benefit expense included in the consolidated statements of income is as follows:

	Years Ended December 31		
	2019	2018	2017
Net incurred medical claims:			
Commercial & Specialty Business	$ 25,752	$ 23,638	$ 29,005
Government Business	52,443	45,013	40,239
Total net incurred medical claims	78,195	68,651	69,244
Quality improvement and other claims expense	3,591	3,244	2,992
Benefit expense	$ 81,786	$ 71,895	$ 72,236

Incurred claims development, net of reinsurance, for the Commercial & Specialty Business for the years ended December 31, 2019, 2018 and 2017 is as follows:

Commercial & Specialty Business	Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Years	2017 (Unaudited)	2018 (Unaudited)	2019
2017 & Prior	$ 31,731	$ 31,275	$ 31,241
2018		24,094	23,938
2019			25,942
Total			$ 81,121

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

Paid claims development, net of reinsurance, for the Commercial & Specialty Business for the years ended December 31, 2019, 2018 and 2017 is as follows:

Commercial & Specialty Business	Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Years	2017 (Unaudited)	2018 (Unaudited)	2019
2017 & Prior	$ 28,426	$ 31,160	$ 31,210
2018		21,633	23,860
2019			23,026
Total			$ 78,096

At December 31, 2019, the total of incurred but not reported liabilities plus expected development on reported claims for the Commercial & Specialty Business was $31, $78 and $2,916 for the claim years 2017 and prior, 2018 and 2019, respectively.

At December 31, 2019, the cumulative number of reported claims for the Commercial & Specialty Business was 121, 89 and 84 for the claim years 2017 and prior, 2018 and 2019, respectively.

Incurred claims development, net of reinsurance, for the Government Business as of and for the years ended December 31, 2019, 2018 and 2017 is as follows:

Government Business	Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Years	2017 (Unaudited)	2018 (Unaudited)	2019
2017 & Prior	$ 44,706	$ 44,232	$ 44,120
2018		45,686	45,488
2019			52,753
Total			$ 142,361

Paid claims development, net of reinsurance, for the Government Business as of and for the years ended December 31, 2019, 2018 and 2017 is as follows:

Government Business	Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Years	2017 (Unaudited)	2018 (Unaudited)	2019
2017 & Prior	$ 40,302	$ 44,147	$ 44,104
2018		41,115	45,400
2019			47,268
Total			$ 136,772

At December 31, 2019, the total of incurred but not reported liabilities plus expected development on reported claims for the Government Business was $16, $89 and $5,484 for the claim years 2017 and prior, 2018 and 2019, respectively.

At December 31, 2019, the cumulative number of reported claims for the Government Business was 221, 216 and 230 for the claim years 2017 and prior, 2018 and 2019, respectively.

The information about incurred claims development, paid claims development and cumulative number of reported claims for the years ended December 31, 2017 and 2018, for both the Commercial & Specialty Business and Government Business, is unaudited and presented as supplementary information.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

The cumulative number of reported claims for each claim year, for both the Commercial & Specialty Business and Government Business, have been developed using historical data captured by our claim payment systems. The provided claim amounts are not a precise tool for understanding utilization of medical services. They could be impacted by a variety of factors including changes in provider billing practices, provider reimbursement arrangements, mix of services, benefit design or processing systems. The cumulative number of reported claims has been provided to comply with FASB accounting standards and is not used by management in its claims analysis. Our cumulative number of reported claims may not be comparable to similar measures reported by other health benefits companies.

The reconciliation of the Commercial & Specialty Business and Government Business incurred and paid claims development information for the three years ended December 31, 2019, reflected in the tables above, to the consolidated ending balance for medical claims payable included in the consolidated balance sheet, as of December 31, 2019, is as follows:

	Commercial & Specialty Business	Government Business	Total
Cumulative incurred claims and allocated claim adjustment expenses, net of reinsurance	$ 81,121	$ 142,361	$ 223,482
Less: Cumulative paid claims and allocated claim adjustment expenses, net of reinsurance	78,096	136,772	214,868
Net medical claims payable, end of year	3,025	5,589	8,614
Ceded medical claims payable, end of year	14	19	33
Insurance lines other than short duration	—	195	195
Gross medical claims payable, end of year	$ 3,039	$ 5,803	$ 8,842

12. Debt

Short-term Borrowings

We are a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati and the Federal Home Loan Bank of Atlanta, or collectively, the FHLBs. As a member we have the ability to obtain short-term cash advances, subject to certain minimum collateral requirements. At December 31, 2019 and 2018, $650 and $645, respectively, were outstanding under our short-term FHLB borrowings. These outstanding short-term FHLB borrowings at December 31, 2019 and 2018 had fixed interest rates of 1.664% and 2.458%, respectively.

Through certain subsidiaries, we have entered into multiple 364-day lines of credit, or the Subsidiary Credit Facilities, with separate lenders for general corporate purposes. The Subsidiary Credit Facilities provide combined credit of up to $600. The interest rate on each line of credit is based on the LIBOR rate plus a predetermined rate. Our ability to borrow under the lines of credit is subject to compliance with certain covenants. At December 31, 2019 and 2018, $50 and $500, respectively, were outstanding under our Subsidiary Credit Facilities.

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Notes to Consolidated Financial Statements (continued)

Long-term Debt

The carrying value of long-term debt at December 31, 2019 and 2018 consists of the following:

	2019	2018
Senior unsecured notes:		
2.250%, due 2019	$ —	$ 849
2.500%, due 2020	899	897
4.350%, due 2020	699	688
3.700%, due 2021	699	698
2.950%, due 2022	747	747
3.125%, due 2022	847	846
3.300%, due 2023	1,013	1,000
3.350%, due 2024	846	846
3.500%, due 2024	795	794
2.375%, due 2025	845	—
3.650%, due 2027	1,590	1,589
4.101%, due 2028	1,253	1,250
2.875%, due 2029	819	—
5.950%, due 2034	334	334
5.850%, due 2036	396	396
6.375%, due 2037	366	366
5.800%, due 2040	124	124
4.625%, due 2042	888	887
4.650%, due 2043	987	986
4.650%, due 2044	792	791
5.100%, due 2044	594	594
4.375%, due 2047	1,386	1,386
4.550%, due 2048	838	838
3.700%, due 2049	811	—
4.850%, due 2054	247	247
Surplus note:		
9.000%, due 2027	25	25
Senior convertible debentures:		
2.750%, due 2042	145	191
Variable rate debt:		
Commercial paper program	400	697
Total long-term debt	19,385	18,066
Current portion of long-term debt	(1,598)	(849)
Long-term debt, less current portion	$ 17,787	$ 17,217

All debt is a direct obligation of Anthem, Inc., except for the surplus note, the FHLB borrowings and the Subsidiary Credit Facilities.

We generally issue senior unsecured notes, or Notes, for long-term borrowing purposes. Certain of these Notes may have a call feature that allows us to redeem the Notes at any time at our option and/or a put feature that allows a Note holder to

redeem the Notes upon the occurrence of both a change in control event and a downgrade of the Notes below an investment grade rating.

On September 9, 2019, we issued $850 aggregate principal amount of 2.375% Notes due 2025, or the 2025 Notes, $825 aggregate principal amount of 2.875% Notes due 2029, or the 2029 Notes, and $825 aggregate principal amount of 3.700% Notes due 2049, or the 2049 Notes, under our shelf registration statement. Interest on the 2025 Notes is payable semi-annually in arrears on January 15 and July 15 of each year, commencing January 15, 2020. Interest on the 2029 Notes and the 2049 Notes is payable semi-annually in arrears on March 15 and September 15 each year, commencing March 15, 2020. The proceeds were used for working capital and general corporate purposes, including, but not limited to, the repurchase of our common stock pursuant to our share repurchase program, repayment of short-term and long-term debt and to fund acquisitions.

On August 15, 2019, we repaid, at maturity, the $850 outstanding balance of our 2.250% senior unsecured notes.

On July 16, 2018, we repaid, at maturity, the $650 outstanding balance of our 2.300% senior unsecured notes. On January 15, 2018, we repaid, at maturity, the $625 outstanding balance of our 1.875% senior unsecured notes.

On May 1, 2018, we settled our Equity Units stock purchase contracts at a settlement rate of 0.2412 shares of our common stock, using a market value formula set forth in the Equity Units purchase contracts. This resulted in the issuance of approximately 6 shares. We had issued 25 Equity Units on May 12, 2015, pursuant to an underwriting agreement dated May 6, 2015, in an aggregate principal amount of $1,250. Each Equity Unit had a stated amount of $50 (whole dollars) and consisted of a purchase contract obligating the holder to purchase a certain number of shares of our common stock on May 1, 2018, subject to earlier termination or settlement, for a price in cash of $50 (whole dollars); and a 5% undivided beneficial ownership interest in $1,000 (whole dollars) principal amount of our 1.900% remarketable subordinated notes, or RSNs, due 2028. On March 2, 2018, we remarketed the RSNs and used the proceeds to purchase U.S. Treasury securities that were pledged to secure the stock purchase obligations of the holders of the Equity Units. The purchasers of the RSNs transferred the RSNs to us in exchange for $1,250 principal amount of our 4.101% senior notes due 2028, or the 2028 Notes, and a cash payment of $4. We canceled the RSNs upon receipt and recognized a loss on extinguishment of debt of $18. At the remarketing, we also issued $850 aggregate principal amount of 4.550% notes due 2048, or the 2048 Notes, under our shelf registration statement. We used the proceeds from the 2048 Notes for working capital and general corporate purposes. Interest on the 2028 Notes and the 2048 Notes is payable semi-annually in arrears on March 1 and September 1 of each year, commencing on September 1, 2018.

On November 21, 2017, we issued $900 aggregate principal amount of 2.500% Notes due 2020, or the 2020 Notes, $750 aggregate principal amount of 2.950% Notes due 2022, or the 2022 Notes, $850 aggregate principal amount of 3.350% Notes due 2024, or the 2024 Notes, $1,600 aggregate principal amount of 3.650% Notes due 2027, or the 2027 Notes and $1,400 aggregate principal amount of 4.375% Notes due 2047, or the 2047 Notes, under our shelf registration statement. Interest on the 2020 Notes is payable semi-annually in arrears on May 21 and November 21 of each year, commencing on May 21, 2018. Interest on the 2022 Notes, the 2024 Notes, the 2027 Notes and the 2047 Notes is payable semi-annually in arrears on June 1 and December 1 of each year, commencing on June 1, 2018. The net proceeds were used to fund the acquisitions of HealthSun and America's 1st Choice; and redemption of the Tender Notes, discussed below.

On November 14, 2017, we initiated a cash tender offer to purchase any and all of our 7.000% Notes due 2019, or the Any and All Notes, and certain of our 5.950% Notes due 2034, 5.850% Notes due 2036, 6.375% Notes due 2037, 5.800% Notes due 2040 and 5.100% Notes due 2044, or the Maximum Tender Offer Notes, and collectively with the Any and All Notes, the Tender Notes. On November 21, 2017, we repurchased $185 aggregate principal amount of the Any and All Notes, plus applicable premium and accrued and unpaid interest, for cash totaling $199. On November 30, 2017, we repurchased $836 aggregate principal amount of the Maximum Tender Offer Notes, plus applicable premium and accrued and unpaid interest, for cash totaling $1,095. We recognized a loss on extinguishment of debt of $266 for the repurchase of the Tender Notes.

On December 14, 2017, we redeemed the $255 remaining outstanding principal balance of our 7.000% Notes due 2019, plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling $275. We recognized a loss on extinguishment of debt of $14 for the repurchase of these Notes.

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Notes to Consolidated Financial Statements (continued)

The surplus note is an unsecured obligation of Anthem Insurance Companies, Inc., or Anthem Insurance, a wholly owned subsidiary, and is subordinate in right of payment to all of Anthem Insurance's existing and future indebtedness. Any payment of interest or principal on the surplus note may be made only with the prior approval of the Indiana Department of Insurance, or IDOI, and only out of capital and surplus funds of Anthem Insurance that the IDOI determines to be available for the payment under Indiana insurance laws.

We have a senior revolving credit facility, or the 5-Year Facility, with a group of lenders for general corporate purposes. In June 2019, we amended and restated the credit agreement for the 5-Year Facility to, among other things, extend the maturity date from August 2020 to June 2024 and decrease the amount of credit available from $3,500 to $2,500. In June 2019, we also entered into a 364-day senior revolving credit facility, or 364-Day Facility, with a group of lenders for general corporate purposes, which provides for credit in the amount of $1,000 and matures in June 2020. There were no amounts outstanding under the 5-Year Facility or the 364-Day Facility at any time during the years ended December 31, 2019 or 2018.

We have an authorized commercial paper program of up to $3,500, the proceeds of which may be used for general corporate purposes. In August 2019, we increased the amount available under the commercial paper program from $2,500 to $3,500. At December 31, 2019, we had $400 outstanding under our commercial paper program with a weighted-average interest rate of 1.8528%. At December 31, 2018, we had $697 outstanding under our commercial paper program with a weighted-average interest rate of 2.8270%. Commercial paper borrowings have been classified as long-term debt at December 31, 2019 and 2018, as our general practice and intent is to replace short-term commercial paper outstanding at expiration with additional short-term commercial paper for an uninterrupted period extending for more than one year, and we have the ability to redeem our commercial paper with borrowings under the senior revolving credit facilities described above.

During the year ended December 31, 2015, we entered into a bridge facility commitment letter and a joinder agreement, and a term loan facility, to finance a portion of the consideration under the now terminated Cigna Merger Agreement. In January 2017, we reduced the size of the bridge facility from $22,500 to $19,500 and extended the termination date under the Cigna Merger Agreement, as well as the availability of commitments under the bridge facility and term loan facility, to April 30, 2017. We recorded $108 of interest expense related to the amortization of the bridge loan facility and other related fees during the year ended December 31, 2017. The commitment of the lenders to provide the bridge facility and term loan facility expired on April 30, 2017.

Convertible Debentures

On October 9, 2012, we issued $1,500 of senior convertible debentures, or the Debentures, in a private offering to qualified institutional buyers pursuant to Rule 144A under the Securities Act of 1933, as amended, or the Securities Act. The Debentures are governed by an indenture dated as of October 9, 2012 between us and The Bank of New York Mellon Trust Company, N.A., as trustee, or the Indenture. The Debentures bear interest at a rate of 2.750% per year, payable semi-annually in arrears in cash on April 15 and October 15 of each year, and mature on October 15, 2042, unless earlier redeemed, repurchased or converted into shares of common stock at the applicable conversion rate. The Debentures also have a contingent interest feature that will require us to pay additional interest based on certain thresholds and for certain events, as defined in the Indenture, beginning on October 15, 2022.

Holders may convert their Debentures at their option prior to the close of business on the business day immediately preceding April 15, 2042, only under the following circumstances: (1) during any fiscal quarter if the last reported sale price of our common stock for at least 20 trading days during a period of 30 consecutive trading days ending on the last trading day of the preceding fiscal quarter is greater than or equal to 130% of the applicable conversion price on each applicable trading day; (2) during the five business day period after any 10 consecutive trading day period, or the measurement period, in which the trading price per $1,000 (whole dollars) principal amount of Debentures for each trading day of that measurement period was less than 98% of the product of the last reported sale price of our common stock and the applicable conversion rate on each such day; (3) if we call any or all of the Debentures for redemption, at any time prior to the close of business on the third scheduled trading day prior to the redemption date; or (4) upon the occurrence of specified corporate events, as defined in the Indenture. On and after April 15, 2042 and until the close of business on the third scheduled trading day immediately preceding the Debentures' maturity date of October 15, 2042, holders may convert their Debentures into common stock at any time irrespective of the preceding circumstances. The Debentures are redeemable at our option at any time on or after October 20, 2022, upon the occurrence of certain events, as defined in the Indenture.

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Notes to Consolidated Financial Statements (continued)

Upon conversion of the Debentures, we will deliver cash up to the aggregate principal amount of the Debentures converted. With respect to any conversion obligation in excess of the aggregate principal amount of the Debentures converted, we have the option to settle the excess with cash, shares of our common stock or a combination thereof based on a daily conversion value, determined in accordance with the Indenture. The initial conversion rate for the Debentures was 13.2319 shares of our common stock per Debenture, which represented a 25% conversion premium based on the closing price of $60.46 per share of our common stock on October 2, 2012 (the date the Debentures' terms were finalized) and is equivalent to an initial conversion price of $75.575 per share of our common stock.

During the year ended December 31, 2019, we repurchased $15 of the aggregate principal balance of the Debentures. In addition, $57 aggregate principal amount of the Debentures was surrendered for conversion by certain holders in accordance with the terms and provisions of the Indenture. We elected to settle the excess of the principal amount of the repurchases and conversions with cash for total payments of $273. We recognized a loss on the extinguishment of debt related to the Debentures of $2, based on the fair values of the debt on the repurchase and conversion settlement dates. During the year ended December 31, 2018, $109 aggregate principal amount of the Debentures was surrendered for conversion. We elected to settle the excess of the principal amount of the conversions with cash for total payments of $402. We recognized a gain on the extinguishment of debt related to the debentures of $7. During the year ended December 31, 2017, $117 aggregate principal amount of the Debentures was surrendered for conversion. We elected to settle the excess of the principal amount of the conversions with cash for total payments of $345 and recognized a loss on the extinguishment of debt related to the debentures of $2.

As of December 31, 2019, our common stock was last traded at a price of $302.03 per share. If the remaining Debentures had been converted or matured at December 31, 2019, we would have been obligated to pay the principal of the Debentures plus an amount in cash or shares equal to $691. The Debentures and underlying shares of our common stock have not been and will not be registered under the Securities Act, or any state securities laws, and may not be offered or sold in the United States absent registration or an applicable exemption from registration requirements.

We have accounted for the Debentures in accordance with the cash conversion guidance in FASB guidance for debt with conversion and other options. As a result, the value of the embedded conversion option, net of deferred taxes and equity issuance costs, has been bifurcated from its debt host and recorded as a component of additional paid-in capital in our consolidated balance sheets.

The following table summarizes, at December 31, 2019, the related balances, conversion rate and conversion price of the Debentures:

Outstanding principal amount	$	215
Unamortized debt discount	$	68
Net debt carrying amount	$	145
Equity component carrying amount	$	78
Conversion rate (shares of common stock per $1,000 of principal amount)		13.9500
Effective conversion price (per $1,000 of principal amount)	$	71.6843

The remaining amortization period of the unamortized debt discount as of December 31, 2019 is approximately 23 years. The unamortized discount will be amortized into interest expense using the effective interest method based on an effective interest rate of 5.130%, which represents the market interest rate for a comparable debt instrument that does not have a conversion feature. During the years ended December 31, 2019, 2018 and 2017, we recognized $9, $12 and $17, respectively, of interest expense related to the Debentures, of which $7, $10 and $14, respectively, represented interest expense recognized at the stated interest rate of 2.750% and $2, $2 and $3, respectively, represented interest expense resulting from amortization of the debt discount.

Total interest paid during 2019, 2018 and 2017 was $755, $728, and $778, respectively.

We were in compliance with all applicable covenants under all of our outstanding debt agreements at December 31, 2019 and 2018.

Future maturities of all long-term debt outstanding at December 31, 2019 are as follows: 2020, $1,998; 2021, $699; 2022, $1,594; 2023, $1,013; 2024, $1,641 and thereafter, $12,440.

13. Commitments and Contingencies

Litigation and Regulatory Proceedings

In the ordinary course of business, we are defendants in, or parties to, a number of pending or threatened legal actions or proceedings. To the extent a plaintiff or plaintiffs in the following cases have specified in their complaint or in other court filings the amount of damages being sought, we have noted those alleged damages in the descriptions below. With respect to the cases described below, we contest liability and/or the amount of damages in each matter and believe we have meritorious defenses.

Where available information indicates that it is probable that a loss has been incurred as of the date of the consolidated financial statements and we can reasonably estimate the amount of that loss, we accrue the estimated loss by a charge to income. In many proceedings, however, it is difficult to determine whether any loss is probable or reasonably possible. In addition, even where loss is possible or an exposure to loss exists in excess of the liability already accrued with respect to a previously identified loss contingency, it is not always possible to reasonably estimate the amount of the possible loss or range of loss.

With respect to many of the proceedings to which we are a party, we cannot provide an estimate of the possible losses, or the range of possible losses in excess of the amount, if any, accrued, for various reasons, including but not limited to some or all of the following: (i) there are novel or unsettled legal issues presented, (ii) the proceedings are in early stages, (iii) there is uncertainty as to the likelihood of a class being certified or decertified or the ultimate size and scope of the class, (iv) there is uncertainty as to the outcome of pending appeals or motions, (v) there are significant factual issues to be resolved, and/or (vi) in many cases, the plaintiffs have not specified damages in their complaint or in court filings. For those legal proceedings where a loss is probable, or reasonably possible, and for which it is possible to reasonably estimate the amount of the possible loss or range of losses, we currently believe that the range of possible losses, in excess of established reserves is, in the aggregate, from $0 to approximately $750 at December 31, 2019. This estimated aggregate range of reasonably possible losses is based upon currently available information taking into account our best estimate of such losses for which such an estimate can be made.

Blue Cross Blue Shield Antitrust Litigation

We are a defendant in multiple lawsuits that were initially filed in 2012 against the BCBSA and Blue Cross and/or Blue Shield licensees, or Blue plans, across the country. The cases were consolidated into a single, multi-district proceeding captioned *In re Blue Cross Blue Shield Antitrust Litigation* that is pending in the United States District Court for the Northern District of Alabama, or the Court. Generally, the suits allege that the BCBSA and the Blue plans have conspired to horizontally allocate geographic markets through license agreements, best efforts rules that limit the percentage of non-Blue revenue of each plan, restrictions on acquisitions rules governing the BlueCard and National Accounts programs and other arrangements in violation of the Sherman Antitrust Act, or Sherman Act, and related state laws. The cases were brought by two putative nationwide classes of plaintiffs, health plan subscribers and providers, and actions filed in twenty-eight states have been consolidated into the multi-district proceeding.

In response to cross motions for partial summary judgment by plaintiffs and defendants, the Court issued an order in April 2018 determining that the defendants' aggregation of geographic market allocations and output restrictions are to be analyzed under a per se standard of review, and the BlueCard program and other alleged Section 1 Sherman Act violations are to be analyzed under the rule of reason standard of review. The Court also found that there remain genuine issues of material fact as to whether defendants operate as a single entity with regard to the enforcement of the Blue Cross Blue Shield trademarks. No dates have been set for either the final pretrial conferences or trials in these actions. In March 2019, the Court issued a Fourth Amended Scheduling Order requiring that briefing on motions for class certification and related expert reports, merits and damages expert reports, and certain dispositive motions occur in 2019. In April 2019, plaintiffs filed their motions for class certification in conjunction with their supporting expert reports. Defendants filed their motions to exclude plaintiffs' experts, as well as their opposition to plaintiffs' motions for class certification, in July 2019. The case has been stayed until further notice from the Court.

We intend to vigorously defend these suits; however, their ultimate outcome cannot be presently determined.

Blue Cross of California Taxation Litigation

In July 2013, our California affiliate Blue Cross of California (doing business as Anthem Blue Cross), or BCC, was named as a defendant in a California taxpayer action filed in Los Angeles County Superior Court, captioned *Michael D. Myers v. State Board of Equalization, et al.* This action was brought under a California statute that permits an individual taxpayer to sue a governmental agency when the taxpayer believes the agency has failed to enforce governing law. Plaintiff contends that BCC, a licensed Health Care Service Plan, or HCSP, is an "insurer" for purposes of taxation despite acknowledging it is not an "insurer" under regulatory law. At the time, under California law, "insurers" were required to pay a gross premiums tax, or GPT, calculated as 2.35% on gross premiums. As a licensed HCSP, BCC has paid the California Corporate Franchise Tax, or CFT, the tax paid by California businesses generally. Plaintiff contends that BCC must pay the GPT rather than the CFT, and seeks a writ of mandate directing the taxing agencies to collect the GPT and an order requiring BCC to pay GPT back taxes, interest, and penalties for the eight-year period prior to the filing of the complaint.

In March 2018, the Superior Court denied BCC's motion for judgment on the pleadings and similar motions brought by other entities. We filed a writ of mandate in the California Court of Appeal. Although the California Court of Appeal initially accepted our writ, it later indicated that it will not hear the issues raised by our writ until the case concludes in the Superior Court. The Superior Court has postponed the March 2020 trial date to July 2020. The parties are currently engaged in discovery and are in the process of retaining experts. Because GPT is constitutionally imposed in lieu of certain other taxes, BCC has filed protective tax refund claims with the City of Los Angeles, the California Department of Health Care Services and the Franchise Tax Board to protect its rights to recover certain taxes previously paid should BCC eventually be determined to be subject to the GPT for the tax periods at issue in the litigation. BCC intends to vigorously defend this suit; however, its ultimate outcome cannot be presently determined.

Express Scripts, Inc. Pharmacy Benefit Management Litigation

In March 2016, we filed a lawsuit against Express Scripts, Inc., or Express Scripts, our vendor for PBM services, captioned *Anthem, Inc. v. Express Scripts, Inc.*, in the U.S. District Court for the Southern District of New York. The lawsuit seeks to recover over $14,800 in damages for pharmacy pricing that is higher than competitive benchmark pricing under the agreement between the parties, or the ESI PBM Agreement, over $158 in damages related to operational breaches, as well as various declarations under the ESI PBM Agreement between the parties, including that Express Scripts: (i) breached its obligation to negotiate in good faith and to agree in writing to new pricing terms; (ii) was required to provide competitive benchmark pricing to us through the term of the ESI PBM Agreement; (iii) has breached the ESI PBM Agreement; and (iv) is required under the ESI PBM Agreement to provide post-termination services, at competitive benchmark pricing, for one year following any termination.

Express Scripts has disputed our contractual claims and is seeking declaratory judgments: (i) regarding the timing of the periodic pricing review under the ESI PBM Agreement; and (ii) that it has no obligation to ensure that we receive any specific level of pricing, that we have no contractual right to any change in pricing under the ESI PBM Agreement and that its sole obligation is to negotiate proposed pricing terms in good faith. In the alternative, Express Scripts claims that we have been unjustly enriched by its payment of $4,675 at the time we entered into the ESI PBM Agreement. In March 2017, the court granted our motion to dismiss Express Scripts' counterclaims for (i) breach of the implied covenant of good faith and fair dealing, and (ii) unjust enrichment with prejudice. The only remaining claims are for breach of contract and declaratory relief. Fact discovery has been completed. We intend to vigorously pursue our claims and defend against any counterclaims, which we believe are without merit; however, the ultimate outcome cannot be presently determined.

In re Express Scripts/Anthem ERISA Litigation

We are a defendant in a class action lawsuit that was initially filed in June 2016 against Anthem, Inc. and Express Scripts, which has been consolidated into a single multi-district lawsuit captioned *In Re Express Scripts/Anthem ERISA Litigation,* in the U.S. District Court for the Southern District of New York. The consolidated complaint was filed by plaintiffs against Express Scripts and us on behalf of all persons who are participants in or beneficiaries of any ERISA or non-ERISA healthcare plan from December 1, 2009 to December 31, 2019 in which we provided prescription drug benefits through the ESI PBM Agreement and paid a percentage based co-insurance payment in the course of using that prescription drug benefit. The plaintiffs allege that we breached our duties, either under ERISA or with respect to the implied covenant of

good faith and fair dealing implied in the health plans, (i) by failing to adequately monitor Express Scripts' pricing under the ESI PBM Agreement and (ii) by placing our own pecuniary interest above the best interests of our insureds by allegedly agreeing to higher pricing in the ESI PBM Agreement in exchange for the purchase price for our NextRx PBM business, and (iii) with respect to the non-ERISA members, by negotiating and entering into the ESI PBM Agreement that was allegedly detrimental to the interests of such non-ERISA members. Plaintiffs seek to hold us and Express Scripts jointly and severally liable and to recover all losses suffered by the proposed class, equitable relief, disgorgement of alleged ill-gotten gains, injunctive relief, attorney's fees and costs and interest.

In April 2017, we filed a motion to dismiss the claims brought against us, and it was granted, without prejudice, in January 2018. Plaintiffs filed a notice of appeal with the United States Court of Appeals for the Second Circuit, which was heard in October 2018 but has not yet been decided. We intend to vigorously defend this suit; however, its ultimate outcome cannot be presently determined.

Cigna Corporation Merger Litigation

In July 2015, we and Cigna announced that we entered into the Cigna Merger Agreement, pursuant to which we would acquire all outstanding shares of Cigna. In July 2016, the U.S. Department of Justice, or DOJ, along with certain state attorneys general, filed a civil antitrust lawsuit in the U.S. District Court for the District of Columbia, or District Court, seeking to block the merger. In February 2017, Cigna purported to terminate the Cigna Merger Agreement and commenced litigation against us in the Delaware Court of Chancery, or Delaware Court, seeking damages, including the $1,850 termination fee pursuant to the terms of the Cigna Merger Agreement, and a declaratory judgment that its purported termination of the Cigna Merger Agreement was lawful, among other claims, which is captioned *Cigna Corp. v. Anthem Inc.*

Also in February 2017, we initiated our own litigation against Cigna in the Delaware Court seeking a temporary restraining order to enjoin Cigna from terminating the Cigna Merger Agreement, specific performance compelling Cigna to comply with the Cigna Merger Agreement and damages, which is captioned *Anthem Inc. v. Cigna Corp*. In April 2017, the U.S. Circuit Court of Appeals for the District of Columbia affirmed the ruling of the District Court, which blocked the merger. In May 2017, after the Delaware Court denied our motion to enjoin Cigna from terminating the Cigna Merger Agreement, we delivered to Cigna a notice terminating the Cigna Merger Agreement.

In the Delaware Court litigation, trial commenced in late February 2019 and concluded in March 2019. The Delaware Court held closing argument in November 2019 and took the matter under consideration. In February 2020, the Delaware Court requested supplemental briefing. The parties have been instructed to negotiate a schedule for the supplemental submissions. We believe Cigna's allegations are without merit, and we intend to vigorously pursue our claims and defend against Cigna's allegations; however, the ultimate outcome of our litigation with Cigna cannot be presently determined.

In October 2018, a shareholder filed a derivative lawsuit in the State of Indiana Marion County Superior Court, captioned *Henry Bittmann, Derivatively, et al. v. Joseph R Swedish, et al.*, purportedly on behalf of us and our shareholders against certain current and former directors and officers alleging breaches of fiduciary duties, unjust enrichment and corporate waste associated with the Cigna Merger Agreement. This case has been stayed at the request of the parties pending the outcome of our litigation with Cigna in the Delaware Court. This lawsuit's ultimate outcome cannot be presently determined.

U.S. Department of Justice (DOJ) Civil Investigative Demands

Beginning in December 2016, the DOJ has issued civil investigative demands to us to discover information about our chart review and risk adjustment programs under Parts C and D of the Medicare program. We understand the DOJ is investigating the programs of other Medicare Advantage health plans, along with providers and vendors. We continue to cooperate with the DOJ's investigation, and the ultimate outcome cannot presently be determined.

Cyber Attack Regulatory Proceedings and Litigation

In February 2015, we reported that we were the target of a sophisticated external cyber attack, during which the attackers gained unauthorized access to certain of our information technology systems and obtained personal information related to many individuals and employees. To date, there is no evidence that credit card or medical information was accessed or

obtained. Upon discovery of the cyber attack, we took immediate action to remediate the security vulnerability and have continued to implement security enhancements since this incident.

Federal and state agencies are investigating, or have investigated, events related to the cyber attack, including how it occurred, its consequences and our responses. The investigations have all been resolved with the exception of an ongoing investigation by a multi-state group of attorneys general, which remains outstanding. Although we are cooperating in this investigation, we may be subject to additional fines or other obligations. We intend to vigorously defend the remaining regulatory investigation; however, its ultimate outcome cannot be presently determined.

We have contingency plans and insurance coverage for certain expenses and potential liabilities of this nature and will pursue coverage for all applicable losses; however, the ultimate outcome of our pursuit of insurance coverage cannot be presently determined.

Other Contingencies

From time to time, we and certain of our subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. We, like HMOs and health insurers generally, exclude certain healthcare and other services from coverage under our HMO, PPO and other plans. We are, in the ordinary course of business, subject to the claims of our enrollees arising out of decisions to restrict or deny reimbursement for uncovered services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on us. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable reimbursement of coverage claims.

In addition to the lawsuits described above, we are also involved in other pending and threatened litigation of the character incidental to our business, and are from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits, reviews and administrative proceedings include routine and special inquiries by state insurance departments, state attorneys general, the U.S. Attorney General and subcommittees of the U.S. Congress. Such investigations, audits, reviews and administrative proceedings could result in the imposition of civil or criminal fines, penalties, other sanctions and additional rules, regulations or other restrictions on our business operations. Any liability that may result from any one of these actions, or in the aggregate, could have a material adverse effect on our consolidated financial position or results of operations.

Contractual Obligations and Commitments

In the second quarter of 2019, we began using our new pharmacy benefits manager called IngenioRx to market and sell a PBM product to fully-insured and self-funded Anthem health plan customers throughout the country, as well as to customers outside of the health plans we own. This comprehensive product portfolio includes features such as drug formularies, a pharmacy network, prescription drug database, member services and mail order capabilities. Also beginning in the second quarter of 2019, we began delegating certain PBM administrative functions, such as claims processing and prescription fulfillment, to CaremarkPCS Health, L.L.C., or CVS Health, which is a subsidiary of CVS Health Corporation, pursuant to a five-year agreement with CVS Health, or the CVS PBM Agreement. We intend to retain the responsibilities for IngenioRx's clinical and formulary strategy and development, member and employer experiences, operations, sales, marketing, account management and retail network strategy. From December 2009 through December 2019, we delegated certain PBM functions and administrative services to Express Scripts pursuant to the ESI PBM Agreement. In January 2019, we exercised our contractual right to terminate the ESI PBM Agreement earlier than the original expiration date of December 31, 2019, due to the acquisition of Express Scripts by Cigna. We began transitioning existing members from Express Scripts to IngenioRx in the second quarter of 2019, and completed the transition of all of our members on January 1, 2020. Prior to the termination of the ESI PBM Agreement, Express Scripts managed the network of pharmacy providers, operated mail order pharmacies and processed prescription drug claims on our behalf, while we sold and supported the product for our members, made formulary decisions, sold drug benefit design strategy and provided front line member support. Express Scripts continues to provide certain audit and run out transition services related to our PBM business. Notwithstanding our termination of the ESI PBM Agreement, the litigation between us and Express Scripts regarding the ESI PBM Agreement continues. For additional information regarding this lawsuit, refer to the *Litigation and Regulatory Proceedings–Express Scripts, Inc. Pharmacy Benefit Management Litigation* section above. We believe we have appropriately recognized all rights and obligations under the ESI PBM Agreement as of December 31, 2019.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

Vulnerability from Concentrations

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash equivalents, investment securities, premium receivables and instruments held through hedging activities. All investment securities are managed by professional investment managers within policies authorized by our Board of Directors. Such policies limit the amounts that may be invested in any one issuer and prescribe certain investee company criteria. Concentrations of credit risk with respect to premium receivables are limited due to the large number of employer groups that constitute our customer base in the states in which we conduct business. As of December 31, 2019, there were no significant concentrations of financial instruments in a single investee, industry or geographic location.

14. Capital Stock

Stock Incentive Plans

Our Board of Directors has adopted the 2017 Anthem Incentive Compensation Plan, or 2017 Incentive Plan, which has been approved by our shareholders. The term of the 2017 Incentive Plan is such that no awards may be granted on or after May 18, 2027. The 2017 Incentive Plan gives authority to the Compensation Committee of the Board of Directors to make incentive awards to our non-employee directors, employees and consultants, consisting of stock options, stock, restricted stock, restricted stock units, cash-based awards, stock appreciation rights, performance shares and performance units. The 2017 Incentive Plan limits the number of available shares for issuance to 37.5 shares, subject to adjustment as set forth in the 2017 Incentive Plan.

Stock options are granted for a fixed number of shares with an exercise price at least equal to the fair value of the shares at the grant date. Historically, stock options have vested over three years in equal semi-annual installments and generally have a term of ten years from the grant date. Amendments to the 2017 Incentive Plan, effective July 1, 2018, require future grants of stock options to vest in three equal annual installments.

Certain option grants contain provisions whereby the employee continues to vest in the award subsequent to termination due to retirement. Our attribution method for newly granted awards considers all vesting and other provisions, including retirement eligibility, in determining the requisite service period over which the fair value of the awards will be recognized.

Awards of restricted stock or restricted stock units are issued at the fair value of the stock on the grant date and may also include one or more performance measures that must be met for the award to vest. For restricted stock or restricted stock units without performance measures, the restrictions lapse in three equal annual installments. Restricted stock or restricted stock units with performance measures vest in three year installments. Performance units issued in 2019 will vest in 2022, based on earnings targets over the three year period of 2019 to 2021. Performance units issued in 2018 will vest in 2021, based on earnings targets over the three year period of 2018 to 2020. Performance units issued in 2017 will vest in 2020, based on earnings targets over the three year period of 2017 to 2019.

For the years ended December 31, 2019, 2018 and 2017, we recognized share-based compensation expense of $294, $226 and $170, respectively, as well as related tax benefits of $78, $61 and $68, respectively.

A summary of stock option activity for the year ended December 31, 2019 is as follows:

	Number of Shares	Weighted-Average Option Price per Share	Weighted-Average Remaining Contractual Life (Years)	Aggregate Intrinsic Value
Outstanding at January 1, 2019	3.7	$ 149.65		
Granted	0.7	306.61		
Exercised	(1.2)	126.10		
Forfeited or expired	(0.1)	241.26		
Outstanding at December 31, 2019	3.1	190.31	6.18	$ 355
Exercisable at December 31, 2019	2.0	145.37	4.93	$ 312

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

The intrinsic value of options exercised during the years ended December 31, 2019, 2018 and 2017 amounted to $188, $172 and $192, respectively. We recognized tax benefits of $52, $47 and $76 during the years ended December 31, 2019, 2018 and 2017, respectively, from option exercises and disqualifying dispositions. During the years ended December 31, 2019, 2018 and 2017, we received cash of $143, $141 and $200, respectively, from exercises of stock options.

The total fair value of restricted stock awards that vested during the years ended December 31, 2019, 2018 and 2017 was $245, $237 and $127, respectively.

A summary of the status of nonvested restricted stock activity, including restricted stock units, for the year ended December 31, 2019 is as follows:

	Restricted Stock Shares and Units	Weighted-Average Grant Date Fair Value per Share
Nonvested at January 1, 2019	1.7	$ 183.32
Granted	0.6	305.88
Vested	(0.8)	153.79
Forfeited	(0.1)	242.38
Nonvested at December 31, 2019	1.4	242.47

During the year ended December 31, 2019, we granted approximately 0.2 restricted stock units that are contingent upon us achieving earning targets over the three year period of 2019 to 2021. These grants have been included in the activity shown above, but will be subject to adjustment at the end of 2021, based on results in the three year period.

As of December 31, 2019, the total remaining unrecognized compensation expense related to nonvested stock options and restricted stock, including restricted stock units, amounted to $25 and $139, respectively, which will be amortized over the weighted-average remaining requisite service periods of 11 months and 12 months, respectively.

As of December 31, 2019, there were approximately 20.5 shares of common stock available for future grants under the 2017 Incentive Plan.

Fair Value

We use a binomial lattice valuation model to estimate the fair value of all stock options granted. Expected volatility assumptions used in the binomial lattice model are based on an analysis of implied volatilities of publicly traded options on our stock and historical volatility of our stock price. The risk-free interest rate is derived from the U.S. Treasury strip rates at the time of the grant. The expected term of the options was derived from the outputs of the binomial lattice model, which incorporates post-vesting forfeiture assumptions based on an analysis of historical data. The dividend yield was based on our estimate of future dividend yields. Similar groups of employees that have dissimilar exercise behavior are considered separately for valuation purposes. We utilize the multiple-grant approach for recognizing compensation expense associated with each separately vesting portion of the share-based award.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

The following weighted-average assumptions were used to estimate the fair values of options granted during the years ended December 31, 2019, 2018 and 2017:

	2019	2018	2017
Risk-free interest rate	2.69%	2.90%	2.31%
Volatility factor	25.00%	30.00%	32.00%
Dividend yield (annual)	1.00%	1.30%	1.60%
Weighted-average expected life (years)	4.40	3.70	4.00

The following weighted-average fair values were determined for the years ending December 31, 2019, 2018 and 2017:

	2019	2018	2017
Options granted during the year	$ 68.66	$ 55.48	$ 40.88
Restricted stock awards granted during the year	305.88	233.73	174.44

The binomial lattice option-pricing model requires the input of highly subjective assumptions including the expected stock price volatility. Because our stock option grants have characteristics significantly different from those of traded options, and because changes in the subjective input assumptions can materially affect the fair value estimate, in our opinion, existing models do not necessarily provide a reliable single measure of the fair value of our stock option grants.

Employee Stock Purchase Plan

We have registered 14.0 shares of common stock for the Employee Stock Purchase Plan, or the Stock Purchase Plan, which is intended to provide a means to encourage and assist employees in acquiring a stock ownership interest in Anthem. Pursuant to the terms of the Stock Purchase Plan, an eligible employee is permitted to purchase no more than $25,000 (actual dollars) worth of stock in any calendar year, based on the fair value of the stock at the end of each plan quarter. Employees become participants by electing payroll deductions from 1% to 15% of gross compensation. Once purchased, the stock is accumulated in the employee's investment account. The Stock Purchase Plan allows participants to purchase shares of our common stock at a discounted price per share of 90% of the fair value of a share of common stock on the lower of the first or last trading day of the plan quarter purchase period. The Stock Purchase Plan discount was recognized as compensation expense for the year ended December 31, 2019, based on GAAP guidance. There were 0.2 shares issued during the year ended December 31, 2019. As of December 31, 2019, 4.9 shares were available for issuance under the Stock Purchase Plan.

Use of Capital and Stock Repurchase Program

We regularly review the appropriate use of capital, including acquisitions, common stock and debt security repurchases and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

A summary of the cash dividend activity for the years ended December 31, 2019 and 2018 is as follows:

Declaration Date	Record Date	Payment Date	Cash Dividend per Share	Total
Year ended December 31, 2019				
January 29, 2019	March 18, 2019	March 29, 2019	$ 0.80	$ 206
April 23, 2019	June 10, 2019	June 25, 2019	0.80	206
July 23, 2019	September 10, 2019	September 25, 2019	0.80	204
October 22, 2019	December 5, 2019	December 20, 2019	0.80	202
Year ended December 31, 2018				
January 30, 2018	March 9, 2018	March 23, 2018	$ 0.75	$ 192
April 24, 2018	June 8, 2018	June 25, 2018	0.75	196
July 24, 2018	September 10, 2018	September 25, 2018	0.75	195
October 30, 2018	December 5, 2018	December 21, 2018	0.75	193

On January 28, 2020, our Audit Committee declared a quarterly cash dividend to shareholders of $0.95 per share on the outstanding shares of our common stock. This quarterly dividend is payable on March 27, 2020 to the shareholders of record as of March 16, 2020.

Under our Board of Directors' authorization, we maintain a common stock repurchase program. On December 7, 2017, the Board of Directors authorized a $5,000 increase to the common stock repurchase program. Repurchases may be made from time to time at prevailing market prices, subject to certain restrictions on volume, pricing and timing. The repurchases are effected from time to time in the open market, through negotiated transactions, including accelerated share repurchase agreements, and through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. Our stock repurchase program is discretionary, as we are under no obligation to repurchase shares. We repurchase shares under the program when we believe it is a prudent use of capital. The excess cost of the repurchased shares over par value is charged on a pro rata basis to additional paid-in capital and retained earnings.

A summary of common stock repurchases for the years ended December 31, 2019 and 2018 is as follows:

	Years Ended December 31	
	2019	2018
Shares repurchased	6.3	6.8
Average price per share	$ 268.65	$ 248.34
Aggregate cost	$ 1,701	$ 1,685
Authorization remaining at end of year	$ 3,792	$ 5,493

We expect to utilize the remaining authorized amount over a multi-year period, subject to market and industry conditions.

For additional information regarding the use of capital for debt security repurchases, see Note 12, "Debt."

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Notes to Consolidated Financial Statements (continued)

15. Accumulated Other Comprehensive Loss

A reconciliation of the components of accumulated other comprehensive loss at December 31, 2019 and 2018 is as follows:

	2019	2018
Investments:		
Gross unrealized gains	$ 720	$ 173
Gross unrealized losses	(44)	(371)
Net pretax unrealized gains (losses)	676	(198)
Deferred tax (liability) asset	(155)	39
Net unrealized gains (losses) on investments	521	(159)
Non-credit components of OTTI on investments:		
Gross unrealized losses	(3)	(3)
Deferred tax asset	1	1
Net unrealized non-credit component of OTTI on investments	(2)	(2)
Cash flow hedges:		
Gross unrealized losses	(331)	(311)
Deferred tax asset	69	65
Net unrealized losses on cash flow hedges	(262)	(246)
Defined benefit pension plans:		
Deferred net actuarial loss	(734)	(751)
Deferred prior service cost	(1)	(1)
Deferred tax asset	188	193
Net unrecognized periodic benefit costs for defined benefit pension plans	(547)	(559)
Postretirement benefit plans:		
Deferred net actuarial loss	(25)	(58)
Deferred prior service credits	19	34
Deferred tax asset	2	6
Net unrecognized periodic benefit costs for postretirement benefit plans	(4)	(18)
Foreign currency translation adjustments:		
Gross unrealized losses	(3)	(3)
Deferred tax asset	1	1
Net unrealized losses on foreign currency translation adjustments	(2)	(2)
Accumulated other comprehensive loss	$ (296)	$ (986)

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

Other comprehensive income (loss) reclassification adjustments for the years ended December 31, 2019, 2018 and 2017 are as follows:

	2019	2018	2017
Investments:			
Net holding gain (loss) on investment securities arising during the period, net of tax (expense) benefit of $(198), $133, and ($153), respectively	$ 695	$ (465)	$ 280
Reclassification adjustment for net realized (gain) loss on investment securities, net of tax expense (benefit) of $4, $(13), and $58, respectively	(15)	47	(107)
Total reclassification adjustment on investments	680	(418)	173
Non-credit component of OTTI on investments:			
Non-credit component of OTTI on investments, net of tax benefit (expense) of $0, $1, and ($3), respectively	—	(2)	4
Cash flow hedges:			
Holding (loss) gain, net of tax benefit (expense) of $4, $(10), and $35, respectively	(16)	37	(65)
Other:			
Net change in unrecognized periodic benefit costs for defined benefit pension and postretirement benefit plans, net of tax (expense) benefit of $(9), $29, and $(35), respectively	26	(90)	51
Foreign currency translation adjustment, net of tax expense of $0, $0, and ($1), respectively	—	(1)	3
Net gain (loss) recognized in other comprehensive loss, net of tax (expense) benefit of $(199), $140, and ($99), respectively	$ 690	$ (474)	$ 166

16. Reinsurance

We reinsure certain risks with other companies and assume risk from other companies. We remain primarily liable to policyholders under ceded insurance contracts and are contingently liable for amounts recoverable from reinsurers in the event that such reinsurers do not meet their contractual obligations.

A summary of direct, assumed and ceded premiums written and earned for the years ended December 31, 2019, 2018 and 2017 is as follows:

	2019		2018		2017	
	Written	Earned	Written	Earned	Written	Earned
Direct	$ 93,953	$ 93,505	$ 84,835	$ 85,213	$ 83,974	$ 83,418
Assumed	822	713	264	259	275	275
Ceded	(45)	(45)	(51)	(51)	(44)	(45)
Net premiums	$ 94,730	$ 94,173	$ 85,048	$ 85,421	$ 84,205	$ 83,648
Percentage—assumed to net premiums	0.9%	0.8%	0.3%	0.3%	0.3%	0.3%

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

A summary of net premiums written and earned by segment (see Note 19, "Segment Information") for the years ended December 31, 2019, 2018 and 2017 is as follows:

	2019		2018		2017	
	Written	Earned	Written	Earned	Written	Earned
Reportable segments:						
Commercial & Specialty Business	$ 32,113	$ 31,944	$ 30,661	$ 30,532	$ 35,382	$ 35,503
Government Business	62,617	62,229	54,387	54,889	48,823	48,145
Net premiums	$ 94,730	$ 94,173	$ 85,048	$ 85,421	$ 84,205	$ 83,648

The effect of reinsurance on benefit expense for the years ended December 31, 2019, 2018 and 2017 is as follows:

	2019	2018	2017
Direct	$ 81,254	$ 71,749	$ 72,135
Assumed	589	219	217
Ceded	(57)	(73)	(116)
Net benefit expense	$ 81,786	$ 71,895	$ 72,236

The effect of reinsurance on certain assets and liabilities at December 31, 2019 and 2018 is as follows:

	2019	2018
Policy liabilities, assumed	$ 213	$ 50
Unearned income, assumed	114	6
Premiums payable, ceded	11	17
Premiums receivable, assumed	35	37

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

17. Leases

We lease office space and certain computer and related equipment using noncancelable operating leases. Our leases have remaining lease terms of 1 year to 15 years.

The information related to our leases is as follows:

	Balance Sheet Location	December 31, 2019
Operating Leases		
Right-of-use assets	Other noncurrent assets	$ 575
Lease liabilities, current	Other current liabilities	158
Lease liabilities, noncurrent	Other noncurrent liabilities	482

	Year Ended December 31, 2019
Lease Expense	
Operating lease expense	$ 198
Short-term lease expense	46
Sublease income	(16)
Total lease expense	$ 228
Other information	
Operating cash paid for amounts included in the measurement of lease liabilities, operating leases	$ 176
Right-of-use assets obtained in exchange for new lease liabilities, operating leases	$ 112
Weighted average remaining lease term, operating leases	6 years
Weighted average discount rate, operating leases	4.09%

Lease expense for 2018 and 2017 was $207 and $205, respectively.

At December 31, 2019, future lease payments for noncancelable operating leases with initial or remaining terms of one year or more are as follows:

2020	$ 172
2021	149
2022	136
2023	116
2024	87
Thereafter	135
Total future minimum payments	$ 795
Less imputed interest	(155)
Total lease liabilities	$ 640

As of December 31, 2019, we have additional operating leases for building spaces that have not yet commenced, and some building spaces are being constructed by the lessors and their agents. These leases have terms of up to 12 years and are expected to commence on various dates during 2020 and 2021 when the construction is complete and we take possession of the buildings. The undiscounted lease payments for these leases, which are not included in the tables above, aggregate $394.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

18. Earnings per Share

The denominator for basic and diluted earnings per share at December 31, 2019, 2018 and 2017 is as follows:

	2019	2018	2017
Denominator for basic earnings per share—weighted-average shares	255.5	258.1	261.5
Effect of dilutive securities—employee stock options, non-vested restricted stock awards, convertible debentures and equity units	4.8	6.1	6.3
Denominator for diluted earnings per share	260.3	264.2	267.8

During the years ended December 31, 2019, 2018 and 2017, weighted-average shares related to certain stock options of 0.6, 0.3 and 0.4, respectively, were excluded from the denominator for diluted earnings per share because the stock options were anti-dilutive. The Equity Unit purchase contracts were settled in May 2018, and approximately 6.0 shares of our common stock were issued and included in the basic earnings per share calculation.

During the years ended December 31, 2019, 2018 and 2017, we issued approximately 0.2, 0.3 and 0.4 restricted stock units, respectively, of which vesting was contingent upon us meeting certain earnings targets. Contingent restricted stock units are excluded from the denominator for diluted earnings per share and are included only if and when the contingency is met. The 2019 contingent restricted stock units are being measured over the three year period of 2019 through 2021, the 2018 contingent restricted stock units are being measured over the three year period of 2018 through 2020 and the 2017 contingent restricted stock units are being measured over the three year period of 2017 through 2019. Contingent restricted stock units generally vest in March of the year following each measurement period.

19. Segment Information

Our organizational structure is comprised of three reportable segments: Commercial & Specialty Business; Government Business; and Other.

Our Commercial & Specialty Business segment includes our Local Group, National Accounts, Individual and Specialty businesses. Business units in the Commercial & Specialty Business segment offer fully-insured health products; provide a broad array of managed care services to self-funded customers including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services; and provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits.

Our Government Business segment includes our Medicare and Medicaid businesses, National Government Services, or NGS, and services provided to the federal government in connection with the FEHB program. Our Medicare business includes services such as Medicare Supplement plans; Medicare Advantage, including Special Needs Plans; Medicare Part D; and dual-eligible programs through Medicare-Medicaid Plans. Our Medicaid business includes our managed care alternatives through publicly funded healthcare programs, including Medicaid, ACA-related Medicaid expansion programs, Temporary Assistance for Needy Families programs, programs for seniors and people with disabilities, Children's Health Insurance Programs, and specialty programs such as those focused on long-term services and support, HIV/AIDS, foster care, behavioral health and/or substance abuse disorders, and intellectual disabilities or developmental disabilities. NGS acts as a Medicare contractor for the federal government in several regions across the nation.

Prior to the second quarter of 2019, our Other segment included certain eliminations and corporate expenses not allocated to either of our other reportable segments. Beginning with the second quarter of 2019, our Other segment also includes IngenioRx, our PBM, which began operations during the second quarter of 2019. In addition, during the second quarter, we reclassified our integrated health services business, our Diversified Business Group, or DBG, from our Government Business segment to the Other segment to reflect changes in how our segments are being managed. Amounts for prior years have been reclassified to conform to the current year presentation for comparability. Based on the FASB guidance, as of December 31, 2019, IngenioRx and DBG did not collectively meet the quantitative thresholds for a reportable segment.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

We define operating revenues to include premium income and administrative fees and other revenues. Operating revenues are derived from premiums and fees received, primarily from the sale and administration of health benefit products. Operating gain is calculated as total operating revenue less benefit expense, cost of products sold and selling, general and administrative expense.

Through our participation in various federal government programs, we generated approximately 20.7%, 19.8% and 17.8% of our total consolidated revenues from agencies of the U.S. government for the years ended December 31, 2019, 2018, and 2017, respectively. These revenues are contained in the Government Business segment.

The accounting policies of the segments are consistent with those described in the summary of significant accounting policies in Note 2, "Basis of Presentation and Significant Accounting Policies," except that certain shared administrative expenses for each segment are recognized on a pro rata allocated basis, which in the aggregate approximates the consolidated expense. Any difference between the allocated expenses and actual consolidated expense is included in other expenses not allocated to reportable segments. Affiliated revenues represent revenues or cost for services provided by IngenioRx and DBG to our subsidiaries, are recorded at cost or management's estimate of fair market value, and are eliminated in consolidation. We evaluate performance of the reportable segments based on operating gain or loss as defined above. We evaluate net investment income, net realized gains on financial instruments, OTTI losses recognized in income, interest expense, amortization expense, gain or loss on extinguishment of debt, income taxes and assets and liabilities on a consolidated basis, as these items are managed in a corporate shared service environment and are not the responsibility of segment operating management.

For our segment reporting, operating gains (losses) generated from IngenioRx and DBG affiliated activity have been included in our Commercial & Specialty Business and Government Business based upon their utilization of services from IngenioRx and DBG.

Financial data by reportable segment for the years ended December 31, 2019, 2018 and 2017 is as follows:

	Commercial & Specialty Business	Government Business	Other	Eliminations	Total
Year ended December 31, 2019					
Operating revenue - unaffiliated	$ 37,421	$ 62,632	$ 3,088	$ —	$ 103,141
Operating revenue - affiliated	—	—	4,607	(4,607)	—
Operating gain (loss)	4,046	2,054	(101)	—	5,999
Depreciation and amortization of property and equipment	—	—	675	—	675
Year ended December 31, 2018					
Operating revenue - unaffiliated	$ 35,782	$ 55,348	$ 211	$ —	$ 91,341
Operating revenue - affiliated	—	—	1,308	(1,308)	—
Operating gain (loss)	3,600	1,928	(102)	—	5,426
Depreciation and amortization of property and equipment	—	—	652	—	652
Year ended December 31, 2017					
Operating revenue - unaffiliated	$ 40,363	$ 48,587	$ 111	$ —	$ 89,061
Operating revenue - affiliated	—	—	16	(16)	—
Operating gain (loss)	2,847	1,442	(114)	—	4,175
Depreciation and amortization of property and equipment	—	—	601	—	601

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

The major product revenues for each of the reportable segments for the years ended December 31, 2019, 2018 and 2017 are as follows:

	2019	2018	2017
Commercial & Specialty Business			
Managed care products	$ 30,311	$ 29,012	$ 33,971
Managed care services	5,451	5,218	4,732
Dental/Vision products and services	1,302	1,220	1,218
Other	357	332	442
Total Commercial & Specialty Business	37,421	35,782	40,363
Government Business			
Managed care products	62,229	54,889	48,144
Managed care services	403	459	443
Total Government Business	62,632	55,348	48,587
Other			
Other	7,695	1,519	127
Eliminations			
Eliminations	(4,607)	(1,308)	(16)
Total product revenues	$ 103,141	$ 91,341	$ 89,061

The classification between managed care products and managed care services in the above table primarily distinguishes between the levels of risk assumed. Managed care products represent insurance products where we bear the insurance risk, whereas managed care services represent product offerings where we provide claims adjudication and other administrative services to the customer, but the customer principally bears the insurance risk.

Asset, liability and equity details by reportable segment have not been disclosed, as we do not internally report such information.

A reconciliation of reportable segments' operating revenue to the amounts of total revenues included in our consolidated statements of income for the years ended December 31, 2019, 2018 and 2017 is as follows:

	2019	2018	2017
Reportable segments operating revenues	$ 103,141	$ 91,341	$ 89,061
Net investment income	1,005	970	867
Net realized gains (losses) on financial instruments	114	(180)	145
Other-than-temporary impairment losses recognized in income	(47)	(26)	(33)
Total revenues	$ 104,213	$ 92,105	$ 90,040

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

A reconciliation of reportable segments' operating gain to income before income tax expense included in our consolidated statements of income for the years ended December 31, 2019, 2018 and 2017 is as follows:

	2019	2018	2017
Reportable segments operating gain	$ 5,999	$ 5,426	$ 4,175
Net investment income	1,005	970	867
Net realized gains (losses) on financial instruments	114	(180)	145
Other-than-temporary impairment losses recognized in income	(47)	(26)	(33)
Interest expense	(746)	(753)	(739)
Amortization of other intangible assets	(338)	(358)	(169)
Loss on extinguishment of debt	(2)	(11)	(282)
Income before income tax expense	$ 5,985	$ 5,068	$ 3,964

20. Related Party Transactions

We have a 19.50% equity investment in National Accounts Service Company, LLC, or NASCO, which processes National Accounts claims and provides other administrative services for us and certain other BCBS plans. Administrative expenses incurred related to NASCO services totaled $78, $79 and $73, for the years ended December 31, 2019, 2018 and 2017, respectively. Amounts due to NASCO were $4 and $5 at December 31, 2019 and 2018, respectively.

We have an equity investment in APC Passe, LLC, which offers Medicaid products in Arkansas. During the year ended December 31, 2019, in the normal course of business, we assumed premiums of $408 from APC Passe, LLC, which is included in our total assumed premiums (see Note 16, "Reinsurance").

21. Statutory Information

The majority of our insurance and HMO subsidiaries report their accounts in conformity with accounting practices prescribed or permitted by state insurance regulatory authorities, commonly referred to as statutory accounting, which vary in certain respects from GAAP. However, certain of our insurance and HMO subsidiaries, including BCC, Blue Cross of California Partnership Plan, Inc., Golden West Health Plan, Inc. and CareMore Health Plan are regulated by the California Department of Managed Health Care, or DMHC, and report their accounts in conformity with GAAP (these entities are collectively referred to as the "DMHC regulated entities"). Typical differences of GAAP reporting as compared to statutory reporting are the recognition of all assets including those that are non-admitted for statutory purposes and recognition of all deferred tax assets without regard to statutory limits. The National Association of Insurance Commissioners, or NAIC, developed a codified version of the statutory accounting principles, designed to foster more consistency among the states for accounting guidelines and reporting. Prescribed statutory accounting practices are set forth in a variety of publications of the NAIC as well as state laws, regulations and general administrative rules.

Our ability to pay dividends and credit obligations is significantly dependent on receipt of dividends from our subsidiaries. The payment of dividends to us by our insurance and HMO subsidiaries without prior approval of the insurance departments of each subsidiary's domiciliary jurisdiction is limited by formula. Dividends in excess of these amounts are subject to prior approval by the respective state insurance departments or the DMHC.

Our statutory basis insurance and HMO subsidiaries are subject to risk-based capital, or RBC, requirements. RBC is a method developed by the NAIC to determine the minimum amount of statutory capital appropriate for an insurance company or HMO to support its overall business operations in consideration of its size and risk profile. The formula for determining the amount of RBC specifies various factors, weighted based on the perceived degree of risk, which are applied to certain financial balances and financial activity. Below minimum RBC requirements are classified within certain levels, each of which requires specified corrective action. Additionally, the DMHC regulated entities are subject to capital and solvency requirements as prescribed by the DMHC. As of December 31, 2019 and 2018, all of our regulated subsidiaries exceeded the minimum applicable mandatory RBC requirements and/or capital and solvency requirements of their applicable governmental regulator. The statutory RBC necessary to satisfy regulatory requirements of our statutory basis insurance and HMO subsidiaries was approximately $5,500 and $4,800 as of December 31, 2019 and 2018, respectively. The tangible net

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

equity required for the DMHC regulated entities was approximately $610 and $570 as of December 31, 2019 and 2018, respectively.

Statutory-basis capital and surplus of our insurance and HMO subsidiaries and capital and surplus of our other regulated subsidiaries, excluding the DMHC regulated entities, was $13,044 and $12,038 at December 31, 2019 and 2018, respectively. Statutory-basis net income of our insurance and HMO subsidiaries and net income of our other regulated subsidiaries, excluding the DMHC regulated entities, was $3,840, $3,412 and $2,674 for 2019, 2018 and 2017, respectively. GAAP equity of the DMHC regulated entities was $3,359 and $3,125 at December 31, 2019 and 2018, respectively. GAAP net income of the DMHC regulated entities was $878, $789 and $1,047 for the years ended December 31, 2019, 2018 and 2017, respectively.

22. Selected Quarterly Financial Data (Unaudited)

Selected quarterly financial data is as follows:

	For the Quarter Ended			
	March 31	June 30	September 30	December 31
2019				
Total revenues	$ 24,666	$ 25,466	$ 26,674	$ 27,407
Income before income tax expense	1,945	1,453	1,489	1,098
Net income	1,551	1,139	1,183	934
Basic net income per share	$ 6.03	$ 4.44	$ 4.64	$ 3.69
Diluted net income per share	5.91	4.36	4.55	3.62
2018				
Total revenues	$ 22,537	$ 22,944	$ 23,251	$ 23,373
Income before income tax expense	1,780	1,504	1,242	542
Net income	1,312	1,054	960	424
Basic net income per share	$ 5.13	$ 4.07	$ 3.70	$ 1.64
Diluted net income per share	4.99	3.98	3.62	1.61

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE.

There have been no changes in or disagreements with our independent registered public accounting firm on accounting or financial disclosures.

ITEM 9A. CONTROLS AND PROCEDURES.

Evaluation of Disclosure Controls and Procedures

We carried out an evaluation as of December 31, 2019, under the supervision and with the participation of our management, including our Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures as defined in Rule 13a-15(e) of the Exchange Act. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures are effective in timely alerting them to material information relating to us (including our consolidated subsidiaries) required to be disclosed in our reports under the Exchange Act. In addition, based on that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective in ensuring that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosures.

Management's Report on Internal Control Over Financial Reporting

Management, under the supervision and with the participation of the principal executive officer and principal financial officer, of Anthem, Inc., or the Company, is responsible for establishing and maintaining effective internal control over financial reporting, or Internal Control, as such term is defined in the Exchange Act. The Company's Internal Control is designed to provide reasonable assurance regarding the reliability of the Company's financial reporting and the preparation of financial statements for external reporting purposes in accordance with U.S. generally accepted accounting principles, or GAAP. The Company's Internal Control includes those policies and procedures that (i) pertain to the maintenance of records that in reasonable detail accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with GAAP, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the financial statements.

Because of inherent limitations in any Internal Control, no matter how well designed, misstatements due to error or fraud may occur and not be detected. Accordingly, even effective Internal Control can provide only reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with GAAP.

Management, under the supervision and with the participation of the principal executive officer and principal financial officer, assessed the effectiveness of the Company's Internal Control as of December 31, 2019. Management's assessment was based on criteria established in Internal Control—Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission.

Based on management's assessment, management has concluded that the Company's Internal Control was effective as of December 31, 2019 to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external reporting purposes in accordance with GAAP.

Ernst & Young LLP, the Company's independent registered public accounting firm, has audited the consolidated financial statements of the Company for the year ended December 31, 2019, and has also issued an audit report dated February 19, 2020, on the effectiveness of the Company's Internal Control as of December 31, 2019, which is included in this Annual Report on Form 10-K.

/s/ GAIL K. BOUDREAUX	/s/ JOHN E. GALLINA
President and Chief Executive Officer	Executive Vice President and Chief Financial Officer

Changes in Internal Control Over Financial Reporting

During the three months ended December 31, 2019, we implemented certain additional internal controls associated with our new IngenioRx PBM business. Other than these new controls, there have been no changes in our internal control over financial reporting that occurred during the three months ended December 31, 2019 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of Anthem, Inc.

Opinion on Internal Control Over Financial Reporting

We have audited Anthem, Inc.'s internal control over financial reporting as of December 31, 2019, based on criteria established in Internal Control–Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, Anthem, Inc. (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2019, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of Anthem, Inc. as of December 31, 2019 and 2018, the related consolidated statements of income, comprehensive income, shareholders' equity, and cash flows for each of the three years in the period ended December 31, 2019, and the related notes and financial statement schedule listed in the Index at Item 15(c) and our report dated February 19, 2020 expressed an unqualified opinion thereon.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ ERNST & YOUNG LLP

Indianapolis, Indiana
February 19, 2020

ITEM 9B. OTHER INFORMATION.

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE.

The information required by this Item concerning our Executive Officers, Directors and nominees for Director, Audit Committee members and financial expert(s) and concerning disclosure of any delinquent filers under Section 16(a) of the Exchange Act and our Code of Conduct is incorporated herein by reference from our definitive Proxy Statement for our 2020 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 11. EXECUTIVE COMPENSATION.

The information required by this Item concerning remuneration of our Executive Officers and Directors, material transactions involving such Executive Officers and Directors and Compensation Committee interlocks, as well as the Compensation Committee Report and CEO Pay Ratio disclosure are incorporated herein by reference from our definitive Proxy Statement for our 2020 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS.

Securities Authorized for Issuance under Equity Compensation Plans

Securities authorized for issuance under the our equity compensation plans as of December 31, 2019 are as follows:

Plan Category[1]	Number of securities to be issued upon exercise of outstanding options, warrants and rights[2] (a)	Weighted-average exercise price of outstanding options, warrants and rights[3] (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))[4] (c)
Equity compensation plans approved by shareholders as of December 31, 2019	**6,011,131**	**$190.31**	**25,381,110**

1 We have no equity compensation plans pursuant to which awards may be granted in the future that have not been approved by shareholders.

2 Includes shares that may be issued under the Anthem Incentive Compensation Plan and the Anthem 2017 Incentive Compensation Plan pursuant to the following outstanding awards: **3,143,948** stock options, **575,389** unvested restricted stock units, and **2,291,794** performance stock units (assuming that the outstanding performance stock units are earned at the maximum award level).

3 Represents the weighted average exercise price of outstanding stock options. Does not take into consideration outstanding restricted stock units or performance stock units, which, once vested, may be converted into shares of our common stock on a one-for-one basis upon distribution at no additional cost.

4 Excludes securities reflected in the first column, "Number of securities to be issued upon exercise of outstanding options, warrants and rights". Includes **20,528,003** shares of common stock available for issuance as stock options, restricted stock awards, performance stock awards, performance awards and stock appreciation rights under the Anthem 2017 Incentive Compensation Plan at December 31, 2019. Includes **4,853,107** shares of common stock available for issuance under the Stock Purchase Plan at December 31, 2019.

The information required by this Item concerning the stock ownership of management and five percent beneficial owners is incorporated herein by reference from our definitive Proxy Statement for our 2020 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE.

The information required by this Item concerning certain relationships and related person transactions and director independence is incorporated herein by reference from our definitive Proxy Statement for our 2020 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES.

The information required by this Item concerning principal accountant fees and services is incorporated herein by reference from our definitive Proxy Statement for our 2020 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES.

(a) 1. Financial Statements:

The following consolidated financial statements of the Company are set forth in Part II, Item 8:

Report of Independent Registered Public Accounting Firm

Consolidated Balance Sheets as of December 31, 2019 and 2018

Consolidated Statements of Income for the years ended December 31, 2019, 2018, and 2017

Consolidated Statements of Comprehensive Income for the years ended December 31, 2019, 2018, and 2017

Consolidated Statements of Shareholders' Equity for the years ended December 31, 2019, 2018 and 2017

Consolidated Statements of Cash Flows for the years ended December 31, 2019, 2018 and 2017

Notes to Consolidated Financial Statements

2. Financial Statement Schedule:

The following financial statement schedule of the Company is included in Item 15(c):

Schedule II—Condensed Financial Information of Registrant (Parent Company Only).

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore, have been omitted.

3. Exhibits required to be filed as part of this report:

Exhibit Number	Exhibit
2.1	Agreement and Plan of Merger, dated as of July 23, 2015 among Anthem, Inc., Anthem Merger Sub. Corp. and Cigna Corporation, incorporated by reference to Exhibit 2.1 to the Company's Current Report on Form 8-K filed on July 27, 2015.
3.1	Amended and Restated Articles of Incorporation of the Company, as amended and restated effective May 15, 2019, incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on May 15, 2019.
3.2	Bylaws of the Company, as amended effective May 15, 2019, incorporated by reference to Exhibit 3.2 to the Company's Current Report on Form 8-K/A filed on June 5, 2019.
4.1	Form of Specimen Certificate of the Company's common stock, $0.01 par value per share, incorporated by reference to Exhibit 4.3 to the Company's Post-Effective Amendment No.1 to Form S-8 Registration Statement filed on May 23, 2017.
4.2	Indenture, dated as of December 9, 2004, between the Company and The Bank of New York Trust Company, N.A., as trustee, including the Form of the Company's 5.950% Notes due 2034, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on December 15, 2004.
4.3	Indenture, dated as of January 10, 2006, between the Company and The Bank of New York Mellon Trust Company, N.A. (formerly known as The Bank of New York Trust Company, N.A.), as trustee, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on January 11, 2006.
	(a) Form of 5.85% Notes due 2036, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on January 11, 2006.
	(b) Form of 6.375% Notes due 2037, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on June 8, 2007.

Exhibit Number	Exhibit
	(c) Form of 4.350% Notes due 2020, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on August 12, 2010.
	(d) Form of 5.800% Notes due 2040, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on August 12, 2010.
	(e) Form of 3.700% Notes due 2021, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on August 15, 2011.
	(f) Form of 3.125% Notes due 2022, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on May 7, 2012.
	(g) Form of 4.625% Notes due 2042, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on May 7, 2012.
	(h) Form of 3.300% Notes due 2023, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on September 10, 2012.
	(i) Form of 4.650% Notes due 2043, incorporated by reference to Exhibit 4.5 to the Company's Current Report on Form 8-K filed on September 10, 2012.
	(j) Form of 5.100% Notes due 2044, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on July 31, 2013.
	(k) Form of 3.500% Notes due 2024, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on August 12, 2014.
	(l) Form of 4.650% Notes due 2044, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on August 12, 2014.
	(m) Form of 4.850% Notes due 2054, incorporated by reference to Exhibit 4.5 to the Company's Current Report on Form 8-K filed on August 12, 2014.
4.4	Indenture dated as of October 9, 2012 between the Company and The Bank of New York Mellon Trust Company, N.A. as trustee, including the Form of the 2.750% Senior Convertible Debentures due 2042, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on October 9, 2012.
4.5	Subordinated Indenture, dated as of May 12, 2015, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on May 12, 2015.
4.6	Indenture dated as of November 21, 2017 between the Company and The Bank of New York Mellon Trust Company, N.A. as trustee, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on November 21, 2017.
	(a) Form of 2.500% Notes due 2020, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on November 21, 2017.
	(b) Form of 2.950% Notes due 2022, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on November 21, 2017.
	(c) Form of 3.350% Notes due 2024, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on November 21, 2017.
	(d) Form of 3.650% Notes due 2027, incorporated by reference to Exhibit 4.5 to the Company's Current Report on Form 8-K filed on November 21, 2017.
	(e) Form of 4.375% Notes due 2047, incorporated by reference to Exhibit 4.6 to the Company's Current Report on Form 8-K filed on November 21, 2017.
	(f) Form of 4.101% Notes due 2028, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on March 2, 2018.
	(g) Form of 4.550% Notes due 2048, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on March 2, 2018.
	(h) Form of 2.375% Notes due 2025, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on September 9, 2019.

Exhibit Number		Exhibit
	(i)	Form of 2.875% Notes due 2029, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on September 9, 2019.
	(j)	Form of 3.700% Notes due 2049, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on September 9, 2019.
4.7		Upon the request of the Securities and Exchange Commission, the Company will furnish copies of any other instruments defining the rights of holders of long-term debt of the Company or its subsidiaries.
4.8		Description of the Company's Securities Registered Pursuant to Section 12 of the Exchange Act.
10.1	*	Anthem Incentive Compensation Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed on December 2, 2014.
	(a)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2014, incorporated by reference to Exhibit 10.2(p) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014.
	(b)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2015, incorporated by reference to Exhibit 10.2(n) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015.
	(c)	Form of Amendment, dated March 9, 2016, to Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2014, incorporated by reference to Exhibit 10.2(m) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
	(d)	Form of Amendment, dated March 9, 2016, to Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2015, incorporated by reference to Exhibit 10.2(p) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
	(e)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2016 and 2017, incorporated by reference to Exhibit 10.2(s) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
	(f)	Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2017, incorporated by reference to Exhibit 10.2(t) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
10.2	*	2017 Anthem Incentive Compensation Plan, as amended and restated effective October 1, 2019, incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2019.
	(a)	Form of Incentive Compensation Plan Performance Stock Unit Award Agreement for 2017, incorporated by reference to Exhibit 10.1(r) to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2017.
	(b)	Form of Incentive Compensation Plan Performance Stock Unit Award Agreement for the Chief Executive Officer for 2017, incorporated by reference to Exhibit 10.2(b) to the Company's Annual Report on Form 10-K for the year ended December 31, 2017.
	(c)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2018, incorporated by reference to Exhibit 10.2(d) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2018.
	(d)	Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2018, incorporated by reference to Exhibit 10.2(e) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2018.
	(e)	Form of Incentive Compensation Plan Performance Stock Unit Award Agreement for 2018, incorporated by reference to Exhibit 10.2(f) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2018.
	(f)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement commencing July 2018, incorporated by reference to Exhibit 10.2(h) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2018.
	(g)	Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement commencing July 2018, incorporated by reference to Exhibit 10.2(i) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2018.

Exhibit Number		Exhibit
	(h)	Form of Incentive Compensation Plan Performance Stock Unit Award Agreement commencing July 2018, incorporated by reference to Exhibit 10.2(j) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2018.
	(i)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2019, incorporated by reference to Exhibit 10.2(l) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2019.
	(j)	Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2019, incorporated by reference to Exhibit 10.2(m) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2019.
	(k)	Form of Incentive Compensation Plan Performance Stock Unit Award Agreement for 2019, incorporated by reference to Exhibit 10.2(n) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2019.
10.3	*	Anthem, Inc. Comprehensive Nonqualified Deferred Compensation Plan, as amended and restated effective October 1, 2019, incorporated by reference to Exhibit 10.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2019.
10.4	*	Anthem, Inc. Executive Agreement Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.4 to the Company's Annual Report on Form 10-K for the year ended December 31, 2014.
	(a)	First Amendment, dated March 9, 2016, to Executive Agreement Plan, incorporated by reference to Exhibit 10.4(a) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
	(b)	Second Amendment, dated January 6, 2017, to Executive Agreement Plan, incorporated by reference to Exhibit 10.3(b) to the Company's Annual Report on Form 10-K for the year ended December 31, 2016.
	(c)	Third Amendment, dated August 27, 2018, to Executive Agreement Plan, incorporated by reference to Exhibit 10.4(c) to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2018.
10.5	*	Anthem, Inc. Executive Salary Continuation Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.5 to the Company's Annual Report on Form 10-K for the year ended December 31, 2015.
10.6	*	Anthem, Inc. Directed Executive Compensation Plan amended effective January 1, 2020.
10.7	*	Anthem, Inc. Board of Directors Compensation Program, as amended effective May 15, 2019, incorporated by reference to Exhibit 10.7 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2019.
10.8	*	Anthem Board of Directors' Deferred Compensation Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.8 to the Company's Annual Report on Form 10-K for the year ended December 31, 2014.
10.9	* (a)	Form of Employment Agreement between the Company and each of the following: John E. Gallina, Peter D. Haytaian, Gloria McCarthy and Thomas C. Zielinski, incorporated by reference to Exhibit A to Exhibit 10.41 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2007.
	(b)	Form of Employment Agreement between the Company and Gail Boudreaux, incorporated by reference to Exhibit A to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on November 6, 2017.
	(c)	Form of Employment Agreement between the Company and each of the following: Felicia F. Norwood, Prakash Patel and Leah Stark incorporated by reference to Exhibit 10.9(d) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2018.
10.10	*	Offer Letter, by and between the Company and Gail Boudreaux, dated as of November 5, 2017, incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on November 6, 2017.
10.11		Blue Cross License Agreement by and between Blue Cross Blue Shield Association and the Company, including revisions, if any, adopted by the Member Plans through November 21, 2019.
10.12		Blue Shield License Agreement by and between Blue Cross Blue Shield Association and the Company, including revisions, if any, adopted by the Member Plans through November 21, 2019.

Exhibit Number	Exhibit
21	Subsidiaries of the Company.
23	Consent of Independent Registered Public Accounting Firm.
31.1	Certification of Chief Executive Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Exchange Act Rules, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification of Chief Financial Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Exchange Act Rules, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101	The following materials from Anthem, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2019, formatted in Inline XBRL (Inline Extensible Business Reporting Language): (i) the Consolidated Balance Sheets; (ii) the Consolidated Statements of Income; (iii) the Consolidated Statements of Comprehensive Income; (iv) the Consolidated Statements of Cash Flows; (v) the Consolidated Statements of Shareholders' Equity; (vi) the Notes to Consolidated Financial Statements and (vii) Financial Statement Schedule II. The instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
104	Cover Page Interactive Data File formatted in Inline XBRL and contained in Exhibit 101.

* Indicates management contracts or compensatory plans or arrangements.

(b) Exhibits

The response to this portion of Item 15 is set forth in paragraph (a) 3 above.

(c) Financial Statement Schedule

Schedule II—Condensed Financial Information of Registrant (Parent Company Only).

ITEM 16. FORM 10-K SUMMARY.

None.

Schedule II—Condensed Financial Information of Registrant

Anthem, Inc. (Parent Company Only)
Balance Sheets

(In millions, except share data)	December 31, 2019	December 31, 2018
Assets		
Current assets:		
Cash and cash equivalents	$ 1,818	$ 1,290
Fixed maturity securities, current (amortized cost of $592 and $589)	602	573
Equity securities, current	253	86
Other invested assets, current	4	10
Other receivables	92	131
Income taxes receivable	170	—
Net due from subsidiaries	602	170
Securities lending collateral	17	35
Other current assets	462	320
Total current assets	4,020	2,615
Long-term investments:		
Equity securities	6	6
Other invested assets, long-term	651	616
Property and equipment, net	170	186
Deferred tax assets, net	216	209
Investments in subsidiaries	47,423	44,877
Other noncurrent assets	263	225
Total assets	$ 52,749	$ 48,734
Liabilities and shareholders' equity		
Liabilities		
Current liabilities:		
Accounts payable and accrued expenses	$ 887	$ 1,429
Security trades pending payable	9	—
Securities lending payable	17	35
Income taxes payable	—	112
Current portion of long-term debt	1,598	849
Other current liabilities	237	235
Total current liabilities	2,748	2,660
Long-term debt, less current portion	17,762	17,192
Other noncurrent liabilities	511	341
Total liabilities	21,021	20,193
Commitments and contingencies—Note 5		
Shareholders' equity		
Preferred stock, without par value, shares authorized - 100,000,000; shares issued and outstanding - none	—	—
Common stock, par value $0.01, shares authorized - 900,000,000; shares issued and outstanding - 252,922,161 and 257,395,577	3	3
Additional paid-in capital	9,448	9,536
Retained earnings	22,573	19,988
Accumulated other comprehensive loss	(296)	(986)
Total shareholders' equity	31,728	28,541
Total liabilities and shareholders' equity	$ 52,749	$ 48,734

See accompanying notes.

Anthem, Inc. (Parent Company Only)
Statements of Income

(In millions)	Years ended December 31		
	2019	**2018**	**2017**
Revenues			
Net investment income	$ 81	$ 39	$ 64
Net realized losses on financial instruments	(65)	(46)	(18)
Other-than-temporary impairment losses on investments:			
Total other-than-temporary impairment losses on investments	(23)	(15)	(7)
Portion of other-than-temporary impairment losses recognized in other comprehensive income (loss)	3	—	—
Other-than-temporary impairment losses recognized in income	(20)	(15)	(7)
Administrative fees and other revenue	22	2	—
Total revenues (losses)	18	(20)	39
Expenses			
General and administrative expense	88	86	437
Interest expense	723	723	727
Loss on extinguishment of debt	2	11	283
Total expenses	813	820	1,447
Loss before income tax credits and equity in net income of subsidiaries	(795)	(840)	(1,408)
Income tax credits	(251)	(238)	(216)
Equity in net income of subsidiaries	5,351	4,352	5,035
Net income	$ 4,807	$ 3,750	$ 3,843

See accompanying notes.

Anthem, Inc. (Parent Company Only)
Statements of Comprehensive Income

(in millions)	Years ended December 31		
	2019	2018	2017
Net income	$ 4,807	$ 3,750	$ 3,843
Other comprehensive income, net of tax:			
Change in net unrealized gains/losses on investments	680	(418)	173
Change in non-credit component of other-than-temporary impairment losses on investments	—	(2)	4
Change in net unrealized gains/losses on cash flow hedges	(16)	37	(65)
Change in net periodic pension and postretirement costs	26	(90)	51
Foreign currency translation adjustments	—	(1)	3
Other comprehensive income (loss)	690	(474)	166
Total comprehensive income	$ 5,497	$ 3,276	$ 4,009

See accompanying notes.

Anthem, Inc. (Parent Company Only)
Statements of Cash Flows

(In millions)	Years ended December 31 2019	2018	2017
Operating activities			
Net income	$ 4,807	$ 3,750	$ 3,843
Adjustments to reconcile net income to net cash provided by operating activities:			
Undistributed earnings of subsidiaries	(1,561)	(744)	(2,437)
Net realized losses on financial instruments	65	46	18
Other-than-temporary impairment losses recognized in income	20	15	7
Loss on extinguishment of debt	2	11	283
Deferred income taxes	2	(43)	(33)
Amortization, net of accretion	37	43	25
Depreciation expense	69	70	69
Share-based compensation	294	226	170
Changes in operating assets and liabilities:			
Receivables, net	41	(73)	(17)
Other invested assets, current	6	(5)	(1)
Other assets	(235)	(225)	(102)
Amounts due (from)/ to subsidiaries	(432)	2,259	(1,034)
Accounts payable and accrued expenses	(608)	303	491
Other liabilities	186	154	(61)
Income taxes	(282)	187	(6)
Other, net	—	1	(2)
Net cash provided by operating activities	2,411	5,975	1,213
Investing activities			
Purchases of investments	(9,682)	(800)	(3,814)
Proceeds from sales, maturities, calls and redemptions of investments	9,457	1,865	2,595
Changes in collateral and settlement of non-hedging derivatives	—	—	65
Capitalization of subsidiaries	(232)	(4,379)	(124)
Changes in securities lending collateral	18	(21)	25
Purchases of property and equipment, net of sales	(54)	(137)	(44)
Other, net	—	4	18
Net cash used in investing activities	(493)	(3,468)	(1,279)
Financing activities			
Net (repayments of) proceeds from commercial paper borrowings	(297)	(107)	175
Proceeds from long-term borrowings	2,473	835	5,458
Repayments of long-term borrowings	(1,123)	(1,684)	(2,815)
Changes in securities lending payable	(18)	21	(25)
Changes in bank overdrafts	64	(107)	51
Premiums paid on equity call options	(1)	—	—
Proceeds from sale of put options	—	1	1
Proceeds from issuance of common stock under Equity Units stock purchase contracts	—	1,250	—
Repurchase and retirement of common stock	(1,701)	(1,685)	(1,998)
Change in collateral and settlements of debt-related derivatives	(34)	23	(149)
Cash dividends	(856)	(812)	(737)
Proceeds from issuance of common stock under employee stock plans	187	173	225
Taxes paid through withholding of common stock under employee stock plans	(84)	(81)	(47)
Net cash (used in) provided by financing activities	(1,390)	(2,173)	139
Change in cash and cash equivalents	528	334	73
Cash and cash equivalents at beginning of year	1,290	956	883
Cash and cash equivalents at end of year	$ 1,818	$ 1,290	$ 956

See accompanying notes.

Anthem, Inc.
(Parent Company Only)
Notes to Condensed Financial Statements

December 31, 2019
(In Millions, Except Per Share Data)

1. Basis of Presentation and Significant Accounting Policies

In the parent company only financial statements of Anthem, Inc., or Anthem, Anthem's investment in subsidiaries is stated at cost plus equity in undistributed earnings of the subsidiaries. Anthem's share of net income of its unconsolidated subsidiaries is included in income using the equity method of accounting.

Certain amounts presented in the parent company only financial statements are eliminated in the consolidated financial statements of Anthem.

Anthem's parent company only financial statements should be read in conjunction with Anthem's audited consolidated financial statements and the accompanying notes included in Part II, Item 8 of this Annual Report on Form 10-K.

2. Subsidiary Transactions

Dividends from Subsidiaries

Anthem received cash dividends from subsidiaries of $3,790, $3,606 and $2,268 during 2019, 2018 and 2017, respectively.

Dividends to Subsidiaries

Certain subsidiaries of Anthem own shares of Anthem common stock. Anthem paid cash dividends to subsidiaries related to these shares of common stock in the amount of $38, $36 and $32 during 2019, 2018 and 2017, respectively.

Investments in Subsidiaries

Capital contributions to subsidiaries were $232, $4,379 and $124 during 2019, 2018 and 2017, respectively.

Amounts Due to and From Subsidiaries

At December 31, 2019 and 2018, Anthem reported amounts due from subsidiaries of $602 and $170, respectively. The amounts due from subsidiaries primarily include amounts for allocated administrative expenses or daily cash management activities. These items are routinely settled, and as such, are classified as current assets or liabilities.

Guarantees on Behalf of Subsidiaries

Anthem guarantees contractual or financial obligations or solvency requirements for certain of its subsidiaries. These guarantees approximated $569 at December 31, 2019. There were no payments made on these guarantees in 2019.

3. Derivative Financial Instruments

The information regarding derivative financial instruments contained in Note 5, "Derivative Financial Instruments," of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K, is incorporated herein by reference.

4. Long-Term Debt

The information regarding long-term debt contained in Note 12, "Debt," of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K, is incorporated herein by reference.

5. Commitments and Contingencies

The information regarding commitments and contingencies contained in Note 13, "Commitments and Contingencies," of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K, is incorporated herein by reference.

6. Capital Stock

The information regarding capital stock contained in Note 14, "Capital Stock," of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K, is incorporated herein by reference.

7. Leases

Beginning in 2019, certain of our leases, including the lease for our principal executive offices located at 220 Virginia Avenue, Indianapolis, Indiana, are obligations of Anthem, Inc. (Parent Company). At December 31, 2019, these leases had an aggregate right-of-use asset of $99, a lease liability balance of $83, operating lease expense of $7 and future lease payments as follows: 2020, $11; 2021, $11; 2022, $11; 2023, $12; 2024, $11; and thereafter $70. All other information regarding leases is contained in Note 17, "Leases," of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

ANTHEM, INC.

By: /s/ GAIL K. BOUDREAUX

Gail K. Boudreaux
President and Chief Executive Officer

Dated: February 19, 2020

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ GAIL K. BOUDREAUX **Gail K. Boudreaux**	President and Chief Executive Officer, Director (Principal Executive Officer)	February 19, 2020
/s/ JOHN E. GALLINA **John E. Gallina**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 19, 2020
/s/ RONALD W. PENCZEK **Ronald W. Penczek**	Senior Vice President and Chief Accounting Officer (Principal Accounting Officer)	February 19, 2020
/s/ ELIZABETH E. TALLETT **Elizabeth E. Tallett**	Chair of the Board	February 19, 2020
/s/ R. KERRY CLARK **R. Kerry Clark**	Director	February 19, 2020
/s/ ROBERT L. DIXON, JR. **Robert L. Dixon, Jr.**	Director	February 19, 2020
/s/ LEWIS HAY III **Lewis Hay III**	Director	February 19, 2020
/s/ JULIE A. HILL **Julie A. Hill**	Director	February 19, 2020
/s/ BAHIJA JALLAL **Bahija Jallal**	Director	February 19, 2020
/s/ ANTONIO F. NERI **Antonio F. Neri**	Director	February 19, 2020
/s/ RAMIRO G. PERU **Ramiro G. Peru**	Director	February 19, 2020
/s/ RYAN M. SCHNEIDER **Ryan M. Schneider**	Director	February 19, 2020

Exhibit 31.1

**CERTIFICATION PURSUANT TO
RULE 13a-14(a) AND RULE 15d-14(a) OF THE EXCHANGE ACT RULES,
AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002**

I, Gail K. Boudreaux, certify that:

1. I have reviewed this report on Form 10-K of Anthem, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):

   a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 19, 2020

/s/ GAIL K. BOUDREAUX

President and Chief Executive Officer

Exhibit 31.2

**CERTIFICATION PURSUANT TO
RULE 13a-14(a) AND RULE 15d-14(a) OF THE EXCHANGE ACT RULES,
AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002**

I, John E. Gallina, certify that:

1. I have reviewed this report on Form 10-K of Anthem, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):

   a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 19, 2020

/s/ JOHN E. GALLINA
Executive Vice President and
Chief Financial Officer

Exhibit 32.1

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of Anthem, Inc. (the "Company") on Form 10-K for the period ended December 31, 2019 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Gail K. Boudreaux, President and Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ GAIL K. BOUDREAUX

Gail K. Boudreaux
President and Chief Executive Officer
February 19, 2020

Exhibit 32.2

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of Anthem, Inc. (the "Company") on Form 10-K for the period ended December 31, 2019 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, John E. Gallina, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ JOHN E. GALLINA

John E. Gallina
Executive Vice President and Chief Financial Officer
February 19, 2020

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2020

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number: 001-16751

ANTHEM, INC.
(Exact name of registrant as specified in its charter)

Indiana	**35-2145715**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification Number)**

220 Virginia Avenue
Indianapolis, Indiana 46204
(Address of principal executive offices) (Zip Code)

Registrant's telephone number, including area code: (800) 331-1476

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading symbol(s)	Name of each exchange on which registered
Common Stock, Par Value $0.01	ANTM	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes x No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No x

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes x No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes x No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐	Smaller reporting company	☐
Emerging growth company	☐		

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. x

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No x

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant (assuming solely for the purposes of this calculation that all directors and executive officers of the registrant are "affiliates") as of June 30, 2020 was approximately $66,230,779,383.

As of February 4, 2021, 244,905,689 shares of the registrant's common stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Annual Report on Form 10-K incorporates by reference information from the registrant's Definitive Proxy Statement for the Annual Meeting of Shareholders to be held May 26, 2021.

Anthem, Inc.

Annual Report on Form 10-K
For the Year Ended December 31, 2020

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References in this Annual Report on Form 10-K to the terms "we," "our," "us," "Anthem" or the "Company" refer to Anthem, Inc., an Indiana corporation, and, unless the context otherwise requires, its direct and indirect subsidiaries. References to the term "states" include the District of Columbia, unless the context otherwise requires.

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K, including Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations," contains certain forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements reflect our views about future events and financial performance and are generally not historical facts. Words such as "expect," "feel," "believe," "will," "may," "should," "anticipate," "intend," "estimate," "project," "forecast," "plan" and similar expressions are intended to identify forward-looking statements. These statements include, but are not limited to: financial projections and estimates and their underlying assumptions; statements regarding plans, objectives and expectations with respect to future operations, products and services; and statements regarding future performance. Such statements are subject to certain risks and uncertainties, many of which are difficult to predict and generally beyond our control, that could cause actual results to differ materially from those expressed in, or implied or projected by, the forward-looking statements. You are cautioned not to place undue reliance on these forward-looking statements that speak only as of the date hereof. You are also urged to carefully review and consider the various risks and other disclosures discussed in our reports filed with the U.S. Securities and Exchange Commission from time to time, which attempt to advise interested parties of the factors that affect our business. Except to the extent otherwise required by federal securities laws, we do not undertake any obligation to republish revised forward-looking statements to reflect events or circumstances after the date hereof. These risks and uncertainties include, but are not limited to: the impact of large scale medical emergencies, such as public health epidemics and pandemics, including COVID-19, and catastrophes; trends in healthcare costs and utilization rates; our ability to secure sufficient premium rates, including regulatory approval for and implementation of such rates; the impact of federal and state regulation, including ongoing changes in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended (collectively, the "ACA"), and the ultimate outcome of legal challenges to the ACA; changes in economic and market conditions, as well as regulations that may negatively affect our liquidity and investment portfolios; our ability to contract with providers on cost-effective and competitive terms; competitive pressures and our ability to adapt to changes in the industry and develop and implement strategic growth opportunities; reduced enrollment; unauthorized disclosure of member or employee sensitive or confidential information, including the impact and outcome of any investigations, inquiries, claims and litigation related thereto; risks and uncertainties regarding Medicare and Medicaid programs, including those related to non-compliance with the complex regulations imposed thereon; our ability to maintain and achieve improvement in Centers for Medicare and Medicaid Services Star ratings and other quality scores and funding risks with respect to revenue received from participation therein; a negative change in our healthcare product mix; costs and other liabilities associated with litigation, government investigations, audits or reviews; the ultimate outcome of litigation between Cigna Corporation, and us related to the merger agreement between the parties and the potential for such litigation to cause us to incur substantial additional costs, including potential settlement and judgment costs; risks and uncertainties related to our pharmacy benefit management ("PBM") business, including non-compliance by any party with the PBM services agreement between us and CaremarkPCS Health, L.L.C.; medical malpractice or professional liability claims or other risks related to healthcare and PBM services provided by our subsidiaries; general risks associated with mergers, acquisitions, joint ventures and strategic alliances; possible impairment of the value of our intangible assets if future results do not adequately support goodwill and other intangible assets; possible restrictions in the payment of dividends from our subsidiaries and increases in required minimum levels of capital; our ability to repurchase shares of our common stock and pay dividends on our common stock due to the adequacy of our cash flow and earnings and other considerations; the potential negative effect from our substantial amount of outstanding indebtedness; a downgrade in our financial strength ratings; the effects of any negative publicity related to the health benefits industry in general or us in particular; failure to effectively maintain and modernize our information systems; events that may negatively affect our licenses with the Blue Cross and Blue Shield Association; the impact of international laws and regulations; changes in U.S. tax laws; intense competition to attract and retain employees; and various laws and provisions in our governing documents that may prevent or discourage takeovers and business combinations.

PART I

ITEM 1. BUSINESS.

General

We are one of the largest health benefits companies in the United States in terms of medical membership, serving approximately 43 million medical members through our affiliated health plans as of December 31, 2020. We deliver a number of leading health benefit solutions through a broad portfolio of integrated health plans and related services, along with a wide range of specialty products as well as flexible spending accounts. In the second quarter of 2019, we began using our pharmacy benefits manager called IngenioRx to market and offer pharmacy benefits management ("PBM") services to our affiliated health plan customers throughout the country, as well as to customers outside of the health plans we own. In addition, we are expanding our business into integrated health services through our Diversified Business Group, which includes certain of our subsidiaries such as AIM Specialty Health, Aspire Health, and Beacon Health Options, Inc. ("Beacon") and other companies. At the time of its acquisition in 2020, Beacon was the largest independently held behavioral health organization in the country. Our acquisition of Beacon aligns with our strategy to diversify into health services and deliver both integrated solutions and care delivery models that personalize care for people with complex and chronic conditions.

We are an independent licensee of the Blue Cross and Blue Shield Association ("BCBSA"), an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield ("BCBS") licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (in the New York City metropolitan area and upstate New York), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas, we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, and Empire Blue Cross Blue Shield or Empire Blue Cross. We also conduct business through arrangements with other BCBS licensees as well as other strategic partners. Through our subsidiaries, we also serve customers in numerous states across the country as AIM Specialty Health, Amerigroup, Aspire Health, Beacon, CareMore, Freedom Health, HealthLink, HealthSun, Optimum HealthCare, Simply Healthcare, and/or UniCare. We are licensed to conduct insurance operations in all 50 states and the District of Columbia through our subsidiaries.

For our insurance products, based on the level of risk we assume in the product contract, we categorize principal funding arrangements as fully-insured and self-funded. Fully-insured products are products in which we indemnify our policyholders against costs for health benefits. Self-funded products are offered to customers, generally larger employers, who elect to retain most or all of the financial risk associated with their employees' healthcare costs. Some self-funded customers choose to purchase stop loss coverage to limit their retained risk. For our fully-insured products, we charge a premium and assume the risk for the cost of covered healthcare services. Under self-funded products, we charge a fee for services and the employer or plan sponsor funds or reimburses us for the healthcare costs. In addition, we charge a premium to underwrite stop loss insurance for employers that maintain self-funded health plans. We also generate revenues from providing PBM services including prescription drug fulfillment.

We offer a broad spectrum of network-based managed care plans to Large Group, Small Group, Individual, Medicaid and Medicare markets. Our managed care plans include: Preferred Provider Organizations ("PPOs"); Health Maintenance Organizations ("HMOs"); Point-of-Service ("POS") plans; traditional indemnity plans and other hybrid plans, including Consumer-Driven Health Plans ("CDHPs"); and hospital only and limited benefit products. In addition, we provide a broad array of managed care services to self-funded customers, including claims processing, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services. We provide an array of specialty and other insurance products and services such as PBM services, dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal healthcare. We also provide services to the federal government in connection with our Federal Health Products & Services business ("FHPS") which administers the Federal Employees Health Benefits ("FEHB") Program.

An ongoing focus on healthcare costs by employers, the government and consumers has continued to drive the growth of alternatives to traditional indemnity health insurance. HMO, PPO and hybrid plans are among the various forms of managed care products that have been developed. Through these types of products, insurers attempt to contain the cost of healthcare by

negotiating contracts with hospitals, physicians and other providers to deliver high-quality healthcare to members at favorable rates. These products usually feature medical management and other quality and cost optimization measures such as pre-admission review and approval for certain non-emergency services, pre-authorization of outpatient surgical procedures, network credentialing to determine that network physicians and hospitals have the required certifications and expertise, and various levels of care management programs to help members better understand and navigate the healthcare system. In addition, providers may have incentives to achieve certain quality measures, may share medical cost risk or may have other incentives to deliver quality medical services in a cost-effective manner. Also, certain plans offer members incentives for healthy behaviors, such as smoking cessation and weight management. Members are charged periodic, prepaid premiums and generally pay co-payments, coinsurance and/or deductibles when they receive services. While the distinctions between the various types of plans have lessened over recent years, PPO, POS and CDHP products generally provide reduced benefits for out-of-network services, while traditional HMO products generally provide little to no reimbursement for non-emergency out-of-network utilization, but often offer more generous benefit coverage. An HMO plan may also require members to select one of the network primary care physicians ("PCPs") to coordinate their care and approve any specialist or other services.

Economic factors, greater consumer and employer sophistication and accountability have resulted in an increased demand for choice in both product/benefit designs and provider network configurations. As a result, we continue to offer our broad access PPO networks with multiple benefit designs, but are also focused on leveraging our provider collaboration initiatives with our accountable care organization ("ACO") partnerships to develop both narrow and tiered network offerings. This array of network and product configurations allows both the employer and the employee to design and select the combination of benefit designs (e.g., traditional PPOs, high deductibles, health reimbursement accounts, health savings accounts, PCP based products, tiered copays) and networks (e.g., broad, narrow, tiered, closed or exclusive provider, and open) that optimize choice, quality and price at the consumer, employer and market level. We believe we are well-positioned in each of our states to respond to these market preferences.

Our medical membership includes seven different customer types: Local Group, Individual, National Accounts, BlueCard®, Medicare, Medicaid and FEHB. In addition, we also serve customers who purchase one or more of our other products or services that are often ancillary to our health business.

Our products are generally developed and marketed with an emphasis on the differing needs of our customers. In particular, our product development and marketing efforts take into account the differing characteristics between the various customers served by us, as well as the unique needs of educational and public entities, labor groups, FEHB program, national employers and state-run programs servicing low-income, high-risk and underserved markets. Overall, we seek to establish pricing and product designs to provide value for our customers while achieving an appropriate level of profitability for each of our customer categories balanced with the competitive objective to grow market share. We believe that one of the keys to our success has been our focus on these distinct customer types, which better enables us to develop benefit plans and services that meet our customers' unique needs. Further, IngenioRx was built to simplify pharmacy care and focus on the whole person, and we expect it will make it easier for our customers to achieve better health outcomes at a lower total cost of care.

We market our Individual, Medicare and certain Local Group products through direct marketing activities and an extensive network of independent agents, brokers and retail partnerships. Products for National Accounts and Local Group customers with a larger employee base are generally sold through independent brokers or consultants retained by the customer who work with industry specialists from our in-house sales force. In the Individual and Small Group markets, we offer on-exchange products through state- or federally-facilitated marketplaces, referred to as public exchanges, and off-exchange products. Federal subsidies are available for certain members, subject to income and family size, who purchase public exchange products.

Being a licensee of the BCBS association of companies, of which there were 36 independent primary licensees including us as of December 31, 2020, provides significant market value, especially when competing for very large multi-state employer groups. For example, each BCBS member company is able to utilize other BCBS licensees' substantial provider networks and discounts when any BCBS member works or travels outside of the state in which their policy is written. This program is referred to as BlueCard® and is a source of revenue when we provide member services in the states where we are the BCBS licensee to individuals who are customers of BCBS plans not affiliated with us. This program also provides a national provider network for our members when they travel to other states. See "BCBSA Licenses" herein for additional information on our BCBSA licenses. We refer to members in our service areas licensed by the BCBSA as our BCBS-branded

business. Non-BCBS-branded business refers to members in our non-BCBS-branded Amerigroup, Freedom Health, HealthSun, Optimum Health Care and Simply Healthcare plans, as well as Beacon, HealthLink and UniCare members.

For additional information describing each of our customer types, detailed marketing efforts and changes in medical membership over the last three years, see “Management’s Discussion and Analysis of Financial Condition and Results of Operations” included in Part II, Item 7 of this Annual Report on Form 10-K.

Our results of operations depend in large part on our ability to accurately predict and effectively manage healthcare costs through effective contracting with providers of care to our members, product pricing, medical management and health and wellness programs, including service coordination and case management for addressing complex and specialized healthcare needs, innovative product design and our ability to maintain or achieve improvement in our Centers for Medicare and Medicaid Services (“CMS”) Star ratings. CMS Star ratings affect Medicare Advantage plan reimbursements as well as our eligibility to earn quality-based bonus payments for those plans. See “Regulation” herein for additional information on our CMS Star ratings. For additional information on our networks and provider relations, product pricing and healthcare cost management programs, see “Networks and Provider Relations”, “Pricing and Underwriting of Our Products”, “Medical Management Programs”, “Care Management Programs” and “Healthcare Quality Initiatives” herein.

Advances in medical technology, increases in specialty drug costs, increases in hospital expenditures and other provider costs, the aging of the population, other demographic characteristics and the COVID-19 pandemic continue to contribute to rising healthcare costs. Our managed care plans and products are designed to encourage providers and members to participate in quality, cost-effective health benefit programs by using the full range of our innovative medical management services, quality initiatives and financial incentives. Our market share and high business retention rates enable us to realize the long-term benefits of investing in preventive and early detection programs. Our ability to provide cost-effective health benefits products and services is enhanced through a disciplined approach to internal cost containment, prudent management of our risk exposure and successful integration of acquired businesses. In addition, our ability to manage selling, general and administrative costs continues to be a driver of our overall profitability.

The future results of our operations will also be impacted by certain external forces and resulting changes in our business model and strategy. The continuing growth in our government-sponsored business exposes us to increased regulatory oversight. The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended (collectively, the “ACA”), has changed and may continue to make broad-based changes to the U.S. healthcare system. The ACA presented us with new growth opportunities, but also introduced new risks, regulatory challenges and uncertainties, and required changes in the way products are designed, underwritten, priced, distributed and administered. We currently offer Individual ACA-compliant products in 103 of the 143 rating regions in which we operate. Our strategy has been, and will continue to be, to only participate in rating regions where we have an appropriate level of confidence that these markets are on a path toward sustainability, including, but not limited to, factors such as expected financial performance, regulatory environment, and underlying market characteristics. Changes to our business environment are likely to continue as elected officials at the national and state levels continue to enact, and both elected officials and candidates for election continue to propose, significant modifications to existing laws and regulations, including changes to taxes and fees. In addition, the legal challenges regarding the ACA, including a federal district court decision invalidating the ACA, which was argued before the U.S. Supreme Court in November 2020 and has been stayed pending the U.S. Supreme Court’s decision, continue to contribute to this uncertainty. We will continue to evaluate the impact of the ACA as additional guidance is made available and any further developments or judicial rulings occur. For additional discussion, see “Regulation” herein and Part I, Item 1A “Risk Factors” in this Annual Report on Form 10-K.

In addition to the external forces discussed in the preceding paragraph, our results of operations are impacted by levels and mix of membership which can change as a result of the quality and pricing of our health benefits products and services, aging population, economic conditions, changes in unemployment, acquisitions, entry into new markets and expansions in or exits from existing markets. These membership trends could be negatively impacted by various factors that could have a material adverse effect on our future results of operations such as general economic downturns that result in business failures, failure to obtain new customers or retain existing customers, premium increases, benefit changes or our exit from a specific market. See Part I, Item 1A “Risk Factors” and Part II, Item 7 “Management’s Discussion and Analysis of Financial Condition and Results of Operations” included in this Annual Report on Form 10-K.

We believe healthcare is local and that we have the strong local presence required to understand and meet local customer needs with regard to any product they are enrolled in with us. Further, we believe we are well-positioned to deliver what customers want: innovative, choice-based and affordable products; distinctive service; simplified transactions; and better access to information for quality care. Our local presence, combined with our national expertise, has created opportunities for collaborative programs that reward physicians and hospitals for clinical quality and excellence. We feel that our commitment to health improvement and care management provides added value to customers and healthcare professionals. Ultimately, we believe that practical and sustainable improvements in healthcare must focus on improving healthcare quality while managing costs for total affordability. We have implemented initiatives driving payment innovation and partnering with providers to lower cost and improve the quality of healthcare for our members, and we continue to develop new and innovative ways to effectively manage risk and engage our members. Further, we are expanding our financial arrangements with providers to include payment models that encourage value-based care. We believe focusing on quality of care rather than volume of care is the foundation for improving patient outcomes. Our value-based payment model supports patient-centered care by improving collaboration between providers and health partners and delivering to our patients the right care, at the right time, in the right place. In addition, we are focused on achieving efficiencies from our national scale while optimizing service performance for our customers. Finally, we expect to continue to rationalize our portfolio of businesses and products and align our investments to capitalize on new opportunities to drive growth in our existing markets and expand into new markets in the future.

We continue to enhance interactions with customers, providers, brokers, agents, employees and other stakeholders through digital technology and improving internal operations. Our approach includes not only the sales and distribution of health benefits products through digital technology, but also implementing advanced capabilities that improve services benefiting customers, agents, brokers, and providers while optimizing administrative costs. These enhancements can also help improve the quality, coordination and safety of healthcare through increased communications between patients and their physicians.

At Anthem, we strive to improve the health of humanity. We believe in working together to achieve our mission of improving lives and communities, simplifying healthcare and expecting more. As we seek to accomplish these goals through a collaborative focus on execution and delivering for those we serve, our vision is to be the most innovative, valuable and inclusive health partner. We focus on ensuring quality products and services that give members access to the care they need. With an unyielding commitment to meeting the needs of our diverse customers, we are guided by the following values:

- Leadership – Redefine what is possible
- Community – Committed, connected, invested
- Integrity – Do the right thing, with a spirit of excellence
- Agility – Delivery today, transform tomorrow
- Diversity – Open your hearts and minds

In pursuing our vision, we intend to transform healthcare by providing trusted and caring solutions and delivering quality products and services that give customers access to the care they need. At the same time, we will focus on earnings, organic membership growth, improvements in our operating cost structure, strategic acquisitions and the efficient use of capital.

COVID-19

In March 2020, the World Health Organization declared the outbreak of a novel strain of coronavirus ("COVID-19") a global health pandemic. The COVID-19 pandemic continues to evolve, and the virus and mitigation efforts have continued to impact the global economy, cause market instability, increase unemployment in the United States, and put pressure on the healthcare system, and it has impacted and will continue to impact our membership and benefit expense. As the COVID-19 pandemic continues, we remain focused on increasing access and coverage for our members, making changes to our membership benefits and business operations and adapting tools and policies to assist consumers and care providers, including:

- Waiving cost-sharing for COVID-19 diagnostic tests and treatment;
- Providing expanded telehealth coverage for our Medicare and Medicaid plans, where permissible, and waiving cost-sharing for in-network telehealth visits, including telephonic visits and those for mental health;
- Providing expanded telehealth coverage for our members in fully-insured employer plans and Individual plans (we also waived cost-sharing for in-network telehealth and phone visits through September 30, 2020);
- Encouraging the use of home delivery services to enable access to necessary medications and relaxing early prescription refill policies for maintenance and specialty medications for our members in fully-insured employer plans and Individual plans at least through September 30, 2020, and for Medicare and Medicaid plans in accordance with applicable regulations;
- Providing a one-month premium credit to members enrolled in select individual plans and to fully insured employer group customers ranging from 10 to 15 percent of the monthly premium;
- Providing a one-month premium credit of 50 percent of the monthly premium to individuals in stand-alone and group dental plans;
- Leveraging data and advanced analytics to provide innovative solutions in response to the COVID-19 pandemic, and introducing a suite of digital tools that serve various functions, including providing member data and updates related to COVID-19, aggregating real-time COVID-19 data to present trends and predictions for our communities, and providing individuals with resources for mental health and free or reduced-cost programs that provide food, transportation, childcare and more;
- Providing support to care provider partners of our affiliated health plans to help them continue to focus on caring for patients, including funding and financial assistance, working with care providers to accelerate claims processing for outstanding accounts receivables, resolve claims where possible and appropriate, and accelerate payments to support state-specific Medicaid programs;
- Simplifying access to care by temporarily suspending select prior authorization requirements for certain services and equipment critical to COVID-19 treatment;
- Offering in-network dental providers a $10 personal protective equipment credit per patient, per visit, through December 31, 2020;
- Transitioning the majority of our employees to a remote work environment, expanding our employee benefits to provide additional support, imposing travel limitations and implementing workplace modifications consistent with the Centers for Disease Control and Prevention guidelines and social distancing protocols;
- Committing to lifting up our local communities through a variety of partnership and relief efforts, contributing $50 million to the Anthem Foundation to support its COVID-19 response and recovery efforts to help areas of greatest need, including care provider safety, food insecurity, and mental and behavioral health resources; and
- Sponsoring and participating in collaborative efforts to promote innovative solutions related to COVID-19 and healthcare needs caused by the pandemic.

For additional discussion see Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations–COVID-19" included in this Annual Report on Form 10-K. For information regarding our risks related to the COVID-19 pandemic and our other risk factors, see Part I, Item 1A, "Risk Factors," included in this Annual Report on Form 10-K.

Competition

The managed care industry is highly competitive, both nationally and in our local markets. Competition continues to be intense due to aggressive marketing, pricing, government-sponsored programs bid activity, business consolidations, new strategic alliances, new competitors in the market, a proliferation of new products, technological advancements, the impact of legislative reform, increased quality awareness and price sensitivity among customers and changing market practice such as increased usage of telehealth.

We believe that participants in the managed care industry compete for customers based on quality of service, price, access to provider networks, access to care management and wellness programs (including health information), innovation, effective use of technology such as electronic data transfer, breadth and flexibility of products and benefits, expertise and reputation (including National Committee on Quality Assurance ("NCQA") accreditation status as well as CMS Star ratings), brand recognition and financial stability. Our ability to attract and retain customers is substantially tied to our ability to distinguish ourselves from our competitors in these areas.

We believe our exclusive right to market products under the most recognized brand in the industry, BCBS, in our most significant markets provides us with greater brand recognition over competitive product offerings. Typically, we are the largest participant in each of our BCBS branded markets and, thus, are a closely-watched target by other insurance competitors.

Product pricing remains competitive and we strive to price our healthcare benefit products and design our Medicare and Medicaid bids consistent with anticipated underlying medical trends. We believe our pricing and bid strategy, based on predictive modeling, proprietary research and data-driven processes, has positioned us to benefit from the potential growth opportunities available through entry into new markets, expansions in existing markets and as a result of any future changes to the current regulatory scheme. We believe that our pricing and bid strategy, brand name and network quality will provide a strong foundation for membership growth opportunities in the future.

Our provider networks give us a highly competitive unit cost position and provide distinctive service levels which allow us to offer a broad range of affordable health benefit products to our customers. To build our provider networks, we compete with other health benefits plans for the best contracts with hospitals, physicians and other providers. We believe that physicians and other providers primarily consider customer volume, reimbursement rates, timeliness of reimbursement and administrative service capabilities along with the reduction of non-value added administrative tasks when deciding whether to contract with a health benefits plan.

At the sales and distribution level, we compete for qualified agents and brokers to recommend and distribute our products. Strong competition exists among insurance companies and health benefits plans for agents and brokers with demonstrated ability to secure new business and maintain existing accounts. We believe that the quality and price of our products, support services, reputation and prior relationships, along with a reasonable commission structure, are the factors agents and brokers consider in choosing whether to market our products. We believe that we have good relationships with our agents and brokers, and that our products, support services and commission structure compare favorably to those of our competitors in all of our markets.

In addition, the PBM industry is highly competitive, and IngenioRx is subject to competition from national, regional and local PBMs, insurers, health plans, large retail pharmacy chains, large retail stores, supermarkets, other mail order pharmacies, web pharmacies and specialty pharmacies. Strong competition within the PBM industry has generated greater demand for lower product and service pricing, increased revenue sharing and enhanced product and service offerings.

Reportable Segments

We manage our operations through four reportable segments: Commercial & Specialty Business, Government Business, IngenioRx and Other. We regularly evaluate the appropriateness of our reportable segments, particularly in light of organizational changes, merger and acquisition activity and changing laws and regulations.

Our Commercial & Specialty Business and Government Business segments both offer a diversified mix of managed care products, including PPOs, HMOs, traditional indemnity benefits and POS plans, as well as a variety of hybrid benefit plans including CDHPs, hospital only and limited benefit products.

Our Commercial & Specialty Business segment includes our Local Group, National Accounts, Individual and Specialty businesses. Business units in the Commercial & Specialty Business segment offer fully-insured health products; provide a broad array of managed care services to self-funded customers including claims processing, stop loss insurance, provider network access, medical cost management, disease management, wellness programs, underwriting, actuarial services and other administrative services; and provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits.

Our Government Business segment includes our Medicare and Medicaid businesses, National Government Services ("NGS") and services provided to the federal government in connection with our FHPS business. Medicaid makes federal matching funds available to all states for the delivery of healthcare benefits to eligible individuals, principally those with incomes below specified levels who meet other state-specified requirements. Medicaid is structured to allow each state to establish its own eligibility standards, benefits package, payment rates and program administration under broad federal guidelines. Our Medicare customers are Medicare-eligible individual members age 65 and over who have enrolled in Medicare Advantage, a managed care alternative for the Medicare program, or who have purchased Medicare Supplement benefit coverage, some disabled members under age 65, or members of all ages with end stage renal disease. Medicare Supplement policies are sold to Medicare recipients as supplements to the benefits they receive from the Medicare program. Medicare Supplement policy rates are filed with, and in some cases approved by, state insurance departments. Most of the premium for Medicare Advantage is based on bids submitted to CMS and paid directly by the federal government on behalf of the participant who may also be charged a small premium. Additionally, through our alliance partnership engagements with larger provider groups and BCBS plans, we offer a variety of Medicaid and Medicare services that include joint ventures, administrative service offerings, and full-risk arrangements. NGS acts as a Medicare contractor for the federal government in several regions across the nation.

Our IngenioRx segment includes our PBM business, which began its operations during the second quarter of 2019. IngenioRx markets and offers PBM services to our affiliated health plan customers, as well as to external customers outside of the health plans we own. IngenioRx has a comprehensive PBM services portfolio, which includes services such as formulary management, pharmacy networks, prescription drug database, member services and mail order capabilities. In 2019, IngenioRx was included in our Other reportable segment.

Our Other segment includes our Diversified Business Group ("DBG"), which is our integrated health services business, and certain eliminations and corporate expenses not allocated to our other reportable segments.

For additional information, see Note 20, "Segment Information", of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We experience seasonality in our Commercial & Specialty Business and Government Business segments. While our premium revenues are not seasonal, our benefit costs typically increase during the year as our fully-insured members pay their annual deductibles and reach their out-of-pocket maximum limits. However, this seasonality may change in the future as the COVID-19 pandemic continues and COVID-19 vaccines become widely available. Our expenses associated with COVID-19, including testing and treatment and the actions taken to support our members in response to the pandemic, accelerated in the fourth quarter of 2020 and exceeded the benefit we experienced during the quarter from the lower volume of healthcare claims attributable to decreased utilization of non-COVID-19 health services.

Through our participation in various federal government programs, we generated approximately 20.3%, 20.7% and 19.8% of our total consolidated revenues from agencies of the U.S. government for the years ended December 31, 2020, 2019 and 2018, respectively. These revenues are contained in the Government Business segment. An immaterial amount of our total consolidated revenues is derived from activities outside of the U.S.

Product and Service Descriptions

A general description of our products and services is provided below:

Preferred Provider Organization: PPO products offer the member an option to select any healthcare provider, with benefits reimbursed by us at a higher level when care is received from a participating network provider. Increasingly, customers are choosing our PPO products offered with an exclusive provider organization, which eliminates coverage out of

network. Coverage is subject to co-payments or deductibles and coinsurance, with member cost sharing usually limited by out-of-pocket maximums.

Consumer-Driven Health Plans: CDHPs provide consumers with increased financial responsibility, choice and control regarding how their healthcare dollars are spent. Generally, CDHPs combine a high-deductible PPO plan with an employer-funded and/or employee-funded personal care account, which may result in tax benefits to the employee. Some or all of the dollars remaining in the personal care account at year-end can be rolled over to the next year for future healthcare needs.

Traditional Indemnity: Indemnity products offer the member an option to select any healthcare provider for covered services. Coverage is subject to deductibles and coinsurance, with member cost sharing usually limited by out-of-pocket maximums.

Health Maintenance Organization: HMO products include comprehensive managed care benefits, generally through a participating network of physicians, hospitals and other providers. A member in one of our HMOs must typically select a PCP from our network. PCPs generally are family practitioners, internists or pediatricians who provide necessary preventive and primary medical care, and are generally responsible for coordinating other necessary healthcare services. We offer HMO plans with varying levels of co-payments, which result in different levels of premium rates.

Point-of-Service: POS products blend the characteristics of HMO, PPO and indemnity plans. Members can have comprehensive HMO-style benefits through participating network providers with minimum out-of-pocket expenses (co-payments) and also can go directly, without a referral, to any provider they choose, subject to, among other things, certain deductibles and coinsurance. Member cost sharing is limited by out-of-pocket maximums.

Public Exchange and Off-Exchange Products: Individual and Small Group products cover essential health benefits as defined in the ACA along with many other requirements and cost-sharing features. Individual and Small Group products offered on and off the public exchanges meet the definition of the "metal" product requirements (bronze, silver, gold and platinum) and each metal product must satisfy a specific actuarial value with respect to essential benefits. Health insurers participating on the public exchanges must offer at least one silver and one gold product.

Administrative Services: In addition to fully-insured products, we provide administrative services to Large Group, Small Group and National Account employers that maintain self-funded health plans. These administrative services include claims processing, medical cost management, disease management, wellness programs, underwriting, actuarial services and other administrative services for self-funded employers. Self-funded health plans are also able to use our provider networks and to realize savings through our negotiated provider arrangements, while allowing employers the ability to design certain health benefit plans in accordance with their own requirements and objectives. We also underwrite stop loss insurance for self-funded plans.

BlueCard®: BlueCard® is a national program that links participating healthcare providers and independent BCBS plans. BlueCard® host members are generally members who reside in or travel to a state in which an Anthem subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer-sponsored health plan serviced by a non-Anthem controlled BCBS licensee, which is the "home" plan. We perform certain administrative functions for BlueCard® host members, including claims pricing and administration for which we receive administrative fees from the BlueCard® members' home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan.

Medicare Plans: We offer a wide variety of plans, products and options to individuals age 65 and older such as Medicare Supplement plans; Medicare Advantage, including Special Needs Plans ("SNPs"), also known as Medicare Advantage SNPs; Medicare Part D Prescription Drug Plans ("Medicare Part D"); and dual-eligible programs through Medicare-Medicaid Plans ("MMPs"). Medicare Supplement plans typically pay the difference between healthcare costs incurred by a beneficiary and amounts paid by Medicare. Medicare Advantage plans provide Medicare beneficiaries with a managed care alternative to traditional Medicare and often include a Medicare Part D benefit. In addition, our Medicare Advantage SNPs provide tailored benefits to special needs individuals who are institutionalized or have severe or disabling chronic conditions and to dual-eligible customers, who are low-income seniors and persons under age 65 with disabilities. Medicare Advantage SNPs are coordinated care plans specifically designed to provide targeted care, covering all the healthcare services considered medically necessary for members and often providing professional care coordination services, with personal guidance and programs that help members maintain their health. Medicare Advantage membership also

includes Medicare Advantage members in our Group Retiree Solutions business who are related to National Accounts, retired members of Local Group accounts, or retired members of groups who are not affiliated with our Commercial accounts who have selected a Medicare Advantage product through us. Medicare Part D offers a prescription drug plan to Medicare and MMP beneficiaries. MMP is a demonstration program focused on serving members who are dually eligible for Medicaid and Medicare, which was established as a result of the passage of the ACA.

Individual Plans: We offer a full range of health insurance plans with a variety of options and deductibles for individuals who are not covered by employer-sponsored coverage and are not eligible for government sponsored plans, such as Medicare and/or Medicaid. Individual policies are generally sold through independent agents and brokers, retail partnerships, our in-house sales force or via the exchanges. Individual business is sold on a fully-insured basis. We offer on-exchange products through public exchanges and off-exchange products. Federal premium subsidies are available only for certain public exchange Individual products. Unsubsidized Individual customers are generally more sensitive to product pricing and, to a lesser extent, the configuration of the network and the efficiency of administration. Instability in the Individual market has resulted in a targeted approach where we offer products in select geographies.

Medicaid Plans and Other State-Sponsored Programs: We have state contracts to serve members enrolled in publicly funded healthcare programs, including Medicaid; ACA-related Medicaid expansion programs; Temporary Assistance for Needy Families ("TANF"); programs for seniors and people with disabilities ("SPD"); Children's Health Insurance Programs ("CHIP"); and specialty programs such as those focused on long-term services and support ("LTSS"), HIV/AIDS, children living in foster care, behavioral health and/or substance abuse disorders, and intellectual disabilities and/or developmental disabilities ("ID/DD programs"). The Medicaid program makes federal matching funds available to all states for the delivery of healthcare benefits for low income and/or high medical risk individuals. These programs are managed by the individual states based on broad federal guidelines. TANF is a state and federally funded program designed for a population consisting primarily of low-income children and their guardians. SPD is a federal income supplement program designed for Supplemental Security Income recipients; however, states can broaden eligibility criteria. This population generally consists of low-income seniors and people with disabilities. CHIP is a state and federally funded program that provides healthcare coverage to children not otherwise covered by Medicaid or other insurance programs. LTSS is a state and federally funded program that offers states a broad and flexible set of program design options and covers the delivery of long-term services and support for our members who receive home and community- or institution-based services for long-term care. Our HIV/AIDS program is a state and federally sponsored program that provides services to those living with HIV/AIDS. Our foster care program is a state and federally sponsored program serving children with complex needs within the foster care system. Our behavioral health program is a state and federally sponsored program providing services to those with mental health and/or substance abuse disorders. ID/DD is a state and federally sponsored program serving those living with limitations in intellectual functioning and adaptive behavior learning disabilities. Our Medicaid plans also cover certain dual-eligible customers, as previously described above, who also receive Medicare benefits. We provide Medicaid and other state sponsored services, such as administrative services, in Arkansas, California, Colorado, Florida, Georgia, Indiana, Iowa, Kentucky, Louisiana, Maryland, Minnesota, Missouri, Nebraska, Nevada, New Jersey, New York, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia, and Wisconsin.

Pharmacy Products: In the second quarter of 2019, we began using IngenioRx to market and offer PBM services to our affiliated health plan customers throughout the country, as well as to customers outside of the health plans we own. Our comprehensive PBM services portfolio includes features such as formulary management, pharmacy networks, a prescription drug database, member services, and mail order capabilities. IngenioRx delegates certain PBM administrative functions, such as claims processing and prescription fulfillment, to CaremarkPCS Health, L.L.C., which is a subsidiary of CVS Health Corporation ("CVS Health"), pursuant to a five-year agreement (the "CVS PBM Agreement"). With IngenioRx, we retain the responsibilities for clinical and formulary strategy and development, member and employer experiences, operations, sales, marketing, account management and retail network strategy. From December 2009 through December 2019, we delegated certain PBM functions and administrative services to Express Scripts Inc. ("Express Scripts"). Express Scripts managed the network of pharmacy providers, operated mail order pharmacies and processed prescription drug claims on our behalf, while we sold and supported the product for our members, made formulary decisions, sold drug benefit design strategy and provided front line member support. We began transitioning existing members from Express Scripts to IngenioRx in the second quarter of 2019, and completed the transition by January 1, 2020.

Behavioral Health: We offer managed care and member services for behavioral health and/or substance use disorders under contracts with state publicly funded healthcare programs, including Medicare and Medicaid, and through private health

plans and ACOs. In addition, we provide management and member benefit services for employee assistance plans to private employers and the federal government's Military OneSource support services. Through our subsidiary, Beacon, we also provide direct behavioral health counseling services through licensed clinicians in convenient and accessible locations, principally within a retail store environment.

Life Insurance: We offer an array of competitive individual and group life insurance benefit products to both Large Group and Small Group customers in conjunction with our health plans. The life insurance products include term life and accidental death and dismemberment.

Disability: We offer short-term and long-term disability products, usually in conjunction with our health plans.

Dental: Our dental plans include networks in certain states in which we operate. Many of the dental benefits are provided to customers enrolled in our health plans and are offered on both a fully-insured and self-funded basis. Our members also have access to additional dental providers through our participation in the National Dental GRID, a national dental network developed by and for BCBS plans. The National Dental GRID includes dentists in all 50 states and the District of Columbia and provides multi-state customers with a national solution that offers in-network discounts across the country. Additionally, we offer managed dental services to other healthcare plans to assist those plans in providing dental benefits to their customers.

Vision Services and Products: Our vision plans include networks within the states in which we operate. Many of the vision benefits are provided to customers enrolled in our health plans and are offered on both a fully-insured and self-funded basis.

Medicare Administrative Operations: Through our subsidiary, NGS, we serve as a fiscal intermediary, carrier and Medicare administrative contractor for the federal government by providing administrative services for the Medicare program, Parts A and B, which generally provides coverage for persons who are 65 or older and for persons who are under 65 and disabled or with end-stage renal disease. Part A of the Medicare program provides coverage for services provided by hospitals, skilled nursing facilities and other healthcare facilities. Part B of the Medicare program provides coverage for services provided by physicians, physical and occupational therapists and other professional providers, as well as certain durable medical equipment and medical supplies.

Radiology Benefit Management: We offer outpatient diagnostic imaging management services to health plans, which promote the most appropriate use of clinical services to improve the quality of care delivered to members. These services include utilization management for advanced diagnostic imaging procedures, network development and optimization, patient safety, claims adjudication and provider payment.

Personal Healthcare Guidance: We offer evidence-based and analytics-driven personal healthcare guidance. These services help improve the quality, coordination and safety of healthcare, enhance communications between patients and their physicians, and reduce medical costs.

Networks and Provider Relations

Our relationships with physicians, hospitals and professionals that render healthcare services to our members are guided by local, regional and national standards for network development, reimbursement and contract methodologies. While following industry standards, we are simultaneously seeking to lead transformation efforts within our healthcare system, moving from a fragmented model premised on episodic intervention to one based on proactive, coordinated care built around the needs of the patient. A key element of this transformation involves a transition from traditional fee-for-service payment models to models where providers are paid based on the value, both in quality and affordability, of the care they deliver.

We establish "market-based" hospital reimbursement payments that we believe are fair, but aggressive, and among the most competitive in the market. We also seek to ensure that physicians in our network are paid in a timely manner at appropriate rates. In many instances, we deploy multi-year contracting strategies, including case rates or fixed rates, to limit our exposure to medical cost inflation and to increase cost predictability. We maintain both broad and narrow provider networks to ensure member choice, based on both price and access needs, while implementing programs designed to improve the quality of care our members receive. Increasingly, we are supplementing our broad-based networks with smaller or more

cost-effective networks that are designed to be attractive to a more price-sensitive customer segment, such as public exchange customers.

Our reimbursement strategies vary across markets and depend on the degree of consolidation and integration of physician groups and hospitals. Under a fee-for-service reimbursement methodology for physicians, fee schedules are developed at the state level based on an assessment of several factors and conditions, including the CMS resource-based relative value system ("RBRVS"), medical practice cost inflation and physician supply. We utilize CMS RBRVS fee schedules as a reference point for fee schedule development and analysis. The RBRVS structure was developed, maintained, and updated by CMS and is used by the Medicare program and other major payers. In addition, we have implemented and continue to expand physician incentive contracting, or "pay-for-performance," which ties physician payment levels to performance on clinical measures.

While we generally do not delegate full financial responsibility to our physician providers in the form of capitation-based reimbursement, we maintain capitation-based arrangements in certain markets where we determine that market dynamics result in it being a useful method to lower costs and reduce underwriting risk.

Our hospital contracts provide for a variety of reimbursement arrangements depending on local market dynamics and current hospital utilization efficiency. Most hospitals are reimbursed a fixed amount per day or reimbursed a per-case amount, per admission, for inpatient covered services. A small percentage of hospitals, primarily rural, sole community hospitals, are reimbursed on a discount from approved charge basis for covered services. Our "per-case" reimbursement methods utilize many of the same attributes contained in Medicare's Diagnosis Related Groups methodology. Hospital outpatient services are reimbursed by fixed case rates, fee schedules or percent of approved charges. Our hospital contracts recognize unique hospital attributes, such as academic medical centers or community hospitals, and the volume of care performed for our members. To improve predictability of expected costs, we frequently use a multi-year contracting approach with providers. In addition, the majority of our hospital contracts include a pay-for-performance component where reimbursement levels are linked to improved clinical performance, patient safety and medical error reduction.

Our provider engagement and contracting strategies are moving away from "unit price" or volume-based payment models to payment models that align compensation with the value delivered as measured by healthcare outcomes, quality and cost. Our Enhanced Personal Health Care program augments traditional fee-for-service with shared savings opportunities for providers when actual healthcare costs are below projected costs and providers meet specific quality measures. The quality measures are based on nationally accepted, credible standards (e.g., NCQA, the American Diabetes Association and the American Academy of Pediatrics) and span preventive, acute and chronic care. We understand, however, that payment incentives alone are insufficient to create the large-scale, system-wide transformation required to achieve meaningful impacts on cost, quality and member experience. Accordingly, we are investing in care delivery transformation and population health management support structures to help providers succeed under value-based payment models. This support includes our web-based population health management technology and teams of dedicated practice consultants who work alongside providers, sharing best practices, and helping them leverage our data to the benefit of their patients. In some of these arrangements, participating physician practices receive a per-member, per-month clinical coordination fee to compensate them for important care management activities that occur outside of the patient visit (e.g., purchasing an electronic health record or hiring care management nurses), all of which have been shown to reduce healthcare costs and improve care outcomes. Since the launch of our Enhanced Personal Health Care program, we now have arrangements with provider organizations covering 52% of our PCPs and have rolled this program out in each of the 14 states where we operate as a licensee of the BCBSA.

Medical Management Programs

Our medical management programs include a broad array of activities that facilitate improvements in the quality of care provided to our members and promote cost-effective medical care. These medical management activities and programs are administered and directed by physicians and nurses. The goals of our medical management strategies are to ensure that the care delivered to our members is supported by appropriate medical and scientific evidence, is received on a timely basis and occurs in the most appropriate setting. The following is a general description of our medical management programs, which are available to our members depending on the particular plan or product in which they participate:

Precertification: A traditional medical management program involves assessment of the appropriateness of certain hospitalizations and other medical services prior to the services being rendered. For example, precertification is used to

determine whether a set of hospital and medical services is being appropriately applied to the member's clinical condition, in accordance with criteria for medical necessity as that term is defined in the member's benefits contract. All of our health plans have implemented precertification programs for selected medical services including surgeries, major diagnostic procedures, devices, drugs and other services to help members maximize benefits and avoid unnecessary charges or penalties. Through our American Imaging Management, Inc. subsidiary, doing business as AIM Specialty Health ("AIM") we promote appropriate, safe and affordable member care in the areas of imaging, sleep disorders, cardiac testing, oncology drugs and musculoskeletal procedures. These expanded specialty benefit management solutions leverage clinical expertise and technology to engage our provider communities and members in more effective and efficient use of outpatient services.

Care coordination: Another traditional medical management strategy we use is care coordination, which is based on nationally recognized criteria developed by third-party medical specialists. With inpatient care coordination, the requirements and intensity of services during a patient's hospital stay are reviewed, at times by an onsite, skilled nurse professional in collaboration with the hospital's medical and nursing staff, in order to coordinate care and determine the most effective transition of care from the hospital setting. In addition, continued stay cases are reviewed with physician medical directors to ensure appropriate utilization of medical services. We also coordinate care for outpatient services to help ensure that patients with chronic conditions who receive care from multiple physicians are able to manage the exchange of information between physicians and coordinate office visits to their physicians.

Case management: We have implemented a medical management strategy focused on identifying the small percentage of the membership that will require a high level of intervention and assistance to manage their healthcare needs. Case management identifies members who are likely to be re-admitted to the hospital through claims analysis using predictive modeling techniques, the use of health risk assessment data, utilization management reports and referrals from a physician or one of our other programs, such as the 24/7 NurseLine. Registered nurses, medical directors, behavioral health experts, pharmacists and other clinicians focus on these members and help them coordinate their care through pharmacy compliance, post-hospital care, follow-up visits to see their physician and support in their home. Increasingly, we collaborate with our providers and key health partners within the member's provider care team by providing actionable patient data insights, practice-coaching capabilities, technology and programs and products that help our providers and health partners to successfully deliver the right care, at the right time, in the right place.

Formulary management: We have developed formularies, which are selections of drugs based on clinical quality and effectiveness. A pharmacy and therapeutics committee of physicians uses scientific and clinical evidence to ensure that our members have access to the appropriate drug therapies and receive these therapies through proper settings.

Medical policy: A medical policy committee determines our national policies and guidelines for the application of medical technologies, procedures and services. This committee is comprised of internal and external physician leaders from various specialties and areas of the country. We also work in cooperation with academic medical centers, practicing community physicians and medical specialty organizations. All guidelines and policies are reviewed at least once a year or as new published clinical evidence becomes available.

Quality programs: We are actively engaged with our hospital and physician networks to enable them to improve medical and surgical care and achieve better outcomes for our members. We endorse, encourage and incentivize hospitals and physicians to support national initiatives to improve the quality of clinical care and patient outcomes and to reduce medication errors and hospital infections.

External review procedures: We work with outside experts through a process of external review to provide our members scientifically and clinically, evidence-based medical care. When we receive member concerns, we have formal appeals procedures that ultimately allow coverage disputes related to medical necessity decisions under the benefits contract to be settled by independent expert physicians.

Provider cost comparison tools: Through Estimate Your Cost, Care & Cost Finder, and other web-based tools, our members can compare cost estimates, quality accreditation data and patient reviews for common services at contracted providers, with cost estimates for facility, professional and ancillary services. These cost estimates bundle related services typically performed at the time of the procedure, not just for the procedure itself. Users can review cost data for over 400 common, shop-able medical procedures in all states. Members can also estimate out-of-pocket costs based on a member's own benefit coverage, deductible, and out-of-pocket maximum. We also offer information on overall facility

ratings and patient experience using trusted third-party data. We continue to work on enhancing and evolving our tools to assist members in making informed and value-based healthcare decisions. In addition, we collaborate with an external independent vendor to support employers wanting to purchase a consumer engagement solution with certain additional functionality.

Anthem Health Guide: Anthem Health Guide integrates the customer service experience with clinical and wellness coaching to provide easier navigation of healthcare services for our members. Anthem Health Guide provides members with education on benefit options and digital opportunities that fit member references, and makes recommendations for eligible clinical programs to ensure members are connected to the most appropriate care and clinical resources. By allowing members to connect with us using voice, click-to-chat, secure email and mobile technology, we enhance our ability to engage with our members.

Anthem Whole Health Connection: Anthem Whole Health Connection is a differentiated approach to whole person health that connects medical, pharmacy, dental, vision, disability, behavioral health and supplemental health clinical and claims data to proactively identify health issues earlier and engage our members with their health providers in new ways to support health, lower costs and deliver a better healthcare experience. Anthem Whole Health Connection is included when Anthem health benefits are combined with one or more of the Anthem pharmacy, dental, vision, life, disability, behavioral health or supplemental health coverage plans.

Care Management Programs

We continue to expand our *360º Health* suite of integrated care management programs and tools. *360º Health* offers the following programs, among others, which are available to our members depending on the particular plan or product in which they participate, and have been proven to increase quality and reduce medical costs for our members:

ConditionCare and *FutureMoms* are care management and maternity management programs that serve as adjuncts to physician care. Skilled nurse professionals, with added support from our team of dietitians, social workers, pharmacists, health educators and other health professionals, help participants understand their condition, their doctor's orders and how to become a better self-manager of their condition. We also offer members infertility consultation through our SpecialOffers@Anthem program, a comprehensive and integrated assembly of discounted health and wellness products and services from a variety of the nation's leading retailers.

24/7 NurseLine offers access to qualified, registered nurses anytime. This allows our members to make informed decisions about the appropriate level of care and avoid unnecessary worry. This program also includes a referral process to the nearest urgent care facility, a robust audio library, accessible by phone, with more than 600 health and wellness topics, as well as on-line health education topics designed to educate members about symptoms and treatment of many common health concerns.

MyHealth Advantage utilizes integrated information systems and sophisticated data analytics to help our members improve their compliance with evidence-based care guidelines, providing personal care notes that alert members to potential gaps in care, enable more prudent healthcare choices, and assist in the realization of member out-of-pocket cost savings. Key opportunities are also shared with physicians through Availity® at the time of membership eligibility verification. Availity® is an electronic data interchange system that allows for the exchange of health information among providers over a secure network.

MyHealth Coach provides our members with a professional guide who helps them navigate the healthcare system and make better decisions about their well-being. *MyHealth Coach* proactively reaches out to people who are at risk for potentially serious health issues or have complex healthcare needs. Our health coaches help participants understand and manage chronic conditions, handle any health and wellness related services they need and make smart lifestyle choices.

HealthyLifestyles helps employees transform unhealthy habits into positive ones by focusing on behaviors that can have a positive effect on their health and their employer's financial well-being. *HealthyLifestyles* programs include smoking cessation, weight management, stress management, physical activity, and diet and nutrition.

Behavioral Health Case Management is a comprehensive program supporting a wide range of members who are impacted by their behavioral health condition, including specialty areas such as eating disorders, anxiety, depression and

substance abuse. The program assists members and their families with obtaining appropriate behavioral health treatment, offering community resources, providing education and telephonic support, and promoting provider collaboration.

Autism Spectrum Disorder Program is a specialized case management program staffed by a dedicated team of clinicians who have been trained on the unique challenges and needs of families with a member who has a diagnosis of autism spectrum disorder. These clinicians provide education, information on community resources to help with care and support, guidance on the appropriate usage of benefits, and assistance in exploring effective treatments, such as medical services, that may help the member and their families.

Employee Assistance Programs provide 24/7 telephonic support for personal and crisis events. Members also gain access to many resources that allow support within work and personal life by providing quick and easy access to confidential resources to help meet the challenges of daily life. Examples of services available include counseling, referral assistance with child care, health and wellness, financial issues, legal issues, adoption and daily living.

Healthcare Quality Initiatives

Increasingly, the healthcare industry is able to define quality healthcare based on preventive health measurements, outcomes of care and optimal care management for chronic disease. A key to our success has been our ability to work with our network physicians and hospitals to improve the quality and outcomes of the healthcare services provided to our members. Our ability to promote quality medical care has been recognized by NCQA, the largest and most respected national accreditation program for managed care health plans.

Several quality healthcare measures, including the Healthcare Effectiveness Data and Information Set ("HEDIS®"), have been incorporated into NCQA's accreditation processes. HEDIS® measures range from preventive services, such as screening mammography and pediatric immunization, to elements of care, including decreasing the complications of diabetes and improving treatment for patients with heart disease. In 2020, NCQA announced that it was eliminating its then-existing status levels for health plans and moving to CMS Star ratings in order to make accreditation ratings more transparent. Accredited plans earn ratings after they submit HEDIS/CAHPS reporting and can advertise the rating alongside their accreditation seal. Due to the COVID-19 pandemic, NCQA did not release 2020-2021 Health Plan Ratings or Star ratings for any product line. CMS reported Star ratings for Medicare; however, HEDIS/CAHPS utilized the scores from the 2018 measurement year.

Even though the utilization of clinical data for scoring is uncertain, we continued to support our members by promoting health and wellness in a variety of ways. In an effort to promote the importance of preventive screenings and chronic condition management, we conducted check-in calls to high-risk Medicaid and Medicare members at the onset of the COVID-19 pandemic to address access to medication, adequate food supply and social isolation. Outreach was also conducted to remind our members of overdue screenings and appointment scheduling assistance was provided, when requested by the member. Additionally, to address our members' concerns over potential exposure to COVID-19, we deployed home lab kits to members enabling them to complete colon cancer screenings and manage their diabetes in the safety of their own homes.

Our wholly-owned health outcomes research subsidiary, HealthCore, Inc. ("HealthCore") generates consistent and actionable evidence to support decision making while helping to guide fresh initiatives for a range of stakeholders in the healthcare industry. By leveraging a rich array of medical and pharmacy utilization data queried from administrative claims, patient surveys, medical charts and laboratory diagnostics, among other health records, HealthCore's multi-disciplinary research teams develop a broad spectrum of safety, clinical research trials, effectiveness, pharmacoepidemiology, and health economics evidence. HealthCore's real world evidence and comparative effectiveness research, among other data, have played roles in the product planning and development campaigns of biotechnology and pharmaceutical companies and today it lists most of the leading biologics and drug manufacturers as clients or alliance partners.

Our AIM subsidiary supports quality by implementing clinical appropriateness and patient safety solutions for advanced imaging procedures, cardiology, sleep medicine, medical oncology, radiation therapy, rehabilitative, certain outpatient surgical and musculoskeletal services. These programs, based on widely accepted and evidence-based clinical guidelines, promote the most appropriate use of clinical services to improve the quality of overall healthcare delivered to our members and members of other health plans that are covered under AIM's programs. To provide additional impact to its clinical appropriateness program, AIM has also implemented a provider assessment program, OptiNet®, which promotes more

informed selection of diagnostic imaging and testing facilities by providing cost and facility information to physician offices at the point that a procedure is ordered. We have also leveraged AIM's provider network assessment information to proactively engage and educate our members about imaging providers and sleep testing choices based on site capabilities and cost differences. This program is another example of how we facilitate improvements in the quality of care provided to our members and promote cost-effective medical care.

Pricing and Underwriting of Our Products

We price our products based on our assessment of current healthcare claim costs and emerging healthcare cost trends, combined with charges for administrative expenses, risk and profit, including charges for the ACA taxes and fees, where applicable. We continually review our product designs and pricing guidelines on a national and regional basis so that our products remain competitive and consistent with our profitability goals and strategies.

Our revenue on Medicare policies is based on annual bids submitted to CMS. We base the commercial and Medicaid premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period. In applying our pricing to each employer group and customer, we aim to maintain consistent, competitive, disciplined underwriting standards. We employ our proprietary accumulated actuarial and financial data to determine underwriting and pricing parameters for both our fully-insured and self-funded businesses.

In most circumstances, our pricing and underwriting decisions follow a prospective rating process in which a fixed premium is determined at the beginning of the contract period. For our fully-insured business, any deviation, favorable or unfavorable, from the medical costs assumed in determining the premium is our responsibility. Some of our larger groups employ retrospective rating reviews, where positive experience is partially refunded to the group, and negative experience is charged against a rate stabilization fund established from the group's favorable experience or charged against future favorable experience. In addition, our ACA and government fully-insured contracts may include minimum medical loss ratio, risk adjustment, or risk corridor arrangements, which also stabilize premiums based upon claims experience.

Our pharmacy pricing through IngenioRx is presented to market via discounts off the average wholesale price for drugs dispensed through the retail, mail and specialty channels as well as through rebate projections. We utilize group-specific script data, formulary, network and clinical care program selection combined with administrative expense, risk and profit guidance to set market competitive pricing discounts and rebate projections. Pharmacy pricing guidelines guide the underwriting process and undergo an annual external review process to ensure market competitiveness.

BCBSA Licenses

We are a party to license agreements with the BCBSA that entitle us to the exclusive, and in certain areas, non-exclusive use of the Blue Cross and Blue Shield names and marks in assigned geographic territories. BCBSA is a national trade association of Blue Cross and Blue Shield licensees, the primary function of which is to promote and preserve the integrity of the BCBS names and marks, as well as provide certain coordination among the member companies. Each BCBSA licensee is an independent legal organization and is not responsible for obligations of other BCBSA member organizations. Although we have no right to market products and services using the BCBS names and marks outside of the states in which we are licensed to sell BCBS products, in accordance with the subscriber settlement agreement and release ("Subscriber Settlement Agreement") that was agreed to in 2020 by the BCBSA and Blue Cross and/or Blue Shield licensees, including us (the "Blue plans"), some large national employers with self-funded benefits plans have a right to request a bid for insurance coverage from a second Blue plan in addition to the local Blue plan. We are required to pay an annual license fee to the BCBSA based on enrollment and also to comply with various requirements and restrictions regarding our operations and our use of the BCBS names and marks. These requirements and restrictions include, among other things: minimum capital and liquidity requirements; enrollment and customer service performance requirements; participation in programs that provide portability of membership between plans; disclosures to the BCBSA relating to enrollment and financial conditions; disclosures as to the structure of the BCBS system in contracts with third parties and in public statements; plan governance requirements; cybersecurity requirements; a requirement that at least 80% (or, in the case of Blue Cross of California, substantially all) of a licensee's annual combined local net revenue, as defined by the BCBSA, attributable to healthcare plans and related services within its service areas must be sold, marketed, administered or underwritten under the BCBS names and marks; a requirement that at least two-thirds of a licensee's annual combined national net revenue, as defined by the BCBSA, attributable to healthcare plans and related services must be sold, marketed, administered or underwritten under the BCBS names and marks; a requirement that neither a plan nor any of its licensed affiliates may permit an entity other than a plan or

a licensed affiliate to obtain control of the plan or the licensed affiliate or to acquire a substantial portion of its assets related to licensable services; governance requirements such as a requirement that we divide our Board of Directors into three classes serving staggered three-year terms; a requirement that we guarantee certain contractual and financial obligations of our licensed affiliates; and a requirement that we indemnify the BCBSA against any claims asserted against it resulting from the contractual and financial obligations of any subsidiary that serves as a fiscal intermediary providing administrative services for Medicare Parts A and B. In addition, a change of control or violation of the BCBSA ownership limitations on our capital stock, impending financial insolvency or the appointment of a trustee or receiver or the commencement of any action against us seeking our dissolution could cause a termination of our BCBSA license agreements.

We believe that we and our licensed affiliates are currently in compliance with these standards. The standards under the license agreements may be modified in certain instances by the BCBSA. See Part I, Item 1A “Risk Factors” in this Annual Report on Form 10-K for additional details on the impact if we were not to comply with these license agreements and Note 14, “Commitments and Contingencies - *Litigation and Regulatory Proceedings – Blue Cross Blue Shield Antitrust Litigation”* of the Notes to our Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on the Subscriber Settlement Agreement.

Regulation

General

Our operations are subject to comprehensive and detailed state, federal and international regulation throughout the jurisdictions in which we do business. These laws and regulations, which can vary significantly from jurisdiction to jurisdiction, restrict how we conduct our businesses and result in additional burdens and costs to us. Further, federal and state laws and regulations are subject to amendments and changing interpretations in each jurisdiction. The application of these complex legal and regulatory requirements to the detailed operation of our businesses creates areas of uncertainty. In addition, there are numerous proposed healthcare laws and regulations at the federal and state levels, including single payer, Medicare for All and public option proposals, some of which could materially adversely affect our businesses if they were to be enacted.

Supervisory agencies, including federal and state regulators and departments of health, insurance and corporation, have broad authority to:

- grant, suspend and revoke licenses to transact business;
- regulate our products and services in great detail;
- regulate, limit, or suspend our ability to market products, including participation in Medicare and the ACA public exchanges;
- determine through a procurement process our ability to participate in certain programs, including state Medicaid programs;
- retroactively adjust premium rates;
- monitor our solvency and reserve adequacy;
- scrutinize our investment activities on the basis of quality, diversification and other quantitative criteria; and
- impose monetary and criminal sanctions for non-compliance with regulatory requirements.

To carry out these tasks, these government entities periodically examine our operations and accounts.

The health benefits business also may be adversely impacted by court and regulatory decisions that expand or invalidate the interpretations of existing statutes and regulations. It is uncertain whether we could recoup, through higher premiums or other measures, the increased costs of mandated benefits or other increased costs caused by potential legislation, regulation or court rulings. See Part I, Item 1A “Risk Factors” in this Annual Report on Form 10-K.

COVID-19

Federal and state legislation has been enacted, and is likely to continue to be enacted, in response to the COVID-19 pandemic that has had, and we expect will continue to have, a significant impact on all of our lines of business, including mandates to waive cost-sharing on COVID-19 vaccination, testing, treatment and related services. The federal government enacted the Coronavirus Preparedness and Response Supplemental Appropriations Act, the Families First Coronavirus Response Act and the Coronavirus Aid, Relief and Economic Security ("CARES") Act in March 2020, the Paycheck Protection Program and Health Care Enhancement Act in April 2020, and the Consolidated Appropriations Act of 2021 in December 2020 (the "Appropriations Act"). These acts provide, among other things, prohibitions on prior authorization and cost-sharing for certain items and services related to COVID-19 tests, reforms including waiving Medicare originating site restrictions for qualified providers providing telehealth services, financial support to healthcare providers, including expansion of the Medicare accelerated payment program to all providers receiving Medicare payments, and funding to replenish and administer small business loan programs to help small businesses keep their workers employed and healthcare benefits covered in the group market.

Regulatory changes have also been enacted, and are likely to continue to be enacted, at the state and federal level in response to the COVID-19 pandemic. Those changes, which could have a significant impact on health benefits, consumer eligibility for public programs, and our cash flows, include mandated expansion of premium payment terms including the time period for which claims can be denied for lack of payment, mandates related to prior authorizations and payment levels to providers, additional consumer enrollment windows, and an increased ability to provide services through telehealth. We are providing extensions to premium payment terms in certain situations and working closely with state regulators that are mandating or requesting such relief.

The Appropriations Act

The Appropriations Act contains a number of provisions that may have a material effect upon our business, including procedures and coverage requirements related to surprise medical bills and new mandates for continuity of care for certain patients, price comparison tools, disclosure of broker compensation and reporting on pharmacy benefits and drug costs. The various health plan-related requirements of the Appropriations Act will go into effect on January 1, 2022, and our first report on pharmacy benefits and drug costs due on December 27, 2021.

State Regulation of Insurance Companies and HMOs

Our insurance and HMO subsidiaries must obtain a certificate of authority and maintain that license in the jurisdictions in which they conduct business. The National Association of Insurance Commissioners ("NAIC") has adopted model regulations that, where adopted by states, require expanded governance practices, risk and solvency assessment reporting and the filing of periodic financial and operating reports. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. Health insurers and HMOs are subject to state examination and periodic license renewal.

In addition, we are regulated as an insurance holding company and are subject to the insurance holding company acts of the states in which our insurance company and HMO subsidiaries are domiciled. These acts contain certain reporting requirements, as well as restrictions on transactions between an insurer or HMO and its affiliates, and may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies. These holding company laws and regulations generally require registration with applicable state departments of insurance and the filing of reports describing capital structure, ownership, financial condition, certain intercompany transactions, enterprise risks, corporate governance and general business operations. In addition, state insurance holding company laws and regulations require notice or prior regulatory approval of transactions including acquisitions, material intercompany transfers of assets, guarantees and other transactions between the regulated companies and their affiliates, including parent holding companies. Applicable state insurance holding company acts also restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. "Control" is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person. Dispositions of control generally are also regulated under the state insurance holding company acts.

The states of domicile of our regulated subsidiaries have statutory risk-based capital ("RBC") requirements for health and other insurance companies and HMOs based on the Risk-Based Capital (RBC) For Health Organizations Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company's investments and products. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year. The law requires increasing degrees of regulatory oversight and intervention as a company's RBC declines. As of December 31, 2020, the RBC levels of our insurance and HMO subsidiaries exceeded all applicable mandatory RBC requirements. For more information on RBC capital and additional liquidity and capital requirements for a licensee of the BCBSA, see "Management's Discussion and Analysis of Financial Condition and Results of Operations–Liquidity and Capital Resources–*Risk-Based Capital*," included in Part II, Item 7 of this Annual Report on Form 10-K.

Ongoing Requirements and Changes Stemming from the ACA

The ACA significantly changed the United States healthcare system. While we anticipate continued efforts to invalidate, modify, repeal or replace the ACA, either through Congress or court challenges, we expect the major portions of the ACA to remain in place and continue to significantly impact our business operations and results of operations, including pricing, minimum medical loss ratios ("MLRs") and the geographies in which our products are available.

The ACA prohibits lifetime limits, certain annual limits, member cost-sharing on specified preventive benefits and pre-existing condition exclusions. Further, the ACA implemented certain requirements for insurers, including changes to Medicare Advantage payments and the minimum MLR provision that requires insurers to pay rebates to customers when insurers do not meet or exceed the specified MLR thresholds. In addition, the ACA also required a number of other changes with significant effects on both federal and state health insurance markets, including strict rules on how health insurance is rated, what benefits must be offered, the assessment of new taxes and fees (including annual fees on health insurance companies), the creation of public exchanges for Individuals and Small Groups, the availability of premium subsidies for qualified individuals, and expansions in eligibility for Medicaid. Changes to our business environment are likely to continue as elected officials at the national and state levels continue to enact, and both elected officials and candidates for election continue to propose, significant modifications to existing laws and regulations, including changes to taxes and fees. In addition, the legal challenges regarding the ACA, including a federal district court decision invalidating the ACA in its entirety, which was argued before the U.S. Supreme Court in November 2020 and has been stayed pending the U.S. Supreme Court's decision, continue to contribute to this uncertainty.

In a separate development, in April 2020, the U.S. Supreme Court ruled that the federal government is required to pay health insurance companies for amounts owed, as calculated under the risk corridor program of the ACA. In June 2020, the U.S. Court of Federal Claims entered a final judgment stipulating that we are entitled to reimbursement for risk corridor amounts from 2014, 2015 and 2016. At the end of December 2020, the U.S. Department of Health and Human Services ("HHS") issued guidance on how to treat the risk corridor recoveries, which requires us to revise previously filed minimum MLR reports and issue incremental MLR rebate payments. We recognized the net premium impact of the risk corridor recoveries in the fourth quarter of 2020. We will continue to review and evaluate the impact of the ACA as any further developments or judicial rulings occur.

In general, the Individual market risk pool that includes public exchange markets has become less healthy since its inception in 2014 and continues to exhibit risk volatility. Based on our experience in public exchange markets to date, we have made adjustments to our premium rates and participation footprint and continue to evaluate the performance of our public exchange plans. In addition, insurers have faced uncertainties related to federal government funding for various ACA programs. These factors may have a material adverse effect on our results of operations if premiums are not adequate or do not appropriately reflect the acuity of these individuals. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions utilized in setting premium rates could have a material adverse effect on our results of operations, financial position, and cash flows.

Further, implementation of the ACA brings with it significant oversight responsibilities by health insurers that may result in increased governmental audits, increased assertions of False Claims Act violations, and an increased risk of other litigation.

Federal regulatory agencies continue to modify regulations and guidance related to the ACA and markets more broadly. Some of the more significant ACA rules are described below:

- The minimum MLR thresholds by line of business for the Commercial market, as defined by HHS, are as follows:

Line of Business	%
Large Group	85
Small Group	80
Individual	80

New York state regulations require us to meet a more restrictive MLR threshold of 82% for both Small Group and Individual lines of business. The minimum MLR thresholds disclosed above are based on definitions of an MLR calculation provided by HHS, or specific states, as applicable, and differ from our calculation of "benefit expense ratio" based on premium revenue and benefit expense as reported in accordance with U.S. generally accepted accounting principles ("GAAP"). Furthermore, the definitions of the lines of business differ under the various federal and state regulations and may not correspond to our lines of business. Definitions under the MLR regulation also impact insurers differently depending upon their organizational structure or tax status, which could result in a competitive advantage to some insurance providers that may not be available to us, resulting in an uneven playing field in the industry.

The ACA also imposed a separate minimum MLR threshold of 85% for Medicare Advantage and Medicare Part D prescription drug plans ("Medicare Part D plans"). Medicare Advantage or Medicare Part D plans that do not meet this threshold will have to pay a minimum MLR rebate. If a plan's MLR is below 85% for three consecutive years, enrollment will be restricted. A Medicare Advantage or Medicare Part D plan contract will be terminated if the plan's MLR is below 85% for five consecutive years.

In addition, state Medicaid programs are required to set managed care capitation rates such that a minimum 85% MLR is projected to be achieved; however, states are not required to collect remittances if the minimum MLR is not achieved.

Approximately 54.8% and 20.2% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2020. Approximately 58.9% and 20.8% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2019.

- The ACA created an incentive payment program for Medicare Advantage plans. CMS developed the Medicare Advantage Star ratings system, which awards between 1.0 and 5.0 stars to Medicare Advantage plans based on performance in several categories, including quality of care and customer service. The Star ratings are used by CMS to award quality-based bonus payments to plans that receive a rating of 4.0 or higher. The methodology and measures included in the Star ratings system can be modified by CMS annually. As of December 31, 2020, all of our Medicare Advantage plans have received a rating of 3.0 or higher.

- Regulations require premium rate increases to be reviewed for Small Group and Individual products above specified thresholds, and may be adjusted from time to time. The regulations provide for state insurance regulators to conduct the reviews, except for cases where a state does not have an "effective" rate review program or in federal enforcement states, in which cases HHS will conduct the reviews for any rate increase.

- The ACA precludes health insurers from using health status and gender in the determination of the insurance premium.

- The ACA imposed an annual Health Insurance Provider Fee ("HIP Fee") on health insurers that write certain types of health insurance on U.S. risks, which has been permanently eliminated effective January 1, 2021. The HIP Fee was allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to the amount of health insurance premium for all U.S. health risk for those certain lines of business written during the preceding calendar year. The HIP Fee was non-deductible for federal income tax purposes. Our affected products were priced to cover the increased selling, general and administrative and income

tax expenses associated with the HIP Fee when it was in effect. The total amount due from allocations to health insurers was $15.5 billion for 2020 and was suspended for 2019.

- Medicare Advantage reimbursement rates will not increase as much as they would otherwise due to the payment formula promulgated by the ACA that continues to impact reimbursements. We also expect further and ongoing regulatory guidance on a number of issues related to Medicare, including evolving methodology for ratings and quality bonus payments. CMS is also proposing changes to its program that audits data submitted under the risk adjustment programs in a way that would increase financial recoveries from plans.

Drug Benefit and Pharmacy Benefit Manager Regulation

Pharmacy benefit managers are regulated at both the federal and state levels and must comply with federal and state statutes and regulations governing labeling, packaging, advertising and adulteration of prescription drugs, dispensing of controlled substances, and licensing. In recent years the federal government has banned certain business practices, including “gag clauses,” which prohibited pharmacists from informing patients when a lower cost drug was available as a substitute, and “clawbacks,” which occurred when pharmacy benefit managers sought to recoup the difference between the reimbursed cost of the drug and the patient’s copay and the drug itself was less expensive than the copay paid by the patient. Regulation in the states varies dramatically and ranges from licensure of PBMs as third-party administrators, licensure specifically as a pharmacy benefit manager, and licensure accompanied by additional disclosures and limitations of business practices to varying degrees. The NAIC is working on a PBM model law that, if adopted widely, could result in a more standardized approach to PBM regulation in the states in the future. However, in December 2020, the U.S. Supreme Court let stand an Arkansas law regulating PBMs, which could be a precursor to greater state regulation of PBMs in the future.

A number of proposals are being considered at the federal and state levels that would increase regulation of drug benefits and pharmacy benefit managers. Such proposals under consideration include (1) regulation of rebates from drug manufacturers that would require rebate dollars to be applied at the point-of-sale, (2) federal policy changes to set the prices for a subset of drugs covered under the Medicare program, (3) reforms to the Medicare drug benefit, such as beneficiary cost-sharing changes that aim to lower consumer costs, (4) attempts at both the federal and state levels to ban the use of spread pricing contracts in both the Commercial and Medicaid markets, and (5) electronic prior authorizations of drugs. These reforms have the potential to have broad impacts on our PBM business and could materially adversely affect our business if they are enacted.

Privacy, Confidentiality and Data Standards Regulation

The federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the administrative simplification provisions of HIPAA impose a number of requirements on covered entities (including insurers, HMOs, group health plans, providers and clearinghouses) and their business associates relating to the use, disclosure and safeguarding of protected health information. These requirements include uniform standards of common electronic healthcare transactions; privacy and security regulations; and unique identifier rules for employers, health plans and providers.

Also, the Health Information Technology for Economic and Clinical Health (“HITECH”) Act provisions of the American Recovery and Reinvestment Act of 2009 and corresponding implementing regulations have imposed additional requirements on the use and disclosure of protected health information such as additional breach notification and reporting requirements, contracting requirements for HIPAA business associate agreements, strengthened enforcement mechanisms and increased penalties for HIPAA violations. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

The federal Gramm-Leach-Bliley Act generally places restrictions on the disclosure of non-public information to non-affiliated third parties, and requires financial institutions, including insurers, to provide customers with notice regarding how their non-public personal information is used, including an opportunity to “opt out” of certain disclosures. State departments of insurance and certain federal agencies adopted implementing regulations as required by federal law.

The Cybersecurity Information Sharing Act of 2015 encourages organizations to share cyber threat indicators with the federal government and, among other things, directed HHS to develop a set of voluntary cybersecurity best practices for organizations in the healthcare industry.

In addition, public exchanges are required to adhere to privacy and security standards with respect to personally identifiable information and to impose privacy and security standards that are at least as protective as those the public exchange has implemented for itself on insurers offering plans through the public exchanges and their designated downstream entities, including pharmacy benefit managers and other business associates. These standards may differ from, and be more stringent than, HIPAA.

Furthermore, states have begun enacting more comprehensive privacy laws and regulations addressing consumer rights to data protection or transparency that may affect our privacy and security practices, such as state laws like the California Consumer Privacy Act that govern the use, disclosure and protection of member data and impose additional breach notification requirements. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Complying with conflicting cybersecurity regulations and varying enforcement philosophies, which may differ from state to state, requires significant resources and may materially and adversely affect our ability to standardize our products and services across state lines.

Federal regulations have been finalized in the following areas that will materially impact our operations:

- Federal regulations on data interoperability that will require claims data to be made available to third parties unaffiliated with Anthem; and
- Federal regulations requiring hospitals and health insurers to publish negotiated prices for services.

Federal regulations have also been proposed that will expand the final regulation on data interoperability to require health insurers to build new application programming interfaces to afford patients access to their health information and require electronic prior authorizations for commercial Qualified Health Plans in the federal exchange as well as Medicaid and CHIP fee-for-service and managed care organizations. These regulations are expected to materially impact our operations if finalized.

Employee Retirement Income Security Act of 1974

The provision of services to certain employee welfare benefit plans is subject to the Employee Retirement Income Security Act of 1974, as amended (“ERISA”) a complex set of laws and regulations subject to interpretation and enforcement by the Internal Revenue Service (“IRS”) and the Department of Labor. ERISA regulates certain aspects of the relationships between us, the employers that maintain employee welfare benefit plans subject to ERISA and participants in such plans. Some of our administrative services and other activities may also be subject to regulation under ERISA. In addition, certain states require licensure or registration of companies providing third-party claims administration services for benefit plans. We provide a variety of products and services to employee welfare benefit plans that are covered by ERISA. Plans subject to ERISA can also be subject to state laws, and the question of whether and to what extent ERISA preempts a state law has been, and will continue to be, interpreted by many courts.

Guaranty Fund Assessments

Under insolvency or guaranty association laws in most states, insurance companies and HMOs can be assessed for amounts paid by guaranty funds for policyholder losses incurred when an insurance company or HMO becomes insolvent. Most state insolvency or guaranty association laws currently provide for assessments based upon the amount of premiums received on insurance underwritten within such state (with a minimum amount payable even if no premium is received). Under many of these guaranty association laws, assessments are made retrospectively. Some states permit insurers or HMOs to recover assessments paid through full or partial premium tax offsets or through future policyholder surcharges. The amount and timing of any future assessments cannot be predicted with certainty; however, future assessments are likely to occur.

Human Capital

At Anthem, it starts with our culture, and our associates are critical to fulfilling our purpose of improving the health of humanity. As of December 31, 2020, we had approximately 83,400 associates. We are working to build a high performance culture that enhances our ability to deliver on our commitments and guides us to address the challenges of today. We believe that our culture allows us to attract and retain talented and experienced individuals to support the communities we serve. Our

associates actively participate through online feedback tools and we leverage these associate feedback tools and engagement surveys to monitor and take action on responses.

Inclusion & Diversity

The diversity of our associates is central to achieving key strategies and improving performance. We believe a diverse and inclusive workforce enables a deeper connection with members and drives greater business results. We honor the diversity of our associates—in gender, race/ethnicity, age, gender identity, sexual orientation, socio-economic status, language, nationality, abilities and life experiences. As of December 31, 2020, our U.S. associate population was approximately 76% female and 48% ethnically diverse.

Talent Development

Growing and developing our talent internally is key to our succession plans and our ability to lead at our best every day. To inspire a high-performance culture and promote talent excellence, we offer individual, career and leadership development opportunities, encouraging associates to continually learn and grow. We offer various instructor-led and virtual instructor-led programs and maintain a vast curriculum of relevant, on-demand learning and development resources.

Health & Wellbeing

We have the privilege of touching the lives of millions of people each day, and for us, this starts with the health of our own associates. To improve the health and wellbeing of our associates, we offer a comprehensive compensation package, including competitive salaries, a 401(k) plan and medical, dental, vision and disability coverage. In addition, we offer our associates wellness and behavioral programs and tools to help them get and stay healthy and more easily manage their work and personal lives.

COVID-19 Response

We moved swiftly in our response to the COVID-19 pandemic to promote the safety of our associates and best serve our members and communities. In March of 2020, we implemented business continuity plans, transitioning the majority of our associates to remote work environments, while maintaining service operations. We have provided our associates with additional benefits, support and resources to help them manage the complexities of working from home and handling caregiver and family needs. In addition to their current benefits, we are providing up to 80 hours of COVID-related additional paid time off for associates to use when they are unable to work due to quarantine or illness or to provide care to a family member, and we provided a one-month premium holiday and added an extra paid day off as a “Wellness Holiday” on December 31, 2020. In addition to our associate assistance program, we provide materials and behavioral health resources to our associates that address important emotional health issues.

Available Information

We are a large accelerated filer (as defined in Rule 12b-2 of the Securities Exchange Act of 1934, as amended (the “Exchange Act”)) and are required, pursuant to Item 101 of Regulation S-K, to provide certain information regarding our website and the availability of certain documents filed with or furnished to the U.S. Securities and Exchange Commission (“SEC”). The SEC maintains a website that contains reports, proxy and information statements and other information regarding issuers at www.sec.gov. Our website is www.antheminc.com. We have included our website address throughout this Annual Report on Form 10-K as a textual reference only. The information contained on, or accessible through, our website is not incorporated into this Annual Report on Form 10-K. We make available, free of charge, by mail or through our website, our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act as soon as reasonably practicable after we electronically file such material with or furnish it to the SEC. We also include on our website our Corporate Governance Guidelines, our Code of Conduct and the charter of each standing committee of our Board of Directors. In addition, we intend to disclose on our website any amendments to, or waivers from, our Code of Conduct that are required to be publicly disclosed pursuant to rules of the SEC and the New York Stock Exchange (“NYSE”). Anthem, Inc. is an Indiana corporation incorporated on July 17, 2001.

ITEM 1A. RISK FACTORS.

In evaluating our business, the risks described below, as well as the other information contained in this Annual Report on Form 10-K, should be carefully considered. Any one or more of such risks could materially and adversely affect our business, financial condition, results of operations and stock price and could cause our actual results of operations and financial condition to vary materially from past or anticipated future results of operations and financial condition. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial may also adversely affect us.

BUSINESS RISKS

The outbreak of the COVID-19 pandemic and measures taken to prevent its spread are adversely affecting our business in a number of ways, and we are unable to predict the full extent of those impacts on our business, cash flows, financial condition and results of operations, but the impact could be material.

The COVID-19 pandemic is evolving, and the impact of COVID-19, and the actions taken to contain its spread or address its impact, could have a material adverse effect on our operations and financial results in the future. We continue to closely monitor developments related to the COVID-19 pandemic to assess its ongoing impact on our business. The extent of this impact will depend on future developments, which are highly uncertain and cannot be predicted at this time, including, but not limited to, the transmission rate, duration and spread of the outbreak, its severity, the extent and effectiveness of the actions taken to contain the spread of the virus and address its impacts, and how quickly and to what extent normal economic and operating conditions can resume. Factors that could negatively impact our ability to operate successfully during or following the COVID-19 pandemic, or that could otherwise significantly adversely impact and disrupt our business, cash flows, financial condition and results of operations include, but are not limited to, the following:

- Continued increases in healthcare costs due to higher utilization rates of medical facilities and services, medical expenses and other increases in associated hospital and pharmaceutical costs. We continue to offer our members expanded benefit coverage, such as providing full coverage for COVID-19 testing and treatment and governmental action has required, and may continue to require, us to provide additional coverage.
- Decreased predictability of Medicare and Medicaid rates due to changes in utilization of medical facilities and services, medical expenses, and other costs as a result of the impact of COVID-19. We experienced rate adjustments from certain state Medicaid regulators in 2020 in response to decreased utilization of medical facilities and services, and we may experience further adjustments in the future with regard to current and prior year rates.
- Increased estimation uncertainty on our claims liability due to the impact of COVID-19 on healthcare utilization and medical claims submission.
- A reduction in enrollment in our health benefits and PBM products and services, or a continued change in membership mix to less profitable lines of business, as a result of reductions in workforce by existing customers and other impacts of an economic downturn.
- Cash flow volatility or shortfalls caused by an increase in delayed, delinquent or non-collectable payments from customers and government payers.
- Reductions in our operating effectiveness as our employees work from home or otherwise are impacted by COVID-19. The majority of our workforce continues to work remotely in an effort to mitigate the spread of COVID-19, which may exacerbate certain risks to our business, including an increased demand for information technology resources, increased risk of phishing and other cybersecurity attacks, and increased risk of unauthorized dissemination of sensitive personal information or proprietary or confidential information about us, our members or other third parties.
- Disruptions in our normal business operations due to disruptions in public and private infrastructure, including communications, financial services and supply chains.
- Loss of functionality due to the disruption of services provided to us by third-party vendors, including as a result of financial difficulties experienced by such vendors and the impact of vendor employees working from home or otherwise being impacted by COVID-19.
- A decrease in the value of our investments, which may result in losses charged to income.
- Increased cost of capital and limited ability to access the capital markets due to disruption and volatility in global financial markets or a downgrade in our credit rating.

If we fail to appropriately predict, price for and manage healthcare costs, the profitability of our products could decline, which could materially adversely affect our business, cash flows, financial condition and results of operations.

Our profitability depends in large part on accurately predicting and pricing healthcare costs and on our ability to manage future healthcare costs through medical management, product design, negotiation of favorable provider contracts and underwriting criteria. Total healthcare costs are affected by the number of individual services rendered, the cost of each service and the type of service rendered. Numerous factors affecting the cost of healthcare may adversely affect our ability to predict and manage healthcare costs, as well as our business, cash flows, financial condition and results of operations. These factors include, among others, changes in healthcare practices, demographic characteristics including the aging population, medical cost inflation, the introduction of new technologies, drugs and treatments, increased cost of individual services, increases in the cost and number of prescription drugs, clusters of high cost cases, increased use of services, including due to natural catastrophes or other large-scale medical emergencies, epidemics or pandemics such as COVID-19, new treatment guidelines, new mandated benefits (such as the expansion of essential benefits coverage) and changes to other regulations impacting our business, such as the health plan price transparency regulations issued in October 2020 by the U.S. Departments of Health and Human Services, Labor and Treasury (the “Health Plan Transparency Rule”) and the Appropriations Act.

Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of premium revenues can result in significant changes in our results of operations. Generally, our premiums on Commercial policies and Medicaid contracts are fixed for a 12-month period and are determined several months prior to the commencement of the premium period. Our revenue on Medicare policies is based on bids submitted to CMS six months prior to the start of the contract year. Accordingly, the costs we incur in excess of our benefit cost projections generally are not recovered in the contract year through higher premiums. Existing Medicaid contract rates are often established by the applicable state, and our actual costs may exceed those rates. Although we base our Commercial premiums, our Medicare and Medicaid bids, and our acceptance of state-established Medicaid rates on our estimates of future medical costs over the fixed contract period, many factors, including those discussed above, may cause actual costs to exceed those estimated and reflected in premiums and bids.

Although federal and state premium and risk adjustment mechanisms could help offset healthcare benefit costs in excess of our projections if our assumptions utilized in setting our premium rates are significantly different than actual results, our results of operations and financial condition could still be adversely affected. The reserves that we establish for health insurance policy benefits and other contractual rights and benefits are based upon assumptions concerning a number of factors, including trends in healthcare costs, expenses, general economic conditions and other factors. To the extent the actual claims experience is unfavorable as compared to our underlying assumptions, our incurred losses would increase and future earnings could be adversely affected.

In addition to the challenge of managing healthcare costs, we face pressure to contain premium rates. Our customers may renegotiate their contracts to seek to contain their costs or may move to a competitor to obtain more favorable premiums. Further, federal and state regulatory agencies may restrict or prevent entirely our ability to implement changes in premium rates. A limitation on our ability to increase or maintain our premium or reimbursement levels or a significant loss of membership resulting from our need to increase or maintain premium or reimbursement levels could adversely affect our business, cash flows, financial condition and results of operations.

A significant reduction in the enrollment in our health benefits programs or PBM products or services, particularly in states where we have large regional concentrations, could have an adverse effect on our business, cash flows, financial condition and results of operations.

A significant reduction in the number of enrollees in our health benefits programs or PBM products or services could adversely affect our business, cash flows, financial condition and results of operations. Factors that could contribute to a reduction in enrollment include: reductions in workforce by existing customers; a general economic upturn that results in fewer individuals being eligible for Medicaid programs; a general economic downturn that results in business failures and high unemployment rates, as has been experienced as a result of the COVID-19 pandemic; employers no longer offering certain healthcare coverage as an employee benefit or electing to offer coverage on a voluntary, employee-funded basis; participation on public exchanges; federal and state regulatory changes; failure to obtain new customers or retain existing

customers; premium increases and benefit changes; our exit from a specific market; negative publicity and news coverage; and failure to attain or maintain nationally recognized accreditations.

The states in which we operate that have the largest concentrations of revenues include California, Florida, Georgia, Indiana, New York, Ohio, Texas and Virginia. Due to this concentration of business in these states, we are exposed to potential losses resulting from the risk of state-specific or regional economic downturns impacting these states. If any such negative economic conditions do not improve, we may experience a reduction in existing and new business, which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

A cyber attack or other privacy or data security incident could result in an unauthorized disclosure of sensitive or confidential information, cause a loss of data, disrupt a large amount of our operations, give rise to remediation or other expenses, expose us to liability under federal and state laws, and subject us to litigation and investigations, which could have an adverse effect on our business, cash flows, financial condition and results of operations.

As part of our normal operations, we collect, process and retain certain sensitive and confidential information. We are subject to a variety of continuously evolving federal, state and international laws and rules regarding the use and disclosure of certain sensitive or confidential information, including HIPAA, the HITECH Act, the Gramm-Leach-Bliley Act and numerous state laws governing personal information. Our facilities and systems, and those of our third-party service providers, are regularly the target of, and may be vulnerable to, cyber attacks, security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other threats.

We have been, and may in the future be subject to litigation and governmental investigations related to cyber attacks and security breaches, which could divert the attention of management from the operation of our business, result in reputational damage and have a material adverse impact on our business, cash flows, financial condition and results of operations. While we have contingency plans and insurance coverage for potential liabilities of this nature, they may not be sufficient to cover all claims and liabilities.

We cannot ensure that we will be able to identify, prevent or contain the effects of cyber attacks or other cybersecurity risks that bypass our security measures or disrupt our information technology systems or business. We have security technologies, processes and procedures in place to protect against cybersecurity risks and security breaches. However, hardware, software or applications we develop or procure from third parties may contain defects in design, manufacturer defects or other problems that could unexpectedly compromise information security. In addition, because the techniques used to obtain unauthorized access, disable or degrade service or sabotage systems change frequently, are becoming increasingly sophisticated, and may not immediately produce signs of intrusion, we may be unable to anticipate these techniques, timely discover or counter them or implement adequate preventative measures. Viruses, worms or other malicious software programs may be used to attack our systems or otherwise exploit any security vulnerabilities, and such security attacks may cause system disruptions or shutdowns, or may cause personal information or proprietary or confidential information to be misappropriated or compromised. As a result, cybersecurity and the continued development and enhancement of our controls, processes and practices designed to protect our systems, computers, software, data and networks from attack, damage and unauthorized access remain a priority for us.

Noncompliance with any privacy or security laws and regulations, or any security breach, cyber attack or cybersecurity breach, and any incident involving the misappropriation, loss or other unauthorized disclosure or use of, or access to, sensitive or confidential information, whether by us or by one of our third-party service providers, could require us to expend significant resources to continue to modify or enhance our protective measures and to remediate any damage. In addition, this could negatively affect our operations, cause system disruptions, damage our reputation, cause membership losses and contract breaches, and could also result in regulatory enforcement actions, material fines and penalties, litigation or other actions that could have a material adverse effect on our business, cash flows, financial condition and results of operations.

There are various risks associated with participating in Medicaid and Medicare programs, including dependence upon government funding and the timing of payments, compliance with government contracts and increased regulatory oversight.

We contract with various federal and state agencies, including CMS, to provide managed healthcare services, such as Medicare Advantage, Medicare Part D, Medicare Supplement, Medicaid, TANF, SPD, LTSS, CHIP, ACA-related Medicaid expansion programs and various specialty programs. We also provide various administrative services for several other entities

offering medical and/or prescription drug plans to their Medicaid or Medicare eligible members through our affiliated companies, and we offer employer group waiver plans which provide medical and/or prescription drug coverage to retirees. We are also participating in programs in several states for the care of dual-eligible members. Regulatory reform initiatives or changes in existing laws or regulations applicable to these programs, or their interpretations, are difficult to predict and could have a material adverse effect on our business, cash flows, financial condition and results of operations.

Revenues from the Medicare and Medicaid programs are dependent, in whole or in part, upon annual funding from the federal government and/or applicable state governments, and base premium rates paid by each state or federal agency differ depending upon a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region, benefit mix, member eligibility category and risk scores. Future rates may be affected by continued government efforts to contain costs as well as federal and state budgetary constraints, and certain state contracts are subject to cancellation in the event of the unavailability of state funds. Additionally, ongoing CMS system changes related to the data it uses to calculate risk scores in the Medicare Advantage program may impact our federal funding. If the federal government or any state in which we operate were to decrease rates paid to us, pay us less than the amount necessary to keep pace with our cost trends, cancel our contracts retroactively or seek an adjustment to previously negotiated rates, it could have a material adverse effect on our business, cash flows, financial condition and results of operations. In addition, various states' MMPs are still subject to uncertainty surrounding payment rates and other requirements, which could affect where we seek to participate in these programs. An unexpected reduction in payments, inadequate government funding or significantly delayed payments for these programs may adversely affect our business, cash flows, financial condition and results of operations.

Other potential risks associated with Medicare Advantage and Medicare Part D plans include increased medical or pharmaceutical costs, data corrections identified as a result of ongoing auditing and monitoring activities, potential uncollectability of receivables resulting from processing and/or verifying enrollment, inadequacy of underwriting assumptions, inability to receive and process correct information (including inability due to systems issues by the federal government, the applicable state government or us), uncollectability of premiums from members, and limited enrollment periods. Actual results may be materially different than our assumptions and estimates and could have a material adverse effect on our business, financial condition and results of operations. Finally, there is the possibility that the Medicare Advantage program could be significantly impacted by any future modification, repeal or replacement of the ACA.

Our contracts with CMS and state governmental agencies contain certain provisions regarding data submission, risk adjustment, provider network maintenance, quality measures, claims payment, encounter data, continuity of care, call center performance and other requirements specific to federal and state program regulations. We have been subject in the past, and may again be in the future, to administrative actions, fines, penalties, liquidated damages or retrospective adjustments in payments made to our health plans as a result of a failure to comply with those requirements, which has impacted and in the future could impact our profitability. Due to decreased utilization of medical facilities and services as a result of the COVID-19 pandemic, we experienced retroactive rate adjustments by certain state Medicaid agencies, and rate adjustments may continue in the future. As members have accessed care during the COVID-19 pandemic, we have experienced increased difficulty obtaining provider information required by CMS and state governmental agencies and, as a result, may have difficulty meeting these quality measures. In addition, we could be required to file a corrective plan of action with additional penalties for noncompliance, which could have a negative impact on future membership enrollment levels. Further, our existing CMS or state Medicaid contracts have not always been renewed, we have not always been awarded new contracts as a result of the competitive procurement process, and in some cases we have lost members under existing contracts as a result of a post-award challenge, each of which could take place again in the future and have a material adverse effect on our business, cash flows, financial condition and results of operations.

Further, the Star Rating System utilized by CMS to evaluate Medicare Advantage Plans may have a significant effect on our revenue, as higher-rated plans tend to experience increased enrollment and plans with a Star rating of 4.0 or higher are eligible for quality-based bonus payments and can market to and enroll members year-round. If we do not maintain or continue to improve our Star ratings, fail to meet or exceed our competitors' Star ratings, or if quality-based bonus payments are reduced or eliminated, we may experience a negative impact on our revenues and the benefits that our plans can offer, which could materially and adversely affect the marketability of our plans, our membership levels, results of operations, financial condition and cash flows. Similarly, if we fail to meet or exceed any performance standards imposed by state Medicaid programs in which we participate, we may not receive performance-based bonus payments or may incur penalties.

In addition, our failure to comply with federal and state healthcare laws and regulations applicable to our participation in Medicaid and Medicare programs, including those directed at preventing fraud, abuse and discrimination in government-funded programs, could result in investigations, litigation, fines, restrictions on, or exclusions from, program participation, or the imposition of corporate integrity agreements or other agreements with a federal or state governmental agency, any of which could adversely impact our business, cash flows, financial condition and results of operations.

We are periodically subject to government audits, including CMS Risk Adjustment Data Validation ("RADV") audits of our Medicare Advantage Plans to validate diagnostic data, patient claims and financial reporting, and audits of our Medicare Part D plans by the Medicare Part D Recovery Audit Contractor ("RAC") as well as state Medicaid RAC programs authorized by the ACA. These audits could result in significant adjustments in payments made to our health plans, which could adversely affect our financial condition and results of operations. If we fail to report and correct errors discovered through our own auditing procedures or during a RADV or RAC audit, or otherwise fail to comply with applicable laws and regulations, we could be subject to fines, civil penalties or other sanctions which could have a material adverse effect on our ability to participate in these programs, and on our financial condition, cash flows and results of operations.

Our Medicare and Medicaid contracts are also subject to various MLR rules, including minimum MLR thresholds, rebate requirements and audits, which could adversely affect our membership and revenues if any of our state Medicare or Medicaid plans do not meet an applicable minimum MLR threshold. If a Medicare Advantage, MMP or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to participate in open enrollment. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS.

A change in our healthcare product mix may impact our profitability.

Our healthcare products that involve greater potential risk generally tend to be more profitable than administrative services products and those healthcare products where the employer groups assume the underwriting risks. Individuals and small employer groups are more likely to purchase our higher-risk healthcare products because such purchasers are generally unable or unwilling to bear greater liability for healthcare expenditures. Typically, government-sponsored programs also involve our higher-risk healthcare products. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on our cash flows, financial condition and results of operations.

If we fail to develop and maintain satisfactory relationships with hospitals, physicians, PBM service providers and other healthcare providers, our business, cash flows, financial condition and results of operations may be adversely affected.

Our profitability is dependent in part upon our ability to contract on favorable terms with hospitals, physicians, PBM service providers and supply chain partners and other healthcare providers. Physicians, hospitals and other healthcare providers may elect not to contract with us, and the failure to secure or maintain cost-effective healthcare provider contracts on competitive terms may result in a loss of membership or higher medical costs, which could adversely affect our business. In addition, consolidation among healthcare providers, ACO practice management companies, and other organizational structures that physicians, hospitals and other care providers choose, as well as the ability of larger employers to contract directly with providers, may change the way that these providers interact with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which may impact our relationship with these providers or affect the way that we price our products and estimate our costs and may require us to incur costs to change our operations, which could adversely affect our business, cash flows, financial condition and results of operations. In addition, price transparency initiatives, such as the Health Plan Transparency Rule, may impact our ability to obtain or maintain favorable contract terms. For example, beginning in 2021, hospitals will be required to publish online payer-specific negotiated charges for each item or services the hospital provides.

Our inability to contract with providers, or if providers attempt to use their market position to negotiate more favorable contracts or place us at a competitive disadvantage, or the inability of providers to provide adequate care, could adversely affect our business. In addition, we do not have contracts with all providers that render services to our members and, as a result, may not have a pre-established agreement about the amount of compensation those out-of-network providers will accept for the services they render, which can result in significant litigation or arbitration proceedings, or provider attempts to obtain payment from our members for the difference between the amount we have paid and the amount they have charged.

We are dependent on the success of our relationships with third parties for various services and functions.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Certain of these third parties provide us with significant portions of our business infrastructure and operating requirements. For example, a single vendor provides us with a wide range of technology infrastructure services, including end user (help desk and field support), data center, mainframe, storage and database services, cloud infrastructure and multi-cloud management services, and we are subject to the risks of any operational failure, termination or other restraints in this arrangement. We could become overly dependent on key vendors, which could cause us to lose core competencies. A termination of our agreements with, or disruption in the performance of, one or more of these service providers could result in service disruptions or unavailability, reduced service quality and effectiveness, increased or duplicative costs or an inability to meet our obligations to our customers. In addition, we may also have to seek alternative service providers, which may be unavailable or only available on less favorable contract terms. Any of these outcomes could adversely affect our business, reputation, cash flows, financial condition and operating results.

Our PBM services business in particular would be adversely affected if we are unable to contract on favorable terms with third-party vendors, including pharmaceutical manufacturers. We delegate certain PBM administrative functions, such as claims processing and prescription fulfillment, to CVS Health pursuant to the CVS PBM Agreement. If CVS Health fails to provide PBM services as contractually required, we may not be able to meet the full demands of our customers, which could have a material adverse effect on our business, reputation and results of operations. For additional information on the CVS PBM Agreement, see “Business — Product and Service Descriptions,” in Part I, Item 1 of this Annual Report on Form 10-K.

The failure to effectively maintain and upgrade our information systems could adversely affect our business.

Our business depends significantly on effective information systems, and we have many different information systems for our various businesses, including those that we have acquired as a result of our merger and acquisition activities. Our information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and develop new systems in order to keep pace with continuing changes in information processing technology, emerging cybersecurity risks and threats, changing customer preferences, evolving industry and regulatory standards and legal requirements, including as a result of the ACA, the Health Plan Transparency Rule, the Appropriations Act and proposed federal data interoperability regulations. In addition, we may from time to time obtain significant portions of our systems-related or other services or facilities from independent third parties, which may make our operations vulnerable if such third parties fail to perform adequately.

Failure to adequately implement and maintain effective and efficient information systems with sufficiently advanced technological capabilities, or our failure to efficiently and effectively consolidate our information systems to eliminate redundant or obsolete applications, could result in competitive and cost disadvantages to us compared to our competitors, and a diversion of management’s time and could have a material adverse effect on our business, financial condition and results of operations. If the information we rely upon to run our business were found to be inaccurate or unreliable or if we fail to adequately maintain our information systems and data integrity effectively, we could experience problems in determining medical cost estimates and establishing appropriate pricing and reserves, have disputes with customers and providers, face regulatory problems, including sanctions and penalties, incur increases in operating expenses or suffer other adverse consequences, including a decrease in membership.

Large-scale medical emergencies may have a material adverse effect on our business, cash flows, financial condition and results of operations.

Natural disasters, war, terrorism, political events, global climate change and other similar occurrences could create large-scale medical emergencies or otherwise have a material adverse effect on our business, cash flows, financial condition and results of operations. Large-scale medical emergencies can take many forms and can cause widespread illness and death and have other far-reaching impact. For example, the ongoing COVID-19 global pandemic has caused illness, deaths, quarantines, business and school shutdowns, reductions in business activity, travel and financial transactions, unemployment, labor shortages, supply chain interruptions and overall economic and financial market instability. In addition, federal and state law enforcement officials have issued warnings about potential terrorist activity involving biological and other weapons, and natural disasters such as hurricanes and the potential for a widespread pandemic of influenza or other illness coupled with the lack of availability of appropriate preventative medicines could have a significant impact on the health of the population

of widespread areas. If the United States were to experience widespread bioterrorism or other attacks, large-scale natural disasters in our concentrated coverage areas or an epidemic or pandemic such as the ongoing COVID-19 pandemic, our covered medical expenses could rise, our operations could be interrupted and we could experience a material adverse effect on our business, cash flows, financial condition and results of operations or, in the event of extreme circumstances, our viability could be threatened. Furthermore, global climate change could result in certain types of natural disasters occurring more frequently or with more intense effects, and may have a long-term effect on general economic conditions and the healthcare or pharmacy industry in particular, which could adversely affect our business and financial results. For additional information, see the risk factor above describing the impact of the COVID-19 pandemic on our business, cash flows, financial condition and results of operations.

LEGAL, REGULATORY AND PUBLIC POLICY RISKS

We are subject to significant government regulation, and changes or proposed changes in the regulation of our business by federal and state regulators may adversely affect our business, cash flows, financial condition and results of operations and the market price of our securities.

We are subject to significant state and federal regulation associated with many aspects of our business, including, but not limited to, licensing, premiums, marketing activities, provider contracting, access and payment standards, and corporate governance and financial reporting matters, as described in greater detail in Part I, Item 1 “Business—Regulation” in this Annual Report on Form 10-K. Further, the integration into our business of entities that we acquire, or the expansion of our business into new areas, may affect the way in which existing laws and rules apply to us, including by subjecting us to laws and rules that did not previously apply to us.

Changes in existing laws, rules and regulatory interpretation or future laws, rules, regulatory interpretations or judgments could force us to change how we conduct our business, affect the products we offer (and where we offer them), restrict revenue and enrollment growth, increase our costs, including operating, healthcare technology and administrative costs, restrict our ability to obtain new product approvals and implement changes in premium rates and require enhancements to our compliance infrastructure and internal controls environment, which could adversely impact our business and results of operations. In addition, legislative and/or regulatory policies or proposals that seek to manage the healthcare industry or otherwise impact our business may cause the market price of our securities to decrease, even if such policies or proposals never become effective.

We are required to obtain and maintain insurance and other regulatory approvals to market certain of our products, to increase prices for certain regulated products and to consummate some of our acquisitions and dispositions. Delays in obtaining or failure to obtain or maintain these approvals, as well as future regulatory action by state or federal authorities, could have a material adverse effect on the profitability or marketability of our health benefits or managed care products or on our business, financial condition and results of operations. For example, requirements in the Health Plan Transparency Rule and the Appropriations Act including the price comparison tool and other requirements have the potential to increase healthcare costs and our operating costs in order to comply, and also may impact provider negotiations and market pricing. In addition, changes in government regulations or policies that apply to government-sponsored programs such as Medicare and Medicaid including, among other things, reimbursement levels, eligibility requirements, benefit coverage requirements and additional governmental participation, could also adversely affect our business, cash flows, financial condition and results of operations. Where states allow certain programs to expire or have not opted for Medicaid expansion under the ACA, we could experience reduced Medicaid enrollment and reduced growth opportunities. If future modifications to laws and regulations significantly reduce Medicaid enrollment, our Medicaid business will be negatively impacted.

We have experienced assessments in the past under state or federal insolvency or guaranty association laws applicable to insurance companies, HMOs and other payers, and may experience assessments in the future if, for example, premiums established by other companies for their health insurance products, including certain long-term care products, are inadequate to cover their costs. Any such assessment could expose us to the risk of paying a portion of an impaired or insolvent insurance company’s claims through state guaranty associations. We are not currently able to estimate our potential financial obligations, losses, or the availability of offsets associated with potential guaranty association assessments; however, any significant increase in guaranty association assessments could have a material adverse effect on our business, cash flows, financial condition and results of operations.

We expect state legislatures will continue to focus on healthcare delivery and financing issues, including actions to reduce or limit increases to premium payments, provider billing protections, and broader reforms of their health insurance markets. State ballot initiatives can also be put to voters that would substantially impair our operating environment. If enacted into law, these state proposals could have a material adverse impact on our business, cash flows, operations or financial condition.

Additionally, from time to time, Congress has considered, and may consider in the future, various forms of managed care reform legislation which, if adopted, could fundamentally alter the treatment of coverage decisions under ERISA and could increase our costs, expose us to expanded liability or require us to revise the ways in which we conduct business. There have been legislative attempts to limit ERISA's preemptive effect on state laws and litigants' ability to seek damages beyond the benefits offered under their plans. If adopted, such limitations could increase our liability exposure, permit greater state regulation of our operations, and expand the scope of damages, including punitive damages, litigants could be awarded.

The ongoing changes to the ACA and related laws and regulations could adversely affect our business, cash flows, financial condition and results of operations.

The ongoing changes in federal and state laws and regulations stemming from the ACA, including the steps that have been taken to amend, repeal and limit the scope and application of the ACA, continue to represent significant challenges to the U.S. healthcare system. We are unable to predict how these events will ultimately be resolved, what impact the 2020 U.S. Presidential and Senate elections may have, and what the ultimate impact may be on our business, including, but not limited to, our products, services, processes and technology, and on our relationships with current and future customers and healthcare providers. The legal challenges regarding the ACA, including a federal district court decision invalidating the ACA in its entirety, which was argued before the U.S. Supreme Court in November 2020 and has been stayed pending the U.S. Supreme Court's decision, continue to contribute to this uncertainty. Further regulations and modifications to the ACA at the federal or state level, including a judicial invalidation of the ACA, could significantly impact the market for our products, the regulations applicable to us and the fees and taxes payable by us and otherwise have significant effects on our business and future operations, some of which may adversely affect our results of operations and financial condition.

In general, the risk pool for the Individual market, which includes public exchange markets, has become less healthy since its inception in 2014 and continues to exhibit risk volatility. In addition, insurers have faced uncertainties related to federal government funding for various ACA programs. Based on our experience in public exchange markets to date, we have made adjustments to our premium rates and geographic participation, and will continue to evaluate the performance of our public exchange plans, the future viability of the public exchanges and availability of federal subsidies, and may make further adjustments to our rates and participation going forward. These factors may have a material adverse effect on our results of operations if premiums are not adequate or do not appropriately reflect the acuity of these individuals. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions utilized in setting premium rates could have a material adverse effect on our results of operations, financial position, and cash flows.

For additional information related to the ACA, see Part I, Item 1 "Business" and Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" of this Annual Report on Form 10-K.

We are subject to various risks associated with our international operations.

Certain of our subsidiaries that provide services to some of our health plans operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business related to, among other things, taxation, intellectual property, investment, management control, labor, anti-fraud, anti-corruption and privacy and data protection regulations. In addition, we are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business and significant reputational harm.

We face risks related to litigation.

We are, and may in the future be, a party to a variety of legal actions that may affect our business, such as administrative charges before government agencies, employment and employment discrimination-related suits, employee benefit claims, breach of contract actions, tort claims and intellectual property-related litigation. In addition, because of the nature of our

business, we are subject to a variety of legal actions relating to our business operations, including the design, administration and offering of our products and services. These could include claims relating to the denial or limitation of healthcare benefits; federal and state false claims act laws; dispensing of drugs associated with our PBM business; professional liability claims arising out of the delivery of healthcare and related services to the public; development or application of medical policies and coverage and clinical guidelines; medical malpractice actions; product liability claims; allegations of anti-competitive and unfair business activities; provider disputes over reimbursement and contracts; provider tiering programs; narrow networks; termination of provider contracts; the recovery of overpayments from providers; self-funded business; disputes over co-payment calculations; reimbursement of out-of-network claims; the failure to disclose certain business practices; the failure to comply with various state or federal laws, including but not limited to, ERISA and the Mental Health Parity Act; and customer audits and contract performance, including government contracts. These actions or proceedings could result in substantial costs to us, require our officers to spend substantial time focused on the litigation, and result in negative media attention, and may adversely affect our business, reputation, financial condition, results of operations and cash flows.

We are also involved in, or may in the future be party to, pending or threatened litigation of the character incidental to the business we transact or arising out of our operations, including, but not limited to, breaches of security and violations of privacy requirements, shareholder actions, compliance with federal and state laws and regulations (including qui tam or "whistleblower" actions), or sales and acquisitions of businesses or assets (including as a result of the now terminated Agreement and Plan of Merger between us and Cigna Corporation, or as more fully described under Note 14, "Commitments and Contingencies - *Litigation and Regulatory Proceedings - Cigna Corporation Merger Litigation*," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K). From time to time, we are involved as a party in various governmental investigations, audits, reviews and administrative proceedings, including challenges relating to the award of government contracts. These investigations, audits and reviews include routine and special investigations by various state insurance departments, various federal regulators including CMS and the HHS Office of Inspector General, state attorneys general, the Department of Justice, and various offices of the U.S. Attorney General. Following an investigation, we may be subject to civil or criminal fines, penalties and other sanctions if we are determined to be in violation of applicable laws or regulations. Liabilities that may result from these actions could have a material adverse effect on our cash flows, results of operations and financial condition.

Recent court decisions and legislative activity may increase our exposure for any of these types of claims. In some cases, substantial non-economic (including injunctive relief), treble or punitive damages may be sought. Although we maintain insurance coverage for some of these potential liabilities, some liabilities and damages may not be covered by insurance, insurers may dispute coverage or the amount of insurance may not be enough to cover the damages awarded. In addition, insurance coverage for all or certain forms of liability may become unavailable or prohibitively expensive in the future. Any adverse judgment against us resulting in such damage awards could result in negative publicity and have an adverse effect on our cash flows, results of operations and financial condition.

There are various risks associated with providing healthcare services.

The direct provision of healthcare services by certain of our subsidiaries involves risks of additional litigation arising from medical malpractice actions based on our treatment decisions or brought against us or our associates for alleged malpractice or professional liability claims arising out of the delivery of healthcare and related services. In addition, liability may arise from maintaining healthcare premises that serve the public. The defense of any actions may result in significant expenses, and if we fail to maintain adequate insurance coverage for these liabilities, or if such insurance is not available, the resulting costs could adversely affect our business, cash flows, financial condition and results of operations.

Additionally, many states in which certain of our subsidiaries operate limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals. Business corporations generally may not exercise control over the medical decisions of physicians, and we are not licensed to practice medicine. Rules and regulations relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary from state to state. Further, certain federal and state laws, including those covering our Medicare and Medicaid plans, prohibit the offer, payment, solicitation or receipt of any form of remuneration to induce, or in return for, the referral of patient care opportunities and also generally prohibit physicians from making referrals to any entity providing certain designated health services if the referring physician or related person has an ownership or financial interest in the entity. Any enforcement

actions by governmental officials alleging non-compliance with these rules and regulations could adversely affect our business, cash flows, financial condition and results of operations.

Our PBM services business and related operations are subject to a number of risks and uncertainties that are in addition to those we face in our core healthcare business.

We provide PBM services through our IngenioRx business, and we are responsible to regulators and our customers for the delivery of those PBM services that we contract to provide. Our PBM services business is subject to the risks inherent in the dispensing, packaging, fulfillment and distribution of pharmaceuticals and other healthcare products, including exposure to liabilities and reputational harm related to purported dispensing and other operational errors by us or our PBM services suppliers. Any failure by us or one of our PBM services suppliers to adhere to the laws and regulations applicable to the dispensing of pharmaceuticals could subject our PBM business to civil and criminal penalties.

Our PBM services business is subject to federal and state laws and regulations that govern its relationships with pharmaceutical manufacturers, physicians, pharmacies and customers, including without limitation, federal and state anti-kickback laws, beneficiary inducement laws, consumer protection laws, ERISA, HIPAA and laws related to the operation of internet and mail-service pharmacies, as well as an increasing number of licensure, registration and other laws and accreditation standards that impact the business practices of a PBM services business. In addition, the practice of pharmacy is subject to federal and state laws and regulation, including those of state boards of pharmacy, individual state-controlled substance authorities, the U.S. Drug Enforcement Agency and the U.S. Food and Drug Administration. Also, we and our third-party vendors are subject to registration requirements and state and federal laws concerning labeling, packaging, advertising, handling and adulteration of prescription drugs and dispensing of controlled substances. Noncompliance with applicable laws and regulations by us or our third-party vendors could have material adverse effects on our business, results of operations, financial condition, liquidity and reputation.

Federal and state legislatures also regularly consider new regulations and changes to existing regulations for the industry that could materially affect current industry practices and our business, including the regulation implemented by HHS in November 2020 related to rebates and the pricing of pharmaceuticals, the Appropriations Act, and potential new regulations regarding rebates, fees from pharmaceutical companies, the development and use of formularies and other utilization management tools, the use of average wholesale prices or other pricing benchmarks, pricing for specialty pharmaceuticals, limited access to networks and pharmacy network reimbursement methodologies. In December 2020, the U.S. Supreme Court let stand an Arkansas law regulating PBMs that may be a precursor to greater state regulation of PBMs.

We are a party to license agreements with the BCBSA that entitle us to the exclusive and, in certain areas, non-exclusive use of the BCBS names and marks in our geographic territories. The termination of these license agreements or changes in the terms and conditions of these license agreements could adversely affect our business, cash flows, financial condition and results of operations.

Our license agreements with the BCBSA contain certain requirements and restrictions regarding our operations and our use of the BCBS names and marks, and failure to comply with those requirements could result in a termination of the license agreements. The license agreements may be modified by the BCBSA, which could have a material adverse effect on our future expansion plans or results of operations. Further, BCBS licensees have certain requirements to perform administrative services for members of other BCBS licensees. As of December 31, 2020, we provided services to approximately 32 million Blue Cross and/or Blue Shield enrollees. If we or another BCBS licensee are not in compliance with all legal requirements or are unable to perform administrative services as required, this could have an adverse effect on our members and our ability to maintain our licenses, which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

Upon the occurrence of an event causing termination of the license agreements, we would no longer have the right to use the BCBS names and marks or to sell BCBS health insurance products and services in one or more of our service areas. Furthermore, the BCBSA would be free to issue a license to use the BCBS names and marks in these service areas to another entity. Our existing BCBS members would be provided with instructions for obtaining alternative products and services licensed by the BCBSA. We believe that the BCBS names and marks are valuable identifiers of our products and services in the marketplace.

Upon termination of either license agreement, the BCBSA would have the right to impose a “Re-establishment Fee” upon us, which would be used in part to fund the establishment of a replacement Blue Cross and/or Blue Shield licensee in the vacated service area. The fee is set at $98.33 per licensed enrollee. If the Re-establishment Fee was applied to our total Blue Cross and/or Blue Shield enrollees of approximately 32 million as of December 31, 2020, we would be assessed approximately $3 billion by the BCBSA. As a result, termination of the license agreements would have a material adverse effect on our business, cash flows, financial condition and results of operations.

For more information on the BCBSA license agreements, including requirements, restrictions and termination events set forth in these license agreements, see Part I, Item 1, “Business — BCBSA Licenses” of this Annual Report on Form 10-K.

Indiana law, other applicable laws, our articles of incorporation and bylaws, and provisions of our BCBSA license agreements may prevent or discourage takeovers and business combinations that our shareholders might consider to be in their best interest.

Indiana law, other applicable laws and regulations and provisions in our articles of incorporation and bylaws may delay, defer, prevent or render more difficult a takeover attempt that our shareholders might consider to be in their best interests. For instance, they may prevent our shareholders from receiving the benefit from any premium to the market price of our common stock offered by a bidder in a takeover context or adversely affect the price that some investors are willing to pay for our stock.

The insurance holding company acts and certain health statutes of the states in which our insurance company or HMO subsidiaries are regulated restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Further, the Indiana Business Corporation Law contains business combination provisions that, in general, prohibit for five years any business combination with a beneficial owner of 10% or more of our common stock unless the holder’s acquisition of the stock was approved in advance by our Board of Directors.

Our articles of incorporation and bylaws contain provisions that could have anti-takeover effects and may delay, defer or prevent a takeover attempt that our shareholders might consider to be in their best interests. Our articles of incorporation provide that no person may beneficially own shares of voting capital stock in excess of specified ownership limits, except with the prior approval of a majority of the “continuing directors.” The ownership limits, which may not be exceeded without the prior approval of the BCBSA, are the following: (1) for any institutional investor (as defined in our articles of incorporation), one share less than 10% of our outstanding voting securities; (2) for any non-institutional investor (as defined in our articles of incorporation), one share less than 5% of our outstanding voting securities; and (3) for any person, one share less than the number of shares of our common stock or other equity securities (or a combination thereof) representing a 20% ownership interest in us.

In addition, our articles of incorporation and bylaws: divide our Board of Directors into three classes serving staggered three-year terms (which is required by our license agreement with the BCBSA); permit our Board of Directors to determine the terms of and issue one or more series of preferred stock without further action by shareholders; restrict the maximum number of directors and the ability to increase that number; limit the ability of shareholders to remove directors; impose restrictions on shareholders’ ability to fill vacancies on our Board of Directors; impose advance notice requirements for shareholder proposals and nominations of directors to be considered at meetings of shareholders; prohibit shareholders from amending certain provisions of our bylaws; and impose restrictions on who may call a special meeting of shareholders.

The health benefits industry is subject to negative publicity, which could adversely affect our business, cash flows, financial condition and results of operations.

The health benefits industry is subject to negative publicity, which can arise from, among other things, increases in premium rates, industry consolidation, cost of care initiatives and debate around existing or proposed legislation. Negative publicity may result in increased regulation and legislative review of industry practices, which may further increase our costs of doing business and adversely affect our profitability by limiting our ability to market or provide our products and services, requiring us to change our products and services, or increasing the regulatory oversight under which we operate. In addition, any negative publicity concerning the BCBSA or other BCBSA licensees may adversely affect us and the sale of our health benefits products and services. Negative public perception or publicity of the health benefits industry in general, the BCBSA, other BCBSA licensees, or us or our key vendors in particular, could adversely affect our business, cash flows, financial condition and results of operations.

STRATEGIC RISKS

We face competition in many of our markets, and if we fail to adequately adapt to changes in our industry and develop and implement strategic growth opportunities, our ability to compete and grow may be adversely affected.

As a health benefits company, we operate in a highly competitive environment and in an industry that is subject to significant changes from and competition due to legislative reform, business consolidations, new strategic alliances, new market entrants, aggressive marketing practices, technological advancements and changing market practices such as increasing usage of telehealth. We also will have to respond to pricing and other actions taken by existing competitors and potentially disruptive new entrants in the public exchanges and in our other lines of business. These factors have produced and will likely continue to produce significant pressures on our profitability. Furthermore, decisions to buy our products and services are increasingly made or influenced by consumers, through means such as direct purchasing (for example, Medicare Advantage plans) and insurance exchanges that allow individual choice, or by large employers that may increasingly have the ability to contract directly with providers. This creates unique market pressures, and in order to compete effectively in the consumer-driven marketplace, we will be required to develop and deliver innovative and potentially disruptive products and services to satisfy evolving market demands.

In addition, the PBM industry is highly competitive, and IngenioRx is subject to competition from national, regional and local PBMs, other insurers, health plans, large retail pharmacy chains, large retail stores, supermarkets, other mail order and web pharmacies, discount cards and specialty pharmacies. Strong competition within the PBM business has generated greater demand for lower product and service pricing, increased revenue sharing and enhanced product and service offerings. Our inability to maintain positive trends, contract on favorable terms with pharmaceutical manufacturers for, among other things, rebates, discounts and administrative fees or a failure to identify and implement new ways to mitigate pricing pressures, could negatively impact our ability to attract or retain customers, negatively impact our margins and have a material adverse effect on our business and results of operations. In addition, legislative reforms such as the regulation issued by HHS in November 2020 related to rebates, and the Appropriations Act, which requires reporting of plan spending, the cost of plan pharmacy benefits, enrollee premiums and any manufacturer rebates received by the plan or issuer, may adversely affect our competitive position, cash flows, financial condition and results of operations.

In order to profitably grow our business in the future, we need to not only grow our profitable medical membership, but also continue to diversify our sources of revenue and earnings, including through the increased sale of our specialty products, such as dental, vision and other supplemental products, expansion of products, expansion of our non-insurance assets and establishment of new cost of care solutions, including innovations in PBM services. If we are unable to acquire or develop and successfully manage new opportunities that further our strategic objectives and differentiate our products from our competitors, our ability to profitably grow our business could be adversely affected.

We are currently dependent on the non-exclusive services of independent agents and brokers in the marketing of our healthcare products, particularly with respect to individuals, seniors and local group customers. We face intense competition for the services and allegiance of these independent agents and brokers, who may also market the products of our competitors. Our relationship with our brokers and independent agents could be adversely impacted by changes in our business practices to address legislative changes, including potential reductions in commissions and consulting fees paid to agents and brokers. We cannot ensure that we will be able to compete successfully against current and future competitors for these services or that competitive pressures faced by us will not materially and adversely affect our business, cash flows, financial condition and results of operations.

For additional information, see “Business — Competition,” in Part I, Item 1 of this Annual Report on Form 10-K.

We have built a significant portion of our current business through mergers and acquisitions, joint ventures and strategic alliances, and we expect to pursue such opportunities in the future.

The following are some of the risks associated with mergers, acquisitions, joint ventures and strategic alliances, referred to collectively as business combinations, that could have a material adverse effect on our business, cash flows, financial condition and results of operations:

- some of the business combinations may not achieve anticipated revenues, earnings or cash flow, business opportunities, synergies, growth prospects and other anticipated benefits;

- we may assume liabilities that were not disclosed to us or which were underestimated;
- we may experience difficulties in integrating business combinations, be unable to integrate business combinations successfully or as quickly as expected and be unable to realize anticipated economic, operational and other benefits in a timely manner or at all;
- business combinations, and proposed business combinations that are not completed, could disrupt our ongoing business, lead to the incurrence of significant fees, distract management, result in the loss of key employees, divert resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies and procedures;
- we may finance future business combinations by issuing common stock for some or all of the purchase price, which could dilute the ownership interests of our shareholders;
- we may compete with other firms, some of which may have greater financial and other resources, to acquire attractive companies;
- we may experience disputes with our partners in our strategic alliances and joint ventures, which could result in litigation or a loss of business; and
- future business combinations may make it difficult to comply with the requirements of the BCBSA and lead to an increased risk that our BCBSA license agreements may be terminated.

We face intense competition to attract and retain employees. Further, managing key executive transition, succession and retention is critical to our success.

Our success depends on our ability to attract and retain qualified employees and to integrate employees who have joined us through acquisitions. We face intense competition for qualified employees, and there can be no assurance that we will be able to attract and retain such employees or that such competition among potential employers will not result in increasing salaries. An inability to retain existing employees or attract additional employees could have a material adverse effect on our business, cash flows, financial condition and results of operations.

We would be adversely affected if we fail to adequately plan for the succession of our President and Chief Executive Officer and other senior management or retain key executives. While we have succession plans in place for members of our senior management, and employment arrangements with certain key executives, these plans and arrangements do not guarantee that the services of our senior executives will continue to be available to us or that we will be able to attract, transition and retain suitable successors.

FINANCIAL RISKS

As a holding company, we are dependent on dividends from our subsidiaries. These dividends are necessary to pay our outstanding indebtedness. Our regulated subsidiaries are subject to state regulations, including restrictions on the payment of dividends, maintenance of minimum levels of capital and restrictions on investment portfolios.

As a holding company, we are dependent on dividends and administrative expense reimbursements from our subsidiaries. Our regulated subsidiaries are not obligated to make funds available to us, and creditors of our subsidiaries will have a superior claim to certain of our subsidiaries' assets. Furthermore, among other restrictions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends. In some states, we have made special undertakings that may limit the ability of our regulated subsidiaries to pay dividends. In addition, our subsidiaries' ability to make any payments to us will also depend on their earnings, the terms of their indebtedness, business and tax considerations and other legal restrictions. Our ability to repurchase shares or pay dividends in the future to our shareholders and meet our obligations, including paying operating expenses and debt service on our outstanding and future indebtedness, will depend upon the receipt of dividends from our subsidiaries. An inability of our subsidiaries to pay dividends in the future in an amount sufficient for us to meet our financial obligations may materially adversely affect our business, cash flows, financial condition and results of operations.

Most of our regulated subsidiaries are subject to RBC standards or other forms of minimum capital requirements imposed by their states of domicile that require them to report their results of risk-based capital calculations to the departments of insurance and the NAIC. Failure to maintain the minimum RBC standards could subject our regulated subsidiaries to corrective action, including state supervision or liquidation. Changes to the existing RBC standards and the

NAIC's December 2020 adoption of an RBC requirement at the holding company level, which requires submission of the first report in May 2023, could further restrict our or our regulated subsidiaries' ability to pay dividends and adversely affect our business. In addition, as discussed in more detail above, we are a party to license agreements with the BCBSA which contain certain requirements and restrictions regarding our operations, including minimum capital and liquidity requirements, which could restrict the ability of our regulated subsidiaries to pay dividends.

Our regulated subsidiaries are subject to state laws and regulations that require diversification of their investment portfolios and limit the amount of investments in certain riskier investment categories, such as below-investment-grade fixed maturity securities, mortgage loans, real estate and equity investments, which could generate higher returns on their investments. Failure to comply with these laws and regulations might cause investments exceeding regulatory limitations to be treated as non-admitted assets for purposes of measuring statutory surplus and risk-based capital, and, in some instances, require the sale of those investments.

We have substantial indebtedness outstanding and may incur additional indebtedness in the future, which could adversely affect our ability to pursue desirable business opportunities and to react to changes in the economy or our industry, and exposes us to interest rate risk to the extent of our variable rate indebtedness.

Our debt service obligations require us to use a portion of our cash flow to pay interest and principal on debt instead of for other corporate purposes, including funding future expansion. If our cash flow and capital resources are insufficient to service our debt obligations, we may be forced to seek extraordinary dividends from our subsidiaries, sell assets, seek additional equity or debt capital or restructure our debt. However, these measures might be unsuccessful or inadequate to meet scheduled debt service obligations, or may not be available on commercially reasonable terms.

We may also incur future debt obligations that might subject us to restrictive covenants that could affect our financial and operational flexibility. Our breach or failure to comply with any of these covenants could result in a default under our credit facilities or other indebtedness. If we default under our credit agreement, the lenders could cease to make further extensions of credit or cause all of our outstanding debt obligations under our credit agreement to become immediately due and payable, together with accrued and unpaid interest. If the indebtedness under our notes or our credit agreement or our other indebtedness is accelerated, we may be unable to repay or finance the amounts due, on commercially reasonable terms, or at all.

A downgrade in our credit ratings could have an adverse effect on our business, cash flows, financial condition and results of operations.

Claims-paying ability as well as financial strength and debt ratings by nationally recognized statistical rating organizations are important factors in establishing the competitive position of insurance companies and health benefits companies. We believe our strong credit ratings are an important factor in marketing our products to customers. In addition, if our credit ratings are downgraded or placed under review, our business, cash flows, financial condition and results of operations could be adversely impacted by limitations on future borrowings and a potential increase in our borrowing costs. Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future.

The value of our intangible assets may become impaired.

As of December 31, 2020, we had $31 billion of goodwill and other intangible assets, representing 36% of our total consolidated assets. In accordance with applicable accounting standards, we periodically evaluate our goodwill and other intangible assets for potential impairment, using assumptions and judgments regarding the estimated fair value of our reporting units. Estimated fair values might be significantly different if other reasonable assumptions and estimates were to be used. If estimated fair values are less than the carrying values of goodwill and other intangible assets with indefinite lives in future impairment tests, or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

The value we place on intangible assets may be adversely impacted if existing or future business combinations fail to perform in a manner consistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. In addition, the estimated value of our reporting units may be impacted as a result of business decisions we

make associated with any future changes to laws and regulations, which could unfavorably affect the carrying value of certain goodwill and other intangible assets and result in impairment charges in future periods. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially affect our results of operations and shareholders' equity which could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value may result in a loss charged to income.

We maintain a significant investment portfolio of cash equivalents and short-term and long-term investments in a variety of securities, which are subject to general credit, liquidity, market and interest rate risks. As a result, we may experience a reduction in value or loss of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition. Changes in the economic environment, including periods of increased volatility in the securities markets such as those experienced in 2020 related to the ongoing COVID-19 pandemic, can increase the difficulty of assessing investment impairment and increase the risk of potential impairment of these assets. There is continuing risk that declines in fair value may occur and material impairments may be charged to income in future periods, resulting in realized losses.

GENERAL RISKS

Changes in tax laws and regulations could have a material adverse effect on our business, cash flow, financial condition and results of operations. In addition, we may not be able to realize the value of our deferred tax assets.

Changes in tax laws and regulations , including a potential increase in U.S. corporate tax rates or changes in the deductibility of expenses, or changes in the interpretation of tax laws and regulations by federal and/or state authorities, could have a material impact on the future value of our deferred tax assets and deferred tax liabilities, could result in significant one-time charges in the current or future taxable years and could increase our future U.S. tax expense. In addition, we are regularly audited by federal and other tax authorities. Although we believe our tax positions comply with applicable tax law, the final determination of audits and any related litigation in the jurisdictions where we are subject to taxation could be materially different from our historical income provisions and accruals. These changes could have a material adverse effect on our business, cash flow, financial condition and results of operations.

In addition, any future increase in our valuation allowance with regard to our deferred tax assets would result in additional income tax expense and a decrease in shareholders' equity, which could materially affect our financial position and results of operations in the period in which the increase occurs. A material decrease in shareholders' equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

We also face other risks that could adversely affect our business, financial condition or results of operations, which include:

- adverse securities and credit market conditions, which could impact our ability to meet liquidity needs;
- any requirement to restate financial results in the event of inappropriate application of accounting principles;
- a significant failure of our internal control over financial reporting;
- failure of our prevention and control systems related to employee compliance with internal policies, including data security;
- provider fraud that is not prevented or detected and impacts our medical costs or those of self-insured customers;
- failure to protect our proprietary information; and
- failure of our corporate governance policies or procedures.

ITEM 1B. UNRESOLVED SEC STAFF COMMENTS.

None.

ITEM 2. PROPERTIES.

We lease our principal executive offices located at 220 Virginia Avenue, Indianapolis, Indiana. In addition to this location, we have operating facilities located in each state where we operate as licensees of the BCBSA, in each state where Amerigroup conducts business and in certain other states and countries where our other subsidiaries operate. A majority of these locations are also leased properties. Our facilities support our various business segments. We modified certain of our workforce practices in 2020 in response to the COVID-19 pandemic, including having the majority of our workforce work remotely. In the third quarter of 2020, our management introduced enterprise-wide initiatives to streamline our operations and optimize our business, including a reduction of our office space footprint. We believe that our properties are adequate and suitable for our business as presently conducted; however, we are continuing to evaluate our real estate strategy as it relates to the impact of the COVID-19 pandemic and the changing needs of a more remote workforce.

ITEM 3. LEGAL PROCEEDINGS.

For information regarding our legal proceedings, see Note 14, “Commitments and Contingencies - *Litigation and Regulatory Proceedings,*” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K, which information is incorporated herein by reference.

ITEM 4. MINE SAFETY DISCLOSURES.

Not applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES.

Market Information

Our common stock, par value $0.01 per share, is listed on the NYSE under the symbol "ANTM."

Holders

As of February 4, 2021, there were 55,764 shareholders of record of our common stock.

Securities Authorized for Issuance under Equity Compensation Plans

The information required by this Item concerning securities authorized for issuance under our equity compensation plans is set forth in Part III, Item 12 "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters" in this Annual Report on Form 10-K.

Issuer Purchases of Equity Securities

The following table presents information related to our repurchases of common stock for the periods indicated (*in millions, except share and per share data*):

Period	Total Number of Shares Purchased[1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Programs[2]	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Programs
October 1, 2020 to October 31, 2020	1,236,624	$ 288.64	1,234,200	$ 2,093
November 1, 2020 to November 30, 2020	1,483,621	310.05	1,481,675	1,634
December 1, 2020 to December 31, 2020	1,744,143	314.04	1,725,700	1,092
	4,464,388		4,441,575	

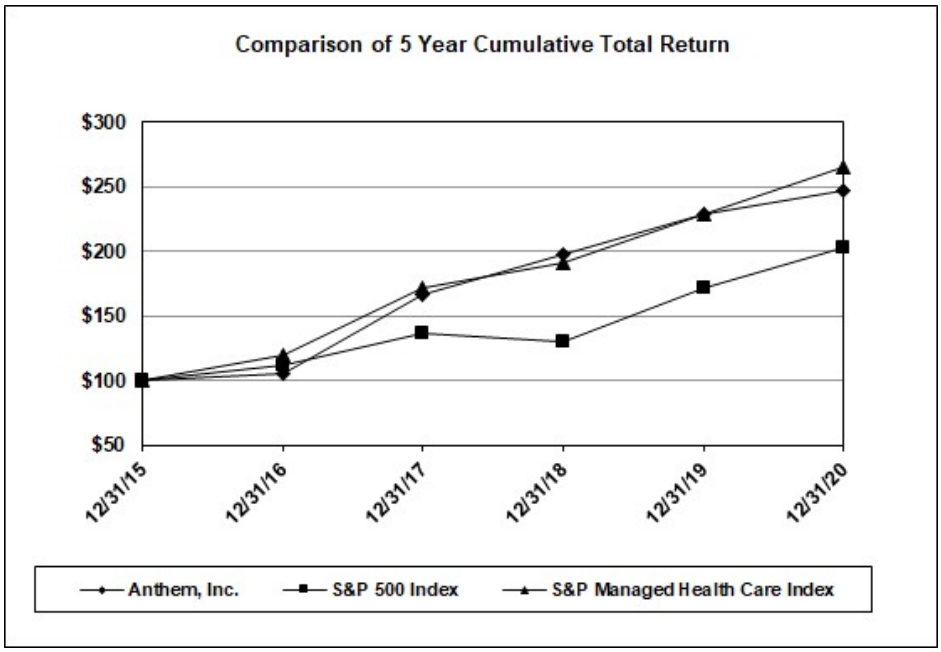
1 Total number of shares purchased includes 22,813 shares delivered to or withheld by us in connection with employee payroll tax withholding upon exercise or vesting of stock awards. Stock grants to employees and directors and stock issued for stock option plans and stock purchase plans in the consolidated statements of shareholders' equity are shown net of these shares purchased.

2 Represents the number of shares repurchased through the common stock repurchase program authorized by our Board of Directors, which the Board evaluates periodically. During the year ended December 31, 2020, we repurchased 9,429,067 shares at an aggregate cost of $2,700 under the program, including the cost of options to purchase shares. The Board of Directors has authorized our common stock repurchase program since 2003. On January 26, 2021, our Audit Committee, pursuant to authorization granted by the Board of Directors, authorized a $5,000 increase to our common stock repurchase program. No duration has been placed on our common stock repurchase program, and we reserve the right to discontinue the program at any time.

Performance Graph

The following Performance Graph and related information compares the cumulative total return to shareholders of our common stock for the period from December 31, 2015 through December 31, 2020, with the cumulative total return over such period of (i) the Standard & Poor's 500 Stock Index (the "S&P 500 Index") and (ii) the Standard & Poor's Managed Health Care Index (the "S&P Managed Health Care Index"). The graph assumes an investment of $100 on December 31, 2015 in each of our common stock, the S&P 500 Index and the S&P Managed Health Care Index (and the reinvestment of all dividends).

The comparisons shown in the graph below are based on historical data, and we caution that the stock price performance shown in the graph below is not indicative of, and is not intended to forecast, the potential future performance of our common stock. Information used in the graph was obtained from S&P Global Market Intelligence, a source believed to be reliable, but we are not responsible for any errors or omissions in such information. The following graph and related information shall not be deemed "soliciting materials" or to be "filed" with the SEC, nor shall such information be incorporated by reference into any future filing under the Exchange Act, except to the extent that we specifically incorporate it by reference into such filing.



	December 31,					
	2015	2016	2017	2018	2019	2020
Anthem, Inc.	$ 100	$ 105	$ 167	$ 197	$ 229	$ 247
S&P 500 Index	100	112	136	130	171	203
S&P Managed Health Care Index	100	120	172	191	229	266

Based upon an initial investment of $100 on December 31, 2015 with dividends reinvested.

ITEM 6. SELECTED FINANCIAL DATA.

The table below provides selected consolidated financial data of Anthem. The information has been derived from our consolidated financial statements for each of the years in the five-year period ended December 31, 2020. You should read this selected consolidated financial data in conjunction with the audited consolidated financial statements and notes as of and for the year ended December 31, 2020 included in Part II, Item 8 "Financial Statements and Supplementary Data," and Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K.

	As of and for the Years Ended December 31				
	2020 [1]	2019	2018 [1]	2017 [1]	2016
(in millions, except where indicated and except per share data)					
Income Statement Data					
Total operating revenue[2]	$ 120,808	$ 103,141	$ 91,341	$ 89,061	$ 84,194
Total revenues	121,867	104,213	92,105	90,040	84,863
Net income	4,572	4,807	3,750	3,843	2,470
Per Share Data					
Basic net income per share	$ 18.23	$ 18.81	$ 14.53	$ 14.70	$ 9.39
Diluted net income per share	17.98	18.47	14.19	14.35	9.21
Dividends per share	3.80	3.20	3.00	2.70	2.60
Other Data (unaudited)					
Benefit expense ratio[3]	84.6 %	86.8 %	84.2 %	86.4 %	84.8 %
Selling, general and administrative expense ratio[4]	14.4 %	13.0 %	15.3 %	14.2 %	14.9 %
Income before income tax expense as a percentage of total revenues	5.1 %	5.7 %	5.5 %	4.4 %	5.4 %
Net income as a percentage of total revenues	3.8 %	4.6 %	4.1 %	4.3 %	2.9 %
Medical membership (*in thousands*)	42,925	41,000	39,938	40,299	39,940
Balance Sheet Data					
Cash and investments[5]	$ 31,295	$ 26,127	$ 22,639	$ 25,179	$ 23,263
Total assets	86,615	77,453	71,571	70,540	65,083
Long-term debt, less current portion	19,335	17,787	17,217	17,382	14,359
Total liabilities	53,416	45,725	43,030	44,037	39,982
Total shareholders' equity	33,199	31,728	28,541	26,503	25,101

1 The net assets of and results of operations for Beacon, America's 1st Choice and HealthSun are included from their respective acquisition dates of February 28, 2020, February 15, 2018 and December 21, 2017, respectively.
2 Operating revenue is obtained by adding premiums, product revenue, and administrative fees and other revenue.
3 The benefit expense ratio represents benefit expenses as a percentage of premium revenue.
4 The selling, general and administrative expense ratio represents selling, general and administrative expenses as a percentage of total operating revenue.
5 Cash and investments is obtained by adding cash and cash equivalents, current and long-term fixed maturity securities and equity securities.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS.

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

This Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A"), should be read in conjunction with our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K. References to the terms "we," "our," "us," "Anthem" or the "Company" used throughout this MD&A refer to Anthem, Inc., an Indiana corporation, and, unless the context otherwise requires, its direct and indirect subsidiaries. References to the "states" include the District of Columbia, unless the context otherwise requires.

This section of this Annual Report on Form 10-K generally discusses 2020 and 2019 items and year-over-year comparisons between 2020 and 2019. A detailed discussion of 2018 items and year-over-year comparisons between 2019 and 2018 that are not included in this Annual Report on Form 10-K can be found in "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2019.

Overview

We are one of the largest health benefits companies in the United States in terms of medical membership, serving approximately 43 medical members through our affiliated health plans as of December 31, 2020. We are an independent licensee of the Blue Cross and Blue Shield Association ("BCBSA"), an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield ("BCBS") licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (in the New York City metropolitan area and upstate New York), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas, we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, and Empire Blue Cross Blue Shield or Empire Blue Cross. In addition, we conduct business through arrangements with other BCBS licensees as well as other strategic partners. Through our subsidiaries, we also serve customers in numerous states across the country as AIM Specialty Health, Amerigroup, Aspire Health, Beacon, CareMore, Freedom Health, HealthLink, HealthSun, Optimum HealthCare, Simply Healthcare, and/or UniCare. Also, in the second quarter of 2019, we began providing pharmacy benefits management ("PBM") services through our IngenioRx subsidiary. We are licensed to conduct insurance operations in all 50 states and the District of Columbia through our subsidiaries.

We manage our operations through four reportable segments: Commercial & Specialty Business, Government Business, IngenioRx and Other. In 2019, IngenioRx was included in our Other reportable segment. Amounts for 2019 have been reclassified to conform to the current year presentation of our reportable segments for comparability.

Our operating revenue consists of premiums, product revenue, and administrative fees and other revenue. Premium revenue is generated from fully-insured contracts where we indemnify our policyholders against costs for covered health and life insurance benefits. Product revenue represents services performed by IngenioRx for unaffiliated PBM customers and includes ingredient costs (net of any rebates or discounts), including co-payments made by or on behalf of the customer, and administrative fees. Unaffiliated PBM customers include our self-funded groups that contract with IngenioRx for PBM services and external customers outside of the health plans we own. Administrative fees and other revenue come from fees from our self-funded customers for the processing of transactions or network discount savings realized, revenues from our Medicare processing business and revenues from other health-related businesses, including disease management programs and miscellaneous other income.

Our benefit expense primarily includes costs of care for health services consumed by our fully-insured members, such as outpatient care, inpatient hospital care, professional services (primarily physician care) and pharmacy benefit costs. All four components are affected both by unit costs and utilization rates. Unit costs include the cost of outpatient medical procedures per visit, inpatient hospital care per admission, physician fees per office visit and prescription drug prices. Utilization rates represent the volume of consumption of health services and typically vary with the age and health status of our members and their social and lifestyle choices, along with clinical protocols and medical practice patterns in each of our markets. A portion of benefit expense recognized in each reporting period consists of actuarial estimates of claims incurred but not yet paid by

us. Any changes in these estimates are recorded in the period the need for such an adjustment arises. While we offer a diversified mix of managed care products and services through our managed care plans, our aggregate cost of care can fluctuate based on a change in the overall mix of these products and services. Our managed care plans include: Preferred Provider Organizations; Health Maintenance Organizations ("HMOs"); Point-of-Service plans; traditional indemnity plans and other hybrid plans, including Consumer-Driven Health Plans; and hospital only and limited benefit products.

We classify certain quality improvement costs as benefit expense. Quality improvement activities are those designed to improve member health outcomes, prevent hospital readmissions and improve patient safety. They also include expenses for wellness and health promotion provided to our members. These quality improvement costs may be comprised of expenses incurred for: (i) medical management, including care coordination and case management; (ii) health and wellness, including disease management services for such conditions as diabetes, high-risk pregnancies, congestive heart failure and asthma management and wellness initiatives like weight-loss programs and smoking cessation treatments; and (iii) clinical health policy, such as identification and use of best clinical practices to avoid harm, identifying clinical errors and safety concerns, and identifying potential adverse drug interactions.

Our cost of products sold represents the cost of pharmaceuticals dispensed by IngenioRx for our unaffiliated PBM customers (net of rebates or discounts), including any co-payments made by or on behalf of the customer, per-claim administrative fees for prescription fulfillment and certain direct costs related to sales and administration of customer contracts.

Our selling, general and administrative expenses consist of fixed and variable costs. Examples of fixed costs are depreciation, amortization and certain facilities expenses. Certain variable costs, such as premium taxes, vary directly with premium volume. Commission expense generally varies with premium or membership volume. Other variable costs, such as salaries and benefits, do not vary directly with changes in premium but are more aligned with changes in membership. The acquisition or loss of a significant block of business would likely impact staffing levels and thus, associated compensation expense. Other variable costs include professional and consulting expenses and advertising. Other factors can impact our administrative cost structure, including systems efficiencies, inflation and changes in productivity.

Our results of operations depend in large part on our ability to accurately predict and effectively manage healthcare costs through effective contracting with providers of care to our members, product pricing, medical management and health and wellness programs, innovative product design and our ability to maintain or achieve improvement in our CMS Star ratings. Several economic factors related to healthcare costs, such as regulatory mandates of coverage as well as direct-to-consumer advertising by providers and pharmaceutical companies, have a direct impact on the volume of care consumed by our members. The potential effect of escalating healthcare costs, any changes in our ability to negotiate competitive rates with our providers and any regulatory or market-driven restrictions on our ability to obtain adequate premium rates to offset overall inflation in healthcare costs, including increases in unit costs and utilization resulting from the aging of the population and other demographics, the impact of epidemics and pandemics, as well as advances in medical technology, may impose further risks to our ability to profitably underwrite our business, and may have a material adverse impact on our results of operations.

For additional information about our business and reportable segments, see Part I, Item 1, "Business" and Note 20, "Segment Information" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

COVID-19

In March 2020, the World Health Organization declared the outbreak of a novel strain of coronavirus ("COVID-19") a global health pandemic. At the onset of the pandemic, to prevent its spread, most states issued shelter-in-place or stay-at-home orders, which generally required the businesses not considered essential to close their physical offices. While these orders were largely lifted during the second quarter of 2020, many states and local authorities continued to impose certain restrictions on the conduct of businesses and individuals.

The COVID-19 pandemic continues to evolve, and the virus and mitigation efforts have continued to impact the global economy, cause market instability, increase unemployment and put pressure on the healthcare system. The COVID-19 pandemic has impacted and will continue to impact our membership and benefit expense and has influenced and will likely continue to influence member behavior, impacting how members access healthcare services. Although increased unemployment caused by the COVID-19 pandemic resulted in a decline in our Local Group membership, our Medicaid

membership grew as a result of the temporary suspension of eligibility recertification efforts in response to the COVID-19 pandemic. While reduced or cancelled utilization of non-COVID-19 health services by our members decreased our claim costs overall in 2020, in the second half of 2020 utilization of such services began to rebound, and non-COVID-19 claim costs began to normalize as the shelter-in-place, stay-at-home orders and other restrictions on the conduct of businesses were lifted. Our expenses in 2020 included additional costs to cover COVID-19 related testing, treatment, expanded coverage of insurance benefits, waivers for cost-sharing and actions to support our providers. Furthermore, our expenses associated with COVID-19, including testing and treatment and the actions taken to support our members in response to the pandemic, accelerated in the fourth quarter of 2020 and exceeded the benefit we experienced during the quarter from the lower volume of healthcare claims attributable to decreased utilization of non-COVID-19 health services.

We remain focused on increasing access and coverage for our members and made several changes to our membership benefits and business operations, adopted tools and policies to assist consumers and care providers and provided support to our associates and our local communities, which were discussed in Part I, Item 1, “Business — COVID-19,” of this Annual Report on Form 10-K. Further, during 2020 we proactively took several actions to preserve our liquidity and financial flexibility and minimize the effects of the COVID-19 pandemic, including:

- Borrowing under our senior revolving credit facility in March 2020, which was repaid in April 2020;
- Delaying certain tax payments as permitted by the IRS and the Coronavirus Aid, Relief, and Economic Security Act (the “CARES Act”); and
- Temporarily suspending our share repurchase activity in March 2020, which was resumed in late June 2020.

The COVID-19 pandemic has created unique and unprecedented challenges, and although it has impacted and will likely continue to impact our membership and benefit expense, it did not have a material adverse effect on our reported results in 2020. However, this may change in the future as the COVID-19 pandemic is evolving, and the extent of its impact will depend on future developments, which are highly uncertain and cannot be predicted at this time. We will continue to monitor the COVID-19 pandemic as well as resulting legislative and regulatory changes that may impact our business. For additional discussion regarding our risks related to the COVID-19 pandemic and our other risk factors, see Part I, Item 1A, “Risk Factors” in this Annual Report on Form 10-K and “Business Trends” in this MD&A.

Business Trends

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended (collectively, the “ACA”), has changed and may continue to make broad-based changes to the U.S. healthcare system. We expect the ACA will continue to impact our business model and strategy. Also, the legal challenges regarding the ACA, including a federal district court decision invalidating the ACA, which was argued before the U.S. Supreme Court in November 2020 and has been stayed pending the U.S. Supreme Court’s decision, could significantly disrupt our business. We currently offer Individual ACA-compliant products in 103 of the 143 rating regions in which we operate. Our strategy has been, and will continue to be, to only participate in rating regions where we have an appropriate level of confidence that these markets are on a path toward sustainability, including, but not limited to, factors such as expected financial performance, regulatory environment, and underlying market characteristics. In addition, the continuing growth in our government-sponsored business exposes us to increased regulatory oversight.

In the second quarter of 2019, we began using IngenioRx to market and offer PBM services to our affiliated health plan customers throughout the country, as well as to customers outside of the health plans we own. Our comprehensive PBM services portfolio includes features such as formulary management, pharmacy networks, a prescription drug database, member services and mail order capabilities. IngenioRx delegates certain PBM administrative functions, such as claims processing and prescription fulfillment, to CaremarkPCS Health, L.L.C., which is a subsidiary of CVS Health Corporation, pursuant to a five-year agreement. With IngenioRx, we retain the responsibilities for clinical and formulary strategy and development, member and employer experiences, operations, sales, marketing, account management and retail network strategy. From December 2009 through December 2019, we delegated certain PBM functions and administrative services to Express Scripts, Inc. (“Express Scripts”). We began transitioning existing members from Express Scripts to IngenioRx in the second quarter of 2019, and completed the transition of all of our members by January 1, 2020.

Pricing Trends: We strive to price our healthcare benefit products consistent with anticipated underlying medical cost trends. We continue to closely monitor the COVID-19 pandemic and the impacts it may have on our pricing, such as surges

in COVID-19 hospitalizations, infection rates, and the cost of COVID-19 vaccines. We frequently make adjustments to respond to legislative and regulatory changes as well as pricing and other actions taken by existing competitors and new market entrants. Product pricing in our Commercial & Specialty Business segment, including our Individual and Small Group lines of business, remains competitive. Revenues from the Medicare and Medicaid programs are dependent, in whole or in part, upon annual funding from the federal government and/or applicable state governments. The ACA imposed an annual Health Insurance Provider Fee ("HIP Fee") on health insurers that write certain types of health insurance on U.S. risks. We priced our affected products to cover the impact of the HIP Fee when it was in effect. The HIP Fee was suspended for 2019, was resumed for 2020 and has been permanently repealed beginning in 2021.

Medical Cost Trends: Our medical cost trends are primarily driven by increases in the utilization of services across all provider types and the unit cost increases of these services. We work to mitigate these trends through various medical management programs such as utilization management, condition management, program integrity and specialty pharmacy management, as well as benefit design changes. There are many drivers of medical cost trends that can cause variance from our estimates, such as changes in the level and mix of services utilized, regulatory changes, aging of the population, health status and other demographic characteristics of our members, epidemics, pandemics, advances in medical technology, new high cost prescription drugs, and healthcare provider or member fraud. Our underlying Local Group medical cost trends reflect the "allowed amount," or contractual rate, paid to providers.

The COVID-19 pandemic has caused a decrease in utilization of non-COVID-19 health services, which decreased our claim costs in 2020. While the utilization of such services began to rebound and claim costs began to normalize in the second half of 2020, further increases in the utilization of such services may increase our claim costs in the future and affect our medical cost trends. Our expenses in 2020 include additional costs to cover COVID-19 related testing, treatment, expanded benefits coverage and waivers for cost-sharing. In response to the current crisis, we expanded coverage for certain members in our affiliated health plans for testing and treatment related to a COVID-19 diagnosis. Governmental action has required us to provide full coverage for COVID-19 testing to our members, and future governmental action could require us to provide additional coverage, including, for example, vaccines. Increased member demand for care, along with continued COVID-19 care, testing and vaccination costs, are expected to result in increased future medical costs. The continued cost and volume of covered services related to the COVID-19 pandemic may have a material adverse effect on our future claim costs. We continue to closely monitor the COVID-19 pandemic and its impacts on our business, financial condition, results of operations and medical cost trends.

For additional discussion regarding business trends, see Part I, Item 1, "Business" of this Annual Report on Form 10-K.

Regulatory Trends and Uncertainties

Federal and state legislation has been enacted, and is likely to continue to be enacted, in response to the COVID-19 pandemic that has had, and we expect will continue to have, a significant impact on all of our lines of business, including mandates to waive cost-sharing on COVID-19 testing, treatment and related services. The federal government enacted the Coronavirus Preparedness and Response Supplemental Appropriations Act, the Families First Coronavirus Response Act and the CARES Act in March 2020, the Paycheck Protection Program and Health Care Enhancement Act in April 2020 and the Consolidated Appropriations Act of 2021 in December 2020 (the "Appropriations Act"). These acts provide, among other things, prohibitions on prior authorization and cost-sharing for certain items and services related to COVID-19 tests, reforms including waiving Medicare originating site restrictions for qualified providers providing telehealth services, financial support to healthcare providers, including expansion of the Medicare accelerated payment program to all providers receiving Medicare payments, and funding to replenish and administer small business loan programs to help small businesses keep their workers employed and healthcare benefits covered in the group market.

The Appropriations Act contains a number of provisions that may have a material effect upon our business, including procedures and coverage requirements related to surprise medical bills and new mandates for continuity of care for certain patients, price comparison tools, disclosure of broker compensation and reporting on pharmacy benefits and drug costs. The various health plan-related requirements of the Appropriations Act will go into effect on January 1, 2022, and our first report on pharmacy benefits and drug costs is due December 27, 2021.

Regulatory changes have also been enacted, and are likely to continue to be enacted, at the state and federal level in response to the COVID-19 pandemic. Those changes, which could have a significant impact on health benefits, consumer

eligibility for public programs, and our cash flows, include mandated expansion of premium payment terms including the time period for which claims can be denied for lack of payment, mandates related to prior authorizations and payment levels to providers, additional consumer enrollment windows, and an increased ability to provide services through telehealth. We are providing extensions to premium payment terms in certain situations and working closely with state regulators that are mandating or requesting such relief.

The ACA presented us with new growth opportunities, but also introduced new risks, regulatory challenges and uncertainties, and required changes in the way products are designed, underwritten, priced, distributed and administered. Changes to our business environment are likely to continue as elected officials at the national and state levels continue to enact, and both elected officials and candidates for election continue to propose, significant modifications to existing laws and regulations, including changes to taxes and fees. In addition, the legal challenges regarding the ACA, including a federal district court decision invalidating the ACA in its entirety, which was argued before the U.S. Supreme Court in November 2020 and has been stayed pending the U.S. Supreme Court's decision, continue to contribute to this uncertainty. In a separate development, in April 2020, the U.S. Supreme Court ruled that the federal government is required to pay health insurance companies for amounts owed, as calculated under the risk corridor program of the ACA. In June 2020, the U.S. Court of Federal Claims entered a final judgment stipulating that we are entitled to reimbursement for risk corridor amounts from 2014, 2015 and 2016. At the end of December 2020, the U.S. Department of Health and Human Services ("HHS") issued final guidance on how to treat the risk corridor recoveries that we expect to receive. Based on the guidance from HHS, we revised previously filed minimum medical loss ratio ("MLR") reports and recognized the net premium impact of the risk corridor recoveries in the fourth quarter of 2020. We will continue to evaluate the impact of the ACA as any further developments or judicial rulings occur.

The annual HIP Fee, which has been permanently eliminated beginning in 2021, was allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to the amount of health insurance premium for all U.S. health risk for those certain lines of business written during the preceding calendar year. The HIP Fee was non-deductible for federal income tax purposes. Our affected products were priced to cover the increased selling, general and administrative and income tax expenses associated with the HIP Fee when applicable. The HIP Fee was suspended for 2019. For 2020, the HIP Fee resumed and the total amount due from allocations to health insurers was $15,523. For the year ended December 31, 2020, we recognized $1,570 as selling, general and administrative expense related to the HIP Fee. There was no corresponding expense for 2019 due to the suspension of the HIP Fee for 2019. The HIP Fee has been permanently eliminated beginning in 2021.

As a result of the ACA, the HHS issued MLR regulations that require us to meet minimum MLR thresholds of 85% for Large Group and 80% for Small Group and Individual lines of business. Plans that do not meet the minimum thresholds have to pay a MLR rebate. For purposes of determining MLR rebates, HHS has defined the types of costs that should be included in the MLR rebate calculation. However, certain components of the MLR calculation as defined by HHS cannot be classified consistently under U.S. generally accepted accounting principles ("GAAP"). While considered benefit expense or a reduction of premium revenue by HHS, certain of these costs are classified as other types of expense, such as selling, general and administrative expense or income tax expense, in our GAAP basis financial statements. Accordingly, the benefit expense ratio determined using our consolidated GAAP operating results is not comparable to the MLR calculated under HHS regulations.

The ACA also imposed a separate minimum MLR threshold of 85% for Medicare Advantage and Medicare Part D prescription drug plans ("Medicare Part D"). Medicare Advantage or Medicare Part D plans that do not meet this threshold have to pay an MLR rebate. If a plan's MLR is below 85% for three consecutive years, enrollment is restricted. A Medicare Advantage or Medicare Part D plan contract will be terminated if the plan's MLR is below 85% for five consecutive years.

For additional discussion regarding regulatory trends and uncertainties, and risk factors that could cause actual results to differ materially from those contained in forward-looking statements made in this Annual Report on Form 10-K, see Part I, Item 1, "Business — Regulation" and Part I, Item 1A, "Risk Factors."

Other Significant Items

Business and Operational Matters

On February 2, 2021, we announced our entrance into an agreement with InnovaCare Health, L.P. to acquire its Puerto Rico-based subsidiaries, including MMM Holdings, LLC ("MMM") and its Medicare Advantage plan MMM Healthcare, LLC, Medicaid plan and other affiliated companies. MMM is an integrated healthcare organization and seeks to provide its Medicare Advantage and Medicaid members with a whole health experience through its network of specialized clinics and wholly owned independent physician associations. This acquisition aligns with our vision to be an innovative, valuable and inclusive healthcare partner by providing care management programs that improve the lives of the people we serve. The acquisition is expected to close by the end of the second quarter of 2021 and is subject to standard closing conditions and customary approvals.

In 2020, we introduced enterprise-wide initiatives to optimize our business and as a result, recorded a charge of $653 in selling, general and administrative expenses. We believe these initiatives largely represent the next step forward in our progression towards becoming a more agile organization, including process automation and a reduction in our office space footprint. For additional information, see Note 4, "Business Optimization Initiatives" and Note 18, "Leases," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

On February 28, 2020, we completed our acquisition of Beacon Health Options, Inc. ("Beacon"), the largest independently held behavioral health organization in the country. At the time of acquisition, Beacon served more than thirty-four million individuals across all fifty states. This acquisition aligned with our strategy to diversify into health services and deliver both integrated solutions and care delivery models that personalize care for people with complex and chronic conditions. For additional information, see Note 3, "Business Acquisitions," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

In February 2018, we completed our acquisition of Freedom Health, Inc., Optimum HealthCare, Inc., America's 1st Choice of South Carolina, Inc. and related entities. This Medicare Advantage organization offers HMO products, including Chronic Special Needs Plans and Dual-Eligible Special Needs Plans, under its Freedom Health and Optimum HealthCare brands in Florida and its America's 1st Choice of South Carolina brand in South Carolina. This acquisition aligned with our plans for continued growth in the Medicare Advantage and Special Needs populations.

Other significant transactions in recent years that have impacted or will impact our capital structure or that have influenced or will influence how we conduct our business operations include our Board of Directors' declarations of dividends on our common stock, repurchases of our common stock, debt repurchases and new debt issuances (2020 and prior). For additional information regarding these transactions, see Note 13, "Debt" and Note 15, "Capital Stock," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Litigation Matters

In the consolidated multi-district proceeding in the United States District Court for the Northern District of Alabama (the "Court") captioned *In re Blue Cross Blue Shield Antitrust Litigation* ("BCBSA Litigation"), the Blue Cross Blue Shield Association (the "BCBSA"), and Blue Cross and/or Blue Shield licensees, including us (the "Blue plans") have approved a settlement agreement and release (the "Subscriber Settlement Agreement") with the plaintiffs representing a putative nationwide class of health plan subscribers. Generally, the lawsuits in the BCBSA Litigation challenge elements of the licensing agreements between the BCBSA and the independently owned and operated Blue plans. The cases were brought by two putative nationwide classes of plaintiffs, health plan subscribers and providers, and the Subscriber Settlement Agreement applies only to the putative subscriber class. No settlement agreement has been reached with the provider plaintiffs at this time, and the defendants continue to contest the consolidated cases brought by the provider plaintiffs.

If approved by the Court, the Subscriber Settlement Agreement will require the defendants to make a monetary settlement payment, our portion of which is estimated to be $594, and will contain certain non-monetary terms including (i) eliminating the "national best efforts" rule in the BCBSA license agreements (which rule limits the percentage of non-Blue revenue permitted for each Blue plan) and (ii) allowing for some large national employers with self-funded benefit plans to request a bid for insurance coverage from a second Blue plan in addition to the local Blue plan. We recognized our estimated payment obligation of $548, net of third-party insurance coverage received as of December 31, 2020.

On November 30, 2020, the Court issued an order preliminarily approving the Subscriber Settlement Agreement, following which members of the Subscriber class were provided notice of the Settlement Agreement and an opportunity to opt out of the class. All terms of the Subscriber Settlement Agreement are subject to final approval by the Court before they become effective. Objections to the settlement as well as the deadline for those that wish to opt-out from the settlement must be submitted by July 28, 2021. Claims must be filed by November 5, 2021. A final approval hearing has been scheduled for October 20, 2021. If the Court grants approval of the Subscriber Settlement Agreement, and after all appellate rights have expired or have been exhausted in a manner that affirms the Court's final order and judgment, the defendants' payment and non-monetary obligations under the Subscriber Settlement Agreement will become effective. For additional information regarding this lawsuit, see Note 14, "Commitments and Contingencies - *Litigation and Regulatory Proceedings – Blue Cross Blue Shield Antitrust Litigation*," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

In August 2020, the Delaware Court of Chancery ruled that neither we nor Cigna Corporation could collect damages in connection with the now terminated Agreement and Plan of Merger, between us and Cigna Corporation. Cigna filed a notice of appeal in November 2020 challenging the trial court's opinion that Anthem did not owe Cigna a termination fee. Cigna filed its appellate brief in December 2020, and we filed a response in January 2021. For additional information, see Note 14, "Commitments and Contingencies - *Litigation and Regulatory Proceedings - Cigna Corporation Merger Litigation,*" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

In January 2019, we exercised our contractual right to terminate our PBM Agreement with Express Scripts (the "ESI PBM Agreement") and we completed the transition of our members from Express Scripts to IngenioRx by January 1, 2020. Notwithstanding our termination of the ESI PBM Agreement, the litigation between us and Express Scripts regarding the ESI PBM Agreement continues. For additional information regarding this lawsuit, see Note 14, "Commitments and Contingencies - *Litigation and Regulatory Proceedings - Express Scripts, Inc. Pharmacy Benefit Management Litigation,*" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Selected Operating Performance

During the year ended December 31, 2020, total medical membership increased by 1.9, or 4.7%. Our medical membership grew in both our Government Business and Commercial & Specialty Business segments. The increase in medical membership in our Government Business segment was driven by organic growth in our Medicaid business due to the temporary suspension of eligibility recertification efforts in our markets in response to the COVID-19 pandemic, as well as acquisitions, and growth in our Medicare business. The increase in medical membership in our Commercial & Specialty Business segment was primarily driven by growth in our self-funded business, partially offset by declines in our fully-insured Local Group membership due to negative in-group changes as a result of increased unemployment caused by the COVID-19 pandemic.

Operating revenue for the year ended December 31, 2020 was $120,808, an increase of $17,667, or 17.1%, from the year ended December 31, 2019. The increase in operating revenue was primarily driven by higher premium revenue in our Government Business segment, as well as increased pharmacy product revenue related to the launch of IngenioRx.

Net income for the year ended December 31, 2020 was $4,572, a decrease of $235, or 4.9%, from the year ended December 31, 2019. The decrease in net income was a result of lower operating results in our Commercial & Specialty Business segment, which was largely driven by costs associated with actions taken to support our members and providers in response to the COVID-19 pandemic and costs for COVID-19 related care, as well as our estimated payment obligation related to the BCBSA Litigation and expenses related to our business optimization initiatives recognized in 2020, higher income tax expense, and a decrease in net earnings from investment activities. These decreases in net income were largely offset by higher operating results in our IngenioRx and Government Business segments.

Our fully-diluted earnings per share ("EPS") for the year ended December 31, 2020 were $17.98, a decrease of $0.49, or 2.7%, from the year ended December 31, 2019. Our diluted shares for the year ended December 31, 2020 were 254.3, a decrease of 6.0, or 2.3%, compared to the year ended December 31, 2019. The decrease in EPS resulted from the decrease in net income, partially offset by the impact of a lower number of shares outstanding in 2020.

Operating cash flow for the year ended December 31, 2020 was $10,688, or approximately 2.3 times net income. Operating cash flow for the year ended December 31, 2019 was $6,061, or approximately 1.3 times net income. The increase in operating cash flow was primarily due to the impact of the timing of working capital changes. The increase was further due to membership growth in our Government Business segment and higher net income in 2020, excluding the non-cash impact of accrued expenses related to our business optimization initiatives and the BCBSA Litigation.

Our results of operations discussed throughout this MD&A are determined in accordance with GAAP. We also calculate operating gain to further aid investors in understanding and analyzing our core operating results. We define operating revenue as premium income, product revenue and administrative fees and other revenue. Operating gain is calculated as total operating revenue less benefit expense, cost of products sold and selling, general and administrative expense. We use these measures as a basis for evaluating segment performance, allocating resources, forecasting future operating periods and setting incentive compensation targets. This information is not intended to be considered in isolation or as a substitute for income before income tax expense, net income or EPS prepared in accordance with GAAP, and may not be comparable to similarly titled measures reported by other companies. For additional details on operating gain, see our "Reportable Segments Results of Operations" discussion included in this MD&A. For a reconciliation of reportable segment operating revenue to the amounts of total revenue included in the consolidated statements of income and a reconciliation of reportable segment operating gain to income before income tax expense, see Note 20, "Segment Information," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We intend to expand through a combination of organic growth, strategic acquisitions and efficient use of capital in both existing and new markets. Our growth strategy is designed to enable us to take advantage of additional economies of scale, as well as providing us access to new and evolving technologies and products. In addition, we believe geographic and product diversity reduces our exposure to local or regional regulatory, economic and competitive pressures and provides us with increased opportunities for growth. In 2019, we began using IngenioRx to market and offer PBM services, and we expect IngenioRx to improve our ability to integrate pharmacy benefits within our medical and specialty platform. In 2020, we continued growing our government-sponsored business. In all other markets, we intend to maintain our position by delivering excellent service, offering competitively priced products, providing access to high-quality provider networks and effectively capitalizing on the brand strength of the Blue Cross and Blue Shield names and marks.

Membership

Our medical membership includes seven different customer types: Local Group, Individual, National Accounts, BlueCard®, Medicare, Medicaid and our Federal Employees Health Benefits ("FEHB") Program. BCBS-branded business generally refers to members in our service areas licensed by the BCBSA. Non-BCBS-branded business refers to members in our non-BCBS-branded Amerigroup, Freedom Health, HealthSun, Optimum HealthCare and Simply Healthcare plans, as well as Beacon, HealthLink and UniCare members. In addition to the above medical membership, we also serve customers who purchase one or more of our other products or services that are often ancillary to our health business.

- Local Group consists of those employer customers with less than 5% of eligible employees located outside of the headquarter state, as well as customers with more than 5% of eligible employees located outside of the headquarter state with up to 5,000 eligible employees. In addition, Local Group includes Student Health and UniCare members. Local Group accounts are generally sold through brokers or consultants who work with industry specialists from our in-house sales force and are offered both on and off the public exchanges. Local Group insurance premiums may be based on claims incurred by the group or sold on a self-insured basis. The customer's buying decision is typically based upon the size and breadth of our networks, customer service, the quality of our medical management services, the administrative cost included in our quoted price, our financial stability, our reputation and our ability to effectively service large complex accounts. Local Group accounted for 36.4%, 38.2% and 39.4% of our medical members at December 31, 2020, 2019 and 2018, respectively.
- Individual consists of individual customers under age 65 and their covered dependents. Individual policies are generally sold through independent agents and brokers, retail partnerships, our in-house sales force or via the exchanges. Individual business is sold on a fully-insured basis. We offer on-exchange products through public exchanges and off-exchange products. Federal premium subsidies are available only for certain public exchange Individual products. Unsubsidized Individual customers are generally more sensitive to product pricing and, to a lesser extent, the configuration of the network and the efficiency of administration. Customer turnover is generally

higher with Individual as compared to Local Group. Individual business accounted for 1.6%, 1.7% and 1.6% of our medical members at December 31, 2020, 2019 and 2018, respectively.

- National Accounts generally consist of multi-state employer groups primarily headquartered in an Anthem service area with at least 5% of the eligible employees located outside of the headquarter state and with more than 5,000 eligible employees. Some exceptions are allowed based on broker and consultant relationships. Service area is defined as the geographic area in which we are licensed to sell BCBS products. National Accounts are generally sold through independent brokers or consultants retained by the customer working with our in-house sales force. We believe we have an advantage when competing for very large National Accounts due to the size and breadth of our networks and our ability to access the national provider networks of other BCBS companies at their competitive local market rates. National Accounts represented 18.0%, 18.5% and 19.0% of our medical members at December 31, 2020, 2019 and 2018, respectively.
- BlueCard® host customers represent enrollees of Blue Cross and/or Blue Shield plans not owned by Anthem who receive healthcare services in our BCBSA licensed markets. BlueCard® membership consists of estimated host members using the national BlueCard® program. Host members are generally members who reside in or travel to a state in which an Anthem subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer-sponsored health plan issued by a non-Anthem controlled BCBSA licensee (the "home plan"). We perform certain functions including claims pricing and administration for BlueCard® members, for which we receive administrative fees from the BlueCard® members' home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan. Host members are computed using, among other things, the average number of BlueCard® claims received per month. BlueCard® host membership accounted for 14.1%, 14.8% and 14.6% of our medical members at December 31, 2020, 2019 and 2018, respectively.
- Medicare customers are Medicare-eligible individual members age 65 and over who have enrolled in Medicare Supplement plans; Medicare Advantage, including Special Needs Plans ("SNPs"), also known as Medicare Advantage SNPs; Medicare Part D; and dual-eligible programs through Medicare-Medicaid Plans ("MMPs"). Medicare Supplement plans typically pay the difference between healthcare costs incurred by a beneficiary and amounts paid by Medicare. Medicare Advantage plans provide Medicare beneficiaries with a managed care alternative to traditional Medicare and often include a Medicare Part D benefit. In addition, our Medicare Advantage SNPs provide tailored benefits to special needs individuals who are institutionalized or have severe or disabling chronic conditions and to dual-eligible customers, who are low-income seniors and persons under age 65 with disabilities. Medicare Advantage SNPs are coordinated care plans specifically designed to provide targeted care, covering all the healthcare services considered medically necessary for members and often providing professional care coordination services, with personal guidance and programs that help members maintain their health. Medicare Advantage membership also includes Medicare Advantage members in our Group Retiree Solutions business who are related to National Accounts, retired members of Local Group accounts, or retired members of groups who are not affiliated with our Commercial accounts who have selected a Medicare Advantage product through us. Medicare Part D offers a prescription drug plan to Medicare and MMP beneficiaries. MMP, which was established as a result of the passage of the ACA, is a demonstration program focused on serving members who are dually eligible for Medicaid and Medicare. Medicare Supplement and Medicare Advantage products are marketed in the same manner, primarily through independent agents and brokers. Medicare business accounted for 5.5%, 5.2% and 4.6% of our medical members at December 31, 2020, 2019 and 2018, respectively.
- Medicaid membership represents eligible members who receive healthcare benefits through publicly funded healthcare programs, including Medicaid, ACA-related Medicaid expansion programs, Temporary Assistance for Needy Families, programs for seniors and people with disabilities, Children's Health Insurance Programs, and specialty programs such as those focused on long-term services and support, HIV/AIDS, foster care, behavioral health and/or substance abuse disorders, and intellectual disabilities or developmental disabilities, among others. Total Medicaid program business accounted for 20.6%, 17.7% and 16.8% of our medical members at December 31, 2020, 2019 and 2018, respectively.

- FEHB members consist of United States government employees and their dependents within our geographic markets through our participation in the national contract between the BCBSA and the U.S. Office of Personnel Management. FEHB business accounted for 3.8% of our medical members at December 31, 2020 and 3.9% at both December 31, 2019 and 2018.

In addition to reporting our medical membership by customer type, we report by funding arrangement according to the level of risk that we assume in the product contract. Our two principal funding arrangement categories are fully-insured and self-funded. Fully-insured products are products in which we indemnify our policyholders against costs for health benefits. Self-funded products are offered to customers, generally larger employers, who elect to retain most or all of the financial risk associated with their employees' healthcare costs. Some self-funded customers choose to purchase stop loss coverage to limit their retained risk.

The following table presents our medical membership by customer type, funding arrangement and reportable segment as of December 31, 2020, 2019 and 2018. Also included below is other membership by product. At this time, the following table does not include membership resulting from our acquisition of Beacon. The medical membership and other membership presented are unaudited and in certain instances include estimates of the number of members represented by each contract at the end of the period.

	December 31			2020 vs. 2019		2019 vs. 2018	
(In thousands)	2020	2019	2018	Change	% Change	Change	% Change
Medical Membership							
Customer Type							
Local Group	15,614	15,682	15,733	(68)	(0.4)%	(51)	(0.3)%
Individual	680	684	655	(4)	(0.6)%	29	4.4 %
National:							
National Accounts	7,736	7,596	7,588	140	1.8 %	8	0.1 %
BlueCard®	6,059	6,060	5,838	(1)	— %	222	3.8 %
Total National	13,795	13,656	13,426	139	1.0 %	230	1.7 %
Medicare:							
Medicare Advantage	1,428	1,214	1,006	214	17.6 %	208	20.7 %
Medicare Supplement	933	905	846	28	3.1 %	59	7.0 %
Total Medicare	2,361	2,119	1,852	242	11.4 %	267	14.4 %
Medicaid	8,852	7,265	6,716	1,587	21.8 %	549	8.2 %
FEHB	1,623	1,594	1,556	29	1.8 %	38	2.4 %
Total Medical Membership by Customer Type	42,925	41,000	39,938	1,925	4.7 %	1,062	2.7 %
Funding Arrangement							
Self-Funded	25,629	25,418	25,287	211	0.8 %	131	0.5 %
Fully-Insured	17,296	15,582	14,651	1,714	11.0 %	931	6.4 %
Total Medical Membership by Funding Arrangement	42,925	41,000	39,938	1,925	4.7 %	1,062	2.7 %
Reportable Segment							
Commercial & Specialty Business	30,089	30,022	29,814	67	0.2 %	208	0.7 %
Government Business	12,836	10,978	10,124	1,858	16.9 %	854	8.4 %
Total Medical Membership by Reportable Segment	42,925	41,000	39,938	1,925	4.7 %	1,062	2.7 %
Other Membership							
Life and Disability Members	5,064	5,259	4,795	(195)	(3.7)%	464	9.7 %
Dental Members	6,385	6,263	5,807	122	1.9 %	456	7.9 %
Dental Administration Members	1,316	5,516	5,327	(4,200)	(76.1)%	189	3.5 %
Vision Members	7,536	7,261	6,946	275	3.8 %	315	4.5 %
Medicare Part D Standalone Members	413	283	309	130	45.9 %	(26)	(8.4)%

December 31, 2020 Compared to December 31, 2019

Medical Membership

Total medical membership grew in both our Government Business and Commercial & Specialty Business segments as well as by funding arrangement. Fully-insured membership increased primarily due to growth in our Medicaid and Medicare businesses, partially offset by membership decreases in our fully-insured Local Group business. Local Group membership decreased due to negative in-group changes as a result of increased unemployment caused by the COVID-19 pandemic,

which was partially offset by sales exceeding lapses. Self-funded medical membership increased primarily as a result of membership increases in our National Accounts business driven by our acquisition of a third-party administrator. Medicaid membership increased primarily due to organic growth in existing markets due to the temporary suspension of eligibility recertification during the COVID-19 pandemic as well as our acquisition of Medicaid plans in Missouri and Nebraska in 2020. Medicare membership increased primarily due to higher sales.

Other Membership

Our other membership can be impacted by changes in our medical membership, as our medical members often purchase our other products that are ancillary to our health business. Life and disability membership decreased due to higher lapses in our fully-insured Local Group business. Dental membership increased primarily due to new sales and growth in our National Accounts and membership growth in our FEHB program, as well as new sales in our Individual product offerings. Dental administration membership decreased due to the lapse of a large dental administration services contract. Vision membership increased due to higher sales in our Medicare and Local Group businesses.

Consolidated Results of Operations

Our consolidated summarized results of operations and other information for the years ended December 31, 2020, 2019 and 2018 are as follows:

	Years Ended December 31			Change			
				2020 vs. 2019		2019 vs. 2018	
	2020	2019	2018	$	%	$	%
Total operating revenue	$ 120,808	$ 103,141	$ 91,341	$ 17,667	17.1 %	$ 11,800	12.9 %
Net investment income	877	1,005	970	(128)	(12.7)%	35	3.6 %
Net realized gains (losses) on financial instruments	182	67	(206)	115	(171.6)%	273	(132.5)%
Total revenues	121,867	104,213	92,105	17,654	16.9 %	12,108	13.1 %
Benefit expense	88,045	81,786	71,895	6,259	7.7 %	9,891	13.8 %
Cost of products sold	8,953	1,992	—	6,961	349.4 %	1,992	NM
Selling, general and administrative expense	17,450	13,364	14,020	4,086	30.6 %	(656)	(4.7)%
Other expense[1]	1,181	1,086	1,122	95	8.7 %	(36)	(3.2)%
Total expenses	115,629	98,228	87,037	17,401	17.7 %	11,191	12.9 %
Income before income tax expense	6,238	5,985	5,068	253	4.2 %	917	18.1 %
Income tax expense	1,666	1,178	1,318	488	41.4 %	(140)	(10.6)%
Net income	$ 4,572	$ 4,807	$ 3,750	$ (235)	(4.9)%	$ 1,057	28.2 %
Average diluted shares outstanding	254.3	260.3	264.2	(6.0)	(2.3)%	(3.9)	(1.5)%
Diluted net income per share	$ 17.98	$ 18.47	$ 14.19	$ (0.49)	(2.7)%	$ 4.28	30.2 %
Effective tax rate	26.7 %	19.7 %	26.0 %		700bp[3]		(630)bp[3]
Benefit expense ratio[2]	84.6 %	86.8 %	84.2 %		(220)bp[3]		260bp[3]
Selling, general and administrative expense ratio[4]	14.4 %	13.0 %	15.3 %		140bp[3]		(230)bp[3]
Income before income tax expense as a percentage of total revenues	5.1 %	5.7 %	5.5 %		(60)bp[3]		20bp[3]
Net income as a percentage of total revenues	3.8 %	4.6 %	4.1 %		(80)bp[3]		50bp[3]

Certain of the following definitions are also applicable to all other results of operations tables in this discussion:

NM Not meaningful.

1 Includes interest expense, amortization of other intangible assets and loss on extinguishment of debt.

2 Benefit expense ratio represents benefit expense as a percentage of premium revenue. Premiums for the years ended December 31, 2020, 2019 and 2018 were $104,109, $94,173 and $85,421, respectively. Premiums are included in total operating revenue presented above.

3 bp = basis point; one hundred basis points = 1%.
4 Selling, general and administrative expense ratio represents selling, general and administrative expense as a percentage of total operating revenue.

Year Ended December 31, 2020 Compared to the Year Ended December 31, 2019

Total operating revenue increased as a result of higher premium revenue due mainly to membership growth in our Government Business segment related to our Medicaid and Medicare businesses and rate increases designed to cover the impact of the HIP Fee reinstatement for 2020. The increase in operating revenue was further attributable to an increase in pharmacy product revenue as we completed the transition of all of our unaffiliated PBM customers to IngenioRx between the second quarter of 2019 and January 1, 2020. The increase in operating revenue was partially offset by a decrease in premiums in our Commercial & Specialty Business segment related to fully-insured membership declines as a result of increased unemployment caused by the COVID-19 pandemic.

Net investment income decreased primarily due to losses from other invested assets and lower yields on our short term investments. The losses on our other invested assets were primarily due to losses from energy sector private equity funds recognized in 2020 as a result of a decrease in the worldwide demand for energy due to the COVID-19 pandemic.

Net realized gains on financial instruments increased primarily due to the changes in the fair values of our investments in equity securities. This increase was partially offset by a decrease in net realized gains on sales of equity securities.

Benefit expense increased primarily due to increased costs as a result of growth in our Medicaid and Medicare membership and overall cost trends across our businesses including increased expense to cover COVID-19 related costs such as testing, treatment, expanded coverage of insurance benefits, waivers for cost-sharing and actions taken to support our members in response to the pandemic. These increases were partially offset by the lower volume of healthcare claims experienced resulting from decreased utilization of non-COVID-19 health services during the COVID-19 pandemic.

Our benefit expense ratio decreased primarily due to the COVID-19 impact of lower utilization rates of healthcare benefits, and to a lesser extent, the HIP Fee reinstatement for 2020. These decreases were partially offset by increased benefit costs associated with actions taken to support our members in response to the pandemic and COVID-19 related care. The decreases were further offset by the impact of retroactive rate adjustments in our Medicaid business and premium credits provided in response to the COVID-19 pandemic to our members enrolled in select Individual plans and fully-insured employer customers.

Cost of products sold increased as we completed the transition of all of our unaffiliated PBM customers to IngenioRx between the second quarter of 2019, when it began its operations, and January 1, 2020.

Selling, general and administrative expense increased primarily due to the reinstatement of the HIP Fee for 2020 and increased spend to support growth in our businesses. The increase was further due to the recognition of expenses related to our business optimization initiatives and the BCBSA Litigation during 2020.

Our selling, general and administrative expense ratio increased as a result of the higher selling, general and administrative expenses discussed above, partially offset by the growth in operating revenue.

Our effective income tax rate increased primarily due to the reinstatement of the non-tax deductible HIP Fee for 2020.

Our net income as a percentage of total revenue decreased as a result of all factors discussed above.

Reportable Segments Results of Operations

Beginning in 2020, IngenioRx met the quantitative thresholds for a reportable segment and the results of our operations are now described through four reportable segments: Commercial & Specialty Business, Government Business, IngenioRx and Other. We use operating gain to evaluate the performance of our reportable segments. Operating gain is calculated as total operating revenue less benefit expense, cost of products sold and selling, general and administrative expense. It does not include net investment income, net realized gains (losses) on financial instruments, interest expense, amortization of other intangible assets, loss on extinguishment of debt or income taxes, as these items are managed in a corporate shared service environment and are not the responsibility of operating segment management.

The discussion of segment results presented below is based on operating gain, as described above, and operating margin, which is calculated as operating gain divided by operating revenue. Our definition of operating gain and operating margin may not be comparable to similarly titled measures reported by other companies. We use these measures as a basis for evaluating segment performance, allocating resources, forecasting future operating periods and setting incentive compensation targets. This information is not intended to be considered in isolation or as a substitute for income before income tax expense, net income or EPS, prepared in accordance with GAAP. For our 2019 segment reporting, operating gain generated from IngenioRx activities were allocated and included in our Commercial & Specialty Business and Government Business based upon their utilization of those services, which aligns with the method by which we assessed the 2019 operating performance of our reportable segments. Beginning January 1, 2020, we are managing the operating performance of each of our segments on a standalone basis. Prior year 2019 allocations were not restated to conform to the 2020 presentation; however, operating margins for IngenioRx were approximately 8% in 2019. For additional information, see Note 20, "Segment Information," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

The following table presents a summary of our reportable segment financial information for the years ended December 31, 2020, 2019 and 2018:

	Years Ended December 31			Change			
				2020 vs. 2019		2019 vs. 2018	
	2020	2019	2018	$	%	$	%
Operating Revenue							
Commercial & Specialty Business	$ 36,699	$ 37,421	$ 35,782	$ (722)	(1.9)%	$ 1,639	4.6 %
Government Business	71,572	62,632	55,348	8,940	14.3 %	7,284	13.2 %
IngenioRx	21,911	5,402	—	16,509	305.6 %	5,402	NM
Other	6,057	2,293	1,519	3,764	164.2 %	774	51.0 %
Eliminations	(15,431)	(4,607)	(1,308)	(10,824)	234.9 %	(3,299)	252.2 %
Total operating revenue	$ 120,808	$ 103,141	$ 91,341	$ 17,667	17.1 %	$ 11,800	12.9 %
Operating Gain (Loss)							
Commercial & Specialty Business[1]	$ 2,681	$ 4,032	$ 3,600	(1,351)	(33.5)%	432	12.0 %
Government Business[2]	2,444	2,056	1,928	388	18.9 %	128	6.6 %
IngenioRx[3]	1,361	—	—	1,361	NM	—	NM
Other[4]	(126)	(89)	(102)	(37)	41.6 %	13	(12.7)%
Operating Margin							
Commercial & Specialty Business	7.3	10.8 %	10.1 %		(350)bp[5]		70bp[5]
Government Business	3.4	3.3 %	3.5 %		10bp[5]		(20)bp[5]
IngenioRx	6.2	— %	NM		NM		NM

NM Not meaningful.
1 Includes expenses of $524 for the BCBSA Litigation and $311 for business optimization initiatives recognized in 2020.
2 Includes expenses of $205 for business optimization initiatives and $24 for the BCBSA Litigation recognized in 2020.
3 Includes expenses of $4 for business optimization initiatives recognized in 2020.
4 Includes expenses of $133 for business optimization initiatives recognized in 2020.
5 bp = basis point; one hundred basis points = 1%.

Year Ended December 31, 2020 Compared to the Year Ended December 31, 2019

Commercial & Specialty Business

Operating revenue decreased primarily due to fully-insured membership declines as a result of increased unemployment caused by the COVID-19 pandemic. The decrease in operating revenue was further attributable to the absence of pharmacy

administrative fee revenue that is now being recognized within the IngenioRx segment and the impact of premium credits provided to certain members in response to the COVID-19 pandemic. These decreases were partially offset by higher premium revenue resulting from rate increases designed to cover the impact of the HIP Fee reinstatement for 2020.

The decrease in operating gain was primarily driven by costs associated with actions taken to support our members and providers in response to the pandemic and COVID-19 related care, as well as expenses for the BCBSA Litigation and business optimization initiatives recognized in 2020. The decrease was further attributable to the shift of pharmacy earnings to our IngenioRx segment and the impact of premium credits provided to certain members in response to the COVID-19 pandemic. The decrease was partially offset by the impact of the lower volume of healthcare claims attributable to decreased utilization of non-COVID-19 health services during the COVID-19 pandemic.

Government Business

Operating revenue increased primarily due to higher premium revenue as a result of membership growth in our Medicaid business driven by the temporary suspension of eligibility recertification efforts during the COVID-19 pandemic, acquisitions and new expansions, as well as membership growth in our Medicare business. The increase in premium revenue was further attributable to the HIP Fee reinstatement for 2020.

The increase in operating gain was primarily driven by the lower volume of healthcare claims attributable to decreased utilization of non-COVID-19 health services during the COVID-19 pandemic. The increase was partially offset by costs associated with actions taken to support our members in response to the pandemic and COVID-19 related care and retroactive rate adjustments and higher experience-rated refunds in our Medicaid business. The increase in operating gain was further offset by increased spend to support growth and expenses for business optimization initiatives recognized in 2020.

IngenioRx

Operating revenue and operating gain increased as a result of the transition of our existing members to IngenioRx, which commenced its operations during the second quarter of 2019. Operating revenue represents product revenues from services performed for our fully-insured affiliated health plans and self-funded customers and external customers outside of the health plans we own. Product revenues and cost of goods sold for our fully-insured affiliated health plan customers are eliminated in consolidation. Operating gain represents operating revenue less cost of products sold and selling, general and administrative expenses.

Other

Operating revenue increased due to our acquisition of Beacon in February 2020 and higher administrative fees and other revenue from services performed by DBG in certain markets.

The increase in operating loss was driven by expenses recognized for our business optimization initiatives.

Critical Accounting Policies and Estimates

We prepare our consolidated financial statements in conformity with GAAP. Application of GAAP requires management to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes and within this MD&A. We consider our most important accounting policies that require significant estimates and management judgment to be those policies with respect to liabilities for medical claims payable, income taxes, goodwill and other intangible assets, investments and retirement benefits, which are discussed below. Our other significant accounting policies are summarized in Note 2, “Basis of Presentation and Significant Accounting Policies,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We continually evaluate the accounting policies and estimates used to prepare the consolidated financial statements. In general, our estimates are based on historical experience, evaluation of current trends, information from third-party professionals and various other assumptions that we believe to be reasonable under the known facts and circumstances. Estimates can require a significant amount of judgment, and a different set of assumptions could result in material changes to our reported results.

Medical Claims Payable

The most subjective accounting estimate in our consolidated financial statements is our liability for medical claims payable. At December 31, 2020, this liability was $11,359 and represented 21% of our total consolidated liabilities. We record this liability and the corresponding benefit expense for incurred but not paid claims, including the estimated costs of processing such claims. Incurred but not paid claims include (1) an estimate for claims that are incurred but not reported, as well as claims reported to us but not yet processed through our systems, which approximated 96%, or $10,925, of our total medical claims liability as of December 31, 2020; and (2) claims reported to us and processed through our systems but not yet paid, which approximated 4%, or $434, of the total medical claims payable as of December 31, 2020. The level of claims payable processed through our systems but not yet paid may fluctuate from one period-end to the next, from approximately 1% to 5% of our total medical claims liability, due to timing of when claim payments are made.

Liabilities for both claims incurred but not reported and reported but not yet processed through our systems are determined in the aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Actuarial Standards of Practice require that the claim liabilities be appropriate under moderately adverse circumstances. We determine the amount of the liability for incurred but not paid claims by following a detailed actuarial process that uses both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities. Under this process, historical paid claims data is formatted into “claim triangles,” which compare claim incurred dates to the dates of claim payments. This information is analyzed to create “completion factors” that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the period-end date to estimate the ultimate claim expense incurred for the period. Actuarial estimates of incurred but not paid claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims.

For the most recent incurred months (typically the most recent two months), the percentage of claims paid for claims incurred in those months is generally low. This makes the completion factor methodology less reliable for such months. Therefore, incurred claims for recent months are not projected from historical completion and payment patterns; rather, they are projected by estimating the claims expense for those months based on recent claims expense levels and healthcare trend levels (“trend factors”).

Because the reserve methodology is based upon historical information, it must be adjusted for known or suspected operational and environmental changes. These adjustments are made by our actuaries based on their knowledge and their estimate of emerging impacts to benefit costs and payment speed. Circumstances to be considered in developing our best estimate of reserves include changes in utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations. A comparison of prior period liabilities to re-estimated claim liabilities based on subsequent claims development is also considered in making the liability determination. In our comparison to prior periods, the methods and assumptions are not changed as reserves are recalculated; rather, the availability of additional paid claims information drives changes in the re-estimate of the unpaid claim liability. To the extent appropriate, changes in such development are recorded as a change to current period benefit expense. The impact from COVID-19 on healthcare utilization and medical claims submission patterns has increased estimation uncertainty on our incurred but not reported liability at December 31, 2020. Slowdowns in claims submission patterns and increases in utilization levels for COVID-19 testing and treatment during the fourth quarter of 2020 are the primary factors that lead to the increased estimation uncertainty.

We regularly review and set assumptions regarding cost trends and utilization when initially establishing claim liabilities. We continually monitor and adjust the claims liability and benefit expense based on subsequent paid claims activity. If it is determined that our assumptions regarding cost trends and utilization are materially different than actual results, our income statement and financial position could be impacted in future periods. Adjustments of prior year estimates may result in additional benefit expense or a reduction of benefit expense in the period an adjustment is made. Further, due to the considerable variability of healthcare costs, adjustments to claim liabilities occur each period and are sometimes significant as compared to the net income recorded in that period. Prior period development is recognized immediately upon the actuary’s judgment that a portion of the prior period liability is no longer needed or that an additional liability should have been accrued. That determination is made when sufficient information is available to ascertain that the re-estimate of the liability is reasonable.

While there are many factors that are used as a part of the estimation of our medical claims payable liability, the two key assumptions having the most significant impact on our incurred but not paid claims liability as of December 31, 2020 were the completion and trend factors. As discussed above, these two key assumptions can be influenced by utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations.

There is variation in the reasonable choice of completion factors by duration for durations of three months through twelve months where the completion factors have the most significant impact. As previously discussed, completion factors tend to be less reliable for the most recent months and therefore are not specifically utilized for months one and two. In our analysis for the claim liabilities at December 31, 2020, the variability in months three to five was estimated to be between 40 and 90 basis points, while months six through twelve have much lower estimated variability ranging from 0 to 30 basis points.

The difference in completion factor assumptions, assuming moderately adverse experience, results in variability of 2%, or approximately $204, in the December 31, 2020 incurred but not paid claims liability, depending on the completion factors chosen. It is important to note that the completion factor methodology inherently assumes that historical completion rates will be reflective of the current period. However, it is possible that the actual completion rates for the current period will develop differently from historical patterns and therefore could fall outside the possible variations described herein.

The other major assumption used in the establishment of the December 31, 2020 incurred but not paid claim liability was the trend factors. In our analysis for the period ended December 31, 2020, there was a 320 basis point differential in the high and low trend factors assuming moderately adverse experience. This range of trend factors would imply variability of 4%, or approximately $427, in the incurred but not paid claims liability, depending upon the trend factors used. Because historical trend factors are often not representative of current claim trends, the trend experience for the most recent six to nine months, plus knowledge of recent events likely affecting current trends, have been taken into consideration in establishing the incurred but not paid claims liability at December 31, 2020. The COVID-19 pandemic continues to have a significant impact on 2020 dates of service. Our expenses associated with COVID-19 accelerated in the fourth quarter of 2020 and exceeded the benefit from lower volume of healthcare claims attributable to decreased utilization of non-COVID-19 health services. We will continue to monitor emerging experience in order to better understand the possible implications to our reserves.

See Note 12, “Medical Claims Payable,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K, for a reconciliation of the beginning and ending balance for medical claims payable for the years ended December 31, 2020, 2019 and 2018. Components of the total incurred claims for each year include amounts accrued for current year estimated claims expense as well as adjustments to prior year estimated accruals. In Note 12, “Medical Claims Payable,” the line labeled “Net incurred medical claims: Prior years redundancies” accounts for those adjustments made to prior year estimates. The impact of any reduction of “Net incurred medical claims: Prior years redundancies” may be offset as we establish the estimate of “Net incurred medical claims: Current year.” Our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for our claims. When we recognize a release of the redundancy, we disclose the amount that is not in the ordinary course of business, if material.

The ratio of current year medical claims paid as a percent of current year net medical claims incurred was 87.7% for 2020, 89.3% for 2019 and 90.2% for 2018. This ratio serves as an indicator of claims processing speed whereby 2020 claims were processed at a slower speed than in 2019 and 2018.

We calculate the percentage of prior year redundancies in the current year as a percent of prior year net incurred claims payable less prior year redundancies in the current year in order to demonstrate the development of the prior year reserves. For the year ended December 31, 2020, this metric was 8.0%, largely driven by favorable trend factor development at the end of 2019 as well as favorable completion factor development from 2019. For the year ended December 31, 2019, this metric was 7.4%, largely driven by favorable trend factor development at the end of 2018 as well as favorable completion factor development from 2018. For the year ended December 31, 2018, this metric was 13.7%, largely driven by favorable trend factor development at the end of 2017 as well as favorable completion factor development from 2017.

We calculate the percentage of prior year redundancies in the current year as a percent of prior year net incurred medical claims to indicate the percentage of redundancy included in the preceding year calculation of current year net incurred

medical claims. We believe this calculation supports the reasonableness of our prior year estimate of incurred medical claims and the consistency in our methodology. For the year ended December 31, 2020, this metric was 0.8%, which was calculated using the redundancy of $637. This metric was 0.7% for 2019 and 1.3% for 2018. We believe these metrics demonstrate an appropriate level of reserve conservatism.

The following table shows the variance between total net incurred medical claims as reported in Note 12, "Medical Claims Payable," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K, for each of 2019 and 2018 and the incurred claims for such years had it been determined retrospectively (computed as the difference between "net incurred medical claims – current year" for the year shown and "net incurred medical claims – prior years redundancies" for the immediately following year):

	Years Ended December 31	
	2019	2018
Total net incurred medical claims, as reported	$ 78,195	$ 68,651
Retrospective basis, as described above	78,058	69,081
Variance	$ 137	$ (430)
Variance to total net incurred medical claims, as reported	0.2 %	(0.6)%

Given that our business is primarily short tailed (which means that medical claims are generally paid within twelve months of the member receiving service from the provider), the variance to total net incurred medical claims, as reported above, is used to assess the reasonableness of our estimate of ultimate incurred medical claims for a given calendar year with the benefit of one year of experience. We expect that substantially all of the development of the 2020 estimate of medical claims payable will be known during 2021.

The 2019 variance to total net incurred medical claims, as reported of 0.2% was greater than the 2018 percentage of (0.6)%. This was driven by the fact that the change in the prior year redundancy reported for 2020 as compared to 2019 was greater than the change in the prior year redundancy reported for 2019 as compared to 2018.

Income Taxes

We account for income taxes in accordance with the Financial Accounting Standards Board ("FASB") guidance, which requires, among other things, the separate recognition of deferred tax assets and deferred tax liabilities. Such deferred tax assets and deferred tax liabilities represent the tax effect of temporary differences between financial reporting and tax reporting measured at tax rates enacted at the time the deferred tax asset or liability is recorded. A valuation allowance must be established for deferred tax assets if it is "more likely than not" that all or a portion may be unrealized. Our judgment is required in determining an appropriate valuation allowance.

At each financial reporting date, we assess the adequacy of the valuation allowance by evaluating each of our deferred tax assets based on the following:

- the types of temporary differences that created the deferred tax asset;
- the amount of taxes paid in prior periods and available for a carry-back claim;
- the tax rate at which the deferred tax assets will likely be utilized in the future;
- the forecasted future taxable income, and therefore, likely future deduction of the deferred tax item; and
- any significant other issues impacting the likely realization of the benefit of the temporary differences.

We, like other companies, frequently face challenges from tax authorities regarding the amount of taxes due. These challenges include questions regarding the timing and amount of deductions that we have taken on our tax returns. In evaluating any additional tax liability associated with various positions taken in our tax return filings, we record additional liabilities for potential adverse tax outcomes. Based on our evaluation of our tax positions, we believe we have appropriately accrued for uncertain tax benefits, as required by the applicable guidance. To the extent we prevail in matters we have accrued for, our future effective tax rate would be reduced and net income would increase. If we are required to pay more

than accrued, our future effective tax rate would increase and net income would decrease. Our effective tax rate and net income in any given future period could be materially impacted.

In the ordinary course of business, we are regularly audited by federal and other tax authorities, and from time to time, these audits result in proposed assessments. We believe our tax positions comply with applicable tax law, and we intend to defend our positions vigorously through the federal, state and local appeals processes. We believe we have adequately provided for any reasonably foreseeable outcome related to these matters. Accordingly, although their ultimate resolution may require additional tax payments, we do not anticipate any material impact on our results of operations or financial condition from these matters.

For additional information, see Note 8, “Income Taxes,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Goodwill and Other Intangible Assets

Our consolidated goodwill at December 31, 2020 was $21,691 and other intangible assets were $9,405. The sum of goodwill and other intangible assets represented 35.9% of our total consolidated assets and 93.7% of our consolidated shareholders’ equity at December 31, 2020.

We follow FASB guidance for business combinations and goodwill and other intangible assets, which specifies the types of acquired intangible assets that are required to be recognized and reported separately from goodwill. Under the guidance, goodwill and other intangible assets (with indefinite lives) are not amortized but are tested for impairment at least annually. Furthermore, goodwill and other intangible assets are allocated to reporting units for purposes of the annual impairment test. Our impairment tests require us to make assumptions and judgments regarding the estimated fair value of our reporting units, which include goodwill and other intangible assets. In addition, certain other intangible assets with indefinite lives, such as trademarks, are also tested separately.

We complete our annual impairment tests of existing goodwill and other intangible assets with indefinite lives during the fourth quarter of each year. These tests involve the use of estimates related to the fair value of goodwill at the reporting unit level and other intangible assets with indefinite lives, and require a significant degree of management judgment and the use of subjective assumptions. Certain interim impairment tests are also performed when potential impairment indicators exist or changes in our business or other triggering events occur. We have the option of first performing a qualitative assessment for each reporting unit to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount, which is an indication that our goodwill may be impaired. These qualitative impairment tests include assessing events and factors that could affect the fair value of the indefinite-lived intangible assets. Our procedures include assessing our financial performance, macroeconomic conditions, industry and market considerations, various asset specific factors and entity specific events. If we determine that a reporting unit’s goodwill may be impaired after utilizing these qualitative impairment analysis procedures, we are required to perform a quantitative impairment test.

Our quantitative impairment test utilizes the projected income and market valuation approaches for goodwill and the projected income approach for our indefinite lived intangible assets. Use of the projected income and market valuation approaches for our goodwill impairment test reflects our view that both valuation methodologies provide a reasonable estimate of fair value. The projected income approach is developed using assumptions about future revenue, expenses and net income derived from our internal planning process. These estimated future cash flows are then discounted. Our assumed discount rate is based on our industry’s weighted-average cost of capital. Market valuations are based on observed multiples of certain measures including revenue; earnings before interest, taxes, depreciation and amortization; and book value of invested capital (debt and equity) and include market comparisons to publicly traded companies in our industry.

We did not incur any impairment losses as a result of our 2020 annual impairment tests, as it was determined that it is more likely than not that the estimated fair values of our reporting units were substantially in excess of the carrying values as of December 31, 2020. Additionally, we do not believe that the estimated fair values of our reporting units are at risk of becoming impaired in the next twelve months.

If estimated fair values are less than the carrying values of goodwill and other intangibles with indefinite lives in future annual impairment tests, or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

For additional information, see Note 3, “Business Acquisitions” and Note 10, “Goodwill and Other Intangible Assets,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Investments

Current and long-term marketable investment securities were $25,554 at December 31, 2020 and represented 29.5% of our total consolidated assets at December 31, 2020. We classify fixed maturity securities in our investment portfolio as “available-for-sale” and report those securities at fair value. Certain fixed maturity securities are available to support current operations and, accordingly, we classify such investments as current assets without regard to their contractual maturity. Investments used to satisfy contractual, regulatory or other requirements are classified as long-term, without regard to contractual maturity.

Our impairment review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis, using both qualitative and quantitative factors. Such factors considered include the extent to which a security’s market value has been less than its cost, the reasons for the decline in value (i.e., credit event compared to liquidity, general credit spread widening, currency exchange rate or interest rate factors), financial condition and near term prospects of the issuer, including the credit ratings and changes in the credit ratings of the issuer, recommendations of investment advisors, and forecasts of economic, market or industry trends.

Prior to 2020, our fixed maturity securities were evaluated for other-than-temporary impairment where credit-related impairments were presented within the other-than-temporary impairment losses recognized in our consolidated statements of income with an adjustment to the security’s amortized cost basis. Effective January 1, 2020, if a fixed maturity security is in an unrealized loss position and we have the intent to sell the fixed maturity security, or it is more likely than not that we will have to sell the fixed maturity security before recovery of its amortized cost basis, we write down the fixed maturity security’s cost basis to fair value and record an impairment loss in our consolidated statements of income. For impaired fixed maturity securities that we do not intend to sell or if it is more likely than not that we will not have to sell such securities, but we expect that we will not fully recover the amortized cost basis, we recognize the credit component of the impairment as an allowance for credit loss in our consolidated balance sheets and record an impairment loss in our consolidated statements of income. The non-credit component of the impairment is recognized in accumulated other comprehensive income. Furthermore, unrealized losses entirely caused by non-credit-related factors related to fixed maturity securities for which we expect to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive income.

The credit component of an impairment is determined primarily by comparing the net present value of projected future cash flows with the amortized cost basis of the fixed maturity security. The net present value is calculated by discounting our best estimate of projected future cash flows at the effective interest rate implicit in the fixed maturity security at the date of purchase. For mortgage-backed and asset-backed securities, cash flow estimates are based on assumptions regarding the underlying collateral, including prepayment speeds, vintage, type of underlying asset, geographic concentrations, default rates, recoveries and changes in value. For all other securities, cash flow estimates are driven by assumptions regarding probability of default, including changes in credit ratings and estimates regarding timing and amount of recoveries associated with a default.

We have a committee of accounting and investment associates and management that is responsible for managing the impairment review process. We believe we have adequately reviewed our investment securities for impairment and that our investment securities are carried at fair value. We have established an allowance for credit loss and recorded credit loss expense as a reflection of our expected impairment losses. Given the inherent uncertainty of changes in market conditions and the significant judgments involved, there is continuing risk that declines in fair value may occur and additional impairment losses on investments may be recorded in future periods.

In addition to marketable investment securities, we held additional long-term investments of $4,285, or 4.9% of total consolidated assets, at December 31, 2020. These long-term investments consisted primarily of certain other equity investments, the cash surrender value of corporate-owned life insurance policies and real estate. Due to their less liquid nature, these investments are classified as long-term.

The COVID-19 pandemic and efforts to prevent its spread have significantly impacted the global economy, causing market instability and declines in the fair value of our investment holdings in the energy sector and consumer-driven

industries such as travel, entertainment and retail. While the markets have stabilized since the onset of the COVID-19 pandemic, the extent and length of the recovery remain uncertain. Further, the energy sector and consumer-driven industries remain distressed. Given this market uncertainty, there is a risk that our investments that have declined may not recover in future periods.

Through our investing activities, we are exposed to financial market risks, including those resulting from changes in interest rates and changes in equity market valuations. We manage market risks through our investment policy, which establishes credit quality limits and limits on investments in individual issuers. Ineffective management of these risks could have an impact on our future results of operations and financial condition. Our investment portfolio includes fixed maturity securities with a fair value of $23,995 at December 31, 2020. The weighted-average credit rating of these securities was "A" as of December 31, 2020. Included in this balance are investments in fixed maturity securities of states, municipalities and political subdivisions of $1,010 that are guaranteed by third parties. With the exception of twenty-one securities with a fair value of $34, these securities are all investment-grade and carry a weighted-average credit rating of "AA" as of December 31, 2020. The securities are guaranteed by a number of different guarantors, and we do not have any material exposure to any single guarantor, neither indirectly through the guarantees, nor directly through investment in the guarantor. Further, due to the high underlying credit rating of the issuers, the weighted-average credit rating of the fixed maturity securities without a guarantee, for which such information is available, was "A" as of December 31, 2020.

Fair values of fixed maturity and equity securities are based on quoted market prices, where available. These fair values are obtained primarily from third-party pricing services, which generally use Level I or Level II inputs for the determination of fair value in accordance with FASB guidance for fair value measurements and disclosures. We have controls in place to review the pricing services' qualifications and procedures used to determine fair values. In addition, we periodically review the pricing services' pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable.

We obtain quoted market prices for each security from the pricing services, which are derived through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available market observable information. For securities not actively traded, the pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in these valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. As we are responsible for the determination of fair value, we perform analysis on the prices received from the pricing services to determine whether the prices are reasonable estimates of fair value. Our analysis includes procedures such as a review of month-to-month price fluctuations and price comparisons to secondary pricing services. There were no adjustments to quoted market prices obtained from the pricing services during the years ended December 31, 2020 and 2019.

In certain circumstances, it may not be possible to derive pricing model inputs from observable market activity, and therefore, such inputs are estimated internally. Such securities are designated Level III in accordance with FASB guidance. Securities designated Level III at December 31, 2020 totaled $392 and represented approximately 1.3% of our total assets measured at fair value on a recurring basis. Our Level III securities primarily consisted of certain corporate securities and equity securities for which observable inputs were not always available and the fair values of these securities were estimated using inputs including, but not limited to, prepayment speeds, credit spreads, default rates and benchmark yields.

For additional information, see Part II, Item 7A, "Quantitative and Qualitative Disclosures about Market Risk," and Note 2, "Basis of Presentation and Significant Accounting Policies," Note 5, "Investments," and Note 7, "Fair Value," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Retirement Benefits

Pension Benefits

We sponsor defined benefit pension plans for some of our employees. These plans are accounted for in accordance with FASB guidance for retirement benefits, which requires that amounts recognized in financial statements be determined on an actuarial basis. As permitted by the guidance, we calculate the value of plan assets as described below. Further, the difference between our expected rate of return and the actual performance of plan assets, as well as certain changes in pension liabilities, are amortized over future periods.

An important factor in determining our pension expense is the assumption for expected long-term return on plan assets. As of our December 31, 2020 measurement date, we selected a weighted-average long-term rate of return on plan assets of 6.72%. We use a total portfolio return analysis in the development of our assumption. Factors such as past market performance, the long-term relationship between fixed maturity and equity securities, interest rates, inflation and asset allocations are considered in the assumption. The assumption includes an estimate of the additional return expected from active management of the investment portfolio. Peer data and an average of historical returns are also reviewed for appropriateness of the selected assumption. We believe our assumption of future returns is reasonable. However, if we lower our expected long-term return on plan assets, future contributions to the pension plan and pension expense would likely increase.

This assumed long-term rate of return on assets is applied to a calculated value of plan assets, which recognizes changes in the fair value of plan assets in a systematic manner over three years, producing the expected return on plan assets that is included in the determination of pension expense. We apply a corridor approach to amortize unrecognized actuarial gains or losses. Under this approach, only accumulated net actuarial gains or losses in excess of 10% of the greater of the projected benefit obligation or the fair value of plan assets are amortized over the average remaining service or lifetime of the workforce as a component of pension expense. The net deferral of past asset gains or losses affects the calculated value of plan assets and, ultimately, future pension expense.

The discount rate reflects the current rate at which the pension liabilities could be effectively settled at the end of the year based on our most recent measurement date. We use the annual spot rate approach for setting our discount rate. Under the spot rate approach, individual spot rates from a full yield curve of published rates are used to discount each plan's cash flows to determine the plan's obligation. At the December 31, 2020 measurement date, the weighted-average discount rate under the annual spot rate approach was 2.24%, compared to 3.11% at the December 31, 2019 measurement date. The net effect of changes in the discount rate, as well as the net effect of other changes in actuarial assumptions and experience, have been deferred and amortized as a component of pension expense in accordance with FASB guidance.

In managing the plan assets, our objective is to be a responsible fiduciary while minimizing financial risk. Plan assets include a diversified mix of equity securities, investment grade fixed maturity securities and other types of investments across a range of sectors and levels of capitalization to maximize long-term return for a prudent level of risk. In addition to producing a reasonable return, the investment strategy seeks to minimize the volatility in our expense and cash flow.

Effective January 1, 2019, we curtailed the benefits under the Anthem Cash Balance Plan B pension plan. All grandfathered participants no longer have pay credits added to their accounts, but continue to earn interest on existing account balances. Participants continue to earn years of pension service for vesting purposes.

Other Postretirement Benefits

We provide most associates with certain medical, vision and dental benefits upon retirement. We use various actuarial assumptions, including a discount rate and the expected trend in healthcare costs, to estimate the costs and benefit obligations for our retiree benefits.

At our December 31, 2020 measurement date, the selected discount rate for all plans was 1.99%, compared to a discount rate of 2.93% at the December 31, 2019 measurement rate. We developed this rate using the annual spot rate approach as described above.

The assumed healthcare cost trend rates used to measure the expected cost of pre-Medicare (those who are not currently eligible for Medicare benefits) other benefits at our December 31, 2020 measurement date was 7.00% for 2021 with a gradual decline to 4.50% by the year 2033. The assumed healthcare cost trend rates used to measure the expected cost of post-Medicare (those who are currently eligible for Medicare benefits) other benefits at our December 31, 2020 measurement date was 5.50% for 2021 with a gradual decline to 4.50% by the year 2033. These estimated trend rates are subject to change in the future.

For additional information regarding our retirement benefits, see Note 11, "Retirement Benefits," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

New Accounting Pronouncements

For information regarding new accounting pronouncements that were issued or became effective during the year ended December 31, 2020 that had, or are expected to have, a material impact on our financial position, results of operations or financial statement disclosures, see the "*Recently Adopted Accounting Guidance*" and "*Recent Accounting Guidance Not Yet Adopted*" sections of Note 2, "Basis of Presentation and Significant Accounting Policies," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Liquidity and Capital Resources

Introduction

Our cash receipts result primarily from premiums, product revenue, administrative fees and other revenue, investment income, proceeds from the sale or maturity of our investment securities, proceeds from borrowings, and proceeds from the issuance of common stock under our employee stock plans. Cash disbursements result mainly from claims payments, administrative expenses, taxes, purchases of investment securities, interest expense, payments on borrowings, acquisitions, capital expenditures, repurchases of our debt securities and common stock and the payment of cash dividends. Cash outflows fluctuate with the amount and timing of settlement of these transactions. Any future decline in our profitability would likely have an unfavorable impact on our liquidity.

The COVID-19 pandemic and the related mitigation efforts have significantly impacted the economy, causing market instability and increasing unemployment in the United States. While the full impact of COVID-19 on our business remains uncertain, it could have a material adverse effect on our claim payments, collection of our premiums, product or administrative fee revenues, our investments and our ability to access credit. Additional discussion regarding the impact of COVID-19 can be found elsewhere in this MD&A.

We manage our cash, investments and capital structure so we are able to meet the short-term and long-term obligations of our business while maintaining financial flexibility and liquidity. We forecast, analyze and monitor our cash flows to enable investment and financing within the overall constraints of our financial strategy.

To preserve our liquidity and financial flexibility and to minimize the effects of the COVID-19 pandemic, we proactively took several actions during 2020, including borrowing under our senior revolving credit facility in March 2020, which was repaid in April 2020; delaying certain tax payments as permitted by the IRS and the CARES Act; and temporarily suspending our share repurchase activity in March 2020, which was resumed in late June 2020. We may take additional actions going forward to maximize our liquidity, including increasing our borrowings from existing or new Federal Home Loan Bank memberships and other available borrowings. We will continue to monitor the market conditions and seek to act in a prudent manner.

A substantial portion of the assets held by our regulated subsidiaries are in the form of cash and cash equivalents and investments. After considering expected cash flows from operating activities, we generally invest cash that exceeds our near term obligations in longer term marketable fixed maturity securities to improve our overall investment income returns. Our investment strategy is to make investments consistent with insurance statutes and other regulatory requirements, while preserving our asset base. Our investments are generally available-for-sale to meet liquidity and other needs. Our subsidiaries pay out excess capital annually in the form of dividends to their respective parent companies for general corporate use, as permitted by applicable regulations.

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, debt ratings, contractual restrictions, regulatory requirements and market conditions. The securities and credit markets have in the past experienced higher than normal volatility, although current market conditions are more stable. During recent years, the federal government and various governmental agencies have taken a number of steps to strengthen the regulation of the financial services market. In addition, governments around the world have developed their own plans to provide stability and security in the credit markets and to ensure adequate capital in certain financial institutions. Further, in response to the COVID-19 pandemic, the federal government has established a number of programs to provide liquidity to the financial system that provides lending to states, municipalities, and eligible businesses.

A summary of our major sources and uses of cash and cash equivalents for the years ended December 31, 2020, 2019 and 2018 is as follows:

	Years Ended December 31			$ Change	
	2020	2019	2018	2020 vs. 2019	2019 vs. 2018
Sources of Cash:					
Net cash provided by operating activities	$ 10,688	$ 6,061	$ 3,827	$ 4,627	$ 2,234
Proceeds from sales, maturities, calls and redemptions of investments, net of purchases	—	—	1,929	—	(1,929)
Issuance of common stock under Equity Units stock purchase contracts	—	—	1,250	—	(1,250)
Issuances of commercial paper and short- and long-term debt, net of repayments	—	608	—	(608)	608
Issuances of common stock under employee stock plans	176	187	173	(11)	14
Other sources of cash, net	315	—	—	315	—
Total sources of cash	11,179	6,856	7,179	4,323	(323)
Uses of Cash:					
Purchases of investments, net of proceeds from sales, maturities, calls and redemptions	(3,433)	(1,919)	—	(1,514)	(1,919)
Repurchase and retirement of common stock	(2,700)	(1,701)	(1,685)	(999)	(16)
Purchases of subsidiaries, net of cash acquired	(1,976)	—	(1,760)	(1,976)	1,760
Purchases of property and equipment	(1,021)	(1,077)	(1,208)	56	131
Repayments of commercial paper and short- and long-term debt, net of issuances	(298)	—	(1,086)	(298)	1,086
Cash dividends	(954)	(818)	(776)	(136)	(42)
Other uses of cash, net	—	(338)	(337)	338	(1)
Total uses of cash	(10,382)	(5,853)	(6,852)	(4,529)	999
Effect of foreign exchange rates on cash and cash equivalents	7	—	(2)	7	2
Net increase in cash and cash equivalents	$ 804	$ 1,003	$ 325	$ (199)	$ 678

Liquidity—Year Ended December 31, 2020 Compared to Year Ended December 31, 2019

The increase in cash provided by operating activities was primarily due to the impact of the timing of working capital changes. The increase was further due to membership growth in our Government Business segment and higher net income in 2020, excluding the non-cash impact of accrued expenses related to our business optimization initiatives and the BCBSA Litigation.

Other significant changes in sources and uses of cash year-over-year included increases in cash used for acquisitions, net purchases of investments and cash used for repurchase and retirement of common stock.

Financial Condition

We maintained a strong financial condition and liquidity position, with consolidated cash, cash equivalents and investments in fixed maturity and equity securities of $31,295 at December 31, 2020. Since December 31, 2019, total cash, cash equivalents and investments in fixed maturity and equity securities increased by $5,168, primarily due to cash generated from operations. This increase was partially offset by cash used for common stock repurchases, acquisitions, purchases of property and equipment and cash dividends paid to shareholders.

Many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid to their respective parent companies. Certain accounting practices prescribed by insurance regulatory authorities, or statutory accounting practices, differ from GAAP. Changes that occur in statutory accounting practices, if any, could impact our subsidiaries' future dividend capacity. In addition, we have agreed to certain

undertakings to regulatory authorities, including the requirement to maintain certain capital levels in certain of our subsidiaries.

At December 31, 2020, we held $1,747 of cash, cash equivalents and investments at the parent company, which are available for general corporate use, including investment in our businesses, acquisitions, potential future common stock repurchases and dividends to shareholders, repurchases of debt securities and debt and interest payments.

Debt

Periodically, we access capital markets and issue debt ("Notes") for long-term borrowing purposes, for example, to refinance debt, to finance acquisitions or for share repurchases. Certain of these Notes may have a call feature that allows us to redeem the Notes at any time at our option and/or a put feature that allows a Note holder to redeem the Notes upon the occurrence of both a change in control event and a downgrade of the Notes below an investment grade rating. For more information on our debt, including redemptions and issuances, see Note 13, "Debt" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We calculate our consolidated debt-to-capital ratio, a non-GAAP measure, from the amounts presented on our audited consolidated balance sheets included in Part II, Item 8 of this Annual Report on Form 10-K. Our debt-to-capital ratio is calculated as total debt divided by total debt plus total shareholders' equity. Total debt is the sum of short-term borrowings, current portion of long-term debt, long-term debt, less current portion, and lease liabilities. We believe our debt-to-capital ratio assists investors and rating agencies in measuring our overall leverage and additional borrowing capacity. In addition, our bank covenants include a maximum debt-to-capital ratio that we cannot and did not exceed. Our debt-to-capital ratio may not be comparable to similarly titled measures reported by other companies. Our consolidated debt-to-capital ratio was 38.7% and 39.5% as of December 31, 2020 and 2019, respectively.

Our senior debt is rated "A" by S&P Global, "BBB" by Fitch Ratings, Inc., "Baa2" by Moody's Investor Service, Inc. and "bbb+" by AM Best Company, Inc. We intend to maintain our senior debt investment grade ratings. If our credit ratings are downgraded, our business, financial condition and results of operations could be adversely impacted by limitations on future borrowings and a potential increase in our borrowing costs.

Future Sources and Uses of Liquidity

We have a shelf registration statement on file with the SEC to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansions.

We have a senior revolving credit facility (the "5-Year Facility") with a group of lenders for general corporate purposes. In June 2019, we amended and restated the credit agreement for the 5-Year Facility to, among other things, extend the maturity date from August 2020 to June 2024 and decrease the amount of credit available from $3,500 to $2,500. In June 2019, we also entered into a 364-day senior revolving credit facility (the "364-Day Facility") with a group of lenders for general corporate purposes, which provides for credit in the amount of $1,000. In May 2020, we amended and extended the 364-Day Facility, which now matures in June 2021. Our ability to borrow under these credit facilities is subject to compliance with certain covenants. We do not believe the restrictions contained in these covenants materially affect our financial or operating flexibility. As of December 31, 2020, we were in compliance with all of our debt covenants. There were no amounts outstanding under the 5-Year Facility or the 364-Day Facility at December 31, 2020.

Through certain subsidiaries, we have entered into multiple 364-day lines of credit (the "Subsidiary Credit Facilities") with separate lenders for general corporate purposes. The Subsidiary Credit Facilities provide combined credit up to $300. Our ability to borrow under the Subsidiary Credit Facilities is subject to compliance with certain covenants. At December 31, 2020, we had no outstanding borrowings under the Subsidiary Credit Facilities.

We have a $3,500 commercial paper program, the proceeds of which may be used for general corporate purposes. Should commercial paper issuance be unavailable, we have the ability to use a combination of cash on hand and/or our two senior revolving credit facilities, which provide for combined credit in the amount of $3,500, to redeem any outstanding commercial

paper upon maturity. While there is no assurance in the current economic environment, we believe the lenders participating in our credit facilities, if market conditions allow, would be willing to provide financing in accordance with their legal obligations. At December 31, 2020, we had $250 outstanding under our commercial paper program.

We are a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati, the Federal Home Loan Bank of Atlanta and the Federal Home Loan Bank of New York, collectively (the "FHLBs"). As a member, we have the ability to obtain short-term cash advances, subject to certain minimum collateral requirements. At December 31, 2020, we had no outstanding short-term borrowings from the FHLBs.

As discussed in "*Financial Condition*" above, many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid. Based upon these requirements, we currently estimate that approximately $2,505 of dividends will be paid to the parent company during 2021. During 2020, we received $3,618 of dividends from our subsidiaries.

We regularly review the appropriate use of capital, including acquisitions, common stock and debt security repurchases and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors.

On January 26, 2021, our Audit Committee declared a quarterly cash dividend to shareholders of $1.13 per share on the outstanding shares of our common stock. This quarterly dividend is payable on March 25, 2021 to the shareholders of record as of March 10, 2021.

Under our Board of Directors' authorization, we maintain a common stock repurchase program. As of December 31, 2020, we had Board authorization of $1,092 to repurchase our common stock. On January 26, 2021, our Audit Committee, pursuant to authorization granted by the Board of Directors, authorized a $5,000 increase to our common stock repurchase program.

For additional information regarding our sources and uses of capital, see Note 5, "Investments," Note 6, "Derivative Financial Instruments," Note 13, "Debt" and Note 15, "Capital Stock–*Use of Capital–Dividends and Stock Repurchase Program*" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Contractual Obligations and Commitments

Our estimated contractual obligations and commitments as of December 31, 2020 are as follows:

		Payments Due by Period			
	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
On-Balance Sheet:					
Debt[1]	$ 31,066	$ 1,679	$ 3,953	$ 17,641	$ 7,793
Operating leases, including imputed interest[2]	982	197	336	213	236
Investment commitments[3]	20	11	7	1	1
Other long-term liabilities[4]	716	9	284	281	142
Off-Balance Sheet:					
Purchase obligations[5]	5,761	975	3,143	1,523	120
Operating leases, including imputed interest[2]	139	6	24	24	85
Investment commitments[6]	1,320	270	448	61	541
Total contractual obligations and commitments	$ 40,004	$ 3,147	$ 8,195	$ 19,744	$ 8,918

1 Includes estimated interest expense.
2 See Note 18, "Leases," of the Notes to Consolidated Financial Statements, included in Part II, Item 8 of this Annual Report on Form 10-K.

3 Represents low income housing tax credits.
4 Primarily consists of reserves for future policy benefits, projected other postretirement benefits, deferred compensation, supplemental executive retirement plan liabilities and certain other miscellaneous long-term obligations. Estimated future payments for funded pension benefits have been excluded from this table, as we had no funding requirements under ERISA at December 31, 2020 as a result of the value of the assets in the plans.
5 Includes estimated payments for future services under contractual arrangements from third-party service contracts.
6 Includes unfunded capital commitments for alternative investments.

The above table does not contain $282 of gross liabilities for uncertain tax positions and interest for which we cannot reasonably estimate the timing of the resolutions with the respective taxing authorities. For further information, see Note 8, “Income Taxes,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

In addition to the contractual obligations and commitments discussed above, we have a variety of other contractual agreements related to acquiring materials and services used in our operations. However, we do not believe these other agreements contain material noncancelable commitments.

We believe that funds from future operating cash flows, cash and investments and funds available under our senior revolving credit facilities and/or from public or private financing sources will be sufficient for future operations and commitments, and for capital acquisitions and other strategic transactions.

Off-Balance Sheet Arrangements

We do not have any off-balance sheet derivative instruments, guarantee transactions, agreements or other contractual arrangements or any indemnification agreements that will require funding in future periods. We have not transferred assets to an unconsolidated entity that serves as credit, liquidity or market risk support to such entity. We do not hold any variable interest in an unconsolidated entity where such entity provides us with financing, liquidity, market risk or credit risk support.

Risk-Based Capital

Our regulated subsidiaries’ states of domicile have statutory risk-based capital (“RBC”) requirements for health and other insurance companies and HMOs largely based on the National Association of Insurance Commissioners (“NAIC”) Risk-Based Capital (RBC) For Health Organizations Model Act (“RBC Model Act”). These RBC requirements are intended to measure capital adequacy, taking into account the risk characteristics of an insurer’s investments and products. The NAIC sets forth the formula for calculating the RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual insurance company’s business. In general, under the RBC Model Act, an insurance company must submit a report of its RBC level to the state insurance department or insurance commissioner, as appropriate, at the end of each calendar year. Our regulated subsidiaries’ respective RBC levels as of December 31, 2020, which was the most recent date for which reporting was required, were in excess of all applicable mandatory RBC requirements. In addition to exceeding these RBC requirements, we are in compliance with the liquidity and capital requirements for a licensee of the BCBSA and with the tangible net worth requirements applicable to certain of our California subsidiaries.

For additional information, see Note 22, “Statutory Information,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK.

(In Millions, Except As Otherwise Stated Herein)

As a result of our investing and borrowing activities, we are exposed to financial market risks, including those resulting from changes in interest rates and changes in market valuations. Potential impacts discussed below are based upon sensitivity analyses performed on our financial position as of December 31, 2020. Actual results could vary from these estimates. Our primary objectives with our investment portfolio are to provide safety and preservation of capital, sufficient liquidity to meet cash flow requirements, the integration of investment strategy with the business operations and an attainment of a competitive after-tax total return.

Investments

Our investment portfolio is exposed to three primary sources of risk: credit quality risk, interest rate risk and market valuation risk.

The primary risks associated with our fixed maturity securities, which are classified as available-for-sale, are credit quality risk and interest rate risk. Credit quality risk is defined as the risk of a credit event, such as a ratings downgrade or default, to an individual fixed maturity security and the potential loss attributable to that event. Credit quality risk is managed through our investment policy, which establishes credit quality limitations on the overall portfolio as well as diversification and percentage limits on securities of individual issuers. The result is a well-diversified portfolio of fixed maturity securities, with an average credit rating of approximately "A." Interest rate risk is defined as the potential for economic losses on fixed maturity securities due to a change in market interest rates. Our fixed maturity portfolio is invested primarily in U.S. government securities, corporate bonds, asset-backed bonds, mortgage-related securities and municipal bonds, all of which have exposure to changes in the level of market interest rates. Interest rate risk is managed by maintaining asset duration within a band based upon our liabilities, operating performance and liquidity needs. Additionally, we have the capability of holding any security to maturity, which would allow us to realize full par value.

Investments in fixed maturity securities include corporate securities, which account for 45.4% of our total fixed maturity securities at December 31, 2020 and are subject to credit/default risk. In a declining economic environment, corporate yields will usually increase, prompted by concern over the ability of corporations to make interest payments, thus causing a decrease in the price of corporate securities, and the decline in value of the corporate fixed maturity portfolio. We manage this risk through fundamental credit analysis, diversification of issuers and industries and an average credit rating of our corporate fixed maturity portfolio of approximately "BBB."

Market risk for fixed maturity securities is addressed by actively managing the duration, allocation and diversification of our investment portfolio. We have evaluated the impact on the fixed maturity portfolio's fair value considering an immediate 100 basis point change in interest rates. A 100 basis point increase in interest rates would result in an approximate $998 decrease in fair value, whereas a 100 basis point decrease in interest rates would result in an approximate $1,039 increase in fair value. While we classify our fixed maturity securities as "available-for-sale" for accounting purposes, we believe our cash flows and the duration of our portfolio should allow us to hold securities to maturity, thereby avoiding the recognition of losses should interest rates rise significantly.

Our equity portfolio is comprised of large capitalization and small capitalization domestic equities, foreign equities, exchange-traded funds and index mutual funds. Our equity portfolio is subject to the volatility inherent in the stock market, driven by concerns over economic conditions, earnings and sales growth, inflation, and consumer confidence. These systemic risks cannot be managed through diversification alone. However, more routine risks, such as stock/industry specific risks, are managed by investing in a diversified equity portfolio.

Our other invested assets, reported within our long-term investments, are primarily subject to private market exposures, including private equity, real estate, and private credit investments. These investments are also indirectly subject to market valuation risk, as public market valuations will form a basis for valuations for these investments. Given their illiquid nature, we focus on appropriate sizing of these investments relative to our liquidity needs and risk tolerance. Our risk tolerance is formed by the level of illiquidity and short-term price movements from market valuation risk we are willing to accept relative to the higher long-term expected returns over the life of these investments.

As of December 31, 2020, 6.1% of our marketable investments were equity securities. An immediate 10% decrease in each equity investment's value, arising from market movement, would result in a fair value decrease of $156. Alternatively, an immediate 10% increase in each equity investment's value, attributable to the same factor, would result in a fair value increase of $156.

For additional information regarding our investments, see Note 5, "Investments," of the Notes to Consolidated Financial Statements included in Part II, Item 8 and "Critical Accounting Policies and Estimates - *Investments*" within Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K.

Long-Term Debt

Our total long-term debt at December 31, 2020 consisted of senior unsecured notes, convertible debentures, commercial paper and subordinated surplus notes issued by one of our insurance subsidiaries. At December 31, 2020, the carrying value and estimated fair value of our long-term debt was $20,035 and $24,269, respectively. This debt is subject to interest rate risk, as these instruments have fixed interest rates and the fair value is affected by changes in market interest rates. Should interest rates increase or decrease in the future, the estimated fair value of our fixed rate debt would decrease or increase accordingly.

For additional information regarding our long-term debt, see Note 7, “Fair Value” and Note 13, “Debt,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Derivatives

We have exposure to economic losses due to interest rate risk arising from changes in the level or volatility of interest rates. We attempt to mitigate our exposure to interest rate risk through the use of derivative financial instruments. These strategies include the use of interest rate swaps and forward contracts, which are used to lock-in interest rates or to hedge (on an economic basis) interest rate risks associated with variable rate debt. We have used these types of instruments as designated hedges against specific liabilities.

Changes in interest rates will affect the estimated fair value of these derivatives. As of December 31, 2020, we recorded a net asset of $37, the estimated fair value of the swaps at that date. We have evaluated the impact on the interest rate swaps’ fair value considering an immediate 100 basis point change in interest rates. A 100 basis point increase in interest rates would result in an approximate $18 decrease in fair value, whereas a 100 basis point decrease in interest rates would result in an approximate $18 increase in fair value.

For additional information regarding our derivatives, see Note 6, “Derivative Financial Instruments” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA.

ANTHEM, INC.

CONSOLIDATED FINANCIAL STATEMENTS

Years ended December 31, 2020, 2019 and 2018

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Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of Anthem, Inc.

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Anthem, Inc. (the Company) as of December 31, 2020 and 2019, the related consolidated statements of income, comprehensive income, shareholders' equity, and cash flows for each of the three years in the period ended December 31, 2020, and the related notes and financial statement schedule listed in the Index at Item 15(c) (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2020 and 2019, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2020, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2020, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework), and our report dated February 18, 2021 expressed an unqualified opinion thereon.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matter

The critical audit matter communicated below is a matter arising from the current period audit of the financial statements that was communicated or required to be communicated to the audit committee and that: (1) relates to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective, or complex judgments. The communication of the critical audit matter does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matter below, providing a separate opinion on the critical audit matter or on the account or disclosures to which it relates.

Valuation of Incurred but Not Paid Claims

Description of the Matter	Medical claims payable was $11,359 million at December 31, 2020, a significant portion of which related to the Company's estimate for claims that are incurred but not paid. As discussed in Note 2 to the consolidated financial statements, the Company's liability for incurred but not paid claims is determined using actuarial methods that include a number of factors and assumptions, including completion factors, which represent the average percentage of total incurred claims that have been paid through a given date after being incurred based on historical paid claims data, and trend factors, which represent an estimate of claims expense based on recent claims expense levels and healthcare cost levels. There is significant uncertainty inherent in determining management's best estimate of completion and trend factors, which are used to calculate actuarial estimates of incurred but not paid claims. Auditing management's estimate of incurred but not paid claims was complex and required the involvement of our actuarial specialists due to the highly judgmental nature of the completion and trend factor assumptions used in the valuation process. The significant judgment was primarily due to the sensitivity of management's best estimate of completion and trend factor assumptions, which have a significant impact on the valuation of incurred but not paid claims.
How We Addressed the Matter in Our Audit	We obtained an understanding, evaluated the design and tested the operating effectiveness of controls over the Company's actuarial process for estimating the liability for incurred but not paid claims. These audit procedures included among others, testing management review controls over completion and trend factor assumptions and the review and approval processes that management has in place for estimating the liability for incurred but not paid claims. To test the Company's liability for incurred but not paid claims, our audit procedures included, among others, testing the completeness and accuracy of the underlying claims and membership data recorded in the source claims processing and disbursement systems to the data used by management in developing completion and trend factor assumptions and agreeing a sample of incurred and paid claims to source documentation. With the support of actuarial specialists, we analyzed the Company's completion and trend factor assumptions based on historical claim experience and emerging cost trends, and independently calculated a range of reasonable reserve estimates for comparison to management's best estimate of the liability for incurred but not paid claims. Additionally, we performed a review of the prior period liabilities for incurred but not paid claims to subsequent claims development.

/s/ ERNST & YOUNG LLP

We have served as the Company's auditor since 1944.

Indianapolis, Indiana
February 18, 2021

Anthem, Inc.
Consolidated Balance Sheets

	December 31, 2020	December 31, 2019
(In millions, except share data)		
Assets		
Current assets:		
Cash and cash equivalents	$ 5,741	$ 4,937
Fixed maturity securities, current (amortized cost of $22,222 and $19,021; allowance for credit losses of $7 and $0)	23,433	19,676
Equity securities	1,559	1,009
Premium receivables	5,279	5,014
Self-funded receivables	2,849	2,570
Other receivables	2,830	2,807
Other current assets	4,060	3,020
Total current assets	45,751	39,033
Long-term investments:		
Fixed maturity securities (amortized cost of $532 and $487; allowance for credit losses of $0 and $0)	562	505
Other invested assets	4,285	4,258
Property and equipment, net	3,483	3,133
Goodwill	21,691	20,500
Other intangible assets	9,405	8,674
Other noncurrent assets	1,438	1,350
Total assets	$ 86,615	$ 77,453
Liabilities and shareholders' equity		
Liabilities		
Current liabilities:		
Medical claims payable	$ 11,359	$ 8,842
Other policyholder liabilities	4,590	3,050
Unearned income	1,259	1,017
Accounts payable and accrued expenses	5,493	4,198
Short-term borrowings	—	700
Current portion of long-term debt	700	1,598
Other current liabilities	6,052	4,127
Total current liabilities	29,453	23,532
Long-term debt, less current portion	19,335	17,787
Reserves for future policy benefits	794	759
Deferred tax liabilities, net	2,019	2,227
Other noncurrent liabilities	1,815	1,420
Total liabilities	53,416	45,725
Commitments and contingencies—Note 14		
Shareholders' equity		
Preferred stock, without par value, shares authorized - 100,000,000; shares issued and outstanding - none	—	—
Common stock, par value $0.01, shares authorized - 900,000,000; shares issued and outstanding - 245,401,430 and 252,922,161	3	3
Additional paid-in capital	9,244	9,448
Retained earnings	23,802	22,573
Accumulated other comprehensive income (loss)	150	(296)
Total shareholders' equity	33,199	31,728
Total liabilities and shareholders' equity	$ 86,615	$ 77,453

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Income

(In millions, except per share data)	Years Ended December 31 2020	2019	2018
Revenues			
Premiums	$ 104,109	$ 94,173	$ 85,421
Product revenue	10,384	2,760	—
Administrative fees and other revenue	6,315	6,208	5,920
Total operating revenue	120,808	103,141	91,341
Net investment income	877	1,005	970
Net realized gains (losses) on financial instruments	182	67	(206)
Total revenues	121,867	104,213	92,105
Expenses			
Benefit expense	88,045	81,786	71,895
Cost of products sold	8,953	1,992	—
Selling, general and administrative expense	17,450	13,364	14,020
Interest expense	784	746	753
Amortization of other intangible assets	361	338	358
Loss on extinguishment of debt	36	2	11
Total expenses	115,629	98,228	87,037
Income before income tax expense	6,238	5,985	5,068
Income tax expense	1,666	1,178	1,318
Net income	$ 4,572	$ 4,807	$ 3,750
Net income per share			
Basic	$ 18.23	$ 18.81	$ 14.53
Diluted	$ 17.98	$ 18.47	$ 14.19
Dividends per share	$ 3.80	$ 3.20	$ 3.00

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Comprehensive Income

(In millions)	Years Ended December 31		
	2020	2019	2018
Net income	$ 4,572	$ 4,807	$ 3,750
Other comprehensive income (loss), net of tax:			
Change in net unrealized gains/losses on investments	428	680	(418)
Change in non-credit component of impairment losses on investments	—	—	(2)
Change in net unrealized gains/losses on cash flow hedges	12	(16)	37
Change in net periodic pension and postretirement costs	(1)	26	(90)
Foreign currency translation adjustments	7	—	(1)
Other comprehensive income (loss)	446	690	(474)
Total comprehensive income	$ 5,018	$ 5,497	$ 3,276

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Cash Flows

(In millions)	Years Ended December 31 2020	2019	2018
Operating activities			
Net income	$ 4,572	$ 4,807	$ 3,750
Adjustments to reconcile net income to net cash provided by operating activities:			
Net realized (gains) losses on financial instruments	(182)	(67)	206
Depreciation and amortization	1,154	1,133	1,132
Deferred income taxes	(540)	81	91
Impairment of property and equipment	198	—	—
Share-based compensation	283	294	226
Changes in operating assets and liabilities:			
Receivables, net	(256)	(1,053)	(695)
Other invested assets	(32)	(48)	(1)
Other assets	(283)	(170)	(26)
Policy liabilities	3,528	1,826	(1,059)
Unearned income	202	115	(36)
Accounts payable and other liabilities	1,978	(445)	97
Income taxes	72	(325)	323
Other, net	(6)	(87)	(181)
Net cash provided by operating activities	10,688	6,061	3,827
Investing activities			
Purchases of investments	(19,492)	(22,954)	(9,671)
Proceeds from sale of investments	11,318	18,598	9,662
Maturities, calls and redemptions from investments	4,741	2,437	1,938
Changes in securities lending collateral	(849)	254	(149)
Purchases of subsidiaries, net of cash acquired	(1,976)	—	(1,760)
Purchases of property and equipment	(1,021)	(1,077)	(1,208)
Other, net	(45)	(50)	(71)
Net cash used in investing activities	(7,324)	(2,792)	(1,259)
Financing activities			
Net repayments of commercial paper borrowings	(150)	(297)	(107)
Proceeds from long-term borrowings	2,484	2,473	835
Repayments of long-term borrowings	(1,932)	(1,123)	(1,684)
Proceeds from short-term borrowings	970	7,590	9,120
Repayments of short-term borrowings	(1,670)	(8,035)	(9,250)
Changes in securities lending payable	849	(254)	150
Proceeds from issuance of common stock under Equity Units stock purchase contracts	—	—	1,250
Repurchase and retirement of common stock	(2,700)	(1,701)	(1,685)
Cash dividends	(954)	(818)	(776)
Proceeds from issuance of common stock under employee stock plans	176	187	173
Taxes paid through withholding of common stock under employee stock plans	(128)	(84)	(81)
Other, net	488	(204)	(186)
Net cash used in financing activities	(2,567)	(2,266)	(2,241)
Effect of foreign exchange rates on cash and cash equivalents	7	—	(2)
Change in cash and cash equivalents	804	1,003	325
Cash and cash equivalents at beginning of year	4,937	3,934	3,609
Cash and cash equivalents at end of year	$ 5,741	$ 4,937	$ 3,934

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Shareholders' Equity

(In millions)	Common Stock Number of Shares	Common Stock Par Value	Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total Shareholders' Equity
January 1, 2018	256.1	$ 3	$ 8,547	$ 18,374	$ (421)	$ 26,503
Net income	—	—	—	3,750	—	3,750
Other comprehensive loss	—	—	—	—	(474)	(474)
Issuance of common stock under Equity Units stock purchase contracts	6.0	—	1,250	—	—	1,250
Premiums for and settlement of equity options	—	—	1	—	—	1
Repurchase and retirement of common stock	(6.8)	—	(243)	(1,442)	—	(1,685)
Dividends and dividend equivalents	—	—	—	(785)	—	(785)
Issuance of common stock under employee stock plans, net of related tax benefits	2.1	—	318	—	—	318
Convertible debenture conversions	—	—	(337)	—	—	(337)
Adoption of Accounting Standards Update No. 2018-02	—	—	—	91	(91)	—
December 31, 2018	257.4	3	9,536	19,988	(986)	28,541
Adoption of Accounting Standards Update No. 2016-02	—	—	—	26	—	26
January 1, 2019	257.4	3	9,536	20,014	(986)	28,567
Net income	—	—	—	4,807	—	4,807
Other comprehensive income	—	—	—	—	690	690
Repurchase and retirement of common stock	(6.3)	—	(275)	(1,426)	—	(1,701)
Dividends and dividend equivalents	—	—	—	(822)	—	(822)
Issuance of common stock under employee stock plans, net of related tax benefits	1.8	—	396	—	—	396
Convertible debenture conversions	—	—	(209)	—	—	(209)
December 31, 2019	252.9	3	9,448	22,573	(296)	31,728
Adoption of Accounting Standards Update No. 2016-13 (Note 2)	—	—	—	(35)	—	(35)
January 1, 2020	252.9	3	9,448	22,538	(296)	31,693
Net income	—	—	—	4,572	—	4,572
Other comprehensive income	—	—	—	—	446	446
Repurchase and retirement of common stock	(9.4)	—	(353)	(2,347)	—	(2,700)
Dividends and dividend equivalents	—	—	—	(961)	—	(961)
Issuance of common stock under employee stock plans, net of related tax benefits	1.9	—	330	—	—	330
Convertible debenture repurchases and conversions	—	—	(181)	—	—	(181)
December 31, 2020	245.4	$ 3	$ 9,244	$ 23,802	$ 150	$ 33,199

See accompanying notes.

Anthem, Inc.

Notes to Consolidated Financial Statements

December 31, 2020

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

1. Organization

References to the terms “we,” “our,” “us” or “Anthem” used throughout these Notes to Consolidated Financial Statements refer to Anthem, Inc., an Indiana corporation, and unless the context otherwise requires, its direct and indirect subsidiaries.

We are one of the largest health benefits companies in the United States in terms of medical membership, serving approximately 43 medical members through our affiliated health plans as of December 31, 2020. We offer a broad spectrum of network-based managed care plans to Large Group, Small Group, Individual, Medicaid and Medicare markets. Our managed care plans include: Preferred Provider Organizations (“PPOs”); Health Maintenance Organizations (“HMOs”); Point-of-Service plans; traditional indemnity plans and other hybrid plans, including Consumer-Driven Health Plans; and hospital only and limited benefit products. In addition, we provide a broad array of managed care services to self-funded customers, including claims processing, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services. We provide an array of specialty and other insurance products and services such as pharmacy benefits management (“PBM”), dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal healthcare. We also provide services to the federal government in connection with our Federal Health Products & Services business, which administers the Federal Employees Health Benefits (“FEHB”) Program.

We are an independent licensee of the Blue Cross and Blue Shield Association (“BCBSA”), an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield (“BCBS”) licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (in the New York City metropolitan area and upstate New York), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas, we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, and Empire Blue Cross Blue Shield or Empire Blue Cross. We also conduct business through arrangements with other BCBS licensees as well as other strategic partners. Through our subsidiaries, we also serve customers in numerous states across the country as AIM Specialty Health, Amerigroup, Aspire Health, Beacon, CareMore, Freedom Health, HealthLink, HealthSun, Optimum HealthCare, Simply Healthcare, and/or UniCare. Also, in the second quarter of 2019, we began providing PBM services through our IngenioRx subsidiary. We are licensed to conduct insurance operations in all 50 states and the District of Columbia through our subsidiaries.

2. Basis of Presentation and Significant Accounting Policies

Basis of Presentation: The accompanying consolidated financial statements include the accounts of Anthem and its subsidiaries and have been prepared in conformity with U.S. generally accepted accounting principles (“GAAP”). All significant intercompany accounts and transactions have been eliminated in consolidation.

Certain of our subsidiaries operate outside of the United States and have functional currencies other than the U.S. dollar (“USD”). We translate the assets and liabilities of those subsidiaries to USD using the exchange rate in effect at the end of the period. We translate the revenues and expenses of those subsidiaries to USD using the average exchange rates in effect during the period. The net effect of these translation adjustments is included in “Foreign currency translation adjustments” in our consolidated statements of comprehensive income.

Reclassifications: Certain prior year amounts have been reclassified to conform to the current year presentation.

Use of Estimates: The preparation of consolidated financial statements in conformity with GAAP requires us to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and Cash Equivalents: Cash and cash equivalents includes available cash and all highly liquid investments with maturities of three months or less when purchased. We control a number of bank accounts that are used exclusively to hold customer funds for the administration of customer benefits, and we have cash and cash equivalents on deposit to meet certain regulatory requirements. These amounts totaled $170 and $215 at December 31, 2020 and 2019, respectively, and are included in the cash and cash equivalents line on our consolidated balance sheets.

Investments: We classify fixed maturity securities in our investment portfolio as “available-for-sale” and report those securities at fair value. Certain fixed maturity securities are available to support current operations and, accordingly, we classify such investments as current assets without regard to their contractual maturity. Investments used to satisfy contractual, regulatory or other requirements are classified as long-term, without regard to contractual maturity.

Prior to 2020, our fixed maturity securities were evaluated for other-than-temporary impairment where credit-related impairments were presented within the other-than-temporary impairment losses recognized in our consolidated statements of income with an adjustment to the security’s amortized cost basis. Effective January 1, 2020, if a fixed maturity security is in an unrealized loss position and we have the intent to sell the fixed maturity security, or it is more likely than not that we will have to sell the fixed maturity security before recovery of its amortized cost basis, we write down the fixed maturity security’s cost basis to fair value and record an impairment loss in our consolidated statements of income. For impaired fixed maturity securities that we do not intend to sell or if it is more likely than not that we will not have to sell such securities, but we expect that we will not fully recover the amortized cost basis, we recognize the credit component of the impairment as an allowance for credit loss in our consolidated balance sheets and record an impairment loss in our consolidated statements of income. The non-credit component of the impairment is recognized in accumulated other comprehensive income. Furthermore, unrealized losses entirely caused by non-credit-related factors related to fixed maturity securities for which we expect to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive income.

The credit component of an impairment is determined primarily by comparing the net present value of projected future cash flows with the amortized cost basis of the fixed maturity security. The net present value is calculated by discounting our best estimate of projected future cash flows at the effective interest rate implicit in the fixed maturity security at the date of purchase. For mortgage-backed and asset-backed securities, cash flow estimates are based on assumptions regarding the underlying collateral, including prepayment speeds, vintage, type of underlying asset, geographic concentrations, default rates, recoveries and changes in value. For all other securities, cash flow estimates are driven by assumptions regarding probability of default, including changes in credit ratings and estimates regarding timing and amount of recoveries associated with a default.

For asset-backed securities included in fixed maturity securities, we recognize income using an effective yield based on anticipated prepayments and the estimated economic life of the securities. When estimates of prepayments change, the effective yield is recalculated to reflect actual payments to date and anticipated future payments. The net investment in the securities is adjusted to the amount that would have existed had the new effective yield been applied since the purchase date of the securities. Such adjustments are reported within net investment income.

In accordance with the Financial Accounting Standards Board (“FASB”) guidance, the changes in fair value of our marketable equity securities are recognized in our results of operations within net realized gains and losses on financial instruments.

We have corporate-owned life insurance policies on certain participants in our deferred compensation plans and other members of management. The cash surrender value of the corporate-owned life insurance policies is reported under the caption “Other invested assets” in our consolidated balance sheets.

We use the equity method of accounting for investments in companies in which our ownership interest may enable us to influence the operating or financial decisions of the investee company. Our proportionate share of equity in net income of these unconsolidated affiliates is reported within net investment income. The equity method investments are reported under the caption “Other invested assets” in our consolidated balance sheets.

Investment income is recorded when earned. All securities sold resulting in investment gains and losses are recorded on the trade date. Realized gains and losses are determined on the basis of the cost or amortized cost of the specific securities sold.

We participate in securities lending programs whereby marketable securities in our investment portfolio are transferred to independent brokers or dealers in exchange for cash and securities collateral. Under FASB guidance related to accounting for transfers and servicing of financial assets and extinguishments of liabilities, we recognize the collateral as an asset, which is reported as securities lending collateral on our consolidated balance sheets, and we record a corresponding liability for the obligation to return the collateral to the borrower, which is reported as securities lending payable. The securities on loan are reported in the applicable investment category on our consolidated balance sheets. Unrealized gains or losses on securities lending collateral are included in accumulated other comprehensive income as a separate component of shareholders' equity. The market value of loaned securities and that of the collateral pledged can fluctuate in non-synchronized fashions. To the extent the loaned securities' value appreciates faster or depreciates slower than the value of the collateral pledged, we are exposed to the risk of the shortfall. As a primary mitigating mechanism, the loaned securities and collateral pledged are marked to market on a daily basis and the shortfall, if any, is collected accordingly. Secondarily, the collateral level is set at 102% of the value of the loaned securities, which provides a cushion before any shortfall arises. The investment of the cash collateral is subject to market risk, which is managed by limiting the investments to higher quality and shorter duration instruments.

Receivables: Receivables are reported net of amounts for expected credit losses. The allowance for doubtful accounts is based on historical collection trends, future forecasts and our judgment regarding the ability to collect specific accounts.

Premium receivables include the uncollected amounts from insured groups, individuals and government programs. Premium receivables are reported net of an allowance for doubtful accounts of $146 and $237 at December 31, 2020 and 2019, respectively.

Self-funded receivables include administrative fees, claims and other amounts due from self-funded customers. Self-funded receivables are reported net of an allowance for doubtful accounts of $54 and $46 at December 31, 2020 and 2019, respectively.

Other receivables include pharmacy rebates, provider advances, claims recoveries, reinsurance receivables, proceeds due from brokers on investment trades, other government receivables and other miscellaneous amounts due to us. These receivables are reported net of an allowance for doubtful accounts of $374 and $242 at December 31, 2020 and 2019, respectively.

Income Taxes: We file a consolidated income tax return. Deferred income tax assets and liabilities are recognized for temporary differences between the financial statement and tax return basis of assets and liabilities based on enacted tax rates and laws. The deferred tax benefits of the deferred tax assets are recognized to the extent realization of such benefits is more likely than not. Deferred income tax expense or benefit generally represents the net change in deferred income tax assets and liabilities during the year, excluding the impact from amounts initially recorded for business combinations, if any, and amounts recorded to accumulated other comprehensive income. Current income tax expense represents the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported.

We account for income tax contingencies in accordance with FASB guidance that contains a model to address uncertainty in tax positions and clarifies the accounting for income taxes by prescribing a minimum recognition threshold, which all income tax positions must achieve before being recognized in the financial statements.

Property and Equipment: Property and equipment is recorded at cost, net of accumulated depreciation. Depreciation is computed principally by the straight-line method over estimated useful lives ranging from fifteen to thirty-nine years for buildings and improvements, three to five years for computer equipment and software, and the lesser of the remaining life of the building lease, if any, or seven years for furniture and other equipment. Leasehold improvements are depreciated over the term of the related lease. Certain costs related to the development or purchase of internal-use software are capitalized and amortized over estimated useful lives ranging from five to ten years.

Goodwill and Other Intangible Assets: FASB guidance requires business combinations to be accounted for using the acquisition method of accounting, and it also specifies the types of acquired intangible assets that are required to be

recognized and reported separately from goodwill. Goodwill represents the excess of the cost of acquisition over the fair value of net assets acquired. Other intangible assets represent the values assigned to customer relationships, provider and hospital networks, Blue Cross and Blue Shield and other trademarks, licenses and other agreements, such as non-compete. Goodwill and other intangible assets are allocated to reportable segments based on the relative fair value of the components of the businesses acquired.

Goodwill and other intangible assets with indefinite lives are not amortized but are tested for impairment at least annually. Goodwill and other intangible assets are allocated to reporting units for purposes of the annual goodwill impairment test. Other intangible assets with indefinite lives, such as trademarks, are tested for impairment separately. We complete our annual impairment tests of existing goodwill and other intangible assets with indefinite lives during the fourth quarter of each year. Our impairment tests require us to make assumptions and judgments regarding the estimated fair value of our reporting units, including goodwill and other intangible assets with indefinite lives. Certain interim impairment tests are also performed when potential impairment indicators exist or changes in our business or other triggering events occur.

FASB guidance allows for qualitative assessments of whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount for purposes of a goodwill impairment analysis and whether it is more likely than not that an indefinite-lived intangible asset is impaired for purposes of an indefinite-lived intangible asset impairment analysis. Estimated fair values developed based on our assumptions and judgments might be different if other reasonable assumptions and estimates were to be used. Qualitative analysis involves assessing situations and developments that could affect key drivers used to evaluate whether the fair value of our goodwill and indefinite-lived intangible assets are impaired. Our procedures include assessing our financial performance, macroeconomic conditions, industry and market considerations, various asset specific factors, and entity specific events.

Quantitative analysis must be performed if qualitative analyses are not conclusive. Entities also have the option to bypass the assessment of qualitative factors and proceed directly to performing quantitative analyses. Fair value for purposes of a quantitative goodwill impairment test is calculated using a blend of the projected income and market valuation approaches. The projected income approach is developed using assumptions about future revenue, expenses and net income derived from our internal planning process. Our assumed discount rate is based on our industry's weighted-average cost of capital and reflects volatility associated with the cost of equity capital. Market valuations include market comparisons to publicly traded companies in our industry and are based on observed multiples of certain measures including revenue; earnings before interest, taxes, depreciation and amortization ("EBITDA"); and book value of invested capital.

A goodwill impairment loss is recognized to the extent that the carrying amount exceeds the asset's fair value. This determination is made at the reporting unit level and consists of one step. The fair value of a reporting unit is determined and compared to its carrying amount. If the carrying amount of a reporting unit exceeds its fair value, an impairment loss is recognized. This goodwill impairment loss is equal to the excess of the reporting unit's carrying amount over its fair value.

Fair value for purposes of a quantitative impairment test for indefinite-lived intangible assets is estimated using a projected income approach. We recognize an impairment loss when the estimated fair value of indefinite-lived intangible assets is less than the carrying value. If significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

Derivative Financial Instruments: We primarily invest in the following types of derivative financial instruments: interest rate swaps, futures, forward contracts, put and call options, swaptions, embedded derivatives and warrants. Derivatives embedded within non-derivative instruments, such as options embedded in convertible fixed maturity securities, are bifurcated from the host instrument when the embedded derivative is not clearly and closely related to the host instrument. Our use of derivatives is limited by statutes and regulations promulgated by the various regulatory bodies to which we are subject, and by our own derivative policy. Our derivative use is generally limited to hedging purposes, on an economic basis, and we generally do not use derivative instruments for speculative purposes.

We have exposure to economic losses due to interest rate risk arising from changes in the level or volatility of interest rates. We attempt to mitigate our exposure to interest rate risk through active portfolio management, including rebalancing our existing portfolios of assets and liabilities, as well as changing the characteristics of investments to be purchased or sold in the future. In addition, derivative financial instruments are used to modify the interest rate exposure of certain liabilities or forecasted transactions. These strategies include the use of interest rate swaps and forward contracts, which are used to lock-

in interest rates or to hedge, on an economic basis, interest rate risks associated with variable rate debt. We have used these types of instruments as designated hedges against specific liabilities.

All investments in derivatives are recorded as assets or liabilities at fair value. If certain correlation, hedge effectiveness and risk reduction criteria are met, a derivative may be specifically designated as a hedge of exposure to changes in fair value or cash flow. The accounting for changes in the fair value of a derivative depends on the intended use of the derivative and the nature of any hedge designation thereon. Amounts excluded from the assessment of hedge effectiveness, if any, are reported in results of operations immediately. If the derivative is not designated as a hedge, the gain or loss resulting from the change in the fair value of the derivative is recognized in results of operations in the period of change. Cash flows associated with the settlement of non-designated derivatives are shown on a net basis in investing activity in our consolidated statements of cash flow.

From time to time, we may also purchase derivatives to hedge, on an economic basis, our exposure to foreign currency exchange fluctuations associated with the operations of certain of our subsidiaries. We generally use futures or forward contracts for these transactions. We generally do not designate these contracts as hedges and, accordingly, the changes in fair value of these derivatives are recognized in results of operations immediately.

Credit exposure associated with non-performance by the counterparties to derivative instruments is generally limited to the uncollateralized fair value of the asset related to instruments recognized in the consolidated balance sheets. We attempt to mitigate the risk of non-performance by selecting counterparties with high credit ratings and monitoring their creditworthiness and by diversifying derivatives among multiple counterparties. At December 31, 2020, we believe there were no material concentrations of credit risk with any individual counterparty.

We generally enter into master netting agreements, which reduce credit risk by permitting net settlement of transactions with the same counterparty. Certain of our derivative agreements also contain credit support provisions that require us or the counterparty to post collateral if there are declines in the derivative fair value or our credit rating. The derivative assets and derivative liabilities are reported at their fair values net of collateral and netting by the counterparty.

Retirement Benefits: We recognize the funded status of pension and other postretirement benefit plans on the consolidated balance sheets based on fiscal-year-end measurements of plan assets and benefit obligations. Prepaid pension benefits represent prepaid costs related to defined benefit pension plans and are reported with other noncurrent assets. Postretirement benefits represent outstanding obligations for retiree medical, life, vision and dental benefits. Liabilities for pension and other postretirement benefits are reported with current and noncurrent liabilities based on the amount by which the actuarial present value of benefits payable in the next twelve months included in the benefit obligation exceeds the fair value of plan assets.

We determine the expected return on plan assets using the calculated value of plan assets, which recognizes changes in the fair value of plan assets in a systematic manner over three years. We apply a corridor approach to amortize unrecognized actuarial gains or losses. Under this approach, only accumulated net actuarial gains or losses in excess of 10% of the greater of the projected benefit obligation or the fair value of plan assets are amortized over the average remaining service or lifetime of the workforce as a component of net periodic benefit cost.

The discount rate reflects the current rate at which the pension liabilities could be effectively settled at the end of the year based on our most recent measurement date. We use the annual spot rate approach for setting our discount rate. Under the spot rate approach, individual spot rates from a full yield curve of published rates are used to discount each plan’s cash flows to determine the plan’s obligations.

The assumed healthcare cost trend rates used to measure the expected cost of other postretirement benefits are based on an initial assumed healthcare cost trend rate declining to an ultimate healthcare cost trend rate over a select number of years.

Medical Claims Payable: Liabilities for medical claims payable include estimated provisions for incurred but not paid claims on an undiscounted basis, as well as estimated provisions for expenses related to the processing of claims. Incurred but not paid claims include (1) an estimate for claims that are incurred but not reported, as well as claims reported to us but not yet processed through our systems; and (2) claims reported to us and processed through our systems but not yet paid.

Liabilities for both claims incurred but not reported and reported but not yet processed through our systems are determined in the aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Actuarial Standards of Practice require that the claim liabilities be appropriate under moderately adverse circumstances. We determine the amount of the liability for incurred but not paid claims by following a detailed actuarial process that uses both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities. Under this process, historical paid claims data is formatted into "claim triangles," which compare claim incurred dates to the dates of claim payments. This information is analyzed to create "completion factors" that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the period-end date to estimate the ultimate claim expense incurred for the period. Actuarial estimates of incurred but not paid claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims.

For the most recent incurred months (typically the most recent two months), the percentage of claims paid for claims incurred in those months is generally low. This makes the completion factor methodology less reliable for such months. Therefore, incurred claims for recent months are not projected from historical completion and payment patterns; rather, they are projected by estimating the claims expense for those months based on recent claims expense levels and healthcare trend levels ("trend factors").

We regularly review and set assumptions regarding cost trends and utilization when initially establishing claim liabilities. We continually monitor and adjust the claims liability and benefit expense based on subsequent paid claims activity. If it is determined that our assumptions regarding cost trends and utilization are materially different than actual results, our income statement and financial position could be impacted in future periods.

Premium deficiencies are recognized when it is probable that expected claims and administrative expenses will exceed future premiums on existing medical insurance contracts without consideration of investment income. Determination of premium deficiencies for longer duration life and disability contracts includes consideration of investment income. For purposes of premium deficiencies, contracts are deemed to be either short or long duration and are grouped in a manner consistent with our method of acquiring, servicing and measuring the profitability of such contracts. Once established, premium deficiencies are released commensurate with actual claims experience over the remaining life of the contract. No premium deficiencies were established at December 31, 2020 or 2019.

Benefit expense includes incurred medical claims as well as quality improvement expenses for our fully-insured members. Quality improvement activities are those designed to improve member health outcomes, prevent hospital readmissions and improve patient safety. They also include expenses for wellness and health promotion provided to our members.

Reserves for Future Policy Benefits: Reserves for future policy benefits include liabilities for life and long-term disability insurance policy benefits based upon interest, mortality and morbidity assumptions from published actuarial tables, modified based upon our experience. Future policy benefits also include liabilities for insurance policies for which some of the premiums received in earlier years are intended to pay anticipated benefits to be incurred in future years. Future policy benefits are continually monitored and reviewed, and when reserves are adjusted, differences are reflected in benefit expense.

The current portion of reserves for future policy benefits relates to the portion of such reserves that we expect to pay within one year. We believe that our liabilities for future policy benefits, along with future premiums received, are adequate to satisfy our ultimate benefit liability; however, these estimates are inherently subject to a number of variable circumstances. Consequently, the actual results could differ materially from the amounts recorded in our consolidated financial statements.

Other Policyholder Liabilities: Other policyholder liabilities include rate stabilization reserves associated with retrospectively rated insurance contracts and certain case-specific reserves. Other policyholder liabilities also include liabilities for premium refunds based upon the minimum medical loss ratio ("MLR"), the relative health risk of members, and other contractual or regulatory requirements. Rate stabilization reserves represent accumulated premiums that exceed what customers owe us based on actual claim experience. The timing of payment of these retrospectively rated refunds is based on the contractual terms with our customers and can vary from period to period based on the specific contractual requirements.

We are required to meet certain minimum MLR thresholds prescribed by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended (collectively the "ACA"). If we do not meet or

exceed the minimum MLR thresholds specified by the ACA, we are required to pay rebates to certain customers. Minimum MLR rebates are calculated by subsidiary, state and applicable line of business (Large Group, Small Group, Individual and Medicare) in accordance with regulations issued by the Department of Health and Human Services ("HHS"). Such calculations are made using estimated calendar year medical loss expense and premiums, as defined by HHS.

We follow HHS guidelines for determining the types of expenses that may be included in our minimum MLR rebate calculations, which differ from benefit expense and premiums as reported in our consolidated financial statements prepared in conformity with GAAP. Certain amounts reported as expense in our consolidated GAAP financial statements may be reported as a reduction of premiums in accordance with HHS regulations. In addition, profit amounts included in our payments to third-party administrative service providers are recorded as benefit expense in our consolidated GAAP financial statements, while HHS does not allow for the inclusion of these expenses within the medical loss expense for purposes of calculating minimum MLR.

Revenue Recognition: Premiums for fully-insured contracts are recognized as revenue over the period insurance coverage is provided, and, if applicable, net of amounts recognized for MLR rebates, risk adjustment, reinsurance and risk corridor under contractual premium stabilization arrangements, the ACA or other regulatory requirements. Premium payments from contracted government agencies are based on eligibility lists produced by the government agencies. Premiums related to the unexpired contractual coverage periods are reflected in the accompanying consolidated balance sheets as unearned income. Premiums include revenue adjustments for retrospectively rated contracts where revenue is based on the estimated loss experience of the contract. Premium rates for certain lines of business are subject to approval by the Department of Insurance of each respective state. Additionally, delays in annual premium rate changes from contracted government agencies require that we defer the recognition of any increases to the period in which the premium rates become final. The value of the impact can be significant in the period in which it is recognized depending on the magnitude of the premium rate increase, the membership to which it applies and the length of the delay between the effective date of the rate increase and the final contract date. Premium rate decreases are recognized in the period the change in premium rate becomes effective and the change in the rate is known, which may be prior to the period when the contract amendment affecting the rate is finalized.

Administrative fees and other revenue include revenue from certain group contracts that provide for the group to be at risk for all, or with supplemental insurance arrangements, a portion, of their claims experience. We charge these self-funded groups an administrative fee, which is based on the number of members in a group or the group's claim experience. In addition, administrative fees and other revenue include amounts received for the administration of Medicare or certain other government programs. Under our self-funded arrangements, revenue is recognized as administrative services are performed. All benefit payments under these programs are excluded from benefit expense.

Product revenue includes revenue for services performed by our IngenioRx PBM for unaffiliated PBM customers. Unaffiliated PBM customers include our self-funded groups that have contracted with IngenioRx for PBM services and, beginning on January 1, 2020, third-party health plans. Product revenues and costs of goods sold for our affiliated health plans are eliminated in consolidation. Product revenue for PBM services is recognized using the gross method at the negotiated contract price when IngenioRx has concluded that it is the principal and it controls the services before prescription drugs are transferred to the customer. IngenioRx determined it is the principal due to its contractual rights to design and develop a listing of prescription drugs offered to the customer (formulary management); its control over establishing the pharmacy network available to the customer to have its prescription fulfilled (network management); and its discretion over establishing the pricing for prescription drugs. Overall, control over these activities indicate IngenioRx is primarily responsible for fulfilling the promise to provide PBM services. Product revenue includes ingredient costs (net of any rebates or discounts), including any co-payments made by or on behalf of the customer, and administrative fees. IngenioRx recognizes revenue when control of the prescription drugs is transferred to customers, in an amount it expects to be entitled to in exchange for the products or services provided.

For our non-fully-insured contracts, we had no material contract assets, contract liabilities or deferred contract costs recorded on our consolidated balance sheet at December 31, 2020. Revenue recognized in 2020 and 2019 from performance obligations related to prior years, such as due to changes in transaction price, was not material. For contracts that have an original expected duration of greater than one year, revenue expected to be recognized in future periods related to unfulfilled contractual performance obligations and contracts with variable consideration related to undelivered performance obligations is not material.

Cost of Products Sold: IngenioRx's cost of products sold includes the cost of prescription drugs dispensed to unaffiliated PBM customers (net of rebates or discounts). This cost includes any co-payments made by or on behalf of the customer. Cost of products sold also includes per-claim administrative fees for prescription fulfillment by its vendor and certain IngenioRx direct costs related to sales and administration of customer contracts.

Share-Based Compensation: Our current compensation philosophy provides for share-based compensation, including stock options, restricted stock awards and an employee stock purchase plan. Stock options are granted for a fixed number of shares with an exercise price at least equal to the fair value of the shares at the date of the grant. Restricted stock awards are issued at the fair value of the stock on the grant date. The employee stock purchase plan allows for a purchase price per share which is 90% of the fair value of a share of common stock on the lower of the first or last trading day of the plan quarter. The employee stock purchase plan discount is recognized as compensation expense based on GAAP guidance. All other share-based payments to employees are recognized as compensation expense in our consolidated statements of income based on their fair values. Additionally, excess tax benefits, which result from actual tax benefits realized when awards vest or options are exercised exceeding deferred tax benefits previously recognized based on grant date fair value, are recognized as tax benefits in the income statement. Our share-based employee compensation plans and assumptions are described in Note 15, "Capital Stock."

***Advertising and Marketing Costs*:** We use print, broadcast and other advertising to promote our products and to develop our corporate image. We market our products through direct marketing activities and an extensive network of independent agents, brokers and retail partnerships for Individual and Medicare customers, and for certain Local Group customers with a smaller employee base. Products for National Accounts and Local Group customers with a larger employee base are generally sold through independent brokers or consultants retained by the customer who work with industry specialists from our in-house sales force. In the Individual and Small Group markets, we offer products through state or federally facilitated marketplaces, or public exchanges, and off-exchange products. The cost of advertising and marketing for product promotion is expensed as incurred, while advertising and marketing costs associated with our corporate image are expensed when first aired. Total advertising and marketing expense was $558, $467 and $385 for the years ended December 31, 2020, 2019 and 2018, respectively.

***Health Insurance Provider Fee*:** The ACA imposed an annual Health Insurance Provider Fee ("HIP Fee") on health insurers that write certain types of health insurance on U.S. risks, which has been permanently repealed effective January 1, 2021. The HIP Fee was allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to the amount of health insurance premium for all U.S. health risk for those certain lines of business written during the preceding calendar year. We recorded our estimated liability for the HIP Fee in full at the beginning of the year with a corresponding deferred asset that was amortized on a straight-line basis to selling, general and administrative expense. The final calculation and payment of the annual HIP Fee was due by September 30th of each fee year. The HIP Fee was non-deductible for federal income tax purposes. Our affected products were priced to cover the increased selling, general and administrative and income tax expenses associated with the HIP Fee when it was in effect. The total amount due from allocations to health insurers was $14,300 for 2018. The HIP Fee was suspended for 2019, resumed and increased to $15,523 for 2020 and has been permanently eliminated beginning in 2021. For the years ended December 31, 2020 and 2018, we recognized $1,570 and $1,544, respectively, as selling, general and administrative expense related to the HIP Fee. There was no corresponding expense for 2019 due to the suspension of the HIP Fee for 2019.

Leases: We lease office space and certain computer and related equipment under noncancelable operating leases. We determine whether an arrangement is or contains a lease at its inception. We recognize lease liabilities based on the present value of the minimum lease payments not yet paid by using the lease term, any amounts probable of being owed under any residual value guarantees and the discount rate determined at lease commencement. As our leases do not generally provide an implicit rate, we use our incremental secured borrowing rate commensurate with the underlying lease terms to determine the present value of our lease payments. Our lease liabilities may include amounts for options to extend or terminate a lease when it is reasonably certain that we will exercise that option. We recognize operating right-of-use ("ROU") assets at an amount equal to the lease liability adjusted for prepaid or accrued rent, the remaining balance of any lease incentives and unamortized initial direct costs.

The operating lease liabilities are reported in other current liabilities and other noncurrent liabilities and the related ROU assets are reported in other noncurrent assets on our consolidated balance sheets. Lease expense for our operating leases is calculated on a straight-line basis over the lease term and is reported in selling, general and administrative expense on our

consolidated statements of income. For our office space leases, we account for the lease and non-lease components (such as common area maintenance) as a single lease component. We also do not recognize a lease liability or ROU asset for our office space leases whose lease terms, at commencement, are twelve months or less and that do not include a purchase option or option to extend that we are reasonably certain to exercise.

We assess our ROU assets for impairment when there are indicators and compare the carrying amount of the ROU asset to its estimated undiscounted future cash flows. If the estimated undiscounted future cash flows are less than the carrying amount of the ROU asset, an impairment calculation is performed. An impairment loss is recorded for the difference of the ROU asset's carrying value that exceeds its estimated discounted cash flows. During 2020, we recorded $258 for impairment and abandonment of ROU assets. See Note 18, "Leases" for additional information about the ROU asset impairment and abandonment charges.

Earnings per Share: Earnings per share amounts, on a basic and diluted basis, have been calculated based upon the weighted-average common shares outstanding for the period.

Basic earnings per share excludes dilution and is computed by dividing income available to common shareholders by the weighted-average number of common shares outstanding for the period. Diluted earnings per share may include the dilutive effect of stock options, restricted stock, convertible debentures and Equity Units, using the treasury stock method. See Note 13, "Debt," for a description of our Equity Units. The treasury stock method assumes exercise of stock options and vesting of restricted stock, with the assumed proceeds used to purchase common stock at the average market price for the period. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Recently Adopted Accounting Guidance: The FASB issued Accounting Standards Update No. 2021-01, *Reference Rate Reform (Topic 848)* ("ASU 2021-01") in January 2021, and Accounting Standards Update No. 2020-04, *Reference Rate Reform (Topic 848): Facilitation of the Effects of Reference Rate Reform on Financial Reporting* ("ASU 2020-04") in March 2020. ASU 2021-01 and ASU 2020-04 provide optional expedients and exceptions for applying GAAP to contract modifications and hedging relationships, subject to meeting certain criteria, that reference the London Interbank Offered Rate ("LIBOR") or another reference rate expected to be discontinued because of the reference rate reform. The provisions must be applied at a Topic, Subtopic, or Industry Subtopic level for all transactions other than derivatives, which may be applied at a hedging relationship level. We adopted ASU 2021-01 on January 7, 2021 and ASU 2020-04 on November 2, 2020, and the adoptions did not have an impact on our consolidated financial position, results of operations or cash flows.

In November 2019, the FASB issued Accounting Standards Update No. 2019-11, *Codification Improvements to Topic 326, Financial Instruments—Credit Losses*. In May 2019, the FASB issued Accounting Standards Update No. 2019-05, *Financial Instruments—Credit Losses (Topic 326): Targeted Transition Relief*. In April 2019, the FASB issued Accounting Standards Update No. 2019-04, *Codification Improvements to Topic 326, Financial Instruments—Credit Losses, Topic 815, Derivatives and Hedging, and Topic 825, Financial Instruments*. In November 2018, the FASB issued Accounting Standards Update No. 2018-19, *Codification Improvements to Topic 326, Financial Instruments—Credit Losses*. These updates provide an option to irrevocably elect to measure certain individual financial assets at fair value instead of amortized cost and provide additional clarification and implementation guidance on certain aspects of the previously issued Accounting Standards Update No. 2016-13, *Financial Instruments—Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments* ("ASU 2016-13") and have the same effective date and transition requirements as ASU 2016-13. ASU 2016-13 introduces a current expected credit loss model for measuring expected credit losses for certain types of financial instruments held at the reporting date based on historical experience, current conditions and reasonable supportable forecasts. ASU 2016-13 replaces the incurred loss model for measuring expected credit losses, requires expected losses on available-for-sale debt securities to be recognized through an allowance for credit losses rather than as reductions in the amortized cost of the securities and provides for additional disclosure requirements. ASU 2016-13 requires a cumulative-effect adjustment to the opening balance of retained earnings on the balance sheet at the date of adoption and a prospective transition approach for debt securities for which an other-than-temporary impairment had been recognized before the adoption date. The effect of a prospective transition approach is to maintain the same amortized cost basis before and after the date of adoption. We adopted ASU 2016-13 on January 1, 2020, and recognized a cumulative-effect adjustment of $35 to our opening retained earnings for credit related allowances on receivables. The adoption did not have an impact on our consolidated statements of income or cash flows.

In August 2018, the FASB issued Accounting Standards Update No. 2018-15, *Intangibles—Goodwill and Other—Internal-Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract* ("ASU 2018-15"). The amendments in ASU 2018-15 require implementation costs incurred by customers in cloud computing arrangements to be deferred and recognized over the term of the arrangement, if those costs would be capitalized by the customer in a software licensing arrangement under the internal-use software guidance. The amendments also require an entity to disclose the nature of its hosting arrangements and adhere to certain presentation requirements in its balance sheet, income statement and statement of cash flows. We adopted ASU 2018-15 on January 1, 2020 using a prospective approach for all implementation costs incurred after the date of adoption, and the adoption did not have an impact on our consolidated financial position, results of operations or cash flows.

In August 2018, the FASB issued Accounting Standards Update No. 2018-14, *Compensation—Retirement Benefits - Defined Benefit Plans—General (Subtopic 715-20): Disclosure Framework—Changes to the Disclosure Requirements for Defined Benefit Plans* ("ASU 2018-14"). The amendments in ASU 2018-14 eliminate, add, and modify certain disclosure requirements for employers that sponsor defined benefit pension or other postretirement plans. We adopted the disclosure requirements of ASU 2018-14 on December 31, 2020, and the adoption did not have an impact on our consolidated financial position, results of operations or cash flows.

In August 2018, the FASB issued Accounting Standards Update No. 2018-13, *Fair Value Measurement (Topic 820): Disclosure Framework—Changes to the Disclosure Requirements for Fair Value Measurement* ("ASU 2018-13"). The amendments in ASU 2018-13 eliminate, add, and modify certain disclosure requirements for fair value measurements. The amendments became effective for interim and annual periods beginning after December 15, 2019, with early adoption permitted for either the entirety of ASU 2018-13 or only the provisions that eliminate or modify disclosure requirements. We early adopted the provisions that eliminate and modify disclosure requirements, on a retrospective basis, effective in our 2018 Annual Report on Form 10-K. We adopted the new disclosure requirements on January 1, 2020, on a prospective basis.

In January 2017, the FASB issued Accounting Standards Update No. 2017-04, *Intangibles - Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment* ("ASU 2017-04"). This update removes Step 2 of the goodwill impairment test under the then-existing guidance, which required a hypothetical purchase price allocation. The new guidance requires an impairment charge to be recognized for the amount by which the carrying amount exceeds the reporting unit's fair value. We adopted ASU 2017-04 on January 1, 2020, and the adoption did not have an impact on our consolidated financial position, results of operations or cash flows.

Recent Accounting Guidance Not Yet Adopted: In November 2020, the FASB issued Accounting Standards Update No. 2020-11, *Financial Services—Insurance (Topic 944): Effective Date and Early Application* ("ASU 2020-11"). The amendments in ASU 2020-11 make changes to the effective date and early application of Accounting Standards Update No. 2018-12, *Financial Services—Insurance (Topic 944): Targeted Improvements to the Accounting for Long-Duration Contracts* ("ASU 2018-12") which was issued in November 2018. The amendments in ASU 2020-11 have extended the original effective date by one year and now the amendments are required for our interim and annual reporting periods beginning after December 15, 2022. The amendments in ASU 2018-12 make changes to a variety of areas to simplify or improve the existing recognition, measurement, presentation and disclosure requirements for long-duration contracts issued by an insurance entity. The amendments require insurers to annually review the assumptions they make about their policyholders and update the liabilities for future policy benefits if the assumptions change. The amendments also simplify the amortization of deferred contract acquisition costs and add new disclosure requirements about the assumptions insurers use to measure their liabilities and how they may affect future cash flows. The amendments related to the liability for future policy benefits for traditional and limited-payment contracts and deferred acquisition costs are to be applied to contracts in force as of the beginning of the earliest period presented, with an option to apply such amendments retrospectively with a cumulative-effect adjustment to the opening balance of retained earnings as of the earliest period presented. The amendments for market risk benefits are to be applied retrospectively. We are currently evaluating the effects the adoption of ASU 2020-11 and ASU 2018-12 will have on our consolidated financial position, results of operations, cash flows, and related disclosures.

In October 2020, the FASB issued Accounting Standards Update No. 2020-08, *Codification Improvements to Subtopic 310-20, Receivables—Nonrefundable Fees and Other Costs* ("ASU 2020-08"). The amendments clarify when an entity should assess whether a callable debt security is within the scope of accounting guidance, which impacts the amortization period for nonrefundable fees and other costs. ASU 2020-08 is effective for interim and annual reporting periods beginning

after December 15, 2020, with early adoption permitted. Upon adoption, the amendments are to be applied on a prospective basis as of the beginning of the period of adoption for existing or newly purchased callable debt securities. We adopted ASU 2020-08 on January 1, 2021, and the adoption did not have an impact on our consolidated financial position, results of operations or cash flows.

In August 2020, the FASB issued Accounting Standards Update No. 2020-06, *Debt—Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging—Contracts in Entity's Own Equity (Subtopic 815-40): Accounting for Convertible Instruments and Contracts in an Entity's Own Equity* ("ASU 2020-06"). The amendments eliminate two of the three accounting models that require separate accounting for convertible features of debt securities, simplify the contract settlement assessment for equity classification, require the use of the if-converted method for all convertible instruments in the diluted earnings per share calculation and expand disclosure requirements. The amendments are effective for our annual and interim reporting periods beginning after December 15, 2021, with early adoption permitted for reporting periods beginning after December 15, 2020. The guidance can be applied on a full retrospective basis to all periods presented or a modified retrospective basis with a cumulative effect adjustment to the opening balance of retained earnings during the period of adoption. We are currently evaluating the effects the adoption of ASU 2020-06 will have on our consolidated financial statements and disclosures.

In December 2019, the FASB issued Accounting Standards Update No. 2019-12, *Income Taxes (Topic 740): Simplifying the Accounting for Income Taxes* ("ASU 2019-12"). The amendments in ASU 2019-12 remove certain exceptions to the general principles in Accounting Standards Codification Topic 740. The amendments also clarify and amend existing guidance to improve consistent application. The amendments are effective for our annual reporting periods beginning after December 15, 2020, with early adoption permitted. The transition method (retrospective, modified retrospective, or prospective basis) related to the amendments depends on the applicable guidance, and all amendments for which there is no transition guidance specified are to be applied on a prospective basis. We adopted ASU 2019-12 on January 1, 2021, and the adoption did not have an impact on our consolidated financial position, results of operations or cash flows.

There were no other new accounting pronouncements that were issued or became effective during the year ended December 31, 2020 that had, or are expected to have, a material impact on our financial position, results of operations, cash flows or financial statement disclosures.

3. Business Acquisitions

Pending Acquisition of MMM Holdings LLC and Affiliates

On February 2, 2021, we announced our entrance into an agreement with InnovaCare Health, L.P. to acquire its Puerto Rico-based subsidiaries, including MMM Holdings, LLC ("MMM") and its Medicare Advantage plan MMM Healthcare, LLC, Medicaid plan and other affiliated companies. MMM is an integrated healthcare organization and seeks to provide its Medicare Advantage and Medicaid members with a whole health experience through its network of specialized clinics and wholly owned independent physician associations. This acquisition aligns with our vision to be an innovative, valuable and inclusive healthcare partner by providing care management programs that improve the lives of the people we serve. The acquisition is expected to close by the end of the second quarter of 2021 and is subject to standard closing conditions and customary approvals.

Beacon Health Options, Inc.

On February 28, 2020, we completed our acquisition of Beacon Health Options, Inc. ("Beacon") the largest independently held behavioral health organization in the country. At the time of acquisition, Beacon served more than thirty-four million individuals across all fifty states. This acquisition aligned with our strategy to diversify into health services and deliver both integrated solutions and care delivery models that personalize care for people with complex and chronic conditions.

In accordance with FASB accounting guidance for business combinations, the consideration transferred was allocated to the preliminary fair value of Beacon's assets acquired and liabilities assumed, including identifiable intangible assets. The excess of the consideration transferred over the preliminary fair value of net assets acquired resulted in preliminary goodwill of $1,072 at December 31, 2020, all of which was allocated to our Other segment. Preliminary goodwill recognized from the acquisition of Beacon primarily relates to the future economic benefits arising from the assets acquired and is consistent with

our stated intentions and strategy. As of December 31, 2020, the initial accounting for the acquisition has not been finalized. Any additional payments or receipts of cash resulting from contractual purchase price adjustments or any subsequent adjustments made to the assets acquired or liabilities assumed during the measurement period will continue to be recorded as an adjustment to goodwill.

The preliminary fair value of the net assets acquired from Beacon includes $752 of other intangible assets at December 31, 2020, which primarily consist of finite-lived customer relationships with amortization periods ranging from 9 to 21 years. The results of operations of Beacon are included in our consolidated financial statements within our Other segment for the period following February 28, 2020. The pro forma effects of this acquisition for prior periods were not material to our consolidated results of operations.

4. Business Optimization Initiatives

During 2020, our management introduced enterprise-wide initiatives to optimize our business and, as a result, we recorded a charge of $653 in selling, general and administrative expenses. This charge includes $258 for impairment and abandonment of operating-lease related right-of-use assets, $198 for impairment and abandonment of property and equipment and $197 for future payments for employee termination costs in connection with the repositioning and reskilling of our workforce. The charges recognized in the Commercial & Specialty Business, Government Business, IngenioRx and Other segments in 2020, were $311, $205, $4 and $133, respectively. See also Note 20, “Segment Information”. We expect most of the employee termination costs to be paid by the end of 2021. We believe these initiatives largely represent the next step forward in our progression towards becoming a more agile organization, including process automation and a reduction in our office space footprint.

A summary of the employee termination costs activity for the year ended December 31, 2020 and ending balance at December 31, 2020 is as follows:

	Commercial & Specialty Business	Government Business	IngenioRx	Other	Total
2020 Business Optimization Initiatives					
Employee termination costs:					
Costs incurred in 2020	$ 96	$ 92	$ 1	$ 8	$ 197
Payments made in 2020	(4)	(4)	—	(2)	(10)
Total liabilities for employee termination costs ending balance at December 31, 2020	$ 92	$ 88	$ 1	$ 6	$ 187

5. Investments

A summary of current and long-term fixed maturity securities, available-for-sale, at December 31, 2020 and 2019 is as follows:

	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses		Allowance For Credit Losses	Estimated Fair Value	Non-Credit Component of Impairment Recognized in Accumulated Other Comprehensive Loss
			Less than 12 Months	12 Months or Greater			
December 31, 2020:							
Fixed maturity securities:							
United States Government securities	$ 765	$ 11	$ (2)	$ —	$ —	$ 774	$ —
Government sponsored securities	63	6	—	—	—	69	—
Foreign government securities	290	17	(2)	—	—	305	—
States, municipalities and political subdivisions, tax-exempt	5,185	395	(1)	—	—	5,579	—
Corporate securities	10,233	697	(20)	(11)	(7)	10,892	(1)
Residential mortgage-backed securities	4,208	154	(8)	(9)	—	4,345	(2)
Commercial mortgage-backed securities	73	3	(1)	(3)	—	72	—
Other securities	1,937	33	(5)	(6)	—	1,959	—
Total fixed maturity securities	$ 22,754	$ 1,316	$ (39)	$ (29)	$ (7)	$ 23,995	$ (3)
December 31, 2019							
Fixed maturity securities:							
United States Government securities	$ 524	$ 4	$ (3)	$ —	$ —	$ 525	$ —
Government sponsored securities	136	5	—	—	—	141	—
States, municipalities and political subdivisions, tax-exempt	4,592	262	(3)	—	—	4,851	—
Corporate securities	8,870	339	(9)	(15)	—	9,185	(3)
Residential mortgage-backed securities	3,654	87	(6)	(3)	—	3,732	—
Commercial mortgage-backed securities	84	2	—	—	—	86	—
Other securities	1,648	21	(3)	(5)	—	1,661	—
Total fixed maturity securities	$ 19,508	$ 720	$ (24)	$ (23)	$ —	$ 20,181	$ (3)

For fixed maturity securities in an unrealized loss position at December 31, 2020 and 2019, the following table summarizes the aggregate fair values and gross unrealized losses by length of time those securities have continuously been in an unrealized loss position.

	Less than 12 Months			12 Months or Greater		
	Number of Securities	Estimated Fair Value	Gross Unrealized Loss	Number of Securities	Estimated Fair Value	Gross Unrealized Loss
(Securities are whole amounts)						
December 31, 2020:						
Fixed maturity securities:						
United States Government securities	27	$ 301	$ (2)	—	$ —	$ —
Government sponsored securities	—	—	—	1	—	—
Foreign government securities	55	35	(2)	9	4	—
States, municipalities and political subdivisions, tax-exempt	36	57	(1)	1	3	—
Corporate securities	646	765	(20)	150	169	(11)
Residential mortgage-backed securities	224	442	(8)	90	110	(9)
Commercial mortgage-backed securities	6	16	(1)	3	4	(3)
Other securities	207	509	(5)	79	179	(6)
Total fixed maturity securities	1,201	$ 2,125	$ (39)	333	$ 469	$ (29)
December 31, 2019						
Fixed maturity securities:						
United States Government securities	27	$ 250	$ (3)	2	$ 1	$ —
Government sponsored securities	14	12	—	3	1	—
States, municipalities and political subdivisions, tax-exempt	114	306	(3)	14	11	—
Corporate securities	386	558	(9)	224	286	(15)
Residential mortgage-backed securities	321	635	(6)	189	237	(3)
Commercial mortgage-backed securities	1	3	—	4	8	—
Other securities	166	415	(3)	113	358	(5)
Total fixed maturity securities	1,029	$ 2,179	$ (24)	549	$ 902	$ (23)

Below are discussions by security type for unrealized losses and credit losses as of December 31, 2020:

Corporate securities: An allowance for credit losses on certain retail, travel and entertainment, energy, and basic materials sector fixed maturity corporate securities has been determined based on qualitative and quantitative factors including credit rating, decline in fair value and industry condition along with other available market data. With multiple risk factors present, these securities were reviewed for expected future cash flow to determine the portion of unrealized losses that were credit related and to record an allowance for credit losses. Unrealized losses on our other corporate securities were largely due to market conditions relating to the COVID-19 pandemic; however, qualitative factors did not indicate a credit loss as of December 31, 2020. We do not intend to sell these investments and it is likely we will not have to sell these investments prior to maturity or recovery of amortized cost.

As for the remaining securities shown in the table above, unrealized losses on these securities have not been recognized into income because we do not intend to sell these investments and it is likely that we will not be required to sell these investments prior to their anticipated recovery. The decline in fair value is largely due to changes in interest rates and other market conditions. We have evaluated these securities for any change in credit rating and have determined that no allowance is necessary. The fair value is expected to recover as the securities approach maturity.

The table below presents a roll-forward by major security type of the allowance for credit losses on fixed maturity securities available-for-sale held at period end for the year ended December 31, 2020:

Year Ended December 31, 2020	Corporate Securities	Foreign Government Securities	Total
Allowance for credit losses:			
Beginning balance	$ —	$ —	$ —
Additions for securities for which no previous expected credit losses were recognized	64	1	65
Securities sold during the period	(17)	(1)	(18)
Decreases to the allowance for credit losses on securities	(40)	—	(40)
Total allowance for credit losses	$ 7	$ —	$ 7

The amortized cost and fair value of fixed maturity securities at December 31, 2020, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because the issuers of the securities may have the right to prepay obligations.

	Amortized Cost	Estimated Fair Value
Due in one year or less	$ 592	$ 595
Due after one year through five years	5,981	6,261
Due after five years through ten years	6,874	7,296
Due after ten years	5,026	5,426
Mortgage-backed securities	4,281	4,417
Total fixed maturity securities	$ 22,754	$ 23,995

Equity Securities

A summary of current equity securities at December 31, 2020 and 2019 is as follows:

	December 31, 2020	December 31, 2019
Equity Securities:		
Exchange traded funds	$ 1,154	$ 44
Fixed maturity mutual funds	144	643
Common equity securities	201	237
Private equity securities	60	85
Total	$ 1,559	$ 1,009

Investment Income

The major categories of net investment income for the years ended December 31, 2020, 2019 and 2018 are as follows:

	2020	2019	2018
Fixed maturity securities	$ 725	$ 721	$ 681
Equity securities	71	100	86
Cash equivalents	28	64	51
Other	91	149	193
Investment income	915	1,034	1,011
Investment expense	(38)	(29)	(41)
Net investment income	$ 877	$ 1,005	$ 970

Investment Gains

Net realized investment gains/losses and the net change in unrealized appreciation/depreciation on investments for the years ended December 31, 2020, 2019 and 2018 are as follows:

	2020	2019	2018
Net realized gains (losses):			
Fixed maturity securities:			
Gross realized gains from sales	$ 175	$ 125	$ 85
Gross realized losses from sales	(105)	(59)	(116)
Impairment losses recognized in income	(7)	(13)	(9)
Net realized gains (losses) from sales of fixed maturity securities	63	53	(40)
Equity securities:			
Gross realized gains	269	147	77
Gross realized losses	(75)	(84)	(276)
Net realized gains (losses) on equity securities	194	63	(199)
Other investments:			
Gross realized gains from sales	18	3	27
Gross realized losses from sales	—	(1)	—
Impairment losses recognized in income	(91)	(34)	(17)
Net realized gains (losses) from sales of other investments	(73)	(32)	10
Net realized gains (losses) on investments	184	84	(229)
Change in net unrealized gains (losses) on investments:			
Fixed maturity securities	575	874	(529)
Equity securities	—	—	—
Other investments	(5)	—	5
Total change in net unrealized gains (losses) on investments	570	874	(524)
Deferred income tax (expense) benefit	(142)	(194)	106
Change in net unrealized gains (losses) on investments	428	680	(418)
Net realized gains (losses) on investments and change in net unrealized gains (losses) on investments	$ 612	$ 764	$ (647)

The gains and losses related to equity securities for the years ended December 31, 2020 and 2019 are as follows:

	2020	2019	2018
Net realized gains (losses) recognized on equity securities	$ 194	$ 63	$ (199)
Less: Net realized (gains) losses recognized on equity securities sold during the period	(61)	(39)	57
Unrealized gains (losses) recognized in income on equity securities still held at December 31	$ 133	$ 24	$ (142)

A primary objective in the management of our fixed maturity and equity portfolios is to maximize total return relative to underlying liabilities and respective liquidity needs. In achieving this goal, assets may be sold to take advantage of market conditions or other investment opportunities as well as tax considerations. Sales will generally produce realized gains and losses. In the ordinary course of business, we may sell securities at a loss for a number of reasons, including, but not limited to: (i) changes in the investment environment; (ii) expectations that the fair value could deteriorate further; (iii) desire to reduce exposure to an issuer or an industry; (iv) changes in credit quality; or (v) changes in expected cash flow.

Proceeds from sales, maturities, calls or redemptions of fixed maturity securities and the related gross realized gains and gross realized losses for the years ended December 31 are as follows:

	2020	2019	2018
Proceeds	$ 11,122	$ 8,351	$ 8,380
Gross realized gains	175	125	85
Gross realized losses	(105)	(59)	(116)

A significant judgment in the valuation of investments is the determination of when a credit loss has occurred. We follow a consistent and systematic process for recognizing impairments on securities that sustain credit declines in value. We have established a committee responsible for the impairment review process. The decision to impair a security incorporates both quantitative criteria and qualitative information. The impairment review process considers a number of factors including, but not limited to: (i) the extent to which the fair value is less than book value, (ii) the financial condition and near term prospects of the issuer, (iii) our intent and ability to retain impaired investments for a period of time sufficient to allow for any anticipated recovery in fair value, (iv) our intent to sell or the likelihood that we will need to sell a fixed maturity security before recovery of its amortized cost basis, (v) whether the debtor is current on interest and principal payments, (vi) the reasons for the decline in value (i.e., credit event compared to liquidity, general credit spread widening, currency exchange rate or interest rate factors) and (vii) general market conditions and industry or sector specific factors. For securities that are deemed to be credit impaired, an allowance is created.

Investment securities are exposed to various risks, such as interest rate, market and credit. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is possible that changes in these risk factors in the near term could have a material adverse impact on our results of operations or shareholders' equity.

At December 31, 2020 and 2019, there were no individual investments that exceeded 10% of shareholders' equity.

At December 31, 2020 and 2019, there were three and zero, respectively, fixed maturity investments that did not produce income during the years then ended.

As of December 31, 2020 and 2019, we had committed approximately $1,320 and $999, respectively, to future capital calls from various third-party investments in exchange for an ownership interest in the related entities.

At December 31, 2020 and 2019, securities with carrying values of approximately $562 and $505, respectively, were deposited by our insurance subsidiaries under requirements of regulatory authorities.

Securities Lending Programs

The fair value of the collateral received at the time of the securities lending transactions amounted to $1,199 and $351 at December 31, 2020 and 2019, respectively. The value of the collateral represented 102% and 103% of the market value of the securities on loan at December 31, 2020 and 2019, respectively.

The remaining contractual maturities of our securities lending transactions at December 31, 2020 is as follows:

	Overnight and Continuous
Securities lending transactions	
Cash	$ 1,056
United States Government securities	143
Total	$ 1,199

6. Derivative Financial Instruments

We primarily invest in the following types of derivative financial instruments: interest rate swaps, futures, forward contracts, put and call options, swaptions, embedded derivatives and warrants. We also enter into master netting agreements which reduce credit risk by permitting net settlement of transactions. At December 31, 2020 and 2019, we had received collateral of $37 and $22, respectively, related to our derivative financial instruments.

A summary of the aggregate contractual or notional amounts and estimated fair values related to derivative financial instruments at December 31, 2020 and 2019 is as follows:

	Contractual/ Notional Amount	Balance Sheet Location	Estimated Fair Value	
			Asset	(Liability)
December 31, 2020				
Hedging instruments				
Interest rate swaps - fixed to floating	$ 575	Other assets/other liabilities	$ 37	$ —
Non-hedging instruments				
Interest rate swaps	27	Equity securities	—	—
Futures	183	Equity securities	6	(5)
Subtotal non-hedging	210	Subtotal non-hedging	6	(5)
Total derivatives	$ 785	Total derivatives	43	(5)
		Amounts netted	—	—
		Net derivatives	$ 43	$ (5)
December 31, 2019				
Hedging instruments				
Interest rate swaps - fixed to floating	$ 1,200	Other assets/other liabilities	$ 22	$ (1)
Non-hedging instruments				
Interest rate swaps	1	Equity securities	—	—
Futures	134	Equity securities	1	—
Subtotal non-hedging	135	Subtotal non-hedging	1	—
Total derivatives	$ 1,335	Total derivatives	23	(1)
		Amounts netted	(1)	1
		Net derivatives	$ 22	$ —

Fair Value Hedges

We have entered into various interest rate swap contracts to convert a portion of our interest rate exposure on our long-term debt from fixed rates to floating rates. The floating rates payable on all of our fair value hedges are benchmarked to the LIBOR. A summary of our outstanding fair value hedges at December 31, 2020 and 2019 is as follows:

Type of Fair Value Hedges	Year Entered Into	Outstanding Notional Amount		Interest Rate Received	Expiration Date
		2020	2019		
Interest rate swap	2020	$ 75	$ —	4.101 %	September 1, 2027
Interest rate swap	2018	50	50	4.101	September 1, 2027
Interest rate swap	2018	450	450	3.300	January 15, 2023
Interest rate swap	2018	—	90	4.350	August 15, 2020
Interest rate swap	2017	—	50	4.350	August 15, 2020
Interest rate swap	2015	—	200	4.350	August 15, 2020
Interest rate swap	2014	—	150	4.350	August 15, 2020
Interest rate swap	2013	—	10	4.350	August 15, 2020
Interest rate swap	2012	—	200	4.350	August 15, 2020
Total notional amount outstanding		$ 575	$ 1,200		

The following amounts were recorded on our consolidated balance sheets related to cumulative basis adjustments for fair value hedges at December 31, 2020 and 2019:

Balance Sheet Classification in Which Hedged Item is Included	Carrying Amount of Hedged Liability		Cumulative Amount of Fair Value Hedging Adjustment Included in the Carrying Amount of the Hedged Liability	
	2020	2019	2020	2019
Current portion of long term-debt	$ 700	$ 1,598	$ 37	$ 22
Long-term debt	19,335	17,787	—	(1)

Cash Flow Hedges

We have entered into a series of forward starting pay fixed interest rate swaps with the objective of eliminating the variability of cash flows in the interest payments on future financings that were anticipated at the time of entering into the swaps. During 2020, swaps in the notional amount of $725 were terminated. All swaps have expired or were terminated as of December 31, 2020.

The unrecognized loss for all expired and terminated cash flow hedges included in accumulated other comprehensive income (loss), net of tax, was $250 and $262 at December 31, 2020 and 2019, respectively. As of December 31, 2020, the total amount of amortization over the next twelve months for all cash flow hedges is estimated to increase interest expense by approximately $14. No amounts were excluded from effectiveness testing.

A summary of the effect of cash flow hedges in accumulated other comprehensive income (loss) for the years ended December 31, 2020, 2019 and 2018 is as follows:

Type of Cash Flow Hedge	Hedge Loss Recognized in Other Comprehensive Income (Loss)	Income Statement Location of Loss Reclassification from Accumulated Other Comprehensive Income (Loss)	Hedge Loss Reclassified from Accumulated Other Comprehensive Income (Loss)
Year ended December 31, 2020			
Forward starting pay fixed swaps	$ —	Interest expense	$ (15)
Year ended December 31, 2019			
Forward starting pay fixed swaps	(35)	Interest expense	(15)
Year ended December 31, 2018			
Forward starting pay fixed swaps	(33)	Interest expense	(14)

Income Statement Relationship of Fair Value and Cash Flow Hedging

A summary of the relationship between the effects of fair value and cash flow hedges on the total amount of income and expense presented in our consolidated statements of income for the years ended December 31, 2020, 2019 and 2018 is as follows:

	Classification and Amount of Gain (Loss) Recognized in Income on Fair Value and Cash Flow Hedging Relationships					
	2020		2019		2018	
	Net Realized Gains (Losses) on Financial Instruments	Interest Expense	Net Realized Gains (Losses) on Financial Instruments	Interest Expense	Net Realized Gains (Losses) on Financial Instruments	Interest Expense
Total amount of income or expense in the income statement in which the effects of fair value or cash flow hedges are recorded	$ 182	$ (784)	$ 67	$ (746)	$ (206)	$ (753)
Gain (loss) on fair value hedging relationships:						
Interest rate swaps:						
Hedged items	—	(15)	—	2	—	—
Derivatives designated as hedging instruments	—	15	—	(2)	—	—
Loss on cash flow hedging relationships:						
Forward starting pay fixed swaps:						
Amount of loss reclassified from accumulated other comprehensive loss into net income	—	(15)	—	(15)	—	(14)

Non-Hedging Derivatives

A summary of the effect of non-hedging derivatives on our consolidated statements of income for the years ended December 31, 2020, 2019 and 2018 is as follows:

Type of Non-hedging Derivatives	Income Statement Location of Gain (Loss) Recognized	Derivative Gain (Loss) Recognized
Year ended December 31, 2020		
Interest rate swaps	Net realized gains (losses) on financial instruments	$ (1)
Options	Net realized gains (losses) on financial instruments	(5)
Futures	Net realized gains (losses) on financial instruments	4
Total		$ (2)
Year ended December 31, 2019		
Interest rate swaps	Net realized gains (losses) on financial instruments	$ 1
Options	Net realized gains (losses) on financial instruments	(8)
Futures	Net realized gains (losses) on financial instruments	(10)
Total		$ (17)
Year ended December 31, 2018		
Interest rate swaps	Net realized gains (losses) on financial instruments	$ 14
Options	Net realized gains (losses) on financial instruments	1
Futures	Net realized gains (losses) on financial instruments	8
Total		$ 23

7. Fair Value

Assets and liabilities recorded at fair value in the consolidated balance sheets are categorized based upon the level of judgment associated with the inputs used to measure their fair value. Level inputs, as defined by FASB guidance for fair value measurements and disclosures, are as follows:

Level Input:	Input Definition:
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.
Level III	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date.

The following methods, assumptions and inputs were used to determine the fair value of each class of the following assets and liabilities recorded at fair value in the consolidated balance sheets:

Cash equivalents: Cash equivalents primarily consist of highly rated money market funds with maturities of three months or less, and are purchased daily at par value with specified yield rates. Due to the high ratings and short-term nature of the funds, we designate all cash equivalents as Level I.

Fixed maturity securities, available-for-sale: Fair values of available-for-sale fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third-party pricing services, which generally use Level I or Level II inputs for the determination of fair value to facilitate fair value measurements and disclosures. Level II securities primarily include corporate securities, securities from states, municipalities and political subdivisions, mortgage-backed securities, United States Government securities, foreign government securities, and certain other asset-backed securities. For securities not actively traded, the pricing services may use quoted market prices of

comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. We have controls in place to review the pricing services' qualifications and procedures used to determine fair values. In addition, we periodically review the pricing services' pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. We also have certain fixed maturity securities, primarily corporate debt securities, that are designated Level III securities. For these securities, the valuation methodologies may incorporate broker quotes or discounted cash flow analyses using assumptions for inputs such as expected cash flows, benchmark yields, credit spreads, default rates and prepayment speeds that are not observable in the markets.

Equity securities: Fair values of equity securities are generally designated as Level I and are based on quoted market prices. For certain equity securities, quoted market prices for the identical security are not always available, and the fair value is estimated by reference to similar securities for which quoted prices are available. These securities are designated Level II. We also have certain equity securities, including private equity securities, for which the fair value is estimated based on each security's current condition and future cash flow projections. Such securities are designated Level III. The fair values of these private equity securities are generally based on either broker quotes or discounted cash flow projections using assumptions for inputs such as the weighted-average cost of capital, long-term revenue growth rates and earnings before interest, taxes, depreciation and amortization, and/or revenue multiples that are not observable in the markets.

Securities lending collateral: Fair values of securities lending collateral are based on quoted market prices, where available. These fair values are obtained primarily from third-party pricing services, which generally use Level I or Level II inputs for the determination of fair value, to facilitate fair value measurements and disclosures.

Derivatives: Fair values are based on the quoted market prices by the financial institution that is the counterparty to the derivative transaction. We independently verify prices provided by the counterparties using valuation models that incorporate market observable inputs for similar derivative transactions. Derivatives are designated as Level II securities. Derivatives presented within the fair value hierarchy table below are presented on a gross basis and not on a master netting basis by counterparty.

In addition, the following methods and assumptions were used to determine the fair value of each class of pension benefit plan assets and other benefit plan assets not defined above (see Note 11, "Retirement Benefits," for fair values of benefit plan assets):

Mutual funds: Fair values are based on quoted market prices, which represent the net asset value ("NAV") of the shares held.

Partnership investments: Fair values are estimated based on the plan's proportionate share of the undistributed partners' capital as reported in audited financial statements of the partnership. In accordance with FASB guidance, certain investments that are measured at fair value using the NAV per share as a practical expedient have been classified in the fair value hierarchy. The fair value amounts presented are intended to permit reconciliation of the fair value hierarchy to the total investments of the master trust.

Commingled fund: Fair value is based on NAV per fund share, primarily derived from the quoted prices in active markets on the underlying equity securities.

Contract with insurance company: Fair value of the contract in the insurance company general investment account is determined by the insurance company based on the fair value of the underlying investments of the account.

Investment in DOL 103-12 trust: Fair value is based on the plan's proportionate share of the fair value of investments held by the trust, qualified as a Department of Labor Regulation 2520.103-12 entity ("DOL 103-12 trust") as reported in the audited financial statements of the trust, where the trustee applies fair value measurements to the underlying investments of the trust.

Life insurance contracts: Fair value is based on the cash surrender value of the policies as reported by the insurer.

A summary of fair value measurements by level for assets and liabilities measured at fair value on a recurring basis at December 31, 2020 and 2019 is as follows:

	Level I	Level II	Level III	Total
December 31, 2020				
Assets:				
Cash equivalents	$ 3,163	$ —	$ —	$ 3,163
Fixed maturity securities, available-for-sale:				
United States Government securities	—	774	—	774
Government sponsored securities	—	69	—	69
Foreign government securities	—	305	—	305
States, municipalities and political subdivisions, tax-exempt	—	5,579	—	5,579
Corporate securities	—	10,567	325	10,892
Residential mortgage-backed securities	—	4,343	2	4,345
Commercial mortgage-backed securities	—	72	—	72
Other securities	—	1,954	5	1,959
Total fixed maturity securities, available-for-sale	—	23,663	332	23,995
Equity securities:				
Exchange traded funds	1,154	—	—	1,154
Fixed maturity mutual funds	—	144	—	144
Common equity securities	171	30	—	201
Private equity securities	—	—	60	60
Total equity securities	1,325	174	60	1,559
Securities lending collateral	—	1,199	—	1,199
Derivatives	—	43	—	43
Total assets	$ 4,488	$ 25,079	$ 392	$ 29,959
Liabilities:				
Derivatives	$ —	$ (5)	$ —	$ (5)
Total liabilities	$ —	$ (5)	$ —	$ (5)
December 31, 2019				
Assets:				
Cash equivalents	$ 2,015	$ —	$ —	$ 2,015
Fixed maturity securities, available-for-sale:				
United States Government securities	—	525	—	525
Government sponsored securities	—	141	—	141
States, municipalities and political subdivisions, tax-exempt	—	4,851	—	4,851
Corporate securities	—	8,882	303	9,185
Residential mortgage-backed securities	—	3,730	2	3,732
Commercial mortgage-backed securities	—	86	—	86
Other securities	—	1,654	7	1,661
Total fixed maturity securities, available-for-sale	—	19,869	312	20,181
Equity securities:				
Exchange traded funds	44	—	—	44
Fixed maturity mutual funds	—	643	—	643
Common equity securities	206	31	—	237
Private equity securities	—	—	85	85
Total equity securities	250	674	85	1,009
Securities lending collateral	—	353	—	353
Derivatives	—	23	—	23
Total assets	$ 2,265	$ 20,919	$ 397	$ 23,581
Liabilities:				
Derivatives	$ —	$ (1)	$ —	$ (1)
Total liabilities	$ —	$ (1)	$ —	$ (1)

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level III inputs for the years ended December 31, 2020, 2019 and 2018 is as follows:

	Corporate Securities	Residential Mortgage-backed Securities	Other Securities	Equity Securities	Total
Year ended December 31, 2020					
Beginning balance at January 1, 2020	$ 303	$ 2	$ 7	$ 85	$ 397
Total gains (losses):					
Recognized in net income	(3)	—	—	(19)	(22)
Recognized in accumulated other comprehensive income	(5)	—	—	—	(5)
Purchases	85	—	—	16	101
Sales	(19)	—	—	(22)	(41)
Settlements	(44)	—	(2)	—	(46)
Transfers into Level III	10	—	—	—	10
Transfers out of Level III	(2)	—	—	—	(2)
Ending balance at December 31, 2020	$ 325	$ 2	$ 5	$ 60	$ 392
Change in unrealized gains or losses included in net income related to assets still held at December 31, 2020	$ —	$ —	$ —	$ (19)	$ (19)
Year ended December 31, 2019					
Beginning balance at January 1, 2019	$ 287	$ 6	$ 17	$ 313	$ 623
Total gains (losses):					
Recognized in net income	(7)	—	—	(6)	(13)
Recognized in accumulated other comprehensive loss	3	—	—	—	3
Purchases	122	—	2	65	189
Sales	(22)	—	—	(79)	(101)
Settlements	(71)	(2)	(6)	—	(79)
Transfers into Level III	—	—	3	2	5
Transfers out of Level III	(9)	(2)	(9)	(210)	(230)
Ending balance at December 31, 2019	$ 303	$ 2	$ 7	$ 85	$ 397
Change in unrealized gains or losses included in net income related to assets still held at December 31, 2019	$ —	$ —	$ —	$ 6	$ 6
Year ended December 31, 2018					
Beginning balance at January 1, 2018	$ 229	$ 5	$ 16	$ 287	$ 537
Total gains (losses):					
Recognized in net income	1	—	—	(229)	(228)
Recognized in accumulated other comprehensive loss	(5)	—	—	—	(5)
Purchases	120	2	18	290	430
Sales	(33)	—	(1)	(35)	(69)
Settlements	(88)	(1)	(10)	—	(99)
Transfers into Level III	65	—	9	—	74
Transfers out of Level III	(2)	—	(15)	—	(17)
Ending balance at December 31, 2018	$ 287	$ 6	$ 17	$ 313	$ 623
Change in unrealized gains or losses included in net income related to assets still held at December 31, 2018	$ —	$ —	$ —	$ 30	$ 30

There were no individually material transfers into or out of Level III during the years ended December 31, 2020, 2019 or 2018.

Certain assets and liabilities are measured at fair value on a nonrecurring basis; that is, the instruments are not measured at fair value on an ongoing basis but are subject to fair value adjustments only in certain circumstances. As disclosed in Note 3, “Business Acquisitions,” we completed our acquisition of Beacon on February 28, 2020. The preliminary values of net assets acquired in our acquisition of Beacon and resulting goodwill and other intangible assets were recorded at fair

value primarily using Level III inputs. The majority of Beacon's assets acquired and liabilities assumed were recorded at their carrying values as of the respective date of acquisition, as their carrying values approximated their fair values due to their short-term nature. The preliminary fair values of goodwill and other intangible assets acquired in our acquisition of Beacon were internally estimated based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets could be expected to generate in the future. We developed internal estimates for the expected cash flows and discount rate in the present value calculation. Other than the assets acquired and liabilities assumed in our acquisition of Beacon described above, there were no material assets or liabilities measured at fair value on a nonrecurring basis during the years ended December 31, 2020 or 2019.

Our valuation policy is determined by members of our treasury and accounting departments. Whenever possible, our policy is to obtain quoted market prices in active markets to estimate fair values for recognition and disclosure purposes. Where quoted market prices in active markets are not available, fair values are estimated using discounted cash flow analyses, broker quotes, unobservable inputs or other valuation techniques. These techniques are significantly affected by our assumptions, including discount rates and estimates of future cash flows. The use of assumptions for unobservable inputs for the determination of fair value involves a level of judgment and uncertainty. Changes in assumptions that reasonably could have been different at the reporting date may result in a higher or lower determination of fair value. Changes in fair value measurements, if significant, may affect performance of cash flows.

Potential taxes and other transaction costs are not considered in estimating fair values. Our valuation policy is generally to obtain quoted prices for each security from third-party pricing services, which are derived through recently reported trades for identical or similar securities making adjustments through the reporting date based upon available market observable information. As we are responsible for the determination of fair value, we perform analysis on the prices received from the pricing services to determine whether the prices are reasonable estimates of fair value. This analysis is performed by our internal treasury personnel who are familiar with our investment portfolios, the pricing services engaged and the valuation techniques and inputs used. Our analysis includes procedures such as a review of month-to-month price fluctuations and price comparisons to secondary pricing services. There were no adjustments to quoted market prices obtained from the pricing services during the years ended December 31, 2020, 2019 or 2018.

In addition to the preceding disclosures on assets recorded at fair value in the consolidated balance sheets, FASB guidance also requires the disclosure of fair values for certain other financial instruments for which it is practicable to estimate fair value, whether or not such values are recognized in the consolidated balance sheets.

Non-financial instruments such as real estate, property and equipment, other current assets, deferred income taxes, intangible assets and certain financial instruments, such as policy liabilities, are excluded from the fair value disclosures. Therefore, the fair value amounts cannot be aggregated to determine our underlying economic value.

The carrying amounts reported in the consolidated balance sheets for cash, accrued investment income, premium receivables, self-funded receivables, other receivables, income taxes receivable, unearned income, accounts payable and accrued expenses, security trades pending payable, securities lending payable and certain other current liabilities approximate fair value because of the short-term nature of these items. These assets and liabilities are not listed in the table below.

The following methods and assumptions were used to estimate the fair value of each class of financial instrument that is recorded at its carrying value on the consolidated balance sheets:

Other invested assets: Other invested asset primarily include our investments in limited partnerships, joint ventures and other non-controlled corporations, as well as the cash surrender value of corporate-owned life insurance policies. Investments in limited partnerships, joint ventures and other non-controlled corporations are carried at our share in the entities' undistributed earnings, which approximates fair value. The carrying value of corporate-owned life insurance policies represents the cash surrender value as reported by the respective insurer, which approximates fair value.

Short-term borrowings: The fair value of our short-term borrowings is based on quoted market prices for the same or similar debt, or if no quoted market prices were available, on the current market interest rates estimated to be available to us for debt of similar terms and remaining maturities.

Long-term debt—commercial paper: The carrying amount for commercial paper approximates fair value, as the underlying instruments have variable interest rates at market value.

Long-term debt—senior unsecured notes and surplus notes: The fair values of our notes are based on quoted market prices in active markets for the same or similar debt, or, if no quoted market prices are available, on the current market observable rates estimated to be available to us for debt of similar terms and remaining maturities.

Long-term debt—convertible debentures: The fair value of our convertible debentures is based on the quoted market price in the active private market in which the convertible debentures trade.

A summary of the estimated fair values by level of each class of financial instrument that is recorded at its carrying value on our consolidated balance sheets at December 31, 2020 and 2019 is as follows:

	Carrying Value	Estimated Fair Value			
		Level I	Level II	Level III	Total
December 31, 2020					
Assets:					
Other invested assets	$ 4,285	$ —	$ —	$ 4,285	$ 4,285
Liabilities:					
Debt:					
Commercial paper	250	—	250	—	250
Notes	19,677	—	23,307	—	23,307
Convertible debentures	108	—	712	—	712
December 31, 2019					
Assets:					
Other invested assets	$ 4,258	$ —	$ —	$ 4,258	$ 4,258
Liabilities:					
Debt:					
Short-term borrowings	700	—	700	—	700
Commercial paper	400	—	400	—	400
Notes	18,840	—	20,470	—	20,470
Convertible debentures	145	—	904	—	904

8. Income Taxes

The components of deferred income taxes at December 31, 2020 and 2019 are as follows:

	2020	2019
Deferred income tax assets:		
Accrued expenses	$ 588	$ 331
Bad debt reserves	143	89
Insurance reserves	187	139
Lease liabilities	204	180
Retirement liabilities	205	216
Deferred compensation	31	28
Federal and state operating loss carryforwards	274	124
Other	113	71
Subtotal	1,745	1,178
Less: valuation allowance	(84)	(45)
Total deferred income tax assets	1,661	1,133
Deferred income tax liabilities:		
Federal and state intangible assets	2,073	1,999
Capitalized software	670	554
Depreciation and amortization	37	62
Investment basis	407	230
Retirement assets	260	249
Lease right-of-use asset	131	164
Prepaid expenses	102	102
Total deferred income tax liabilities	3,680	3,360
Net deferred income tax liabilities	$ 2,019	$ 2,227

In the table above, certain amounts for the year ended December 31, 2019 have been reclassified from a net to gross presentation to more fully reflect the federal and state tax effects by type of temporary difference. This reclassification does not impact amounts presented in the financial statements.

As of December 31, 2020, the Company's undistributed earnings from non-U.S. subsidiaries are intended to be indefinitely reinvested in non-U.S. operations, and therefore no U.S. deferred taxes have been recorded.

Significant components of the provision for income taxes for the years ended December 31, 2020, 2019 and 2018 consist of the following:

	2020	2019	2018
Current tax expense:			
Federal	$ 1,731	$ 1,019	$ 1,128
State and local	461	84	78
Total current tax expense	2,192	1,103	1,206
Deferred tax (benefit) expense	(526)	75	112
Total income tax expense	$ 1,666	$ 1,178	$ 1,318

State and local current tax expense is reported gross of federal benefit, and includes amounts related to audit settlements, uncertain tax positions, state tax credits and true up of prior years' tax. Such items are included in multiple lines in the following rate reconciliation table on a net of federal tax basis.

A reconciliation of income tax expense recorded in the consolidated statements of income and amounts computed at the statutory federal income tax rate for the years ended December 31, 2020, 2019 and 2018 is as follows:

	2020		2019		2018	
	Amount	Percent	Amount	Percent	Amount	Percent
Amount at statutory rate	$ 1,310	21.0 %	$ 1,257	21.0 %	$ 1,064	21.0 %
State and local income taxes net of federal tax expense/benefit	235	3.8	138	2.3	63	1.2
Tax exempt interest and dividends received deduction	(22)	(0.4)	(24)	(0.4)	(27)	(0.5)
HIP fee	330	5.3	—	—	324	6.4
Basis adjustments from recent acquisitions	(110)	(1.8)	—	—	(28)	(0.6)
Tax Cuts and Jobs Act	—	—	—	—	(28)	(0.6)
Other, net	(77)	(1.2)	(193)	(3.2)	(50)	(0.9)
Total income tax expense	$ 1,666	26.7 %	$ 1,178	19.7 %	$ 1,318	26.0 %

During the year ended December 31, 2020, we recognized income tax expense of $1,666, or $6.55 per diluted share, which included income tax expense of $330, or $1.30 per diluted share as a result of the non-tax deductibility of the HIP Fee payment, which was reinstated for 2020.

During the year ended December 31, 2019, we recognized income tax expense of $1,178, or $4.53 per diluted share. The HIP Fee payment was suspended for 2019.

During the year ended December 31, 2018, we recognized income tax expense of $324, or $1.23 per diluted share, as a result of the non-tax deductibility of the HIP Fee payment.

On December 22, 2017, the federal government enacted the Tax Cuts and Jobs Act, which contains significant changes to corporate taxation, including, but not limited to, reducing the U.S. federal corporate income tax rate from 35% to 21% and modifying or limiting many business deductions. At December 31, 2018, we completed our accounting for the tax effects of enactment of the Tax Cuts and Jobs Act and there was no material change to our 2017 provisional amount. In addition we reclassified, for our interim and annual reporting periods beginning on January 1, 2018, $91 of stranded tax effects from accumulated other comprehensive loss to retained earnings on our consolidated balance sheets.

The change in the carrying amount of gross unrecognized tax benefits from uncertain tax positions for the years ended December 31, 2020 and 2019 is as follows:

	2020	2019
Balance at January 1	$ 146	$ 241
Additions based on:		
Tax positions related to current year	76	1
Tax positions related to prior years	40	—
Reductions based on:		
Tax positions related to prior years	(13)	(63)
Settlements with taxing authorities	—	(33)
Balance at December 31	$ 249	$ 146

The table above excludes interest, net of related tax benefits, which is treated as income tax expense (benefit) under our accounting policy. The interest is included in the amounts described in the following paragraph.

The amount of unrecognized tax benefits that would impact our effective tax rate in future periods, if recognized, was $227 and $140 at December 31, 2020 and 2019, respectively. Also included in the table above, at December 31, 2020, is $2 that would be recognized as an adjustment to additional paid-in capital, which would not affect our effective tax rate. In addition to the contingent liabilities included in the table above, during 2017 we filed protective state income tax refund claims of approximately $310. There were no equivalent protective state income tax refund claims filed in 2020, 2019, or 2018.

For the year ended December 31, 2020, we recognized a net interest expense of $7. For the years ended December 31, 2019 and 2018, we recognized a net interest (benefit) expense of $(11) and $15, respectively. We had accrued approximately $33 and $26 for the payment of interest at December 31, 2020 and 2019, respectively.

As of December 31, 2020, as further described below, certain tax years remain open to examination by the Internal Revenue Service ("IRS") and various state and local authorities. As a result of these examinations and discussions with taxing agencies, we have recorded amounts for uncertain tax positions. It is anticipated that the amount of unrecognized tax benefits will change in the next twelve months due to possible settlements of audits and changes in temporary items. However, the ultimate resolution of these items is dependent on the completion of negotiations with various taxing authorities. While it is difficult to determine when other tax settlements will actually occur, it is reasonably possible that one could occur in the next twelve months and our unrecognized tax benefits could change within a range of approximately ($15) to ($147).

We are a member of the IRS Compliance Assurance Process ("CAP"). The objective of CAP is to reduce taxpayer burden and uncertainty while assuring the IRS of the accuracy of tax returns prior to filing, thereby reducing or eliminating the need for post-filing examinations.

As of December 31, 2020, the IRS examination of our 2020 and 2019 tax years continues to be in process.

In certain states, we pay premium taxes in lieu of state income taxes. Premium taxes are reported in selling, general and administrative expense.

At December 31, 2020, we had federal net operating loss carryforwards of $40 that will expire beginning 2033 through 2037 and $7 that have an indefinite carryforward period; state net operating loss carryforwards expire beginning 2022 through 2040, with some having an indefinite carryforward period.

During 2020, 2019 and 2018, federal income taxes paid totaled $1,790, $1,403 and $738, respectively.

9. Property and Equipment

A summary of property and equipment at December 31, 2020 and 2019 is as follows:

	2020	2019
Computer software, purchased and internally developed	$ 5,247	$ 4,314
Computer equipment, furniture and other equipment	1,218	1,264
Leasehold improvements	671	715
Building and improvements	174	169
Land and improvements	17	17
Property and equipment, gross	7,327	6,479
Accumulated depreciation and amortization	(3,844)	(3,346)
Property and equipment, net	$ 3,483	$ 3,133

Depreciation expense for 2020, 2019 and 2018 was $176, $147 and $124, respectively. Amortization expense on computer software and leasehold improvements for 2020, 2019 and 2018 was $462, $528 and $528, respectively, which includes amortization expense on computer software, both purchased and internally developed, for 2020, 2019 and 2018 of $412, $450 and $465, respectively. Capitalized costs related to the internal development of software of $4,783 and $3,939 at December 31, 2020 and 2019, respectively, are reported with computer software.

Our activities as disclosed in Note 4, "Business Optimization Initiatives", include impairment of property and equipment. We recorded an impairment charge of $198 for property and equipment in 2020 which is in selling, general and administrative expenses.

10. Goodwill and Other Intangible Assets

A summary of the change in the carrying amount of goodwill for our segments (see Note 20, "Segment Information") for 2020 and 2019 is as follows:

	Commercial and Specialty Business	Government Business	IngenioRx	Other	Total
Balance as of January 1, 2019	$ 11,551	$ 8,953	$ —	$ —	$ 20,504
Adjustments	—	(674)	—	670	(4)
Balance as of December 31, 2019	11,551	8,279	—	670	20,500
Acquisitions and adjustments	42	52	48	1,049	1,191
Balance as of December 31, 2020	$ 11,593	$ 8,331	$ 48	$ 1,719	$ 21,691
Accumulated impairment as of December 31, 2020	$ (41)	$ —	$ —	$ —	$ (41)

Goodwill adjustments in 2019 include certain reclassifications made for changes in segment reporting. For additional information, see Note 20, "Segment Information".

As required by FASB guidance, we completed annual impairment tests of existing goodwill and other intangible assets with indefinite lives during 2020, 2019 and 2018. We perform these annual impairment tests during the fourth quarter. FASB guidance also requires interim impairment testing to be performed when potential impairment indicators exist. These tests involve the use of estimates related to the fair value of goodwill and intangible assets with indefinite lives and require a significant degree of management judgment and the use of subjective assumptions. Qualitative testing procedures include assessing our financial performance, macroeconomic conditions, industry and market considerations, various asset specific factors and entity specific events. For quantitative testing, the fair values are estimated using the projected income and market valuation approaches, incorporating Level III internal estimates for inputs, including, but not limited to, revenue projections, income projections, cash flows and discount rates. We did not incur any impairment losses in 2020, 2019 or 2018, as the estimated fair values of our reporting units were substantially in excess of their carrying values.

The components of other intangible assets as of December 31, 2020 and 2019 are as follows:

	2020			2019		
	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
Intangible assets with finite lives:						
Customer relationships	$ 5,180	$ (3,766)	$ 1,414	$ 4,500	$ (3,469)	$ 1,031
Provider and hospital relationships	323	(114)	209	228	(98)	130
Other	444	(177)	267	352	(129)	223
Total	5,947	(4,057)	1,890	5,080	(3,696)	1,384
Intangible assets with indefinite lives:						
Blue Cross and Blue Shield and other trademarks	6,299	—	6,299	6,299	—	6,299
State Medicaid licenses	1,216	—	1,216	991	—	991
Total	7,515	—	7,515	7,290	—	7,290
Other intangible assets	$ 13,462	$ (4,057)	$ 9,405	$ 12,370	$ (3,696)	$ 8,674

As of December 31, 2020, the estimated amortization expense for each of the five succeeding years is as follows: 2021, $324; 2022, $271; 2023, $233; 2024, $196; and 2025, $159.

11. Retirement Benefits

We sponsor various non-contributory employee defined benefit plans through certain subsidiaries.

The Anthem Cash Balance Plan A and the Anthem Cash Balance Plan B are cash balance pension plans covering certain eligible employees of the affiliated companies that participate in these plans. Effective January 1, 2006, benefits were curtailed, with the result that most participants stopped accruing benefits but continue to earn interest on benefits accrued prior to the curtailment. Certain participants subject to collective bargaining and certain other participants who met grandfathering rules continued to accrue benefits. Participants who did not receive credits and/or benefit accruals were included in the Anthem Cash Balance Plan A, while employees who were still receiving credits and/or benefits participated in the Anthem Cash Balance Plan B. Effective January 1, 2019, benefits under the Anthem Cash Balance Plan B were curtailed. All grandfathered participants no longer have pay credits added to their accounts but continue to earn interest on existing account balances. Participants continue to earn years of pension service for vesting purposes. Several pension plans acquired through various corporate mergers and acquisitions were merged into these plans in prior years.

The Employees' Retirement Plan of Blue Cross of California (the "BCC Plan") is a defined benefit pension plan that covers eligible employees of Blue Cross of California who are covered by a collective bargaining agreement. Effective January 1, 2007, benefits were curtailed under the BCC Plan with the result that no Blue Cross of California employees hired or rehired after December 31, 2006 are eligible to participate in the BCC Plan.

All of the plans' assets consist primarily of equity securities, fixed maturity securities, investment funds and cash. The funding policies for all plans are to contribute amounts at least sufficient to meet the minimum funding requirements set forth in the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), as further amended by the Pension Protection Act of 2006, and in accordance with income tax regulations, plus such additional amounts as are necessary to provide assets sufficient to meet the benefits to be paid to plan participants.

The following tables disclose consolidated "pension benefits," which include the defined benefit pension plans described above, and consolidated "other benefits," which include postretirement health and welfare benefits including medical, vision and dental benefits offered to certain employees. Calculations were computed using assumptions at the December 31 measurement dates.

The reconciliation of the benefit obligation is as follows:

	Pension Benefits		Other Benefits	
	2020	2019	2020	2019
Benefit obligation at beginning of year	$ 1,880	$ 1,743	$ 423	$ 431
Service cost	—	—	1	1
Interest cost	47	62	10	15
Plan participant contributions	—	—	18	17
Actuarial loss (gain)	219	200	(15)	5
Settlements	(80)	(35)	—	—
Benefits paid	(57)	(90)	(38)	(46)
Benefit obligation at end of year	$ 2,009	$ 1,880	$ 399	$ 423

The changes in the fair value of plan assets are as follows:

	Pension Benefits		Other Benefits	
	2020	2019	2020	2019
Fair value of plan assets at beginning of year	$ 2,026	$ 1,818	$ 367	$ 336
Actual return on plan assets	290	329	33	55
Employer contributions	7	4	11	5
Plan participant contributions	—	—	18	17
Settlements	(80)	(35)	—	—
Benefits paid	(57)	(90)	(38)	(46)
Fair value of plan assets at end of year	$ 2,186	$ 2,026	$ 391	$ 367

The net amount included in the consolidated balance sheets is as follows:

	Pension Benefits		Other Benefits	
	2020	2019	2020	2019
Noncurrent assets	$ 248	$ 212	$ —	$ —
Current liabilities	(6)	(6)	—	—
Noncurrent liabilities	(65)	(60)	(8)	(56)
Net amount at December 31	$ 177	$ 146	$ (8)	$ (56)

The net amounts included in accumulated other comprehensive income (loss) that have not been recognized as components of net periodic benefit costs are as follows:

	Pension Benefits		Other Benefits	
	2020	2019	2020	2019
Net actuarial loss	$ 749	$ 734	$ 3	$ 25
Prior service cost (credit)	—	1	(12)	(19)
Net amount before tax at December 31	$ 749	$ 735	$ (9)	$ 6

The accumulated benefit obligation for the defined benefit pension plans was $2,007 and $1,878 at December 31, 2020 and 2019, respectively.

As of December 31, 2020, certain pension plans had accumulated benefit obligations in excess of plan assets. Such plans had accumulated benefit obligation and fair value of plan assets of $111 and $42, respectively. For those same plans, the projected benefit obligation was also in excess of plan assets. Such plans had projected benefit obligation and fair value of plan assets of $113 and $42, respectively.

The weighted-average assumptions used in calculating the benefit obligations for all plans are as follows:

	Pension Benefits		Other Benefits	
	2020	2019	2020	2019
Discount rate	2.24 %	3.11 %	1.99 %	2.93 %
Rate of compensation increase	3.00 %	3.00 %	3.00 %	3.00 %
Expected rate of return on plan assets	6.72 %	7.33 %	6.60 %	7.00 %
Interest crediting rate	3.82 %	3.82 %	0.87 %	1.81 %

The components of net periodic benefit credit included in the consolidated statements of income are as follows:

	2020	2019	2018
Pension Benefits			
Service cost	$ —	$ —	$ 8
Interest cost	47	62	55
Expected return on assets	(138)	(138)	(147)
Recognized actuarial loss	24	17	22
Settlement loss	29	9	5
Net periodic benefit credit	$ (38)	$ (50)	$ (57)
Other Benefits			
Service cost	$ 1	$ 1	$ 1
Interest cost	10	15	15
Expected return on assets	(25)	(22)	(24)
Recognized actuarial loss	—	2	3
Amortization of prior service credit	(7)	(12)	(12)
Net periodic benefit credit	$ (21)	$ (16)	$ (17)

During the years ended December 31, 2020, 2019 and 2018, we incurred total settlement losses of $29, $9 and $5, respectively, as lump-sum payments exceeded the service cost and interest cost components of net periodic benefit cost for certain of our plans.

The weighted-average assumptions used in calculating the net periodic benefit cost for all plans are as follows:

	2020	2019	2018
Pension Benefits			
Discount rate	3.11 %	4.15 %	3.44 %
Rate of compensation increase	3.00 %	3.00 %	3.00 %
Expected rate of return on plan assets	7.33 %	7.44 %	7.83 %
Interest crediting rate	3.82 %	3.83 %	3.82 %
Other Benefits			
Discount rate	2.93 %	4.04 %	3.42 %
Rate of compensation increase	3.00 %	3.00 %	3.00 %
Expected rate of return on plan assets	7.00 %	7.00 %	7.00 %
Interest crediting rate	1.81 %	3.12 %	2.35 %

The assumed healthcare cost trend rates used to measure the expected cost of pre-Medicare (those who are not currently eligible for Medicare benefits) other benefits at our December 31, 2020 measurement date was 7.00% for 2021 with a gradual decline to 4.50% by the year 2033. The assumed healthcare cost trend rates used to measure the expected cost of post-Medicare (those who are currently eligible for Medicare benefits) other benefits at our December 31, 2020 measurement date was 5.50% for 2021 with a gradual decline to 4.50% by the year 2033. These estimated trend rates are subject to change in the future.

Plan assets include a diversified mix of equity securities, investment grade fixed maturity securities and other types of investments across a range of sectors and levels of capitalization to maximize long-term return for a prudent level of risk. The weighted-average target allocation for pension benefit plan assets is 44% equity securities, 48% fixed maturity securities, and 8% to all other types of investments. Equity securities primarily include a mix of domestic securities, foreign securities and

mutual funds invested in equities. Fixed maturity securities primarily include treasury securities, corporate bonds and asset-backed investments issued by corporations and the U.S. government. Other types of investments primarily include insurance contracts designed specifically for employee benefit plans and a commingled fund comprised primarily of equity securities. As of December 31, 2020, there were no significant concentrations of investments in the pension benefit assets or other benefit assets. No plan assets were invested in Anthem common stock.

The partnerships hold various types of underlying assets such as real estate and investments in oil and gas companies. Generally, the partnership interests are not redeemable and are transferable only with the consent of the general partner. Unfunded commitments related to all partnership interests totaled approximately $3 and $29 at December 31, 2020 and 2019, respectively.

Pension benefit assets and other benefit assets recorded at fair value are categorized based upon the level of judgment associated with the inputs used to measure their fair value.

The fair values of our pension benefit assets and other benefit assets by asset category and level inputs at December 31, 2020, excluding cash, investment income receivable and amounts due to/from brokers, resulting in a net asset of $64, are as follows (see Note 7, "Fair Value," for additional information regarding the definition of level inputs):

	Level I	Level II	Level III	Total
December 31, 2020				
Pension Benefit Assets:				
Equity securities:				
U.S. securities	$ 710	$ —	$ —	$ 710
Foreign securities	238	—	—	238
Mutual funds	42	—	—	42
Fixed maturity securities:				
Government securities	—	237	—	237
Corporate securities	—	394	—	394
Asset-backed securities	—	137	—	137
Other types of investments:				
Commingled fund	—	112	—	112
Insurance company contracts	—	—	189	189
Total pension benefit assets at fair value	$ 990	$ 880	$ 189	2,059
Partnership investments				74
Total pension benefit assets				$ 2,133
Other Benefit Assets:				
Equity securities:				
U.S. securities	$ 9	$ —	$ —	$ 9
Foreign securities	3	—	—	3
Mutual funds	23	—	—	23
Fixed maturity securities:				
Government securities	—	2	—	2
Corporate securities	—	4	—	4
Asset-backed securities	—	3	—	3
Other types of investments:				
Commingled fund	—	2	—	2
Life insurance contracts	—	—	323	323
Investment in DOL 103-12 trust	—	11	—	11
Total other benefit assets	$ 35	$ 22	$ 323	$ 380

The fair values of our pension benefit assets and other benefit assets by asset category and level inputs at December 31, 2019, excluding cash, investment income receivable and amounts due to/from brokers, resulting in a net asset of $64, are as follows:

	Level I	Level II	Level III	Total
December 31, 2019				
Pension Benefit Assets:				
Equity securities:				
U.S. securities	$ 626	$ —	$ —	$ 626
Foreign securities	197	—	—	197
Mutual funds	38	—	—	38
Fixed maturity securities:				
Government securities	—	252	—	252
Corporate securities	—	339	—	339
Asset-backed securities	—	163	—	163
Other types of investments:				
Insurance company contracts	—	—	175	175
Commingled fund	—	136	—	136
Total pension benefit assets at fair value	$ 861	$ 890	$ 175	1,926
Partnership investments				52
Total pension benefit assets				$ 1,978
Other Benefit Assets:				
Equity securities:				
U.S. securities	$ 8	$ —	$ —	$ 8
Foreign securities	2	—	—	2
Mutual funds	25	—	—	25
Fixed maturity securities:				
Government securities	—	2	—	2
Corporate securities	—	4	—	4
Asset-backed securities	—	3	—	3
Other types of investments:				
Life insurance contracts	—	—	294	294
Investment in DOL 103-12 trust	—	12	—	12
Commingled fund	—	1	—	1
Total other benefit assets at fair value	$ 35	$ 22	$ 294	$ 351

A reconciliation of the beginning and ending balances of plan assets measured at fair value using Level III inputs for the years ended December 31, 2020, 2019 and 2018 is as follows:

	Insurance Company Contracts	Life Insurance Contracts	Total
Year ended December 31, 2020			
Beginning balance at January 1, 2020	$ 175	$ 294	$ 469
Actual return on plan assets relating to assets still held at the reporting date	7	29	36
Purchases	15	—	15
Sales	(8)	—	(8)
Ending balance at December 31, 2020	$ 189	$ 323	$ 512
Year ended December 31, 2019			
Beginning balance at January 1, 2019	$ 166	$ 249	$ 415
Actual return on plan assets relating to assets still held at the reporting date	12	45	57
Purchases	6	—	6
Sales	(9)	—	(9)
Ending balance at December 31, 2019	$ 175	$ 294	$ 469
Year ended December 31, 2018			
Beginning balance at January 1, 2018	$ 173	$ 269	$ 442
Actual return on plan assets relating to assets still held at the reporting date	(7)	(15)	(22)
Purchases	8	—	8
Sales	(8)	(5)	(13)
Ending balance at December 31, 2018	$ 166	$ 249	$ 415

There were no other transfers into or out of Level III during the years ended December 31, 2020, 2019 or 2018.

Our current funding strategy is to fund an amount at least equal to the minimum required funding as determined under ERISA with consideration of maximum tax deductible amounts. We may elect to make discretionary contributions up to the maximum amount deductible for income tax purposes. For the years ended December 31, 2020, 2019 and 2018, no material contributions were necessary to meet ERISA required funding levels. However, during each of the years ended December 31, 2020, 2019 and 2018, we made tax deductible discretionary contributions to the pension benefit plans of $7, $4, and $4. Employer contributions to other benefit plans represent discretionary contributions and do not include payments to retirees for current benefits.

Our estimated future payments for pension benefits and postretirement benefits, which reflect expected future service, as appropriate, are as follows:

	Pension Benefits	Other Benefits
2021	$ 131	$ 35
2022	128	34
2023	126	32
2024	121	31
2025	119	30
2026 - 2030	552	125

In addition to the defined benefit plans, we maintain the Anthem 401(k) Plan, which is a qualified defined contribution plan covering substantially all employees. Voluntary employee contributions are matched by us subject to certain limitations. Contributions made by us totaled $221, $201 and $211 during 2020, 2019 and 2018, respectively. Contributions in 2018 include approximately $58 for a one time contribution made to employees following the enactment of the Tax Cuts and Jobs Act.

12. Medical Claims Payable

A reconciliation of the beginning and ending balances for medical claims payable, by segment (see Note 20, "Segment Information"), for the year ended December 31, 2020 is as follows:

	Commercial & Specialty Business	Government Business	Other	Total
Gross medical claims payable, beginning of year	$ 3,039	$ 5,608	$ —	$ 8,647
Ceded medical claims payable, beginning of year	(14)	(19)	—	(33)
Net medical claims payable, beginning of year	3,025	5,589	—	8,614
Business combinations and purchase adjustments	—	141	198	339
Net incurred medical claims:				
Current year	24,894	58,912	1,288	85,094
Prior years redundancies	(375)	(262)	—	(637)
Total net incurred medical claims	24,519	58,650	1,288	84,457
Net payments attributable to:				
Current year medical claims	21,736	51,602	1,291	74,629
Prior years medical claims	2,527	5,165	—	7,692
Total net payments	24,263	56,767	1,291	82,321
Net medical claims payable, end of year	3,281	7,613	195	11,089
Ceded medical claims payable, end of year	13	33	—	46
Gross medical claims payable, end of year	$ 3,294	$ 7,646	$ 195	$ 11,135

Activity in our Other segment resulted from our acquisition of Beacon.

A reconciliation of the beginning and ending balances for medical claims payable, by segment, for the year ended December 31, 2019 is as follows:

	Commercial & Specialty Business	Government Business	Total
Gross medical claims payable, beginning of year	$ 2,586	$ 4,680	$ 7,266
Ceded medical claims payable, beginning of year	(10)	(24)	(34)
Net medical claims payable, beginning of year	2,576	4,656	7,232
Net incurred medical claims:			
Current year	25,942	52,753	78,695
Prior years redundancies	(190)	(310)	(500)
Total net incurred medical claims	25,752	52,443	78,195
Net payments attributable to:			
Current year medical claims	23,026	47,268	70,294
Prior years medical claims	2,277	4,242	6,519
Total net payments	25,303	51,510	76,813
Net medical claims payable, end of year	3,025	5,589	8,614
Ceded medical claims payable, end of year	14	19	33
Gross medical claims payable, end of year	$ 3,039	$ 5,608	$ 8,647

A reconciliation of the beginning and ending balances for medical claims payable, by segment, for the year ended December 31, 2018 is as follows:

	Commercial & Specialty Business	Government Business	Total
Gross medical claims payable, beginning of year	$ 3,383	$ 4,431	$ 7,814
Ceded medical claims payable, beginning of year	(78)	(27)	(105)
Net medical claims payable, beginning of year	3,305	4,404	7,709
Business combinations and purchase adjustments	—	199	199
Net incurred medical claims:			
Current year	24,094	45,487	69,581
Prior years redundancies	(456)	(474)	(930)
Total net incurred medical claims	23,638	45,013	68,651
Net payments attributable to:			
Current year medical claims	21,633	41,115	62,748
Prior years medical claims	2,734	3,845	6,579
Total net payments	24,367	44,960	69,327
Net medical claims payable, end of year	2,576	4,656	7,232
Ceded medical claims payable, end of year	10	24	34
Gross medical claims payable, end of year	$ 2,586	$ 4,680	$ 7,266

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any period-end are continually reviewed and re-estimated as information regarding actual claims payments, or runout, becomes known. This information is compared to the originally established year end liability. Negative amounts reported for incurred medical claims related to prior years result from claims being settled for amounts less than originally estimated. The prior year redundancy of $637 shown above for the year ended December 31, 2020 represents an estimate

based on paid claim activity from January 1, 2020 to December 31, 2020. Medical claim liabilities are usually described as having a "short tail," which means that they are generally paid within twelve months of the member receiving service from the provider. Accordingly, the majority of the $637 redundancy relates to claims incurred in calendar year 2019.

The following table provides a summary of the two key assumptions having the most significant impact on our incurred but not paid liability estimates for the years ended December 31, 2020, 2019 and 2018, which are the completion and trend factors. These two key assumptions can be influenced by utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations. The impact from COVID-19 on healthcare utilization and medical claims submission patterns has increased estimation uncertainty on our incurred but not reported liability at December 31, 2020. Slowdowns in claims submission patterns and increases in utilization levels for COVID-19 testing and treatment during the fourth quarter of 2020 are the primary factors that lead to the increased estimation uncertainty.

	Favorable Developments by Changes in Key Assumptions		
	2020	2019	2018
Assumed trend factors	$ (599)	$ (325)	$ (515)
Assumed completion factors	(38)	(175)	(415)
Total	$ (637)	$ (500)	$ (930)

The favorable development recognized in 2020 resulted primarily from trend factors in late 2019 developing more favorably than originally expected as well as a smaller contribution from completion factor development.

The favorable development recognized in 2019 resulted primarily from trend in late 2018 developing more favorably than originally expected as well as a smaller but significant contribution from completion factor development.

The favorable development recognized in 2018 resulted from trend and completion factors developing more favorably than originally expected.

The reconciliation of net incurred medical claims to benefit expense included in the consolidated statements of income is as follows:

	Years Ended December 31		
	2020	2019	2018
Net incurred medical claims:			
Commercial & Specialty Business	$ 24,519	$ 25,752	$ 23,638
Government Business	58,650	52,443	45,013
Other	1,288	—	—
Total net incurred medical claims	84,457	78,195	68,651
Quality improvement and other claims expense	3,588	3,591	3,244
Benefit expense	$ 88,045	$ 81,786	$ 71,895

Incurred claims development, net of reinsurance, for the Commercial & Specialty Business for the years ended December 31, 2020, 2019 and 2018 is as follows:

Commercial & Specialty Business	Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Years	**2018 (Unaudited)**	**2019 (Unaudited)**	**2020**
2018 & Prior	$ 26,943	$ 26,753	$ 26,747
2019		25,942	25,572
2020			24,894
Total			$ 77,213

Paid claims development, net of reinsurance, for the Commercial & Specialty Business for the years ended December 31, 2020, 2019 and 2018 is as follows:

Commercial & Specialty Business	Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Years	**2018 (Unaudited)**	**2019 (Unaudited)**	**2020**
2018 & Prior	$ 24,367	$ 26,643	$ 26,721
2019		23,026	25,475
2020			21,736
Total			$ 73,932

At December 31, 2020, the total of incurred but not reported liabilities plus expected development on reported claims for the Commercial & Specialty Business was $26, $97 and $3,158 for the claim years 2018 and prior, 2019 and 2020, respectively.

At December 31, 2020, the cumulative number of reported claims for the Commercial & Specialty Business was 93, 87 and 74 for the claim years 2018 and prior, 2019 and 2020, respectively.

Incurred claims development, net of reinsurance, for the Government Business as of and for the years ended December 31, 2020, 2019 and 2018 is as follows:

Government Business	Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Years	**2018 (Unaudited)**	**2019 (Unaudited)**	**2020**
2018 & Prior	$ 49,616	$ 49,306	$ 49,278
2019		52,753	52,518
2020			59,053
Total			$ 160,849

Paid claims development, net of reinsurance, for the Government Business as of and for the years ended December 31, 2020, 2019 and 2018 is as follows:

Government Business	Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Years	**2018 (Unaudited)**	**2019 (Unaudited)**	**2020**
2018 & Prior	$ 44,959	$ 49,201	$ 49,231
2019		47,269	52,403
2020			51,602
Total			$ 153,236

At December 31, 2020, the total of incurred but not reported liabilities plus expected development on reported claims for the Government Business was $47, $115 and $7,451 for the claim years 2018 and prior, 2019 and 2020, respectively.

At December 31, 2020, the cumulative number of reported claims for the Government Business was 225, 241 and 236 for the claim years 2018 and prior, 2019 and 2020, respectively.

Incurred claims development, net of reinsurance, for Other as of and for the years ended December 31, 2020, 2019 and 2018 is as follows:

Other	Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Years	**2018 (Unaudited)**	**2019 (Unaudited)**	**2020**
2018 & Prior	$ —	$ —	$ —
2019		—	—
2020			1,486
Total			$ 1,486

Paid claims development, net of reinsurance, for Other as of and for the years ended December 31, 2020, 2019 and 2018 is as follows:

Other	Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Years	**2018 (Unaudited)**	**2019 (Unaudited)**	**2020**
2018 & Prior	$ —	$ —	$ —
2019		—	—
2020			1,291
Total			$ 1,291

At December 31, 2020, the total of incurred but not reported liabilities plus expected development on reported claims for Other was $0, $0 and $195 for the claim years 2018 and prior, 2019 and 2020, respectively.

At December 31, 2020, the cumulative number of reported claims for Other was $0, $0, and $27 for the claim years 2018 and prior, 2019 and 2020, respectively.

The information about incurred claims development, paid claims development and cumulative number of reported claims for the years ended December 31, 2018 and 2019 for our Commercial & Specialty Business, Government Business and Other, is unaudited and presented as supplementary information.

The cumulative number of reported claims for each claim year for our Commercial & Specialty Business, Government Business and Other have been developed using historical data captured by our claim payment systems. The provided claim

amounts are not a precise tool for understanding utilization of medical services. They could be impacted by a variety of factors including changes in provider billing practices, provider reimbursement arrangements, mix of services, benefit design or processing systems. The cumulative number of reported claims has been provided to comply with FASB accounting standards and is not used by management in its claims analysis. Our cumulative number of reported claims may not be comparable to similar measures reported by other health benefits companies.

The reconciliation of the Commercial & Specialty Business, Government Business and Other incurred and paid claims development information for the three years ended December 31, 2020, reflected in the tables above, to the consolidated ending balance for medical claims payable included in the consolidated balance sheet, as of December 31, 2020, is as follows:

	Commercial & Specialty Business	Government Business	Other	Total
Cumulative incurred claims and allocated claim adjustment expenses, net of reinsurance	$ 77,213	$ 160,849	$ 1,486	$ 239,548
Less: Cumulative paid claims and allocated claim adjustment expenses, net of reinsurance	73,932	153,236	1,291	228,459
Net medical claims payable, end of year	3,281	7,613	195	11,089
Ceded medical claims payable, end of year	13	33	—	46
Insurance lines other than short duration	—	224	—	224
Gross medical claims payable, end of year	$ 3,294	$ 7,870	$ 195	$ 11,359

13. Debt

Short-term Borrowings

We are a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati, the Federal Home Loan Bank of Atlanta and the Federal Home Loan Bank of New York, (collectively, the “FHLBs”). As a member we have the ability to obtain short-term cash advances, subject to certain minimum collateral requirements. At December 31, 2020 and 2019, $0 and $650, respectively, were outstanding under our short-term FHLB borrowings. Outstanding short-term FHLB borrowings at December 31, 2019 had fixed interest rates of 1.664%.

Through certain subsidiaries, we have entered into multiple 364-day lines of credit (the “Subsidiary Credit Facilities”) with separate lenders for general corporate purposes. The Subsidiary Credit Facilities provide combined credit of up to $300. The interest rate on each line of credit is based on the LIBOR rate plus a predetermined rate. Our ability to borrow under the lines of credit is subject to compliance with certain covenants. At December 31, 2020 and 2019, $0 and $50, respectively, were outstanding under our Subsidiary Credit Facilities.

Long-term Debt

The carrying value of long-term debt at December 31, 2020 and 2019 consists of the following:

	2020	2019
Senior unsecured notes:		
2.500%, due 2020	$ —	$ 899
4.350%, due 2020	—	699
3.700%, due 2021	700	699
2.950%, due 2022	749	747
3.125%, due 2022	848	847
3.300%, due 2023	1,027	1,013
3.350%, due 2024	847	846
3.500%, due 2024	796	795
2.375%, due 2025	1,253	845
3.650%, due 2027	1,591	1,590
4.101%, due 2028	1,257	1,253
2.875%, due 2029	819	819
2.250%, due 2030	1,089	—
5.950%, due 2034	334	334
5.850%, due 2036	396	396
6.375%, due 2037	366	366
5.800%, due 2040	114	124
4.625%, due 2042	873	888
4.650%, due 2043	978	987
4.650%, due 2044	779	792
5.100%, due 2044	565	594
4.375%, due 2047	1,387	1,386
4.550%, due 2048	839	838
3.700%, due 2049	811	811
3.125%, due 2050	987	—
4.850%, due 2054	247	247
Surplus note:		
9.000%, due 2027	25	25
Senior convertible debentures:		
2.750%, due 2042	108	145
Variable rate debt:		
Commercial paper program	250	400
Total long-term debt	20,035	19,385
Current portion of long-term debt	(700)	(1,598)
Long-term debt, less current portion	$ 19,335	$ 17,787

All debt is a direct obligation of Anthem, Inc., except for the surplus note, the FHLB borrowings and the Subsidiary Credit Facilities.

We generally issue senior unsecured notes ("Notes") for long-term borrowing purposes. Certain of these Notes may have a call feature that allows us to redeem the Notes at any time at our option and/or a put feature that allows a Note holder to redeem the Notes upon the occurrence of both a change in control event and a downgrade of the Notes below an investment grade rating.

On November 23, 2020, we repaid, at maturity, the $900 outstanding balance of our 2.500% senior unsecured notes. On August 17, 2020, we repaid, at maturity, the $700 outstanding balance of our 4.350% senior unsecured notes.

Additionally, during the year ended December 31, 2020, we repurchased $79 of outstanding principal amount of certain other senior unsecured notes, plus applicable premium for early redemption plus accrued and unpaid interest, for cash totaling $109. We recognized a loss on extinguishment of debt of $30 for the repurchase of these notes.

On May 5, 2020, we issued $400 aggregate principal amount of additional senior notes pursuant to a reopening of our existing 2.375% Notes due 2025 (the "2025 Notes"), $1,100 aggregate principal amount of 2.250% Notes due 2030 (the "2030 Notes"), and $1,000 aggregate principal amount of 3.125% Notes due 2050 (the "2050 Notes") under our shelf registration statement. The 2025 Notes constitute an additional issuance of our 2.375% notes due 2025, of which $850 aggregate principal amount was issued on September 9, 2019. Interest on the 2025 Notes is deemed to have accrued from January 15, 2020 and is payable semi-annually in arrears on January 15 and July 15 of each year, commencing July 15, 2020. Interest on the 2030 Notes and 2050 Notes is payable semi-annually in arrears on May 15 and November 15 of each year, commencing November 15, 2020. The proceeds were used for working capital and general corporate purposes, including, but not limited to, repayment of short-term and long-term debt, repurchase of our common stock pursuant to our share repurchase program and to fund acquisitions.

On September 9, 2019, we issued $850 aggregate principal amount of the 2025 Notes, $825 aggregate principal amount of 2.875% Notes due 2029 (the "2029 Notes"), and $825 aggregate principal amount of 3.700% Notes due 2049 (the "2049 Notes") under our shelf registration statement. Interest on the 2025 Notes is payable semi-annually in arrears on January 15 and July 15 of each year, commencing January 15, 2020. Interest on the 2029 Notes and the 2049 Notes is payable semi-annually in arrears on March 15 and September 15 each year, commencing March 15, 2020. The proceeds were used for working capital and general corporate purposes, including, but not limited to, the repurchase of our common stock pursuant to our share repurchase program, repayment of short-term and long-term debt and to fund acquisitions.

On August 15, 2019, we repaid, at maturity, the $850 outstanding balance of our 2.250% senior unsecured notes.

On July 16, 2018, we repaid, at maturity, the $650 outstanding balance of our 2.300% senior unsecured notes. On January 15, 2018, we repaid, at maturity, the $625 outstanding balance of our 1.875% senior unsecured notes.

On May 1, 2018, we settled our Equity Units stock purchase contracts at a settlement rate of 0.2412 shares of our common stock, using a market value formula set forth in the Equity Units purchase contracts. This resulted in the issuance of approximately 6 shares. We had issued 25 Equity Units on May 12, 2015, pursuant to an underwriting agreement dated May 6, 2015, in an aggregate principal amount of $1,250. Each Equity Unit had a stated amount of $50 (whole dollars) and consisted of a purchase contract obligating the holder to purchase a certain number of shares of our common stock on May 1, 2018, subject to earlier termination or settlement, for a price in cash of $50 (whole dollars); and a 5% undivided beneficial ownership interest in $1,000 (whole dollars) principal amount of our 1.900% remarketable subordinated notes ("RSNs"), due 2028. On March 2, 2018, we remarketed the RSNs and used the proceeds to purchase U.S. Treasury securities that were pledged to secure the stock purchase obligations of the holders of the Equity Units. The purchasers of the RSNs transferred the RSNs to us in exchange for $1,250 principal amount of our 4.101% senior notes due 2028 (the "2028 Notes"), and a cash payment of $4. We canceled the RSNs upon receipt and recognized a loss on extinguishment of debt of $18. At the remarketing, we also issued $850 aggregate principal amount of 4.550% notes due 2048 (the "2048 Notes") under our shelf registration statement. We used the proceeds from the 2048 Notes for working capital and general corporate purposes. Interest on the 2028 Notes and the 2048 Notes is payable semi-annually in arrears on March 1 and September 1 of each year, commencing on September 1, 2018.

The surplus note is an unsecured obligation of Anthem Insurance Companies, Inc. ("Anthem Insurance"), a wholly owned subsidiary, and is subordinate in right of payment to all of Anthem Insurance's existing and future indebtedness. Any payment of interest or principal on the surplus note may be made only with the prior approval of the Indiana Department of

Insurance ("IDOI") and only out of capital and surplus funds of Anthem Insurance that the IDOI determines to be available for the payment under Indiana insurance laws.

We have a senior revolving credit facility (the "5-Year Facility") with a group of lenders for general corporate purposes. The 5-Year Facility provides credit up to $2,500 and matures in June 2024. We also have a 364-day senior revolving credit facility (the "364-Day Facility") with a group of lenders for general corporate purposes, which provides for credit in the amount of $1,000. In May 2020, we amended and extended the 364-Day Facility, which now matures in June 2021. Our ability to borrow under these credit facilities is subject to compliance with certain covenants, including covenants requiring us to maintain a defined debt-to-capital ratio of not more than 60%, subject to increase in certain circumstances set forth in the applicable credit agreement. As of December 31, 2020, our debt-to-capital ratio, as defined and calculated under the credit facilities, was 37.6%. We do not believe the restrictions contained in any of our credit facility covenants materially affect our financial or operating flexibility. As of December 31, 2020, we were in compliance with all of the debt covenants under these credit facilities. There were no amounts outstanding under the 364-Day Facility at any time during the years ended December 31, 2020 or the year ended December 31, 2019. At December 31, 2020 and December 31, 2019, there were no amounts outstanding under our 5-Year Facility.

We have an authorized commercial paper program of up to $3,500, the proceeds of which may be used for general corporate purposes. At December 31, 2020, we had $250 outstanding under our commercial paper program with a weighted-average interest rate of 0.1600%. At December 31, 2019, we had $400 outstanding under our commercial paper program with a weighted-average interest rate of 1.8528%. Commercial paper borrowings have been classified as long-term debt at December 31, 2020 and 2019, as our general practice and intent is to replace short-term commercial paper outstanding at expiration with additional short-term commercial paper for an uninterrupted period extending for more than one year, and we have the ability to redeem our commercial paper with borrowings under the senior revolving credit facilities described above.

Convertible Debentures

On October 9, 2012, we issued $1,500 of senior convertible debentures (the "Debentures") in a private offering to qualified institutional buyers pursuant to Rule 144A under the Securities Act of 1933, as amended (the "Securities Act"). The Debentures are governed by an indenture dated as of October 9, 2012 between us and The Bank of New York Mellon Trust Company, N.A., as trustee (the "Indenture"). The Debentures bear interest at a rate of 2.750% per year, payable semi-annually in arrears in cash on April 15 and October 15 of each year, and mature on October 15, 2042, unless earlier redeemed, repurchased or converted into shares of common stock at the applicable conversion rate. The Debentures also have a contingent interest feature that will require us to pay additional interest based on certain thresholds and for certain events, as defined in the Indenture, beginning on October 15, 2022.

Holders may convert their Debentures at their option prior to the close of business on the business day immediately preceding April 15, 2042, only under the following circumstances: (1) during any fiscal quarter if the last reported sale price of our common stock for at least 20 trading days during a period of 30 consecutive trading days ending on the last trading day of the preceding fiscal quarter is greater than or equal to 130% of the applicable conversion price on each applicable trading day; (2) during the five business day period after any 10 consecutive trading day period (the "measurement period") in which the trading price per $1,000 (whole dollars) principal amount of Debentures for each trading day of that measurement period was less than 98% of the product of the last reported sale price of our common stock and the applicable conversion rate on each such day; (3) if we call any or all of the Debentures for redemption, at any time prior to the close of business on the third scheduled trading day prior to the redemption date; or (4) upon the occurrence of specified corporate events, as defined in the Indenture. On and after April 15, 2042 and until the close of business on the third scheduled trading day immediately preceding the Debentures' maturity date of October 15, 2042, holders may convert their Debentures into common stock at any time irrespective of the preceding circumstances. The Debentures are redeemable at our option at any time on or after October 20, 2022, upon the occurrence of certain events, as defined in the Indenture.

Upon conversion of the Debentures, we will deliver cash up to the aggregate principal amount of the Debentures converted. With respect to any conversion obligation in excess of the aggregate principal amount of the Debentures converted, we have the option to settle the excess with cash, shares of our common stock or a combination thereof based on a daily conversion value, determined in accordance with the Indenture. The initial conversion rate for the Debentures was 13.2319 shares of our common stock per Debenture, which represented a 25% conversion premium based on the closing price of $60.46 per share of our common stock on October 2, 2012 (the date the Debentures' terms were finalized) and is equivalent to an initial conversion price of $75.575 per share of our common stock.

During the year ended December 31, 2020, $56 aggregate principal amount of the Debentures was surrendered for conversion by certain holders in accordance with the terms and provisions of the Indenture. We elected to settle the excess of the principal amount of the conversions with cash for total payments of $222. We recognized a loss on the extinguishment of debt related to the Debentures of $6, based on the fair values of the debt on the conversion settlement dates. During the year ended December 31, 2019, we repurchased $15 of the aggregate principal balance of the Debentures. In addition, $57 aggregate principal amount of the Debentures was surrendered for conversion by certain holders in accordance with the terms and provisions of the Indenture. We elected to settle the excess of the principal amount of the repurchases and conversions with cash for total payments of $273. We recognized a loss on the extinguishment of debt related to the Debentures of $2. During the year ended December 31, 2018, $109 aggregate principal amount of the Debentures was surrendered for conversion. We elected to settle the excess of the principal amount of the conversions with cash for total payments of $402. We recognized a gain on the extinguishment of debt related to the Debentures of $7.

As of December 31, 2020, our common stock was last traded at a price of $321.09 per share. If the remaining Debentures had been converted or matured at December 31, 2020, we would have been obligated to pay the principal of the Debentures plus an amount in cash or shares equal to $560. The Debentures and underlying shares of our common stock have not been and will not be registered under the Securities Act, or any state securities laws, and may not be offered or sold in the United States absent registration or an applicable exemption from registration requirements.

We have accounted for the Debentures in accordance with the cash conversion guidance in FASB guidance for debt with conversion and other options. As a result, the value of the embedded conversion option, net of deferred taxes and equity issuance costs, has been bifurcated from its debt host and recorded as a component of additional paid-in capital in our consolidated balance sheets.

The following table summarizes, at December 31, 2020, the related balances, conversion rate and conversion price of the Debentures:

Outstanding principal amount	$	159
Unamortized debt discount	$	49
Net debt carrying amount	$	108
Equity component carrying amount	$	58
Conversion rate (shares of common stock per $1,000 of principal amount)		14.0808
Effective conversion price (per $1,000 of principal amount)	$	71.0187

The remaining amortization period of the unamortized debt discount as of December 31, 2020 is approximately 22 years. The unamortized discount will be amortized into interest expense using the effective interest method based on an effective interest rate of 5.130%, which represents the market interest rate for a comparable debt instrument that does not have a conversion feature. During the years ended December 31, 2020, 2019 and 2018, we recognized $6, $9 and $12, respectively, of interest expense related to the Debentures, of which $5, $7 and $10, respectively, represented interest expense recognized at the stated interest rate of 2.750% and $1, $2 and $2, respectively, represented interest expense resulting from amortization of the debt discount.

Total interest paid during 2020, 2019 and 2018 was $794, $755, and $728, respectively.

We were in compliance with all applicable covenants under all of our outstanding debt agreements at December 31, 2020 and 2019.

Future maturities of all long-term debt outstanding at December 31, 2020 are as follows: 2021, $950; 2022, $1,597; 2023, $1,027; 2024, $1,643; 2025, $1,253 and thereafter, $13,565.

14. Commitments and Contingencies

Litigation and Regulatory Proceedings

In the ordinary course of business, we are defendants in, or parties to, a number of pending or threatened legal actions or proceedings. To the extent a plaintiff or plaintiffs in the following cases have specified in their complaint or in other court

filings the amount of damages being sought, we have noted those alleged damages in the descriptions below. With respect to the cases described below, we contest liability and/or the amount of damages in each matter and believe we have meritorious defenses.

Where available information indicates that it is probable that a loss has been incurred as of the date of the consolidated financial statements and we can reasonably estimate the amount of that loss, we accrue the estimated loss by a charge to income. In many proceedings, however, it is difficult to determine whether any loss is probable or reasonably possible. In addition, even where loss is possible or an exposure to loss exists in excess of the liability already accrued with respect to a previously identified loss contingency, it is not always possible to reasonably estimate the amount of the possible loss or range of loss.

With respect to many of the proceedings to which we are a party, we cannot provide an estimate of the possible losses, or the range of possible losses in excess of the amount, if any, accrued, for various reasons, including but not limited to some or all of the following: (i) there are novel or unsettled legal issues presented, (ii) the proceedings are in early stages, (iii) there is uncertainty as to the likelihood of a class being certified or decertified or the ultimate size and scope of the class, (iv) there is uncertainty as to the outcome of pending appeals or motions, (v) there are significant factual issues to be resolved, and/or (vi) in many cases, the plaintiffs have not specified damages in their complaint or in court filings. For those legal proceedings where a loss is probable, or reasonably possible, and for which it is possible to reasonably estimate the amount of the possible loss or range of losses, we currently believe that the range of possible losses, in excess of established reserves is, in the aggregate, from $0 to approximately $250 at December 31, 2020. This estimated aggregate range of reasonably possible losses is based upon currently available information taking into account our best estimate of such losses for which such an estimate can be made.

Blue Cross Blue Shield Antitrust Litigation

We are a defendant in multiple lawsuits that were initially filed in 2012 against the BCBSA and Blue Cross and/or Blue Shield licensees (the “Blue plans”) across the country. Cases filed in twenty-eight states were consolidated into a single, multi-district proceeding captioned *In re Blue Cross Blue Shield Antitrust Litigation* that is pending in the United States District Court for the Northern District of Alabama (the “Court”). Generally, the suits allege that the BCBSA and the Blue plans have conspired to horizontally allocate geographic markets through license agreements, best efforts rules that limit the percentage of non-Blue revenue of each plan, restrictions on acquisitions, rules governing the BlueCard® and National Accounts programs and other arrangements in violation of the Sherman Antitrust Act (“Sherman Act”) and related state laws. The cases were brought by two putative nationwide classes of plaintiffs, health plan subscribers and providers.

In response to cross motions for partial summary judgment by plaintiffs and defendants, the Court issued an order in April 2018 determining that the defendants’ aggregation of geographic market allocations and output restrictions are to be analyzed under a per se standard of review, and the BlueCard® program and other alleged Section 1 Sherman Act violations are to be analyzed under the rule of reason standard of review. The Court also found that there remain genuine issues of material fact as to whether the defendants operate as a single entity with regard to the enforcement of the Blue Cross Blue Shield trademarks. In April 2019, plaintiffs filed their motions for class certification in conjunction with their supporting expert reports, and the defendants filed their motions to exclude plaintiffs’ experts, as well as their opposition to plaintiffs’ motions for class certification, in July 2019.

The BCBSA and Blue plans have approved a settlement agreement and release (the “Subscriber Settlement Agreement”) with the subscriber plaintiffs. If approved by the Court, the Subscriber Settlement Agreement will require the defendants to make a monetary settlement payment, our portion of which is estimated to be $594, and will contain certain non-monetary terms including (i) eliminating the “national best efforts” rule in the BCBSA license agreements (which rule limits the percentage of non-Blue revenue permitted for each Blue plan) and (ii) allowing for some large national employers with self-funded benefit plans to request a bid for insurance coverage from a second Blue plan in addition to the local Blue plan. We recognized our estimated payment obligation of $548, net of third party insurance coverage received as of December 31, 2020.

On November 30, 2020, the Court issued an order preliminarily approving the Subscriber Settlement Agreement, following which members of the Subscriber class were provided notice of the Settlement Agreement and an opportunity to opt out of the class. All terms of the Subscriber Settlement Agreement are subject to final approval by the Court before they

become effective. Objections to the settlement as well as the deadline for those that wish to opt-out from the settlement must be submitted by July 28, 2021. Claims must be filed by November 5, 2021. A final approval hearing has been scheduled for October 20, 2021. If the Court grants approval of the Subscriber Settlement Agreement, and after all appellate rights have expired or have been exhausted in a manner that affirms the Court's final order and judgment, the defendants' payment and non-monetary obligations under the Subscriber Settlement Agreement will become effective.

In October 2020, after the Court lifted the stay as to the provider litigation, provider plaintiffs filed a renewed motion for class certification, and defendants filed an opposition to that motion. We intend to continue to vigorously defend the provider suit; however, its ultimate outcome cannot be presently determined.

Blue Cross of California Taxation Litigation

In July 2013, our California affiliate Blue Cross of California (doing business as Anthem Blue Cross) ("BCC") was named as a defendant in a California taxpayer action filed in Los Angeles County Superior Court (the "Superior Court") captioned *Michael D. Myers v. State Board of Equalization, et al.* This action was brought under a California statute that permits an individual taxpayer to sue a governmental agency when the taxpayer believes the agency has failed to enforce governing law. Plaintiff contends that BCC, a licensed Health Care Service Plan, is an "insurer" for purposes of taxation despite acknowledging it is not an "insurer" under regulatory law. At the time, under California law, "insurers" were required to pay a gross premiums tax ("GPT") calculated as 2.35% on gross premiums. As a licensed Health Care Service Plan, BCC has paid the California Corporate Franchise Tax ("CFT"), the tax paid by California businesses generally. Plaintiff contends that BCC must pay the GPT rather than the CFT, and seeks a writ of mandate directing the taxing agencies to collect the GPT and an order requiring BCC to pay GPT back taxes, interest, and penalties for the eight-year period prior to the filing of the complaint.

Because the GPT is constitutionally imposed in lieu of certain other taxes, BCC has filed protective tax refund claims with the City of Los Angeles, the California Department of Health Care Services and the Franchise Tax Board to protect its rights to recover certain taxes previously paid should BCC eventually be determined to be subject to the GPT for the tax periods at issue in the litigation.

In March 2018, the Superior Court denied BCC's motion for judgment on the pleadings and similar motions brought by other entities. BCC filed a motion for summary judgment with the Superior Court, which was heard in October 2020. In December 2020, the Superior Court granted BCC's motion for summary judgment, dismissing the plaintiff's lawsuit. We intend to vigorously defend any appeal of this lawsuit.

Express Scripts, Inc. Pharmacy Benefit Management Litigation

In March 2016, we filed a lawsuit against Express Scripts, Inc. ("Express Scripts"), our vendor at the time for PBM services, captioned *Anthem, Inc. v. Express Scripts, Inc.*, in the U.S. District Court for the Southern District of New York. The lawsuit seeks to recover over $14,800 in damages for pharmacy pricing that is higher than competitive benchmark pricing under the agreement between the parties (the "ESI PBM Agreement"), over $158 in damages related to operational breaches, as well as various declarations under the ESI PBM Agreement, including that Express Scripts: (i) breached its obligation to negotiate in good faith and to agree in writing to new pricing terms; (ii) was required to provide competitive benchmark pricing to us through the term of the ESI PBM Agreement; (iii) has breached the ESI PBM Agreement; and (iv) is required under the ESI PBM Agreement to provide post-termination services, at competitive benchmark pricing, for one year following any termination.

Express Scripts has disputed our contractual claims and is seeking declaratory judgments: (i) regarding the timing of the periodic pricing review under the ESI PBM Agreement, and (ii) that it has no obligation to ensure that we receive any specific level of pricing, that we have no contractual right to any change in pricing under the ESI PBM Agreement and that its sole obligation is to negotiate proposed pricing terms in good faith. In the alternative, Express Scripts claims that we have been unjustly enriched by its payment of $4,675 at the time we entered into the ESI PBM Agreement. In March 2017, the court granted our motion to dismiss Express Scripts' counterclaims for (i) breach of the implied covenant of good faith and fair dealing, and (ii) unjust enrichment with prejudice. The only remaining claims are for breach of contract and declaratory relief. Rebuttal expert reports were submitted in October 2020, discovery must be completed in April 2021, and motions for summary judgment must be filed in May 2021. We intend to vigorously pursue our claims and defend against any counterclaims, which we believe are without merit; however, the ultimate outcome cannot be presently determined.

In re Express Scripts/Anthem ERISA Litigation

We are a defendant in a class action lawsuit that was initially filed in June 2016 against Anthem, Inc. and Express Scripts, which has been consolidated into a single multi-district lawsuit captioned *In Re Express Scripts/Anthem ERISA Litigation,* in the U.S. District Court for the Southern District of New York. The consolidated complaint was filed by plaintiffs against Express Scripts and us on behalf of all persons who are participants in or beneficiaries of any ERISA or non-ERISA healthcare plan from December 1, 2009 to December 31, 2019 in which we provided prescription drug benefits through the ESI PBM Agreement and paid a percentage based co-insurance payment in the course of using that prescription drug benefit. The plaintiffs allege that we breached our duties, either under ERISA or with respect to the implied covenant of good faith and fair dealing implied in the health plans, (i) by failing to adequately monitor Express Scripts' pricing under the ESI PBM Agreement, (ii) by placing our own pecuniary interest above the best interests of our insureds by allegedly agreeing to higher pricing in the ESI PBM Agreement in exchange for the purchase price for our NextRx PBM business, and (iii) with respect to the non-ERISA members, by negotiating and entering into the ESI PBM Agreement that was allegedly detrimental to the interests of such non-ERISA members. Plaintiffs seek to hold us and Express Scripts jointly and severally liable and to recover all losses suffered by the proposed class, equitable relief, disgorgement of alleged ill-gotten gains, injunctive relief, attorney's fees and costs and interest.

In April 2017, we filed a motion to dismiss the claims brought against us, and it was granted, without prejudice, in January 2018. Plaintiffs filed a notice of appeal with the United States Court of Appeals for the Second Circuit (the "Second Circuit"), which was heard in October 2018. In December 2020, the Second Circuit affirmed the trial court's decision dismissing the ERISA complaint. Plaintiffs have filed a Petition for Rehearing and Rehearing En Banc. We intend to vigorously defend this suit; however, its ultimate outcome cannot be presently determined.

Cigna Corporation Merger Litigation

In July 2015, we and Cigna Corporation ("Cigna") announced that we entered into the Cigna Agreement and Plan of Merger ("Cigna Merger Agreement") pursuant to which we would acquire all outstanding shares of Cigna. In July 2016, the U.S. Department of Justice ("DOJ") along with certain state attorneys general, filed a civil antitrust lawsuit in the U.S. District Court for the District of Columbia ("District Court") seeking to block the merger. In February 2017, Cigna purported to terminate the Cigna Merger Agreement and commenced litigation against us in the Delaware Court of Chancery ("Delaware Court") seeking damages, including the $1,850 termination fee pursuant to the terms of the Cigna Merger Agreement, and a declaratory judgment that its purported termination of the Cigna Merger Agreement was lawful, among other claims, which is captioned *Cigna Corp. v. Anthem Inc.*

Also in February 2017, we initiated our own litigation against Cigna in the Delaware Court seeking a temporary restraining order to enjoin Cigna from terminating the Cigna Merger Agreement, specific performance compelling Cigna to comply with the Cigna Merger Agreement and damages, which is captioned *Anthem Inc. v. Cigna Corp*. In April 2017, the U.S. Circuit Court of Appeals for the District of Columbia affirmed the ruling of the District Court, which blocked the merger. In May 2017, after the Delaware Court denied our motion to enjoin Cigna from terminating the Cigna Merger Agreement, we delivered to Cigna a notice terminating the Cigna Merger Agreement.

In the Delaware Court litigation, trial commenced in late February 2019 and concluded in March 2019. The Delaware Court held closing arguments in November 2019 and took the matter under consideration. In August 2020, the Delaware Court issued an opinion finding that neither party was owed damages and that we did not owe Cigna the $1,850 termination fee. The Delaware Court issued an order implementing its opinion in October 2020. Cigna filed its notice of appeal in November 2020 challenging the Court's decision that Anthem did not owe Cigna a termination fee. Cigna filed its appellate brief in December 2020, and we filed our response in January 2021. We believe Cigna's allegations are without merit and we intend to vigorously defend against Cigna's allegations; however, the ultimate outcome of the appeal of this litigation with Cigna cannot be presently determined.

In October 2018, a shareholder filed a derivative lawsuit in the State of Indiana Marion County Superior Court, captioned *Henry Bittmann, Derivatively, et al. v. Joseph R Swedish, et al.*, purportedly on behalf of us and our shareholders against certain current and former directors and officers alleging breaches of fiduciary duties, unjust enrichment and corporate waste associated with the Cigna Merger Agreement. This case has been stayed at the request of the parties pending

the outcome of our litigation with Cigna in the Delaware Court. This lawsuit's ultimate outcome cannot be presently determined.

Medicare Risk Adjustment Litigation

In March 2020, the DOJ filed a civil lawsuit against Anthem, Inc. in the U.S. District Court for the Southern District of New York in a case captioned *United States v. Anthem, Inc*. The DOJ's suit alleges, among other things, that we falsely certified the accuracy of the diagnosis data we submitted to the Centers for Medicare and Medicaid Services ("CMS") for risk-adjustment purposes under Medicare Part C and knowingly failed to delete inaccurate diagnosis codes. The DOJ further alleges that, as a result of these purported acts, we caused CMS to calculate the risk-adjustment payments based on inaccurate diagnosis information, which enabled us to obtain unspecified amounts of payments in Medicare funds in violation of the False Claims Act. The DOJ filed an amended complaint in July 2020, alleging the same causes of action but revising some of its allegations. In September 2020, we filed a motion to transfer the lawsuit to the Southern District of Ohio, a motion to dismiss part of the lawsuit, and a motion to strike certain allegations in the amended complaint. The motions are fully briefed and no decision has been rendered. We intend to continue to vigorously defend this suit; however, the ultimate outcome cannot be presently determined.

Investigations of CareMore and HealthSun

With the assistance of outside counsel, we are conducting investigations of risk-adjustment practices involving data submitted to CMS (unrelated to our retrospective chart review program) at CareMore Health Plans, Inc. ("CareMore"), one of our California subsidiaries, and HealthSun Health Plans, Inc. ("HealthSun"), one of our Florida subsidiaries. Our CareMore investigation has resulted in the termination of CareMore's relationship with one contracted provider in California. Our HealthSun investigation focuses on risk adjustment practices initiated prior to our acquisition of HealthSun in December 2017 that continued after the acquisition. We have voluntarily self-disclosed the existence of both of our investigations to CMS and the Criminal Division of the DOJ, which then initiated an investigation. We are cooperating with the government's investigation. We are in the process of analyzing the scope of potential data corrections to be submitted to CMS. We have also asserted indemnity claims for escrowed funds under the HealthSun purchase agreement for, among other things, breach of healthcare and financial representation provisions, based on the conduct discovered during our investigation. We are in active litigation with two groups of sellers regarding part of the escrowed funds in cases captioned *Shareholder Representative Services, LLC v. ATH Holding Company, LLC and Highland Acquisition Holdings, LLC* and *LPPAS Representative, LLC v. ATH Holding Company, LLC,* both pending in the Delaware Court.

Cyber Attack Regulatory Proceedings and Litigation

In February 2015, we reported that we were the target of a sophisticated external cyber attack during which the attackers gained unauthorized access to certain of our information technology systems and obtained personal information related to many individuals and employees. To date, there is no evidence that credit card or medical information was accessed or obtained. Upon discovery of the cyber attack, we took immediate action to remediate the security vulnerability and have continued to implement security enhancements since this incident.

Federal and state agencies have investigated events related to the cyber attack, including how it occurred, its consequences and our responses. In September 2020, we entered into a settlement to resolve the investigation by a multi-state group of attorneys general, which was the final outstanding matter related to the 2015 cyber attack. We have undertaken commitments that align with our ongoing and consistent focus to protect information in addition to a monetary payment of $39, which was fully accrued in a prior period.

We have contingency plans and insurance coverage for certain expenses and potential liabilities of this nature and will pursue coverage for all applicable losses; however, the ultimate outcome of our pursuit of insurance coverage cannot be presently determined.

Other Contingencies

From time to time, we and certain of our subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. We, like HMOs and health insurers generally, exclude certain healthcare and other services from coverage under our HMO, PPO and other plans. We are, in the ordinary course of

business, subject to the claims of our enrollees arising out of decisions to restrict or deny reimbursement for uncovered services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on us. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable reimbursement of coverage claims.

In addition to the lawsuits described above, we are also involved in other pending and threatened litigation of the character incidental to our business, and are from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits, reviews and administrative proceedings include routine and special inquiries by state insurance departments, state attorneys general, the U.S. Attorney General and subcommittees of the U.S. Congress. Such investigations, audits, reviews and administrative proceedings could result in the imposition of civil or criminal fines, penalties, other sanctions and additional rules, regulations or other restrictions on our business operations. Any liability that may result from any one of these actions, or in the aggregate, could have a material adverse effect on our consolidated financial position or results of operations.

Contractual Obligations and Commitments

In March 2020, we entered into an agreement with a vendor for information technology infrastructure and related management and support services through June 2025. The new agreement supersedes certain prior agreements for such services and includes provisions for additional services not provided under those agreements. Our remaining commitment under this agreement at December 31, 2020 is approximately $1,426. We will have the ability to terminate the agreement upon the occurrence of certain events, subject to early termination fees.

Beginning in the second quarter of 2019, we began using our pharmacy benefits manager IngenioRx, Inc. (“IngenioRx”) to market and offer PBM services to our fully-insured and self-funded affiliated health plan customers, as well as to external customers outside of the health plans we own. The comprehensive prescription benefits management services portfolio includes, but is not limited to, formulary management, pharmacy networks, prescription drug database, member services and mail order capabilities. Also in the second quarter of 2019, IngenioRx began delegating certain PBM administrative functions, such as claims processing and prescription fulfillment, to CaremarkPCS Health, L.L.C., which is a subsidiary of CVS Health Corporation, pursuant to a five-year agreement. With IngenioRx, we retain the responsibilities for clinical and formulary strategy and development, member and employer experiences, operations, sales, marketing, account management and retail network strategy.

Vulnerability from Concentrations

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash equivalents, investment securities, premium receivables and instruments held through hedging activities. All investment securities are managed by professional investment managers within policies authorized by our Board of Directors. Such policies limit the amounts that may be invested in any one issuer and prescribe certain investee company criteria. Concentrations of credit risk with respect to premium receivables are limited due to the large number of employer groups that constitute our customer base in the states in which we conduct business. As of December 31, 2020, there were no significant concentrations of financial instruments in a single investee, industry or geographic location.

15. Capital Stock

Stock Incentive Plans

Our Board of Directors has adopted the 2017 Anthem Incentive Compensation Plan (“2017 Incentive Plan”) which has been approved by our shareholders. The term of the 2017 Incentive Plan is such that no awards may be granted on or after May 18, 2027. The 2017 Incentive Plan gives authority to the Compensation Committee of the Board of Directors to make incentive awards to our non-employee directors, employees and consultants, consisting of stock options, stock, restricted stock, restricted stock units, cash-based awards, stock appreciation rights, performance shares and performance units. The 2017 Incentive Plan limits the number of available shares for issuance to 37.5 shares, subject to adjustment as set forth in the 2017 Incentive Plan.

Stock options are granted for a fixed number of shares with an exercise price at least equal to the fair value of the shares at the grant date. Stock options vest over three years in equal annual installments and generally have a term of ten years from the grant date.

Certain option grants contain provisions whereby the employee continues to vest in the award subsequent to termination due to retirement. Our attribution method for newly granted awards considers all vesting and other provisions, including retirement eligibility, in determining the requisite service period over which the fair value of the awards will be recognized.

Awards of restricted stock or restricted stock units are issued at the fair value of the stock on the grant date and may also include one or more performance measures that must be met for the award to vest. For restricted stock or restricted stock units without performance measures, the restrictions lapse in three equal annual installments. Restricted stock or restricted stock units with performance measures vest in three year installments. Performance units issued in 2020 will vest in 2023, based on certain revenue and earnings targets over the three year period of 2020 to 2022. Performance units issued in 2019 will vest in 2022, based on certain revenue and earnings targets over the three year period of 2019 to 2021. Performance units issued in 2018 will vest in 2021, based on certain revenue and earnings targets over the three year period of 2018 to 2020.

For the years ended December 31, 2020, 2019 and 2018, we recognized share-based compensation expense of $283, $294 and $226, respectively, as well as related tax benefits of $74, $78 and $61, respectively.

A summary of stock option activity for the year ended December 31, 2020 is as follows:

	Number of Shares	Weighted-Average Option Price per Share	Weighted-Average Remaining Contractual Life (Years)	Aggregate Intrinsic Value
Outstanding at January 1, 2020	3.1	$ 190.28		
Granted	1.0	271.61		
Exercised	(0.9)	136.89		
Forfeited or expired	(0.1)	273.91		
Outstanding at December 31, 2020	3.1	230.00	6.75	$ 280
Exercisable at December 31, 2020	1.6	185.08	5.37	$ 217

The intrinsic value of options exercised during the years ended December 31, 2020, 2019 and 2018 amounted to $147, $188 and $172, respectively. We recognized tax benefits of $40, $52 and $47 during the years ended December 31, 2020, 2019 and 2018, respectively, from option exercises and disqualifying dispositions. During the years ended December 31, 2020, 2019 and 2018, we received cash of $129, $143 and $141, respectively, from exercises of stock options.

The total fair value of restricted stock awards that vested during the years ended December 31, 2020, 2019 and 2018 was $335, $245 and $237, respectively.

A summary of the status of nonvested restricted stock activity, including restricted stock units, for the year ended December 31, 2020 is as follows:

	Restricted Stock Shares and Units	Weighted-Average Grant Date Fair Value per Share
Nonvested at January 1, 2020	1.4	$ 242.54
Granted	1.3	272.37
Vested	(1.3)	196.25
Forfeited	(0.1)	272.50
Nonvested at December 31, 2020	1.3	272.51

During the year ended December 31, 2020, we granted approximately 0.3 restricted stock units that are contingent upon us achieving certain revenue and earning targets over the three year period of 2020 to 2022. These grants have been included in the activity shown above, but will be subject to adjustment at the end of 2022, based on results in the three year period.

As of December 31, 2020, the total remaining unrecognized compensation expense related to nonvested stock options and restricted stock, including restricted stock units, amounted to $30 and $154, respectively, which will be amortized over the weighted-average remaining requisite service periods of 11 months and 13 months, respectively.

As of December 31, 2020, there were approximately 19.5 shares of common stock available for future grants under the 2017 Incentive Plan.

Fair Value

We use a binomial lattice valuation model to estimate the fair value of all stock options granted. Expected volatility assumptions used in the binomial lattice model are based on an analysis of implied volatilities of publicly traded options on our stock and historical volatility of our stock price. The risk-free interest rate is derived from the U.S. Treasury strip rates at the time of the grant. The expected term of the options was derived from the outputs of the binomial lattice model, which incorporates post-vesting forfeiture assumptions based on an analysis of historical data. The dividend yield was based on our estimate of future dividend yields. Similar groups of employees that have dissimilar exercise behavior are considered separately for valuation purposes. We utilize the multiple-grant approach for recognizing compensation expense associated with each separately vesting portion of the share-based award.

The following weighted-average assumptions were used to estimate the fair values of options granted during the years ended December 31, 2020, 2019 and 2018:

	2020	2019	2018
Risk-free interest rate	1.30 %	2.69 %	2.90 %
Volatility factor	26.00 %	25.00 %	30.00 %
Dividend yield (annual)	1.40 %	1.00 %	1.30 %
Weighted-average expected life (years)	4.30	4.40	3.70

The following weighted-average fair values were determined for the years ending December 31, 2020, 2019 and 2018:

	2020	2019	2018
Options granted during the year	$ 54.05	$ 68.66	$ 55.48
Restricted stock awards granted during the year	272.37	305.88	233.73

The binomial lattice option-pricing model requires the input of highly subjective assumptions including the expected stock price volatility. Because our stock option grants have characteristics significantly different from those of traded options, and because changes in the subjective input assumptions can materially affect the fair value estimate, in our opinion, existing models do not necessarily provide a reliable single measure of the fair value of our stock option grants.

Employee Stock Purchase Plan

We have registered 14.0 shares of common stock for the Employee Stock Purchase Plan (the “Stock Purchase Plan”) which is intended to provide a means to encourage and assist employees in acquiring a stock ownership interest in Anthem. Pursuant to the terms of the Stock Purchase Plan, an eligible employee is permitted to purchase no more than $25,000 (actual dollars) worth of stock in any calendar year, based on the fair value of the stock at the end of each plan quarter. Employees become participants by electing payroll deductions from 1% to 15% of gross compensation. Once purchased, the stock is accumulated in the employee’s investment account. The Stock Purchase Plan allows participants to purchase shares of our common stock at a discounted price per share of 90% of the fair value of a share of common stock on the lower of the first or last trading day of the plan quarter purchase period. The Stock Purchase Plan discount was recognized as compensation expense for the year ended December 31, 2020, based on GAAP guidance. There were 0.2 shares issued during the year ended December 31, 2020. As of December 31, 2020, 4.6 shares were available for issuance under the Stock Purchase Plan.

Use of Capital and Stock Repurchase Program

We regularly review the appropriate use of capital, including acquisitions, common stock and debt security repurchases and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors.

A summary of the cash dividend activity for the years ended December 31, 2020 and 2019 is as follows:

Declaration Date	Record Date	Payment Date	Cash Dividend per Share	Total
Year ended December 31, 2020				
January 28, 2020	March 16, 2020	March 27, 2020	$ 0.95	$ 240
April 28, 2020	June 10, 2020	June 25, 2020	0.95	242
July 28, 2020	September 10, 2020	September 25, 2020	0.95	238
October 27, 2020	December 7, 2020	December 22, 2020	0.95	234
Year ended December 31, 2019				
January 29, 2019	March 18, 2019	March 29, 2019	$ 0.80	$ 206
April 23, 2019	June 10, 2019	June 25, 2019	0.80	206
July 23, 2019	September 10, 2019	September 25, 2019	0.80	204
October 22, 2019	December 5, 2019	December 20, 2019	0.80	202

On January 26, 2021, our Audit Committee declared a quarterly cash dividend to shareholders of $1.13 per share on the outstanding shares of our common stock. This quarterly dividend is payable on March 25, 2021 to the shareholders of record as of March 10, 2021.

Under our Board of Directors' authorization, we maintain a common stock repurchase program. On January 26, 2021, our Audit Committee, pursuant to authorization granted by the Board of Directors, authorized a $5,000 increase to our common stock repurchase program. Repurchases may be made from time to time at prevailing market prices, subject to certain restrictions on volume, pricing and timing. The repurchases are effected from time to time in the open market, through negotiated transactions, including accelerated share repurchase agreements, and through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. Our stock repurchase program is discretionary, as we are under no obligation to repurchase shares. We repurchase shares under the program when we believe it is a prudent use of capital. The excess cost of the repurchased shares over par value is charged on a pro rata basis to additional paid-in capital and retained earnings. We temporarily suspended our share repurchase program in March 2020 as a precautionary measure in light of the COVID-19 pandemic, but resumed the program in late June 2020 after market conditions improved.

A summary of common stock repurchases for the years ended December 31, 2020 and 2019 is as follows:

	Years Ended December 31	
	2020	2019
Shares repurchased	9.4	6.3
Average price per share	$ 286.35	$ 268.65
Aggregate cost	$ 2,700	$ 1,701
Authorization remaining at end of year	$ 1,092	$ 3,792

We expect to utilize the remaining authorized amount over a multi-year period, subject to market and industry conditions.

For additional information regarding the use of capital for debt security repurchases, see Note 13, "Debt."

16. Accumulated Other Comprehensive Income

A reconciliation of the components of accumulated other comprehensive income (loss) at December 31, 2020 and 2019 is as follows:

	2020	2019
Investments:		
Gross unrealized gains	$ 1,316	$ 720
Gross unrealized losses	(65)	(44)
Net pretax unrealized gains	1,251	676
Deferred tax liability	(302)	(155)
Net unrealized gains on investments	949	521
Non-credit components of impairments on investments:		
Gross unrealized losses	(3)	(3)
Deferred tax asset	1	1
Net unrealized non-credit component of impairments on investments	(2)	(2)
Cash flow hedges:		
Gross unrealized losses	(316)	(331)
Deferred tax asset	66	69
Net unrealized losses on cash flow hedges	(250)	(262)
Defined benefit pension plans:		
Deferred net actuarial loss	(749)	(734)
Deferred prior service cost	—	(1)
Deferred tax asset	190	188
Net unrecognized periodic benefit costs for defined benefit pension plans	(559)	(547)
Postretirement benefit plans:		
Deferred net actuarial loss	(3)	(25)
Deferred prior service credits	12	19
Deferred tax (liability) asset	(2)	2
Net unrecognized periodic benefit credit (costs) for postretirement benefit plans	7	(4)
Foreign currency translation adjustments:		
Gross unrealized gains (losses)	6	(3)
Deferred tax (liability) asset	(1)	1
Net unrealized gains (losses) on foreign currency translation adjustments	5	(2)
Accumulated other comprehensive income (loss)	$ 150	$ (296)

Other comprehensive income (loss) reclassification adjustments for the years ended December 31, 2020, 2019 and 2018 are as follows:

	2020	2019	2018
Investments:			
Net holding gain (loss) on investment securities arising during the period, net of tax (expense) benefit of $(160), $(198), and $133, respectively	$ 478	$ 695	$ (465)
Reclassification adjustment for net realized (gain) loss on investment securities, net of tax expense (benefit) of $13, $4, and $(13), respectively	(50)	(15)	47
Total reclassification adjustment on investments	428	680	(418)
Non-credit component of impairments on investments:			
Non-credit component of impairments on investments, net of tax benefit of $0, $0, and $1, respectively	—	—	(2)
Cash flow hedges:			
Holding gain (loss), net of tax (expense) benefit of $(3), $4, and $(10), respectively	12	(16)	37
Other:			
Net change in unrecognized periodic benefit costs for defined benefit pension and postretirement benefit plans, net of tax (expense) benefit of $(2), $(9), and $29, respectively	(1)	26	(90)
Foreign currency translation adjustment, net of tax expense of $2, $0, and $0, respectively	7	—	(1)
Net gain (loss) recognized in other comprehensive income (loss), net of tax (expense) benefit of $(154), $(199), and $140, respectively	$ 446	$ 690	$ (474)

17. Reinsurance

We reinsure certain risks with other companies and assume risk from other companies. We remain primarily liable to policyholders under ceded insurance contracts and are contingently liable for amounts recoverable from reinsurers in the event that such reinsurers do not meet their contractual obligations.

A summary of direct, assumed and ceded premiums written and earned for the years ended December 31, 2020, 2019 and 2018 is as follows:

	2020		2019		2018	
	Written	Earned	Written	Earned	Written	Earned
Direct	$ 102,479	$ 100,832	$ 91,579	$ 91,131	$ 83,652	$ 84,030
Assumed	3,326	3,356	3,196	3,087	1,447	1,442
Ceded	(79)	(79)	(45)	(45)	(51)	(51)
Net premiums	$ 105,726	$ 104,109	$ 94,730	$ 94,173	$ 85,048	$ 85,421
Percentage—assumed to net premiums	3.1 %	3.2 %	3.4 %	3.3 %	1.7 %	1.7 %

The table above includes certain reclassifications between direct and assumed premiums for 2019 and 2018. These reclassifications did not impact any amounts presented in the consolidated financial statements.

A summary of net premiums written and earned by segment (see Note 20, "Segment Information") for the years ended December 31, 2020, 2019 and 2018 is as follows:

	2020		2019		2018	
	Written	Earned	Written	Earned	Written	Earned
Reportable segments:						
Commercial & Specialty Business	$ 31,745	$ 31,471	$ 32,113	$ 31,944	$ 30,661	$ 30,532
Government Business	72,308	71,188	62,617	62,229	54,387	54,889
Other	1,673	1,450	—	—	—	—
Net premiums	$ 105,726	$ 104,109	$ 94,730	$ 94,173	$ 85,048	$ 85,421

The effect of reinsurance on benefit expense for the years ended December 31, 2020, 2019 and 2018 is as follows:

	2020	2019	2018
Direct	$ 85,168	$ 79,110	$ 70,789
Assumed	2,967	2,733	1,179
Ceded	(90)	(57)	(73)
Net benefit expense	$ 88,045	$ 81,786	$ 71,895

The effect of reinsurance on certain assets and liabilities at December 31, 2020 and 2019 is as follows:

	2020	2019
Policy liabilities, assumed	$ 490	$ 471
Unearned income, assumed	85	114
Premiums payable, ceded	12	11
Premiums receivable, assumed	347	324

18. Leases

We lease office space and certain computer and related equipment using noncancelable operating leases. Our leases have remaining lease terms of 1 year to 14 years.

The information related to our leases is as follows:

	Balance Sheet Location	December 31, 2020	December 31, 2019
Operating Leases			
Right-of-use assets	Other noncurrent assets	$ 646	$ 575
Lease liabilities, current	Other current liabilities	110	158
Lease liabilities, noncurrent	Other noncurrent liabilities	847	482

	Years Ended December 31	
	2020	2019
Lease Expense		
Operating lease expense	$ 438	$ 198
Short-term lease expense	50	46
Sublease income	(9)	(16)
Total lease expense	$ 479	$ 228

Lease expense for 2018 was $207.

Our activities as disclosed in Note 4, "Business Optimization Initiatives", include reducing our office space footprint. As a result, we performed an interim impairment test and recorded an impairment charge of $258 for affected right-of-use assets in 2020 which is included in the operating lease expense shown above.

	Years Ended December 31	
	2020	2019
Other information		
Operating cash paid for amounts included in the measurement of lease liabilities, operating leases	$ 207	$ 176
Right-of-use assets obtained in exchange for new lease liabilities, operating leases	$ 384	$ 112
Weighted average remaining lease term in years, operating leases	7	6
Weighted average discount rate, operating leases	3.21 %	4.09 %

At December 31, 2020, future lease payments for noncancelable operating leases with initial or remaining terms of one year or more are as follows:

2021	$ 197
2022	180
2023	156
2024	125
2025	88
Thereafter	236
Total future minimum payments	$ 982
Less imputed interest	(25)
Total lease liabilities	$ 957

As of December 31, 2020, we have additional operating leases for building spaces that have not yet commenced, and some building spaces are being constructed by the lessors and their agents. These leases have terms of up to 12 years and are expected to commence on various dates during 2021 when the construction is complete and we take possession of the buildings. The undiscounted lease payments for these leases, which are not included in the tables above, aggregate $139.

19. Earnings per Share

The denominator for basic and diluted earnings per share at December 31, 2020, 2019 and 2018 is as follows:

	2020	2019	2018
Denominator for basic earnings per share—weighted-average shares	250.8	255.5	258.1
Effect of dilutive securities—employee stock options, non-vested restricted stock awards, convertible debentures and equity units	3.5	4.8	6.1
Denominator for diluted earnings per share	254.3	260.3	264.2

During the years ended December 31, 2020, 2019 and 2018, weighted-average shares related to certain stock options of 1.2, 0.6 and 0.3, respectively, were excluded from the denominator for diluted earnings per share because the stock options were anti-dilutive. The Equity Unit purchase contracts were settled in May 2018, and approximately 6.0 shares of our common stock were issued and included in the basic earnings per share calculation.

During the years ended December 31, 2020, 2019 and 2018, we issued approximately 0.3, 0.2 and 0.3 restricted stock units, respectively, of which vesting was contingent upon us meeting certain earnings targets. Contingent restricted stock units are excluded from the denominator for diluted earnings per share and are included only if and when the contingency is met. The 2020 contingent restricted stock units are being measured over the three year period of 2020 through 2022, the 2019 contingent restricted stock units are being measured over the three year period of 2019 through 2021 and the 2018 contingent restricted stock units are being measured over the three year period of 2018 through 2020. Contingent restricted stock units generally vest in March of the year following each measurement period.

20. Segment Information

Beginning in 2020, IngenioRx meets the quantitative threshold for a reportable segment based on the FASB guidance. The results of our operations are now described through four reportable segments: Commercial & Specialty Business, Government Business, IngenioRx and Other.

Our Commercial & Specialty Business segment includes our Local Group, National Accounts, Individual and Specialty businesses. Business units in the Commercial & Specialty Business segment offer fully-insured health products; provide a broad array of managed care services to self-funded customers including claims processing, stop loss insurance, provider network access, medical cost management, disease management, wellness programs, underwriting, actuarial services and other administrative services; and provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits.

Our Government Business segment includes our Medicare and Medicaid businesses, National Government Services ("NGS") and services provided to the federal government in connection with the FEHB program. Our Medicare business includes services such as Medicare Supplement plans; Medicare Advantage, including Special Needs Plans; Medicare Part D; and dual-eligible programs through Medicare-Medicaid Plans. Medicare Advantage membership also includes Medicare Advantage members in our Group Retiree Solutions business who are related to National Accounts, retired members of Local Group accounts, or retired members of groups who are not affiliated with our Commercial accounts who have selected a Medicare Advantage product through us. Our Medicaid business includes our managed care alternatives through publicly funded healthcare programs, including Medicaid, ACA-related Medicaid expansion programs, Temporary Assistance for Needy Families programs, programs for seniors and people with disabilities, Children's Health Insurance Programs, and specialty programs such as those focused on long-term services and support, HIV/AIDS, foster care, behavioral health and/or substance abuse disorders, and intellectual disabilities or developmental disabilities. NGS acts as a Medicare contractor for the federal government in several regions across the nation.

Our IngenioRx segment includes our PBM business, which began its operations during the second quarter of 2019. IngenioRx markets and offers PBM services to our affiliated health plan customers, as well as to external customers outside of the health plans we own. IngenioRx has a comprehensive PBM services portfolio, which includes services such as formulary management, pharmacy networks, prescription drug database, member services and mail order capabilities. In 2019, IngenioRx was included in our Other reportable segment. Amounts for 2019 have been reclassified to conform to the current year presentation for comparability.

Our Other segment includes our Diversified Business Group ("DBG"), which is our integrated health services business, and certain eliminations and corporate expenses not allocated to our other reportable segments. Also, beginning on February 28, 2020, our Other segment includes Beacon.

We define operating revenues to include premium income, product revenue and administrative fees and other revenues. Operating revenues are derived from premiums and fees received, primarily from the sale and administration of health benefit products. Operating gain is calculated as total operating revenue less benefit expense, cost of products sold and selling, general and administrative expense.

Through our participation in various federal government programs, we generated approximately 20.3%, 20.7% and 19.8% of our total consolidated revenues from agencies of the U.S. government for the years ended December 31, 2020, 2019, and 2018, respectively. These revenues are contained in the Government Business segment.

The accounting policies of the segments are consistent with those described in the summary of significant accounting policies in Note 2, "Basis of Presentation and Significant Accounting Policies," except that certain shared administrative expenses for each segment are recognized on a pro rata allocated basis, which in the aggregate approximates the consolidated expense. Any difference between the allocated expenses and actual consolidated expense is included in other expenses not allocated to reportable segments. Affiliated revenues represent revenues or cost for services provided by IngenioRx and DBG to our subsidiaries, are recorded at cost or management's estimate of fair market value, and are eliminated in consolidation. We evaluate performance of the reportable segments based on operating gain or loss as defined above. We evaluate net investment income, net realized gains (losses) on financial instruments, interest expense, amortization expense, gain or loss on extinguishment of debt, income taxes and assets and liabilities on a consolidated basis, as these items are managed in a corporate shared service environment and are not the responsibility of segment operating management.

For our 2019 segment reporting, operating gain generated from IngenioRx activities were allocated and included in our Commercial & Specialty Business and Government Business based upon their utilization of those services, which aligns with the method by which we assessed the 2019 operating performance of our reportable segments. Beginning January 1, 2020, we are managing the operating performance of each of our segments on a standalone basis. Prior year 2019 allocations were not restated to conform to the 2020 presentation; however, operating margins for IngenioRx were approximately 8% in 2019.

Financial data by reportable segment for the years ended December 31, 2020, 2019 and 2018 is as follows:

	Commercial & Specialty Business	Government Business	IngenioRx	Other	Eliminations	Total
Year ended December 31, 2020						
Operating revenue - unaffiliated	$ 36,699	$ 71,572	10,384	$ 2,153	$ —	$ 120,808
Operating revenue - affiliated	—	—	11,527	3,904	(15,431)	—
Operating gain (loss)	2,681	2,444	1,361	(126)	—	6,360
Depreciation and amortization of property and equipment	—	—	—	638	—	638
Year ended December 31, 2019						
Operating revenue - unaffiliated	$ 37,421	$ 62,632	2,007	$ 1,081	$ —	$ 103,141
Operating revenue - affiliated	—	—	3,395	1,212	(4,607)	—
Operating gain (loss)	4,032	2,056	—	(89)	—	5,999
Depreciation and amortization of property and equipment	—	—	—	675	—	675
Year ended December 31, 2018						
Operating revenue - unaffiliated	$ 35,782	$ 55,348	—	$ 211	$ —	$ 91,341
Operating revenue - affiliated	—	—	—	1,308	(1,308)	—
Operating gain (loss)	3,600	1,928	—	(102)	—	5,426
Depreciation and amortization of property and equipment	—	—	—	652	—	652

The major product revenues for each of the reportable segments for the years ended December 31, 2020, 2019 and 2018 are as follows:

	2020	2019	2018
Commercial & Specialty Business			
Managed care products	$ 29,815	$ 30,311	$ 29,012
Managed care services	5,296	5,451	5,218
Dental/Vision products and services	1,231	1,302	1,220
Other	357	357	332
Total Commercial & Specialty Business	36,699	37,421	35,782
Government Business			
Managed care products	71,188	62,229	54,889
Managed care services	384	403	459
Total Government Business	71,572	62,632	55,348
IngenioRx			
Pharmacy products and services	21,911	5,402	—
Other			
Integrated health services	5,787	2,149	1,489
Other	270	144	30
Total Other Business	6,057	2,293	1,519
Eliminations			
Eliminations	(15,431)	(4,607)	(1,308)
Total product revenues	$ 120,808	$ 103,141	$ 91,341

The classification between managed care products and managed care services in the above table primarily distinguishes between the levels of risk assumed. Managed care products represent insurance products where we bear the insurance risk, whereas managed care services represent product offerings where we provide claims adjudication and other administrative services to the customer, but the customer principally bears the insurance risk.

Asset, liability and equity details by reportable segment have not been disclosed, as we do not internally report such information.

A reconciliation of reportable segments' operating revenue to the amounts of total revenues included in our consolidated statements of income for the years ended December 31, 2020, 2019 and 2018 is as follows:

	2020	2019	2018
Reportable segments operating revenues	$ 120,808	$ 103,141	$ 91,341
Net investment income	877	1,005	970
Net realized gains (losses) on financial instruments	182	67	(206)
Total revenues	$ 121,867	$ 104,213	$ 92,105

A reconciliation of reportable segments' operating gain to income before income tax expense included in our consolidated statements of income for the years ended December 31, 2020, 2019 and 2018 is as follows:

	2020	2019	2018
Reportable segments operating gain	$ 6,360	$ 5,999	$ 5,426
Net investment income	877	1,005	970
Net realized gains (losses) on financial instruments	182	67	(206)
Interest expense	(784)	(746)	(753)
Amortization of other intangible assets	(361)	(338)	(358)
Loss on extinguishment of debt	(36)	(2)	(11)
Income before income tax expense	$ 6,238	$ 5,985	$ 5,068

21. Related Party Transactions

We have a 19.50% equity investment in National Accounts Service Company, LLC ("NASCO") which processes National Accounts claims and provides other administrative services for us and certain other BCBS plans. Administrative expenses incurred related to NASCO services totaled $58, $78 and $79, for the years ended December 31, 2020, 2019 and 2018, respectively. Amounts due to NASCO were $5 and $4 at December 31, 2020 and 2019, respectively.

We have an equity investment in APC Passe, LLC, which offers Medicaid products in Arkansas. During the years ended December 31, 2020 and 2019, in the normal course of business, we assumed premiums of $446 and $408, respectively, from APC Passe, LLC, which is included in our total assumed premiums (see Note 17, "Reinsurance"). Amounts due to APC Passe, LLC were $115 and $162 at December 31, 2020 and 2019, respectively.

22. Statutory Information

The majority of our insurance and HMO subsidiaries report their accounts in conformity with accounting practices prescribed or permitted by state insurance regulatory authorities, commonly referred to as statutory accounting, which vary in certain respects from GAAP. However, certain of our insurance and HMO subsidiaries, including BCC, Blue Cross of California Partnership Plan, Inc., Golden West Health Plan, Inc., Beacon Health Options of California, Inc. and CareMore Health Plan are regulated by the California Department of Managed Health Care ("DMHC") and report their accounts in conformity with GAAP (these entities are collectively referred to as the "DMHC regulated entities"). Typical differences of GAAP reporting as compared to statutory reporting are the recognition of all assets including those that are non-admitted for statutory purposes and recognition of all deferred tax assets without regard to statutory limits. The National Association of Insurance Commissioners ("NAIC") developed a codified version of the statutory accounting principles, designed to foster more consistency among the states for accounting guidelines and reporting. Prescribed statutory accounting practices are set forth in a variety of publications of the NAIC as well as state laws, regulations and general administrative rules.

Our ability to pay dividends and credit obligations is significantly dependent on receipt of dividends from our subsidiaries. The payment of dividends to us by our insurance and HMO subsidiaries without prior approval of the insurance departments of each subsidiary's domiciliary jurisdiction is limited by formula. Dividends in excess of these amounts are subject to prior approval by the respective state insurance departments or the DMHC.

Our statutory basis insurance and HMO subsidiaries are subject to risk-based capital ("RBC") requirements. RBC is a method developed by the NAIC to determine the minimum amount of statutory capital appropriate for an insurance company or HMO to support its overall business operations in consideration of its size and risk profile. The formula for determining the amount of RBC specifies various factors, weighted based on the perceived degree of risk, which are applied to certain financial balances and financial activity. Below minimum RBC requirements are classified within certain levels, each of which requires specified corrective action. Additionally, the DMHC regulated entities are subject to capital and solvency requirements as prescribed by the DMHC. As of December 31, 2020 and 2019, all of our regulated subsidiaries exceeded the minimum applicable mandatory RBC requirements and/or capital and solvency requirements of their applicable governmental regulator. The statutory RBC necessary to satisfy regulatory requirements of our statutory basis insurance and HMO subsidiaries was approximately $5,800 and $5,500 as of December 31, 2020 and 2019, respectively. The tangible net

equity required for the DMHC regulated entities was approximately $600 and $610 as of December 31, 2020 and 2019, respectively.

Statutory-basis capital and surplus of our insurance and HMO subsidiaries and capital and surplus of our other regulated subsidiaries, excluding the DMHC regulated entities, was $13,717 and $13,044 at December 31, 2020 and 2019, respectively. Statutory-basis net income of our insurance and HMO subsidiaries and net income of our other regulated subsidiaries, excluding the DMHC regulated entities, was $3,170, $3,840 and $3,412 for 2020, 2019 and 2018, respectively. GAAP equity of the DMHC regulated entities was $3,851 and $3,359 at December 31, 2020 and 2019, respectively. GAAP net income of the DMHC regulated entities was $753, $878 and $789 for the years ended December 31, 2020, 2019 and 2018, respectively.

23. Selected Quarterly Financial Data (Unaudited)

Selected quarterly financial data is as follows:

	For the Quarter Ended			
	March 31	June 30	September 30	December 31
2020				
Total revenues	$ 29,621	$ 29,264	$ 31,158	$ 31,824
Income before income tax expense	2,089	3,149	389	611
Net income	1,523	2,276	222	551
Basic net income per share	$ 6.03	$ 9.02	$ 0.88	$ 2.23
Diluted net income per share	5.94	8.91	0.87	2.19
2019				
Total revenues	$ 24,666	$ 25,466	$ 26,674	$ 27,407
Income before income tax expense	1,945	1,453	1,489	1,098
Net income	1,551	1,139	1,183	934
Basic net income per share	$ 6.03	$ 4.44	$ 4.64	$ 3.69
Diluted net income per share	5.91	4.36	4.55	3.62

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE.

There have been no changes in or disagreements with our independent registered public accounting firm on accounting or financial disclosures.

ITEM 9A. CONTROLS AND PROCEDURES.

Evaluation of Disclosure Controls and Procedures

We carried out an evaluation as of December 31, 2020, under the supervision and with the participation of our management, including our Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures as defined in Rule 13a-15(e) of the Exchange Act. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures are effective in timely alerting them to material information relating to us (including our consolidated subsidiaries) required to be disclosed in our reports under the Exchange Act. In addition, based on that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective in ensuring that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosures.

Management's Report on Internal Control over Financial Reporting

Management, under the supervision and with the participation of the principal executive officer and principal financial officer, of Anthem, Inc. (the "Company") is responsible for establishing and maintaining effective internal control over financial reporting ("Internal Control"), as such term is defined in the Exchange Act. The Company's Internal Control is designed to provide reasonable assurance regarding the reliability of the Company's financial reporting and the preparation of financial statements for external reporting purposes in accordance with U.S. generally accepted accounting principles ("GAAP"). The Company's Internal Control includes those policies and procedures that (i) pertain to the maintenance of records that in reasonable detail accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with GAAP, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the financial statements.

Because of inherent limitations in any Internal Control, no matter how well designed, misstatements due to error or fraud may occur and not be detected. Accordingly, even effective Internal Control can provide only reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with GAAP.

Management, under the supervision and with the participation of the principal executive officer and principal financial officer, assessed the effectiveness of the Company's Internal Control as of December 31, 2020. Management's assessment was based on criteria established in Internal Control —Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission.

The Company completed its acquisition of Beacon Health Options, Inc. on February 28, 2020. As permitted by the U.S. Securities and Exchange Commission, management's assessment as of December 31, 2020 did not include the Internal Control of Beacon Health Options, Inc., which is included in the Company's consolidated financial statements as of December 31, 2020. Such operations of Beacon Health Options, Inc. constituted 3% and 6% of the Company's total assets and net assets, respectively, as of December 31, 2020, and 2% and 0% of the Company's total revenues and net income for the year then ended.

Based on management's assessment, which excluded an assessment of Internal Control of Beacon Health Options, Inc., management has concluded that the Company's Internal Control was effective as of December 31, 2020 to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external reporting purposes in accordance with GAAP.

Ernst & Young LLP, the Company's independent registered public accounting firm, has audited the consolidated financial statements of the Company for the year ended December 31, 2020, and has also issued an audit report dated February 18, 2021, on the effectiveness of the Company's Internal Control as of December 31, 2020, which is included in this Annual Report on Form 10-K.

/s/ GAIL K. BOUDREAUX	/s/ JOHN E. GALLINA
President and Chief Executive Officer	Executive Vice President and Chief Financial Officer

Changes in Internal Control Over Financial Reporting

There have been no changes in our internal control over financial reporting that occurred during the three months ended December 31, 2020 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of Anthem, Inc.

Opinion on Internal Control Over Financial Reporting

We have audited Anthem, Inc.'s internal control over financial reporting as of December 31, 2020, based on criteria established in Internal Control–Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, Anthem, Inc. (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2020, based on the COSO criteria.

As indicated in the accompanying Management's Report on Internal Control Over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Beacon Health Options, Inc., which is included in the 2020 consolidated financial statements of the Company and constituted 3% and 6% of total and net assets, respectively, as of December 31, 2020 and 2% and 0% of revenues and net income, respectively, for the year then ended. Our audit of internal control over financial reporting of the Company also did not include an evaluation of the internal control over financial reporting of Beacon Health Options, Inc.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of Anthem, Inc. as of December 31, 2020 and 2019, the related consolidated statements of income, comprehensive income, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2020, and the related notes and financial statement schedule listed in the Index at Item 15(c) and our report dated February 18, 2021 expressed an unqualified opinion thereon.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ ERNST & YOUNG LLP

Indianapolis, Indiana
February 18, 2021

ITEM 9B. OTHER INFORMATION.

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE.

The information required by this Item concerning our Executive Officers, Directors and nominees for Director, Audit Committee members and financial expert(s) and concerning disclosure of any delinquent filers under Section 16(a) of the Exchange Act and our Code of Conduct is incorporated herein by reference from our definitive Proxy Statement for our 2021 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 11. EXECUTIVE COMPENSATION.

The information required by this Item concerning remuneration of our Executive Officers and Directors, material transactions involving such Executive Officers and Directors and Compensation Committee interlocks, as well as the Compensation and Talent Committee Report and CEO Pay Ratio disclosure are incorporated herein by reference from our definitive Proxy Statement for our 2021 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS.

Securities Authorized for Issuance under Equity Compensation Plans

Securities authorized for issuance under our equity compensation plans as of December 31, 2020 are as follows:

Plan Category[1]	Number of securities to be issued upon exercise of outstanding options, warrants and rights[2] (a)	Weighted-average exercise price of outstanding options, warrants and rights[3] (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))[4] (c)
Equity compensation plans approved by shareholders as of December 31, 2020	**5,367,044**	**$230.00**	**24,139,655**

1 We have no equity compensation plans pursuant to which awards may be granted in the future that have not been approved by shareholders.
2 Includes shares that may be issued under the Anthem Incentive Compensation Plan and the Anthem 2017 Incentive Compensation Plan pursuant to the following outstanding awards: **3,071,776** stock options, **625,254** unvested restricted stock units, and **1,670,014** performance stock units (assuming that the outstanding performance stock units are earned at the maximum award level).
3 Represents the weighted average exercise price of outstanding stock options. Does not take into consideration outstanding restricted stock units or performance stock units, which, once vested, may be converted into shares of our common stock on a one-for-one basis upon distribution at no additional cost.
4 Excludes securities reflected in the first column, "Number of securities to be issued upon exercise of outstanding options, warrants and rights". Includes **19,498,782** shares of common stock available for issuance as stock options, restricted stock awards, performance stock awards, performance awards and stock appreciation rights under the Anthem 2017 Incentive Compensation Plan at December 31, 2020. Includes **4,640,873** shares of common stock available for issuance under the Stock Purchase Plan at December 31, 2020.

The information required by this Item concerning the stock ownership of management and five percent beneficial owners is incorporated herein by reference from our definitive Proxy Statement for our 2021 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE.

The information required by this Item concerning certain relationships and related person transactions and director independence is incorporated herein by reference from our definitive Proxy Statement for our 2021 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES.

The information required by this Item concerning principal accountant fees and services is incorporated herein by reference from our definitive Proxy Statement for our 2021 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES.

(a) 1. Financial Statements:

The following consolidated financial statements of the Company are set forth in Part II, Item 8:

Report of Independent Registered Public Accounting Firm

Consolidated Balance Sheets as of December 31, 2020 and 2019

Consolidated Statements of Income for the years ended December 31, 2020, 2019, and 2018

Consolidated Statements of Comprehensive Income for the years ended December 31, 2020, 2019, and 2018

Consolidated Statements of Shareholders' Equity for the years ended December 31, 2020, 2019 and 2018

Consolidated Statements of Cash Flows for the years ended December 31, 2020, 2019 and 2018

Notes to Consolidated Financial Statements

2. Financial Statement Schedule:

The following financial statement schedule of the Company is included in Item 15(c):

Schedule II—Condensed Financial Information of Registrant (Parent Company Only).

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore, have been omitted.

3. Exhibits required to be filed as part of this report:

Exhibit Number	Exhibit
3.1	Amended and Restated Articles of Incorporation of the Company, as amended and restated effective May 15, 2019, incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on May 15, 2019.
3.2	Bylaws of the Company, as amended effective September 30, 2020, incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on October 6, 2020
4.1	Form of Specimen Certificate of the Company's common stock, $0.01 par value per share, incorporated by reference to Exhibit 4.3 to the Company's Post-Effective Amendment No.1 to Form S-8 Registration Statement filed on May 23, 2017.
4.2	Indenture, dated as of December 9, 2004, between the Company and The Bank of New York Trust Company, N.A., as trustee, including the Form of the Company's 5.950% Notes due 2034, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on December 15, 2004.
4.3	Indenture, dated as of January 10, 2006, between the Company and The Bank of New York Mellon Trust Company, N.A. (formerly known as The Bank of New York Trust Company, N.A.), as trustee, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on January 11, 2006.
(a)	Form of 5.85% Notes due 2036, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on January 11, 2006.
(b)	Form of 6.375% Notes due 2037, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on June 8, 2007.
(c)	Form of 5.800% Notes due 2040, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on August 12, 2010.
(d)	Form of 3.700% Notes due 2021, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on August 15, 2011.

Exhibit Number		Exhibit
	(e)	Form of 3.125% Notes due 2022, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on May 7, 2012.
	(f)	Form of 4.625% Notes due 2042, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on May 7, 2012.
	(g)	Form of 3.300% Notes due 2023, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on September 10, 2012.
	(h)	Form of 4.650% Notes due 2043, incorporated by reference to Exhibit 4.5 to the Company's Current Report on Form 8-K filed on September 10, 2012.
	(i)	Form of 5.100% Notes due 2044, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on July 31, 2013.
	(j)	Form of 3.500% Notes due 2024, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on August 12, 2014.
	(k)	Form of 4.650% Notes due 2044, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on August 12, 2014.
	(l)	Form of 4.850% Notes due 2054, incorporated by reference to Exhibit 4.5 to the Company's Current Report on Form 8-K filed on August 12, 2014.
4.4		Indenture dated as of October 9, 2012 between the Company and The Bank of New York Mellon Trust Company, N.A. as trustee, including the Form of the 2.750% Senior Convertible Debentures due 2042, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on October 9, 2012.
4.5		Subordinated Indenture, dated as of May 12, 2015, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on May 12, 2015.
4.6		Indenture dated as of November 21, 2017 between the Company and The Bank of New York Mellon Trust Company, N.A. as trustee, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on November 21, 2017.
	(a)	Form of 2.950% Notes due 2022, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on November 21, 2017.
	(b)	Form of 3.350% Notes due 2024, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on November 21, 2017.
	(c)	Form of 3.650% Notes due 2027, incorporated by reference to Exhibit 4.5 to the Company's Current Report on Form 8-K filed on November 21, 2017.
	(d)	Form of 4.375% Notes due 2047, incorporated by reference to Exhibit 4.6 to the Company's Current Report on Form 8-K filed on November 21, 2017.
	(e)	Form of 4.101% Notes due 2028, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on March 2, 2018.
	(f)	Form of 4.550% Notes due 2048, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on March 2, 2018.
	(g)	Form of 2.375% Notes due 2025, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on September 9, 2019.
	(h)	Form of 2.875% Notes due 2029, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on September 9, 2019.
	(i)	Form of 3.700% Notes due 2049, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on September 9, 2019.

Exhibit Number		Exhibit
	(j)	Form of the 2.250% Notes due 2030, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on May 5, 2020.
	(k)	Form of the 3.125% Notes due 2050, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on May 5, 2020.
4.7		Upon the request of the Securities and Exchange Commission, the Company will furnish copies of any other instruments defining the rights of holders of long-term debt of the Company or its subsidiaries.
4.8		Description of the Company's Securities Registered Pursuant to Section 12 of the Exchange Act.
10.1 *		Anthem Incentive Compensation Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed on December 2, 2014.
	(a)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2014, incorporated by reference to Exhibit 10.2(p) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014.
	(b)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2015, incorporated by reference to Exhibit 10.2(n) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015.
	(c)	Form of Amendment, dated March 9, 2016, to Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2014, incorporated by reference to Exhibit 10.2(m) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
	(d)	Form of Amendment, dated March 9, 2016, to Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2015, incorporated by reference to Exhibit 10.2(p) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
	(e)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2016 and 2017, incorporated by reference to Exhibit 10.2(s) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
	(f)	Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2017, incorporated by reference to Exhibit 10.2(t) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
10.2	*	2017 Anthem Incentive Compensation Plan, as amended and restated effective October 1, 2019, incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2019.
	(a)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2018, incorporated by reference to Exhibit 10.2(d) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2018.
	(b)	Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2018, incorporated by reference to Exhibit 10.2(e) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2018.
	(c)	Form of Incentive Compensation Plan Performance Stock Unit Award Agreement for 2018, incorporated by reference to Exhibit 10.2(f) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2018.
	(d)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement commencing July 2018, incorporated by reference to Exhibit 10.2(h) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2018.
	(e)	Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement commencing July 2018, incorporated by reference to Exhibit 10.2(i) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2018.

Exhibit Number		Exhibit
	(f)	Form of Incentive Compensation Plan Performance Stock Unit Award Agreement commencing July 2018, incorporated by reference to Exhibit 10.2(j) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2018.
	(g)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2019, incorporated by reference to Exhibit 10.2(l) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2019.
	(h)	Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2019, incorporated by reference to Exhibit 10.2(m) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2019.
	(i)	Form of Incentive Compensation Plan Performance Stock Unit Award Agreement for 2019, incorporated by reference to Exhibit 10.2(n) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2019.
	(j)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2020, incorporated by reference to Exhibit 10.2(l) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2020.
	(k)	Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2020, incorporated by reference to Exhibit 10.2(m) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2020.
	(l)	Form of Incentive Compensation Plan Performance Stock Unit Award Agreement for 2020, incorporated by reference to Exhibit 10.2(n) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2020.
10.3	*	Anthem, Inc. Comprehensive Nonqualified Deferred Compensation Plan, as amended and restated effective October 1, 2019, incorporated by reference to Exhibit 10.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2019.
10.4	*	Anthem, Inc. Executive Agreement Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.4 to the Company's Annual Report on Form 10-K for the year ended December 31, 2014.
	(a)	First Amendment, dated March 9, 2016, to Executive Agreement Plan, incorporated by reference to Exhibit 10.4(a) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
	(b)	Second Amendment, dated January 6, 2017, to Executive Agreement Plan, incorporated by reference to Exhibit 10.3(b) to the Company's Annual Report on Form 10-K for the year ended December 31, 2016.
	(c)	Third Amendment, dated August 27, 2018, to Executive Agreement Plan, incorporated by reference to Exhibit 10.4(c) to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2018.
10.5	*	Anthem, Inc. Executive Salary Continuation Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.5 to the Company's Annual Report on Form 10-K for the year ended December 31, 2015.
10.6	*	Anthem, Inc. Directed Executive Compensation Plan amended effective January 1, 2020.
10.7	*	Anthem, Inc. Board of Directors Compensation Program, as amended effective May 15, 2019, incorporated by reference to Exhibit 10.7 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2019.
10.8	*	Anthem Board of Directors' Deferred Compensation Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.8 to the Company's Annual Report on Form 10-K for the year ended December 31, 2014.
10.9	* (a)	Form of Employment Agreement between the Company and each of the following: John E. Gallina, Peter D. Haytaian, and Gloria McCarthy, incorporated by reference to Exhibit A to Exhibit 10.41 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2007.

Exhibit Number	Exhibit
	(b) Form of Employment Agreement between the Company and Gail Boudreaux, incorporated by reference to Exhibit A to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on November 6, 2017.
	(c) Form of Employment Agreement between the Company and each of the following: Felicia F. Norwood, Prakash Patel, Leah Stark, Jeffrey D. Alter, and Blair W. Todt incorporated by reference to Exhibit 10.9(d) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2018.
10.10	* Offer Letter, by and between the Company and Gail Boudreaux, dated as of November 5, 2017, incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on November 6, 2017.
10.11	Blue Cross License Agreement by and between Blue Cross Blue Shield Association and the Company, including revisions, if any, adopted by the Member Plans through September 17, 2020.
10.12	Blue Shield License Agreement by and between Blue Cross Blue Shield Association and the Company, including revisions, if any, adopted by the Member Plans through September 17, 2020.
21	Subsidiaries of the Company.
23	Consent of Independent Registered Public Accounting Firm.
31.1	Certification of Chief Executive Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Exchange Act Rules, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification of Chief Financial Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Exchange Act Rules, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101	The following materials from Anthem, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2020, formatted in Inline XBRL (Inline Extensible Business Reporting Language): (i) the Consolidated Balance Sheets; (ii) the Consolidated Statements of Income; (iii) the Consolidated Statements of Comprehensive Income; (iv) the Consolidated Statements of Cash Flows; (v) the Consolidated Statements of Shareholders' Equity; (vi) the Notes to Consolidated Financial Statements and (vii) Financial Statement Schedule II. The instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
104	Cover Page Interactive Data File formatted in Inline XBRL and contained in Exhibit 101.

* Indicates management contracts or compensatory plans or arrangements.

(b) Exhibits

The response to this portion of Item 15 is set forth in paragraph (a) 3 above.

(c) Financial Statement Schedule

Schedule II—Condensed Financial Information of Registrant (Parent Company Only).

ITEM 16. FORM 10-K SUMMARY.

None.

Schedule II—Condensed Financial Information of Registrant

Anthem, Inc. (Parent Company Only)
Balance Sheets

(In millions, except share data)	December 31, 2020	December 31, 2019
Assets		
Current assets:		
Cash and cash equivalents	$ 700	$ 1,818
Fixed maturity securities, current (amortized cost of $594 and $592; allowance for credit losses of $0 and $0)	608	602
Equity securities	439	253
Other receivables	41	92
Net due from subsidiaries	—	602
Other current assets	800	653
Total current assets	2,588	4,020
Other invested assets	664	657
Property and equipment, net	209	170
Deferred tax assets, net	391	216
Investments in subsidiaries	51,739	47,423
Other noncurrent assets	211	263
Total assets	$ 55,802	$ 52,749
Liabilities and shareholders' equity		
Liabilities		
Current liabilities:		
Accounts payable and accrued expenses	$ 429	$ 887
Net due to subsidiaries	1,239	—
Current portion of long-term debt	700	1,598
Other current liabilities	494	263
Total current liabilities	2,862	2,748
Long-term debt, less current portion	19,310	17,762
Other noncurrent liabilities	431	511
Total liabilities	22,603	21,021
Commitments and contingencies—Note 5		
Shareholders' equity		
Preferred stock, without par value, shares authorized - 100,000,000; shares issued and outstanding - none	—	—
Common stock, par value $0.01, shares authorized - 900,000,000; shares issued and outstanding - 245,401,430 and 252,922,161	3	3
Additional paid-in capital	9,244	9,448
Retained earnings	23,802	22,573
Accumulated other comprehensive income (loss)	150	(296)
Total shareholders' equity	33,199	31,728
Total liabilities and shareholders' equity	$ 55,802	$ 52,749

See accompanying notes.

Anthem, Inc. (Parent Company Only)
Statements of Income

(In millions)	Years ended December 31		
	2020	2019	2018
Revenues			
Net investment income	$ 65	$ 81	$ 39
Net realized gains (losses) on financial instruments	28	(85)	(61)
Administrative fees and other revenue	22	22	2
Total revenues (losses)	115	18	(20)
Expenses			
General and administrative expense	169	88	86
Interest expense	779	723	723
Loss on extinguishment of debt	36	2	11
Total expenses	984	813	820
Loss before income tax credits and equity in net income of subsidiaries	(869)	(795)	(840)
Income tax credits	(386)	(251)	(238)
Equity in net income of subsidiaries	5,055	5,351	4,352
Net income	$ 4,572	$ 4,807	$ 3,750

See accompanying notes.

Anthem, Inc. (Parent Company Only)
Statements of Comprehensive Income

(in millions)	Years ended December 31		
	2020	2019	2018
Net income	$ 4,572	$ 4,807	$ 3,750
Other comprehensive income, net of tax:			
Change in net unrealized gains/losses on investments	428	680	(418)
Change in non-credit component of impairment losses on investments	—	—	(2)
Change in net unrealized gains/losses on cash flow hedges	12	(16)	37
Change in net periodic pension and postretirement costs	(1)	26	(90)
Foreign currency translation adjustments	7	—	(1)
Other comprehensive income (loss)	446	690	(474)
Total comprehensive income	$ 5,018	$ 5,497	$ 3,276

See accompanying notes.

Anthem, Inc. (Parent Company Only)
Statements of Cash Flows

(In millions)	Years ended December 31 2020	2019	2018
Operating activities			
Net income	$ 4,572	$ 4,807	$ 3,750
Adjustments to reconcile net income to net cash provided by operating activities:			
Undistributed earnings of subsidiaries	(1,418)	(1,561)	(744)
Net realized (gains) losses on financial instruments	(28)	85	61
Deferred income taxes	(178)	2	(43)
Impairment of property and equipment	10	—	—
Depreciation and amortization	96	106	113
Share-based compensation	283	294	226
Changes in operating assets and liabilities:			
Receivables, net	53	41	(73)
Other invested assets	(27)	6	(5)
Other assets	33	(235)	(225)
Amounts due to/(from) subsidiaries	1,841	(432)	2,259
Accounts payable and other liabilities	(554)	(422)	457
Income taxes	87	(282)	187
Other, net	40	2	12
Net cash provided by operating activities	4,810	2,411	5,975
Investing activities			
Purchases of investments	(2,729)	(9,682)	(800)
Proceeds from sales, maturities, calls and redemptions of investments	2,593	9,457	1,865
Capitalization of subsidiaries	(2,460)	(232)	(4,379)
Changes in securities lending collateral	(234)	18	(21)
Purchases of property and equipment, net of sales	(107)	(54)	(137)
Other, net	11	—	4
Net cash used in investing activities	(2,926)	(493)	(3,468)
Financing activities			
Net repayments of commercial paper borrowings	(150)	(297)	(107)
Proceeds from long-term borrowings	2,484	2,473	835
Repayments of long-term borrowings	(1,932)	(1,123)	(1,684)
Changes in securities lending payable	234	(18)	21
Proceeds from issuance of common stock under Equity Units stock purchase contracts	—	—	1,250
Repurchase and retirement of common stock	(2,700)	(1,701)	(1,685)
Cash dividends	(1,000)	(856)	(812)
Proceeds from issuance of common stock under employee stock plans	176	187	173
Taxes paid through withholding of common stock under employee stock plans	(128)	(84)	(81)
Other, net	14	29	(83)
Net cash used in financing activities	(3,002)	(1,390)	(2,173)
Change in cash and cash equivalents	(1,118)	528	334
Cash and cash equivalents at beginning of year	1,818	1,290	956
Cash and cash equivalents at end of year	$ 700	$ 1,818	$ 1,290

See accompanying notes.

Anthem, Inc.
(Parent Company Only)
Notes to Condensed Financial Statements

December 31, 2020
(In Millions, Except Per Share Data)

1. Basis of Presentation and Significant Accounting Policies

In the parent company only financial statements of Anthem, Inc. ("Anthem") Anthem's investment in subsidiaries is stated at cost plus equity in undistributed earnings of the subsidiaries. Anthem's share of net income of its unconsolidated subsidiaries is included in income using the equity method of accounting.

Certain amounts presented in the parent company only financial statements are eliminated in the consolidated financial statements of Anthem.

Anthem's parent company only financial statements should be read in conjunction with Anthem's audited consolidated financial statements and the accompanying notes included in Part II, Item 8 of this Annual Report on Form 10-K.

2. Subsidiary Transactions

Dividends from Subsidiaries

Anthem received cash dividends from subsidiaries of $3,618, $3,790 and $3,606 during 2020, 2019 and 2018, respectively.

Dividends to Subsidiaries

Certain subsidiaries of Anthem own shares of Anthem common stock. Anthem paid cash dividends to subsidiaries related to these shares of common stock in the amount of $46, $38 and $36 during 2020, 2019 and 2018, respectively.

Investments in Subsidiaries

Capital contributions to subsidiaries were $2,460, $232 and $4,379 during 2020, 2019 and 2018, respectively.

Amounts Due to and From Subsidiaries

At December 31, 2020 and 2019, Anthem reported amounts due to and from subsidiaries of $1,239 and $602, respectively. The amounts due from subsidiaries primarily include amounts for allocated administrative expenses or daily cash management activities. These items are routinely settled, and as such, are classified as current assets or liabilities.

Guarantees on Behalf of Subsidiaries

Anthem guarantees contractual or financial obligations or solvency requirements for certain of its subsidiaries. These guarantees approximated $538 at December 31, 2020. There were no payments made on these guarantees in 2020.

3. Derivative Financial Instruments

The information regarding derivative financial instruments contained in Note 6, "Derivative Financial Instruments," of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K, is incorporated herein by reference.

4. Long-Term Debt

The information regarding long-term debt contained in Note 13, "Debt," of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K, is incorporated herein by reference.

5. Commitments and Contingencies

The information regarding commitments and contingencies contained in Note 14, “Commitments and Contingencies,” of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K, is incorporated herein by reference.

6. Capital Stock

The information regarding capital stock contained in Note 15, “Capital Stock,” of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K, is incorporated herein by reference.

7. Leases

Beginning in 2019, certain of our leases, including the lease for our principal executive offices located at 220 Virginia Avenue, Indianapolis, Indiana, are obligations of Anthem, Inc. (Parent Company). At December 31, 2020, these leases had an aggregate right-of-use asset of $95, a lease liability balance of $98, operating lease expense of $15 and future lease payments as follows: 2021, $21; 2022, $19; 2023, $16; 2024, $13; 2025, $11; and thereafter $59. At December 31, 2019, the aggregate right-of-use asset balance was $39, the lease liability balance was $40, and the operating lease expense recognized in 2019 was $7. All other information regarding leases is contained in Note 18, “Leases,” of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K. Our activities as disclosed in Note 4, “Business Optimization Initiatives” of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K, include reducing our office space footprint. As a result, we performed an interim impairment test and recorded an impairment charge of $1 for affected right-of-use assets in 2020 which is included in the operating lease expense shown above.

8. Property and Equipment

The information regarding property and equipment contained in Note 9, “Property and Equipment,” of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K, is incorporated herein by reference. Our activities as disclosed in Note 4, “Business Optimization Initiatives” of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K, include impairment and abandonment of property and equipment. We recorded an impairment charge of $10 for property and equipment which is included in general and administrative expenses.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

ANTHEM, INC.

By: /s/ GAIL K. BOUDREAUX
Gail K. Boudreaux
President and Chief Executive Officer

Dated: February 18, 2021

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ GAIL K. BOUDREAUX **Gail K. Boudreaux**	President and Chief Executive Officer, Director (Principal Executive Officer)	February 18, 2021
/s/ JOHN E. GALLINA **John E. Gallina**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 18, 2021
/s/ RONALD W. PENCZEK **Ronald W. Penczek**	Senior Vice President and Chief Accounting Officer (Principal Accounting Officer)	February 18, 2021
/s/ ELIZABETH E. TALLETT **Elizabeth E. Tallett**	Chair of the Board	February 18, 2021
/s/ R. KERRY CLARK **R. Kerry Clark**	Director	February 18, 2021
/s/ ROBERT L. DIXON, JR. **Robert L. Dixon, Jr.**	Director	February 18, 2021
/s/ LEWIS HAY III **Lewis Hay III**	Director	February 18, 2021
/s/ JULIE A. HILL **Julie A. Hill**	Director	February 18, 2021
/s/ BAHIJA JALLAL **Bahija Jallal**	Director	February 18, 2021
/s/ ANTONIO F. NERI **Antonio F. Neri**	Director	February 18, 2021
/s/ RAMIRO G. PERU **Ramiro G. Peru**	Director	February 18, 2021
/s/ RYAN M. SCHNEIDER **Ryan M. Schneider**	Director	February 18, 2021

EXHIBIT 4.8

DESCRIPTION OF THE REGISTRANT'S SECURITIES REGISTERED PURSUANT TO SECTION 12 OF THE SECURITIES EXCHANGE ACT OF 1934

The common stock of Anthem, Inc. ("Anthem," "we," "our," or "us") is the only class of securities registered under Section 12 of the Securities Exchange Act of 1934, as amended (the "Exchange Act").

The following is a summary of the general terms and provisions of our common stock. This summary does not purport to be complete and is subject to and qualified by reference to our amended and restated articles of incorporation, as amended (our "articles of incorporation") and our bylaws, as amended (our "bylaws"), both of which are filed as exhibits to our most recent Annual Report on Form 10-K filed with the Securities and Exchange Commission (the "SEC"). For additional information, please read our articles of incorporation, our bylaws and the applicable provisions of the Indiana Business Corporation Law, as amended (the "IBCL").

General

We are authorized to issue up to 900,000,000 shares of common stock, par value $0.01 per share, as well as up to 100,000,000 shares of preferred stock, without par value. We have no shares of preferred stock issued or outstanding.

Each holder of our common stock is entitled to one vote per share of record on all matters to be voted upon by the shareholders. Holders do not have cumulative voting rights in the election of directors or any other matter. Subject to the preferential rights of the holders of any preferred stock that may at the time be outstanding, each share of common stock will entitle the holder of that share to an equal and ratable right to receive dividends or other distributions (other than purchases, redemptions or other acquisitions of shares by us) if declared from time to time by our board of directors and if there are sufficient funds to legally pay a dividend.

In the event of our liquidation, dissolution or winding up, whether voluntary or involuntary, the holders of common stock will be entitled to share ratably in all assets remaining after payments to creditors and after satisfaction of the liquidation preference, if any, of the holders of any preferred stock that may at the time be outstanding. Holders of common stock have no preemptive or redemption rights and will not be subject to further calls or assessments by us.

Our common stock trades on the New York Stock Exchange under the symbol "ANTM." Computershare Trust Company, N.A. is the registrar, transfer agent, conversion agent and dividend disbursing agent for the common stock.

Authorized But Unissued Shares

Indiana law does not require shareholder approval for any issuance of authorized shares. Authorized but unissued shares may be used for a variety of corporate purposes, including future public or private offerings to raise additional capital or to facilitate corporate acquisitions. One of the effects of the existence of authorized but unissued shares may be to enable our board of directors to issue shares to persons friendly to current management, which issuance could render more difficult or discourage an attempt to obtain control of us by means of a merger, tender offer, proxy contest or otherwise, and thereby protect the continuity of current management and possibly deprive the shareholders of opportunities to sell their shares of common stock at prices higher than prevailing market prices. In addition, depending on the rights prescribed for any series of preferred stock that may be issued, the issuance of preferred stock could have an adverse effect on the voting power of the holders of common stock or could impose restrictions upon the payment of dividends and other distributions to the holders of common stock.

Limitations on Ownership of Our Common Stock in Articles of Incorporation

As required under our licenses with the Blue Cross and Blue Shield Association ("BCBSA"), our articles of incorporation contain certain limitations on the ownership of our common stock. Our articles of incorporation provide that no person may beneficially own shares of voting capital stock in excess of specified ownership limits,

except with the prior approval of a majority of the "continuing directors." The ownership limits, which may not be exceeded without the prior approval of the BCBSA, are the following:

- for any institutional investor (as defined in our articles of incorporation), one share less than 10% of our outstanding voting securities;
- for any non-institutional investor (as defined in our articles of incorporation), one share less than 5% of our outstanding voting securities; and
- for any person, one share less than the number of shares of our common stock or other equity securities (or a combination thereof) representing a 20% ownership interest in us.

Any transfer of stock that would result in any person beneficially owning shares of capital stock in excess of any ownership limit will result in the intended transferee acquiring no rights in the shares exceeding such ownership limit (with certain exceptions) and the person's excess shares will be deemed transferred to an escrow agent to be held until the shares are transferred to a person whose ownership of the shares will not violate the ownership limit.

Certain Other Provisions of Our Articles of Incorporation and Bylaws

Certain other provisions of our articles of incorporation and bylaws may delay or make more difficult unsolicited acquisitions or changes of control of us. These provisions could have the effect of discouraging third parties from making proposals involving an unsolicited acquisition or change in control of us, although these proposals, if made, might be considered desirable by a majority of our shareholders. These provisions may also have the effect of making it more difficult for third parties to cause the replacement of the current management without the concurrence of the board of directors. These provisions include:

- the division of the board of directors into three classes serving staggered terms of office of three years;
- provisions limiting the maximum number of directors to 19 and requiring that any increase in the number of directors then in effect must be approved by a majority of continuing directors;
- provisions requiring that, except in certain limited circumstances, the filling of any vacancy on the board of directors must be approved by a majority of continuing directors;
- permitting a special meeting of shareholders to be called only by the board of directors, the Chair of the Board, the Lead Director, the Chief Executive Officer, the President, or upon the written demand of any one or more shareholders owning at least 20% of our outstanding common stock; and
- requirements for advance notice for raising business or making nominations at shareholders' meetings.

Our bylaws provide that if the requirement for a classified board structure set forth in our licenses with the BCBSA is eliminated or otherwise no longer applicable to the Company, the board of directors will take all necessary actions to implement the elimination of the classified board structure and the annual election of all directors, which shall be phased in over a three-year period commencing with the first annual meeting of shareholders occurring at least 90 days after the board of directors determines that such requirement is eliminated or is otherwise no longer applicable to the Company.

Our bylaws establish an advance notice procedure with regard to business to be brought before an annual or special meeting of shareholders and advance notice and proxy access procedures with regard to the nomination of candidates for election as directors, other than by or at the direction of the board of directors. Although our bylaws do not give the board of directors any power to approve or disapprove shareholder nominations for the election of directors or proposals for action, they may have the effect of precluding a contest for the election of directors or the consideration of shareholder proposals if the established procedures are not followed, and of discouraging or deterring a third party from conducting a solicitation of proxies to elect its own slate of directors or to approve its proposal without regard to whether consideration of those nominees or proposals might be harmful or beneficial to us and our shareholders.

In addition, our bylaws provide that, unless we consent in writing to the selection of an alternative forum, the sole and exclusive forum for (a) any derivative action or proceeding brought on our behalf, (b) any action asserting a claim for breach of a fiduciary duty owed by any of our directors, officers, employees or agents to us or certain specified constituents of ours, (c) any action asserting a claim arising pursuant to any provision of the IBCL or our articles of incorporation or bylaws, or (d) any action asserting a claim governed by the internal affairs doctrine, will be, to the fullest extent permitted by law, the Marion Superior Court in Marion County, Indiana or, if the Marion Superior Court lacks jurisdiction, the United States District Court for the Southern District of Indiana.

Amendment and Repeal of Bylaws

Our articles of incorporation and bylaws provide that the bylaws may be altered, amended or repealed by either (1) the affirmative vote of a majority of the entire number of directors, or (2) except for certain provisions of the bylaws, the affirmative vote, at a shareholder meeting, of at least a majority of the votes entitled to be cast by the holders of the outstanding shares of all classes of our stock entitled to vote generally in the election of directors, considered for this purpose as a single voting group.

Certain Provisions of the Indiana Business Corporation Law

As an Indiana corporation, we are governed by the IBCL. The following are some of the more significant provisions of the IBCL that may delay, prevent or make more difficult certain unsolicited acquisitions or changes of control of us. These provisions also may have the effect of preventing changes in our management. It is possible that these provisions could make it more difficult to accomplish transactions which shareholders may otherwise deem to be in their best interest.

Control Share Acquisitions. Under Chapter 42 of the IBCL, an acquiring person or group who acquires, directly or indirectly, ownership of, or the power to direct the exercise of voting power with respect to, issued and outstanding "control shares" in an "issuing public corporation" may not exercise voting rights on any control shares unless these voting rights are conferred by a majority vote of the disinterested shareholders of the issuing public corporation at a special meeting of those shareholders held upon the request and at the expense of the acquiring person. If the acquiring person has acquired control shares with a majority or more of the voting power, and the control shares are accorded full voting rights by the disinterested shareholders, all shareholders of the issuing public corporation have dissenters' rights to receive the fair value of their shares pursuant to Chapter 44 of the IBCL. We are an "issuing public corporation" as defined under Chapter 42.

Under Chapter 42, "control shares" means shares acquired by a person that, when added to all other shares of the issuing public corporation owned by that person or in respect to which that person may exercise or direct the exercise of voting power, would otherwise entitle that person to exercise voting power of the issuing public corporation in the election of directors within any of the following ranges: (i) one-fifth or more but less than one-third; (ii) one-third or more but less than a majority; or (iii) a majority or more.

Chapter 42 does not apply if, before a control share acquisition is made, the corporation's articles of incorporation or bylaws, including a bylaw adopted by the corporation's board of directors, provide that they do not apply. Our bylaws provide that we are not subject to Chapter 42; however, our board of directors could amend our bylaws to rescind our election to opt out of Chapter 42.

Certain Business Combinations. Chapter 43 of the IBCL restricts the ability of an Indiana corporation that has 100 or more shareholders to engage in any business combinations with an "interested shareholder" for five years after the date the shareholder became an "interested shareholder" (such date, the "share acquisition date"), unless the business combination or the purchase of shares by the interested shareholder on the interested shareholder's share acquisition date is approved by the board of directors of the corporation before the share acquisition date. If such prior approval is not obtained, the interested shareholder may effect a business combination after the five-year period only if that shareholder receives approval from a majority of the disinterested shareholders or the offer meets specified fair price criteria.

For purposes of Chapter 43, "interested shareholder" means any person, other than the corporation or its subsidiaries, who is (1) the beneficial owner, directly or indirectly, of 10% or more of the voting power of the outstanding voting shares of the corporation or (2) an affiliate or associate of the corporation, which at any time within the five-year period immediately before the date in question, was the beneficial owner, directly or indirectly, of 10% or more of the voting power of the then outstanding shares of the corporation.

Chapter 43 does not apply to corporations that elect not to be subject to Chapter 43 in an amendment to their articles of incorporation approved by a majority of the disinterested shareholders. That amendment, however, cannot become effective until 18 months after its passage and would apply only to share acquisitions occurring after its effective date. Our articles of incorporation do not exclude us from Chapter 43.

Mandatory Classified Board of Directors. Under Chapter 33 of the IBCL, a corporation with a class of voting shares registered with the SEC under Section 12 of the Exchange Act must have a classified board of directors unless the corporation adopts a bylaw expressly electing not to be governed by this provision. Although our articles of incorporation and bylaws provide for a classified board of directors so long as we are required to do so under our licenses with the BCBSA, we adopted an amendment to our bylaws electing not to be subject to this mandatory requirement effective July 29, 2009.

Unanimous Written Consent of Shareholders. Under Chapter 29 of the IBCL, as well as our articles of incorporation and our bylaws, any action required or permitted to be taken by the holders of common stock may be effected only at an annual meeting or special meeting of such holders, and shareholders may act in lieu of such meetings only by unanimous written consent.

Summary of the Anthem, Inc. Directed Executive Compensation (DEC) Program (effective January 1, 2020)

Directed Executive Compensation (DEC) is an executive perquisite plan that provides officers of Anthem, Inc. (the "Company") with flexibility to tailor certain benefits to meet their needs with a combination of cash (Cash Credits) and reimbursement of allowable expenses (Core Credits).

Cash Credits are paid directly to the executive and may be used to pay for a variety of expenses that may be incurred in his or her role with the Company. Core Credits are available as a reimbursement for allowable expenses related to the executive's financial health. The amount of Cash Credits and Core Credits the executive receives is based upon their position. The CEO receives Core Credits of $27,000 and Cash Credits of $27,000. Other Named Executive officers receive Core Credits of $15,000 and Cash Credits of $15,000.

Executives newly hired or promoted into an executive position will participate in the program at the beginning of the month following the date of hire or promotion. New participants receive a prorated portion of both the Cash and Core Credits based on full calendar months of service in the position.

Cash Credits

Cash Credits are paid to the executive monthly on the first paycheck of the month and may be used for his or her choice of benefits. The executive does not need to document how these credits are utilized.

Core Credits

Core Credits are available to reimburse executives for costs associated with allowable expenses related to their financial health. An executive can use his or her Core Credits to be reimbursed for:

- Investment Advisor Fees
- Investment Management Fees
- Financial Counseling Fees
- Retirement Planning and Advice
- Tax Preparation and Advice Fees
- Estate Planning Fees
- Legal Fees or legal software associated with:
    - Anthem compensation and/or benefits program review
    - Tax Preparation issues
    - Estate Planning issues
    - Financial Counseling issues
- Tax and Investment Software
- Tax, Investment and Financial Subscriptions

BLUE CROSS LICENSE AGREEMENT

(Includes revisions, if any, adopted by Member Plans through their September 17, 2020 meeting)

This agreement by and between Blue Cross and Blue Shield Association ("BCBSA") and The Blue Cross Plan, known as___(the "Plan").

Preamble

WHEREAS, the Plan and/or its predecessor(s) in interest (collectively the "Plan") had the right to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") for health care plans in its service area, which was essentially local in nature;

WHEREAS, the Plan was desirous of assuring nationwide protection of the Licensed Marks, maintaining uniform quality controls among Plans, facilitating the provision of cost effective health care services to the public and otherwise benefiting the public;

WHEREAS, to better attain such ends, the Plan and the predecessor of BCBSA in 1972 simultaneously executed the BCA License Agreement (s) and the Ownership Agreement; and

WHEREAS, BCBSA and the Plan desire to supercede said Agreement(s) and to revise certain provisions of the Ownership Agreement to reflect their current practices and to assure the continued integrity of the Licensed Marks and of the BLUE CROSS system;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

Agreement

1. BCBSA hereby grants to the Plan, upon the terms and conditions of this License Agreement ("Agreement" or "Primary License Agreement"), the right to use BLUE CROSS in its trade and/or corporate name (the "Licensed Name"), and the right to use the Licensed Marks, in the sale, marketing and administration of health care plans and related services in the Service Area set forth and defined in paragraph 5 below. As used herein, health care plans and related services shall include acting as a nonprofit health care plan, a for-profit health care plan, or mutual health insurer operating on a not-for-profit or for-profit basis, under state law; financing access to health care services; when working with a bank that holds the relevant license to use the Licensed Name and Marks, offering: (i) tax- favored savings accounts for medical expenses and means for accessing such accounts, such as debit cards or checks, that are provided solely to support access to such tax- favored savings accounts, all pursuant to such license, or (ii) prepaid rewards cards that are provided for completion of a wellness program, all pursuant to such license; providing health care management and administration; administering, but not underwriting, non-health portions of Workers' Compensation Insurance; delivering health care services, except hospital services (as defined in the Guidelines to Membership Standards Applicable to Regular Members); and performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by a group account to its members, including benefit plans not provided by the Plan, provided that the Plan has contracted to provide Health Coverage under the Licensed Marks to the account (as the terms "Health Coverage," "Eligibility" and "Enrollment" are defined in Exhibit 4, Paragraph 2.t.).

2. The Plan may use the Licensed Marks and Name in connection with the offering of: i) health care plans and related services in the Service Area through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the "Controlled Affiliate License Agreement"); and ii) insurance coverages offered by life insurers under the applicable law in the Service Area, other than those which the Plan may offer in its own name, provided through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1A hereto (the "Controlled Affiliate License Agreement Applicable to Life Insurance Companies") or the Agreement attached as Exhibit 1A1 hereto (the "Controlled Affiliate Trademark License Agreement for Life and Disability Insurance Products") and further provided that the offering of such services does not and will not dilute or tarnish the unique value of the Licensed Marks and Name; and iii) administration and underwriting of Workers' Compensation Insurance Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the "Controlled Affiliate License"); and iv) regional Medicare Advantage PPO products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1B hereto (the "Controlled Affiliate License Agreement Applicable to Regional Medicare Advantage PPO Products"); and v) regional Medicare Part D Prescription Drug Plan products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1C hereto (the "Controlled Affiliate License Agreement Applicable to Regional Medicare Part D Prescription Drug Plan Products"). As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans and, if the entity meets the standards of Paragraph 2a.B but not Paragraph2a.A, the entity, its owners, and persons

Amended as of September 19, 2014

with authority to select or appoint members or board members, other than a Plan or Plans, have received written approval of BCBSA. Absent written approval by BCBSA of an alternative method of control, bona fide control shall have the meaning set forth in Paragraphs 2a. and 2b.

2a. With respect to the Controlled Affiliate Licenses authorized in clauses i) through iii) of Paragraph 2, bona fide control shall mean that a Plan (the "Sponsoring Plan") authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to this Primary License Agreement with BCBSA must have:

A. The legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; (b) to exercise control over the policy and operations of the Controlled Affiliate; (c) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control more than 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee; or

B. The legal authority directly or indirectly through wholly-owned subsidiaries (b) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; (c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan. Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

1. Change its legal and/or trade name;

2. Change the geographic area in which it operates;

3. Change any of the types of businesses in which it engages;

4. Create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

5. Sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;

6. Make any loans or advances except in the ordinary course of business;

Amended as of March 26, 2015

7. Enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners of the Controlled Affiliate or persons or entities with the authority to select or appoint members or board members of the Controlled
Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

8. Conduct any business other than under the Licensed Marks and Name;

9. Take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks or Names.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control at least 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee; or

C. With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services, the legal authority by the Sponsoring Plan together with such other Plans (a) to select all members of the Controlled Affiliate's governing body; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; (c) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the "Addendum to Controlled Affiliate License" attached as Exhibit B-1 to Exhibit 1 attached hereto; or

Amended as of June 20, 2019

D. With respect to a Controlled Affiliate that is 100% controlled by a Sponsoring Plan which on a Blue-branded basis offers solely a Basic Medicare Part D Prescription Drug product, the legal authority by the Sponsoring Plan: (a) to select all members of the Controlled Affiliate's governing body; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; (c) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by the Plan shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and Participating Plan as defined on the Controlled Affiliate License Agreement shall execute the "Addendum to Controlled Affiliate License" attached as Exhibit B-2 to Exhibit 1 attached hereto.

E. With respect to a Controlled Affiliate that operates as a clinic, the legal authority by the Sponsoring Plan to exercise control over the policy and operations of the Controlled Affiliate as defined in Exhibit 1, Standard 1(E) and the Guidelines to Administer Standard 1(E). In addition, if the clinic is for- profit, the Sponsoring Plan shall own at least 50% of the Controlled Affiliate and prevent any change in the articles of incorporation, bylaws or other establishing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur.

2b. With respect to the Controlled Affiliate License Agreements authorized in clauses iv) and v) of Paragraph 2, bona fide control shall mean that the Controlled Affiliate is organized and operated in such a manner that it meets the following requirements:

A. The Controlled Affiliate is owned or controlled by two or more Plans authorized to use the Licensed Marks pursuant to this License Agreement with BCBSA (for purposes of this subparagraph A. through subparagraph C., the "Controlling Plans"); and

Amended as of June 20, 2019

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B. Each Controlling Plan is authorized pursuant to this Agreement to use the Licensed Marks in a geographic area in the Region (as that term is defined in such Controlled Affiliate License Agreements) and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

C. The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur; and (c) to exercise control over the policy and operations of the Controlled Affiliate. Notwithstanding anything to the contrary in (a) through (c) of this subparagraph E., the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

1. Change its legal and/or trade names;

2. Change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

3. Change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

4. Take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Amended as of June 19, 2014

(The next page is page 3)

3. With respect to a Controlled Affiliate that is not licensed to use the Licensed Marks and Name, the Plan may, in communications that contain the Licensed Marks or Name, indicate its corporate relationship to the Affiliate and permit such Affiliate to indicate its corporate relationship to the Plan, solely in the circumstances, style and manner specified by BCBSA from time-to-time in regulations of general application consistent with the avoidance of confusion or mistake or the dilution or tarnishment of the Licensed Marks and Name. No rights are hereby created in any Controlled Affiliate to use the Licensed Marks or Name in its own name or otherwise.

4. The Plan recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Plan further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide. The Plan agrees (a) to maintain in good standing its membership in BCBSA; (b) promptly to pay its dues to BCBSA, said dues to represent the royalties for this License Agreement; (c) materially to comply with all applicable laws; (d) to comply with the Membership Standards Applicable to Regular Members of BCBSA, a current copy of which is attached as Exhibit 2 hereto; and (e) reasonably to permit BCBSA, upon a written, good faith request and during reasonable business hours, to inspect the Plan's books and records necessary to ascertain compliance herewith. As to other Plans and third parties, BCBSA shall maintain the confidentiality of all documents and information furnished by the Plan pursuant hereto, or pursuant to the Membership Standards, and clearly designated by the Plan as containing proprietary information of the Plan.

5. The rights hereby granted are exclusive to the Plan within the geographical area(s) served by the Plan on June 30, 1972, and/or as to which the Plan has been granted a subsequent license, which is hereby defined as the "Service Area," except that BCBSA reserves the right to use the Licensed Marks in said Service Area, and except to the extent that said Service Area may overlap areas served by one or more other licensed Blue Cross Plans as of said date or subsequent license, as to which overlapping areas the rights hereby granted are nonexclusive as to such other Plan or Plans only.

Amended as of June 19, 2014

6. Except as expressly provided by BCBSA with respect to National Accounts, Government Programs and certain other necessary and collateral uses, the current rules and regulations governing which are attached as Exhibit 3 and Exhibit 4 hereto, and are contained in other documents referenced herein, or as expressly provided herein, the Plan may not use the Licensed Marks and Name outside the Service Area or in connection with other goods and services, nor may the Plan use the Licensed Marks or Name in a manner which is intended to transfer in the Service Area the goodwill associated therewith to another mark or name. Nothing herein shall be construed to prevent the Plan from engaging in lawful activity anywhere under other marks and names not confusingly similar to the Licensed Marks and Name, provided that engaging in such activity does and will not dilute or tarnish the unique value of the Licensed Marks and Name. In addition to any and all remedies available hereunder, BCBSA may impose monetary fines on the Plan for the Plan's use of the Licensed Marks and Names outside the Service Area, and provided that the procedure used in imposing a fine is consistent with procedures specifically prescribed by BCBSA from time to time in regulations of general application. In the case of regional Medicare Advantage PPO and regional Medicare Part D Prescription Drug Plan products offered by consenting and participating Plans in a region that includes the Service Areas, or portions thereof, of more than one Plan, such fine may be imposed jointly on the consenting and participating Plans for use of the Licensed Marks and Name in any geographic area of the region in which a Plan having exclusive rights to the Licensed Marks and Name does not consent to and participate in such offering, provided that the basis for imposition of such fine is consistent with rules specifically prescribed by BCBSA from time to time in regulations of general application.

7. The Plan agrees that it will display the Licensed Marks and Name only in such form, style and manner as shall be specifically prescribed by BCBSA from time-to-time in regulations of general application in order to prevent impairment of the distinctiveness of the Licensed Marks and Name and the goodwill pertaining thereto. The Plan shall cause to appear on all materials on or in connection with which the Licensed Marks or Name are used such legends, markings and notices as BCBSA may reasonably request in order to give appropriate notice of service mark or other proprietary rights therein or pertaining thereto.

8. BCBSA agrees that: (a) it will not grant any other license effective during the term of this License Agreement for the use of the Licensed Marks or Name which is inconsistent with the rights granted to the Plan hereunder; and (b) it will not itself use the Licensed Marks in derogation of the rights of the Plan or in a manner to deprive the Plan of the full benefits of this License Agreement, provided that BCBSA shall have the right to use the Licensed Marks in conjunction with any national offering under the Federal Employees Health Benefits Program in the manner set forth in Exhibit 4, Paragraph 4 (including subparagraphs) to this License Agreement. The Plan agrees that it will not attack the title of BCBSA in and to the Licensed Marks or Name or attack the validity of the Licensed Marks or of this License Agreement. The Plan further agrees that all use by it of the Licensed Marks and Name or any similar mark or name shall inure to the benefit of BCBSA, and the Plan shall cooperate with BCBSA in effectuating the assignment to BCBSA of any service mark or trademark registrations of the Licensed Marks or any similar mark or name held by the Plan or a Controlled Affiliate of the Plan, all or any portion of which registration consists of the Licensed Marks.

Amended as of November 16, 2006

9. (a). Should the Plan fail to comply with the provisions of paragraphs 2-4, 6, 7 and/or 12, and not cure such failure within thirty (30) days of receiving written notice thereof (or commence curing such failure within such thirty day period and continue diligent efforts to complete the curing of such failure if such curing cannot reasonably be completed within such thirty day period), BCBSA shall have the right to issue a notice that the Plan is in a state of noncompliance. Except as to the termination of a Plan's License Agreement or the merger of two or more Plans, disputes as to noncompliance, and all other disputes between or among BCBSA, the Plan, other Plans and/or Controlled Affiliates, shall be submitted promptly to mediation and mandatory dispute resolution pursuant to the rules and regulations of BCBSA, a current copy of which is attached as Exhibit 5 hereto, and shall be timely presented and resolved. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. If a state of noncompliance as aforesaid is undisputed by the Plan or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the License Agreement. Except, however, as provided in paragraphs 9(d)(iii), 15(a)(i)-(viii), and 15(a)(x) below, no Plan's license to use the Licensed Marks and Name may be finally terminated for any reason without the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

(b). Notwithstanding any other provision of this License Agreement, a Plan's license to use the Licensed Marks and Name may be forthwith terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to Member Plans for: (i) failure to comply with any minimum capital or liquidity requirement under the Membership Standard on Financial Responsibility; or (ii) impending financial insolvency; or
(iii) the pendency of any action instituted against the Plan seeking its dissolution or liquidation or its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property of business, unless this License Agreement has been earlier terminated under paragraph 15(a); or (iv) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans and/or the Licensed Marks.

Amended as of March 16, 2006

(c). To the extent not otherwise provided therein, neither: (i) the Membership Standards Applicable to Regular Members of BCBSA; nor (ii) the rules and regulations governing Government Programs and certain other uses; nor (iii) the rules and regulations governing mediation and mandatory dispute resolution, may be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans. The rules and regulations governing National Accounts and other national programs required by the Membership Standards Applicable to Regular Members of BCBSA (Exhibit 2) are contained, in addition to those set forth in Exhibit 3, in the following documents, as amended from time to time: (1) the Inter-Plan Programs Policies and Provisions; (2) Inter- Plan Medicare Advantage Program Policies and Provisions. The voting requirements specified in rules and regulations governing such national programs may not be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans.

Amended as of November 21, 2014

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(d). The Plan may operate as a for-profit company on the following conditions:

(i) The Plan shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement and the Plan's membership in BCBSA.

(ii) The Plan shall not use the licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Plan in any securities market. The Plan shall use the licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(iii) Plan's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Plan knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Plan (“Excess Institutional Voter”), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Plan knows, or there is an SEC filing indicating that, any Noninstitutional Investor has become the Beneficial Owner of securities representing 5% or more of the voting power of the Plan (“Excess Noninstitutional Voter”) unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Plan knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner of 20% or more of the Plan’s then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 9(d)(iv) below (“Excess Owner”), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Plan went public constituted the Board of Directors of the Plan (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Plan went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Plan consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Plan in a writing received by BCBSA prior to such automatic termination becoming effective, the provisions of this paragraph 9(d)(iii) may be waived, in whole or in part,

Amended as of September 17, 1997

upon the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 9(d)(iii)(a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Plan's license to use the Licensed Marks and Name is terminated pursuant to this Paragraph 9(d)(iii), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Plan demonstrates that the Person referred to in clause (a), (b) or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(iv) The Plan shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities or (iii) such other securities as the Plan may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(v) For purposes of paragraph 9(d)(iii), the following definitions shall apply:

(a) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(b) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

(i) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

Amended as of September 17, 1997

(ii) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(iii) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (b)(ii)(B) above) or disposing of any securities of the Plan.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding," when used with reference to a Person's Beneficial Ownership of securities of the Plan, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(c) A Person shall be deemed an “Institutional Investor” if (but only if) such Person (i) is an entity or group identified in the SEC’s Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person’s Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 10 of SEC Schedule 13G as constituted on June 1, 1997.

(d) “Noninstitutional Investor” means any Person who is not an Institutional Investor.

(e) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

Amended as of September 17, 1997

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10. This License Agreement shall remain in effect: (a) until terminated as provided herein; or (b) until this and all such other License Agreements are terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans; or (c) until termination of aforesaid Ownership Agreement; or
(d) until terminated by the Plan upon eighteen (18) months written notice to BCBSA or upon a shorter notice period approved by BCBSA in writing at its sole discretion.

11. Except as otherwise provided in paragraph 15 below or by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans, or unless this and all such other License Agreements are simultaneously terminated by force of law, the termination of this License Agreement for any reason whatsoever shall cause the reversion to BCBSA of all rights in and to the Licensed Marks and Name, and the Plan agrees that it will promptly discontinue all use of the Licensed Marks and Name, will not use them thereafter, and will promptly, upon written notice from BCBSA, change its corporate name so as to eliminate the Licensed Name therefrom.

12. The license hereby granted to Plan to use the Licensed Marks and Name is and shall be personal to the Plan so licensed and shall not be assignable by any act of the Plan, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Plan mortgage or part with possession or control of this license or any right hereunder, and the Plan shall have no right to grant any sublicense to use the Licensed Marks and Name.

13. BCBSA shall maintain appropriate service mark registrations of the Licensed Marks and BCBSA shall take such lawful steps and proceedings as may be necessary or proper to prevent use of the Licensed Marks by any person who is not authorized to use the same. Any actions or proceedings undertaken by BCBSA under the provisions of this paragraph shall be at BCBSA's sole cost and expense. BCBSA shall have the sole right to determine whether or not any legal action shall be taken on account of unauthorized use of the Licensed Marks, such right not to be unreasonably exercised. The Plan shall report any unlawful usage of the Licensed Marks to BCBSA in writing and agrees, free of charge, to cooperate fully with BCBSA's program of enforcing and protecting the service mark rights, trade name rights and other rights in the Licensed Marks.

14. The Plan hereby agrees to save, defend, indemnify and hold BCBSA and any other Plan(s) harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of the activities of the Plan or of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan. BCBSA hereby agrees to save, defend, indemnify and hold the Plan and any other Plan(s) harmless from and against all claims, damages, liabilities And costs of every kind, nature and description which may arise exclusively and directly as a result of the activities of BCBSA.

Amended as of June 21, 2012

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15. (a). This Agreement shall automatically terminate upon the occurrence of any of the following events: (i) a voluntary petition shall be filed by the Plan or by BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against the Plan or BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Plan or BCBSA respectively, or (iii) an order for relief is entered against the Plan or BCBSA in any case under the bankruptcy laws of the United States, or the Plan or BCBSA is adjudged bankrupt or insolvent (as that term is defined in the Uniform Commercial Code as enacted in the state of Illinois) by any court of competent jurisdiction, or (iv) the Plan or BCBSA makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of the Plan or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Plan or BCBSA respectively, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of the Plan's or BCBSA's property or business is appointed, or the Plan or BCBSA is ordered dissolved or liquidated, or (ix) the Plan shall fail to pay its dues and shall not cure such failure within thirty (30) days of receiving written notice thereof, or (x) if, due to regulatory action, the Plan together with any applicable Controlled Affiliate becomes unable to do business using the Names and Marks in any State or portion thereof included in its Service Area, provided that: (i) automatic termination shall not occur prior to the exhaustion by any such Plan of its rights to appeal or challenge such regulatory action; and (ii) in the event the Plan is licensed to do business using the Names and Marks in multiple States or portions of States, the termination of its License Agreement shall be solely limited to the State(s) or portions thereof in which the regulatory action applies. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Plan's or BCBSA's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 15(a)(vii) and (viii) of this Agreement.

Amended as of March 26, 2015

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(b). BCBSA, or the Plans (as provided and in addition to the rights conferred in Paragraph 10(b) above), may terminate this Agreement immediately upon written notice upon the occurrence of either of the following events: (a) the Plan or BCBSA becomes insolvent (as that term is defined in the Uniform Commercial Code enacted in the state of Illinois), or (b) any final judgment against the Plan or BCBSA remains unsatisfied or unbonded of record for a period of sixty (60) days or longer.

(c). If this License Agreement is terminated as to BCBSA for any reason stated in subparagraphs 15(a) and (b) above, the ownership of the Licensed Marks shall revert to each of the Plans as provided in the Ownership Agreement.

(d). Upon termination of this License Agreement or any Controlled Affiliate License Agreement of a Larger Controlled Affiliate, as defined in Exhibit 1 to this License Agreement, the following conditions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 15 (a)(x)(ii) of this Agreement, the notices, national account listing, payment and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated:

(i) The terminated entity shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the terminated entity or its Controlled Affiliates under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination or, if termination is pursuant to paragraph 10(d) of this Agreement, within 15 days after the written notice to BCBSA described in paragraph 10(d).

(ii) The terminated entity shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the terminated entity is involved (in a Control, Participating or Servicing capacity), identifying the national account and the terminated entity's role therein. For those accounts where the terminated entity is the Control Plan, the Plan must also indicate the Participating and Servicing Plans in the national account syndicate.

Amended as of June 16, 2005

(iii) Unless the cause of termination is an event stated in paragraph 15(a) or (b) above respecting BCBSA, the Plan and its Licensed Controlled Affiliates shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re-Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. The Re-Establishment Fee shall be indexed to a base fee of $80. The Re-Establishment Fee through December 31, 2005 shall be $80. The Re-Establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was $278.60, $285.00 and $290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be $83.27 (100% of the base fee plus $1.84 for calendar year 2005 and $1.43 for calendar year 2006). Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (a) the end of the last fiscal year of the terminated entity which ended prior to termination or (b) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph (d)(iii) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Plan to fall below 100% of the Health Risk-Based Capital formula or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and

Amended as of June 16, 2005

three-fourths of the total then current weighted vote of all the Plans), measured as of the date of termination and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plan or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Plan (and/or its Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph only to the extent that such payments exceed the amounts due to BCBSA pursuant to subparagraph 15(d)(vi) and any costs associated with reestablishing the Service Area, including any payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the terminated entity.

(iv). The terminated entity shall comply with all financial settlement procedures set forth in BCBSA's License Termination Contingency Plan, as amended from time to time and shall work diligently and in good faith with BCBSA, any Alternative Control Licensee or Replacement Licensee and any existing or potential

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new account for Blue-branded products and services to minimize the disruption of termination, and honor, to the fullest extent possible, the desire of accounts to continue to receive or obtain Blue-branded products and services through a new Licensee ("Transition"). Such diligence and good faith on the part of the terminated entity shall include, but not be limited to: (a) working cooperatively with BCBSA to protect the Names and Marks from potential harm; (b) cooperating with BCBSA's use of the Names and Marks in the terminated entity's former service area during the termination and Transition; (c) transmitting, upon the request of an existing Blue account or of BCBSA with consent and on behalf of an existing Blue account, all member and account-data relating to the Federal Employee Program to BCBSA, and all member and account data relating to other programs to an Alternative Control Licensee or Replacement Licensee; (d) working with BCBSA and the Alternative Control or Replacement Licensee with respect to potential new Blue accounts headquartered in the terminated entity's former service area; (e) continuing to service Blue accounts during the Transition; (f) continuing to comply with National Programs, Federal Employee Program and NASCO policies and procedures and all voluntary BCBSA programs, policies and performance standards, such as Away From Home Care, including being responsible for payment of all penalties for non-compliance duly levied in conformity with the License Agreements, Membership Standards, or the Federal Employee Program agreements, that may arise during the Transition; (g) maintaining and providing access to its provider networks, as defined by Federal Employee Program agreements and National Account Program Policies and Provisions, and Inter-Plan Programs Policies and Provisions, and making those networks and discounts available to members and providers who participate in National Programs and the Federal Employee Program during the Transition; (h) maintaining its technical connections and processing capabilities during the Transition; and (i) working diligently to conclude all financial settlements and account reconciliations as negotiated in the termination transition agreement.

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(v) Notwithstanding any other provision in this Agreement, BCBSA shall have the right, with the approval of its Board of Directors, to assess additional fines against the terminated entity during the Transition in the event it fails to maintain and provide access to provider networks as defined by Federal Employee Program agreements, National Account Program Policies and Provisions, and Inter-Plan Programs Policies and Provisions, and/or pass on applicable discounts. Such fines shall be in addition to any other assessments, fees or liquidated damages payable herein, or under existing policies and programs and shall be imposed to make whole BCBSA and/or the Plans. Terminated entity shall pay any such fines to BCBSA no later than 30 days after they are approved by the Board of Directors.

(vi) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third-party auditor to examine and audit the books and records of the terminated entity and its Licensed Controlled Affiliates to verify compliance with the terms and requirements this paragraph 15(d).

(vii) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.

(viii) As to a breach of 15 (d) (i), (ii), (iii), (iv), (vi), or (vii) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 15 (d) (i), (ii), (iv), (vi), or (vii) by the Plan, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

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(ix) In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Plan and its Licensed Controlled Affiliates shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

(e).BCBSA shall be entitled to enjoin the Plan or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this License Agreement unless the License Agreement has been terminated pursuant to paragraph 10 (d) of this Agreement upon the required six (6) month written notice.

(f). BCBSA acknowledges that it is not the owner of assets of the Plan.

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16. This Agreement supersedes any and all other agreements between the parties with respect to the subject matter herein, and contains all of the covenants and agreements of the parties as to the licensing of the Licensed Marks and Name. This Agreement may be amended only by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

17. If any provision or any part of any provision of this Agreement is judicially declared unlawful, each and every other provision, or any part of any provision, shall continue in full force and effect notwithstanding such judicial declaration.

18. No waiver by BCBSA or the Plan of any breach or default in performance on the part of BCBSA or the Plan or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

19a. All notices provided for hereunder shall be in writing and shall be sent in duplicate by regular mail to BCBSA or the Plan at the address currently published for each by BCBSA and shall be marked respectively to the attention of the President and, if any, the General Counsel, of BCBSA or the Plan.

19b. Except as provided in paragraphs 9(b), 9(d)(iii), 15(a), and 15(b) above, this Agreement may be terminated for a breach only upon at least 30 days' written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Member Plans.

19c. For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty- six (36) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

Amended as of June 16, 2006

(The next page is page 9)

20. Nothing herein contained shall be construed to constitute the parties hereto as partners or joint venturers, or either as the agent of the other, and Plan shall have no right to bind or obligate BCBSA in any way, nor shall it represent that it has any right to do so. BCBSA shall have no liability to third parties with respect to any aspect of the business, activities, operations, products, or services of the Plan.

21. This Agreement shall be governed, construed and interpreted in accordance with the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By___

Title___

Date___

PLAN:

By___

Title___

Date___

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EXHIBIT 1

BLUE CROSS
CONTROLLED AFFILIATE LICENSE AGREEMENT
(**Includes revisions adopted by Member Plans through their September 17, 2020 meeting**)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and __("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan, known as __ ("Plan" or "Sponsoring Plan"), which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, Plan and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name");

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with: (i) health care plans and related services, as defined in BCBSA's License Agreement with Plan, and administering the non-health portion of workers' compensation insurance, and (ii) underwriting the indemnity portion of workers' compensation insurance, provided that Controlled Affiliate's total premium revenue comprises less than 15 percent of the Sponsoring Plan's net subscription revenue.

This grant of rights is non-exclusive and is limited to the Service Area served by the Plan Subject to paragraph 3A(3) of this Agreement, Controlled Affiliate may use the Licensed Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Service Area under any name or mark; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market, unless such Controlled Affiliate is a not-for-profit company which may use the Licensed Marks and Name, or an approved derivative therefor, to identify itself in debt securities markets. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

Amended as of March 26, 2015

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report or reports to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that the Sponsoring Plan has:

(1) The legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and

(c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates;

(iii) change any of the type(s) of businesses in which it engages;

Amended as of September 19, 2014

(iv) create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

(v) sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;

(vi) make any loans or advances except in the ordinary course of business;

(vii) enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

(viii) conduct any business other than under the Licensed Marks and Name;

(ix) take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control at least 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee.

Or

(2) the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof and;

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and

(c) to exercise control over the policy and operations of the Controlled Affiliate.

Amended as of March 26, 2015

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control more than 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee.

Or

(3) With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services, the Sponsoring Plan has the legal authority together with such other Plans:

(a) to select all members of the Controlled Affiliate's governing body; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and

(c) to exercise control over the policy and operations of the Controlled Affiliate. In

addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit

Controlled Affiliate with the Sponsoring Plan and such other Plans each having an ownership interest. Such control and ownership by Plans must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute a separate Addendum to Controlled Affiliate License Agreement attached hereto as Exhibit B-1 for each product noted in Paragraph 2E(3) that is licensed to use the Marks.

Or

(4) With respect to a Controlled Affiliate that is 100% controlled by a Sponsoring Plan which on a Blue-branded basis, only offers a Basic Medicare Part D Prescription Drug Plan product, the Sponsoring Plan has the legal authority:

(a) to select all members of the Controlled Affiliate's governing body; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and

(c) to exercise control over the policy and operations of the Controlled Affiliate.

Amended June 20, 2019

In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by Sponsoring Plan must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Participating Plan as defined in Exhibit B-2 and the Sponsoring Plan shall execute the Addendum to Controlled Affiliate License Agreement attached hereto as Exhibit B-2.

Or

(5) With respect to a Controlled Affiliate that operates as a clinic, absent an alternative method of control approved in writing by BCBSA, the Sponsoring Plan shall have bona fide operational control over the Controlled Affiliate as specified in Exhibit A, Standard 1(E) and the Guidelines to Administer Standard 1(E). In addition, if the clinic is for-profit, the Sponsoring Plan shall own at least 50% of the Controlled Affiliate and prevent any change in the articles of incorporation, bylaws or other establishing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur.

3. FOR-PROFIT, PUBLICLY TRADED LICENSEES

A. The Controlled Affiliate may operate as a for-profit publicly traded company on the following conditions:

(1) The Controlled Affiliate shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement.

(2) The Controlled Affiliate shall provide 90 days advance written notice to BCBSA prior to the initial filing with the SEC.

(3) The Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Controlled Affiliate in any securities market. The Controlled Affiliate shall use the Licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(4) The Controlled Affiliate's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Controlled Affiliate ("Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Noninstitutional Investor, other than a Plan or Plans or Controlled Affiliate Licensee or Licensees has become the Beneficial Owner of securities representing 5% or more of the voting power of the Controlled Affiliate ("Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner, other than a

Amended as of June 20, 2019

Plan or Plans or Controlled Affiliate Licensee or Licensees, of 20% or more of the Controlled Affiliate's then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 3A(4) below ("Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Controlled Affiliate went public constituted the Board of Directors of the Controlled Affiliate (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Controlled Affiliate went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Controlled Affiliate consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Sponsoring Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Controlled Affiliate in a writing received by BCBSA prior to such automatic termination becoming effective, the provisions of this paragraph 3A(4) may be waived, in whole or in part, upon the affirmative vote of a majority of the disinterested Plans and majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 3A(4) (a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Controlled Affiliate's license, or any other license, to use the Licensed Marks and Name is terminated pursuant to Paragraph 3A(4), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Controlled Affiliate demonstrates that the Person referred to in clause (a), (b), or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(5) The Controlled Affiliate shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities or (iii) such other securities as the Controlled Affiliate may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

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(6) For purposes of paragraph 3A(4) above, the following definitions shall apply:

(i) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(ii) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

(1) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

(2) which such Person or any of such Person's Affiliates or Associates has

(A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

3. which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (ii)2(B) above) or disposing of any securities of the Controlled Affiliate.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding," when used with reference to a Person's Beneficial Ownership of securities of the Controlled Affiliate, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

Amended as of March 26, 2015

(iii) A Person shall be deemed an "Institutional Investor" if (but only if) such Person (i) is an entity or group identified in the SEC's Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person's Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 10 of SEC Schedule 13G as constituted on June 1, 1997.

(iv) "Noninstitutional Investor" means any Person who is not an Institutional Investor.

(v) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

4. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Service Area the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. If Controlled Affiliate meets the standards of 2E(1) but not 2E(2) above and any of Controlled Affiliate's advertising or promotional material is reasonably determined by BCBSA and/or the Plan to be in contravention of rules and regulations governing the use of the Licensed Marks and Name, Controlled Affiliate shall for ninety (90) days thereafter obtain prior approval from BCBSA of advertising and promotional efforts using the Licensed Marks and Name, approval or disapproval thereof to be forthcoming within five (5) business days of receipt of same by BCBSA or its designee. In all advertising and promotional efforts, Controlled Affiliate shall observe the Service Area limitations applicable to Plan.

Amended as of March 26, 2015

E. Notwithstanding any other provision in the Plan's License Agreement with BCBSA or in this Agreement, Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name.

5. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

6. INFRINGEMENT

Controlled Affiliate shall promptly notify Plan and Plan shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

7. LIABILITY INDEMNIFICATION

Controlled Affiliate and Plan hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to: (i) Controlled Affiliate's rendering of services under the Licensed Marks and Name; or (ii) the activities of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan or Controlled Affiliate.

8. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) the Plan ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement the Plan ceases to be authorized to use the Licensed Names and Marks in the geographic area served by the Controlled Affiliate provided, however, that if the Controlled Affiliate is serving more than one State or portions thereof, the termination of this Agreement shall be limited to the State(s) or portions thereof in

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which the Plan's license to use the Licensed Marks and Names is terminated. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of thisAgreement; or (3) impending financial insolvency; or (4) for a Smaller Controlled Affiliate (as defined in Exhibit A), failure to comply with any of the applicable requirements of Standards 2, 3, 4, 5 or 7 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 8(E); or (6) failure by a Controlled Affiliate that meets the standards of 2E(1) but not 2E(2) above to obtain BCBSA's written consent to a change in the identity of any owner, in the extent of ownership, or in the identity of any person or entity with the authority to select or appoint members or board members, provided that as to publicly traded Controlled Affiliates this provision shall apply only if the change affects a person or entity that owns at least 5% of the Controlled Affiliate's stock before or after the change; or (7) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans, any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 8(B), 8(C) or 8(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Plan shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 8(B), 8(C) or 8(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between BCBSA, the Plan and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for

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specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 8(B) and 8(E) of this Agreement, this license to use the Licensed
Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 10 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be

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deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 8(E)(3)(vii) and (viii) of this Agreement.

(4) The for-profit, publicly traded Controlled Affiliate is terminated pursuant to Paragraph 3A(4) of this Agreement. In which case, the licenses of any Controlled Affiliates directly or indirectly owned by the terminated for-profit, publicly traded Controlled Affiliate also shall immediately terminate as provided for in paragraph 3A(4) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 8(B) hereof, or in the event the Controlled Affiliate is a Larger Controlled Affiliate (as defined in Exhibit A), upon termination of this Agreement, the provisions of Paragraph 8.G. shall not apply and the following provisions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 8(B)(ii) of this Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated.

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

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(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re- Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area.

The Re-Establishment Fee shall be indexed to a base fee of $80. The Re-Establishment Fee through December 31, 2005 shall be $80. The Re-establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then- current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was $278.60, $285.00 and $290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be $83.27 (100% of base fee plus $1.84 for calendar year 2005 and $1.43 for calendar year 2006). Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Plan or any other Licensed Controlled Affiliates of the Plan to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re- Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re- Establishment Fee have been finally resolved; and provided further that the award shall be

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based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Plan or its other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 8.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 8.M. and any costs associated with reestablishing the Service Area, including payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third party auditor to examine and audit the books and records of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan to verify compliance with this paragraph 8.H.

(5) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.

(6) As to a breach of 8.H.(1), (2), (3), (4) or (5) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 8.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. This Agreement shall remain in effect until terminated by the Controlled Affiliate or the Plan upon not less than eighteen (18) months written notice to the Association or upon a shorter notice period approved by BCBSA in writing at its sole discretion, or until terminated as otherwise provided herein. The Plan's right to terminate without cause upon such notice is unfettered and may be exercised in the Plan's sole discretion.

J. In the event the Controlled Affiliate is a Smaller Controlled Affiliate (as defined in Exhibit A), the Controlled Affiliate agrees to be jointly liable for the amount described in H.3. and M. hereof upon termination of the BCBSA license agreement of any Larger Controlled Affiliate of the Plan.

K. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless the Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of the Plan's license agreement upon the required 18 months written notice.

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L. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

M. In the event that the Plan has more than 50 percent voting control of the Controlled Affiliate under Paragraph 2(E)(2) above and is a Larger Controlled Affiliate (as defined in Exhibit A), then the vote called for in Paragraphs 8(C) and 8(D) above shall require the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

N. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

9. DISPUTE RESOLUTION

The parties agree that any disputes between them or between or among either of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

10. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit C.

11. JOINT VENTURE

Nothing contained in the Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

12. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

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13. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

14. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

15. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question.

Notwithstanding the foregoing provision, if there are thirty-six (36) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

Amended as of March 26, 2015

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16. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

17. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By:___

Date:___

Plan:

By:___

Date:___

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:___

Date:___

Amended as of March 26, 2015

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS
September 2020
PREAMBLE

For purposes of definition:

- A "smaller Controlled Affiliate:" (1) comprises less than fifteen percent (15%) of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed);* or (2) underwrites the indemnity portion of workers' compensation insurance and has total premium revenue less than 15 percent of the Sponsoring Plan's net subscription revenue.

- A "larger Controlled Affiliate" comprises fifteen percent (15%) or more of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed.)*

Changes in Controlled Affiliate status:

If **any** Controlled Affiliate's status changes regarding: its Plan ownership level, its risk acceptance or direct delivery of medical care, the Controlled Affiliate shall notify BCBSA within thirty (30) days of such occurrence in writing and come into compliance with the applicable standards within six (6) months.

If a smaller Controlled Affiliate's health and workers' compensation administration business reaches or surpasses fifteen percent (15%) of the total member enrollment of the Sponsoring Plan and licensed Controlled Affiliates, the Controlled Affiliate shall:

Amended as of September 19, 2014

EXHIBIT A (continued)

1. Within thirty (30) days, notify BCBSA of this fact in writing, including evidence that the Controlled Affiliate meets the minimum liquidity and capital (BCBSA "Health Risk-Based Capital (HRBC)" as defined by the NAIC and state-established minimum reserve) requirements of the larger Controlled Affiliate Financial Responsibility standard; and

2. Within six (6) months after reaching or surpassing the fifteen percent (15%) threshold, demonstrate compliance with all license requirements for a larger Controlled Affiliate.

If a Controlled Affiliate that underwrites the indemnity portion of workers' compensation insurance receives a change in rating or proposed change in rating, the Controlled Affiliate shall notify BCBSA within 30 days of notification by the external rating agency.

*For purposes of this calculation, The

numerator equals:

Applicant Controlled Affiliate's member enrollment, as defined in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

The denominator equals:

Numerator PLUS Sponsoring Plan and all other licensed Controlled Affiliates' member enrollment, as reported in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

Amended as of September 19, 2014

EXHIBIT A (continued)

STANDARDS FOR LICENSED CONTROLLED AFFILIATES

Each licensed controlled affiliate shall be subject to certain standards as determined below:

1. What percent of the licensed controlled affiliate is controlled by the Sponsoring Plan and other Plans?

More than 50% by Sponsoring Plan	50% by Sponsoring Plan	100% Plan control but less than 50% Sponsoring Plan Control and it offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services	100% Sponsoring Plan control and on a Blue- branded basis, it only offers a Basic Medicare Part D Prescription Drug Plan product	At least 50% by Sponsoring Plan or operational Control by Sponsoring Plan and it solely operates as a Clinic as defined in Standard 1E.
Ò Standard 1A, 4	Ò Standard 1B, 4	Ò	Ò Standard 1D, 4	Ò Standard 1E, 4

IN ADDITION,

2. Is risk being assumed?

Yes			No	
Ò		Ø	÷	Ò
Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance Ò Standards 7A-7E, 11	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance Ò Standard 2 (Guidelines 1.1,1.2) and Standard 11	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance Ò Standard 6H	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates Ò Standard 2 (Guidelines 1.1,1.3) and Standard 11	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates Ò Standard 6H

IN ADDITION,

3. Is medical care being directly provided as a staff model HMO?

Yes	No
Ò Standard 3A	Ò Standard 3B

Amended June 20, 2019

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EXHIBIT A (continued)

STANDARDS FOR LICENSED CONTROLLED AFFILIATES

Each licensed controlled affiliate shall be subject to certain standards as determined below:

IN ADDITION,

4. Is the licensed controlled affiliate operating as a Clinic as defined in Standard 1(E

Yes

Ò

Standard 3C and Standard 2, 1.4 (if organized as a health plan that also operates as a Clinic)

5. If the controlled affiliate has health or workers' compensation administration business, does such business comprise 15% or more of the total member enrollment of Plan and its licensed Controlled Affiliates?

Yes	No		
Ò	÷	÷	Ø
Standards 6A-6J	Controlled Affiliate is not a former primary licensee and is not subject to Standard 1(C) Standards 5,8,9B,10,11	Controlled Affiliate is a former primary licensee Ò Standards 5,8,9A,10,11	Controlled Affiliate is not a former primary licensee and is subject to Standard 1(C) Ò Standards 5,8,9B,11

Amended June 20, 2019

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EXHIBIT A (continued)

Standard 1 - Organization and Governance

1A.) The Standard for more than 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA , has the legal authority, directly or indirectly through wholly-owned subsidiaries: 1) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; and 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and 3) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate.

1B.) The Standard for 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA has the legal authority, directly or indirectly through wholly-owned subsidiaries:

1) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; and

2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and

3) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan.

Amended as of September 19, 2014

EXHIBIT A (continued)

Notwithstanding anything to the contrary in 1) through 3) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by Sponsoring Plan before the Controlled Affiliate can:

- change the geographic area in which it operates
- change its legal and/or trade names
- change any of the types of businesses in which it engages
- create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business
- sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced
- make any loans or advances except in the ordinary course of business
- enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate)
- conduct any business other than under the Licensed Marks and Name
- take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate.

Amended September 19, 2014

1C.) The Standard for a Controlled Affiliate that offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and service and has 100% Plan control but less than 50% Sponsoring Plan Control is:

A Controlled Affiliate shall be organized and operated in such a manner that (i) it offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services; and (ii) a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA has the legal authority together with Other Plans:

1) to select all members of the Controlled Affiliate's governing body; and

2) to prevent any change in the articles of incorporation, bylaws, or other establishing or governing documents of the Controlled Affiliate; and

3) to exercise control over the policy and operations of the Controlled Affiliate. In

addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the Addendum to Controlled Affiliate License.

1D.) The Standard for a Controlled Affiliate that on a Blue-branded basis only offers a Basic Medicare Part D Prescription Drug Plan product and has 100% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that (i) on a Blue-branded basis, it only offers a Basic Medicare Part D Prescription Drug Plan product; and (ii) the Sponsoring Plan has the legal authority:

1) to select all members of the Controlled Affiliate's governing body; and

2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and

3) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by Sponsoring Plan must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA.

Further, the Sponsoring Plan and Participating Plan shall execute the Addendum to Controlled Affiliate License.

1E.) The Standard for a Controlled Affiliate that operates as a Clinic and the Sponsoring Plan has control of the Clinic is:

A Controlled Affiliate shall be organized in such a manner that it operates as a Clinic and the Sponsoring Plan exercises operation control over the Controlled Affiliate.

In addition, if the Clinic is for-profit, the Sponsoring Plan shall own at least 50% of the Controlled Affiliate and prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate.

Amended June 20, 2019

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EXHIBIT A (continued)

Standard 2 – Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. If a risk-assuming Controlled Affiliate ceases operations for any reason, Blue Cross and/or Blue Cross Plan coverage will be offered to all Controlled Affiliate subscribers without exclusions, limitations or conditions based on health status. If a nonrisk-assuming Controlled Affiliate ceases operations for any reason, Sponsoring Plan will provide for services to its customers. The requirements of the preceding two sentences shall apply to all lines of business unless a line of business is specially exempted from the requirement(s) by the BCBSA Board of Directors.

Standard 3 – State Licensure/Certification

3A.) The Standard for a Controlled Affiliate that employs, owns or contracts on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification for its medical care providers to operate under applicable state laws.

3B.) The Standard for a Controlled Affiliate that does not employ, own or contract on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification to operate under applicable state laws.

3C.) The Standard for a Controlled Affiliate that operates as a Clinic as defined in Standard 1(E) is:

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

Standard 4 – Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of 1) the structure of the Blue Cross and Blue Shield System; and 2) the independent nature of every licensee; and 3) the Controlled Affiliate's financial condition.

Amended as of June 20, 2019

EXHIBIT A (continued)

Standard 5 – Reports and Records for Certain Smaller Controlled Affiliates

For a smaller Controlled Affiliate that does not underwrite the indemnity portion of workers' compensation insurance, the Standard is:

A Controlled Affiliate and/or its Sponsoring licensed Plan shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 – Other Standards for Larger Controlled Affiliates

Standards 6(A) – (I) that follow apply to larger Controlled Affiliates.

Standard 6(A): Board of Directors

A Controlled Affiliate Governing Board shall act in the interest of its Corporation in providing cost-effective health care services to its customers. A Controlled Affiliate shall maintain a governing Board, which shall control the Controlled Affiliate, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 6(B): Responsiveness to Customers

A Controlled Affiliate shall be operated in a manner responsive to customer needs and requirements.

Standard 6(C): Participation in National Programs

A Controlled Affiliate shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the licensees and ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's Service Area.

Amended as of September 19, 2014

EXHIBIT A (continued)

Standard 6(C): Participation in National Programs (continued)

Such programs are applicable to licensees, and include:

1. BlueCard Program;
2. Inter-Plan Teleprocessing System (ITS);
3. National Account Programs
4. Business Associate Agreement for Blue Cross and Blue Shield Licensees, effective April 14, 2003; and
5. Inter-Plan Medicare Advantage Program.

Standard 6(D): Financial Performance Requirements

In addition to requirements under the national programs listed in Standard 6C: Participation in National Programs, a Controlled Affiliate shall take such action as required to ensure its financial performance in programs and contracts of an inter-licensee nature or where BCBSA is a party.

Standard 6(E): Cooperation with Plan Performance Response Process

A Controlled Affiliate shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Plan Performance Response Process and in addressing Controlled Affiliate performance problems identified thereunder.

Standard 6(F): Independent Financial Rating

A Controlled Affiliate shall obtain a rating of its financial strength from an independent rating agency approved by BCBSA's Board of Directors for such purpose.

Standard 6(G): Local and National Best Efforts

Notwithstanding any other provision in the Plan’s License Agreement with BCBSA or in this License Agreement, during each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Cross Mark.

Amended as of November 21, 2014

EXHIBIT A (continued)

Standard 6(H): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 6(I): Reports and Records

A Controlled Affiliate shall furnish to BCBSA on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between BCBSA and Controlled Affiliate. Such reports and records are the following:

A) BCBSA Controlled Affiliate Licensure Information Request; and

B) Triennial trade name and service mark usage material, including disclosure material; and

C) Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, or changes in the identity of the Controlled Affiliate's Principal Officers, and changes in risk acceptance, contract growth, or direct delivery of medical care; and

D) Semi-annual “Health Risk-Based Capital (HRBC) Report” as defined by the NAIC, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), and

Amended as of November 17, 2011

EXHIBIT A (continued)

Standard 6(J): Control by Unlicensed Entities Prohibited

No Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Standard 7 - Other Standards for Risk-Assuming Workers' Compensation Controlled Affiliates

Standards 7(A) - (E) that follow apply to Controlled Affiliates that underwrite the indemnity portion of workers' compensation insurance.

Standard 7 (A): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 7(B): Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Controlled Affiliate Licensure Information Request; and

B. Triennial trade name and service mark usage materials, including disclosure materials; and

C. Annual Certified Audit Report, Annual Statement as filed with the State Insurance Department (with all attachments), Annual NAIC's Risk-Based Capital Worksheets for Property and Casualty Insurers; and

D. Quarterly Estimated Risk-Based Capital for Property and Casualty Insurers, Insurance Department Examination Report; and

Amended as of November 17, 2011

EXHIBIT A (continued)

Standard 7(B): Reports and Records, continued

E. Notification of all changes and proposed changes to independent ratings within 30 days of receipt and submission of a copy of all rating reports; and

F. Changes in the ownership and governance of the Controlled Affiliate including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 7(C): Loss Prevention

A Controlled Affiliate shall apply loss prevention protocol to both new and existing business.

Standard 7(D): Claims Administration

A Controlled Affiliate shall maintain an effective claims administration process that includes all the necessary functions to assure prompt and proper resolution of medical and indemnity claims.

Standard 7(E): Disability and Provider Management

A Controlled Affiliate shall arrange for the provision of appropriate and necessary medical and rehabilitative services to facilitate early intervention by medical professionals and timely and appropriate return to work.

Amended as of November 16, 2000

EXHIBIT A (continued)

Standard 8 - Cooperation with Controlled Affiliate License Performance Response Process Protocol

A Controlled Affiliate and its Sponsoring Plan shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Controlled Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing Controlled Affiliate compliance problems identified thereunder.

Standard 9(A) - Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees

A smaller controlled affiliate that formerly was a Primary Licensee shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:
   - BlueCard Program;
   - Inter-Plan Teleprocessing System (ITS);
   - National Account Programs.

B. Financial Requirements include:
   - Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
   - A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Amended as of November 21, 2014

EXHIBIT A (continued)

Standard 9(A) - Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees

C. Reporting requirements include:

- The Semi-annual Health Risk-Based Capital (HRBC) Report.

Amended as of June 13, 2002

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EXHIBIT A (continued)

Standard 9(B) - Participation in National Programs by Smaller Controlled Affiliates

A smaller controlled affiliate shall participate in national programs in accordance with BlueCard and other relevant Policies and Provisions shall effectively and efficiently participate in national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:
- BlueCard Program;
- Inter-Plan Teleprocessing System (ITS);
- National Account Programs.

B. Financial Requirements include:
- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Amended as of June 20, 2013

EXHIBIT A (continued)

Standard 10 - Participation in Inter-Plan Medicare Advantage Program

A smaller controlled affiliate for which this standard applies pursuant to the Preamble section of Exhibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area.

National program requirements include:

A. Inter-Plan Medicare Advantage Program.

Standard 11: Participation in Master Business Associate Agreement by Smaller Controlled Affiliate Licensees

Effective April 14, 2003, all smaller controlled affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of September 19, 2014

EXHIBIT B-1

ADDENDUM TO CONTROLLED AFFILIATE LICENSE TO BE EXECUTED BY CONTROLLED AFFILIATES LICENSED UNDER CONTROLLED AFFILIATE LICENSE STANDARD 1C.

ADDENDUM TO CONTROLLED AFFILIATE LICENSE

This Addendum is made to that certain Blue Cross Controlled Affiliate License Agreement executed by and among Blue Cross and Blue Shield Association ("Licensor"), __("Controlled Affiliate Licensee") and __("Sponsoring Plan") dated the __ day of___,___("Agreement"). The parties to this Addendum are Licensor, Controlled Affiliate Licensee, Sponsoring Plan, and the undersigned other Plans ('Other Plans"). This Addendum is made and shall be deemed effective as of the date of the Agreement.

WHEREAS, the Sponsoring Plan asserts that it can serve the Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans market in its Service Area more efficiently and with less risk through an enterprise jointly owned and controlled with other Plans than through a wholly owned and Controlled Affiliate Licensee.

WHEREAS, in such circumstance Controlled Affiliate License Standard 1C permits the licensing of a Controlled Affiliate that is less than 50% owned and controlled by the Sponsoring Plan but which is 100% owned and controlled by Plans including the Sponsoring Plan, subject to certain conditions;

WHEREAS, one such condition is that the Sponsoring Plan and all such other owning and controlling Plans enter into this Addendum;

NOW THEREFORE, for good and valuable consideration, including the promises and covenants set forth herein, the parties agree as follows:

1. This Addendum is limited to [identify product name].

2. The Sponsoring Plan shall participate operationally in Controlled Affiliate's business that is conducted under the Licensed Marks. The parties understand that participation may take many forms, one of which should be providing a network of providers in the Service Area of the Controlled Affiliate for the Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans services being offered under the Agreement and being involved in network development and provider engagement functions.

3. Each of the Other Plans agrees that (i) it will cooperate fully with the Sponsoring Plan and BCBSA as needed to enable Sponsoring Plan and

Controlled Affiliate Licensee to meet their obligations to Licensor under the Agreement and all associated rules and regulations of Licensor, including the Brand Regulations, (ii) it will not take any action, either individually or jointly with any of the Other Plans, that would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement, and (iii) it will not fail to take any action, either individually or jointly with any of the Other Plans, where such failure would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement.

4. Each of the Other Plans acknowledges that it has reviewed the Agreement and understands that Sponsoring Plan has the right to terminate the Agreement without cause upon notice as provided in Paragraph 8 of the Agreement, and that such right is unfettered and may be exercised by Sponsoring Plan in its sole discretion.

WHEREFORE, by signing below the parties agree to be bound to the terms stated herein.

BLUE CROSS BLUE SHIELD ASSOCIATION

By: __

[Controlled Affiliate Licensee]

By: __

[Sponsoring Plan]

By: __

[Other Plan 1]

By: __

[Other Plan 2]

By: __

Amended September 27, 2018

EXHIBIT B-2

ADDENDUM TO CONTROLLED AFFILIATE LICENSE TO BE EXECUTED BY CONTROLLED AFFILIATES LICENSED UNDER CONTROLLED AFFILIATE LICENSE STANDARD 1D.

ADDENDUM TO CONTROLLED AFFILIATE LICENSE

This Addendum is made to that certain Blue Cross Controlled Affiliate License Agreement executed by and among Blue Cross and Blue Shield Association ("Licensor"),___("Controlled Affiliate Licensee"),
__("Sponsoring Plan") and
_____ ("Participating Plan") dated the __ day of___,___("Agreement").

WHEREAS, the Participating Plan is defined as the Plan that holds the Primary License with BCBSA to use the Service Marks in the Service Area where the Controlled Affiliate will use the Service Marks;

WHEREAS, the Participating Plan asserts that it can offer a lower cost Basic Medicare Part D Prescription Drug Plan product more efficiently in the Participating Plan's Service Area through the Controlled Affiliate Licensee;

WHEREAS, the Controlled Affiliate shall only use the Service Marks inside of the Participating Plan(s) Service Area subject to each Participating Plan signing a separate Addendum;

WHEREAS, in such circumstance Controlled Affiliate License Standard 1D permits the licensing of a Controlled Affiliate that is 100% owned and controlled by a Sponsoring Plan, subject to certain conditions;

WHEREAS, one such condition is that the Sponsoring Plan, Controlled Affiliate and the Participating Plan enter into this Addendum;

NOW THEREFORE, for good and valuable consideration, including the promises and covenants set forth herein, the parties agree as follows:

1. The Participating Plan shall participate in Controlled Affiliate's business that is conducted under the Licensed Marks. The parties understand that the Participating Plan shall conduct sales support and marketing of the Controlled Affiliate's Basic Medicare Part D Prescription Drug Plan product offered in the Participating Plan's Service Area. Any other form of participation shall require BCBSA's written approval.

2. Participating Plan agrees that (i) it will cooperate fully with the Sponsoring Plan and BCBSA as needed to enable Sponsoring Plan and

Controlled Affiliate Licensee to meet their obligations to Licensor under the Agreement and all associated rules and regulations of Licensor, including the Brand Regulations, (ii) it will not take any action that would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement, and (iii) it will not fail to take any action, either individually or jointly with the Sponsoring Plan or Controlled Affiliate Licensee, where such failure would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement.

3. The Controlled Affiliate Licensee shall only use the Licensed Marks authorized by the Participating Plan in connection with the Basic Medicare Part D Prescription Drug Plan product offered in the Participating Plan's Service Area.

4. The Sponsoring Plan and Controlled Affiliate acknowledge that it has reviewed the Agreement and understands that Participating Plan has the right to terminate this Agreement: (i) immediately upon the expiration or termination of the Plan Participation Agreement by and between Participating Plan and Controlled Affiliate upon written notice to the Sponsoring Plan, Controlled Affiliate Licensee and Licensor, or (ii) without cause upon 18 months written notice to the Sponsoring Plan, Controlled Affiliate Licensee and Licensor, and that such right is unfettered and may be exercised by Participating Plan in its sole discretion. In the event that Participating Plan and Controlled Affiliate fail to execute the Plan Participation Agreement by __(Date), Participating Plan may terminate this Agreement immediately upon notice to Sponsoring Plan, Controlled Affiliate Licensee and Licensor.

5. This Agreement and all of Controlled Affiliate Licensee's rights hereunder shall immediately terminate without any further action by any party or entity in the event that the Sponsoring Plan or Participating Plan ceases to be authorized to use the Licensed Marks and Name.

WHEREFORE, by signing below the parties agree to be bound to the terms stated herein.

BLUE CROSS BLUE SHIELD ASSOCIATION

By: __

[Controlled Affiliate Licensee]

By: __

[Sponsoring Plan]

By: __

[Participating Plan]

By: __

Amended September 27, 2018

EXHIBIT C
ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENT

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

FOR RISK PRODUCTS:

For Controlled Affiliates not underwriting the indemnity portion of workers' compensation insurance:

An amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For Controlled Affiliates underwriting the indemnity portion of workers' compensation insurance:

An amount equal to 0.35 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus, an annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 7.

Amended as of September 19, 2014

EXHIBIT C (continued)

FOR NONRISK PRODUCTS:

For third-party administrative business, an amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For non-third party administrative business (e.g., case management, provider networks, etc.), an amount equal to 0.24 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus:

1) An annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 6 D.

2) An annual fee of $2,000 per license for all other Controlled Affiliates.

The foregoing shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® License are issued to the same Controlled Affiliate. In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Amended as of September 19, 2014

EXHIBIT 1A

CONTROLLED AFFILIATE LICENSE AGREEMENT APPLICABLE TO LIFE INSURANCE COMPANIES

(Includes revisions adopted by Member Plans through their September 17, 2020 meeting)

This agreement by and among Blue Cross and Blue Shield Association ("BCBSA") __("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as_____("Plan").

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, the Plan and the Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name");

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Controlled Affiliate the exclusive right to use the licensed Marks and Names in connection with and only in connection with those life insurance and related services authorized by applicable state law, other than health care plans and related services (as defined in the Plan's License Agreements with BCBSA) which services are not separately licensed to Controlled Affiliate by BCBSA, in the Service Area served by the Plan, except that BCBSA reserves the right to use the Licensed Marks and Name in said Service Area, and except to the extent that said Service Area may overlap the area or areas served by one or more other licensed Blue Cross Plans as of the date of this License as to which overlapping areas the rights hereby granted are non-exclusive as to such other Plan or Plans and their respective Licensed Controlled Affiliates only. Controlled Affiliate cannot use the Licensed Marks or Name outside the Service Area or in its legal or trade name; provided, however, that if and only for so long as Controlled Affiliate also holds a Blue Cross Controlled Affiliate License Agreement applicable to health care plans and related services, Controlled Affiliate may use the Licensed Marks and Name in its legal and trade name according to the terms of such license agreement.

Amended as of June 12, 2003

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2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in relation to the sale, marketing and rendering of authorized products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A as it may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans. Absent written approval by BCBSA of an alternative method of control, bona fide control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having not less than 51% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Plan or Plans shall own at least 51% of any for-profit Controlled Affiliate. If the Controlled Affiliate is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items (a) and (c) above, proxies representing 51% of the votes at any meeting of the policyholders and shall demonstrate that there is no reason to believe this such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

3. SERVICE MARK USE

Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks, and shall comply with such rules (applicable to all Controlled Affiliates licensed to use the Marks) relative to service mark use, as are issued from time-to-time by BCBSA. If there is any public reference to the affiliation between the Plan and the Controlled Affiliate, all of the Controlled Affiliate's licensed services in the Service Area of the Plan shall be rendered under the Licensed Marks. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENTS

Controlled Affiliate shall promptly notify Plan and BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate hereby agrees to save, defend, indemnify and hold Plan and BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Controlled Affiliate's rendering of health care services under the Licensed Marks.

7. LICENSE TERM

The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods upon evidence satisfactory to the Plan and BCBSA that Controlled Affiliate meets the then applicable quality control standards, unless one of the parties hereto notifies the other party of the termination hereof at least sixty (60) days prior to expiration of any license period.

This Agreement may be terminated by the Plan or by BCBSA for cause at any time provided that Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Controlled Affiliate's failure to abide by the quality control provisions of Paragraph 2, above, shall be considered a proper ground for cancellation of this Agreement.

This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

A. Controlled Affiliate shall no longer comply with Standard No. 1 (Organization and Governance) of Exhibit A or, following an opportunity to cure, with the remaining quality control provisions of Exhibit A, as it may be amended from time-to-time; or

B. Plan ceases to be authorized to use the Licensed Marks; or

C. Appropriate dues for Controlled Affiliate pursuant to item 8 hereof, which are the royalties for this License Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks including any use in its trade name.

In the event of any disagreement between Plan and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of the Blue Cross and Blue Shield Association and provide instruction on how the customer can contact the Blue Cross and Blue Shield Association or a designated licensee to obtain further information on securing coverage. The written notification required by this paragraph shall be in writing and in a form approved by the Association. The Association shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. DUES

Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

- An annual fee of five thousand dollars ($5,000) per license, plus
- .05% of gross revenue per year from branded group products, plus
- .5% of gross revenue per year from branded individual products plus
- .14% of gross revenue per year from branded individual annuity products.

Amended as of November 20, 1997

The foregoing percentages shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® license are issued to the same entity. In the event that any License period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Plan will promptly and timely transmit to BCBSA all dues owed by Controlled Affiliate as determined by the above formula and if Plan shall fail to do so, Controlled Affiliate shall pay such dues directly.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

9A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-six (36) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

10. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

Amended as of November 20, 1997

11. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by a writing executed by all parties.

12. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way effect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

13. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

Amended as of June 16, 2005

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____ Date:___

Controlled Affiliate:

By:___ Date:___

Plan:

By:_____ Date:___

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EXHIBIT A
CONTROLLED AFFILIATE LICENSE STANDARDS LIFE INSURANCE COMPANIES
Page 1 of 2

PREAMBLE

The standards for licensing Life Insurance Companies (Life and Health Insurance companies, as defined by state statute) are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three- fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote of all Plans. Each Licensed Plan is required to use a standard controlled affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Life Insurance Company maintains compliance with the license standards.

An organization meeting the following standards shall be eligible for a license to use the Licensed Marks within the service area of its sponsoring Licensed Plan to the extent and the manner authorized under the Controlled Affiliate License applicable to Life Insurance Companies and the principal license to the Plan.

Standard 1 - Organization and Governance

The LIC shall be organized and operated in such a manner that it is controlled by a licensed Plan or Plans which have, directly or indirectly: 1) not less than 51% of the voting control of the LIC; and 2) the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the LIC with which it does not concur; and 3) operational control of the LIC.

If the LIC is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items 1 and 2 above, proxies representing at least 51% of the votes at any policyholder meeting and shall demonstrate that there is no reason to believe such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

Standard 2 - State Licensure

The LIC must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life and health insurance company in each state in which the LIC does business.

EXHIBIT A
CONTROLLED AFFILIATE LICENSE STANDARDS LIFE INSURANCE COMPANIES
Page 2 of 2

Standard 3 - Records and Examination

The LIC and its sponsoring licensed Plan(s) shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the LIC as may be required in order to establish compliance with the license agreement. The LIC and its sponsoring licensed Plan(s) shall permit BCBSA to examine the affairs of the LIC and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the sponsoring Plan(s).

Standard 4 - Mediation

The LIC and its sponsoring Plan(s) shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed controlled affiliate, a licensed Plan or BCBSA.

Standard 5 - Financial Responsibility

The LIC shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with Affiliate License Performance Response Process Protocol

The LIC and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing LIC compliance problems identified thereunder.

Exhibit 1A1

CONTROLLED AFFILIATE TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILTY INSURANCE PRODUCTS

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and___, (“Life and Disability Controlled Affiliate”) which is a company offering life and disability insurance products owned and controlled by_____,___, __ (individually, “Sponsoring Plan” and when referred to collectively, “Sponsoring Plans”).

Whereas, BCBSA is the owner of the BLUE CROSS and BLUE SHIELD word and design service marks and any derivatives thereof (“Licensed Marks”);

Whereas, each Sponsoring Plan is licensed separately by BCBSA to use one or more of the Licensed Marks in a particular Service Area;

Whereas, the Sponsoring Plans and the Life and Disability Controlled Affiliate desire that the latter be entitled to use the appropriate Licensed Marks in connection with life and disability insurance products in some or all of such Sponsoring Plans’ Service Areas and in the Service Areas of other Regular Member Plans, as defined in the BCBSA By-laws, (“Blue Plans”) consistent with the terms of this Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

A. Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Life and Disability Controlled Affiliate the limited right to use the Licensed Marks in connection with and only in connection with the following life and disability insurance products authorized by state law: (1) Group: Term Life, Long Term Disability, Whole Life, Benefit Life, Universal Life; (2)
Individual: Term Life, Whole Life, Dependent Life, Spouse Life; (3)
Other: Disability Income, Short Term Disability, Long Term Disability, Income Replacement; and (4) such other life and disability products approved by BCBSA in writing (“Licensed Products”) in the Service Areas served by the Sponsoring Plans or in the Service Area or Areas of one or more other licensed Blue Plans, provided that such Blue Plans have consented to such use as authorized by this Agreement. Life and Disability Controlled Affiliate may not use the Licensed Marks in its legal or trade name.

B. Notwithstanding that the license granted to Life and Disability Controlled Affiliate is a license to use all of the Licensed Marks, Life and Disability Controlled Affiliate may only use those of the Licensed Marks in the Service Area of a Sponsoring Plan or other consenting Blue Plan as described below that such Plan is authorized to use as a Blue Plan pursuant to its separate license agreements with BCBSA.

C. Life and Disability Controlled Affiliate may use the Licensed Marks in the Service Areas of Sponsoring Plans or in the Service Area of a Blue Plan that is not a signatory to this Agreement only after such Sponsoring Plan(s) or non-signatory Blue Plan consents to such use by executing a written consent in substantially the same form as the Consent Agreement attached as Exhibit B.

D. The following provisions apply with respect to Consent Agreements once such agreements have been fully and properly executed:

(1) All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in the Service Area of Sponsoring Plan or consenting Blue Plan (hereinafter, such consenting Sponsoring Plan or consenting Blue Plan collectively referred to "Consenting Plan(s)") must clearly identify the Consenting Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");

(2) To the extent the Consenting Plan has separate divisions or other Affiliates that use the Licensed Marks in distinct geographic areas within its Service Area, consent obtained under this Agreement may be limited to one or more of such specific geographic areas as specified by the Consenting Plan in its signed Consent Agreement. For purposes of this entire Agreement, all references to the Service Area of a Sponsoring Plan, Blue Plan or Consenting Plan may include the entire Service Area or a distinct geographic area within such Service Area as specified in this Section 1 D (2);

(3) Where BCBSA has licensed two or more Blue Plans to use the same Licensed Marks in the same Service Area, in addition to the requirements set forth in Section D (1) above, the sales, marketing and advertising materials referenced in such section above must be communicated to the Consenting Plan's existing and prospective accounts through or with the approval of such Consenting Plan, and the personnel of such Consenting Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in- person or via telephone, video or internet conference) with both existing and prospective accounts of the Consenting Plan;

(4) Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the Consenting Plan has been granted by BCBSA the license to use under its Blue Plan license

(5) agreements (for example, if a Consenting Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).

(6) If a Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless BCBSA and the Consenting Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.

2. QUALITY CONTROL

A. Life and Disability Controlled Affiliate agrees to use the Licensed Marks only in relation to the sale, marketing and administration of the Licensed Products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A and the Guidelines to Administer the Standards for Trademark License Agreement for Life and Disability Insurance Products attached thereto.

B. Life and Disability Controlled Affiliate agrees that BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Life and Disability Controlled Affiliate's rendering of service and use of the Licensed Marks.

C. Life and Disability Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by BCBSA) a report to BCBSA demonstrating Life and Disability Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Life and Disability Controlled Affiliate is defined as: An entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of

incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

3. SERVICE MARK USE

Life and Disability Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and shall ensure all uses of the Licensed Marks comply with the BCBSA Brand Regulations, as amended by BCBSA from time to time. Life and Disability Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Life and Disability Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

The license hereby granted to Life and Disability Controlled Affiliate to use the Licensed Marks is and shall be personal to Life and Disability Controlled Affiliate and shall not be assignable by any act of the Life and Disability Controlled Affiliate, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Life and Disability Controlled Affiliate mortgage or part with possession or control of this license or any right hereunder, and the Life and Disability Controlled Affiliate shall have no right to grant any sublicense to use the Licensed Marks.

5. INFRINGEMENTS

Life and Disability Controlled Affiliate shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Life and Disability Controlled Affiliate shall not be entitled to require BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Life and Disability Controlled Affiliate agrees to render to BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA. BCBSA shall have sole control of the defense and resolution of any claim of infringement brought or threatened by others.

6. LIABILITY INDEMNIFICATION

Life and Disability Controlled Affiliate hereby agrees to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Life and Disability Controlled Affiliate's conduct.

7. LICENSE TERM

A. The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods, unless either BCBSA or Life and Disability Controlled Affiliate notifies the other party in writing of the termination hereof at least sixty (60) days prior to expiration of any license period.

B. This Agreement may be terminated by BCBSA for cause at any time provided that Life and Disability Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Life and Disability Controlled Affiliate's failure to abide by the conditions regarding use of the Licensed Marks set forth in Section 1 of this Agreement or the quality control provisions of Section 2 (other than with respect to Section 2 D which is subject to immediate termination as stated in Section 7 C (1) below) shall be considered proper grounds for termination of this Agreement.

C. This Agreement and all of Life and Disability Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Life and Disability Controlled Affiliate shall no longer comply with Section 2 D (or Standard No. 1 (Organization and Governance) of Exhibit A); or

(2) Any Sponsoring Plan ceases to be authorized to use the Licensed Marks; or

(3) Appropriate fees for Life and Disability Controlled Affiliate pursuant to Section 8 of this Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Life and Disability Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks.

In the event of any disagreement between Life and Disability Controlled Affiliate and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Life and Disability Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. ROYALTIES

Life and Disability Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

- An annual fee of five thousand dollars ($5,000) per license, plus
- .05% of gross revenue per year from group products sold under the Licensed Marks, plus
- .5% of gross revenue per year from individual products sold under the Licensed Marks

In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Life and Disability Controlled Affiliate will promptly and timely transmit to BCBSA all fees owed by Life and Disability Controlled Affiliate as determined by the above formula.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between any Sponsoring Plan and Life and Disability Controlled Affiliate or between among them and/or BCBSA.

10. VOTING

For all provisions of this Agreement referring to voting, the term ‘Plans’ shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the

Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-six
(36) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by:
(a) a writing signed by all parties; or (b) a writing approved by the affirmative vote of three-fourths of the Blue Plans and three-fourths of the total then current weighted vote of all the Blue Plans as officially recorded by the BCBSA Corporate Secretary. Upon such adoption by the Blue Plans, this Agreement and all other Trademark License Agreements for Life and Disability Insurance Products then in effect shall simultaneously be amended.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Life and Disability Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____ Date:___

Life and Disability Controlled Affiliate:

By:___ Date:___

Sponsoring Plan:

By:_____ Date:___ Name:_____ **Sponsoring Plan:**

By:_____ Date:____ Name:_____ **[Add other Sponsoring Plans as necessary]**

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EXHIBIT A

LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS
Page 1 of 2

Standard 1 - Organization and Governance

Any Life and Disability Controlled Affiliate licensed under the Trademark License Agreement for Life and Disability Insurance Products ("licensee") shall be organized and operated in such a manner that it is an entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

Standard 2 - State Licensure

The licensee must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life company in each state in which the licensee does business.

Standard 3 - Records and Examination

The licensee shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the licensee as may be required in order to establish compliance with the Agreement. The licensee shall permit BCBSA to examine the affairs of the licensee and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the Sponsoring Plan(s).

Standard 4 - Mediation

The licensee, its Sponsoring Plan(s) and all consenting Blue Plans shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed Life and Disability Controlled Affiliate, a Sponsoring Plan and or consenting Blue Plan or BCBSA.

EXHIBIT A

LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS
Page 2 of 2

Standard 5 - Financial Responsibility

The licensee shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with BCBSA Governance

The licensee shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of and in addressing licensee compliance problems that may be identified in connection with the operation or administration of the Trademark License Agreement for Life and Disability Insurance Products.

EXHIBIT B

CONSENT AGREEMENT

This Consent Agreement is made and entered into by and among the undersigned Blue Plan, and_____("Life and Disability Controlled Affiliate"), and the Blue Cross and Blue Shield Association ("BCBSA") and shall be deemed effective on___("Effective Date").

Whereas, BCBSA owns the Blue Cross and Blue Shield word and design service marks and any derivative mark thereof (the "Brands");

Whereas, the undersigned Blue Plan is licensed to use one or more of the Brands within a specific geographic area ("Service Area");

Whereas Life and Disability Controlled Affiliate is licensed by BCBSA to use one or more of the Brands to offer life and disability insurance products ("Products") as defined and authorized in the Trademark License Agreement for Life and Disability Insurance Products ("Life and Disability License Agreement");

Whereas neither the Blue Plan nor its affiliates offer the Products under any of the Brands in such Blue Plan's Service Area or portion thereof where Blue Plan has consented to sale of the Products by Life and Disability Controlled Affiliate; and

Whereas BCBSA and the undersigned Blue Plan desire to consent to Life and Disability Controlled Affiliate's use of the Brands in Blue Plan's Service Area consistent with the terms of the Life and Disability License Agreement and this Consent Agreement.

Now, therefore, in consideration of the obligations and conditions stated in this Agreement, Blue Plan, Life and Disability Controlled Affiliate and BCBSA agree as follows:

1. Life and Disability Controlled Affiliate may market, sell, administer and underwrite the Products in Blue Plan's Service Area under the Brands licensed to Blue Plan in such Service Area subject to the terms of this Consent Agreement, the Life and Disability License Agreement and Blue Plan's license agreement(s) with BCBSA. Life and Disability Controlled Affiliate's rights under the Brands to offer the Products under the Brands are limited to offering the Products only under the Brand(s) licensed to the consenting Blue Plan.

2. Life and Disability Controlled Affiliate shall work with the undersigned Blue Plan to develop a written sales and marketing agreement that identifies the relationship between it and Blue Plan for the sales, marketing and customer service for the Products. The term of the sales and marketing agreement shall be the same as the term of this Consent Agreement.

3. All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in a consenting Blue Plan's Service Area must clearly identify the consenting Blue Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");

4. Life and Disability Controlled Affiliate may use the Brands to sell the Products in the following Service Area or portion thereof as designated by Blue Plan:

5. If two or more Blue Plans to use the same Licensed Marks in the same Service Area, Life and Disability Controlled Affiliate shall work with the consenting Blue Plan in the following manner: (a) the sales, marketing and advertising materials must be communicated to the consenting Blue Plan's existing and prospective accounts through or with the approval of such Blue Plan, and (b) the personnel of such Blue Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the consenting Blue Plan;

6. Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the consenting Blue Plan has been granted by BCBSA the license to use under its license agreement (for example, if a consenting Blue Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).

7. If this Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless each BCBSA and the Blue Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.

8. The term of this Consent Agreement shall be one year from the Effective Date. Unless either Blue Plan or Life and Disability Controlled Affiliate provides the other party with written notice of its desire not to renew this Consent Agreement at least 60 days prior to expiration of the term or any extended term or unless terminated as provided in Paragraph 9 below, this Consent Agreement shall automatically renew for subsequent one year periods.

9. This Consent Agreement may be terminated as follows:

   a. Upon mutual written consent of Life and Disability Controlled Affiliate and Blue Plan;

   b. By Blue Plan or Life and Disability Controlled Affiliate upon 60 days advance written notice to the non-terminating party and BCBSA; or

   c. By Blue Plan immediately if Life and Disability Controlled Affiliate does not comply with this Consent Agreement or the sales protocol agreement.

10. This Consent Agreement shall automatically terminate if Blue Plan's primary licensee agreement terminates for any reason or if the Life and Disability License Agreement terminates for any reason.

Agreed and Accepted by: [Blue

Plan]:

By:___

Title:___

BLUE CROSS AND BLUE SHIELD ASSOCIATION:

By:___

Title:___

LIFE AND DISABILITY CONTROLLED AFFILIATE:

By:___

Title:___

3

Exhibit 1B

BLUE CROSS
CONTROLLED AFFILIATE LICENSE AGREEMENT APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS
(Adopted by Member Plans at their September 17, 2020 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and___("Controlled Affiliate"), a Controlled Affiliate of the Blue

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Advantage PPO products in geographic regions designated by CMS (hereafter "regional MAPPO products").

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name") to offer regional MAPPO products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. <u>GRANT OF LICENSE</u>

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional MAPPO products and related services.

This grant of rights is non-exclusive and is limited to the following states: __ (the "Region"). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

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3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional MAPPO products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this

Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or
1. failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and
(viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x)(ii) of the Blue Cross License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and

any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last

known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with
0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-six (36) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By:___

Date:___

Controlling Plan:

By: __

Date:___

Controlling Plan:

By: __

Date:___

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:___

Date:___

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EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS
September 2020

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Advantage PPO Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

(b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) exercise control over the policy and operations of the Controlled Affiliate; and

EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

a. the structure of the Blue Cross and Blue Shield System; and
b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Cross Marks.

Standard 7 - Participation in Certain National Programs

A Controlled Affiliate shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area.

National program requirements include:

a. Inter-Plan Teleprocessing System (ITS); and

b. Inter-Plan Medicare Advantage Program.

Standard 8 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of November 15, 2007

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EXHIBIT B

**ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS**

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional MAPPO products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

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Exhibit 1C

BLUE CROSS
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS
(Adopted by Member Plans at their September 17, 2020 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and__("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Part D Prescription Drug Plan products in geographic regions designated by CMS (hereafter "regional PDP products)."

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name") to offer regional PDP products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. <u>GRANT OF LICENSE</u>

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional PDP products and related services.

This grant of rights is non-exclusive and is limited to the following states: __ (the "Region"). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing Body having not less than 100% voting control thereof;

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i)change its legal and/or trade names;

(ii)change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional PDP products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or
1. failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to

complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its

dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and
(viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x)(ii) of the Blue Cross

License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths

of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with
0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-six (36) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By:___

Date:___

Controlling Plan:

By: __

Date:___

Controlling Plan:

By: __

Date:___

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:___

Date:___

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EXHIBIT A

**CONTROLLED AFFILIATE LICENSE STANDARDS
APPLICABLE TO REGIONAL MEDICARE
PART D PRESCRIPTION DRUG PLAN PRODUCTS**

September 2020

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Part D Prescription Drug Plan Products are established by BCBSA and are subject to change from time- to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

(b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) exercise control over the policy and operations of the Controlled Affiliate; and

EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

a. the structure of the Blue Cross and Blue Shield System; and
b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Cross Marks.

Standard 7 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

EXHIBIT B

ROYALTY FORMULA FOR SECTION 9 OF THE CONTROLLED AFFILIATE LICENSE AGREEMENTS APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional PDP products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

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EXHIBIT 2

Membership Standards
Page 1 of 5

Preamble

The Membership Standards apply to all organizations seeking to become or to continue as Regular Members of the Blue Cross and Blue Shield Association. Any organization seeking to become a Regular Member must be found to be in substantial compliance with all Membership Standards at the time membership is granted and the organization must be found to be in substantial compliance with all Membership Standards for a period of two (2) years preceding the date of its application. If Membership is sought by an entity which controls or is controlled by one or more Plans, such compliance shall be determined on the basis of compliance by such Plan or Plans.

The Regular Member Plans shall have authority to interpret these Standards.

A Regular Member Plan that operates as a “Shell Holding Company” is defined as an entity that assumes no underwriting risk and has less than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) and less than 5% of the consolidated enterprise net general and administrative expenses.

A Regular Member Plan that operates as a “Hybrid Holding Company” is defined as an entity that assumes no underwriting risk and has either more than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) or more than 5% of the consolidated enterprise net general and administrative expenses.

Standard 1: A Plan shall maintain a governing Board, which shall control the Plan and ensure that the Plan follows appropriate practices of corporate governance. A Plan's Board shall not be controlled by any special interest group, shall make an annual determination that a majority of its directors are independent, and shall act in the best interest of its Corporation and its customers. The Board shall be composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Amended as of March 15, 2007

EXHIBIT 2

Membership Standards
Page 2 of 5

Standard 2: A Plan shall furnish to the Association on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between the Association and the Plans. Such reports and records are the following:

A. BCBSA Membership Information Request;

B. Triennial trade name and service mark usage material, including disclosure material under Standard 7;

C. Changes in the governance of the Plan, including changes in a Plan's Charter, Articles of Incorporation, or Bylaws, changes in a Plan's Board composition, or changes in the identity of the Plan's Principal Officers;

D. Quarterly Financial Report, Semi-annual “Health Risk- Based Capital (HRBC) Report” as defined by the NAIC, Annual Budget, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), Plan, Subsidiary and Affiliate Report; and

- Plans that are a Shell Holding Company as defined in the Preamble hereto are required to furnish only a calendar year-end “Health Risk-Based Capital (HRBC) Report” as defined by the NAIC.

Amended as of November 17, 2011

EXHIBIT 2

Membership Standards
Page 3 of 5

E. Quarterly Enrollment Report, Quarterly Member Touchpoint Measures Index (MTM) through 12/31/2011, and Semi-annual MTM Index starting 1/1/2012 and thereafter.

- For purposes of MTM reporting only, a Plan shall file a separate MTM report for each Geographic Market.

Standard 3: A Plan shall be operated in a manner that provides reasonable financial assurance that it can fulfill its contractual obligations to its customers.

Standard 4: A Plan shall be operated in a manner responsive to customer needs and requirements.

Standard 5: A Plan shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the Plans and ease of claims processing for customers receiving benefits outside of the Plan's Service Area.

Such programs are applicable to Blue Cross and Blue Shield Plans, and include:

A. Inter-Plan Teleprocessing System (ITS);
B. BlueCard Program;
C. National Account Programs;
D. Business Associate Agreement for Blue Cross and Blue Shield Licensees, effective April 14, 2003; and
E. Inter-Plan Medicare Advantage Program.

Amended as of November 21, 2014

EXHIBIT 2

Membership Standards
Page 4 of 5

Standard 6: In addition to requirements under the national programs listed in Standard 5: Participation in National Programs, a Plan shall take such action as required to ensure its financial performance in programs and contracts of an inter-Plan nature or where the Association is a party.

Standard 7: A Plan shall make adequate disclosure in contracting with third parties and in disseminating public statements of (i) the structure of the Blue Cross and Blue Shield System,
(ii) the independent nature of every Plan, and (iii) the Plan's financial condition.

Standard 8: A Plan shall cooperate with the Association's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Plan Performance Response Process and in addressing Plan performance problems identified thereunder.

Standard 9: A Plan shall obtain a rating of its financial strength from an independent rating agency approved by the Association's Board of Directors for such purpose.

Standard 10: Notwithstanding any other provision in this License Agreement, during each year, a Plan and its Controlled Affiliate(s) engaged in providing licensable services (excluding Life Insurance and Charitable Foundation Services) shall use their best efforts to promote and build the value of the Blue Cross Marks.

Standard 11: Neither a Plan nor any Larger Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Plan or Larger Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Amended as of June 16, 2005

EXHIBIT 2

Membership Standards
Page 5 of 5

Standard 12: No provider network, or portion thereof, shall be rented or otherwise made available to a National Competitor if the Licensed Marks or Names are used in any way with such network.

A provider network may be rented or otherwise made available, provided there is no use of the Licensed Marks or Names with respect to the network being rented.

Standard 13: Each Plan shall operate in a manner to reasonably: 1) protect the security and confidentiality of Personally Identifiable Information (PII) and Protected Health Information (PHI); 2) protect the Brands from reputational damage; and 3) cooperate with BCBSA and other Plans if a data security incident or data breach occurs.

Amended as of June 18, 2015

EXHIBIT 3

**GUIDELINES WITH RESPECT TO USE OF
LICENSED NAME AND MARKS IN CONNECTION WITH NATIONAL ACCOUNTS**

Page 1 of 3

1. The strength of the Blue Cross/Blue Cross National Accounts mechanism, and the continued provision of cost effective, quality health care benefits to National Accounts, are predicated on locally managed provider networks coordinated on a national scale in a manner consistent with effective service to National Account customers and consistent with the preservation of the integrity of the Blue Cross/Blue Shield system and the Licensed Marks. These guidelines shall be interpreted in keeping with such ends.

2. A National Account is an entity with employee and/or retiree locations in more than one Plan's Service Area. Unless otherwise agreed, a National Account is deemed located in the Service Area in which the corporate headquarters of the National Account is located. A local plant, office or division headquarters of an entity may be deemed a separate National Account when that local plant, office or division headquarters 1) has employee locations in more than one Service Area, and 2) has independent health benefit decision- making authority for the employees working at such local plant, office or division headquarters and for employees working at other locations outside the Service Area. In such a case, the local plant, office or division headquarters is a National Account that is deemed located in the Service Area in which such local plant, office or division headquarters is located. The Control Plan of a National Account is the Plan in whose Service Area the National Account is located. A participating ("Par") Plan is a Plan in whose Service Area the National Account has employee and/or retiree locations, but in which the National Account is not located. In the event that a National Account parent company consolidates health benefit-decision making for itself and its wholly-owned subsidiary companies, the parent company and the subsidiary companies shall be considered one National Account. The Control Plan for such a National Account shall be the Plan in whose Service Area the parent company headquarters is located.

3. The National Account Guidelines enunciated herein below shall be applicable only with respect to the business of new National Accounts acquired after January 1, 1991.

4. Control Plans shall utilize National Account identification cards complying with then currently effective BCBSA graphic standards in connection with all National Accounts business to facilitate administration thereof, to minimize subscriber and provider confusion, and to reflect a commitment to cooperation among Plans.

Amended as of June 12, 2003

EXHIBIT 3

Page 2 of 3

5. Disputes among Plans and/or BCBSA as to the interpretation or implementation of these Guidelines or as to other National Accounts issues shall be submitted to mediation and mandatory dispute resolution as provided in the License Agreement. For two years from the effective date of the License Agreement, however, such disputes shall be subject to mediation only, with the results of such mediation to be collected and reported in order to establish more definitive operating parameters for National Accounts business and to serve as ground rules for future binding dispute resolution.

6. The Control Plan may use the BlueCard Program (as defined by IPPC) to deliver benefits to employees and non-Medicare eligible retirees in a Participating Plan's service area if an alternative arrangement with the Participating Plan cannot be negotiated. The Participating Plan's minimum servicing requirement for those employees and non-Medicare retirees in its service area is to deliver benefits using the BlueCard Program. Account delivery is subject to the policies, provisions and procedures of the BlueCard Program.

7. For provider payments in a Participating Plan's area (on non-BlueCard claims), payment to the provider may be made by the Participating Plan or the Control Plan at the Participating Plan's option. If the Participating Plan elects to pay the provider, it may not withhold payment of a claim verified by the Control Plan or its designated processor, and payment must be in conformity with service criteria established by the Board of Directors of BCBSA (or an authorized committee thereof) to assure prompt payment, good service and minimum confusion with providers and subscribers. The Control Plan, at the Participating Plan's request, will also assure that measures are taken to protect the confidentiality of the data pertaining to provider reimbursement levels and profiles.

Amended as of June 14, 1996

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8. The Control Plan, in its financial agreements with a National Account, is expected to reasonably reflect the aggregate amount of differentials passed along to the Control Plan by all Participating Plans in a National Account.

9. Other than in contracting with health care providers or soliciting such contracts in areas contiguous to a Plan's Service Area in order to serve its subscribers or those of its licensed Controlled Affiliate residing or working in its Service Area, a Control Plan may not use the Licensed Marks and/or Name, as a tag line or otherwise, to negotiate directly with providers outside its Service Area.

Amended as of March 13, 2003

EXHIBIT 4

GOVERNMENT PROGRAMS AND CERTAIN OTHER USES

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1. A Plan and its licensed Controlled Affiliate may use the Licensed Marks and Name in bidding on and executing a contract to serve a Government Program, and in thereafter communicating with the Government concerning the Program. With respect, however, to such contracts entered into after the 1st day of January, 1991, the Licensed Marks and Name will not be used in communications or transactions with beneficiaries or providers in the Government Program located outside a Plan's Service Area, unless the Plan can demonstrate to the satisfaction of BCBSA's governing body that such a restriction on use of the Licensed Marks and Name will jeopardize its ability to procure the contract for the Government Program. As to both existing and future contracts for Government Programs, Plans will discontinue use of the Licensed Marks and Name as to beneficiaries and Providers outside their Service Area as expeditiously as circumstances reasonably permit. Effective January 1, 1995, except as provided in the first sentence above, all use by a Plan of the Licensed Marks and Name in Government Programs outside of the Plan's Service Area shall be discontinued. Incidental communications outside a Plan's Service Area with resident or former resident beneficiaries of the Plan, and other categories of necessary incidental communications approved by BCBSA, are not prohibited. For purposes of this Paragraph 1, the term “Government Programs” shall mean Medicare Part A, Medicare Part B and other non-risk government programs.

2. In connection with activity otherwise in furtherance of the License Agreement, a Plan and its Controlled Affiliates that are licensed to use the Licensed Marks and Name in its Service Area pursuant to the Controlled Affiliate License Agreements authorized in clauses a) through c) of Paragraph 2 of the Plan’s License Agreement with BCBSA may use the Licensed Marks and Name outside the Plan’s Service Area in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

2.1 Common Business Communications

a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);

b. distributing business cards other than in marketing and selling;

c. advertising in publications or electronic media solely to persons for employment;

Amended as of June 19, 2014

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2.2 Marketing Spillover

a. advertising in print, electronic or other media which serve, as a substantial market, the Service Area of the Plan or licensed Controlled Affiliate, provided that no Plan or Controlled Affiliate may advertise outside its Service Area on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Service Area;

b. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Plan's Service Area or that of a licensed Controlled Affiliate;

2.3 Provider Contracting

a. contracting with health care providers or soliciting such contracts in areas contiguous to the Plan's Service Area in order to serve its subscribers or those of such licensed Controlled Affiliates residing or working in its service area;

b. issuing a small sign containing the legal name or trade name of the Plan or such licensed Controlled Affiliates for display by a provider to identify the latter as a participating provider of the Plan or Controlled Affiliate;

c. negotiating case-specific reimbursement rates with a provider that does not have a contract applicable to a specific member’s services rendered or to be rendered with the Licensee (or any of the Licensees in the case of overlapping Service Areas) in whose Service Area the health care provider is located, so long as

(1) the Licensee engaging in the negotiations complies with all applicable Inter-Plan Programs Policies and Provisions and Brand Regulations related to case-specific rate negotiations, and

(2) the Licensee (or all Licensees in the case of overlapping Service Areas) in whose Service Area the health care provider is located provides consent before negotiations commence.

Amended as of January 22, 2019

EXHIBIT 4

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d. contracting with a pharmacy management organization ("Pharmacy Intermediary") to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;

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e. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided that (1) the Plan and the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Plan's Service Area, and (2) neither the Plan's or the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Plan's Service Area;

f. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;

g. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;

h. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Plan's Service Area;

i. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Plan's Service Area;

j. contracting with a specialty pharmaceutical company for non- routine biological therapeutics that are ordered by a health care professional located within the Plan's Service Area;

k. contracting with a company that operates provider sites in the Plan's Service Area, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Plan's Service Area;

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l. contracting with a company that makes health care professionals available in the Plans' Service Area (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Plan's Service Area.

m. permitting Control/Home Plans' ability to resolve members' service issues requiring outreach to out-of-area providers as set forth in the Inter-Plan Programs and Inter-Plan Medicare Advantage Program Policies.

2.4 Services to National Accounts

a. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee (as those terms are defined in the Inter-Plan Programs Policies and Provisions ("IP Policies")) to offer Blue-branded Health Coverage to the National Account, offering Blue-branded Health and Wellness Programs to all members of the National Account, including members who have not enrolled in the Blue-branded Health Coverage ("non-Blue Health Coverage members"), provided that:

(i) the Plan and/or licensed Controlled Affiliate has no contact or interaction with providers outside of the Plan's Service Area, except as specifically provided in the IP Policies and in 2.4 (b); and

(ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Brands a local plant, office or division of the account that is outside of the Plan's Service Area, the Plan and/or licensed Controlled Affiliate may not offer Blue-branded Health and Wellness Programs to any employees working at such local plant, office or division without the consent of such other Licensee; and

(iii) if the Plan and/or licensed Controlled Affiliate provides an information card to the non-Blue Health Coverage members, the card may not display the Symbols in the masthead, must contain a prominent disclosure conveying that it is not a health insurance card, and otherwise must be designed so that it is dissimilar to a Blue member identification card.

Amended as of September 17, 2020

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2.4 Services to National Accounts (continued)

For purposes of this subparagraph a, the following definitions apply:

"Health and Wellness Program" shall mean a program that includes at least one of the following elements or a related element:

- Health Risk Assessment and/or Preventive Screenings
- Exercise and Fitness Programs
- Health and Wellness Events (e.g., attendance at a health fair, a 5K walk)
- Nutrition and Weight Management
- Health Education (e.g., smoking cessation classes)
- Prenatal and Parenting Education
- Disease or Chronic Condition Management

The above listing is intended to represent examples of the types of programs that may be offered, and other programs, including those offered through different media such as the internet or telephonically, may also be deemed Health and Wellness programs.

"Health Coverage" shall mean providing or administering medical, surgical, hospital, major medical, or catastrophic coverage, or any HMO, PPO, POS or other managed care plan for the foregoing services.

b. as part of a Health and Wellness Program that is otherwise compliant with Brand Regulation 4.11.4(a), contracting with a health and wellness organization to gain access to providers to deliver a discrete health and wellness event ("Event") held at a National Account's worksite outside of the Licensee's Service Area, provided that:

(i) the services delivered at the Event are limited to fingerstick screenings for cholesterol and glucose, seasonal flu immunizations, blood pressure measurements, body mass index measurements, and other routine screenings, immunizations and measurements; and

(ii) neither such services nor their costs are applied as claims against any benefit plan; and

(iii) the Event is presented during one or more limited periods during a benefit year and is available to all employees at the worksite.

Amended as of March 26, 2015

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c. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee to offer Blue-branded Health Coverage to the National Account, performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by the National Account to its members, including benefit plans that are not underwritten or administered by the Plan, provided that:

(i) in performing such functions, the Plan and/or licensed Controlled Affiliate does not use the Brands in any communications with health care providers outside of the Plan's Service Area, and otherwise limits its use of the Brands outside of the Service Area to communications with the account's members, the other benefit plan providers with which the account has contracted and other reasonably necessary communications to perform such functions; and

(ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Brands a local plant, office or division of the account that is outside of the Plan's Service Area, the Plan and/or licensed Controlled Affiliate may not perform Eligibility and Enrollment functions for employees working at such local plant, office or division without the consent of such other Licensee;

d. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee to perform or investigate fraud, waste and abuse investigation activities for a non- participating provider in a Par/Host Plan's service area, as long as the Control/Home Plan is given permission to do so by the Par/Host Plan and specific conditions are met in accordance with Inter-Plan Programs and Inter-Plan Medicare Advantage Program policies.

For purposes of this subparagraph b, the following definitions apply: "Health

Coverage" has the meaning set forth in subparagraph 2.4.a.

Amended September 27, 2018

EXHIBIT 4

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"Eligibility" means services that manage the account's eligibility data and determine or process determinations relating to eligibility for benefit plans offered by the account to its employees, including such services as:

- monitoring and auditing data to ensure that only entitled individuals are enrolled in each such benefit plan;
- review of eligibility documentation (e.g. marriage licenses, birth certificates, student status verification letters, employment records);
- identification of key member segments such as over-age dependents, part-time employees, employees reaching certain milestones (e.g. Medicare-eligible, retirees);
- termination of coverage for those individuals found to be ineligible for coverage under a benefit plan, and, if applicable, generation of a COBRA event; and
- management of "hour-banking" for union environments in which union members can bank hours to remain eligible for benefits.

"Enrollment" means services that enroll eligible individuals and their spouses/dependents or terminate or change their enrollment in the account's benefit plans on an ongoing basis and during open enrollment periods, including such services as:

- the coordination of each step in open enrollment process from project planning and system set-up to the generation of confirmation statements;
- ongoing enrollment support for new hires and changes due to life events and work status adjustments;
- evidence of insurability (EOI) administration for life and disability coverage;
- transmission of eligibility/enrollment information to the account's benefit plan providers;
- review and reconciliation of error reports received from the account's benefit plan providers; and
- transmission of information to the account's payroll system (e.g., benefit deductions, employee demographic data).

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2.5 Knowledge Sharing

a. submitting scholarly articles authored or co-authored by the Plan or Controlled Affiliate or its respective employees for publication in peer-reviewed journals;

b. permitting an internal representative of the Licensee (e.g., officer, employee) to speak or present at a conference or symposium outside of the Licensee's Service Area regarding either (i) healthcare financing, administration, delivery or policy, or (ii) topics within the representative's functional discipline or expertise at the Licensee, for which the event sponsor will issue communications to promote, administer, and/or recap the event that will identify the Licensee's representative as a participant. The communications outside of the Licensee's Service Area that mention the Licensee's representative shall be limited to materials and digital media provided to attendees, on-site signage, advertising in relevant trade publications, direct mail and email to attendees and prospective attendees, and the sponsor's website. Participation in any conference or symposium outside of the Licensee's Service Area may not be for the purpose of marketing or selling products or services.

If the Licensee's representative wishes to use the Brands in any manner, including use in his/her title, when participating as a speaker or presenter outside of the Licensee's Service Area about a topic that is not related to healthcare financing, administration, delivery, or policy, or to topics within the representative's functional discipline or expertise at the Licensee, the Licensee must notify BCBSA and receive prior approval from BCBSA before participating;

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2.6 Other Uses

a. entering into a license agreement between and among BCBSA, the Plan and a debit card issuer located outside the Plan's Service Area, and entering into a corresponding operating agreement or agreements, in order to offer a debit card bearing the Licensed Marks and Name to eligible persons as defined by the aforementioned license agreement;

b. appearing in communications issued by an independent third party to recognize outstanding performance of the Plan or Controlled Affiliate or a member of the Plan's or Controlled Affiliate's senior management as part of an established program of the third party for which the Plan has provided information to be considered for the recognition, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;

c. to identify itself as being a joint sponsor of an event, program or activity along with other Plans or such Plans' licensed Controlled Affiliates, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;

d. hosting meetings or events (collectively, "events") in Washington, D.C. or a Plan's State Capitol related to policy and business issues in the Licensee's Service Area, or hosting events in conjunction with the assemblies or conventions of national political parties. Such events may not involve marketing or selling products or services. Use of the Brands outside the Licensee's Service Area in connection with such events shall be limited to materials and digital media provided to attendees and prospective attendees and onsite signage. For any such events in Washington, D.C. that are open to attendees other than government officials or their staffs, or are briefings open to all Congressional staff, or are otherwise likely to receive media coverage, the Licensee is required to provide advance notice to BCBSA. For events hosted outside of Washington, D.C. in conjunction with the assemblies or conventions of national political parties, the Licensee is required to provide advance notice to BCBSA and to the local Plan(s);

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e. permitting an affiliate that is not licensed to use the Licensed Marks to identify its corporate relationship with the Plan, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time.

3. In connection with activity otherwise in furtherance of the License Agreement, a Controlled Affiliate that is licensed to use the Licensed Marks and Name pursuant to a Controlled Affiliate License Agreement authorized in clauses d) or e) of Paragraph 2 of the Plan's License Agreement with BCBSA may use the Licensed Marks and Name outside the Region (as that term is defined in such respective Controlled Affiliate License Agreements) in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);

b. distributing business cards other than in marketing and selling;

c. contracting with health care providers or soliciting such contracts in areas contiguous to the Region in order to serve its subscribers residing in the Region, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans in connection with such contracting unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;

d. issuing a small sign containing the legal name or trade name of the Controlled Affiliate for display by a provider to identify the latter as a participating provider of the Controlled Affiliate, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans on such signs unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;

e. advertising in publications or electronic media solely to persons for employment;

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f. advertising in print, electronic or other media which serve, as a substantial market, the Region, provided that the Controlled Affiliate may not advertise outside its Region on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Region, and provided further that any such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to advertise in such media;

g. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Region, provided that such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to send direct mail to such zip code plus 4.

h. [Intentionally left blank, pending review by the Inter-Plan Programs Committee of the applicability of the case management rule to such Controlled Affiliates.]

i. contracting with a pharmacy management organization ("Pharmacy Intermediary") to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for the Controlled Affiliate's regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective Controlled Affiliate License Agreements, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;

j. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit to the Controlled Affiliate's regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective

EXHIBIT 4

Controlled Affiliate License Agreements, provided that (1) the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Region, and (2) neither the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Region;

k. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for the Controlled Affiliate's regional Medicare Advantage PPO members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;

l. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for the Controlled Affiliate's regional Medicare Advantage members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;

m. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Controlled Affiliate's Region;

n. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Controlled Affiliate's Region;

o. contracting with a specialty pharmaceutical company for non- routine biological therapeutics that are ordered by a health care professional located within the Region;

p. contracting with a company that operates provider sites in the Region, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Region;

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q. contracting with a company that makes health care professionals available in the Region (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Region.

4. BCBSA shall retain the right to use the Licensed Marks in conjunction with the Federal Employee Program and with any other national offering made to federal employees pursuant to the Federal Employees Health Benefits Program (FEHBP), including the right to license such use to its vendors, but only in the following manner.

   a. the Licensed Marks may only be used by BCBSA with the term “Federal Employee Program”, “Federal”, “FEP”, or similar language identifying the program as a benefit program for federal employees;

   b. the Licensed Marks may not be used by BCBSA with the name(s) of a specific Plan or Plans and;

   c. any use by BCBSA in conjunction with a new national FEHBP program proposed after the enactment of this amendment will require the approval of the BCBSA Board of Directors.

5. Where required by applicable state or local law or regulation, a Plan or its licensed Controlled Affiliate may submit documents that contain the Brands to, and file forms that contain the Brands with, state or local regulators in a state not included in its Service Area, provided that it gives reasonable advance notice to the local Plan of its intent to submit such documents or file such forms. Notwithstanding, in no event may a Plan or its licensed Controlled Affiliate use the Brands to register, or to obtain or maintain a license, a certificate of authority, or an equivalent document authorizing it to act as a risk-bearing entity or third party administrator in a state not included in its Service Area. If the local Plan advises BCBSA that it believes its License Agreement has been or would be violated by any submission or filing, BCBSA shall determine whether such submission or filing is required by state or local law or regulation and violates the License Agreement, subject to the Plan’s or licensed Controlled Affiliate’s rights to obtain an independent review of such determination under Paragraph 9(a) and Exhibit 5 of its License Agreement or Paragraph 8 of the Controlled Affiliate License. For purposes of this paragraph, “local Plan” is defined as each Plan whose Service Area includes all or part of the state in which the foregoing applicable state or local law or regulation has been enacted.

Amended as of March 26, 2015

EXHIBIT 5

MEDIATION AND MANDATORY DISPUTE RESOLUTION (MMDR) RULES

The Blue Cross and Blue Shield Plans ("Plans") and the Blue Cross Blue Shield Association ("BCBSA") recognize and acknowledge that the Blue Cross and Blue Shield system is a unique nonprofit and for-profit system offering cost effective health care financing and services. The Plans and BCBSA desire to utilize Mediation and Mandatory Dispute Resolution ("MMDR") to avoid expensive and time-consuming litigation that may otherwise occur in the federal and state judicial systems. Even MMDR should be viewed, however, as methods of last resort, all other procedures for dispute resolution having failed. Except as otherwise provided in the License Agreements, the Plans, their Controlled Affiliates and BCBSA agree to submit all disputes to MMDR pursuant to these Rules and in lieu of litigation.

1. Initiation of Proceedings

A. Pre-MMDR Efforts

Before filing a Complaint to invoke the MMDR process, the CEO of a complaining party, or his/her designated representative, shall undertake good faith efforts with the other side(s) to try to resolve any dispute.

B. Complaint

To commence a proceeding, the complaining party (or parties) shall provide by certified mail, return receipt requested, a written Complaint to the BCBSA Corporate Secretary (which shall also constitute service on BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) named therein.
The Complaint shall contain:

i. identification of the complaining party (or parties) requesting the proceeding;

ii. identification of the respondent(s);

iii. identification of any other persons or entities who are interested in a resolution of the dispute;

iv. a full statement describing the nature of the dispute;

v. identification of all of the issues that are being submitted for resolution;

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vi. the remedy sought;

vii. a statement as to whether the complaining party (or parties) elect(s) first to pursue Mediation;

viii. any request, if applicable, that the matter be handled on an expedited basis and the reasons there for;

ix. a statement signed by the CEO of the complaining party affirming that the CEO has undertaken efforts, or has directed efforts to be undertaken, to resolve the dispute before resorting to the MMDR process;

The complaining party (or parties) shall file and serve with the Complaint copies of all documents which the party (or parties) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

C. Answer

Within twenty (20) days after receipt of the Complaint, each respondent shall serve on BCBSA and on the complaining party (or parties);

i. a full Answer to the aforesaid Complaint;

ii. a statement of any Counterclaims against the complaining party (or parties), providing with respect thereto the information specified in Paragraph 1.B., above;

iii. a statement as to whether the respondent elects to first pursue Mediation; and

iv. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor.

The respondent(s) shall file and serve with the Answer or by the date of the Initial Conference set forth in Paragraph 3.C., below, copies of all documents which the respondent(s) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

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D. Reply To Counterclaim

Within ten (10) days after receipt of any Counterclaim, the complaining party (or parties) shall serve on BCBSA and on the responding party (or parties), a Reply to the Counterclaim. Such Reply must provide the same information required by Paragraph 1.C., above.

2. Mediation

To facilitate the mediation of disputes between or among BCBSA, the Plans and/or their Controlled Affiliates, the BCBSA Board has provided for Mediation under these Rules. Mediation may be pursued in lieu of or in an effort to obviate the Mandatory Dispute Resolution process, and all parties are strongly urged, but not required, to exhaust the mediation procedure provided for herein. In the event any party refuses to proceed with Mediation, the parties shall proceed immediately to Mandatory Dispute Resolution, as provided in Section 3.

A. Selection of Mediators

If all parties agree to pursue Mediation, they shall promptly attempt to agree upon: (i) the number of mediators desired, not to exceed three mediators; and (ii) the selection of experienced mediator(s) from an independent entity to mediate all disputes set forth in the Complaint and Answer (and Counterclaim and Reply, if any). In the event the parties are unable to agree upon the selection or number of mediators, both within five (5) days of the service of the Answer or Reply to Counterclaim, whichever is later, the BCBSA Corporate Secretary shall immediately refer the matter to a nationally recognized professional ADR organization (such as CPR or JAMS) for mediation by a single mediator to be selected by the ADR organization.

B. Binding Decision

Before the Mediation Hearing described below, the BCBSA Corporate Secretary shall contact the parties to determine whether they wish to be bound by any recommendation of the selected mediator(s) for resolution of the disputes. If all wish to be bound, the Corporate Secretary will send appropriate documentation to them for their signatures before the Mediation Hearing begins.

Amended as of September 20, 2007

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C. Mediation Procedure

The Mediator(s) shall apply the mediation procedures and processes provided for herein (not the rules of the ADR organization with which they are affiliated) and shall promptly advise the parties of a scheduled Mediation Hearing date. Unless a party requests an expedited procedure, or unless all parties to the proceeding agree to one or more extensions of time, the Mediation Hearing set forth below shall be completed within forty (40) days of BCBSA's receipt of the Complaint. The selected mediator(s), unless the parties otherwise agree, shall adhere to the following procedure:

i. Each party must be represented by its CEO or other representative who has been delegated full authority to resolve the dispute. However, parties may send additional representatives as they see fit.

ii. Each party will be given one-half hour to present its case, beginning with the complaining party (or parties), followed by the other party or parties. The parties are free to structure their presentations as they see fit, using oral statements or direct examination of witnesses. However, neither cross-examination nor questioning of opposing representatives will be permitted. At the close of each presentation, the selected mediator(s) will be given an opportunity to ask questions of the presenters and witnesses. All parties must be present throughout the Mediation Hearing. The selected mediator(s) may extend the time allowed for each party's presentation at the Mediation Hearing. The selected mediator(s) may meet in executive session, outside the presence of the parties, or may meet with the parties separately, to discuss the controversy.

iii. After the close of the presentations, the parties will attempt to negotiate a settlement of the dispute. If the parties desire, the selected mediator(s), or any one or more of the selected mediators, will sit in on the negotiations.

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iv. After the close of the presentations, the selected mediator(s) may meet privately to agree upon a recommendation for resolution of the dispute which would be submitted to the parties for their consideration and approval. If the parties have previously agreed to be bound by the results of this procedure, this recommendation shall be binding upon the parties.

v. The purpose of the Mediation Hearing is to assist the parties to settle their grievances short of mandatory dispute resolution. As a result, the Mediation Hearing has been designed to be as informal as possible. Rules of evidence shall not apply. There will be no transcript of the proceedings, and no party may make a tape recording of the Mediation Hearing.

vi. In order to facilitate a free and open discussion, the Mediation proceeding shall remain confidential. A "Stipulation to Confidentiality" which prohibits future use of settlement offers, all position papers or other statements furnished to the selected mediator(s), and decisions or recommendations in any Mediation proceeding shall be executed by each party.

vii. Upon request of the selected mediator(s), or one of the parties, BCBSA staff may also submit documentation at any time during the proceedings.

D. Notice of Termination of Mediation

If the Mediation cannot be completed within the prescribed or agreed time period due to the lack of cooperation of any party, as determined by the selected mediator(s), or if the Mediation does not result in a final resolution of all disputes at the Mediation Hearing or within ten (10) days after the Mediation Hearing, any party or any one of the selected mediators shall so notify the BCBSA Corporate Secretary, who shall promptly issue a Notice of Termination of Mediation to all parties, to the selected mediator(s), and to the MDR Administrator. Such notice shall serve to bring the Mediation to an end and to initiate Mandatory Dispute Resolution. Upon agreement of all parties and the mediator(s), the Mediation process may continue at the same time the MDR process is invoked. In such case, the Notice of Termination of Mediation described above serves to initiate the MDR proceeding, but does not terminate mediation proceedings, which may proceed simultaneous with the MDR proceeding.

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3. Mandatory Dispute Resolution (MDR)

If any party elects not to first pursue Mediation, or if a Notice of Termination of Mediation is issued as set forth in Paragraph 2.D., above, then the unresolved disputes set forth in any Complaint and Answer (and Counterclaim and Reply, if any) shall be subject to mandatory binding arbitration (herein referred to as "MDR").

A. MDR Administrator

The Administrator for purposes of Mandatory Arbitration shall be an independent nationally recognized entity such as CPR or JAMS, specializing in alternative dispute resolution. In the event the parties pursued Mediation with CPR, JAMS or a similar organization, that organization also shall serve as the MDR Administrator, unless all parties notify the BCBSA Corporate Secretary in writing within two (2) days of receiving the Notice of Termination of Mediation that they wish to pursue MDR with another nationally recognized organization serving as MDR Administrator.

In the event the parties (i) did not pursue Mediation, (ii) pursued mediation with a Mediator not affiliated with an ADR organization that offers a panel of arbitrators, or (iii) all parties that pursued Mediation notified the BCBSA Corporate Secretary that they wish to have an MDR Administrator that is different from the organization with which their mediator was affiliated, they shall promptly attempt to agree on a nationally recognized ADR entity that supplies a panel of arbitrators. If they reach such agreement within five (5) days of the Notice of Termination of Mediation or receipt of the Answer or Reply to Counterclaim (whichever is later), the parties shall promptly inform the BCBSA Corporate Secretary of their agreed upon ADR organization. In the event the parties are unable to reach agreement on an MDR Administrator within that timeframe, the BCBSA Corporate Secretary shall immediately refer the matter to CPR, JAMS or a similar organization for MDR.

Any person who served as a Mediator shall not serve as an arbitrator for the same or similar dispute for purposes of MDR.

B. Rules for MDR

The rules controlling all aspects of MDR shall be exclusively those provided for herein. The rules promulgated or otherwise used by the MDR Administrator organization shall not apply.

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C. Initial Conference

Within seven (7) days after a Notice of Termination has issued or the matter has otherwise been referred to an MDR Administrator, or within five (5) days after the time for filing and serving the Answer or Reply to any Counterclaim (whichever is later) if the parties elect first not to mediate, the parties shall confer with the Administrator to discuss selecting a dispute resolution panel ("the Panel"). This conference (the “Initial Conference”) may be by telephone. The parties are encouraged to agree to the composition of the Panel and to present that agreement to the Administrator at the Initial Conference. If the parties do not agree on the composition of the Panel by the time of the Initial Conference, or by any extension thereof agreed to by all parties and the Administrator, then the Panel Selection Process set forth in subparagraph D, below, shall be followed.

D. Panel Selection Process

The Administrator shall designate, prior to the Initial Conference, at least seven potential arbitrators. Each party shall be permitted to strike any designee for cause and the Administrator shall determine the sufficiency thereof in its sole discretion. The Administrator will designate a replacement for any designee so stricken. Each party shall then be permitted one peremptory strike from the list of designees. The Administrator shall set the dates for exercising all strikes, which shall be set to encourage the prompt selection of arbitrators.

After the parties exercise any designee strikes for cause and their peremptory strike against any designee of their choice, the parties shall each rank the remaining panel members in order of preference and provide the Administrator, without serving on any other party, their ranked list. The Administrator shall not disclose any party’s ranked list to members of the panel or to other parties.

From the remaining designees, and after considering opportunities to maximize, so far as possible, the collectively stated arbitrator preferences provided by the parties on their ranked lists, the Administrator shall select a three member Panel. The Panel Selection Process shall be completed no later than ten (10) days after the Initial Conference.

Each Arbitrator shall be compensated at his or her normal hourly rate or, in the absence of an established rate, at a reasonable hourly rate to be promptly fixed by the Administrator for all time spent in connection with the proceedings and shall be reimbursed for any travel and other reasonable expenses.

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E. Duties Of The Arbitrators

The Panel shall promptly designate a Presiding Arbitrator for the purposes reflected below, but shall retain the power to review and modify any ruling or other action of said Presiding Arbitrator. Each Arbitrator shall be an independent Arbitrator, shall be governed by the Code of Ethics for Arbitrators in Commercial Disputes and shall at or prior to the commencement of any Arbitration Hearing take an oath to that effect. Each Arbitrator shall promptly disclose in writing to the Panel and to the parties any circumstances, whenever arising, that might cause doubt as to such Arbitrator's compliance, or ability to comply, with said Code of Ethics, and, absent resignation by such Arbitrator, the remaining Arbitrators shall determine in their sole discretion whether the circumstances so disclosed constitute grounds for disqualification and for replacement. With respect to such circumstances arising or coming to the attention of a party after an Arbitrator's selection, a party may likewise request the Arbitrator's resignation or a determination as to disqualification by the remaining Arbitrators. With respect to a sole Arbitrator, the determination as to disqualification shall be made by the Administrator.

There shall be no ex parte communication between the parties or their counsel and any member of the Panel.

F. Panel's Jurisdiction And Authority

The Panel's jurisdiction and authority shall extend to all disputes between or among the Plans, their Controlled Affiliates, and/or BCBSA, except for those disputes excepted from these MMDR procedures as set forth in the License Agreements.

With the exception of punitive or treble damages, the Panel shall have full authority to award the relief it deems appropriate to resolve the parties' disputes, including monetary awards and injunctions, mandatory or prohibitory. The Panel has no authority to award punitive or treble damages except that the Panel may allocate or assess responsibility for punitive or treble damages assessed by another tribunal. Subject to the above limitations, the Panel may, by way of example, but not of limitation:

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i. interpret or construe the meaning of any terms, phrase or provision in any license between BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.

ii. determine whether BCBSA, a Plan or a Controlled Affiliate has violated the terms or conditions of any license between the BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.

iii. decide challenges as to its own jurisdiction.

iv. issue such orders for interim relief as it deems appropriate pending Hearing and Award in any Arbitration.

It is understood that the Panel is expected to resolve issues based on governing principles of law, preserving to the maximum extent legally possible the continued integrity of the Licensed Marks and the BLUE CROSS/BLUE SHIELD system. The Panel shall apply federal law to all issues which, if asserted in the United States District Court, would give rise to federal question jurisdiction, 28 U.S.C. § 1331. The Panel shall apply Illinois law to all issues involving interpretation, performance or construction of any License Agreement or Controlled Affiliate License Agreement unless the agreement otherwise provides. As to other issues, the Panel shall choose the applicable law based on conflicts of law principles of the State of Illinois.

G. Administrative Conference

Within five (5) days of the Panel being selected, the Presiding Arbitrator shall confer with the parties and the other members of the Panel and shall schedule, in writing, a conference in which the parties and the Panel shall participate (the "Administrative Conference"). The Administrative Conference shall take place no later than fifteen (15) days after the Panel is selected. At the Administrative Conference the parties and the Panel shall discuss the scheduling of the Arbitration Hearing and any other matter appropriate to be considered, including but not limited to: any written discovery in the form of requests for production of documents or requests to admit facts; the identity of any witness whose deposition a party may desire and a showing of exceptional good cause for the taking of any such deposition; the desirability of bifurcation or other separation of the issues; the need for and the type of record of conferences and hearings, including the need for transcripts; the need for expert witnesses and

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how expert testimony should be presented; the appropriateness of motions to dismiss and/or for full or partial summary judgment; consideration of stipulations; the desirability of presenting any direct testimony in writing; and the necessity for any on-site inspection by the Panel. If the parties agree, the Administrative Conference may be by telephone.

H. Discovery

i. ***Requests for Production of Documents***: All requests for the production of documents must be served no later than five (5) days after the date of the Initial Conference. Within twenty (20) days after receipt of a request for production of documents, a party shall (a) serve responses and objections to the request,
(b) produce all responsive, non-privileged documents to the requesting party, and (c) to the extent any responsive documents are withheld on the grounds of attorney-client privilege or work product, produce a log identifying such documents in the manner specified in Fed. R. Civ. P. 26(b)(5). If, after reviewing a privilege log, the requesting party believes attorney-client privilege or work product protection was improperly claimed by the producing party with respect to any document, the requesting party may ask the Presiding Arbitrator to conduct an in-camera inspection of the same. With respect to documentary and other discovery produced in any MDR proceeding by BCBSA, the fact that a party's CEO or other senior officers may serve on the BCBSA Board of Directors, BCBSA Board Committees or other BCBSA work groups, task forces and the like, shall not be a basis for defeating an otherwise valid claim of attorney-client privilege or work product protection over such documentary or other discovery materials by BCBSA.

ii. ***Requests for Admissions***: Requests for Admissions may be served up to twenty-one (21) days prior to the discovery cut-off set by the Presiding Arbitrator. A party served with Requests For Admissions must respond within twenty (20) days of receipt of said request. The good faith use of and response to Requests for Admissions is encouraged, and the Panel shall have full discretion, with reference to the Federal Rules of Civil Procedure, in awarding appropriate sanctions with respect to abuse of the procedure.

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iii. ***Depositions**:* As a general rule, the parties will not be permitted to take party or non-party deposition testimony for discovery purposes. The Presiding Arbitrator, in his or her sole discretion, shall have the authority to permit a party to take such deposition testimony upon a showing of exceptional good cause. The parties will be permitted to take de bene esse deposition[1] testimony to the fullest extent permitted by law of any witness who cannot be compelled to testify at the Arbitration Hearing. No deposition, for discovery purposes or otherwise, shall exceed three (3) hours, excluding objections and colloquy of counsel. Depositions may be recorded in any manner recognized by the Federal Rules of Civil Procedure and the parties shall specify in each notice of deposition or request for permission to take deposition testimony the manner in which such deposition shall be recorded.

iv. ***Expert witness(es)***: If a party intends to present the testimony of an expert witness during the oral hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2)
A. ten (10) days prior to the discovery cut-off set by the Presiding Arbitrator. If a party intends to present the testimony of a rebuttal expert witness during the Arbitration Hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2)(B) within twenty (20) days after the date on which the written statement of the expert witness whose testimony is to be rebutted was produced.

v. ***Discovery cut-off**:* The Presiding Arbitrator shall determine the date on which the discovery period will end, but the discovery period shall not exceed thirty (30) days from the date of the Administrative Conference without the agreement of all parties.

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[1] As used in these Rules, "de bene esse deposition" means a deposition that is not taken for discovery purposes, but is taken for the purpose of reading part or all of the deposition transcript into the record at the Arbitration Hearing, to the extent permitted by the Panel, because the witness cannot be compelled to testify at the Arbitration Hearing or has exercised a right provided under these Rules to provide deposition testimony in lieu of testimony at the Arbitration Hearing.

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vi. ***Additional discovery***: Any additional discovery will be at the discretion of the Presiding Arbitrator.

vii. ***Discovery Disputes****:* Any discovery disputes shall be raised by motion to the Presiding Arbitrator, who is authorized to resolve all such disputes, and whose resolution will be binding on the parties unless modified by the Arbitration Panel. Prior to raising any discovery dispute with the Presiding Arbitrator, the parties shall meet and confer, telephonically or in person, in an attempt to resolve or narrow the dispute. If a party refuses to comply with a decision resolving a discovery dispute, the Panel, in keeping with Fed. R. Civ. P. 37, may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for resolution adversely to that party.

viii. ***Extensions****:* The time for responding to discovery requests may be extended by the Presiding Arbitrator for good and sufficient cause shown. Any request for such an extension shall be made in writing.

I. Panel Suggested Settlement/Mediation

At any point during the proceedings, the Panel at the request of any party or on its own initiative, may suggest that the parties explore settlement and that they do so at or before the conclusion of the Arbitration Hearing, and the Panel shall give such assistance in settlement negotiations as the parties may request and the Panel may deem appropriate. Alternatively, the Panel may direct the parties to endeavor to mediate their disputes as provided above, or to explore a mini-trial proceeding, or to have an independent party render a neutral evaluation of the parties' respective positions. The Panel shall enter such sanctions as it deems appropriate with respect to any party failing to pursue in good faith such Mediation or other alternate dispute resolution methods.

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J. Subpoenas on Third Parties

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq*., and subject to Paragraph 3.G(iii) above, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan or any officer, employee or director of a third party Blue Plan, to compel deposition testimony or the production of documents, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena.

K. Arbitration Hearing

An Arbitration Hearing will be held within thirty (30) days after the Administrative Conference if no discovery is taken, or within thirty (30) days after the close of discovery, unless all parties and the Panel agree to extend the Arbitration Hearing date, or unless the parties agree in writing to waive the Arbitration Hearing. The parties may mutually agree on the location of the Arbitration Hearing. If the parties fail to agree, the Arbitration Hearing shall be held in Chicago, Illinois, or at such other location determined by the Presiding Arbitrator to be most convenient to the participants. The Panel will determine the date(s) and time(s) of the Arbitration Hearing(s) after consultation with all parties and shall provide reasonable notice thereof to all parties or their representatives.

L. Arbitration Hearing Memoranda

Twenty (20) days prior to the Arbitration Hearing, each party shall submit to the other party (or parties) and to the Panel an Arbitration Hearing Memorandum which sets forth the applicable law and any argument as to any relevant issue. The Arbitration Hearing Memorandum will supplement, and not repeat, the allegations, information and documents contained in or with the Complaint, Answer, Counterclaim and Reply, if any. Ten (10) days prior to the Arbitration Hearing, each party shall submit to each other party a list of all expert and fact witnesses (but not including rebuttal fact witness) that such party intends to have testify at the Arbitration Hearing and a brief summary of the testimony each such witness is expected to give. In addition, no later than five (5) days prior to the Arbitration, each party may submit to each other party and to the Panel a Response Arbitration Hearing Memorandum which sets forth any response to another party's Arbitration Hearing Memorandum.

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M. Notice For Testimony

Ten (10) days prior to the Arbitration Hearing, any party may serve a Notice on any other party (or parties) requesting the attendance at the Arbitration Hearing of any officer, employee or director of the other party (or parties) for the purpose of providing noncumulative testimony. If a party fails to produce one of its officers, employees or directors whose noncumulative testimony during the Arbitration Hearing is reasonably requested by an adverse party, the Panel may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for mandatory dispute resolution adversely to that party; provided, however, that a party may refuse to produce a director to testify if, within two (2) days of receiving a notice requesting the attendance of such director at the Arbitration Hearing, the party agrees to make the director available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. This Rule may not be used for the purpose of burdening or harassing any party, and the Presiding Arbitrator may impose such orders as are appropriate so as to prevent or remedy any such burden or harassment.

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq.*, twenty (20) days or more prior to the Arbitration Hearing, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan, BCBSA or any officer, employee or director of a third party Blue Plan or BCBSA for the purpose of providing noncummulative testimony at the Arbitration Hearing, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena; provided however, that a director of a third party Blue Plan or BCBSA may refuse to testify if, within two (2) days of receiving a subpoena requesting the attendance of such director at the Arbitration Hearing, the director agrees to make him/herself available for a de bene esse deposition at a mutually convenient time at any location within fifty
(50) miles of the director's primary residence chosen by the party requesting the director's testimony. Each Blue Plan agrees to waive, on its own behalf and on behalf of its directors and officers, any objection it otherwise might have to any such subpoena based on service, venue or extraterritoriality.

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N. Arbitration Hearing Procedures

i. ***Attendance at Arbitration Hearing***: Any person having a direct interest in the proceeding is entitled to attend the Arbitration Hearing. The Presiding Arbitrator shall otherwise have the power to require the exclusion of any witness, other than a party or other essential person, during the testimony of any other witness. It shall be discretionary with the Presiding Arbitrator to determine the propriety of the attendance of any other person.

ii. ***Confidentiality***: The Panel and all parties shall maintain the privacy of the Arbitration Proceeding. The parties and the Panel shall treat the Arbitration Hearing and any discovery or other proceedings or events related thereto, including any award resulting therefrom, as confidential except as otherwise necessary in connection with a judicial challenge to or enforcement of an award or unless otherwise required by law.

iii. ***Stenographic Record***: Any party, or if the parties do not object, the Panel, may request that a stenographic or other record be made of any Arbitration Hearing or portion thereof. The costs of the recording and/or of preparing the transcript shall be borne by the requesting party and by any party who receives a copy thereof. If the Panel requests a recording and/or a transcript, the costs thereof shall be borne equally by the parties.

iv. ***Oaths***: The Panel may require witnesses to testify under oath or affirmation administered by any duly qualified person and, if requested by any party, shall do so.

v. ***Order of Arbitration Hearing***: An Arbitration Hearing shall be opened by the recording of the date, time, and place of the Arbitration Hearing, and the presence of the Panel, the parties, and their representatives, if any. The Panel may, at the beginning of the Arbitration Hearing, ask for statements clarifying the issues involved.

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Unless otherwise agreed, the complaining party (or parties) shall then present evidence to support their claim(s). The respondent(s) shall then present evidence supporting their defenses and Counterclaims, if any. The complaining party (or parties) shall then present evidence supporting defenses to the Counterclaims, if any, and rebuttal.

Witnesses for each party shall submit to questions by adverse parties and/or the Panel.

The Panel has the discretion to vary these procedures, but shall afford a full and equal opportunity to all parties for the presentation of any material and relevant evidence.

vi. ***Evidence***: The parties may offer such evidence as is relevant and material to the dispute and shall produce such evidence as the Panel may deem necessary to an understanding and resolution of the dispute. Unless good cause is shown, as determined by the Panel or agreed to by all other parties, no party shall be permitted to offer evidence at the Arbitration Hearing which was not disclosed prior to the Arbitration Hearing by that party. The Panel may receive and consider the evidence of witnesses by affidavit upon such terms as the Panel deems appropriate.

The Panel shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence, other than enforcement of the attorney-client privilege and the work product protection, shall not be necessary. The Federal Rules of Evidence shall be considered by the Panel in conducting the Arbitration Hearing but those rules shall not be controlling. All evidence shall be taken in the presence of the Panel and all of the parties, except where any party is in default or has waived the right to be present.

Settlement offers by any party in connection with Mediation or MDR proceedings, decisions or recommendations of the selected mediators, and a party's position papers or statements furnished to the selected mediators shall not be admissible evidence or considered by the Panel without the consent of all parties.

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vii. ***Closing of Arbitration Hearing***: The Presiding Arbitrator shall specifically inquire of all parties whether they have any further proofs to offer or witnesses to be heard. Upon receiving negative replies or if he or she is satisfied that the record is complete, the Presiding Arbitrator shall declare the Arbitration Hearing closed with an appropriate notation made on the record. Subject to being reopened as provided below, the time within which the Panel is required to make the award shall commence to run, in the absence of contrary agreement by the parties, upon the closing of the Arbitration Hearing.

With respect to complex disputes, the Panel may, in its sole discretion, defer the closing of the Arbitration Hearing for a period of up to thirty (30) days after the presentation of proofs in order to permit the parties to submit post-hearing briefs and argument, as the Panel deems appropriate, prior to making an award.

For good cause, the Arbitration Hearing may be reopened for up to thirty (30) days on the Panel's initiative, or upon application of a party, at any time before the award is made

O. Awards

An Award must be in writing and shall be made promptly by the Panel and, unless otherwise agreed by the parties or specified by law, no later than thirty (30) days from the date of closing the Arbitration Hearing. If all parties so request, the Award shall contain findings of fact and conclusions of law. The Award, and all other rulings and determinations by the Panel, may be by a majority vote.

Parties shall accept as legal delivery of the Award the placing of the Award or a true copy thereof in the mail addressed to a party or its representative at its last known address or personal service of the Award on a party or its representative.

Awards are binding only on the parties to the Arbitration and are not binding on any non-parties to the Arbitration and may not be used or cited as precedent in any other proceeding.

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After the expiration of twenty (20) days from initial delivery, the Award (with corrections, if any) shall be final and binding on the parties, and the parties shall undertake to carry out the Award without delay.

Proceedings to confirm, modify or vacate an Award shall be conducted in conformity with and controlled by the Federal Arbitration Act. 9 U.S.C. § 1, *et seq*.

P. Return of Documents

Within sixty (60) days after the Award and the conclusion of any judicial proceedings with respect thereto, each party and the Panel shall return any documents produced by any other party, including all copies thereof. If a party receives a discovery request in any other proceeding which would require it to produce any documents produced to it by any other party in a proceeding hereunder, it shall not produce such documents without first notifying the producing party and giving said party reasonable time to respond, if appropriate, to the discovery request.

4. Miscellaneous

A. Expedited Procedures

Any party to a Mediation may direct a request for an expedited Mediation Hearing to the Chairman of the Mediation Committee, to the selected Mediators, and to all other parties at any time. The Chairman of the Mediation Committee, or at his or her direction, the then selected Mediators, shall grant any request which is supported by good and sufficient reasons. If such a request is granted, the Mediation shall be completed within as short a period as practicable, as determined by the Chairman of the Mediation Committee or, at his or her direction, the then selected Mediators.

Any party to an Arbitration may direct a request for expedited proceedings to the Administrator, to the Panel, and to all other parties at any time. The Administrator, or the Presiding Arbitrator if the Panel has been selected, shall grant any such request which is supported by good and sufficient reasons. If such a request is granted, the Arbitration shall be completed within as short a time as practicable, as determined by the Administrator and/or the Presiding Arbitrator.

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B. Temporary or Preliminary Injunctive Relief

Any party may seek temporary or preliminary injunctive relief with the filing of a Complaint or at any time thereafter. If such relief is sought prior to the time that an Arbitration Panel has been selected, then the Administrator shall select a single Arbitrator who is a lawyer who has no interest in the subject matter of the dispute, and no connection to any of the parties, to hear and determine the request for temporary or preliminary injunction. If such relief is sought after the time that an Arbitration Panel has been selected, then the Arbitration Panel will hear and determine the request. The request for temporary or preliminary injunctive relief will be determined with reference to the temporary or preliminary injunction standards set forth in Fed. R. Civ. P. 65.

C. Defaults and Proceedings in the Absence of a Party

Whenever a party fails to comply with the MDR Rules in a manner deemed material by the Panel, the Panel shall fix a reasonable time for compliance and, if the party does not comply within said period, the Panel may enter an Order of default or afford such other relief as it deems appropriate.
Arbitration may proceed in the event of a default or in the absence of any party who, after due notice, fails to be present or fails to obtain an extension. An Award shall not be made solely on the default or absence of a party, but the Panel shall require the party who is present to submit such evidence as the Panel may require for the making of findings, determinations, conclusions, and Awards.

D. Notice

Each party shall be deemed to have consented that any papers, notices, or process necessary or proper for the initiation or continuation of a proceeding under these rules or for any court action in connection therewith may be served on a party by mail addressed to the party or its representative at its last known address or by personal service, in or outside the state where the MDR proceeding is to be held.

The Corporate Secretary and the parties may also use facsimile transmission, telex, telegram, or other written forms of electronic communication to give the notices required by these rules.

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E. Expenses

The expenses of witnesses shall be paid by the party causing or requesting the appearance of such witnesses. All expenses of the MDR proceeding, including compensation, required travel and other reasonable expenses of the Panel, and the cost of any proof produced at the direct request of the Panel, shall be borne equally by the parties and shall be paid periodically on a timely basis, unless they agree otherwise or unless the Panel in the Award assesses such expenses, or any part thereof against any party (or parties). In exceptional cases, the Panel may award reasonable attorneys' fees as an item of expense, and the Panel shall promptly determine the amount of such fees based on affidavits or such other proofs as the Panel deems sufficient.

F. Disqualification or Disability of A Panel Member

In the event that any Arbitrator of a Panel with more than one Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the remaining Panel member(s):

i. shall designate a replacement, subject to the right of any party to challenge such replacement for cause.

ii. shall decide the extent to which previously held hearings shall be repeated.

If the remaining Panel members consider the proceedings to have progressed to a stage as to make replacement impracticable, the parties may agree, as an alternative to the recommencement of the Mandatory Dispute Resolution process, to resolution of the dispute by the remaining Panel members.

In the event that a single Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the Administrator shall appoint a successor, subject to the right of any party to challenge such successor for cause, and the successor shall decide the extent to which previously held proceedings shall be repeated.

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G. Extensions of Time

Subject to the provisions of Paragraph 3.H.(viii.), any time limit set forth in these Rules may be extended upon agreement of the parties and approval of: (1) the Mediator if the proceeding is then in Mediation; (2) the Administrator if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (3) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected.

H. Intervention

The Plans, their Controlled Affiliates, and BCBSA, to the extent subject to MMDR pursuant to their License Agreements, shall have the right to move to intervene in any pending Arbitration. A written motion for intervention shall be made to: (1) the Administrator, if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (2) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected. The written motion for intervention shall be delivered to the BCBSA Corporate Secretary (which shall also constitute service on the BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) which are parties to the proceeding. Any party to the proceeding can submit written objections to the motion to intervene. The motion for intervention shall be granted upon good cause shown. Intervention also may be allowed by stipulation of the parties to the Arbitration proceeding. Intervention shall be allowed upon such terms as the Arbitration Panel decides.

I. BCBSA Assistance in Resolution of Disputes

The resources and personnel of the BCBSA may be requested by any member Plan at any time to try to resolve disputes with another Plan.

J. Neutral Evaluation

The parties can voluntarily agree at any time to have an independent party render a neutral evaluation of the parties' respective positions.

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K. Recovery of Attorney Fees and Expenses

i. Motions to Compel

Nothwithstanding any other provisions of these Rules, any Party subject to the License Agreements (for purposes of this Section K and all of its sub- sections only hereinafter referred to collectively and individually as a "Party") that initiates a court action or administrative proceeding solely to compel adherence to these Rules shall not be determined to have violated these Rules by initiating such action or proceeding.

ii. Recovery of Fees, Expenses and Costs

The Arbitration Panel may, in its sole discretion, award a Party its reasonable attorneys' fees, expenses and costs associated with a filing to compel adherence to these Rules and/or reasonable attorneys' fees, expenses and costs incurred in responding to an action filed in violation of these Rules; provided, however, that neither fees, expenses, nor costs shall be awarded by the Arbitration Panel if the Party from which the award is sought can demonstrate to the Arbitration panel, in its sole discretion, that it did not violate these Rules or that it had reasonable grounds for believing that its action did not violate these Rules.

iii. Requests for Reimbursement

For purposes of this Section K, any Party may request reimbursement of fees, expenses and/or costs by submitting said request in writing to the Arbitration Panel at any time before an award is delivered pursuant Paragraph to 3.O above with a copy to the Party from which reimbursement is sought, explaining why it is entitled to such reimbursement. The Party from which reimbursement is sought shall have twenty (20) days to submit a response to such request to the Arbitration Panel with a copy to the Party seeking reimbursement.

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L. Calculation of Time and Deadlines

In computing any period of time prescribed or allowed under these rules, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not one of the aforementioned days. When the period of time prescribed is less than six (6) days, intermediate Saturdays, Sundays and legal holidays shall be excluded in the computation. As used in this rule, “legal holiday” includes New Year’s Day, Martin Luther King, Jr. Day, Washington’s Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day and any other day appointed as a holiday by the President or the Congress of the United States.

Amended as of September 20, 2007

BLUE SHIELD LICENSE AGREEMENT

(Includes revisions, if any, adopted by Member Plans through their September 17, 2020 meeting)

This agreement by and between Blue Cross and Blue Shield Association ("BCBSA") and The Blue Shield Plan, known as _____ (the "Plan").

Preamble

WHEREAS, the Plan and/or its predecessor(s) in interest (collectively the "Plan") had the right to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") for health care plans in its service area, which was essentially local in nature;

WHEREAS, the Plan was desirous of assuring nationwide protection of the Licensed Marks, maintaining uniform quality controls among Plans, facilitating the provision of cost effective health care services to the public and otherwise benefiting the public;

WHEREAS, to better attain such ends, the Plan and the predecessor of BCBSA executed the Agreement(s) Relating to the Collective Service Mark "Blue Shield"; and

WHEREAS, BCBSA and the Plan desire to supercede said Agreement(s) to reflect their current practices and to assure the continued integrity of the Licensed Marks and of the BLUE SHIELD system;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

Agreement

1. BCBSA hereby grants to the Plan, upon the terms and conditions of this License Agreement ("Agreement" or "Primary License Agreement"), the right to use BLUE SHIELD in its trade and/or corporate name (the "Licensed Name"), and the right to use the Licensed Marks, in the sale, marketing and administration of health care plans and related services in the Service Area set forth and defined in paragraph 5 below. As used herein, health care plans and related services shall include acting as a nonprofit health care plan, a for-profit health care plan, or mutual health insurer operating on a not-for-profit or for-profit basis, under state law; financing access to health care services; when working with a bank that holds the relevant license to use the Licensed Name and Marks, offering: (i) tax-favored savings accounts for medical expenses and means for accessing such accounts, such as debit cards or checks, that are provided solely to support access to such tax-favored savings accounts, all pursuant to such license, or (ii) prepaid rewards cards that are provided for completion of a wellness program, all pursuant to such license; providing health care management and administration; administering, but not underwriting, non-health portions of Workers' Compensation Insurance; delivering health care services, except hospital services (as defined in the Guidelines to Membership Standards Applicable to Regular Members); and performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by a group account to its members, including benefit plans not provided by the Plan, provided that the Plan has contracted to provide Health Coverage under the Licensed Marks to the account (as the terms "Health Coverage", "Eligibility" and "Enrollment" are defined in Exhibit 4, Paragraph 2.t.).

2. The Plan may use the Licensed Marks and Name in connection with the offering of: i) health care plans and related services in the Service Area through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the "Controlled Affiliate License Agreement"); and ii) insurance coverages offered by life insurers under the applicable law in the Service Area, other than those which the Plan may offer in its own name, provided through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1A hereto (the "Controlled Affiliate License Agreement Applicable to Life Insurance Companies") or the Agreement attached as Exhibit 1A1 hereto (the "Controlled Affiliate Trademark License Agreement for Life and Disability Insurance Products") and further provided that the offering of such services does not and will not dilute or tarnish the unique value of the Licensed Marks and Name; and iii) administration and underwriting of Workers' Compensation Insurance Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the "Controlled Affiliate License"); and iv) regional Medicare Advantage PPO Products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1B hereto (the "Controlled Affiliate License Agreement Applicable to Regional Medicare Advantage PPO Products"); and v) regional Medicare Part D Prescription Drug Plan products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1C hereto (the "Controlled Affiliate License Agreement Applicable to Regional Medicare Part D Prescription Drug Plan Products"). As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans and, if the entity meets the standards of Paragraph 2a.B but not Paragraph 2a.A, the entity, its owners, and persons with

Amended as of September 19, 2014

authority to select or appoint members or board members, other than a Plan or Plans, have received written approval of BCBSA. Absent written approval by BCBSA of an alternative method of control, bona fide control shall have the meaning set forth in Paragraphs 2a. and 2b.

2a. With respect to the Controlled Affiliate Licenses authorized in clauses i) through iii) of Paragraph 2, bona fide control shall mean that a Plan (the "Sponsoring Plan") authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to this Primary License Agreement with BCBSA must have:

A. The legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; (b) to exercise control over the policy and operations of the Controlled Affiliate; (c) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control more than 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee; or

B. The legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; (c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan. Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

1. Change its legal and/or trade name;

2. Change the geographic area in which it operates;

3. Change any of the types of businesses in which it engages;

4. Create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

5. Sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;

6. Make any loans or advances except in the ordinary course of business;

Amended as of March 26, 2015

7. Enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners of the Controlled Affiliate or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

8. Conduct any business other than under the Licensed Marks and Name;

9. Take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks or Names.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control at least 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee; or

C. With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services, the legal authority by the Sponsoring Plan together with such other Plans (a) to select all members of the Controlled Affiliate's governing body; (b) to prevent any change in the articles of incorporation, bylaws, or other establishing or governing documents of the Controlled Affiliate; (c) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the "Addendum to Controlled Affiliate License" attached as Exhibit B-1 to Exhibit 1 attached hereto; or

Amended as of June 20, 2019

D. With respect to a Controlled Affiliate that is 100% controlled by a Sponsoring Plan which on a Blue-branded basis, offers solely a Basic Medicare Part D Prescription Drug product, the legal authority by the Sponsoring Plan (a) to select all members of the Controlled Affiliate's governing body; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; (c) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by the Plan shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and Participating Plan as defined on the Controlled Affiliate License Agreement shall execute the "Addendum to Controlled Affiliate License" attached as Exhibit B-2 to Exhibit 1 attached hereto.

E. With respect to a Controlled Affiliate that operates as a clinic, the legal authority by the Sponsoring Plan to exercise control over the policy and operations of the Controlled Affiliate as defined in Exhibit 1, Standard 1(E) and the Guidelines to Administer Standard 1 (E). In addition, if the clinic is for-profit, the Sponsoring Plan shall own at least 50% of the Controlled Affiliate and prevent any change in the articles of incorporation, bylaws or other establishing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur.

2b. With respect to the Controlled Affiliate License Agreements authorized in clauses iv) and v) of Paragraph 2, bona fide control shall mean that the Controlled Affiliate is organized and operated in such a manner that it meets the following requirements:

A. The Controlled Affiliate is owned or controlled by two or more Plans authorized to use the Licensed Marks pursuant to this License Agreement with BCBSA (for purposes of this subparagraph A. through subparagraph C., the "Controlling Plans"); and

Amended as of June 20, 2019

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B. Each Controlling Plan is authorized pursuant to this Agreement to use the Licensed Marks in a geographic area in the Region (as that term is defined in such Controlled Affiliate License Agreements) and every
geographic area in the Region is so licensed to at least one of the Controlling Plans; and

C. The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur; and (c) to exercise control over the policy and operations of the Controlled Affiliate. Notwithstanding anything to the contrary in (a) through (c) of this subparagraph E., the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

1. Change its legal and/or trade names;

2. Change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

3. Change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

4. Take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly- owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Amended as of June 20, 2019

(the next page is 3)

3. With respect to a Controlled Affiliate that is not licensed to use the Licensed Marks and Name, the Plan may, in communications that contain the Licensed Marks or Name, indicate its corporate relationship to the Affiliate and permit such Affiliate to indicate its corporate relationship to the Plan, solely in the circumstances, style and manner specified by BCBSA from time-to-time in regulations of general application consistent with the avoidance of confusion or mistake or the dilution or tarnishment of the Licensed Marks and Name. No rights are hereby created in any Controlled Affiliate to use the Licensed Marks or Name in its own name or otherwise.

4. The Plan recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Plan further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide. The Plan agrees (a) to maintain in good standing its membership in BCBSA; (b) promptly to pay its dues to BCBSA, said dues to represent the royalties for this License Agreement; (c) materially to comply with all applicable laws; (d) to comply with the Membership Standards Applicable to Regular Members of BCBSA, a current copy of which is attached as Exhibit 2 hereto; and (e) reasonably to permit BCBSA, upon a written, good faith request and during reasonable business hours, to inspect the Plan's books and records necessary to ascertain compliance herewith. As to other Plans and third parties, BCBSA shall maintain the confidentiality of all documents and information furnished by the Plan pursuant hereto, or pursuant to the Membership Standards, and clearly designated by the Plan as containing proprietary information of the Plan.

5. The rights hereby granted are exclusive to the Plan within the geographical area(s) served by the Plan on June 30, 1972, and/or as to which the Plan has been granted a subsequent license, which is hereby defined as the "Service Area," except that BCBSA reserves the right to use the Licensed Marks in said Service Area, and except to the extent that said Service Area may overlap areas served by one or more other licensed Blue Shield Plans as of said date or subsequent license, as to which overlapping areas the rights hereby granted are nonexclusive as to such other Plan or Plans only.

Amended as of June 19, 2014

6. Except as expressly provided by BCBSA with respect to National Accounts, Government Programs and certain other necessary and collateral uses, the current rules and regulations governing which are attached as Exhibit 3 and Exhibit 4 hereto, and are contained in other documents referenced herein, or as expressly provided herein, the Plan may not use the Licensed Marks and Name outside the Service Area or in connection with other goods and services, nor may the Plan use the Licensed Marks or Name in a manner which is intended to transfer in the Service Area the goodwill associated therewith to another mark or name. Nothing herein shall be construed to prevent the Plan from engaging in lawful activity anywhere under other marks and names not confusingly similar to the Licensed Marks and Name, provided that engaging in such activity does and will not dilute or tarnish the unique value of the Licensed Marks and Name. In addition to any and all remedies available hereunder, BCBSA may impose monetary fines on the Plan for the Plan's use of the Licensed Marks and Names outside the Service Area, and provided that the procedure used in imposing a fine is consistent with procedures specifically prescribed by BCBSA from time to time in regulations of general application. In the case of regional Medicare Advantage PPO and regional Medicare Part D Prescription Drug Plan products offered by consenting and participating Plans in a region that includes the Service Areas, or portions thereof, of more than one Plan, such fine may be imposed jointly on the consenting and participating Plans for use of the Licensed Marks and Name in any geographic area of the region in which a Plan having exclusive rights to the Licensed Marks and Name does not consent to and participate in such offering, provided that the basis for imposition of such fine is consistent with rules specifically prescribed by BCBSA from time to time in regulations of general application.

7. The Plan agrees that it will display the Licensed Marks and Name only in such form, style and manner as shall be specifically prescribed by BCBSA from time-to-time in regulations of general application in order to prevent impairment of the distinctiveness of the Licensed Marks and Name and the goodwill pertaining thereto.
The Plan shall cause to appear on all materials on or in connection with which the Licensed Marks or Name are used such legends, markings and notices as BCBSA may reasonably request in order to give appropriate notice of service mark or other proprietary rights therein or pertaining thereto.

8. BCBSA agrees that: (a) it will not grant any other license effective during the term of this License Agreement for the use of the Licensed Marks or Name which is inconsistent with the rights granted to the Plan hereunder; and (b) it will not itself use the Licensed Marks in derogation of the rights of the Plan or in a manner to deprive the Plan of the full benefits of this License Agreement, provided that BCBSA shall have the right to use the Licensed Marks in conjunction with any national offering under the Federal Employees Health Benefits Program in the manner set forth in Exhibit 4, Paragraph 4 (including subparagraphs) to this License Agreement. The Plan agrees that it will not attack the title of BCBSA in and to the Licensed Marks or Name or attack the validity of the Licensed Marks or of this License Agreement. The Plan further agrees that all use by it of the Licensed Marks and Name or any similar mark or name shall inure to the benefit of BCBSA, and the Plan shall cooperate with BCBSA in effectuating the assignment to BCBSA of any service mark or trademark registrations of the Licensed Marks or any similar mark or name held by the Plan or a Controlled Affiliate of the Plan, all or any portion of which registration consists of the Licensed Marks.

Amended as of November 16, 2006

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9. (a). Should the Plan fail to comply with the provisions of paragraphs 2-4, 6, 7 and/or 12, and not cure such failure within thirty (30) days of receiving written notice thereof (or commence curing such failure within such thirty day period and continue diligent efforts to complete the curing of such failure if such curing cannot reasonably be completed within such thirty day period), BCBSA shall have the right to issue a notice that the Plan is in a state of noncompliance. Except as to the termination of a Plan's License Agreement or the merger of two or more Plans, disputes as to noncompliance, and all other disputes between or among BCBSA, the Plan, other Plans and/or Controlled Affiliates, shall be submitted promptly to mediation and mandatory dispute resolution pursuant to the rules and regulations of BCBSA, a current copy of which is attached as Exhibit 5 hereto, and shall be timely presented and resolved. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. If a state of noncompliance as aforesaid is undisputed by the Plan or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the License Agreement. Except, however, as provided in paragraphs 9(d)(iii), 15(a)(i)-(viii), and 15(a)(x) below, no Plan's license to use the Licensed Marks and Name may be finally terminated for any reason without the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

(b). Notwithstanding any other provision of this License Agreement, a Plan's license to use the Licensed Marks and Name may be forthwith terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to Member Plans for: (i) failure to comply with any minimum capital or liquidity requirement under the Membership Standard on Financial Responsibility; or (ii) impending financial insolvency; or (iii) the pendency of any action instituted against the Plan seeking its dissolution or liquidation or its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property of business, unless this License Agreement has been earlier terminated under paragraph 15(a); or (iv) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans and/or the Licensed Marks.

Amended as of March 16, 2006

(c). To the extent not otherwise provided therein, neither: (i) the Membership Standards Applicable to Regular Members of BCBSA; nor (ii) the rules and regulations governing Government Programs and certain other uses; nor (iii) the rules and regulations governing mediation and mandatory dispute resolution, may be amended unless and until each such amendment is first adopted by the affirmative vote of threefourths of the Plans and of threefourths of the total then current weighted vote of all the Plans. The rules and regulations governing National Accounts and other national programs required by the Membership Standards Applicable to Regular Members of BCBSA (Exhibit 2) are contained, in addition to those set forth in Exhibit 3, in the following documents, as amended from time to time: (1) the Inter-Plan Programs Policies and Provisions; (2) Inter-Plan Medicare Advantage Program Policies and Provisions. The voting requirements specified in rules and regulations governing such national programs may not be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans.

Amended as of November 21, 2014

(d). The Plan may operate as a for-profit company on the following conditions:

(i) The Plan shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement and the Plan's membership in BCBSA.

(ii) The Plan shall not use the licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Plan in any securities market. The Plan shall use the Licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(iii) The Plan's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Plan knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Plan ("Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Plan knows, or there is an SEC filing indicating that, any Noninstitutional Investor has become the Beneficial Owner of securities representing 5% or more of the voting power of the Plan ("Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Plan knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner of 20% or more of the Plan's then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 9(d)(iv) below ("Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Plan went public constituted the Board of Directors of the Plan (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Plan went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Plan consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Plan in a writing received by BCBSA prior to such automatic termination

Amended as of September 17, 1997

becoming effective, the provisions of this paragraph 9(d)(iii) may be waived, in whole or in part, upon the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 9(d)(iii)(a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Plan's license to use the Licensed Marks and Name is terminated pursuant to this Paragraph 9(d)(iii), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Plan demonstrates that the Person referred to in clause (a), (b) or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(iv) The Plan shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities or (iii) such other securities as the Plan may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(v) For purposes of paragraph 9(d)(iii), the following definitions shall apply:

(a) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(b) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

Amended as of September 17, 1997

(i) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

(ii) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(iii) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (b)(ii)(B) above) or disposing of any securities of the Plan.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding," when used with reference to a Person's Beneficial Ownership of securities of the Plan, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(c) A Person shall be deemed an “Institutional Investor” if (but only if) such Person (i) is an entity or group identified in the SEC’s Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person’s Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 10 of SEC Schedule 13G as constituted on June 1, 1997.

(d) “Noninstitutional Investor” means any Person who is not an Institutional Investor.

(e) Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

Amended as of September 17, 1997

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10. This License Agreement shall remain in effect: (a) until terminated as provided herein; or (b) until this and all such other License Agreements are terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans; (c) until terminated by the Plan upon eighteen (18) months written notice to BCBSA or upon a shorter notice period approved by BCBSA in writing at its sole discretion.

11. Except as otherwise provided in paragraph 15 below or by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans, or unless this and all such other License Agreements are simultaneously terminated by force of law, the termination of this License Agreement for any reason whatsoever shall cause the reversion to BCBSA of all rights in and to the Licensed Marks and Name, and the Plan agrees that it will promptly discontinue all use of the Licensed Marks and Name, will not use them thereafter, and will promptly, upon written notice from BCBSA, change its corporate name so as to eliminate the Licensed Name therefrom.

12. The license hereby granted to Plan to use the Licensed Marks and Name is and shall be personal to the Plan so licensed and shall not be assignable by any act of the Plan, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Plan mortgage or part with possession or control of this license or any right hereunder, and the Plan shall have no right to grant any sublicense to use the Licensed Marks and Name.

13. BCBSA shall maintain appropriate service mark registrations of the Licensed Marks and BCBSA shall take such lawful steps and proceedings as may be necessary or proper to prevent use of the Licensed Marks by any person who is not authorized to use the same. Any actions or proceedings undertaken by BCBSA under the provisions of this paragraph shall be at BCBSA's sole cost and expense. BCBSA shall have the sole right to determine whether or not any legal action shall be taken on account of unauthorized use of the Licensed Marks, such right not to be unreasonably exercised. The Plan shall report any unlawful usage of the Licensed Marks to BCBSA in writing and agrees, free of charge, to cooperate fully with BCBSA's program of enforcing and protecting the service mark rights, trade name rights and other rights in the Licensed Marks.

14. The Plan hereby agrees to save, defend, indemnify and hold BCBSA And any other Plan(s) harmless from and against all claims, damages, liabilities and Costs of every kind, nature and description which may arise as a result of the activities of the Plan or of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan. BCBSA hereby agrees to save, defend, indemnify and hold the Plan and any other Plan(s) harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise exclusively and directly as a result of the activities of BCBSA.

Amended as of June 21, 2012

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15. (a). This Agreement shall automatically terminate upon the occurrence of any of the following events: (i) a voluntary petition shall be filed by the Plan or by BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against the Plan or BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Plan or BCBSA respectively, or (iii) an order for relief is entered against the Plan or BCBSA in any case under the bankruptcy laws of the United States, or the Plan or BCBSA is adjudged bankrupt or insolvent (as that term is defined in the Uniform Commercial Code as enacted in the state of Illinois) by any court of competent jurisdiction, or (iv) the Plan or BCBSA makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of the Plan or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Plan or BCBSA respectively, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association’s Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of the Plan's or BCBSA's property or business is appointed, or the Plan or BCBSA is ordered dissolved or liquidated, or (ix) the Plan shall fail to pay its dues and shall not cure such failure within thirty (30) days of receiving written notice thereof, or (x) if, due to regulatory action, the Plan together with any applicable Controlled Affiliate becomes unable to do business using the Names and Marks in any State or portion thereof included in its Service Area, provided that: (i) automatic termination shall not occur prior to the exhaustion by any such Plan of its rights to appeal or challenge such regulatory action; and (ii) in the event the Plan is licensed to do business using the Names and Marks in multiple States or portions of States, the termination of its License Agreement shall be solely limited to the State(s) or portions thereof in which the regulatory action applies. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

Notwithstanding any other provision of this Agreement, a declaration or a
request for declaration of the existence of a trust over any of the Plan's or BCBSA's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 15(a)(vii) and (viii) of this Agreement.

Amended as of March 26, 2015

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(b). BCBSA, or the Plans (as provided and in addition to the rights conferred in Paragraph 10(b) above), may terminate this Agreement immediately upon written notice upon the occurrence of either of the following events: (a) the Plan or BCBSA becomes insolvent (as that term is defined in the Uniform Commercial Code enacted in the state of Illinois), or (b) any final judgment against the Plan or BCBSA remains unsatisfied or unbonded of record for a period of sixty (60) days or longer.

(c). If this License Agreement is terminated as to BCBSA for any reason stated in subparagraphs 15(a) and (b) above, the ownership of the Licensed Marks shall revert to each of the Plans.

(d). Upon termination of this License Agreement or any Controlled Affiliate License Agreement of a Larger Controlled Affiliate, as defined in Exhibit 1 to this License Agreement, the following conditions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 15 (a)(x)(ii) of this Agreement, the notices, national account listing, payment and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated:

(i) The terminated entity shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the terminated entity or its Controlled Affiliates under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination or, if termination is pursuant to paragraph 10(d) of this Agreement, within 15 days after the written notice to BCBSA described in paragraph 10(d).

(ii) The terminated entity shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the terminated entity is involved (in a Control, Participating or Servicing capacity), identifying the national account and the terminated entity's role therein. For those accounts where the terminated entity is the Control Plan, the Plan must also indicate the Participating and Servicing Plans in the national account syndicate.

Amended as of June 16, 2005

(iii) Unless the cause of termination is an event stated in paragraph 15(a) or (b) above respecting BCBSA, the Plan and its Licensed Controlled Affiliates shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates;

provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re-Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. The Re-Establishment Fee shall be indexed to a base fee of $80. The Re-Establishment Fee through December 31, 2005 shall be $80. The Re-Establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was $278.60, $285.00 and $290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be $83.27 (100% of the base fee plus $1.84 for calendar year 2005 and $1.43 for calendar year 2006). Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (a) the end of the last fiscal year of the terminated entity which ended prior to termination or (b) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph (d)(iii) shall be due only

Amended as of June 16, 2005

to the extent that, in BCBSA's opinion, it does not cause the net worth of the Plan to fall below 100% of the Health Risk-Based Capital formula or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and three-fourths of the
total then current weighted vote of all the Plans), measured as of the date of termination and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plan or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re-Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Plan (and/or its Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph only to the extent that such payments exceed the amounts due to BCBSA pursuant to subparagraph 15(d)(vi) and any costs associated with reestablishing the Service Area, including any payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the terminated entity.

(iv) The terminated entity shall comply with all financial settlement procedures set forth in BCBSA's License Termination Contingency Plan, as amended from time to time and shall work diligently and in good faith with

Amended as of June 16, 2005

BCBSA, any Alternative Control Licensee or Replacement Licensee and any existing or potential new account for Blue-branded products and services to minimize the disruption of termination, and honor, to the fullest extent possible, the desire of accounts to continue to receive or obtain Blue-branded products and services through a new Licensee ("Transition"). Such diligence and good faith on the part of the terminated entity shall include, but not be limited to: (a) working cooperatively with BCBSA to protect the
Names and Marks from potential harm; (b) cooperating with BCBSA's use of the Names and Marks in the terminated entity's former service area during the termination and Transition; (c) transmitting, upon the request of an existing Blue account or of BCBSA with
consent and on behalf of an existing Blue account, all member and account-data relating to the Federal Employee Program to BCBSA, and all member and account data relating to other programs to an Alternative Control Licensee or Replacement Licensee; (d) working with BCBSA and the Alternative Control or Replacement Licensee with respect to potential new Blue accounts headquartered in the terminated entity's former service area; (e) continuing to service Blue accounts during the Transition; (f) continuing to comply with National Programs, Federal Employee Program and NASCO policies and procedures and all voluntary BCBSA programs, policies and performance standards, such as Away From Home Care, including being responsible for payment of all penalties for non-compliance duly levied in conformity with the License Agreements, Membership Standards, or the Federal Employee Program agreements, that may arise during the Transition; (g) maintaining and providing access to its provider networks, as defined by Federal Employee Program agreements and National Account Program Policies and Provisions, and Inter-Plan Programs Policies and Provisions, and making those networks and discounts available to members and providers who participate in National Programs and the Federal Employee Program during the Transition; (h) maintaining its technical connections and processing capabilities during the Transition; and (i) working diligently to conclude all financial settlements and account reconciliations as negotiated in the termination transition agreement.

Amended as of November 16, 2006

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(v) Notwithstanding any other provision in this Agreement, BCBSA shall have the right, with the approval of its Board of Directors, to assess additional fines against the terminated entity during the Transition in the event it fails to maintain and provide access to provider networks as defined by Federal Employee Program agreements, National Account Program Policies and Provisions, and Inter-Plans Programs Policies and Provisions, and/or pass on applicable discounts. Such fines shall be in addition to any other assessments, fees or liquidated damages payable herein, or under existing policies and programs and shall be imposed to make whole BCBSA and/or the Plans. Terminated entity shall pay any such fines to BCBSA no later than 30 days after they are approved by the Board of Directors.

(vi) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third-party auditor to examine and audit the books and records of the terminated entity and its Licensed Controlled Affiliates to verify compliance with the terms and requirements of this paragraph 15(d).

(vii) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.

(viii) As to a breach of 15 (d) (i), (ii), (iii), (iv), (vi), or (vii) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 15 (d) (i), (ii), (iv), (vi), or (vii) by the Plan, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

Amended as of November 16, 2006

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(ix) In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Plan and its Licensed Controlled Affiliates shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

(e). BCBSA shall be entitled to enjoin the Plan or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this License Agreement unless the License Agreement has been terminated pursuant to paragraph 10 (d) of this Agreement upon the required six (6) month written notice.

(f). BCBSA acknowledges that it is not the owner of assets of the Plan.

Amended as of June 16, 2006

16. This Agreement supersedes any and all other agreements between the parties with respect to the subject matter herein, and contains all of the covenants and agreements of the parties as to the licensing of the Licensed Marks and Name. This Agreement may be amended only by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

17. If any provision or any part of any provision of this Agreement is judicially declared unlawful, each and every other provision, or any part of any provision, shall continue in full force and effect notwithstanding such judicial declaration.

18. No waiver by BCBSA or the Plan of any breach or default in performance on the part of BCBSA or the Plan or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

19a. All notices provided for hereunder shall be in writing and shall be sent in duplicate by regular mail to BCBSA or the Plan at the address currently published for each by BCBSA and shall be marked respectively to the attention of the President and, if any, the General Counsel, of BCBSA or the Plan.

19b. Except as provided in paragraphs 9(b), 9(d)(iii), 15(a), and 15(b) above, this Agreement may be terminated for a breach only upon at least 30 days' written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Member Plans.

19c. For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-six (36) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

Amended as of June 16, 2006

(The next page is page 9)

20. Nothing herein contained shall be construed to constitute the parties hereto as partners or joint venturers, or either as the agent of the other, and Plan shall have no right to bind or obligate BCBSA in any way, nor shall it represent that it has any right to do so. BCBSA shall have no liability to third parties with respect to any aspect of the business, activities, operations, products, or services of the Plan.

21. This Agreement shall be governed, construed and interpreted in accordance with the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By_____

Title_____

Date_____

Plan:

By_____

Title_____

Date_____

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EXHIBIT 1

BLUE SHIELD
CONTROLLED AFFILIATE LICENSE AGREEMENT
(Includes revisions adopted by Member Plans through their September 17, 2020 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Shield Plan, known as _____ ("Plan" or "Sponsoring Plan"), which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, Plan and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name");

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with: (i) health care plans and related services, as defined in BCBSA's License Agreement with Plan, and administering the non-health portion of workers' compensation insurance, and (ii) underwriting the indemnity portion of workers' compensation insurance, provided that Controlled Affiliate's total premium revenue comprises less than 15 percent of the Sponsoring Plan's net subscription revenue.

This grant of rights is non-exclusive and is limited to the Service Area served by the Plan. Subject to Paragraph 3A(3) of this Agreement, Controlled Affiliate may use the Licensed Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Service Area under any name or mark; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market, unless such Controlled Affiliate is a not-for-profit company which may use the Licensed Marks and Name, or an approved derivative therefor, to identify itself in debt securities markets. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

Amended as of March 26, 2015

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report or reports to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that the Sponsoring Plan has:

(1) The legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate’s governing body having not less than 50% voting control thereof; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and

(c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate’s establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates;

(iii) change any of the type(s) of businesses in which it engages;

Amended as of September 19, 2014

(iv) create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

(v) sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;

(vi) make any loans or advances except in the ordinary course of business;

(vii) enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

(viii) conduct any business other than under the Licensed Marks and Name;

(ix) take any action that Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control at least 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee.

Or

(2) The legal authority directly or indirectly through wholly-owned subsidiaries;

(a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof and to:

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; and

c) to exercise control over the policy and operations of the Controlled Affiliate.

Amended as of March 26, 2015

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In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control more than 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee.

Or

(3) With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services, the Sponsoring Plan has the legal authority together with such other Plans:

(a) to select all members of the Controlled Affiliate's governing body; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and

(c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such control and ownership by Plans must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute a separate Addendum to Controlled Affiliate License Agreement attached hereto as Exhibit B-1 for each product noted in Paragraph 2E(3) that is licensed to use the Marks.

Or

(4) With respect to a Controlled Affiliate that is 100% controlled by a Sponsoring Plan which on a Blue-branded basis offers solely a Basic Medicare Part D Prescription Drug product, the Sponsoring Plan has the legal authority:

(a) to select all members of the Controlled Affiliate's governing body; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and

(c) to exercise control over the policy and operations of the Controlled Affiliate.

Amended June 20, 2019

In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by Sponsoring Plan must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA, Further, the Participating Plan as defined in Exhibit B-2 and the Sponsoring Plan shall execute the Addendum to Controlled Affiliate License Agreement attached hereto as Exhibit B-2.

Or

(5) With respect to a Controlled Affiliate that is operating as a clinic, absent an alternative method of control approved in writing by BCBSA, the Sponsoring Plan shall have bonafide operational control over the Controlled Affiliate as specified in Exhibit A, Standard 1 (E) and the Guidelines to Administer Standard 1 (E). In addition, if the clinic is for-profit, the Sponsoring Plan shall own at least 50% of the Controlled Affiliate and prevent any change in the articles of incorporation, bylaws or other establishing documents of the Controlled Affiliate with which it does not concur.

3. FOR-PROFIT, PUBLICLY TRADED LICENSEES

A. The Controlled Affiliate may operate as a for-profit publicly traded company on the following conditions:

(1) The Controlled Affiliate shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement.

(2) The Controlled Affiliate shall provide 90 days advance written notice to BCBSA prior to the initial filing with the SEC.

(3) The Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Controlled Affiliate in any securities market. The Controlled Affiliate shall use the Licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(4) The Controlled Affiliate's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Controlled Affiliate ("Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Noninstitutional Investor, other than a Plan or Plans or Controlled Affiliate licensee or licensees has become the Beneficial Owner of securities representing 5% or more of the voting power of the Controlled Affiliate ("Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after

Amended as of June 29, 2019

the Controlled Affiliate knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner, other than a Plan or Plans or Controlled Affiliate licensee or licensees, of 20% or more of the Controlled Affiliate's then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under Paragraph 3A(4) below ("Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Controlled Affiliate went public constituted the Board of Directors of the Controlled Affiliate (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Controlled Affiliate went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Controlled Affiliate consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Sponsoring Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Controlled Affiliate in a writing received by BCBSA prior to such automatic termination becoming effective, the provision of this paragraph 3A(4) may be waived, in whole or in part, upon the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 3A(4)(a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Controlled Affiliate's license, or any other license, to use the Licensed Marks and Name is terminated pursuant to Paragraph 3A(4), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Controlled Affiliate demonstrates that the Person referred to in clause (a), (b) or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(5) The Controlled Affiliate shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities, or (iii) such other securities as the Controlled Affiliate may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner. **Amended as of March 26, 2015**

(6) For purposes of paragraph 3(A) above, the following definitions shall apply:

(i) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(ii) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

(1) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

(2) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(3) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (ii)2(B) above) or disposing of any securities of the Controlled Affiliate.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding", when used with reference to a Person's Beneficial Ownership of securities of the Controlled Affiliate, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

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(iii) A Person shall be deemed an "Institutional Investor" if (but only if) such Person (i) is an entity or group identified in the SEC's Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person's Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 1 of SEC Schedule 13G as constituted on June 1, 1997.

(iv) "Noninstitutional Investor" means any Person who is not an Institutional Investor.

(v) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

4. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Service Area the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. If Controlled Affiliate meets the standards of 2E(1) but not 2E(2) above and any of Controlled Affiliate's advertising or promotional material is reasonably determined by BCBSA and/or the Plan to be in contravention of rules and regulations governing the use of the Licensed Marks and Name, Controlled Affiliate shall for ninety (90) days thereafter obtain prior approval from BCBSA of advertising and promotional efforts using the Licensed Marks and Name, approval or disapproval thereof to be forthcoming within five (5) business days of receipt of same by BCBSA or its designee.
In all advertising and promotional efforts, Controlled Affiliate shall observe the Service Area limitations applicable to Plan.

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E. Notwithstanding any other provision in the Plan's License Agreement with BCBSA or in this Agreement, Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name.

5. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

6. INFRINGEMENT

Controlled Affiliate shall promptly notify Plan and Plan shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that

may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

7. LIABILITY INDEMNIFICATION

Controlled Affiliate and Plan hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to: (i) Controlled Affiliate's rendering of services under the Licensed Marks and Name; or (ii) the activities of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan or Controlled Affiliate.

8. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) the Plan ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement the Plan ceases to be authorized to use the Licensed Names and Marks in the geographic area served by the Controlled Affiliate provided, however, that if the Controlled Affiliate is serving more than one State or portions thereof, the termination of this Agreement shall be

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limited to the State(s) or portions thereof in which the Plan's license to use the Licensed Marks and Names is terminated. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) for a Smaller Controlled Affiliate (as defined in Exhibit A), failure to comply with any of the applicable requirements of Standards 2, 3, 4, 5 or 7 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 8(E); or (6) failure by a Controlled Affiliate that meets the standards of 2E(1) but not 2E(2) above to obtain BCBSA's written consent to a change in the identity of any owner, in the extent of ownership, or in the identity of any person or entity with the authority to select or appoint members or board members, provided that as to publicly traded Controlled Affiliates this provision shall apply only if the change affects a person or entity that owns at least 5% of the Controlled Affiliate's stock before or after the change; or (7) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans, any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 8(B), 8(C) or 8(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Plan shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 8(B), 8(C) or 8(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between BCBSA, the Plan and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute

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resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 8(B) and 8(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 10 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to

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constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 8(E)(3)(vii) and (viii) of this Agreement.

(4) The for-profit, publicly traded Controlled Affiliate is terminated pursuant to Paragraph 3A(4) of this Agreement. In which case, the licenses of any controlled Affiliates directly or indirectly owned by the terminated for profit, publicly traded Controlled Affiliate also shall immediately terminate as provided for in paragraph 3A(4) of this Agreement

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 8(b) hereof, or in the event the Controlled Affiliate is a Larger Controlled Affiliate (as defined in Exhibit A), upon termination of this Agreement, the provisions of Paragraph 8.G. shall not apply and the following provisions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 8(B)(ii) of this Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

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(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re-Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area.

The Re-Establishment Fee shall be indexed to a base fee of $80. The Re-Establishment Fee through December 31, 2005 shall be $80. The Re-Establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was $278.60, $285.00 and $290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be $83.27 (100% of base fee plus $1.84 for calendar year 2005 and $1.43 for calendar year 2006. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Plan or any other Licensed Controlled Affiliates of the Plan to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re-Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided

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further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Plan or its other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 8.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 8.M. and any cost associated with reestablishing the Service Area, including any payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third party auditor to examine and audit the books and records of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan to verify compliance with this paragraph 8.H.

(5) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.

(6) As to a breach of 8.H.(1), (2), (3), (4) or (5) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 8.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. This Agreement shall remain in effect until terminated by the Controlled Affiliate or the Plan upon not less than eighteen (18) months written notice to the Association or upon a shorter notice period approved by BCBSA in writing at its sole discretion, or until terminated as otherwise provided herein. The Plan's right to terminate without cause upon such notice is unfettered and may be exercised in the Plan's sole discretion.

J. In the event the Controlled Affiliate is a Smaller Controlled Affiliate (as defined in Exhibit A), the Controlled Affiliate agrees to be jointly liable for the amount described in H.3.and M. hereof upon termination of the BCBSA license agreement of any Larger Controlled Affiliate of the Plan.

K. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless the Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of the Plan's license agreement upon the required 18 months written notice.

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L. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

M. In the event that the Plan has more than 50 percent voting control of the Controlled Affiliate under Paragraph 2(E)(2) above and is a Larger Controlled Affiliate (as defined in Exhibit A), then the vote called for in Paragraphs 8(C) and 8(D)
above shall require the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

N. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

9. DISPUTE RESOLUTION

The parties agree that any disputes between them or between or among either of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

10. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit C.

11. JOINT VENTURE

Nothing contained in the Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

12. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

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13. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

14. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

15. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question.

Notwithstanding the foregoing provision, if there are thirty-six (36) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

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16. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

17. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By:_____

Date:_____

Plan:

By:_____

Date:_____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____

Date:_____

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EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS
September 2020
PREAMBLE

For purposes of definition:

- A "smaller Controlled Affiliate:" (1) comprises less than fifteen percent (15%) of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed);* or (2) underwrites the indemnity portion of workers' compensation insurance and has total premium revenue less than 15 percent of the Sponsoring Plan's net subscription revenue.

- A "larger Controlled Affiliate" comprises fifteen percent (15%) or more of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed.)*

Changes in Controlled Affiliate status:

If **any** Controlled Affiliate's status changes regarding: its Plan ownership level, its risk acceptance or direct delivery of medical care, the Controlled Affiliate shall notify BCBSA within thirty (30) days of such occurrence in writing and come into compliance with the applicable standards within six (6) months.

If a smaller Controlled Affiliate's health and workers' compensation administration business reaches or surpasses fifteen percent (15%) of the total member enrollment of the Sponsoring Plan and licensed Controlled Affiliates, the Controlled Affiliate shall:

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EXHIBIT A (continued)

1. Within thirty (30) days, notify BCBSA of this fact in writing, including evidence that the Controlled Affiliate meets the minimum liquidity and capital (BCBSA "Health Risk-Based Capital (HRBC)" as defined by the NAIC and state-established minimum reserve) requirements of the larger Controlled Affiliate Financial Responsibility standard; and

2. Within six (6) months after reaching or surpassing the fifteen percent (15%) threshold, demonstrate compliance with all license requirements for a larger Controlled Affiliate.

If a Controlled Affiliate that underwrites the indemnity portion of workers' compensation insurance receives a change in rating or proposed change in rating, the Controlled Affiliate shall notify BCBSA within 30 days of notification by the external rating agency.

*For purposes of this calculation,

The numerator equals:

Applicant Controlled Affiliate's member enrollment, as defined in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

The denominator equals:

Numerator PLUS Sponsoring Plan and all other licensed Controlled Affiliates' member enrollment, as reported in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

Amended as of September 19, 2014

EXHIBIT A (continued)

STANDARDS FOR LICENSED CONTROLLED AFFILIATES

Each licensed controlled affiliate shall be subject to certain standards as determined below:

1. What percent of the licensed controlled affiliate is controlled by the Sponsoring Plan and other Plans?

More than 50% by Sponsoring Plan Ò Standard 1A, 4	50% by Sponsoring Plan Ò Standard 1B, 4	100% Plan Control but less than 50% Sponsoring Plan Control and it offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services Ò Standard 1C, 4	100% Sponsoring Plan control and on a Blue-branded basis, it only offers Basic Medicare Part D Prescription Drug Plan product Ò Standard 1D, 4	At least 50% by Sponsoring Plan or operational Control by Sponsoring Plan and it solely operates as a Clinic as defined in Standard 1E. Ò Standard 1E, 4

IN ADDITION,

2. Is risk being assumed?

Yes			No	
÷	Ò	Ø	÷	Ò
Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance Ò Standards 7A-7E, 11	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance Ò Standard 2 (Guidelines 1.1,1.2) and Standard 11	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance Ò Standard 6H	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates ò Standard 2 (Guidelines 1.1,1.3) and Standard 11	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates Ò Standard 6H

IN ADDITION,

3. Is medical care being directly provided as a staff model HMO?

Yes	No
Ò Standard 3A	Ò Standard 3B

Amended as of June 20, 2019

EXHIBIT A (continued)

STANDARDS FOR LICENSED CONTROLLED AFFILIATES

Each licensed controlled affiliate shall be subject to certain standards as determined below:

IN ADDITION,

4. Is the licensed controlled affiliate operating as a Clinic, as defined in Standard 1(E)?

Yes
Ò
Standard 3C and Standard 2, 1.4 (if organized as a health plan that also operates as a Clinic.

5. If the controlled affiliate has health or workers' compensation administration business, does such business comprise 15% or more of the total member enrollment of Plan and its licensed Controlled Affiliates?

Yes	No		
Ò	÷	÷	Ø
Standards 6A-6J	Controlled Affiliate is not a former primary licensee and is not subject to Standard 1(C) Ò Standards 5,8,9B,10,11	Controlled Affiliate is a former primary licensee Ò Standards 5,8,9A,10,11	Controlled Affiliate is not a former primary licensee and is subject to Standard 1(C) Ò Standards 5,8,9B,11

Amended as of June 20, 2019

EXHIBIT A (continued)

Standard 1 - Organization and Governance

1A.) The Standard for more than 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA has the legal authority, directly or indirectly through wholly-owned subsidiaries: 1) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; and 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; and 3) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate.

1B.) The Standard for 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA has the legal authority, directly or indirectly through wholly-owned subsidiaries:

1) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; and

2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; and

3) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan.

Amended September 19, 2014

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EXHIBIT A (continued)

Notwithstanding anything to the contrary in 1) through 3) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

- change the geographic area in which it operates
- change its legal and/or trade names
- change any of the types of businesses in which it engages
- create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business
- sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced
- make any loans or advances except in the ordinary course of business
- enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate)
- conduct any business other than under the Licensed Marks and Name
- take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate.

Amended September 27, 2018

1C.) The Standard for a Controlled Affiliate that offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and service and has100% Plan control but less than 50% Sponsoring Plan Control:

A Controlled Affiliate shall be organized and operated in such a manner that (i) it offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services; and (ii) a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA (the "Sponsoring Plan,) has the legal authority together with Other Plans:

1) to select all members of the Controlled Affiliate's governing body; and

2) to prevent any change in the articles of incorporation, bylaws, or other establishing or governing documents of the Controlled Affiliate; and

3) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the Addendum to Controlled Affiliate License.

1D). The Standard for a Controlled Affiliate that on a Blue-branded basis, only offers a Basic Medicare Part D Prescription Drug product and has 100% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that (i) on a Blue-branded basis, it only offers a Basic Medicare Part D Prescription Drug product; and (ii) the Sponsoring Plan has the legal authority:

1) to select all members of the Controlled Affiliate's governing body; and

2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and

3) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by Sponsoring Plan must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA.

Further, the Sponsoring Plan and Participating Plan shall execute the Addendum to Controlled Affiliate License.

1E). The Standard for a Controlled Affiliate that operates as a Clinic and the Sponsoring Plan has control of the Clinic is:

A Controlled Affiliate shall be organized in such a manner that it operates as a Clinic and Sponsoring Plan exercises operational control over the Controlled Affiliate.

In addition, if the Clinic is for-profit, the Sponsoring Plan shall own at least 50% of the Controlled Affiliate and prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate.

Amended June 20, 2019

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EXHIBIT A (continued)

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. If a risk-assuming Controlled Affiliate ceases operations for any reason, Blue Cross and/or Blue Cross Plan coverage will be offered to all Controlled Affiliate subscribers without exclusions, limitations or conditions based on health status. If a nonrisk-assuming Controlled Affiliate ceases operations for any reason, Sponsoring Plan will provide for services to its customers.
The requirements of the preceding two sentences shall apply to all lines of business unless a line of business is specially exempted from the requirement(s) by the BCBSA Board of Directors.

Standard 3 - State Licensure/Certification

3A.) The Standard for a Controlled Affiliate that employs, owns or contracts on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification for its medical care providers to operate under applicable state laws.

3B.) The Standard for a Controlled Affiliate that does not employ, own or contract on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification to operate under applicable state laws.

3C.) The Standard for a Controlled Affiliate that operates as a Clinic as defined in Standard 1(E) is:

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of 1) the structure of the Blue Cross and Blue Shield System; and 2) the independent nature of every licensee; and 3) the Controlled Affiliate's financial condition.

Amended as of June 20, 2019

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EXHIBIT A (continued)

Standard 5 - Reports and Records for Certain Smaller Controlled Affiliates

For a smaller Controlled Affiliate that does not underwrite the indemnity portion of workers' compensation insurance, the Standard is:

A Controlled Affiliate and/or its Sponsoring licensed Plan shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Other Standards for Larger Controlled Affiliates

Standards 6(A) - (I) that follow apply to larger Controlled Affiliates.

Standard 6(A): Board of Directors

A Controlled Affiliate Governing Board shall act in the interest of its Corporation in providing cost-effective health care services to its customers. A Controlled Affiliate shall maintain a governing Board, which shall control the Controlled Affiliate, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 6(B): Responsiveness to Customers

A Controlled Affiliate shall be operated in a manner responsive to customer needs and requirements.

Standard 6(C): Participation in National Programs

A Controlled Affiliate shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the licensees and ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's Service Area.

Amended as of September 19, 2014

EXHIBIT A (continued)

Standard 6(C): Participation in National Programs (continued)

Such programs are applicable to licensees, and include:

1. BlueCard Program;
2. InterPlan Teleprocessing System (ITS);
3. National Account Programs;
4. Business Associate Agreement for Blue Cross and Blue Shield Licensees, effective April 14, 2003; and
5. Inter-Plan Medicare Advantage Program.

Standard 6(D): Financial Performance Requirements

In addition to requirements under the national programs listed in
Standard 6C: Participation in National Programs, a Controlled Affiliate shall take such action as required to ensure its financial performance in programs and contracts of an inter-licensee nature or where BCBSA is a party.

Standard 6(E): Cooperation with Plan Performance Response Process

A Controlled Affiliate shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Plan Performance Response Process and in addressing Controlled Affiliate performance problems identified thereunder.

Standard 6(F): Independent Financial Rating

A Controlled Affiliate shall obtain a rating of its financial strength from an independent rating agency approved by BCBSA's Board of Directors for such purpose.

Standard 6(G): Local and National Best Efforts

Notwithstanding any other provision in the Plan’s License Agreement with BCBSA or in this License Agreement, during each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Shield Mark.

Amended as of November 21, 2014

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EXHIBIT A (continued)

Standard 6(H): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 6(I): Reports and Records

A Controlled Affiliate shall furnish to BCBSA on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between BCBSA and Controlled Affiliate. Such reports and records are the following:

A) BCBSA Controlled Affiliate Licensure Information Request; and

B) Triennial trade name and service mark usage material, including disclosure material; and

C) Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, or changes in the identity of the Controlled Affiliate's Principal Officers, and changes in risk acceptance, contract growth, or direct delivery of medical care; and

D) Semi-annual “Health Risk-Based Capital (HRBC) Report” as defined by the NAIC, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), and

Amended as of November 17, 2011

EXHIBIT A (continued)

Standard 6(J): Control by Unlicensed Entities Prohibited

No Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Standard 7 - Other Standards for Risk-Assuming Workers' Compensation Controlled Affiliates

Standards 7(A) - (E) that follow apply to Controlled Affiliates that underwrite the indemnity portion of workers' compensation insurance.

Standard 7 (A): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 7(B): Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Controlled Affiliate Licensure Information Request; and

B. Triennial trade name and service mark usage materials, including disclosure materials; and

C. Annual Certified Audit Report, Annual Statement as filed with the State Insurance Department (with all attachments), Annual NAIC's Risk-Based Capital Worksheets for Property and Casualty Insurers; and

D. Quarterly Estimated Risk-Based Capital for Property and Casualty Insurers, Insurance Department Examination Report; and

Amended as of November 17, 2011

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EXHIBIT A (continued)

E. Notification of all changes and proposed changes to independent ratings within 30 days of receipt and submission of a copy of all rating reports; and

F. Changes in the ownership and governance of the Controlled Affiliate including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 7(C): Loss Prevention

A Controlled Affiliate shall apply loss prevention protocol to both new and existing business.

Standard 7(D): Claims Administration

A Controlled Affiliate shall maintain an effective claims administration process that includes all the necessary functions to assure prompt and proper resolution of medical and indemnity claims.

Standard 7(E): Disability and Provider Management

A Controlled Affiliate shall arrange for the provision of appropriate and necessary medical and rehabilitative services to facilitate early intervention by medical professionals and timely and appropriate return to work.

Amended as of November 16, 2000

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EXHIBIT A (continued)

Standard 8 - Cooperation with Controlled Affiliate License Performance Response Process Protocol

A Controlled Affiliate and its Sponsoring Plan shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Controlled Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing Controlled Affiliate compliance problems identified thereunder.

Standard 9(A) - Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees

A smaller controlled affiliate that formerly was a Primary Licensee shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:
   - BlueCard Program;
   - Inter-Plan Teleprocessing System (ITS);
   - National Account Programs.

B. Financial Requirements include:
   - Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
   - A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Amended as of November 21, 2014

EXHIBIT A (continued)

Standard 9(A) - Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees

C. Reporting requirements include:

a. The Semi-annual Health Risk-Based Capital (HRBC) Report.

Amended as of June 13, 2002

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Exhibit A (continued)

Standard 9(B) - Participation in National Programs by Smaller Controlled Affiliates

A smaller controlled affiliate shall participate in national programs in accordance with BlueCard and other relevant Policies and Provisions shall effectively and efficiently participate in national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter-Plan Teleprocessing System (ITS);
- National Account Programs.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Amended as of June 20, 2013

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EXHIBIT A (continued)

Standard 10 - Participation in Inter-Plan Medicare Advantage Program

A smaller controlled affiliate for which this standard applies pursuant to the Preamble section of Exhibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area.

National program requirements include:

A. Inter-Plan Medicare Advantage Program.

Standard 11: Participation in Master Business Associate Agreement by Smaller Controlled Affiliate Licensees

Effective April 14, 2003, all smaller controlled affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of September 19, 2014

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EXHIBIT B-1

ADDENDUM TO CONTROLLED AFFILIATE LICENSE TO BE EXECUTED BY CONTROLLED AFFILIATES LICENSED UNDER CONTROLLED AFFILIATE LICENSE STANDARD 1C.

ADDENDUM TO CONTROLLED AFFILIATE LICENSE

This Addendum is made to that certain Blue Shield Controlled Affiliate License Agreement executed by and among Blue Cross and Blue Shield Association ("Licensor"), _____ ("Controlled Affiliate Licensee") and _____("Sponsoring Plan") dated the _____ day of _____ , _____ ("Agreement"). The parties to this Addendum are Licensor, Controlled Affiliate Licensee, Sponsoring Plan, and the undersigned other Plans ('Other Plans"). This Addendum is made and shall be deemed effective as of the date of the Agreement.

WHEREAS, the Sponsoring Plan asserts that it can serve the Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans market in its Service Area more efficiently and with less risk through an enterprise jointly owned and controlled with other Plans than through a wholly owned and Controlled Affiliate Licensee;

WHEREAS, in such circumstance Controlled Affiliate License Standard 1C permits the licensing of a Controlled Affiliate that is less than 50% owned and controlled by the Sponsoring Plan but which is 100% owned and controlled by Plans including the Sponsoring Plan, subject to certain conditions;

WHEREAS, one such condition is that the Sponsoring Plan and all such other owning and controlling Plans enter into this Addendum;

NOW THEREFORE, for good and valuable consideration, including the promises and covenants set forth herein, the parties agree as follows:

1. This Addendum is limited to [identify product name].

2. The Sponsoring Plan shall participate operationally in Controlled Affiliate's business that is conducted under the Licensed Marks. The parties understand that participation may take many forms, one of which should be providing a network of providers in the Service Area of the Controlled Affiliate for the Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans services being offered under the Agreement and being involved in network development and provider engagement functions.

3. Each of the Other Plans agrees that (i) it will cooperate fully with the Sponsoring Plan and BCBSA as needed to enable Sponsoring Plan and Controlled Affiliate Licensee to meet their obligations to Licensor under the Agreement and all associated rules and regulations of Licensor, including the Brand Regulations, (ii) it

will not take any action, either individually or jointly with any of the Other Plans, that would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement, and (iii) it will not fail to take any action, either individually or jointly with any of the Other Plans, where such failure would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement.

4. Each of the Other Plans acknowledges that it has reviewed the Agreement and understands that Sponsoring Plan has the right to terminate the Agreement without cause upon notice as provided in Paragraph 8 of the Agreement, and that such right is unfettered and may be exercised by Sponsoring Plan in its sole discretion.

WHEREFORE, by signing below the parties agree to be bound to the terms stated herein.

BLUE CROSS BLUE SHIELD ASSOCIATION

By: _____

[Controlled Affiliate Licensee]

By: _____

[Sponsoring Plan]

By: _____

[Other Plan 1]

By: _____

[Other Plan 2]

By: _____

Amended as of September 27, 2018

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EXHIBIT B-2

ADDENDUM TO CONTROLLED AFFILIATE LICENSE TO BE EXECUTED BY CONTROLLED AFFILIATES LICENSED UNDER CONTROLLED AFFILIATE LICENSE STANDARD 1D.

ADDENDUM TO CONTROLLED AFFILIATE LICENSE

This Addendum is made to that certain Blue Shield Controlled Affiliate License Agreement executed by and among Blue Cross and Blue Shield Association ("Licensor"), _____ ("Controlled Affiliate Licensee"), _____("Sponsoring Plan") and _____ ("Participating Plan") dated the _____ day of _____ , _____ ("Agreement").

WHEREAS, the Participating Plan is defined as the Plan that holds the Primary License with BCBSA to use the Service Marks in the Service Area where the Controlled Affiliate will use the Service Marks;

WHEREAS, the Participating Plan asserts that it can offer a lower cost Basic Medicare Part D Prescription Drug Plan product more efficiently in the Participating Plan's Service Area through the Controlled Affiliate Licensee;

WHEREAS, the Controlled Affiliate shall only use the Service Marks inside of the Participating Plan(s) Service Area subject to each Participating Plan signing a separate Addendum;

WHEREAS, in such circumstance Controlled Affiliate License Standard 1D permits the licensing of a Controlled Affiliate that is 100% owned and controlled by a Sponsoring Plan, subject to certain conditions;

WHEREAS, one such condition is that the Sponsoring Plan, Controlled Affiliate and the Participating Plan enter into this Addendum;

NOW THEREFORE, for good and valuable consideration, including the promises and covenants set forth herein, the parties agree as follows:

1. The Participating Plan shall participate in Controlled Affiliate's business that is conducted under the Licensed Marks. The parties understand that the Participating Plan shall conduct sales support and marketing of the Controlled Affiliate's Basic Medicare Part D Prescription Drug Plan product offered in the Participating Plan's Service Area. Any other form of participation shall require BCBSA's written approval.

2. Participating Plan agrees that (i) it will cooperate fully with the Sponsoring Plan and BCBSA as needed to enable Sponsoring Plan and

Controlled Affiliate Licensee to meet their obligations to Licensor under the Agreement and all associated rules and regulations of Licensor, including the Brand Regulations, (ii) it will not take any action that would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement, and (iii) it will not fail to take any action, either individually or jointly with the Sponsoring Plan or Controlled Affiliate Licensee, where such failure would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement.

3. The Controlled Affiliate Licensee shall only use the Licensed Marks authorized by the Participating Plan in connection with the Basic Medicare Part D Prescription Drug Plan product offered in the Participating Plan's Service Area.

4. The Sponsoring Plan and Controlled Affiliate acknowledge that it has reviewed the Agreement and understands that Participating Plan has the right to terminate this Agreement: (i) immediately upon the expiration or termination of the Plan Participation Agreement by and between Participating Plan and Controlled Affiliate upon written notice to the Sponsoring Plan, Controlled Affiliate Licensee and Licensor, or (ii) without cause upon 18 months written notice to the Sponsoring Plan, Controlled Affiliate Licensee and Licensor, and that such right is unfettered and may be exercised by Participating Plan in its sole discretion. In the event that Participating Plan and Controlled Affiliate fail to execute the Plan Participation Agreement by _____(Date), Participating Plan may terminate this Agreement immediately upon notice to Sponsoring Plan, Controlled Affiliate Licensee and Licensor.

5. This Agreement and all of Controlled Affiliate Licensee's rights hereunder shall immediately terminate without any further action by any party or entity in the event that the Sponsoring Plan or Participating Plan ceases to be authorized to use the Licensed Marks and Name.

WHEREFORE, by signing below the parties agree to be bound to the terms stated herein.

BLUE CROSS BLUE SHIELD ASSOCIATION

By: _____

[Controlled Affiliate Licensee]

By: _____

[Sponsoring Plan]

By: _____

[Participating Plan]

By: _____ **Amended March 17, 2016**

EXHIBIT C
ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENT

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

FOR RISK PRODUCTS:

For Controlled Affiliates not underwriting the indemnity portion of workers' compensation insurance:

An amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For Controlled Affiliates underwriting the indemnity portion of workers' compensation insurance:

An amount equal to 0.35 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus, an annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 7.

Amended as of September, 19, 2014

EXHIBIT C (continued)

FOR NONRISK PRODUCTS:

For third-party administrative business, an amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For non-third party administrative business (e.g., case management, provider networks, etc.), an amount equal to 0.24 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus:

1) An annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 6 D.

2) An annual fee of $2,000 per license for all other Controlled Affiliates.

The foregoing shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® License are issued to the same Controlled Affiliate. In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Amended as of September 19, 2014

EXHIBIT 1A

CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO LIFE INSURANCE COMPANIES
(Includes revisions adopted by Member Plans through their September 17, 2020 meeting)

This agreement by and among Blue Cross and Blue Shield Association ("BCBSA") _____("Controlled Affiliate"), a Controlled Affiliate of the Blue Shield Plan(s), known as _____("Plan").
WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, the Plan and the Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name");

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Controlled Affiliate the exclusive right to use the licensed Marks and Names in connection with and only in connection with those life insurance and related services authorized by applicable state law, other than health care plans and related services (as defined in the Plan's License Agreements with BCBSA) which services are not separately licensed to Controlled Affiliate by BCBSA, in the Service Area served by the Plan, except that BCBSA reserves the right to use the Licensed Marks and Name in said Service Area, and except to the extent that said Service Area may overlap the area or areas served by one or more other licensed Blue Shield Plans as of the date of this License as to which overlapping areas the rights hereby granted are non-exclusive as to such other Plan or Plans and their respective Licensed Controlled Affiliates only. Controlled Affiliate cannot use the Licensed Marks or Name outside the Service Area or in its legal or trade name; provided, however, that if and only for so long as Controlled Affiliate also holds a Blue Shield Affiliate License Agreement applicable to health care plans and related services, Controlled Affiliate may use the Licensed Marks and Name in its legal and trade name according to the terms of such license agreement.

Amended as of June 12, 2003

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in relation to the sale, marketing and rendering of authorized products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A as it may be amended by BCBSA from timetotime.

B. Controlled Affiliate agrees that Plan and/or BCBSA may, from timetotime, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans. Absent written approval by BCBSA of an alternative method of control, bona fide control shall mean the legal authority, directly or indirectly through whollyowned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having not less than 51% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Plan or Plans shall own at least 51% of any forprofit Controlled Affiliate. If the Controlled Affiliate is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items (a) and (c) above, proxies representing 51% of the votes at any meeting of the policyholders and shall demonstrate that there is no reason to believe this such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

3. SERVICE MARK USE

Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks, and shall comply with such rules (applicable to all Controlled Affiliates licensed to use the Marks) relative to service mark use, as are issued from timetotime by BCBSA. If there is any public reference to the affiliation between the Plan and the Controlled Affiliate, all of the Controlled Affiliate's licensed services in the Service Area of the Plan shall be rendered under the Licensed Marks. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Controlled Affiliate shall inure to the benefit of BCBSA. -2-

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENTS

Controlled Affiliate shall promptly notify Plan and BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate hereby agrees to save, defend, indemnify and hold Plan and BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Controlled Affiliate's rendering of health care services under the Licensed Marks.

7. LICENSE TERM

The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods upon evidence satisfactory to the Plan and BCBSA that Controlled Affiliate meets the then applicable quality control standards, unless one of the parties hereto notifies the other party of the termination hereof at least sixty (60) days prior to expiration of any license period.

This Agreement may be terminated by the Plan or by BCBSA for cause at any time provided that Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Controlled Affiliate's failure to abide by the quality control provisions of Paragraph 2, above, shall be considered a proper ground for cancellation of this Agreement.

This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

A. Controlled Affiliate shall no longer comply with Standard No. 1 (Organization and Governance) of Exhibit A or, following an opportunity to cure, with the remaining quality control provisions of Exhibit A, as it may be amended from time-to-time; or

B. Plan ceases to be authorized to use the Licensed Marks; or

C. Appropriate dues for Controlled Affiliate pursuant to item 8 hereof, which are the royalties for this License Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks including any use in its trade name.

In the event of any disagreement between Plan and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of the Blue Cross and Blue Shield Association and provide instruction on how the customer can contact the Blue Cross and Blue Shield Association or a designated licensee to obtain further information on securing coverage. The written notification required by this paragraph shall be in writing and in a form approved by the Association. The Association shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. DUES

Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

An annual fee of five thousand dollars ($5,000) per license, plus

.05% of gross revenue per year from branded group products, plus

.5% of gross revenue per year from branded individual products plus

.14% of gross revenue per year from branded individual annuity products.

The foregoing percentages shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® license are issued to the same entity. In the event that any License period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Plan will promptly and timely transmit to BCBSA all dues owed by Controlled Affiliate as determined by the above formula and if Plan shall fail to do so, Controlled Affiliate shall pay such dues directly.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

9A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with
0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-six (36) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

10. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

Amended as of November 20, 1997

11. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by a writing executed by all parties.

12. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way effect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

13. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

Amended as of June 16, 2005

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IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_

Date:_

Controlled Affiliate

By:_

Date:_

Plan

By:_

Date:_

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EXHIBIT A
CONTROLLED AFFILIATE LICENSE STANDARDS
LIFE INSURANCE COMPANIES
Page 1 of 2

PREAMBLE

The standards for licensing Life Insurance Companies (Life and Health Insurance companies, as defined by state statute) are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote of all Plans. Each Licensed Plan is required to use a standard controlled affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Life Insurance Company maintains compliance with the license standards.

An organization meeting the following standards shall be eligible for a license to use the Licensed Marks within the service area of its sponsoring Licensed Plan to the extent and the manner authorized under the Controlled Affiliate License applicable to Life Insurance Companies and the principal license to the Plan.

Standard 1 - Organization and Governance

The LIC shall be organized and operated in such a manner that it is controlled by a licensed Plan or Plans which have, directly or indirectly: 1) not less than 51% of the voting control of the LIC; and 2) the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the LIC with which it does not concur; and 3) operational control of the LIC.

If the LIC is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items 1 and 2 above, proxies representing at least 51% of the votes at any policyholder meeting and shall demonstrate that there is no reason to believe such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

Standard 2 - State Licensure

The LIC must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life and health insurance company in each state in which the LIC does business.

EXHIBIT A
CONTROLLED AFFILIATE LICENSE STANDARDS
LIFE INSURANCE COMPANIES
Page 2 of 2

Standard 3 - Records and Examination

The LIC and its sponsoring licensed Plan(s) shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the LIC as may be required in order to establish compliance with the license agreement. The LIC and its sponsoring licensed Plan(s) shall permit BCBSA to examine the affairs of the LIC and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the sponsoring Plan(s).

Standard 4 - Mediation

The LIC and its sponsoring Plan(s) shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed controlled affiliate, a licensed Plan or BCBSA.

Standard 5 - Financial Responsibility

The LIC shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with Affiliate License Performance Response Process Protocol

The LIC and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing LIC compliance problems identified thereunder.

Exhibit 1A1

CONTROLLED AFFILIATE
TRADEMARK LICENSE AGREEMENT
FOR LIFE AND DISABILTY INSURANCE PRODUCTS

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____, ("Life and Disability Controlled Affiliate") which is a company offering life and disability insurance products owned and controlled by _____, _____, _____ (individually, "Sponsoring Plan" and when referred to collectively, "Sponsoring Plans").

Whereas, BCBSA is the owner of the BLUE CROSS and BLUE SHIELD word and design service marks and any derivatives thereof ("Licensed Marks");

Whereas, each Sponsoring Plan is licensed separately by BCBSA to use one or more of the Licensed Marks in a particular Service Area;

Whereas, the Sponsoring Plans and the Life and Disability Controlled Affiliate desire that the latter be entitled to use the appropriate Licensed Marks in connection with life and disability insurance products in some or all of such Sponsoring Plans' Service Areas and in the Service Areas of other Regular Member Plans, as defined in the BCBSA By-laws, ("Blue Plans") consistent with the terms of this Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. <u>GRANT OF LICENSE</u>

a. Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Life and Disability Controlled Affiliate the limited right to use the Licensed Marks in connection with and only in connection with the following life and disability insurance products authorized by state law: (1) Group: Term Life, Long Term Disability, Whole Life, Benefit Life, Universal Life; (2) Individual: Term Life, Whole Life, Dependent Life, Spouse Life; (3) Other: Disability Income, Short Term Disability, Long Term Disability, Income Replacement; and (4) such other life and disability products approved by BCBSA in writing ("Licensed Products") in the Service Areas served by the Sponsoring Plans or in the Service Area or Areas of one or more other licensed Blue Plans, provided that such Blue Plans have consented to such use as authorized by this Agreement. Life and Disability Controlled Affiliate may not use the Licensed Marks in its legal or trade name.

b. Notwithstanding that the license granted to Life and Disability Controlled Affiliate is a license to use all of the Licensed Marks, Life and Disability Controlled Affiliate may only use those of the Licensed Marks in the Service Area of a Sponsoring Plan or other consenting Blue Plan as described below that such Plan is authorized to use as a Blue Plan pursuant to its separate license agreements with BCBSA.

c. Life and Disability Controlled Affiliate may use the Licensed Marks in the Service Areas of Sponsoring Plans or in the Service Area of a Blue Plan that is not a signatory to this Agreement only after such Sponsoring Plan(s) or non-signatory Blue Plan consents to such use by executing a written consent in substantially the same form as the Consent Agreement attached as Exhibit B.

d. The following provisions apply with respect to Consent Agreements once such agreements have been fully and properly executed:

i. All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in the Service Area of Sponsoring Plan or consenting Blue Plan (hereinafter, such consenting Sponsoring Plan or consenting Blue Plan collectively referred to "Consenting Plan(s)") must clearly identify the Consenting Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");

ii. To the extent the Consenting Plan has separate divisions or other Affiliates that use the Licensed Marks in distinct geographic areas within its Service Area, consent obtained under this Agreement may be limited to one or more of such specific geographic areas as specified by the Consenting Plan in its signed Consent Agreement. For purposes of this entire Agreement, all references to the Service Area of a Sponsoring Plan, Blue Plan or Consenting Plan may include the entire Service Area or a distinct geographic area within such Service Area as specified in this Section 1 D (2);

iii. Where BCBSA has licensed two or more Blue Plans to use the same Licensed Marks in the same Service Area, in addition to the requirements set forth in Section D (1) above, the sales, marketing and advertising materials referenced in such section above must be communicated to the Consenting Plan's existing and prospective accounts through or with the approval of such Consenting Plan, and the personnel of such Consenting Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the Consenting Plan;

iv.Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the Consenting Plan has been granted by BCBSA the license to use under its Blue Plan license agreements (for example, if a Consenting Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).

v.If a Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless BCBSA and the Consenting Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.

2. QUALITY CONTROL

A. Life and Disability Controlled Affiliate agrees to use the Licensed Marks only in relation to the sale, marketing and administration of the Licensed Products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A and the Guidelines to Administer the Standards for Trademark License Agreement for Life and Disability Insurance Products attached thereto.

B. Life and Disability Controlled Affiliate agrees that BCBSA may, from timetotime, upon reasonable notice, review and inspect the manner and method of Life and Disability Controlled Affiliate's rendering of service and use of the Licensed Marks.

C. Life and Disability Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by BCBSA) a report to BCBSA demonstrating Life and Disability Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Life and Disability Controlled Affiliate is defined as: An entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance -3-

thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

3. SERVICE MARK USE

Life and Disability Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and shall ensure all uses of the Licensed Marks comply with the BCBSA Brand Regulations, as amended by BCBSA from time to time. Life and Disability Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Life and Disability Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

The license hereby granted to Life and Disability Controlled Affiliate to use the Licensed Marks is and shall be personal to Life and Disability Controlled Affiliate and shall not be assignable by any act of the Life and Disability Controlled Affiliate, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Life and Disability Controlled Affiliate mortgage or part with possession or control of this license or any right hereunder, and the Life and Disability Controlled Affiliate shall have no right to grant any sublicense to use the Licensed Marks.

5. INFRINGEMENTS

Life and Disability Controlled Affiliate shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Life and Disability Controlled Affiliate shall not be entitled to require BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Life and Disability Controlled Affiliate agrees to render to BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA. BCBSA shall have sole control of the defense and resolution of any claim of infringement brought or threatened by others.

6. LIABILITY INDEMNIFICATION

Life and Disability Controlled Affiliate hereby agrees to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Life and Disability Controlled Affiliate's conduct.

7. LICENSE TERM

A. The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods, unless either BCBSA or Life and Disability Controlled Affiliate notifies the other party in writing of the termination hereof at least sixty (60) days prior to expiration of any license period.

B. This Agreement may be terminated by BCBSA for cause at any time provided that Life and Disability Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Life and Disability Controlled Affiliate's failure to abide by the conditions regarding use of the Licensed Marks set forth in Section 1 of this Agreement or the quality control provisions of Section 2 (other than with respect to Section 2 D which is subject to immediate termination as stated in Section 7 C (1) below) shall be considered proper grounds for termination of this Agreement.

C. This Agreement and all of Life and Disability Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(i)Life and Disability Controlled Affiliate shall no longer comply with Section 2 D (or Standard No. 1 (Organization and Governance) of Exhibit A); or

(ii)Any Sponsoring Plan ceases to be authorized to use the Licensed Marks; or

(iii)Appropriate fees for Life and Disability Controlled Affiliate pursuant to Section 8 of this Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Life and Disability Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks.

In the event of any disagreement between Life and Disability Controlled Affiliate and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Life and Disability Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. ROYALTIES

Life and Disability Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

- An annual fee of five thousand dollars ($5,000) per license, plus
- .05% of gross revenue per year from group products sold under the Licensed Marks, plus
- .5% of gross revenue per year from individual products sold under the Licensed Marks

In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Life and Disability Controlled Affiliate will promptly and timely transmit to BCBSA all fees owed by Life and Disability Controlled Affiliate as determined by the above formula.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between any Sponsoring Plan and Life and Disability Controlled Affiliate or between among them and/or BCBSA.

10. VOTING

For all provisions of this Agreement referring to voting, the term ‘Plans’ shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the

Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-six (36) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by: (a) a writing signed by all parties; or (b) a writing approved by the affirmative vote of three-fourths of the Blue Plans and three-fourths of the total then current weighted vote of all the Blue Plans as officially recorded by the BCBSA Corporate Secretary. Upon such adoption by the Blue Plans, this Agreement and all other Trademark License Agreements for Life and Disability Insurance Products then in effect shall simultaneously be amended.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Life and Disability Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_

Date:_

Life and Disability Controlled Affiliate:

By:_

Date:_

Sponsoring Plan:

By:___

Date:_

Name:_____

Sponsoring Plan:

By:___

Date:_

Name:_____

[Add other Sponsoring Plans as necessary]

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EXHIBIT A

LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS
Page 1 of 2

Standard 1 - Organization and Governance

Any Life and Disability Controlled Affiliate licensed under the Trademark License Agreement for Life and Disability Insurance Products ("licensee") shall be organized and operated in such a manner that it is an entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

Standard 2 - State Licensure

The licensee must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life company in each state in which the licensee does business.

Standard 3 - Records and Examination

The licensee shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the licensee as may be required in order to establish compliance with the Agreement. The licensee shall permit BCBSA to examine the affairs of the licensee and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the Sponsoring Plan(s).

Standard 4 - Mediation

The licensee, its Sponsoring Plan(s) and all consenting Blue Plans shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed Life and Disability Controlled Affiliate, a Sponsoring Plan and or consenting Blue Plan or BCBSA.

EXHIBIT A
LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS
Page 2 of 2

Standard 5 - Financial Responsibility

The licensee shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with BCBSA Governance

The licensee shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of and in addressing licensee compliance problems that may be identified in connection with the operation or administration of the Trademark License Agreement for Life and Disability Insurance Products.

EXHIBIT B
CONSENT AGREEMENT

This Consent Agreement is made and entered into by and among the undersigned Blue Plan, and _____ ("Life and Disability Controlled Affiliate"), and the Blue Cross and Blue Shield Association ("BCBSA") and shall be deemed effective on _____ ("Effective Date").

Whereas, BCBSA owns the Blue Cross and Blue Shield word and design service marks and any derivative mark thereof (the "Brands");

Whereas, the undersigned Blue Plan is licensed to use one or more of the Brands within a specific geographic area ("Service Area");

Whereas Life and Disability Controlled Affiliate is licensed by BCBSA to use one or more of the Brands to offer life and disability insurance products ("Products") as defined and authorized in the Trademark License Agreement for Life and Disability Insurance Products ("Life and Disability License Agreement");

Whereas neither the Blue Plan nor its affiliates offer the Products under any of the Brands in such Blue Plan's Service Area or portion thereof where Blue Plan has consented to sale of the Products by Life and Disability Controlled Affiliate; and

Whereas BCBSA and the undersigned Blue Plan desire to consent to Life and Disability Controlled Affiliate's use of the Brands in Blue Plan's Service Area consistent with the terms of the Life and Disability License Agreement and this Consent Agreement.

Now, therefore, in consideration of the obligations and conditions stated in this Agreement, Blue Plan, Life and Disability Controlled Affiliate and BCBSA agree as follows:

1. Life and Disability Controlled Affiliate may market, sell, administer and underwrite the Products in Blue Plan's Service Area under the Brands licensed to Blue Plan in such Service Area subject to the terms of this Consent Agreement, the Life and Disability License Agreement and Blue Plan's license agreement(s) with BCBSA. Life and Disability Controlled Affiliate's rights under the Brands to offer the Products under the Brands are limited to offering the Products only under the Brand(s) licensed to the consenting Blue Plan.

2. Life and Disability Controlled Affiliate shall work with the undersigned Blue Plan to develop a written sales and marketing agreement that
identifies the relationship between it and Blue Plan for the sales, marketing and customer service for the Products. The term of the sales and marketing agreement shall be the same as the term of this Consent Agreement.

3. All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in a consenting Blue Plan's Service Area must clearly identify the consenting Blue Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");

4. Life and Disability Controlled Affiliate may use the Brands to sell the Products in the following Service Area or portion thereof as designated by Blue Plan:

_____

5. If two or more Blue Plans to use the same Licensed Marks in the same Service Area, Life and Disability Controlled Affiliate shall work with the consenting Blue Plan in the following manner: (a) the sales, marketing and advertising materials must be communicated to the consenting Blue Plan's existing and prospective accounts through or with the approval of such Blue Plan, and (b) the personnel of such Blue Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the consenting Blue Plan;

6. Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the consenting Blue Plan has been granted by BCBSA the license to use under its license agreement (for example, if a consenting Blue Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).

7. If this Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless each BCBSA and the Blue Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.

8. The term of this Consent Agreement shall be one year from the Effective Date. Unless either Blue Plan or Life and Disability Controlled Affiliate provides the other party with written notice of its desire not to renew this Consent Agreement at least 60 days prior to expiration of the term or any extended term or unless terminated as provided in Paragraph 9 below, this Consent Agreement shall automatically renew for subsequent one year periods.

9. This Consent Agreement may be terminated as follows:

   a. Upon mutual written consent of Life and Disability Controlled Affiliate and Blue Plan;

   b. By Blue Plan or Life and Disability Controlled Affiliate upon 60 days advance written notice to the non-terminating party and BCBSA; or

   c. By Blue Plan immediately if Life and Disability Controlled Affiliate does not comply with this Consent Agreement or the sales protocol agreement.

10. This Consent Agreement shall automatically terminate if Blue Plan's primary licensee agreement terminates for any reason or if the Life and Disability License Agreement terminates for any reason.

Agreed and Accepted by:

[Blue Plan]:

By:_____

Title:_____

BLUE CROSS AND BLUE SHIELD ASSOCIATION:

By:_____

Title:_____

LIFE AND DISABILITY CONTROLLED AFFILIATE:

By:_____

Title:_____

3

Exhibit 1B

BLUE SHIELD
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS
(Adopted by Member Plans at their September 17, 2020)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Advantage PPO products in geographic regions designated by CMS (hereafter "regional MAPPO products").

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name") to offer regional MAPPO products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. <u>GRANT OF LICENSE</u>

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional MAPPO products and related services.

This grant of rights is non-exclusive and is limited to the following states: _____ (the "Region"). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

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(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i)change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional MAPPO products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Shield License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this

Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or

proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this
paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall

have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x)(ii) of the Blue Shield License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and

any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the

foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license
termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other

Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the

Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last

known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with
0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-six (36) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By:_____

Date:_____

Controlling Plan:

By: _____

Date:_____

Controlling Plan:

By: _____

Date:_____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____

Date:_____

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EXHIBIT A
CONTROLLED AFFILIATE LICENSE STANDARDS
APPLICABLE TO REGIONAL MEDICARE
ADVANTAGE PPO PRODUCTS
September 2020

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Advantage PPO Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

(b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) exercise control over the policy and operations of the Controlled Affiliate; and

EXHIBIT A (continued)
Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

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EXHIBIT A (continued)
Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

a. the structure of the Blue Cross and Blue Shield System; and
b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Shield Marks.

Standard 7 - Participation in Certain National Programs

A Controlled Affiliate shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area.

National program requirements include:

a. Inter-Plan Teleprocessing System (ITS); and

b. Inter-Plan Medicare Advantage Program.

Standard 8 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of November 15, 2007

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EXHIBIT B

**ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS**

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional MAPPO products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

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Exhibit 1C

BLUE SHIELD
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS
(Adopted by Member Plans at their September 17, 2020 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Part D Prescription Drug Plan products in geographic regions designated by CMS (hereafter "regional PDP products").

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name") to offer regional PDP products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional PDP products and related services.

This grant of rights is non-exclusive and is limited to the following states: _____ (the "Region"). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional PDP products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Shield License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to

complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim

trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x)(ii) of the Blue Shield License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license

termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's
license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-six (36) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By:_____

Date:_____

Controlling Plan:

By: _____

Date:_____

Controlling Plan:

By: _____

Date:_____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____

Date:_____

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EXHIBIT A
CONTROLLED AFFILIATE LICENSE STANDARDS
APPLICABLE TO REGIONAL MEDICARE
PART D PRESCRIPTION DRUG PLAN PRODUCTS
September 2020

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Part D Prescription Drug Plan Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

(b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) exercise control over the policy and operations of the Controlled Affiliate; and

EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

a. the structure of the Blue Cross and Blue Shield System; and
b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Shield Marks.

Standard 7 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

EXHIBIT B

**ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS**

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional PDP products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

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EXHIBIT 2

Membership Standards
Page 1 of 5

Preamble

The Membership Standards apply to all organizations seeking to become or to continue as Regular Members of the Blue Cross and Blue Shield Association. Any organization seeking to become a Regular Member must be found to be in substantial compliance with all Membership Standards at the time membership is granted and the organization must be found to be in substantial compliance with all Membership Standards for a period of two (2) years preceding the date of its application. If Membership is sought by an entity which controls or is controlled by one or more Plans, such compliance shall be determined on the basis of compliance by such Plan or Plans.

The Regular Member Plans shall have authority to interpret these Standards.

A Regular Member Plan that operates as a “Shell Holding Company” is defined as an entity that assumes no underwriting risk and has less than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) and less than 5% of the consolidated enterprise net general and administrative expenses.

A Regular Member Plan that operates as a “Hybrid Holding Company” is defined as an entity that assumes no underwriting risk and has either more than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) or more than 5% of the consolidated enterprise net general and administrative expenses.

Standard 1: A Plan shall maintain a governing Board, which shall control the Plan and ensure that the Plan follows appropriate practices of corporate governance. A Plan's Board shall not be controlled by any special interest group, shall make an annual determination that a majority of its directors are independent, and shall act in the best interest of its Corporation and its customers. The Board shall be composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Amended as of March 15, 2007

EXHIBIT 2
Membership Standards
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Standard 2: A Plan shall furnish to the Association on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between the Association and the Plans. Such reports and records are the following:

A. BCBSA Membership Information Request;

B. Triennial trade name and service mark usage material, including disclosure material under Standard 7;

C. Changes in the governance of the Plan, including changes in a Plan's Charter, Articles of Incorporation, or Bylaws, changes in a Plan's Board composition, or changes in the identity of the Plan's Principal Officers;

D. Quarterly Financial Report, Semi-annual “Health Risk-Based Capital (HRBC) Report” as defined by the NAIC, Annual Budget, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), Plan, Subsidiary and Affiliate Report; and

- Plans that are a Shell Holding Company as defined in the Preamble hereto are required to furnish only a calendar year-end “Health Risk-Based Capital (HRBC) Report” as defined by the NAIC.

Amended as of November 17,2011

EXHIBIT 2

Membership Standards
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E. Quarterly Enrollment Report, Quarterly Member Touchpoint Measures Index (MTM) through 12/31/2011, and Semi-annual MTM Index starting 1/1/2012 and thereafter.

- For purposes of MTM reporting only, a Plan shall file a separate MTM report for each Geographic Market.

Standard 3: A Plan shall be operated in a manner that provides reasonable financial assurance that it can fulfill its contractual obligations to its customers.

Standard 4: A Plan shall be operated in a manner responsive to customer needs and requirements.

Standard 5: A Plan shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the Plans and ease of claims processing for customers receiving benefits outside of the Plan's Service Area.

Such programs are applicable to Blue Cross and Blue Shield Plans, and include:

A. Inter-Plan Teleprocessing System (ITS);
B. BlueCard Program;
C. National Account Programs;
D. Business Associate Agreement for Blue Cross and Blue Shield Licensees, effective April 14, 2003; and
E. Inter-Plan Medicare Advantage Program.

Amended as of November 21, 2014

EXHIBIT 2
Membership Standards
Page 4 of 5

Standard 6: In addition to requirements under the national programs listed in Standard 5: Participation in National Programs, a Plan shall take such action as required to ensure its financial performance in programs and contracts of an inter-Plan nature or where the Association is a party.

Standard 7: A Plan shall make adequate disclosure in contracting with third parties and in disseminating public statements of (i) the structure of the Blue Cross and Blue Shield System, (ii) the independent nature of every Plan, and (iii) the Plan's financial condition.

Standard 8: A Plan shall cooperate with the Association's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Plan Performance Response Process and in addressing Plan performance problems identified thereunder.

Standard 9: A Plan shall obtain a rating of its financial strength from an independent rating agency approved by the Association's Board of Directors for such purpose.

Standard 10: Notwithstanding any other provision in this License Agreement, during each year, a Plan and its Controlled Affiliate(s) engaged in providing licensable services (excluding Life Insurance and Charitable Foundation Services) shall use their best efforts to promote and build the value of the Blue Shield Marks.

Standard 11: Neither a Plan nor any Larger Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Plan or Larger Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Amended as of June 16, 2005

EXHIBIT 2

Membership Standards
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Standard 12: No provider network, or portion thereof, shall be rented or otherwise made available to a National Competitor if the Licensed Marks or Names are used in any way with such network.

A provider network may be rented or otherwise made available, provided there is no use of the Licensed Marks or Names with respect to the network being rented.

Standard 13: Each Plan shall operate in a manner to reasonably: 1) protect the security and confidentiality of Personally Identifiable Information (PII) and Protected Health Information (PHI); 2) protect the Brands from reputational damage; and 3) cooperate with BCBSA and other Plans if a data security incident or data breach occurs.

Amended as of June 18, 2015

EXHIBIT 3

**GUIDELINES WITH RESPECT TO USE OF
LICENSED NAME AND MARKS IN CONNECTION WITH NATIONAL ACCOUNTS**

Page 1 of 3

1. The strength of the Blue Cross/Blue Shield National Accounts mechanism, and the continued provision of cost effective, quality health care benefits to National Accounts, are predicated on locally managed provider networks coordinated on a national scale in a manner consistent with effective service to National Account customers and consistent with the preservation of the integrity of the Blue Cross/Blue Shield system and the Licensed Marks. These guidelines shall be interpreted in keeping with such ends.

2. A National Account is an entity with employee and/or retiree locations in more than one Plan's Service Area. Unless otherwise agreed, a National Account is deemed located in the Service Area in which the corporate headquarters of the National Account is located. A local plant, office or division headquarters of an entity may be deemed a separate National Account when that local plant, office or division headquarters 1) has employee locations in more than one Service Area, and 2) has independent health benefit decision-making authority for the employees working at such local plant, office or division headquarters and for employees working at other locations outside the Service Area. In such a case, the local plant, office or division headquarters is a National Account that is deemed located in the Service Area in which such local plant, office or division headquarters is located. The Control Plan of a National Account is the Plan in whose Service Area the National Account is located. A participating ("Par") Plan is a Plan in whose Service Area the National Account has employee and/or retiree locations, but in which the National Account is not located. In the event that a National Account parent company consolidates health benefit-decision making for itself and its wholly-owned subsidiary companies, the parent company and the subsidiary companies shall be considered one National Account. The Control Plan for such a National Account shall be the Plan in whose Service Area the parent company headquarters is located.

3. The National Account Guidelines enunciated herein below shall be applicable only with respect to the business of new National Accounts acquired after January 1, 1991.

4. Control Plans shall utilize National Account identification cards complying with then currently effective BCBSA graphic standards in connection with all National Accounts business to facilitate administration thereof, to minimize subscriber and provider confusion, and to reflect a commitment to cooperation among Plans.

Amended as of June 12, 2003

Exhibit 3
Page 2 of 3

5. Disputes among Plans and/or BCBSA as to the interpretation or implementation of these Guidelines or as to other National Accounts issues shall be submitted to mediation and mandatory dispute resolution as provided in the License Agreement. For two years from the effective date of the License Agreement, however, such disputes shall be subject to mediation only, with the results of such mediation to be collected and reported in order to establish more definitive operating parameters for National Accounts business and to serve as ground rules for future binding dispute resolution.

6. The Control Plan may use the BlueCard Program (as defined by IPPC) to deliver benefits to employees and non-Medicare eligible retirees in a Participating Plan's service area if an alternative arrangement with the Participating Plan cannot be negotiated. The Participating Plan's minimum servicing requirement for those employees and non-Medicare retirees in its service area is to deliver benefits using the BlueCard Program. Account delivery is subject to the policies, provisions and procedures of the BlueCard Program.

7. For provider payments in a Participating Plan's area (on non-BlueCard claims), payment to the provider may be made by the Participating Plan or the Control Plan at the Participating Plan's option. If the Participating Plan elects to pay the provider, it may not withhold payment of a claim verified by the Control Plan or its designated processor, and payment must be in conformity with service criteria established by the Board of Directors of BCBSA (or an authorized committee thereof) to assure prompt payment, good service and minimum confusion with providers and subscribers. The Control Plan, at the Participating Plan's request, will also assure that measures are taken to protect the confidentiality of the data pertaining to provider reimbursement levels and profiles.

Amended as of June 14, 1996

Exhibit 3
Page 3 of 3

8. The Control Plan, in its financial agreements with a National Account, is expected to reasonably reflect the aggregate amount of differentials passed along to the Control Plan by all Participating Plans in a National Account.

9. Other than in contracting with health care providers or soliciting such contracts in areas contiguous to a Plan's Service Area in order to serve its subscribers or those of its licensed Controlled Affiliate residing or working in its Service Area, a Control Plan may not use the Licensed Marks and/or Name, as a tag line or otherwise, to negotiate directly with providers outside its Service Area.

Amended as of March 13, 2003

Exhibit 4
GOVERNMENT PROGRAMS AND CERTAIN OTHER USES

Page 1 of 14

1. A Plan and its licensed Controlled Affiliate may use the Licensed Marks and Name in bidding on and executing a contract to serve a Government Program, and in thereafter communicating with the Government concerning the Program. With respect, however, to such contracts entered into after the 1st day of January, 1991, the Licensed Marks and Name will not be used in communications or transactions with beneficiaries or providers in the Government Program located outside a Plan's Service Area, unless the Plan can demonstrate to the satisfaction of BCBSA's governing body that such a restriction on use of the Licensed Marks and Name will jeopardize its ability to procure the contract for the Government Program. As to both existing and future contracts for Government Programs, Plans will discontinue use of the Licensed Marks and Name as to beneficiaries and Providers outside their Service Area as expeditiously as circumstances reasonably permit. Effective January 1, 1995, except as provided in the first sentence above, all use by a Plan of the Licensed Marks and Name in Government Programs outside of the Plan's Service Area shall be discontinued. Incidental communications outside a Plan's Service Area with resident or former resident beneficiaries of the Plan, and other categories of necessary incidental communications approved by BCBSA, are not prohibited. For purposes of this Paragraph 1, the term “Government Programs” shall mean Medicare Part A, Medicare Part B and other non-risk government programs.

2. In connection with activity otherwise in furtherance of the License Agreement, a Plan and its Controlled Affiliates that are licensed to use the Licensed Marks and Name in its Service Area pursuant to the Controlled Affiliate License Agreements authorized in clauses a) through c) of Paragraph 2 of the Plan’s License Agreement with BCBSA may use the Licensed Marks and Name outside the Plan’s Service Area in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

2.1 Common Business Communications

a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);

b. distributing business cards other than in marketing and selling;

c. advertising in publications or electronic media solely to persons for employment;

Amended as of June 19, 2014

EXHIBIT 4

Page 2 of 14

2.2 Marketing Spillover

a. advertising in print, electronic or other media which serve, as a substantial market, the Service Area of the Plan or licensed Controlled Affiliate, provided that no Plan or Controlled Affiliate may advertise outside its Service Area on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Service Area;

b. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Plan's Service Area or that of a licensed Controlled Affiliate;

2.3 Provider Contracting

a. contracting with health care providers or soliciting such contracts in areas contiguous to the Plan's Service Area in order to serve its subscribers or those of such licensed Controlled Affiliates residing or working in its service area;

b. issuing a small sign containing the legal name or trade name of the Plan or such licensed Controlled Affiliates for display by a provider to identify the latter as a participating provider of the Plan or Controlled Affiliate;

c. negotiating case-specific reimbursement rates with a provider that does not have a contract applicable to a specific member's services rendered or to be rendered with the Licensee (or any of the Licensees in the case of overlapping Service Areas) in whose Service Area the health care provider is located, so long as

(1) the Licensee engaging in the negotiations complies with all applicable Inter-Plan Programs Policies and Provisions and Brand Regulations related to case-specific rate negotiations, and

(2) the Licensee (or all Licensees in the case of overlapping Service Areas) in whose Service Area the health care provider is located provides consent before negotiations commence.

Amended as of January 22, 2019

EXHIBIT 4

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d. contracting with a pharmacy management organization ("Pharmacy Intermediary") to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;

Amended as of January 22, 2019

EXHIBIT 4

e. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided that (1) the Plan and the Controlled Affiliate may
not contract directly with pharmacists or pharmacy stores outside the Plan's Service Area, and (2) neither the Plan's or the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Plan's Service Area;

f. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;

g. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;

h. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Plan's Service Area;

i. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Plan's Service Area;

j. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Plan's Service Area;

k. contracting with a company that operates provider sites in the Plan's Service Area, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Plan's Service Area;

EXHIBIT 4

l. contracting with a company that makes health care professionals available in the Plan's Service Area (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Plan's Service Area.

m. Permitting Control/Home Plans' ability to resolve members' service issues requiring outreach to out-of-area providers as set forth in the Inter-Plan Programs and Inter-Plan Medicare Advantage Program Policies.

2.4 Services to National Accounts

a. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee (as those terms are defined in the Inter-Plan Programs Policies and Provisions ("IP Policies")) to offer Blue-branded Health Coverage to the National Account, offering Blue-branded Health and Wellness Programs to all members of the National Account, including members who have not enrolled in the Blue-branded Health Coverage ("non-Blue Health Coverage members"), provided that:

(i) the Plan and/or Licensed Controlled Affiliate has no contact or interaction with providers outside of the Plan's Service Area, except as specifically provided in the IP Policies and in 2.4(b); and

(ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Brands a local plant, office or division of the account that is outside of the Plan's Service Area, the Plan and/or licensed Controlled Affiliate may not offer Blue-branded Health and Wellness Programs to any employees working at such local plant, office or division without the consent of such other Licensee; and

(iii) if the Plan and/or licensed Controlled Affiliate provides an information card to the non-Blue Health Coverage members, the card may not display the Symbols in the masthead, must contain a prominent disclosure conveying that it is not a health insurance card, and otherwise must be designed so that it is dissimilar to a Blue member identification card.

Amended as of September 17, 2020

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2.4 Services to National Accounts (continued)

For purposes of this subparagraph a, the following definitions apply:

"Health and Wellness Program" shall mean a program that includes at least one of the following elements or a related element:

- Health Risk Assessment and/or Preventive Screenings
- Exercise and Fitness Programs
- Health and Wellness Events (e.g., attendance at a health fair, a 5K walk)
- Nutrition and Weight Management
- Health Education (e.g., smoking cessation classes)
- Prenatal and Parenting Education
- Disease or Chronic Condition Management

The above listing is intended to represent examples of the types of programs that may be offered, and other programs, including those offered through different media such as the internet or telephonically, may also be deemed Health and Wellness programs.

"Health Coverage" shall mean providing or administering medical, surgical, hospital, major medical, or catastrophic coverage, or any HMO, PPO, POS or other managed care plan for the foregoing services.

b. as part of a Health and Wellness Program that is otherwise compliant with Brand Regulation 4.11.4(a), contracting with a health and wellness organization to gain access to providers to deliver a discrete health and wellness event ("Event") held at a National Account's worksite outside of the Licensee's Service Area, provided that:

(i) the services delivered at the Event are limited to fingerstick screenings for cholesterol and glucose, seasonal flu immunizations, blood pressure measurements, body mass index measurements, and other routine screenings, immunizations and measurements; and

(ii) neither such services nor their costs are applied as claims against any benefit plan; and

(iii) the Event is presented during one or more limited periods during a benefit year and is available to all employees at the worksite.

Amended as of March 26, 2015

EXHIBIT 4

c. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee to offer Blue-branded Health Coverage to the National Account, performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by the National Account to its members, including benefit plans that are not underwritten or administered by the Plan, provided that:

(i) in performing such functions, the Plan and/or licensed Controlled Affiliate does not use the Brands in any communications with health care providers outside of the Plan's Service Area, and otherwise limits its use of the Brands outside of the Service Area to communications with the account's members, the other benefit plan providers with which the account has contracted and other reasonably necessary communications to perform such functions; and

(ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Brands a local plant, office or division of the account that is outside of the Plan's Service Area, the Plan and/or licensed Controlled Affiliate may not perform Eligibility and Enrollment functions for employees working at such local plant, office or division without the consent of such other Licensee;

d. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee to perform or investigate fraud, waste and abuse investigation activities for a non-participating provider in a Par/Host Plan's service area, as long as the Control/Home Plan is given permission to do so by the Par/Host Plan and specific conditions are met in accordance with Inter-Plan Programs and Inter-Plan Medicare Advantage Program policies.

For purposes of this subparagraph b, the following definitions apply:

"Health Coverage" has the meaning set forth in subparagraph 2.4.a.

Amended as of September 27, 2018

EXHIBIT 4

"Eligibility" means services that manage the account's eligibility data and determine or process determinations relating to eligibility for benefit plans offered by the account to its employees, including such services as:

- monitoring and auditing data to ensure that only entitled individuals are enrolled in each such benefit plan;
- review of eligibility documentation (e.g. marriage licenses, birth certificates, student status verification letters, employment records);
- identification of key member segments such as over-age dependents, part-time employees, employees reaching certain milestones (e.g. Medicare-eligible, retirees);
- termination of coverage for those individuals found to be ineligible for coverage under a benefit plan, and, if applicable, generation of a COBRA event; and
- management of "hour-banking" for union environments in which union members can bank hours to remain eligible for benefits.

"Enrollment" means services that enroll eligible individuals and their spouses/dependents or terminate or change their enrollment in the account's benefit plans on an ongoing basis and during open enrollment periods, including such services as:

- the coordination of each step in open enrollment process from project planning and system set-up to the generation of confirmation statements;
- ongoing enrollment support for new hires and changes due to life events and work status adjustments;
- evidence of insurability (EOI) administration for life and disability coverage;
- transmission of eligibility/enrollment information to the account's benefit plan providers;
- review and reconciliation of error reports received from the account's benefit plan providers; and
- transmission of information to the account's payroll system (e.g., benefit deductions, employee demographic data).

Amended as of March 26, 2015

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2.5 Knowledge Sharing

a. submitting scholarly articles authored or co-authored by the Plan or Controlled Affiliate or its respective employees for publication in peer-reviewed journals;

b. permitting an internal representative of the Licensee (e.g., officer, employee) to speak or present at a conference or symposium outside of the Licensee's Service Area regarding either (i) healthcare financing, administration, delivery or policy, or (ii) topics within the representative's functional discipline or expertise at the Licensee, for which the event sponsor will issue communications to promote, administer, and/or recap the event that will identify the Licensee's representative as a participant. The communications outside of the Licensee's Service Area that mention the Licensee's representative shall be limited to materials and digital media provided to attendees, on-site signage, advertising in relevant trade publications, direct mail and email to attendees and prospective attendees, and the sponsor's website, Participation in any conference or symposium outside of the Licensee's Service Area may not be for the purpose of marketing or selling products or services.

If the Licensee's representative wishes to use the Brands in any manner, including use in his/her title, when participating as a speaker or presenter outside of the Licensee's Service Area about a topic that is not related to healthcare financing, administration, delivery, or policy, or to topics within the representative's functional discipline or expertise at the Licensee, the Licensee must notify BCBSA and receive prior approval from BCBSA before participating.

Amended as of March 26, 2015

EXHIBIT 4

2.6 Other Uses

a. entering into a license agreement between and among BCBSA, the Plan and a debit card issuer located outside the Plan's Service Area, and entering into a corresponding operating agreement or agreements, in order to offer a debit card bearing the Licensed Marks and Name to eligible persons as defined by the aforementioned license agreement;

b. appearing in communications issued by an independent third party to recognize outstanding performance of the Plan or Controlled Affiliate or a member of the Plan's or Controlled Affiliate's senior management as part of an established program of the third party for which the Plan has provided information to be considered for the recognition, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;

c. to identify itself as being a joint sponsor of an event, program or activity along with other Plans or such Plans' licensed Controlled Affiliates, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;

d. hosting meetings or events (collectively, "events") in Washington, D.C. or a Plan's State Capitol related to policy and business issues in the Licensee's Service Area, or hosting events in conjunction with the assemblies or conventions of national political parties. Such events may not involve marketing or selling products or services. Use of the Brands outside the Licensee's Service Area in connection with such events shall be limited to materials and digital media provided to attendees and prospective attendees and onsite signage. For any such events in Washington, D.C. that are open to attendees other than government officials or their staffs, or are briefings open to all Congressional staff, or are otherwise likely to receive media coverage, the Licensee is required to provide advance notice to BCBSA. For events hosted outside of Washington, D.C. in conjunction with the assemblies or conventions of national political parties, the Licensee is required to provide advance notice to BCGSA and to the local Plan(s);

Amended as of March 26, 2015

EXHIBIT 4

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e. permitting an affiliate that is not licensed to use the Licensed Marks to identify its corporate relationship with the Plan, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time.

3. In connection with activity otherwise in furtherance of the License Agreement, a Controlled Affiliate that is licensed to use the Licensed Marks and Name pursuant to a Controlled Affiliate License Agreement authorized in clauses d) or e) of Paragraph 2 of the Plan's License Agreement with BCBSA may use the Licensed Marks and Name outside the Region (as that term is defined in such respective Controlled Affiliate License Agreements) in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);

b. distributing business cards other than in marketing and selling;

c. contracting with health care providers or soliciting such contracts in areas contiguous to the Region in order to serve its subscribers residing in the Region, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans in connection with such contracting unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;

d. issuing a small sign containing the legal name or trade name of the Controlled Affiliate for display by a provider to identify the latter as a participating provider of the Controlled Affiliate, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans on such signs unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;

advertising in publications or electronic media solely to persons for employment;

Amended as of March 26, 2015

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f. advertising in print, electronic or other media which serve, as a substantial market, the Region, provided that the Controlled Affiliate may not advertise outside its Region on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Region, and provided further that any such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to advertise in such media;

g. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Region, provided that such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to send direct mail to such zip code plus 4.

h. [Intentionally left blank, pending review by the Inter-Plan Programs Committee of the applicability of the case management rule to such Controlled Affiliates.]

i. contracting with a pharmacy management organization (“Pharmacy Intermediary”) to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for the Controlled Affiliate’s regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective Controlled Affiliate License Agreements, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;

j. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit to the Controlled Affiliate’s regional Medicare Advantage PPO
or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective

EXHIBIT 4

Controlled Affiliate License Agreements, provided that (1) the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Region, and (2) neither the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Region;

k. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for the Controlled Affiliate's regional Medicare Advantage PPO members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;

l. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for the Controlled Affiliate's regional Medicare Advantage members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;

m. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Controlled Affiliate's Region;

n. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Controlled Affiliate's Region;

o. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Region;

p. contracting with a company that operates provider sites in the Region, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Region;

EXHIBIT 4

q. contracting with a company that makes health care professionals available in the Region (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Region.

4. BCBSA shall retain the right to use the Licensed Marks in conjunction with the Federal Employee Program and with any other national offering made to federal employees pursuant to the Federal Employees Health Benefits Program (FEHBP), including the right to license such use to its vendors, but only in the following manner.

   a. the Licensed Marks may only be used by BCBSA with the term “Federal Employee Program”, “Federal”, “FEP”, or similar language identifying the program as a benefit program for federal employees;

   b. the Licensed Marks may not be used by BCBSA with the name(s) of a specific Plan or Plans and;

   c. any use by BCBSA in conjunction with a new national FEHBP program proposed after the enactment of this amendment will require the approval of the BCBSA Board of Directors.

5. Where required by applicable state or local law or regulation, a Plan or its licensed Controlled Affiliate may submit documents that contain the Brands to, and file forms that contain the Brands with, state or local regulators in a state not included in its Service Area, provided that it gives reasonable advance notice to the local Plan of its intent to submit such documents or file such forms. Notwithstanding, in no event may a Plan or its licensed Controlled Affiliate use the Brands to register, or to obtain or maintain a license, a certificate of authority, or an equivalent document authorizing it to act as a risk-bearing entity or third party administrator in a state not included in its Service Area. If the local Plan advises BCBSA that it believes its License Agreement has been or would be violated by any submission or filing, BCBSA shall determine whether such submission or filing is required by state or local law or regulation and violates the License Agreement, subject to the Plan’s or licensed Controlled Affiliate’s rights to obtain an independent review of such determination under Paragraph 9(a) and Exhibit 5 of its License Agreement or Paragraph 8 of the Controlled Affiliate License. For purposes of this paragraph, “local Plan” is defined as each Plan whose Service Area includes all or part of the state in which the foregoing applicable state or local law or regulation has been enacted.

Amended as of March 26, 2015

EXHIBIT 5

MEDIATION AND MANDATORY DISPUTE RESOLUTION (MMDR) RULES

The Blue Cross and Blue Shield Plans ("Plans") and the Blue Cross Blue Shield Association ("BCBSA") recognize and acknowledge that the Blue Cross and Blue Shield system is a unique nonprofit and for-profit system offering cost effective health care financing and services. The Plans and BCBSA desire to utilize Mediation and Mandatory Dispute Resolution ("MMDR") to avoid expensive and time-consuming litigation that may otherwise occur in the federal and state judicial systems. Even MMDR should be viewed, however, as methods of last resort, all other procedures for dispute resolution having failed. Except as otherwise provided in the License Agreements, the Plans, their Controlled Affiliates and BCBSA agree to submit all disputes to MMDR pursuant to these Rules and in lieu of litigation.

1. Initiation of Proceedings

A. Pre-MMDR Efforts

Before filing a Complaint to invoke the MMDR process, the CEO of a complaining party, or his/her designated representative, shall undertake good faith efforts with the other side(s) to try to resolve any dispute.

B. Complaint

To commence a proceeding, the complaining party (or parties) shall provide by certified mail, return receipt requested, a written Complaint to the BCBSA Corporate Secretary (which shall also constitute service on BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) named therein. The Complaint shall contain:

i. identification of the complaining party (or parties) requesting the proceeding;

ii. identification of the respondent(s);

iii. identification of any other persons or entities who are interested in a resolution of the dispute;

iv. a full statement describing the nature of the dispute;

v. identification of all of the issues that are being submitted for resolution;

Amended as of November 21, 1996

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vi. the remedy sought;

vii. a statement as to whether the complaining party (or parties) elect(s) first to pursue Mediation;

viii. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor; and

ix. a statement signed by the CEO of the complaining party affirming that the CEO has undertaken efforts, or has directed efforts to be undertaken, to resolve the dispute before resorting to the MMDR process.

The complaining party (or parties) shall file and serve with the Complaint copies of all documents which the party (or parties) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

C. Answer

Within twenty (20) days after receipt of the Complaint, each respondent shall serve on BCBSA and on the complaining party (or parties):

i. a full Answer to the aforesaid Complaint;

ii. a statement of any Counterclaims against the complaining party (or parties), providing with respect thereto the information specified in Paragraph 1.B., above;

iii. a statement as to whether the respondent elects to first pursue Mediation; and

iv. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor.

The respondent(s) shall file and serve with the Answer or by the date of the Initial Conference set forth in Paragraph 3.C., below, copies of all documents which the respondent(s) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

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D. Reply To Counterclaim

Within ten (10) days after receipt of any Counterclaim, the complaining party (or parties) shall serve on BCBSA and on the responding party (or parties) a Reply to the Counterclaim. Such Reply must provide the same information required by Paragraph 1.C., above.

2. Mediation

To facilitate the mediation of disputes between or among BCBSA, the Plans and/or their Controlled Affiliates, the BCBSA Board has provided for Mediation under these Rules. Mediation may be pursued in lieu of or in an effort to obviate the Mandatory Dispute Resolution process, and all parties are strongly urged, but not required, to exhaust the mediation procedure provided for herein. In the event any party refuses to proceed with Mediation, the parties shall proceed immediately to Mandatory Dispute Resolution, as provided in Section 3.

A. Selection of Mediators

If all parties agree to pursue Mediation, they shall promptly attempt to agree upon: (i) the number of mediators desired, not to exceed three mediators; and (ii) the selection of experienced mediator(s) from an independent entity to mediate all disputes set forth in the Complaint and Answer (and Counterclaim and Reply, if any). In the event the parties are unable to agree upon the selection or number of mediators, both within five (5) days of the service of the Answer or Reply to Counterclaim, whichever is later, the BCBSA Corporate Secretary shall immediately refer the matter to a nationally recognized professional ADR organization (such as CPR or JAMS) for mediation by a single mediator to be selected by the ADR organization.

B. Binding Decision

Before the Mediation Hearing described below, the BCBSA Corporate Secretary shall contact the parties to determine whether they wish to be bound by any recommendation of the selected mediator(s) for resolution of the disputes. If all wish to be bound, the Corporate Secretary will send appropriate documentation to them for their signatures before the Mediation Hearing begins.

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C. Mediation Procedure

The Mediator(s) shall apply the mediation procedures and processes provided for herein (not the rules of the ADR organization with which they are affiliated) and shall promptly advise the parties of a scheduled Mediation Hearing date. Unless a party requests an expedited procedure, or unless all parties to the proceeding agree to one or more extensions of time, the Mediation Hearing set forth below shall be completed within forty (40) days of BCBSA's receipt of the Complaint. The selected mediator(s), unless the parties otherwise agree, shall adhere to the following procedure:

i. Each party must be represented by its CEO or other representative who has been delegated full authority to resolve the dispute. However, parties may send additional representatives as they see fit.

ii. Each party will be given one-half hour to present its case, beginning with the complaining party (or parties), followed by the other party or parties. The parties are free to structure their presentations as they see fit, using oral statements or direct examination of witnesses. However, neither cross-examination nor questioning of opposing representatives will be permitted. At the close of each presentation, the selected mediator(s) will be given an opportunity to ask questions of the presenters and witnesses. All parties must be present throughout the Mediation Hearing. The selected mediator(s) may extend the time allowed for each party's presentation at the Mediation Hearing. The selected mediator(s) may meet in executive session, outside the presence of the parties, or may meet with the parties separately, to discuss the controversy.

iii. After the close of the presentations, the parties will attempt to negotiate a settlement of the dispute. If the parties desire, the selected mediators, or any one or more of the selected mediator(s), will sit in on the negotiations.

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iv. After the close of the presentations, the selected mediator(s) may meet privately to agree upon a recommendation for resolution of the dispute which would be submitted to the parties for their consideration and approval. If the parties have previously agreed to be bound by the results of this procedure, this recommendation shall be binding upon the parties.

v. The purpose of the Mediation Hearing is to assist the parties to settle their grievances short of mandatory dispute resolution. As a result, the Mediation Hearing has been designed to be as informal as possible. Rules of evidence shall not apply. There will be no transcript of the proceedings, and no party may make a tape recording of the Mediation Hearing.

vi. In order to facilitate a free and open discussion, the Mediation proceeding shall remain confidential. A "Stipulation to Confidentiality" which prohibits future use of settlement offers, all position papers or other statements furnished to the selected mediator(s), and decisions or recommendations in any Mediation proceeding shall be executed by each party.

vii. Upon request of the selected mediator(s), or one of the parties, BCBSA staff may also submit documentation at any time during the proceedings.

D. Notice of Termination of Mediation

If the Mediation cannot be completed within the prescribed or agreed time period due to the lack of cooperation of any party, as determined by the selected mediator(s), or if the Mediation does not result in a final resolution of all disputes at the Mediation Hearing or within ten (10) days after the Mediation Hearing, any party or any one of the selected mediator(s) shall so notify the BCBSA Corporate Secretary, who shall promptly issue a Notice of Termination of Mediation to all parties, to the selected mediator(s), and to the MDR Administrator. Such notice shall serve to bring the Mediation to an end and to initiate Mandatory Dispute Resolution. Upon agreement of all parties and the mediator(s), the Mediation process may continue at the same time the MDR process is invoked. In such case, the Notice of Termination of Mediation described above serves to initiate the MDR proceeding, but does not terminate mediation proceedings, which may proceed simultaneous with the MDR proceeding.

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3. Mandatory Dispute Resolution (MDR)

If any party elects not to first pursue Mediation, or if a Notice of Termination of Mediation is issued as set forth in Paragraph 2.D., above, then the unresolved disputes set forth in any Complaint and Answer (and Counterclaim and Reply, if any) shall be subject to mandatory binding arbitration (herein referred to as "MDR").

A. MDR Administrator

The Administrator for purposes of Mandatory Arbitration shall be an independent nationally recognized entity such as CPR or JAMS, specializing in alternative dispute resolution. In the event the parties pursued Mediation with CPR, JAMS or a similar organization, that organization also shall serve as the MDR Administrator, unless all parties notify the BCBSA Corporate Secretary in writing within two (2) days of receiving the Notice of Termination of Mediation that they wish to pursue MDR with another nationally recognized organization serving as MDR Administrator.

In the event the parties (i) did not pursue Mediation, (ii) pursued mediation with a Mediator not affiliated with an ADR organization that offers a panel of arbitrators, or (iii) all parties that pursued Mediation notified the BCBSA Corporate Secretary that they wish to have an MDR Administrator that is different from the organization with which their mediator was affiliated, they shall promptly attempt to agree on a nationally recognized ADR entity that supplies a panel of arbitrators. If they reach such agreement within five (5) days of the Notice of Termination of Mediation or receipt of the Answer or Reply to Counterclaim (whichever is later), the parties shall promptly inform the BCBSA Corporate Secretary of their agreed upon ADR organization. In the event the parties are unable to reach agreement on an MDR Administrator within that timeframe, the BCBSA Corporate Secretary shall immediately refer the matter to CPR, JAMS or a similar organization for MDR.

Any person who served as a Mediator shall not serve as an arbitrator for the same or similar dispute for purposes of MDR.

B. Rules for MDR

The rules controlling all aspects of MDR shall be exclusively those provided for herein. The rules promulgated or otherwise used by the MDR Administrator organization shall not apply.

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C. Initial Conference

Within seven (7) days after a Notice of Termination has issued, or the matter has otherwise been referred to an MDR Administrator, or within five (5) days after the time for filing and serving the Answer or Reply to any Counterclaim (whichever is later) if the parties elect first not to mediate, the parties shall confer with the Administrator to discuss selecting a dispute resolution panel ("the Panel"). This conference (the “Initial Conference”) may be by telephone. The parties are encouraged to agree to the composition of the Panel and to present that agreement to the Administrator at the Initial Conference. If the parties do not agree on the composition of the Panel by the time of the Initial Conference, or by any extension thereof agreed to by all parties and the Administrator, then the Panel Selection Process set forth in subparagraph D, below, shall be followed.

D. Panel Selection Process

The Administrator shall designate, prior to the Initial Conference, at least seven potential arbitrators. Each party shall be permitted to strike any designee for cause and the Administrator shall determine the sufficiency thereof in its sole discretion. The Administrator will designate a replacement for any designee so stricken. Each party shall then be permitted one peremptory strike from the list of designees. The Administrator shall set the dates for exercising all strikes, which shall be set to encourage the prompt selection of arbitrators.

After the parties exercise any designee strikes for cause and their peremptory strike against any designee of their choice, the parties shall each rank the remaining panel members in order of preference and provide the Administrator, without serving on any other party, their ranked list. The Administrator shall not disclose any party’s ranked list to members of the panel or to other parties.

From the remaining designees, and after considering opportunities to maximize, so far as possible, the collectively stated arbitrator preferences provided by the parties on their ranked lists, the Administrator shall select a three member Panel. The Panel Selection Process shall be completed no later than ten (10) days after the Initial Conference.

Each Arbitrator shall be compensated at his or her normal hourly rate or, in the absence of an established rate, at a reasonable hourly rate to be promptly fixed by the Administrator for all time spent in connection with the proceedings and shall be reimbursed for any travel and other reasonable expenses.

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E. Duties Of The Arbitrators

The Panel shall promptly designate a Presiding Arbitrator for the purposes reflected below, but shall retain the power to review and modify any ruling or other action of said Presiding Arbitrator. Each Arbitrator shall be an independent Arbitrator, shall be governed by the Code of Ethics for Arbitrators in Commercial Disputes, and shall at or prior to the commencement of any Arbitration Hearing take an oath to that effect. Each Arbitrator shall promptly disclose in writing to the Panel and to the parties any circumstances, whenever arising, that might cause doubt as to such Arbitrator's compliance, or ability to comply, with said Code of Ethics, and, absent resignation by such Arbitrator, the remaining Arbitrators shall determine in their sole discretion whether the circumstances so disclosed constitute grounds for disqualification and for replacement. With respect to such circumstances arising or coming to the attention of a party after an Arbitrator's selection, a party may likewise request the Arbitrator's resignation or a determination as to disqualification by the remaining Arbitrators. With respect to a sole Arbitrator, the determination as to disqualification shall be made by the Administrator.

There shall be no ex parte communication between the parties or their counsel and any member of the Panel.

F. Panel's Jurisdiction And Authority

The Panel's jurisdiction and authority shall extend to all disputes between or among the Plans, their Controlled Affiliates, and/or BCBSA, except for those disputes excepted from these MMDR procedures as set forth in the License Agreements.

With the exception of punitive or treble damages, the Panel shall have full authority to award the relief it deems appropriate to resolve the parties' disputes, including monetary awards and injunctions, mandatory or prohibitory. The Panel has no authority to award punitive or treble damages except that the Panel may allocate or assess responsibility for punitive or treble damages assessed by another tribunal. Subject to the above limitations, the Panel may, by way of example, but not of limitation:

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i. interpret or construe the meaning of any terms, phrase or provision in any license between BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.

ii. determine whether BCBSA, a Plan or a Controlled Affiliate has violated the terms or conditions of any license between the BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.

iii. decide challenges as to its own jurisdiction.

iv. issue such orders for interim relief as it deems appropriate pending Hearing and Award in any Arbitration.

It is understood that the Panel is expected to resolve issues based on governing principles of law, preserving to the maximum extent legally possible the continued integrity of the Licensed Marks and the BLUE CROSS/BLUE SHIELD system. The Panel shall apply federal law to all issues which, if asserted in the United States District Court, would give rise to federal question jurisdiction, 28 U.S.C. § 1331. The Panel shall apply Illinois law to all issues involving interpretation, performance or construction of any License Agreement or Controlled Affiliate License Agreement unless the agreement otherwise provides. As to other issues, the Panel shall choose the applicable law based on conflicts of law principles of the State of Illinois.

G. Administrative Conference

Within five (5) days of the Panel being selected, the Presiding Arbitrator shall confer with the parties and the other members of the Panel and shall schedule, in writing, a conference in which the parties and the Panel shall participate (the “Administrative Conference”). The Administrative Conference shall take place no later than fifteen (15) days after the Panel is selected. At the Administrative Conference the parties and the Panel shall discuss the scheduling of the Arbitration Hearing and any other matter appropriate to be considered, including but not limited to: any written discovery in the form of requests for production of documents or requests to admit facts; the identity of any witness whose deposition a party may desire and a showing of exceptional good cause for the taking

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of any such deposition; the desirability of bifurcation or other separation of the issues; the need for and the type of record of conferences and hearings, including the need for transcripts; the need for expert witnesses and how expert testimony should be presented; the appropriateness of motions to dismiss and/or for full or partial summary judgment; consideration of stipulations; the desirability of presenting any direct testimony in writing; and the necessity for any on-site inspection by the Panel. If the parties agree, the Administrative Conference may be by telephone.

H. Discovery

i. ***Requests for Production of Documents***: All requests for the production of documents must be served no later than five (5) days after the date of the Initial Conference. Within twenty (20) days after receipt of a request for production of documents, a party shall (a) serve responses and objections to the request, (b) produce all responsive, non-privileged documents to the requesting party, and (c) to the extent any responsive documents are withheld on the grounds of attorney-client privilege or work product, produce a log identifying such documents in the manner specified in Fed. R. Civ. P. 26(b)(5). If, after reviewing a privilege log, the requesting party believes attorney-client privilege or work product protection was improperly claimed by the producing party with respect to any document, the requesting party may ask the Presiding Arbitrator to conduct an in-camera inspection of the same. With respect to documentary and other discovery produced in any MDR proceeding by BCBSA, the fact that a party's CEO or other senior officers may serve on the BCBSA Board of Directors, BCBSA Board Committees or other BCBSA work groups, task forces and the like, shall not be a basis for defeating an otherwise valid claim of attorney-client privilege or work product protection over such documentary or other discovery materials by BCBSA.

ii. ***Requests for Admissions***: Requests for Admissions may be served up to twenty-one (21) days prior to the discovery cut-off set by the Presiding Arbitrator. A party served with Requests For Admissions must respond within twenty (20) days of receipt of said request. The good faith use of and response to Requests for Admissions is encouraged, and the Panel shall have full discretion, with reference to the Federal Rules of Civil Procedure, in awarding appropriate sanctions with respect to abuse of the procedure.

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iii. ***Depositions:*** As a general rule, the parties will not be permitted to take party or non-party deposition testimony for discovery purposes. The Presiding Arbitrator, in his or her sole discretion, shall have the authority to permit a party to take such deposition testimony upon a showing of exceptional good cause. The parties will be permitted to take de bene esse deposition[1] testimony to the fullest extent permitted by law of any witness who cannot be compelled to testify at the Arbitration Hearing. No deposition, for discovery purposes or otherwise, shall exceed three (3) hours, excluding objections and colloquy of counsel. Depositions may be recorded in any manner recognized by the Federal Rules of Civil Procedure and the parties shall specify in each notice of deposition or request for permission to take deposition testimony the manner in which such deposition shall be recorded.

iv. ***Expert witness(es)***: If a party intends to present the testimony of an expert witness during the oral hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2)(B) ten (10) days prior to the discovery cut-off set by the Presiding Arbitrator. If a party intends to present the testimony of a rebuttal expert witness during the Arbitration Hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2)(B) within twenty (20) days after the date on which the written statement of the expert witness whose testimony is to be rebutted was produced.

v. ***Discovery cut-off****:* The Presiding Arbitrator shall determine the date on which the discovery period will end, but the discovery period shall not exceed thirty (30) days from the date of the Administrative Conference without the agreement of all parties.

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[1] As used in these Rules, "de bene esse deposition" means a deposition that is not taken for discovery purposes, but is taken for the purpose of reading part or all of the deposition transcript into the record at the Arbitration Hearing, to the extent permitted by the Panel, because the witness cannot be compelled to testify at the Arbitration Hearing or has exercised a right provided under these Rules to provide deposition testimony in lieu of testimony at the Arbitration Hearing.

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vi. ***Additional discovery***: Any additional discovery will be at the discretion of the Presiding Arbitrator.

vii. ***Discovery Disputes:*** Any discovery disputes shall be raised by motion to the Presiding Arbitrator, who is authorized to resolve all such disputes, and whose resolution will be binding on the parties unless modified by the Arbitration Panel. Prior to raising any discovery dispute with the Presiding Arbitrator, the parties shall meet and confer, telephonically or in person, in an attempt to resolve or narrow the dispute. If a party refuses to comply with a decision resolving a discovery dispute, the Panel, in keeping with Fed. R. Civ. P. 37, may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for resolution adversely to that party.

viii. ***Extensions:*** The time for responding to discovery requests may be extended by the Presiding Arbitrator for good and sufficient cause shown. Any request for such an extension shall be made in writing.

I. Panel Suggested Settlement/Mediation

At any point during the proceedings, the Panel at the request of any party or on its own initiative, may suggest that the parties explore settlement and that they do so at or before the conclusion of the Arbitration Hearing, and the Panel shall give such assistance in settlement negotiations as the parties may request and the Panel may deem appropriate. Alternatively, the Panel may direct the parties to endeavor to mediate their disputes as provided above, or to explore a mini-trial proceeding, or to have an independent party render a neutral evaluation of the parties' respective positions. The Panel shall enter such sanctions as it deems appropriate with respect to any party failing to pursue in good faith such Mediation or other alternate dispute resolution methods.

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J. Subpoenas on Third Parties

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq*., and subject to Paragraph 3.G(iii) above, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan or any officer, employee or director of a third party Blue Plan, to compel deposition testimony or the production of documents, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena.

K. Arbitration Hearing

An Arbitration Hearing will be held within thirty (30) days after the Administrative Conference if no discovery is taken, or within thirty (30) days after the close of discovery, unless all parties and the Panel agree to extend the Arbitration Hearing date, or unless the parties agree in writing to waive the Arbitration Hearing. The parties may mutually agree on the location of the Arbitration Hearing. If the parties fail to agree, the Arbitration Hearing shall be held in Chicago, Illinois, or at such other location determined by the Presiding Arbitrator to be most convenient to the participants. The Panel will determine the date(s) and time(s) of the Arbitration Hearing(s) after consultation with all parties and shall provide reasonable notice thereof to all parties or their representatives.

L. Arbitration Hearing Memoranda

Twenty (20) days prior to the Arbitration Hearing, each party shall submit to the other party (or parties) and to the Panel an Arbitration Hearing Memorandum which sets forth the applicable law and any argument as to any relevant issue. The Arbitration Hearing Memorandum will supplement, and not repeat, the allegations, information and documents contained in or with the Complaint, Answer, Counterclaim and Reply, if any. Ten (10) days prior to the Arbitration Hearing, each party shall submit to each other party a list of all expert and fact witnesses (but not including rebuttal fact witness) that such party intends to have testify at the Arbitration Hearing and a brief summary of the testimony each such witness is expected to give. In addition, no later than five (5) days prior to the Arbitration, each party may submit to each other party and to the Panel a Response Arbitration Hearing Memorandum which sets forth any response to another party's Arbitration Hearing Memorandum.

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M. Notice For Testimony

Ten (10) days prior to the Arbitration Hearing, any party may serve a Notice on any other party (or parties) requesting the attendance at the Arbitration Hearing of any officer, employee or director of the other party (or parties) for the purpose of providing noncumulative testimony. If a party fails to produce one of its officers, employees or directors whose noncumulative testimony during the Arbitration Hearing is reasonably requested by an adverse party, the Panel may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for mandatory dispute resolution adversely to that party; provided, however, that a party may refuse to produce a director to testify if, within two (2) days of receiving a notice requesting the attendance of such director at the Arbitration Hearing, the party agrees to make the director available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. This Rule may not be used for the purpose of burdening or harassing any party, and the Presiding Arbitrator may impose such orders as are appropriate so as to prevent or remedy any such burden or harassment.

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq.*, twenty (20) days or more prior to the Arbitration Hearing, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan, BCBSA or any officer, employee or director of a third party Blue Plan or BCBSA for the purpose of providing noncumulative testimony at the Arbitration Hearing, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena; provided however, that a director of a third party Blue Plan or BCBSA may refuse to testify if, within two (2) days of receiving a subpoena requesting the attendance of such director at the Arbitration Hearing, the director agrees to make him/herself available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. Each Blue Plan agrees to waive, on its own behalf and on behalf of its directors and officers, any objection it otherwise might have to any such subpoena based on service, venue or extraterritoriality.

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N. Arbitration Hearing Procedures

i. ***Attendance at Arbitration Hearing***: Any person having a direct interest in the proceeding is entitled to attend the Arbitration Hearing. The Presiding Arbitrator shall otherwise have the power to require the exclusion of any witness, other than a party or other essential person, during the testimony of any other witness. It shall be discretionary with the Presiding Arbitrator to determine the propriety of the attendance of any other person.

ii. ***Confidentiality***: The Panel and all parties shall maintain the privacy of the Arbitration Proceeding. The parties and the Panel shall treat the Arbitration Hearing and any discovery or other proceedings or events related thereto, including any award resulting therefrom, as confidential except as otherwise necessary in connection with a judicial challenge to or enforcement of an award or unless otherwise required by law.

iii. ***Stenographic Record***: Any party, or if the parties do not object, the Panel, may request that a stenographic or other record be made of any Arbitration Hearing or portion thereof. The costs of the recording and/or of preparing the transcript shall be borne by the requesting party and by any party who receives a copy thereof. If the Panel requests a recording and/or a transcript, the costs thereof shall be borne equally by the parties.

iv. ***Oaths***: The Panel may require witnesses to testify under oath or affirmation administered by any duly qualified person and, if requested by any party, shall do so.

v. ***Order of Arbitration Hearing***: An Arbitration Hearing shall be opened by the recording of the date, time, and place of the Arbitration Hearing, and the presence of the Panel, the parties, and their representatives, if any. The Panel may, at the beginning of the Arbitration Hearing, ask for statements clarifying the issues involved.

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Unless otherwise agreed, the complaining party (or parties) shall then present evidence to support their claim(s). The respondent(s) shall then present evidence supporting their defenses and Counterclaims, if any. The complaining party (or parties) shall then present evidence supporting defenses to the Counterclaims, if any, and rebuttal.

Witnesses for each party shall submit to questions by adverse parties and/or the Panel.

The Panel has the discretion to vary these procedures, but shall afford a full and equal opportunity to all parties for the presentation of any material and relevant evidence.

vi. ***Evidence***: The parties may offer such evidence as is relevant and material to the dispute and shall produce such evidence as the Panel may deem necessary to an understanding and resolution of the dispute. Unless good cause is shown, as determined by the Panel or agreed to by all other parties, no party shall be permitted to offer evidence at the Arbitration Hearing which was not disclosed prior to the Arbitration Hearing by that party. The Panel may receive and consider the evidence of witnesses by affidavit upon such terms as the Panel deems appropriate.

The Panel shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence, other than enforcement of the attorney-client privilege and the work product protection, shall not be necessary. The Federal Rules of Evidence shall be considered by the Panel in conducting the Arbitration Hearing but those rules shall not be controlling. All evidence shall be taken in the presence of the Panel and all of the parties, except where any party is in default or has waived the right to be present.

Settlement offers by any party in connection with Mediation or MDR proceedings, decisions or recommendations of the selected mediators, and a party's position papers or statements furnished to the selected mediators shall not be admissible evidence or considered by the Panel without the consent of all parties.

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vii. ***Closing of Arbitration Hearing***: The Presiding Arbitrator shall specifically inquire of all parties whether they have any further proofs to offer or witnesses to be heard. Upon receiving negative replies or if he or she is satisfied that the record is complete, the Presiding Arbitrator shall declare the Arbitration Hearing closed with an appropriate notation made on the record. Subject to being reopened as provided below, the time within which the Panel is required to make the award shall commence to run, in the absence of contrary agreement by the parties, upon the closing of the Arbitration Hearing.

With respect to complex disputes, the Panel may, in its sole discretion, defer the closing of the Arbitration Hearing for a period of up to thirty (30) days after the presentation of proofs in order to permit the parties to submit post-hearing briefs and argument, as the Panel deems appropriate, prior to making an award.

For good cause, the Arbitration Hearing may be reopened for up to thirty (30) days on the Panel's initiative, or upon application of a party, at any time before the award is made

O. Awards

An Award must be in writing and shall be made promptly by the Panel and, unless otherwise agreed by the parties or specified by law, no later than thirty (30) days from the date of closing the Arbitration Hearing. If all parties so request, the Award shall contain findings of fact and conclusions of law. The Award, and all other rulings and determinations by the Panel, may be by a majority vote.

Parties shall accept as legal delivery of the Award the placing of the Award or a true copy thereof in the mail addressed to a party or its representative at its last known address or personal service of the Award on a party or its representative.

Awards are binding only on the parties to the Arbitration and are not binding on any non-parties to the Arbitration and may not be used or cited as precedent in any other proceeding.

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After the expiration of twenty (20) days from initial delivery, the Award (with corrections, if any) shall be final and binding on the parties, and the parties shall undertake to carry out the Award without delay.

Proceedings to confirm, modify or vacate an Award shall be conducted in conformity with and controlled by the Federal Arbitration Act. 9 U.S.C. § 1, *et seq*.

P. Return of Documents

Within sixty (60) days after the Award and the conclusion of any judicial proceedings with respect thereto, each party and the Panel shall return any documents produced by any other party, including all copies thereof. If a party receives a discovery request in any other proceeding which would require it to produce any documents produced to it by any other party in a proceeding hereunder, it shall not produce such documents without first notifying the producing party and giving said party reasonable time to respond, if appropriate, to the discovery request.

4. Miscellaneous

A. Expedited Procedures

Any party to a Mediation may direct a request for an expedited Mediation Hearing to the Chairman of the Mediation Committee, to the selected Mediators, and to all other parties at any time. The Chairman of the Mediation Committee, or at his or her direction, the then selected Mediators, shall grant any request which is supported by good and sufficient reasons. If such a request is granted, the Mediation shall be completed within as short a period as practicable, as determined by the Chairman of the Mediation Committee or, at his or her direction, the then selected Mediators.

Any party to an Arbitration may direct a request for expedited proceedings to the Administrator, to the Panel, and to all other parties at any time. The Administrator, or the Presiding Arbitrator if the Panel has been selected, shall grant any such request which is supported by good and sufficient reasons. If such a request is granted, the Arbitration shall be completed within as short a time as practicable, as determined by the Administrator and/or the Presiding Arbitrator.

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B. Temporary or Preliminary Injunctive Relief

Any party may seek temporary or preliminary injunctive relief with the filing of a Complaint or at any time thereafter. If such relief is sought prior to the time that an Arbitration Panel has been selected, then the Administrator shall select a single Arbitrator who is a lawyer who has no interest in the subject matter of the dispute, and no connection to any of the parties, to hear and determine the request for temporary or preliminary injunction. If such relief is sought after the time that an Arbitration Panel has been selected, then the Arbitration Panel will hear and determine the request. The request for temporary or preliminary injunctive relief will be determined with reference to the temporary or preliminary injunction standards set forth in Fed. R. Civ. P. 65.

C. Defaults and Proceedings in the Absence of a Party

Whenever a party fails to comply with the MDR Rules in a manner deemed material by the Panel, the Panel shall fix a reasonable time for compliance and, if the party does not comply within said period, the Panel may enter an Order of default or afford such other relief as it deems appropriate. Arbitration may proceed in the event of a default or in the absence of any party who, after due notice, fails to be present or fails to obtain an extension. An Award shall not be made solely on the default or absence of a party, but the Panel shall require the party who is present to submit such evidence as the Panel may require for the making of findings, determinations, conclusions, and Awards.

D. Notice

Each party shall be deemed to have consented that any papers, notices, or process necessary or proper for the initiation or continuation of a proceeding under these rules or for any court action in connection therewith may be served on a party by mail addressed to the party or its representative at its last known address or by personal service, in or outside the state where the MDR proceeding is to be held.

The Corporate Secretary and the parties may also use facsimile transmission, telex, telegram, or other written forms of electronic communication to give the notices required by these rules.

EXHIBIT 5

E. Expenses

The expenses of witnesses shall be paid by the party causing or requesting the appearance of such witnesses. All expenses of the MDR proceeding, including compensation, required travel and other reasonable expenses of the Panel, and the cost of any proof produced at the direct request of the Panel, shall be borne equally by the parties and shall be paid periodically on a timely basis, unless they agree otherwise or unless the Panel in the Award assesses such expenses, or any part thereof against any party (or parties). In exceptional cases, the Panel may award reasonable attorneys' fees as an item of expense, and the Panel shall promptly determine the amount of such fees based on affidavits or such other proofs as the Panel deems sufficient.

F. Disqualification or Disability of A Panel Member

In the event that any Arbitrator of a Panel with more than one Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the remaining Panel member(s):

i. shall designate a replacement, subject to the right of any party to challenge such replacement for cause.

ii. shall decide the extent to which previously held hearings shall be repeated.

If the remaining Panel members consider the proceedings to have progressed to a stage as to make replacement impracticable, the parties may agree, as an alternative to the recommencement of the Mandatory Dispute Resolution process, to resolution of the dispute by the remaining Panel members.

In the event that a single Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the Administrator shall appoint a successor, subject to the right of any party to challenge such successor for cause, and the successor shall decide the extent to which previously held proceedings shall be repeated.

EXHIBIT 5

G. Extensions of Time

Subject to the provisions of Paragraph 3.H.(viii), any time limit set forth in these Rules may be extended upon agreement of the parties and approval of: (1) the Mediator if the proceeding is then in Mediation; (2) the Administrator if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (3) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected.

H. Intervention

The Plans, their Controlled Affiliates, and BCBSA, to the extent subject to MMDR pursuant to their License Agreements, shall have the right to move to intervene in any pending Arbitration. A written motion for intervention shall be made to: (1) the Administrator, if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (2) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected. The written motion for intervention shall be delivered to the BCBSA Corporate Secretary (which shall also constitute service on the BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) which are parties to the proceeding. Any party to the proceeding can submit written objections to the motion to intervene. The motion for intervention shall be granted upon good cause shown. Intervention also may be allowed by stipulation of the parties to the Arbitration proceeding. Intervention shall be allowed upon such terms as the Arbitration Panel decides.

I. BCBSA Assistance In Resolution of Disputes

The resources and personnel of the BCBSA may be requested by any member Plan at any time to try to resolve disputes with another Plan.

J. Neutral Evaluation

The parties can voluntarily agree at any time to have an independent party render a neutral evaluation of the parties' respective positions.

Amended as of September 20, 2007

EXHIBIT 5
Page 22 of 23

K. Recovery of Attorney Fees and Expenses

i. Motions to Compel

Nothwithstanding any other provisions of these Rules, any Party subject to the License Agreements (for purposes of this Section K and all of its sub-sections only hereinafter referred to collectively and individually as a "Party") that initiates a court action or administrative proceeding solely to compel adherence to these Rules shall not be determined to have violated these Rules by initiating such action or proceeding.

ii Recovery of Fees, Expenses and Costs

The Arbitration Panel may, in its sole discretion, award a Party its reasonable attorneys' fees, expenses and costs associated with a filing to compel adherence to these Rules and/or reasonable attorneys' fees, expenses and costs incurred in responding to an action filed in violation of these Rules; provided, however, that neither fees, expenses, nor costs shall be awarded by the Arbitration Panel if the Party from which the award is sought can demonstrate to the Arbitration panel, in its sole discretion, that it did not violate these Rules or that it had reasonable grounds for believing that its action did not violate these Rules.

iii Requests for Reimbursement

For purposes of this Section K, any Party may request reimbursement of fees, expenses and/or costs by submitting said request in writing to the Arbitration Panel at any time before an award is delivered pursuant to Paragraph 3.O above, with a copy to the Party from which reimbursement is sought, explaining why it is entitled to such reimbursement. The Party from which reimbursement is sought shall have twenty (20) days to submit a response to such request to the Arbitration Panel with a copy to the Party seeking reimbursement.

Amended as of September 20, 2007

EXHIBIT 5
Page 23 of 23

L. Calculation of Time and Deadlines

In computing any period of time prescribed or allowed under these rules, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not one of the aforementioned days. When the period of time prescribed is less than six (6) days, intermediate Saturdays, Sundays and legal holidays shall be excluded in the computation. As used in this rule, “legal holiday” includes New Year’s Day, Martin Luther King, Jr. Day, Washington’s Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day and any other day appointed as a holiday by the President or the Congress of the United States.

Amended as of September 20, 2007

Exhibit 21

SUBSIDIARIES OF THE COMPANY

Legal Name	*Domestic Jurisdiction*	*Doing Business As*
Alliance Care Management, LLC	Delaware	
American Imaging Management, Inc.	Illinois	AIM Specialty Health
America's 1st Choice of South Carolina, Inc.	South Carolina	
America's Health Management Services, Inc.	South Carolina	
AMERIGROUP Community Care of New Mexico, Inc.	New Mexico	
AMERIGROUP Corporation	Delaware	AMERIGROUP CORPORATION; AGP Corporation; AMGP; AMGP Corporation; AMGP Missouri
Amerigroup Delaware, Inc.	Delaware	
Amerigroup District of Columbia, Inc.	District of Columbia	
Amerigroup Insurance Company	Texas	
Amerigroup Iowa, Inc.	Iowa	
Amerigroup IPA of New York, LLC	New York	
Amerigroup Kansas, Inc.	Kansas	
AMERIGROUP Maryland, Inc.	Maryland	AMERIGROUP Community Care
Amerigroup Mississippi, Inc.	Mississippi	
AMERIGROUP New Jersey, Inc.	New Jersey	AMERIGROUP Community Care
AMERIGROUP Ohio, Inc.	Ohio	AMERIGROUP Community Care
Amerigroup Oklahoma Inc.	Oklahoma	
Amerigroup Partnership Plan, LLC	Illinois	
Amerigroup Pennsylvania, Inc.	Pennsylvania	
AMERIGROUP Tennessee, Inc.	Tennessee	AMERIGROUP Community Care
AMERIGROUP Texas, Inc.	Texas	AMERIGROUP Community Care
AMERIGROUP Washington, Inc.	Washington	
AMGP Georgia Managed Care Company, Inc.	Georgia	AMERIGROUP; AMERIGROUP Community Care; AMERIGROUP Georgia; AMGP Georgia
AMH Health Plans of Maine, Inc.	Maine	
AMH Health, LLC	Maine	
Anthem Blue Cross Life and Health Insurance Company	California	
Anthem Financial, Inc.	Delaware	
Anthem Health Plans of Kentucky, Inc.	Kentucky	Anthem Blue Cross and Blue Shield
Anthem Health Plans of Maine, Inc.	Maine	Anthem Blue Cross and Blue Shield; Associated Hospital Service
Anthem Health Plans of New Hampshire, Inc.	New Hampshire	Anthem Blue Cross and Blue Shield
Anthem Health Plans of Virginia, Inc.	Virginia	Anthem Blue Cross and Blue Shield
Anthem Health Plans, Inc.	Connecticut	Anthem Blue Cross and Blue Shield
Anthem Holding Corp.	Indiana	Anthem Properties, Inc.
Anthem Innovation Israel, Ltd.	Israel	
Anthem Insurance Companies, Inc.	Indiana	Anthem Blue Cross and Blue Shield; Blue Cross and Blue Shield of Indiana; Empire Blue Cross-Retiree Solutions; Empire Blue Cross Blue Shield-Retiree Solutions; Anthem BC Health Insurance Company;
Anthem Kentucky Managed Care Plan, Inc.	Kentucky	Anthem Blue Cross and Blue Shield Medicaid
Anthem Life & Disability Insurance Company	New York	
Anthem Life Insurance Company	Indiana	
Anthem Partnership Holding Company, LLC	Indiana	

Anthem Services Company, LLC	Indiana	
Anthem Southeast, Inc.	Indiana	
Anthem UM Services, Inc.	Indiana	
Anthem Workers' Compensation, LLC	Indiana	
Applied Pathways LLC	Illinois	
Arcus Enterprises, Inc.	Delaware	
Aspire Health, Inc.	Delaware	
Associated Group, Inc.	Indiana	
ATH Holding Company, LLC	Indiana	
Beacon CBHM LLC	Delaware	
Beacon Health Financing LLC	Delaware	
Beacon Health Holdings LLC	Delaware	
Beacon Health Options Care Services, Inc.	Delaware	
Beacon Health Options Holdco, Inc.	Delaware	
Beacon Health Options of California, Inc.	California	
Beacon Health Options of Ohio, Inc.	Ohio	
Beacon Health Options of Pennsylvania, Inc.	Pennsylvania	
Beacon Health Options, Inc.	Virginia	
Beacon Health Strategies LLC	Massachusetts	
Beacon Health Vista Parent, Inc.	Delaware	
Beacon Plan Funding, LLC	Delaware	
BHS IPA, LLC	New York	
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	Georgia	Anthem Blue Cross and Blue Shield
Blue Cross Blue Shield of Wisconsin	Wisconsin	Anthem Blue Cross and Blue Shield
Blue Cross of California	California	Anthem Blue Cross
Blue Cross of California Partnership Plan, Inc.	California	Anthem Blue Cross Partnership Plan
BVO Holdings, LLC	Delaware	
CareMarket, Inc.	Indiana	Sydney Care
CareMore Health Plan	California	
CareMore Health Plan of Arizona, Inc.	Arizona	
CareMore Health Plan of Nevada	Nevada	
CareMore Health Plan of Texas, Inc.	Texas	
CareMore Health System	California	
CareMore, LLC	Indiana	
CCHA, LLC	Colorado	Colorado Community Health Alliance
Cerulean Companies, Inc.	Georgia	
CHCS IPA, Inc.	New York	
Claim Management Services, Inc.	Wisconsin	Anthem Blue Cross and Blue Shield
Community Care Health Plan of Louisiana, Inc.	Louisiana	Healthy Blue
Community Care Health Plan of Nebraska, Inc.	Nebraska	WellCare of Nebraska; Healthy Blue
Community Care Health Plan of Nevada, Inc.	Nevada	Anthem Blue Cross and Blue Shield Healthcare Solutions; AMERIGROUP Community Care
Community Insurance Company	Ohio	Anthem Blue Cross and Blue Shield;
Compcare Health Services Insurance Corporation	Wisconsin	Anthem Blue Cross and Blue Shield;
Crossroads Acquisition Corp.	Delaware	
DBG Holdings, Inc.	Indiana	
DeCare Analytics, LLC	Minnesota	
DeCare Dental Health International, LLC	Minnesota	
DeCare Dental Insurance Ireland, Ltd.	Ireland	

DeCare Dental Networks, LLC	Minnesota	
DeCare Dental, LLC	Minnesota	
DeCare Operations Ireland, Limited	Ireland	
Delivery Network, LLC	Florida	
Designated Agent Company, Inc.	Kentucky	
EasyScripts Cutler Bay, LLC	Florida	
EasyScripts Hialeah, LLC	Florida	
EasyScripts Westchester, LLC	Florida	
EasyScripts, LLC	Florida	
EHC Benefits Agency, Inc.	New York	
Empire HealthChoice Assurance, Inc.	New York	Empire Blue Cross; Empire Blue Cross Blue Shield
Empire HealthChoice HMO, Inc.	New York	Empire Blue Cross HMO; Empire Blue Cross Blue Shield HMO
Federal Government Solutions, LLC	Wisconsin	
FHC Health Systems, Inc.	Virginia	
Florida Health Partners, Inc.	Florida	
Freedom Health, Inc.	Florida	
Golden West Health Plan, Inc.	California	
GR Health Solutions, LLC	Pennsylvania	
Greater Georgia Life Insurance Company	Georgia	Anthem Life
Group Retiree Health Solutions, Inc.	Pennsylvania	
Health Core, Inc.	Delaware	
Health Management Corporation	Virginia	LiveHealth Online; HMC of Virginia; Health Management of Virginia, Inc.
Health Ventures Partner, L.L.C.	Illinois	
HealthKeepers, Inc.	Virginia	
HealthLink HMO, Inc.	Missouri	HealthLink HMO
HealthLink Insurance Company	Illinois	
HealthLink, Inc.	Illinois	
HealthPlus HP, LLC	New York	Empire BlueCross BlueShield HealthPlus; Empire BlueCross HealthPlus
HealthSun Health Plans, Inc.	Florida	
HealthSun Physicians Network I, LLC	Florida	
HealthSun Physicians Network, LLC	Florida	
Healthy Alliance Life Insurance Company	Missouri	Anthem Blue Cross and Blue Shield
HEP AP Holdings, Inc.	Delaware	
Highland Acquisition Holdings, LLC	Delaware	
Highland Intermediate Holdings, LLC	Delaware	
Highland Investor Holdings, LLC	Delaware	
HMO Colorado, Inc.	Colorado	HMO Colorado; HMO Nevada
HMO Missouri, Inc.	Missouri	Amerigroup Missouri; Anthem Blue Cross and Blue Shield
IEC Group Holdings, Inc.	Idaho	
IEC Group, Inc.	Idaho	AmeriBen
Imaging Management Holdings, LLC	Delaware	
IngenioRx, Inc.	Indiana	Ingenio, Inc.; IngenioRx Administrators
Legato Health Technologies, LLP	India	
Legato Health Technologies Philippines, Inc.	Philippines	
Legato Holdings I, Inc.	Indiana	Legato Health Technologies
Legato Holdings II, LLC	Indiana	

Living Complete Technologies, Inc.	Maryland	TAI Software, Inc.
Massachusetts Behavioral Health Partnership, LLP	Massachusetts	
Matthew Thornton Health Plan, Inc.	New Hampshire	
Meridian Resource Company, LLC	Wisconsin	
Missouri Care, Incorporated	Missouri	Healthy Blue; Missouri Care; Missouri Care Health Plan
Momentum Health Partners, LLC	North Carolina	
Nash Holding Company, LLC	Delaware	
National Government Services, Inc.	Indiana	NGS of Indiana
New England Research Institutes, Inc.	Massachusetts	Summit Community Care
NGS Federal, LLC	Indiana	
North Florida Behavioral Health Partners, Inc.	Florida	
Optimum Healthcare, Inc.	Florida	
OPTIONS Health Care, Inc.	Delaware	
Park Square Holdings, Inc.	California	
Park Square I, Inc.	California	
Park Square II, Inc.	California	
Pasteur Medical Bird Road, LLC	Florida	
Pasteur Medical Center, LLC	Delaware	
Pasteur Medical Cutler Bay, LLC	Florida	
Pasteur Medical Group, LLC	Florida	
Pasteur Medical Hialeah Gardens, LLC	Florida	
Pasteur Medical Kendall, LLC	Florida	
Pasteur Medical Management, LLC	Florida	
Pasteur Medical Miami Gardens, LLC	Florida	
Pasteur Medical North Miami Beach, LLC	Florida	
Pasteur Medical Partners, LLC	Florida	
Resolution Health, Inc.	Delaware	Delaware Resolution Health, Inc.
RightCHOICE Managed Care, Inc.	Delaware	RightCHOICE Benefit Administrators; Anthem Blue Cross and Blue Shield;
Rocky Mountain Hospital and Medical Service, Inc.	Colorado	Anthem Blue Cross and Blue Shield; Anthem Blue Cross Blue Shield
SellCore, Inc.	Delaware	SellCore Insurance Services, Inc.
Simply Healthcare Plans, Inc.	Florida	Clear Health Alliance; Better Health; Amerigroup Florida
Southeast Services, Inc.	Virginia	
State Sponsored Services, Inc.	Indiana	Amerigroup GBD Disease Management Program; Anthem GBD Disease Management Program; Amerigroup GBD Behavioral Health; Anthem GBD Behavioral Health
The Anthem Companies of California, Inc.	California	
The Anthem Companies, Inc.	Indiana	
TrustSolutions, LLC	Wisconsin	
UNICARE Health Plan of West Virginia, Inc.	West Virginia	
UNICARE Illinois Services, Inc.	Illinois	
UniCare Life & Health Insurance Company	Indiana	UNICARE Adjuster
UNICARE National Services, Inc.	Delaware	
UniCare Specialty Services, Inc.	Delaware	
Value Health Reinsurance, Inc.	Arizona	
ValueOptions Federal Services, Inc.	Virginia	
ValueOptions of Kansas, Inc.	Kansas	

ValueOptions of New Jersey, Inc.	New Jersey	
ValueOptions of Texas, Inc.	Texas	
Valus, Inc.	Indiana	DBG, Inc.
Wellmax Health Medical Centers, LLC	Florida	
Wellmax Health Physicians Network, LLC	Florida	
WellPoint Acquisition, LLC	Indiana	
WellPoint California Services, Inc.	Delaware	
WellPoint Dental Services, Inc.	Delaware	
WellPoint Health Solutions, Inc.	Indiana	
WellPoint Holding Corp.	Delaware	
WellPoint Information Technology Services, Inc.	California	
WellPoint Insurance Services, Inc.	Hawaii	
WellPoint Military Care Corporation	Indiana	
Wisconsin Collaborative Insurance Company	Wisconsin	
WPMI, LLC	Delaware	
Zip Drug Inc.	Delaware	

Exhibit 23

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in the following Registration Statements:

- Form S-8 No. 333-84906 and Form S-8 No. 333-129334 pertaining to the Anthem 401(k) Plan;
- Form S-8 No. 333-156099 pertaining to the Anthem, Inc. Employee Stock Purchase Plan;
- Form S-8 No. 333-159830 pertaining to the Anthem Incentive Compensation Plan;
- Form S-8 No. 333-218190 pertaining to the 2017 Anthem Incentive Compensation Plan; and
- Form S-3 No. 333-249877 pertaining to the Anthem, Inc. registration of senior debt securities, subordinated debt securities, preferred stock, common stock, depositary shares, warrants, rights, stock purchase contracts and stock purchase units

of our reports dated February 18, 2021, with respect to the consolidated financial statements and financial statement schedule listed in the Index at Item 15(c) of Anthem, Inc., and the effectiveness of internal control over financial reporting of Anthem, Inc., included in its Annual Report (Form 10-K) for the year ended December 31, 2020.

/S/ ERNST & YOUNG LLP

Indianapolis, Indiana
February 18, 2021

Exhibit 31.1

CERTIFICATION PURSUANT TO
RULE 13a-14(a) AND RULE 15d-14(a) OF THE EXCHANGE ACT RULES,
AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Gail K. Boudreaux, certify that:

1. I have reviewed this report on Form 10-K of Anthem, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):

   a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 18, 2021

/s/ GAIL K. BOUDREAUX
President and Chief Executive Officer

Exhibit 31.2

CERTIFICATION PURSUANT TO
RULE 13a-14(a) AND RULE 15d-14(a) OF THE EXCHANGE ACT RULES,
AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, John E. Gallina, certify that:

1. I have reviewed this report on Form 10-K of Anthem, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):

   a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 18, 2021

/s/ JOHN E. GALLINA
Executive Vice President and
Chief Financial Officer

Exhibit 32.1

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of Anthem, Inc. (the "Company") on Form 10-K for the period ended December 31, 2020 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Gail K. Boudreaux, President and Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ GAIL K. BOUDREAUX

Gail K. Boudreaux
President and Chief Executive Officer
February 18, 2021

Exhibit 32.2

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of Anthem, Inc. (the "Company") on Form 10-K for the period ended December 31, 2020 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, John E. Gallina, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ JOHN E. GALLINA

John E. Gallina
Executive Vice President and Chief Financial Officer
February 18, 2021

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the Quarterly Period Ended September 30, 2021

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number: 001-16751

ANTHEM, INC.

(Exact name of registrant as specified in its charter)

Indiana	**35-2145715**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification Number)**

220 Virginia Avenue
Indianapolis, Indiana 46204
(Address of principal executive offices) (Zip Code)

Registrant's telephone number, including area code: (800) 331-1476

Not Applicable
(Former name, former address and former fiscal year, if changed since last report)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading symbol(s)	Name of each exchange on which registered
Common Stock, $0.01 par value	ANTM	New York Stock Exchange

Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer", "accelerated filer", "smaller reporting company", and "emerging growth company" in Rule 12b-2 of the Exchange Act:

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐	Smaller reporting company	☐
Emerging growth company	☐		

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of October 14, 2021, 242,714,676 shares of the Registrant's Common Stock were outstanding.

Anthem, Inc.

Quarterly Report on Form 10-Q
For the Period Ended September 30, 2021

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PART I. FINANCIAL INFORMATION
ITEM 1. FINANCIAL STATEMENTS

Anthem, Inc.
Consolidated Balance Sheets

(In millions, except share data)	September 30, 2021 (Unaudited)	December 31, 2020
Assets		
Current assets:		
Cash and cash equivalents	$ 5,490	$ 5,741
Fixed maturity securities (amortized cost of $25,495 and $22,222; allowance for credit losses of $6 and $7)	26,348	23,433
Equity securities	2,119	1,559
Premium receivables	6,008	5,279
Self-funded receivables	3,349	2,849
Other receivables	3,450	2,830
Other current assets	5,140	4,060
Total current assets	51,904	45,751
Long-term investments:		
Fixed maturity securities (amortized cost of $606 and $532; allowance for credit losses of $0 and $0)	625	562
Other invested assets	4,959	4,285
Property and equipment, net	3,835	3,483
Goodwill	24,184	21,691
Other intangible assets	10,749	9,405
Other noncurrent assets	1,804	1,438
Total assets	$ 98,060	$ 86,615
Liabilities and equity		
Liabilities		
Current liabilities:		
Medical claims payable	$ 13,562	$ 11,359
Other policyholder liabilities	5,201	4,590
Unearned income	954	1,259
Accounts payable and accrued expenses	5,960	5,493
Short-term borrowings	175	—
Current portion of long-term debt	849	700
Other current liabilities	8,461	6,052
Total current liabilities	35,162	29,453
Long-term debt, less current portion	21,761	19,335
Reserves for future policy benefits	788	794
Deferred tax liabilities, net	2,629	2,019
Other noncurrent liabilities	1,912	1,815
Total liabilities	62,252	53,416
Commitments and contingencies – Note 11		
Shareholders' equity		
Preferred stock, without par value, shares authorized – 100,000,000; shares issued and outstanding – none	—	—
Common stock, par value $0.01, shares authorized – 900,000,000; shares issued and outstanding – 242,847,676 and 245,401,430	2	3
Additional paid-in capital	9,138	9,244
Retained earnings	26,700	23,802
Accumulated other comprehensive (loss) income	(103)	150
Total shareholders' equity	35,737	33,199
Noncontrolling interests	71	—
Total equity	35,808	33,199
Total liabilities and equity	$ 98,060	$ 86,615

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Income
(Unaudited)

(In millions, except per share data)	Three Months Ended September 30		Nine Months Ended September 30	
	2021	**2020**	**2021**	**2020**
Revenues				
Premiums	$ 30,395	$ 26,392	$ 86,604	$ 77,001
Product revenue	3,353	2,598	9,132	7,485
Administrative fees and other revenue	1,800	1,659	5,189	4,789
Total operating revenue	35,548	30,649	100,925	89,275
Net investment income	335	280	1,026	591
Net realized (losses) gains on financial instruments	(61)	229	107	177
Total revenues	35,822	31,158	102,058	90,043
Expenses				
Benefit expense	26,645	22,921	75,107	63,957
Cost of products sold	2,898	2,222	7,825	6,431
Selling, general and administrative expense	3,946	5,305	11,692	13,132
Interest expense	201	198	598	593
Amortization of other intangible assets	136	93	306	269
Loss on extinguishment of debt	—	30	5	34
Total expenses	33,826	30,769	95,533	84,416
Income before income tax expense	1,996	389	6,525	5,627
Income tax expense	494	167	1,555	1,606
Net income	1,502	222	4,970	4,021
Net loss (income) attributable to noncontrolling interests	7	—	(3)	—
Shareholders' net income	$ 1,509	$ 222	$ 4,967	$ 4,021
Shareholders' net income per share				
Basic	$ 6.20	$ 0.88	$ 20.33	$ 15.96
Diluted	$ 6.13	$ 0.87	$ 20.09	$ 15.75
Dividends per share	$ 1.13	$ 0.95	$ 3.39	$ 2.85

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Comprehensive Income
(Unaudited)

(In millions)	Three Months Ended September 30		Nine Months Ended September 30	
	2021	**2020**	**2021**	**2020**
Net income	$ 1,502	$ 222	$ 4,970	$ 4,021
Other comprehensive (loss) income, net of tax:				
Change in net unrealized losses/gains on investments	(97)	113	(284)	154
Change in non-credit component of impairment losses on investments	(1)	16	1	(6)
Change in net unrealized gains/losses on cash flow hedges	4	4	10	10
Change in net periodic pension and postretirement costs	8	8	26	25
Foreign currency translation adjustments	(1)	1	(7)	1
Other comprehensive (loss) income	(87)	142	(254)	184
Net loss (income) attributable to noncontrolling interests	7	—	(3)	—
Other comprehensive loss attributable to noncontrolling interests	1	—	1	—
Total shareholders' comprehensive income	$ 1,423	$ 364	$ 4,714	$ 4,205

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Cash Flows
(Unaudited)

(In millions)	Nine Months Ended September 30 2021	2020
Operating activities		
Net income	$ 4,970	$ 4,021
Adjustments to reconcile net income to net cash provided by operating activities:		
Net realized gains on financial instruments	(107)	(177)
Depreciation and amortization	942	864
Deferred income taxes	114	(102)
Impairment of property and equipment	—	195
Share-based compensation	196	214
Changes in operating assets and liabilities:		
Receivables, net	(1,751)	(845)
Other invested assets	(56)	6
Other assets	(470)	(988)
Policy liabilities	2,328	1,624
Unearned income	(308)	(95)
Accounts payable and other liabilities	1,093	1,953
Income taxes	168	104
Other, net	(427)	101
Net cash provided by operating activities	6,692	6,875
Investing activities		
Purchases of investments	(15,130)	(16,708)
Proceeds from sale of investments	8,339	8,739
Maturities, calls and redemptions from investments	3,388	3,763
Changes in securities lending collateral	(1,030)	(668)
Purchases of subsidiaries, net of cash acquired	(3,442)	(1,973)
Purchases of property and equipment	(747)	(743)
Other, net	(50)	(39)
Net cash used in investing activities	(8,672)	(7,629)
Financing activities		
Net repayments of commercial paper borrowings	(150)	(400)
Proceeds from long-term borrowings	3,462	2,485
Repayments of long-term borrowings	(954)	(964)
Proceeds from short-term borrowings	175	970
Repayments of short-term borrowings	—	(1,520)
Changes in securities lending payable	1,030	668
Repurchase and retirement of common stock	(1,378)	(1,342)
Cash dividends	(831)	(720)
Proceeds from issuance of common stock under employee stock plans	161	112
Taxes paid through withholding of common stock under employee stock plans	(101)	(112)
Other, net	324	623
Net cash provided by (used in) financing activities	1,738	(200)
Effect of foreign exchange rates on cash and cash equivalents	(9)	1
Change in cash and cash equivalents	(251)	(953)
Cash and cash equivalents at beginning of period	5,741	4,937
Cash and cash equivalents at end of period	$ 5,490	$ 3,984

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Shareholders' Equity
(Unaudited)

	Nine Months Ended September 30, 2021						
	Common Stock						
(In millions)	Number of Shares	Par Value	Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Noncontrolling Interests	Total Equity
January 1, 2021	245.4	$ 3	$ 9,244	$ 23,802	$ 150	$ —	$ 33,199
Net income	—	—	—	1,665	—	2	1,667
Other comprehensive loss	—	—	—	—	(345)	(2)	(347)
Noncontrolling interests adjustment	—	—	—	—	—	65	65
Repurchase and retirement of common stock	(1.4)	(1)	(53)	(393)	—	—	(447)
Dividends and dividend equivalents	—	—	—	(281)	—	—	(281)
Issuance of common stock under employee stock plans, net of related tax benefits	0.9	—	62	—	—	—	62
March 31, 2021	244.9	2	9,253	24,793	(195)	65	33,918
Net income	—	—	—	1,793	—	8	1,801
Other comprehensive income	—	—	—	—	178	2	180
Noncontrolling interests adjustment	—	—	—	—	—	3	3
Repurchase and retirement of common stock	(1.3)	—	(47)	(433)	—	—	(480)
Dividends and dividend equivalents	—	—	—	(279)	—	—	(279)
Issuance of common stock under employee stock plans, net of related tax benefits	0.3	—	119	—	—	—	119
Convertible debenture repurchases and conversions	—	—	(216)	—	—	—	(216)
June 30, 2021	243.9	2	9,109	25,874	(17)	78	35,046
Net income (loss)	—	—	—	1,509	—	(7)	1,502
Other comprehensive loss	—	—	—	—	(86)	(1)	(87)
Noncontrolling interest adjustment	—	—	—	—	—	1	1
Repurchase and retirement of common stock	(1.2)	—	(44)	(407)	—	—	(451)
Dividends and dividend equivalents	—	—	—	(276)	—	—	(276)
Issuance of common stock under employee stock plans, net of related tax benefits	0.1	—	75	—	—	—	75
Convertible debenture repurchases and conversions	—	—	(2)	—	—	—	(2)
September 30, 2021	242.8	$ 2	$ 9,138	$ 26,700	$ (103)	$ 71	$ 35,808

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Shareholders' Equity (continued)
(Unaudited)

	Nine Months Ended September 30, 2020						
	Common Stock						
(In millions)	Number of Shares	Par Value	Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive (Loss) Income	Noncontrolling Interests	Total Equity
December 31, 2019 (audited)	252.9	$ 3	$ 9,448	$ 22,573	$ (296)	$ —	$ 31,728
Adoption of Accounting Standards Update No. 2016-13	—	—	—	(35)	—	—	(35)
January 1, 2020	252.9	3	9,448	22,538	(296)	—	31,693
Net income	—	—	—	1,523	—	—	1,523
Other comprehensive loss	—	—	—	—	(712)	—	(712)
Repurchase and retirement of common stock	(1.9)	—	(71)	(458)	—	—	(529)
Dividends and dividend equivalents	—	—	—	(243)	—	—	(243)
Issuance of common stock under employee stock plans, net of related tax benefits	1.0	—	3	—	—	—	3
Convertible debenture repurchases and conversions	—	—	(42)	—	—	—	(42)
March 31, 2020	252.0	3	9,338	23,360	(1,008)	—	31,693
Net income	—	—	—	2,276	—	—	2,276
Other comprehensive income	—	—	—	—	754	—	754
Repurchase and retirement of common stock	(0.2)	—	(9)	(46)	—	—	(55)
Dividends and dividend equivalents	—	—	—	(244)	—	—	(244)
Issuance of common stock under employee stock plans, net of related tax benefits	0.3	—	113	—	—	—	113
Convertible debenture repurchases and conversions	—	—	(82)	—	—	—	(82)
June 30, 2020	252.1	3	9,360	25,346	(254)	—	34,455
Net income	—	—	—	222	—	—	222
Other comprehensive income	—	—	—	—	142	—	142
Repurchase and retirement of common stock	(2.9)	—	(106)	(652)	—	—	(758)
Dividends and dividend equivalents	—	—	—	(238)	—	—	(238)
Issuance of common stock under employee stock plans, net of related tax benefits	0.2	—	98	—	—	—	98
September 30, 2020	249.4	$ 3	$ 9,352	$ 24,678	$ (112)	$ —	$ 33,921

See accompanying notes.

Anthem, Inc.
Notes to Consolidated Financial Statements
(Unaudited)
September 30, 2021

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

1. Organization

References to the terms "we," "our," "us" or "Anthem" used throughout these Notes to Consolidated Financial Statements refer to Anthem, Inc., an Indiana corporation, and unless the context otherwise requires, its direct and indirect subsidiaries. References to the "states" include the District of Columbia and Puerto Rico, unless the context otherwise requires.

We are one of the largest health benefits companies in the United States in terms of medical membership, serving approximately 45 medical members through our affiliated health plans as of September 30, 2021. We offer a broad spectrum of network-based managed care plans to Individual, Group, Medicaid and Medicare markets. Our managed care plans include: Preferred Provider Organizations ("PPOs"); Health Maintenance Organizations ("HMOs"); Point-of-Service plans; traditional indemnity plans and other hybrid plans, including Consumer-Driven Health Plans; and hospital only and limited benefit products. In addition, we provide a broad array of managed care services to fee-based customers, including claims processing, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services. We provide an array of specialty and other insurance products and services such as pharmacy benefits management ("PBM"), dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal healthcare. We also provide services to the federal government in connection with our Federal Health Products & Services business, which administers the Federal Employees Health Benefits ("FEHB") Program.

We are an independent licensee of the Blue Cross and Blue Shield Association ("BCBSA"), an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield ("BCBS") licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (in the New York City metropolitan area and upstate New York), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas, we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, and Empire Blue Cross Blue Shield or Empire Blue Cross. We also conduct business through arrangements with other BCBS licensees as well as other strategic partners. Through our subsidiaries, we also serve customers in numerous states and Puerto Rico as AIM Specialty Health, Amerigroup, Aspire Health, Beacon, CareMore, Freedom Health, HealthLink, HealthSun, MMM, Optimum HealthCare, Simply Healthcare, and/or UniCare. Also, we provide PBM services through our IngenioRx, Inc. ("IngenioRx") subsidiary. We are licensed to conduct insurance operations in all 50 states, the District of Columbia and Puerto Rico through our subsidiaries.

2. Basis of Presentation and Significant Accounting Policies

Basis of Presentation: The accompanying unaudited consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles ("GAAP") for interim financial reporting. Accordingly, they do not include all of the information and footnotes required by GAAP for annual financial statements. We have omitted certain footnote disclosures that would substantially duplicate the disclosures in our 2020 Annual Report on Form 10-K, unless the information contained in those disclosures materially changed or is required by GAAP. Certain prior year amounts have been reclassified to conform to the current year presentation. In the opinion of management, all adjustments, including normal recurring adjustments, necessary for a fair statement of the consolidated financial statements as of and for the three and nine months ended September 30, 2021 and 2020 have been recorded. The results of operations for the three and nine months ended September 30, 2021 are not necessarily indicative of the results that may be expected for the full year ending December 31, 2021, or any other period. These unaudited consolidated financial statements should be read in conjunction with our audited consolidated financial statements as of and for the year ended December 31, 2020 included in our 2020 Annual Report on Form 10-K.

Certain of our subsidiaries operate outside of the United States and have functional currencies other than the U.S. dollar ("USD"). We translate the assets and liabilities of those subsidiaries to USD using the exchange rate in effect at the end of the period. We translate the revenues and expenses of those subsidiaries to USD using the average exchange rates in effect during the period. The net effect of these translation adjustments is included in "Foreign currency translation adjustments" in our consolidated statements of comprehensive income.

Cash and Cash Equivalents: We control a number of bank accounts that are used exclusively to hold customer funds for the administration of customer benefits, and we have cash and cash equivalents on deposit to meet certain regulatory requirements. These amounts totaled $186 and $170 at September 30, 2021 and December 31, 2020, respectively, and are included in the cash and cash equivalents line on our consolidated balance sheets.

Investments: We classify fixed maturity securities in our investment portfolio as "available-for-sale" and report those securities at fair value. Certain fixed maturity securities are available to support current operations and, accordingly, we classify such investments as current assets without regard to their contractual maturity. Investments used to satisfy contractual, regulatory or other requirements are classified as long-term, without regard to contractual maturity.

If a fixed maturity security is in an unrealized loss position and we have the intent to sell the fixed maturity security, or it is more likely than not that we will have to sell the fixed maturity security before recovery of its amortized cost basis, we write down the fixed maturity security's cost basis to fair value and record an impairment loss in our consolidated statements of income. For impaired fixed maturity securities that we do not intend to sell or if it is more likely than not that we will not have to sell such securities, but we expect that we will not fully recover the amortized cost basis, we recognize the credit component of the impairment as an allowance for credit loss in our consolidated balance sheets and record an impairment loss in our consolidated statements of income. The non-credit component of the impairment is recognized in accumulated other comprehensive (loss) income. Furthermore, unrealized losses entirely caused by non-credit-related factors related to fixed maturity securities for which we expect to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive (loss) income.

The credit component of an impairment is determined primarily by comparing the net present value of projected future cash flows with the amortized cost basis of the fixed maturity security. The net present value is calculated by discounting our best estimate of projected future cash flows at the effective interest rate implicit in the fixed maturity security at the date of purchase. For mortgage-backed and asset-backed securities, cash flow estimates are based on assumptions regarding the underlying collateral, including prepayment speeds, vintage, type of underlying asset, geographic concentrations, default rates, recoveries and changes in value. For all other securities, cash flow estimates are driven by assumptions regarding probability of default, including changes in credit ratings and estimates regarding timing and amount of recoveries associated with a default.

For asset-backed securities included in fixed maturity securities, we recognize income using an effective yield based on anticipated prepayments and the estimated economic life of the securities. When estimates of prepayments change, the effective yield is recalculated to reflect actual payments to date and anticipated future payments. The net investment in the securities is adjusted to the amount that would have existed had the new effective yield been applied since the purchase date of the securities. Such adjustments are reported within net investment income.

The changes in fair value of our marketable equity securities are recognized in our results of operations within net realized gains and losses on financial instruments. Certain marketable equity securities are held to satisfy contractual obligations, and are reported under the caption "Other invested assets" in our consolidated balance sheets.

We have corporate-owned life insurance policies on certain participants in our deferred compensation plans and other members of management. The cash surrender value of the corporate-owned life insurance policies is reported under the caption "Other invested assets" in our consolidated balance sheets.

We use the equity method of accounting for investments in companies in which our ownership interest may enable us to influence the operating or financial decisions of the investee company. Our proportionate share of equity in net income of these unconsolidated affiliates is reported within net investment income. The equity method investments are reported under the caption "Other invested assets" in our consolidated balance sheets.

Investment income is recorded when earned. All securities sold resulting in investment gains and losses are recorded on the trade date. Realized gains and losses are determined on the basis of the cost or amortized cost of the specific securities sold.

We participate in securities lending programs whereby marketable securities in our investment portfolio are transferred to independent brokers or dealers in exchange for cash and securities collateral. We recognize the collateral as an asset, which is reported under the caption "Other current assets" in our consolidated balance sheets, and we record a corresponding liability for the obligation to return the collateral to the borrower, which is reported under the caption "Other current liabilities" in our consolidated balance sheets. The securities on loan are reported in the applicable investment category on our consolidated balance sheets. Unrealized gains or losses on securities lending collateral are included in accumulated other comprehensive (loss) income as a separate component of shareholders' equity. The market value of loaned securities and that of the collateral pledged can fluctuate in non-synchronized fashions. To the extent the loaned securities' value appreciates faster or depreciates slower than the value of the collateral pledged, we are exposed to the risk of the shortfall. As a primary mitigating mechanism, the loaned securities and collateral pledged are marked to market on a daily basis and the shortfall, if any, is collected accordingly. Secondarily, the collateral level is set at 102% of the value of the loaned securities, which provides a cushion before any shortfall arises. The investment of the cash collateral is subject to market risk, which is managed by limiting the investments to higher quality and shorter duration instruments.

Receivables: Receivables are reported net of amounts for expected credit losses. The allowance for doubtful accounts is based on historical collection trends, future forecasts and our judgment regarding the ability to collect specific accounts.

Premium receivables include the uncollected amounts from insured groups, individuals and government programs. Premium receivables are reported net of an allowance for doubtful accounts of $141 and $146 at September 30, 2021 and December 31, 2020, respectively.

Self-funded receivables include administrative fees, claims and other amounts due from self-funded customers. Self-funded receivables are reported net of an allowance for doubtful accounts of $49 and $54 at September 30, 2021 and December 31, 2020, respectively.

Other receivables include pharmacy rebates, provider advances, claims recoveries, reinsurance receivables, proceeds due from brokers on investment trades, accrued investment income, and other miscellaneous amounts due to us. These receivables are reported net of an allowance for doubtful accounts of $550 and $374 at September 30, 2021 and December 31, 2020, respectively.

Revenue Recognition: For our fee-based contracts, we had no material contract assets, contract liabilities or deferred contract costs recorded on our consolidated balance sheet at September 30, 2021. For the three and nine months ended September 30, 2021, revenue recognized from performance obligations related to prior periods, such as due to changes in transaction price, was not material. For contracts that have an original expected duration of greater than one year, revenue expected to be recognized in future periods related to unfulfilled contractual performance obligations and contracts with variable consideration related to undelivered performance obligations is not material.

Recently Adopted Accounting Guidance: In January 2021, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update No. 2021-01, *Reference Rate Reform (Topic 848)* ("ASU 2021-01"). The amendments in ASU 2021-01 provide optional expedients and exceptions for applying GAAP to contract modifications and hedging relationships, subject to meeting certain criteria, that reference the London Interbank Offered Rate ("LIBOR") or another reference rate expected to be discontinued because of the reference rate reform. The provisions must be applied at a Topic, Subtopic, or Industry Subtopic level for all transactions other than derivatives, which may be applied at a hedging relationship level. We adopted ASU 2021-01 on January 7, 2021, and the adoption did not have an impact on our consolidated financial position, results of operations or cash flows.

In October 2020, the FASB issued Accounting Standards Update No. 2020-08, *Codification Improvements to Subtopic 310-20, Receivables—Nonrefundable Fees and Other Costs* ("ASU 2020-08"). The amendments in ASU 2020-08 clarify when an entity should assess whether a callable debt security is within the scope of accounting guidance, which impacts the amortization period for nonrefundable fees and other costs. ASU 2020-08 became effective for interim and annual reporting periods beginning after December 15, 2020. The amendments are to be applied on a prospective basis as of the beginning of

the period of adoption for existing or newly purchased callable debt securities. We adopted ASU 2020-08 on January 1, 2021, and the adoption did not have an impact on our consolidated financial position, results of operations or cash flows.

In December 2019, the FASB issued Accounting Standards Update No. 2019-12, *Income Taxes (Topic 740): Simplifying the Accounting for Income Taxes* ("ASU 2019-12"). The amendments in ASU 2019-12 remove certain exceptions to the general principles in Accounting Standards Codification Topic 740. The amendments also clarify and amend existing guidance to improve consistent application. The amendments became effective for our annual reporting periods beginning after December 15, 2020. The transition method (retrospective, modified retrospective, or prospective basis) related to the amendments depends on the applicable guidance, and all amendments for which there is no transition guidance specified are to be applied on a prospective basis. We adopted ASU 2019-12 on January 1, 2021, and the adoption did not have an impact on our consolidated financial position, results of operations or cash flows.

Recent Accounting Guidance Not Yet Adopted: In November 2020, the FASB issued Accounting Standards Update No. 2020-11, *Financial Services—Insurance (Topic 944): Effective Date and Early Application* ("ASU 2020-11"). The amendments in ASU 2020-11 make changes to the effective date and early application of Accounting Standards Update No. 2018-12, *Financial Services—Insurance (Topic 944): Targeted Improvements to the Accounting for Long-Duration Contracts* ("ASU 2018-12"), which was issued in November 2018. The amendments in ASU 2020-11 have extended the original effective date by one year, and now the amendments are required for our interim and annual reporting periods beginning after December 15, 2022. The amendments in ASU 2018-12 make changes to a variety of areas to simplify or improve the existing recognition, measurement, presentation and disclosure requirements for long-duration contracts issued by an insurance entity. The amendments require insurers to annually review the assumptions they make about their policyholders and update the liabilities for future policy benefits if the assumptions change. The amendments also simplify the amortization of deferred contract acquisition costs and add new disclosure requirements about the assumptions insurers use to measure their liabilities and how they may affect future cash flows. The amendments related to the liability for future policy benefits for traditional and limited-payment contracts and deferred acquisition costs are to be applied to contracts in force as of the beginning of the earliest period presented, with an option to apply such amendments retrospectively with a cumulative-effect adjustment to the opening balance of retained earnings as of the earliest period presented. The amendments for market risk benefits are to be applied retrospectively. We are currently evaluating the effects the adoption of ASU 2020-11 and ASU 2018-12 will have on our consolidated financial position, results of operations, cash flows, and related disclosures.

In August 2020, the FASB issued Accounting Standards Update No. 2020-06, *Debt—Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging—Contracts in Entity's Own Equity (Subtopic 815-40): Accounting for Convertible Instruments and Contracts in an Entity's Own Equity* ("ASU 2020-06"). The amendments eliminate two of the three accounting models that require separate accounting for convertible features of debt securities, simplify the contract settlement assessment for equity classification, require the use of the if-converted method for all convertible instruments in the diluted earnings per share calculation and expand disclosure requirements. The amendments are effective for our annual and interim reporting periods beginning after December 15, 2021, with early adoption permitted for reporting periods beginning after December 15, 2020. The guidance can be applied on a full retrospective basis to all periods presented or a modified retrospective basis with a cumulative effect adjustment to the opening balance of retained earnings during the period of adoption. We are currently evaluating the effects the adoption of ASU 2020-06 will have on our consolidated financial statements and disclosures.

There were no other new accounting pronouncements that were issued or became effective since the issuance of our 2020 Annual Report on Form 10-K that had, or are expected to have, a material impact on our consolidated financial position, results of operations or cash flows.

3. Business Acquisitions

MMM Holdings, LLC and Affiliates

On June 29, 2021, we completed our acquisition of MMM Holdings, LLC ("MMM"), and its Medicare Advantage plan, Medicaid plan and other affiliated companies from InnovaCare Health, L.P. MMM is a Puerto Rico-based integrated healthcare organization and seeks to provide its Medicare Advantage and Medicaid members with a whole health experience through its network of specialized clinics and wholly owned independent physician associations. This acquisition aligns with

our vision to be an innovative, valuable and inclusive healthcare partner by providing care management programs that improve the lives of the people we serve.

In accordance with FASB accounting guidance for business combinations, the consideration transferred was allocated to the fair value of MMM's assets acquired and liabilities assumed, including identifiable intangible assets. The excess of consideration transferred over the fair value of net assets acquired resulted in preliminary goodwill of $1,956 at September 30, 2021, all of which was allocated to our Government Business segment. Preliminary goodwill recognized from the acquisition of MMM primarily relates to the future economic benefits arising from the assets acquired and is consistent with our stated intentions and strategy. As of September 30, 2021, the initial accounting for the acquisition had not been finalized. Any additional payments or receipts of cash resulting from contractual purchase price adjustments or any subsequent adjustments made to the assets acquired or liabilities assumed during the measurement period will continue to be recorded as an adjustment to goodwill.

The preliminary fair value of the net assets acquired from MMM includes $1,313 of other intangible assets at September 30, 2021, which primarily consists of member relationships with amortization periods ranging from 12 to 15 years. The results of operations of MMM are included in our consolidated financial statements within our Government Business segment for the period following June 29, 2021. The proforma effects of this acquisition for prior periods were not material to our consolidated results of operations.

myNEXUS, Inc.

On April 28, 2021, we completed our acquisition of myNEXUS, Inc. ("myNEXUS") from WindRose Health Investors, a comprehensive home-based nursing management company for payors. At the time of acquisition, myNEXUS delivered integrated clinical support services for Medicare Advantage members across twenty states. This acquisition aligns with our strategy to manage integrated, whole person multi-site care and support, by providing national, large-scale expertise to manage nursing services in the home and facilitate transitions of care.

In accordance with FASB accounting guidance for business combinations, the consideration transferred was allocated to the fair value of myNEXUS' assets acquired and liabilities assumed, including identifiable intangible assets. The excess of consideration transferred over the fair value of net assets acquired resulted in preliminary goodwill of $520 at September 30, 2021, all of which was allocated to our Other segment. Preliminary goodwill recognized from the acquisition of myNEXUS primarily relates to the future economic benefits arising from the assets acquired and is consistent with our stated intentions and strategy. As of September 30, 2021, the initial accounting for the acquisition has not been finalized. Any additional payments or receipts of cash resulting from contractual purchase price adjustments or any subsequent adjustments made to the assets acquired or liabilities assumed during the measurement period will continue to be recorded as an adjustment to goodwill.

The preliminary fair value of the net assets acquired from myNEXUS includes $284 of other intangible assets at September 30, 2021, which primarily consist of finite-lived customer relationships with amortization periods of 15 years. The results of operations of myNEXUS are included in our consolidated financial statements within our Other segment for the period following April 28, 2021. The proforma effects of this acquisition for prior periods were not material to our consolidated results of operations.

Beacon Health Options, Inc.

On February 28, 2020, we completed our acquisition of Beacon Health Options, Inc. ("Beacon"), which was the largest independently held behavioral health organization in the country. At the time of acquisition, Beacon served more than thirty-four million individuals across all fifty states. This acquisition aligned with our strategy to diversify into health services and deliver both integrated solutions and care delivery models that personalize care for people with complex and chronic conditions.

In accordance with FASB accounting guidance for business combinations, the consideration transferred was allocated to the fair value of Beacon's assets acquired and liabilities assumed, including identifiable intangible assets. The excess of the consideration transferred over the fair value of net assets acquired resulted in preliminary goodwill of $1,072 at December 31, 2020, all of which was allocated to our Other segment. Preliminary goodwill recognized from the acquisition of Beacon primarily relates to the future economic benefits arising from the assets acquired and is consistent with our stated intentions

and strategy. Goodwill was adjusted by $9 through the end of the measurement period in February 2021 related to finalization of income tax considerations, resulting in final goodwill of $1,081 as of September 30, 2021.

The fair value of the net assets acquired from Beacon includes $752 of other intangible assets at September 30, 2021, which primarily consist of finite-lived customer relationships with amortization periods ranging from 8 to 25 years. The results of operations of Beacon are included in our consolidated financial statements within our Other segment for the period following February 28, 2020. The proforma effects of this acquisition for prior periods were not material to our consolidated results of operations.

4. Business Optimization Initiatives

During the third quarter of 2020, management introduced enterprise-wide initiatives to optimize our business, including process automation and a reduction in our office space footprint and, as a result, we recognized a liability in 2020 for future payments for employee termination costs in connection with the repositioning and reskilling of our workforce. We believe these initiatives largely represent the next step forward in our progression towards becoming a more agile organization.

A summary of the activity related to the liability for the employee termination costs during the nine months ended September 30, 2021, by reportable segment, is as follows:

	Commercial & Specialty Business	Government Business	IngenioRx	Other	Total
2020 Business Optimization Initiatives					
Employee termination costs:					
Liability for employee termination costs at January 1, 2021	$ 92	$ 88	$ 1	$ 6	$ 187
Payments	(21)	(20)	—	(2)	(43)
Liability for employee termination costs at September 30, 2021	$ 71	$ 68	$ 1	$ 4	$ 144

5. Investments

Fixed Maturity Securities

We evaluate our available-for-sale fixed maturity securities for declines based on qualitative and quantitative factors. We have established an allowance for credit loss and recorded credit loss expense as a reflection of our expected impairment losses. We continue to review our investment portfolios under our impairment review policy. Given the inherent uncertainty of changes in market conditions and the significant judgments involved, there is a continuing risk that declines in fair value may occur and additional material impairment losses on investments may be recorded in future periods.

A summary of current and long-term fixed maturity securities, available-for-sale, at September 30, 2021 and December 31, 2020 is as follows:

	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses		Allowance For Credit Losses	Estimated Fair Value	Non-Credit Component of Impairment Recognized in Accumulated Other Comprehensive (Loss) Income
			Less than 12 Months	12 Months or Greater			
September 30, 2021							
Fixed maturity securities:							
United States Government securities	$ 1,259	$ 6	$ (8)	$ (4)	$ —	$ 1,253	$ —
Government sponsored securities	55	4	—	—	—	59	—
Foreign government securities	346	7	(7)	(2)	—	344	—
States, municipalities and political subdivisions	5,231	319	(6)	(1)	—	5,543	—
Corporate securities	12,118	509	(38)	(11)	(4)	12,574	(1)
Residential mortgage-backed securities	4,224	108	(13)	(7)	(2)	4,310	—
Commercial mortgage-backed securities	66	2	—	(3)	—	65	—
Other securities	2,802	31	(3)	(5)	—	2,825	—
Total fixed maturity securities	$ 26,101	$ 986	$ (75)	$ (33)	$ (6)	$ 26,973	$ (1)
December 31, 2020							
Fixed maturity securities:							
United States Government securities	$ 765	$ 11	$ (2)	$ —	$ —	$ 774	$ —
Government sponsored securities	63	6	—	—	—	69	—
Foreign government securities	290	17	(2)	—	—	305	—
States, municipalities and political subdivisions	5,185	395	(1)	—	—	5,579	—
Corporate securities	10,233	697	(20)	(11)	(7)	10,892	(1)
Residential mortgage-backed securities	4,208	154	(8)	(9)	—	4,345	(2)
Commercial mortgage-backed securities	73	3	(1)	(3)	—	72	—
Other securities	1,937	33	(5)	(6)	—	1,959	—
Total fixed maturity securities	$ 22,754	$ 1,316	$ (39)	$ (29)	$ (7)	$ 23,995	$ (3)

For fixed maturity securities in an unrealized loss position at September 30, 2021 and December 31, 2020, the following table summarizes the aggregate fair values and gross unrealized losses by length of time those securities have continuously been in an unrealized loss position:

	Less than 12 Months			12 Months or Greater		
(Securities are whole amounts)	Number of Securities	Estimated Fair Value	Gross Unrealized Loss	Number of Securities	Estimated Fair Value	Gross Unrealized Loss
September 30, 2021						
Fixed maturity securities:						
United States Government securities	62	$ 702	$ (8)	17	$ 141	$ (4)
Government sponsored securities	1	1	—	—	—	—
Foreign government securities	191	155	(7)	22	10	(2)
States, municipalities and political subdivisions	254	516	(6)	4	11	(1)
Corporate securities	1,478	2,321	(38)	225	273	(11)
Residential mortgage-backed securities	418	1,430	(13)	101	108	(7)
Commercial mortgage-backed securities	1	1	—	4	7	(3)
Other securities	255	720	(3)	53	110	(5)
Total fixed maturity securities	2,660	$ 5,846	$ (75)	426	$ 660	$ (33)
December 31, 2020						
Fixed maturity securities:						
United States Government securities	27	$ 301	$ (2)	—	$ —	$ —
Government sponsored securities	—	—	—	1	—	—
Foreign government securities	55	35	(2)	9	4	—
States, municipalities and political subdivisions	36	57	(1)	1	3	—
Corporate securities	646	765	(20)	150	169	(11)
Residential mortgage-backed securities	224	442	(8)	90	110	(9)
Commercial mortgage-backed securities	6	16	(1)	3	4	(3)
Other securities	207	509	(5)	79	179	(6)
Total fixed maturity securities	1,201	$ 2,125	$ (39)	333	$ 469	$ (29)

Below are discussions by security type for unrealized losses and credit losses as of September 30, 2021:

Corporate securities: An allowance for credit losses on certain retail, travel and entertainment and energy sector fixed maturity corporate securities has been determined based on qualitative and quantitative factors including credit rating, decline in fair value and industry condition along with other available market data. With multiple risk factors present, these securities were reviewed for expected future cash flow to determine the portion of unrealized losses that were credit related and to record an allowance for credit losses. Unrealized losses on our other corporate securities were largely due to market conditions relating to the COVID-19 pandemic; however, qualitative factors did not indicate a credit loss as of September 30, 2021. We do not intend to sell these investments and it is likely we will not have to sell these investments prior to maturity or recovery of amortized cost.

Residential mortgage-backed securities: An allowance for credit loss was established on certain residential mortgage-backed securities. Notification of maturity and coupon default, as well as a significant and sustained decline in fair value, were factors to indicate a credit loss. No other mortgage securities had material unrealized losses or qualitative factors to indicate a credit loss. We do not intend to sell these investments and it is likely we will not be required to sell these investments prior to maturity or recovery of amortized cost.

As for the remaining securities shown in the table above, unrealized losses on these securities have not been recognized into income because we do not intend to sell these investments and it is likely that we will not be required to sell these investments prior to their anticipated recovery. The decline in fair value is largely due to changes in interest rates and other market conditions. We have evaluated these securities for any change in credit rating and have determined that no allowance is necessary. The fair value is expected to recover as the securities approach maturity.

The table below presents a roll-forward by major security type of the allowance for credit losses on fixed maturity securities available-for-sale held at period end for the three and nine months ended September 30, 2021 and 2020:

	Three Months Ended September 30, 2021			Nine Months Ended September 30, 2021		
	Corporate Securities	Residential mortgage-backed securities	Total	Corporate Securities	Residential mortgage-backed securities	Total
Allowance for credit losses:						
Beginning balance	$ 4	$ 2	$ 6	$ 7	$ —	$ 7
Additions for securities for which no previous expected credit losses were recognized	—	—	—	1	—	1
Securities sold during the period	—	—	—	(2)	—	(2)
(Decreases) increases to the allowance for credit losses on securities	—	—	—	(2)	2	—
Total allowance for credit losses, ending balance	$ 4	$ 2	$ 6	$ 4	$ 2	$ 6

	Three Months Ended September 30, 2020			Nine Months Ended September 30, 2020		
	Corporate Securities	Foreign Government Securities	Total	Corporate Securities	Foreign Government Securities	Total
Allowance for credit losses:						
Beginning balance	$ 23	$ 1	$ 24	$ —	$ —	$ —
Additions for securities for which no previous expected credit losses were recognized	1	—	1	61	1	62
Securities sold during the period	(5)	—	(5)	(13)	—	(13)
Decreases to the allowance for credit losses on securities	(8)	—	(8)	(37)	—	(37)
Total allowance for credit losses, ending balance	$ 11	$ 1	$ 12	$ 11	$ 1	$ 12

The amortized cost and fair value of fixed maturity securities at September 30, 2021, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because the issuers of the securities may have the right to prepay obligations.

	Amortized Cost	Estimated Fair Value
Due in one year or less	$ 770	$ 774
Due after one year through five years	6,599	6,821
Due after five years through ten years	8,682	8,948
Due after ten years	5,760	6,055
Mortgage-backed securities	4,290	4,375
Total fixed maturity securities	$ 26,101	$ 26,973

Proceeds from sales, maturities, calls or redemptions of fixed maturity securities during the three and nine months ended September 30, 2021 and 2020 are as follows:

	Three Months Ended September 30		Nine Months Ended September 30	
	2021	2020	2021	2020
Proceeds	$ 2,620	$ 4,597	$ 8,570	$ 9,146

In the ordinary course of business, we may sell securities at a loss for a number of reasons, including, but not limited to: (i) changes in the investment environment; (ii) expectation that the fair value could deteriorate further; (iii) desire to reduce exposure to an issuer or an industry; (iv) changes in credit quality; or (v) changes in expected cash flow.

All securities sold resulting in investment gains and losses are recorded on the trade date. Realized gains and losses are determined on the basis of the cost or amortized cost of the specific securities sold.

Equity Securities

A summary of marketable equity securities at September 30, 2021 and December 31, 2020 is as follows:

	September 30, 2021	December 31, 2020
Equity securities:		
Exchange traded funds	$ 1,941	$ 1,154
Fixed maturity mutual funds	—	144
Common equity securities	94	201
Private equity securities	84	60
Total	$ 2,119	$ 1,559

Other Invested Assets

Other invested assets include primarily our investments in limited partnerships, joint ventures and other non-controlled corporations, as well as the cash surrender value of corporate-owned life insurance policies. Investments in limited partnerships, joint ventures and other non-controlled corporations are carried at our share in the entities' undistributed earnings, which approximates fair value. Financial information for certain of these investments are reported on a one or three month lag due to the timing of when we receive financial information from the companies.

Investment Gains and Losses

Net realized investment (losses) gains on investments for the three and nine months ended September 30, 2021 and 2020 are as follows:

	Three Months Ended September 30		Nine Months Ended September 30	
	2021	2020	2021	2020
Net realized (losses) gains:				
Fixed maturity securities:				
Gross realized gains from sales	$ 30	$ 52	$ 133	$ 131
Gross realized losses from sales	(8)	(14)	(32)	(84)
Impairment recoveries (losses) recognized in income	—	11	1	(13)
Net realized gains from sales of fixed maturity securities	22	49	102	34
Equity securities:				
Gross realized gains	10	207	32	260
Gross realized losses	(15)	(19)	(85)	(77)
Net realized (losses) gains on equity securities	(5)	188	(53)	183
Other invested assets:				
Realized (losses) gains	(91)	10	4	17
Impairment recoveries (losses) recognized in income	1	(16)	(5)	(51)
Net realized losses from sales of other investments	(90)	(6)	(1)	(34)
Net realized (losses) gains on investments	$ (73)	$ 231	$ 48	$ 183

The gains and losses related to equity securities for the three and nine months ended September 30, 2021 and 2020 are as follows:

	Three Months Ended September 30		Nine Months Ended September 30	
	2021	2020	2021	2020
Net realized (losses) gains recognized on equity securities	$ (5)	$ 188	$ (53)	$ 183
Less: Net realized (losses) gains recognized on equity securities sold during the period	(1)	13	(57)	20
Unrealized (losses) gains recognized on equity securities still held at the end of the period	$ (4)	$ 175	$ 4	$ 163

Accrued Investment Income

At September 30, 2021 and December 31, 2020, accrued investment income totaled $197 and $188, respectively. We recognize accrued investment income under the caption “Other receivables” on our consolidated balance sheets.

Securities Lending Programs

We participate in securities lending programs whereby marketable securities in our investment portfolio are transferred to independent brokers or dealers in exchange for cash and securities collateral. The fair value of the collateral received at the time of the transactions amounted to $2,229 and $1,199 at September 30, 2021 and December 31, 2020, respectively. The value of the collateral represented 102% of the market value of the securities on loan at each of September 30, 2021 and December 31, 2020. We recognize the collateral as an asset under the caption “Other current assets” in our consolidated balance sheets, and we recognize a corresponding liability for the obligation to return the collateral to the borrower under the

caption "Other current liabilities." The securities on loan are reported in the applicable investment category on our consolidated balance sheets.

The remaining contractual maturity of our securities lending agreements at September 30, 2021 is as follows:

	Overnight and Continuous
Securities lending collateral	
Cash	$ 2,028
United States Government securities	200
Other securities	1
Total	$ 2,229

6. Derivative Financial Instruments

We primarily invest in the following types of derivative financial instruments: interest rate swaps, futures, forward contracts, put and call options, swaptions, embedded derivatives and warrants. We also enter into master netting agreements, which reduce credit risk by permitting net settlement of transactions.

We have entered into various interest rate swap contracts to convert a portion of our interest rate exposure on our long-term debt from fixed rates to floating rates. The floating rates payable on all of our fair value hedges are benchmarked to LIBOR. Any amounts recognized for changes in fair value of these derivatives are included in the captions "Other current assets," or "Other noncurrent assets," or "Other current liabilities" or "Other noncurrent liabilities" in our consolidated balance sheets.

We have previously entered into a series of forward starting pay fixed interest rate swaps with the objective of reducing the variability of cash flows in the interest payments on future financings that were anticipated at the time of entering into the swaps.

The unrecognized loss for all expired and terminated cash flow hedges included in accumulated other comprehensive (loss) income, net of tax, was $240 and $250 at September 30, 2021 and December 31, 2020, respectively.

During the three and nine months ended September 30, 2021, we recognized net realized gains on non-hedging derivatives of $12 and $59, respectively. During the three and nine months ended September 30, 2020, we recognized net realized losses on non-hedging derivatives of $2 and $6, respectively.

For additional information relating to the fair value of our derivative assets and liabilities, see Note 7, "Fair Value," of this Form 10-Q.

7. Fair Value

Assets and liabilities recorded at fair value in our consolidated balance sheets are categorized based upon the level of judgment associated with the inputs used to measure their fair value. Level inputs, as defined by FASB guidance for fair value measurements and disclosures, are as follows:

Level Input	Input Definition
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.
Level III	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date.

The following methods, assumptions and inputs were used to determine the fair value of each class of the following assets and liabilities recorded at fair value in our consolidated balance sheets:

Cash equivalents: Cash equivalents primarily consist of highly rated money market funds with maturities of three months or less and are purchased daily at par value with specified yield rates. Due to the high ratings and short-term nature of the funds, we designate all cash equivalents as Level I.

Fixed maturity securities, available-for-sale: Fair values of available-for-sale fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third-party pricing services, which generally use Level I or Level II inputs for the determination of fair value to facilitate fair value measurements and disclosures. Level II securities primarily include corporate securities, securities from states, municipalities and political subdivisions, mortgage-backed securities, United States Government securities, foreign government securities, and certain other asset-backed securities. For securities not actively traded, the pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. We have controls in place to review the pricing services' qualifications and procedures used to determine fair values. In addition, we periodically review the pricing services' pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. We also have certain fixed maturity securities, primarily corporate debt securities, which are designated Level III securities. For these securities, the valuation methodologies may incorporate broker quotes or discounted cash flow analyses using assumptions for inputs such as expected cash flows, benchmark yields, credit spreads, default rates and prepayment speeds that are not observable in the markets.

Equity securities: Fair values of equity securities are generally designated as Level I and are based on quoted market prices. For certain equity securities, quoted market prices for the identical security are not always available, and the fair value is estimated by reference to similar securities for which quoted prices are available. These securities are designated Level II. We also have certain equity securities, including private equity securities, for which the fair value is estimated based on each security's current condition and future cash flow projections. Such securities are designated Level III. The fair values of these private equity securities are generally based on either broker quotes or discounted cash flow projections using assumptions for inputs such as the weighted-average cost of capital, long-term revenue growth rates and earnings before interest, taxes, depreciation and amortization, and/or revenue multiples that are not observable in the markets.

Securities lending collateral: Fair values of securities lending collateral are based on quoted market prices, where available. These fair values are obtained primarily from third-party pricing services, which generally use Level I or Level II inputs for the determination of fair value, to facilitate fair value measurements and disclosures.

Derivatives: Fair values are based on the quoted market prices by the financial institution that is the counterparty to the derivative transaction. We independently verify prices provided by the counterparties using valuation models that incorporate observable market inputs for similar derivative transactions. Derivatives are designated as Level II securities. Derivatives presented within the fair value hierarchy table below are presented on a gross basis and not on a master netting basis by counterparty.

A summary of fair value measurements by level for assets and liabilities measured at fair value on a recurring basis at September 30, 2021 and December 31, 2020 is as follows:

	Level I	Level II	Level III	Total
September 30, 2021				
Assets:				
Cash equivalents	$ 2,527	$ —	$ —	$ 2,527
Fixed maturity securities, available-for-sale:				
United States Government securities	—	1,253	—	1,253
Government sponsored securities	—	59	—	59
Foreign government securities	—	344	—	344
States, municipalities and political subdivisions, tax-exempt	—	5,543	—	5,543
Corporate securities	—	12,240	334	12,574
Residential mortgage-backed securities	—	4,309	1	4,310
Commercial mortgage-backed securities	—	65	—	65
Other securities	—	2,823	2	2,825
Total fixed maturity securities, available-for-sale	—	26,636	337	26,973
Equity securities:				
Exchange traded funds	1,941	—	—	1,941
Common equity securities	15	79	—	94
Private equity securities	—	—	84	84
Total equity securities	1,956	79	84	2,119
Other invested assets - common equity securities	154	—	—	154
Securities lending collateral	—	2,229	—	2,229
Derivatives	—	116	—	116
Total assets	$ 4,637	$ 29,060	$ 421	$ 34,118
Liabilities:				
Derivatives	$ —	$ (40)	$ —	$ (40)
Total liabilities	$ —	$ (40)	$ —	$ (40)
December 31, 2020				
Assets:				
Cash equivalents	$ 3,163	$ —	$ —	$ 3,163
Fixed maturity securities, available-for-sale:				
United States Government securities	—	774	—	774
Government sponsored securities	—	69	—	69
Foreign government securities	—	305	—	305
States, municipalities and political subdivisions, tax-exempt	—	5,579	—	5,579
Corporate securities	—	10,567	325	10,892
Residential mortgage-backed securities	—	4,343	2	4,345
Commercial mortgage-backed securities	—	72	—	72
Other securities	—	1,954	5	1,959
Total fixed maturity securities, available-for-sale	—	23,663	332	23,995
Equity securities:				
Exchange traded funds	1,154	—	—	1,154
Fixed maturity mutual funds	—	144	—	144
Common equity securities	171	30	—	201
Private equity securities	—	—	60	60
Total equity securities	1,325	174	60	1,559
Securities lending collateral	—	1,199	—	1,199
Derivatives	—	43	—	43
Total assets	$ 4,488	$ 25,079	$ 392	$ 29,959
Liabilities:				
Derivatives	$ —	$ (5)	$ —	$ (5)
Total liabilities	$ —	$ (5)	$ —	$ (5)

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level III inputs for the three months ended September 30, 2021 and 2020 is as follows:

	Corporate Securities	Residential Mortgage-backed Securities	Other Securities	Equity Securities	Total
Three Months Ended September 30, 2021					
Beginning balance at July 1, 2021	$ 351	$ 2	$ 7	$ 77	$ 437
Total gains (losses):					
Recognized in net income	1	—	—	5	6
Recognized in accumulated other comprehensive (loss) income	(1)	—	—	—	(1)
Purchases	34	—	—	3	37
Sales	—	—	—	(1)	(1)
Settlements	(47)	—	—	—	(47)
Transfers out of Level III	(4)	(1)	(5)	—	(10)
Ending balance at September 30, 2021	$ 334	$ 1	$ 2	$ 84	$ 421
Change in unrealized losses included in net income related to assets still held at September 30, 2021	$ —	$ —	$ —	$ 5	$ 5
Three Months Ended September 30, 2020					
Beginning balance at July 1, 2020	$ 314	$ 2	$ 5	$ 62	$ 383
Total (losses) gains:					
Recognized in net income	(1)	—	—	(3)	(4)
Recognized in accumulated other comprehensive (loss) income	14	—	—	—	14
Purchases	5	—	—	2	7
Sales	(5)	—	—	—	(5)
Settlements	(14)	—	—	—	(14)
Ending balance at September 30, 2020	$ 313	$ 2	$ 5	$ 61	$ 381
Change in unrealized losses included in net income related to assets still held at September 30, 2020	$ —	$ —	$ —	$ (3)	$ (3)

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level III inputs for the nine months ended September 30, 2021 and 2020 is as follows:

	Corporate Securities	Residential Mortgage-backed Securities	Other Securities	Equity Securities	Total
Nine Months Ended September 30, 2021					
Beginning balance at January 1, 2021	$ 325	$ 2	$ 5	$ 60	$ 392
Total gains:					
Recognized in net income	2	—	—	17	19
Recognized in accumulated other comprehensive (loss) income	4	—	—	—	4
Purchases	135	—	—	11	146
Sales	(12)	—	—	(4)	(16)
Settlements	(118)	—	(1)	—	(119)
Transfers out of Level III	(2)	(1)	(2)	—	(5)
Ending balance at September 30, 2021	$ 334	$ 1	$ 2	$ 84	$ 421
Change in unrealized losses included in net income related to assets still held at September 30, 2021	$ —	$ —	$ —	$ 17	$ 17
Nine Months Ended September 30, 2020					
Beginning balance at January 1, 2020	$ 303	$ 2	$ 7	$ 85	$ 397
Total losses:					
Recognized in net income	(2)	—	—	(19)	(21)
Recognized in accumulated other comprehensive (loss) income	(3)	—	—	—	(3)
Purchases	44	—	—	17	61
Sales	(9)	—	—	(22)	(31)
Settlements	(33)	—	(2)	—	(35)
Transfers into Level III	13	—	—	—	13
Ending balance at September 30, 2020	$ 313	$ 2	$ 5	$ 61	$ 381
Change in unrealized losses included in net income related to assets still held at September 30, 2020	$ —	$ —	$ —	$ (20)	$ (20)

There were no individually material transfers into or out of Level III during the three and nine months ended September 30, 2021 or 2020.

Certain assets and liabilities are measured at fair value on a nonrecurring basis; that is, the instruments are not measured at fair value on an ongoing basis but are subject to fair value adjustments only in certain circumstances. As disclosed in Note 3, “Business Acquisitions,” we completed our acquisitions of myNEXUS and MMM during the second quarter of 2021, as well as our acquisition of Beacon during the first quarter of 2020. The net assets acquired in our acquisitions of myNEXUS, MMM and Beacon and resulting goodwill and other intangible assets were recorded at fair value primarily using Level III inputs. The majority of assets acquired and liabilities assumed were recorded at their carrying values as of the respective date of acquisition, as their carrying values approximated their fair values due to their short-term nature. The fair values of goodwill and other intangible assets acquired in our acquisitions of myNEXUS, MMM and Beacon were internally estimated based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets could be expected to generate in the future. We developed internal estimates for the expected cash flows and discount rate in the present value calculation. Other than the assets acquired and liabilities assumed in our acquisitions of myNEXUS, MMM and Beacon described above, there were no material assets or liabilities measured at fair value on a nonrecurring basis during the three and nine months ended September 30, 2021 or 2020.

Our valuation policy is determined by members of our treasury and accounting departments. Whenever possible, our policy is to obtain quoted market prices in active markets to estimate fair values for recognition and disclosure purposes. Where quoted market prices in active markets are not available, fair values are estimated using discounted cash flow analyses, broker quotes, unobservable inputs or other valuation techniques. These techniques are significantly affected by our assumptions, including discount rates and estimates of future cash flows. The use of assumptions for unobservable inputs for the determination of fair value involves a level of judgment and uncertainty. Changes in assumptions that reasonably could have been different at the reporting date may result in a higher or lower determination of fair value. Changes in fair value measurements, if significant, may affect performance of cash flows.

Potential taxes and other transaction costs are not considered in estimating fair values. Our valuation policy is generally to obtain quoted prices for each security from third-party pricing services, which are derived through recently reported trades for identical or similar securities making adjustments through the reporting date based upon available market observable information. As we are responsible for the determination of fair value, we perform analysis on the prices received from the pricing services to determine whether the prices are reasonable estimates of fair value. This analysis is performed by our internal treasury personnel who are familiar with our investment portfolios, the pricing services engaged and the valuation techniques and inputs used. Our analysis includes procedures such as a review of month-to-month price fluctuations and price comparisons to secondary pricing services. There were no adjustments to quoted market prices obtained from the pricing services during the three and nine months ended September 30, 2021 or 2020.

In addition to the preceding disclosures on assets recorded at fair value in the consolidated balance sheets, FASB guidance also requires the disclosure of fair values for certain other financial instruments for which it is practicable to estimate fair value, whether or not such values are recognized in our consolidated balance sheets.

Non-financial instruments such as real estate, property and equipment, other current or noncurrent assets, deferred income taxes, intangible assets and certain financial instruments, such as policy liabilities, are excluded from the fair value disclosures. Therefore, the fair value amounts cannot be aggregated to determine our underlying economic value.

The carrying amounts for cash, premium receivables, self-funded receivables, other receivables, unearned income, accounts payable and accrued expenses, and certain other current liabilities approximate fair value because of the short-term nature of these items. These assets and liabilities are not listed in the table below.

The following methods and assumptions were used to estimate the fair value of each class of financial instrument that is recorded at its carrying value in our consolidated balance sheets:

Other invested assets: Other invested assets include primarily our investments in limited partnerships, joint ventures and other non-controlled corporations, as well as the cash surrender value of corporate-owned life insurance policies. Investments in limited partnerships, joint ventures and other non-controlled corporations are carried at our share in the entities' undistributed earnings, which approximates fair value. The carrying value of corporate-owned life insurance policies represents the cash surrender value as reported by the respective insurer, which approximates fair value.

Short-term borrowings: The fair value of our short-term borrowings is based on quoted market prices for the same or similar debt, or, if no quoted market prices were available, on the current market interest rates estimated to be available to us for debt of similar terms and remaining maturities.

Long-term debt – commercial paper: The carrying amount for commercial paper approximates fair value, as the underlying instruments have variable interest rates at market value.

Long-term debt – senior unsecured notes and surplus notes: The fair values of our notes are based on quoted market prices in active markets for the same or similar debt, or, if no quoted market prices are available, on the current market observable rates estimated to be available to us for debt of similar terms and remaining maturities.

Long-term debt – convertible debentures: The fair value of our convertible debentures is based on the quoted market price in the active private market in which the convertible debentures trade.

A summary of the estimated fair values by level of each class of financial instrument that is recorded at its carrying value on our consolidated balance sheets at September 30, 2021 and December 31, 2020 is as follows:

	Carrying Value	Estimated Fair Value			
		Level I	Level II	Level III	Total
September 30, 2021					
Assets:					
Other invested assets	$ 4,805	$ —	$ —	$ 4,805	$ 4,805
Liabilities:					
Debt:					
Short-term borrowings	175	—	175	—	175
Commercial paper	100	—	100	—	100
Notes	22,433	—	25,188	—	25,188
Convertible debentures	77	—	596	—	596
December 31, 2020					
Assets:					
Other invested assets	$ 4,285	$ —	$ —	$ 4,285	$ 4,285
Liabilities:					
Debt:					
Commercial paper	250	—	250	—	250
Notes	19,677	—	23,307	—	23,307
Convertible debentures	108	—	712	—	712

8. Income Taxes

During the three months ended September 30, 2021 and 2020, we recognized income tax expense of $494 and $167, respectively, which represent effective income tax rates of 24.7% and 42.9%, respectively. The decrease in our effective income tax rate was primarily due to the repeal of the non-tax deductible Health Insurance Provider Fee, or HIP Fee, for years after 2020, applied to our quarterly results, which in 2020, included the impact of expenses for business optimization initiatives and the BCBSA litigation accrual recognized during the three months ended September 30, 2020.

During the nine months ended September 30, 2021 and 2020, we recognized income tax expense of $1,555 and $1,606, respectively, which represent effective income tax rates of 23.8% and 28.5%, respectively. The decrease in our effective income tax rate was primarily due to the repeal of the non-tax deductible HIP Fee for years after 2020.

Income taxes receivable totaled $95 and $262 at September 30, 2021 and December 31, 2020, respectively. We recognize the income tax receivable as an asset under the caption “Other current assets” in our consolidated balance sheets.

9. Medical Claims Payable

A reconciliation of the beginning and ending balances for medical claims payable, by segment (see Note 15, "Segment Information"), for the nine months ended September 30, 2021 is as follows:

	Commercial & Specialty Business	Government Business	Other	Total
Gross medical claims payable, beginning of period	$ 3,294	$ 7,646	$ 195	$ 11,135
Ceded medical claims payable, beginning of period	(13)	(33)	—	(46)
Net medical claims payable, beginning of period	3,281	7,613	195	11,089
Business combinations and purchase adjustments	—	375	45	420
Net incurred medical claims:				
Current period	20,499	52,422	1,176	74,097
Prior periods redundancies	(496)	(1,309)	(17)	(1,822)
Total net incurred medical claims	20,003	51,113	1,159	72,275
Net payments attributable to:				
Current period medical claims	16,985	44,160	978	62,123
Prior periods medical claims	2,450	5,781	169	8,400
Total net payments	19,435	49,941	1,147	70,523
Net medical claims payable, end of period	3,849	9,160	252	13,261
Ceded medical claims payable, end of period	15	23	—	38
Gross medical claims payable, end of period	$ 3,864	$ 9,183	$ 252	$ 13,299

At September 30, 2021, the total of net incurred but not reported liabilities plus expected development on reported claims for the Commercial & Specialty Business was $52, $283 and $3,514 for the claim years 2019 and prior, 2020 and 2021, respectively.

At September 30, 2021, the total of net incurred but not reported liabilities plus expected development on reported claims for the Government Business was $79, $444 and $8,637 for the claim years 2019 and prior, 2020 and 2021, respectively.

At September 30, 2021, the total of net incurred but not reported liabilities plus expected development on reported claims for Other was $0, $9 and $243 for the claim years 2019 and prior, 2020 and 2021, respectively.

A reconciliation of the beginning and ending balances for medical claims payable, by segment (see Note 15, "Segment Information"), for the nine months ended September 30, 2020 is as follows:

	Commercial & Specialty Business	Government Business	Other	Total
Gross medical claims payable, beginning of period	$ 3,039	$ 5,608	$ —	$ 8,647
Ceded medical claims payable, beginning of period	(14)	(19)	—	(33)
Net medical claims payable, beginning of period	3,025	5,589	—	8,614
Business combinations and purchase adjustments	—	141	198	339
Net incurred medical claims:				
Current period	17,964	43,135	878	61,977
Prior periods redundancies	(379)	(321)	—	(700)
Total net incurred medical claims	17,585	42,814	878	61,277
Net payments attributable to:				
Current period medical claims	15,319	36,680	880	52,879
Prior periods medical claims	2,426	5,063	—	7,489
Total net payments	17,745	41,743	880	60,368
Net medical claims payable, end of period	2,865	6,801	196	9,862
Ceded medical claims payable, end of period	102	27	—	129
Gross medical claims payable, end of period	$ 2,967	$ 6,828	$ 196	$ 9,991

The favorable development recognized in the nine months ended September 30, 2021 and 2020 resulted primarily from trend factors in late 2020 and late 2019, respectively, developing more favorably than originally expected. Favorable development in the completion factors resulting from the latter parts of 2020 and 2019, respectively, developing faster than expected also contributed to the favorability. The impact from COVID-19 on healthcare utilization and medical claims submission patterns continues to provide increased estimation uncertainty on our incurred but not reported liability at September 30, 2021.

The reconciliation of net incurred medical claims to benefit expense included in our consolidated statements of income for periods in 2021 is as follows:

	Three Months Ended			Nine Months Ended
	March 31, 2021	June 30, 2021	September 30, 2021	September 30, 2021
Net incurred medical claims:				
Commercial & Specialty Business	$ 6,072	$ 6,718	$ 7,213	$ 20,003
Government Business	16,319	16,723	18,071	51,113
Other	336	403	420	1,159
Total net incurred medical claims	22,727	23,844	25,704	72,275
Quality improvement and other claims expense	972	919	941	2,832
Benefit expense	$ 23,699	$ 24,763	$ 26,645	$ 75,107

The reconciliation of net incurred medical claims to benefit expense included in our consolidated statements of income for periods in 2020 is as follows:

	Three Months Ended			Nine Months Ended
	March 31, 2020	June 30, 2020	September 30, 2020	September 30, 2020
Net incurred medical claims:				
Commercial & Specialty Business	$ 5,797	$ 5,147	$ 6,641	$ 17,585
Government Business	14,603	13,233	14,978	42,814
Other	130	368	380	878
Total net incurred medical claims	20,530	18,748	21,999	61,277
Quality improvement and other claims expense	959	799	922	2,680
Benefit expense	$ 21,489	$ 19,547	$ 22,921	$ 63,957

The reconciliation of the medical claims payable reflected in the tables above to the consolidated ending balance for medical claims payable included in the consolidated balance sheet, as of September 30, 2021, is as follows:

	Commercial & Specialty Business	Government Business	Other	Total
Net medical claims payable, end of period	$ 3,849	$ 9,160	$ 252	$ 13,261
Ceded medical claims payable, end of period	15	23	—	38
Insurance lines other than short duration	—	263	—	263
Gross medical claims payable, end of period	$ 3,864	$ 9,446	$ 252	$ 13,562

10. Debt

We generally issue senior unsecured notes for long-term borrowing purposes. At September 30, 2021 and December 31, 2020, we had $22,408 and $19,652, respectively, outstanding under these notes.

On May 15, 2021, we redeemed the $700 outstanding principal balance of our 3.700% Notes due August 15, 2021 at a redemption price equal to 100% of the aggregate principal amount of the notes being redeemed, plus accrued and unpaid interest.

On March 17, 2021, we issued $500 aggregate principal amount of 0.450% Notes due 2023 (the “2023 Notes”), $750 aggregate principal amount of 1.500% Notes due 2026 (the “2026 Notes”), $1,000 aggregate principal amount of 2.550% Notes due 2031 (the “2031 Notes”) and $1,250 aggregate principal amount of 3.600% Notes due 2051 (the “2051 Notes”) under our shelf registration statement. Interest on the 2023 Notes, 2026 Notes, 2031 Notes and 2051 Notes is payable semi-annually in arrears on March 15 and September 15 of each year, commencing September 15, 2021. We used the net proceeds for working capital and general corporate purposes, including, but not limited to, the funding of acquisitions, repayment of short-term and long-term debt and the repurchase of our common stock pursuant to our share repurchase program.

We have an unsecured surplus note with an outstanding principal balance of $25 at both September 30, 2021 and December 31, 2020.

We have a senior revolving credit facility (the “5-Year Facility”) with a group of lenders for general corporate purposes. The 5-Year Facility provides credit up to $2,500 and matures in June 2024. On June 3, 2021, we terminated our 364-day senior revolving credit facility (the “prior 364-Day Facility”), which was scheduled to mature in June 2021, and entered into a new 364-day senior revolving credit facility (the “new 364-Day Facility” and together with the 5-Year Facility, the “Credit Facilities”) with a group of lenders for general corporate purposes. The new 364-Day Facility provides for credit in the amount of $1,000 and matures in June 2022. Our ability to borrow under these Credit Facilities is subject to compliance with certain covenants, including covenants requiring us to maintain a defined debt-to-capital ratio of not more than 60%, subject to increase in certain circumstances set forth in the applicable credit agreement. As of September 30, 2021, our debt-to-

capital ratio, as defined and calculated under the Credit Facilities, was 38.9%. We do not believe the restrictions contained in the covenants under our Credit Facilities materially affect our financial or operating flexibility. As of September 30, 2021, we were in compliance with all of the debt covenants under these Credit Facilities. There were no amounts outstanding under the prior 364-Day Facility or the new 364-Day Facility at any time during the nine months ended September 30, 2021 or the year ended December 31, 2020. At September 30, 2021 and December 31, 2020, there were no amounts outstanding under our 5-Year Facility.

Through certain subsidiaries, we have entered into multiple 364-day lines of credit (the "Subsidiary Credit Facilities") with separate lenders for general corporate purposes. The Subsidiary Credit Facilities provide combined credit of up to $200. At September 30, 2021 and December 31, 2020, there were no amounts outstanding under our Subsidiary Credit Facilities.

We have an authorized commercial paper program of up to $3,500, the proceeds of which may be used for general corporate purposes. At September 30, 2021 and December 31, 2020, we had $100 and $250, respectively, outstanding under this program.

We have outstanding senior unsecured convertible debentures due 2042 (the "Debentures"), which are governed by an indenture (the "indenture") between us and The Bank of New York Mellon Trust Company, N.A., as trustee. We have accounted for the Debentures in accordance with the FASB cash conversion guidance for debt with conversion and other options. As a result, the value of the embedded conversion option (net of deferred taxes and equity issuance costs) has been bifurcated from its debt host and recorded as a component of additional paid-in capital in our consolidated balance sheets. During the three and nine months ended September 30, 2021, $0 and $47, respectively, of aggregate principal amount of the Debentures were surrendered for conversion by certain holders in accordance with the terms and provisions of the indenture. We elected to settle the excess of the principal amount of the conversions with cash for total payments during the three and nine months ended September 30, 2021 of $2 and $254, respectively. We recognized a loss on the extinguishment of debt related to the Debentures of $0 and $5, respectively, for the three and nine months ended September 30, 2021, based on the fair values of the debt on the conversion settlement dates.

The following table summarizes at September 30, 2021 the related balances, conversion rate and conversion price of the Debentures:

Outstanding principal amount	$	112
Unamortized debt discount	$	34
Net debt carrying amount	$	77
Equity component carrying amount	$	41
Conversion rate (shares of common stock per $1,000 of principal amount)		14.1784
Effective conversion price (per $1,000 of principal amount)	$	70.5298

We are a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati, the Federal Home Loan Bank of Atlanta and the Federal Home Loan Bank of New York (collectively, the "FHLBs"). As a member, we have the ability to obtain short-term cash advances, subject to certain minimum collateral requirements. We had $175 and $0 of outstanding short-term borrowings from the FHLBs at September 30, 2021 and December 31, 2020, respectively.

All debt is a direct obligation of Anthem, Inc., except for the surplus note, the FHLB borrowings, and the Subsidiary Credit Facilities.

11. Commitments and Contingencies

Litigation and Regulatory Proceedings

In the ordinary course of business, we are defendants in, or parties to, a number of pending or threatened legal actions or proceedings. To the extent a plaintiff or plaintiffs in the following cases have specified in their complaint or in other court filings the amount of damages being sought, we have noted those alleged damages in the descriptions below. With respect to

the cases described below, we contest liability and/or the amount of damages in each matter and believe we have meritorious defenses.

Where available information indicates that it is probable that a loss has been incurred as of the date of the consolidated financial statements and we can reasonably estimate the amount of that loss, we accrue the estimated loss by a charge to income. In many proceedings, however, it is difficult to determine whether any loss is probable or reasonably possible. In addition, even where loss is possible or an exposure to loss exists in excess of the liability already accrued with respect to a previously identified loss contingency, it is not always possible to reasonably estimate the amount of the possible loss or range of loss.

With respect to many of the proceedings to which we are a party, we cannot provide an estimate of the possible losses, or the range of possible losses in excess of the amount, if any, accrued, for various reasons, including but not limited to some or all of the following: (i) there are novel or unsettled legal issues presented, (ii) the proceedings are in early stages, (iii) there is uncertainty as to the likelihood of a class being certified or decertified or the ultimate size and scope of the class, (iv) there is uncertainty as to the outcome of pending appeals or motions, (v) there are significant factual issues to be resolved, and/or (vi) in many cases, the plaintiffs have not specified damages in their complaint or in court filings. For those legal proceedings where a loss is probable, or reasonably possible, and for which it is possible to reasonably estimate the amount of the possible loss or range of losses, we currently believe that the range of possible losses, in excess of established reserves is, in the aggregate, from $0 to approximately $250 at September 30, 2021. This estimated aggregate range of reasonably possible losses is based upon currently available information taking into account our best estimate of such losses for which such an estimate can be made.

Blue Cross Blue Shield Antitrust Litigation

We are a defendant in multiple lawsuits that were initially filed in 2012 against the BCBSA and Blue Cross and/or Blue Shield licensees (the "Blue plans") across the country. Cases filed in twenty-eight states were consolidated into a single, multi-district proceeding captioned *In re Blue Cross Blue Shield Antitrust Litigation* that is pending in the United States District Court for the Northern District of Alabama (the "Court"). Generally, the suits allege that the BCBSA and the Blue plans have conspired to horizontally allocate geographic markets through license agreements, best efforts rules that limit the percentage of non-Blue revenue of each plan, restrictions on acquisitions, rules governing the BlueCard® and National Accounts programs and other arrangements in violation of the Sherman Antitrust Act ("Sherman Act") and related state laws. The cases were brought by two putative nationwide classes of plaintiffs, health plan subscribers and providers.

In April 2018, the Court issued an order on the parties' cross motions for partial summary judgment determining that the defendants' aggregation of geographic market allocations and output restrictions are to be analyzed under a per se standard of review, and the BlueCard® program and other alleged Section 1 Sherman Act violations are to be analyzed under the rule of reason standard of review. The Court also found that there remain genuine issues of material fact as to whether the defendants operate as a single entity with regard to the enforcement of the Blue Cross Blue Shield trademarks. In April 2019, the plaintiffs filed motions for class certification, which defendants opposed.

The BCBSA and Blue plans have entered into a settlement agreement and release (the "Subscriber Settlement Agreement") with the subscriber plaintiffs. If approved by the Court, the Subscriber Settlement Agreement will require the defendants to make a monetary settlement payment, our portion of which is estimated to be $594, and will contain certain non-monetary terms including (i) eliminating the "national best efforts" rule in the BCBSA license agreements (which rule limits the percentage of non-Blue revenue permitted for each Blue plan) and (ii) allowing for some large national employers with self-funded benefit plans to request a bid for insurance coverage from a second Blue plan in addition to their local Blue plan. As of September 30, 2021, the liability balance accrued for our estimated remaining payment obligation was $507, net of payments made.

In November 2020, the Court issued an order preliminarily approving the Subscriber Settlement Agreement, following which members of the subscriber class were provided notice of the Subscriber Settlement Agreement and an opportunity to opt out of the class. All terms of the Subscriber Settlement Agreement are subject to final approval by the Court. The deadlines for objections to the settlement, as well as the deadline for those who wish to opt out from the settlement, was July 28, 2021 and a small number of subscribers submitted valid opt outs by the deadline. Claims for settlement payments by members of the subscriber class must be filed by November 5, 2021. Final approval briefs in support of the subscriber settlement were filed on September 3, 2021. A final approval hearing is scheduled for October 21, 2021. If the Court grants

approval of the Subscriber Settlement Agreement, and after all appellate rights have expired or have been exhausted in a manner that affirms the Court's final order and judgment, the defendants' payment and non-monetary obligations under the Subscriber Settlement Agreement will become effective.

In October 2020, after the Court lifted the stay as to the provider litigation, provider plaintiffs filed a renewed motion for class certification, which defendants opposed. In March 2021, the Court issued an order terminating the pending motion for class certification until the Court determines the standard of review applicable to providers' claims. In May 2021, the defendants and provider plaintiffs filed renewed standard of review motions which are now fully briefed. In June 2021, the parties filed summary judgment motions not critically dependent on class certification, which are now fully briefed. We intend to continue to vigorously defend the provider suit; however, its ultimate outcome cannot be presently determined.

Blue Cross of California Taxation Litigation

In July 2013, our California affiliate Blue Cross of California (doing business as Anthem Blue Cross) ("BCC") was named as a defendant in a California taxpayer action filed in Los Angeles County Superior Court (the "Superior Court") captioned *Michael D. Myers v. State Board of Equalization, et al.* This action was brought under a California statute that permits an individual taxpayer to sue a governmental agency when the taxpayer believes the agency has failed to enforce governing law. Plaintiff contends that BCC, a licensed Health Care Service Plan, is an "insurer" for purposes of taxation despite acknowledging it is not an "insurer" under regulatory law. At the time, under California law, "insurers" were required to pay a gross premiums tax ("GPT") calculated as 2.35% on gross premiums. As a licensed Health Care Service Plan, BCC has paid the California Corporate Franchise Tax ("CFT"), the tax paid by California businesses generally. Plaintiff contends that BCC must pay the GPT rather than the CFT, and seeks a writ of mandate directing the taxing agencies to collect the GPT and an order requiring BCC to pay GPT back taxes, interest, and penalties for the eight-year period prior to the filing of the complaint.

Because the GPT is constitutionally imposed in lieu of certain other taxes, BCC has filed protective tax refund claims with the City of Los Angeles, the California Department of Health Care Services and the Franchise Tax Board to protect its rights to recover certain taxes previously paid should BCC eventually be determined to be subject to the GPT for the tax periods at issue in the litigation.

In March 2018, the Superior Court denied BCC's motion for judgment on the pleadings and similar motions brought by other entities. BCC filed a motion for summary judgment with the Superior Court, which was heard in October 2020. In December 2020, the Superior Court granted BCC's motion for summary judgment, dismissing the plaintiff's lawsuit. Plaintiff has appealed the order granting summary judgment. We estimate that the briefing on the appeal will be complete by the end of 2021 and that oral arguments will be scheduled sometime in 2022. We intend to vigorously defend the appeal of this lawsuit.

Express Scripts, Inc. Pharmacy Benefit Management Litigation

In March 2016, we filed a lawsuit against Express Scripts, Inc. ("Express Scripts"), our vendor at the time for PBM services, captioned *Anthem, Inc. v. Express Scripts, Inc.*, in the U.S. District Court for the Southern District of New York. The lawsuit seeks to recover over $14,800 in damages for pharmacy pricing that is higher than competitive benchmark pricing under the agreement between the parties (the "ESI PBM Agreement"), over $158 in damages related to operational breaches, as well as various declarations under the ESI PBM Agreement, including that Express Scripts: (i) breached its obligation to negotiate in good faith and to agree in writing to new pricing terms; (ii) was required to provide competitive benchmark pricing to us through the term of the ESI PBM Agreement; (iii) has breached the ESI PBM Agreement; and (iv) is required under the ESI PBM Agreement to provide post-termination services, at competitive benchmark pricing, for one year following any termination.

Express Scripts has disputed our contractual claims and is seeking declaratory judgments: (i) regarding the timing of the periodic pricing review under the ESI PBM Agreement, and (ii) that it has no obligation to ensure that we receive any specific level of pricing, that we have no contractual right to any change in pricing under the ESI PBM Agreement and that its sole obligation is to negotiate proposed pricing terms in good faith. In the alternative, Express Scripts claims that we have been unjustly enriched by its payment of $4,675 at the time we entered into the ESI PBM Agreement. In March 2017, the court granted our motion to dismiss Express Scripts' counterclaims for (i) breach of the implied covenant of good faith and fair dealing and (ii) unjust enrichment with prejudice. The only remaining claims are for breach of contract and declaratory

relief. In August 2021, Express Scripts filed a motion for summary judgment. Our opposition to the motion is due in October 2021, and Express Scripts' reply to our opposition is due in November 2021. We intend to vigorously pursue our claims and defend against any counterclaims, which we believe are without merit; however, the ultimate outcome cannot be presently determined.

In re Express Scripts/Anthem ERISA Litigation

We are a defendant in a class action lawsuit that was initially filed in June 2016 against Anthem, Inc. and Express Scripts, which has been consolidated into a single multi-district lawsuit captioned *In re Express Scripts/Anthem ERISA Litigation,* in the U.S. District Court for the Southern District of New York. The consolidated complaint was filed by plaintiffs against Express Scripts and us on behalf of all persons who are participants in or beneficiaries of any ERISA or non-ERISA healthcare plan from December 1, 2009 to December 31, 2019 in which we provided prescription drug benefits through the ESI PBM Agreement and paid a percentage based co-insurance payment in the course of using that prescription drug benefit. The plaintiffs allege that we breached our duties, either under ERISA or with respect to the implied covenant of good faith and fair dealing implied in the health plans, (i) by failing to adequately monitor Express Scripts' pricing under the ESI PBM Agreement, (ii) by placing our own pecuniary interest above the best interests of our insureds by allegedly agreeing to higher pricing in the ESI PBM Agreement in exchange for the purchase price for our NextRx PBM business, and (iii) with respect to the non-ERISA members, by negotiating and entering into the ESI PBM Agreement that was allegedly detrimental to the interests of such non-ERISA members. Plaintiffs seek to hold us and Express Scripts jointly and severally liable and to recover all losses allegedly suffered by the proposed class, equitable relief, disgorgement of alleged ill-gotten gains, injunctive relief, attorney's fees and costs and interest.

In April 2017, we filed a motion to dismiss the claims brought against us, and it was granted, without prejudice, in January 2018. Plaintiffs filed a notice of appeal with the United States Court of Appeals for the Second Circuit (the "Second Circuit"), which was heard in October 2018. In December 2020, the Second Circuit affirmed the trial court's decision dismissing the ERISA complaint. Plaintiffs filed a Petition for Rehearing and Rehearing En Banc. Plaintiff's Petition for Rehearing was denied. Plaintiffs filed a Writ of Certiorari with the U.S. Supreme Court, which we have opposed. We intend to vigorously defend this suit; however, its ultimate outcome cannot be presently determined.

Medicare Risk Adjustment Litigation

In March 2020, the U.S. Department of Justice ("DOJ") filed a civil lawsuit against Anthem, Inc. in the U.S. District Court for the Southern District of New York in a case captioned *United States v. Anthem, Inc*. The DOJ's suit alleges, among other things, that we falsely certified the accuracy of the diagnosis data we submitted to the Centers for Medicare and Medicaid Services ("CMS") for risk-adjustment purposes under Medicare Part C and knowingly failed to delete inaccurate diagnosis codes. The DOJ further alleges that, as a result of these purported acts, we caused CMS to calculate the risk-adjustment payments based on inaccurate diagnosis information, which enabled us to obtain unspecified amounts of payments in Medicare funds in violation of the False Claims Act. The DOJ filed an amended complaint in July 2020, alleging the same causes of action but revising some of its allegations. In September 2020, we filed a motion to transfer the lawsuit to the Southern District of Ohio, a motion to dismiss part of the lawsuit, and a motion to strike certain allegations in the amended complaint. The motions are fully briefed and no decision has been rendered. We intend to continue to vigorously defend this suit; however, the ultimate outcome cannot be presently determined.

Investigations of CareMore and HealthSun

With the assistance of outside counsel, we are conducting investigations of risk-adjustment practices involving data submitted to CMS (unrelated to our retrospective chart review program) at CareMore Health Plans, Inc. ("CareMore"), one of our California subsidiaries, and HealthSun Health Plans, Inc. ("HealthSun"), one of our Florida subsidiaries. Our CareMore investigation has resulted in the termination of CareMore's relationship with one contracted provider in California. Our HealthSun investigation focuses on risk adjustment practices initiated prior to our acquisition of HealthSun in December 2017 that continued after the acquisition. We have voluntarily self-disclosed the existence of both of our investigations to CMS and the Criminal Division of the DOJ, and most recently, to the Civil Division of the DOJ. We are cooperating with the ongoing investigations of the Criminal and Civil Divisions related to these risk adjustment practices. We are in the process of analyzing the scope of potential data corrections to be submitted to CMS. We have also asserted indemnity claims for escrowed funds under the HealthSun purchase agreement for, among other things, breach of healthcare and financial

representation provisions, based on the conduct discovered during our investigation. We are in active litigation with two groups of sellers regarding part of the escrowed funds in cases captioned *Shareholder Representative Services, LLC v. ATH Holding Company, LLC and Highland Acquisition Holdings, LLC* and *LPPAS Representative, LLC v. ATH Holding Company, LLC,* both pending in the Delaware Court of Chancery.

Other Contingencies

From time to time, we and certain of our subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. We, like HMOs and health insurers generally, exclude certain healthcare and other services from coverage under our HMO, PPO and other plans. We are, in the ordinary course of business, subject to the claims of our enrollees arising out of decisions to restrict or deny reimbursement for uncovered services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on us. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable reimbursement of coverage claims.

In addition to the lawsuits described above, we are also involved in other pending and threatened litigation of the character incidental to our business, and are from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits, reviews and administrative proceedings include routine and special inquiries by state insurance departments, state attorneys general, the U.S. Attorney General and subcommittees of the U.S. Congress. Such investigations, audits, reviews and administrative proceedings could result in the imposition of civil or criminal fines, penalties, other sanctions and additional rules, regulations or other restrictions on our business operations. Any liability that may result from any one of these actions, or in the aggregate, could have a material adverse effect on our consolidated financial position or results of operations.

Contractual Obligations and Commitments

In March 2020, we entered into an agreement with a vendor for information technology infrastructure and related management and support services through June 2025. The new agreement supersedes certain prior agreements for such services and includes provisions for additional services not provided under those agreements. Our remaining commitment under this agreement at September 30, 2021 is approximately $1,104. We will have the ability to terminate the agreement upon the occurrence of certain events, subject to early termination fees.

In the second quarter of 2019, we began using our pharmacy benefits manager IngenioRx to market and offer PBM services to our affiliated health plan customers, as well as to external customers outside of the health plans we own. The comprehensive prescription benefits management services portfolio includes, but is not limited to, formulary management, pharmacy networks, prescription drug database, member services and mail order capabilities. IngenioRx delegates certain PBM administrative functions, such as claims processing and prescription fulfillment, to CaremarkPCS Health, L.L.C., which is a subsidiary of CVS Health Corporation, pursuant to a five-year agreement. With IngenioRx, we retain the responsibilities for clinical and formulary strategy and development, member and employer experiences, operations, sales, marketing, account management and retail network strategy.

12. Capital Stock

Use of Capital – Dividends and Stock Repurchase Program

We regularly review the appropriate use of capital, including acquisitions, common stock and debt security repurchases and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors.

A summary of our cash dividend activity for the nine months ended September 30, 2021 and 2020 is as follows:

Declaration Date	Record Date	Payment Date	Cash Dividend per Share	Total
Nine Months Ended September 30, 2021				
January 26, 2021	March 10, 2021	March 25, 2021	$1.13	$ 277
April 20, 2021	June 10, 2021	June 25, 2021	$1.13	$ 278
July 20, 2021	September 10, 2021	September 24, 2021	$1.13	$ 276
Nine Months Ended September 30, 2020				
January 28, 2020	March 16, 2020	March 27, 2020	$0.95	$ 240
April 28, 2020	June 10, 2020	June 25, 2020	$0.95	$ 242
July 28, 2020	September 10, 2020	September 25, 2020	$0.95	$ 238

On October 19, 2021, our Audit Committee declared a fourth quarter 2021 dividend to shareholders of $1.13 per share, payable on December 21, 2021 to shareholders of record at the close of business on December 3, 2021.

Under our Board of Directors' authorization, we maintain a common stock repurchase program. On January 26, 2021, our Audit Committee, pursuant to authorization granted by the Board of Directors, authorized a $5,000 increase to the common stock repurchase program. Repurchases may be made from time to time at prevailing market prices, subject to certain restrictions on volume, pricing and timing. The repurchases are effected from time to time in the open market, through negotiated transactions, including accelerated share repurchase agreements, and through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. Our stock repurchase program is discretionary, as we are under no obligation to repurchase shares. We repurchase shares under the program when we believe it is a prudent use of capital. The excess cost of the repurchased shares over par value is charged on a pro rata basis to additional paid-in capital and retained earnings.

A summary of common stock repurchases for the nine months ended September 30, 2021 and 2020 is as follows:

	Nine Months Ended September 30	
	2021	2020
Shares repurchased	3.9	5.0
Average price per share	$ 356.43	$ 269.15
Aggregate cost	$ 1,378	$ 1,342
Authorization remaining at the end of the period	$ 4,714	$ 2,450

For additional information regarding the use of capital for debt security repurchases, see Note 10, "Debt," included in this Form 10-Q and Note 13, "Debt," to our audited consolidated financial statements as of and for the year ended December 31, 2020 included in our 2020 Annual Report on Form 10-K.

Stock Incentive Plans

A summary of stock option activity for the nine months ended September 30, 2021 is as follows:

	Number of Shares	Weighted-Average Option Price per Share	Weighted-Average Remaining Contractual Life (Years)	Aggregate Intrinsic Value
Outstanding at January 1, 2021	3.1	$ 230.00		
Granted	0.7	313.48		
Exercised	(0.6)	196.29		
Forfeited or expired	(0.1)	285.46		
Outstanding at September 30, 2021	3.1	254.23	6.90	$ 364
Exercisable at September 30, 2021	1.6	215.64	5.67	$ 250

A summary of the nonvested restricted stock activity, including restricted stock units, for the nine months ended September 30, 2021 is as follows:

	Restricted Stock Shares and Units	Weighted-Average Grant Date Fair Value per Share
Nonvested at January 1, 2021	1.3	$ 272.51
Granted	1.0	315.54
Vested	(0.9)	244.82
Forfeited	(0.1)	289.45
Nonvested at September 30, 2021	1.3	298.12

During the nine months ended September 30, 2021, we granted approximately 0.3 restricted stock units that are contingent upon us achieving earnings targets over the three year period from 2021 to 2023. These grants have been included in the activity shown above, but will be subject to adjustment at the end of 2023 based on results in the three year period.

During the nine months ended September 30, 2021, we granted an additional 0.4 restricted stock units associated with our 2018 grants that were earned as a result of satisfactory completion of performance measures between 2018 and 2020. These grants and vested shares have been included in the activity shown above.

Fair Value

We use a binomial lattice valuation model to estimate the fair value of all stock options granted. For a more detailed discussion of our stock incentive plan fair value methodology, see Note 15, “Capital Stock,” to our audited consolidated financial statements as of and for the year ended December 31, 2020 included in our 2020 Annual Report on Form 10-K.

The following weighted-average assumptions were used to estimate the fair values of options granted during the nine months ended September 30, 2021 and 2020:

	Nine Months Ended September 30	
	2021	2020
Risk-free interest rate	1.44 %	1.30 %
Volatility factor	30.00 %	26.00 %
Quarterly dividend yield	0.360 %	0.350 %
Weighted-average expected life (years)	5.50	4.30

The following weighted-average fair values per option or share were determined for the nine months ended September 30, 2021 and 2020:

	Nine Months Ended September 30	
	2021	2020
Options granted during the period	$ 79.51	$ 54.02
Restricted stock awards granted during the period	315.54	272.11

13. Accumulated Other Comprehensive Loss

A reconciliation of the components of accumulated other comprehensive loss at September 30, 2021 and 2020 is as follows:

	September 30	
	2021	2020
Investments:		
Gross unrealized gains	$ 986	$ 1,136
Gross unrealized losses	(107)	(245)
Net pre-tax unrealized gains	879	891
Deferred tax liability	(210)	(216)
Adjustment for noncontrolling interest	(3)	—
Net unrealized gains on investments	666	675
Non-credit components of impairments on investments:		
Gross unrealized losses	(1)	(11)
Deferred tax asset	—	3
Net unrealized non-credit component of impairments on investments	(1)	(8)
Cash flow hedges:		
Gross unrealized losses	(304)	(319)
Deferred tax asset	64	67
Net unrealized losses on cash flow hedges	(240)	(252)
Defined benefit pension plans:		
Deferred net actuarial loss	(710)	(695)
Deferred prior service credits	—	(1)
Deferred tax asset	180	178
Net unrecognized periodic benefit costs for defined benefit pension plans	(530)	(518)
Postretirement benefit plans:		
Deferred net actuarial loss	(3)	(25)
Deferred prior service costs	9	14
Deferred tax (liability) asset	(2)	3
Net unrecognized periodic benefit credit (costs) for postretirement benefit plans	4	(8)
Foreign currency translation adjustments:		
Gross unrealized losses	(3)	(1)
Deferred tax asset	1	—
Net unrealized losses on foreign currency translation adjustments	(2)	(1)
Accumulated other comprehensive loss	$ (103)	$ (112)

Other comprehensive (loss) income reclassification adjustments for the three months ended September 30, 2021 and 2020 are as follows:

	Three Months Ended September 30	
	2021	2020
Investments:		
Net holding (loss) gain on investment securities arising during the period, net of tax benefit (expense) of $25 and ($43), respectively	$ (80)	$ 152
Reclassification adjustment for net realized gain on investment securities, net of tax expense of $5 and $10, respectively	(17)	(39)
Total reclassification adjustment on investments	(97)	113
Non-credit component of impairments on investments:		
Non-credit component of impairments on investments, net of tax expense of $0 and ($5), respectively	(1)	16
Cash flow hedges:		
Holding gain, net of tax expense of ($0) and ($0), respectively	4	4
Other:		
Net change in unrecognized periodic benefit costs for defined benefit pension and postretirement benefit plans, net of tax expense of ($4) and ($2), respectively	8	8
Foreign currency translation adjustment, net of tax benefit (expense) of $1 and ($1), respectively	(1)	1
Net (loss) gain recognized in other shareholders' comprehensive income, net of tax benefit (expense) of $27 and ($41), respectively	(87)	142
Net loss related to noncontrolling interests, net of tax benefit of $0 and $0, respectively	1	—
Net (loss) gain recognized in other comprehensive (loss) income, net of tax benefit (expense) of $27 and ($41), respectively	$ (86)	$ 142

Other comprehensive (loss) income reclassification adjustments for the nine months ended September 30, 2021 and 2020 are as follows:

	Nine Months Ended September 30	
	2021	2020
Investments:		
Net holding (loss) gain on investment securities arising during the period, net of tax benefit (expense) of $71 and ($68), respectively	$ (203)	$ 182
Reclassification adjustment for net realized gain on investment securities, net of tax expense of $21 and $7, respectively	(81)	(28)
Total reclassification adjustment on investments	(284)	154
Non-credit component of impairments on investments:		
Non-credit component of impairments on investments, net of tax (expense) benefit of ($1) and $2, respectively	1	(6)
Cash flow hedges:		
Holding gain, net of tax expense of ($2) and ($2), respectively	10	10
Other:		
Net change in unrecognized periodic benefit costs for defined benefit pension and postretirement benefit plans, net of tax expense of ($10) and ($9), respectively	26	25
Foreign currency translation adjustment, net of tax benefit (expense) of $2 and ($1), respectively	(7)	1
Net (loss) gain recognized in other shareholders' comprehensive income, net of tax benefit (expense) of $81 and ($71), respectively	(254)	184
Net loss related to noncontrolling interests, net of tax benefit of $1 and $0, respectively	1	—
Net (loss) gain recognized in other comprehensive (loss) income, net of tax benefit (expense) of $82 and ($71), respectively	$ (253)	$ 184

14. Earnings per Share

The denominator for basic and diluted earnings per share for the three and nine months ended September 30, 2021 and 2020 is as follows:

	Three Months Ended September 30		Nine Months Ended September 30	
	2021	2020	2021	2020
Denominator for basic earnings per share – weighted-average shares	243.4	251.0	244.3	251.9
Effect of dilutive securities – employee stock options, nonvested restricted stock awards and convertible debentures	2.6	3.2	2.9	3.4
Denominator for diluted earnings per share	246.0	254.2	247.2	255.3

During the three months ended September 30, 2021 and 2020, weighted-average shares related to certain stock options of 0.0 and 1.6, respectively, were excluded from the denominator for diluted earnings per share because the stock options were anti-dilutive. During the nine months ended September 30, 2021 and 2020, weighted-average shares related to certain stock options of 0.3 and 1.4, respectively, were excluded from the denominator for diluted earnings per share because the stock options were anti-dilutive.

During the three and nine months ended September 30, 2021, we issued approximately 0.1 and 1.0 restricted stock units, respectively, under our stock incentive plans, 0.3 of which vesting is contingent upon us meeting specified annual earnings targets for the three year period of 2021 through 2023. During the three and nine months ended September 30, 2020, we issued approximately 0.0 and 1.3 restricted stock units, respectively, under our stock incentive plans, 0.3 of which vesting is contingent upon us meeting specified annual earnings targets for the three year period of 2020 through 2022. The contingent restricted stock units have been excluded from the denominator for diluted earnings per share and will be included only if and when the contingency is met.

15. Segment Information

The results of our operations are described through four reportable segments: Commercial & Specialty Business, Government Business, IngenioRx and Other.

Our Commercial & Specialty Business segment offers plans and services to our Individual, Group risk-based, Group fee-based, BlueCard, and Specialty customers. The Commercial & Specialty Business segment offers health products on a full-risk basis; provides a broad array of managed care services to fee-based customers, including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services; and provides an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits.

Our Government Business segment includes our Medicare and Medicaid businesses, National Government Services ("NGS"), and services provided to the federal government in connection with the FEHB program. Our Medicare business includes services such as Medicare Supplement plans; Medicare Advantage, including Special Needs Plans; Medicare Part D; and dual-eligible programs through Medicare-Medicaid Plans. Medicare Advantage membership also includes Medicare Advantage members in our Group Retiree Solutions business who are retired members of Commercial accounts or retired members of groups who are not affiliated with our Commercial accounts who have selected a Medicare Advantage product through us. Our Medicaid business includes our managed care alternatives through publicly funded healthcare programs, including Medicaid, Medicaid expansion programs related to the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended, Temporary Assistance for Needy Families programs, programs for seniors and people with disabilities, Children's Health Insurance Programs, and specialty programs such as those focused on long-term services and support, HIV/AIDS, foster care, behavioral health and/or substance abuse disorders, and intellectual disabilities or developmental disabilities. NGS acts as a Medicare contractor for the federal government in several regions across the nation.

Our IngenioRx segment includes our PBM business, which began its operations during the second quarter of 2019. IngenioRx markets and offers PBM services to our affiliated health plan customers, as well as to external customers outside of the health plans we own. IngenioRx has a comprehensive PBM services portfolio, which includes services such as formulary management, pharmacy networks, prescription drug database, member services and mail order capabilities.

Our Other segment includes our Diversified Business Group ("DBG"), which is our integrated health services business, and certain eliminations and corporate expenses not allocated to our other reportable segments.

Affiliated revenues represent revenues or cost for services provided by IngenioRx and DBG to our subsidiaries, are recorded at cost or management's estimate of fair market value, and are eliminated in consolidation.

Financial data by reportable segment for the three and nine months ended September 30, 2021 and 2020 is as follows:

	Commercial & Specialty Business	Government Business	IngenioRx	Other	Eliminations	Total
Three Months Ended September 30, 2021						
Operating revenue - unaffiliated	$ 9,863	$ 21,658	$ 3,369	$ 658	$ —	$ 35,548
Operating revenue - affiliated	—	—	3,180	2,012	(5,192)	—
Operating gain	620	967	445	27	—	2,059
Three Months Ended September 30, 2020						
Operating revenue - unaffiliated	$ 9,326	$ 18,101	$ 2,598	$ 624	$ —	$ 30,649
Operating revenue - affiliated	—	—	2,984	1,174	(4,158)	—
Operating (loss) gain	(234)	246	345	(156)	—	201
Nine Months Ended September 30, 2021						
Operating revenue - unaffiliated	$ 28,904	$ 61,007	$ 9,131	$ 1,883	$ —	$ 100,925
Operating revenue - affiliated	—	—	9,499	5,674	(15,173)	—
Operating gain	2,679	2,313	1,257	52	—	6,301
Nine Months Ended September 30, 2020						
Operating revenue - unaffiliated	$ 27,476	$ 52,809	$ 7,485	$ 1,505	$ —	$ 89,275
Operating revenue - affiliated	—	—	8,563	2,772	(11,335)	—
Operating gain (loss)	2,558	2,275	998	(76)	—	5,755

The major product revenues for each of the reportable segments for the three and nine months ended September 30, 2021 and 2020 are as follows:

	Three Months Ended September 30		Nine Months Ended September 30	
	2021	2020	2021	2020
Commercial & Specialty Business				
Managed care products	$ 8,005	$ 7,523	$ 23,481	$ 22,209
Managed care services	1,489	1,391	4,291	4,036
Dental/Vision products and services	342	318	1,013	917
Other	27	94	119	314
Total Commercial & Specialty Business	9,863	9,326	28,904	27,476
Government Business				
Managed care products	21,565	17,999	60,711	52,523
Managed care services	93	102	296	286
Total Government Business	21,658	18,101	61,007	52,809
IngenioRx				
Pharmacy products and services	6,549	5,582	18,630	16,048
Total IngenioRx	6,549	5,582	18,630	16,048
Other				
Integrated health services	2,506	1,716	7,121	4,040
Other	164	82	436	237
Total Other Business	2,670	1,798	7,557	4,277
Eliminations				
Eliminations	(5,192)	(4,158)	(15,173)	(11,335)
Total product revenues	$ 35,548	$ 30,649	$ 100,925	$ 89,275

The classification between managed care products and managed care services in the above table primarily distinguishes between the levels of risk assumed. Managed care products represent insurance products where we bear the insurance risk, whereas managed care services represent product offerings where we provide claims adjudication and other administrative services to the customer, but the customer principally bears the insurance risk.

A reconciliation of reportable segments' operating revenue to the amounts of total revenues included in our consolidated statements of income for the three and nine months ended September 30, 2021 and 2020 is as follows:

	Three Months Ended September 30		Nine Months Ended September 30	
	2021	2020	2021	2020
Reportable segments' operating revenue	$ 35,548	$ 30,649	$100,925	$ 89,275
Net investment income	335	280	1,026	591
Net realized (losses) gains on financial instruments	(61)	229	107	177
Total revenues	$ 35,822	$ 31,158	$102,058	$ 90,043

A reconciliation of reportable segments' operating gain to income before income tax expense included in our consolidated statements of income for the three and nine months ended September 30, 2021 and 2020 is as follows:

	Three Months Ended September 30		Nine Months Ended September 30	
	2021	2020	2021	2020
Reportable segments' operating gain	$ 2,059	$ 201	$ 6,301	$ 5,755
Net investment income	335	280	1,026	591
Net realized (losses) gains on financial instruments	(61)	229	107	177
Interest expense	(201)	(198)	(598)	(593)
Amortization of other intangible assets	(136)	(93)	(306)	(269)
Loss on extinguishment of debt	—	(30)	(5)	(34)
Income before income tax expense	$ 1,996	$ 389	$ 6,525	$ 5,627

16. Leases

We lease office space and certain computer and related equipment using noncancellable operating leases. Our leases have remaining lease terms of 1 year to 13 years.

The information related to our leases is as follows:

	Balance Sheet Location	September 30, 2021	December 31, 2020
Operating Leases			
Right-of-use assets	Other noncurrent assets	$ 685	$ 646
Lease liabilities, current	Other current liabilities	141	110
Lease liabilities, noncurrent	Other noncurrent liabilities	806	847

	Three Months Ended September 30		Nine Months Ended September 30	
	2021	2020	2021	2020
Lease Expense				
Operating lease expense	$ 37	$ 272	$ 100	$ 378
Short-term lease expense	10	11	34	38
Sublease income	(1)	(1)	(3)	(8)
Total lease expense	$ 46	$ 282	$ 131	$ 408
Other information				
Operating cash paid for amounts included in the measurement of lease liabilities, operating leases	$ 53	$ 47	$ 141	$ 137
Right-of-use assets obtained in exchange for new lease liabilities, operating leases	$ 32	$ 17	$ 192	$ 372

As of September 30, 2021 and December 31, 2020, the weighted average remaining lease term of our operating leases was 6 years and 7 years, respectively. The lease liabilities reflect a weighted average discount rate of 2.82% at September 30, 2021 and 3.21% at December 31, 2020.

The operating lease expense for the three and nine months ended September 30, 2020 shown above included an impairment charge of $224 for affected right-of-use assets for reducing our office space footprint.

Future lease payments for noncancellable operating leases with initial or remaining terms of one year or more are as follows:

2021 (excluding the nine months ended September 30, 2021)	$	53
2022		209
2023		189
2024		161
2025		119
Thereafter		353
Total future minimum payments		1,084
Less imputed interest		(137)
Total lease liabilities	$	947

As of September 30, 2021, we have additional operating leases for building spaces that have not yet commenced, and some building spaces are being constructed by the lessors and their agents. These leases have terms of up to 11 years and are expected to commence on various dates during the fourth quarter of 2021 when the construction is complete and we take possession of the buildings. The undiscounted lease payments for these leases, which are not included in the tables above, aggregate to $65.

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

(In Millions, Except Per Share Data or as Otherwise Stated Herein)

This Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") should be read in conjunction with the accompanying consolidated financial statements and notes, our consolidated financial statements and notes as of and for the year ended December 31, 2020 and the MD&A included in our 2020 Annual Report on Form 10-K. References to the terms "we," "our," "us," or "Anthem" used throughout this MD&A refer to Anthem, Inc., an Indiana corporation, and unless the context otherwise requires, its direct and indirect subsidiaries. References to the "states" include the District of Columbia and Puerto Rico, unless the context otherwise requires.

Results of operations, cost of care trends, investment yields and other measures for the three and nine months ended September 30, 2021 are not necessarily indicative of the results and trends that may be expected for the full year ending December 31, 2021, or any other period.

Overview

We are one of the largest health benefits companies in the United States in terms of medical membership, serving approximately 45 medical members through our affiliated health plans as of September 30, 2021. We are an independent licensee of the Blue Cross and Blue Shield Association ("BCBSA"), an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield ("BCBS") licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (in the New York City metropolitan area and upstate New York), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas, we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, and Empire Blue Cross Blue Shield or Empire Blue Cross. We also conduct business through arrangements with other BCBS licensees as well as other strategic partners. Through our subsidiaries, we also serve customers in numerous states and Puerto Rico as AIM Specialty Health, Amerigroup, Aspire Health, Beacon, CareMore, Freedom Health, HealthLink, HealthSun, MMM, Optimum HealthCare, Simply Healthcare, and/or UniCare. Pharmacy benefits management ("PBM") services are offered through our IngenioRx subsidiary. We are licensed to conduct insurance operations in all fifty states, the District of Columbia and Puerto Rico through our subsidiaries.

For additional information about our organization, see Part I, Item 1, "Business" and Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations," included in our 2020 Annual Report on Form 10-K. Additional information on our segments can be found in this MD&A and in Note 15, "Segment Information" of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Form 10-Q.

COVID-19

The COVID-19 pandemic continues to impact the global economy, cause market instability and put pressure on the healthcare system, and it has impacted, and will likely continue to impact, our membership, our benefit expense and our members' behavior, including how members access healthcare. We continue to assist our customers, providers, members and communities in addressing the effects of the COVID-19 pandemic, including by providing expanded benefit coverage for COVID-19 diagnostic tests, treatment and vaccine administration and taking steps to increase vaccinations by enabling, educating, and encouraging vaccine acceptance among our members as well as in the communities in which we operate.

COVID-19 care, testing and vaccine administration, and the impact of new COVID-19 variants, have resulted in increased medical costs for us in 2021. Since June 30, 2020, our Medicaid membership has grown as a result of the temporary suspension of eligibility recertification in response to the COVID-19 pandemic, which will remain suspended at least until the first quarter of 2022. Our Commercial fee-based membership has decreased in this same period due to in-group attrition likely attributable to the COVID-19 pandemic. See "Business Trends - *Medical Cost Trends*" below for a discussion of the impact of COVID-19 on our healthcare costs.

The COVID-19 pandemic continues to evolve and the full extent of its impact will depend on future developments, which are highly uncertain and cannot be predicted at this time. We will continue to monitor the COVID-19 pandemic as well

as resulting legislative and regulatory changes to manage our response and assess and mitigate potential adverse impacts to our business. For additional discussion related to the COVID-19 pandemic and our risk factors, see Part I, Item 1, "Business–COVID-19", Part I, Item 1A, "Risk Factors" and Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations–COVID-19" included in our 2020 Annual Report on Form 10-K.

Business Trends

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended (collectively, the "ACA") has changed and may continue to make broad-based changes to the U.S. healthcare system. In June 2021, the U.S. Supreme Court issued its opinion and dismissed the latest legal challenge to the constitutionality of the ACA, leaving the law intact. We expect the ACA will continue to impact our business model and strategy. In 2020, we made the decision to modestly expand our participation in the Individual ACA-compliant market for 2021. Our strategy has been, and will continue to be, to only participate in rating regions where we have an appropriate level of confidence that these markets are on a path toward sustainability, including, but not limited to, factors such as expected financial performance, regulatory environment, and underlying market characteristics. We currently offer Individual ACA-compliant products in 103 of the 143 rating regions in which we operate. In addition, the continuing growth in our government-sponsored business exposes us to increased regulatory oversight.

Our IngenioRx subsidiary markets and offers PBM services to our affiliated health plan customers throughout the country, as well as to customers outside of the health plans we own. Our comprehensive PBM services portfolio includes services such as formulary management, pharmacy networks, a prescription drug database, member services and mail order capabilities. IngenioRx delegates certain PBM administrative functions, such as claims processing and prescription fulfillment, to CaremarkPCS Health, L.L.C., which is a subsidiary of CVS Health Corporation, pursuant to a five-year agreement. With IngenioRx, we retain the responsibilities for clinical and formulary strategy and development, member and employer experiences, operations, sales, marketing, account management and retail network strategy.

Pricing Trends: We strive to price our healthcare benefit products consistent with anticipated underlying medical cost trends. We continue to closely monitor the COVID-19 pandemic (including new COVID-19 variants, which may be more contagious or severe, or less responsive to treatment or vaccines) and the impacts it may have on our pricing, such as surges in COVID-19 related hospitalizations, infection rates, the cost of COVID-19 vaccines and the return of non-COVID-19 healthcare utilization to our estimate of normal levels, based on historical utilization patterns. We frequently make adjustments to respond to legislative and regulatory changes as well as pricing and other actions taken by existing competitors and new market entrants. Product pricing in our Commercial & Specialty Business segment, including our Individual and Small Group lines of business, remains competitive. Revenues from the Medicare and Medicaid programs are dependent, in whole or in part, upon annual funding from the federal government and/or applicable state governments. The ACA imposed an annual Health Insurance Provider Fee ("HIP Fee") on health insurers that write certain types of health insurance on U.S. risks. When applicable, we priced our affected products to cover the impact of the HIP Fee, including during 2020. The HIP Fee has been permanently repealed beginning in 2021.

Medical Cost Trends: Our medical cost trends are primarily driven by increases in the utilization of services across all provider types and the unit cost increases of these services. We work to mitigate these trends through various medical management programs such as utilization management, condition management, program integrity and specialty pharmacy management, as well as benefit design changes. There are many drivers of medical cost trends that can cause variance from our estimates, such as changes in the level and mix of services utilized, regulatory changes, aging of the population, health status and other demographic characteristics of our members, epidemics, pandemics, advances in medical technology, new high cost prescription drugs, and healthcare provider or member fraud.

The COVID-19 pandemic initially caused a decrease in utilization of non-COVID-19 health services, which decreased our claim costs in 2020. Over the course of the first half of 2021, our non-COVID-19 healthcare utilization experience gradually increased toward normalized levels, while COVID-19 related healthcare expenses declined and COVID-19 vaccination administration costs increased. During the third quarter of 2021, the COVID-19 Delta variant caused a significant increase in COVID-19 related healthcare utilization as a result of increased testing, treatment, and hospitalization costs, which was partially offset by a reduction in non-COVID-19 healthcare utilization. The reduction in non-COVID-19 healthcare utilization was particularly notable in the inpatient setting, as some regions limited elective surgeries in order to preserve limited resources to treat patients hospitalized with COVID-19.

Our expenses in 2020 and the first nine months of 2021 included additional costs to cover COVID-19 related testing, treatment and vaccine administration. In the fourth quarter of 2021, we expect COVID-19 related healthcare expenses to decline from the surge experienced during the third quarter of 2021 related to the Delta variant and utilization of non-COVID-19 healthcare services to recover toward the levels experienced in 2021 prior to the Delta surge. We anticipate additional COVID-19 vaccination costs as young children become eligible for the vaccine and more adults choose to receive the vaccine and booster doses. Further increases and pent-up demand in the utilization of non-COVID-19 healthcare services, as well as increases in acuity associated with deferred services and the long-term health complications of COVID-19, may increase our claim costs in the future and affect our medical cost trends. We continue to monitor the COVID-19 pandemic and its impacts on our business, financial condition, results of operations and medical cost trends.

For additional discussion regarding business trends, see Part I, Item 1, “Business” included in our 2020 Annual Report on Form 10-K.

Regulatory Trends and Uncertainties

Federal and state governments have enacted, and may continue to enact, legislation and regulations in response to the COVID-19 pandemic that have had, and we expect will continue to have, a significant impact on healthcare benefits, consumer eligibility for public programs and our cash flows for all of our lines of business. These actions, which are or have been in effect for various durations, provide, among other things:

- waivers on cost-sharing on COVID-19 testing, treatment, vaccines and related services;
- reforms, including waiving Medicare originating site restrictions for qualified providers providing telehealth services;
- financial support to healthcare providers, including expansion of the Medicare accelerated payment program to all providers receiving Medicare payments;
- mandated expansion of premium payment terms, including the time period for which claims can be denied for lack of payment; and
- mandates related to prior authorizations and payment levels to providers, additional consumer enrollment windows and an increased ability to provide telehealth services.

The Consolidated Appropriations Act of 2021, which was enacted in December 2020 (the “Appropriations Act”), contains a number of provisions that may have a material effect upon our business, including procedures and coverage requirements related to surprise medical bills and new mandates for continuity of care for certain patients, price comparison tools, disclosure of broker compensation and reporting on pharmacy benefits and drug costs. The health plan-related requirements of the Appropriations Act have varying effective dates beginning as early as December 2021, some of which have been extended since the enactment of the Appropriations Act.

The American Rescue Plan Act of 2021, (the “Rescue Plan”), which was enacted in March 2021, contains several health-related provisions that have impacted our business, including expansion of premium tax credits for our Individual exchange business and full subsidization of the Consolidated Omnibus Budget Reconciliation Act (“COBRA”) continuation coverage for those who were involuntarily terminated or had their work hours reduced. The Rescue Plan’s premium tax provisions became effective in January 2021, while the COBRA premium subsidization extended from April through September 2021.

The ACA presented us with new growth opportunities, but also introduced new risks, regulatory challenges and uncertainties, and required changes in the way products are designed, underwritten, priced, distributed and administered. Changes to our business environment are likely to continue as elected officials at the national and state levels continue to enact, and both elected officials and candidates for election continue to propose, significant modifications to existing laws and regulations, including changes to taxes and fees. We will continue to evaluate the impact of the ACA as any further developments or judicial rulings occur.

For additional discussion regarding regulatory trends and uncertainties and risk factors, see Part I, Item 1, “Business – Regulation”, Part I, Item 1A, “Risk Factors”, and the “Regulatory Trends and Uncertainties” section of Part II, Item 7, “Management’s Discussion and Analysis of Financial Condition and Results of Operations” included in our 2020 Annual Report on Form 10-K.

Other Significant Items

Business and Operational Matters

On June 29, 2021, we completed our acquisition of MMM Holdings, LLC ("MMM") and its Medicare Advantage plan, Medicaid plan and other affiliated companies from InnovaCare Health, L.P. MMM is a Puerto Rico-based integrated healthcare organization and seeks to provide its Medicare Advantage and Medicaid members with a whole health experience through its network of specialized clinics and wholly owned independent physician associations. This acquisition aligns with our vision to be an innovative, valuable and inclusive healthcare partner by providing care management programs that improve the lives of the people we serve.

On April 28, 2021, we completed our acquisition of myNEXUS, Inc. ("myNEXUS") from WindRose Health Investors. myNEXUS is a comprehensive home-based nursing management company for payors and, at the time of acquisition, delivered integrated clinical support services for Medicare Advantage members across twenty states. This acquisition aligns with our strategy to manage integrated, whole person multi-site care and support by providing national, large-scale expertise to manage nursing services in the home and facilitate transitions of care.

On February 28, 2020, we completed our acquisition of Beacon Health Options, Inc. ("Beacon"), the largest independently held behavioral health organization in the country. At the time of acquisition, Beacon served more than thirty-four million individuals across all fifty states. This acquisition aligned with our strategy to diversify into health services and deliver both integrated solutions and care delivery models that personalize care for people with complex and chronic conditions.

For additional information, see Note 3, "Business Acquisitions," of the Notes to Consolidated Financial Statements included in Part 1, Item 1 of this Form 10-Q.

In 2020, we introduced enterprise-wide initiatives to optimize our business, and as a result, recorded a charge of $653 in selling, general and administrative expenses for the year ended December 31, 2020. We believe these initiatives largely represent the next step forward in our progression towards becoming a more agile organization, including process automation and a reduction in our office space footprint. For additional information see Note 4, "Business Optimization Initiatives" and Note 16, "Leases" of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Form 10-Q.

Litigation Matters

In the consolidated multi-district proceeding in the United States District Court for the Northern District of Alabama (the "Court") captioned *In re Blue Cross Blue Shield Antitrust Litigation* ("BCBSA Litigation"), the BCBSA and Blue Cross and/or Blue Shield licensees, including us (the "Blue plans"), have approved a settlement agreement and release (the "Subscriber Settlement Agreement") with the plaintiffs representing a putative nationwide class of health plan subscribers. Generally, the lawsuits in the BCBSA Litigation challenge elements of the licensing agreements between the BCBSA and the independently owned and operated Blue plans. The cases were brought by two putative nationwide classes of plaintiffs, health plan subscribers and providers, and the Subscriber Settlement Agreement applies only to the putative subscriber class. No settlement agreement has been reached with the provider plaintiffs at this time, and the defendants continue to contest the consolidated cases brought by the provider plaintiffs.

If approved by the Court, the Subscriber Settlement Agreement will require the defendants to make a monetary settlement payment, our portion of which is estimated to be $594, and will include certain non-monetary terms. As of September 30, 2021, the liability balance accrued for our estimated remaining payment obligation was $507, net of payments made. All terms of the Subscriber Settlement Agreement are subject to approval by the Court before they become effective. For additional information regarding the BCBSA Litigation, see Note 11, "Commitments and Contingencies – *Litigation and Regulatory Proceedings – Blue Cross Blue Shield Antitrust Litigation*," of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Form 10-Q.

In January 2019, we exercised our contractual right to terminate our PBM agreement (the "ESI PBM Agreement") with Express Scripts, Inc. ("Express Scripts"). We completed the transition of our members from Express Scripts to IngenioRx by January 1, 2020. Notwithstanding our termination of the ESI PBM Agreement, the litigation between us and Express Scripts regarding the ESI PBM Agreement continues. For additional information regarding this lawsuit, see Note 11, "Commitments

and Contingencies – *Litigation and Regulatory Proceedings – Express Scripts, Inc. Pharmacy Benefit Management Litigation,*" of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Form 10-Q.

Selected Operating Performance

For the twelve months ended September 30, 2021, total medical membership increased 2.4, or 5.7%. Our medical membership grew in both our Government Business and Commercial & Specialty Business segments. The increase in our Government Business membership was primarily driven by increases in our Medicaid membership, including organic growth resulting from the temporary suspension of eligibility recertification during the COVID-19 pandemic, which will remain suspended at least until the first quarter of 2022, our acquisition of MMM on June 29, 2021, the launch of our HealthyBlue managed care alliance in North Carolina and organic growth in our Medicare Advantage business. Commercial & Specialty Business membership growth included increases in Group risk-based membership resulting from sales exceeding lapses and increases in Individual membership due to the ACA expansion in 2021, partially offset by declines in Group fee-based membership due to in-group attrition likely resulting from the COVID-19 pandemic.

Operating revenue for the three months ended September 30, 2021 was $35,548, an increase of $4,899, or 16.0%, from the three months ended September 30, 2020. The increase in operating revenue for the three months ended September 30, 2021 compared to 2020 was primarily driven by higher premium revenue due mainly to membership growth in our Government Business segment, including related to our acquisition of MMM, and increased product revenue in our IngenioRx segment. These increases were partially offset by the impact of lower premium revenue associated with the repeal of the HIP Fee for 2021. Operating revenue for the nine months ended September 30, 2021 was $100,925, an increase of $11,650, or 13.0%, from the nine months ended September 30, 2020. The increase in operating revenue for the nine months ended September 30, 2021 compared to 2020 was primarily driven by higher premium revenue due mainly to membership growth in our Government Business segment, including related to the acquisition of MMM, increased product revenue in our IngenioRx segment and premium rate increases in our Commercial & Specialty Business segment. These increases were partially offset by the impact of lower premium revenue associated with the repeal of the HIP Fee for 2021.

Net income for the three months ended September 30, 2021 was $1,502, an increase of $1,280, or 576.6%, from the three months ended September 30, 2020. The increase in net income for the three months ended September 30, 2021 was primarily due to increased operating gain in all of our business segments, primarily the result of the absence of charges in 2021 for our business optimization initiatives and the BCBSA litigation accrual recognized during the third quarter of 2020. Net income for the nine months ended September 30, 2021 was $4,970, an increase of $949, or 23.6% from the nine months ended September 30, 2020. The increase in net income for the nine months ended September 30, 2021 was primarily due to increased operating gain in all of our business segments, primarily due to the absence of charges in 2021 for our business optimization initiatives and the BCBSA litigation accrual recognized during the third quarter of 2020. These operating gain increases were partially offset by increased COVID-19 and non-COVID-19 healthcare costs.

Our fully-diluted shareholders' earnings per share ("EPS") was $6.13 for the three months ended September 30, 2021, which represented a 604.6% increase from EPS of $0.87 for the three months ended September 30, 2020. Our fully-diluted shareholders' EPS was $20.09 for the nine months ended September 30, 2021, which represented a 27.6% increase from fully-diluted EPS of $15.75 for the nine months ended September 30, 2020. The increase in EPS for the three and nine months ended September 30, 2021 compared to 2020 resulted primarily from the increase in net income, as well as lower shares outstanding in 2021.

Operating cash flow for the nine months ended September 30, 2021 and 2020 was $6,692 and $6,875, respectively. The decrease in operating cash flow was primarily driven by the timing of working capital changes, partially offset by higher net income in 2021.

Membership

In the first quarter of 2021, we updated our medical membership reporting to better align with how we view our business. Our medical membership now includes the following customer types: Individual, Group risk-based, Group fee-based, BlueCard®, Medicare, Medicaid and our Federal Employees Health Benefits ("FEHB") Program. BCBS-branded business generally refers to members in our service areas licensed by the BCBSA. Non-BCBS-branded business refers to members in our non-BCBS-branded Amerigroup, Freedom Health, HealthSun, MMM, Optimum HealthCare and Simply Healthcare plans, as well as HealthLink and UniCare members. In addition to the above medical membership, we also serve customers who purchase one or more of our other products or services that are often ancillary to our health business.

- Individual consists of individual customers under age 65 and their covered dependents. Individual policies are generally sold through independent agents and brokers, retail partnerships, our in-house sales force or via the exchanges. Individual business is sold on a risked-based basis. We offer on-exchange products through public exchanges and off-exchange products. Federal premium subsidies are available only for certain public exchange Individual products. Unsubsidized Individual customers are generally more sensitive to product pricing and, to a lesser extent, the configuration of the network and the efficiency of administration. Customer turnover is generally higher with Individual as compared to Group risk-based business.
- Group risk-based consists of employer customers who purchase products on a full-risk basis, which are products for which we charge a premium and indemnify our policyholders against costs for health benefits. Group risk-based accounts include Local Group customers and National Accounts. Local Group consists of those employer customers with less than 5% of eligible employees located outside of the headquarter state, as well as customers with more than 5% of eligible employees located outside of the headquarter state with up to 5,000 eligible employees. In addition, Local Group includes Student Health members. National Accounts generally consist of multi-state employer groups primarily headquartered in an Anthem service area with at least 5% of the eligible employees located outside of the headquarter state and with more than 5,000 eligible employees. Some exceptions are allowed based on broker and consultant relationships. Group risk-based accounts are generally sold through brokers or consultants who work with industry specialists from our in-house sales force and are offered both on and off the public exchanges.
- Group fee-based customers represent employer groups, Local Group, including UniCare members, and National Accounts, who purchase fee-based products and elect to retain most or all of the financial risk associated with their employees' healthcare costs. Some fee-based customers choose to purchase stop loss coverage to limit their retained risk. Group fee-based accounts are generally sold through independent brokers or consultants retained by the customer working with our in-house sales force.
- BlueCard® host customers represent enrollees of Blue Cross and/or Blue Shield plans not owned by Anthem who receive healthcare services in our BCBSA licensed markets. BlueCard® membership consists of estimated host members using the national BlueCard® program. Host members are generally members who reside in or travel to a state in which an Anthem subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer-sponsored health plan issued by a non-Anthem controlled BCBSA licensee (the "home Blue plan"). We perform certain functions, including claims pricing and administration, for BlueCard® members, for which we receive administrative fees from the BlueCard® members' home Blue plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home Blue plan. Host members are computed using, among other things, the average number of BlueCard® claims received per month.
- Medicare customers are Medicare-eligible individual members age 65 and over who have enrolled in Medicare Supplement plans; Medicare Advantage, including Special Needs Plans ("SNPs"), also known as Medicare Advantage SNPs; Medicare Part D; and dual-eligible programs through Medicare-Medicaid Plans ("MMPs"). Medicare Supplement plans typically pay the difference between healthcare costs incurred by a beneficiary and amounts paid by Medicare. Medicare Advantage plans provide Medicare beneficiaries with a managed care alternative to traditional Medicare and often include a Medicare Part D benefit. In addition, our Medicare Advantage SNPs provide tailored benefits to special needs individuals who are institutionalized or have severe or disabling chronic conditions and to dual-eligible customers, who are low-income seniors and persons under age 65 with disabilities. Medicare Advantage SNPs are coordinated care plans specifically designed to provide targeted care, covering all the healthcare services considered medically necessary for members and often providing professional care coordination services, with personal guidance and programs that help members maintain their health. Medicare Advantage membership also includes Medicare Advantage members in our Group Retiree Solutions business who

are retired members of Commercial accounts or retired members of groups who are not affiliated with our Commercial accounts who have selected a Medicare Advantage product through us. Medicare Part D offers a prescription drug plan to Medicare and MMP beneficiaries. MMP, which was established as a result of the passage of the ACA, is a demonstration program focused on serving members who are dually eligible for Medicaid and Medicare. Medicare Supplement and Medicare Advantage products are marketed in the same manner, primarily through independent agents and brokers.

- Medicaid membership represents eligible members who receive healthcare benefits through publicly funded healthcare programs, including Medicaid, ACA-related Medicaid expansion programs, Temporary Assistance for Needy Families, programs for seniors and people with disabilities, Children's Health Insurance Programs, and specialty programs such as those focused on long-term services and support, HIV/AIDS, foster care, behavioral health and/or substance abuse disorders, and intellectual disabilities or developmental disabilities, among others.
- FEHB members consist of United States government employees and their dependents within our geographic markets through our participation in the national contract between the BCBSA and the U.S. Office of Personnel Management.

The following table presents our medical membership by reportable segment and customer type as of September 30, 2021 and 2020. Also included below is other membership by product. The medical membership and other membership data presented are unaudited and in certain instances include estimates of the number of members represented by each contract at the end of the period.

	September 30			
(In thousands)	**2021**	**2020**	**Change**	**% Change**
Medical Membership				
Commercial & Specialty Business:				
Individual	769	701	68	9.7 %
Group Risk-Based	3,946	3,774	172	4.6 %
Commercial Risk-Based	4,715	4,475	240	5.4 %
BlueCard®	6,166	6,106	60	1.0 %
Group Fee-Based	19,370	19,508	(138)	(0.7)%
Commercial Fee-Based	25,536	25,614	(78)	(0.3)%
Total Commercial & Specialty Business	30,251	30,089	162	0.5 %
Government Business:				
Medicare Advantage	1,853	1,416	437	30.9 %
Medicare Supplement	947	933	14	1.5 %
Total Medicare	2,800	2,349	451	19.2 %
Medicaid	10,391	8,569	1,822	21.3 %
Federal Employees Health Benefits	1,629	1,618	11	0.7 %
Total Government Business	14,820	12,536	2,284	18.2 %
Total Medical Membership	45,071	42,625	2,446	5.7 %
Other Membership				
Life and Disability Members	4,695	5,029	(334)	(6.6)%
Dental Members	6,637	6,356	281	4.4 %
Dental Administration Members	1,486	1,315	171	13.0 %
Vision Members	7,974	7,487	487	6.5 %
Medicare Part D Standalone Members	438	405	33	8.1 %

Medical Membership

Total medical membership increased primarily due to growth in our Government Business, which was driven primarily by increases in our Medicaid membership, including organic growth resulting from the temporary suspension of eligibility

recertification during the COVID-19 pandemic, growth resulting from our acquisition of MMM on June 29, 2021 and the launch of our HealthyBlue managed care alliance in North Carolina. Our Medicare Advantage membership also increased due to organic growth. Increases in Group risked-based membership resulting from sales exceeding lapses and increases in Individual membership due to our ACA expansion in 2021 also contributed to overall membership increases. Declines in our Group fee-based membership due to in-group attrition likely attributable to the COVID-19 pandemic partially offset the increases in our medical membership.

Other Membership

Our other membership can be impacted by changes in our medical membership, as our medical members often purchase our other products that are ancillary to our health business. Life and disability membership decreased primarily due to the loss of a Group risked-based account and membership decreases in our Group fee-based business. Dental membership increased primarily due to higher sales in our Individual and Group risk-based accounts and growth in our FEHB program. Dental administration membership increased due to growth in our FEHB program. Vision membership increased as a result of growth in our Medicare business.

Consolidated Results of Operations

Our consolidated summarized results of operations and other financial information for the three and nine months ended September 30, 2021 and 2020 are as follows:

	Three Months Ended September 30		Nine Months Ended September 30		Change: Three Months Ended September 30 2021 vs. 2020		Change: Nine Months Ended September 30 2021 vs. 2020	
	2021	2020	2021	2020	$	%	$	%
Total operating revenue	$35,548	$30,649	$100,925	$89,275	$ 4,899	16.0 %	$ 11,650	13.0 %
Net investment income	335	280	1,026	591	55	19.6 %	435	73.6 %
Net realized (losses) gains on financial instruments	(61)	229	107	177	(290)	NM	(70)	(39.5)%
Total revenues	35,822	31,158	102,058	90,043	4,664	15.0 %	12,015	13.3 %
Benefit expense	26,645	22,921	75,107	63,957	3,724	16.2 %	11,150	17.4 %
Cost of products sold	2,898	2,222	7,825	6,431	676	30.4 %	1,394	21.7 %
Selling, general and administrative expense	3,946	5,305	11,692	13,132	(1,359)	(25.6)%	(1,440)	(11.0)%
Other expense[1]	337	321	909	896	16	5.0 %	13	1.5 %
Total expenses	33,826	30,769	95,533	84,416	3,057	9.9 %	11,117	13.2 %
Income before income tax expense	1,996	389	6,525	5,627	1,607	413.1 %	898	16.0 %
Income tax expense	494	167	1,555	1,606	327	195.8 %	(51)	(3.2)%
Net income	$ 1,502	$ 222	$ 4,970	$ 4,021	$ 1,280	576.6 %	$ 949	23.6 %
Net loss (income) attributable to noncontrolling interests	7	—	(3)	—	7	NM	(3)	NM
Shareholders' net income	$ 1,509	$ 222	$ 4,967	$ 4,021	$ 1,287	579.7 %	$ 946	23.5 %
Average diluted shares outstanding	246.0	254.2	247.2	255.3	(8.2)	(3.2)%	(8.1)	(3.2)%
Diluted shareholders' net income per share	$ 6.13	$ 0.87	$ 20.09	$ 15.75	$ 5.26	604.6 %	$ 4.34	27.6 %
Effective tax rate	24.7 %	42.9 %	23.8 %	28.5 %		(1820) bp[3]		(470) bp[3]
Benefit expense ratio[2]	87.7 %	86.8 %	86.7 %	83.1 %		90 bp[3]		360 bp[3]
Selling, general and administrative expense ratio[4]	11.1 %	17.3 %	11.6 %	14.7 %		(620) bp[3]		(310) bp[3]
Income before income tax expense as a percentage of total revenues	5.6 %	1.2 %	6.4 %	6.2 %		440 bp[3]		20 bp[3]
Shareholders' net income as a percentage of total revenues	4.2 %	0.7 %	4.9 %	4.5 %		350 bp[3]		40 bp[3]

Certain of the following definitions are also applicable to all other results of operations tables in this discussion:

NM Not meaningful.

1 Includes interest expense, amortization of other intangible assets and loss on extinguishment of debt.

2 Benefit expense ratio represents benefit expense as a percentage of premium revenue. Premiums for the three months ended September 30, 2021 and 2020 were $30,395 and $26,392, respectively. Premiums for the nine months ended September 30, 2021 and 2020 were $86,604 and $77,001, respectively.

3 bp = basis point; one hundred basis points = 1%.

4 Selling, general and administrative expense ratio represents selling, general and administrative expense as a percentage of total operating revenue.

Three Months Ended September 30, 2021 Compared to the Three Months Ended September 30, 2020

Total operating revenue increased primarily as a result of higher premium revenue due mainly to membership growth in our Government Business segment, including related to our acquisition of MMM, and increased product revenue in our IngenioRx segment. These increases were partially offset by the impact of lower premium revenue associated with the repeal of the HIP Fee for 2021.

Net investment income increased primarily due to increases in income from other invested assets, partially offset by declines in fixed maturity income due to lower yields on fixed maturity securities.

We recognized net realized losses on financial instruments for the three months ended September 30, 2021 compared to net realized gains on financial instruments for the three months ended September 30, 2020. The change was primarily due to the fair value of equity securities still held moving from gains to losses, which is recorded in earnings.

Benefit expense increased primarily due to cost increases resulting from membership growth in our Medicaid and Medicare businesses, including related to our acquisition of MMM and increased COVID-19 healthcare costs for both our Commercial & Specialty Business and Government Business segments.

Our benefit expense ratio increased primarily due to the repeal of the HIP Fee for 2021, partially offset by the impact of negative rate adjustments within our Medicaid business in 2020.

Cost of products sold reflects the cost of pharmaceuticals dispensed by IngenioRx for our unaffiliated PBM customers. Cost of products sold increased as the corresponding pharmacy product revenues increased.

Selling, general and administrative expense decreased primarily due to the absence of charges in 2021 for our business optimization initiatives and the BCBSA litigation accrual that were both recognized during the third quarter of 2020, as well as the repeal of the HIP Fee for 2021. These decreases were partially offset by increased costs to support growth in our businesses.

Our selling, general and administrative expense ratio decreased primarily due to the absence of charges in 2021 for our business optimization initiatives and the BCBSA litigation accrual which were both recognized in the third quarter of 2020, increased operating revenue in 2021 and the repeal of the HIP Fee for 2021. These items were partially offset by increased costs to support growth in our businesses.

Our effective income tax rate decreased primarily due to the repeal of the HIP Fee, for years after 2020, applied to our quarterly results, which in 2020, included the impact of expenses for business optimization initiatives and the BCBSA litigation accrual recognized during the three months ended September 30, 2020.

Our shareholders' net income as a percentage of total revenues increased in 2021 as compared to 2020 as a result of all factors discussed above.

Nine Months Ended September 30, 2021 Compared to the Nine Months Ended September 30, 2020

Total operating revenue increased primarily as a result of higher premium revenue due mainly to membership growth in our Government Business segment, including the acquisition of MMM, and increased product revenue in our IngenioRx segment. These increases were partially offset by the impact of lower premium revenue associated with the repeal of the HIP Fee for 2021.

Net investment income increased primarily due to increases in income from other invested assets, partially offset by declines in fixed maturity income due to lower yields on fixed maturity securities.

Net realized gains on financial instruments decreased primarily due to a change from gains to losses in the fair value of equity securities still held, which is recorded in earnings, partially offset by a change from losses to gains on other invested assets and higher net realized gains on fixed maturity securities.

Benefit expense increased primarily due to cost increases resulting from membership growth in our non-MMM Medicaid and Medicare businesses and increased COVID-19 and non-COVID-19 healthcare costs for both our Commercial & Specialty Business and Government Business segments.

Our benefit expense ratio increased primarily due to increased COVID-19 and non-COVID-19 healthcare costs for both our Commercial & Specialty Business and Government Business segments, and, to a lesser extent, the repeal of the HIP Fee for 2021.

Cost of products sold reflects the cost of pharmaceuticals dispensed by IngenioRx for our unaffiliated PBM customers. Cost of products sold increased as the corresponding pharmacy product revenues increased.

Selling, general and administrative expense decreased primarily due to the absence of charges in 2021 for our business optimization initiatives and the BCBSA litigation accrual recognized during the third quarter of 2020, as well as the repeal of the HIP Fee for 2021. These decreases were partially offset by increased costs to support growth in our businesses.

Our selling, general and administrative expense ratio decreased primarily due to increased operating revenue in 2021, the absence of charges in 2021 for our business optimization initiatives and the BCBSA litigation accrual recognized in the third quarter of 2020 and the repeal of the HIP Fee for 2021. These items were partially offset by increased costs to support growth in our businesses.

Our effective income tax rate decreased primarily due to the repeal of the HIP Fee for 2021, which was non-deductible for tax purposes.

Our shareholders' net income as a percentage of total revenues increased in 2021 as compared to 2020 as a result of all factors discussed above.

Reportable Segments Results of Operations

Our results of operations discussed throughout this MD&A are determined in accordance with U.S. generally accepted accounting principles ("GAAP"). We also calculate operating gain and operating margin to further aid investors in understanding and analyzing our core operating results and comparing them among periods. We define operating revenue as premium income, product revenue and administrative fees and other revenue. Operating gain is calculated as total operating revenue less benefit expense, cost of products sold and selling, general and administrative expense. It does not include net investment income, net realized gains (losses) on financial instruments, interest expense, amortization of other intangible assets, loss on extinguishment of debt or income taxes, as these items are managed in our corporate shared service environment and are not the responsibility of operating segment management. Operating margin is calculated as operating gain divided by operating revenue. We use these measures as a basis for evaluating segment performance, allocating resources, forecasting future operating periods and setting incentive compensation targets. This information is not intended to be considered in isolation or as a substitute for income before income tax expense, shareholders' net income or EPS prepared in accordance with GAAP, and may not be comparable to similarly titled measures reported by other companies. For a reconciliation of reportable segments' operating revenue to the amounts of total revenue included in the consolidated statements of income and a reconciliation of reportable segments' operating gain to income before income tax expense, see Note 15, "Segment Information," of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Form 10-Q.

Results of our operations are described through four reportable segments: Commercial & Specialty Business, Government Business, IngenioRx and Other. For additional information, see Note 15, "Segment Information," of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Form 10-Q.

The following table presents a summary of the reportable segment financial information for the three and nine months ended September 30, 2021 and 2020:

	Three Months Ended September 30		Nine Months Ended September 30		Change			
					Three Months Ended September 30		Nine Months Ended September 30	
					2021 vs 2020		2021 vs 2020	
	2021	2020	2021	2020	$	%	$	%
Operating Revenue								
Commercial & Specialty Business	$ 9,863	$ 9,326	$ 28,904	$27,476	$ 537	5.8 %	$ 1,428	5.2 %
Government Business	21,658	18,101	61,007	52,809	3,557	19.7 %	8,198	15.5 %
IngenioRx	6,549	5,582	18,630	16,048	967	17.3 %	2,582	16.1 %
Other	2,670	1,798	7,557	4,277	872	48.5 %	3,280	76.7 %
Eliminations	(5,192)	(4,158)	(15,173)	(11,335)	(1,034)	NM	(3,838)	NM
Total operating revenue	$ 35,548	$30,649	$100,925	$89,275	$ 4,899	16.0 %	$ 11,650	13.0 %
Operating Gain (Loss)								
Commercial & Specialty Business[1]	$ 620	$ (234)	$ 2,679	$ 2,558	$ 854	NM	$ 121	4.7 %
Government Business[2]	967	246	2,313	2,275	721	293.1 %	38	1.7 %
IngenioRx[3]	445	345	1,257	998	100	29.0 %	259	26.0 %
Other[4]	27	(156)	52	(76)	183	NM	128	NM
Operating Margin								
Commercial & Specialty Business	6.3 %	(2.5)%	9.3 %	9.3 %		880 bp		0 bp
Government Business	4.5 %	1.4 %	3.8 %	4.3 %		310 bp		(50) bp
IngenioRx	6.8 %	6.2 %	6.7 %	6.2 %		60 bp		50 bp

1 Includes expenses of $566 for the BCBSA litigation accrual and $299 for business optimization initiatives recognized in the three and nine months ended September 30, 2020.
2 Includes expenses of $183 for business optimization initiatives and $28 for the BCBSA litigation accrual recognized in the three and nine months ended September 30, 2020.
3 Includes expenses of $3 for business optimization initiatives recognized in the three and nine months ended September 30, 2020.
4 Includes expenses of $122 for business optimization initiatives recognized in the three and nine months ended September 30, 2020.

Three Months Ended September 30, 2021 Compared to the Three Months Ended September 30, 2020

Commercial & Specialty Business

Operating revenue increased primarily due to increased membership in our Commercial risk-based businesses, premium rate increases in our Commercial risk-based businesses designed to cover medical cost trends and administrative fee increases in our Group fee-based business. These increases were partially offset by the impact of lower premium revenue associated with the repeal of the HIP Fee for 2021.

Operating gain increased primarily due to the absence of charges in 2021 for the BCBSA litigation accrual and our business optimization initiatives, which were both recognized during the third quarter of 2020.

Government Business

Operating revenue increased primarily due to higher premium revenue growth in our non-MMM Medicaid business, driven by the temporary suspension of eligibility recertification, which will remain suspended at least until the first quarter of 2022. The acquisition of MMM on June 29, 2021 and non-MMM membership growth in our Medicare business also

contributed to the operating revenue growth. These increases were partially offset by the impact of lower premium revenue associated with the repeal of the HIP Fee for 2021.

The increase in operating gain was primarily driven by the impact of negative rate adjustments within our Medicaid business in 2020 related to COVID-19, the absence of charges in 2021 for our business optimization initiatives recognized during the third quarter of 2020 and membership growth in our Medicaid and Medicare businesses, including related to the acquisition of MMM on June 29, 2021.

IngenioRx

Operating revenue increased as a result of higher drug spend from IngenioRx customers, including spend related to increased Medicaid membership within our Government Business segment.

The increase in operating gain was primarily driven by growth in integrated medical and pharmacy members in 2021.

Other

Operating revenue increased primarily due to higher administrative fees and other revenue for services performed by our Diversified Business Group for our Commercial & Specialty Business and Government Business segments.

We recognized an operating gain for the three months ended September 30, 2021 compared to an operating loss for the three months ended September 30, 2020. The change was primarily driven by the absence of charges in 2021 for our business optimization initiatives recognized during the third quarter of 2020 and a decline in unallocated corporate expenses in 2021.

Nine Months Ended September 30, 2021 Compared to the Nine Months Ended September 30, 2020

Commercial & Specialty Business

Operating revenue increased primarily due to premium rate increases in our Group risk-based business designed to cover medical cost trends, increased membership in our Commercial risk-based businesses, administrative fee increases in our Group fee-based business and the non-recurring premium credits provided to members enrolled in select Group and Individual health plans in response to the COVID-19 pandemic in the second quarter of 2020. These increases were partially offset by the impact of lower premium revenue associated with the repeal of the HIP Fee for 2021.

Operating gain increased primarily due to the absence of charges in 2021 for the BCBSA litigation accrual and our business optimization initiatives, that were both recognized during the third quarter of 2020, as well as the non-recurring premium credits that were provided to members enrolled in select Group and Individual health plans in response to the COVID-19 pandemic in the second quarter of 2020. These increases were partially offset by increased COVID-19 and non-COVID-19 healthcare costs in 2021.

Government Business

Operating revenue increased primarily due to higher premium revenue growth in our non-MMM Medicaid business, driven by the temporary suspension of eligibility recertification, which will remain suspended at least until the first quarter of 2022. Non-MMM membership growth in our Medicare business and the acquisition of MMM on June 29, 2021 also contributed to operating revenue growth. These increases were partially offset by the impact of lower premium revenue associated with the repeal of the HIP Fee for 2021, increased experience-rated refunds in our Medicaid business and lower risk revenue.

The increase in operating gain was primarily driven by increased revenue resulting from membership growth in our Medicaid and Medicare businesses, including related to the acquisition of MMM on June 29, 2021 and the absence of charges in 2021 for our business optimization initiatives recognized during the third quarter of 2020. These increases were partially offset by an increase in COVID-19 and non-COVID-19 healthcare costs, increased experience-rated refunds in our Medicare business and lower risk revenue.

IngenioRx

Operating revenue increased as a result of higher drug spend from IngenioRx customers, including spend related to increased Medicaid membership within our Government Business segment.

The increase in operating gain was primarily driven by growth in integrated medical and pharmacy members in 2021.

Other

Operating revenue increased primarily due to higher administrative fees and other revenue for services performed by our Diversified Business Group for our Commercial & Specialty Business and Government Business segments.

We recognized an operating gain for the nine months ended September 30, 2021 compared to an operating loss for the nine months ended September 30, 2020. The change was primarily driven by the absence of charges in 2021 for our business optimization initiatives recognized during the third quarter of 2020 and a decline in unallocated corporate expenses in 2021, partially offset by an increase in non-COVID 19 utilization impacting the risk sharing arrangements within the Diversified Business Group, as utilization was depressed during the nine months ended September 30, 2020.

Critical Accounting Policies and Estimates

We prepare our consolidated financial statements in conformity with GAAP. Application of GAAP requires management to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes and within this MD&A. We consider our most important accounting policies that require significant estimates and management judgment to be those policies with respect to liabilities for medical claims payable, income taxes, goodwill and other intangible assets, investments and retirement benefits. Our accounting policies related to these items are discussed in our 2020 Annual Report on Form 10-K in Note 2, “Basis of Presentation and Significant Accounting Policies,” to our audited consolidated financial statements as of and for the year ended December 31, 2020, as well as in the “Critical Accounting Policies and Estimates” section of Part II, Item 7, “Management’s Discussion and Analysis of Financial Condition and Results of Operations.” As of September 30, 2021, our critical accounting policies and estimates have not changed from those described in our 2020 Annual Report on Form 10-K.

Medical Claims Payable

The most subjective accounting estimate in our consolidated financial statements is our liability for medical claims payable. Our accounting policies related to medical claims payable are discussed in the references cited above. As of September 30, 2021, our critical accounting policies and estimates related to medical claims payable have not changed from those described in our 2020 Annual Report on Form 10-K. For a reconciliation of the beginning and ending balance for medical claims payable for the nine months ended September 30, 2021 and 2020, see Note 9, “Medical Claims Payable,” of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Form 10-Q.

The following table provides a summary of the two key assumptions having the most significant impact on our incurred but not paid liability estimates for the nine months ended September 30, 2021 and 2020, which are the trend and completion factors. These two key assumptions can be influenced by utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations. The impact from COVID-19 on healthcare utilization and medical claims submission patterns continues to provide increased estimation uncertainty on our incurred but not reported liability at September 30, 2021.

	Favorable Developments by Changes in Key Assumptions	
	Nine Months Ended September 30	
	2021	2020
Assumed trend factors	$ 1,443	$ 606
Assumed completion factors	379	94
Total	$ 1,822	$ 700

The favorable development recognized in the nine months ended September 30, 2021 and 2020 resulted primarily from trend factors in late 2020 and late 2019, respectively, developing more favorably than originally expected. Favorable development in the completion factors resulting from the latter parts of 2020 and 2019 developing faster than expected also contributed to the favorability.

The ratio of current year medical claims paid as a percent of current year net medical claims incurred was 83.8% and 85.3% for the nine months ended September 30, 2021 and 2020, respectively. This ratio serves as an indicator of claims processing speed whereby claims payments slowed down slightly during the nine months ended September 30, 2021 as compared to the nine months ended September 30, 2020. This was driven by the strengthening of incurred but not reported claims, within our medical claims payable, to account for an increase in overall payment cycle time.

We calculate the percentage of prior year redundancies in the current period as a percent of prior year net medical claims payable less prior year redundancies in the current period in order to demonstrate the development of prior year reserves. For the nine months ended September 30, 2021, this metric was 19.7%, largely driven by favorable trend factor development at the end of 2020 as well as favorable completion factor development from 2019 and 2020. For the nine months ended September 30, 2020, this metric was 8.8%, largely driven by favorable trend factor development at the end of 2019 as well as favorable completion factor development from 2019.

We calculate the percentage of prior year redundancies in the current period as a percent of prior year net incurred medical claims to indicate the percentage of redundancy included in the preceding year calculation of current year net incurred medical claims. We believe this calculation supports the reasonableness of our prior year estimate of incurred medical claims and the consistency in our methodology. For the nine months ended September 30, 2021, this metric was 2.2%, which was calculated using the redundancy of $1,822. For the nine months ended September 30, 2020, the comparable metric was 0.9%, which was calculated using the redundancy of $700. We believe these metrics demonstrate an appropriate level of reserve conservatism.

New Accounting Pronouncements

For information regarding new accounting pronouncements that were adopted and new accounting pronouncements that were issued during the nine months ended September 30, 2021, see the "*Recently Adopted Accounting Guidance*" and "*Recent Accounting Guidance Not Yet Adopted*" sections of Note 2, "Basis of Presentation and Significant Accounting Policies," of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Form 10-Q.

Liquidity and Capital Resources

Sources and Uses of Capital

Our cash receipts result primarily from premiums, product revenue, administrative fees and other revenue, investment income, proceeds from the sale or maturity of our investment securities, proceeds from borrowings, and proceeds from the issuance of common stock under our employee stock plans. Cash disbursements result mainly from claims payments, administrative expenses, taxes, purchases of investment securities, interest expense, payments on borrowings, acquisitions, capital expenditures, repurchases of our debt securities and common stock and the payment of cash dividends. Cash outflows fluctuate with the amount and timing of settlement of these transactions. Any future decline in our profitability would likely have an unfavorable impact on our liquidity.

For a more detailed overview of our liquidity and capital resources management, see the "*Introduction*" section included in the "Liquidity and Capital Resources" section of Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in our 2020 Annual Report on Form 10-K.

For additional information regarding our sources and uses of capital during the three and nine months ended September 30, 2021, see Note 6, "Derivative Financial Instruments," Note 10, "Debt," and Note 12, "Capital Stock – *Use of Capital – Dividends and Stock Repurchase Program,*" of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Form 10-Q.

Liquidity

A summary of our major sources and uses of cash and cash equivalents for the nine months ended September 30, 2021 and 2020 is as follows:

	Nine Months Ended September 30		2021 vs. 2020
	2021	2020	Change
Sources of Cash:			
Net cash provided by operating activities	$ 6,692	$ 6,875	$ (183)
Issuances of commercial paper and short- and long-term debt, net of repayments	2,533	570	1,963
Proceeds from issuance of common stock under employee stock plans	161	112	49
Other sources of cash, net	173	474	(301)
Total sources of cash	9,559	8,031	1,528
Uses of Cash:			
Purchases of investments, net of proceeds from sales, maturities, calls and redemptions	(3,403)	(4,207)	804
Purchases of subsidiaries, net of cash acquired	(3,442)	(1,973)	(1,469)
Repurchase and retirement of common stock	(1,378)	(1,342)	(36)
Purchases of property and equipment	(747)	(743)	(4)
Cash dividends	(831)	(720)	(111)
Total uses of cash	(9,801)	(8,985)	(816)
Effect of foreign exchange rates on cash and cash equivalents	(9)	1	(10)
Net decrease in cash and cash equivalents	$ (251)	$ (953)	$ 702

The decrease in cash provided by operating activities was primarily driven by the timing of working capital changes, partially offset by higher net income in 2021.

Other significant changes in sources or uses of cash year-over-year included an increase in net proceeds received from the issuance of commercial paper and short-term and long-term debt, net of repayments, an increase in cash paid for the purchase of subsidiaries, net of cash acquired, and a decrease in purchases of investments, net of proceeds from sales, maturities, calls and redemptions.

Financial Condition

We maintained a strong financial condition and liquidity position, with consolidated cash, cash equivalents and investments in fixed maturity and equity securities of $34,582 at September 30, 2021. Since December 31, 2020, total cash, cash equivalents and investments in fixed maturity and equity securities increased by $3,287, primarily due to cash generated from operations and net proceeds from the issuance of commercial paper and short-term and long-term debt. The increase was partially offset by cash used for acquisitions, common stock repurchases, dividends paid to shareholders and purchases of property and equipment.

Many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid to their respective parent companies. Certain accounting practices prescribed by insurance regulatory authorities, or statutory accounting practices, differ from GAAP. Changes that occur in statutory accounting practices, if any, could impact our subsidiaries' future dividend capacity. In addition, we have agreed to certain undertakings to regulatory authorities, including requirements to maintain certain capital levels in certain of our subsidiaries.

At September 30, 2021, we held $1,360 of cash, cash equivalents and investments at the parent company, which are available for general corporate use, including investment in our businesses, acquisitions, potential future common stock repurchases and dividends to shareholders, repurchases of debt securities and debt and interest payments.

Debt

Periodically, we access capital markets and issue debt ("Notes") for long-term borrowing purposes, for example, to refinance debt, to finance acquisitions or for share repurchases. Certain of these Notes may have a call feature that allows us to redeem the Notes at any time at our option and/or a put feature that allows a Note holder to redeem the Notes upon the occurrence of both a change in control event and a downgrade of the Notes below an investment grade rating. For more information on our debt, including redemptions and issuances, see Note 10, "Debt," of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Form 10-Q.

We calculate our consolidated debt-to-capital ratio, a non-GAAP measure, from the amounts presented on our consolidated balance sheets included in Part I, Item 1 of this Form 10-Q. Our debt-to-capital ratio is calculated as total debt divided by total debt plus total shareholders' equity. Total debt is the sum of short-term borrowings, current portion of long-term debt and long-term debt, less current portion. We believe our debt-to-capital ratio assists investors and rating agencies in measuring our overall leverage and additional borrowing capacity. In addition, our bank covenants include a maximum debt-to-capital ratio that we cannot and did not exceed. Our debt-to-capital ratio may not be comparable to similarly titled measures reported by other companies. Our consolidated debt-to-capital ratio was 38.9% and 37.6% as of September 30, 2021 and December 31, 2020, respectively. The increase in our consolidated debt-to-capital ratio was primarily due to the debt issued in our March 2021 Notes offering, offset by our redemption of Notes in May 2021.

Our senior debt is rated "A" by S&P Global Ratings, "BBB" by Fitch Ratings, Inc., "Baa2" by Moody's Investor Service, Inc. and "bbb+" by AM Best Company, Inc. We intend to maintain our senior debt investment grade ratings. If our credit ratings are downgraded, our business, liquidity, financial condition and results of operations could be adversely impacted by limitations on future borrowings and a potential increase in our borrowing costs.

Future Sources and Uses of Liquidity

We have a senior revolving credit facility (the "5-Year Facility") with a group of lenders for general corporate purposes. The 5-Year Facility provides credit up to $2,500 and matures in June 2024. On June 3, 2021, we terminated our 364-day senior revolving credit facility, which was scheduled to mature in June 2021 (the "prior 364-Day Facility"), and entered into a new 364-day senior revolving credit facility (the "new 364-Day Facility" and together with the 5-Year Facility, the "Credit Facilities") with a group of lenders for general corporate purposes. The new 364-Day Facility provides for credit in the amount of $1,000 and matures in June 2022. Our ability to borrow under these Credit Facilities is subject to compliance with certain covenants, including covenants requiring us to maintain a defined debt-to-capital ratio of not more than 60%, subject to increase in certain circumstances set forth in the applicable credit agreement. As of September 30, 2021, our debt-to-capital ratio, as defined and calculated under the Credit Facilities, was 38.9%. We do not believe the restrictions contained in any of our Credit Facility covenants materially affect our financial or operating flexibility. As of September 30, 2021, we were in compliance with all of the debt covenants under these Credit Facilities. There were no amounts outstanding under the prior 364-Day Facility or the new 364-Day Facility at any time during the nine months ended September 30, 2021 or the year

ended December 31, 2020. At September 30, 2021 and December 31, 2020, there were no amounts outstanding under our 5-Year Facility.

We have an authorized commercial paper program of up to $3,500, the proceeds of which may be used for general corporate purposes. Should commercial paper issuance become unavailable, we intend to use a combination of cash on hand and/or our Credit Facilities, which provide for combined credit up to $3,500, to redeem any outstanding commercial paper upon maturity. While there is no assurance in the current economic environment, we believe the lenders participating in our Credit Facilities, if market conditions allow, will be willing to provide financing in accordance with their legal obligations. At September 30, 2021, we had $100 outstanding under our commercial paper program.

We have a shelf registration statement on file with the U.S. Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries, the financing of possible acquisitions or business expansions or the repurchase of shares of our common stock.

We regularly review the appropriate use of capital, including acquisitions, common stock and debt security repurchases and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors.

For additional information regarding our sources and uses of capital at September 30, 2021, see Note 5, “Investments,” Note 6, “Derivative Financial Instruments,” Note 10, “Debt,” and Note 12, “Capital Stock – *Use of Capital – Dividends and Stock Repurchase Program,*” of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Form 10-Q.

Risk-Based Capital

Our regulated subsidiaries’ states of domicile have statutory risk-based capital (“RBC”) requirements for health and other insurance companies and health maintenance organizations largely based on the National Association of Insurance Commissioners (“NAIC”) Risk-Based Capital (RBC) for Insurers Model Act (the “RBC Model Act”). These RBC requirements are intended to measure capital adequacy, taking into account the risk characteristics of an insurer’s investments and products. The NAIC sets forth the formula for calculating the RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual insurance company’s business. In general, under the RBC Model Act, an insurance company must submit a report of its RBC level to the state insurance department or insurance commissioner, as appropriate, at the end of each calendar year. Our regulated subsidiaries’ respective RBC levels as of December 31, 2020, which was the most recent date for which reporting was required, were in excess of all mandatory RBC requirements. In addition to exceeding the RBC requirements, we are in compliance with the liquidity and capital requirements for a licensee of the BCBSA and with the tangible net equity requirements applicable to certain of our California subsidiaries.

For additional information, see Note 22, “Statutory Information,” in our audited consolidated financial statements as of and for the year ended December 31, 2020 included in our 2020 Annual Report on Form 10-K.

Contractual Obligations and Commitments

We believe that funds from future operating cash flows, cash and investments and funds available under our 5-Year Facility and our new 364-Day Facility senior revolving credit facilities and/or from public or private financing sources will be sufficient for future operations and commitments, and for capital acquisitions and other strategic transactions.

There have been no material changes to our Contractual Obligations and Commitments disclosure in our 2020 Annual Report on Form 10-K other than an increase in our borrowings. For additional information regarding our estimated contractual obligations and commitments, see Note 6, “Derivative Financial Instruments,” Note 10, “Debt,” and the “*Other Contingencies*” and “*Contractual Obligations and Commitments*” sections of Note 11 “Commitments and Contingencies,” of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Form 10-Q.

FORWARD-LOOKING STATEMENTS

This document contains certain forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements reflect our views about future events and financial performance and are generally not historical facts. Words such as "expect," "feel," "believe," "will," "may," "should," "anticipate," "intend," "estimate," "project," "forecast," "plan" and similar expressions are intended to identify forward-looking statements. These statements include, but are not limited to: financial projections and estimates and their underlying assumptions; statements regarding plans, objectives and expectations with respect to future operations, products and services; and statements regarding future performance. Such statements are subject to certain risks and uncertainties, many of which are difficult to predict and generally beyond our control, that could cause actual results to differ materially from those expressed in, or implied or projected by, the forward-looking statements. You are cautioned not to place undue reliance on these forward-looking statements that speak only as of the date hereof. You are also urged to carefully review and consider the various risks and other disclosures discussed in our reports filed with the U.S. Securities and Exchange Commission from time to time, which attempt to advise interested parties of the factors that affect our business. Except to the extent otherwise required by federal securities laws, we do not undertake any obligation to republish revised forward-looking statements to reflect events or circumstances after the date hereof. These risks and uncertainties include, but are not limited to: the impact of large scale medical emergencies, such as public health epidemics and pandemics, including COVID-19, and catastrophes; trends in healthcare costs and utilization rates; our ability to secure sufficient premium rates, including regulatory approval for and implementation of such rates; the impact of federal and state regulation, including ongoing changes in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended; changes in economic and market conditions, as well as regulations that may negatively affect our liquidity and investment portfolios; our ability to contract with providers on cost-effective and competitive terms; competitive pressures and our ability to adapt to changes in the industry and develop and implement strategic growth opportunities; reduced enrollment; unauthorized disclosure of member or employee sensitive or confidential information, including the impact and outcome of any investigations, inquiries, claims and litigation related thereto; risks and uncertainties regarding Medicare and Medicaid programs, including those related to non-compliance with the complex regulations imposed thereon; our ability to maintain and achieve improvement in Centers for Medicare and Medicaid Services Star ratings and other quality scores and funding risks with respect to revenue received from participation therein; a negative change in our healthcare product mix; costs and other liabilities associated with litigation, government investigations, audits or reviews; risks and uncertainties related to our pharmacy benefit management ("PBM") business, including non-compliance by any party with the PBM services agreement between us and CaremarkPCS Health, L.L.C.; medical malpractice or professional liability claims or other risks related to healthcare and PBM services provided by our subsidiaries; general risks associated with mergers, acquisitions, joint ventures and strategic alliances; changes in U.S. tax laws; possible impairment of the value of our intangible assets if future results do not adequately support goodwill and other intangible assets; possible restrictions in the payment of dividends from our subsidiaries and increases in required minimum levels of capital; our ability to repurchase shares of our common stock and pay dividends on our common stock due to the adequacy of our cash flow and earnings and other considerations; the potential negative effect from our substantial amount of outstanding indebtedness; a downgrade in our financial strength ratings; the effects of any negative publicity related to the health benefits industry in general or us in particular; failure to effectively maintain and modernize our information systems; events that may negatively affect our licenses with the Blue Cross and Blue Shield Association; the impact of international laws and regulations; intense competition to attract and retain employees; and various laws and provisions in our governing documents that may prevent or discourage takeovers and business combinations.

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

For a discussion of our market risks, refer to Item 7A, "Quantitative and Qualitative Disclosures about Market Risk," included in our 2020 Annual Report on Form 10-K. There have been no material changes to any of these risks since December 31, 2020.

ITEM 4. CONTROLS AND PROCEDURES

We carried out an evaluation as of September 30, 2021, under the supervision and with the participation of our management, including our Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures as defined in Rule 13a-15(e) of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Based upon that evaluation, the Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures are effective in timely alerting them to material information relating to us (including our consolidated subsidiaries) required to be disclosed in our reports under the Exchange Act. In addition, based on that evaluation, the Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective in ensuring that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is accumulated and communicated to our management, including the Chief Executive Officer and Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosures.

There have been no changes in our internal control over financial reporting that occurred during the three months ended September 30, 2021 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS

For information regarding legal proceedings at September 30, 2021, see the "*Litigation and Regulatory Proceedings,*" and "*Other Contingencies*" sections of Note 11, "Commitments and Contingencies" of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Form 10-Q, which information is incorporated herein by reference.

ITEM 1A. RISK FACTORS

There have been no material changes to the risk factors disclosed in our 2020 Annual Report on Form 10-K.

ITEM 2. UNREGISTERED SALES OF EQUITY SECURITIES AND USE OF PROCEEDS

Issuer Purchases of Equity Securities

The following table presents information related to our repurchases of common stock for the periods indicated:

Period	Total Number of Shares Purchased[1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Programs[2]	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Programs
(in millions, except share and per share data)				
July 1, 2021 to July 31, 2021	442,555	$ 385.96	432,400	$ 4,998
August 1, 2021 to August 31, 2021	497,244	375.96	495,759	4,812
September 1, 2021 to September 30, 2021	269,524	372.85	260,806	4,714
	1,209,323		1,188,965	

1 Total number of shares purchased includes 20,358 shares delivered to or withheld by us in connection with employee payroll tax withholding upon the exercise or vesting of stock awards. Stock grants to employees and directors and stock issued for stock option plans and stock purchase plans in the consolidated statements of shareholders' equity are shown net of these shares purchased.

2 Represents the number of shares repurchased through the common stock repurchase program authorized by our Board of Directors, which the Board of Directors evaluates periodically. During the three months ended September 30, 2021, we repurchased 1,188,965 shares at a total cost of $450 under the program, including the cost of options to purchase shares. The Board of Directors has authorized our common stock repurchase program since 2003. The most recent authorized increase to the program was $5,000 on January 26, 2021 by our Audit Committee, pursuant to authorization granted by the Board of Directors. No duration has been placed on our common stock repurchase program, and we reserve the right to discontinue the program at any time.

ITEM 3. DEFAULTS UPON SENIOR SECURITIES

None.

ITEM 4. MINE SAFETY DISCLOSURES

None.

ITEM 5. OTHER INFORMATION

None.

ITEM 6. EXHIBITS

Exhibit Number	Exhibit
3.1	Amended and Restated Articles of Incorporation of the Company, as amended and restated effective May 15, 2019, incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on May 15, 2019.
3.2	Bylaws of the Company, as amended effective September 30, 2020, incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on October 6, 2020.
4.7	Upon the request of the U.S. Securities and Exchange Commission, the Company will furnish copies of any other instruments defining the rights of holders of long-term debt of the Company or its subsidiaries.
31.1	Certification of Chief Executive Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Exchange Act Rules, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification of Chief Financial Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Exchange Act Rules, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101	The following material from Anthem, Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2021, formatted in Inline XBRL (Inline Extensible Business Reporting Language): (i) the Consolidated Balance Sheets; (ii) the Consolidated Statements of Income; (iii) the Consolidated Statements of Comprehensive Income; (iv) the Consolidated Statements of Cash Flows; (v) the Consolidated Statements of Shareholders' Equity; and (vi) Notes to Consolidated Financial Statements. The instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
104	Cover Page Interactive Data File formatted in Inline XBRL and contained in Exhibit 101.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

ANTHEM, INC.
Registrant

October 20, 2021 By: /s/ JOHN E. GALLINA

John E. Gallina
Executive Vice President and Chief Financial Officer
(Duly Authorized Officer and Principal Financial Officer)

October 20, 2021 By: /s/ RONALD W. PENCZEK

Ronald W. Penczek
Senior Vice President and Chief Accounting Officer
(Principal Accounting Officer)

Exhibit 31.1

**CERTIFICATION PURSUANT TO
RULE 13a-14(a) AND RULE 15d-14(a) OF THE EXCHANGE ACT RULES,
AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002**

I, Gail K. Boudreaux, certify that:

1. I have reviewed this report on Form 10-Q of Anthem, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):

   a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

October 20, 2021

/s/ GAIL K. BOUDREAUX

President and Chief Executive Officer

Exhibit 31.2

**CERTIFICATION PURSUANT TO
RULE 13a-14(a) AND RULE 15d-14(a) OF THE EXCHANGE ACT RULES,
AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002**

I, John E. Gallina, certify that:

1. I have reviewed this report on Form 10-Q of Anthem, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):

   a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

October 20, 2021

/s/ JOHN E. GALLINA
Executive Vice President and
Chief Financial Officer

Exhibit 32.1

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report of Anthem, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2021 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Gail K. Boudreaux, President and Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ GAIL K. BOUDREAUX

Gail K. Boudreaux
President and Chief Executive Officer
October 20, 2021

Exhibit 32.2

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report of Anthem, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2021 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, John E. Gallina, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ JOHN E. GALLINA

John E. Gallina
Executive Vice President and Chief Financial Officer
October 20, 2021

Coordinated Care Procurement - 4.3.2.6 Pro Forma Finanical Template

Instructions

Balance Sheet
Please report each line item requested in the Balance Sheet on a Calendar Year Basis Enter the Plan name in B1. The plan name will flow through to the other reports. Risk-Based Capital (RBC) ratio is defined as the ratio of Total Adjusted Capital divided by Authorized Control Level RBC. RBC is calculated by applying risk factors to various assets, credits, premiums, reserves and off-balance sheet items, where the factor ishigher for those items with greater underlying risk and lower for those tiems with lower under lying risk.

Profit and Loss (P&L) Statement
Please report each line item requested in the P&L statement on a Calendar Year Basis

Cash Flow Statement
Please report each line item requested in the cash flow statement on a Calendar Year Basis

Medical Loss Ratio (MLR)

Medical Loss Ratio Rebate Calculation – MSCAN (Please report on a State Fiscal Year (SFY) basis (July 1 - June 30)

Purpose of the report: Monitor the share of premium revenues the CCO spends on member services and quality improvement activities (MLR Rebate Calc.); calculate the MLR Pricing Percentage Calculation for each reporting period (MLR Rebate Calc.); calculate the total dollar amounts associated with the Adjusted HCQI and HIT Expenses by Reporting Categories for each reporting period (this is to track total HCQI and HIT expenditures in relation to medical expenses) [MLR Rebate Calc.]; and compare the financial impact of the Annual Medical Loss Ratio (MLR) Report to the Annual Mississippi Insurance Department Statement of Revenue and Expenses Financial Statement as filed by the CCOs (MLR Rebate Calc.).

Capitation Revenue and Tax Assessments

1. Total YTD Capitation Revenue. Sum of total capitation payments, Line 1
2. DO NOT USE THIS LINE
3. Less: Allocation for Premium Taxes
4. Less: Other taxes and other Revenue Based Assessments: Income taxes from earnings applicable to the respective Medicaid operations in the State of Mississippi (exclusive of investment activities) for the MLR reporting year. Any changes in estimates utilized should be adjusted to actual costs in subsequent MLR reporting periods. If there is a deferred tax asset generated for the year's operations, no amount should be reported for income taxes.
5. NET Current YTD Adjusted Premium Revenue (automatically calculated): Difference of Premium Tax Component of Reported Revenue and Total YTD Capitation Revenue

MLR Medical and Administrative Expenses

6a. Total Net Medical Expenses from Income Statement: Insert Total Net Medical Expenses from CCOs Income Statement
6b. DO NOT USE THIS LINE, Line 3
6c. DO NOT USE THIS LINE, Line 4
7. Incurred Claim Adjustment Additions. The additions total is the sum of incurred claim adjustment additions, as specified in Exhibit C of the MississippiCAN Contract.
8. Incurred Claim Adjustment Deductions. The additions total is the sum of incurred claim adjustment deductions, as specified in Exhibit C, of the MississippiCAN Contract
9. Incurred Claim Adjustment Exclusions. The additions total is the sum of incurred claim adjustment exclusions, as specified in Exhibit C, Of the MississippiCAN Contract
10. Adjusted Net Medical Expenses (automatically calculated): Sum of Total Net Medical Expenses from Income Statement and Incurred Claim Adjustment Additions minus Incurred Claim Adjustment Deductions minus Incurred Claim Adjustment Exclusions

HealthCare Quality Improvement (HCQI) and HealthCare Information Technology (HIT) Meaningful Use Expenses

11. HCQI and HIT Administrative Expenses from Income Statement: Insert HCQI and HIT administrative expenses from Income Statement
12. Adjustments or Exclusions to HCQI/HIT Meaningful Use Expenses: Enter detailed information in Supplemental Adjustments tab in Category 4 section. This line is the sum of adjustments or exclusions, as specified in Exhibit C of the MississippiCAN Contract
13. Adjusted HCQI/HIT Expenses: Sum of HCQI and HIT Administrative Expenses from Income Statement and Adjustments or Exclusions to HCQI/HIT Meaningful Use Expenses
14. Other Non-Claims Costs: For reporting purposes only, this is not included in the numerator
15. Program Integrity Costs: Enter detailed information in the Program Integrity Cost tab.
16. Total Adjusted Current YTD MLR Expenditures (automatically calculated): Sum of Adjusted Net Medical Expenses and Adjusted HCQI/HIT Expenses
17. Reporting MLR Percentage (automatically calculated): Total Adjusted MLR Expenses divided by Total Adjusted Current YTD MLR Expenditures
18. MLR Percentage Requirement for Rebate Calculation (automatically calculated): 87.5% as consistent with the Exhibit C of the MississippiCAN Contract
19. Percentage Below 87.5% Requirement (automatically calculated): The difference between MLR Percentage Requirement for Rebate Calculation and MLR Percentage Achieved
20. Dollar Amount of Rebate Requirement (automatically calculated): Percentage Below 87.5% Requirement multiplied by Total Adjusted Current YTD MLR Expenditures

Credibility Adjustment Applied

In alignment with MLR requirements, as defined in 42 CFR 438.8(b), the credibility adjustment is used to account for random statistical variation related to the number of enrollees in a managed care plan. The credibility adjustment categorizes managed care plans into three groups:

- Fully-credible. Managed care plans in this group, it is highly likely that the difference between the actual and target MLR is statistically significant and not due to random variation.
- Partially-credible. Managed care plans in this group, it is somewhat likely that the difference between the actual and target MLR is statistically significant but such difference could, at least in part, be due to random variation.
- Non-credible. Managed care plans with insufficient claims experience, measured in terms of member months, to calculate a reliable MLR.

The template will automatically calculate the MLR credibility adjustment required based upon the table in the template provided by CMS.

21. MLR Member Months: Enter the sum of beneficiary count for the year to date period for each reporting period.
22. MLR Member Months (Annualized)
23. Credibility Adjustment
24. Adjustment Reporting MLR Percentage
25. MLR Percentage Requirement for Rebate Calculation
26. Percentage below 87.5% Requirement
27. Dollar Amount of Rebate Required

Denials
Enter the expected denial percentage rates for each of the three (3) categories requested for each state fiscal year. The rates should be based on your projection but taking into account what you have done historically in other markets with denials. Please include any additional information to help the rates.

Assumptions
Provide any additional detail here for assumptions used in the pro forma of the financials.

[redacted]

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Amerigroup

Amerigroup Customer Service Training Program

Through a grant, Amerigroup funded the Amerigroup Customer Service Training program with Goodwill of Mississippi. The customer service pathway will include opportunities for participants to gain instruction, jointly provided by Goodwill Industries of Mississippi, Inc. and Holmes Community College, with the possibility to earn credentials in multiple areas. These areas include the following: Adult Education; Smart Start Course, including ACT's National Career Readiness Certificate; Customer Service and Sales; and Digital Literacy. To date, the program has had 20 graduates.

4.3.3 Organization and Staffing

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[END OF RESPONSE]

Key Position: Job Description
Title of Position: Chief Executive Officer (CEO)
Description of Position: The full-time, Mississippi-based CEO has ultimate accountability and decision-making authority in the day-to-day administration of our MississippiCAN and CHIP Programs and services, including compliance with all provisions of the Contract. As part of this role, we entrust the CEO to represent our Coordinated Care Organization (CCO) in all matters pertaining to Contract requirements and to serve as the central liaison between our CCO and the Division. This includes fostering strong and collaborative relationships, including those with leaders from other CCOs, and addressing all inquiries, issues, and requests made by the Division. With primary responsibility for achieving the fiscal, operational, legislative, regulatory, and human resources objectives for our CCO, the CEO is authorized and empowered to make operational and financial decisions, including rate negotiations for Mississippi business, claims payment, and Provider relations/contracting.
Description of Responsibilities of Position: Our CEO oversees the strategic direction, administration, and management of our MississippiCAN and CHIP Program services. This includes responsibility for the following: ▪ Serves as the thought leader at the helm of innovation and impactful changes that will maximize MississippiCAN and CHIP Program efficiency and responsiveness ▪ ***Maintains full accountability to the Division as Contract Officer to ensure timely and effective delivery on all requirements of the MississippiCAN and CHIP Contracts*** ▪ Aligns strategy to achieve business goals and build a culture of accountability with people who are results driven, innovative, and committed to excellence ▪ Secures and coordinates the top-level talent and resources necessary to meet all Contract requirements ▪ Builds strategic partnerships with community organizations, State agencies, Providers, and all stakeholders in the Mississippi system of care ▪ Maintains accountability to make decisions about coordinated care activities and represents our CCO at meetings required by the Division ▪ Remains accountable for profit and loss management responsibilities, including cost management, budgeting, forecasting of premium rates and renewals, and growth ▪ Oversees and participates in the development of growth and retention strategies, including marketing and communication initiatives based on the changing needs of our membership ▪ Monitors and manages implementation of key Mississippi regulatory and legislative relationships and processes, including eligibility, benefits design, networks, administrative requirements, and new programs and services ▪ Establishes policies and processes to ensure continuous compliance across the organizations
Minimum Experience Required: ▪ Experience with Mississippi Medicaid and/or CMS quality program management and accreditation process, which should include a working knowledge of Population Health programs that are common to Medicaid managed care ▪ At least 10 years of direct experience within the healthcare field, preferably in a managed care organization in Mississippi or in a comparable capacity ▪ Experience in administering services that support Members with complex conditions ▪ Experience in building relationships with stakeholders and in implementing new program and services ▪ Strong knowledge of Medicaid, managed care philosophy, and extensive local knowledge of Mississippi communities, resources, Providers, State agencies, and stakeholders
Skills Required: As the leader of our CCO, this role requires exceptional management, communication, analytical, and problem-solving skills, including negotiation and conflict resolution. The CEO must have an approachable, collaborative style with an eye for talent and be a champion of inclusion and diversity. The role

must also be able to keep leadership and the entire team's focus on Members and making sure the programs and services we provide are responsive to their needs.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: The CEO must have extensive local knowledge and understanding of the populations and communities we will serve in Mississippi, to help drive our CCO operations in meeting the needs of our Members, Providers, and the Division. This includes familiarity with the Mississippi legislature and the Mississippi Medicaid Technical Amendments bill, which authorizes managed care in the state.

Key Position: Job Description
Title of Position: Chief Operating Officer (COO)
Description of Position: The full-time, Mississippi-based COO oversees day-to-day business activities conducted pursuant to this Contract, and will work in tandem with the CEO in the fiscal and operational management of our organization. In this role, the COO provides key input and assists in developing and driving the strategic vision, goals, objectives, policies, and decision-making for our MississippiCAN and CHIP Programs and services. The COO will also be proactive in leading strategic discussions among partners, including the Division, CCO partners, and community stakeholders, to execute on collaborative statewide strategies.
Description of Responsibilities of Position: Our COO maintains responsibility for the effective and efficient operations of our CCO, with responsibilities that include: ▪ Collaborates internally with staff across departments to identify gaps and improve processes when needed ▪ Identifies and adopts operational best practices and metrics to achieve strategic goals and provide timely reports on operational progress and milestones to the Division ▪ Creates seamless processes between our local CCO operations and the national shared support services that augment our programs and services ▪ Develops and implements key operational indicators to be used for monitoring and analyzing our operations ▪ Oversees development and delivery of a comprehensive set of custom reports for the Division including quality management (QM) analytics and operational informatics to provide accountability and transparency to the Division ▪ Serves as a liaison and builds relationships with Providers, regulatory agencies, and stakeholders to help maximize the quality of programs and services we deliver ▪ Stays up to date on activities across our organization, including network development and Provider experience, medical management, Care Management (CM), QM, finance, and regulatory and compliance
Minimum Experience Required: The COO role requires at least 10 years of relevant experience, which includes nine years of in-depth managed care operations experience or any combination of education and experience that provides an equivalent background.
Skills Required: The COO must have strong oral, written, and interpersonal communication and facilitation skills, along with the ability to analyze and problem solve. In addition, strategic thinking and project management skills are a plus along with capabilities to analyze and evaluate data to support meaningful decision-making. Strong understanding of operational requirements of MississippiCAN and Mississippi CHIP Programs.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:** Relevant certification such as Project Management or Six Sigma is preferred.
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**

Any additional information relevant to this position: The COO must have extensive local knowledge and understanding of the populations and communities in Mississippi, to help drive our CCO operations. Must have knowledge of the Division's Managed Care Quality Strategy with the ability to integrate it into management and operational practices. The COO must understand the Mississippi legislative process and the Mississippi Medicaid Technical Amendments bill, which authorizes managed care in the state.

Key Position: Job Description
Title of Position: Chief Financial Officer (CFO)
Description of Position: The full-time, Mississippi-based CFO role oversees the financial-related functions of our CCO, which includes working with key leadership on strategic financial decisions and making sure we meet all Contract requirements for financial performance and reporting. This role also develops financial contracts, interfaces, and processes to assure fiscal integrity and oversees the measurement and benchmarking of financial trends.
Description of Responsibilities of Position: Our CFO maintains responsibility for fiscal operations and fiscal accountability, with responsibilities that include the following: ▪ Directs the overall budget, forecast, and cost-allocation processes, providing senior leadership with insights to maximize investment of resources ▪ Acts as a financial liaison for the Division ▪ Maintains responsibility for achieving medical cost and Medical Loss Ratio targets ▪ Reviews Provider contracts to help ensure appropriate financial arrangements are in place ▪ Oversees the establishment of cost of care targets and remains accountable for achieving operating gain targets set in budgets and forecasts ▪ Serves as a subject matter expert on financial reimbursement policies and payment mechanisms ▪ Analyzes, reviews, reports, and presents on financial performance with key leadership ▪ Collaborates with CCO leadership to ensure focus on current results versus budget, current financial performance trends, and the identification and implementation of strategies to manage review, medical, and gross margin ▪ Interfaces with regulatory and audit personnel to assure fiscal accountability
Minimum Experience Required: The CFO must have 8 to 10 years of progressive financial experience in accounting, financial reporting, business analysis, budgeting, forecasting, and strategic and tactical planning within a health insurance/managed care environment. The role must also have experience working in complex business environments that include multiple entities and highly regulated operations, or any combination of education and experience that would provide an equivalent background.
Skills Required: To ensure the fiscal health of our Mississippi operations, the CFO must be well versed in statistical/financial tools and modeling. They must possess strong leadership and communication skills as well as problem-solving, facilitation, and analytical capabilities. The role must also be highly proficient in the Microsoft Office Suite (Excel, PowerPoint, Outlook) and be adept at understanding managed care, growth, and risks to provide forecasts and strategic recommendations.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [X] No** If yes, list below: CPA preferred
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**

Any additional information relevant to this position: For the CFO role, additional desired qualifications include an understanding of the annual rate-setting process for the MississippiCAN and CHIP Programs. The CFO will be expected to work in collaboration with the Division and State actuaries to review financial data and understand cost trends. The CFO will be expected to have knowledge of and experience with monitoring quality performance measures and Value-Based Purchasing as it relates to quality withholds.

Key Position: Job Description
Title of Position: Medical Director
Description of Position: Our Mississippi-licensed and locally based Medical Director position oversees the delivery of covered services and clinical decision-making for our CCO. Dedicated full-time to MississippiCAN and CHIP Program administration, this role spearheads all clinical functions and serves as a leader for our CM, care coordination, Population Health, and utilization management areas.
Description of Responsibilities of Position: Our Medical Director is accountable for all clinical operations, programs, and services, with responsibilities that include the following: ▪ Manages the administration of physical and/or behavioral health medical services, to ensure Members receive the most appropriate care and supports ▪ Develops and implements programs to improve quality, cost, and outcomes ▪ Provides clinical consultation and serves as clinical/strategic advisor to enhance clinical operations ▪ Supports clinical staff to ensure timely and consistent responses to Members and Providers by providing guidance and consultation on referrals, denials, Grievances, and Appeals ▪ Reviews and addresses potential quality of care issues, which includes participating in the development, implementation, and oversight of corrective action plans ▪ Conducts peer-to-peer clinical reviews with attending physicians or other Providers to discuss review determinations ▪ Serves on Quality Workgroups as required by the Division, including the Mississippi Coordinated Care Quality Workgroup ▪ Plays an integral role in overseeing and developing clinical practice guidelines and clinical policies and procedures ▪ Liaises between our CCO and Providers ▪ Participates in integrated rounds in tandem with our Population Health, Behavioral Health, and Perinatal Health Directors to support and provide consultation to clinical staff on individual treatment plans ▪ Serves as a resource and consultant to other areas of the company, including QM, to help ensure the highest HEDIS® and National Committee for Quality Assurance (NCQA) ratings ▪ Participates and/or chairs committees, including Quality Management Committee, Clinical Services Committee, Medical Policy and Technology Assessment Committee, and Health Equity Advisory Council ▪ Leads, develops, directs, and implements clinical and non-clinical activities that impact healthcare quality cost and outcomes ▪ Identifies and develops opportunities for innovation to increase effectiveness and quality ▪ Oversees clinical staff who will meet weekly to evaluate demographic information, medical information, and social determinants that can influence a Member's pattern of care, and design interventions to avoid admissions and readmissions
Minimum Experience Required: In addition to being a licensed practicing physician in Mississippi or an actively practicing physician in Mississippi during the last five years, the Medical Director must have at least 10 years of clinical experience or any combination of education and experience that would provide an equivalent background. The role must also have three or more years of clinical experience and knowledge serving Mississippi and MississippiCAN and CHIP Programs.
Skills Required: The Medical Director role requires excellent communication and facilitation skills, along with the ability to analyze and resolve complex issues. This position must also have in-depth knowledge of managed care, relevant State and federal regulations, and proven ability to build and maintain positive working relationships with Providers, community-based organizations (CBOs), and stakeholders.
Are there any educational requirements for this position? **[x] Yes [ ] No**

If yes, list below: Requires a Medical Doctor or Doctor of Osteopathy. Master's degree in business administration, public health, healthcare administration, or related field preferred.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** Current Mississippi license to practice medicine with no restrictions or limitations. Must also be board-certified in a specialty recognized by the American Board of Medical Specialists.
Are there any continuing education requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Minimum of 40 hours of category I continuing education medical credits per two-year cycle.
Any additional information relevant to this position: The Medical Director will be expected to participate in advisory committees, associations, and/or organizations that provide strategic clinical guidance to regulators and legislators, such as the Medical Care Advisory Committee. This role will engage in statewide collaboration initiatives with peers at other CCOs and Mississippi State agencies such as Department of Health, Mental Health, and Child Protection Services.

Key Position: Job Description
Title of Position: Perinatal Health Director
Description of Position: The Mississippi-based Perinatal Health Director spearheads the development and implementation of our policies, procedures, and programs related to perinatal health services. As a licensed physician specializing in obstetrics and gynecology, this role builds relationships and serves as a liaison between our CCO and Providers and drives our comprehensive suite of culturally competent solutions that support pregnant moms and their babies.
Description of Responsibilities of Position: Our Perinatal Health Director has responsibilities that include the following: ▪ Provides consultation and guidance for staff on referrals, denials, Grievances, and Appeals ▪ Reviews and addresses potential quality of care issues, which includes participating in the development, implementation, and oversight of corrective action plans ▪ Serves on Quality Workgroups as required by the Division ▪ ***Serves as a liaison between the CCO and Providers with regard to perinatal policy and programs*** ▪ ***Oversees clinical innovations in perinatal care and develops initiatives to address health disparities in maternal and infant health*** ▪ Collaborates with staff across our affiliates and national organization to leverage evidence-based perinatal programs and customize them to address the needs of our Mississippi moms and babies ▪ Participates on committees, including Quality Management Committee, Clinical Services Committee, Health Equity Advisory Council, and more ▪ Develop and drive initiatives that increase Provider awareness on interventions and supports available for maternal and child health ▪ Participates in developing and reviewing clinical practice guidelines and clinical policies and procedures ▪ Participates in integrated rounds in tandem with our Population Health, Behavioral Health, and Medical Director to support and provide consultation to clinical staff on individual treatment plans
Minimum Experience Required: The Perinatal Health Director must be either an actively practicing physician with a specialty in obstetrics and gynecology in Mississippi or have been an actively practicing physician in Mississippi with a specialty in obstetrics and gynecology in the past five years and be in Mississippi.
Skills Required: The Perinatal Health Director must have strong oral, written, and interpersonal communication skills, including the ability to communicate with all levels of staff and a diverse range of Members, Providers, and stakeholders. This role must also have excellent problem-solving and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Requires a Medical Doctor or Doctor of Osteopathy. Master's degree in business administration, public health, healthcare administration, or related field preferred.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** Current Mississippi license to practice medicine with no restrictions or limitations. Board-certified in Obstetrics and Gynecology.
Are there any continuing education requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Minimum of 40 hours of Category I continuing education medical credits per two-year cycle.

Any additional information relevant to this position: This role must also be familiar with Mississippi's perinatal health initiatives and priority areas of the Mississippi State Department of Health, including smoking cessation among pregnant women, infant safe-sleep practices, access to inter-conception care, and increased breastfeeding among all groups of women.

Key Position: Job Description
Title of Position: Behavioral Health Director
Description of Position: The Mississippi-based Behavioral Health Director spearheads the development and implementation of our policies, procedures, and programs related to behavioral health services. As a licensed physician specializing in behavioral health (BH), this role builds relationships and serves as a liaison between our CCO and Providers and drives our comprehensive suite of culturally competent solutions that support those with mental health or substance use issues.
Description of Responsibilities of Position: Our Behavioral Health Director has responsibilities that include the following: ▪ Develops and manages programs and initiatives related to behavioral health, including CM services, our 24-hour BH/Substance Use Disorder (SUD) line, and our BH network of Providers ▪ Works closely with utilization management staff to identify and address potential under- or over-utilization of BH services ▪ Provides consultation and guidance for staff on referrals, denials, Grievances, and Appeals ▪ Reviews and addresses potential quality of care issues, which includes participating in the development, implementation, and oversight of corrective action plans ▪ Serves on Quality Workgroups as required by the Division ▪ Acts as liaison to BH Providers for peer reviews and consultation on evidenced-based practices and clinical guidelines ▪ Collaborates with staff across our affiliates and national organization to leverage evidence-based BH programs and customize them to address the needs of our Mississippi Members ▪ Participates on committees, including the Quality Management Committee, Clinical Services Committee, and Health Equity Advisory Council ▪ Develops and drives initiatives that increase Provider awareness on interventions and supports available for BH ▪ Serves as the primary liaison with BH community resources, including community mental health centers and specialty Providers ▪ Participates in developing and reviewing clinical practice guidelines and clinical policies and procedures ▪ Participates in integrated rounds in tandem with our Population Health, Perinatal Health, and Medical Director to support and provide consultation to clinical staff on individual treatment plans
Minimum Experience Required: The Behavioral Health Director must either be an actively practicing physician in Mississippi with a specialty in BH, or have actively practiced in Mississippi with a specialty in BH in the past five years.
Skills Required: The Behavioral Health Director must have strong oral, written, and interpersonal communication skills, including the ability to communicate with all levels of staff and a diverse range of Members, Providers, and stakeholders. This role must also have excellent problem-solving and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Doctor of Medicine or Doctor of Osteopathy with a specialty in BH.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** Current Mississippi license to practice medicine with no restrictions or limitations. Board-certified in Psychiatry.

Are there any continuing education requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Minimum of 40 hours of category I continuing education medical credits per two-year cycle.
Any additional information relevant to this position: This role must also be familiar with Mississippi's BH priorities and have knowledge of the state's mental health system, including any current gaps, pending legislation, or court orders that may influence access to care. The Behavioral Health Director will also collaborate with community mental health centers and BH Providers across the state to understand and address BH care gaps.

Key Position: Job Description
Title of Position: Chief Information Officer
Description of Position: The Chief Information Officer role oversees information technology and systems to support our operations, including submission of accurate and timely Member encounter data.
Description of Responsibilities of Position: Chief Information Officer responsibilities include the following: ▪ Analyzes information technology solutions and works in tandem with vendors on implementations, upgrades, and issue resolution ▪ Updates and maintains our Business Continuity and Disaster Recovery Plan ▪ Develops and oversees a Technology Plan and Forecast to assess tools, applications, and infrastructure across functional areas to make sure we are providing Member-focused, integrated technologies that help us improve outcomes ▪ Functions as single point of contact for business and IT partners ▪ Coordinates and leads multiple teams on initiating, developing, designing, and implementing new change initiatives ▪ Directs, reviews, and approves communications and leads meetings with area lead contacts to gather needs and issues ▪ Works in collaboration with our Claims Administrator and Data and Analytics Manager to assure the encounter data system is configured appropriately to generate submissions that meet all MississippiCAN and CHIP Contract requirements ▪ Monitors the reconciliation process, providing oversight to ensure completeness, accuracy, timeliness metrics, and correction ▪ Acts as a liaison to leverage technology initiatives and best practices from affiliates and interfaces with the national Encounters team ▪ Executes appropriate business associate agreements and reviews and authorizes all cloud access requests submitted by Division staff, verifying the identity of users prior to granting credentials
Minimum Experience Required: The Chief Information Officer role requires at least eight years of progressive experience leading continuous improvement efforts, evaluating existing systems, and implementing process improvements. This role must have broad Medicaid industry and technology knowledge, including cloud technologies, automation preferred. Experience interacting directly with State and federal regulatory agencies is also preferred. Experience crafting or contributing to technology strategy preferred.
Skills Required: This role must have exceptional technical knowledge and skills to champion technology that improves the experience of our Members and Providers. In addition, the Chief Information Officer must have a strong understanding of portfolio management methodology, tools, and processes.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**

Any additional information relevant to this position: This role must have detailed knowledge of the Division's IT procurement and CMS IT approval and certification and extensive understanding of the Contract reporting and data exchange requirements. Experience in managed care with a focus on infrastructure, security, compliance, and delivery to drive quality results is also preferred.

Key Position: Job Description
Title of Position: Compliance Officer
Description of Position: The Mississippi-based Compliance Officer oversees the policies, programs, and processes related to regulatory compliance with MississippiCAN and CHIP Program requirements. The role provides guidance for the development and implementation of our Medicaid Compliance program and serves as the primary point of contact for the Division.
Description of Responsibilities of Position: The Compliance Officer will be primarily responsible for designing, implementing, and overseeing policies and programs to maintain compliance with the Contract and all applicable State and federal rules and regulations. Additional responsibilities include the following: ▪ Monitors compliance standards and stays up to date on the latest requirements and regulations that impact MississippiCAN and CHIP Programs ▪ Reviews and maintains accountability for the completeness, accuracy, and timeliness of reporting and data submissions to the Division ▪ Evaluates existing policies and procedures to coordinate internal practices and confirm continuous compliance ▪ Develops the annual Compliance Plan and oversees program integrity for the organization, which includes directing initiatives pertaining to risk assessments, audits, training, and readiness ▪ Leads compliance monitoring to identify process gaps, validate compliance levels, map processes, draft corrective actions/remediation plans, oversee implementation of corrective actions, and prepare reports/presentations ▪ Manages complex investigations and documents findings related to compliance and program integrity
Minimum Experience Required: The Compliance Officer must have 8 to 10 years of healthcare, regulatory, ethics, compliance, or privacy experience, or any combination of education and experience that would provide an equivalent background.
Skills Required: This role must develop strong relationships with key leaders to identify and address compliance risks and failures and manage action plans designed to fully mitigate risk(s). Must have strong leadership/managerial skills and ability to motivate/coach other staff.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's or Juris Doctor preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: This role must have extensive knowledge of MississippiCAN and CHIP Program requirements, along with a background in Medicaid and managed care and reside in Mississippi. The Compliance Officer must have knowledge of State and federal Medicaid requirements as it relates to CCO functions in areas such as, but not limited to, operations and quality. Knowledge of the Medicaid Managed Care Quality Strategy would be beneficial for this role.

Key Position: Job Description
Title of Position: Project Manager
Description of Position: The full-time dedicated Project Manager is based in Mississippi and maintains responsibility for overseeing the implementation of Contract requirements during the implementation phase, which includes directing and coordinating activity across all work streams.
Description of Responsibilities of Position: To ensure all implementation timelines and goals are met, Project Manager responsibilities include: ▪ Supervises progress of operations, business, product, and technical contributors to ensure the on-time, successful delivery of implementation requirements ▪ Oversees detailed work plans, schedule estimates, resource plans, status reports, and implementation priorities ▪ Assures that factual, timely, and quality implementation tracking, analysis, reporting and communication strategies are used ▪ Works in close conjunction with our national Implementation Management Office, comprised of additional project management professionals, to help prepare operations, systems, and staff to begin serving Mississippians ▪ Meets with implementation team staff daily to discuss progress toward readiness and quickly identify and address issues that arise ▪ Collaborates with key stakeholders and facilitates effective communication for each milestone and deliverable ▪ Defines roles and responsibilities for each key project participant and continuously refines project management processes and methodology as needed to effectively use organizational resources in achieving timelines and goals
Minimum Experience Required: This role must hold a minimum of five years of experience in project management specific to Medicaid. Additionally, the Project Manager must have knowledge of Medicaid managed care programs, with relevant experience navigating similar complex projects.
Skills Required: The Project Manager must be detailed and process oriented, with strong organization, multi-tasking, and tracking skills. Outstanding written and verbal communication skills plus proven ability to build rapport and trust quickly are preferred.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** Project Management certification, Six Sigma is preferred.
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: The Project Manager must have a strong understanding of MississippiCAN and CHIP Program requirements. Prior experience with state Medicaid readiness reviews and implementation timelines will be beneficial.

Key Position: Job Description
Title of Position: Provider Services Manager
Description of Position: The full-time Mississippi-based Provider Services Manager oversees all operations related to the Provider services call center and our Provider Services department, making sure all Providers are equipped with the information and resources they need to best serve Members. This role oversees initiatives and programs focused on Provider education, Contract compliance, and maximizing Provider satisfaction while minimizing administrative burdens.
Description of Responsibilities of Position: The Provider Services Manager directs the communication and complaint resolution strategies between physicians, hospitals, Members, and the public. The role is responsible for the following: ▪ Supervises and fosters a team of professionals dedicated to supporting Providers ▪ Maintains responsibility for hiring, training, coaching, counseling, and evaluating the Provider Services team of employees, including our Provider Services Call Center Representatives ▪ Oversees the Provider Services department budget, which includes funding for developing and maintaining a comprehensive network of Providers ▪ Maintains responsibility for assuring that our Provider Services-related operations comply with all terms and requirements of the Contract ▪ Achieves individual and team performance goals/metrics ▪ Leads Provider Advisory Group meetings with external Providers to secure valuable and actionable feedback on initiatives ▪ Oversees coordination with the State's Credentialing Verification Organization (CVO) ▪ Develops and implements Provider education initiatives and manages the development, updates, and distribution of our Provider manual and other outreach and education programs ▪ Works in conjunction with our Patient-Centered Medical Home (PCMH) Transformation Consultants and Population Health Director to identify and recruit new Provider practices into the PCMH program
Minimum Experience Required: The Provider Services Manager must hold eight or more years of experience with contracting and network development, including implementation of Value-Based Purchasing agreements and supporting implementation of these. The role must also have working knowledge in the areas of practice management, long-term acute care, home health, home infusion, BH, and ambulatory surgery; outpatient experience is preferred.
Skills Required: Requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**

Any additional information relevant to this position: This position supports and educates Providers on how to meet and exceed quality metrics for Value-Based Purchasing. Thus, the role must have the ability to follow reimbursement as directed by the Division and follow appropriate reimbursement methodologies found in the Division fee schedule, Provider billing manual, and State plan or administrative code.

Key Position: Job Description
Title of Position: Network/Contracting Manager
Description of Position: The full-time, Mississippi-based Network/Contracting Manager spearheads the development, growth, and maintenance of a comprehensive Provider Network in Mississippi that is culturally competent and fully responsive to the diverse needs of our Members.
Description of Responsibilities of Position: The Network/Contracting Manager responsibilities include the following: ▪ Serves as a liaison between Providers and internal leadership to communicate and address issues and solutions ▪ Identifies and develops a robust Provider network that helps ensure our Members across Mississippi have access to the full range of services and supports they need ▪ Aligns contracting strategy with medical management strategy ▪ Integrates quality metrics and incentives into contracting process, analyzes the network's quality benchmarks and results, and implements strategies to meet all performance standards related to accessibility and timeliness ▪ Ensures compliance with regulatory and accreditation standards ▪ Works with the Provider Services Manager to develop and launch Provider education initiatives ▪ Oversees contracting and maintenance of all facilities, including hospitals, surgery centers, and other settings ▪ Oversees the development, maintenance, and reconciliation of physician risk contracts and capitated arrangement ▪ Attracts, develops, and manages key contracting and servicing staff ▪ Develops innovative ways to maintain a cost-effective network with adequate access and positive working relationships with Providers ▪ Oversees staff that ensure all network and out-of-network Providers to whom Members may be referred are appropriately licensed in accordance with federal and State law and regulations
Minimum Experience Required: The Network/Contracting Manager must have a minimum of eight years of Provider contracting or physician network development experience, plus at least five years managed care Provider contracting and reimbursement experience to include in-depth knowledge of imbursement methodologies and contracting terms.
Skills Required: This role requires strong oral, written, and interpersonal communication skills, negotiation skills, problem-solving skills, facilitation, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**

Any additional information relevant to this position: This position must also have experience supporting Providers through new program implementation, including orientation, education, and support initiatives that help ensure seamless delivery of services for Members. The role must also be familiar with Mississippi's geography, membership, and the Providers and community resources available. This position must be familiar with the barriers to care in the state, such a Provider shortage — both statewide and specific to smaller geographical areas such as counties or regions.

Key Position: Job Description
Title of Position: Member Services Manager
Description of Position: The full-time, Mississippi-based Member Services Manager is responsible for managing our Member Services functions, including call center operations, and is accountable for meeting all Contract requirements and performance standards.
Description of Responsibilities of Position: The Member Services Manager oversees the day-to-day operations of Member Services, including the following responsibilities: ▪ Maintains compliance with all operational requirements of the Contract ▪ Develops and implements Member Services and outreach programs designed to reach all Members across the state and ensure they have the information they need to access covered services and benefits ▪ Produces daily, weekly, and monthly reports, as well as ad hoc reports to monitor performance and Member inquiries and requests (to identify trends and resolutions as needed) ▪ Manages and confirms that Member services staff are following established policies, guidelines, and scripts, and are meeting quality standards
Minimum Experience Required: The Member Services Manager must hold a minimum of three years of experience leading and managing teams, plus five years of related customer service experience. In addition, the role must demonstrate knowledge and experience in operational analyses, processes, and performance indicators.
Skills Required: The role requires exceptional leadership and oral, written, and interpersonal communication skills. This includes a keen ability to understand our Members in Mississippi and build relationships. The role must also possess problem-solving, facilitation, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** High school diploma or equivalent; associate degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: To be culturally responsive to Members and address their needs effectively, our Member Services Manager must have knowledge of the state's geography, communities, and the diverse populations we will serve through the MississippiCAN and CHIP Programs. Prior experience working with a vulnerable population and knowledge of benefits in the MississippiCAN and CHIP Programs will be beneficial.

Key Position: Job Description
Title of Position: Quality Management Director
Description of Position: The full-time, Mississippi-based Quality Management Director is a healthcare practitioner who spearheads our QM and improvement activities and aligns these activities with the Division's priorities as well as our overall Population Health strategy. The Director also maintains compliance with all Contract, State, and federal requirements and supports the NCQA Accreditation Manager to achieve and maintain full accreditation status.
Description of Responsibilities of Position: The Quality Management Director drives the development, coordination, communication, and implementation of our clinical quality initiatives to help ensure our Members receive the best services and supports to address their needs. The role's responsibilities include the following: ▪ Directs our QM team staff and their activities, including monitoring and auditing our healthcare delivery system (including internal processes and procedures, service quality, and clinical quality) ▪ Oversees all aspects of our annual QM program, including performance improvement projects, work plans, and annual evaluations ▪ Works collaboratively with our parent company's regional head of QM to implement best practices and coordinate HEDIS and CAHPS® reporting and measures ▪ Acts as a key contributor and leader on the Population Health Council to inform and develop strategies to address health disparities across Mississippi communities ▪ Collaborates with other leaders in developing, monitoring, and evaluating HEDIS improvement action plans and year-round medical record reviews ▪ Monitors and reports quality measures for the Division, CMS, and accrediting requirements ▪ Assists the Compliance Officer in overseeing our operations to meet the Division's goals of improving the health outcomes of Members in Mississippi ▪ Facilitates a multidisciplinary approach to resolving issues and improving processes ▪ Reviews and evaluates our organization's performance and fosters participation across departments in performance improvement initiatives to share and learn best practices
Minimum Experience Required: The Quality Management Director must have at least five years of experience in a healthcare environment or any combination of education and experience, which would provide an equivalent background. Clinical program development and implementation experience is preferred, along with experience implementing rapid-cycle improvement techniques that demonstrate material improvements.
Skills Required: The Quality Management Director must have demonstrated skills in quality improvement concepts, healthcare data analysis, and data-mining methods. The role must have practical knowledge of the tools and techniques for continuous quality improvement, including the ability to analyze and interpret data to identify population trends, issues, and health disparities that exist in Mississippi.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in a clinical or healthcare field (for example, nursing, epidemiology, health sciences); master's degree and Certified Professional in Healthcare Quality (CPHQ) certification preferred.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** Registered Nurse (RN) or equivalent clinical licensure required; CPHQ preferred.

Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: The Quality Management Director must be able to develop quality strategies that align with the Division's goals or requirements related to the overall Managed Care Quality Strategy. The role must also be able to bring together a diverse group of stakeholders from across Mississippi, including other CCOs, CBOs, advocates, and Providers, to help drive the best quality metrics and outcomes in collaboration with the Division.

Key Position: Job Description
Title of Position: Care Management Director
Description of Position: The full-time, Mississippi-based Care Management Director oversees our CM services and the CM team of staff who support Members, including Care Managers, Care Management Navigators, and Community Health Workers (CHWs).
Description of Responsibilities of Position: The Care Management Director leads the CM team in addressing Members' needs, helping them navigate the healthcare system and maximizing the use of benefits and services available to achieve the best outcomes. The Director's responsibilities include the following: ▪ Provides leadership over the administration of day-to-day CM services, leveraging knowledge of processes, programs, systems, and data to provide oversight ▪ Oversees CM processes and policies to make sure they continuously meet Contract requirements and meet quality of care standards ▪ Gathers and interprets data and metrics to optimize CM services ▪ Serves as an advocate for our Members, making sure we have the information and supports in place to help guide them through the healthcare system ▪ Supervises the CM team and helps coach them in the care coordination process, facilitating a multidisciplinary approach between all parties involved in care (patient, family, friends, Providers, caregivers, etc.) ▪ Maintains responsibility for the development and accuracy of CM reports as required by the Contract ▪ Identifies and addresses gaps and barriers in CM services in conjunction with clinical leadership (Medical Director, Behavioral Health Director, and Perinatal Health Director) ▪ Makes decisions related to identifying and resolving complex technical and operational problems within CM and leads the CM team of highly specialized professional employees in outreach and support initiatives designed to maximize Member health and well-being
Minimum Experience Required: The Care Management Director must have at least five years of experience in healthcare management, or any combination of education and experience that would provide an equivalent background.
Skills Required: This role requires strong leadership and clinical knowledge, as well as exceptional communication, problem-solving, facilitation, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Associate or bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** Current active unrestricted RN, PA, LSW, LCSW, LPC, LMHC, or another accepted Mississippi license. Certified Case Manager Certification preferred.
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: The Care Management Director should also have knowledge and experience working with Mississippi community organizations and State agencies, as well as a background serving Members in the state who have complex needs that require CM services. The role must also keenly understand the closed-loop referral process, CHW model, and PCMHs.

Key Position: Job Description
Title of Position: Population Health Director
Description of Position: The full-time, Mississippi-based Population Health Director provides oversight and direction for designing, implementing, and supporting our Population Health model and initiatives.
Description of Responsibilities of Position: The Population Health Director drives a wide range of programs and initiatives designed to reduce health disparities, advance health equity, and improve outcomes for our membership. Responsibilities for this role include the following: ▪ Works with other key personnel and clinical leadership to develop partnerships, collaborations, and referral arrangements for the provision of Population Health programs and services ▪ Uses Population Health analytics to identify populations and sub-populations with disparate health outcomes and underlying factors for health, social, and environmental disparities ▪ Chairs the Health Equity Advisory Council, which informs and guides efforts to create an equitable health experience for all Members ▪ Manages the coordination and development of relationships with local public health agencies and CBOs to bridge public health initiatives to our programs and services ▪ Develops and implements the annual Population Health Strategy and oversees the execution of Health Literacy Campaigns ▪ Oversees processes for analyzing and acting on Population Health data ▪ Guides our overall strategy and initiatives to address Social Determinants of Health (SDOH) ▪ Directs the development and implementation of community management, outreach, and enrollee advocate initiatives and teams ▪ Serves as a liaison to the Division, working collaboratively with staff to assure we meet the Division's Population Health reporting needs throughout the Contract and identify targeted interventions aligned with the Division's goals and objectives for Population Health ▪ Works in conjunction with our Provider Services Manager and PCMH Transformation Consultants to identify and recruit new Provider practices into the PCMH program
Minimum Experience Required: The Population Health Director must have at least eight years of experience in a health-related field, plus experience working with local CBOs and other relevant stakeholders.
Skills Required: The Population Health Director must be data-savvy and analytical, with proficiency in Microsoft Office and other analytics software. The role must also have strong leadership and communication skills, with the ability to foster relationships across a broad range of stakeholders.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; advanced degree in nursing, epidemiology, or related field preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:**

Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:**
Any additional information relevant to this position: The Population Health Director should also have knowledge and experience working with Mississippi community organizations and State agencies, as well as underserved populations. The Population Health Director should have experience identifying unmet SDOH needs within populations and geographical regions and leveraging CBOs to help meet the needs. The role must also keenly understand the closed-loop referral process and CHW model, as well as PCMHs.

Key Position: Job Description
Title of Position: Utilization Management (UM) Coordinator
Description of Position: The UM Coordinator is a healthcare practitioner who oversees our UM functions that help ensure the delivery of essential services and supports that address Members' total health and SDOH needs. Uses clinical knowledge, communication skills, and independent critical thinking skills to interpret criteria, policies, and procedures that provide the best and most appropriate treatment, care, or services for Members.
Description of Responsibilities of Position: The UM Coordinator works in collaboration with our Medical Director and integrated UM team to provide UM activities guided by Mississippi-specific policies and procedures and nationally recognized best practices. Additional responsibilities include the following: ▪ Uses clinical knowledge, communication skills, and critical thinking to interpret criteria, policies, and procedures that provide the best and most appropriate treatment and services for Members ▪ Participates on key committees, including the Health Equity Advisory Council and the Clinical Services Committee ▪ Ensures program compliance and identifies opportunities to improve Members' experience and quality outcomes ▪ Oversees the development and execution of medical and case management policies, procedures, and guidelines ▪ Assists in developing clinical management guidelines ▪ Verifies that medical management activities are contracted, reviewed, and reported ▪ Supports quality initiatives and activities, including clinical indicators reporting, focus studies, and HEDIS reporting
Minimum Experience Required: The UM Coordinator must have a minimum of five years of clinical experience, including prior management experience, or any combination of education and experience that would provide an equivalent background. NCQA accreditation and HEDIS reporting experience is also preferred.
Skills Required: The UM Coordinator must have strong oral, written, and interpersonal communication skills, as well as problem-solving, facilitation, and analytical skills.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Requires a bachelor's degree in a healthcare field. Master's degree in a healthcare field or MBA with healthcare concentration preferred.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** Current active unrestricted RN, PA, LSW, LCSW, LPC, LMHC, or another accepted Mississippi license.
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:**
Any additional information relevant to this position: The UM Coordinator must also have knowledge of clinical practice guidelines, as well as CM, care coordination, and utilization review processes, and an understanding or background with vulnerable populations, including Mississippi Medicaid and CHIP Members. Our UM Coordinator must also have knowledge across care settings (inpatient, outpatient, emergency services, home health, and public health) plus experience assuring smooth transitions between levels of care with minimal to no disruption in appropriate medical services.

Key Position: Job Description
Title of Position: Grievance and Appeals Coordinator
Description of Position: The Grievance and Appeals Coordinator maintains responsibility for the processing and resolutions of Grievances and Appeals.
Description of Responsibilities of Position: This role is responsible for reviewing, analyzing, and processing Grievances and Appeals to meet Contract requirements and help assure timely resolution for Members and Providers. The Coordinator's responsibilities also include: ▪ Uses guidelines and review tools to conduct extensive research and analyze the Grievance and Appeal issue(s) and pertinent claims and medical records to either approve or summarize and route to nursing and/or medical staff for review ▪ Prepares files for internal and external review by analysts, medical staff, or outside consultants and triages clinical and non-clinical inquiries, Grievances, and Appeals ▪ Prepares case files for committees/hearings and summarizes essential information for the Medical Director and legal counsel ▪ Tracks and prepares reports and trends on Grievances and Appeals to inform our quality initiatives and reporting to the Division
Minimum Experience Required: The Grievance and Appeals Coordinator must have at least three to five years working in Grievances and Appeals, claims, or customer service, or any combination of education and experience that would provide an equivalent background.
Skills Required: This role requires strong oral, written, and interpersonal communication skills, as well as problem-solving, facilitation, and analytical skills. The role also requires an understanding of managed care principles.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Requires a high school diploma or equivalent; associate degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: A strong background and understanding of State and federal regulations, including MississippiCAN and CHIP covered benefits and services, is essential to the success of our Grievance and Appeals Coordinator. In addition, the role needs experience with notification and scheduling timeframes, plus a working knowledge of HIPAA.

Key Position: Job Description
Title of Position: Claims Administrator
Description of Position: Our Claims Administrator oversees claims processing and adjudication, making sure claims are paid timely and accurate, and in accordance with Contract requirements.
Description of Responsibilities of Position: The Claims Administrator responsibilities also include: ▪ Manages the development and refinement of claims administration in accordance with State and federal regulations ▪ Oversees the full cycle of claims-process automation, identifying and leveraging data and technology to improve quality and maintain cost-effectiveness ▪ Performs root cause and audits of claims projects to determine trends and subsequently make recommendations for actions ▪ Maintains accountability for coordination of benefits program and policies to optimize payment accuracy ▪ Creates innovative solutions to automate processes and build reports, dashboards, and metrics to provide actionable insights on claims-handling and payment processes ▪ Oversees internal and external claims communication, making sure claims issues are handled professionally and timely
Minimum Experience Required: The Claims Administrator must have three to five years of claims operations and technical knowledge of claims systems.
Skills Required: This role requires strong analytical skills and attention to detail, as well as communication, facilitation, and problem-solving skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:**
Any additional information relevant to this position: The Claims Administrator must also have knowledge of medical codes as well as an understanding of managed care principles, end-to-end claims cycle, and MississippiCAN and CHIP covered benefits, services, and reimbursement.

Key Position: Job Description
Title of Position: Data and Analytics Manager
Description of Position: The Data and Analytics Manager verifies that data across our organization conforms to the Division's standards and policies, ensuring data quality and delivery.
Description of Responsibilities of Position: The Data and Analytics Manager maintains responsibility for the following: ▪ Manages the planning, development, and delivery of reporting and analytics solutions that help drive our operations and the delivery of high-quality care ▪ Supports key stakeholder partnerships by providing and leveraging data that is easily accessed and understood to support initiatives and provide key insights, such as health disparity trends ▪ Oversees the design and delivery of reports and visualizations that analyze business functions, key operations, and performance metrics in line with the reporting and analytics strategy ▪ Resolves complex data issues using analytical and technical skills ▪ Collaborates with cross-functional teams to develop and disseminate data across multiple sources and systems
Minimum Experience Required: The Data and Analytics Manager must have five to seven years of experience in reporting and analytics, stakeholder management, learning, and general business analysis. The role must also have experience designing high-impact visualizations, dashboards, and reports that make data more accessible, understandable, and usable.
Skills Required: The role requires advanced presentation, organization, and meeting facilitation skills and the ability to advise and work well under pressure.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: For the Data and Analytics Manager role, we also prefer knowledge of MississippiCAN and CHIP Programs, as well as managed care data integration, reporting, and management tools. This role must have the skills to anticipate any compliance issues or emerging gaps in access through data analytics.

Key Position: Job Description
Title of Position: Clinical Pharmacist
Description of Position: The Clinical Pharmacist role is responsible for coordinating all pharmacy services and related reporting.
Description of Responsibilities of Position: The Clinical Pharmacist serves as the primary contact for our pharmacy services, which includes the following responsibilities: ▪ Develops and implements clinical pharmacy program initiatives and processes to promote quality and cost-effective drug utilization ▪ Works collaboratively with the Division's Pharmacy Benefits Administrator (PBA) in all aspects of pharmacy administration and services, including making sure there are no disruptions in a Member's medication for those transitioning to or from another CCO ▪ Supports and collaborates with the PBA as needed with the pharmacy lock-in program, as directed by the Division ▪ Monitors the Division's Preferred Drug List (PDL) and works with Providers and Care Managers on changes to the PDL that may impact Members' prescribed medications ▪ Oversees clinical pharmacy operations and staff to make sure all related Contract deliverables are met, and maintains policies and processes, training, and communication related to pharmacy services ▪ Provides guidance related to Member medications during multidisciplinary rounds and liaises with the PBA for medication coverage and prescription fulfillment issues ▪ Develops pharmacy programs in conjunction with the PBA to address polypharmacy and other issues impacting Mississippi ▪ Manages both internal and external stakeholder communications for pharmacy ▪ Maintains responsibility for making sure the required drug utilization reports are submitted accurately and punctually to the Division weekly and resolves any disputes related to the data within 30 calendar days from notification by the Division
Minimum Experience Required: The Clinical Pharmacist must have three to five years of managed care pharmacy experience, including knowledge of current healthcare and managed care pharmacy practices (or any combination of education and experience that would provide an equivalent background). The role must also have advanced knowledge of pharmacy programs, policies, and procedures across Medicaid managed care organization operations, including UM, QM, and pharmaceutical requirements.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, including the ability to develop a collaborative relationship with the Division's PBA. The role must also possess problem-solving, facilitation, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Doctor of Pharmacy degree.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** Current State license to practice pharmacy as a Registered Pharmacist (RPH) required; professional designation preferred.
Are there any continuing education requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Minimum of 15 hours of continuing education credits per licensure annually.

Any additional information relevant to this position: The Clinical Pharmacist must have knowledge of MississippiCAN and CHIP covered services and benefits, as well as the ability to evaluate scientific evidence and best practices to apply these principles to best serve our Members. Extensive knowledge of medication therapies, treatment guidelines, and regulatory requirements is also preferred.

Key Position: Job Description
Title of Position: Member Encounters Data Analyst
Description of Position: The Member Encounters Data Analyst is responsible for end-to-end encounter data management operations, verifying timely and accurate reports and Member Encounter Data to the Division.
Description of Responsibilities of Position: The Member Encounters Data Analyst responsibilities include the following: ▪ Analyzes complex encounter process issues (both inbound and external), using data from a variety of internal and external sources to provide insight that supports decision-making ▪ Works in conjunction with the national Encounters team, which supports sharing of best practices and lessons learned to help ensure overall encounter data compliance ▪ Monitors encounter processes, submission requirements, and performance metrics to help ensure we continuously meet all Contract requirements related to encounter data ▪ Conducts root cause analyses of claims/encounters processing and submission to identify and resolve issues as quickly as possible ▪ Verifies the encounter process to verify rigorous validation of data accuracy from claim adjudication through encounter file creation ▪ Works collaboratively across departments to design and implement system changes to meet encounter data-processing and submission standards and goals ▪ Develops and disseminates reports to appropriate department leads for error resolution, follow-up, and performance monitoring ▪ Participates in a workgroup to identify and promptly resolve data and process issues across the organization
Minimum Experience Required: Three to five years related experience in an actuarial environment performing financial reporting, rate development, evaluation of risk contingencies and trend projections; or any combination of education and experience that would provide an equivalent background.
Skills Required: The role requires strong problem-solving, facilitation, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Requires a BS/BA degree in mathematics, statistics, or a healthcare-related field.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: This role also must have knowledge of Mississippi Medicaid and CHIP reimbursement methodology, along with experience with CMS required reporting. Prior experience with Mississippi fee-for-service and managed care claims adjudication processes is also needed.

Key Position: Job Description
Title of Position: Provider Network Manager
Description of Position: The Provider Network Manager is responsible for network development, network adequacy, and initial Provider training and education. The Provider Network Manager is responsible for ensuring that all network Providers and all out-of-network Providers to whom Members may be referred are properly licensed in accordance with federal and State laws and regulations.
Description of Responsibilities of Position: The Provider Network Manager responsibilities include the following: ▪ In conjunction with the Network/Contracting Manager, negotiates high-priority physician group and facility contracts ▪ Targets and recruits additional Providers to increase network adequacy ▪ Develops and deploys strategic network planning tools to drive Provider services and contracting strategy across the state ▪ Facilitates strategic planning and documentation of network management standards and processes ▪ Responsible for interfacing with the centralized credentialing vendor as necessary
Minimum Experience Required: Three years of experience in contracting, Provider relations, Provider servicing; experience working with smaller institutional Providers, professional Providers with more complex contracts, medical groups, physician groups, small hospitals that are not part of a health system, ancillary Providers, Providers in areas with increased competition; or greater Provider education around managed care concepts.
Skills Required: The role requires strong oral, written, negotiation, and interpersonal communication skills, including relationship management. The role must also possess problem-solving, facilitation, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in health or business-related field, or equivalent experience.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: This role must have knowledge of gaps in access to care, both statewide and in smaller geographical areas such as regions or counties. The role will assist the Network/Contracting Manager to help ensure Provider contracts comply with State, federal, and plan guidelines.

Key Position: Job Description
Title of Position: Marketing and Community Outreach Manager
Description of Position: The Marketing and Community Outreach Manager is responsible for overseeing all marketing, public relations, and community outreach activities.
Description of Responsibilities of Position: The Marketing and Community Outreach Manager oversees a team of Marketing and Community Outreach Representatives who are charged with identifying and fostering relationships with community stakeholders to drive information, education, and awareness of MississippiCAN and CHIP Programs and benefits across the state. The role's responsibilities also include: ▪ Oversees the development of a Marketing Work Plan, submitted annually to the Division for approval ▪ Maintains accountability for ensuring all marketing and informational materials are developed at the third-grade reading level as outlined by Flesch-Kincaid or other approved readability standard score ▪ Creates initiatives, policies, and processes to reach Members across the state and provide easily understandable and accessible information on covered benefits and services ▪ Oversees the process for identifying, tracking, and resolving any complaints or issues related to marketing (and reports to the Division any complaints that cannot be resolved satisfactorily for further resolution) ▪ Makes sure the entire team complies with all relevant statues and regulations with regards to marketing, including adherence to State and federal requirements for marketing, communication, and promotional activities ▪ Develops educational materials and initiatives to assist Members or potential Members with understanding Enrollment, benefits, and other related topics ▪ Submits all marketing materials to the Division within 60 calendar days prior to distribution for approval
Minimum Experience Required: Five years of experience developing impactful relationships that drive engagement with CBOs and faith-based organizations; five years of experience leading and developing talent while creating bench strength and opportunities for professional growth within the team.
Skills Required: The Marketing and Community Outreach Manager must have outstanding written and verbal communication skills; proven ability to build rapport and trust quickly is preferred.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in marketing, communications, or related field or equivalent experience.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: The Marketing and Community Outreach Manager should have experience in interacting with vulnerable populations, plus the ability to develop and maintain relationships with CBOs and Members. The role must also have the ability to assist Members and connect them with Care Managers or other program areas as appropriate. The role must have broad knowledge of Mississippi communities, including the diversity of populations and the health disparities that exist.

Key Position: Job Description
Title of Position: Marketing and Community Outreach Representatives
Description of Position: The Marketing and Community Outreach Representative leverages focused outreach initiatives and processes to engage Members and potential Members to keep them informed of healthcare services.
Description of Responsibilities of Position: The Marketing and Community Outreach Representatives assist Members and potential Members by providing them with information on covered benefits and services and information on Enrollment. Representative responsibilities also include the following: ▪ Identifies, develops, and builds relationships with community organizations, Provider offices, and faith-based organizations to reach individuals in the community ▪ Identifies and helps address cultural, linguistic, or SDOH barriers regarding current and potential Members and communicate issues to management so that processes and initiatives can be tailored to support these individuals ▪ Conducts marketing presentations to increase effectiveness in establishing rapport, assessing individual needs, and communicating product/benefit features and differences
Minimum Experience Required: Four years of experience in managed care/healthcare or sales/marketing environment; experience working with communities of all different ethnicities, cultural backgrounds, diverse populations, and/or underserved communities or any combination of education and experience that would provide an equivalent background.
Skills Required: The Marketing and Community Outreach Representatives must have strong customer relations, written, and interpersonal skills. Bilingual preferred.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Associate or bachelor's degree in relevant area of study.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: The role must have broad knowledge of Mississippi communities, including the diversity of populations and the health disparities that exist.

Key Position: Job Description
Title of Position: Value-Add Community Outreach Representative
Description of Position: The Value-Add Community Outreach Representative assists Members and potential Members by providing them with information on covered benefits and services and information on Enrollment.
Description of Responsibilities of Position: Value-Add Community Outreach Representative responsibilities also include: ▪ Identifying, developing, and building relationships with community organizations, Provider offices, and faith-based organizations to reach individuals in the community ▪ Identifying and helping address cultural, linguistic, or SDOH barriers regarding current and potential Members and communicating issues to management so that processes and initiatives can be tailored to support these individuals ▪ Conducting presentations to increase effectiveness in establishing rapport, assessing individual needs, and communicating product/benefit features and differences
Minimum Experience Required: Four years of experience in managed care/healthcare or sales/marketing environment; experience working with communities of all different ethnicities, cultural backgrounds, diverse populations, and/or underserved communities or any combination of education and experience that would provide an equivalent background.
Skills Required: The Value-Add Community Outreach Representatives must have strong customer relations, written, and interpersonal skills. Bilingual preferred.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Associate or bachelor's degree in relevant area of study.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: The role must have broad knowledge of Mississippi communities, including the diversity of populations and the health disparities that exist.

Key Position: Job Description
Title of Position: Administrative Assistant
Description of Position: Provides administrative level support to management and team members. Prioritizes management requests in order to meet business objectives. Supports the day-to-day administrative operations.
Description of Responsibilities of Position: Primary duties may include, but are not limited to: maintaining general files, ordering supplies, screening phone calls, and coordinating meetings. This role will also compile and distribute meeting minutes; coordinate travel plans and submit expense reports; compile, collate, and assembles meeting/presentation materials; and receive and respond to routine correspondence following established procedures.
Minimum Experience Required: Two years of administrative experience that include proficiency with personal computer and appropriate software, or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires minimum typing skills of 45 words per minute and good proof-reading skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** High school diploma or GED.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Appeals Nurse
Description of Position: Responsible for investigating and processing medical necessity Appeals requests from Members and Providers.
Description of Responsibilities of Position: This role will conduct investigations and reviews of Member and Provider medical necessity Appeals; review prospective, inpatient, or retrospective medical records of denied services for medical necessity; and prepare recommendations to either uphold or deny appeal to be reviewed by the Medical Director for approval. This role will maintain documentation and logs of Appeal/Grievance information on relevant tracking systems and mainframe systems and ensure that Appeals and grievances are resolved timely, meeting regulatory timeframes. This role will generate written correspondence to Providers, Members, and regulatory entities.
Minimum Experience Required: Two years of experience in a managed care healthcare setting.
Skills Required: The role require strong oral, written and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Associate or bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** Current active unrestricted RN, PA, LSW, LCSW, LPC, LMHC, or another accepted Mississippi license.
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Care Delivery Transformation Consultants
Description of Position: Obtains and analyzes Provider-specific cost and quality data and reports for cost of care and quality improvement opportunities; helps Providers target high-risk Members and gaps in care based on reports provided.
Description of Responsibilities of Position: This role supports the CCO's implementation of Population Health management, care coordination, and CM strategies; identifies action plans for Providers to implement to improve cost, quality, and the patient experience; and participates in the design, development, and implementation of community learning forums. This role serves as the point of contact for Providers and primary care practices, including program onboarding, facilitating routine meetings between the CCO and the Provider office. Serves as the subject matter expert and liaison with CM to facilitate clinical processes between the CCO and the Provider office. This role creates and hosts tailored learning opportunities to support the deployment of program interventions and hosts collaborative learning events that allow practices to learn from one another and national experts.
Minimum Experience Required: Five to ten years of healthcare experience; or any combination of education and experience, which would provide an equivalent background. Physician environment experience in practice transformation/quality improvement, ambulatory care setting quality and efficiency metrics, Population Health and CM structures, data analytics, and electronic health records preferred. Clinical background and/or MBA not required but a plus.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Claims Representatives
Description of Position: Investigates and facilitates the resolution of claims issues, including incorrectly paid claims, by working with multiple operational areas and health plans and analyzing the systems and processes involved in Member Enrollment, Provider information management, benefits configuration, and/or claims processing.
Description of Responsibilities of Position: Identifies the interdependencies of the resolution of claims errors on other activities within operations. Assists in reviews of State or federal complaints related to claims. Coordinates the efforts of several internal departments to determine appropriate resolution of issues within strict timelines. Interacts with network Providers and health plans regularly to manage expectations, communicate risks and status updates, and ensure issues are fully resolved.
Minimum Experience Required: Three to five years of claims experience; or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires communication, problem-solving, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** High school diploma or GED; Associate degree preferred
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Encounters Staff
Description of Position: The Encounters staff build and submit encounter data files, perform analyses related to encounter data quality, develop reports, formulate recommendations, and provide guidance for business units related to encounters metrics.
Description of Responsibilities of Position: The staff develops and analyzes encounter data performance reports (for example, timeliness or accuracy) and provides notations of performance deviations and anomalies. The Encounters staff provides consultation to other business areas, leadership, or subcontractors.
Minimum Experience Required: Minimum of five years of experience with relational databases and knowledge of query tools and statistical software is required. Ability to manipulate large sets of data. or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires strong analytical, organizational, presentation, and problem-solving skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Clinical Compliance Consultant
Description of Position: Responsible for completing regulatory audits of vendors that are required to meet compliance standards with federal, State, and NCQA rules and regulations, as applicable.
Description of Responsibilities of Position: Serves as point of contact, coordinating and collaborating with regulatory bodies and business partners to ensure compliance with regulatory, accrediting, and CCO quality of care and service requirements. Assists with the interpretation of applicable laws and regulations. Develops tools that assist in determining exposure to regulatory and/or accreditation risks. Identifies opportunities to manage and mitigate those risks. Works with business management areas to develop metrics for monitoring program objectives and policies and procedures that support compliance with regulatory and accreditation standards. Compiles information related to quality improvement and compliance monitoring activities for internal use and external audits and maintains relevant records. Provides guidance and oversight to business units to ensure ongoing regulatory or accreditation compliance and monitors corrective action plans relating to regulatory or accreditation compliance. Makes recommendations to business unit partners for improvements or remediation to risk management, regulatory, and accreditation compliance programs. Monitors development and use of metrics for regulatory compliance. Monitors business unit initiatives relating to the development and implementation of a risk management program for UM activities.
Minimum Experience Required: Five years of professional experience including three years of regulatory, compliance, accreditation, and/or auditing experience or any combination of education and experience, which would provide an equivalent background. Knowledge of clinical regulatory requirements such as experience with CMS and State regulatory and accreditation requirements preferred.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Associate or bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** Current active unrestricted RN, PA, LSW, LCSW, LPC, LMHC, or another accepted Mississippi license.
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Clinical Program Manager
Description of Position: Works side-by-side with clinical leadership and the clinical team to ensure that the CCO is meeting or exceeding performance benchmarks and contractual obligations. This role understands business processes and proactively identifies the need for creative and innovative changes to processes to support Member needs.
Description of Responsibilities of Position: Responsible for working with management to identify and implement varied projects, programs, and plans that support achievement of business unit and enterprise goals. Identifies potential issues, project charge, and scope. Leads efforts to identify best practices. Identifies impacted parties, business partners, and resources required. Develops and designs processes and systems that support business needs. Designs methods for integrating function and process. Conducts cost/benefit analyses. Builds support for business change throughout the business unit.
Minimum Experience Required: Five to eight years of process or project-related experience that includes experience in successfully developing and managing projects with fairly significant operating budget and knowledge of process redesign; or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Clinical Quality Auditor
Description of Position: This role will help confirm clinical quality through the auditing process, such as conducting on-site audits of prospective and existing physicians and independent practice groups. The Clinical Quality Auditor role will verify that both utilization and quality programs continuously meet criteria. The role will collect and analyze data to formulate recommendations and solutions based on audit trends and results, and monitors all clinical practice guidelines.
Description of Responsibilities of Position: Responsible for participating in clinical QM activities that ensure programs meet accreditation and regulatory standards. Primary duties may include, but are not limited to: Prepares team for oversight audits. Prepares corrective action plans in response to oversight body's request. Conducts audits of QM processes and files. Writes policies and procedures and assists with development of provider manuals, audit tools, and guidelines. Responsible for specific QM processes/functions (for example, compliance, Grievances/Appeals, or HEDIS/quality improvement projects). Assists manager with day-to-day monitoring and prioritizing of workflows and activities. Develops and improves departmental processes and operations. Monitors goals, performance, and processes. Assists with issues of non-compliance.
Minimum Experience Required: Two years of managed care experience in quality improvement, risk management, or utilization review, plus knowledge of local and national QM and regulatory standards, including NCQA and HEDIS. Five years of experience in UM, quality assurance and/or regulatory/accreditation standards/audits including three years of QM experience; or any combination of education and experience, which would provide an equivalent background.
Skills Required: Requires strong oral, written and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Associate or bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** Current active unrestricted RN, PA, LSW, LCSW, LPC, LMHC, or another accepted Mississippi license. Bachelor's of Science in Nursing (BSN) and CPHQ and prior project management experience is preferred.
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Clinical Quality Program Manager
Description of Position: This role oversees process improvements and Performance Improvement Plans (PIPs) as well as continuous data analysis for HEDIS projects, facilitates HEDIS and PIP workgroups within the CCO, and works collaboratively with functional leads. The Clinical Quality Program Manager will also support the QM Director in go-live preparations.
Description of Responsibilities of Position: Leads state-level quality strategy meetings, develops a quality plan, and ensures integration of quality into the overall business process. Works with the clinical intervention team to design studies to identify barriers to medical interventions. Ensures that study methodology is sound and appropriate reporting is in place. Develops PIPs and oversees the clinical quality improvement activities/projects to improve the quality of care for Members. Assures compliance with corporate quality improvement (QI) work plans. Assures that all QI activities are relevant to the needs of targeted population. Maintains effective documentation of research programs to meet regulatory and Accreditation Standards. Provides oversight to assure accurate and complete quantitative analysis of clinical data and presentation of data analysis results.
Minimum Experience Required: Four years of healthcare quality or data analysis experience (or any combination of education and experience that provides an equivalent background).
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Associate or bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** Current active unrestricted RN, PA, LSW, LCSW, LPC, LMHC, or another accepted Mississippi license. BSN and CPHQ and prior project management experience is preferred.
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Quality and PIP Coordinator
Description of Position: This position will oversee PIP interventions and track data to identify trends and outcomes. The Quality and PIP Coordinator will work cross functionally with other departments and oversee activities that support PIP goals.
Description of Responsibilities of Position: Ensures integration of quality into the overall business process. Performs assessments to identify gaps in the enterprises quality and technology assessment processes and initiates actions to correct these gaps. Assures accuracy and completeness of input provided to internal and external QI committees and timely implementation of appropriate interventions. Oversees the clinical quality improvement activities/projects to implement appropriate clinical interventions to improve the quality of care for Members. Assures compliance with corporate QI work plans. Assures QI activities are relevant to the targeted population. Assures compliance with practice guideline, delegation, and continuity and coordination of care standards.
Minimum Experience Required: This role requires a as well as three years of healthcare quality or data analysis experience (or any combination of education and experience that provides an equivalent background).
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Associate or bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** Current active unrestricted RN, PA, LSW, LCSW, LPC, LMHC, or another accepted Mississippi license. BSN and CPHQ and prior project management experience is preferred.
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Diabetes Educator
Description of Position: This position will reach out to Members to provide information on managing diabetes and to offer diabetic nutritional classes. The Diabetes Educator will also work with Providers and community stakeholders on best practices for closing diabetes gaps.
Description of Responsibilities of Position: Ensures integration of quality into the overall business process. Performs assessments to identify gaps in the enterprises quality and technology assessment processes and initiates actions to correct these gaps. Assures accuracy and completeness of input provided to internal and external QI committees and timely implementation of appropriate interventions. Oversees the clinical quality improvement activities/projects to implement appropriate clinical interventions to improve the quality of care for Members. Assures compliance with corporate QI work plans. Assures QI activities are relevant to the targeted population.
Minimum Experience Required: This role requires a as well as three years of healthcare quality or data analysis experience (or any combination of education and experience that provides an equivalent background).
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:** A current unrestricted license or certification in an applicable field is preferred, such as CPHQ, and Diabetes Education certification.
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: EPSDT Coordinator
Description of Position: The EPSDT Coordinator will oversee the EPSDT program including strategy, data analysis, and development of QI activities. This position will track outcomes and use the Plan-Do-Study-Act model for continued quality improvement.
Description of Responsibilities of Position: Ensures integration of quality into the overall business process. Performs assessments to identify gaps in the enterprises quality and technology assessment processes and initiates actions to correct these gaps. Assures accuracy and completeness of input provided to internal and external QI committees and timely implementation of appropriate interventions. Oversees the clinical quality improvement activities/projects to implement appropriate clinical interventions to improve the quality of care for Members. Assures compliance with corporate QI work plans. Assures QI activities are relevant to the targeted population. Assures compliance to practice guideline, delegation, and continuity and coordination of care standards.
Minimum Experience Required: This role requires a as well as three years of healthcare quality or data analysis experience (or any combination of education and experience that provides an equivalent background).
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Associate or bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** Current active unrestricted RN, PA, LSW, LCSW, LPC, LMHC, or another accepted Mississippi license. BSN and CPHQ and prior project management experience is preferred.
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Employment Specialist
Description of Position: This position serves as an expert in and of employment and workforce development across the market. This role will direct and oversee employment strategies and relationships that will be in partnership with counties and community agencies. This position is essential to these programs, as they will require standing up with outreach, development and implementation, along with ensuring Member Enrollment in appropriate programs. This position is ultimately responsible and accountable for evaluation of all programs (employment and health for ROI) and reporting outcomes to leadership.
Description of Responsibilities of Position: Economic growth, workforce development, and education that leads to economic stability are top priorities of Mississippi and Governor Tate Reeves. These priorities have been challenging due to the severe continuing need individuals and families are facing across the U.S. due to the COVID-19 pandemic. Our Mississippi CCO will prioritize ensuring access to employment opportunities for our Members, including four new initiatives as part of the new Contract to support our Members. These solutions are different components to a comprehensive employment strategy model designed to: ▪ Deploy a flexible, multi-faceted approach that addresses a spectrum of needs and aligns with the State's areas of interest — despite current unpredictability ▪ Use proven, integrated solutions that impact multiple segments of membership — increasing efficiency ▪ Leverage embedded local resources to determine needs of individual Members, foster partnerships, and drive action for outcomes ▪ Make investments in evidence-based practice models for employment that leverage additional external expertise, and show organizational commitment to local workforce development efforts
Minimum Experience Required: Five to eight years of process or project-related experience that includes experience in successfully developing and managing projects with fairly significant operating budget and knowledge of process redesign; or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Foster Care Specialist
Description of Position: This position will have experience and expertise with children, adolescents, and transition aged-youth programs, and will specialize in supporting the social needs of foster care Members as well as their families and caregivers.
Description of Responsibilities of Position: The Foster Care Specialist will have a broad knowledge of the various SDOH domains, specifically those that impact youth and adolescents, and will focus on the complex systems and domains that influence and interact with the foster care population, including but not limited to trauma-informed support and navigation of community-based specialty services. This position will be familiar with the services available through Mississippi State agencies, and will assist Care Managers, CM teams, and CBOs help address non-medical barriers for Members and individuals in alternate situation or home placement settings. They will be responsible for collaborating with CBOs supporting this population, and developing and operationalizing SDOH projects that increase capacity and improve overall health.
Minimum Experience Required: Five to eight years of process or project-related experience that includes experience in successfully developing and managing projects with fairly significant operating budget and knowledge of process redesign; or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Government Relations Director
Description of Position: Responsible for developing and implementing strategies to advocate for company and large state-specific legislative and regulatory positions. In the most complex legislative and/or regulatory environments, directs and oversees the resolution of highly complex, varied and sensitive political issues within the region, and may have federal or multi-state responsibility.
Description of Responsibilities of Position: Establishes and maintains strong relationships with legislators, regulators, other policymakers, and their staff that will support membership growth. Develops strategies for utilizing political action committees and/or corporate political contributions. Makes internal and external written and oral presentations on behalf of the company. Develops coalitions and target grassroots networks. Manages budgets and issues of importance to our national company and contracted lobbying staff and may act as a team lead.
Minimum Experience Required: Eight years of legislative, regulatory, political, public affairs or industry experience; or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Grievance and Appeals Representatives
Description of Position: The Grievance and Appeals Representative conducts investigations and reviews of customer grievances and Appeals involving provision of service and benefit coverage issues.
Description of Responsibilities of Position: The Representative contacts customers to gather information and communicate disposition of case and documents interactions. The Representative generates written correspondence to customers such as Members, Providers, and regulatory agencies. The Representative performs research to respond to inquiries and interprets policy provisions to determine the Member's benefits. The Representative assures appropriate resolution to inquiries, grievances, and Appeals within specified timeframes established by either regulatory/accreditation agencies or customer needs. The Grievance and Appeals Representative proactively identifies barriers to customer satisfaction and recommends actions to address operational challenges.
Minimum Experience Required: One to three years of experience in the health insurance business including customer service experience; or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires good verbal and written communication, organizational, interpersonal skills and PC proficiency.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** High school diploma or GED.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Housing Specialist
Description of Position: This position will serve as an expert in and of housing and further directs and oversees the new housing programs that will be in partnership with counties and community agencies.
Description of Responsibilities of Position: This position will support the CCO's housing programs as well as community housing community collaborations. They will require standing up with outreach, design, development and implementation, along with operationalizing and integrating into Member care coordination across CCO functional areas. This position is ultimately responsible and accountable for evaluation of all programs (housing and health for ROI) and reporting outcomes to leadership.
Minimum Experience Required: Five to eight years of process- or project-related experience that includes experience in successfully developing and managing projects with fairly significant operating budget and knowledge of process redesign; or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Investigators
Description of Position: Responsible for providing leadership and guidance to the Special Investigation Unit on investigating, collecting, researching, and analyzing billing data to detect fraudulent, abusive, or wasteful activities and practices.
Description of Responsibilities of Position: Provides comprehensive, sound judgment in the application of various investigative methodologies to team members and effectively evaluate and recommend focused investigative activities involving market trends that suggest fraud, waste, and abuse within the healthcare industry. Through use of appropriate system tools, provides training for and conducts analysis of data to detect fraudulent, abusive, or wasteful payments to Providers and subscribers. Prepares statistical and financial analyses and reports to document findings and maintains up-to-date case files for management review.
Minimum Experience Required: More than five years of related experience in healthcare insurance and healthcare insurance investigation, law enforcement, or any combination of education and experience which would provide an equivalent background. Knowledge of plan policies and procedures in all facets of benefit programs management with heavy emphasis in negotiation preferred.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:** Professional certification of CFE, AHFI, CPC, Paralegal, RN, JD, or related designation preferred.
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Medical Directors
Description of Position: Responsible for providing day-to-day guidance, support, and leadership for the clinical and quality activities and supporting the Medical Director in assuring the clinical integrity of broad and significant clinical programs and identifies.
Description of Responsibilities of Position: Develops opportunities for innovation to increase effectiveness and quality. Provides support to clinicians in daily tasks and assuring timely and consistent responses to Members and Providers, conducts peer-to-peer clinical reviews with attending physicians or other ordering Providers to discuss review determinations, and conducts office visits with Providers and external physicians as necessary. May participate in a physician on-call rotation for a 24/7 pre-certification unit, assists in the practitioner appeal reviews, appropriateness criteria reviews, medical policy, and technology assessments, setting and implementing QI initiatives, and practitioner/provider credentialing. Serves as a resource and consultant to other areas of the company and may be required to represent the company to external entities and/or serve on external committees, and conduct peer clinical and/or appeal case reviews and peer-to-peer clinical reviews with attending physicians or other ordering Providers to discuss review determinations.
Minimum Experience Required: Minimum of 10 years of clinical experience or any combination of education and experience which would provide an equivalent background. Three or more years of experience and knowledge of Mississippi and MississippiCAN and CHIP Programs.
Skills Required: Requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Requires a Medical Doctor or Doctor of Osteopathy.
Are any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** Current Mississippi license to practice medicine with no restrictions or limitations. Board-certified in a specialty recognized by the American Board of Medical Specialists.
Are there any continuing education requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Minimum of 40 hours of category I continuing education medical credits per two-year cycle.
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Member and Provider Services Call Center Representatives
Description of Position: Member and Provider Services Call Center Representatives have access to real time data on Members, including, but not limited to, eligibility status and all service and utilization data.
Description of Responsibilities of Position: Analyzes problems and provides information/solutions. Thoroughly documents inquiry outcomes for accurate tracking and analysis. Develops and maintains positive customer relations and coordinates with various functions within the company to ensure customer requests and questions are handled appropriately and in a timely manner. Researches and analyzes data to address operational challenges and customer service issues. Provides external and internal customers with requested information. Proficient in all basic customer service functions. Receives and places follow-up telephone calls/emails to answer customer questions.
Minimum Experience Required: Three years of customer service experience; or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** High school diploma or GED.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Network Analyst
Description of Position: Responsible for providing technical support to the Network Development team by producing, analyzing, interpreting, and using reports needed for network analytics
Description of Responsibilities of Position: Conducts research and analyses of new and existing provider networks. Primary duties may include, but are not limited to: Participates in the development of new target networks in a strategic geographic location; monitoring team and Provider performance (volume and processing statistics); generating mass notifications for Providers; and data sharing across multiple platforms. Conducts network analysis through GeoAccess and other metrics to determine network needs across all service levels.
Minimum Experience Required: Three years of analytical, business or operational experience in healthcare delivery system and/or network services; or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: OB Practice Consultant
Description of Position: Assesses current practice patterns, assets, and challenges utilizing Medical Home Index, NCQA standards, HEDIS audits, site reviews, and medical records reviews. In partnership with the PCP, evaluates results of the Member's initial assessment. Establishes a project plan with the Provider that includes goals and objectives for improvement.
Description of Responsibilities of Position: Provides ongoing Provider support and sustains the partnership. Establishes regular meetings to track progress. Identifies and facilitates practices to obtain NCQA certification as a PCMH. Improves the understanding and sensitivity to the unique needs of pregnant women and their caregivers.
Minimum Experience Required: Five years of managed care experience; two years of clinical experience; two years of professional presentations to small and large audiences; or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Associate or bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** Current active unrestricted RN, PA, LSW, LCSW, LPC, LMHC, or another accepted Mississippi license.
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Patient-Centered Medical Home (PCMH) Transformation Consultants
Description of Position: This team will work closely with our Population Health Director and Provider Services Manager to identify and recruit new Provider practices into the PCMH program.
Description of Responsibilities of Position: Deliver guidance, training, and technical assistance to Provider groups who are working towards achieving or maintaining PCMH recognition, including walking Providers through the initial application or re-certification process.
Minimum Experience Required: Five years of medical management experience; or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Associate or bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** Current active unrestricted RN, PA, LSW, LCSW, LPC, LMHC, or another accepted Mississippi license; NCQA PCMH Content Expert Certification.
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Director Health Care Management
Description of Position: Oversees the development and execution of medical and CM policies, procedures, and guidelines, and assists in developing clinical management guidelines. Ensures medical management activities are contracted, reviewed, and reported.
Description of Responsibilities of Position: Primary duties may include, but are not limited to: Directs and provides leadership for designing, developing, and implementing integrated medical management program to meet the demographic and epidemiological needs of the populations serviced. Partners with other CCOs/corporate leaders to develop and deliver innovative CM services, root cause analyses, and solutions to achieve quality outcomes. Directs Healthcare Management Program including chronic condition management, CM, and UM. Provides expert consultation to local plan staff on benefits interpretation and utilization and QM matters. Ensures support for compliance with NCQA and assures compliance with State/and or federal program requirements.
Minimum Experience Required: Ten years of clinical work experience, including prior management experience; or any combination of education and experience, which would provide an equivalent background. Previous experience with NCQA accreditation and HEDIS reporting required.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Associate or bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** Current active unrestricted RN, PA, LSW, LCSW, LPC, LMHC, or another accepted Mississippi license.
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Program Advisor
Description of Position: Program Advisor responsibilities include executive reporting, project communications, management of issues logs and change requests, facilitating project meetings, managing deliverables, and assuring resolution of escalated issues.
Description of Responsibilities of Position: Develops and coordinates presentations and materials for executive management meetings, internal and external speaking engagements, and meetings. Responsible for the implementation and execution of strategy that includes change management, sponsorship and buy-in, and advocacy efforts to get business results. Provides process, project, and change management methodology coaching/consulting support for initiatives including regulatory and mandated projects, healthcare reform special projects, and corporate initiatives. Leads, identifies, tracks, and reports on areas for increased efficiency. Develops, monitors, and tracks metrics supporting budget and spend. Manages variance process, staffing plans, and adds to staff (budget neutral).
Minimum Experience Required: Three to five years of experience in large-scale project management and/or project implementation with multi-year, organization-wide, cross-functional initiative launches that include vendor management and negotiation expertise; or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Program Integrity Manager
Description of Position: Oversees the monitoring and enforcement of the fraud, waste, and abuse compliance program to prevent and detect potential fraud, waste, and abuse activities pursuant to State and federal rules and regulations.
Description of Responsibilities of Position: Has detailed technical knowledge of claims payment accuracy and participates on cross-functional teams focused on problem remediation and long-term resolution. Anticipates the effect of changes in the business environment on future claim errors. Evaluates regulatory compliance and healthcare reform changes to determine potential impact. Evaluates Provider activities to assist in the detection of fraud, waste, and abuse activities. Monitors provisions of the compliance plan, including fraud, waste, and abuse policies and procedures, investigates unusual incidents, and implements corrective action plans. Develops and analyzes monthly reports. Develops project plans and oversees project execution, issue management, and progress reporting. Develops processes to support early detection of systemic issues causing operational inefficiencies.
Minimum Experience Required: More than eight years of experience with operations, financial reporting, and analysis, audit guidelines, budgeting, and multi-state operations and processes; experience with complex business environments including multiple entity and highly automated situations; five years of management experience; or any combination of education and experience which would provide an equivalent background. Managed care experience strongly preferred.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Program Integrity Staff
Description of Position: The Special Investigation Unit staff investigate assigned cases, collect, research, and analyze claim data to detect fraudulent, abusive, or wasteful activities/practices.
Description of Responsibilities of Position: The staff use appropriate system tools and databases for analysis of data and review of professional and facility claims to detect fraudulent, abusive, or wasteful healthcare insurance payments to Providers and subscribers. The Special Investigation Unit staff prepare statistical/financial analyses and reports to document findings and maintain up-to-date electronic case files for management review. The staff submit final case reports and notification of findings letters to Providers. They receive offers of settlement for review and discussion with management.
Minimum Experience Required: More than two years of related experience, preferably in healthcare insurance departments such as Grievance and Appeals, contracting or claim operations, or law enforcement; or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Provider Call Center Manager
Description of Position: Responsible for providing oversight for Provider Services Call Center Representatives. Responsible for establishing departmental policies and procedures.
Description of Responsibilities of Position: Directs implementation and administration of benefit programs. Prepares and communicates information to appropriate parties regarding benefit programs, procedures, changes, and government-mandated disclosures. Audits to monitor efficiency and compliance with policies; prepares specialized reports; and may be assigned to special project work consistent with the role and dictated by the needs of the CCO.
Minimum Experience Required: Two to three years of previous management experience and five years of customer service experience; or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Provider Experience Consultants
Description of Position: This role develops and maintains positive relationships with Provider community by maintaining regular on-site and/or virtual/digital visits, communicating administrative and programmatic changes, providing education, and resolving Provider issues.
Description of Responsibilities of Position: Serves as a primary contact for Providers, maintaining knowledge and resources to resolve complex Provider challenges, including researching and promptly resolving Provider issues and Appeals. Works across CCO departments to triage issues and submit work requests. Conducts follow-up on Annual Provider Satisfaction Surveys and required Corrective Action Plan implementation. Coordinates prompt claims resolution through direct contact with Providers, claims, pricing, and medical management department. Identifies and reports on Provider utilization patterns that have a direct impact on the quality of service delivery.
Minimum Experience Required: Five years of customer service experience including two years of experience as a Network Management Representative; or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: SDOH Specialist
Description of Position: Building relationships with and developing SDOH programs with CBOs will a critical component to the Mississippi CCO.
Description of Responsibilities of Position: The SDOH Specialist will be responsible for making connections and collaborating with CBOs of varied expertise who address the varied social needs of residents and communities. This role will have a broad and wide knowledge of all SDOH domains and their impact to health, as well as a familiarity with the Mississippi communities, organizations, and social systems across the state. This position will assist Care Managers and CM teams help address social barriers for Members, and will be responsible for partnering with CBOs to develop, implement, and evaluate programs that include but are not limited to domains such as food insecurity, education, personal safety, social isolation, and environmental challenges.
Minimum Experience Required: Five to eight years of process or project-related experience that includes experience in successfully developing and managing projects with fairly significant operating budget and knowledge of process redesign; or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: SDOH Training Specialist
Description of Position: Works with CCO leadership to deliver training to all Member-facing staff on a variety of topics including specialized training for Population Health solutions like housing, employment services, and cultural competency.
Description of Responsibilities of Position: Primary duties may include but are not limited to: Facilitating learning events that are performance-based, delivering synchronous and asynchronous learning events using various media; employing rapid course development methodologies to quickly meet client needs; managing classroom and learner participation; and escalating issues to our Learning and Development team and client leadership when necessary. This role will measure, track, and evaluate learner and client satisfaction.
Minimum Experience Required: Two years of training experience; or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Telehealth Program Manager
Description of Position: This role will work with Providers to assure that they have the information and resources needed to successfully implement or expand telehealth services in their practices. This will include the dissemination of information, training, supplies, and assistance with technical and billing issues.
Description of Responsibilities of Position: Champions telehealth programs and meet on-site or virtually with Providers to offer technical assistance, including, but not limited to helping Providers launch their telehealth platforms, conducting test runs of telehealth software, and providing training on compliant telehealth claims submissions.
Minimum Experience Required: Five to eight years of process or project-related experience that includes experience in successfully developing and managing projects with fairly significant operating budget and knowledge of process redesign; or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Vendor Oversight Manager
Description of Position: Oversees vendor performance, ensuring each is compliant with all Contract requirements.
Description of Responsibilities of Position: Serves as a liaison between the Division and our partners to assure any requirement changes or performance issues are directly communicated and appropriately escalated to the partner to achieve resolution. They will be an integral part of the Subcontractor Management team, which will also include shared services resources and CCO leadership.
Minimum Experience Required: Three to five years of increasingly responsible professional-level contract management/vendor management experience; or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Transportation Specialist
Description of Position: This position will be familiar with the urban, suburban, and rural landscapes and available transit services within Mississippi, including public, private, non-profit, volunteer, and CCO benefits-based Non-Emergency Transportation services that are available to Members and residents of the community.
Description of Responsibilities of Position: The Transportation Specialist will be responsible for overseeing all Non-Emergency Transportation services and will help Members connect with transportation options that best support a Member's overall health. Additionally, this role will build relationships with Mississippi organizations and agencies to understand the challenges, successes and opportunities they experience with transportation infrastructure, and develop and implement programs to help residents access the places they need to go.
Minimum Experience Required: Five to eight years of process or project-related experience that includes experience in successfully developing and managing projects with fairly significant operating budget and knowledge of process redesign; or any combination of education and experience, which would provide an equivalent background.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Utilization Management Clinician
Description of Position: Responsible for managing psychiatric and SUD facility-based and outpatient professional treatment health benefits through telephonic or written review.
Description of Responsibilities of Position: Primary duties may include but are not limited to: Using appropriate screening criteria knowledge and clinical judgment to assess Member needs to ensure access to medically necessary, quality behavioral healthcare in a cost-effective setting in accordance with UM clinical guidelines and the Contract. Will refer cases to Peer Reviewers as appropriate. Performs psychiatric and SUD assessments, coordination, implementation, case planning, monitoring, and evaluation to promote quality Member outcomes that optimize Member health benefits and promote effective use of health benefits and community resources.
Minimum Experience Required: Three to five years of acute care clinical experience or case management, UM, or managed care experience, which would provide an equivalent background.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Associate or bachelor's degree in relevant area of study; master's degree preferred.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** Current active unrestricted RN, PA, LSW, LCSW, LPC, LMHC, or another accepted Mississippi license.
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Medical Management Specialists
Description of Position: Medical Management Specialists are responsible for supporting our medical management process, which includes handling more complex file reviews and inquiries from Members and Providers. These Specialists perform all necessary medical assessments and help make sure we meet all Members' CM needs.
Description of Responsibilities of Position: The Medical Management Specialist gathers clinical information and determines the appropriate area to refer or assign a case (such as UM). Specialists consult with clinical reviewers or the Medical Director to ensure medically appropriate, high-quality care. Additional responsibilities include the following: • Provides information regarding network Providers or general program information when requested • Maintains and updates tracking databases, prepares reports, and documents all actions related to review and determinations • Provides non-clinical support, which excludes conducting any UM review activities that require interpretation of clinical information
Minimum Experience Required: Five years of administrative and customer service experience with knowledge of managed care or Medicaid concepts or any combination of education and experience, which would provide an equivalent background.
Skills Required: Effective interpersonal and active listening skills. Effective written/verbal communication, physician relationships, and customer satisfaction skills. Ability to multi-task and prioritize.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** High school diploma or GED.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Care Manager
Description of Position: Our Care Managers offer personalized support to address Members' needs, help them and their families make informed decisions, coordinate care, and support them in improving their health. This position will also work to increase health literacy and advance health equity.
Description of Responsibilities of Position: Care Managers build trust and rapport with Members and their families or caregivers. They work collaboratively with other Care Managers, Providers, and others involved in the Member's care to support care coordination and development of an individualized treatment plan. Additional responsibilities include the following: • Makes sure that Members are receiving the most appropriate care and services • Supports the Member and Provider in providing post-stabilization services needed to make sure the Member's health remains stable following an admission • Provides ongoing care coordination and discharge planning with the Member or their family/caregivers, facility, and treating Providers • Addresses Members' needs, including SDOH, by coordinating care across the continuum and informing Members and their family on resources, supports, and tools available to them • Identifies gaps in care and reaches out to Members to understand and address root causes • Participates in the closed-loop referral process to make sure that referrals for medical services and community-based services are completed • Participates and assists as necessary in development of the reassessment plan of care and makes changes in the plan of care based upon findings • Documents any change in a Member's condition and authorizes services to visit Member for an assessment and possible change in the treatment plan • Communicates with primary care or PCMH concerning an emergency room visit
Minimum Experience Required: We require all our Care Managers to have three or more years of relevant clinical experience, such as acute care, health education, case management, and telephonic or in-person coaching. We also look for specialized clinical experience, such as a background in maternal health; the child welfare system; experience assisting Members with complex psychiatric, substance use, or medical disorders; or experience working with American Indian communities. Experience working with or significant knowledge of CBOs, State agencies, and wraparound services in the geographical areas in which the live/work. For our American Indian Care Manager, we require equivalent education and experience, along with training and demonstrated knowledge of American Indian communities in Mississippi.
Skills Required: Requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Graduate from accredited school from program relevant to licensure requirement; bachelor's or master's level preferred.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** All Care Managers must hold a current unrestricted Mississippi license in Nursing (RN), Counseling (Licensed Professional Counselor, Licensed Marriage and Family Therapist), or Social Work (Licensed Clinical Social Worker, Licensed Master Social Worker).
Are there any continuing education requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Minimum of 20 hours of continuing education medical credits per licensure renewal cycle.

Any additional information relevant to this position: This position will participate in a two-day training on Person Centered Thinking© by the Learning Community for Person Centered Practices, which is an interactive course that teaches skills and tools to better assist Members in living the life they want in their communities.

Key Position: Job Description
Title of Position: Care Management Navigator
Description of Position: The Care Management Navigator (CMN) leverages critical thinking skills and judgment to collaborate with and support Care Managers in facilitating positive health outcomes for Members. CMNs work as part of the CM team on initiatives and strategies designed to increase health literacy and advance health equity.
Description of Responsibilities of Position: Our CMNs maintain responsibility for the following: • Supports Care Managers in assisting and connecting Members to the resources they need • Provides home visits when necessary and in conjunction with the CM team to evaluate Member needs • Helps Members navigate the healthcare system and manage their conditions, identifying appropriate community resources, and participating in the care coordination process • Participates in outreach and engagement initiatives to reach Members in their communities across the state and provide information and supports
Minimum Experience Required: CMNs must have experience working with or significant knowledge of CBOs, State agencies, and wraparound services in Mississippi communities. They must also have one year of relevant experience or any combination of education and experience that would provide an equivalent background.
Skills Required: The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** High school diploma or GED.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** As applicable to role, including but not limited to Peer Support Specialist and postpartum Doula certification.
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: This position will participate in a two-day training on Person Centered Thinking by the Learning Community for Person Centered Practices, which is an interactive course that teaches skills and tools to better assist Members in living the life they want in their communities.

Key Position: Job Description
Title of Position: Community Health Worker
Description of Position: The CHW uses crucial thinking skills and judgment to collaborate with and support Care Managers and CMNs to facilitate positive health outcomes for Members. CHWs serve as part of the overall CM team on initiatives and strategies designed to increase health literacy and advance health equity.
Description of Responsibilities of Position: The CHW is responsible for developing strong relationships with community organizations and stakeholders and in building trust with Members and their families/caregivers to support prevention focused care. The CHW's additional responsibilities include: • Connects with Members in their preferred location (for example, center, facility, home, community setting) • Conducts wellness checks in the home as needed and in conjunction with the CM team • Participates in remote monitoring program education for individuals with specific health conditions • Serves as a bridge to help link Members to services and supports, particularly those who may be harder to reach • Identifies and addresses disparities among Members and facilitates culturally and linguistically responsive communication to make sure their needs are addressed
Minimum Experience Required: The CHW must have experience working with or significant knowledge of CBOs, State agencies, and wraparound services across Mississippi.
Skills Required: The role must also have critical thinking skills and judgment to collaborate and inform the CM process to facilitate appropriate healthcare outcomes for Members.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** High school diploma or GED.
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**
Any additional information relevant to this position: This position will participate in a four-day training on CHW core skills and capacity, which addresses key topics for building rapport and engaging Members, such as cultural competency, implicit bias, health literacy, and motivational interviewing.

Key Position: Job Description
Title of Position: Transitional Care Nurses
Description of Position: As part of the CM team that support transitions of care, this role will be responsible for working in conjunction with UM staff and our Medical Director, Perinatal Health Director, and Behavioral Health Director to assure continuity of care as Members transition from one level of care to another.
Description of Responsibilities of Position: Transitional Care Nurses will be responsible for the following: • Administers appropriate Member assessments, develops Transition of Care/treatment plans, completes review of claims, conducts medication reviews, and maintains documentation of telephonic contacts, case notes, referrals, and actions taken/recommended • Works with the Member and family or caregiver to improve adherence with medications and treatment • Helps ensure the Member and any family caregiver(s) are informed and understand how to manage their health • Coordinates with hospital discharge planners to promote safe transitions from the inpatient setting
Minimum Experience Required: Transitional Care Nurses must have three or more years of relevant clinical experience, such as acute care, health education, case management, and telephonic or in-person coaching.
Skills Required: Requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Graduate from accredited school from program relevant to licensure requirement; bachelor's or master's level preferred.
Are any professional licenses or certifications required for this position? **[x] Yes [ ] No** **If yes, list below:** Must hold a current unrestricted Mississippi license in Nursing (RN) plus at least three years of relevant experience in the field.
Are there any continuing education requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Minimum of 20 hours of continuing education medical credits per licensure renewal cycle.
Any additional information relevant to this position: This position will participate in a two-day training on Person Centered Thinking by the Learning Community for Person Centered Practices, an interactive course that teaches skills and tools to better assist Members in living the life they want in their communities.

Key Position: Job Description
Title of Position: Systems and Reporting Analysts
Description of Position: The Systems and Reporting Analysts are responsible for developing, maintaining, and improving reports and dashboards, to support achievement of key deliverables and performance indicators.
Description of Responsibilities of Position: The role provides reports on a daily, weekly, and monthly, as well as ad hoc basis, to ensure timely information and insights are provided in support of operations. Additional responsibilities include: • Serves as the designee to respond to issues involving systems and reporting, Member encounter data, Grievances and Appeals, quality assessment, Member and Provider Services, EPSDT, medical management, CM, and all other aspects of covered benefits and services delivery by our CCO • Completes metrics research and analysis to support performance improvement initiatives • Analyzes data available through reports to identify trends and issues requiring process re-engineering or system optimizations
Minimum Experience Required: The Systems and Reporting Analyst must have three to five years of experience in reporting and analytics, stakeholder management, learning, and general business analysis. The role must also have experience designing high-impact visualizations, dashboards, and reports that make data more accessible, understandable, and usable.
Skills Required: The role requires strong analytical, organizational, and problem-solving skills. The Systems and Reporting Analyst is focused on complex and varied metrics, making recommendations, and assisting CCO leadership.
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree in relevant area of study or equivalent combination of education and experience.
Are any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:**
Any additional information relevant to this position: For the Systems and Reporting Analyst, we also prefer knowledge of MississippiCAN and CHIP Programs, as well as managed care data integration, reporting, and management tools. This role must have the skills to anticipate any compliance issues or emerging gaps in access through data analytics.

[END OF RESPONSE]

4.3.3.3 Administrative Requirements

1. Administrative Office

Amerigroup Mississippi, Inc. (Amerigroup) has finalized a letter of intent to lease 10,067 square feet of office space at 750 Woodlands Parkway, Ridgeland, Mississippi. This facility is located 10 miles from the Division's High Street location in Jackson, Mississippi, in accordance with the requirement detailed in Contract Section 1.14, for our office to be located within 15 miles of the Division's offices. We are attaching a signed letter of attestation (Appendix H) confirming that our administrative office will be located within 15 miles of the Division's offices at 550 High Street in Jackson. Our office will house approximately 96 Amerigroup staff, which represents 39% of our total Mississippi-based workforce. Executive leaders and staff members from multiple departments, such as Finance, Member Services, Provider Services, Medical Management, Quality Management, and others, will be housed at this location.

In addition to this administrative office facility in Ridgeland, Amerigroup has established a Wellness Center in the Jackson Medical Mall. This space currently hosts our Health Equity Advisory Council meetings and serves as a community resource for a variety of purposes, including but not limited to hosting our community-based partners that need space for trainings, computer training, and Zumba sessions. We will be expanding its use for other purposes: health literacy education, financial literacy education, and employment/resume building sessions, among other types of activities that will benefit our Members and the local community.

Division Office Space

We welcome the opportunity to collaborate with the Division, and within our administrative offices, we will dedicate private workspace for Division staff. We will make this space and any requested technology and supplies available to the Division with 24 hours' notice. This space will include a desk and chair, computer with a printer, internet access, telephone, and office supplies. In addition, Division staff will be provided access to other Amerigroup equipment and amenities, such as a copier with scanning capabilities.

2. Administrative Records and Data

Per Contract Section 16.1, Amerigroup's administrative records and data will be accessible to the Division and authorized State or external reviewers at our office located at 750 Woodlands Parkway, Ridgeland, Mississippi.

Storing and Maintaining Administrative Records

Electronic data will be housed in our Management Information System (MIS). Critical electronic data is replicated from our organization's data centers (Richmond, Virginia, Virginia Beach, Virginia, Cerritos, California, and Ashburn, Virginia) to the owned remote Disaster Recovery site. Access to this data will be governed through our Records Management program, as described in the section that follows. We will maintain and make available for review all records during the entire term of the Contract and for no less than 10 years after, or until all audits, litigation, or other legal actions are resolved.

Amerigroup's MIS will store information about services provided to our MississippiCAN and CHIP Members through claims submitted by their Providers and encounters from our subcontractors. Our MIS will maintain the history of Member claims processed for all services — medical, behavioral health, vision, dental, and transportation, including those provided by subcontractors. Our MIS will also maintain comprehensive information on functional areas supporting our MississippiCAN and CHIP Programs, including enrollment/disenrollment; complaints, Grievances, and Appeals; utilization and quality management; call center use and statistics; training records; Medical Loss Ratio reports; and all relevant medical information relating to individual Members. Our MIS security protocols will balance safeguarding Protected Health Information with the ease of appropriate access to information.

Process and Time Frame for Retrieving Records

Amerigroup will comply with any requests for records from the Division or other State or authorized external review representative and deliver the information in the manner and format specified. Virtually all data will be

available online (not in storage/archive). Records will be readily retrievable within three business days from our administrative offices, facilitating prompt access and request fulfillment.

Our local, dedicated Mississippi Compliance Officer will capture all requests for information from the Division, including the specified due date and format, and make certain that our response meets the processes and time frames detailed in Contract Section 10.1. The Compliance Officer will:

- Log the request and due date in the regulatory tracking system
- Forward the request to the appropriate business owner/subcontractor, specifying an internal due date in advance of the required date
- Review the provided information to confirm that it is complete and in the required format
- Submit the information to the Division or requesting entity and log request completion

The Compliance Officer will address any follow-up questions from the Division after their review.

Amerigroup's Records Management Program

Our Records Management program will provide a consistent, effective approach to managing company records from their creation to destruction. The program provides each business unit with direction and support for managing the life cycle of its records, including appropriate retention, storage, retrieval, and disposal. The Records Management program applies to all employees, subcontractors, and consultants.

Amerigroup's Records Management Program

- Covers records that support business operations, regardless of media
- Meets Division and federal requirements
- Applies to all employees, consultants, and subcontractors
- Is communicated to all and monitored for compliance

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A record is a document created, received, or maintained during business operations, regardless of media. Record media include electronic records, written and printed documents, letters, reports, worksheets, and email.

The Records Management program works toward the following objectives:

- Records stored in an appropriate, safe, and accessible manner
- Records efficiently retrieved for legal, audit, or other business purposes
- Records maintained in compliance with applicable laws and regulations
- Provision for the identification and preservation of records relevant to pending or reasonably foreseeable legal or administrative proceedings or audits
- Appropriate disposal of records when retention periods are satisfied

Our Compliance Officer works with the national Records Management team to oversee the program, including compliance, security, and access. Records that have fulfilled their official retention period are required to be reviewed for legal holds by the Legal department and the Records Manager prior to destruction. In general, records involved in Special Investigation Unit investigations are retained for a minimum period of as required by contract and/or state law(s). These materials may be stored on site at a company office, or off site at a vendor facility that specializes in records retention and security.

All employees receive annual training on the Records Management program, which includes modules about:

- Complying with policies and laws on retention, storage, maintenance, and destruction of information
- Using local desktop procedures, including the Record Retention Schedule for the employee's department
- Understanding where to go and who to contact for additional information

Employees also have access to documents on specific program requirements, including Records Management Procedures, Records Retention Schedule, and Destruction of Confidential and Proprietary Information.

4.3.3.3 Administrative Requirements (Marked) – 5 points

Offeror attests to the following:

3. The Offeror will have an Administrative Office within fifteen (15) miles of the Mississippi Division of Medicaid's Central Office at the Walter Sillers Building, Jackson, Mississippi 39201-1399, as required by the RFQ.

Amerigroup Mississippi, Inc.
Name of Offeror

Tara Clark
Printed name of person attesting for Offeror

President and Chief Executive Officer
Title of person attesting for Offeror

Signature of person attesting for Offeror

3/2/2022
Date

[END OF RESPONSE]

4.3.3.4 Staffing

Amerigroup's staffing approach reflects our belief that healthcare solutions are most effective when developed and delivered locally. As described throughout this section, we are proud to bring a local team that will support the Division's mission and vision and achieve the best outcomes for Members. Championed by our top-tier leaders in managed care who live and work in the state, our organizational culture and staffing structure will promote continuous process improvement, so that we deliver the best for our Members, Providers, and the Division.

1. Staffing Ratios Per Enrolled Member

As one of the first lines of contact, we will recruit and hire Member Services employees who have the background and passion to assist Members and families with the information they need, when they need it. We complement this with ongoing training that provides personal and professional growth for these staff, which in turn brings value to Members by assuring they have a positive, helpful experience. Additionally, we make sure our employees have the right tools and resources to meet Member needs and to excel in fulfilling their role and responsibilities, including best practice and resource guides, well-defined policies and procedures, electronic tools, and access to subject matter experts.

Table 4.3.3.4-1 describes the staffing ratios we will use per enrolled Member as well as our supervisor to staff ratios. With a strong team of Member Services Call Center Representatives, we will maintain processes for continuous monitoring, forecasting, and adjusting our staffing levels, as needed, to meet performance standards and the requirements outlined in Contract Section 5.

[redacted]

We use staffing information, levels, and ratios based on our affiliates' experience serving 10.6 million Medicaid Members across 26 other markets, relying on real-time reports to identify and respond to unplanned call volumes. Our Workforce Management team functions as an information hub, recognizing trends across all our call centers.

We will leverage this trend information to forecast staffing for our local Mississippi Member services call center. Combining call volume and average handling time data with membership projections and other sources of data, such as seasonal variations, we will produce a forecast of monthly call volumes and average handle times. The forecasts are developed in half-hourly intervals, by day. From these forecasts, we then create staffing schedules. We will review and adjust forecasts at regular intervals to account for changes in membership, actual performance, upcoming program or benefit changes, and seasonal factors.

Monthly, we will submit a report to the Division that includes the call center staffing to call ratio, including recommendations on appropriate staffing based on Call Center Sufficiency Standards, as required in Contract Section 5.1.6. Further, to rapidly respond to substantial increases in call volumes, we can expand our call answering queue to include designated backup in other call center locations. We will also routinely route a

percentage of calls to these locations to make sure that, in the event of an interruption in local services, Members who contact us will be assisted by Member Services Call Center Representatives (MSCCRs) who are both trained and current on the needs of Mississippi. While our system prioritizes Mississippi-based staff to answer calls from Mississippians, there are approximately [redacted] staff in other call centers who can also provide backup call coverage, when needed, and who will have easy access to Mississippi-specific reference materials and job aides.

Job Qualifications for Member Services Call Center Employees

[redacted]

Training and Education for Member Services

Our Member Services staff will receive special training to answer calls compassionately and respectfully, providing clear and simple information and assistance. Beginning with new hire training, we will educate these staff on our Member-centered approach to care, best practices, and strategies for engaging Members and families. Throughout their employment, we will provide continuous training, coaching, and supervision to support employees in consistently applying these principles when serving our Members. We teach employees to demonstrate our values through the choices they make in daily interactions with each Member, and that a single action by any one employee impacts the customer experience. We conduct our training in a controlled environment with supervision and coaching, including listening to recorded and live calls to provide real-time feedback, followed by an evaluation period. Our training curriculum and resources incorporate several educational strategies to accommodate different learning styles. This includes written materials, interactive class discussions, and computer-based tutorials to support employees in acquiring the skills necessary to deliver knowledgeable and accessible assistance and services to our Members.

Initial Training

All employees serving Members will attend an initial orientation about Amerigroup, HIPAA privacy compliance requirements, the MississippiCAN and CHIP Programs, and our membership base. MSCCRs will then participate in an intensive [redacted] training course before they begin answering live calls from Members in the nesting environment, where we make sure new representatives will be closely monitored and have support resources immediately available to them. The nesting period is that period of training when the representative is nearing the end of training and the period where they can function independently or "leave the nest." The full training will continue for a total of [redacted] days and is delivered in segments in which an MSCCR learns certain processes and applies those processes for a short period of time. Next, the representative will return to the classroom and learn additional skills that build on the first segment. Our training process will include the following components:

- **Classroom Training.** An experienced trainer who has in-depth knowledge of Mississippi Members and covered benefits and services will facilitate a multi-week training program.
- **Systems Training.** MSCCRs will also be trained to use our knowledge management system and integrated desktop application for real-time access to program requirements, covered services, eligibility, and claims data. Training includes:
  - **Nesting Calls.** Live calls will be received to acclimate employees to system tools and resources.
  - **Nesting Huddles.** Call Center leaders meet with their employees daily to discuss situational events they encountered for clarification or resolution.
  - **Quality Review.** During the nesting period, we increase call monitoring to make sure employees are performing to our standards.

Our training program for Member Services complies with the requirements outlined in Contract Section 5.1.5 and assures that staff know how to effectively respond to any question or concern, including how to appropriately transfer a Member to a Care Manager, the 24-hour BH/SUD line, or the 24-hour nurse advice line. Our local Social Determinants of Health (SDOH) Training Specialist, who will report to our Chief Information Officer, will oversee training programs and will maintain comprehensive documentation of staff training, curriculum, schedules, and attendance. All training will include timeframes for completion and tests for individual and organizational comprehension. Quarterly, we will submit reports in accordance with Contract requirements detailing trainings conducted, topics covered, and the number and positions of staff who

completed the trainings. Depending on the training and mode of delivery, our monitoring mechanism to verify completion includes completed training schedules from managers and system records of web-based trainings.

In Table 4.3.3.4-2, we outline our broad topic areas of training. Our structured, classroom-based curriculum includes modules that cover topics such as the role of primary care/patient-centered medical homes; fraud, waste, and abuse; cultural sensitivity, how to interact with Members in a culturally appropriate manner and recognize callers with language barriers; health equity and implicit bias; local Providers and resources; and more. The curriculum also includes priority topics, such as trauma-informed care, suicide prevention, and opioid use disorder.

Table 4.3.3.4-2. Our Member services training prepares staff to meet Member needs.

Training Area	Topics Covered
Program-specific Topics	▪ Overview and history of MississippiCAN and CHIP ▪ Medicaid managed care ▪ MississippiCAN and CHIP structure, Contract, and program requirements ▪ Populations served ▪ Cultural competency, including health literacy, health equity, and implicit bias ▪ Enrollment and eligibility policies ▪ Covered benefits and services, including physical health, BH, pharmacy, Value-Added Benefits, including enhanced dental, vision, and non-emergency transportation, and Member incentive programs ▪ Member rights and responsibilities ▪ How to access care ▪ Preventive care services ▪ Members with specialized healthcare needs ▪ Care Management programs and services ▪ Referrals to community-based resources ▪ Fraud, waste, and abuse and the False Claims Act ▪ Advance directives ▪ Mississippi Provider network
Member Services Call Center Core Topics	▪ Basic system tools for communication and customer service ▪ Interacting with Members in a compassionate, empathetic, and trauma-informed way ▪ Systems training and online resources ▪ Caller verification process ▪ Cultural sensitivity, including assisting Members with limited English proficiency, Members who are deaf or hard of hearing, and Members who may have communication difficulties or challenging behaviors ▪ Crisis situations, including suicide warning signs and appropriate actions to take ▪ Care Management process, including connecting Members with their Care Manager, appropriately identifying Members who need Care Management (CM) referrals or who wish to self-refer for CM, and internal warm transfer processes ▪ Processes to address ID card replacement, balance billing inquiries, primacy care changes, and Member complaints, Grievances, and Appeals ▪ How to address disenrollment requests

Prior to interacting with Members and families, MSCCRs must also successfully complete formal training on recognizing and responding to crisis calls, including how to recognize suicide warning signs, triage situations, and identify appropriate actions to take. We have developed specific training in collaboration with the Zero Suicide Institute and the National Action Alliance on Suicide Prevention to implement a best practice for suicide risk prevention. All MSCCRs will receive training and follow strict guidelines to recognize an emergent or urgent call comes in; staff will listen for signs of distress, depression, anxiety, or intent of callers to harm

themselves or others. If the Member is experiencing a crisis, our staff will warm transfer the call to bring a licensed clinician who is trained and experienced in BH on the line to address the crisis in real time.

We will also offer specialized training, referred to as the CARE service curriculum, to enhance the ability of our staff to connect with Members and provide a positive Amerigroup experience, including seamless warm hand-offs when appropriate. CARE training assures our MSCCRs:

- **C**onnect with Members on a personal level and show genuine interest
- **A**lways communicate with confidence and knowledge
- **R**esolve inquiries by taking responsibility and presenting solutions
- **E**nd with a positive lasting impression

[redacted]

Ongoing Training

After our MSCCRs receive their initial training and begin taking Member calls, they will benefit from continued training assuring their skills remain fresh and they have up-to-date knowledge of MississippiCAN and CHIP Programs and services. These employees will receive trainings at least quarterly, in accordance with requirements in Contract Section 5.1.5. Our training platform capabilities provide a comprehensive way to alert, track, monitor, and assure staff complete required trainings for their positions and ongoing or refresher courses as required or indicated.

When we introduce a new product or system, we will make certain MSCCRs receive training and fully understand it. Our staff will also receive updates about continued Medicaid changes and requirements, including "Late Breaking News" articles; Provider bulletins; State Plan Amendments, CHIP State Plan Amendments, and Administrative Code Filings; Provider Billing Handbook; and MississippiCAN and CHIP updates, as indicated in the Contract. We will also offer courses to enhance service skills and professional development, such as:

- Identifying and responding to customer styles
- Understanding how to uniquely serve each Member
- Understanding the defining moment in a Member interaction
- Implementing standards to stay in tune to Member needs and expectations

Employees will also receive ongoing training on handling calls received; how to assist callers with accessing medical services; cultural competency (including diversity training, Mississippi geography, and cultural references); and assisting Members with limited English proficiency. We offer these trainings through numerous methods such as online, in-person, group, and individual trainings.

2. Staffing Ratios per Enrolled Provider

Our Provider Services Call Center Representatives (PSCCRs) will offer comprehensive, personalized assistance to help Providers who have questions, concerns, or complaints. Timely and accurate responses and assistance are essential to building a collaborative relationship with our Providers. Our Provider services call center is the centralized point of contact to simplify services (including automated self-service after hours) on things like eligibility, benefits, authorization, and the resolution of claims issues. Table 4.3.3.4-3 describes our staffing ratios for PSCCRs per enrolled Provider as well as our supervisor to staff ratios.

Making sure the Provider services call center remains appropriately staffed requires a two-part process: developing a forecasting model tailored to Mississippi and then monitoring calls in real time. With affiliates in 26 Medicaid and CHIP markets, we bring extensive call center experience that has taught us to develop forecasts at each half-hourly interval, by day, and ongoing. From these, we plan, create, and maintain employee schedules, time off, and off-phone activities.

We will monitor the call center in real time to identify times when actual call volume is higher or lower than expected and will move staff to the queues where they are needed throughout the day to maintain optimal levels of service. We will use weekly, monthly, and quarterly reports to predict call volumes and establish initial staffing levels. We then use more frequent data (as often as every 15 minutes) to adjust the number of staff who are taking calls. If there is a material difference between the volume of calls coming in and the forecasted number, we will add or remove PSCCRs from the queue. When a representative is removed from the queue, they will be released to complete assigned training. When call volume is higher than expected, leadership will pull data related to the call types and reach out to our Provider Experience team as necessary to gain a better understanding of what is driving the calls and what can be done to proactively address the issue (for example, notification on the website, fax blast, or outreach from network relations staff).

Further, if call volume increases beyond the capacity of our scheduled representatives to respond, or if there is a natural disaster, we can expand the call answering queue to include designated backup representatives in other locations.

Job Qualifications for Provider Services Call Center Employees

Training and Education for Provider Services Call Center Employees

Our PSCCRs will undergo the same initial orientation and ongoing training as our Member services call center staff, outlined earlier in Question 1. This includes customized training on MississippiCAN and CHIP Program requirements and benefits as well as claims processing, so that they can assist Providers with services, eligibility, claims, and other information they may need. Beginning with new hire training, we will educate these employees on our Member-centered approach to care, best practices, and strategies for engaging callers. Throughout their employment, we will provide continuous training, coaching, and supervision that support consistent application of these principles when serving our Members and Providers.

We will conduct training in controlled environments with supervision and coaching, followed by evaluation. Our curriculum will cover a variety of topics, including Member Services core training including cultural competency, Provider Services training, and training specific to MississippiCAN and CHIP Programs. The training curriculum will support our staff in building the skills necessary to deliver knowledgeable and accessible assistance and services. ***Providers can be confident they are talking to a skilled representative with complete knowledge of issues who is committed to solving the inquiry on the first call.***

Before they begin answering live calls from Providers, our PSCCRs must complete an intensive -day training course, where we make sure new representatives are closely monitored and have support resources immediately available to them. Full training will continue for a total of days and will be delivered in segments in which employees learn certain processes and apply those processes for a brief period. Next, these employees will return to the classroom and learn additional skills that build on the first segment. We will submit quarterly reports to the Division detailing the trainings conducted, topics covered, and the number and positions of staff completing the trainings.

Like our Member Services training, our PSCCRs will benefit from ongoing training to keep their skills fresh, and they will be continuously engaged in professional development. We will provide education at least quarterly focused on Medicaid, MississippiCAN and CHIP including changes and requirements via "Late Breaking News" articles; Provider Bulletins; State Plan amendments, CHIP State Plan Amendments, and Administrative Code Filings; the Division's Provider Billing Handbook; and MississippiCAN and CHIP Program updates.

3. Quality Management Staff and Their Qualifications

Every employee at Amerigroup is a champion of quality and contributes to our culture of continuous quality improvement. To support the success of quality management (QM), we will bring a strong, local cross-functional team backed by national resources. Our best-in-class QM programs will be fully customized to meet the local needs of Mississippians. Our CEO and Medical Directors bring deep knowledge and experience serving Mississippians and will be integral to shaping our quality agenda to support the Division's goals and to advance health equity. We are excited to have these key leaders to our Mississippi operations. Further, we designed our QM program to encourage inclusive participation from a wide range of stakeholders – Members, Providers, subcontractor partners, and community organizations. Our QM program is grounded in NCQA health plan standards and best practices, and our team holds accountability for driving the program's success.

Amerigroup's skilled and qualified local QM staff will include:

[redacted]

[redacted]

[redacted]

4. Amerigroup's Local Care Management Team

Our overall Population Health approach drives our efforts to design customized CM programs that prioritize Mississippi's challenges and the Division's goals as well as meet Member needs and improve health literacy. Across our organization and affiliates, we have built strong CM programs backed by highly skilled and trained CM teams — all of whom work together across local communities to reach and engage Members. We will offer similar programs tailored to support the Division's goals and to address Mississippi's challenges, such as the high rates of infant mortality and preterm births, the prevalence of chronic conditions such as diabetes, and health disparities that exist.

Role of the Care Manager and Care Management Team

Our CM team structure facilitates localized Care Management at the site of care, in the home, or in the community, while also equipping our system partners (Providers or community-based organizations) with tools, analytics, and support to address the physical health, BH, and social needs of Members. As a single, fully integrated unit, our CM team includes Care Managers, Care Management Navigators, and Community Health Workers who will closely mirror the communities they serve by bringing knowledge of local resources, nuances, culture, language, and norms. With a strong understanding of the community, they will also help drive the development of partnerships and initiatives with community-based organizations, state agencies, and wraparound resources available in the state. In addition, our CM team includes Transitional Care Nurses, who coordinate continuity of care for Members and make sure their transition from one level of care to another is seamless.

This fully integrated structure is reflected in our leadership and the composition of our team. The team will be led by our Medical Director, a Mississippi-licensed family practitioner who has built strong relationships with Providers across the state. The Medical Director will spearhead the CM team, including the Mississippi-licensed Perinatal Health Director (who will be hired prior to implementation) and Mississippi-licensed BH Director, a practitioner board-certified in adult, child/adolescent, and forensic psychiatry.

These clinical leadership roles will be actively involved in all clinical and quality program components, utilization management (UM) decisions, and quality assurance activities. They will oversee the development and update of clinical care standards, practice guidelines, and protocols to help assure all of our care coordination and CM programs are responsive to the needs of Mississippians.

Our Population Health Director will also be part of our leadership, overseeing health literacy campaigns, programs and strategies designed to help reduce health disparities and advance health equity. This Population Health Director will work collaboratively with our CM team to help assure we are providing individualized care and support that addresses Members' needs currently and as their health and social circumstances change over time.

Together, these clinical leaders will support a team of dedicated professionals, including a Care Management Director to manage the day-to-day clinical activities of our CM team, who are structured to be as close to Members as possible, serving Members in the communities where they live and work. Above all, our CM team will help make healthcare easier and less overwhelming for our Members, serving as advocates and working with Members and their families to help them understand the types of services available, how to make informed decisions, and how to participate in their own healthcare. They will coordinate all aspects of a Member's care and bring the multidisciplinary team together to develop treatment plans that reflect the Member's strengths and goals.

Education, Training, and Experience Required for Care Managers

Table 4.3.3.4-4 highlights our CM team and the minimum qualifications for each role. The team incudes specialized Care Managers with experience working with specific populations to make sure we fully meet our Members' needs and get them connected to treatment as quickly as possible. Our Care Management Navigators and Community Health Workers extend the reach of our Care Managers and will work in conjunction with them to further support and connect Members to the most appropriate services. Additionally, our Transitional Care Nurses work in tandem with the rest of the CM team along with UM staff and our Medical Directors to thoroughly monitor care for Members as they transition and assure continuity and access to the follow-up services and supports needed.

[redacted]

Assuring Care Managers Are Culturally Competent and Understand Member Needs
We recognize Members are most likely to access care and follow treatment plans when healthcare systems and services are culturally competent and linguistically accessible. ***Hiring our CM team from the same communities they will serve enhances their understanding of the local culture, values, and beliefs of our Members.***

Our CM programs place Members and their families at the center of care planning with culturally responsive supports to help them manage health conditions and improve outcomes. To assure all of our CM team staff are culturally competent and understand Member needs, we will incorporate several strategies in our overall training approach. First, our Care Managers (and all staff who interact with Members) will receive cultural competency training during initial onboarding and annually thereafter. This comprehensive training includes applicable laws (such as the Civil Rights Act and ADA), cultural competency, healthcare literacy, and the language interpretation and translation services we offer. New staff must complete this training within 30 days of hire. In addition, the training covers implicit bias as well as the development of disability-related cultural competency skills so that Care Managers and other staff who directly assist Members have a better understanding of the perspectives of people who rely on supports — including the creativity and resiliency of individuals and families in their local communities and knowledge related to improving SDOH. Our SDOH Training Specialist will monitor attendance, and we will submit a quarterly report to the Division listing employee completion in accordance with Contract Section 5.1.5.

In addition, CM staff will have access to a Diversity and Inclusion Toolbox, which offers an all-in-one training resource that combines research-based strategies and practical tools to help develop inclusive leadership skills and promote behaviors that are the foundation of an inclusive culture. The toolbox includes a comprehensive, searchable database that helps staff understand the influence of culture on one's beliefs, values, and behaviors in general and specifically, in a healthcare environment. The toolbox provides information on more than 50 different cultural groups on such topics as communication, family patterns, nutrition, treatment protocols, and ethno-pharmacological issues. It also features material on mitigating unconscious bias, inclusion of people with disabilities, and religious diversity in the workplace.

To help assure our CM staff fully understand Member needs, we will also cross-train them on how to recognize and address the whole person. We incorporate evidence-based best practice programs into our CM training to facilitate the delivery of whole person care, such as Person Centered Thinking© by the Learning Community for Person Centered Practices, trauma-informed care, recovery and resiliency, and motivational interviewing. ***This training shifts the traditional model of care delivery from leading care coordination activities for Members to working with them to establish their own goals and make their own decisions that improve their overall health and wellness.***

Beyond training, our CM team will consider the unique circumstances of each Member when connecting them to services. Based on each Member's unique needs, our holistic approach helps us determine the intensity needed for Member outreach, align appropriate coordination and supports, and prioritize interventions. While data and risk stratification can help us predict Member needs, we understand these do not replace the clinical judgement of our trained and licensed Care Managers. All of our Care Managers recognize that each Member's risk and needs are affected by more than a diagnosis. They will consider acuity level, self-management skills, healthcare system navigation skills, natural supports (personal relationships, family, close friends), unmet social needs, geographic location, and the presence of health disparities to identify the appropriate level of support needed.

We will align Care Manager assignments to Members based on their unique circumstances, assigning one that most clearly meets their primary need. For example, a Member with high-risk pregnancy will be assigned an

OB Care Manager, who will provide personalized support and care coordination aligned with the woman's risk level throughout her pregnancy and post-partum.

Additionally, we will bring the best clinical knowledge to support Members by holding integrated care rounds where our Care Managers can solicit feedback and leverage team expertise from a variety of sources, including UM clinicians, clinical managers and team leaders, the Diabetes Educator, Population Health and Care Management Directors, and Medical Directors. Care Managers will have access to expertise, best practices, and physician sub-specialties across our affiliate plans to further support their knowledge in addressing Member needs.

Ability to Reach Care Management Ratios Described in the Draft Contract

Amerigroup has established processes and procedures to make sure that CM staffing resources are aligned with Member needs across the state and will meet Care Management ratios of at least 40:1 (Members to Care Managers), as described in Contract Section 7.3. Across our CM team, leadership will have access to reporting that will help determine staffing decisions. Additionally, we will regularly submit reports regarding our staffing resources to the Division, as requested.

We designed our CM program to address the varying needs of Members, recognizing that Members who have more complex needs may require more intensive time and support. We will assign and maintain CM ratios according to the Contract requirements and to assure each Member's safety and health using factors such as:

- Level of care coordination and CM required
- Acuity and complexity of the Member's clinical and SDOH needs
- Language and cultural preferences
- Geography and population distribution
- Contact frequency and modalities
- Amount, scope, and duration of service needs
- Care Manager qualifications, experience, access to supportive staff, and proximity to the Member

We will assign Care Managers with relevant experience that will best meet a Member's specific needs. ***From North Mississippi to the Delta, Pine Belt, and Gulf Coast areas, our CM team will be local and will work throughout Mississippi so that we can easily reach and connect Members to the continuum of services and supports they need in their communities.*** Our CM team leadership will routinely evaluate our Care Manager staffing to determine if new resources are needed by region or if we are seeing trends where staffing should be shifted, based on engagement, case acuity, or anticipated Member growth. Leadership will use several variables to determine and adjust staffing needs, including case mix, stratification and risk scores, face-to-face outreach needs, and geographic location of Members in comparison to the CM team.

Training and Education Provided to the CM Team

We equip our Care Managers and the entire CM team with the education, training, and resources they need to be successful in their roles. From day one, we will offer comprehensive new hire and ongoing specialized training for the staff we hire in Mississippi. All CM team staff will undergo a 90-day orientation and training period during which they will learn the basic functions of their job and the policies and procedures that will govern our Mississippi program operations.

At the center of this curriculum is our interdisciplinary team approach — the full integration of physical, behavioral, functional, and social health. All CM team staff must master the requisite skills to coordinate services and supports for Members with co-occurring disorders. Following classroom instruction and skills practice, they will receive on-the-job training for at least the remainder of the 90-day training period.

Through training on motivational interviewing, we aim to enhance our CM team's skills to better engage Members, build rapport, and support a Member's ideas, concerns, and ability to make their own choices. ***Following orientation, CM staff will receive two full-day trainings on Person-Centered Thinking by the Learning Community for Person Centered Practices, an interactive course that teaches skills and tools to better assist Members in living the life they want in their communities.*** Table 4.3.3.4-5 provides a sample of our training topics.

Table 4.3.3.4-5. Preparing our CM team to meet the individual needs of Members: core training topic samples.

CM Team Training Topics		
MississippiCAN and CHIP Benefits and Covered Services	Division Contract Requirements	Cultural Competency, Health Literacy, and Health Equity
Predominant Chronic Conditions in Mississippi	Care Management Theory and Practice	Social Risk Factors that Impact Care (Economic Stability, Housing, and Environmental Impacts)
Mississippi's Regional Strengths and Challenges	Community-based Resources Across the State	Clinical Practice Guidelines for Physical and Behavioral Health
Medical Necessity	Predictive Modeling and Stratification	Risk Levels – Services and Supports Across Each level
Motivational Interviewing	Trauma-informed Care	Adverse Childhood Experiences
Integrated Care Approach	UM Principles, Protocols, and Tools	Care Coordination Processes
Recovery and Resiliency	Behavioral Health, Including Co-Occurring Disorders, Harm Reduction, and Suicide Prevention	Collaboration with Providers, State Agencies, and Stakeholders
Monitoring Member Progress in Care	Discharge Planning	Programs for Members Who Have Specialized Healthcare Needs
Transitions of Care Process	Quality Management Program	Pharmacy Benefit and Medication Management
Fraud, Waste, and Abuse	Legal and Ethical Issues in Care Coordination and Management	Incident and Reporting of Adverse Events and Grievances
Value-Added Benefits	Addressing Inappropriate Emergency Room Use	Working with Other Case Managers (Foster Care, Adoption Assistance)

To hone our CM team's skills to engage Members and deepen our reach in communities, we are also providing four-day training on CHW core skills and capacity, led by Susan Mayfield-Johnson, PhD, MCHES, an Associate Professor at the University of Southern Mississippi. Dr. Mayfield-Johnson teaches graduate students in the health education emphasis area. She also serves as the Director of the Center for Sustainable Health Outreach (CSHO). CSHO has been designated as a best practice CHW model for rural health, and centers on curriculum development, training, and evaluation of CHW models with various health disparate and underserved populations. Dr. Mayfield-Johnson's classes also address key topics for building rapport and engaging Members, such as cultural competency, implicit bias, health literacy, and motivational interviewing.

Ongoing and Continuing Education for Our CM Team

After orientation, our CM team will receive monthly quality assurance audits and feedback on their performance as well as ongoing. We build training into annual performance goals and our clinical leadership will work with each Care Manager to identify, plan, and meet individual training needs. Through our Mississippi Medicaid Academy, we will provide sustained training over time rather than relying on one-time types of training. The Academy is a powerful vehicle that helps us facilitate robust, uniform, and compliant training for our staff. The Academy platform is flexible

and enables us to offer customized training for MississippiCAN and CHIP Programs based on best practices. We will routinely provide our CM team with ongoing training as well as annual refresher courses on Contract requirements, cultural competency, compliance, ethics, and HIPAA. Through the Academy, our CM team can also access self-directed training modules in addition to our core required curriculum.

We Support Continuing Education and Development for Care Managers

From the moment our employees join our team, they have access to resources to support their professional development. Employees will have access to more than 10,000 development resources to support their career aspirations, and this includes the courses required to prepare for over 100 certifications, as well as courses that qualify for continuing education credits to support various licenses — all free of charge.

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Further, we will offer tuition reimbursement and paid time off to attend training that will fulfill continuing education needs for our licensed Care Managers. CM staff will also have access to an online catalog of resources on the company intranet to further hone their skills. Through our Academy platform, we have a comprehensive way to alert, track, monitor, and assure CM team staff complete specifically required trainings for their positions and ongoing refresher courses as required. Our approach streamlines developing, delivering, and reporting on training into one system, which makes it easy for staff to complete training and obtain the latest evidence-based best practices. Our staff can also access trainers certified in professional development courses, such as Meyers-Briggs, Unconscious Bias, and Discovery Insights.

5. Process for Obtaining NCQA Accreditation Status

Amerigroup has robust processes to obtain (and maintain) NCQA accreditation. As a new plan in Mississippi, we will leverage these processes along with the experience and support from our parent company and affiliates to achieve NCQA accreditation within the first 18 months of operating in the state. We will also obtain Multicultural Health Care distinction as outlined in Contract Section 8.2. We recognize that NCQA will phase out Multicultural Health Care Distinction on June 30, 2022 and will replace this with Health Equity Accreditation as of July 1, 2022 and will obtain this distinction.

Across our organization and affiliates, we prioritize NCQA accreditation as part of our commitment to industry best practices so that our Members receive the highest quality of care. Our Medicaid affiliates in 21 states hold Health Plan Accreditation — Accredited Status from NCQA, while the remaining markets are newer and in process of obtaining this status. ***From our parent company to our affiliates, we have a 100% success rate on accreditation applications and meeting required timeframes to achieve this. As a whole, we have not had any unsuccessful submissions for NCQA Health Plan Accreditation.***

Working Toward NCQA Accreditation

To help assure the accreditation process runs smoothly, we will have a local Accreditation Manager dedicated to Mississippi. This position will be supported by our National Medicaid Quality and Accreditation department, a team that brings years of NCQA and Quality experience. For example, two Directors are current NCQA surveyors and one is a Surveyor in Training. The Mississippi Accreditation Manager will have access to The National Quality and Accreditation team's best practices and processes for obtaining NCQA accreditation via ongoing meetings, an accreditation playbook, reports and materials for core standards, and multi-level review of CCO documentation to help prepare for NCQA review. We will undergo extensive preparation to achieve accreditation with the highest star rating.

We will prepare for accreditation by applying within six months of the MississippiCAN and CHIP go-live date, beginning the three-month survey process within 15 months, and participating in the full survey within the first 18 months. Consistent with our affiliates' experience, we will prepare for NCQA to review our policies and

procedures and evaluate the standards for their Interim option. Once we achieve Interim accreditation, we will prepare for the subsequent CCO accreditation surveys.

During the process, we will provide updates to the Division as well as any changes to timelines as appropriate, as outlined in Contract Section 8.2. We will also provide all documents related to accreditation annually to the Division and will submit for re-accreditation at least once every three years. In addition, we will authorize NCQA to provide the Division with our NCQA review including accreditation status, survey type, level (as applicable) as well as any recommended actions, summary of findings, and accreditation expiration date. We will post our accreditation status to our Mississippi plan website.

Additional NCQA Accreditations That Define Quality and Drive Better Outcomes

Our organization and affiliates are bolstered by additional NCQA accreditations and distinctions — all of which will help support our Mississippi operations in bringing best practices and accredited-programs to Members from day one.

We are highly invested in the disciplined quality approach promoted by NCQA standards, as evidenced by our affiliates' additional recognitions.

As a member of the Anthem, Inc. family of health plans, Amerigroup also benefits from the expertise, proven industry-leading experts, and tools of our parent organization, Anthem, Inc. (Anthem), and its subsidiaries. Anthem holds NCQA Population Health Program Accreditation, which is awarded to organizations that align operations to manage different Population Health needs efficiently, and work to reduce duplicated efforts and healthcare waste associated with misaligned goals.[1]

Our National Medical Management department has held NCQA Population Health Accreditation (formerly known as Disease Management Accreditation) for the following chronic condition management programs: chronic obstructive pulmonary disorder, coronary artery disease, congestive heart failure, depression, diabetes, asthma, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), and schizophrenia. In 2018, the department was also accredited in child/adolescent depression. NCQA awards this status to organizations that meet or exceed its accreditation standards and report results for a specified number of chronic condition management performance measures. We will make these programs available to our Mississippi health plan, which will help empower Members to self-manage their chronic conditions and complex needs.

Our organization also holds full Managed Behavioral Health Organization (MBHO) Accreditation, achieving a near perfect score for all MBHO Utilization Management program and policy elements, and a "High" on all file review elements.[2] This accreditation reflects our organization's commitment to evidence-based practices for the provision of high-quality care, access, Member protections, and integration of physical and BH. ***We will leverage this NCQA-accredited BH and Population Health approach, driven by our Mississippi-based leadership and local care and UM teams to provide seamless, integrated services to MississippiCAN and CHIP Members.***

Further, 18 of our affiliates hold Multicultural Health Care Distinction, demonstrating our overall commitment to culturally and linguistically responsive programs and services. In addition, our Florida Medicaid health plan

[1] The accreditation is maintained through an Anthem, Inc. subsidiary corporation, State Sponsored Services, Inc.
[2] The MBHO Accreditation is maintained through an Anthem, Inc. subsidiary corporation, Anthem GBD Behavioral Health

affiliate is one of nine organizations nationally participating in the Health Equity Accreditation Plus pilot with NCQA, and we will adopt best practices from this affiliate to implement in Mississippi.

Six of our Medicaid affiliates currently hold Long-Term Services and Supports (LTSS) Distinction from NCQA, with plans to add additional markets in the future. In addition to these specialty recognitions, the NCQA team submits a full Medicaid Corporate Survey every three years with specific requirements submitted annually. In January 2022, the Enterprise Case Management team submitted for Case Management Accreditation through NCQA.

6. Fraud, Waste, and Abuse Program Staff and Their Qualifications

Our comprehensive Fraud, Waste, and Abuse (FWA) program includes dedicated staff from our Program Integrity Unit who are empowered by an integrated system of activities, processes, and controls. Our program will involve virtually every department across our local CCO and backed by a national Program Integrity Unit (PIU). We know FWA prevention is important to the Division. We pride ourselves on being good stewards of state funds and will work collaboratively with the Division and Medicaid Fraud Control Unit as our affiliates have successfully done in other states.

Our PIU spans the full spectrum of healthcare services and leverages our affiliates' 31 years of Medicaid Managed Care experience along with more than 80 years of commercial and Medicare experience. The PIU uses proven systems, controls, operational processes, and experience to guard against FWA. Professional capabilities among these program integrity staff are varied and diverse: their backgrounds include retired law enforcement professionals from local, state, military, and national levels; certified professional coders; claims processors; and Provider network, nursing, and pharmacy fraud investigators.

With experience and collaboration across all lines of business, not just Medicaid, our reach is expansive in preventing FWA. This provides us with greater insight into billing patterns, utilization trends, and potential areas of focus for Mississippi's healthcare system.

Expansive FWA Strategies to Detect and Prevent Fraud

To increase our reach, investigators from all our affiliates — including Medicaid, Medicare, and commercial plans — meet monthly to present case-specific outcomes and highlight known or emerging schemes across the country. These regular meetings create a valuable setting for collaboration as well as for sharing tips on data mining, investigative techniques, and case development, and greatly expand our capacity to detect and prevent fraud.

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To combat FWA, we use an array of proven strategies ranging from "feet on the ground" local insight to industry-leading high-tech systems and analyses. Multiple teams help us identify, review, recover, and report improper payments and activities. These diverse teams consist of highly trained and experienced individuals who will support our local Mississippi Program Integrity staff.

Our local Compliance Officer will serve as the primary point of contact for the Division. Reporting directly to our Mississippi CEO, the Compliance Officer will design and implement the Compliance Plan for Mississippi along with related policies and procedures to work in tandem with the PIU.

In addition to our Compliance Officer, the PIU will include Mississippi-based staff who hold the following minimum education and qualifications:

[redacted]

[redacted]

7. Responding to Division Requests Regarding Complaints, Ad Hoc Reports, and More

Through a centralized approach overseen by our local Compliance Officer and Regulatory Oversight Manager, we will make it easy for the Division to submit requests in writing, orally, or electronically. Regardless of how the Division chooses to submit, we will route all requests to our dedicated Regulatory Oversight Manager for assignment, coordination, and submission. In accordance with the requirements outlined in Contract Section 1.10, all Division requests for assistance will be acknowledged within one business day of receipt and will include the required date of resolution in accordance. We will complete all requests to the Division's satisfaction within five business days unless the Division specifies another timeframe and will prioritize urgent requests (as designated by the Division) without unreasonable delay. We acknowledge the Division's examples outlined in Contract Section 1.10 of urgent requests and will complete these requests within the specified timeframe or within five business days from receipt if no timeframe is given.

Our Regulatory Oversight Manager will track all requests submitted by the Division, using an intranet site that features automatic notification functionality – from initial distribution of the request through its completion. All requests will be completed by our Mississippi-based functional area business owners who understand the MississippiCAN and CHIP Programs and the nuances of the state. These business owners will receive requests from a centralized email address to make Division requests easily identifiable and trackable. Our CCO leadership can also access the site to view both active and historical requests and responses.

We will acknowledge Division requests in the same manner as received (for example, in writing or electronically). If we receive a request orally, we will acknowledge receipt orally, and then follow up immediately with written or electronic acknowledgement. Our Regulatory Oversight Manager will submit a

detailed completion summary advising the Division of our action and resolution, which contains all necessary information for the Division to determine the request has been completed and conforming to any Division specifications (such as form, format, or content of the summary). We understand these completion summaries must be submitted on or before the required completion date (and that this summary does not in and of itself constitute completion of a request from the Division).

8. Staff Responsible for Subrogation and Third-Party Liability Activities

Amerigroup will proactively identify third-party coverage, coordinate benefits, and pursue post-payment recovery from liable third parties, and we will integrate this approach throughout operations — claims adjudication, Provider education, system configuration, and partnership with our subcontractor partners. Our program will operate in accordance with all applicable state and federal laws, and the State Plan, as outlined in Contract Section 12. Further, our cost avoidance and recovery strategies focus on prudently managing healthcare costs with the least impact on Members and Providers.

Our local Mississippi team will maintain ultimate accountability and oversight of our Third-Party Liability (TPL) program. Our Claims Administrator will oversee claims processing and adjudication as well as subrogation and TPL activities. The Claims Administrator will hold at least a bachelor's degree in a relevant field (with a master's preferred) and will have three to five years of claims operations and technical knowledge of claims systems.

This local team will be supported by our national Cost Containment department, which includes more than [redacted] employees with an average tenure of 10 years in Program Integrity. This team specializes in a wide variety of programs, including identification of third-party coverage, cost avoidance through coordination of benefits, overpayment/collections, and subrogation. Our executive leadership will hold twice-monthly TPL meetings to discuss current numbers and how they compare year over year, as well as any issues, concerns, or areas for improvement. By leveraging the systems and proven processes of the national Cost Containment department that supports our affiliate state-sponsored health plans, we can deliver more value, through experience and best practices, and better results for the Mississippi TPL program.

Recovery Opportunities Including Subrogation

Once we adjudicate claims and disburse payments, we will analyze data to retrospectively identify recovery opportunities, including pay-and-chase situations and subrogation. Post-payment recovery activities combine resources from Cost Containment with our Subrogation department to maximize collections.

Our Subrogation department is a dedicated unit of more than [redacted] experienced employees committed to providing dependable and high-value cost containment services. This team includes nine dedicated Subrogation Examiners who investigate and identify recoverable TPL opportunities in tort and casualty losses, and seven Subrogation Employees who handle the TPL file through resolution and recovery of the funds. Qualifications of these roles include:

- Subrogation Examiner positions require a minimum of one year telephone inquiry experience; or any combination of education and experience which would provide an equivalent background.
- Subrogation Analyst positions require two years of experience in TPL or Workers' Compensation subrogation or related field; or any combination of education and/or experience which would provide an equivalent background.

Their mission is to pursue TPL to assure the appropriate party assumes responsibility for paying medical bills to help reduce healthcare costs. The Subrogation department's key function is to recover expenses when a claim is due to accident or injury or another party is liable for the services provided as required in Contract Section

12.3.4. This is in support of the legal right of a CCO to recover sums paid for a Member's healthcare from a legally liable third party, the third party's insurer, or a workers' compensation insurer or program.

9. Staff Responsible for Encounter Reconciliation Policies and Procedures

Amerigroup recognizes the importance of accurate encounter submissions to capitation rates development and risk adjustment calculations, as well as other key functions. With oversight from our Chief Information Officer, our Mississippi-based Member Encounters Data Analyst will be responsible for encounter reconciliation policies and processes. In accordance with Contract Section 1.13.2, the Member Encounters Data Analyst will also serve as the designated person responsible for data processing and the provision of accurate and timely reports and Member Encounter Data to the Division.

In addition, this role will also oversee the evaluation of encounter submissions for completeness, program eligibility, medical appropriateness, and consistency. The Member Encounters Data Analyst will work with Provider and Member services to resolve problems raised through Provider or Member communications and will oversee the process of importing encounters from subcontractor partners and capitated Providers. This person will update the leadership team on performance as well as identified issues or risks.

The Member Encounters Data Analyst will also translate basic business needs into application software requirements. This person will analyze business needs to determine optimal means of meeting those needs, determine encounters business application software requirements to address specific business needs, work with programming staff to assure requirements will be incorporated into the encounters system design and testing, and function as a liaison with users of the software to address questions and issues.

The Member Encounters Data Analyst position requires a bachelor's degree and five to seven years of related experience, or any combination of education and experience that would provide an equivalent background. This role must also have experience in managed care and data analysis, plus a thorough understanding of multiple data sources and formats (including ANSI ASC X12 transaction set). The skills required for this position include excellent analytical, organizational, planning, management, and communication abilities.

The Member Encounters Data Analyst will be supported by a team of two designated Business Information Analysts responsible for encounters processing and related management reporting for the MississippiCAN and CHIP Programs. The Business Information Analyst position requires a bachelor's degree in a related field; two to four years related operational and/or data analysis experience; experience in database structures, and standard query and reporting tools. We will consider several factors to determine staffing levels, including number of Members and anticipated volume of encounters; the products offered that have different encounter reporting requirements; timeliness and frequency of submissions required; and the complexity of Mississippi's financial reconciliation process.

10. Staff Dedicated to the MississippiCAN and CHIP Contract and Shared Staff

Amerigroup's organizational and operational structure reflects our belief that healthcare solutions are most effective when developed and delivered locally, while leveraging our vast network of resources across our affiliates in 26 other markets and our parent company, Anthem. As a result, Members, Providers, and the Division will get the best of both worlds: a strong local team that includes key leaders who oversee all health plan functions, augmented by national shared support staff.

Based on membership volume of 125,000 members, provided by Amendment 4, we plan to hire additional 355 employees for the upcoming contract, including 107 national shared services FTEs. As illustrated in our organization charts (provided in Section 4.3.3.1), we will bring a local staffing model that includes clear lines of reporting and authority that place a priority on responsiveness, flexibility, and ultimate accountability of our key

staff across all areas of operation. We designed this locally based structure to fulfill all Contract requirements and to bring the most qualified leaders to serve our Members. Reporting directly to our CEO, who will guide our health plan operations in Mississippi, our local key personnel will maintain full authority to make service delivery and administration decisions across every aspect of our health plan. Further, our staff will have reach throughout the entire state — including our local office, call center, wellness center, and field-based staff who will be out in Mississippi communities to address the needs of our Members and Providers. For example, our administrative office will house approximately [redacted] of our employees, which represents almost half of our Mississippi-based staff and includes a range of departments, such as our call center hubs, quality, compliance, Provider and Member services, CM, UM, operations, and more.

Figure 4.3.3.4-1 details our health plan structure, including staff dedicated to the Contract and the shared services that are seamlessly integrated into our operations and overseen by our local leadership.

[redacted]

[END OF RESPONSE]

4.3.3.5 Subcontractors

Amerigroup and our proposed subcontractors will offer the Division a true partnership. Through our care delivery and investment in the communities we serve, we will work collaboratively with our subcontractors to improve the life of Mississippians. ***Our philosophy for hiring subcontractors centers on identifying partners that share our vision and commitment to serving Mississippi Members.*** Our subcontractor approach aligns with our whole health Member goals. By selecting the best subcontractors to enhance our offerings and benefits, we will successfully combine a variety of services and supports to best meet Member needs.

We will employ a Mississippi-based ***Vendor Oversight Manager*** to act as a single point of contact for our subcontractors to maximize efficiencies and reduce administrative burden. The Vendor Oversight Manager, in collaboration with the Compliance Officer, will provide the Division with progress updates regarding the services and benefits delivered by our subcontractors. We will adapt the scope and frequency of our oversight activities to reflect the nature of delegated activities and the nuances of services provided, using our contractual obligations to the Division as the foundation of our program. Combined with regular monitoring through audits and reports, our approach will maximize effectiveness in monitoring performance and assuring accountability.

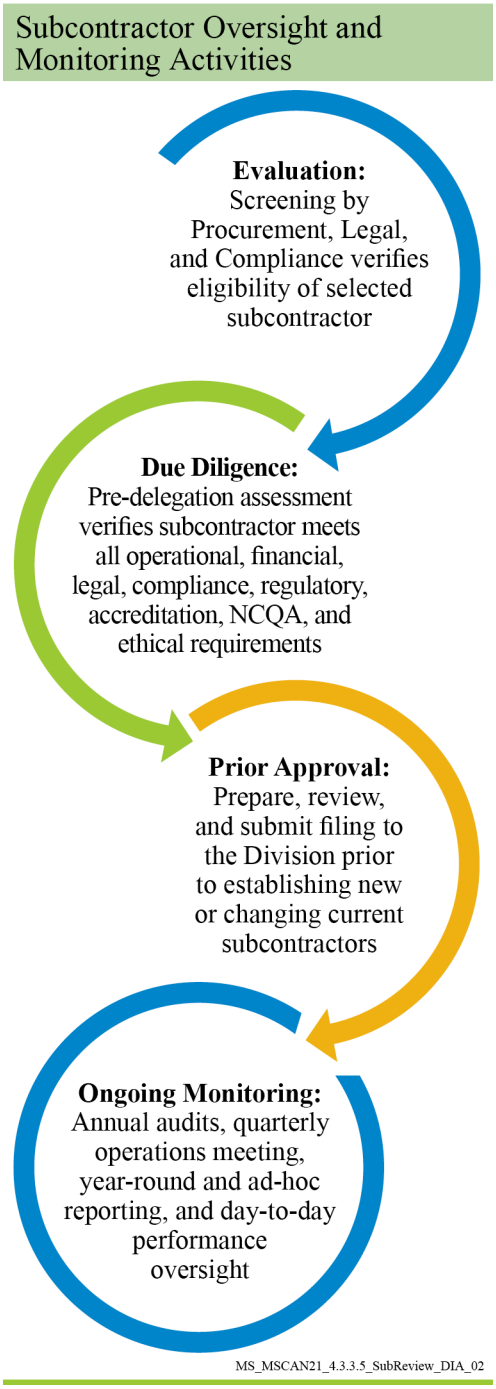
Hiring Subcontractors to Bring Specialized Capabilities

Our selection of subcontractors will be informed by our experienced Coordinated Care Organization (CCO) leadership team and their knowledge of the Mississippi landscape. Amerigroup will rigorously evaluates and select highly qualified subcontractors aligned with our mission and values to best serve Mississippi Members, prioritizing subcontractors that provide quality services to enhance our own.

In addition, we will thoroughly screen potential subcontractors to assure that they have the operational and financial means to fulfill contractual obligations. Amerigroup will apply a number of pre-delegation metrics, assessments, and evaluations when selecting subcontractors such as reviewing:

- Operational capabilities that include analysis of subcontractor's current and future contractual commitments and organizational resources, review of technology and system capabilities, including on-site visits and readiness reviews, and review of operational policies and procedures
- Performance record that incorporates review of subcontractor's quality oversight policies and procedures, and review of performance outcomes achieved for similar contracts
- Subcontractor's references
- Subcontractor's understanding of applicable standards (for example, standards for claims payment) and delegated tasks
- Financial stability with review of audited financial statements, including statement of revenues and expenses, balance sheets, cash flow, unaudited year-to-date financial statements, and actuarial opinions of the incurred but not reported expenses
- Waste, fraud, and abuse violations
- State and federal lists of Providers and entities currently debarred
- State licensing and certification requirements, including review of regulatory compliance history, registrations, exclusions, terminations, sanctions, corrective action plans, and associated performance improvement plans
- Adherence to NCQA subcontractor standards

Our pre-delegation audit confirms that the proposed subcontractors meet our operational, financial, legal, compliance, regulatory, accreditation, and ethical standards. We will also examine the subcontractor's HIPAA Privacy and Security compliance, operating procedures, and staffing ratios. After the subcontractor passes the pre-delegation audit, Amerigroup will submit information on the proposed subcontractor and their delegated functions to the Division for approval.



Creating Subcontract Agreements

Our Procurement department, in cooperation with the Vendor Oversight Manager, will develop subcontract agreements. These agreements incorporate all Contract requirements; local, State, and federal rules and regulations, which include monthly monitoring of State and federal Provider exclusion lists; and Amerigroup standards, policies, and procedures. The agreements will also be reviewed by our Mississippi leadership team, and our Legal, Compliance, Finance, Security, and IT teams.

This process assures each subcontract agreement meets the requirements of 42 C.F.R. 434.6 and incorporates the applicable terms and conditions of Contract Section 13. Our Mississippi Vendor Oversight Manager and Compliance Officer will be responsible for making sure all our subcontract agreements are approved by the Division prior to execution.

Managing Subcontractors to Assure they Meet Members' and Providers' Needs

Championed by our top-tier, Mississippi-based CCO leaders, our organizational culture embraces continuous process improvement; we will deliver operational excellence through targeted actions and processes that are collaborative, agile, and transparent. This culture and process of business operation extends through to the relationship with and management of our subcontractors. We view our subcontractors as an integral extension of our organization, assisting in the delivery of meaningful services to Members. One of the core elements to our process for managing subcontractors is to provide opportunities for collaboration and consistent, ongoing communication for both our subcontractor partners and the Division. Together, our CCO leadership team and the Vendor Oversight Manager will provide support for and oversight of our subcontractors.

To assure success and seamless delivery of services, we will provide training to orient each subcontractor to the MississippiCAN and CHIP Program requirements and contractual expectations. We will also provide Subcontractor Onboarding training for new subcontractors that further delves into the Amerigroup culture and expectations for serving Members, Providers, and the Division.

This vendor management structure will be responsive and responsible for the day-to-day operations and oversight of our subcontractors. As part of our process, we will:

- Perform an annual audit using tools specific to the function delegated and mapped to contractual requirements and accreditation standards
- Obtain and review monthly scorecards with key metrics specific to functions delegated
- Perform data analysis on transactional data submitted to identify potential anomalies, which may trigger a focused review
- Perform periodic Joint Operations Committee meetings, as applicable
- Review complaints and Grievances to identify trends
- Issue formal Corrective Action Plans (CAPs) when instances of non-compliance are identified and perform follow-up to assure remediation
- Report monitoring and oversight activities to the CCO leadership team

For Member-facing/direct services subcontractors, our Vendor Oversight Manager will meet with subcontractors at least monthly to review performance against standards, including trends and report submissions.

When we identify subcontractor deficiencies, risk due to non-compliance, or an increase in volume of complaints, Grievances, or Appeals, we will initiate a CAP. We will emphasize the need to evaluate and implement change as quickly as possible and will track and report on the progress made to remediate the CAP at designated intervals. We will work jointly with the subcontractor and support them through resolution. Together, we will assess lessons learned and cooperatively employ strategies to prevent problems from reoccurring. Providing ongoing support and oversight through well-defined roles, structure, and expectations maximizes effectiveness in monitoring performance, enhances accountability, and avoids compliance issues. Our Vendor Oversight Manager, in collaboration with our Compliance Officer, will notify the Division of any issues that may impact Member benefits and services.

Amerigroup Mississippi, Inc. retains sole responsibility for fulfilling Contract requirements and remains fully and solely accountable for our subcontractors' performance.

4.3.3.5 Subcontractors

4.3.3.5 Appendix H Subcontractors attachments include the following:

- Appendix H: Advanced Monitored Caregiving, Inc. (AMC)
- Appendix H: Anthem, Inc.
- Appendix H: Aunt Bertha
- Appendix H: Beacon Healthcare
- Appendix H: Center for the Study of Services (CSS)
- Appendix H: DentaQuest
- Appendix H: DentaQuest (product name EyeQuest)
- Appendix H: IngenioRx
- Appendix H: MedAware Solutions
- Appendix H: Medical Transportation Management, Inc. (MTM)
- Appendix H: Meridian
- Appendix H: Truth Initiative

4.3.3.5 Subcontractors (Marked) – 20

Subcontractor				
Name of Subcontractor: AMC Health				
TIN/SSN (as applicable): 38-3667661		**The entity is a:** [X] **Subcontractor** [ ] **Wholly-Owned Subsidiary** [ ] **Affiliate under the same common ownership**		
Address Line 1: One World Trade, 85th Floor				
Address Line 2:				
City: New York	**State:** NY	**Zip Code:** 10007	**County:** New York	
Mailing Address (P.O.Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Description of Services to be Rendered by Subcontractor for this Contract: Quantitative and qualitative usage data using an internet-based asthma monitoring tool (FDA-approved inhaler sensor attaches to prescribed medication to assess under or over-utilization).				
How will the Offeror monitor and manage this Subcontractor? Amerigroup Mississippi, Inc. will monitor and manage this subcontractor through initial training, ongoing support, and regular oversight. We will employ a Mississippi Health Plan Leadership team who will include staff from our local operations, quality, and compliance departments as well as a Vendor Oversight Manager (VOM). The VOM will serve as the single point of contact for the Division and will oversee the subcontractor's performance. To monitor and manage the subcontractor while assuring a seamless experience for Members, Providers, and the Division, the VOM will: • Cultivate a strong relationship with the subcontractor • Identify, implement, and manage service quality and operational improvement projects • Interact with, and oversee activities performed by, our departments such as Procurement, Quality, and Claims • Facilitate subcontractor performance reviews and review audit results • Oversee complaints, Grievances and Appeals, and service level agreement adherence • Ensure receipt and reconciliation of all required reporting data • Escalate contract changes or performance issues and provide support through resolution The VOM, in conjunction with the Health Plan Leadership team, will also receive support from national organizational resources that add an additional layer of performance monitoring. The VOM will report up through our Mississippi-based Chief Executive Officer, who will be responsible and accountable for all functional areas. ***We retain sole responsibility for fulfilling contract requirements and full accountability for our subcontractor's performance.***				
Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No **If yes, fill out Prior Experience with Subcontractor for each applicable instance.**				

Prior Experiences with Subcontractor				
Client's Name: Simply Healthcare Plans, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 9250 West Flagler Street				
Address Line 2:				
City: Miami	**State:** FL	**Zip Code:** 33174	**County:** Miami-Dade	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: JoAnn McDaniel-Chinn				
Title: Compliance Director				
Phone Number: (305) 487-4047	**Email Address:** joann.mcdaniel-chinn@anthem.com			
Work Details				
Number of covered lives: 730,525				
Time period of contract: October 2020; more than one and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: [redacted] (Position Titles: Customer Service Representative, Client Success Manager)				
Geographic and population coverage requirements: Florida Statewide. CHIP, TANF, ABD, and Dual Eligibles.				
Publicly funded contract cost: [redacted] (cost of Simply Healthcare Plans, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Remote patient monitoring for asthma in the Amerigroup market of Florida. Monitoring is a type of ambulatory healthcare that allows a participant to use Bluetooth enabled devices to capture biometric data in real-time. AMC Health provides monitoring kits that includes a Bluetooth enabled Propeller device to track data and alerts to both over and under usage of medications. AMC Health also provides interactive voice response (IVR) telephone outreach to Members who do not use the device for two days. Data collected by the devices and IVR are made available in real-time for analysis and follow up Anthem clinicians.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Iowa, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 4800 Westown Parkway				
Address Line 2: Suite 200				
City: West Des Moines	**State:** IA	**Zip Code:** 50266	**County:** Polk	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Martha Crist				
Title: Compliance Director				
Phone Number: (515) 850-8057	**Email Address:** martha.crist@amerigroup.com			
Work Details				
Number of covered lives: 445,885				
Time period of contract: October 2020; more than one and a half years				
Total number of staff hours expended during time period of contract: Total for all program is [redacted]				
Personnel requirements: [redacted] (Position Titles: Customer Services Representative, RNs, Customer Success Manager, Business Intelligence Manager)				
Geographic and population coverage requirements: Iowa Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Iowa, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Remote patient monitoring for heart failure and subsequent co-morbidities in the Amerigroup market of Iowa. Remote patient monitoring is a type of ambulatory healthcare that allows a participant to use Bluetooth enabled devices to capture real-time biometric data and the use of IVR technology to collect subjective data in the form of responses to questions about symptoms and behaviors from participants when their readings are out of range and when a Member has not taken their readings (two days/three times daily). Data collected by the devices and IVR are made available in real-time for analysis and follow up AMC Health clinicians.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Tennessee, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 22 Century Boulevard				
Address Line 2: Suite 220				
City: Nashville	**State:** TN	**Zip Code:** 37214		**County:** Davidson
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Lori Stiffler				
Title: Compliance Director				
Phone Number: (949) 526-3249		**Email Address:** lori.stiffler@amerigroup.com		
Work Details				
Number of covered lives: 501,128				
Time period of contract: October 2020; more than one and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: [redacted] (Position titles: Customer Services Rep., RNs, Customer Success Manager, Business Intelligence Manager)				
Geographic and population coverage requirements: Tennessee Statewide. TANF, CHIP, ABD, Uninsured Adults, and Dual Eligibles.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Tennessee, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Remote patient monitoring for heart failure and subsequent co-morbidities in the Amerigroup market of Tennessee. Remote patient monitoring is a type of ambulatory healthcare that allows a participant to use Bluetooth enabled devices to capture real-time biometric data and the use of IVR technology to collect subjective data in the form of responses to questions about symptoms and behaviors from participants when their readings are out of range and when a Member has not taken their readings (two days/three times daily). Data collected by the devices and IVR are made available in real-time for analysis and follow up AMC Health clinicians.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Texas, Inc., Amerigroup Insurance Company; Anthem Inc. subsidiaries				
Client Location				
Address Line 1: 2509 N Highway 360				
Address Line 2: Suite 300				
City: Grand Prairie	**State:** TX	**Zip Code:** 75050		**County:** Dallas
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Franco Hardy				
Title: Compliance Director				
Phone Number: (757) 536-4723		**Email Address:** Francisco.hardy@amerigroup.com		
Work Details				
Number of covered lives: 1,006,534				
Time period of contract: October 2020; more than one and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: [redacted] (Position titles: Customer Services Rep., RNs, Customer Success Manager, Business Intelligence Manager)				
Geographic and population coverage requirements: Texas Statewide. TANF, CHIP, ABD, Child Welfare, and Dual Eligibles.				
Publicly funded contract cost [redacted] (cost of AMERIGROUP Texas, Inc. health plan's contract with the state).				
Description of work performed under this contract				
1. Remote patient monitoring for heart failure and subsequent co-morbidities in the Amerigroup market of Texas. Remote patient monitoring is a type of ambulatory healthcare that allows a participant to use Bluetooth enabled devices to capture real-time biometric data and the use of IVR technology to collect subjective data in the form of responses to questions about symptoms and behaviors from participants when their readings are out of range and when a Member has not taken their readings (two days/three times daily). Data collected by the devices and IVR are made available in real-time for analysis and follow up AMC Health clinicians. 2. Remote patient monitoring for asthma in the Amerigroup market of Texas. Monitoring is a type of ambulatory healthcare that allows a participant to use Bluetooth enabled devices to capture biometric data in real-time. AMC Health provides monitoring kits that includes a Bluetooth enabled Propeller device to track data and alerts to both over and under usage of medications. AMC Health also provides IVR telephone outreach to Members who do not use the device for				

4.3.3.5 Subcontractors (Marked) – 20

two days. Data collected by the devices and IVR are made available in real-time for analysis and follow up Anthem clinicians.

Prior Experiences with Subcontractor				
Client's Name: HealthKeepers, Inc. dba Anthem HealthKeepers Plus, Amerigroup Partnership Plan, LLC (subcontractor to Dell Children's Health Plan); Anthem Inc. subsidiaries				
Client Location				
Address Line 1: 2015 Staples Mill Road				
Address Line 2:				
City: Richmond	**State:** VA	**Zip Code:** 23230		**County:** Henrico
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Nancy Kaplan				
Title: Director II Compliance				
Phone Number: (757) 375-0747		**Email Address:** Nancy.kaplan@anthem.com		
Work Details				
Number of covered lives: 534,332				
Time period of contract: October 2020; more than one and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: [redacted] (Position titles: Customer Services Representative, RNs, Customer Success Manager, Business Intelligence Manager)				
Geographic and population coverage requirements: Virginia Statewide. ABD, Dual Eligibles, and Child Welfare/Foster Care, TANF, and CHIP.				
Publicly funded contract cost: [redacted] (cost of HealthKeepers, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Remote patient monitoring for heart failure and subsequent co-morbidities in the Amerigroup market of Virginia. Remote patient monitoring is a type of ambulatory healthcare that allows a participant to use Bluetooth enabled devices to capture real-time biometric data and the use of IVR technology to collect subjective data in the form of responses to questions about symptoms and behaviors from participants when their readings are out of range and when a Member has not taken their readings (two days/three times daily). Data collected by the devices and IVR are made available in real-time for analysis and follow up AMC Health clinicians.				

4.3.3.5 Subcontractors (Marked) – 20

Subcontractor				
Name of Subcontractor: Anthem, Inc.				
TIN/SSN (as applicable): 35-2145715	**The entity is a:** **[ ] Subcontractor** **[ ] Wholly-Owned Subsidiary** [X] **Affiliate under the same common ownership**			
Address Line 1: 220 Virginia Avenue				
Address Line 2:				
City: Indianapolis	**State:** IN	**Zip Code:** 46204	**County:** Marion	
Mailing Address (P.O.Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**

Description of Services to be Rendered by Subcontractor for this Contract:
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance. (Please note: our parent company and its affiliates provide administrative support to our utilization management process for functions such as intake and initial screening. However, all utilization management decisions to reduce or deny, in whole or in part, will ultimately be made by local Coordinated Care Organization [CCO] licensed clinical staff.)

These shared and support services will be tailored specifically to Mississippi's needs and will be provided upon direction of the CCO leadership. While we will make use of support services from our parent organization, the subcontract allows us flexibility in how we apply those resources. Our Chief Executive Officer (CEO) will be responsible and accountable for all functional areas, with Mississippi-based key personnel overseeing all operations.

How will the Offeror monitor and manage this Subcontractor?

Amerigroup Mississippi, Inc. will monitor and manage all subcontractors through a Mississippi Health Plan Leadership team which will include staff from our local operations, quality, and compliance departments as well as a Vendor Oversight Manager (VOM). They will receive additional support from national resources that add an additional layer of performance monitoring.

We will hold our affiliate subcontractors, including our parent organization, to the required performance levels using contractual requirements, internally set standards, incentives, penalties, and established policies and procedures, to include enforcement for nonperformance. We will utilize reporting tools and systems analyzing key metrics visualizing our performance against defined targets. Functional area owners will be responsible for the performance and action plans for missed targets, and for regularly reporting performance and any issues to the VOM.

The VOM will serve as the single point of contact for the Division and will oversee the subcontractor's performance. To monitor and manage the subcontractor while assuring a seamless experience for Members, Providers, and the Division, the VOM will:

- Cultivate a strong relationship with the subcontractor and functional area owners
- Identify, implement, and manage service quality and operational improvement projects

4.3.3.5 Subcontractors (Marked) – 20

• Interact with, and oversee activities performed by, our departments such as Quality, Claims, and Enrollment • Facilitate performance reviews and review audit results • Oversee complaints, Grievances and Appeals, and service level agreement adherence • Ensure receipt and reconciliation of all required reporting data • Escalate contract changes or performance issues and provide support through resolution The VOM will report up through our Mississippi-based CEO, who will be responsible and accountable for all functional areas. ***We retain sole responsibility for fulfilling contract requirements and full accountability for our subcontractor's performance.***
Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No **If yes, fill out Prior Experience with Subcontractor for each applicable instance.**

Prior Experiences with Subcontractor				
Client's Name: APC PASSE LLC dba Summit Community Care; Anthem, Inc. subsidiary				
Client Location				
Address Line 1: 605 South Shackleford				
Address Line 2: Ste 440				
City: Little Rock	**State:** AR	**Zip Code:** 72211	**County:** Pulaski	
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Hassan Gardezi				
Title: Interim Compliance Officer				
Phone Number: 225-763-2143	**Email Address:** hassan.gardezi@healthybluela.com			
Work Details				
Number of covered lives: 17,001				
Time period of contract: March 2018–current; more than four years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of APC PASSE staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting APC PASSE operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Administrator/Chief Executive Officer/Chief Operating Officer (CEO), Chief Financial Officer (CFO), Care Coordination Manager, IT/IS (Information Technology/Information Systems) Manager, Compliance Officer, Medical Director, Contract Manager, Data Processing/Reporting Coordinator, Medical/Case Records Review Coordinator, Claims/Encounter Manager, Quality Improvement Manager, Utilization Management Manager, and Fraud Investigation Manager. As discussed above, APC PASSE LLC is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve.				

Geographic and population coverage requirements: Arkansas Statewide. Intellectual and Developmental Disabilities, Behavioral Health (BH), Dual Eligibles, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted] (cost of APC PASSE LLC health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: Anthem Blue Cross of California dba Anthem Blue Cross, Blue Cross of California Partnership Plan, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 21215 Burbank Boulevard				
Address Line 2:				
City: Woodland Hills	**State:** CA	**Zip Code:** 91367		**County:** Los Angeles
Mailing Address (P.O.Box):	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Beth Moldonado				
Title: Director II Compliance				
Phone Number: 805-264-9172		**Email Address:** beth.moldonado@anthem.com		
Work Details				
Number of covered lives: 1,362,860				
Time period of contract: February 1992–current; more than 30 years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of Anthem Blue Cross of California staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting Anthem Blue Cross of California operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Compliance Officer, Full-Time Health Educator, MCP/MEDS/834 Management Information System (MIS) Coordinator, Contractor's Representative, Security Officer. As discussed above, Anthem Blue Cross of California is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve.				
Geographic and population coverage requirements: California Central Valley/Bay Area, California Rural Expansion, Los Angeles Service Area,				

Sacramento County, San Benito County, Tri-County, Tulare County. TANF, ABD, Medicaid Expansion, Dual Eligibles, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted] (cost of Anthem Blue Cross of California health plan's contract with the state)
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: CCHA, LLC dba Colorado Community Health Alliance; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1125 17th Street				
Address Line 2: Suite 1000				
City: Denver	**State:** CO	**Zip Code:** 80202	**County:** Denver	
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Abigail Roa				
Title: Compliance Director				
Phone Number: 913-300-1744		**Email Address:** Abigail.Roa@amerigroup.com		
Work Details				
Number of covered lives: 400,218				
Time period of contract: April 2003–current; more than 18 years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of CCHA, LLC staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting CCHA, LLC operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Program Officer, CFO, Chief Operating Officer (COO), Quality Improvement Director, Health IT and Data Director, UM Director, Regional Contract Manager. As discussed above, CCHA, LLC is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve.				
Geographic and population coverage requirements: Colorado Statewide. ABD, Medicaid Expansion, Dual Eligibles, and Child Welfare/Foster Care.				

4.3.3.5 Subcontractors (Marked) – 20

Publicly funded contract cost: [redacted] (cost of CCHA, LLC health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: Amerigroup District of Columbia, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1001 Pennsylvania Avenue NW				
Address Line 2: Suite 710				
City: Washington	**State:** DC	**Zip Code:** 20004		**County:** District of Columbia
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Barbie Boone CHPC MHP HCAFA DBA				
Title: Compliance Manager				
Phone Number: 757-800-5249		**Email Address:** Barbara.boone@amerigroup.com		
Work Details				
Number of covered lives: 46,931				
Time period of contract: October 2017–September 2020; three years				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually. An integral part of Amerigroup District of Columbia staffing plan was to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale.				
Personnel requirements: Not applicable as plan is not currently active.				
Geographic and population coverage requirements: District of Columbia. TANF, CHIP, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Amerigroup District of Columbia, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.				

Prior Experiences with Subcontractor				
Client's Name: Simply Healthcare Plans, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 9250 West Flagler Street				
Address Line 2:				
City: Miami	**State:** FL	**Zip Code:** 33174	**County:** Miami-Dade	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: JoAnn McDaniel-Chinn				
Title: Compliance Director				
Phone Number: 305-487-4047	**Email Address:** joann.mcdaniel-chinn@anthem.com			
Work Details				
Number of covered lives: 730,525				
Time period of contract: January 2003–current; more than 19 years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of Simply Healthcare Plans, Inc. staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting Simply Healthcare Plans, Inc. operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Contract Manager, Medical Director, Compliance Officer, Fraud Investigative Unit Manager. As discussed above, Simply Healthcare Plans, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve.				
Geographic and population coverage requirements: Florida Statewide. CHIP, TANF, ABD, and Dual Eligibles.				

4.3.3.5 Subcontractors (Marked) – 20

Publicly funded contract cost: [redacted] (cost of Simply Healthcare Plans, Inc. health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: AMGP Georgia Managed Care Company, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 4170 Ashford Dunwoody Road				
Address Line 2: Suite 100				
City: Atlanta	**State:** GA	**Zip Code:** 30319	**County:** DeKalb	
Mailing Address (P.O.Box): 740 West Peachtree Street NW	**City:** Atlanta	**State:** GA	**Zip Code:** 30308	**County:** DeKalb
Direct Contact for Client				
Name: Leticia Mayfield				
Title: Compliance Director				
Phone Number: 678-5887-4855	**Email Address:** Leticia.mayfield@Amerigroup.com			
Work Details				
Number of covered lives: 572,848				
Time period of contract: June 2005 – current; more than 16 years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of AMGP Georgia Managed Care Company, Inc. staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting AMGP Georgia Managed Care Company, Inc. operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: CEO, Member Services Director, Provider Services Director, Utilization Management Director, Medical Director, Quality Management Director, Health Services Director, and the Program Implementation Manager. As discussed above, AMGP Georgia Managed Care Company, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve.				
Geographic and population coverage requirements:				

Georgia Statewide. TANF, CHIP, Child Welfare/Foster Care, and family planning waiver service membership.
Publicly funded contract cost: [redacted] (cost of AMGP Georgia Managed Care Company, Inc. health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: Anthem Insurance Companies, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 220 Virginia Avenue				
Address Line 2:				
City: Indianapolis	**State:** IN	**Zip Code:** 46204	**County:** Marion	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Stephen Egan				
Title: Compliance Director				
Phone Number: 317-617-3426	**Email Address:** Stephen.egan@anthem.com			
Work Details				
Number of covered lives: 705,387				
Time period of contract: 2015–2025; more than six years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of Anthem Insurance Companies, Inc. staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting Anthem Insurance Companies, Inc. operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: CEO, CFO, Compliance Officer, Information Systems (IS) Coordinator, Director (licensed Indiana Health Care Provider), Member Services Manager, Provider Services Manager, Quality Improvement Management Manager, Special Investigation Unit Manager, Utilization Management Manager, BH Manager, Data Compliance Manager, Pharmacy Director, Grievance and Appeals Manager, Claims Manager, Gateway to Work Operations Manager. As discussed above, Anthem Insurance Companies, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve.				

Geographic and population coverage requirements: Indiana Statewide. ABD and Child Welfare/Foster Care, TANF, CHIP, and Medicaid Expansion.
Publicly funded contract cost: [redacted] (cost of Anthem Insurance Companies, Inc. health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Iowa, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 4800 Westown Parkway				
Address Line 2: Suite 200				
City: West Des Moines	**State:** IA	**Zip Code:** 50266	**County:** Polk	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Martha Crist				
Title: Compliance Director				
Phone Number: 515-850-8057	**Email Address:** martha.crist@amerigroup.com			
Work Details				
Number of covered lives: 445,885				
Time period of contract: April 2016–current; more than five years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of AMERIGROUP Iowa, Inc. staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting AMERIGROUP Iowa, Inc. operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Contract Administrator/CEO/ COO, Medical Director (Iowa licensed physician), CFO, Compliance Officer (full-time dedication; closely aligns with Regulatory manager accountabilities), Pharmacy Director (Iowa licensed pharmacist), Grievance and Appeals Manager, Quality Management Manager (Iowa licensed), Utilization Management Manager (Iowa licensed), BH Manager (Iowa licensed), Member Services Manager, Provider Services Manager, Information Services Manager, Claims Administrator, Care Coordination Manager, Program Integrity Manager (located in Iowa office and dedicated 90% of the time), Long Term Care Manager, Government Relations Director*, Ombudsman*. As discussed above, AMERIGROUP Iowa, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their				

staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. * RFP Response promised additional Key Personnel and is incorporated into the Iowa Health Link Contract by reference
Geographic and population coverage requirements: Iowa Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Iowa, Inc. health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: Anthem Kentucky Managed Care Plan, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 13550 Triton Boulevard				
Address Line 2:				
City: Louisville	**State:** KY	**Zip Code:** 40223	**County:** Jefferson	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Cheryl Herre				
Title: Compliance Director				
Phone Number: 502-689-3987		**Email Address:** Cheryl.herre@anthem.com		
Work Details				
Number of covered lives: 168,124				
Time period of contract: January 2014–current; more than eight years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of Anthem Kentucky Managed Care Plan, Inc. staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting Anthem Kentucky Managed Care Plan, Inc. operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Medical Director, Dental Director, Finance Officer, Enrollee Services function, Provider Services function, Quality Improvement Director, BH Director, Case Management Coordinator, EPSDT Coordinator, Foster Care and Subsidized Adoption Liaison, Guardianship Liaison, MIS Director, Claims Processing function, Program Integrity Coordinator, Pharmacy Director, Compliance Director. As discussed above, Anthem Kentucky Managed Care Plan, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve.				

Geographic and population coverage requirements: Kentucky Statewide Ballard, Caldwell, Calloway, Carlisle, Crittenden, Fulton, Graves, Hickman, Livingston, Lyon, Marshall, McCracken, Christian, Daviess, Hancock, Henderson, Hopkins, McLean, Muhlenberg, Ohio, Todd, Trigg, Union, Webster, Adair, Allen, Barren, Butler, Casey, Clinton, Cumberland, Edmonson, Green, Hart, Logan, McCreary, Metcalfe, Monroe, Pulaski, Russell, Simpson, Taylor, Warren, Wayne, Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jackson, Jessamine, Lincoln, Madison, Mercer, Montgomery, Nicholas, Owen, Powell, Rockcastle, Scott, Woodford, Boone, Campbell, Gallatin, Grant, Kenton, Pendleton, Bath, Boyd, Bracken, Carter, Elliott, Fleming, Greenup, Lawrence, Lewis, Mason, Menifee, Morgan, Robertson, Rowan, Bell, Breathitt, Clay, Floyd, Harlan, Johnson, Knott, Knox, Laurel, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry, Pike, Whitley, and Wolfe counties. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted] (cost of Anthem Kentucky Managed Care Plan, Inc. health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: Community Care Health Plan of Louisiana, Inc. dba Healthy Blue; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1500 North 19th Street				
Address Line 2:				
City: Monroe	**State:** LA	**Zip Code:** 71201		**County:** Ouachita
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Hassan Gardezi				
Title: Interim Compliance Officer				
Phone Number: 225-763-2142		**Email Address:** hassan.gardezi@healthybluela.com		
Work Details				
Number of covered lives: 355,069				
Time period of contract: February 2012–current (*new contact awarded); more than 10 years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of Community Care Health Plan of Louisiana, Inc. staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting Community Care Health Plan of Louisiana, Inc. operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Administrator/CEO, Medical Director/Chief Medical Officer (CMO), BH Medical Director, CFO, COO, Program Integrity Officer, Grievance System Manager, Business Continuity Planning and Emergency Coordinator, Contract Compliance Officer, Quality Management Coordinator, Performance/Quality Improvement Coordinator, Maternal Child Health/EPSDT Coordinator, Medical Management Coordinator, Provider Services Manager, Member Services Manager, Claims Administrator, Provider Claims Educator, Case Management Administrator/Manager, Information Management and Systems Director, Encounter Data Quality Coordinator, BH Coordinator, BH Children's System Administrator, Addictionologist or an				

Addiction Services Manager (ASM), BH Case Management Supervisor. As discussed above, Community Care Health Plan of Louisiana, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve.
Geographic and population coverage requirements: Louisiana Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted] (cost of Community Care Health Plan of Louisiana, Inc. health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Maryland, Inc. dba Amerigroup Community Care; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 7550 Teague Road				
Address Line 2: Ste 500				
City: Hanover	**State:** MD	**Zip Code:** 21076	**County:** Anne Arundel	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Lisa Drumm				
Title: Compliance Director				
Phone Number: 757-995-5853	**Email Address:** lisa.drumm@amerigroup.com			
Work Details				
Number of covered lives: 320,013				
Time period of contract: June 1999–current (*contract is evergreen); more than 22 years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of AMERIGROUP Maryland, Inc. staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting AMERIGROUP Maryland, Inc. operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Plan Administrator, Medical Director, Medical Records Director, Enrollment/Disenrollment Director, QA Director, Case Management Director, UM Director, Grievance Director, Marketing Director. As discussed above, AMERIGROUP Maryland, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve.				
Geographic and population coverage requirements:				

Maryland Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Maryland, Inc. health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: Amerigroup Partnership Plan, LLC (Subcontractor to HMO Minnesota dba Blue Plus); Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1285 Northland Drive				
Address Line 2:				
City: Mendota Heights	**State:** MN	**Zip Code:** 55120		**County:** Dakota
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Lucy Mondale				
Title: Compliance Director				
Phone Number: 612-280-4074		**Email Address:** Lucy.Mondale@amerigroup.com		
Work Details				
Number of covered lives: 427,883				
Time period of contract: January 2019–current; more than three years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of HMO Minnesota staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting HMO Minnesota operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: The contract does not designate key staff or personnel but does reference these specific positions throughout the contract: Compliance Officer, Special Investigations Unit (SIU), Mental Health Targeted Case Manager, Chief Executive Officer (CEO), and CFO. As discussed above, HMO Minnesota is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve.				

4.3.3.5 Subcontractors (Marked) – 20

Geographic and population coverage requirements: 87 counties across the state. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted] (cost of Amerigroup Partnership Plan, LLC health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: Missouri Care, Inc. dba Healthy Blue; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1831 Chestnut Street				
Address Line 2:				
City: St. Louis	**State:** MO	**Zip Code:** 63103	**County:** St. Louis	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Russ Oppenborn				
Title: Compliance Officer				
Phone Number: 877-602-9189		**Email Address:** russell.oppenborn@healthybluemo.com		
Work Details				
Number of covered lives: 340,487				
Time period of contract: June 2020–current; more than one and a half years				
Total number of staff hours expended during time period of contract: Approximately [redacted] An integral part of Missouri Care, Inc. staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting Missouri Care, Inc. operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Health Plan Administrator, Clerical and support staff, Medical Director, Dental Consultant, CFO, Quality Assessment and Improvement and Utilization Management Coordinator, Special Programs Coordinator, Care Management Supervisors, BH Coordinator, Prior Authorization Staff, Inpatient Certification Review Staff, Member Services Staff, Provider Services Staff, Compliant, Grievance, and Appeal Coordinator, Claims Administrator/MIS Director, Compliance Officer, and Fraud, Waste, and Abuse investigator (per 100,000 Members). As discussed above, Missouri Care, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to				

determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve.
Geographic and population coverage requirements: Missouri Statewide. TANF, CHIP, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted] (cost of Missouri Care, Inc. health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: Community Care Health Plan of Nebraska, Inc. dba Healthy Blue Nebraska; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 8055 O Street				
Address Line 2: Suite 300				
City: Lincoln	**State:** NE	**Zip Code:** 68510		**County:** Lancaster
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Jennifer Bohnoff				
Title: Director & Market Compliance Officer				
Phone Number: 402-983-5186		**Email Address:** jennifer.bohnoff@healthybluene.com		
Work Details				
Number of covered lives: 11,048				
Time period of contract: January 2017–current; more than five years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of Community Care Health Plan of Nebraska, Inc. staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting Community Care Health Plan of Nebraska, Inc. operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: CEO, Medical Officer, BH Clinical Director, BH Manager, COO, CFO, Program Integrity Officer, Grievance System Manager, Business Continuity Planning and Emergency Coordinator, Contract Compliance Coordinator, Quality Coordinator, Performance and Quality Improvement Coordinator, Maternal Child/EPSDT Coordinator, Medical Management Coordinator, Provider Services Manager, Member Services Manager, Claims Administrator, Provider Claims Educator, Case Management Administrator, Information Management and Systems Director, Encounter Data Quality Coordinator, Tribal Network Liaison, and Pharmacist/Pharmacy Director. As discussed above, Community Care Health Plan of Nebraska is currently supported by a total of [redacted]				

FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve.
Geographic and population coverage requirements: Nebraska Statewide. TANF, CHIP, ABD, and Child Welfare/Foster Care.
Publicly funded contract cost[redacted] (cost of Community Care Health Plan of Nebraska, Inc. health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: Community Care Health Plan of Nevada, Inc. dba Anthem Blue Cross and Blue Shield Healthcare Solutions; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 9133 West Russell Road				
Address Line 2:				
City: Las Vegas	**State:** NV	**Zip Code:** 89148		**County:** Clark
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Tiffany Saunders-Newey				
Title: Compliance Director / Plan Compliance Officer				
Phone Number: 757-409-0980		**Email Address:** tiffany.saunders-newey@anthem.com		
Work Details				
Number of covered lives: 274,479				
Time period of contract: November 2009–current (*awarded new contract); more than 15 years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of Community Care Health Plan of Nevada, Inc. staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting Community Care Health Plan of Nevada, Inc. operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: CEO, CFO, Chief Medical Director, Medical Director of BH, Compliance Officer, Member Services Manager, Provider Services Manager, Grievance and Appeals Coordinator, Claims Administrator, Nevada Medicaid/CHIP Operations Manager, Quality Manager/Cultural Competency, Program Integrity/SIU Manager, Nevada Department of Corrections Manager, Population Health Manager, and Utilization Manager. As discussed above, <Community Care Health Plan of Nevada, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services				

resources, to provide excellent services to Members they serve.
Geographic and population coverage requirements: Nevada Statewide. TANF, CHIP, Medicaid Expansion, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted] (cost of Community Care Health Plan of Nevada, Inc. health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP New Jersey, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1001 Wood Avenue South				
Address Line 2: Suite 800				
City: Iselin	**State:** NJ	**Zip Code:** 08830	**County:** Middlesex	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Mark Horzepa				
Title: Compliance Director				
Phone Number: 732-215-9954	**Email Address:** mark.horzepa@anthem.com			
Work Details				
Number of covered lives: 242,977				
Time period of contract: February 1996–current (*evergreen agreement); more than 26 years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of AMERIGROUP New Jersey, Inc. staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting AMERIGROUP New Jersey, Inc. operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Medical Director, MLTSS Manager, Dental Director, BH Administrator, Financial Officer, Quality Management (QM)/Utilization Review Coordinator, Care Management Supervisor, Medicaid Care Manager, Member Services Unit Head, Provider Services Unit Head, Provider Services Liaison, Encounter Reporting Staff/Claims Processor Supervisor, Grievance Coordinator, MLTSS Member Representative, Nursing Facility Transition/Money Follows the Person Program Staff Person, Participant Direction Liaison, Compliance Officer, Housing Specialist, Pharmacy Director. As discussed above, AMERIGROUP New Jersey is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve.				

Geographic and population coverage requirements: New Jersey Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.
Publicly funded contract cost: [redacted] (cost of AMERIGROUP New Jersey, Inc. health plan's contract with the state)**.**
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: HealthPlus HP, LLC dba Empire BlueCross BlueShield HealthPlus, Amerigroup Partnership Plan, LLC (subcontractor to HealthNow New York, Inc. dba Blue Cross Blue Shield of Western New York); Anthem Inc. subsidiaries				
Client Location				
Address Line 1: 9 Pine Street				
Address Line 2: 14th Floor				
City: New York	**State:** NY	**Zip Code:** 10005		**County:** New York
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Violetta Urba				
Title: Compliance Director				
Phone Number: 914-826-7723		**Email Address:** violetta.urba@amerigroup.com		
Work Details				
Number of covered lives: 548,150				
Time period of contract: January 2005–current; more than 17 years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of HealthNow New York, Inc. staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting HealthNow New York, Inc. operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Utilization management staff, Case Managers, Member Services Staff, Medical Director, HIV Education Staff, behavioral health Director, HARP staff, Provider Services Staff, Compliance Officer, and SIU Director**.** As discussed above, HealthNow New York, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve.				

Geographic and population coverage requirements: Alleghany, Bronx, Cattaraugus, Chautauqua, Delaware, Dutchess, Erie, Genesee, Kings, Nassau, New York, Niagara, Orange, Orleans, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, Westchester, and Wyoming counties. TANF, CHIP, Medicaid Expansion, ABD, Uninsured Adults, and Dual Eligibles.
Publicly funded contract cost: [redacted] (cost of HealthPlus HP, LLC health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: Amerigroup Partnership Plan, LLC (Subcontractor to Blue Cross and Blue Shield of North Carolina); Anthem Inc. subsidiary				
Client Location				
Address Line 1: 11000 Weston Parkway				
Address Line 2:				
City: Cary	**State:** NC	**Zip Code:** 27513		**County:** Wake
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Rochelle Simmons				
Title: Compliance Director				
Phone Number: 770-298-6076		**Email Address:** rochelle.simmons@healthybluenc.com		
Work Details				
Number of covered lives: 438,229				
Time period of contract: June 2021 – current; 1 year				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of Blue Cross and Blue Shield of North Carolina staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting Blue Cross and Blue Shield of North Carolina operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: CEO, CFO, CMO, Chief Compliance Officer, Chief Information Security Officer or Chief Risk Officer, Quality Director, Provider Network Director, Pharmacy Director, BH Director, Director of Population Health and Care Management. As discussed above, Blue Cross and Blue Shield of North Carolina is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve.				

Geographic and population coverage requirements: North Carolina Statewide. TANF, CHIP, and ABD.
Publicly funded contract cost: [redacted] (cost of Amerigroup Partnership Plan, LLC health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: Amerigroup Partnership Plan, LLC (subcontractor to BlueChoice Health Plan of South Carolina, Inc.); Anthem Inc. subsidiary				
Client Location				
Address Line 1: 250 Berry Hill Road				
Address Line 2: Suite 311				
City: Columbia	**State:** SC	**Zip Code:** 29210	**County:** Richland	
Mailing Address (P.O.Box): 4101 Percival Rd	**City:** Columbia	**State:** SC	**Zip Code:** 29229	**County:** Richland
Direct Contact for Client				
Name: Lori Hack				
Title: Director Regulatory Affairs/Compliance Director				
Phone Number: 803-365-3114	**Email Address:** lori.hack@amerigroup.com			
Work Details				
Number of covered lives: 180,229				
Time period of contract: June 2008–current; more than 13 years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of BlueChoice Health Plan of South Carolina, Inc. staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting BlueChoice Health Plan of South Carolina, Inc. operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Administrator (CEO, COO, Executive Director), CFO, Contract Account Manager, Medical Director, Pharmacy Director, QI and/or QM Coordinator, UM Coordinator, Claims and Encounter Manager/Administrator, Compliance Officer, Provider Service Manager, Member Service Manager, Legal, Interagency Liaison, Other Medical Personnel (board-certified psychiatrist or psychologist). As discussed above, BlueChoice Health Plan of South Carolina, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need				

additional employees, including additional shared services resources, to provide excellent services to Members they serve.
Geographic and population coverage requirements: South Carolina Statewide. TANF and ABD.
Publicly funded contract cost: [redacted] (cost of Amerigroup Partnership Plan, LLC health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Tennessee, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 22 Century Boulevard				
Address Line 2: Suite 220				
City: Nashville	**State:** TN	**Zip Code:** 37214		**County:** Davidson
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Lori Stiffler				
Title: Compliance Director				
Phone Number: 949-526-3249		**Email Address:** lori.stiffler@amerigroup.com		
Work Details				
Number of covered lives: 501,128				
Time period of contract: August 2006–current (*awarded new contact, pending execution); more than 15 years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of AMERIGROUP Tennessee, Inc. staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting AMERIGROUP Tennessee, Inc. operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Administrator/Project Director, Transition/Implementation Lead, Medical Director, Medical Director for LTSS programs, Board-certified Psychiatrist, BH Program Director, CHOICES Program Director, ECF CHOICES Program Director, CFO, Information Systems Lead, After hours "on-call" person for TennCare Solutions, Non-discrimination Compliance Coordinator, Member Services Lead, Provider Services Lead, Dedicated CHOICES Lead trainer, Dedicated ECF CHOICES Lead trainer, CHOICES Provider Services and Fiscal Employer Agent Lead, PCMH/THL Trainers and Coaches, Fraud and Abuse Detection Lead, UM Lead, QM Lead, Appeal System Resolution Lead, Claims Management Lead, Court-ordered Services Lead, Litigation Hold Contact,				

Population Health Lead, CHOICES Care Coordination Lead, ECF CHOICES Person-Centered Support Coordination Lead, CHOICES care coordinators, ECF CHOICES support coordinators, Allied health professionals, Consumer Advocate for BH services, Specialized Member Advocate for intellectual and developmental disabilities in each Region, CHOICES Consumer Advocate in each Region, TennCare Kids Services Lead, Department of Children's Services Coordinator, Senior Executive responsible for oversight of subcontractor activities, NEMT Program Coordinator, Dental Benefits Manager Coordinator, PBM Coordinator, TDMHSAS Planning and Policy Councils Coordinator, Employment Services Director, Housing Specialist. As discussed above, AMERIGROUP Tennessee, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve.
Geographic and population coverage requirements: Tennessee Statewide. TANF, CHIP, ABD, Uninsured Adults, and Dual Eligibles.
Publicly funded contract cost [redacted] (cost of AMERIGROUP Tennessee, Inc. health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Texas, Inc., Amerigroup Insurance Company; Anthem Inc. subsidiaries				
Client Location				
Address Line 1: 2509 N Highway 360				
Address Line 2: Suite 300				
City: Grand Prairie	**State:** TX	**Zip Code:** 75050		**County:** Dallas
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Franco Hardy				
Title: Compliance Director				
Phone Number: 757-536-4723		**Email Address:** Francisco.hardy@amerigroup.com		
Work Details				
Number of covered lives: 1,006,534				
Time period of contract: March 2012–current; more than 10 years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of AMERIGROUP Texas, Inc. staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting AMERIGROUP Texas, Inc. operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Executive Director (CEO/COO), Medical Director, Member Services Manager, Management Information Systems Manager, Claims Processing Manager, Provider Network Development and Management Manager, Benefit Administration and Utilization and Care Management Manager, Quality Improvement Manager, BH Services Manager, Financial Functions Manager, Reporting Manager, STAR+PLUS Service Coordinators, SIU. As discussed above, AMERIGROUP Texas, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to				

provide excellent services to Members they serve.
Geographic and population coverage requirements: Texas Statewide. TANF, CHIP, ABD, Child Welfare, and Dual Eligibles.
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Texas, Inc. health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: HealthKeepers, Inc. dba Anthem HealthKeepers Plus, Amerigroup Partnership Plan, LLC (subcontractor to Dell Children's Health Plan); Anthem Inc. subsidiaries				
Client Location				
Address Line 1: 2015 Staples Mill Road				
Address Line 2:				
City: Richmond	**State:** VA	**Zip Code:** 23230		**County:** Henrico
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Nancy Kaplan				
Title: Director II Compliance				
Phone Number: 757-375-0747		**Email Address:** Nancy.kaplan@anthem.com		
Work Details				
Number of covered lives: 534,332				
Time period of contract: July 1996–current; more than 25 years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of Dell Children's Health Plan staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting Dell Children's Health Plan operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: CEO, President, Contract Administrator, CFO, Chief Medical Director/Officer, Pharmacy Director, Medical Management Director, Member Services/Operations Manager, Information Technology Staff, Quality Improvement Manager, Project Executive, Compliance Manager/Director, Compliance Officer, Program Integrity Lead, Encounter Data Manager, anyone key to the Contractor's operations. As discussed above, Dell Children's Health Plan is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent				

services to Members they serve.
Geographic and population coverage requirements: Virginia Statewide. ABD, Dual Eligibles, and Child Welfare/Foster Care, TANF, and CHIP.
Publicly funded contract cost: [redacted] (cost of HealthKeepers, Inc. health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Washington, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 705 5th Avenue South				
Address Line 2: Suite 300				
City: Seattle	**State:** WA	**Zip Code:** 98104	**County:** King	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Sheri Starcher				
Title: Compliance Director				
Phone Number: 206-641-5496	**Email Address:** sheri.starcher@anthem.com			
Work Details				
Number of covered lives: 254,500				
Time period of contract: January 2018–current; more than four years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of AMERIGROUP Washington, Inc. staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting AMERIGROUP Washington, Inc. operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: CEO, CFO, HCA government relations contact, HCA Account Executive, Compliance Officer, Medical Director, BH Medical Director, BH Clinical Director, Tribal Liaison. As discussed above, AMERIGROUP Washington, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve.				
Geographic and population coverage requirements: All Regional Service Areas covering all 39 Washington counties. TANF, CHIP, ABD, and Medicaid Expansion, Medicaid eligible individuals.				

4.3.3.5 Subcontractors (Marked) – 20

Publicly funded contract cost: [redacted] (cost of AMERIGROUP Washington, Inc. health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: UniCare Health Plan of West Virginia, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 200 Association Drive				
Address Line 2: Suite 200				
City: Charleston	**State:** WV	**Zip Code:** 25311		**County:** Kanawha
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Rich Chapman				
Title: Compliance Director				
Phone Number: 304-348-2701		**Email Address:** richard.chapman@anthem.com		
Work Details				
Number of covered lives: 195,791				
Time period of contract: January 2003–current; more than 19 years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of UniCare Health Plan of West Virginia, Inc. staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting UniCare Health Plan of West Virginia, Inc. operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: CEO/COO, Contract Liaison/MHT Administrator, Medical Management Director, BH Medical Director, Member Services Director, Network Development Director, Program Integrity Lead, Community Engagement Director, MHT Member Advocate, CFO, Medical Director, Care Management Director, Quality Director, Claims Payment Director, Provider Relations Director, IT Director, Encounter Data Integrity Manager, Dental Director. As discussed above, UniCare Health Plan of West Virginia, Inc. is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve.				

Geographic and population coverage requirements: West Virginia Statewide. TANF, ABD, CHIP, and Medicaid Expansion.
Publicly funded contract cost: [redacted] (cost of UniCare Health Plan of West Virginia, Inc. health plan's contract with the state)**.**
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

Prior Experiences with Subcontractor				
Client's Name: CompCare Health Services Insurance Corporation dba Anthem BCBS; Anthem Inc. subsidiary				
Client Location				
Address Line 1: N17 W24340 Riverwood Drive				
Address Line 2:				
City: Waukesha	**State:** WI	**Zip Code:** 53188	**County:** Waukesha	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Chryshanee McNeely				
Title: Compliance Manager				
Phone Number: 805-794-4321		**Email Address:** Chryshanee.mcneely@anthem.com		
Work Details				
Number of covered lives: 150,636				
Time period of contract: September 2010–current; more than 11 years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually. An integral part of CompCare Health Services Insurance Corporation staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest level of quality services to Members and Providers and supplement them with designated and dedicated national support shared services through Anthem, Inc., to leverage national best practices and economies of scale. Currently, there are [redacted] FTEs national share services associates supporting CompCare Health Services Insurance Corporation operations. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve. Each manager and department routinely review their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Contract Representative, Care Coordination Staff, Case Management Staff, HMO Representative. As discussed above, CompCare Health Services Insurance Corporation is currently supported by a total of [redacted] FTEs dedicated to the contract. The health plan continually reviews their staffing numbers against quality and service standards to determine whether they need additional employees, including additional shared services resources, to provide excellent services to Members they serve.				
Geographic and population coverage requirements: Wisconsin Statewide.				

TANF, ABD, and Uninsured Adults.
Publicly funded contract cost: [redacted] (cost of CompCare Health Services Insurance Corporation health plan's contract with the state).
Description of work performed under this contract
Administrative and support services such as enrollment; claims processing; third party liability; fraud, waste, and abuse; call center services; utilization management; information technology; reporting; encounters; communications; legal; regulatory; finance; and compliance.

4.3.3.5 Subcontractors (Marked) – 20

Subcontractor				
Name of Subcontractor: Aunt Bertha, a Public Benefit Corporation (also DBA findhelp, a Public Benefit Corporation)				
TIN/SSN (as applicable): 27-3354421		**The entity is a:** [X] **Subcontractor** **[ ] Wholly-Owned Subsidiary** **[ ] Affiliate under the same common ownership**		
Address Line 1: 3429 Executive Center Dr., Suite 100				
Address Line 2:				
City: Austin	**State:** TX	**Zip Code:** 78731	**County:** Travis	
Mailing Address (P.O. Box): 3616 Far West Blvd Suite 117-454	**City:** Austin	**State:** TX	**Zip Code:** 78731	**County:** Travis
Description of Services to be Rendered by Subcontractor for this Contract: Platform to connect Members with local community resources, programs, and services such as food, housing, transportation, and substance use disorder treatment.				
How will the Offeror monitor and manage this Subcontractor? Amerigroup Mississippi, Inc. will monitor and manage this subcontractor through initial training, ongoing support, and regular oversight. We will employ a Mississippi Health Plan Leadership team, who will include staff from our local operations, quality, and compliance departments as well as a Vendor Oversight Manager (VOM). The VOM will serve as the single point of contact for the Division and will oversee the subcontractor's performance. To monitor and manage the subcontractor while assuring a seamless experience for Members, Providers, and the Division, the VOM will: • Cultivate a strong relationship with the subcontractor • Identify, implement, and manage service quality and operational improvement projects • Interact with, and oversee activities performed by, our departments such as Procurement, Quality, and Claims • Facilitate subcontractor performance reviews and review audit results • Oversee complaints, Grievances and Appeals, and service level agreement adherence • Ensure receipt and reconciliation of all required reporting data • Escalate contract changes or performance issues and provide support through resolution The VOM, in conjunction with the Health Plan Leadership team, will also receive support from national organizational resources that add an additional layer of performance monitoring. The VOM will report up through our Mississippi-based Chief Executive Officer, who will be responsible and accountable for all functional areas. ***We retain sole responsibility for fulfilling contract requirements and full accountability for our subcontractor's performance.***				
Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No **If yes, fill out Prior Experience with Subcontractor for each applicable instance.**				

Prior Experiences with Subcontractor				
Client's Name: APC PASSE LLC dba Summit Community Care; Anthem, Inc. subsidiary				
Client Location				
Address Line 1: 605 South Shackleford				
Address Line 2: Ste 440				
City: Little Rock	**State:** AR	**Zip Code:** 72211	**County:** Pulaski	
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Hassan Gardezi				
Title: Interim Compliance Officer				
Phone Number: (225) 763-2143	**Email Address:** hassan.gardezi@healthybluela.com			
Work Details				
Number of covered lives: 17,001				
Time period of contract: 2020–current; less than five years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: Arkansas Statewide. I/DD, BH, Dual Eligibles, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of APC PASSE LLC health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: Anthem Blue Cross of California dba Anthem Blue Cross, Blue Cross of California Partnership Plan, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 21215 Burbank Boulevard				
Address Line 2:				
City: Woodland Hills	**State:** CA	**Zip Code:** 91367		**County:** Los Angeles
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Beth Moldonado				
Title: Director II Compliance				
Phone Number: (805) 264-9172		**Email Address:** beth.moldonado@anthem.com		
Work Details				
Number of covered lives: 1,362,860				
Time period of contract: 2017; more than three years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: CA Central Valley/Bay Area, CA Rural Expansion, Los Angeles Service Area, Sacramento County, San Benito County, Tri-County, Tulare County. TANF, ABD, Medicaid Expansion, Dual Eligibles, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Anthem Blue Cross of California health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: CCHA, LLC dba Colorado Community Health Alliance; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1125 17th Street				
Address Line 2: Suite 1000				
City: Denver	**State:** CO	**Zip Code:** 80202	**County:** Denver	
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Abigail Roa				
Title: Compliance Director				
Phone Number: (913) 300-1744	**Email Address:** Abigail.Roa@amerigroup.com			
Work Details				
Number of covered lives: 400,218				
Time period of contract: 2021–less than five years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: Colorado Statewide. ABD, Medicaid Expansion, Dual Eligibles, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of CCHA, LLC health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: Amerigroup District of Columbia, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1001 Pennsylvania Avenue NW				
Address Line 2: Suite 710				
City: Washington	**State:** DC	**Zip Code:** 20004		**County:** District of Columbia
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Barbie Boone CHPC MHP HCAFA DBA				
Title: Compliance Manager				
Phone Number: (757) 800-5249		**Email Address:** Barbara.boone@amerigroup.com		
Work Details				
Number of covered lives: 46,931				
Time period of contract: October 2017 – September 2020; December 2021 to present				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: District of Columbia. TANF, CHIP, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Amerigroup District of Columbia, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: Simply Healthcare Plans, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 9250 West Flagler Street				
Address Line 2:				
City: Miami	**State:** FL	**Zip Code:** 33174	**County:** Miami-Dade	
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: JoAnn McDaniel-Chinn				
Title: Compliance Director				
Phone Number: (305) 487-4047	**Email Address:** joann.mcdaniel-chinn@anthem.com			
Work Details				
Number of covered lives: 730,525				
Time period of contract: 2018–current; less than five years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: Florida Statewide. CHIP, TANF, ABD, and Dual Eligibles.				
Publicly funded contract cost: [redacted] (cost of Simply Healthcare Plans, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: AMGP Georgia Managed Care Company, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 4170 Ashford Dunwoody Road				
Address Line 2: Suite 100				
City: Atlanta	**State:** GA	**Zip Code:** 30319	**County:** DeKalb	
Mailing Address (P.O. Box): 740 West Peachtree Street NW	**City:** Atlanta	**State:** GA	**Zip Code:** 30308	**County:** DeKalb
Direct Contact for Client				
Name: Leticia Mayfield				
Title: Compliance Director				
Phone Number: (678) 587-4855	**Email Address:** Leticia.mayfield@Amerigroup.com			
Work Details				
Number of covered lives: 572,848				
Time period of contract: 2016–current; more than five years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: Georgia Statewide. TANF, CHIP, Child Welfare/Foster Care, and family planning waiver service membership.				
Publicly funded contract cost: [redacted] (cost of AMGP Georgia Managed Care Company, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: Anthem Insurance Companies, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 220 Virginia Avenue				
Address Line 2:				
City: Indianapolis	**State:** IN	**Zip Code:** 46204	**County:** Marion	
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Stephen Egan				
Title: Compliance Director				
Phone Number: (317) 617-3426	**Email Address:** Stephen.egan@anthem.com			
Work Details				
Number of covered lives: 705,387				
Time period of contract: 2016–current; more than five years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: Indiana Statewide. ABD and Child Welfare/Foster Care, TANF, CHIP, and Medicaid Expansion.				
Publicly funded contract cost: [redacted] (cost of Anthem Insurance Companies, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Iowa, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 4800 Westown Parkway				
Address Line 2: Suite 200				
City: West Des Moines	**State:** IA	**Zip Code:** 50266	**County:** Polk	
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Martha Crist				
Title: Compliance Director				
Phone Number: (515) 850-8057	**Email Address:** martha.crist@amerigroup.com			
Work Details				
Number of covered lives: 445,885				
Time period of contract: 2016–present; more than five years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: Iowa Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Iowa, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: Anthem Kentucky Managed Care Plan, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 13550 Triton Boulevard				
Address Line 2:				
City: Louisville	**State:** KY	**Zip Code:** 40223	**County:** Jefferson	
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Cheryl Herre				
Title: Compliance Director				
Phone Number: (502) 689-3987	**Email Address:** Cheryl.herre@anthem.com			
Work Details				
Number of covered lives: 168,124				
Time period of contract: 2018; more than three years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: Ballard, Caldwell, Calloway, Carlisle, Crittenden, Fulton, Graves, Hickman, Livingston, Lyon, Marshall, McCracken, Christian, Daviess, Hancock, Henderson, Hopkins, McLean, Muhlenberg, Ohio, Todd, Trigg, Union, Webster, Adair, Allen, Barren, Butler, Casey, Clinton, Cumberland, Edmonson, Green, Hart, Logan, McCreary, Metcalfe, Monroe, Pulaski, Russell, Simpson, Taylor, Warren, Wayne, Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jackson, Jessamine, Lincoln, Madison, Mercer, Montgomery, Nicholas, Owen, Powell, Rockcastle, Scott, Woodford, Boone, Campbell, Gallatin, Grant, Kenton, Pendleton, Bath, Boyd, Bracken, Carter, Elliott, Fleming, Greenup, Lawrence, Lewis, Mason, Menifee, Morgan, Robertson, Rowan, Bell, Breathitt, Clay, Floyd, Harlan, Johnson, Knott, Knox, Laurel, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry, Pike, Whitley, and Wolfe counties. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Anthem Kentucky Managed Care Plan, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: Community Care Health Plan of Louisiana, Inc. dba Healthy Blue; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1500 North 19th Street				
Address Line 2:				
City: Monroe	**State:** LA	**Zip Code:** 71201	**County:** Ouachita	
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Hassan Gardezi				
Title: Interim Compliance Officer				
Phone Number: (225) 763-2142	**Email Address:** hassan.gardezi@healthybluela.com			
Work Details				
Number of covered lives: 355,069				
Time period of contract: 2015; more than three years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: Louisiana Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Community Care Health Plan of Louisiana, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Maryland, Inc. dba Amerigroup Community Care; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 7550 Teague Road				
Address Line 2: Ste 500				
City: Hanover	**State:** MD	**Zip Code:** 21076	**County:** Anne Arundel	
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Lisa Drumm				
Title: Compliance Director				
Phone Number: (757) 995-5853	**Email Address:** lisa.drumm@amerigroup.com			
Work Details				
Number of covered lives: 320,013				
Time period of contract: 2017; more than three years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: Maryland Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Maryland, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: Amerigroup Partnership Plan, LLC (Subcontractor to HMO Minnesota dba Blue Plus); Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1285 Northland Drive				
Address Line 2:				
City: Mendota Heights	**State:** MN	**Zip Code:** 55120	**County:** Dakota	
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Lucy Mondale				
Title: Compliance Director				
Phone Number: (612) 280-4074	**Email Address:** Lucy.Mondale@amerigroup.com			
Work Details				
Number of covered lives: 427,883				
Time period of contract: 2020–current; less than five years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: 87 counties across the state. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Amerigroup Partnership Plan, LLC health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: Missouri Care, Inc. dba Healthy Blue; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1831 Chestnut Street				
Address Line 2:				
City: St. Louis	**State:** MO	**Zip Code:** 63103		**County:** St. Louis
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Russ Oppenborn				
Title: Compliance Officer				
Phone Number: (877) 602-9189		**Email Address:** russell.oppenborn@healthybluemo.com		
Work Details				
Number of covered lives: 340,487				
Time period of contract: 2021–current; less than five years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: Missouri Statewide. TANF, CHIP, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Missouri Care, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: Community Care Health Plan of Nebraska, Inc. dba Healthy Blue Nebraska; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 8055 O Street				
Address Line 2: Suite 300				
City: Lincoln	**State:** NE	**Zip Code:** 68510		**County:** Lancaster
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Jennifer Bohnoff				
Title: Director & Market Compliance Officer				
Phone Number: (402) 983-5186		**Email Address:** jennifer.bohnoff@healthybluene.com		
Work Details				
Number of covered lives: 11,048				
Time period of contract: 2021–current; less than five years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: Nebraska Statewide. TANF, CHIP, ABD, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Community Care Health Plan of Nebraska, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: Community Care Health Plan of Nevada, Inc. dba Anthem Blue Cross and Blue Shield Healthcare Solutions; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 9133 West Russell Road				
Address Line 2:				
City: Las Vegas	**State:** NV	**Zip Code:** 89148		**County:** Clark
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Tiffany Saunders-Newey				
Title: Compliance Director / Plan Compliance Officer				
Phone Number: (757) 409-0980		**Email Address:** tiffany.saunders-newey@anthem.com		
Work Details				
Number of covered lives: 274,479				
Time period of contract: 2017; more than three years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: Nevada Statewide. TANF, CHIP, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Community Care Health Plan of Nevada, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP New Jersey, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1001 Wood Avenue South				
Address Line 2: Suite 800				
City: Iselin	**State:** NJ	**Zip Code:** 08830	**County:** Middlesex	
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Mark Horzepa				
Title: Compliance Director				
Phone Number: (732) 215-9954	**Email Address:** mark.horzepa@anthem.com			
Work Details				
Number of covered lives: 242,977				
Time period of contract: 2017; more than three years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: New Jersey Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP New Jersey, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: HealthPlus HP, LLC dba Empire BlueCross BlueShield HealthPlus, Amerigroup Partnership Plan, LLC (subcontractor to HealthNow New York, Inc. dba Blue Cross Blue Shield of Western New York); Anthem Inc. subsidiaries				
Client Location				
Address Line 1: 9 Pine Street				
Address Line 2: 14th Floor				
City: New York	**State:** NY	**Zip Code:** 10005	**County:** New York	
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Violetta Urba				
Title: Compliance Director				
Phone Number: (914) 826-7723	**Email Address:** violetta.urba@amerigroup.com			
Work Details				
Number of covered lives: 548,150				
Time period of contract: 2020–current; less than five years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: Alleghany, Bronx, Cattaraugus, Chautauqua, Delaware, Dutchess, Erie, Genesee, Kings, Nassau, New York, Niagara, Orange, Orleans, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, Westchester, and Wyoming counties. TANF, CHIP, and Medicaid Expansion, ABD, Uninsured Adults, and Dual Eligibles.				
Publicly funded contract cost: [redacted] (cost of HealthPlus HP, LLC health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: Amerigroup Partnership Plan, LLC (subcontractor to BlueChoice Health Plan of South Carolina, Inc.); Anthem Inc. subsidiary				
Client Location				
Address Line 1: 250 Berry Hill Road				
Address Line 2: Suite 311				
City: Columbia	**State:** SC	**Zip Code:** 29210	**County:** Richland	
Mailing Address (P.O. Box): 4101 Percival Rd	**City:** Columbia	**State:** SC	**Zip Code:** 29229	**County:** Richland
Direct Contact for Client				
Name: Lori Hack				
Title: Director Regulatory Affairs/Compliance Director				
Phone Number: (803) 365-3114	**Email Address:** lori.hack@amerigroup.com			
Work Details				
Number of covered lives: 180,229				
Time period of contract: 2016; more than three years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: South Carolina Statewide. TANF and ABD.				
Publicly funded contract cost: [redacted] (cost of Amerigroup Partnership Plan, LLC health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Tennessee, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 22 Century Boulevard				
Address Line 2: Suite 220				
City: Nashville	**State:** TN	**Zip Code:** 37214		**County:** Davidson
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Lori Stiffler				
Title: Compliance Director				
Phone Number: (949) 526-3249		**Email Address:** lori.stiffler@amerigroup.com		
Work Details				
Number of covered lives: 501,128				
Time period of contract: 2016; more than three years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: Tennessee Statewide. TANF, CHIP, ABD, Uninsured Adults, and Dual Eligibles.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Tennessee, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Texas, Inc., Amerigroup Insurance Company; Anthem Inc. subsidiaries				
Client Location				
Address Line 1: 2509 N Highway 360				
Address Line 2: Suite 300				
City: Grand Prairie	**State:** TX	**Zip Code:** 75050		**County:** Dallas
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Franco Hardy				
Title: Compliance Director				
Phone Number: (757) 536-4723		**Email Address:** Francisco.hardy@amerigroup.com		
Work Details				
Number of covered lives: 1,006,534				
Time period of contract: 2015; present; more than five years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: Texas Statewide. TANF, CHIP, ABD, Child Welfare, and Dual Eligibles.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Texas, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: HealthKeepers, Inc. dba Anthem HealthKeepers Plus, Amerigroup Partnership Plan, LLC (subcontractor to Dell Children's Health Plan); Anthem Inc. subsidiaries				
Client Location				
Address Line 1: 2015 Staples Mill Road				
Address Line 2:				
City: Richmond	**State:** VA	**Zip Code:** 23230		**County:** Henrico
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Nancy Kaplan				
Title: Director II Compliance				
Phone Number: (757) 375-0747		**Email Address:** Nancy.kaplan@anthem.com		
Work Details				
Number of covered lives: 534,332				
Time period of contract: 2016; more than three years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: Virginia Statewide. ABD, Dual Eligibles, and Child Welfare/Foster Care, TANF, and CHIP.				
Publicly funded contract cost: [redacted] (cost of HealthKeepers, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Washington, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 705 5th Avenue South				
Address Line 2: Suite 300				
City: Seattle	**State:** WA	**Zip Code:** 98104	**County:** King	
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Sheri Starcher				
Title: Compliance Director				
Phone Number: (206) 641-5496	**Email Address:** sheri.starcher@anthem.com			
Work Details				
Number of covered lives: 254,500				
Time period of contract: 2017; more than three years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: All Regional Service Areas covering all 39 Washington counties. TANF, CHIP, ABD, and Medicaid Expansion, Medicaid eligible individuals.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Washington, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: UniCare Health Plan of West Virginia, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 200 Association Drive				
Address Line 2: Suite 200				
City: Charleston	**State:** WV	**Zip Code:** 25311	**County:** Kanawha	
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Rich Chapman				
Title: Compliance Director				
Phone Number: (304) 348-2701	**Email Address:** richard.chapman@anthem.com			
Work Details				
Number of covered lives: 195,791				
Time period of contract: 2018; more than five years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: West Virginia Statewide. TANF, ABD, CHIP, and Medicaid Expansion.				
Publicly funded contract cost: [redacted] (cost of UniCare Health Plan of West Virginia, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

Prior Experiences with Subcontractor				
Client's Name: CompCare Health Services Insurance Corporation dba Anthem BCBS; Anthem Inc. subsidiary				
Client Location				
Address Line 1: N17 W24340 Riverwood Drive				
Address Line 2:				
City: Waukesha	**State:** WI	**Zip Code:** 53188	**County:** Waukesha	
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Chryshanee McNeely				
Title: Compliance Manager				
Phone Number: (805) 794-4321	**Email Address:** Chryshanee.mcneely@anthem.com			
Work Details				
Number of covered lives: 150,636				
Time period of contract: 2021–present; less than five years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Sr. Customer Success Manager, Community Engagement Manager, and VP Customer Experience.				
Geographic and population coverage requirements: Wisconsin Statewide. TANF, ABD, and Uninsured Adults.				
Publicly funded contract cost: [redacted] (cost of CompCare Health Services Insurance Corporation health plan's contract with the state).				
Description of work performed under this contract				
Access to website to connect Members in need with social programs that cover things like food, housing, and substance use disorder treatment. Other work includes: branded site configuration, prioritized search result ordering, custom reporting configuration, project management, online training, access to reporting and analytics, CBO outreach, ongoing support.				

4.3.3.5 Subcontractors (Marked) – 20

Subcontractor				
Name of Subcontractor: Beacon Health Options, Inc.				
TIN/SSN (as applicable): 54-141-4194		**The entity is a:** **[ ] Subcontractor** **[ ] Wholly-Owned Subsidiary** [X] **Affiliate under the same common ownership**		
Address Line 1: 200 State Street				
Address Line 2: Suite 302				
City: Boston	**State:** MA	**Zip Code:** 02109	**County:** Suffolk	
Mailing Address (P.O.Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Description of Services to be Rendered by Subcontractor for this Contract: 24-hour Behavioral Health/Substance Use Disorder line (Member and Provider); after-hours, weekend, and holiday support for utilization management functions. (Please note: our parent company and its affiliates provide administrative support to our utilization management process for functions such as intake and initial screening. However, all utilization management decisions to reduce or deny, in whole or in part, will ultimately be made by local CCO licensed clinical staff.)				
How will the Offeror monitor and manage this Subcontractor? Amerigroup Mississippi, Inc. will monitor and manage all subcontractors through a Mississippi Health Plan Leadership team, who will include staff from our local operations, quality, and compliance departments as well as a Vendor Oversight Manager (VOM). They will receive additional support from national resources that add an additional layer of performance monitoring. We will hold our affiliate subcontractors to the required performance levels using contractual requirements, internally set standards, incentives, penalties, and established policies and procedures, to include enforcement for nonperformance. We will utilize reporting tools and systems analyzing key metrics visualizing our performance against defined targets. Functional area owners will be responsible for the performance and action plans for missed targets, and for regularly reporting performance and any issues to the VOM. The VOM will serve as the single point of contact for the Division and will oversee the subcontractor's performance. To monitor and manage the subcontractor while assuring a seamless experience for Members, Providers, and the Division, the VOM will: • Cultivate a strong relationship with the subcontractor and functional area owners • Identify, implement, and manage service quality and operational improvement projects • Interact with, and oversee activities performed by, our departments such as Quality, and Claims • Facilitate performance reviews and review audit results • Oversee complaints, Grievances and Appeals, and service level agreement adherence • Ensure receipt and reconciliation of all required reporting data • Escalate contract changes or performance issues and provide support through resolution				

4.3.3.5 Subcontractors (Marked) – 20

The VOM will report up through our Mississippi-based Chief Executive Officer, who will be responsible and accountable for all functional areas. ***We retain sole responsibility for fulfilling contract requirements and full accountability for our subcontractor's performance.***
Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] **Yes** [ ] **No** **If yes, fill out Prior Experience with Subcontractor for each applicable instance.**

Prior Experiences with Subcontractor				
Client's Name: Simply Healthcare Plans, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 9250 West Flagler Street, Suite 600				
Address Line 2:				
City: Miami	**State:** FL	**Zip Code:** 33174		**County:** Miami-Dade
Mailing Address (P.O.Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Holly Prince				
Title: Plan President				
Phone Number: 305-921-2610		**Email Address:** hprince@simplyhealthcareplans.com		
Work Details				
Number of covered lives: 730,525				
Time period of contract: 2013 to current; more than nine years				
Total number of staff hours expended during time period of contract: Currently [redacted] FTEs, increasing to [redacted] FTEs on 5/1/2022 when Beacon is delegated care management functions.				
Personnel requirements: Clinical, Customer Service, Provider Relations, Contracting, Network Management, Utilization Management, Quality Improvement, Claims Management, Administrative Services, Financial and Clinical/Quality analysis, Grievances and Appeals.				
Geographic and population coverage requirements: Florida Statewide. Medicaid and Florida Healthy Kids (CHIP, TANF, ABD, and Dual Eligible).				
Publicly funded contract cost: [redacted] cost of Simply Healthcare Plans, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Beacon performs as a Managed Behavioral Health Organization subcontractor for Simply, and administers the behavioral health benefits for Simply, Clear Health Alliance, and Florida Healthy Kids members.				

4.3.3.5 Subcontractors (Marked) – 20

Subcontractor				
Name of Subcontractor: Center for the Study of Services (CSS)				
TIN/SSN (as applicable): 52-1000466		**The entity is a:** [X] **Subcontractor** **[ ] Wholly-Owned Subsidiary** **[ ] Affiliate under the same common ownership**		
Address Line 1: 1625 K ST NW, 8th Floor				
Address Line 2:				
City: Washington	**State:** DC	**Zip Code:** 20006	**County:** District of Columbia	
Mailing Address (P.O.Box): Not Applicable	**City:**	**State:**	**Zip Code:**	**County:**
Description of Services to be Rendered by Subcontractor for this Contract: Administer Provider satisfaction surveys, and Member satisfaction surveys to assess Member experience with healthcare services delivered in different settings and for specific conditions such as Member CAHPS® surveys and Member behavioral health surveys.				
How will the Offeror monitor and manage this Subcontractor? Amerigroup Mississippi, Inc. will monitor and manage this subcontractor through initial training, ongoing support, and regular oversight. We will employ a Mississippi Health Plan Leadership Team who will include staff from our local operations, quality, and compliance departments, and a Vendor Oversight Manager (VOM). The VOM will serve as the single point of contact for the Division and will oversee the subcontractor's performance. To monitor and manage the subcontractor while assuring a seamless experience for Members, Providers, and the Division, the VOM will: • Cultivate a strong relationship with the subcontractor • Identify, implement, and manage service quality and operational improvement projects • Interact with, and oversee activities performed by, our departments such as Procurement, Quality, and Claims • Facilitate subcontractor performance reviews and review audit results • Oversee complaints, Grievances and Appeals, and service level agreement adherence • Ensure receipt and reconciliation of all required reporting data • Escalate contract changes or performance issues and provide support through resolution The VOM, in conjunction with the Health Plan Leadership team, will also receive support from national organizational resources that add an additional layer of performance monitoring. The VOM will report up through our Mississippi-based Chief Executive Officer, who will be responsible and accountable for all functional areas. ***We retain sole responsibility for fulfilling contract requirements and full accountability for our subcontractor's performance.***				
Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] **Yes [ ] No** **If yes, fill out Prior Experience with Subcontractor for each applicable instance.**				

Prior Experiences with Subcontractor				
Client's Name: APC PASSE LLC dba Summit Community Care; Anthem, Inc. subsidiary				
Client Location				
Address Line 1: 605 South Shackleford				
Address Line 2: Suite 440				
City: Little Rock	**State:** AR	**Zip Code:** 72211	**County:** Pulaski	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Hassan Gardezi				
Title: Interim Compliance Officer				
Phone Number: 225-763-2143	**Email Address:** hassan.gardezi@healthybluela.com			
Work Details				
Number of covered lives: 17,001				
Time period of contract: 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. [redacted] Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. [redacted] Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: Arkansas Statewide. I/DD, BH, Dual Eligibles, and Child Welfare/Foster Care.				
Publicly funded contract cost [redacted] (cost of APC PASSE LLC health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides including CAHPS, BH Member surveys, and Provider satisfaction surveys.				

Prior Experiences with Subcontractor				
Client's Name: Anthem Blue Cross of California dba Anthem Blue Cross, Blue Cross of California Partnership Plan, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 21215 Burbank Boulevard				
Address Line 2:				
City: Woodland Hills	**State:** CA	**Zip Code:** 91367		**County:** Los Angeles
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Beth Moldonado				
Title: Director II Compliance				
Phone Number: 805-264-9172		**Email Address:** beth.moldonado@anthem.com		
Work Details				
Number of covered lives: 1,362,860				
Time period of contract: 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: CA Central Valley/Bay Area, CA Rural Expansion, Los Angeles Service Area, Sacramento County, San Benito County, Tri-County, Tulare County. TANF, ABD, Medicaid Expansion, Dual Eligibles, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Anthem Blue Cross of California health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides CAHPS surveys to assess patient experience with healthcare services delivered in different settings and for specific conditions.				

Prior Experiences with Subcontractor				
Client's Name: Simply Healthcare Plans, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 9250 West Flagler Street				
Address Line 2:				
City: Miami	**State:** FL	**Zip Code:** 33174	**County:** Miami-Dade	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: JoAnn McDaniel-Chinn				
Title: Compliance Director				
Phone Number: 305-487-4047	**Email Address:** joann.mcdaniel-chinn@anthem.com			
Work Details				
Number of covered lives: 730,525				
Time period of contract: 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. [redacted] Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: Florida Statewide. CHIP, TANF, ABD, and Dual Eligibles.				
Publicly funded contract cost: [redacted] (cost of Simply Healthcare Plans, Inc. health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides including CAHPS, BH Member surveys, and Provider satisfaction surveys.				

Prior Experiences with Subcontractor				
Client's Name: AMGP Georgia Managed Care Company, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 4170 Ashford Dunwoody Road				
Address Line 2: Suite 100				
City: Atlanta	**State:** GA	**Zip Code:** 30319	**County:** DeKalb	
Mailing Address (P.O.Box): 740 West Peachtree Street NW	**City:** Atlanta	**State:** GA	**Zip Code:** 30308	**County:** DeKalb
Direct Contact for Client				
Name: Leticia Mayfield				
Title: Compliance Director				
Phone Number: 678-5887-4855	**Email Address:** Leticia.mayfield@Amerigroup.com			
Work Details				
Number of covered lives: 572,848				
Time period of contract: 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. [redacted] Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. [redacted] Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: Georgia Statewide. TANF, CHIP, Child Welfare/Foster Care, and family planning waiver service Membership.				
Publicly funded contract cost: [redacted] (cost of AMGP Georgia Managed Care Company, Inc. health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides CAHPS surveys to assess patient experience with healthcare services delivered in different settings and for specific conditions.				

Prior Experiences with Subcontractor				
Client's Name: Anthem Insurance Companies, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 220 Virginia Avenue				
Address Line 2:				
City: Indianapolis	**State:** IN	**Zip Code:** 46204	**County:** Marion	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Stephen Egan				
Title: Compliance Director				
Phone Number: 317-617-3426	**Email Address:** Stephen.egan@anthem.com			
Work Details				
Number of covered lives: 705,387				
Time period of contract: 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. [redacted] Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. [redacted] Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: Indiana Statewide. ABD and Child Welfare/Foster Care, TANF, CHIP, and Medicaid Expansion.				
Publicly funded contract cost: [redacted] (cost of Anthem Insurance Companies, Inc. health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides CAHPS surveys to assess patient experience with healthcare services delivered in different settings and for specific conditions.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Iowa, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 4800 Westown Parkway				
Address Line 2: Suite 200				
City: West Des Moines	**State:** IA	**Zip Code:** 50266	**County:** Polk	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Martha Crist				
Title: Compliance Director				
Phone Number: 515-850-8057	**Email Address:** martha.crist@amerigroup.com			
Work Details				
Number of covered lives: 445,885				
Time period of contract: 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. [redacted] Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. [redacted] Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: Iowa Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Iowa, Inc. health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides CAHPS surveys to assess patient experience with healthcare services delivered in different settings and for specific conditions.				

Prior Experiences with Subcontractor				
Client's Name: Anthem Kentucky Managed Care Plan, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 13550 Triton Boulevard				
Address Line 2:				
City: Louisville	**State:** KY	**Zip Code:** 40223	**County:** Jefferson	
Mailing Address (P.O.Box): 13550 Triton Blvd	**City:** Louisville	**State:** KY	**Zip Code:** 40223	**County:** Jefferson
Direct Contact for Client				
Name: Cheryl Herre				
Title: Compliance Director				
Phone Number: 502-689-3987	**Email Address:** Cheryl.herre@anthem.com			
Work Details				
Number of covered lives: 168,124				
Time period of contract: 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. [redacted] Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. [redacted] Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: Ballard, Caldwell, Calloway, Carlisle, Crittenden, Fulton, Graves, Hickman, Livingston, Lyon, Marshall, McCracken, Christian, Daviess, Hancock, Henderson, Hopkins, McLean, Muhlenberg, Ohio, Todd, Trigg, Union, Webster, Adair, Allen, Barren, Butler, Casey, Clinton, Cumberland, Edmonson, Green, Hart, Logan, McCreary, Metcalfe, Monroe, Pulaski, Russell, Simpson, Taylor, Warren, Wayne, Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jackson, Jessamine, Lincoln, Madison, Mercer, Montgomery, Nicholas, Owen, Powell, Rockcastle, Scott, Woodford, Boone, Campbell, Gallatin, Grant, Kenton, Pendleton, Bath, Boyd, Bracken, Carter, Elliott, Fleming, Greenup, Lawrence, Lewis, Mason, Menifee, Morgan, Robertson, Rowan, Bell, Breathitt, Clay, Floyd, Harlan, Johnson, Knott, Knox, Laurel, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry, Pike, Whitley, and Wolfe counties. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				

4.3.3.5 Subcontractors (Marked) – 20

Publicly funded contract cost: [redacted] (cost of Anthem Kentucky Managed Care Plan, Inc. health plan's contract with the state).
Description of work performed under this contract
NCQA-certified vendor provides CAHPS surveys to assess patient experience with healthcare services delivered in different settings and for specific conditions.

Prior Experiences with Subcontractor				
Client's Name: Community Care Health Plan of Louisiana, Inc. dba Healthy Blue; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1500 North 19th Street				
Address Line 2:				
City: Monroe	**State:** LA	**Zip Code:** 71201	**County:** Ouachita	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Hassan Gardezi				
Title: Interim Compliance Officer				
Phone Number: 225-763-2142	**Email Address:** hassan.gardezi@healthybluela.com			
Work Details				
Number of covered lives: 355,069				
Time period of contract: 2019–current; two and a half years (*new contract pending)				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. [redacted] Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. [redacted] Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: Louisiana Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Community Care Health Plan of Louisiana, Inc. health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides CAHPS surveys to assess patient experience with healthcare services delivered in different settings and for specific conditions.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Maryland, Inc. dba Amerigroup Community Care; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 7550 Teague Road				
Address Line 2: Suite 500				
City: Hanover	**State:** MD	**Zip Code:** 21076	**County:** Anne Arundel	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Lisa Drumm				
Title: Compliance Director				
Phone Number: 757-995-5853	**Email Address:** lisa.drumm@amerigroup.com			
Work Details				
Number of covered lives: 320,013				
Time period of contract: 2019–current; two and a half years (*contract is evergreen)				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: Maryland Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost [redacted] (cost of AMERIGROUP Maryland, Inc. health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides CAHPS surveys to assess patient experience with healthcare services delivered in different settings and for specific conditions.				

Prior Experiences with Subcontractor				
Client's Name: Missouri Care, Inc. dba Healthy Blue; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1831 Chestnut Street				
Address Line 2:				
City: St. Louis	**State:** MO	**Zip Code:** 63103	**County:** St. Louis	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Russ Oppenborn				
Title: Compliance Officer				
Phone Number: 877-602-9189	**Email Address:** russell.oppenborn@healthybluemo.com			
Work Details				
Number of covered lives: 340,487				
Time period of contract: 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. [redacted] Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: Missouri Statewide. TANF, CHIP, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Missouri Care, Inc. health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides CAHPS surveys to assess patient experience with healthcare services delivered in different settings and for specific conditions.				

Prior Experiences with Subcontractor				
Client's Name: Community Care Health Plan of Nebraska, Inc. dba Healthy Blue Nebraska; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 8055 O Street				
Address Line 2: Suite 300				
City: Lincoln	**State:** NE	**Zip Code:** 68510	**County:** Lancaster	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Jennifer Bohnoff				
Title: Director & Market Compliance Officer				
Phone Number: 402-983-5186	**Email Address:** jennifer.bohnoff@healthybluene.com			
Work Details				
Number of covered lives: 11,048				
Time period of contract: 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. [redacted] Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. [redacted] Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: Nebraska Statewide. TANF, CHIP, ABD, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Community Care Health Plan of Nebraska, Inc. health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides CAHPS surveys to assess patient experience with healthcare services delivered in different settings and for specific conditions.				

Prior Experiences with Subcontractor				
Client's Name: Community Care Health Plan of Nevada, Inc. dba Anthem Blue Cross and Blue Shield Healthcare Solutions; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 9133 West Russell Road				
Address Line 2:				
City: Las Vegas	**State:** NV	**Zip Code:** 89148	**County:** Clark	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Tiffany Saunders-Newey				
Title: Compliance Director/Plan Compliance Officer				
Phone Number: 757-409-0980	**Email Address:** tiffany.saunders-newey@anthem.com			
Work Details				
Number of covered lives: 274,479				
Time period of contract: 2019–2021; two and a half years (*awarded new contract)				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. [redacted] Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. [redacted] Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: Nevada Statewide. TANF, CHIP, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Community Care Health Plan of Nevada, Inc. health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides CAHPS surveys to assess patient experience with healthcare services delivered in different settings and for specific conditions.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP New Jersey, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1001 Wood Avenue South				
Address Line 2: Suite 800				
City: Iselin	**State:** NJ	**Zip Code:** 08830	**County:** Middlesex	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Mark Horzepa				
Title: Compliance Director				
Phone Number: 732-215-9954	**Email Address:** mark.horzepa@anthem.com			
Work Details				
Number of covered lives: 242,977				
Time period of contract: 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. [redacted] Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. [redacted] Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: New Jersey Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP New Jersey, Inc. health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides CAHPS surveys to assess patient experience with healthcare services delivered in different settings and for specific conditions.				

Prior Experiences with Subcontractor				
Client's Name: HealthPlus HP, LLC dba Empire BlueCross BlueShield HealthPlus, Amerigroup Partnership Plan, LLC (subcontractor to HealthNow New York, Inc. dba Blue Cross Blue Shield of Western New York); Anthem Inc. subsidiaries				
Client Location				
Address Line 1: 9 Pine Street				
Address Line 2: 14th Floor				
City: New York	**State:** NY	**Zip Code:** 10005		**County:** New York
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Violetta Urba				
Title: Compliance Director				
Phone Number: 914-826-7723		**Email Address:** violetta.urba@amerigroup.com		
Work Details				
Number of covered lives: 548,150				
Time period of contract: 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. [redacted] Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: Alleghany, Bronx, Cattaraugus, Chautaugua, Delaware, Dutchess, Erie, Genesee, Kings, Nassau, New York, Niagara, Orange, Orleans, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, Westchester, and Wyoming counties. TANF, CHIP, and Medicaid Expansion, ABD, Uninsured Adults, and Dual Eligibles.				
Publicly funded contract cost: [redacted] (cost of HealthPlus HP, LLC health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides CAHPS surveys to assess patient experience with healthcare services delivered in different settings and for specific conditions.				

Prior Experiences with Subcontractor				
Client's Name: Amerigroup Partnership Plan, LLC (Subcontractor to Blue Cross and Blue Shield of North Carolina); Anthem Inc. subsidiary				
Client Location				
Address Line 1: 11000 Weston Parkway				
Address Line 2:				
City: Cary	**State:** NC	**Zip Code:** 27513	**County:** Wake	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Rochelle Simmons				
Title: Compliance Director				
Phone Number: 770-298-6076		**Email Address:** rochelle.simmons@healthybluenc.com		
Work Details				
Number of covered lives: 438,229				
Time period of contract: 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. [redacted] Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. [redacted] Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: North Carolina Statewide. TANF, CHIP, and ABD.				
Publicly funded contract cost: [redacted] (cost of Amerigroup Partnership Plan, LLC health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides CAHPS surveys to assess patient experience with healthcare services delivered in different settings and for specific conditions.				

Prior Experiences with Subcontractor				
Client's Name: Amerigroup Partnership Plan, LLC (subcontractor to BlueChoice Health Plan of South Carolina, Inc.); Anthem Inc. subsidiary				
Client Location				
Address Line 1: 250 Berry Hill Road				
Address Line 2: Suite 311				
City: Columbia	**State:** SC	**Zip Code:** 29210	**County:** Richland	
Mailing Address (P.O.Box): 4101 Percival Rd	**City:** Columbia	**State:** SC	**Zip Code:** 29229	**County:** Richland
Direct Contact for Client				
Name: Lori Hack				
Title: Director Regulatory Affairs/Compliance Director				
Phone Number: 803-365-3114	**Email Address:** lori.hack@amerigroup.com			
Work Details				
Number of covered lives: 180,229				
Time period of contract: 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: South Carolina Statewide. TANF and ABD.				
Publicly funded contract cost: [redacted] (cost of Amerigroup Partnership Plan, LLC health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides CAHPS surveys to assess patient experience with healthcare services delivered in different settings and for specific conditions.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Tennessee, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 22 Century Boulevard				
Address Line 2: Suite 220				
City: Nashville	**State:** TN	**Zip Code:** 37214	**County:** Davidson	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Lori Stiffler				
Title: Compliance Director				
Phone Number: 949-526-3249	**Email Address:** lori.stiffler@amerigroup.com			
Work Details				
Number of covered lives: 501,128				
Time period of contract: 2019–current; two and a half years (*awarded new contract, pending execution)				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. [redacted] Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: Tennessee Statewide. TANF, CHIP, ABD, Uninsured Adults, and Dual Eligibles.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Tennessee, Inc. health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides CAHPS surveys to assess patient experience with healthcare services delivered in different settings and for specific conditions.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Texas, Inc., Amerigroup Insurance Company; Anthem Inc. subsidiaries				
Client Location				
Address Line 1: 2509 N Highway 360				
Address Line 2: Suite 300				
City: Grand Prairie	**State:** TX	**Zip Code:** 75050	**County:** Dallas	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Franco Hardy				
Title: Compliance Director				
Phone Number: 757-536-4723	**Email Address:** Francisco.hardy@amerigroup.com			
Work Details				
Number of covered lives: 1,006,534				
Time period of contract: 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. [redacted] Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. [redacted] Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: Texas Statewide. TANF, CHIP, ABD, Child Welfare, and Dual Eligibles.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Texas, Inc. health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides CAHPS surveys to assess patient experience with healthcare services delivered in different settings and for specific conditions.				

Prior Experiences with Subcontractor				
Client's Name: HealthKeepers, Inc. dba Anthem HealthKeepers Plus, Amerigroup Partnership Plan, LLC (subcontractor to Dell Children's Health Plan); Anthem Inc. subsidiaries				
Client Location				
Address Line 1: 2015 Staples Mill Road				
Address Line 2:				
City: Richmond	**State:** VA	**Zip Code:** 23230	**County:** Henrico	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Nancy Kaplan				
Title: Director II Compliance				
Phone Number: 757-375-0747	**Email Address:** Nancy.kaplan@anthem.com			
Work Details				
Number of covered lives: 534,332				
Time period of contract: 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. [redacted] Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: Virginia Statewide. ABD, Dual Eligibles, and Child Welfare/Foster Care, TANF, and CHIP.				
Publicly funded contract cost: [redacted] (cost of HealthKeepers, Inc. health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides CAHPS surveys to assess patient experience with healthcare services delivered in different settings and for specific conditions.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Washington, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 705 5th Avenue South				
Address Line 2: Suite 300				
City: Seattle	**State:** WA	**Zip Code:** 98104	**County:** King	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Sheri Starcher				
Title: Compliance Director				
Phone Number: 206-641-5496	**Email Address:** sheri.starcher@anthem.com			
Work Details				
Number of covered lives: 254,500				
Time period of contract: 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. [redacted] Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. [redacted] Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: All Regional Service Areas covering all 39 Washington counties. TANF, CHIP, ABD, and Medicaid Expansion, Medicaid eligible individuals.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Washington, Inc. health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides CAHPS surveys to assess patient experience with healthcare services delivered in different settings and for specific conditions.				

Prior Experiences with Subcontractor				
Client's Name: UniCare Health Plan of West Virginia, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 200 Association Drive				
Address Line 2: Suite 200				
City: Charleston	**State:** WV	**Zip Code:** 25311	**County:** Kanawha	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Rich Chapman				
Title: Compliance Director				
Phone Number: 304-348-2701	**Email Address:** richard.chapman@anthem.com			
Work Details				
Number of covered lives: 195,791				
Time period of contract: 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. [redacted] Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. [redacted] Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: West Virginia Statewide. TANF, ABD, CHIP, and Medicaid Expansion.				
Publicly funded contract cost: [redacted] (cost of UniCare Health Plan of West Virginia, Inc. health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides CAHPS surveys to assess patient experience with healthcare services delivered in different settings and for specific conditions.				

Prior Experiences with Subcontractor				
Client's Name: CompCare Health Services Insurance Corporation dba Anthem BCBS; Anthem Inc. subsidiary				
Client Location				
Address Line 1: N17 W24340 Riverwood Drive				
Address Line 2:				
City: Waukesha	**State:** WI	**Zip Code:** 53188	**County:** Waukesha	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Chryshanee McNeely				
Title: Compliance Manager				
Phone Number: 805-794-4321		**Email Address:** Chryshanee.mcneely@anthem.com		
Work Details				
Number of covered lives: 150,636				
Time period of contract: 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours. CSS along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to Members they serve. The President at CSS routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in Membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: [redacted] FTEs: [redacted] Survey Director: Manages plan requirements in the execution of CAHPS surveys. [redacted] Research Associate: Supports the day-to-day tasks related to the plan requirements for CAHPS. [redacted] Research Analyst: Provides technical assistance during quality assurance checks of the CAHPS survey fielding and reporting.				
Geographic and population coverage requirements: Wisconsin Statewide. TANF, ABD, and Uninsured Adults.				
Publicly funded contract cost: [redacted] (cost of CompCare Health Services Insurance Corporation health plan's contract with the state).				
Description of work performed under this contract				
NCQA-certified vendor provides CAHPS surveys to assess patient experience with healthcare services delivered in different settings and for specific conditions.				

4.3.3.5 Subcontractors (Marked) – 20

Subcontractor				
Name of Subcontractor: DSM USA Insurance Company, Inc. (DSM USA). DSM USA is a wholly-owned subsidiary of DentaQuest, LLC (DQ LLC), which owns and manages the DentaQuest organization (collectively, DentaQuest), comprised of companies that hold insurance, third party administrator and similar licenses in nearly every state in the country. DQ LLC provides similar administrative and management services for all of its affiliated benefits companies. Although DSM USA retains sole and ultimate responsibility for compliance with the subcontract and oversight of DQ LLC's performance of the services in connection with the subcontract, the executive leadership team and staff who are charged with fulfilling these requirements are all employed by DQ LLC. For purposes of this document, "Prior Experiences with Subcontractor" shall refer to prior experiences with the DentaQuest organization as a whole.				
TIN/SSN (as applicable): 59-0397210	**The entity is a:** [X] **Subcontractor** [ ] **Wholly-Owned Subsidiary** [ ] **Affiliate under the same common ownership**			
Address Line 1: 465 Medford Street				
Address Line 2:				
City: Boston	**State:** MA	**Zip Code:** 02129-1454	**County:** Suffolk	
Mailing Address (P.O.Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Description of Services to be Rendered by Subcontractor for this Contract: Full spectrum of core and Value-Added dental benefit administration services.				
How will the Offeror monitor and manage this Subcontractor? Amerigroup Mississippi, Inc. will monitor and manage this subcontractor through initial training, ongoing support, and regular oversight. We will employ a Mississippi Health Plan Leadership team who will include staff from our local operations, quality, and compliance departments as well as a Vendor Oversight Manager (VOM). The VOM will serve as the single point of contact for the Division and will oversee the subcontractor's performance. To monitor and manage the subcontractor while assuring a seamless experience for Members, Providers, and the Division, the VOM will: • Cultivate a strong relationship with the subcontractor • Identify, implement, and manage service quality and operational improvement projects • Interact with, and oversee activities performed by, our departments such as Procurement, Quality, and Claims • Facilitate subcontractor performance reviews and review audit results • Oversee complaints, Grievances and Appeals, and service level agreement adherence • Ensure receipt and reconciliation of all required reporting data • Escalate contract changes or performance issues and provide support through resolution The VOM, in conjunction with the Health Plan Leadership Team, will also receive support from national organizational resources that add an additional layer of performance monitoring. The VOM will report up through our Mississippi-based Chief Executive Officer, who will be responsible and accountable for all functional areas. ***We retain sole responsibility for fulfilling contract requirements and full accountability for our subcontractor's performance.***				

4.3.3.5 Subcontractors (Marked) – 20

Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No **If yes, fill out Prior Experience with Subcontractor for each applicable instance.**

Prior Experiences with Subcontractor				
Client's Name: AMGP Georgia Managed Care Company, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 4170 Ashford Dunwoody Road				
Address Line 2: Suite 100				
City: Atlanta	**State:** GA	**Zip Code:** 30319	**County:** DeKalb	
Mailing Address (P.O.Box): 740 West Peachtree Street NW	**City:** Atlanta	**State:** GA	**Zip Code:** 30308	**County:** DeKalb
Direct Contact for Client				
Name: Leticia Mayfield				
Title: Compliance Director				
Phone Number: (678) 587-4855	**Email Address:** Leticia.mayfield@Amerigroup.com			
Work Details				
Number of covered lives: 572,848				
Time period of contract: 2016–current; more than six years				
Total number of staff hours expended during time period of contract: Approximately [redacted] staff hours. DentaQuest along with our oversight team continually review their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to members they serve. The Regional Vice President at DentaQuest routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Additionally, DentaQuest employees are cross trained on multiple client programs to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Account Representative, Dental Director and, [redacted] Provider Representatives.				
Geographic and population coverage requirements: Georgia Statewide. TANF, CHIP, Child Welfare/Foster Care, and family planning waiver service membership.				
Publicly funded contract cost: [redacted] (cost of AMGP Georgia Managed Care Company, Inc. health plan's contract with the state).				
Description of work performed under this contract: Dental services administration including call center, claims processing and payment, utilization management, fraud, waste, and abuse (FWA), and network management.				

Prior Experiences with Subcontractor				
Client's Name: Anthem Insurance Companies, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 220 Virginia Avenue				
Address Line 2:				
City: Indianapolis	**State:** IN	**Zip Code:** 46204	**County:** Marion	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Stephen Egan				
Title: Compliance Director				
Phone Number: (317) 617-3426	**Email Address:** Stephen.egan@anthem.com			
Work Details				
Number of covered lives: 705,387				
Time period of contract: 2015–current; more than six years				
Total number of staff hours expended during time period of contract: Approximately [redacted] staff hours. DentaQuest along with our oversight team continually review their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to members they serve. The Regional Vice President at DentaQuest routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Additionally, DentaQuest employees are cross trained on multiple client programs to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Provider Engagement Representative, Account Executive, and Dental Director.				
Geographic and population coverage requirements: Indiana Statewide. ABD and Child Welfare/Foster Care, TANF, CHIP, and Medicaid Expansion.				
Publicly funded contract cost: [redacted] (cost of Anthem Insurance Companies, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Dental services administration including call center, claims processing and payment, utilization management, FWA, and network management.				

Prior Experiences with Subcontractor				
Client's Name: Anthem Kentucky Managed Care Plan, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 13550 Triton Boulevard				
Address Line 2:				
City: Louisville	**State:** KY	**Zip Code:** 40223	**County:** Jefferson	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Cheryl Herre				
Title: Compliance Director				
Phone Number: (502) 689-3987	**Email Address:** Cheryl.herre@anthem.com			
Work Details				
Number of covered lives: 168,124				
Time period of contract: January 2015–current (*contract is evergreen); more than seven years				
Total number of staff hours expended during time period of contract Approximately [redacted] staff hours. DentaQuest along with our oversight team continually review their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to members they serve. The Regional Vice President at DentaQuest routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Additionally, DentaQuest employees are cross trained on multiple client programs to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Account Representative, local Dental Director, and back up Dental Director for secondary reviews as well as adequate number of Provider Representatives.				
Geographic and population coverage requirements: Ballard, Caldwell, Calloway, Carlisle, Crittenden, Fulton, Graves, Hickman, Livingston, Lyon, Marshall, McCracken, Christian, Daviess, Hancock, Henderson, Hopkins, McLean, Muhlenberg, Ohio, Todd, Trigg, Union, Webster, Adair, Allen, Barren, Butler, Casey, Clinton, Cumberland, Edmonson, Green, Hart, Logan, McCreary, Metcalfe, Monroe, Pulaski, Russell, Simpson, Taylor, Warren, Wayne, Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jackson, Jessamine, Lincoln, Madison, Mercer, Montgomery, Nicholas, Owen, Powell, Rockcastle, Scott, Woodford, Boone, Campbell, Gallatin, Grant, Kenton, Pendleton, Bath, Boyd, Bracken, Carter, Elliott, Fleming, Greenup, Lawrence, Lewis, Mason, Menifee, Morgan, Robertson, Rowan, Bell, Breathitt, Clay, Floyd, Harlan, Johnson, Knott, Knox, Laurel, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry, Pike, Whitley, and Wolfe counties; TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				

4.3.3.5 Subcontractors (Marked) – 20

Publicly funded contract cost: [redacted] (cost of Anthem Kentucky Managed Care Plan, Inc. health plan's contract with the state).
Description of work performed under this contract
Dental services administration including call center, claims processing and payment, utilization management, FWA, and network management.

Prior Experiences with Subcontractor				
Client's Name: Community Care Health Plan of Louisiana, Inc. dba Healthy Blue; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1500 North 19th Street				
Address Line 2:				
City: Monroe	**State:** LA	**Zip Code:** 71201	**County:** Ouachita	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Hassan Gardezi				
Title: Interim Compliance Officer				
Phone Number: (225) 763-2142	**Email Address:** hassan.gardezi@healthybluela.com			
Work Details				
Number of covered lives: 355,069				
Time period of contract: 2015–2021 (*new contact pending); more than seven years				
Total number of staff hours expended during time period of contract: Approximately [redacted] staff hours. DentaQuest along with our oversight team continually review their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to members they serve. The Regional Vice President at DentaQuest routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Additionally, DentaQuest employees are cross trained on multiple client programs to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Account Representative, adequate number of Provider Representatives.				
Geographic and population coverage requirements: Louisiana Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Community Care Health Plan of Louisiana, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Dental services administration including call center, claims processing and payment, utilization management, FWA, and network management.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Maryland, Inc. dba Amerigroup Community Care; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 7550 Teague Road				
Address Line 2: Suite 500				
City: Hanover	**State:** MD	**Zip Code:** 21076	**County:** Anne Arundel	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Lisa Drumm				
Title: Compliance Director				
Phone Number: (757) 995-5853	**Email Address:** lisa.drumm@amerigroup.com			
Work Details				
Number of covered lives: 320,013				
Time period of contract: 1999–current (*contract is evergreen); more than 22 years				
Total number of staff hours expended during time period of contract: Approximately [redacted] staff hours. DentaQuest along with our oversight team continually review their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to members they serve. The Regional Vice President at DentaQuest routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Additionally, DentaQuest employees are cross trained on multiple client programs to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Account Representative, Executive Director, Dental Director.				
Geographic and population coverage requirements: Maryland Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Maryland, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Dental services administration including call center, claims processing and payment, utilization management, FWA, and network management.				

Prior Experiences with Subcontractor				
Client's Name: Missouri Care, Inc. dba Healthy Blue; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1831 Chestnut Street				
Address Line 2:				
City: St. Louis	**State:** MO	**Zip Code:** 63103		**County:** St. Louis
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Russ Oppenborn				
Title: Compliance Officer				
Phone Number: (877) 602-9189		**Email Address:** russell.oppenborn@healthybluemo.com		
Work Details				
Number of covered lives: 340,487				
Time period of contract: March 2020–current (evergreen); two years				
Total number of staff hours expended during time period of contract: Approximately [redacted] staff hours. DentaQuest along with our oversight team continually review their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to members they serve. The Regional Vice President at DentaQuest routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Additionally, DentaQuest employees are cross trained on multiple client programs to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Dental Director.				
Geographic and population coverage requirements: Missouri Statewide. TANF, CHIP, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Missouri Care, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Dental services administration including call center, claims processing and payment, utilization management, FWA, and network management.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Texas, Inc., Amerigroup Insurance Company; Anthem Inc. subsidiaries				
Client Location				
Address Line 1: 2509 N Highway 360				
Address Line 2: Suite 300				
City: Grand Prairie	**State:** TX	**Zip Code:** 75050		**County:** Dallas
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Franco Hardy				
Title: Compliance Director				
Phone Number: (757) 536-4723		**Email Address:** Francisco.hardy@amerigroup.com		
Work Details				
Number of covered lives: 1,006,534				
Time period of contract: September 2013–current (evergreen); more than eight years				
Total number of staff hours expended during time period of contract: Approximately [redacted] staff hours. DentaQuest along with our oversight team continually review their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to members they serve. The Regional Vice President at DentaQuest routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Additionally, DentaQuest employees are cross trained on multiple client programs to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Account Representative.				
Geographic and population coverage requirements: Texas Statewide. TANF, CHIP, ABD, Child Welfare, and Dual Eligibles.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Texas, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Dental services administration including call center, claims processing and payment, utilization management, FWA, and network management.				

Prior Experiences with Subcontractor				
Client's Name: CompCare Health Services Insurance Corporation dba Anthem BCBS; Anthem Inc. subsidiary				
Client Location				
Address Line 1: N17 W24340 Riverwood Drive				
Address Line 2:				
City: Waukesha	**State:** WI	**Zip Code:** 53188	**County:** Waukesha	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Chryshanee McNeely				
Title: Compliance Manager				
Phone Number: (805) 794-4321	**Email Address:** Chryshanee.mcneely@anthem.com			
Work Details				
Number of covered lives: 150,636				
Time period of contract: 2016–current; more than six years				
Total number of staff hours expended during time period of contract: Approximately [redacted] staff hours. DentaQuest along with our oversight team continually review their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to members they serve. The Regional Vice President at DentaQuest routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Additionally, DentaQuest employees are cross trained on multiple client programs to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Account Representative				
Geographic and population coverage requirements: Wisconsin Statewide. TANF, ABD, and Uninsured Adults.				
Publicly funded contract cost: [redacted] (cost of CompCare Health Services Insurance Corporation health plan's contract with the state).				
Description of work performed under this contract				
Dental services administration including call center, claims processing and payment, utilization management, FWA, and network management.				

4.3.3.5 Subcontractors (Marked) – 20

Subcontractor				
Name of Subcontractor: DSM USA Insurance Company, Inc. (DSM USA). DSM USA is a wholly-owned subsidiary of DentaQuest, LLC (DQ LLC), which owns and manages the DentaQuest organization (collectively, DentaQuest), comprised of companies that hold insurance, third party administrator, and similar licenses in nearly every state in the country. DQ LLC provides similar administrative and management services for all of its affiliated benefits companies. Although DSM USA retains sole and ultimate responsibility for compliance with the subcontract and oversight of DQ LLC's performance of the services in connection with the subcontract, the executive leadership team and staff who are charged with fulfilling these requirements are all employed by DQ LLC. For purposes of this document, "Prior Experiences with Subcontractor" shall refer to prior experiences with the DentaQuest organization as a whole.				
TIN/SSN (as applicable): 59-0397210	**The entity is a:** [X] **Subcontractor** [ ] **Wholly-Owned Subsidiary** [ ] **Affiliate under the same common ownership**			
Address Line 1: 465 Medford Street				
Address Line 2:				
City: Boston	**State:** MA	**Zip Code:** 02129-1454	**County:** Suffolk	
Mailing Address (P.O.Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Description of Services to be Rendered by Subcontractor for this Contract: Full spectrum of core and Value-Add vision benefit administration services; EyeQuest				
How will the Offeror monitor and manage this Subcontractor? Amerigroup Mississippi, Inc. will monitor and manage this subcontractor through initial training, ongoing support, and regular oversight. We will employ a Mississippi Health Plan Leadership team, who will include staff from our local operations, quality, and compliance departments as well as a Vendor Oversight Manager (VOM). The VOM will serve as the single point of contact for the Division and will oversee the subcontractor's performance. To monitor and manage the subcontractor while assuring a seamless experience for Members, Providers, and the Division, the VOM will: • Cultivate a strong relationship with the subcontractor • Identify, implement, and manage service quality and operational improvement projects • Interact with, and oversee activities performed by, our departments such as Procurement, Quality, and Claims • Facilitate subcontractor performance reviews and review audit results • Oversee complaints, Grievances and Appeals, and service level agreement adherence • Ensure receipt and reconciliation of all required reporting data • Escalate contract changes or performance issues and provide support through resolution The VOM, in conjunction with the Health Plan Leadership team, will also receive support from national organizational resources that add an additional layer of performance monitoring. The VOM will report up through our Mississippi-based Chief Executive Officer who will be responsible and				

4.3.3.5 Subcontractors (Marked) – 20

accountable for all functional areas. ***We retain sole responsibility for fulfilling contract requirements and full accountability for our subcontractor's performance.***
Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] **Yes** [ ] **No** **If yes, fill out Prior Experience with Subcontractor for each applicable instance.**

Prior Experiences with Subcontractor				
Client's Name: Anthem Kentucky Managed Care Plan, Inc; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 13550 Triton Boulevard				
Address Line 2:				
City: Louisville	**State:** KY	**Zip Code:** 40223	**County:** Jefferson	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Cheryl Herre				
Title: Compliance Director				
Phone Number: (502) 689-3987	**Email Address:** Cheryl.herre@anthem.com			
Work Details				
Number of covered lives: 168,124				
Time period of contract: January 2014–current (evergreen); more than eight years				
Total number of staff hours expended during time period of contract: DentaQuest along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to members they serve. DentaQuest routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Account Representative, [redacted] Kentucky-licensed Medical Directors, and adequate number of Provider Representatives.				
Geographic and population coverage requirements: Ballard, Caldwell, Calloway, Carlisle, Crittenden, Fulton, Graves, Hickman, Livingston, Lyon, Marshall, McCracken, Christian, Daviess, Hancock, Henderson, Hopkins, McLean, Muhlenberg, Ohio, Todd, Trigg, Union, Webster, Adair, Allen, Barren, Butler, Casey, Clinton, Cumberland, Edmonson, Green, Hart, Logan, McCreary, Metcalfe, Monroe, Pulaski, Russell, Simpson, Taylor, Warren, Wayne, Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jackson, Jessamine, Lincoln, Madison, Mercer, Montgomery, Nicholas, Owen, Powell, Rockcastle, Scott, Woodford, Boone, Campbell, Gallatin, Grant, Kenton, Pendleton, Bath, Boyd, Bracken, Carter, Elliott, Fleming, Greenup, Lawrence, Lewis, Mason, Menifee, Morgan, Robertson, Rowan, Bell, Breathitt, Clay, Floyd, Harlan, Johnson, Knott, Knox, Laurel, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry, Pike, Whitley, and Wolfe counties. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Anthem Kentucky Managed Care Plan, Inc. health plan's contract with the state).				
Description of work performed under this contract				

4.3.3.5 Subcontractors (Marked) – 20

Vision services administration including call center, claims processing and payment, utilization management, fraud, waste, and abuse (FWA), and network management.

Prior Experiences with Subcontractor				
Client's Name: Community Care Health Plan of Nevada, Inc. dba Anthem Blue Cross and Blue Shield Healthcare Solutions; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 9133 West Russell Road				
Address Line 2:				
City: Las Vegas	**State:** NV	**Zip Code:** 89148	**County:** Clark	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Tiffany Saunders-Newey				
Title: Compliance Director / Plan Compliance Officer				
Phone Number: (757) 409-0980	**Email Address:** tiffany.saunders-newey@anthem.com			
Work Details				
Number of covered lives: 274,479				
Time period of contract: 2009–2021 (*awarded new contract); more than 12 years				
Total number of staff hours expended during time period of contract: DentaQuest along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to members they serve. DentaQuest routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Managing Client Partner				
Geographic and population coverage requirements: Nevada Statewide. TANF, CHIP, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Community Care Health Plan of Nevada, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Vision services administration including call center, claims processing and payment, utilization management, FWA, and network management.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Tennessee, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 22 Century Boulevard				
Address Line 2: Suite 220				
City: Nashville	**State:** TN	**Zip Code:** 37214		**County:** Davidson
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Lori Stiffler				
Title: Compliance Director				
Phone Number: (949) 526-3249		**Email Address:** lori.stiffler@amerigroup.com		
Work Details				
Number of covered lives: 501,128				
Time period of contract: 2018–2022 (*awarded new contact, pending execution); more than four years				
Total number of staff hours expended during time period of contract: DentaQuest along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to members they serve. DentaQuest routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Account Representative, Executive Director, Dental Director.				
Geographic and population coverage requirements: Tennessee Statewide. TANF, CHIP, ABD, Uninsured Adults, and Dual Eligibles.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Tennessee, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Vision services administration including call center, claims processing and payment, utilization management, FWA, and network management.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Washington, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 705 5th Avenue South				
Address Line 2: Suite 300				
City: Seattle	**State:** WA	**Zip Code:** 98104		**County:** King
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Sheri Starcher				
Title: Compliance Director				
Phone Number: (206) 641-5496		**Email Address:** sheri.starcher@anthem.com		
Work Details				
Number of covered lives: 254,500				
Time period of contract: 2015–current (evergreen); more than seven years				
Total number of staff hours expended during time period of contract: DentaQuest along with oversight team continually reviews their staffing numbers against quality and service standards to determine whether they need additional resources to provide excellent services to members they serve. DentaQuest routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.				
Personnel requirements: Account Representative.				
Geographic and population coverage requirements: All Regional Service Areas covering all 39 Washington counties. TANF, CHIP, ABD, and Medicaid Expansion, Medicaid eligible individuals.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Washington, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Vision services administration including call center, claims processing and payment, utilization management, FWA, and network management.				

4.3.3.5 Subcontractors (Marked) – 20

Subcontractor				
Name of Subcontractor: IngenioRx, Inc.				
TIN/SSN (as applicable): 82-3062245		**The entity is a:** **[ ] Subcontractor** **[ ] Wholly-Owned Subsidiary** [X] **Affiliate under the same common ownership**		
Address Line 1: 450 Headquarters Plaza				
Address Line 2: East Tower, 7th Floor				
City: Morristown	**State:** NJ	**Zip Code:** 07960	**County:** Morris	
Mailing Address (P.O.Box): 450 Headquarters Plaza	**City:** Morristown	**State:** NJ	**Zip Code:** 07960	**County:** Morris
Description of Services to be Rendered by Subcontractor for this Contract: Oversight of medical drug management including medical injectable drug policy/criteria development and review of medical injectable prior authorizations, as well as provide pharmacy clinical quality programs if pharmacy data files are received from the State.				
How will the Offeror monitor and manage this Subcontractor? Amerigroup Mississippi, Inc. will monitor and manage all subcontractors through a Mississippi Health Plan Leadership team, which will include staff from our local operations, quality, and compliance departments as well as a Vendor Oversight Manager (VOM). They will receive additional support from national resources that add an additional layer of performance monitoring. We will hold our affiliate subcontractors to the required performance levels using contractual requirements, internally set standards, incentives, penalties, and established policies and procedures, to include enforcement for nonperformance. We will utilize reporting tools and systems analyzing key metrics visualizing our performance against defined targets. Functional area owners will be responsible for the performance and action plans for missed targets, and for regularly reporting performance and any issues to the VOM. The VOM will serve as the single point of contact for the Division and will oversee the subcontractor's performance. To monitor and manage the subcontractor while assuring a seamless experience for Members, Providers, and the Division, the VOM will: • Cultivate a strong relationship with the subcontractor and functional are owners • Identify, implement, and manage service quality and operational improvement projects • Interact with, and oversee activities performed by, our departments such as Quality, and Claims • Facilitate performance reviews and review audit results • Oversee complaints, Grievances and Appeals, and service level agreement adherence • Ensure receipt and reconciliation of all required reporting data • Escalate contract changes or performance issues and provide support through resolution The VOM will report up through our Mississippi-based Chief Executive Officer, who will be responsible and accountable for all functional areas. ***We retain sole responsibility for fulfilling contract requirements and full accountability for our subcontractor's performance.***				

4.3.3.5 Subcontractors (Marked) – 20

Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No **If yes, fill out Prior Experience with Subcontractor for each applicable instance.**

Prior Experiences with Subcontractor				
Client's Name: APC PASSE LLC dba Summit Community Care; Anthem, Inc. subsidiary				
Client Location				
Address Line 1: 605 South Shackleford				
Address Line 2: Ste 440				
City: Little Rock	**State:** AR	**Zip Code:** 72211	**County:** Pulaski	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Hassan Gardezi				
Title: Interim Compliance Officer				
Phone Number: (225) 763-2143	**Email Address:** hassan.gardezi@healthybluela.com			
Work Details				
Number of covered lives: 17,001				
Time period of contract: October 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: Arkansas Statewide. I/DD, BH, Dual Eligibles, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of APC PASSE LLC health plan's contract with the state).				
Description of work performed under this contract				
Pharmacy Benefits Management.				

Prior Experiences with Subcontractor				
Client's Name: Anthem Blue Cross of California dba Anthem Blue Cross, Blue Cross of California Partnership Plan, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 21215 Burbank Boulevard				
Address Line 2:				
City: Woodland Hills	**State:** CA	**Zip Code:** 91367		**County:** Los Angeles
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Beth Moldonado				
Title: Director II Compliance				
Phone Number: (805) 264-9172		**Email Address:** beth.moldonado@anthem.com		
Work Details				
Number of covered lives: 1,362,860				
Time period of contract: October 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: CA Central Valley/Bay Area, CA Rural Expansion, Los Angeles Service Area, Sacramento County, San Benito County, Tri-County, Tulare County. TANF, ABD, Medicaid Expansion, Dual Eligibles, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Anthem Blue Cross of California health plan's contract with the state).				
Description of work performed under this contract				
Pharmacy Benefits Management through December 2021 January 2022 to current: Oversee medical drug management including medical injectable drug policy/criteria development and review of medical injectable prior authorizations, as well as provide pharmacy clinical quality programs.				

Prior Experiences with Subcontractor				
Client's Name: Amerigroup District of Columbia, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1001 Pennsylvania Avenue NW				
Address Line 2: Suite 710				
City: Washington	**State:** DC	**Zip Code:** 20004		**County:** District of Columbia
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Barbie Boone CHPC MHP HCAFA DBA				
Title: Compliance Manager				
Phone Number: (757) 800-5249		**Email Address:** Barbara.boone@amerigroup.com		
Work Details				
Number of covered lives: 46,931				
Time period of contract: May 2019–September 2020; one and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: District of Columbia. TANF, CHIP, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Amerigroup District of Columbia, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Pharmacy Benefits Management.				

Prior Experiences with Subcontractor				
Client's Name: Simply Healthcare Plans, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 9250 West Flagler Street				
Address Line 2:				
City: Miami	**State:** FL	**Zip Code:** 33174	**County:** Miami-Dade	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: JoAnn McDaniel-Chinn				
Title: Compliance Director				
Phone Number: (305) 487-4047	**Email Address:** joann.mcdaniel-chinn@anthem.com			
Work Details				
Number of covered lives: 730,525				
Time period of contract: October 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: Florida Statewide. CHIP, TANF, ABD, and Dual Eligibles.				
Publicly funded contract cost: [redacted] (cost of Simply Healthcare Plans, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Pharmacy Benefits Management.				

Prior Experiences with Subcontractor				
Client's Name: AMGP Georgia Managed Care Company, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 4170 Ashford Dunwoody Road				
Address Line 2: Suite 100				
City: Atlanta	**State:** GA	**Zip Code:** 30319	**County:** DeKalb	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Leticia Mayfield				
Title: Compliance Director				
Phone Number: (678) 587-4855	**Email Address:** Leticia.mayfield@Amerigroup.com			
Work Details				
Number of covered lives: 572,848				
Time period of contract: May 2019–current; more than two and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: Georgia Statewide. TANF, CHIP, Child Welfare/Foster Care, and family planning waiver service membership.				
Publicly funded contract cost: [redacted] (cost of AMGP Georgia Managed Care Company, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Pharmacy Benefits Management.				

Prior Experiences with Subcontractor				
Client's Name: Anthem Insurance Companies, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 220 Virginia Avenue				
Address Line 2:				
City: Indianapolis	**State:** IN	**Zip Code:** 46204	**County:** Marion	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Stephen Egan				
Title: Compliance Director				
Phone Number: (317) 617-3426	**Email Address:** Stephen.egan@anthem.com			
Work Details				
Number of covered lives: 705,387				
Time period of contract: October 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: Indiana Statewide. ABD and Child Welfare/Foster Care, TANF, CHIP, and Medicaid Expansion.				
Publicly funded contract cost: [redacted] (cost of Anthem Insurance Companies, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Pharmacy Benefits Management.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Iowa, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 4800 Westown Parkway				
Address Line 2: Suite 200				
City: West Des Moines	**State:** IA	**Zip Code:** 50266	**County:** Polk	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Martha Crist				
Title: Compliance Director				
Phone Number: (515) 850-8057	**Email Address:** martha.crist@amerigroup.com			
Work Details				
Number of covered lives: 445,885				
Time period of contract: October 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: Iowa Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Iowa, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Pharmacy Benefits Management.				

Prior Experiences with Subcontractor				
Client's Name: Anthem Kentucky Managed Care Plan, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 13550 Triton Boulevard				
Address Line 2:				
City: Louisville	**State:** KY	**Zip Code:** 40223	**County:** Jefferson	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Cheryl Herre				
Title: Compliance Director				
Phone Number: (502) 689-3987	**Email Address:** Cheryl.herre@anthem.com			
Work Details				
Number of covered lives: 168,124				
Time period of contract: October 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: Ballard, Caldwell, Calloway, Carlisle, Crittenden, Fulton, Graves, Hickman, Livingston, Lyon, Marshall, McCracken, Christian, Daviess, Hancock, Henderson, Hopkins, McLean, Muhlenberg, Ohio, Todd, Trigg, Union, Webster, Adair, Allen, Barren, Butler, Casey, Clinton, Cumberland, Edmonson, Green, Hart, Logan, McCreary, Metcalfe, Monroe, Pulaski, Russell, Simpson, Taylor, Warren, Wayne, Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jackson, Jessamine, Lincoln, Madison, Mercer, Montgomery, Nicholas, Owen, Powell, Rockcastle, Scott, Woodford, Boone, Campbell, Gallatin, Grant, Kenton, Pendleton, Bath, Boyd, Bracken, Carter, Elliott, Fleming, Greenup, Lawrence, Lewis, Mason, Menifee, Morgan, Robertson, Rowan, Bell, Breathitt, Clay, Floyd, Harlan, Johnson, Knott, Knox, Laurel, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry, Pike, Whitley, and Wolfe counties. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care .				
Publicly funded contract cost: [redacted] (cost of Anthem Kentucky Managed Care Plan, Inc. health plan's contract with the state).				
Description of work performed under this contract				

4.3.3.5 Subcontractors (Marked) – 20

Pharmacy Benefit Management through June 2021 July 2021 to current: Oversee medical drug management including medical injectable drug policy/criteria development and review of medical injectable prior authorizations, as well as provide pharmacy clinical quality programs.

Prior Experiences with Subcontractor				
Client's Name: Community Care Health Plan of Louisiana, Inc. dba Healthy Blue; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1500 North 19th Street				
Address Line 2:				
City: Monroe	**State:** LA	**Zip Code:** 71201	**County:** Ouachita	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Hassan Gardezi				
Title: Interim Compliance Officer				
Phone Number: (225) 763-2142	**Email Address:** hassan.gardezi@healthybluela.com			
Work Details				
Number of covered lives: 355,069				
Time period of contract: May 2019–current; more than two and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: Louisiana Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Community Care Health Plan of Louisiana, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Pharmacy Benefits Management.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Maryland, Inc. dba Amerigroup Community Care; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 7550 Teague Road				
Address Line 2: Ste 500				
City: Hanover	**State:** MD	**Zip Code:** 21076	**County:** Anne Arundel	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Lisa Drumm				
Title: Compliance Director				
Phone Number: (757) 995-5853	**Email Address:** lisa.drumm@amerigroup.com			
Work Details				
Number of covered lives: 320,013				
Time period of contract: May 2019–current; more than two and a half years				
Total number of staff hours expended during time period of contract [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: Maryland Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Maryland, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Pharmacy Benefits Management.				

Prior Experiences with Subcontractor				
Client's Name: Community Care Health Plan of Nebraska, Inc. dba Healthy Blue Nebraska; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 8055 O Street				
Address Line 2: Suite 300				
City: Lincoln	**State:** NE	**Zip Code:** 68510		**County:** Lancaster
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Jennifer Bohnoff				
Title: Director & Market Compliance Officer				
Phone Number: (402) 983-5186		**Email Address:** jennifer.bohnoff@healthybluene.com		
Work Details				
Number of covered lives: 11,048				
Time period of contract: January 2021–current; more than one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: Nebraska Statewide. TANF, CHIP, ABD, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Community Care Health Plan of Nebraska, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Pharmacy Benefits Management.				

Prior Experiences with Subcontractor				
Client's Name: Community Care Health Plan of Nevada, Inc. dba Anthem Blue Cross and Blue Shield Healthcare Solutions; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 9133 West Russell Road				
Address Line 2:				
City: Las Vegas	**State:** NV	**Zip Code:** 89148	**County:** Clark	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Tiffany Saunders-Newey				
Title: Compliance Director/Plan Compliance Officer				
Phone Number: (757) 409-0980	**Email Address:** tiffany.saunders-newey@anthem.com			
Work Details				
Number of covered lives: 274,479				
Time period of contract: May 2019–current; more than two and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: Nevada Statewide. TANF, CHIP, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Community Care Health Plan of Nevada, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Pharmacy Benefits Management.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP New Jersey, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1001 Wood Avenue South				
Address Line 2: Suite 800				
City: Iselin	**State:** NJ	**Zip Code:** 08830	**County:** Middlesex	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Mark Horzepa				
Title: Compliance Director				
Phone Number: (732) 215-9954	**Email Address:** mark.horzepa@anthem.com			
Work Details				
Number of covered lives: 242,977				
Time period of contract: October 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: New Jersey Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP New Jersey, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Pharmacy Benefits Management.				

Prior Experiences with Subcontractor				
Client's Name: HealthPlus HP, LLC dba Empire BlueCross BlueShield HealthPlus, Amerigroup Partnership Plan, LLC (subcontractor to HealthNow New York, Inc. dba Blue Cross Blue Shield of Western New York); Anthem Inc. subsidiaries				
Client Location				
Address Line 1: 9 Pine Street				
Address Line 2: 14th Floor				
City: New York	**State:** NY	**Zip Code:** 10005		**County:** New York
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Violetta Urba				
Title: Compliance Director				
Phone Number: (914) 826-7723		**Email Address:** violetta.urba@amerigroup.com		
Work Details				
Number of covered lives: 548,150				
Time period of contract: June 2019 to current; more than two and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: Alleghany, Bronx, Cattaraugus, Chautauqua, Delaware, Dutchess, Erie, Genesee, Kings, Nassau, New York, Niagara, Orange, Orleans, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, Westchester, and Wyoming counties. TANF, CHIP, and Medicaid Expansion, ABD, Uninsured Adults, and Dual Eligibles.				
Publicly funded contract cost: [redacted] (cost of HealthPlus HP, LLC health plan's contract with the state).				
Description of work performed under this contract				
Pharmacy Benefits Management.				

Prior Experiences with Subcontractor				
Client's Name: Amerigroup Partnership Plan, LLC (Subcontractor to Blue Cross and Blue Shield of North Carolina); Anthem Inc. subsidiary				
Client Location				
Address Line 1: 11000 Weston Parkway				
Address Line 2:				
City: Cary	**State:** NC	**Zip Code:** 27513	**County:** Wake	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Rochelle Simmons				
Title: Compliance Director				
Phone Number: (770) 298-6076		**Email Address:** rochelle.simmons@healthybluenc.com		
Work Details				
Number of covered lives: 438,229				
Time period of contract: February 2020–current; more than two years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: North Carolina Statewide. TANF, CHIP, and ABD.				
Publicly funded contract cost: [redacted] (cost of Amerigroup Partnership Plan, LLC health plan's contract with the state).				
Description of work performed under this contract				
Pharmacy Benefits Management.				

Prior Experiences with Subcontractor				
Client's Name: Amerigroup Partnership Plan, LLC (subcontractor to BlueChoice Health Plan of South Carolina, Inc.); Anthem Inc. subsidiary				
Client Location				
Address Line 1: 250 Berry Hill Road				
Address Line 2: Suite 311				
City: Columbia	**State:** SC	**Zip Code:** 29210	**County:** Richland	
Mailing Address (P.O.Box): 4101 Percival Rd	**City:** Columbia	**State:** SC	**Zip Code:** 29229	**County:** Richland
Direct Contact for Client				
Name: Lori Hack				
Title: Director Regulatory Affairs/Compliance Director				
Phone Number: (803) 365-3114	**Email Address:** lori.hack@amerigroup.com			
Work Details				
Number of covered lives: 180,229				
Time period of contract: October 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: South Carolina Statewide. TANF and ABD.				
Publicly funded contract cost: [redacted] (cost of Amerigroup Partnership Plan, LLC health plan's contract with the state).				
Description of work performed under this contract				
Pharmacy Benefits Management.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Tennessee, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 22 Century Boulevard				
Address Line 2: Suite 220				
City: Nashville	**State:** TN	**Zip Code:** 37214	**County:** Davidson	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Lori Stiffler				
Title: Compliance Director				
Phone Number: (949) 526-3249	**Email Address:** lori.stiffler@amerigroup.com			
Work Details				
Number of covered lives: 501,128				
Time period of contract: May 2019–current; more than two and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: Tennessee Statewide. TANF, CHIP, ABD, Uninsured Adults, and Dual Eligibles.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Tennessee, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Oversee medical drug management including medical injectable drug policy/criteria development and review of medical injectable prior authorizations.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Texas, Inc., Amerigroup Insurance Company; Anthem Inc. subsidiaries				
Client Location				
Address Line 1: 2509 N Highway 360				
Address Line 2: Suite 300				
City: Grand Prairie	**State:** TX	**Zip Code:** 75050	**County:** Dallas	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Franco Hardy				
Title: Compliance Director				
Phone Number: (757) 536-4723	**Email Address:** Francisco.hardy@amerigroup.com			
Work Details				
Number of covered lives: 1,006,534				
Time period of contract: October 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: Texas Statewide. TANF, CHIP, ABD, Child Welfare, and Dual Eligibles.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Texas, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Pharmacy Benefits Management.				

Prior Experiences with Subcontractor				
Client's Name: HealthKeepers, Inc. dba Anthem HealthKeepers Plus, Amerigroup Partnership Plan, LLC (subcontractor to Dell Children's Health Plan); Anthem Inc. subsidiaries				
Client Location				
Address Line 1: 2015 Staples Mill Road				
Address Line 2:				
City: Richmond	**State:** VA	**Zip Code:** 23230		**County:** Henrico
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Nancy Kaplan				
Title: Director II Compliance				
Phone Number: (757) 375-0747		**Email Address:** Nancy.kaplan@anthem.com		
Work Details				
Number of covered lives: 534,332				
Time period of contract: October 2019–current; two and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: Virginia Statewide. ABD, Dual Eligibles, and Child Welfare/Foster Care, TANF, and CHIP.				
Publicly funded contract cost: [redacted] (cost of HealthKeepers, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Pharmacy Benefits Management.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Washington, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 705 5th Avenue South				
Address Line 2: Suite 300				
City: Seattle	**State:** WA	**Zip Code:** 98104	**County:** King	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Sheri Starcher				
Title: Compliance Director				
Phone Number: (206) 641-5496	**Email Address:** sheri.starcher@anthem.com			
Work Details				
Number of covered lives: 254,500				
Time period of contract: June 2019–current; more than two and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: All Regional Service Areas covering all 39 Washington counties. TANF, CHIP, ABD, and Medicaid Expansion, Medicaid eligible individuals.				
Publicly funded contract cost [redacted] (cost of AMERIGROUP Washington, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Pharmacy Benefits Management.				

Prior Experiences with Subcontractor				
Client's Name: UniCare Health Plan of West Virginia, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 200 Association Drive				
Address Line 2: Suite 200				
City: Charleston	**State:** WV	**Zip Code:** 25311	**County:** Kanawha	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Rich Chapman				
Title: Compliance Director				
Phone Number: (304) 348-2701	**Email Address:** richard.chapman@anthem.com			
Work Details				
Number of covered lives: 195,791				
Time period of contract: May 2019–current; more than two and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: West Virginia Statewide. TANF, ABD, CHIP, and Medicaid Expansion.				
Publicly funded contract cost: [redacted] (cost of UniCare Health Plan of West Virginia, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Oversee medical drug management including medical injectable drug policy/criteria development and review of medical injectable prior authorizations, as well as provide pharmacy clinical quality programs.				

Prior Experiences with Subcontractor				
Client's Name: CompCare Health Services Insurance Corporation dba Anthem BCBS; Anthem Inc. subsidiary				
Client Location				
Address Line 1: N17 W24340 Riverwood Drive				
Address Line 2:				
City: Waukesha	**State:** WI	**Zip Code:** 53188	**County:** Waukesha	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Chryshanee McNeely				
Title: Compliance Manager				
Phone Number: (805) 794-4321		**Email Address:** Chryshanee.mcneely@anthem.com		
Work Details				
Number of covered lives: 150,636				
Time period of contract: May 2019–current; more than two and a half years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Benefits, Testing, Execution Core Operations, Account Management, Operational Management, Communications, Issue Management, Lock-in Services, Operations Oversight, Knowledge Solutions, Encounters, Compliance, IT Development, Network, Pricing, Benefit Clinical Operations, Clinical Pharmacy Services, Clinical Pharmacy Care Center, Pharmacy Clinical Programs, Clinical and Specialty, Analytics, Prior Authorization Non-clinical, Prior Authorization Clinical.				
Geographic and population coverage requirements: Wisconsin Statewide. TANF, ABD, and Uninsured Adults.				
Publicly funded contract cost: [redacted] (cost of CompCare Health Services Insurance Corporation health plan's contract with the state).				
Description of work performed under this contract				
Oversee medical drug management including medical injectable drug policy/criteria development and review of medical injectable prior authorizations, as well as provide pharmacy clinical quality programs.				

4.3.3.5 Subcontractors (Marked) – 20

Subcontractor				
Name of Subcontractor: MedAware Solutions				
TIN/SSN (as applicable): 47-1060631		**The entity is a:** [X] **Subcontractor** **[ ] Wholly-Owned Subsidiary** **[ ] Affiliate under the same common ownership**		
Address Line 1: 320 Brookes Drive, Suite 227-B				
Address Line 2:				
City: Hazelwood	**State:** MO	**Zip Code:** 63042	**County:** St Louis	
Mailing Address (P.O.Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Description of Services to be Rendered by Subcontractor for this Contract: In-home healthcare using mobile capabilities of paramedics associated with local emergency medical services (EMS) agencies to help Members with complex care needs and limited access regain stability in health.				
How will the Offeror monitor and manage this Subcontractor? Amerigroup Mississippi, Inc. will monitor and manage this subcontractor through initial training, ongoing support, and regular oversight. We will employ a Mississippi Health Plan Leadership team who will include staff from our local operations, quality, and compliance departments as well as a Vendor Oversight Manager (VOM). The VOM will serve as the single point of contact for the Division and will oversee the subcontractor's performance. To monitor and manage the subcontractor while assuring a seamless experience for Members, Providers, and the Division, the VOM will: • Cultivate a strong relationship with the subcontractor • Identify, implement, and manage service quality and operational improvement projects • Interact with, and oversee activities performed by, our departments such as Procurement, Quality, and Claims • Facilitate subcontractor performance reviews and review audit results • Oversee complaints, Grievances and Appeals, and service level agreement adherence • Ensure receipt and reconciliation of all required reporting data • Escalate contract changes or performance issues and provide support through resolution The VOM, in conjunction with the Health Plan Leadership team, will also receive support from national organizational resources that add an additional layer of performance monitoring. The VOM will report up through our Mississippi-based Chief Executive Officer, who will be responsible and accountable for all functional areas. ***We retain sole responsibility for fulfilling contract requirements and full accountability for our subcontractor's performance.***				
Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [ ] Yes [X] No **If yes, fill out Prior Experience with Subcontractor for each applicable instance.**				

Prior Experiences with Subcontractor				
Client's Name: Anthem Insurance Companies, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 220 Virginia Avenue				
Address Line 2:				
City: Indianapolis	**State:** IN	**Zip Code:** 46204	**County:** Marion	
Mailing Address (P.O.Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Stephen Egan				
Title: Compliance Director				
Phone Number: (317) 617-3426	**Email Address:** Stephen.egan@anthem.com			
Work Details				
Number of covered lives: 705,387				
Time period of contract: 2020–present; two years				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours annually.				
Personnel requirements: Director of Operations and Chief Operating Officer. The hours are allocated for speaking with agencies to provide status updates, make sure EMS staff have necessary Member information, etc. These are hours associated with basic administrative work conducted with one EMS agency in the state of Indiana.				
Geographic and population coverage requirements: Indiana Statewide. ABD and Child Welfare/Foster Care, TANF, CHIP, and Medicaid Expansion.				
Publicly funded contract cost: [redacted] (cost of Anthem Insurance Companies, Inc. health plan's contract with the state).				
Description of work performed under this contract				
MedAware Solutions works with local EMS agencies to be proactive with Anthem's high risk patients. Paramedics make home visits and connect with PCP and specialists. Paramedics also educate Members on condition and medication and connect them with additional resources in the allied health field.				

Prior Experiences with Subcontractor				
Client's Name: Missouri Care, Inc. dba Healthy Blue; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1831 Chestnut Street				
Address Line 2:				
City: St. Louis	**State:** MO	**Zip Code:** 63103	**County:** St. Louis	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Russ Oppenborn				
Title: Compliance Officer				
Phone Number: (877) 602-9189	**Email Address:** russell.oppenborn@healthybluemo.com			
Work Details				
Number of covered lives: 340,487				
Time period of contract: 2019–present; three years				
Total number of staff hours expended during time period of contract: Approximately [redacted] annually.				
Personnel requirements: Director of Operations and Chief Operating Officer. These hours are allocated for speaking with agencies to provide status updates, make sure EMS staff have necessary Member information, etc. These are hours associated with basic administrative work conducted with four EMS agencies in the state of Missouri.				
Geographic and population coverage requirements: Missouri Statewide. TANF, CHIP, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Missouri Care, Inc. health plan's contract with the state).				
Description of work performed under this contract				
MedAware Solutions works with local EMS agencies to be proactive with the Anthem high risk patients. Paramedics make home visits and connect with PCP and specialists. Paramedics also educate members on condition and medication and connect them with additional resources in the allied health field.				

4.3.3.5 Subcontractors (Marked) – 20

Subcontractor				
Name of Subcontractor: Medical Transportation Management, Inc. (MTM)				
TIN/SSN (as applicable): 43-1719762		**The entity is a:** [X] **Subcontractor** [ ] **Wholly-Owned Subsidiary** [ ] **Affiliate under the same common ownership**		
Address Line 1: 16 Hawk Ridge Drive				
Address Line 2:				
City: Lake St. Louis	**State:** MO	**Zip Code:** 63367	**County:** St. Charles	
Mailing Address (P.O.Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Description of Services to be Rendered by Subcontractor for this Contract: Non-emergency transportation services.				
How will the Offeror monitor and manage this Subcontractor? Amerigroup Mississippi, Inc. will monitor and manage this subcontractor through initial training, ongoing support, and regular oversight. We will employ a Mississippi Health Plan Leadership team who will include staff from our local operations, quality, and compliance departments as well as a Vendor Oversight Manager (VOM). The VOM will serve as the single point of contact for the Division and will oversee the subcontractor's performance. To monitor and manage the subcontractor while assuring a seamless experience for Members, Providers, and the Division, the VOM will: • Cultivate a strong relationship with the subcontractor • Identify, implement, and manage service quality and operational improvement projects • Interact with, and oversee activities performed by, our departments such as Procurement, Quality, and Claims • Facilitate subcontractor performance reviews and review audit results • Oversee complaints, Grievances and Appeals, and service level agreement adherence • Ensure receipt and reconciliation of all required reporting data • Escalate contract changes or performance issues and provide support through resolution The VOM, in conjunction with the Health Plan Leadership team, will also receive support from national organizational resources that add an additional layer of performance monitoring. The VOM will report up through our Mississippi-based Chief Executive Officer, who will be responsible and accountable for all functional areas. ***We retain sole responsibility for fulfilling contract requirements and full accountability for our subcontractor's performance.***				
Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No **If yes, fill out Prior Experience with Subcontractor for each applicable instance.**				

Prior Experiences with Subcontractor				
Client's Name: Amerigroup District of Columbia, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1001 Pennsylvania Avenue NW				
Address Line 2: Suite 710				
City: Washington	**State:** DC	**Zip Code:** 20004		**County:** District of Columbia
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Barbie Boone CHPC MHP HCAFA DBA				
Title: Compliance Manager				
Phone Number: (757) 800-5249		**Email Address:** Barbara.boone@amerigroup.com		
Work Details				
Number of covered lives: 46,931				
Time period of contract: October 2017–September 2020; three years.				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours/year.				
Personnel requirements: Program Director; Regional Director of Operations; Client Executive; Customer Care Representatives (CCRs); Contact Center Supervisors; Contact Center Manager; Dispatch; Vendor Account Manager; Transportation Manager; Verification Specialists; Resolution Specialists; Electronic Data Interchange; Business Analyst; Helpdesk.				
Geographic and population coverage requirements: District of Columbia. TANF, CHIP, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Amerigroup District of Columbia, Inc. health plan's contract with the state).				
Description of work performed under this contract				
NEMT brokerage; establishing a transportation Provider network, negotiating rates, verifying eligibility, providing call intake, screening for covered services, assigning appropriate mode of transportation, reconciling trips, paying transportation Providers, reporting, and performing community outreach.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Maryland, Inc. dba Amerigroup Community Care; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 7550 Teague Road				
Address Line 2: Suite 500				
City: Hanover	**State:** MD	**Zip Code:** 21076	**County:** Anne Arundel	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Lisa Drumm				
Title: Compliance Director				
Phone Number: (757) 995-5853	**Email Address:** lisa.drumm@amerigroup.com			
Work Details				
Number of covered lives: 320,013				
Time period of contract: June 2016–current; six years.				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours/year.				
Personnel requirements: Program Director; Regional Director of Operations; Client Executive; CCRs; Contact Center Supervisors; Contact Center Manager; Dispatch; Vendor Account Manager; Transportation Manager; Verification Specialists; Resolution Specialists; EDI; Business Analyst; Helpdesk.				
Geographic and population coverage requirements: Maryland Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Maryland, Inc. health plan's contract with the state).				
Description of work performed under this contract				
NEMT brokerage; establishing a transportation Provider network, negotiating rates, verifying eligibility, providing call intake, screening for covered services, assigning appropriate mode of transportation, reconciling trips, paying transportation Providers, reporting, and performing community outreach.				

Prior Experiences with Subcontractor				
Client's Name: Missouri Care, Inc. dba Healthy Blue; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1831 Chestnut Street				
Address Line 2:				
City: St. Louis	**State:** MO	**Zip Code:** 63103		**County:** St. Louis
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Russ Oppenborn				
Title: Compliance Officer				
Phone Number: (877) 602-9189		**Email Address:** russell.oppenborn@healthybluemo.com		
Work Details				
Number of covered lives: 340,487				
Time period of contract: January 2021–current; one year.				
Total number of staff hours expended during time period of contract: Approximately [redacted] hours/year.				
Personnel requirements: Program Director; Regional Director of Operations; Client Executive; CCRs; Contact Center Supervisors; Contact Center Manager; Dispatch; Vendor Account Manager; Transportation Manager; Verification Specialists; Resolution Specialists; EDI; Business Analyst; Helpdesk.				
Geographic and population coverage requirements: Missouri Statewide. TANF, CHIP, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Missouri Care, Inc. health plan's contract with the state).				
Description of work performed under this contract				
NEMT brokerage; establishing a transportation Provider network, negotiating rates, verifying eligibility, providing call intake, screening for covered services, assigning appropriate mode of transportation, reconciling trips, paying transportation Providers, reporting, and performing community outreach.				

4.3.3.5 Subcontractors (Marked) – 20

Subcontractor				
Name of Subcontractor: Meridian Resource Company, LLC (Meridian)				
TIN/SSN (as applicable): 39-2013971		**The entity is a:** **[ ] Subcontractor** **[ ] Wholly-Owned Subsidiary** [X] **Affiliate under the same common ownership**		
Address Line 1: N17W24340 Riverwood Drive				
Address Line 2:				
City: Waukesha	**State:** WI	**Zip Code:** 53188	**County:** Waukesha	
Mailing Address (P.O.Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Description of Services to be Rendered by Subcontractor for this Contract: Medicaid third-party liability recovery from tort and workers' compensation losses.				

How will the Offeror monitor and manage this Subcontractor?

Amerigroup Mississippi, Inc. will monitor and manage all subcontractors through a Mississippi Health Plan Leadership team, which will include staff from our local operations, quality, and compliance departments as well as a Vendor Oversight Manager (VOM). They will receive additional support from national resources that add an additional layer of performance monitoring.

We will hold our affiliate subcontractors, including our parent organization, to the required performance levels using contractual requirements, internally set standards, incentives, penalties, and established policies and procedures, to include enforcement for nonperformance. We will utilize reporting tools and systems analyzing key metrics visualizing our performance against defined targets. Functional area owners will be responsible for the performance and action plans for missed targets, and for regularly reporting performance and any issues to the VOM.

The VOM will serve as the single point of contact for the Division and will oversee the subcontractor's performance. To monitor and manage the subcontractor while assuring a seamless experience for Members, Providers, and the Division, the VOM will:

- Cultivate a strong relationship with the subcontractor and functional area owners
- Identify, implement, and manage service quality and operational improvement projects
- Interact with, and oversee activities performed by, our departments such as Quality, and Claims
- Facilitate performance reviews and review audit results
- Oversee complaints, Grievances and Appeals, and service level agreement adherence
- Ensure receipt and reconciliation of all required reporting data
- Escalate contract changes or performance issues and provide support through resolution

The VOM will report up through our Mississippi-based Chief Executive Officer, who will be responsible and accountable for all functional areas. ***We retain sole responsibility for fulfilling contract requirements and full accountability for our subcontractor's performance.***

Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No

4.3.3.5 Subcontractors (Marked) – 20

If yes, fill out Prior Experience with Subcontractor for each applicable instance.

Prior Experiences with Subcontractor				
Client's Name: APC PASSE LLC dba Summit Community Care; Anthem, Inc subsidiary				
Client Location				
Address Line 1: 605 South Shackleford				
Address Line 2: Ste 440				
City: Little Rock	**State:** AR	**Zip Code:** 72211	**County:** Pulaski	
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Hassan Gardezi				
Title: Interim Compliance Officer				
Phone Number: (225) 763-2143	**Email Address:** hassan.gardezi@healthybluela.com			
Work Details				
Number of covered lives: 17,001				
Time period of contract: 2019–current; three years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: [redacted] Examiners, [redacted] Analysts				
Geographic and population coverage requirements: Arkansas Statewide. I/DD, BH, Dual Eligibles, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of APC PASSE LLC health plan's contract with the state).				
Description of work performed under this contract				
Medicaid third-party liability recovery from tort and workers' compensation losses.				

4.3.3.5 Subcontractors (Marked) – 20

Prior Experiences with Subcontractor				
Client's Name: Simply Healthcare Plans, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 9250 West Flagler Street				
Address Line 2:				
City: Miami	**State:** FL	**Zip Code:** 33174	**County:** Miami-Dade	
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: JoAnn McDaniel-Chinn				
Title: Compliance Director				
Phone Number: (305) 487-4047	**Email Address:** joann.mcdaniel-chinn@anthem.com			
Work Details				
Number of covered lives: 730,525				
Time period of contract: 2021–current; one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: [redacted] Examiners [redacted] Analysts				
Geographic and population coverage requirements: Florida Statewide. CHIP, TANF, ABD, and Dual Eligibles.				
Publicly funded contract cost: [redacted] (cost of Simply Healthcare Plans, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Medicaid third-party liability recovery from tort and workers' compensation losses.				

Prior Experiences with Subcontractor				
Client's Name: AMGP Georgia Managed Care Company, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 4170 Ashford Dunwoody Road				
Address Line 2: Suite 100				
City: Atlanta	**State:** GA	**Zip Code:** 30319	**County:** DeKalb	
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Leticia Mayfield				
Title: Compliance Director				
Phone Number: (678) 587-4855	**Email Address:** Leticia.mayfield@Amerigroup.com			
Work Details				
Number of covered lives: 572,848				
Time period of contract: 2021–current; one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: [redacted] Examiners [redacted] Analysts				
Geographic and population coverage requirements: Georgia Statewide. TANF, CHIP, Child Welfare/Foster Care, and family planning waiver service membership.				
Publicly funded contract cost: [redacted] (cost of AMGP Georgia Managed Care Company, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Medicaid third-party liability recovery from tort and workers' compensation losses.				

Prior Experiences with Subcontractor				
Client's Name: Anthem Insurance Companies, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 220 Virginia Avenue				
Address Line 2:				
City: Indianapolis	**State:** IN	**Zip Code:** 46204	**County:** Marion	
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Stephen Egan				
Title: Compliance Director				
Phone Number: (317) 617-3426	**Email Address:** Stephen.egan@anthem.com			
Work Details				
Number of covered lives: 705,387				
Time period of contract: 2018–current; four years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: [redacted] Examiners, [redacted] Analysts				
Geographic and population coverage requirements: Indiana Statewide. ABD and Child Welfare/Foster Care, TANF, CHIP, and Medicaid Expansion.				
Publicly funded contract cost: [redacted] (cost of Anthem Insurance Companies, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Medicaid third-party liability recovery from tort and workers' compensation losses.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Iowa, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 4800 Westown Parkway				
Address Line 2: Suite 200				
City: West Des Moines	**State:** IA	**Zip Code:** 50266	**County:** Polk	
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Martha Crist				
Title: Compliance Director				
Phone Number: (515) 850-8057	**Email Address:** martha.crist@amerigroup.com			
Work Details				
Number of covered lives: 445,885				
Time period of contract: 2021–current; one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: [redacted] Examiner, [redacted] Analysts				
Geographic and population coverage requirements: Iowa Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost [redacted] (cost of AMERIGROUP Iowa, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Medicaid third-party liability recovery from tort and workers' compensation losses.				

Prior Experiences with Subcontractor				
Client's Name: Anthem Kentucky Managed Care Plan, Inc; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 13550 Triton Boulevard				
Address Line 2:				
City: Louisville	**State:** KY	**Zip Code:** 40223	**County:** Jefferson	
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Cheryl Herre				
Title: Compliance Director				
Phone Number: (502) 689-3987	**Email Address:** Cheryl.herre@anthem.com			
Work Details				
Number of covered lives: 168,124				
Time period of contract: 2021–current; one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: [redacted] Examiner, [redacted] Analyst				
Geographic and population coverage requirements: Ballard, Caldwell, Calloway, Carlisle, Crittenden, Fulton, Graves, Hickman, Livingston, Lyon, Marshall, McCracken, Christian, Daviess, Hancock, Henderson, Hopkins, McLean, Muhlenberg, Ohio, Todd, Trigg, Union, Webster, Adair, Allen, Barren, Butler, Casey, Clinton, Cumberland, Edmonson, Green, Hart, Logan, McCreary, Metcalfe, Monroe, Pulaski, Russell, Simpson, Taylor, Warren, Wayne, Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jackson, Jessamine, Lincoln, Madison, Mercer, Montgomery, Nicholas, Owen, Powell, Rockcastle, Scott, Woodford, Boone, Campbell, Gallatin, Grant, Kenton, Pendleton, Bath, Boyd, Bracken, Carter, Elliott, Fleming, Greenup, Lawrence, Lewis, Mason, Menifee, Morgan, Robertson, Rowan, Bell, Breathitt, Clay, Floyd, Harlan, Johnson, Knott, Knox, Laurel, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry, Pike, Whitley, and Wolfe counties. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Anthem Kentucky Managed Care Plan, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Medicaid third-party liability recovery from tort and workers' compensation losses.				

Prior Experiences with Subcontractor				
Client's Name: Community Care Health Plan of Louisiana, Inc. dba Healthy Blue; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1500 North 19th Street				
Address Line 2:				
City: Monroe	**State:** LA	**Zip Code:** 71201	**County:** Ouachita	
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Hassan Gardezi				
Title: Interim Compliance Officer				
Phone Number: (225) 763-2142	**Email Address:** hassan.gardezi@healthybluela.com			
Work Details				
Number of covered lives: 355,069				
Time period of contract: 2021–current; one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: [redacted] Examiners [redacted] Analysts				
Geographic and population coverage requirements: Louisiana Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost [redacted] (cost of Community Care Health Plan of Louisiana, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Medicaid third-party liability recovery from tort and workers' compensation losses.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Maryland, Inc. dba Amerigroup Community Care; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 7550 Teague Road				
Address Line 2: Ste 500				
City: Hanover	**State:** MD	**Zip Code:** 21076	**County:** Anne Arundel	
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Lisa Drumm				
Title: Compliance Director				
Phone Number: (757) 995-5853	**Email Address:** lisa.drumm@amerigroup.com			
Work Details				
Number of covered lives: 320,013				
Time period of contract: 2021–current; one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: [redacted] Examiners, [redacted] Analyst				
Geographic and population coverage requirements: Maryland Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Maryland, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Medicaid third-party liability recovery from tort and workers' compensation losses.				

Prior Experiences with Subcontractor				
Client's Name: Missouri Care, Inc. dba Healthy Blue; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 1831 Chestnut Street				
Address Line 2:				
City: St. Louis	**State:** MO	**Zip Code:** 63103	**County:** St. Louis	
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Russ Oppenborn				
Title: Compliance Officer				
Phone Number: (877) 602-9189	**Email Address:** russell.oppenborn@healthybluemo.com			
Work Details				
Number of covered lives: 340,487				
Time period of contract: 2021–current; one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: [redacted] Examiner, [redacted] Analyst				
Geographic and population coverage requirements: Missouri Statewide. TANF, CHIP, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Missouri Care, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Medicaid third-party liability recovery from tort and workers' compensation losses.				

Prior Experiences with Subcontractor				
Client's Name: Community Care Health Plan of Nebraska, Inc. dba Healthy Blue Nebraska; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 8055 O Street				
Address Line 2: Suite 300				
City: Lincoln	**State:** NE	**Zip Code:** 68510		**County:** Lancaster
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Jennifer Bohnoff				
Title: Director & Market Compliance Officer				
Phone Number: (402) 983-5186		**Email Address:** jennifer.bohnoff@healthybluene.com		
Work Details				
Number of covered lives: 11,048				
Time period of contract: 2021–current; one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: [redacted] Examiner, [redacted] Analyst				
Geographic and population coverage requirements: Nebraska Statewide. TANF, CHIP, ABD, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Community Care Health Plan of Nebraska, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Medicaid third-party liability recovery from tort and workers' compensation losses.				

Prior Experiences with Subcontractor				
Client's Name: Community Care Health Plan of Nevada, Inc. dba Anthem Blue Cross and Blue Shield Healthcare Solutions; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 9133 West Russell Road				
Address Line 2:				
City: Las Vegas	**State:** NV	**Zip Code:** 89148	**County:** Clark	
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Tiffany Saunders-Newey				
Title: Compliance Director / Plan Compliance Officer				
Phone Number: (757) 409-0980	**Email Address:** tiffany.saunders-newey@anthem.com			
Work Details				
Number of covered lives: 274,479				
Time period of contract: 2021–current; one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: [redacted] Examiners, [redacted] Analyst				
Geographic and population coverage requirements: Nevada Statewide. TANF, CHIP, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Community Care Health Plan of Nevada, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Medicaid third-party liability recovery from tort and workers' compensation losses.				

Prior Experiences with Subcontractor				
Client's Name: HealthPlus HP, LLC dba Empire BlueCross BlueShield HealthPlus, Amerigroup Partnership Plan, LLC (subcontractor to HealthNow New York, Inc. dba Blue Cross Blue Shield of Western New York); Anthem Inc. subsidiaries				
Client Location				
Address Line 1: 9 Pine Street				
Address Line 2: 14th Floor				
City: New York	**State:** NY	**Zip Code:** 10005		**County:** New York
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Violetta Urba				
Title: Compliance Manager				
Phone Number: (914) 826-7723		**Email Address:** violetta.urba@amerigroup.com		
Work Details				
Number of covered lives: 548,150				
Time period of contract: 2021–current; one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: [redacted] Examiner, [redacted] Analyst				
Geographic and population coverage requirements: Alleghany, Bronx, Cattaraugus, Chautauqua, Delaware, Dutchess, Erie, Genesee, Kings, Nassau, New York, Niagara, Orange, Orleans, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, Westchester, and Wyoming counties. TANF, CHIP, and ABD.				
Publicly funded contract cost [redacted] (cost of HealthPlus HP, LLC health plan's contract with the state).				
Description of work performed under this contract				
Medicaid third-party liability recovery from tort and workers' compensation losses.				

Prior Experiences with Subcontractor				
Client's Name: Amerigroup Partnership Plan, LLC (Subcontractor to Blue Cross and Blue Shield of North Carolina); Anthem Inc. subsidiary				
Client Location				
Address Line 1: 11000 Weston Parkway				
Address Line 2:				
City: Cary	**State:** NC	**Zip Code:** 27513	**County:** Wake	
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Rochelle Simmons				
Title: Compliance Director				
Phone Number: (770) 298-6076	**Email Address:** rochelle.simmons@healthybluenc.com			
Work Details				
Number of covered lives: 438,229				
Time period of contract: 2021–current; one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: [redacted] Examiner [redacted] Analyst				
Geographic and population coverage requirements: North Carolina Statewide. TANF, CHIP, and ABD.				
Publicly funded contract cost: [redacted] (cost of Amerigroup Partnership Plan, LLC health plan's contract with the state).				
Description of work performed under this contract				
Medicaid third-party liability recovery from tort and workers' compensation losses.				

Prior Experiences with Subcontractor				
Client's Name: Amerigroup Partnership Plan, LLC (subcontractor to BlueChoice Health Plan of South Carolina, Inc.); Anthem Inc. subsidiary				
Client Location				
Address Line 1: 250 Berry Hill Road				
Address Line 2: Suite 311				
City: Columbia	**State:** SC	**Zip Code:** 29210	**County:** Richland	
Mailing Address (P.O.Box): 4101 Percival Rd	**City:** Columbia	**State:** SC	**Zip Code:** 29229	**County:** Richland
Direct Contact for Client				
Name: Lori Hack				
Title: Director Regulatory Affairs/Compliance Director				
Phone Number: (803) 365-3114	**Email Address:** lori.hack@amerigroup.com			
Work Details				
Number of covered lives: 180,229				
Time period of contract: 2017–current; five years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: [redacted] Examiner, [redacted] Analysts				
Geographic and population coverage requirements: South Carolina Statewide. TANF and ABD.				
Publicly funded contract cost: [redacted] (cost of Amerigroup Partnership Plan, LLC health plan's contract with the state).				
Description of work performed under this contract				
Medicaid third-party liability recovery from tort and workers' compensation losses.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Tennessee, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 22 Century Boulevard				
Address Line 2: Suite 220				
City: Nashville	**State:** TN	**Zip Code:** 37214	**County:** Davidson	
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Lori Stiffler				
Title: Compliance Director				
Phone Number: (949) 526-3249	**Email Address:** lori.stiffler@amerigroup.com			
Work Details				
Number of covered lives: 501,128				
Time period of contract: 2021–current; one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: [redacted] Examiner, [redacted] Analysts				
Geographic and population coverage requirements: Tennessee Statewide. TANF, CHIP, ABD, Uninsured Adults, and Dual Eligibles.				
Publicly funded contract cost: [redacted] cost of AMERIGROUP Tennessee, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Medicaid third-party liability recovery from tort and workers' compensation losses.				

Prior Experiences with Subcontractor				
Client's Name: HealthKeepers, Inc. dba Anthem HealthKeepers Plus, Amerigroup Partnership Plan, LLC (subcontractor to Dell Children's Health Plan); Anthem Inc. subsidiaries				
Client Location				
Address Line 1: 2015 Staples Mill Road				
Address Line 2:				
City: Richmond	**State:** VA	**Zip Code:** 23230	**County:** Henrico	
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Nancy Kaplan				
Title: Director II Compliance				
Phone Number: (757) 375-0747	**Email Address:** Nancy.kaplan@anthem.com			
Work Details				
Number of covered lives: 534,332				
Time period of contract: 2021–current; one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements [redacted] Examiner, [redacted] Analyst				
Geographic and population coverage requirements: Virginia Statewide. ABD, Dual Eligibles, and Child Welfare/Foster Care, TANF, and CHIP.				
Publicly funded contract cost [redacted] (cost of HealthKeepers, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Medicaid third-party liability recovery from tort and workers' compensation losses.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Washington, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 705 5th Avenue South				
Address Line 2: Suite 300				
City: Seattle	**State:** WA	**Zip Code:** 98104	**County:** King	
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Sheri Starcher				
Title: Compliance Director				
Phone Number: (206) 641-5496	**Email Address:** sheri.starcher@anthem.com			
Work Details				
Number of covered lives: 254,500				
Time period of contract: 2021–current; one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements [redacted] Examiner [redacted] Analyst				
Geographic and population coverage requirements: All Regional Service Areas covering all 39 Washington counties. TANF, CHIP, ABD, and Medicaid Expansion, Medicaid eligible individuals.				
Publicly funded contract cost [redacted] (cost of AMERIGROUP Washington, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Medicaid third-party liability recovery from tort and workers' compensation losses.				

Prior Experiences with Subcontractor				
Client's Name: UniCare Health Plan of West Virginia, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 200 Association Drive				
Address Line 2: Suite 200				
City: Charleston	**State:** WV	**Zip Code:** 25311	**County:** Kanawha	
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Rich Chapman				
Title: Compliance Director				
Phone Number: (304) 348-2701	**Email Address:** richard.chapman@anthem.com			
Work Details				
Number of covered lives: 195,791				
Time period of contract: 2017–current; five years				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements [redacted] Examiner, [redacted] Analyst				
Geographic and population coverage requirements: West Virginia Statewide. TANF, ABD, CHIP, and Medicaid Expansion.				
Publicly funded contract cost: [redacted] (cost of UniCare Health Plan of West Virginia, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Medicaid third-party liability recovery from tort and workers' compensation losses.				

Prior Experiences with Subcontractor				
Client's Name: CompCare Health Services Insurance Corporation dba Anthem BCBS; Anthem Inc. subsidiary				
Client Location				
Address Line 1: N17 W24340 Riverwood Drive				
Address Line 2:				
City: Waukesha	**State:** WI	**Zip Code:** 53188	**County:** Waukesha	
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Chryshanee McNeely				
Title: Compliance Manager				
Phone Number: (805) 794-4321		**Email Address:** Chryshanee.mcneely@anthem.com		
Work Details				
Number of covered lives: 150,636				
Time period of contract: 2021–current; one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: [redacted] Examiner, [redacted] Analysts				
Geographic and population coverage requirements: Wisconsin Statewide. TANF, ABD, and Uninsured Adults.				
Publicly funded contract cost [redacted] (cost of CompCare Health Services Insurance Corporation health plan's contract with the state).				
Description of work performed under this contract				
Medicaid third-party liability recovery from tort and workers' compensation losses.				

4.3.3.5 Subcontractors (Marked) – 20

Subcontractor				
Name of Subcontractor: Truth Initiative				
TIN/SSN (as applicable): 91-1956621		**The entity is a:** [X] **Subcontractor** **[ ] Wholly-Owned Subsidiary** **[ ] Affiliate under the same common ownership**		
Address Line 1: 900 G Street, NW				
Address Line 2: 4th Floor				
City: Washington	**State:** DC	**Zip Code:** 20001	**County:** Washington	
Mailing Address (P.O.Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Description of Services to be Rendered by Subcontractor for this Contract: Customized Adult and Teen Tobacco and Vaping Cessation programs: For adults age 18 and over, program offers real-time, personalized engagement with unlimited access to quit plan, peer support, live chat coaching, and text messaging; up to eight weeks of nicotine replacement therapy. For teens ages 13 to 17, program offers text-based support and on-demand content to help young people quit.				
How will the Offeror monitor and manage this Subcontractor? Amerigroup Mississippi, Inc. will monitor and manage this subcontractor through initial training, ongoing support, and regular oversight. We will employ a Mississippi Health Plan Leadership team who will include staff from our local Operations, Quality, and Compliance departments as well as a Vendor Oversight Manager (VOM). The VOM will serve as the single point of contact for the Division and will oversee the subcontractor's performance. To monitor and manage the subcontractor while assuring a seamless experience for Members, Providers, and the Division, the VOM will: • Cultivate a strong relationship with the subcontractor • Identify, implement, and manage service quality and operational improvement projects • Interact with, and oversee activities performed by, our departments such as Procurement, Quality, and Claims • Facilitate subcontractor performance reviews and review audit results • Oversee complaints, Grievances and Appeals, and service level agreement adherence • Ensure receipt and reconciliation of all required reporting data • Escalate contract changes or performance issues and provide support through resolution The VOM, in conjunction with the Health Plan Leadership team, will also receive support from national organizational resources that add an additional layer of performance monitoring. The VOM will report up through our Mississippi-based Chief Executive Officer, who will be responsible and accountable for all functional areas. ***We retain sole responsibility for fulfilling contract requirements and full accountability for our subcontractor's performance.***				
Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] **Yes [ ] No** **If yes, fill out Prior Experience with Subcontractor for each applicable instance.**				

Prior Experiences with Subcontractor				
Client's Name: Anthem Blue Cross of California dba Anthem Blue Cross, Blue Cross of California Partnership Plan, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 21215 Burbank Boulevard				
Address Line 2:				
City: Woodland Hills	**State:** CA	**Zip Code:** 91367		**County:** Los Angeles
Mailing Address (P.O. Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Beth Moldonado				
Title: Director II Compliance				
Phone Number: (805) 264-9172		**Email Address:** beth.moldonado@anthem.com		
Work Details				
Number of covered lives: 1,362,860				
Time period of contract: Less than one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Two employees supporting account				
Geographic and population coverage requirements: CA Central Valley/Bay Area, CA Rural Expansion, Los Angeles Service Area, Sacramento County, San Benito County, Tri-County, Tulare County. TANF, ABD, Medicaid Expansion, Dual Eligibles, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Anthem Blue Cross of California health plan's contract with the state).				
Description of work performed under this contract				
Customized Adult and Teen Programming: Tobacco and Vaping Cessation Program, for adults ages 18 and over, offers real-time, personalized engagement with unlimited access to quit plan, peer support, live chat coaching, and text messaging; up to eight weeks of nicotine replacement therapy. The This Quitting program, for teens ages 13 to 17, offers text-based support and on-demand content to help young people quit.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Iowa, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 4800 Westown Parkway				
Address Line 2: Suite 200				
City: West Des Moines	**State:** IA	**Zip Code:** 50266	**County:** Polk	
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Martha Crist				
Title: Compliance Director				
Phone Number: (515) 850-8057	**Email Address:** martha.crist@amerigroup.com			
Work Details				
Number of covered lives: 445,885				
Time period of contract: Less than one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Two employees supporting this contract				
Geographic and population coverage requirements: Iowa Statewide. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Iowa, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Customized Adult and Teen Programming: Tobacco and Vaping Cessation program, for adults ages 18 and over, offers real-time, personalized engagement with unlimited access to quit plan, peer support, live chat coaching, and text messaging; up to eight weeks of nicotine replacement therapy. The This Quitting program, for teens ages 13 to 17, offers text-based support and on-demand content to help young people quit.				

Prior Experiences with Subcontractor				
Client's Name: Anthem Kentucky Managed Care Plan, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 13550 Triton Boulevard				
Address Line 2:				
City: Louisville	**State:** KY	**Zip Code:** 40223	**County:** Jefferson	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Cheryl Herre				
Title: Compliance Director				
Phone Number: (502) 689-3987	**Email Address:** Cheryl.herre@anthem.com			
Work Details				
Number of covered lives: 168,124				
Time period of contract: Less than one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Two employees supporting this contract				
Geographic and population coverage requirements: Ballard, Caldwell, Calloway, Carlisle, Crittenden, Fulton, Graves, Hickman, Livingston, Lyon, Marshall, McCracken, Christian, Daviess, Hancock, Henderson, Hopkins, McLean, Muhlenberg, Ohio, Todd, Trigg, Union, Webster, Adair, Allen, Barren, Butler, Casey, Clinton, Cumberland, Edmonson, Green, Hart, Logan, McCreary, Metcalfe, Monroe, Pulaski, Russell, Simpson, Taylor, Warren, Wayne, Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jackson, Jessamine, Lincoln, Madison, Mercer, Montgomery, Nicholas, Owen, Powell, Rockcastle, Scott, Woodford, Boone, Campbell, Gallatin, Grant, Kenton, Pendleton, Bath, Boyd, Bracken, Carter, Elliott, Fleming, Greenup, Lawrence, Lewis, Mason, Menifee, Morgan, Robertson, Rowan, Bell, Breathitt, Clay, Floyd, Harlan, Johnson, Knott, Knox, Laurel, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry, Pike, Whitley, and Wolfe counties. TANF, CHIP, ABD, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Anthem Kentucky Managed Care Plan, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Customized Adult and Teen Programming: Tobacco and Vaping Cessation program, for adults ages 18 and over, offers real-time, personalized engagement with unlimited access to quit plan, peer support, live chat coaching, and text messaging; up to eight weeks of nicotine replacement therapy. The This Quitting program, for teens ages 13 to 17, offers text-based support and on-demand content to help young people quit.				

Prior Experiences with Subcontractor				
Client's Name: Community Care Health Plan of Nevada, Inc. dba Anthem Blue Cross and Blue Shield Healthcare Solutions; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 9133 West Russell Road				
Address Line 2:				
City: Las Vegas	**State:** NV	**Zip Code:** 89148	**County:** Clark	
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Tiffany Saunders-Newey				
Title: Compliance Director/Plan Compliance Officer				
Phone Number: (757) 409-0980	**Email Address:** tiffany.saunders-newey@anthem.com			
Work Details				
Number of covered lives: 274,479				
Time period of contract: Less than one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Two employees supporting this contract				
Geographic and population coverage requirements: Nevada Statewide. TANF, CHIP, Medicaid Expansion, and Child Welfare/Foster Care.				
Publicly funded contract cost: [redacted] (cost of Community Care Health Plan of Nevada, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Customized Adult and Teen Programming: Tobacco and Vaping Cessation program, for adults ages 18 and over, offers real-time, personalized engagement with unlimited access to quit plan, peer support, live chat coaching, and text messaging; up to eight weeks of nicotine replacement therapy. The This Quitting program, for teens ages 13 to 17, offers text-based support and on-demand content to help young people quit.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Tennessee, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 22 Century Boulevard				
Address Line 2: Suite 220				
City: Nashville	**State:** TN	**Zip Code:** 37214	**County:** Davidson	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Lori Stiffler				
Title: Compliance Director				
Phone Number: (949) 526-3249	**Email Address:** lori.stiffler@amerigroup.com			
Work Details				
Number of covered lives: 501,128				
Time period of contract: Less than a year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: 2 employees supporting this contract				
Geographic and population coverage requirements: Tennessee Statewide. TANF, CHIP, ABD, Uninsured Adults, and Dual Eligibles.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Tennessee, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Customized Adult and Teen Programming: Tobacco and Vaping Cessation program, for adults ages 18 and over, offers real-time, personalized engagement with unlimited access to quit plan, peer support, live chat coaching, and text messaging; up to eight weeks of nicotine replacement therapy. The This Quitting program, for teens ages 13 to 17, offers text-based support and on-demand content to help young people quit.				

Prior Experiences with Subcontractor				
Client's Name: AMERIGROUP Washington, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 705 5th Avenue South				
Address Line 2: Suite 300				
City: Seattle	**State:** WA	**Zip Code:** 98104	**County:** King	
Mailing Address (P.O.Box): not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Sheri Starcher				
Title: Compliance Director				
Phone Number: (206) 641-5496	**Email Address:** sheri.starcher@anthem.com			
Work Details				
Number of covered lives: 254,500				
Time period of contract: Less than one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Two employees supporting this contract				
Geographic and population coverage requirements: All Regional Service Areas covering all 39 Washington counties. TANF, CHIP, ABD, and Medicaid Expansion, Medicaid eligible individuals.				
Publicly funded contract cost: [redacted] (cost of AMERIGROUP Washington, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Customized Adult and Teen Programming: Tobacco and Vaping Cessation program, for adults ages 18 and over, offers real-time, personalized engagement with unlimited access to quit plan, peer support, live chat coaching, and text messaging; up to eight weeks of nicotine replacement therapy. The This Quitting program, for teens ages 13 to 17, offers text-based support and on-demand content to help young people quit.				

Prior Experiences with Subcontractor				
Client's Name: UniCare Health Plan of West Virginia, Inc.; Anthem Inc. subsidiary				
Client Location				
Address Line 1: 200 Association Drive				
Address Line 2: Suite 200				
City: Charleston	**State:** WV	**Zip Code:** 25311	**County:** Kanawha	
Mailing Address (P.O.Box): Not applicable	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Rich Chapman				
Title: Compliance Director				
Phone Number: (304) 348-2701	**Email Address:** richard.chapman@anthem.com			
Work Details				
Number of covered lives: 195,791				
Time period of contract: Less than one year				
Total number of staff hours expended during time period of contract: [redacted]				
Personnel requirements: Two employees supporting this contract				
Geographic and population coverage requirements: West Virginia Statewide. TANF, ABD, CHIP, and Medicaid Expansion.				
Publicly funded contract cost: [redacted] (cost of UniCare Health Plan of West Virginia, Inc. health plan's contract with the state).				
Description of work performed under this contract				
Customized Adult and Teen Programming: Tobacco and Vaping Cessation program, for adults ages 18 and over, offers real-time, personalized engagement with unlimited access to quit plan, peer support, live chat coaching, and text messaging; up to eight weeks of nicotine replacement therapy. The This Quitting program, for teens ages 13 to 17, offers text-based support and on-demand content to help young people quit.				

[END OF RESPONSE]

4.3.3.6 Economic Impact

Amerigroup Mississippi, Inc.'s (Amerigroup's) collaborative approach fuels program-specific solutions, allowing us to deliver results that address the priorities of the Division of Medicaid (the Division) and meet the diverse and specific needs of Members and the communities they live in. Rooted in a local model and our belief in the power of people working together, we know a healthier future is possible. We are committed to improving the health and lives of Mississippians and will exceed Contract requirements in our reinvestments in the state.

We will invest in and partner with community agencies and organizations to address the Division's health priorities, including: Health Equity, Women's and Maternal Health, Child and Adolescent Health, Behavioral Health, and Chronic Condition Management. As depicted in Figure 4.3.3.6-1, we will invest in a variety of organizations and partners throughout the state's 82 counties to address needs in each priority area and assure equity in our approach. We know that by partnering with communities, Providers, and the State, we can make a difference together.

Together We CAN

Amerigroup will contribute to the economic strength of our state in a multitude of ways, including charitable grants to and partnerships with local community-based organizations (CBOs), contractual relationships with Mississippi-based vendors, and salaries paid to Mississippi-based staff. Our parent organization, Anthem, Inc., and our affiliates will further support the State through their operations. We are dedicated to assuring consumers have expanded access to high-quality, affordable health benefits, and empowering all our Members to live healthy lives.

The organizations we have supported and will support are in communities, addressing the social barriers affecting our members and the challenges they experience. By engaging and supporting community organizations as partners in care, we will build on each other's strengths, improving the health of Mississippi's communities one person at a time. As we look forward, we are committed to further investments aimed at improving our Members' lives and the communities in which they live and we work throughout Mississippi.

[redacted]

Management Qualification: 4.3.3.6 Economic Impact

[redacted]

CONFIDENTIAL
Management Qualification: 4.3.3.6 Economic Impact

[redacted]

Management Qualification: 4.3.3.6 Economic Impact

[redacted]

CONFIDENTIAL Management Qualification: 4.3.3.6 Economic Impact

[redacted]

[redacted]

Management Qualification: 4.3.3.6 Economic Impact

[redacted]

Management Qualification: 4.3.3.6 Economic Impact

[redacted]

[END OF RESPONSE]

Amerigroup

Drive-thru Baby Showers

Since March 2021, Amerigroup has hosted more than nine baby showers across the state. More than 2,100 baby bags were given out to expectant families. Giveaways included everything from diapers and wipes to portable cribs and car seats. Several of the events were combination baby showers and vaccine drive-thrus, held in partnership with hospitals and community health centers, where COVID-19 vaccines were available.

4.3.4 Management and Control

4.3.4.1 Day-to-Day Management

1. Program Management Approach

Amerigroup's organizational and operational structure reflects our belief that healthcare solutions are most effective when developed and delivered locally, while leveraging our vast network of resources across our affiliates in 26 other markets and our parent company, Anthem, Inc. Through our program management approach, we will use multi-functional strategies along with tailored tools, resources, and processes to produce operational efficiencies and meet the needs of our Members, Providers, and the Division. We will also use comprehensive monitoring systems and leverage successes and lessons learned to refine our processes on an ongoing basis.

Our local Chief Executive Officer (CEO) will maintain accountability for our Coordinated Care Organization (CCO) operations and work in conjunction with our local key personnel to maintain full authority for making service delivery and administration decisions across every aspect of our organization. ***We are committed to providing to the Division all that is needed and required to provide evidence of operational excellence and quality in the day-to-day management of our CCO.*** Our qualified leadership team will bring a wealth of knowledge and experience to help shape our strategic vision and carry out our day-to-day program operations effectively.

Over the last 18 months, our leadership team has been conducting administrative, operational, and clinical planning and readiness activities so that we are fully prepared to meet all Contract requirements from day one. Our team has traveled extensively across the state, listening to and learning from its residents, advocates, community-based organizations, healthcare Providers and administrators, and other stakeholders in rural and urban areas. Table 4.3.4.1-1 highlights the local leadership who will be integral to overseeing the effective and efficient day-to-day management of our CCO. They will be responsible for overall performance of the CCO, including all major functional areas, and will monitor performance, assure contractual compliance, prioritize performance improvement activities, perform strategic analyses, and establish program goals to be incorporated into our Annual Quality Management (QM) Work Plan. The leadership team will also routinely monitor business capabilities, functionality, risk, and resource requirements.

Table 4.3.4.1-1. Amerigroup's local leadership will oversee day-to-day management of our operations.

Staffing	Description
Chief Executive Officer (CEO)	Our CEO will be fully accountable for all Contract requirements for the MississippiCAN and CHIP Programs and will oversee all aspects of operations, including implementation and ongoing day-to-day management. The CEO will serve as primary liaison between our CCO and the Division, and will make sure our operations, programs, and strategic partnerships align with the Division's priorities. They will build strategic partnerships with community organizations, State agencies, Providers, and Mississippi system of care stakeholders.
Chief Operating Officer (COO)	The COO will oversee day-to-day business activities conducted pursuant to this Contract and will work in tandem with the CEO in the fiscal and operational management of our organization, including core COO functions (claims, subcontractor management, call center, and data analytics). The COO will identify and adopt operational best practices and metrics to achieve strategic goals and provide timely reports on operational progress and milestones to the Division. The role will create seamless processes between our local CCO operations and the national shared support services that augment our programs, and will develop and implement key operational indicators to be used for monitoring and analyzing our operations. As the Project Manager, our COO will also oversee the implementation of Contract requirements during the implementation phase.

Staffing	Description
Chief Financial Officer (CFO)	The CFO will oversee the financial operations of our CCO, directing overall budget, forecast, and cost allocation processes. The CFO will also oversee annual operating/capital budget and quarterly forecasts to provide senior leadership with tools necessary to maximize investment of resources. Our CFO will be the liaison between the Division and actuaries to develop annual CCO rates, and for providing timely and accurate data in support of financial operations. This role will also develop financial contracts, interfaces, and processes to assure fiscal integrity and oversees the measurement and benchmarking of financial trends.
Medical Director	Our Medical Director will oversee the delivery of covered services and clinical decision-making for our CCO. The Medical Director spearheads all clinical functions and serves as a leader for our Care Management, care coordination, Population Health, and utilization management areas. The role will also manage the administration of physical and/or behavioral health medical services, to make sure Members receive the most appropriate care and supports.
Population Health Director	The Population Health Director will provide oversight and direction for designing, implementing, and supporting our Population Health model and initiatives. This role drives a wide range of programs and initiatives designed to reduce health disparities, advance health equity, and improve outcomes for our membership. This role will also manage the development of relationships with local public health agencies and community-based organizations to bridge public health initiatives to our programs and services.
Chief Information Officer (CIO)	The CIO will coordinate and lead multiple teams on initiating, developing, designing, and implementing new change initiatives and acts as a liaison to leverage initiatives and good practices from other areas. The CIO also will lead the identification and development of independent initiatives across the organization.
Compliance Officer	Our local Compliance Officer will serve as the primary point of contact for the Division on all regulatory and compliance matters. Reporting directly to our Mississippi CEO, the Compliance Officer will design and implement the Compliance Plan for Mississippi, along with related policies and procedures, to work in tandem with the Program Integrity Unit. Our Compliance Officer will lead the development and implementation of policies, procedures, and standards to make sure all aspects of our CCO fully comply with federal, State, and Contract requirements.

We describe in the following sections our overall approach to implement and manage the day-to-to operations of our CCO in serving the MississippiCAN and CHIP Programs. This includes a detailed description of our management approach, data and reporting capabilities, and methods to identify and solve identified concerns and challenges.

A Quality Program and Structure That Helps Assure Successful Program Management

Key to successful program management is our approach to quality every day – through our programs, processes, and our people. Our focus on quality permeates every department and is essential for our day-to-day business, and evident in every interaction we have – with Members, Providers, and stakeholders. ***Achieving the best outcomes and highest quality service delivery is not the responsibility of one program or specific staff: it is infused throughout all departments and operations.***

Mission-driven Committees. We will use multiple cross-functional committees to provide critical support towards meeting the CCO's goals (see Figure 4.3.4.1-1). Our local Quality Management Committee (QMC) comprised of executive leaders including our CEO, Medical Director, Behavioral Health Director, Perinatal Health Director, and QM Director, as well as leaders from the Provider Services, Compliance, and Operations departments, will serve as the hub for all quality improvement (QI)/QM activities and collaborative efforts including various subcommittees and taskforces. Our Medical Director and QM Director will oversee the QMC, which will meet quarterly and provide multidisciplinary and cross-functional direction and oversight of all QM and Population Health strategies to assure the quality, safety, accessibility, and availability of care and services.

The QMC and QI/QM staff will work collaboratively with the Division to assure that we meet their quality goals. The QMC will be accountable to our Mississippi-based Board of Directors and executive management team. Our QMC will also have responsibility for organizational governance, annually approving the QM Program Description, Work Plan, and Program Evaluation. Additionally, our QM program will monitor outcomes and maintain responsibility and accountability for oversight of all activities including delegated activities, ongoing monitoring, evaluation, and actions to improve identified opportunities. QM coordinates with other departments for oversight monitoring and determination that appropriate actions have occurred as outlined in accreditation, State, and federal standards.

Complementing our local QM program, our national Medicaid division will support us through the national Quality Improvement Committee (QIC), promoting adoption of best practices from affiliates, such as boosting access through telemedicine in rural communities. The QIC is our national organization's governing body that reviews and approves all NCQA-required quality reports, including clinical practice guidelines (CPGs), utilization management (UM), credentialing, chronic condition management, behavioral health, healthcare disparities, access and availability, and Member and Provider satisfaction. The QIC provides oversight of QM programs, approves templates for required accreditation reports, and assures that NCQA standards and guidelines are met. Our CCO's senior leaders will also serve as members of the QIC.

While all these committees and councils will serve specific, targeted, and important functions in the effective operation of our CCO, the ***QMC*** and the ***Compliance Committee*** are of particular importance related to day-to-day management. The cross-functional QMC will foster accountability across multiple CCO clinical and business functions and blends local and national resources to monitor quality indicators and apply evidence-based and best practice approaches towards generating improvements in areas of deficiency. For its part, the Compliance Committee will make certain the CCO rigorously adheres to the Contract and to State and federal regulatory and statutory requirements. Our Compliance Officer will be accountable for risk management and monitoring of changes to laws and regulations to assure compliance with State and federal laws, regulations, and mandates. The Compliance Officer will assure the establishment and implementation of policies, procedures, processes, and best practices to promote compliance with applicable laws and contractual obligations.

Additionally, our ***Service Quality Committee*** will provide oversight of and monitor customer service metrics and to provide a forum for discussion and recommendations on interventions that will improve both our Members' and Providers' satisfaction and experience with our CCO.

[redacted]

Best Practices in Cross-functional Management

Our approach towards the implementation and ongoing operation of Amerigroup will be informed and driven by the Contract, local needs and resources, and supported through the experience and expertise of our affiliates and our parent company. Amerigroup will partner with the Division to meet critical program objectives and to proactively identify opportunities to optimize performance. We will leverage established best practices and reporting mechanisms that include the following:

Integrated Business Teams. Amerigroup's cross-functional teams are a management best practice. We will engage a broad spectrum of subject matter expertise in committee structures to support a holistic approach to program management and reduce the risk of operational silos. During key times of transition, such as program implementation or Contract amendment, we will increase the frequency of leadership, project team, and committee meetings to assure the success of the transitioned activities.

Data Capabilities. Our Management Information System (MIS), HITRUST-certified and HIPAA-compliant, is built on a managed Medicaid model and is highly configurable and customizable, allowing us to meet the requirements of the MississippiCAN and CHIP Programs and use data to actively support Providers, manage Member care, and identify opportunities for improvement. Our MIS can quickly process large volumes of Enrollment, utilization, and service data. In addition to standard and ad hoc reports prepared for the Division, Amerigroup will build tailored reports specific to each phase of the Contract to help make sure that Member and Provider needs are met, adequate staffing is in place, and issues are quickly identified, triaged, and resolved. The MIS gives Anthem the flexibility to nimbly respond to changing State needs and requirements. It contains built-in controls to promote the accuracy of data feeds and has eliminated many manual processes in reporting. This reduces the risk of manual error and the administrative effort of collecting, analyzing, and producing actionable information.

Amerigroup's MIS and process enhancements will provide the following key benefits to the State:

- ***Enhanced integrated data infrastructure***, which allows for faster and accurate reporting, allowing for internal review, and timely submission
- ***Execution of a thorough review with built-in controls*** driven by variance analysis
- ***Leveraging expert business owners*** and management who know and understand their data streams and have ready access to resources to research and resolve potential issues
- ***Data warehouse*** designed for warehouse data extraction

Established Policies and Procedures. Amerigroup will have well-defined policies and procedures that complement our reporting and MIS platform, enhancing the quality of financial and non-financial performance data submitted to the Division. These policies and procedures, customized to meet MississippiCAN and CHIP requirements, will support our leadership team in program management and control.

Delivering a Seamless Implementation and Continuously Evolving Through Change Management
To build our Medicaid program on a strong foundation, our local Mississippi Project Manager under the overall guidance and direction of our CEO will collaborate to achieve successful implementation and manage resources, staffing, schedules, risks, and timelines. ***We use project management principles based on the nationally recognized best practice framework, Project Management Body of Knowledge (PMBOK) developed by the Project Management Institute (PMI).***

For large projects, such as the initial implementation of a contract or the addition of another product, we will leverage a "Waterfall" methodology based on PMBOK. A Waterfall methodology is a project management approach that emphasizes a linear progression of a project from beginning to end, involving care planning, detailed documentation, and consecutive execution. This methodology works best for projects with long, detailed plans that require a single timeline — like implementing a Medicaid managed care program in a new market. ***Anthem and its affiliate markets are well-practiced and effective in this type of project management — we have completed more than 270 successful contract implementations on time. Every large project of this type is led by a PMI-certified Project Management Professional.*** Leveraging this expertise and experience, Amerigroup will aggressively address challenges to assure seamless transition for Members and Providers. Table 4.3.4.1-2 provides a high-level task schedule with major activities to support MississippiCAN and CHIP operations.

Superior Project Management

As a former recipient of the PMI Project Management Organization of the Year, our parent company is recognized for superior organizational project management abilities, providing a strong foundation for our successful implementation of MississippiCAN and CHIP.

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Continuously Refining Our Processes

We know that after a successful implementation, the work has just begun. Over the course of a five-year contract, change management is a critical success factor, given the ongoing changes in the industry, external and internal factors, resources, and emerging health conditions (COVID-19, for example). For continuous improvement projects, such enhancing our call center desktop software and claims adjudication systems, we leverage an "Agile" methodology. An Agile methodology works well when the product vision or features are not or do not have to be well-defined. Agile allows project owners to tweak requirements and priorities throughout the course of the project to ultimately deliver a better product to all project stakeholders. This allows us to keep the duration of these projects much shorter, which means that the most important features get to production faster. ***Additionally, we will foster a "can-do" attitude within our team — doing whatever it takes in challenging situations to make things happen and to deliver on our commitments.***

2. Program Control Approach

We will embed programmatic controls throughout our organization. Our program controls for Mississippi will include systematic processes, procedures, reports, checks, and audits that we use to assure we continuously meet program requirements. These controls will be incorporated across our CCO in areas such as QM, UM, Program Integrity, Provider Network, Member Services, Population Health, and Care Management, among other organizational departments. These program control approaches, processes, and tools include but are not limited to:

- **Quality Management.** Our QM program will emphasize improving the health and well-being of MississippiCAN and CHIP Members to achieve Division goals. Where we identify opportunities for improvement, we develop performance or QI plans. These performance improvements are the core of our QM program. Through our program, we will implement multiple quality-driven actions, such as:
  - Using CPGs and monitoring implementation of CPGs
  - Conducting Provider profiling through a multi-pronged strategy using advanced data analytics to determine performance data and sharing information with Providers
- **Utilization Management.** We will develop and maintain a well-structured UM program to coordinate Members' receipt of the most appropriate, medically necessary care, benefits, and services using an impartial, evidence-based, and consistent approach. We will be implementing several UM processes, such as:
  - Conducting Inter-Rater Reliability reviews to assess the accurate and consistent application of medical necessity criteria
  - Monitoring over- and under-utilization by mining utilization data and implementing strategies to address
- **Provider Network.** We are committed to developing and maintaining a comprehensive, robust, efficient, cost-effective Provider Network tailored to meet the needs of our Members. We will use reports and data as part of our monitoring strategies to help us target areas for improvement and to identify potential network enhancement opportunities and targeted contracting initiatives. We will use several mechanisms to monitor network compliance, such as:
  - Reviewing availability and appointment standards, including conducting quarterly audits
  - Conducting annual Provider site visits and reviewing of Provider panel status
- **Member Services.** We will develop reports to showcase the various communications and Member outreach activities we perform to encourage preventive healthcare and program services. These reports also will highlight Member satisfaction, supporting the Division's goal of improving quality outcomes across the healthcare delivery system. We will be reviewing the following:
  - Reviewing Member services call center and 24-hour nurse advice line performance reports for improvement opportunities

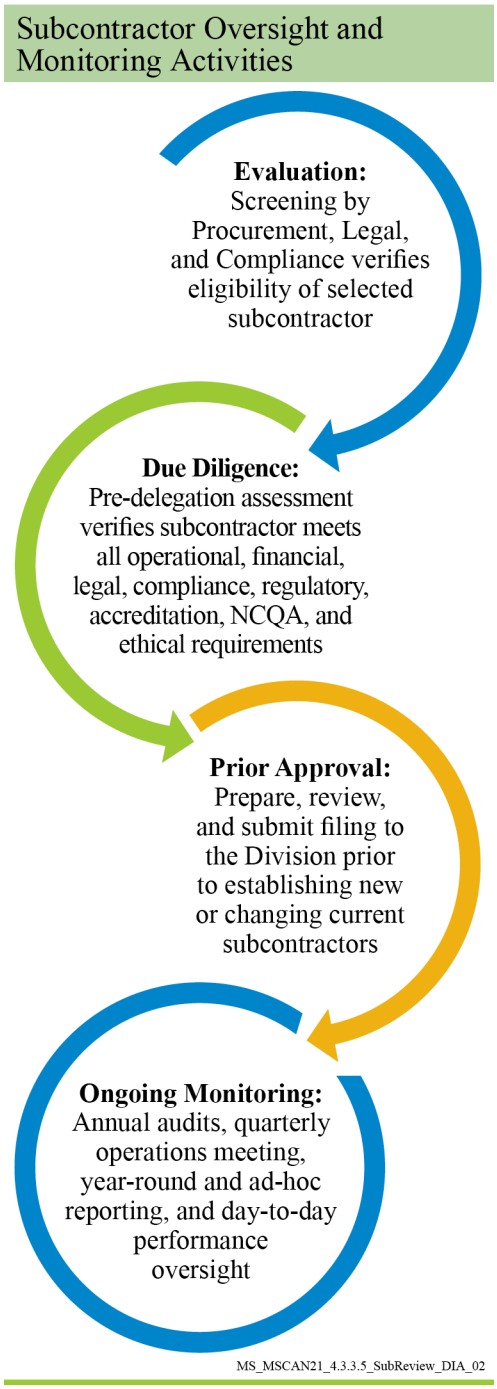
- Identifying Member issues through the Member Grievances Report and Member Appeals Report

Program Controls — Subcontractor Oversight

A critical component to program controls is critical to our day-to-day management and making sure we continuous meet Contract requirements. Our Subcontractor Oversight program includes activities and infrastructure that will enable us to monitor the performance and financial stability of our subcontractors closely and continuously. Our local Vendor Oversight Manager will monitor their compliance with contractual and other requirements to confirm that our Members are receiving the highest quality services. Our collaborative, agile, and transparent oversight processes will deliver operational excellence. Our oversight teams, tools, and protocols will enable us to continuously monitor partner performance via daily collaboration and formalized auditing processes. We have detailed QM approaches to subcontractor oversight in our response to Section 4.2.2.7.B.

Our local Compliance Officer, Vendor Oversight Manager, and Compliance Committee will verify that subcontractor partners comply with all applicable requirements and expectations to meet our quality standards. As part of our process, we will:

- Perform an annual audit using tools specific to the function delegated and mapped to contractual requirements and accreditation standards
- Obtain and review monthly scorecards with key metrics specific to functions delegated
- Perform data analysis on transactional data submitted to identify potential anomalies, which may trigger a focused review
- Perform periodic Joint Operations Committee (JOC) meetings, as applicable
- Review complaints and Grievances to identify trends
- Issue formal Corrective Action Plans (CAPs) when instances of non-compliance are identified and perform follow-up to assure remediation
- Report monitoring and oversight activities to the CCO leadership team



Our Vendor Oversight Manager will have primary responsibility for subcontractor partner compliance with State requirements. Examples of subcontractor partners our Vendor Oversight Manager oversees include Dental Benefit Management, Non-Emergency Medical Transportation Benefit Management, and Survey Administration. The Vendor Oversight Manager will work with our national Delegate/Vendor Oversight and Management Committee (DVOMC) to oversee compliance with all State, federal, NCQA, and CMS program requirements, standards, and expectation, as well as any other applicable regulatory and accreditation standards. The DVOMC reports quarterly to our national QIC and national Operational Compliance Committee.

Program Controls — Regulatory Changes

Furthermore, Amerigroup will use a well-established and effective mechanism for communicating regulatory changes to the business and our subcontractors, facilitating assessment of impact to the organization and monitoring implementation of action plans necessary to comply with the change. Upon receipt or identification of a regulatory change, the Regulatory Oversight Manager will create an alert and disseminate it to all affected employees and stakeholders who serve as assessors. Assessors must evaluate alerts to determine whether the regulatory content affects their unit. If the alert content affects the assessor's unit, the assessor must list planned tasks to meet Contract requirements and document the completion of such tasks. Our Compliance Officer monitors timely assessments and task completion.

Program Controls — Policies and Procedures

Documented policies and procedures that are readily available to employees are an important part of program control. Policies and procedures will help us make sure that we are managing the MississippiCAN and CHIP Programs consistently and serve as an important resource in the event of staff transition.

To develop MississippiCAN and CHIP policies and procedures, we will leverage a centralized repository of approved policies and procedures from our affiliates. Functional area subject matter experts (SMEs) will review this repository to leverage best practices and lessons learned and will tailor these to MississippiCAN and CHIP, in accordance with Contract requirements. If a policy or procedure does not exist, we will develop one. Internal subject experts and business owners will approve finalized policies and procedures, and the Regulatory Oversight Manager will then submit them to the Division for approval. Further, we will review policies and procedures at least annually, following the same process. We describe staff who help develop policies and procedures and their responsibilities in Table 4.3.4.1-3.

Table 4.3.4.1-3. We will develop policies and procedures tailored to MississippiCAN and CHIP.

Position Title	Primary Responsibilities
Policy Owners and Subject Matter Experts	▪ Review policy or procedure for accuracy including validating content against the MississippiCAN and CHIP Contract ▪ Make any necessary changes ▪ Return the revised electronic copy within 10 business days ▪ Review changes resulting from committees and secondary reviewers ▪ Return the revised electronic copy within five business days
Secondary Reviewers	▪ Confirm that cross-functional policies or procedures contain all requirements for all functional areas ▪ Seek Regulatory Oversight Manager input regarding the MississippiCAN and CHIP Program requirements
Regulatory Oversight Manager	▪ Develops MississippiCAN and CHIP policies and procedures and submits to the Division for approval ▪ Provides the Division with "Annual Certification of Policies and Procedures and their Operational Execution"

Data Capabilities Supporting Program Control

Amerigroup will deliver responsive, timely, and accurate data and reports. We will capitalize on the well-developed procedures of our affiliates adapted specifically to the needs and requirements of Mississippi, to assure the quality and timeliness of reports we submit to the Division. Amerigroup's reporting process will include the following key elements:

- Local leadership accountability and oversight of required reporting
- A system that collects, captures, and maintains a comprehensive set of data necessary for report generation and analysis

- Notification systems that trigger remediation action planning when performance of a contractually required service (for example, sending new Member packets within 14 days) falls outside acceptable internal limits (for example, sending Member packets with five days) so that we consistently exceed Contract requirements
- A report tracking system that documents key details on every report/deliverable, including internal and external due dates and assigned primary and secondary business owners
- Report reminders sent to all business owners providing a monthly snapshot of reports due
- A defined process to manage follow-up requests or clarifications from the Division
- A national Reporting team that coordinates and oversees regulatory report changes, new report additions, and ad hoc reporting services
- Documented procedures to communicate reporting changes to business owners who will work with Enterprise Reporting to verify that programmatic changes are made, where applicable, to reflect accurate reporting output

To produce consistently high-quality reports and data for the Division and our internal use, we will use the following in our report generation environment:

- SMEs who understand the intent, content, and meaning of reports
- Information technology experts who maintain and manage our systems
- Analysts who know how to retrieve, associate, and process the data to produce accurate, timely reports that will meet Division requirements

Amerigroup benefits from this collaboration of people across functional areas and data across technology platforms, assuring the accuracy and meaningfulness of our reports. Rigorous edits and controls in our MIS will verify the accuracy of all data.

Our MIS will deliver access to large amounts of service and utilization data to support our management team and the Division. Our ability to identify, execute, and analyze data through regular and ad hoc reports will allow Amerigroup and the Division to evaluate, monitor, and manage programs. To support our internal and Division needs for reports and data analysis, data warehouses in our MIS will maintain online, ready access to Enrollment, service, and other operational information in accordance with HIPAA and HITECH requirements.

3. Manpower and Time Estimating Methods

Amerigroup affiliates have extensive experience developing and maintaining staffing to meet program needs, and we will draw upon this body of knowledge in our recruitment activities. Our effort will begin with developing a robust staffing plan and recruitment strategy based on Mississippi's program requirements, cultural nuances, and Member health and social needs. Operations experts with deep community roots will staff the Amerigroup local team, supported by national best practices experience. Our strong core leadership team, including, but not limited to, the CEO, COO, CFO, Medical Director, Compliance Officer, Behavioral Health Director, Perinatal Health Director, and Population Health Director will provide guidance in developing staffing with the size, skills, and background to support the Division's mission and vision and achieve the best outcomes for Members.

Our manpower and time estimating methods incorporate a number of factors, including anticipated membership size, contractually required positions, and required staffing-to-Member ratios. We then build a robust staffing plan that will also factor in CCO goals and objectives, as outlined in planning documents such as our Annual QM Work Plan, and non-contractually required positions to carry out our innovative solutions and programs. We will also consider dependencies between and among tasks in the Work Plan when estimating resources. These inter-relationships and the related impact on FTE counts will be identified during cross-functional meetings set specifically for this purpose.

With workforce projections and related hiring timeframes, our Human Resources Director will finalize the forecasting of staffing volumes and initiate staff recruitment. The primary resource-planning objective will be to allocate sufficient time and appropriate specialization and talent to be fully prepared to meet Member and Provider needs at go-live and to implement sustainable operations that meet the requirements established by the Division thereafter. We will continually assess membership growth and Member-to-Provider ratios — understanding the importance of rural areas, access, and availability. Examples of our staffing methods include:

Provider Representatives. Our dedicated Provider Representatives will be local, Mississippi-based employees trained to support Providers on everything from claims submission to clinical practice transformation. In accordance with Contract Section 6.9.3.3, we will retain a proportional number of Provider Representatives to adequately assist Providers, which will not be fewer than 30. These Representatives will live in the same communities as our Providers and understand the nuances of the local landscape. Our team of Provider Representatives will report directly to our Provider Services Manager. The Provider Representative team will include Provider Experience Consultants, who will provide general training and operational support; Care Delivery Transformation Consultants, who will provide quality-focused support; and Patient-Centered Medical Home (PCMH) Transformation Consultants, who will support Providers with existing recognition and develop a methodology to identify and recruit new Providers into our PCMH program. The number of representatives located in each region will be proportional to the Provider need, which will be determined by assessing the Provider population, including:

- Number and location of Providers, including whether the locations are urban or rural, and programs served
- Estimated number of annual in-person visits required per Provider, based on Provider type, Member volume, and services rendered, including:
  - At least monthly meetings, including JOC meetings, with large hospital systems and PCP groups
  - At least quarterly meetings with behavioral health professionals, OB-GYNs, and other high-volume specialists
  - At least semi-annual visits for all other Providers, or more frequently based on Provider need
- Estimated number of ad hoc meetings required to provide issue resolution, education on new policies, and specialized needs of smaller, more rural Providers
- Required trainings, including orientations and claims trainings for the first 12 months of the contract
- Other meetings that require Provider Representative participation, including quarterly Medicaid Provider Advisory Council (MPAC) meetings
- Number of Providers participating in our Value-Based Purchasing programs
- Number of PCMH Providers in-network and targeted for recruitment into the PCMH program
- Feedback from Providers received through various channels, including satisfaction surveys and the MPAC
- State priorities and contractual requirements

Care Managers. Leadership will have access to reporting that will help determine staffing decisions to make sure that CM staffing resources are aligned with Member needs across the state and will meet Care Management ratios of at least [redacted] as described in Contract Section 7.3. Additionally, we will regularly submit reports regarding our CM staffing resources to the Division, as requested. We will design our CM program to address the varying needs of Members, recognizing that Members who have more complex needs may require more intensive time and support. We will assign and maintain CM ratios according to the Contract requirements and to assure each Member's safety and health using factors such as:

- Level of care coordination and Care Management required
- Acuity and complexity of the Member's clinical and Social Determinants of Health (SDOH) needs

- Language and cultural preferences
- Geography and population distribution
- Contact frequency and modalities
- Amount, scope, and duration of service needs
- Care Manager qualifications, experience, access to supportive staff, and proximity to the Member

We focus our staffing model on recruiting and hiring the most qualified people with the right skills for the position. We will also offer comprehensive training and benefits packages to champion our staff's success. To function as a trusted and highly responsive partner to the Division, Amerigroup will:

- Attract, hire, and retain experienced and locally knowledgeable leadership and employees
- Develop and maintain comprehensive policies and procedures that clearly define and guide the services our employees provide to Members and Providers

Our recruitment process begins with our Human Resources Talent Acquisition Center of Excellence to post positions and source talent internally and externally. Our CEO will meet on a regular and recurring basis with our designated Mississippi Talent Acquisition Strategist, to assure we are staying on track to fill all positions with qualified staff. We draw from a variety of recruitment sources and activities to attract qualified candidates with requisite skills, including referrals, job search networks, social media campaigns, and strategic partnerships to help source and secure qualified candidates.

4. Sign-off Procedures for Completion of All Deliverables and Major Activities

Amerigroup is committed to meeting all aspects of the MississippiCAN and CHIP Programs outlined in the Contract. Our leaders will be supported by a tracking system that documents the contractual requirements to confirm completion of deliverables and major activities. Each staff member, including leadership, will be responsible for key review points in the reporting process. The following staff list outlines the responsibilities of accountable staff in the reporting process:

- **CEO.** Full and final responsibility for CCO management and satisfying all Contract provisions, including reporting
- **COO.** Oversee day-to-day, operational business activities and reporting for core operational functions such as claims, subcontractor management, call center, and data analytics
- **CFO.** Oversee financial performance and reporting, including budget and accounting systems; the CFO will verify integrity of financial results within the reporting process, including the review and analysis of reports
- **Compliance Officer.** Coordinate across the leadership structure to verify report completion and compliance with Division requirements
- **Key Staff and Functional Business Owners.** Generate, review, and contribute regular reports from their functional areas of expertise; designated key staff will assure ongoing review, accuracy, and compliance with reporting specifications prior to executive review and sign-off
- **Support Staff.** Responsible for generating and collecting much of the primary data that will comprise Amerigroup's regular reports

We will implement proven corporate review and approval processes to assure submission of reports and materials that are accurate, timely, and align with Division expectations. Upon Contract implementation and on an ongoing basis, the Regulatory team will establish a deadline for a deliverable, ad hoc request, or other activity based on Division requirements. We will generate reports in advance of the Division's submission deadline to allow time to review for completeness and accuracy. Our report tracking system will generate email alerts to business owners with reminders about upcoming reports due and notification that a report is ready for review.

The identified business owner will create or update the deliverable and share it electronically with the Regulatory and Compliance teams, which will complete a regulatory/compliance review process. The business owner as well as Compliance and Regulatory teams will review the documents for accuracy with contractual requirements and quality assurance. The business owner will make any needed changes, and the Regulatory team will conduct additional review. After the business owner approves the final version of the deliverable, the Amerigroup leadership team will review and approve the deliverable for submission to the Division. For major activities, Program Management staff track the status and progress against deadlines. The review path depends on the activity. For key initiatives, our CEO will review prior to finalization or submission to the Division.

Review and Sign-off on Member Materials Requiring Division Prior Approval

For Member materials requiring prior Division approval before distribution, we will use a structured review and approval process known as the Collateral Materials Approval Process (CMAP) to assure timeliness, accuracy, and appropriateness. Through CMAP, we will review all communications to current or prospective Members, including marketing, outreach, health education, and health promotion materials, to verify they meet Contract requirements and legal and internal company standards. A multidisciplinary team of SMEs and functional leads, compliance staff, and legal counsel will review materials prior to submission to the Division for approval. CMAP will include a review of content accuracy and understandability, incorporating guidance from CMS Toolkit for Making Written Material Clear and Effective. Written Member materials are at or below a third-grade reading level as verified by the Flesch-Kincaid Grade Level Index.

Once materials receive internal approval from our Marketing Manager and Compliance Officer, our Regulatory department will submit the materials to Division for review. Each item remains in a “pended” status in our internal inventory tracking tool until we receive Division approval. Member materials approved for use by Division are maintained in StoreFront, our central repository of finalized communications.

5. Management of Performance Standards, Milestones, and/or Deliverables

Our leadership team, functional business owners, and QM team will be accountable for monitoring administrative, operational, and clinical performance. We will use a variety of reports, analytics, and tools to evaluate and monitor our performance against the Division’s standards for the MississippiCAN and CHIP Programs. Our custom reports will include charts, tables, and reports to provide visibility into our performance compared to MississippiCAN and CHIP performance standards. These comprehensive reports also will enable leadership to review and analyze our operational data such as claims, Enrollment, and call center metrics against standards in a variety of ways, including by operational area, specific indicator, and timeframe. We will be able to focus on just those areas where we either met, or did not meet, the performance standard and target specific areas for a more thorough review and analysis, gaining insight on the impact of seasonality on operational performance trends, for example. Graphs, spreadsheets, and sorting options deliver additional analytical flexibility and help us monitor our operational performance for the MississippiCAN and CHIP Programs.

Simultaneously, functional owners who are responsible for generating reports will use variance controls to identify changes. When a change is flagged, a reason must be determined and provided. This strategy helps staff maintain current awareness of performance as well as longer-term trends. Additionally, our standardized process will make sure pertinent information is provided to all employees who need it to facilitate effective management review and oversight. An increasingly thorough attestation process, by both functional owners and director-level reviewers, maintains report integrity, highlights changes, and affords our CCO leaders the opportunity to view performance changes and interpret the results.

Sharing Management Reports and Metrics with the Division

We will provide a comprehensive set of custom reports of analytics and informatics data, including HEDIS® rates, Provider authorizations, Grievance and Appeals data, and Care Management outcomes data. These reports will allow for customized views and reporting to help the Division better understand, visualize, and report on MississippiCAN and CHIP initiatives and programs. These reports will guide both the Division and CCO leadership in making collaborative decisions and will provide a line of sight into several functional areas within the CCO. We are committed to working with the Division on providing the data they need when they need it. We will update the reports at least quarterly, and we propose to develop a Quarterly Business Review in which our CCO leadership team will review findings, identify areas of opportunity, and develop solutions in collaboration with the Division. Additionally, we will have a local and dedicated QM analyst to support this work. In Table 4.3.4.1-4, we highlight select key reports and metrics we will provide to the Division.

[redacted]

Each report has a set of proposed metrics to give the Division and other stakeholders an in-depth and expanded picture of our performance. Proposed metrics for key sample reports are included in Table 4.3.4.1-5.

[redacted]

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Leveraging Quality Management to Drive Improvements Across Our Programs and Services
Amerigroup will implement QM best practices refined by our affiliates in 26 markets. Our QM program is structured and data-driven, allowing us to emphasize improving the health and well-being of MississippiCAN and CHIP Members and enhancing our Population Health management strategies to achieve Division goals. Moreover, because we know that one best practice does not fit our local approach, we will blend local expertise, resources, and community relationships with national data and best practices when developing processes and interventions.

Guided by strategic direction from the QM program descriptions and the Division's Quality Strategy, our QM Work Plan will provide a blueprint for the upcoming year and document our objectives, scope of activities, processes, systems, and strategies for evaluating and improving the quality of care. Our QM Work Plan will align with the State's established goals for access to care, Member health outcomes, quality of care, and cost savings. We will submit our QM Work Plan to the Division for approval after it has received approval through the QMC structure. Our annual QM Program Evaluation will document our performance relative to established objectives, activities, and State goals, including the Division's Performance Measures.

As an example of leveraging data to improve performance, our QMC will continuously review SDOH outcomes compared to local demographics and disparities. Our analytics systems will integrate data from external software, which expands race, ethnicity, and language projection capabilities with twice the accuracy of the standard Demographics Predictive Model Report methodology. This interactive, sensitive, and robust data set allows us to identify the needs of Medicaid Members using external context to pinpoint health equity and SDOH needs and map them so factors can be visualized at the county level. Maps are easily filtered by county, Member demographics, and HEDIS compliance status. Our HEAC will also be responsible for informing and evaluating the outcomes our SDOH programming.

6. Internal Quality Control Monitoring
Amerigroup will enact internal quality control through ongoing monitoring and identifying any gaps or areas for improvement. Where issues are found, we will amend staff training and revise procedures to best meet the program goals and Member and Provider needs. A philosophy of continuous monitoring and improvement informs our approach to providing high-quality services through our Member services call center, data

monitoring activities, use of State Fair Hearings results to improve processes, and incorporation of Member Services input. These strategies are in use by our affiliates and have been very beneficial.

Local Plan and National Staff Monitor Compliance and Quality

We embed quality control into each functional area and achieve quality through routine monitoring and activities. For example, each month, Claims Quality will conduct an end-to-end audit of a random sample of claims to verify timeliness, accuracy, and integrity and to evaluate the financial, payment, and statistical accuracy of our claims processing system.

In addition, Amerigroup leadership will hold a monthly meeting to review performance indicators, identify any problems or risks, discuss opportunities for improvement, and work with the Regulatory and Compliance teams to confirm contractual compliance and quality performance. Our Compliance Officer will maintain a work plan with performance metrics, and the Compliance team will meet regularly to review compliance and quality issues. Our Mississippi Compliance staff will build strong relationships with business owners and create an environment where they can bring problems (quality or other) for a proactive response. Amerigroup will also have access to a national internal audit team, which offers an unbiased review of new and ongoing programs to identify problems and highlight operational issues.

Performance Improvement Projects to Address Clinical and Non-clinical Areas That Impact Our Program

Through our process for Performance Improvement Projects (PIPs), we will collaborate across functional areas to plan, create, and define PIP elements that meet Contract requirements to measure and improve performance. We will apply rigorous quality principles that include the Plan-Do-Study-Act (PDSA) approach. Additionally, we will use an end-to-end quality approach to assure improved health outcomes and efficiency including the following functions:

- Document current status
- Identify quantitative and qualitative gaps and trends
- Set goals, objectives, and indicators
- Develop QI Plan
- Monitor and analyze
- Conduct rapid-cycle improvement
- Evaluate continuity and effectiveness
- Share best practices with the Division, CCO partners, Providers, and stakeholders

Our goal is to deliver measurable improvements through Member-centered, individual solutions that support population-driven outcomes throughout the healthcare continuum. Through our QM program, we will measure the success of interventions from initiation through implementation. We will conduct quantitative and qualitative analyses to evaluate the effectiveness of activities in achieving our CCO's clinical and service performance goals. These analyses consider, among other things, potential barriers for achieving desired outcomes and interventions or recommended strategies. Revisions to the QM Work Plan may be initiated in collaboration with the Division in response to findings or reprioritization of projects and new events. Analyses and QM program reports will be communicated to the relevant quality committees. Summary reports will be presented to the Board or its designee.

Incorporating Member Insights into Program Improvements

We will continually improve practices to assure Member satisfaction and quality of care. In all interactions with Members, including our Member Handbook and newsletters, we will invite Members to provide suggestions or feedback regarding their experience with our CCO. Our Mississippi Consumer Advisory Council will also provide advice and counsel to help us better serve our Members and meet their healthcare goals. The Advisory

Council will review complaints and Appeals trends, Member satisfaction data, and other information to help us identify and address potential operational issues.

Further, our QM department will monitor and analyze complaints, Grievances and Appeals data, reporting this information to our QMC quarterly. Our reviews will identify the top three categories of complaints, Grievances, and Appeals for deeper analysis focusing on barriers and solutions for implementation. Results will feed into our QM activities and actions, such as improving our HEDIS and CAHPS® survey satisfaction, or lead to policy clarifications, policy changes, Provider training, staff training, and other organizational responses.

We include an analysis of complaints, Grievances, and Appeals data in our annual QM evaluation. We devote one section of the QM evaluation to complaints, including complaints regarding clinical and behavioral health issues, and another section to Appeals. Each section identifies opportunities and barriers discovered by the analysis of our complaints and Appeals data. Our QMC will review the evaluation and help identify priorities and develop action plans to improve the quality of clinical and non-clinical services our Providers, subcontractors, and employees provide. We will generate a semi-annual Complaint Report that identifies and reports Provider outliers with three or more Member complaints during the previous six-month period. Complaints included in the analysis will include balance billing, office wait times, Provider attitude, treatment delays, missed diagnoses, and refusal to treat. This information will help us monitor access to care and identify issues and trends at an individual Provider level. Our QM department will generate similar, quarterly reports of quality of care events and will escalate outlier trends to the Medical Advisory Committee for follow-up action, as indicated.

7. Program Status Reporting, Including Examples of Types of Reports

Amerigroup will draw upon the extensive experience, expertise, and resources of our parent organization, Anthem, Inc., and its affiliates in developing systems for generating contractually required reports. In this regard, we understand and will comply with all reporting requirements outlined in Contract Section 16, the MississippiCAN and CHIP Reporting Manuals, and the Division's Value-Based Purchasing Work Plan, Performance Measures Manual, and the Annual Managed Care Program Report as defined under 42 C.F.R. §438.66(e).

We also understand the Division reserves the right to request additional information or reports to assist in the determination of Contract compliance, appropriate utilization of public funds, health outcomes of Members, and/or review of any other areas the Division wishes to evaluate. In all cases, we agree to provide these reports by the required dates and timeframes in the formats required by the Division. Leveraging the best practices of our affiliates, we will implement a defined process and method of quality control to drive reporting accuracy and timeliness. We have the established infrastructure and systems in place to streamline data analytics and report development to meet Division requirements for the MississippiCAN and CHIP Programs, including a suite of QM reports and tools. This core set of tools and reports will serve as a starting point for development of the Mississippi-specific capabilities that will enable us not only to meet Contract requirements, but exceed them. In Figure 4.3.4.1-2 and Figure 4.3.4.1-3, we provide examples of reports to monitor progress. Additional Quality Management report samples can be found in Attachment 4.2.2.4-2: QM Report Samples and Excerpts.

[redacted]

[redacted]

Our well-established reporting framework will support report accuracy and completeness and include:

- Leadership accountability and oversight of required reporting
- A system that collects, captures, and maintains a comprehensive set of data necessary for report generation and analysis
- A Mississippi Compliance Officer who will manage and monitor the generation, review, and submission of all deliverables and reports to the Division
- The Regulatory Reporting Center of Excellence (COE) that will develop and maintain a regulatory reporting database that captures comprehensive documentation of the contractual and regulatory reporting obligations for the MississippiCAN and CHIP Programs

- Through this Reporting COE, we will have the capability to produce ad hoc, customized reporting to meet the needs of the Division
- Across our organization, the average time for state ad hoc requests is 7.7 days over the last 13 months. With this robust capability, our affiliated health plans produce an average of 12,000 custom reports a year.

Our Regulatory Oversight Manager will oversee and monitor the generation, review, and submission of all deliverables and reports to the Division, under the direction of the Compliance Officer. As previously outlined, Amerigroup will perform quality reviews on all reports before submission to the Division. We will generate reports in advance of the Division's submission deadline to allow adequate time for a thorough review. Business owners and leadership will review reports for completeness and accuracy prior to submitting to the Regulatory team and the Division. Our report tracking system will generate email alerts to business owners with reminders about upcoming report due dates and as notification that a report is ready for review.

Our local leadership will maintain ownership and oversight of all reporting that supports the MississippiCAN and CHIP Programs, implementing a specific local policy and procedure for the development, review, and submission of all Mississippi regulatory reporting. This procedure will assure consistency and accountability in the development and submission of Division required reports by establishing appropriate mechanisms, processes, methods, and submission practices that will enable us to maintain the appropriate and necessary standards to meet contractual and regulatory obligations.

8. Approach to the Division's Interaction with Contract Management Staff

Amerigroup is committed to regular and proactive communication with the Division in the implementation and ongoing operation of the MississippiCAN and CHIP Program. We recognize the importance and value of communication with all stakeholders, but particularly the Division in the timely implementation and effective ongoing operations of these programs. In the following section, we describe our approach to communicating with the Division for formal and ad hoc purposes.

Formal Contract-related Interaction with the Division

Amerigroup will implement the expanded model for compliance and State agency support that has proven to be a best practice in our affiliate plans. In this model, we will staff both a Compliance and Regulatory team dedicated to Mississippi operations. Our Compliance Officer will serve as the main point of contact for the Division and will coordinate with the Regulatory Oversight Manager to manage reporting, communications, and policy language development.

While the Compliance Officer will be responsible for all Contract compliance functions and local engagement with the Division, the Regulatory Oversight Manager will be responsible for meeting all contractual requirements related to requests from the Division (including initial notification and subsequent updates), as well as submitting deliverables on a timely basis. The Regulatory Oversight Manager will coordinate and monitor the process to make sure the Division receives a satisfactory response within the required timeframe.

Through a centralized approach overseen by our local Compliance Officer and Regulatory Oversight Manager, we will make it easy for the Division to submit requests in writing, orally, or electronically. Regardless of how the Division chooses to submit, we will route all requests to our dedicated Regulatory Oversight Manager for assignment, coordination, and submission. In accordance with the Contract requirements outlined in Section 1.10, all Division requests for assistance will be acknowledged within one business day of receipt and will include the required date of resolution in accordance. We will complete all requests to the Division's satisfaction within five business days unless the Division specifies another timeframe and will prioritize urgent requests (as designated by the Division) without unreasonable delay.

In addition to communicating about Contract matters, we are also committed to participating in ad hoc communication with the Division helpful in identifying risks, addressing emerging issues and concerns, and facilitating resolution of identified issues as they arise. We will actively participate on-site in State meetings and other collaborative activities and will otherwise invest in meeting the Division's expectations and building trust — all towards the goal of developing a relationship that goes far beyond Contract requirements.

[END OF RESPONSE]

4.3.4.2 Problem Management

1. Assessment of Program Risks and Approach to Managing Them

In this section, we define program risk to mean situations and circumstances in which our Coordinated Care Organization (CCO) is at risk of failing to meet a compliance, regulatory, administrative, or service requirement, including those required by Contract, internally defined, or set as an industry standard. Regardless of the nature of the risk posed, we know that early identification and mitigation of these risks is critical in meeting the Division's expectations and in offering accessible, high-quality, and cost-effective healthcare that improves the lives of our Members and the communities in which they reside. By virtue of our parent company, Anthem, Inc.'s (Anthem's), experience, and the experience of our 26 affiliates in Medicaid markets across the country, we bring extensive knowledge about the risks faced by a new entrant, and we discuss in this section how we will assess these risks and effectively manage them.

Data-driven Risk Monitoring

Core to our ability to assess, identify, and address program risk is our data infrastructure and analytic capability. As described in Section 4.2.2.4.C, our data and informatics capabilities are cross-functional and will be leveraged throughout the CCO. We will have a fully integrated, multi-dimensional data infrastructure with data layers accessible via detailed logic, self-service Business Intelligence applications, and a robust suite of automated and dynamic reporting. This data capability will enable us to track our services and performance in a wide variety of areas: Member demographics, claims and encounters, authorizations, and Appeals, CAHPS® and HEDIS®, quality of care, adverse incidents, Member and Provider call center metrics, Grievances and Appeals, cost of care, network adequacy, and claims, among many other indicators. Our leadership team, functional areas, and quality management program will monitor these data and coordinate the development of corrective action when metrics indicate performance outside internally generated performance thresholds. This early detection and intervention process will enable us to continuously maintain performance levels within Contract specifications, industry standards, and other benchmarks.

As referenced in Section 4.3.4.1, our leadership team will be actively monitoring performance across the entire CCO through review of program status reports and dashboards and staying in close communication with the Division when potential risks are identified. We discuss in this section our approach to identifying and managing compliance and regulatory risks and other program risks such as challenges in the implementation process, emerging Member health risks, and risks related to disasters and emergencies.

Managing Compliance and Regulatory Risks

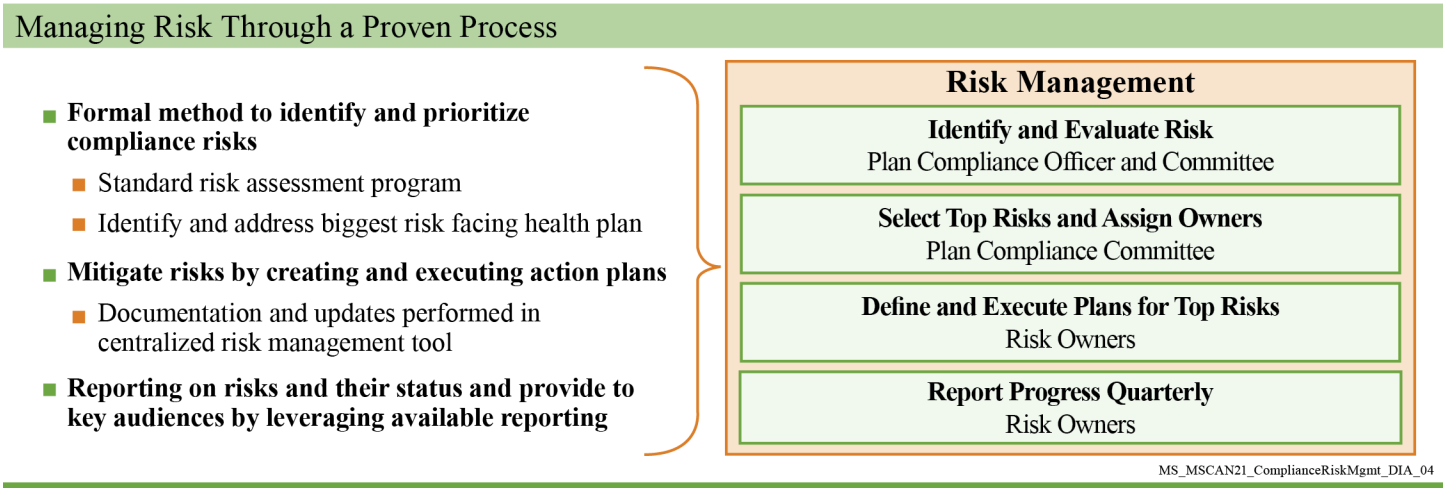
Our Compliance program will leverage a robust system of processes and controls to prevent, identify, and mitigate potential risks. It is founded on the principles of the U.S. Department of Justice's seven fundamental elements of an effective Compliance program:

- Implementing written policies, procedures, and standards of conduct
- Designating a Compliance Officer and establishing a Regulatory Compliance Committee
- Conducting effective training and education
- Conducting internal monitoring and auditing
- Reporting and investigating
- Enforcing standards through well-publicized disciplinary guidelines
- Responding promptly to detected offenses and undertaking corrective action

Our Mississippi Compliance Officer will be accountable for managing compliance and regulatory risks and will work across the CCO to identify and mitigate these risks. In this process, we will use a formal compliance risk management process (shown in Figure 4.3.4.2.1-1) refined and proven across our affiliate health plans. The

Compliance Officer will conduct monthly and quarterly risk assessments to monitor the risk status to confirm our continued compliance with regulatory and contractual obligations. The risk rating will determine the level of monitoring (high to moderate or medium to low). We will monitor high to moderate risks monthly and medium to low risks at least quarterly. Amerigroup will enter risks into a centralized risk database (that includes risks for all affiliates) for monitoring at a local and national Support Services perspective to promote proactive mitigation.

Figure 4.3.4.2.1-1. Assessing and addressing compliance and regulatory risks.



Moreover, a specialized Regulatory Reporting center of excellence and Compliance team will work diligently with business teams to determine how to prevent issues before they occur and address risks in a timely manner. We will also respond quickly to any issues identified by the State or its partners, working to respond quickly to requests, perform root cause analyses on defects, and verify the standard process is followed to prevent the defect from recurring.

Managing Other Program Risks

Mitigating Implementation Risks. As detailed in Section 4.3.4.1, we are fortunate to have a knowledgeable, experienced leadership team in place in Mississippi. In addition to conducting administrative and programmatic planning, this team has been visiting communities across Mississippi to listen to the concerns and needs of community members and representatives of community-based organizations, Providers, and advocates. This knowledge is being incorporated into our implementation and operations planning. Within our formal implementation process, the Implementation team will be employing a structured project management framework and process known as Project Management Body of Knowledge (PMBOK). PMBOK offers methods and tools to develop and monitor specific tasks and deliverables. In this process, we will be using several strategies to mitigate risk, including:

- Establishing strong implementation and project management leads, including our Chief Operating Officer and our Chief Compliance Officer
- Using agile system development methodology to incorporate process flexibility
- Maintaining open channels of communication with the Division and other stakeholders
- Fostering a “can-do” attitude within our team — doing whatever it takes in challenging situations to make things happen when we do not have additional time or resources

In the implementation planning process, we are also leveraging the support of our national Implementation Management Office (IMO). The IMO is a dedicated team of certified project management specialists, focused

on successful implementation of new health plans, programs, and contracts across our parent company, Anthem, and our affiliates. In partnership with our Mississippi leadership team, the IMO will execute a comprehensive implementation approach that has already begun and will extend 90 days after Go-Live.

Tracking and Addressing Emerging Health Risks. Continuous monitoring of health outcomes and improvements will be an integral component of our approach to mitigating healthcare disparities and enhancing health equity. One of the ways we will track disparities is through HEDIS measures, including those for appropriate care, behavioral health (BH), cardiovascular, diabetes care, and prevention. Through the evaluation of these measures, we will be able to identify emerging risks early and deploy and evaluate targeted interventions in response. This process applies to a wide variety of risks associated with poor health outcomes, including social risk factors such as unstable and unsafe housing, unemployment, and lack of transportation. In 2019, our Nevada affiliate responded to HEDIS results indicating that Hispanic Members were at high risk due to a gap in diabetes care and addressed this need by staffing bilingual Spanish and English-speaking Case Managers to educate Members about chronic diabetes management.

Managing Potential Risks During Emergencies. As detailed in Section 4.3.4.4, our draft comprehensive response continuity of operations plan supports the MississippiCAN and CHIP Programs in times of disaster or emergency. This plan outlines measures to maintain services to Members during emergencies through redundant call center operations, Care Manager outreach to at risk Members, waiving of Prior Authorizations (PAs), and suspension of administrative denials. Our Business Continuity Management plan will be tailored to the needs and resources of Mississippians.

2. Anticipated Problem Areas and the Approach to Management of These Areas, Including Loss of Key Personnel and Loss of Other Personnel

With the substantial experience of our parent company and our affiliates, we are aware of the challenges inherent in implementing and operating a Medicaid managed care program. We believe anticipating and rapidly mitigating problems is an approach that optimally reduces any negative impact on our Members and network Providers and allows us to focus on achieving Division goals for MississippiCAN and CHIP.

Amerigroup's management approach therefore focuses on preventing problems through rigorous preparation and anticipation and having systems and protocols in place to address unexpected or unavoidable problems as they occur. As discussed in the prior section, our structured project management approach known as PMBOK offers our staff guidance and tools towards identifying and resolving program and project challenges. As we strategically address anticipated or emergent problems, we will give priority to solutions that are innovative and replicable, produce measurable improvements in care quality, broaden access to resources that address health and social risk factors, and ultimately result in improvements in the health and quality of life of MississippiCAN and CHIP Members and the communities in which they reside.

Engaging Communities, Providers, and Others in Anticipatory Problem Identification

In anticipation of the release of the MississippiCAN and CHIP RFQ, we have been conducting outreach to stakeholders across the state, including Provider organizations, advocates, community- and faith-based organizations, and applicable State entities to learn more about services historically provided to the target populations. Based on our outreach, local leadership knowledge, and the experience gained by our affiliates in Medicaid programs across the country, we anticipate facing some or all the following issues:

- Unexpected loss of key personnel and other personnel
- Limited access to care in rural areas and other areas with low Provider density
- Concerns from Providers about increased administrative burden during and after implementation
- Collecting and maintaining high-quality Member data

The descriptions in the following sections lay out anticipated challenges and problem areas, as well as our approach to quickly and decisively solving these challenges.

Unexpected Loss of Key Personnel and Other Personnel

The success of our Mississippi operations will depend on qualified, stable staffing at all levels of the organization as well as flexible policies and procedures that enable us to scale resources as circumstances dictate and replace key management personnel and other staff quickly and efficiently.

Loss of Key Personnel

Loss of key personnel is inevitable in any organization, and we have policies and systems in place to rapidly fill such positions with highly qualified and experienced individuals. In this regard, we recognize the importance of communicating key program changes, and we will notify the Division within five business days of learning of a key position vacancy or anticipated vacancy within 30 calendar days, as outlined in Contract Section 1.13.1.

Our proactive, anticipatory approach to replacing key personnel uses ***succession planning*** as a key tool. We maintain an online tool in which directors, executives, and key leadership describe job preferences that best align with their experience and aspirations. In addition, leaders complete a career summary in which they outline their experience, education, achievements, and competencies. We use this information to complete a succession plan (updated annually) for a variety of leadership roles within the organization and will have a line of succession in place for all Mississippi key personnel. When a vacancy occurs, we have a robust talent pool of qualified employees across both the national and CCO level who are available for potential leadership opportunities. In this manner, succession planning allows us to:

- Execute our business strategies
- Minimize disruptions to the business, as well as to our Members, Providers, and the Division
- Invest proactively in our leadership talent so that we have readily available personnel at the right time and in the right role

In addition, we identify qualified replacements by requesting referrals from Providers, community leaders, the Division, and other stakeholders and reaching out to known subject matter experts who may be interested in working within the managed care field. Detailed information regarding our strategies and capabilities to hire and retain a skilled and highly qualified workforce is provided in Section 4.3.4.3.

Loss of Other Personnel

Our carefully honed and tested recruitment cycle lets us quickly select appropriate candidates with the needed experience and qualifications, whether addressing loss of personnel or an increase in staffing based on routine capacity reviews. We will deploy a robust staffing plan/recruitment strategy to meet our required staffing levels. We will use a multifaceted approach to attract and retain quality staff as well as address staffing changes.

Rapid Hiring Supports Unexpected Membership Increase

In Iowa and Indiana, when other CCOs left programs mid-contract, our affiliate health plans stepped in to take on additional membership. In doing so, we leveraged our proven systems to rapidly hire and train additional staff members to support a seamless transition for these new Members. MS_MSCAN21_4.3.4.2_ProblemManagement_COB_02

Our recruitment cycle will begin with determining the required skills and qualifications for each position and how it factors into our overall staffing plan. We use a centralized recruiting system to post job openings internally and externally. Our proven recruitment cycle matches highly qualified candidates with the requisite skills and experience to meet the needs and preferences of our Members in an operationally efficient manner. Recruitment methods include an employee referral program, job postings on job search engines and networks, social media campaigns, newspaper ad campaigns when appropriate, and job fairs. We also often collaborate with professional organizations and community stakeholders to promote job openings.

Limited Access to Care in Rural Areas and Other Areas with Low Provider Density

Our extensive analysis and discussions with Mississippi Providers and stakeholders have made it clear that the rural nature of Mississippi presents challenges for Members seeking services. From conversations with advocates and Providers, we know there are areas facing difficulties providing Members with a robust array of services, particularly in primary care, selected specialty areas, and BH. In addition, we know that transportation is a barrier for many rural residents. In Section 4.2.2.2.A., we describe in detail our process for establishing and maintaining an accessible and comprehensive statewide Provider Network. Our Network/Contracting Manager, supported by our Network Contracting team members, will oversee our Access to Care Monitoring Plan. This team will monitor our network to identify network gaps, develop recruitment work plans, and execute the recruitment efforts necessary to build and maintain a comprehensive Provider Network accessible across the state — with a focus on rural areas.

Our affiliates have developed mitigation tactics to address obstacles to care in markets with large rural populations. We will adopt these strategies, as appropriate, in Mississippi to overcome care barriers, including:

In addition, Amerigroup looks forward to working with the Division and other stakeholders to specifically address the shortage of PCPs in Mississippi by:

Delivering Solutions for Non-Emergency Transportation in Rural Areas

Amerigroup will partner with Medical Transportation Management, Inc. (MTM) to identify and implement creative solutions to improve transportation access for Members in rural areas. We selected MTM as our Non-Emergency Transportation vendor because of their current presence in Mississippi and understanding of the needs of Mississippians regarding transportation. Across the country, approximately 20% of MTM total trip volume consists

of rural and remote-rural transportation. MTM has significant experience working in sparsely populated settings and knows the challenges of developing and scheduling transportation in areas with fewer resources.

MTM will provide the resources to make sure rural transportation Providers and volunteers receive the necessary support to successfully deliver safe and timely transportation to rural Mississippi Members. MTM's experience in managing gas mileage reimbursement programs has also proven successful in rural areas where Members may have access to friends or family capable of providing transportation.

Concerns from Providers About Increased Administrative Burden During and After Implementation

We recognize that Providers may have concerns about the extra administrative burden involved in contracting with a new CCO. To address these concerns, we have been reaching out to Providers prior to and after the release of this RFQ to understand, anticipate, and prevent common inefficiencies and frustrations associated with new CCO contracts, in areas such as billing and reimbursement, reporting, and PA. Our methods to prevent some of the common sources of frustration include:

> **Anticipating Provider Issues During ICD-9 to ICD-10 Conversion**
>
> Our Georgia affiliate anticipated disruptions to the Provider Network during the ICD-9 to ICD-10 conversion. To proactively solve for this problem, they monitored Provider performance throughout the conversion process, looking for spikes in denials. If the spike was conversion related, their Provider Relations team reached out to identified Providers and offered technical assistance and training to help them with their process and ease any administrative burden.
>
> MS_MSCAN21_4.3.4.2_AnticipatingProviderIssues_COB_03

- Conducting "test" claims with Providers prior to Contract implementation to make sure issues are identified and resolved prior to go-live
- Implementing an innovative Prior Authorization pass program to reduce administrative burden for select Providers who consistently demonstrate excellence in PA performance and meeting coverage criteria
- Including a Provider Training Coordinator on our Provider Experience team to develop new training content and assess the effectiveness of our program by engaging directly with Providers and working with operations to identify Provider performance trends
- Assigning a local Provider Experience Consultant to every Provider to provide initial and ongoing training and help manage any operational issues
- Processing claims daily to facilitate speedy reimbursement for services
- Identifying Providers with high rates of denials and proactively reaching out to them and their staff to offer training and assistance with their billing processes
- Closely monitoring PA requirements during initial implementation to minimize disruption in services to our

[redacted]

- Assigning dedicated Community Mental Health Center and FQHC/RHC Provider Experience Consultants who will be trained specifically on the nuances of these Provider types, including unique billing requirements, for instance
- Hiring a Provider Training Coordinator and Telehealth Program Manager to be available to work directly with Providers on relevant topics and provide subject matter expertise in training development

We will also leverage the best practices of our affiliates and support Providers through additional training and extra help. For example, during implementation at our Georgia affiliate, staff went to Provider offices to walk them through the process for activities such as logging in to the Provider Portal, requesting authorizations, and submitting claims. They also conducted meet-and-greet events that allowed the CCO staff members to introduce themselves and get to know Providers and medical office staff.

Our local Provider Experience team will actively support Mississippi Providers. In addition to providing Provider dashboards and offering online training, the Representatives will spend time with Providers in their offices. At these visits, our Provider Experience Consultants will educate Providers and their staff provide resources and materials and discuss the dashboards. We will use these personalized visits in Mississippi to deliver information and tools that will help Providers be successful and help them adopt innovations such as VBP payments and Provider incentives.

Maintaining High-quality Member Data

Up-to-date and accurate Member contact information will be critical to our ability to reach and engage our Members. We will take proactive steps to make sure that we have the most accurate data on our Members, including updating our system with new contact information from the daily 834 files, checking the National Change of Address registry before any Member mailings, and identifying additional contact information using LexisNexis MemberPoint. Our affiliates have successfully used this technology to reach difficult to locate Members.

Furthermore, it is critical that CCOs have complete and accurate data regarding Member race and ethnicity. Delivering culturally and linguistically appropriate Member services requires a detailed knowledge of our Member characteristics related, at a minimum, to race, ethnicity, language, and disability, and place of residence. Annually, we will conduct a population analysis that considers the cultural and socioeconomic characteristics and needs of our membership. This analysis will bring together internal and external data that we continuously review to inform our Population Health strategy and our health equity priorities and to identify baseline measures and set targets to adjust programs as needed to improve care and services.

To improve the precision of data from 834-enrollment files relating to missing Member race and ethnicity data, we will use demographic predictive modelling. The modelling process will fill in missing data regarding Member race and ethnicity through analysis of Member name, address, and linguistic coding.

Another proactive step we will take is bar coding our Member ID card mailings. If the postal service returns ID cards as undeliverable, our mailroom staff will scan the bar code and an automated process will update the Member's record in our system to indicate the ID card return. This initiates an automatic call to the Member for a valid address. In addition, our process will include searching claims submissions for the next 90 days, and if we find a different address, send a new ID card to the Member, and notify the Division of the address change. We will create a monthly report that will identify all returned ID cards, with the Member's Mississippi Medicaid ID number, first and last name, incorrect address, and correct address, if available.

Another innovative way, and one that has been our most successful and proactive approach to maintaining high-quality Member Data, is our organization's Address Update Campaign. This campaign was developed to address increased Member transience during the COVID-19 pandemic. Deployed across our affiliates in May 2021, the campaign resulted in 31,000 Members updating their contact information. It was redeployed again in November 2021, resulting in an additional 15,000 Members updating their information. We will use this same approach for MississsippiCAN and CHIP Members to collect, update, and maintain their information.

We will also use other approaches to maintain accurate Member data, including our Member welcome calls, interactions with our Member Services Call Center Representatives, and through our Care Managers. Amerigroup welcomes the opportunity to collaborate with the Division and other Mississippi CCOs to identify the best methods to maintain accurate Member contact information.

3. Approach to Problem Identification and Resolution

While managing risk and anticipating program challenges — as detailed in the prior subsections — can minimize the likelihood of administrative and operational problems and challenges, CCOs will still encounter

problems that require corrective action. Rapid identification and resolution of these problems is critical to limit any negative impact on Members, Providers, and other stakeholders. Next, we describe our approach to identifying and resolving problems.

Problem Identification Process

Amerigroup has extensive capability to generate reports and to populate dashboards with actionable information regarding the CCO's performance, including variance reporting and early warning triggers for areas potentially requiring remedial action. Amerigroup's leadership team, functional area managers, and Quality Management Committee will bear primary responsibility for reviewing data, both quantitative and qualitative, and initiating review and possible corrective action in a broad number of functional areas, including but not limited to:

- Provider Network adequacy
- Subcontractor performance
- Member and Provider call center performance
- CAHPS, HEDIS, and EPSDT measures
- Provider satisfaction
- Enrollment and disenrollment
- Claims processing
- PA
- Fraud, waste, and abuse
- Grievances and Appeals
- Utilization management
- Care Management

The CCO will generate a suite of reports (daily, weekly, monthly) and dashboards that provide data on all key areas of our operation. Data sources may include, without limitation: enrollment information, claims, encounters, authorizations, Appeals, complaints, chronic condition/case management documentation, access and availability survey findings, survey data collected by external bodies such as accreditation entities or CMS, quality improvement studies, State data files, CAHPS, and HEDIS results.

Quantitative and qualitative analyses will be conducted to evaluate the effectiveness of functional area services, including whether performance metrics meet Contract requirements, industry benchmarks, or internal thresholds for corrective action. Data will be aggregated to track and trend over time for identification of optimal and suboptimal CCO performance. These analyses will consider, among other things, potential barriers for achieving desired outcomes and interventions or recommended strategies.

Problem Resolution

The process for resolving identified problems depend upon the magnitude and complexity of the problem. We seek to solve problems efficiently and devote resources towards problem resolution commensurate to the scope, depth, and urgency of the problem. For relatively complex problems requiring cross-functional participation, we use the "Plan-Do-Study-Act" (PDSA) model for problem resolution, as outlined:

Stage 1: Plan

- Recruit team members, identify roles and responsibilities, set timelines, and establish a meeting schedule
- Obtain group agreement about the purpose of the group process, including what the group is trying to accomplish and how change will be measured
- Describe current context and process, answering questions about how the process, program, or service is currently conducted, major steps in the process, and who is involved
- Describe the problem using an aim statement to generate the team's consensus on the nature of the problem
- Identify root cause(s) using tools such as a fishbone diagram or the 5 Whys
- Develop potential solutions based upon the identified root cause(s)
- Develop an action plan, including necessary staff and resources and a plan for measuring change

Stage 2: Do

- Implement action plan, collecting data to evaluate the impact of the solution
- Document problems, unexpected effects, and general observations

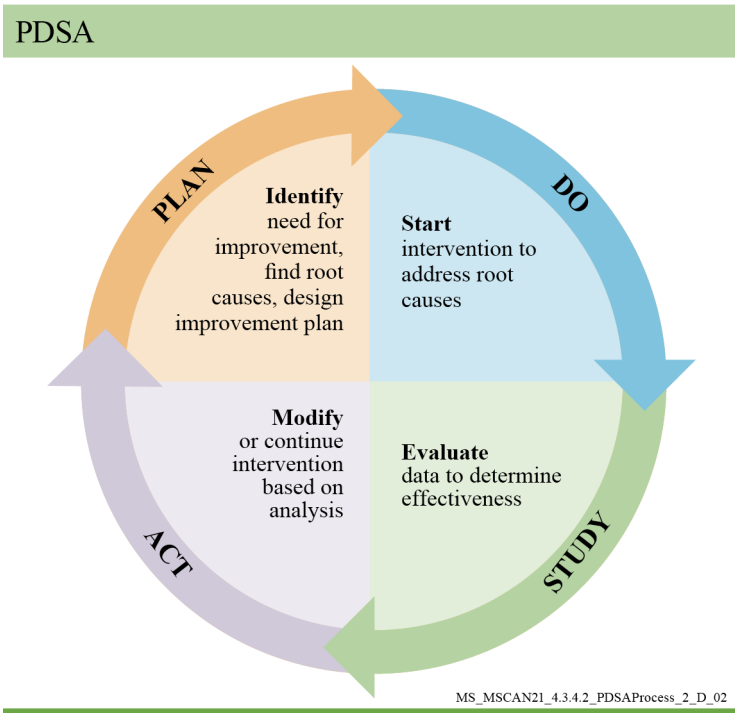
Stage 3: Study

- Examine gathered data and information to determine if the solution resulted in an improvement and the magnitude of the improvement
- Determine if the tested solution was worth the investment of time and resources
- Look for trends and unintended side effects

Stage 4: Act

- If successful, incorporate the solution into routine operations
- Re-evaluate after a period of time to evaluate sustainability or to identify further improvements
- If not successful, return to Stage 1 and re-initiate the process

Figure 4.3.4.2.3-1. We use the PDSA model to resolve problems.



The process of identifying the ***root cause*** of identified problems is a critical step in the PDSA model (Figure 4.3.4.2.3-1). Root cause analysis lends itself to fully understanding how to fix, compensate, or learn from any underlying issues within the root cause. This facilitates the application of what we learn from this analysis to systematically prevent future issues or to repeat successes. In this manner, we will use root cause analysis to modify core process and system issues in a way that prevents future problems.

[END OF RESPONSE]

4.3.4.3 Backup Personnel Plan

We recognize that delivering an integrated, outcomes-focused Coordinated Care Organization (CCO) to serve Mississippians depends on the people who enable our CCO to run day after day. Our people bring our mission, vision, and outcomes to life. We choose our staff by carefully recruiting the most qualified individuals who understand Mississippi and have a strong skill set and background to perform their roles successfully.

Further, the success of our Mississippi operations depends on qualified, stable staffing at all levels of the organization as well as flexible processes so that we can scale resources as circumstances dictate or replace key personnel and management staff quickly and efficiently, should the need arise. With more than 92,500 employees across our parent and affiliate organizations, we have access to an extensive array of national resources to continue to perform the functions outlined in the Contract, even when urgent issues or staff transitions arise. In the event we have staff turnover due to a promotion or voluntary resignation, we have methods to minimize the impact and assure a continued high level of performance.

We require each manager and department to routinely review their specific responsibilities and determine the capacity of the current department by monitoring any changes in volume, membership, program updates, and service delivery to adjust staffing levels to meet Members' needs. Our Mississippi leadership will work closely with their counterparts in our affiliate health plans to share best practices, review new processes and programs, and determine whether global or systemic changes may be required to enhance service delivery. Based on the information we identify, managers will refine existing staffing plans, identify additional resources that can be rapidly mobilized, continue to provide required training, and work with other departments to identify operational efficiencies.

In the event our staffing model must be adjusted to reflect unforeseen increases in workload, we will mobilize a variety of processes and strategies to meet Member, Provider, and the Division of Medicaid (the Division) needs while a permanent solution is put in place. These strategies include, but are not limited to:

- Mobilizing identified backups for each key and suggested staff position that is Member-, Provider-, or State-facing. Functional leaders proactively identify staff to serve as backups and make sure that these team members are ready to serve "as next in line" when needed. This process is completed annually following performance reviews. Succession plans are developed across affiliates and shared to identify those that may take on new roles.
- Training functional area directors and managers to provide the same services as their team members in cases of crisis or unexpected changes, such as a national public health pandemic.
- Maintaining detailed documentation of policies, procedures, and quick reference guides to facilitate a consistent service experience.
- Engaging employees from our national offices and other Medicaid plans to temporarily fill vacant positions.
- Cross-training staff to seamlessly transition functions and minimize any impact.
- Posting the position as quickly as possible while deploying a robust recruitment staff to identify, hire, and onboard a permanent replacement as quickly as possible.
- Working with contract agencies who can quickly augment staff, and our parent company, who has a large-scale temporary services organization available to fill short-term needs.

Replacing Key Personnel

Across our organization and affiliates, we consistently recruit and retain adequate numbers of well-trained employees to meet and exceed our Contract obligations. For example, in recent years, states like Iowa and Indiana experienced managed care organizations (MCOs) exiting their markets before the expiration of their contracts for financial and other reasons. Our affiliates quickly stepped in to support their state partners and

Members who were facing the loss of their MCO, by seamlessly ramping up personnel and operations to transition those Members and assure no disruption in their care occurred. ***In addition, none of our affiliates has ever had an implementation delay because of inability to recruit staff, and we are well prepared to uphold this same high standard in Mississippi.***

With a robust backup plan established that incorporates multiple strategies (including succession planning and flexible staffing procedures), we are prepared to replace key or other staff, regardless of whether it occurs before or after Contract signing. In the event of a loss of key staff, we maintain a list of eligible and highly qualified individuals from which we can expeditiously recruit for any key positions. This list includes individuals we have interviewed and short-listed for positions, local experts in specific areas, qualified employees interested in taking on new roles, and individuals referred to us by our State partners, providers, and other stakeholders.

To facilitate succession planning, we maintain an online tool in which our directors, executives, and key leadership describe job preferences that best align with their experience and aspirations. In addition, leaders complete a career summary in which they outline their experience, education, achievements, and competencies. We use this information to complete a succession plan (updated annually) for a variety of leadership roles within the organization. Our Talent Management team will use the completed succession plans to develop a pool of internal talent and identify a successor (in conjunction with the Hiring Manager and Human Resources). This plan then provides a robust talent pool of qualified employees across both the national and CCO level who are available for potential leadership opportunities with us.

As part of our overall staffing plan, we identify potential replacements for all key positions and those with direct Member contact — a process already underway for our Mississippi team. As needed, we will provide these individuals with any additional training. We also offer shadowing, “stretch” assignments, and collaborative and interdepartmental project work to increase employee competencies. In addition to this plan, we will use a comprehensive approach to recruiting our Mississippi staff that includes professional recruiters, advertising, job fairs, word of mouth, and employee and community referrals. Similar to the way we recruit employees for implementation, we will deploy our resources to fill any key personnel vacancies within 90 days. We will adhere to the requirements outlined in Contract Section 1.13.1, including notifying the Division within five business days of learning of any key position vacancy or anticipated vacancy within the next 30 calendar days. We will also seek Division approval for any proposed replacement for key positions at least 15 days prior to the position’s start date.

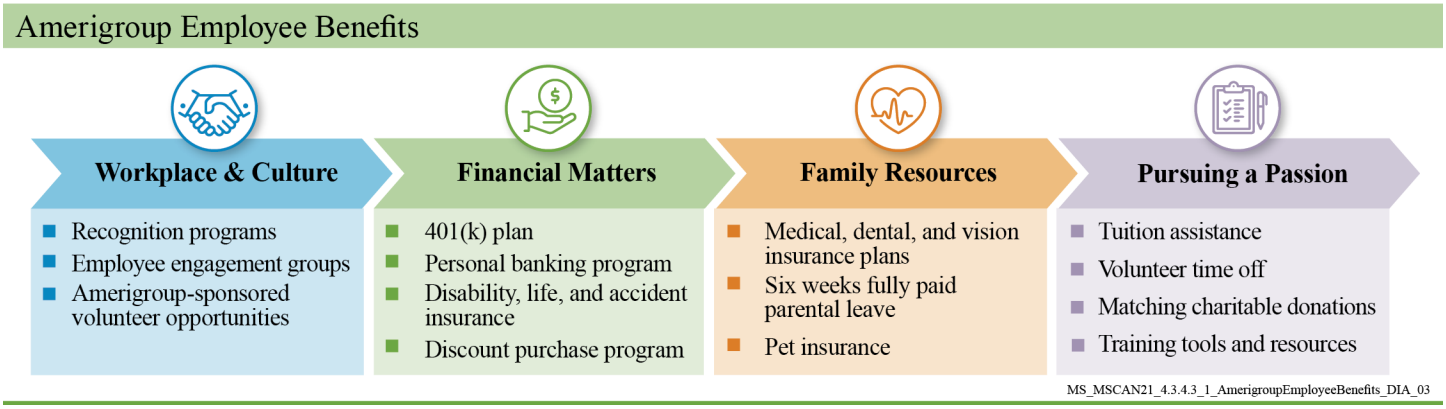
As we conduct the search process, we ask departing key employees to document detailed information on their ongoing activities and projects. This will facilitate a transfer of knowledge between the departing employee and their replacement. We also ask the key employee to attempt to complete any deadline-specific activities before their departure. We strive to identify and hire replacements before the departing employee leaves, providing as much shadowing and knowledge sharing as possible. If this is not possible, we make sure that the departing key employee provides detailed information and documentation about the activities and services to be shared with the individual’s supervisor or interim replacement to minimize transition issues.

Promoting the Longevity of Staff

Amerigroup thoughtfully hires staff, seeking out those who are not just qualified, but dedicated and passionate about the people we serve. Once we identify the right candidate, we work hard to keep them. Providing benefits and programs that enable our employees to take time away from their job, spend time caring for a loved one, welcome a new family member, or simply enjoy a day volunteering for an organization that is personally important to them are all part of our comprehensive program of benefits and strategies that help us retain our staff. We are continuously evaluating and improving our benefits — 2022 additions include additional paid holiday, increased 401(k) matching, and enhanced fertility coverage. This multi-faceted retention strategy

comprises work-life balance offerings, financial compensation, workplace and culture initiatives, health and wellness programs, and professional development opportunities (Figure 4.3.4.3-1).

Figure 4.3.4.3-1. Amerigroup promotes longevity of staff.



Our parent organization provides many of our retention programs and has been recognized as a leader in workplace excellence, including:

- Best Companies to Work For (Fortune, 2021)
- Best Places to Work for LGBTQ Equality (Corporate Equality Index Human Rights Campaign, 2015–2020)
- Best Places for Disability Inclusion, Disability Equality Index (2015–2019)
- Leading Disability Employer (National Organization on Disability, 2017–2018)
- Best Employers for Diversity (Forbes, 2021)
- Top 50 Companies for Diversity (DiversityInc Magazine, 2018)
- LGBTQ Business Equality Excellence Award (Business Equality Network, 2017–2019)
- Best Places to Work for LGBTQ Equality (Corporate Quality Index, 2015–2019)
- Million Dollar Club Recognition (U.S. Hispanic Chamber of Commerce, 2011–2018)
- Best 100 Companies for Women's Leadership Development (Diversity Woman, 2018)
- Best Places for Women to Work (Forbes, 2019)

Above all, we promote an energized workplace — an environment that supports excellence, creativity, engagement, and satisfaction. To bring this goal to reality, we offer several formal and informal ways for employees to give us feedback. Our leadership is transparent with staff, sharing feedback and ideas that are being acted on and reasons why an idea cannot be implemented at the time. We promote an "open door" mentality that encourages any employee to reach out to any member of leadership at any time to share ideas, questions, or concerns.

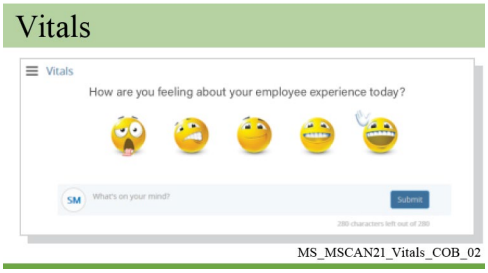
As one way to encourage feedback, we regularly survey our employees to assess their engagement and identify areas for improvement, including job roles, benefits, and the workplace climate. Based on the insights we gain, our leadership will build action plans and share them with employees at town halls and team meetings.

As our affiliates do, we will also hold regular Town Hall meetings led by our CEO and in partnership with members of the leadership team. These Town Halls will involve delivery of content, whether it be a motivational speaker, tips for achieving a better work-life balance, or a deep dive into one of our employee benefits, like educational reimbursement. Each Town Hall has a question-and-answer opportunity for staff to ask questions (anonymously if they prefer). No subject is off limits, and the leadership team will provide real-time answers or follow up with employees individually or in small groups.

For example, during the height of the COVID-19 public health emergency, our affiliates held bi-weekly Town Halls that were focused on work-from-home tips, mental health, and ideas to maintain connections with family, friends, and colleagues. These were critical in providing employees a safe space to express feelings, get advice on working and homeschooling simultaneously, and in staying connected to colleagues. Following each Town Hall, we will administer a survey, soliciting feedback to improve our time together as a team. We take the feedback seriously and act upon it, prioritizing issues involving the work environment so we can continuously provide a healthy environment that supports high performance.

In addition, we will offer an innovative Vitals employee engagement platform. Using this platform, our parent company was able to account daily for employee perspectives when designing internal initiatives to respond to COVID-19 and social unrest. ***In 2021, employees shared more than 43,000 comments and more than 258,000 sentiment submissions on the digital Vitals application (Figure 4.3.4.3-2).***

Figure 4.3.4.3-2. Vitals platform makes it easy for staff to voice their perspectives.



Awards and Recognition

To encourage retention and minimize turnover, we offer rewards and recognition programs that acknowledge employees for their dedication, professional growth, contributions, and exemplary job performance. We offer Service Recognition awards for employees at each five-year milestone. Our Impact Award program offers points or monetary awards for accomplishments that exceed expectations or exemplify our organizational values. Employees can use their points to purchase a variety of items, such as company-branded merchandise, fitness trackers, gift cards, or household items. In 2021, our organization celebrated more than 150,000 employee recognitions, and we are excited to bring this momentum to our Mississippi staff.

Employee Assistance Program

Our Employee Assistance Program (EAP) is a valuable resource to employees for assistance with managing problems at home and at work. EAP provides employees and eligible family members with a no-cost, confidential, and user-friendly resource for life management concerns. Services offered include telephonic and face-to-face sessions with licensed mental health professionals. The EAP also offers consultations with legal and financial services professionals.

Giving Back Supports Staff Longevity

Being able to give back to the community can be a motivator for staying with a company. Thus, we offer structured programs that allow our employees to give back to their communities and support causes near and dear to their hearts. All employees are gifted eight hours of paid time off annually to volunteer. In addition, employees can also take part in a "Dollars for Doers" program, which encourages ample volunteerism by rewarding employees who donate their time. When employees log volunteer hours and they are validated, the employee will receive $10 in their contribution account. This contribution account can accrue up to $1,000 per year, and employees can use those funds to donate to their favorite nonprofit organization.

Fostering an Inclusive, Collaborative Culture

We foster an inclusive and collaborative culture so that all employees feel welcomed, respected, and valued for their unique perspectives. One way we facilitate this culture is through our ***Employee Engagement Groups***, which offer a formalized opportunity for employees to share ideas and perspectives, build relationships, and discuss issues relevant to their common interests, culture, and values. For example, the PRIDE resource group is currently providing input around LGBTQ+ experiences as part of cultural competency training.

Our culture — comprising our values, attitudes, beliefs, and behaviors — is the foundation that supports all that we do. Another initiative designed to strengthen company culture is ***Culture Conversations***, discussions designed to engage every employee in meaningful conversations to bring our culture to life. We will introduce a new topic each month for our Mississippi staff and provide managers with a detailed toolkit to help them facilitate conversations with their teams. Leaders will share feedback with their managers, who will then share pertinent information with the Mississippi CCO Leadership team. We will use this feedback to prioritize programs and resources that help to address the needs of our employees professionally, personally, and socially.

[END OF RESPONSE]

4.3.4.4 Emergency Preparedness Plan

Amerigroup believes that comprehensive emergency preparedness planning, coupled with continuous readiness, is integral to our responsibility as an employer, partner to the Division, and service provider to our Members, Providers, and the communities we serve. To this end, we have a comprehensive emergency response continuity of operations plan to support the MississippiCAN and CHIP Programs. This plan is applicable to multiple emergency scenarios, including but not limited to a natural disaster (for example, hurricane), pandemic, and acts of public enemy. It is a product of plans, systems, best practices, and lessons learned from our affiliates in 26 other markets, with extensive support from our national Business Continuity Management and Technology Services teams. Moreover, we look forward to incorporating any additional tools or resources offered by the Division to assure maximum emergency responsiveness to the specific needs of MississippiCAN and CHIP Members statewide.

Maintaining Communication with Members and Providers

We know that communicating promptly and effectively with our Members, Providers, and the Division is critical in an emergency. We will use numerous methods to notify Members and Providers of an impending or ongoing emergency and to inform them about accessing services during and immediately after the emergency. Depending on the nature of the disruption and its impact on Members and Providers, notifications may be communicated via:

- **Member and Provider Portals.** We may post alerts on our portals notifying Members and Providers of a service disruption and how they can access services.
- **Automated Calls, Text Messages, and Email Messages.** We can generate automated telephone calls, text messages, and emails to communicate information to our Members and Providers. Text messaging also allows us to request information from Members to determine if they have evacuated, need assistance, or in an unsafe situation. This information gathering process enabled us to identify and address Member needs during Hurricane Ida in Louisiana.
- **Personal Calls.** Our employees may make personal calls to vulnerable Members, including but not limited to those in Care Management and others likely to be impacted by the emergency (for instance, Members experiencing housing instability or residing in regions more heavily impacted by the emergency, such as the coastline during a hurricane).
- **Member and Provider Services Call Centers.** Our call centers provide up-to-date information to callers regarding how to access services.
- **Local Media and Other Outlets.** We may use local radio, television, and other means to disseminate emergency information to our Members, Providers, community-based organization partners, and other stakeholders. For instance, during the December 2021 tornadoes in Kentucky, our affiliate widely disseminated flyers and FAQ sheets to schools, shelters, state parks, and community-based organizations to make Members aware of Coordinated Care Organization (CCO) assistance during the emergency.

Regardless of the nature of the emergency, redundant operations for key functions minimizes disruption for Mississippi's Members and Providers. Our Mississippi call center will have eight hours of backup in the event of a power outage. If the Mississippi call center services are disrupted beyond eight hours, we can quickly and seamlessly route calls to another site to continue to serve our Members and Providers like our affiliate did when Hurricane Irma hit Florida. Members in the affected area continued to receive timely, accurate, and program-specific information and services. Using our call center Integrated Desktop and Knowledge Management System, representatives in other facilities will have real-time access to Mississippi covered services, eligibility, and claims data allowing them to support our MississippiCAN and CHIP Members and Providers in the event of a disruption. We will also mobilize Care Managers, Member and Provider Services staff, and clinical staff to assist Members with access to information and services before, during, and after a declared incident.

Plan for Maintaining Services in an Emergency

Maintaining Services for Our Members

Amerigroup has already developed specific disaster management operating procedures and guidelines to address the needs of Members at increased risk of healthcare disruptions and unsafe situations. These procedures and guidelines cover emergency planning, implementing the emergency plan, and considerations for recovery after the emergency. Members who reside in facility settings will follow the facility's emergency and evacuation plans.

Our proactive pre-emergency outreach strategies will include disseminating important information to Members via Care Managers and the public Member website. Care Managers will also assist at risk Members such as older adults and individuals with disabilities in developing disaster plans in the care planning process. During pre-emergency outreach, we will collect critical information to prevent disruption in needed services due to an identified event, business disruption, or emergency.

Leveraging Telehealth Capacity During Emergencies

Our Tennessee affiliate health plan has used its telehealth services, known as LiveHealth Online (LHO), to meet the needs of Members and the communities in which they reside during emergencies and disasters. Our affiliate set up LHO disaster relief services in response to tornadoes in Nashville, COVID-19 outbreaks, and the school shooting at Austin-East Magnet High School. With LHO, they were grateful to offer PH and BH services to Tennesseans impacted by these events at no cost. In times of need, we will bring these resources to Mississippi residents as well.

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Using a suite of automated reports and information from our Care Managers, we will identify high-risk Members based upon clinical and Care Management standards that are executed leading up to and refreshed through the course of the disaster or emergency. This information will then be disseminated to call centers and Care Management staff to facilitate outbound calls to the identified at risk Members to make sure the Members' needs are being met, to assist with evacuation as applicable, and make sure there is an emergency plan in place, whenever possible. Those Members with disabilities, who are older adults, or who have been identified as having specialized behavioral health needs, will be informed of additional services, including our 24-hour Behavioral Health (BH)/Substance Use Disorder (SUD) line and our 24-hour nurse advice line.

In our outreach, we will advise Members on several emergency planning strategies, as referenced in the following list. Additionally, these topics will be added to the public Member website along with further resources Members can use in preparing or responding to the disaster.

- Advising Members to gather identification papers, including Medicaid and Amerigroup ID card, in a waterproof container, in advance of a weather event
- Gathering prescriptions and other necessary medications
  - Advising the Members on early refill and co-payment waivers when applicable
  - Obtaining additional oxygen tanks, nebulizer medication, wound care supplies, etc.
- Documenting Member evacuation locations and notifying a friend or family member, in addition to Amerigroup
- Developing a backup supplies plan in case the Member must evacuate and cannot, or if the Member chooses not to evacuate:
  - Two weeks' worth of bottled water and non-perishable food, including food for service animals, as applicable
  - One month's worth of medications and incontinence supplies
  - Flashlights, batteries, a battery powered radio, a solar-powered battery for phone charging, and other emergency essentials
- Assisting Members with advice on open and accessible shelters and notifying the Division and the Department of Human Services if a Member is evacuated to a local shelter with the assistance of Amerigroup Care Managers

  - High-risk Members will be contacted to make sure they are sheltering safely. If needed, and safe to do so, non-emergency transportation will be arranged for evacuation.
- Work with local Area Agencies on Aging and Centers for Independent Living to make sure we are finding and connecting Members to accessible shelters and supporting any concerns relating to ADA access, service animal refusal, and other barriers to safety and stability

Our goal is to assure continuity of care until the Member's living situation stabilizes. We will initiate Automated Voice Response System calls post-emergency to advise Members of needed information and our availability. Additionally, we will post up-to-date information related to shelters, disaster assistance, and availability of services on the Amerigroup website.

Our Care Managers and Member Services Call Center Representatives will undertake the following steps to assist Members in need, including:

- Assisting Members in locating Providers, whether within or out of Amerigroup's network
- Providing transportation assistance and helping transfer care from one Provider to another in a non-affected area
- Working collaboratively with new Providers to provide reimbursement via single case agreements when necessary, and to provide authorizations for medically necessary services
- Replacing lost, stolen, or damaged durable medical equipment (DME)
- Helping share Member information from our Health Insight platform so that Members can share their health histories with caregivers and other support systems

Care Managers will re-contact their assigned Members as the crisis evolves to confirm they are safe and coordinate delivery of services as needed.

Maintaining Services to Our Providers

Our Providers will be critical to our ability to continue services to our Members in an emergency. Recognizing the importance of the Provider Portal as the primary means to communicate with Providers, we will update the Amerigroup website and Provider Portal with information related to emergency processes. The portal will be the preferred method of Provider communications during times directly before, during, and after an emergency. The portal will be updated as new information is received. The following information will be shared on the Provider Portal:

- Members will not require a referral to seek primary or specialty care
- Emergency services will not require authorization
- Medical advice and assistance available through the 24-hour nurse advice line
- Reminders of online urgent care solution emergency room consultation services and telehealth restriction waivers that will enable Members to receive services
- How to verify Member eligibility in the absence of an ID card
- Reminder of Amerigroup's Member medical record accessibility
- Advice accessible through the 24-hour BH/SUD line
- 24/7 urgent Provider numbers and national customer service numbers
- Authorization guidelines for in- and out-of-network services, including the waiver of:
  - Prior Authorizations
  - Suspension of administrative denials for failure to submit timely clinical justification
  - Ability to accept verbal clinical information
  - Reminder of authorization web portals and fax capabilities
  - Requirements for notifications of admission

- Medical necessity requirements
- Dates of waiver
- Listing of affected areas
- Claim submission time frames

Our Provider Services staff will begin outreaching to affected areas' hospitals and Providers, including physical and mental health, substance use, and specialty care. Other key Providers will include dialysis, DME, and home health agencies.

Our Mississippi CCO leaders for contracting and network development will share which Providers are operational and available for service to our Member Services staff, transportation vendors, Care Management, and Amerigroup's 24-hour nurse advice line partners to aid in facilitation of needed services for affected membership. Behavioral health Providers that have been recruited and trained will be made available to local shelters. We will share this information with the Division.

Additionally, our contracting staff will negotiate single case agreements with Providers in- or out-of-state or out-of-network areas to assure continuity of Member care. Care Management and Health Services staff will be available to assist PCPs and specialty Providers with Member medical information, authorizations, pharmacy, lab, and Care Management treatment plans.

Plan for Maintaining Staffing in an Emergency

Staff Training

Effective and efficient response to any type of emergency or business disruption requires that employees in Mississippi and our national shared services areas understand their roles and responsibilities. Our employees will be prepared to:

- Maintain and update the components of our contingency plans
- Perform emergency tasks
- Designate off-site crisis meeting places and implement crisis communications plans

Amerigroup's required Employee Safety program, Business Continuity Management plan, and Emergency Management program will be available to all employees on our internal website, as will the phone numbers for the Emergency Reporting Hotline, Global Security Operations Center, Corporate Security, Corporate Risk Management, and Corporate Facilities Services. Online courses will be available to all employees, including one on employee safety and emergency response procedures, focusing on the actions employees should or should not take in emergencies. Instructions for evacuations and sheltering in place, managing power failures, fire or smoke, bomb threats or crimes in progress, suspicious packages, severe weather, and earthquake are always available on the employee site and in our in-house Quick Action Guide.

Managing Outages of Employees, Facilities, and Vendors

Amerigroup's contingency plans will go into effect immediately with any disruptive event. Our business continuity-disaster recovery (BC-DR) plan is scenario-neutral to address any situation that disrupts normal operations. If circumstances require assistance from outside Mississippi, we can reach out to our Medicaid affiliates in the Central region (Arkansas, Indiana, Iowa, Louisiana, Minnesota, Tennessee, West Virginia, and Wisconsin) or, if necessary, to our affiliates in the East or West regions.

The Mississippi Management and Local Emergency Response Teams (LERT) will immediately notify the Corporate Incident Response team of the situation and its expected duration. They will also update the National Employee Emergency Information number so employees at any location can get the most current information

related to work and unit functionality. In general, the LERT will continue to assess, inform, plan, and implement work continuity during these events.

People Unavailable. If a local event affects large numbers of employees, the LERT will determine the resources required for business functionality and match business needs to available personnel skill sets. We will use an updated list of all employees to determine who can work, evaluate impact and capacity, and to determine whether temporary or permanent staff are required. They will also determine training needs required to fill any gaps in business function. The LERT is authorized to develop a backlog reduction program using overtime, interim site capability, work redistribution, or any other appropriate method to manage workloads.

Facility Unavailable. For an event such as a fire, flood, or damage to a building, the Mississippi Management and LERT will quickly develop messaging for employees and convey that information to the Corporate Incident Response team. Together, those teams will assess the duration of the facility outage. They will then activate the employee call tree. If necessary, they will compile information about which employees are available to travel to other sites. The primary focus of the LERT in this scenario is redistribution of employees according to need and skill set, with consideration of what training, lodging, transportation, and work materials may be required at interim locations. Finally, the team will begin planning for return to the permanent work site at the time it is expected to be available again.

Vendor Unavailable. When a vendor is unable to work, the LERT will follow a protocol similar to an employee outage, remaining in contact with the vendor for status updates. They will identify the resource gap and any deviation from standard procedures that might be required or alternative vendors for the duration of the primary vendor's unavailability.

Restoration of Daily Operations. Restoring day-to-day operations as quickly as possible will be critical. Our BC-DR plan will include access to a substantial workspace recovery capability using a combination of resources, including network redirection of work, our national organization's worksite recovery capacity, mobile recovery resources, and secure satellite connectivity for voice and data.

[END OF RESPONSE]