
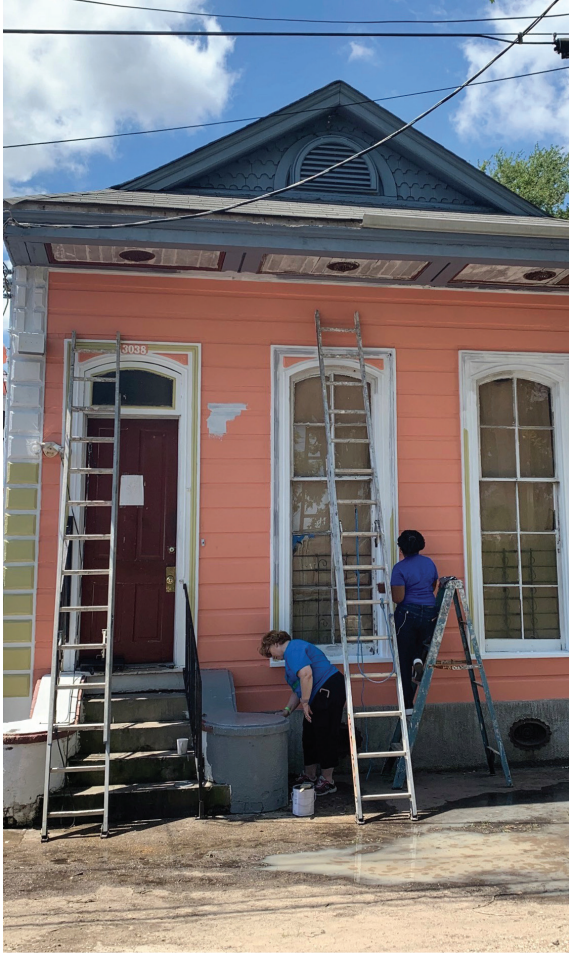


Request for Proposals for Louisiana Medicaid Managed Care Organizations

# REDACTED COPY

## Business and Technical Response

from Community Care Health Plan of Louisiana, Inc., dba Healthy Blue

RFP #: 3000017417

Response Deadline: September 10, 2021 3:00 P.M. (CT)

Healthy Blue

Healthy Blue

"The data contained in pages listed below of the proposal have been submitted in confidence and contain trade secrets and/or privileged or confidential information and such data shall only be disclosed for evaluation purposes, provided that if a contract is awarded to this Proposer as a result of or in connection with the submission of this proposal, the State of Louisiana shall have the right to use or disclose the data therein to the extent provided in the contract. This restriction does not limit the State of Louisiana's right to use or disclose data obtained from any source, including the Proposer, without restrictions."

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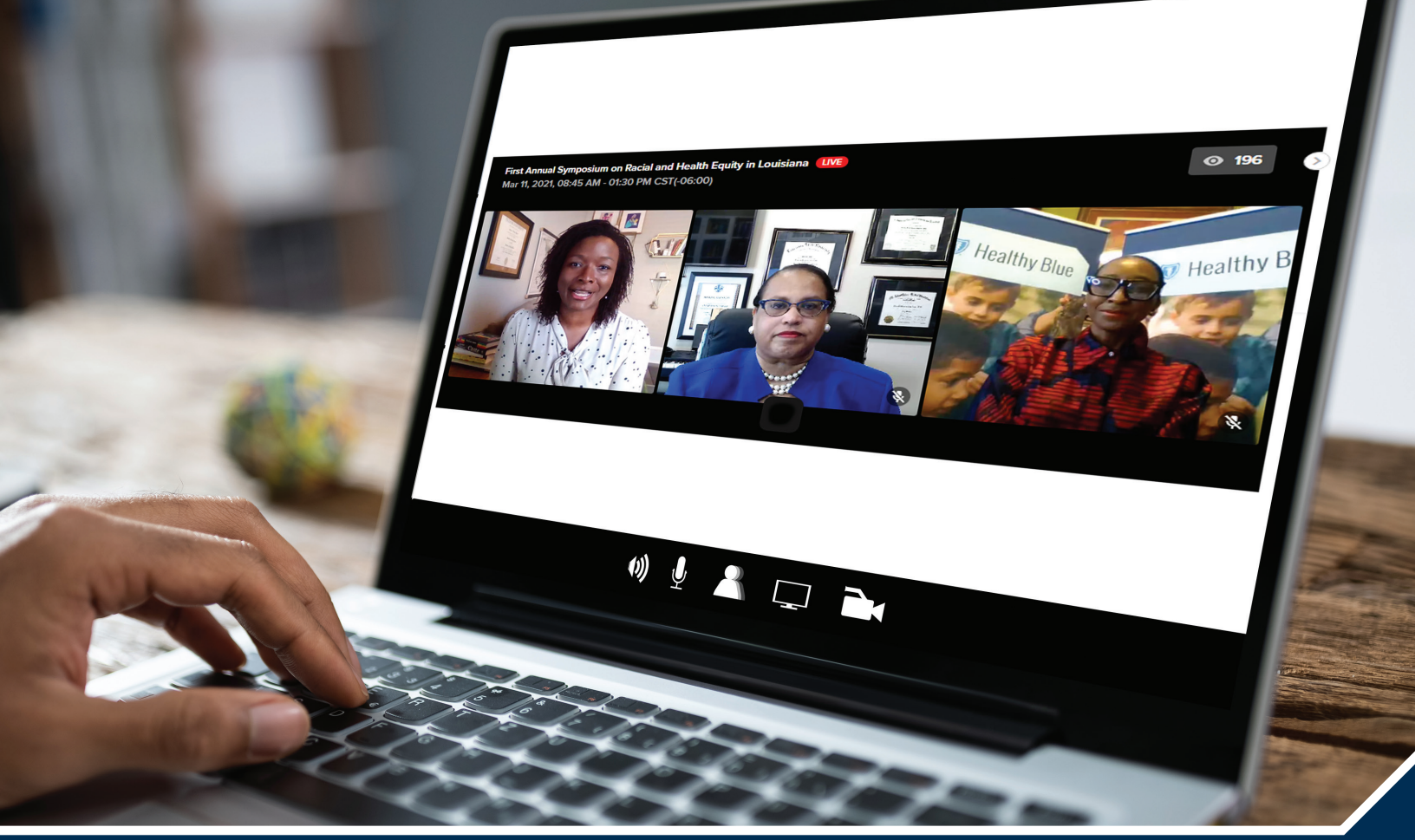


### Promoting Health and Racial Equity in Louisiana

Healthy Blue teamed up with the Louisiana Public Health Institute (LPHI) to launch the inaugural Symposium on Racial and Health Equity in March 2021 with the theme of "Partnerships in Action: Collectively Achieving Racial Equity to Improve the Health of Our Community." At the conclusion of the Symposium, LPHI and Healthy Blue offered participants the opportunity to join a coalition dedicated to ending institutional racism in Louisiana. Healthy Blue will continue this commitment by sponsoring the first Racial Equity Learning Lab later this year.

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## 2.4.1 Proposal Cover Letter



## 2.5 Business Proposal



### Business Proposal Attachments



## 2.6 Technical Proposal

## Technical Proposal Attachments



## 4.4 Veteran and Hudson Initiatives Response

## Building Community and Rebuilding Homes

Healthy Blue sponsored Rebuilding Together's Second Annual Build and Boil event. This event is a fundraiser, a community party, and a volunteer opportunity, bringing people from all over New Orleans together. The Build and Boil event supports Rebuilding Together's mission to improve the quality of life for low-income homeowners in New Orleans, especially homeowners who are elderly, disabled, veterans, or single heads of households with minor children. With Healthy Blue's help, this event raised over $28,000, boiled almost 1,000 pounds of crawfish for the community, and aided five local homeowners.

# 2.4.1

Cover Letter

Healthy Blue

September 2, 2021

Ali Bagbey
Louisiana Department of Health
628 N. Fourth Street
Baton Rouge, LA 70802

RE: Proposal Response to Louisiana Department of Health's Request for Proposals (RFP) #: 3000017417 for Louisiana Medicaid Managed Care Organizations

Dear Ali Bagbey:

Community Care Health Plan of Louisiana, Inc., dba Healthy Blue (Healthy Blue) is pleased to submit our response to RFP #: 3000017417 for Louisiana Medicaid Managed Care Organizations (MCOs). As a current MCO administering services for Healthy Louisiana enrollees, we appreciate the opportunity to continue our long-standing partnership with the Louisiana Department of Health (LDH). As you will see in our proposal response, we have continued to bring the highest quality services, latest innovations, and best practices to Louisiana. We look forward to assisting LDH in improving the lives of the people we serve. Healthy Blue provides the following statements and certifications:

2.4.1.1 Healthy Blue currently has over 230 full-time personnel located across the state. Our headquarters are located at 10000 Perkins Rowe, Ste. G-510, Baton Rouge, LA 70810. Our Louisiana Health Service and Indemnity Company dba Blue Cross and Blue Shield Louisiana (BCBSLA) office is located at 5525 Reitz Avenue Baton Rouge, LA 70808-9029.

2.4.1.2 Our corporate principal office registered with the Louisiana Secretary of State is 10000 Perkins Rowe, Ste. G-510, Baton Rouge, LA 70810. Healthy Blue's website URL is healthybluela.com. Our CEO and principal officer's, Christy Valentine's, contact information is (504) 836-8850 or christy.valentine@healthybluela.com.

2.4.1.3 Healthy Blue issues checks from our administrative office at 10000 Perkins Rowe, Ste. G-510, Baton Rouge, LA 70810.

2.4.1.4 Healthy Blue has conducted business previously as Amerigroup Louisiana, Inc.

2.4.1.5 Healthy Blue is privately held, with the following entities holding 5% interest or more in the organization: Anthem Partnership Holding Company, LLC (75%) and BCBSLA (25%).

2.4.1.6 Healthy Blue operates as a domestic, for-profit corporation organized in the State of Louisiana. Our ultimate parent organization, Anthem, Inc., is a for-profit, publicly traded organization organized in Indiana. Through a joint venture with Anthem, BCBSLA is also an equity owner in Healthy Blue. BCBSLA is a Louisiana non-profit corporation.

2.4.1.7 Healthy Blue operates from the State of Louisiana. We are not an out-of-state Proposer.

2.4.1.8 With the exception of Dr. Christy Valentine, Healthy Blue's CEO, Healthy Blue does not have any current employees who are or were previously employed with State Agencies within the past two years. As required by the MCO Contract, Healthy Blue obtained LDH's prior approval of Dr. Valentine's employment as CEO on February 25, 2021. Dr. Valentine worked for the Louisiana Office of Community Preparedness until June 30, 2020, and has had the privilege of working on the Louisiana State Board of Examiners as a Governing Board Member since 2014.

2.4.1.9 Healthy Blue's federal tax identification number is 26-4674149. Our LAGov vendor number is 310066542, and our Louisiana Department of Revenue number is 1356211.

[redacted]

[redacted]

Thank you for considering our proposal. Should you have questions, do not hesitate to contact me by phone at (504) 836-8850 or email me at christy.valentine@healthybluela.com. We look forward to speaking with you.

Sincerely,

Christy Valentine, MD, MBA
Healthy Blue Chief Executive Officer

# Attachment 2.2.1-1: Secretary's Certification and Board Resolution

Attachment 2.2.1-1 includes the following:

- Attachment 2.2.1-1a: Secretary's Certification
- Attachment 2.2.1-1b: Board Resolution

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SECRETARY'S CERTIFICATE

I, the undersigned, certify that I am the duly elected and acting Secretary of Community Care Health Plan of Louisiana, Inc., a Louisiana corporation (the "Corporation"), and that, as such, I am authorized to execute and deliver this Certification on behalf of the Corporation.

I further certify that Christy Valentine is the duly elected President and Chief Executive Officer of the Corporation and that as President and Chief Executive Officer, and consistent with the Corporation's policies and bylaws, has the signatory authority to bind the Corporation.

IN WITNESS WHEREOF, the undersigned has duly executed and delivered this Certificate as of the 16th day of August 2021.

X

Kathleen S. Kiefer, Secretary
Community Care Health Plan of Louisiana, I...

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**WRITTEN CONSENT IN LIEU OF A**
**MEETING OF THE BOARD OF DIRECTORS OF**
**COMMUNITY CARE HEALTH PLAN OF LOUISIANA, INC.**

March 8, 2021

Removal and Election of Officer

**The undersigned, representing all of the members of the Board of Directors (the "Board") of Community Care Health Plan of Louisiana, Inc., a Louisiana corporation (the "Corporation"), acting by unanimous written consent in lieu of a meeting, hereby consent to the adoption of and adopt the following resolutions as resolutions of the Board of the Corporation:**

**WHEREAS**, the Board has determined that it is in the best interest of the Corporation to remove Aaron A. Lambert as President, Chairperson and Chief Executive Officer and elect Dr. Christy Valentine as his successor; and

**NOW, THEREFORE, BE IT RESOLVED**, that Aaron A. Lambert is hereby removed as President, Chairperson and Chief Executive Officer of the Corporation effective March 8, 2021; and

**FURTHER RESOLVED**, that Dr. Christy Valentine hereby elected as President, Chairperson and Chief Executive Officer of the Corporation effective March 8, 2021, to fill the vacancy created by the removal of Aaron A. Lambert, to serve until the next annual meeting of the Board of the Corporation, or until her resignation, removal, or death.

**The foregoing corporate action shall take effect as of the date first above written and shall have the same force, effect, and validity as though taken by the Board at a meeting duly called and legally held, and the Secretary is hereby directed to place a fully executed copy of this Written Consent in the Minute Book of the Corporation. This Written Consent may be executed in counterparts.**

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Cheryll Bowers-Stephens

DocuSigned by:
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Bryan R. Camerlinck

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Sheldon Faulk
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Sheldon Faulk

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Darrell Langlois
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Darrell S. Langlois

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Ron Penczek
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Ronald W. Penczek

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Neil C. Steffens

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Christy Valentine
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Dr. Christy Valentine

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Jack Young
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Jack L. Young

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### Protecting Our Community from COVID-19

Along with local organizations like 100 Black Women, Healthy Blue collaborated with Walgreens to make vaccines accessible to every eligible patient in our community. Healthy Blue hosted a mobile health equity clinic at the Capital Area Transit System terminal, giving transit riders twelve and older the opportunity to receive the vaccine. As an added incentive to vaccinate, Healthy Blue arranged for the first 100 families to the event to receive fresh produce and protein boxes from Top Box Louisiana.

### Encouraging Healthy Lifestyles Through the Bike Library Program

The SWLA Center for Health Services (SWLA Center) rolled out a new bike fleet funded by Healthy Blue. The bike library launched in July of 2019 and consists of 20 bikes and safety helmets. It is a great opportunity for families to spend a few hours outside to make the first steps toward a healthier lifestyle. Community members visit the Fitness Center at the SWLA Center in Lake Charles to check out a bike and then hit the road. Bikes are free of charge to the community, and they are intended for short-term recreational rides. On June 29, 2021, a local high school track team took advantage of the guided bike ride. Healthy Blue and SWLA Center remain committed the communities they serve.

## 2.5.1 Mandatory Qualifications

Community Care Health Plan of Louisiana, Inc., dba Healthy Blue (Healthy Blue) meets all Mandatory Qualifications, as demonstrated in this section. Where applicable, we have provided the appropriate documentation to support our compliance.

### 2.5.1.1 Meets the Federal Definition of an MCO

Healthy Blue affirms that we meet the federal definition of an MCO, as defined in 42 CFR §438.2. Additionally, we have been continuously licensed as an HMO in Louisiana since 2011 and operational since 2012.

### 2.5.1.2 Healthy Blue Has the Capacity to Perform All Functions

Healthy Blue has the capacity and willingness to perform all functions in this RFP and the Model Contract. We have successfully served Louisiana enrollees (members) and families since 2012 and will continue to meet and exceed applicable Contract requirements. We currently serve 343,000 Medicaid members, and our health plan includes more than 600 Medicaid employees who make Healthy Louisiana's goals central to our organizational mission. Our experienced, local team constantly drives towards simplification and has a history of delivering on commitments. We pride ourselves on being easy to do business with, demonstrated by nine years of successful service in Louisiana Managed Medicaid, more than 27,000 provider and community partnerships, and more than 150 letters of support.

As a partner to the Louisiana Department of Health (LDH), Healthy Blue fully understands the requirements and obligations of our Contract and the operational commitment necessary to meet it. Compliance is an essential part of our culture, and we work continuously to meet federal and State regulations as well as LDH's expectations, requirements, and standards.

Our capacity to serve Louisiana goes beyond performing functions of the RFP — Healthy Blue is committed to improving the health and lives of Louisianians. Backed by the strength of a joint venture between our two parent companies, Anthem, Inc. (Anthem) and Blue Cross and Blue Shield of Louisiana (BCBSLA), we bring a powerful alliance that offers a premier health solution to Medicaid members and a well-established local presence that members recognize and trust. Our local, community-based approach to administering services, coupled with the support and knowledge of our affiliates serving Medicaid members in 24 other markets, enables us to bring lessons learned and best practices to meet the needs of Healthy Louisiana members. We tailor innovative solutions to assist LDH in their goals and objectives. We demonstrate our value and commitment to serving members and performing all functions in the RFP, Model Contract, and MCO Manual throughout our proposal response.

### 2.5.1.3 Healthy Blue Is Not an Excluded Entity

Healthy Blue operates as an MCO and is not an excluded entity as described in 42 CFR §438.808(b).

### 2.5.1.4 Healthy Blue Has Nine Years of Experience as a Louisiana MCO

Since 2012, Healthy Blue has operated as an MCO serving Louisiana's Medicaid managed care program. In addition to our experience as a Medicaid MCO in Louisiana, our affiliate health plans have served Medicaid managed care programs since 1991. Together, we currently serve more than 9.7 million Medicaid members across 25 markets, including our newest markets North Carolina and Puerto Rico. Our affiliate was also recently awarded a contract in Ohio and will begin serving members in January of 2022.

### 2.5.1.5 Recent Contract Awards (Within the Last 36 Months)

We are part of an organization that is one of the nation's largest providers of healthcare for publicly funded programs. Many of our affiliates' programs operate in states with Medicaid managed care populations exceeding 1.5 million enrollees.

Over the last 36 months, our affiliates were awarded contract renewals in Indiana, West Virginia, and Nevada. In addition, our affiliate in Ohio was recently awarded a new contract. In Table 2.5.1.5-1, we have included the markets in which there are more than 1.5 million Medicaid members.

*Table 2.5.1.5-1. Medicaid Managed Care Markets with more than 1.5 Million Members*

| Medicaid Market | Membership |
|---|---|
| California | 11.3 million |
| New York | 5.7 million |
| Texas | 4.7 million |
| Florida | 3.8 million |
| Ohio | 2.7 million |
| New Jersey | 1.8 million |
| Georgia | 1.8 million |
| Washington | 1.7 million |
| Louisiana | 1.7 million |
| Virginia | 1.6 million |
| Indiana | 1.5 million |
| North Carolina | 1.5 million |
| Tennessee | 1.5 million |

### 2.5.1.6 Principal Place of Business Inside the U.S.

Our innovative approaches to address everyday needs are developed locally to meet the unique needs and goals of each member, in collaboration with the providers and communities we serve.

Healthy Blue's principal place of business and headquarters is in the State of Louisiana. Our headquarters are located at 10000 Perkins Rowe, Ste. G-510, Baton Rouge, LA 70810.

[redacted]

# 2.5.2

Conflict of Interest

CONFIDENTIAL

Healthy Blue

## 2.5.2 Conflict of Interest

Healthy Blue recognizes and complies with LDH's requirements regarding conflict of interests, including Model Contract, Section 6.10 (Warranty of Removal of Conflict of Interest). We currently comply with all applicable federal, State, and Contract requirements related to conflicts of interest and will continue to do so. Neither Healthy Blue nor any of our subcontractors have any interest that will conflict with performance of services required under this RFP.

Healthy Blue fully understands the necessity of avoiding, identifying, and effectively mitigating potential conflicts of interest related to our operations. We use well-established conflict of interest safeguards applicable to all employees, subcontractors, and other business partners. Our strict Code of Business Conduct and Ethics obligates employees to:

- Comply with all applicable laws, rules, and regulations related to operations
- Act in an honest manner at all times
- Report any suspected or observed misconduct, including violations of law, policy, or procedure
- Make full and timely disclosure of any situation that may result in a conflict of interest or the appearance of a conflict
- Conduct themselves in a manner that avoids actual or apparent conflict of interests
- Decline gifts, payments, fee services, discounts, valuable privileges, or other favors which would or might appear to improperly influence performance
- Attend our "Do the Right Thing" code of conduct training and complete attestation annually

### 2.5.2.1 Healthy Blue's Signed Proposer's Certification

Healthy Blue has included a signed **Exhibit A**, Certification Statement, with attestations requested in Sections 2.5.2.1, 2.5.2.2, and 2.5.2.3. Our statement attests that no interest will conflict in any manner or degree with the performance required under the Contract, and that Healthy Blue does not have any financial, legal, contractual, or other business interest in LDH's Enrollment Broker or Contractor, or in such vendors' subcontractors.

### 2.5.2.2 Healthy Blue's Signed Proposer's Certification

Healthy Blue has included a signed **Exhibit A**, Certification Statement, with attestations requested in Sections 2.5.2.1, 2.5.2.2, and 2.5.2.3. Our certification attests that no interest will conflict in any manner or degree with the performance required under the Contract, and that neither Healthy Blue, nor our material subcontractors, has any financial, legal, contractual, or other business interest in LDH's Enrollment Broker or Contractor, or in such vendors' subcontractors.

### 2.5.2.3 Healthy Blue's Signed Proposer's Certification

Healthy Blue has included a signed ***Exhibit A***, Certification Statement, with attestations requested in Sections 2.5.2.1, 2.5.2.2, and 2.5.2.3. Our certification attests that Healthy Blue agrees to submit any additional information requested by LDH that may be relevant to our financial, legal, contractual, or other business interests, as they relate to the RFP and Contract.

### 2.5.2.4 Statement on Financial, Legal Contractual, and Other Business Interests

Healthy Blue does not have any financial, legal, contractual, or other business interests, nor do our subcontractors, affiliates, partners, parents, or related entities, that would affect or impact our performance under the Contract.

Healthy Blue relies on affiliated companies for certain administrative services (e.g., claims payment support); however, our parent companies, Anthem, Inc. and BCBSLA, ensure these arrangements are structured and numerous safeguards are in place to prevent potential conflicts of interest.

Through our strict Code of Business Conduct and Ethics, we promote a culture of trust and accountability. The Code's section on conflict of interest covers disclosure procedures, personal financial interests, family and personal relationships, outside employment and other activities, and friends or family working in the industry.

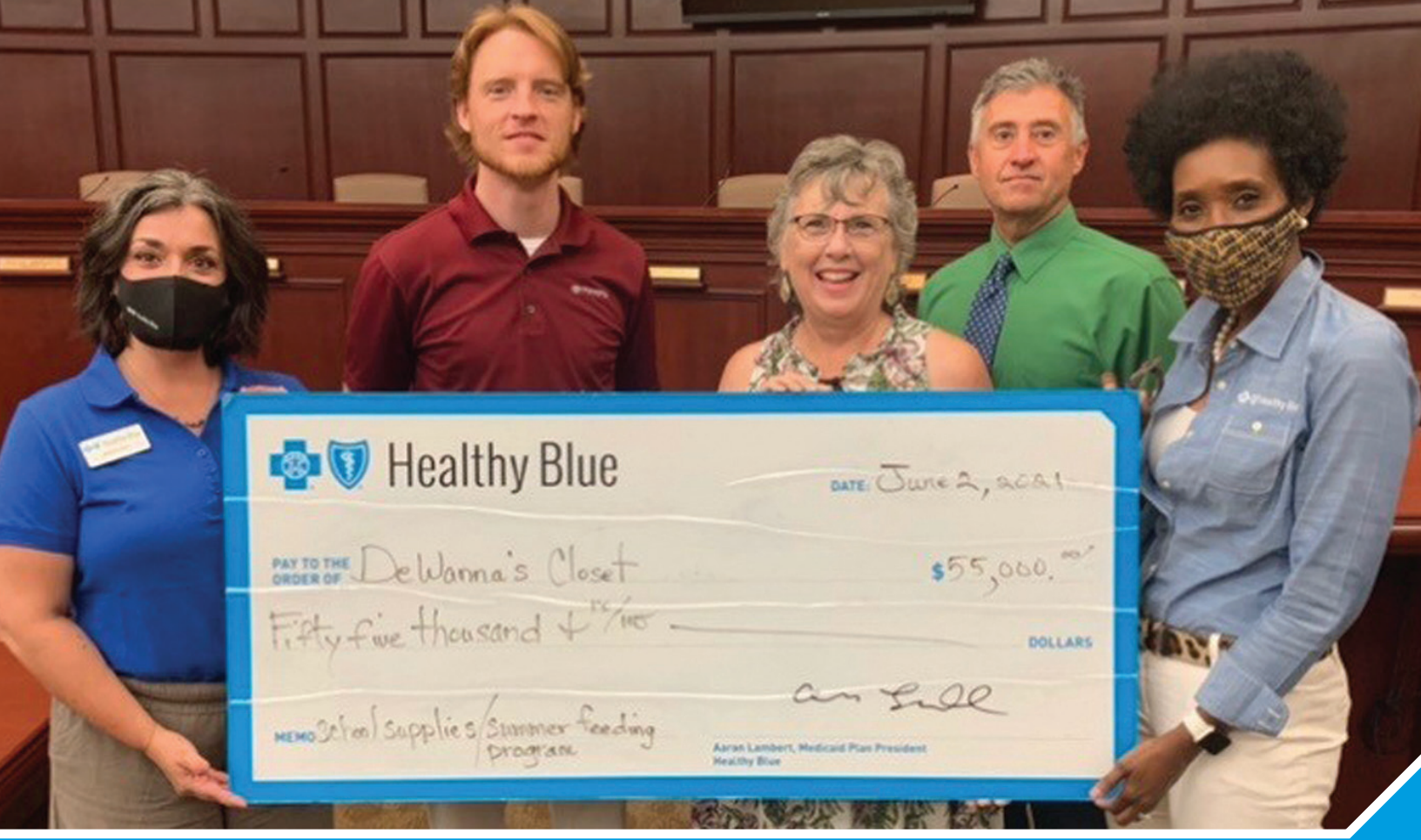
We maintain a conflict of interest policy and procedure to make sure all employees act in the best interest of our organization and avoid conflicts. New and rehired employees must complete a conflict of interest attestation to certify there are no potential conflicts. If employees have a change in status, they must complete the attestation again within 30 days of the change.

Through our Supplier Code of Conduct, we mandate that vendors, contractors, and subcontractors comply with these standards, business practices, and regulatory requirements while conducting business on our behalf. Within our Supplier Code of Conduct, we outline and require subcontractors to confirm they will avoid the appearance of and actual conflicts of interest.

Our Ethics and Compliance team researches and investigates potential conflicts to determine if a conflict exists and takes appropriate steps to resolve them. If we learn of any potential conflict of interest or appearance of a potential conflict of interest — whether identified by us, LDH, providers, or another party — we investigate the root cause, mitigate the conflict, and prevent recurrence. We immediately report identified conflicts to LDH. We embrace transparency, open communication, and continued dialogue across our health plan and with LDH, so we can continue to meet the expectations of LDH, providers, and individuals we serve.

### 2.5.2.5 Other Relevant Information Related to Interests

Neither Healthy Blue nor our material subcontractors have any additional information relevant to our financial, legal, contractual, or other business interests as they relate to the RFP and Contract.




**Working with DeWanna's Closet to Address Food Insecurity Among Youth**

DeWanna's Closet (DC) understands that food insecurity can wreak havoc on a community, especially our youth. DC wanted to start a weekend food program for school-aged kids, and Healthy Blue's grant has given them the jumpstart to pursue the endeavor. Educators within Calcasieu Parish Schools identify students whom they feel may lack consistent nutrition over the weekend. The educators make a confidential referral to DC, who will prepare and supply a nutritional food package that the students can easily transfer from school to home.

# 2.5.3

## Moral or Religious Objections

Healthy Blue

## 2.5.3 Moral or Religious Objections

### 2.5.3.1 and 2.5.3.2 Statement of Attestation

Healthy Blue offers a comprehensive array of services that improve healthcare access and quality for our enrollees. We have reviewed the provisions in the Model Contract, Part 2, Services, and do not have any objections on the basis of moral or religious grounds to providing MCO Covered Services.


**Working with Christian Service of Shreveport to Offer Vaccinations to the Community**

Christian Service of Shreveport is a transitional home for men and women that operates a daily soup kitchen and assists with rent, utilities, and other services. Healthy Blue's partnership with them was established in 2013, and together, we host an annual health fair on-site. This year, however, due to the low vaccination rates in Louisiana, we partnered with David Raines Community Health Centers on Wednesday, July 21, to offer vaccinations at their facility.

# 2.5.4

## Material Subcontractors

Healthy Blue

## 2.5.4 Material Subcontractors

While we use material subcontractors to support the delivery of or payment for covered services under the Healthy Louisiana Contract, Healthy Blue acknowledges total responsibility for the entire Contract.

### 2.5.4.1 Single Point of Contact

Healthy Blue has identified our subcontractor relationships in Table 2.5.4.2-1. Healthy Blue agrees to remain the single point of contact for all subcontractors supporting the Healthy Louisiana Contract covered services.

### 2.5.4.2 Use of Material Subcontractors

Healthy Blue will continue to use material subcontractors to support our delivery of or payment for covered services under the Healthy Louisiana Contract. Table 2.5.4.2-1 identifies the legal name, program area or function, address, and telephone number of each material subcontractor.

*Table 2.5.4.2-1. Healthy Blue Material Subcontractors*

| Subcontractor Legal Entity Name | Function | Address | Telephone Number |
|---|---|---|---|
| **AIM** | Utilization management for some services, including high-tech radiology, nuclear stress testing, and therapy (OT, PT, and speech) services | 8600 West Bryn Mawr Avenue<br>Chicago, IL 60631 | (847) 564-8500 |
| **Anthem, Inc. (Anthem)** | Administrative and support services, including information technology; enrollment; claims processing; Third Party Liability; fraud, waste, and abuse; Member and Provider call services; Encounters; Utilization Management; legal; compliance; regulatory; and finance | 220 Virginia Avenue<br>Indianapolis, IN 46204 | (732) 452-6001 |
| **IngenioRx, Inc. (IngenioRx), with its subcontractor, Outcomes Incorporated dba OutcomesMTM (Outcomes MTM)** | IngenioRx will oversee medical drug management including medical injectable drug policy/criteria development and review of medical injectable prior authorizations, as well as continue to provide pharmacy clinical quality programs, including through their vendor OutcomesMTM | 450 Headquarters Plaza, East Tower, 7th Floor<br>Morristown, NJ 07960 | (833) 419-0530 |
| **Superior Vision Benefit Management, Inc. (Superior Vision)** | Vision services | 939 Elkridge Landing Road<br>Linthicum, MD 21090 | (800) 243-1401 |

As requested, we provide additional information about our material subcontractors in the following sections of the technical proposal:

- 2.6.2.2.3 – Staff Experience and Org Structure
- 2.6.5.4 – Health Equity
- 2.6.11.8 – Quality
- 2.6.13.3 – Claims Management and Systems and Technical Requirements
- 2.6.13.4 – Claims Management and Systems and Technical Requirements

### 2.5.4.3 Provided Exhibit B, Material Subcontractor Response Template

Healthy Blue has provided a completed ***Exhibit B***, Material Subcontractor Response Template and the respective agreement for each of the material subcontractors identified in Table 2.5.4.2-1 as Attachment 2.5.4.3-1: Exhibit B - Material Subcontractor Response Template and Agreement.

### 2.5.4.4 Signed Exhibit A, Certification Statement

We have attached the requested signed attestation for Section 2.5.4.4 as ***Exhibit A***.

The Proposer, Community Care Health Plan of Louisiana, Inc., dba Healthy Blue (Healthy Blue), certifies that it acknowledges and complies with the statements as written in Exhibit A.

Additionally, Healthy Blue certifies that it acknowledges and complies with the statements as written in the sections of the RFP pertaining to Material Subcontractors, specifically:

- 2.5.2 – No interest will conflict in any manner or degree with the performance required under the Contract.
- 2.5.2.1 – Healthy Blue does not have, nor do any of Healthy Blue's subcontractors have, any financial, legal, contractual, or other business interest in LDH's Enrollment Broker Contractor, or in such vendor's subcontractors, if any.
- 2.5.2.3 – Healthy Blue agrees to submit any additional information requested by LDH that, in LDH's judgment, may be relevant to Healthy Blue's financial, legal, contractual, or other business interests as they relate to the RFP and Contract.
- 2.5.4.4.1 – Healthy Blue acknowledges that it will not be relieved of any legal obligations under any Contract resulting from this RFP as a result of any contracts with subcontractors, that it shall be fully responsible for the subcontractor's performance, and that all partnership agreements, subcontracts, and other agreements or arrangements for reimbursement will be in writing and will contain terms consistent with all terms and conditions of the Contract.
- 2.5.4.4.2 – Healthy Blue acknowledges that proposals to use subcontractors shall not cause any additional administrative burden on LDH as a result of the use of multiple entities.
- 2.5.4.4.3 – Healthy Blue acknowledges that unless provided for in the contract, we shall not contract with any other party for any of the services provided for therein without the express prior written approval of LDH.


## Creating Bike- and Pedestrian-friendly Communities Through the Stroll into Safety Program

The Stroll into Safety program educates children, caregivers, and community members about the importance of pedestrian and bicyclist skills, the rules of the road, personal safety, and improving health and environmental conditions. This program is designed to bring attention to bike and pedestrian safety issues in the Greater Baton Rouge Area to create safer and more bike- and pedestrian-friendly communities. The program offers classroom presentations, bike rodeos, safety towns, community education events, and bike/pedestrian school events.

## 2.5.5 Financial Condition

### 2.5.5.1 Demonstrating Sound Financial Condition

Healthy Blue has shown exceptional capacity for growth and the financial stability necessary to successfully partner with LDH since we began serving Louisianans nine years ago. Healthy Blue has remained well-funded throughout our time serving Louisiana members. We anticipate funding increases in capital requirements through income from operations. In the event funding increases do not occur, we have additional support and backing from our parent companies, Anthem and BCBSLA, strongly positioning us to continue to support the Healthy Louisiana program.

As of December 31, 2020, Healthy Blue held over [redacted] in total cash and invested assets. Our statutory net worth was [redacted] which demonstrates a strong financial position with a risk-based capital (RBC) ratio of [redacted] significantly exceeding the LDH requirement of 200% of ACL or $108 million. [redacted] This bond meets the requirements of the Model Contract, Section 4.17.1.

We further demonstrate our financial capacity to meet LDH's requirements in Table 2.5.5.1-1.

[redacted]

Both of our parent companies, Anthem and BCBSLA, are financially strong organizations that provide Healthy Blue with financial backing. Anthem provides necessary financial support through access to capital markets, and we leverage Anthem's financial strength and resources. In 2020, Anthem's combined authorized control level, risk-based capital (ACL RBC) ratio across its insurance and HMO operating subsidiaries was on average approximately 498%. As of December 31, 2020, Anthem held ***$1.7 billion*** in cash and investments.

In 2020, BCBSLA's RBC ratio was 977%, almost five times the federal and State requirements. As of December 31, 2020, BCBSLA held over $2.4 billion in cash and invested assets. BCBSLA recently received its 24th consecutive "A" rating from Standard and Poor's, the world's foremost provider of benchmarks for measuring corporate financial health.

### 2.5.5.1.1 Audited Financial Statements

Healthy Blue has included the requested audited financial statements for the last three years for the Proposer, Community Care Health Plan of Louisiana, Inc. (dba Healthy Blue), and parent organizations Anthem and BCBSLA.

Table 2.5.5.1.1-1 provides the name and type of each entity and attachment name containing the financial statements.

*Table 2.5.5.1.1-1. List of Audited Financial Statements for Requested Entities*

| Entity Name | Entity Type | Attachment Name |
|---|---|---|
| **Healthy Blue (CCHPLA)** | Proposer | Attachment 2.5.5.1.1-1a |
| **Anthem** | Proposer's Ultimate Parent Organization, Substantial Owner (Indirect), and Material Subcontractor | Attachment 2.5.5.1.1-1b |
| **BCBSLA** | Proposer's Substantial Owner (Direct) | Attachment 2.5.5.1.1-1c |


**Supporting Back-to-school Efforts by Donating School Supply Kits**

Healthy Blue will donate more than 6,000 school supply kits this summer to youth across the state to support back-to-school efforts and learning. Since 2016, Healthy Blue has donated more than 30,000 school supply kits to local youth in Louisiana.

# 2.5.6

## Required Forms and Certifications

Healthy Blue

## 2.5.6 Required Forms and Certifications

Healthy Blue has completed and included the following required forms and certifications with our submission:

- Exhibit C – Proposal Compliance Matrix
- Exhibit A – Certification Statement
- Exhibit D – Medicaid Ownership and Disclosure Form

**Exhibit C: Proposal Compliance Matrix**

| | |
|---|---|
| **RFP #:** | 3000017417 |
| **Proposer:** | Community Care Health Plan of Louisiana, Inc., dba Healthy Blue |

| RFP Section | Requirement | Proposal Section | Proposal Page(s) |
|---|---|---|---|
| 2.4 | Table of Contents | Table of Contents | 1-2 |
| 2.4.1 | Cover Letter | 2.4.1 | 1-2 |
| **Business Proposal – Section 2.5** | | | |
| 2.5.1 | Mandatory Qualifications | 2.5.1 | 1 |
| 2.5.2 | Conflict of Interest | 2.5.2 | 2 |
| 2.5.3 | Moral or Religious Objections | 2.5.3 | 3 |
| 2.5.4 | Material Subcontractors | 2.5.4<br>2.5.4.3-1 | 4-5<br>i-351 (Exempt) |
| 2.5.5 | Financial Condition | 2.5.5<br>2.5.5.1.1-1 | 1 (Exempt)<br>i-1,767 (Exempt) |
| 2.5.6 | Required Forms and Certifications: | | |
| 2.5.6.1 | ✓ Proposal Compliance Matrix | 2.5.6 | 1-2 (Exempt) |
| 2.5.6.2 | ✓ Certification Statement | 2.5.6 | 3-4 (Exempt) |
| 2.5.6.3 | ✓ Medicaid Ownership and Disclosure Form | 2.5.6 | 5-58 (Exempt) |
| **Technical Proposal – Section 2.6** | | | |
| 2.6.2 | Proposer Organization and Experience: | | |
| 2.6.2.1 | ✓ Proposer Organization | 2.6.2.1<br>2.6.2.1.3 | 6-7<br>202-231 |
| 2.6.2.2 | ✓ Proposed Staff Qualifications and Organizational Structure | 2.6.2.2<br>2.6.2.2.2-1<br>2.6.2.2.3-1 | 8-13<br>232-239<br>240-243 |
| 2.6.3 | Enrollee Value-Added Benefits | 2.6.3 | 14-28 |
| 2.6.4 | Population Health | 2.6.4 | 29-40 |
| 2.6.5 | Health Equity | 2.6.5 | 41-52 |
| 2.6.6 | Care Management | 2.6.6 | 53-66 |
| 2.6.7 | Case Scenarios | 2.6.7 | 67-111 |
| 2.6.8 | Network Management | 2.6.8 | 112-120 |
| 2.6.9 | Provider Support | 2.6.9 | 121-132 |
| 2.6.10 | Utilization Management | 2.6.10 | 133-147 |
| 2.6.11 | Quality | 2.6.11<br>2.6.11.5-1<br>2.6.11.7-1<br>2.6.11.8-1 | 148-161<br>i-28 (Exempt)<br>1-2 (Exempt)<br>1-2 (Exempt) |
| 2.6.11.6 | Quality Response Template | 2.6.11.6 | 1-2 |
| 2.6.12 | Value-Based Payment | 2.6.12 | 162-171 |
| 2.6.13 | Claims Management and Systems and Technical Requirements | 2.6.13 | 172-181<br>1-30 (Exempt) |
| 2.6.14 | Program Integrity | 2.6.14 | 182-191 |
| 2.6.15 | Physical & Specialized Behavioral Health Integration Requirements | 2.6.15 | 192-201 |
| **Veteran and Hudson Initiative Programs Participation – Sections 1.44 and 4.4** | | | |
| 4.4 | Veteran and Hudson Initiatives Response | 4.4<br>4.4-1 (USB) | 1 (Exempt)<br>1-3 (Exempt) |

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# EXHIBIT A: CERTIFICATION STATEMENT

The undersigned hereby acknowledges she/he has read and understands all requirements and specifications of the Request for Proposals (RFP), including attachments.

**OFFICIAL CONTACT.** The State requests that the Proposer designate one person to receive all documents and the method in which the documents are best delivered. The Proposer should identify the Contact name and fill in the information below: (Print Clearly)

| | |
|---|---|
| Official Contact Name: | Christy Valentine |
| E-mail Address: | christy.valentine@healthybluela.com |
| Facsimile Number with area code: | (225) 763-2180 |
| US Mail Address: | 10000 Perkins Rowe, suite G-510 Baton Rouge, LA 70810 |

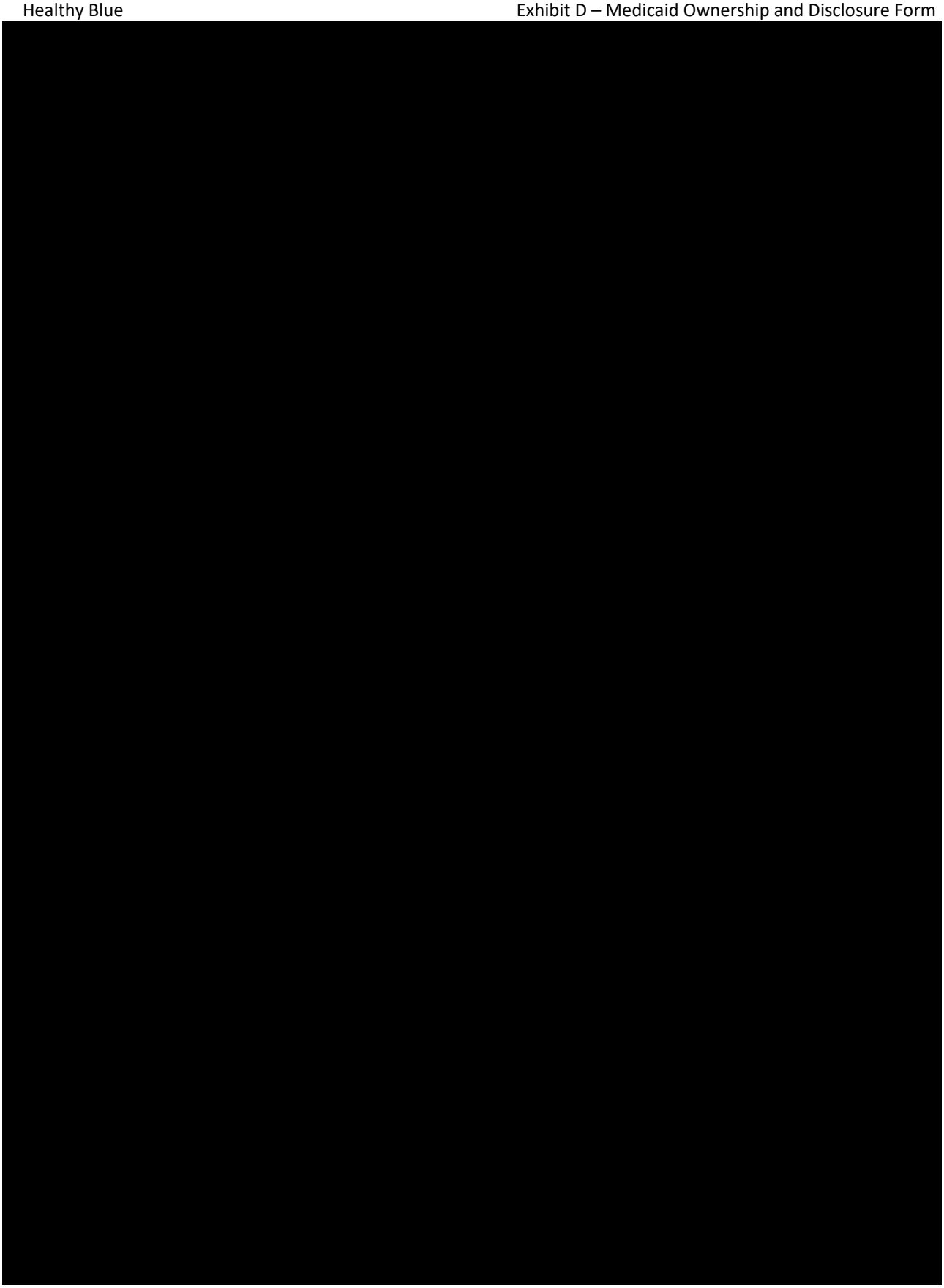
Proposer shall certify that the above information is true and shall grant permission to the State or Agencies to contact the above named person or otherwise verify the information provided.

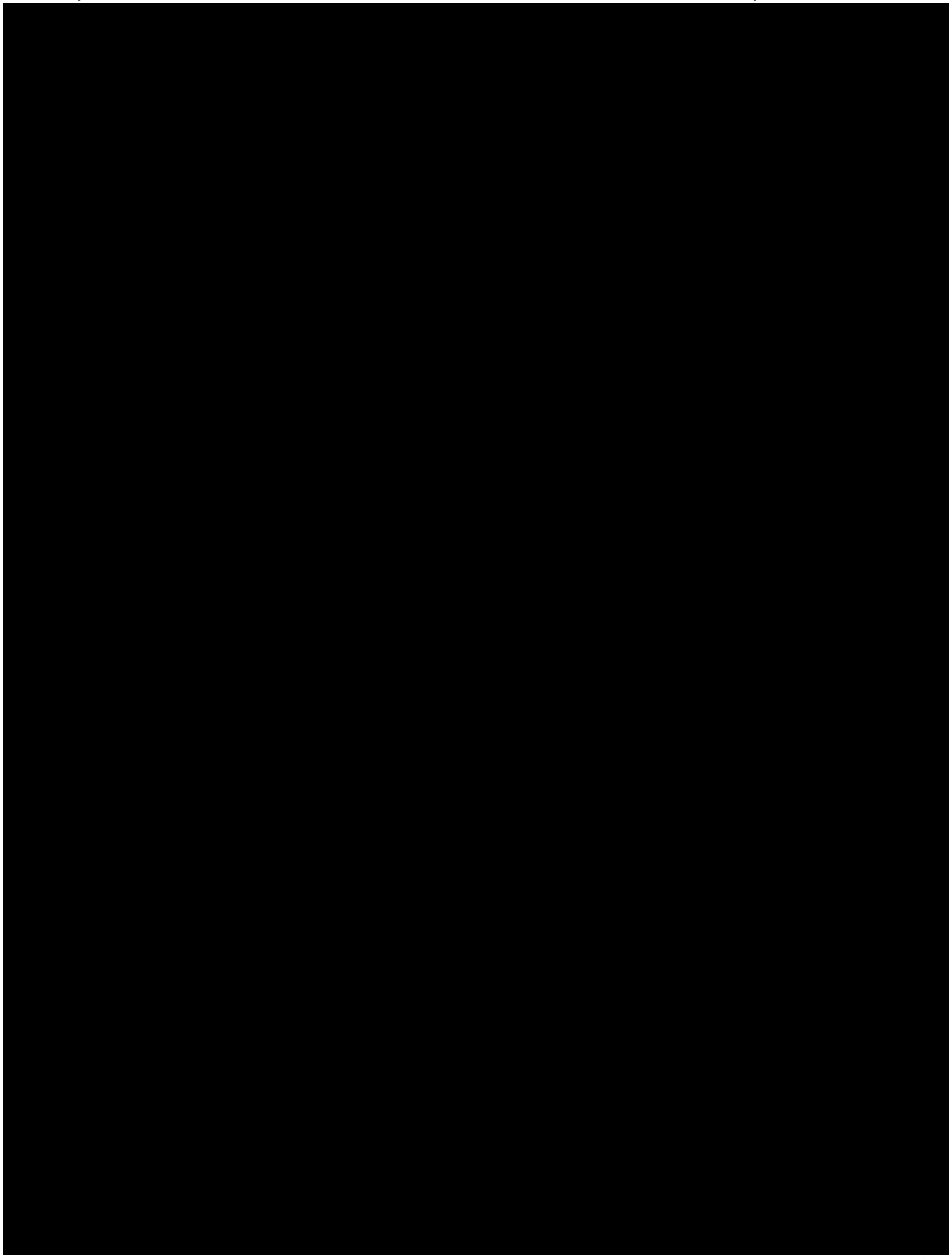
By its submission of this proposal and authorized signature below, Proposer shall certify that:

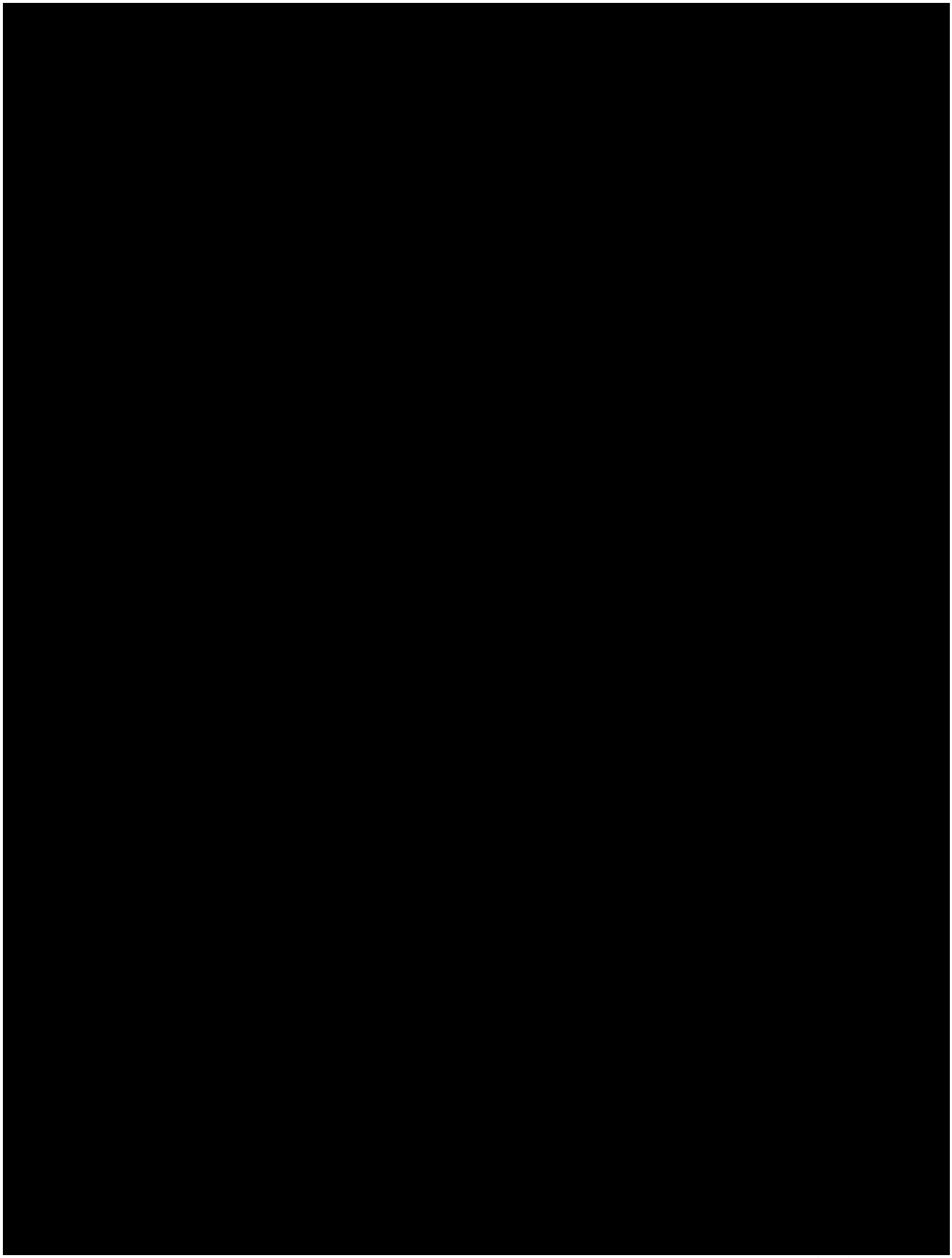
1. The information contained in its response to this RFP is accurate and all copies are correct and complete.
2. Proposer shall comply with each of the mandatory requirements listed in the RFP and will meet or exceed the functional and technical requirements specified therein.
3. Proposer shall accept the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP.
4. Proposer agrees to submit any additional information requested by LDH that, in LDH's judgment, may be relevant to the Proposer's financial, legal, contractual, or other business interests as they relate to the RFP and contract.
5. Proposer does not have any financial, legal, contractual, and other business interest that will conflict in any manner or degree with the performance required under the contract.
6. Proposer does not have, nor does any of the Proposer's Material Subcontractors have, any financial, legal, contractual or other business interest in LDH's Enrollment Broker or in such vendor's subcontractors, if any.
7. Proposer acknowledges it will not be relieved of any legal obligations under any contract resulting from this RFP as a result of any contracts with subcontractors, that it shall be fully responsible for the subcontractor's performance, and that all partnership agreements, subcontracts, and other agreements or arrangements for reimbursement will be in writing and will contain terms consistent with all terms and conditions of the contract.
8. Proposer acknowledges that proposals to use subcontractors shall not cause any additional administrative burden on LDH as a result of the use of multiple entities.
9. Unless provided for in the contract, the Proposer shall not contract with any other party for any of the services provided for therein without the express prior written approval of the Department
10. Proposal shall be valid for at least ninety (90) Calendar Days from the date of proposer's signature below.

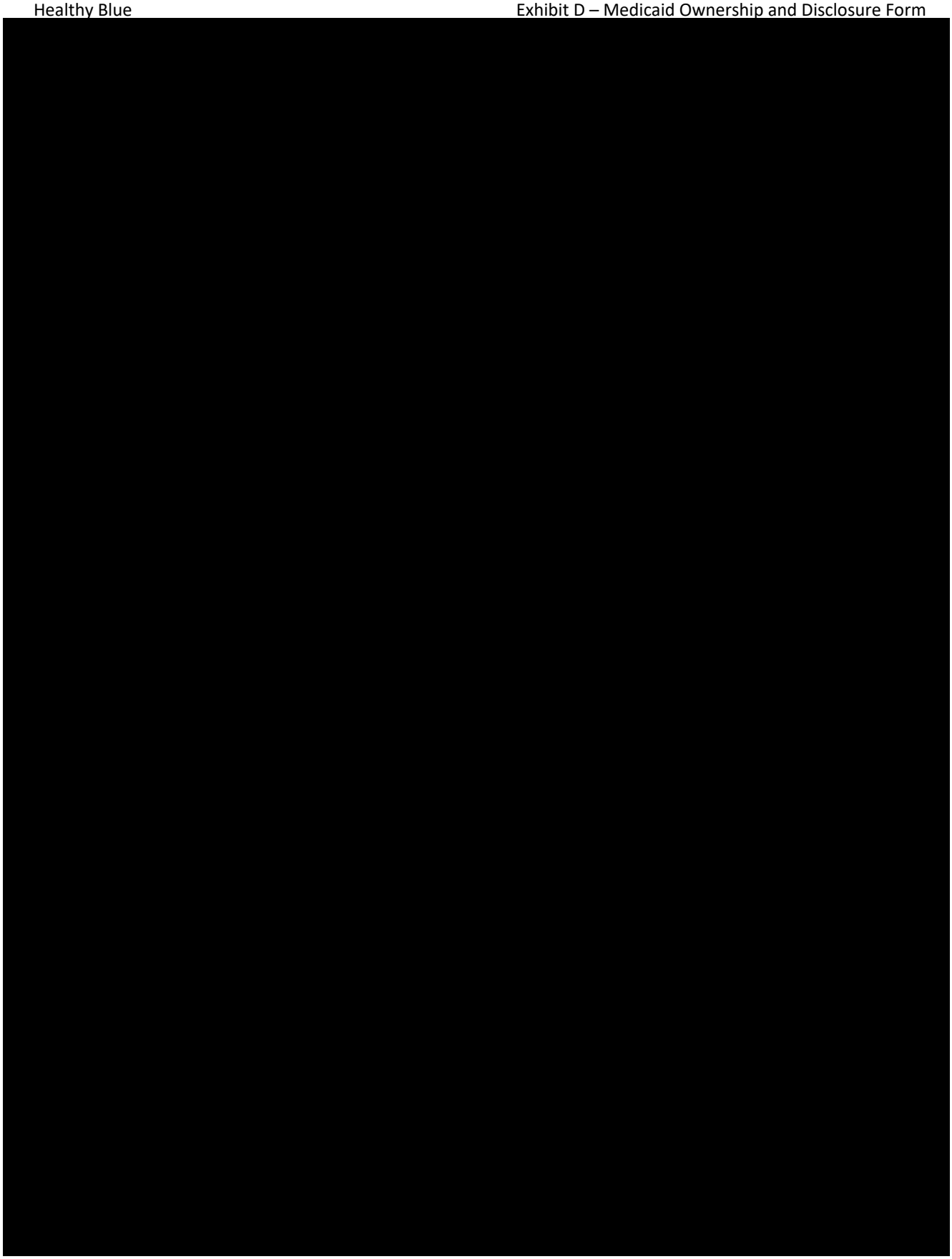
11. Proposer understands that if selected as the successful Proposer, he/she will have twenty (20) Calendar Days in which to complete contract negotiations and twenty (20) Calendar Days from the date of delivery of final contract in which to execute the final contract document.
12. Proposer shall certify, by signing and submitting a proposal for $25,000 or more, that their company, any subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in 2 CFR §200 Subpart F. (A list of parties who have been suspended or debarred can be viewed via the internet at https://www.sam.gov.)
13. Proposer understands that, if selected as a contractor, the Louisiana Department of Revenue must determine that it is current in the filing of all applicable tax returns and reports and in payment of all taxes, interest, penalties, and fees owed to the State and collected by the LDR. Proposer shall comply with La. R.S. 39:1624(A)(10) by providing its seven-digit LDR account number in order for tax payment compliance status to be verified.
14. Proposer further acknowledges its understanding that issuance of a tax clearance certificate by LDR is a necessary precondition to the approval of any contract by the Office of State Procurement. The contracting agency reserves the right to withdraw its consent to any contract without penalty and proceed with alternate arrangements, should a prospective contractor fail to resolve any identified outstanding tax compliance discrepancies with the LDR within seven (7) days of such notification.
15. Proposer certifies and agrees that the following information is correct: In preparing its response, the Proposer has considered all proposals submitted from qualified, potential subcontractors and suppliers, and has not, in the solicitation, selection, or commercial treatment of any subcontractor or supplier, refused to transact or terminated business activities, or taken other actions intended to limit commercial relations, with a person or entity that is engaging in commercial transactions in Israel or Israeli-controlled territories, with the specific intent to accomplish a boycott or divestment of Israel. Proposer also has not retaliated against any person or other entity for reporting such refusal, termination, or commercially limiting actions. The State reserves the right to reject the response of the Proposer if this certification is subsequently determined to be false, and to terminate any contract awarded based on such a false response.
16. Proposer certifies that its proposal was independently arrived at without collusion.

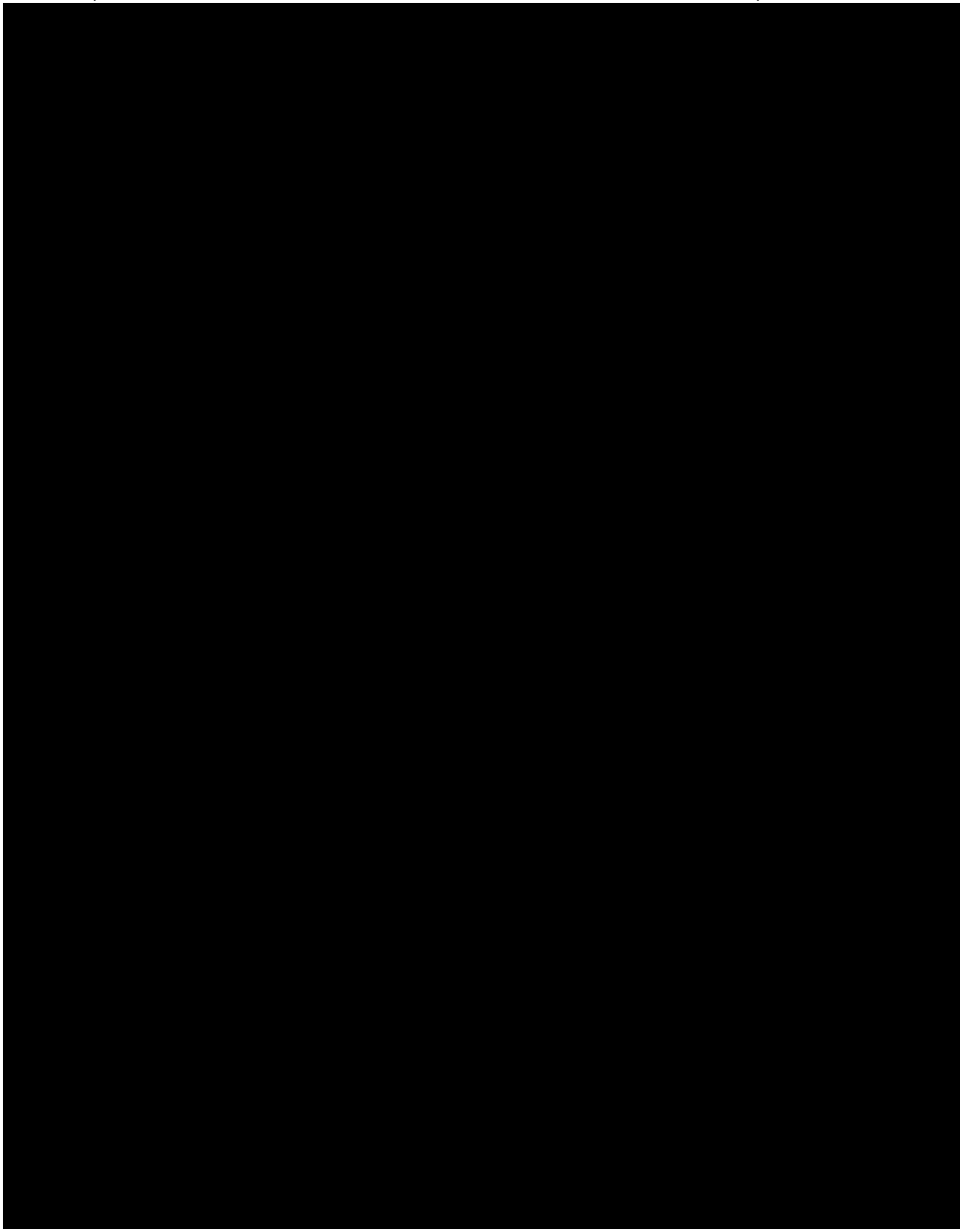
| | |
|---|---|
| Signature of Proposer or Authorized Representative: |  |
| Typed or Printed Name: | Christy Valentine |
| Date: | 9/2/2021 |
| Title: | Chief Executive Officer |
| Company Name: | Community Care Health Plan of Louisiana, Inc. (Vendor #: 310066542) (LDR #: 1356211) |
| Address: | 10000 Perkins Rowe, suite G-510 |
| City: | Baton Rouge |
| State: | LA |
| Zip: | 70810 |

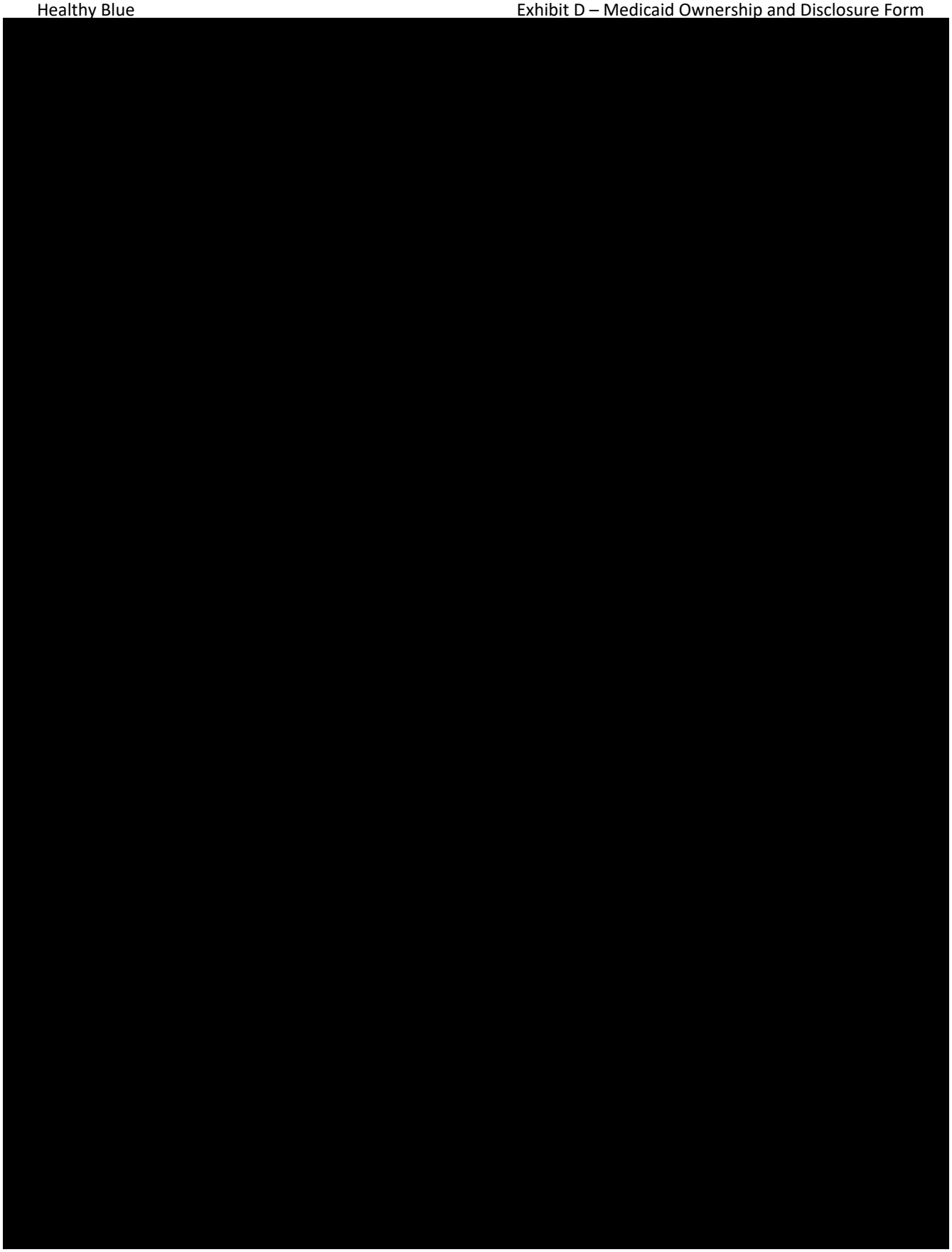


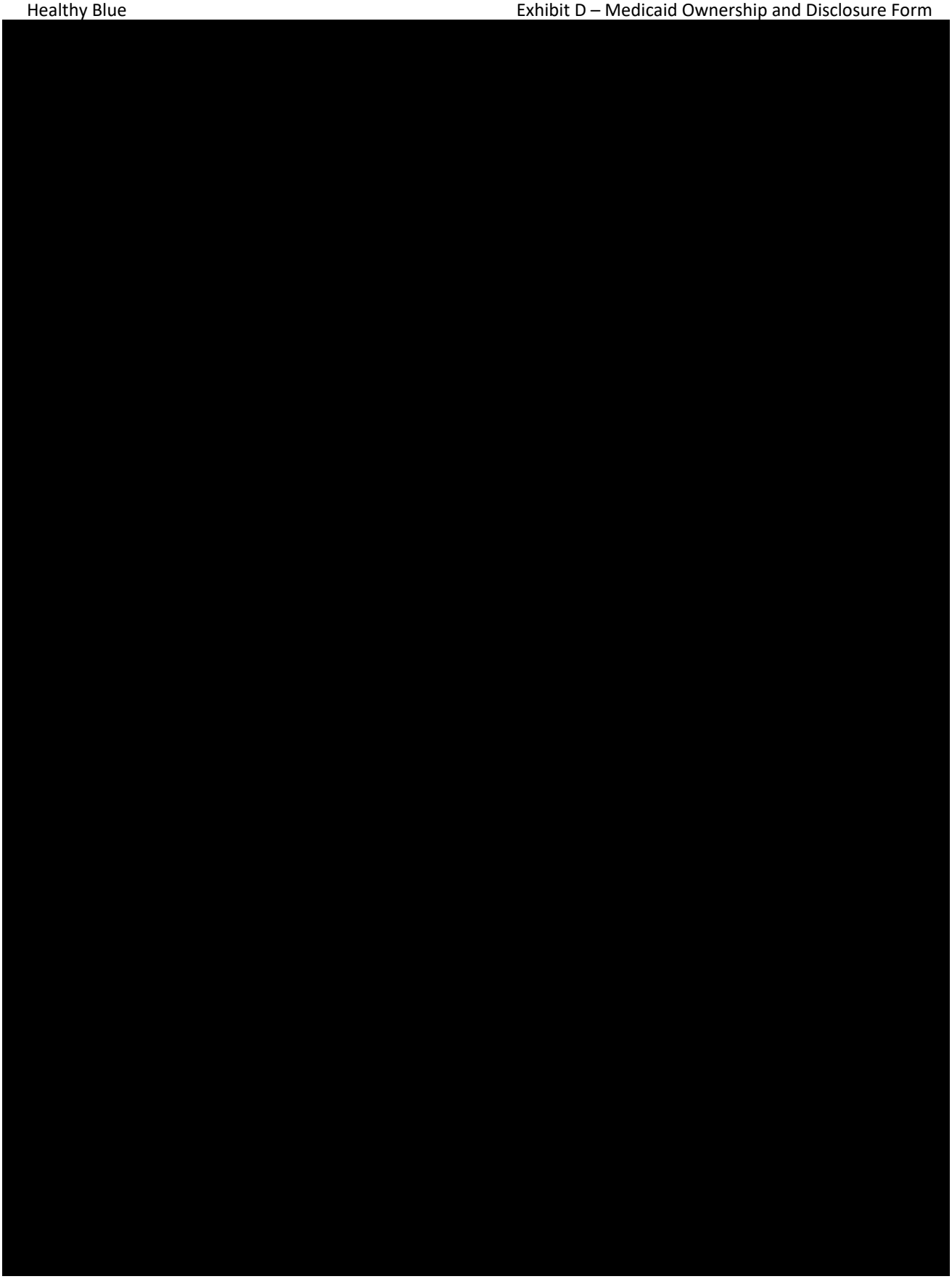


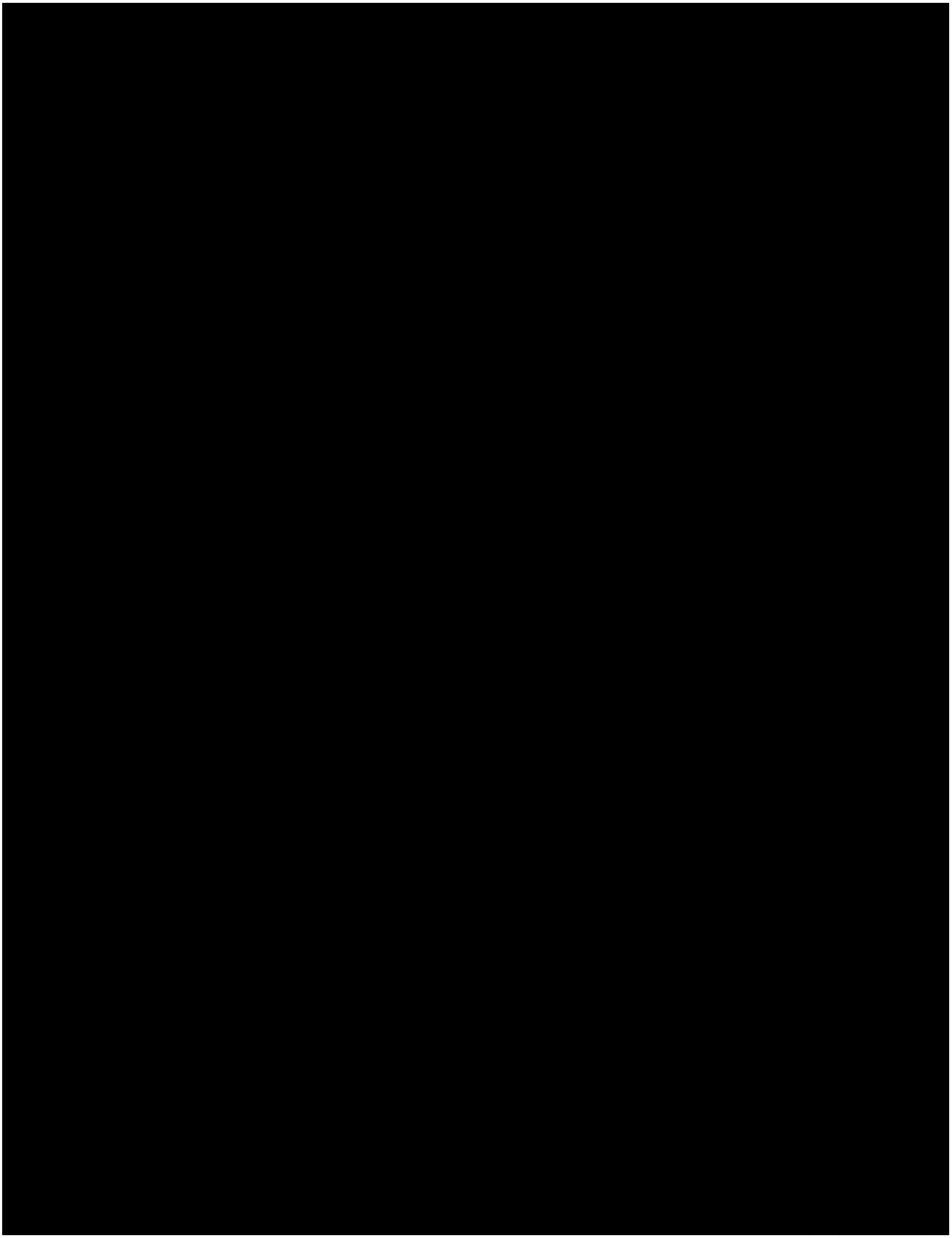


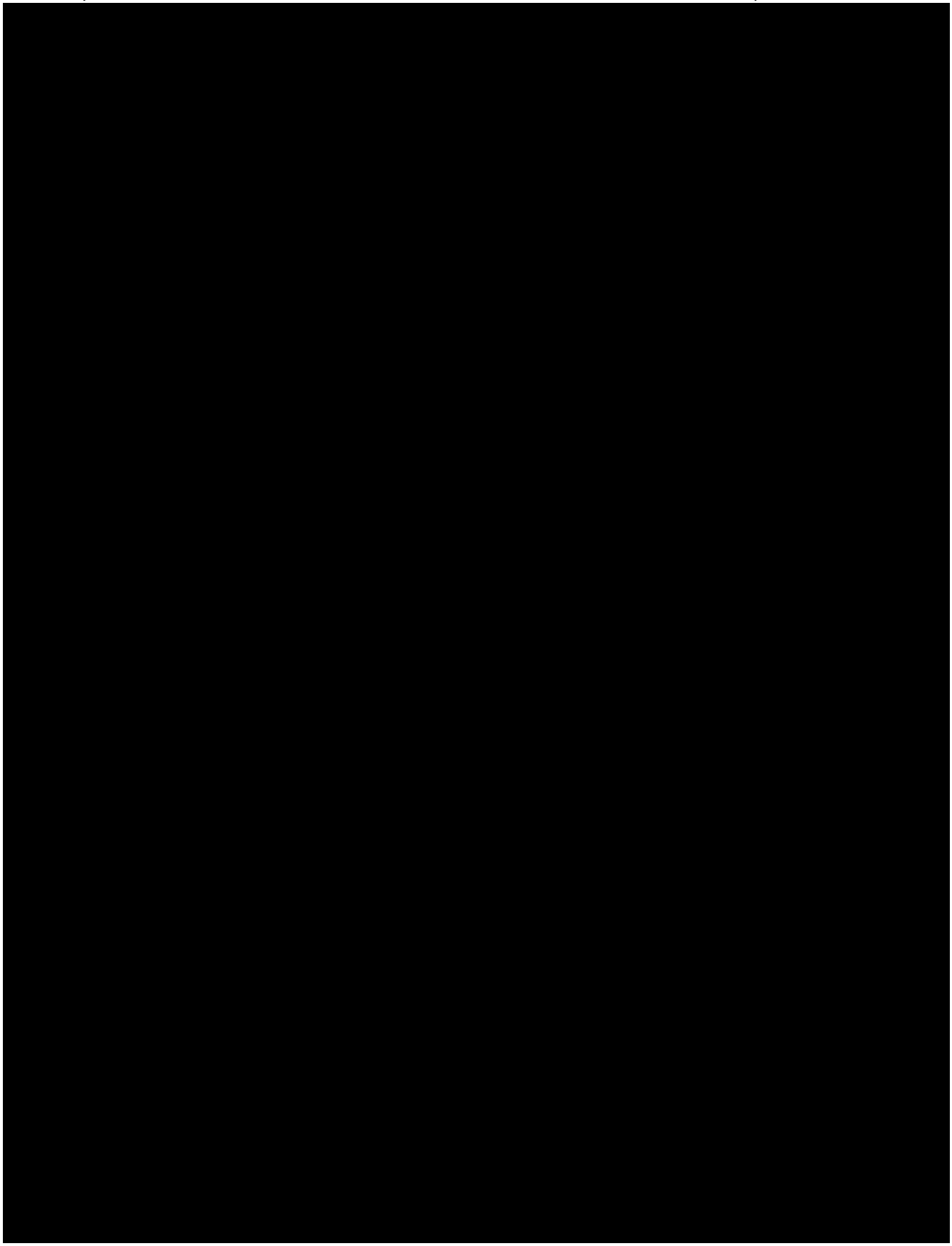


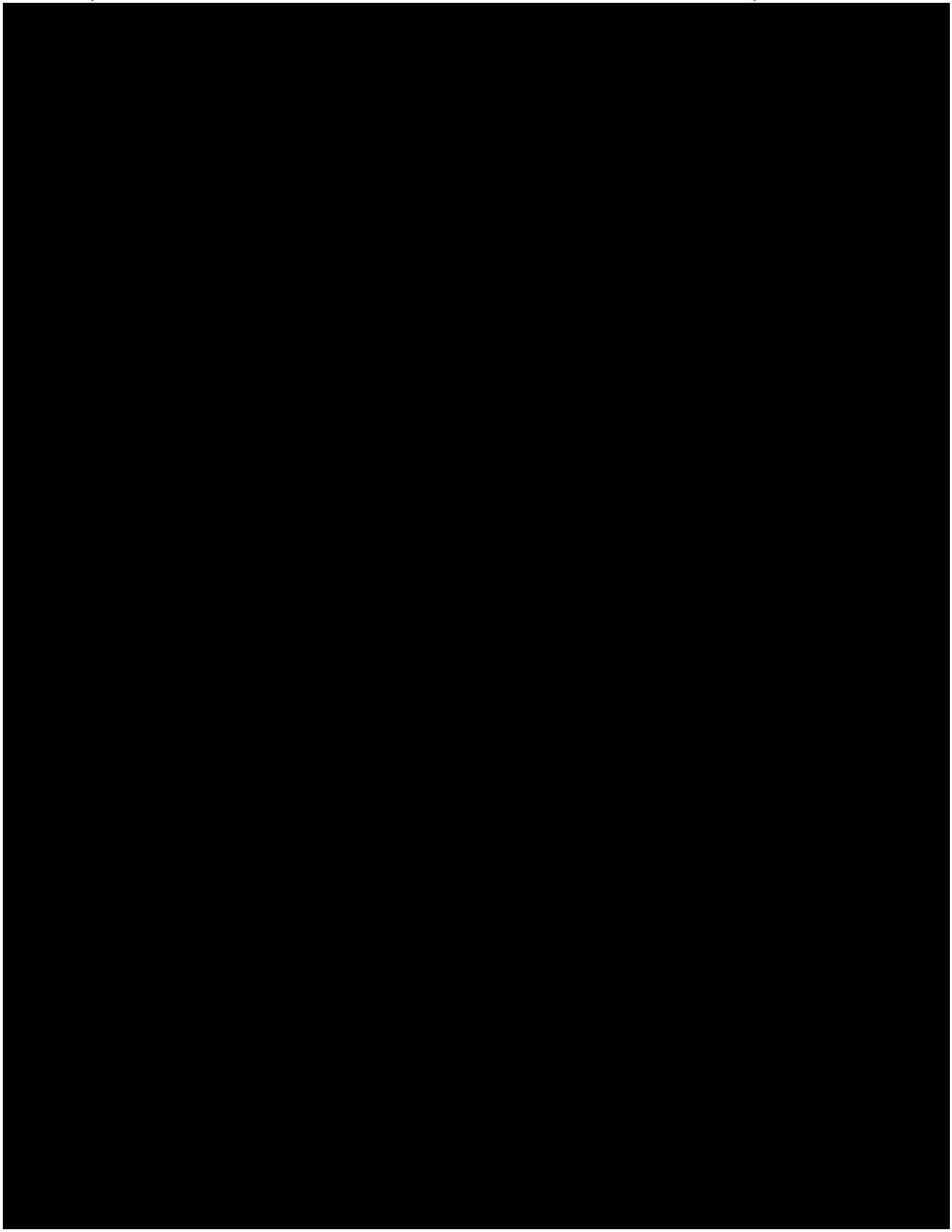


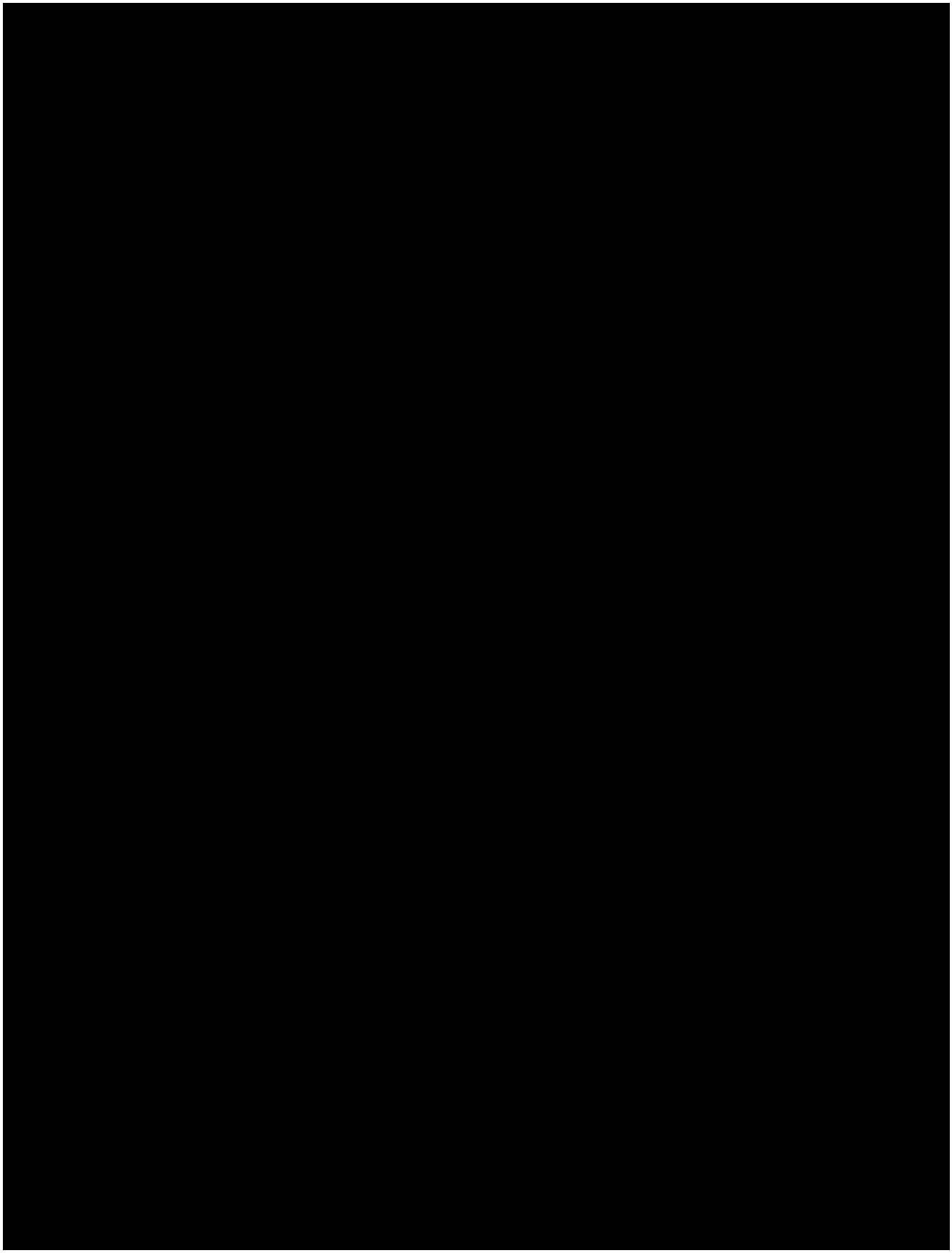


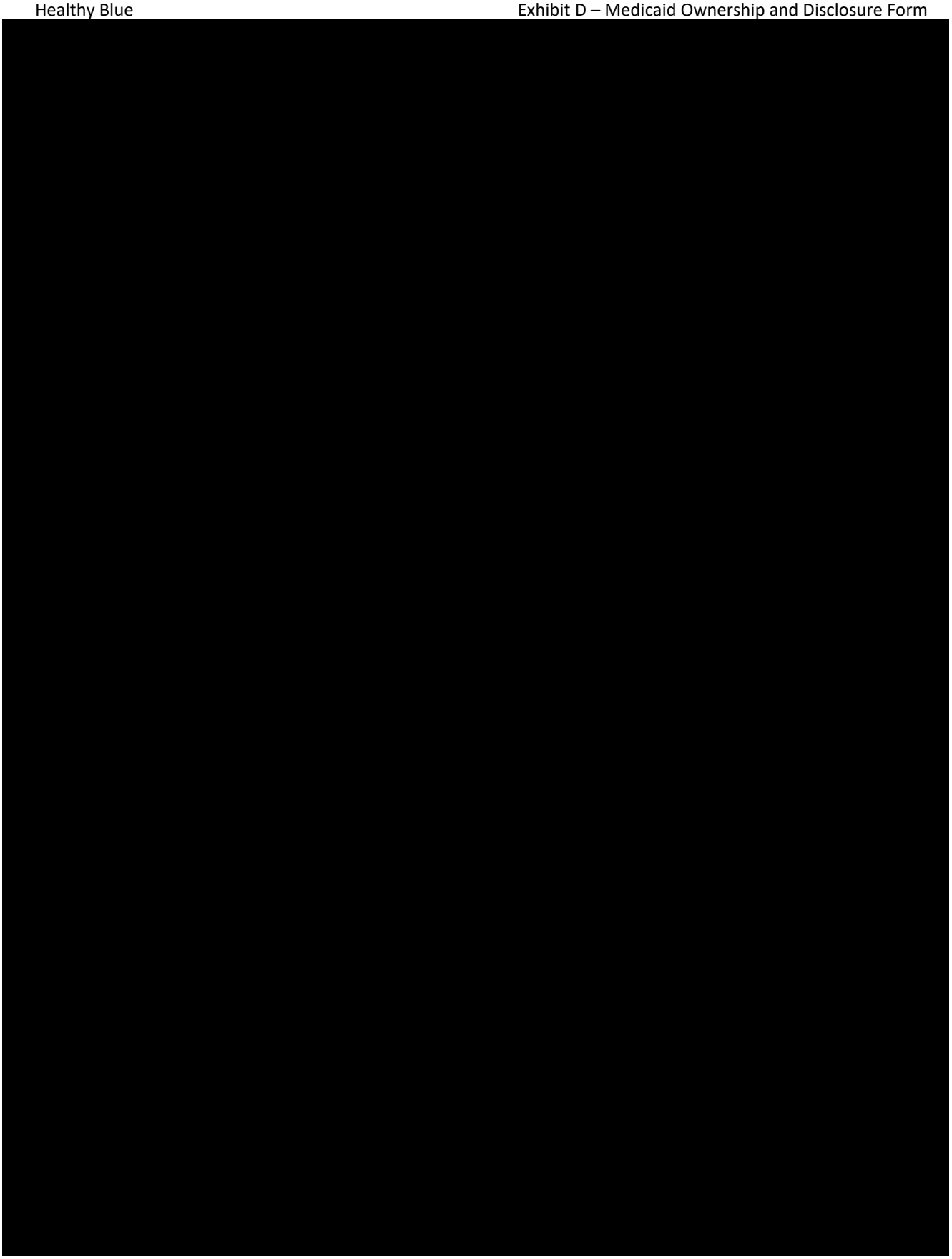


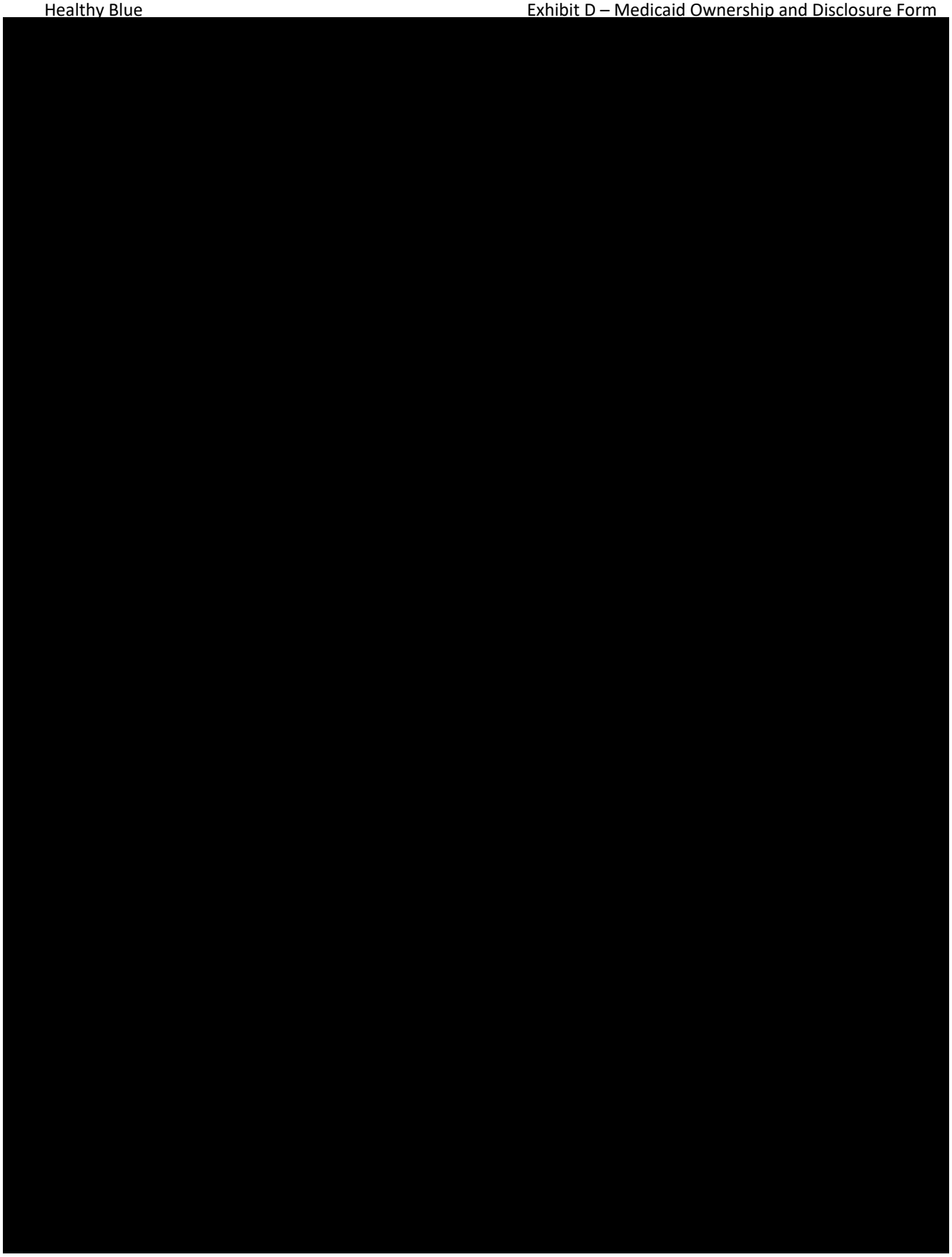


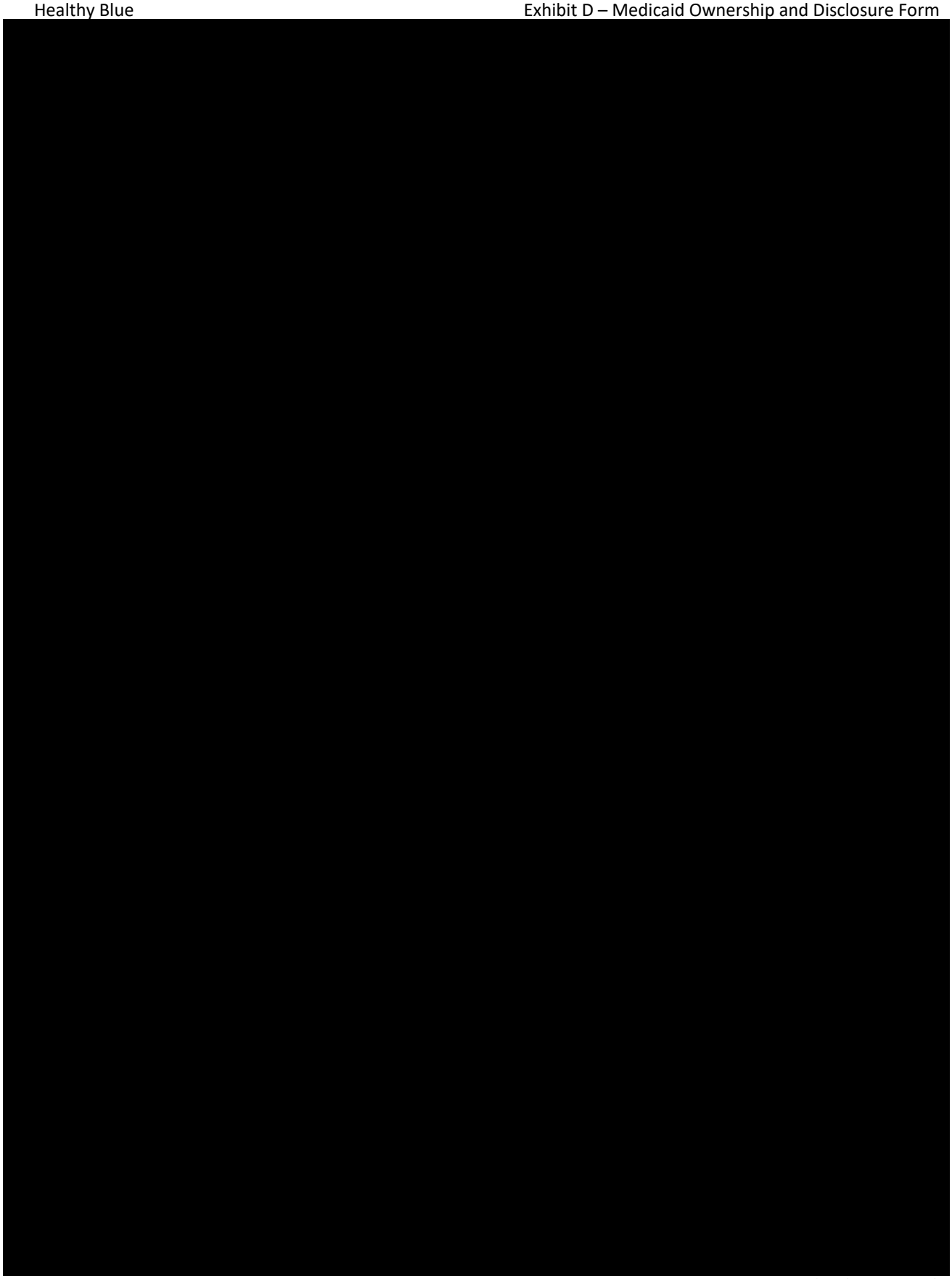


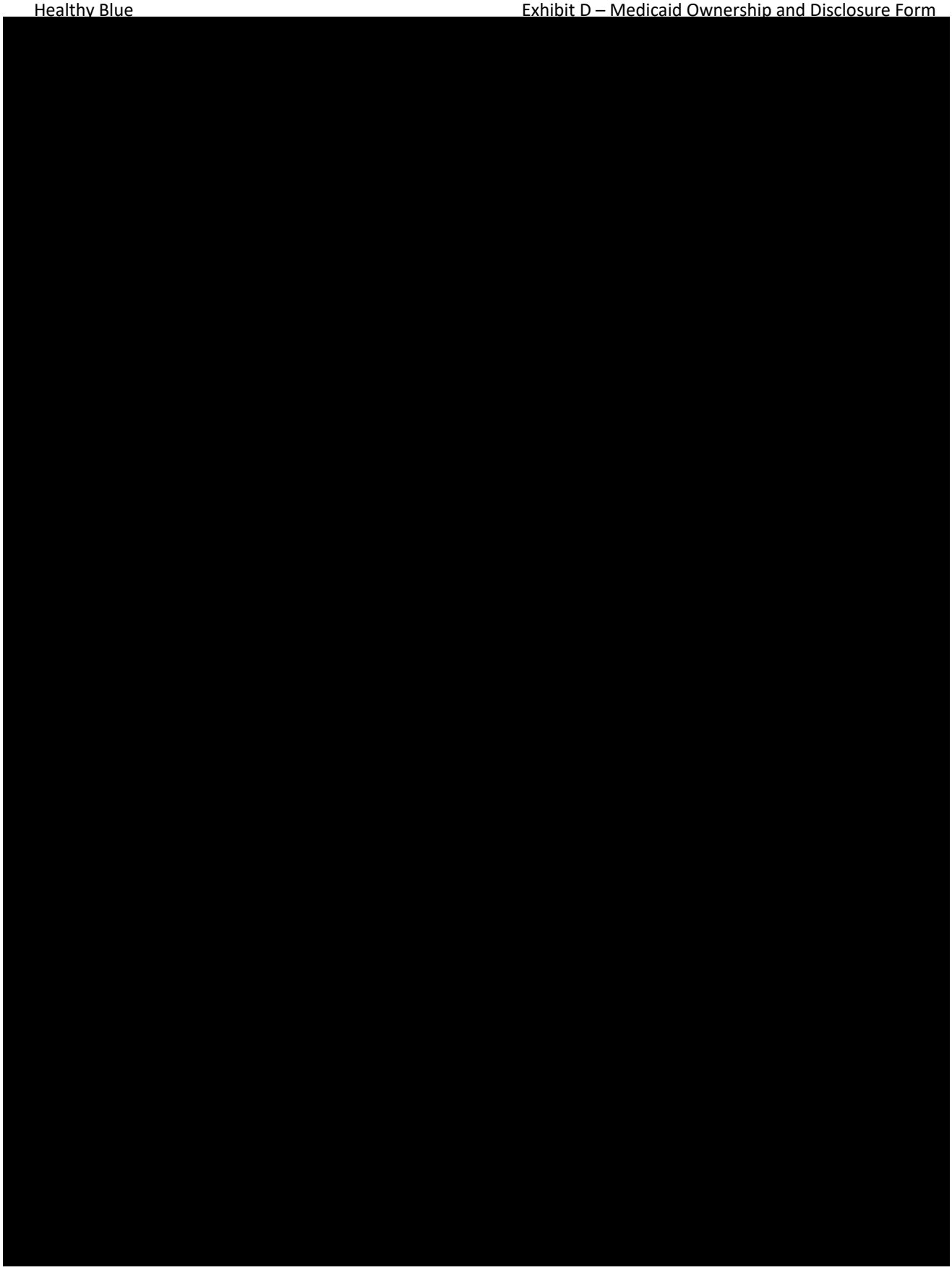


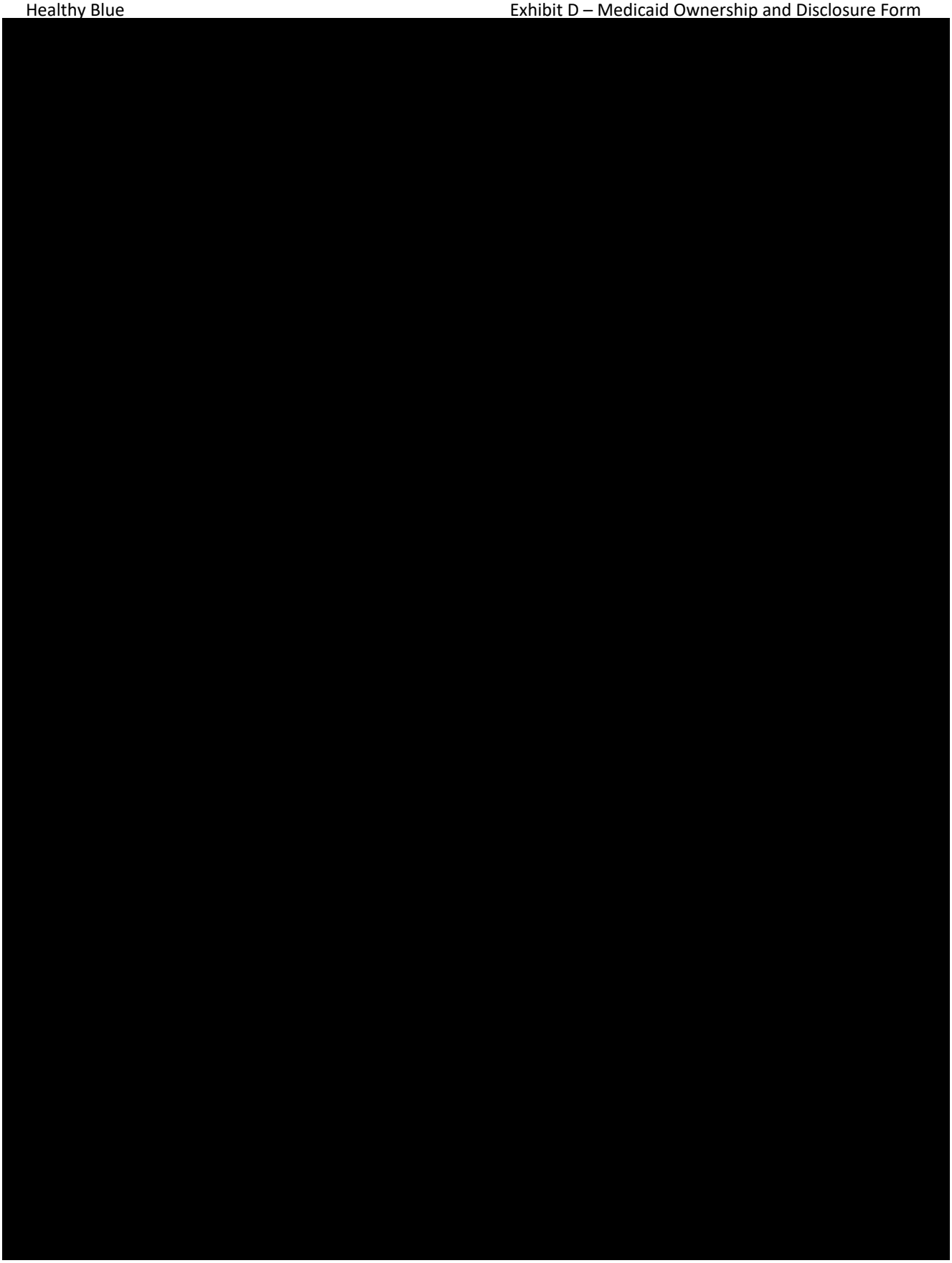












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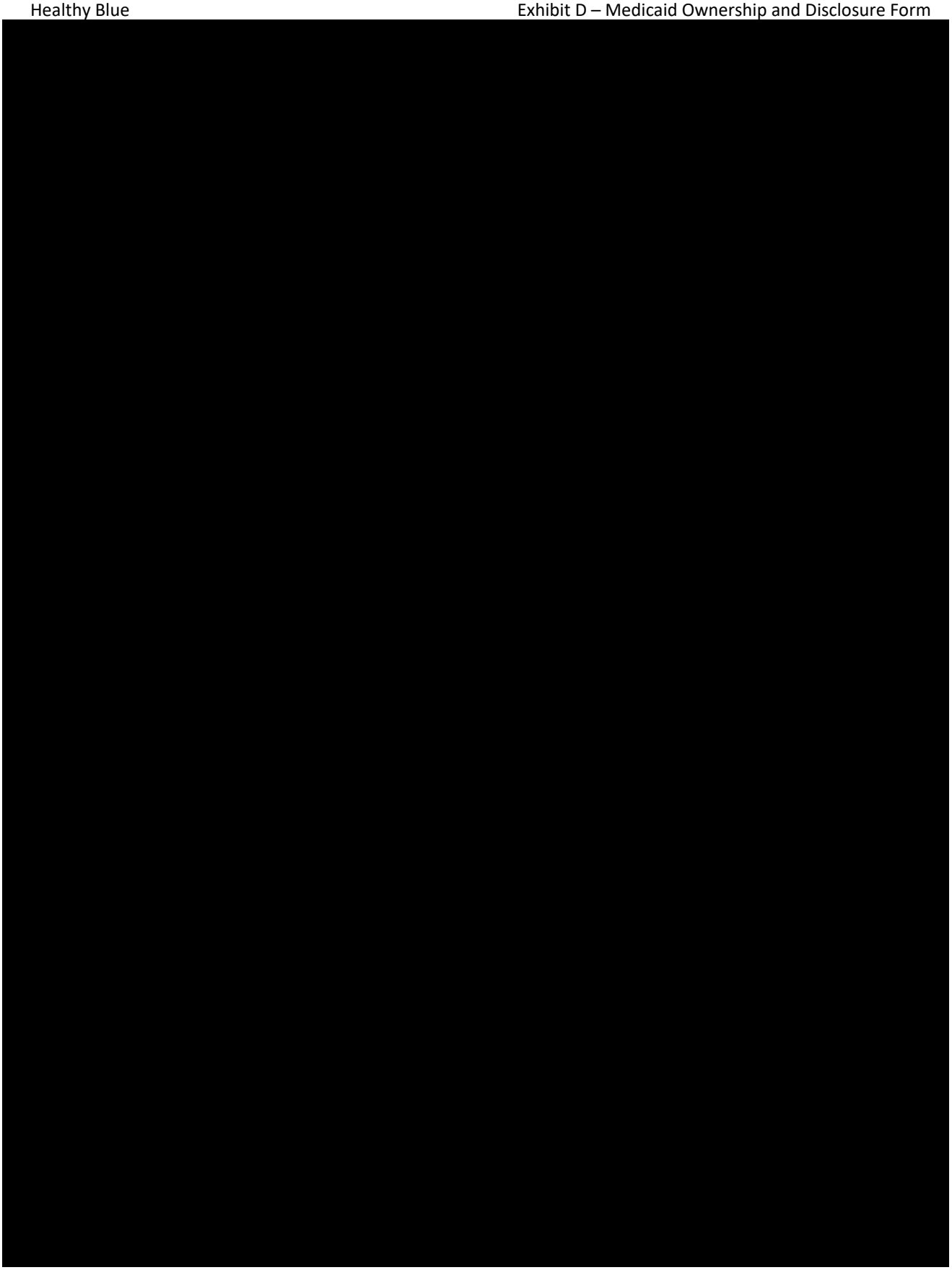

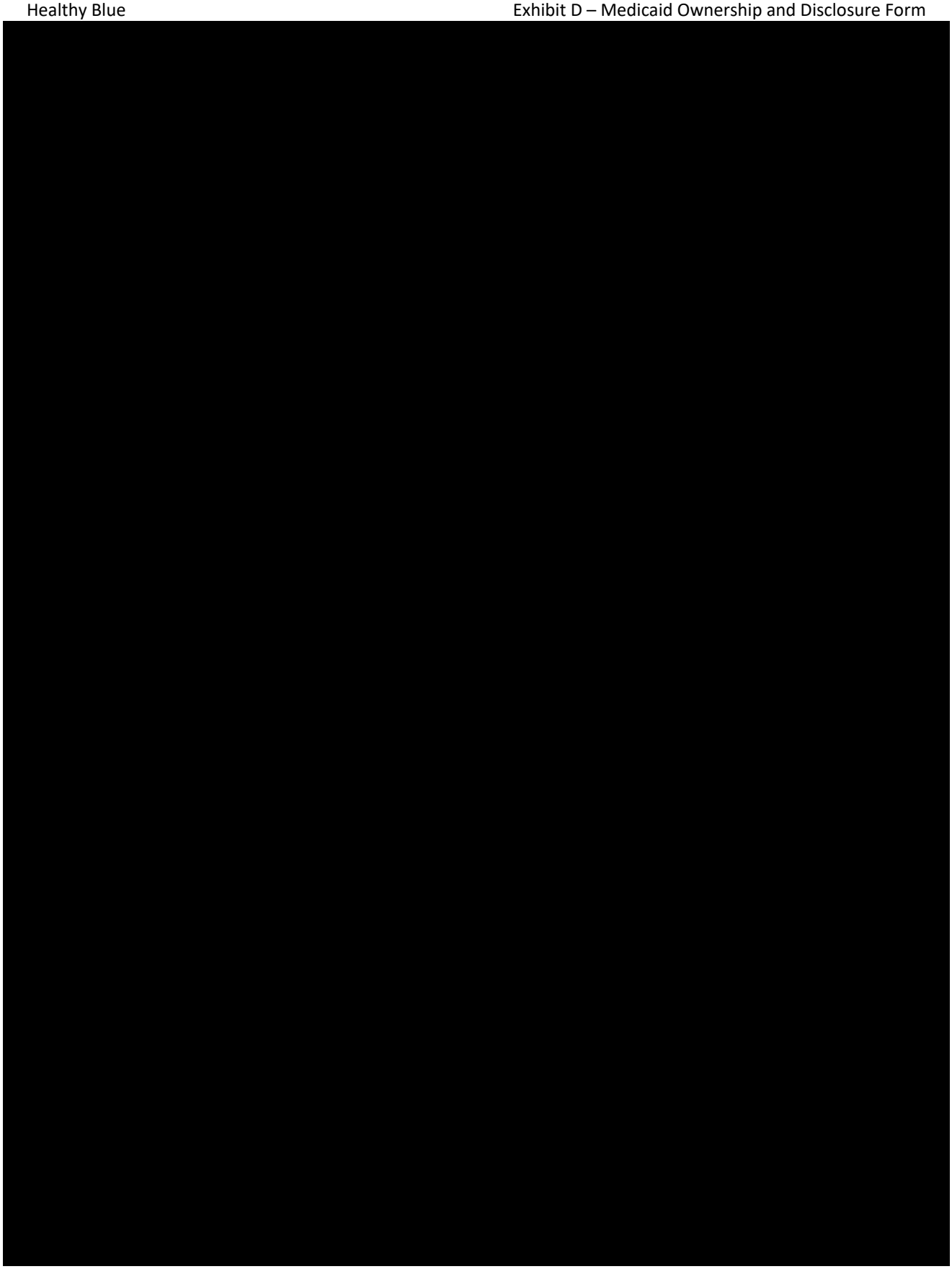

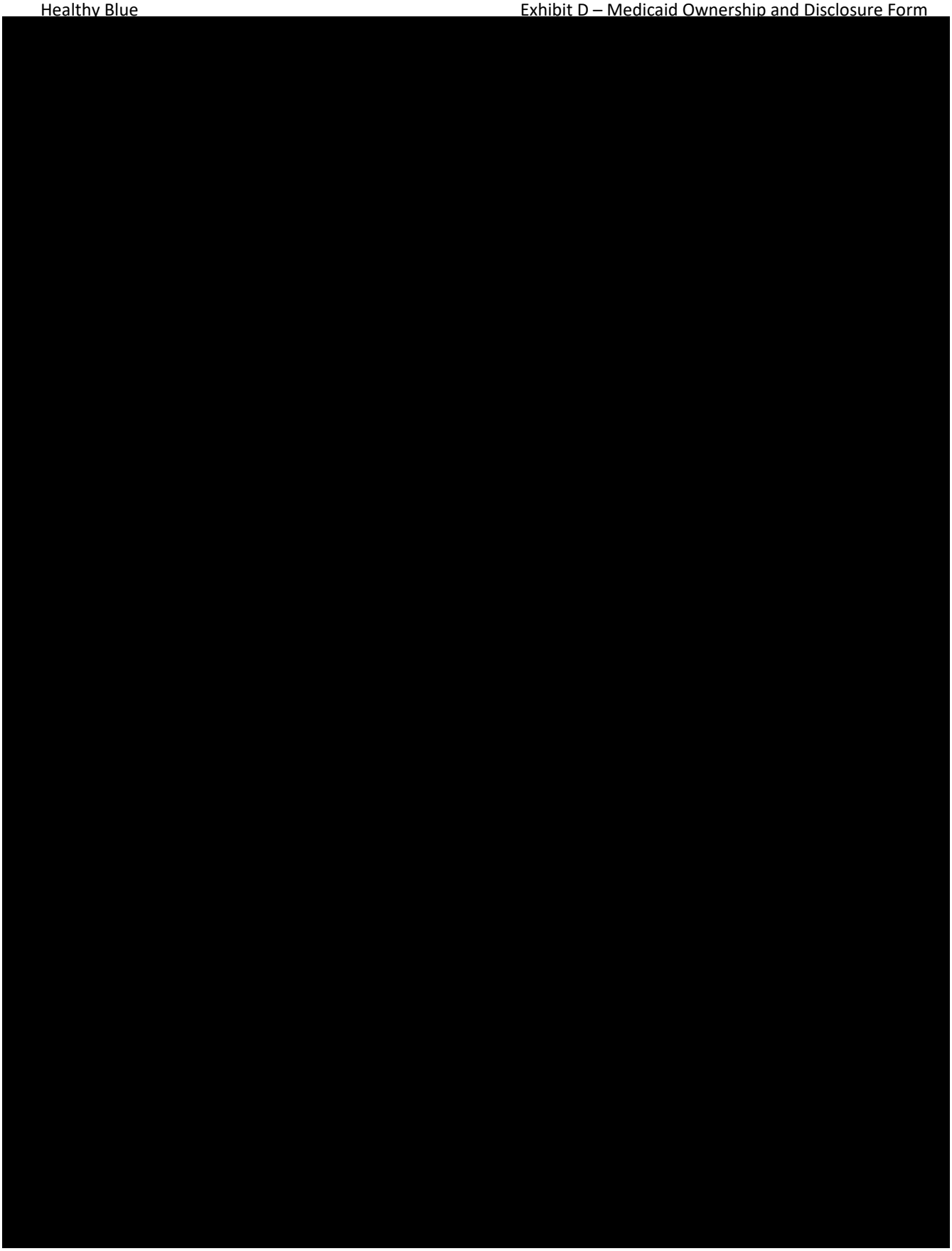

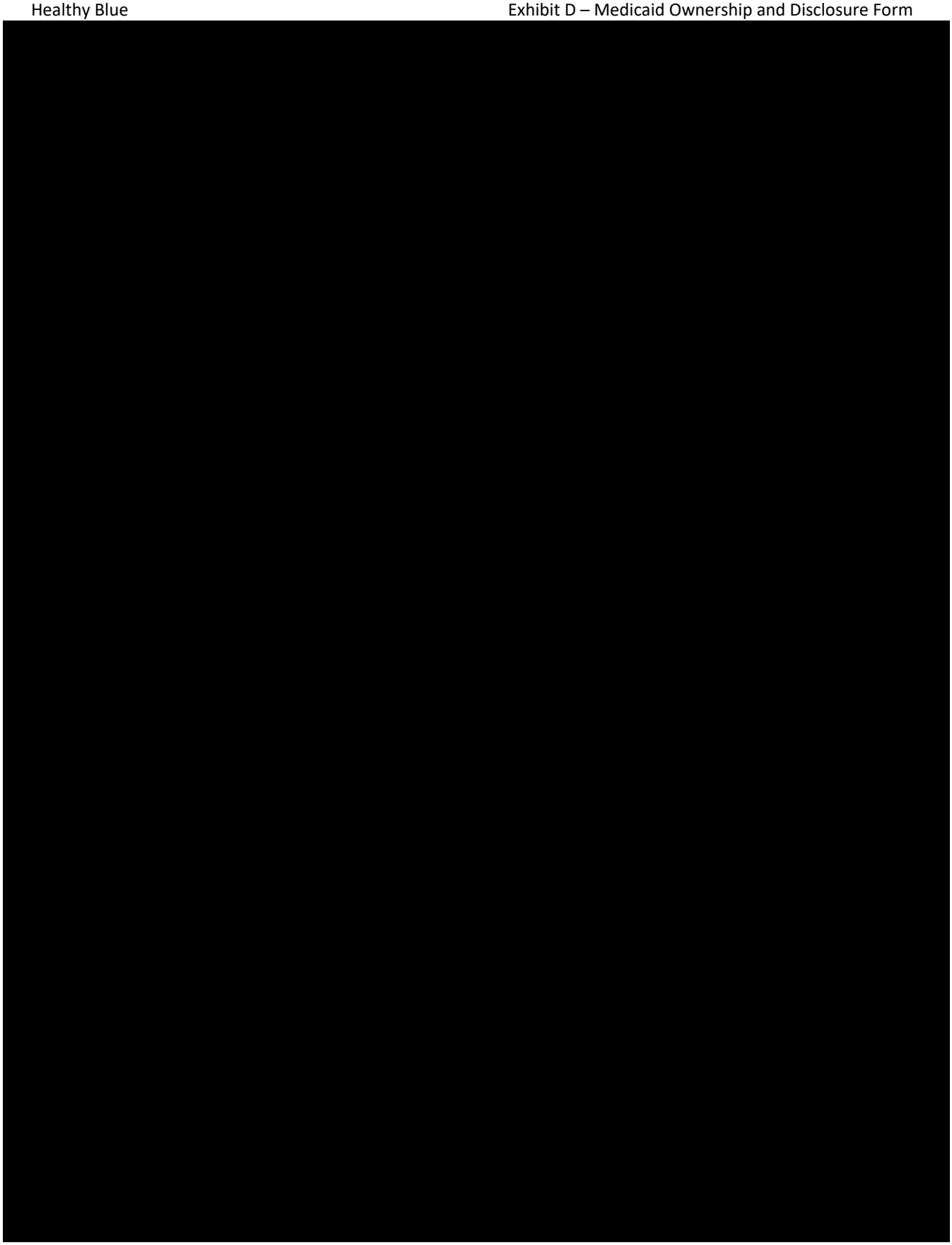

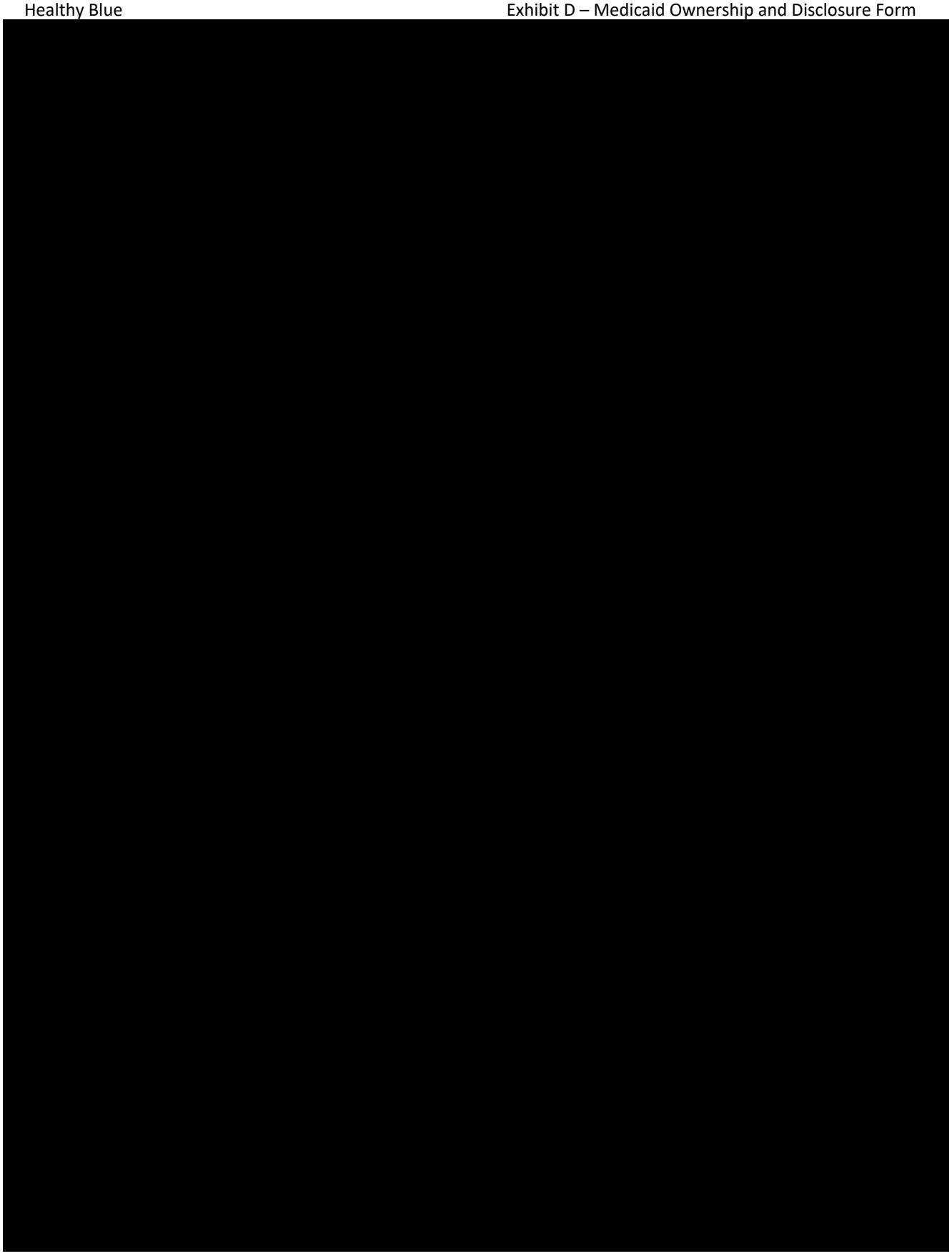

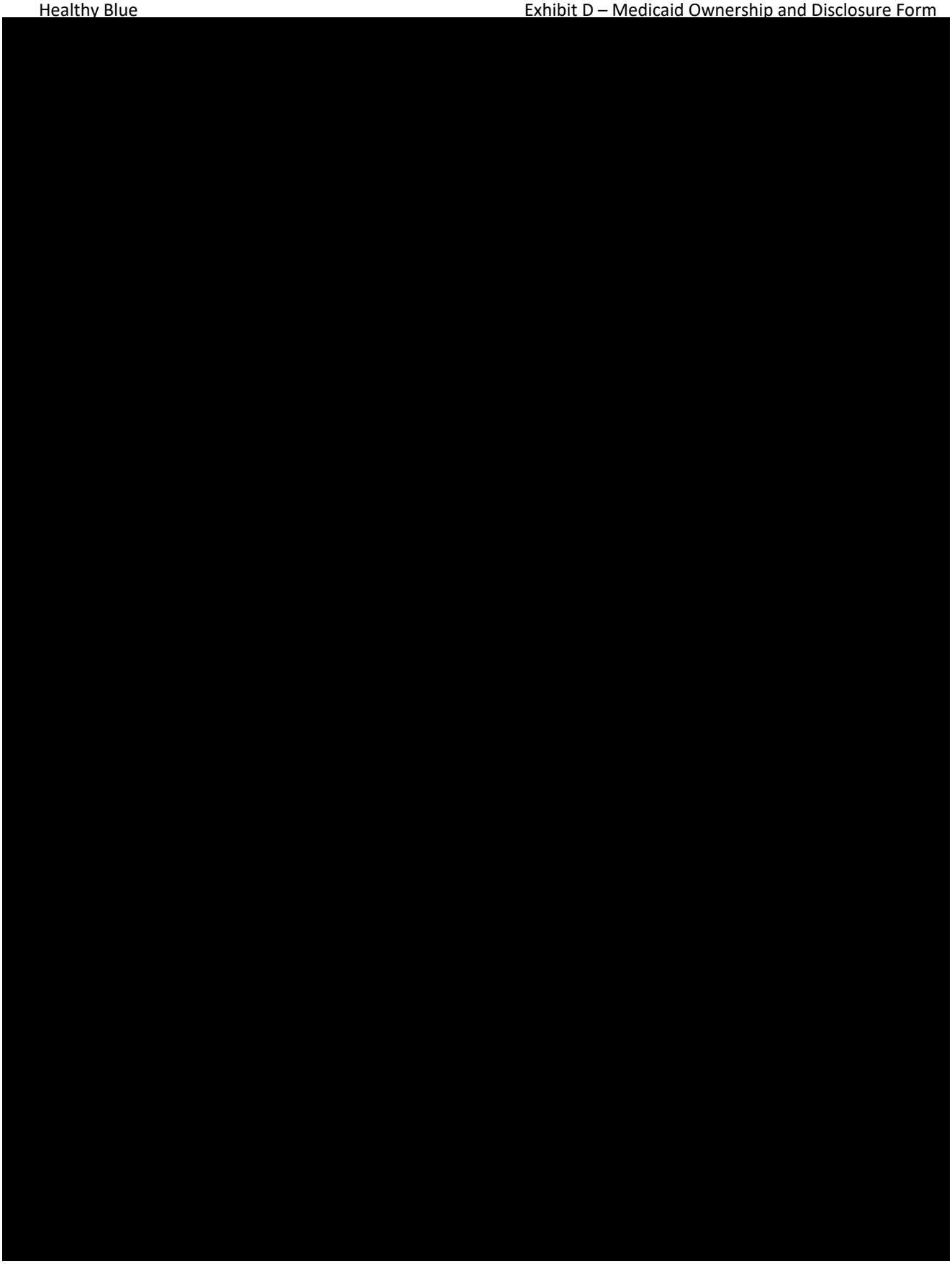

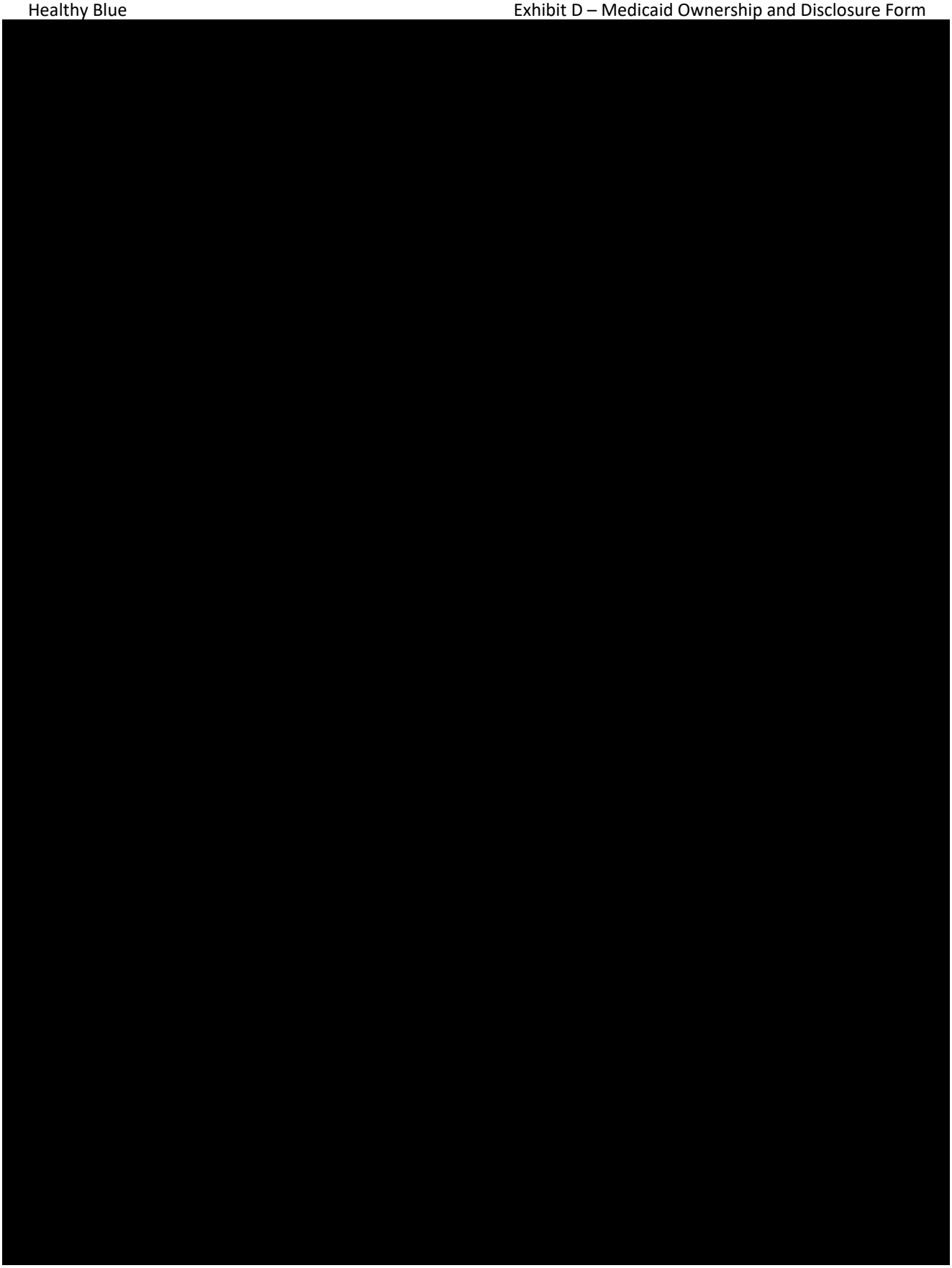

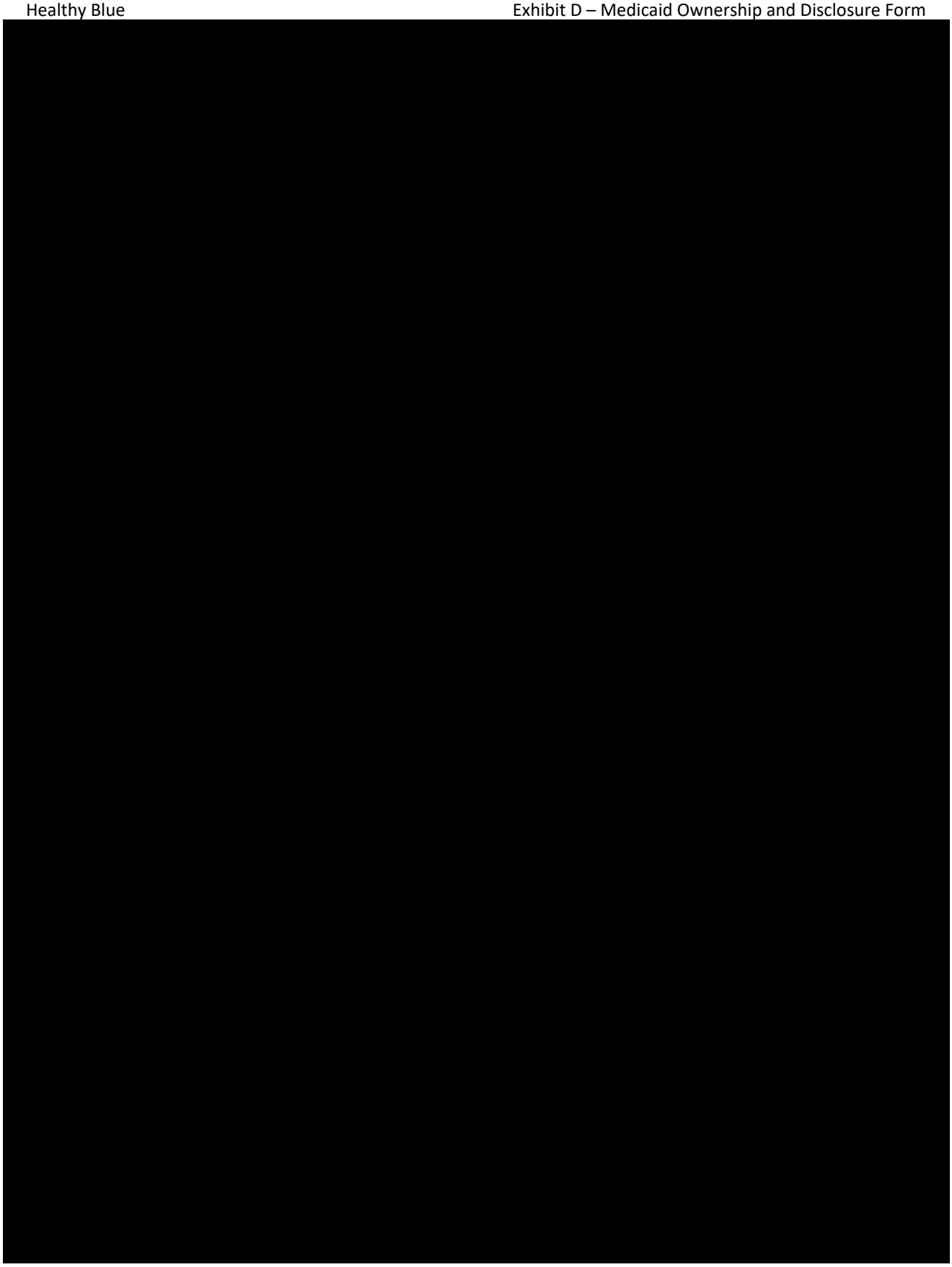

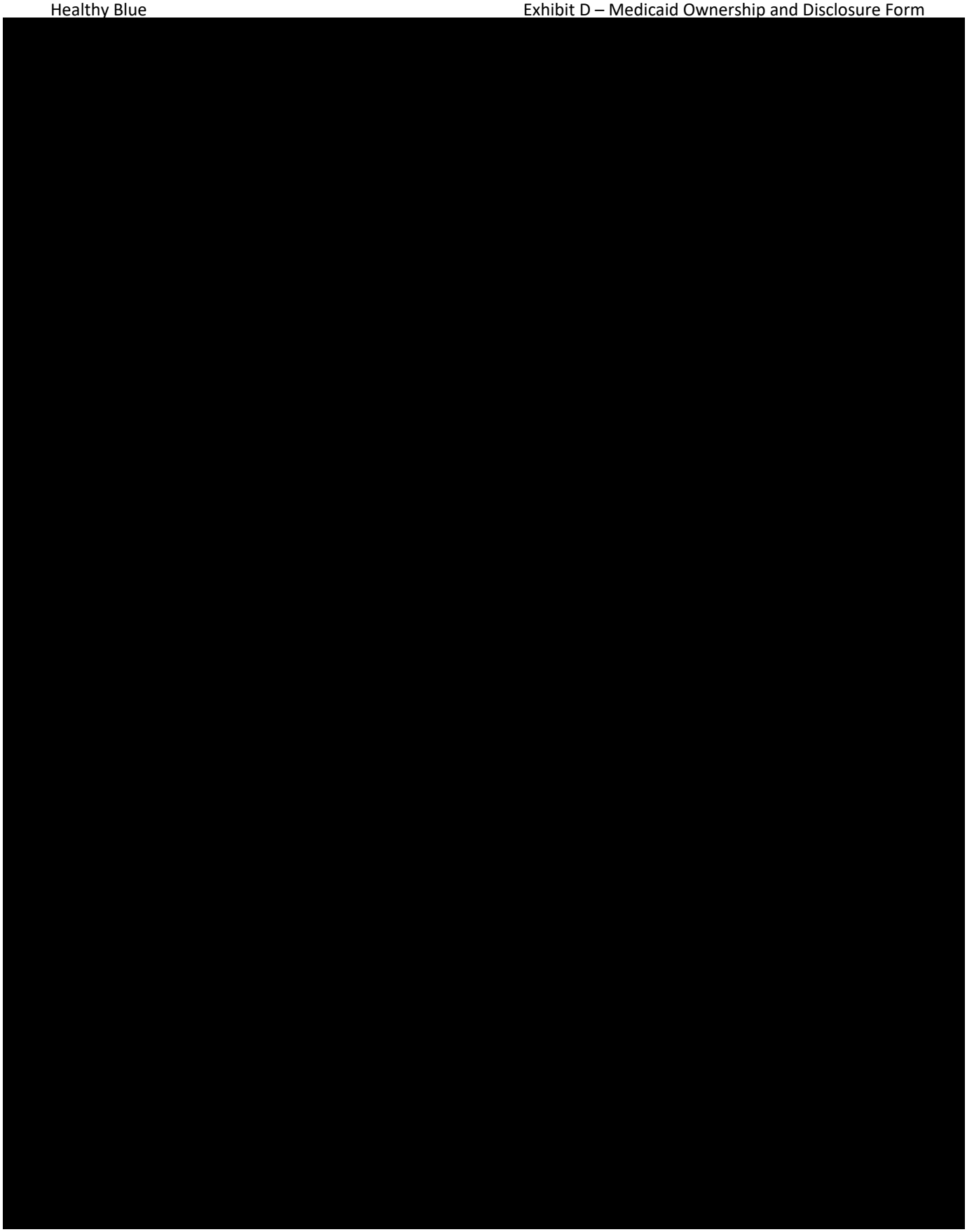

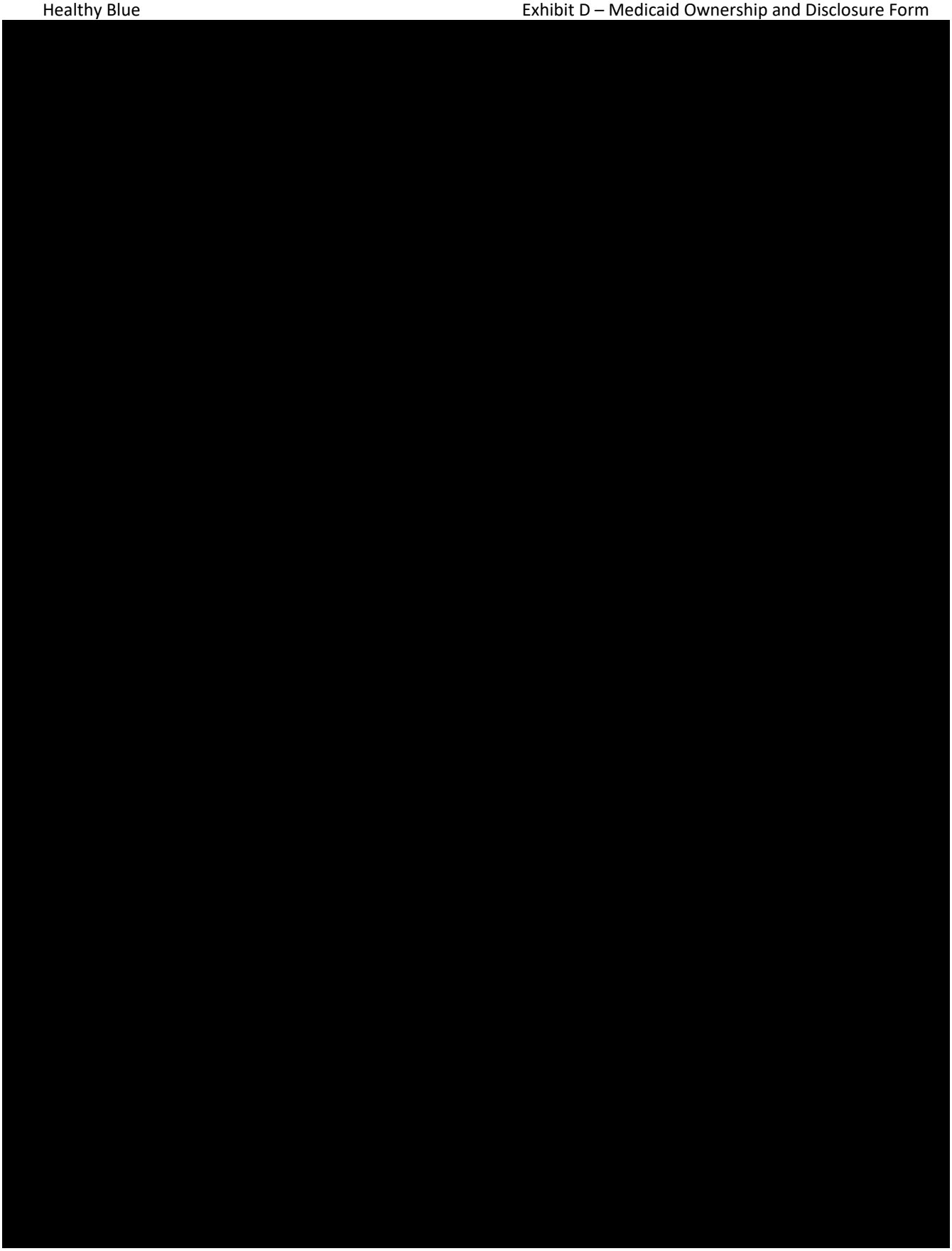

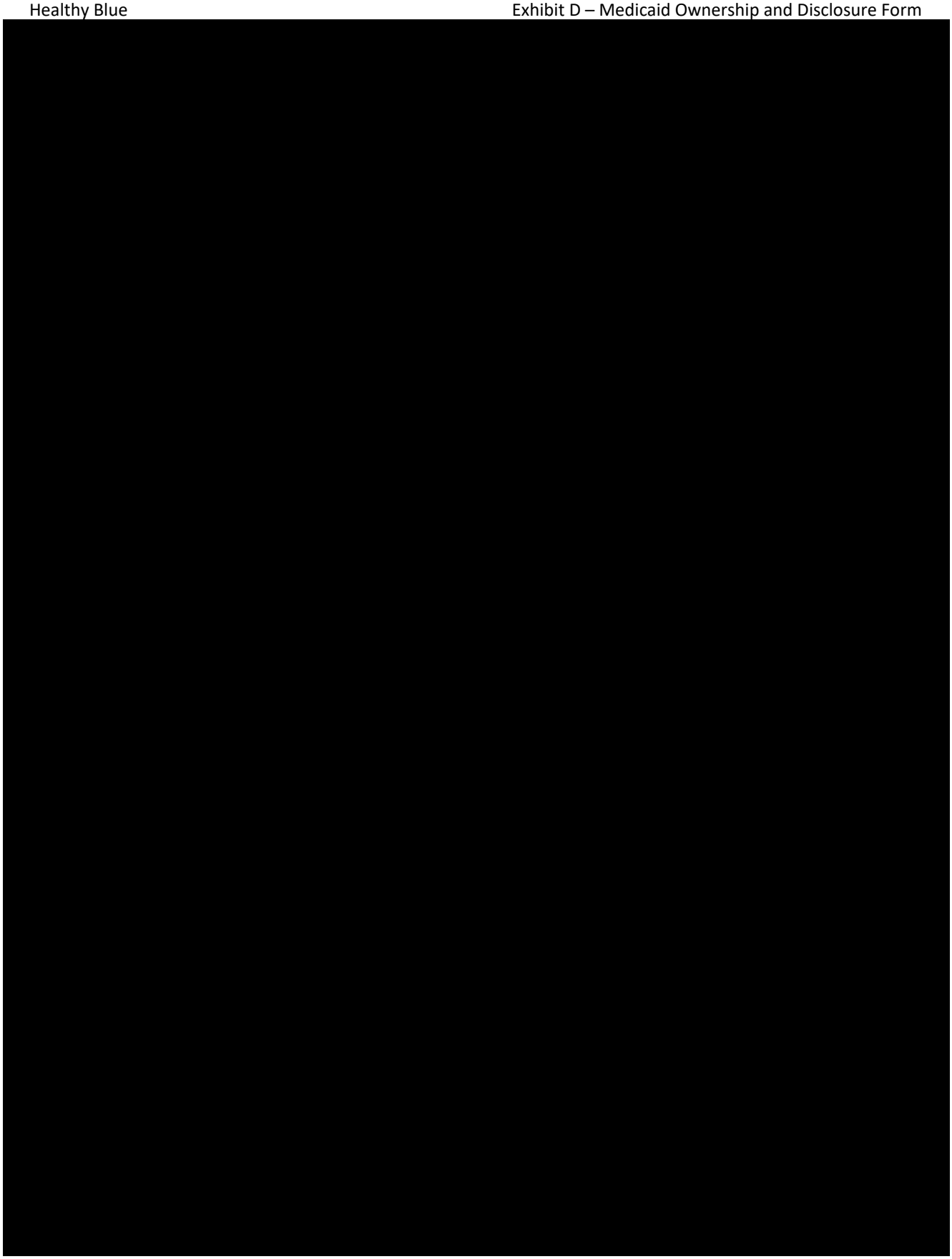

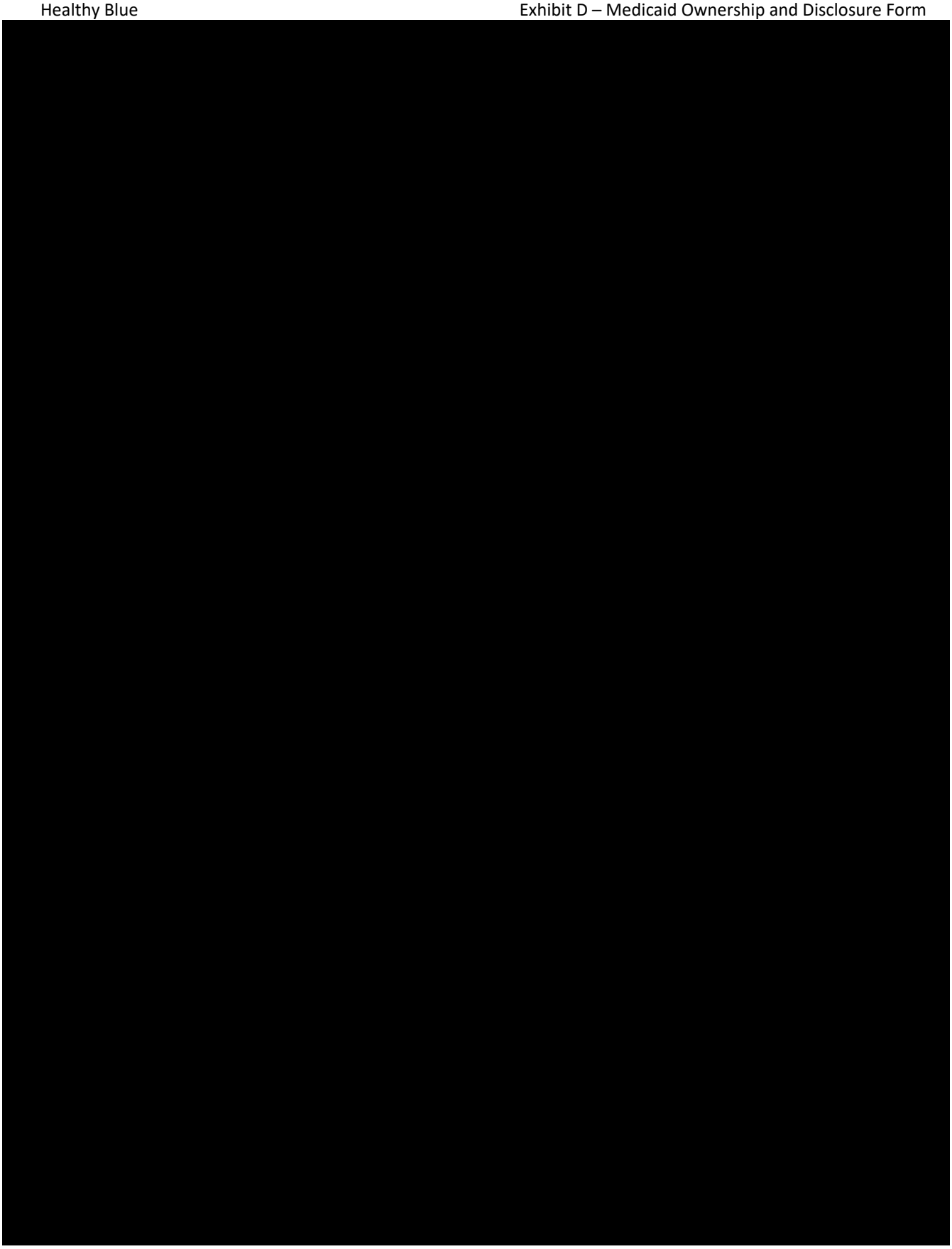

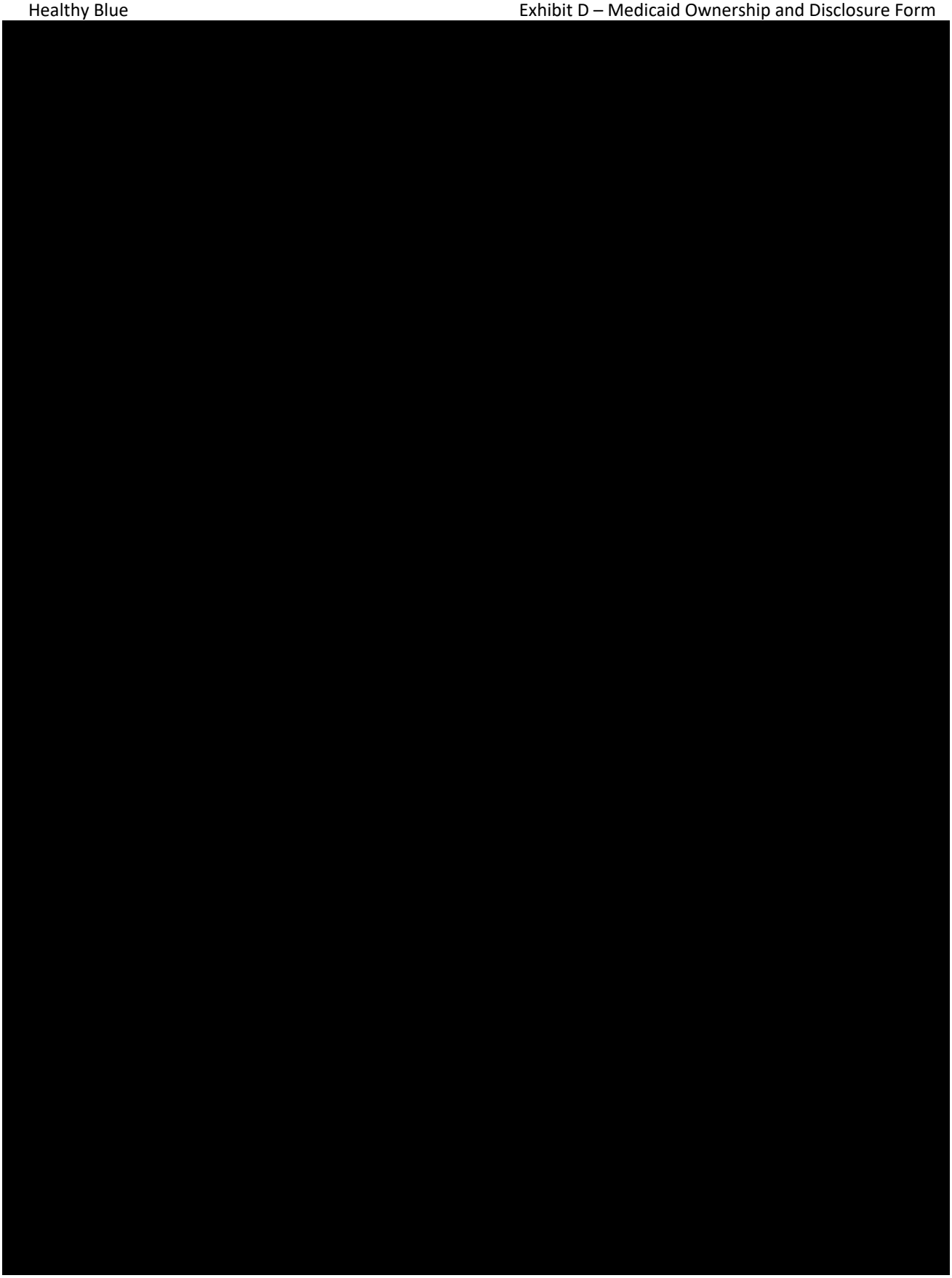

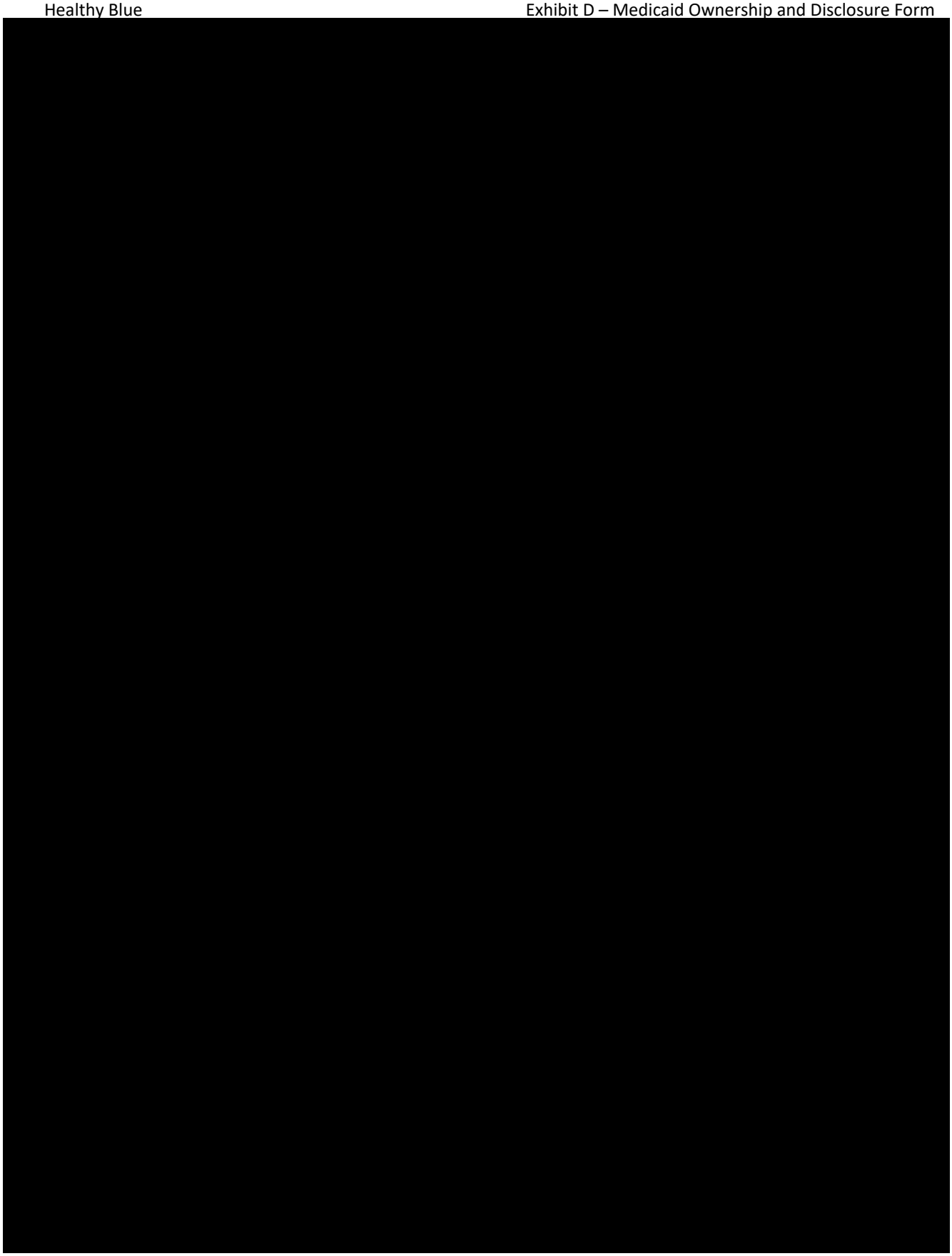

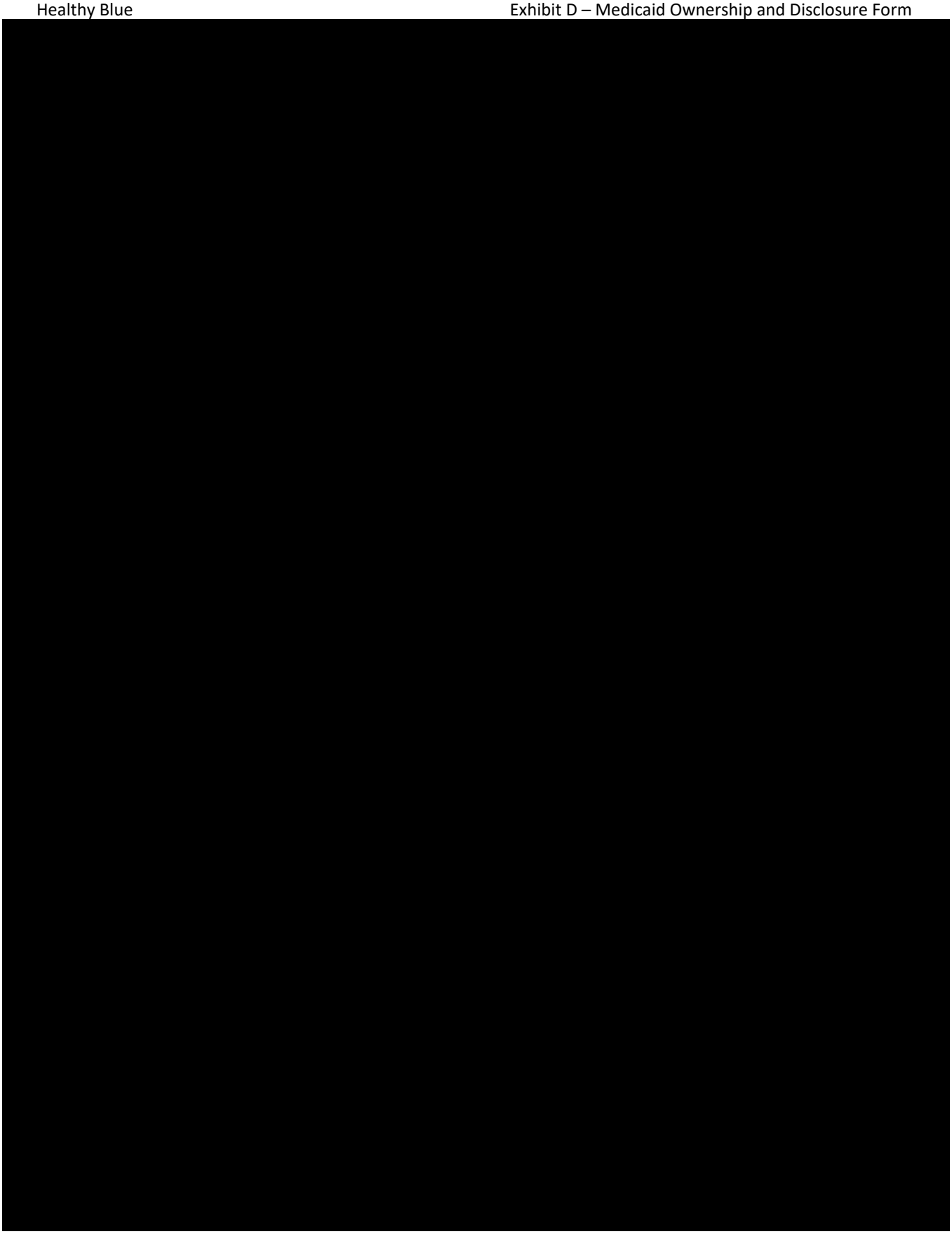

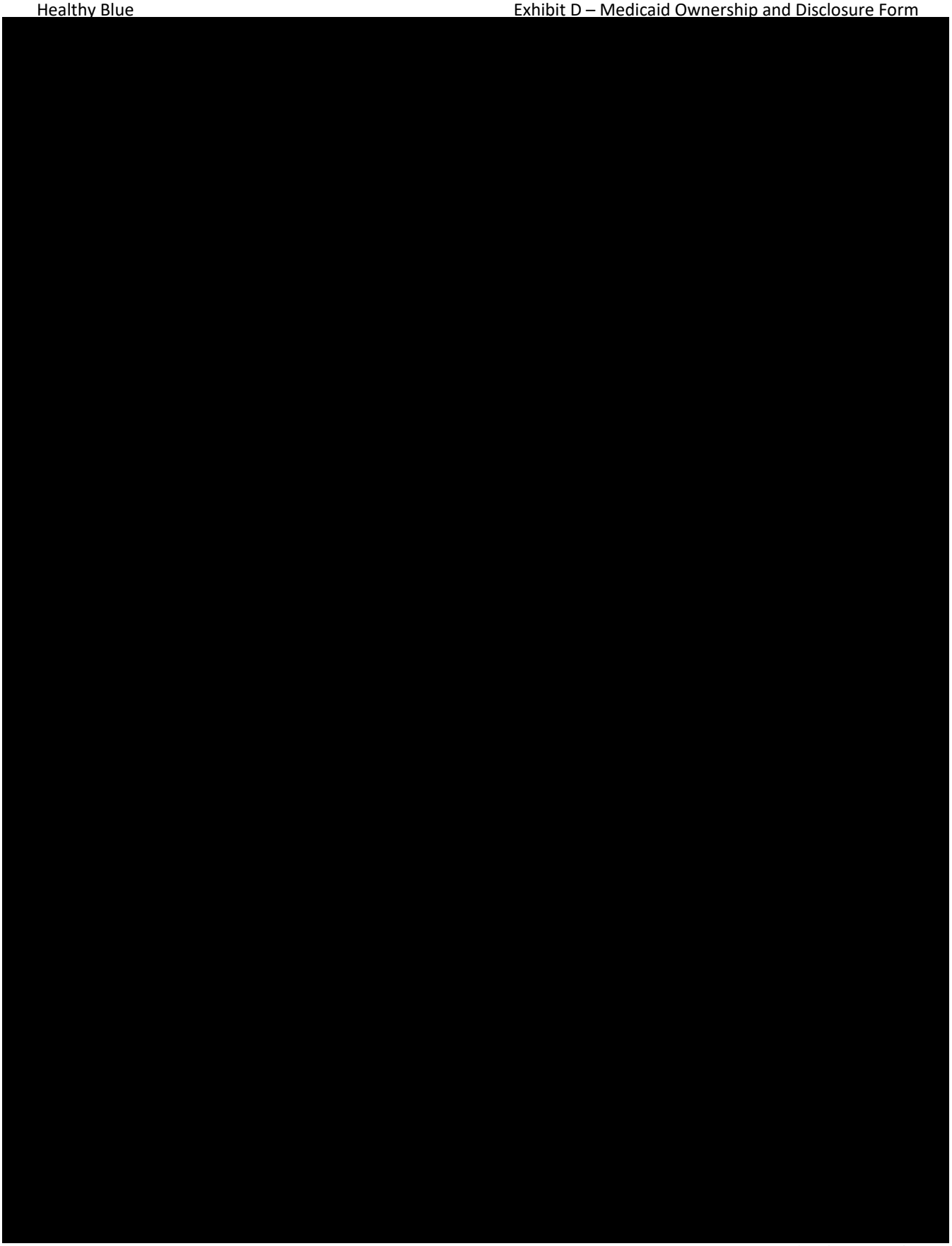

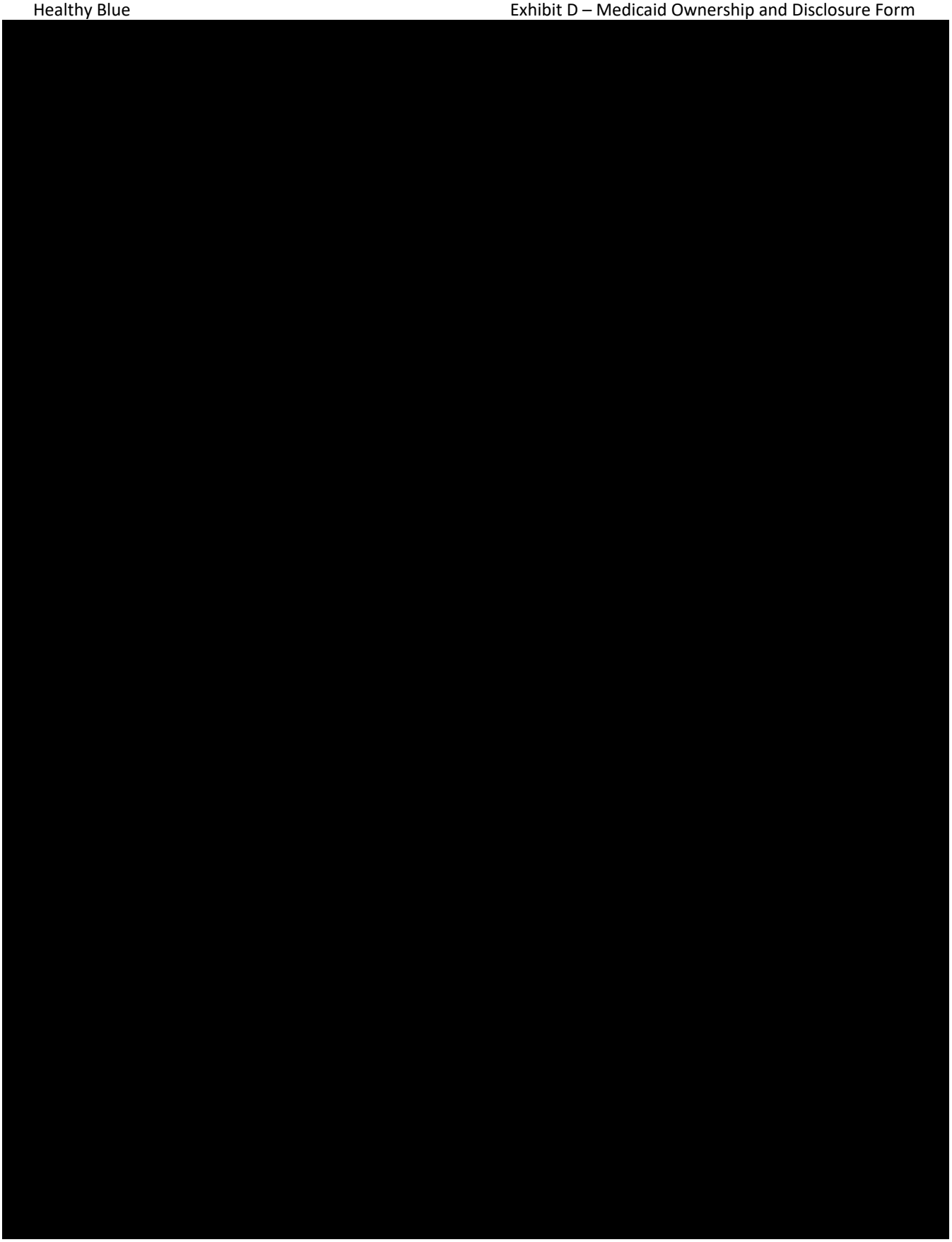

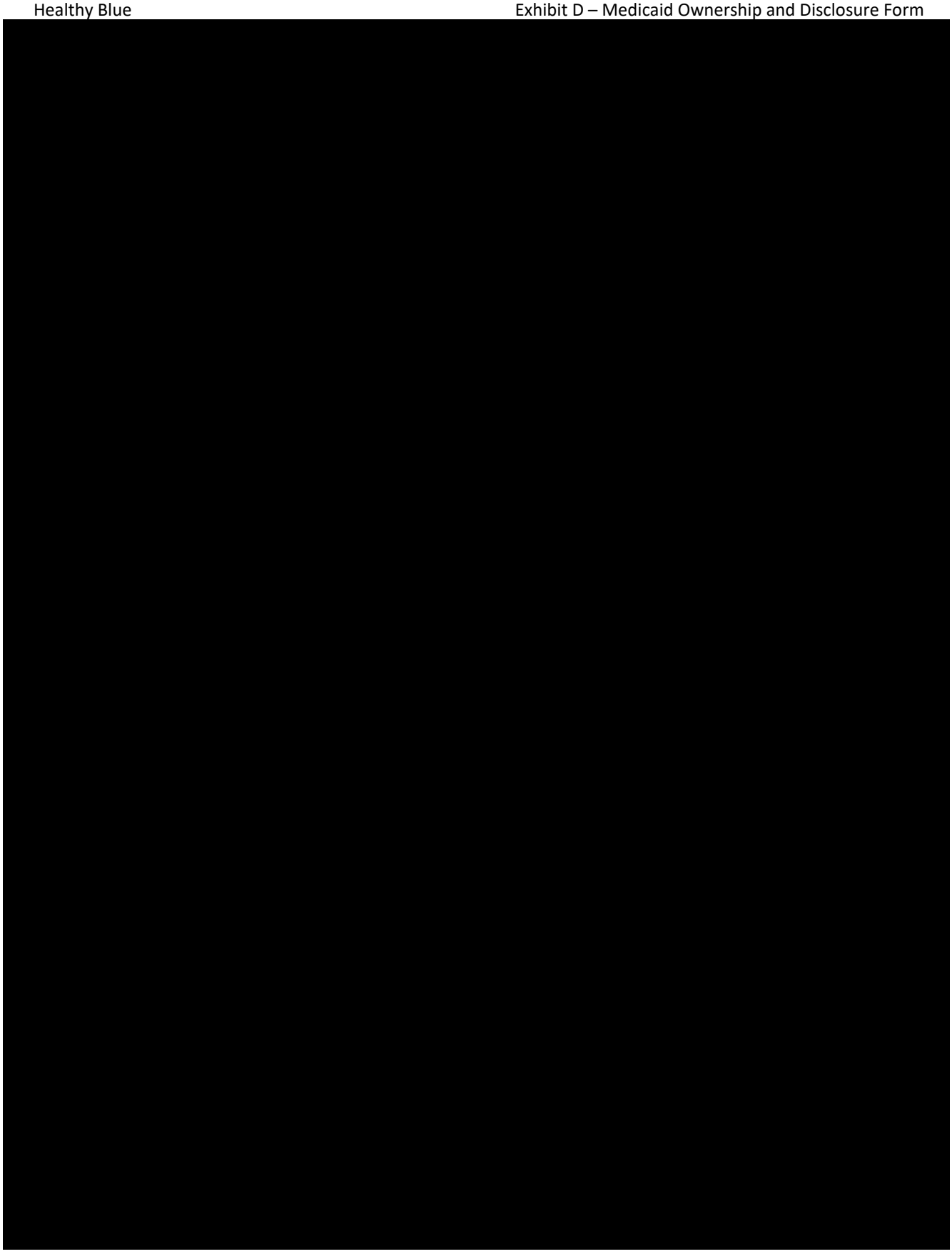

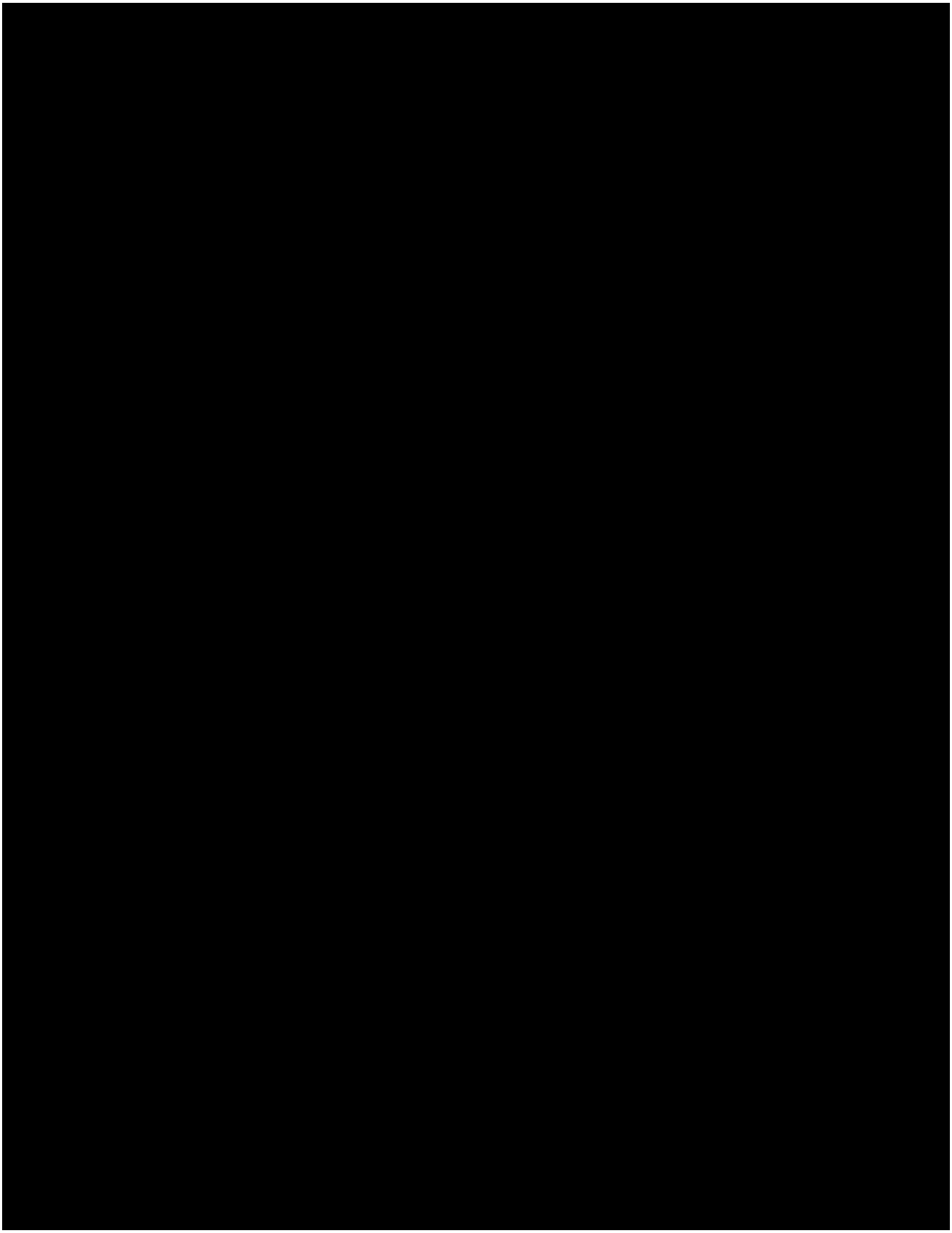

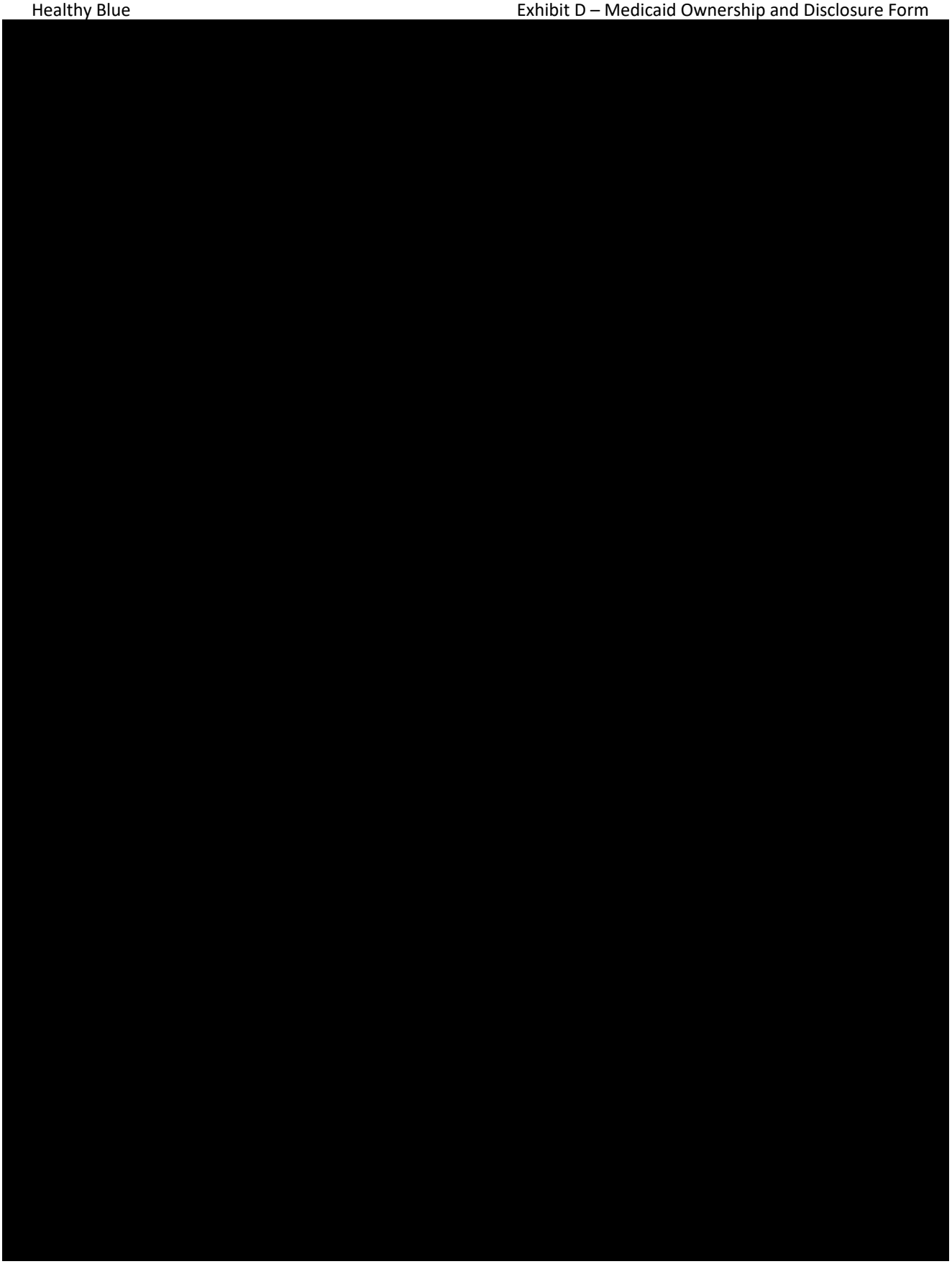

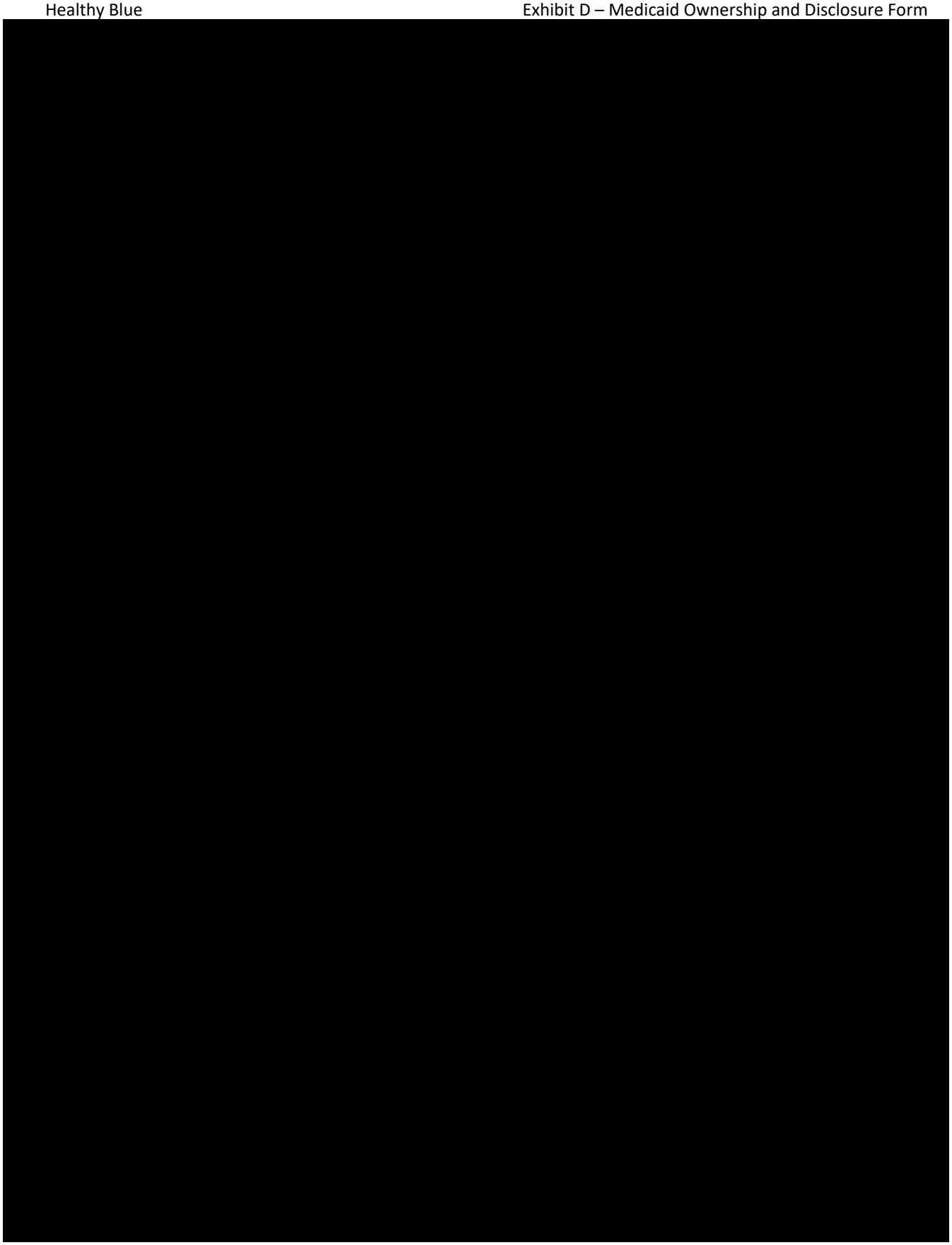

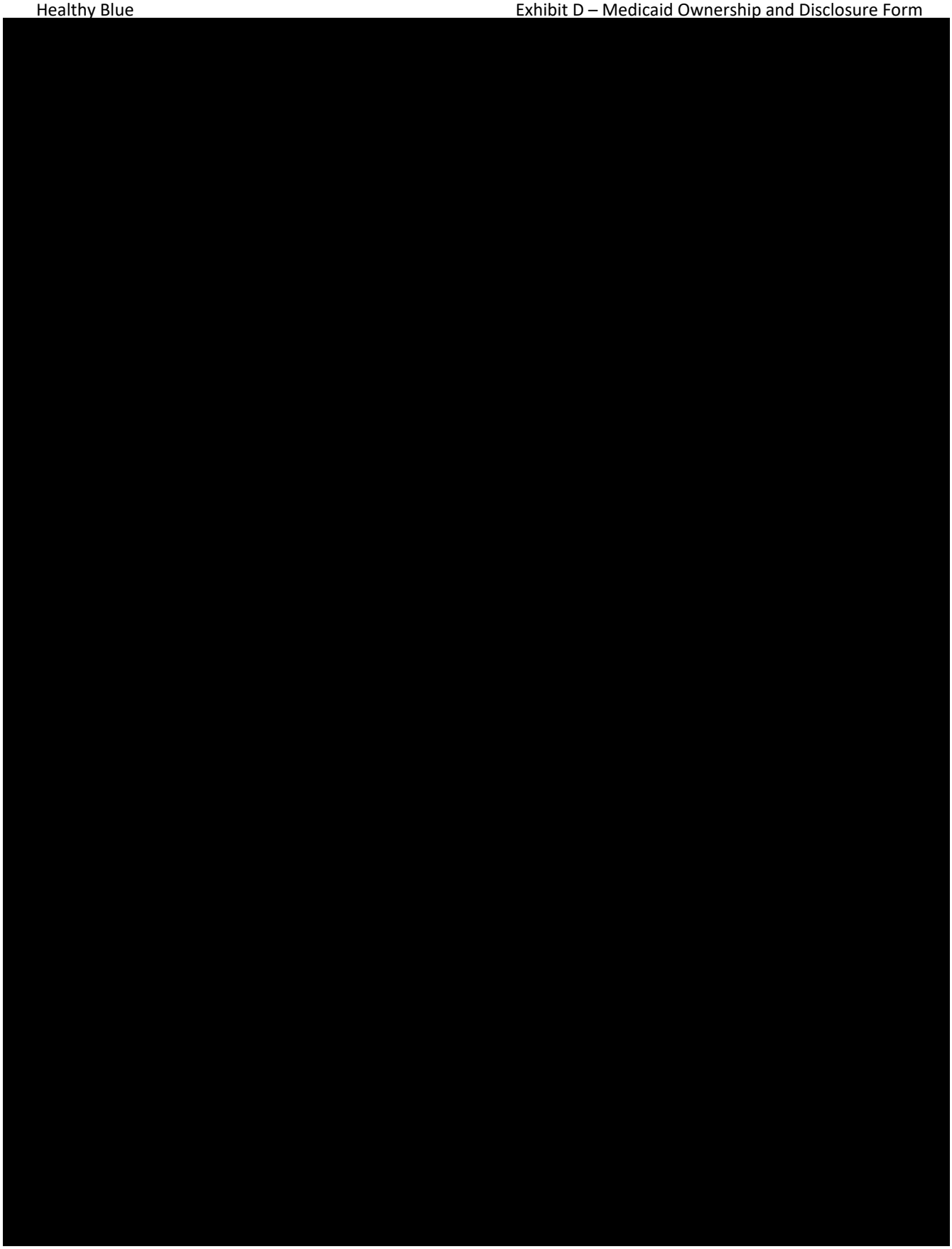

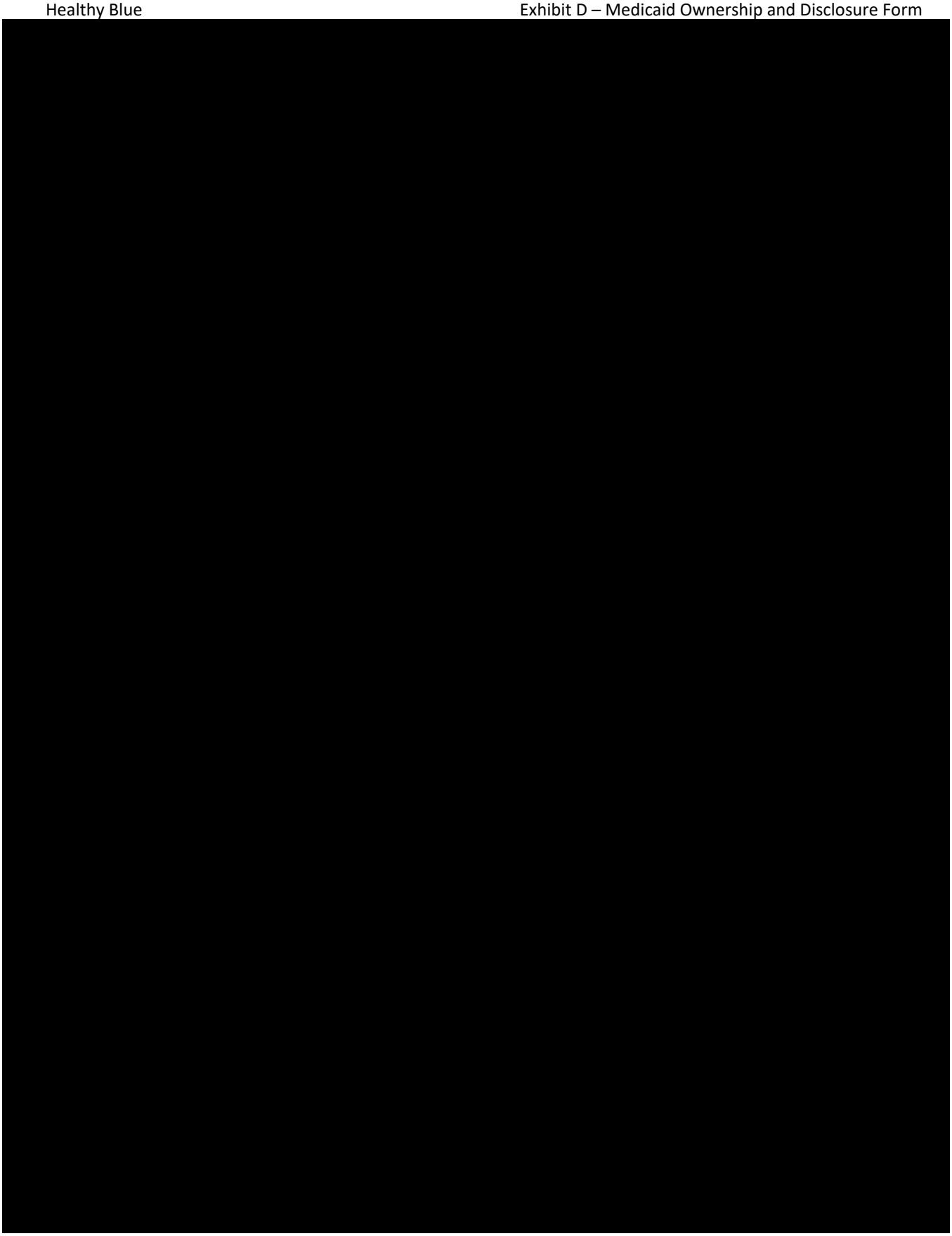

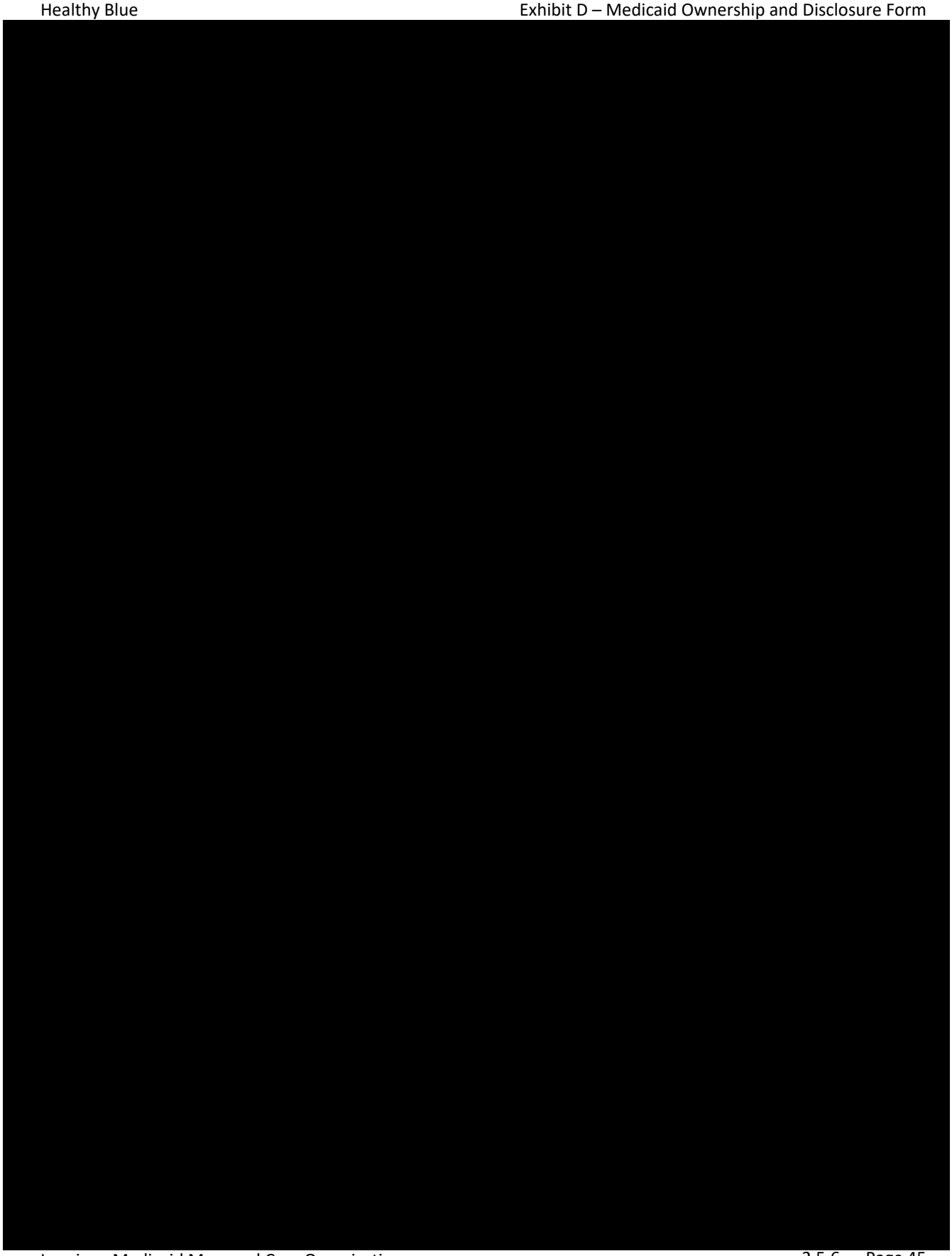

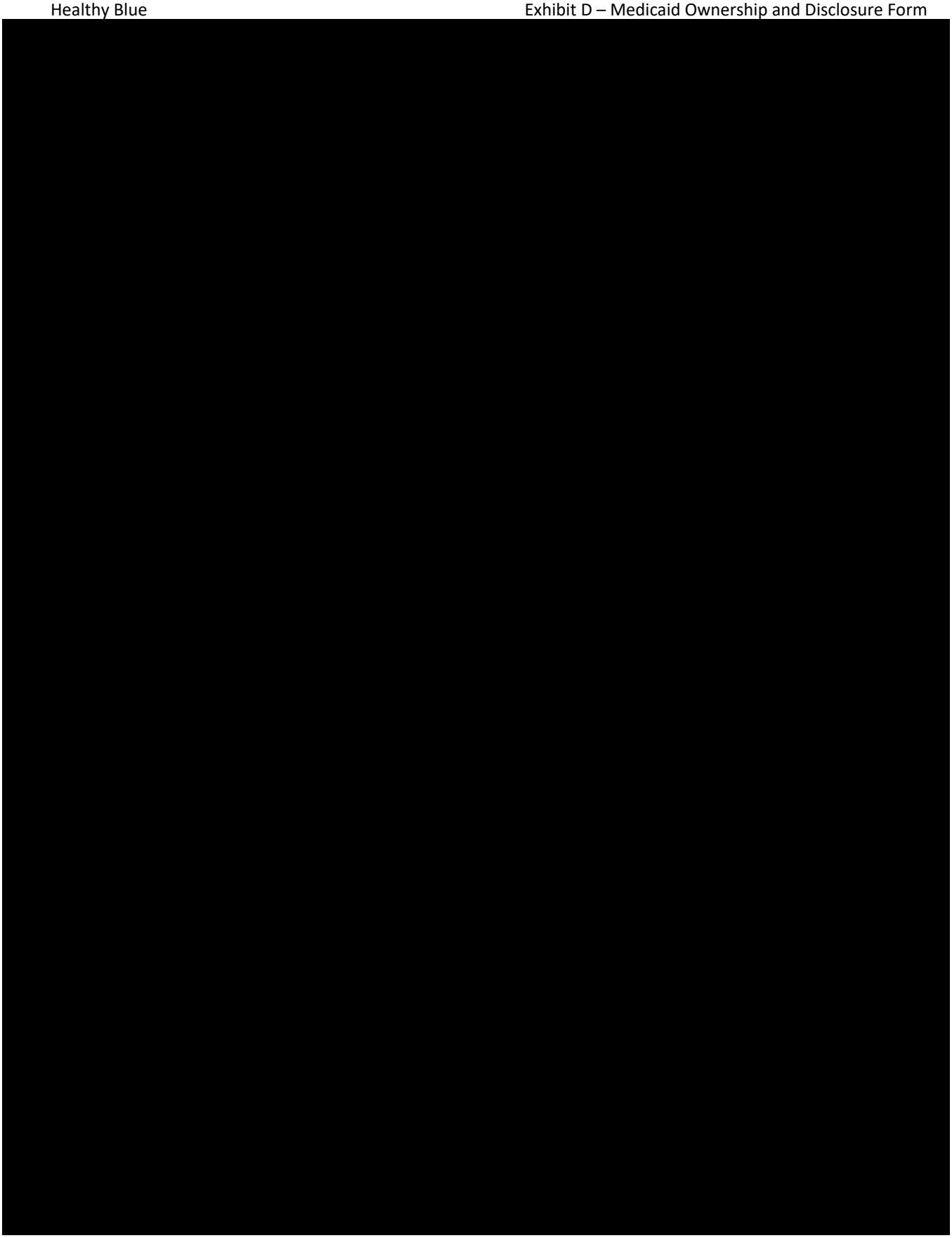

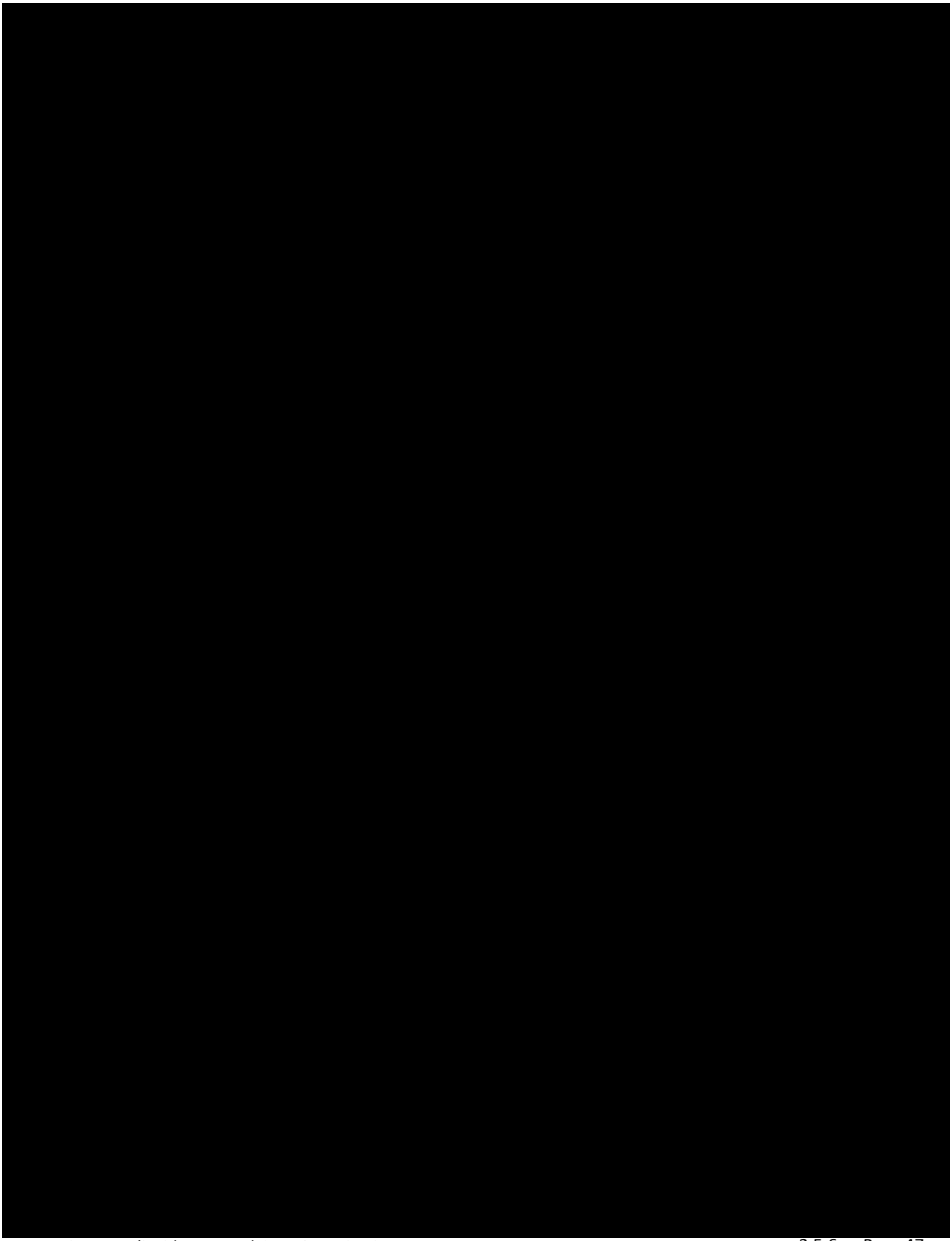

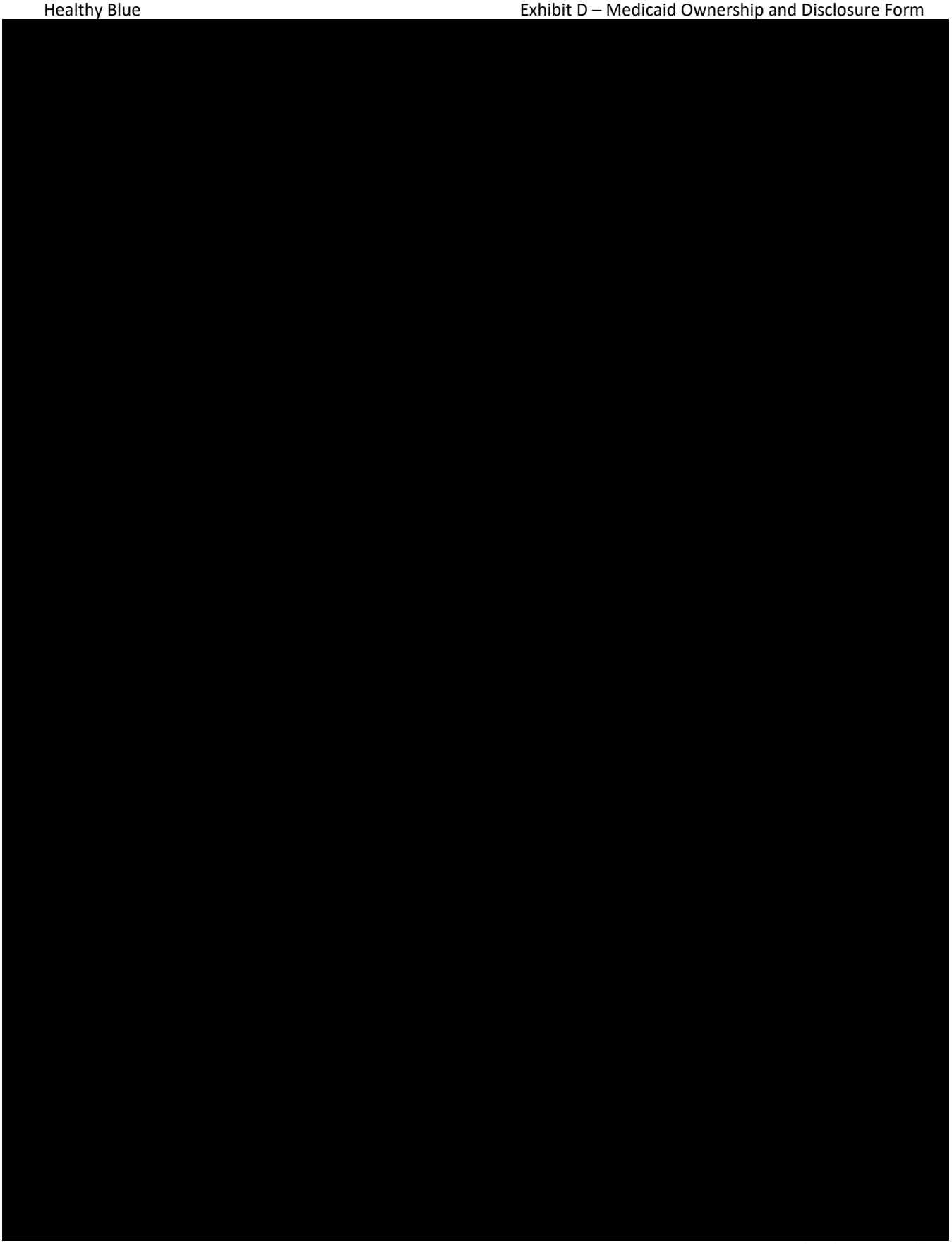

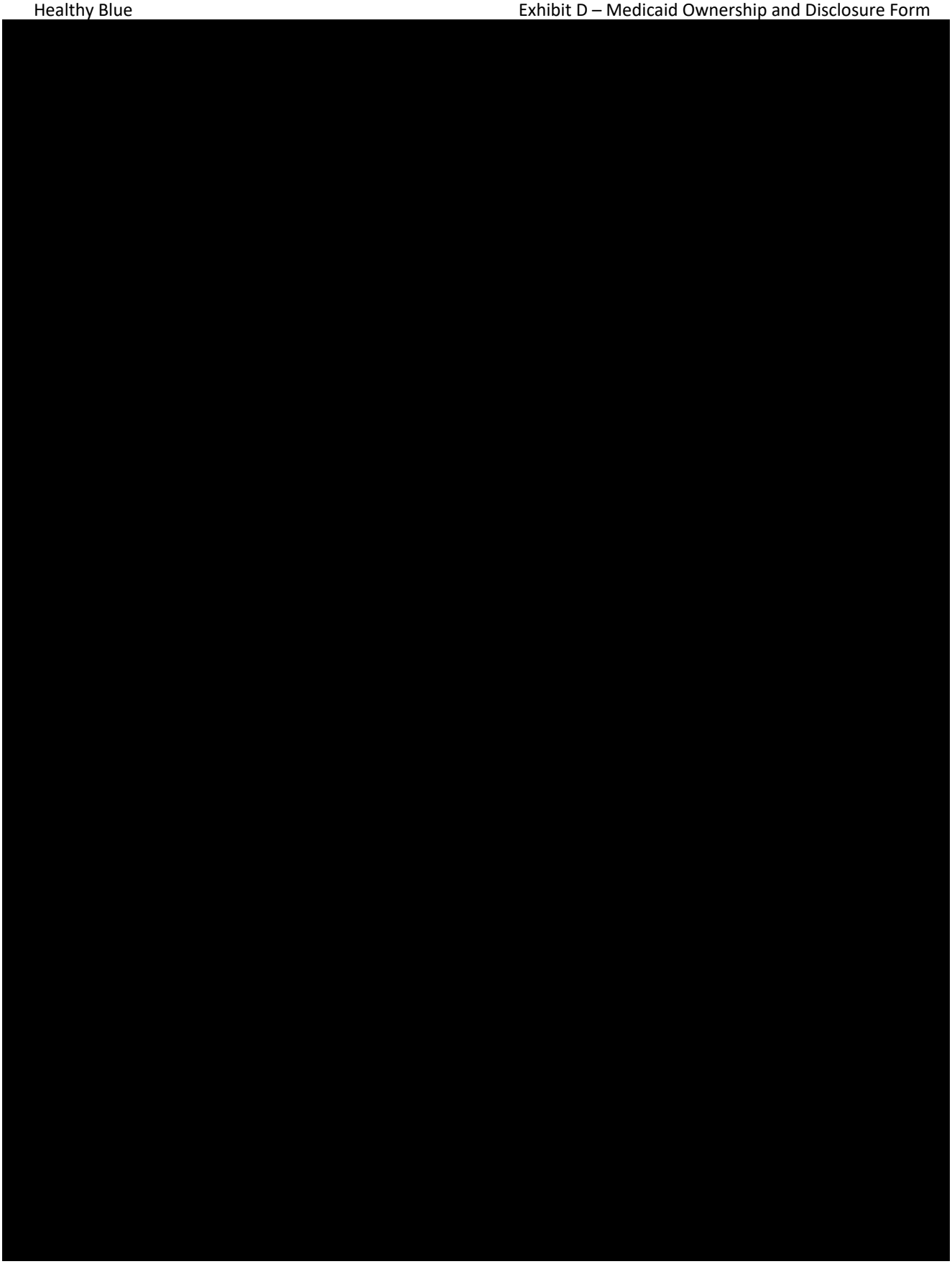

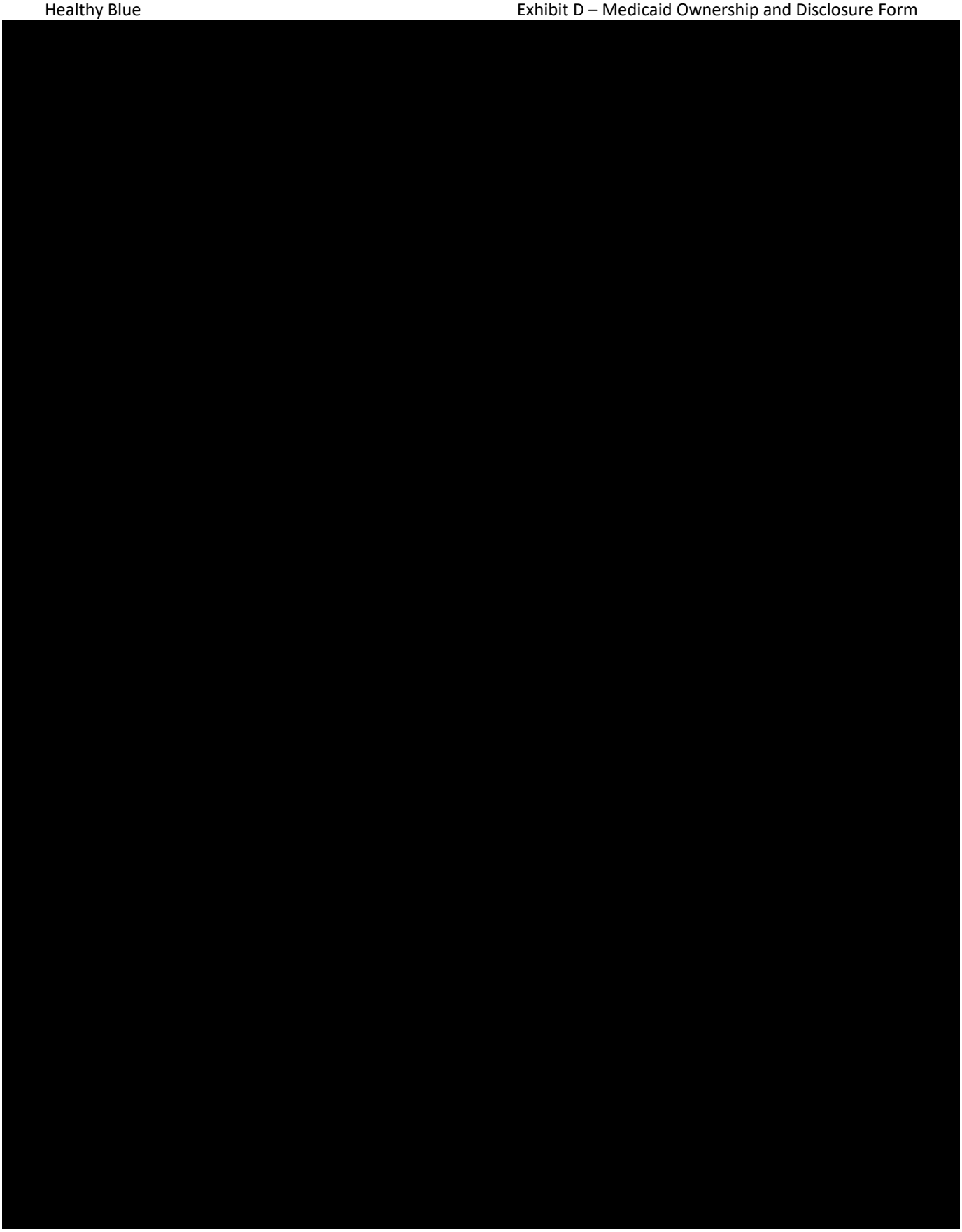

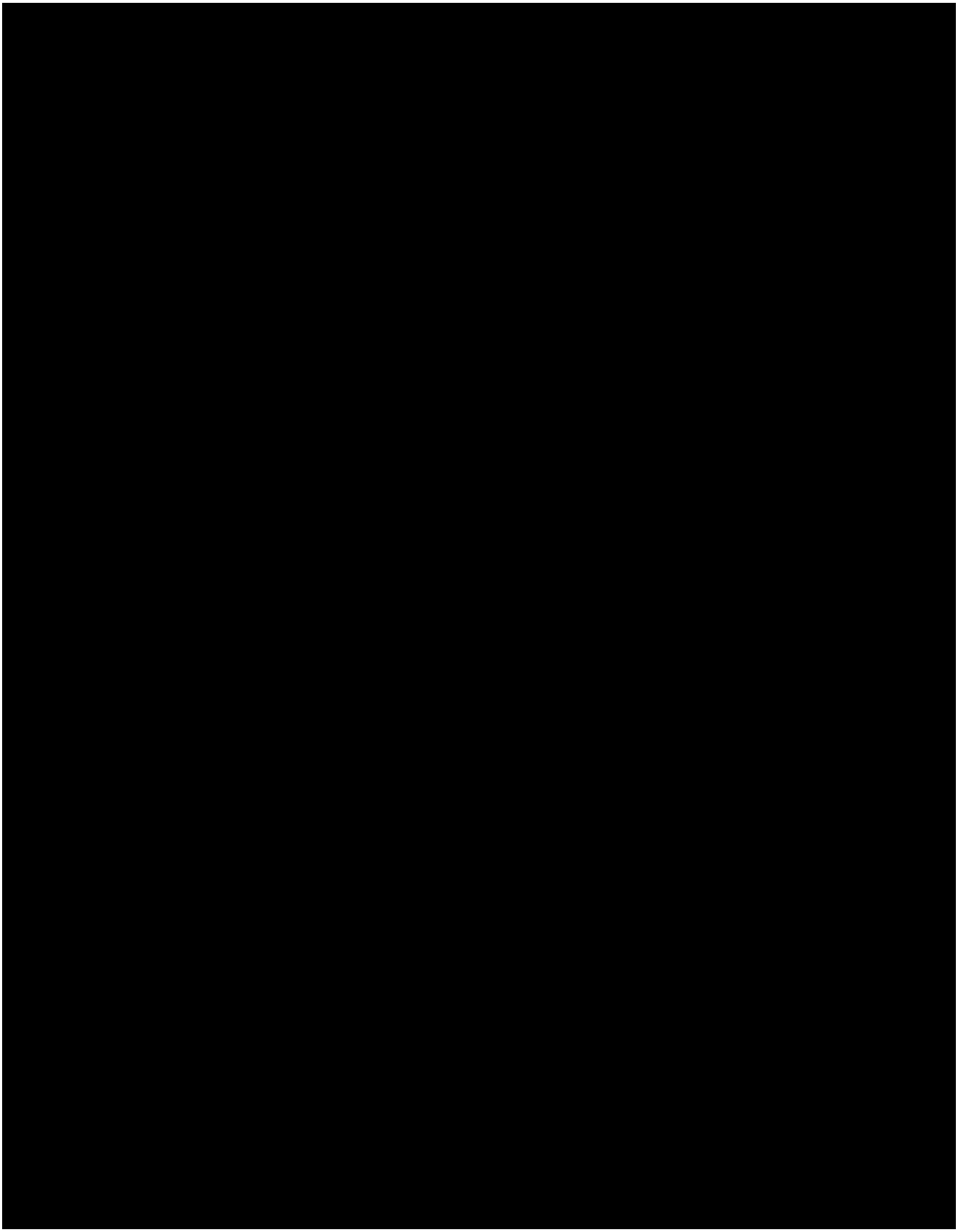

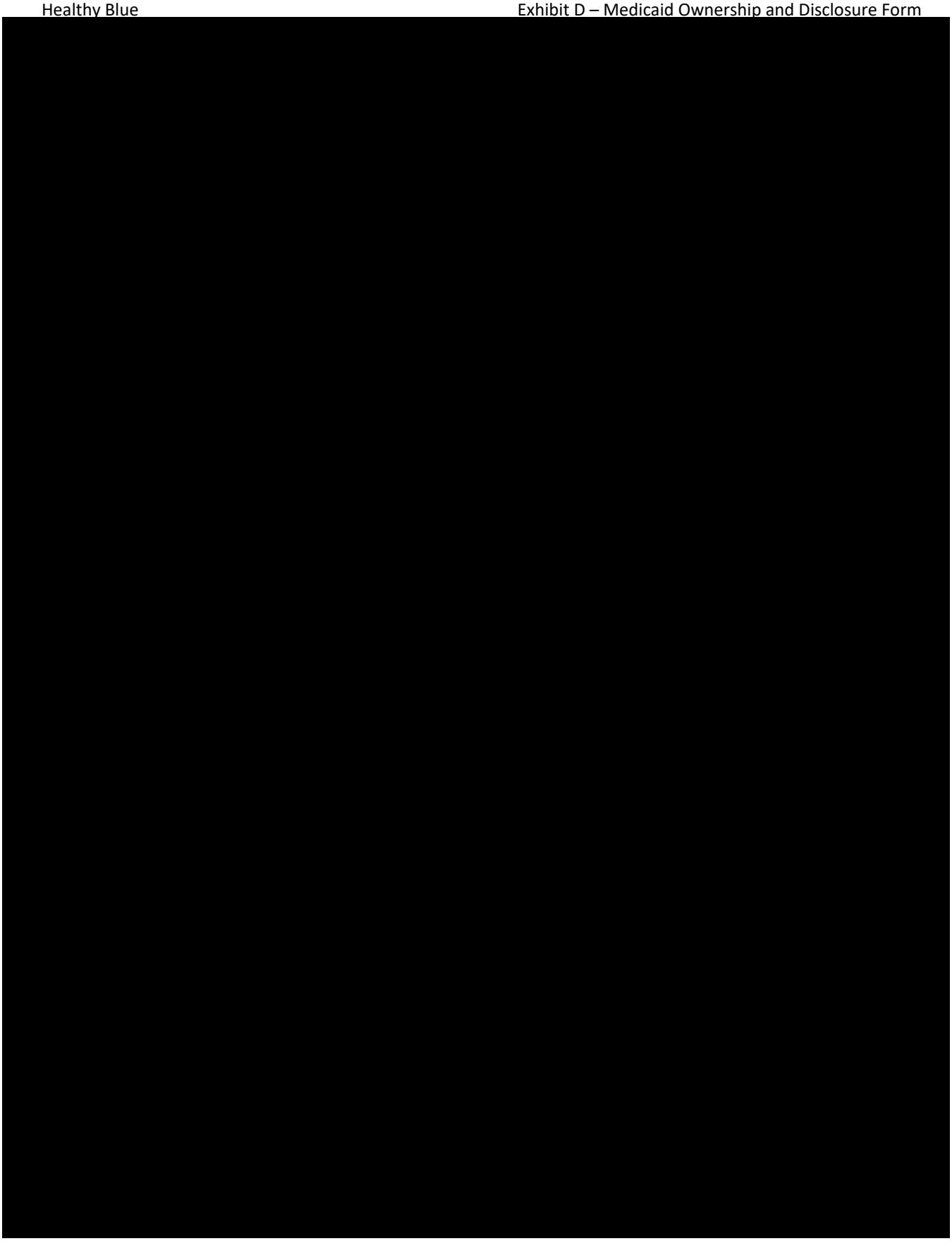

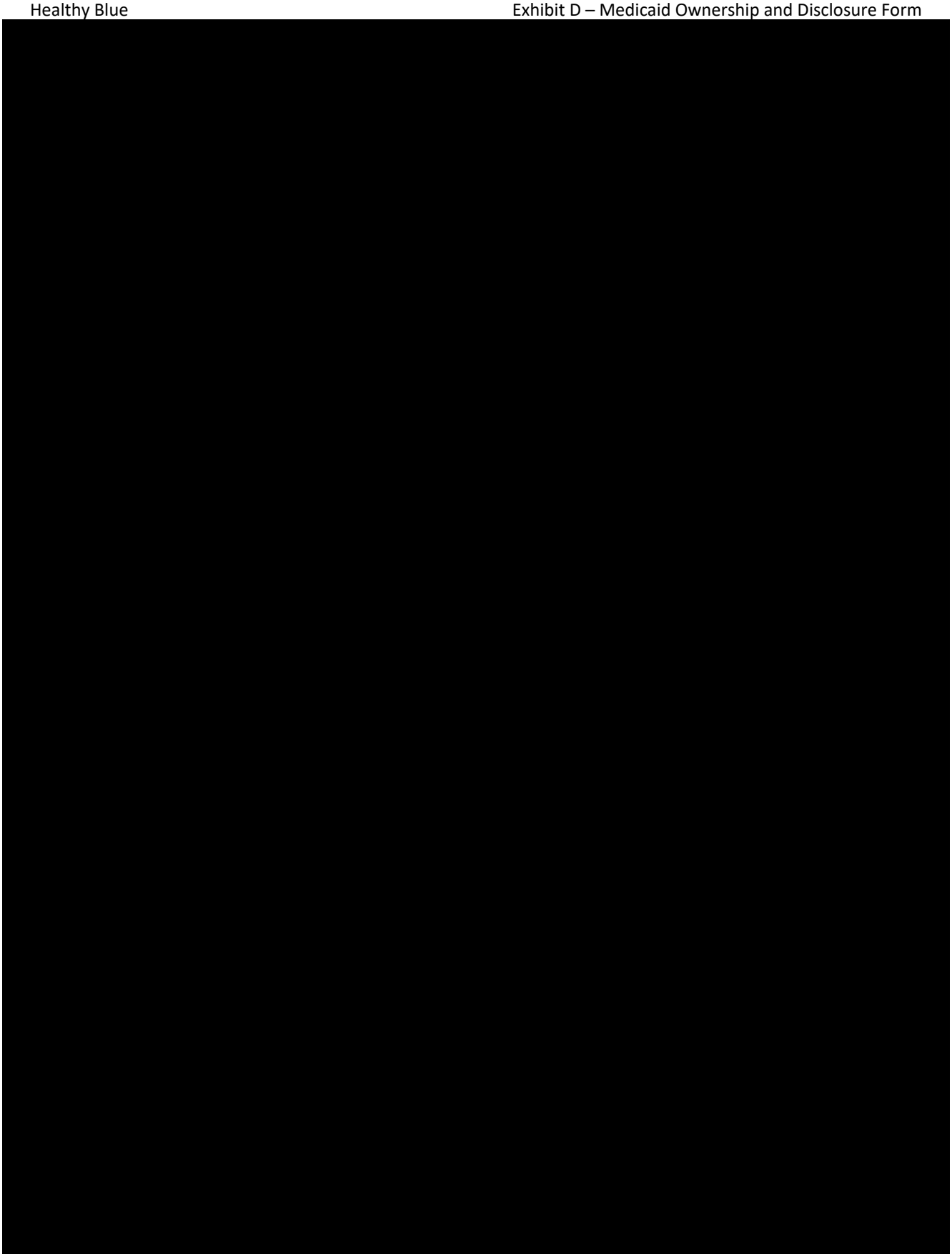

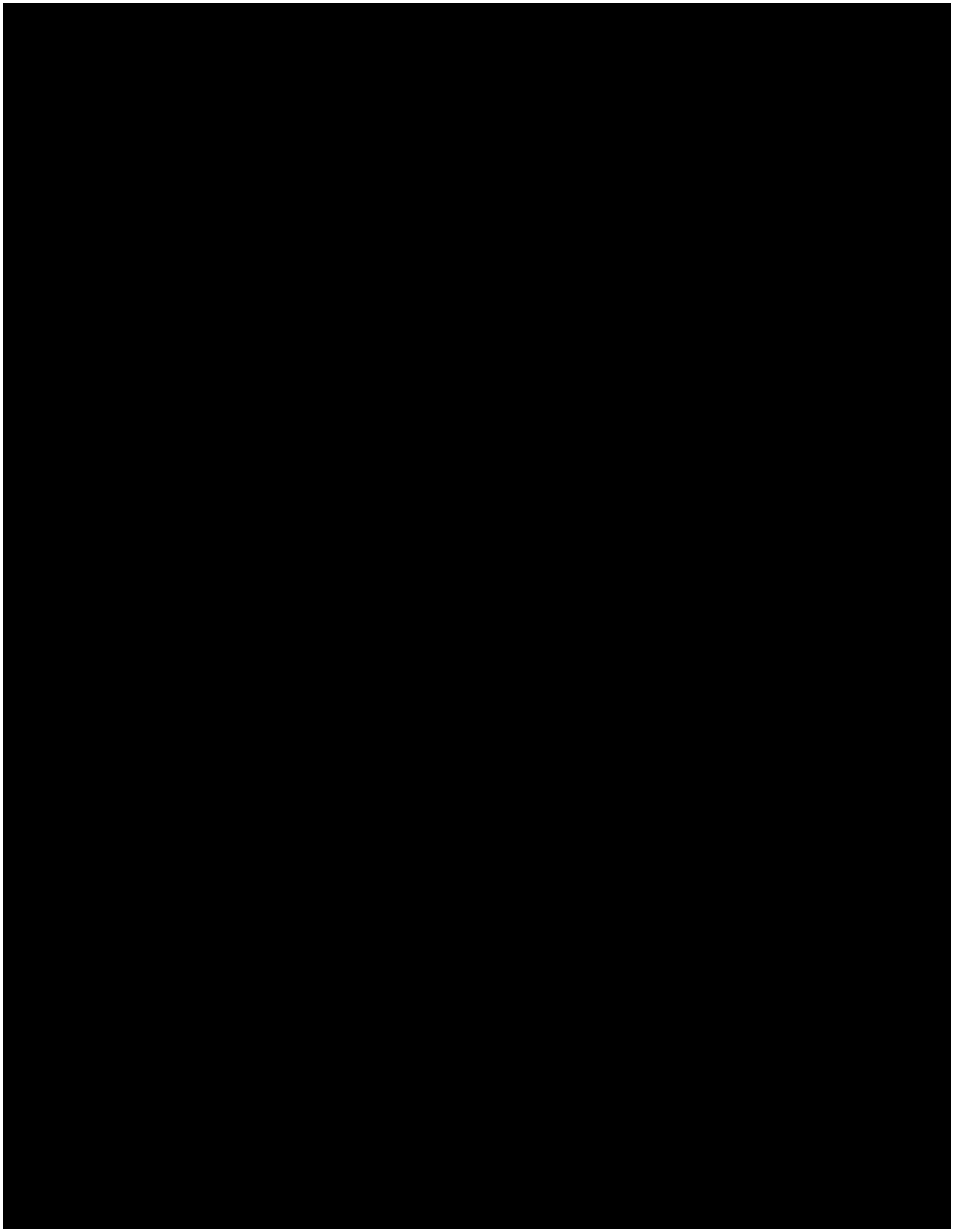

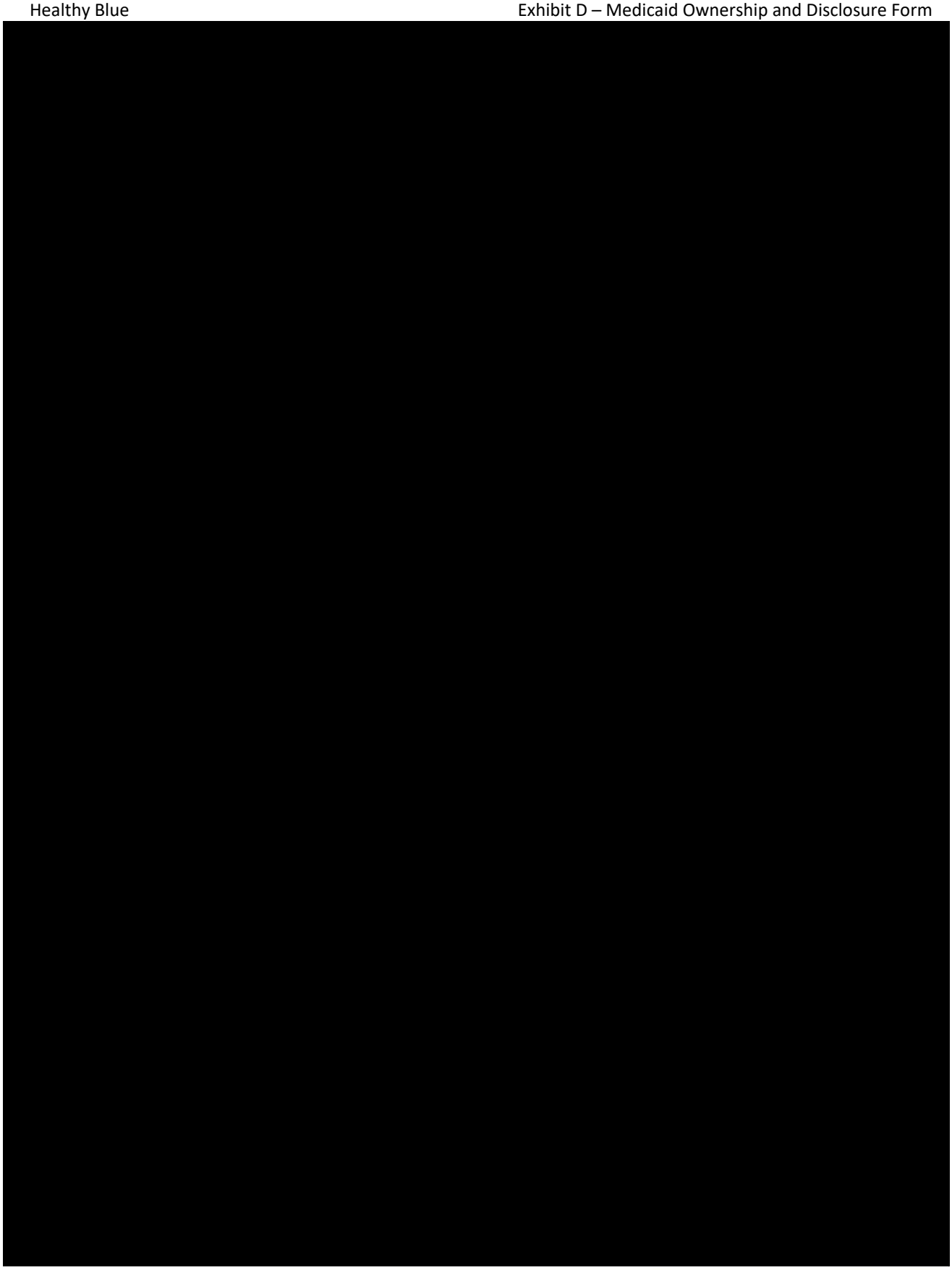

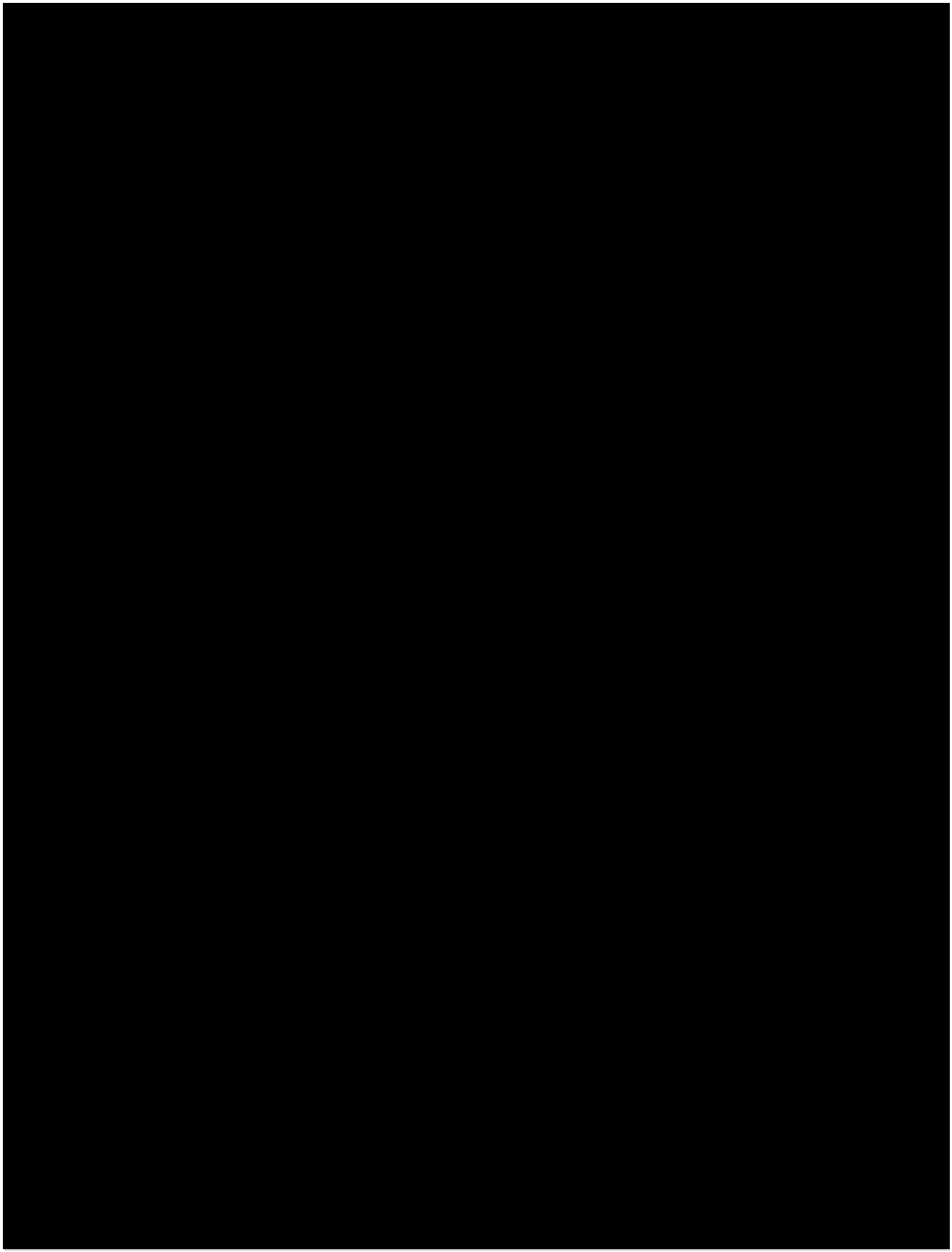

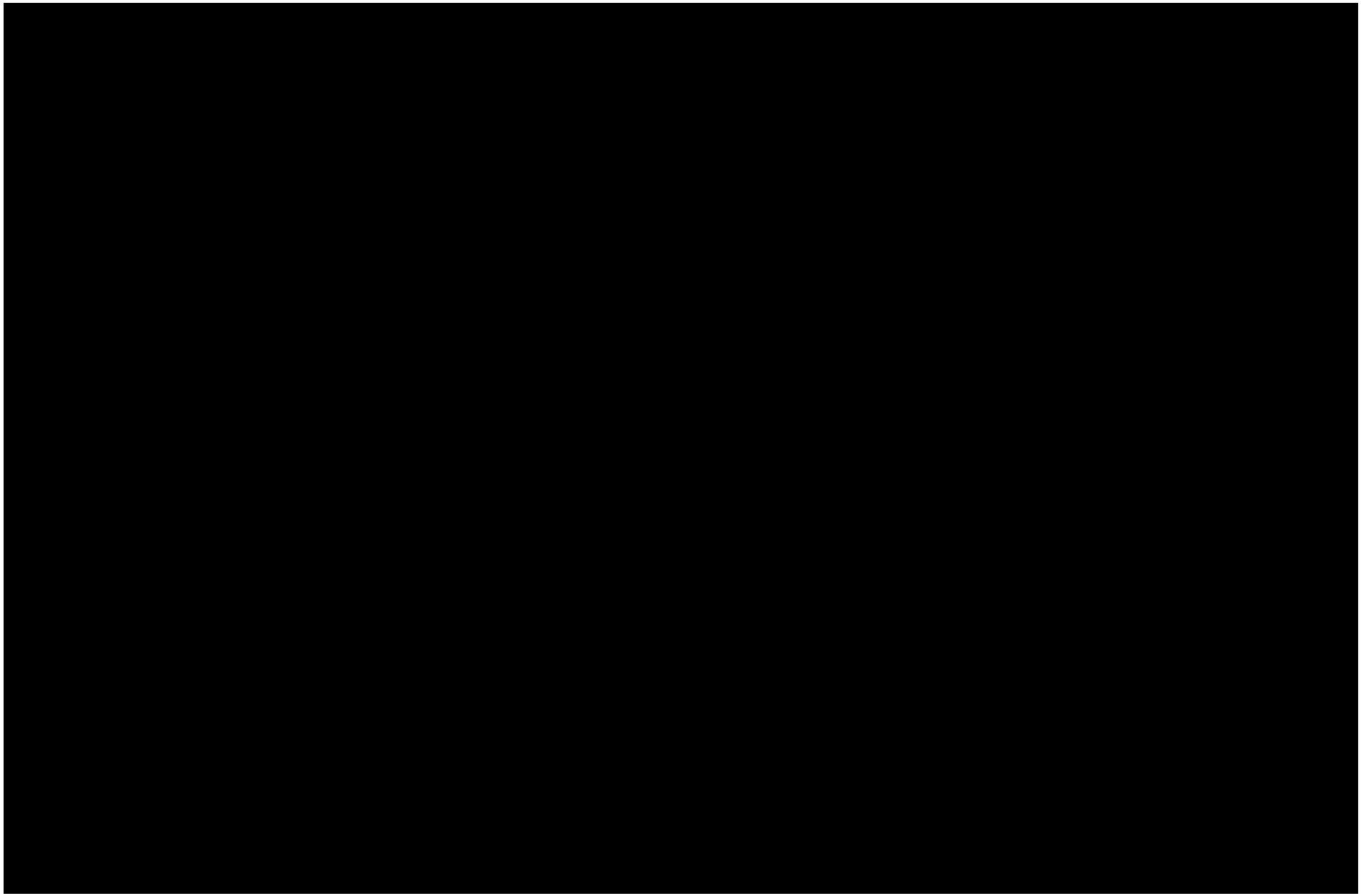

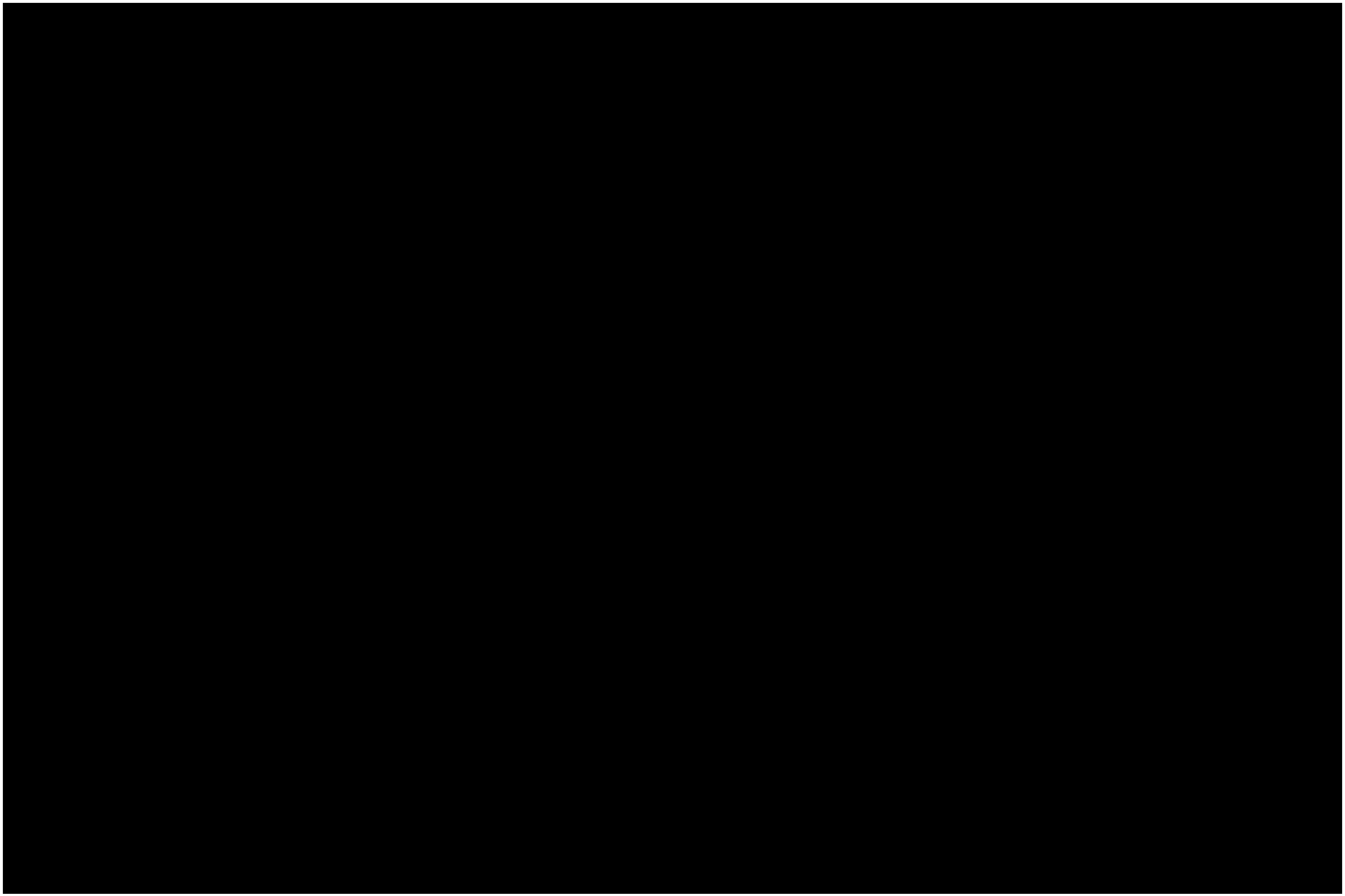



### Sponsoring Total Teen Takeover to Give Teen Voices a Platform

Healthy Blue sponsors Total Teen Takeover, a celebration for the graduates of an eight-week mentoring and workforce development program for young people. Through the program, youth can connect with mentors, explore potential careers, earn industry-recognized certifications, and reinvest in their community through service learning projects. Total Teen Takeover, now in its sixth year, provides a platform to teens to discuss topics important to them, ranging from depression and bullying to mentoring and workforce development. The teens involved are part of an advisory board to help Healthy Blue and our community partners select dynamic and engaging speakers for the event.

# Attachment 2.5.4.3-1

Material Subcontractors

Healthy Blue

# Attachment 2.5.4.3-1: Exhibit B – Material Subcontractor Response Template and Agreement

Attachment 2.5.4.3-1 includes the following:

- Attachment 2.5.4.3-1a: AIM Specialty Health® (AIM) Exhibit B – Material Subcontractor Response Template and Agreement
- Attachment 2.5.4.3-1b: Anthem, Inc. (Anthem) Exhibit B – Material Subcontractor Response Template and Agreement
- Attachment 2.5.4.3-1c: IngenioRx, Inc. (IngenioRx), with their subcontractor Outcomes, Inc. (OutcomesMTM) Exhibit B – Material Subcontractor Response Template and Agreement
- Attachment 2.5.4.3-1d: Superior Vision Benefit Management, Inc. (Superior Vision) Exhibit B – Material Subcontractor Response Template and Agreement

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**Exhibit B: Material Subcontractor Response Template**

| **Proposer (MCO) name:** |
|---|
| Community Care Health Plan of Louisiana, Inc., dba Healthy Blue |
| **Material subcontractor name:** |
| AIM Specialty Health® (AIM) |
| **Description of the Proposer's role and material subcontractor's role:** |
| **Proposer's Role.** Healthy Blue's primary role is to coordinate specialty benefit management services for our enrollees (members), as a covered service. We are ultimately responsible for meeting all contractual requirements. We make sure that the services AIM provides meet or exceed all LDH requirements and are delivered seamlessly to our Healthy Louisiana members in a timely manner. Healthy Blue will continue to monitor, supervise, and enforce contract compliance, as well as promote frequent, open, and effective communication that emphasizes delivery of quality services to members. We will continue to oversee AIM's performance through daily collaboration, regular monitoring, and formalized auditing processes. Healthy Blue believes that maintaining complete visibility into the volume and topics of member grievances and appeals is a critical component of subcontractor oversight. For this reason, we maintain direct responsibility for documenting, tracking, and resolution of all member grievances and appeals. We will continue to work closely with AIM to resolve individual grievances and to address underlying root causes that result in member dissatisfaction.<br>**Material Subcontractor's Role.** AIM's specialty benefit management targets the most complex, costly, and overutilized services in radiology, cardiology, sleep medicine, and medical and radiation oncology. for Healthy Louisiana members. |
| **Explanation of why the Proposer plans to subcontract this service and/or function:** |
| Healthy Blue uses subcontractors who have specialized capabilities, including administration of specialty benefit management services. As a wholly owned subsidiary of our parent company, Anthem, Inc., AIM provides services for multiple Medicaid markets and we prefer to work with them to tailor programs and services that align with Healthy Blue's stringent and specific requirements. AIM Specialty Health® (AIM) is a leader in specialty benefit management, creating sustainable medical cost savings for health plans across the country. With a focus on today's most complex, costly, and overutilized services in radiology, cardiology, sleep medicine, and medical and radiation oncology. |
| **A description of the material subcontractor's organizational experience:** |
| For over 28 years, AIM has been an innovator, leader, and partner to payers. AIM addresses today's growing areas of cost and concern in utilization management and their programs are built off a set of capabilities proven to deliver value, including: clinical appropriateness review, member engagement, value based payment alignment, clinical setting optimization, provider engagement, and claims payment support services. Today AIM works with over 79 health plans serving over 65 million members nationwide to deliver value through clinical appropriateness review, clinical setting optimization, provider collaboration, and member engagement services. |
| **The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:** |

Healthy Blue implements subcontracting processes and procedures to monitor and evaluate material subcontractor performance, ensuring contract requirements are met and determining the return on investment. Healthy Blue maintains an established Subcontractor Oversight Program, refined through nine years of serving Healthy Louisiana members and enhanced by our organization's national expertise and experience. We continue to enhance this program to make sure we deliver timely, appropriate, and quality care and services. Our material subcontract with AIM includes LDH requirements as specified in Model Contract. The agreement includes detailed requirements and service levels, sets clear expectations of how we measure performance and compliance, and specifies the consequences for non-compliance. Healthy Blue will continue to retain ultimate responsibility for adhering to and fully complying with all terms and conditions of our Contract and remain accountable for AIM's performance.

We view our material subcontractors as valued partners and, through a comprehensive vetting process, we select the most qualified that can best serve our members. Our material subcontractors are an extension of Healthy Blue and the services we deliver. We build trusted, collaborative, longstanding relationships with our material subcontractors to coordinate a seamless delivery of services that meet LDH requirements. Healthy Blue will continue to work closely with the State to demonstrate that through AIM, we continue to meet Contract requirements and LDH expectations for delivering high-quality specialty benefit management services to our Healthy Louisiana members.

## Processes to Monitor and Evaluate Performance

We monitor and evaluate AIM's performance through daily collaboration, regular monitoring, and formal auditing processes. We will continue to oversee, monitor, supervise, and enforce contract compliance, as well as promote frequent, open, and effective communication that emphasizes delivery of quality services to members. We monitor AIM to make sure they meet or exceed contractual requirements.

Our Louisiana-based Vendor Oversight Workgroup oversees the performance of our material subcontractors, including AIM. Chaired by our Plan Compliance Officer, Hassan Gardezi, our team includes members of the senior leadership, including our CEO, COO, Medical Director, Provider Relations Director, Quality Director, Subcontractor Account Managers, and other participants as necessary. The team meets monthly and reports to the Compliance Committee at its monthly meetings.

Our Vendor Oversight Workgroup works closely with our national organization oversight teams and committees to verify that the services or functions AIM provides are of the highest quality and performed in a seamless, cost-effective manner. AIM also provides services to five of our affiliates; the resultant oversight and monitoring, at both the local and national levels, offers a number of key benefits, including:

- Accountability to state-specific requirements
- Consistency in management, expectations, and remediation or corrective actions, as well as a high-level review of performance across all states to better identify trends
- Identification of best practices and innovations in one state to be shared with others
- Proactive identification and mitigation of performance variance in a single state, often avoiding impact on other markets

Healthy Blue operates under a culture of continuous quality improvement. Our Subcontractor Oversight Program is successful because we continually refine and enhance our processes and methods of monitoring and evaluating subcontractor performance.

Our Subcontractor Oversight Program begins with a thorough, rigorous evaluation process to confirm that material subcontractors meet operational, financial, legal, compliance, regulatory, accreditation, NCQA, and ethical standards. During our pre-delegation audit, we examine items such as the organization's HIPAA privacy and security compliance, grievance and appeals history, operating procedures, staffing ratios, and financial viability. Healthy Blue will continue to request LDH approval of all material subcontracts, amendments, and substitutions, submitting a completed material subcontractor checklist using the template in the MCO Manual.

Once operational, our program enables us to monitor material subcontractor performance and financial stability. We tailor our program, including the scope and frequency of oversight activities, to the functions and services each material subcontractor provides. We outline the frequency and type of ongoing oversight activities we perform to monitor AIM in Table Exhibit B-1.

*Table Exhibit B-1. Our Oversight Program Monitors AIM Throughout the Life Cycle of the Relationship*

| Frequency | Scope of Oversight Activities |
|---|---|
| Daily | • Work with AIM to answer questions, collaborate on problem solving, discuss opportunities for improvement, and escalate urgent performance concerns<br>• Provide rapid response to complaints and member issues |
| Monthly | • Review AIM regulatory report submissions<br>• Complete Performance Indicator Report on AIM |

| | |
|---|---|
| | • Review performance against standards, including data trends, and report submissions<br>• Review performance with AIM, Account Manager, and the Vendor Oversight Workgroup<br>• Delegation/Vendor Oversight and Management Committee (DVOMC) meeting to discuss performance monitoring, corrective action plans (CAPs), and terminations |
| **Quarterly** | • Meet with AIM to discuss performance across markets and present issues, gaps, and concerns to the DVOMC<br>• Medicaid Financial Analysis team reviews quarterly unaudited financial statement to assess financial solvency<br>• DVOMC reports to the National Quality Improvement Committee to discuss any quality issues with subcontractor performance |
| **Annually** | • Perform audit to confirm that AIM meets operational, systems, financial, legal, compliance, regulatory, accreditation, NCQA, and ethical requirements<br>• Medicaid Financial Analysis team reviews audited financial statements to assess financial solvency<br>• Submit annual audit findings to LDH, including any CAPs<br>• Present audit findings to the DVOMC and the Vendor Oversight Workgroup |

Healthy Blue assigns an Account Manager to each material subcontractor to conduct day-to-day management as well as oversight and performance review. This approach builds trust between our organization and our material subcontractors, which, in turn, helps prevent compliance issues. The Account Manager works hand-in-hand with our Vendor Oversight Workgroup.

Each month, we collect and review AIM performance against a defined set of metrics that represent LDH and Healthy Blue requirements. During monthly meetings, the Account Manager and Vendor Oversight Workgroup meet with AIM to review performance against standards. We share the Performance Indicator Report, discuss both positive and negative data trends, and brainstorm opportunities for improvement. The review includes careful evaluation of performance metrics and, where applicable, network adequacy. Our experience shows that transparency and open, constructive dialogue is critical to maintaining a collaborative partnership with material subcontractors that drives seamless service delivery to members.

While we review all performance metrics, we pay careful attention to member grievances and appeals, looking at topics, volumes, and trends (positive and negative). We work with AIM to resolve individual grievances, as well as identify opportunities for more widespread improvements that would improve member satisfaction.

National oversight functions and a strong governance structure provide an additional level of support to our program. Regular communication between national functions and our Vendor Oversight Workgroup will maintain focus on delivering high-quality services to our members. National oversight functions include:

- The Delegation Operations Committee (DOC) includes representatives from account management, quality, legal, compliance, and other operational areas as needed. The DOC assesses oversight and compliance (with contractual and applicable State, federal, and accreditation standards), monitors CAPs (including recommending escalation), evaluates subcontractor performance through reports analysis, and makes recommendations to DVOMC on findings, as well as the use of audit tools.
- The DVOMC oversees subcontractors serving multiple health plans and is responsible for meeting compliance with State, federal, NCQA, CMS, and individual program requirements and standards, as well as other regulatory or accreditation standards. They report to the National Quality Committee quarterly and the National Quality Improvement Committee semi-annually.
- The National Quality Improvement Committee meets quarterly and reports any subcontractor quality or compliance-related issues to health plan leadership.

## Improving Subcontractor Performance and Results

Healthy Blue always strives to improve the level of service we deliver, and we expect our material subcontractors to do the same. During subcontractor oversight and monitoring, we not only review areas with substandard performance, but will seek out opportunities to “raise the bar” and deliver better service. We use our Subcontractor Scorecard in conjunction with our Performance Indicator Report to monitor performance, track actions taken to improve performance, and drive positive results from our material subcontractors. For material subcontractors that also support our affiliates, our national team’s view of performance across markets can provide early insight into any problems that may affect our Healthy Louisiana operations.

Clearly defined expectations and consistent performance monitoring is a key piece of our Subcontractor Oversight Program, and written agreements detail performance standards and the actions we take to address inadequate or substandard performance. If at any time performance does not meet our expectations, we will take action and work closely with AIM toward a resolution and return to complete and ongoing compliance.

Our subcontractor agreements outline specific service level agreements (SLAs) for each function we delegate that align with LDH requirements. If LDH modifies a standard, as they have done with some performance measures in the Model Contract, we will amend the subcontractor agreement to reflect the change.

If Healthy Blue identifies a performance or operational problem with AIM, we immediately address our concerns by applying a series of escalating interventions, including increased meeting frequency and data submission, development of an informal action plan, development of a CAP, financial penalties, and other sanctions.

Healthy Blue views interventions not as a punitive action, but rather, a documented process to improve performance. The type of intervention depends on a combination of factors, including the severity of the issue and historical performance. For example, a single month of missing an SLA will likely result in increased monitoring and an action plan, while missing an SLA in two consecutive months warrants a CAP. We track and monitor all interventions. In the event that interventions are unsuccessful in generating a sustained performance improvement, we will consider termination and notify LDH the day the decision is made.

## Subcontractor Report Submission and Data Exchanges

Healthy Blue requires that AIM submit two primary types of reports: data we need to fulfill ad hoc and regulatory reporting requirements, and operational information to monitor performance against standards. Account Managers maintain a schedule of due dates for both types of reports and reach out if they are late or submit incomplete or inaccurate data. AIM submits reports, such call center performance, based on an internal due date (ahead of the LDH deadline) to provide time for a thorough quality review. AIM also provides information for each monthly Performance Indicator Report so that we can monitor and manage their performance against a defined set of metrics.

Healthy Blue also requires AIM to submit data files, including encounter data, on a specified schedule. We document not only the schedule (frequency and day/time), but also the format and secure transmission method. If we do not receive a file on its due date, an email alert notifies the Account Manager and prompts outreach to AIM to ascertain the status and reason for the delay. In addition, we maintain a schedule for files we send AIM, including member enrollment data (834 file), and require that they update their database promptly.

## Monitoring the Financial Condition of our Material Subcontractors

Healthy Blue understands that we need to make sure our material subcontractors maintain a strong and sound financial condition in order to avoid member disruption in accessing services. Through our Subcontractor Oversight Program, day-to-day interactions and monitoring activities give us insight into our subcontractors' financial health. We pay careful attention to signs that may indicate problems, such as a drop in claims payment timeliness, changes in encounter completeness or accuracy, or an increase in member complaints. We discuss any concerns at our internal Vendor Oversight Workgroup and Compliance team meetings. In addition, we review the financial stability of AIM each quarter. The review process focuses on identifying any potential issues as early as possible and implementing necessary actions in order to avoid member service disruptions. We leverage our keen understanding of AIM's financial solvency, the risk to our operations, and continued ability to serve Louisiana members.

AIM submits unaudited financial statements quarterly and audited financial statements annually. These financial statements include the profit and loss statement, balance sheet, and statement of cash flow. Each quarterly statement includes both the respective quarter and year-to-date, so that as the year progresses, the team can monitor how the material subcontractor is performing over time.

## Annual Audit Confirms Compliance

An annual audit has been a key part of our Subcontractor Oversight Program since we began operations in Louisiana. We use the annual audit to confirm that AIM continues to meet operational, financial, legal, compliance, regulatory, accreditation, and ethical requirements.

The audit team maintains a schedule for the annual audit of material subcontractor and a comprehensive set of audit tools for each type of function that may be delegated (such as network management, credentialing, claims processing, and call center). A global tool addresses areas such as HIPAA privacy and security; fraud, waste, and abuse; cultural competency; disclosure of ownership; and record retention. Each audit tool lists a series of audit elements applicable to the function and the evidence required to assess compliance. During the audit, the audit team reviews each element, decides whether the subcontractor is compliant or non-compliant, and documents the evidence. The audit process includes review of documents such as policies and procedures, financial statements, member complaints, employee and provider training documents, and provider contract templates. For subcontractors with provider credentialing, authorization, and claims processing responsibilities, the audit team randomly selects sample files for audit.

If the review identifies any deficiencies or areas of improvement, we work with the material subcontractor to develop a CAP that documents all of the corrective actions and steps needed to resolve the identified deficiencies, the name and title of responsible parties, and planned completion dates of each action step. Healthy Blue will submit the results of the annual review and any CAPs associated with the review to LDH.

## Material Subcontractor Return on Investment

We use material subcontractors that have specialized capabilities that Healthy Blue does not have internally, including specialty benefit management. For these services, we use material subcontractors that have established relationships and long-standing experience across our organization, in multiple markets and across multiple lines of business (Medicaid, MMP, and Medicare). We continuously monitor our internal capabilities in order to determine whether we could bring specific capabilities "in-house" and deliver a similar or higher service capability and a more competitive cost structure.

Once operational, we use a number of processes to confirm that the material subcontractor continues to deliver the high-quality services that we expect. Processes cover a number of dimensions, including quality, compliance with performance standards, financial solvency, and strength of the partnership, and include the following:

- Monthly oversight meetings
- Monthly, quarterly, and annual report submission and monitoring
- Quarterly Joint Operations Meetings
- Quarterly and annual financial solvency reviews
- Quarterly review of utilization against cost
- Annual audits

If Healthy Blue determines that the material subcontractor relationship is not delivering the value we expect — to our members, LDH, and the Healthy Louisiana program — we will investigate alternatives.

Instructions: The Proposer should attach the executed or draft contract and indicate compliance witheach of the following checklist items by completing the "Location" column.

| | **Checklist Item** | **Location** (Include Name of Document, Page Number, and Section Number/ Letter) |
|---|---|---|
| 1 | Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between LDH and the MCO and the MCO Manual, and either physically incorporate these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request. | The Memorandum of Understanding (MOU): Company Receiving Services- Amerigroup Louisiana, Inc. Company Supplying Services- AIM Specialty Health ("MOU"). Page 1, "Compliance with Louisiana Medicaid Regulation."; Amendment to the MOU Exhibit B, Page 5, §15 |
| 2 | Include a signature page that contains an MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for executed contracts). | MOU Page 2; Amended MOU, page 2 |
| 3 | Specify the effective dates of the subcontract agreement. | MOU Page 1; Amended MOU Page 1 |
| 4 | Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties. | MOU Exhibit B, page 5, §16 |
| 5 | Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties. | MOU Exhibit B, page 5, §16 |

| | **Checklist Item** | **Location** (Include Name of Document, Page Number, and Section Number/ Letter) |
|---|---|---|
| 6 | Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract. | MOU Exhibit B, page 5, §17 |
| 7 | Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and LDH for any of the reasons described in the contract, the MCO shall immediately make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to LDH. | MOU Exhibit B, page 5, §18 |
| 8 | Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO. | MOU Exhibit B, page 5, §19 |
| 9 | Require that if any requirement in the subcontract is determined by LDH to conflict with the contract between LDH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect. | MOU Exhibit B, page 3, §2b |
| 10 | Identify the population covered by the subcontract. | MOU Exhibit B, page 3, Definitions |
| 11 | Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to enrollees through the last day that the subcontract is in effect. | MOU Exhibit B, page 5, §20 |
| 12 | Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO. | MOU Exhibit B, page 5, §22 |
| 13 | Specify the amount, duration, and scope of benefits and services that are provided by the subcontractor. | MOU Exhibit A, page 3, Roles and Responsibilities; MOU Amendment (1/1/19) page 1; MOU Amendment (08/2021) page 1 |

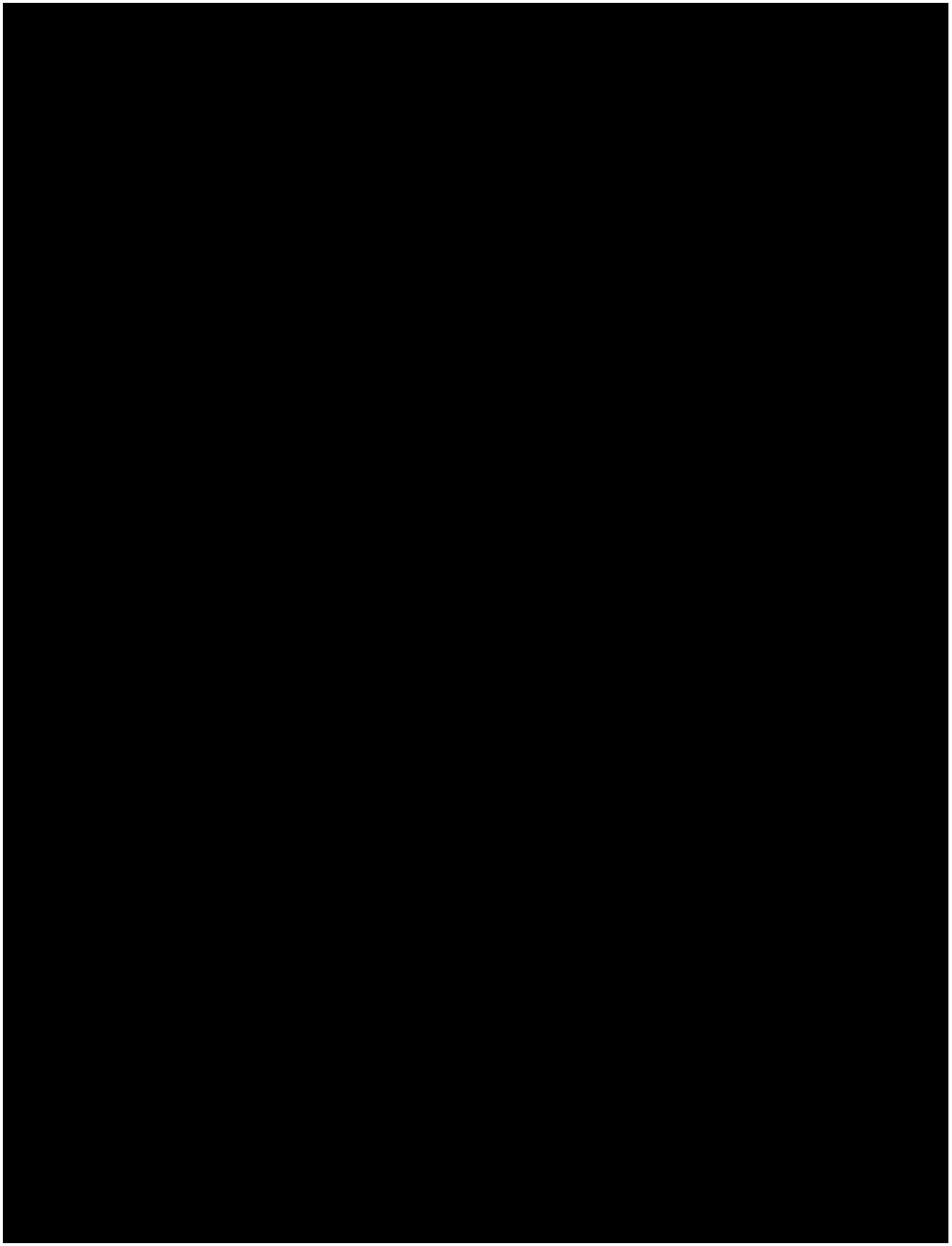
| | **Checklist Item** | **Location** (Include Name of Document, Page Number, and Section Number/ Letter) |
|---|---|---|
| 14 | Provide that emergency services be coordinated without the requirement of prior authorization of any kind. | MOU Exhibit B, page 5, §23 |
| 15 | Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 C.F.R. § 493.1 and 493.3, and any other federal requirements. | MOU Exhibit B, page 5, §24 |
| 16 | Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO enrollees pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between LDH and the MCO). MCO enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended and subject to reasonable charges. | MOU Exhibit B, page 6, §27 |
| 17 | Include record retention requirements as specified in the contract between LDH and the MCO. | MOU Exhibit B, page 6, §28 |
| 18 | Shall make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested. | MOU Exhibit B, page 6, §29 |
| 19 | INTENTIONALLY LEFT BLANK | |
| 20 | Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or LDH or its designee. | MOU Exhibit B, page 7, §30 |

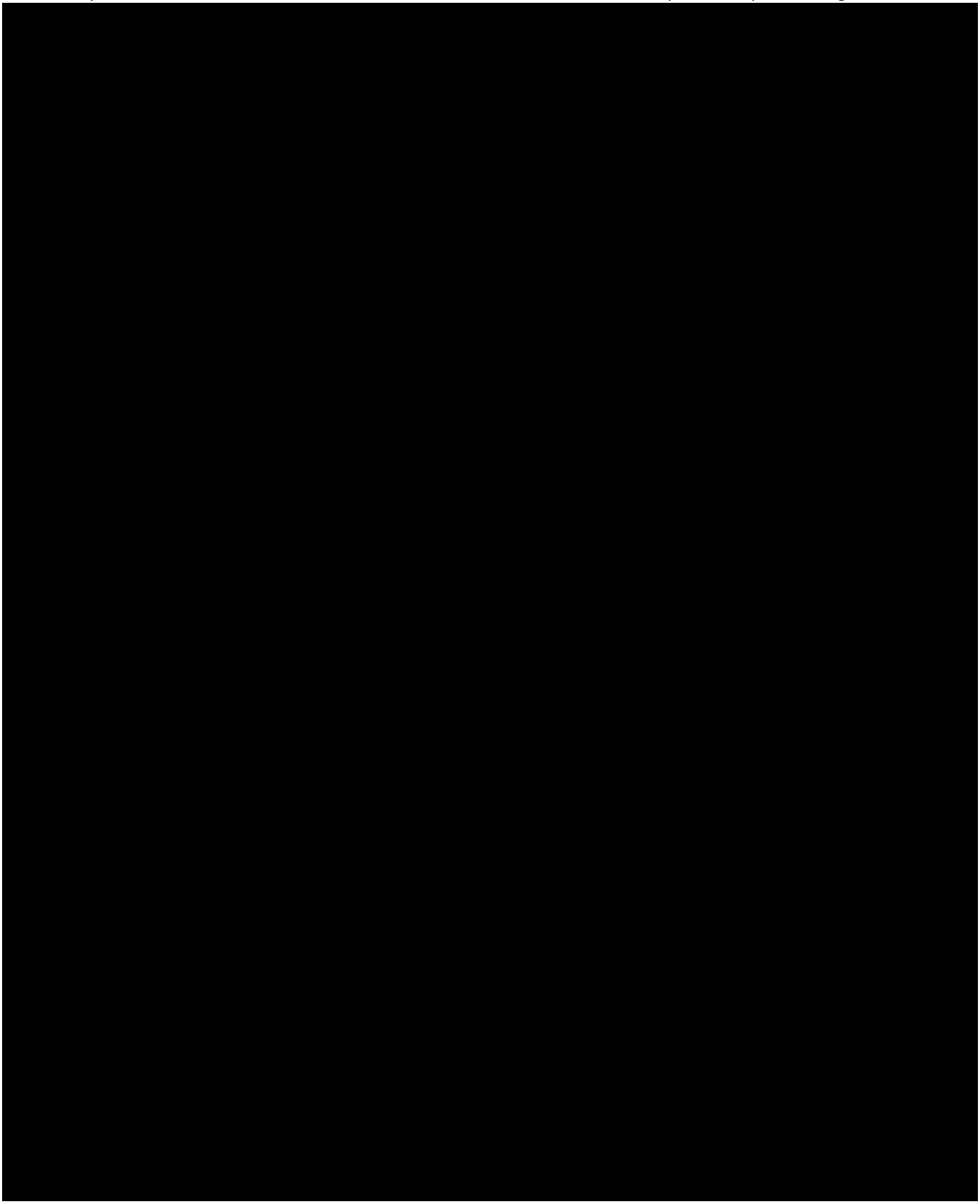
| | **Checklist Item** | **Location** (Include Name of Document, Page Number, and Section Number/ Letter) |
|---|---|---|
| 21 | Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by LDH or its designee. | MOU Exhibit B, page 7, §31 |
| 22 | Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by LDH. | MOU Exhibit B, page 7, §31 |
| 23 | Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontract and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by LDH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate. | MOU Exhibit B, page 7, §32 |
| 24 | Provide for submission of all reports and clinical information to the MCO for reporting purposes required by LDH. | MOU Exhibit B, page 7, §33 |
| 25 | Require safeguarding of information about MCO enrollees according to applicable state and federal laws and regulations and as described in contract between LDH and the MCO. | MOU Exhibit B, page 7, §34 |
| 26 | Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO. | MOU Exhibit B, page 10, §56 |
| 27 | Provide that the subcontractor comply with LDH's claims processing requirements as outlined in the RFP. | MOU Exhibit B, page 7, §35 |
| 28 | Provide that the subcontractor adhere to LDH's timely filing guidelines as outlined in the RFP. | MOU Exhibit B, page 7, §35 |
| 29 | Provide that, if LDH or its subcontractors discover an error or a conflict with a previously adjudicated encounter claim, the subcontractor shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or the MCO, or if circumstances exist that prevent the subcontractor from meeting this time frame, by a specified date approved by LDH. | MOU Exhibit B, page 7, §36 |

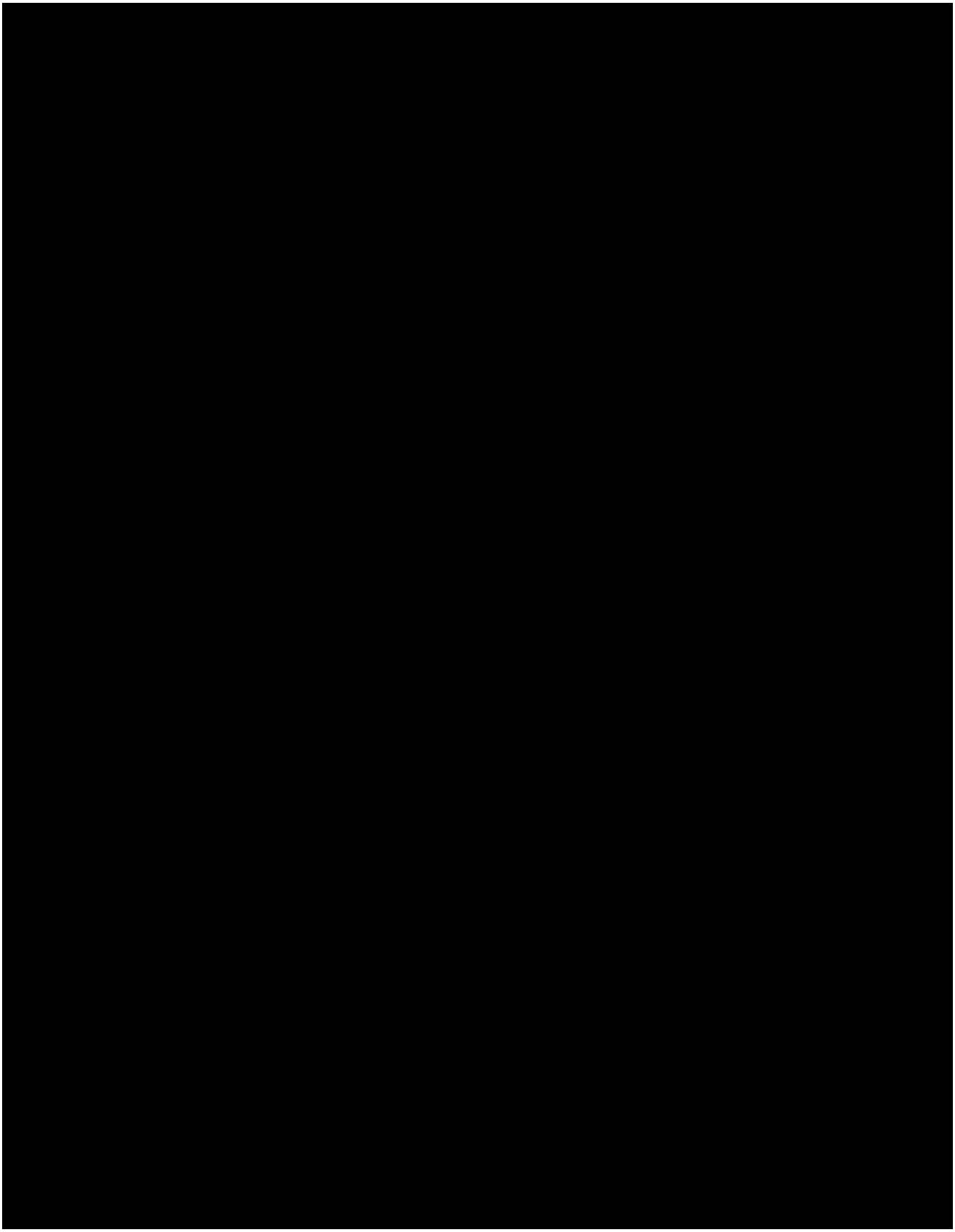
| | **Checklist Item** | **Location** (Include Name of Document, Page Number, and Section Number/ Letter) |
|---|---|---|
| 30 | Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served. | MOU Exhibit B, page 8, §38 |
| 31 | Specify that at all times during the term of the subcontract, thesubcontractor shall indemnify and hold LDH harmless from all claims, losses,or suits relating to activities undertaken pursuant to the contract between LDH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between LDH and the MCO in its entirety in the subcontractor's agreement or by useof other language developed by the MCO and approved by LDH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by LDH. | MOU Exhibit B, page 8, §39 |
| 32 | Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's enrollees and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage. | MOU Exhibit B, page 8, §40 |
| 33 | Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services, and stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where the material subcontractor is based and Louisiana law. | MOU Exhibit B, page 8, §41 |
| 34 | Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective. | MOU Exhibit B, page 8, §42 |
| 35 | Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member. | MOU Exhibit B, page 8, §43 |
| 36 | Include a conflict of interest clause as stated in the contract between LDH and the MCO. | MOU Exhibit B, page 8, §44 |

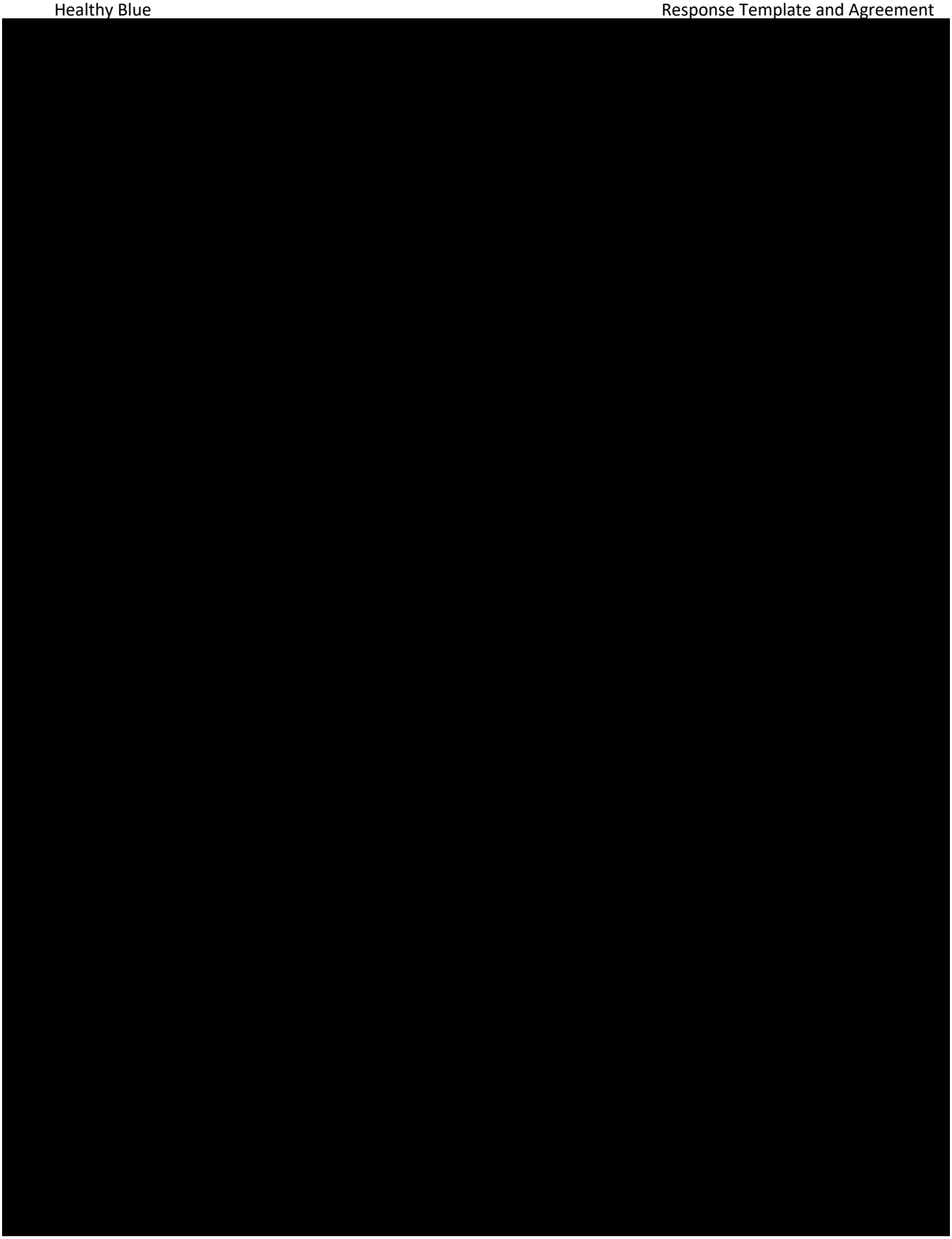
| | **Checklist Item** | **Location** (Include Name of Document, Page Number, and Section Number/ Letter) |
|---|---|---|
| 37 | Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between LDH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor. | MOU Exhibit B, pages 8-9, §45 |
| 38 | Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO. | MOU Exhibit B, page 9, §46 |
| 39 | Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract. | MOU Exhibit B, page 4, §14 |
| 40 | Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity. | MOU Exhibit B, page 10, §54 |
| 41 | Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO. | MOU Exhibit B, page 9, §51 |
| 42 | Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement. | MOU Exhibit B, page 9, §53 |

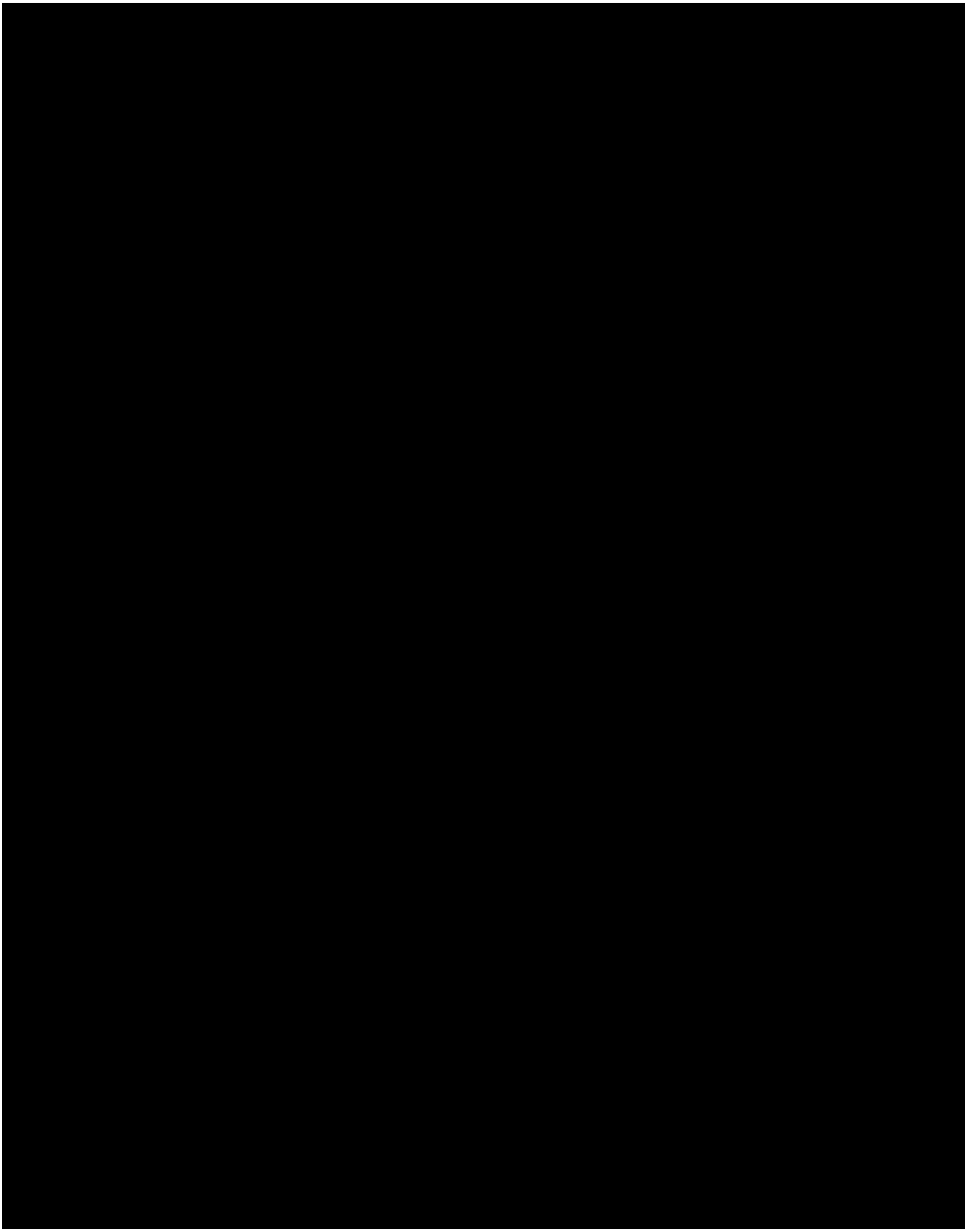
| | **Checklist Item** | **Location** (Include Name of Document, Page Number, and Section Number/ Letter) |
|---|---|---|
| 43 | Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or paymentmechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries. | MOU Exhibit B, page 10, §59 |

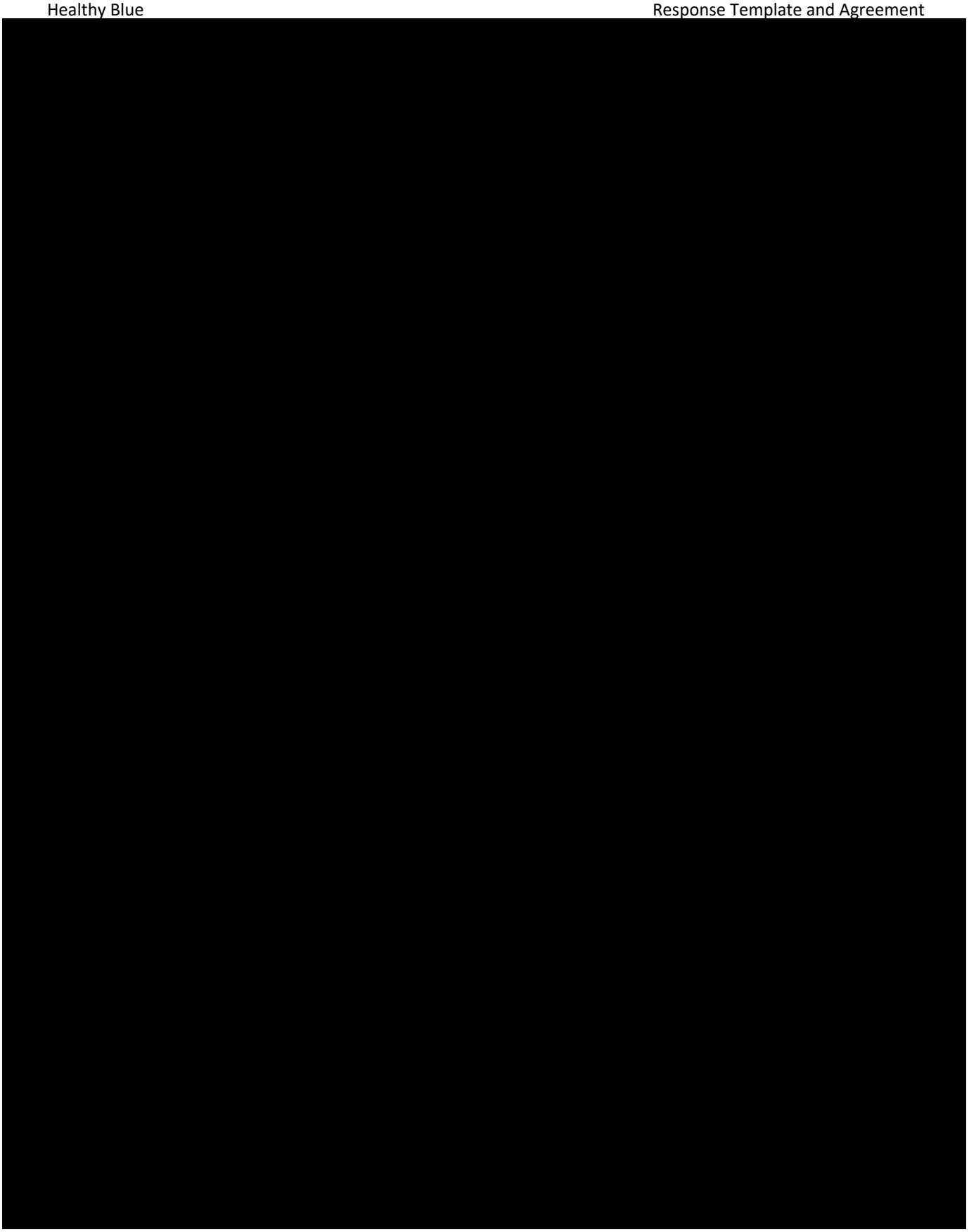


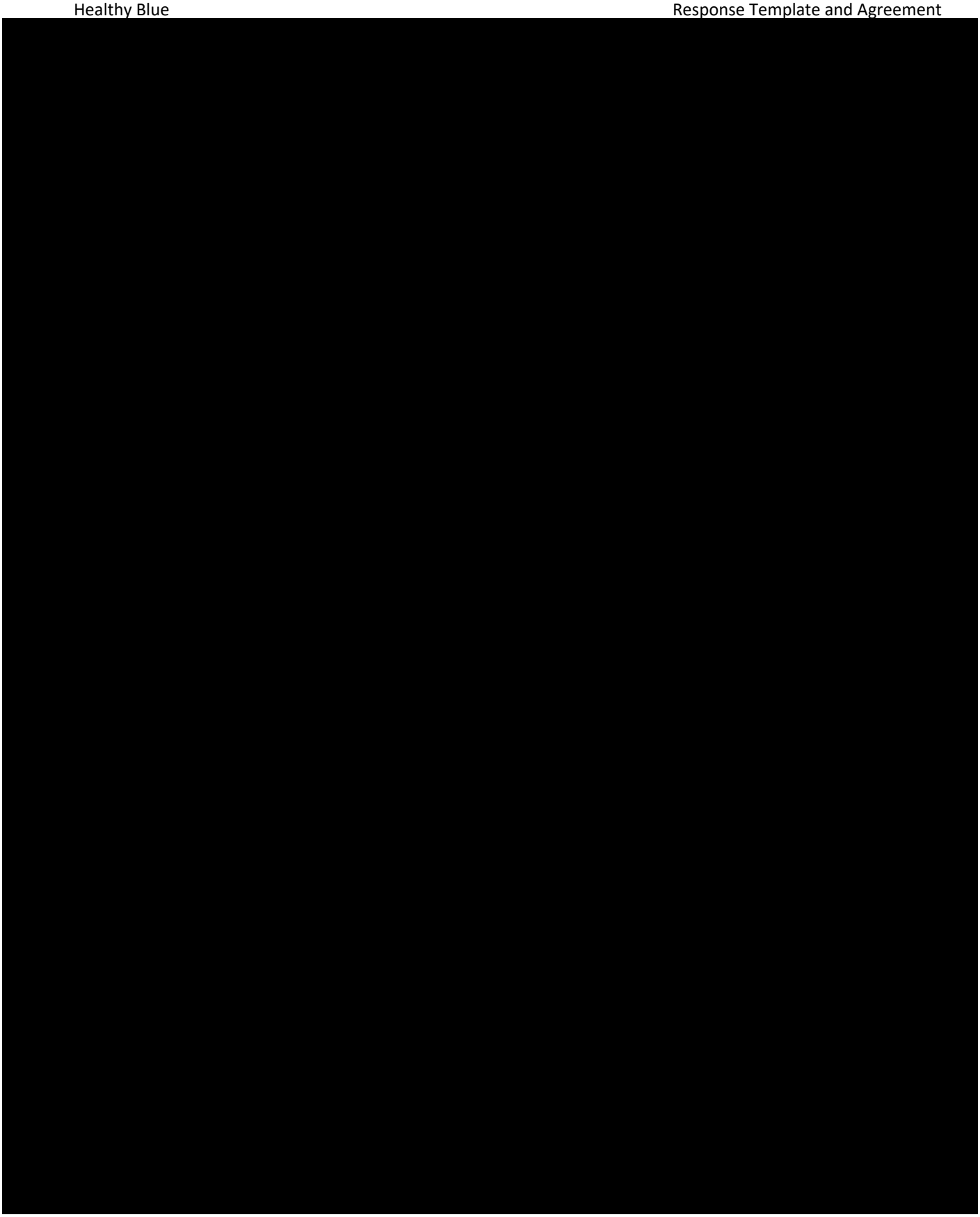


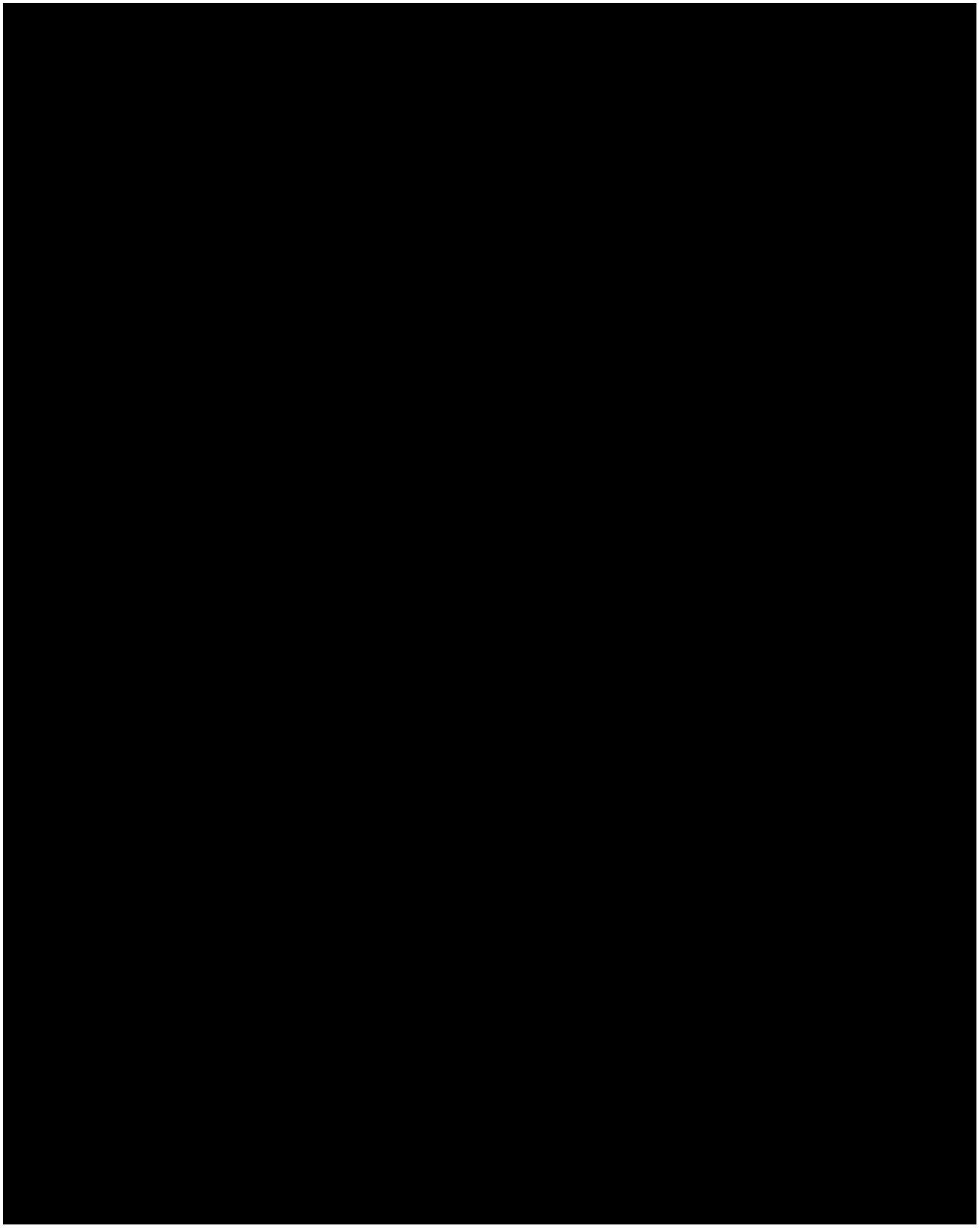


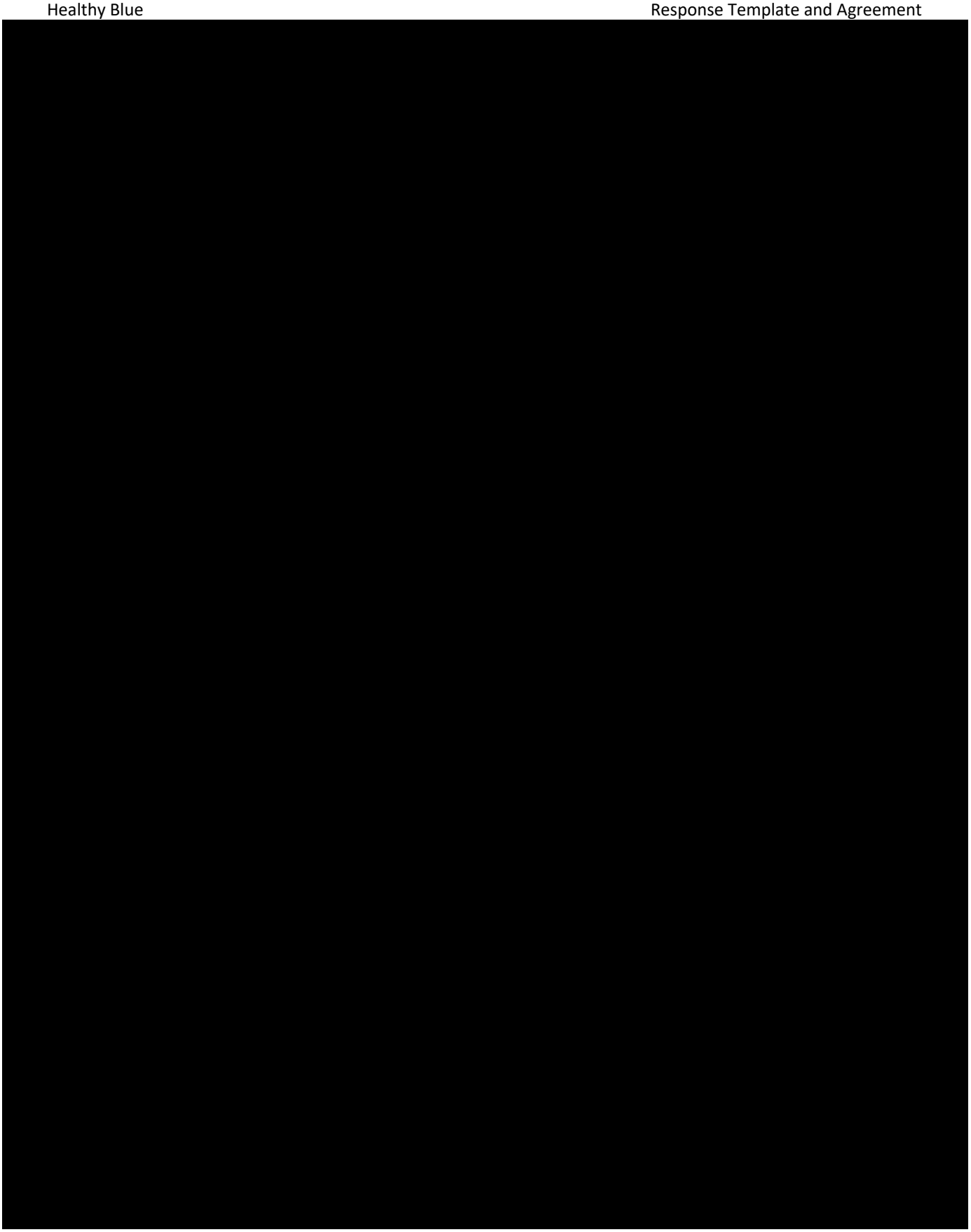


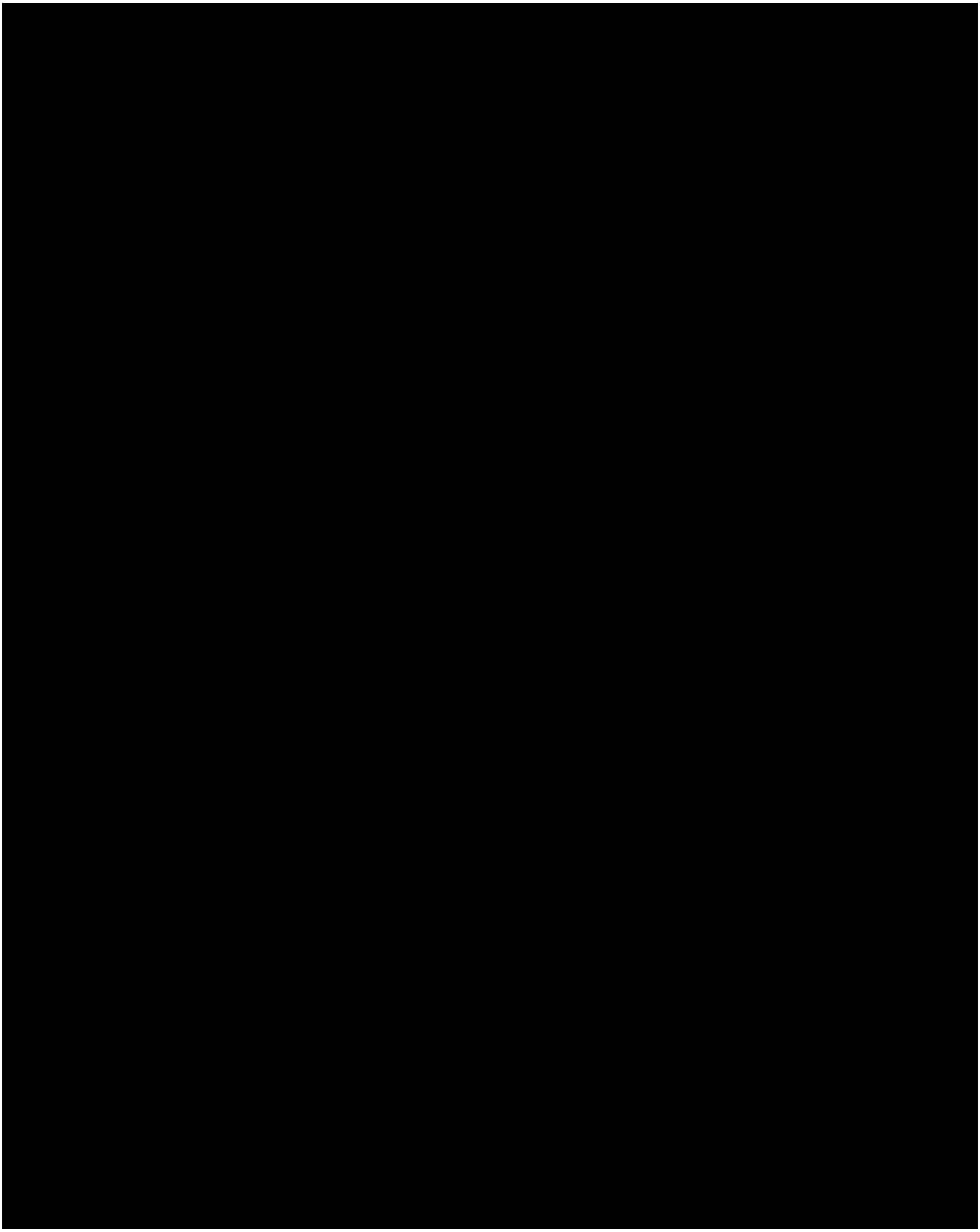


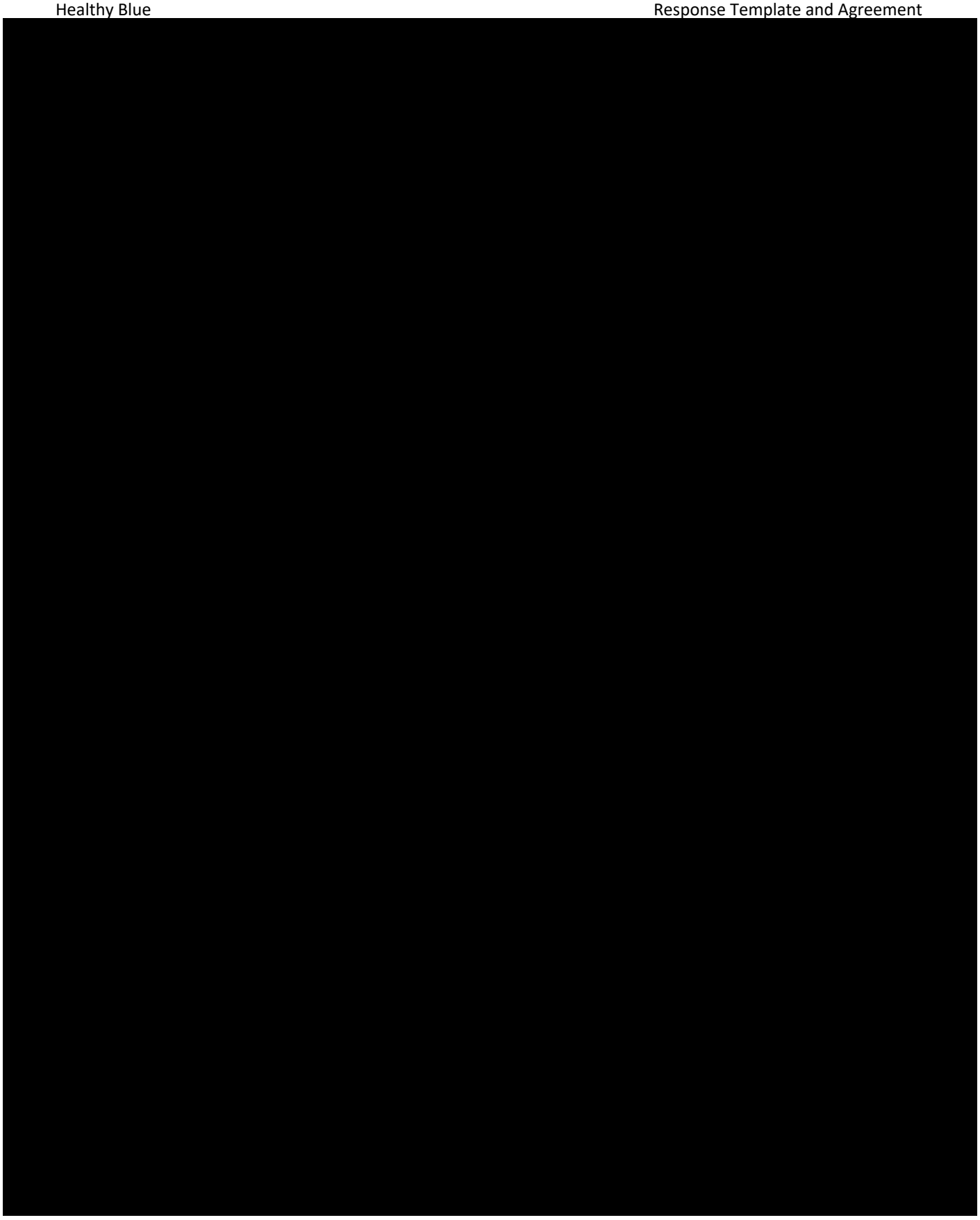


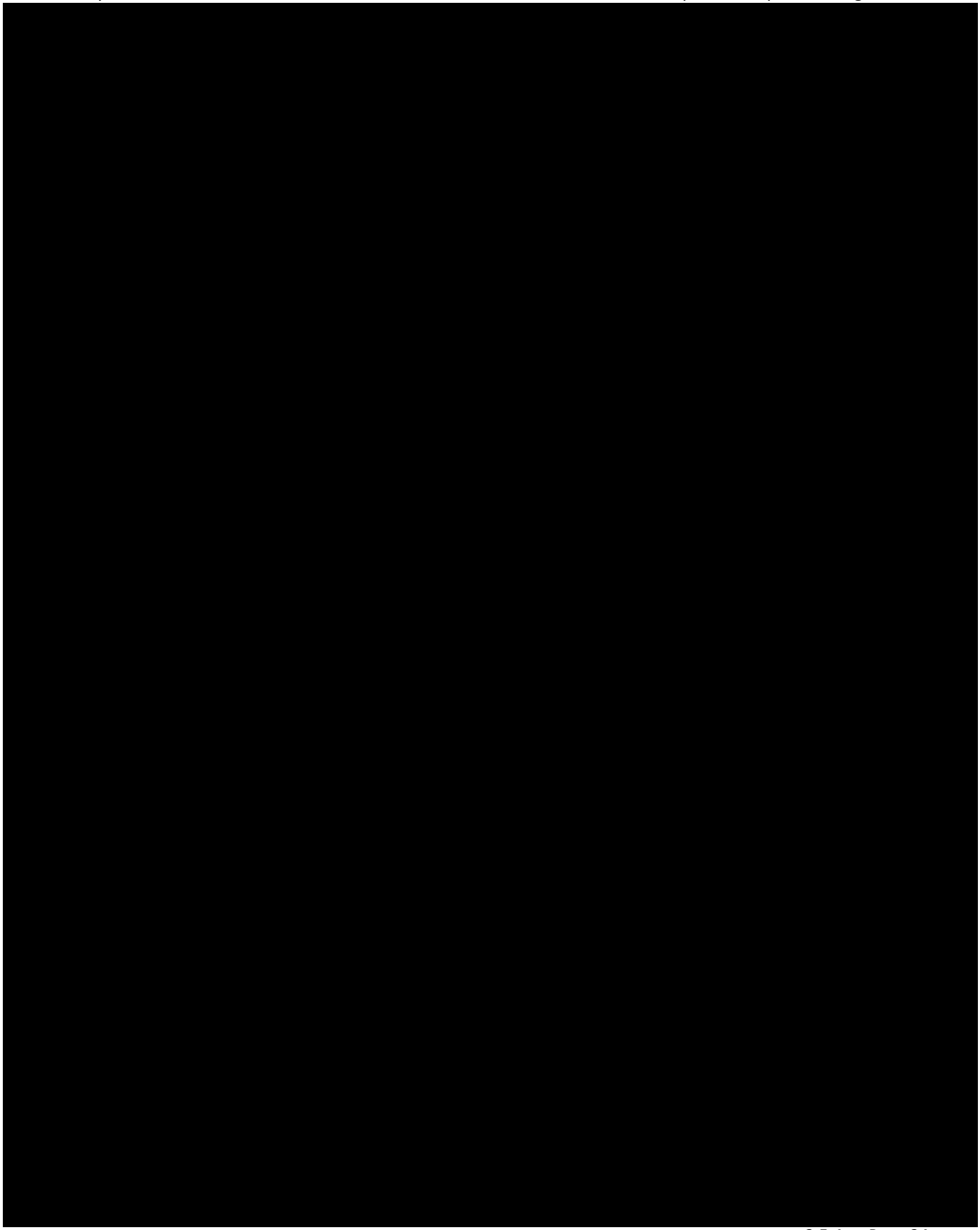


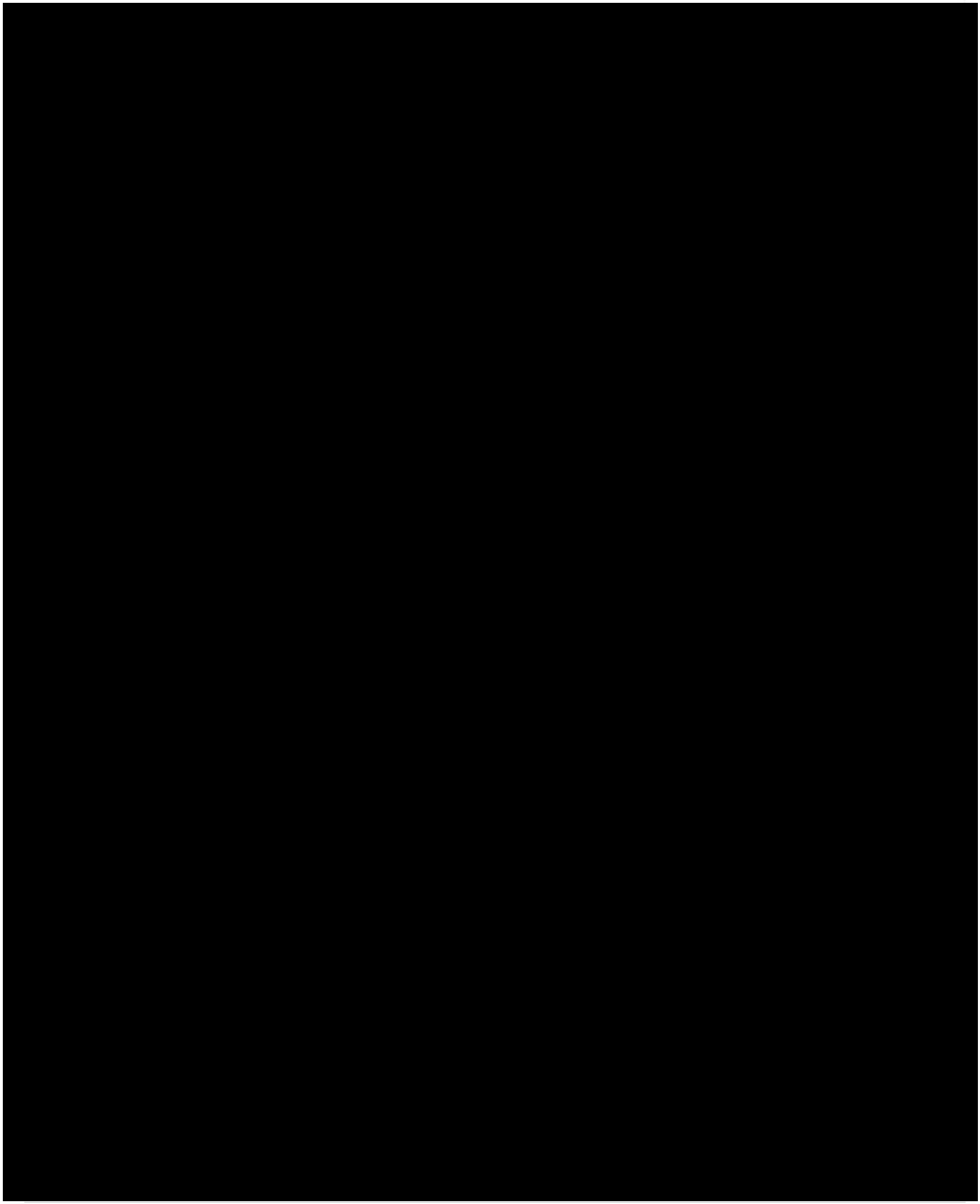


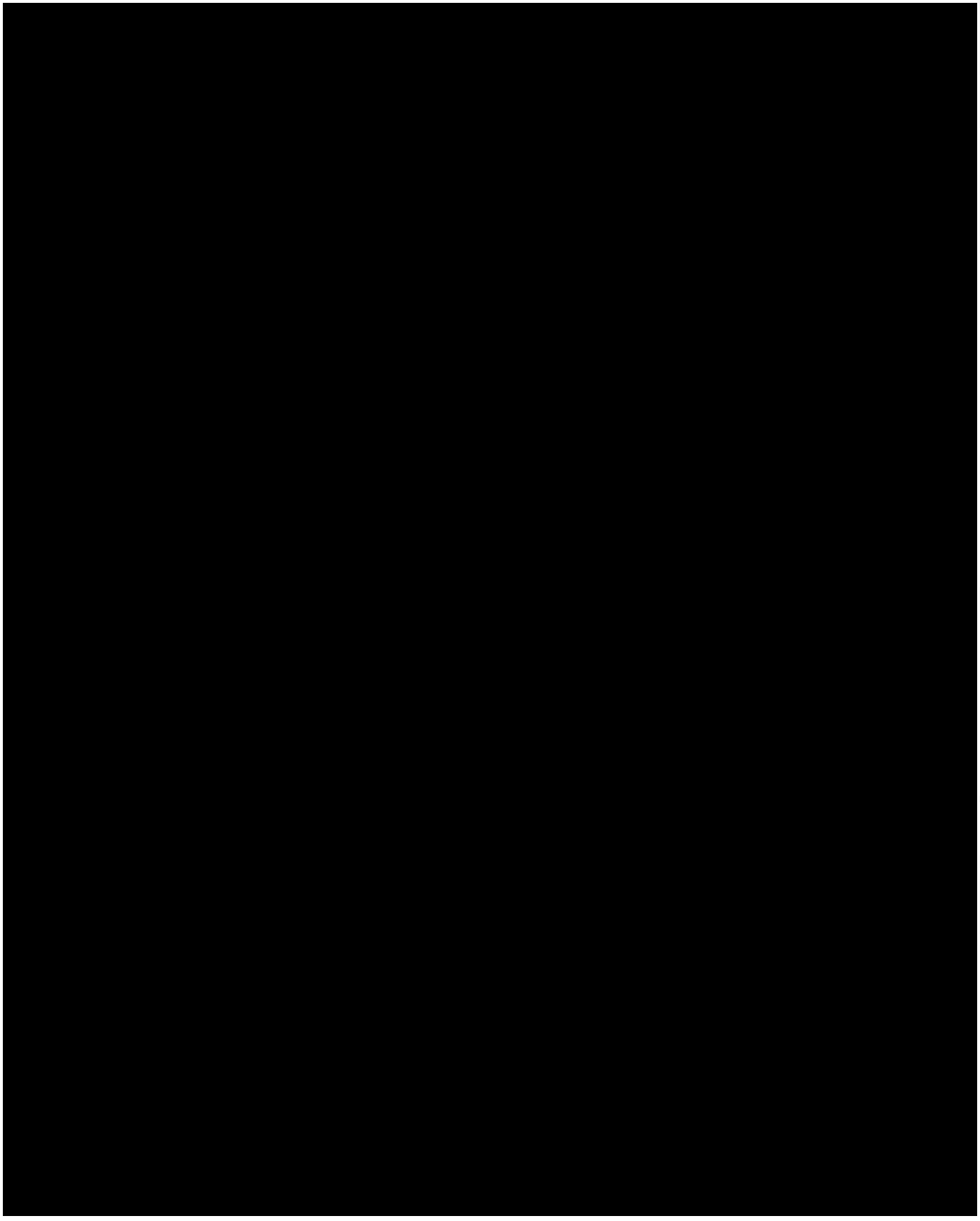


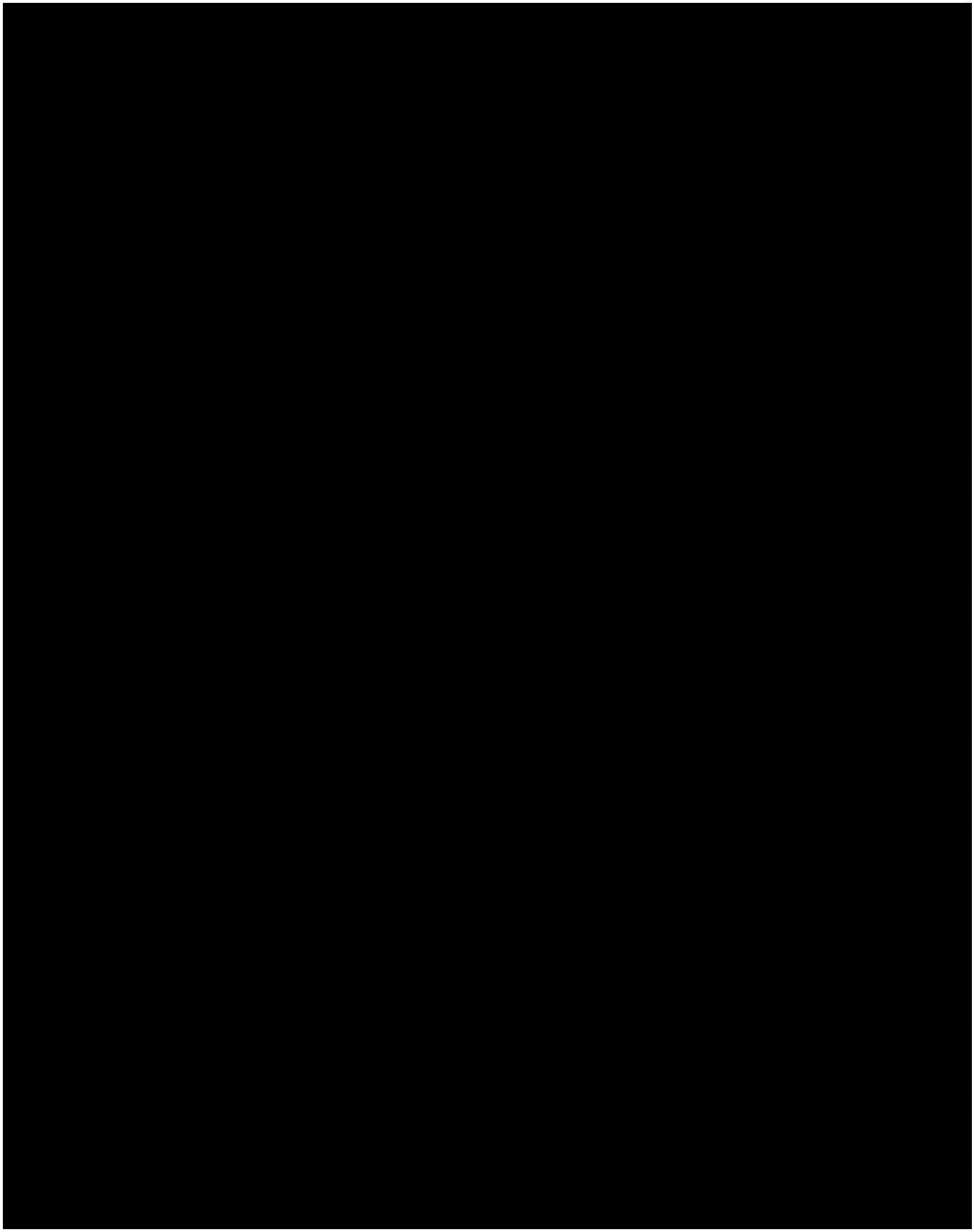


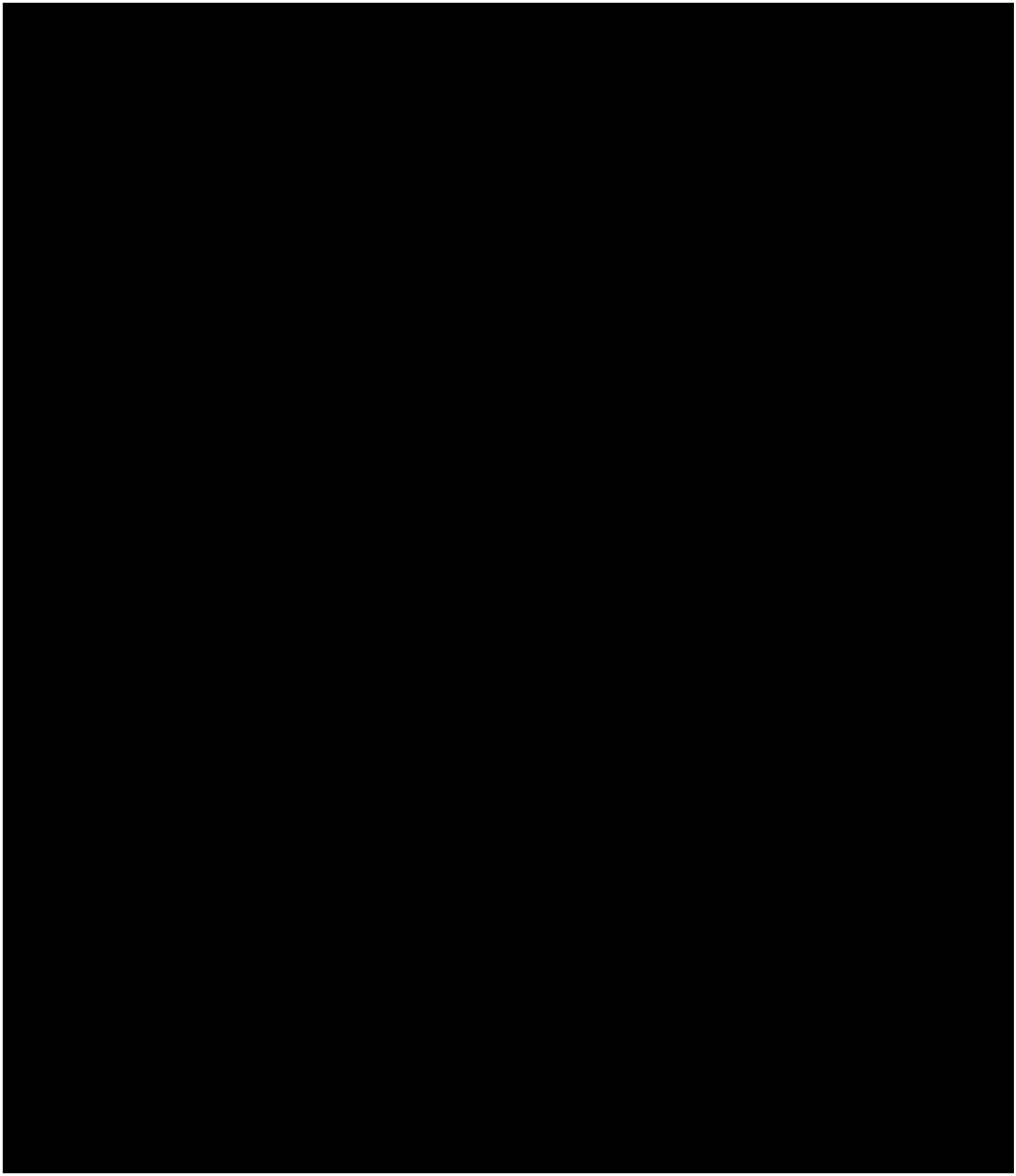


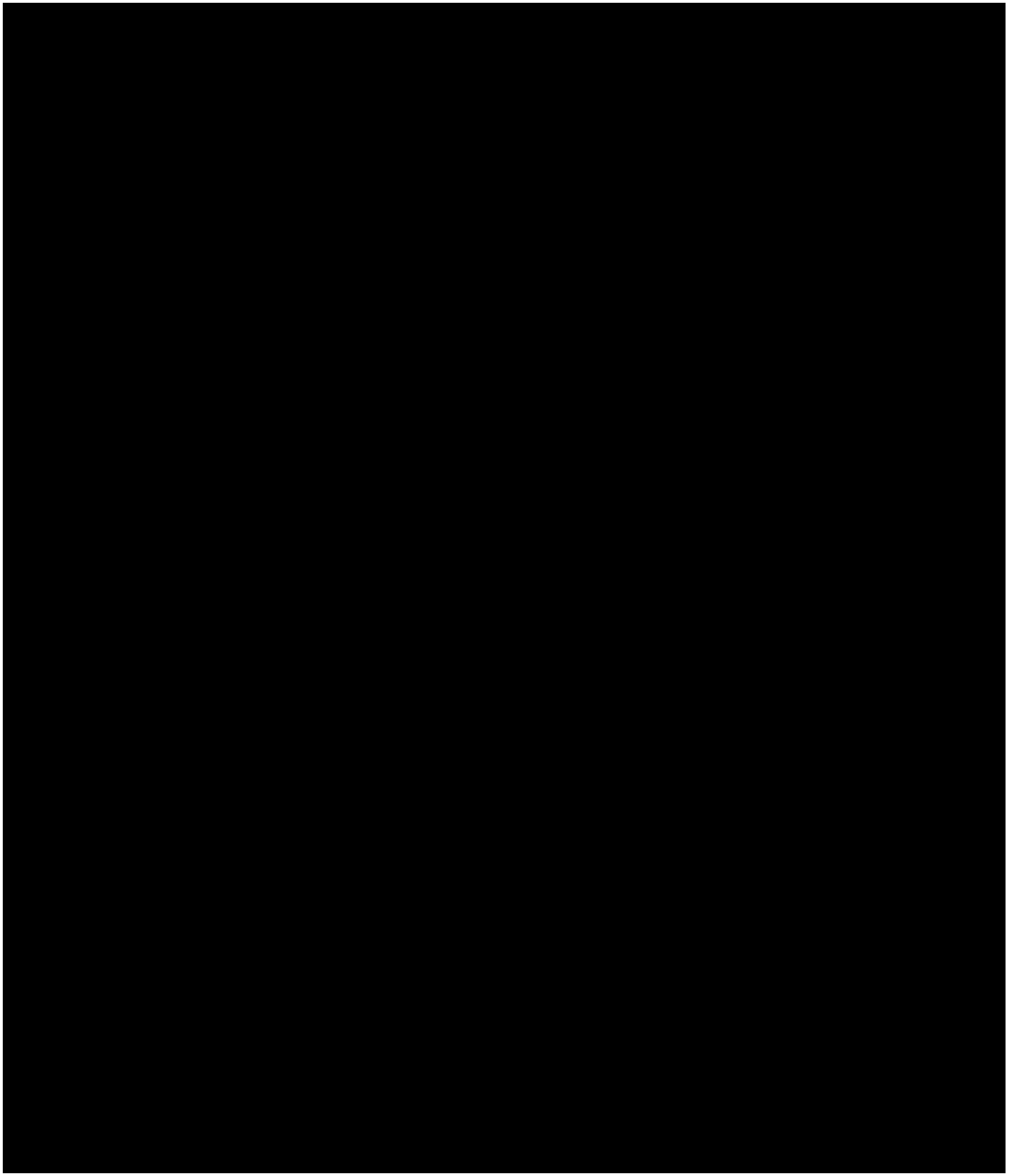












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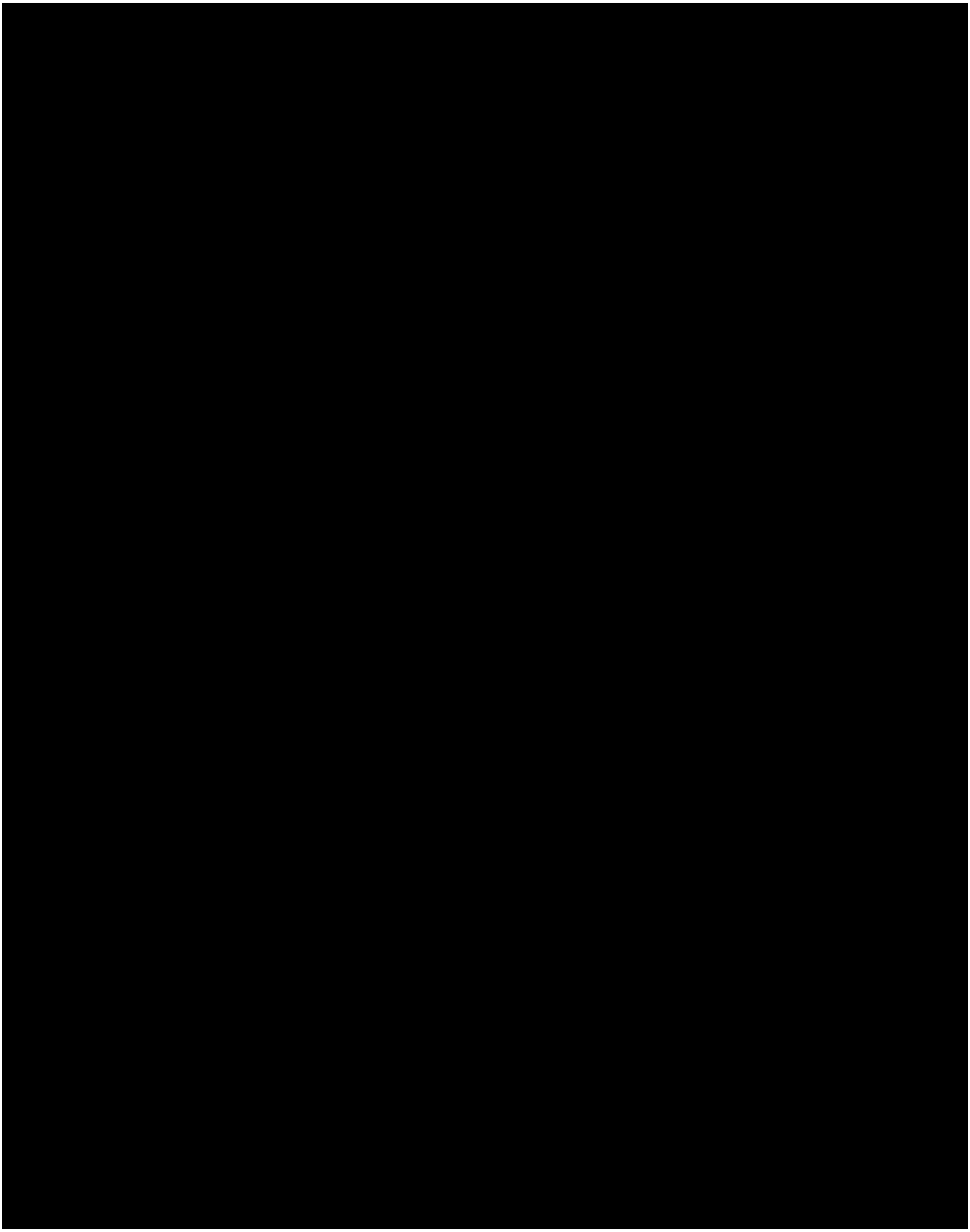

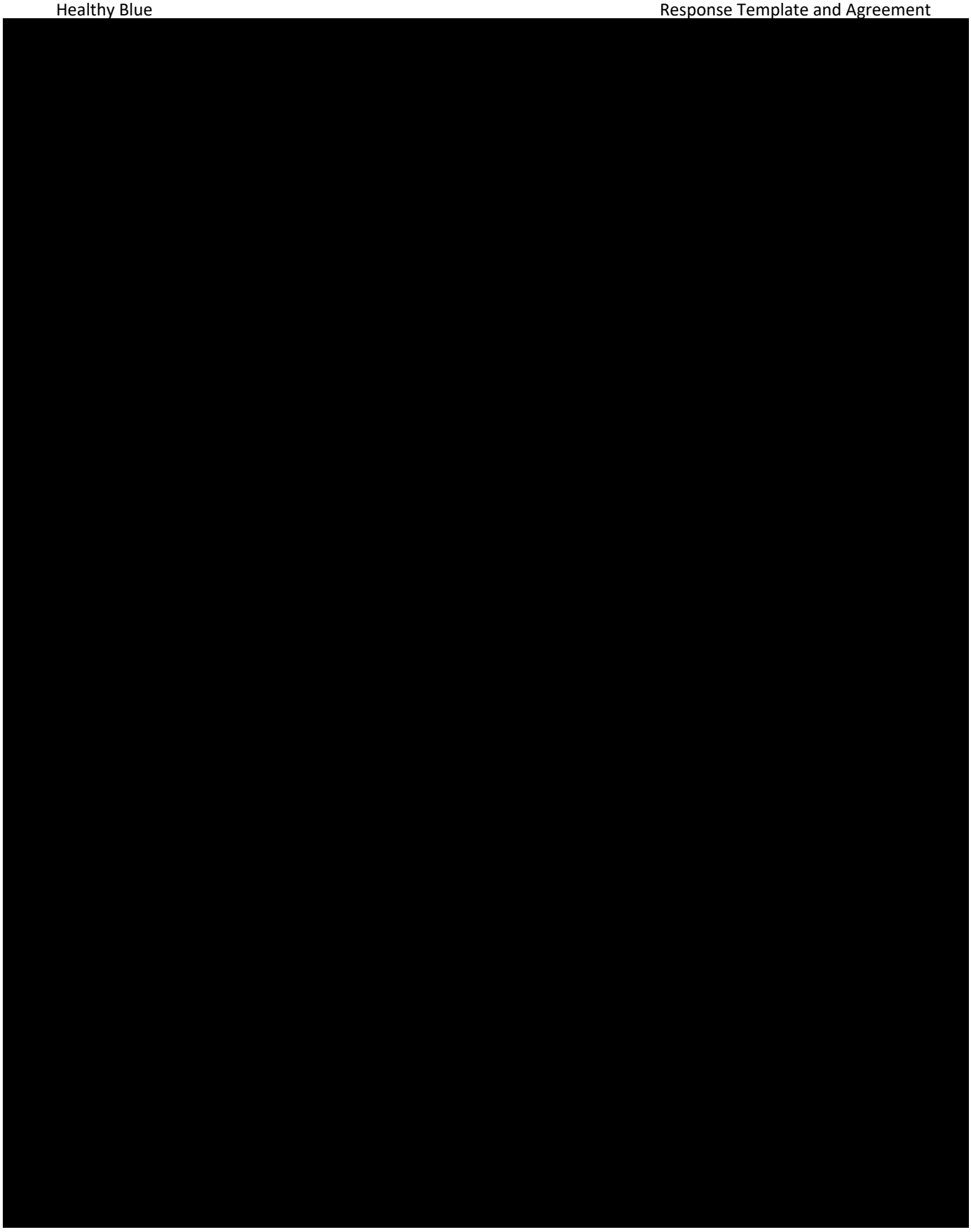

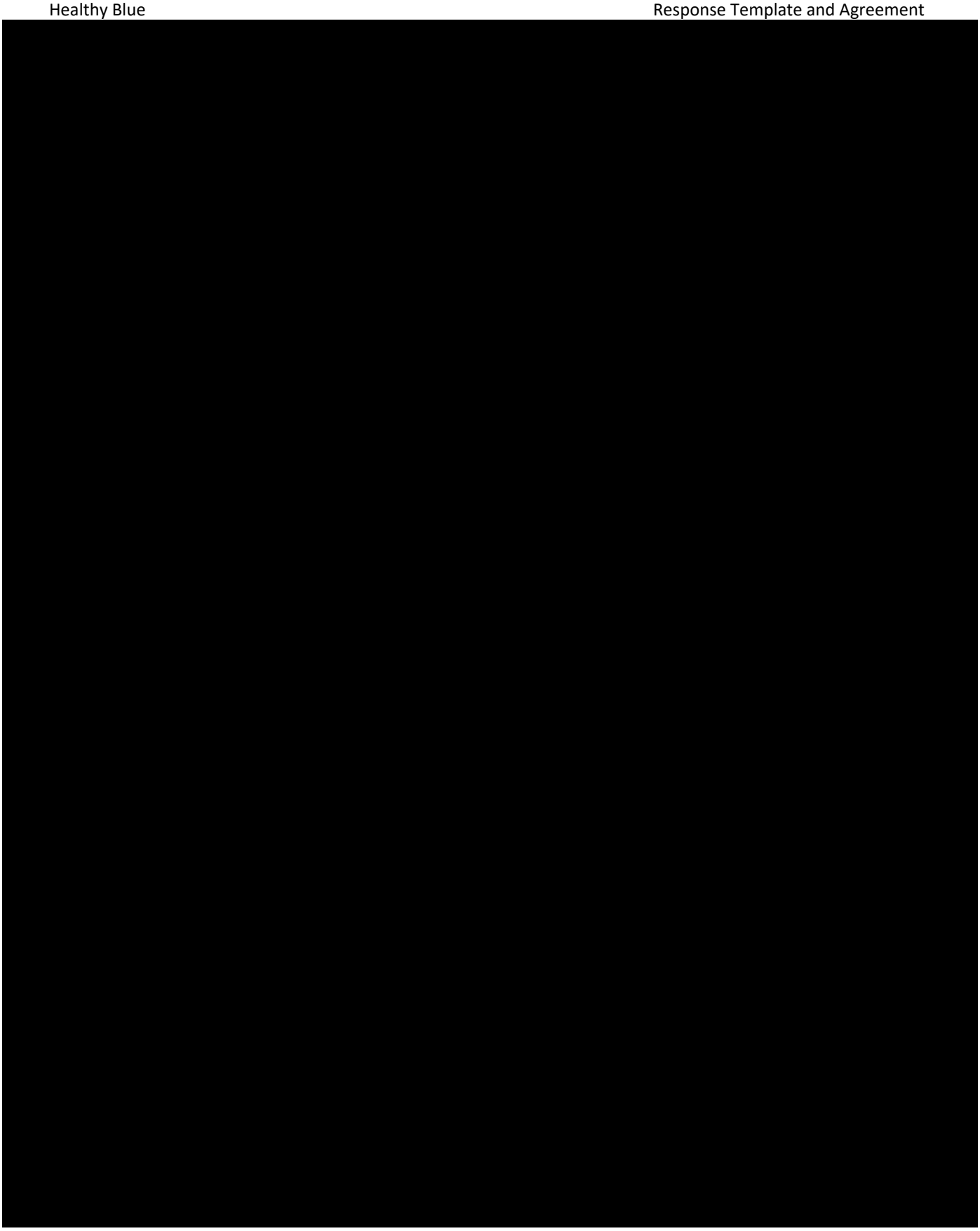

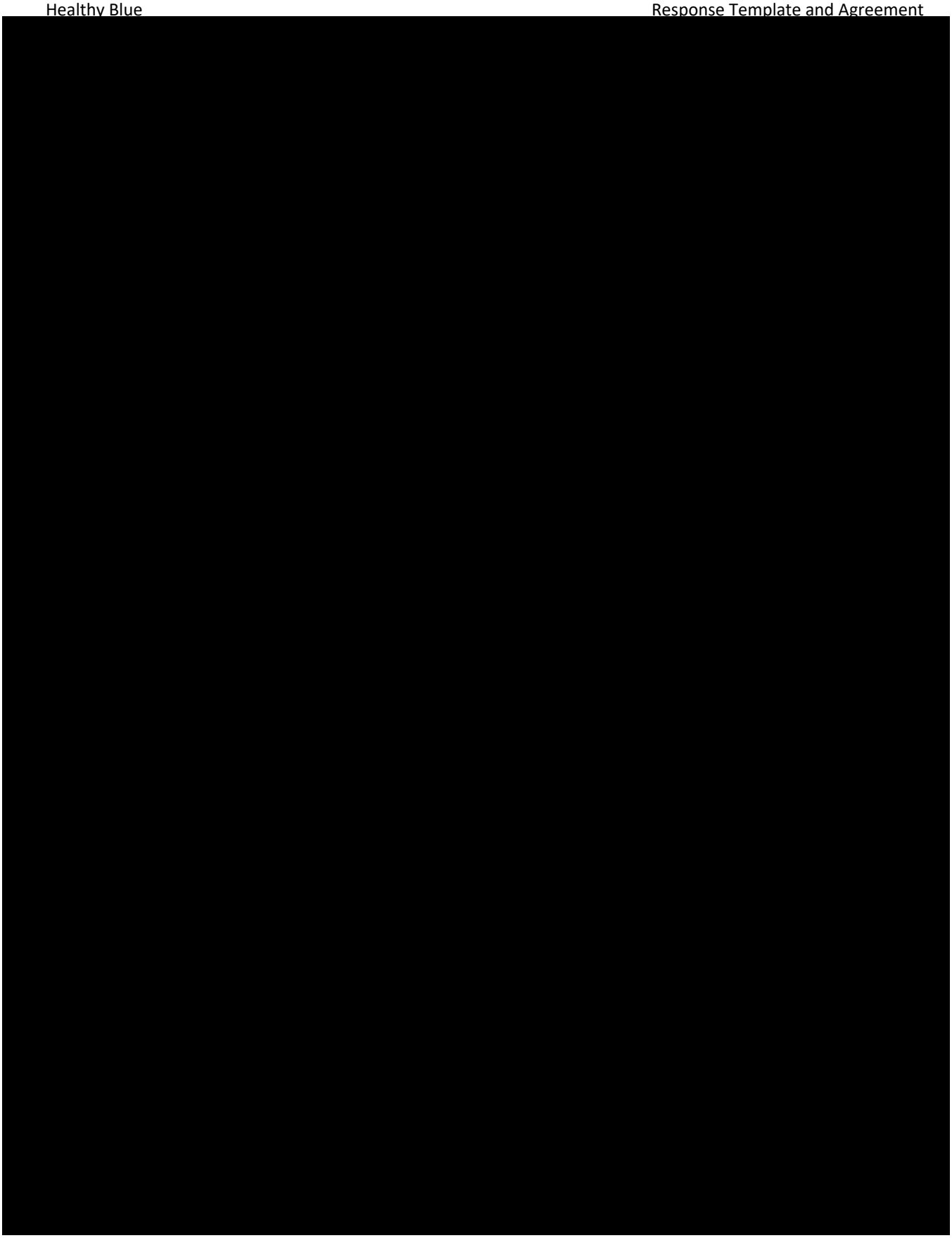

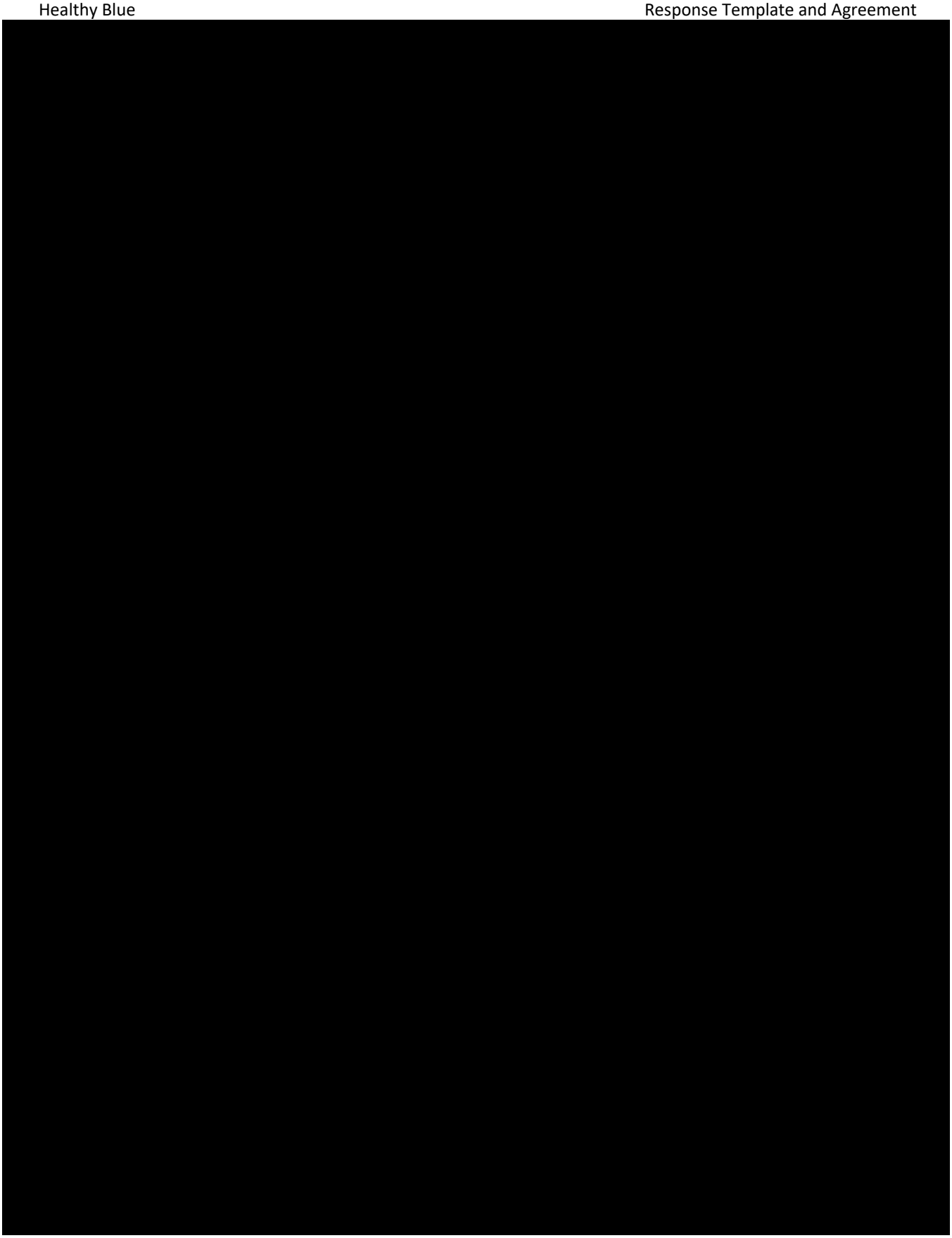

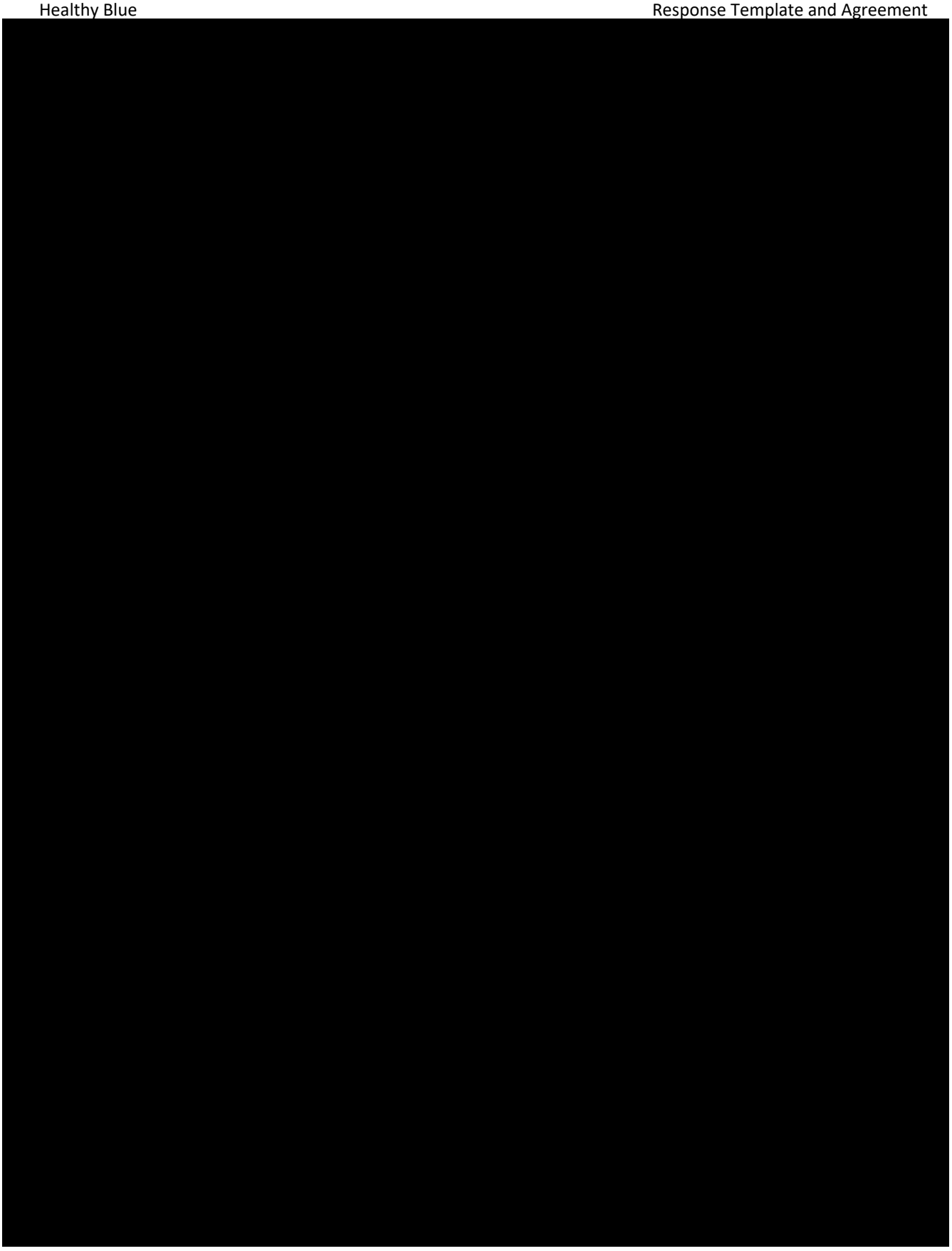

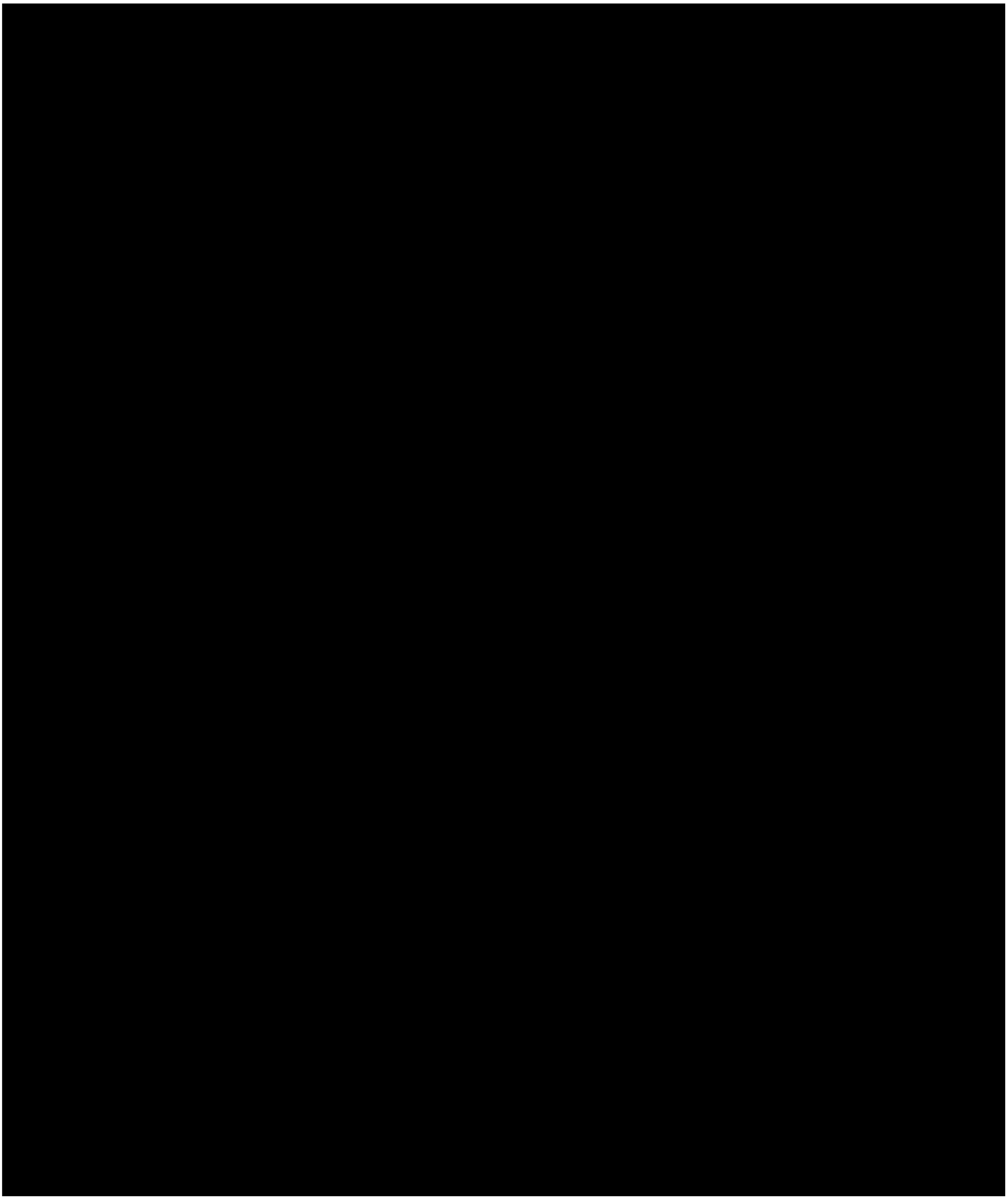

## Exhibit B: Material Subcontractor Response Template

| **Proposer (MCO) name:** |
|---|
| Community Care Health Plan of Louisiana, Inc., dba Healthy Blue |
| **Material subcontractor name:** |
| Anthem, Inc. (Anthem) |
| **Description of the Proposer's role and material subcontractor's role:** |
| **Proposer's Role.** Healthy Blue's primary role is to coordinate administrative services for our enrollees (members), as a covered service. We are ultimately responsible for meeting all contractual requirements. We make sure that the services our subcontractors provide meet or exceed all LDH requirements and are delivered seamlessly to our Healthy Louisiana members in a timely manner. Healthy Blue will continue to monitor, supervise, and enforce contract compliance, as well as promote frequent, open, and effective communication that emphasizes delivery of quality services to members. We will continue to oversee subcontractor performance through daily collaboration, regular monitoring, and formalized auditing processes. Healthy Blue believes that maintaining complete visibility into the volume and topics of member grievances and appeals is a critical component of subcontractor oversight. For this reason, we maintain direct responsibility for documenting, tracking, and resolution of all member grievances and appeals. We will continue to work closely with our local and national to resolve individual grievances and to address underlying root causes that result in member dissatisfaction.<br>**Material Subcontractor's Role.** Anthem, Inc., currently provides and will continue to provide for the upcoming contract, Administrative and support services, including information technology; enrollment; claims processing; Third Party Liability; fraud, waste, and abuse; Member and Provider call services; Encounters; Utilization Management; legal; compliance; regulatory; and finance. |
| **Explanation of why the Proposer plans to subcontract this service and/or function:** |
| As the parent company to Healthy Blue, and with over 30 years of experience providing administrative and support services for health plans across the nation, Anthem offers superior expertise in health benefit solution administration. Healthy Blue uses subcontractors who have specialized capabilities, including administration benefit services. We utilize the services and support of our parent company because we believe that a organization whose core business is benefit administration can help us deliver the best service to our Healthy Louisiana members. We choose vendors who have established relationships and long-standing experience with us, or with our affiliates serving Medicaid members across the country. With experience providing Medicaid services to over 9.7 million members, together with our parent company, we are able to tailor services that align with Healthy Blue's stringent and specific requirements. |
| **A description of the material subcontractor's organizational experience:** |
| Headquartered in Indianapolis, Indiana, Anthem, Inc. is one of the largest healthcare benefits companies in the country. Through its affiliated companies, Anthem, Inc. serves more than 117 million people, including more than 44 million within its family of health plans, more than 9.7 million of whom are enrolled in Medicaid and other state-sponsored programs. Anthem, Inc. strives to be the most innovative, valuable, and inclusive partner in health care. Anthem, Inc.'s affiliated health plans have been coordinating care for individuals for more than 80 years, including more than 30 years for Medicaid members. Our organization's first health plan in California and New York began serving members in 1991.<br>Through its affiliated health plans, Anthem, Inc. companies deliver a number of leading health benefit solutions through a broad portfolio of integrated health care plans and related services, along with a wide range of specialty products such as life and disability insurance benefits, dental, vision, Behavioral Health benefit services, as well as long-term care insurance and flexible spending accounts.<br>Anthem, Inc. affiliate health plans operate contracts similar in the size, scope and complexity to the Louisiana Medicaid Contract in the following states: AR, CA, CO, FL, GA, IN, IA, KY, MD, MN, MO, NE, NC, NV, NJ, NY, SC, TN, TX, VA, WA,WI, WV, and in Puerto Rico. |
| **The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:** |

Healthy Blue maintains an established Subcontractor Oversight Program, refined through our nine years of serving Healthy Louisiana members and supplemented by our organization's national expertise and experience. We continue to enhance this program to make sure we deliver timely, appropriate, and quality care and services. Our material subcontract with Anthem includes LDH requirements as specified in Model Contract. The agreement includes detailed requirements and service levels, sets clear expectations of how we measure performance and compliance, and specifies the consequences for non-compliance. Healthy Blue will continue to retain ultimate responsibility for adhering to and fully complying with all terms and conditions of our Contract and remain accountable for all subcontractor performance.

We view our material subcontractors as valued partners and, through a comprehensive vetting process, we select the most qualified that can best serve our members. Our material subcontractors are an extension of Healthy Blue and the services we deliver. We build trusted, collaborative, longstanding relationships with our material subcontractors to coordinate a seamless delivery of services that meet LDH requirements. Healthy Blue will continue to work closely with the State to demonstrate that through the support we receive from our parent company, Anthem, we continue to meet Contract requirements and LDH expectations for delivering high-quality administrative services to our Healthy Louisiana members.

## Processes to Monitor and Evaluate Performance

We monitor and evaluate affiliate and non-affiliate subcontractor performance through daily collaboration, regular monitoring, and formal auditing processes. We will continue to oversee, monitor, supervise, and enforce contract compliance, as well as promote frequent, open, and effective communication that emphasizes delivery of quality services to members. We monitor subcontractors to make sure they meet or exceed contractual requirements.

Our Louisiana-based Vendor Oversight Workgroup oversees the performance of our material subcontractors, including Anthem. Chaired by our Plan Compliance Officer, Hassan Gardezi, our team includes members of the senior leadership, including our CEO, COO, Medical Director, Provider Relations Director, Quality Director, Subcontractor Account Managers, and other participants as necessary. The team meets monthly and reports to the Compliance Committee at its monthly meetings.

Our Vendor Oversight Workgroup works closely with our national organization oversight teams and committees to verify that the services or functions all subcontractors provide are of the highest quality and performed in a seamless, cost-effective manner.

Healthy Blue operates under a culture of continuous quality improvement. Our Subcontractor Oversight Program is successful because we continually refine and enhance our processes and methods of monitoring and evaluating subcontractor performance.

Each month, we collect and review performance against a defined set of metrics that represent LDH and Healthy Blue requirements. Our Leadership, including our CEO Dr. Valentine reviews and monitors Anthem's performance against these standards. We share the Performance Indicator Report, discuss both positive and negative data trends, and brainstorm opportunities for improvement. The review includes careful evaluation of performance metrics and, where applicable, network adequacy. Our experience shows that transparency and open, constructive dialogue is critical to maintaining a collaborative partnership with material subcontractors that drives seamless service delivery to members.

While we review all performance metrics, we pay careful attention to member grievances and appeals, looking at topics, volumes, and trends (positive and negative). We work with the Subcontractor to resolve individual grievances, as well as identify opportunities for more widespread improvements that would improve member satisfaction.

National oversight functions and a strong governance structure provide an additional level of support to our program. Regular communication between national functions and our Vendor Oversight Workgroup will maintain focus on delivering high-quality services to our members. National oversight functions include:

- The Delegation Operations Committee (DOC) includes representatives from account management, quality, legal, compliance, and other operational areas as needed. The DOC assesses oversight and compliance (with contractual and applicable State, federal, and accreditation standards), monitors CAPs (including recommending escalation), evaluates subcontractor performance through reports analysis, and makes recommendations to DVOMC on findings, as well as the use of audit tools.
- The DVOMC oversees subcontractors serving multiple health plans and is responsible for meeting compliance with State, federal, NCQA, CMS, and individual program requirements and standards, as well as other regulatory or accreditation standards. They report to the National Quality Committee quarterly and the National Quality Improvement Committee semi-annually.
- The National Quality Improvement Committee meets quarterly and reports any subcontractor quality or compliance-related issues to health plan leadership.

### Improving Subcontractor Performance and Results

Healthy Blue always strives to improve the level of service we deliver, and we expect our material subcontractors to do the same. During subcontractor oversight and monitoring, we not only review areas with substandard performance, but will seek out opportunities to "raise the bar" and deliver better service. We use our

Subcontractor Scorecard in conjunction with our Performance Indicator Report to monitor performance, track actions taken to improve performance, and drive positive results from our material subcontractors. For material subcontractors that also support our affiliates, our national team's view of performance across markets can provide early insight into any problems that may affect our Healthy Louisiana operations.

## Material Subcontractor Return on Investment

We use material subcontractors that have specialized capabilities that Healthy Blue does not have internally, including administrative services. For these services, we use material subcontractors that have established relationships and long-standing experience across our organization, in multiple markets and across multiple lines of business (Medicaid, MMP, and Medicare). We continuously monitor our internal capabilities in order to determine whether we could bring specific capabilities "in-house" and deliver a similar or higher service capability and a more competitive cost structure.

Once operational, we use a number of processes to confirm that the material subcontractor continues to deliver the high-quality services that we expect. Processes cover a number of dimensions, including quality, compliance with performance standards, financial solvency, and strength of the partnership, and include the following:

- Monthly oversight meetings
- Monthly, quarterly, and annual report submission and monitoring
- Quarterly Joint Operations Meetings
- Quarterly and annual financial solvency reviews
- Quarterly review of utilization against cost
- Annual audits

With respect to Anthem specifically, our parent company provides Healthy Blue with Louisiana designated support services to supplement our local resources. This allows us to leverage economies of scale to meet Louisiana Medicaid program requirements and realize administrative efficiencies.

Instructions: The Proposer should attach the executed or draft contract and indicate compliance witheach of the following checklist items by completing the "Location" column.

| | **Checklist Item** | **Location** (Include Name of Document, Page Number, and Section Number/Letter) |
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| 1 | Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between LDH and the MCO and the MCO Manual, and either physically incorporate these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request. | FMV Services Attachment, page 2, §5; MOU Exhibit A, Page 4, §15 |
| 2 | Include a signature page that contains an MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for executed contracts). | Master Administrative Services Agreement, page 10; Attachment AGPLA, page 6; First Amendment to the MASA, page 3; FMV Services Attachment, page 4; MOU, page 1 |
| 3 | Specify the effective dates of the subcontract agreement. | Master Administrative Services Agreement, Page 1; First Amendment to Master Administrative Services Agreement, Page 1; FMV Services Attachment, Page 1, MOU, page 1 |
| 4 | Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties. | MOU Exhibit A, page 4, §16 |
| 5 | Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties. | MOU Exhibit A, page 4, §16 |
| 6 | Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract. | MOU Exhibit A, page 4, §17 |

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| 7 | Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and LDH for any of the reasons described in the contract, the MCO shall immediately make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to LDH. | MOU Exhibit A, page 4, §18 |
| 8 | Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO. | MOU Exhibit A, page 4, §19 |
| 9 | Require that if any requirement in the subcontract is determined by LDH to conflict with the contract between LDH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect. | MOU Exhibit A, page 2, §2b |
| 10 | Identify the population covered by the subcontract. | MOU Exhibit A, page 2, Definitions |
| 11 | Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to enrollees through the last day that the subcontract is in effect. | MOU Exhibit A, page 4, §20 |
| 12 | Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO. | MOU Exhibit A, page 4, §22 |
| 13 | Specify the amount, duration, and scope of benefits and services that are provided by the subcontractor. | FMV Services Attachment, page 1, §1 |
| 14 | Provide that emergency services be coordinated without the requirement of prior authorization of any kind. | MOU Exhibit A, page 4, §23 |
| 15 | Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 C.F.R. § 493.1 and 493.3, and any other federal requirements. | MOU Exhibit A, page 4, §24 |
| 16 | Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO enrollees pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between LDH and the MCO). MCO enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended and subject to reasonable charges. | MOU Exhibit A, page 5, §27 |

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| 17 | Include record retention requirements as specified in the contract between LDH and the MCO. | MOU Exhibit A, page 5, §28 |
| 18 | Shall make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested. | MOU Exhibit A, page 5, §29 |
| 19 | INTENTIONALLY LEFT BLANK | |
| 20 | Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or LDH or its designee. | MOU Exhibit A, page 6, §30 |
| 21 | Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by LDH or its designee. | MOU Exhibit A, page 6, §31 |
| 22 | Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by LDH. | MOU Exhibit A, page 6, §31 |
| 23 | Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontract and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by LDH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate. | MOU Exhibit A, page 6, §32 |

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| 24 | Provide for submission of all reports and clinical information to the MCO for reporting purposes required by LDH. | MOU Exhibit A, page 6, §33 |
| 25 | Require safeguarding of information about MCO enrollees according to applicable state and federal laws and regulations and as described in contract between LDH and the MCO. | MOU Exhibit A, page 6, §34 |
| 26 | Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO. | FMV Services Attachment, page 2, §2; MOU Exhibit A, page 9, §56 |
| 27 | Provide that the subcontractor comply with LDH's claims processing requirements as outlined in the RFP. | MOU Exhibit A, page 6, §35 |
| 28 | Provide that the subcontractor adhere to LDH's timely filing guidelines as outlined in the RFP. | MOU Exhibit A, page 6, §35 |
| 29 | Provide that, if LDH or its subcontractors discover an error or a conflict with a previously adjudicated encounter claim, the subcontractor shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or the MCO, or if circumstances exist that prevent the subcontractor from meeting this time frame, by a specified date approved by LDH. | MOU Exhibit A, page 6, §36 |
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| 30 | Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served. | MOU Exhibit A, page 7, §38 |
| 31 | Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold LDH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between LDH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between LDH and the MCO in its entirety in the subcontractor's agreement or by use of other language developed by the MCO and approved by LDH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by LDH. | MOU Exhibit A, page 7, §39 |

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| 32 | Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's enrollees and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage. | MOU Exhibit A, page 7, §40 |
| 33 | Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services, and stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where the material subcontractor is based and Louisiana law. | MOU Exhibit A, page 7, §41 |
| 34 | Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective. | MOU Exhibit A, page 7, §42 |
| 35 | Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member. | MOU Exhibit A, page 7, §43 |
| 36 | Include a conflict of interest clause as stated in the contract between LDH and the MCO. | MOU Exhibit A, page 7-8, §44 |
| 37 | Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between LDH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor. | MOU Exhibit A, pages 8, §45 |
| 38 | Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO. | MOU Exhibit A, page 8, §46 |
| 39 | Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract. | MOU Exhibit A, page 3, §14 |
| 40 | Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity. | MOU Exhibit A, page 9, §54 |
| 41 | Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO. | MOU Exhibit A, page 8, §51 |

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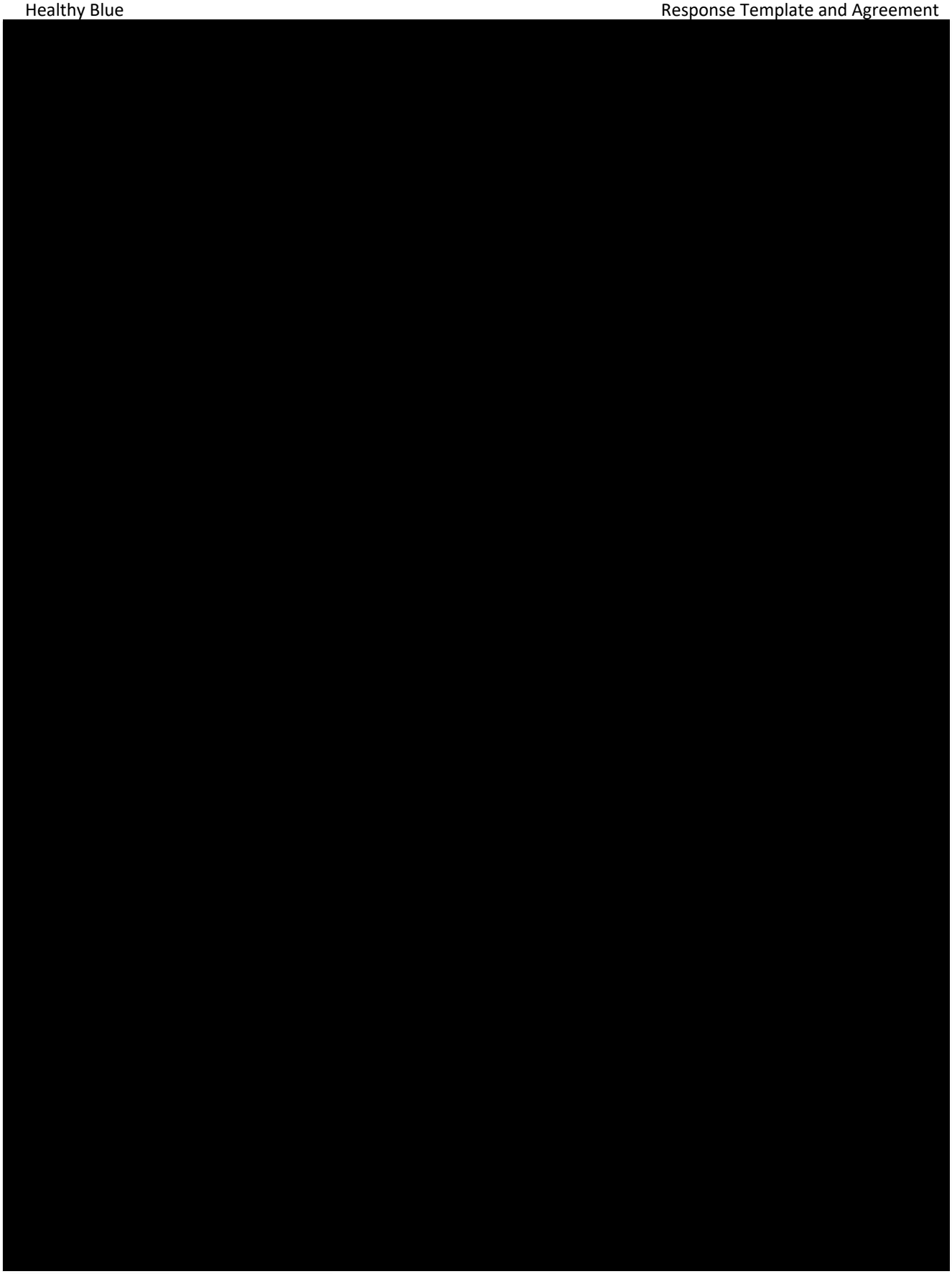
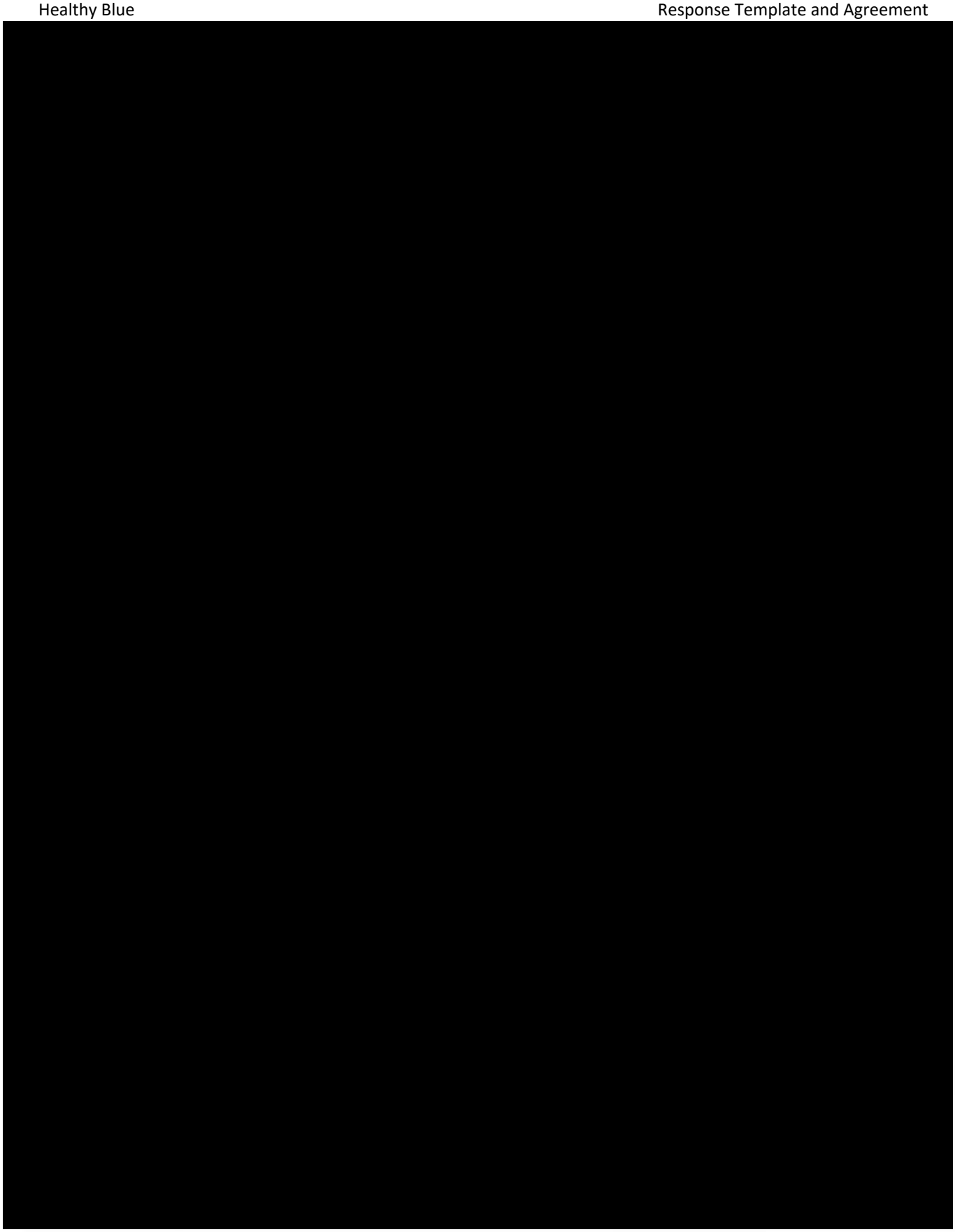
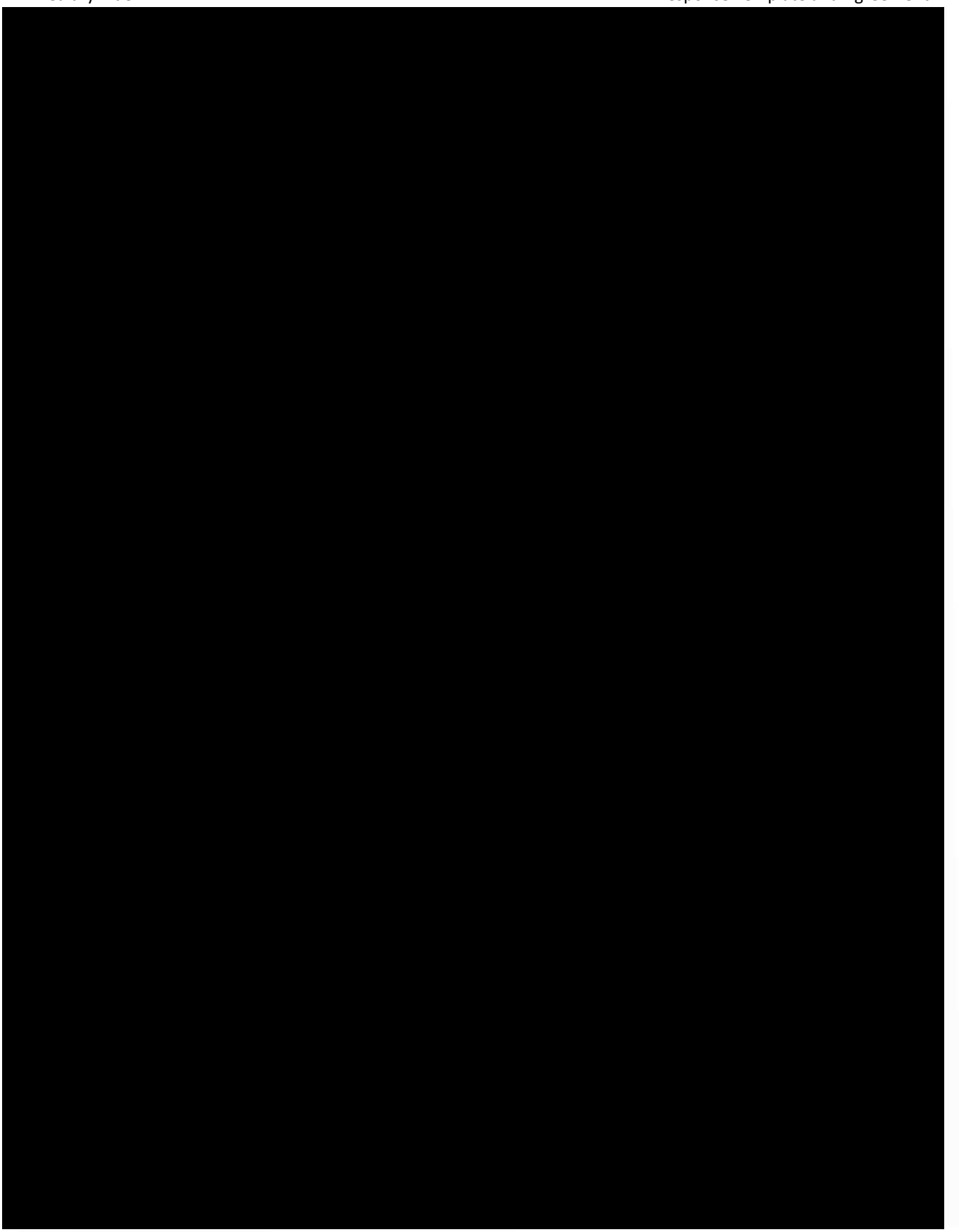
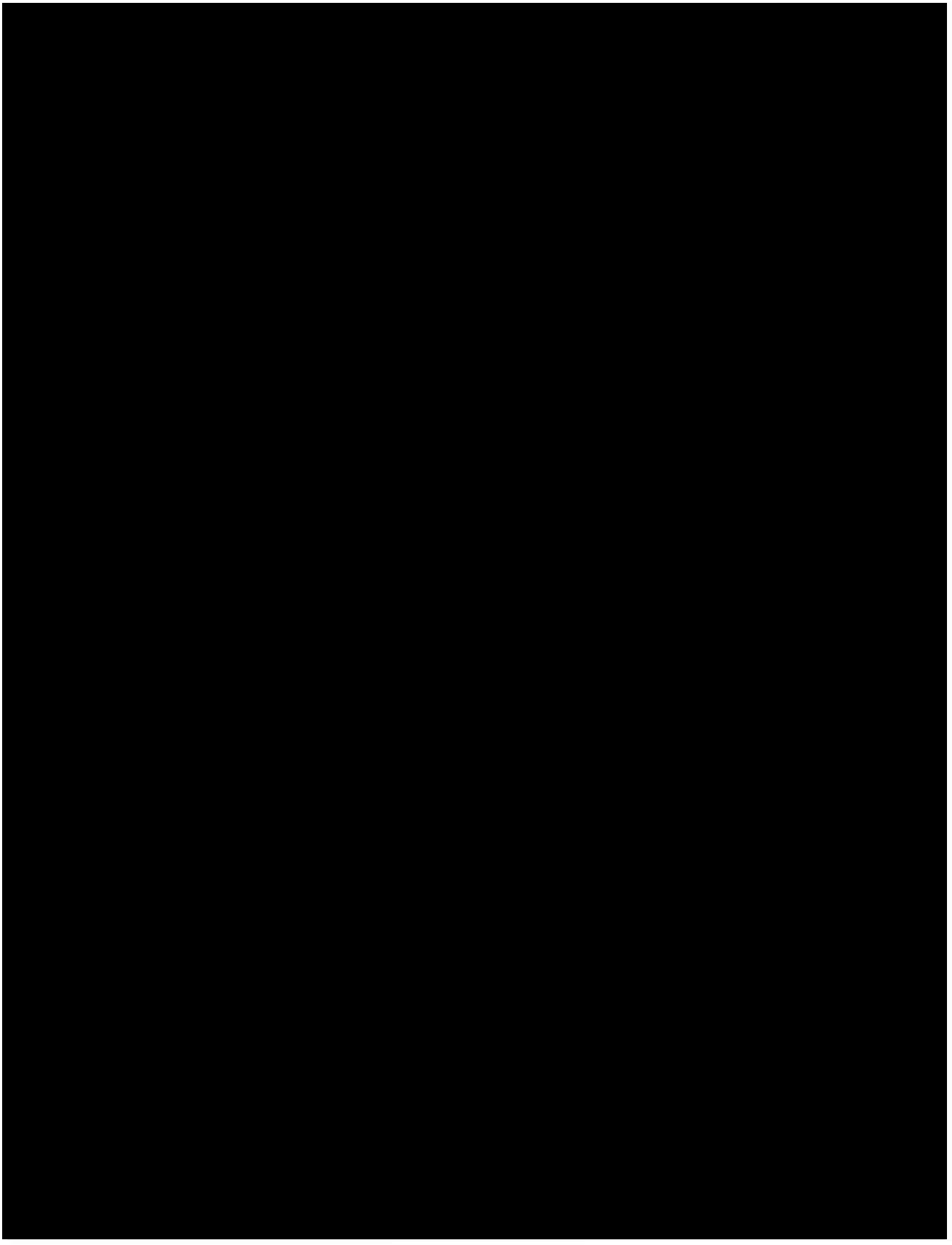
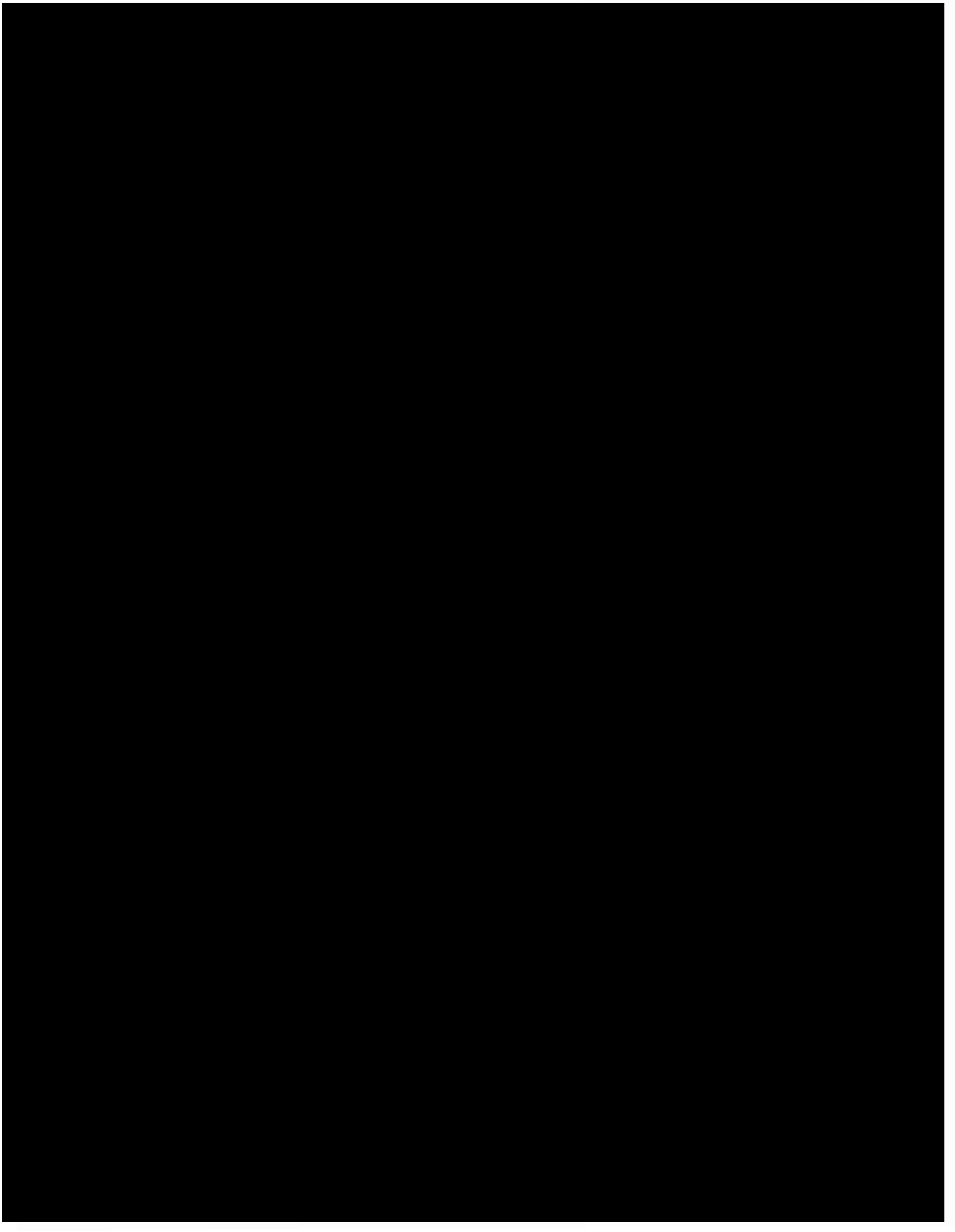
| 42 | Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement. | MOU Exhibit A, page 9, §53 |
| 43 | Contain the following language:<br><br>The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries. | MOU Exhibit A, page 9, §59 |
| 44 | Contain the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request. | MOU Exhibit A, page 5, §29. |

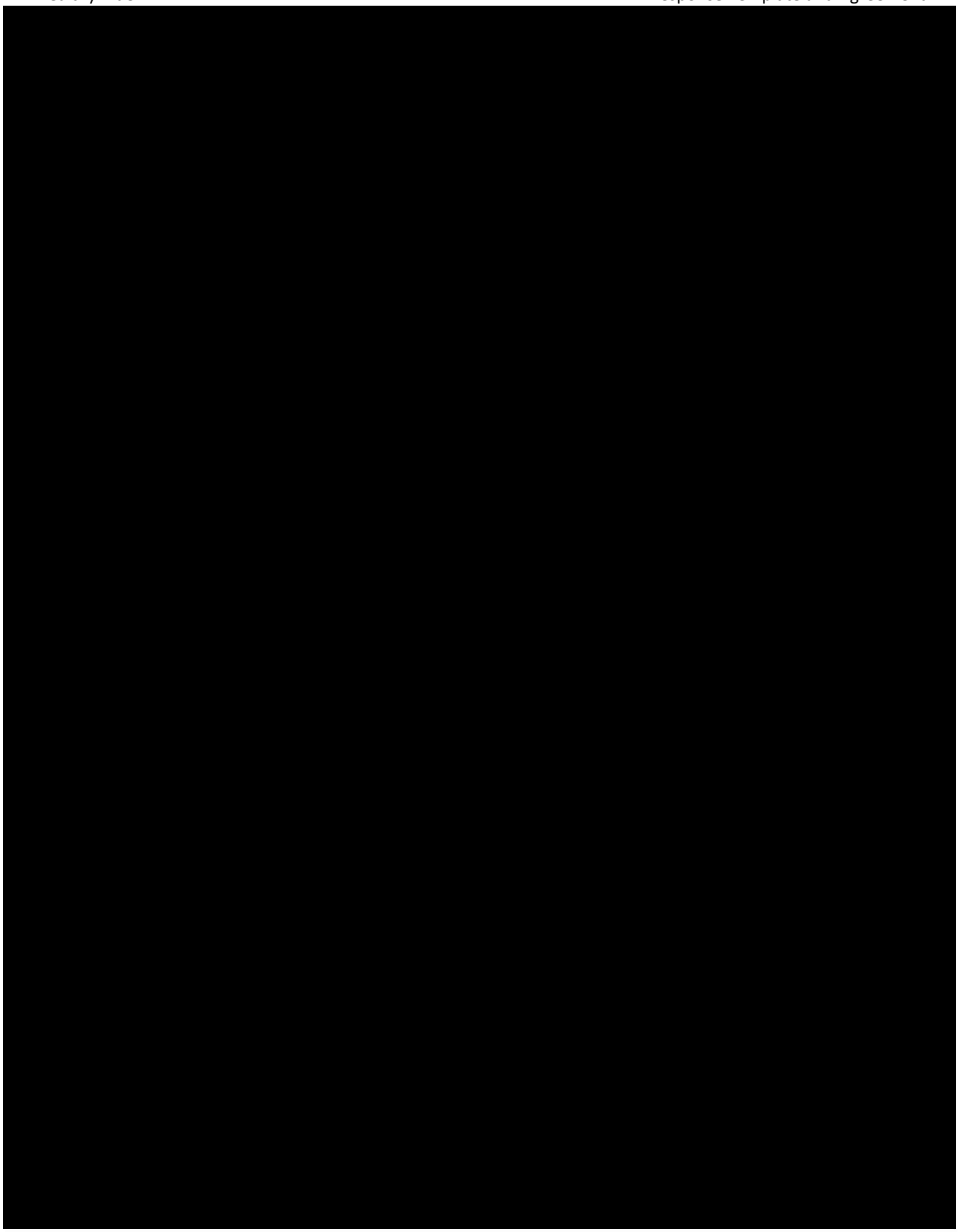


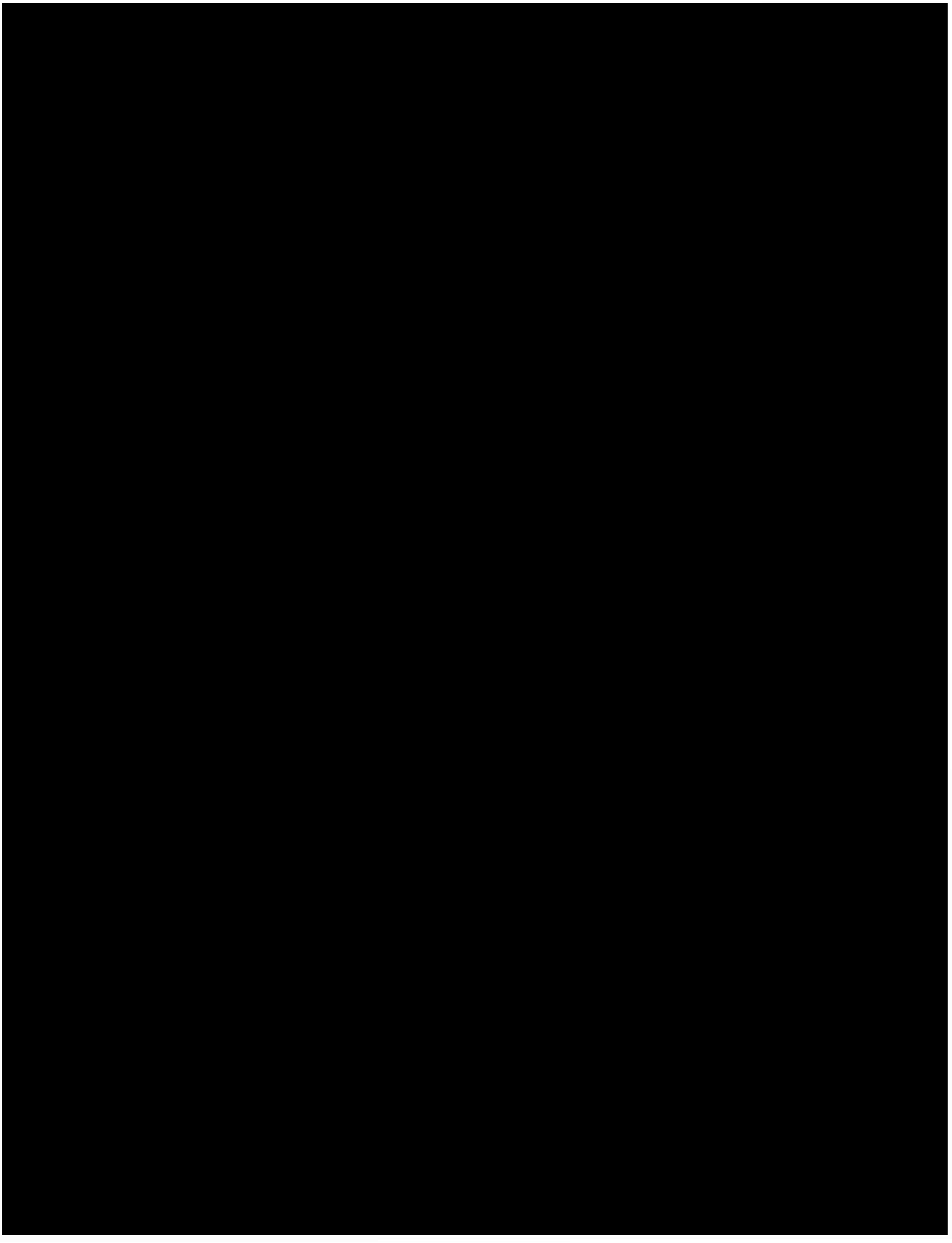


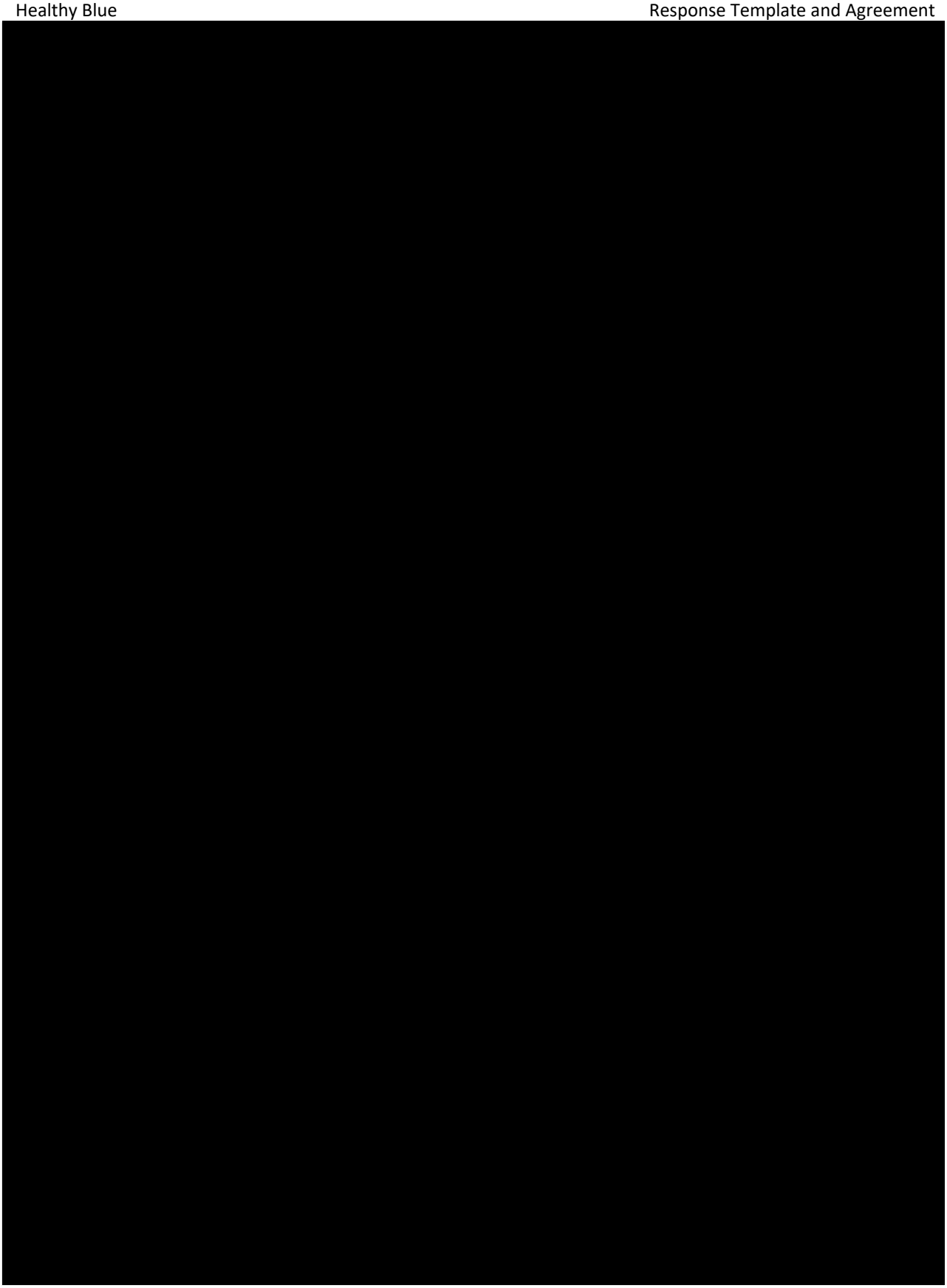


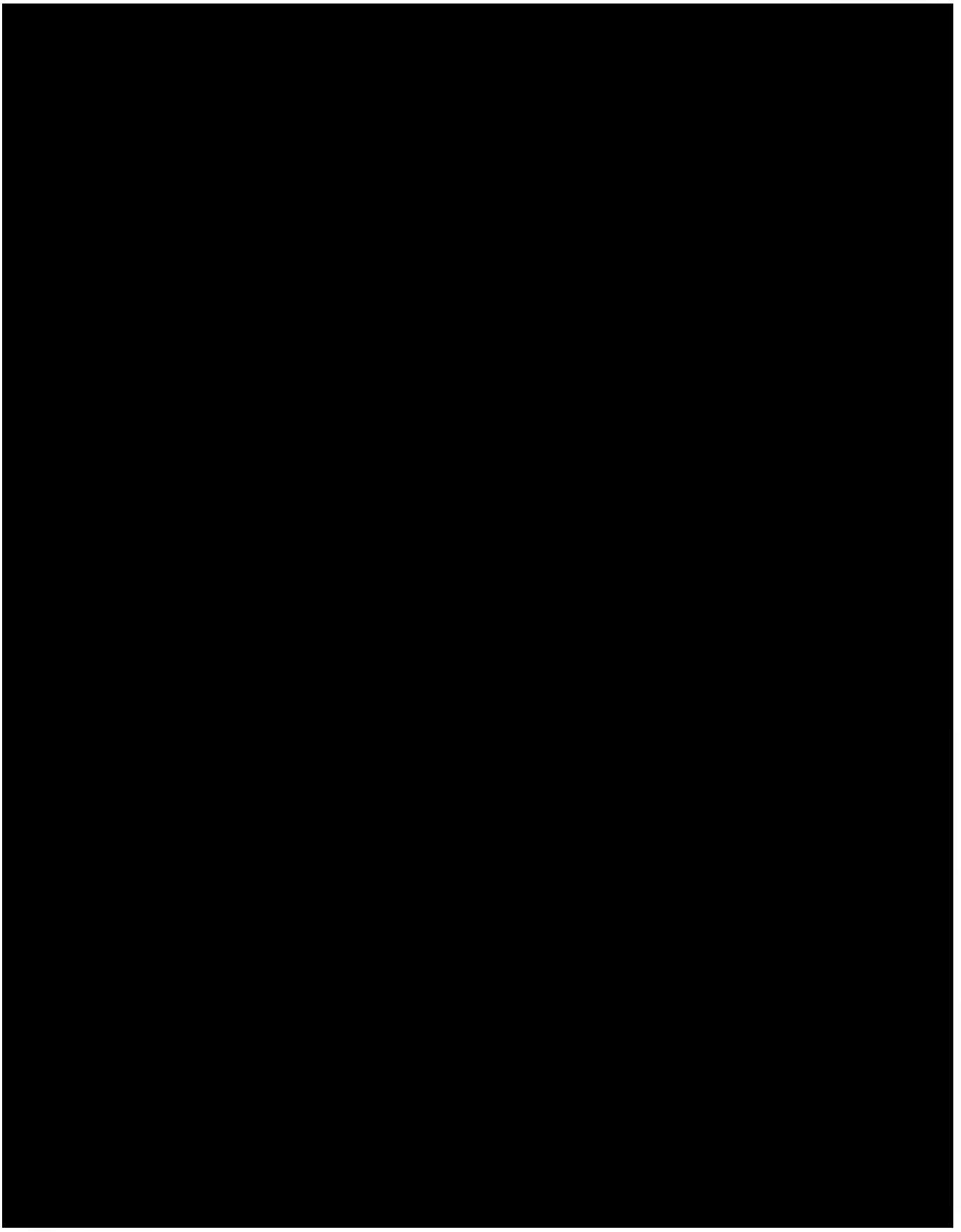


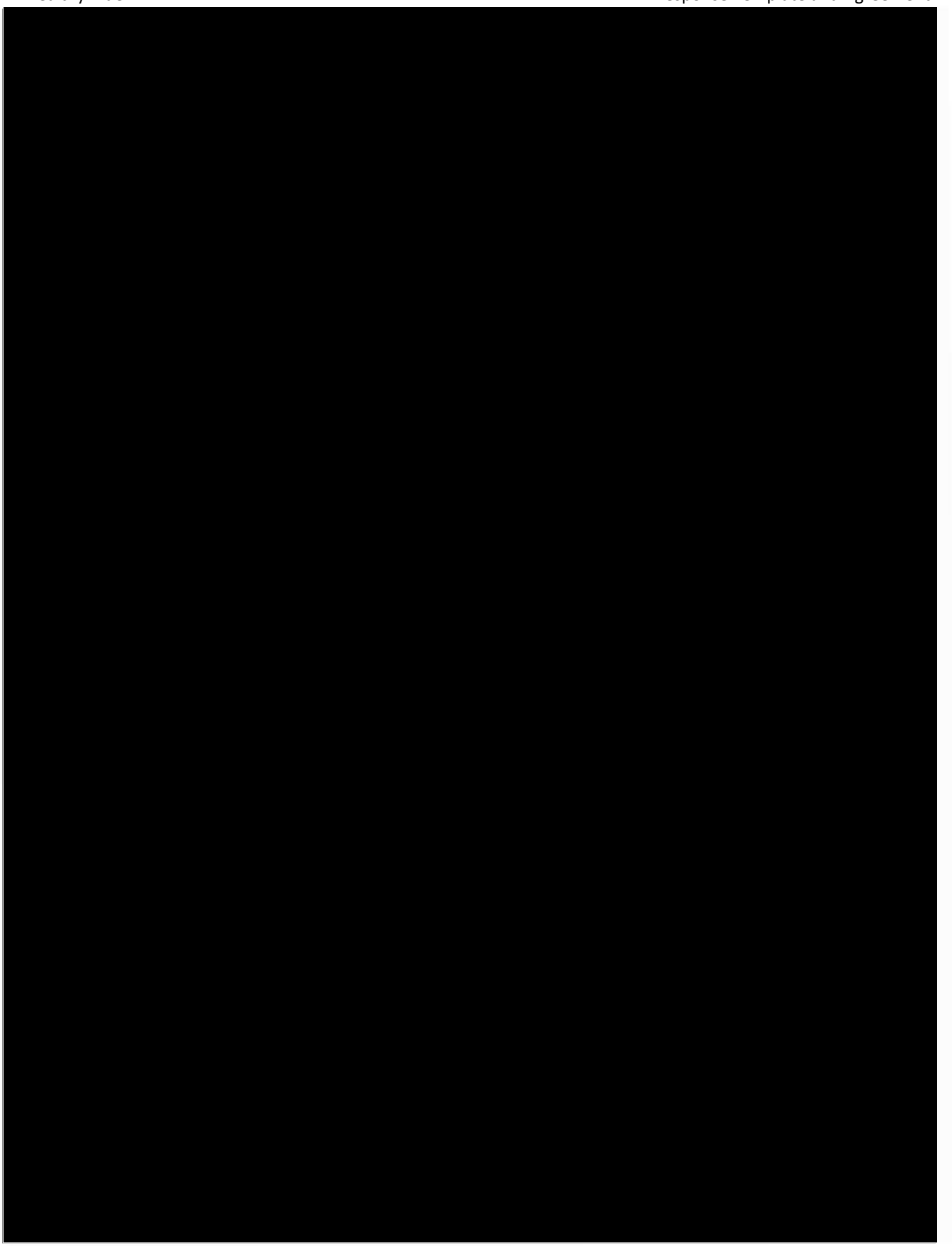


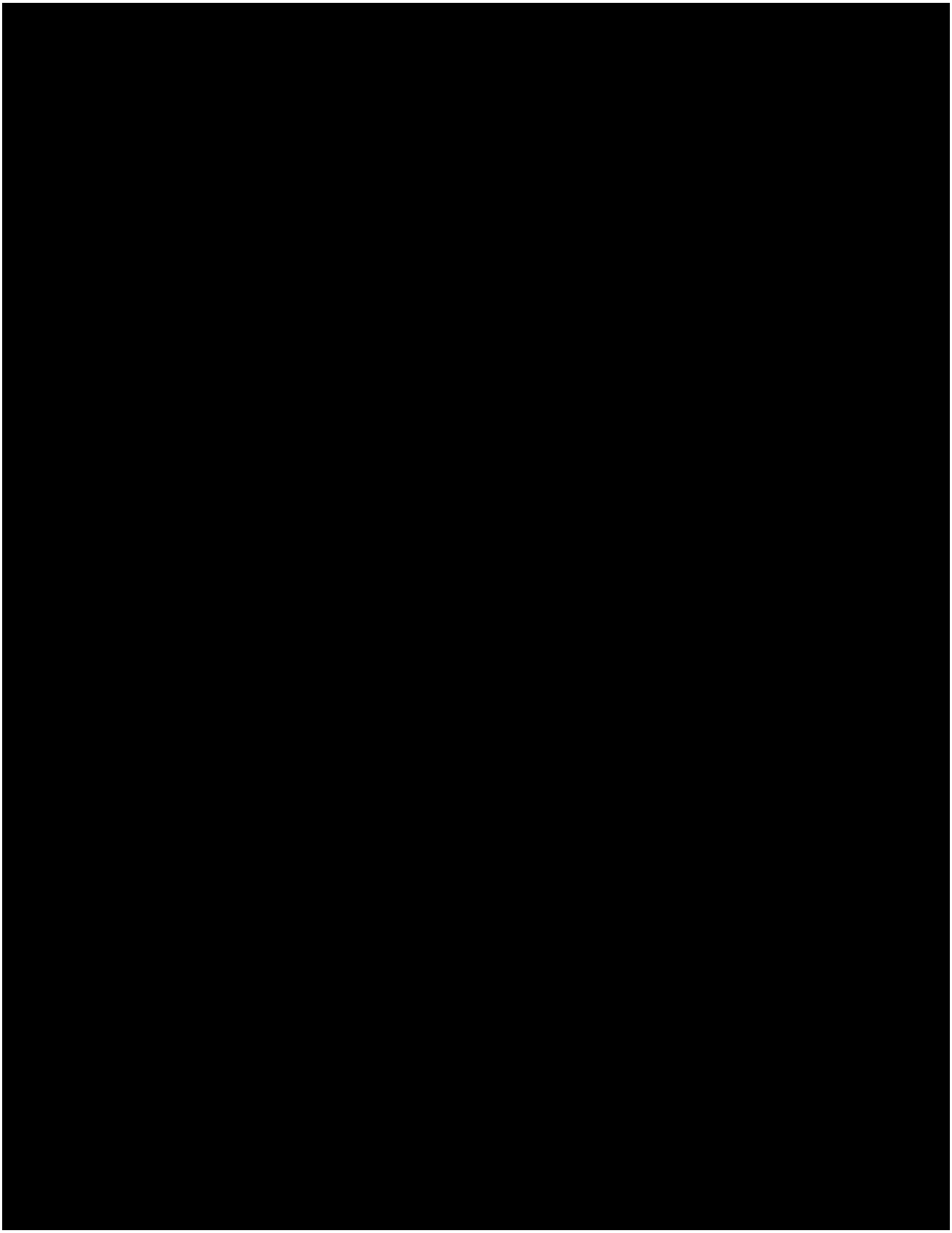


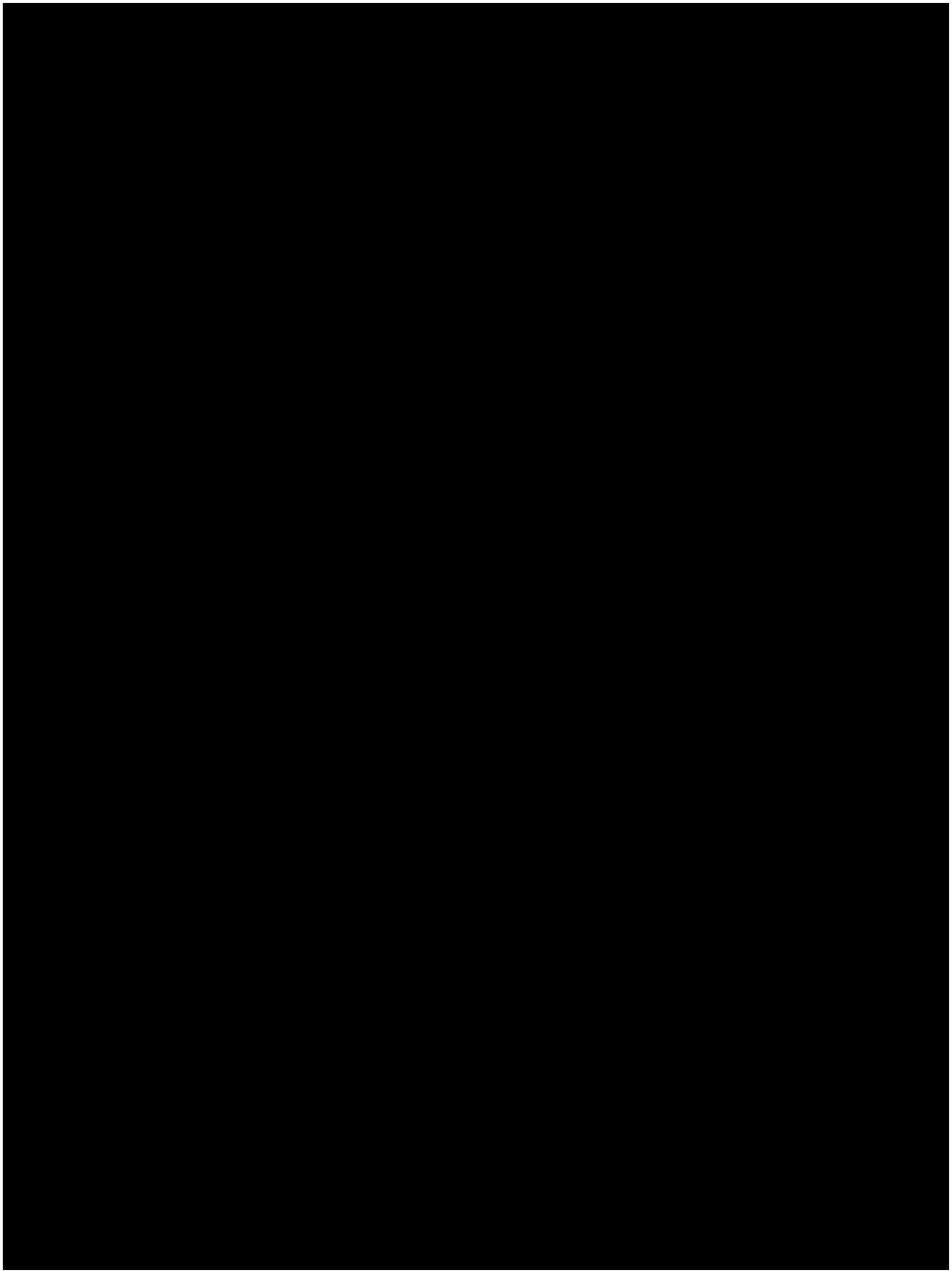


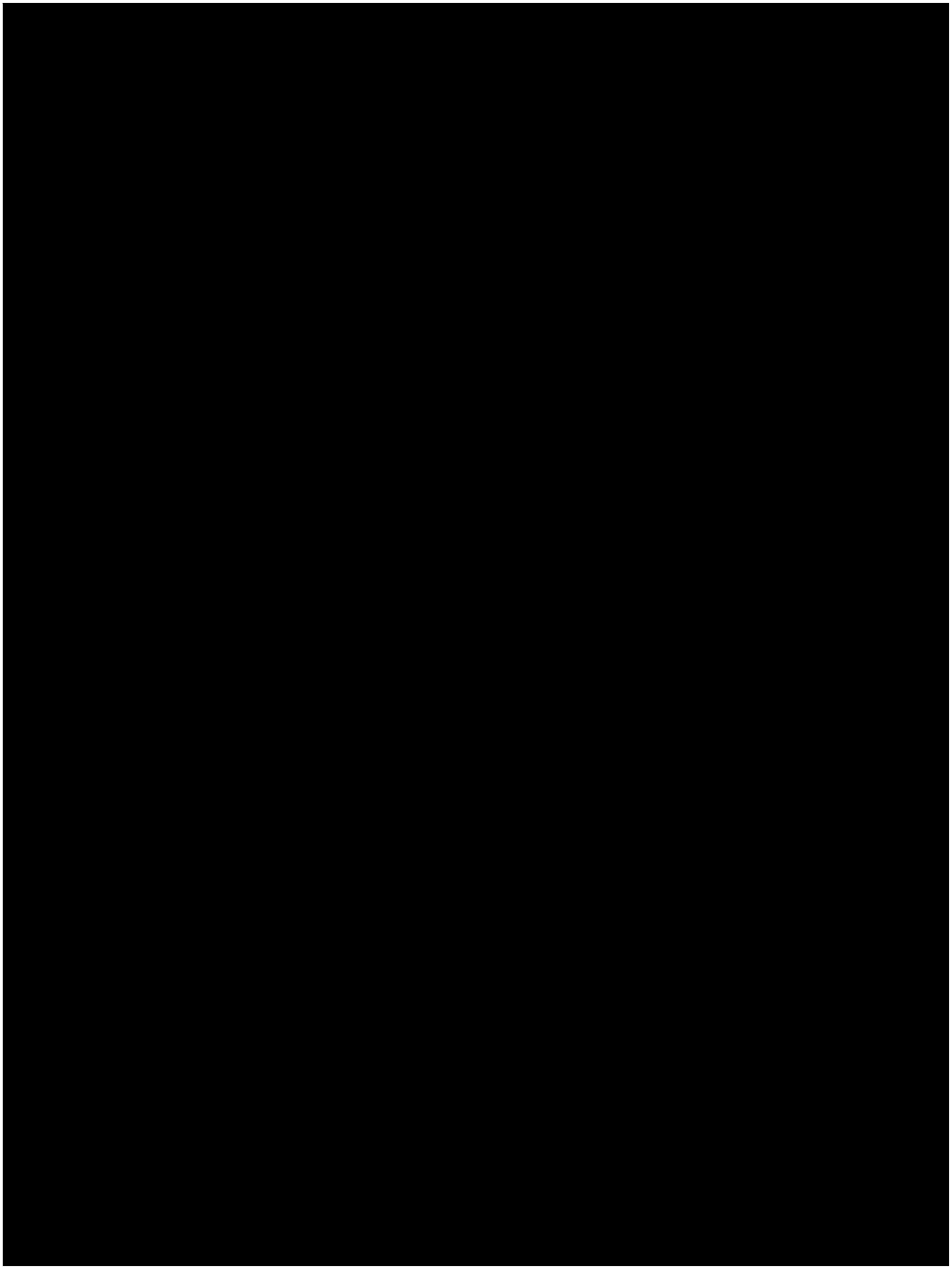


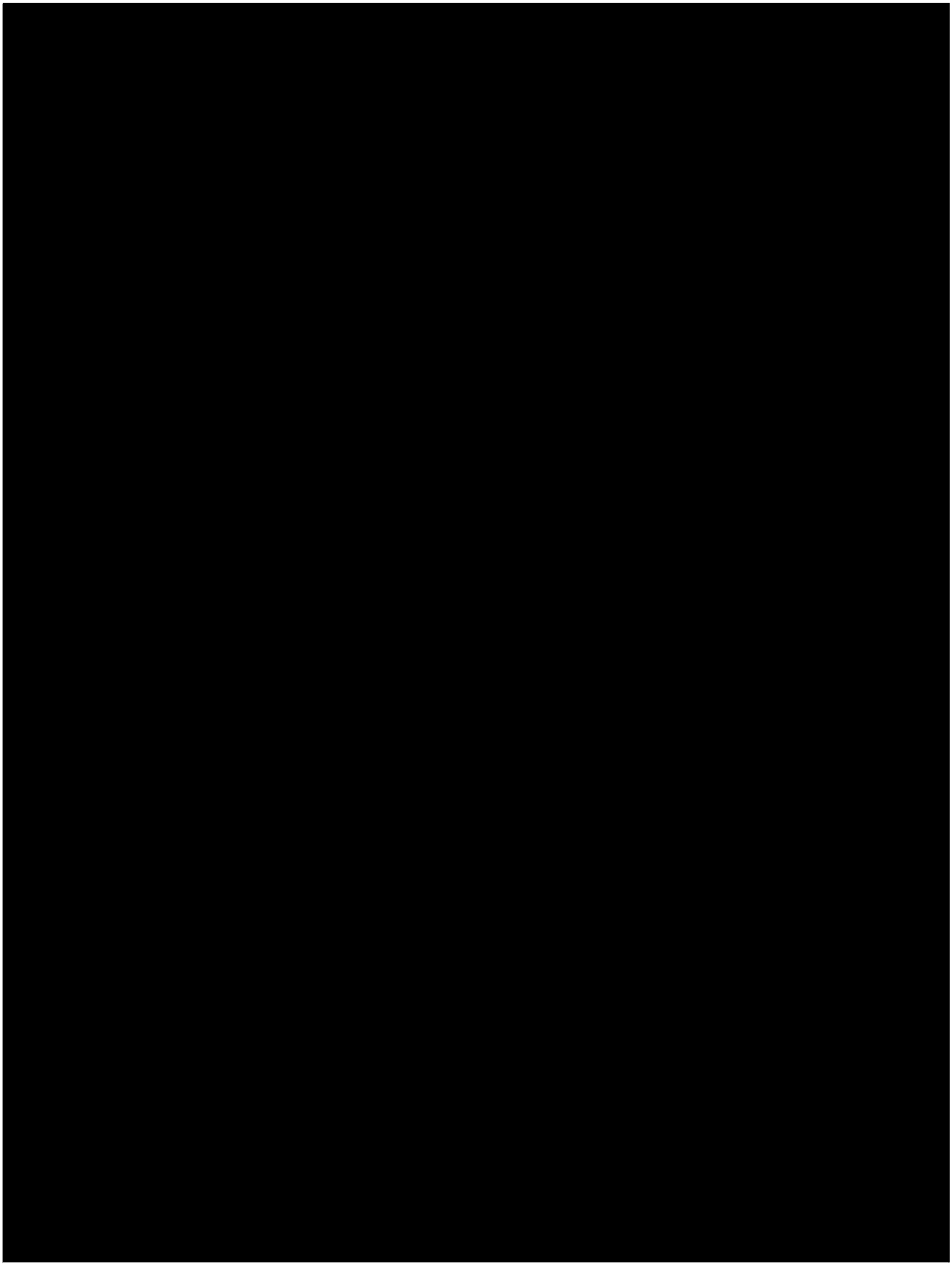


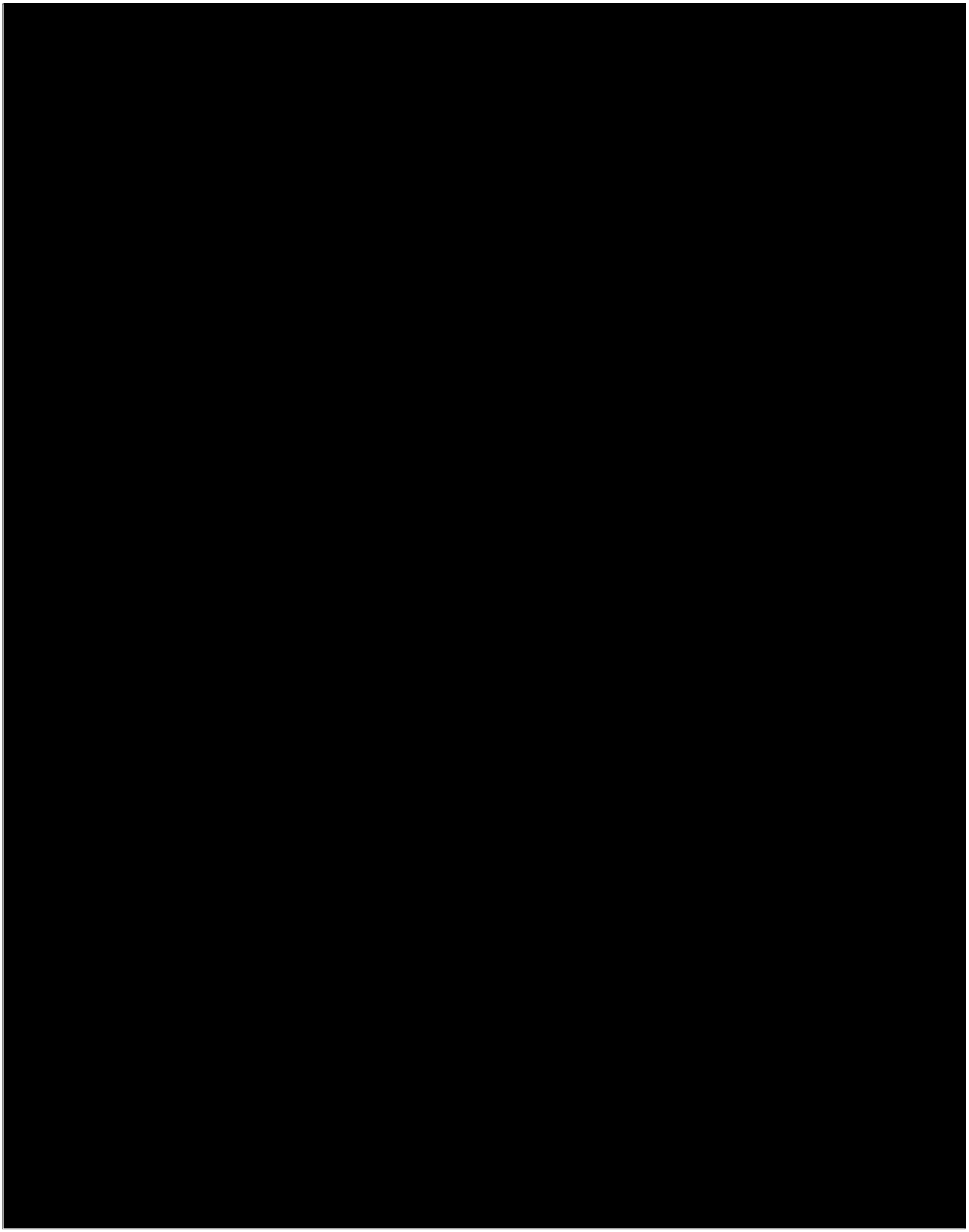


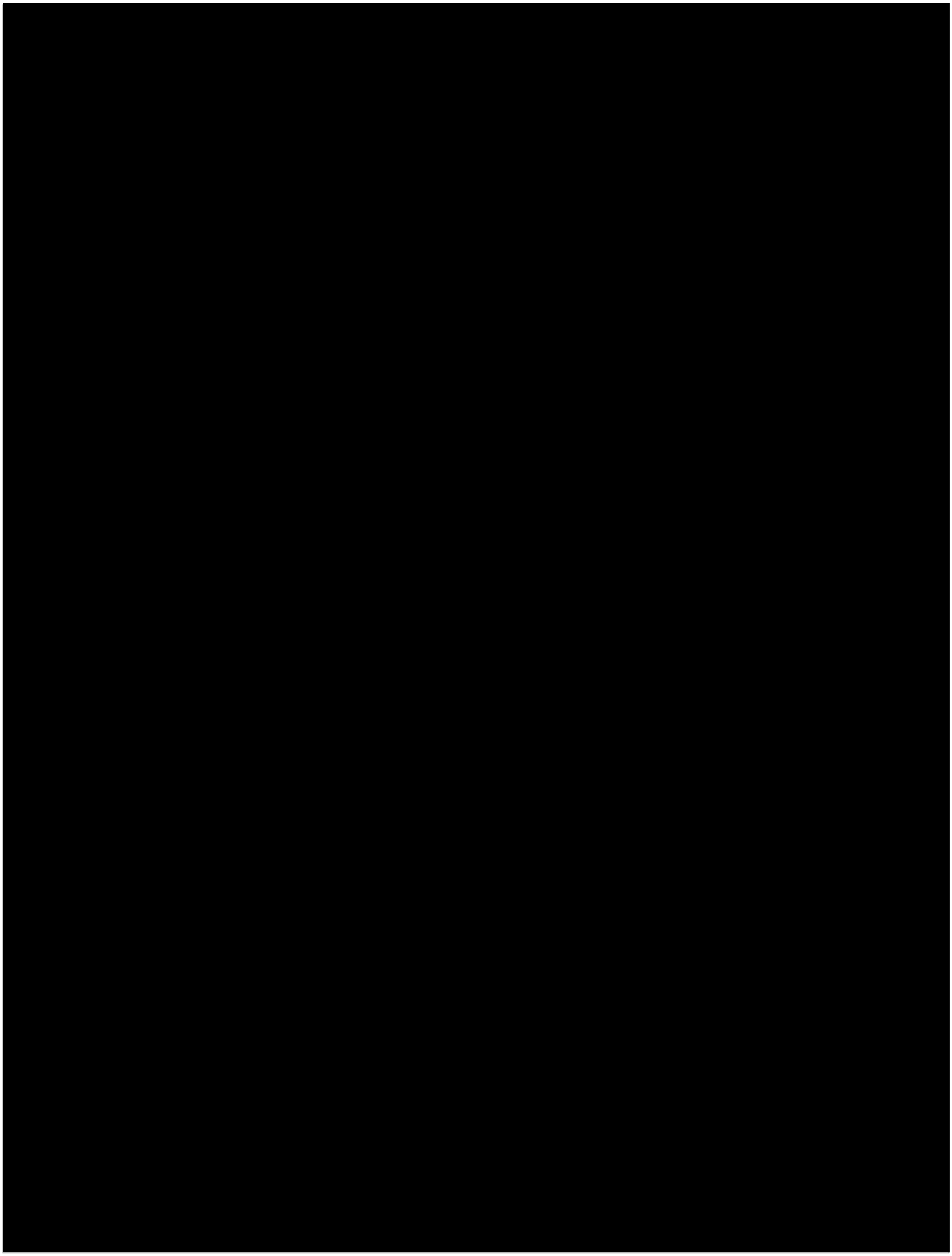


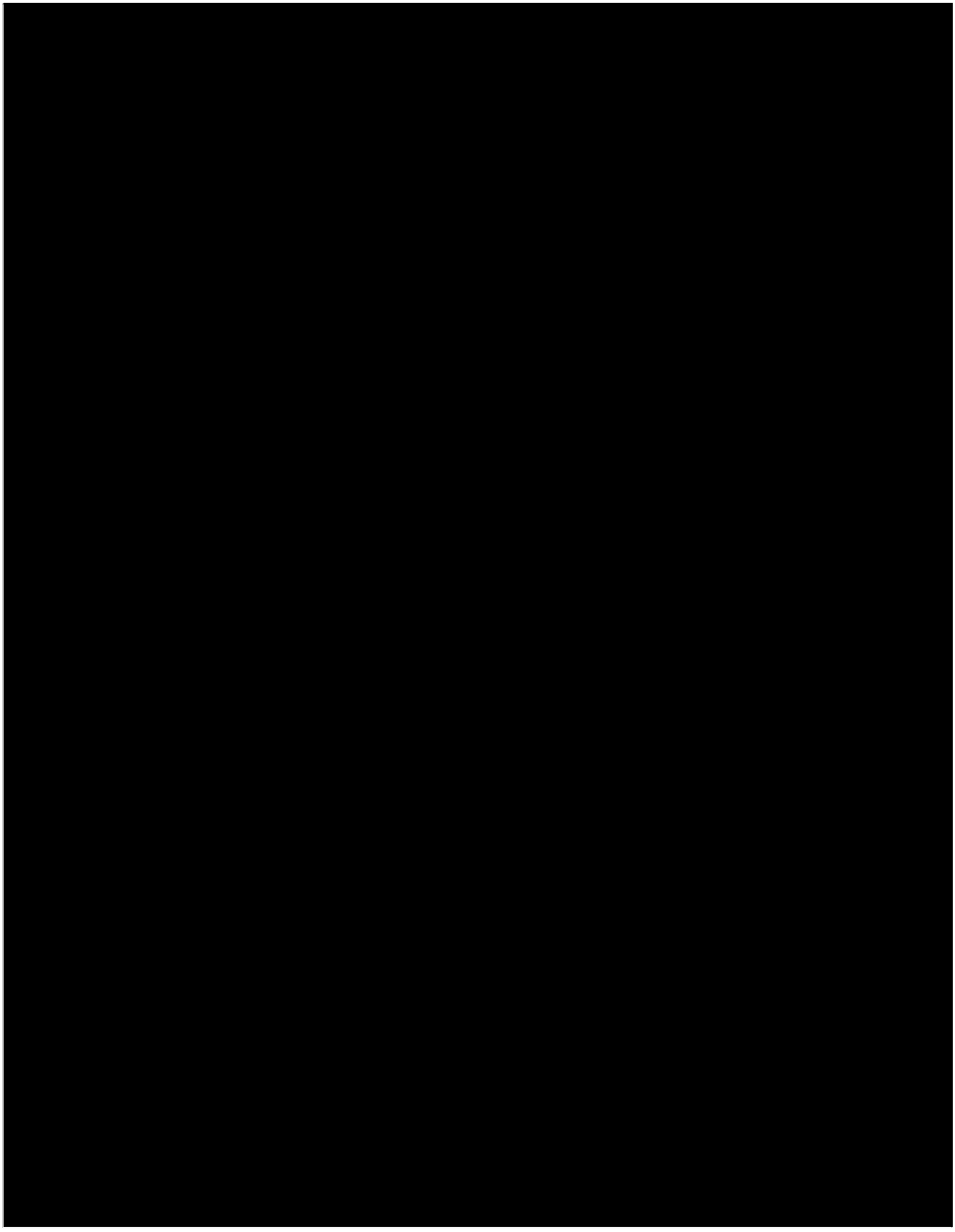


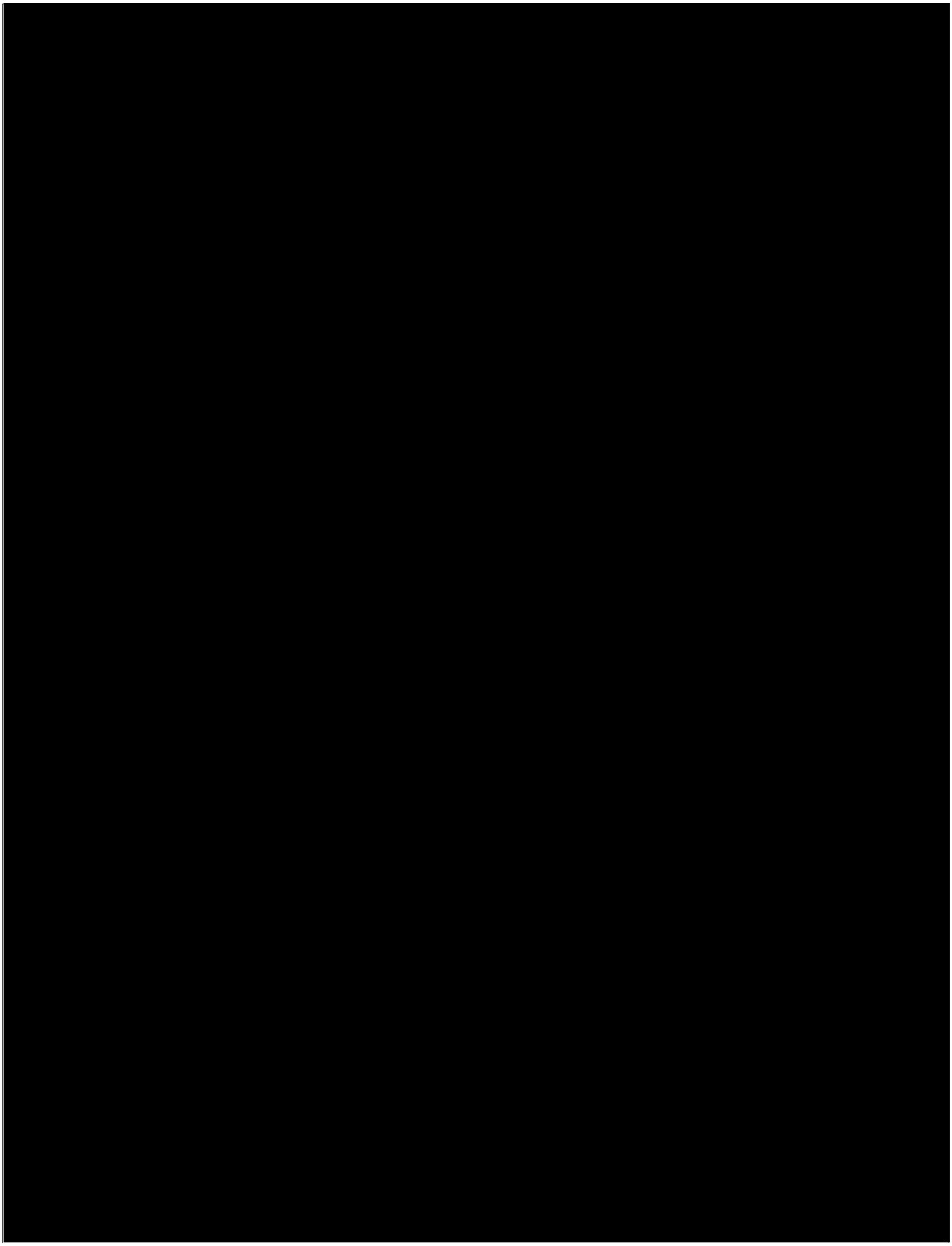


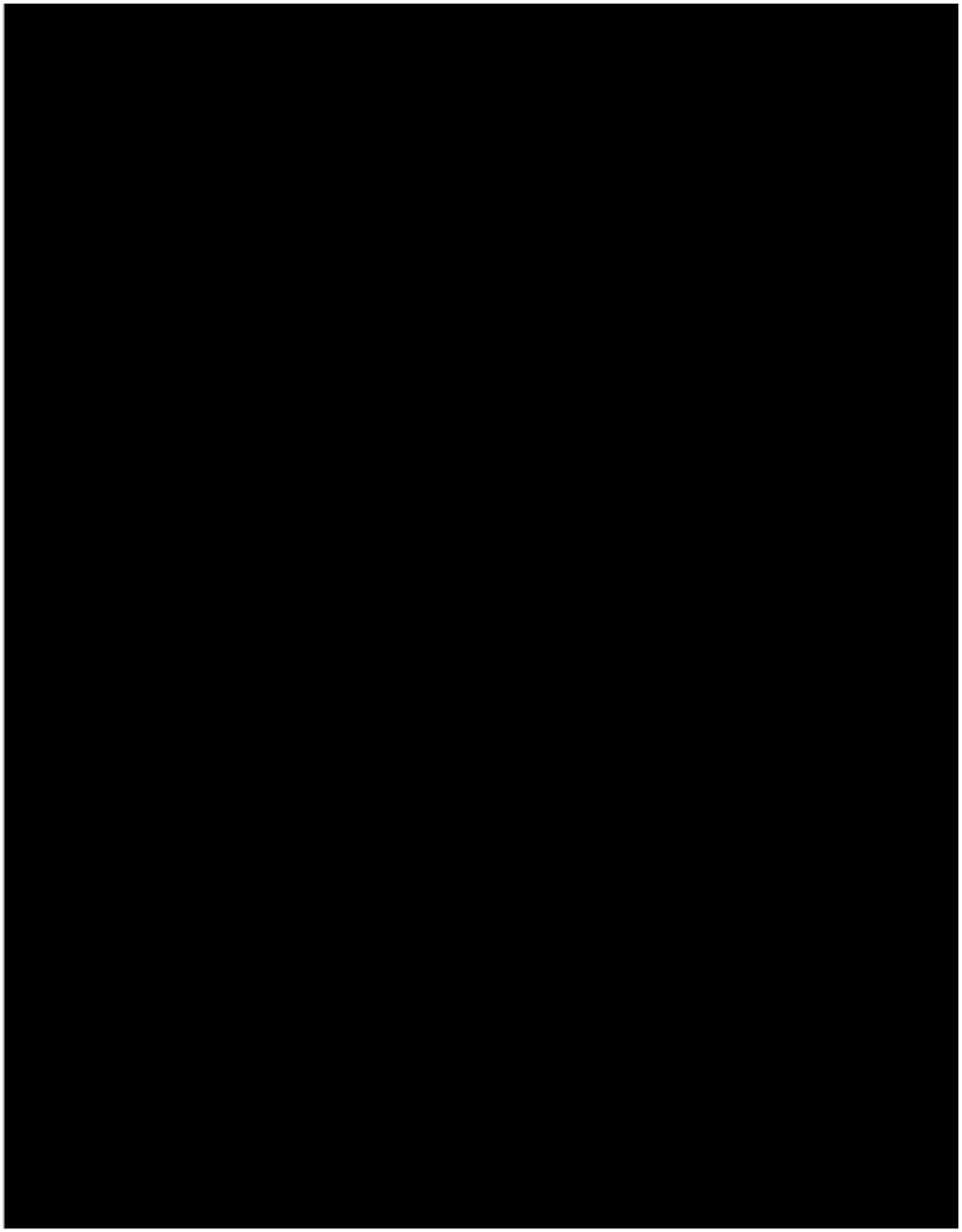


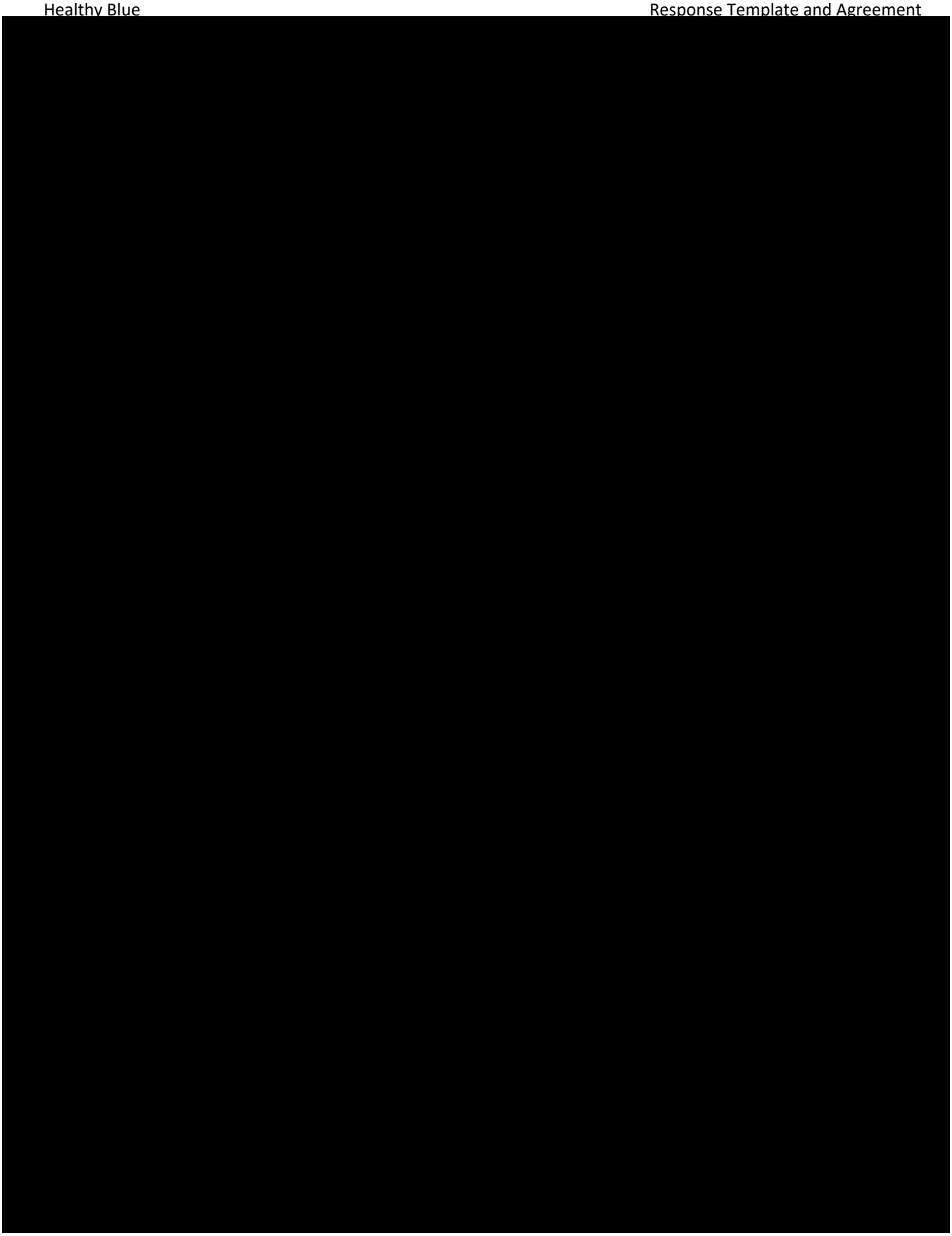


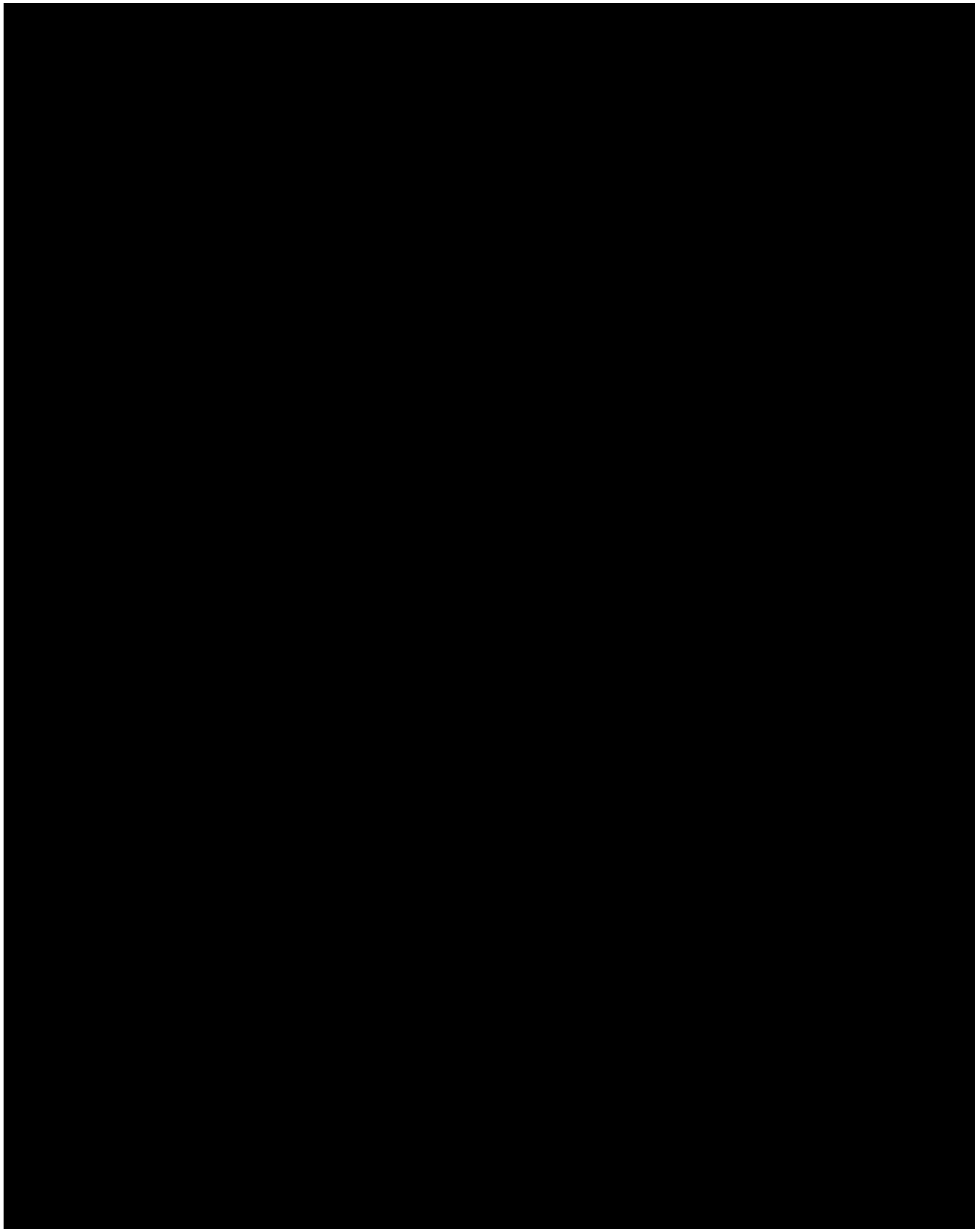


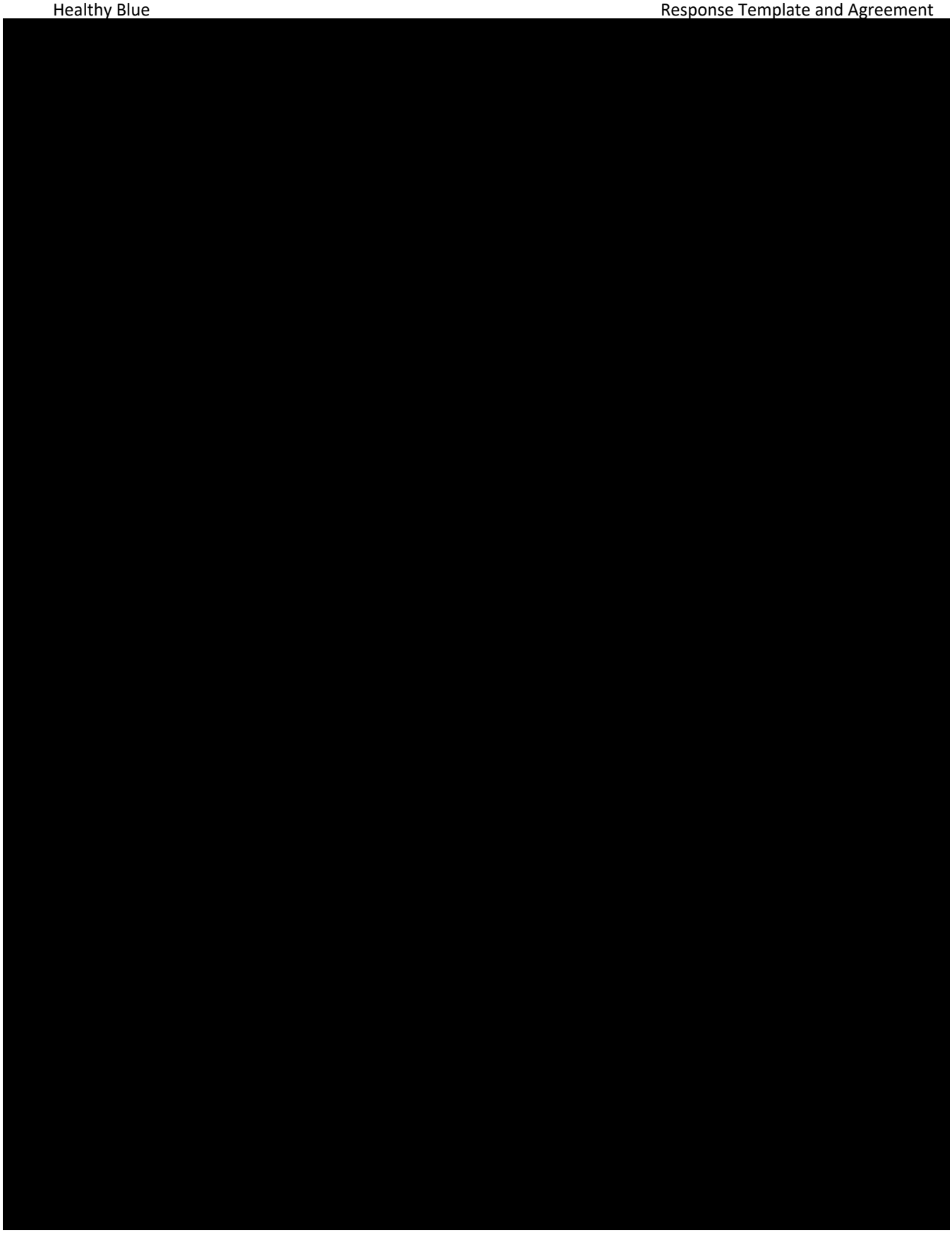


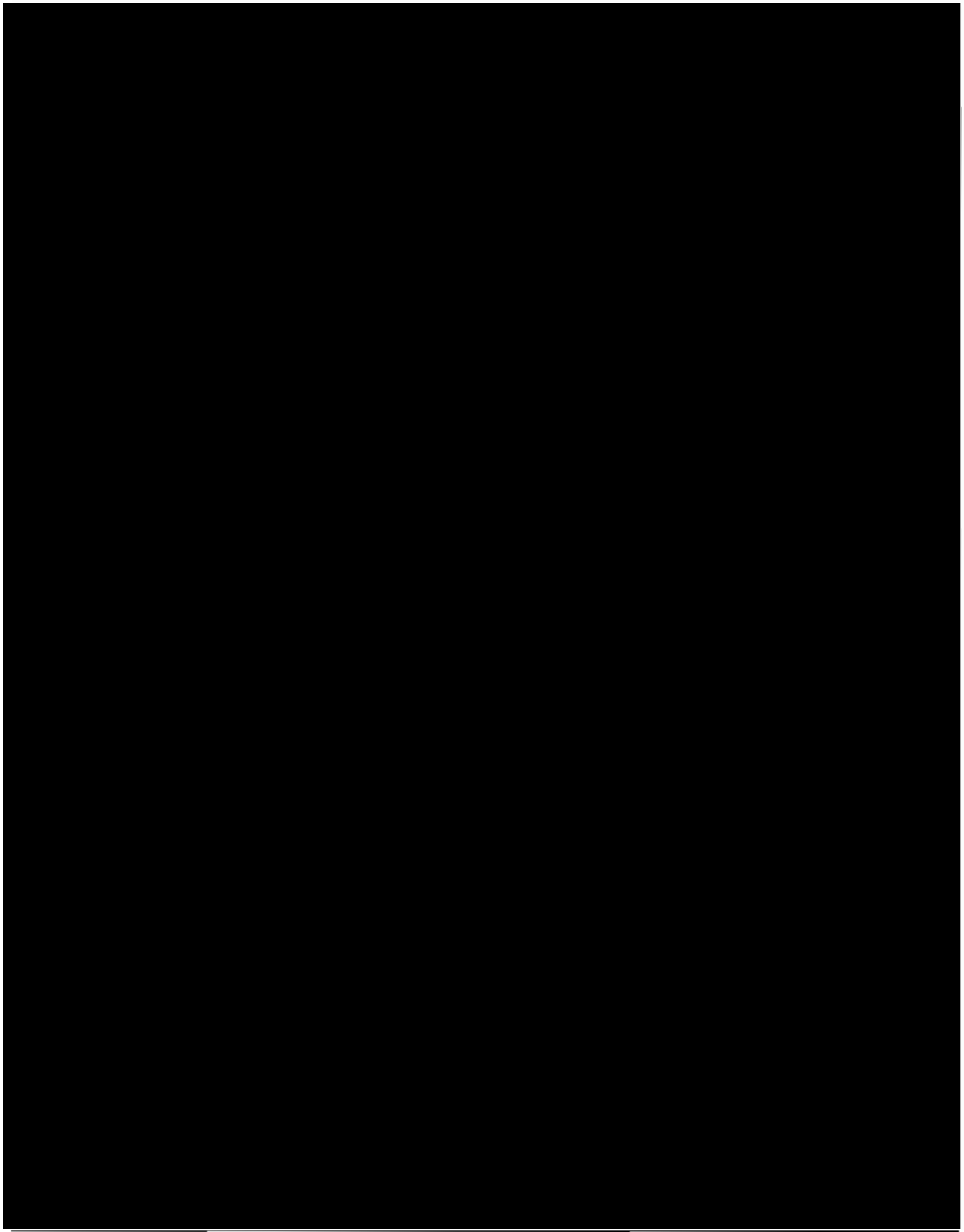


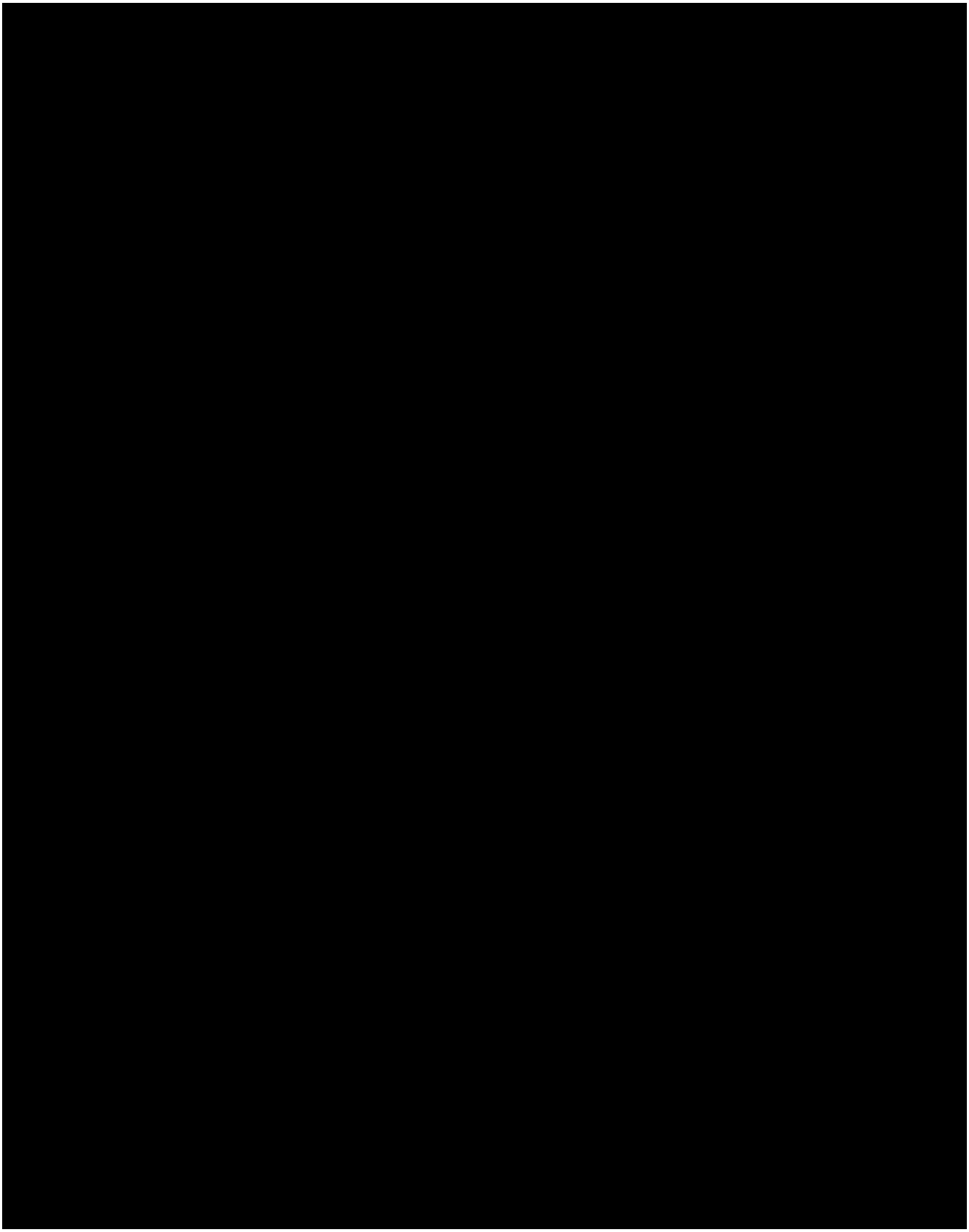


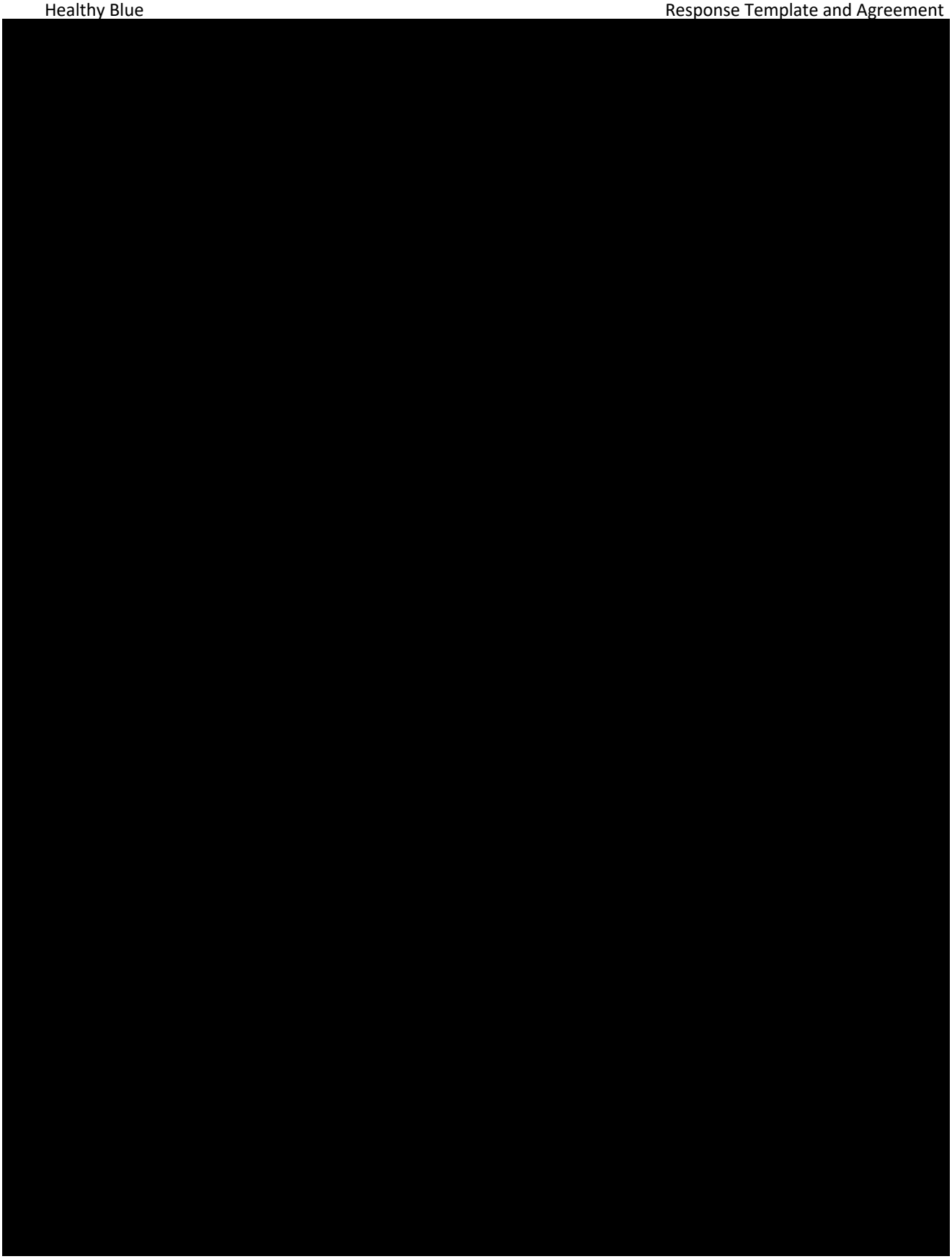


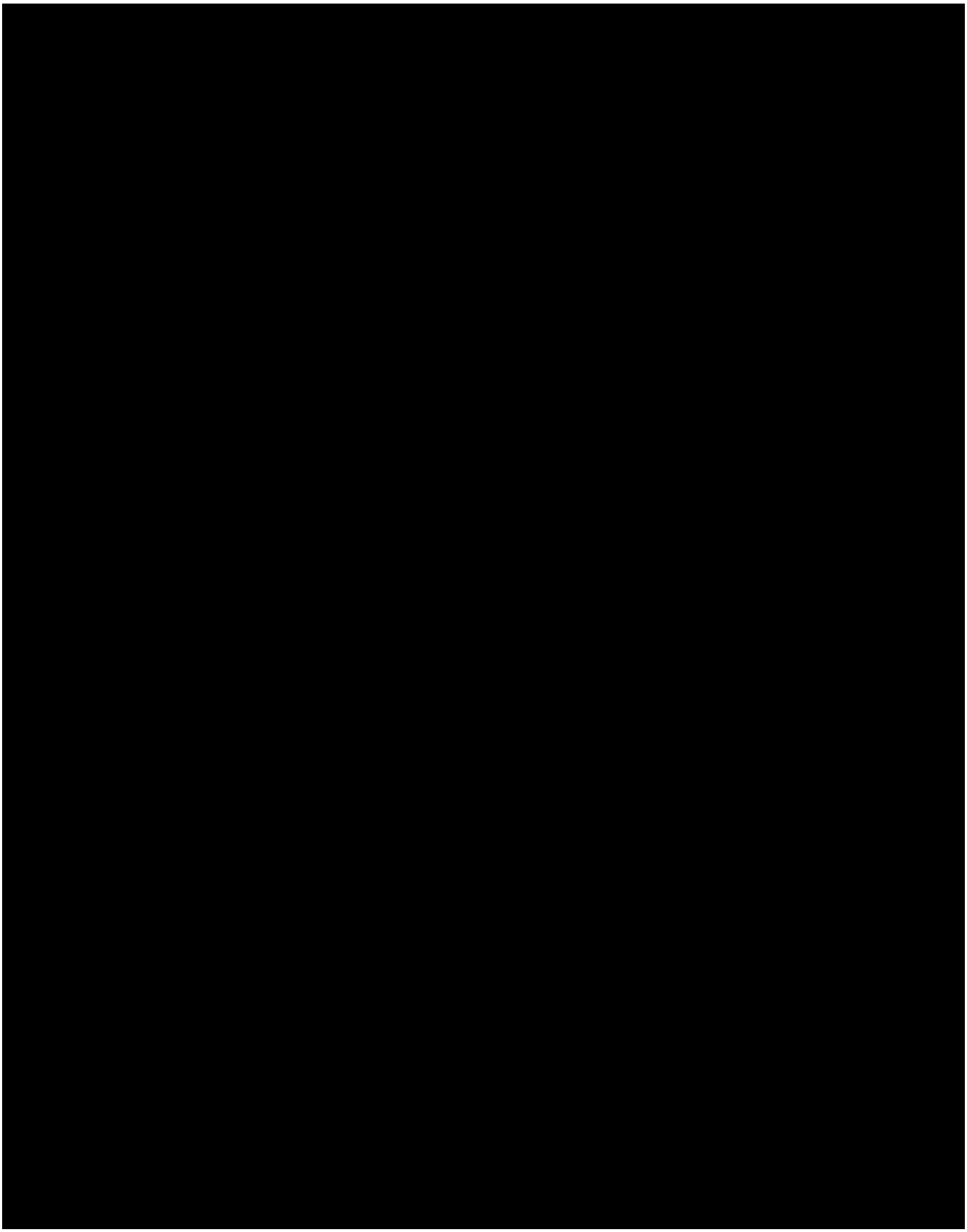


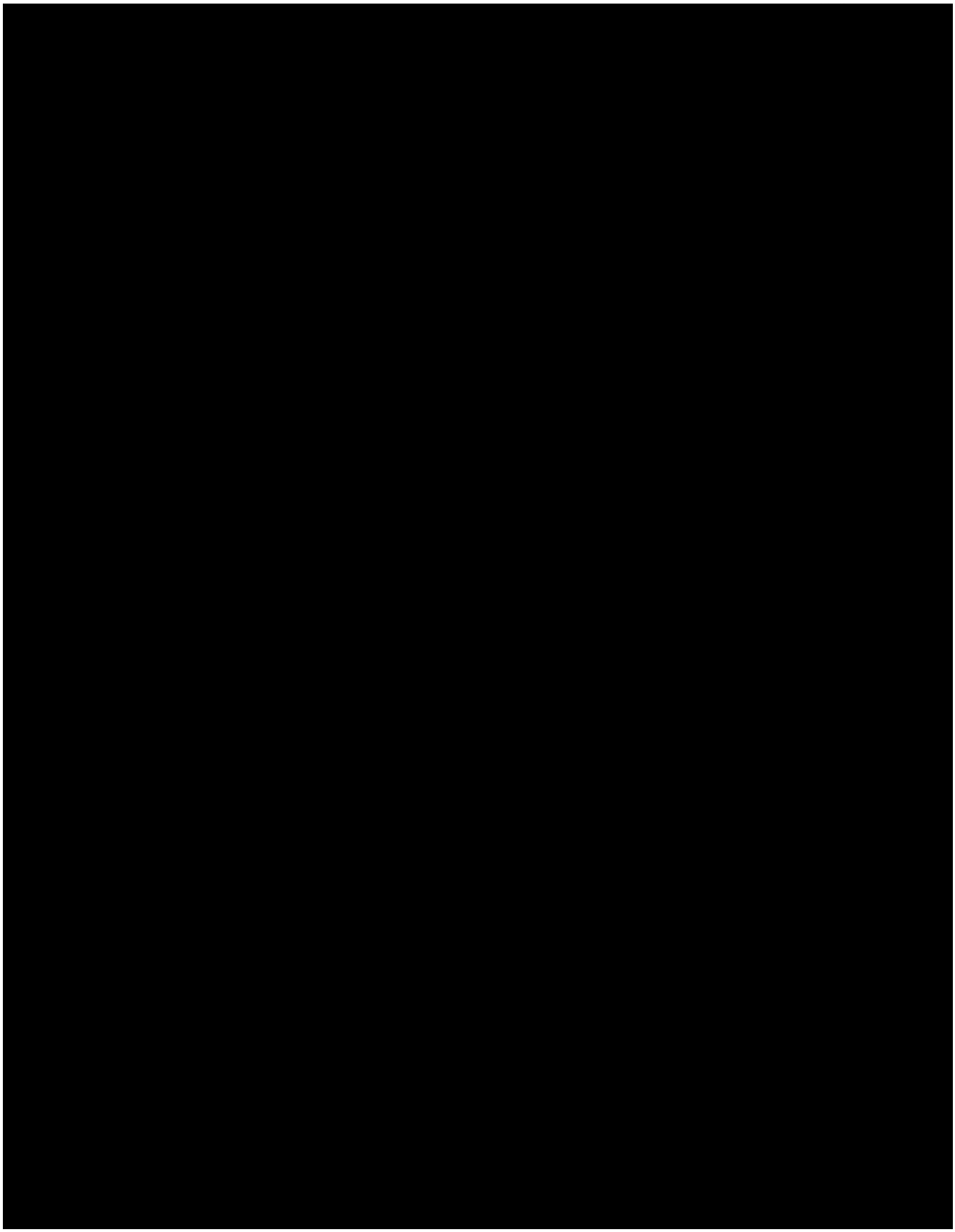


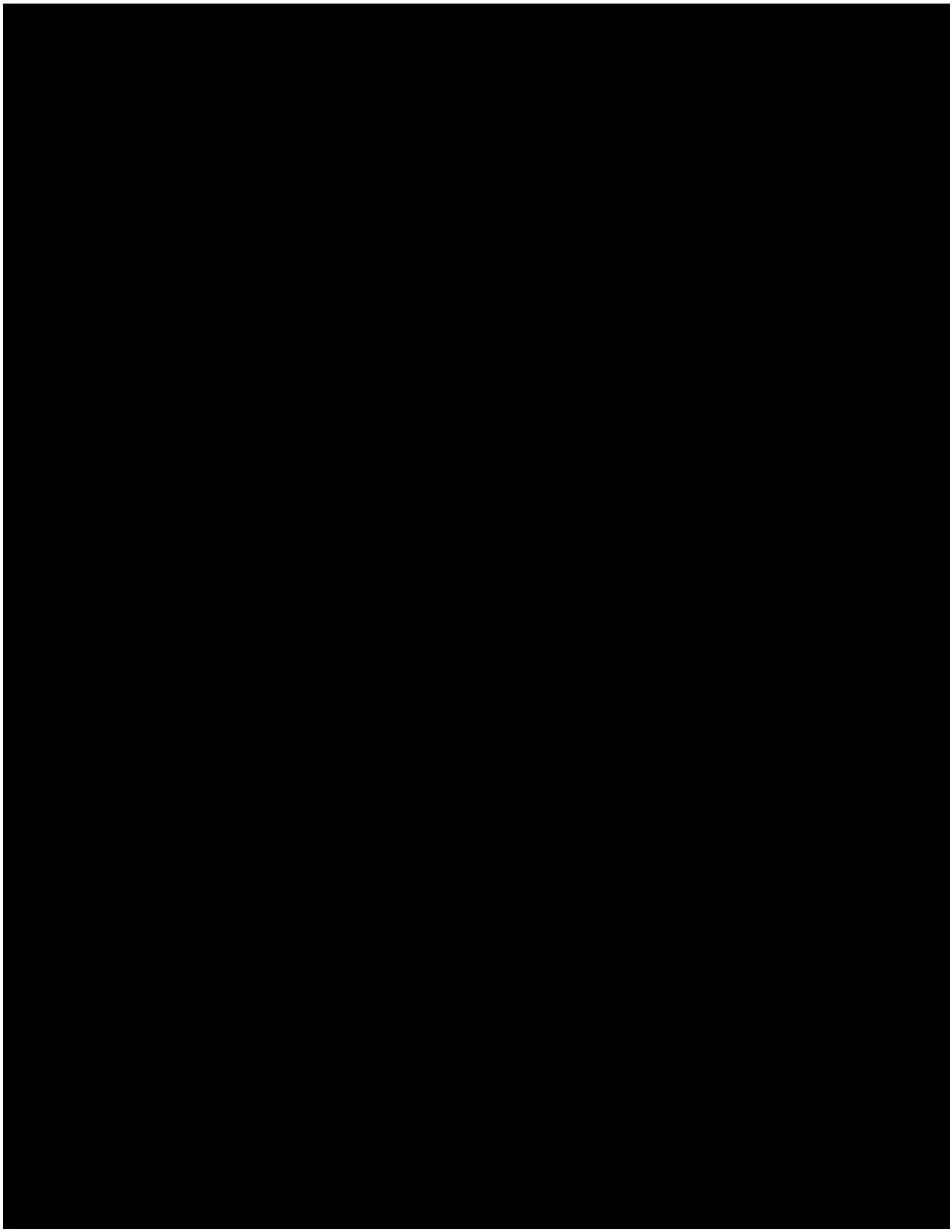


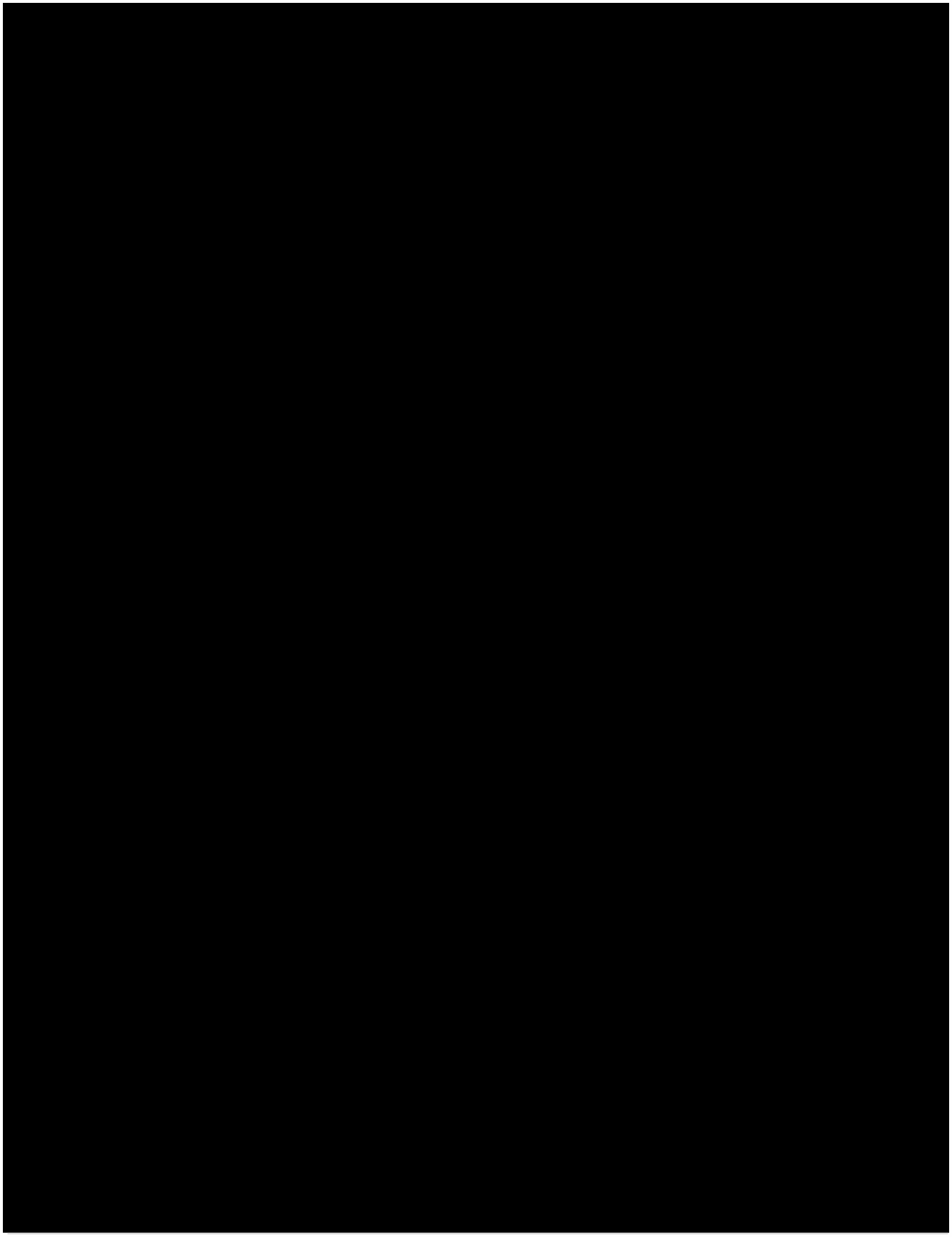


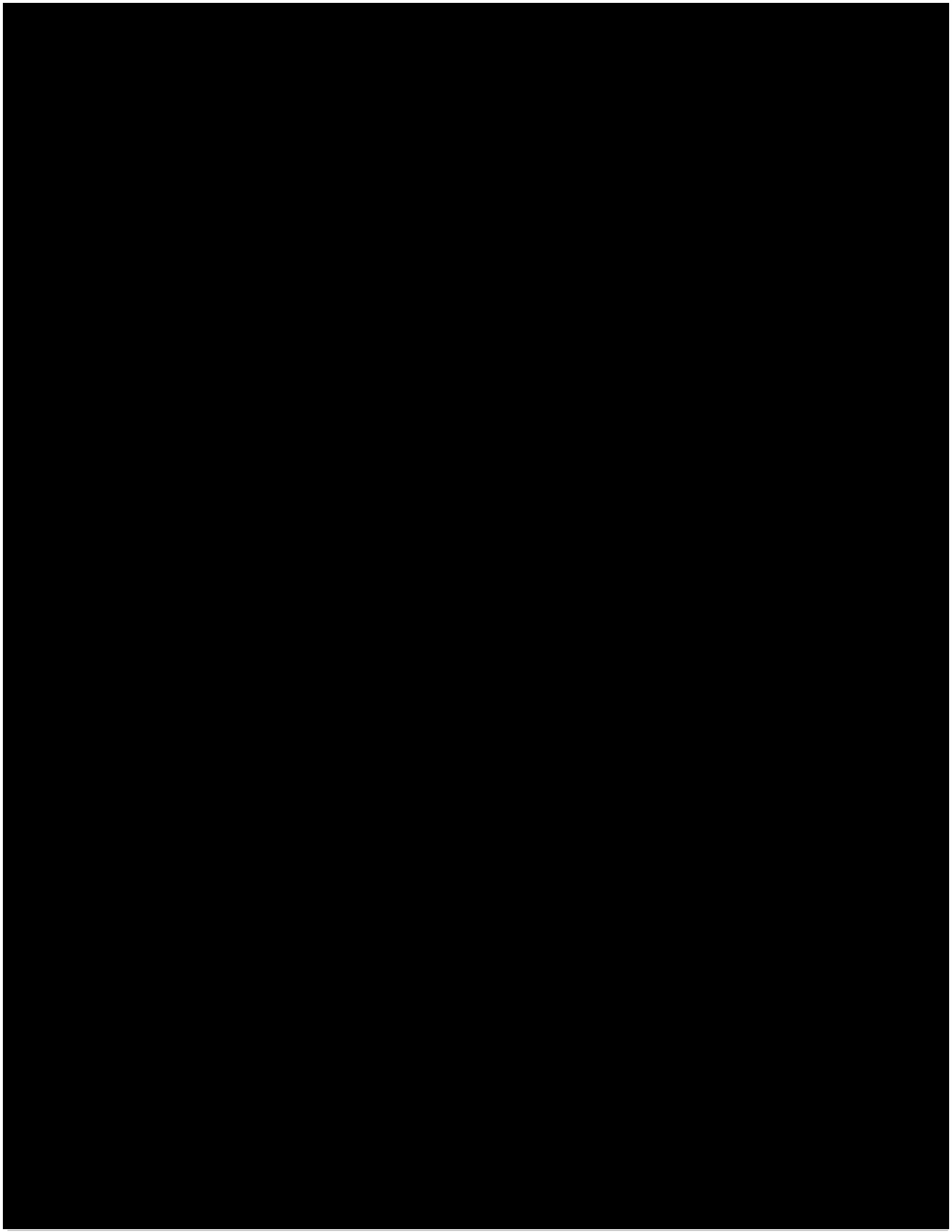


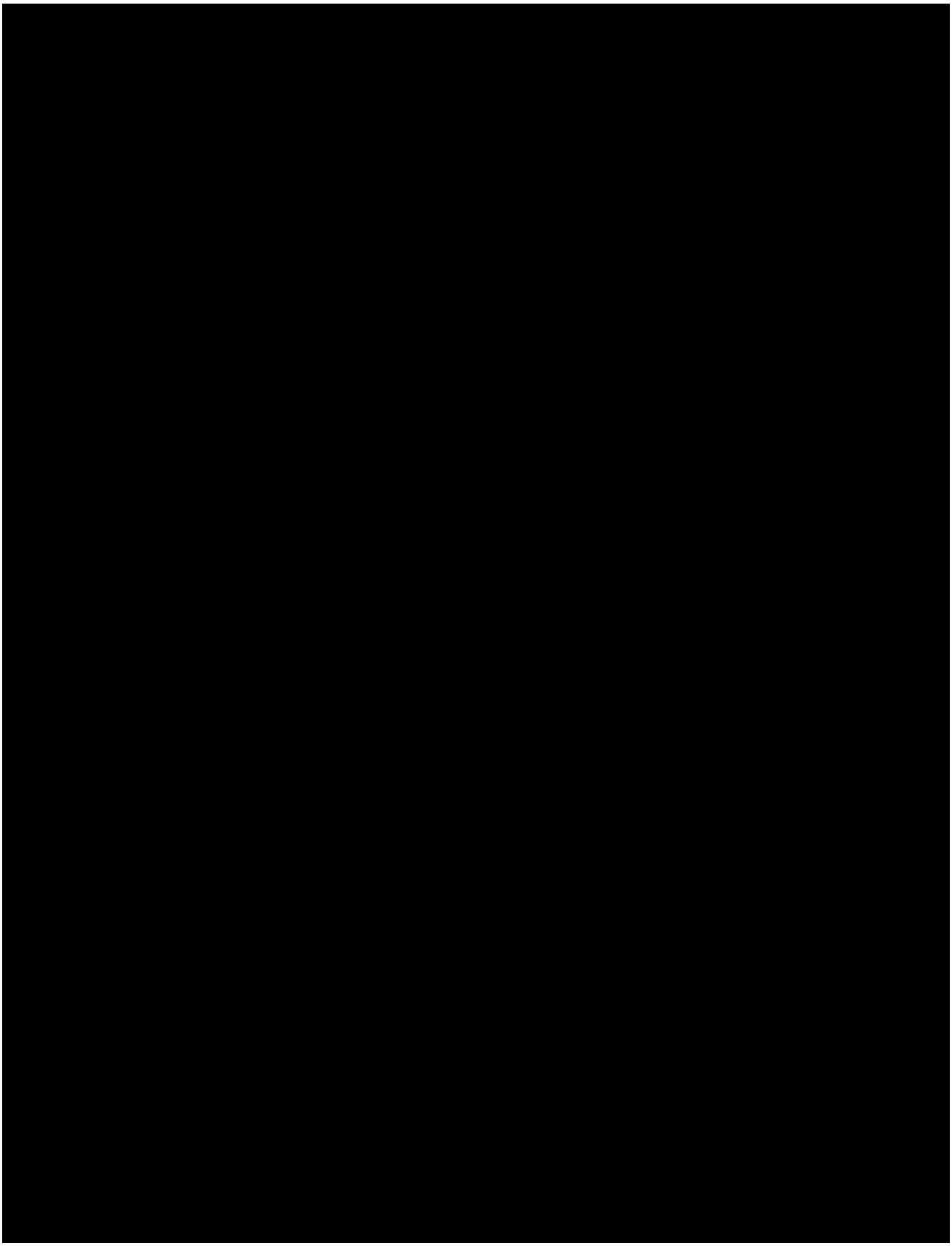


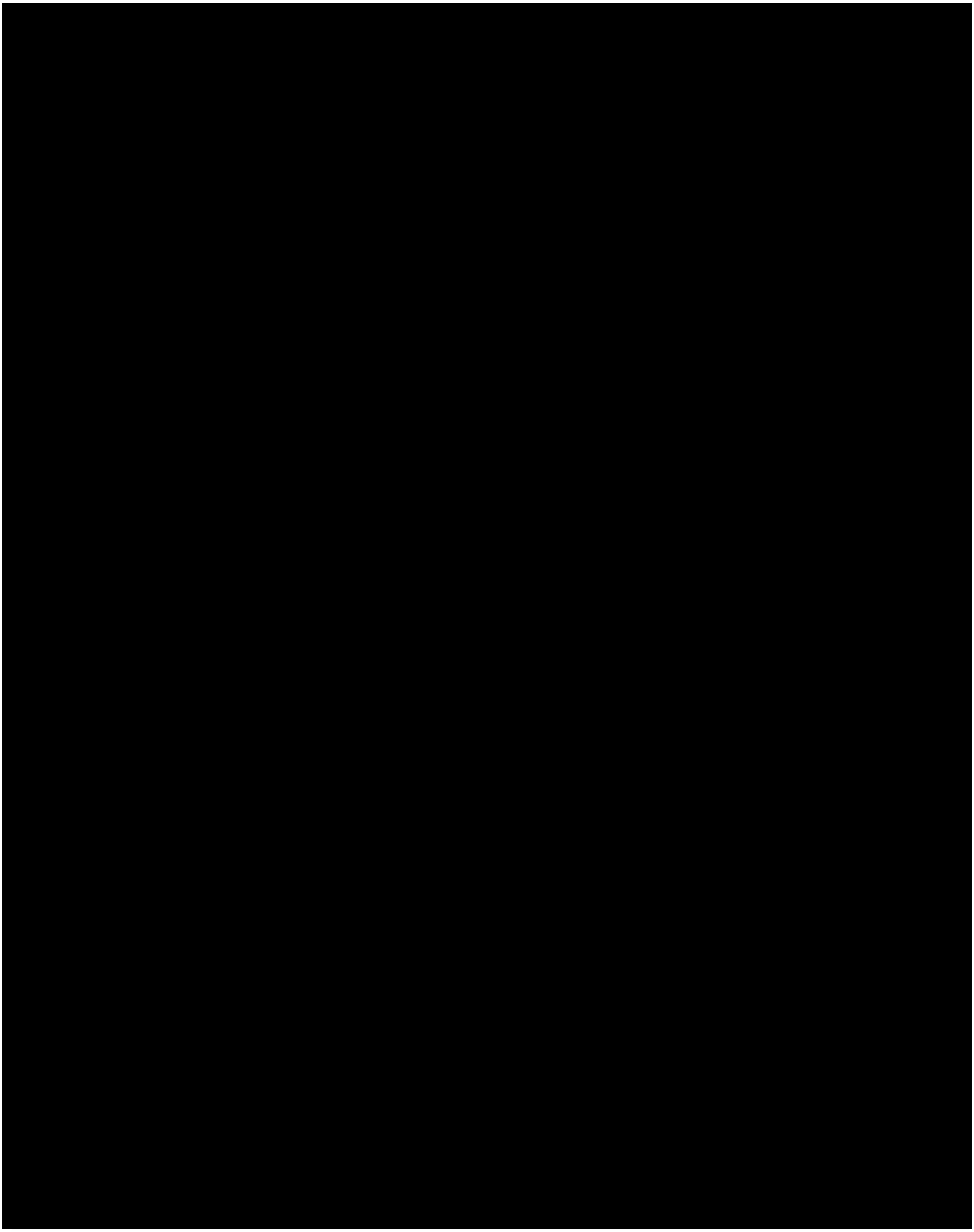


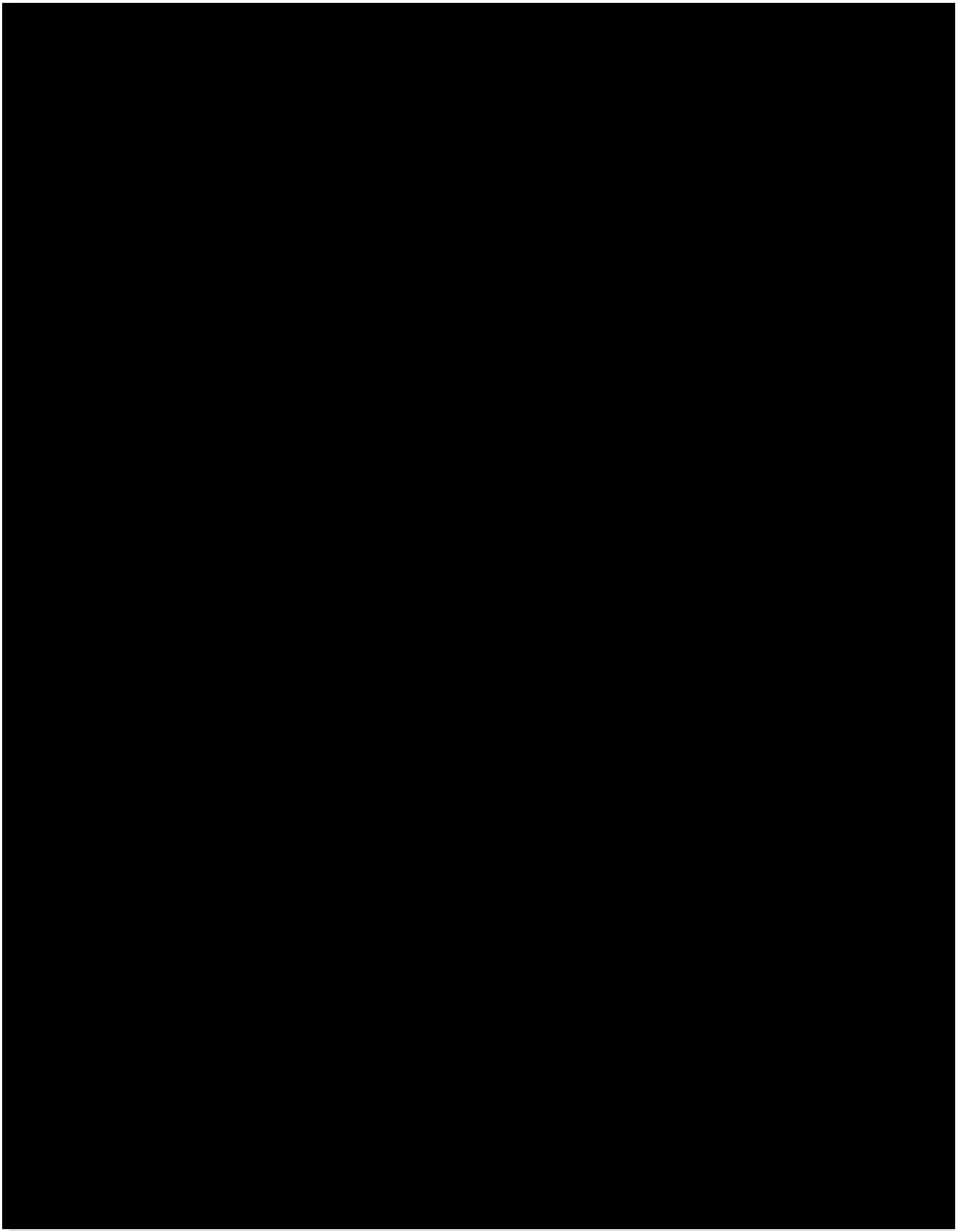


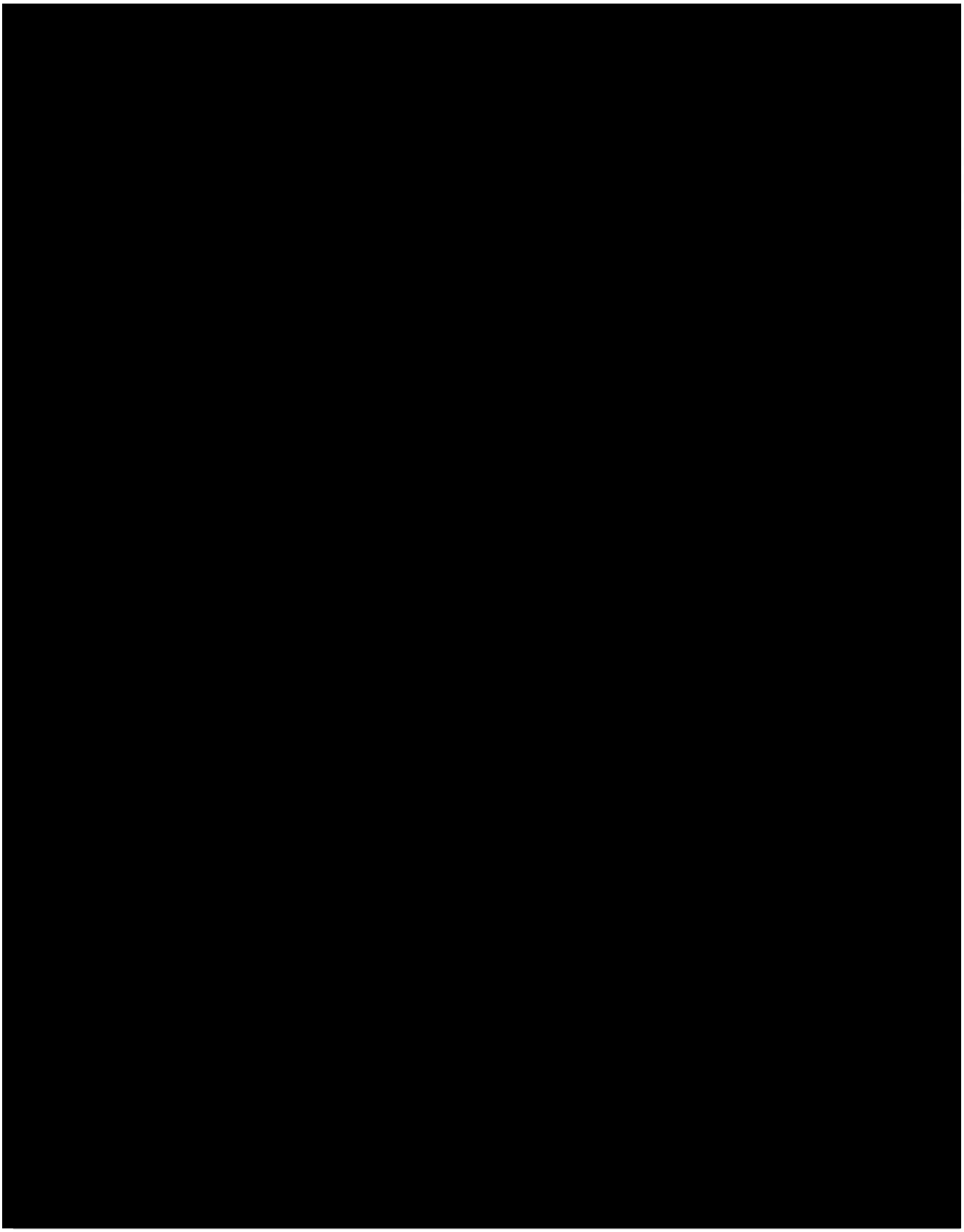


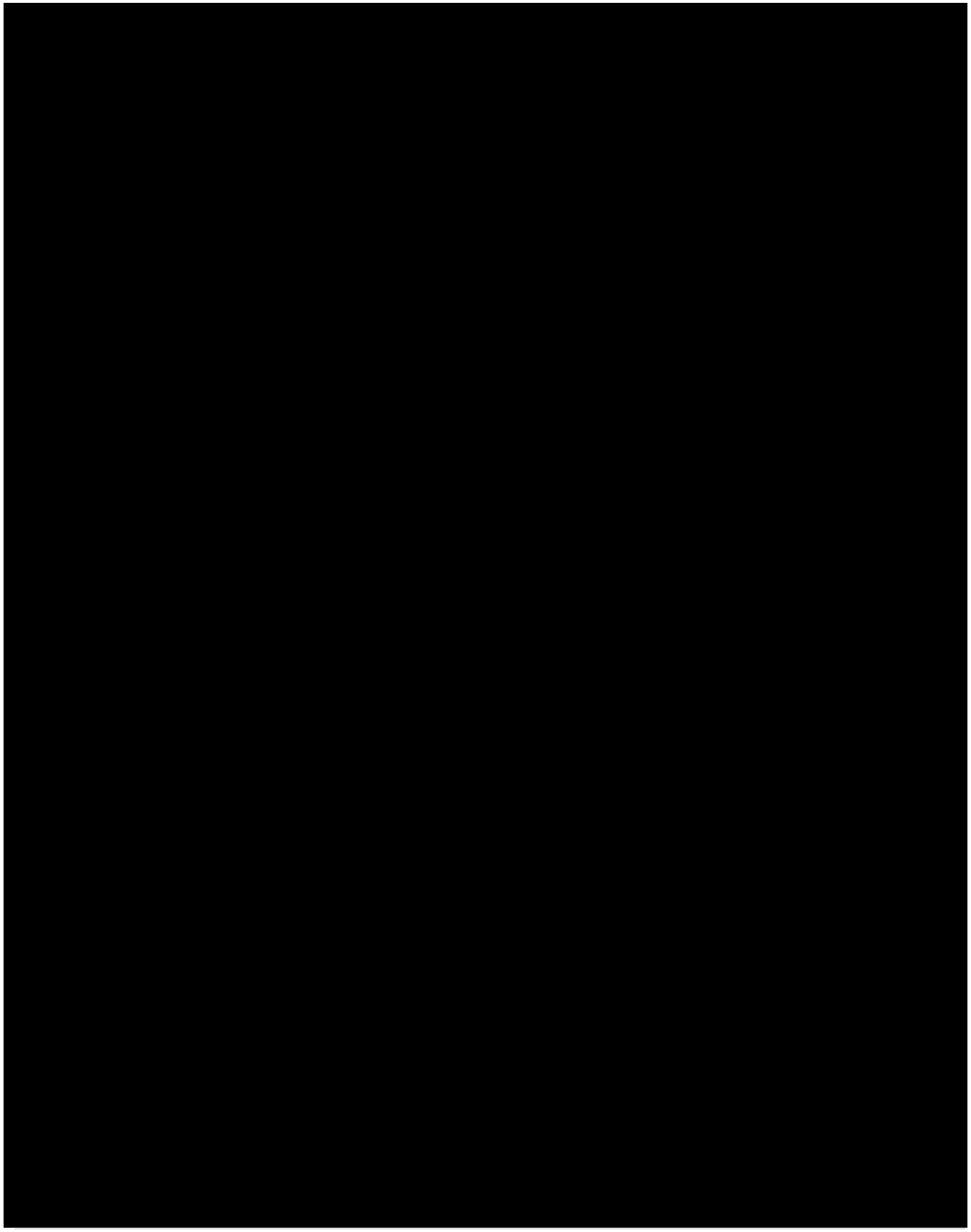


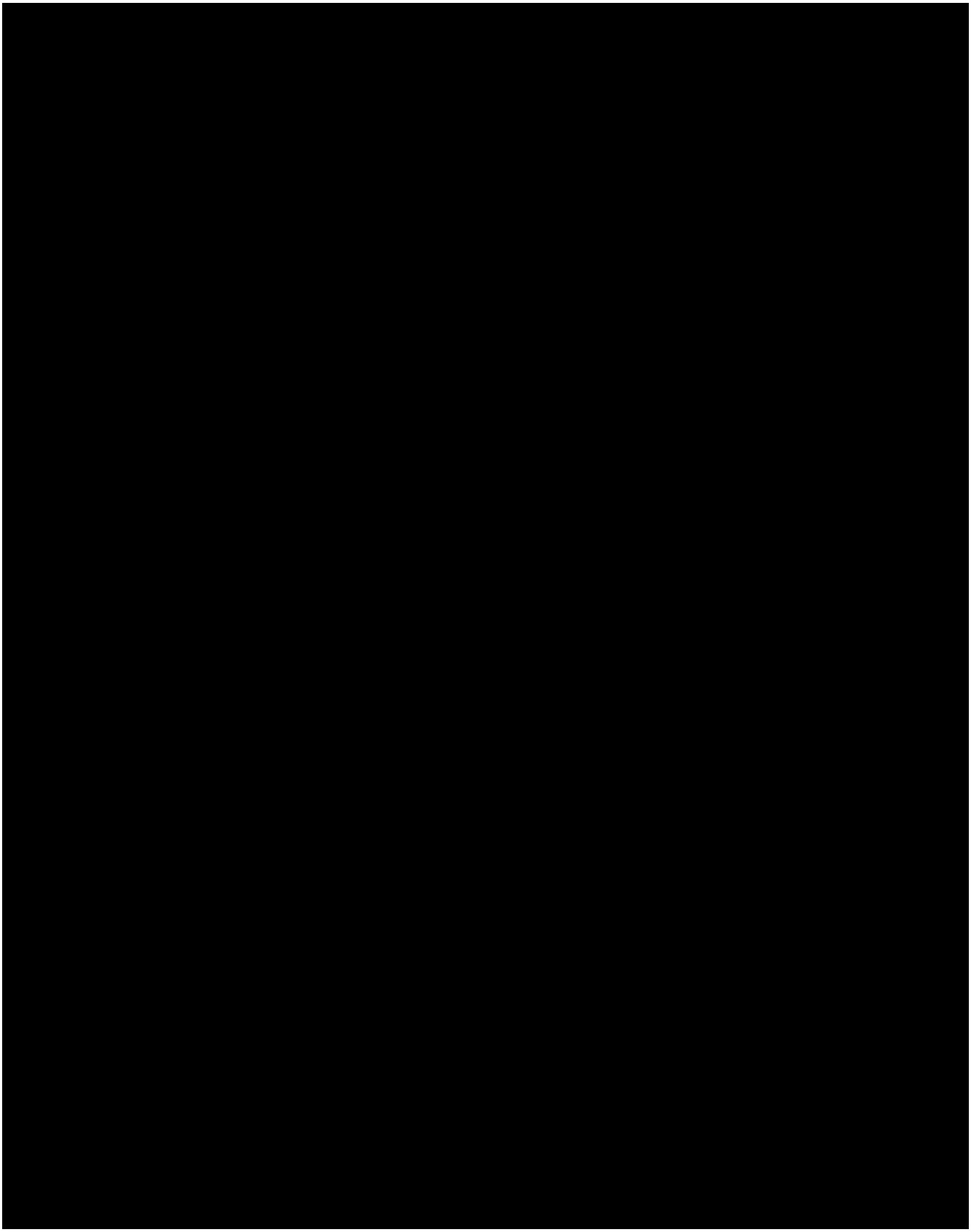












## Exhibit B: Material Subcontractor Response Template

| **Proposer (MCO) name:** |
|---|
| Community Care Health Plan of Louisiana, Inc., dba Healthy Blue |
| **Material subcontractor name:** |
| IngenioRx, Inc. (IngenioRx), with their subcontractor Outcomes, Inc. (OutcomesMTM) |
| **Description of the Proposer's role and material subcontractor's role:** |
| **Proposer's Role.** Healthy Blue's primary role is to coordinate pharmacy services with the single PBM for our enrollees (members). We are ultimately responsible for meeting all contractual requirements. We will make sure that the services IngenioRx provides regarding medical drug management meet or exceed all Louisiana Department of Health (LDH) requirements and are delivered seamlessly to our Healthy Louisiana members in a timely manner. Healthy Blue will monitor, supervise, and enforce contract compliance, as well as promote frequent, open, and effective communication that emphasizes delivery of quality services to members. We will oversee IngenioRx's performance through daily collaboration, regular monitoring, and formalized auditing processes. Healthy Blue believes that maintaining complete visibility into the volume and topics of member grievances and appeals is a critical component of subcontractor oversight. For this reason, we maintain direct responsibility for documenting, tracking, and resolution of all member grievances and appeals. We will work closely with IngenioRx to resolve individual grievances and to address underlying root causes that result in member or provider dissatisfaction.<br><br>**Material Subcontractor's Role.** IngenioRx's current role is to administer a full suite of pharmacy benefit management services, including claim adjudication; pharmacy network; account management; 24/7 member call center services; prior authorizations; rebate administration; reporting and analytics; and clinical services, including formulary design consultation, point of service edits, and clinical programs addressing behavioral health and medication management. Additionally, IngenioRx collaborates with us through meetings and requests for information, striving for excellence and continuous improvement in the delivery of pharmacy services to our members.<br><br>Under the new Contract, IngenioRx will oversee medical drug management, including medical injectable drug policy/criteria development and review of medical injectable prior authorizations, as well as continue to provide retrospective drug utilization review (RDUR) support via pharmacy clinical quality programs, including MTM through its vendor OutcomesMTM.<br><br>OutcomesMTM will perform:<br>▪ Comprehensive Medication Review<br>▪ OTC Consultation<br>▪ Patient Adherence Check-ins<br>▪ Prescriber Consultations<br>▪ Adherence Monitoring Program<br>▪ Patient Education and Monitoring |
| **Explanation of why the Proposer plans to subcontract this service and/or function:** |
| Healthy Blue uses subcontractors to drive efficiency and specialized capability for our stakeholders. We currently subcontract pharmacy services, working closely with IngenioRx to tailor programs and services that align with Healthy Blue's stringent and specific requirements to deliver high-quality services and programs to our Healthy Louisiana members. Under the new Contract, IngenioRx will continue to oversee medical drug management, including medical injectable drug policy/criteria development and review of medical injectable prior authorizations, as well as continue to provide RDUR support via pharmacy clinical quality programs, including MTM through its vendor OutcomesMTM.<br><br>IngenioRx is a subsidiary of our ultimate parent organization, Anthem, Inc. (Anthem). Therefore, IngenioRx has access to Anthem's national resources and is backed by the vast Medicaid experience and expertise of Anthem, facilitating their ability to effectively integrate medical and pharmacy benefits.<br><br>▪ IngenioRx Value Proposition. IngenioRx will add value through its experience as our current PBM, managing not just the pharmacy benefit, but medical drugs and pharmacy clinical quality programs. In addition, IngenioRx will bring its vast experience overseeing medical drug management and pharmacy clinical quality programs for our affiliate health plans. IngenioRx will leverage its experience both in Louisiana and in other markets to assist us in managing medical drugs and meeting RDUR requirements. |
| **A description of the material subcontractor's organizational experience:** |

IngenioRx's team has more than 30 years of PBM experience, encompassing more than 25 years of experience in the Medicaid space. IngenioRx's leadership team has more than 100 years of combined experience in the PBM industry. IngenioRx provides pharmacy benefits to approximately 17 million members across all lines of business and provides pharmacy benefits to more than 7 million Medicaid members in 17 markets. IngenioRx also currently oversees medical drug management services across six states that have carved out the Medicaid prescription drug benefit to the State.

**OutcomesMTM.** OutcomesMTM has been in operation for 22 years. OutcomesMTM, a Cardinal Health company, proactively entered the medication therapy management (MTM) market in January 1999. Based in West Des Moines, Iowa, OutcomesMTM boasts more than 22 years of experience in delivering consultations from a menu of innovative MTM services on behalf of a variety of healthcare market segments. OutcomesMTM currently administers more than 360 MTM programs for healthcare payers, including Medicare Part D, Medicaid, Commercial, Employers, and PBMs. OutcomesMTM clients include some of the largest health plans in the U.S. as well as many regional health plans.

**Experience in Louisiana.** OutcomesMTM has provided MTM services in Louisiana for more than 8 years — since 2013. OutcomesMTM served approximately 30,000 members in Louisiana in 2020. OutcomesMTM currently provides services across multiple lines of business (Medicaid, Medicare, and commercial plans). They have a strong network of retail pharmacies participating in Louisiana serving members for various health plans.

**Medicaid/CHIP Experience in Other States.** OutcomesMTM provides Medicaid/CHIP experience in the following states: IA, KS, KY, FL, LA, MA, MI, MN, MS, NE, OH, OK, OR, PA, VA, and WA.

**The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:**

Healthy Blue maintains an established Subcontractor Oversight Program, refined through our nine years of serving Healthy Louisiana members and enhanced by national expertise and experience. We continue to enhance this program to make sure we deliver timely, appropriate, and quality care and services. Our material subcontract with IngenioRx includes LDH requirements as specified in the Model Contract. The agreement includes detailed requirements and service levels and sets clear expectations of how we measure performance and compliance. Healthy Blue will continue to retain ultimate responsibility for adhering to and fully complying with all terms and conditions of our Contract and remain accountable for IngenioRx's performance.

We view our material subcontractors as valued partners. Our material subcontractors are an extension of Healthy Blue and the services we deliver. We maintain trusted, collaborative relationships with them to coordinate a seamless delivery of services that meet LDH requirements. Healthy Blue will continue to work closely with LDH to demonstrate that through IngenioRx, we will continue to meet Contract requirements and LDH expectations for delivering high-quality medical drug services and pharmacy clinical quality programs to our Healthy Louisiana members.

## Processes to Monitor and Evaluate Performance

We will monitor and evaluate IngenioRx's performance through daily collaboration, regular monitoring, and formal auditing processes. We will oversee, monitor, supervise, and enforce contract compliance, as well as promote frequent, open, and effective communication that emphasizes delivery of quality services to members.

Our Louisiana-based Vendor Oversight Workgroup oversees the performance of our material subcontractors, including IngenioRx. Chaired by our Plan Compliance Officer, Hassan Gardezi, our team includes members of the senior leadership, including our CEO, COO, Pharmacy Director, Medical Director, Provider Relations Director, Quality Director, and other participants as necessary. The team meets monthly and reports to the Compliance Committee at its monthly meetings.

Healthy Blue's Pharmacy Director plays an integral role in oversight of our drug-utilization, medication therapy management, lock-in programs, and medical injectable drug management, as well as oversight of IngenioRx. The Pharmacy Director oversees all pharmacy-related activities and participates in key Healthy Blue committees and meetings, including the Louisiana Quality Management Committee, the Medical Advisory Committee, Plan Compliance meetings, and the twice-yearly Business Operating Review.

Our Vendor Oversight Workgroup works closely with our national Pharmacy Compliance team to verify that the services IngenioRx provides are of the highest quality and performed in a seamless, cost-effective manner.

IngenioRx will also provide services to our affiliates. The resultant oversight and monitoring at both the local and national levels offers a number of key benefits, including:

- Accountability to state-specific requirements
- Consistency in management, expectations, and remediation or corrective actions, as well as a high-level review of performance across all states to better identify trends
- Identification of best practices and innovations in one state to be shared with others
- Proactive identification and mitigation of performance variance in a single state, often avoiding impact on other markets

Healthy Blue operates under a culture of continuous quality improvement. Our Subcontractor Oversight Program is successful because we continually refine and enhance our processes and methods of monitoring and evaluating subcontractor performance.

We tailor our Subcontractor Oversight Program, including the scope and frequency of oversight activities, to the functions and services each material subcontractor provides. We outline the frequency and type of ongoing oversight activities we will perform to monitor IngenioRx in Table Exhibit B-1.

*Table Exhibit B-1. Our Oversight Program Includes Activities at Multiple Frequencies*

| Frequency | Scope of Oversight Activities |
|---|---|
| **Daily** | • Work with IngenioRx to answer questions, collaborate on problem solving, discuss opportunities for improvement, and escalate urgent performance concerns<br>• Provide rapid response to complaints and member issues |
| **Monthly** | • Review IngenioRx regulatory report submissions<br>• Review performance against standards and metrics, including data trends, and report submissions<br>• Review performance with IngenioRx, Pharmacy Compliance, and the Vendor Oversight Workgroup |
| **Quarterly** | • As part of the Medicaid Compliance Committee meeting, review IngenioRx performance across markets, including issues, gaps, and concerns<br>• The National Quality Improvement Committee reports any subcontractor quality or compliance-related issues to health plan leadership |
| **Annually** | • Review outcomes of quality programs such as medication adherence, polypharmacy, and controlled substances<br>• Perform audit to confirm that IngenioRx meets operational, systems, legal, compliance, regulatory, and ethical requirements<br>• Present audit findings to the Vendor Oversight Workgroup<br>• Submit annual audit findings to LDH, including any CAPs |

Each month, we collect and review IngenioRx performance against a defined set of metrics that represent LDH and Healthy Blue requirements. Healthy Blue will review IngenioRx performance against a comprehensive set of performance data that includes all applicable standards and metrics.

Pharmacy Compliance and the Vendor Oversight Workgroup will carefully review performance against standards, such as medical drug prior authorizations. In addition, the review will focus on positive and negative data trends and identify opportunities for improvement.

While we review all performance metrics, we pay careful attention to member grievances and appeals, looking at topics, volumes, and trends (positive and negative). We will work with IngenioRx to resolve individual grievances, as well as identify opportunities for more widespread improvements that would improve member satisfaction.

A monthly IngenioRx Medicaid Health Plan Compliance meeting will provide a forum to review performance against metrics and other important IngenioRx updates. Meetings will include Pharmacy Compliance, IngenioRx business owners (identified based on the meeting agenda), and Healthy Blue staff.

Pharmacy Compliance will also attend a number of key IngenioRx committee meetings, providing an additional level of oversight. As a member of these committees, Pharmacy Compliance will review metrics and quality reports and monitor risks. Specific IngenioRx committees with Pharmacy Compliance participation include the Quality Management Committee, Internal Oversight Committee, and Vendor Oversight Committee. The Internal Oversight Committee identifies, tracks, and trends performance measures and implements actions plans to improve performance. The Vendor Oversight Committee monitors and evaluates the performance of IngenioRx's subcontractors, including OutcomesMTM.

## Improving Subcontractor Performance and Results

Healthy Blue always strives to improve the level of service we deliver, and we expect our material subcontractors to do the same. During subcontractor oversight and monitoring, we not only review areas with substandard performance, but will seek out opportunities to "raise the bar" and deliver better service.

Clearly defined expectations and consistent performance monitoring is a key piece of our Subcontractor Oversight Program, and written agreements detail performance standards and the actions we take to address inadequate or substandard performance. If at any time performance does not meet our expectations, we will take action and work closely with IngenioRx toward a resolution and return to complete and ongoing compliance.

Our subcontractor agreements outline specific service level agreements (SLAs) for each function we delegate that align with LDH requirements. If LDH modifies a standard, as they have done with some performance measures in the Model Contract, we will amend the subcontractor agreement to reflect the change.

If Healthy Blue identifies a performance or operational problem with IngenioRx, we will immediately address our concerns by applying a series of escalating interventions, including increased meeting frequency and data submission, development of an informal action plan, and development of a CAP.

Healthy Blue views interventions not as a punitive action, but rather a documented process to improve performance. The type of intervention depends on a combination of factors, including the severity of the issue and historical performance. For example, a single month of missing an SLA will likely result in increased monitoring and an action plan, while missing an SLA in two consecutive months warrants a CAP. We track and monitor all interventions.

## Subcontractor Report Submission and Data Exchanges

Healthy Blue requires that IngenioRx submit two primary types of reports: data we need to fulfill ad hoc and regulatory reporting requirements, and operational information to monitor performance against standards. Pharmacy Compliance maintains a schedule of due dates for both types of reports and will reach out if they are late or contain incomplete or inaccurate data. IngenioRx will submit reports based on an internal due date (ahead of the LDH deadline) to provide time for a thorough quality review.

In addition, we maintain a schedule for files we send IngenioRx, including member enrollment data (834 file), and require that they update their database promptly.

## Annual Audit Confirms Compliance

An annual audit has been a key part of our Subcontractor Oversight Program since we began operations in Louisiana. We will use the annual audit to confirm that IngenioRx continues to meet operational, legal, compliance, regulatory, and ethical requirements.

The audit team maintains a schedule for the annual audit of material subcontractor and a comprehensive set of audit tools for each type of function that may be delegated (such as network management, credentialing, claims processing, and call center). The audit tool addresses areas such as HIPAA privacy and security; fraud, waste, and abuse; cultural competency; disclosure of ownership; and record retention. Each audit tool lists a series of audit elements applicable to the function and the evidence required to assess compliance. During the audit, the audit team reviews each element, decides whether the subcontractor is compliant or non-compliant, and documents the evidence. The audit process includes review of documents such as policies and procedures, financial statements, member complaints, employee and provider training documents, and provider contract templates. For subcontractors with provider credentialing, authorization, and claims processing responsibilities, the audit team randomly selects sample files for audit.

If the review identifies any deficiencies or areas of improvement, we work with the material subcontractor to develop a CAP that documents all of the corrective actions and steps needed to resolve the identified deficiencies, the name and title of responsible parties, and planned completion dates of each action step. Healthy Blue will submit the results of the annual review and any CAPs associated with the review to LDH.

## Material Subcontractor Return on Investment

We use material subcontractors that have specialized capabilities that Healthy Blue does not have internally, including pharmacy, dental, vision, and transportation. We continuously monitor our internal capabilities in order to determine whether we could bring specific capabilities “in-house” and deliver a similar or higher service capability and a more competitive cost structure.

Across all of our material subcontractors, Healthy Blue uses a number of processes to confirm that the material subcontractor continues to deliver the high-quality services that we expect. Processes cover a number of dimensions, including quality, compliance with performance standards, financial solvency, and strength of the partnership, and include the following:

- Monthly oversight meetings
- Monthly, quarterly, and annual report submission and monitoring
- Quarterly Joint Operations Committee meetings
- Quarterly and annual financial solvency reviews
- Quarterly review of utilization against cost
- Annual audits

If Healthy Blue determines that the material subcontractor relationship is not delivering the value we expect — to our members, LDH, and the Healthy Louisiana program — we will investigate alternatives.

Instructions: The Proposer should attach the executed or draft contract and indicate compliance witheach of the following checklist items by completing the "Location" column.

| | Checklist Item | Location (Include Name of Document, Page Number, and Section Number/Letter) |
|---|---|---|
| 1 | Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between LDH and the MCO and the MCO Manual, and either physically incorporate these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request. | Amendment 37, Exhibit II-H Page 5 Paragraph 2.14 |
| 2 | Include a signature page that contains an MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for executed contracts). | PBM MOU Page 8. Amendment 37, Page 2. Amendment 39, Page 4. Amendment 44, Page 5. Amendment 45, Page 2. Amendment 53, Page 6 |
| 3 | Specify the effective dates of the subcontract agreement. | PBM MOU Page 1 Introduction |
| 4 | Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties. | Amendment 37, Exhibit II-H Page 18 Paragraph 6.31 |
| 5 | Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties. | Amendment 37, Exhibit II-H Page 5 Paragraph 2.15 |
| 6 | Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract. | Amendment 37, Exhibit II-H Page 7 Paragraph 2.36 |
| 7 | Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and LDH for any of the reasons described in the contract, the MCO shall immediately make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to LDH. | Amendment 37, Exhibit II-H Page 5 Paragraph 2.16 |

| | | |
|---|---|---|
| 8 | Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO. | Amendment 37, Exhibit II-H Page 6 Paragraph 2.17 |
| 9 | Require that if any requirement in the subcontract is determined by LDH to conflict with the contract between LDH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect. | Amendment 37, Exhibit II-H Page 6 Paragraph 2.18 |
| 10 | Identify the population covered by the subcontract. | Amendment 37, Exhibit II-H Page 3, Introduction |
| 11 | Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to enrollees through the last day that the subcontract is in effect. | Amendment 37, Exhibit II-H Page6 Paragraph 2.19 |
| 12 | Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO. | PBM MOU, Page 6, Paragraph 5 |
| 13 | Specify the amount, duration, and scope of benefits and services that are provided by the subcontractor. | PBM MOU Pages 1-6 Paragraphs 1 and 3 |
| 14 | Provide that emergency services be coordinated without the requirement of prior authorization of any kind. | Amendment 37, Exhibit II-H Page 22 Paragraph 15 |
| 15 | Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 C.F.R. § 493.1 and 493.3, and any other federal requirements. | N/A |
| 16 | Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO enrollees pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between LDH and the MCO). MCO enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended and subject to reasonable charges. | Amendment 37, Exhibit II-H Page 9 Paragraph 3.5 |

| | | |
|---|---|---|
| 17 | Include record retention requirements as specified in the contract between LDH and the MCO. | Amendment 37, Exhibit II-H Page 9 Paragraph 3.6 and Page 67 Paragraph 25.40 |
| 18 | Shall make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested. | Amendment 37, Exhibit II-H Page 35 Paragraph 35.4 |
| 19 | INTENTIONALLY LEFT BLANK | |
| 20 | Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or LDH or its designee. | Amendment 37, Exhibit II-H Page 10 Paragraph 3.10 |
| 21 | Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by LDH or its designee. | Amendment 37, Exhibit II-H Page 10 Paragraph 3.11 |
| 22 | Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by LDH. | Amendment 37, Exhibit II-H Page 6 Paragraph 2.21 |
| 23 | Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontract and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by LDH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate. | Amendment 37, Exhibit II-H Page 19 Paragraph 6.33 |

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| 24 | Provide for submission of all reports and clinical information to the MCO for reporting purposes required by LDH. | Amendment 37, Exhibit II-H Page 10 Paragraph 3.12 |
| 25 | Require safeguarding of information about MCO enrollees according to applicable state and federal laws and regulations and as described in contract between LDH and the MCO. | Amendment 37, Exhibit II-H Page 68 Paragraph 25.45 |
| 26 | Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO. | PBM MOU Page 6 Paragraph 2 |
| 27 | Provide that the subcontractor comply with LDH's claims processing requirements as outlined in the RFP. | Amendment 37, Exhibit II-H Page 43 Paragraph 44 |
| 28 | Provide that the subcontractor adhere to LDH's timely filing guidelines as outlined in the RFP. | Amendment 37, Exhibit II-H Page 45 Paragraph 44.6 |
| 29 | Provide that, if LDH or its subcontractors discover an error or a conflict with a previously adjudicated encounter claim, the subcontractor shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or the MCO, or if circumstances exist that prevent the subcontractor from meeting this time frame, by a specified date approved by LDH. | Amendment 37, Exhibit II-H Page 50 Paragraph 51.4 |
| 30 | Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served. | Amendment 37, Exhibit II-H Page 6 Paragraph 2.22 |
| 31 | Specify that at all times during the term of the subcontract, thesubcontractor shall indemnify and hold LDH harmless from all claims, losses,or suits relating to activities undertaken pursuant to the contract between LDH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between LDH and the MCO in its entirety in the subcontractor's agreement or by useof other language developed by the MCO and approved by LDH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by LDH. | Amendment 37, Exhibit II-H Page 63 Paragraph 25.23 |
| 32 | Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's enrollees and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage. | Amendment 37, Exhibit II-H Page 6 Paragraph 2.24 |

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| 33 | Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services, and stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where the material subcontractor is based and Louisiana law. | Amendment 37, Exhibit II-H Page6 Paragraphs 2.25 and 2.26 |
| 34 | Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective. | Amendment 37, Exhibit II-H Page6 Paragraph 2.26 |
| 35 | Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member. | Amendment 37, Exhibit II-H Page 6 Paragraph 2.27 |
| 36 | Include a conflict of interest clause as stated in the contract between LDH and the MCO. | Amendment 37, Exhibit II-H Page 58 Paragraph 25.6 And Page 70 Paragraph 25.60 |
| 37 | Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between LDH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor. | Amendment 37, Exhibit II-H Page 7 Paragraph 2.29 |
| 38 | Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO. | Amendment 37, Exhibit II-H Page 7 Paragraph 2.30 |
| 39 | Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract. | Amendment 37, Exhibit II-H Page 56 Paragraph 25.2 Third Bullet |
| 40 | Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity. | Amendment 37, Exhibit II-H Page 7 Paragraph 2.34 |
| 41 | Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO. | Amendment 37, Exhibit II-H Page 24 Paragraph 20.2 |

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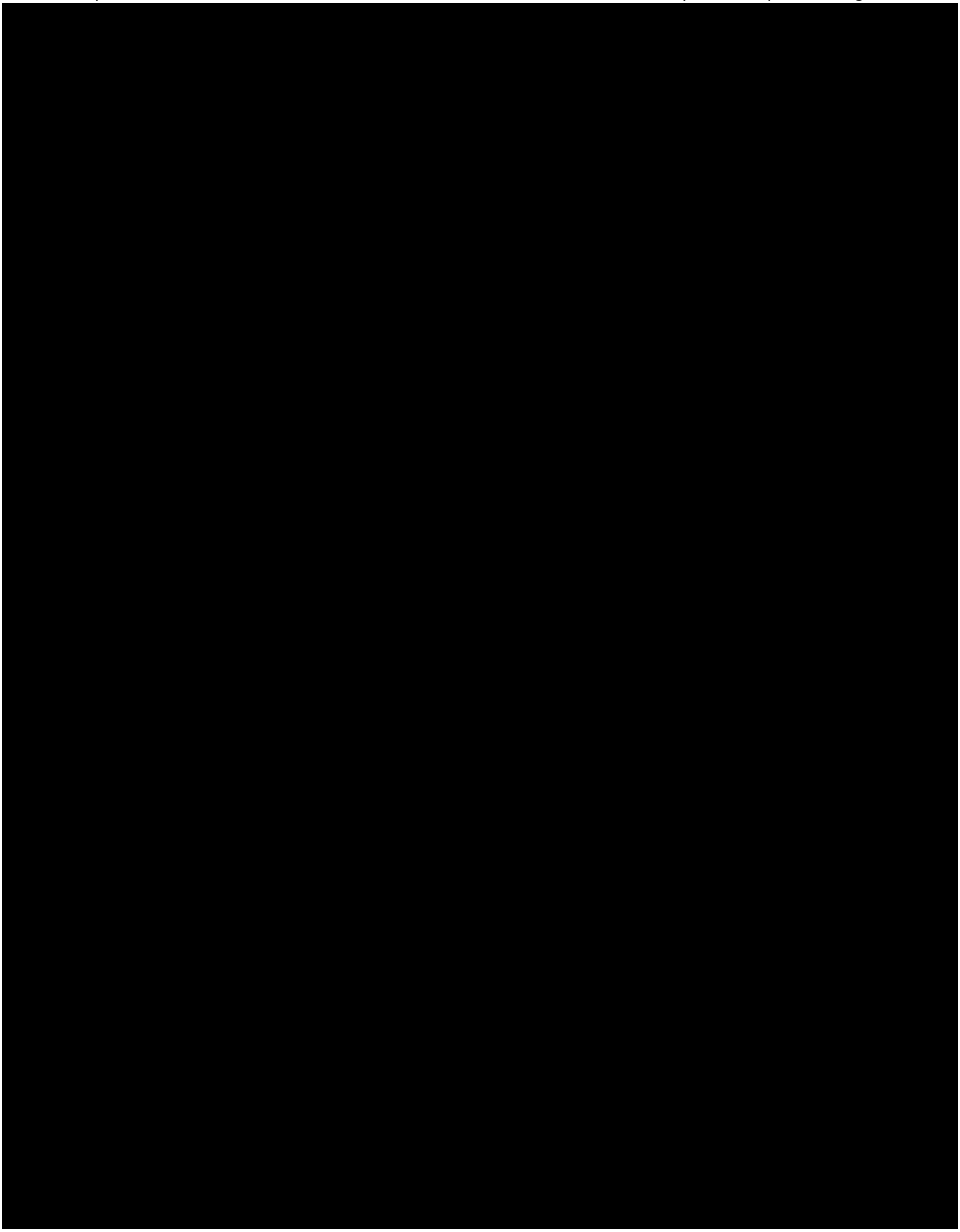
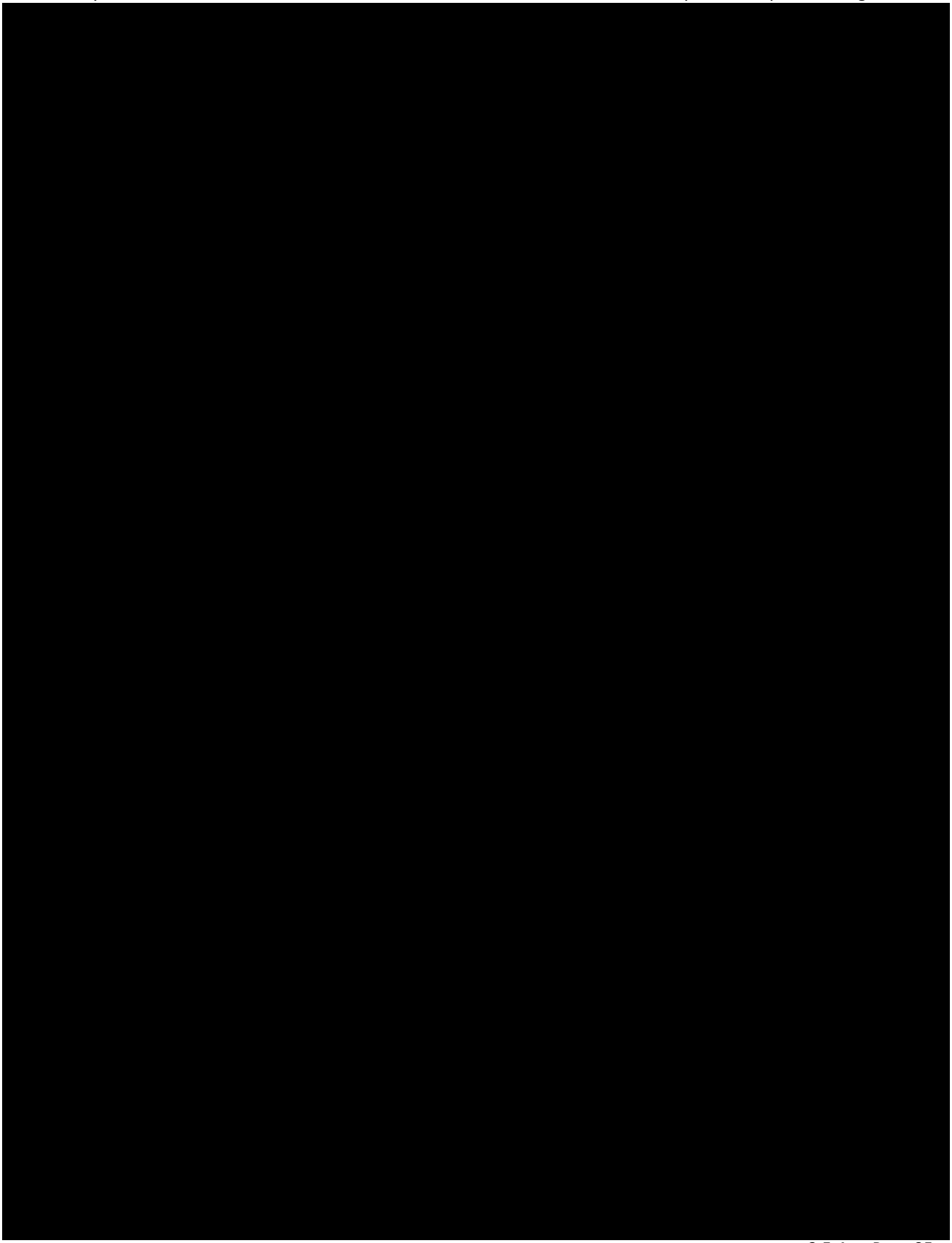
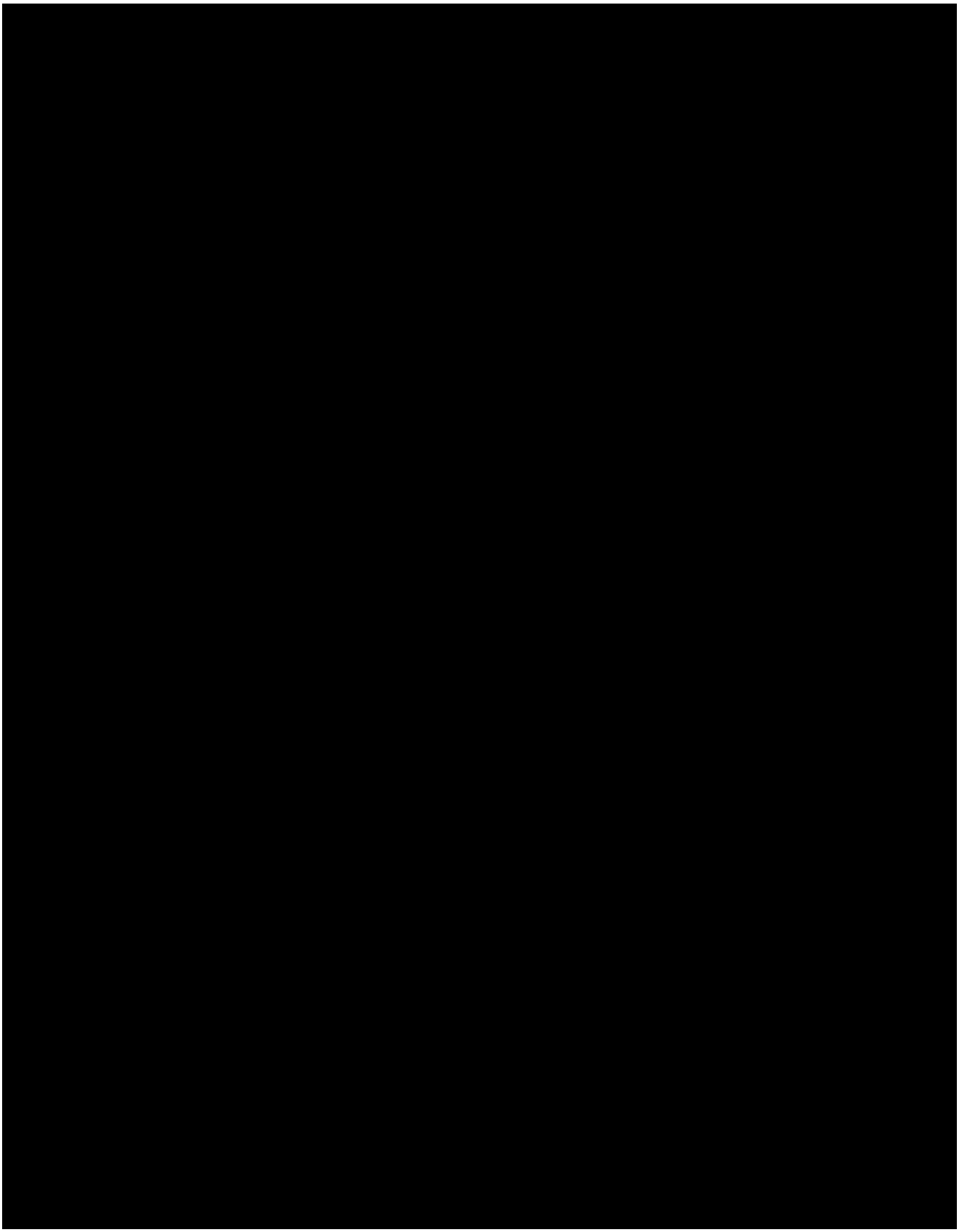
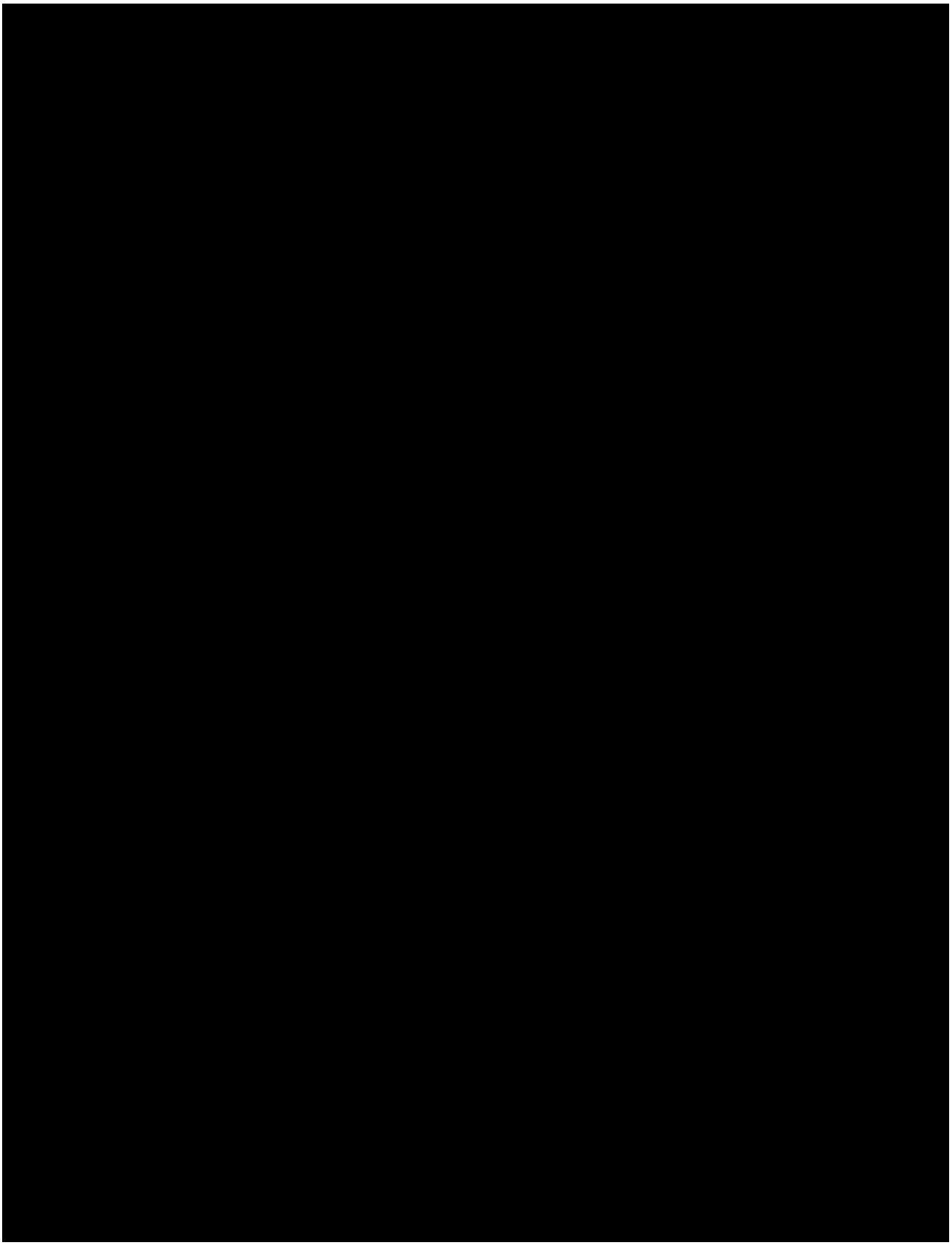
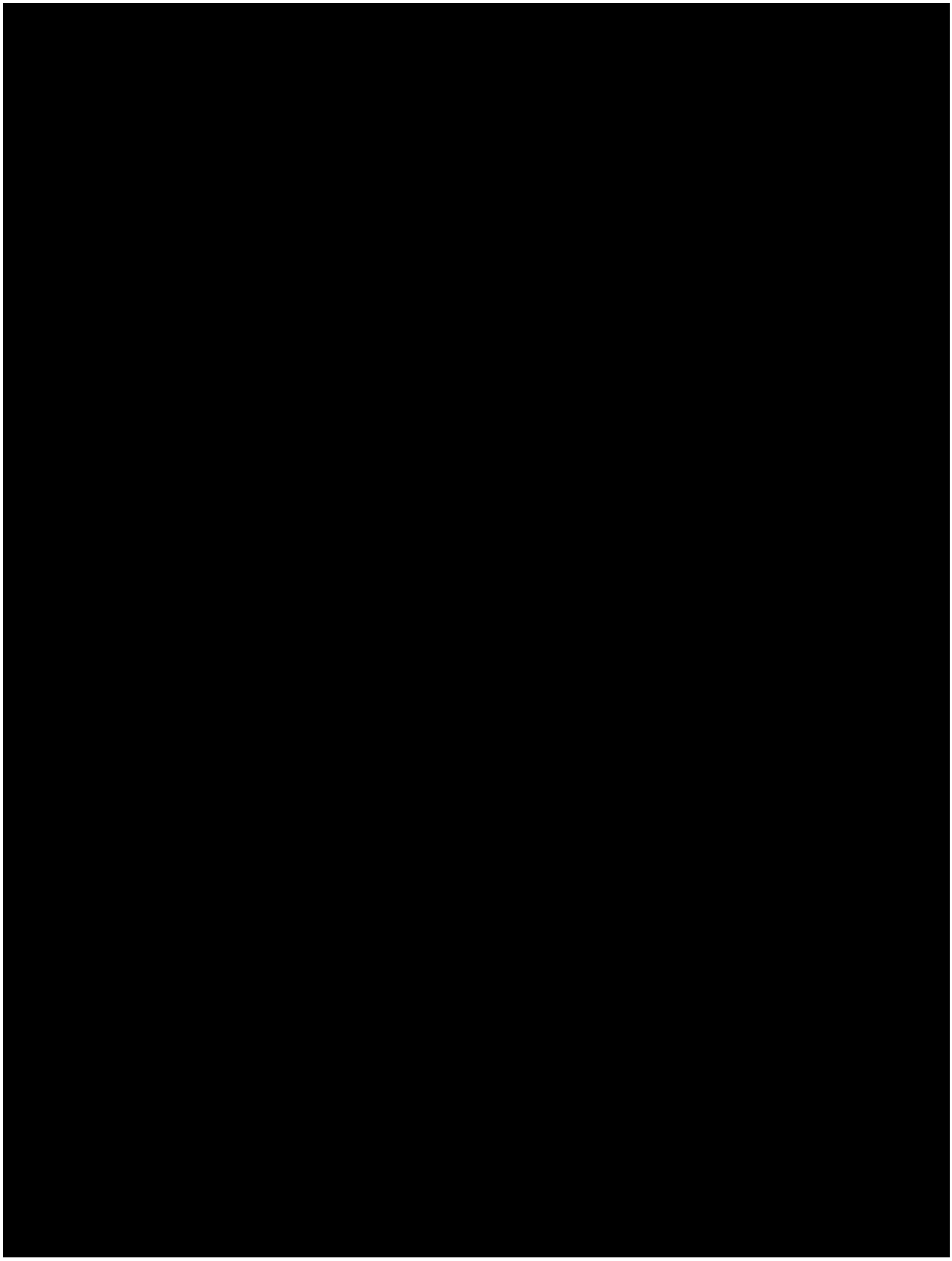
| 42 | Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement. | Amendment 37, Exhibit II-H Page 13<br>Paragraph 5.1 |
| 43 | Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or paymentmechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries. | Amendment 37, Exhibit II-H Page 7<br>Paragraph 2.37 |
| 44 | Contain the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirementshall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. TheMCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request. | Amendment 37, Exhibit II-H Page 9<br>Paragraph 3.9 |

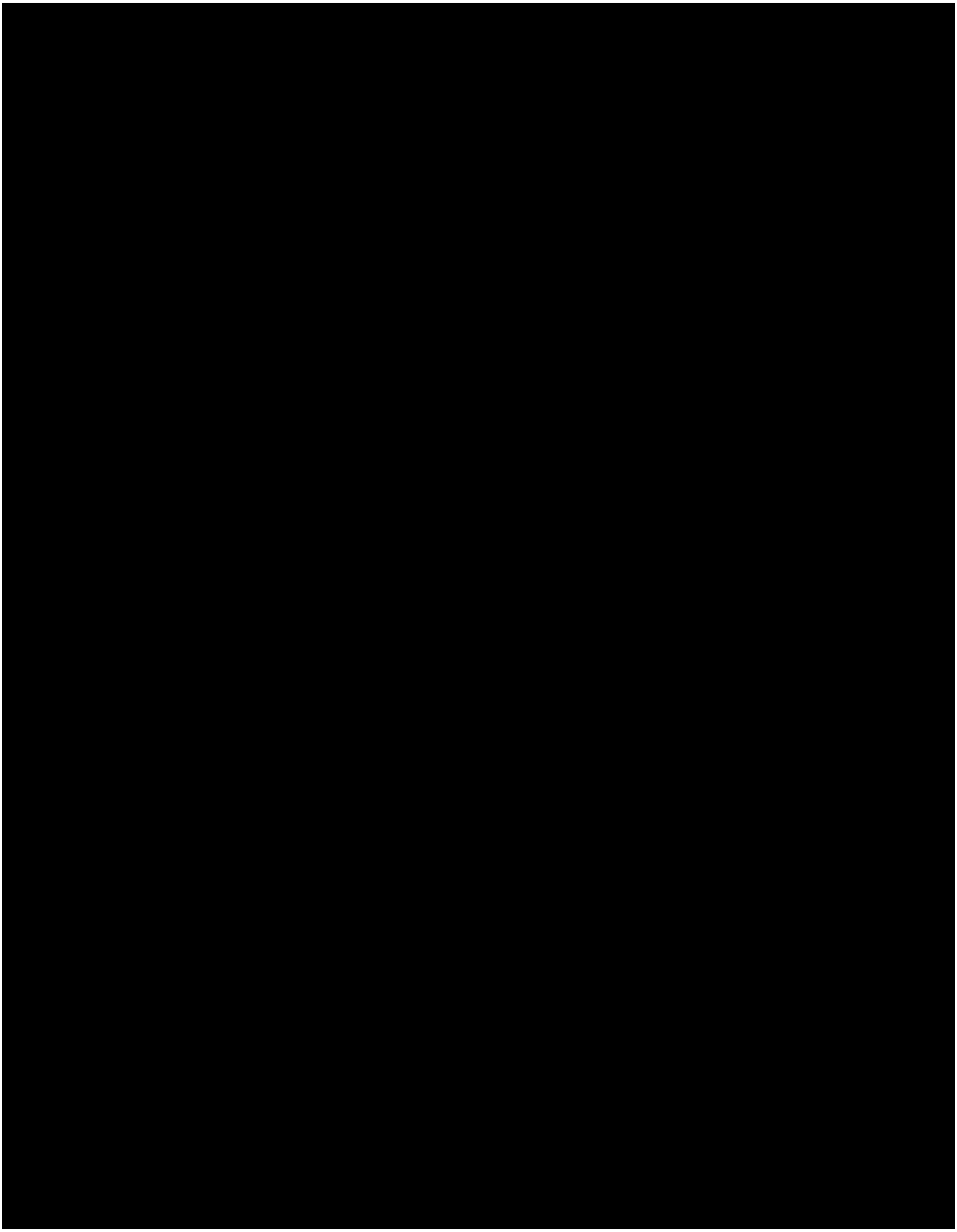


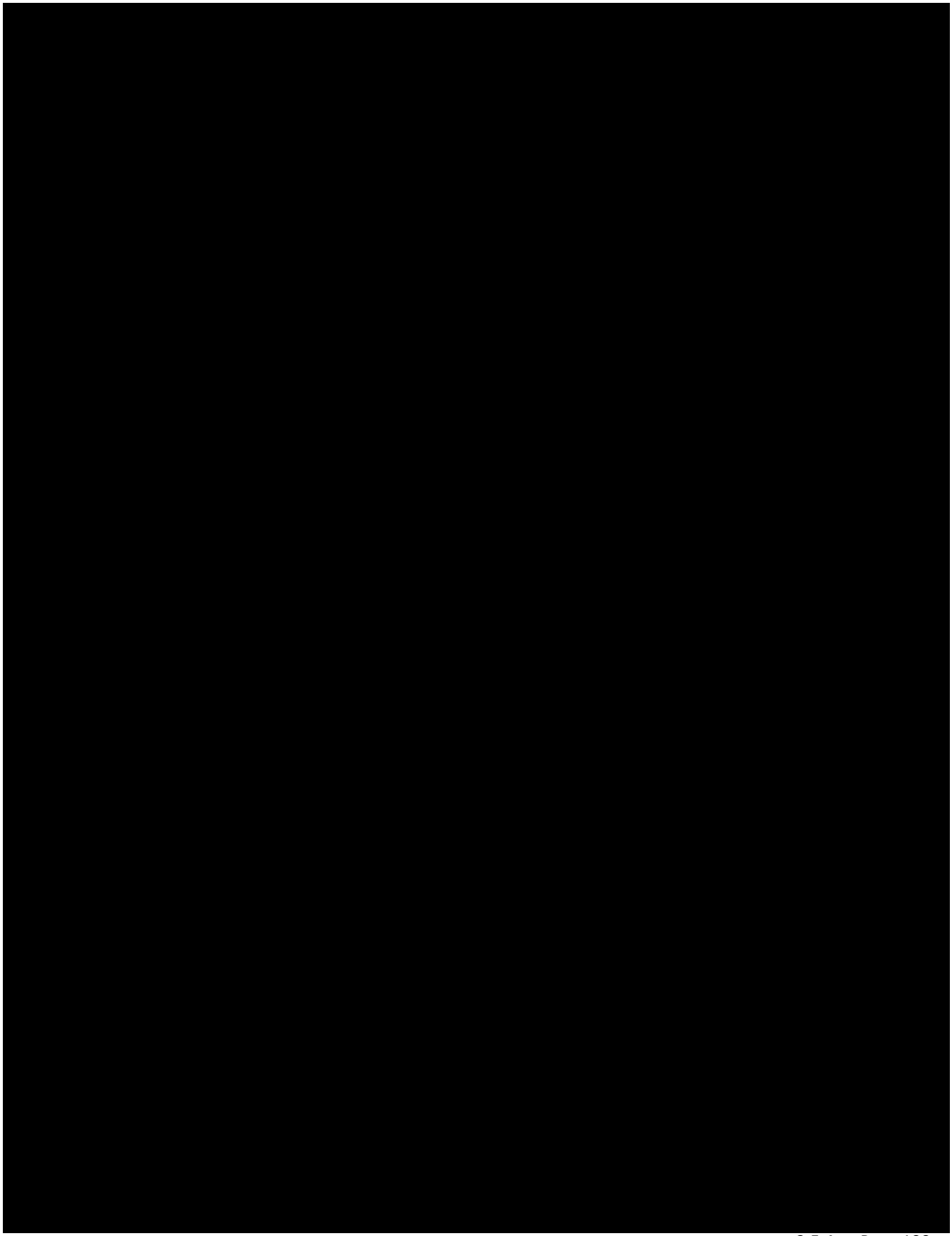


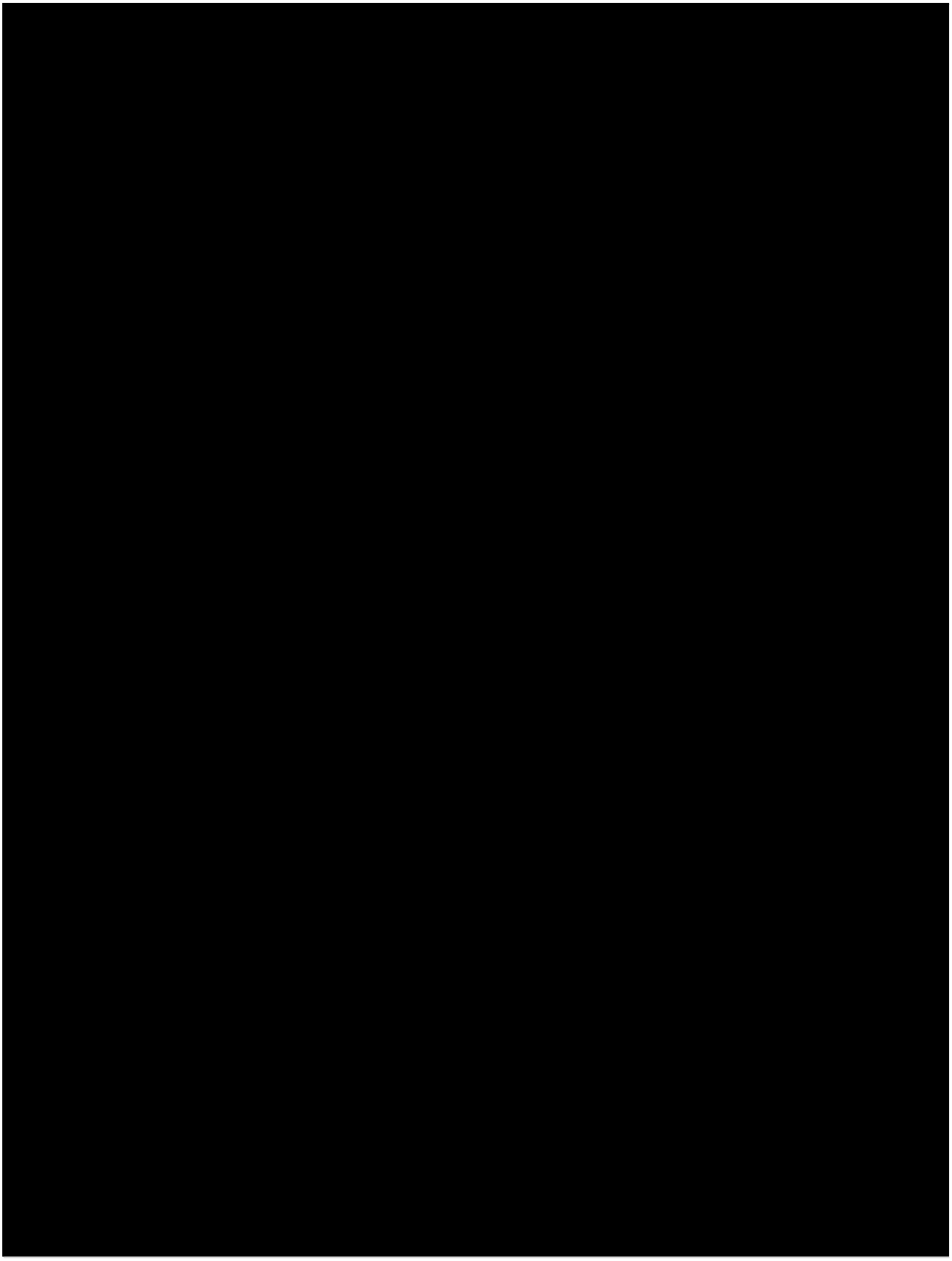


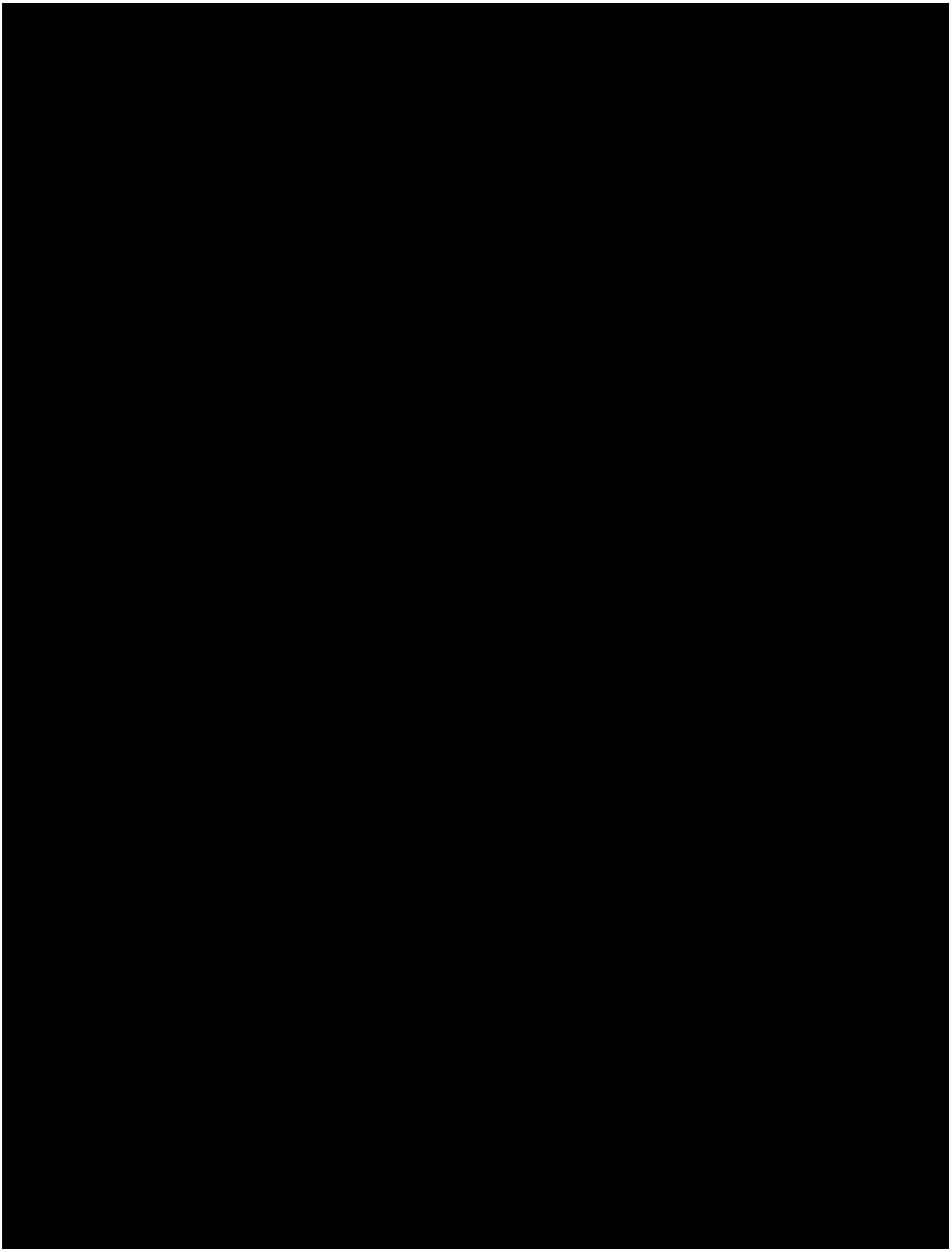


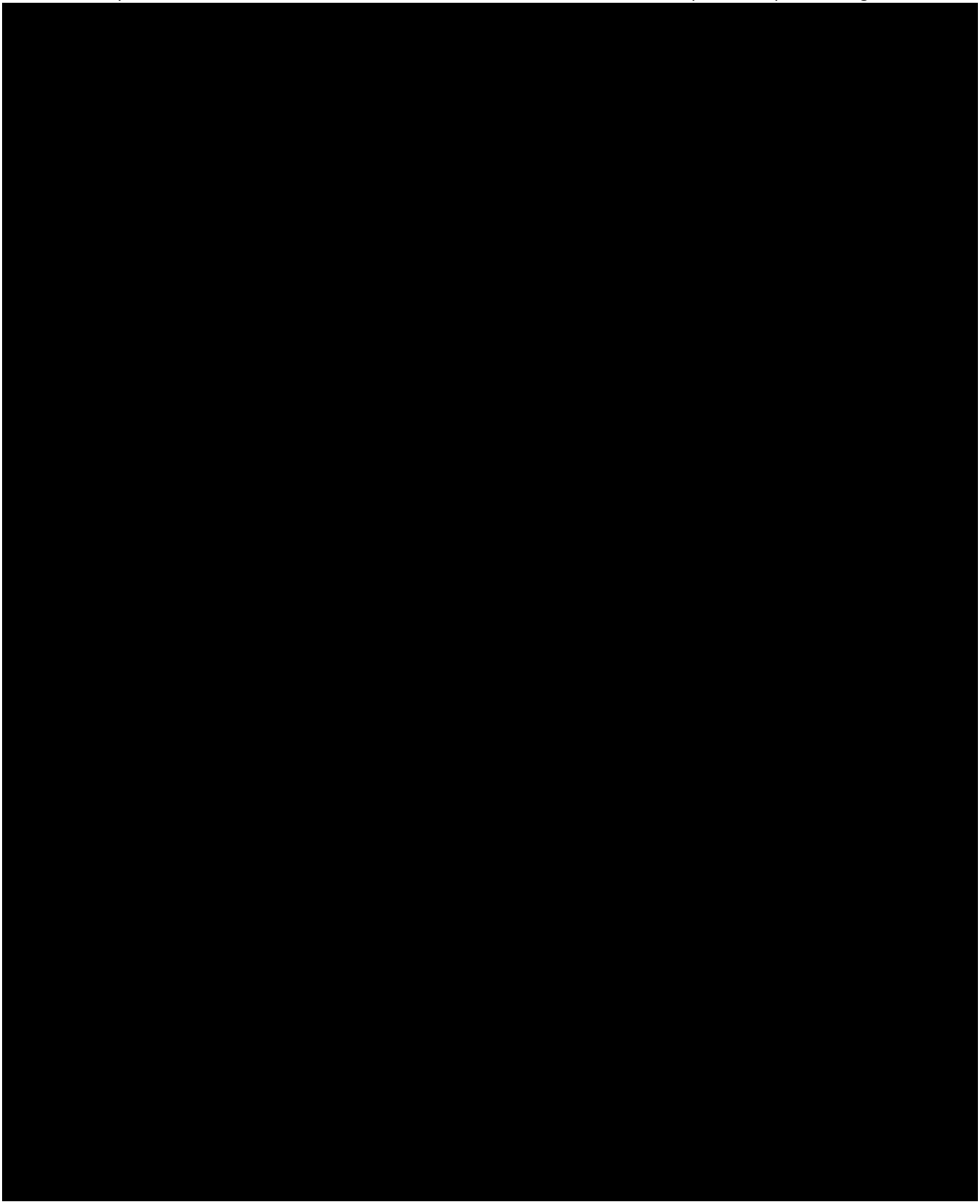


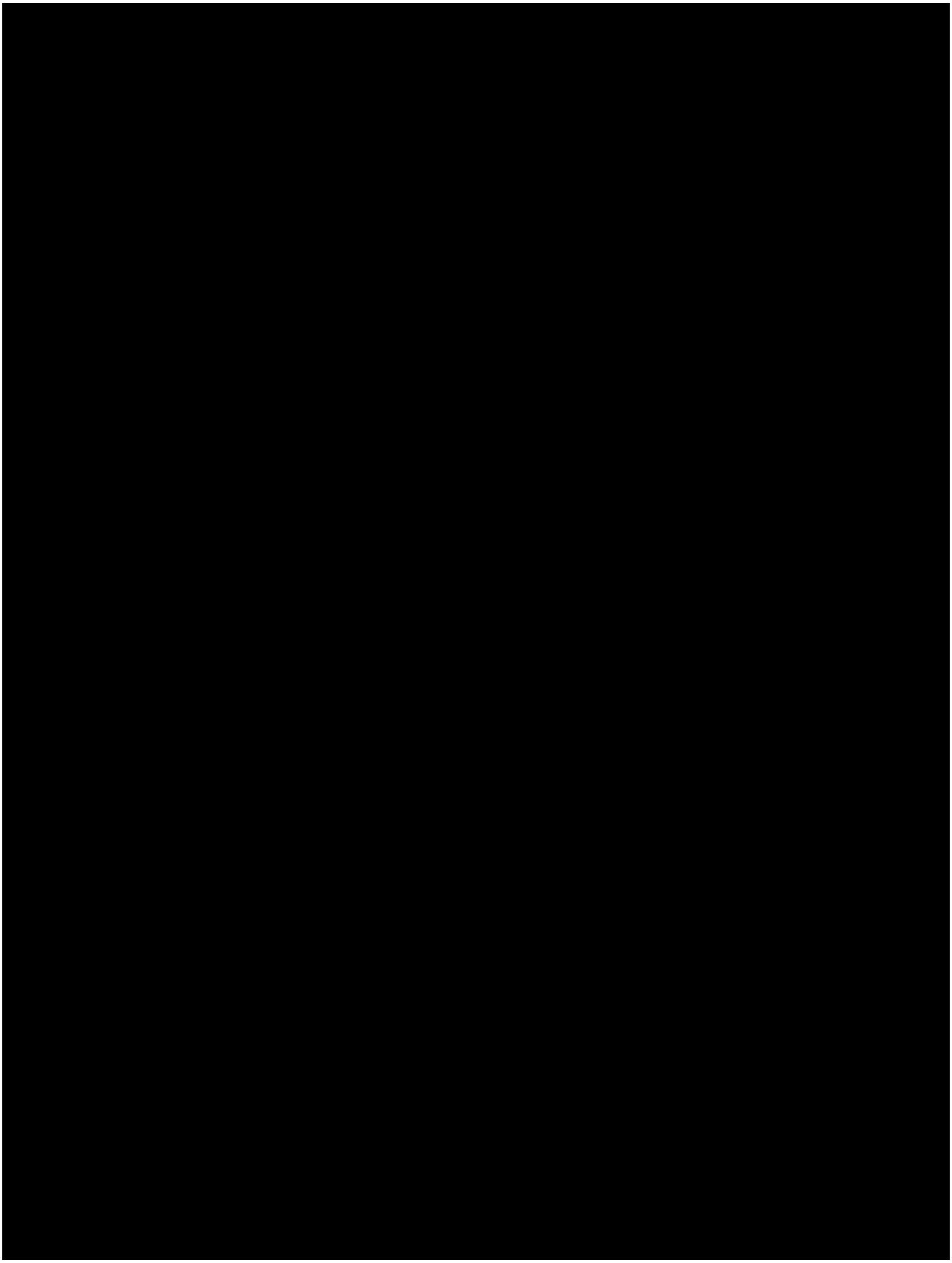


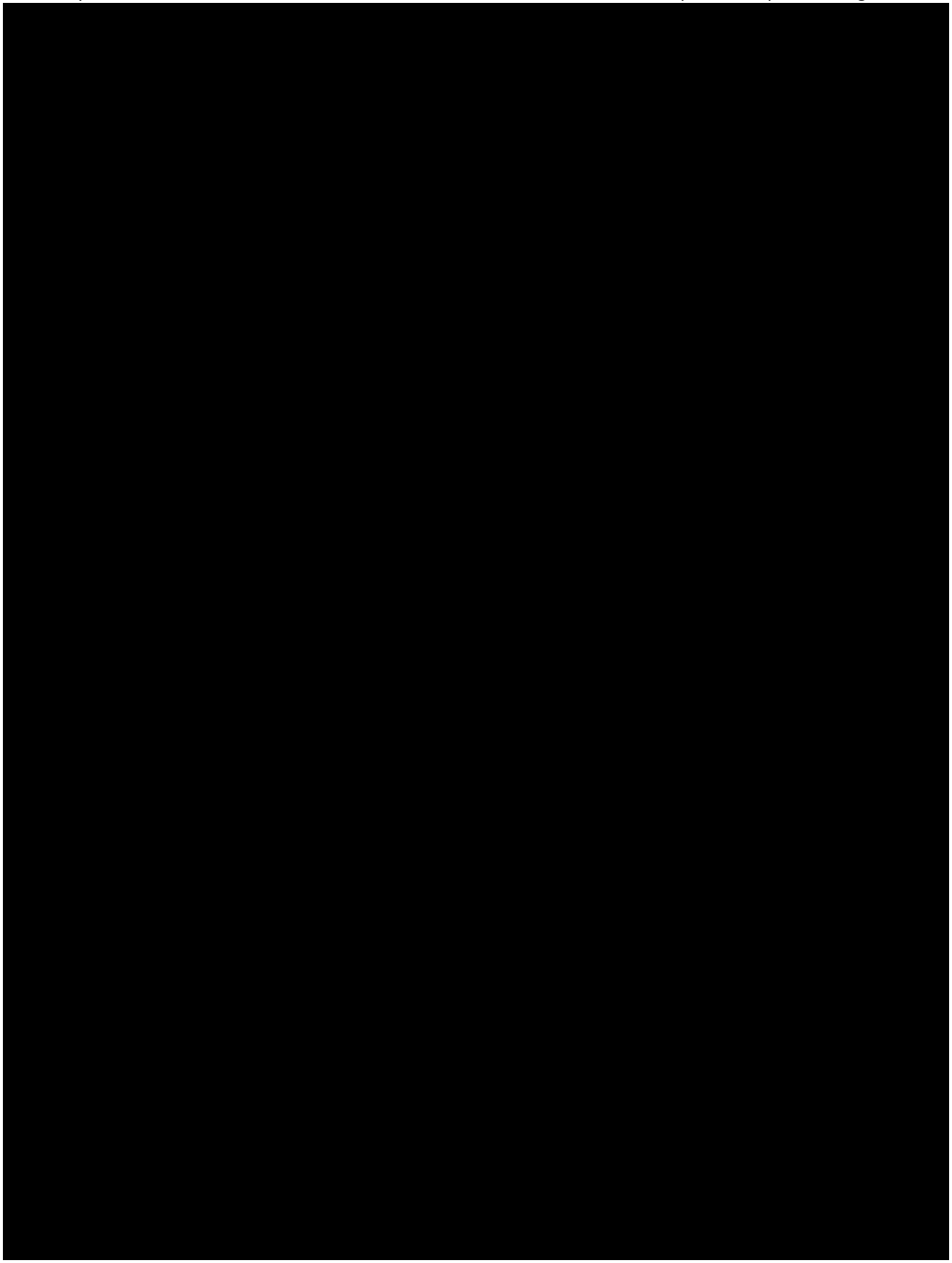


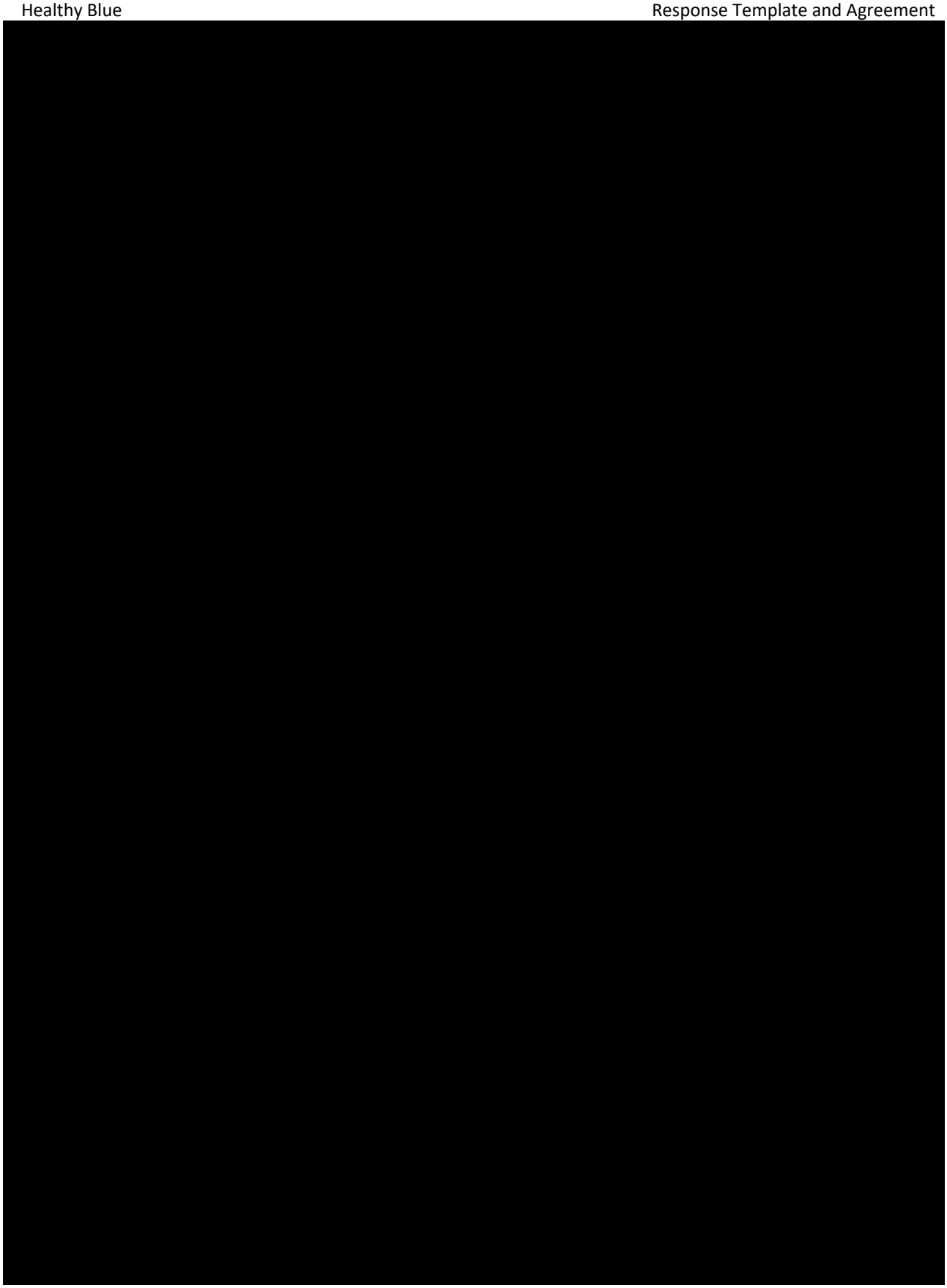


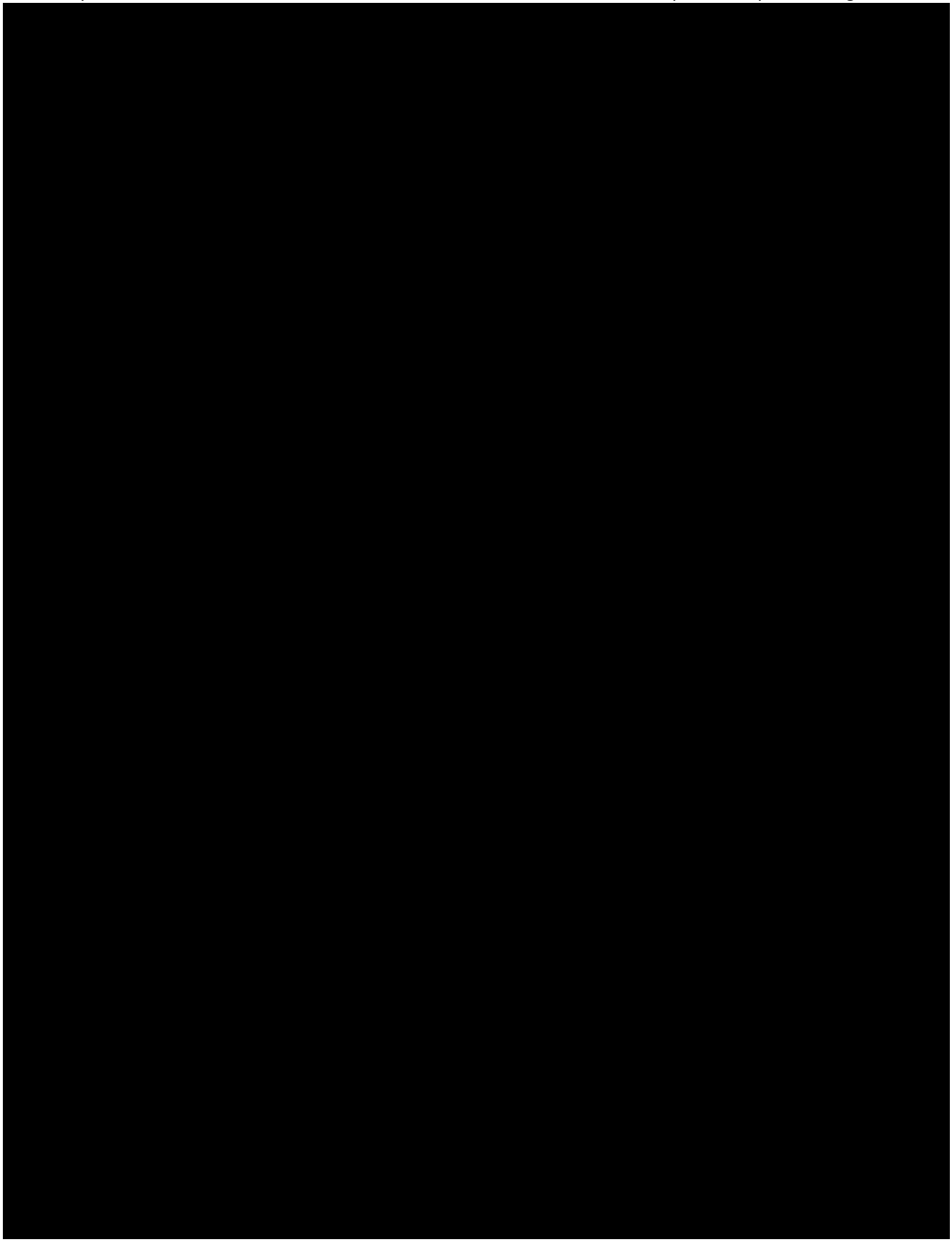


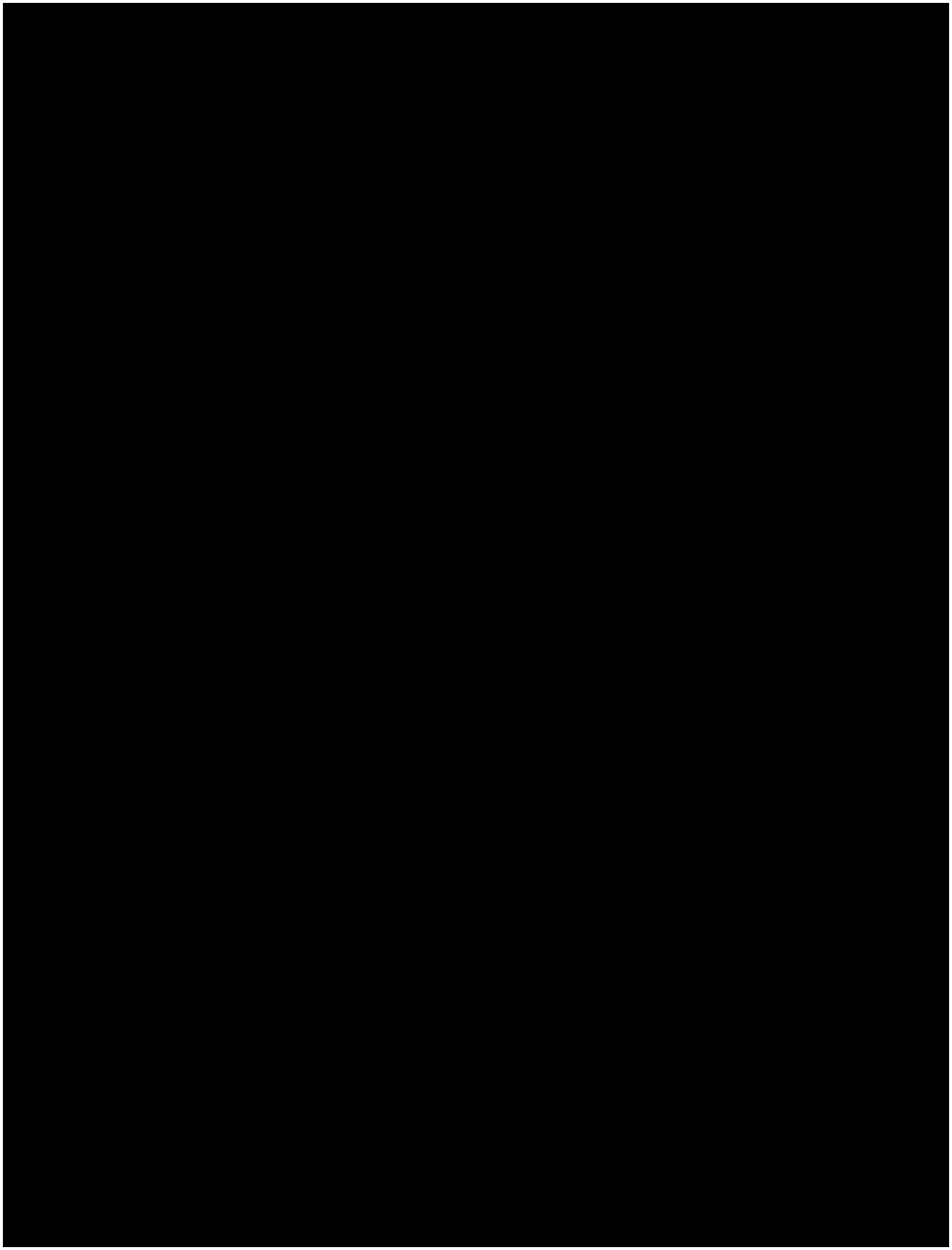


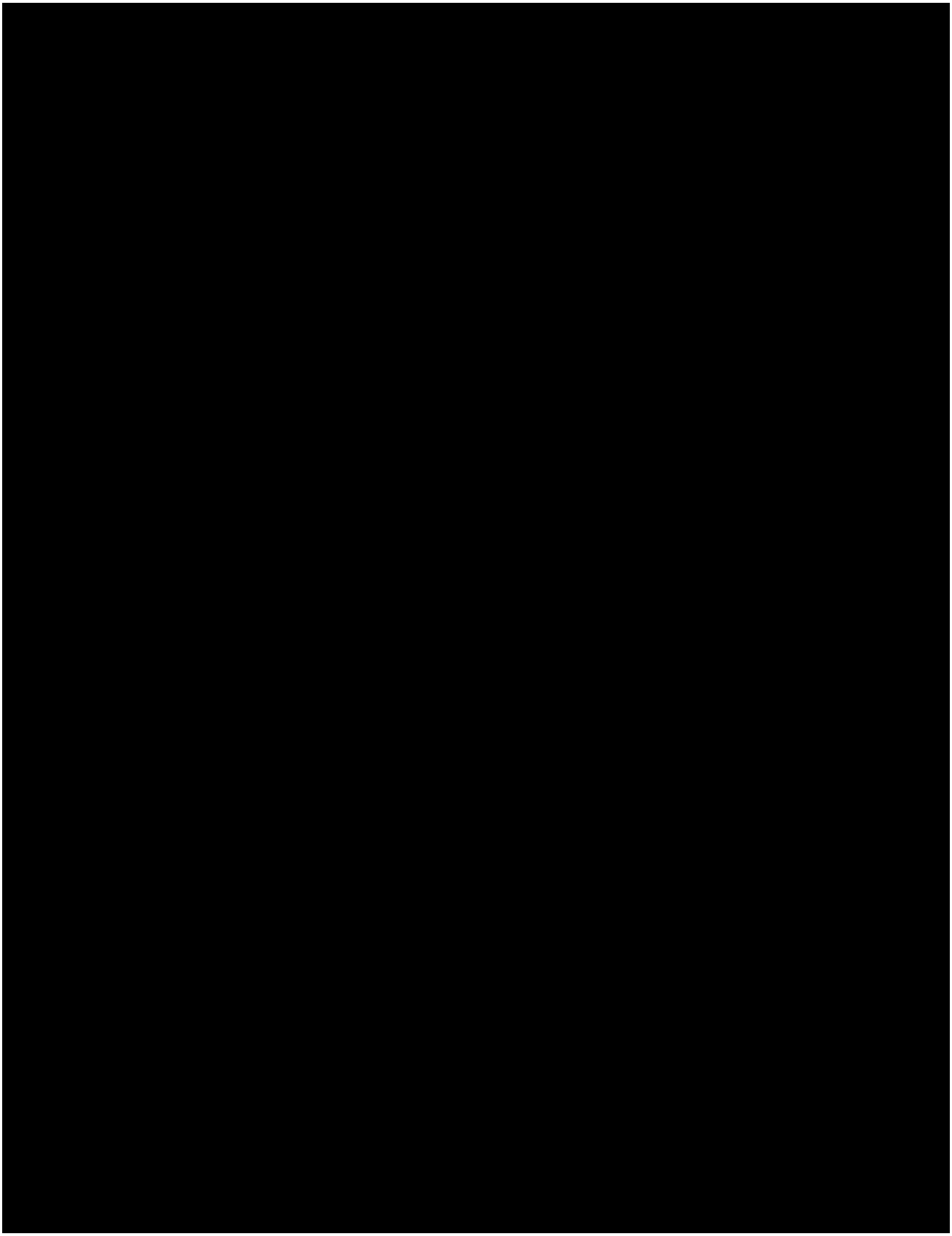


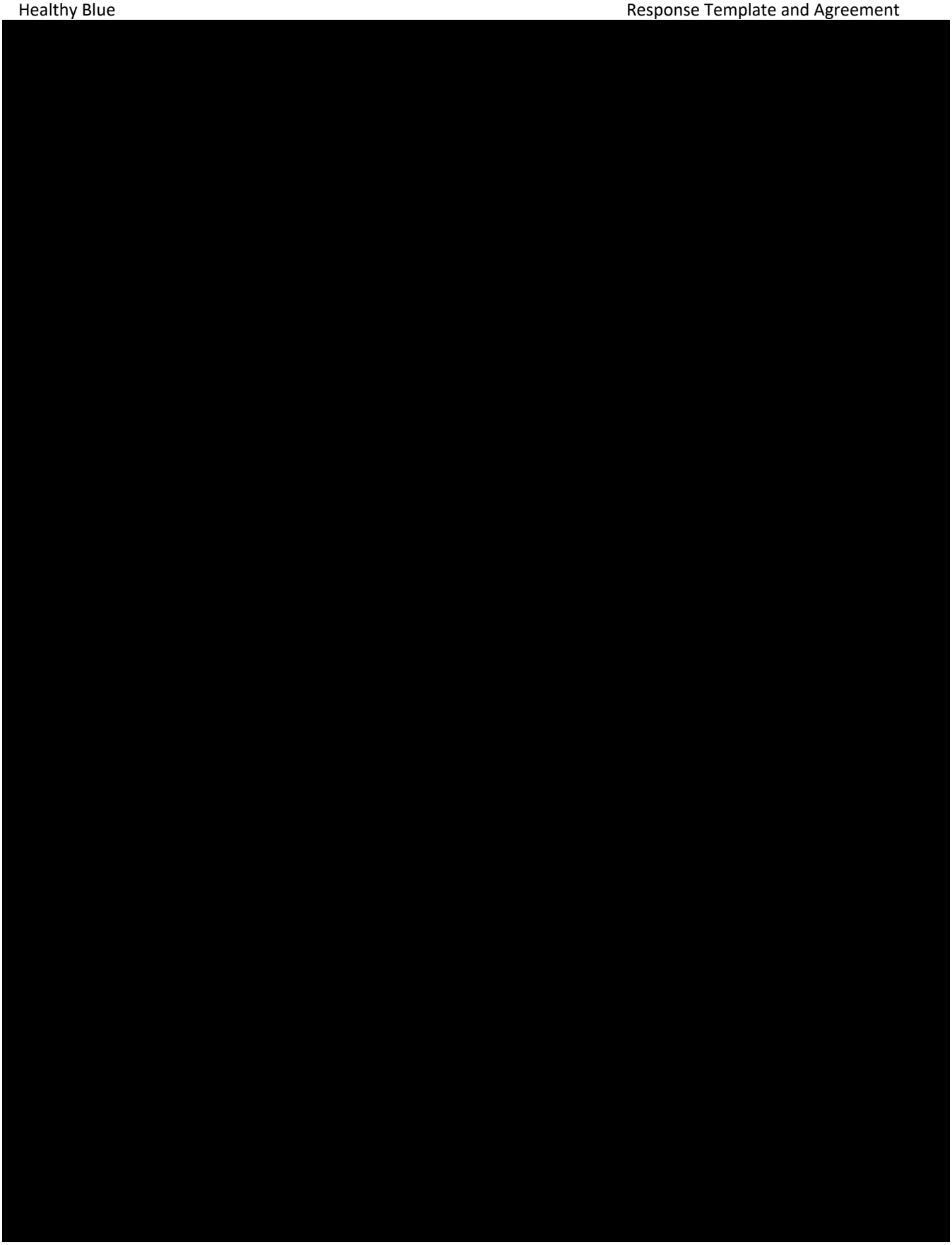


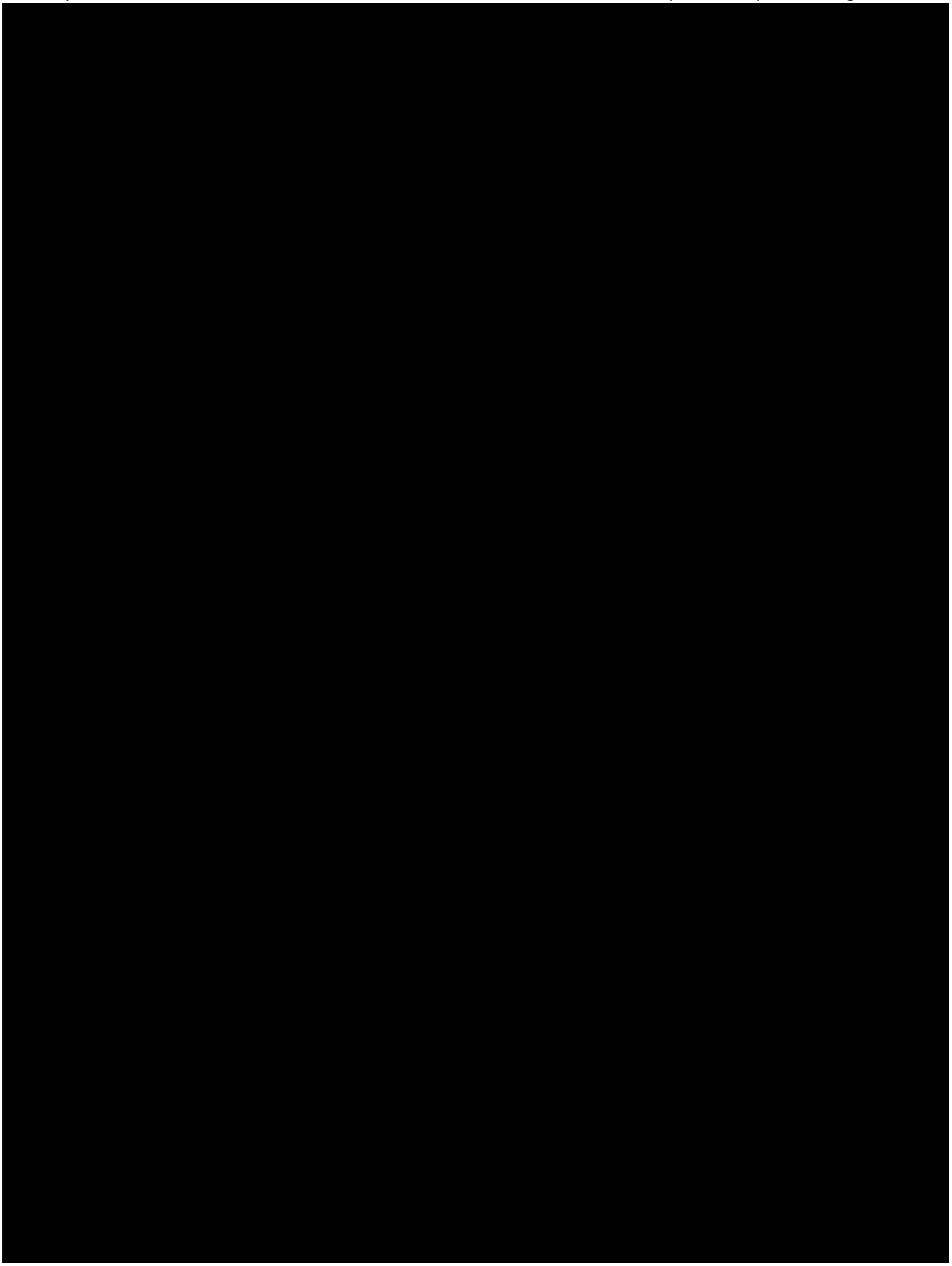


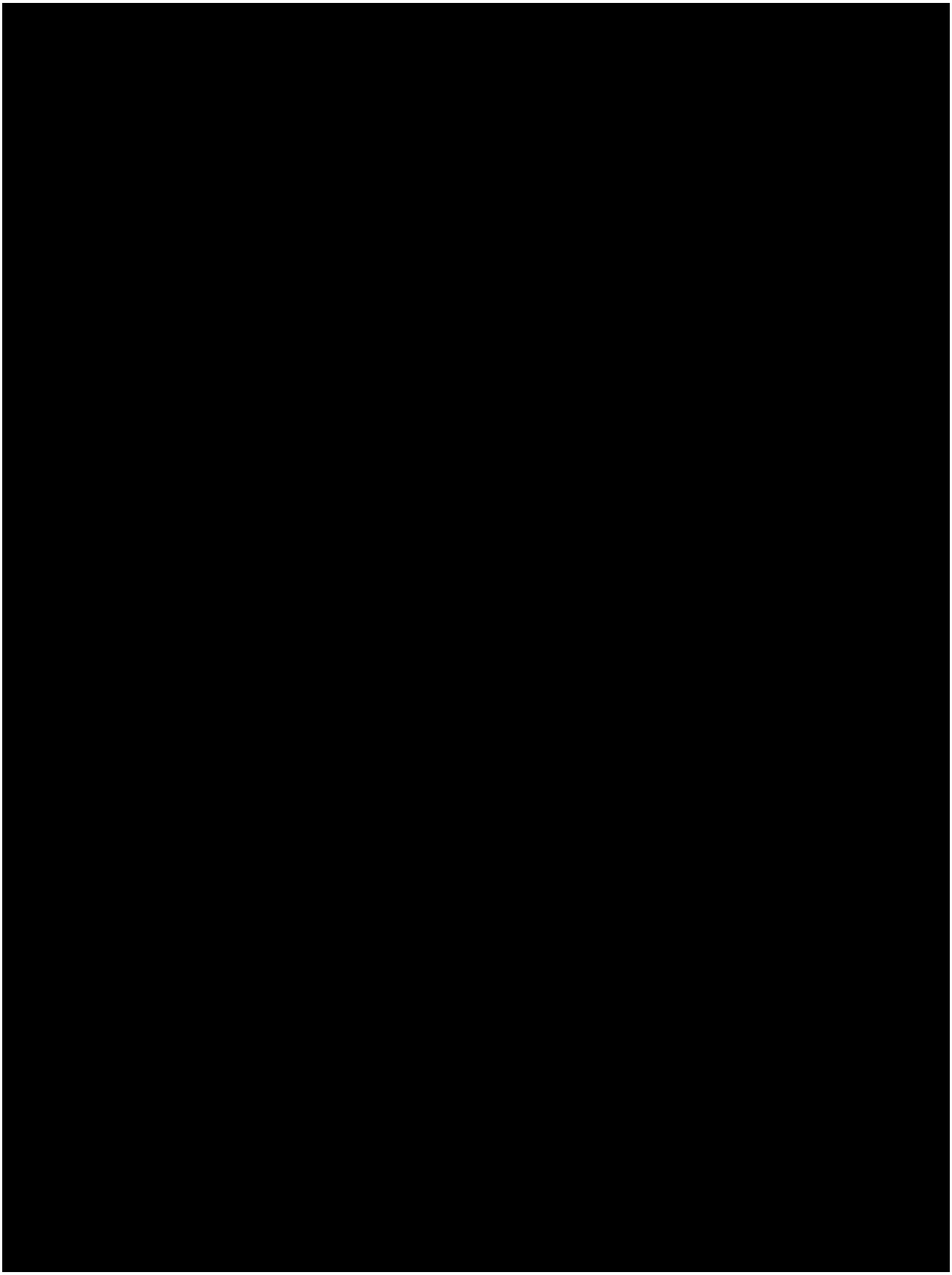


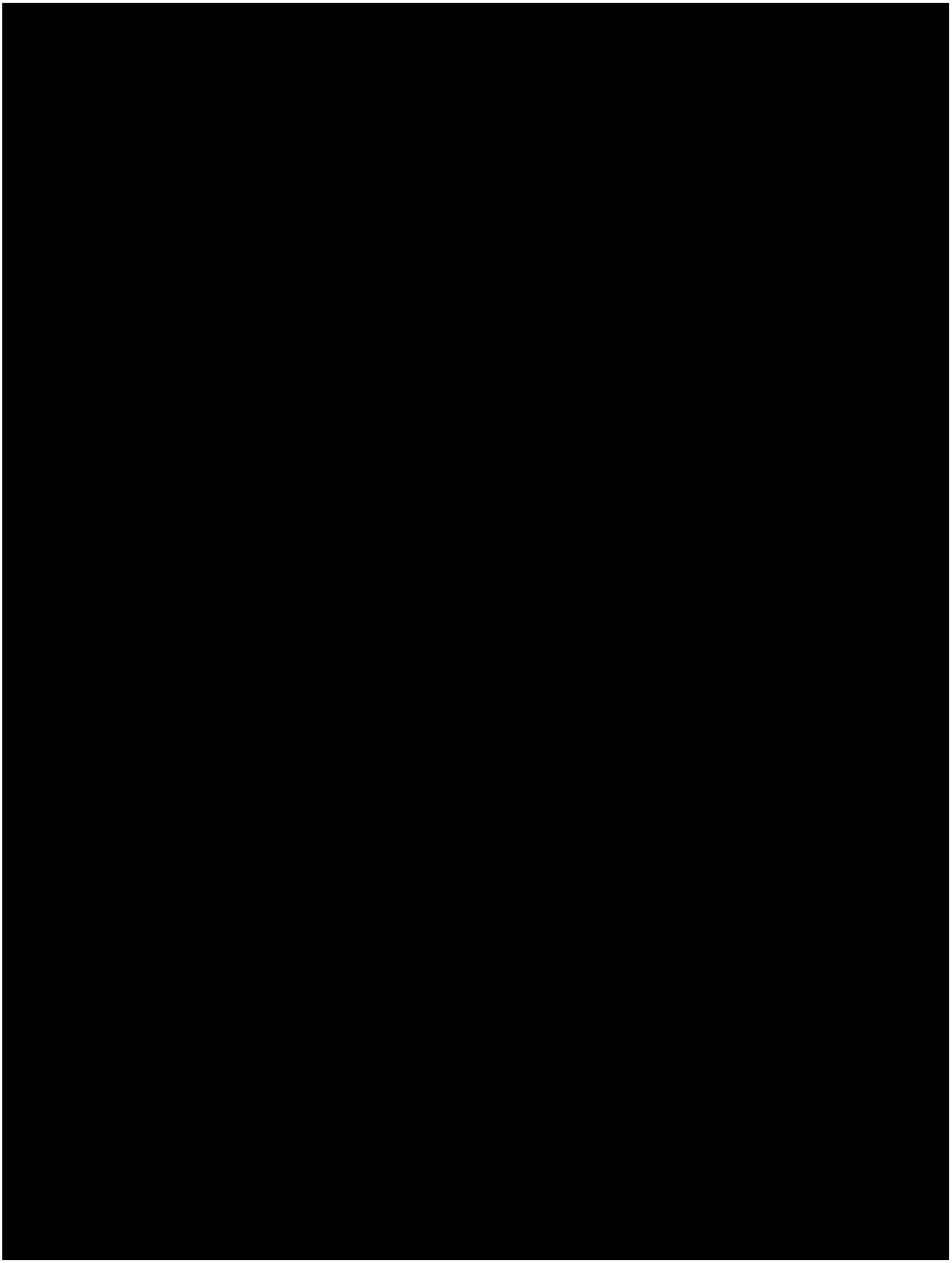


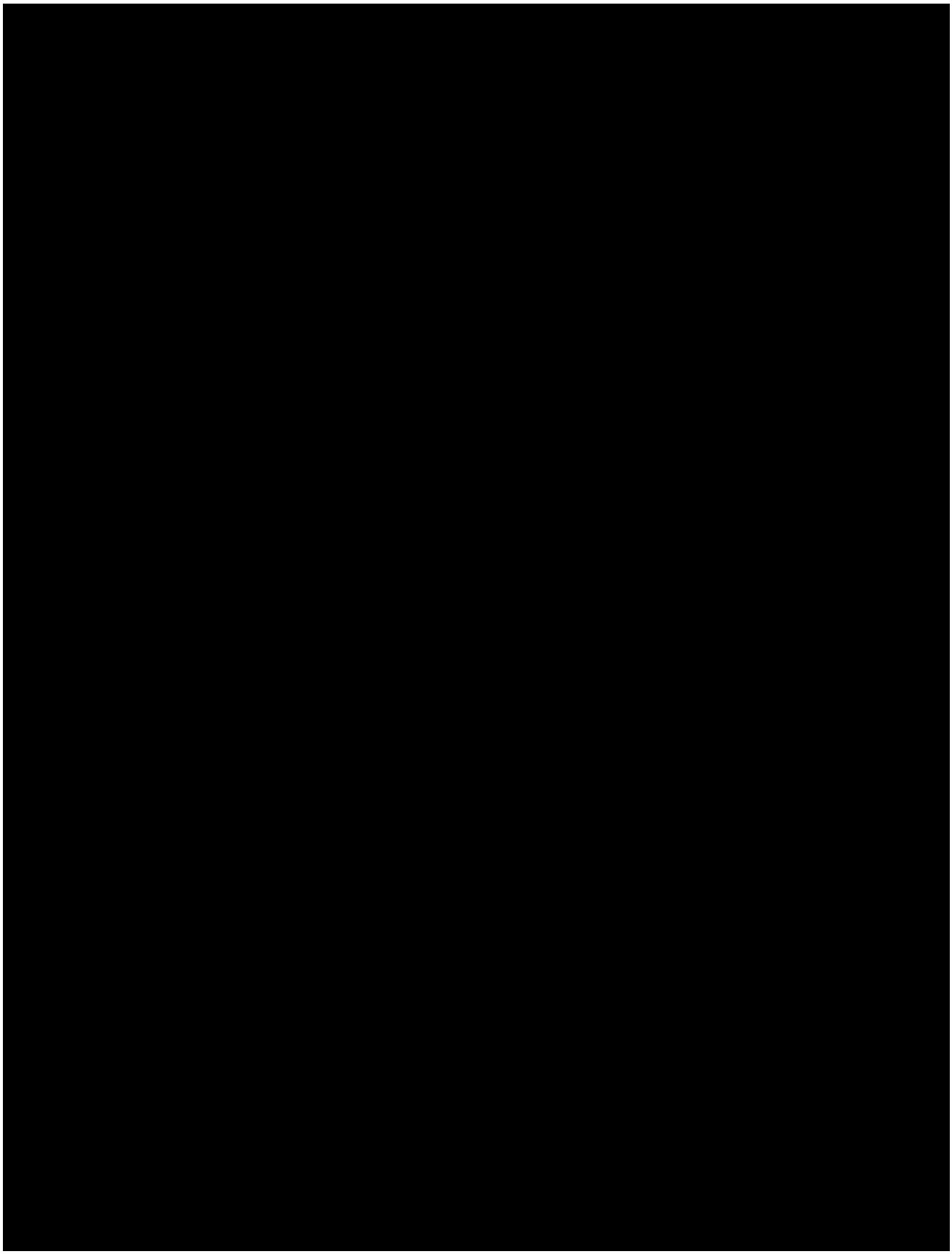


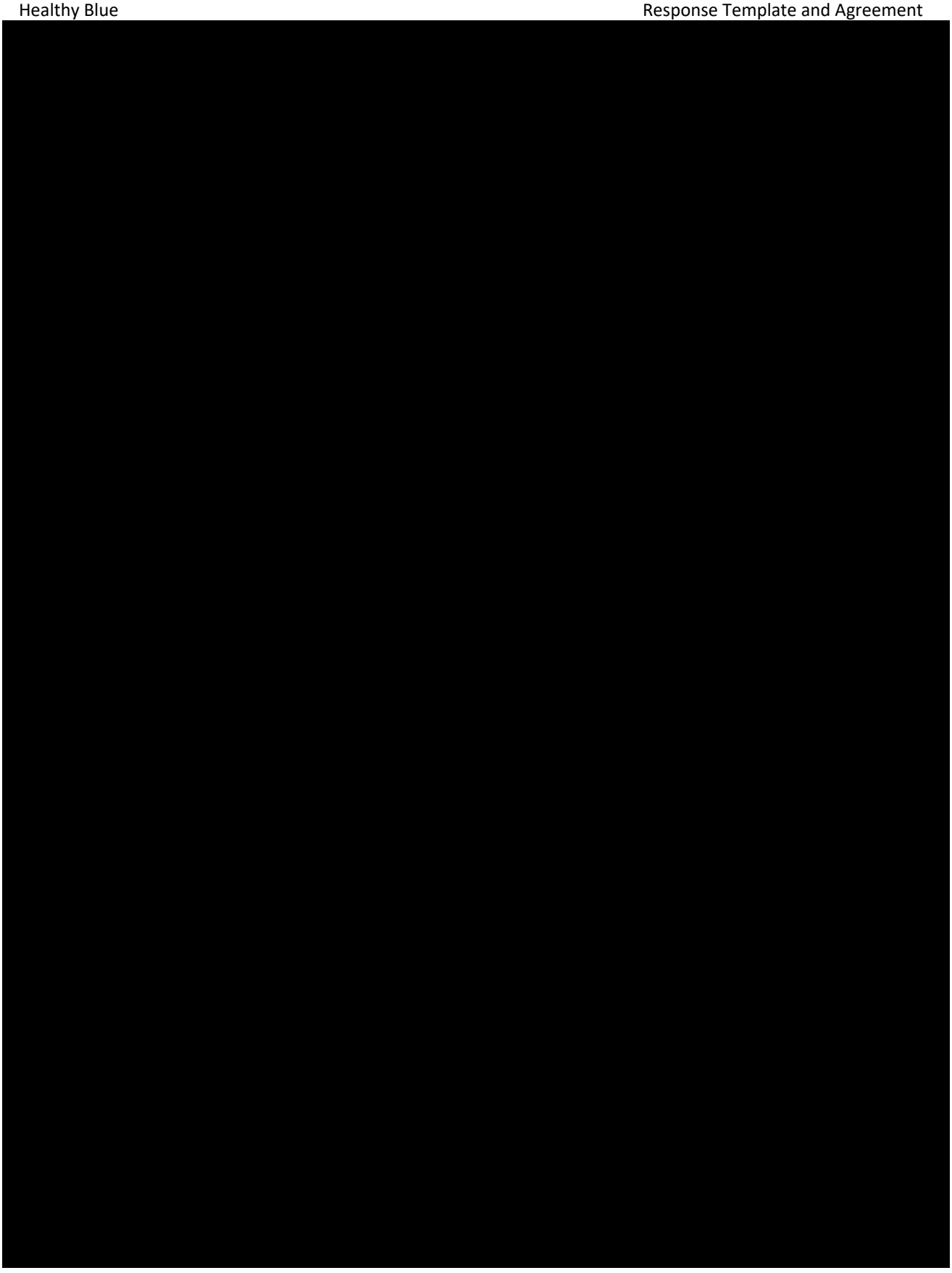


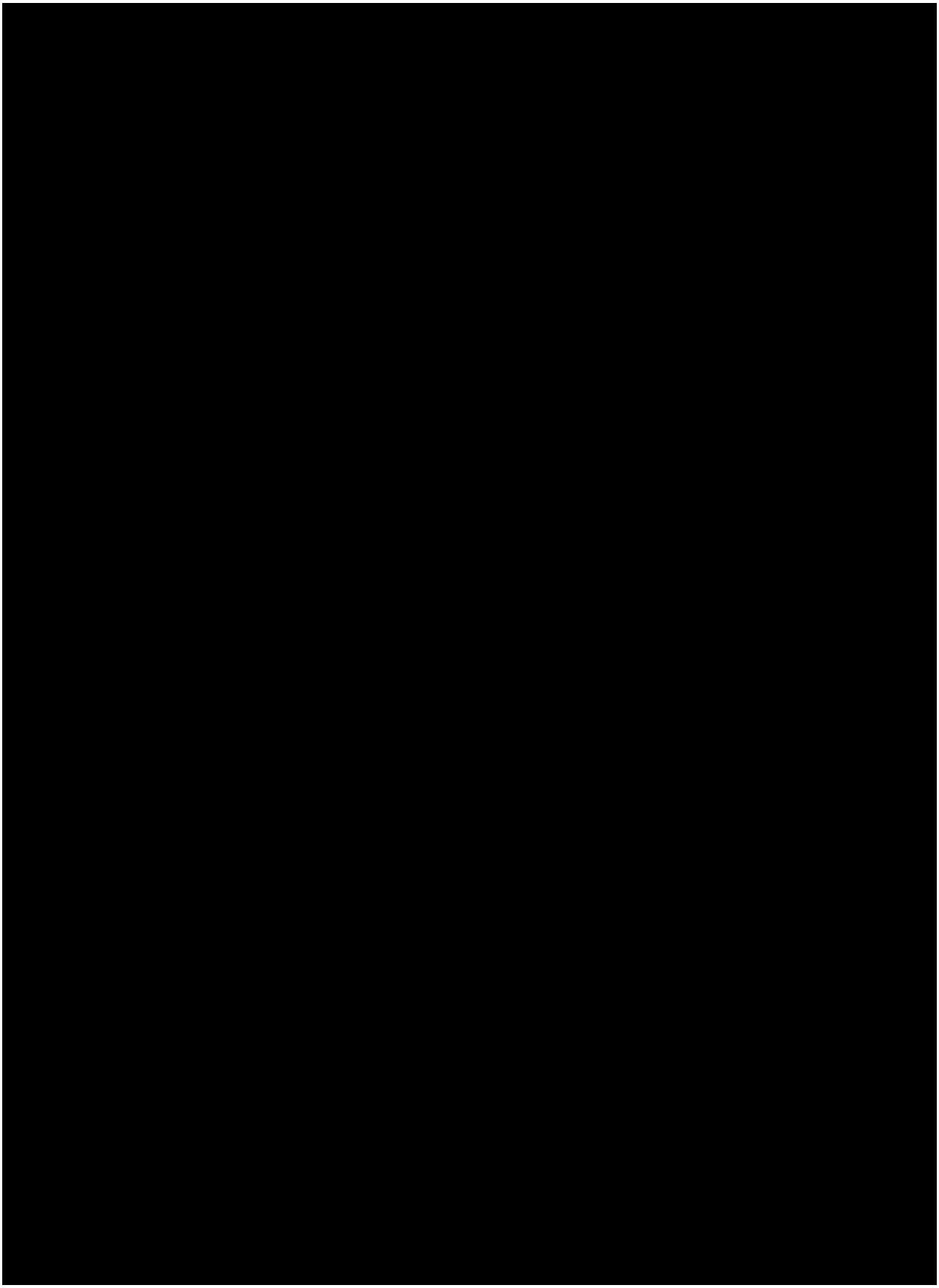


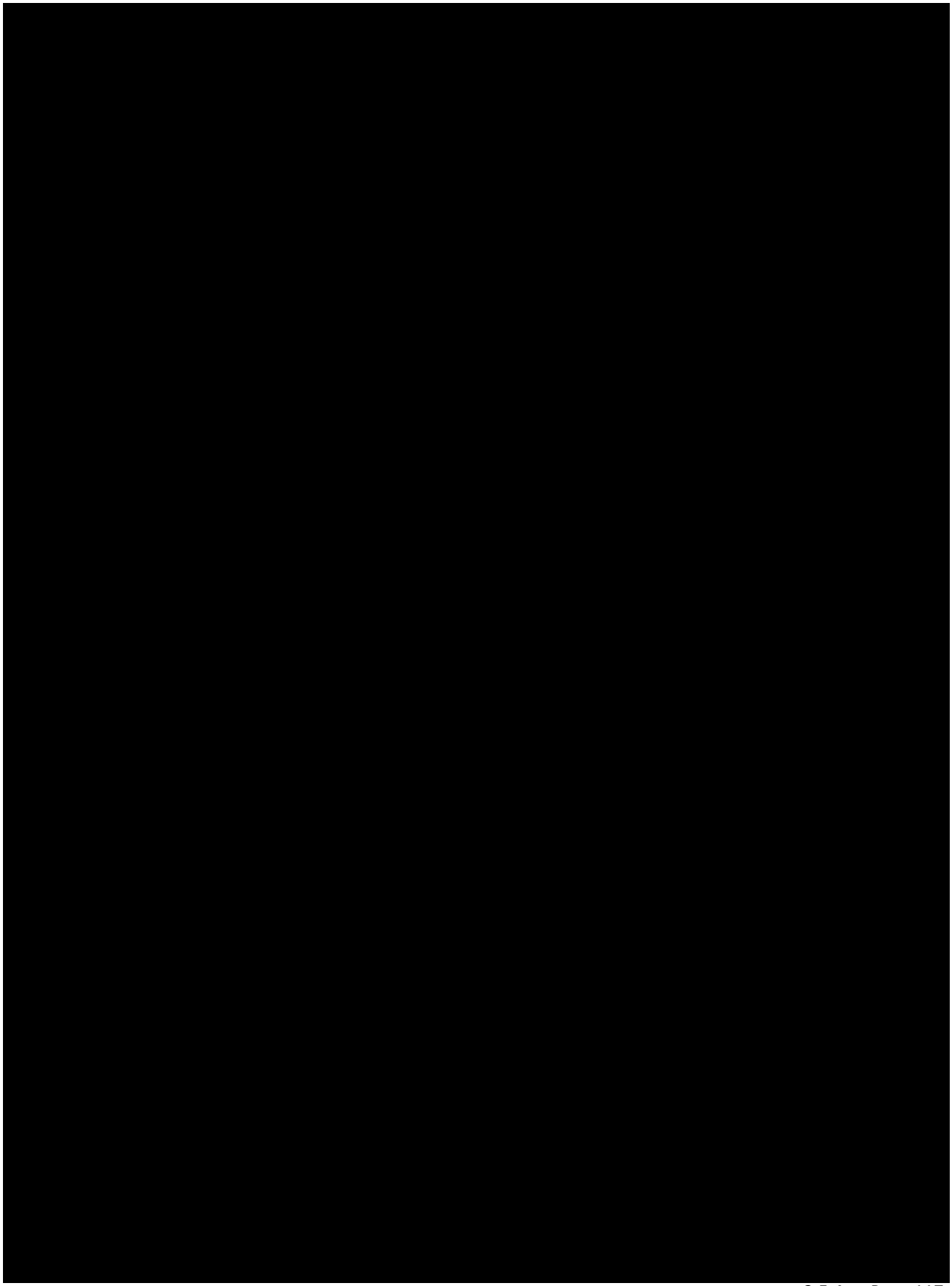


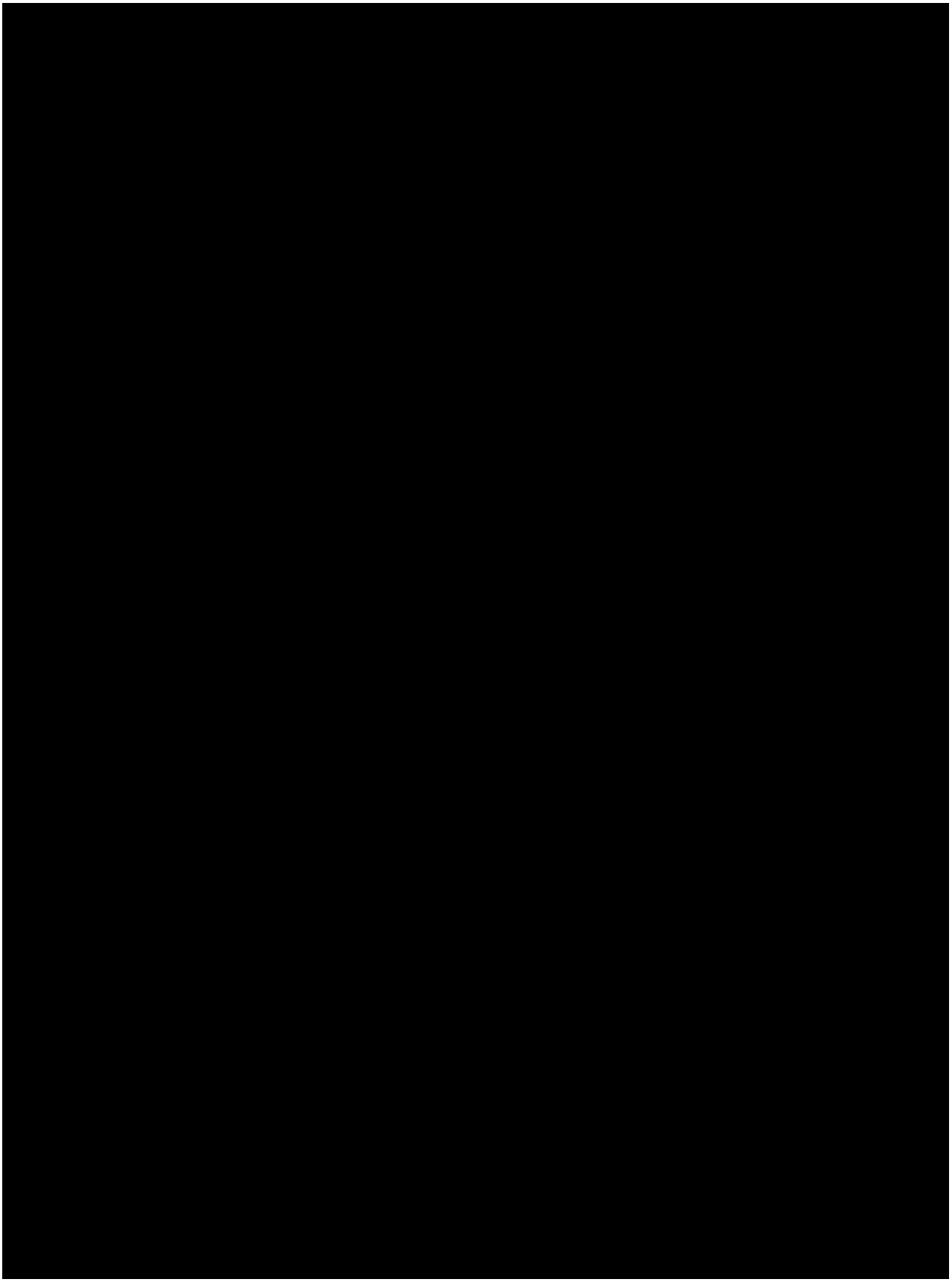


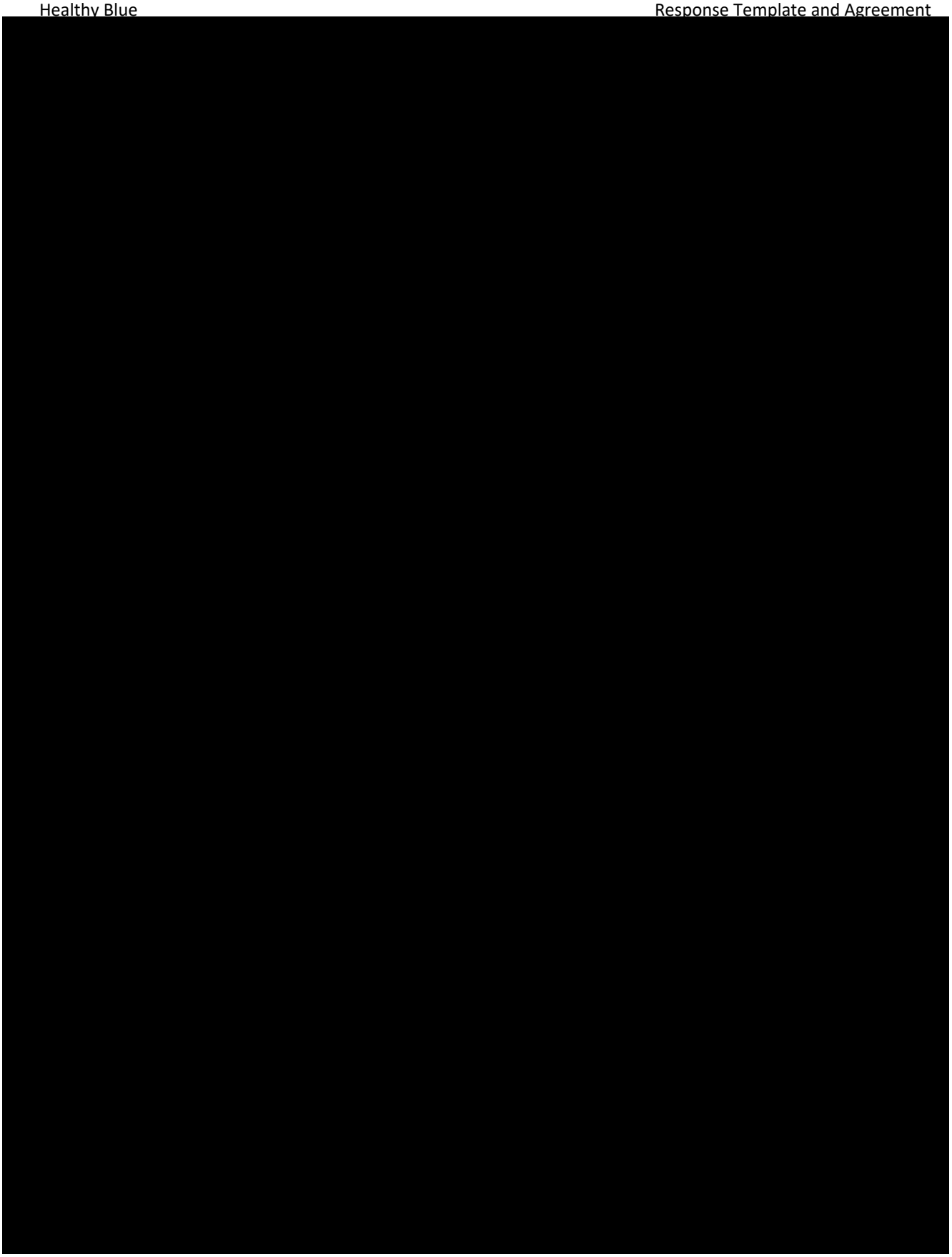


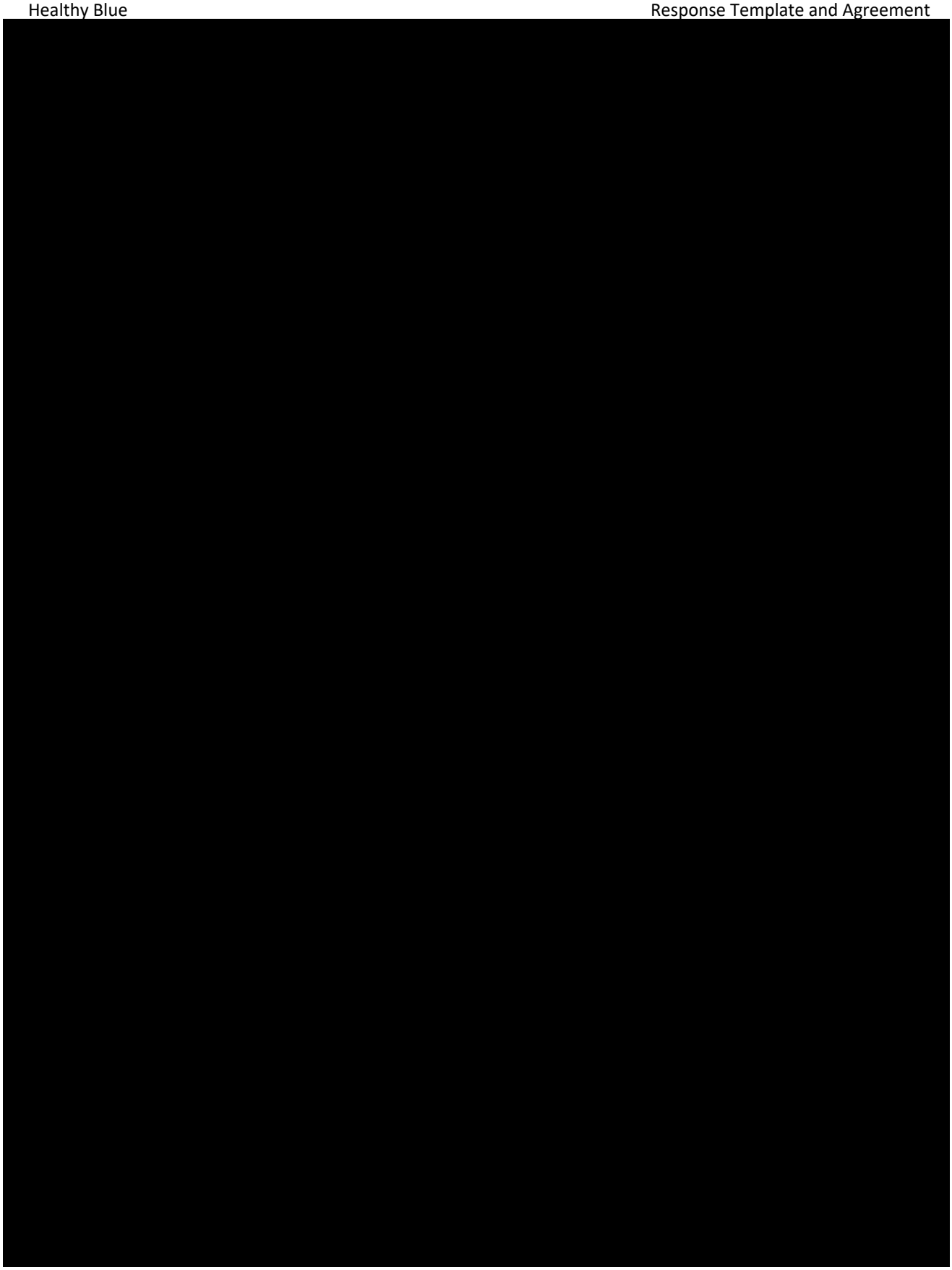


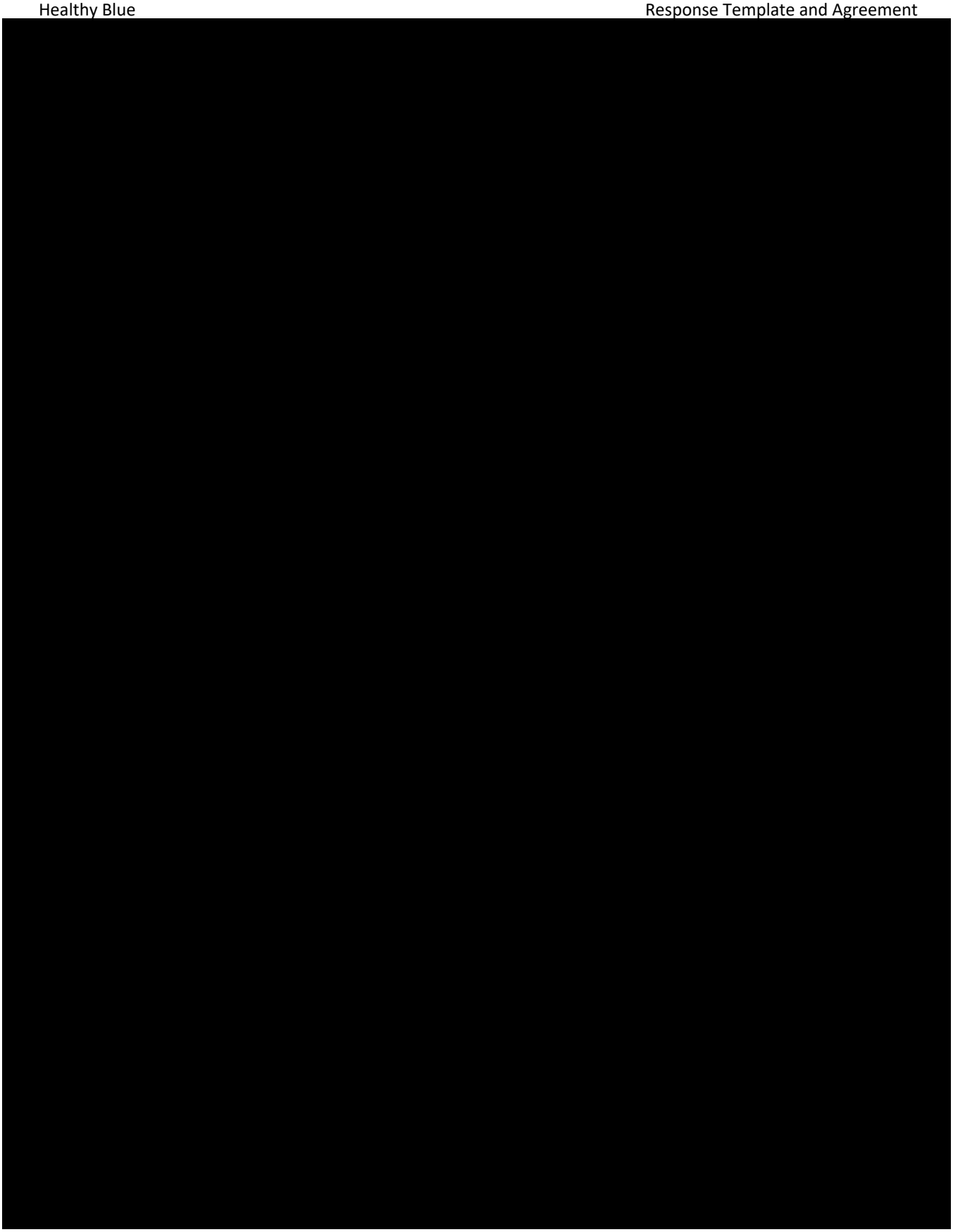


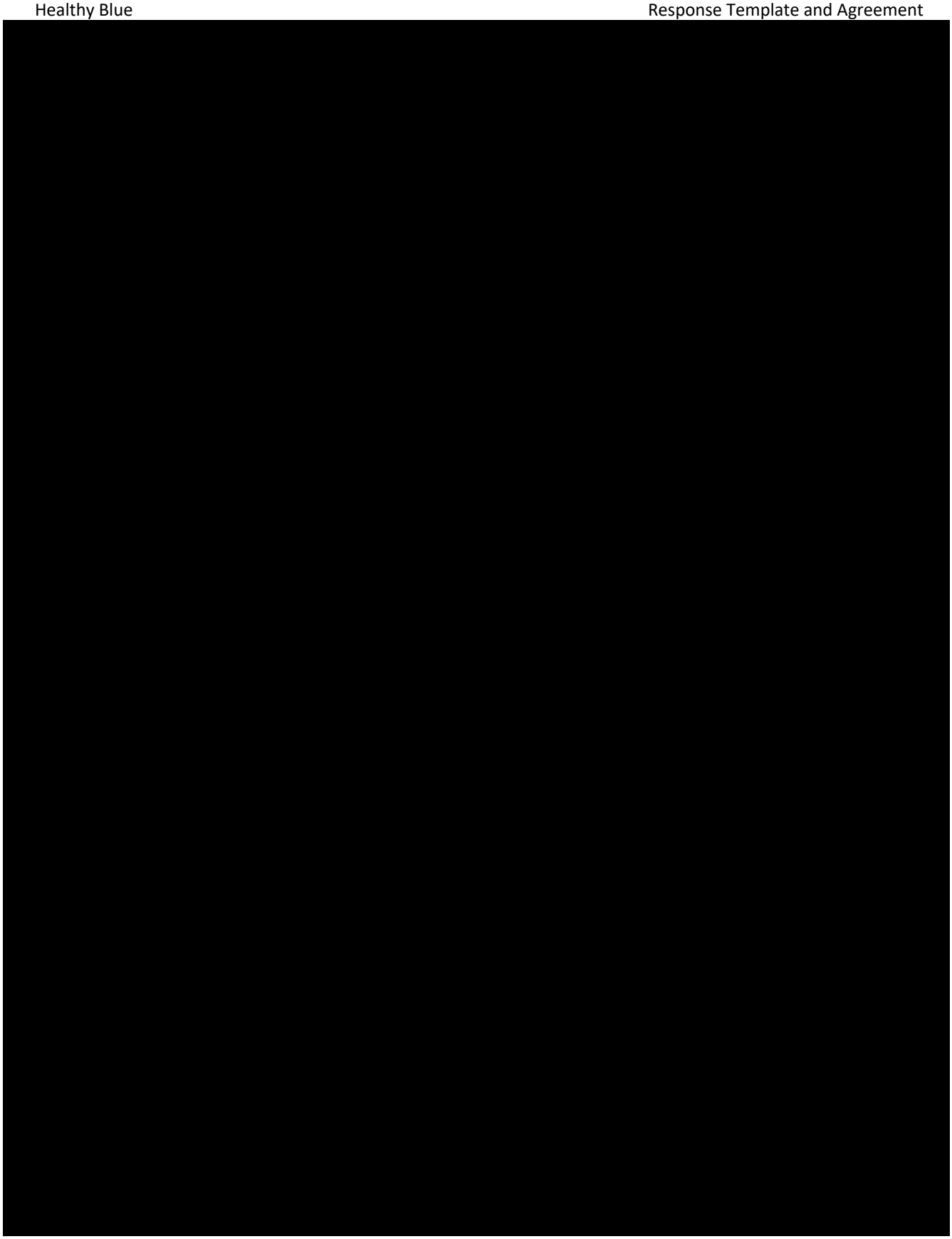


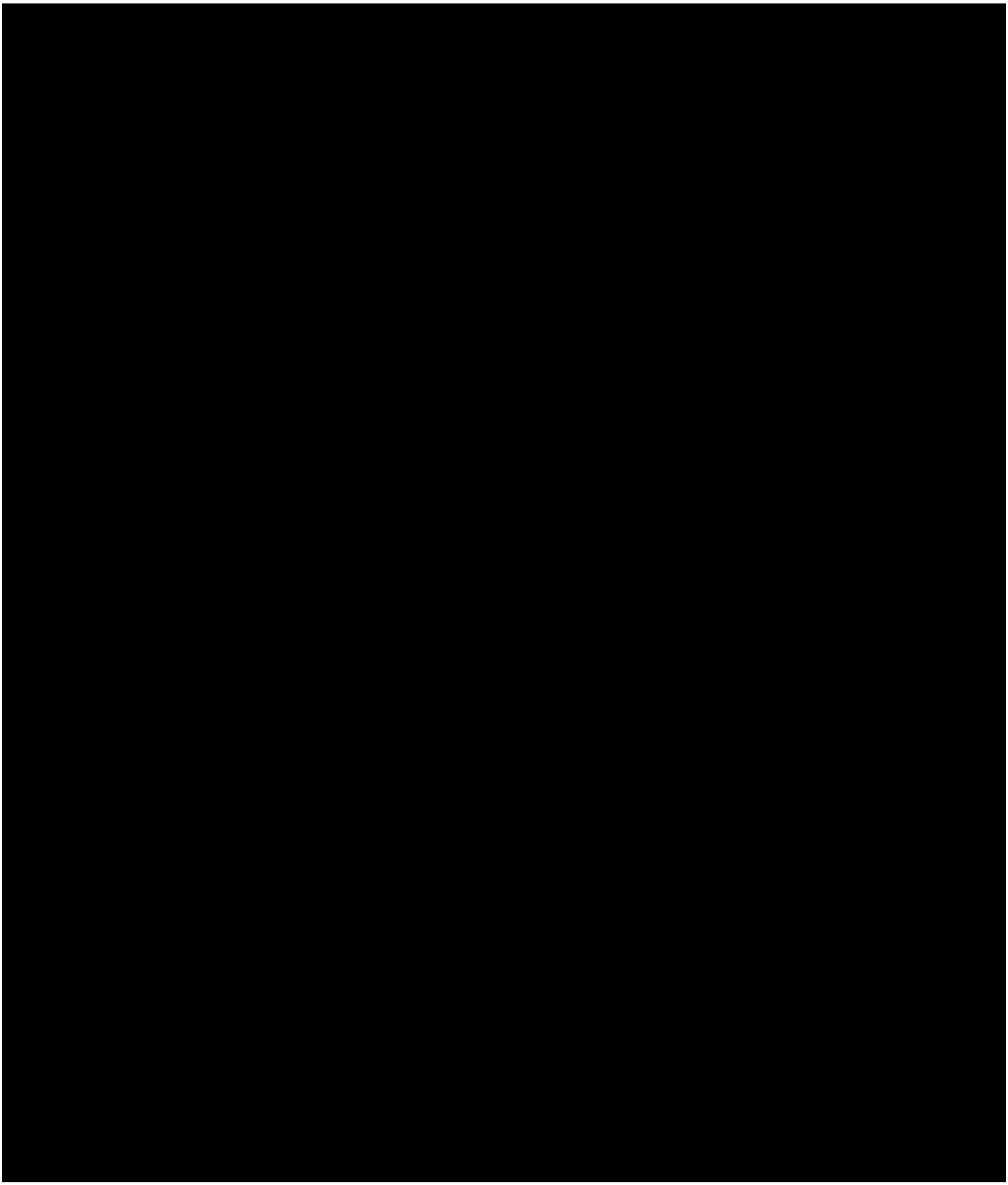


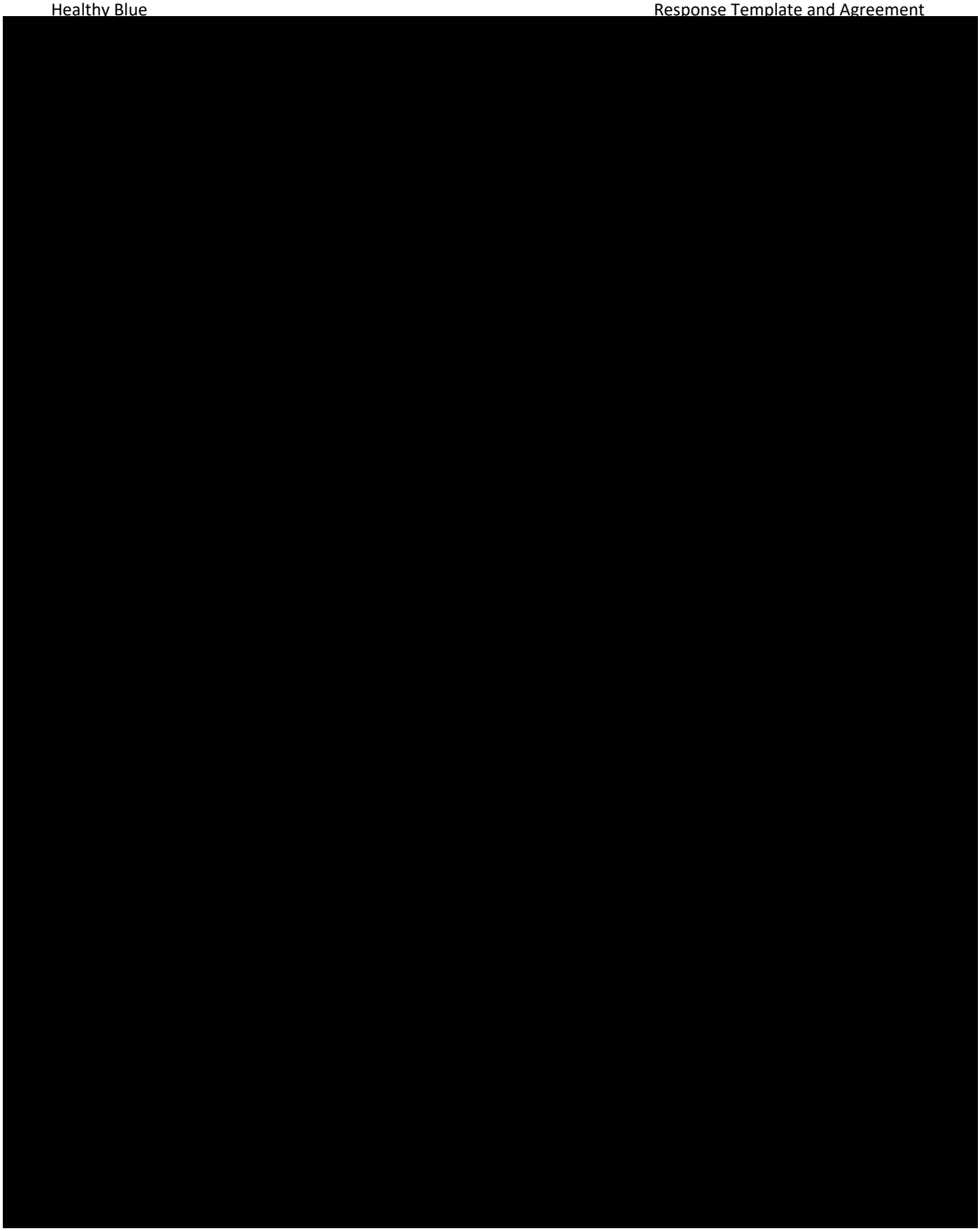


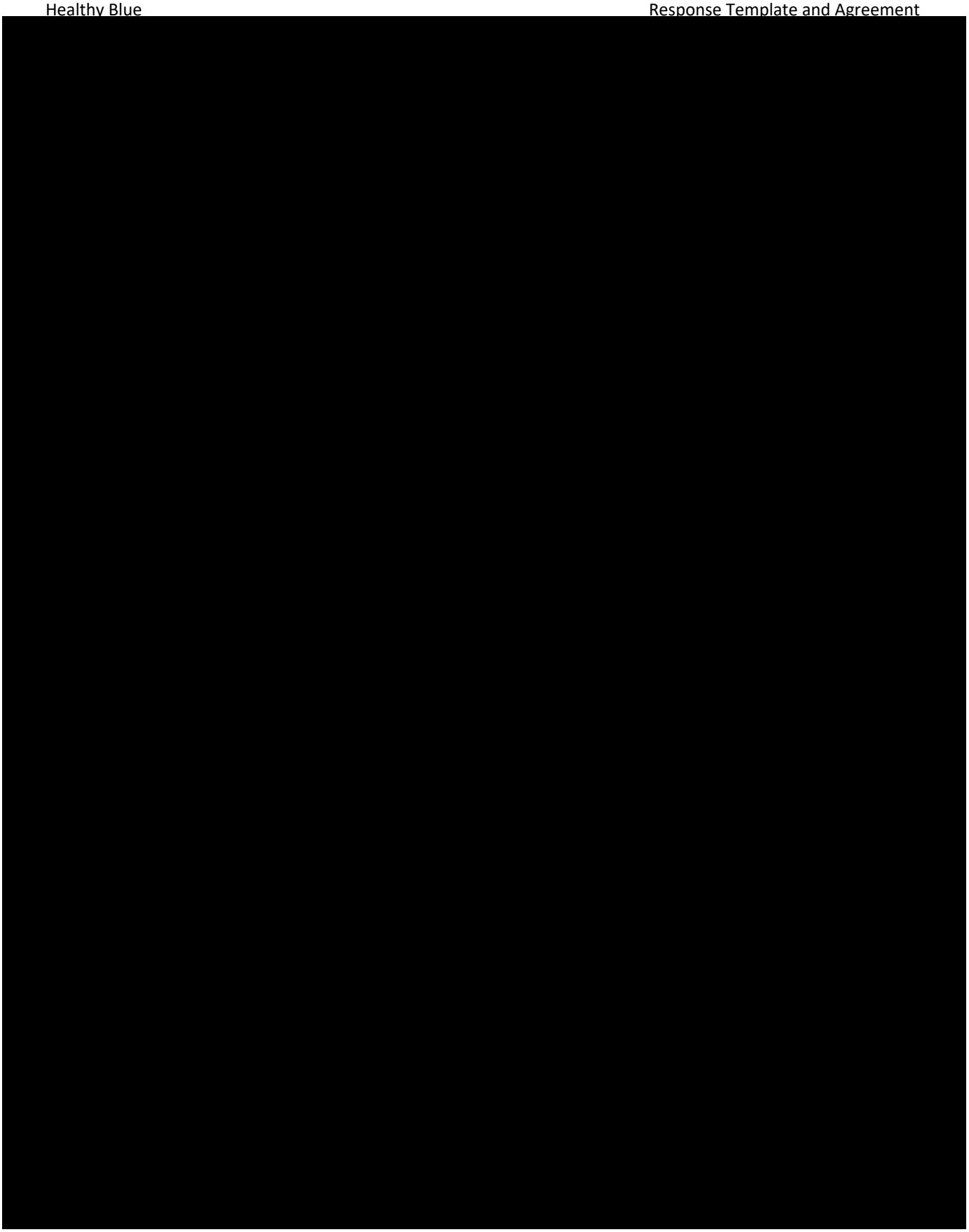


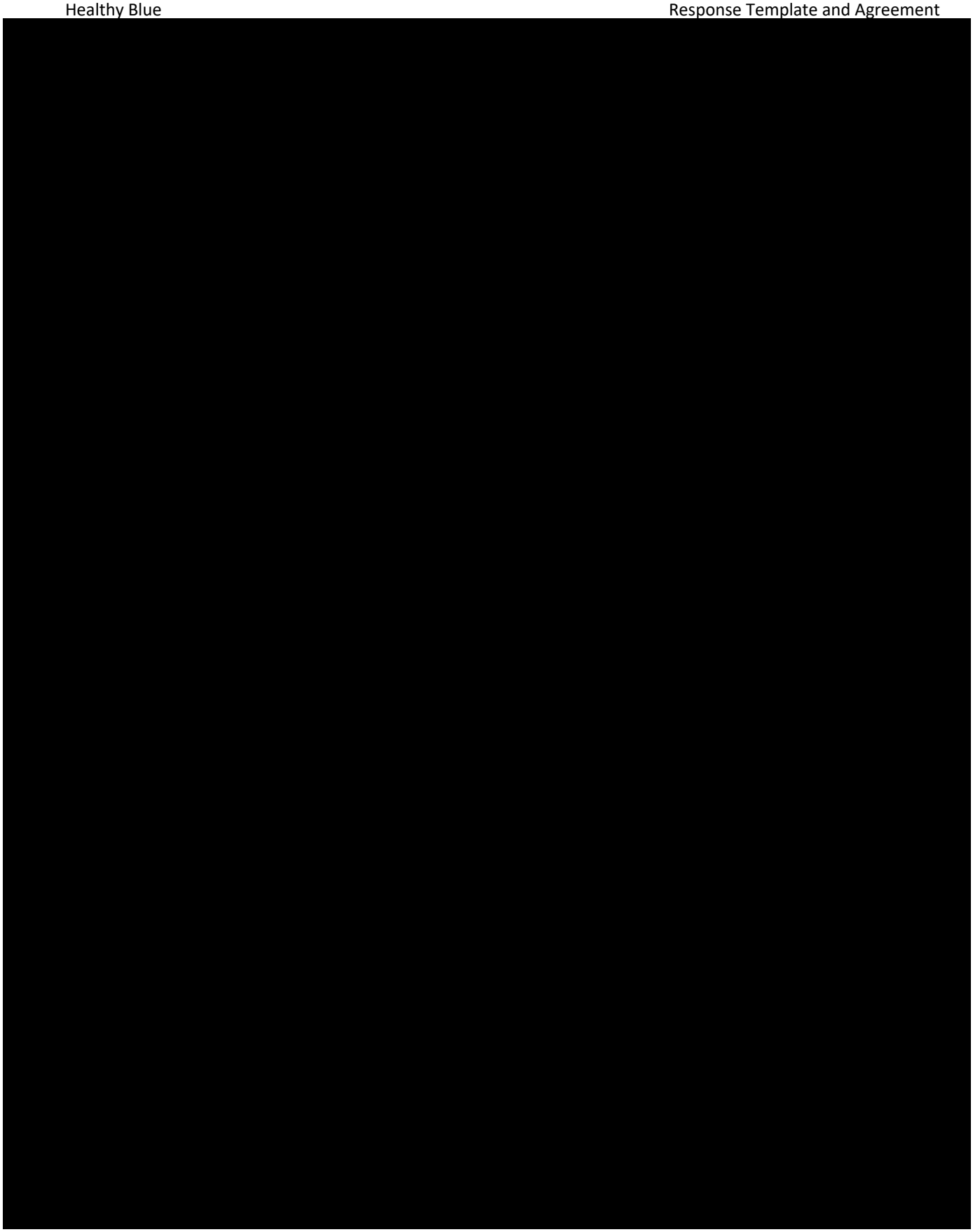


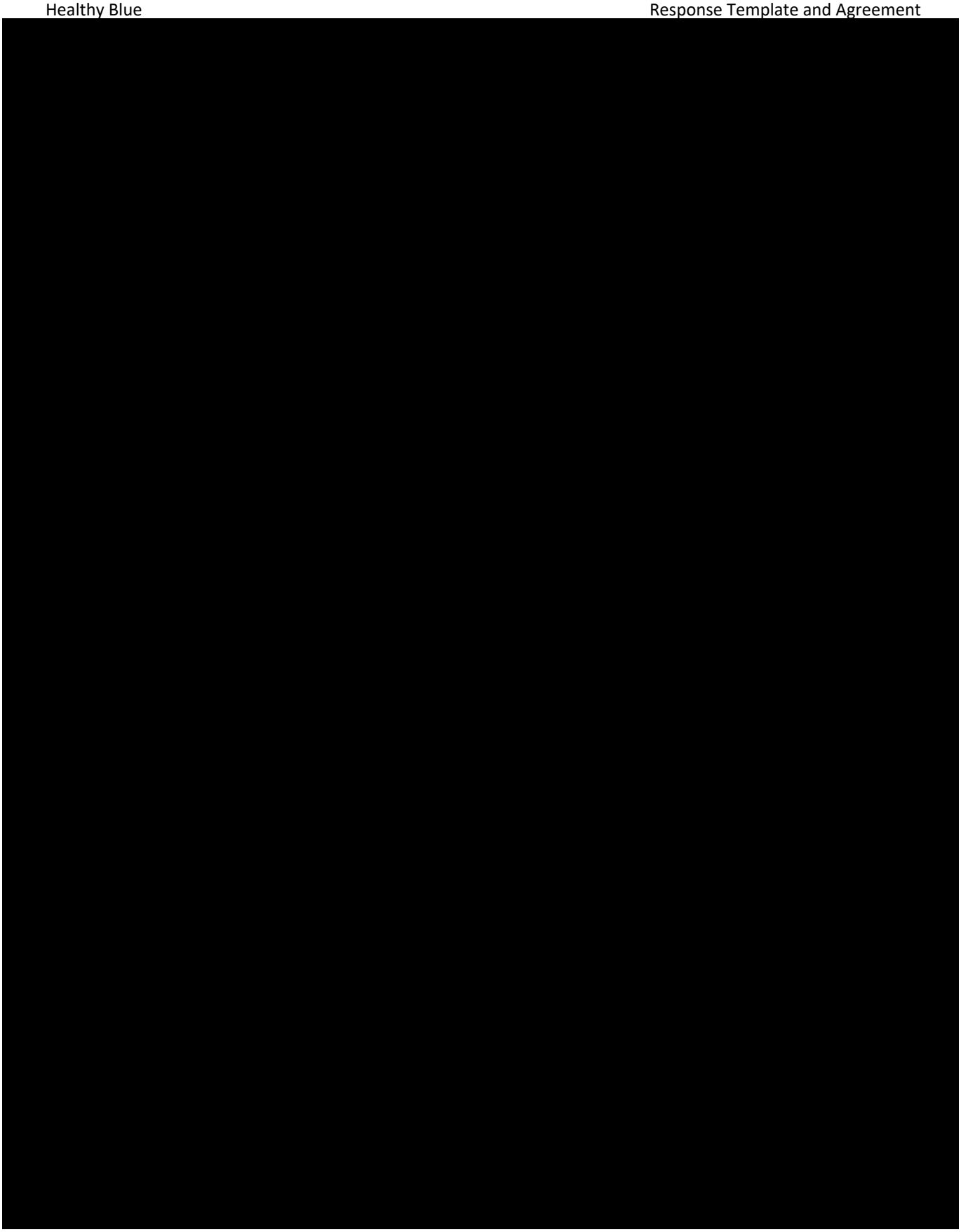


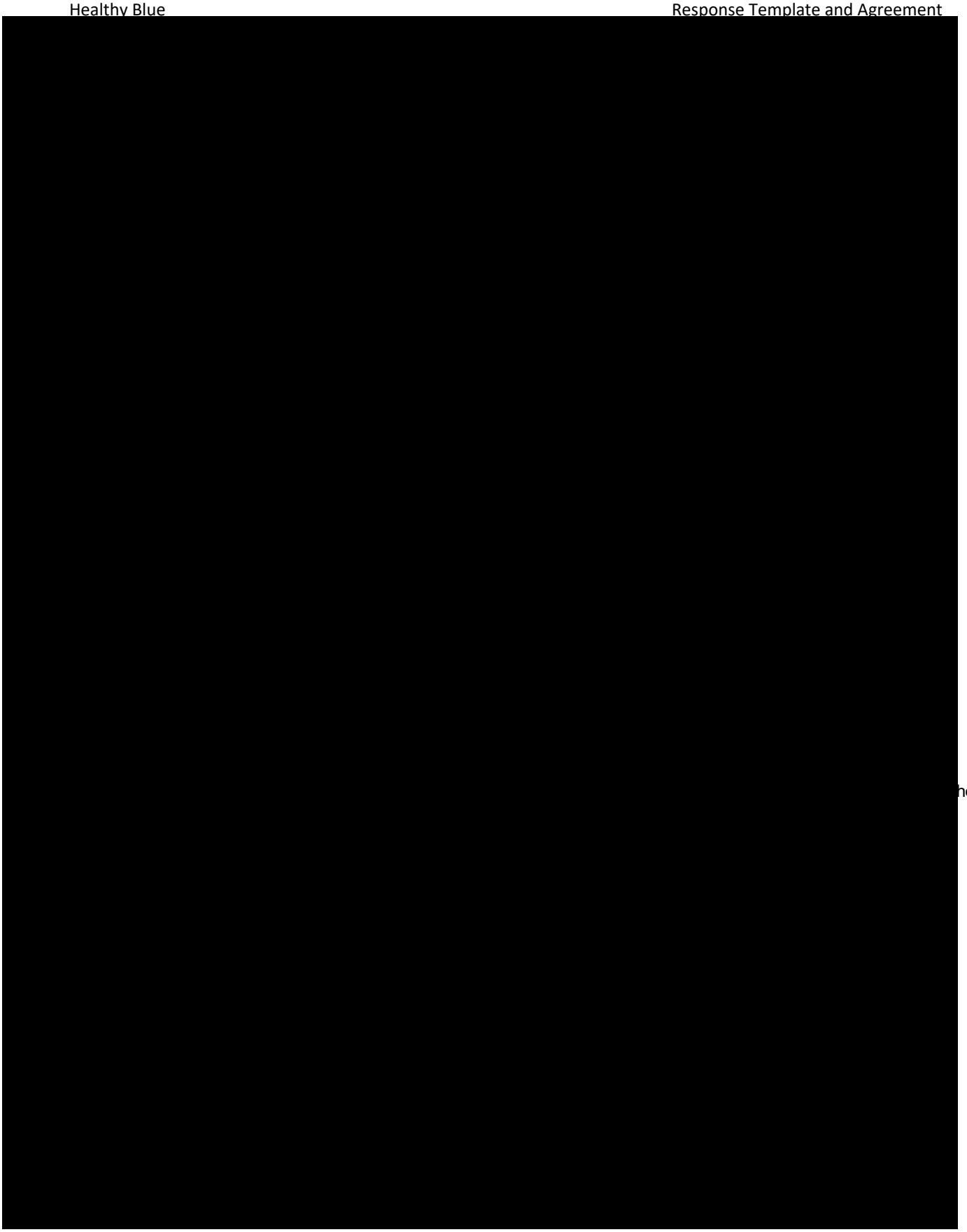


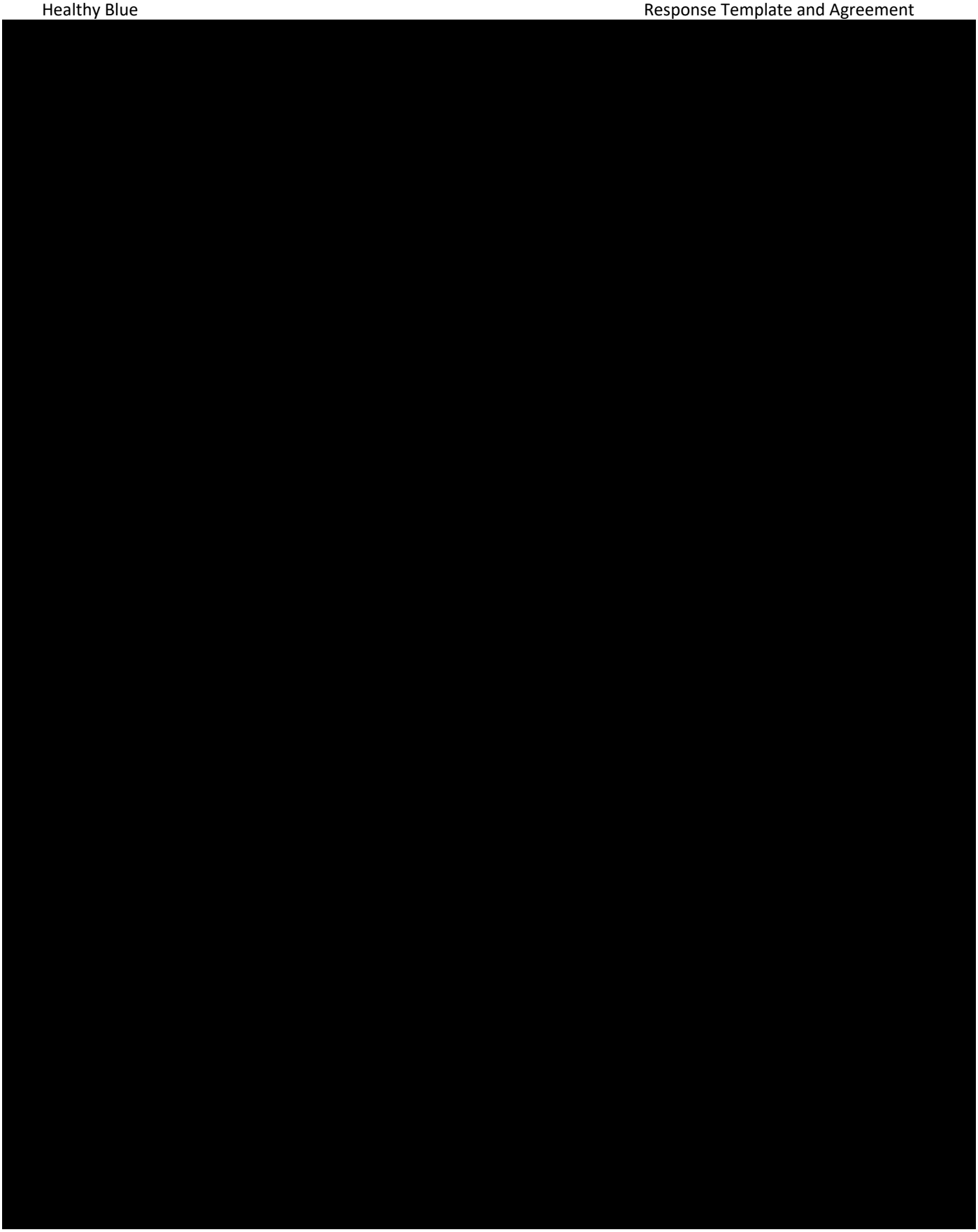


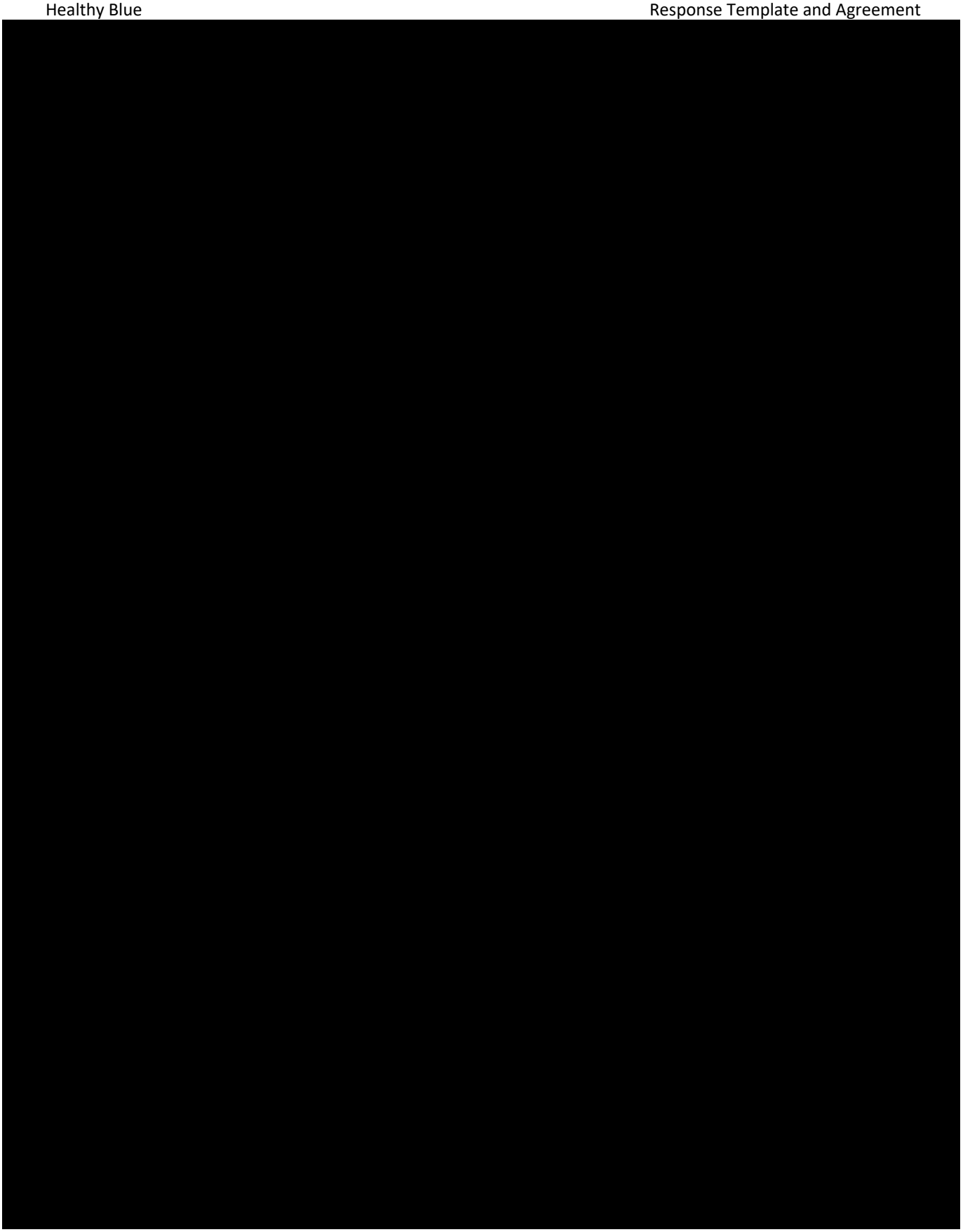


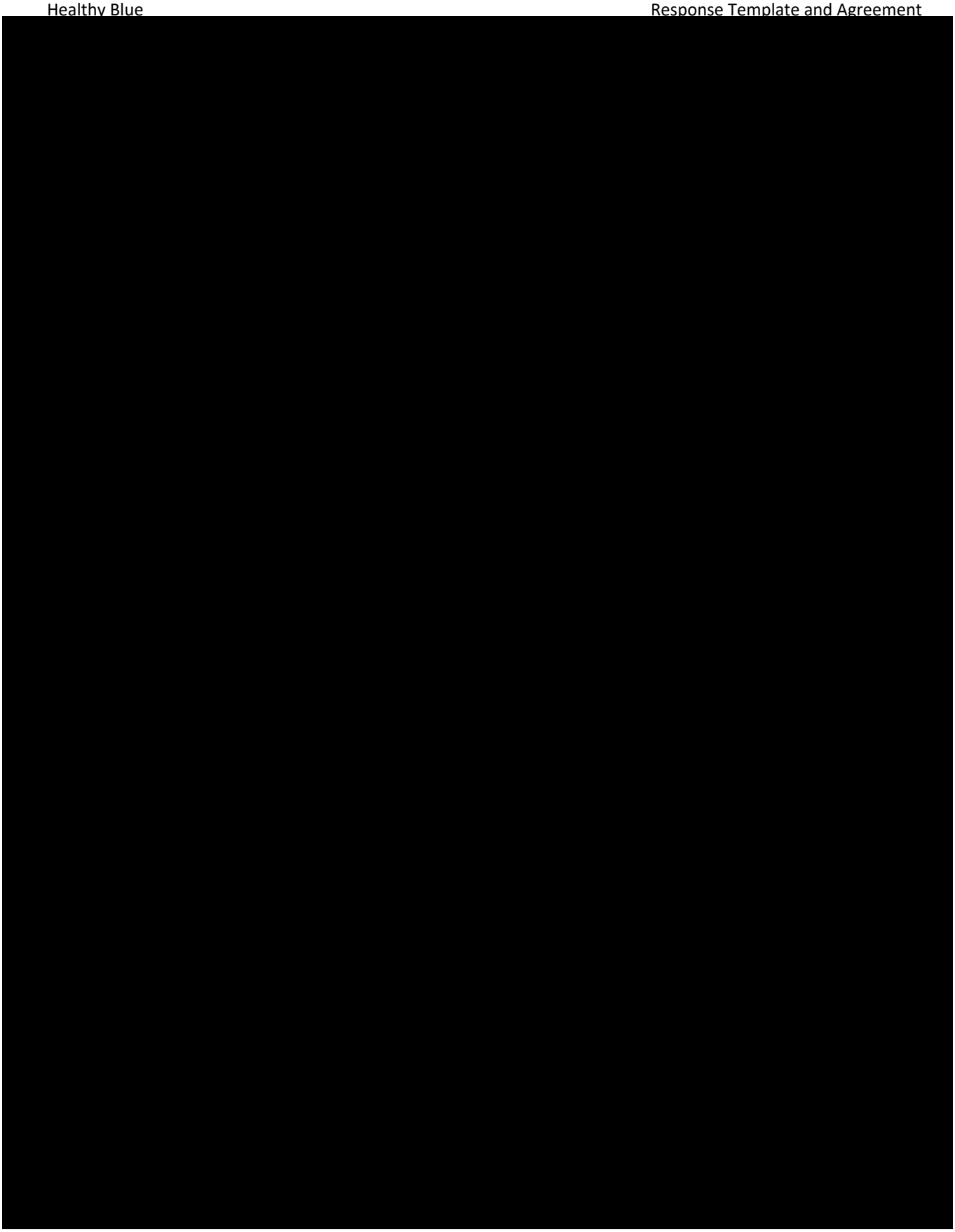


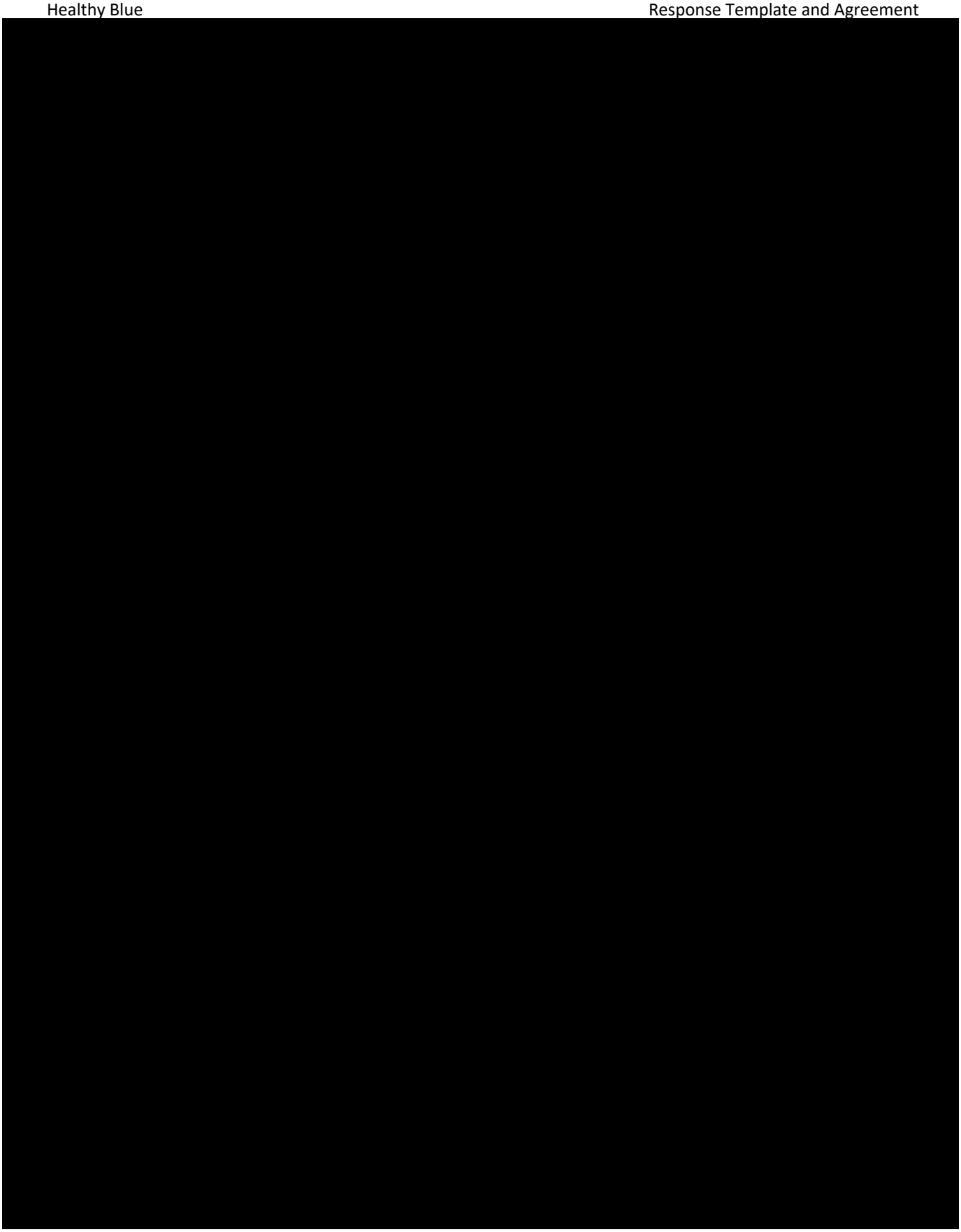


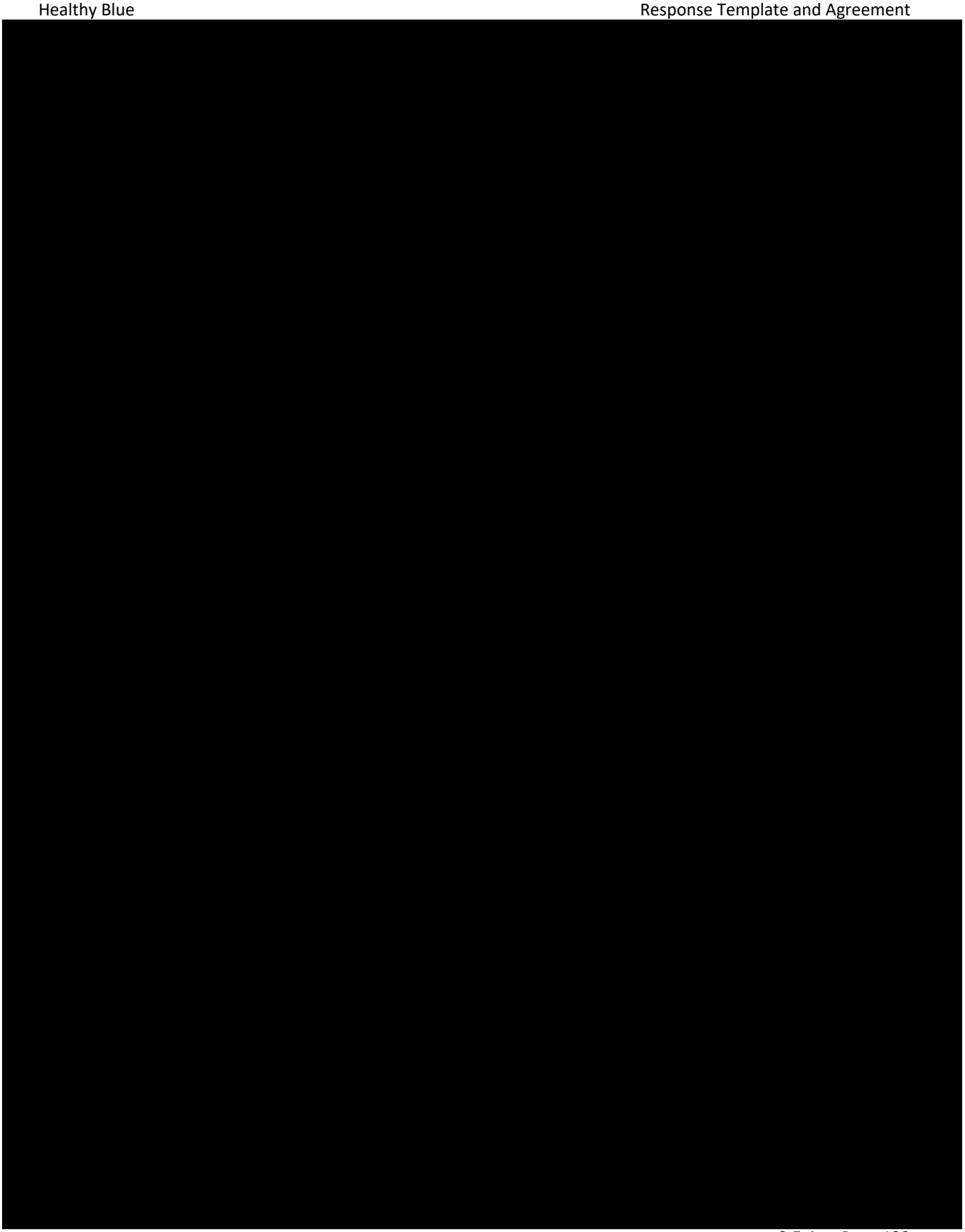


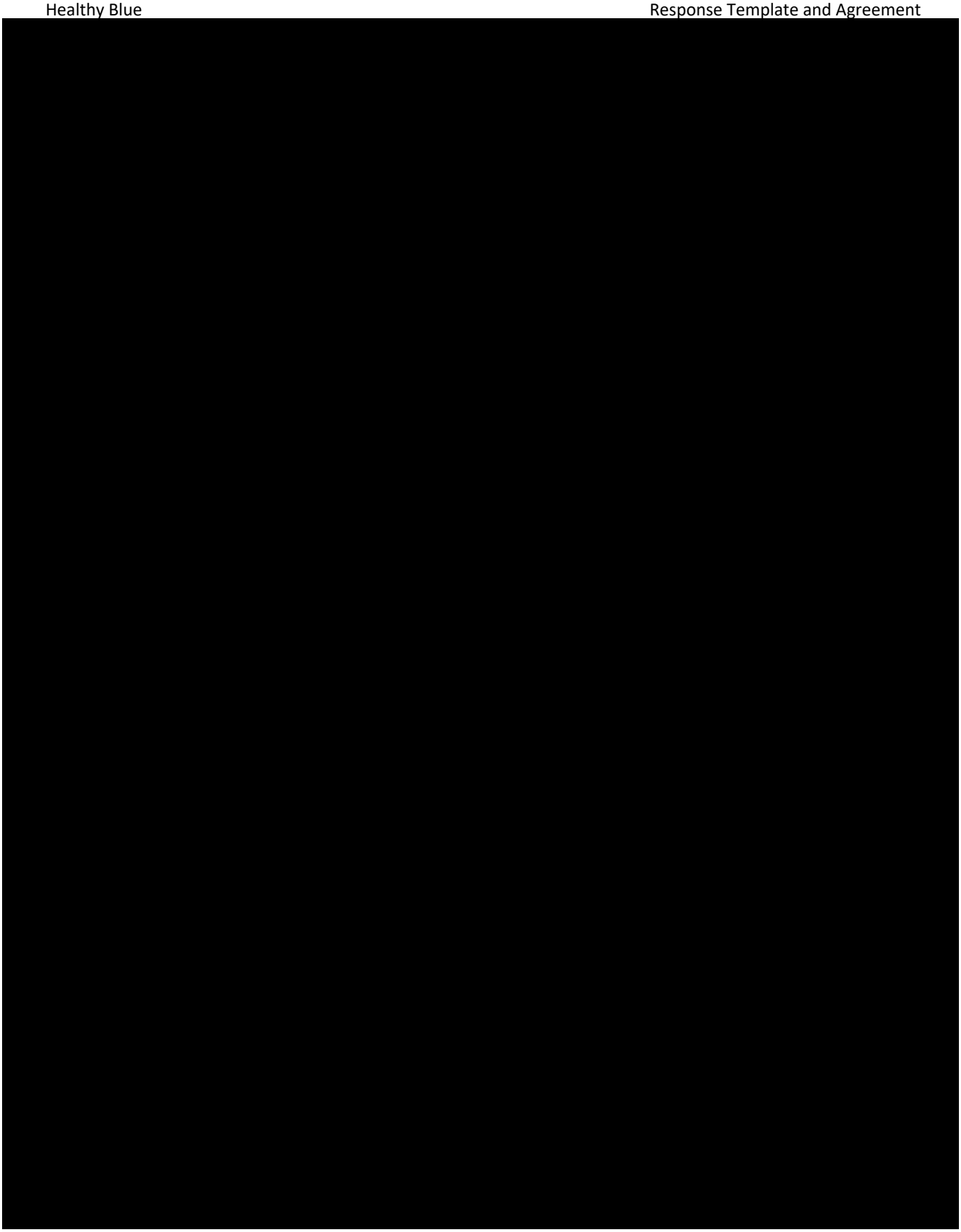


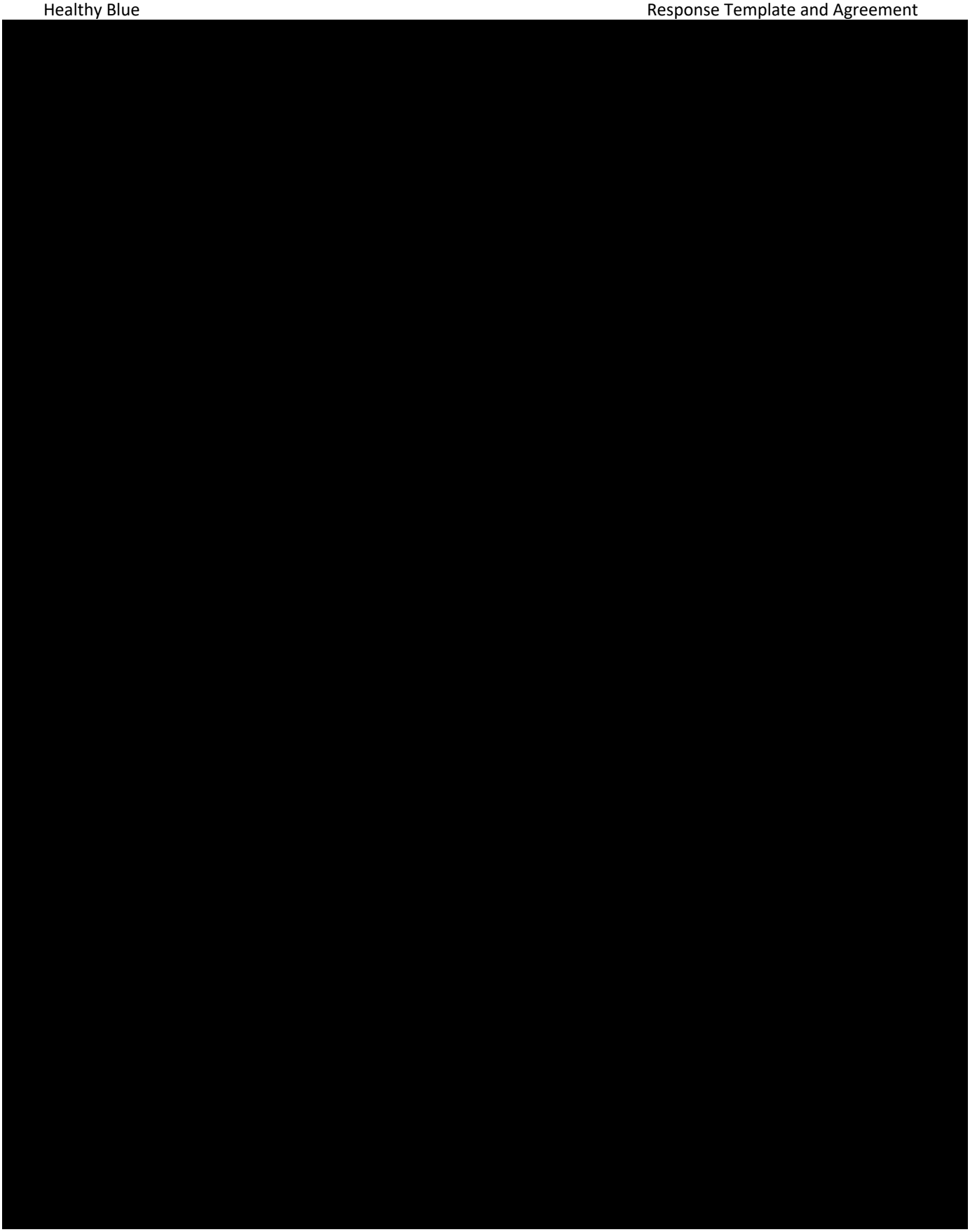


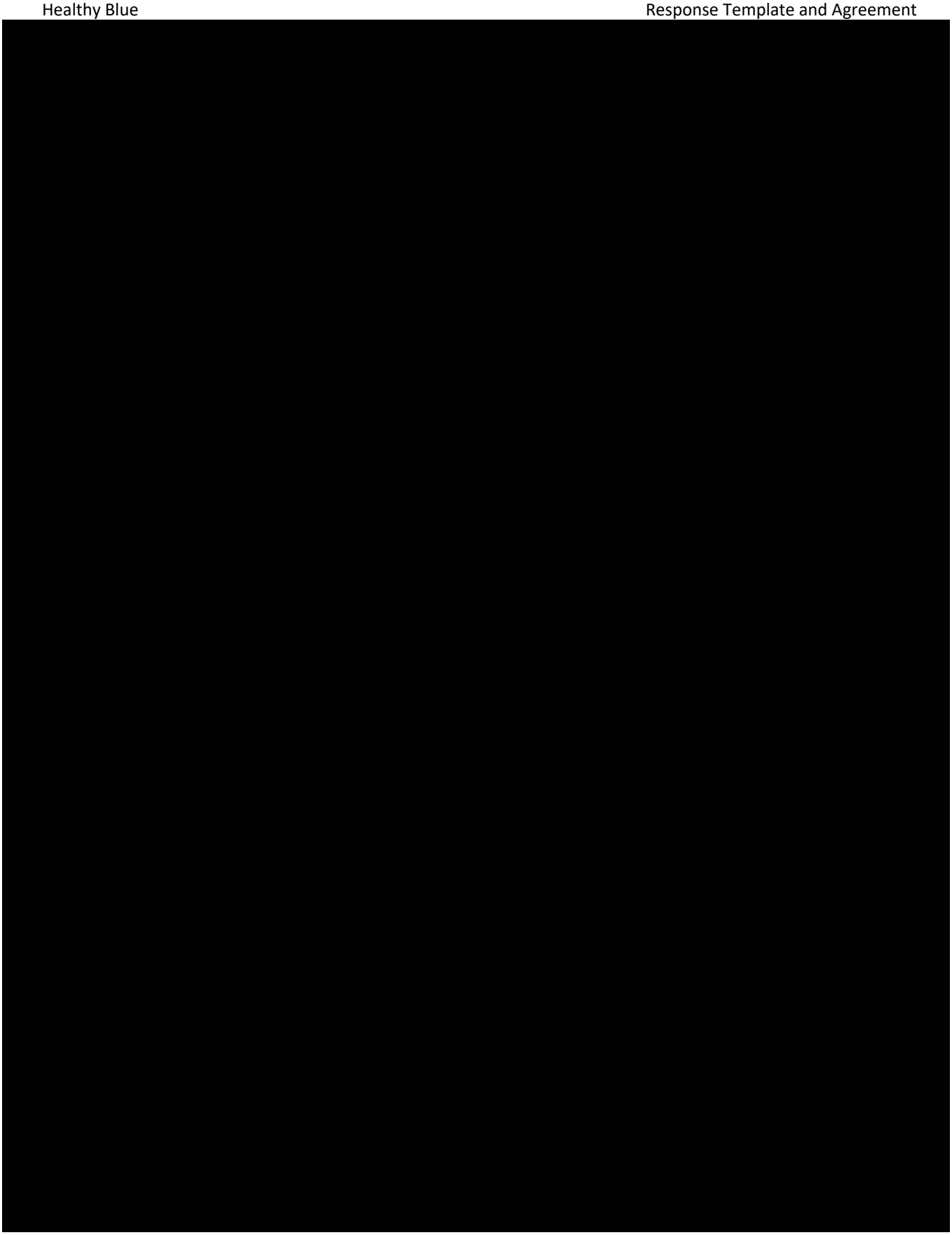


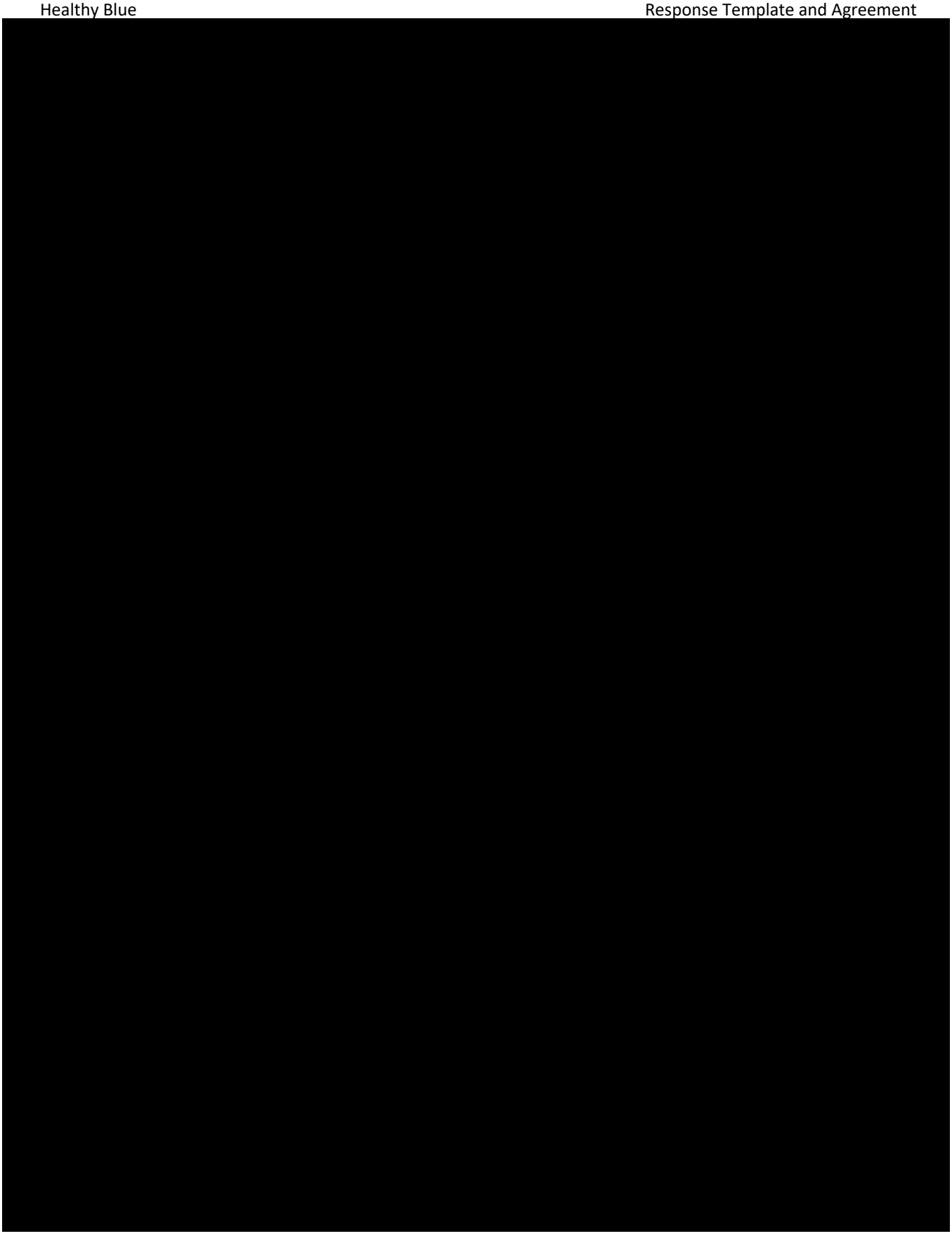


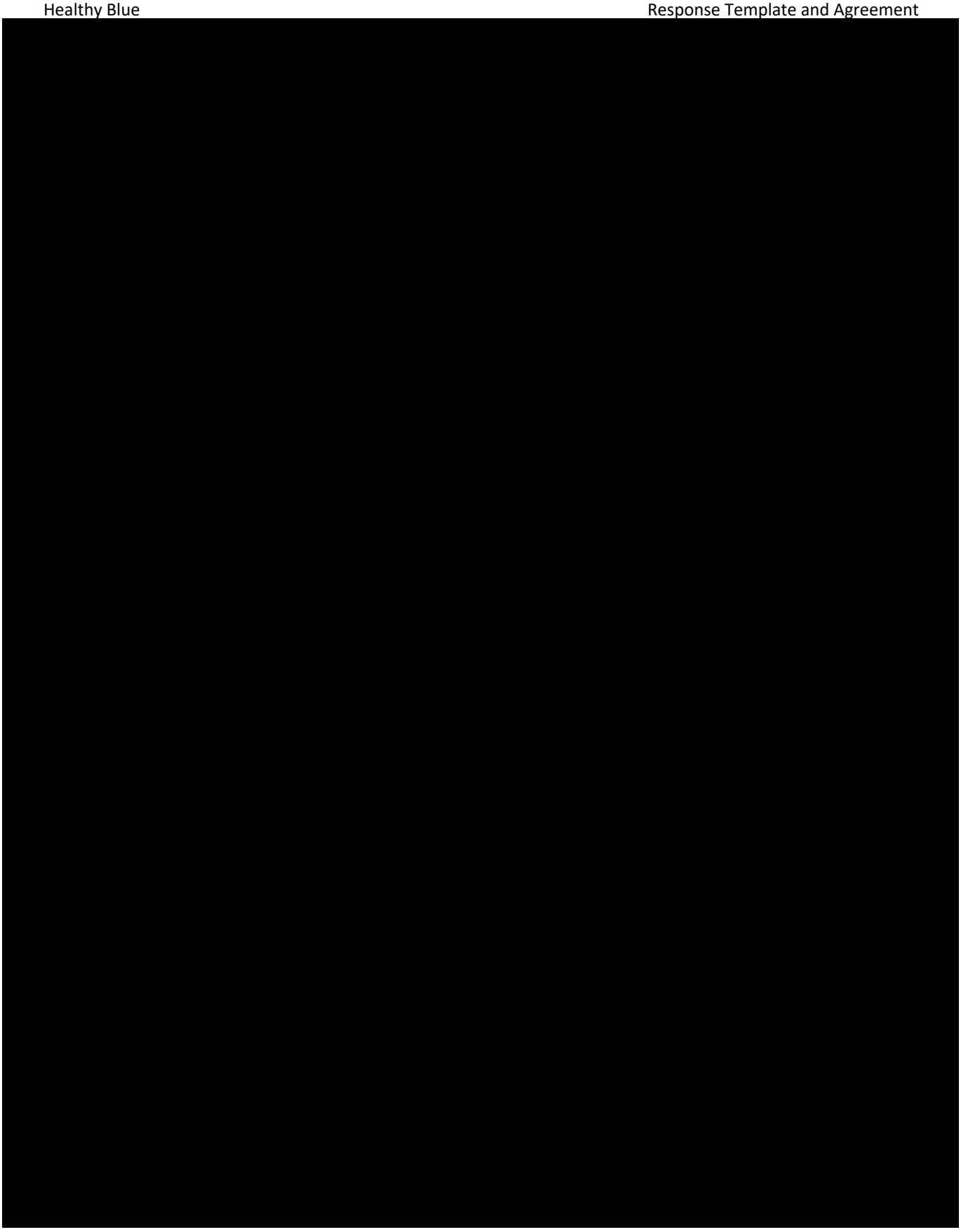


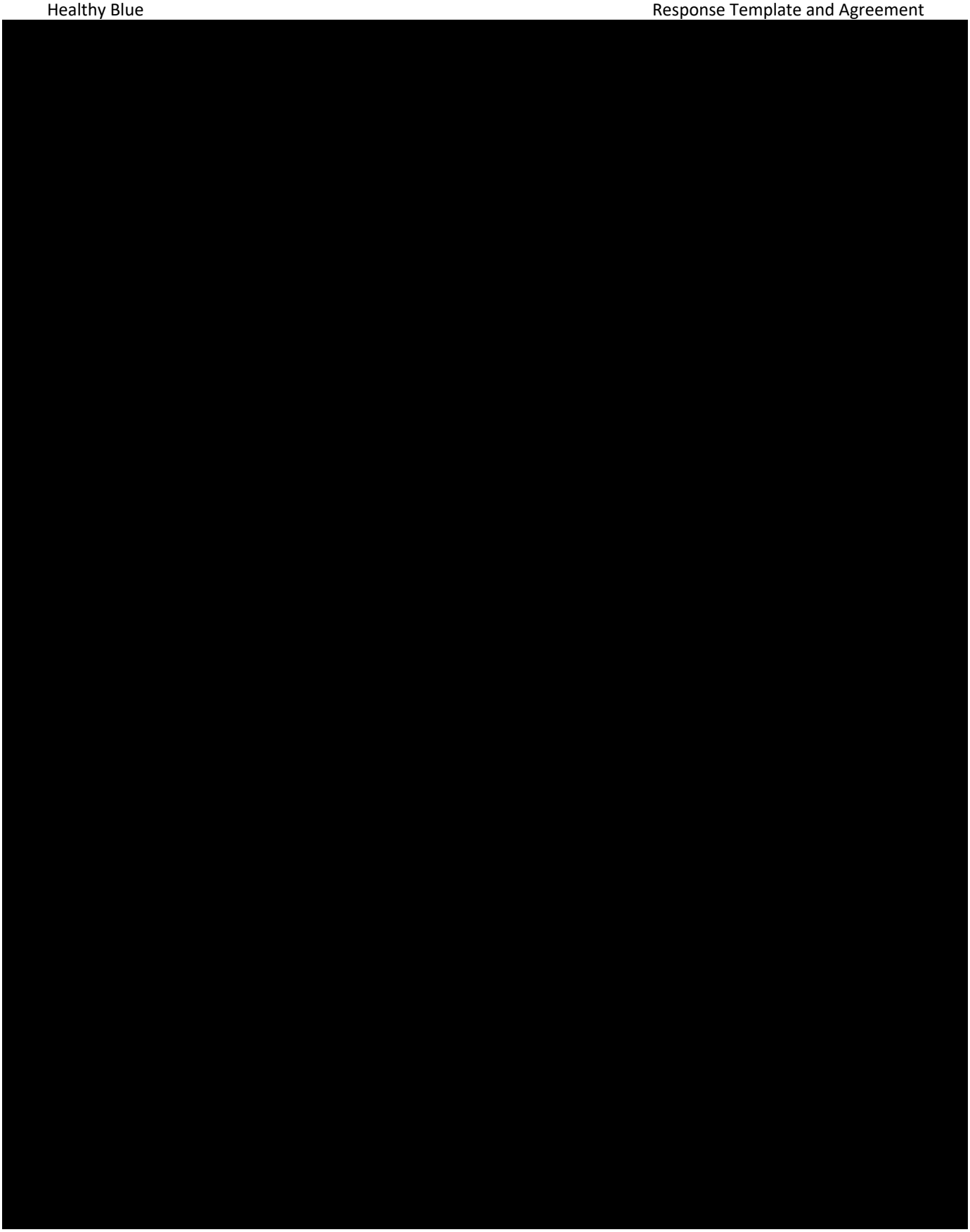


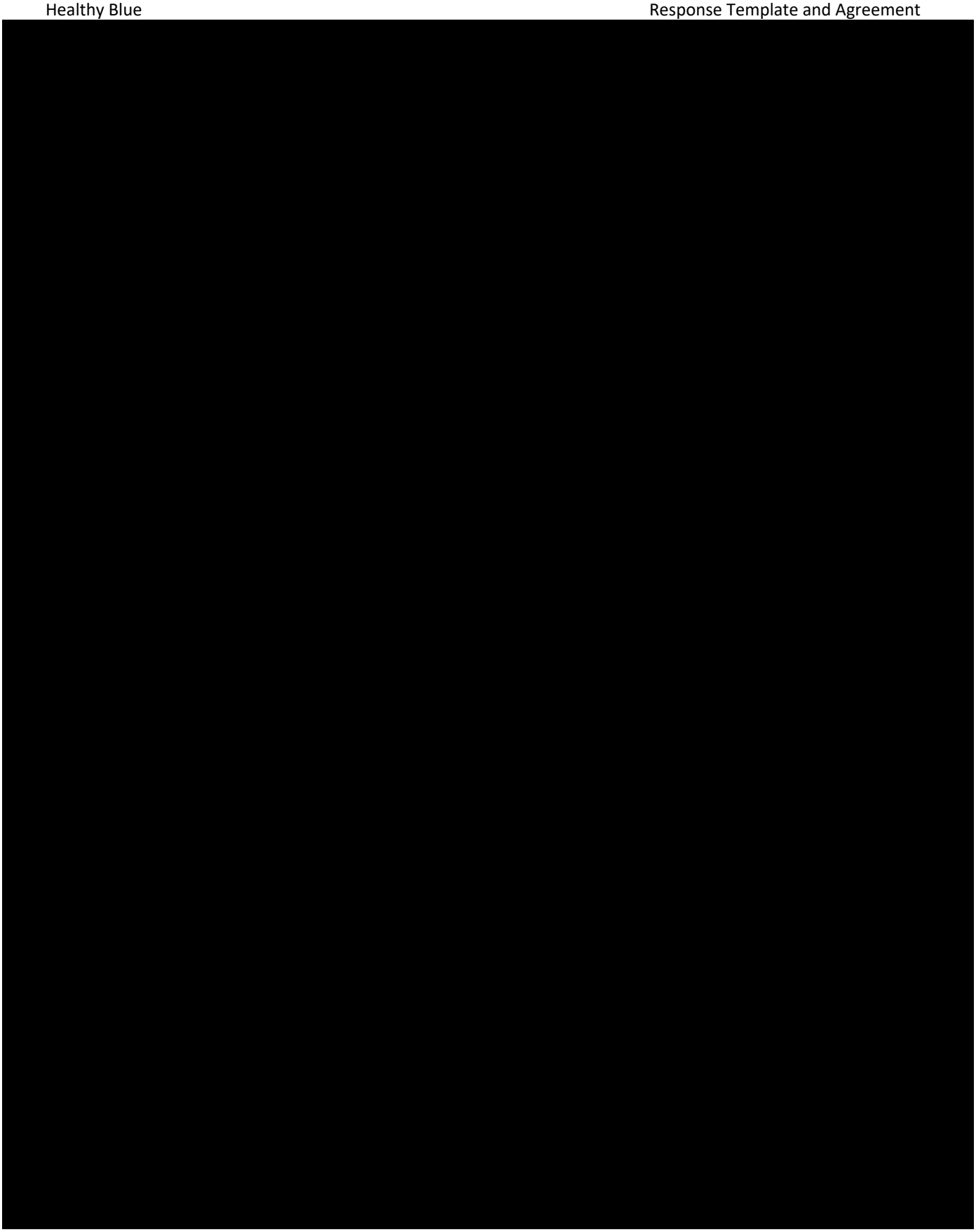


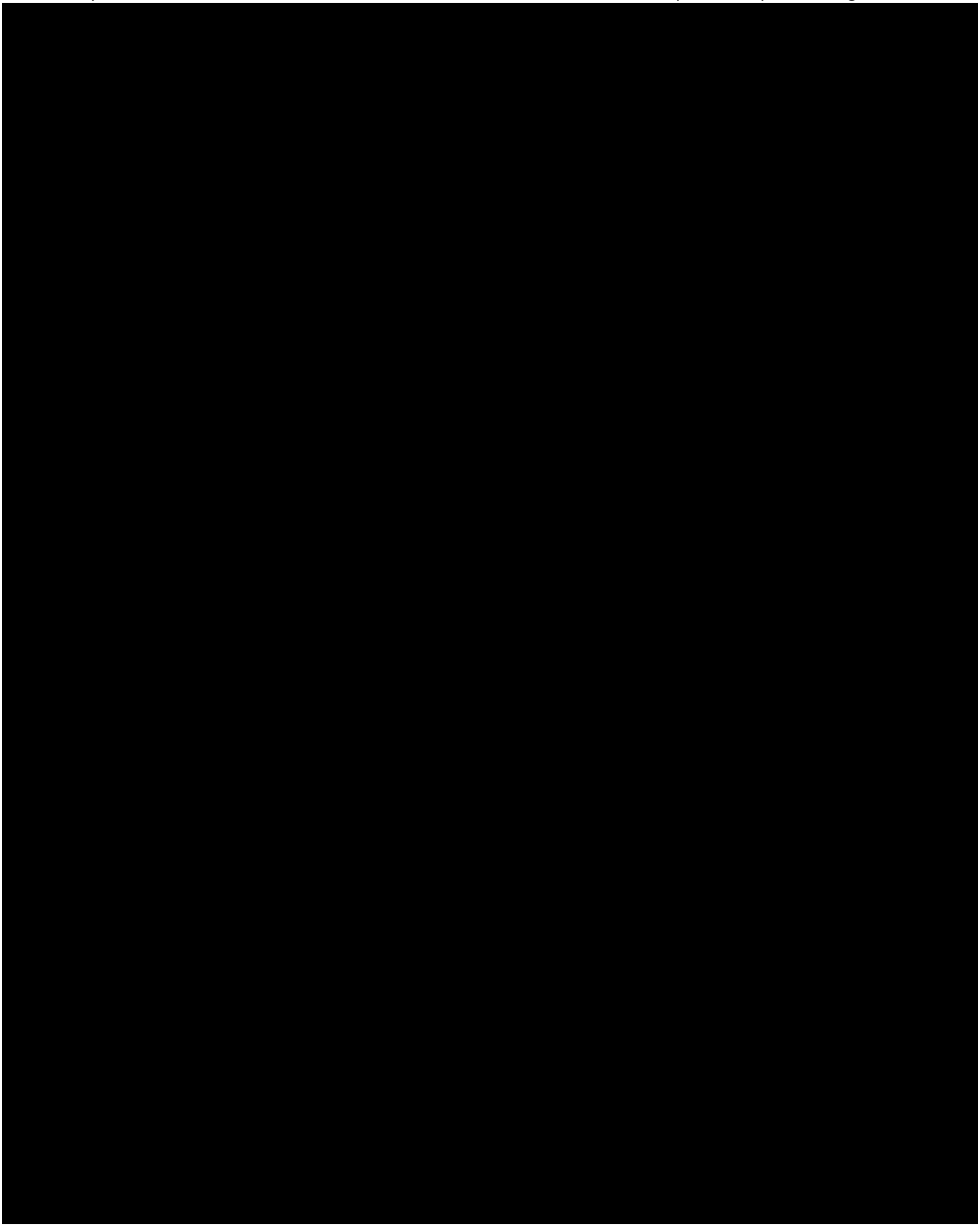


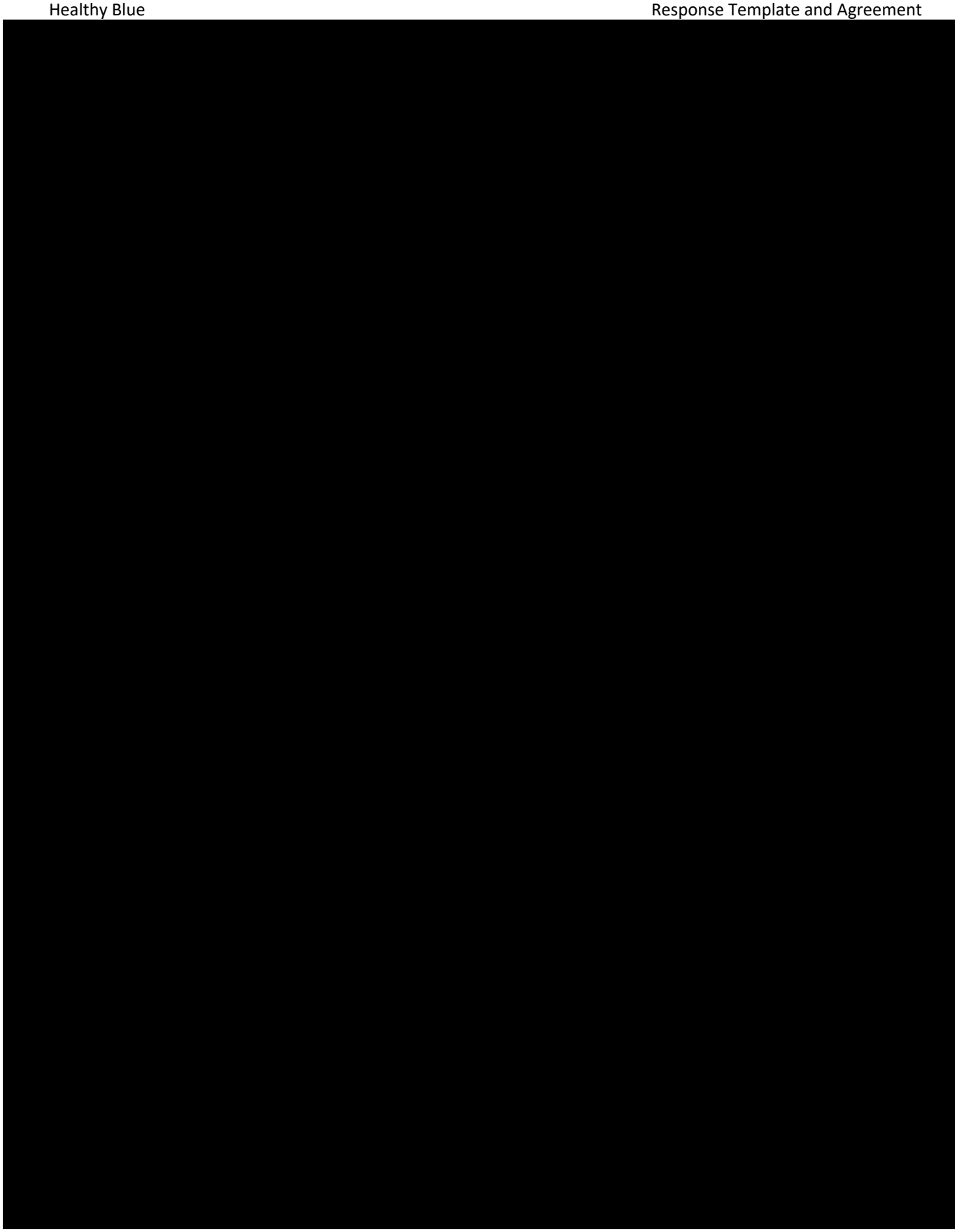


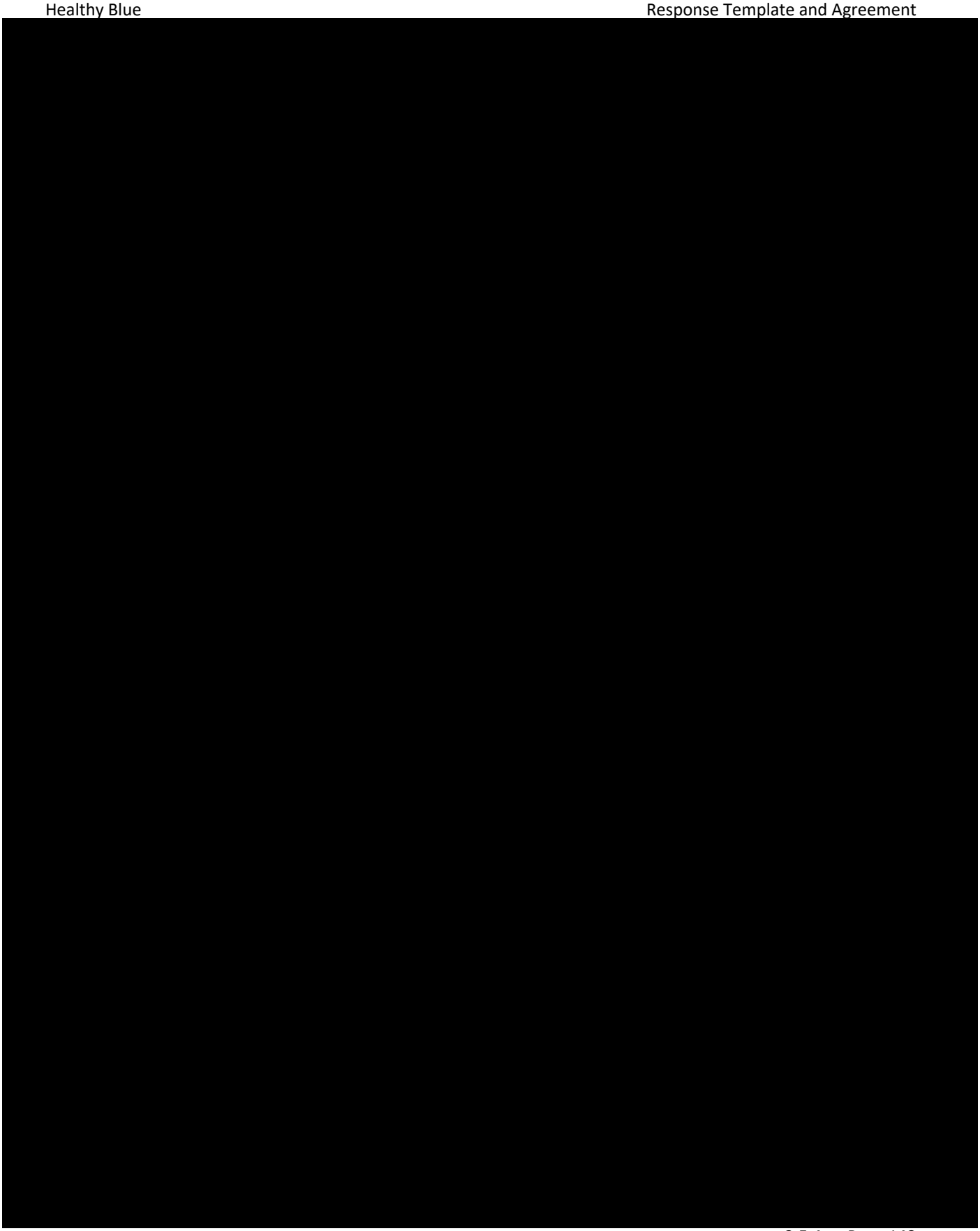


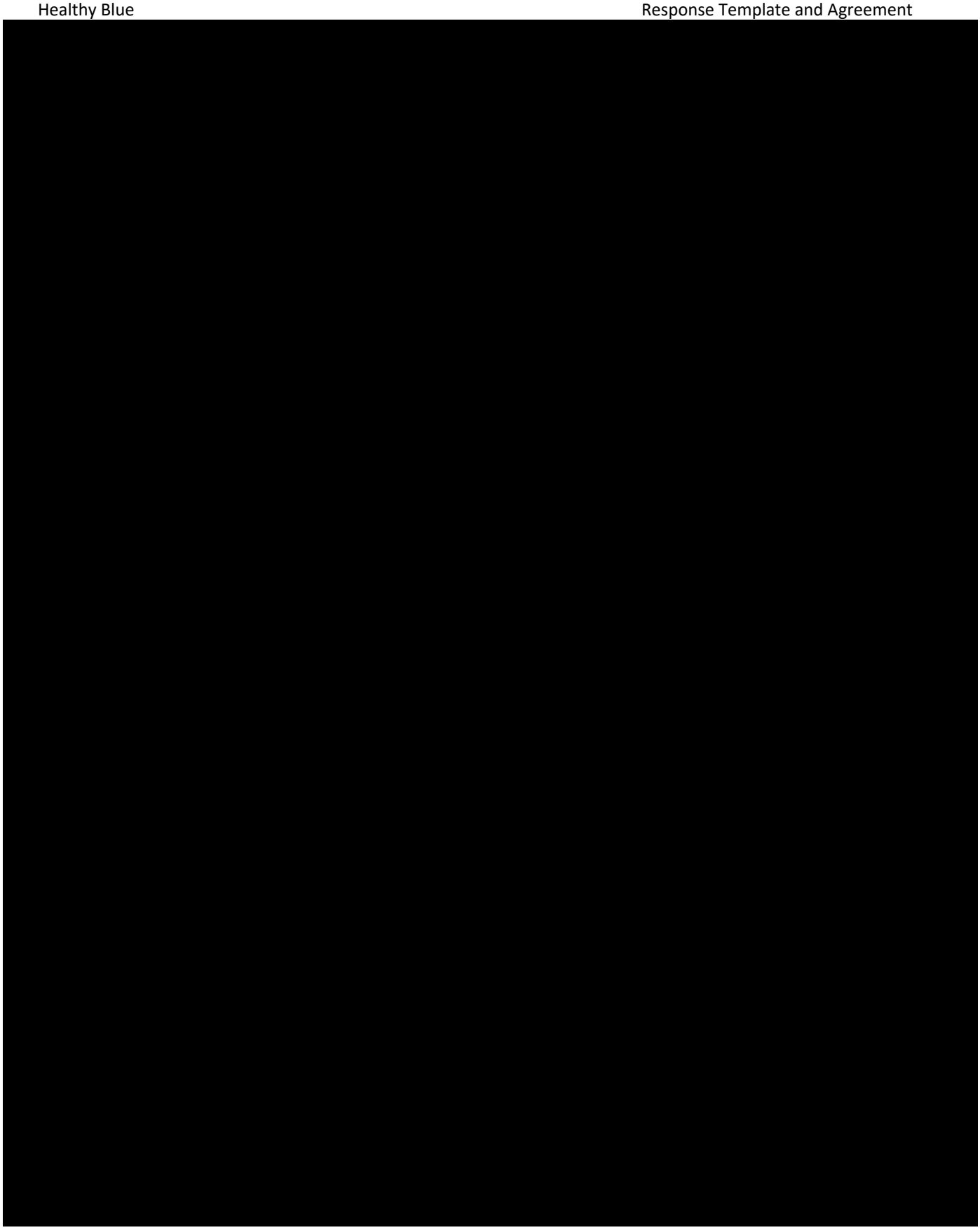


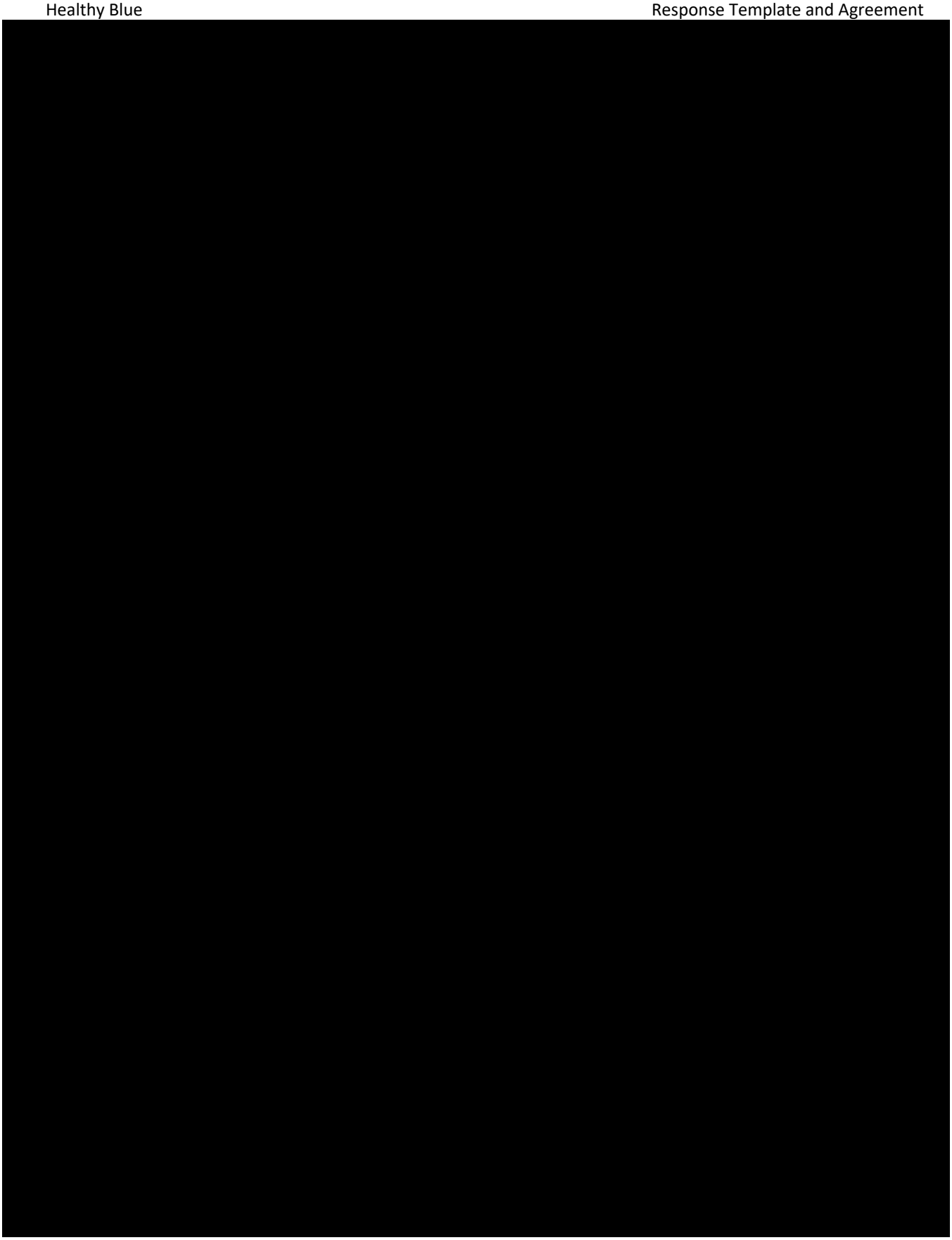


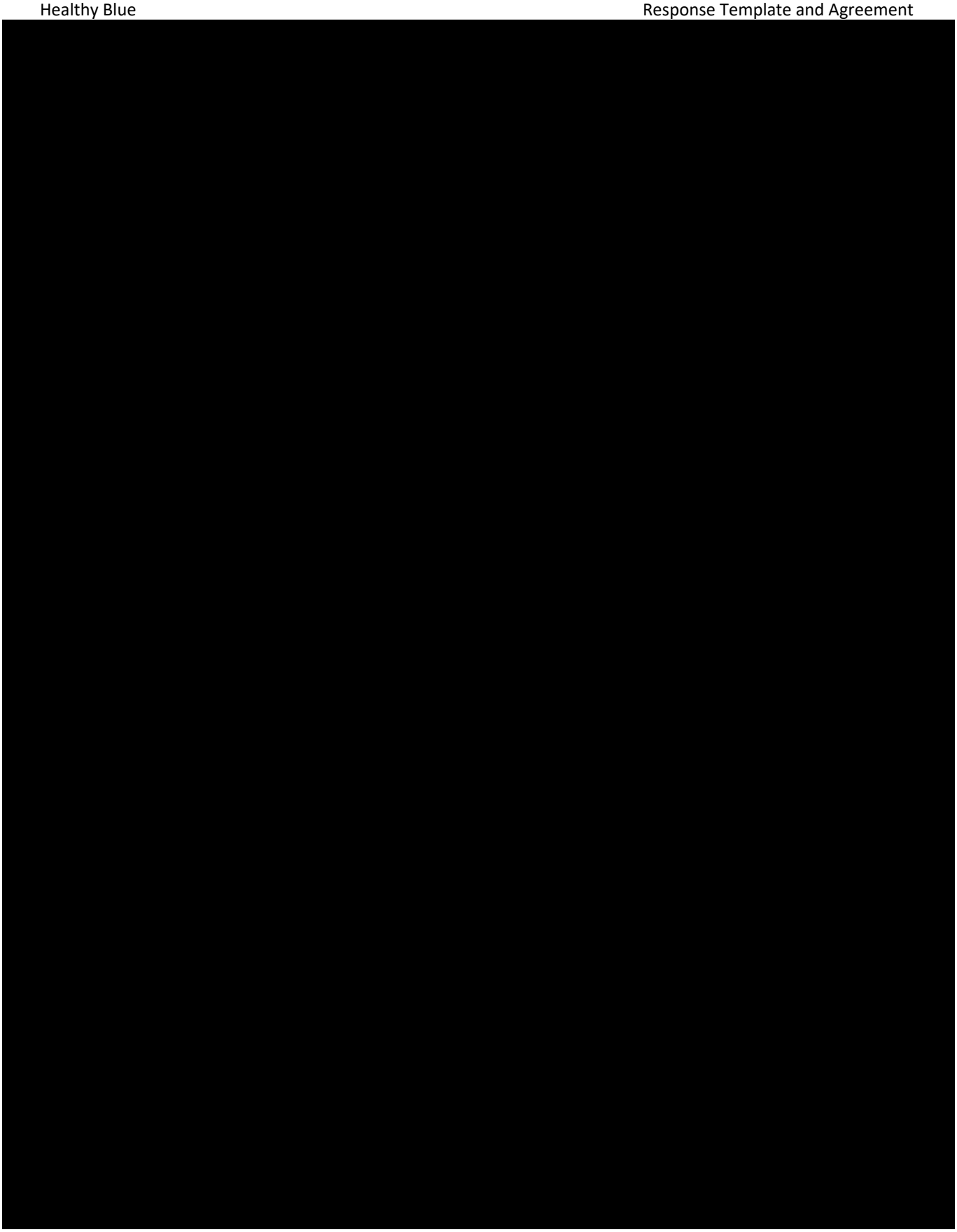


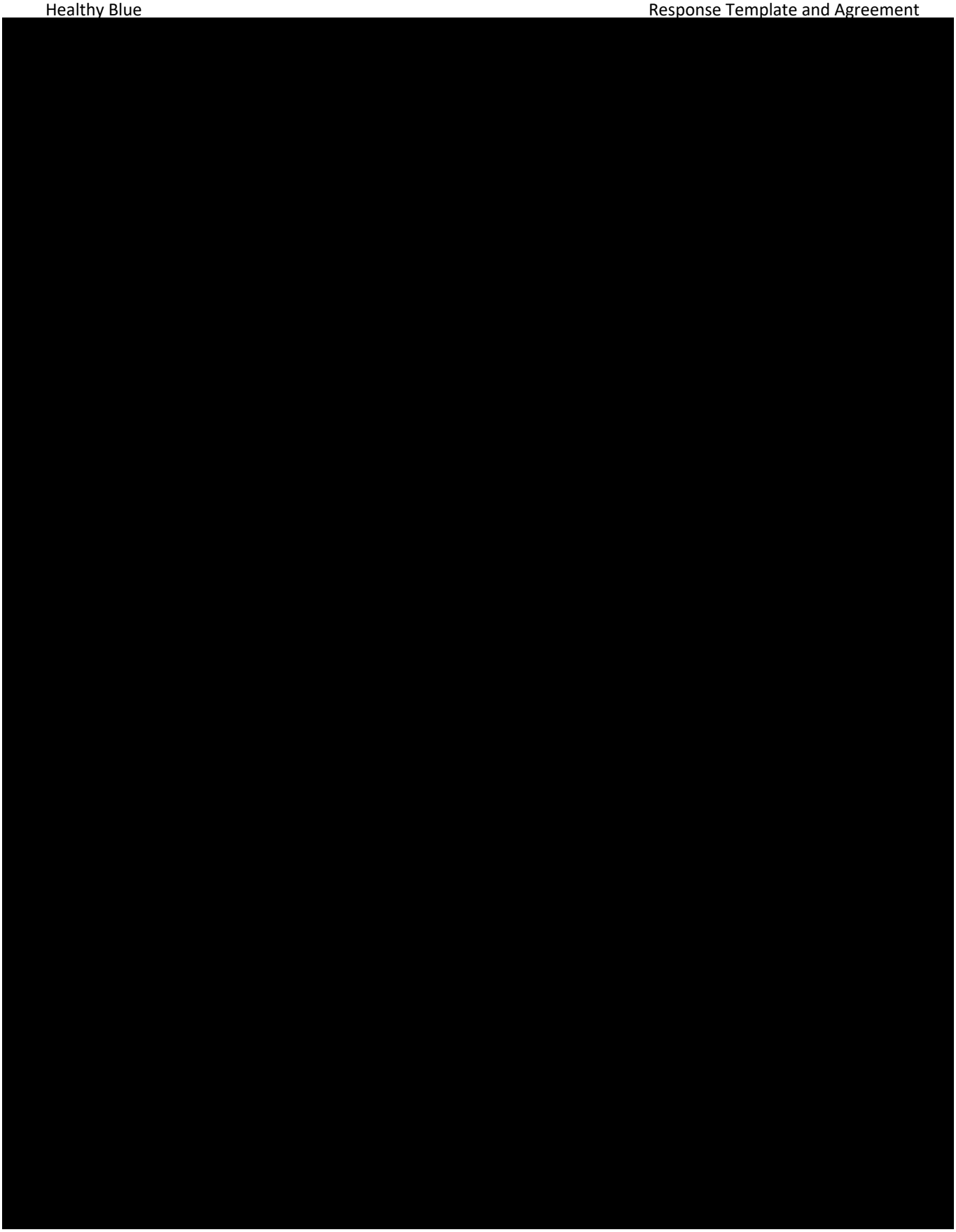


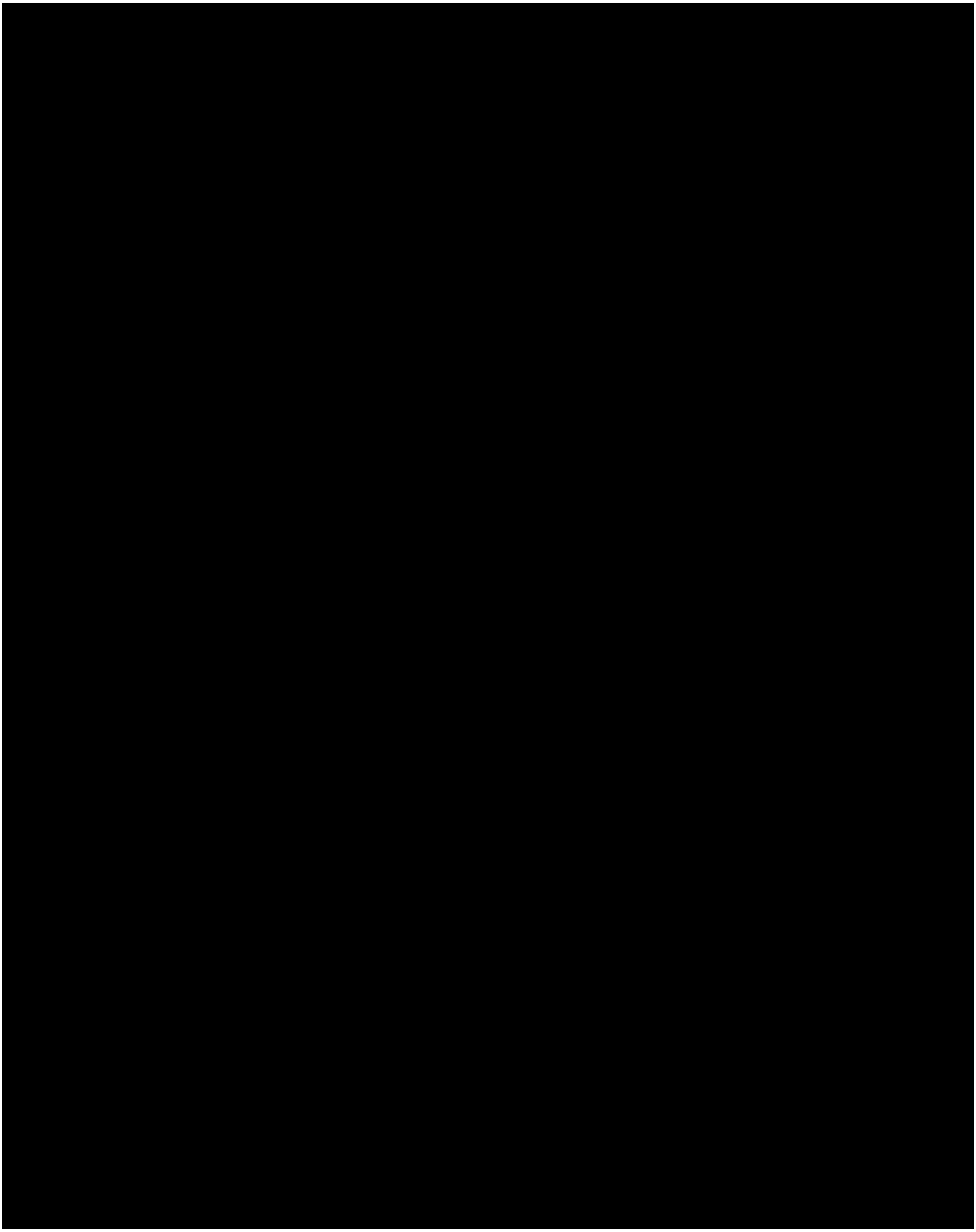


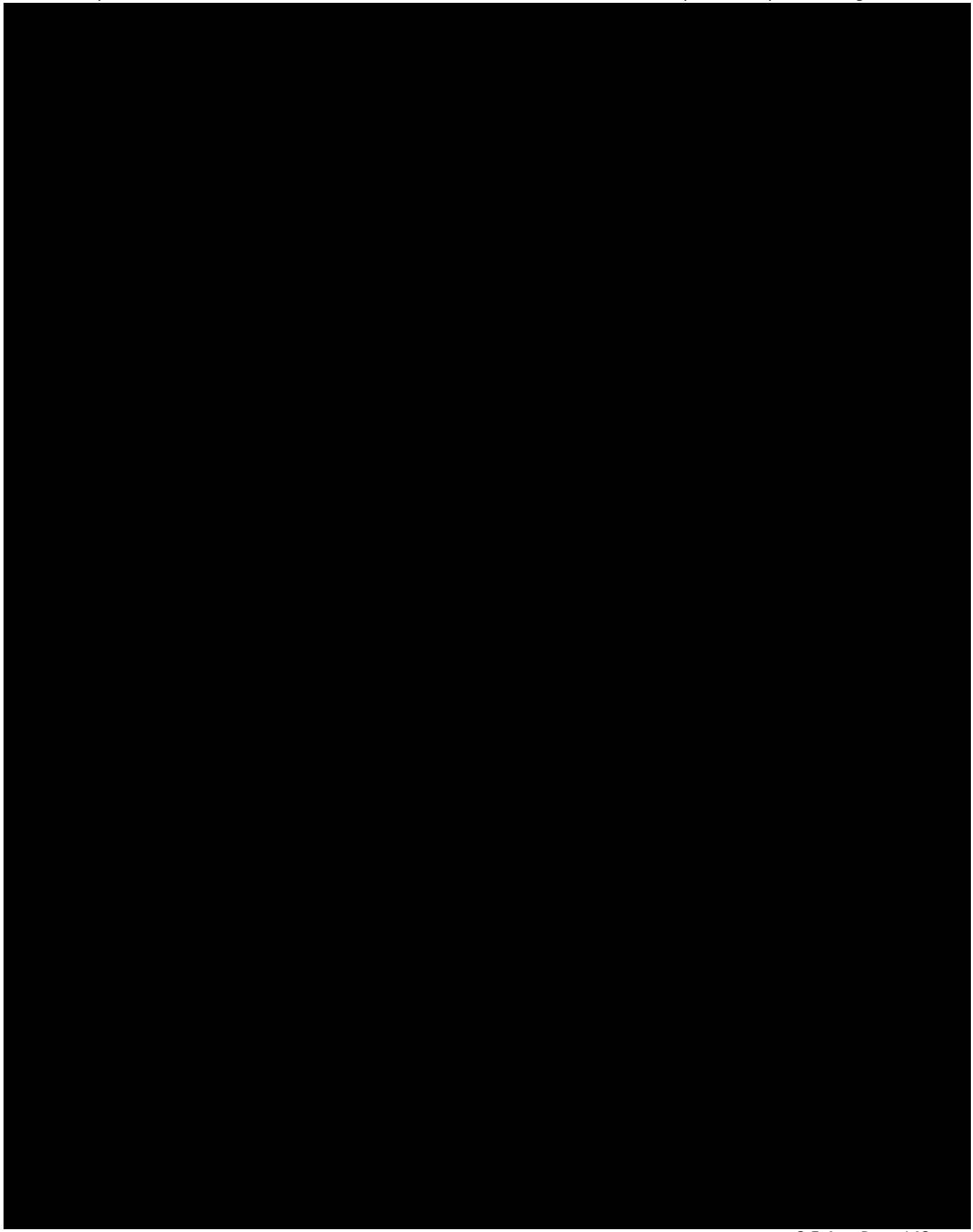


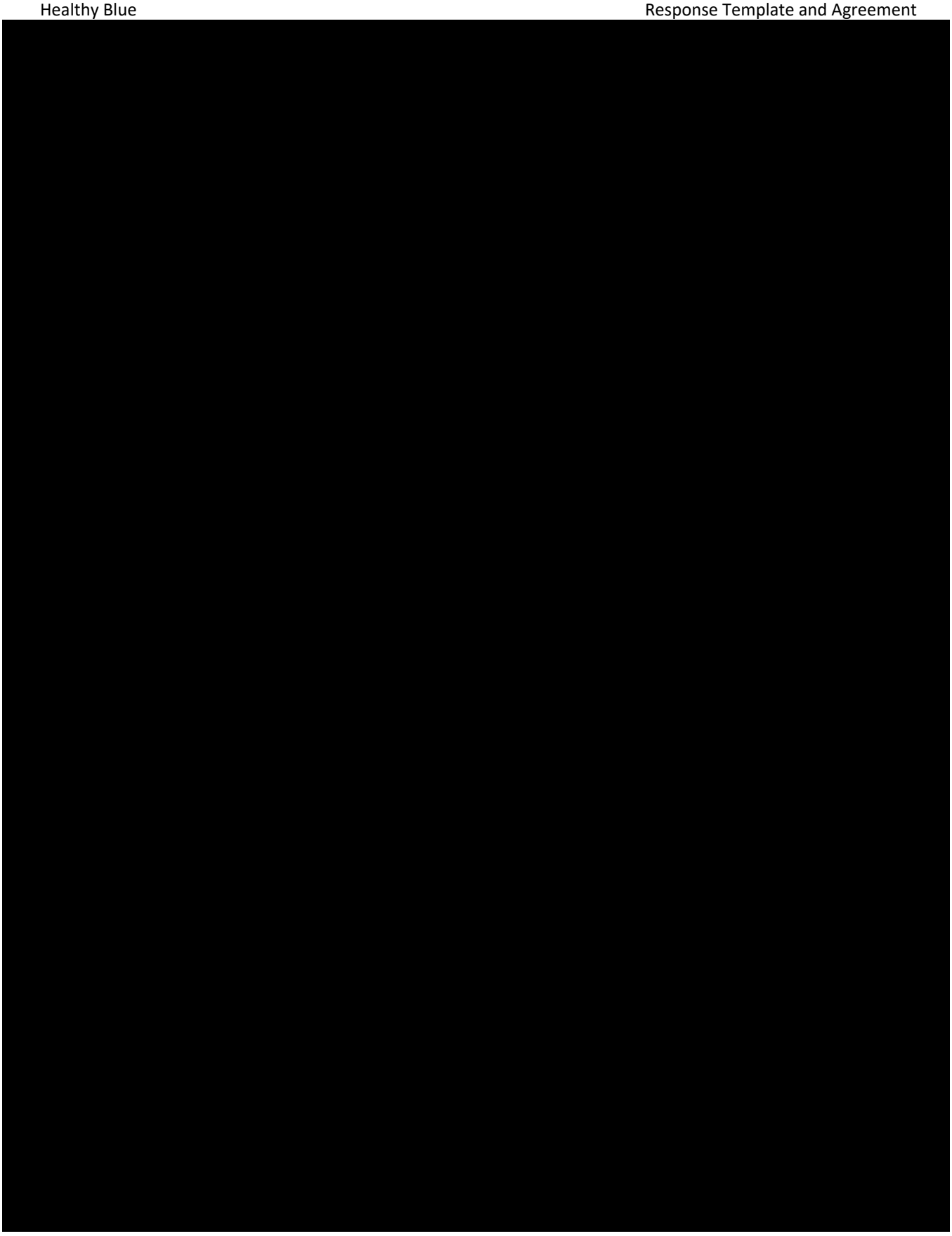


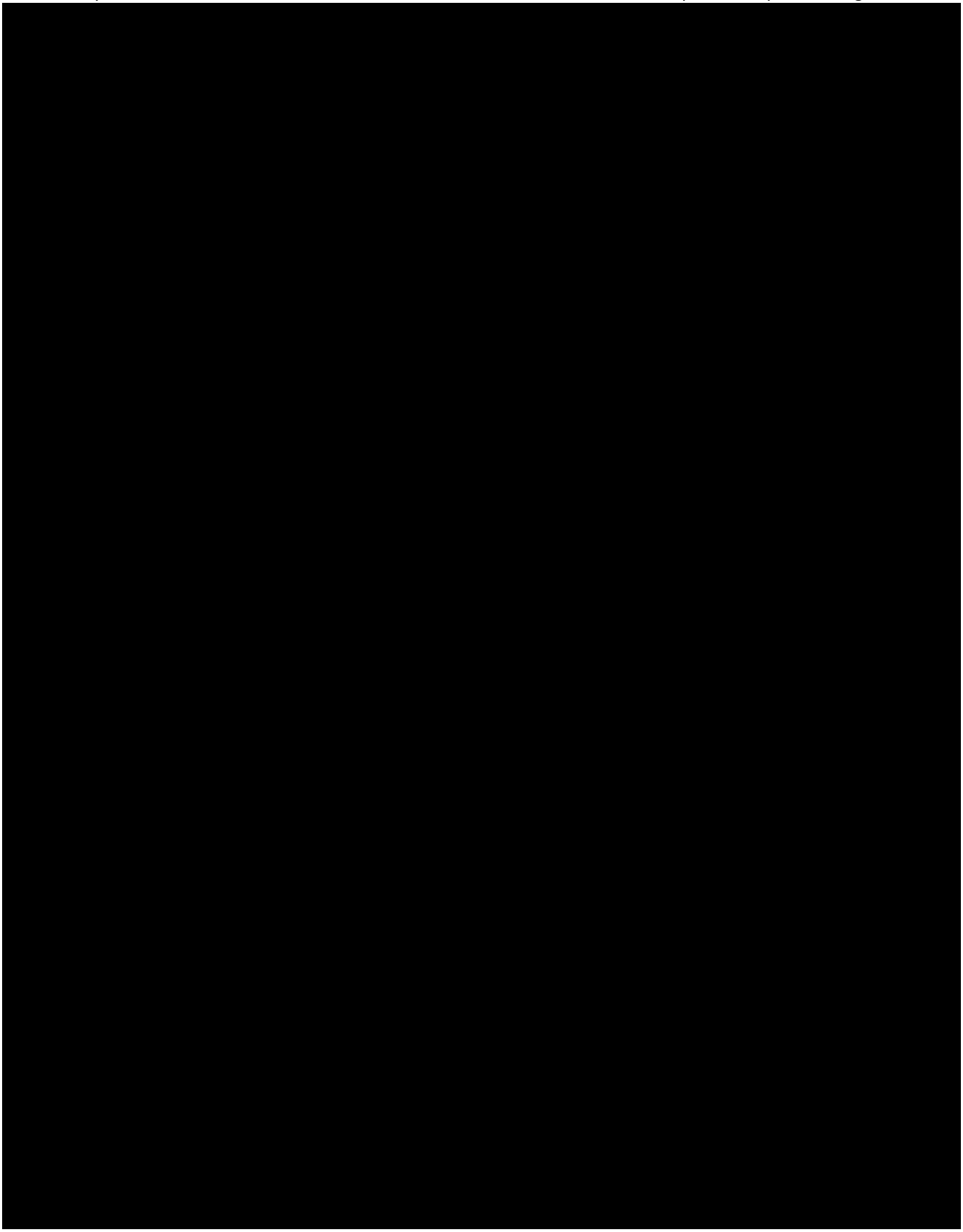


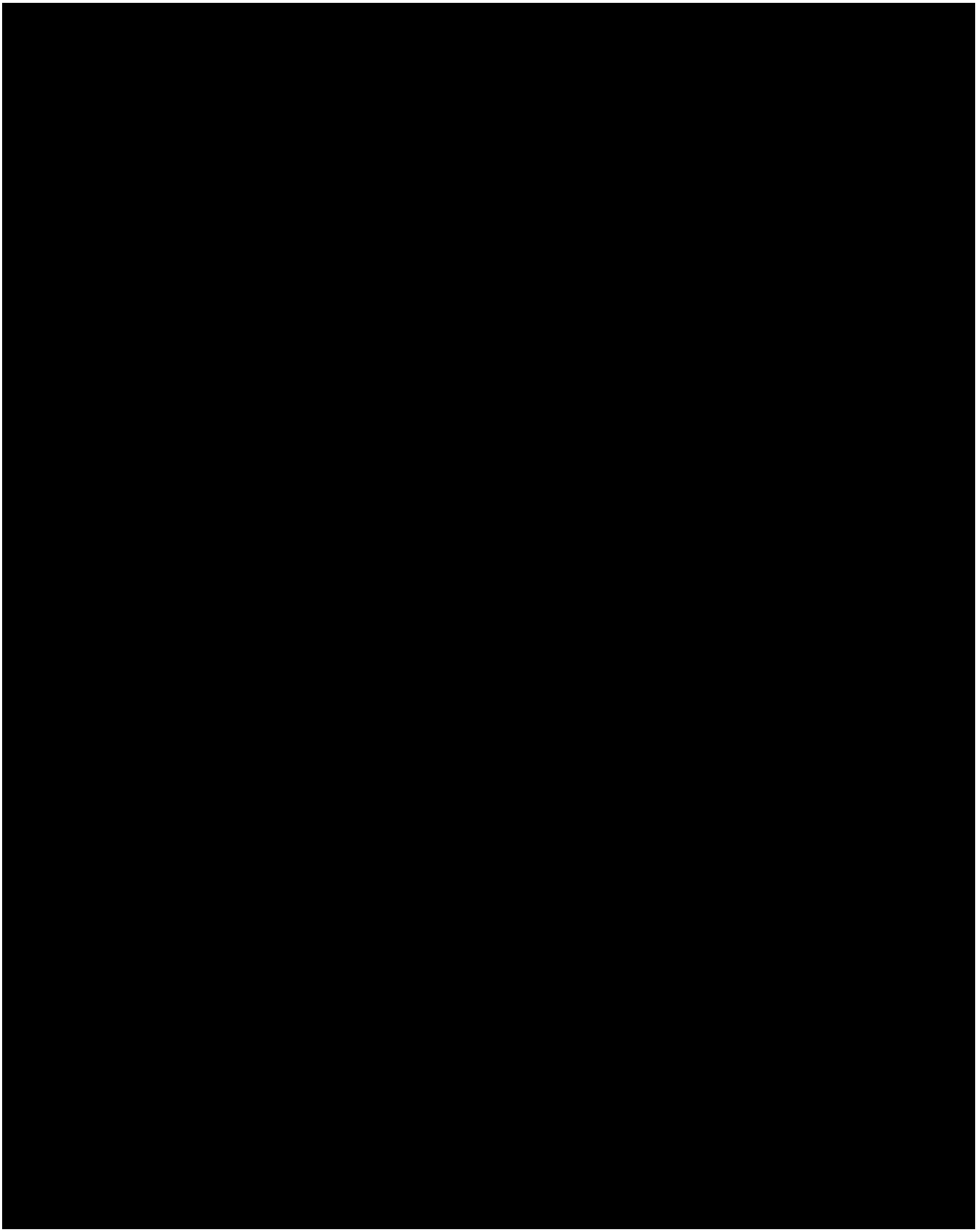


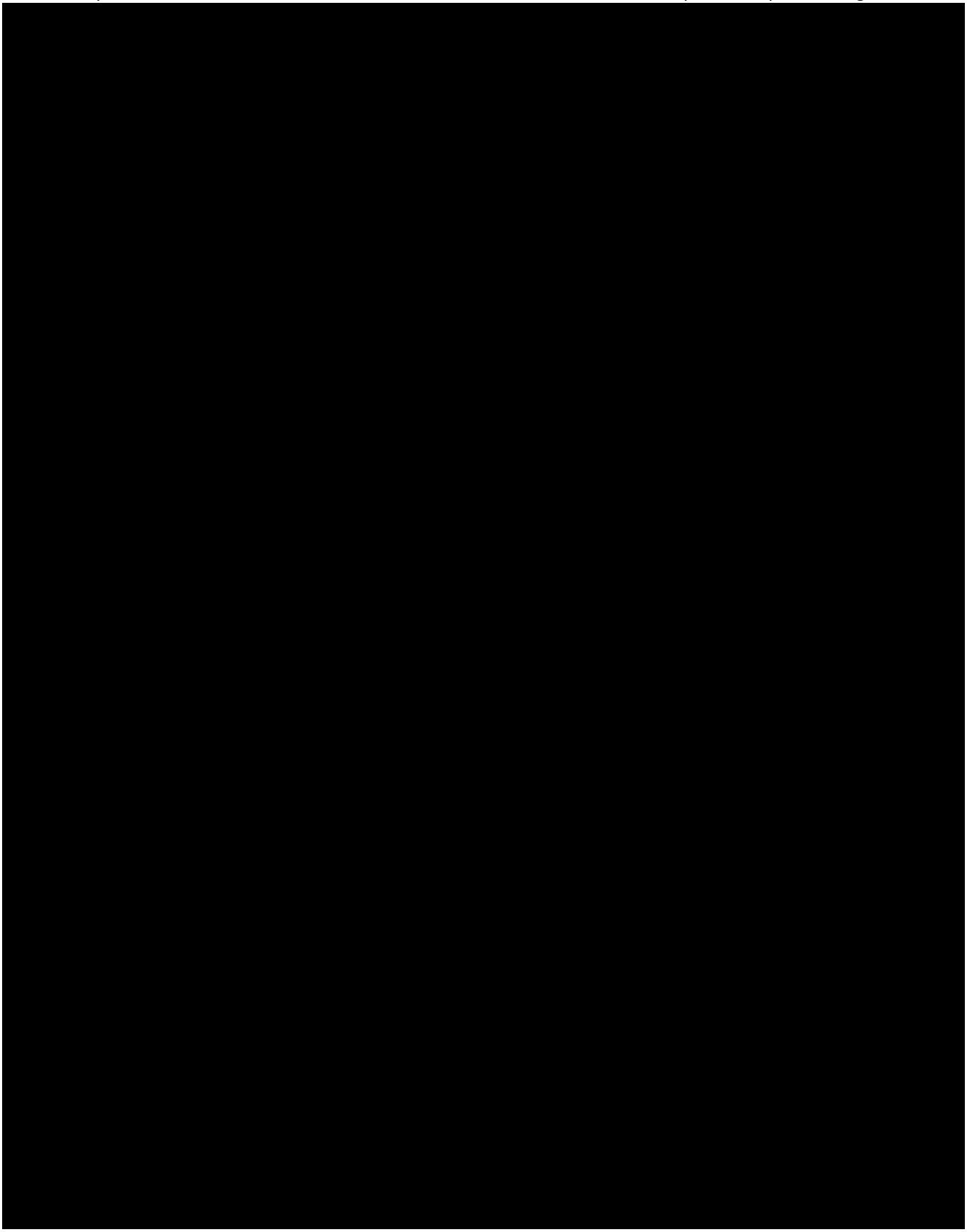


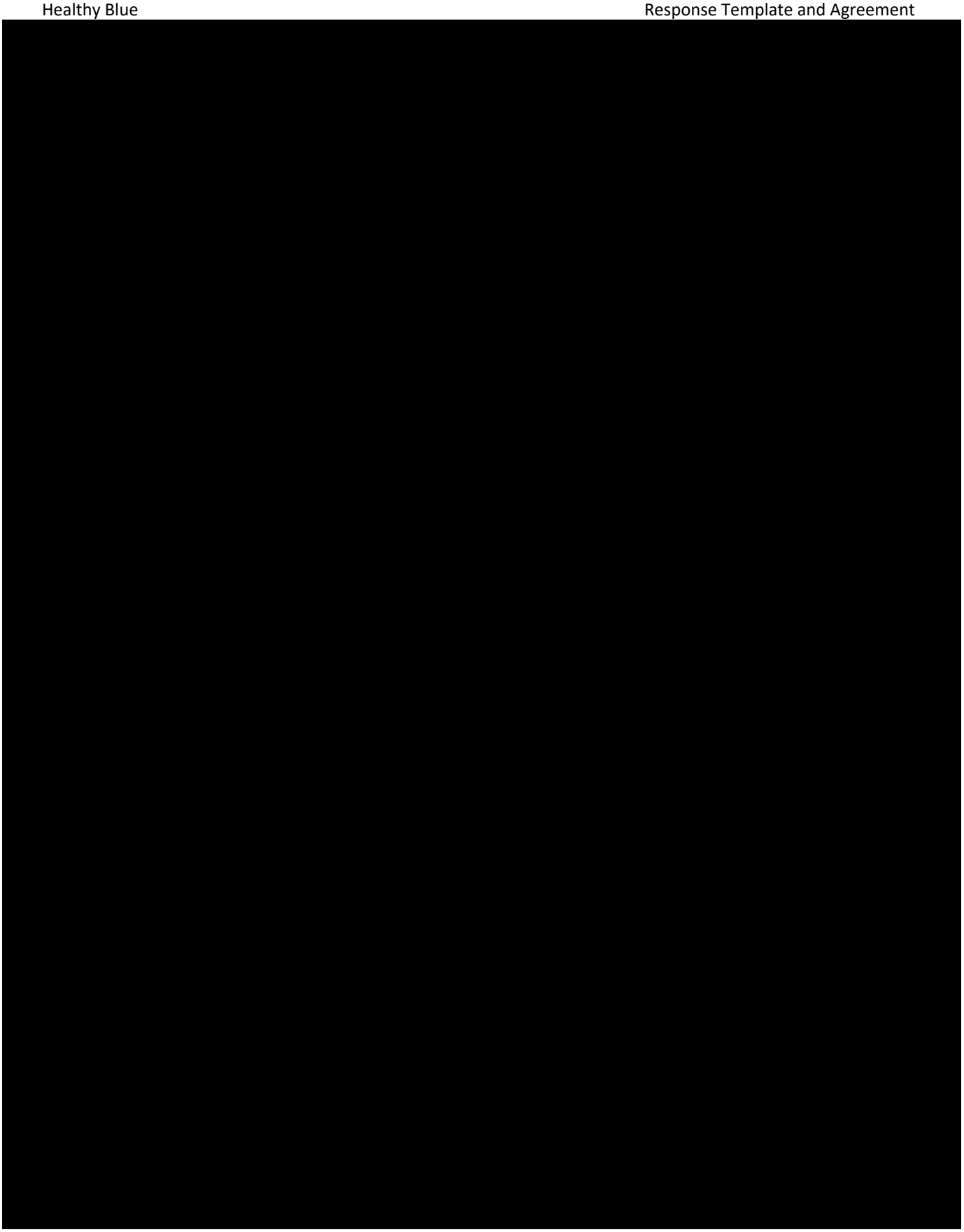


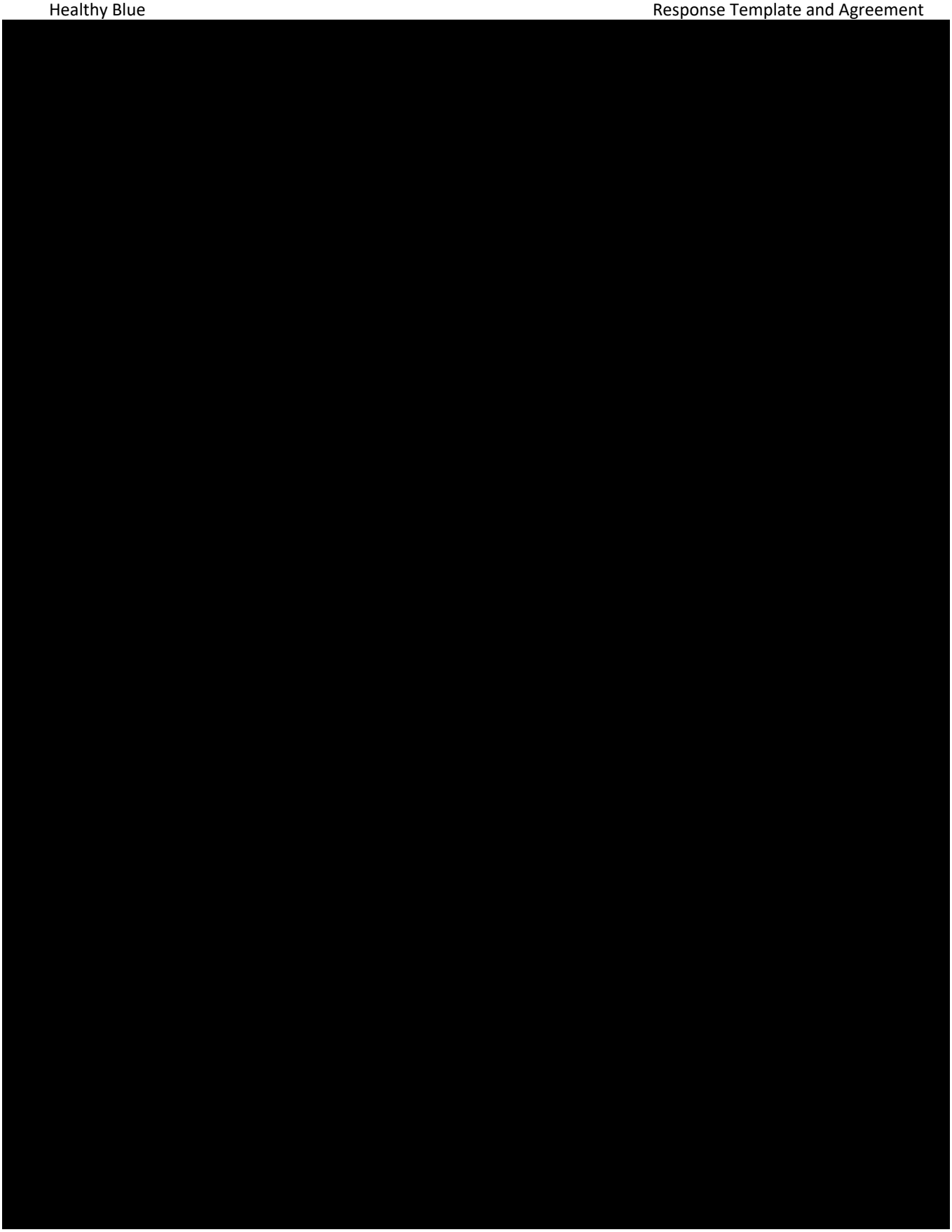


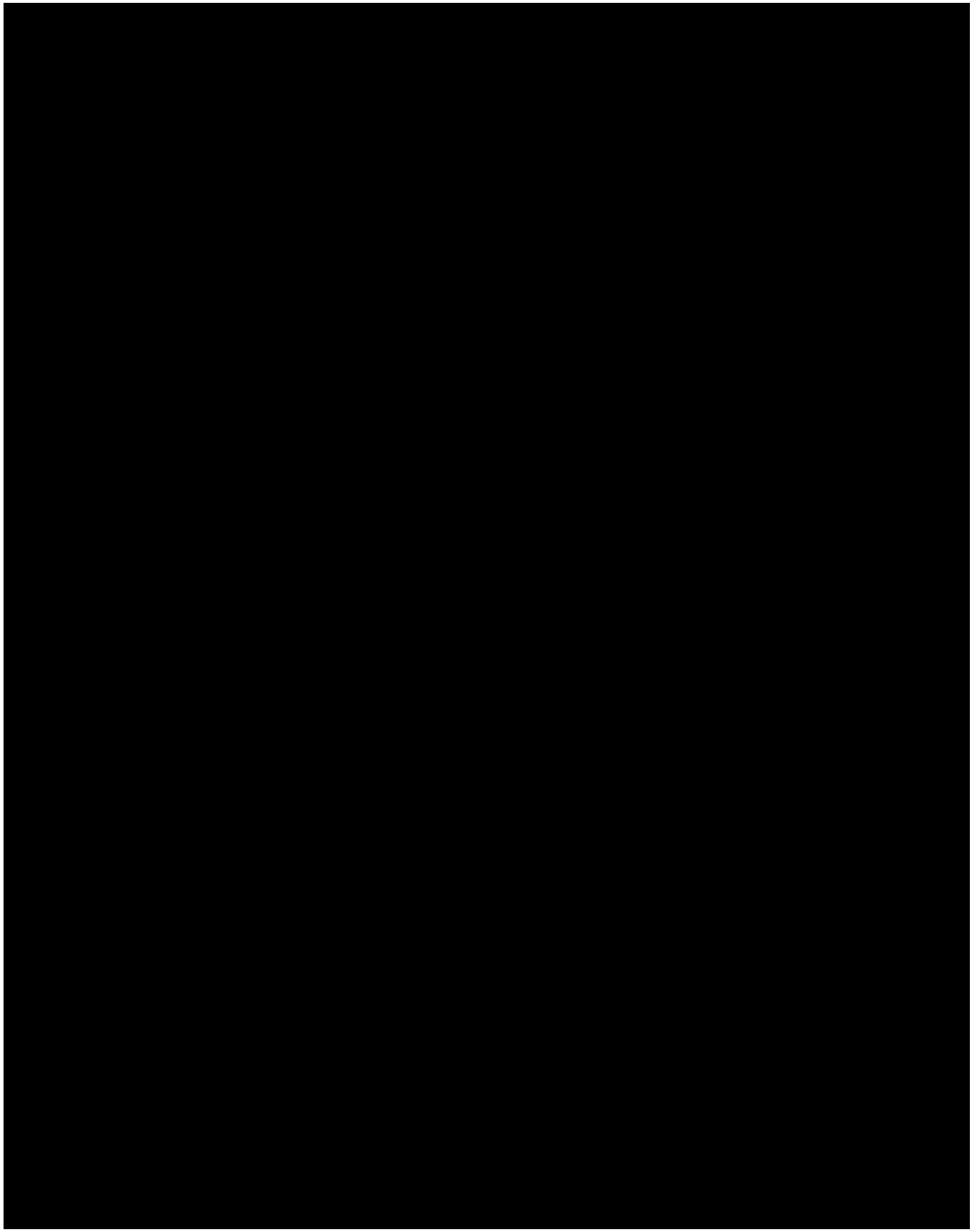


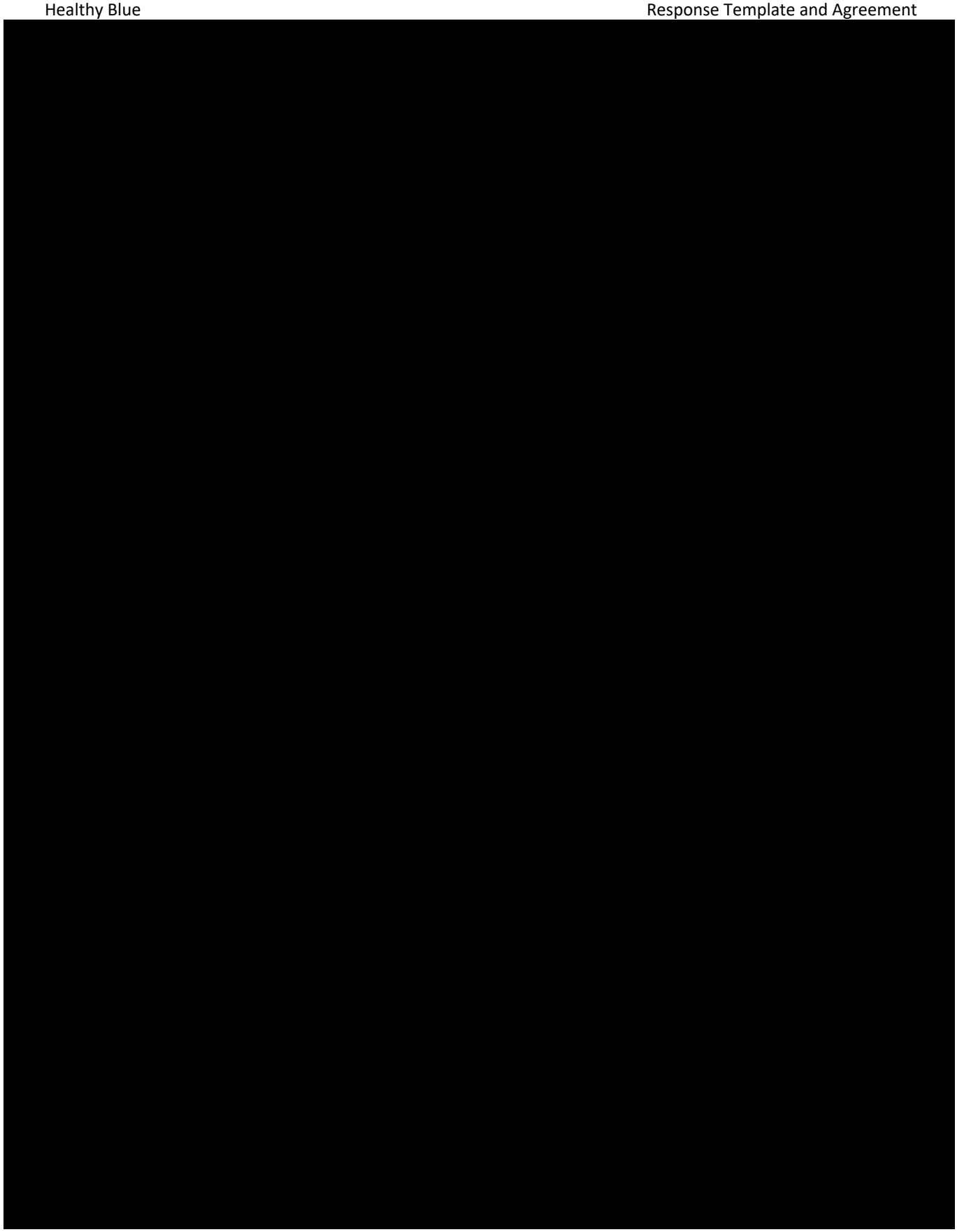


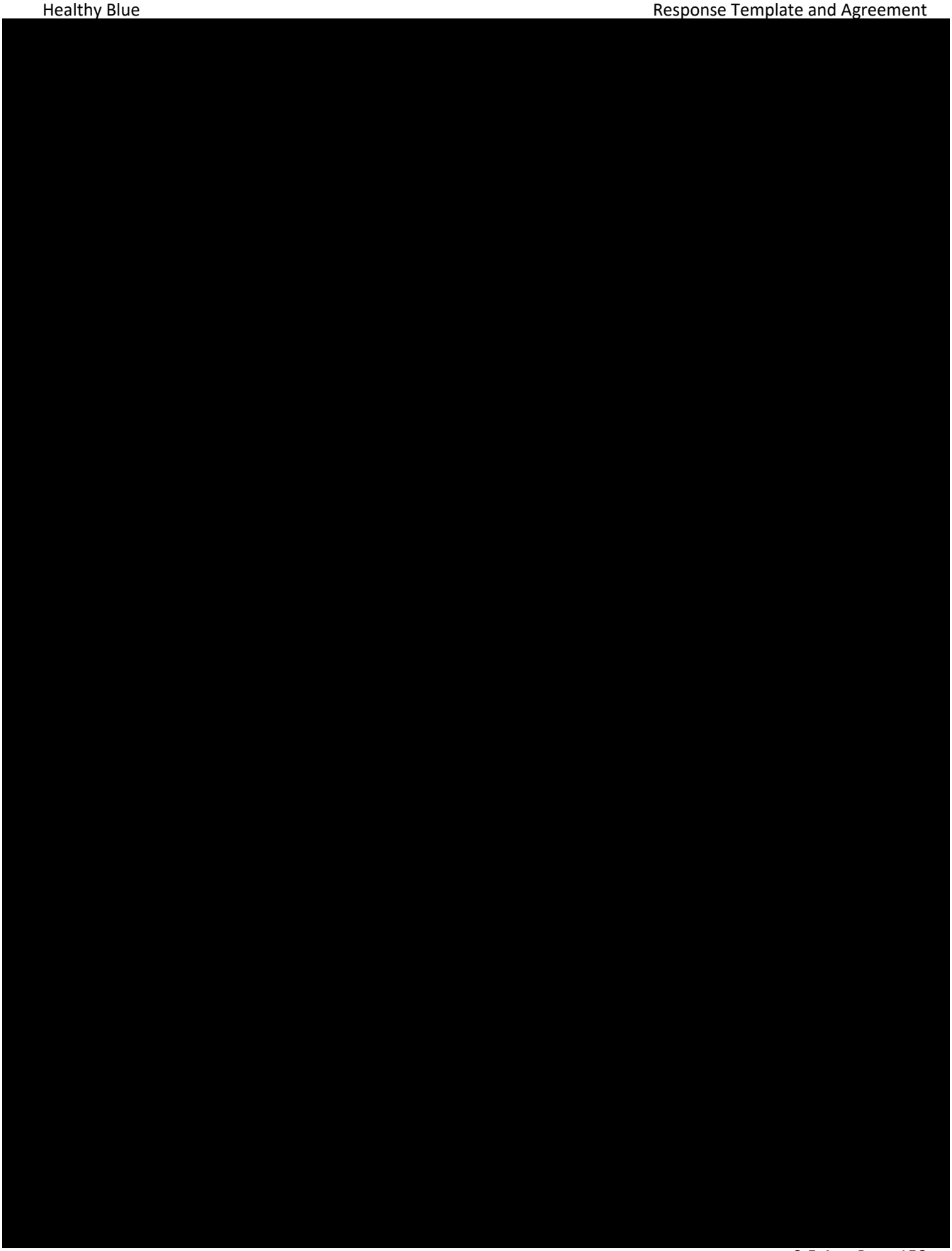


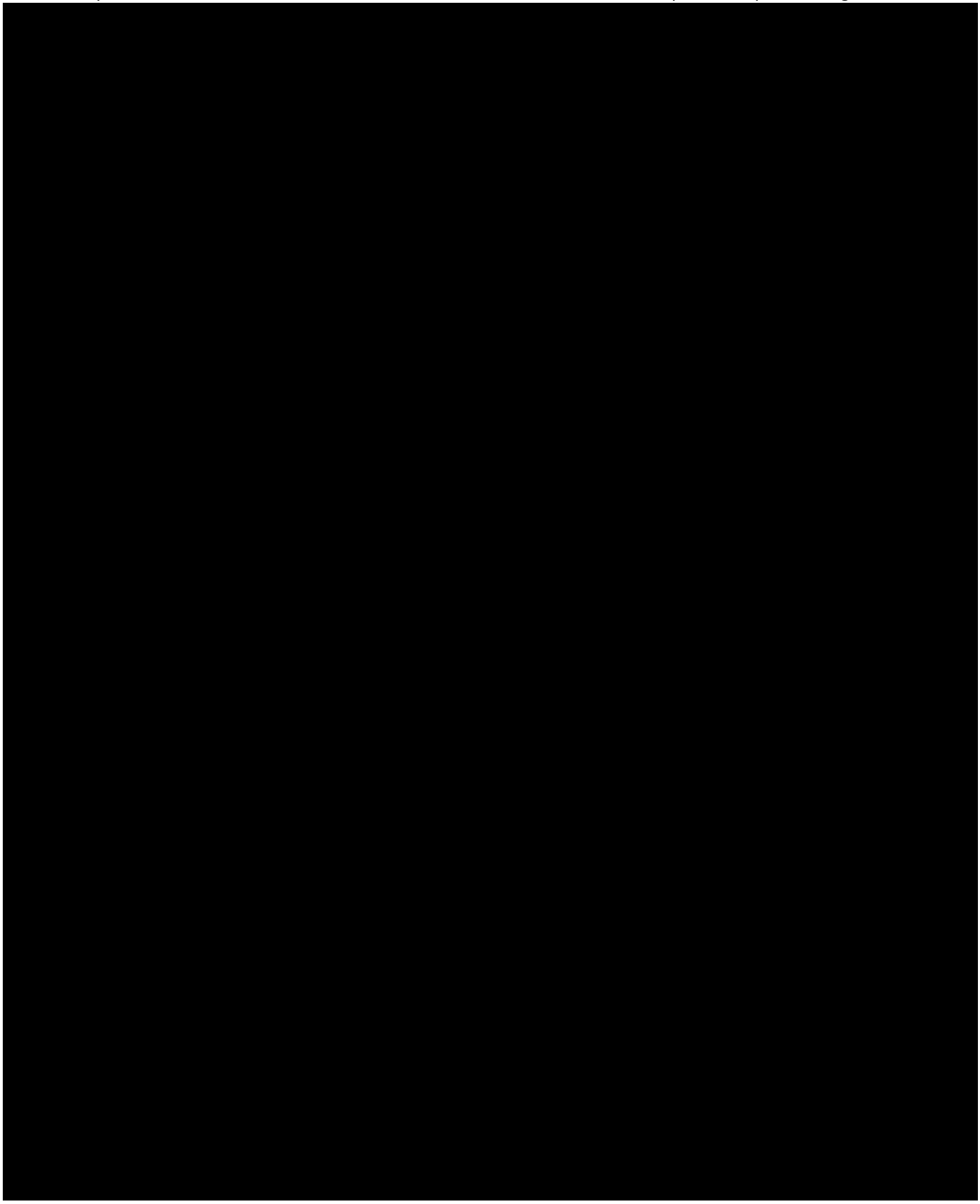


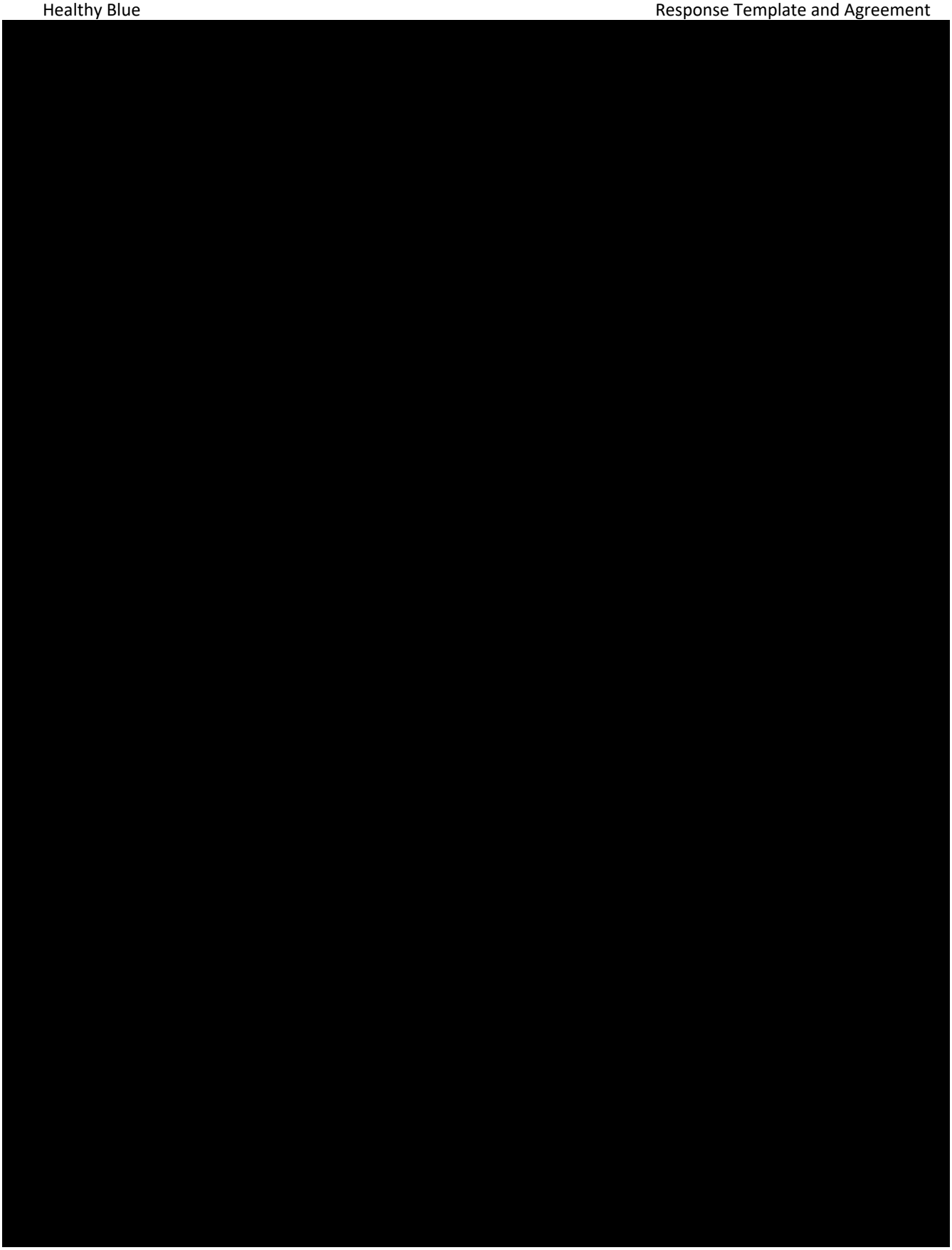


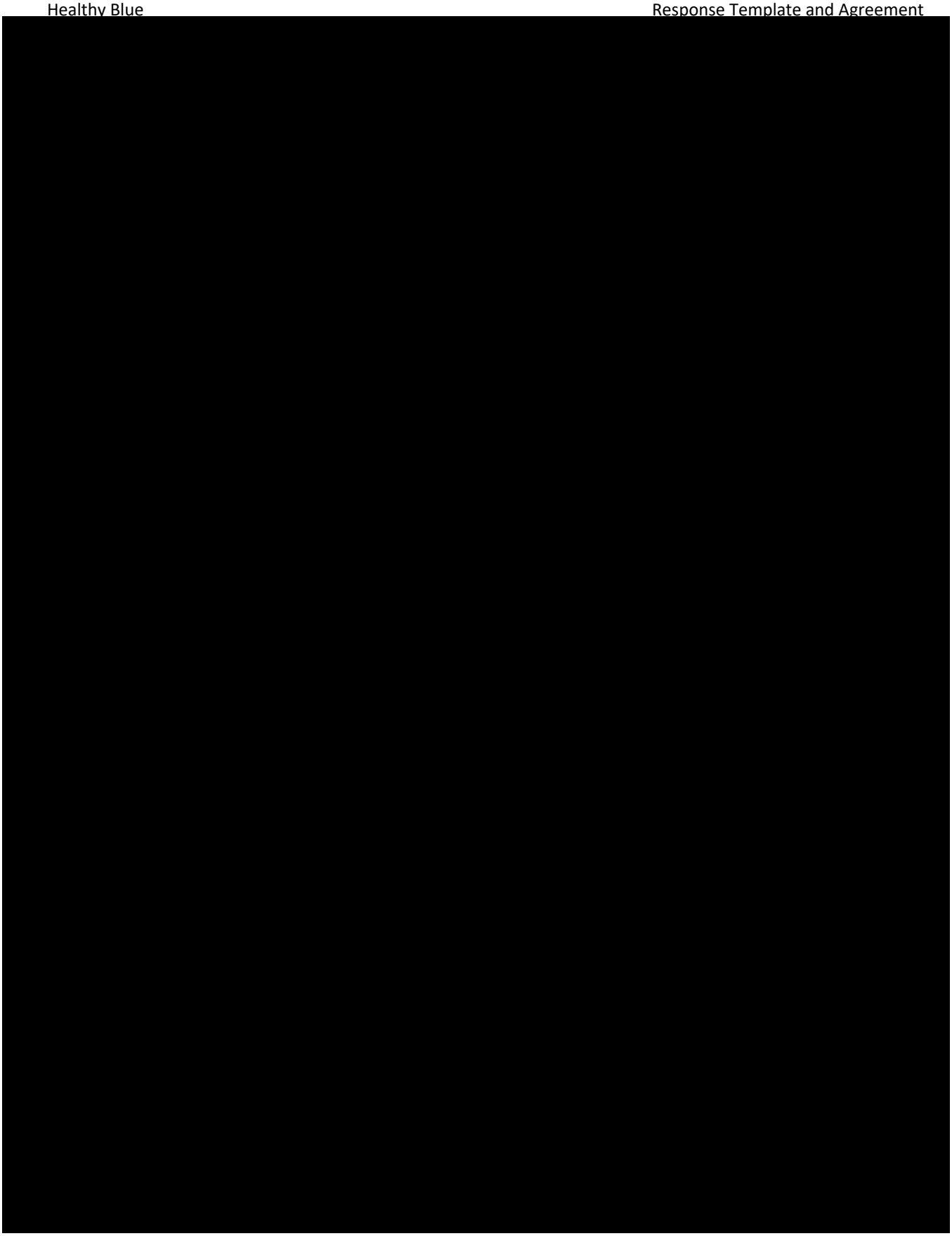


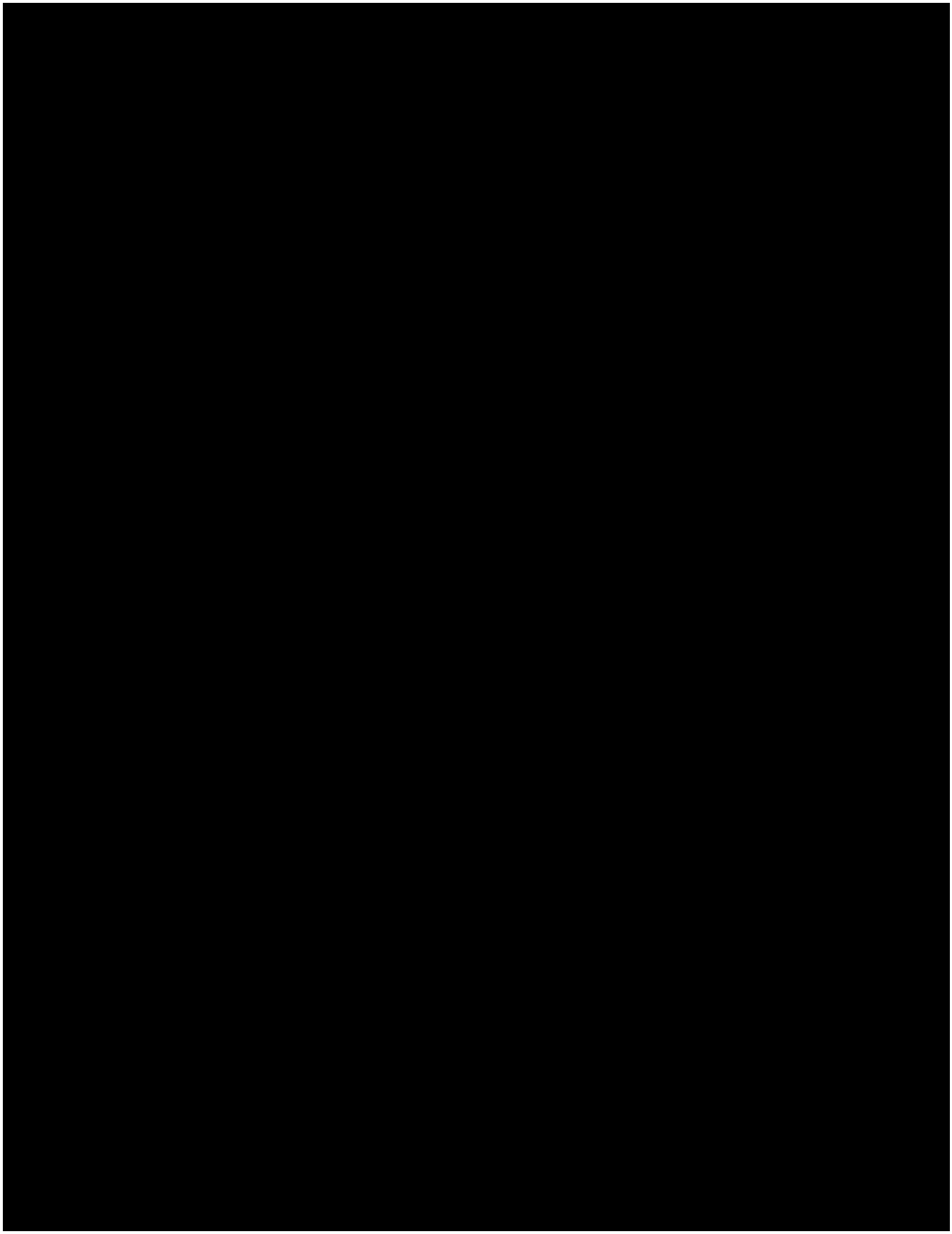


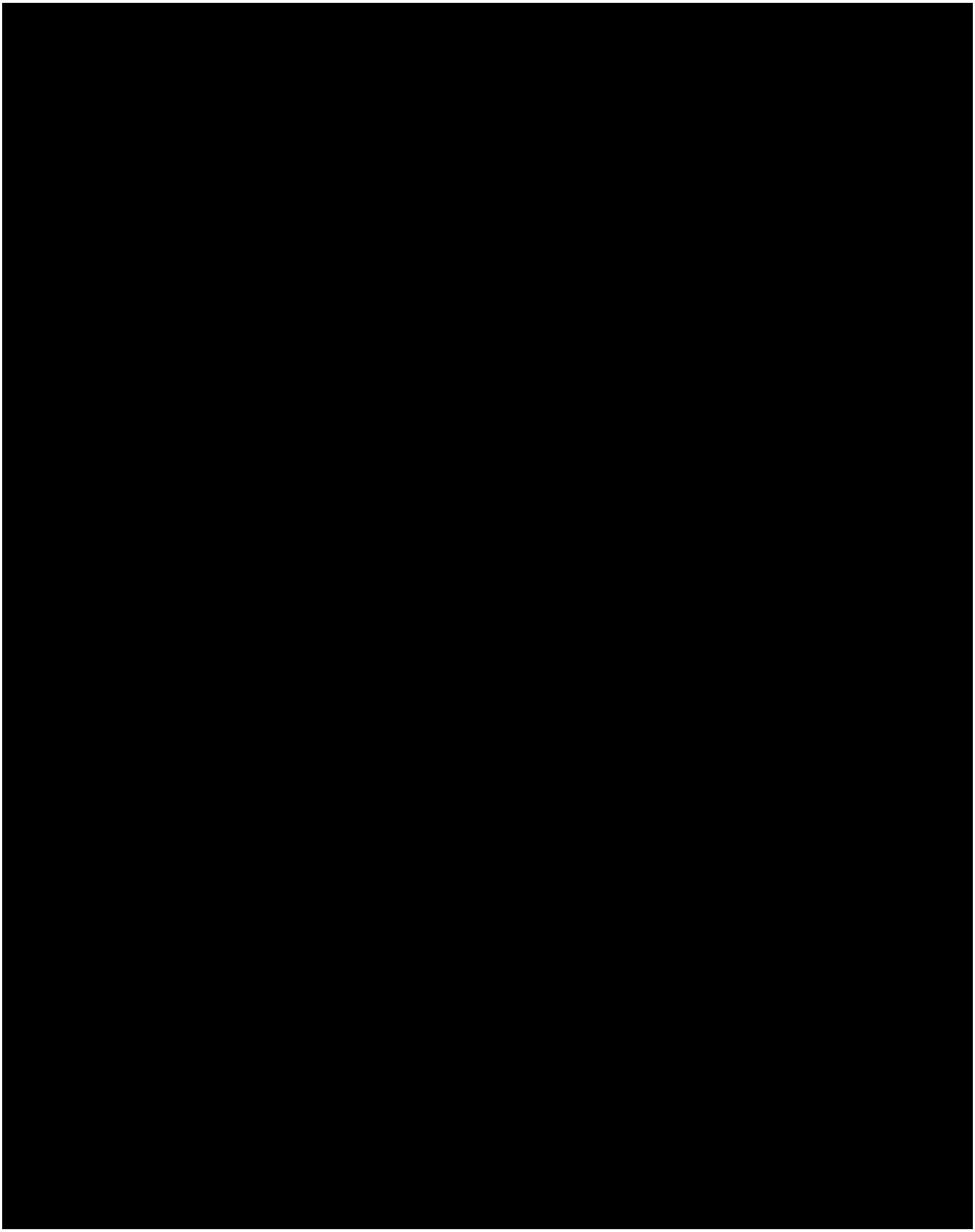


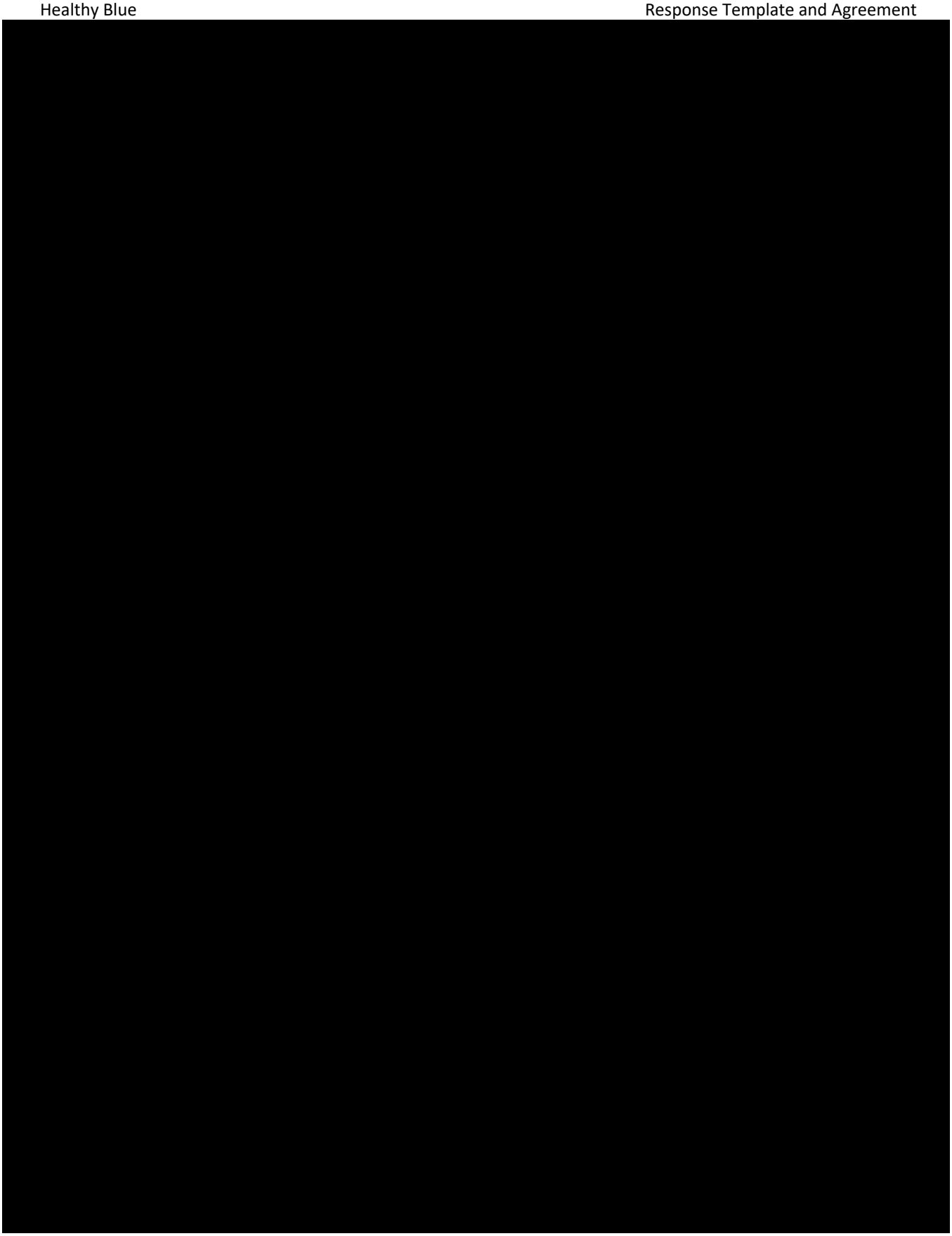


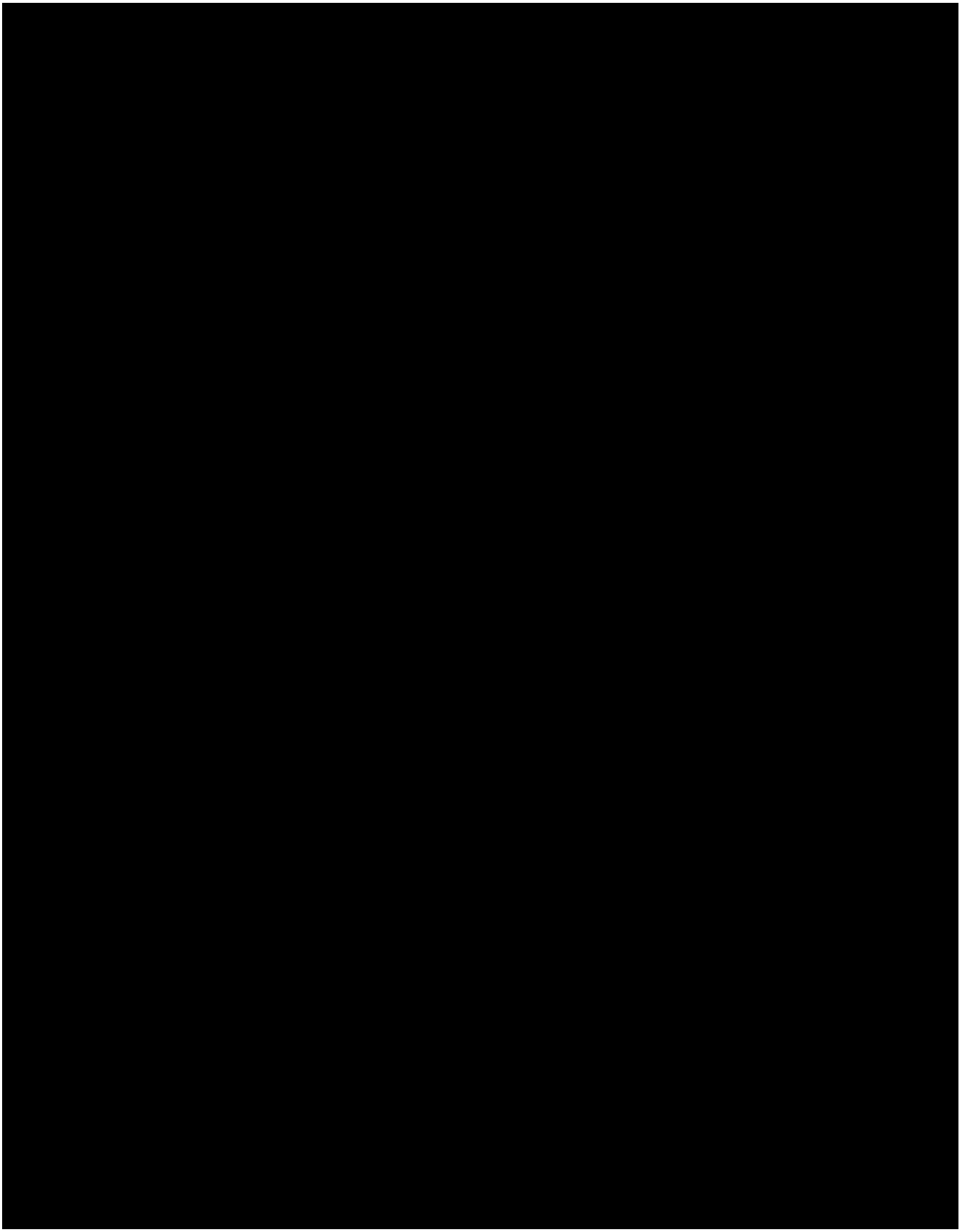


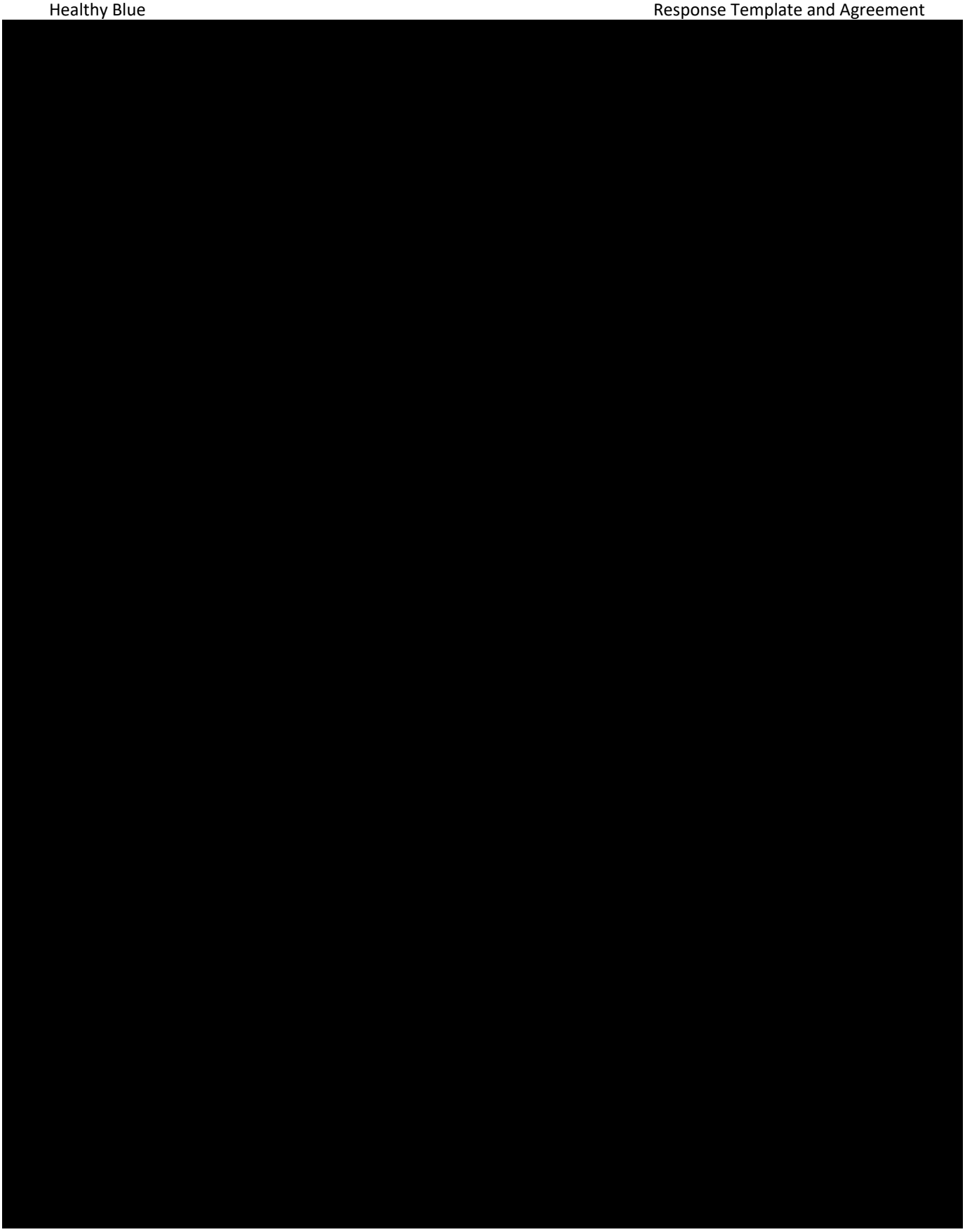


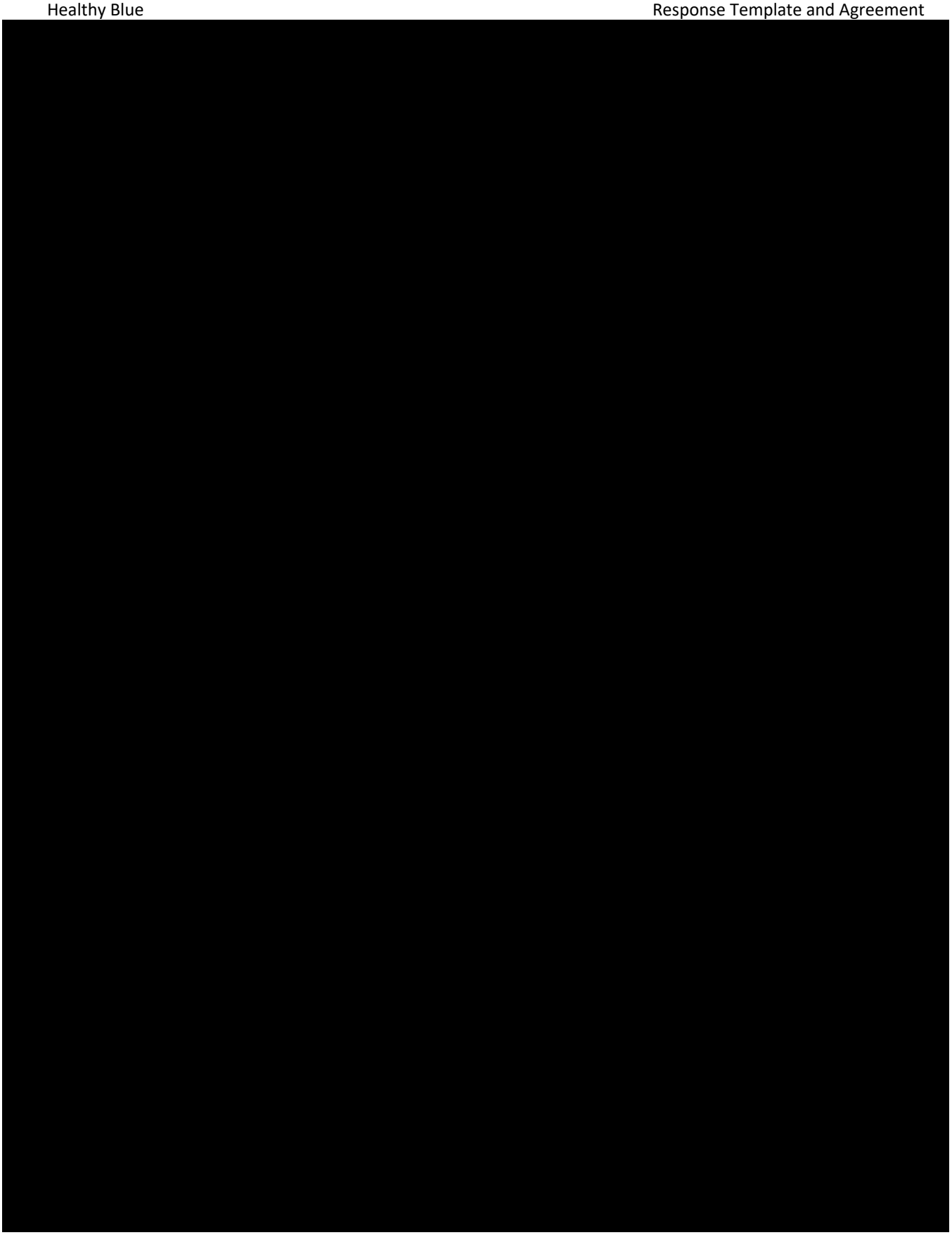


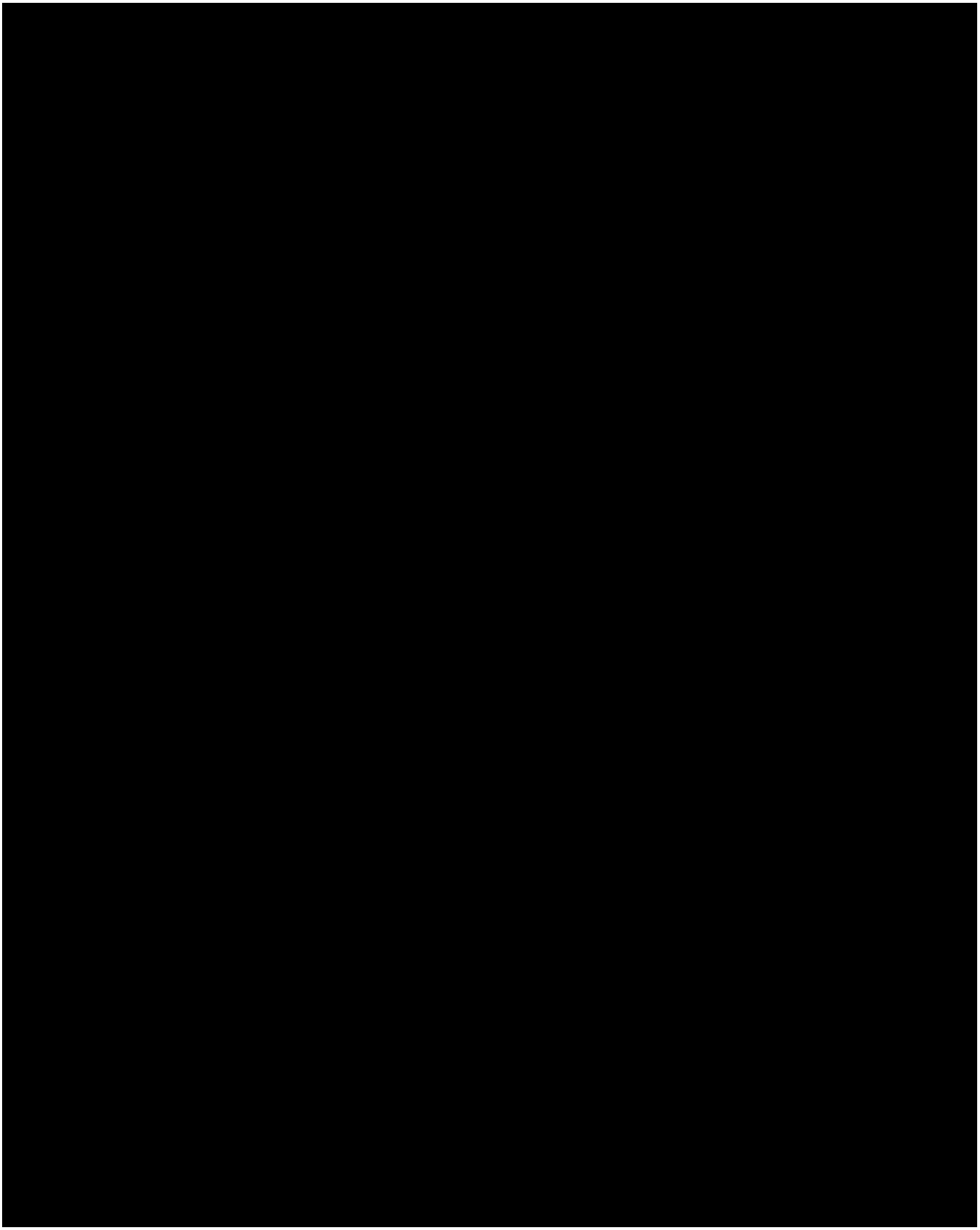


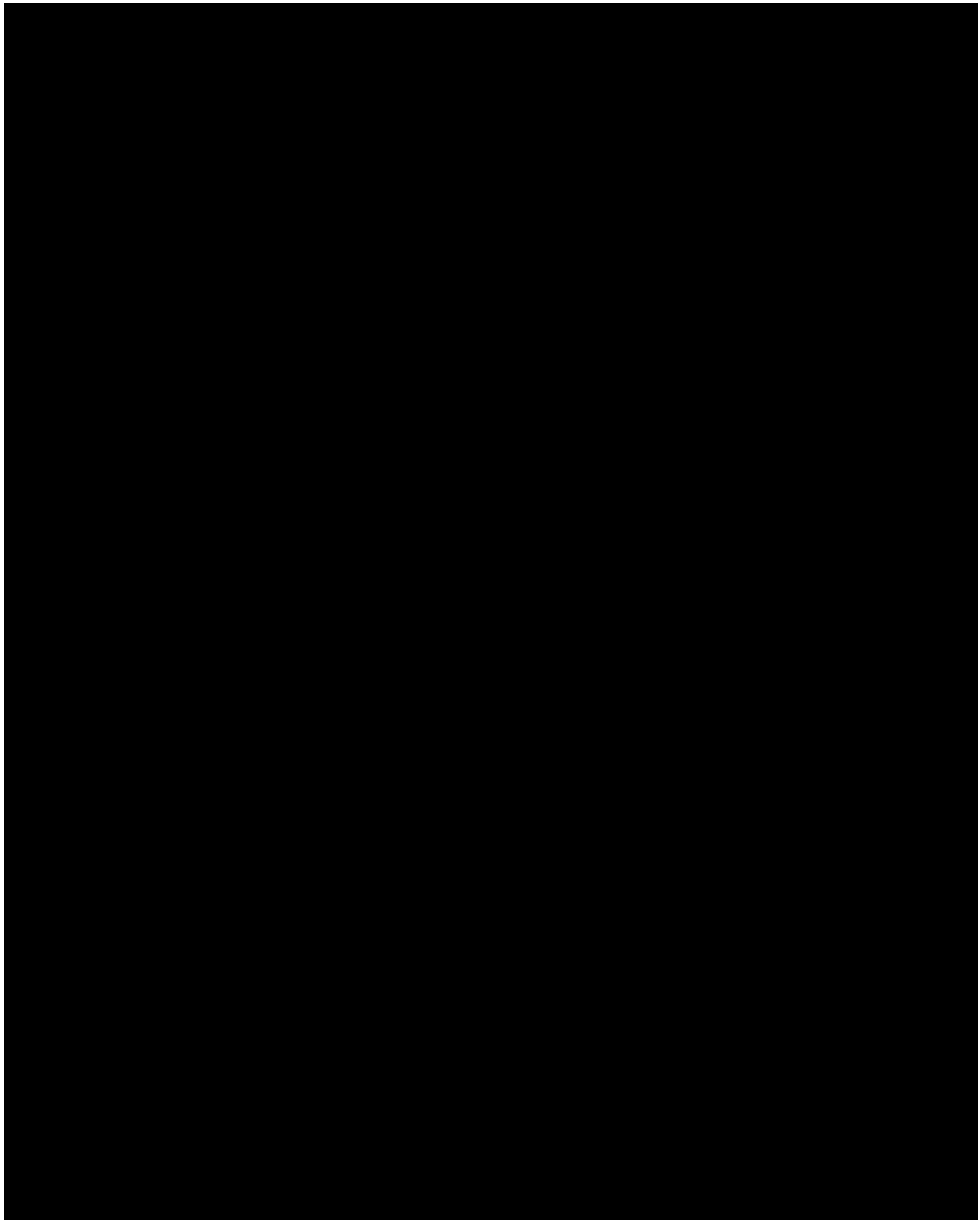


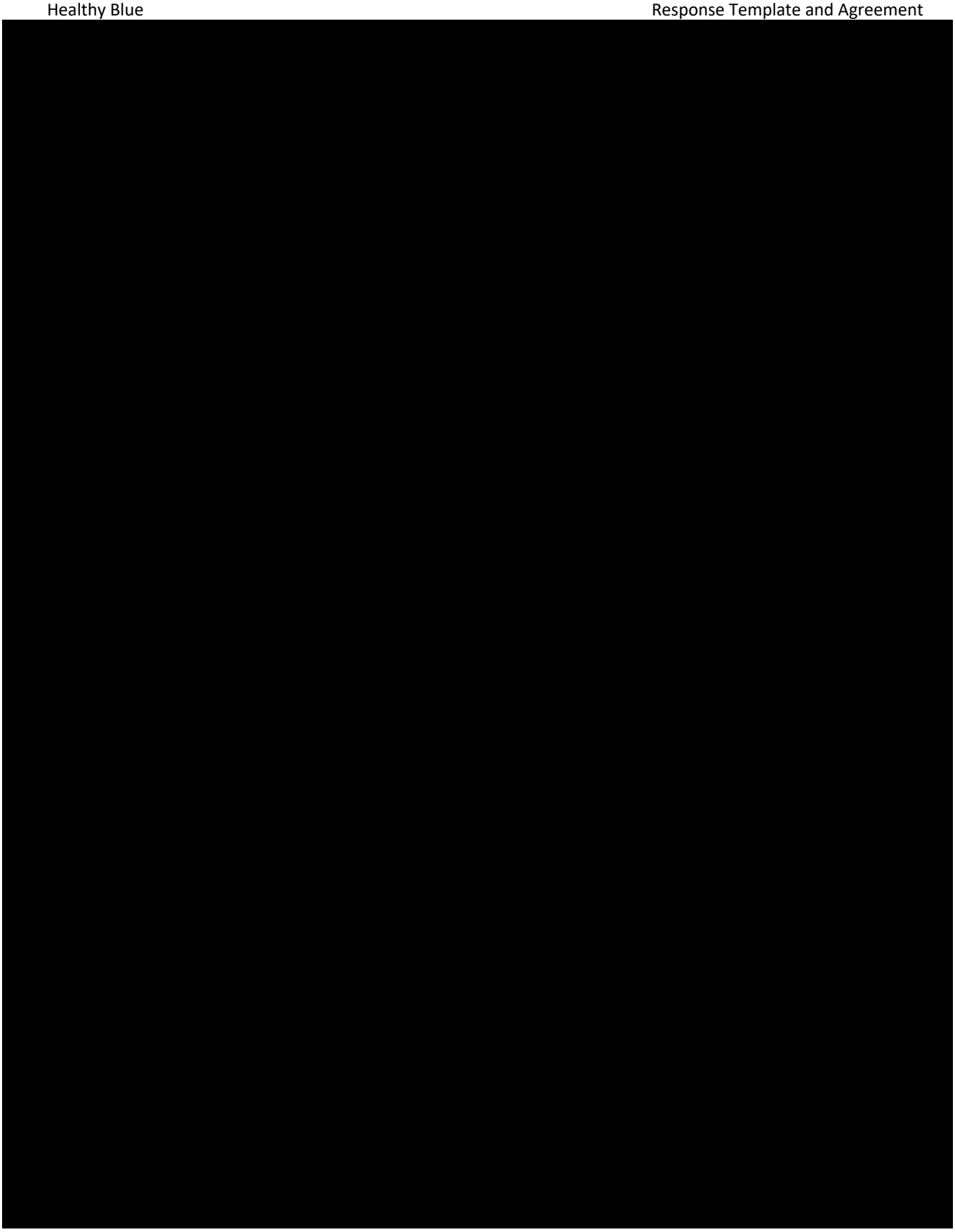


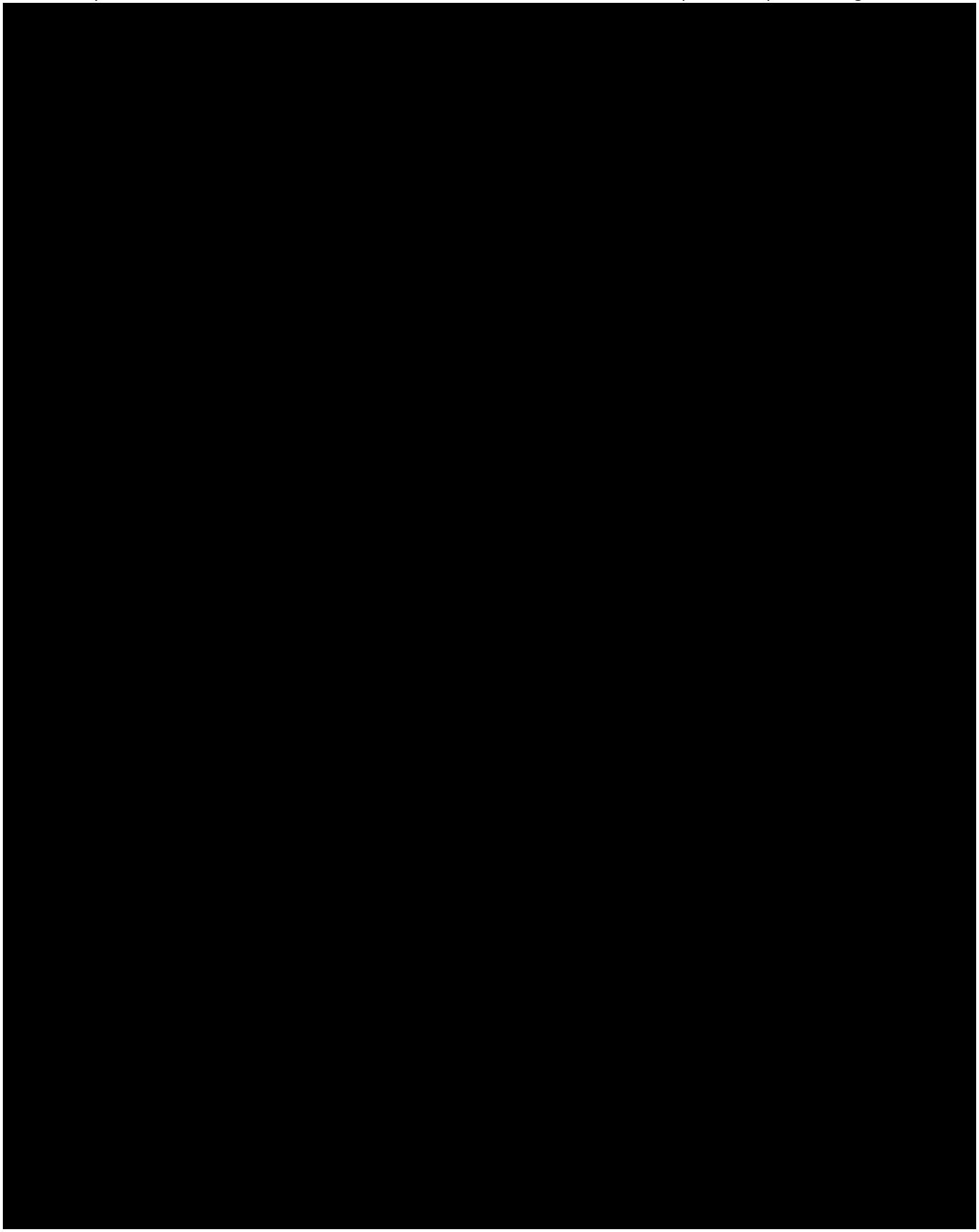


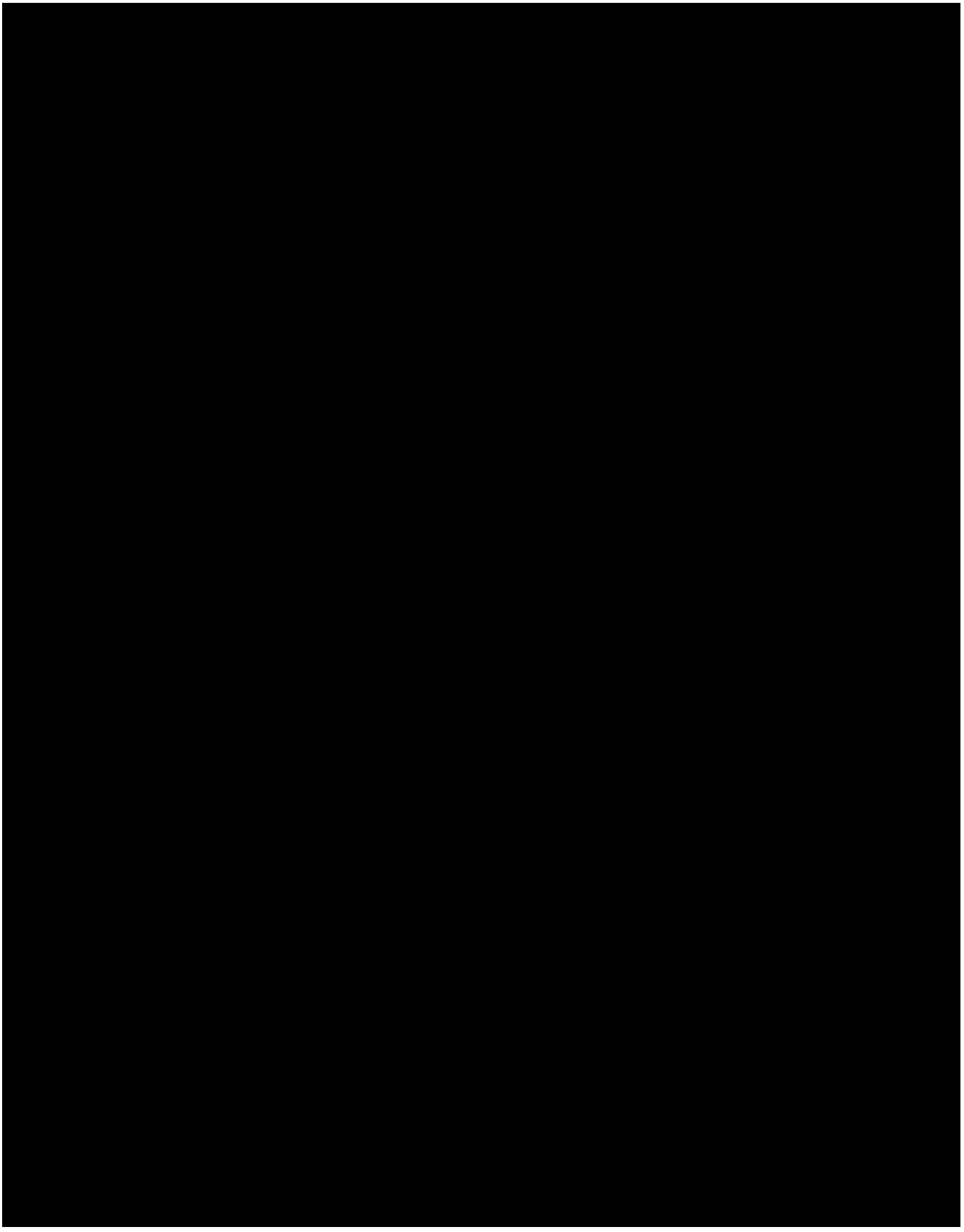


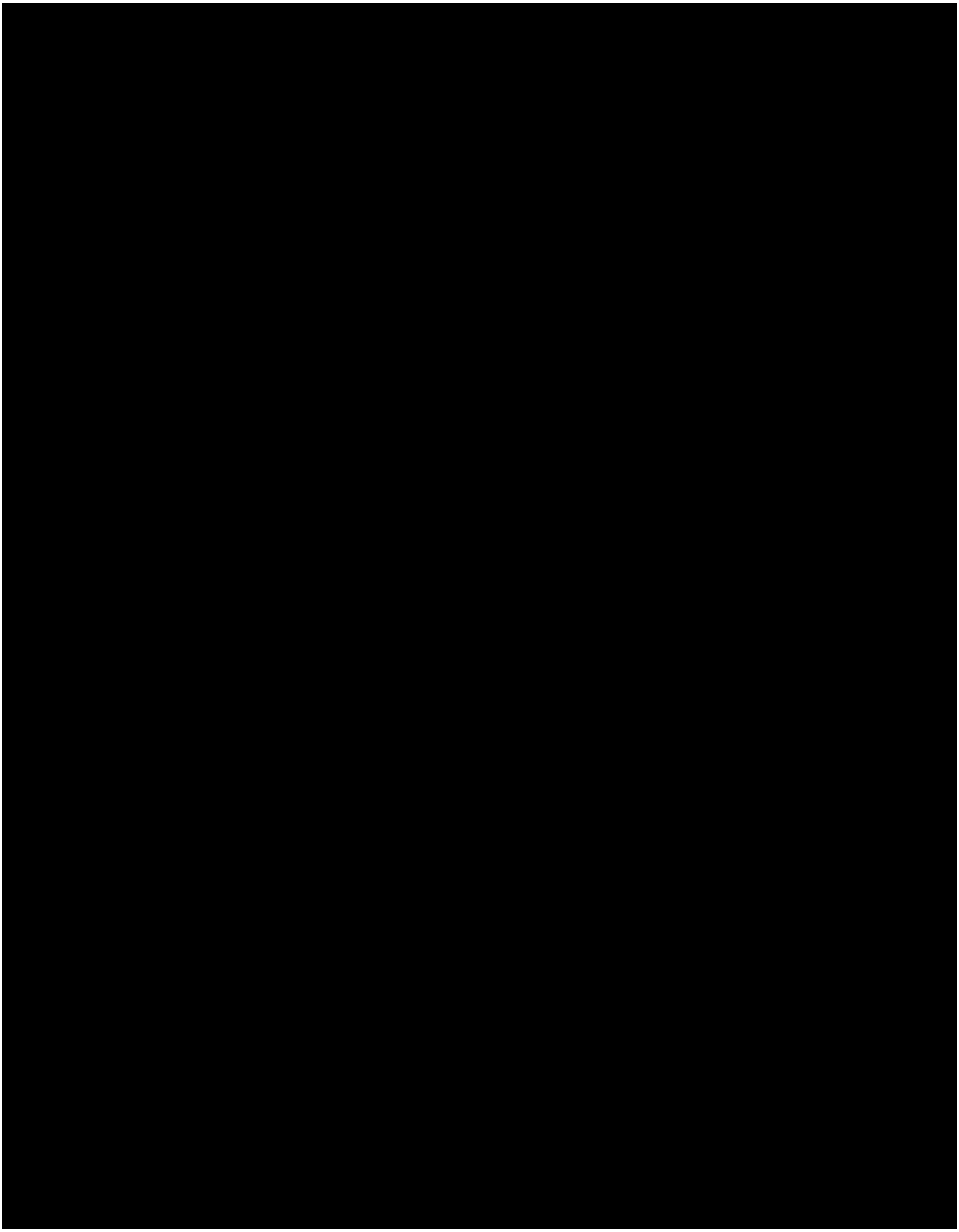


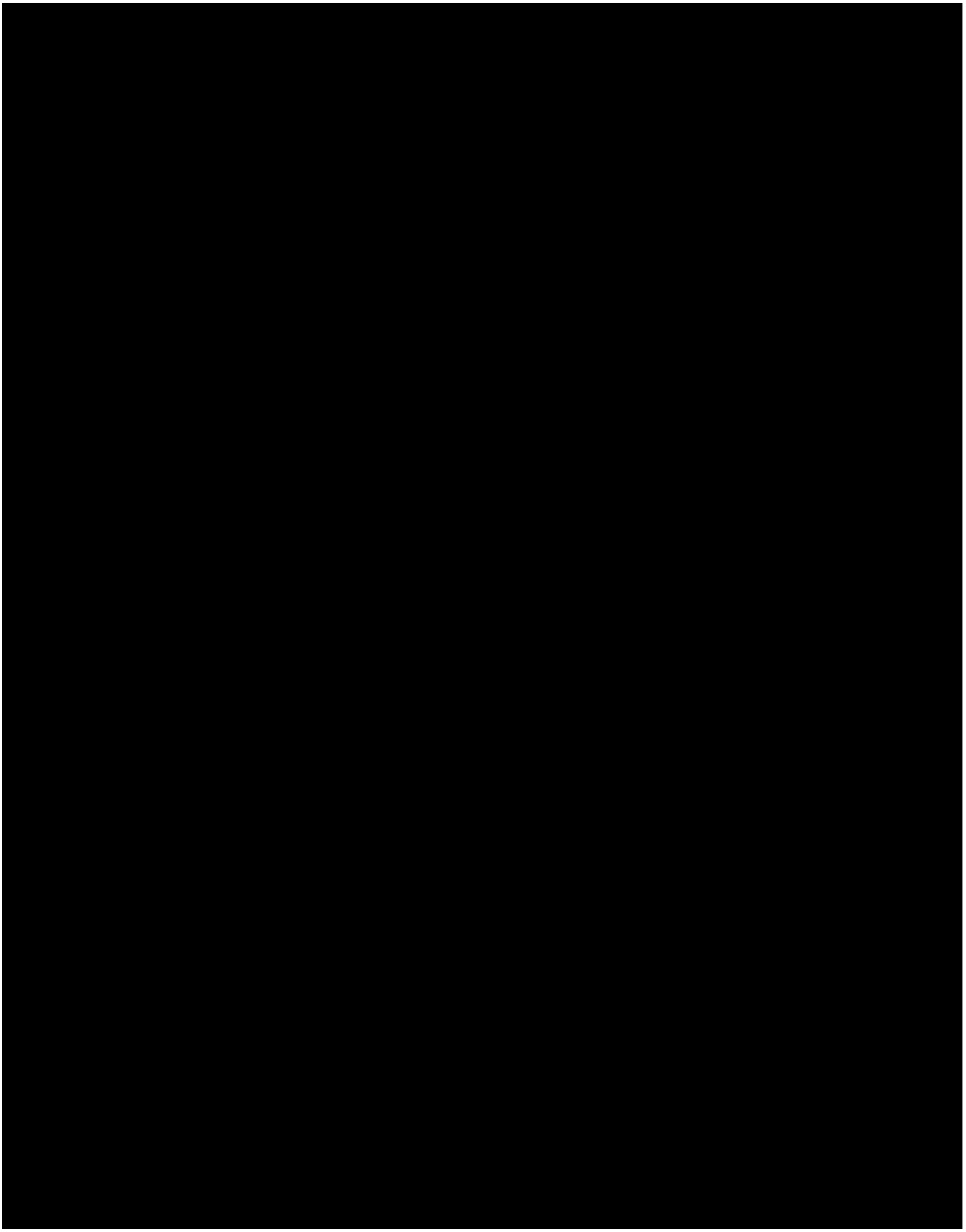


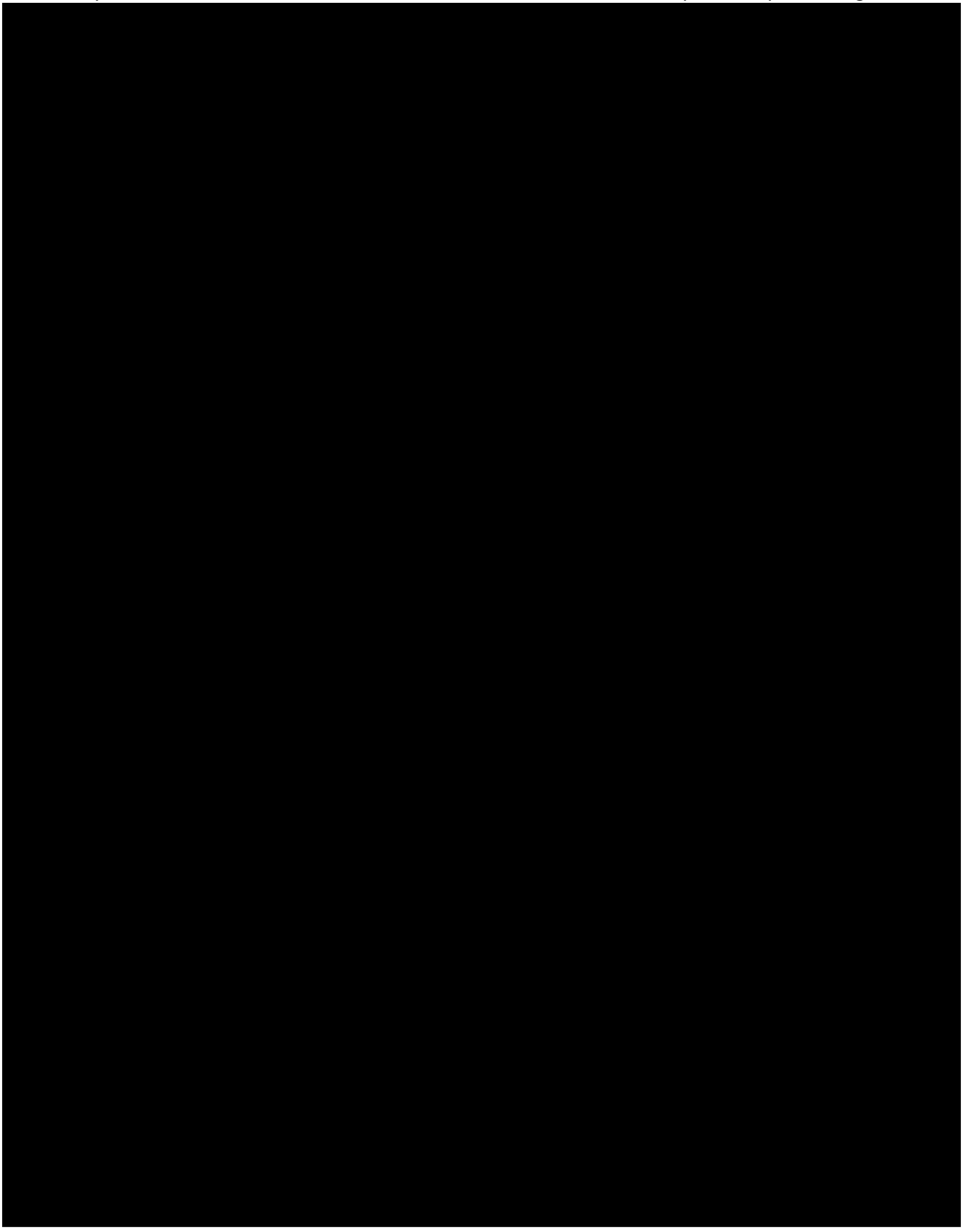


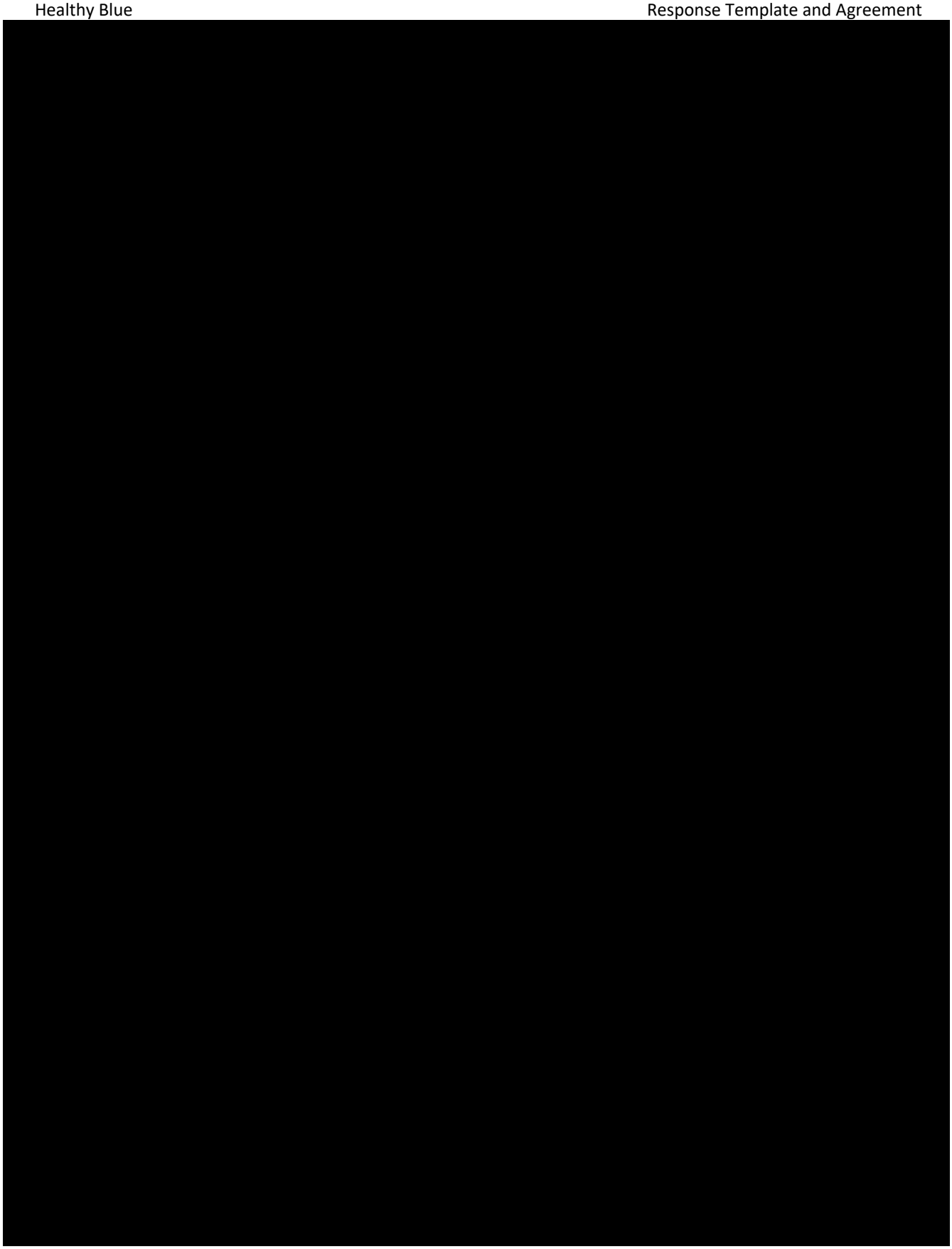


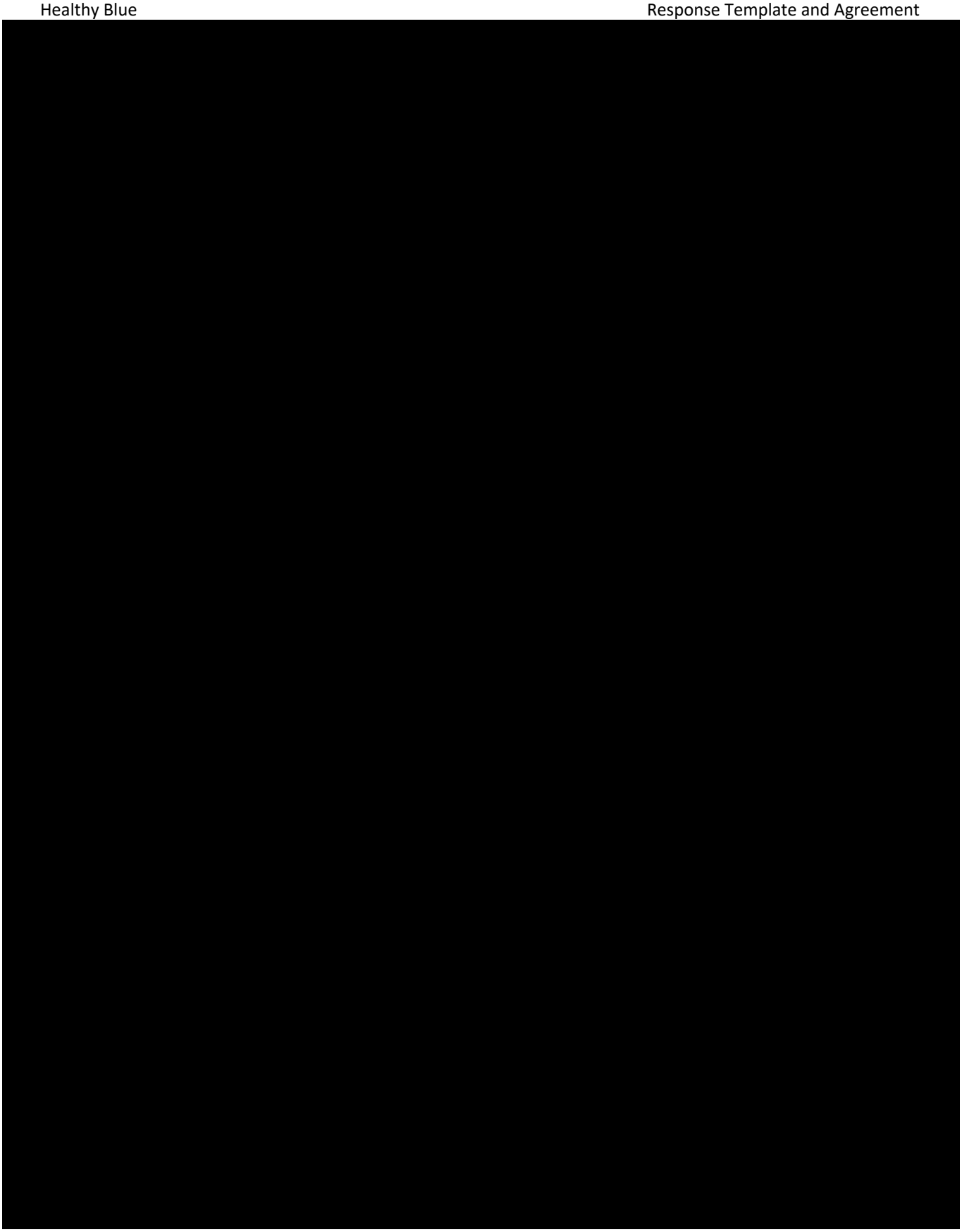


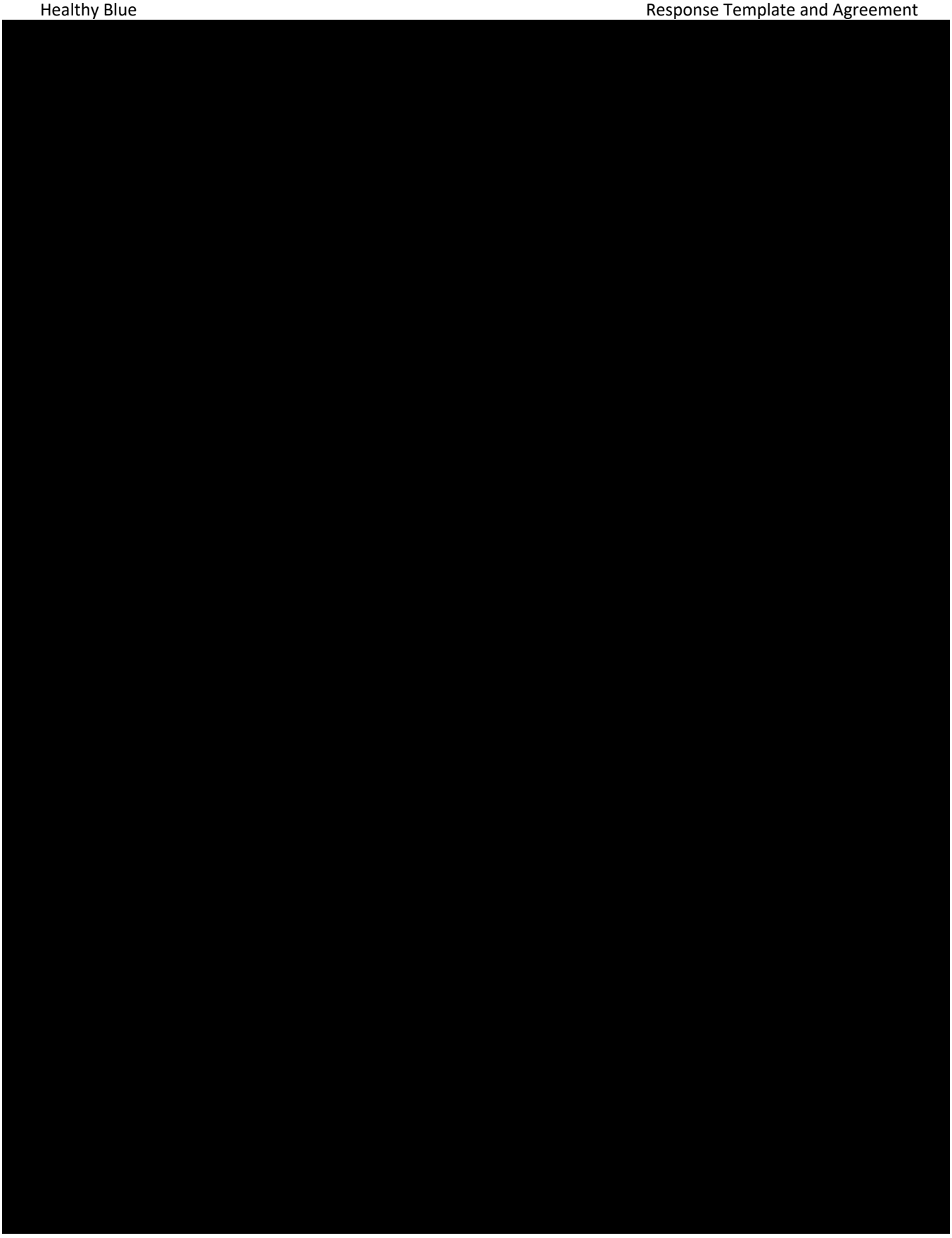


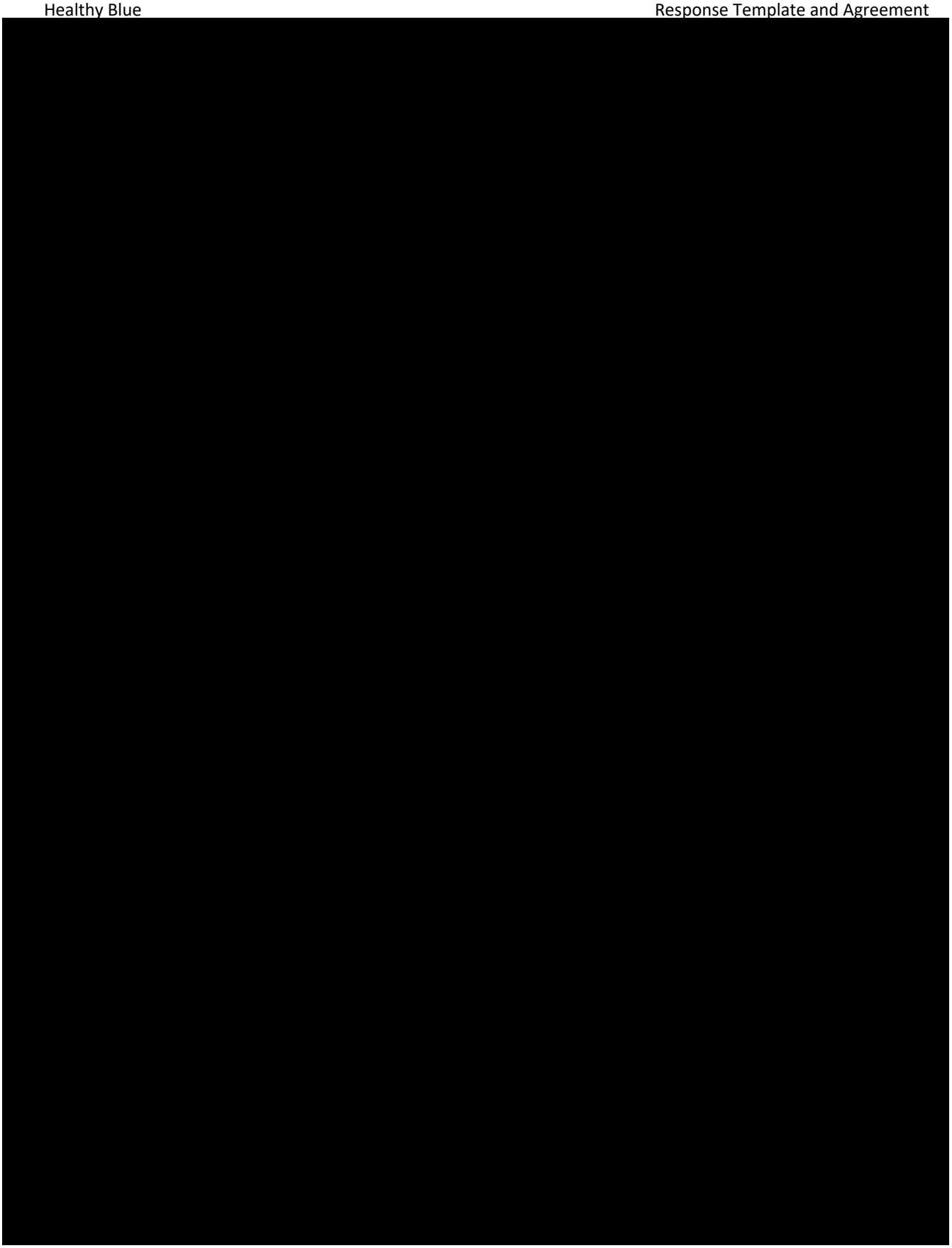


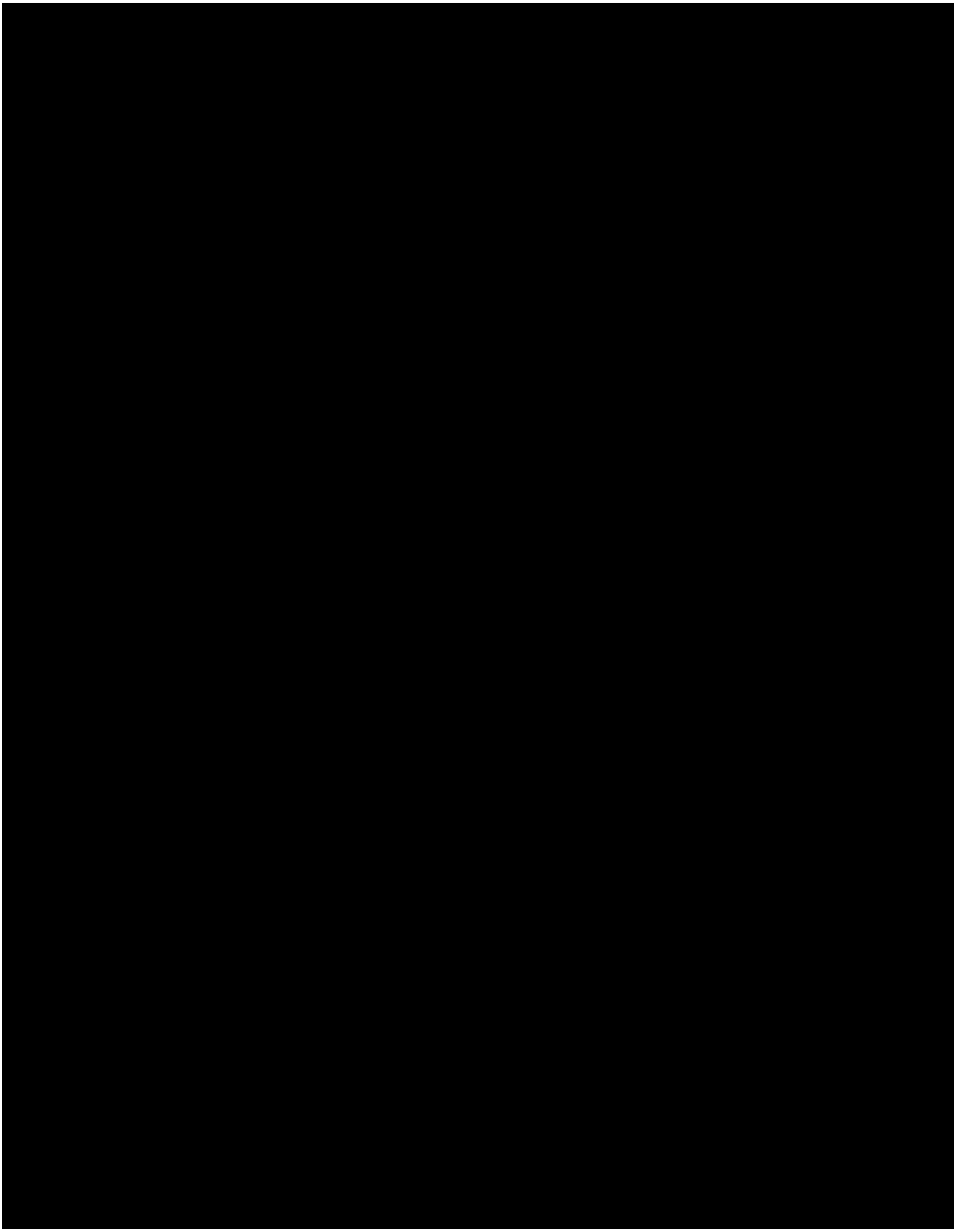


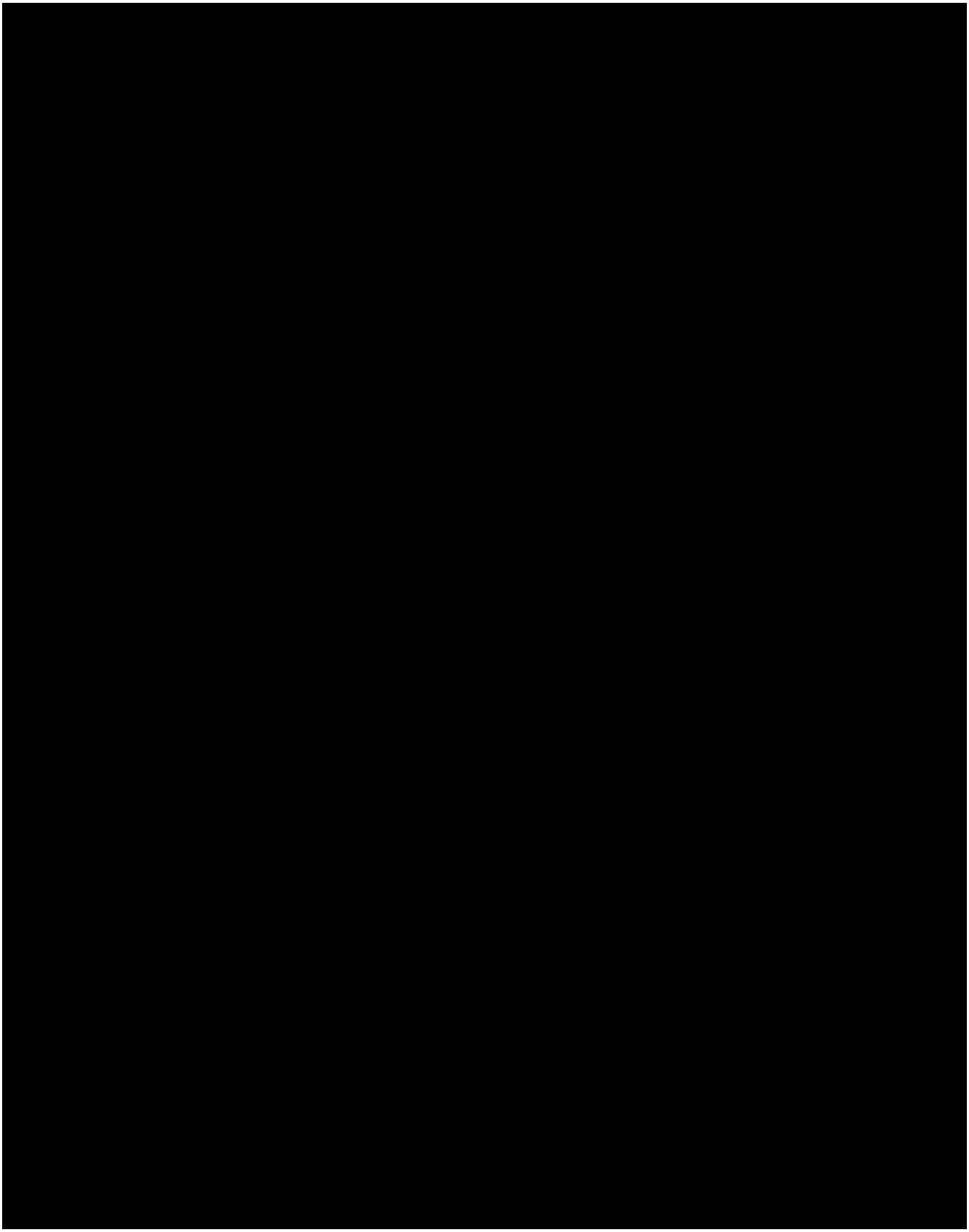


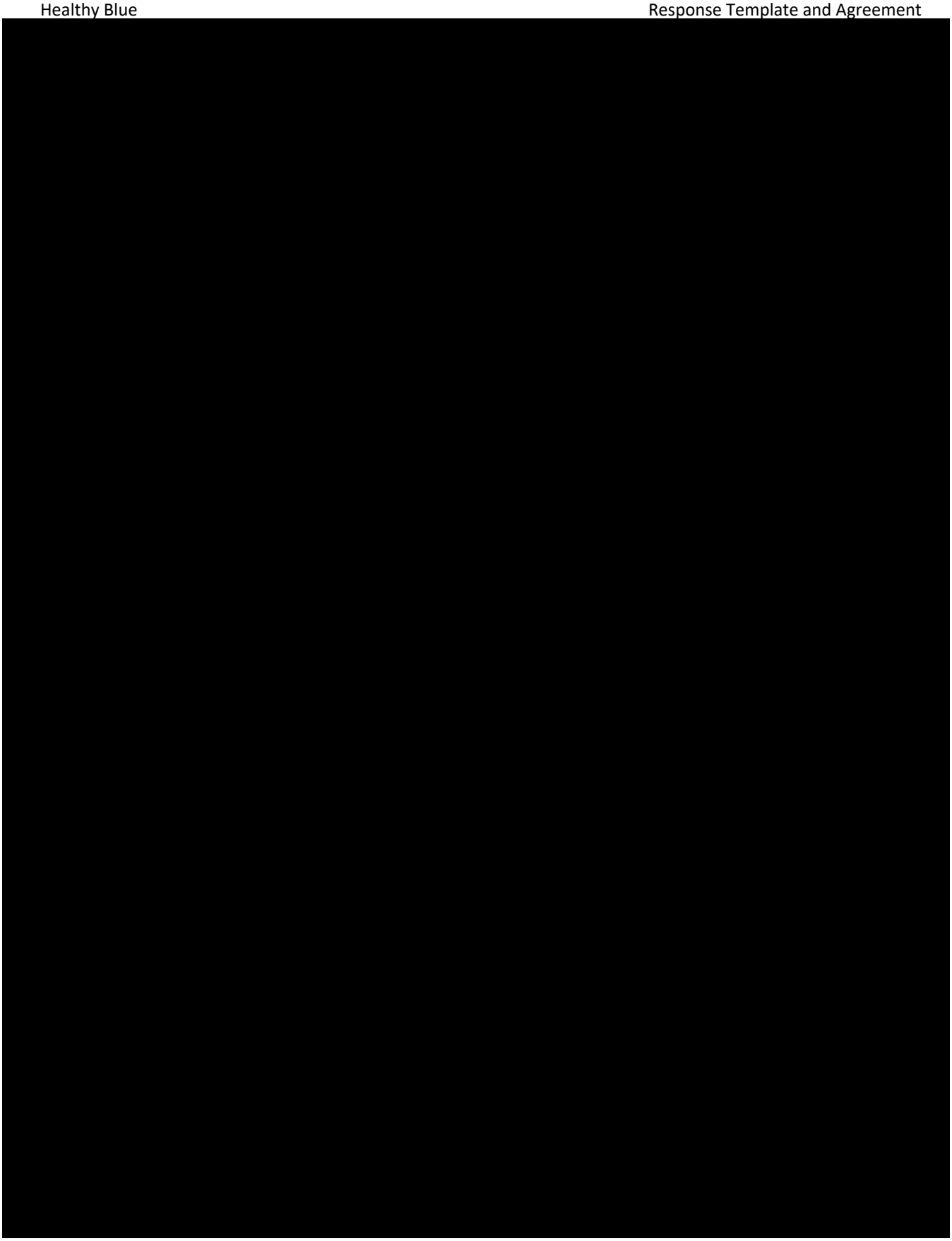


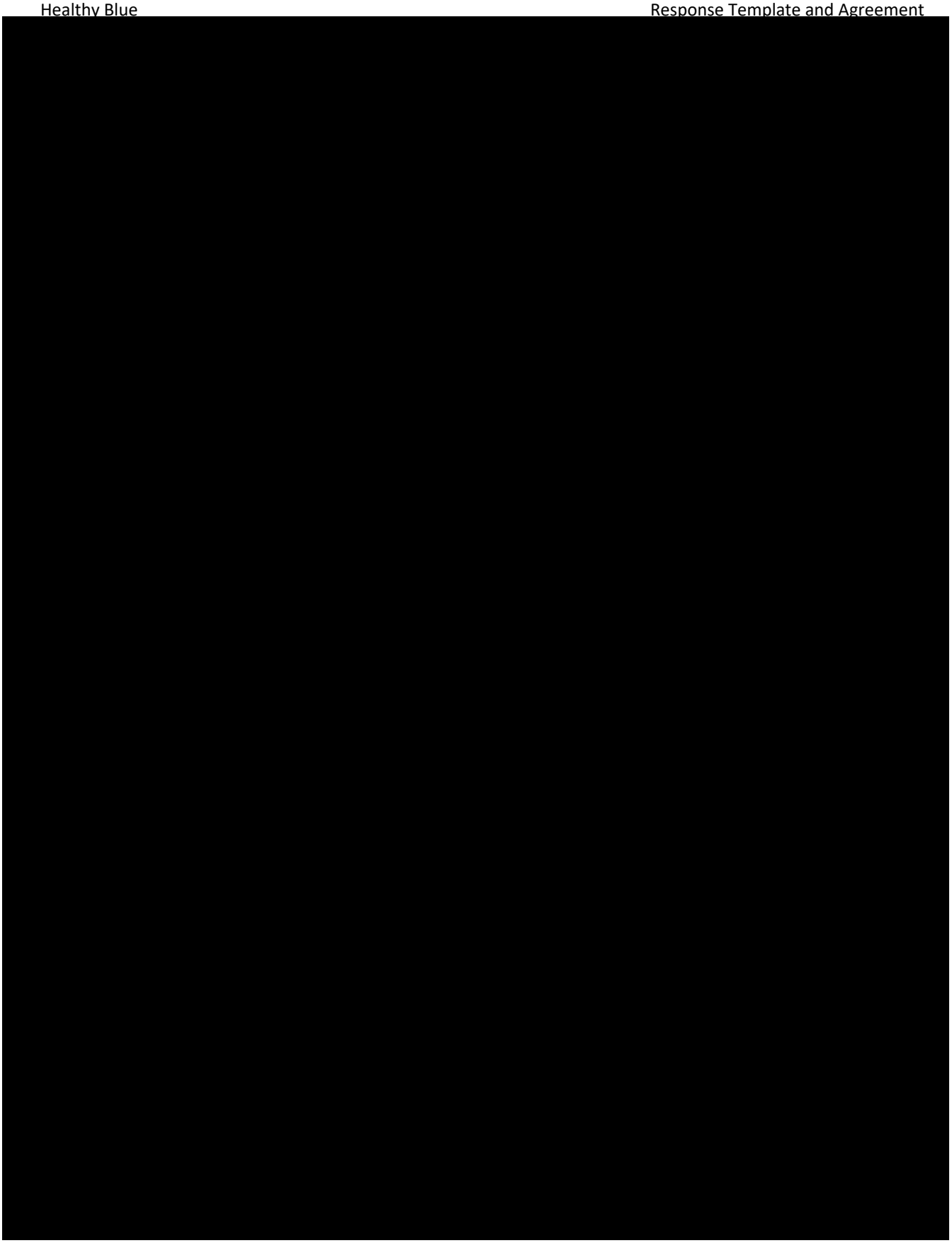


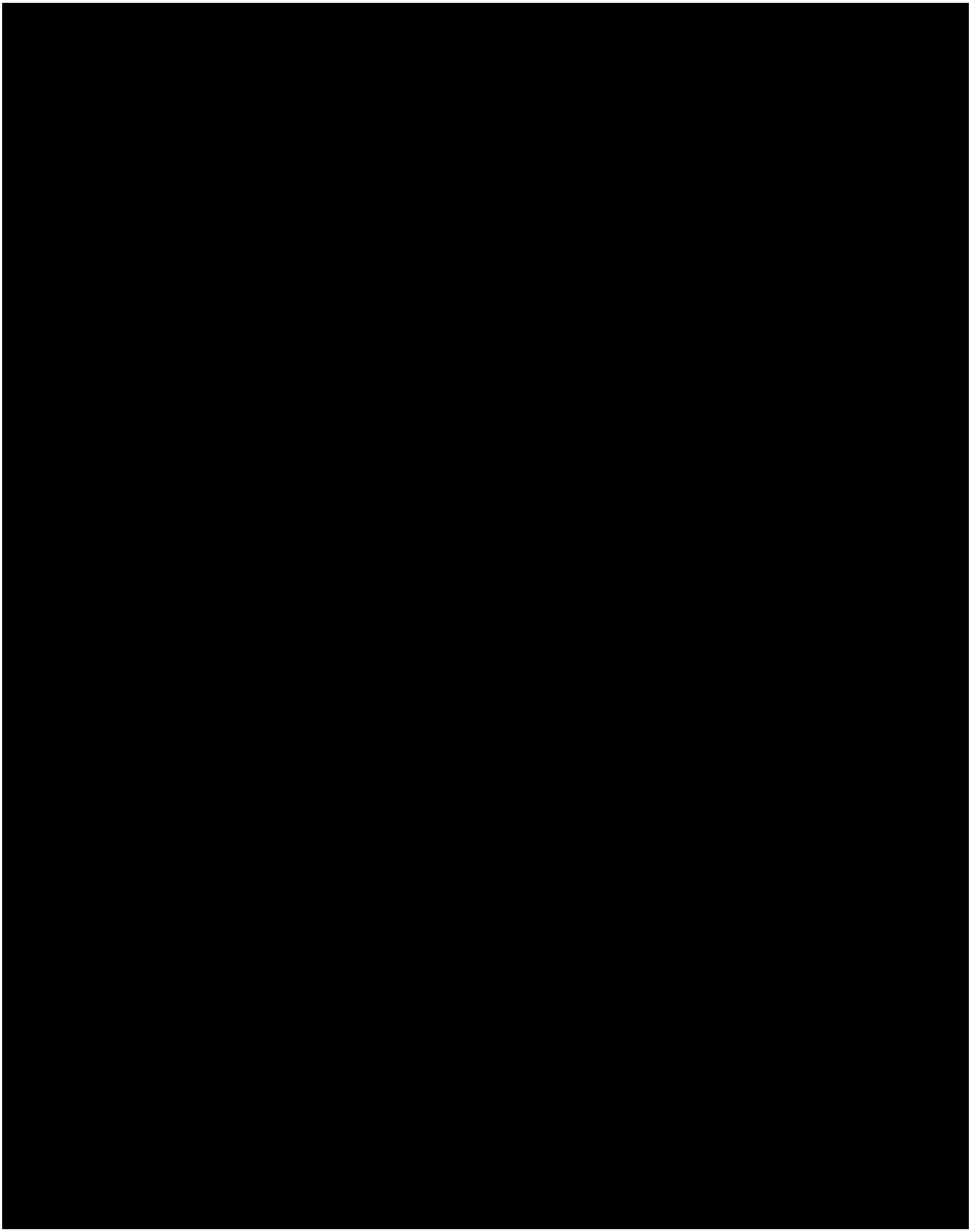


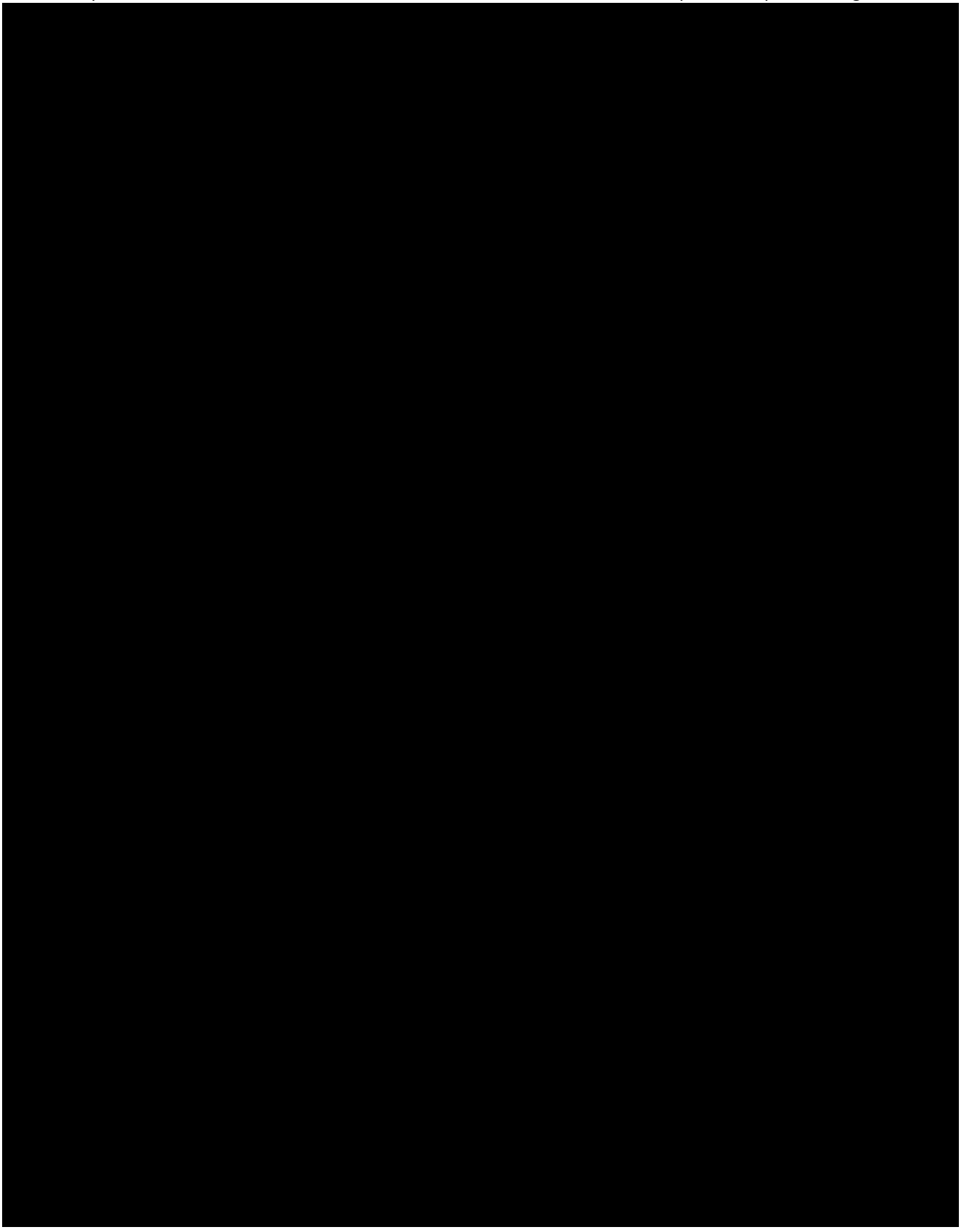


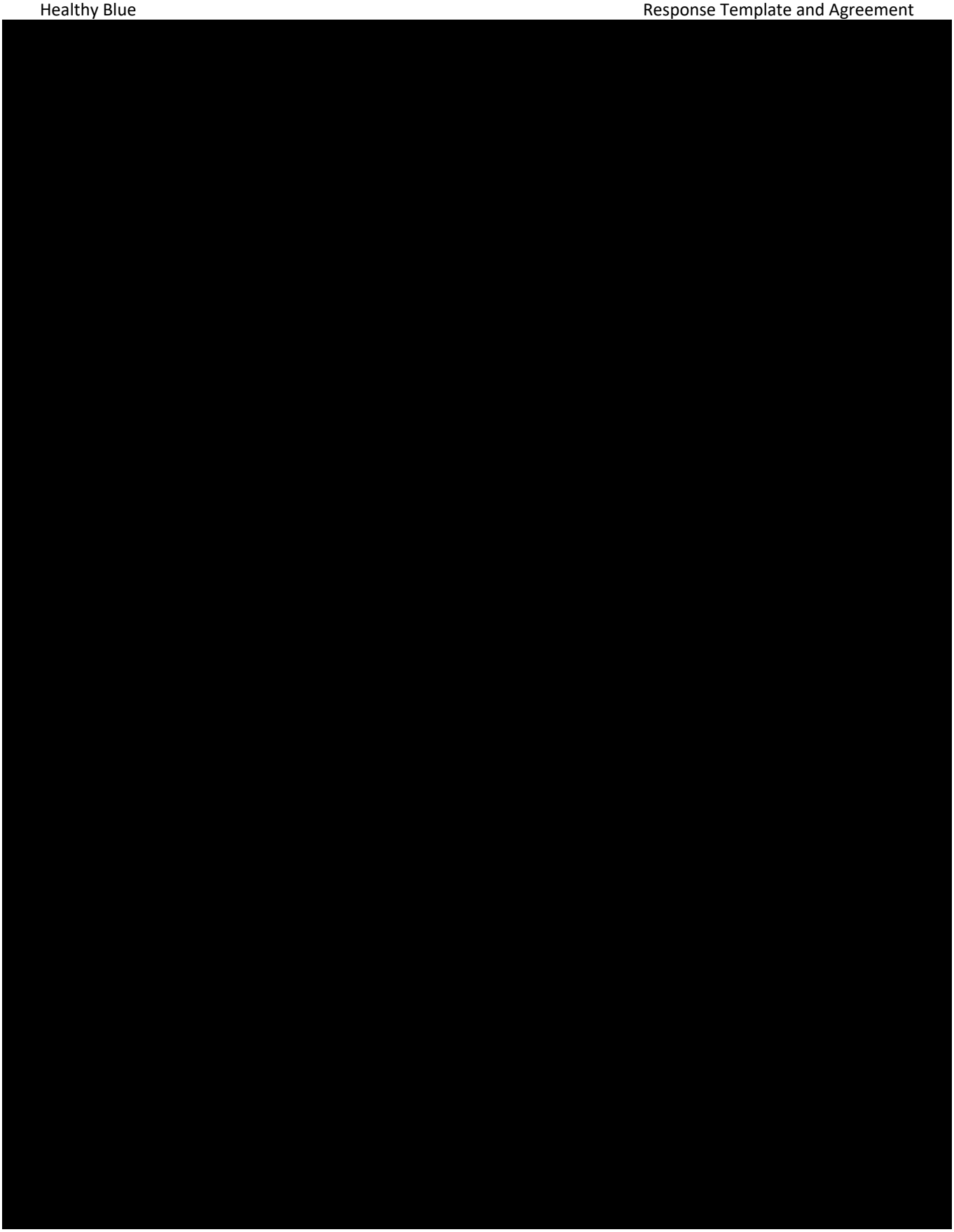


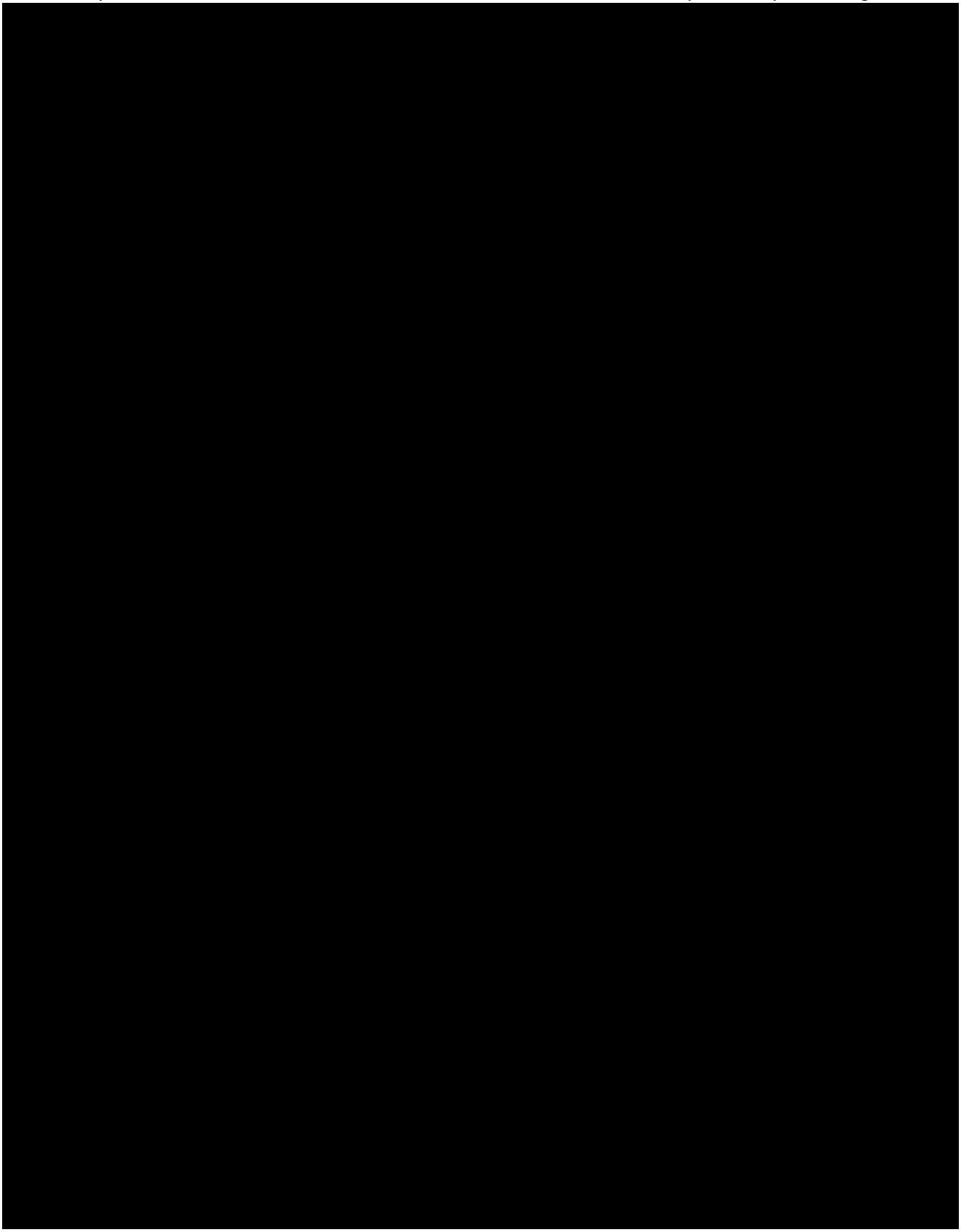


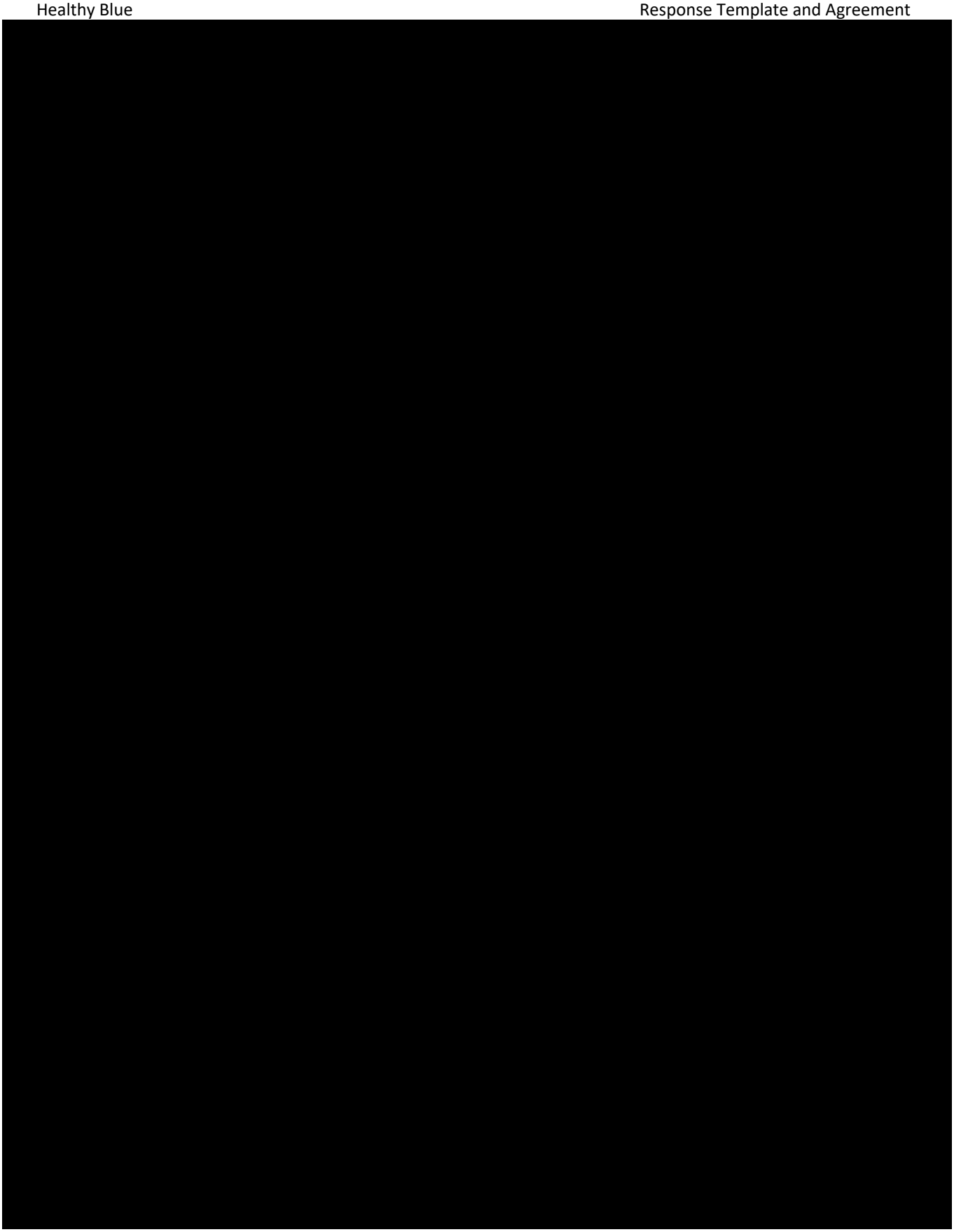


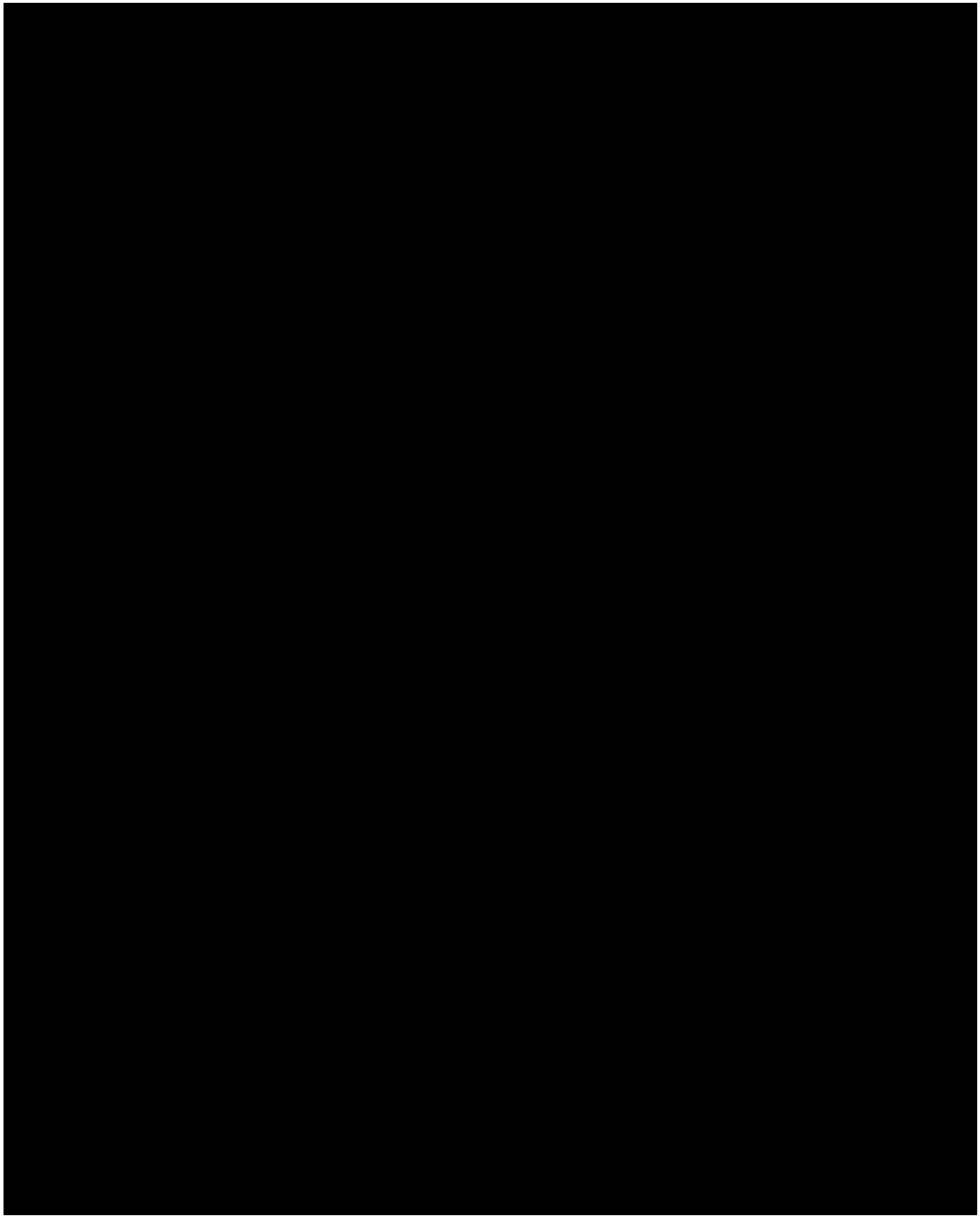


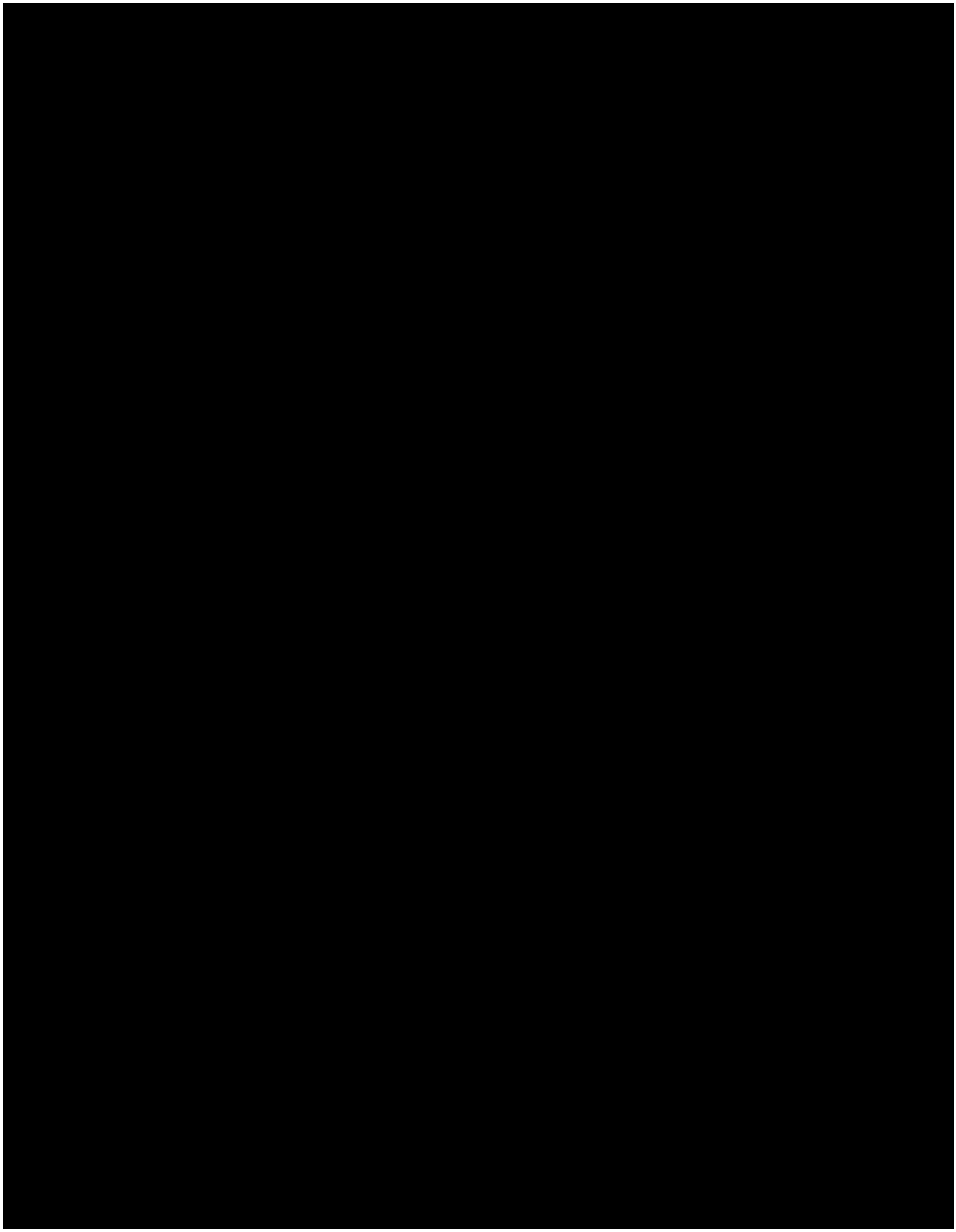


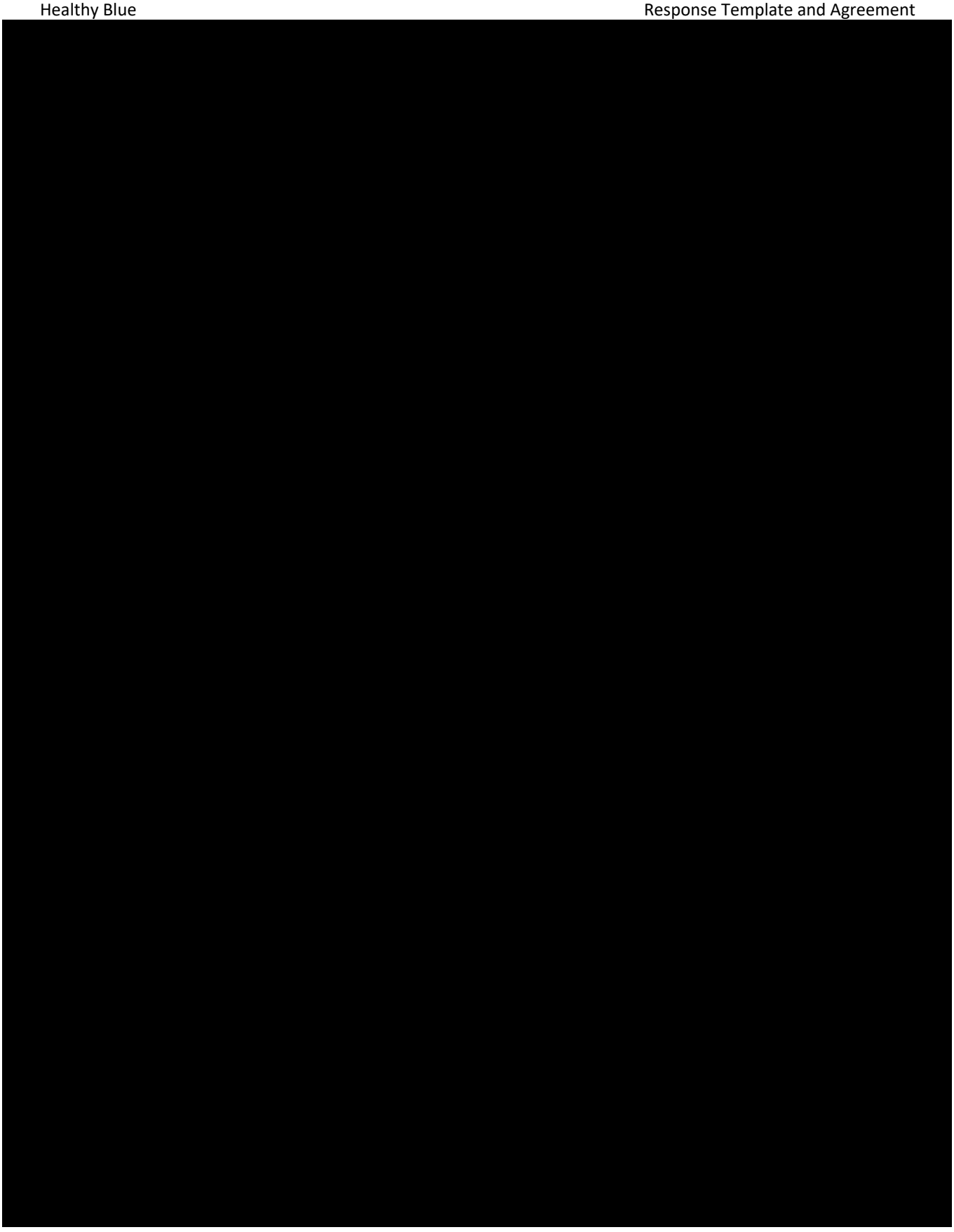


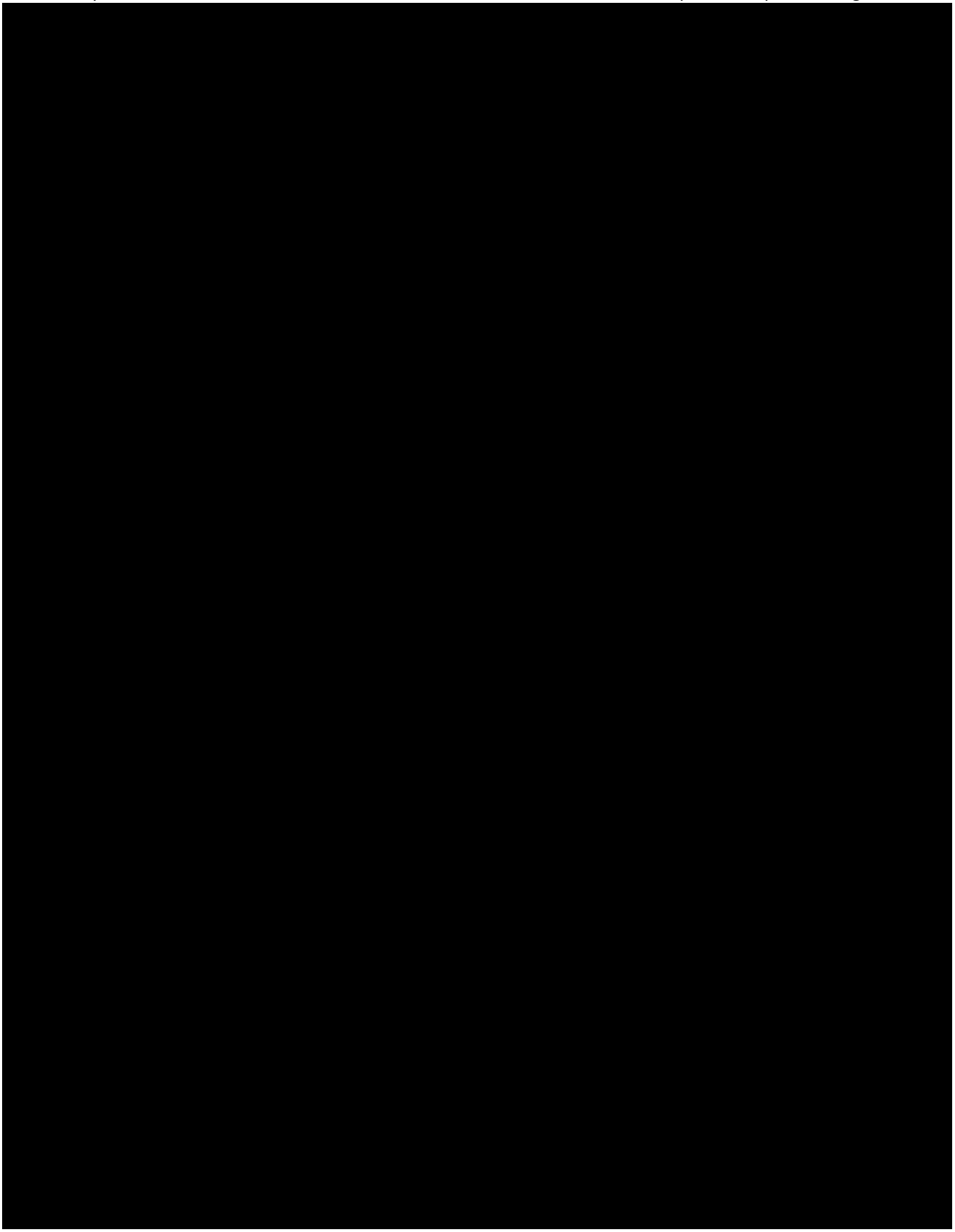


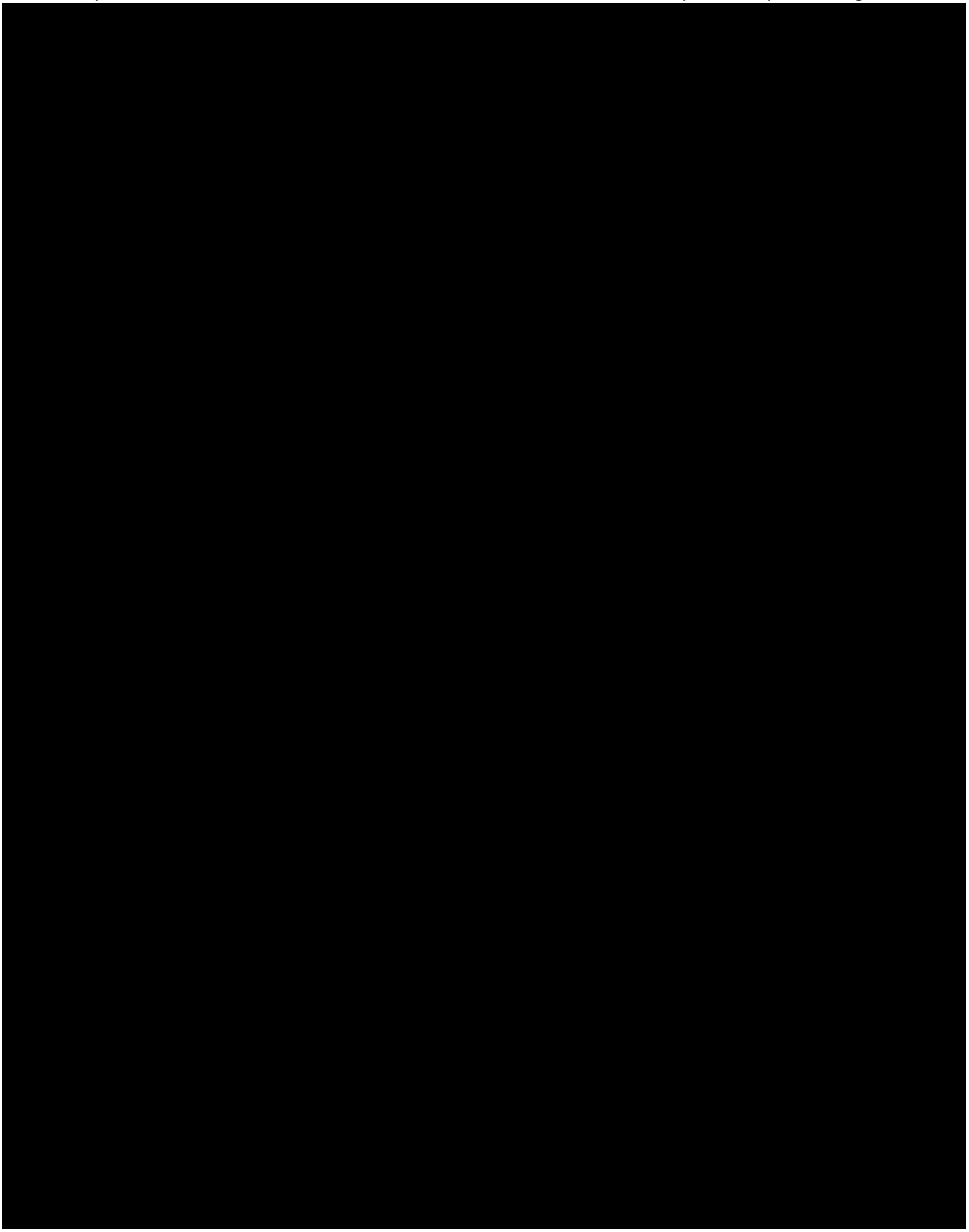












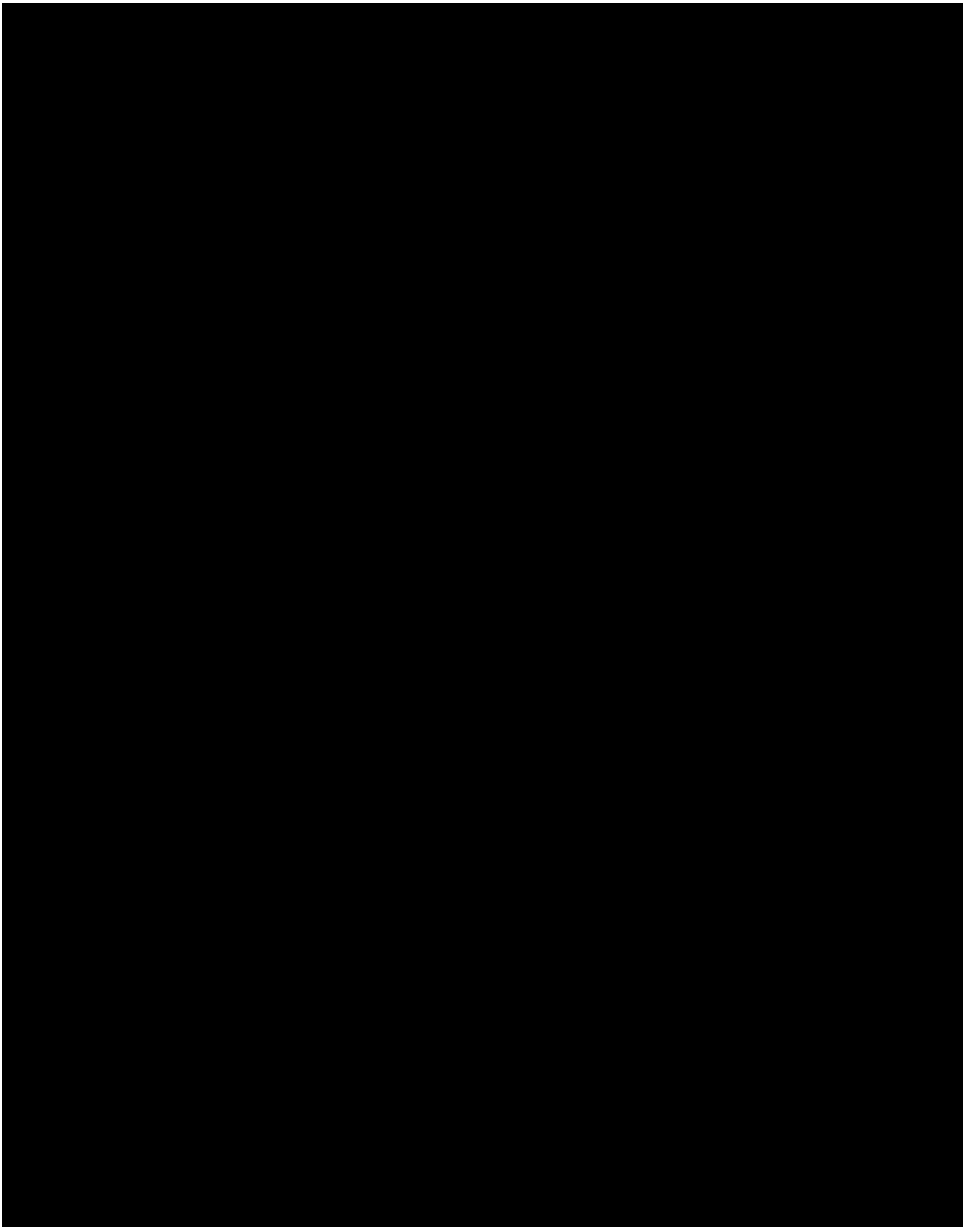


**Exhibit B: Material Subcontractor Response Template**

| Proposer (MCO) name: |
|---|
| Community Care Health Plan of Louisiana, Inc., dba Healthy Blue (Healthy Blue) |
| **Material subcontractor name:** |
| Superior Vision Benefit Management, Inc. (Superior Vision) |
| Description of the Proposer's role and material subcontractor's role: |
| **Proposer's Role.** Healthy Blue's primary role is to coordinate vision services for our enrollees (members), as a covered service and as a value-added benefit (VAB). We are ultimately responsible for meeting all contractual requirements. We make sure that the services Superior Vision provides meet or exceed all Louisiana Department of Health (LDH) requirements and are delivered seamlessly to our Healthy Louisiana members in a timely manner. Healthy Blue will continue to monitor, supervise, and enforce contract compliance, as well as promote frequent, open, and effective communication that emphasizes delivery of quality services to members. We will continue to oversee Superior Vision's performance through daily collaboration, regular monitoring, and formalized auditing processes. Healthy Blue believes that maintaining complete visibility into the volume and topics of member grievances and appeals is a critical component of subcontractor oversight. For this reason, we maintain direct responsibility for documenting, tracking, and resolution of all member grievances and appeals. We will continue to work closely with Superior Vision to resolve individual grievances and to address underlying root causes that result in member dissatisfaction.<br><br>**Material Subcontractor's Role.** Superior Vision's role is to continue to administer routine vision services and as a VAB, including network development and maintenance, claims processing, and call center services. Superior Vision's role is also to comply with all contractual requirements, including:<br>▪ Meeting performance standards documented in the written subcontractor agreement that meet or exceed LDH requirements, such as claims payment timeliness and call center average speed of answer<br>▪ Timely loading of data exchanges, such as member enrollment<br>▪ Timely submission of complete and accurate encounter data to Healthy Blue<br>▪ Timely submission of complete and accurate cash disbursement journals to Healthy Blue<br>▪ Submitting all required standard and ad hoc regulatory reports accurately and timely<br><br>Additionally, we expect Superior Vision to collaborate with us through meetings and requests for information, striving for excellence and continuous improvement in the delivery of vision services to our members. |
| Explanation of why the Proposer plans to subcontract this service and/or function: |
| Healthy Blue uses subcontractors who have specialized capabilities, including administration of vision services. We subcontract vision services because we believe that a subcontractor whose core business is vision, including building and maintaining a network of vision providers, can deliver the best service to our Healthy Louisiana members. We choose vendors who have established relationships and long-standing experience with us, or with our affiliates serving Medicaid members across the country. Superior Vision currently provides vision services for five of our affiliates. Since delivering vision services is Superior Vision's specialty, we prefer to work with them to tailor programs and services that align with Healthy Blue's stringent and specific requirements. |
| A description of the material subcontractor's organizational experience: |
| Superior Vision has more than 25 years of experience managing vision benefits on behalf of both health plans (with an emphasis on government programs) and commercial group business. In 1990, Block Vision began providing high-quality eye care and administrative services, with a focus on serving health plan clients. In December 2014, Block Vision merged with Superior Vision, a leading provider of vision plan coverage to commercial groups on a nationwide basis. This merger positioned the combined company as a national leader in both health plan and commercial vision benefits services. On December 1, 2017, Superior Vision's ownership completed its acquisition of Davis Vision. This partnership leveraged the expertise and services of each company to provide a larger suite of benefit offerings along with the broadest access in the industry to quality vision care. On January 6, 2021, MetLife announced the successful acquisition of Versant Health, owner of Davis Vision and Superior Vision. The transaction closed at the end of the fourth quarter of 2020. Versant Health is operating under the umbrella of MetLife as a wholly owned subsidiary. Together with affiliates, our company currently manages vision benefits on behalf of over 37 million members nationwide.<br><br>Since 1994, Superior Vision has delivered a full-spectrum of vision care services ranging from routine to medical/surgical on behalf of government-sponsored health plans. Today, we provide services to 120 health plan clients in 22 states covering more than 18 million Medicaid, CHIP, and Medicare Advantage members. Superior Vision is the largest administrator of vision benefits for government-sponsored health plans in the nation.<br><br>In Louisiana, Superior Vision has administered vision services for the Medicaid and CHIP programs since the start of managed care in 2012. Superior Vision currently provides comprehensive routine vision and medical eye care |

services to more than 425,000 Louisiana Medicaid and CHIP members.

Superior Vision's experience has led to the development of services designed to meet the unique needs of members, including:

- Providing appropriate accommodations for members with special needs
- Delivering services in a culturally competent manner
- Managing services across the eye care spectrum, including a robust medical eye care management program that allows members to receive uninterrupted care from a single provider when a medical eye condition is detected during the course of a routine eye exam
- Providing data management and program reporting, including compliance with applicable state-required and/or federally required performance standards and reporting templates
- Offering a comprehensive quality management program that complies with NCQA and applicable state and federal standards
- Monitoring and acting on fraud, waste, and abuse as appropriate
- Delivering disease management and member outreach initiatives
- Providing customized account management with a focus on personalized customer service

We are confident that our long-term experience managing services on behalf of Medicaid, Child Health Plus and Medicare Advantage programs makes us uniquely qualified to deliver outstanding service to LDH and to your valued members.

The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:

Healthy Blue maintains an established Subcontractor Oversight Program, refined through our nine years of serving Healthy Louisiana members and enhanced by national expertise and experience. We continue to enhance this program to make sure we deliver timely, appropriate, and quality care and services. Our material subcontract with Superior Vision includes LDH requirements as specified in the Model Contract. The agreement includes detailed requirements and service levels, sets clear expectations of how we measure performance and compliance, and specifies the consequences for non-compliance. Healthy Blue will continue to retain ultimate responsibility for adhering to and fully complying with all terms and conditions of our Contract and remain accountable for Superior Vision's performance.

We view our material subcontractors as valued partners and, through a comprehensive vetting process, we select the most qualified that can best serve our members. Our material subcontractors are an extension of Healthy Blue and the services we deliver. We build trusted, collaborative, long-standing relationships with our material subcontractors to coordinate a seamless delivery of services that meet LDH requirements. Healthy Blue will continue to work closely with the State to demonstrate that through Superior Vision, we continue to meet Contract requirements and LDH expectations for delivering high-quality vision services to our Healthy Louisiana members.

## Processes to Monitor and Evaluate Performance

We monitor and evaluate Superior Vision's performance through daily collaboration, regular monitoring, and formal auditing processes. We will continue to oversee, monitor, supervise, and enforce contract compliance, as well as promote frequent, open, and effective communication that emphasizes delivery of quality services to members. We monitor Superior Vision to make sure they meet or exceed contractual requirements.

Our Louisiana-based Vendor Oversight Workgroup oversees the performance of our material subcontractors, including Superior Vision. Chaired by our Plan Compliance Officer, Hassan Gardezi, our team includes members of senior leadership, including our CEO, COO, Medical Director, Provider Relations Director, Quality Director, Subcontractor Account Managers, and other participants as necessary. The team meets monthly and reports to the Compliance Committee at its monthly meetings.

Our Vendor Oversight Workgroup works closely with our national organization oversight teams and committees to verify that the services or functions Superior Vision provides are of the highest quality and performed in a seamless, cost-effective manner. Superior Vision also provides services to five of our affiliates; the resultant oversight and monitoring at both the local and national levels offers a number of key benefits, including:

- Accountability to state-specific requirements
- Consistency in management, expectations, and remediation or corrective actions, as well as a high-level review of performance across all states to better identify trends
- Identification of best practices and innovations in one state to be shared with others
- Proactive identification and mitigation of performance variance in a single state, often avoiding impact on other markets

Healthy Blue operates under a culture of continuous quality improvement. Our Subcontractor Oversight Program is successful because we continually refine and enhance our processes and methods of monitoring and evaluating subcontractor performance.

Our Subcontractor Oversight Program begins with a thorough, rigorous evaluation process to confirm that material subcontractors meet operational, financial, legal, compliance, regulatory, accreditation, NCQA, and ethical

standards. During our pre-delegation audit, we examine items such as the organization's HIPAA privacy and security compliance, grievance and appeals history, operating procedures, staffing ratios, and financial viability. Healthy Blue will continue to request LDH approval of all material subcontracts, amendments, and substitutions, submitting a completed material subcontractor checklist using the template in the MCO Manual.

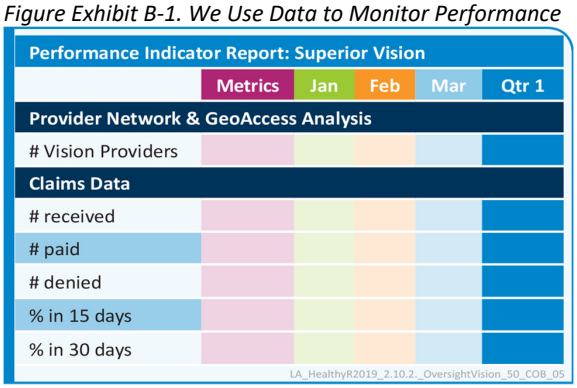
Once operational, our program enables us to monitor material subcontractor performance and financial stability. We tailor our program, including the scope and frequency of oversight activities, to the functions and services each material subcontractor provides. We outline the frequency and type of ongoing oversight activities we perform to monitor Superior Vision in Table Exhibit B-1.

*Table Exhibit B-1. Our Oversight Program Monitors Superior Vision Throughout the Life Cycle of the Relationship*

| Frequency | Scope of Oversight Activities |
|---|---|
| Daily | • Work with Superior Vision to answer questions, collaborate on problem solving, discuss opportunities for improvement, and escalate urgent performance concerns<br>• Provide rapid response to complaints and member issues |
| Monthly | • Review Superior Vision regulatory report submissions<br>• Complete Performance Indicator Report on Superior Vision<br>• Review performance against standards, including data trends, and report submissions<br>• Review performance with Superior Vision, Account Manager, and the Vendor Oversight Workgroup<br>• Delegation/Vendor Oversight and Management Committee (DVOMC) meeting to discuss performance monitoring, corrective action plans (CAPs), and terminations |
| Quarterly | • Meet with Superior Vision to discuss performance across markets and present issues, gaps, and concerns to the DVOMC<br>• Medicaid Financial Analysis team reviews quarterly unaudited financial statement to assess financial solvency<br>• DVOMC reports to the National Quality Improvement Committee to discuss any quality issues with subcontractor performance |
| Annually | • Perform audit to confirm that Superior Vision meets operational, systems, financial, legal, compliance, regulatory, accreditation, NCQA, and ethical requirements<br>• Medicaid Financial Analysis team reviews audited financial statements to assess financial solvency<br>• Submit annual audit findings to LDH, including any CAPs<br>• Present audit findings to the DVOMC and the Vendor Oversight Workgroup |

Healthy Blue assigns an Account Manager to each material subcontractor to conduct day-to-day management as well as oversight and performance review. This approach builds trust between our organization and our material subcontractors, which, in turn, helps prevent compliance issues. The Account Manager works hand-in-hand with our Vendor Oversight Workgroup.

*Figure Exhibit B-1. We Use Data to Monitor Performance*




Shown in Figure Exhibit B-1, our monthly Performance Indicator Report (customized for each material subcontractor) is a key component of our Subcontractor Oversight Program. Each month, we collect and review Superior Vision performance against a defined set of metrics that represent LDH and Healthy Blue requirements. During monthly meetings, the Account Manager and Vendor Oversight Workgroup meet with Superior Vision to review performance against standards. We share the Performance Indicator Report, discuss both positive and negative data trends, and brainstorm opportunities for improvement. The review includes careful evaluation of performance metrics and, where applicable, network adequacy. Our experience shows that transparency and open, constructive dialogue is critical to maintaining a collaborative partnership with material subcontractors that drives seamless service delivery to members.

While we review all performance metrics, we pay careful attention to member grievances and appeals, looking at topics, volumes, and trends (positive and negative). We work with Superior Vision to resolve individual grievances, as well as identify opportunities for more widespread improvements that would improve member satisfaction.

National oversight functions and a strong governance structure provide an additional level of support to our program. Regular communication between national functions and our Vendor Oversight Workgroup will maintain focus on delivering high-quality services to our members. National oversight functions include:

- The Delegation Operations Committee (DOC) includes representatives from account management, quality, legal, compliance, and other operational areas as needed. The DOC assesses oversight and compliance (with contractual and applicable State, federal, and accreditation standards), monitors CAPs (including recommending escalation), evaluates subcontractor performance through reports analysis, and makes recommendations to DVOMC on findings, as well as the use of audit tools.
- The DVOMC oversees subcontractors serving multiple health plans and is responsible for meeting compliance with State, federal, NCQA, CMS, and individual program requirements and standards, as well as other

regulatory or accreditation standards. They report to the National Quality Committee quarterly and the National Quality Improvement Committee semi-annually.

- The National Quality Improvement Committee meets quarterly and reports any subcontractor quality or compliance-related issues to health plan leadership.

## Improving Subcontractor Performance and Results

Healthy Blue always strives to improve the level of service we deliver, and we expect our material subcontractors to do the same. During subcontractor oversight and monitoring, we not only review areas with substandard performance, but will seek out opportunities to "raise the bar" and deliver better service. We use our Subcontractor Scorecard in conjunction with our Performance Indicator Report to monitor performance, track actions taken to improve performance, and drive positive results from our material subcontractors. For material subcontractors that also support our affiliates, our national team's view of performance across markets can provide early insight into any problems that may affect our Healthy Louisiana operations.

Clearly defined expectations and consistent performance monitoring is a key piece of our Subcontractor Oversight Program, and written agreements detail performance standards and the actions we take to address inadequate or substandard performance. If at any time performance does not meet our expectations, we will take action and work closely with Superior Vision toward a resolution and return to complete and ongoing compliance.

Our subcontractor agreements outline specific service level agreements (SLAs) for each function we delegate that align with LDH requirements. For example, we require Superior Vision to pay 90% of clean claims within 15 business days, maintain a call center abandoned rate of not more than 5%, and submit complete, accurate, and timely reports and encounter data. If LDH modifies a standard, as they have done with some performance measures in the Model Contract, we will amend the subcontractor agreement to reflect the change.

If Healthy Blue identifies a performance or operational problem with Superior Vision, we immediately address our concerns by applying a series of escalating interventions, including increased meeting frequency and data submission, development of an informal action plan, development of a CAP, financial penalties, and other sanctions.

Healthy Blue views interventions not as a punitive action, but rather a documented process to improve performance. The type of intervention depends on a combination of factors, including the severity of the issue and historical performance. For example, a single month of missing an SLA will likely result in increased monitoring and an action plan, while missing an SLA in two consecutive months warrants a CAP. We track and monitor all interventions. In the event that interventions are unsuccessful in generating a sustained performance improvement, we will consider termination and notify LDH the day the decision is made.

## Subcontractor Report Submission and Data Exchanges

Healthy Blue requires that Superior Vision submit two primary types of reports: data we need to fulfill ad hoc and regulatory reporting requirements, and operational information to monitor performance against standards. Account Managers maintain a schedule of due dates for both types of reports and reach out if they are late or submit incomplete or inaccurate data. Superior Vision submits reports, such as provider network information, cash disbursement journals, and call center performance, based on an internal due date (ahead of the LDH deadline) to provide time for a thorough quality review. Superior Vision also provides information for each monthly Performance Indicator Report so that we can monitor and manage their performance against a defined set of metrics.

Healthy Blue also requires Superior Vision to submit data files, including encounter data, on a specified schedule. We document not only the schedule (frequency and day/time), but also the format and secure transmission method. If we do not receive a file on its due date, an email alert notifies the Account Manager and prompts outreach to Superior Vision to ascertain the status and reason for the delay. In addition, we maintain a schedule for files we send Superior Vision, including member enrollment data (834 file), and require that they update their database promptly.

## Monitoring the Financial Condition of our Material Subcontractors

Healthy Blue understands that we need to make sure our material subcontractors maintain a strong and sound financial condition in order to avoid member disruption in accessing services. Through our Subcontractor Oversight Program, day-to-day interactions and monitoring activities give us insight into our subcontractors' financial health. We pay careful attention to signs that may indicate problems, such as a drop in claims payment timeliness, changes in encounter completeness or accuracy, or an increase in member complaints. We discuss any concerns at our internal Vendor Oversight Workgroup and Compliance team meetings. In addition, we review the financial stability of Superior Vision each quarter. The review process focuses on identifying any potential issues as early as possible and implementing necessary actions in order to avoid member service disruptions. We leverage our keen understanding of Superior Vision's financial solvency, the risk to our operations, and continued ability to serve Louisiana members.

Superior Vision submits unaudited financial statements quarterly and audited financial statements annually. These financial statements include the profit and loss statement, balance sheet, and statement of cash flow. Each quarterly statement includes both the respective quarter and year-to-date, so that as the year progresses, the team can monitor how the material subcontractor is performing over time.

## Annual Audit Confirms Compliance

An annual audit has been a key part of our Subcontractor Oversight Program since we began operations in Louisiana. We use the annual audit to confirm that Superior Vision continues to meet operational, financial, legal, compliance, regulatory, accreditation, and ethical requirements.

The audit team maintains a schedule for the annual audit of material subcontractor and a comprehensive set of audit tools for each type of function that may be delegated (such as network management, credentialing, claims processing, and call center). A global tool addresses areas such as HIPAA privacy and security; fraud, waste, and abuse; cultural competency; disclosure of ownership; and record retention. Each audit tool lists a series of audit elements applicable to the function and the evidence required to assess compliance. During the audit, the audit team reviews each element, decides whether the subcontractor is compliant or non-compliant, and documents the evidence. The audit process includes review of documents such as policies and procedures, financial statements, member complaints, employee and provider training documents, and provider contract templates. For subcontractors with provider credentialing, authorization, and claims processing responsibilities, the audit team randomly selects sample files for audit.

If the review identifies any deficiencies or areas of improvement, we work with the material subcontractor to develop a CAP that documents all of the corrective actions and steps needed to resolve the identified deficiencies, the name and title of responsible parties, and planned completion dates of each action step. Healthy Blue will submit the results of the annual review and any CAPs associated with the review to LDH.

## Material Subcontractor Return on Investment

We use material subcontractors that have specialized capabilities that Healthy Blue does not have internally, including dental, vision, and transportation. For these services, we use material subcontractors that have established relationships and long-standing experience across our organization, in multiple markets and across multiple lines of business (Medicaid, MMP, and Medicare). We continuously monitor our internal capabilities in order to determine whether we could bring specific capabilities “in-house” and deliver a similar or higher service capability and a more competitive cost structure.

Once operational, we use a number of processes to confirm that the material subcontractor continues to deliver the high-quality services that we expect. Processes cover a number of dimensions, including quality, compliance with performance standards, financial solvency, and strength of the partnership, and include the following:

- Monthly oversight meetings
- Monthly, quarterly, and annual report submission and monitoring
- Quarterly Joint Operations Committee meetings
- Quarterly and annual financial solvency reviews
- Quarterly review of utilization against cost
- Annual audits

If Healthy Blue determines that the material subcontractor relationship is not delivering the value we expect — to our members, LDH, and the Healthy Louisiana program — we will investigate alternatives.

Instructions: The Proposer should attach the executed or draft contract and indicate compliance witheach of the following checklist items by completing the "Location" column.

| | Checklist Item | **Location** (Include Name ofDocument, Page Number, and Section Number/Letter) |
|---|---|---|
| 1 | Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between LDH and the MCO and the MCO Manual, and either physically incorporate these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request. | MSA Amendment (12/1/20), Exhibit A-10, Section 16, Page 5 |
| 2 | Include a signature page that contains an MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for executed contracts). | MSA - Page 30; Participating Provider Network Agreement - Page 27<br>MSA Amendment (12/1/20) - Pages1 & 2 |
| 3 | Specify the effective dates of the subcontract agreement. | MSA - Pages 1 & 30; Participating Provider Network Agreement - Pages 1 & 27; MSA Amendment (12/2/20) - Page1 |
| 4 | Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties. | MSA Amendment (12/1/20), Exhibit A-10, Section 17, Page 5 |
| 5 | Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties. | MSA Amendment (12/1/20), Exhibit A-10,Section 17, Page 5 |
| 6 | Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid whenreduced to writing, duly signed and attached to the original of the subcontract. | MSA Amendment (12/1/20), Exhibit A-10, Section 18, Page 5 |
| 7 | Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and LDH for any of the reasons described in the contract, the MCO shall immediately make available to LDHor its designated representative, in a usable form, any and all records,whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to LDH. | MSA Amendment (12/1/20), Exhibit A-10, Section 19, Page 5 |
| 8 | Ensure the subcontractor shall not, without prior approval of the MCO,enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO. | MSA Amendment (12/1/20), Exhibit A-10, Section 20, Page 5 |

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| 9 | Require that if any requirement in the subcontract is determined by LDH to conflict with the contract between LDH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect. | MSA Amendment (12/1/20), Exhibit A-10,Section 2(b), Page 3 |
| 10 | Identify the population covered by the subcontract. | Amendment to Participating Provider Network Agreement (1/1/20), Exhibit A, Page 4 & Exhibit A-2, Pages 6-7 |
| 11 | Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to enrollees through the last day that the subcontract is in effect. | MSA Amendment (12/1/20), Exhibit A-10, Section 21, Page 6 |
| 12 | Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO. | MSA Amendment (12/1/20), Exhibit A-10, Section 23, Page 6 |
| 13 | Specify the amount, duration, and scope of benefits and services that are provided by the subcontractor. | Amendment to Participating Provider Network Agreement (1/1/20), Exhibit A, Page 4 & Exhibit A-2, Pages 6-7 |
| 14 | Provide that emergency services be coordinated without the requirementof prior authorization of any kind. | MSA Amendment (12/1/20), Exhibit A-10, Section 24, Page 6 |
| 15 | Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 C.F.R. § 493.1 and 493.3, and any other federal requirements. | MSA Amendment (12/1/20), Exhibit A-10,Section 25, Page 6 |
| 16 | Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO enrollees pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between LDH and the MCO). MCO enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided byLa. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended and subject to reasonable charges. | MSA Amendment (12/1/20), Exhibit A-10, Section 28, Page 6 |
| 17 | Include record retention requirements as specified in the contract between LDH and the MCO. | MSA Amendment (12/1/20), Exhibit A-10, Section 29, Page 7 |

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| 18 | Shall make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG), HHS, the StateAuditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, andcontractors, and do on-site reviews of all matters relating to service deliveryas specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records areretained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested. | MSA Amendment (12/1/20), Exhibit A-10, Section 30, Page 7 |
| 19 | INTENTIONALLY LEFT BLANK | |
| 20 | Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or LDH or its designee. | MSA Amendment (12/1/20), Exhibit A-10, Section 32, Page 8 |
| 21 | Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level ofcare which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by LDH or its designee. | MSA Amendment (12/1/20), ExhibitA-10, Section 33, Page 8 |
| 22 | Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by LDH. | MSA Amendment (12/1/20), Exhibit A-10, Section 33, Page 8 |
| 23 | Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontract and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by LDH,the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate. | MSA Amendment (12/1/20), Exhibit A-10, Section 34, Page 8 |
| 24 | Provide for submission of all reports and clinical information to the MCO for reporting purposes required by LDH. | MSA Amendment (12/1/20), Exhibit A-10, Section |
| 25 | Require safeguarding of information about MCO enrollees according to applicable state and federal laws and regulations and as described in contract between LDH and the MCO. | MSA Amendment (12/1/20), Exhibit A-10,Section 36, Page 8 |
| 26 | Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO. | MSA Amendment (12/1/20), Exhibit A-10, Section 58, Page 12 |

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| 27 | Provide that the subcontractor comply with LDH's claims processing requirements as outlined in the RFP. | MSA Amendment (12/1/20), Exhibit A-10, Section 37, Page 8 |
| 28 | Provide that the subcontractor adhere to LDH's timely filing guidelines as outlined in the RFP. | MSA Amendment (12/1/20), Exhibit A-10, Section 37, Page 8 |
| 29 | Provide that, if LDH or its subcontractors discover an error or a conflict witha previously adjudicated encounter claim, the subcontractor shall be required to adjust or void the encounter claim within fourteen (14) calendardays of notification by LDH or the MCO, or if circumstances exist that preventthe subcontractor from meeting this time frame, by a specified date approved by LDH. | MSA Amendment (12/1/20), ExhibitA-10, Section 38, Page 8 |
| 30 | Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served. | MSA Amendment (12/1/20), Exhibit A-10, Section 40, Page 9 |
| 31 | Specify that at all times during the term of the subcontract, thesubcontractor shall indemnify and hold LDH harmless from all claims, losses,or suits relating to activities undertaken pursuant to the contract between LDH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between LDH and the MCO in its entirety in the subcontractor's agreement or by useof other language developed by the MCO and approved by LDH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by LDH. | MSA Amendment (12/1/20), Exhibit A-10, Section 41, Page 9 |
| 32 | Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's enrollees and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and atall times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage. | MSA Amendment (12/1/20), ExhibitA-10, Section 42, Page 9 |
| 33 | Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services, and stipulate that Louisiana law, without regard to itsconflict of laws provisions, will prevail if there is a conflict between the state law where the material subcontractor is based and Louisiana law. | MSA Amendment (12/1/20), Exhibit A-10, Section 43, Page 9 |
| 34 | Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective. | MSA Amendment (12/1/20), Exhibit A-10, Section 44, Page 9 |
| 35 | Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member. | MSA Amendment (12/1/20), Exhibit A-10,Section 45, Page10 |

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| 36 | Include a conflict of interest clause as stated in the contract between LDH and the MCO. | MSA Amendment (12/1/20), Exhibit A-10, Section 46, Page 10 |
| 37 | Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between LDH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor. | MSA Amendment (12/1/20), Exhibit A-10, Section 47, Page 10 |
| 38 | Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO. | MSA Amendment (12/1/20), Exhibit A-10, Section 48, Page 10 |
| 39 | Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract. | MSA Amendment (12/1/20), ExhibitA-10, Section 14, Page 5 |
| 40 | Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity. | MSA Amendment (12/1/20), Exhibit A-10, Section 52 and 56, Page 11 |
| 41 | Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO. | MSA Amendment (12/1/20), Exhibit A-10, Section 53, Page 11 |
| 42 | Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform anyservices under this Contract if that individual is required to have a work visaapproved by the U.S. Department of Homeland Security and such individual has not met this requirement. | MSA Amendment (12/1/20), Exhibit A-10, Section 55, Page 11 |
| 43 | Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or paymentmechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries. | MSA Amendment (12/1/20), Exhibit A-10, Section 61, Page 12 |

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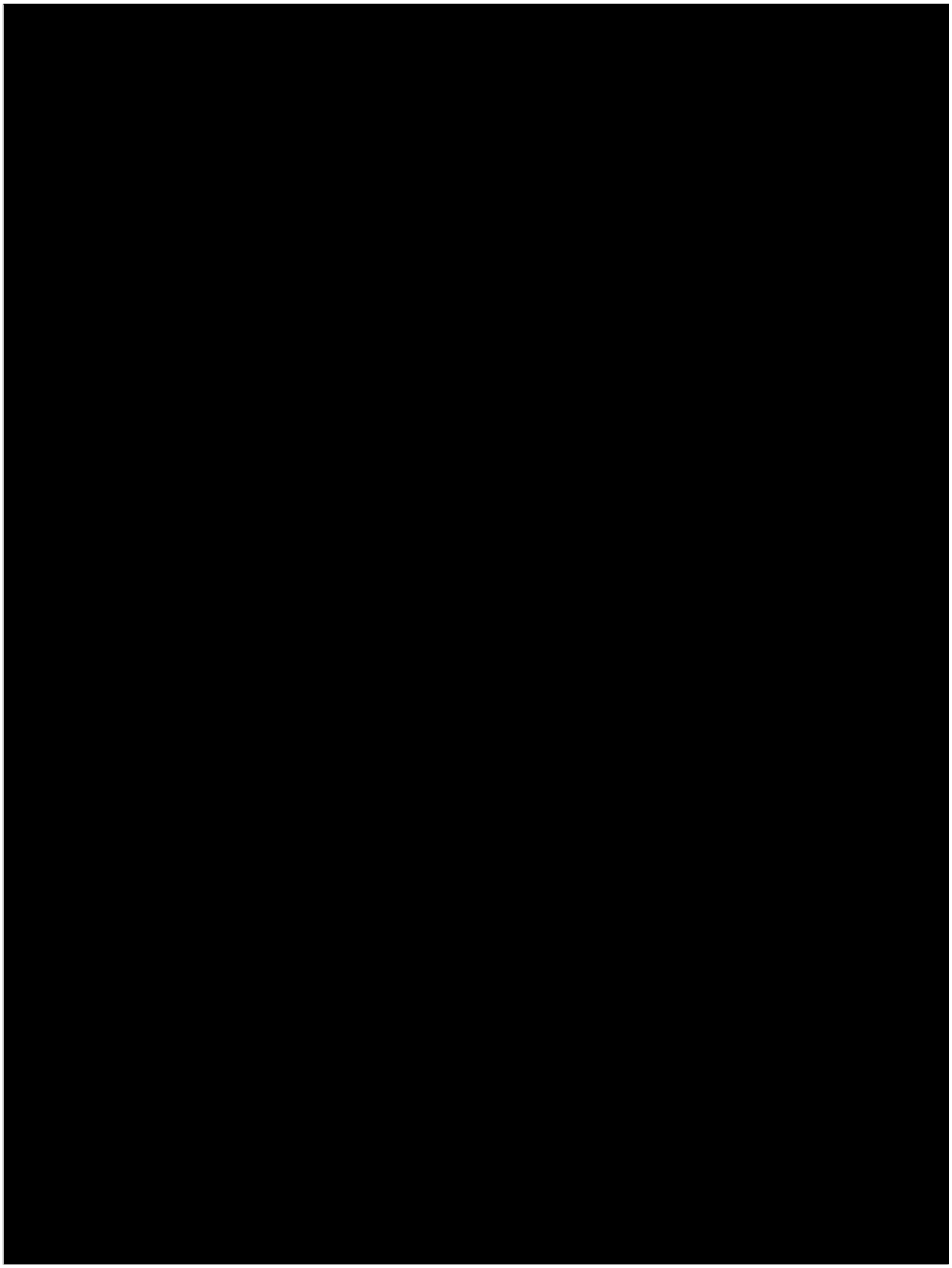
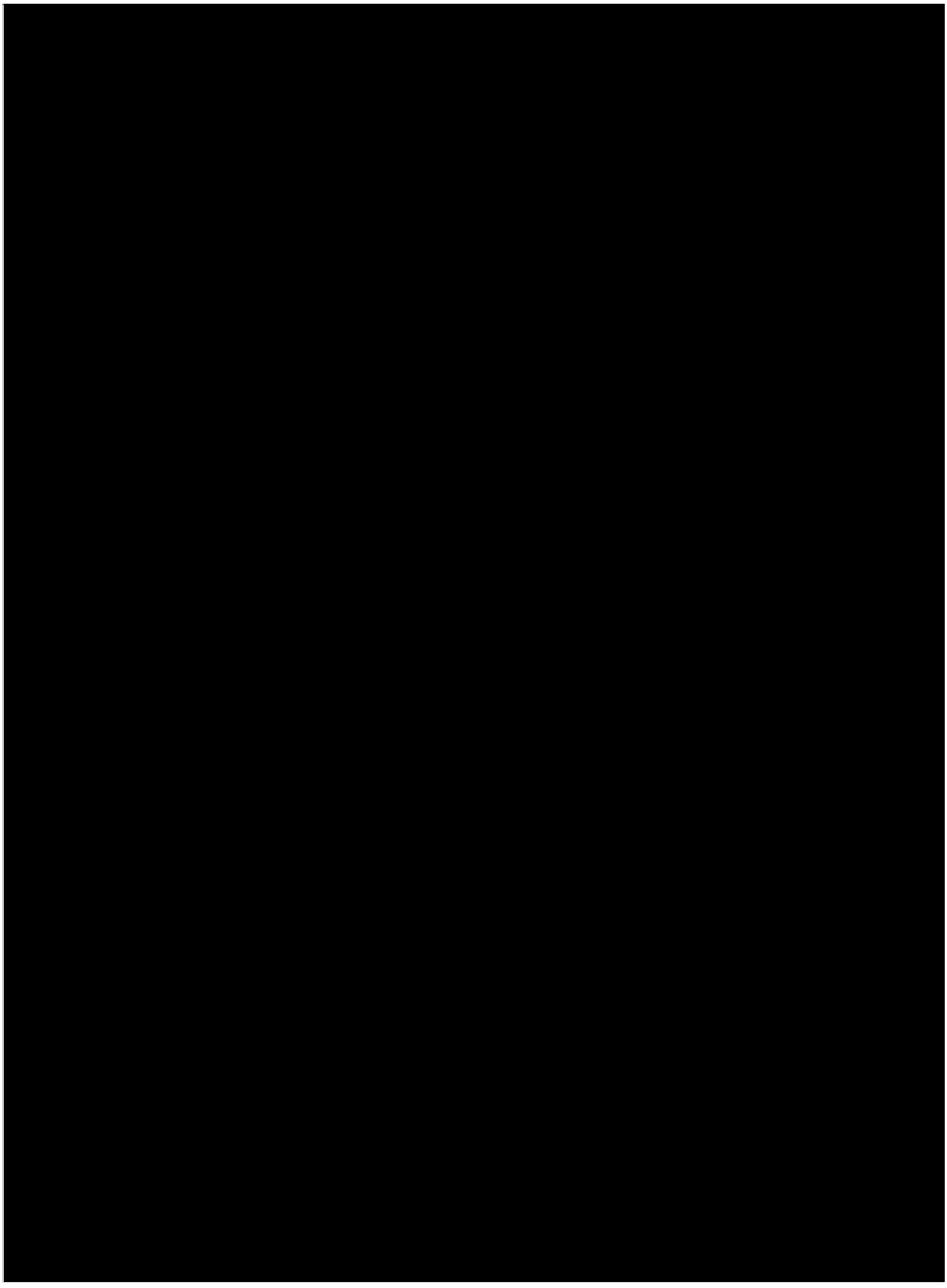
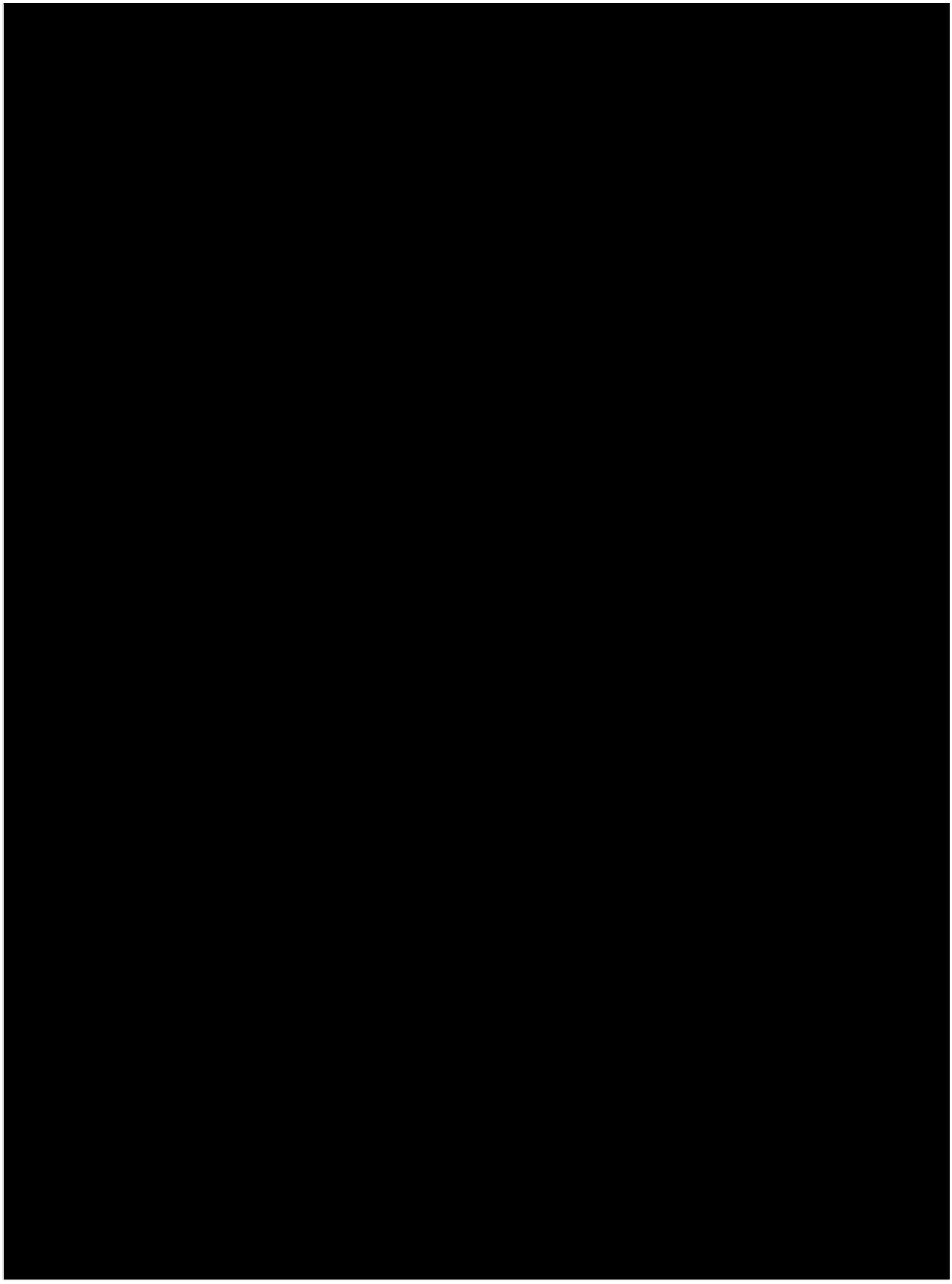
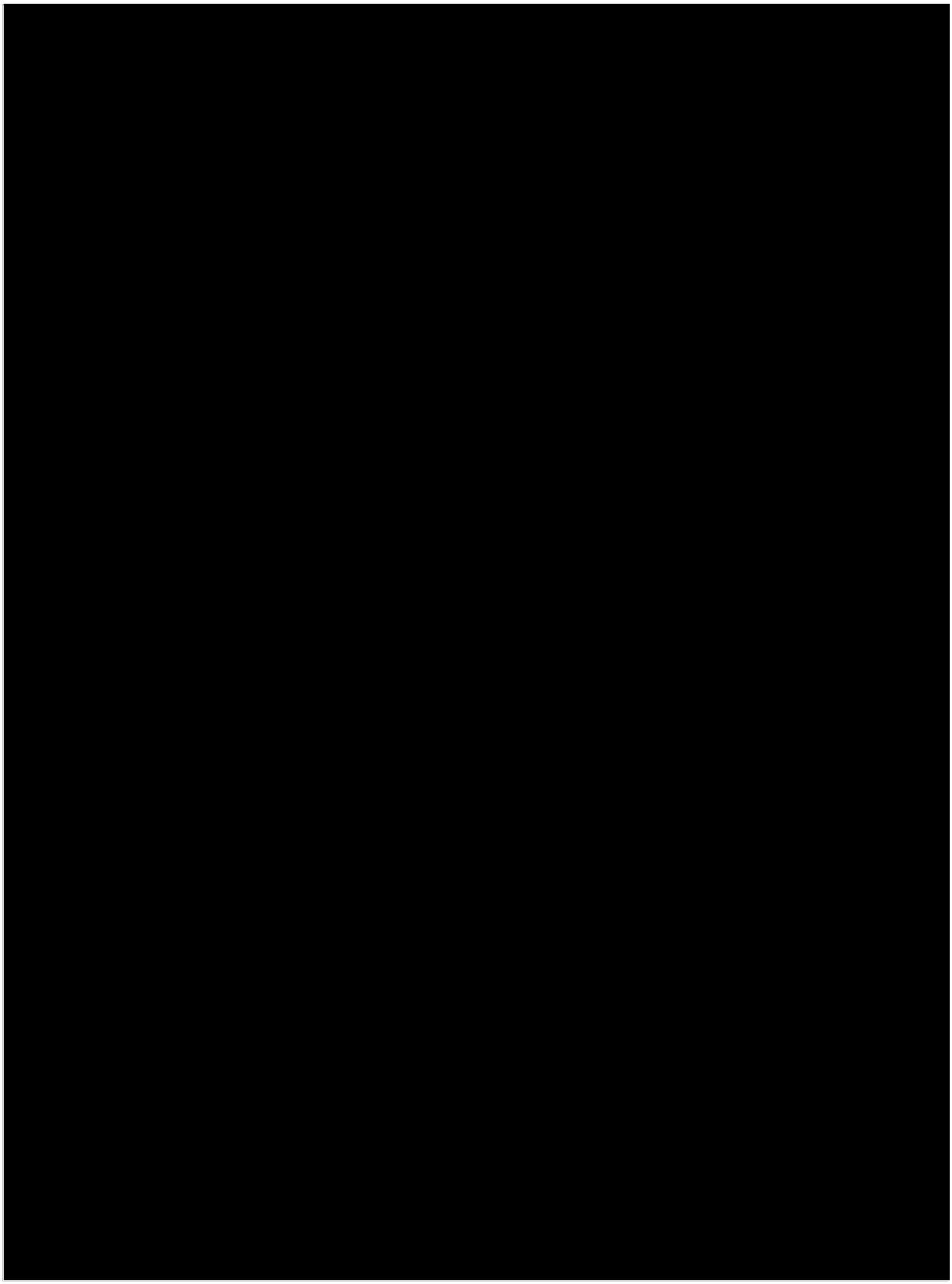
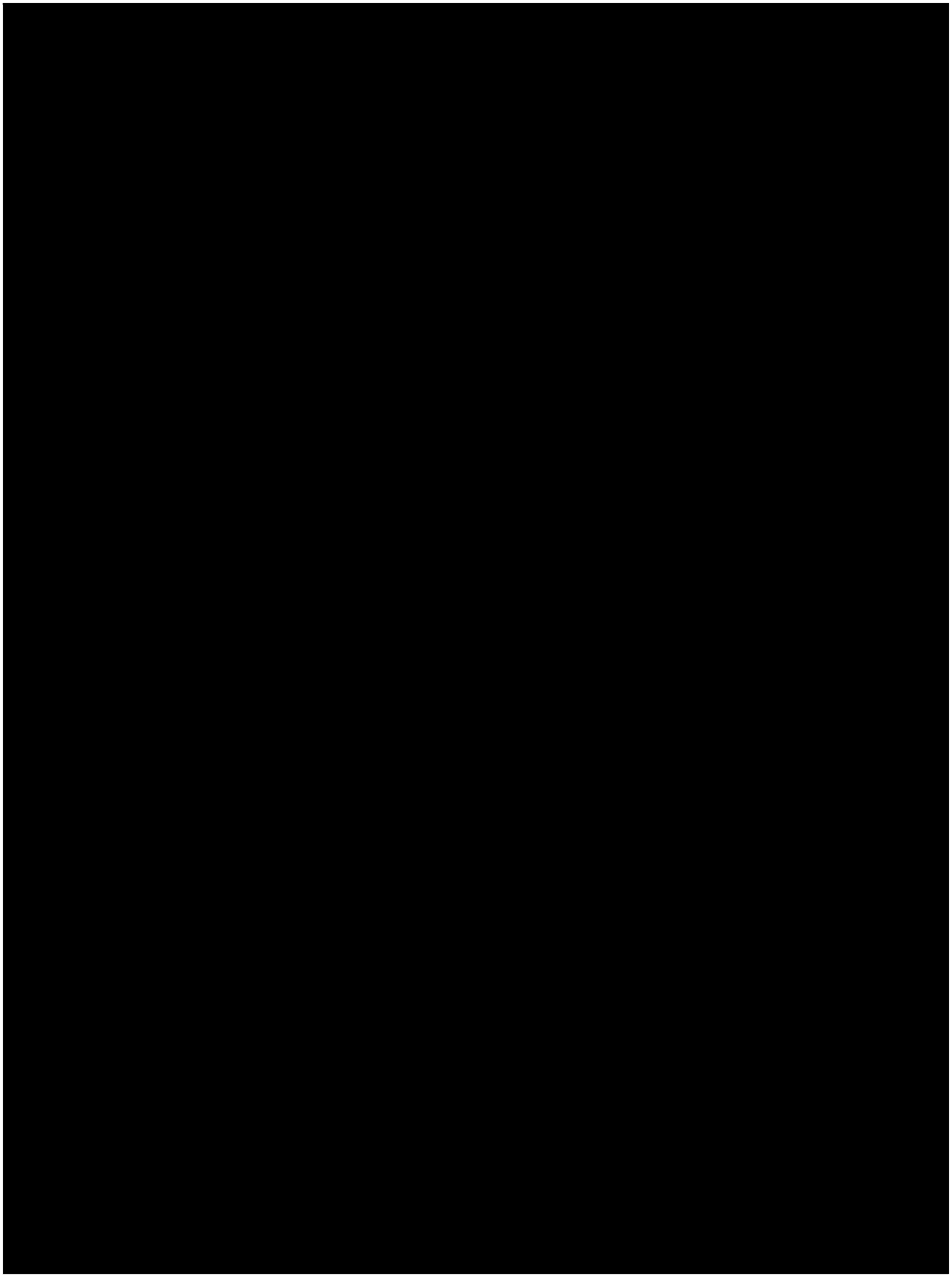
| 44 | Contain the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirementshall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. TheMCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request. | MSA Amendment (12/1/20), Exhibit A-10, Section 30, Page 7 |

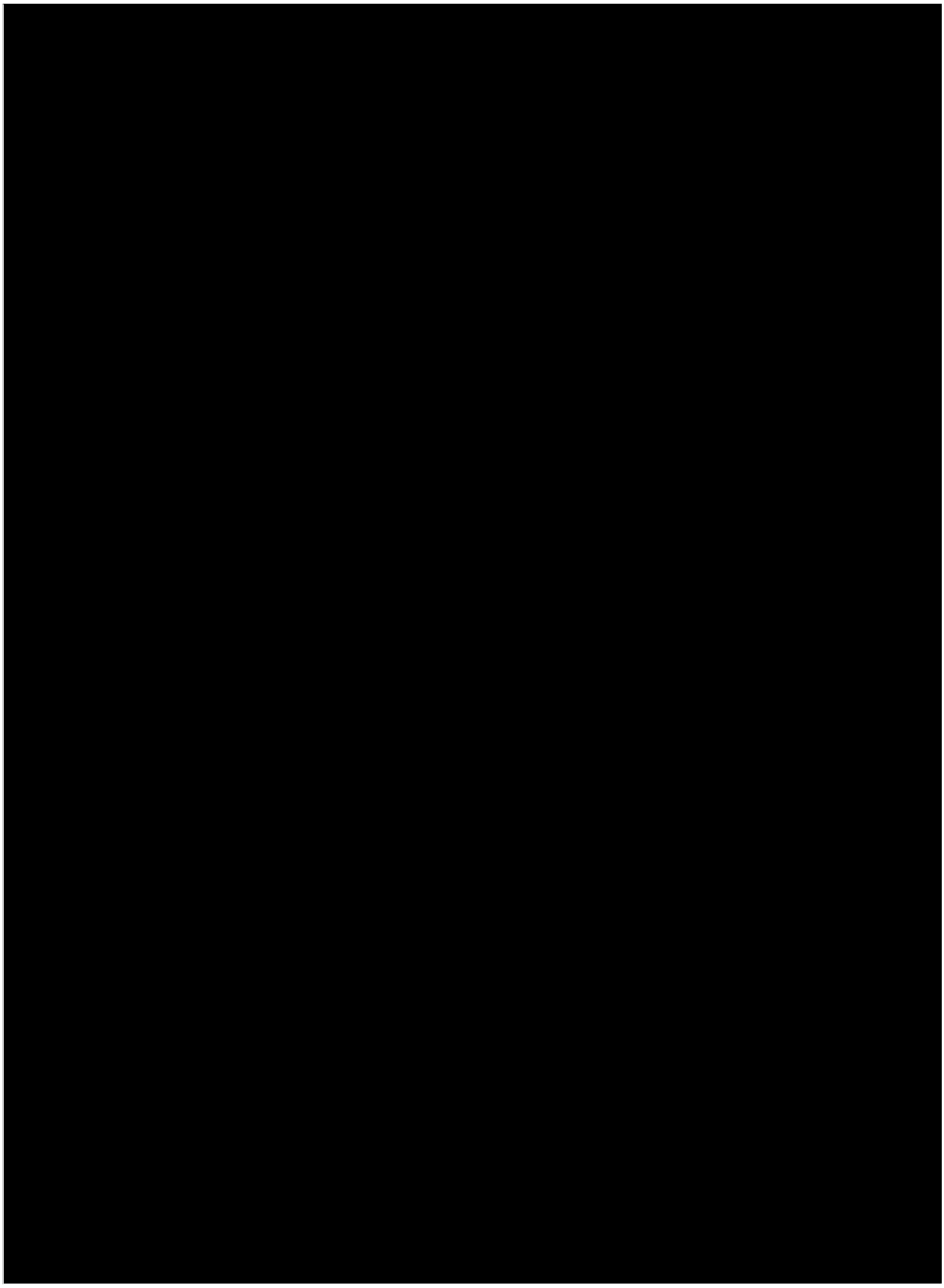


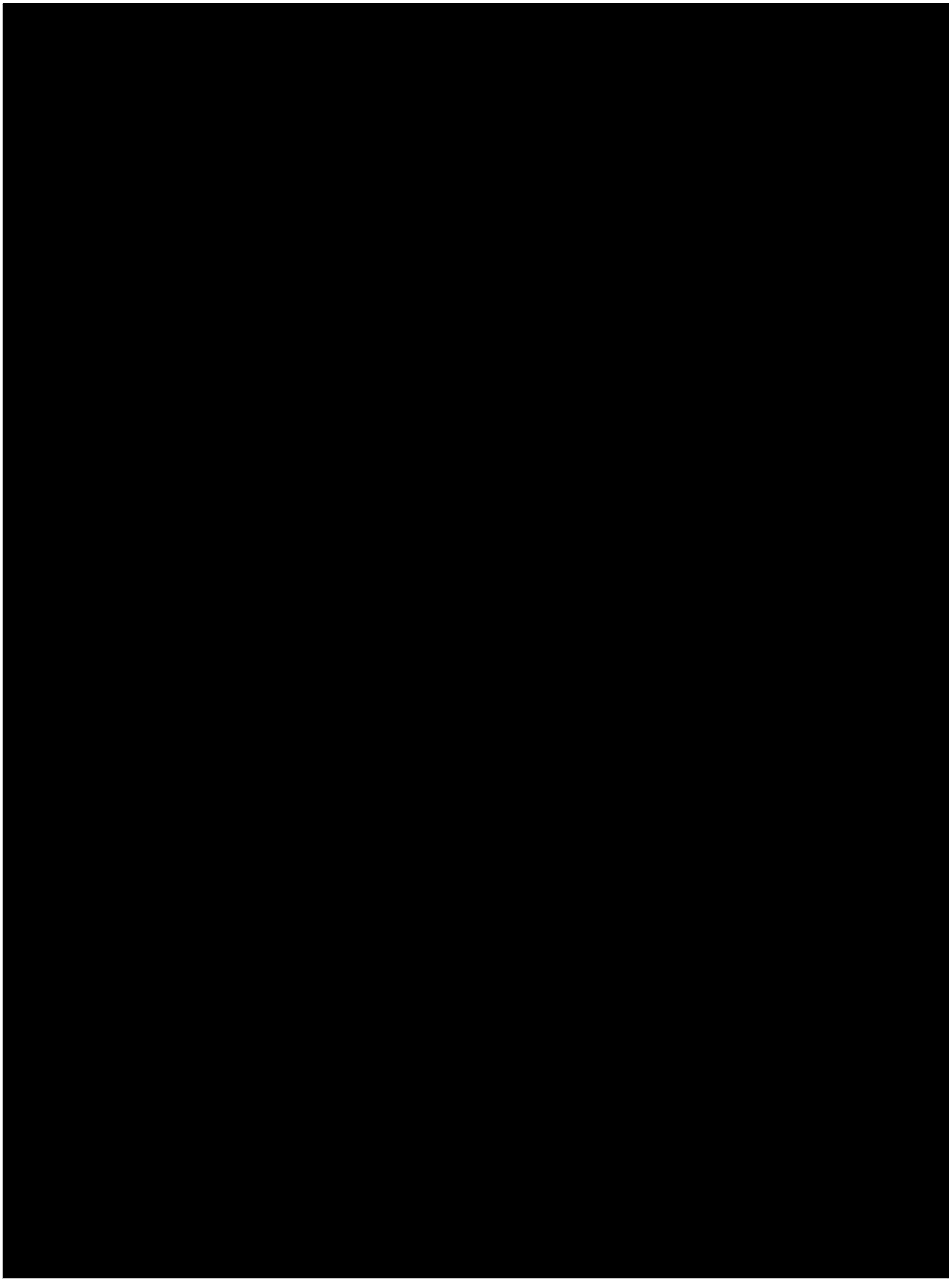


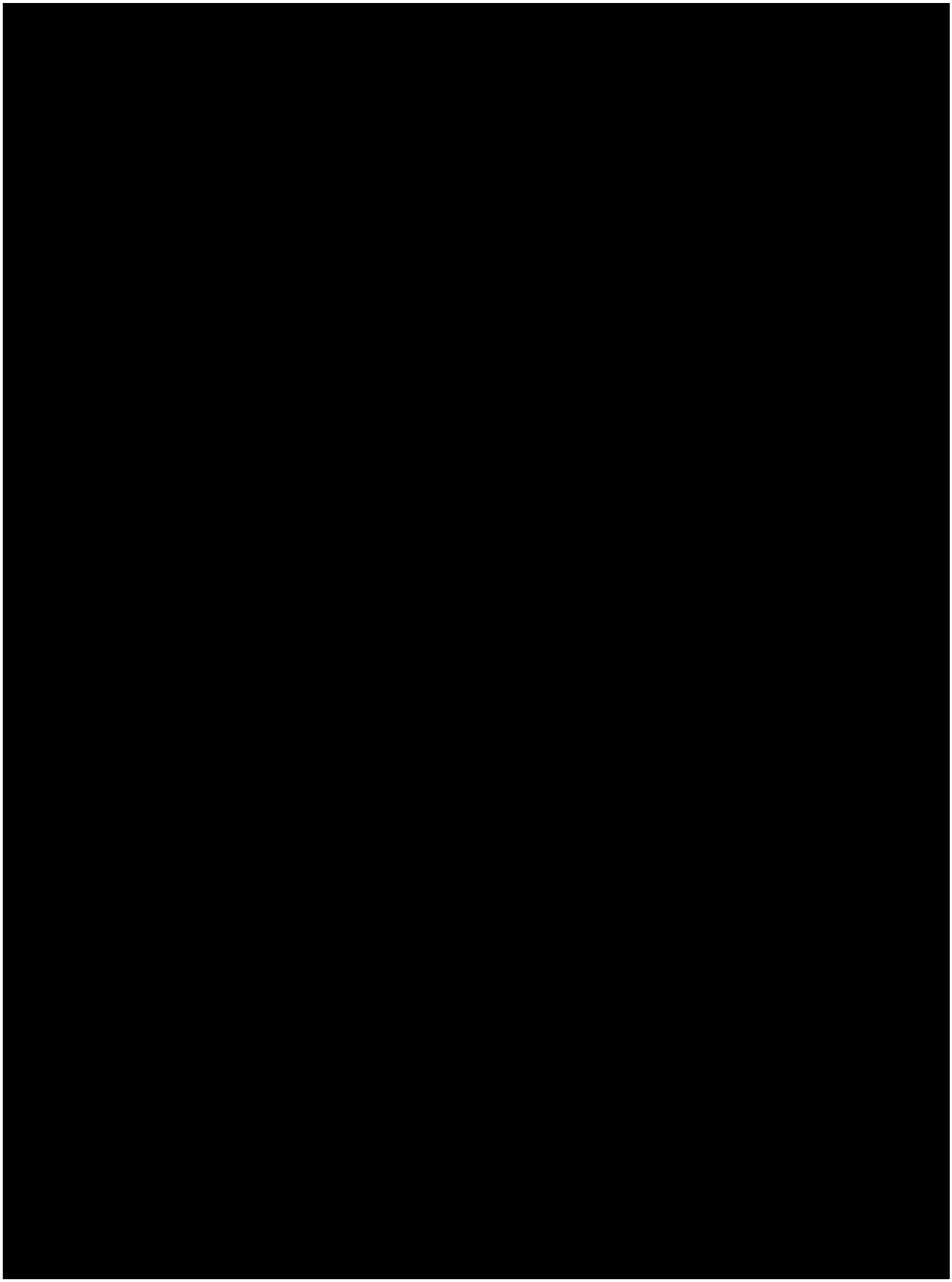


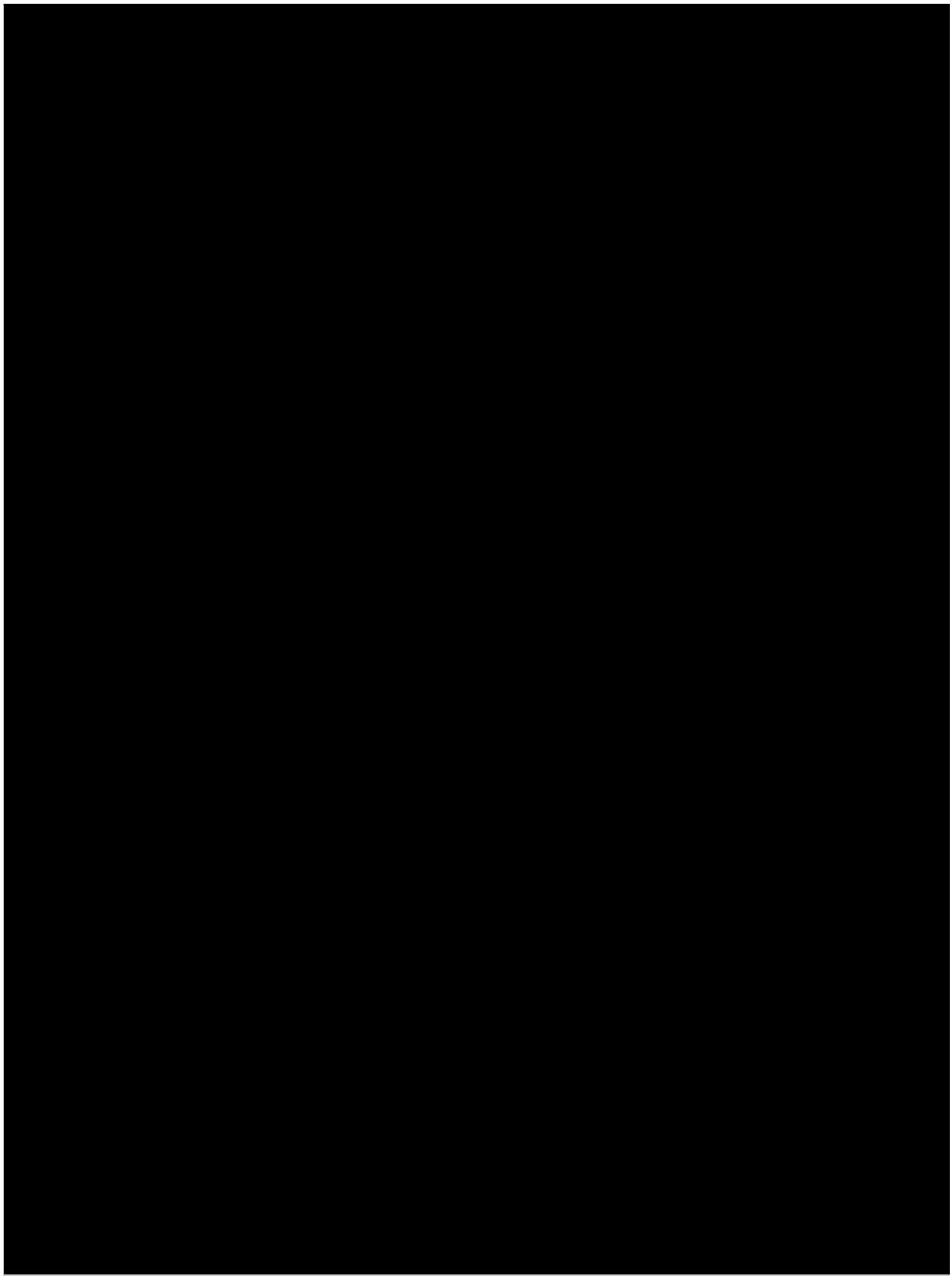


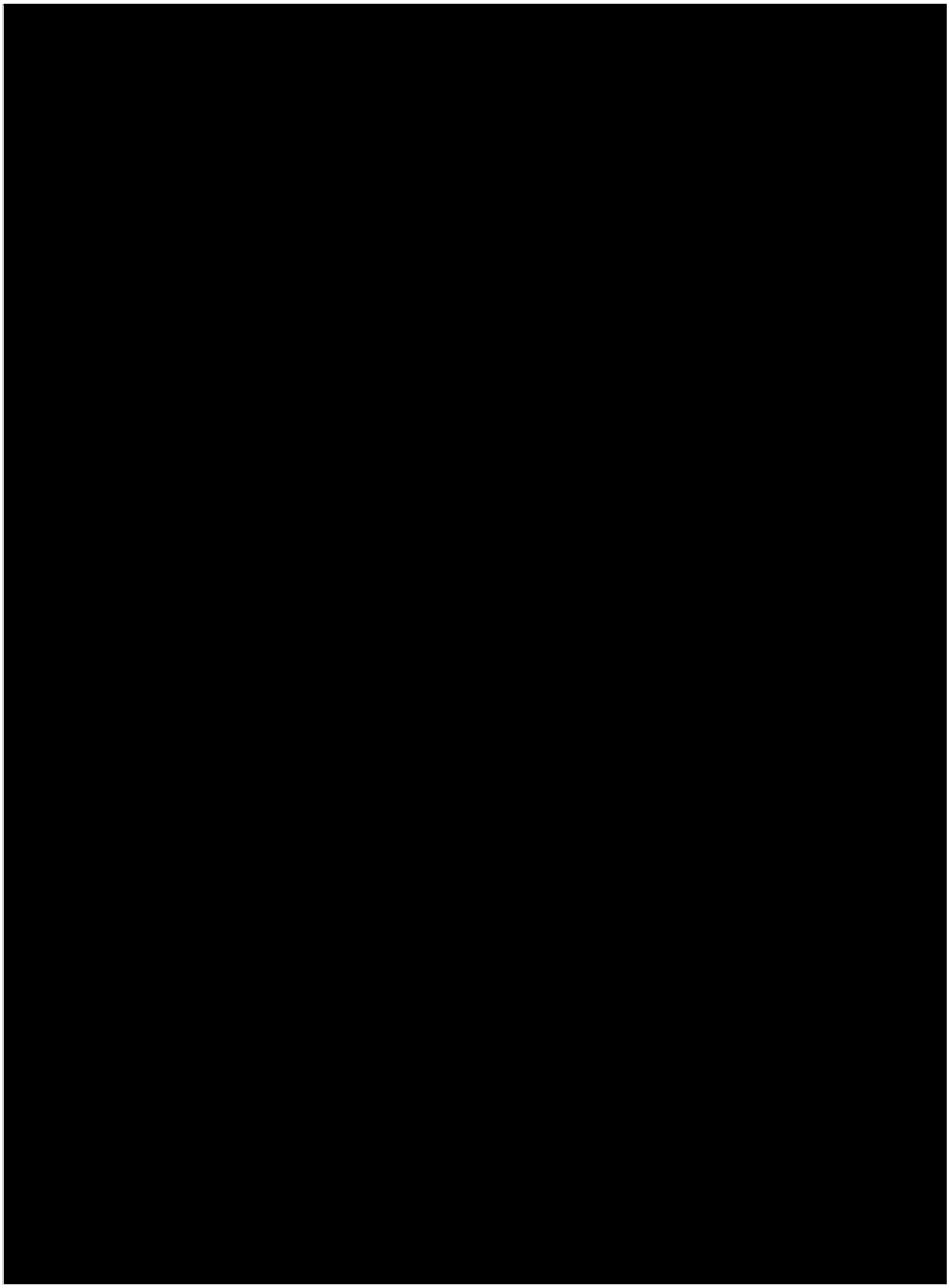


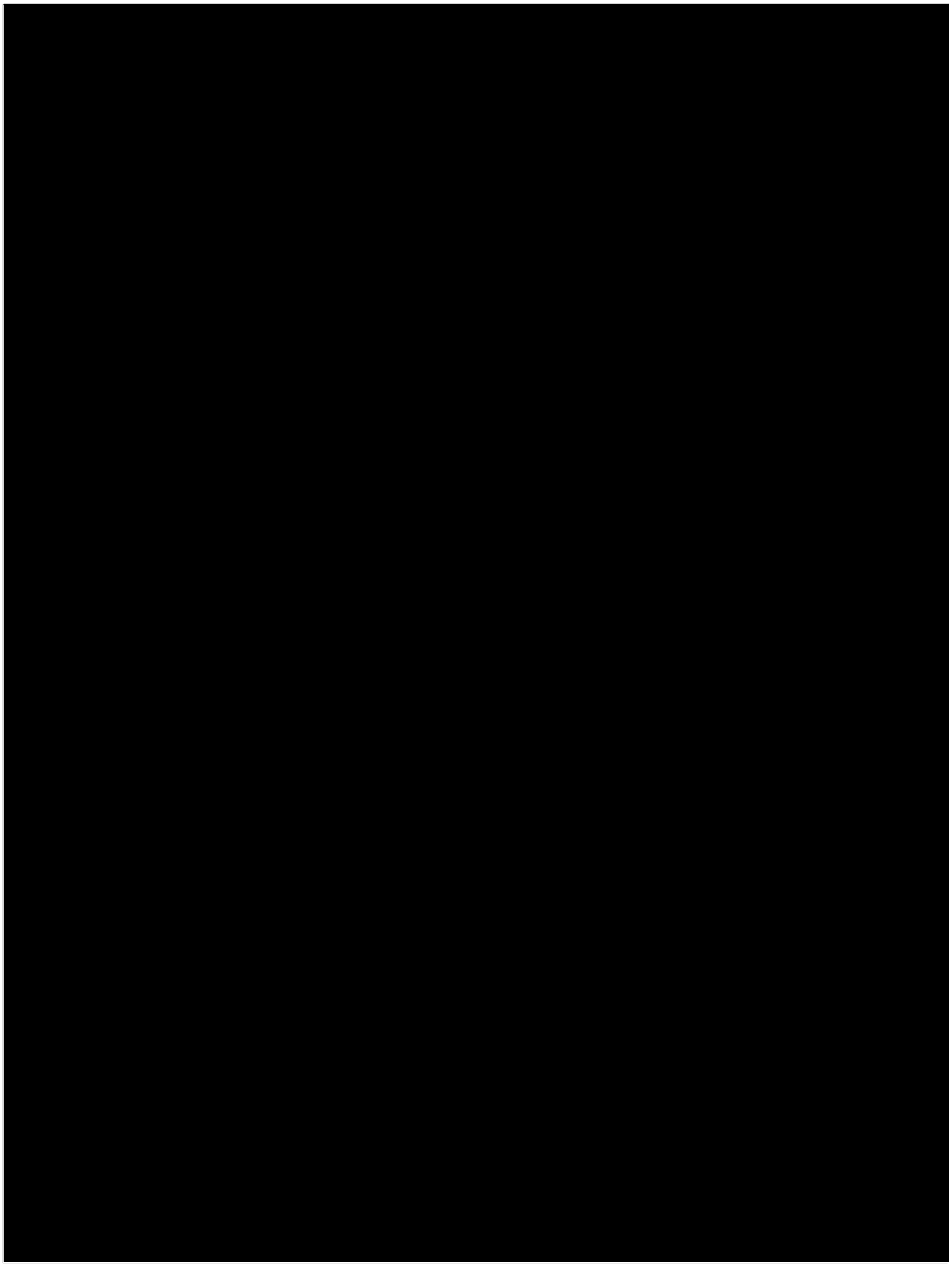


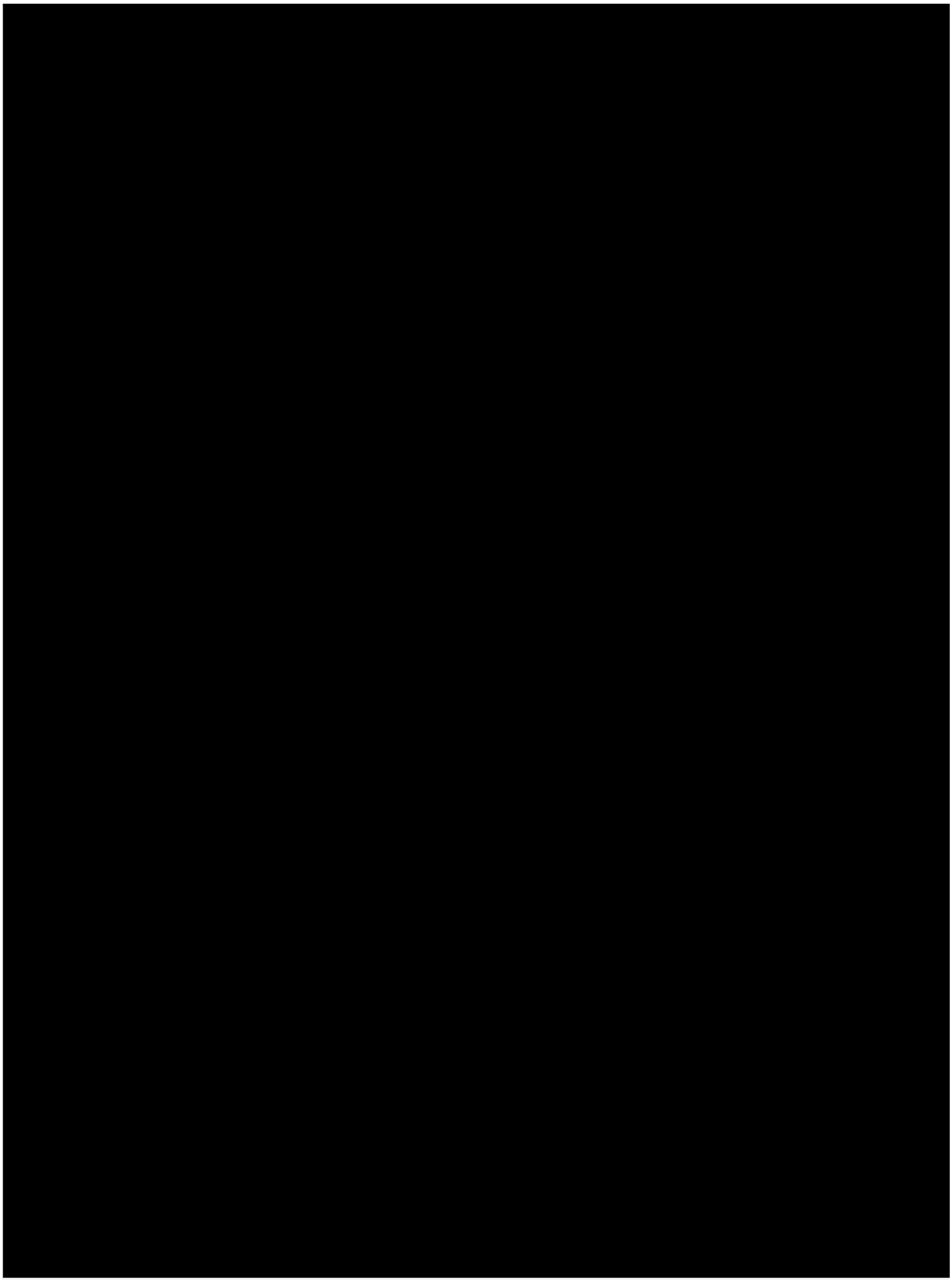


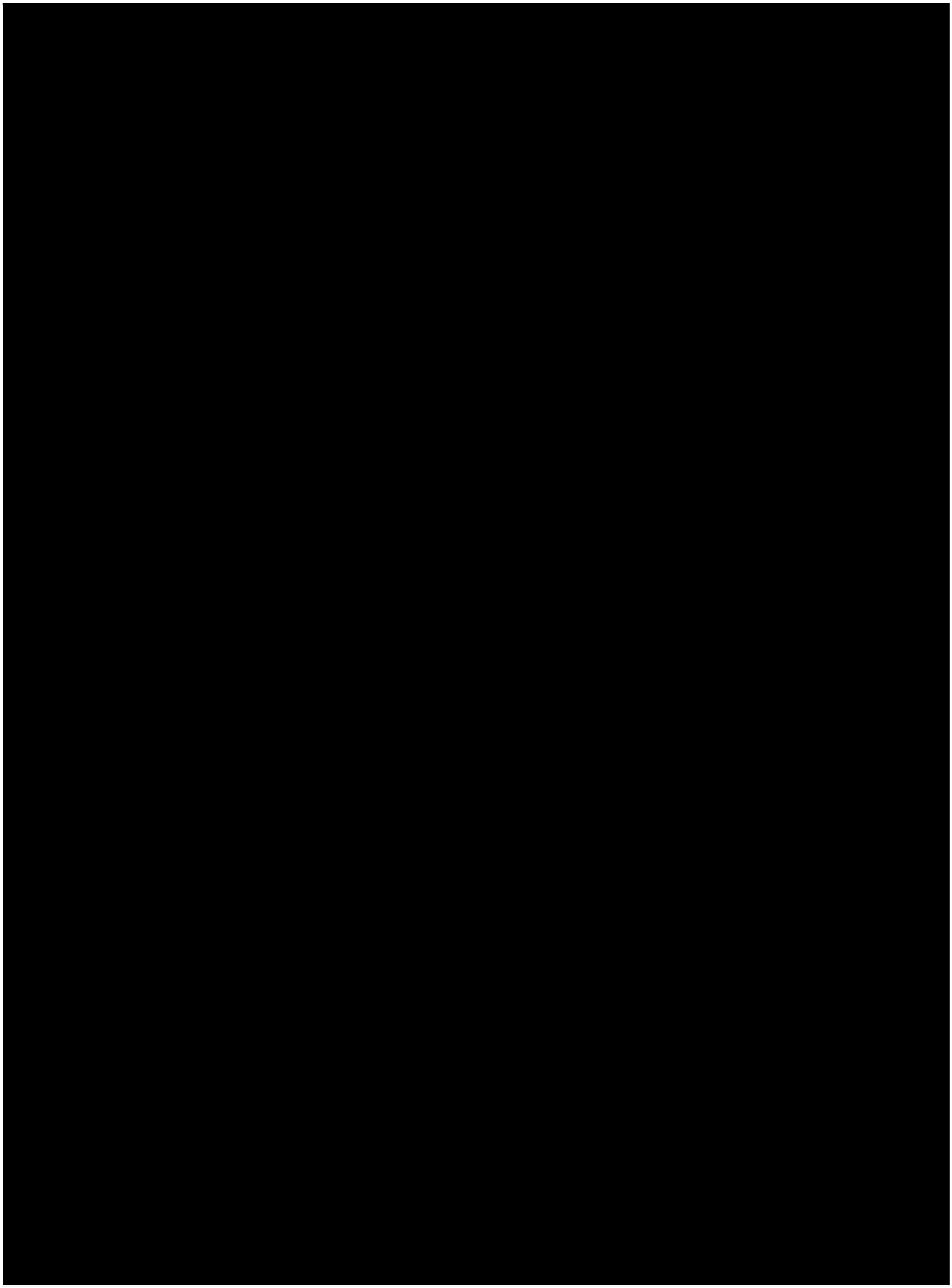


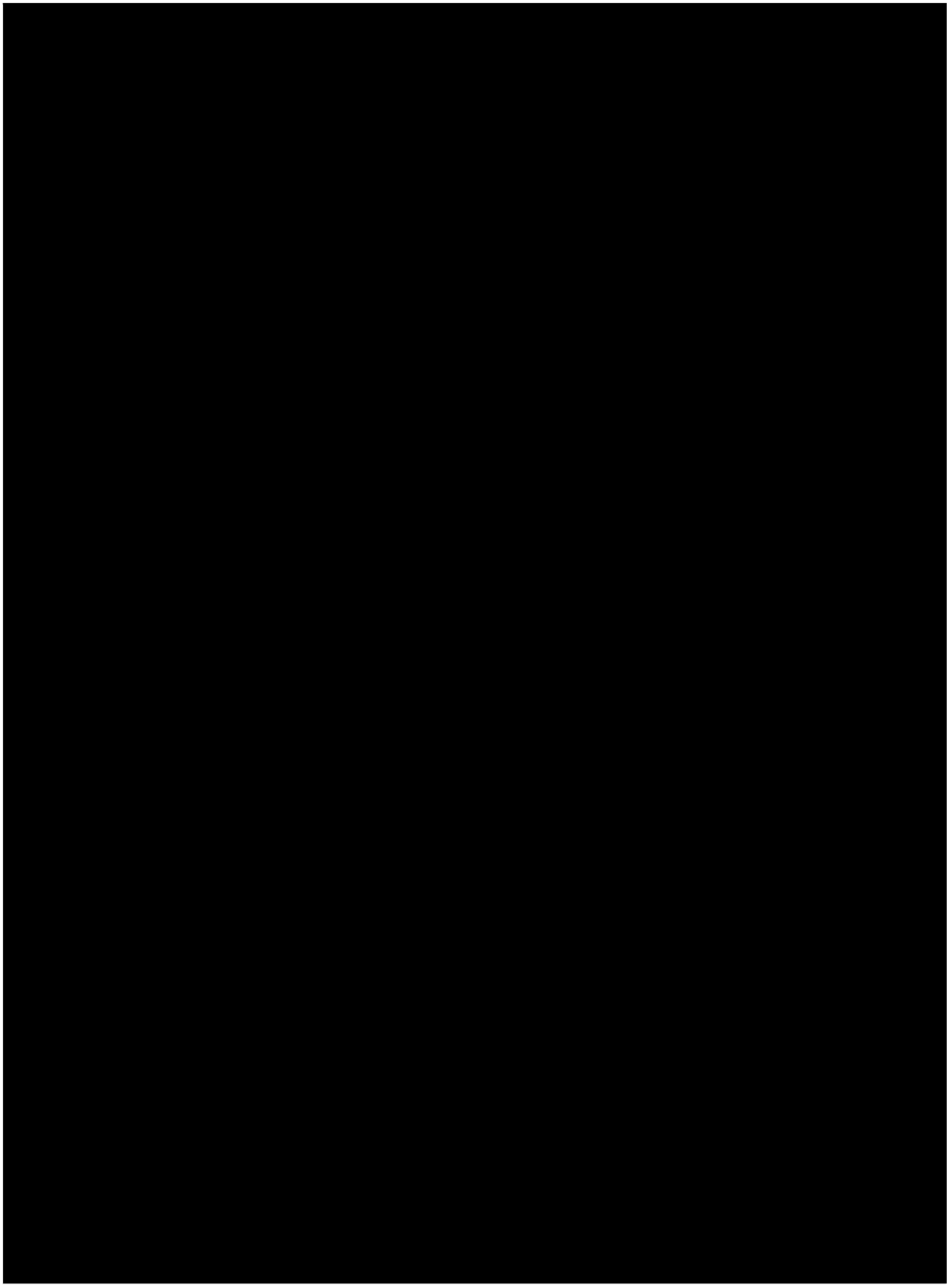


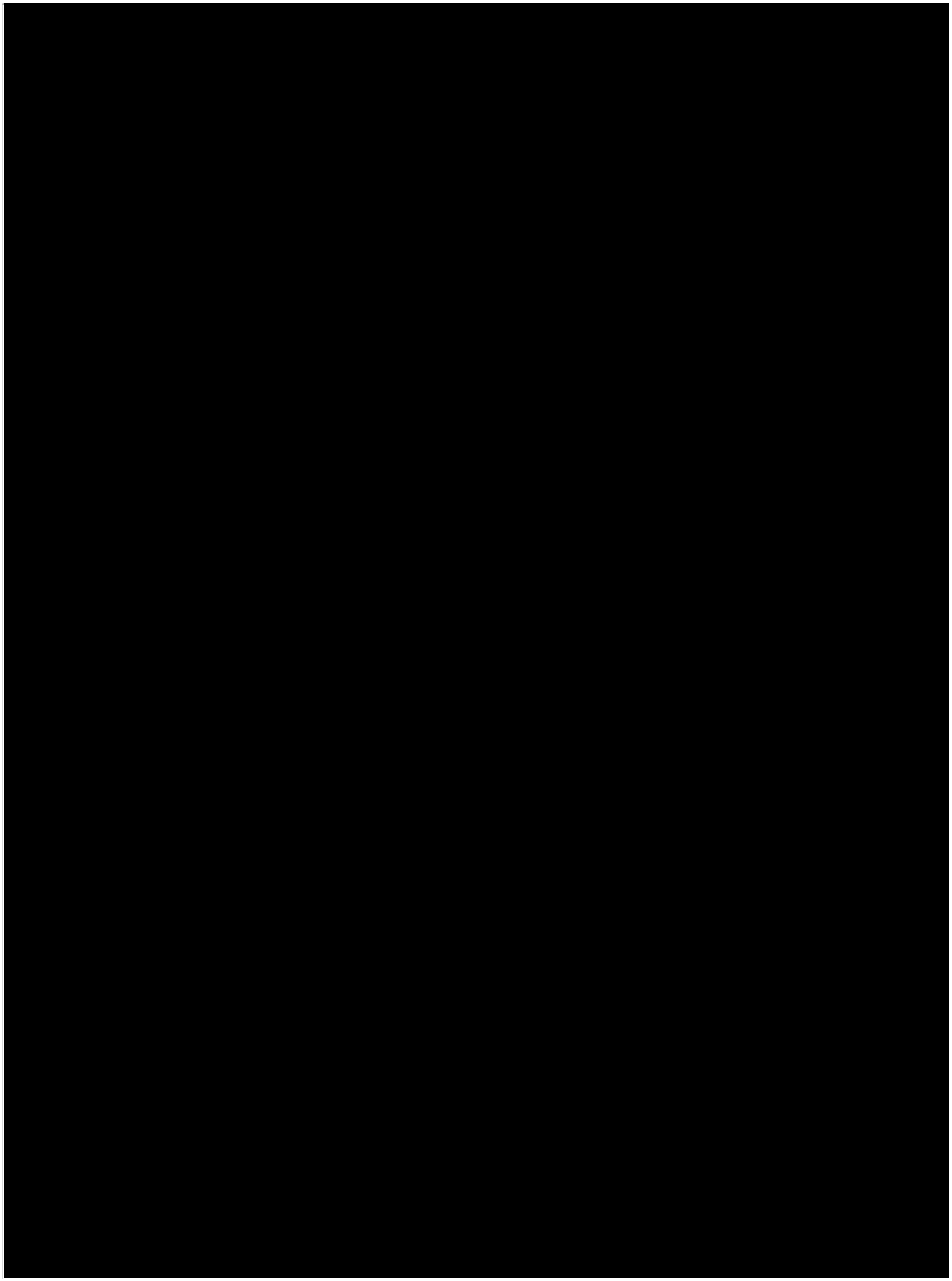


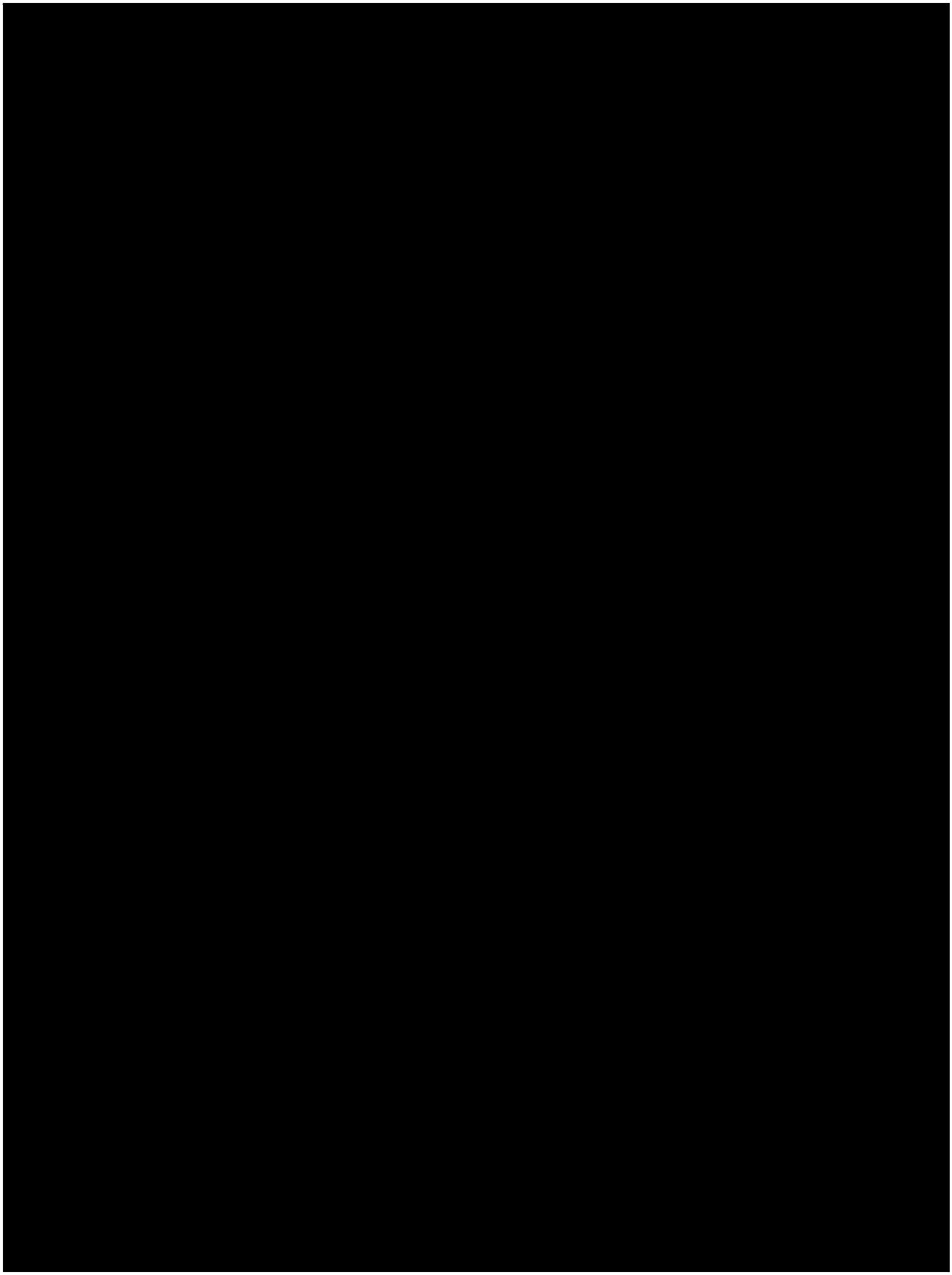


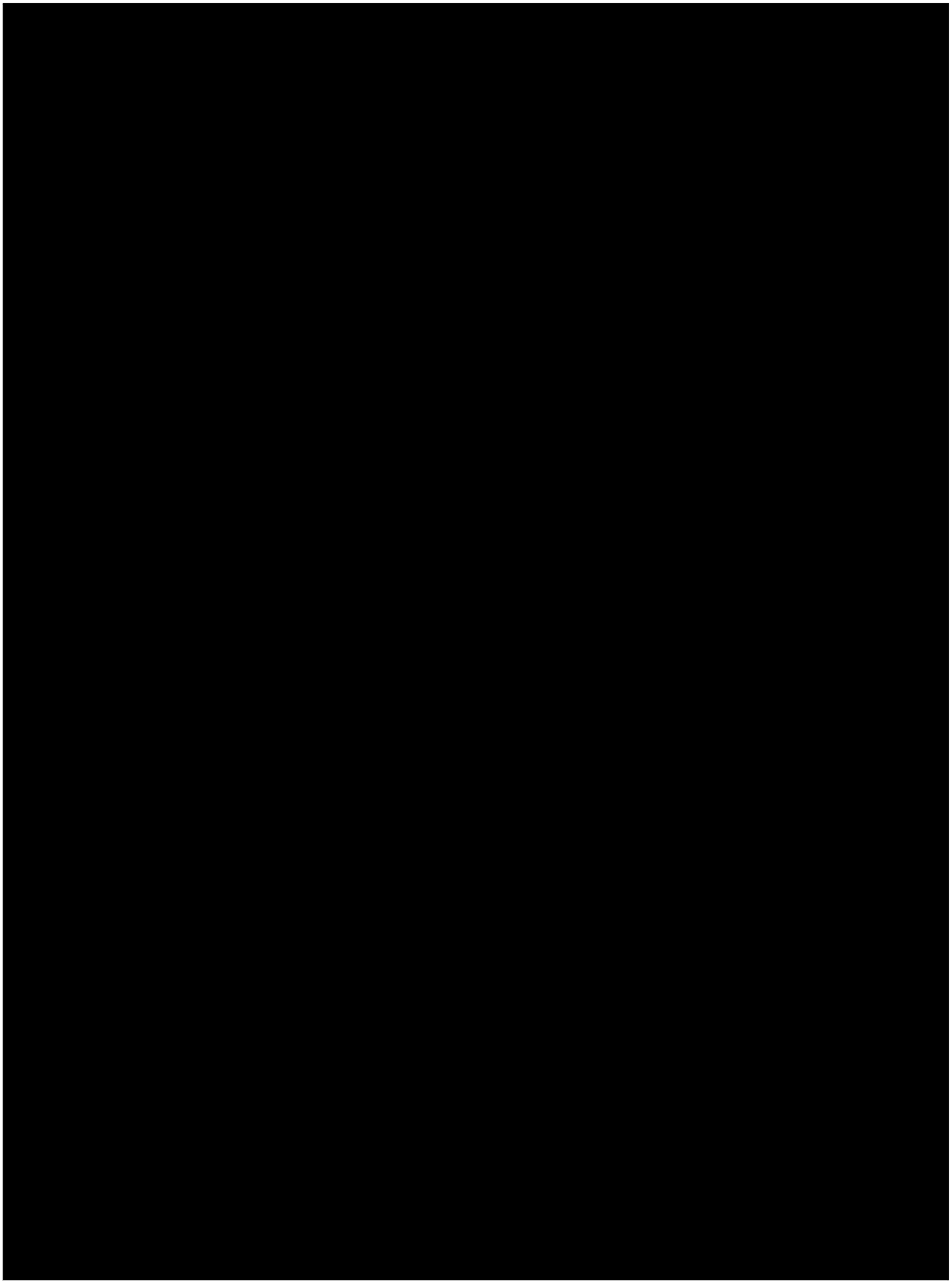


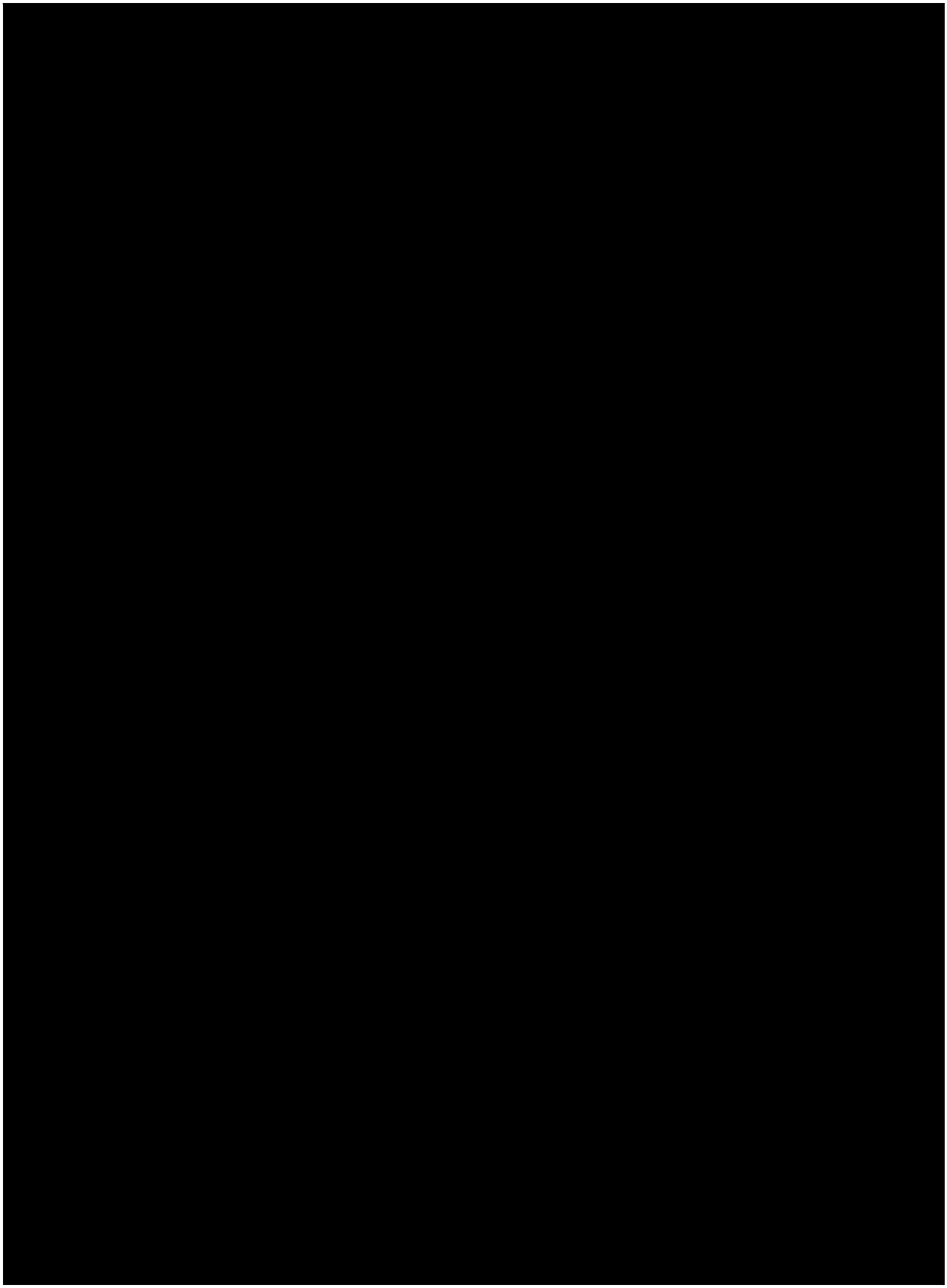


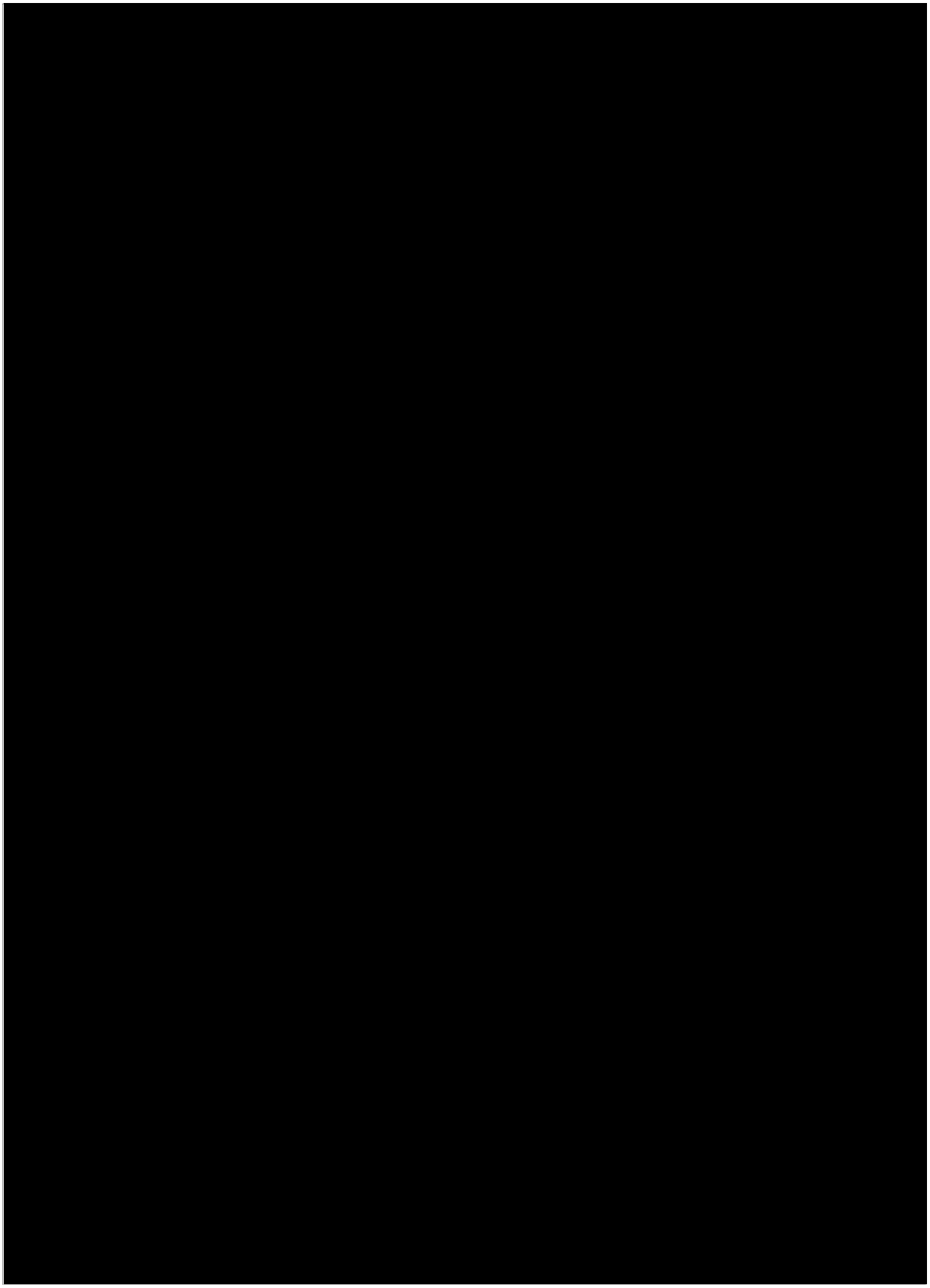


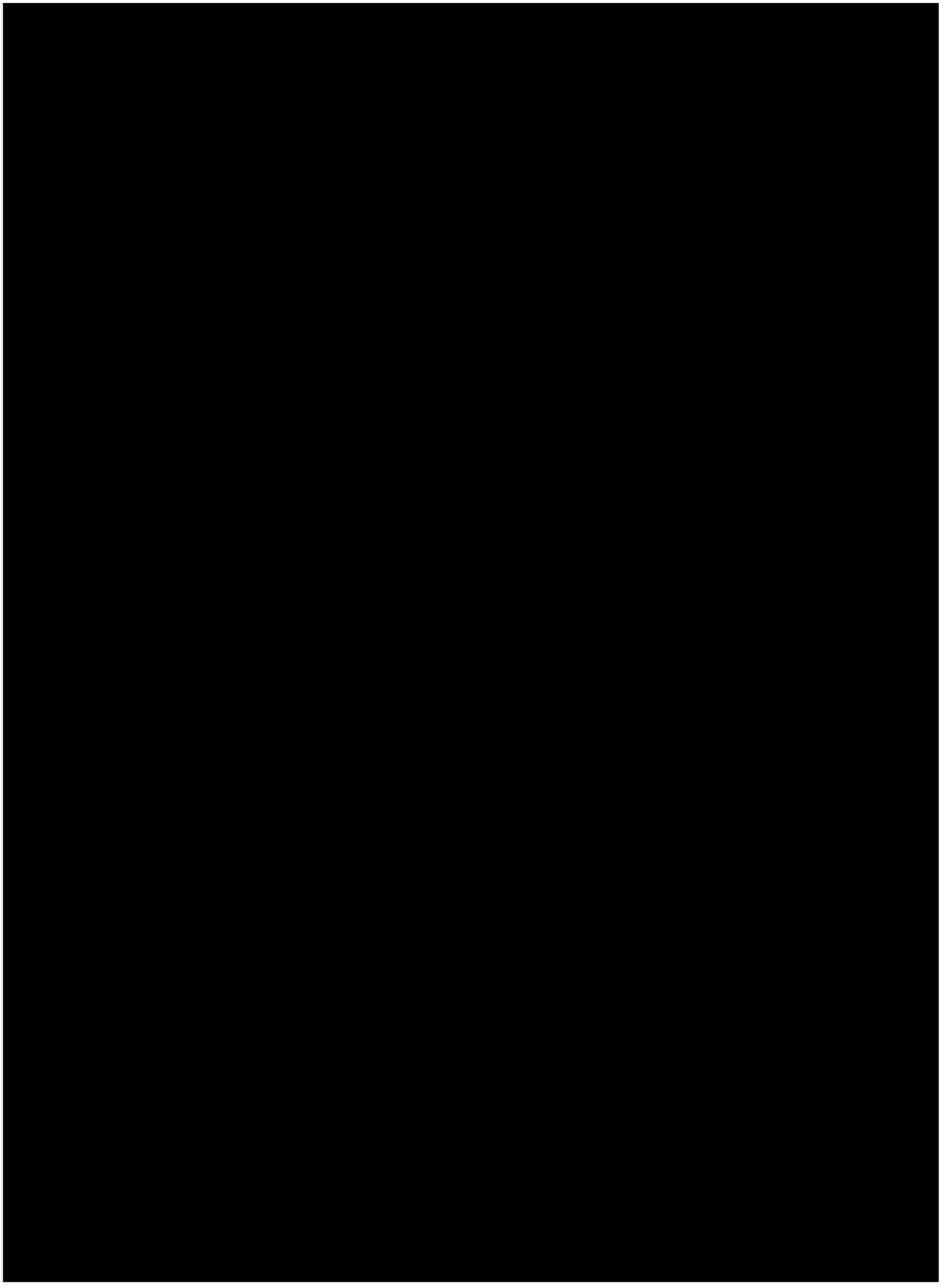


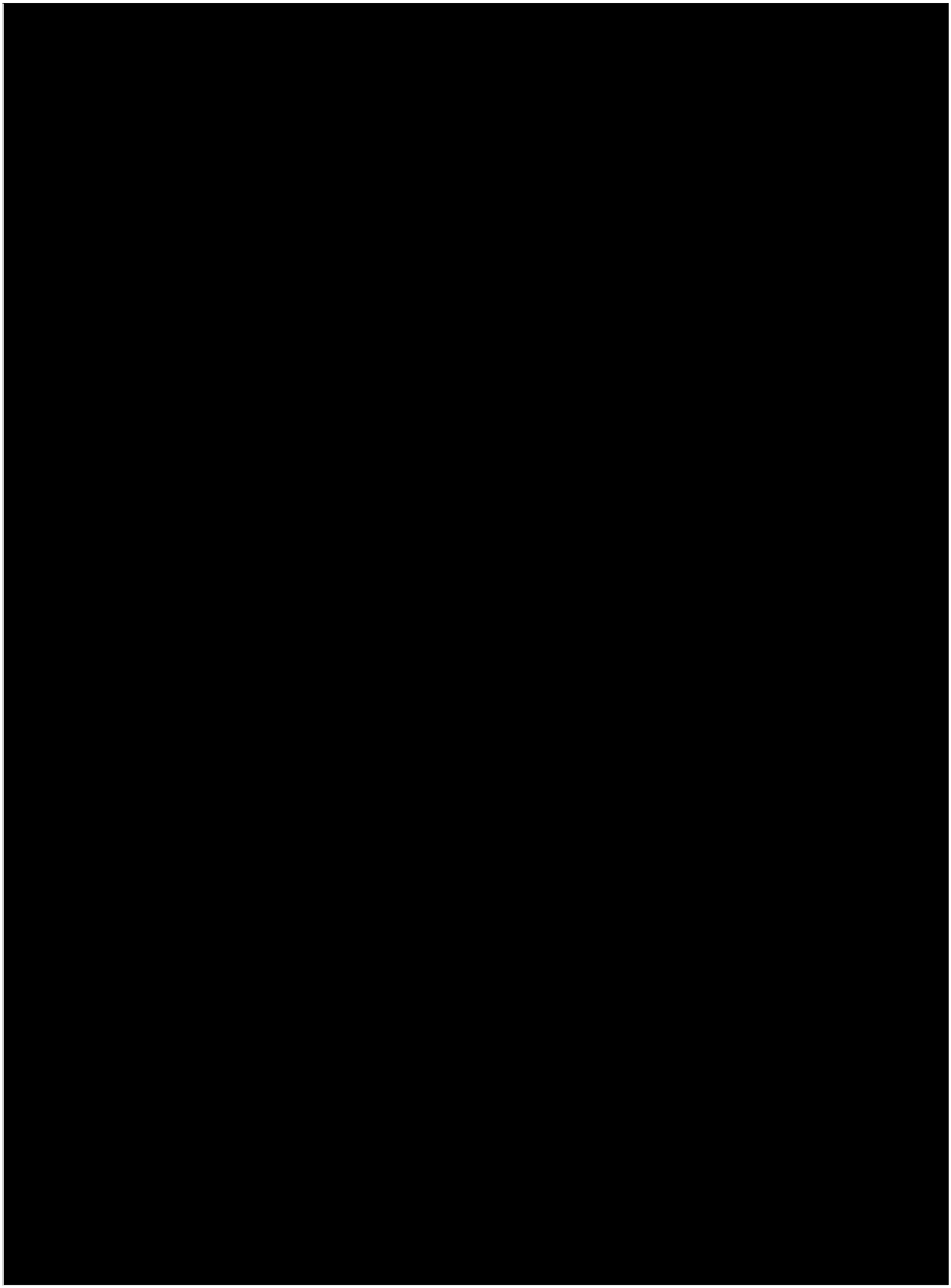


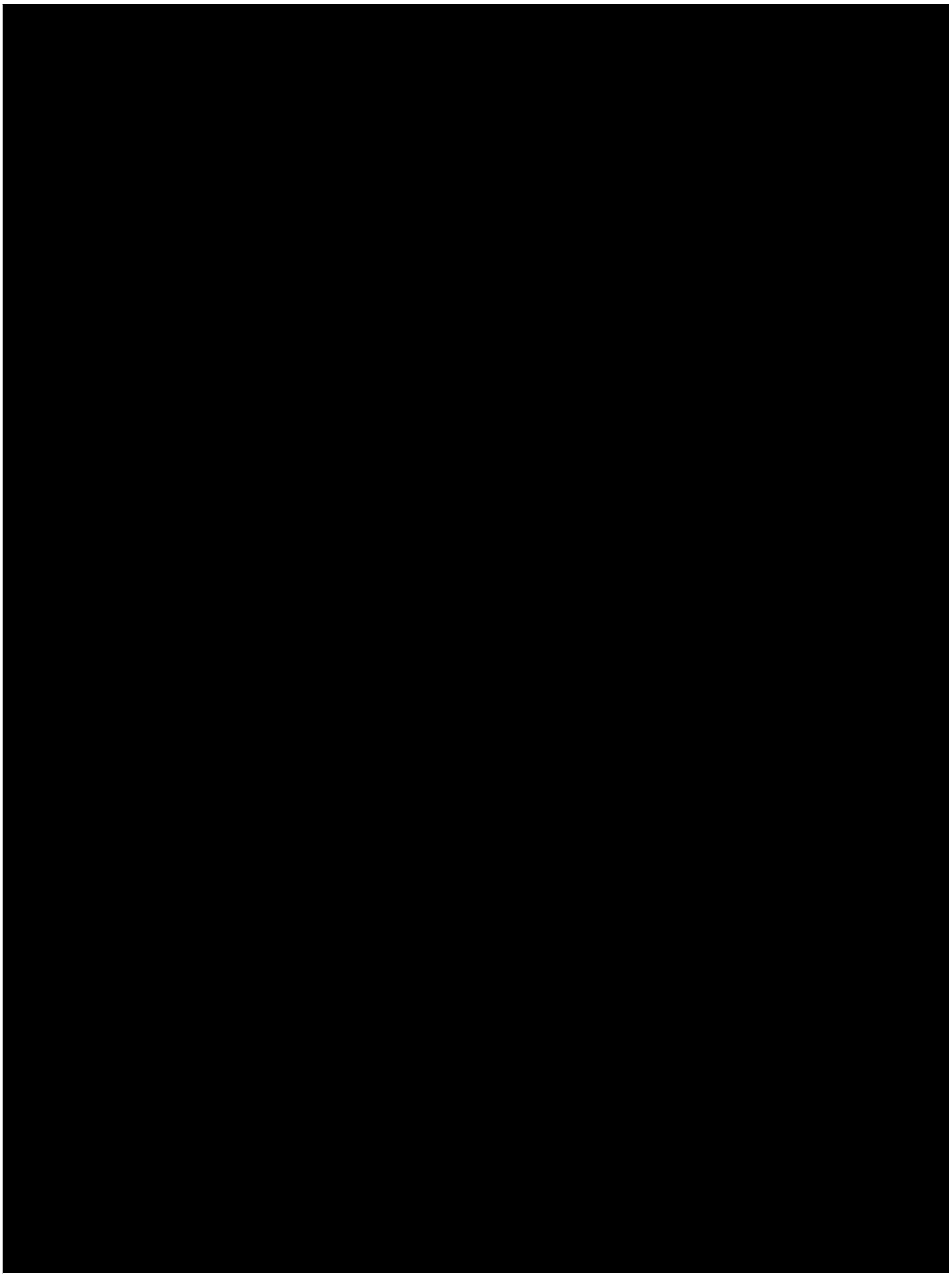


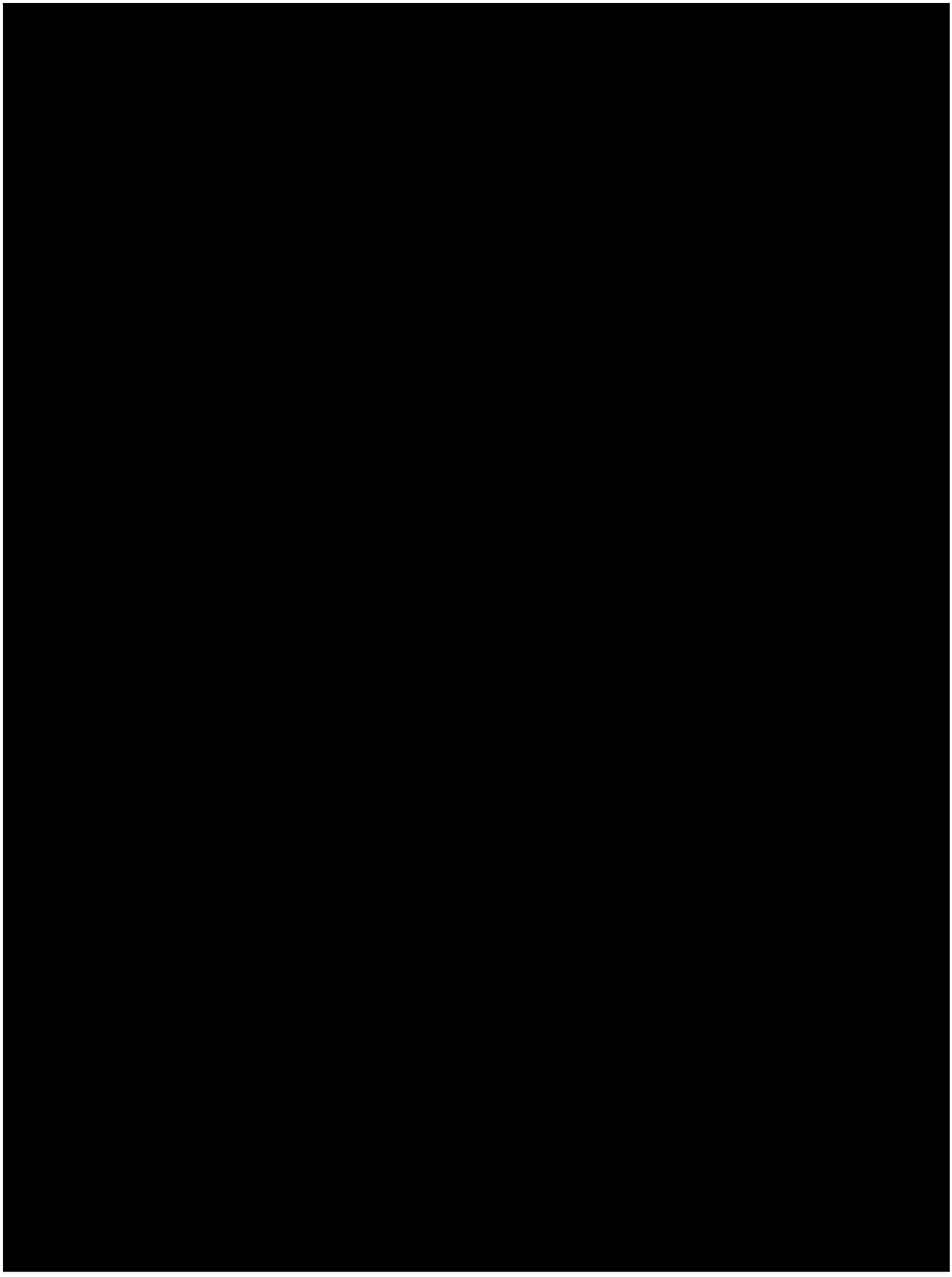


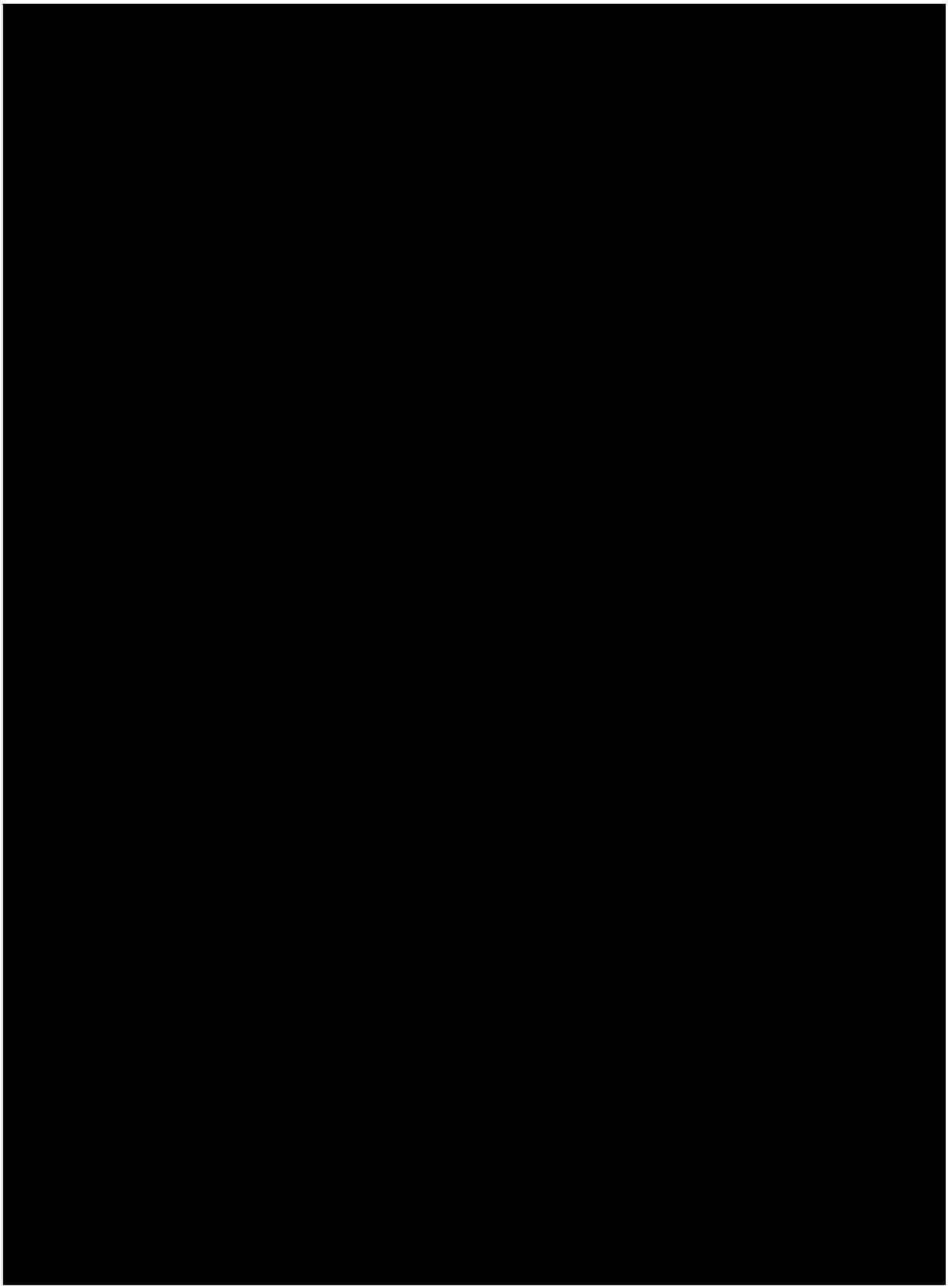


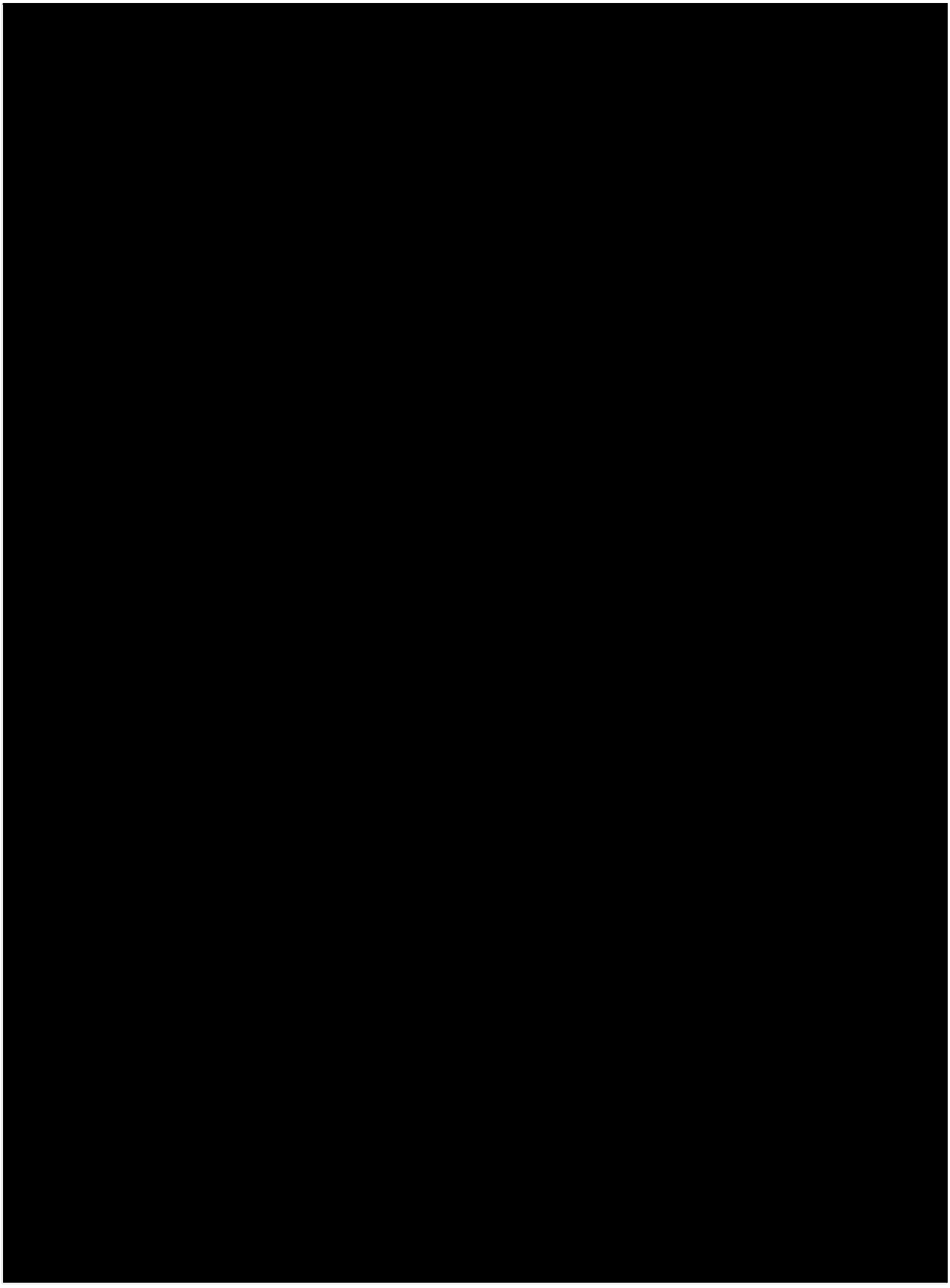


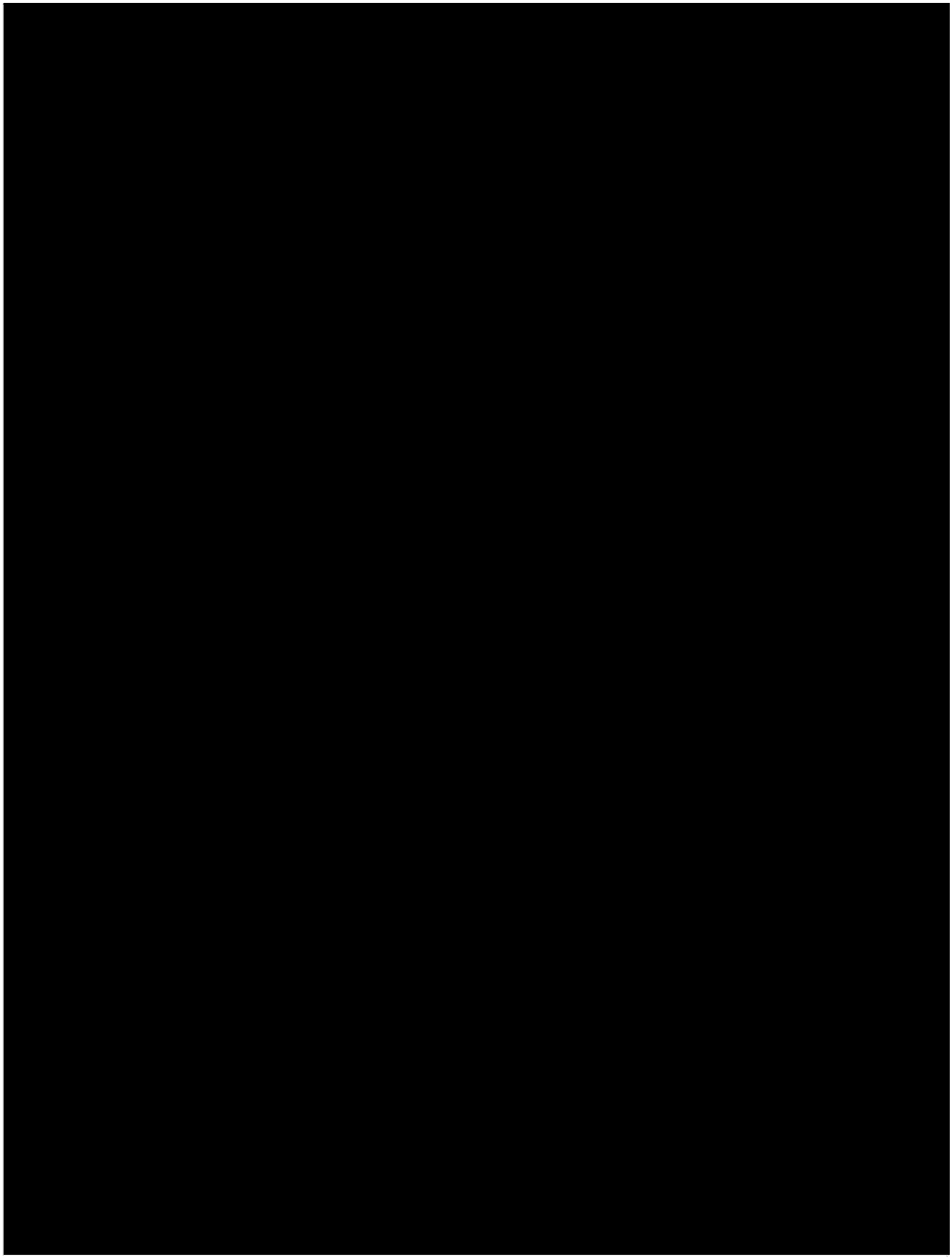


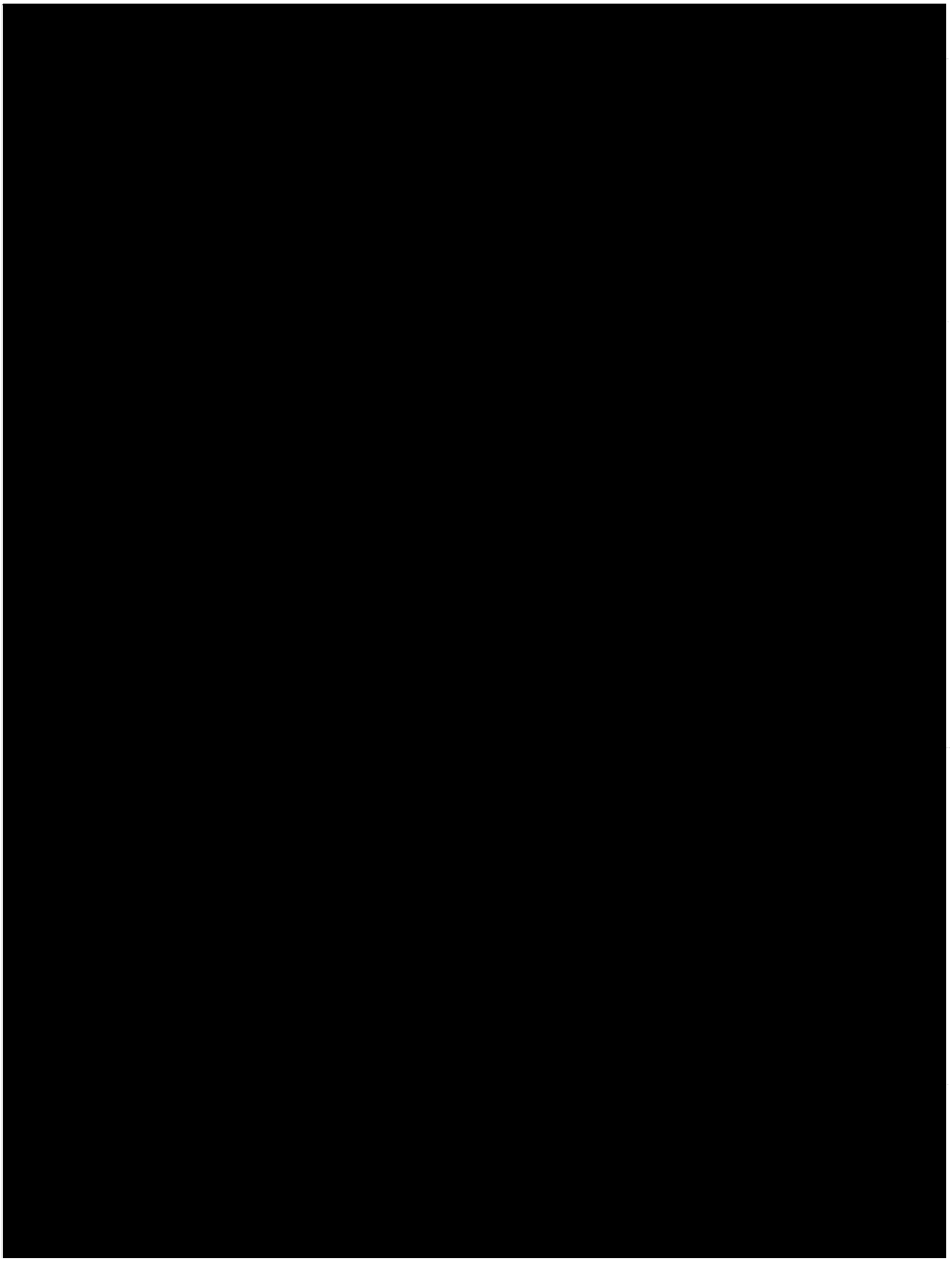


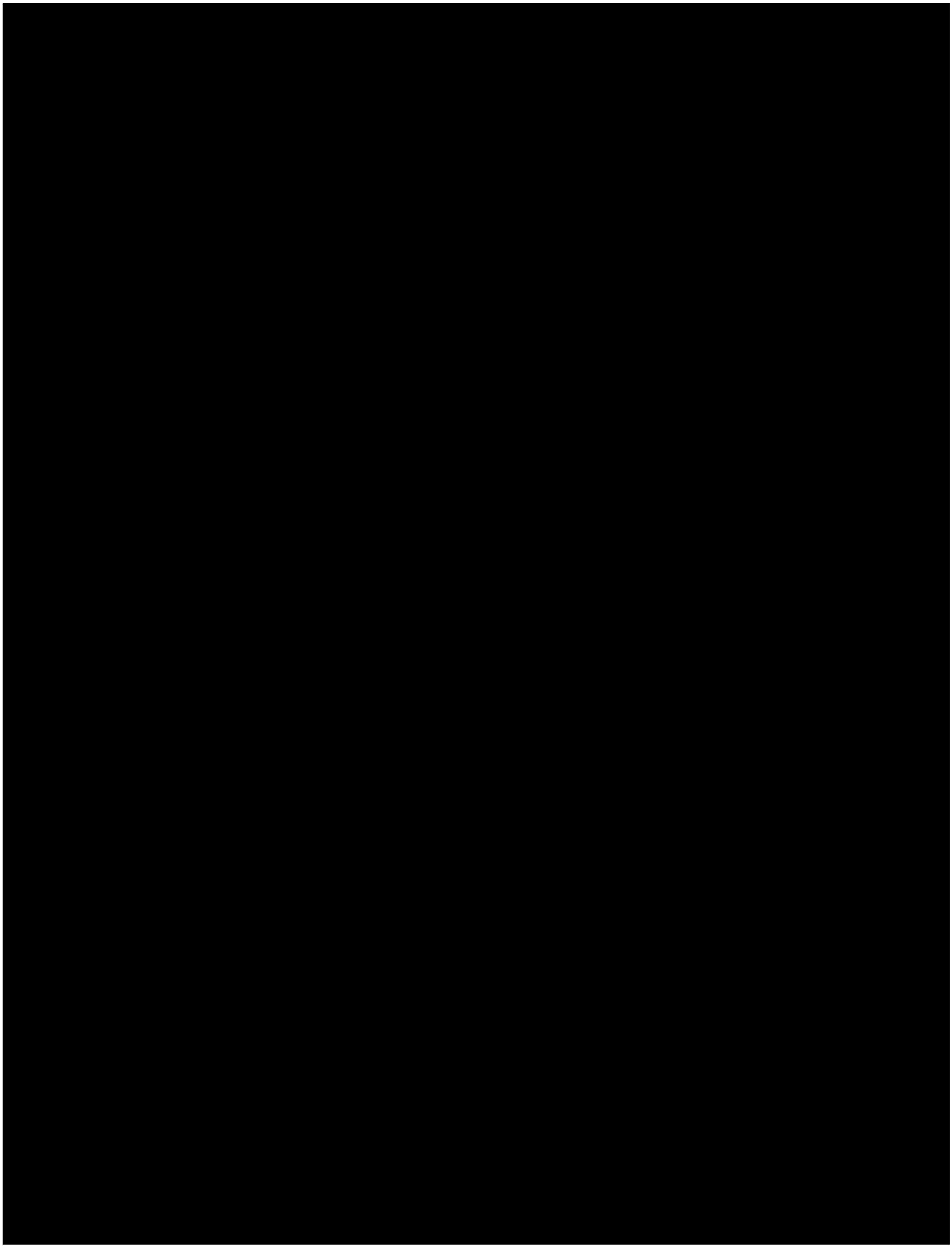


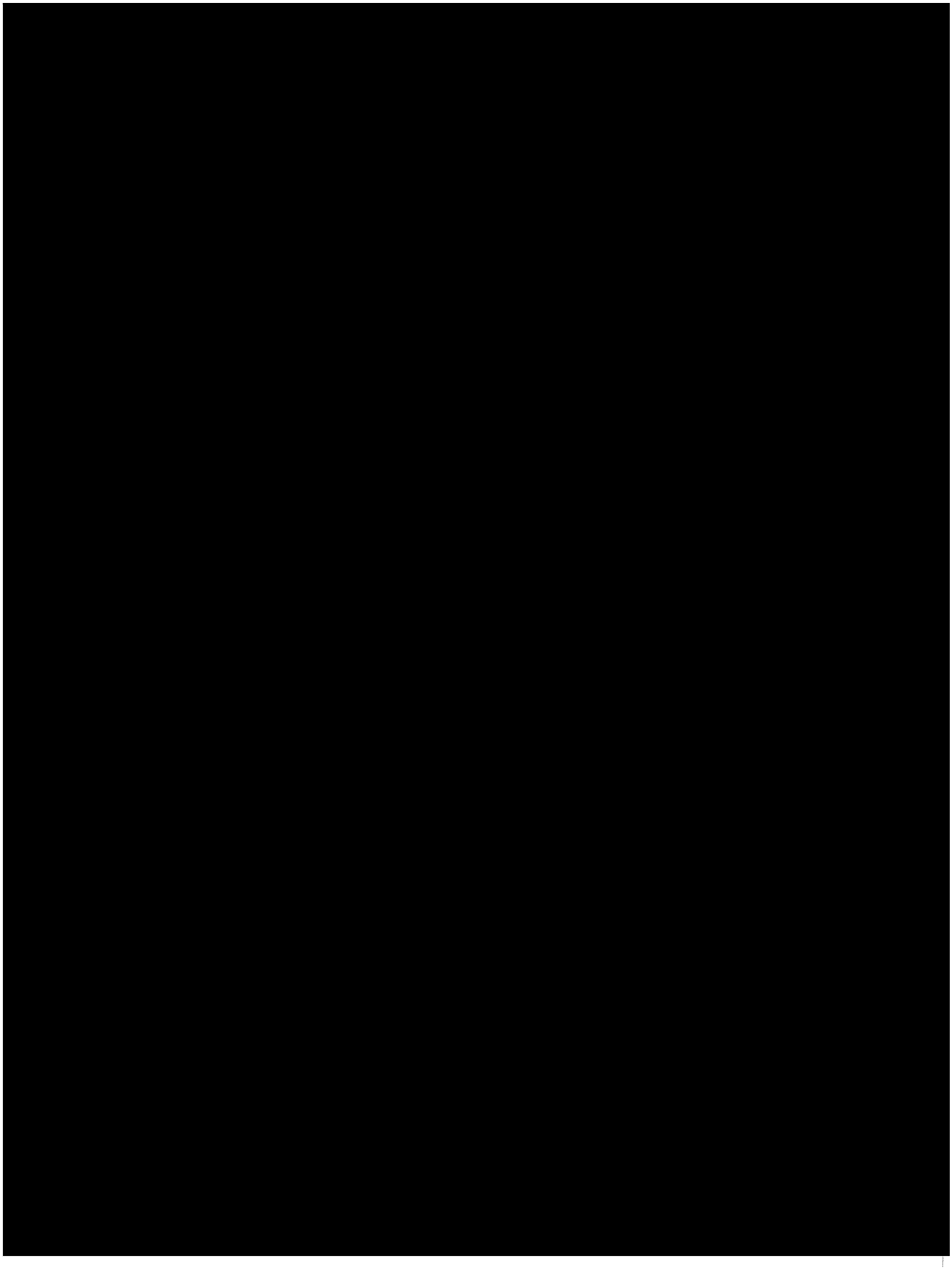


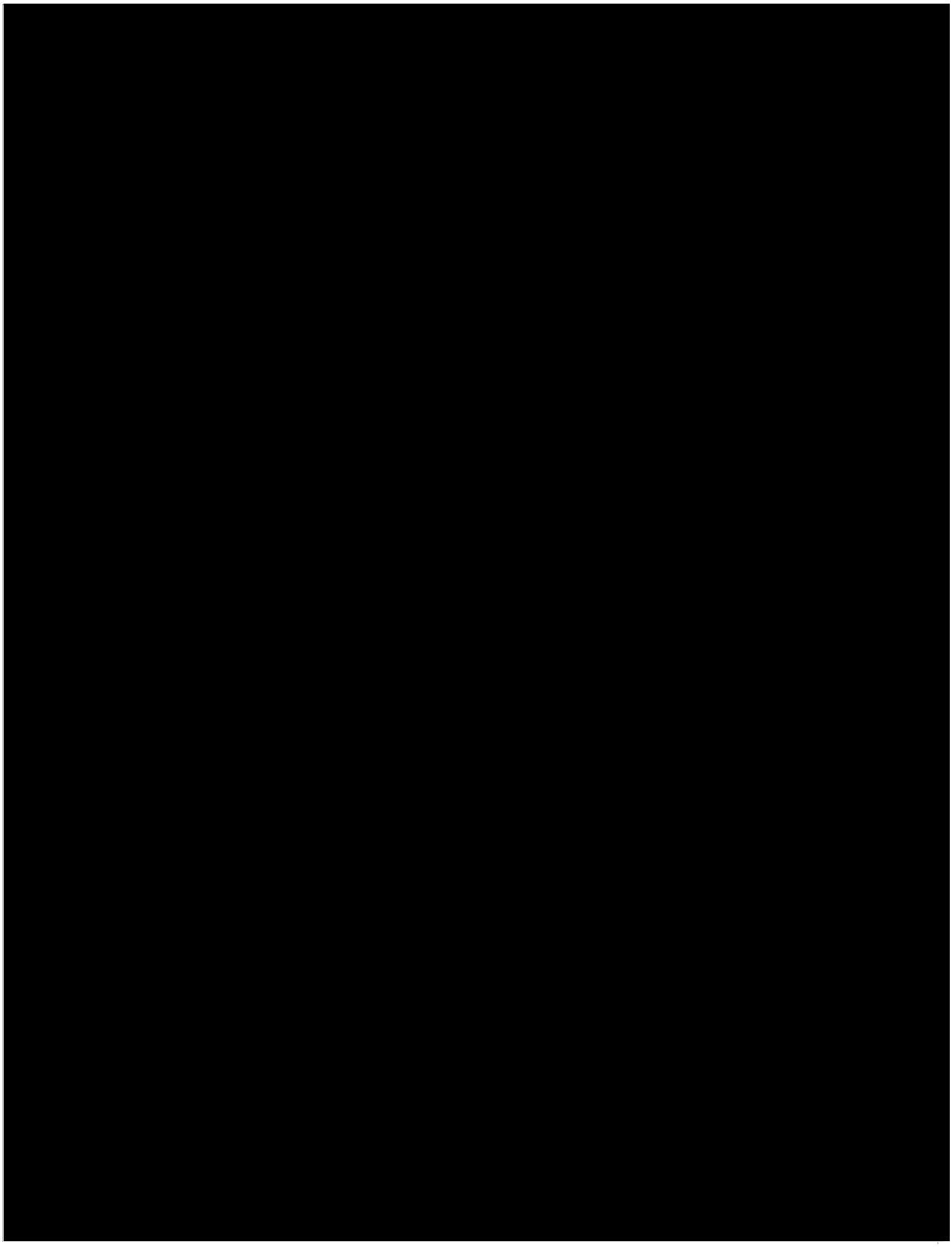


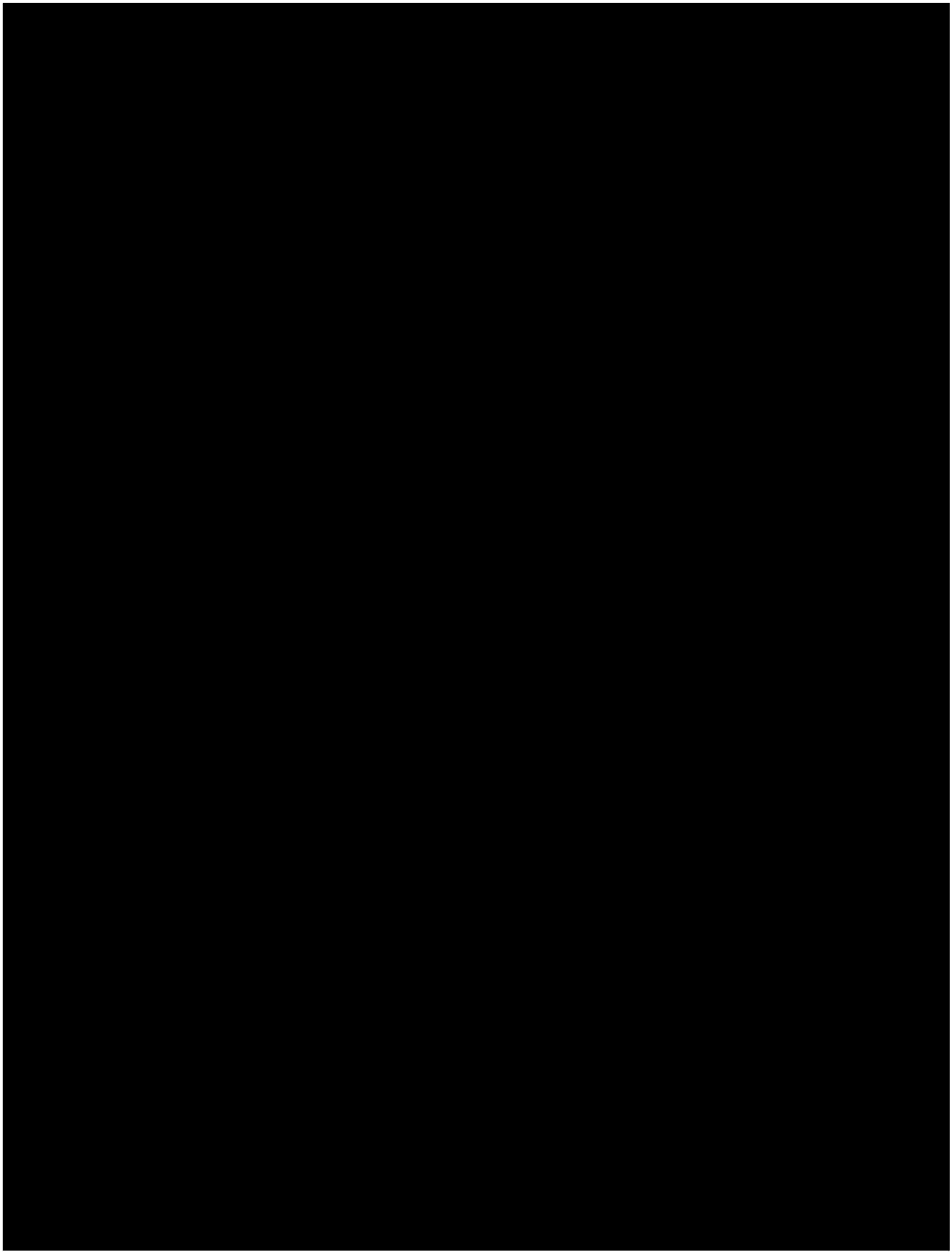


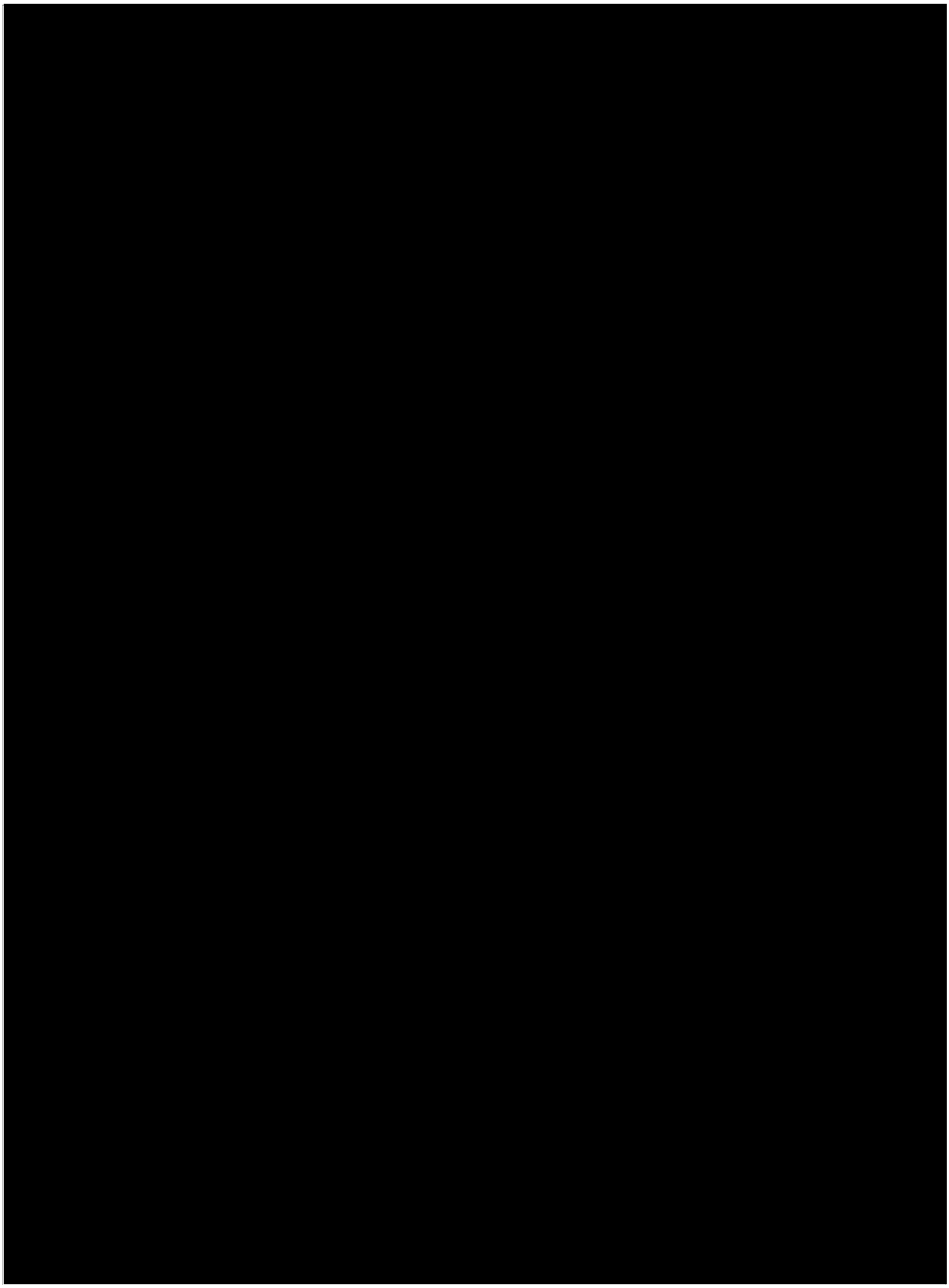


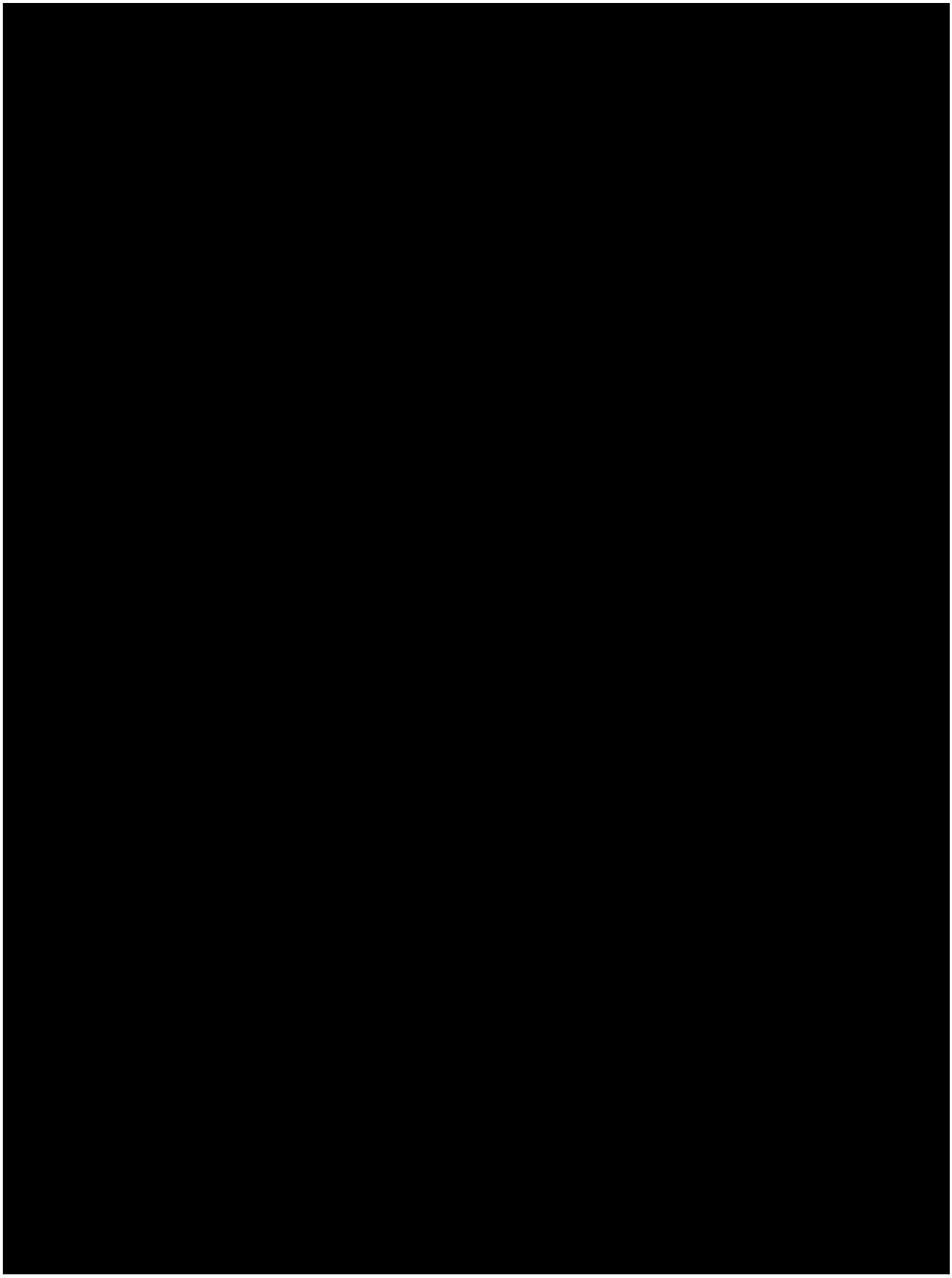


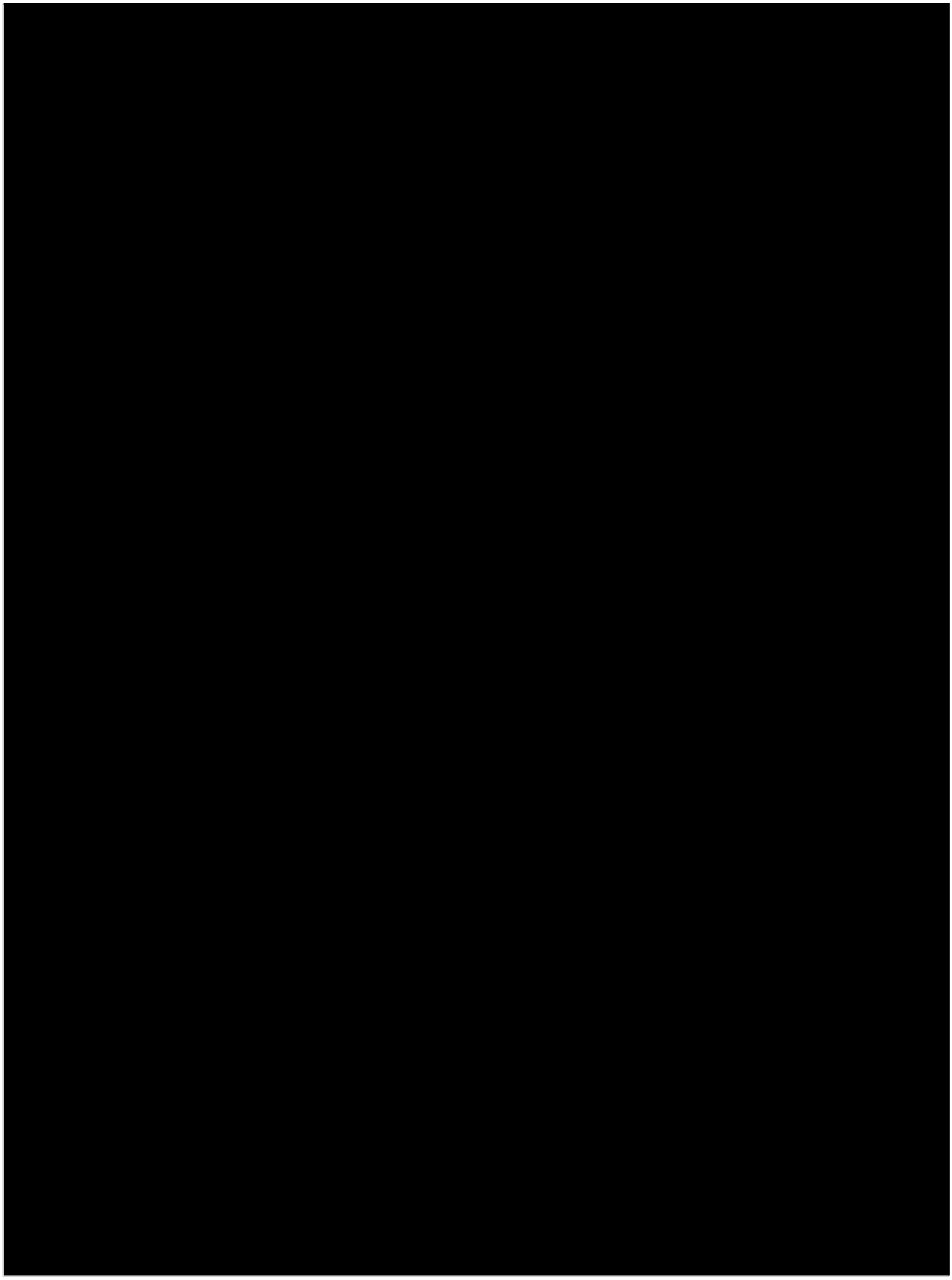


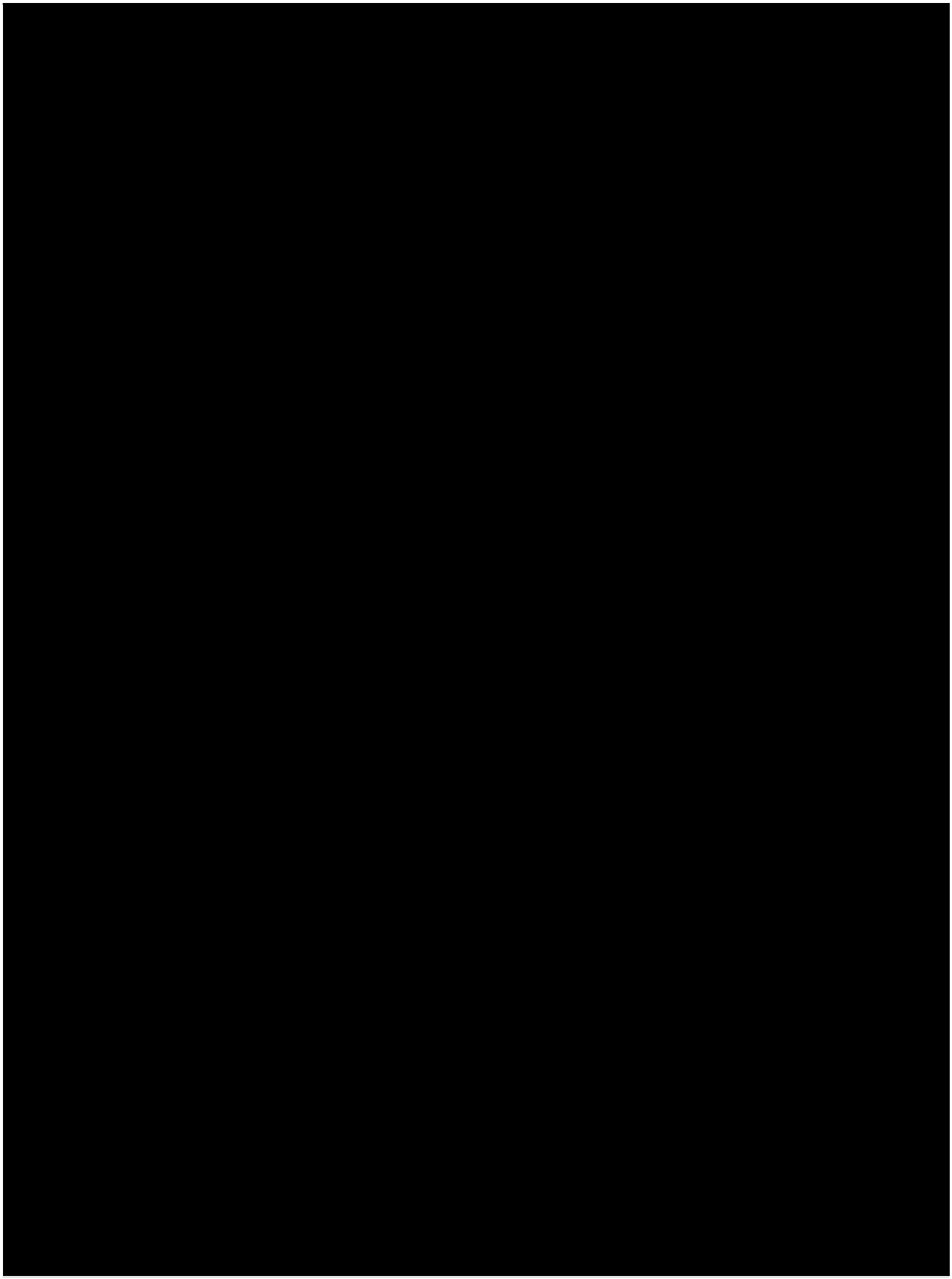


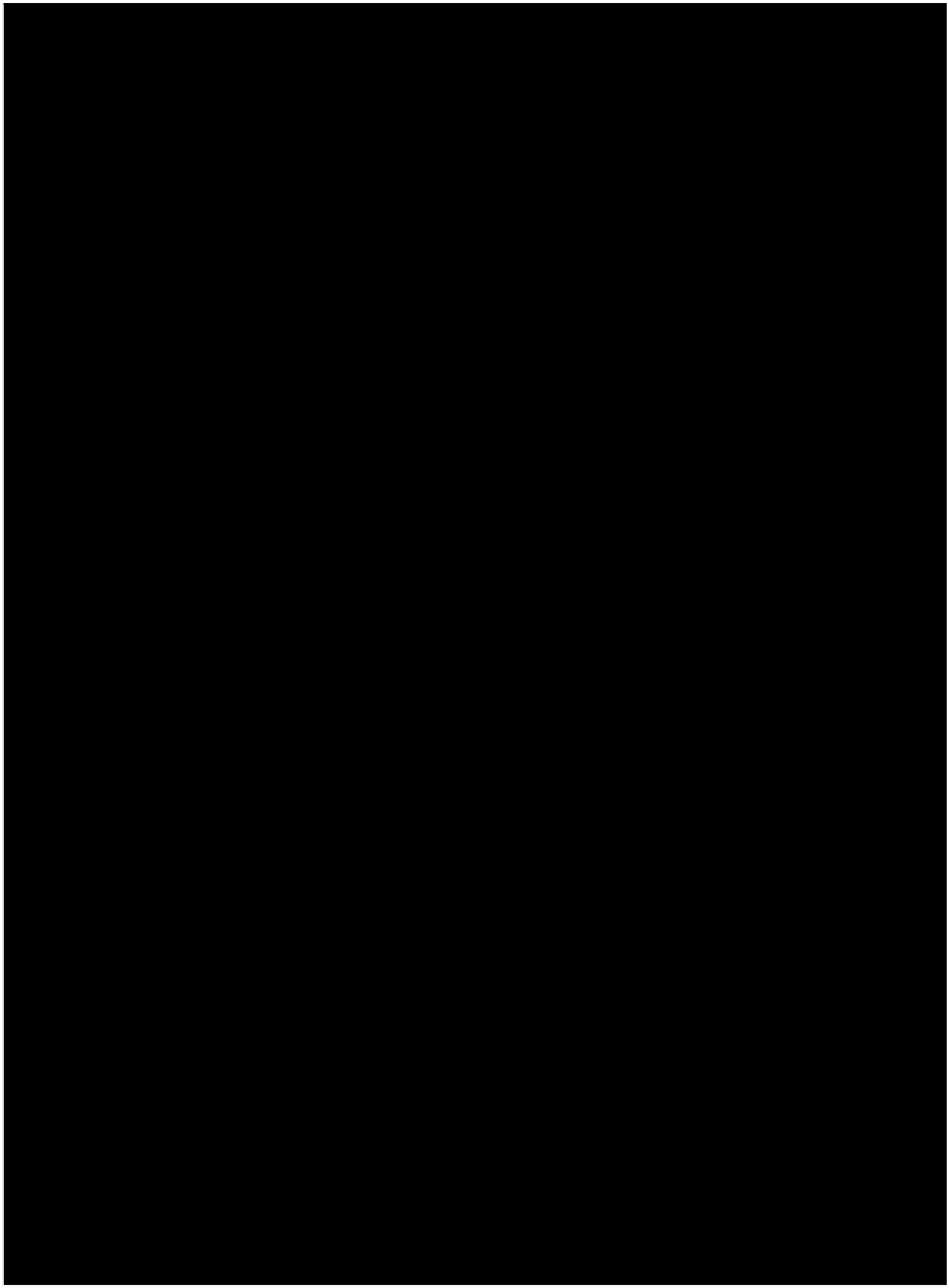


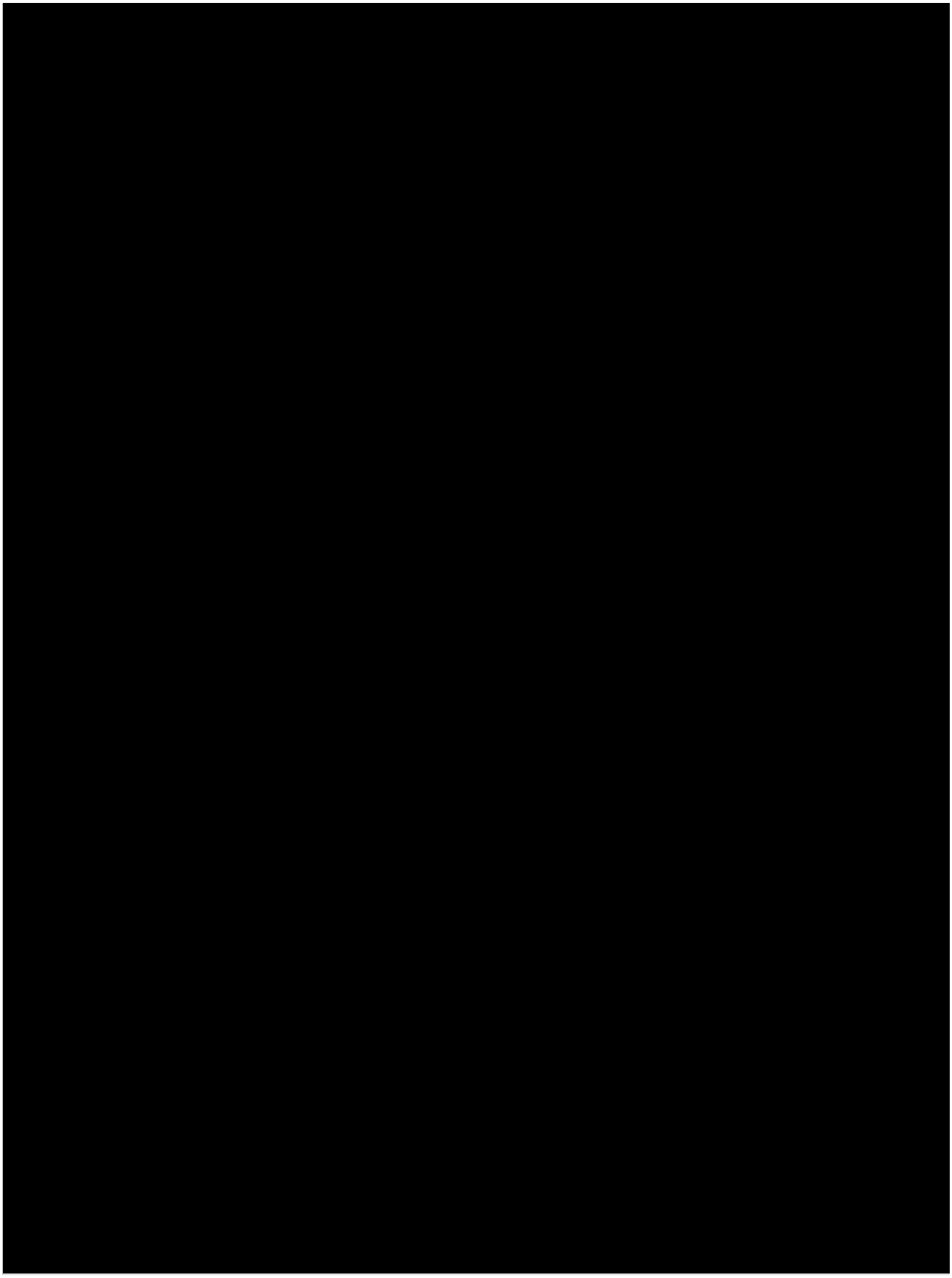


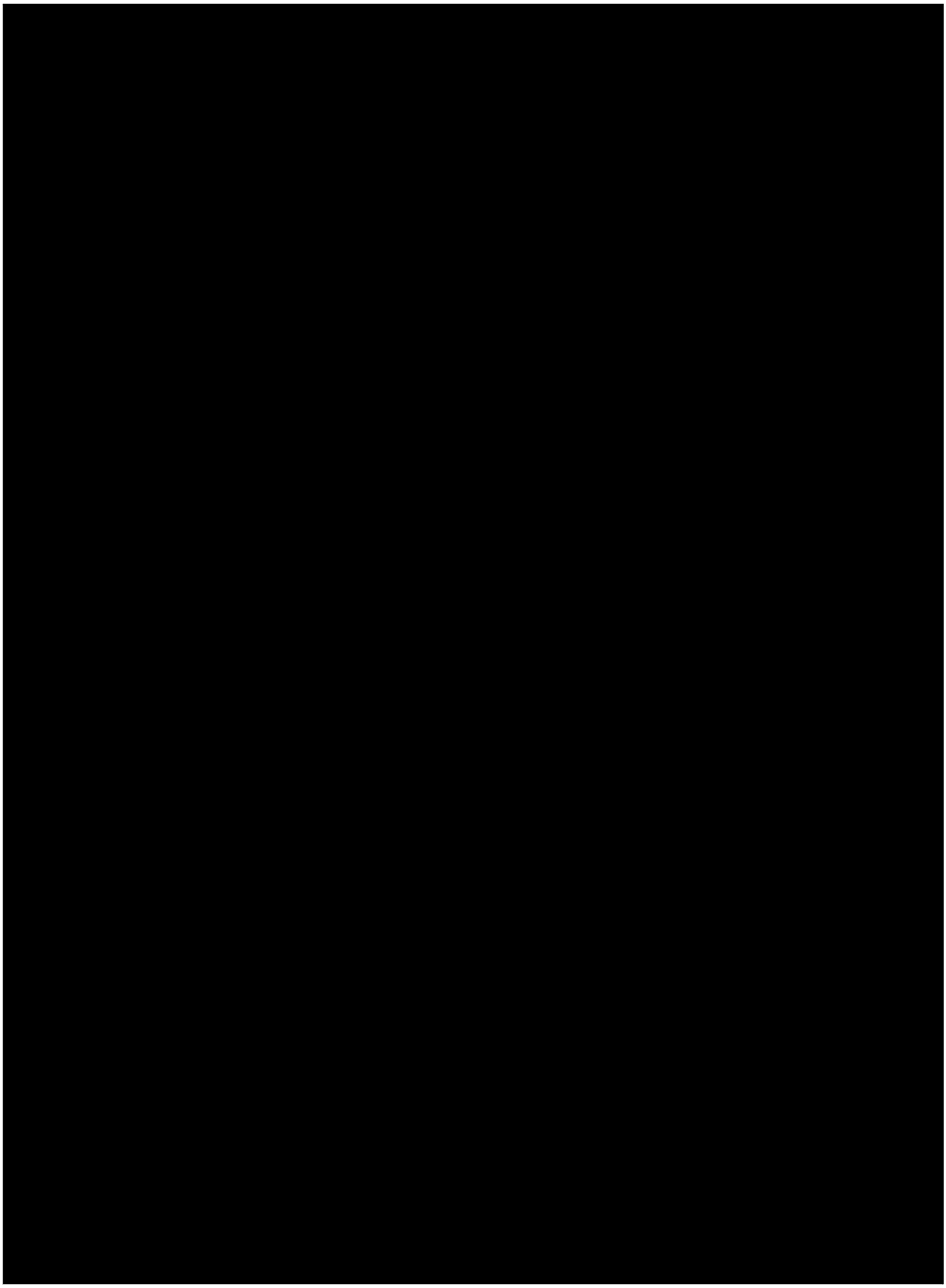


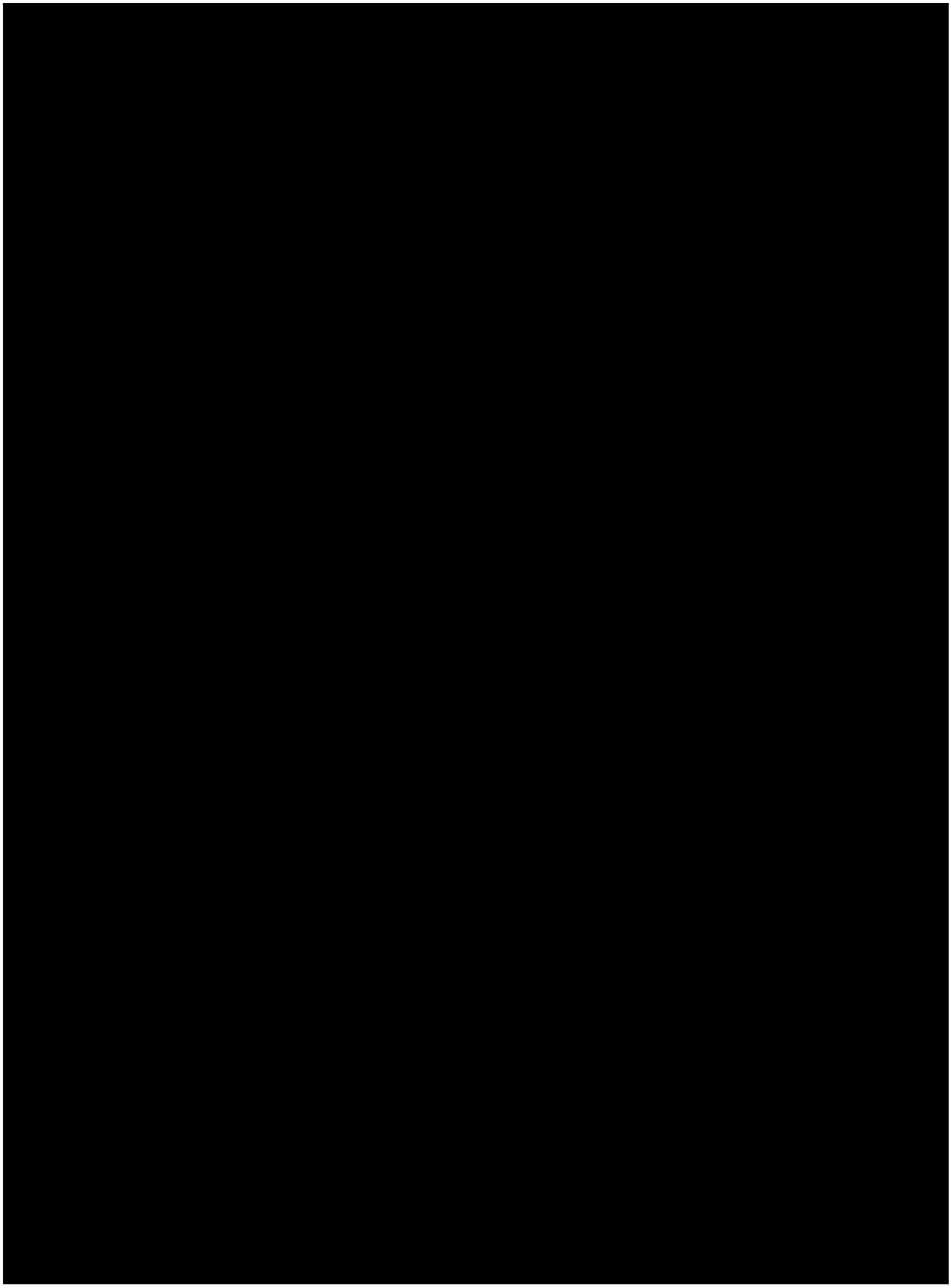


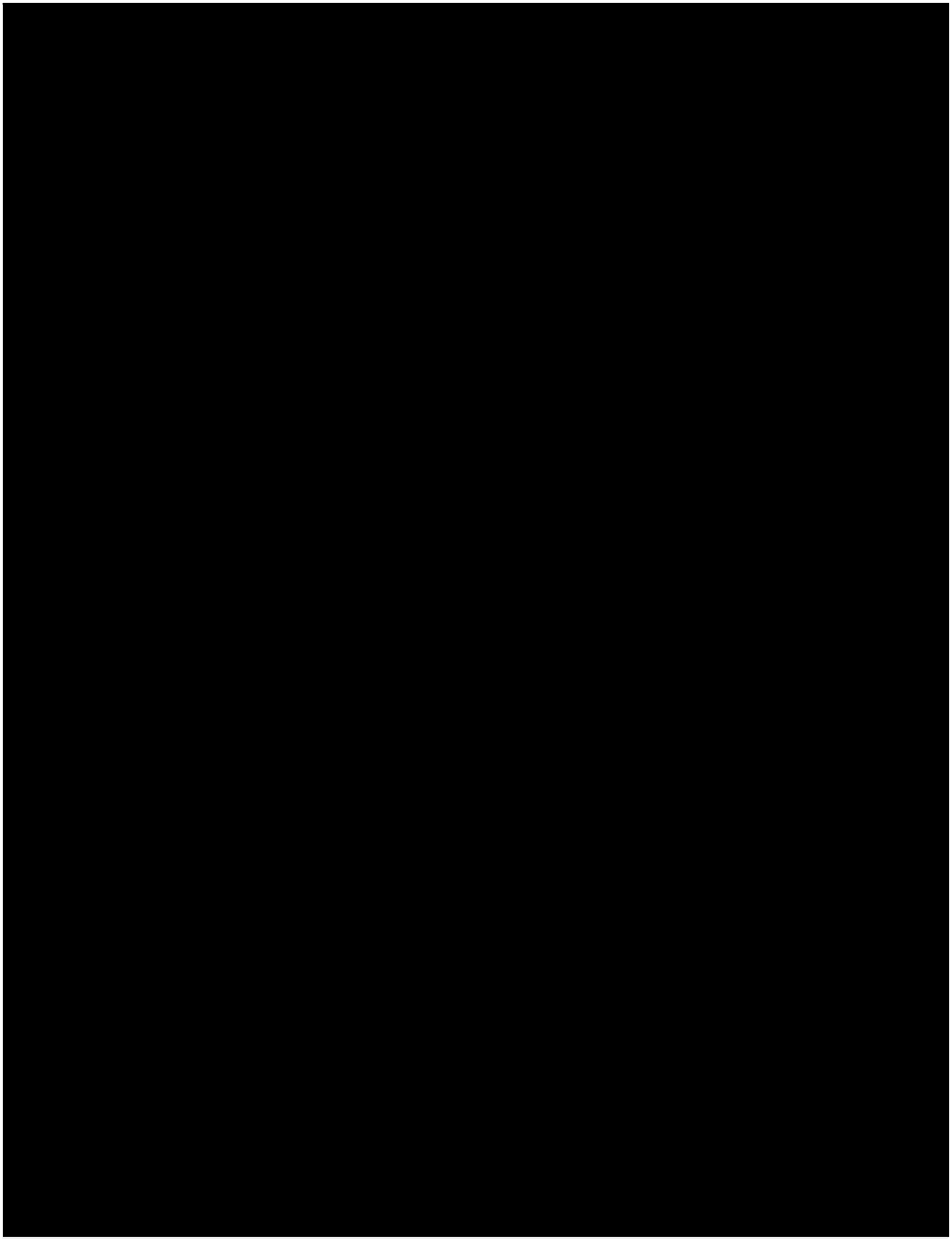


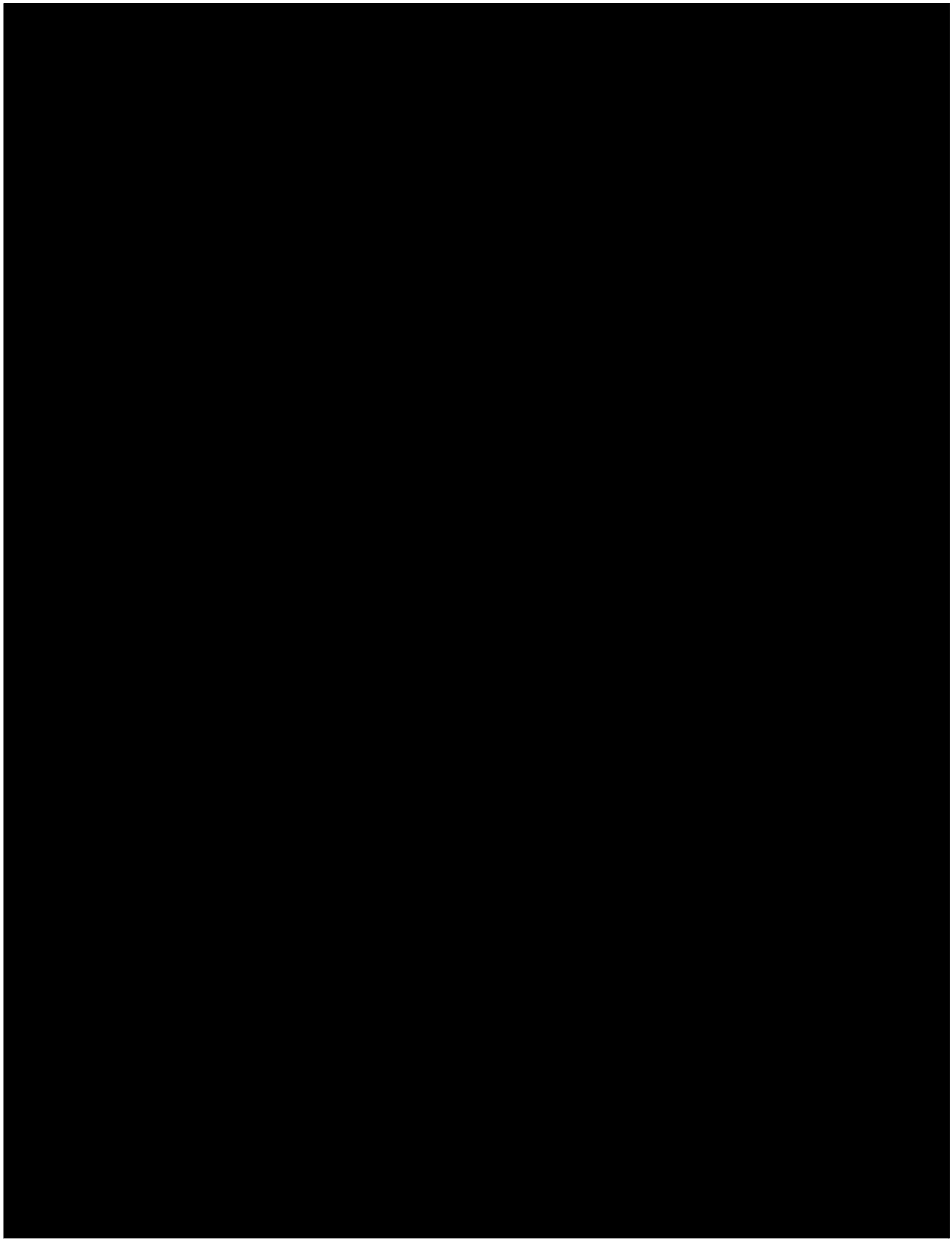


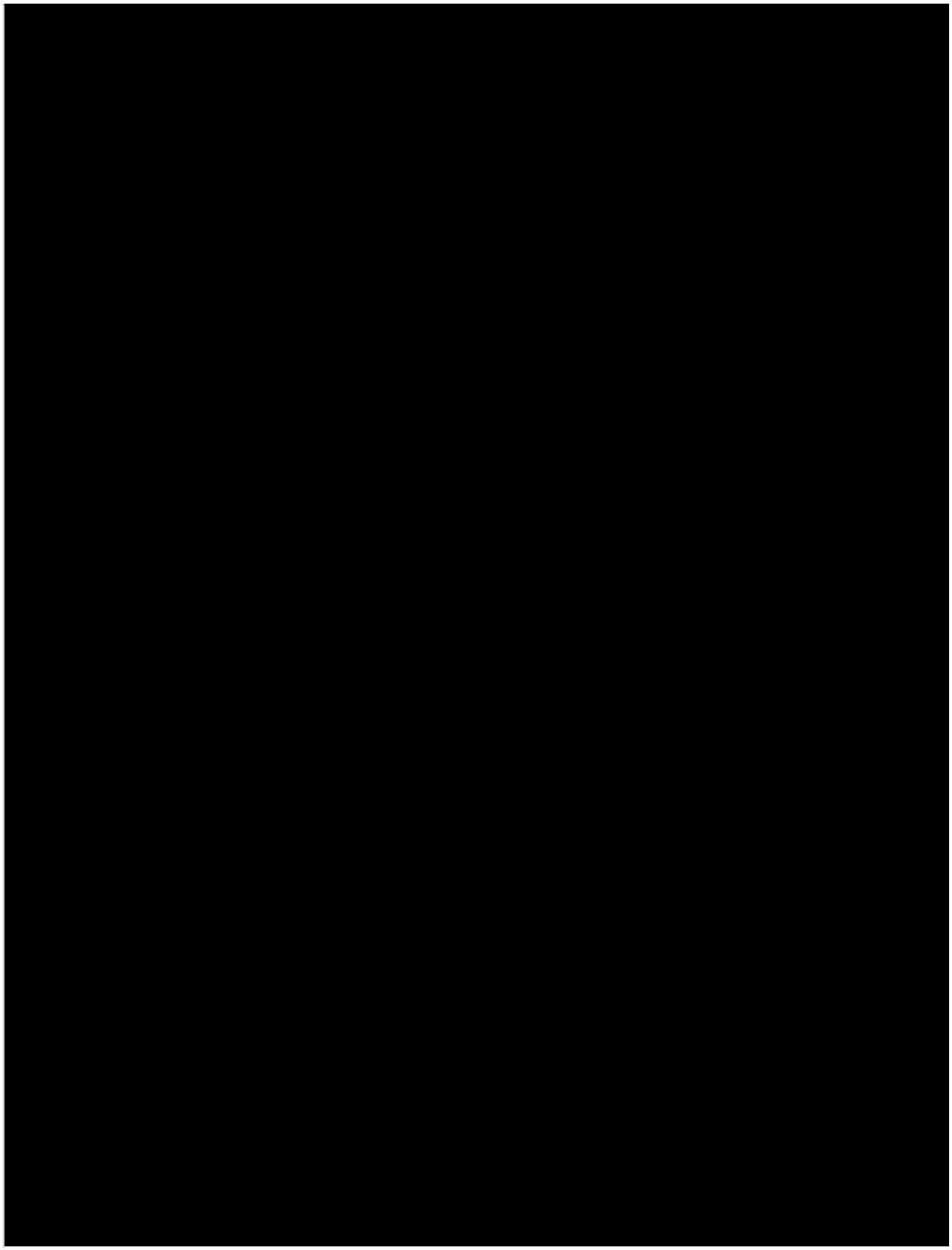


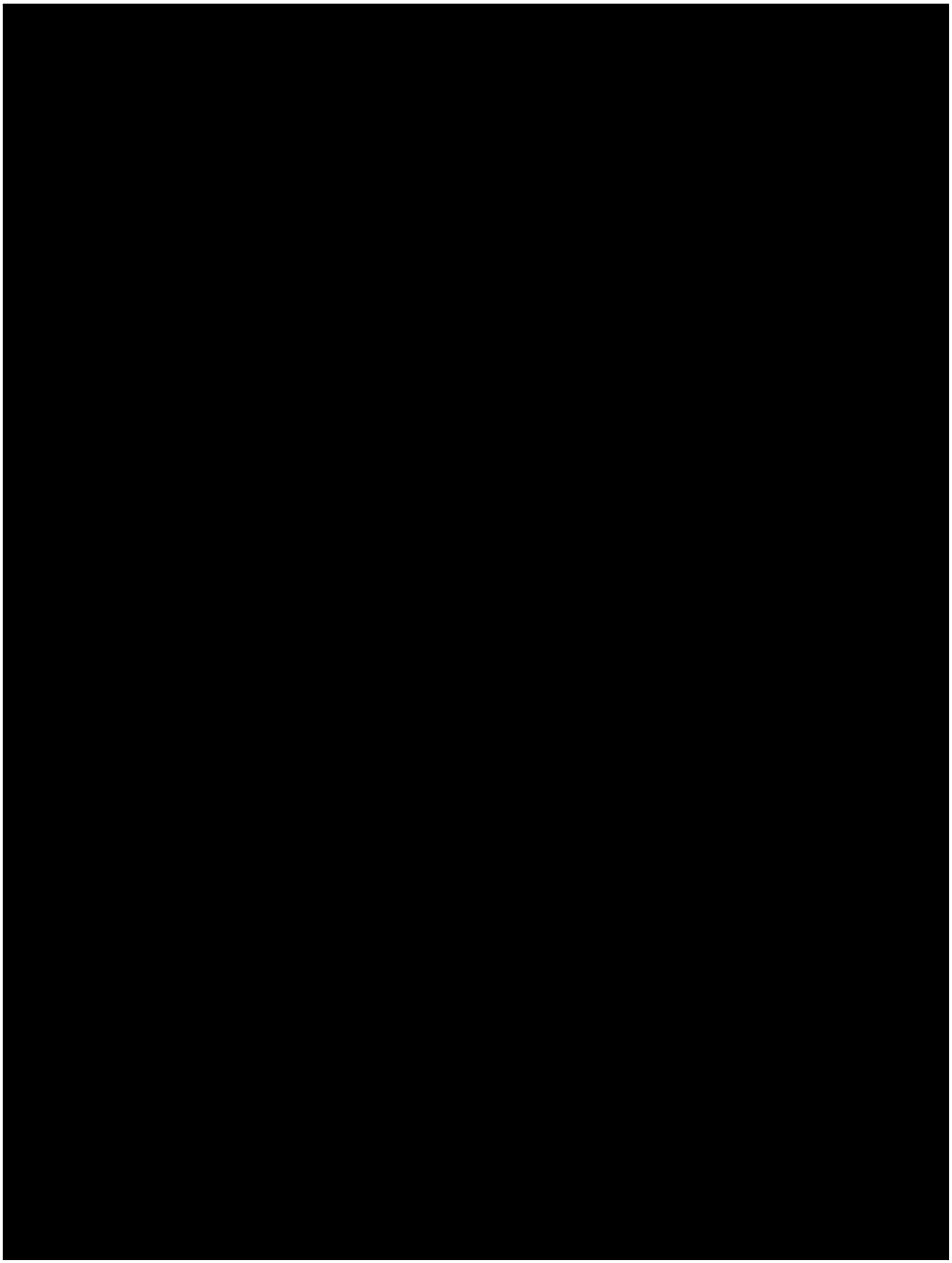


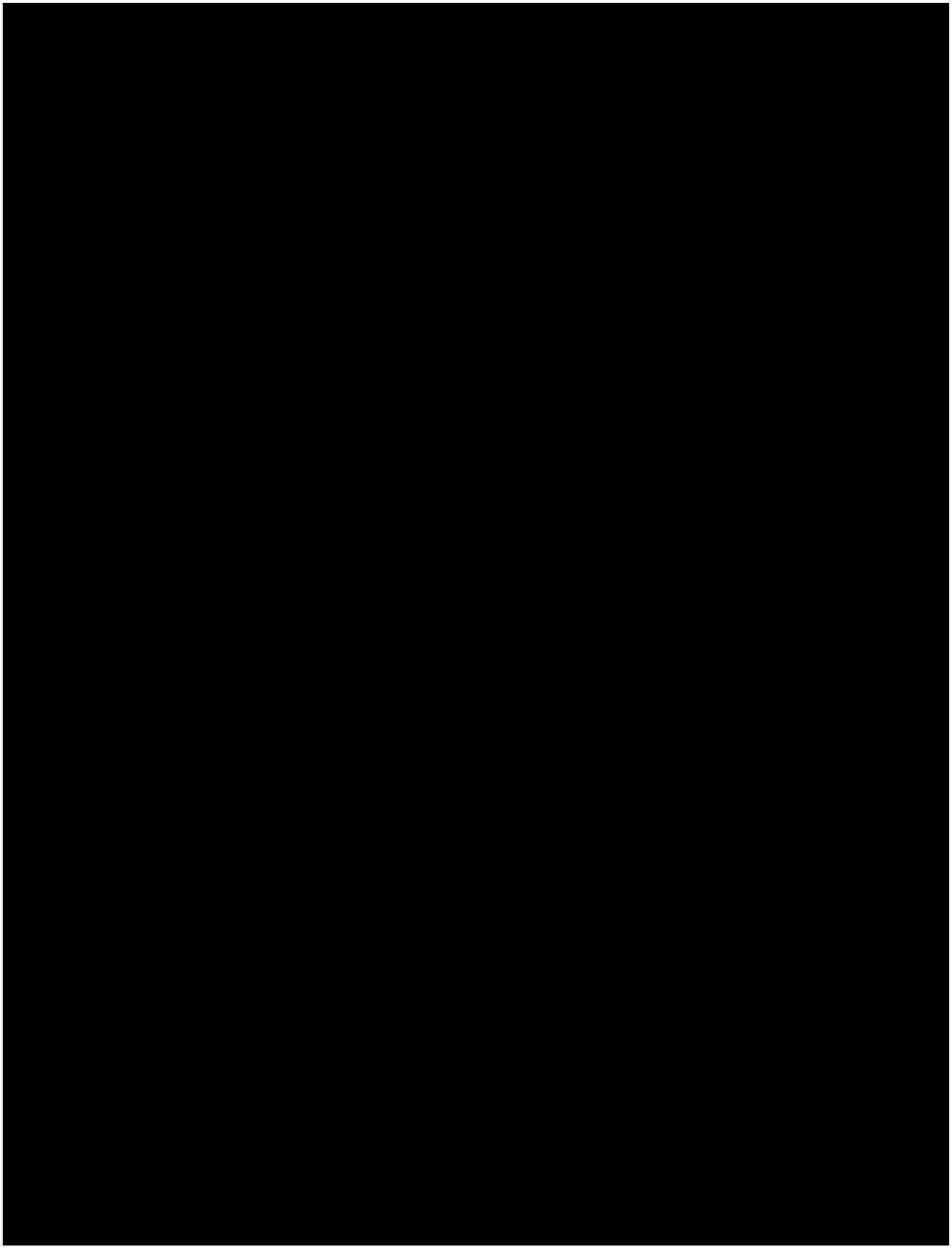


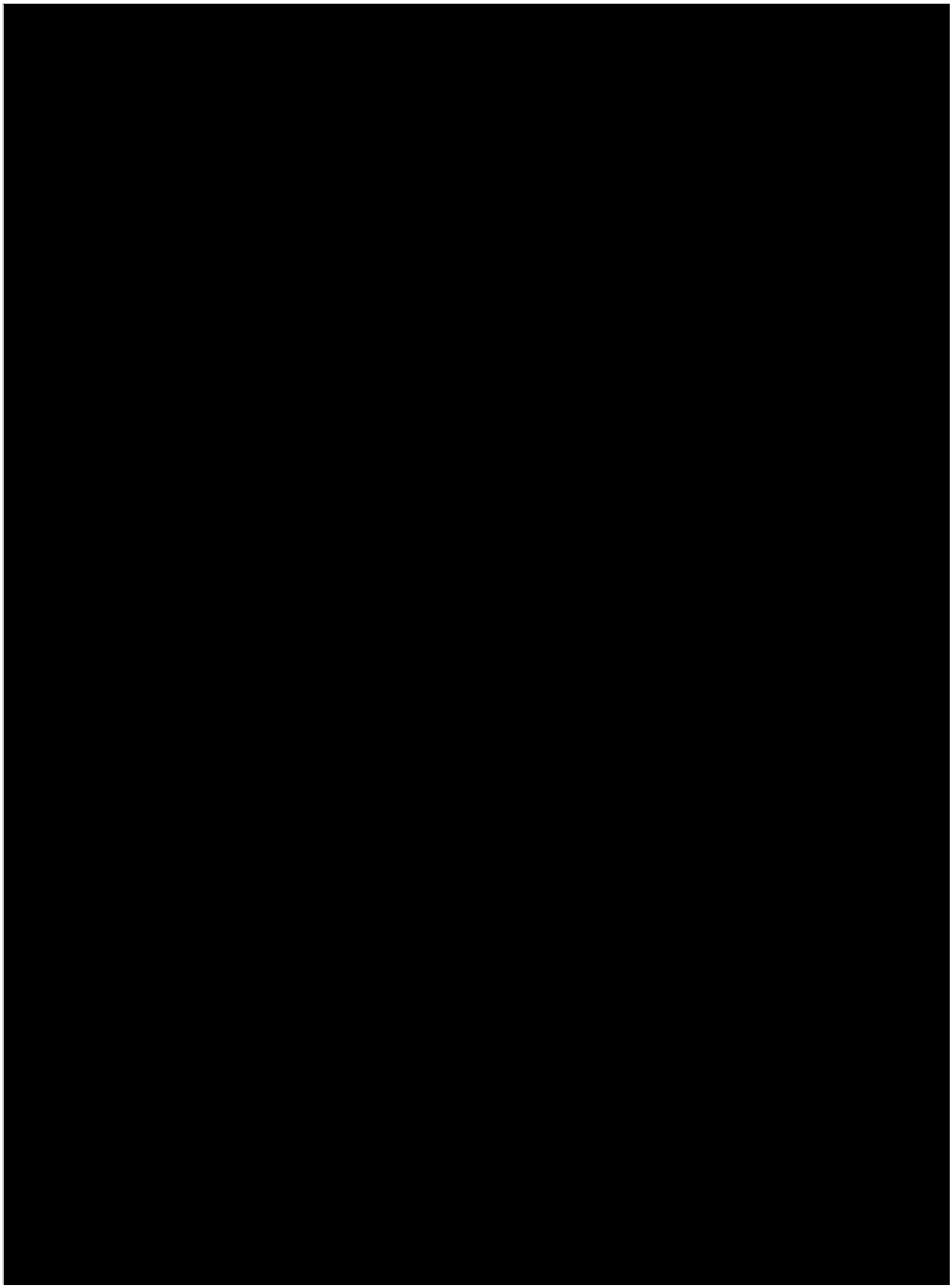


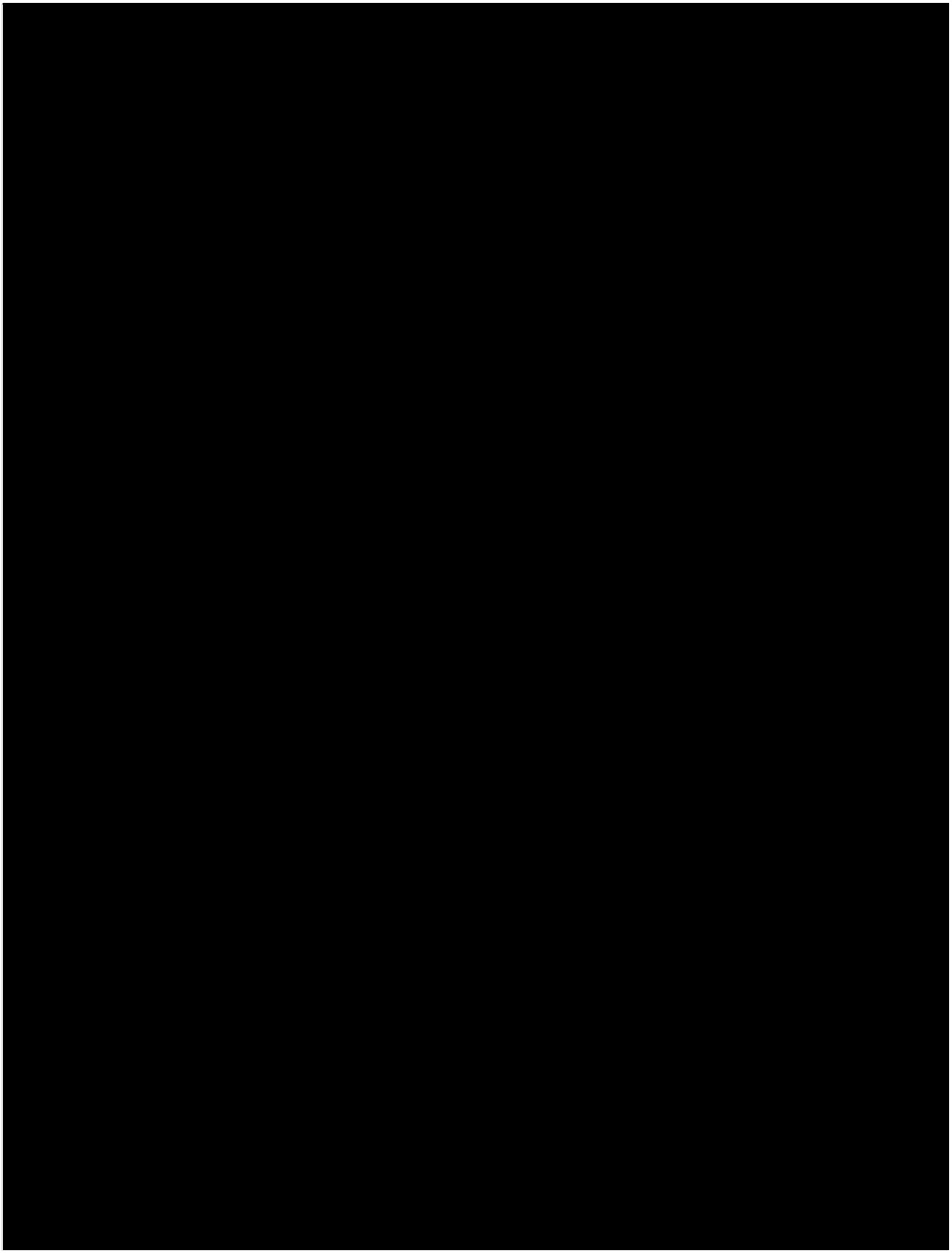


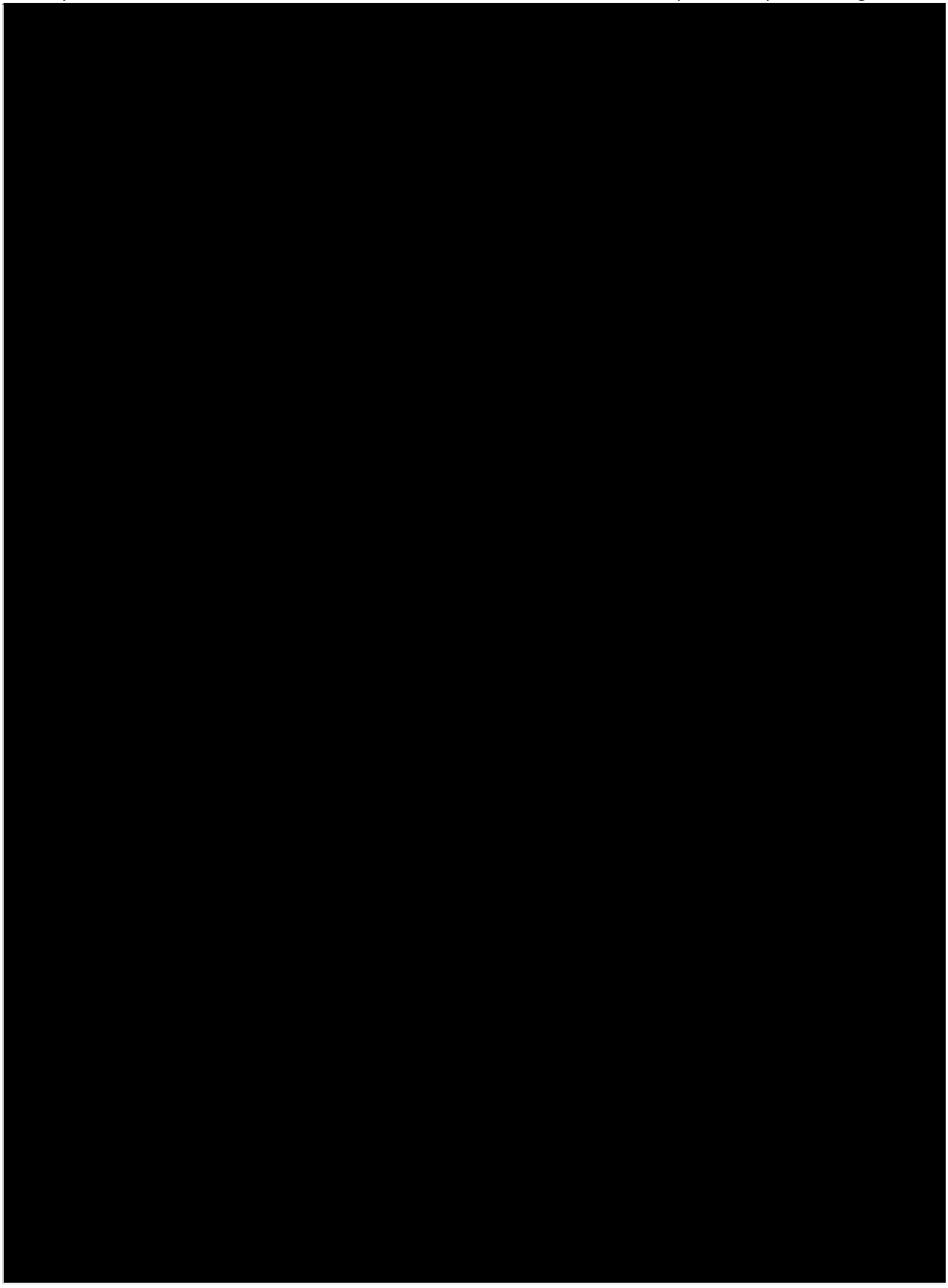


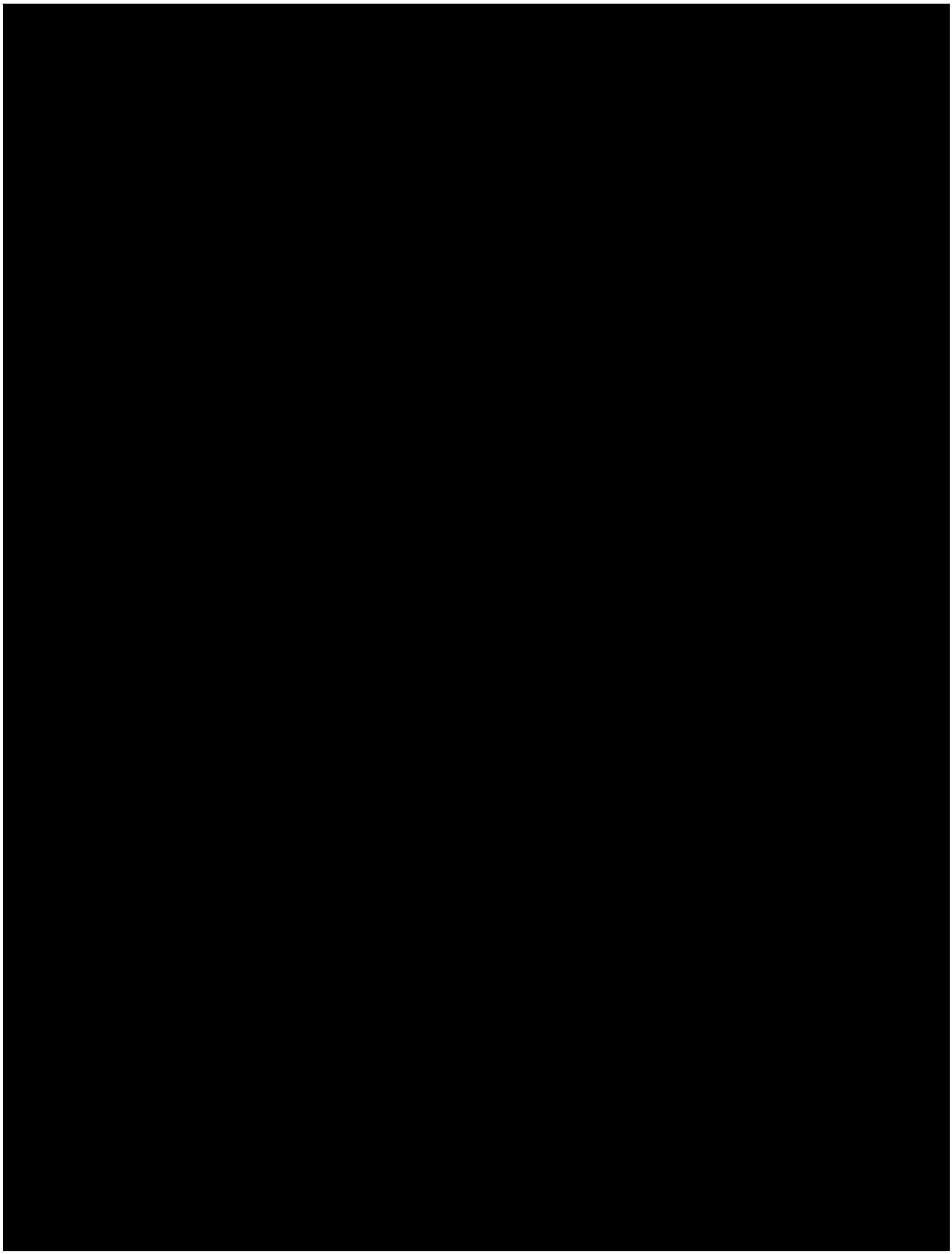


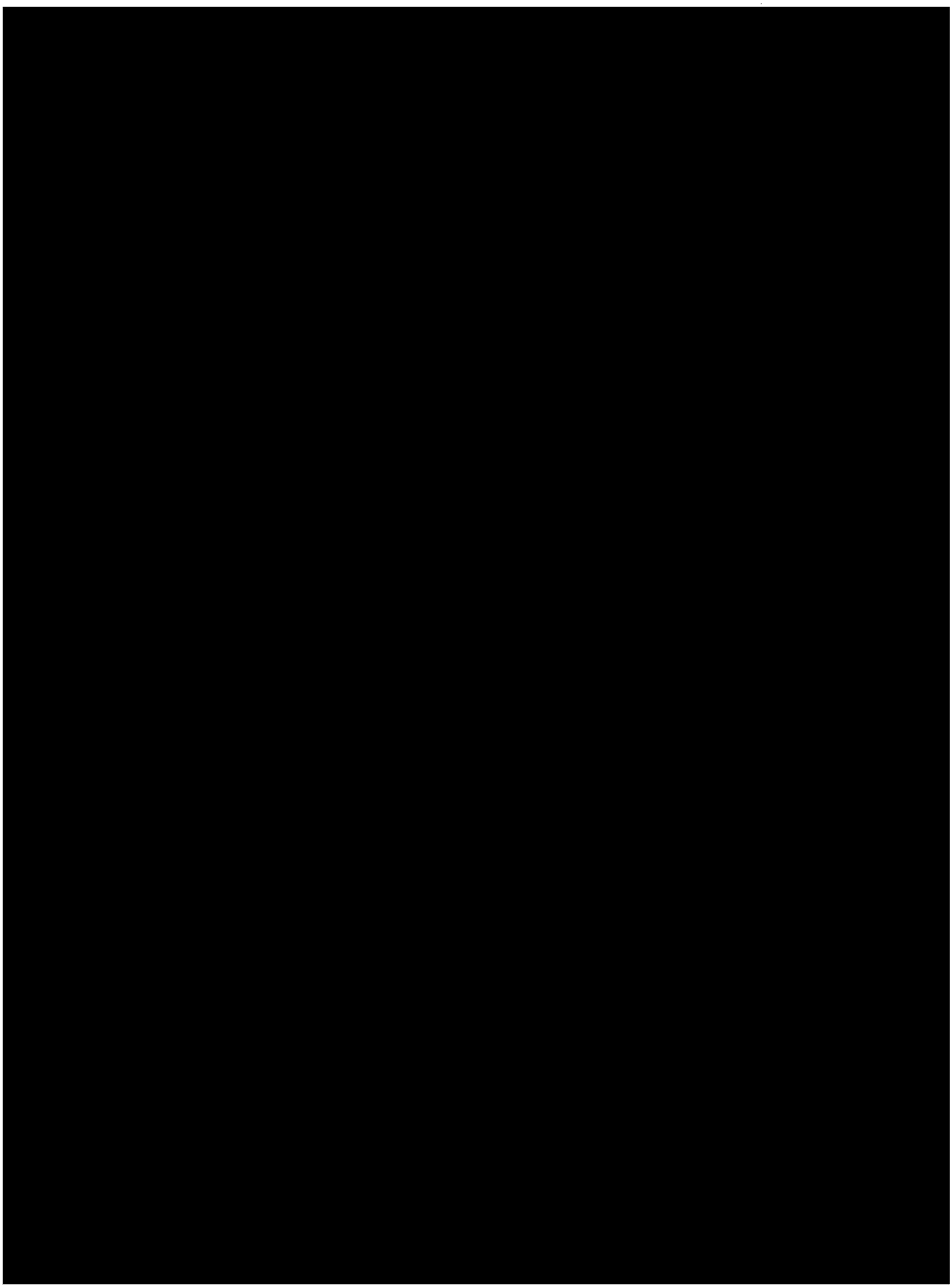


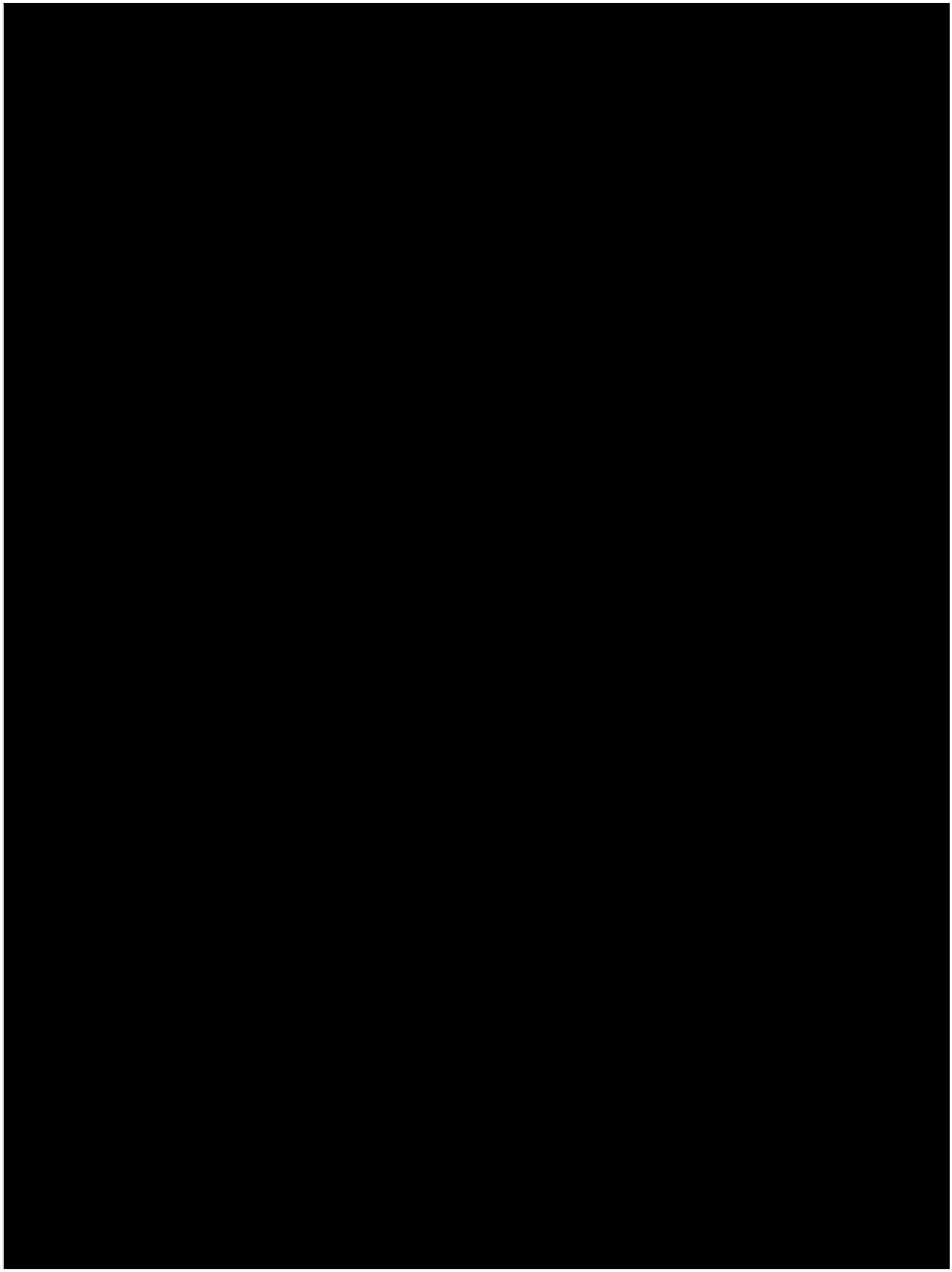


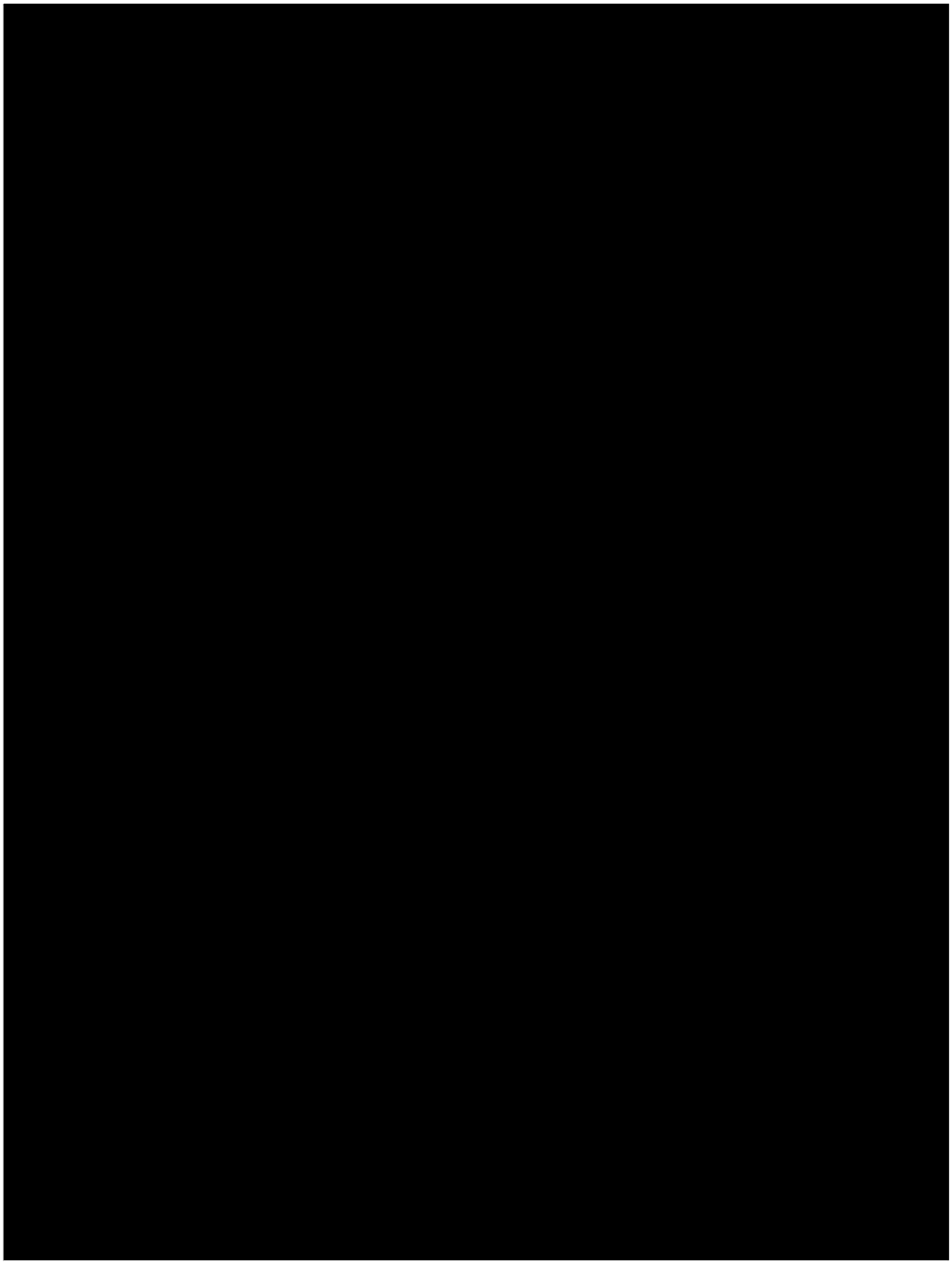


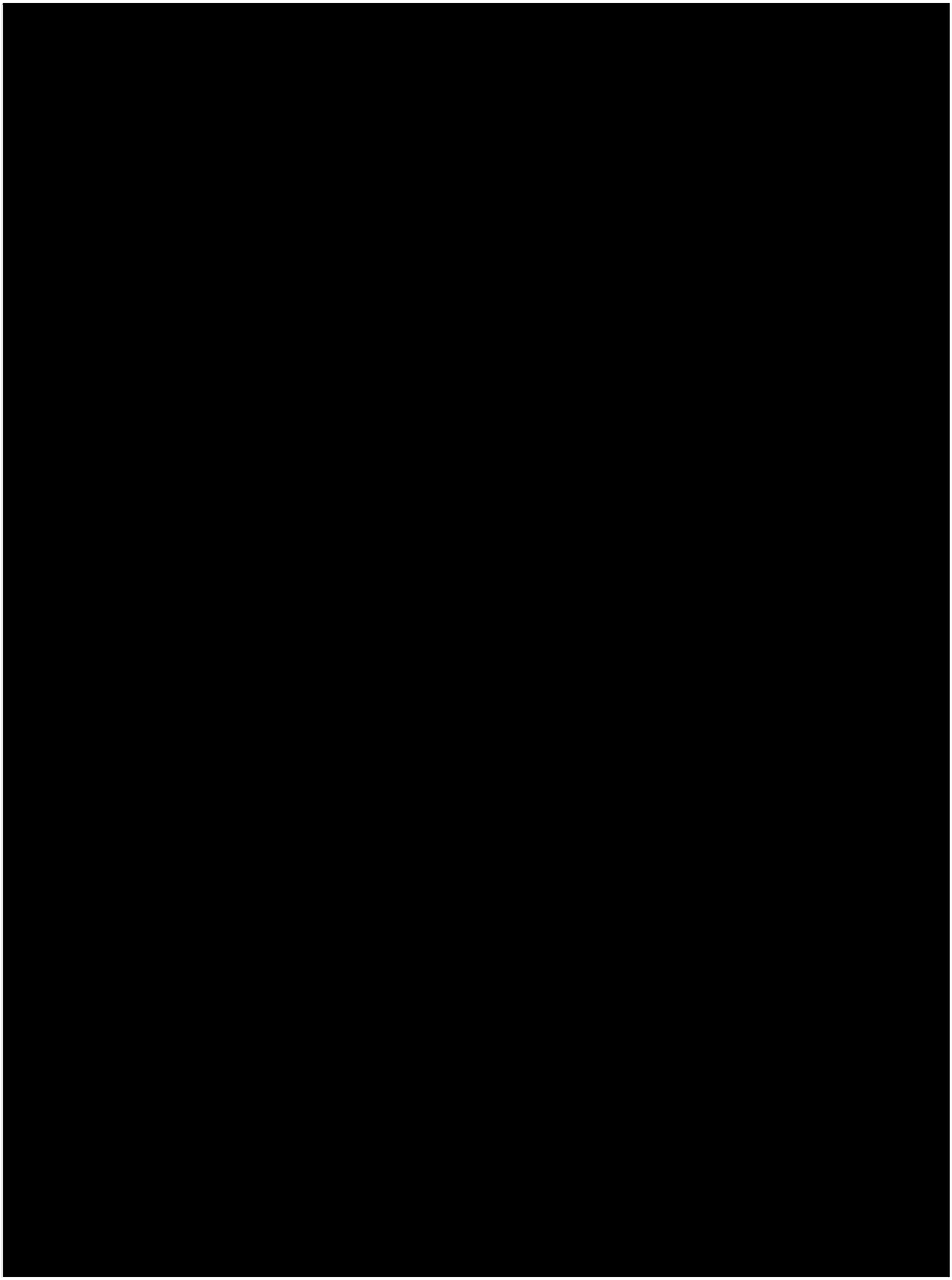


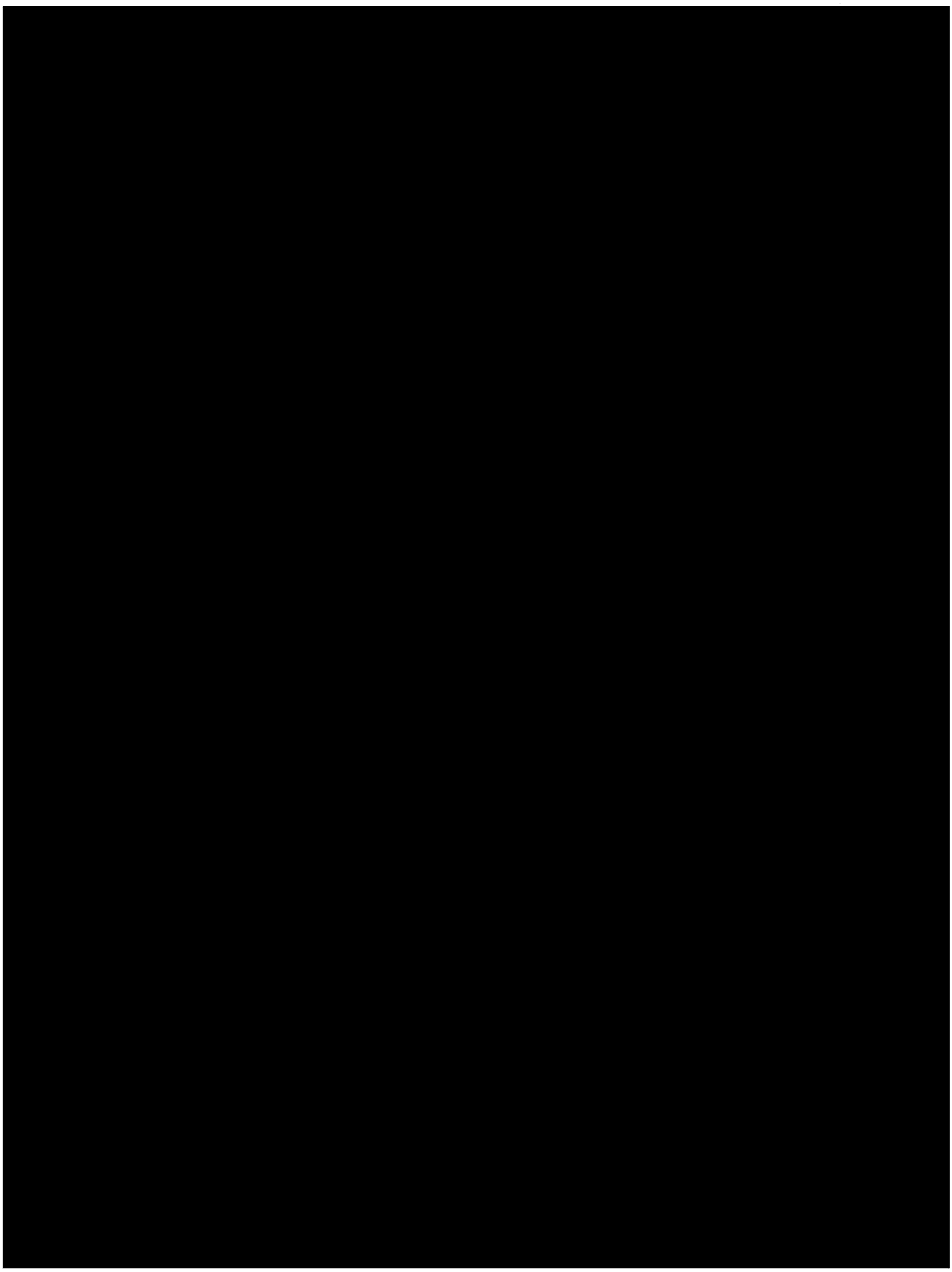


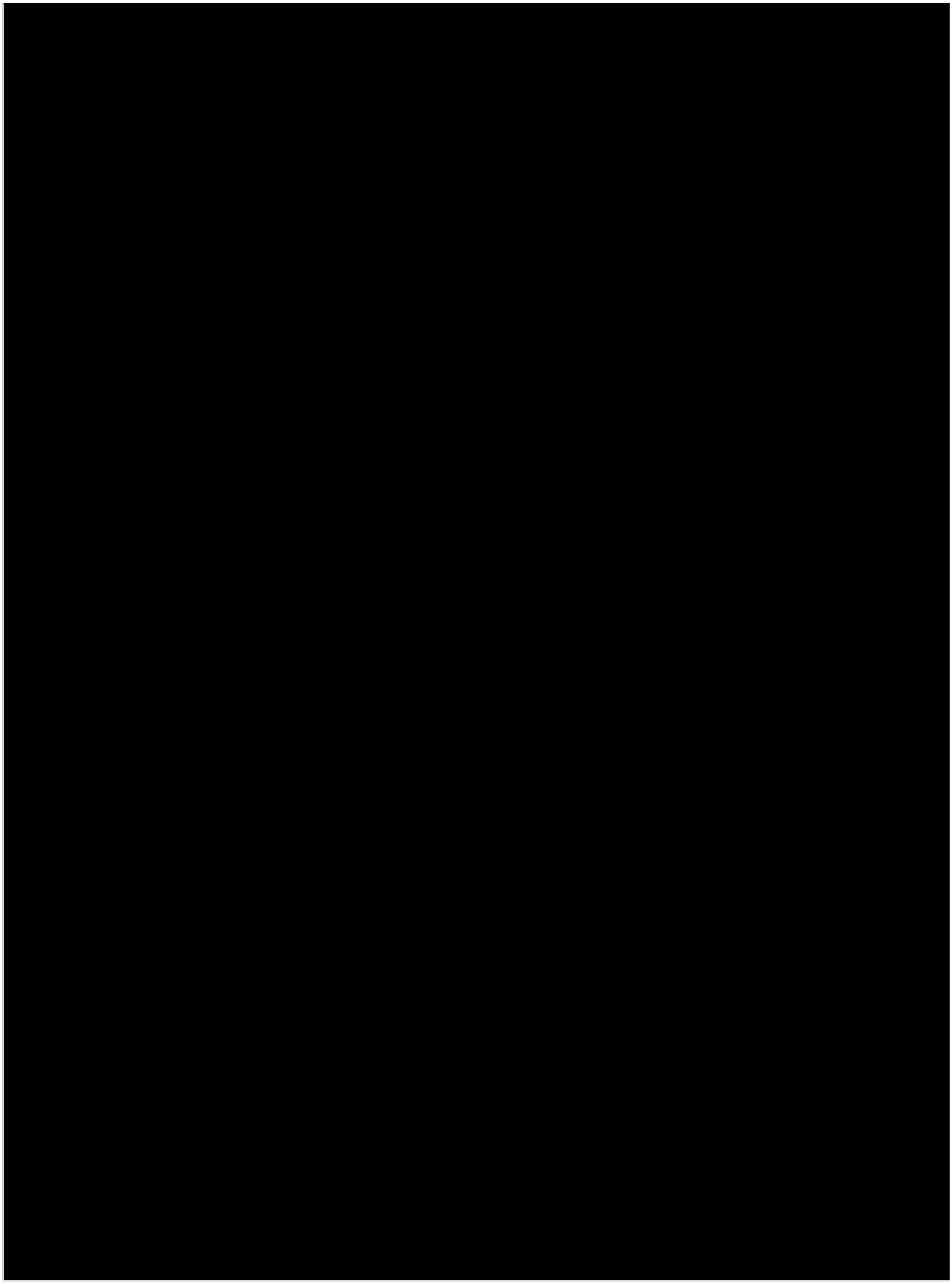


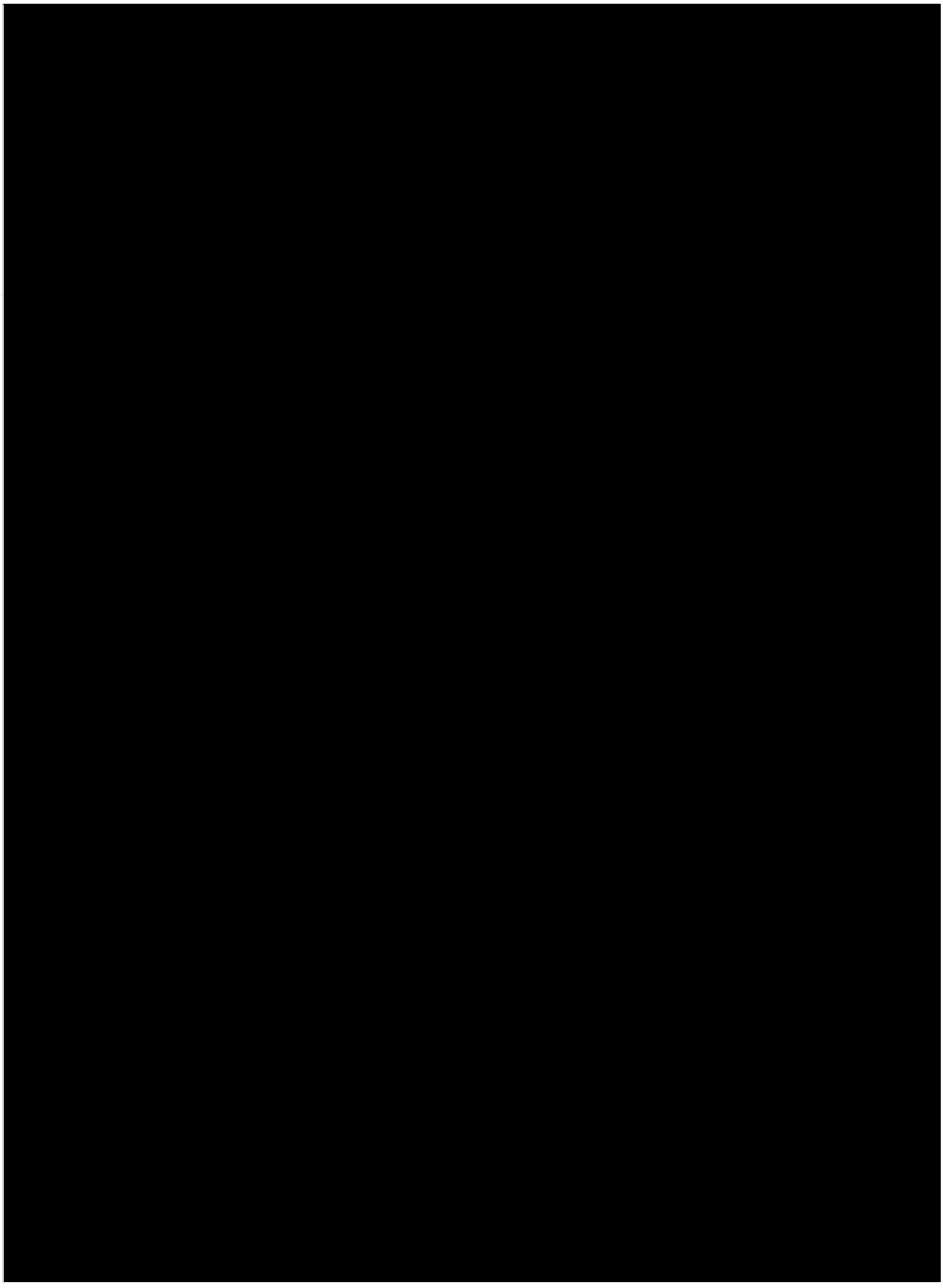


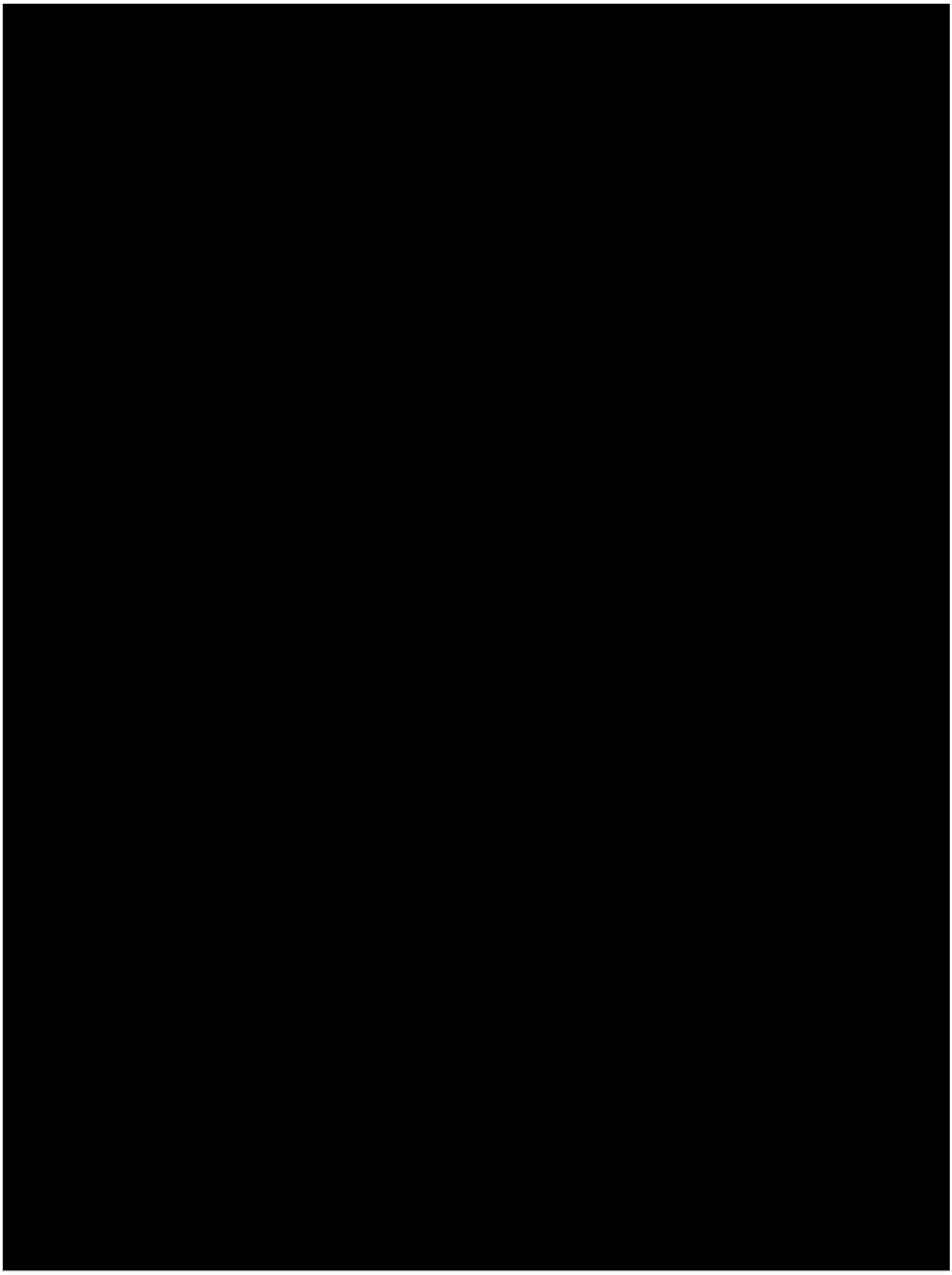


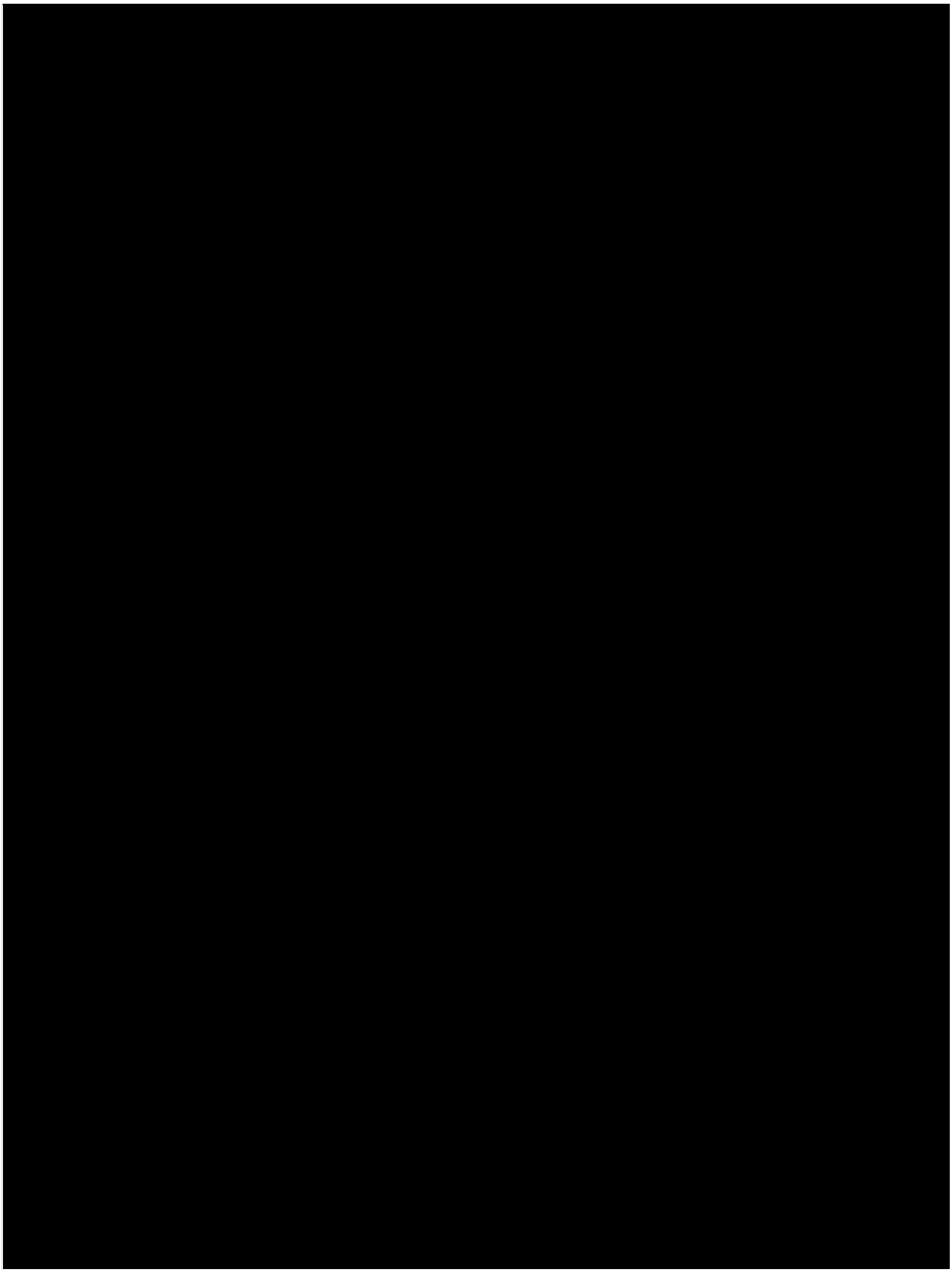


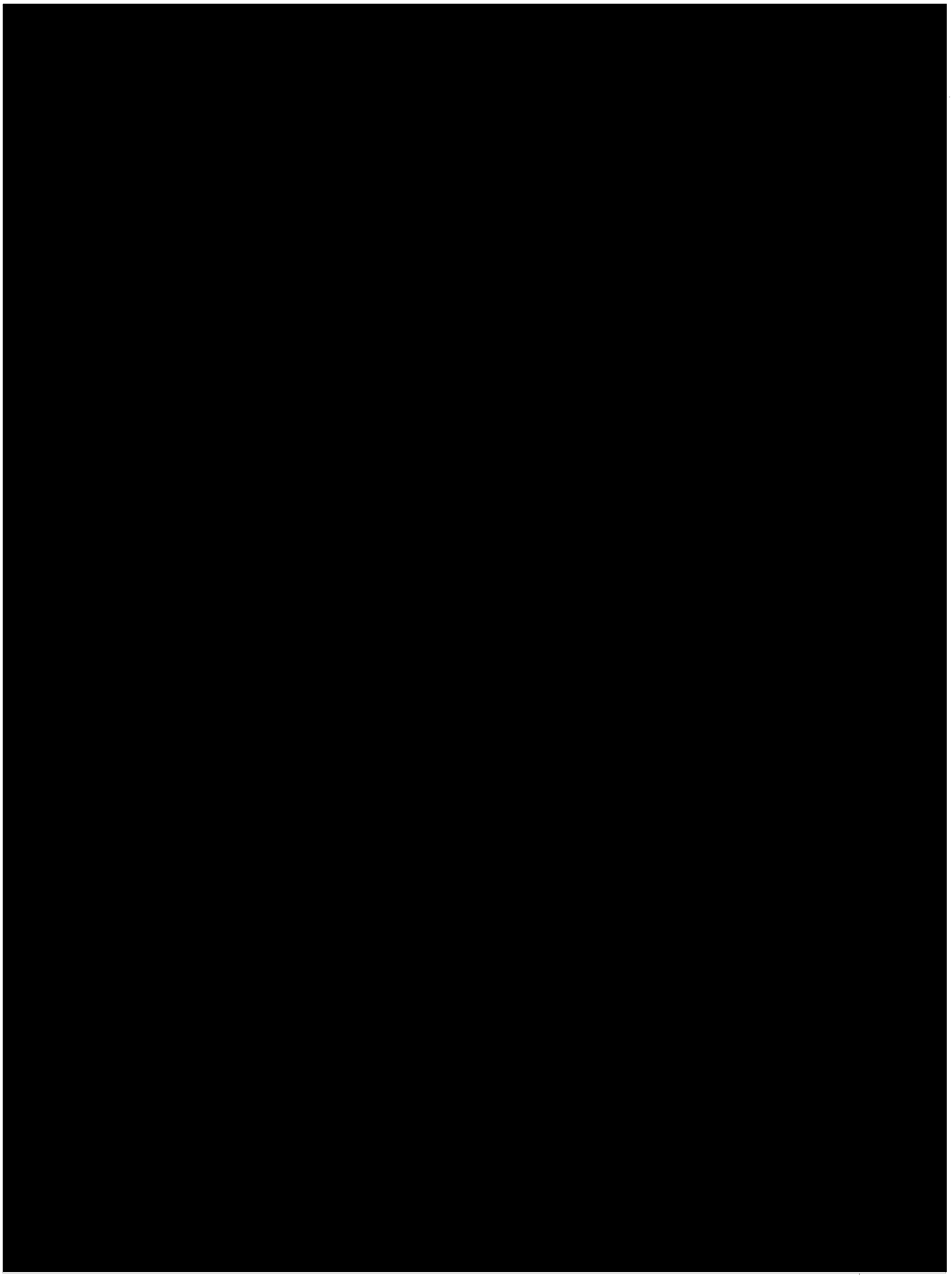


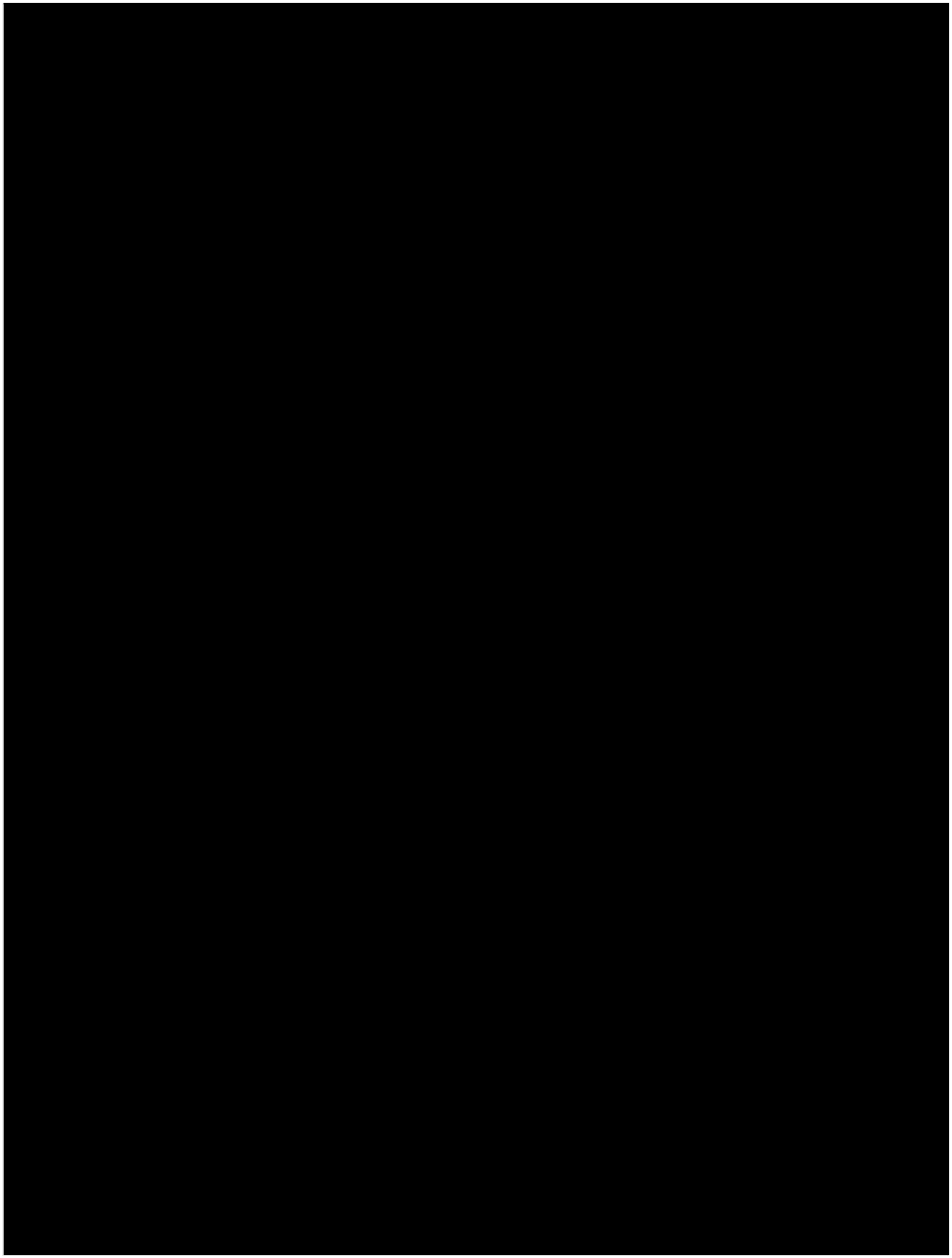


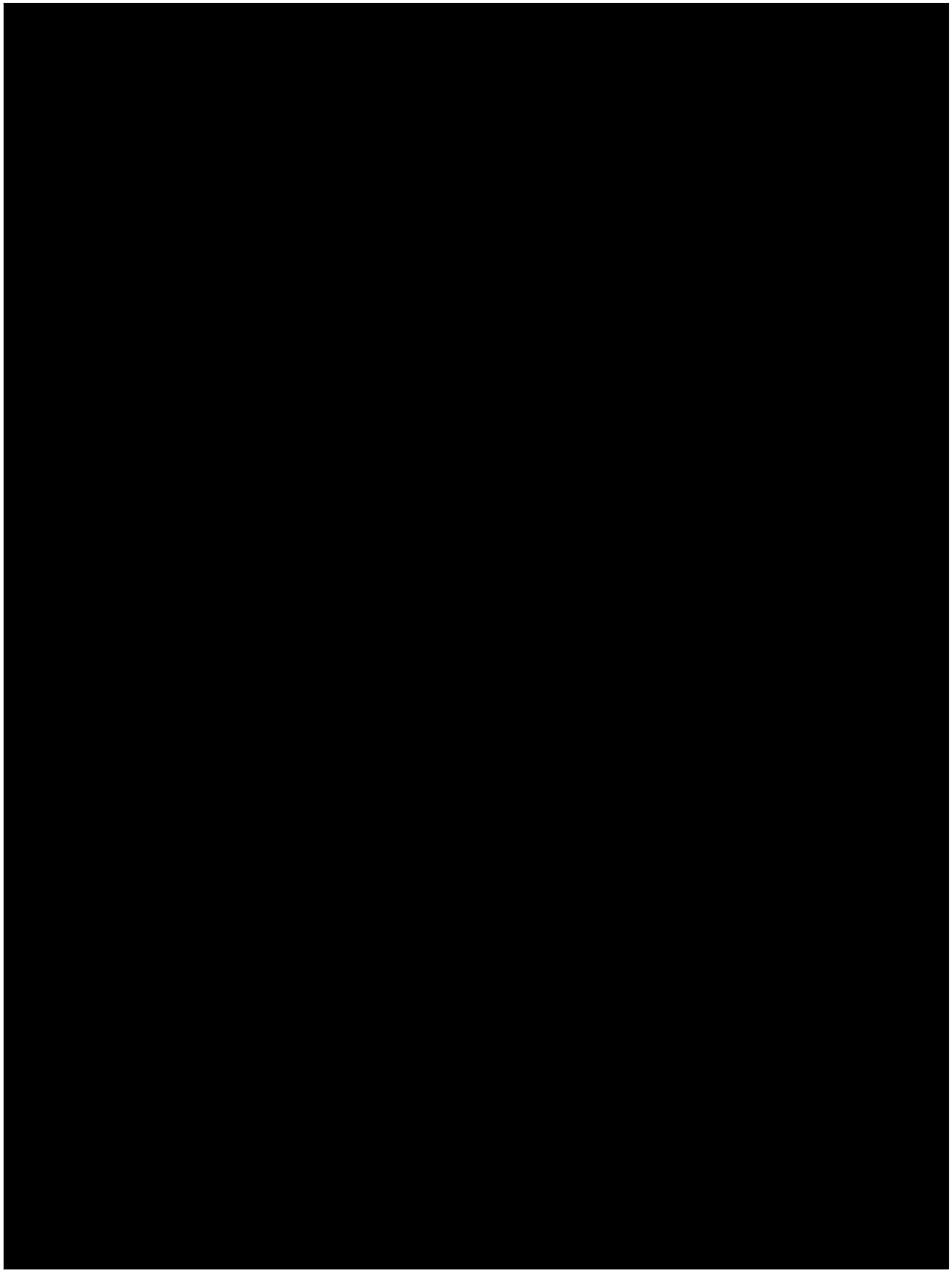


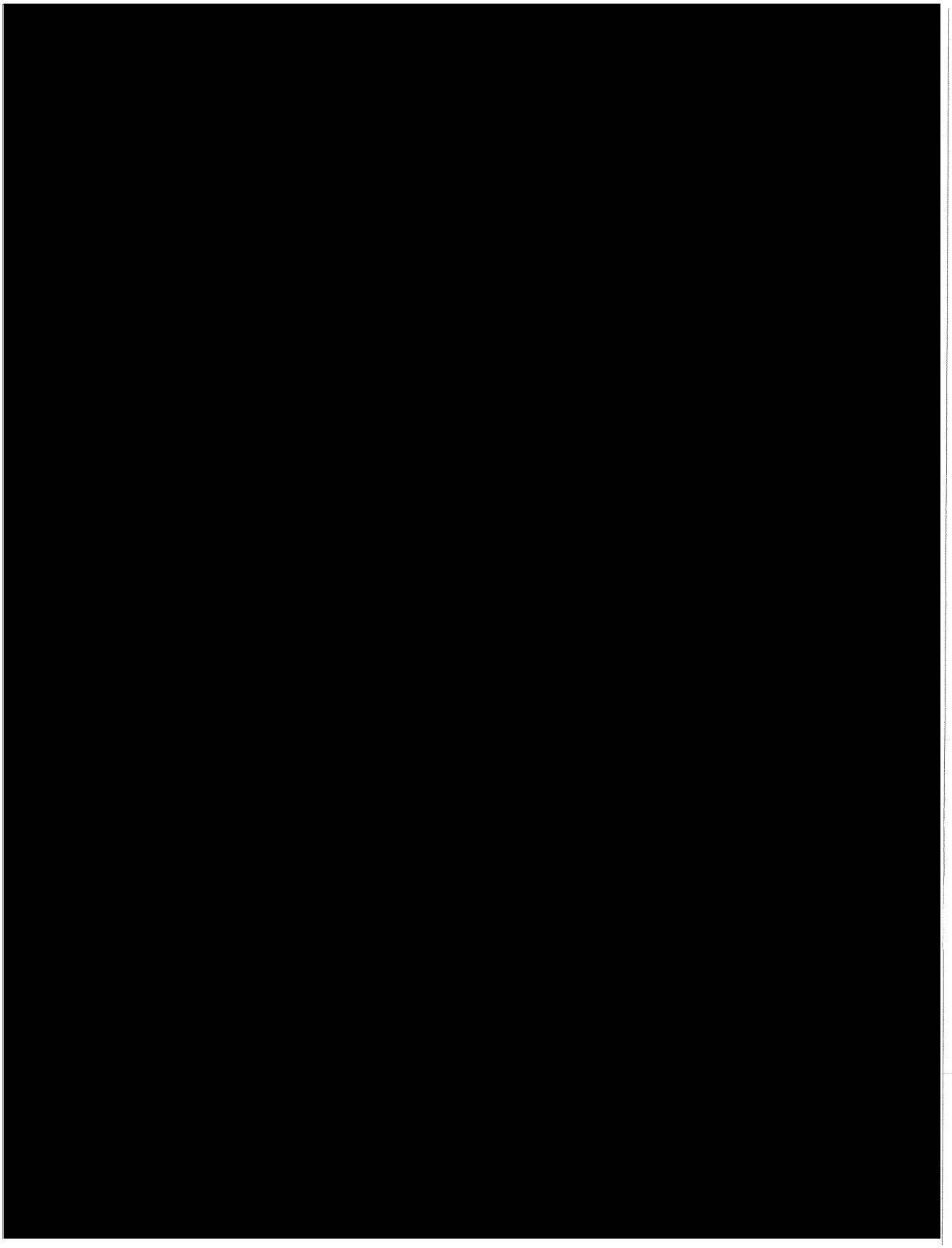


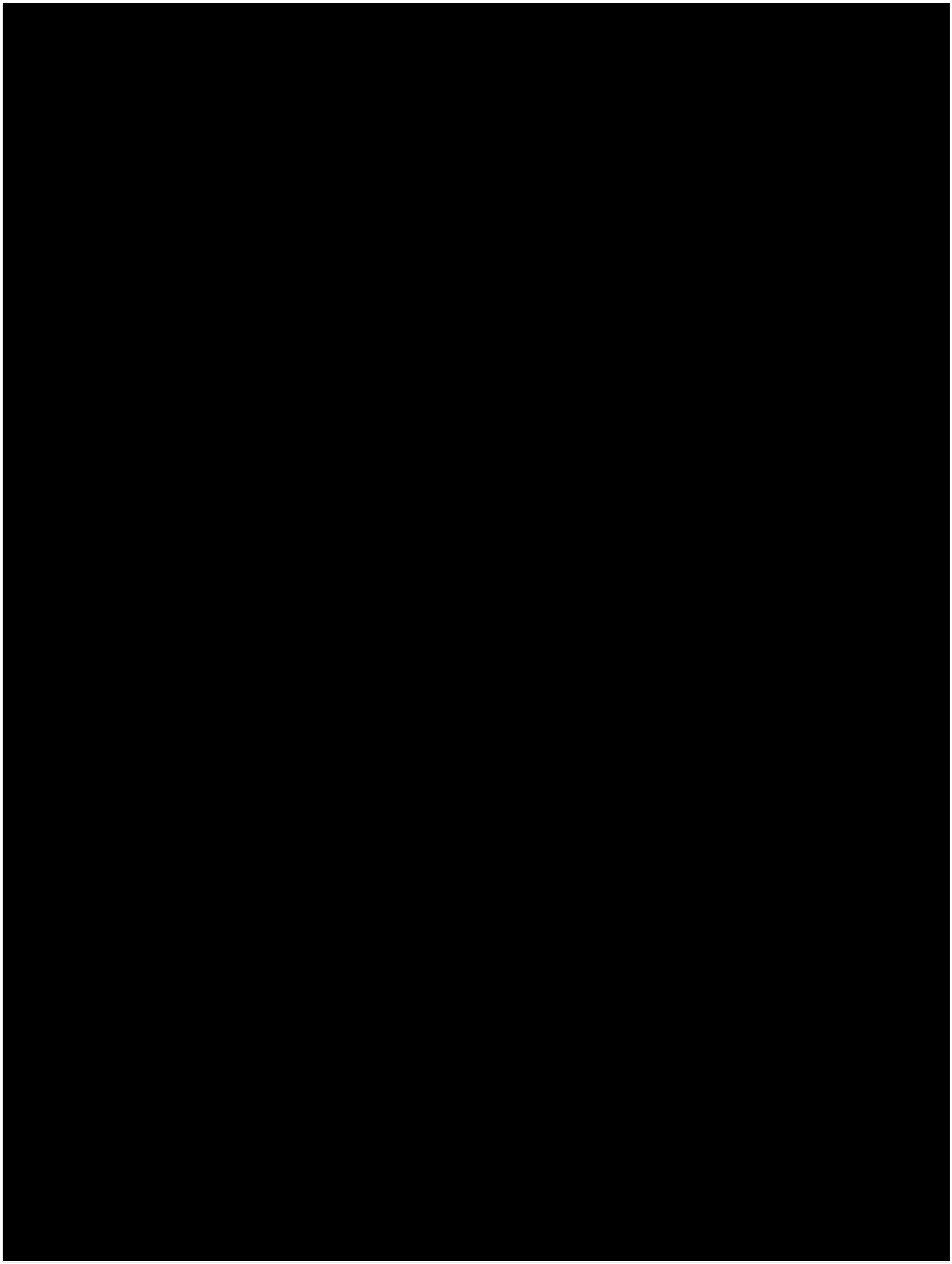


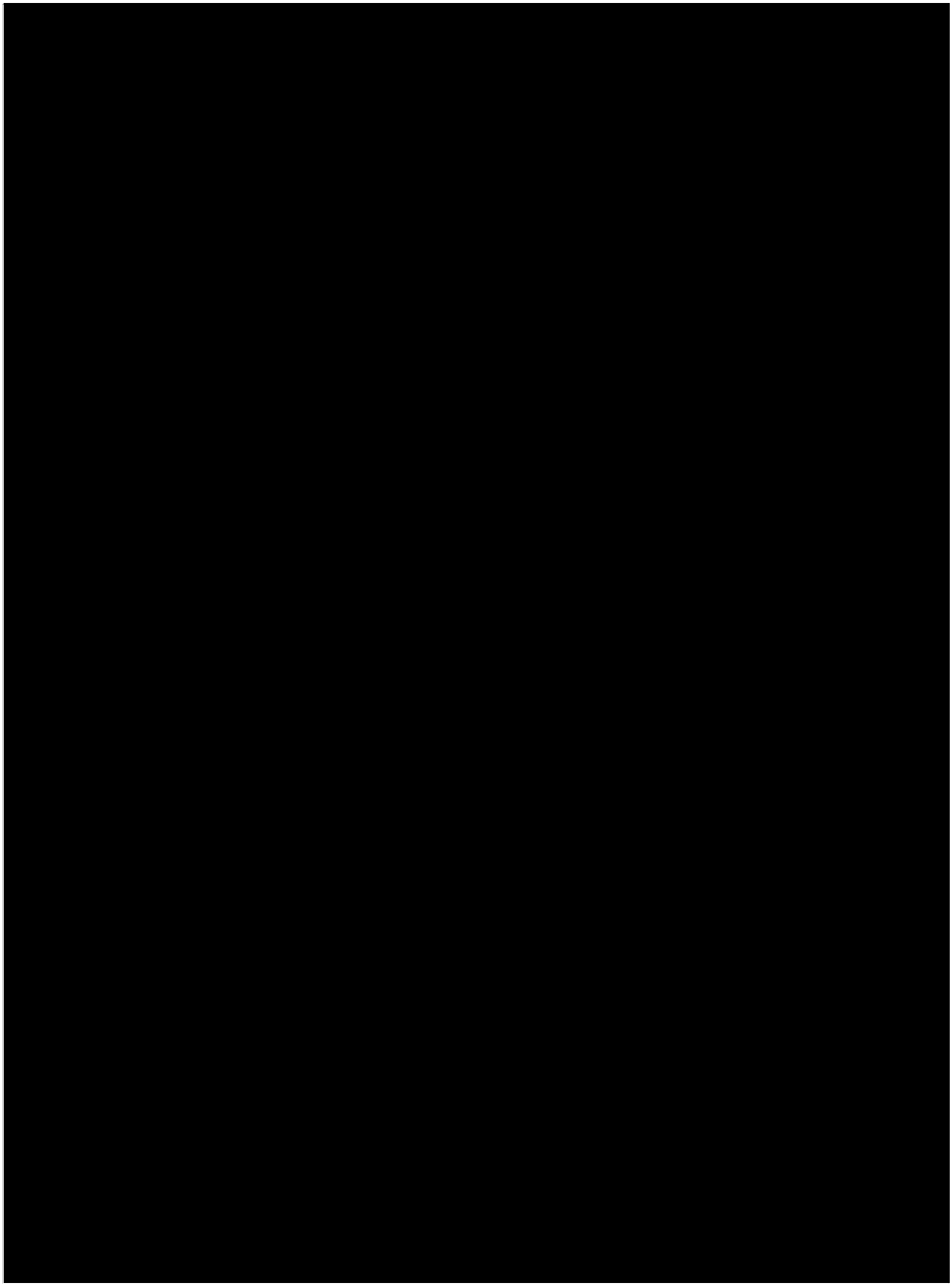


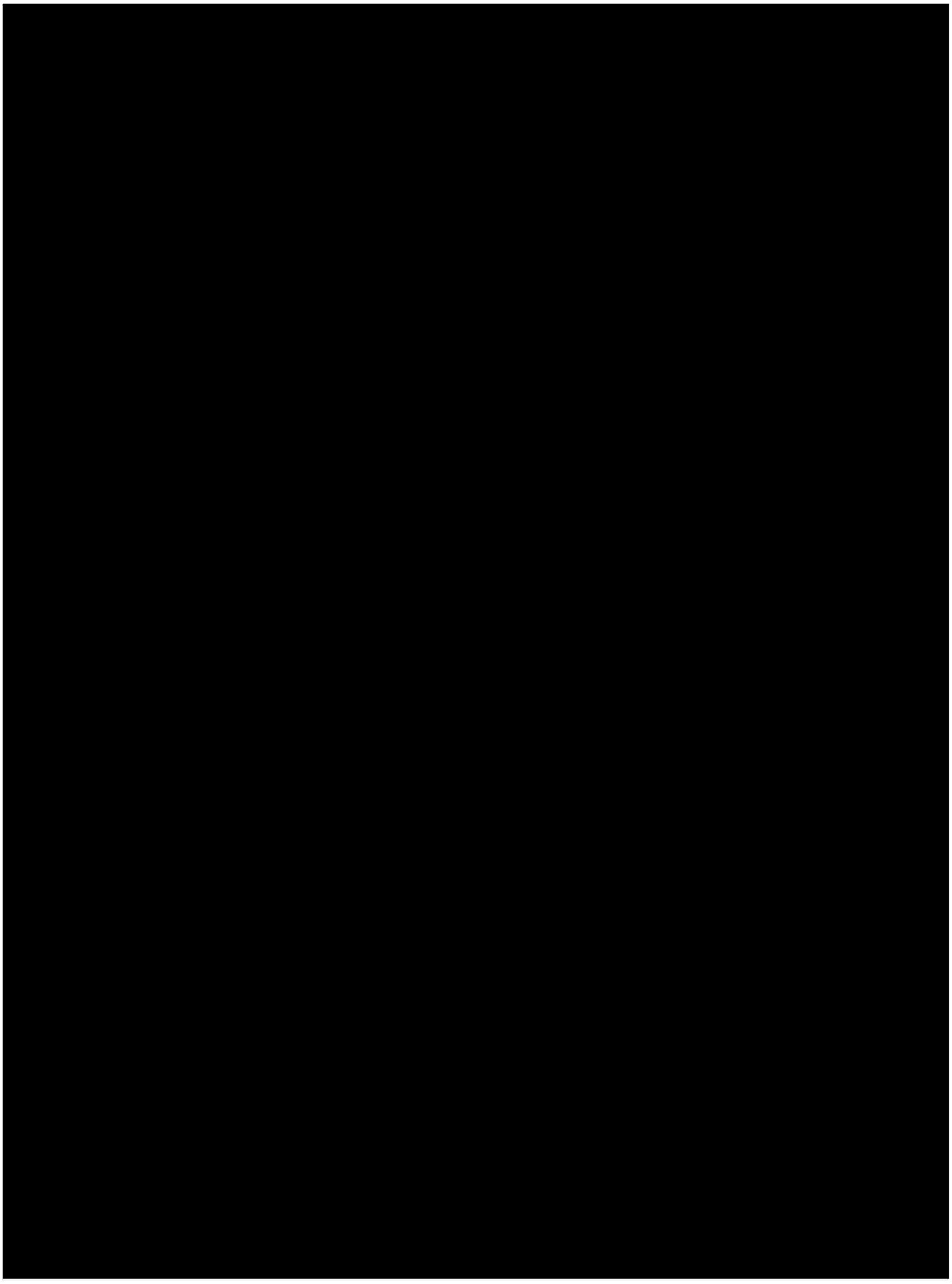


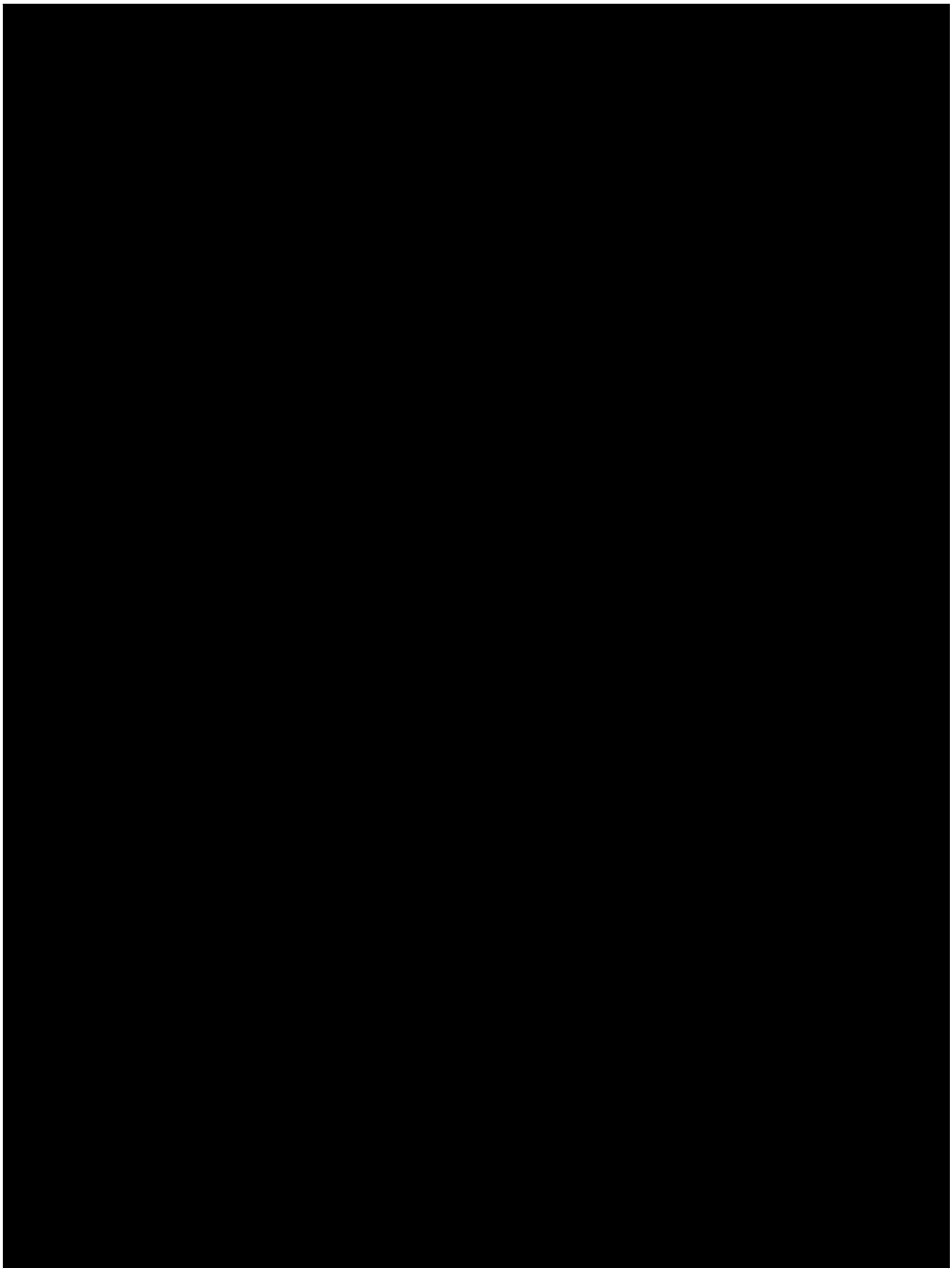


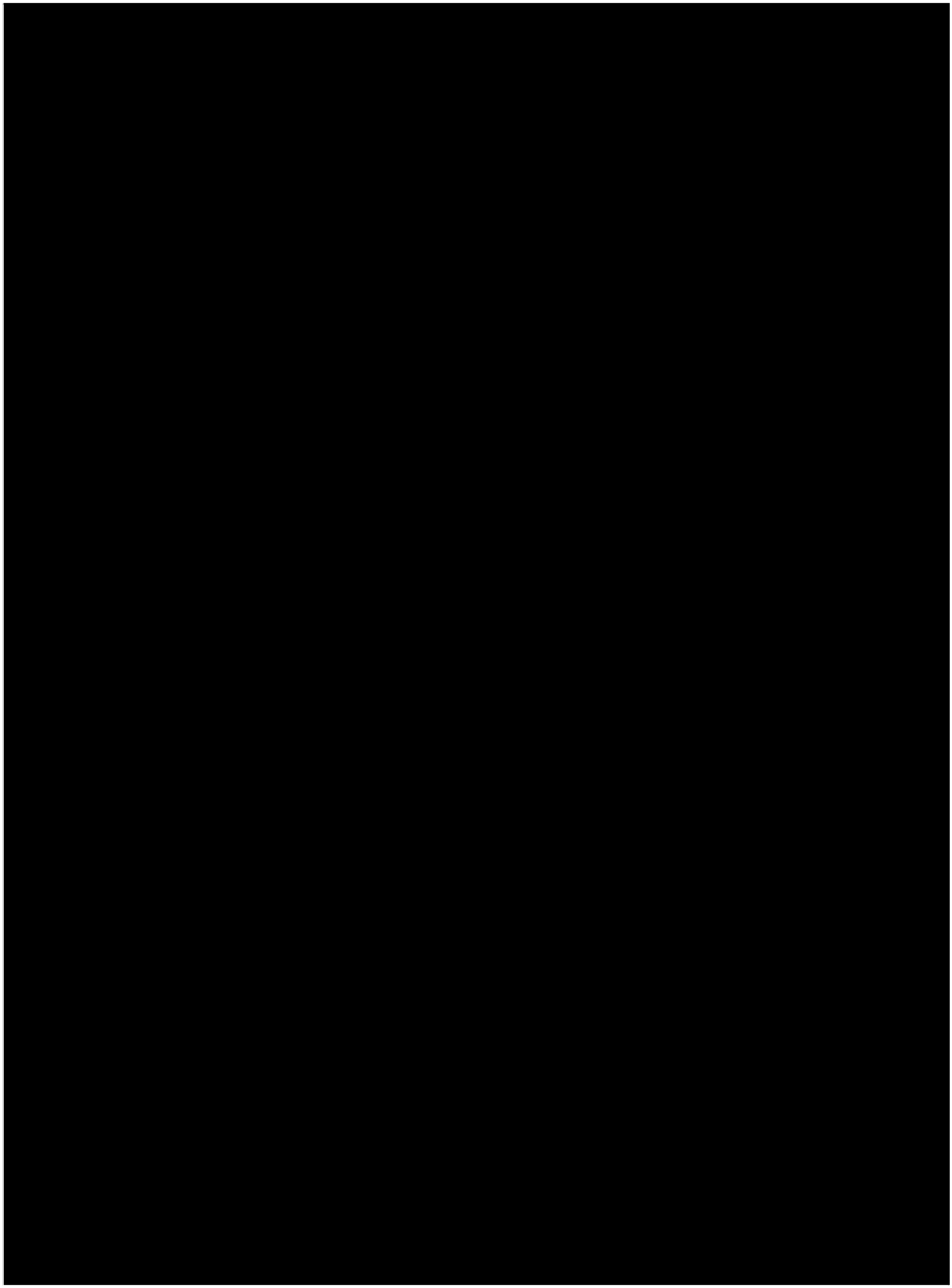


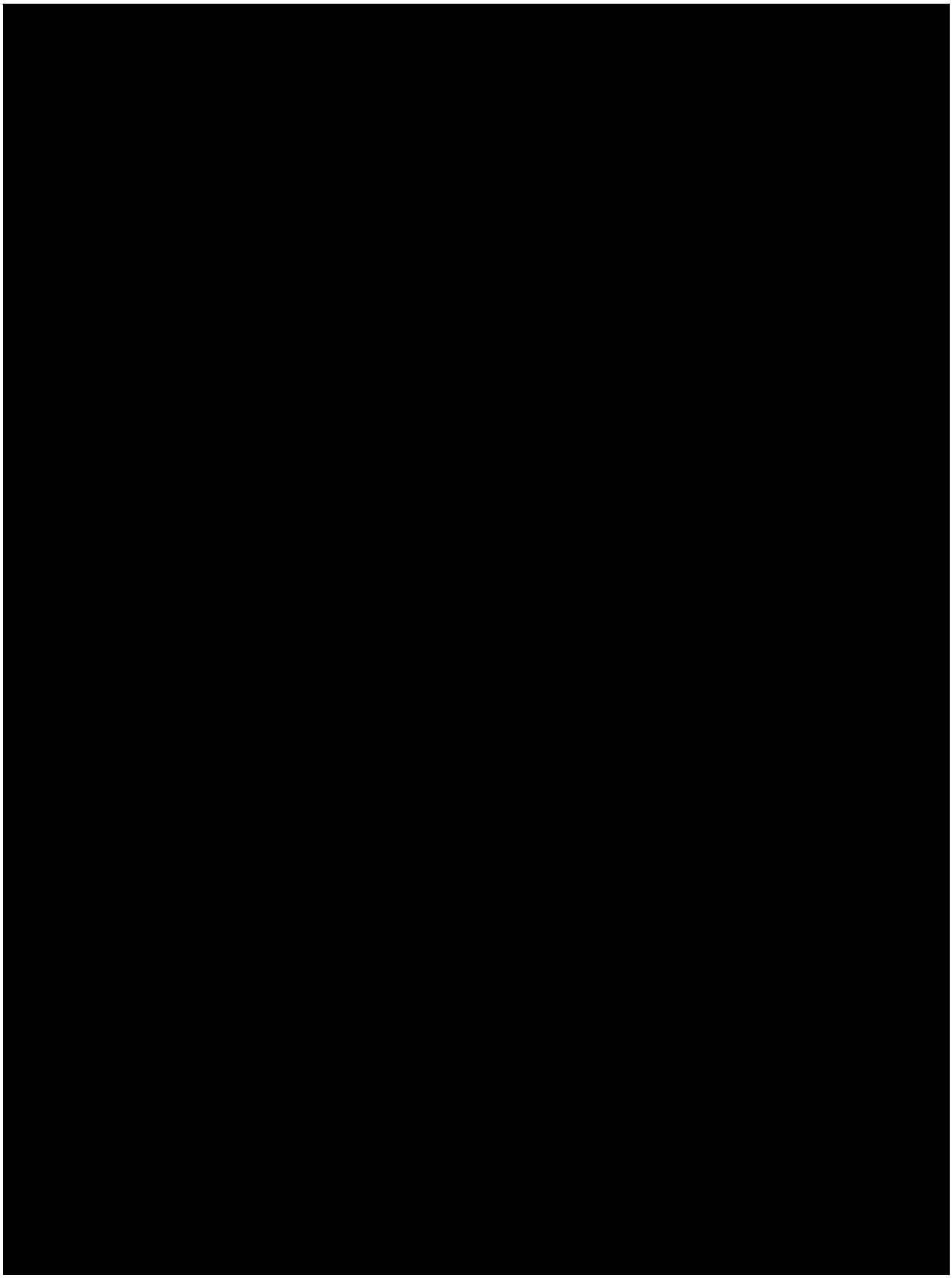


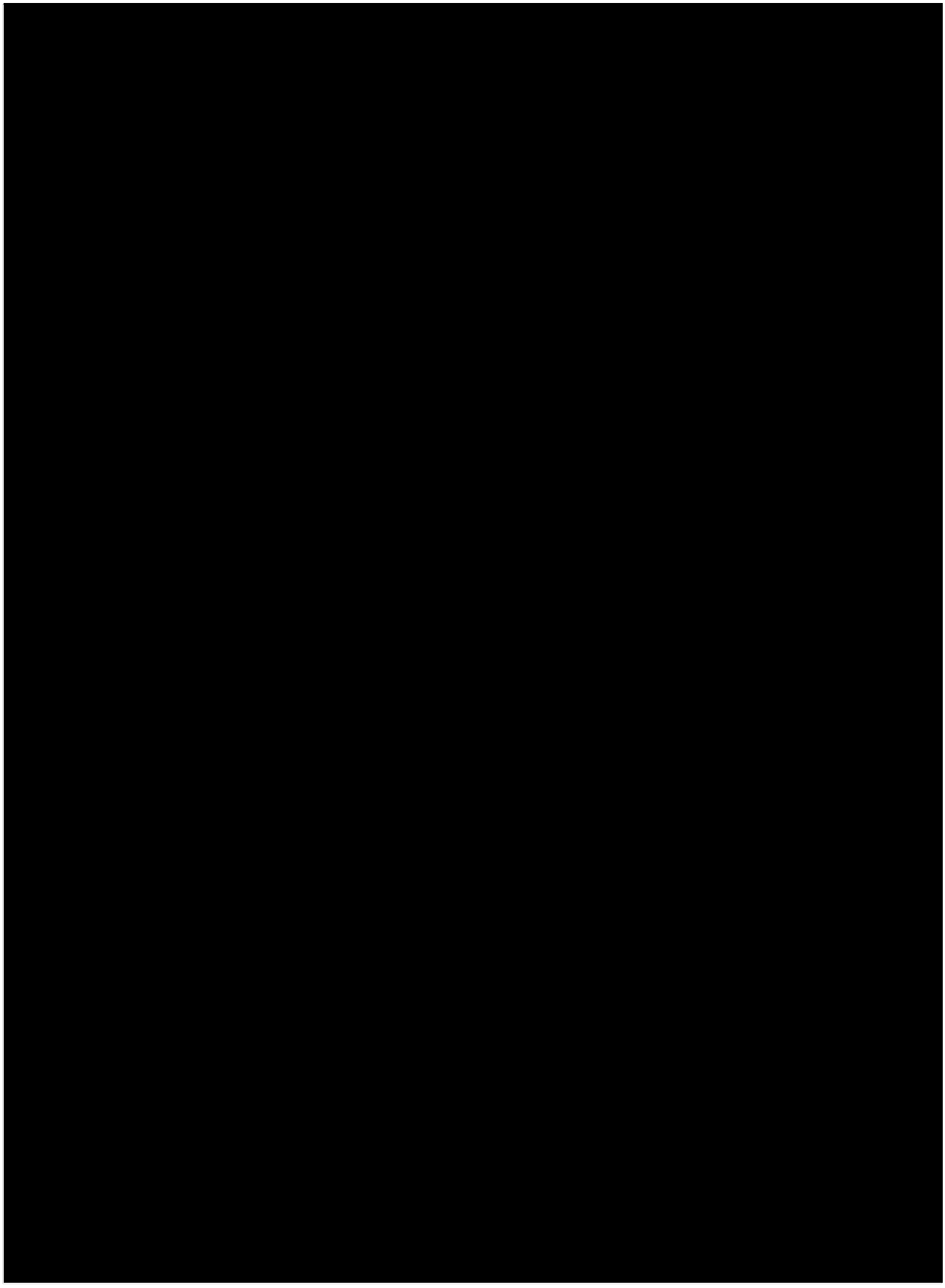


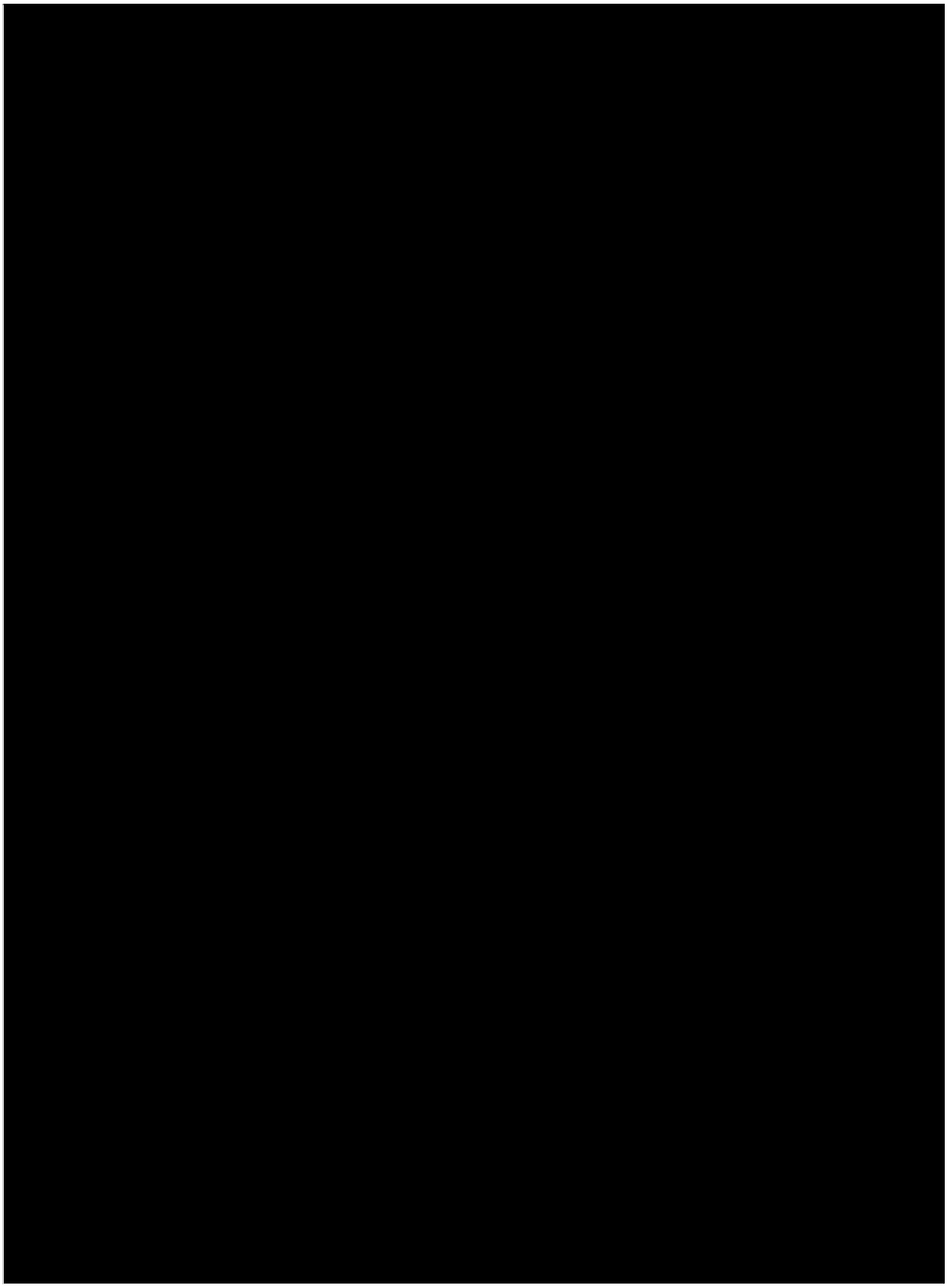


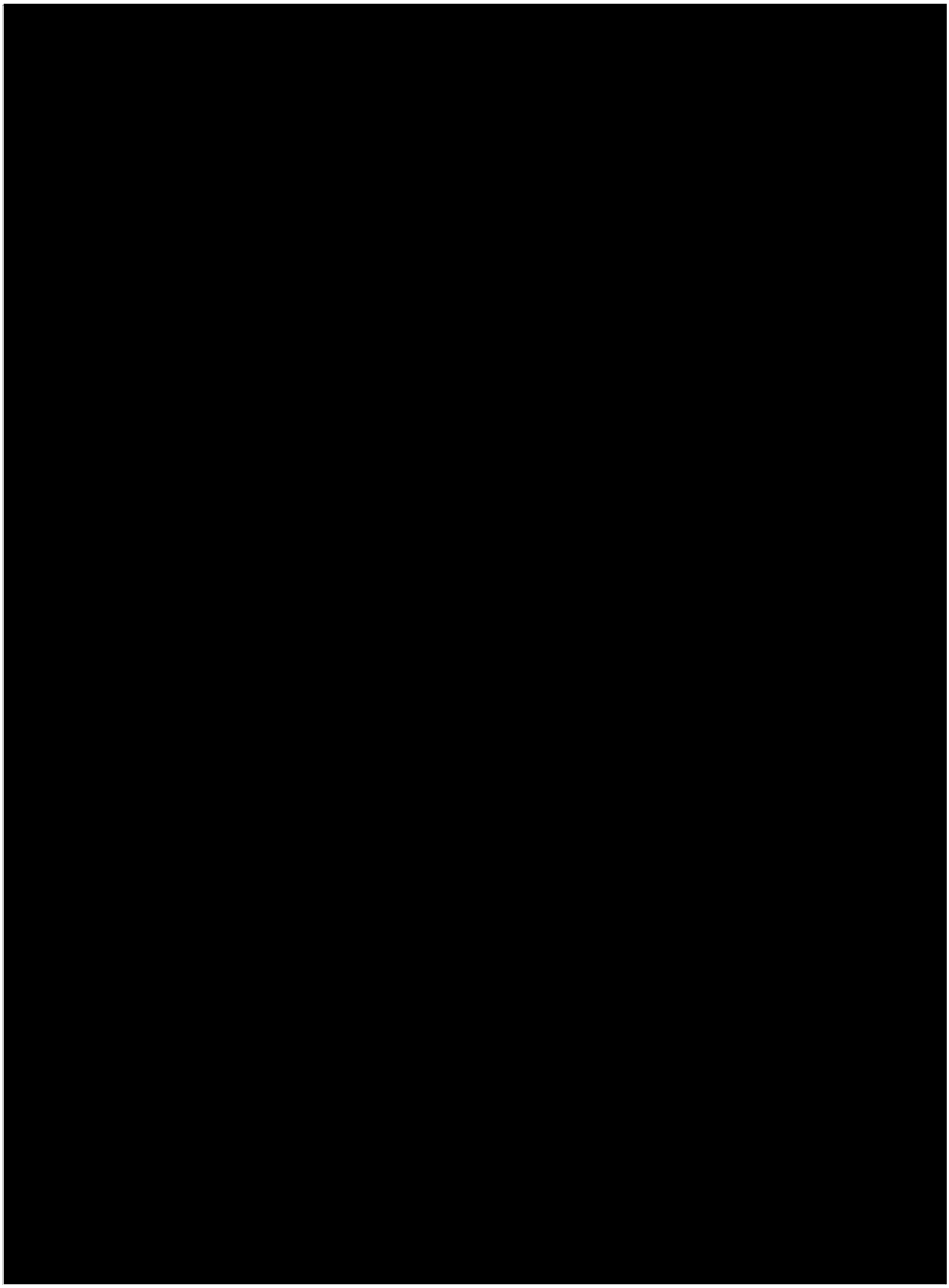


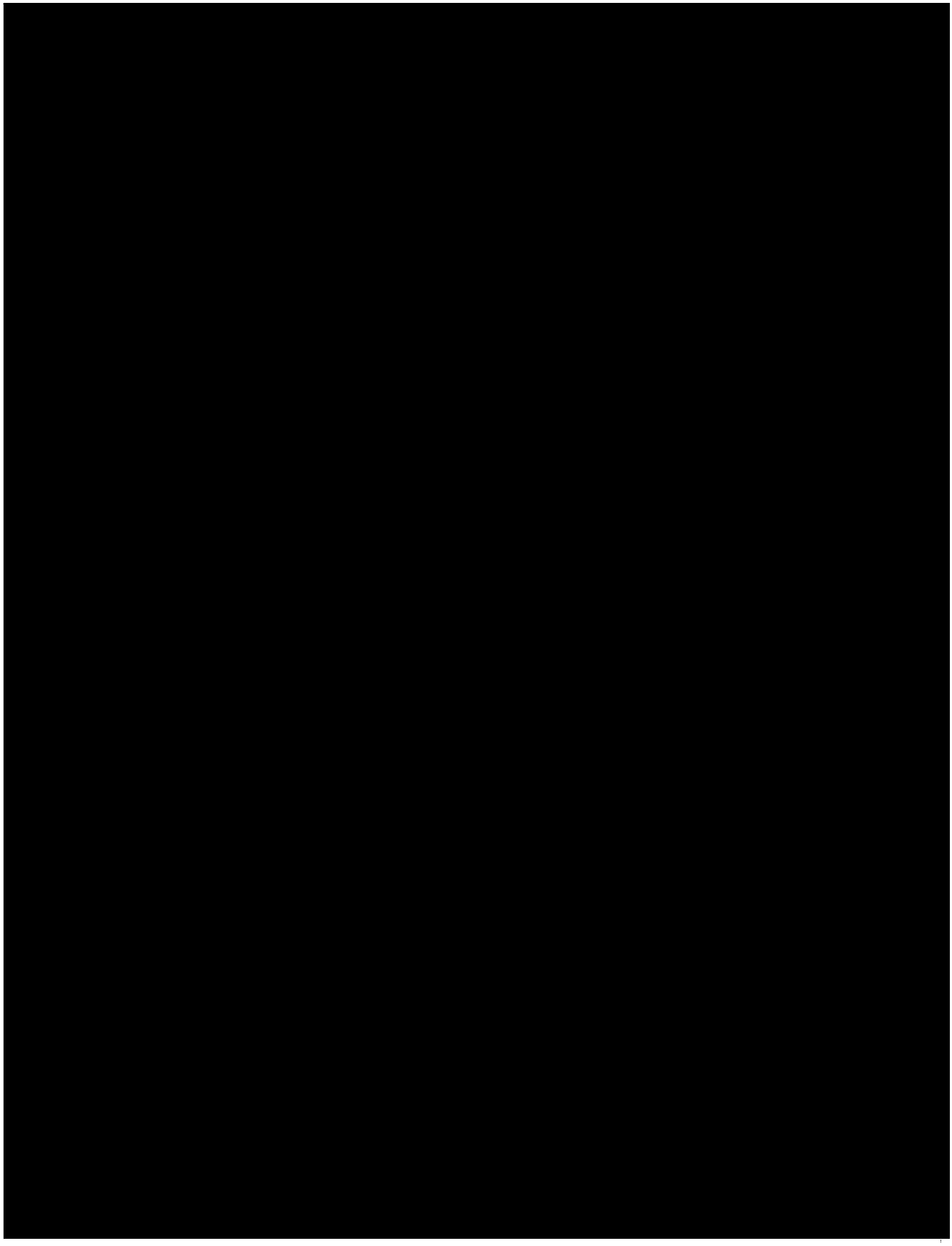


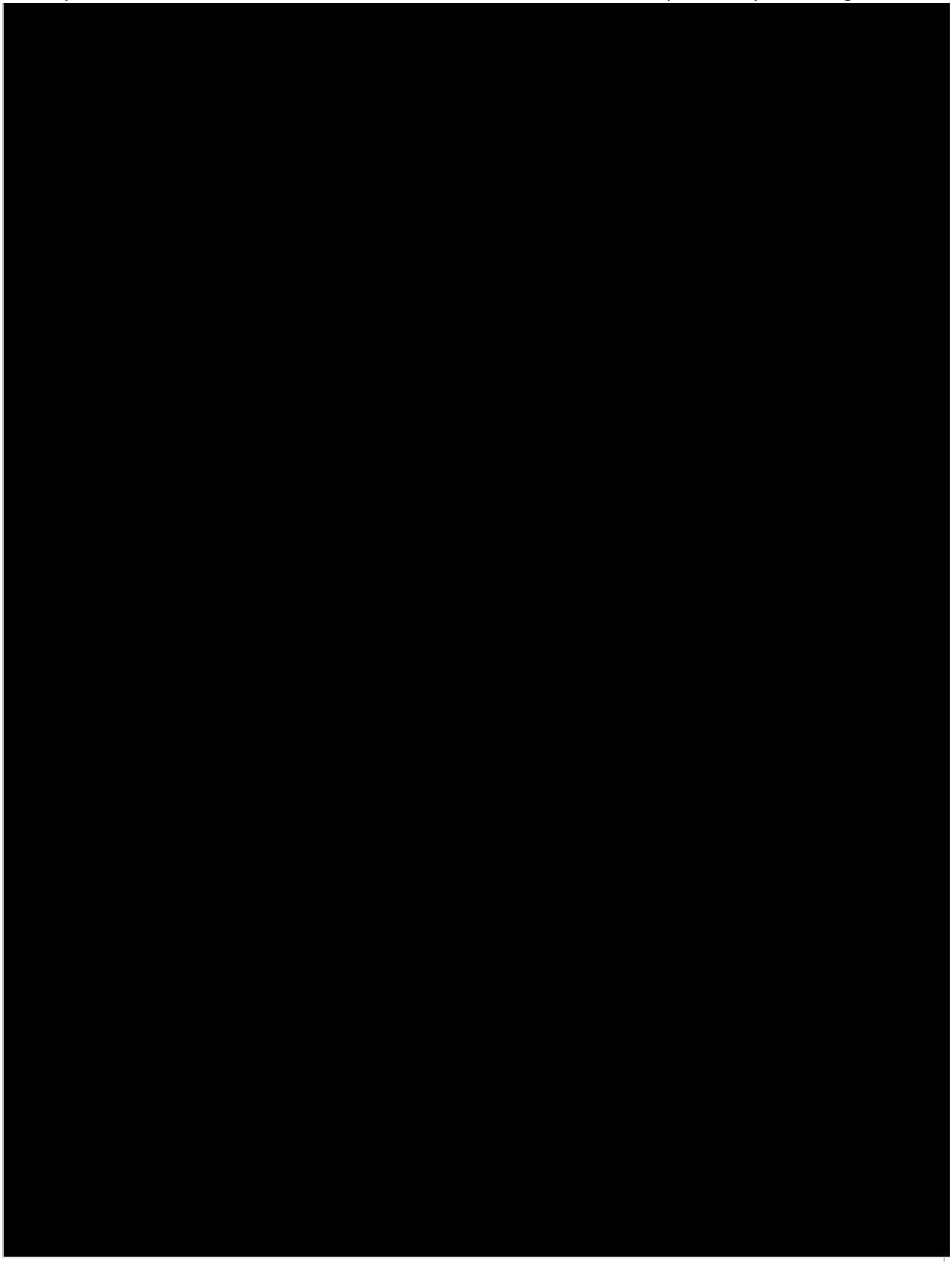


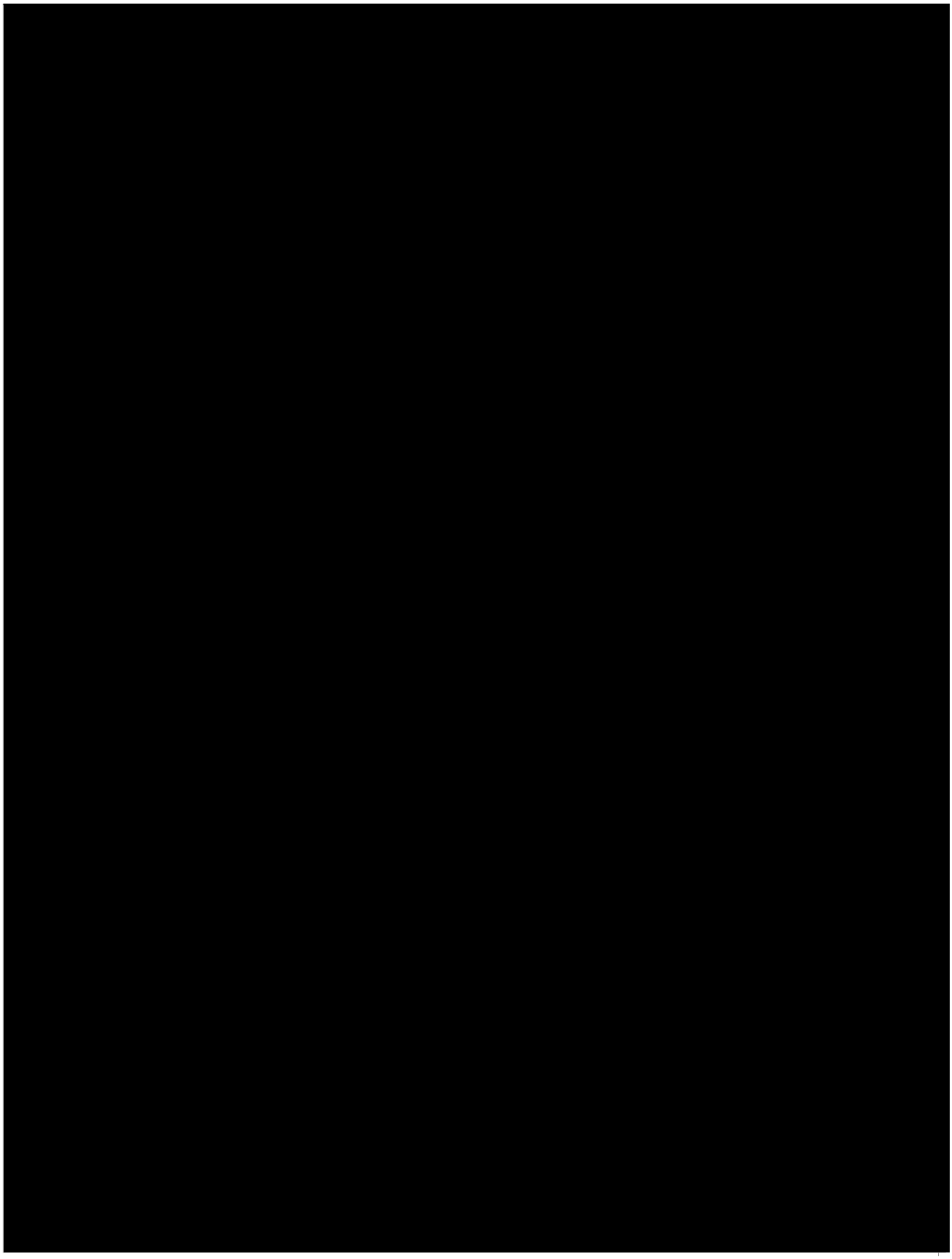


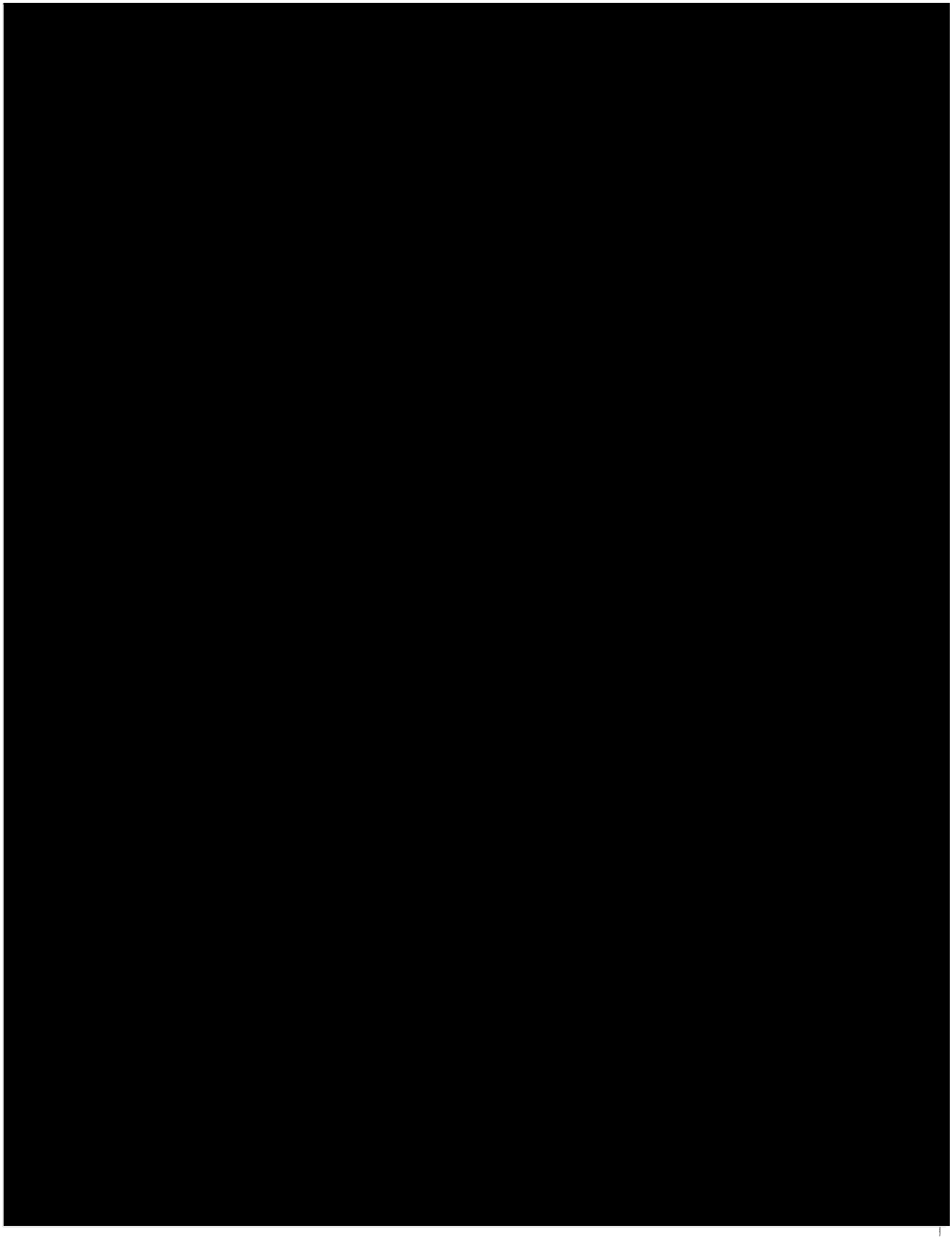


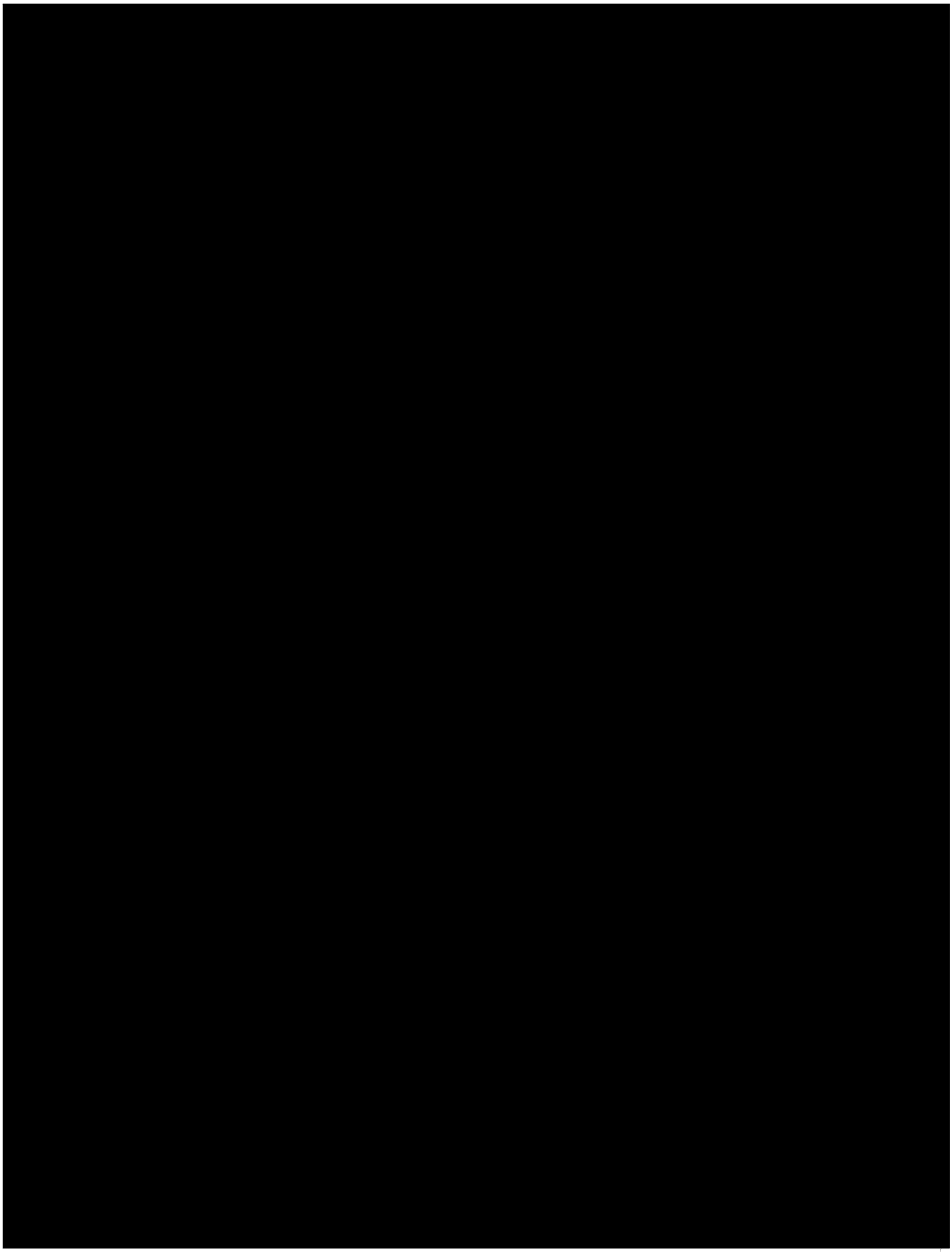


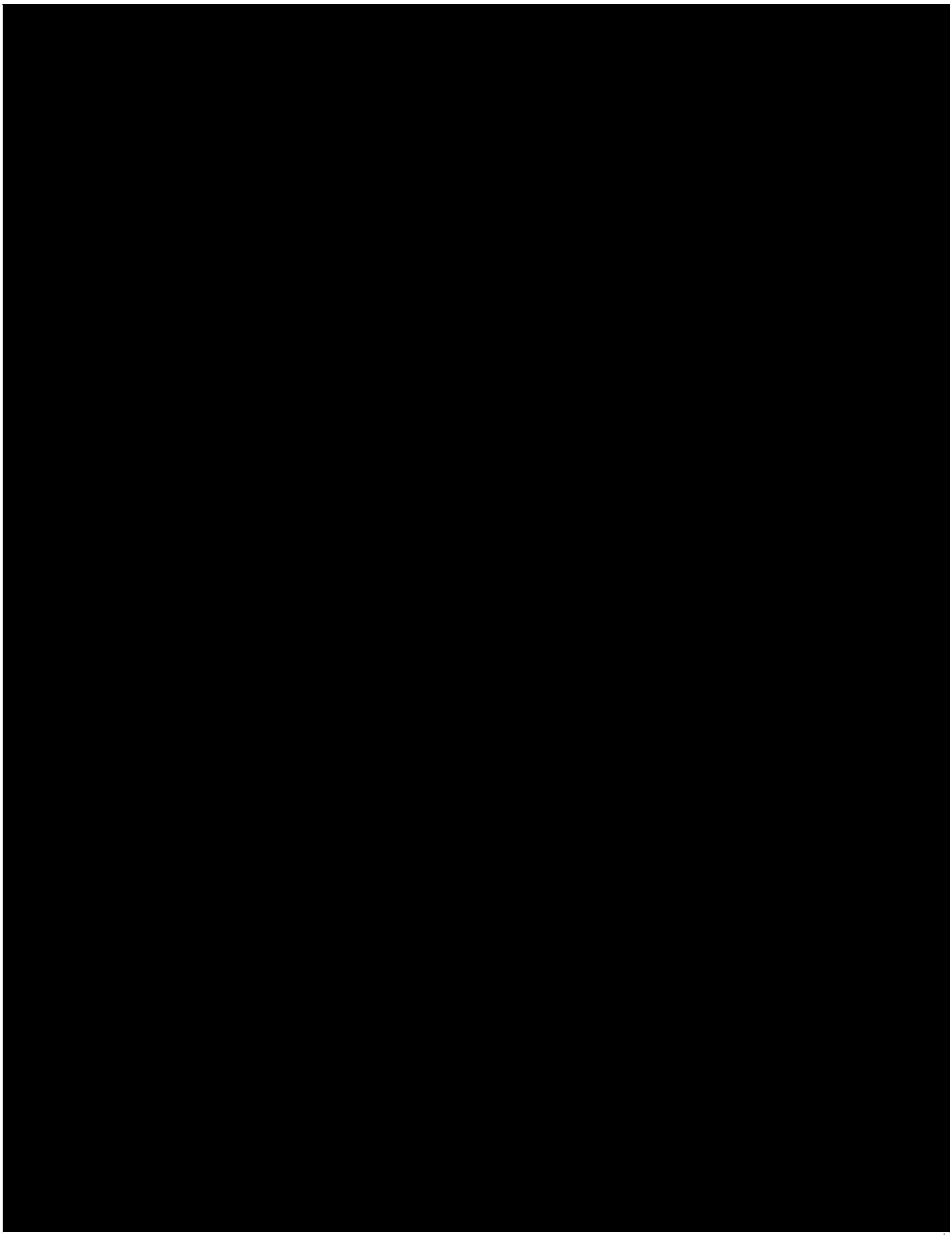


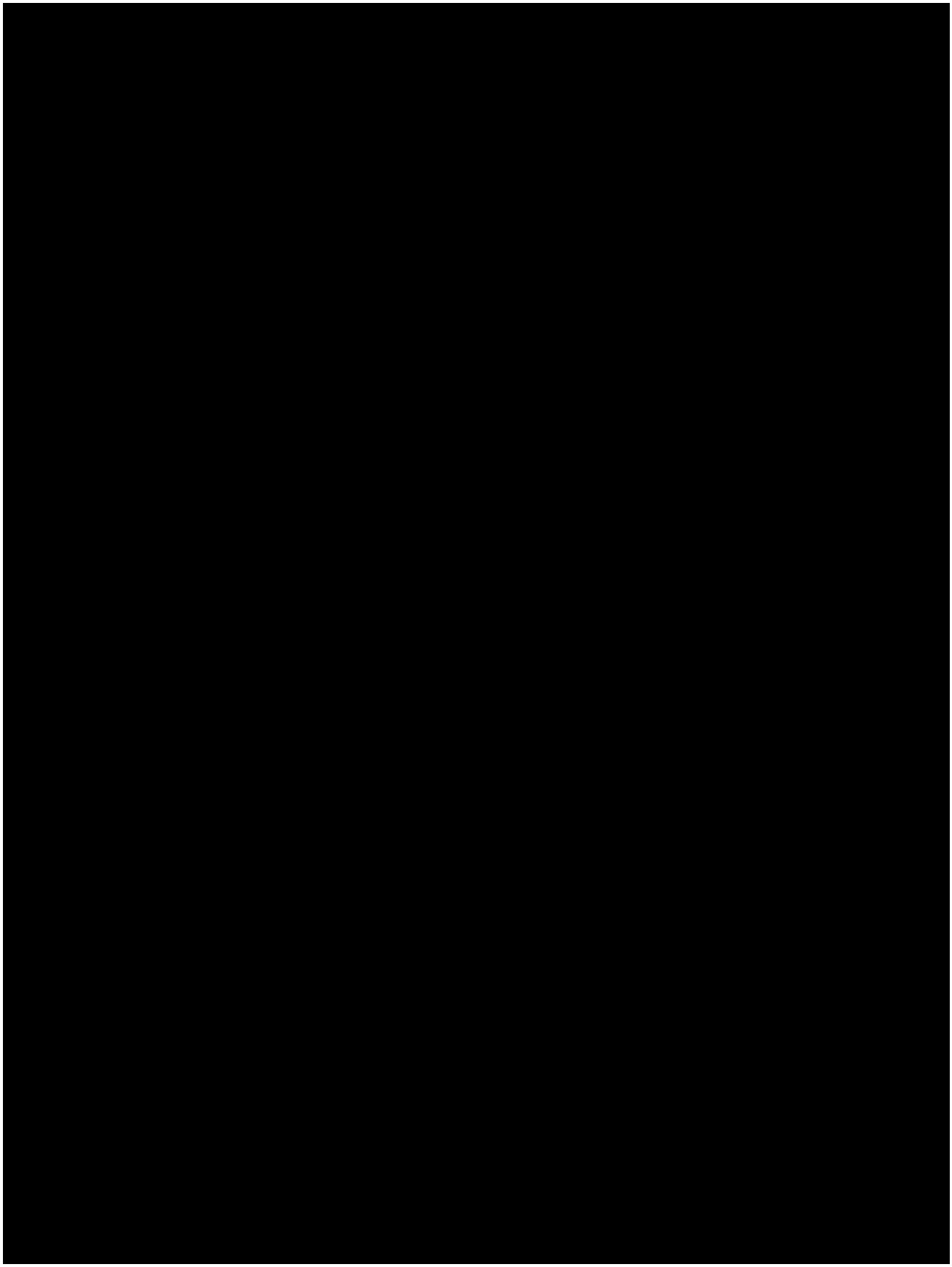


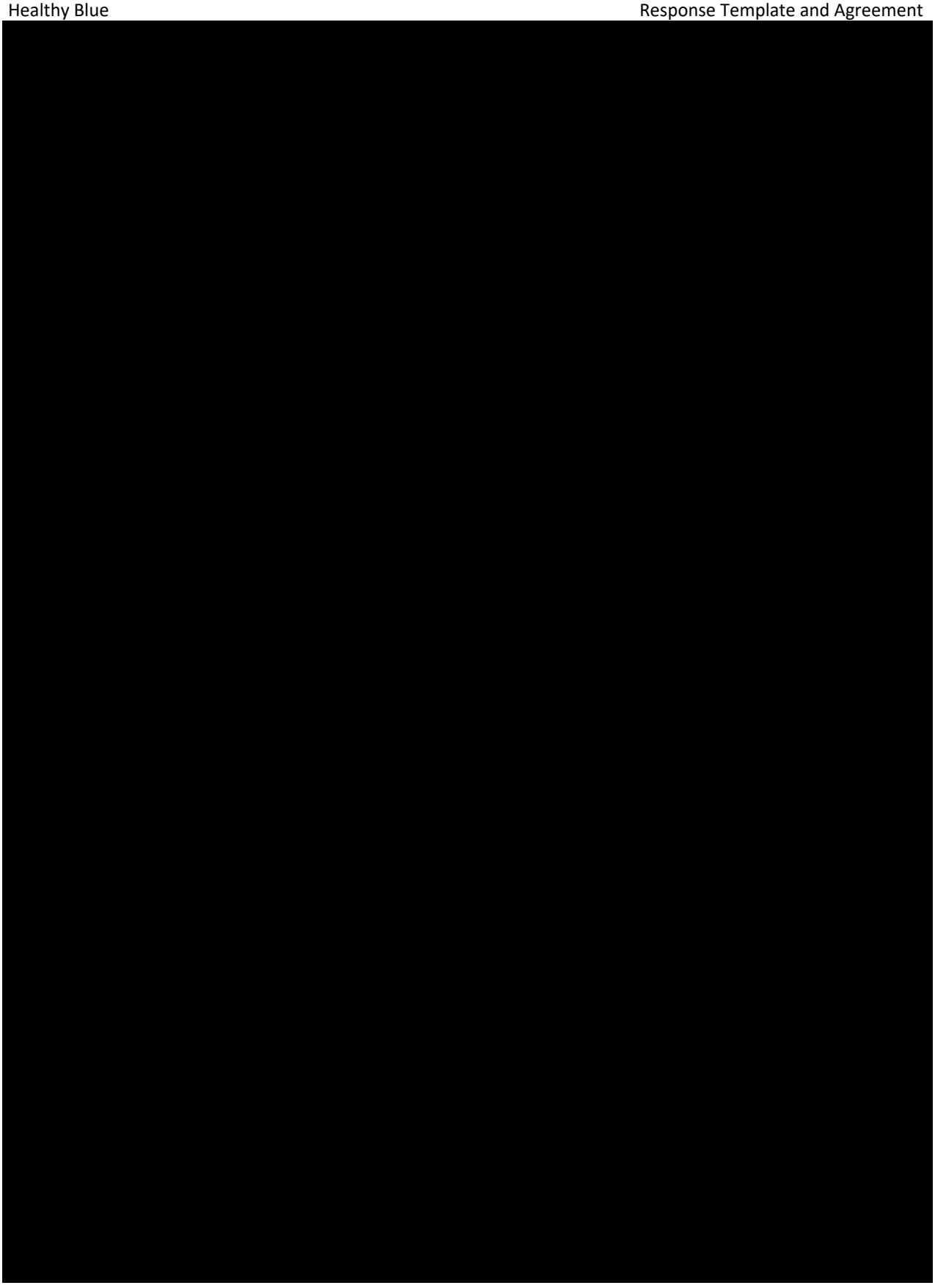


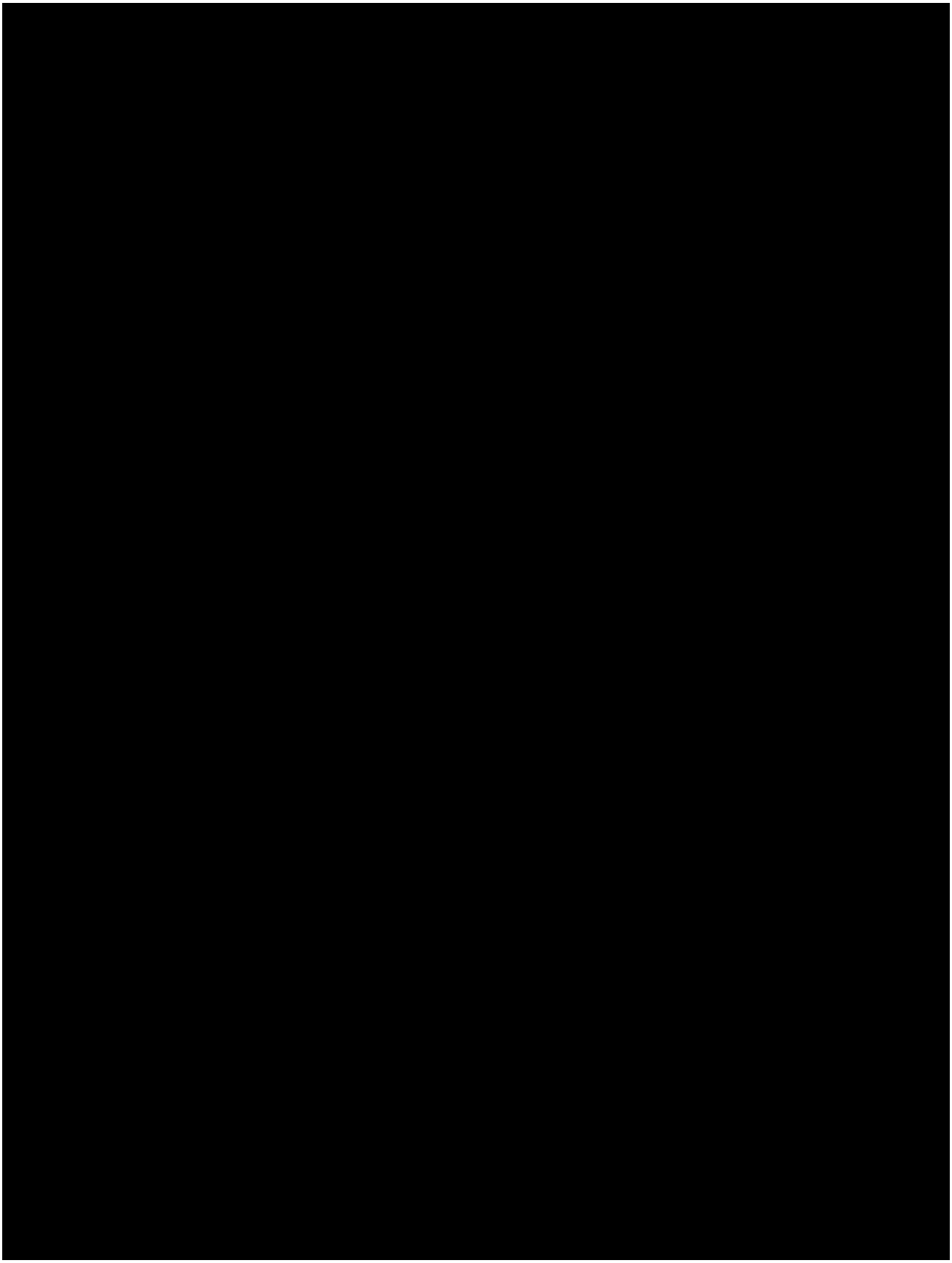


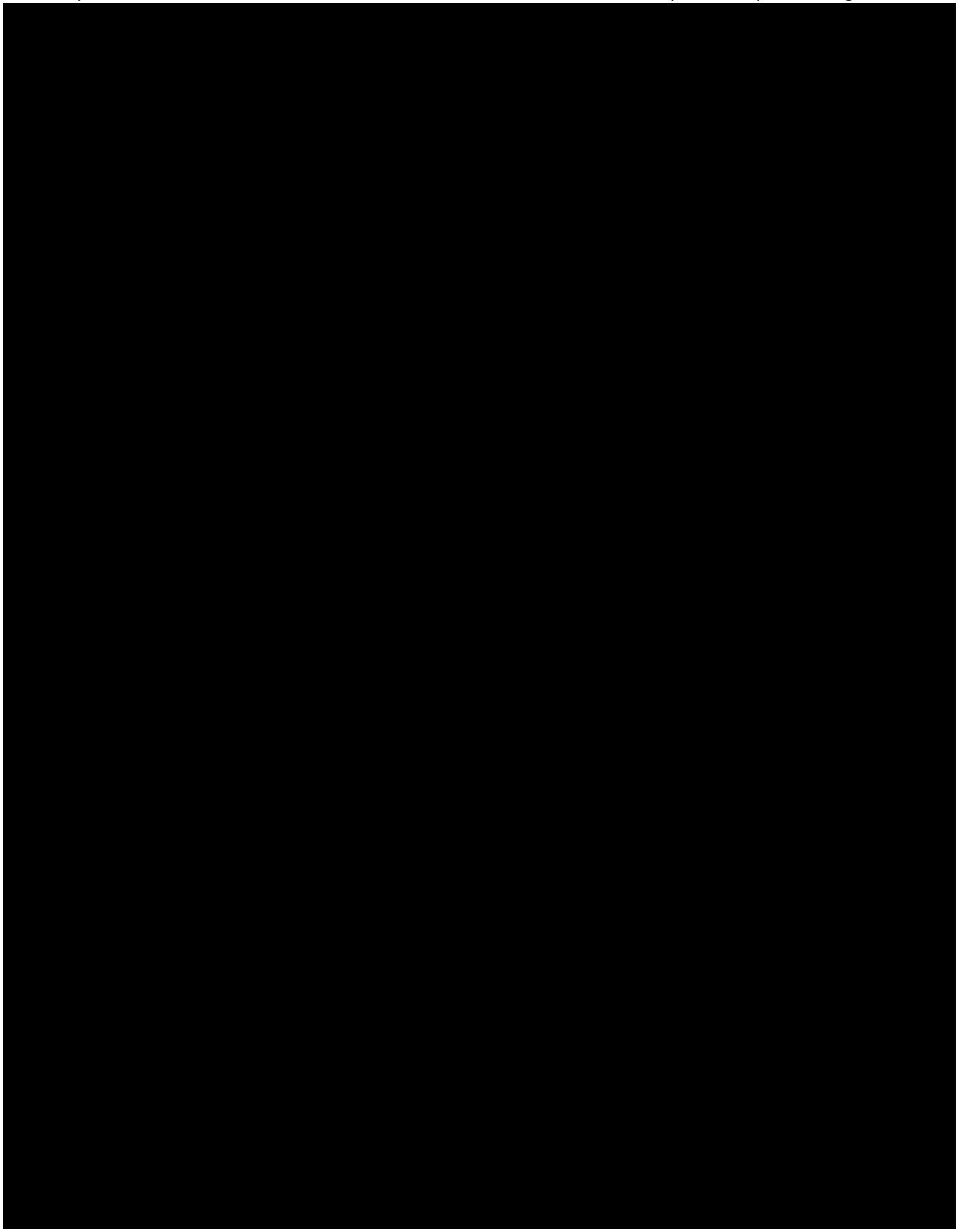


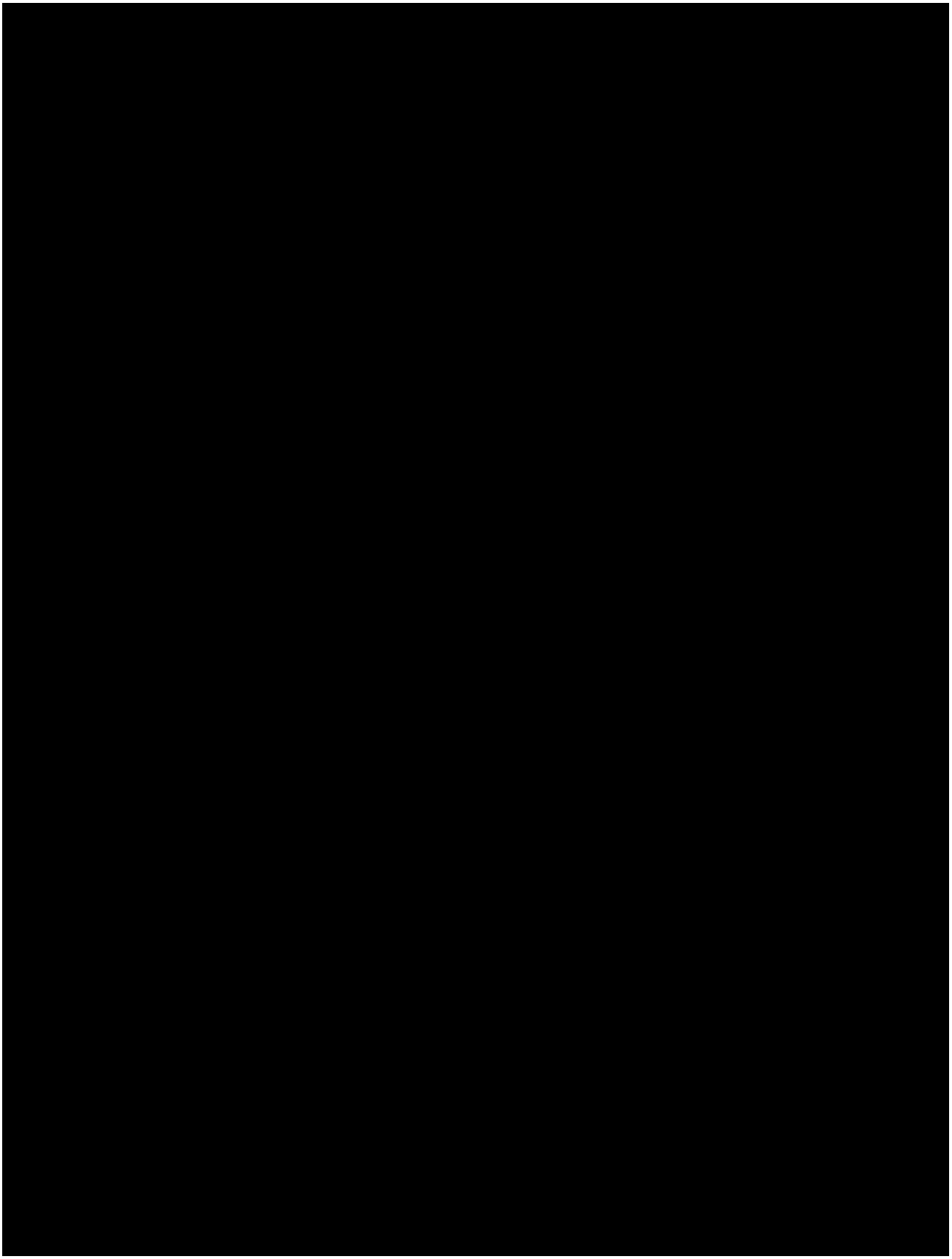


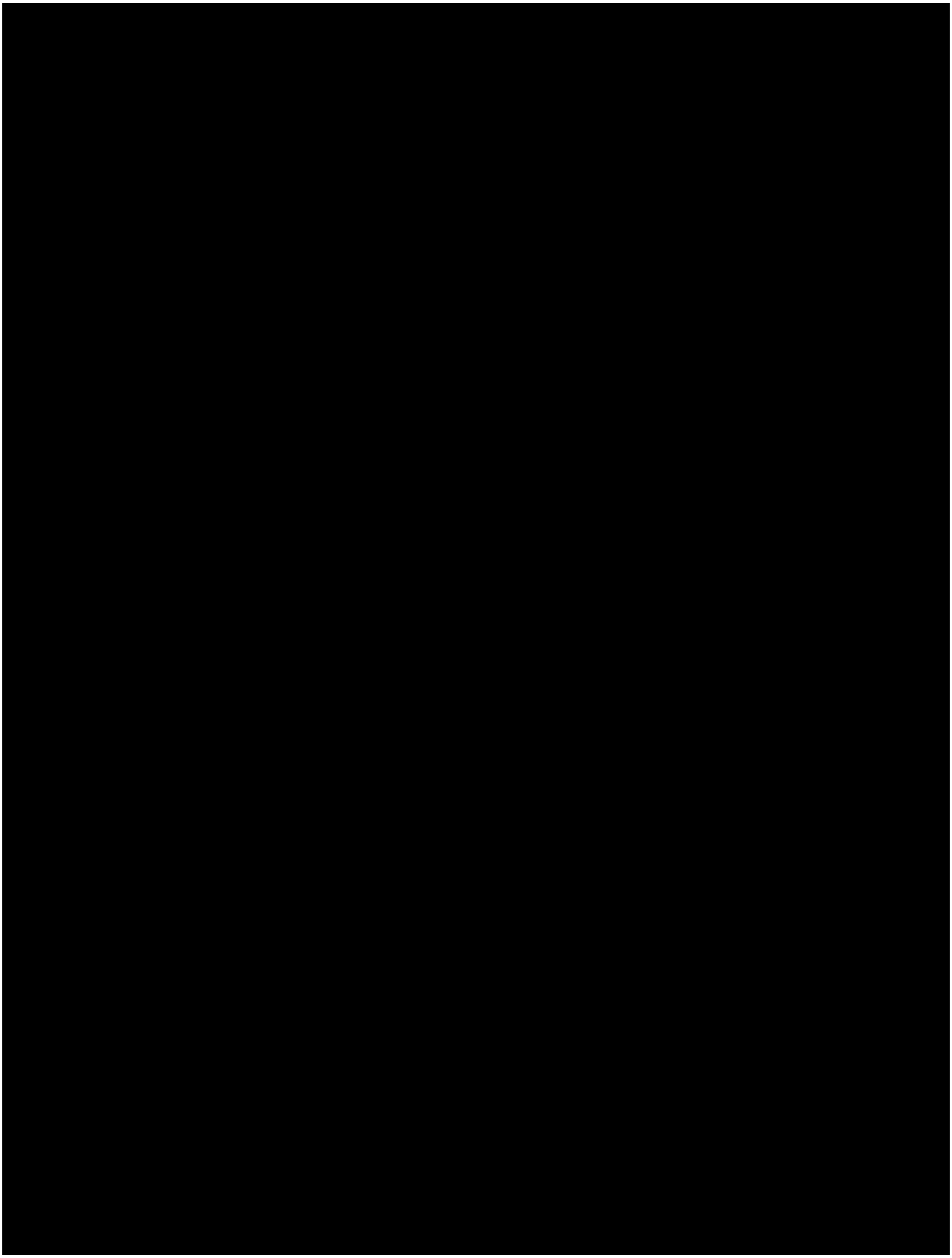


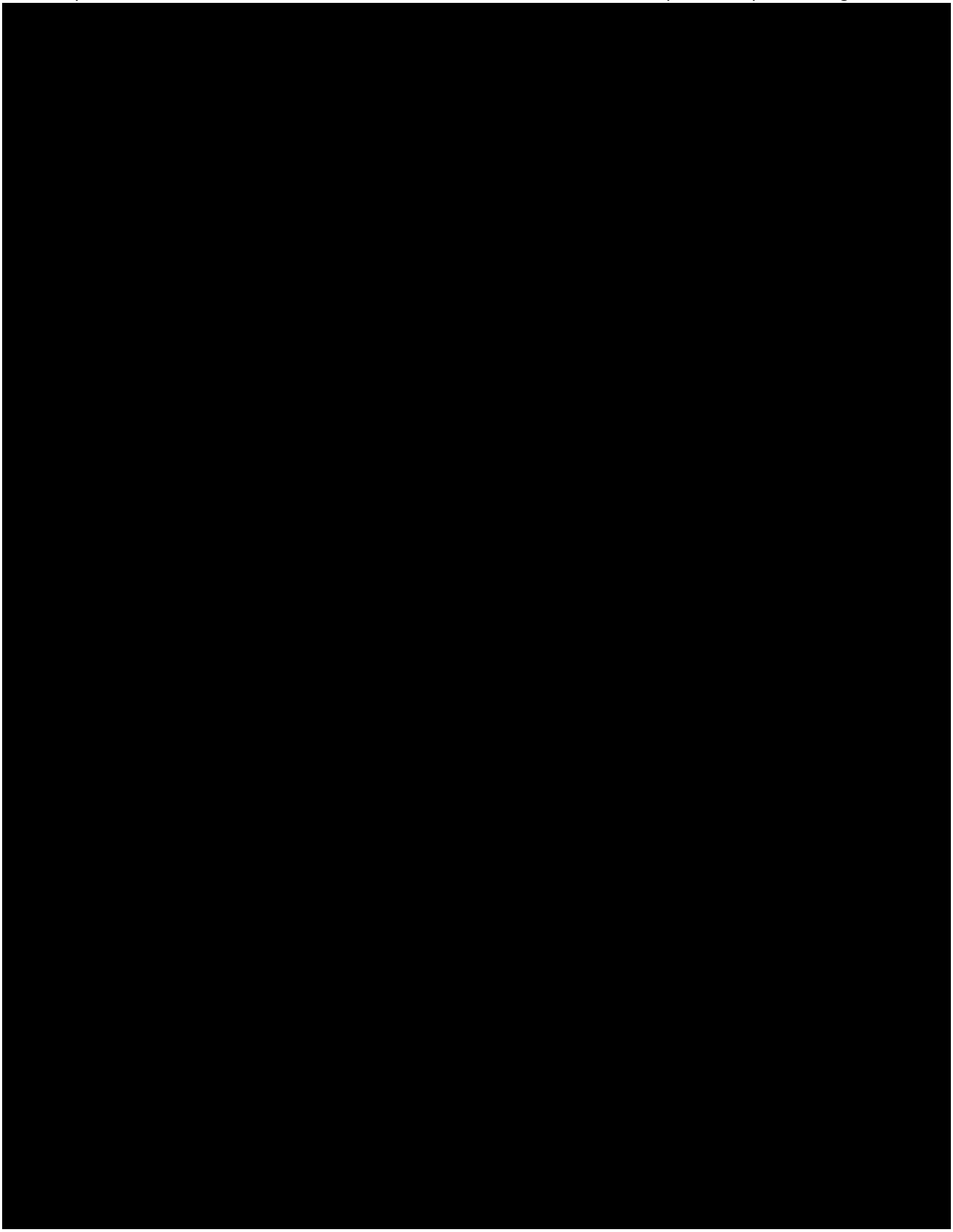


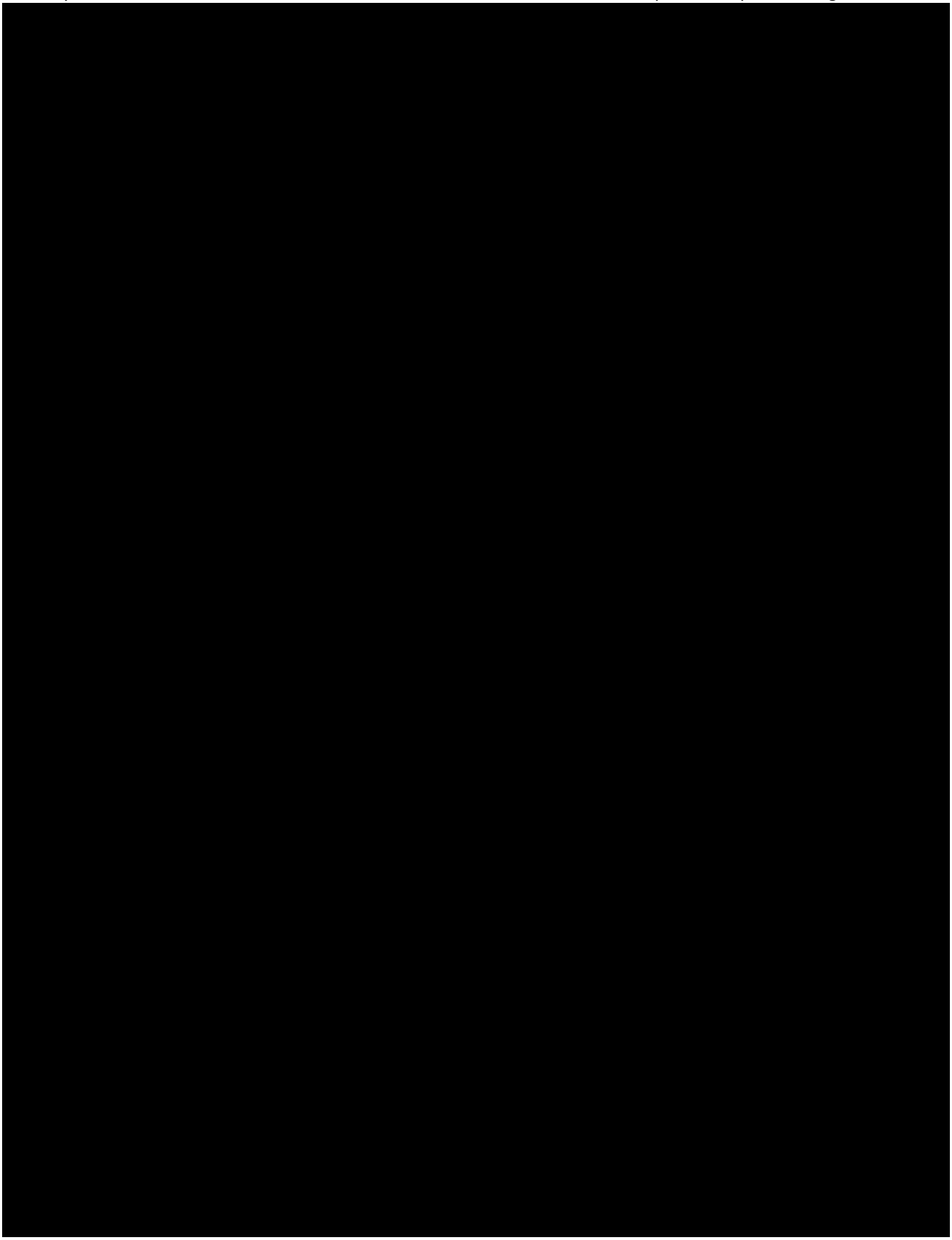


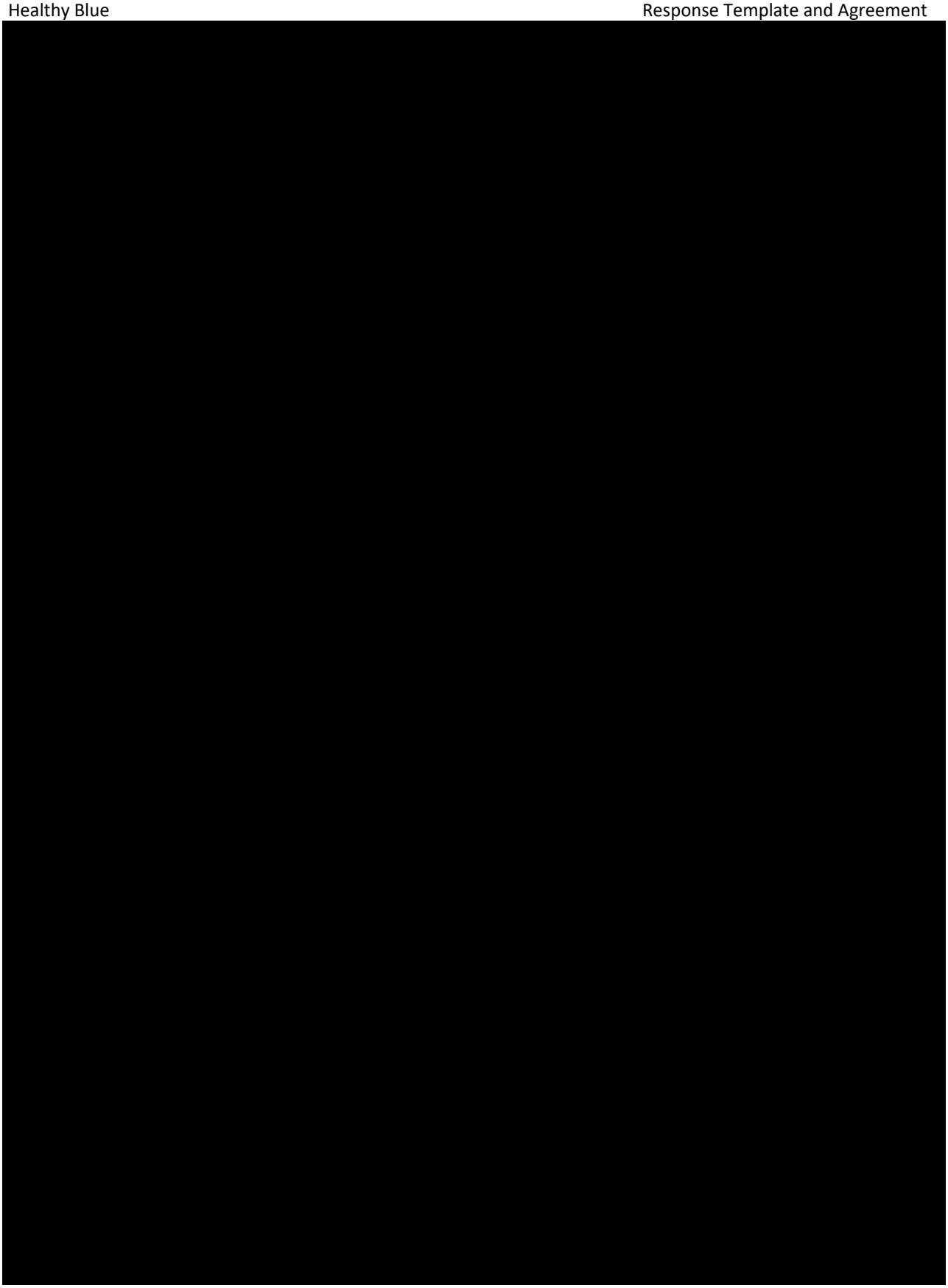


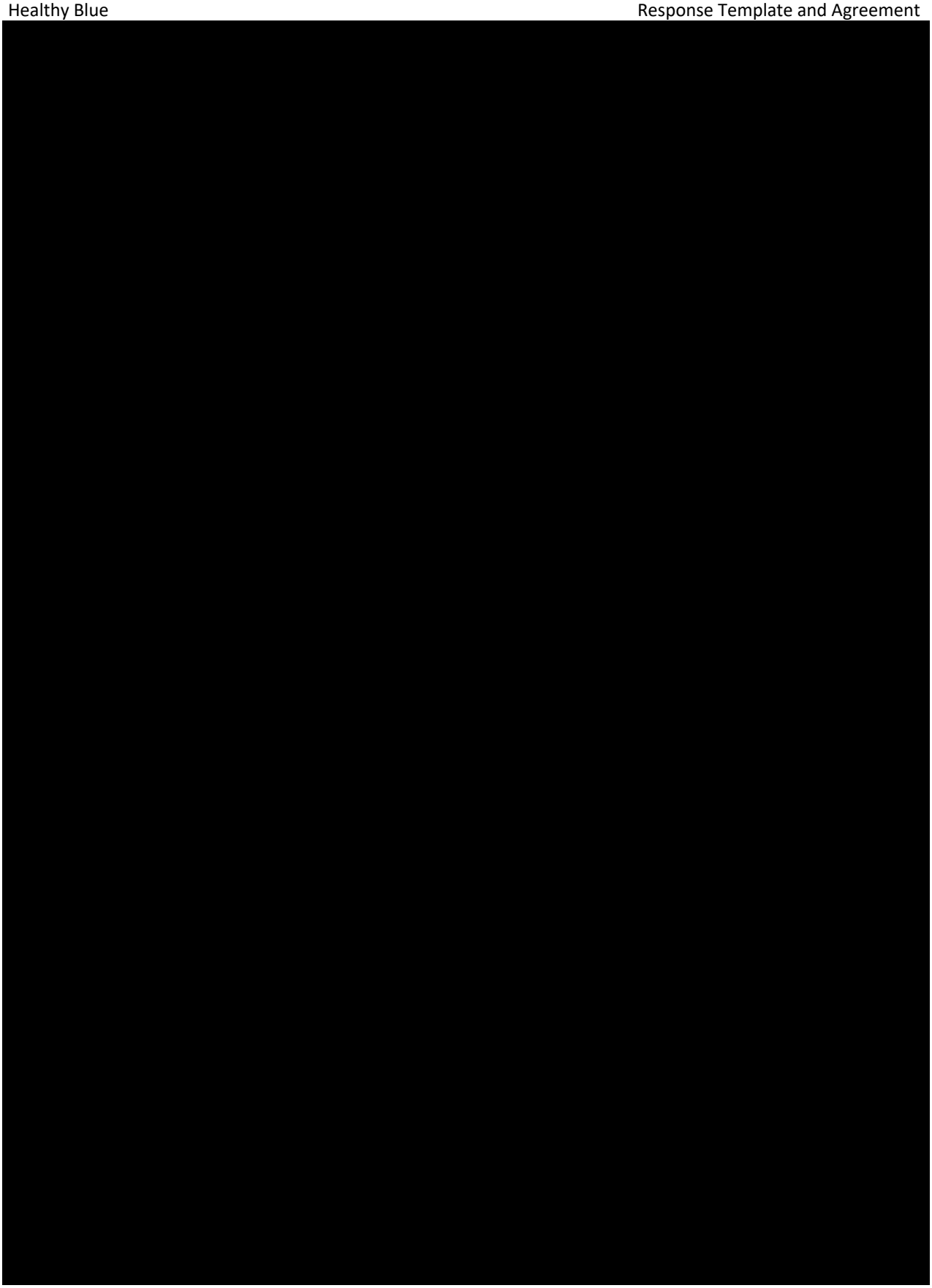


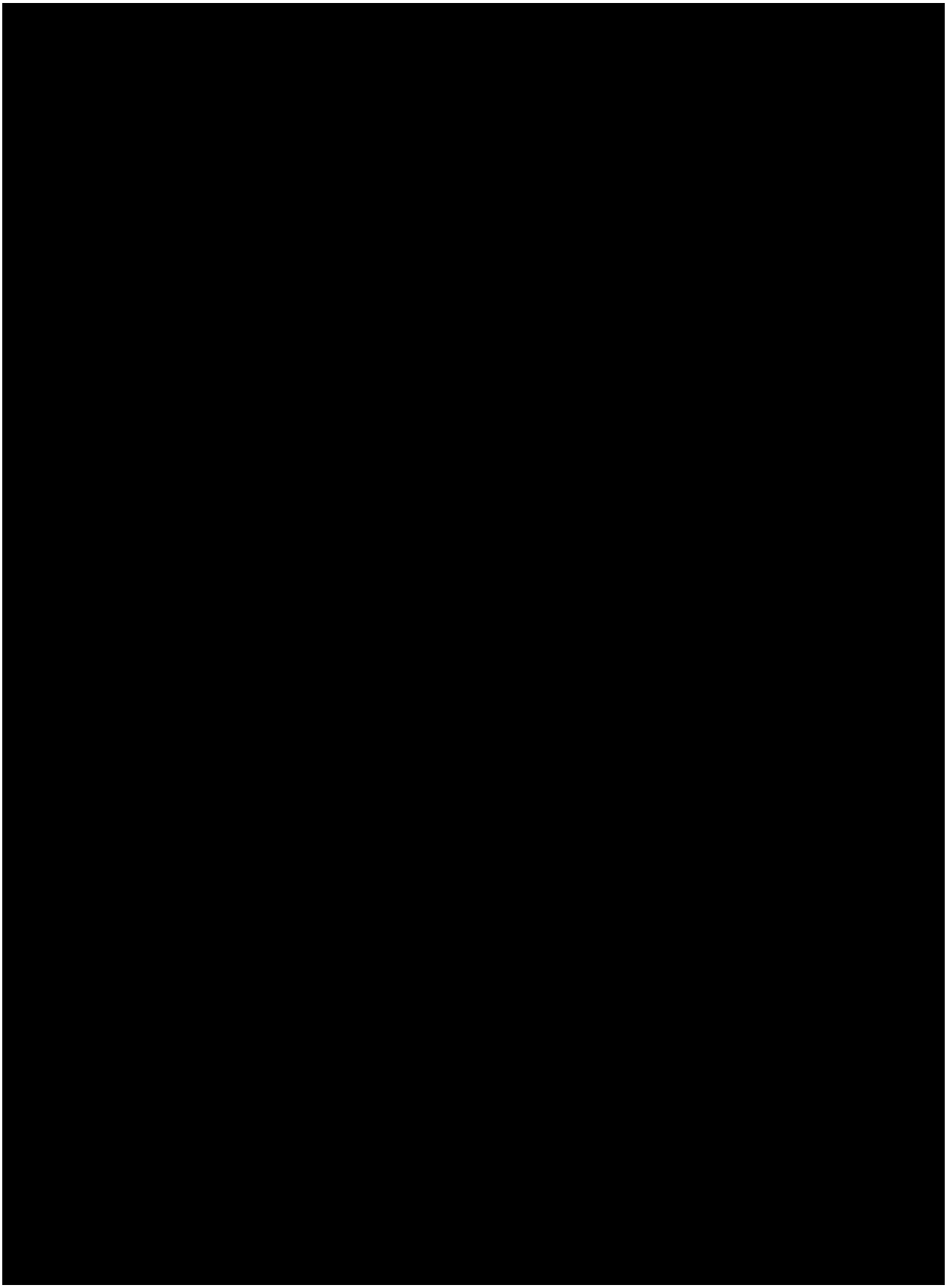


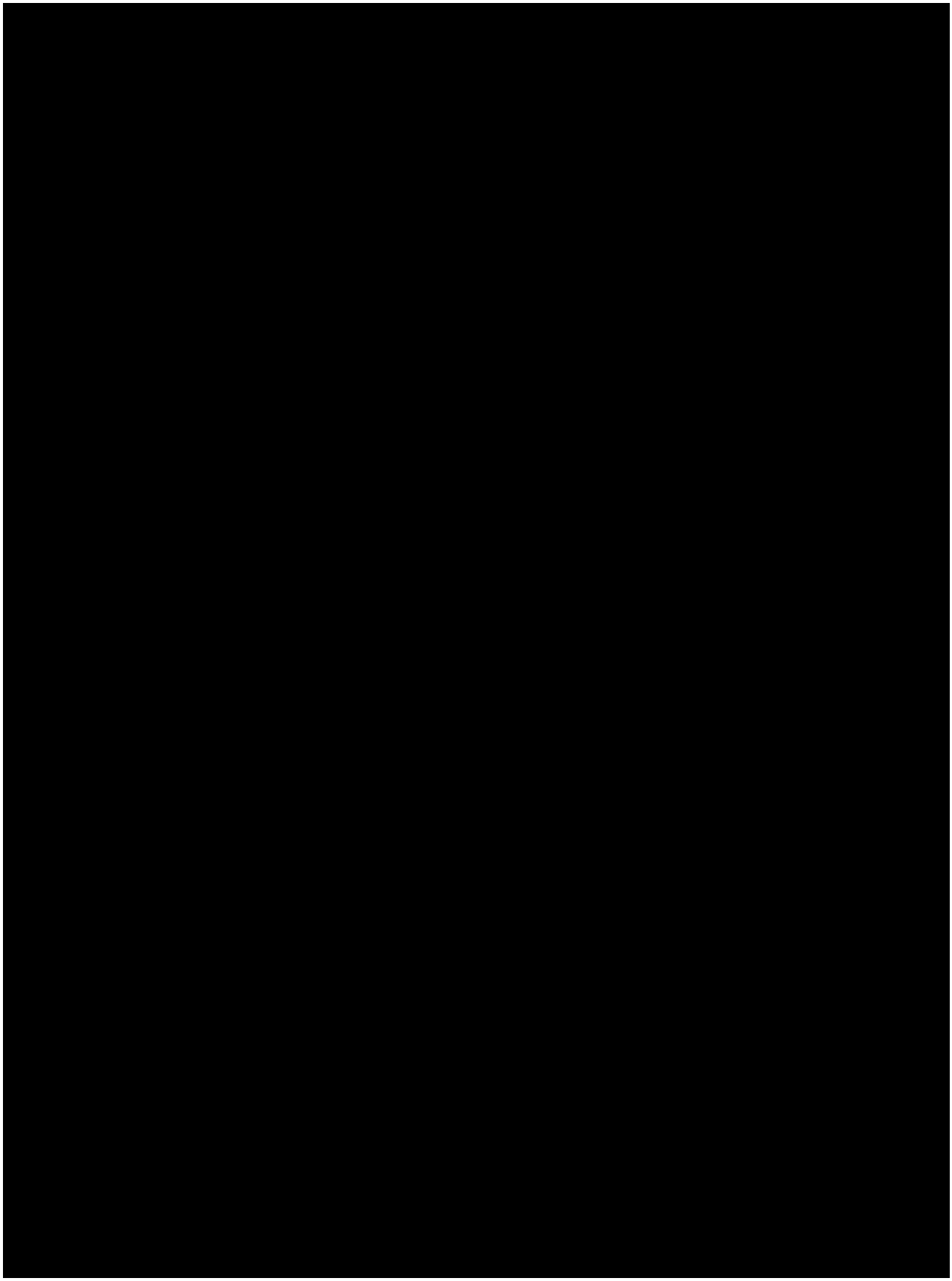


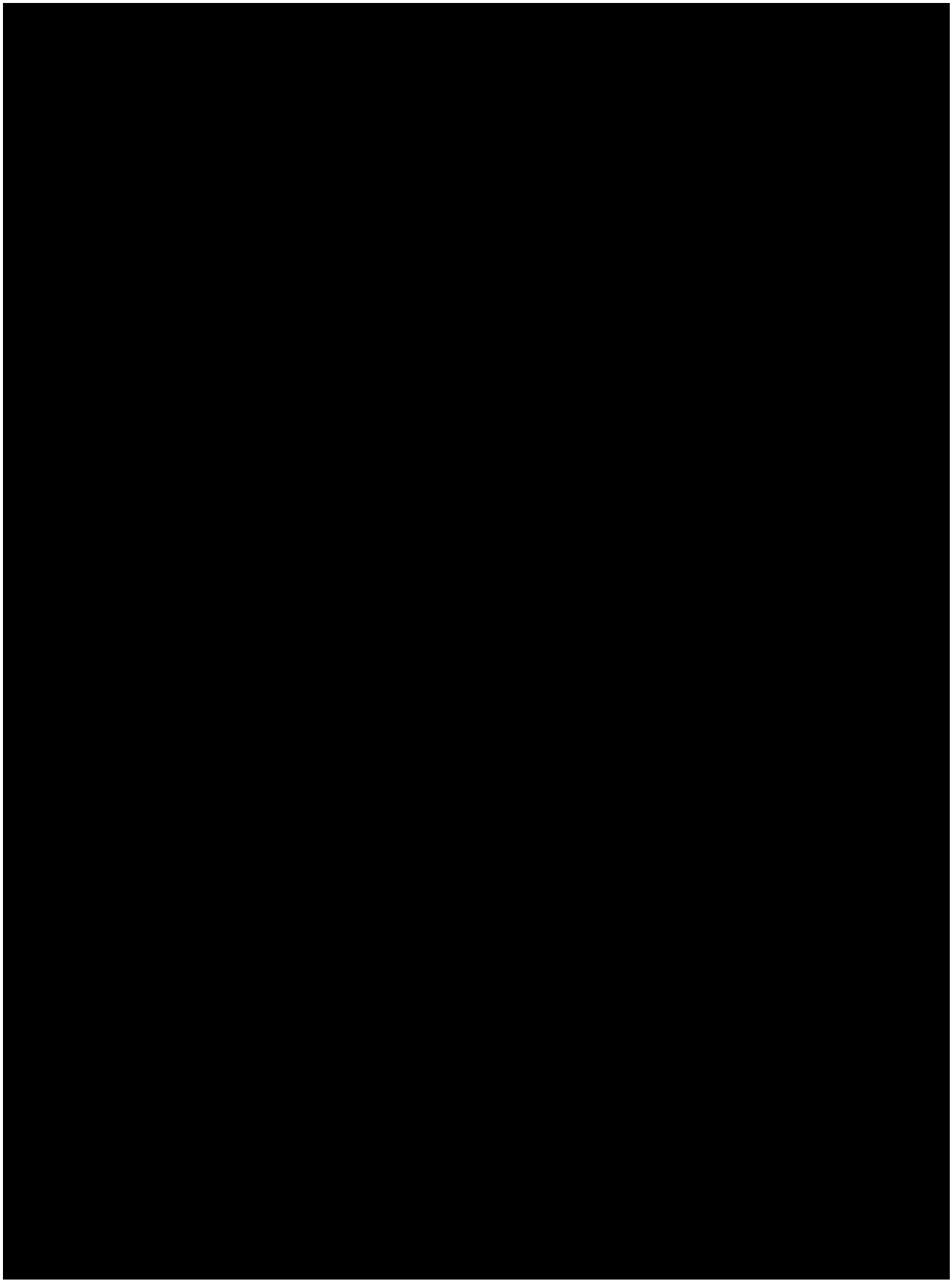


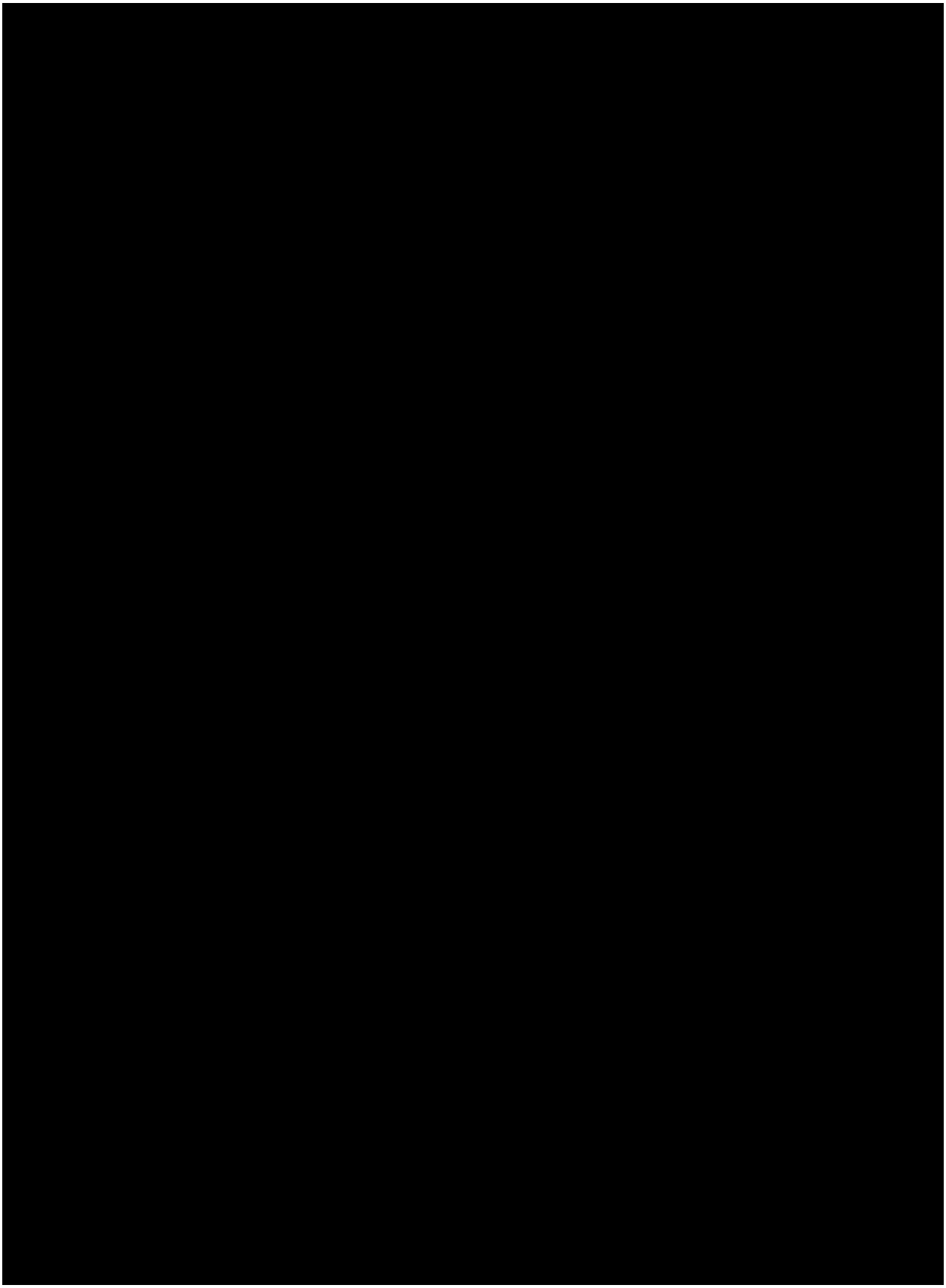


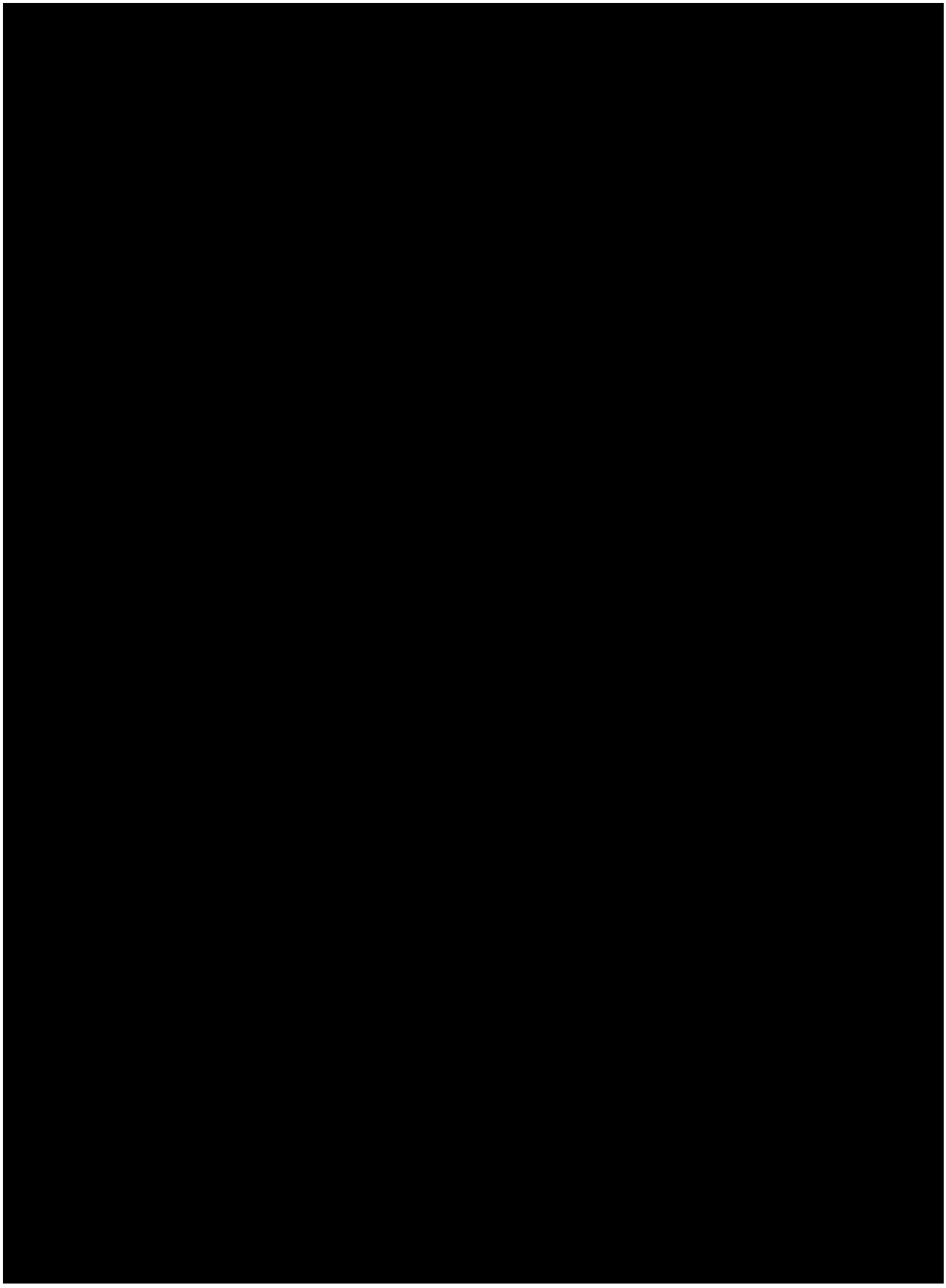


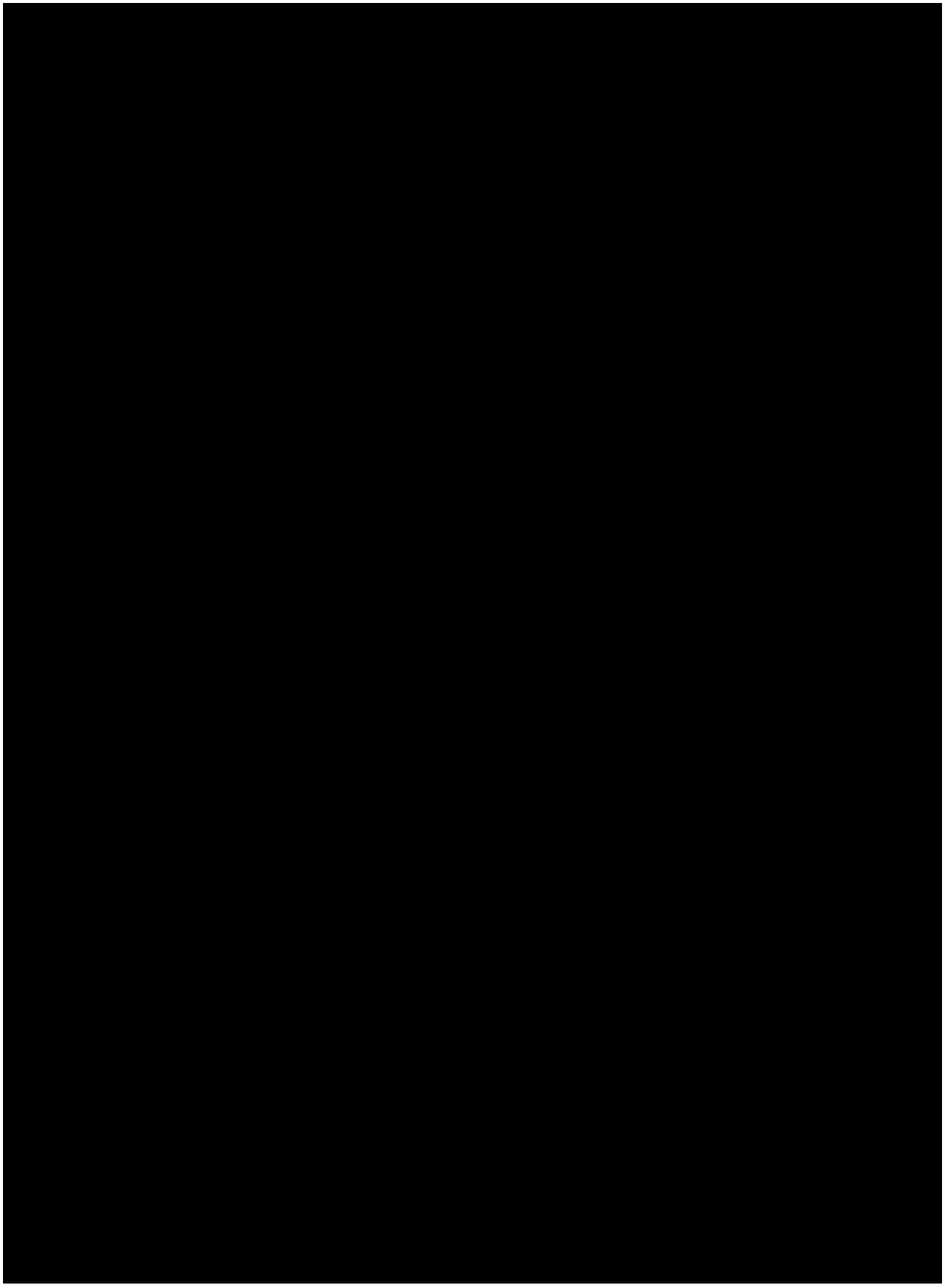


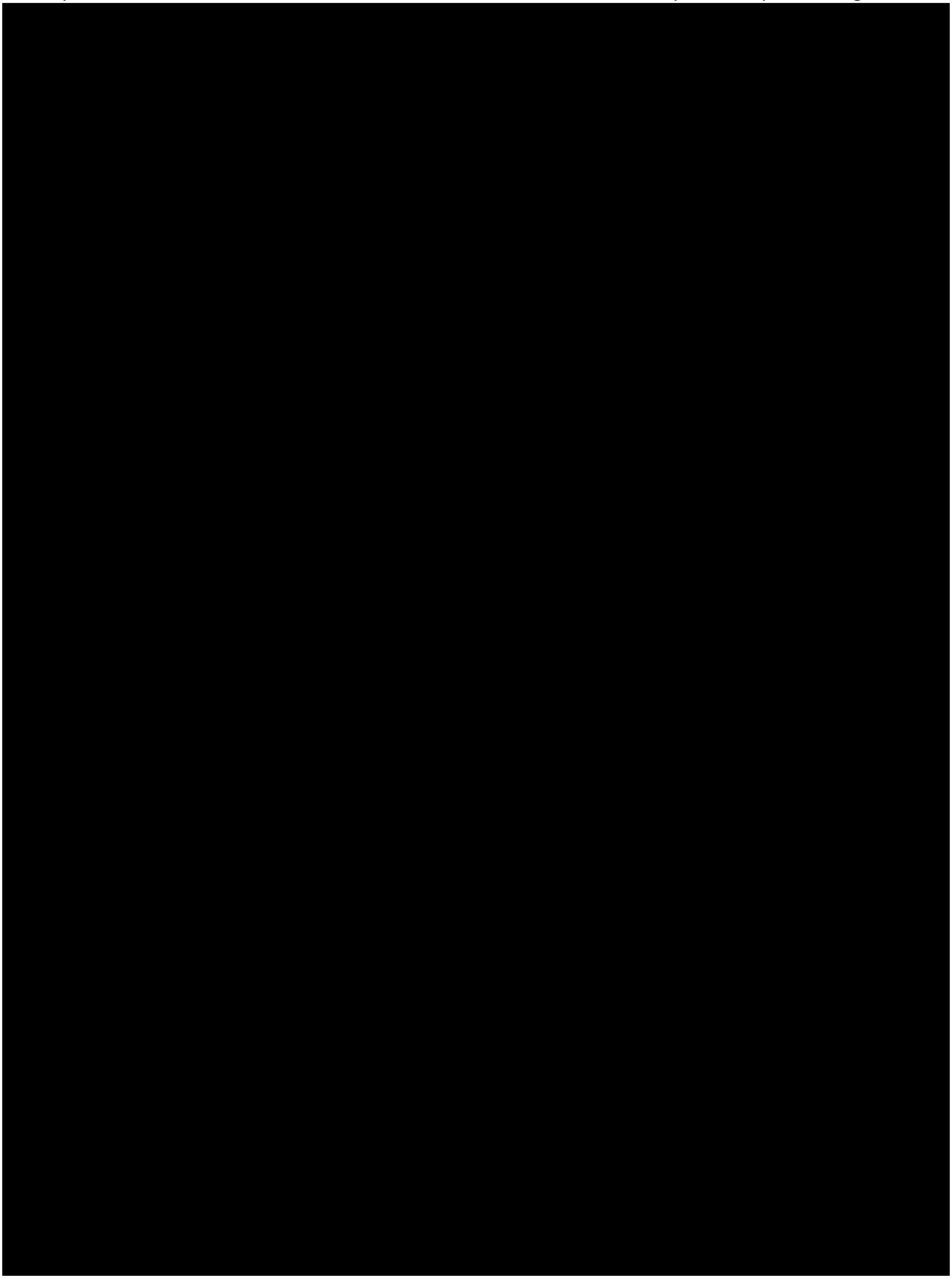


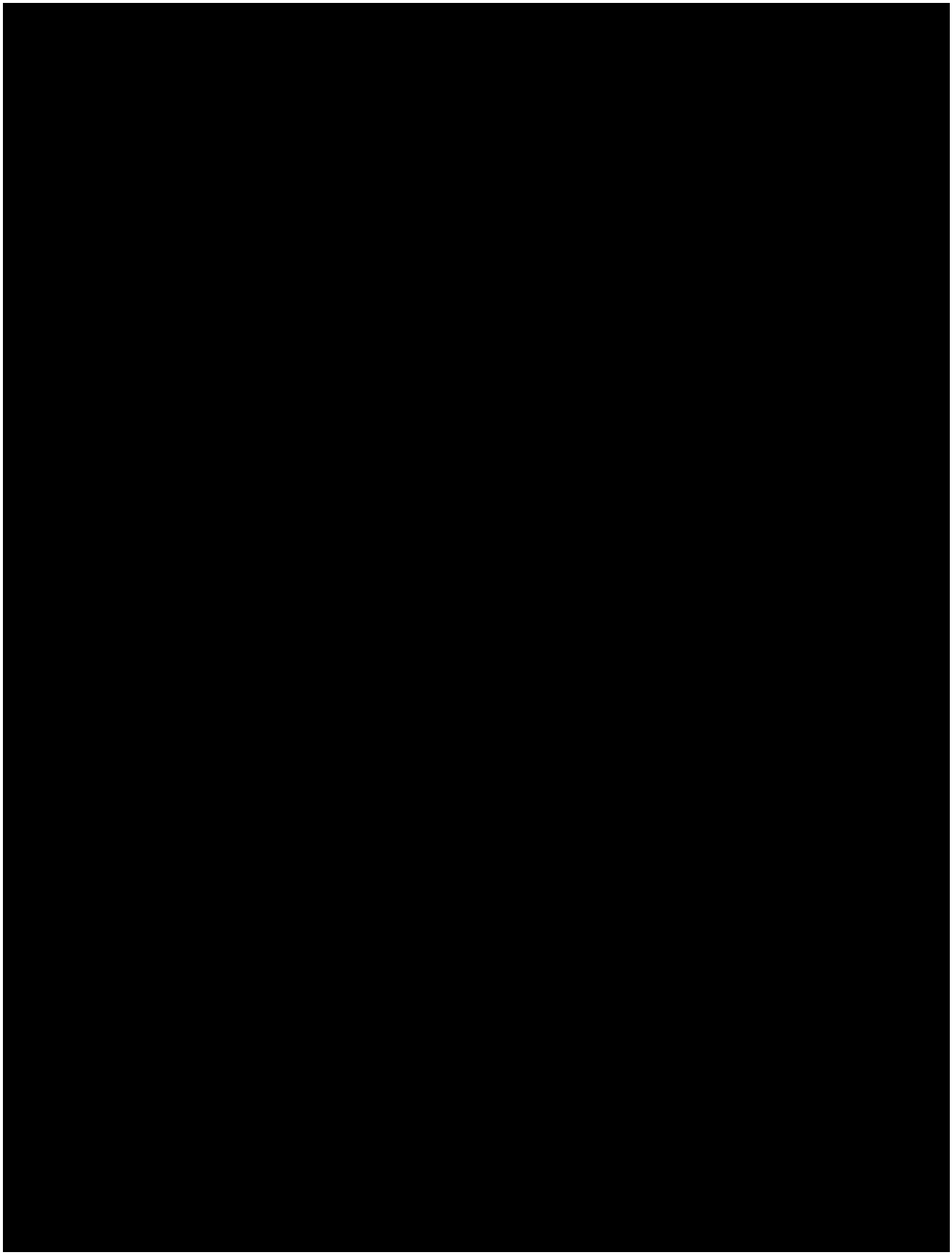


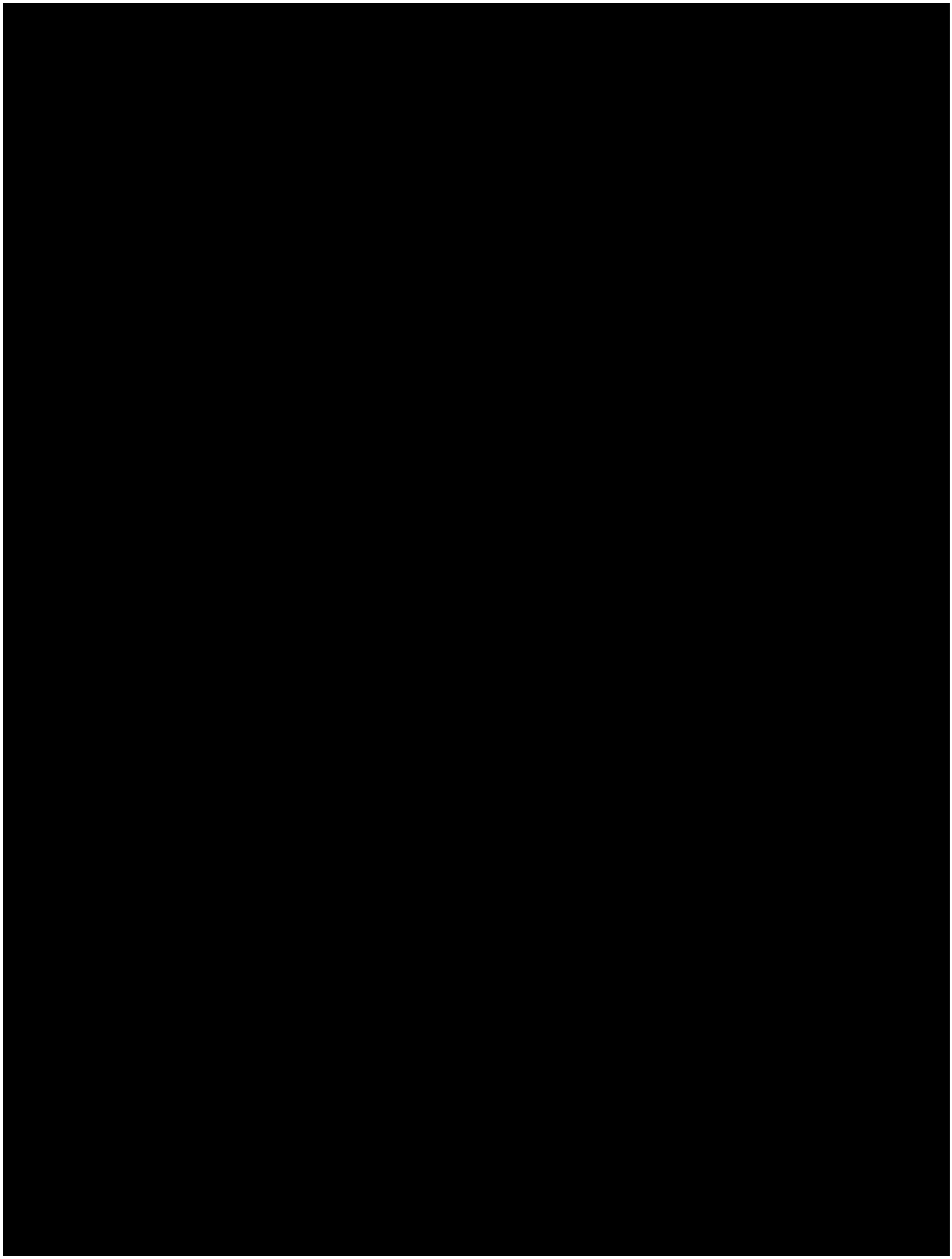


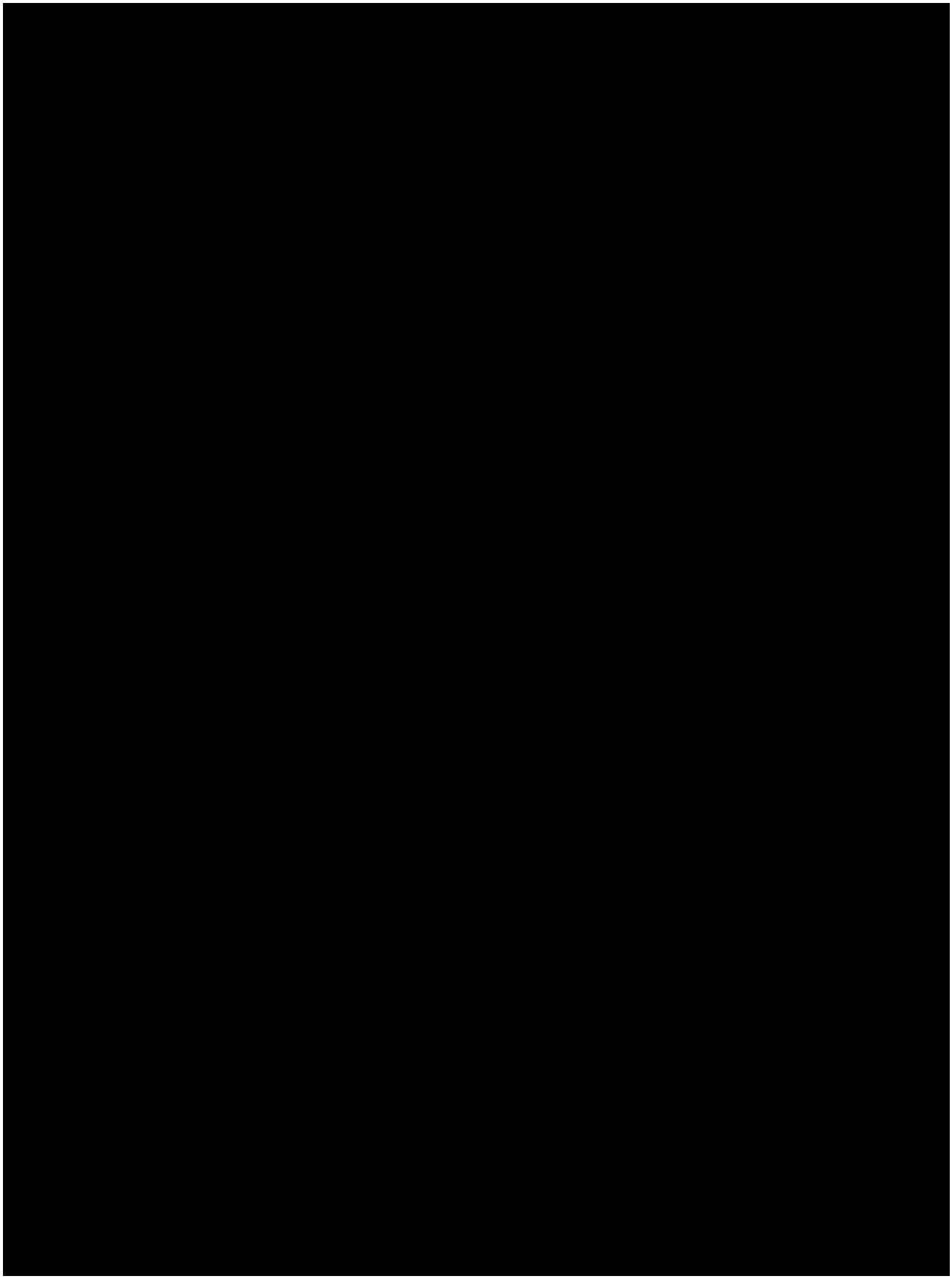


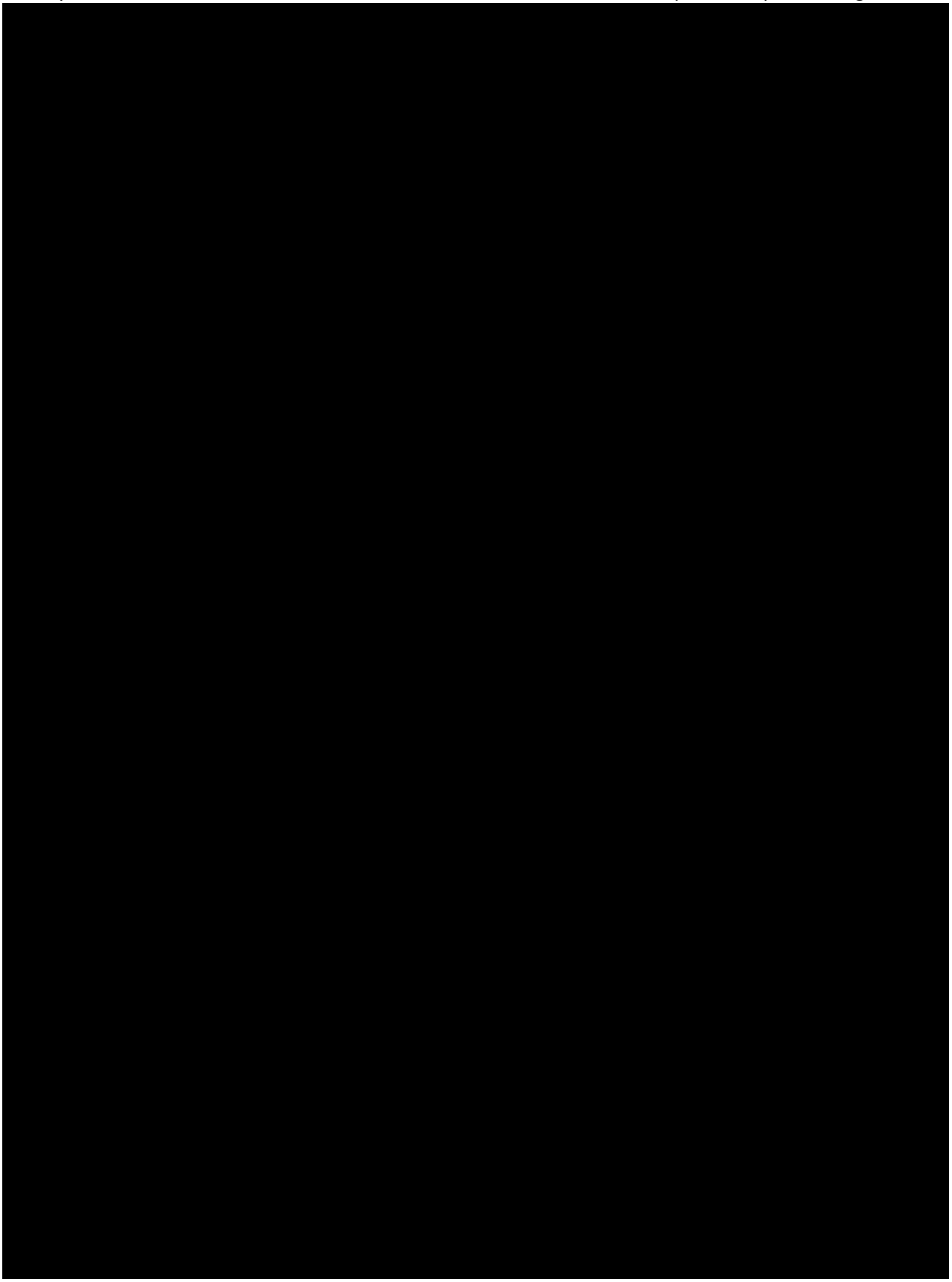


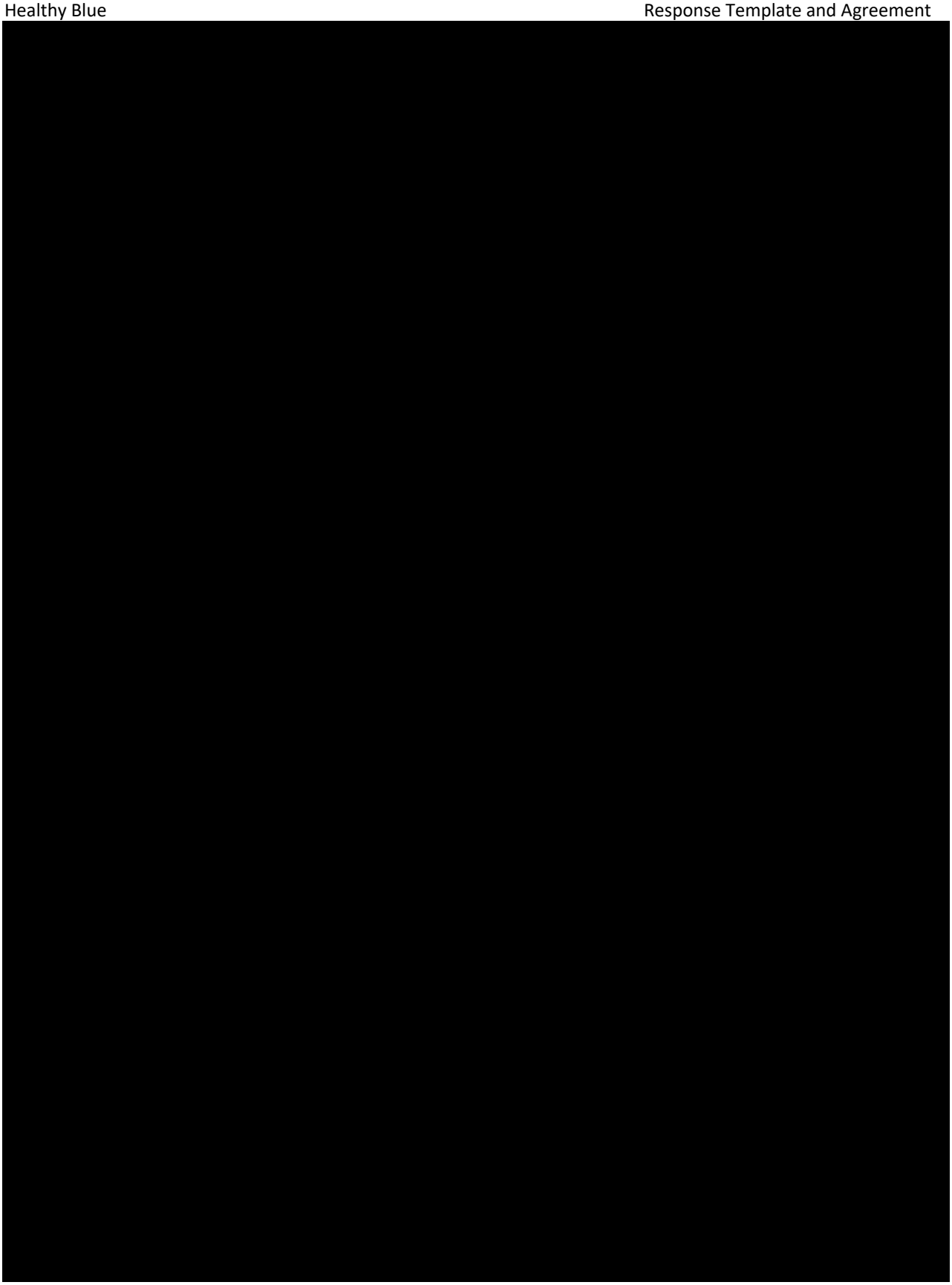


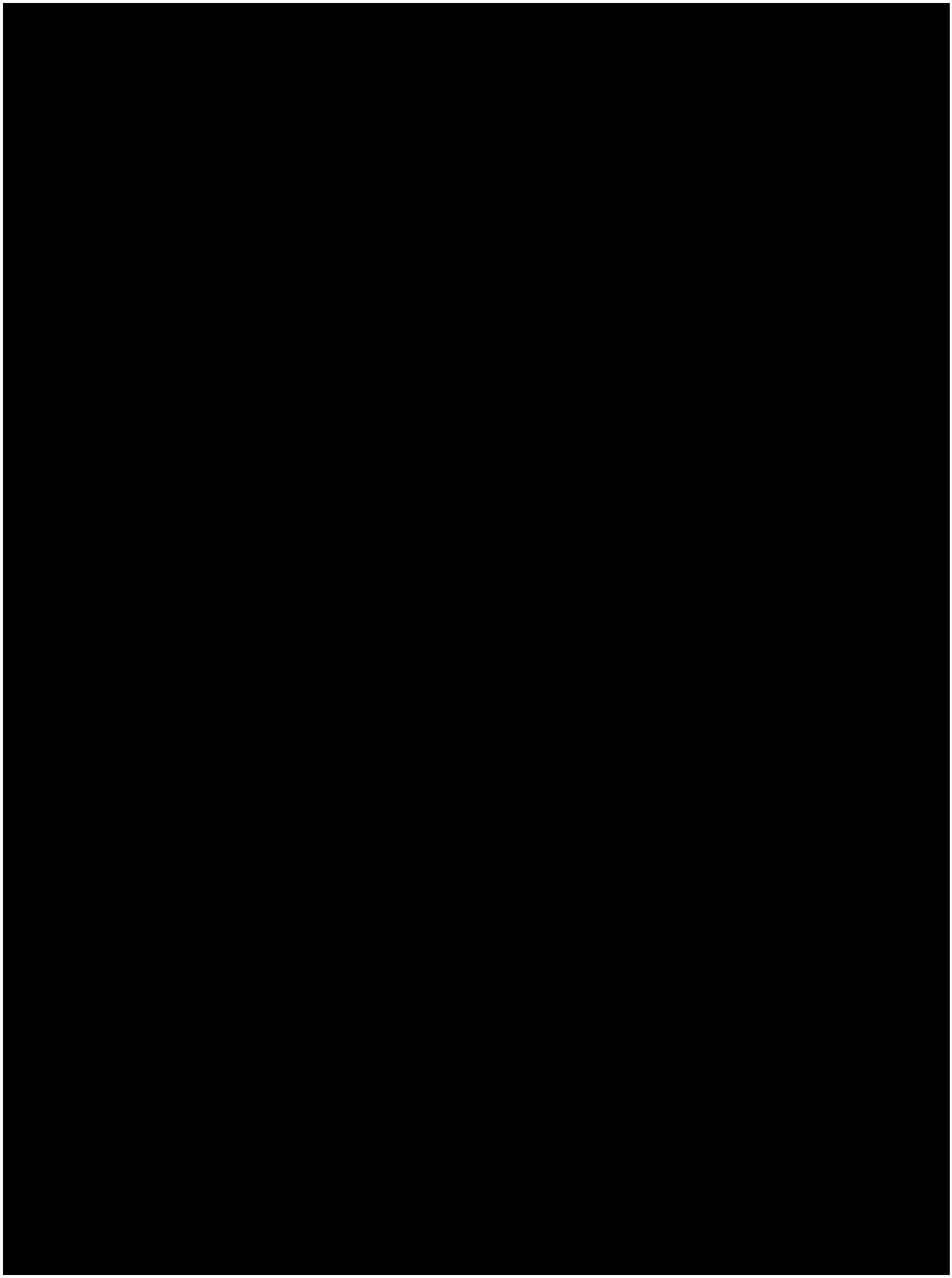


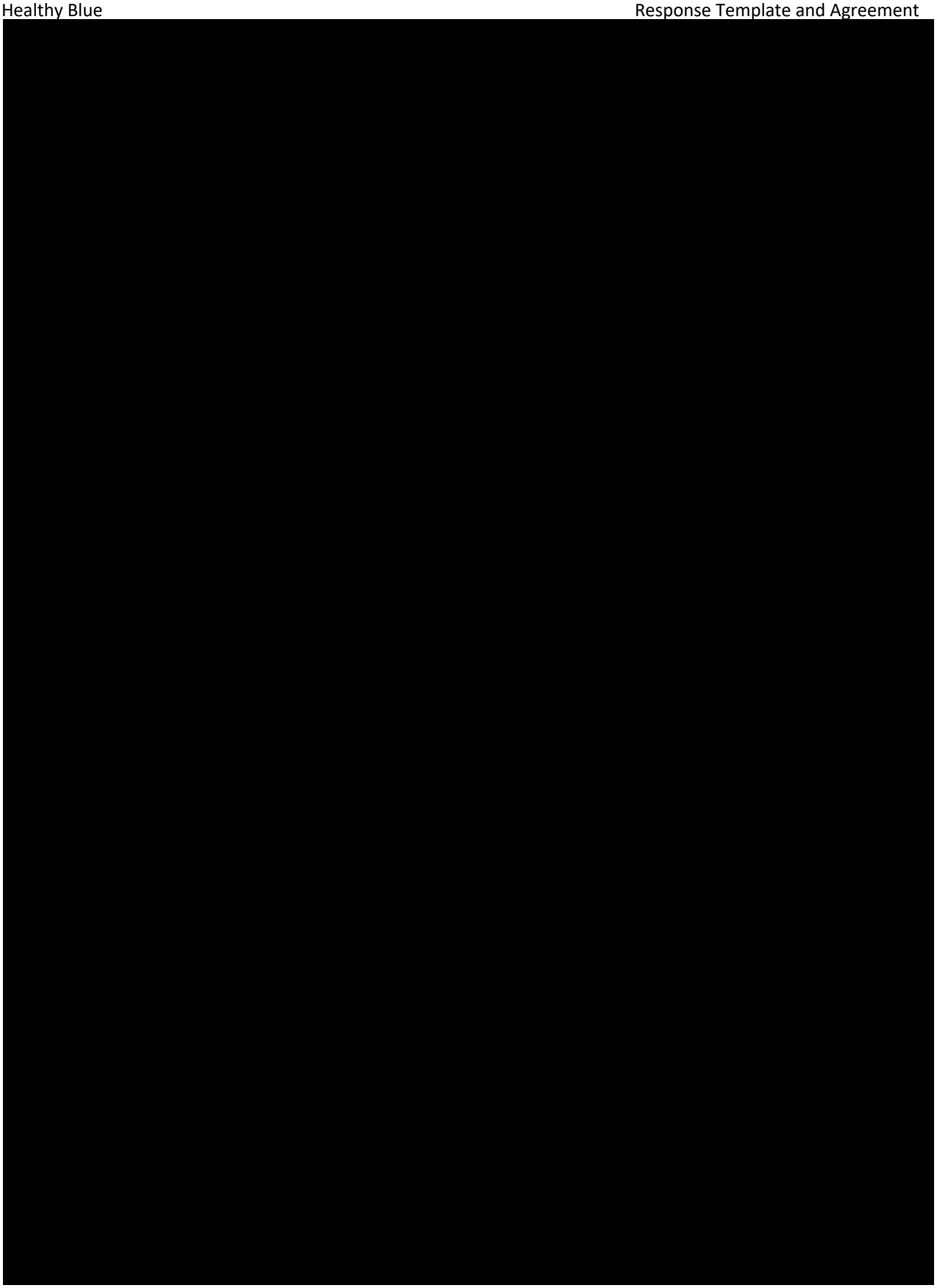


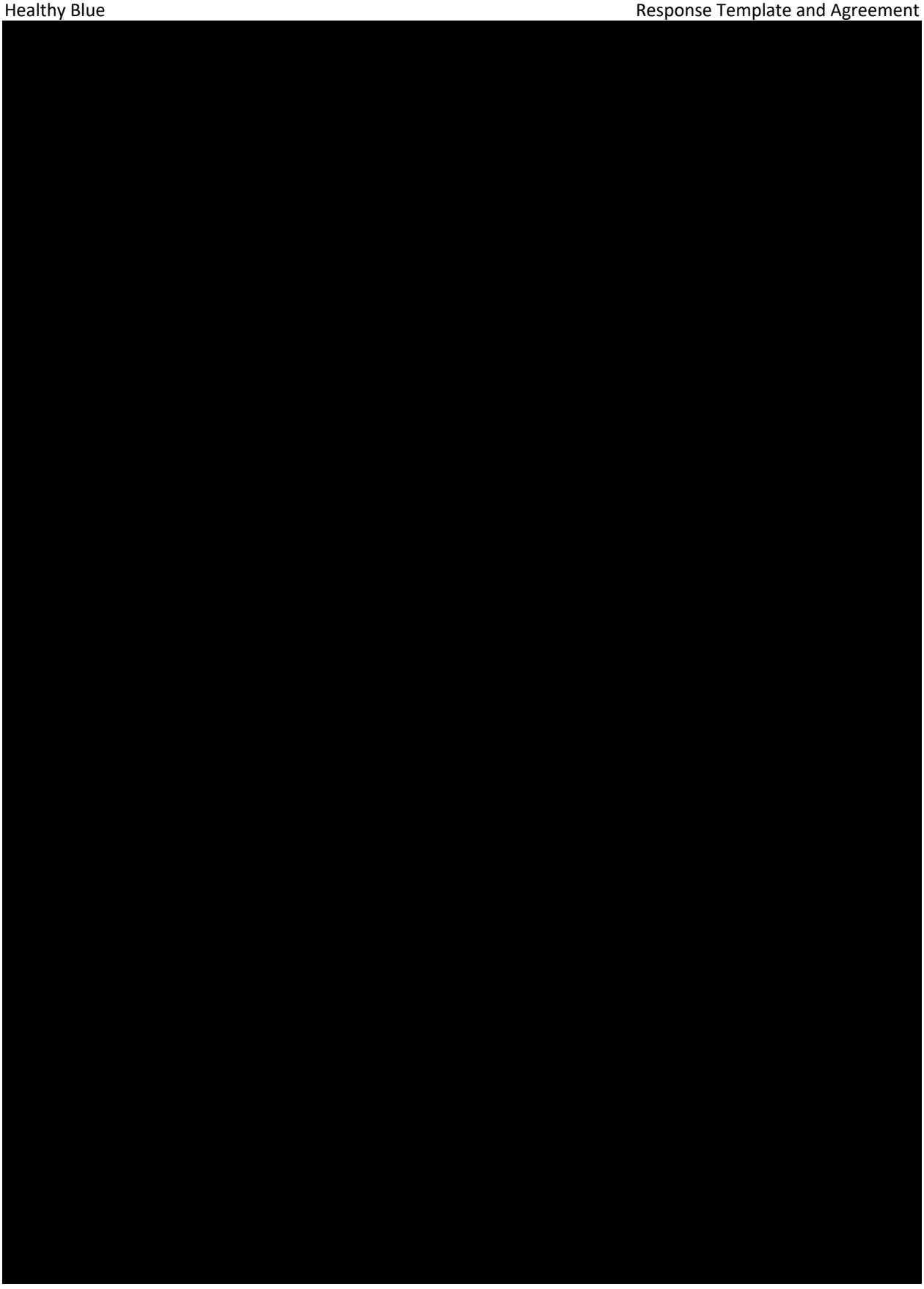


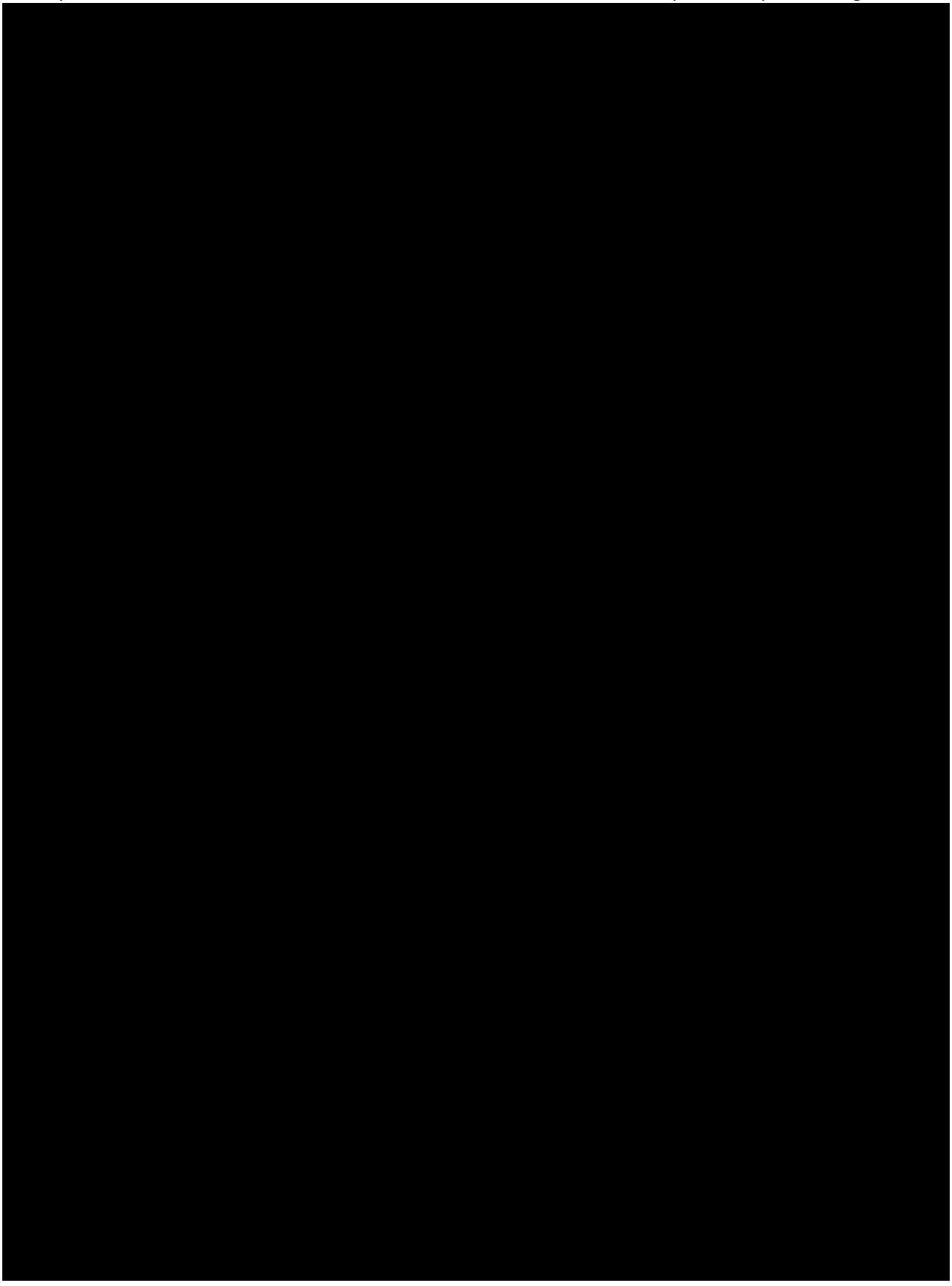


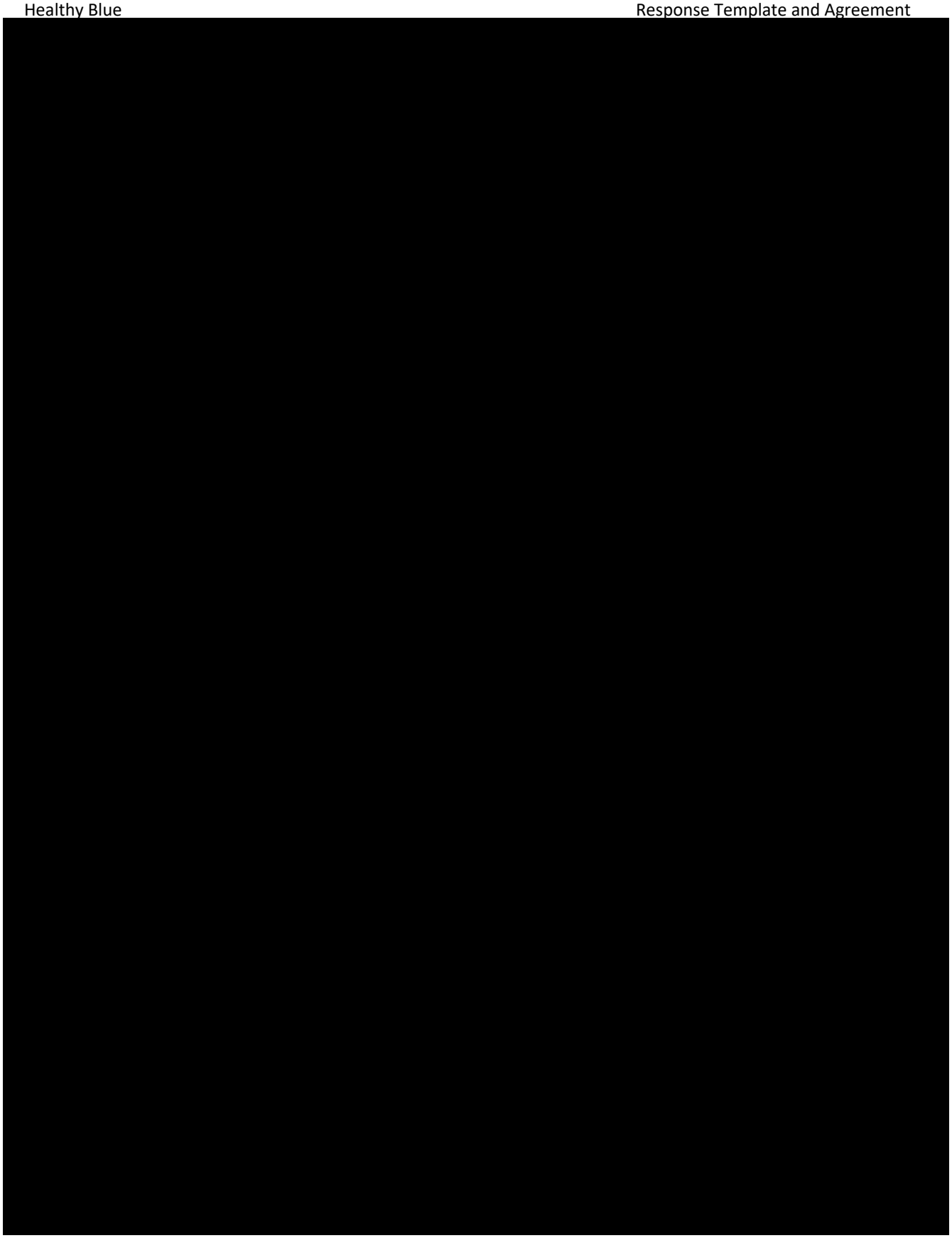


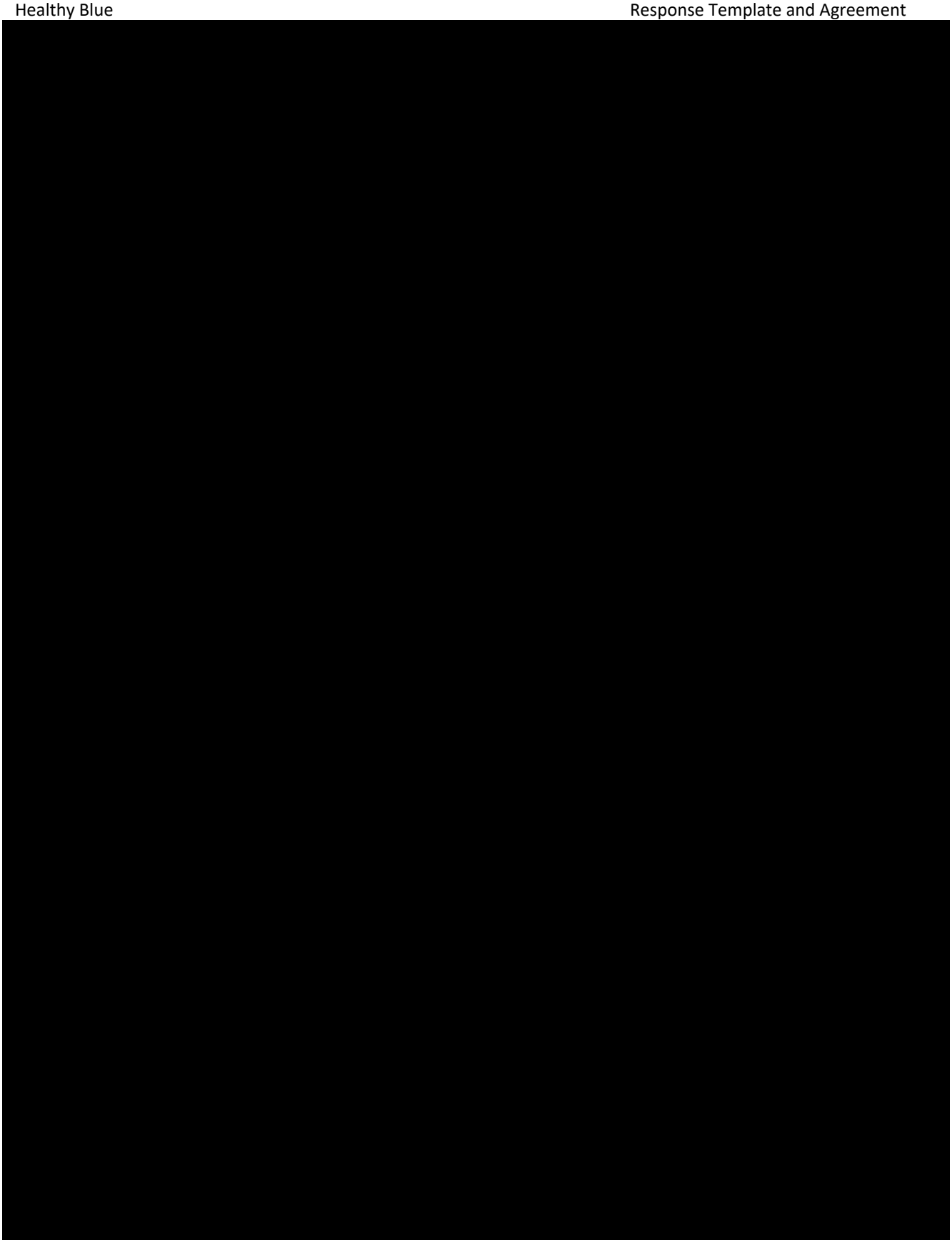


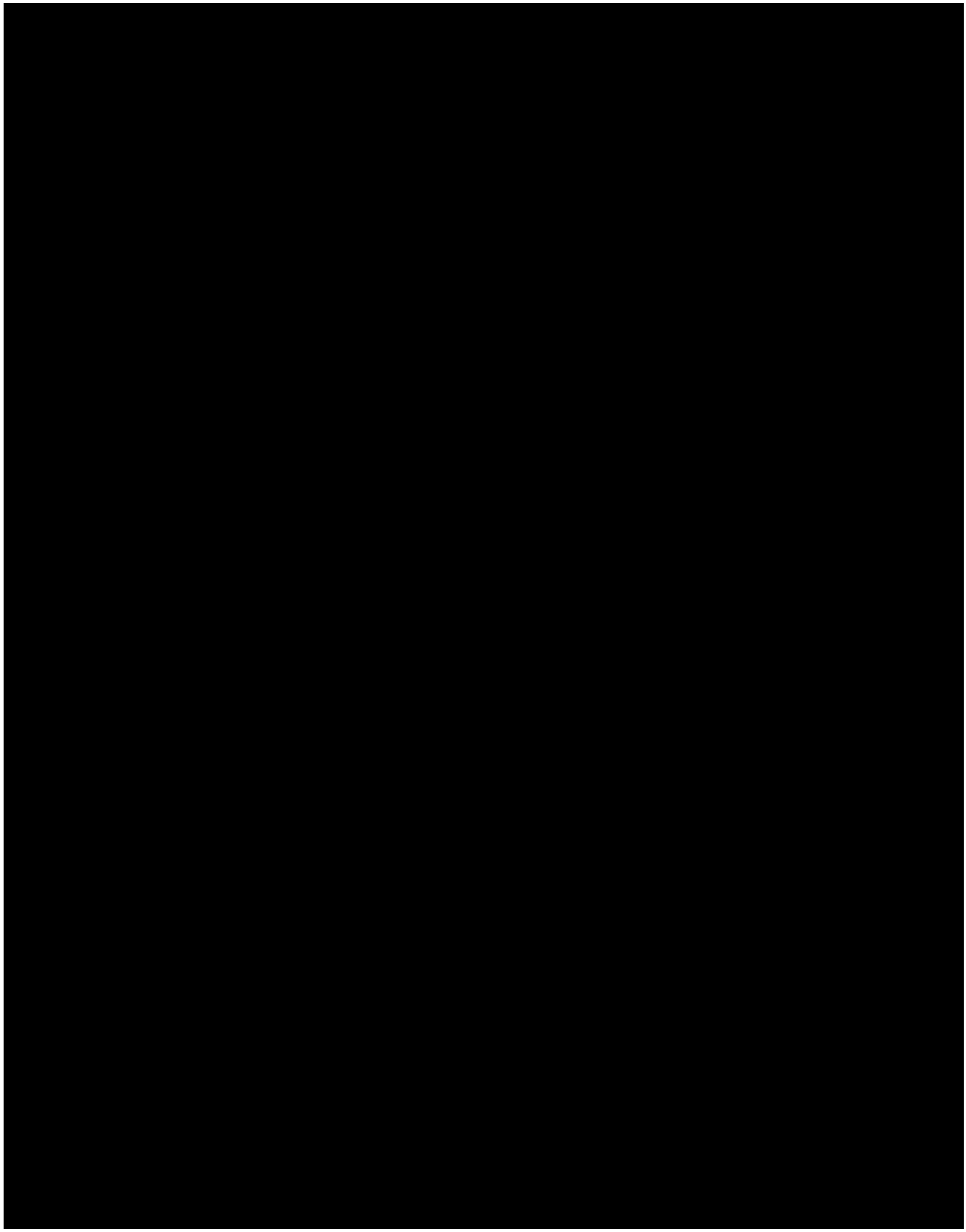


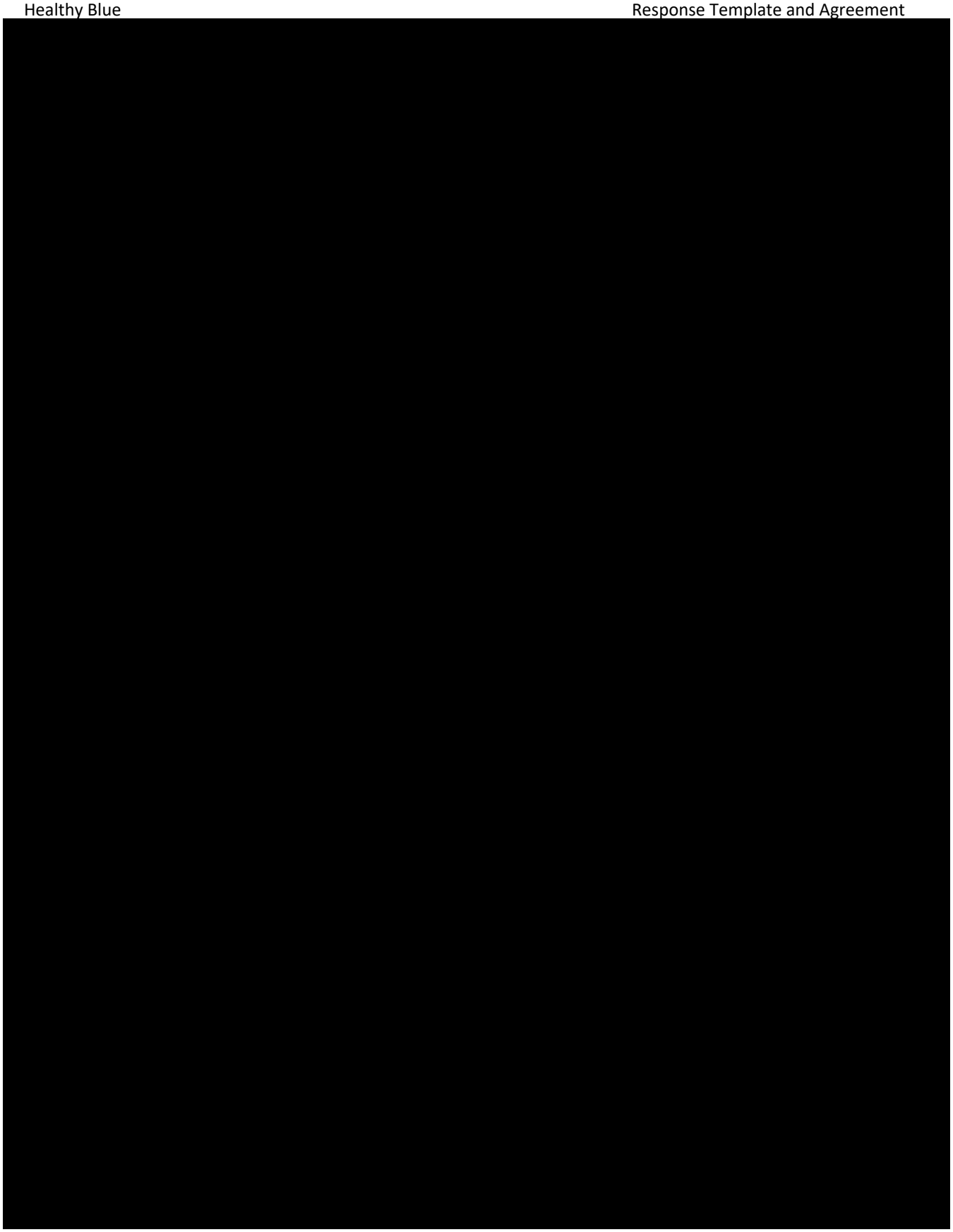


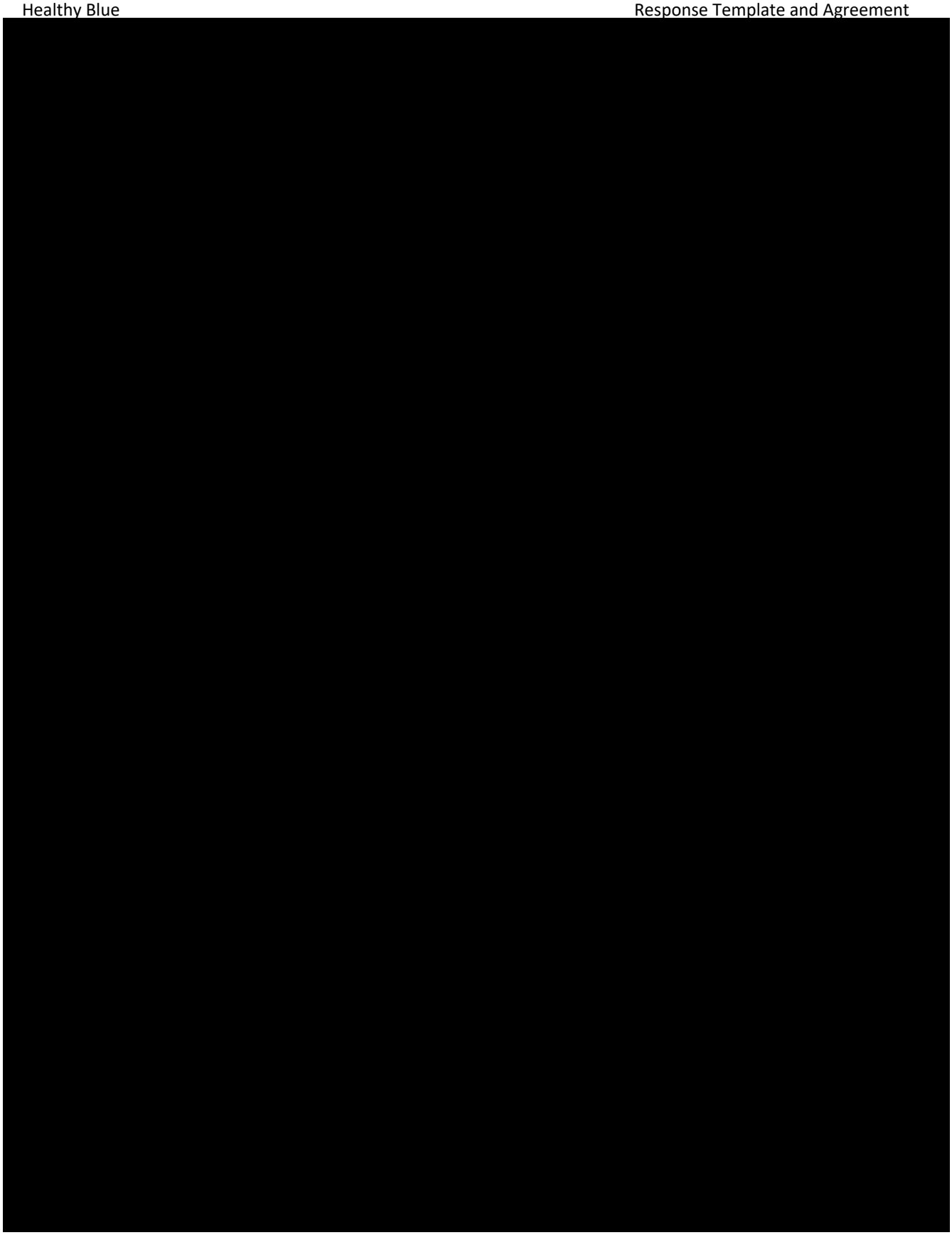


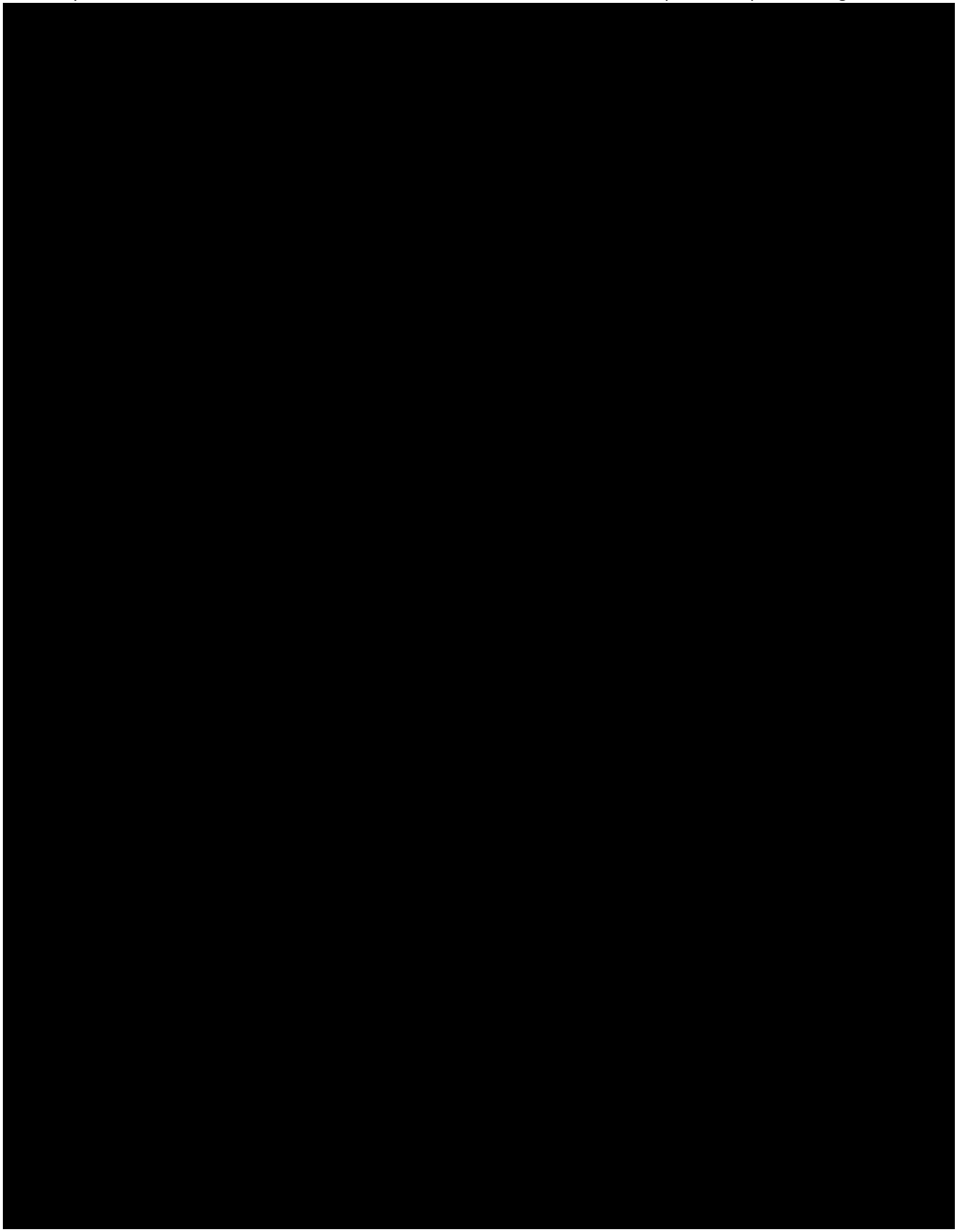


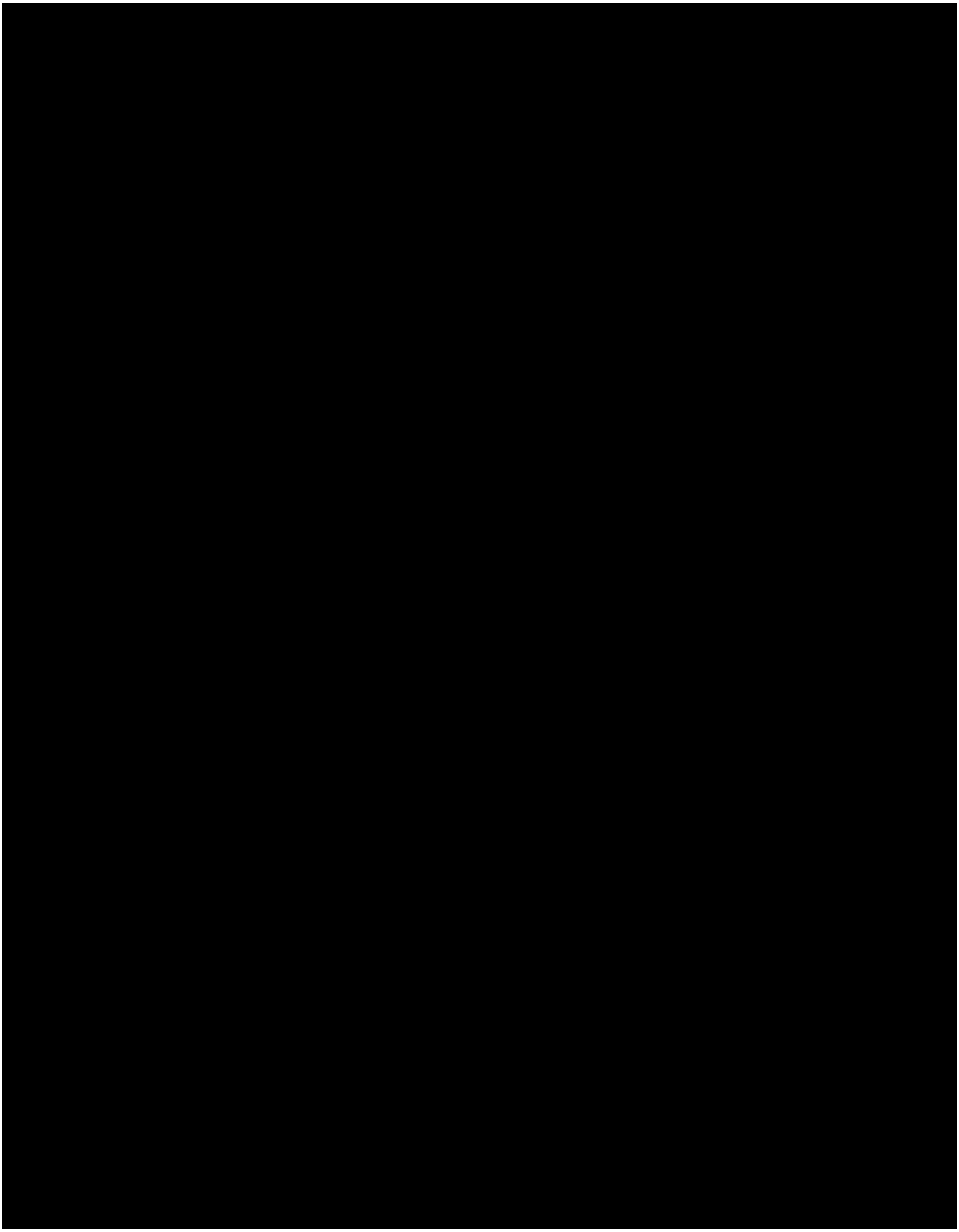


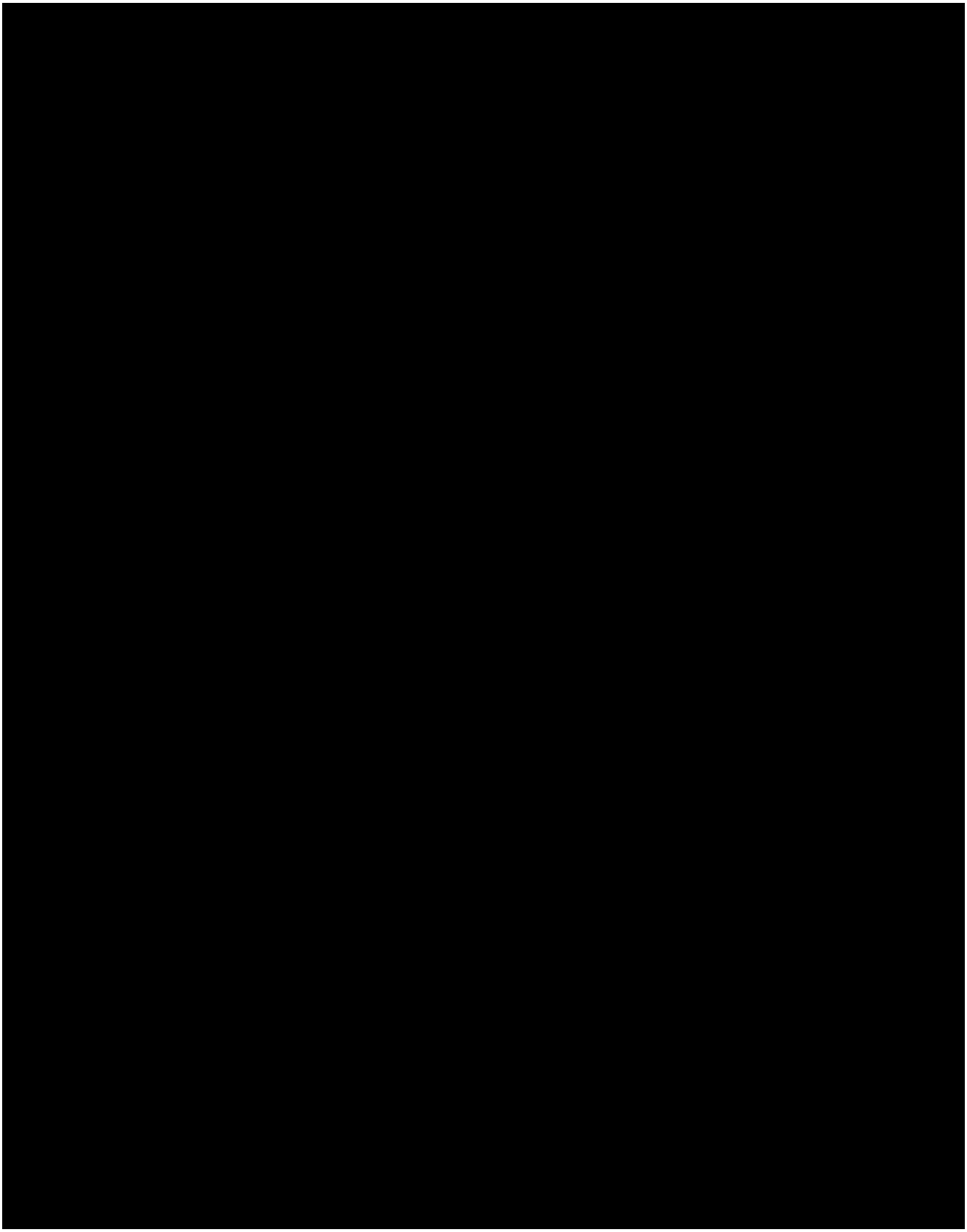


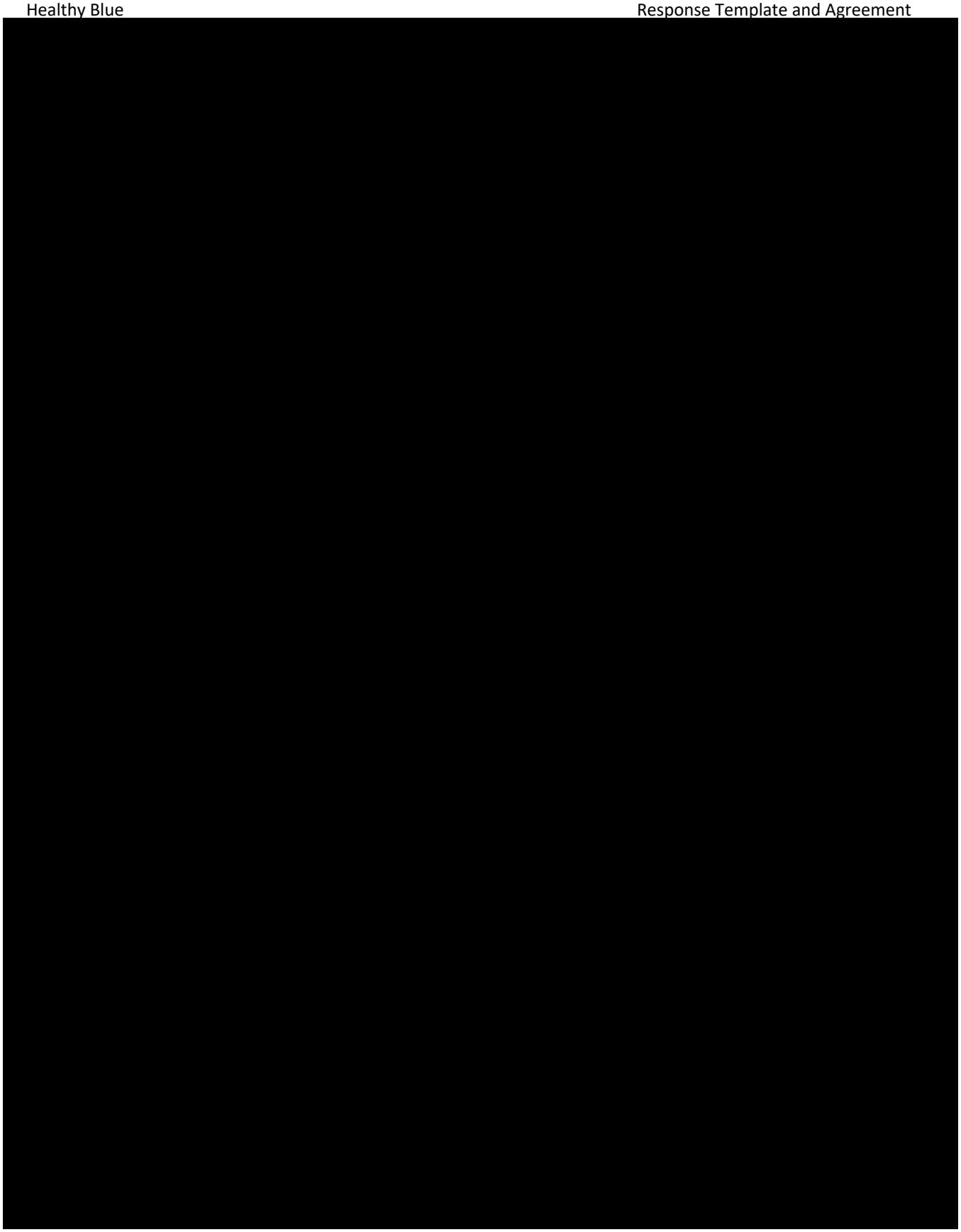


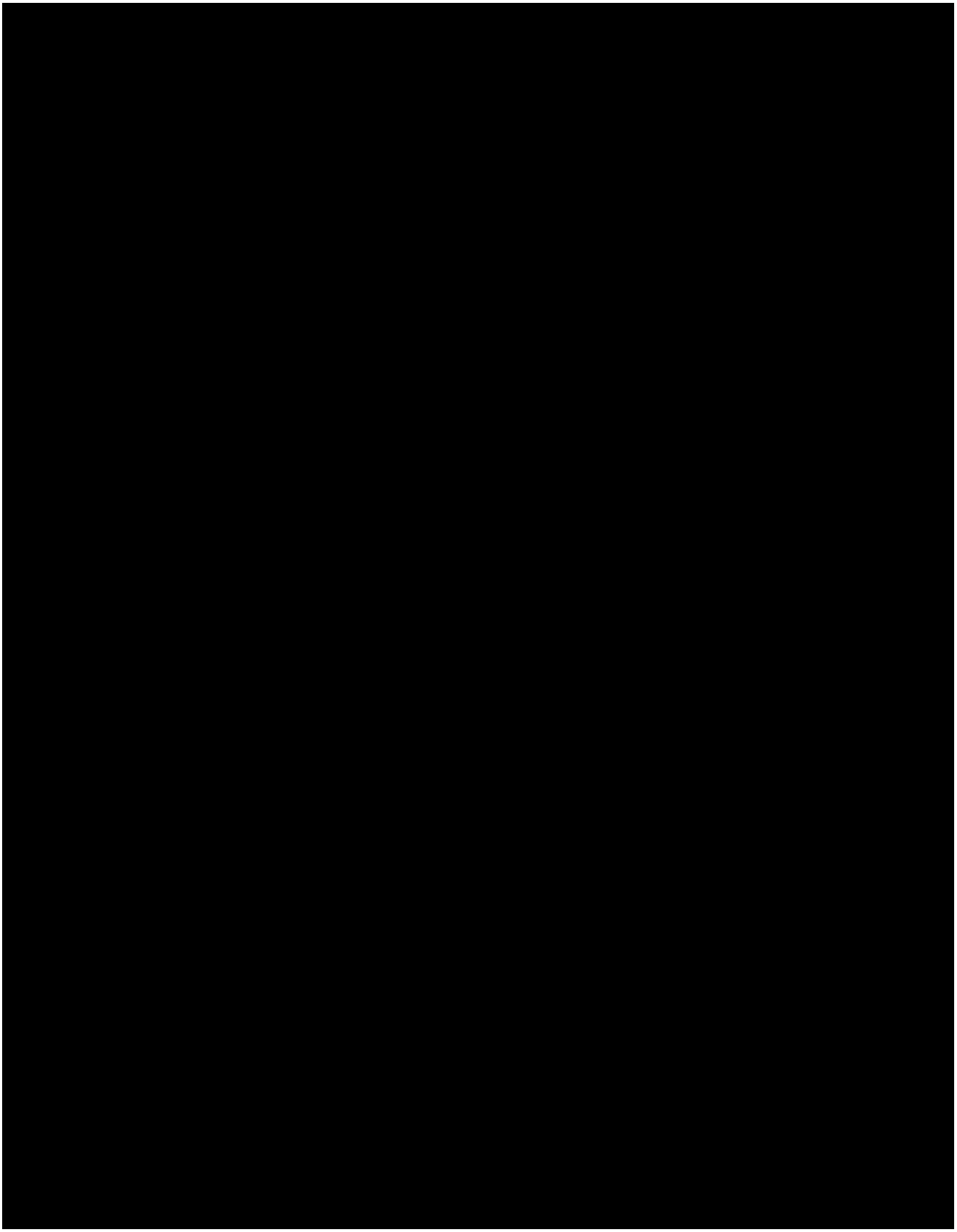


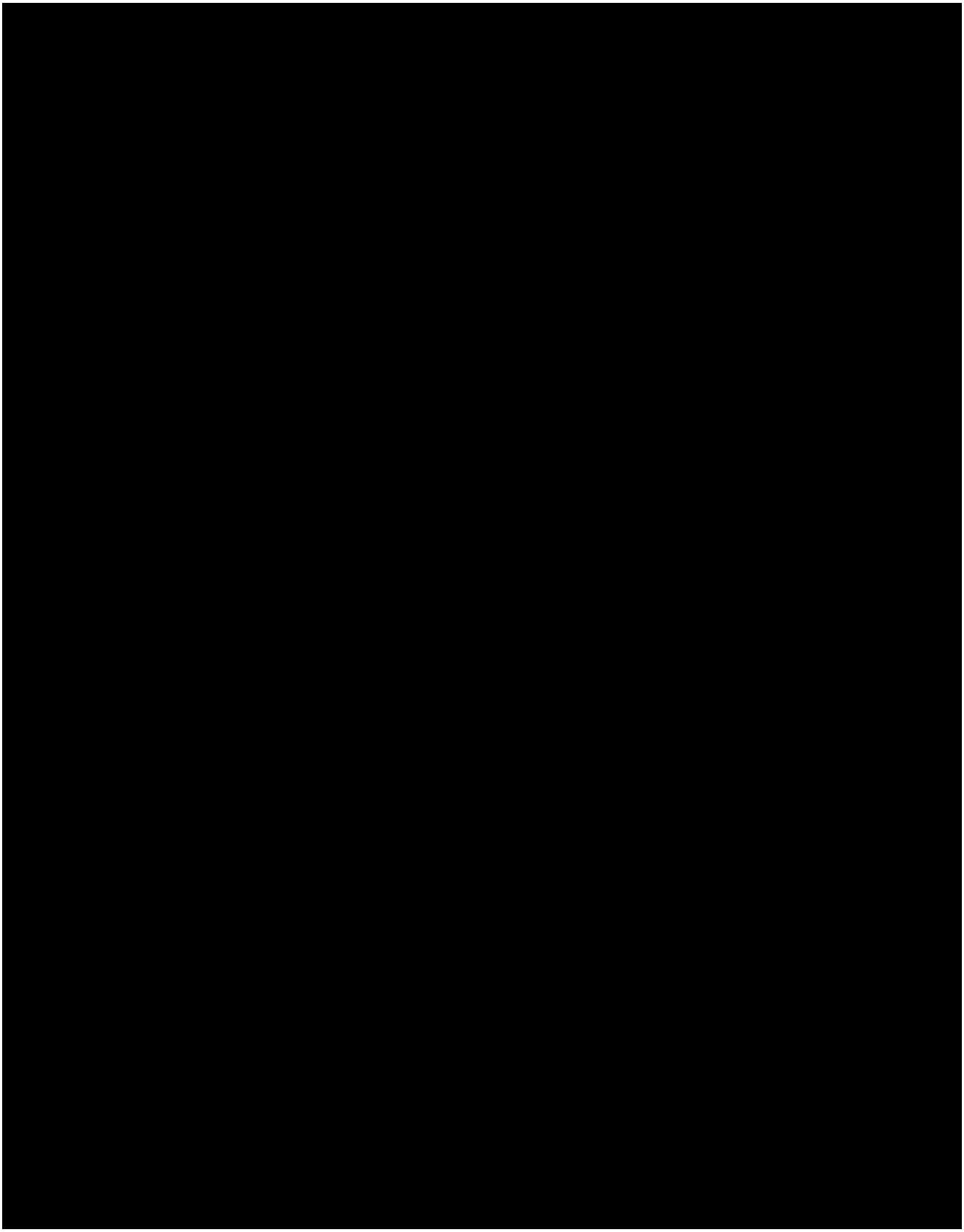


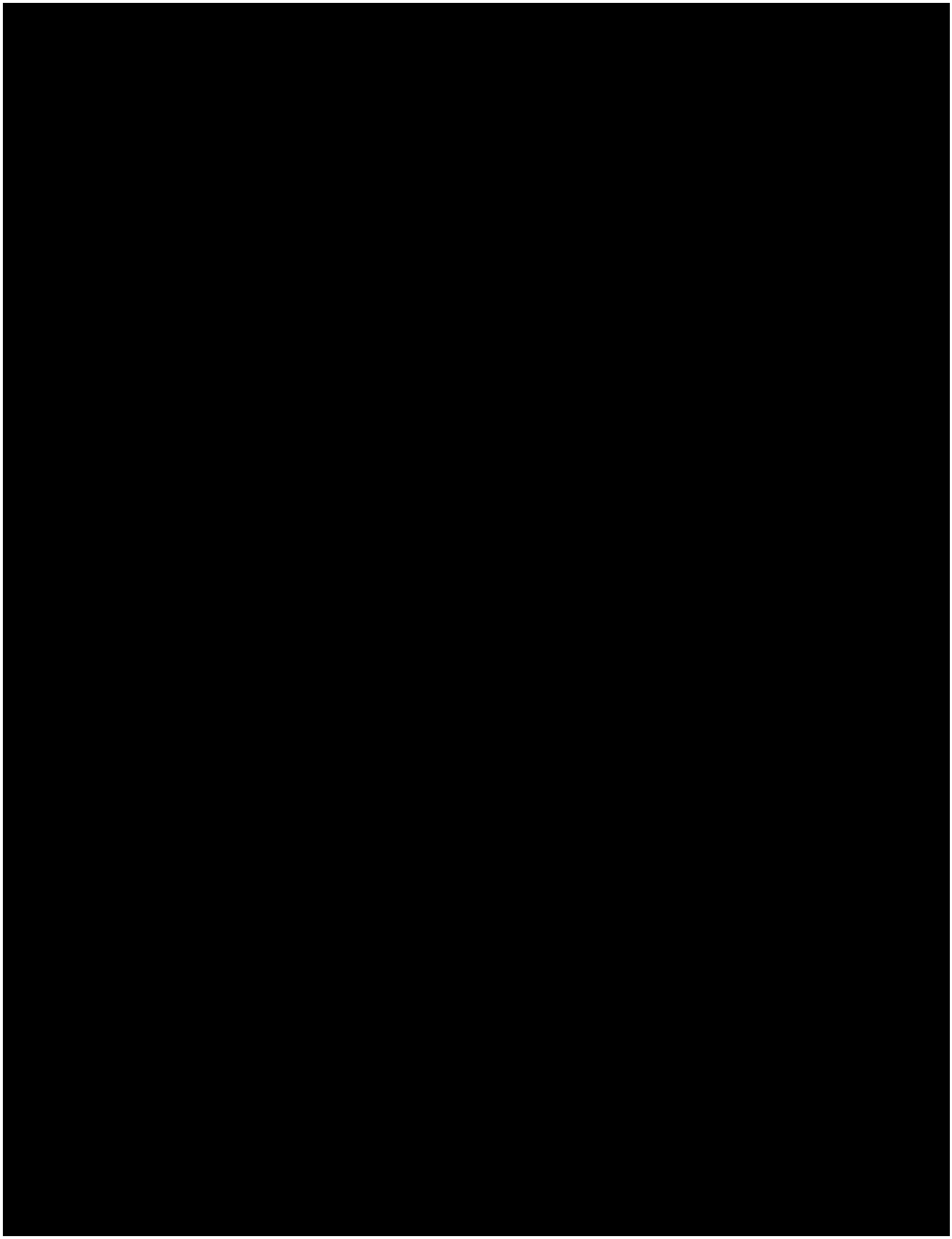


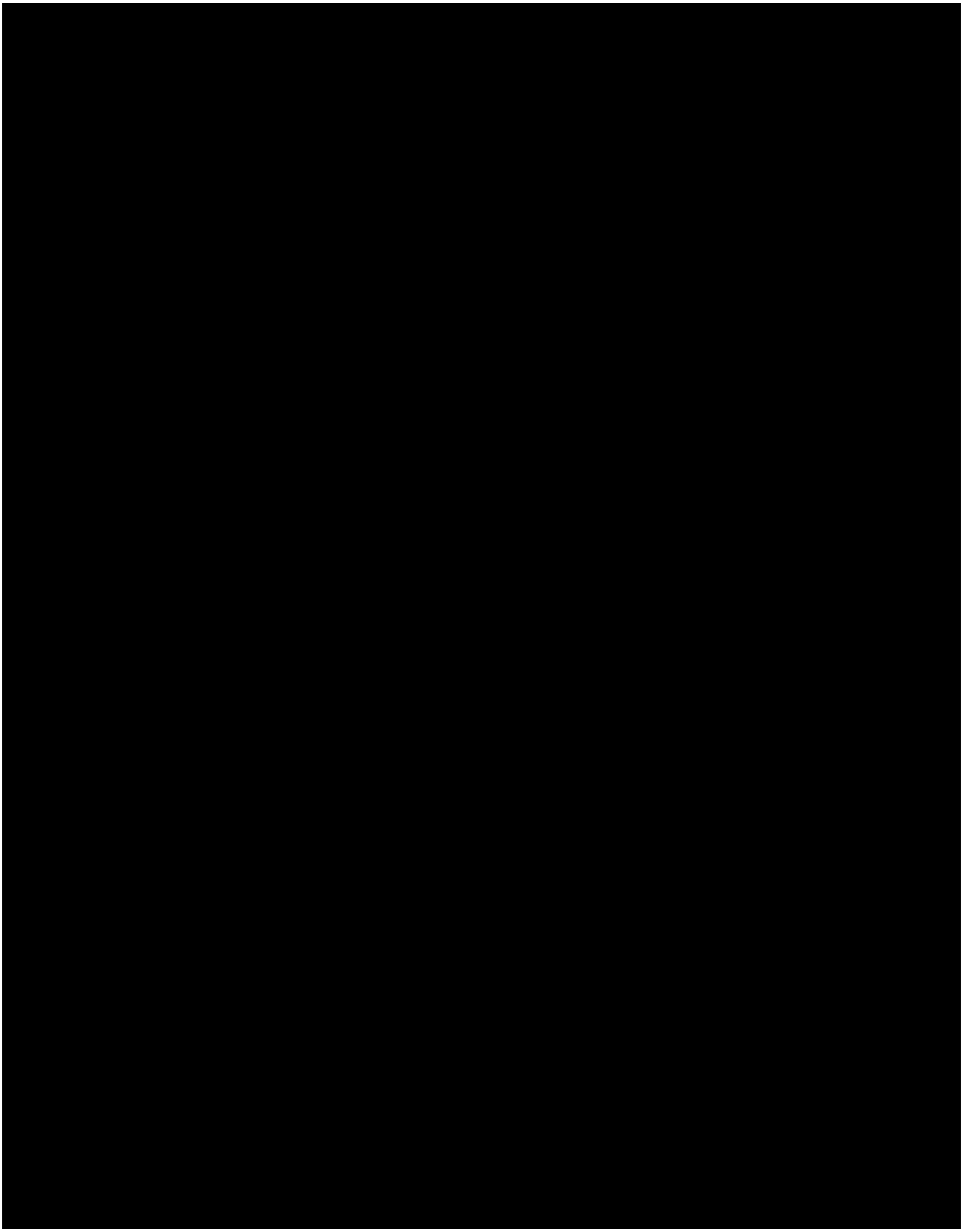


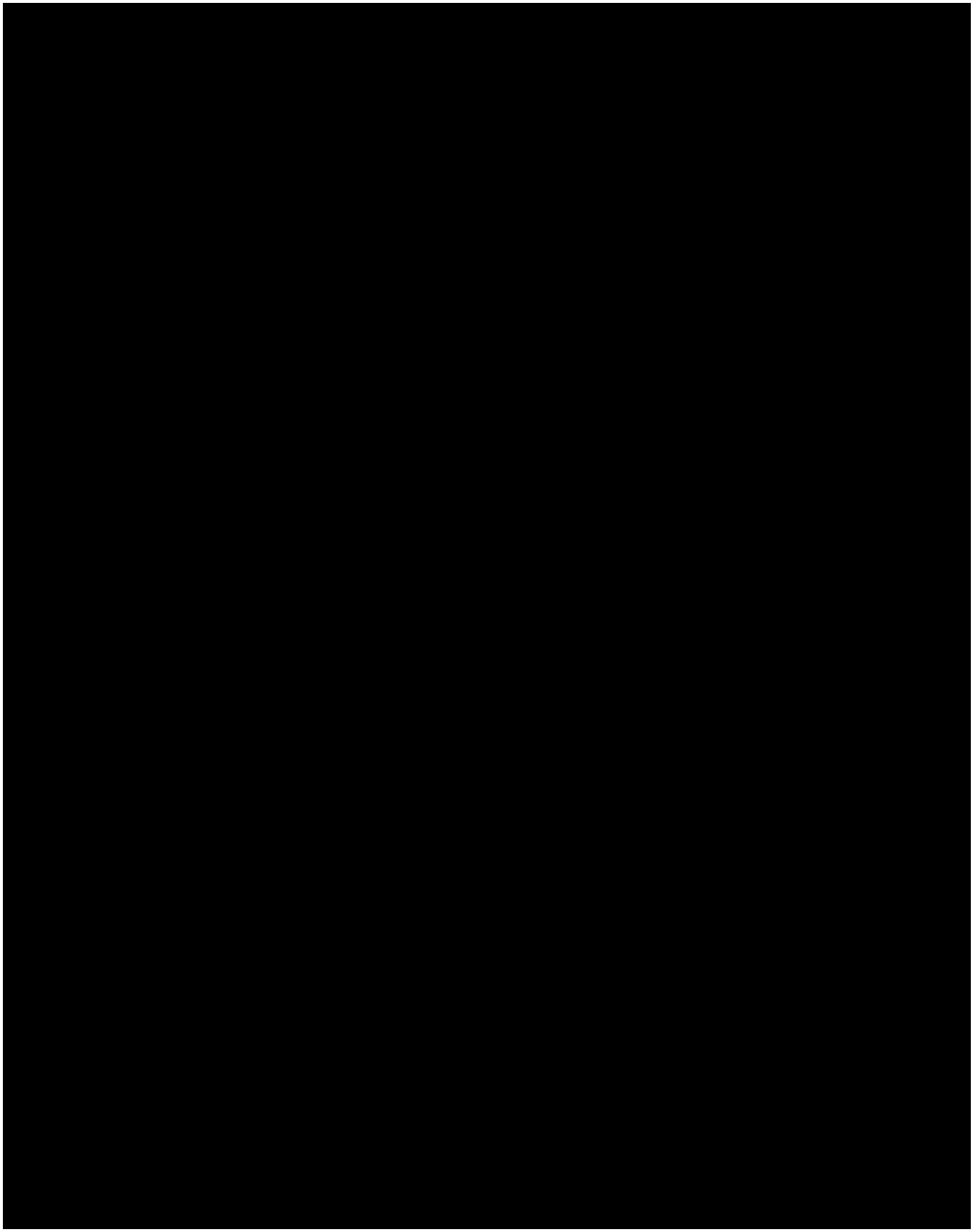


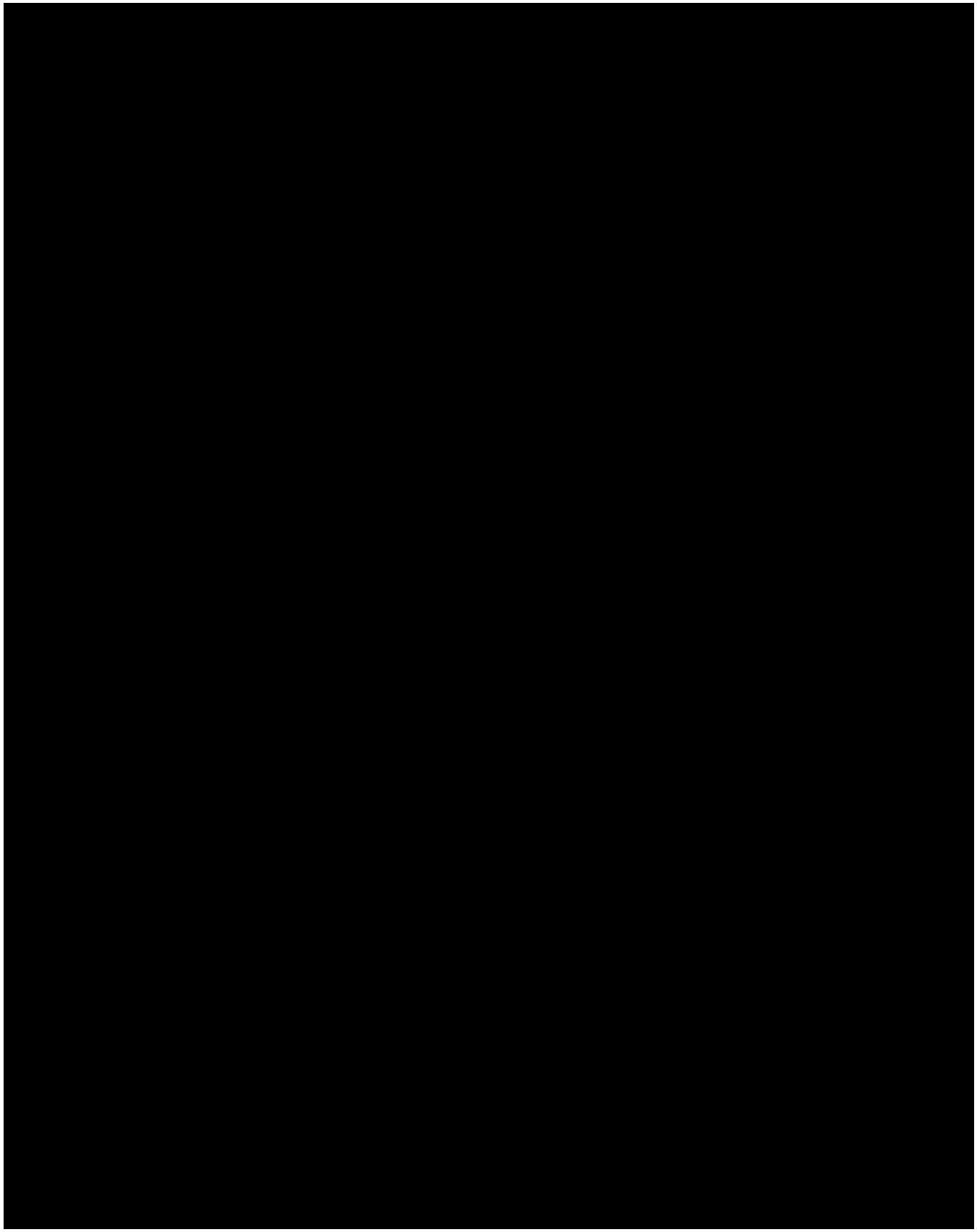


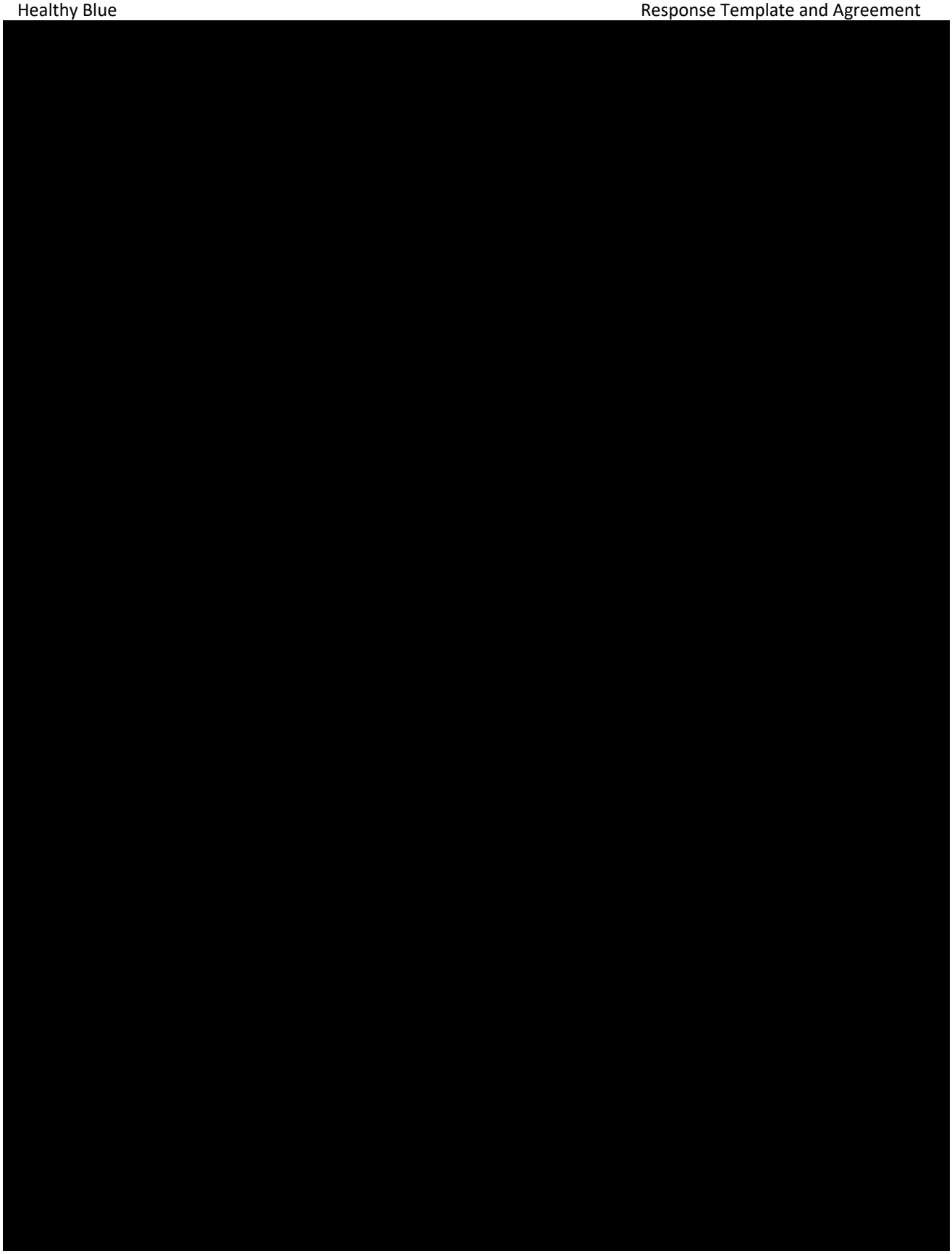


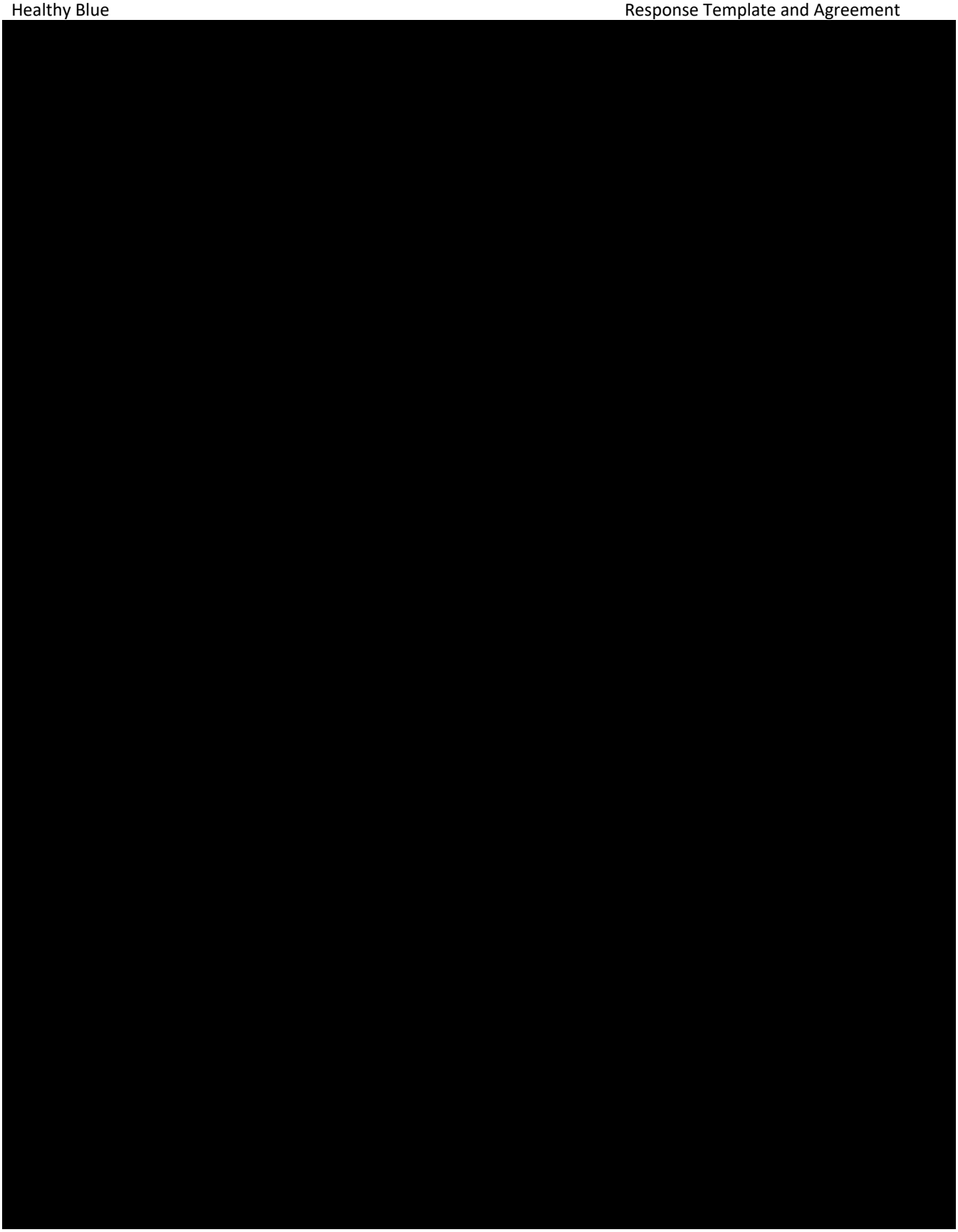


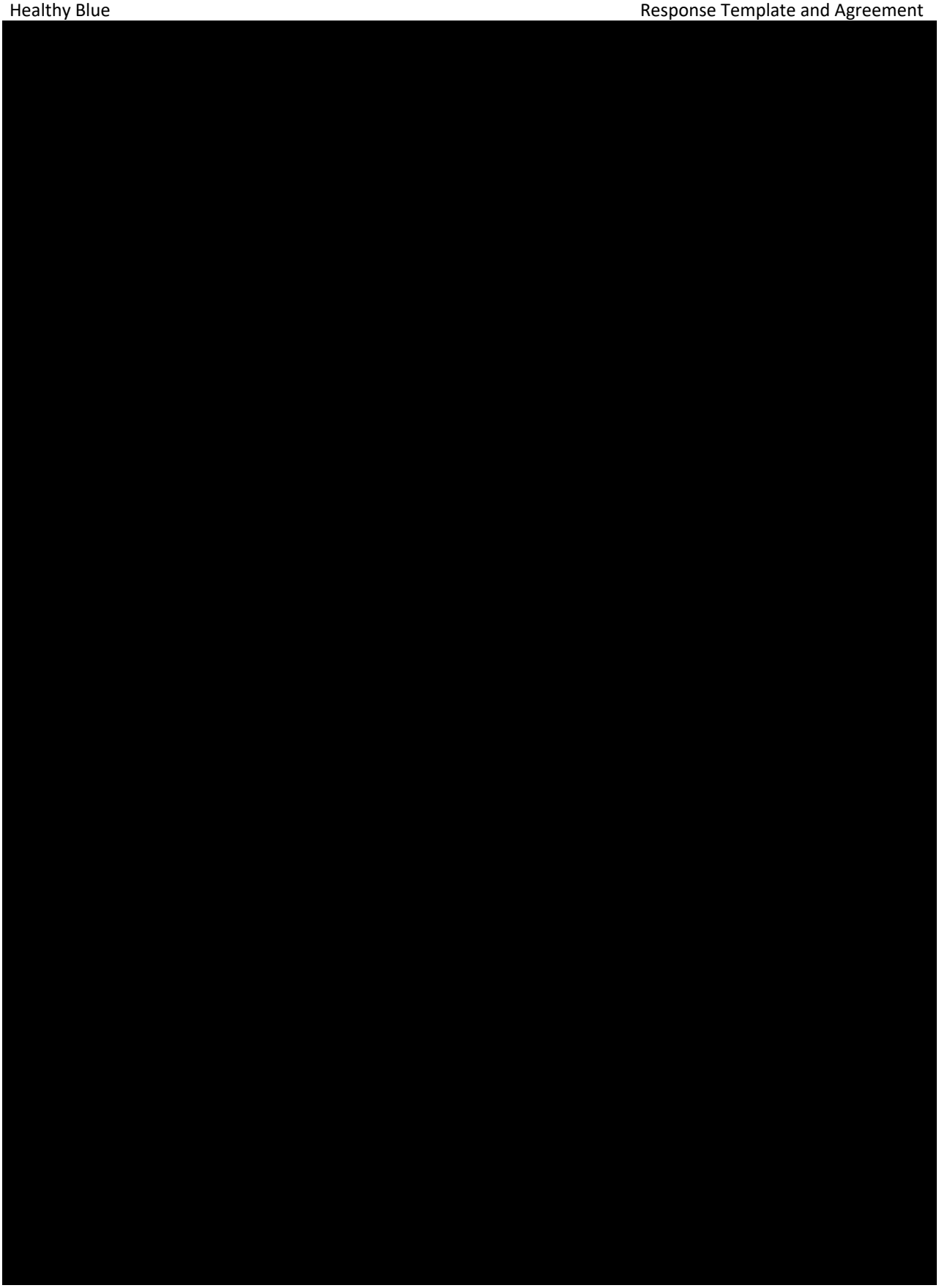


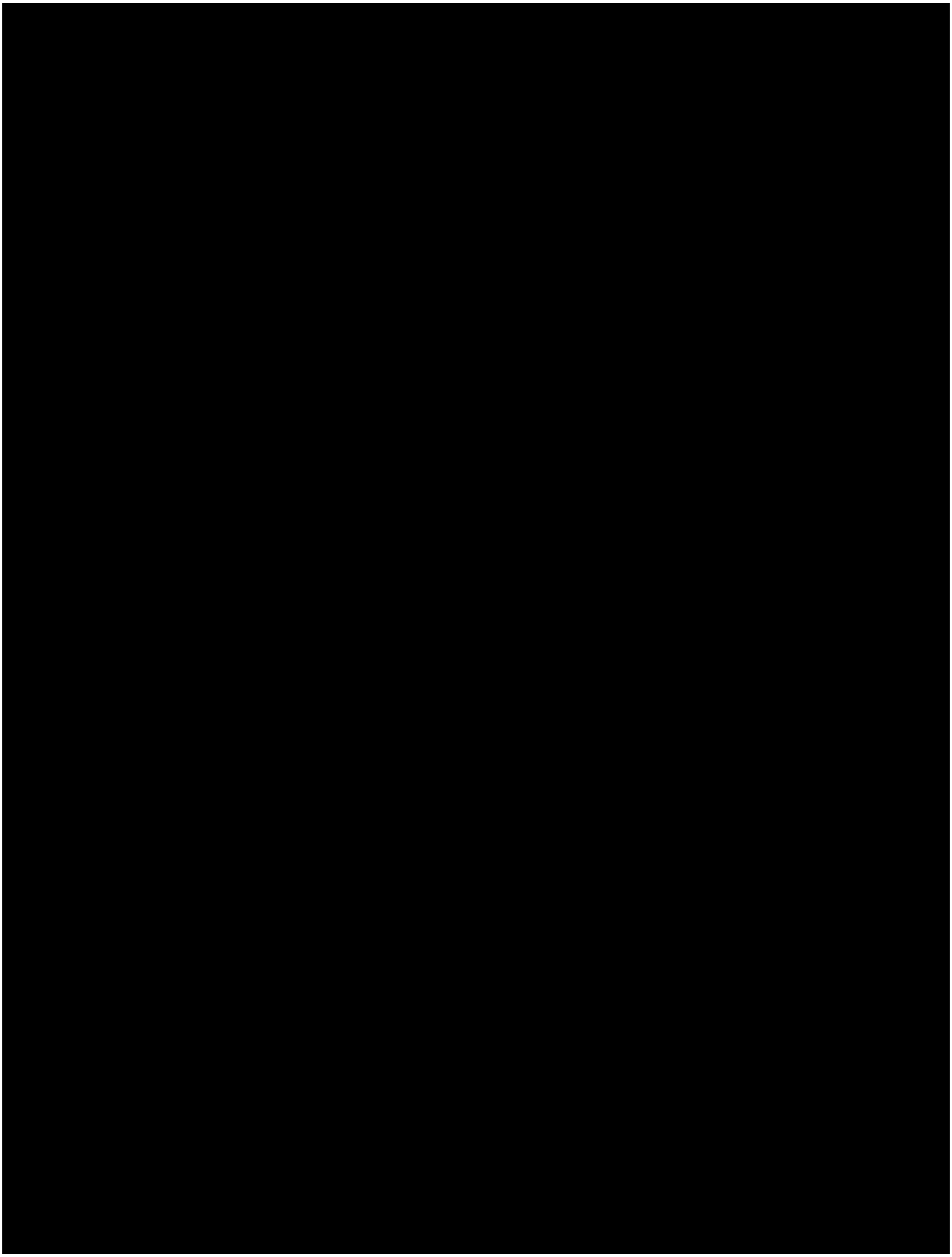


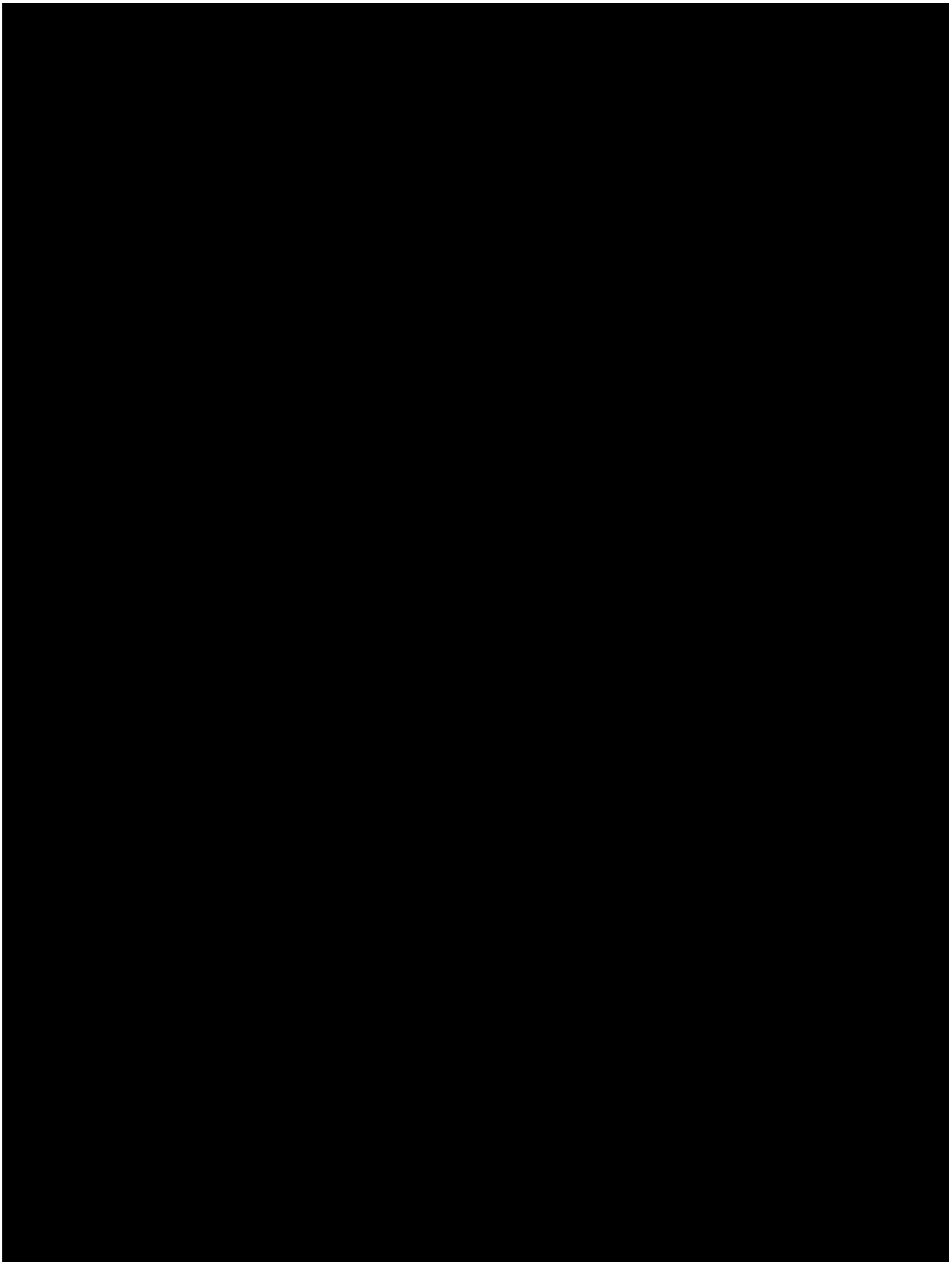


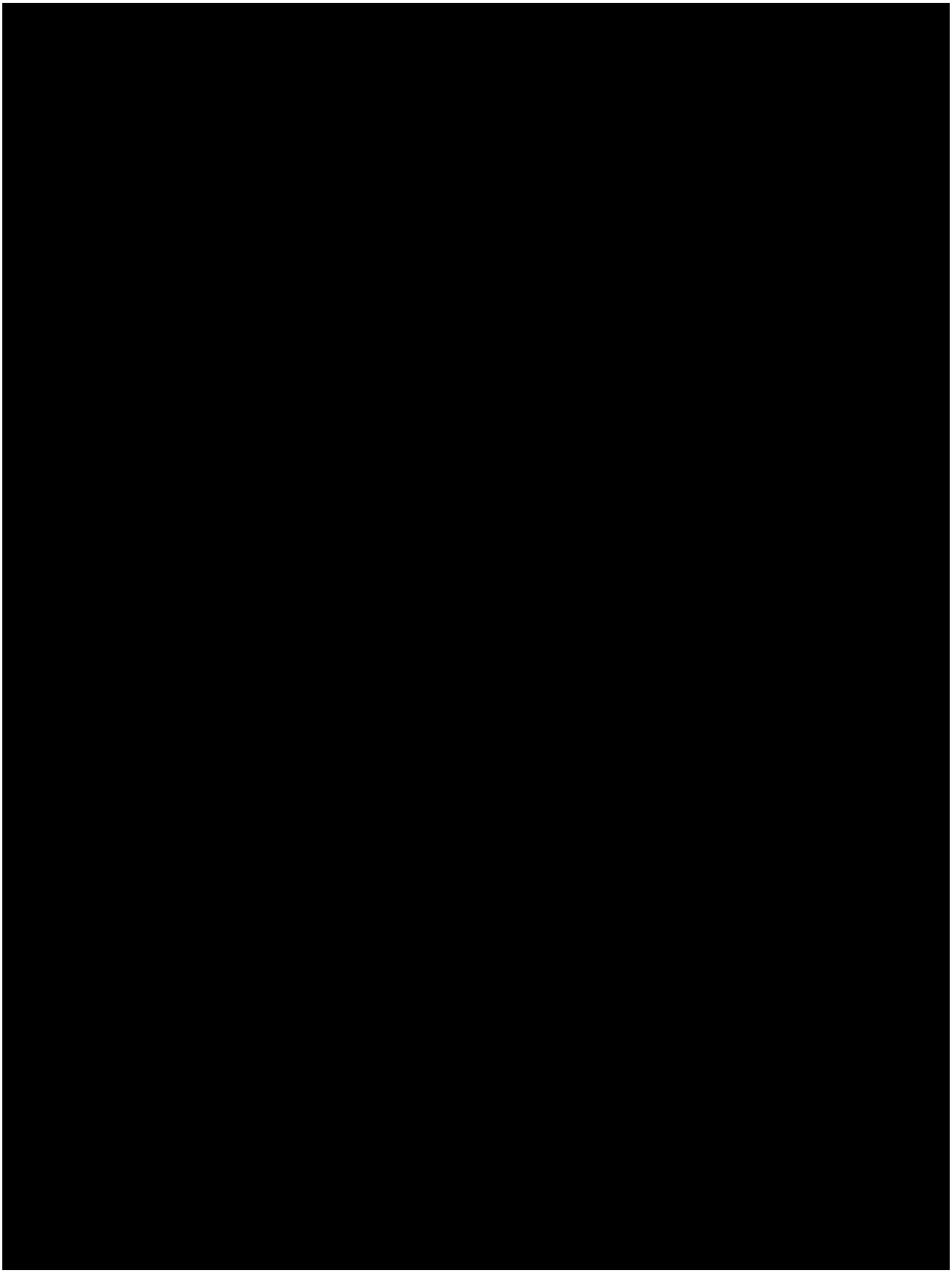


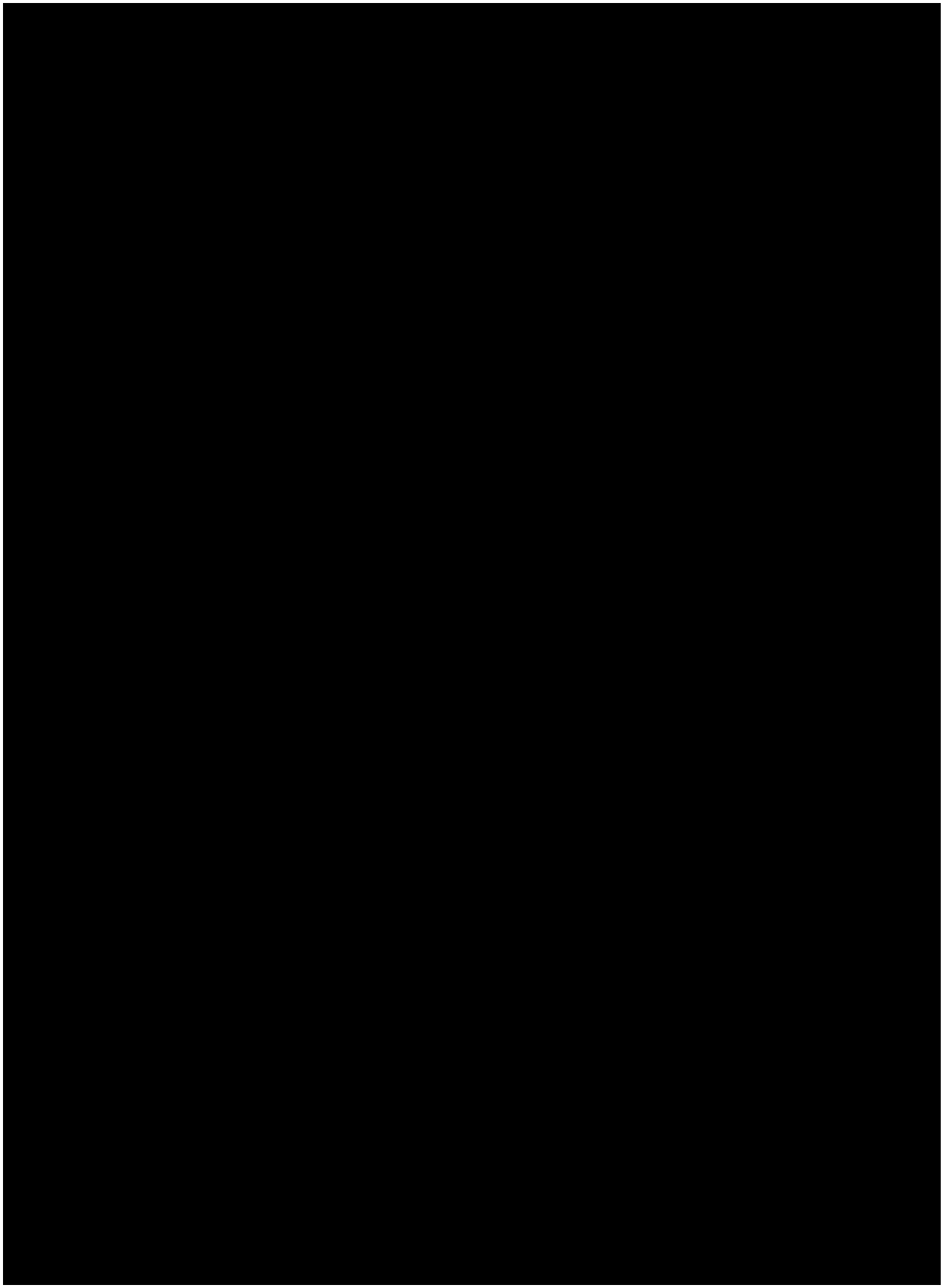


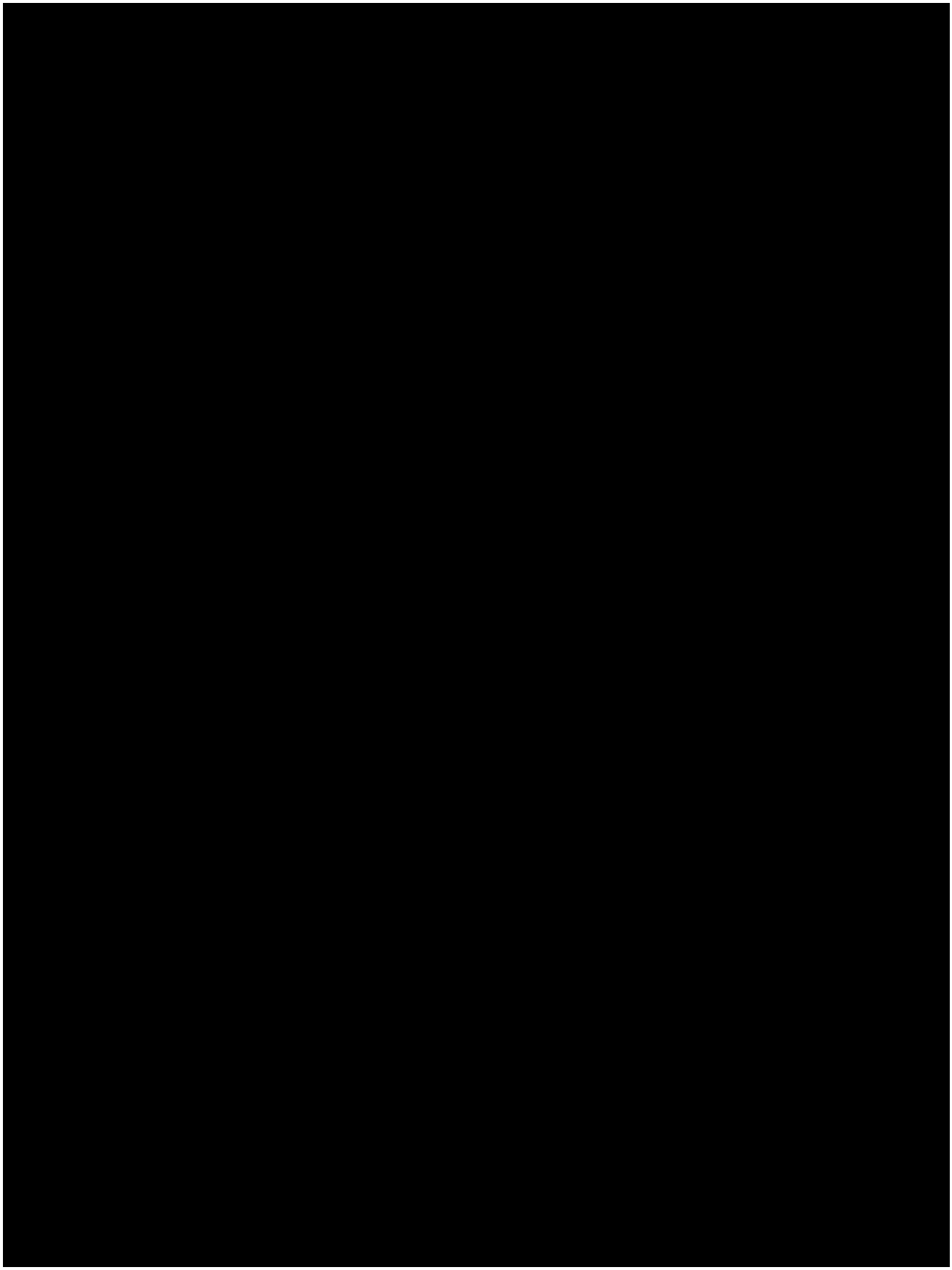


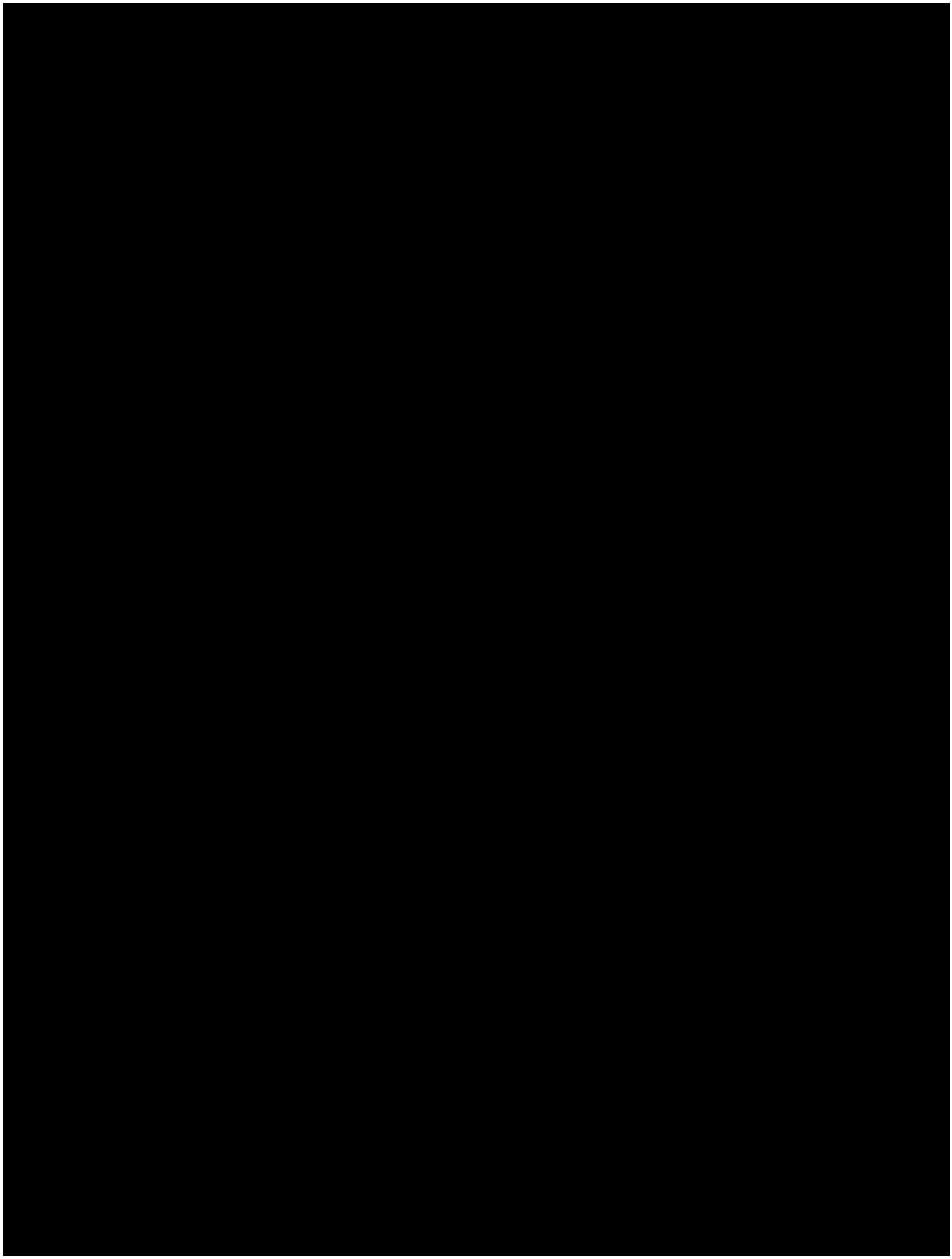


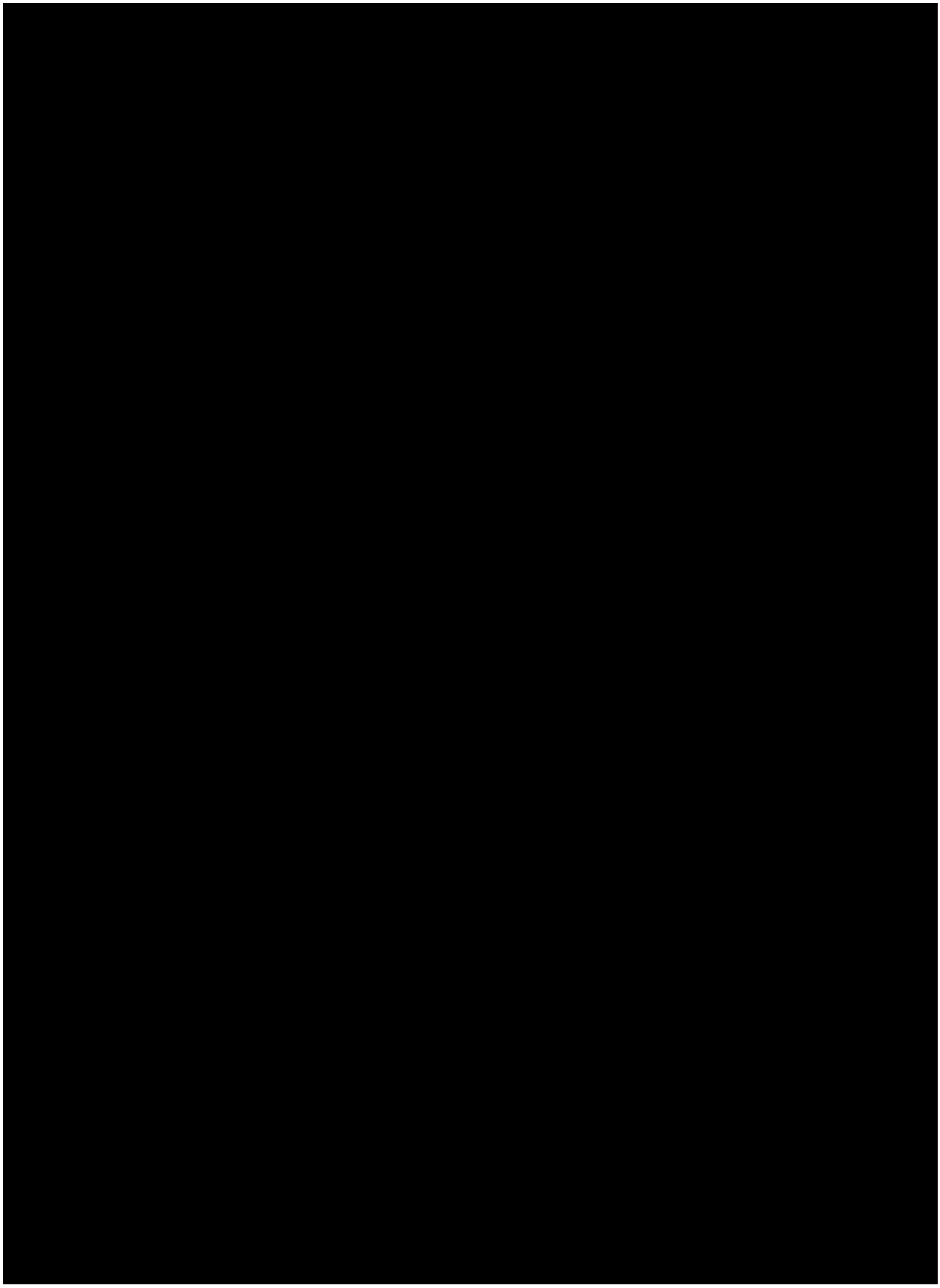


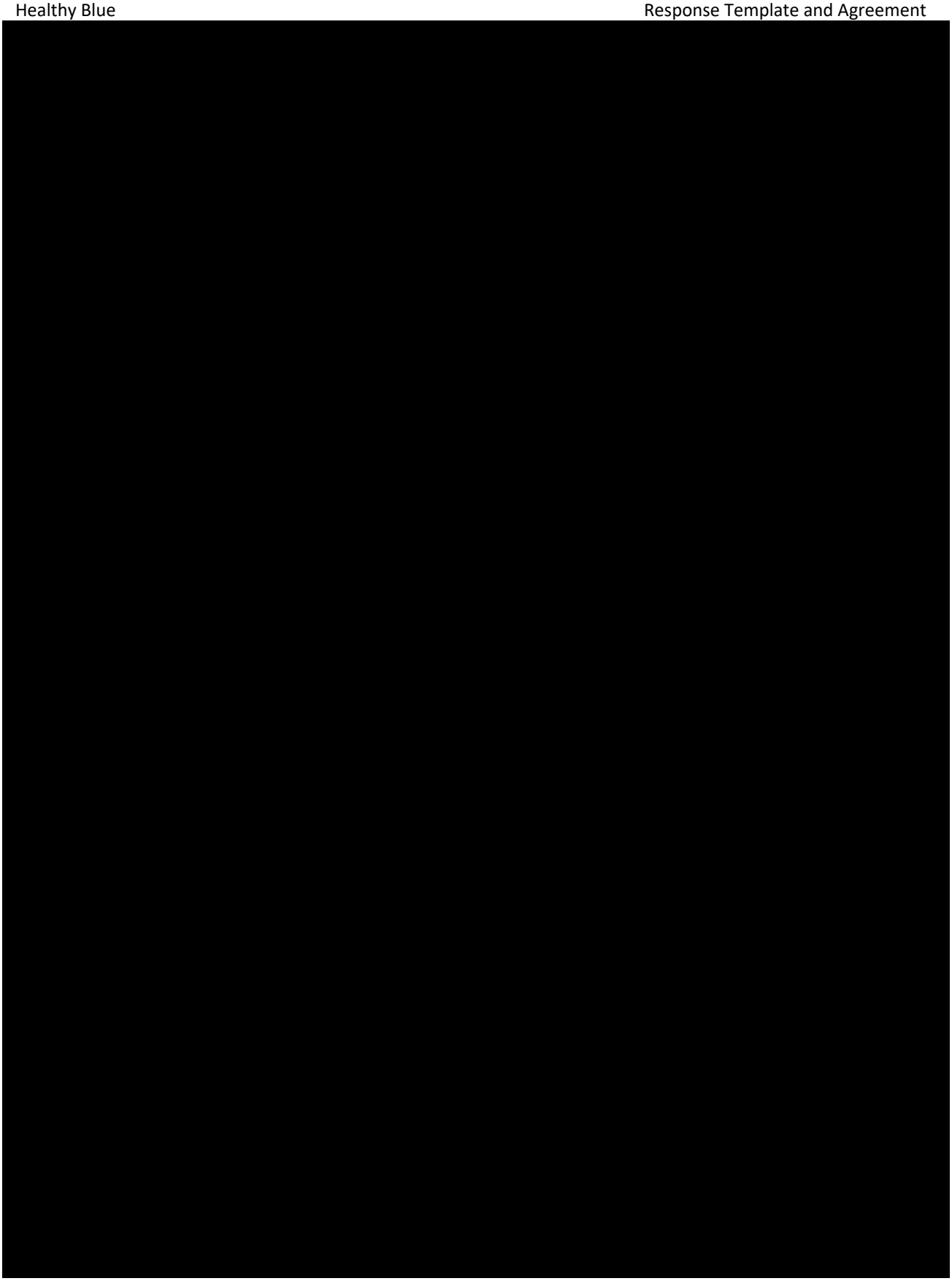


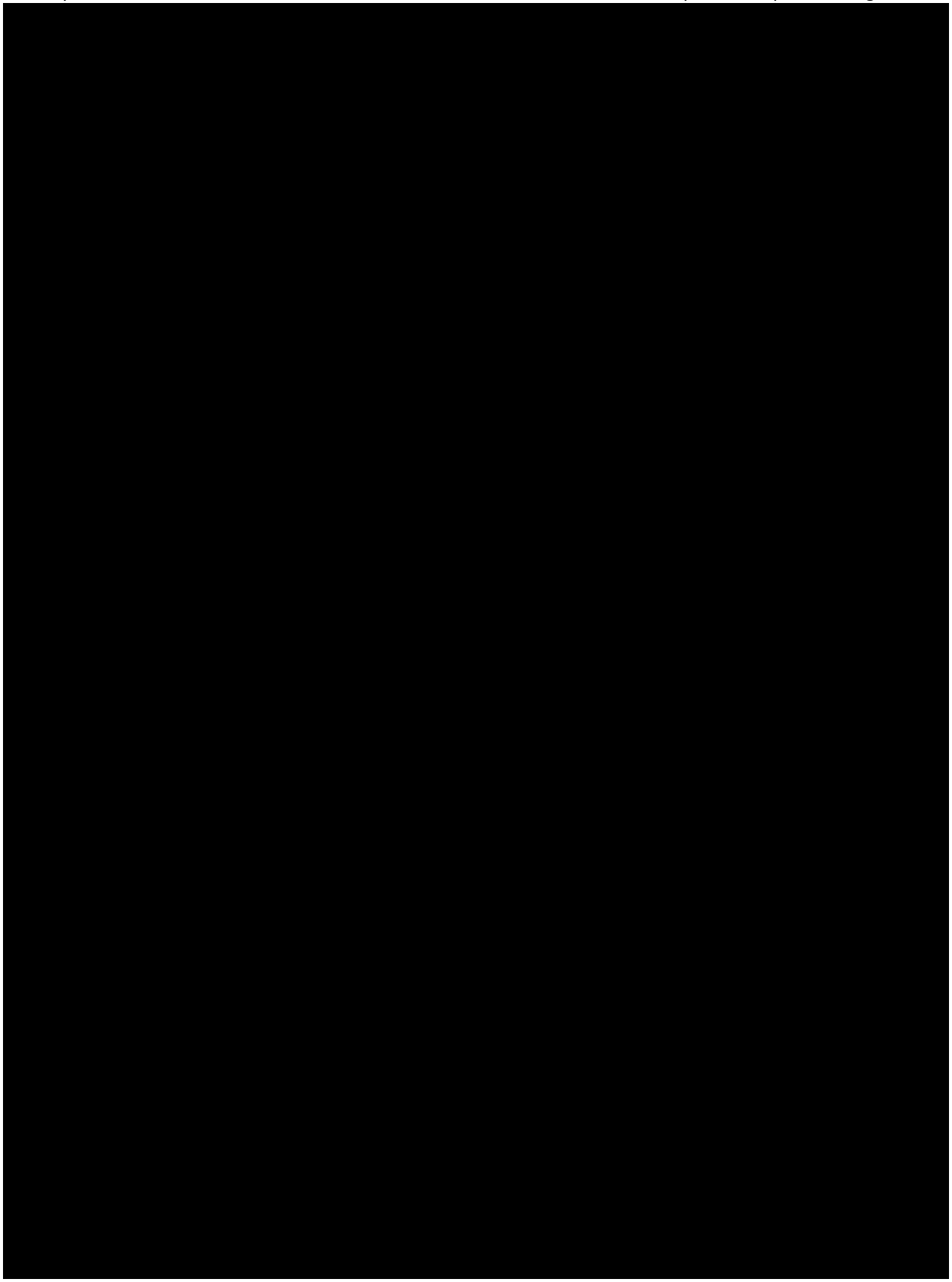


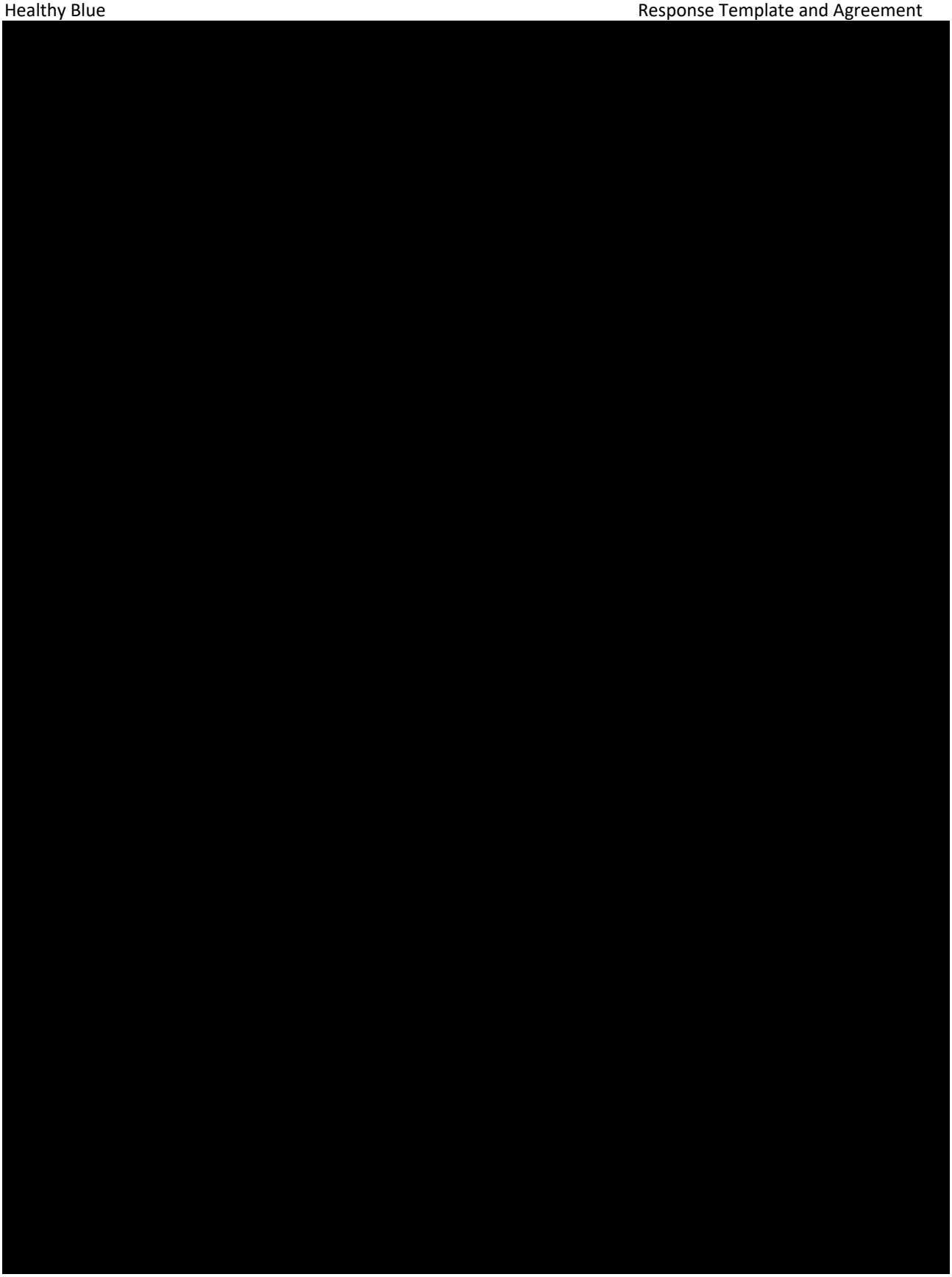


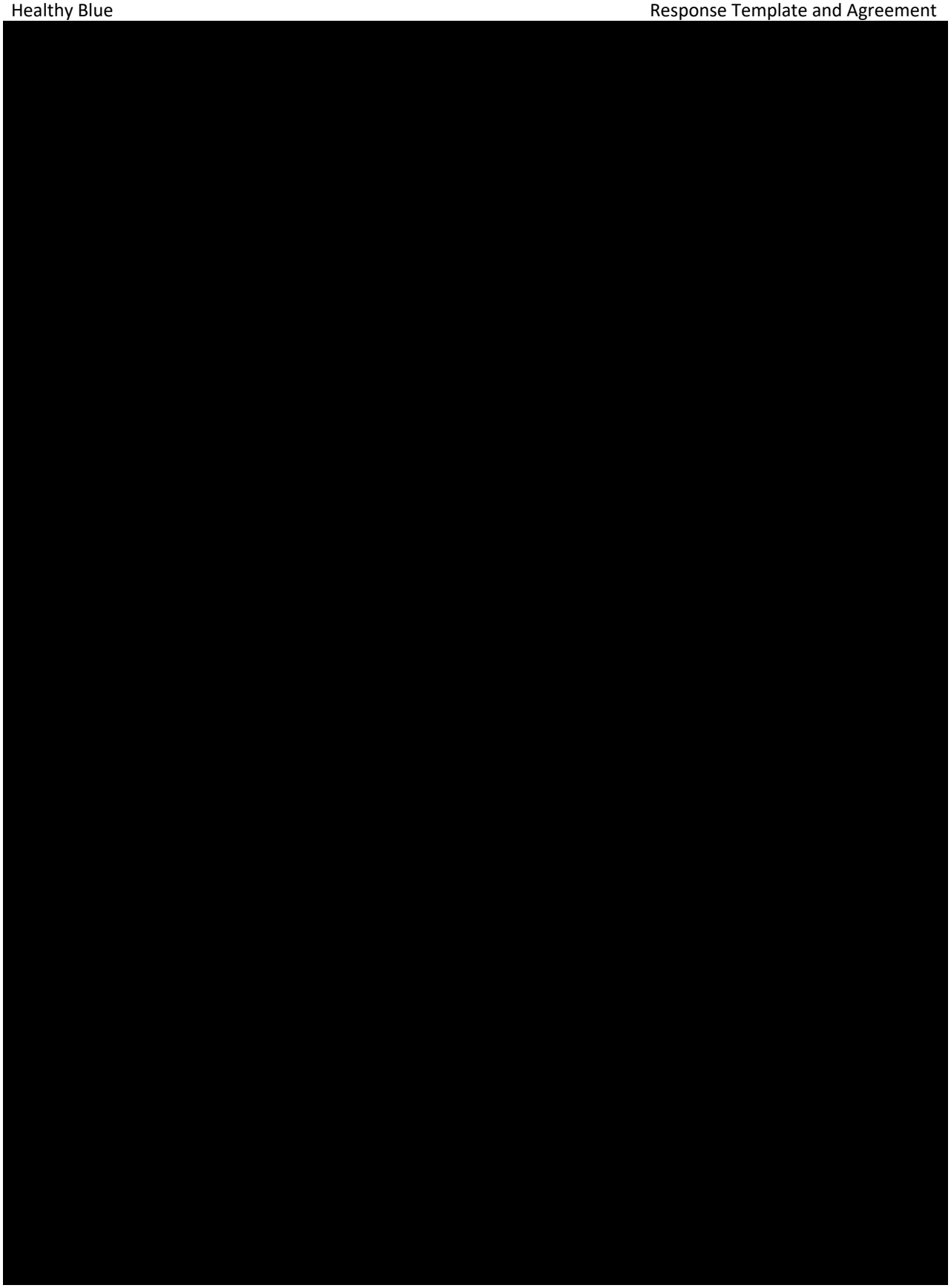


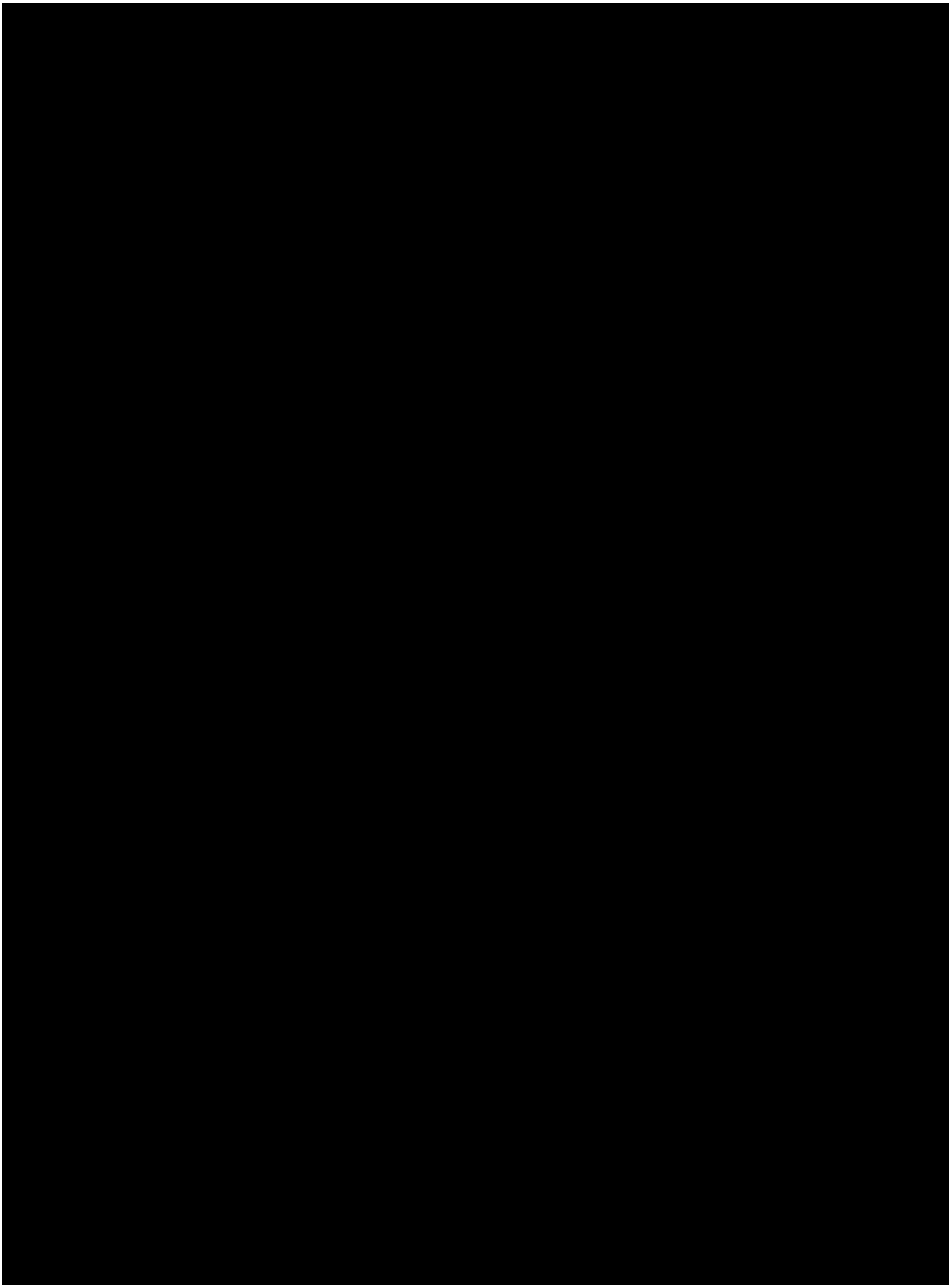


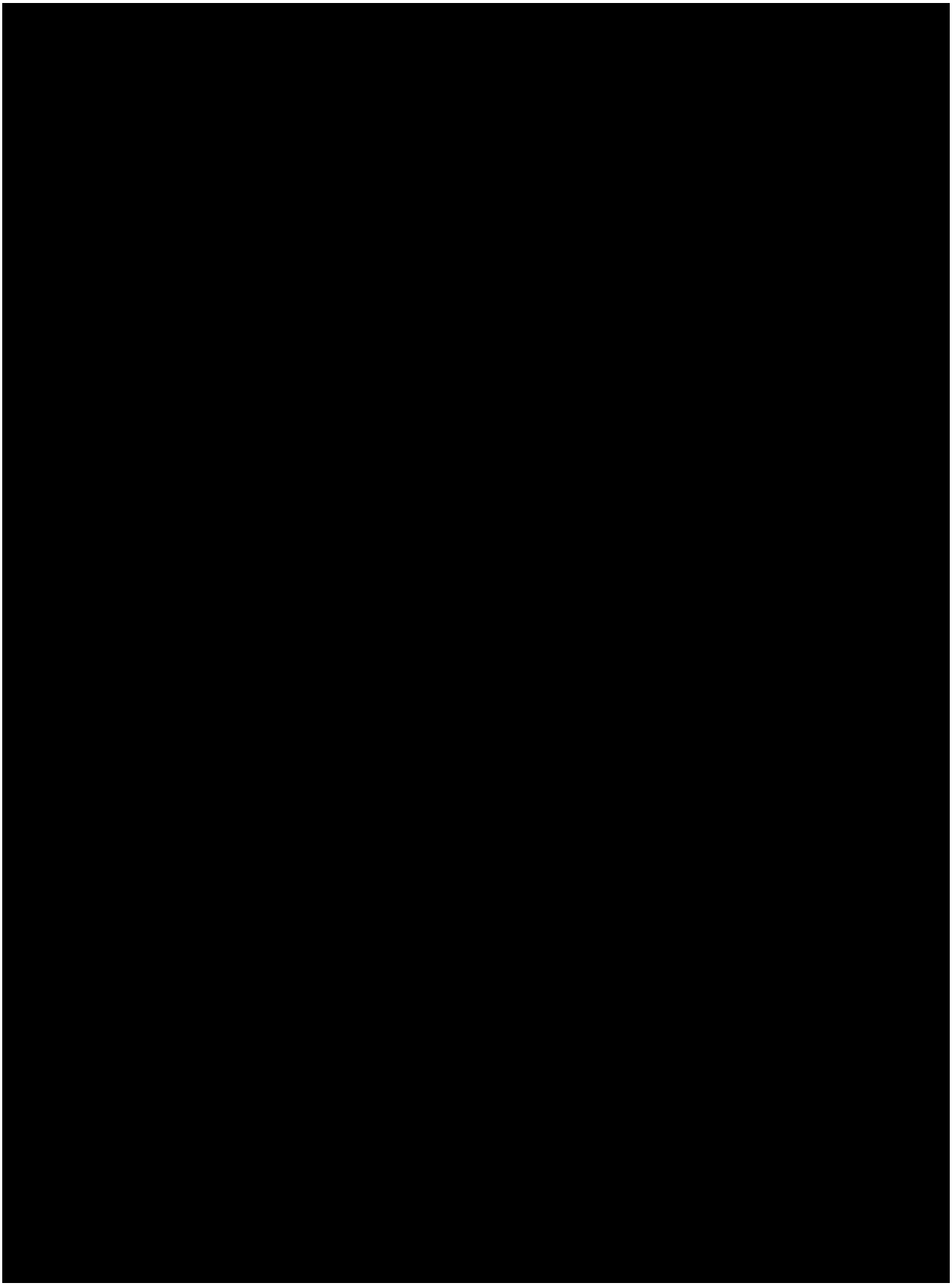


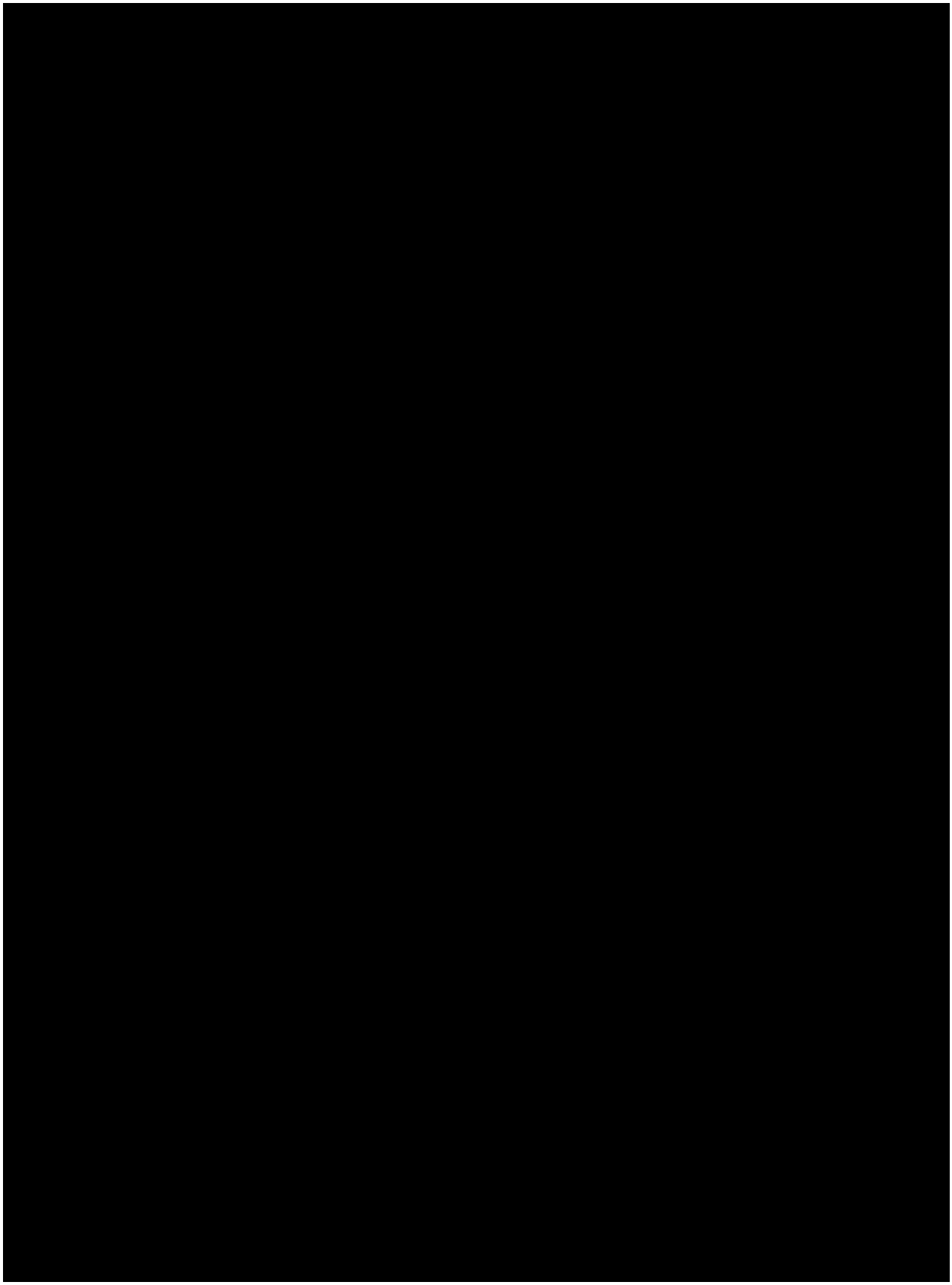


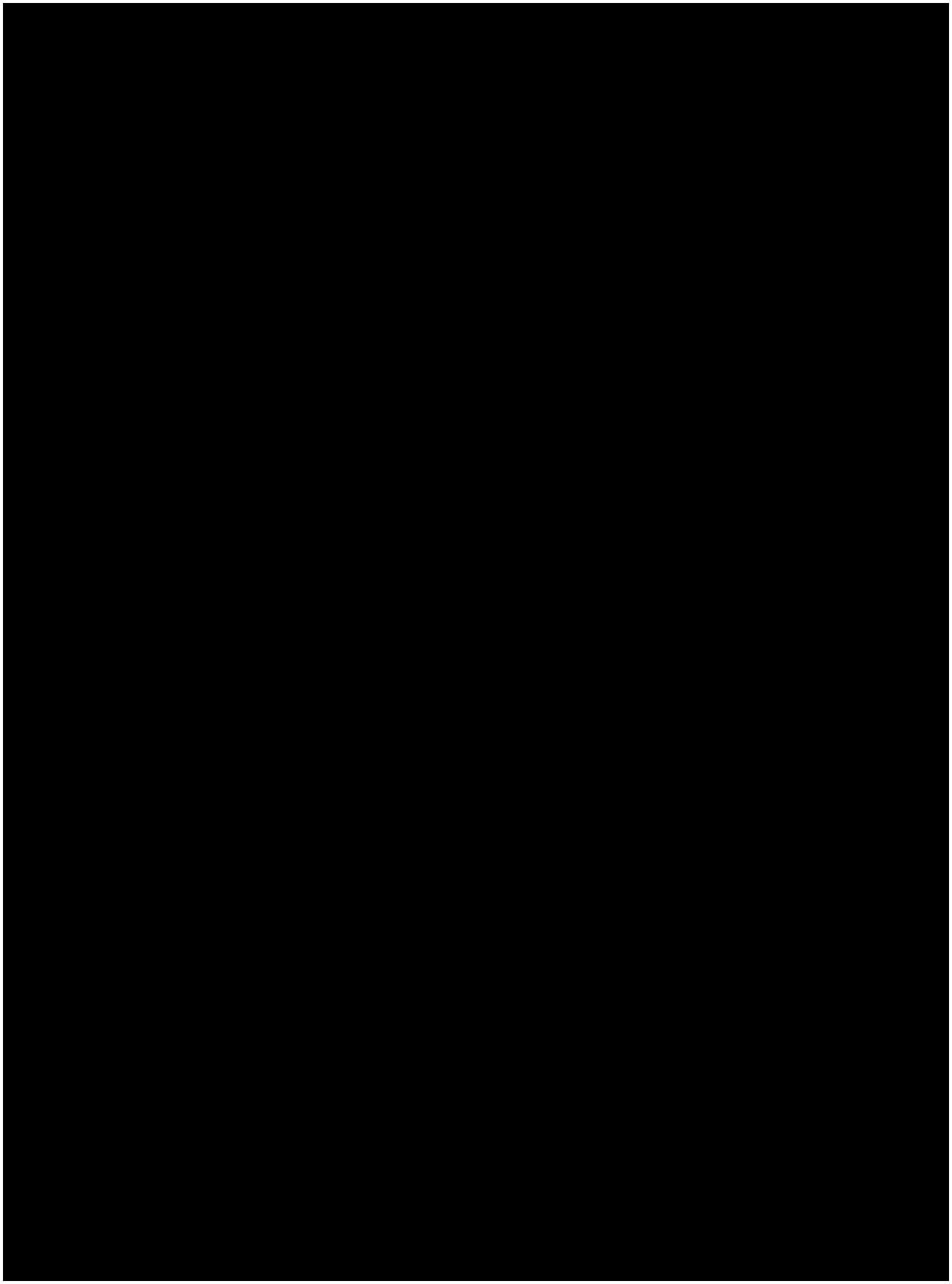


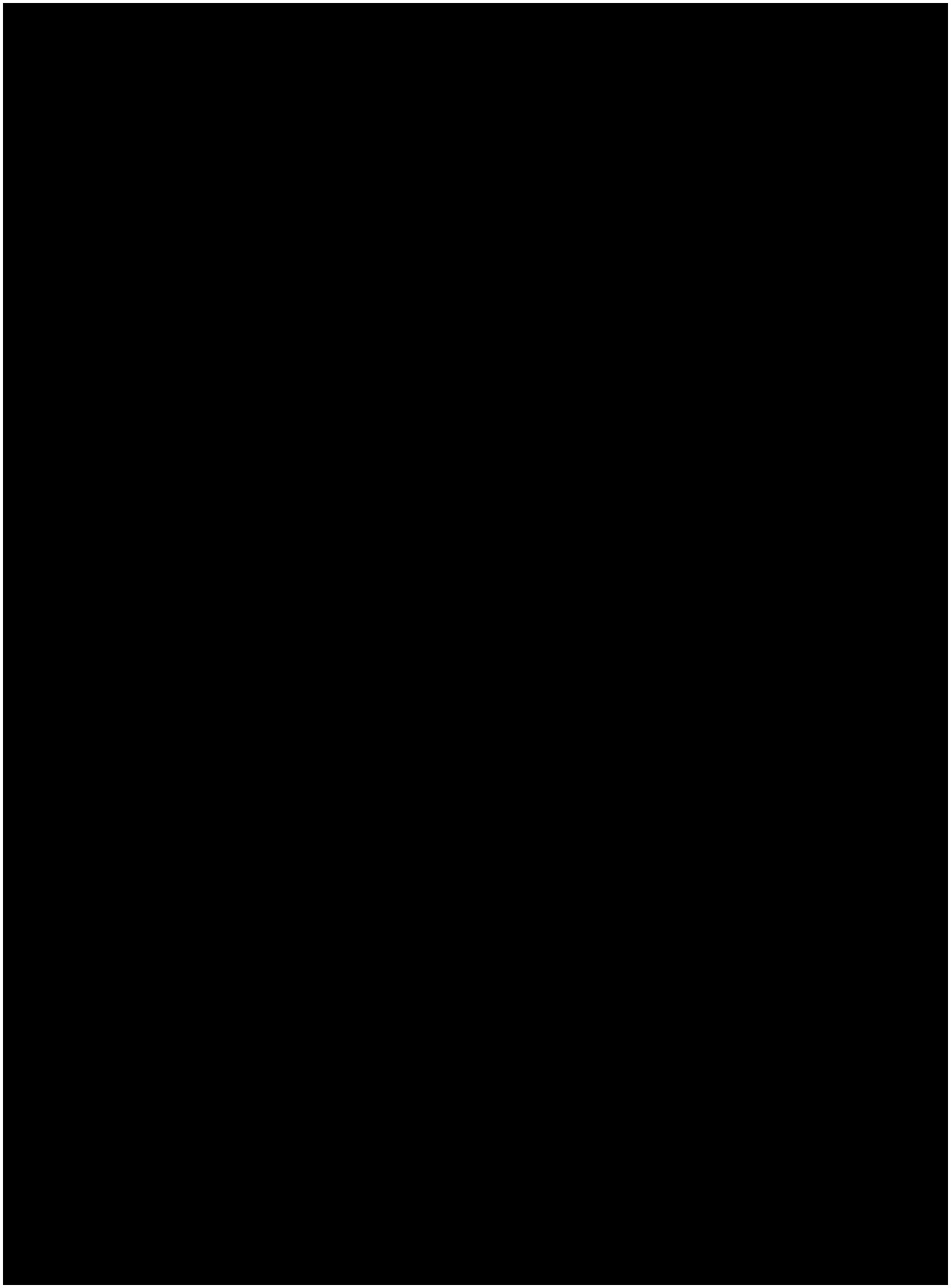


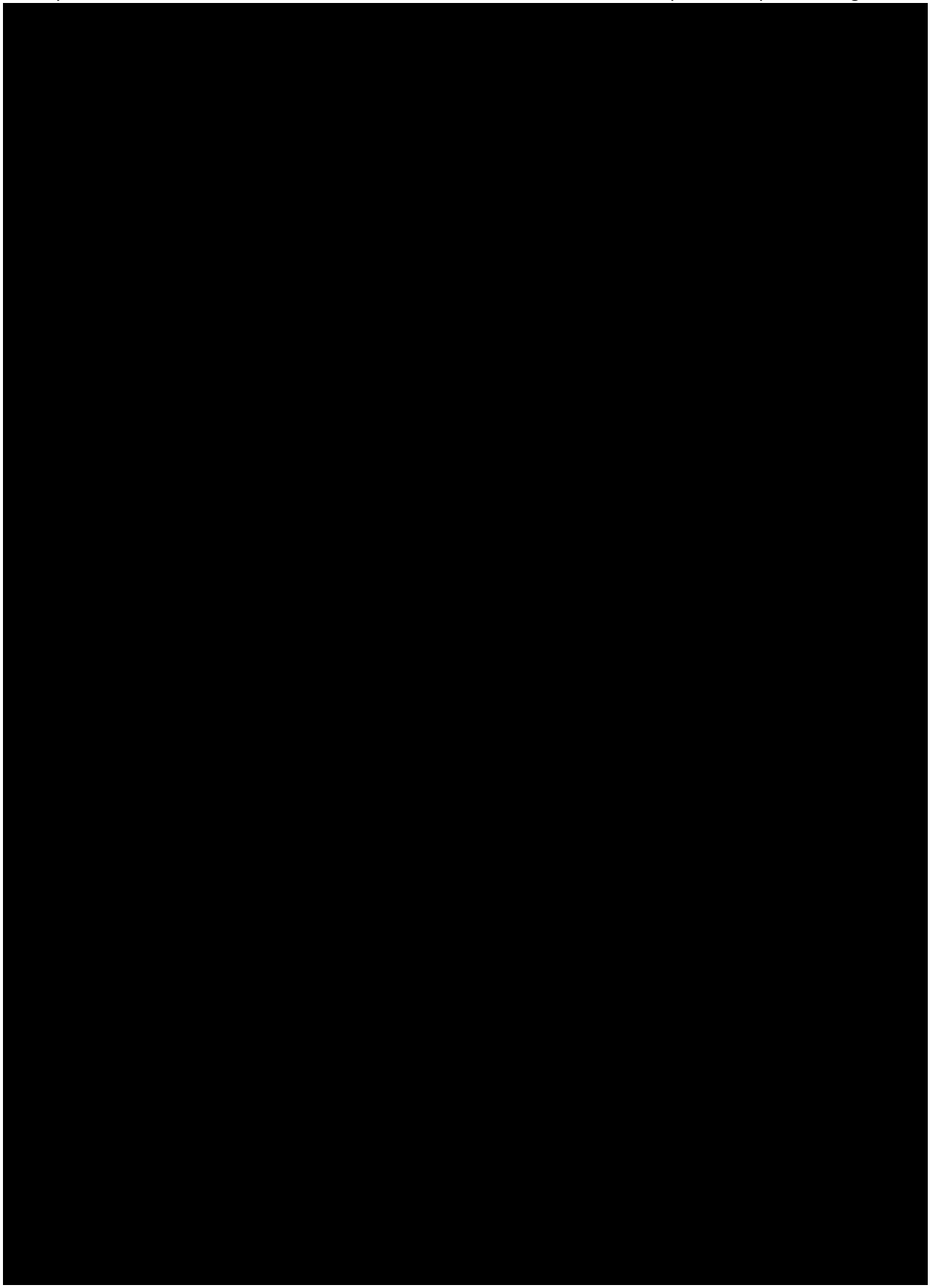


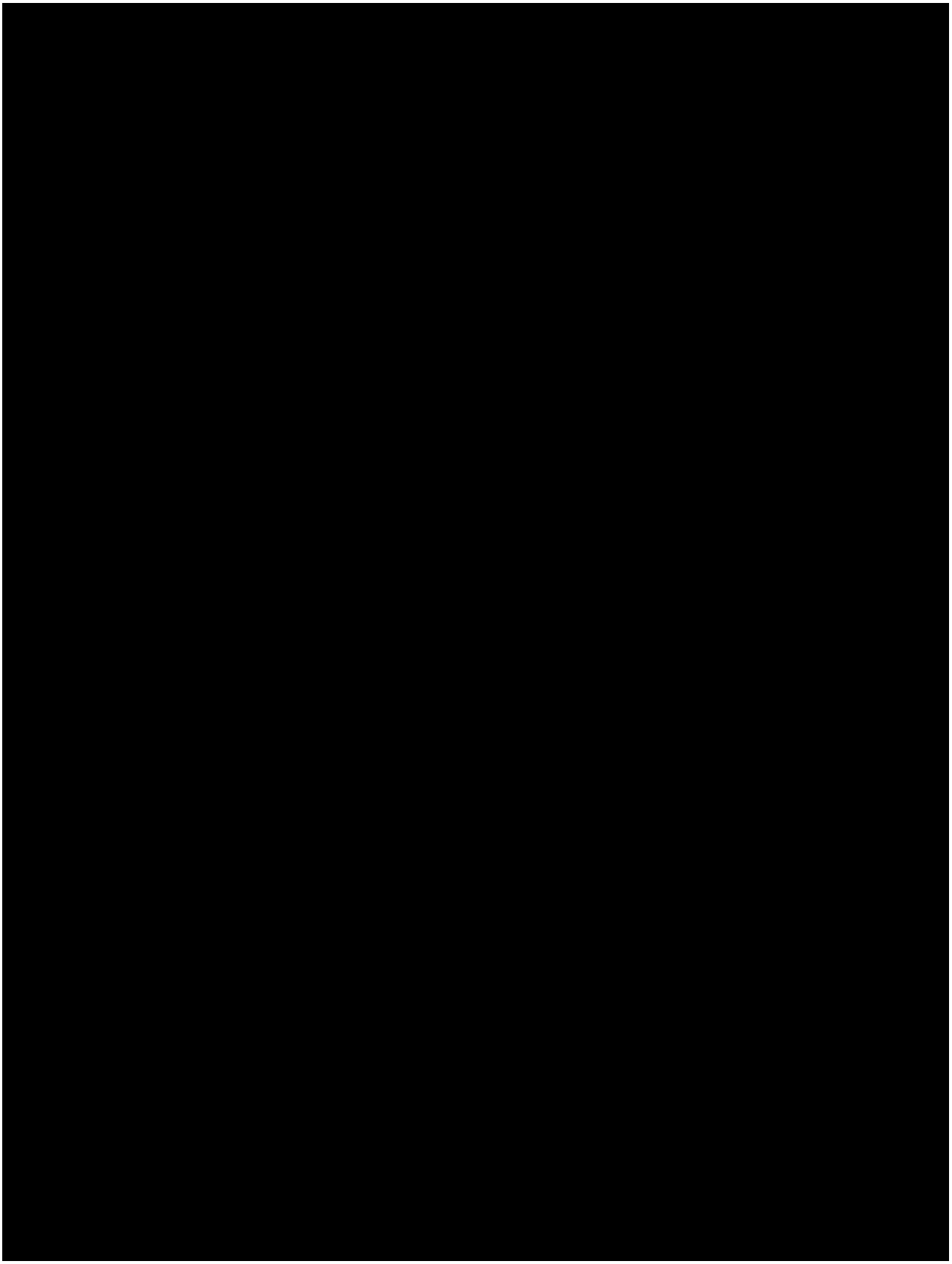


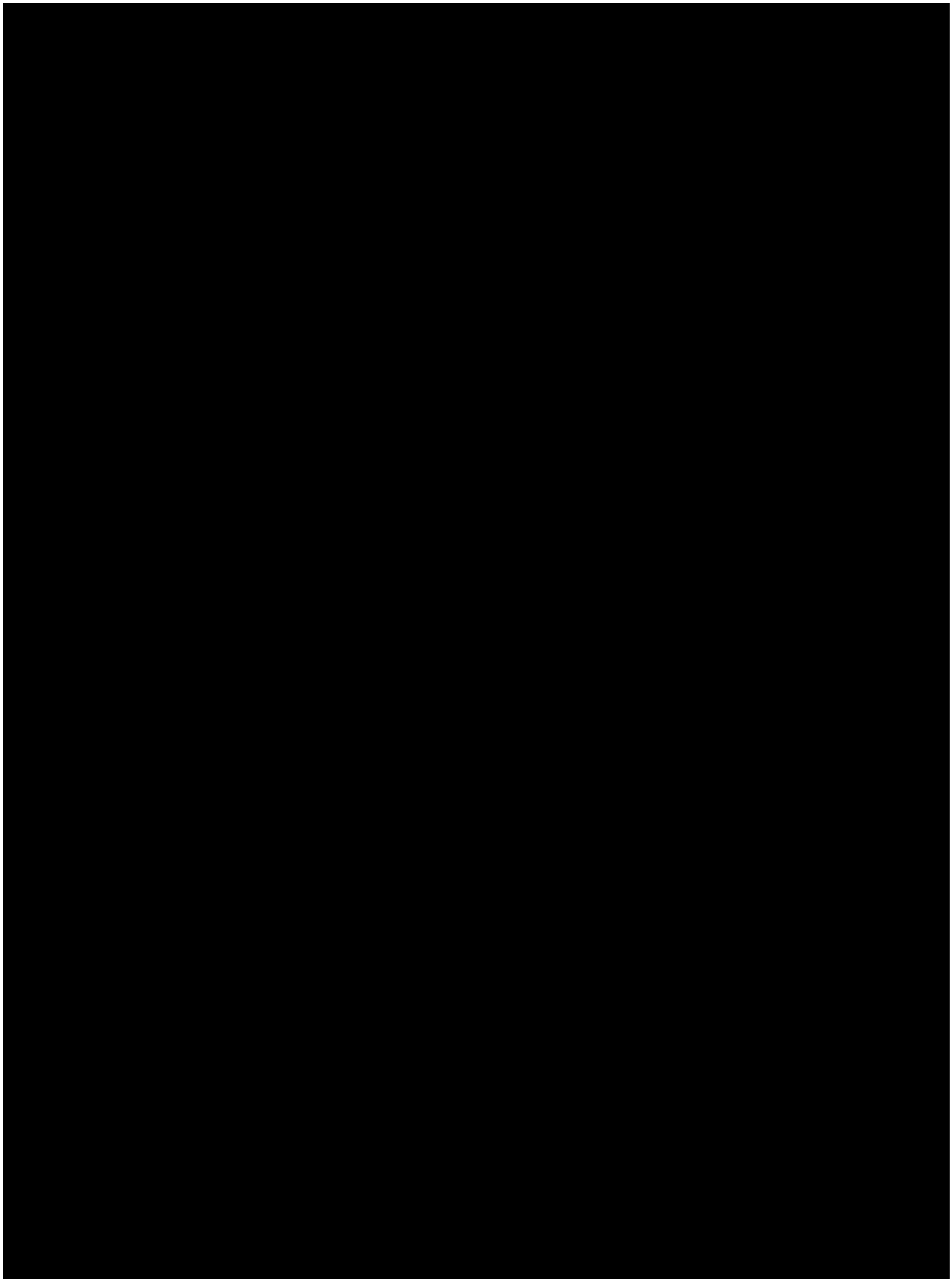


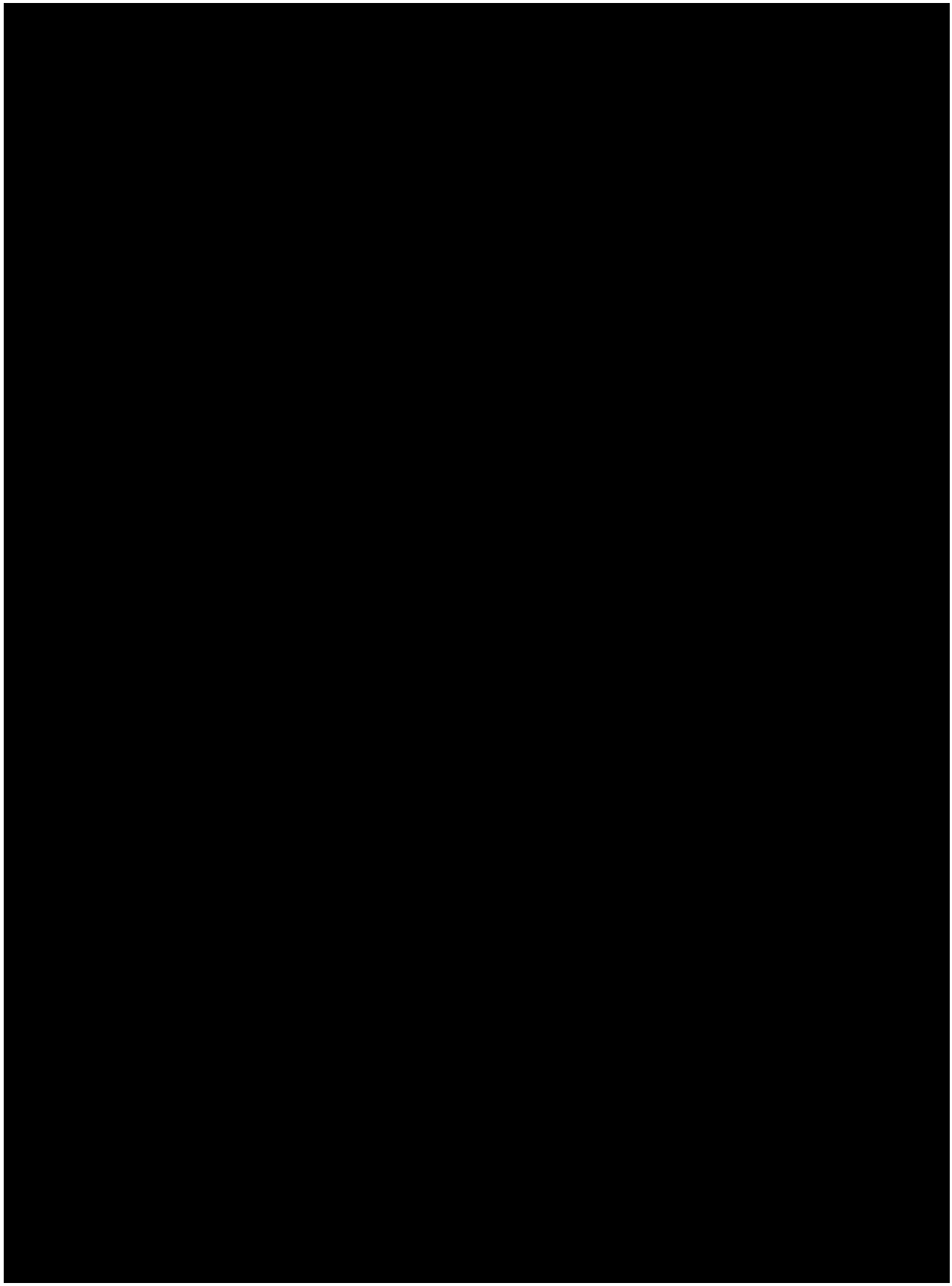


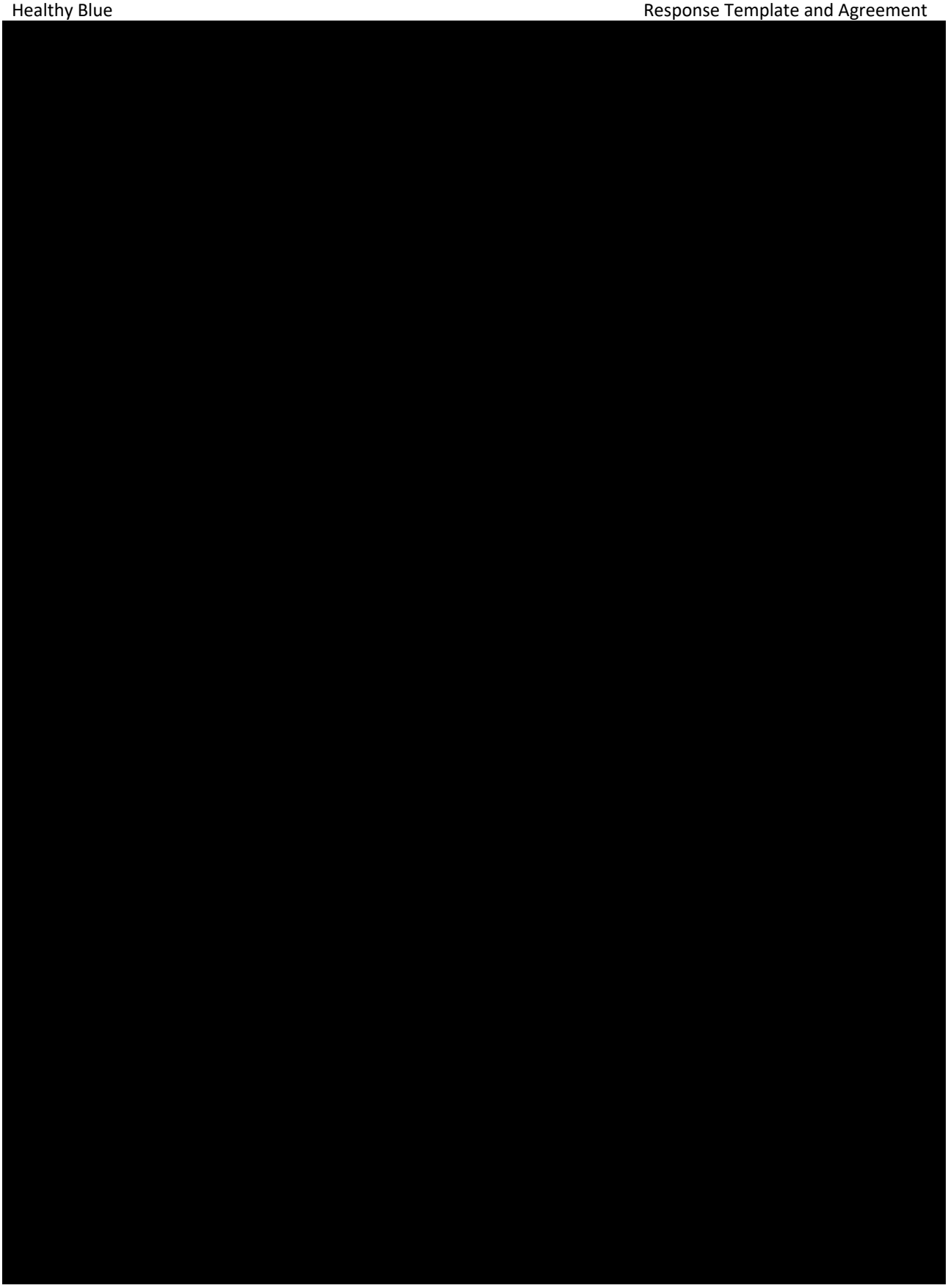


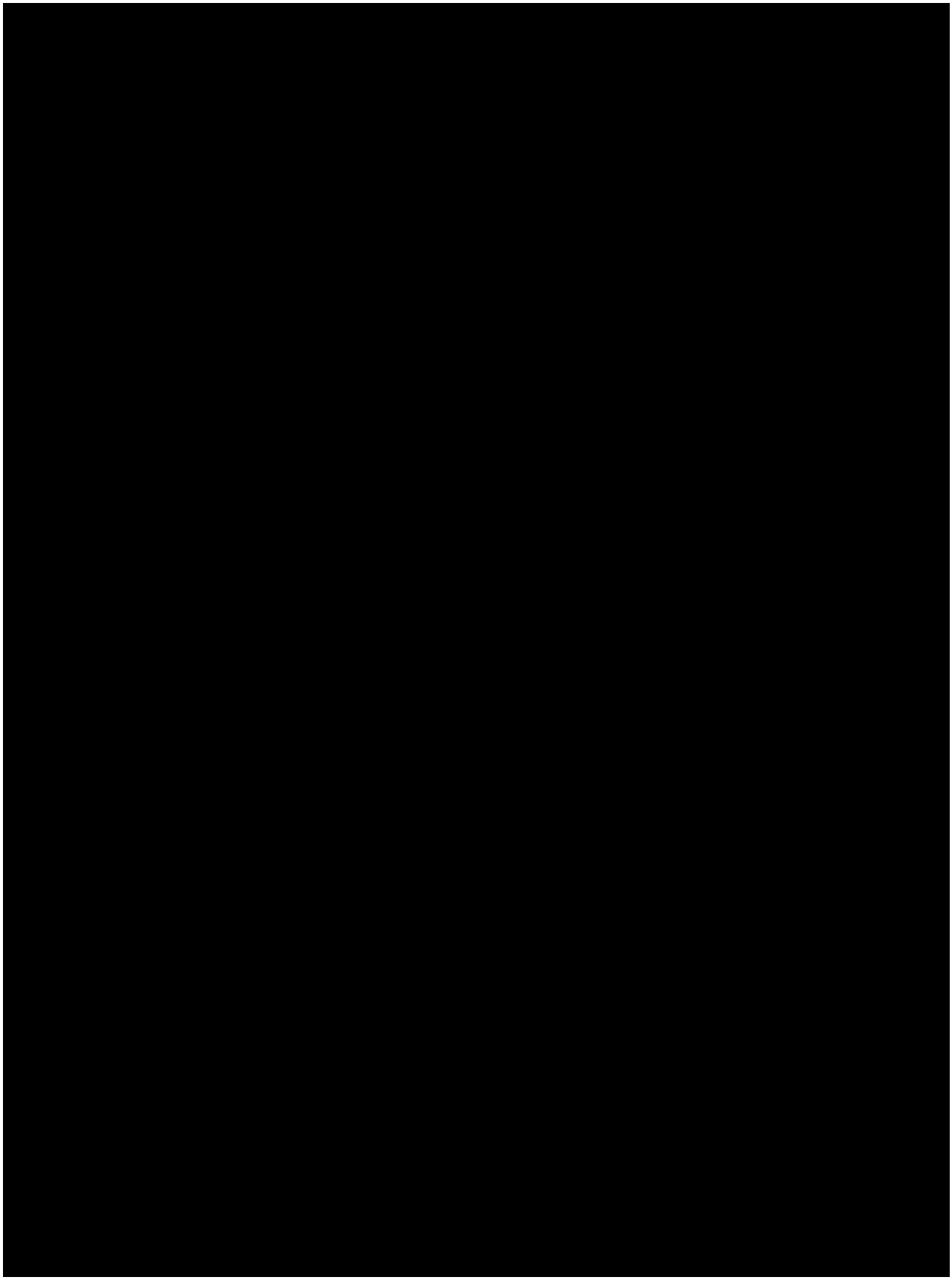


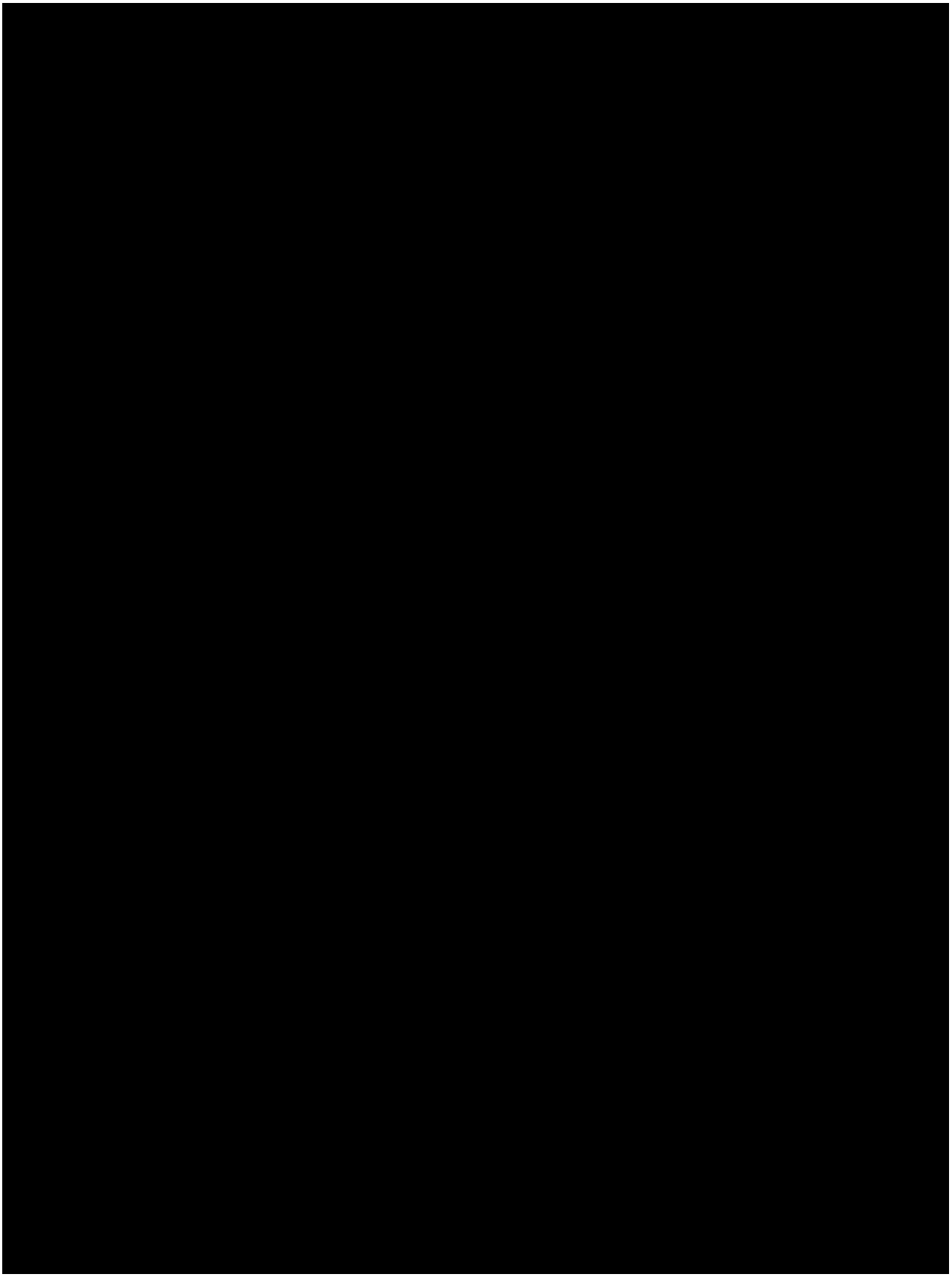


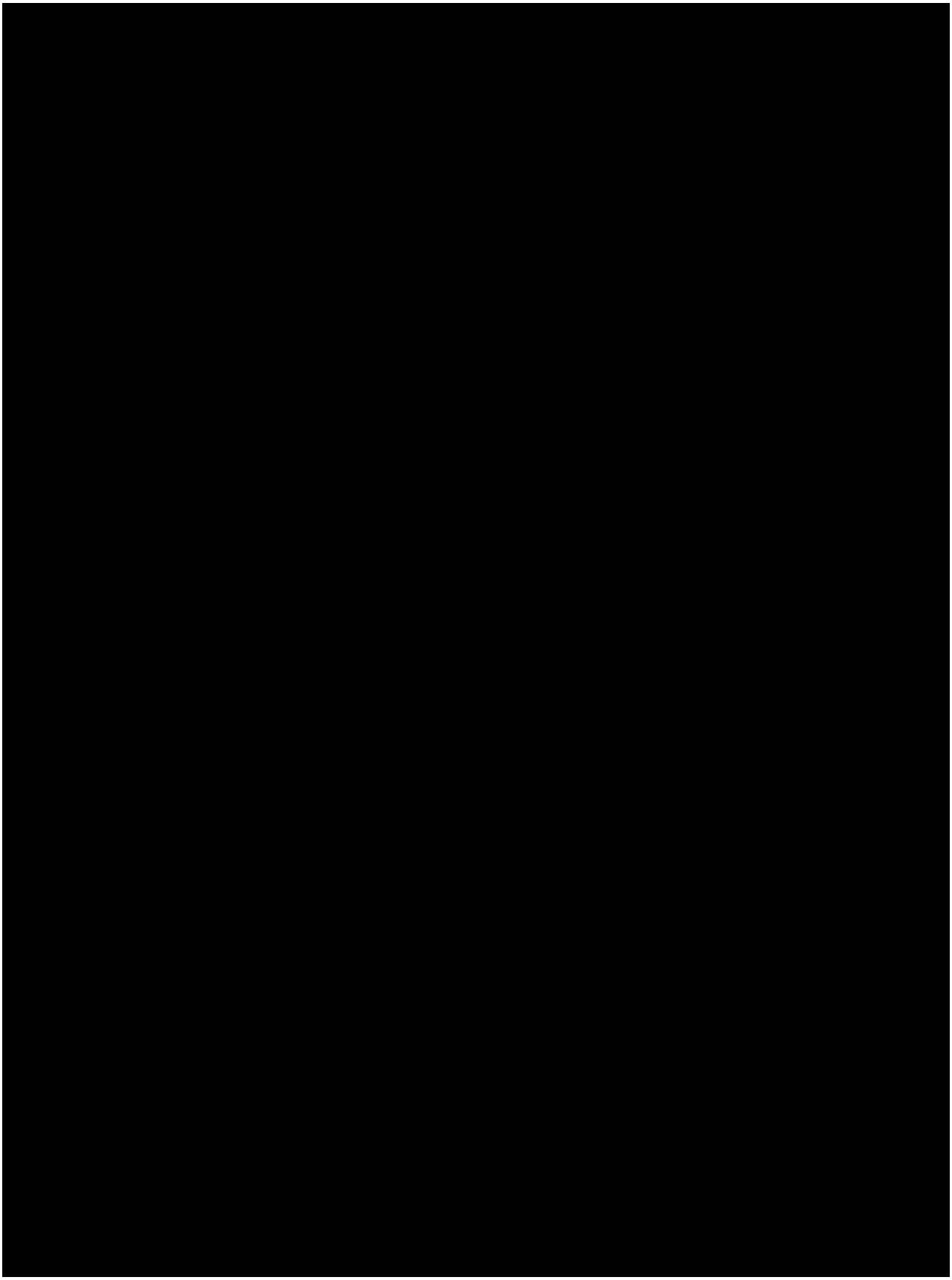


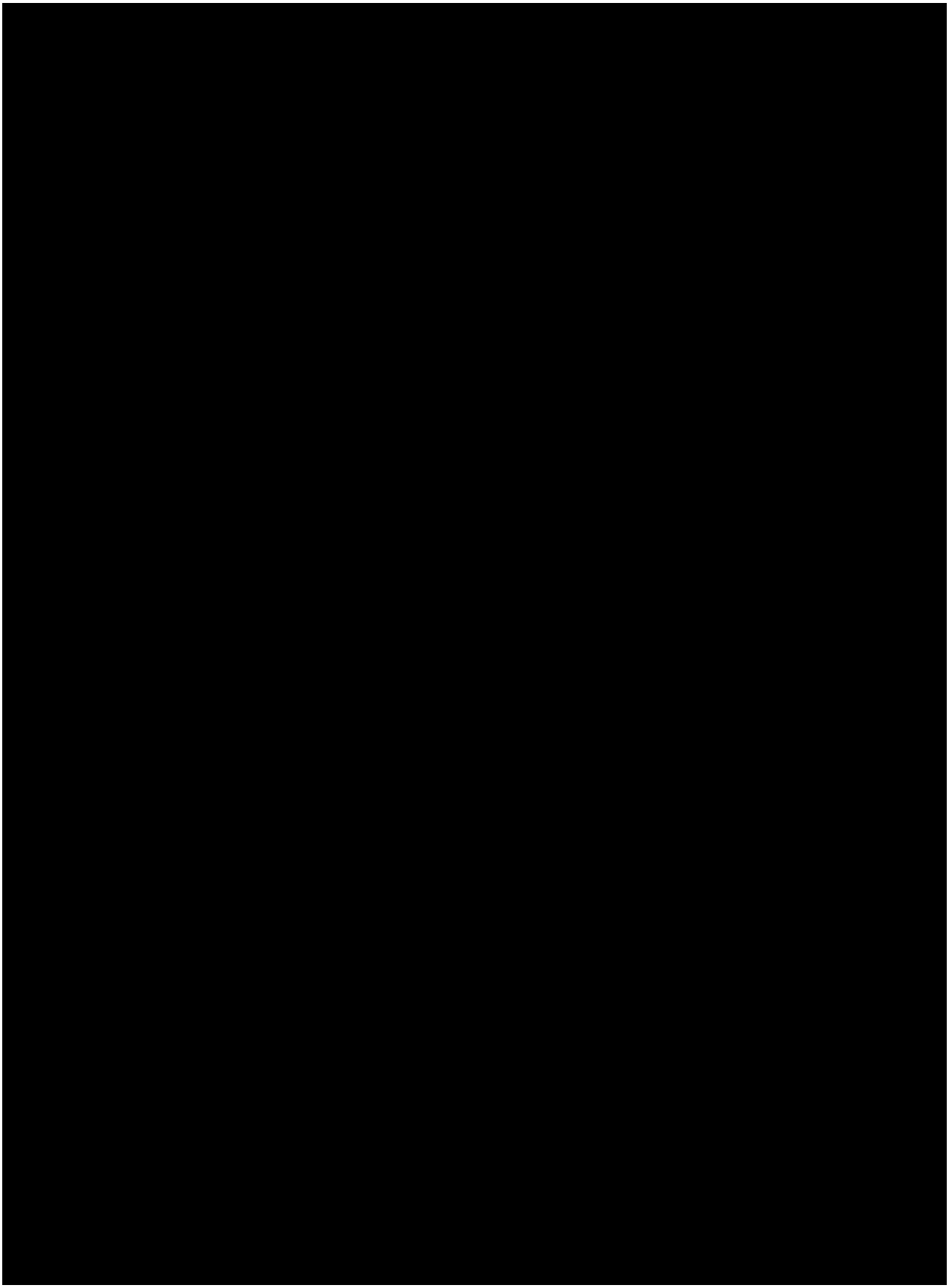


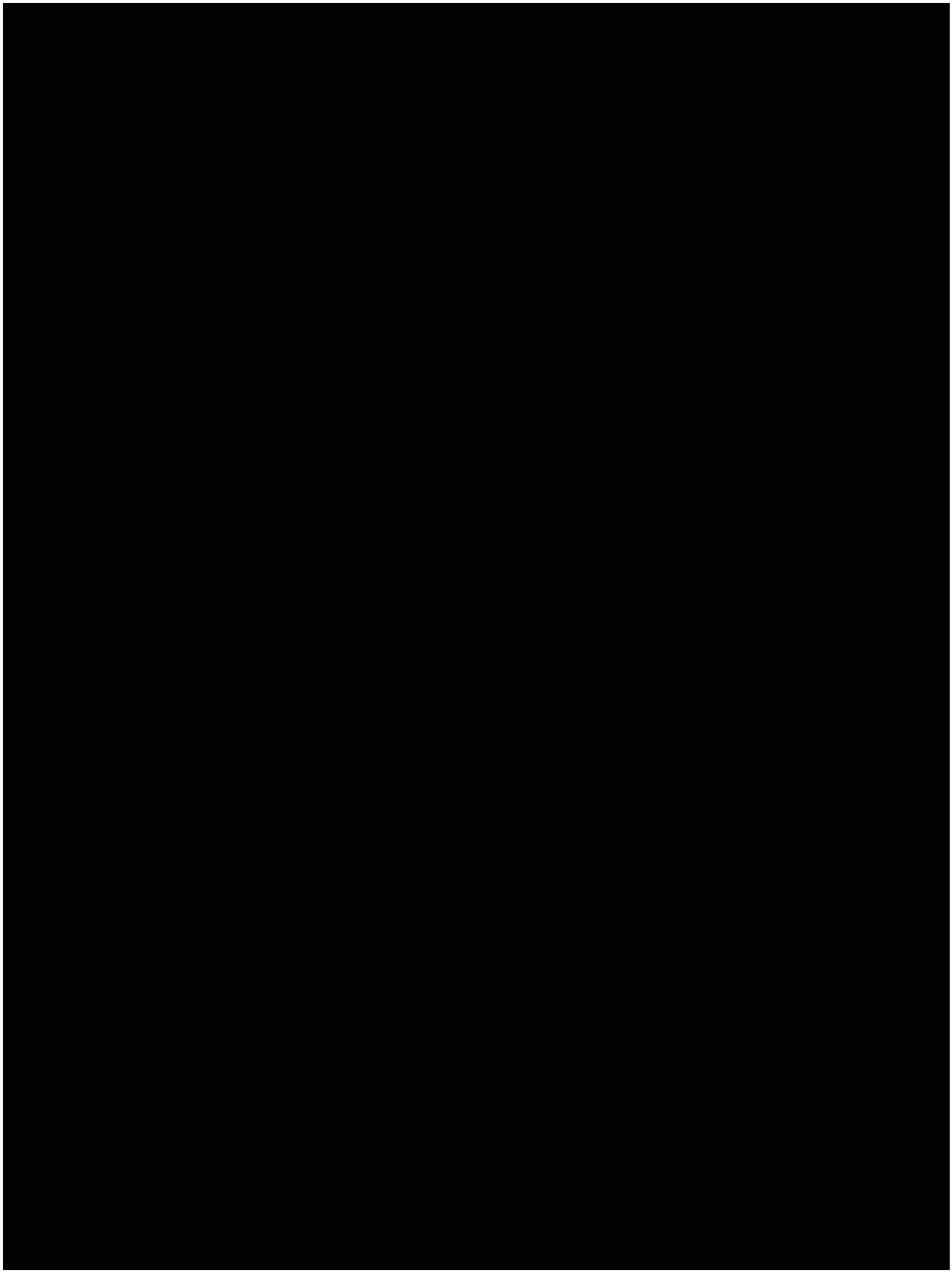


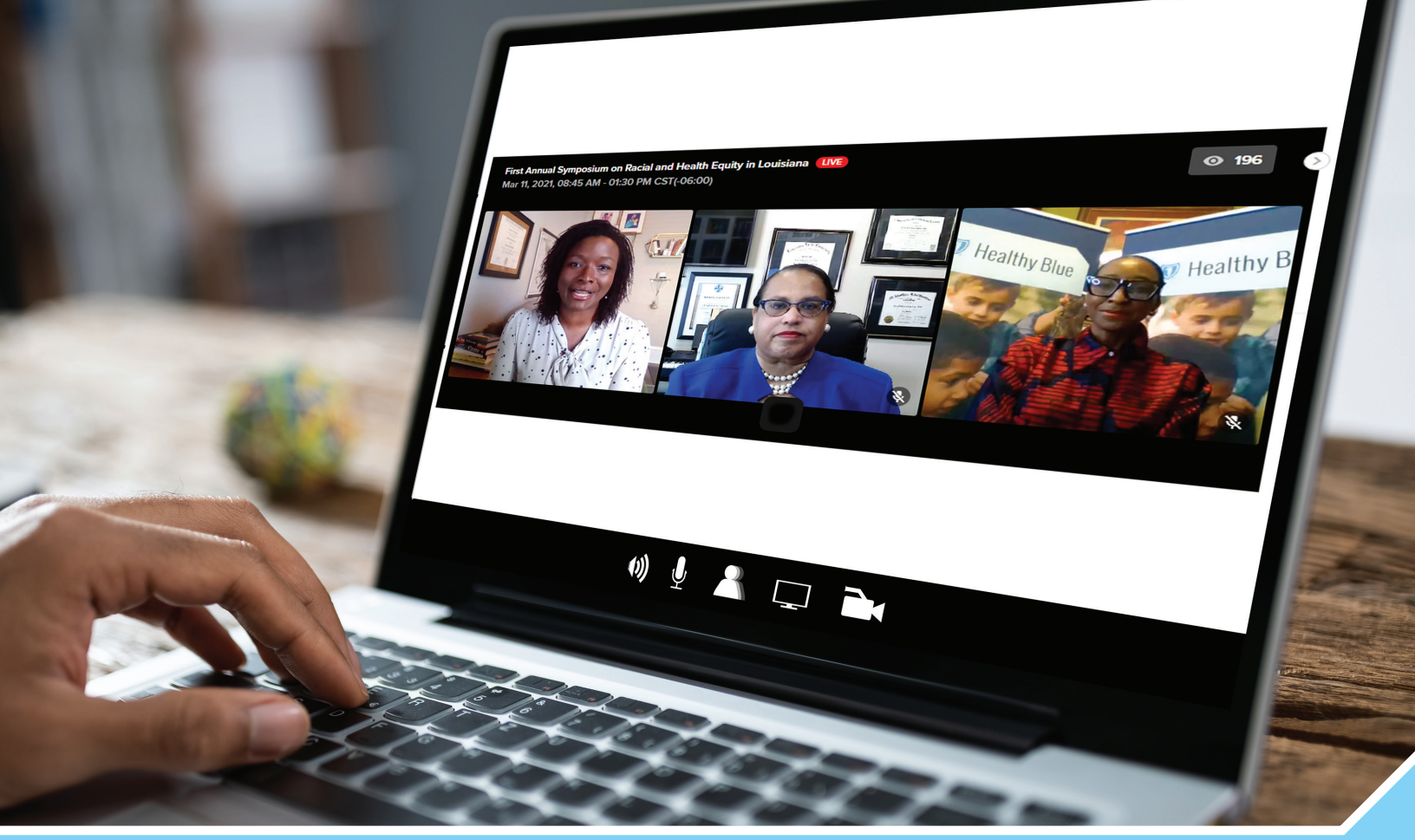













### Promoting Health and Racial Equity in Louisiana

Healthy Blue teamed up with the Louisiana Public Health Institute (LPHI) to launch the inaugural Symposium on Racial and Health Equity in March 2021 with the theme of "Partnerships in Action: Collectively Achieving Racial Equity to Improve the Health of Our Community." At the conclusion of the Symposium, LPHI and Healthy Blue offered participants the opportunity to join a coalition dedicated to ending institutional racism in Louisiana. Healthy Blue will continue this commitment by sponsoring the first Racial Equity Learning Lab later this year.

# Attachment 2.5.5.1.1-1

## Audited Financial Statements

Healthy Blue

## Attachment 2.5.5.1.1-1: Audited Financial Statements

Attachment 2.5.5.1.1-1 includes the following:

- Attachment 2.5.5.1.1-1a: Audited Financial Statements for Community Care Health Plan of Louisiana, Inc. dba Healthy Blue
  - Attachment 2.5.5.1.1-1a.1: Healthy Blue 2018 Audited Financial Statement
  - Attachment 2.5.5.1.1-1a.2: Healthy Blue 2019 Audited Financial Statement
  - Attachment 2.5.5.1.1-1a.3: Healthy Blue 2020 Audited Financial Statement
- Attachment 2.5.5.1.1-1b: SEC Filings for Anthem, Inc.
  - Attachment 2.5.5.1.1-1b.1: Anthem, Inc. 2018 10-K
  - Attachment 2.5.5.1.1-1b.2: Anthem, Inc. 2019 10-K
  - Attachment 2.5.5.1.1-1b.3: Anthem, Inc. 2020 10-K
- Attachment 2.5.5.1.1-1c: Audited Financial Statements for BCBSLA
  - Attachment 2.5.5.1.1-1c.1: BCBSLA 2018 Audited Financial Statement
  - Attachment 2.5.5.1.1-1c.2: BCBSLA 2019 Audited Financial Statement
  - Attachment 2.5.5.1.1-1c.3: BCBSLA 2020 Audited Financial Statement

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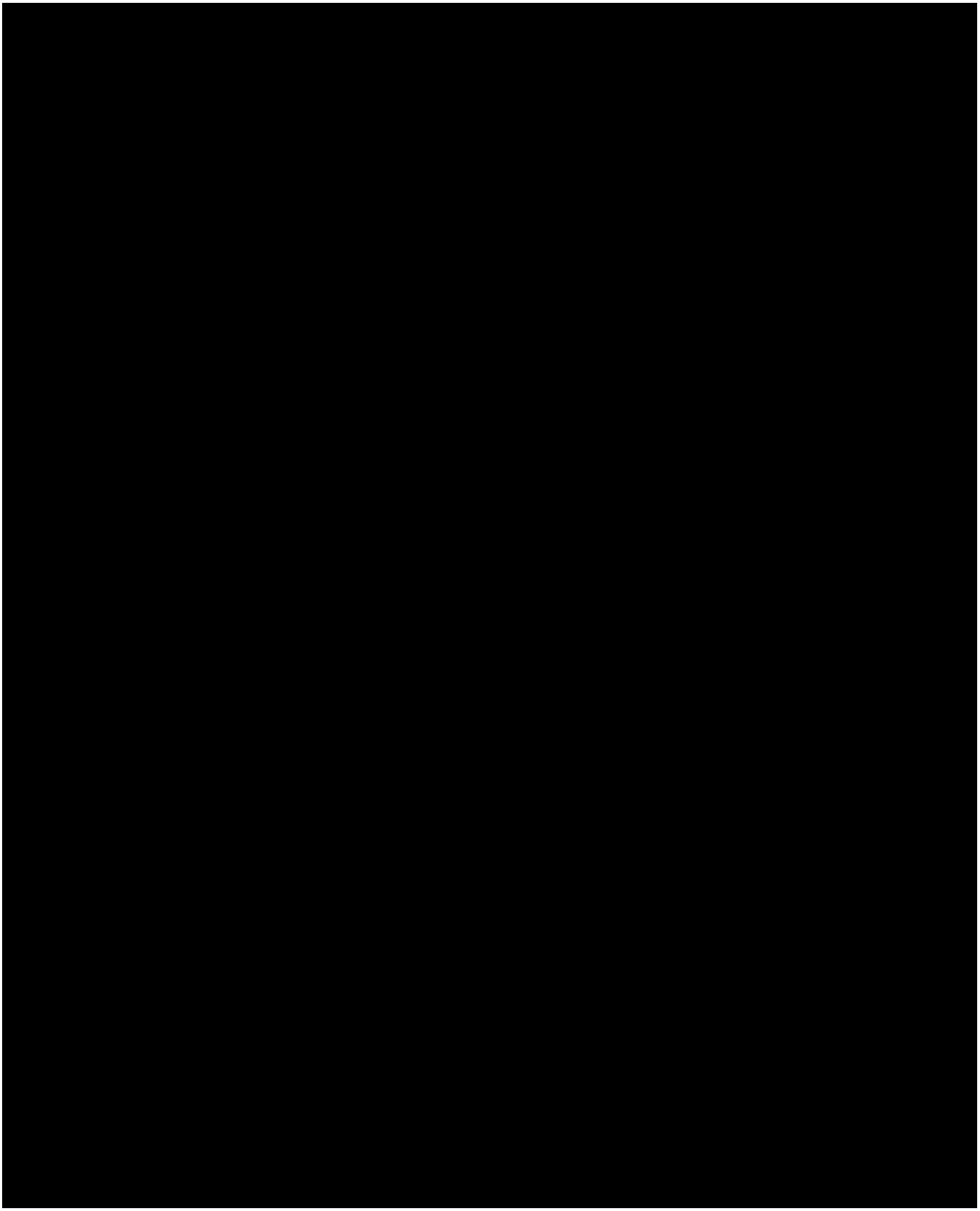
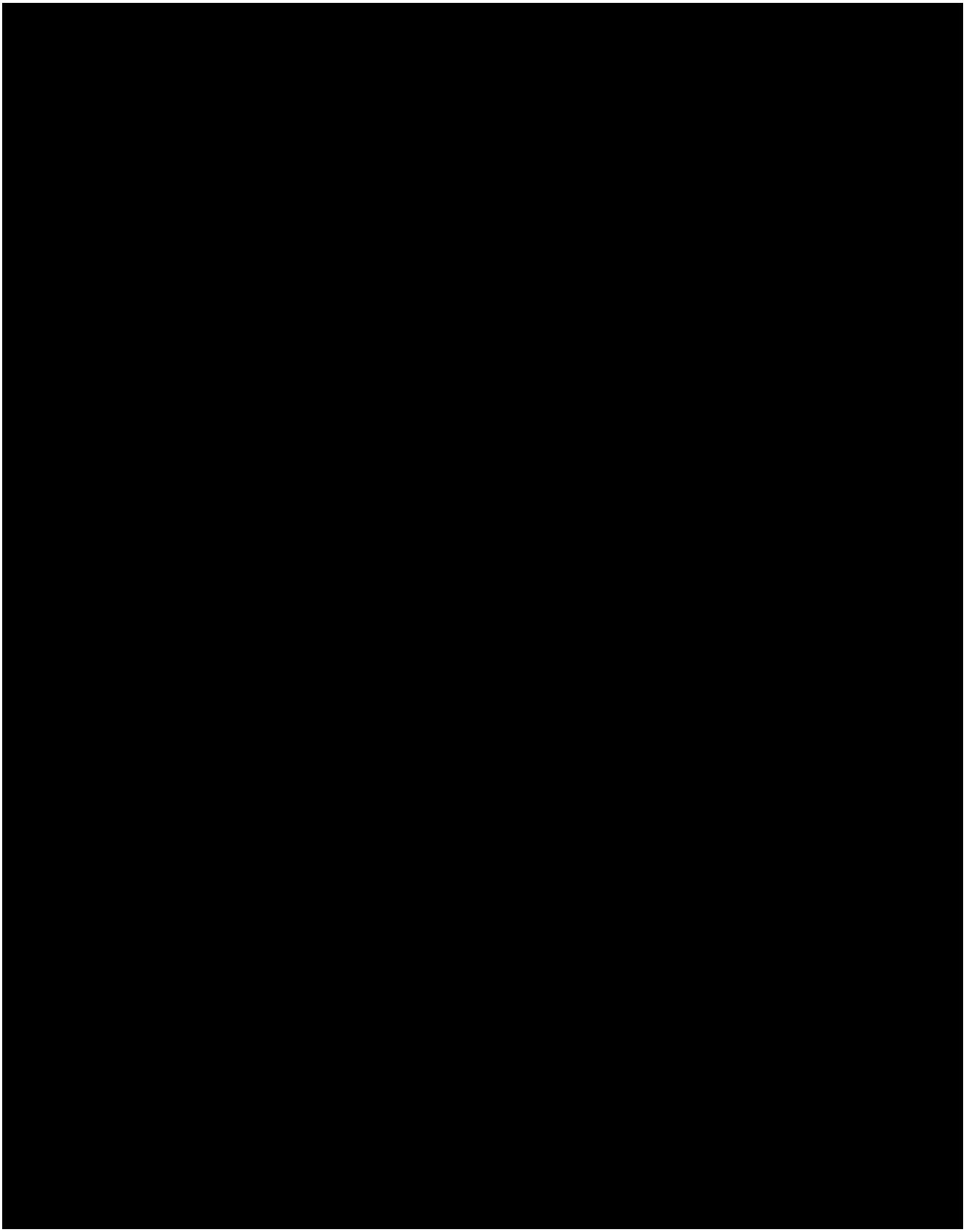
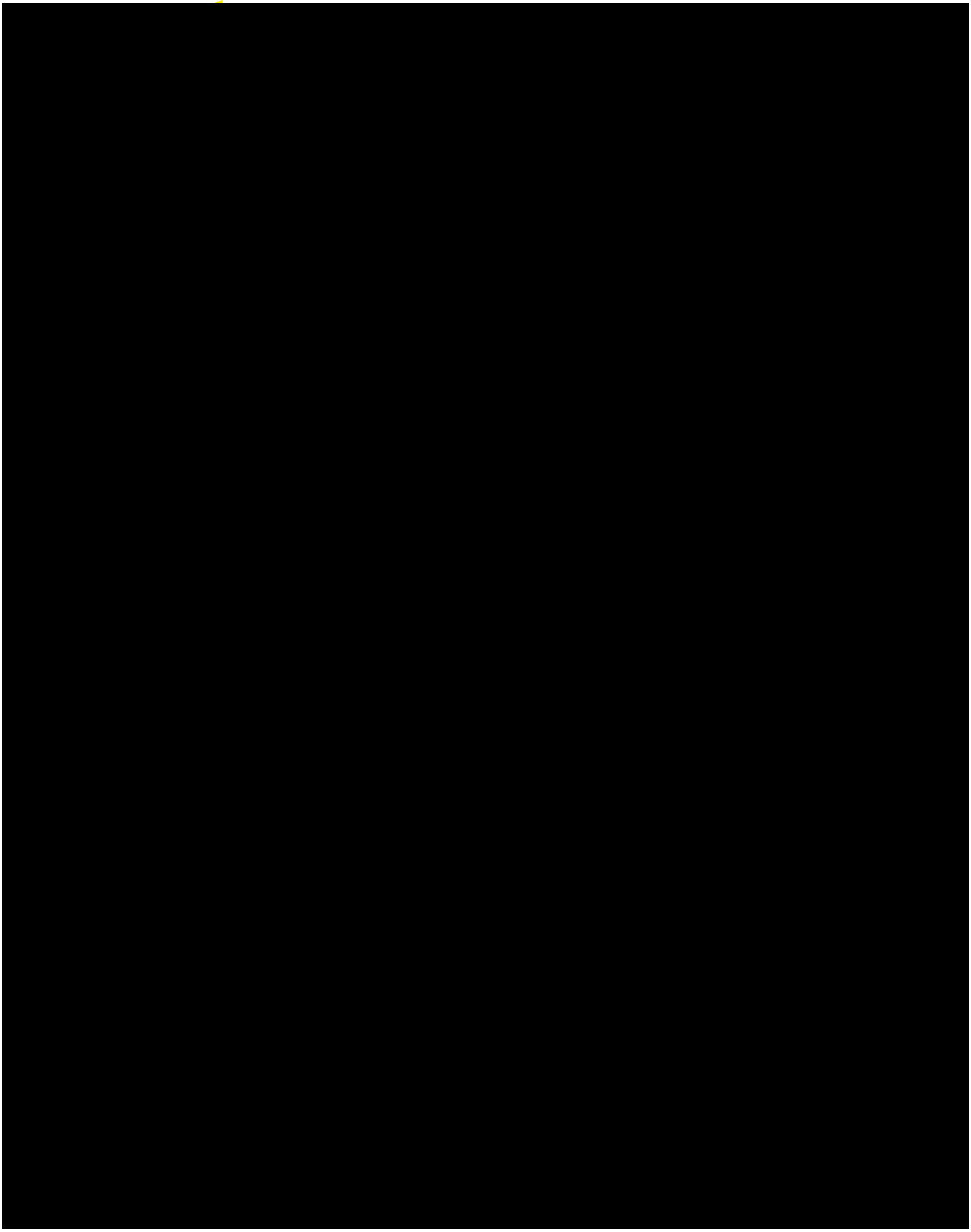
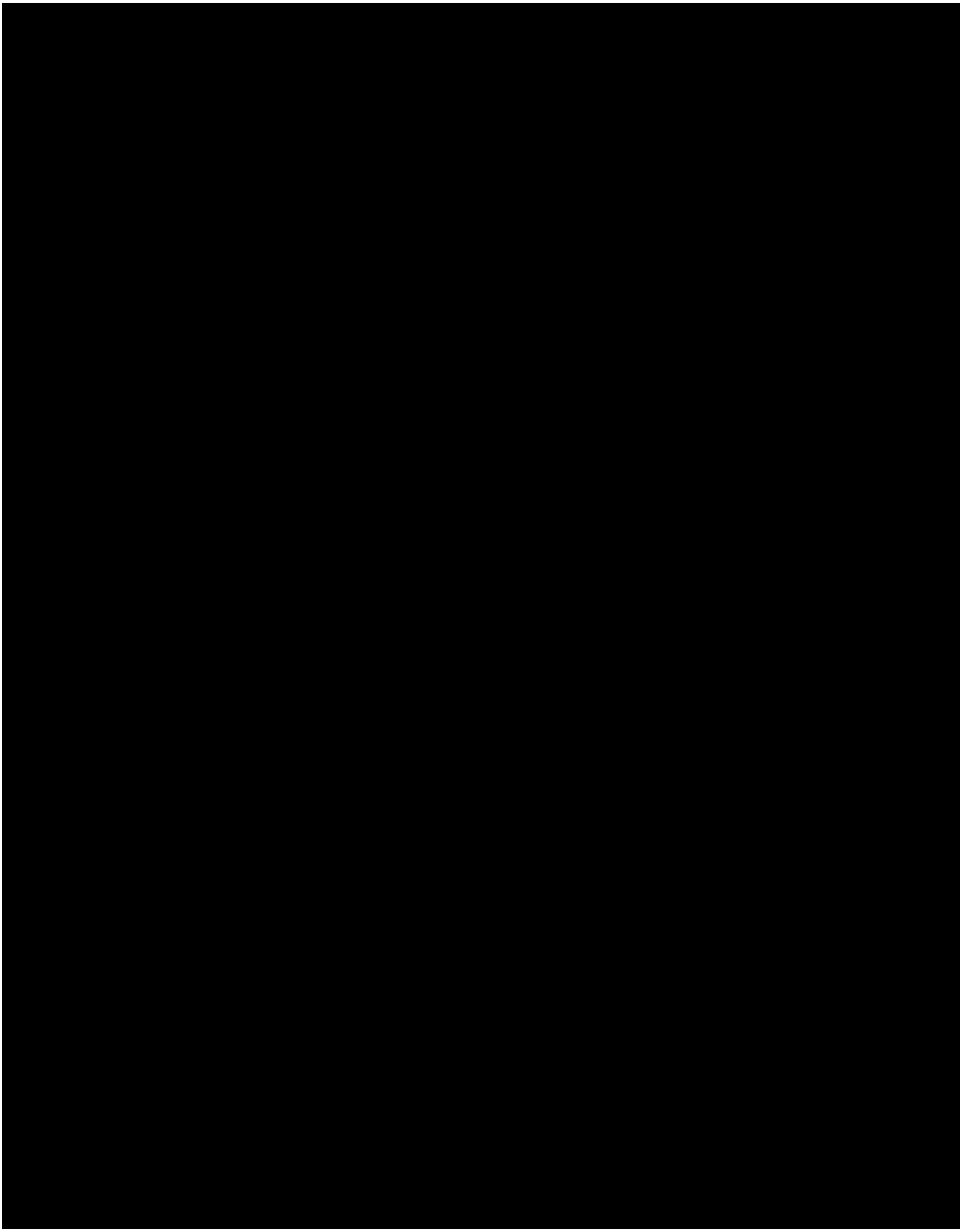
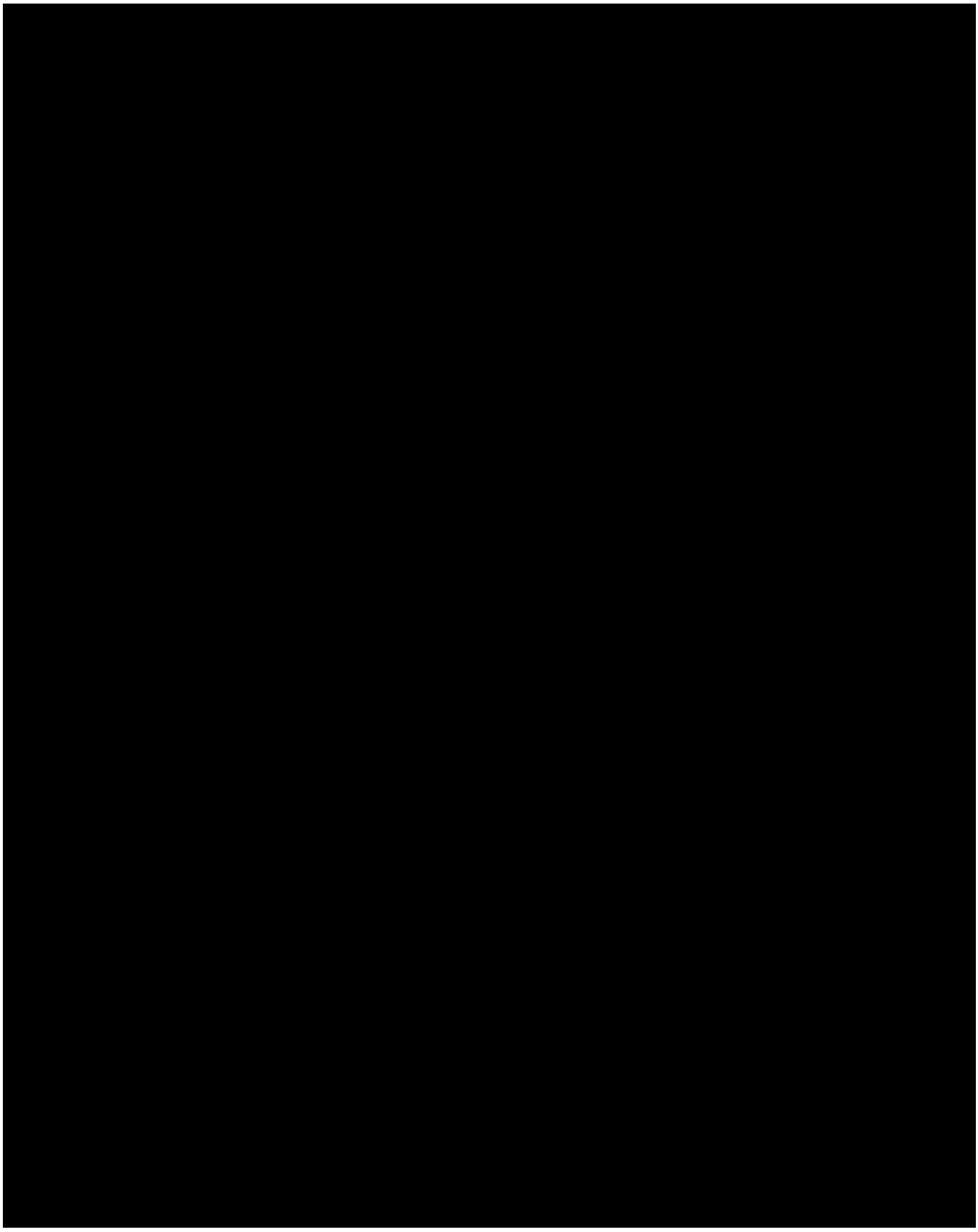
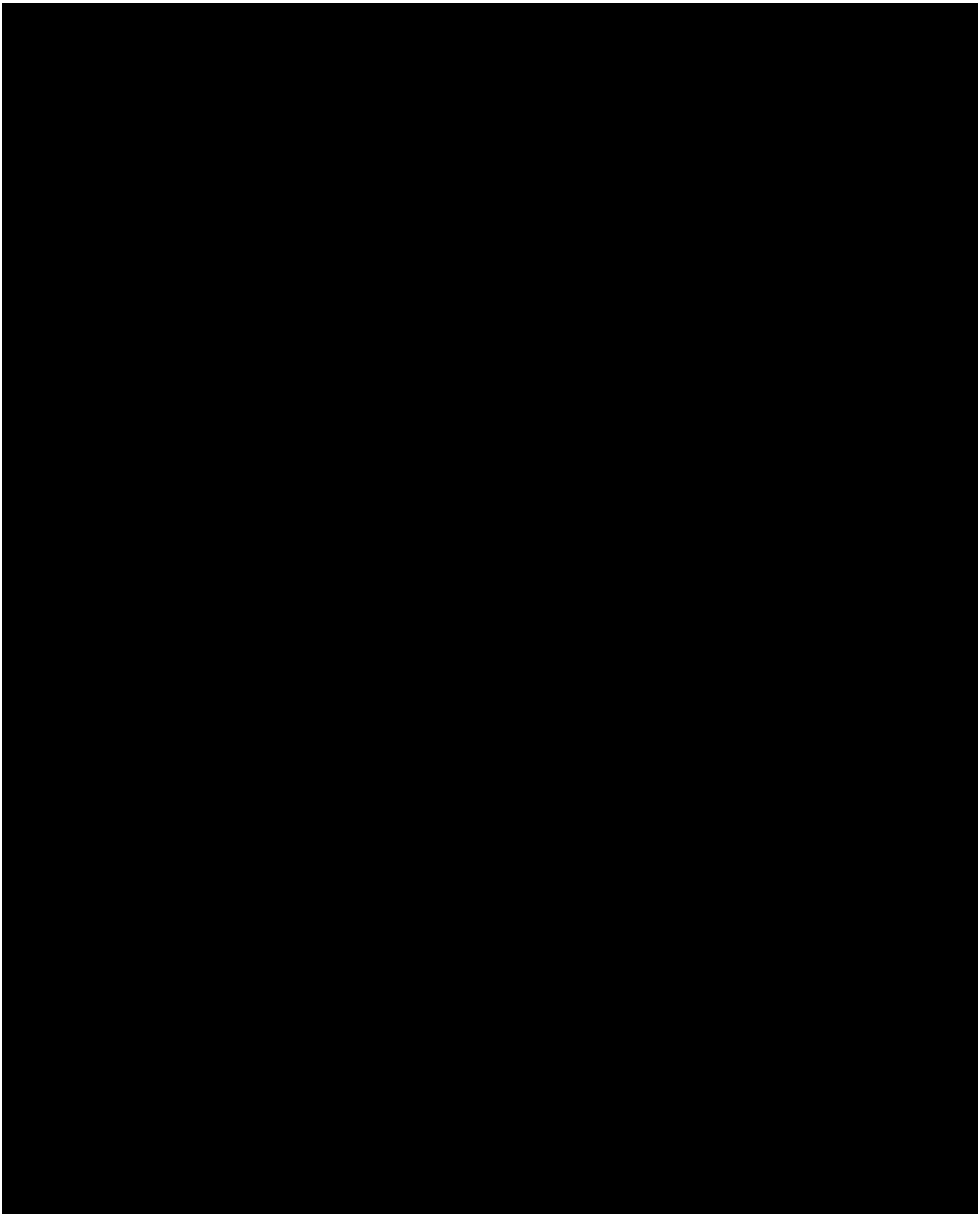


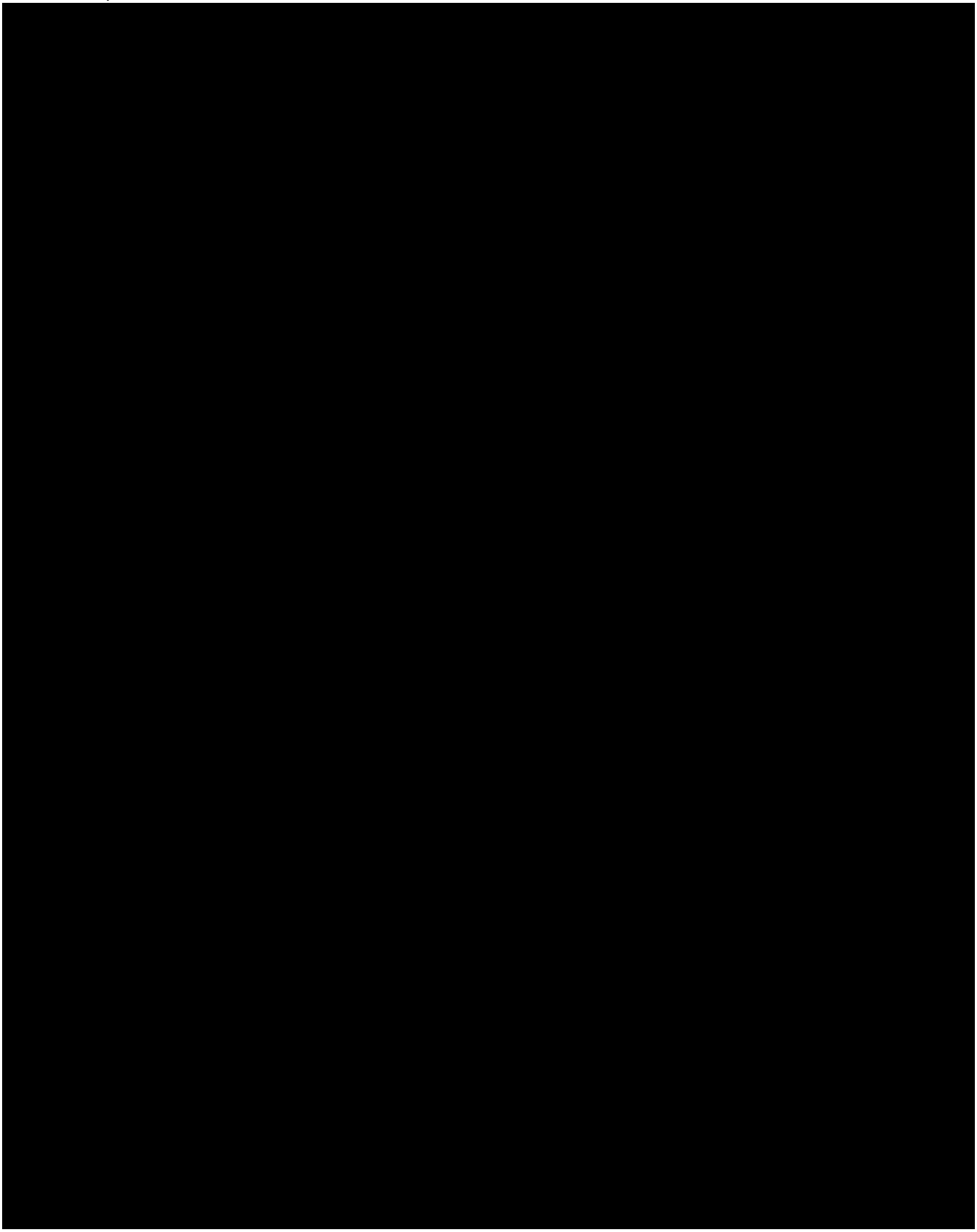


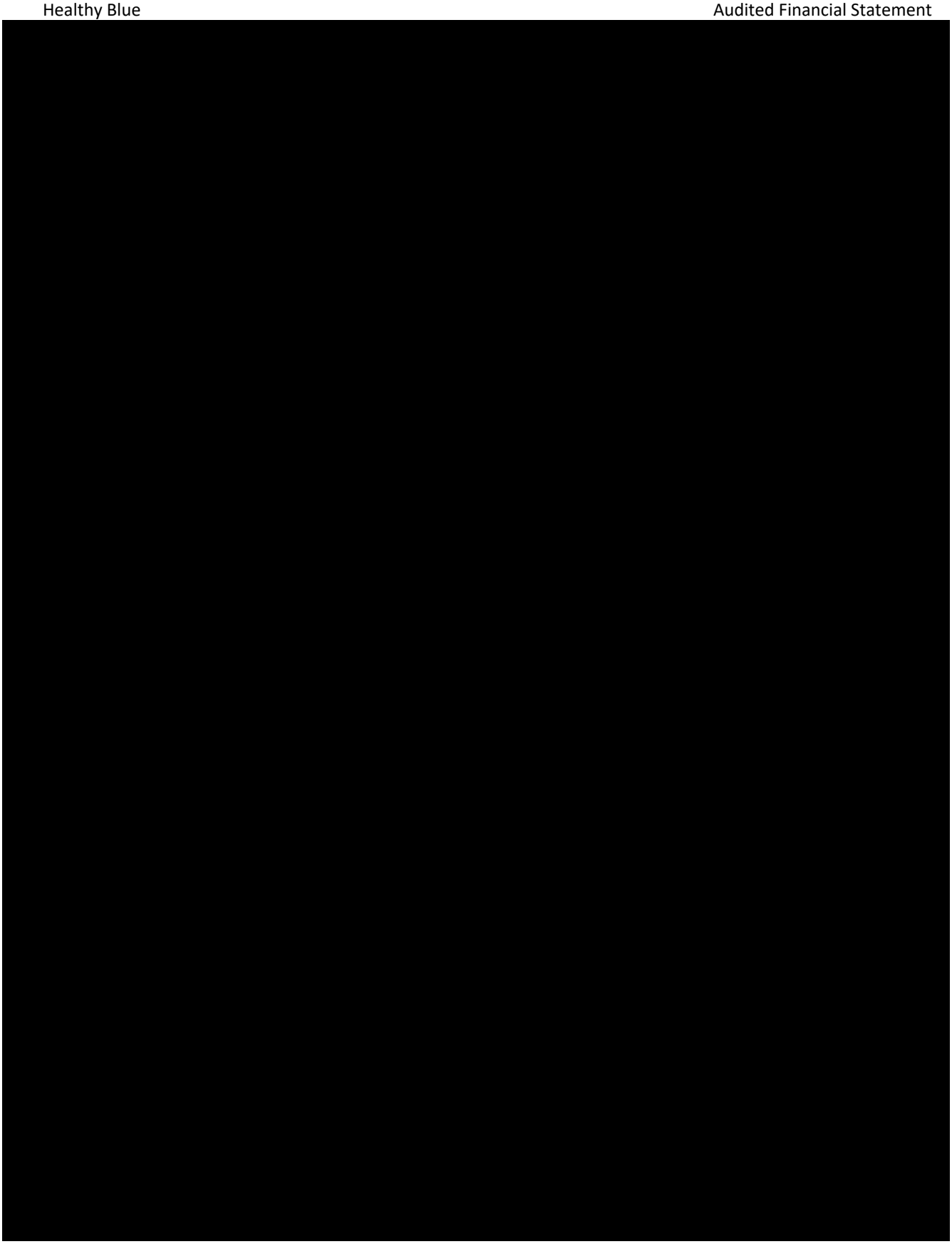


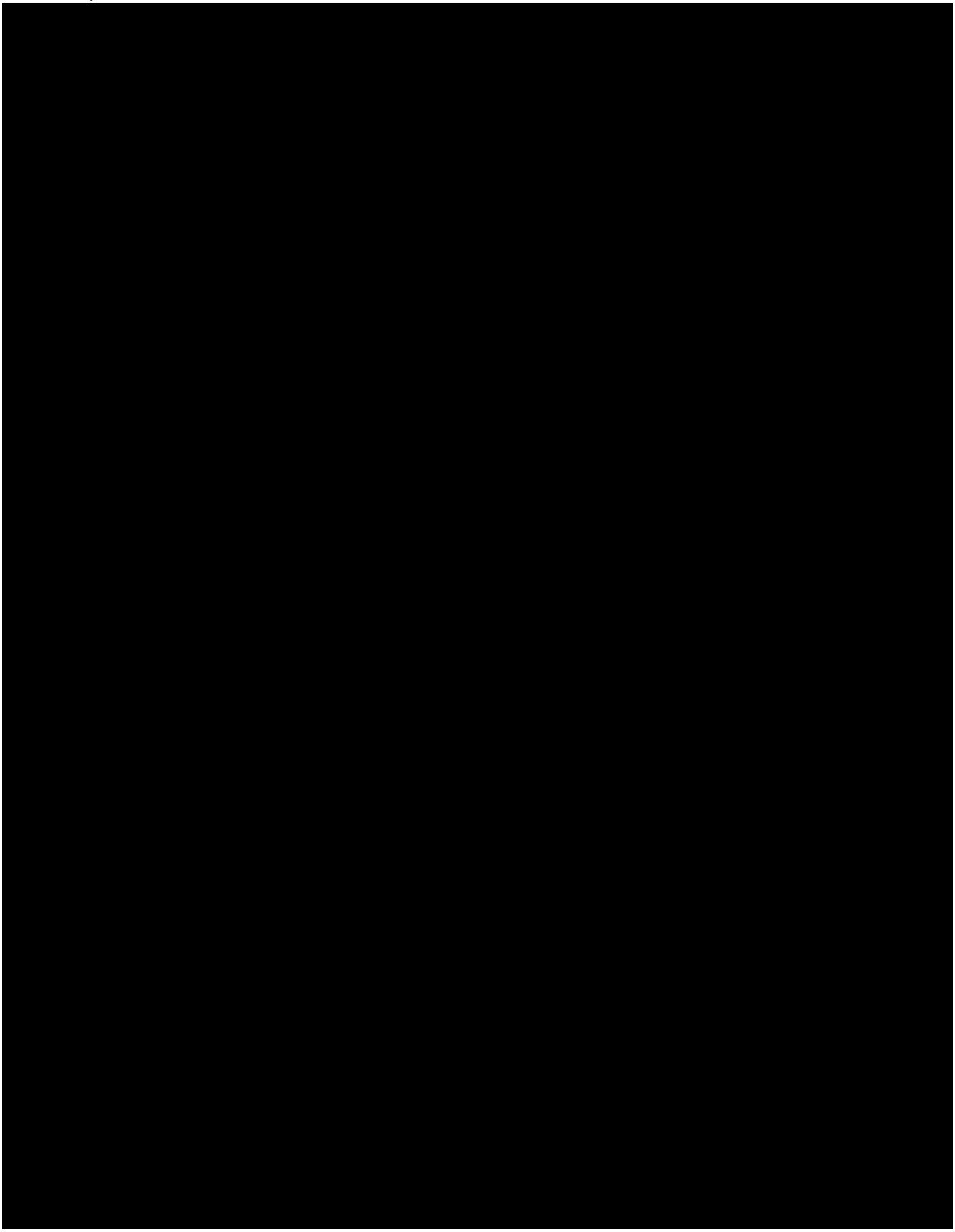


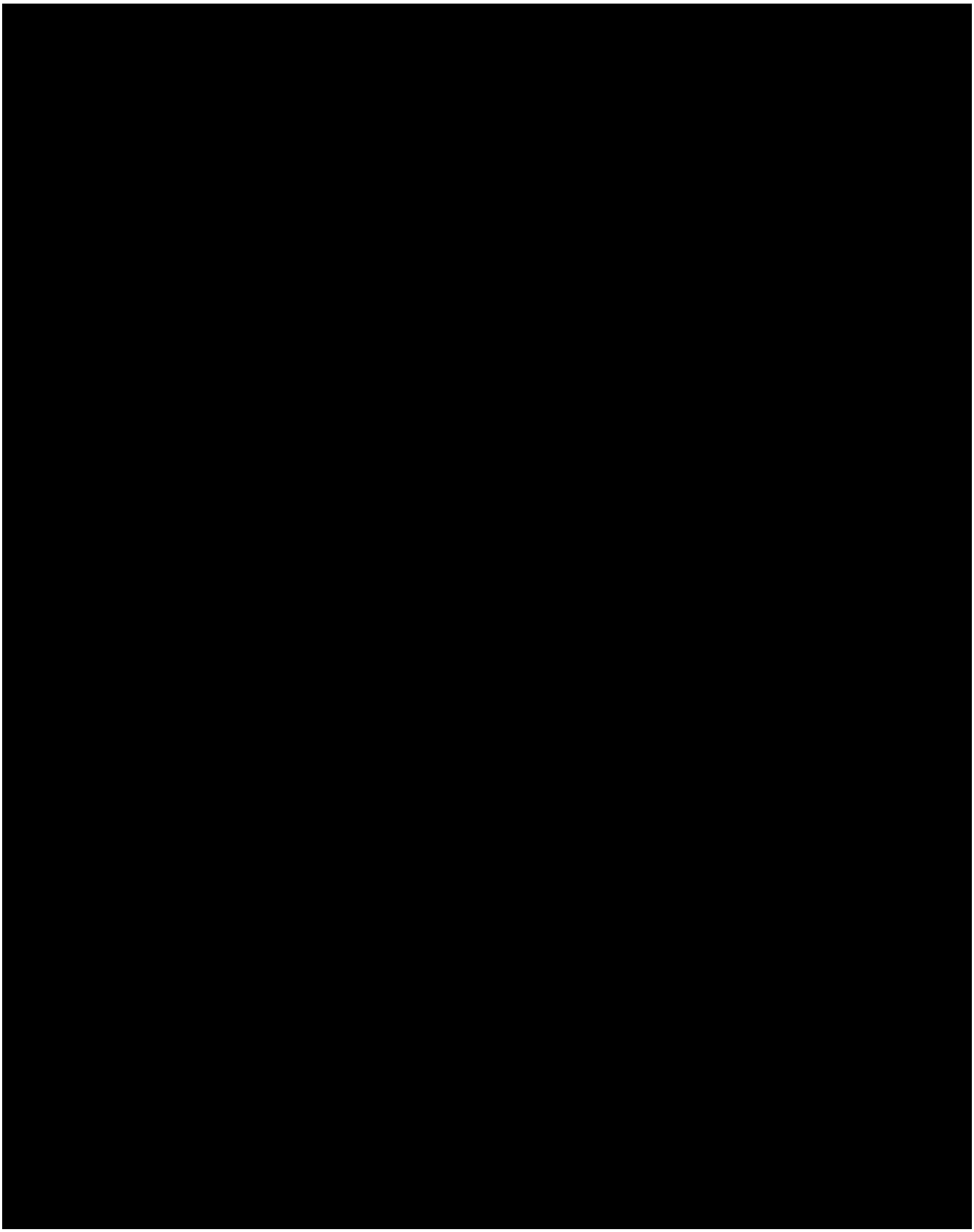


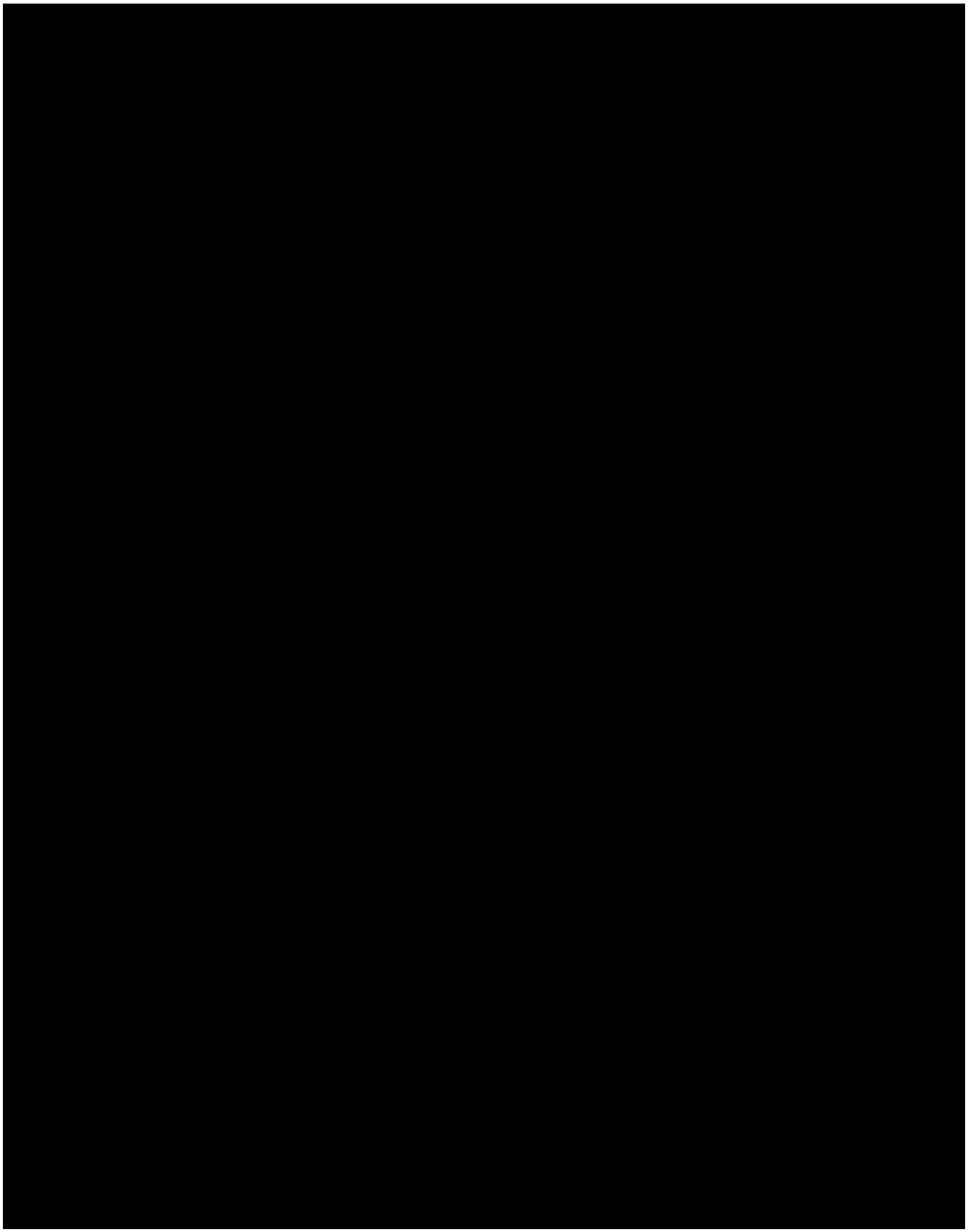


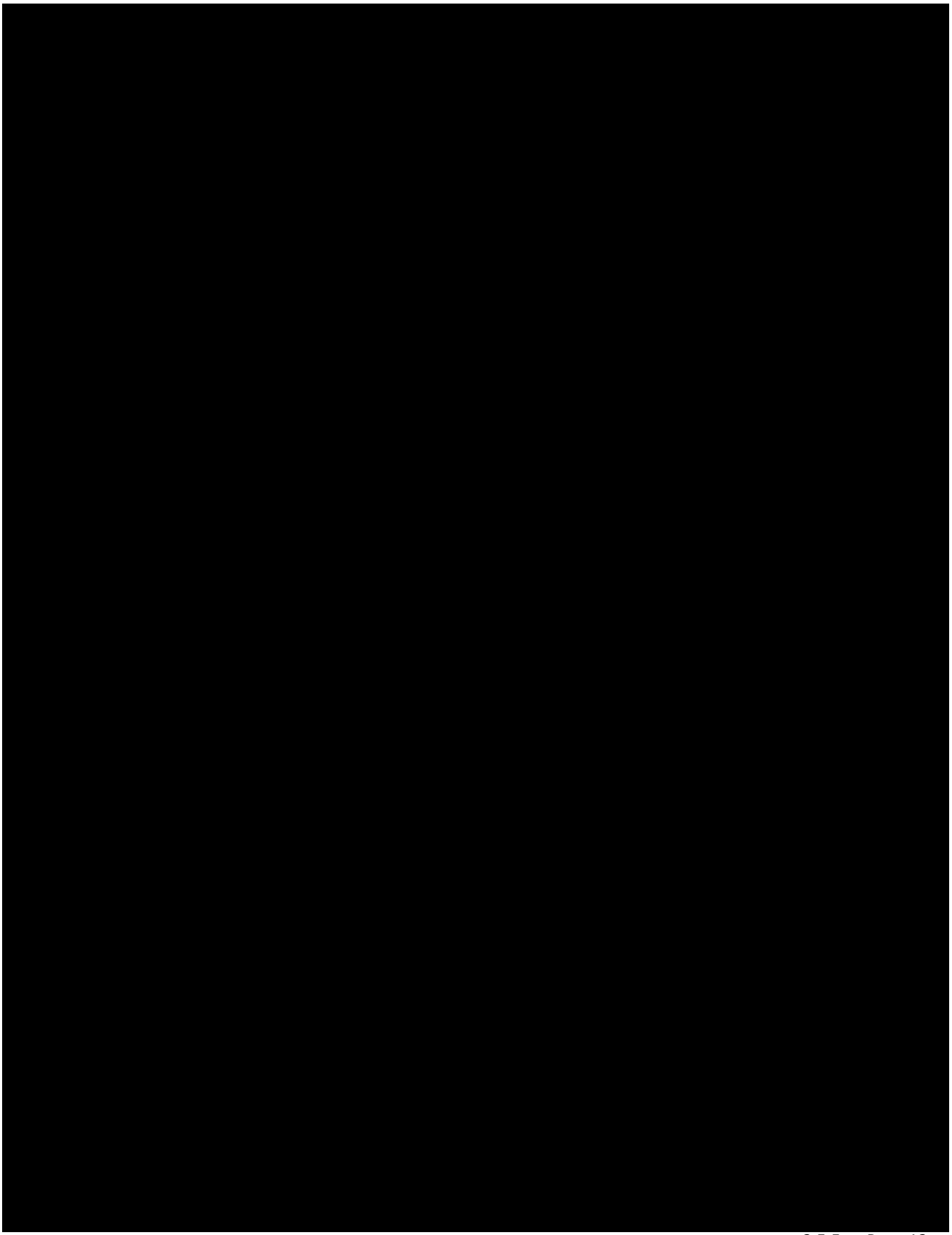


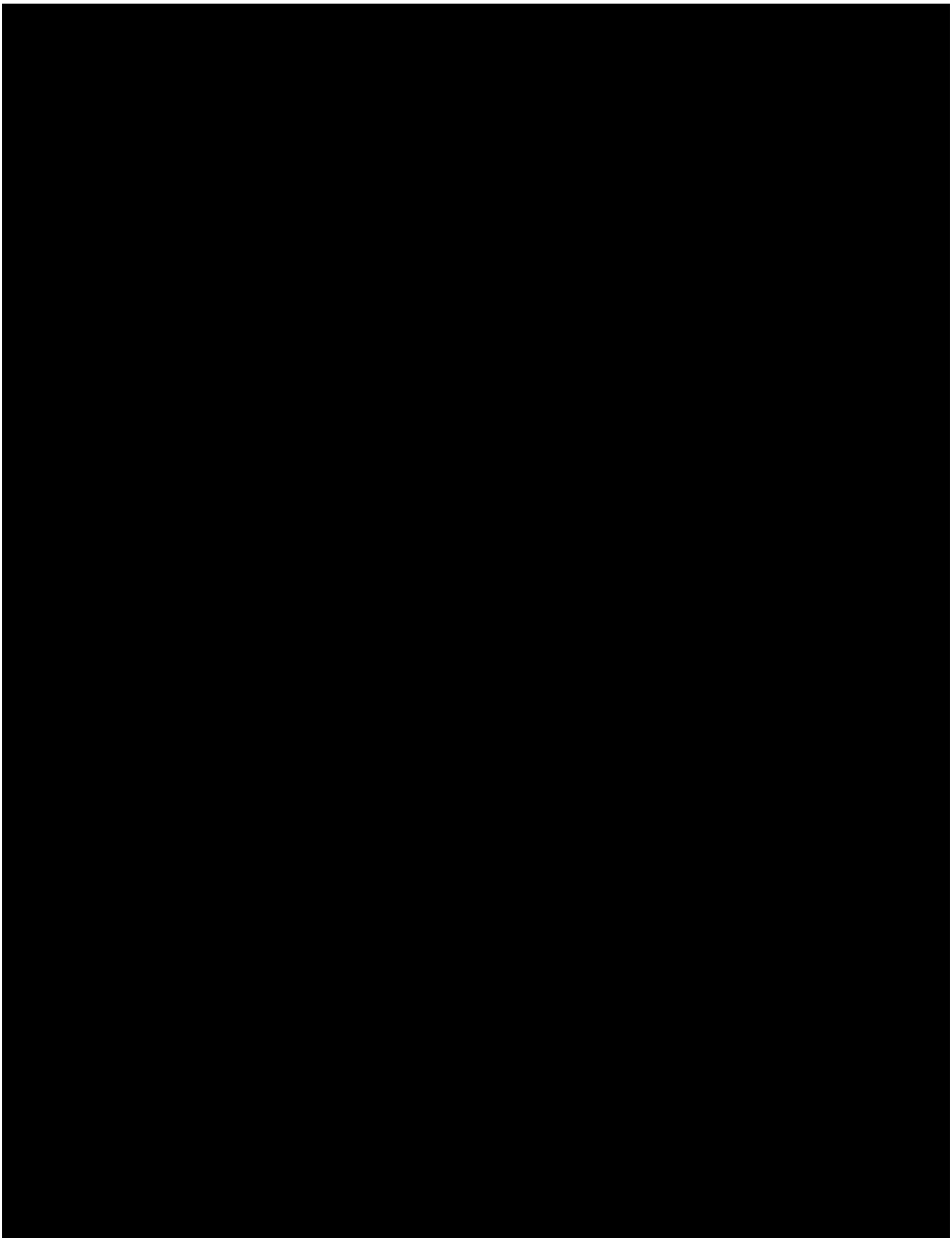


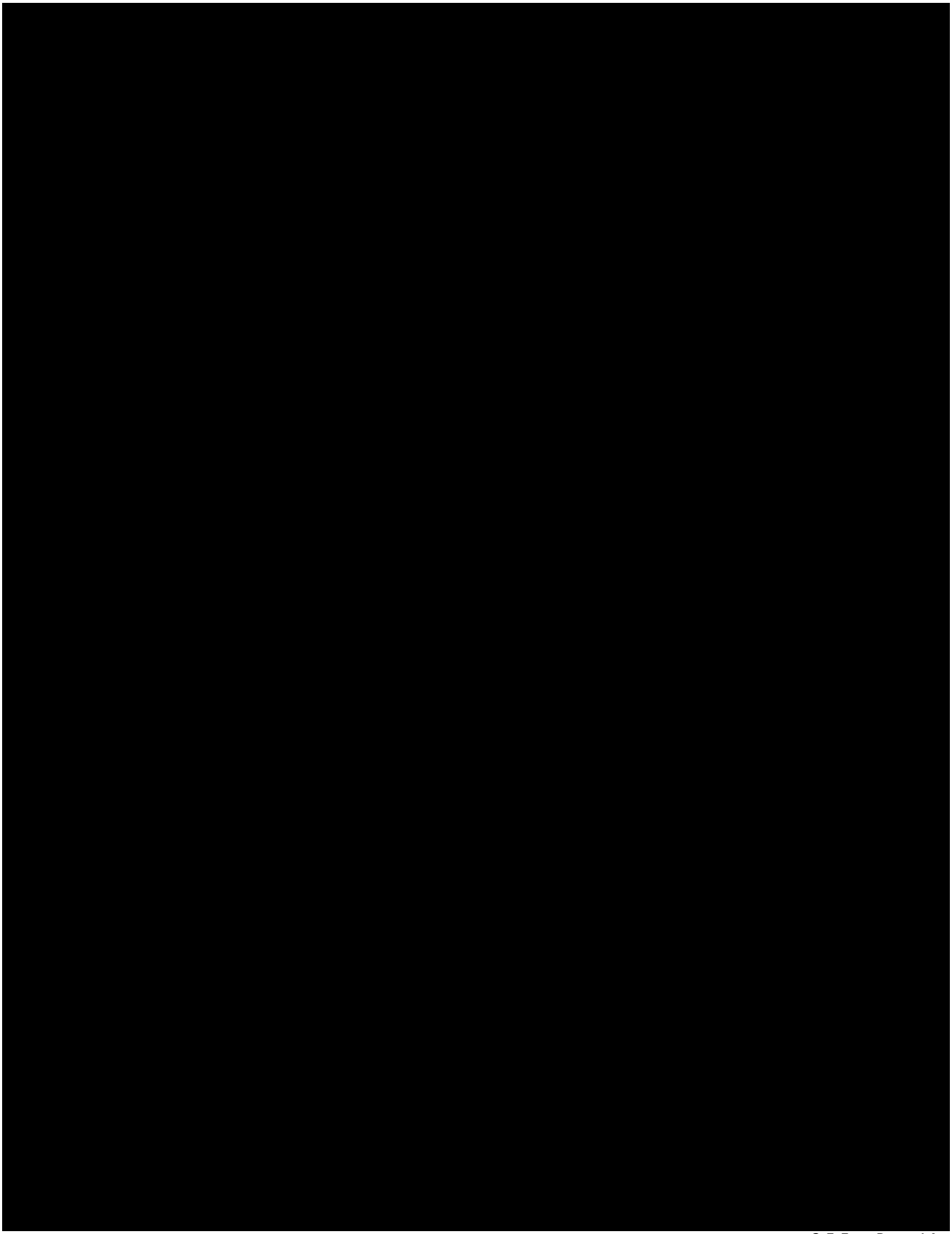


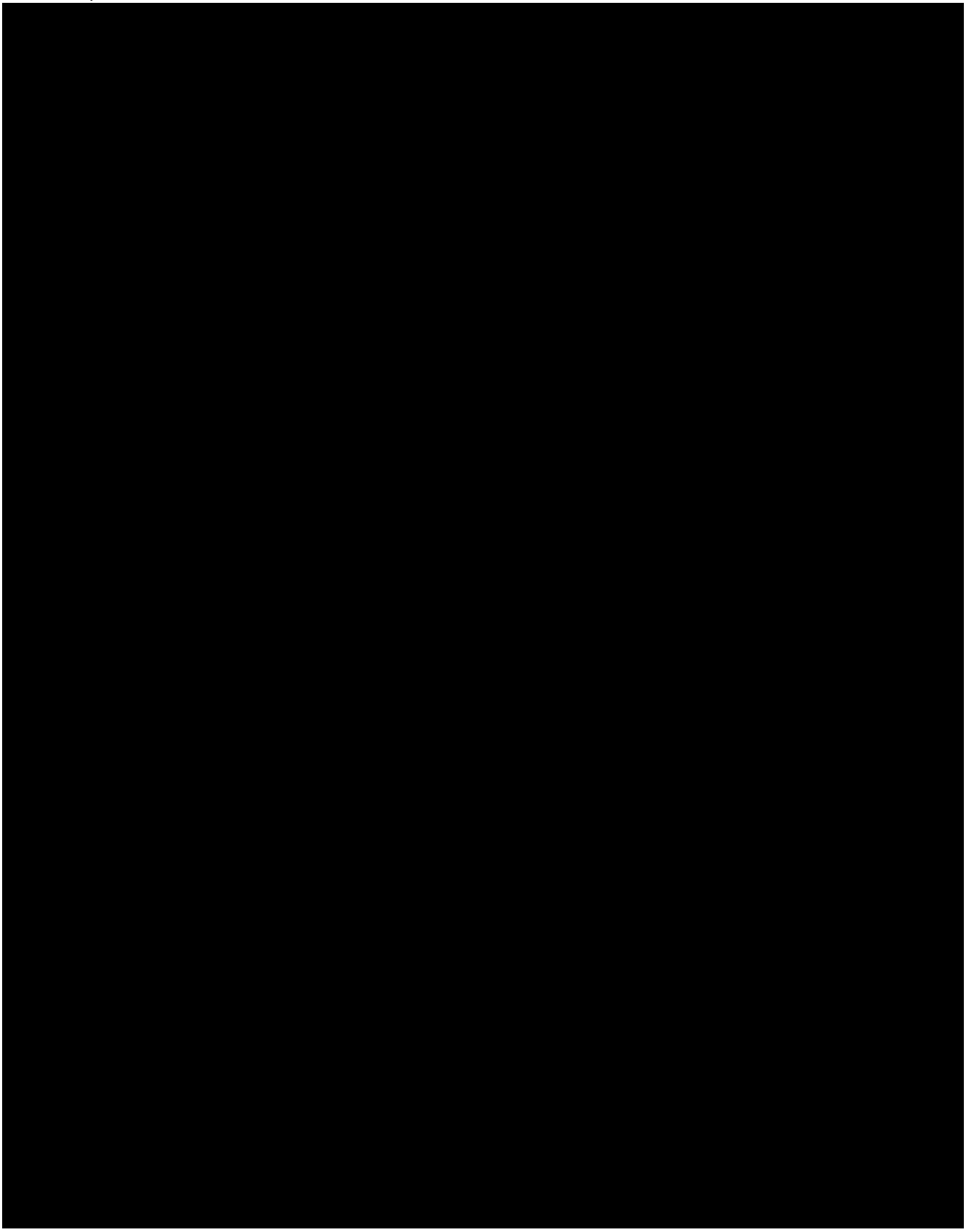


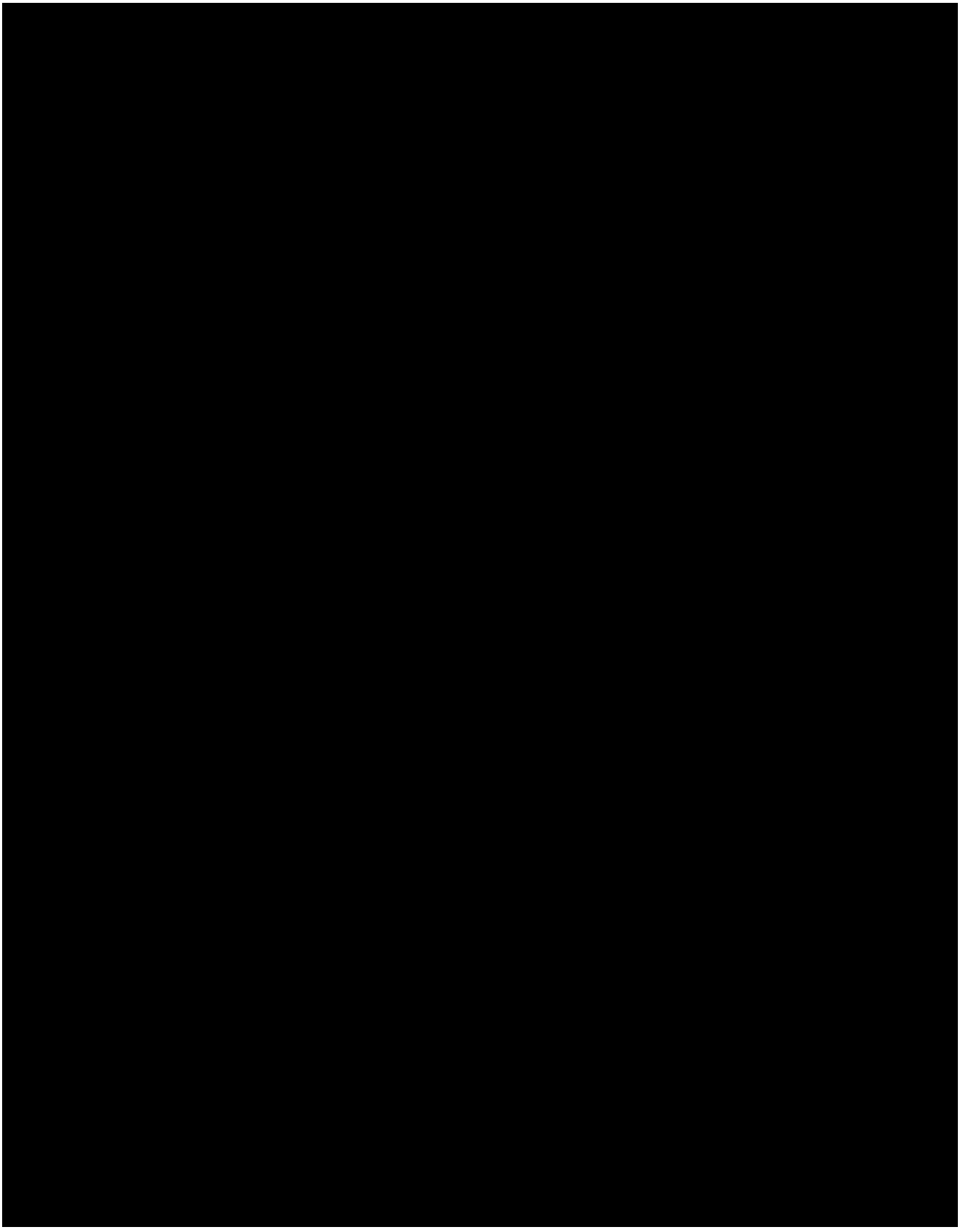


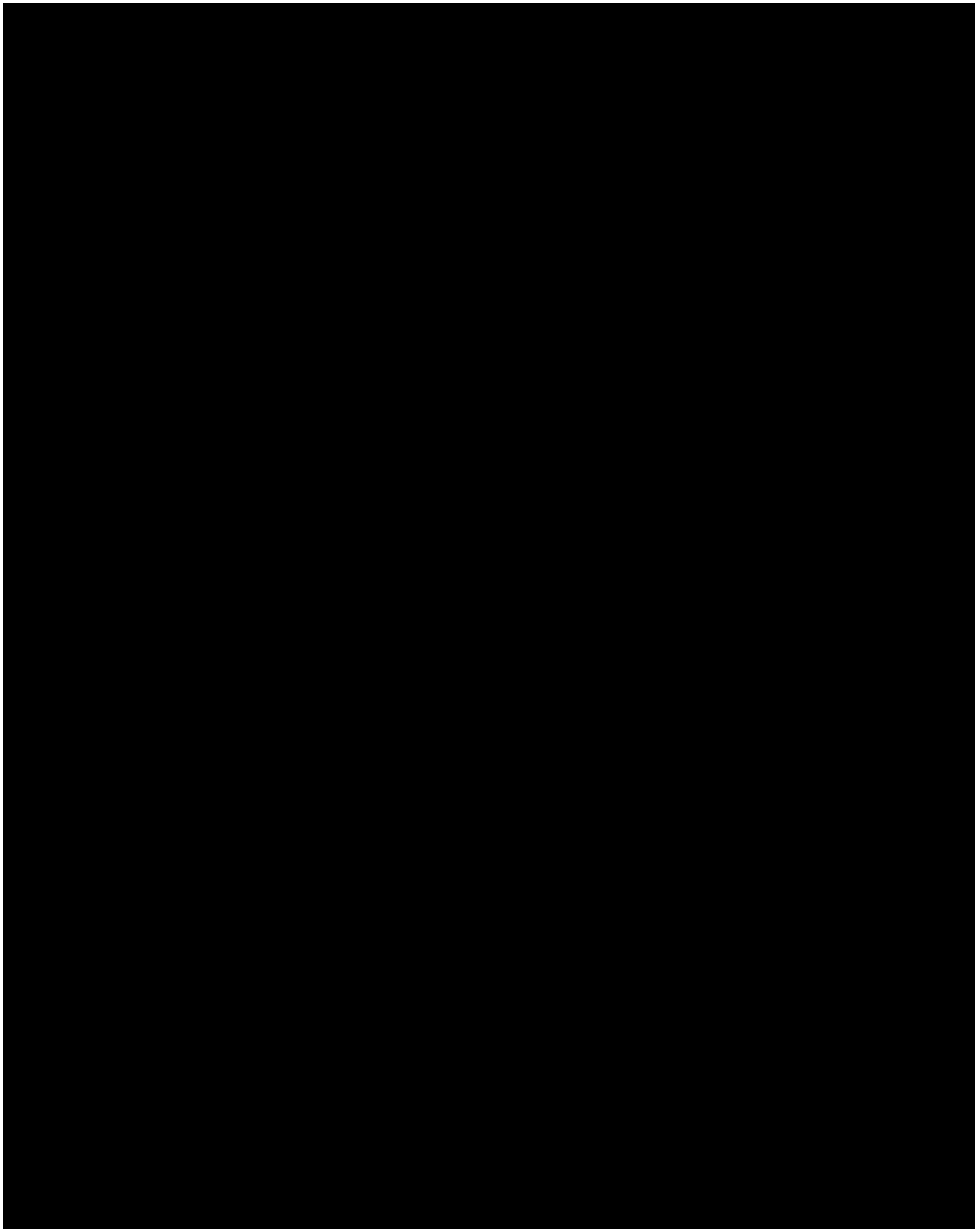


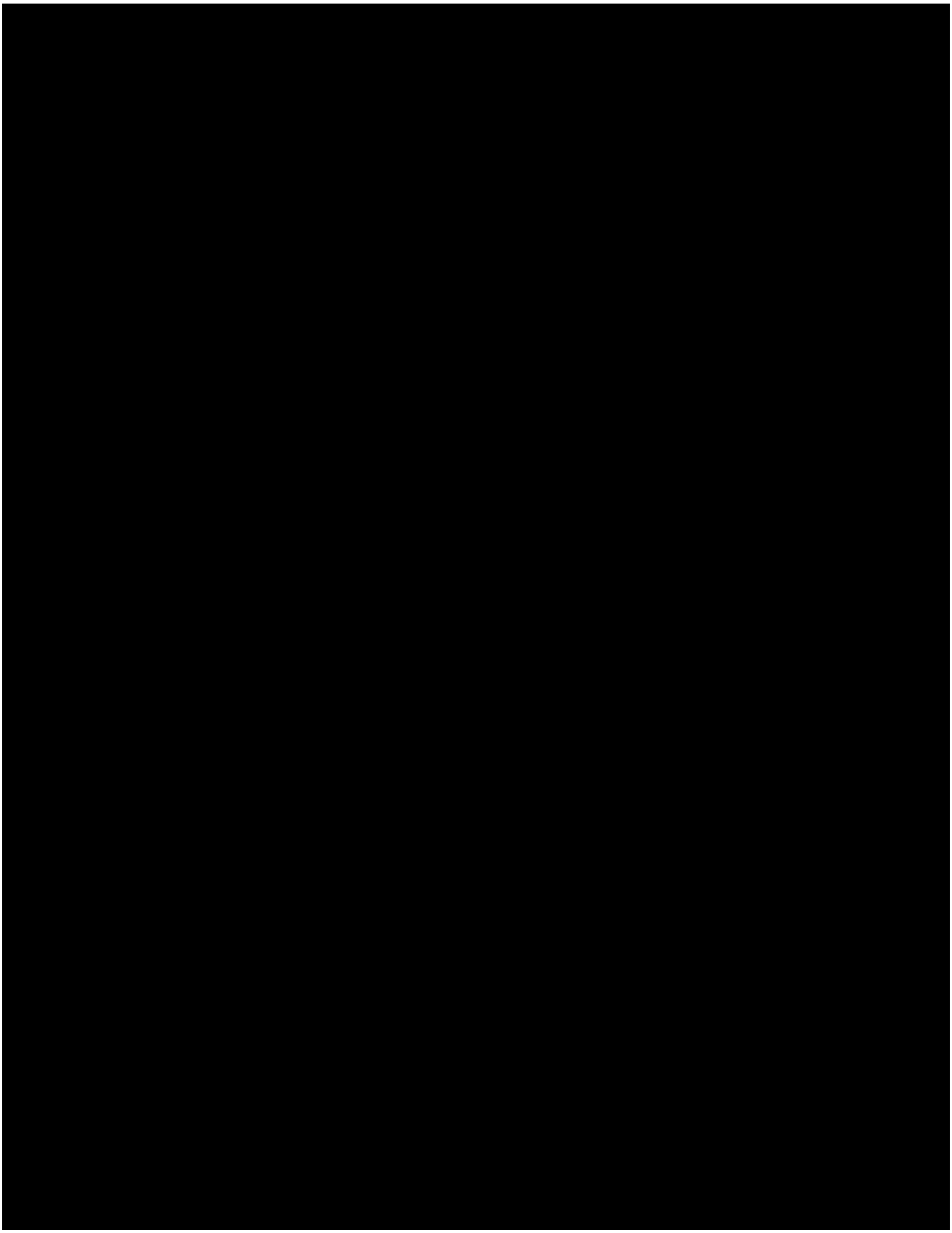


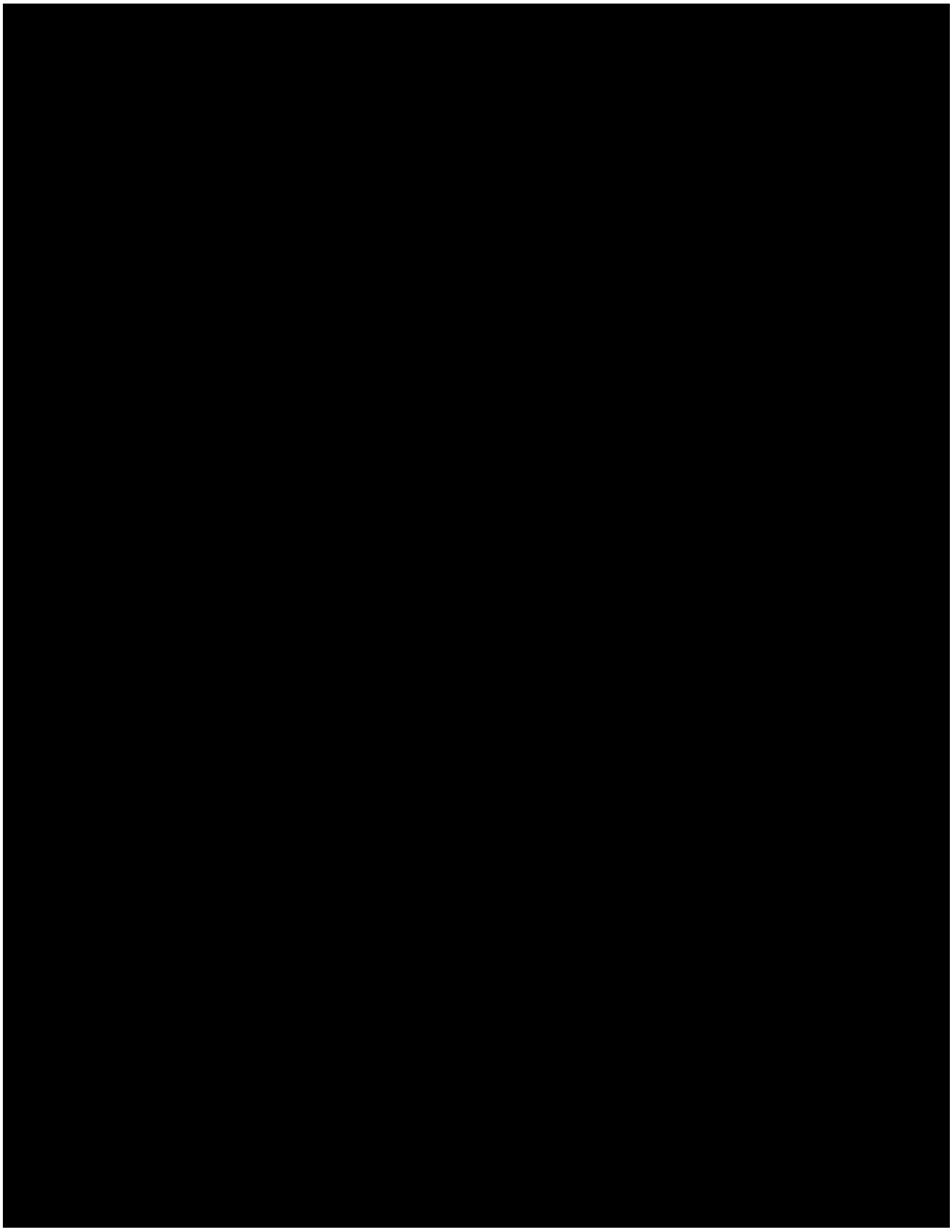


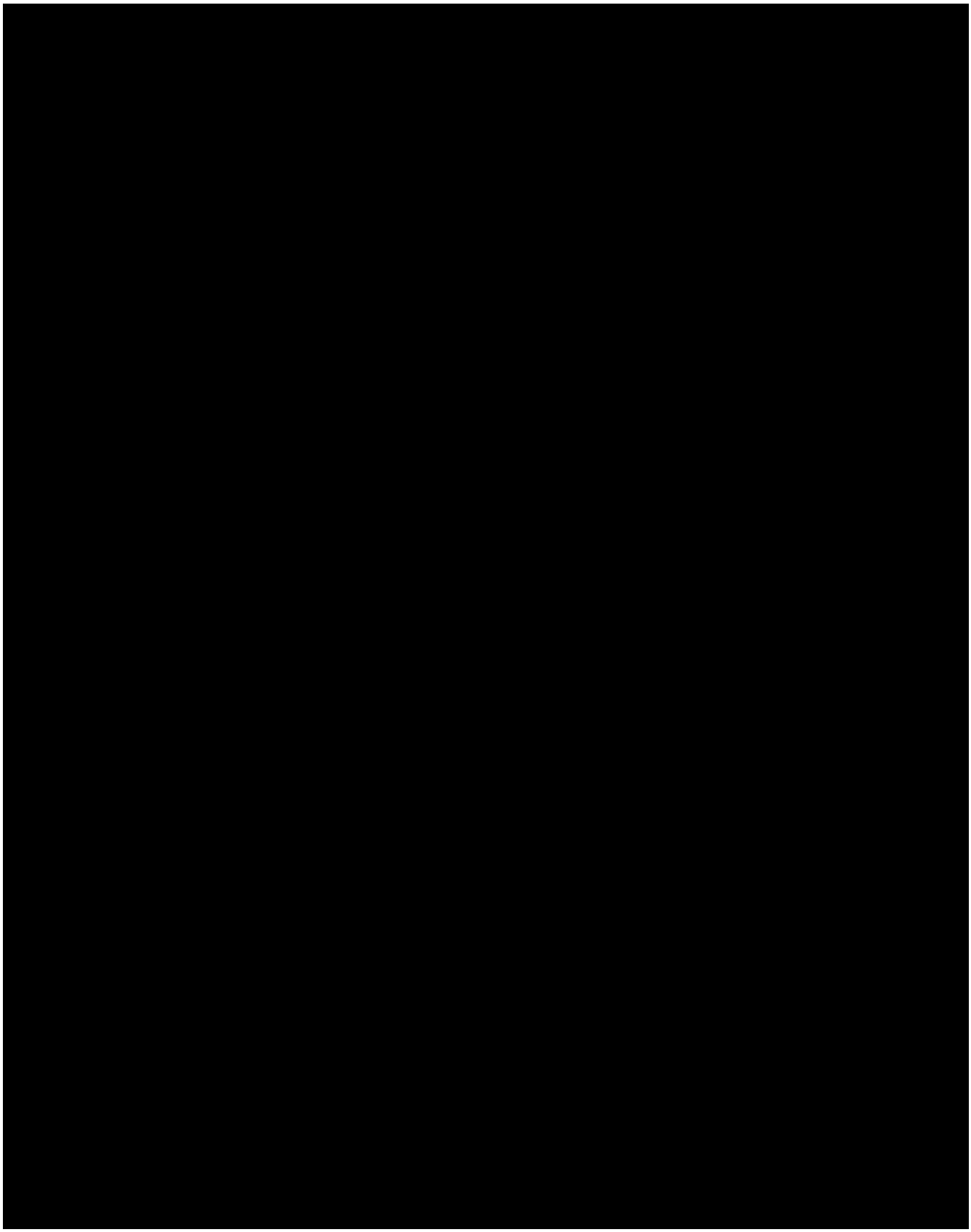


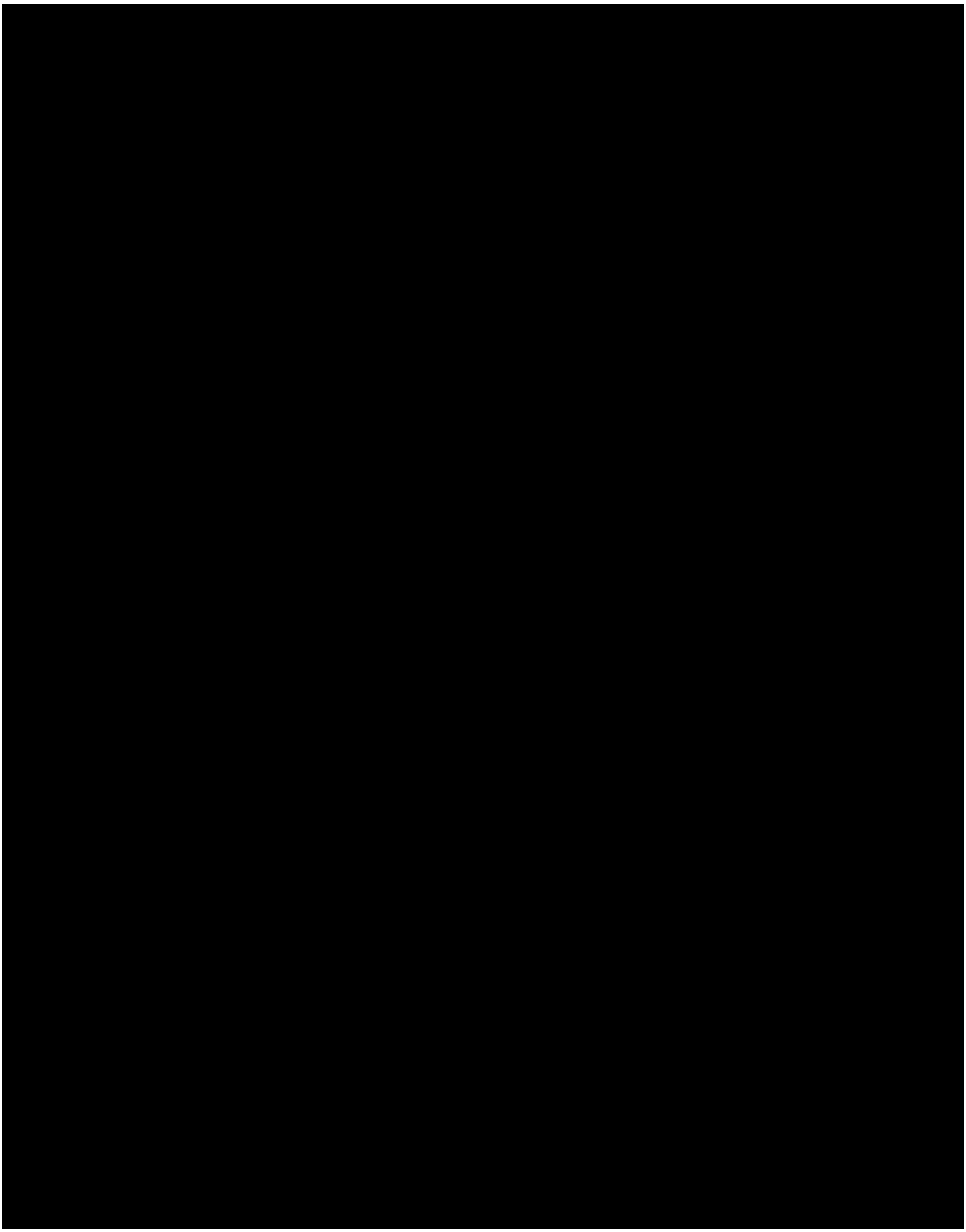


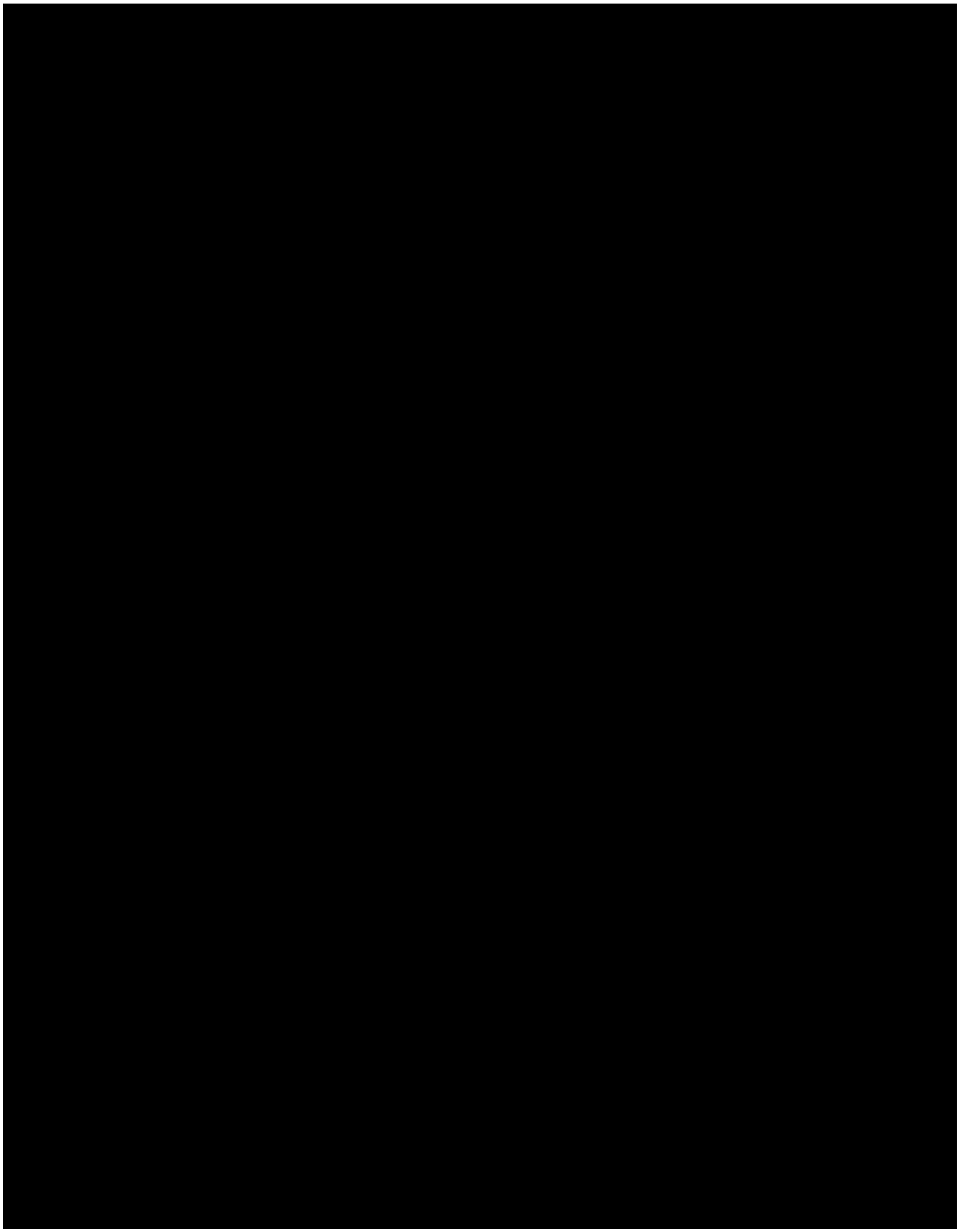


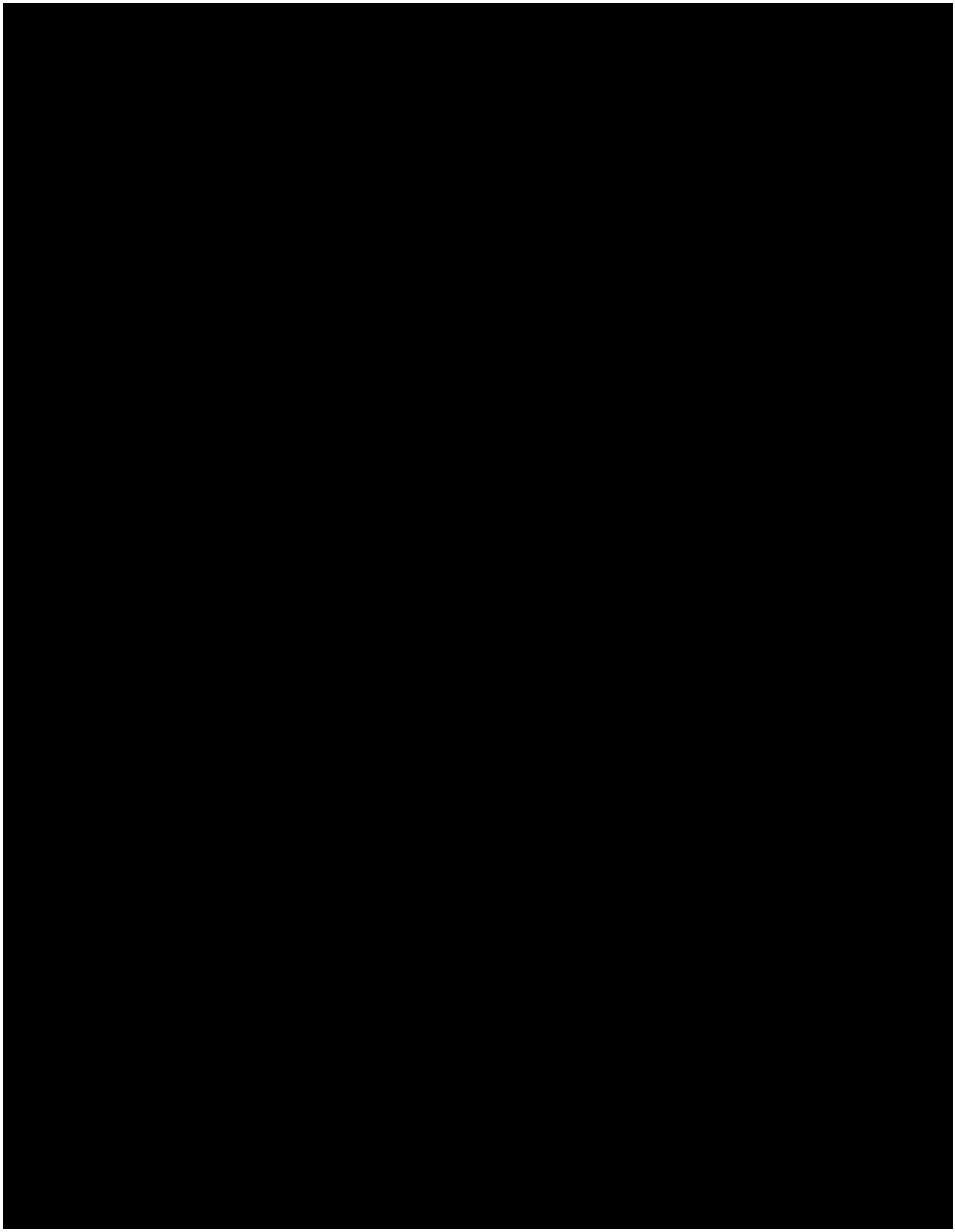


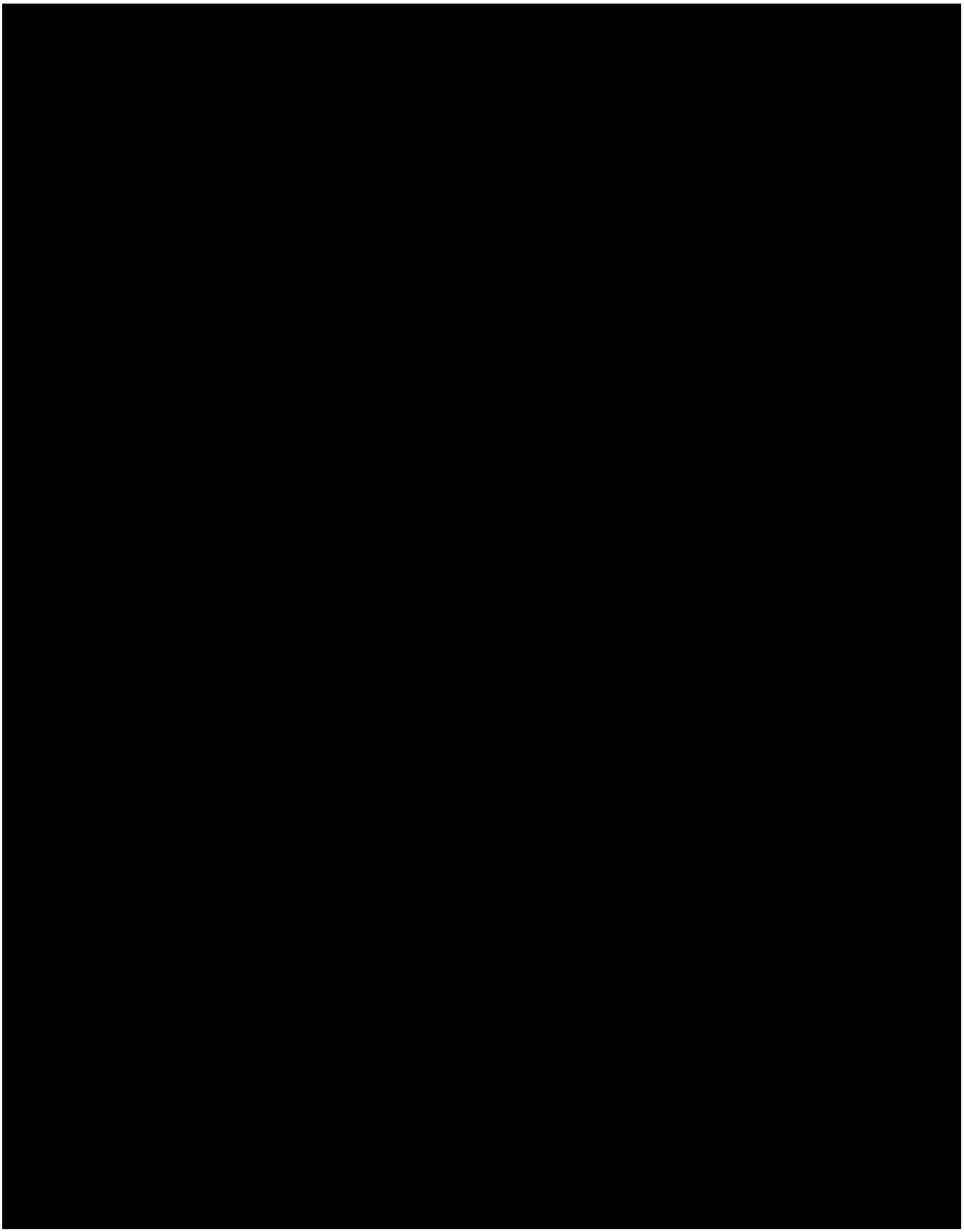


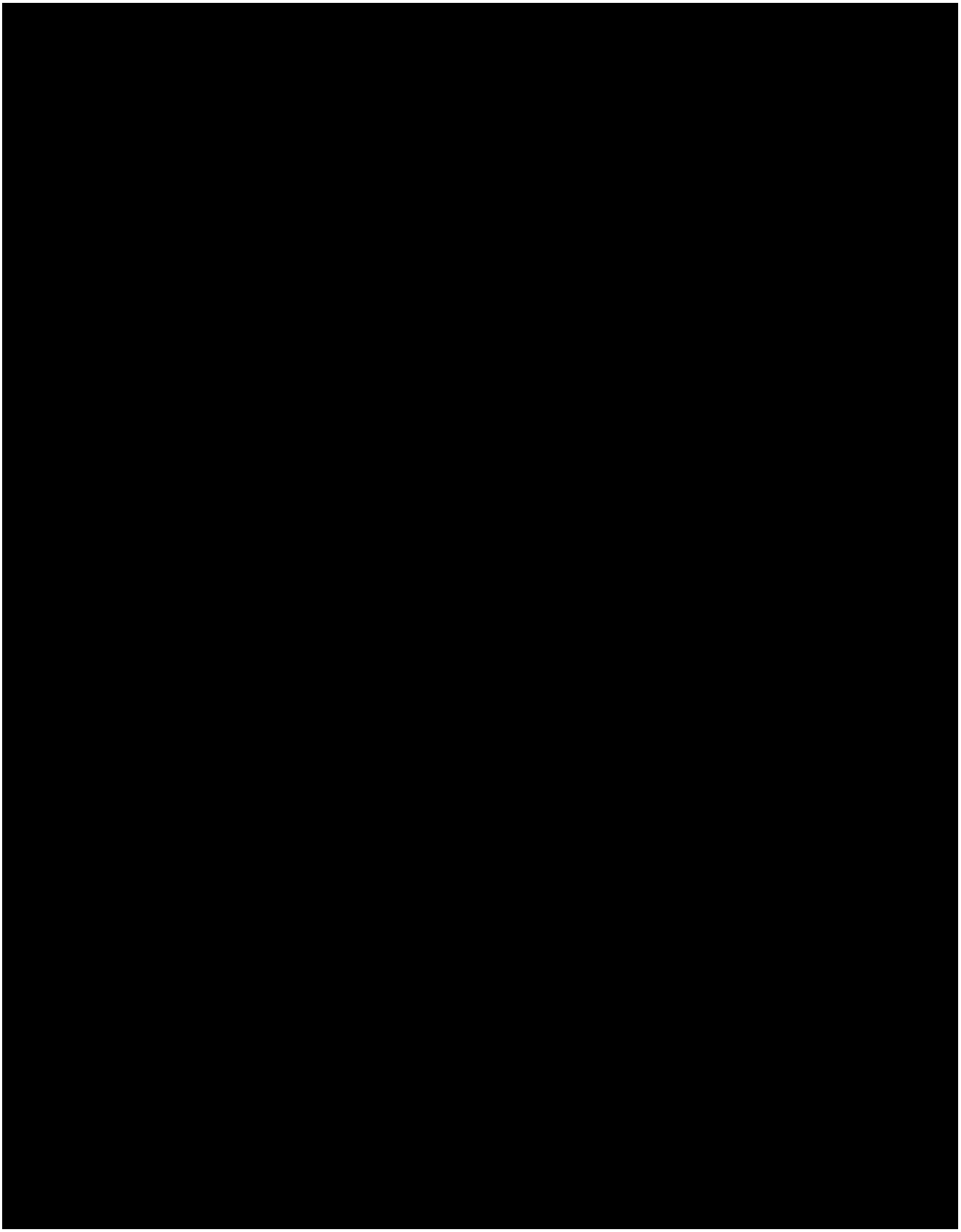


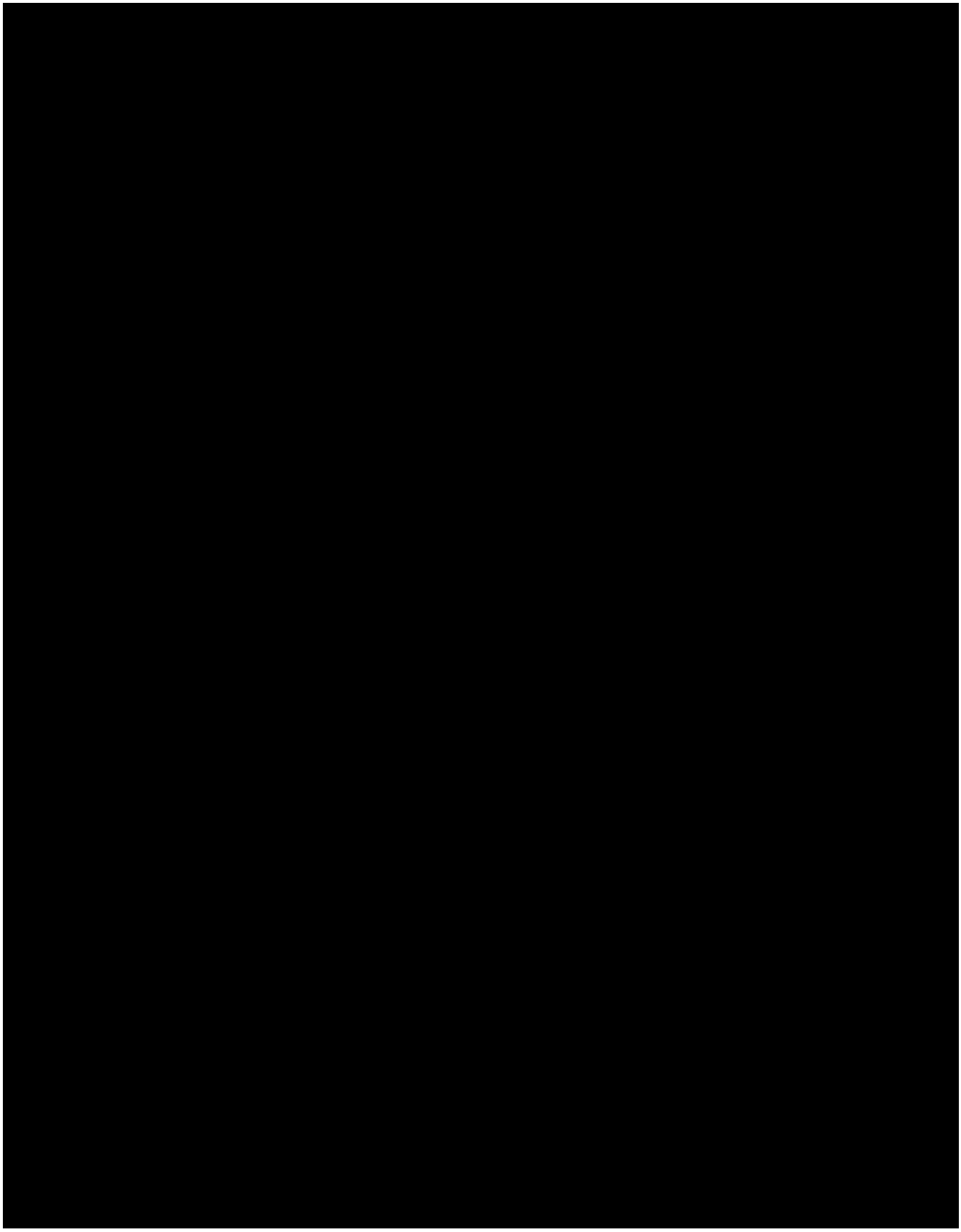


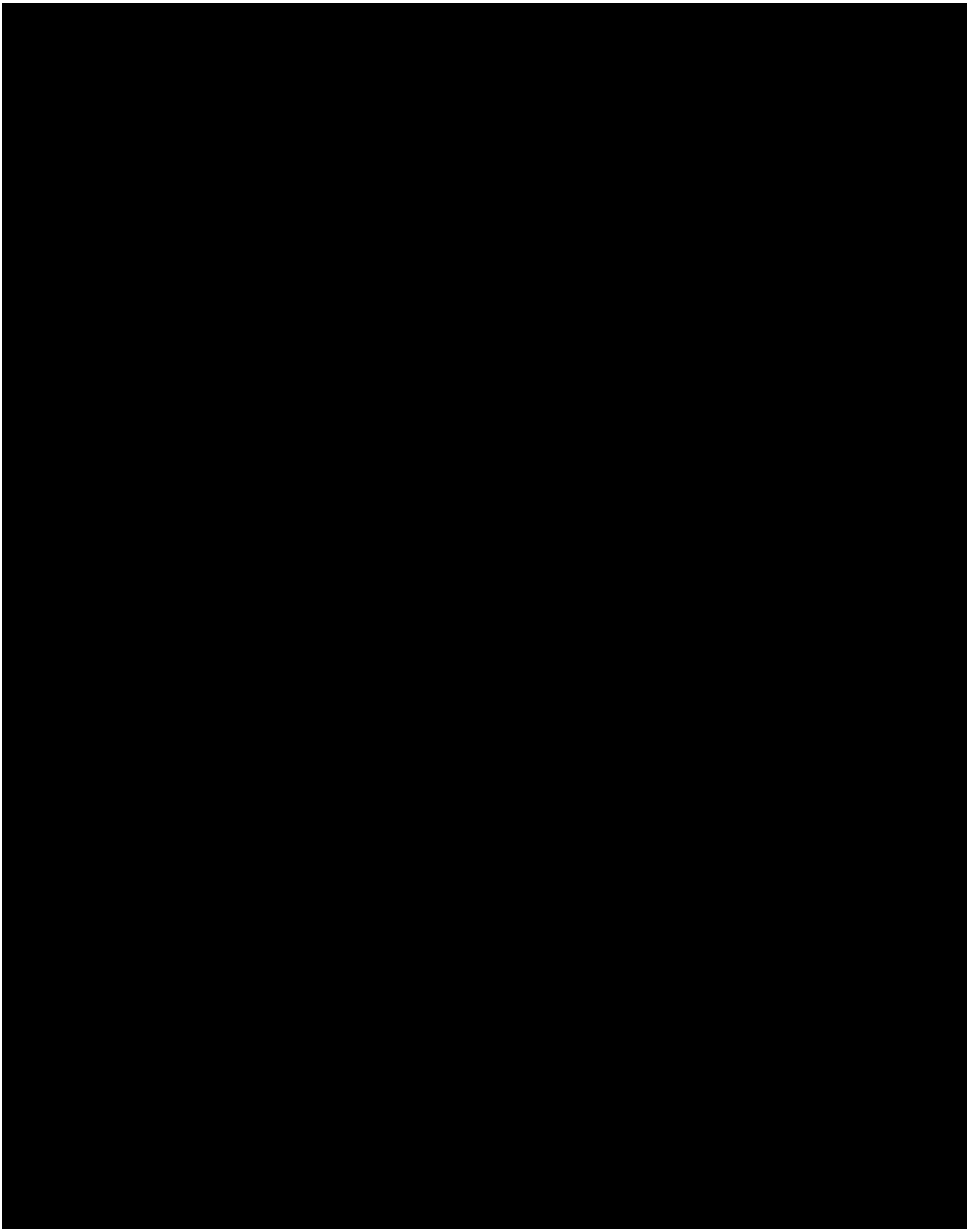


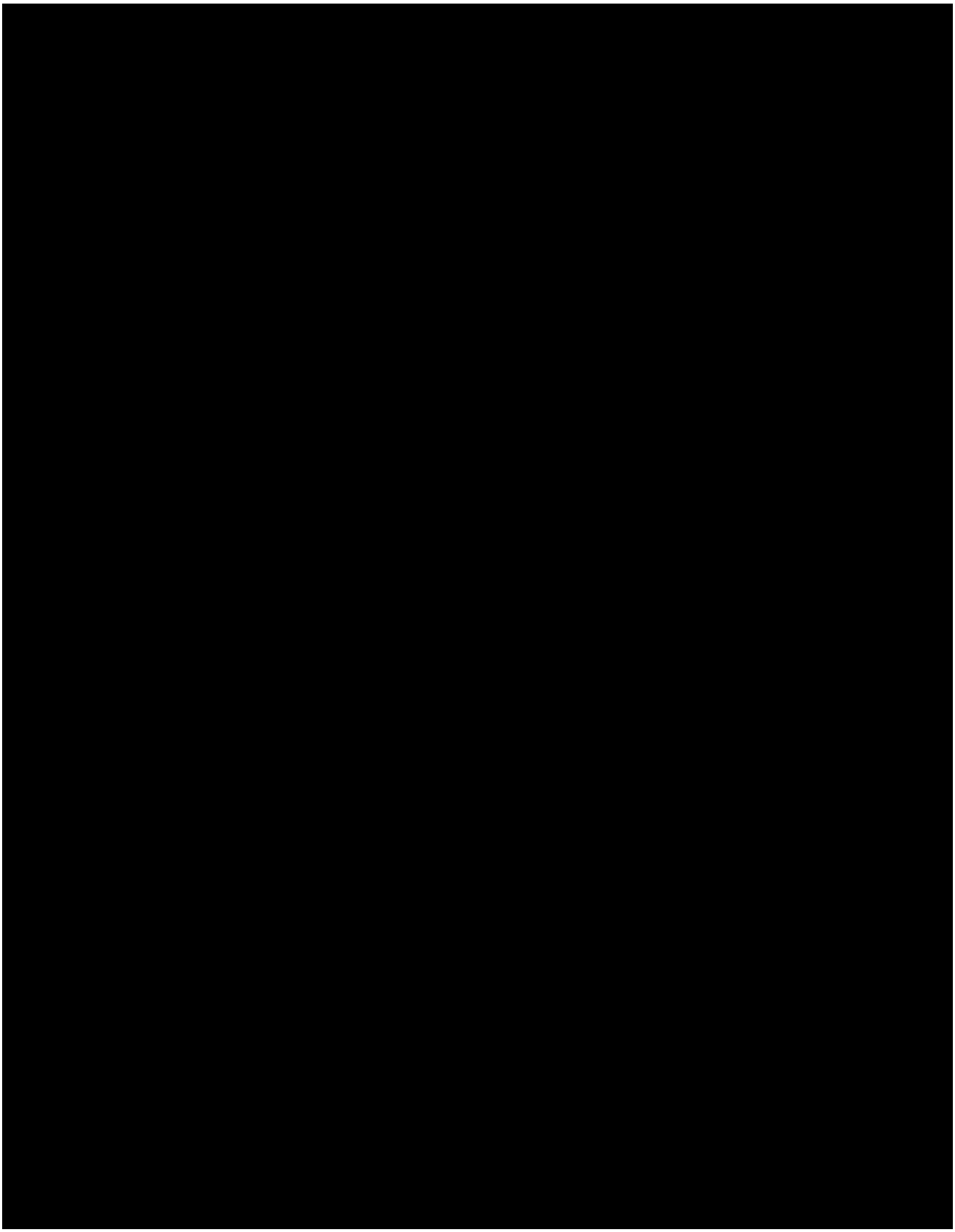


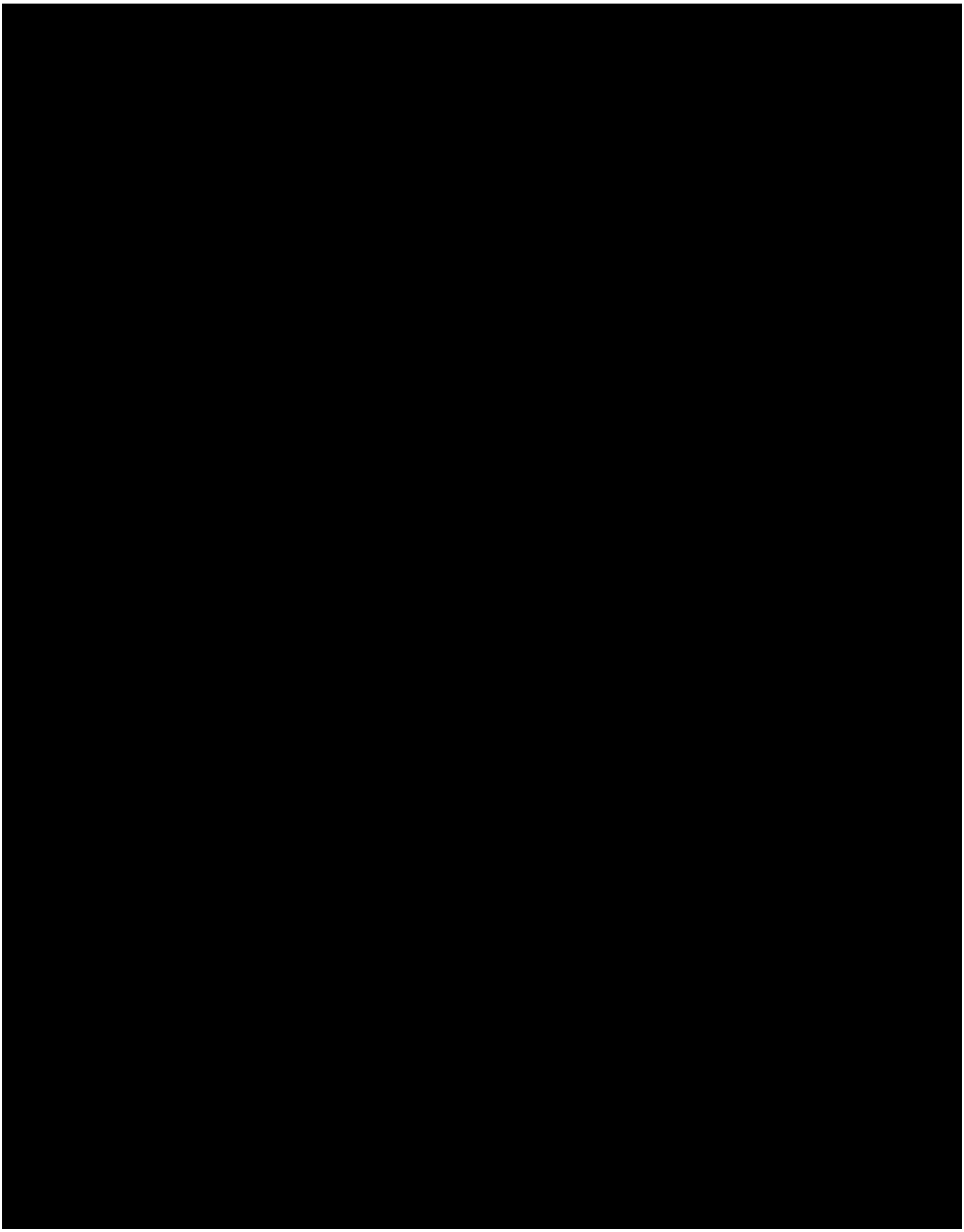


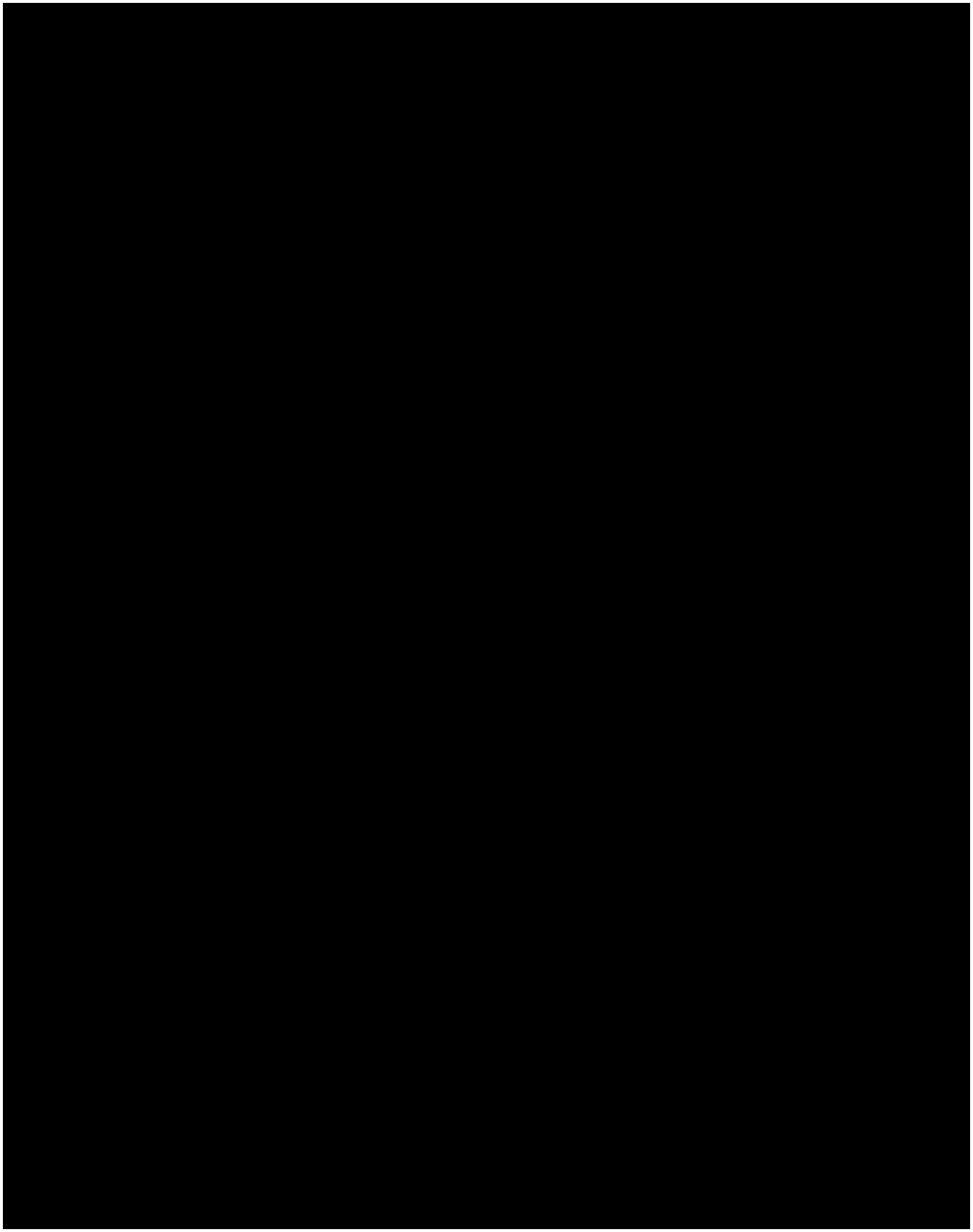


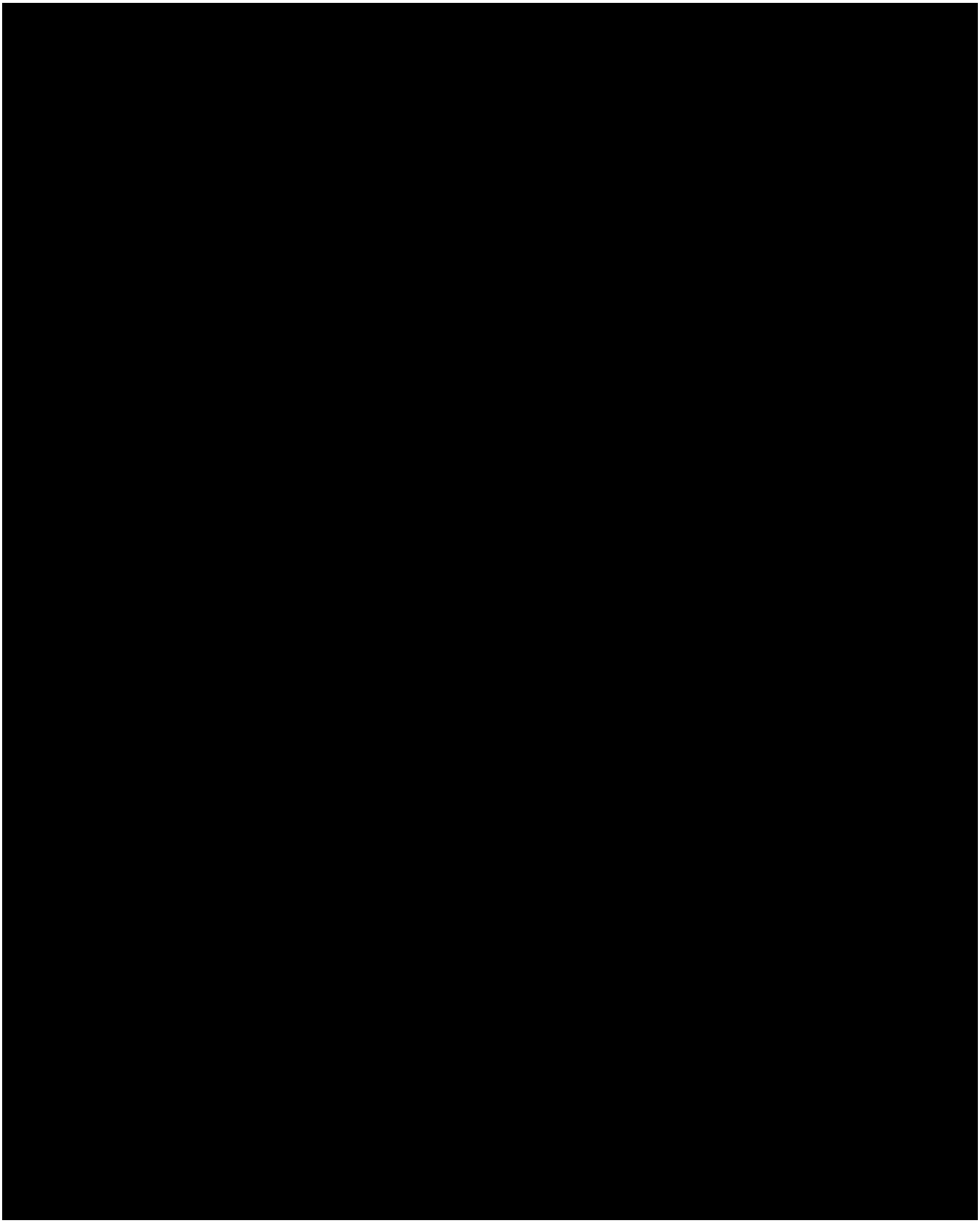


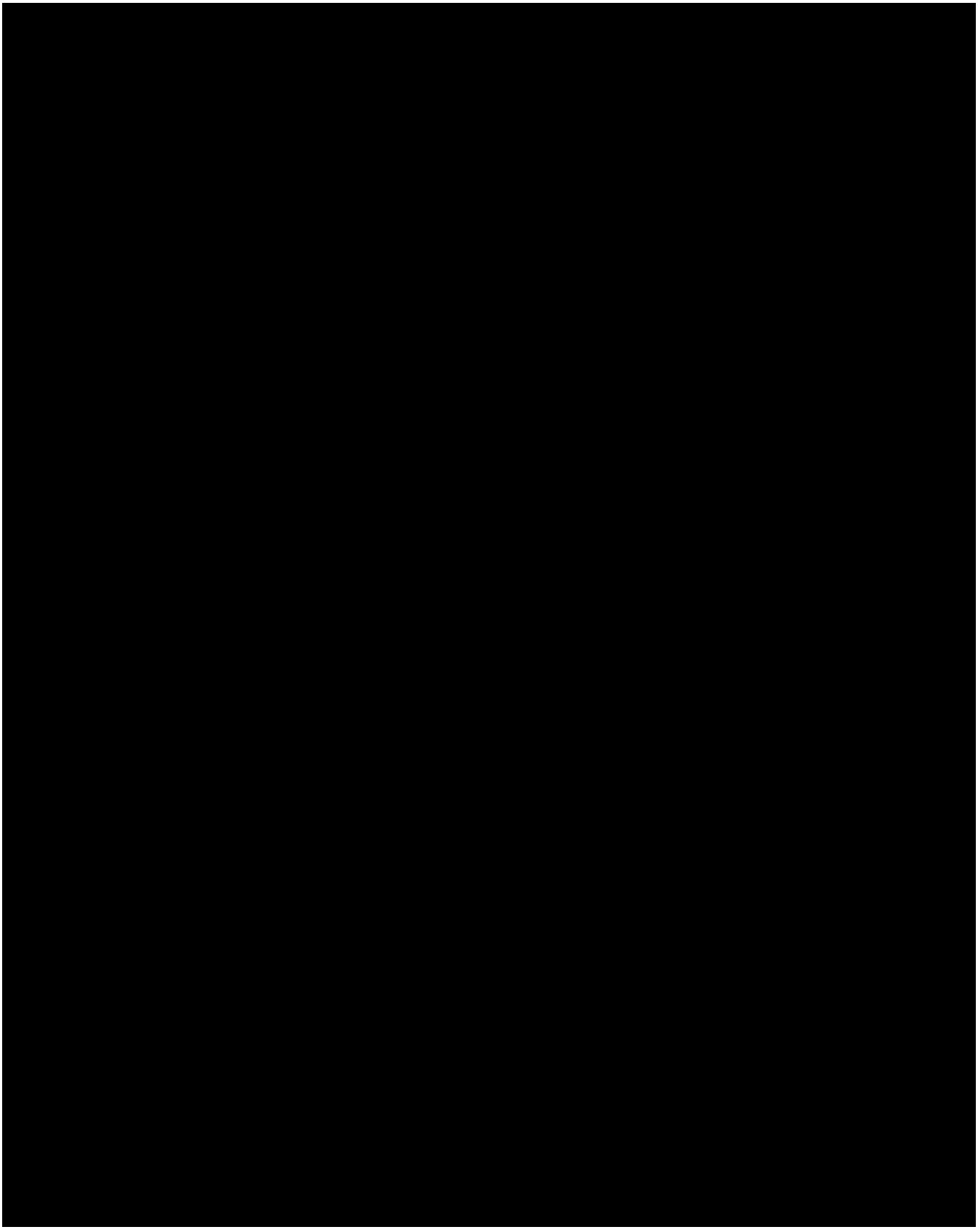


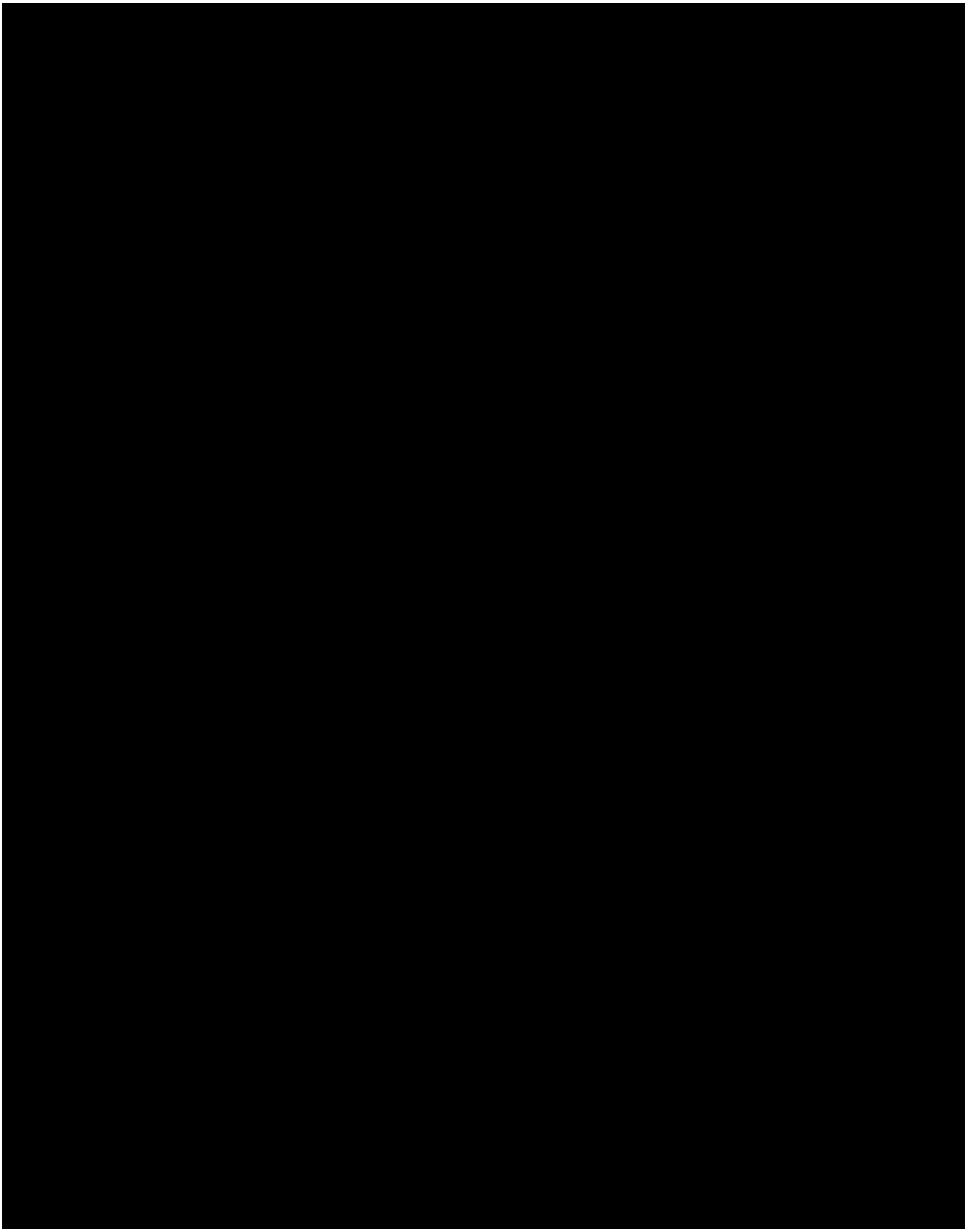


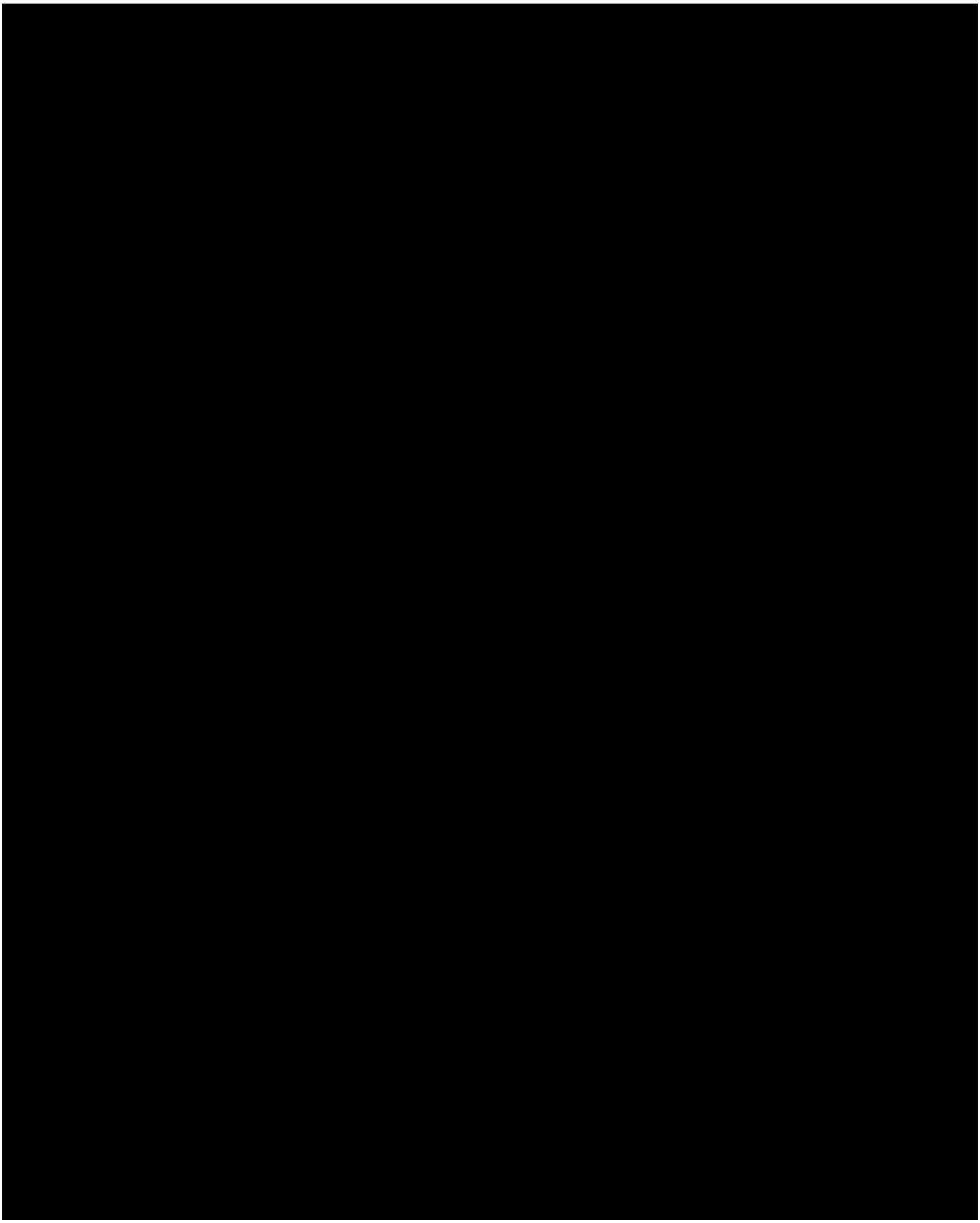


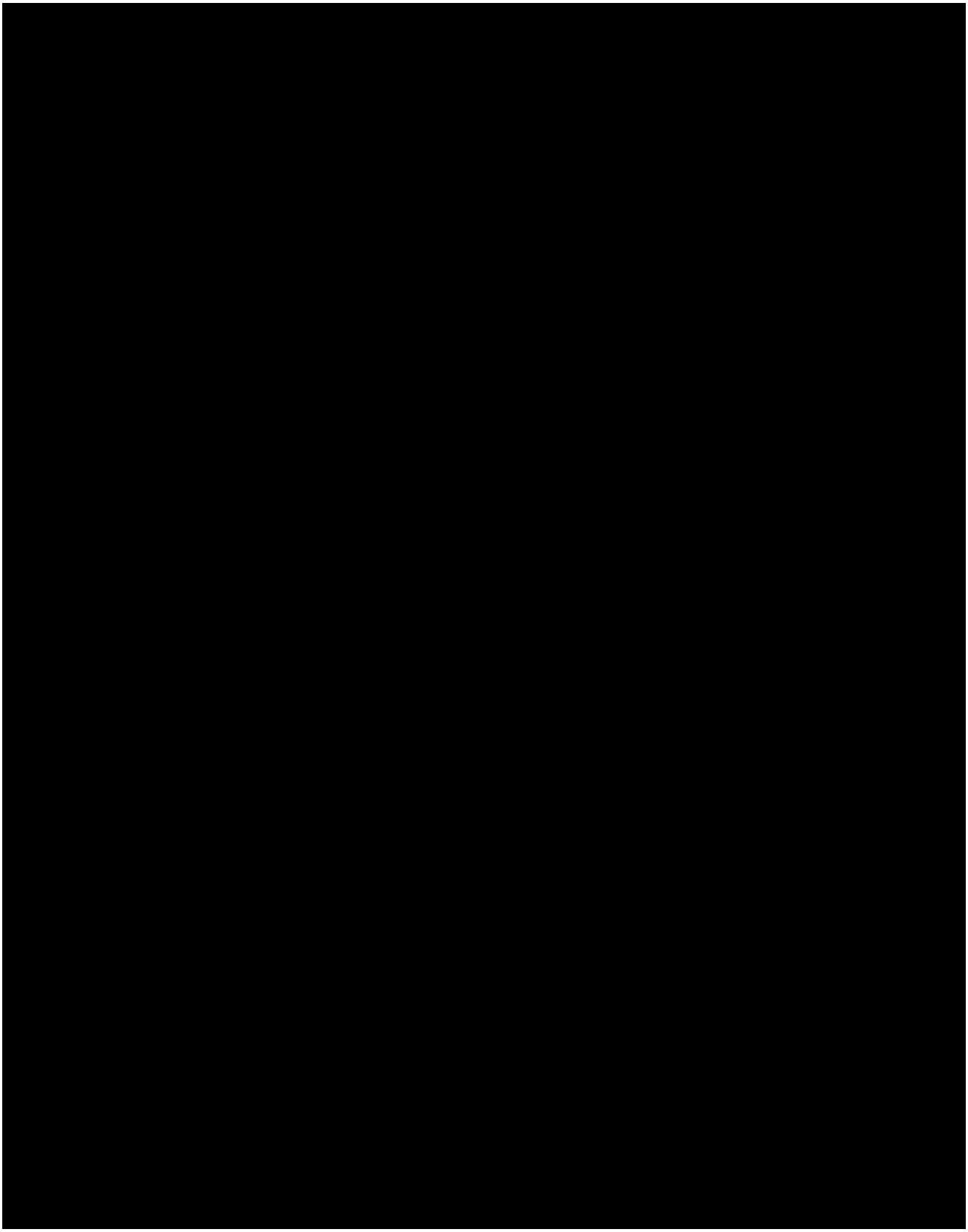


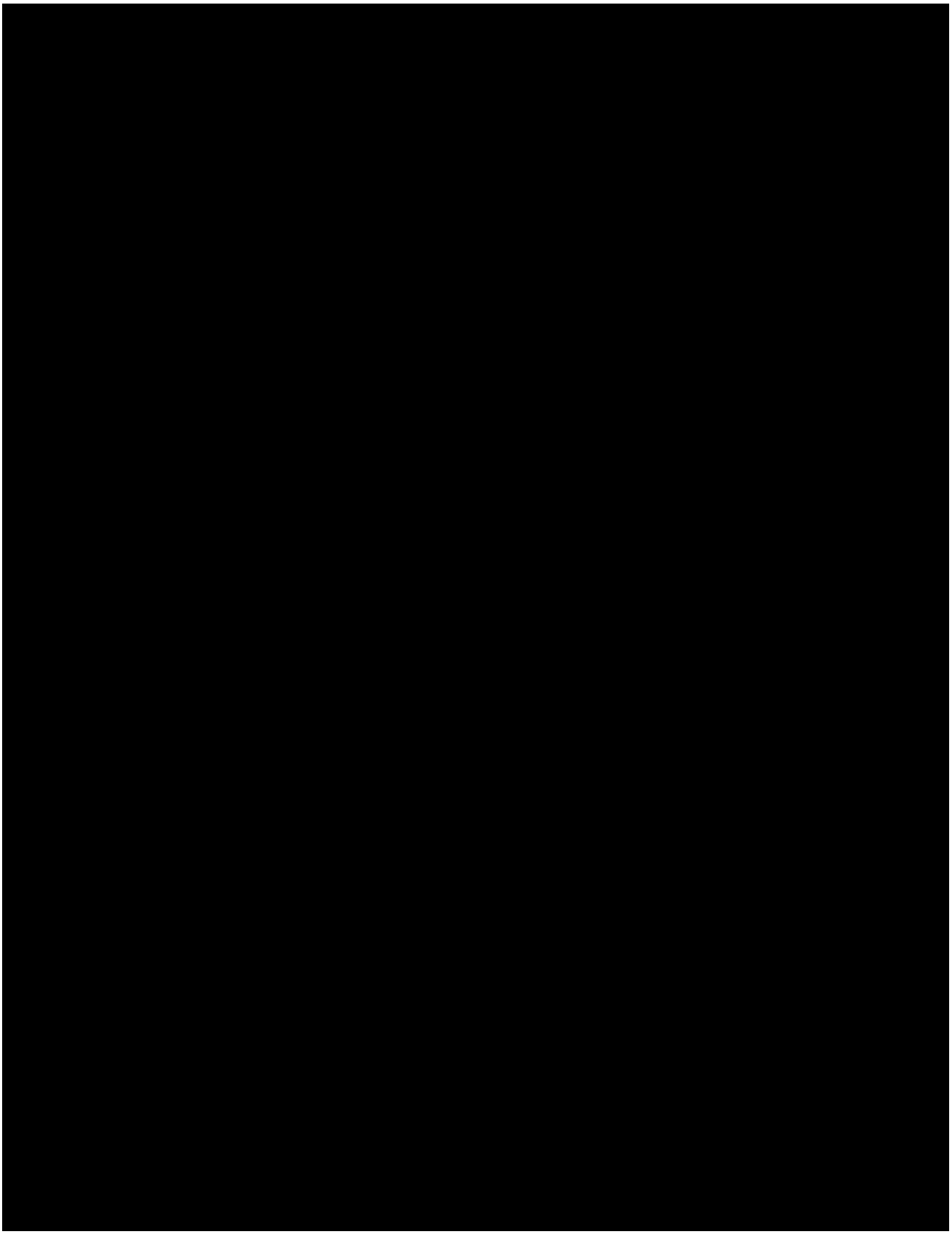


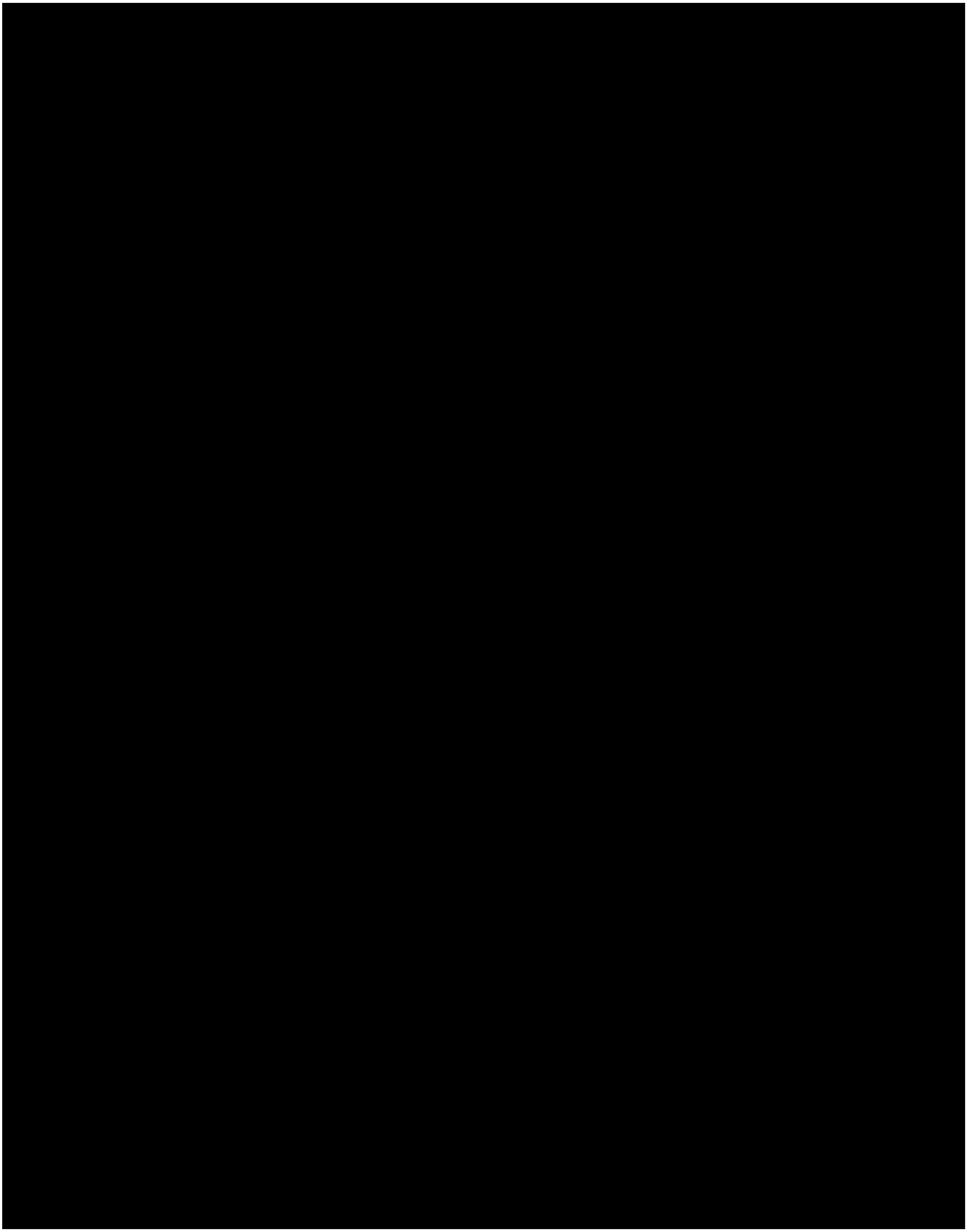


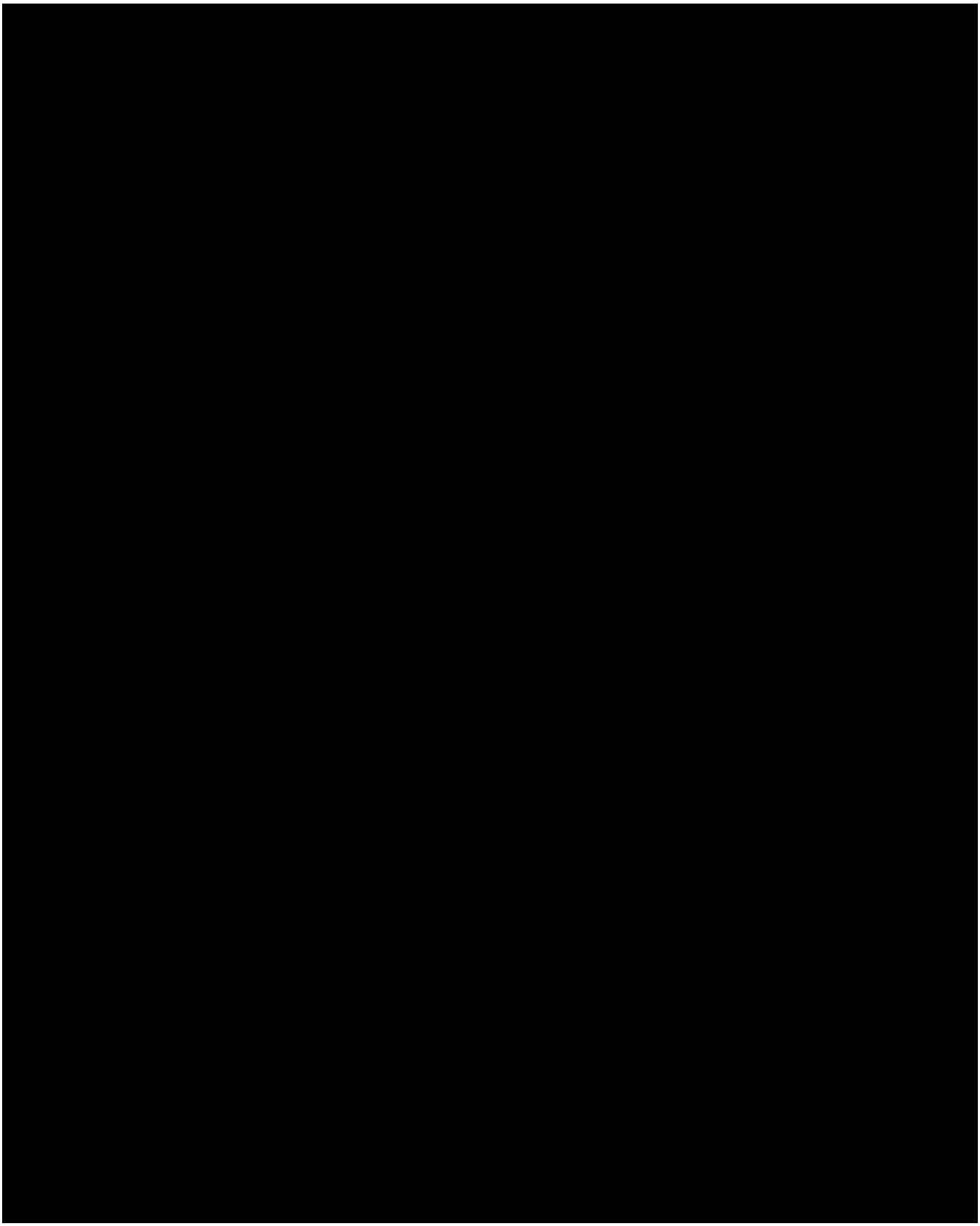


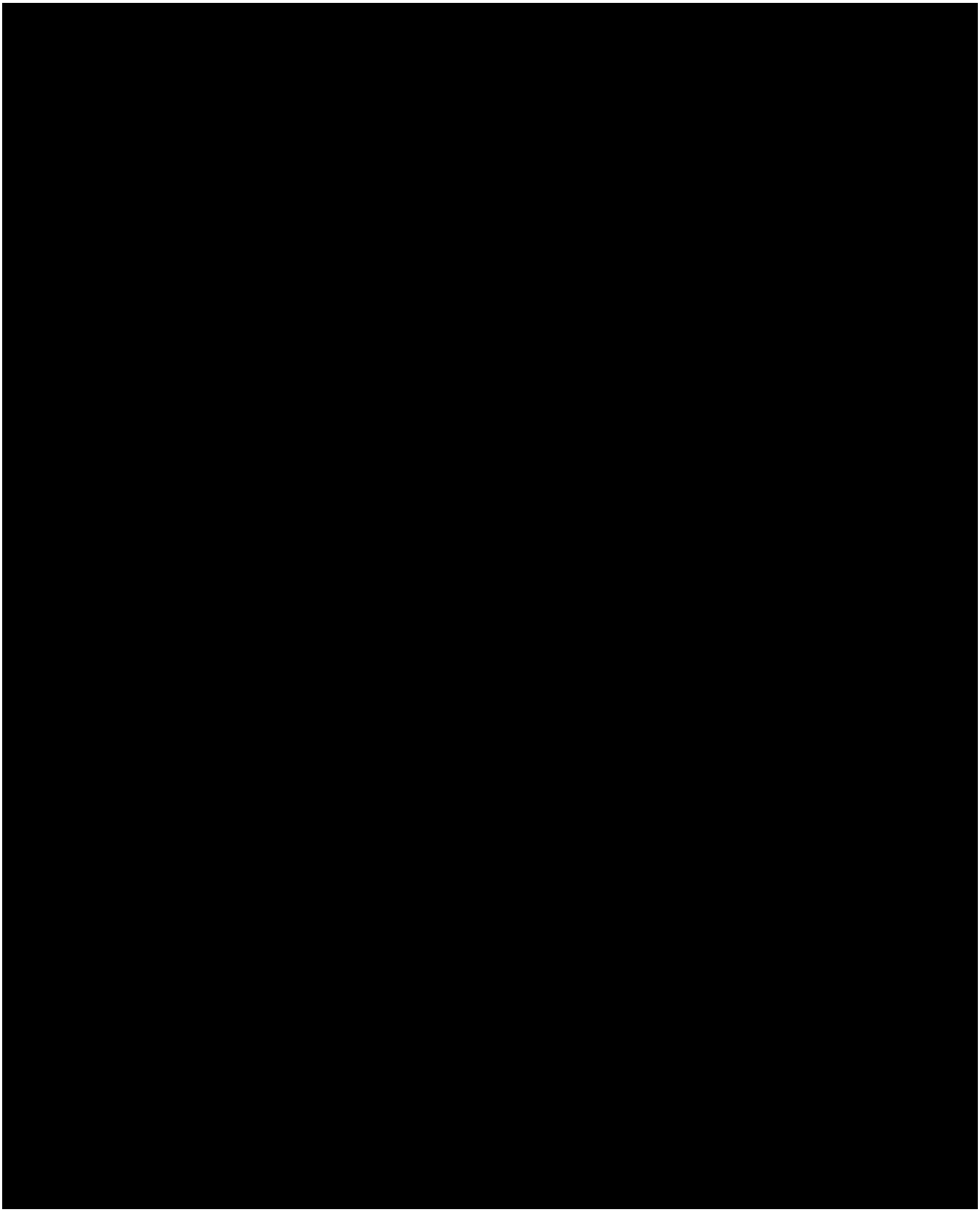


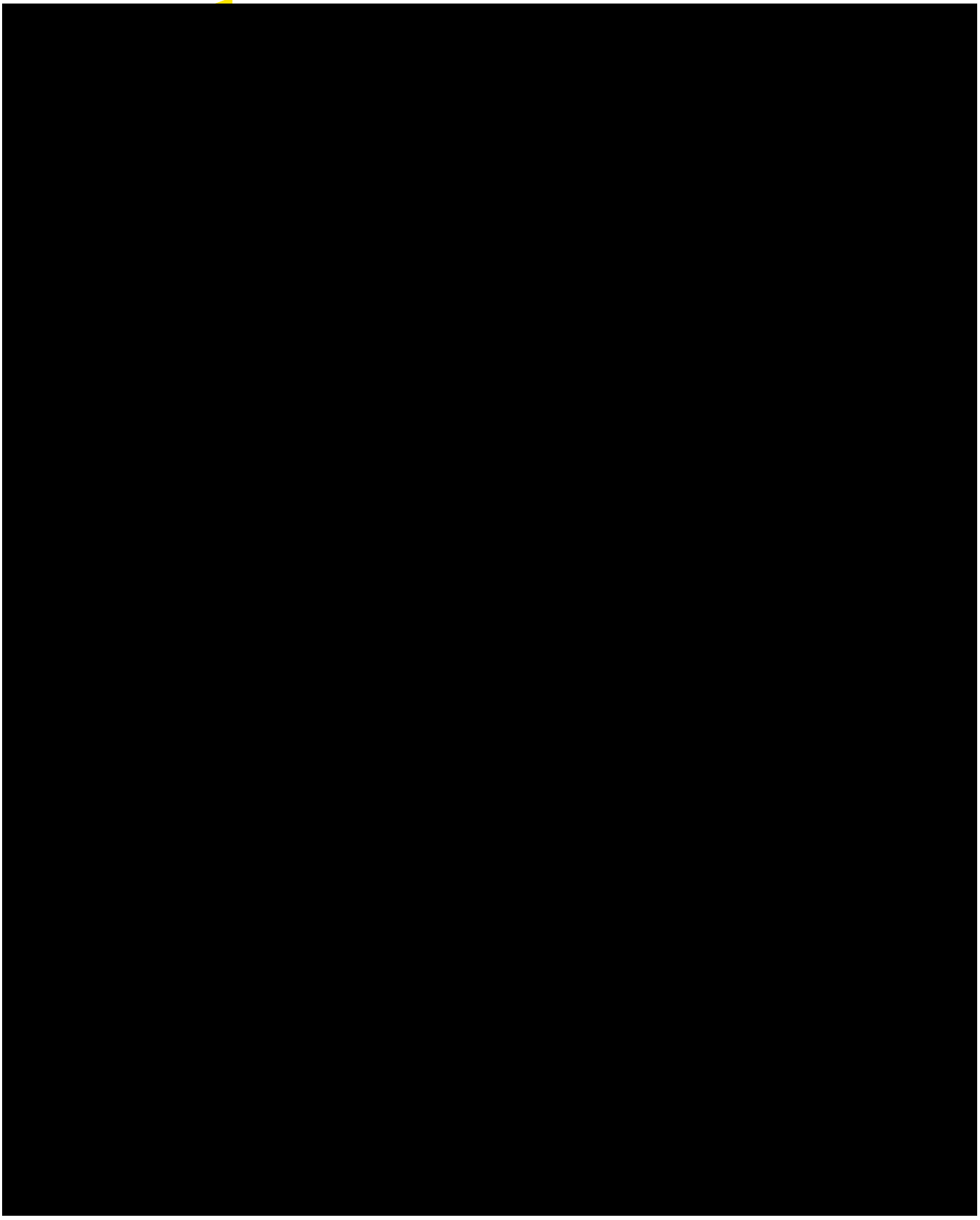


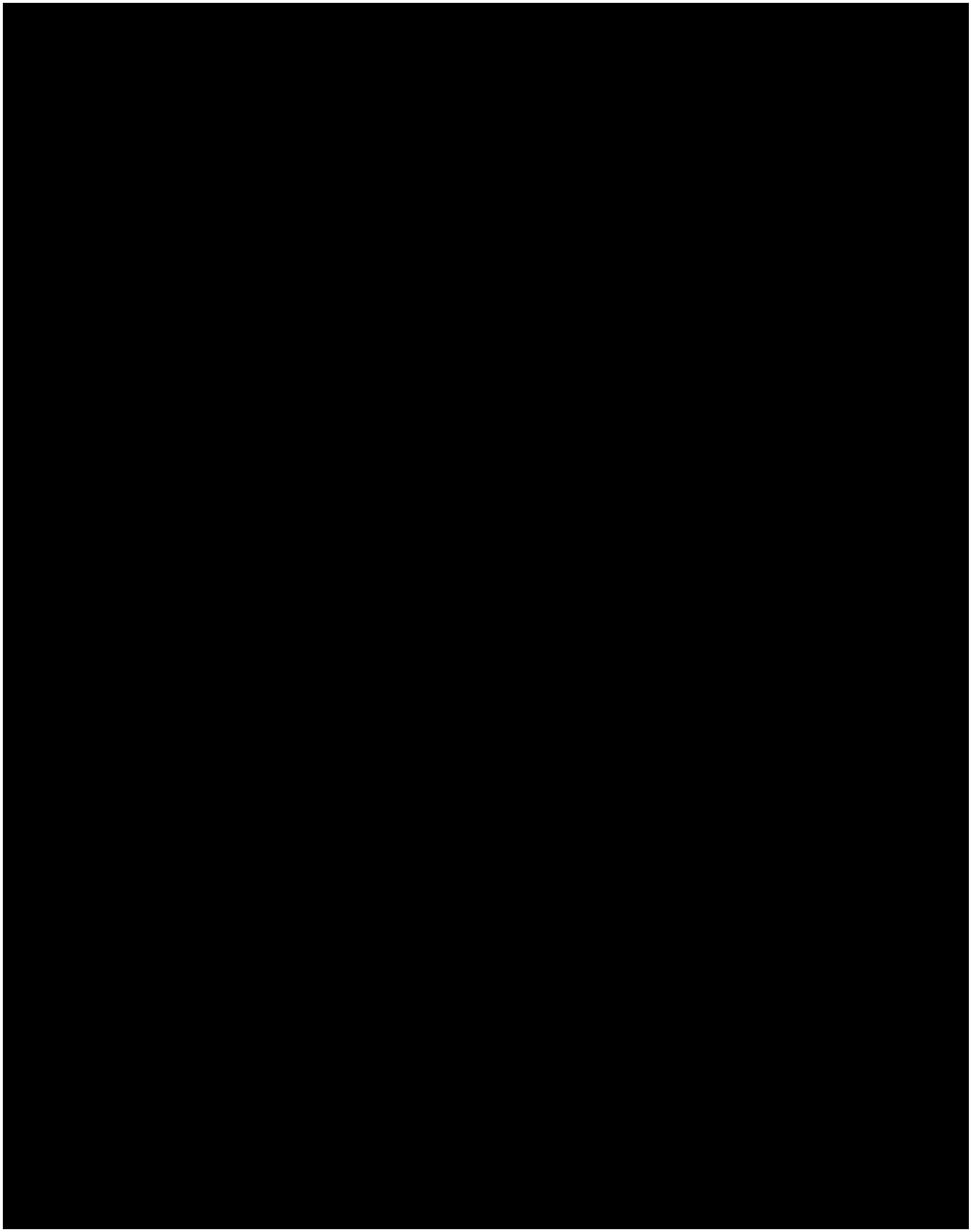


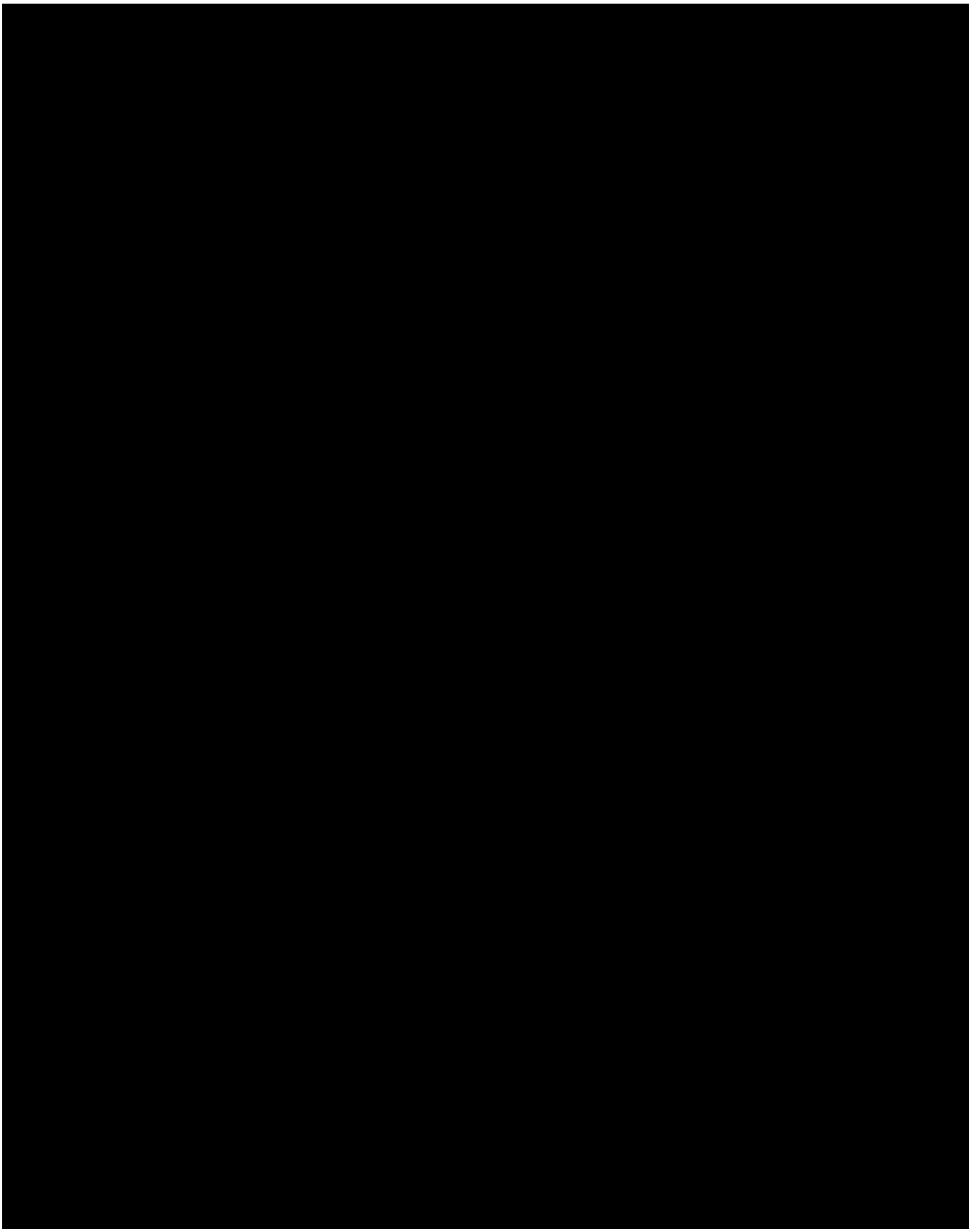


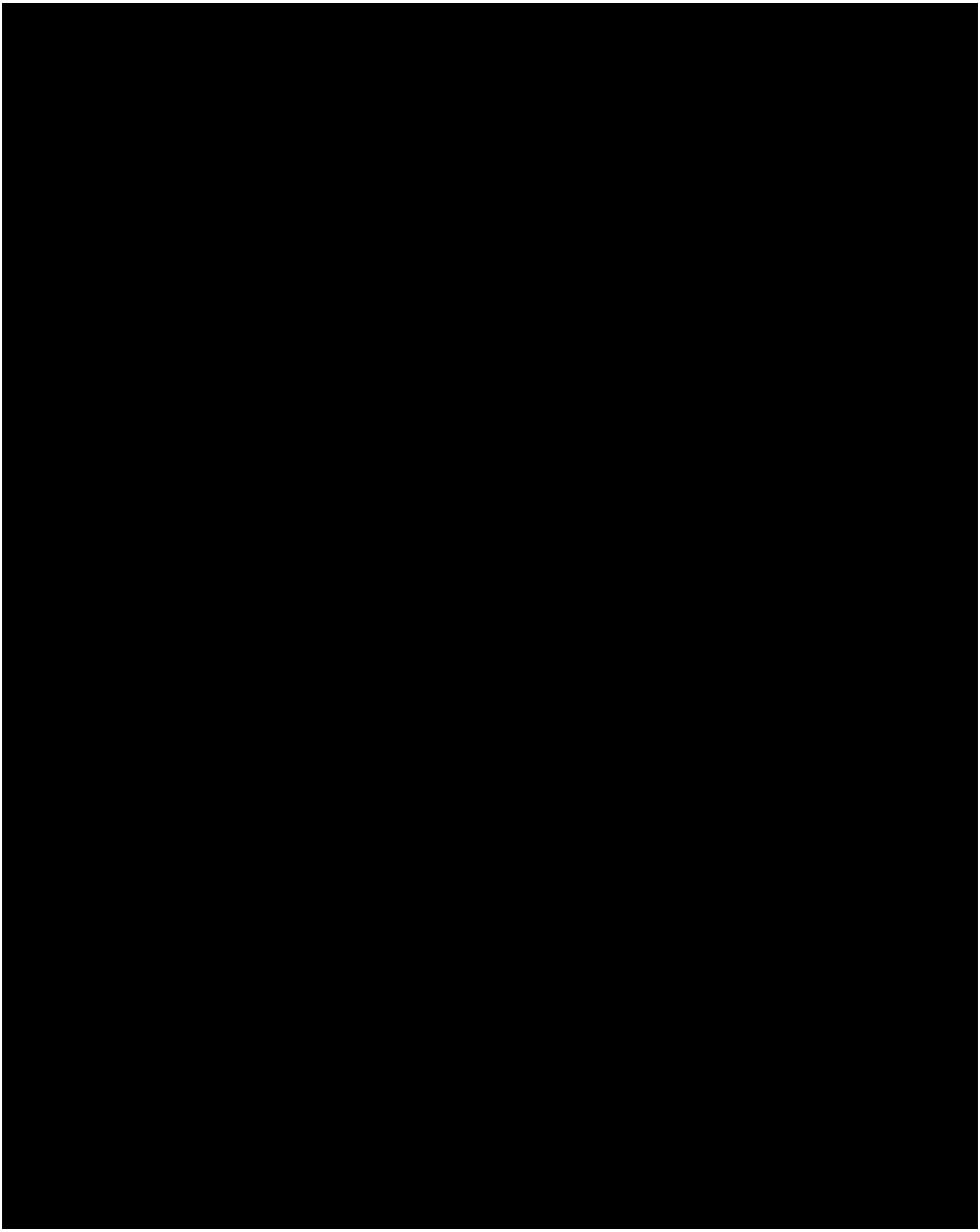


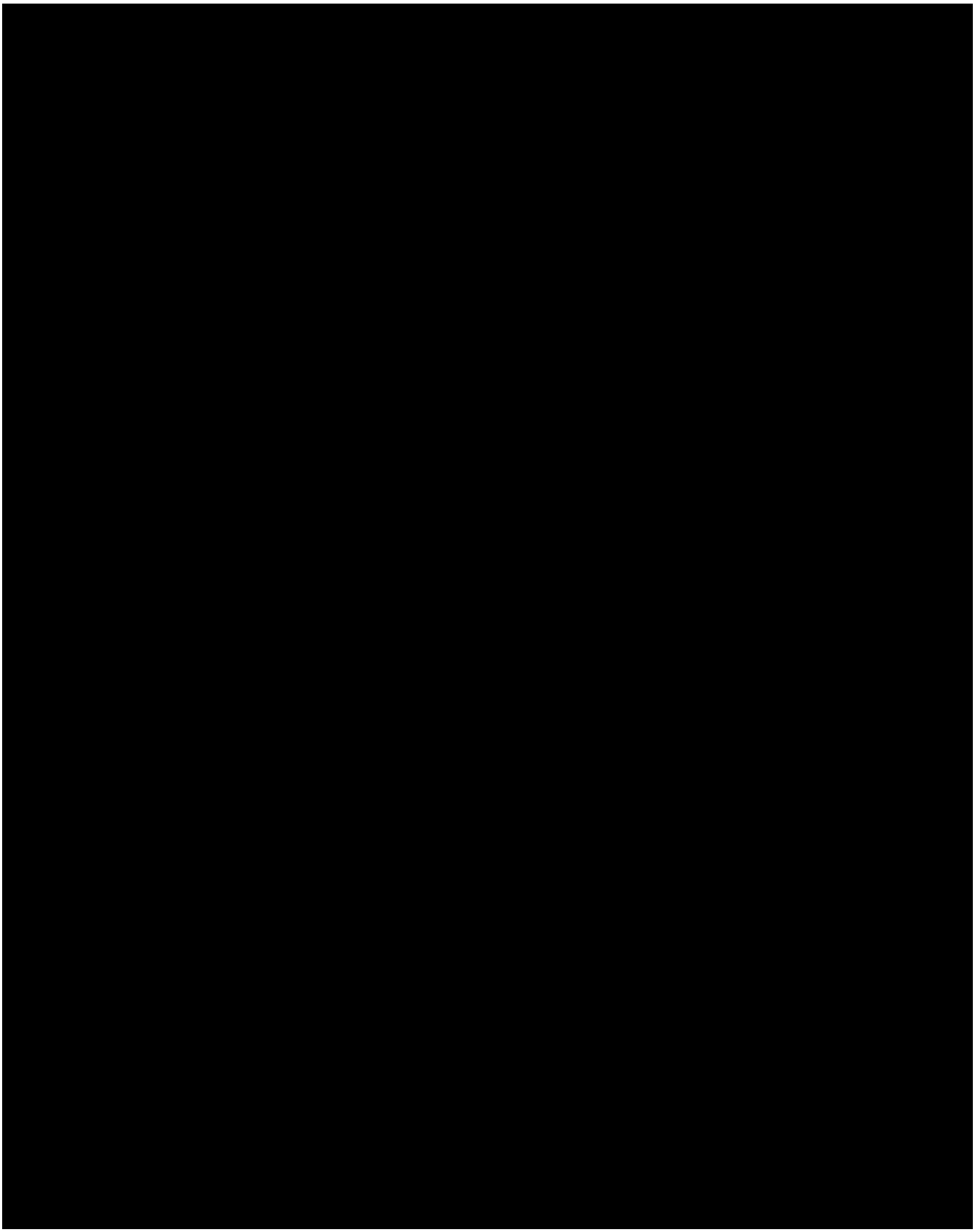


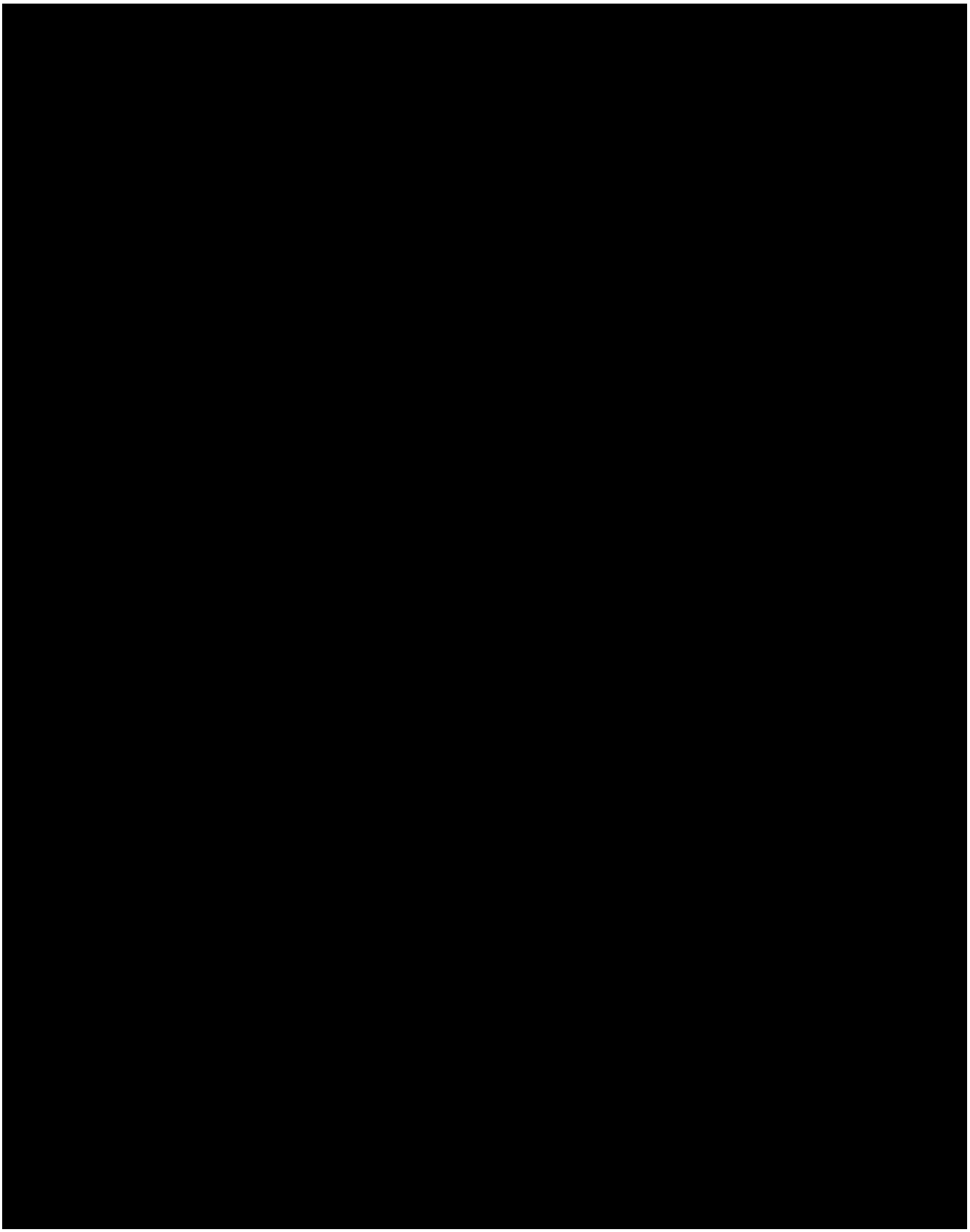


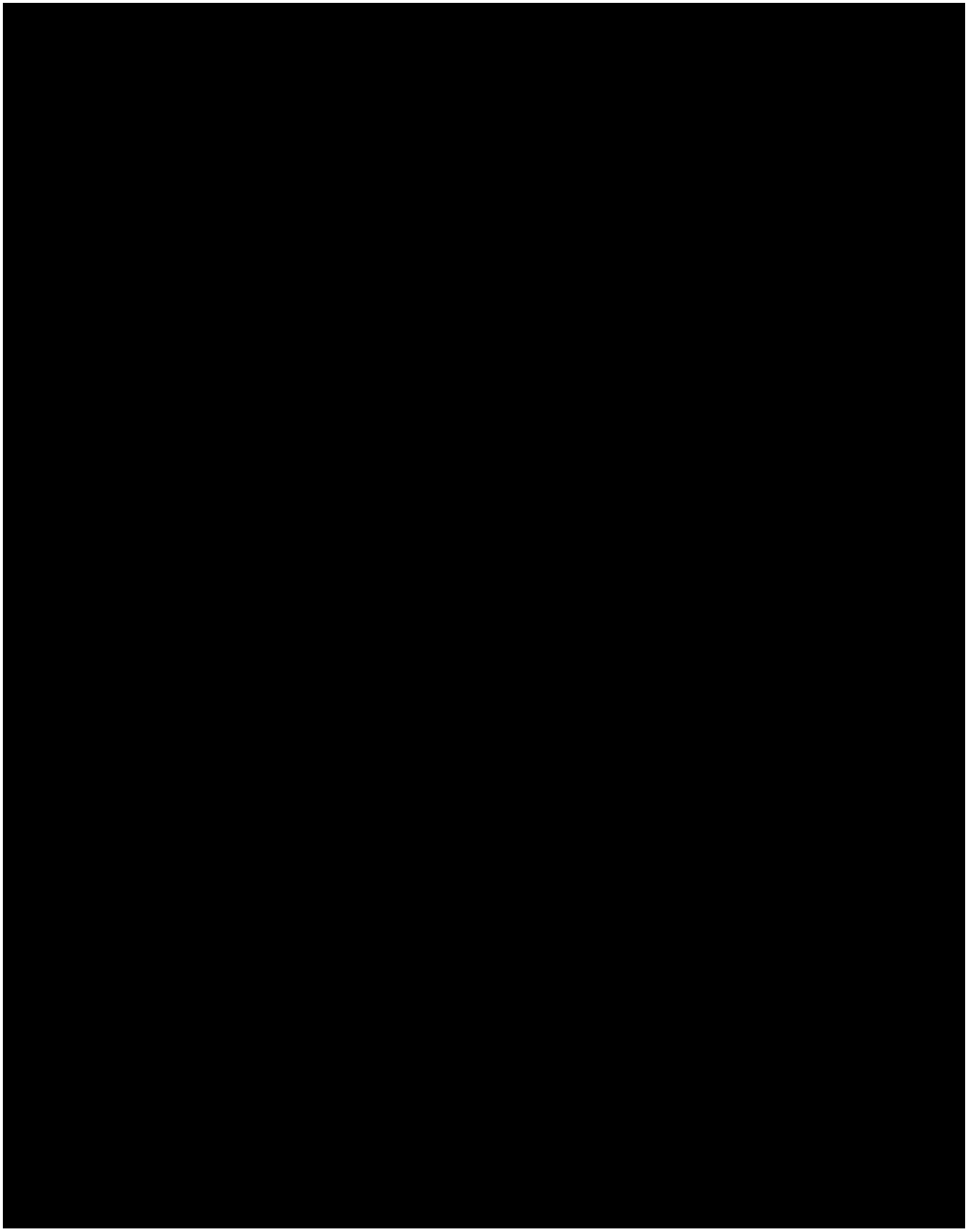


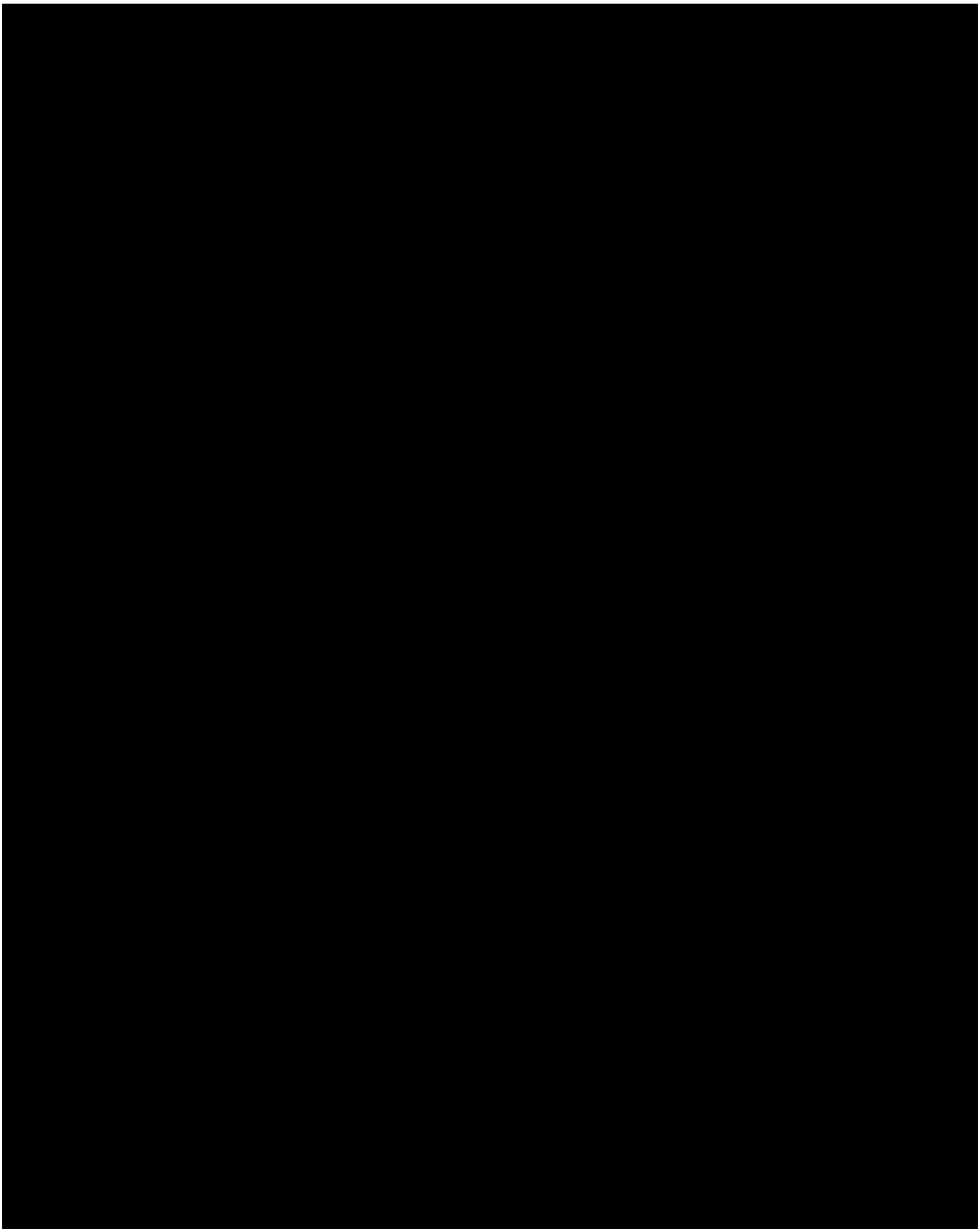


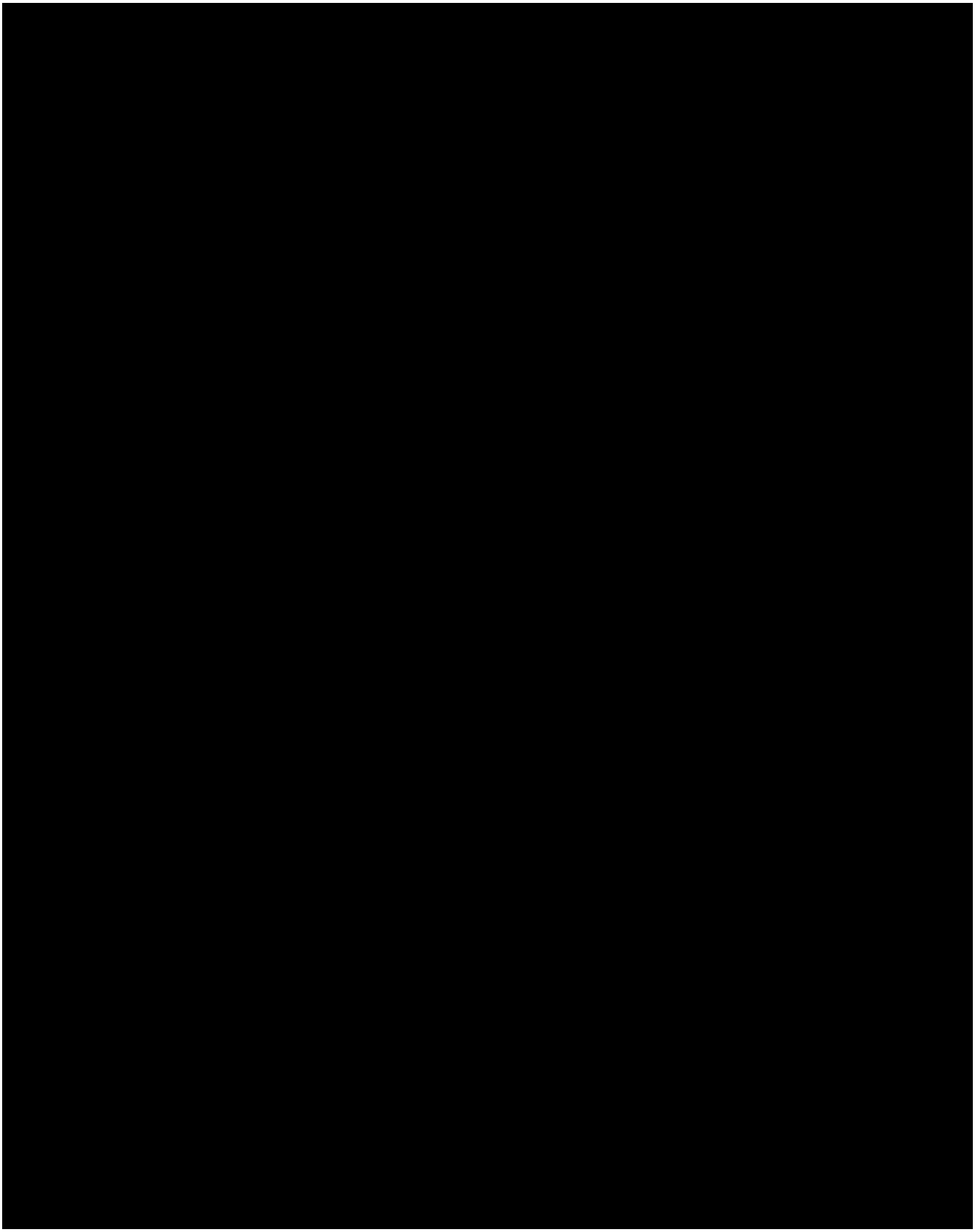


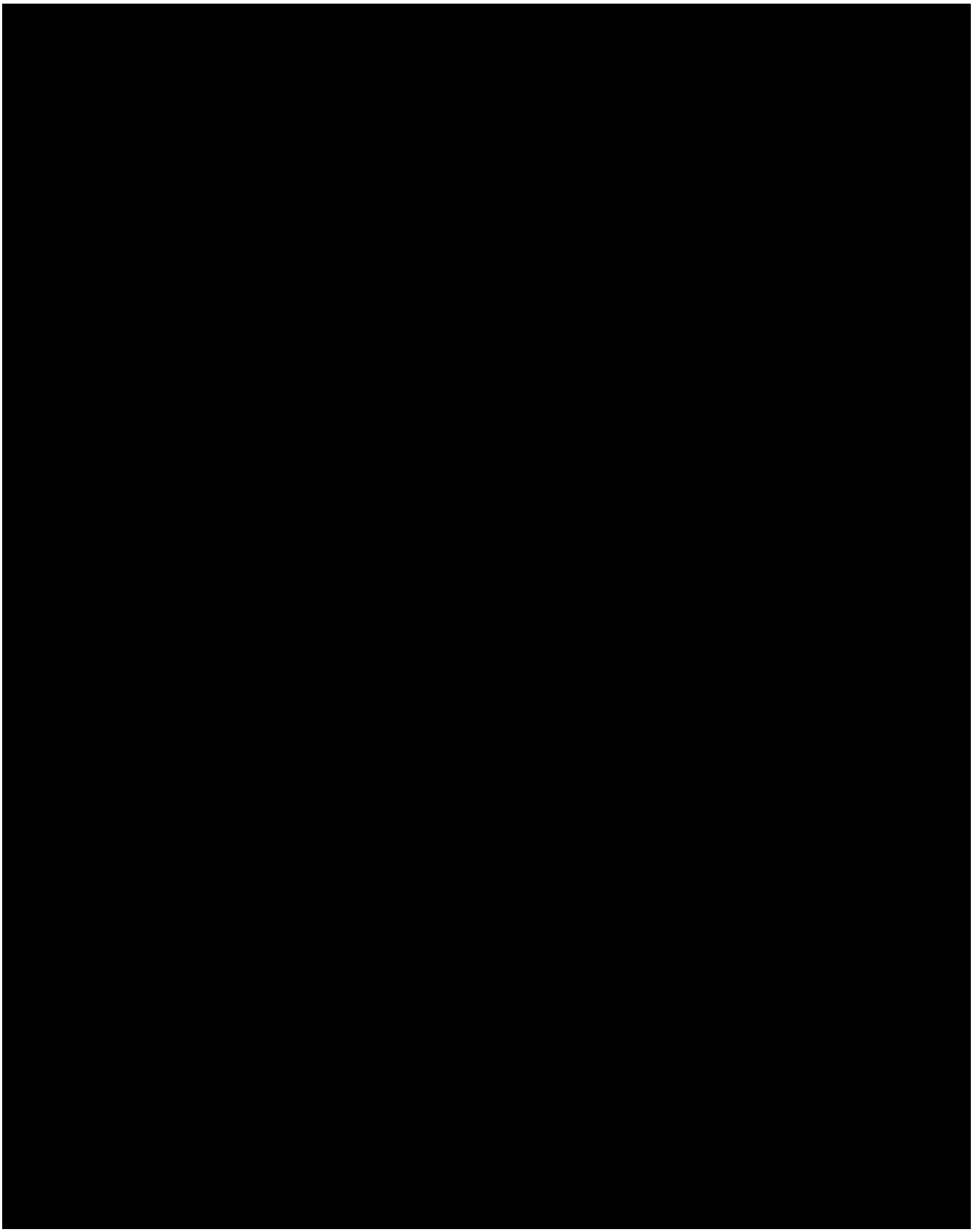


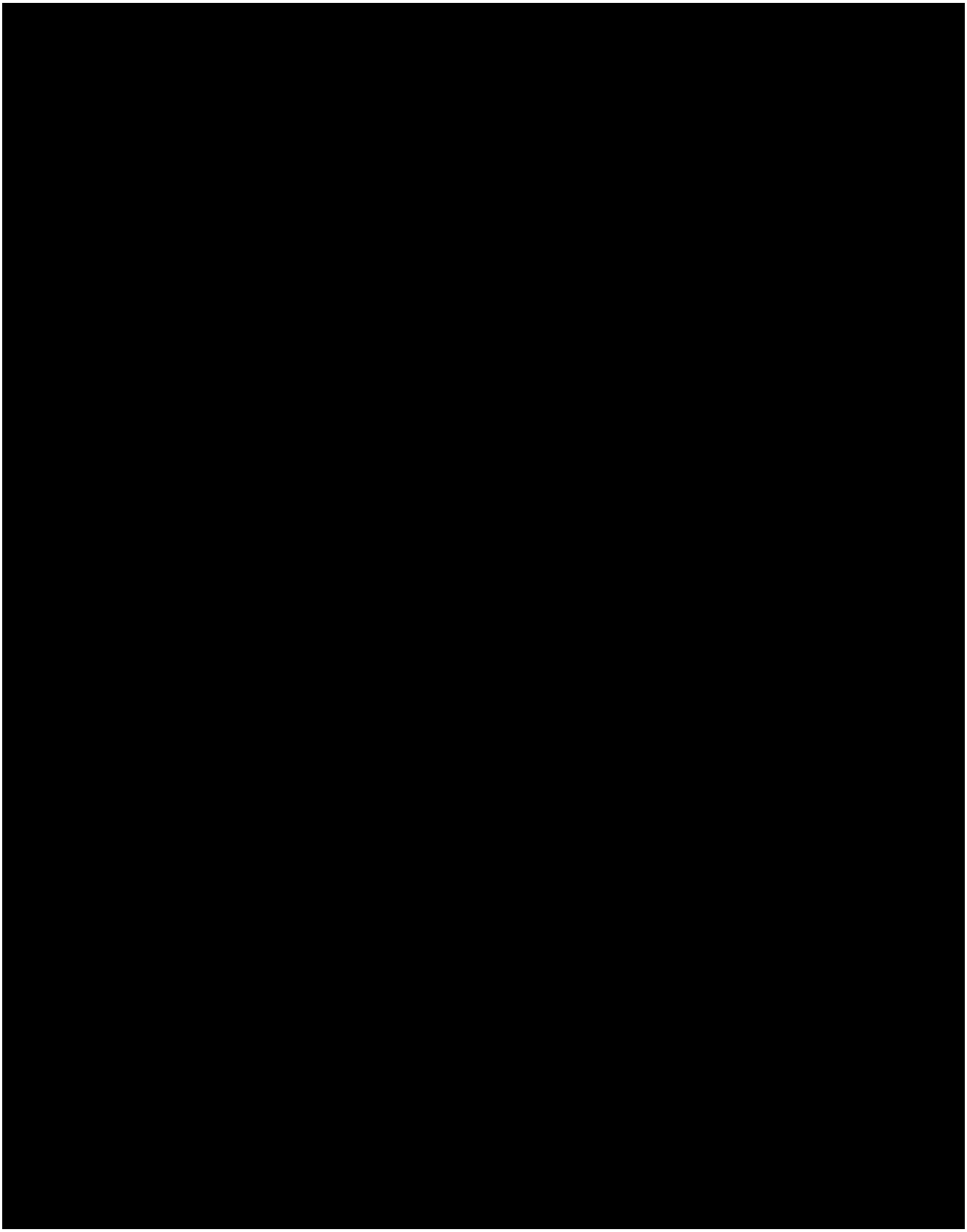


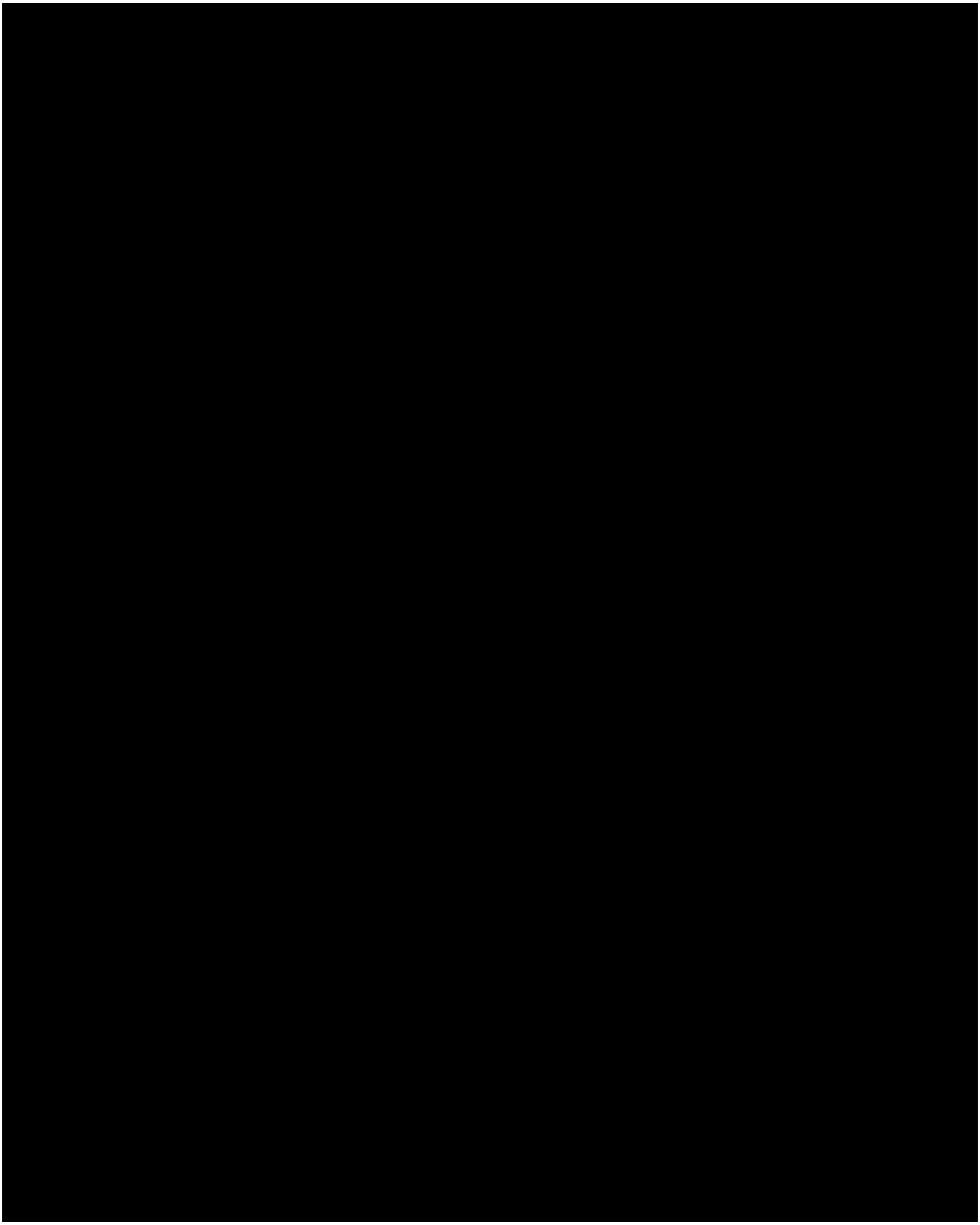


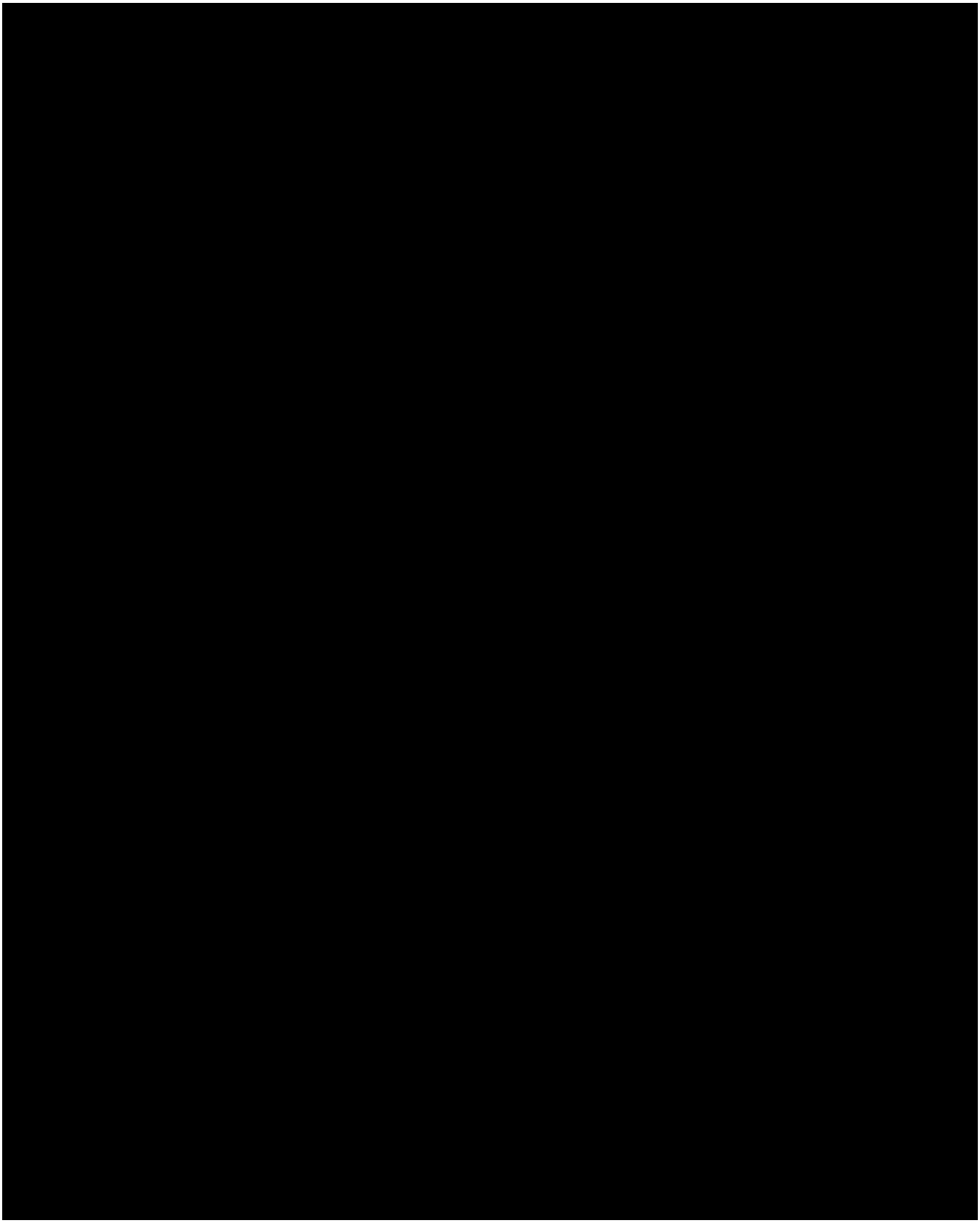


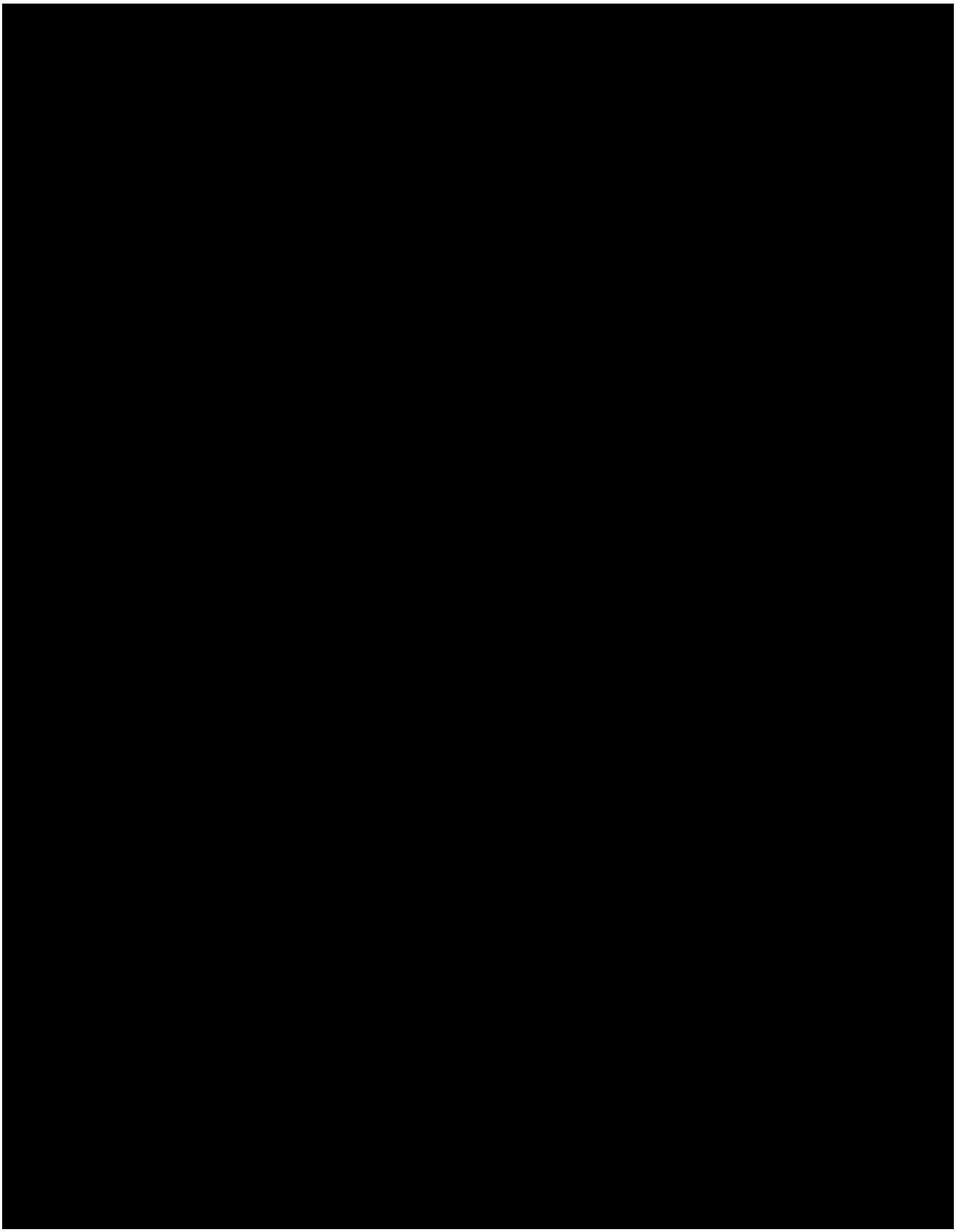


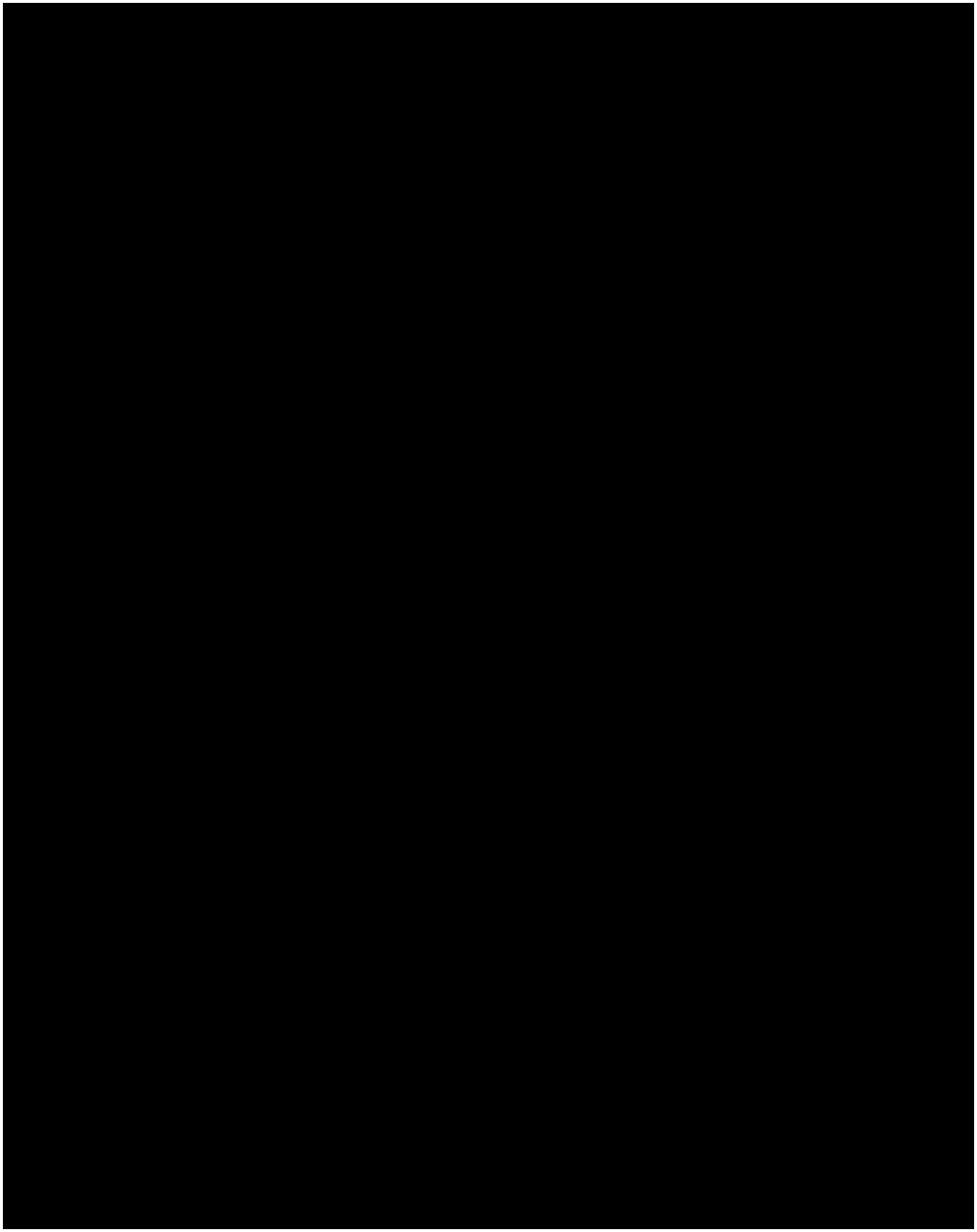


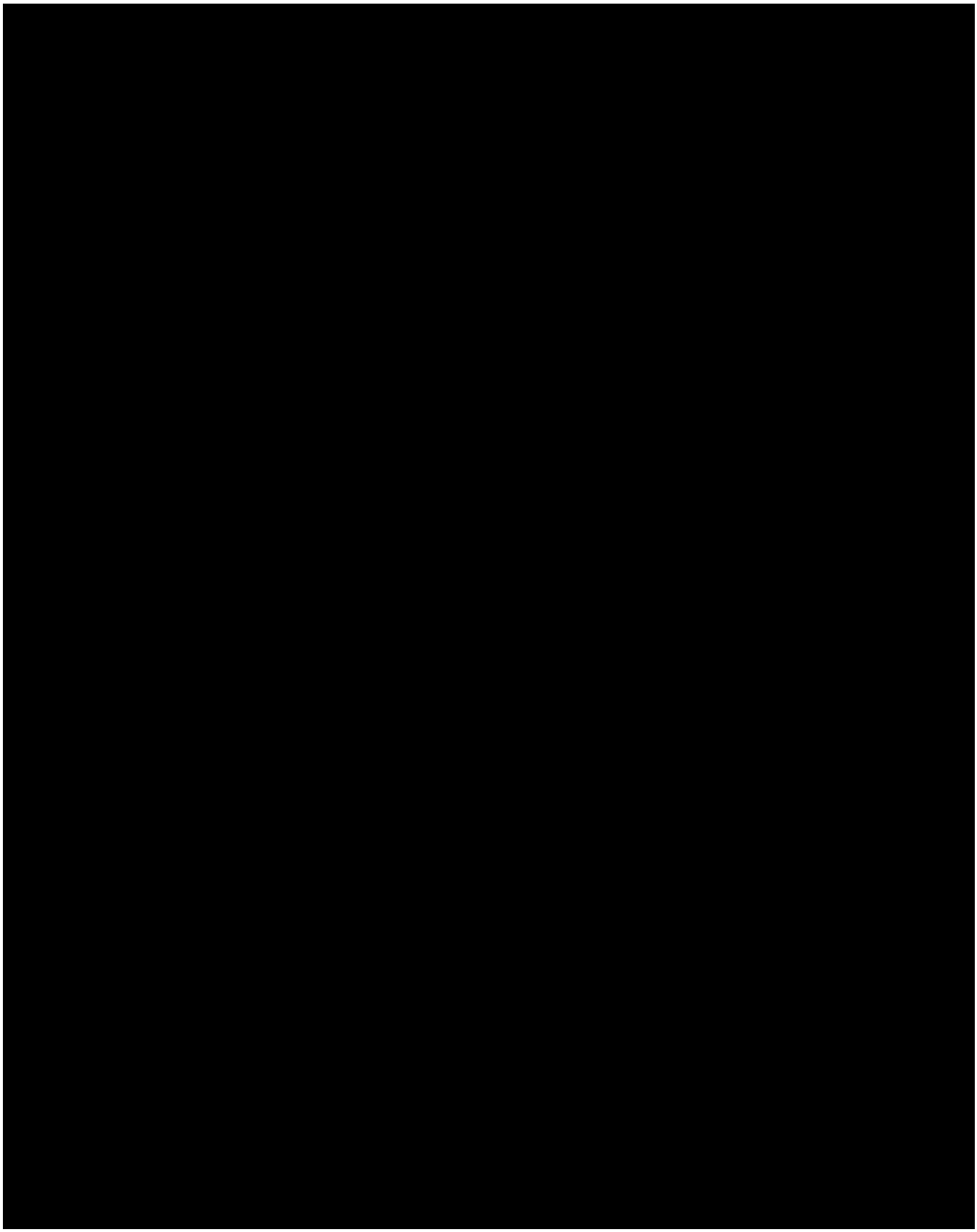


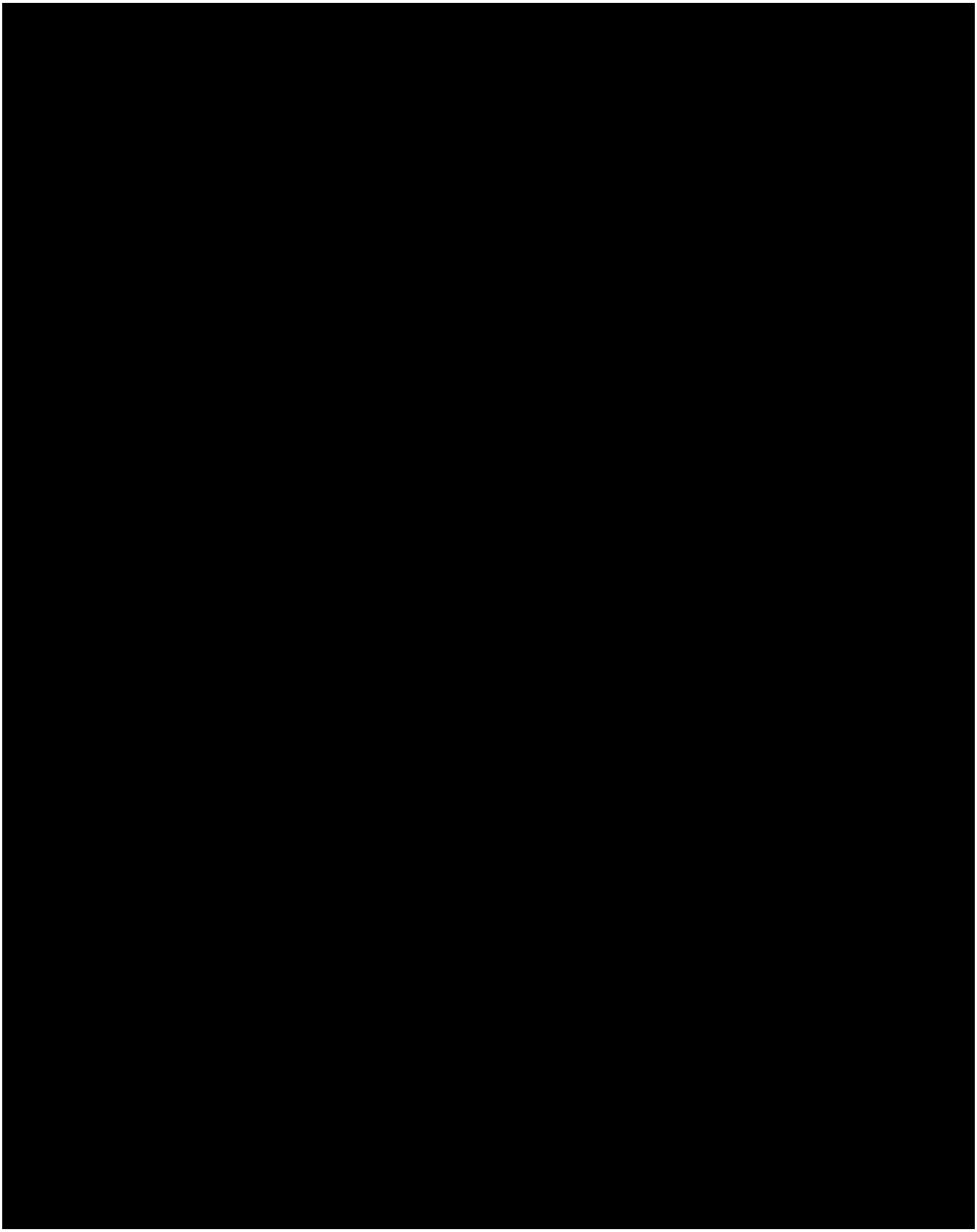


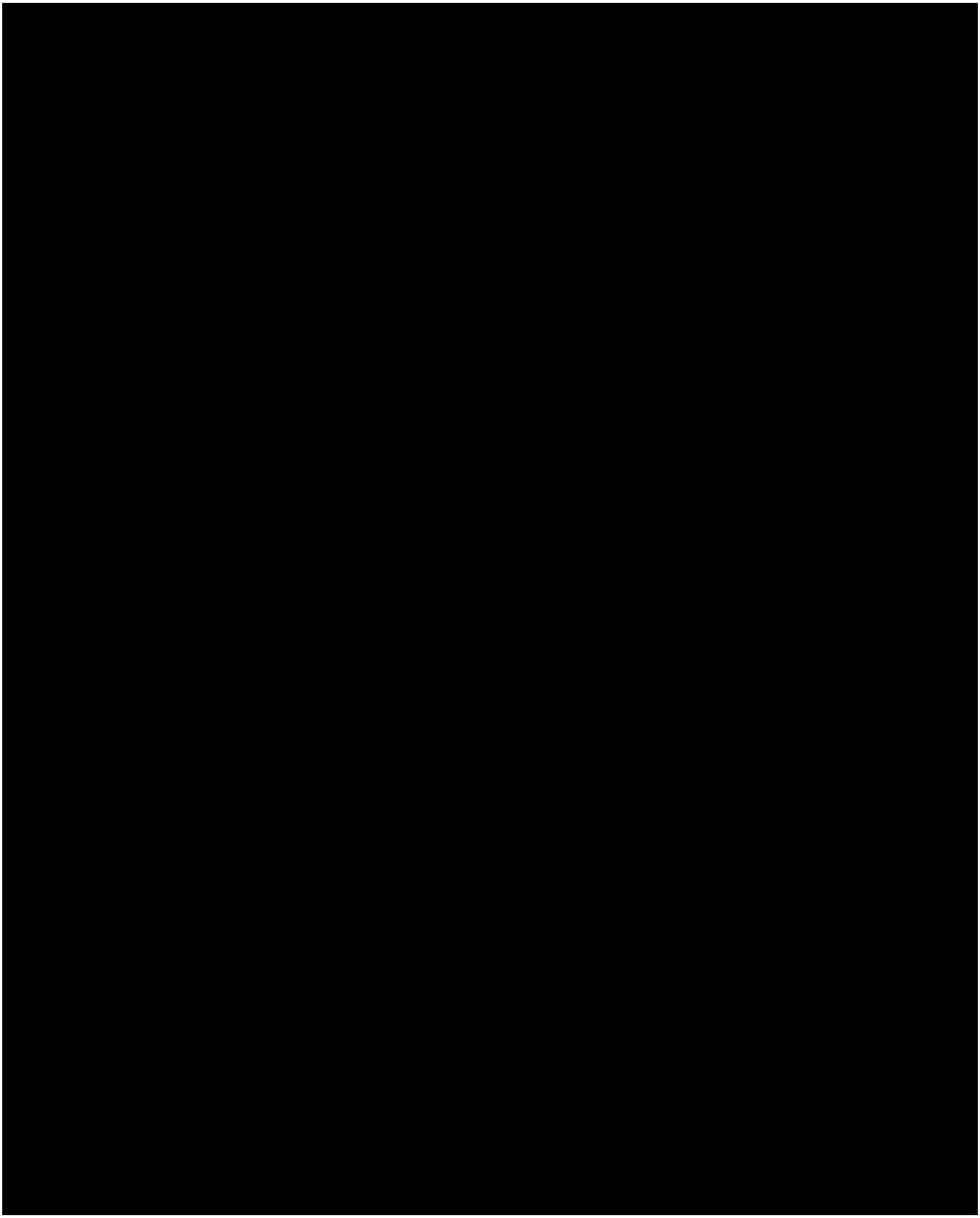


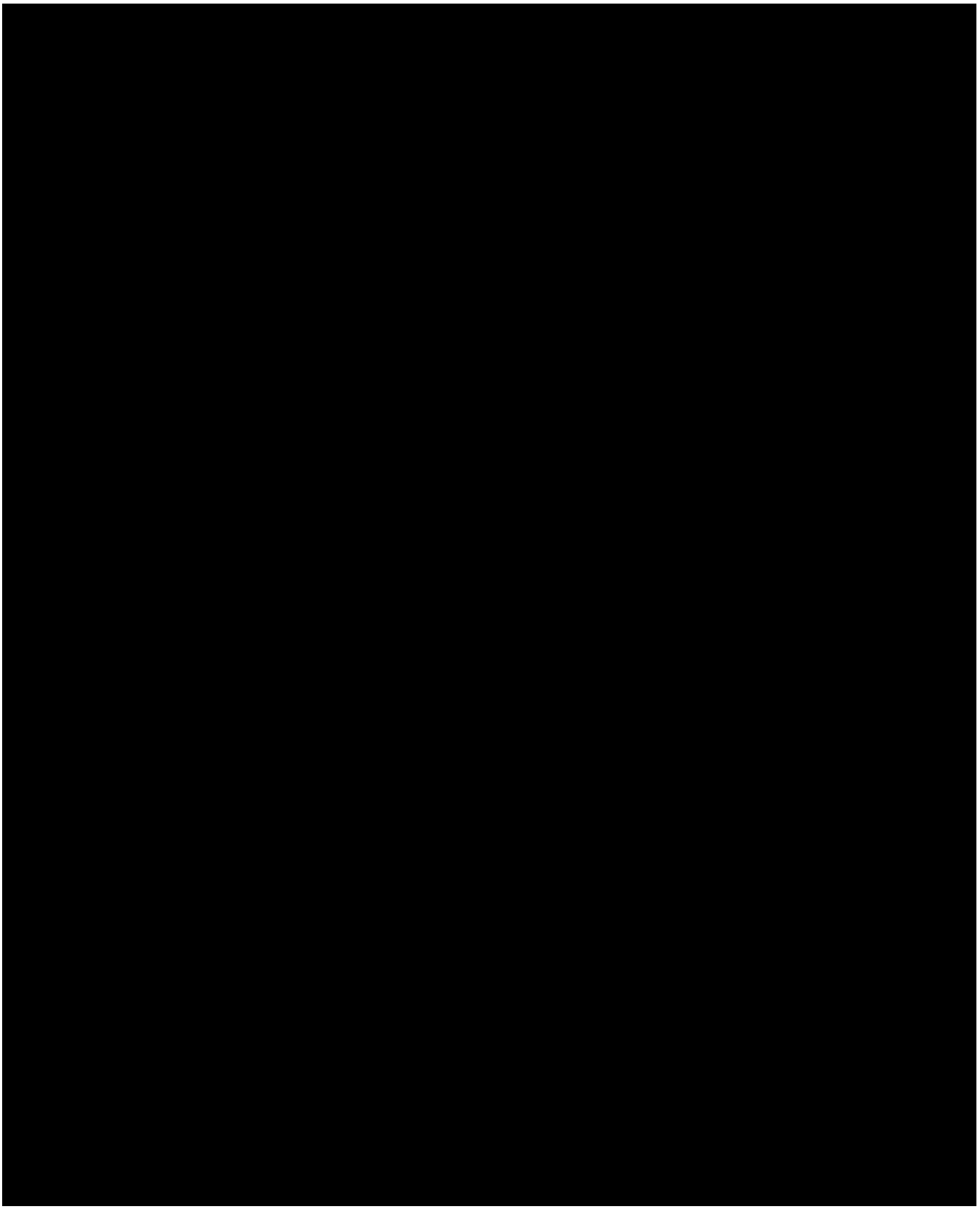


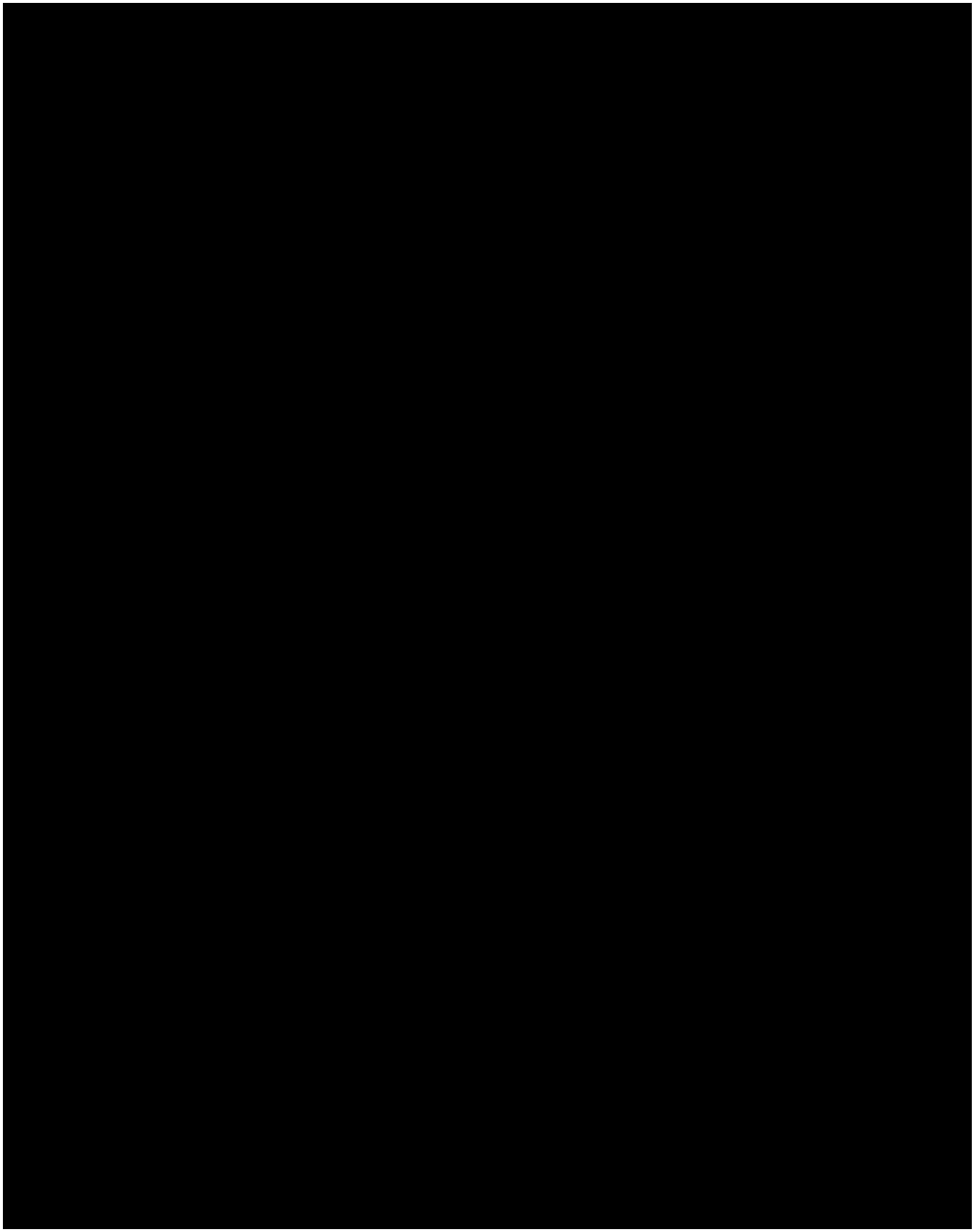


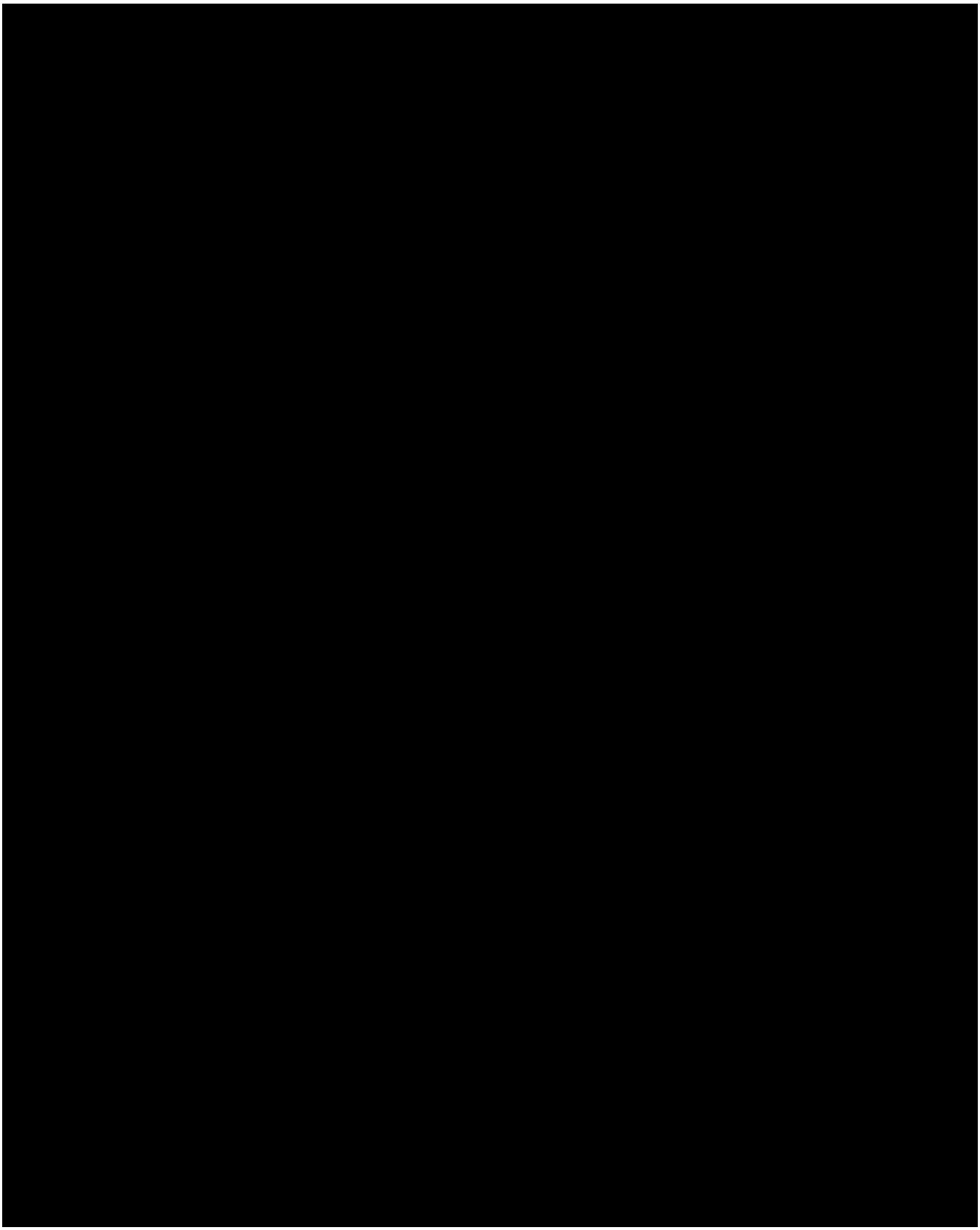


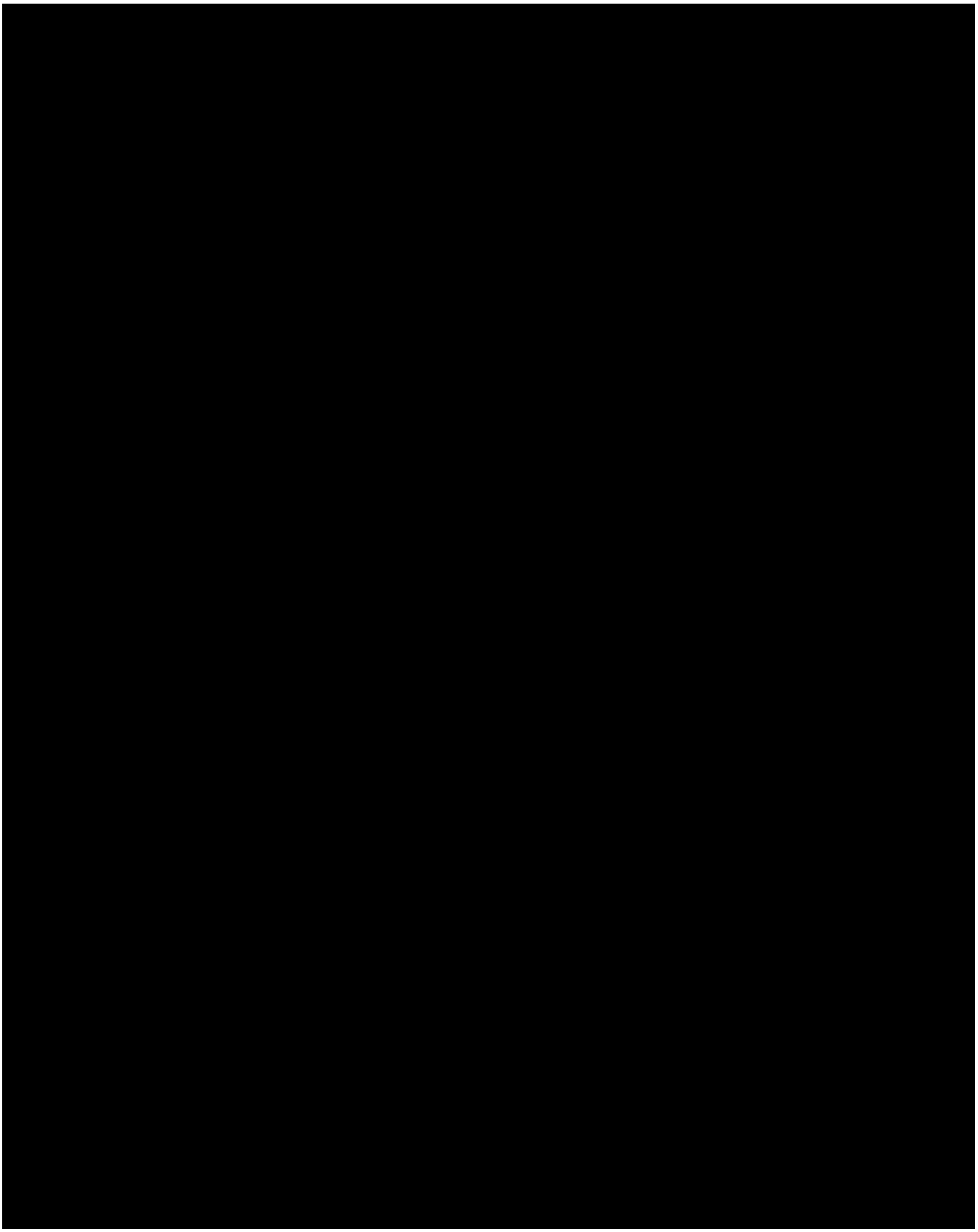


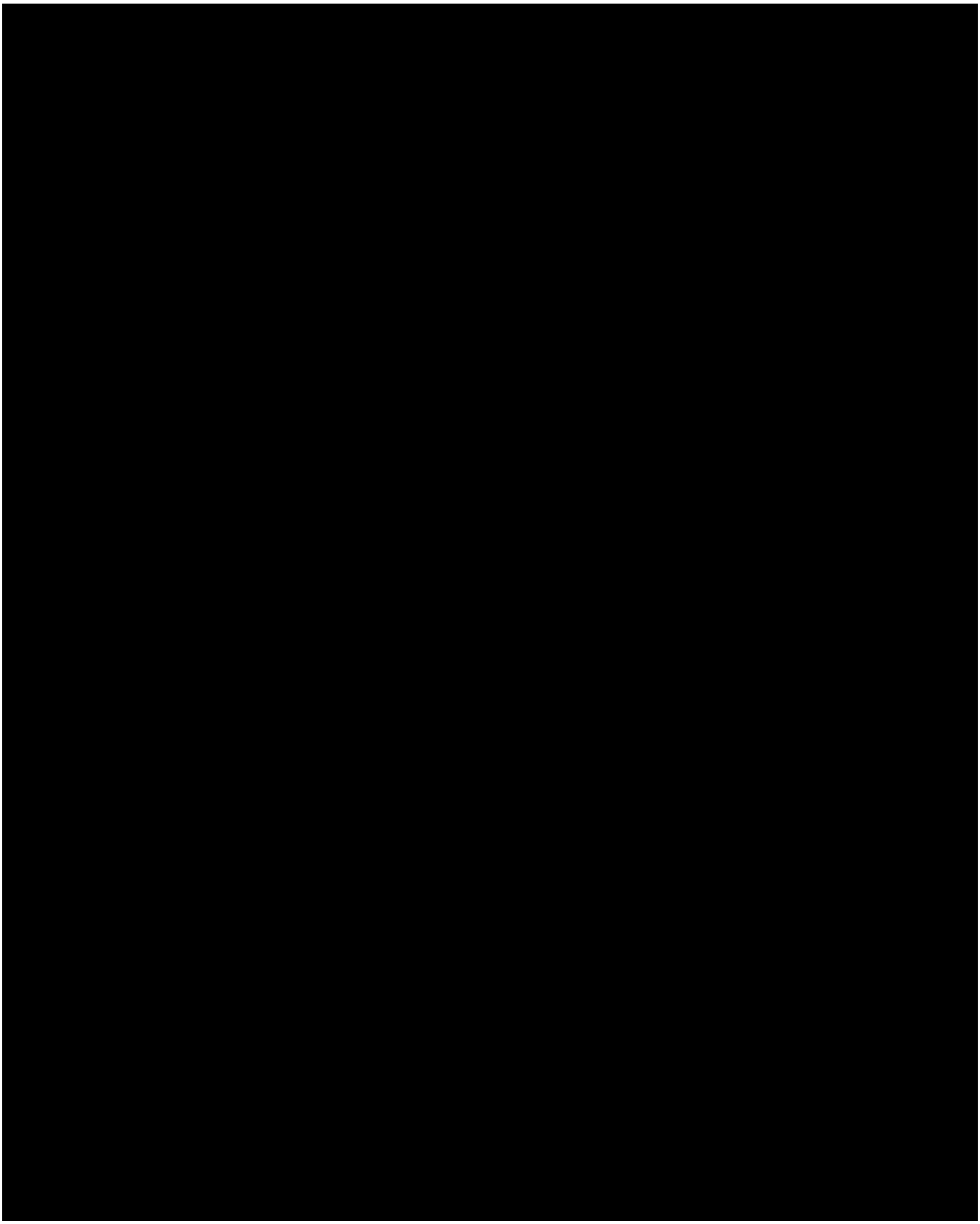


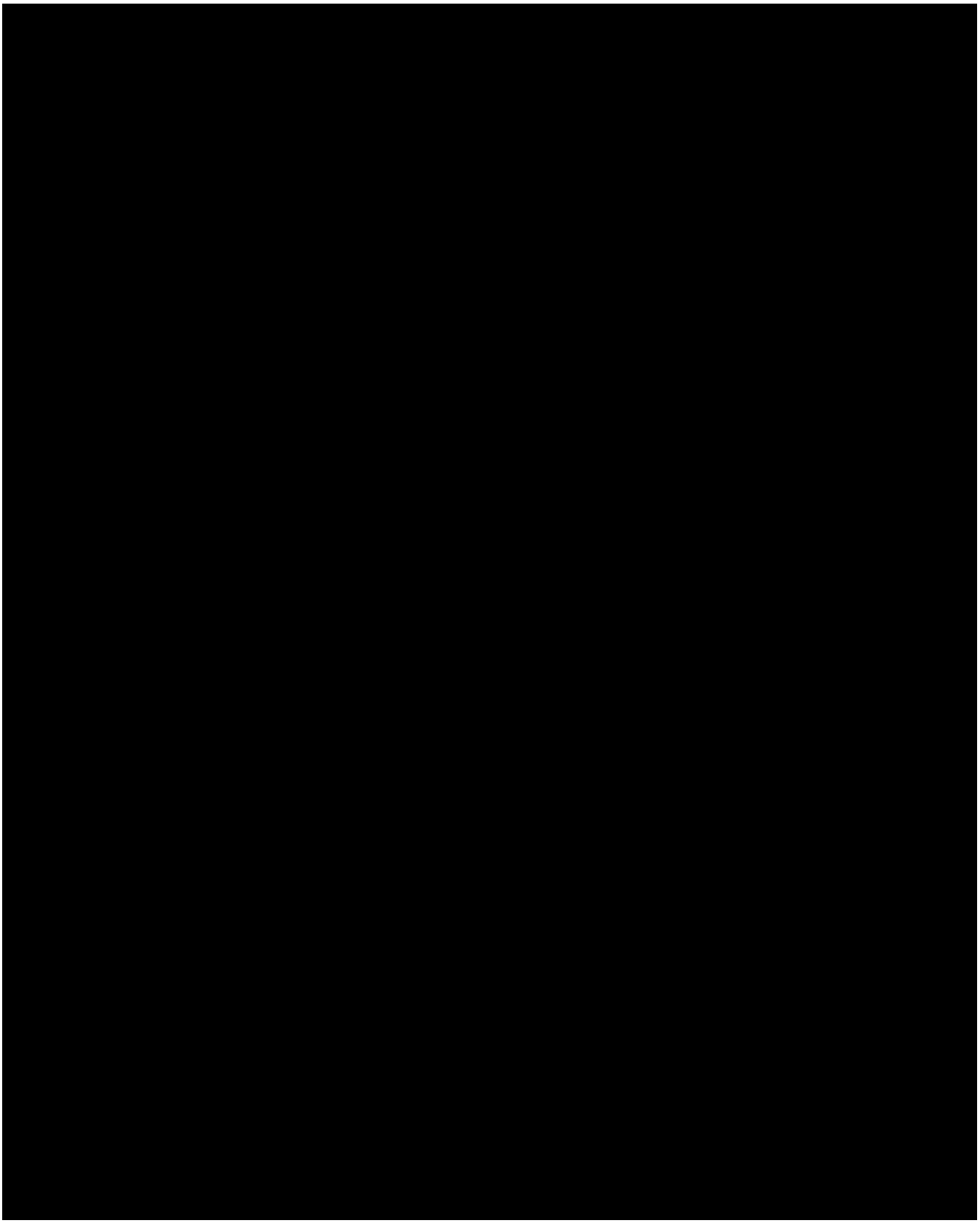


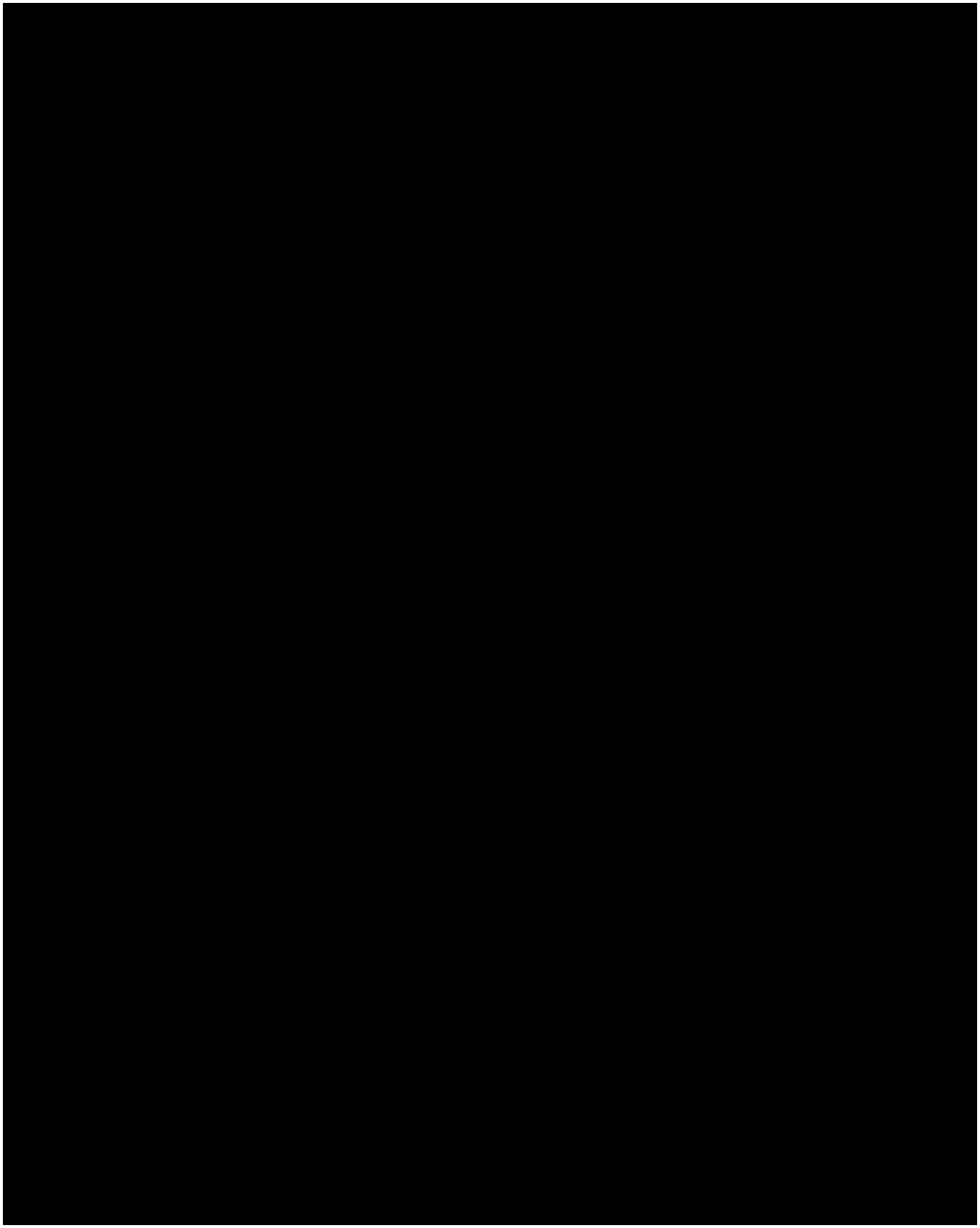


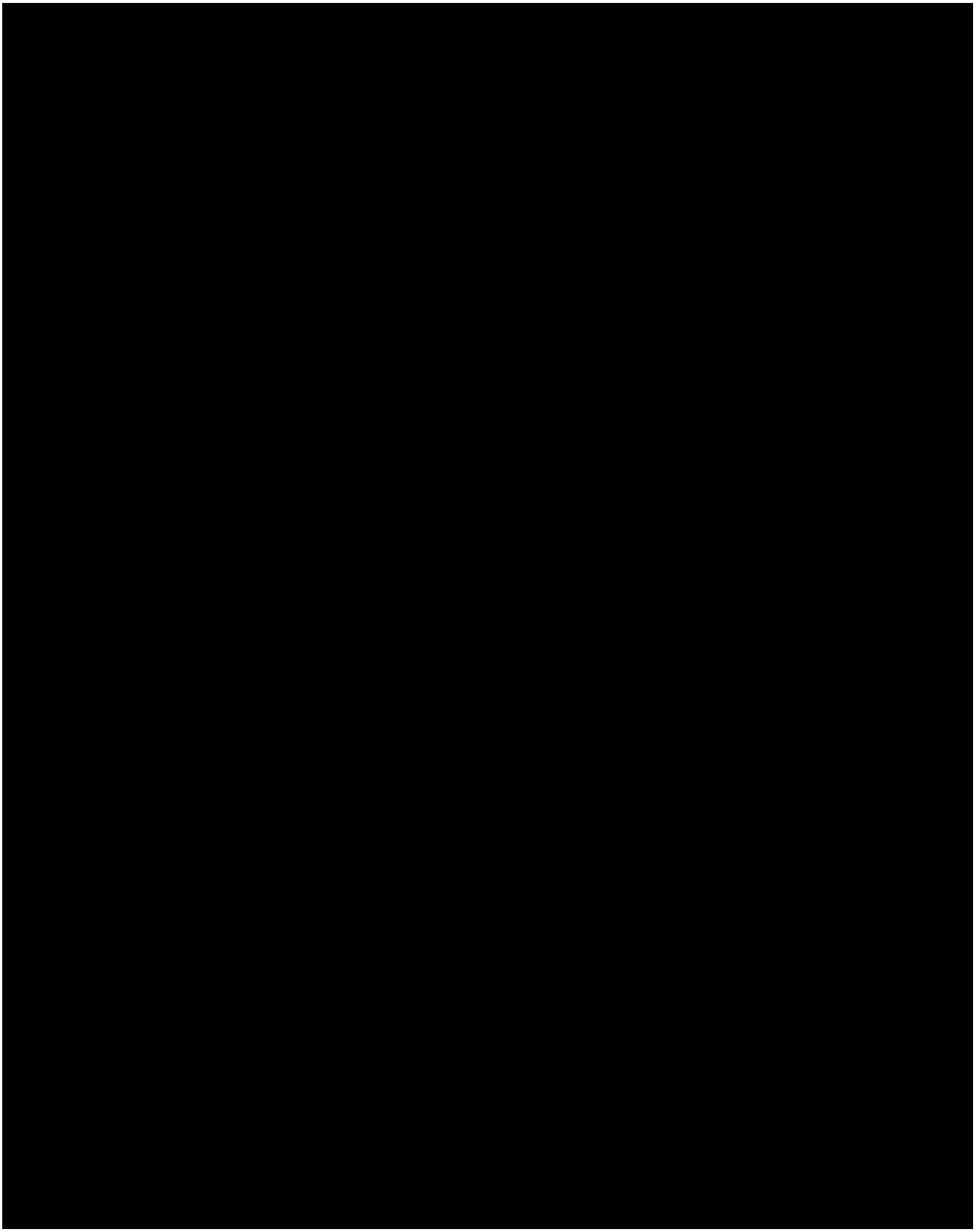


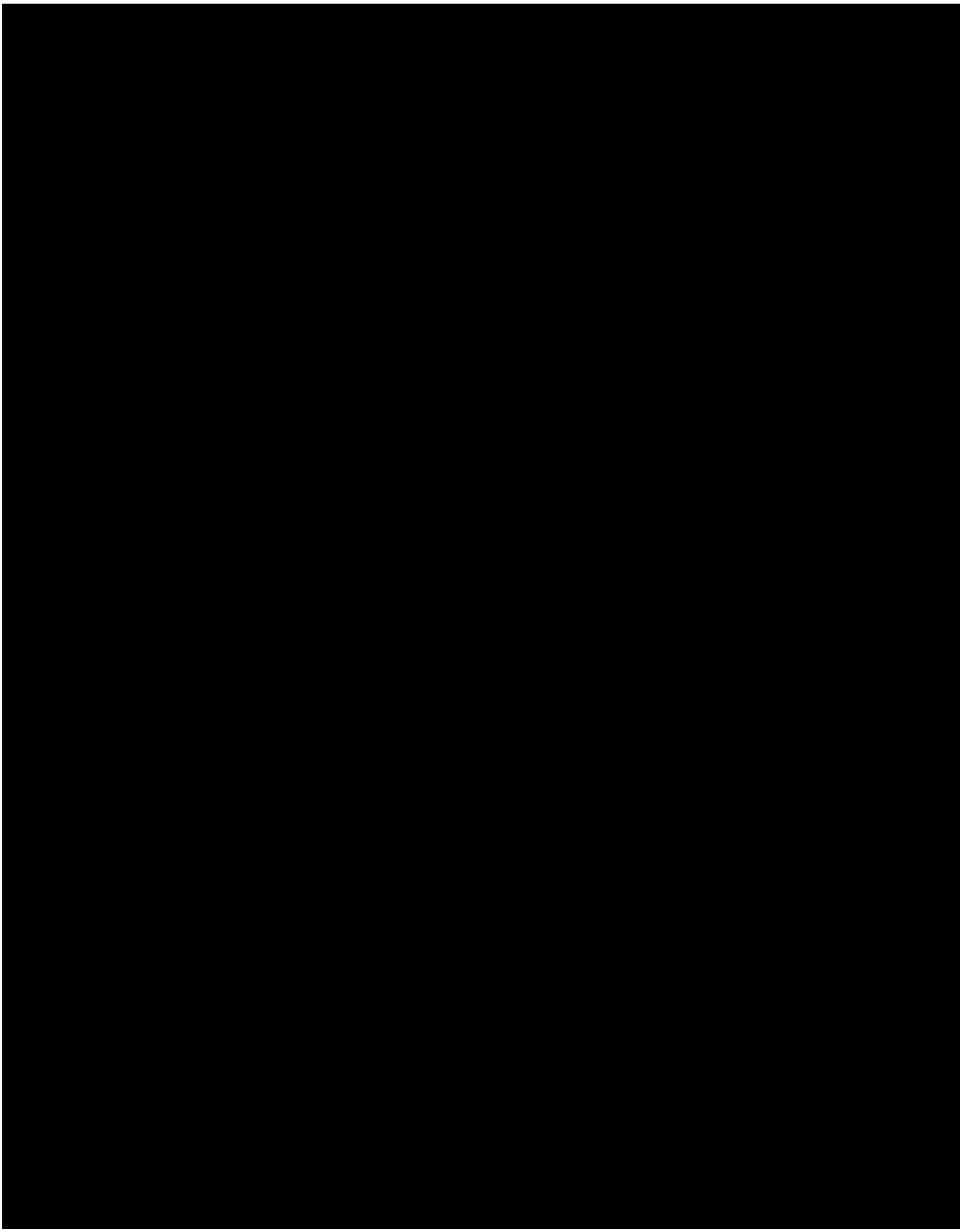


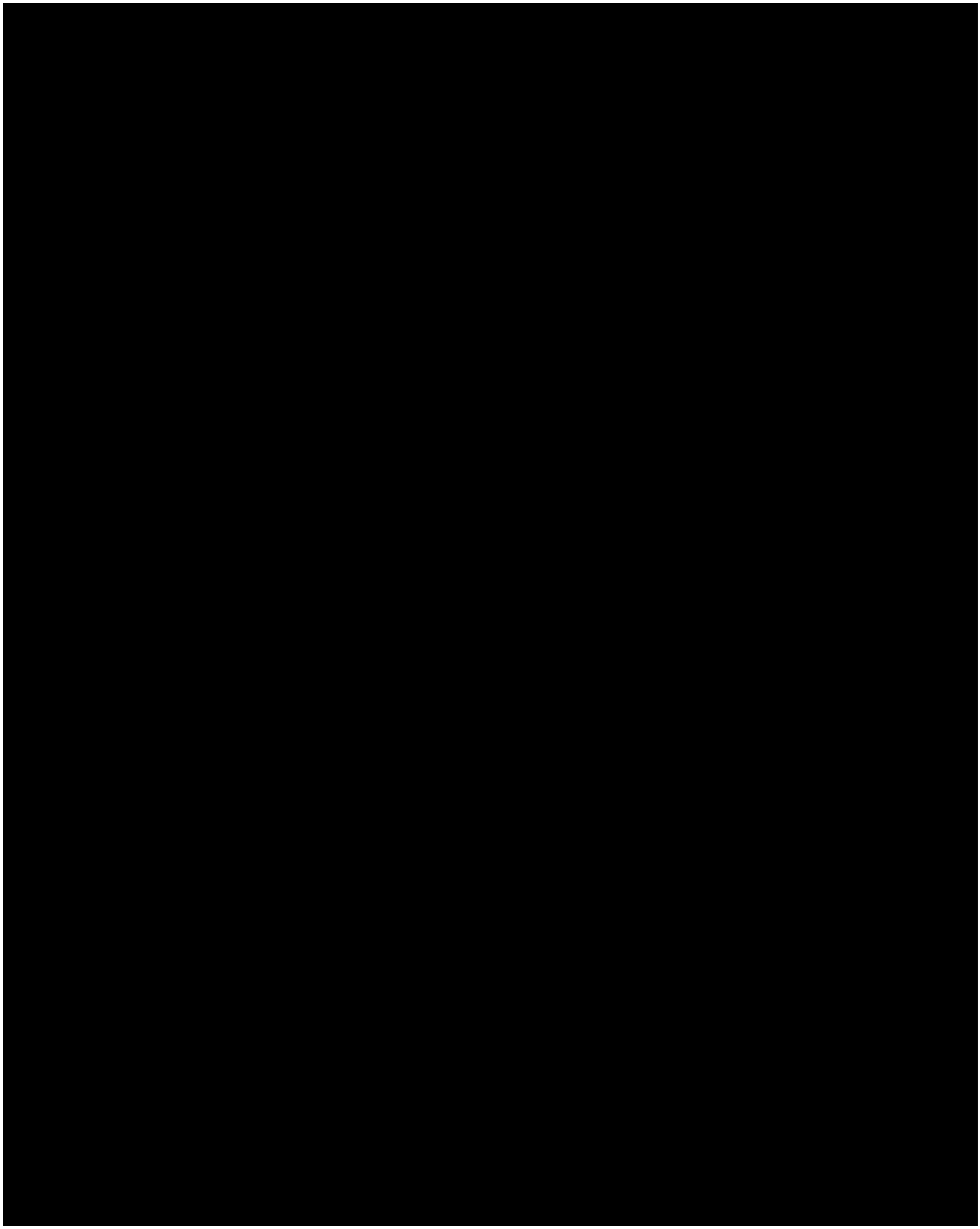


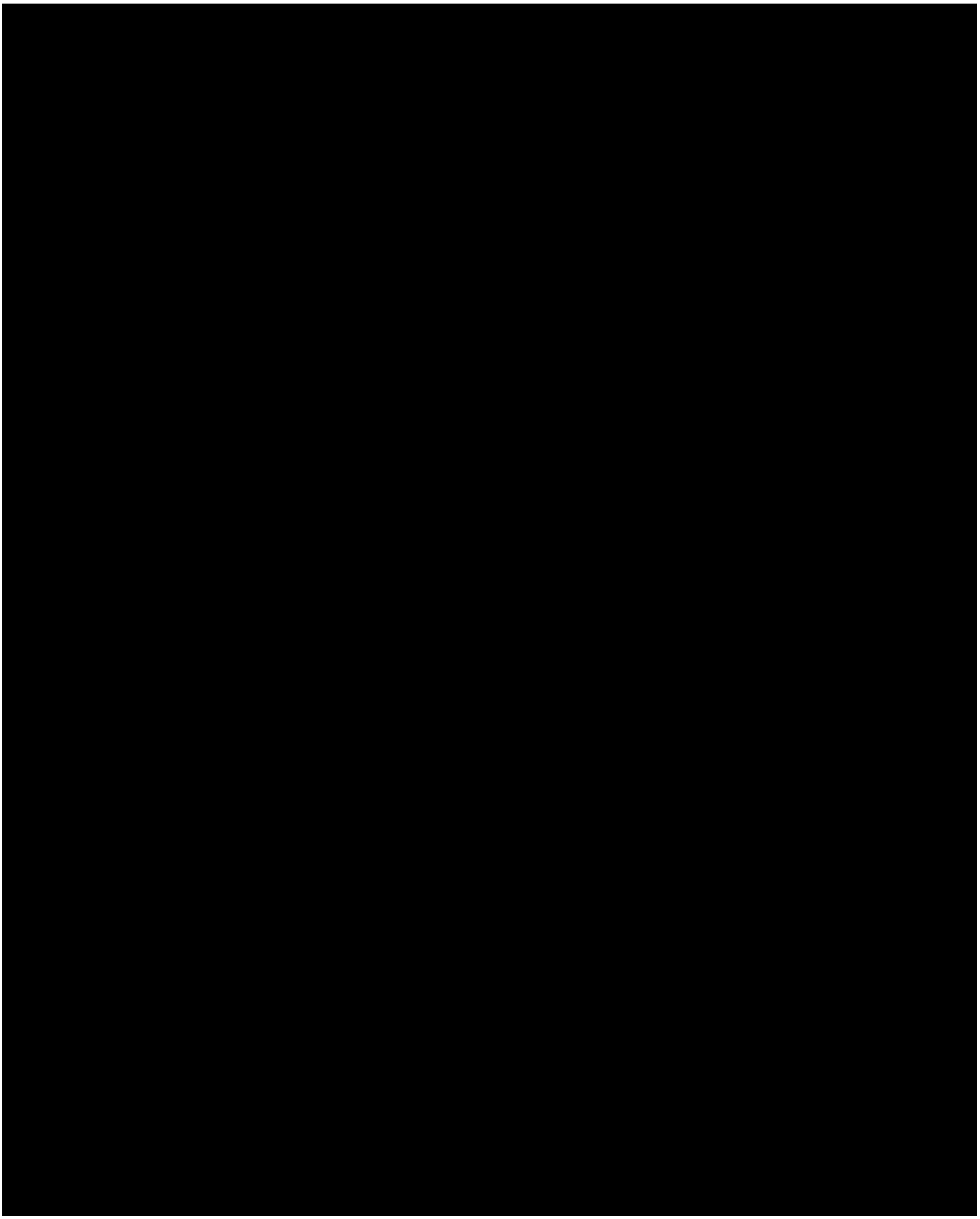


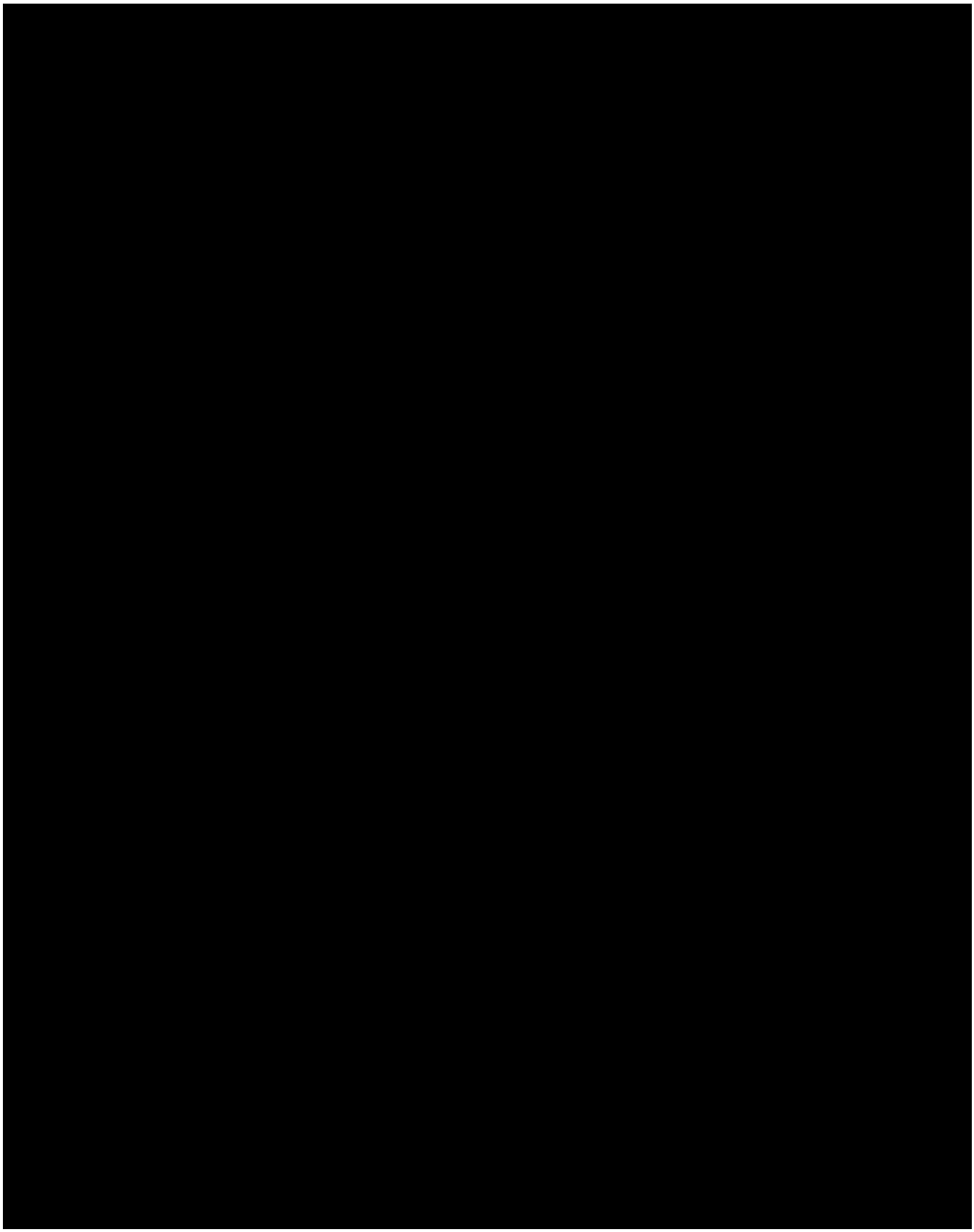


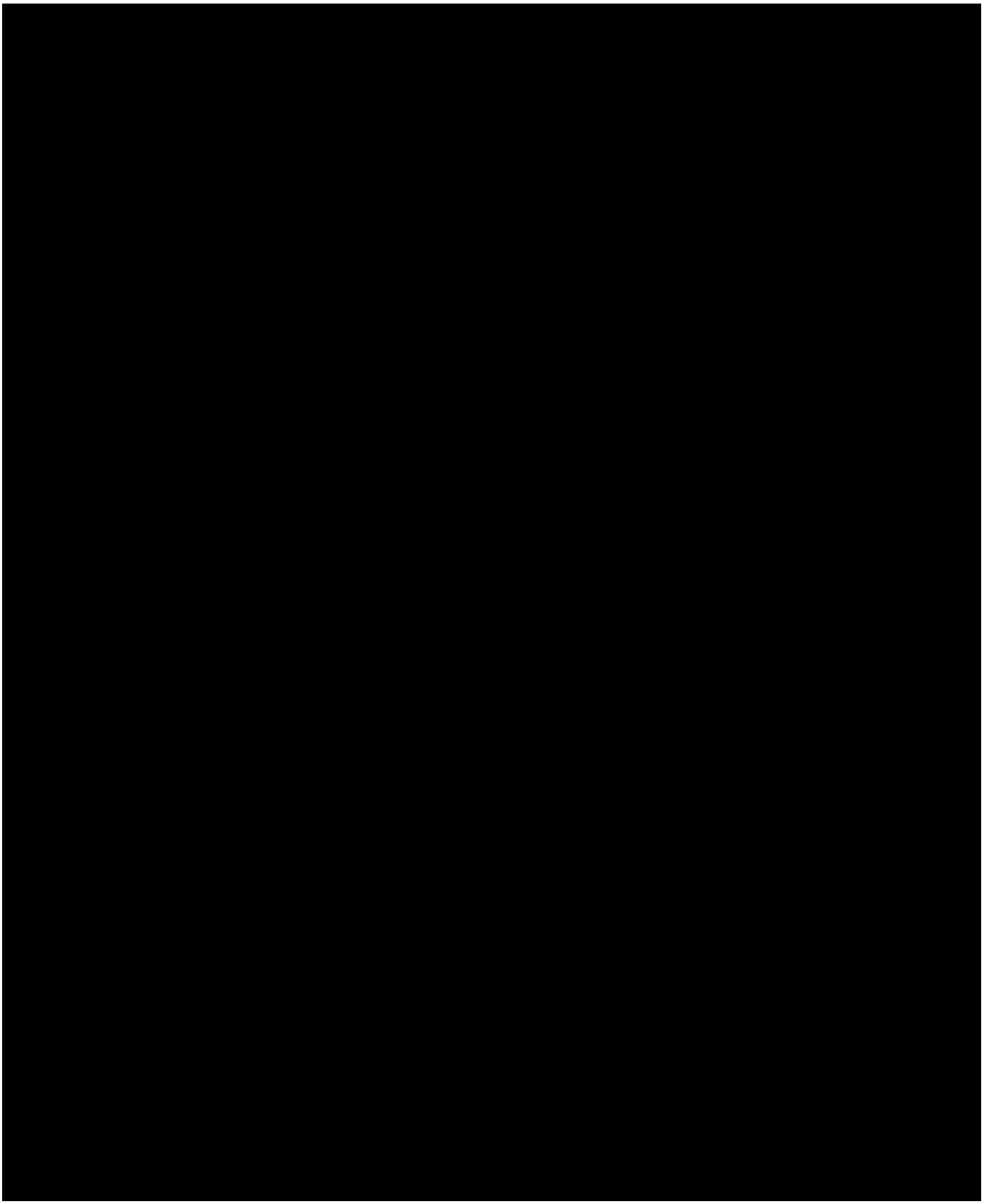


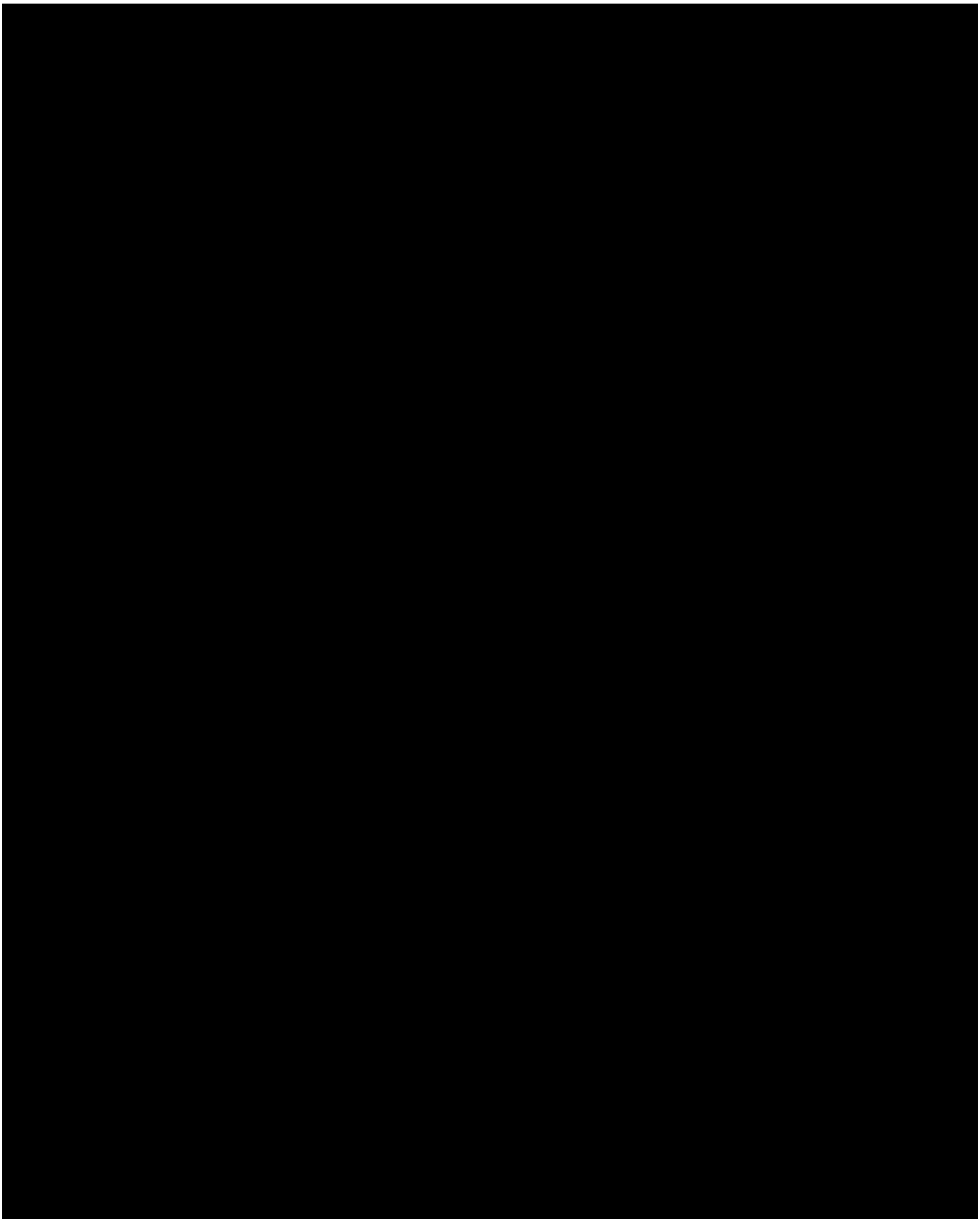


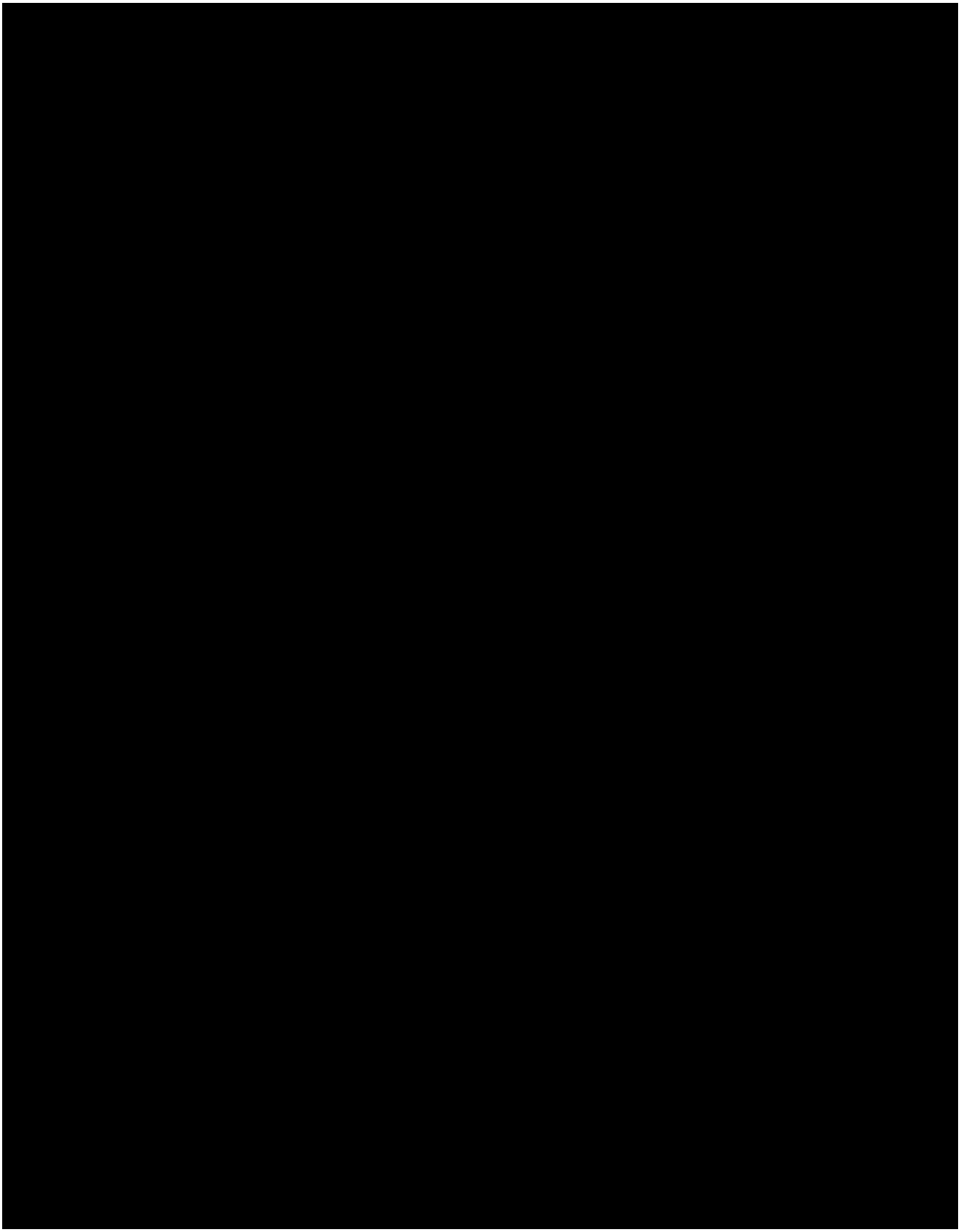


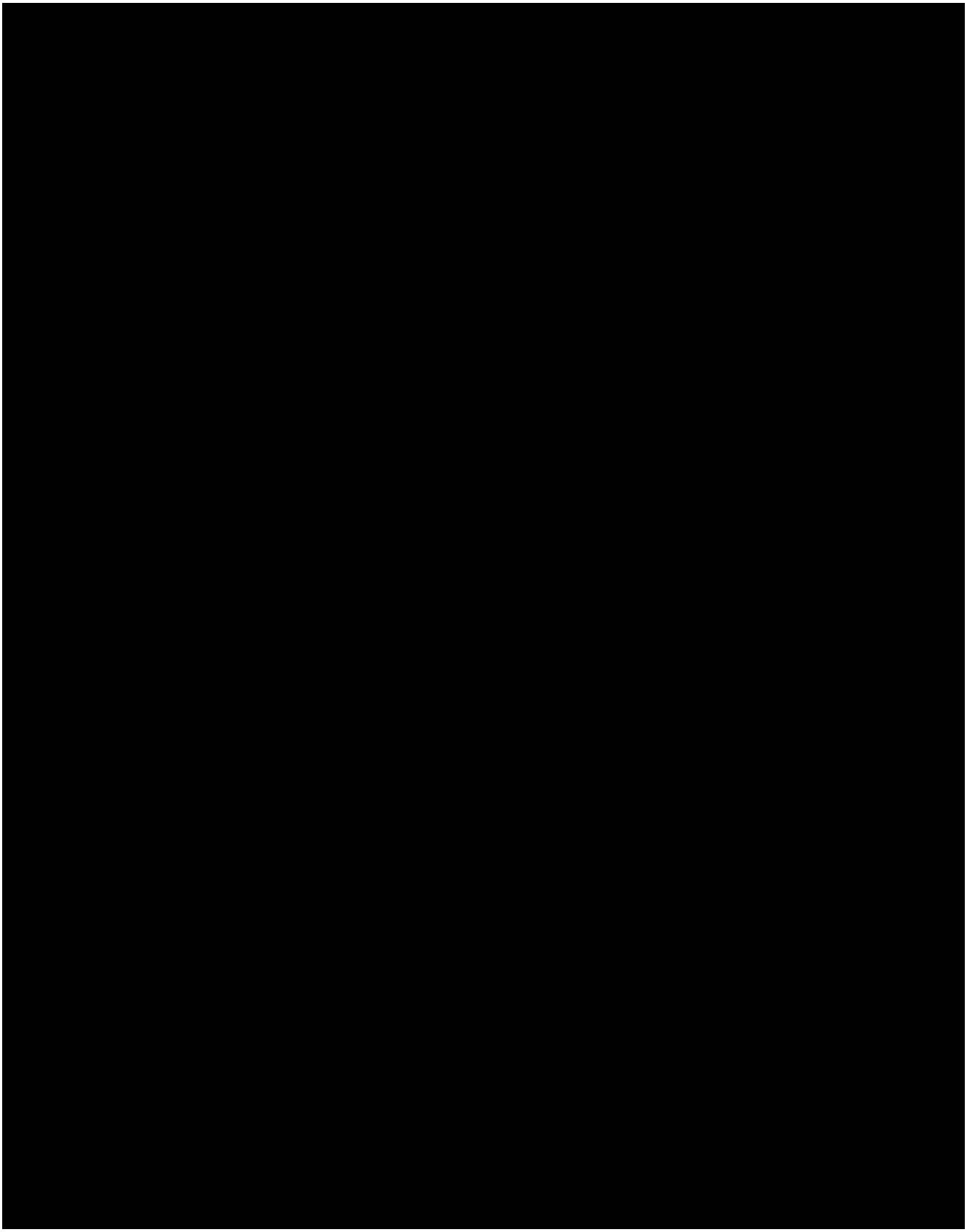


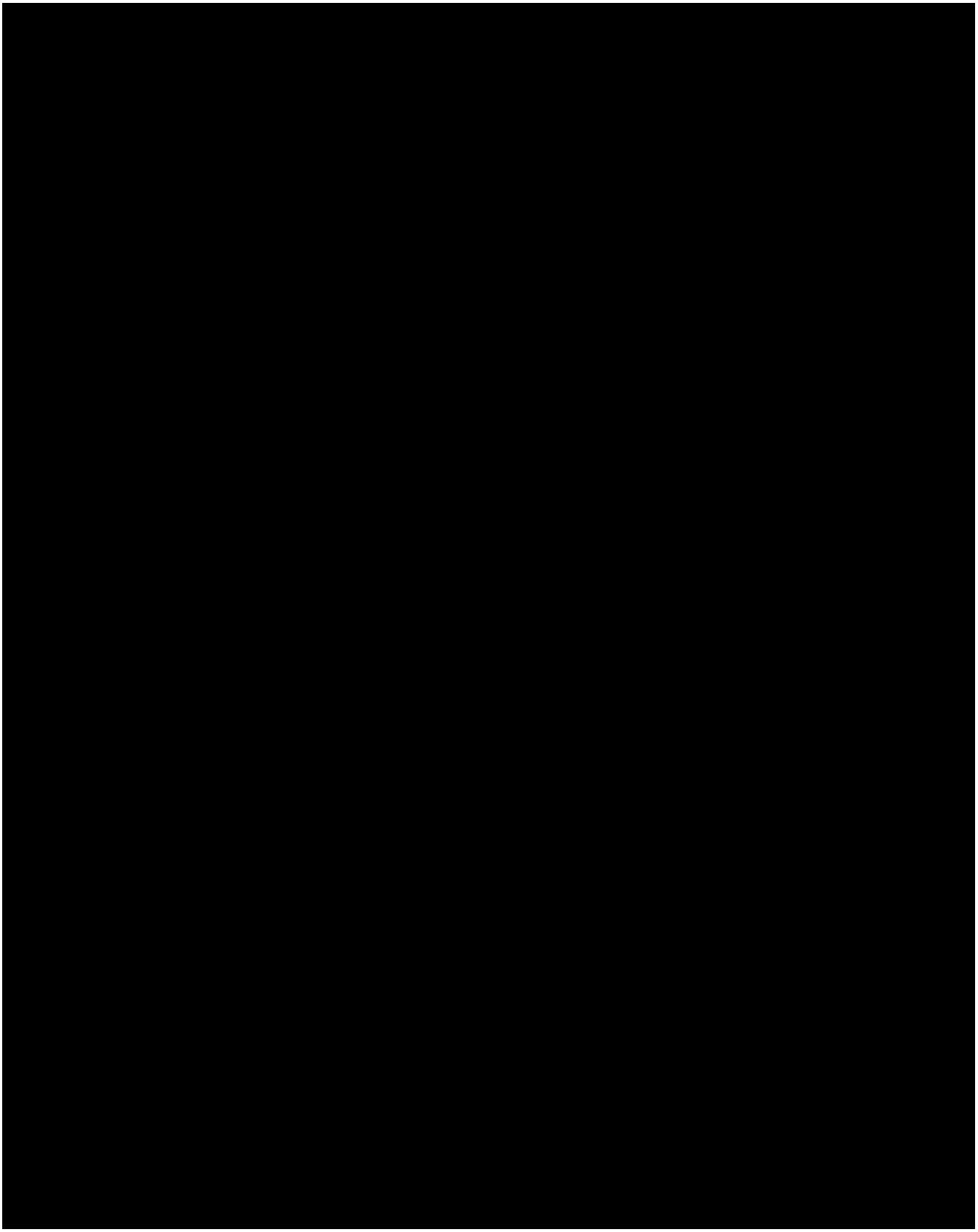


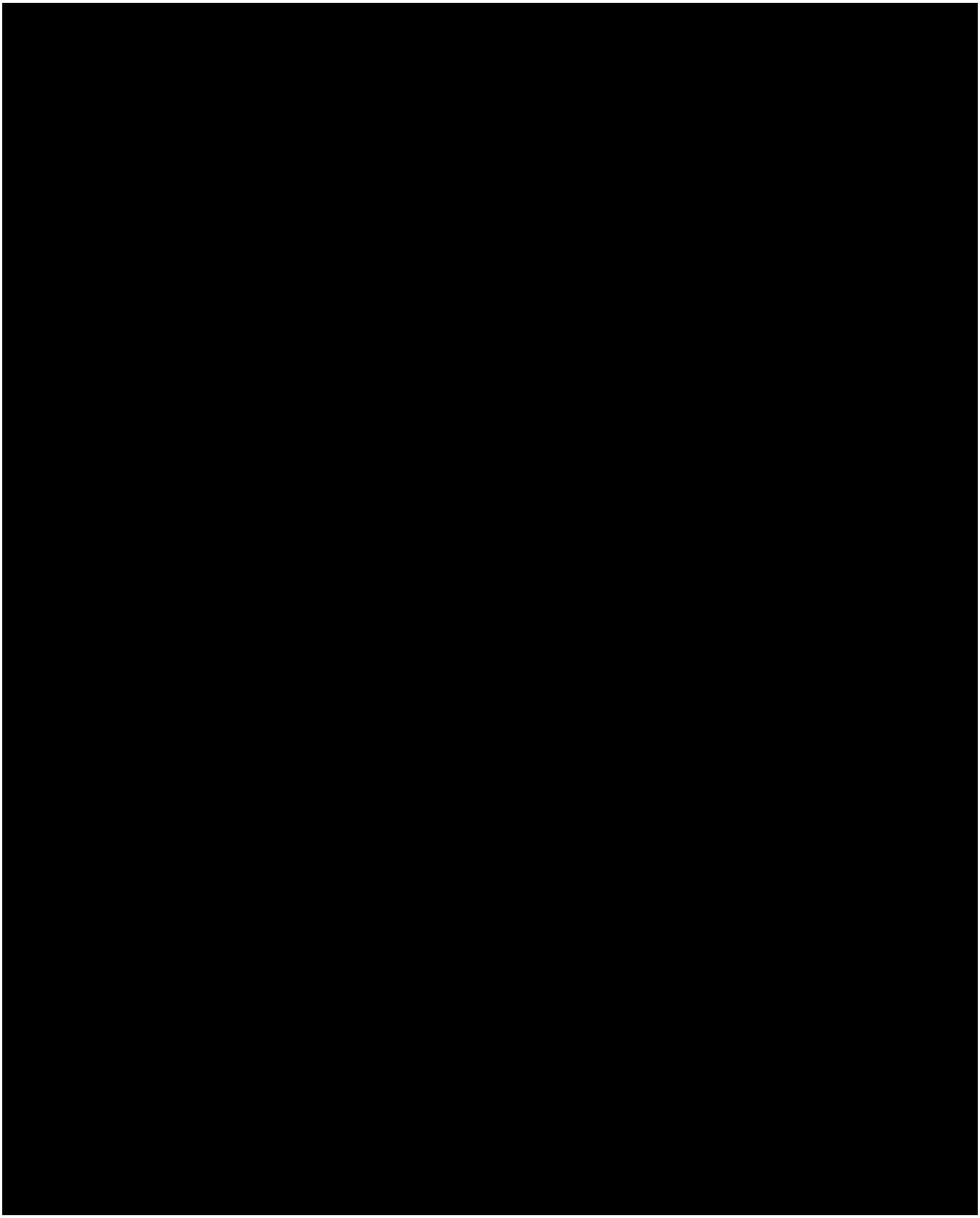


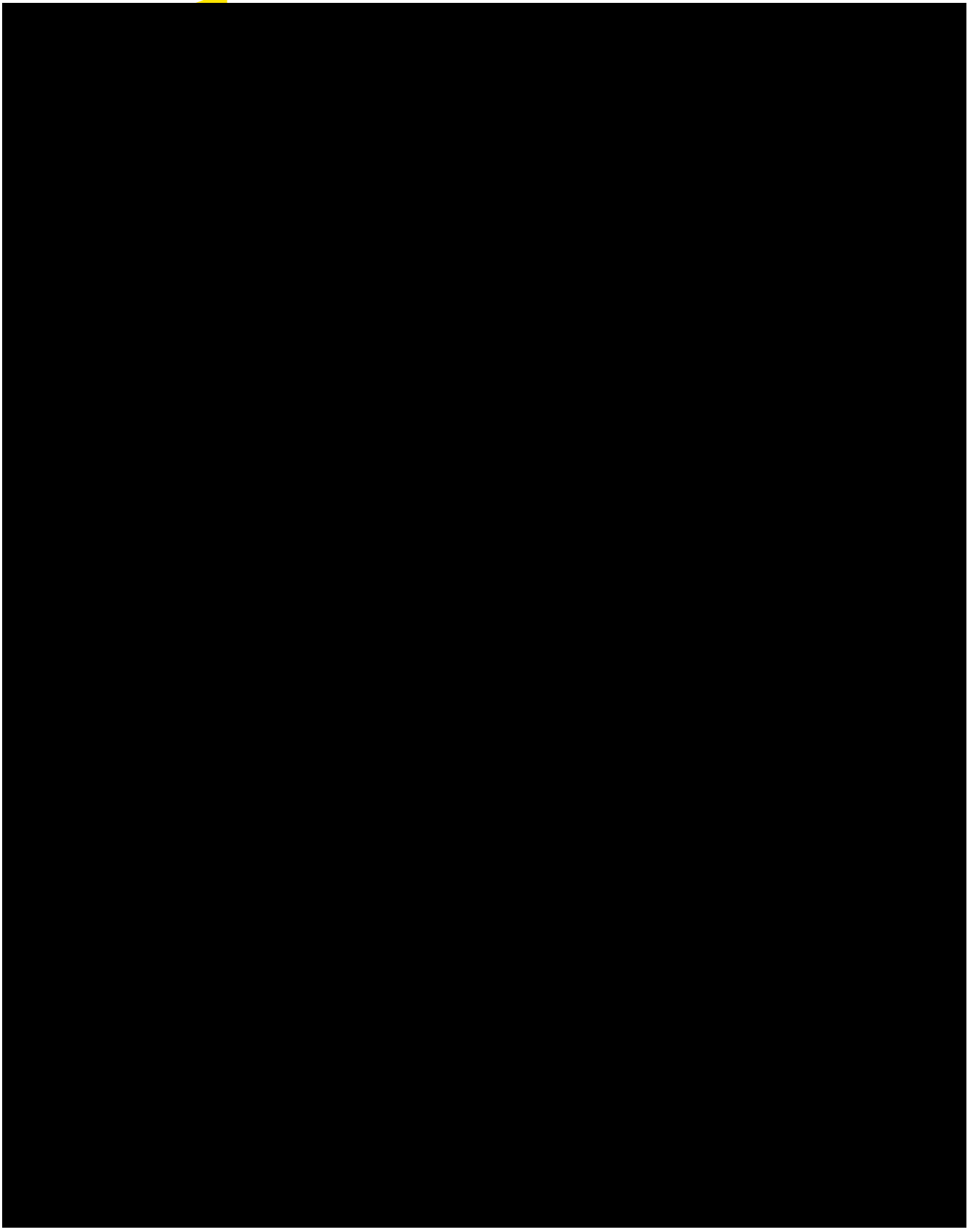


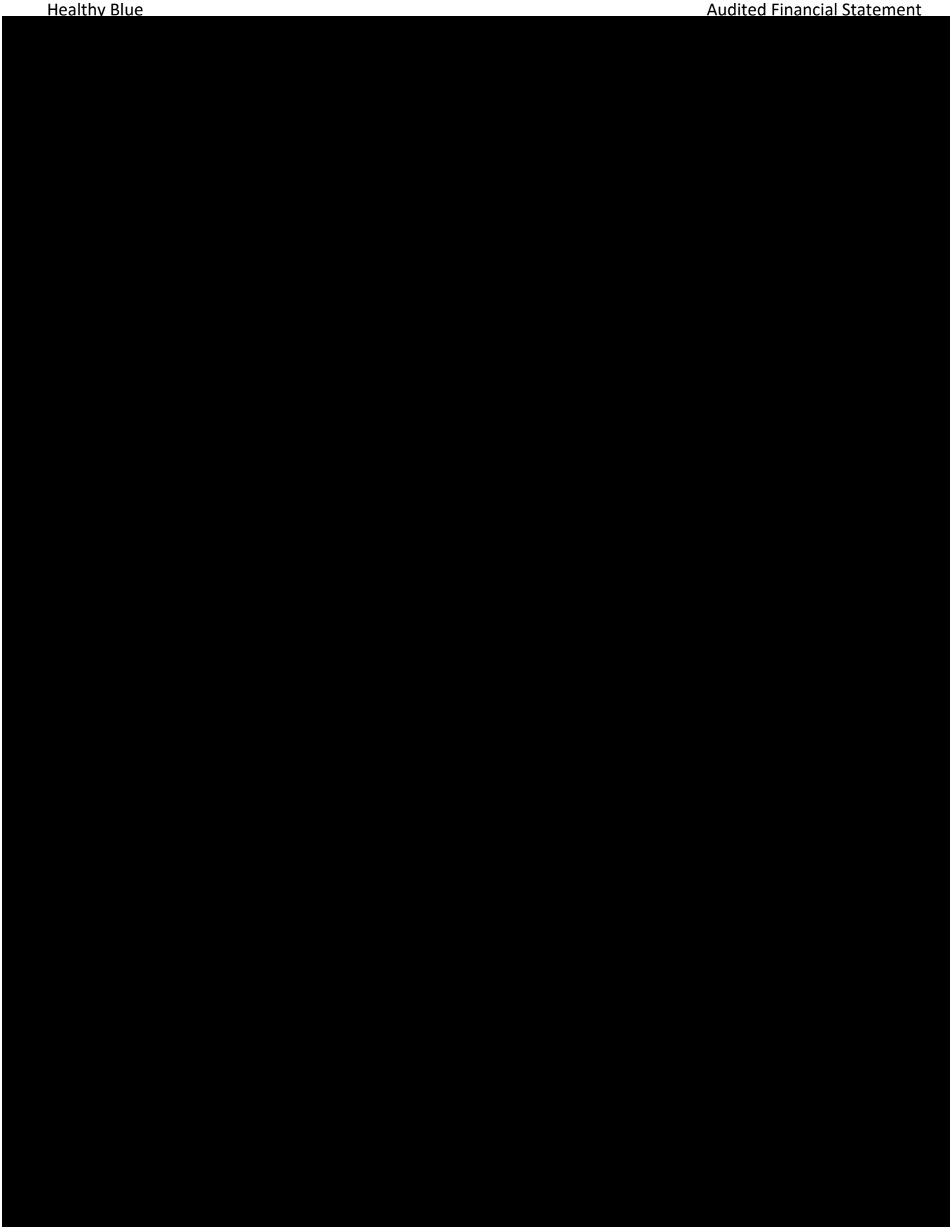


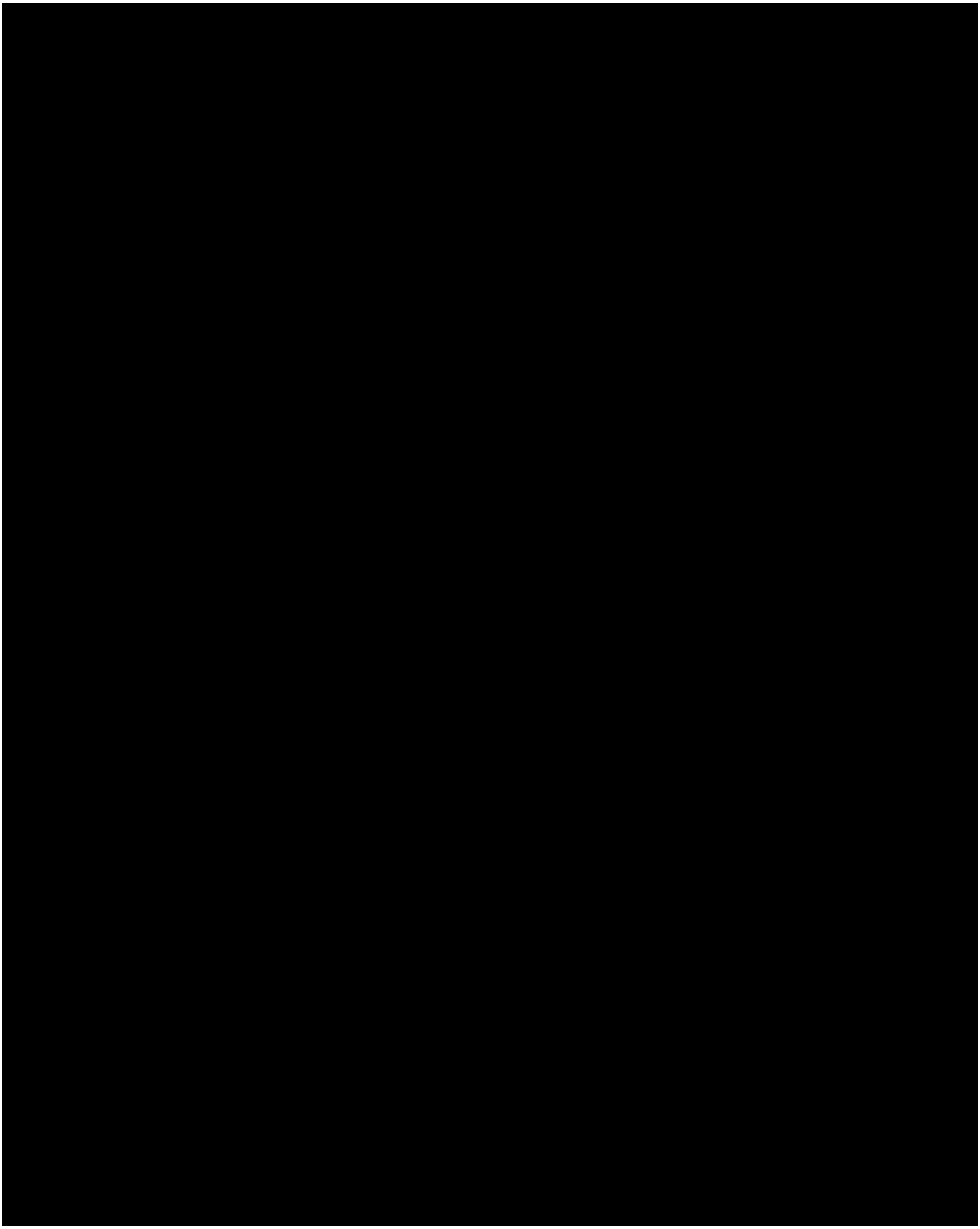


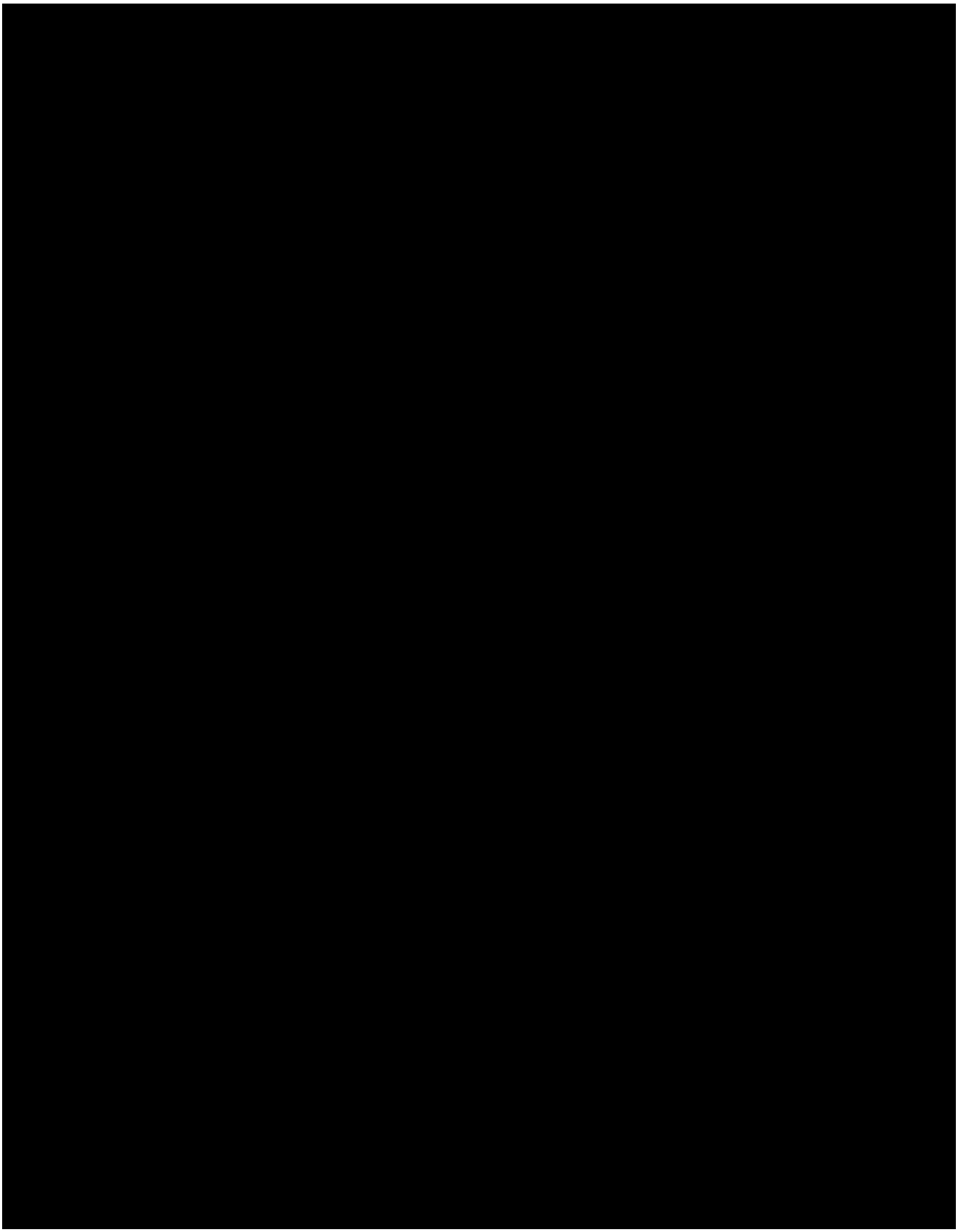


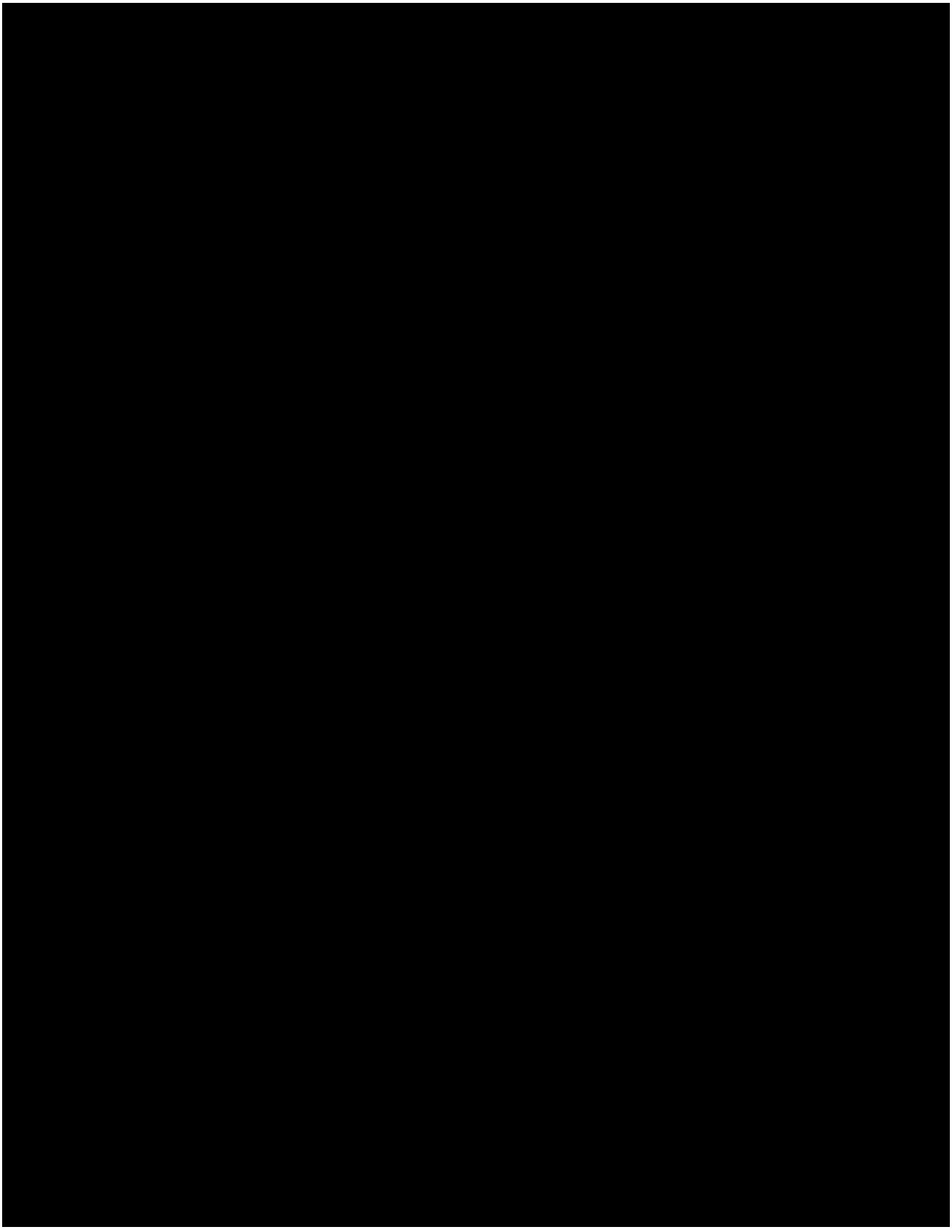


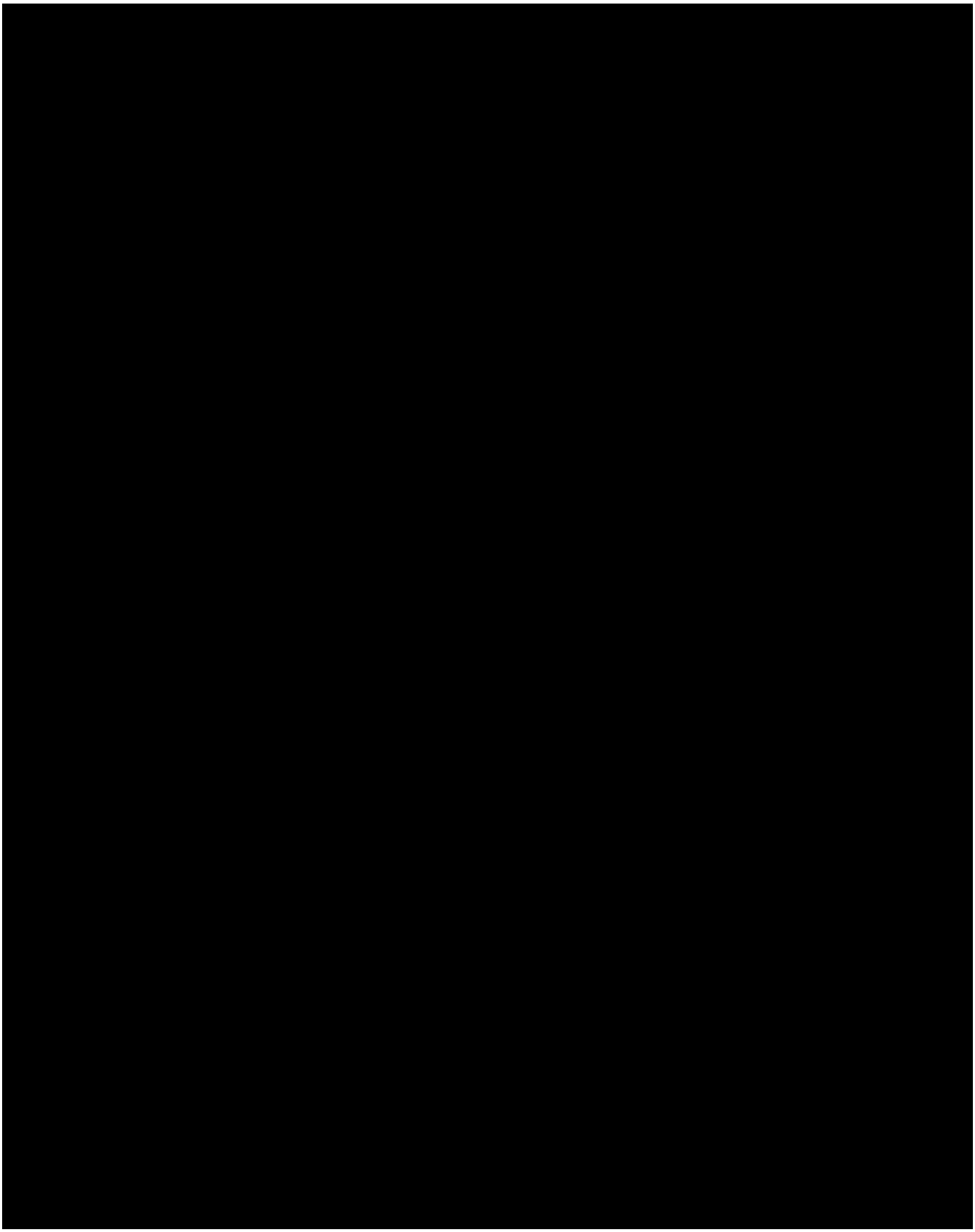


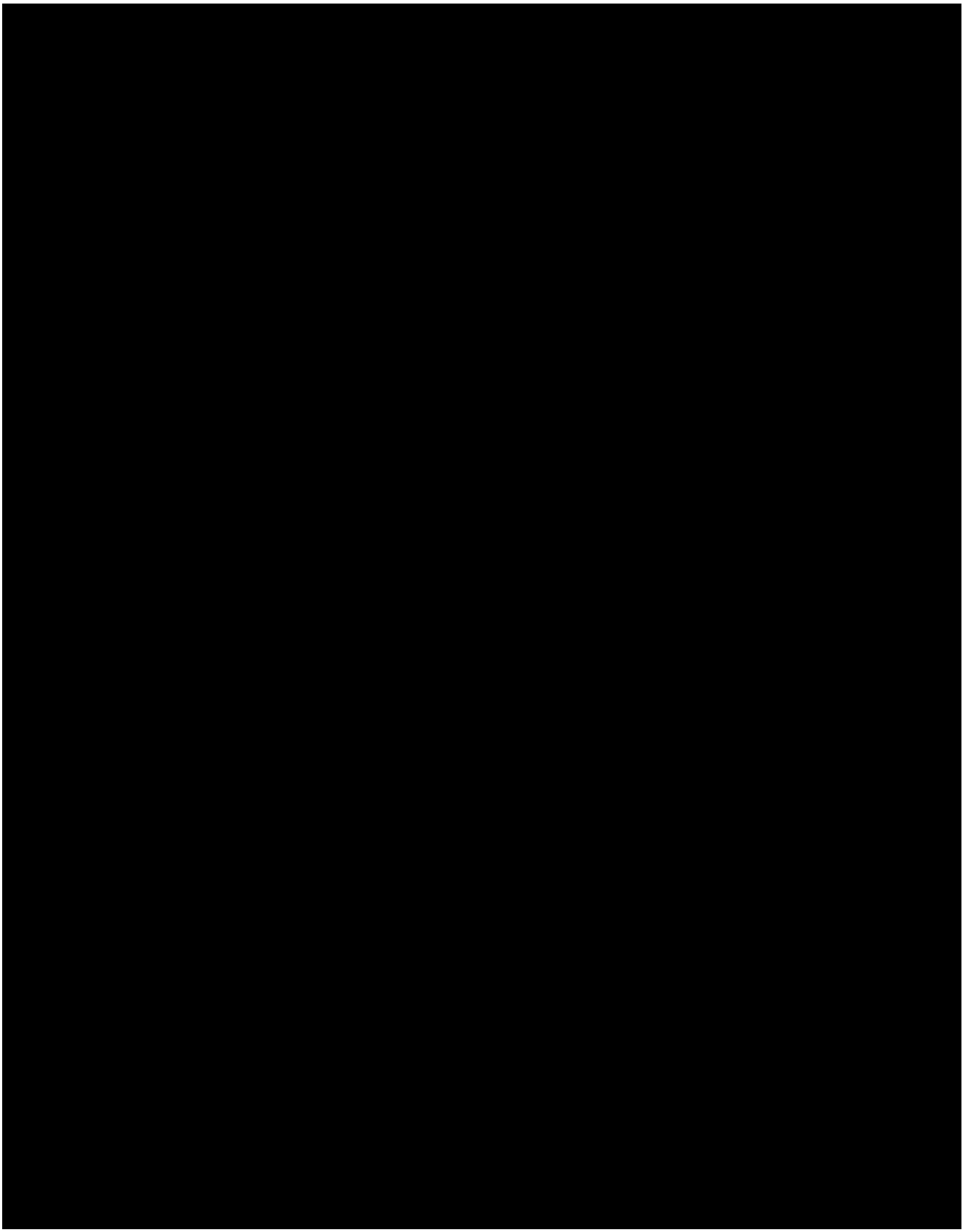


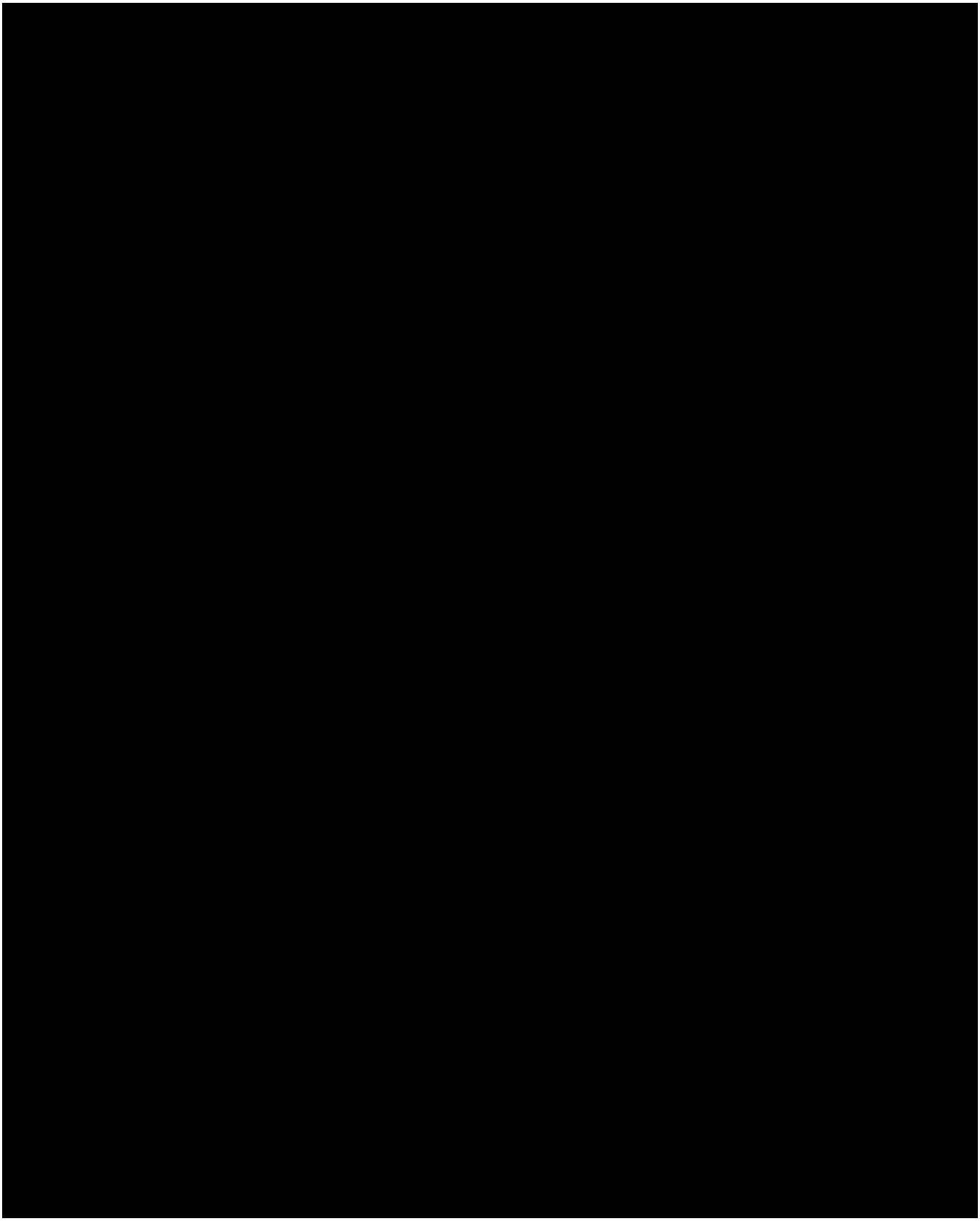


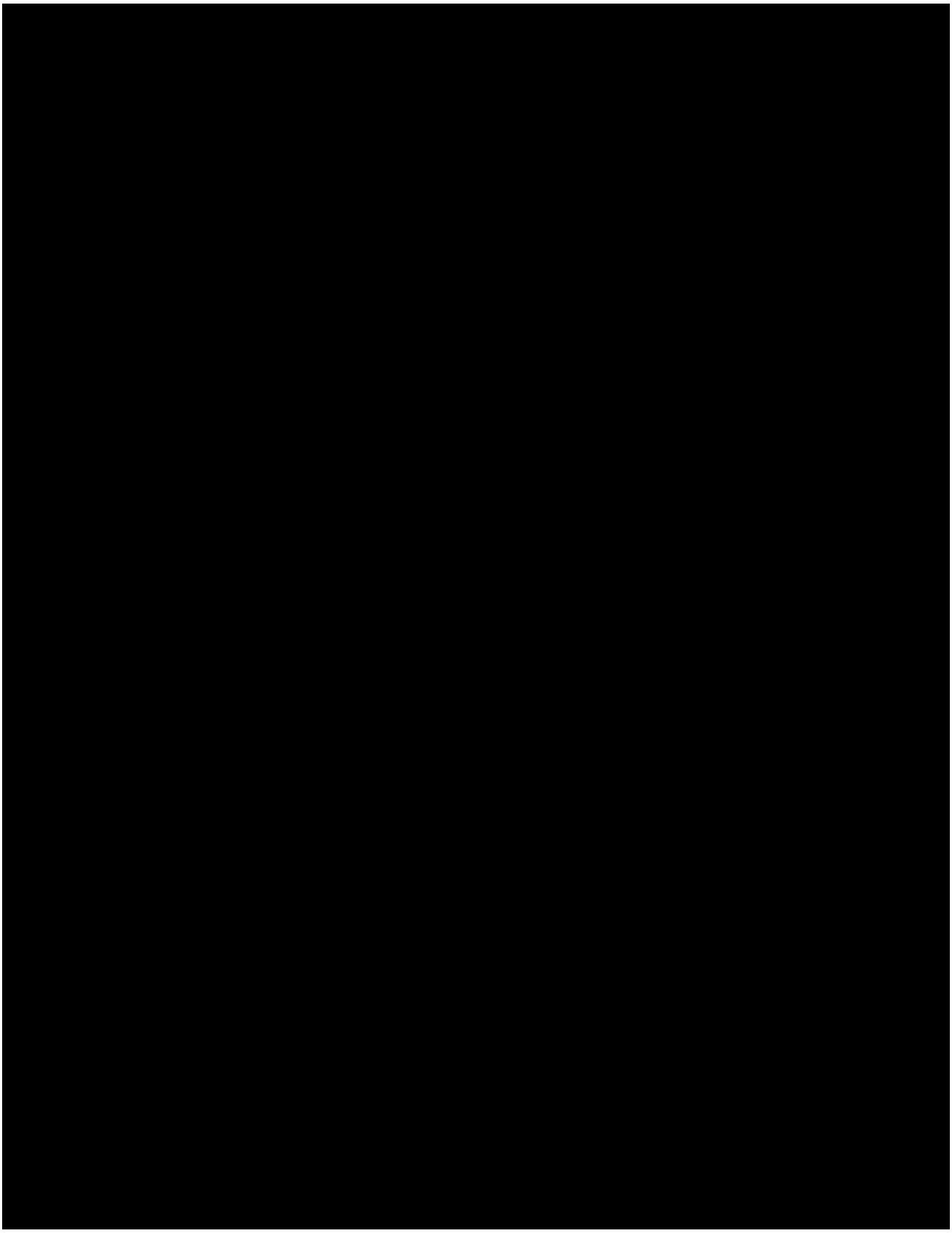


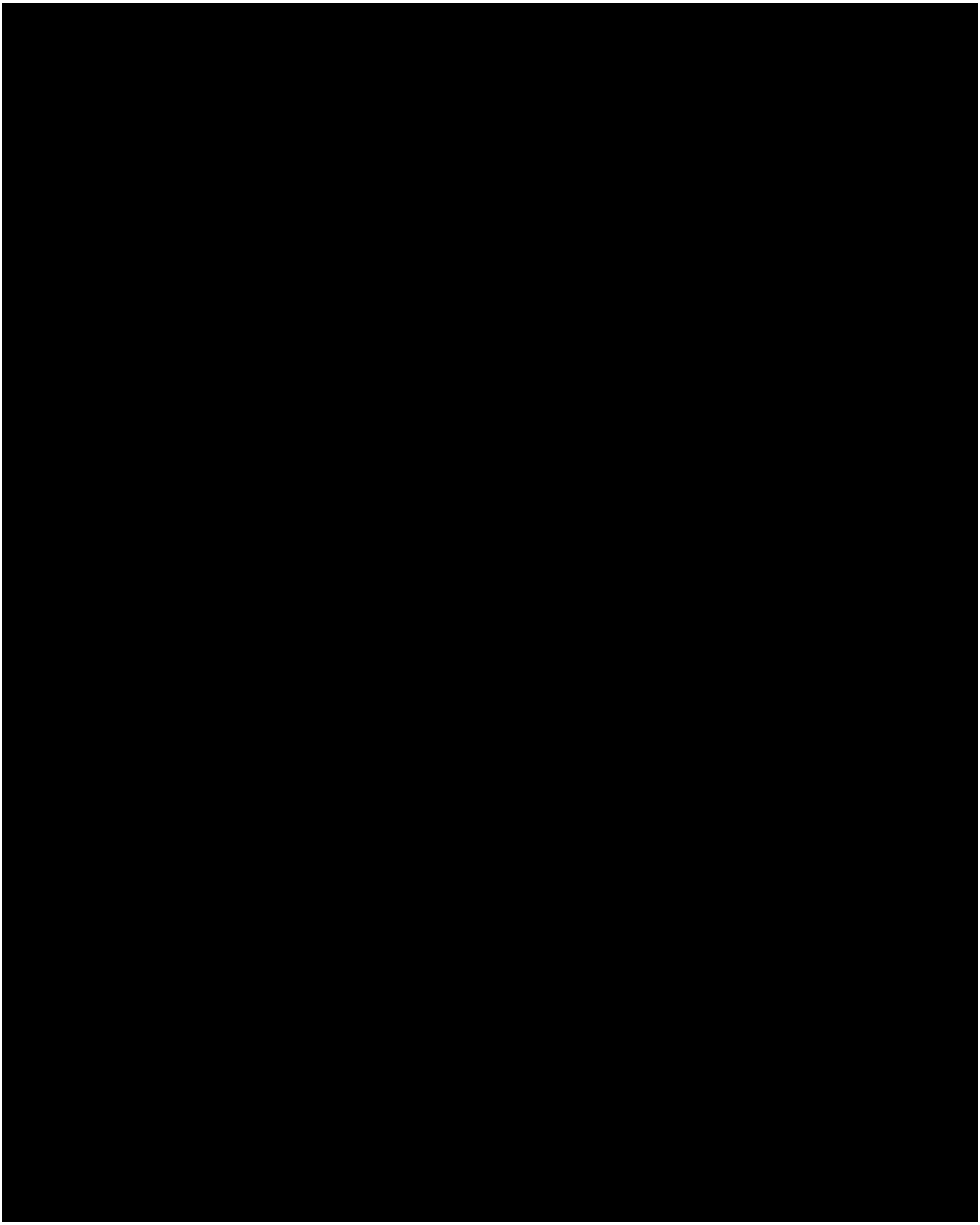


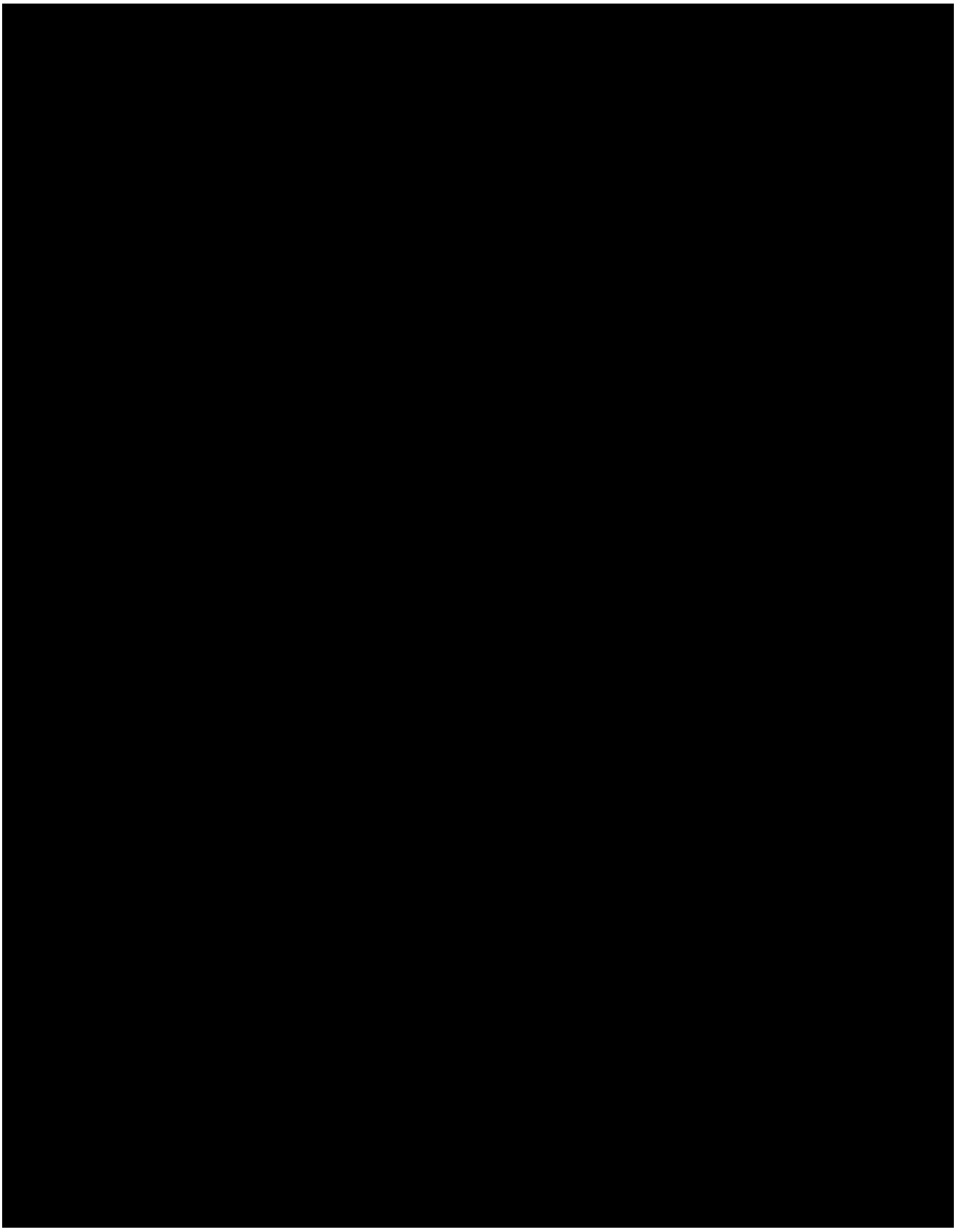


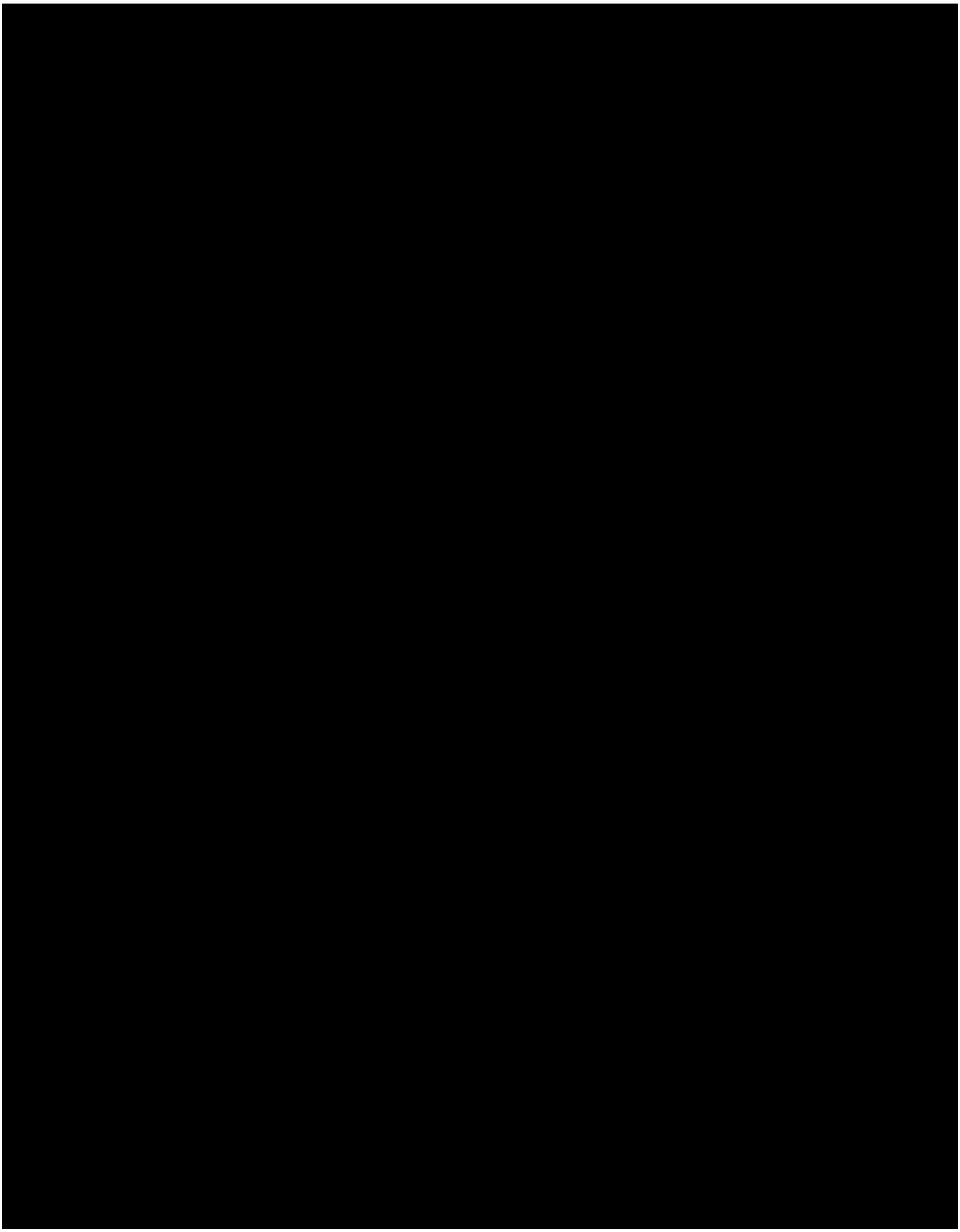


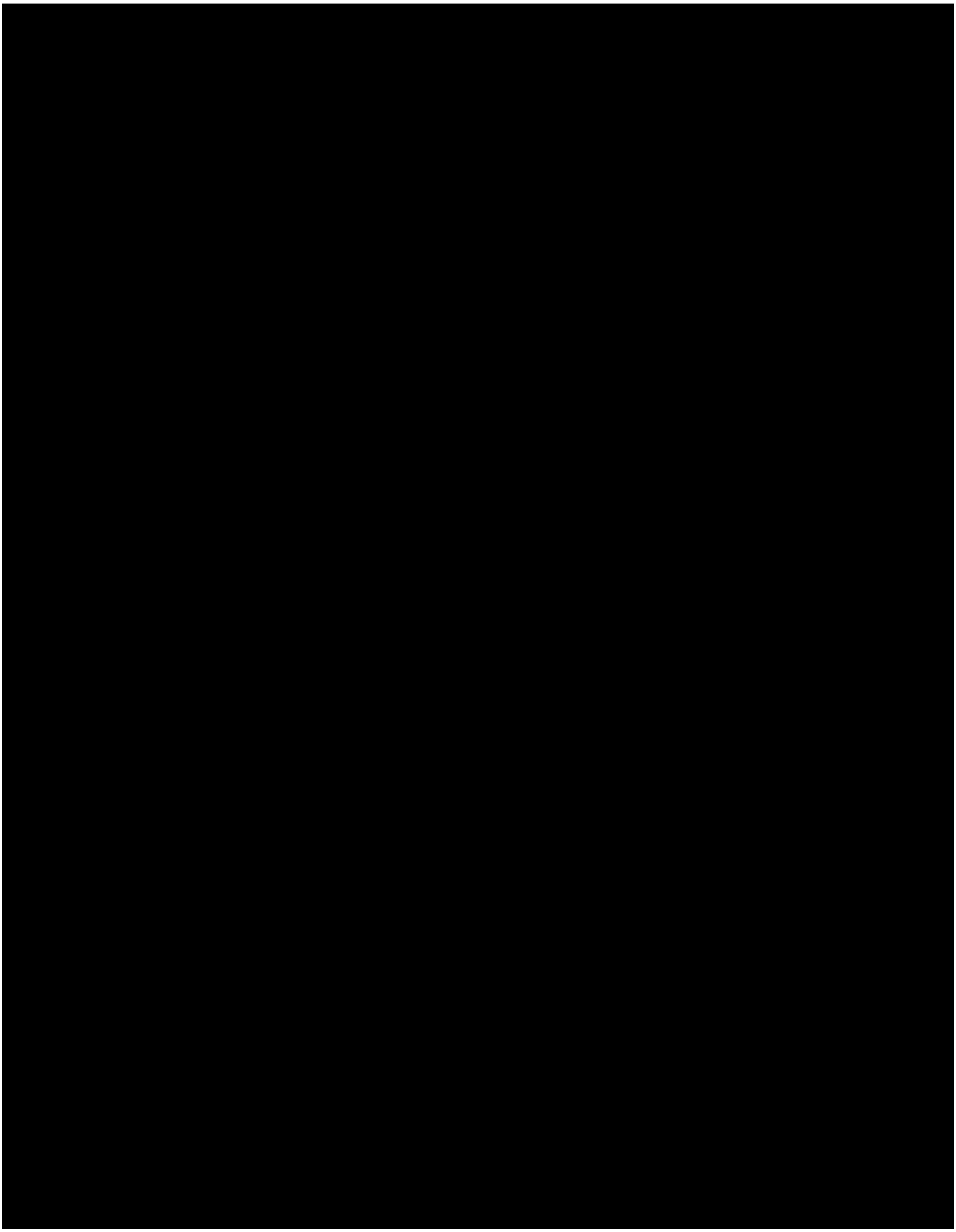


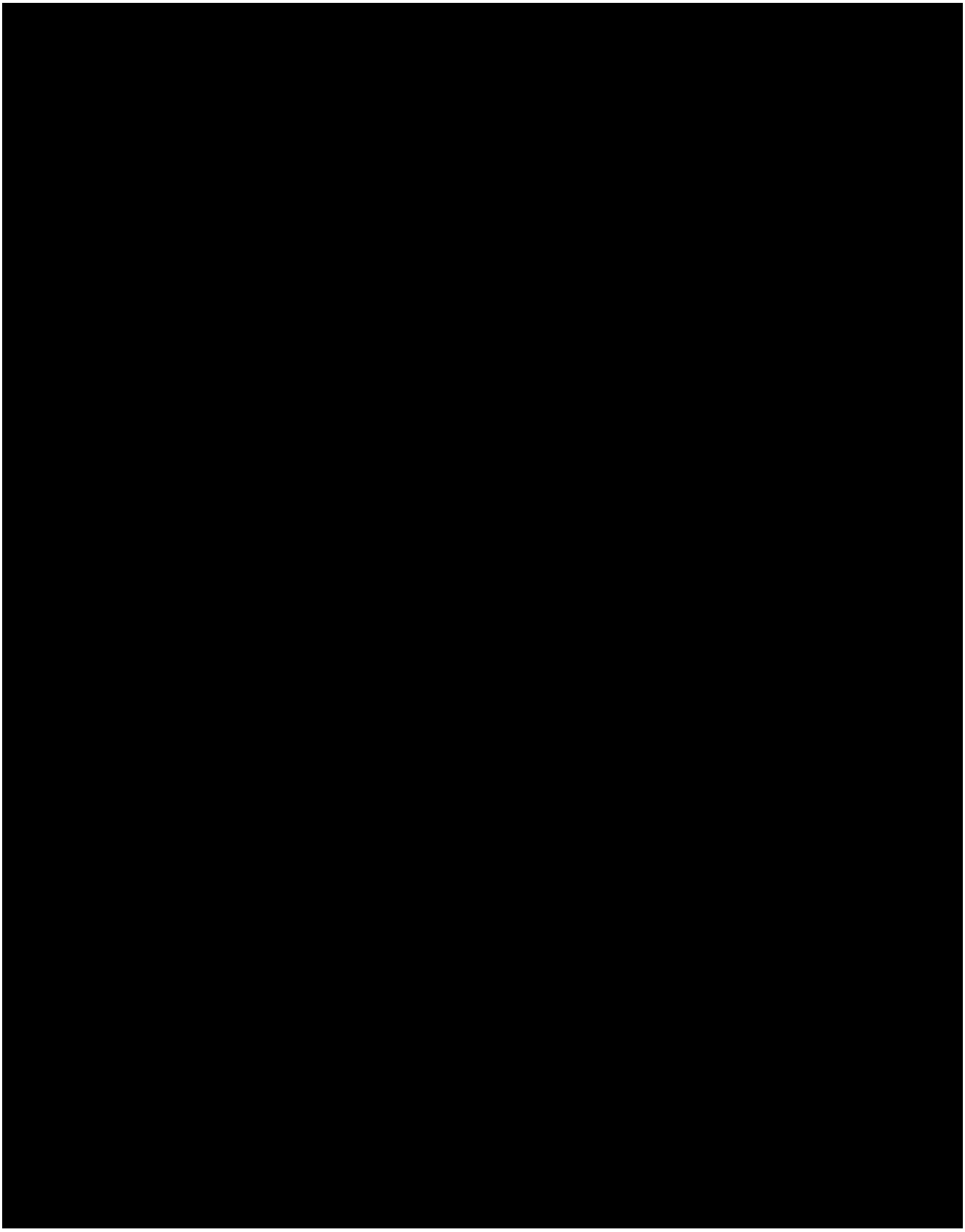


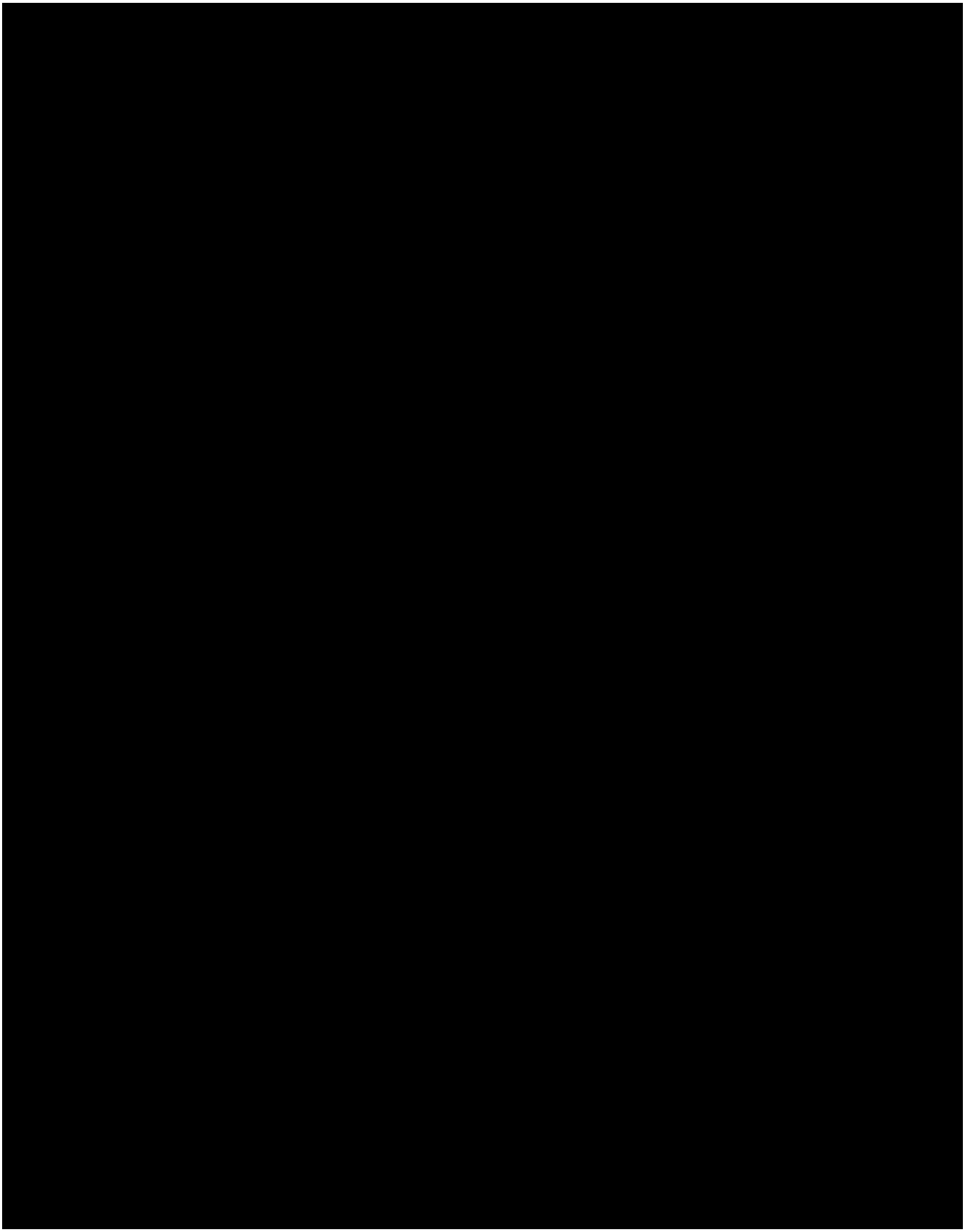


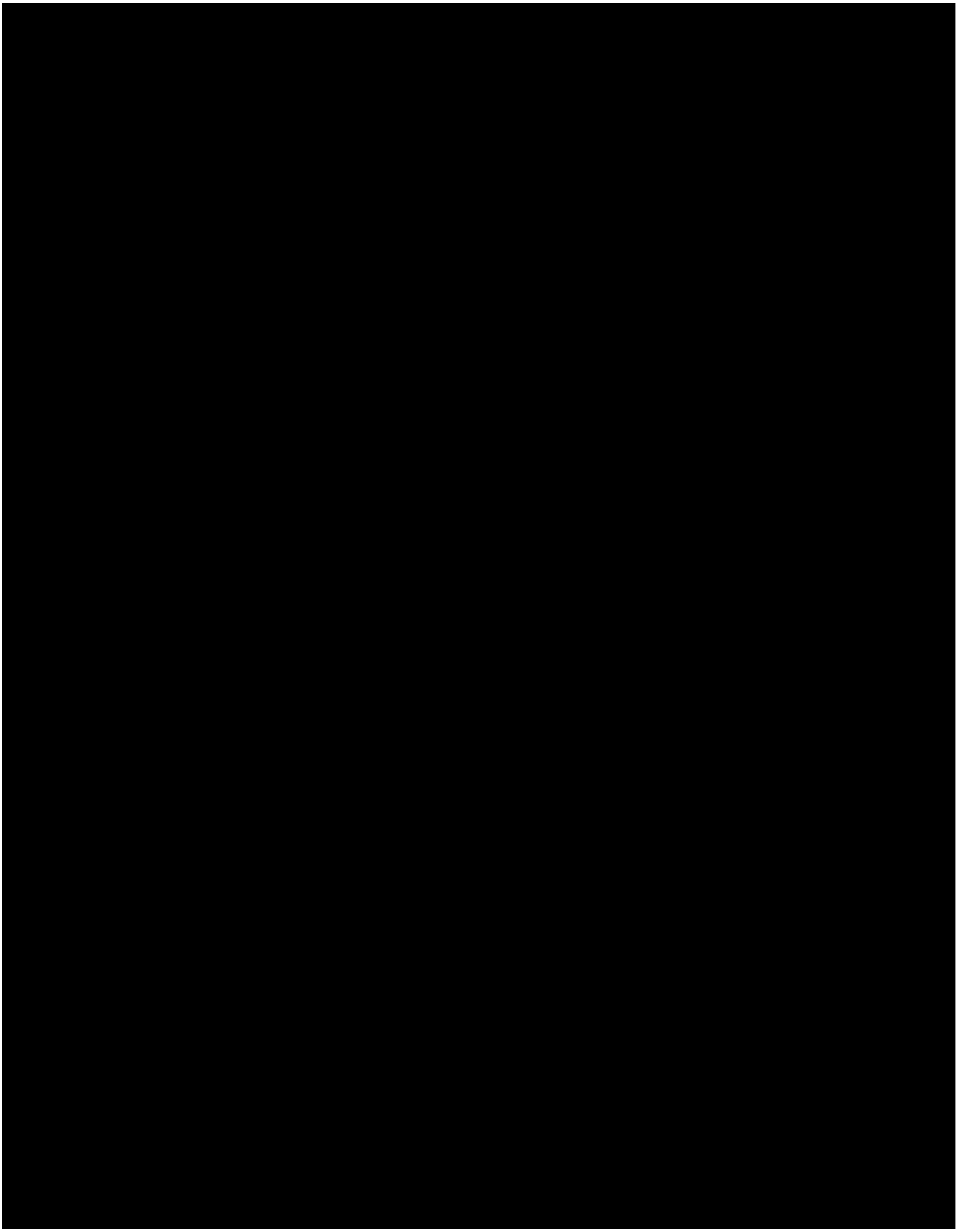


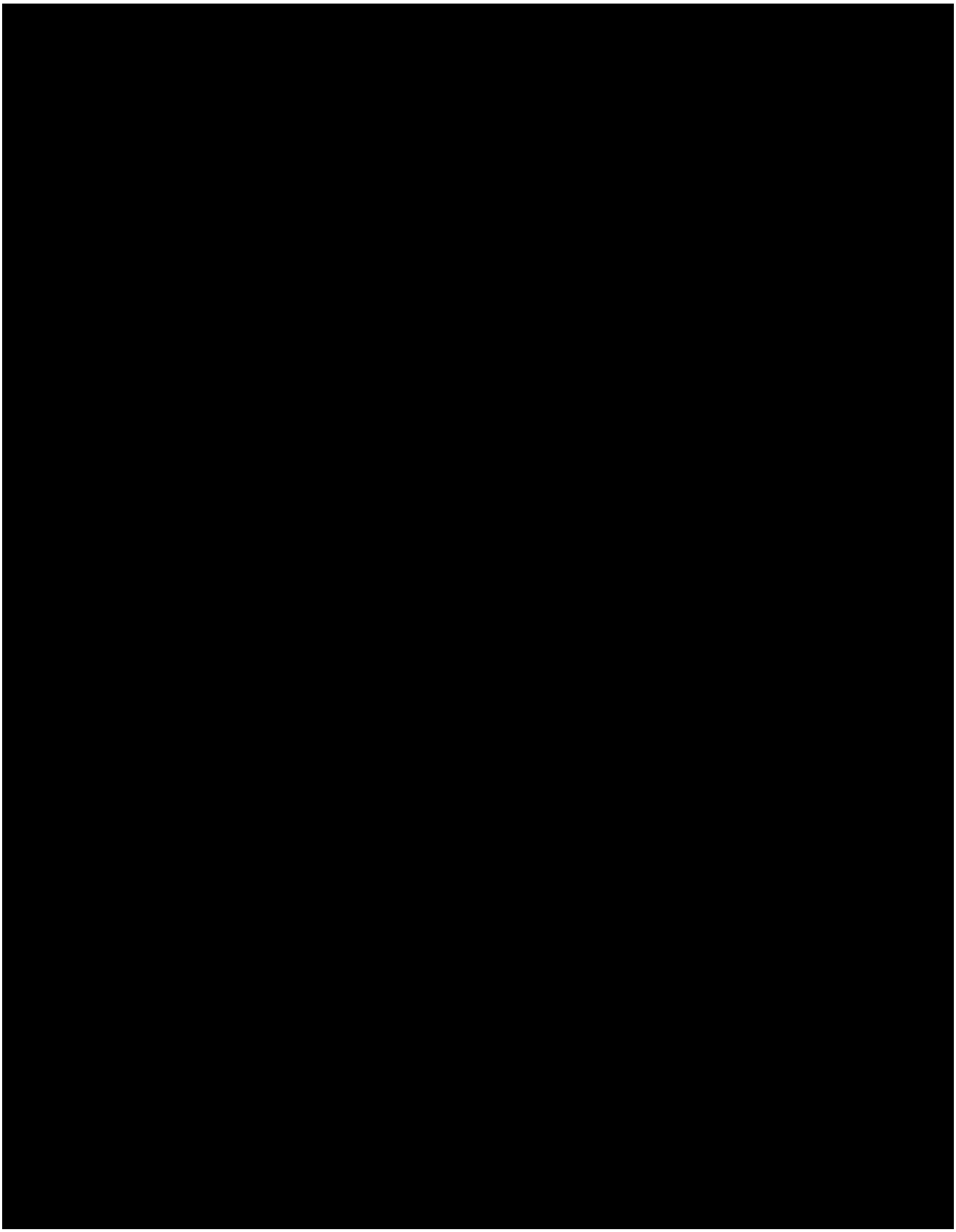


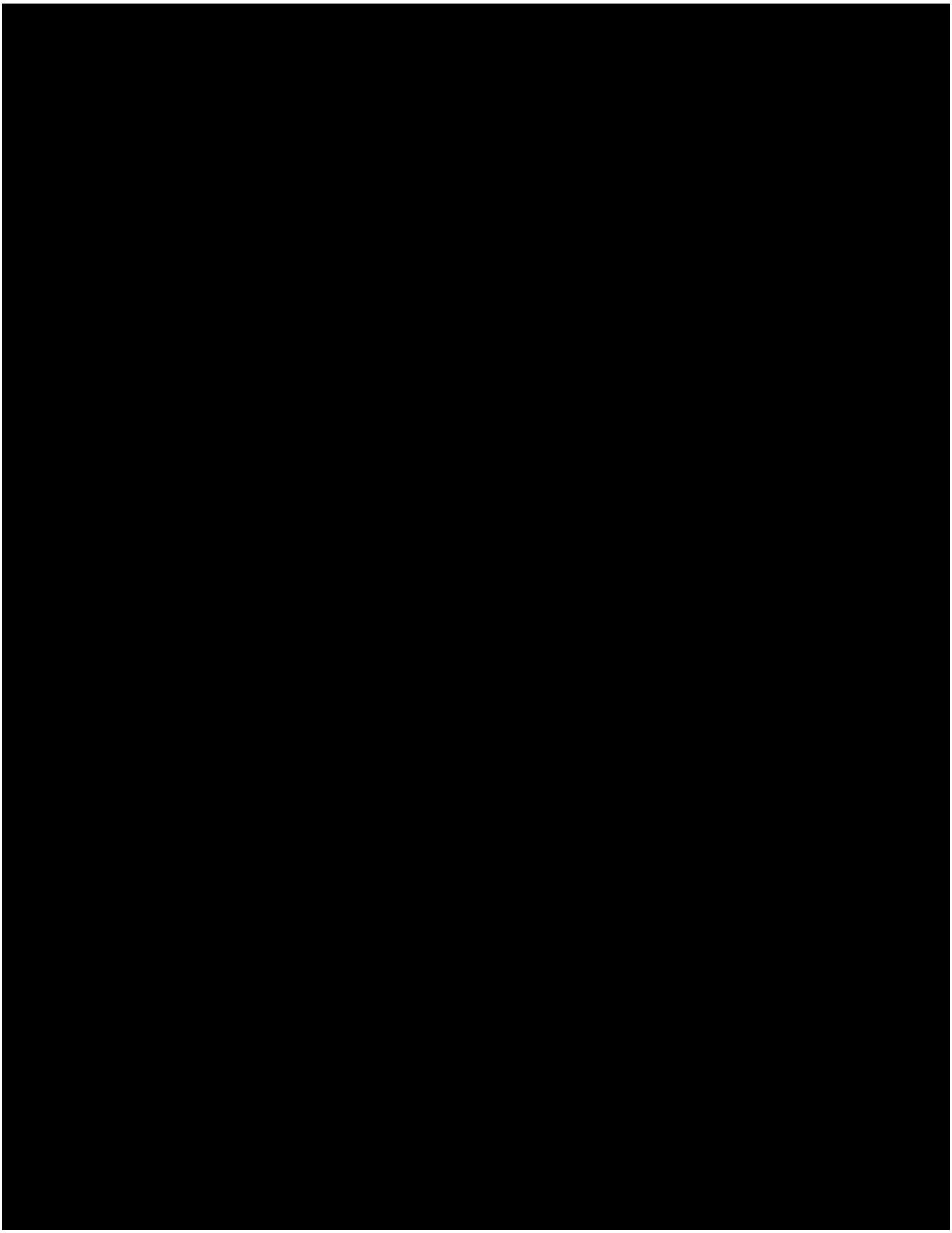


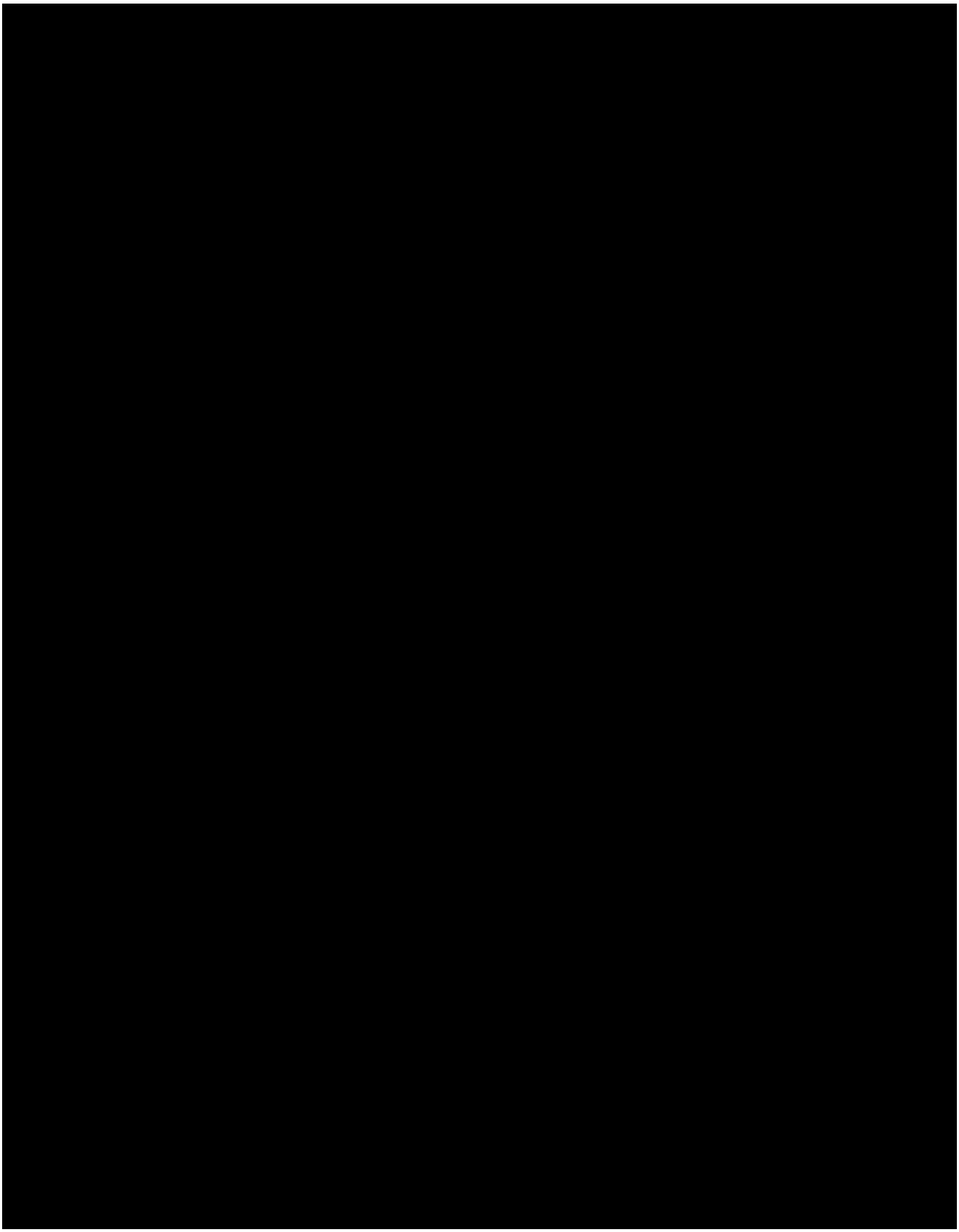


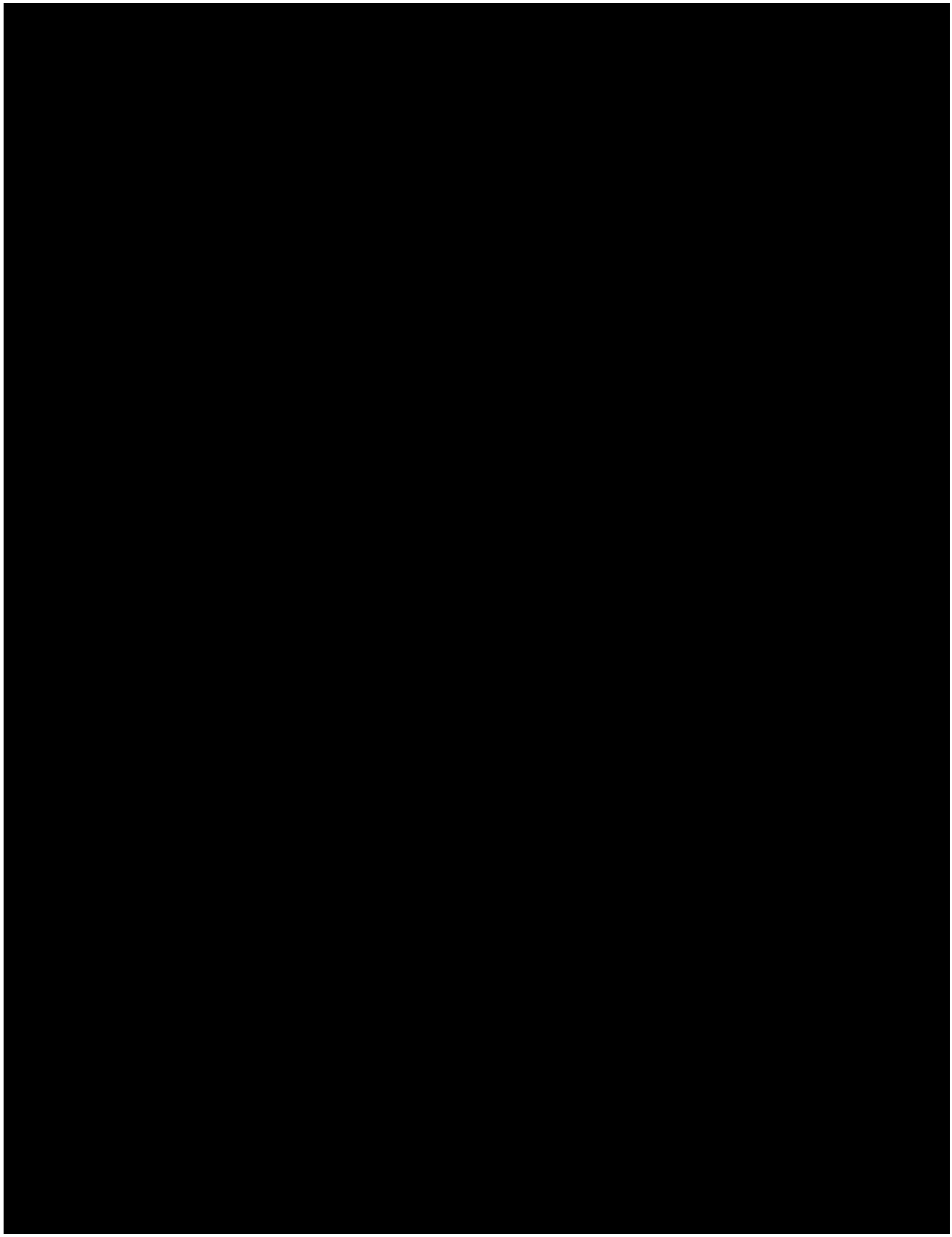


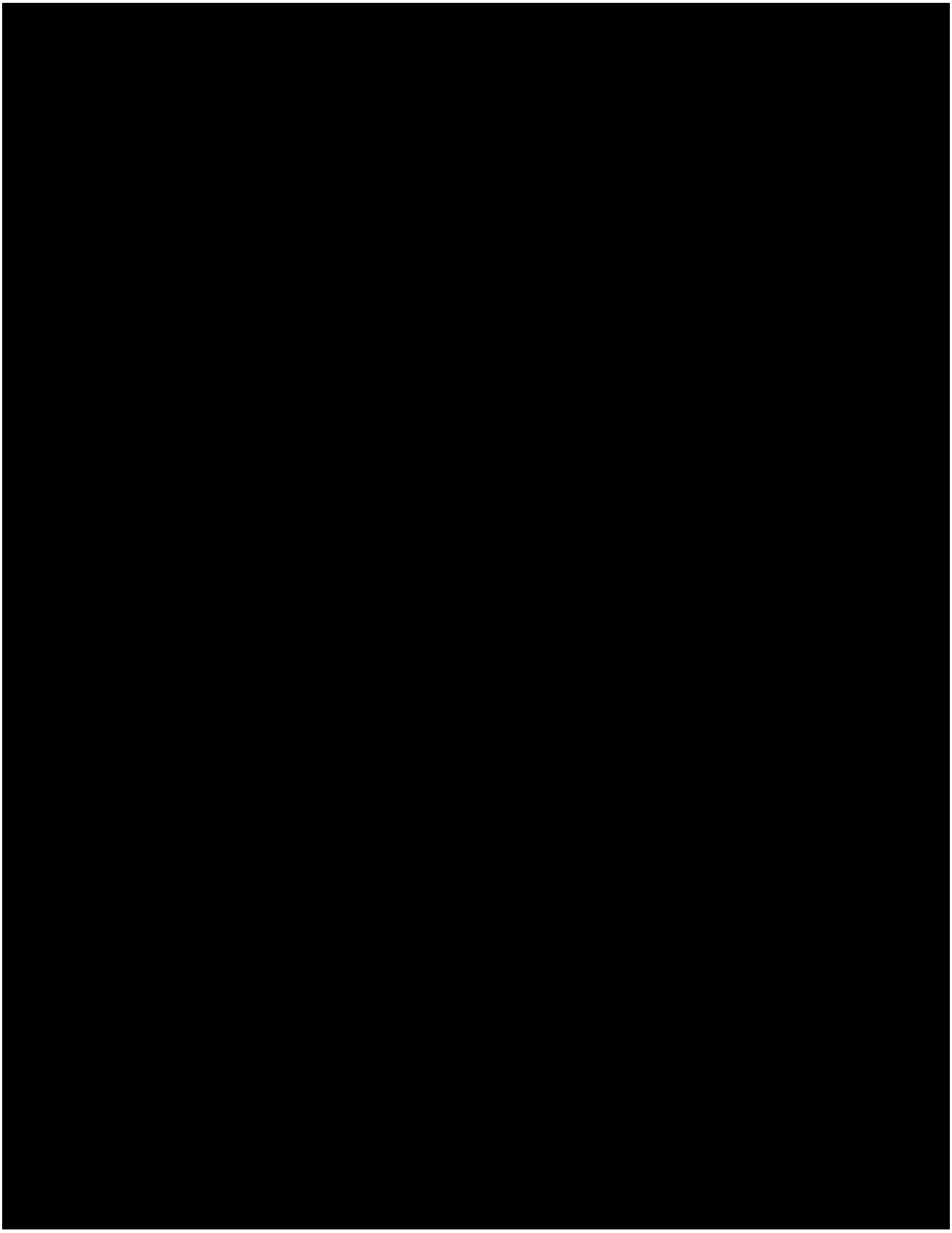


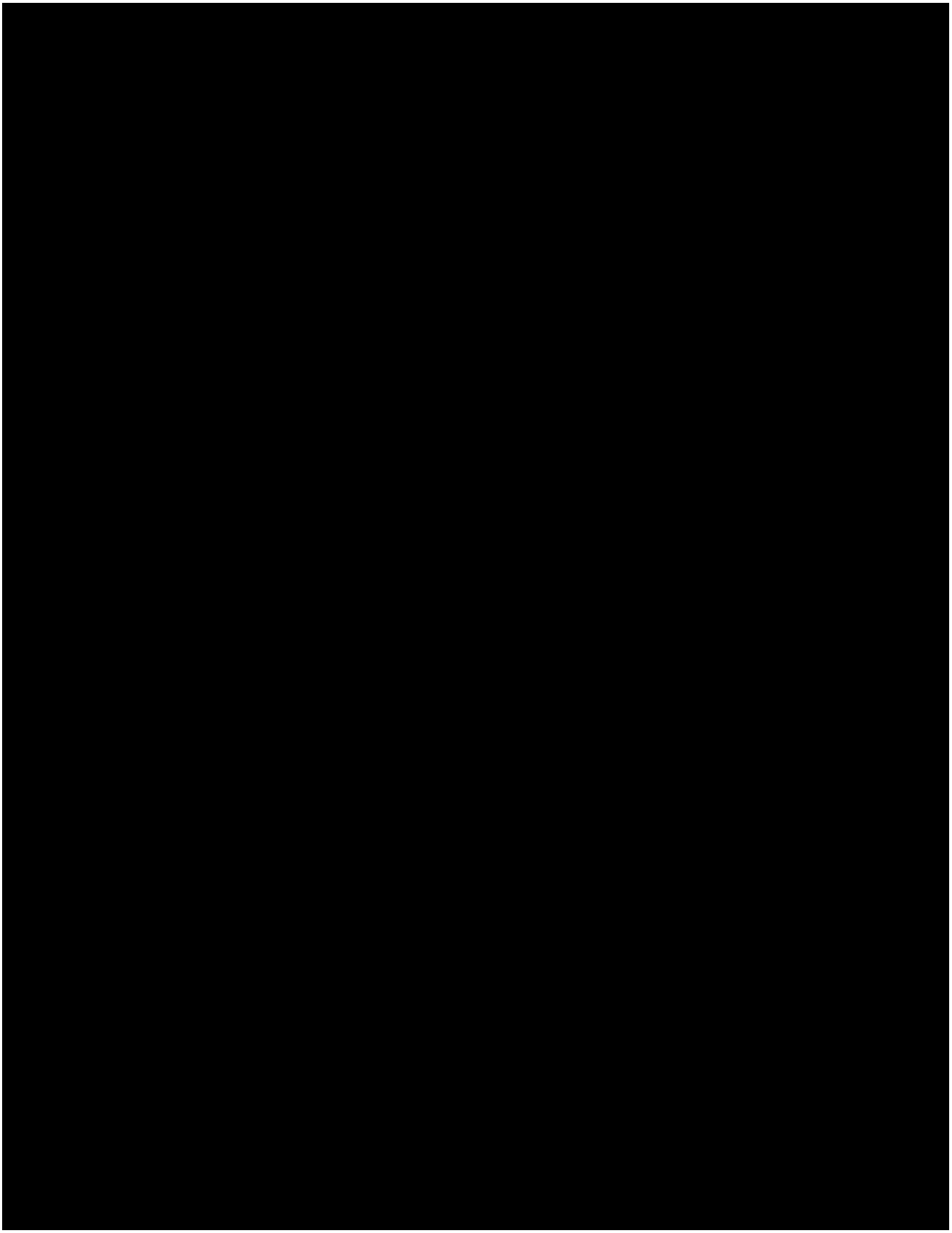


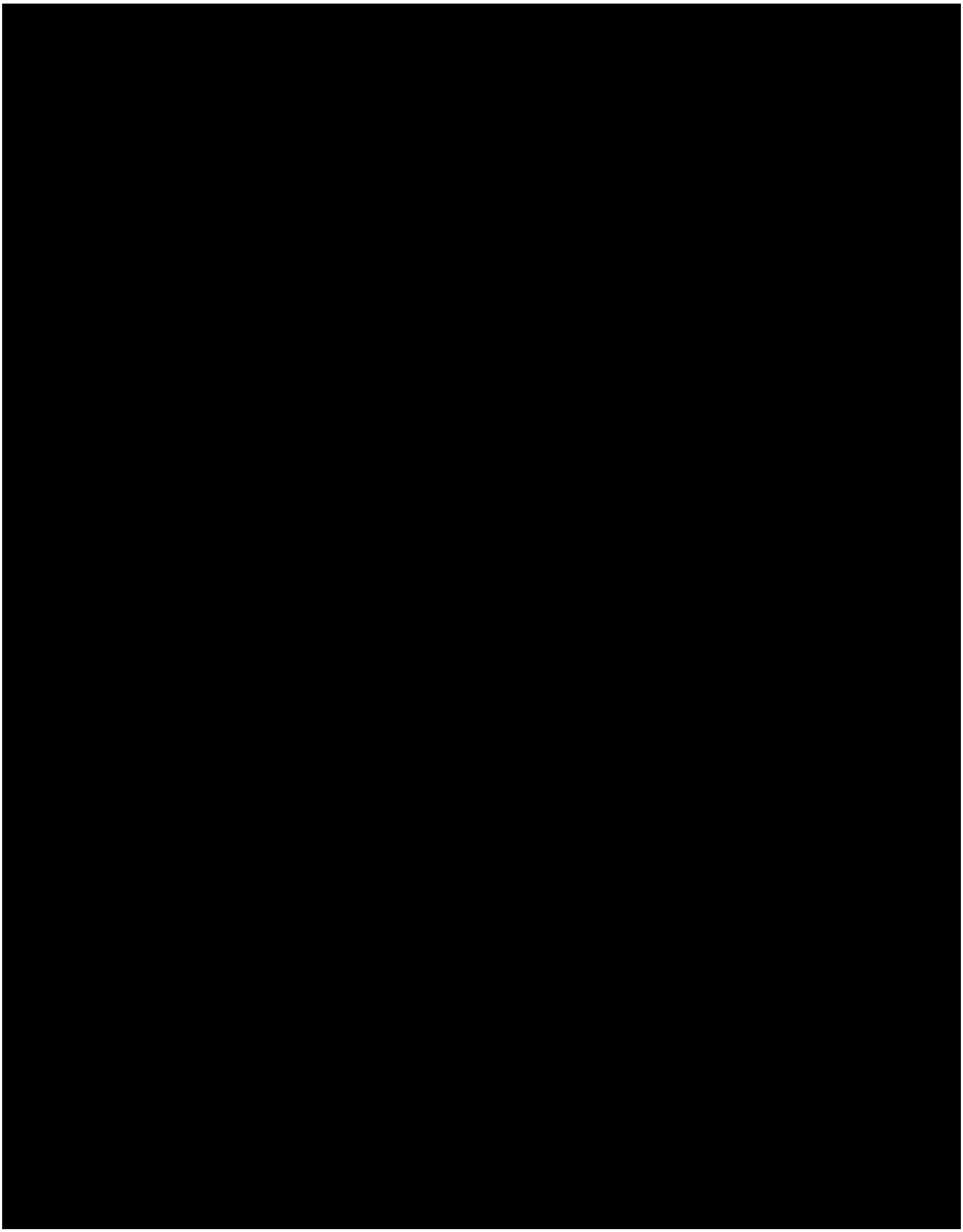


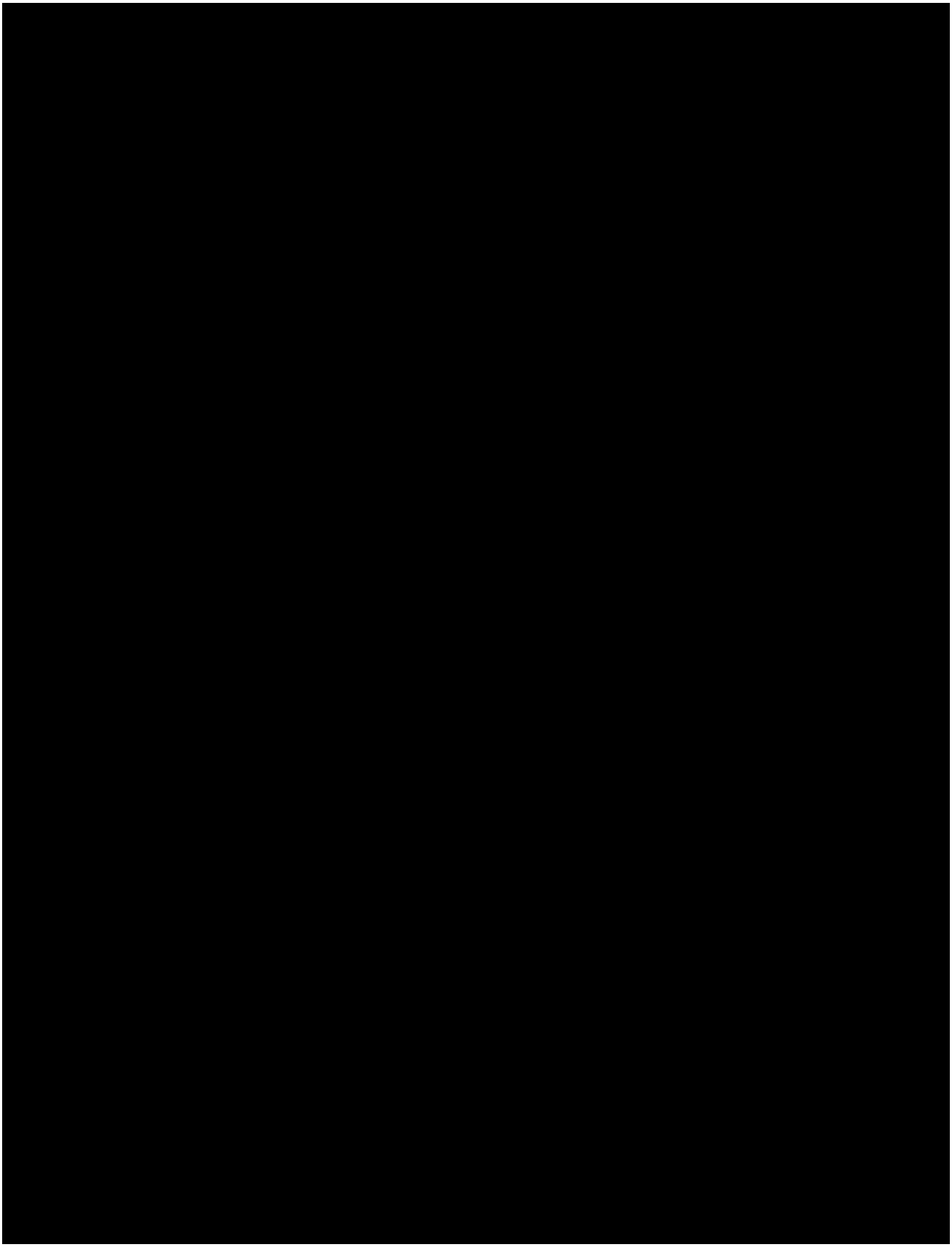


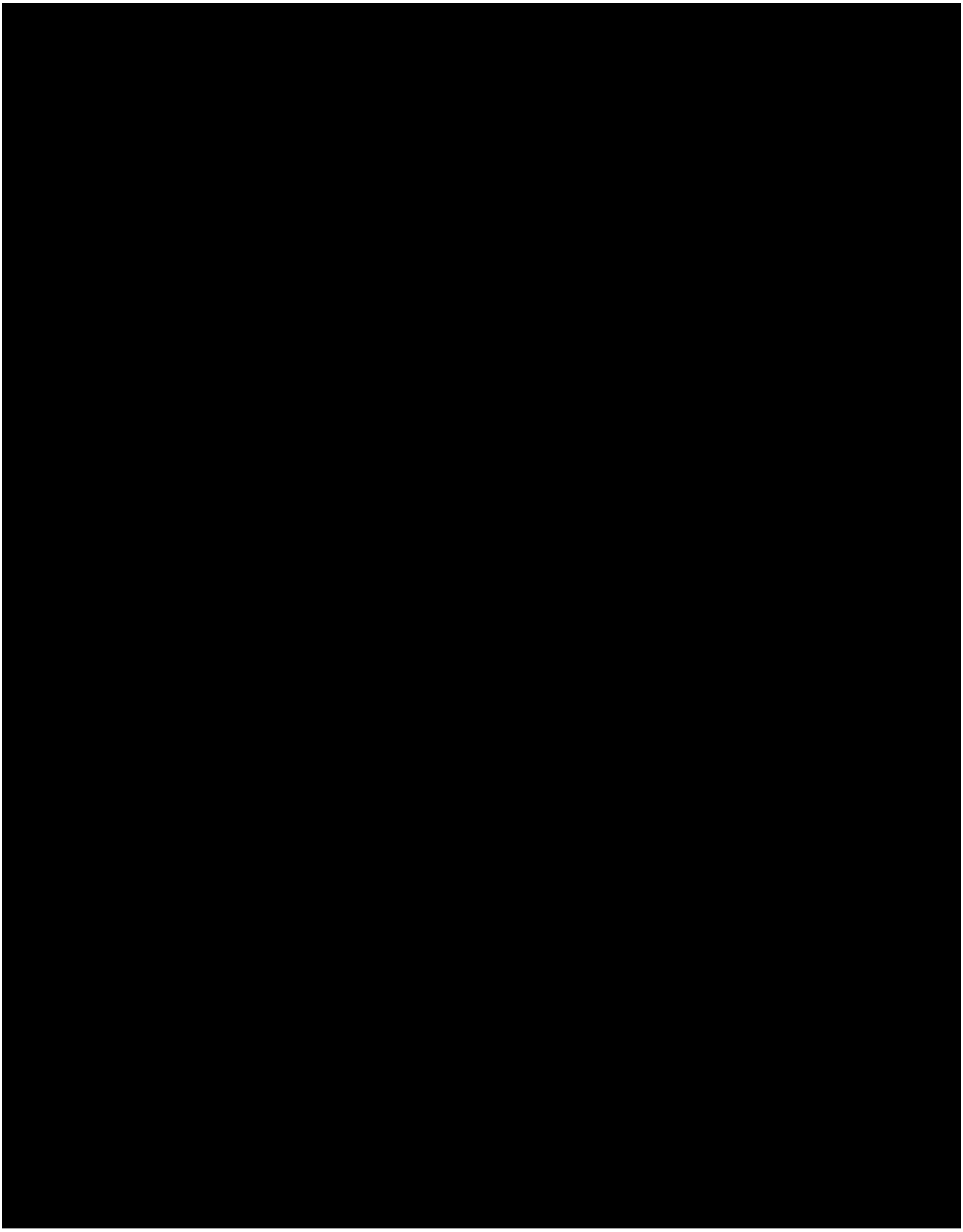


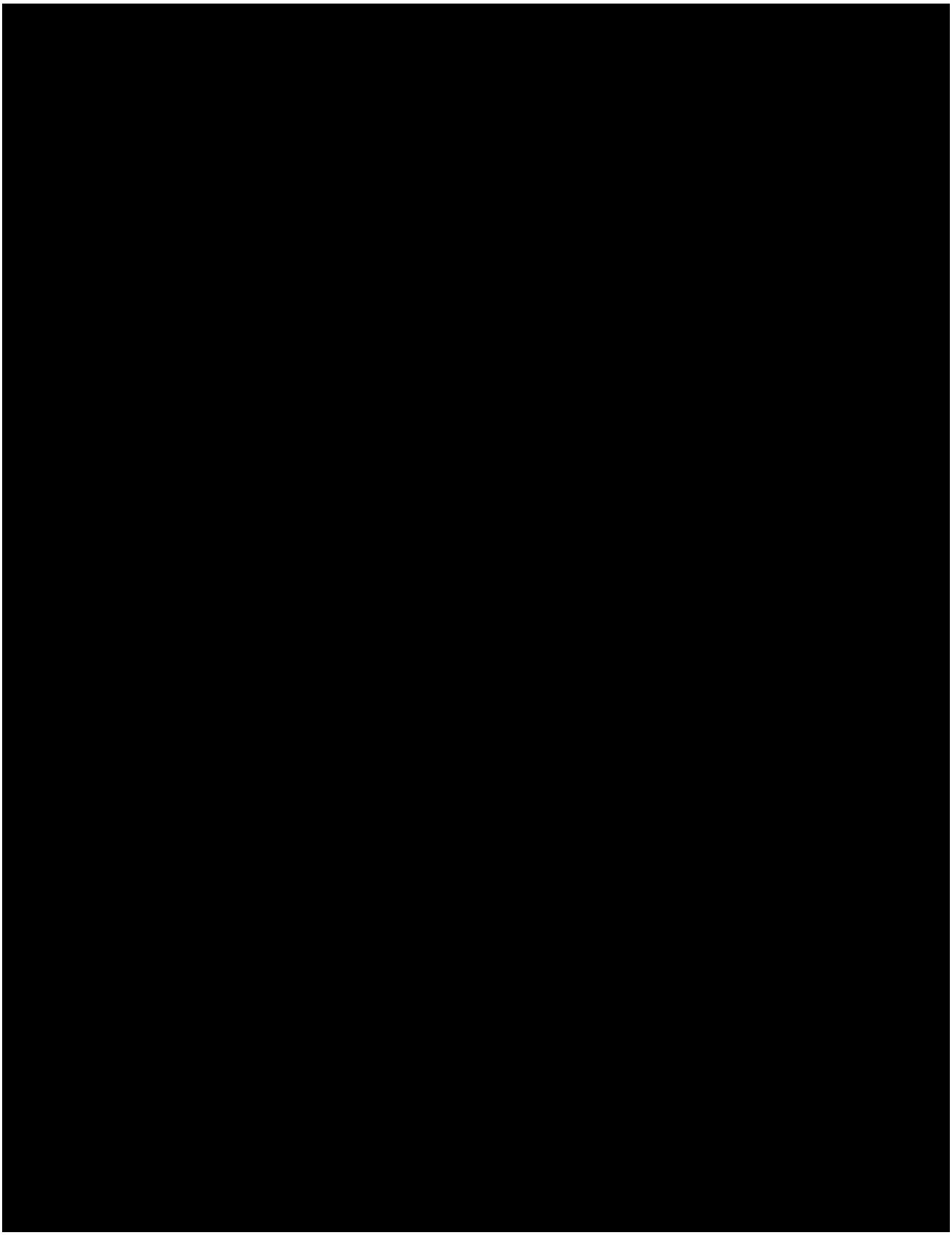


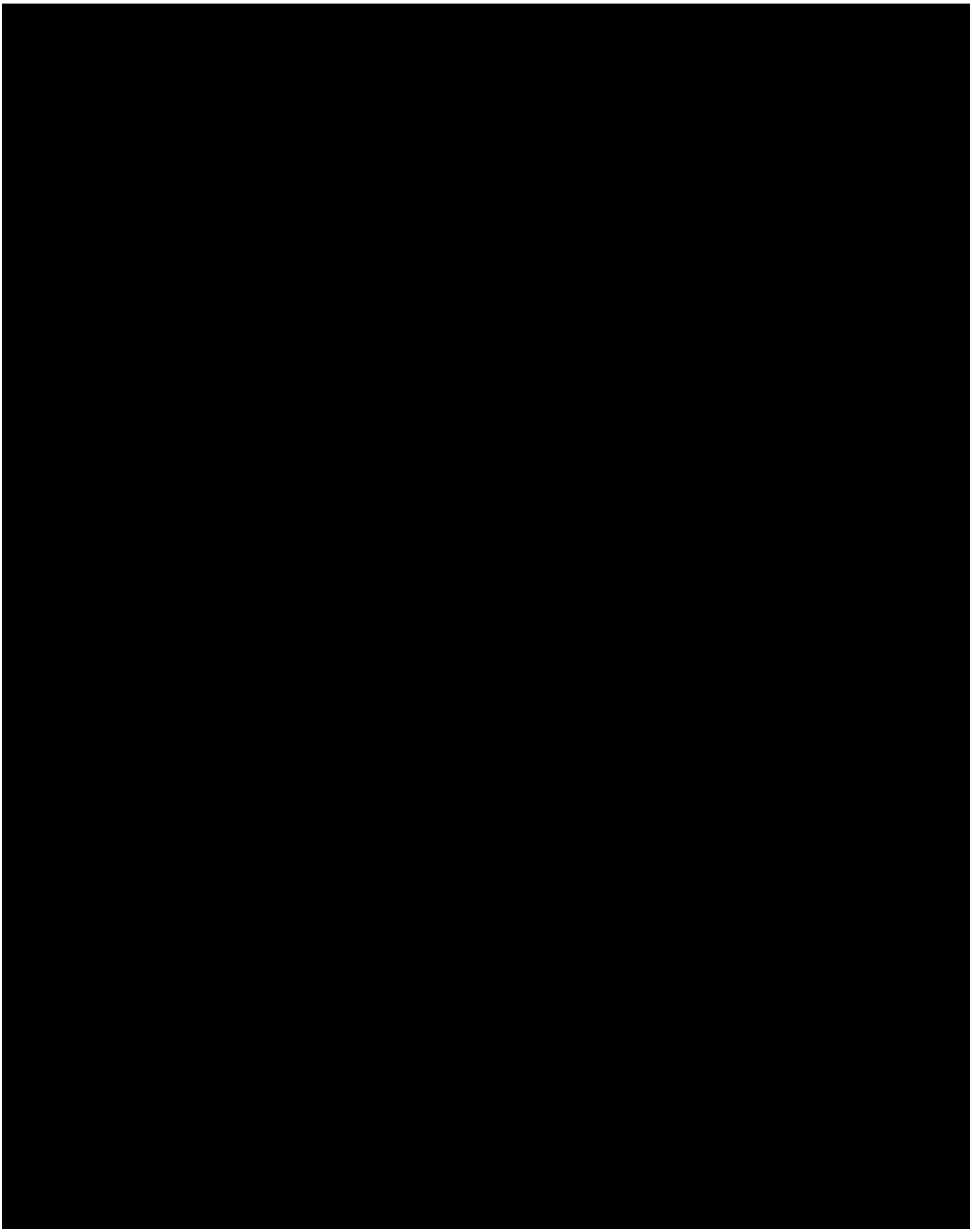


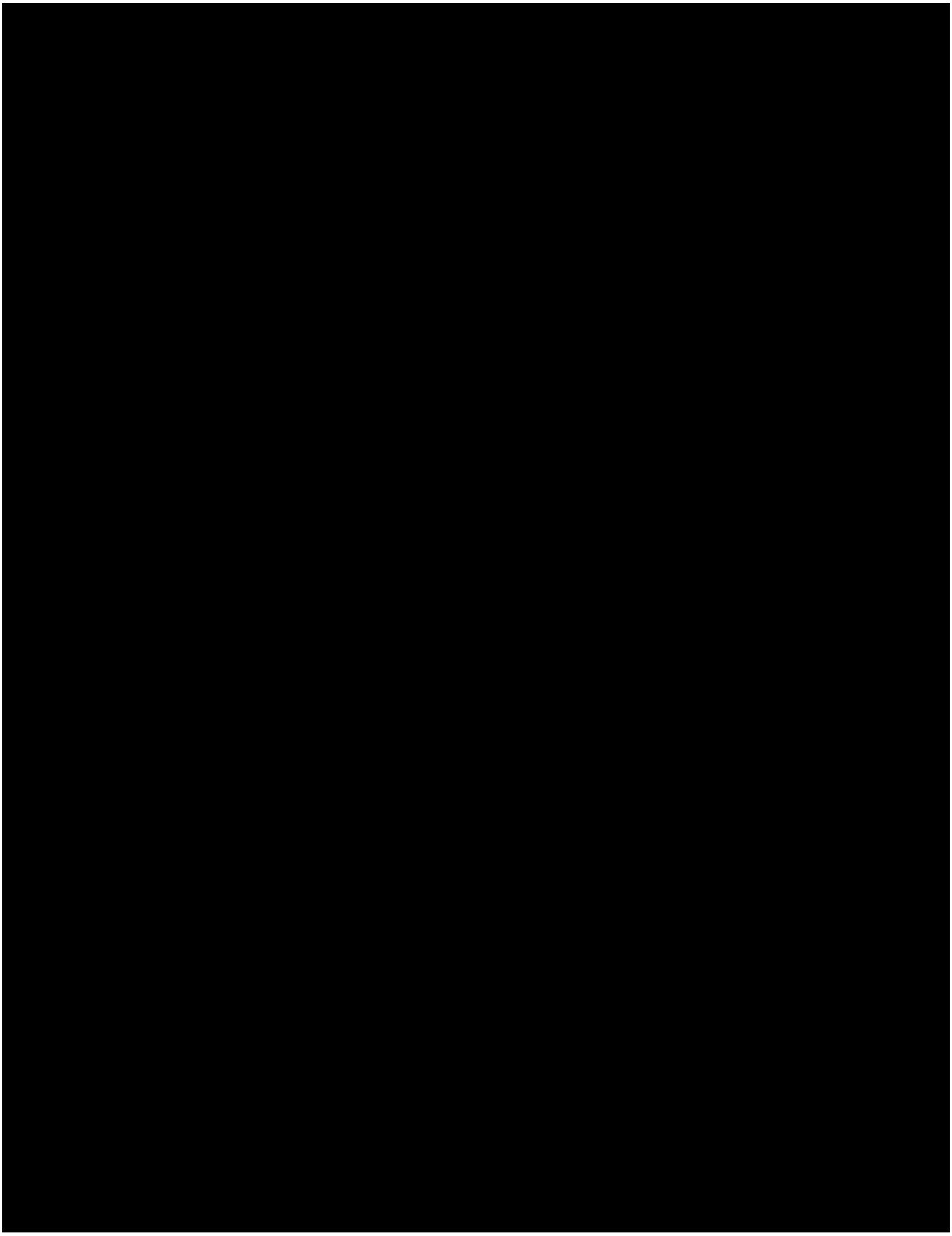


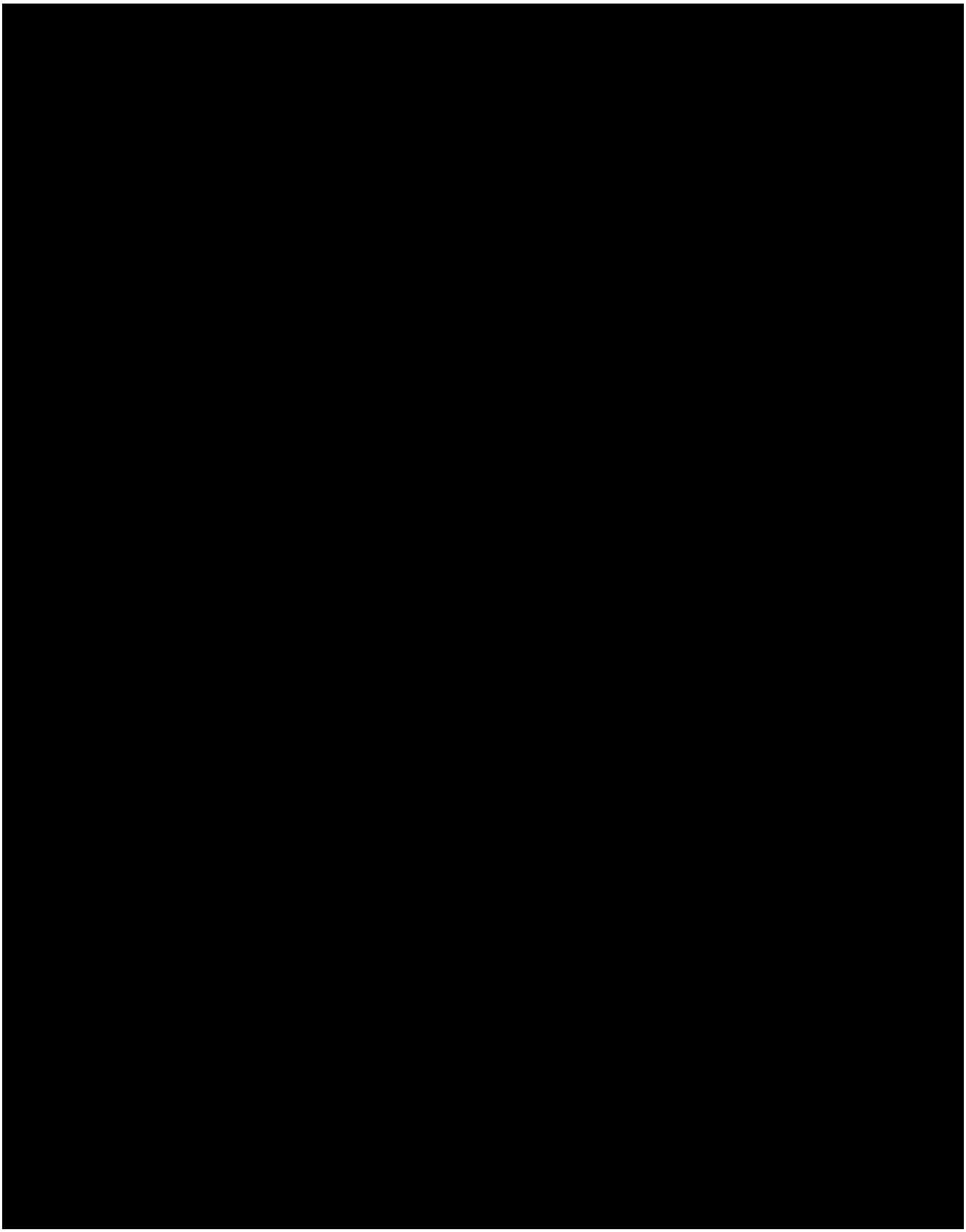


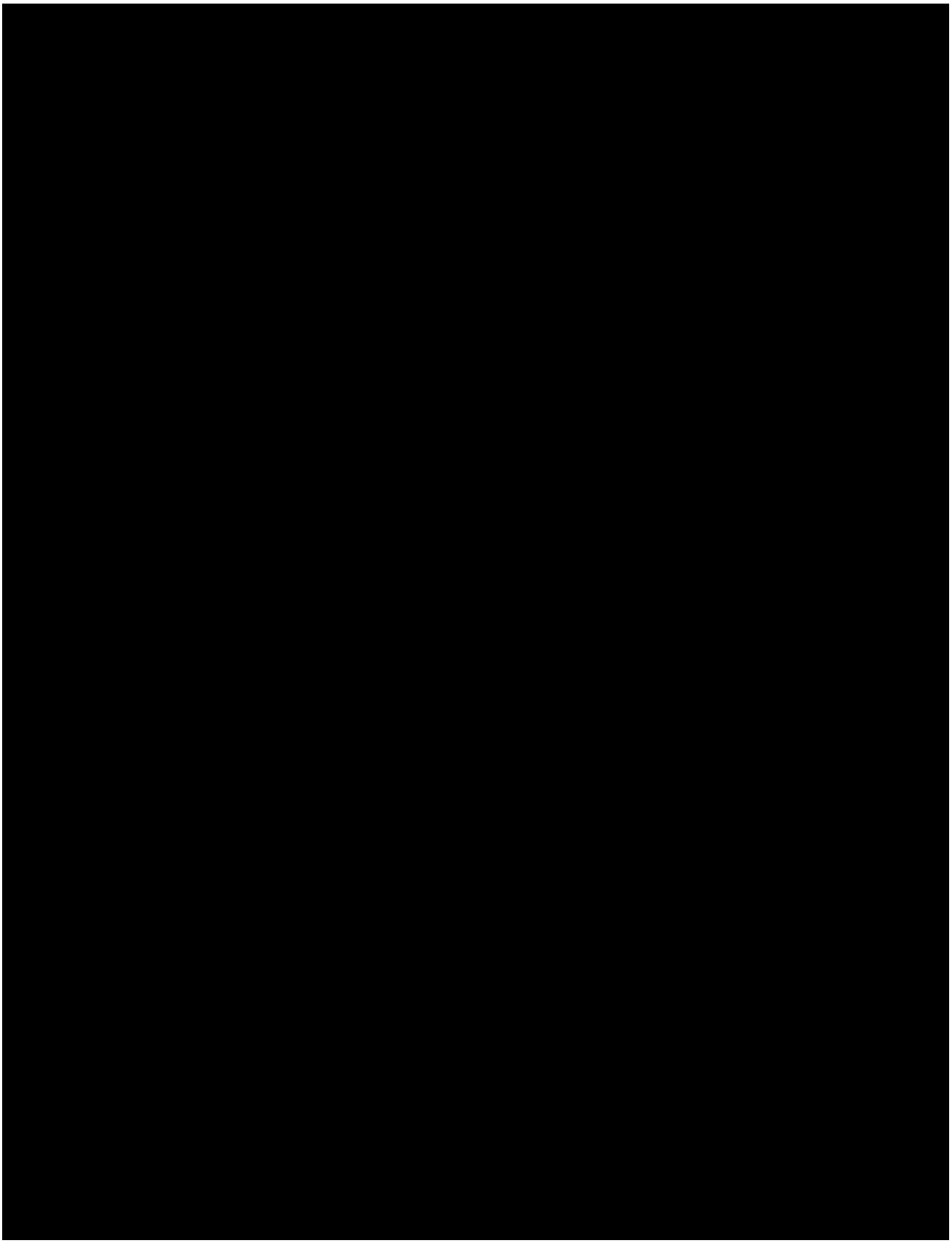


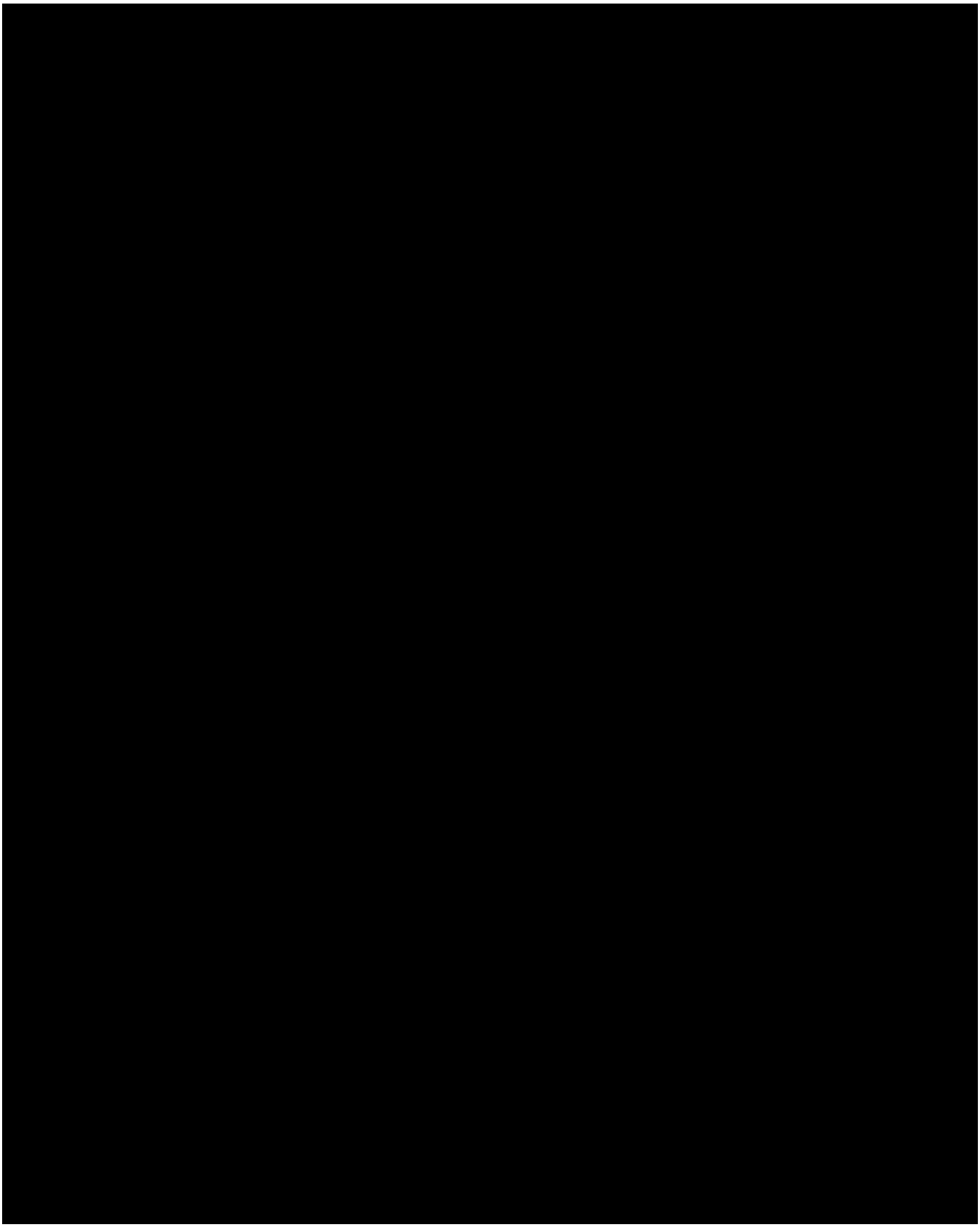


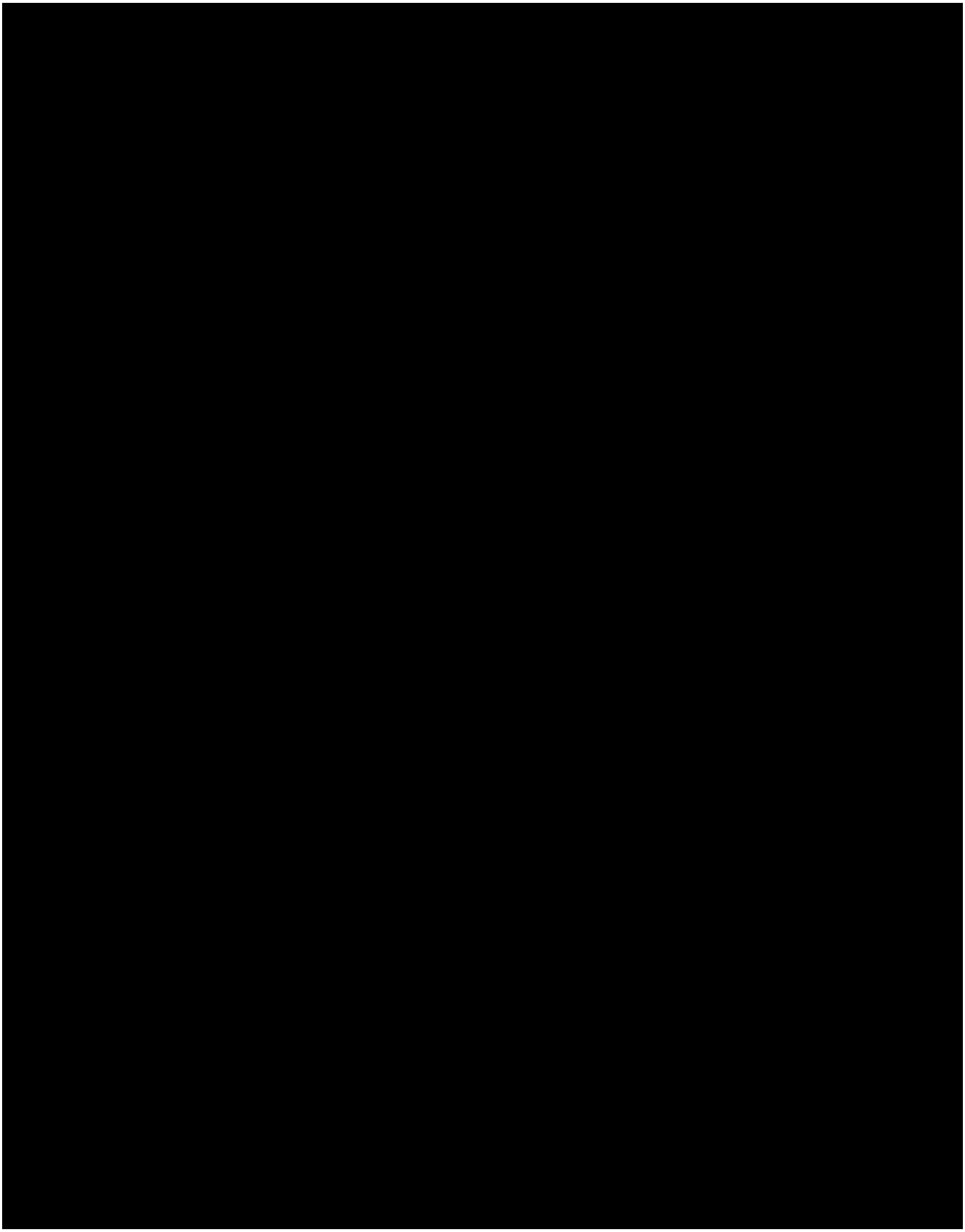


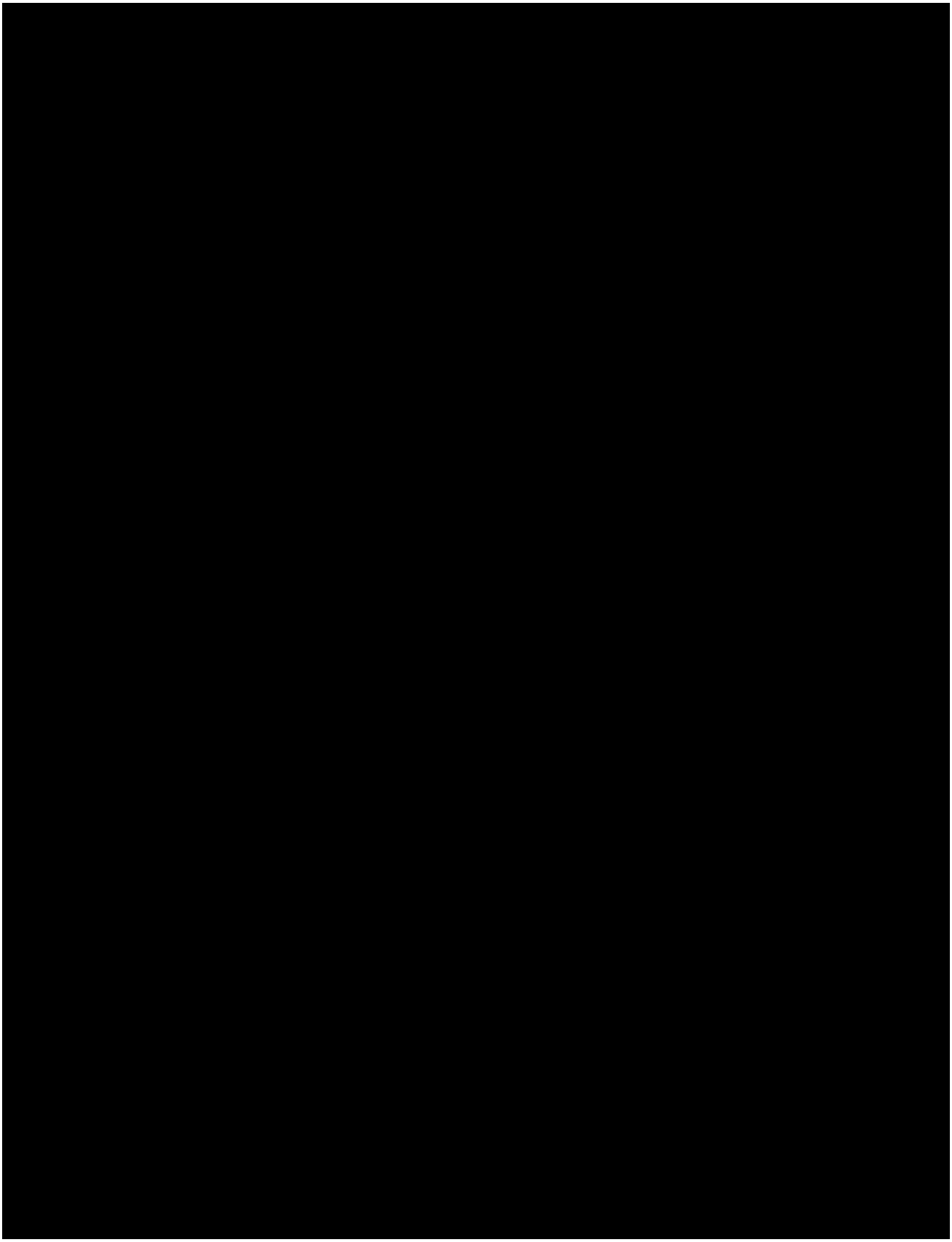


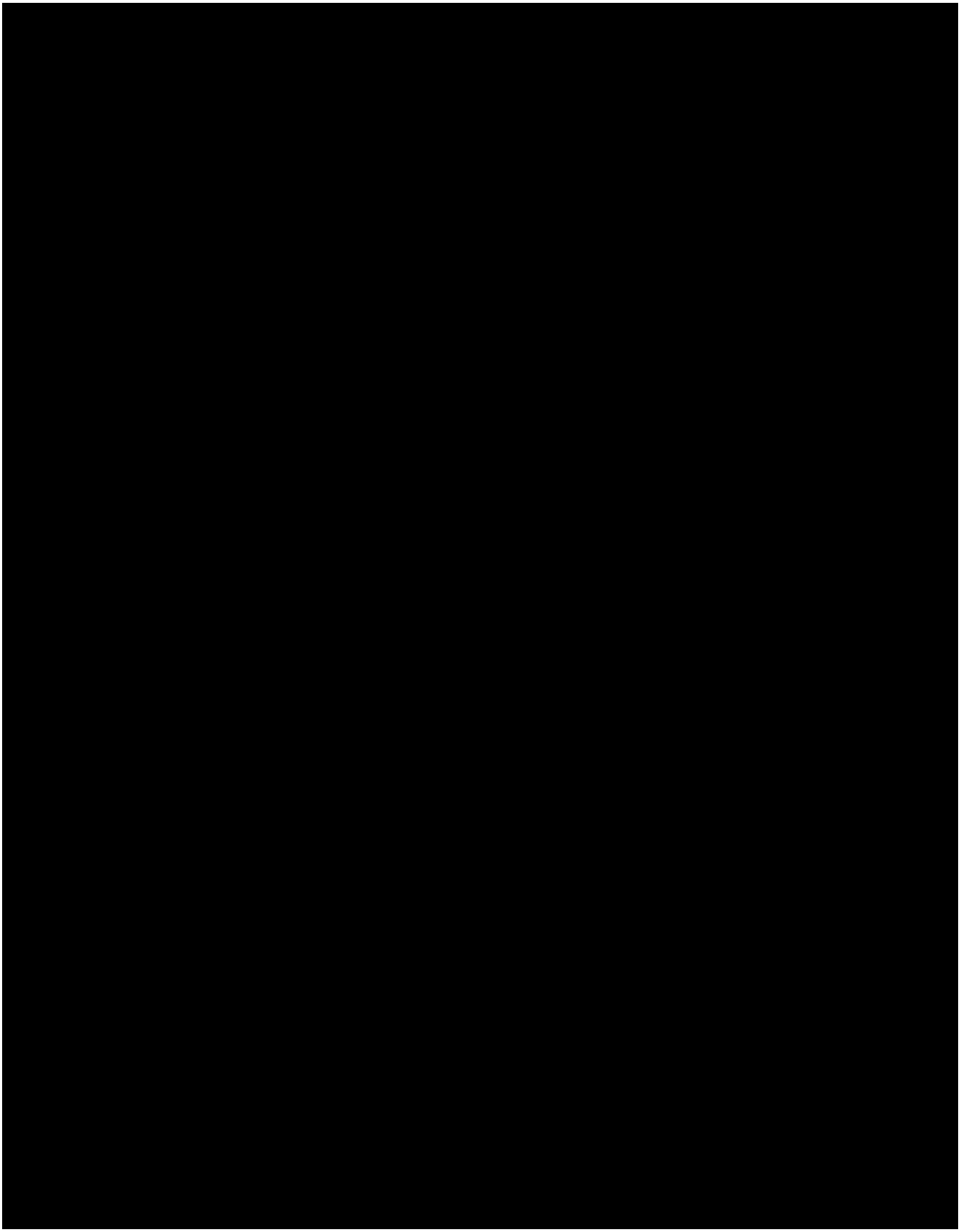


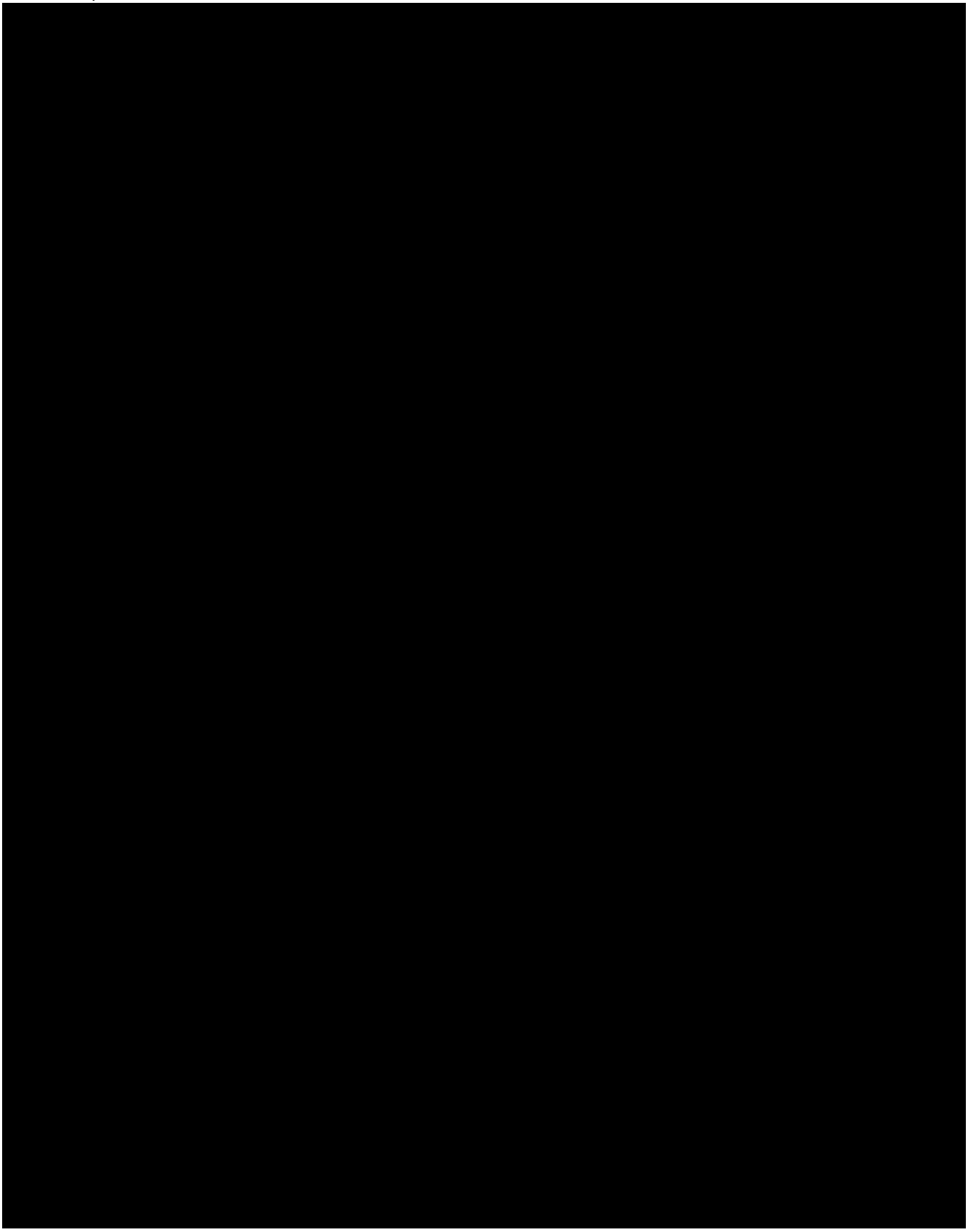


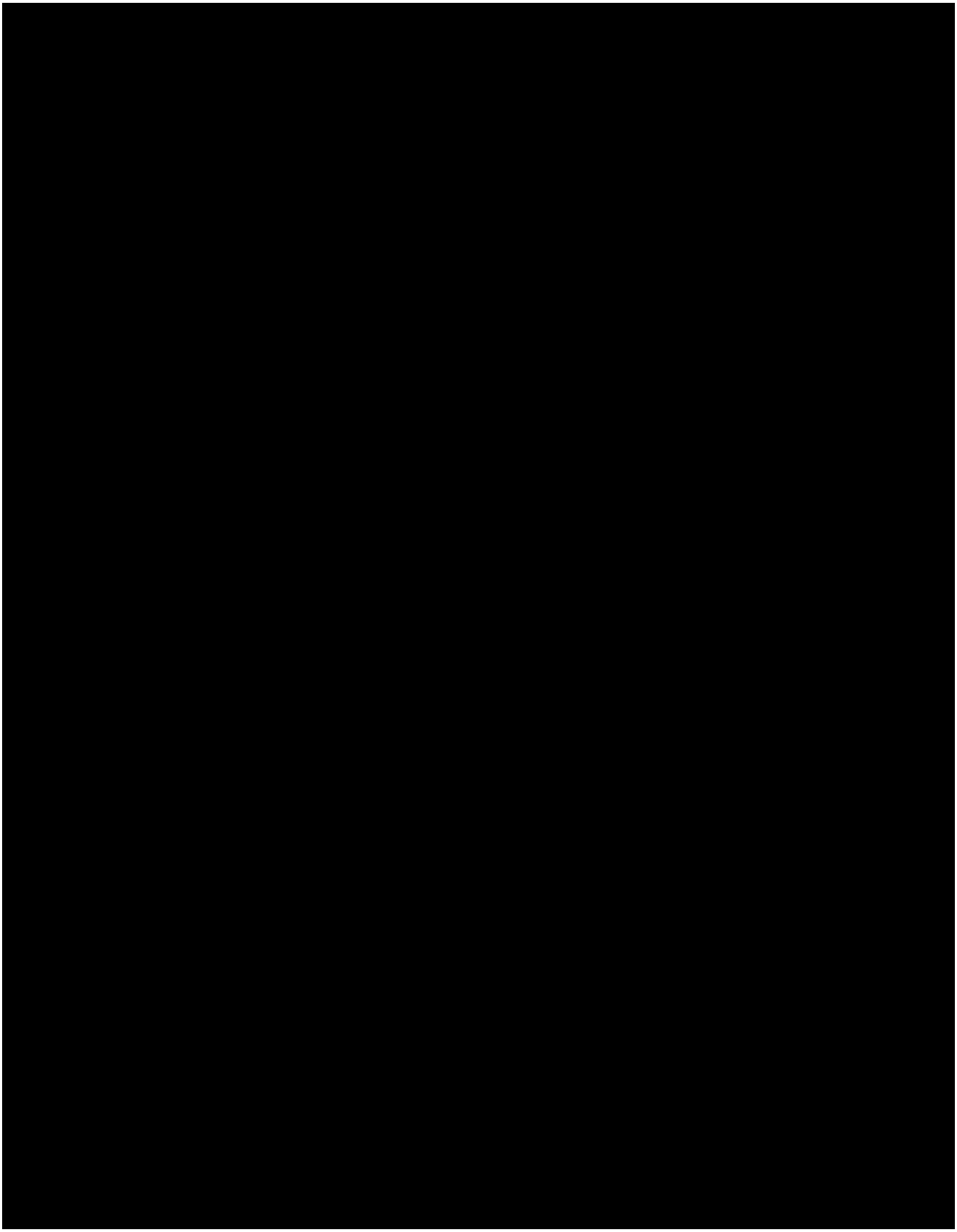


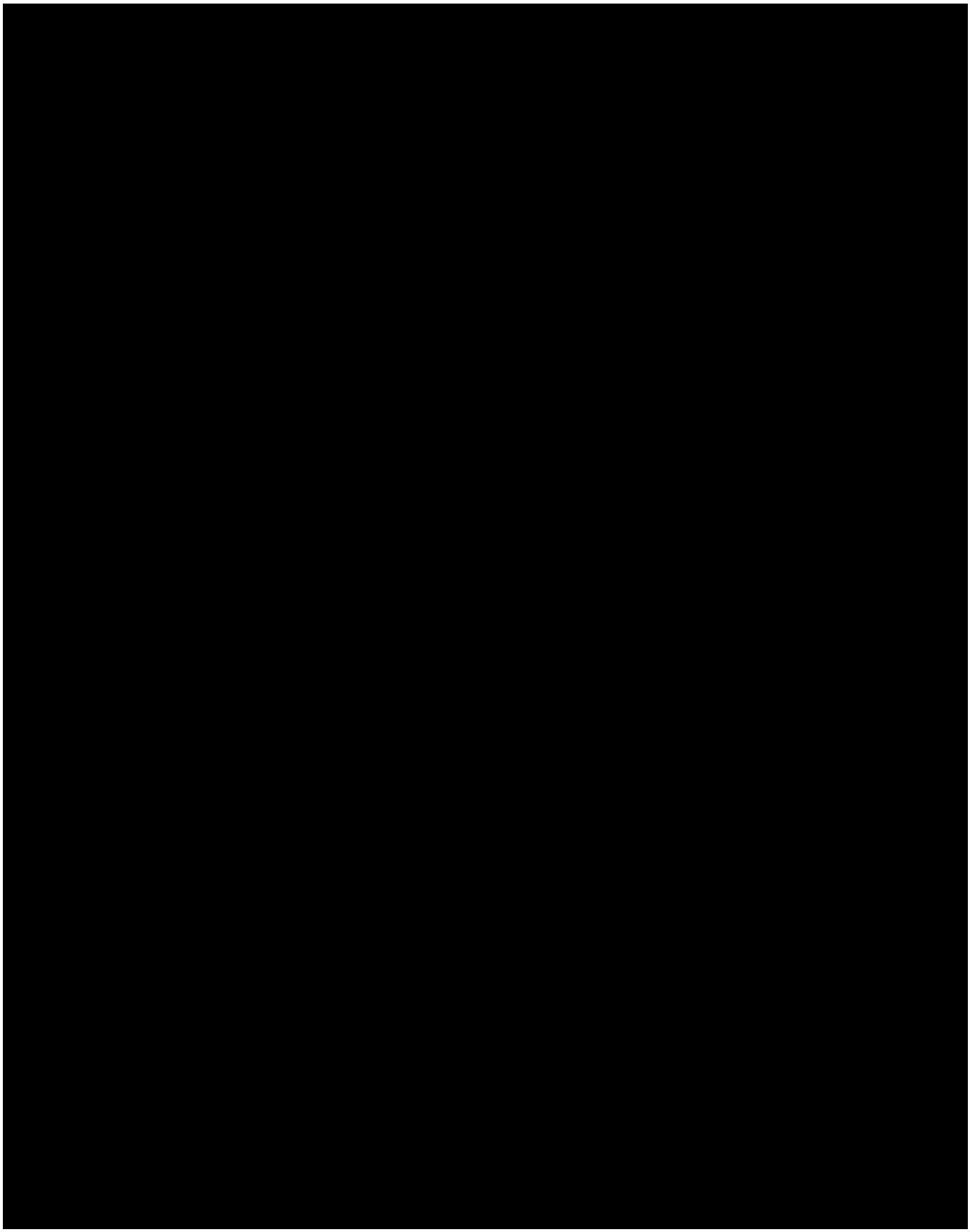












# UNITED STATES
# SECURITIES AND EXCHANGE COMMISSION
**Washington, D.C. 20549**

# 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, 2018
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** | **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 ☒ 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 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. ☒

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 | ☒ | 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 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**

**Table of Contents**

*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 *360° Health* suite of integrated care management programs and tools. *360° 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 | |

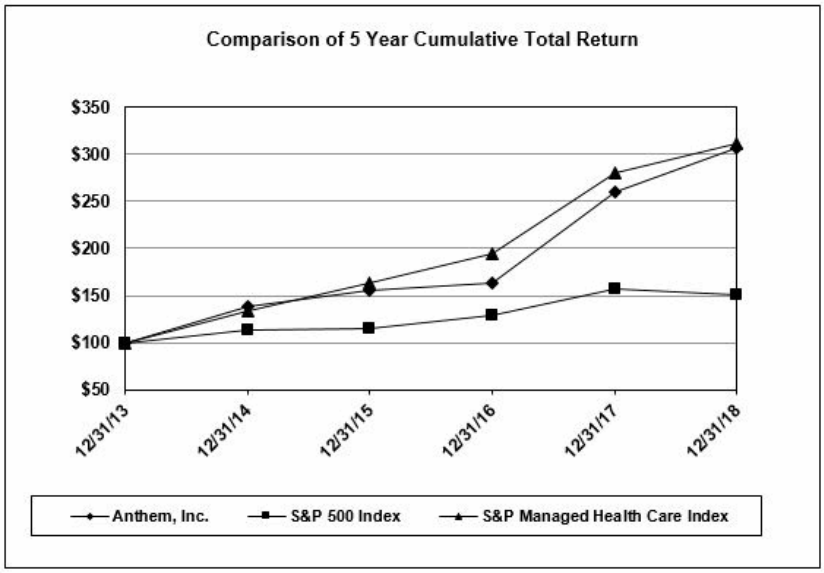
1 Total number of shares purchased includes 14,513 shares delivered to or withheld by us in connection with employee payroll tax withholding upon exercise or vesting of stock awards. Stock grants to employees and directors and stock issued for stock option plans and stock purchase plans in the consolidated 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:

| | Years Ended December 31 | | | Change | | | |
|---|---|---|---|---|---|---|---|
| | | | | 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**

**Contents**

## 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**

| *(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: | | | |
| 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.*

## 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.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

***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.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

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

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

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

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

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.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

***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

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

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

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Notes to Consolidated Financial Statements (continued)

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.

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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 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

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Notes to Consolidated Financial Statements (continued)

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

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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

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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.

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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*."

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**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 | $ — |

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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 |

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

***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 |

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, 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) |

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:

| | 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.

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 $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 |

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. 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) |

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, 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) |

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

***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) | — |

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, 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

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.

*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) |

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, 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,

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Notes to Consolidated Financial Statements (continued)

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.

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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, 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 |

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Notes to Consolidated Financial Statements (continued)

**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.

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Notes to Consolidated Financial Statements (continued)

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

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 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.

Anthem, Inc.
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 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 |

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Notes to Consolidated Financial Statements (continued)

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 |

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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 | |
|---|---|---|---|---|
| | 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% |

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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:

| | 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.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

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 |

Anthem, Inc.
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, 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 |

Anthem, Inc.
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, 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.

Anthem, Inc.
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 |
|---|---|---|
| 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 |

Anthem, Inc.
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, 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

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

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 |

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, 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.

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, 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.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

***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.

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Notes to Consolidated Financial Statements (continued)

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,

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

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

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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

Anthem, Inc.
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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

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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

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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

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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

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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 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. 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.

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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

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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.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

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."

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

**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.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

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% |

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, 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.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

**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.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

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 |

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

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.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

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<br>**Gail K. Boudreaux** | President and Chief Executive Officer, Director (Principal Executive Officer) | February 20, 2019 |
| /s/ JOHN E. GALLINA<br>**John E. Gallina** | Executive Vice President and Chief Financial Officer (Principal Financial Officer) | February 20, 2019 |
| /s/ RONALD W. PENCZEK<br>**Ronald W. Penczek** | Senior Vice President and Chief Accounting Officer (Principal Accounting Officer) | February 20, 2019 |
| /s/ ELIZABETH E. TALLETT<br>**Elizabeth E. Tallett** | Chair of the Board | February 20, 2019 |
| /s/ R. KERRY CLARK<br>**R. Kerry Clark** | Director | February 20, 2019 |
| /s/ ROBERT L. DIXON, JR.<br>**Robert L. Dixon, Jr.** | Director | February 20, 2019 |
| /s/ LEWIS HAY III<br>**Lewis Hay III** | Director | February 20, 2019 |
| /s/ JULIE A. HILL<br>**Julie A. Hill** | Director | February 20, 2019 |
| /s/ BAHIJA JALLAL<br>**Bahija Jallal** | Director | February 20, 2019 |
| /s/ ANTONIO F. NERI<br>**Antonio F. Neri** | Director | February 20, 2019 |
| /s/ RAMIRO G. PERU<br>**Ramiro G. Peru** | Director | February 20, 2019 |
| /s/ GEORGE A. SCHAEFER, JR.<br>**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.

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**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**

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**

-3a-

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**

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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**

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**

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(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**

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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



**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.

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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

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 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.

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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 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**

**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 |
|---|---|---|---|
| ⇩ | ⇩ | ⇩ | ⇩ |
| Standard 1A, 4 | Standard 1B, 4 | Standard 1C, 4 | Standard 1D, 4 |

**IN ADDITION,**

2. Is risk being assumed?

| Yes | | | No | |
|---|---|---|---|---|
| ⇩ | ⇩ | ⇩ | ⇩ | ⇩ |
| Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance | 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 | 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 | Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates | Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates |
| ⇩ | ⇩ | ⇩ | ⇩ | |
| Standards 7A-7E, 11 | Standard 2 (Guidelines 1.1,1.2) and Standard 11 | Standard 6H | Standard 2 (Guidelines 1.1,1.3) and Standard 11 | Standard 6H |

**IN ADDITION,**

3. Is medical care being directly provided?

| Yes | No |
|---|---|
| ⇩ | ⇩ |
| Standard 3A | 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 | | |
|---|---|---|---|
| ⇩ | ⇩ | ⇩ | ⇩ |
| | Controlled Affiliate is not a former primary licensee and is not subject to Standard 1(C) | Controlled Affiliate is a former primary licensee | Controlled Affiliate is not a former primary licensee and is subject to Standard 1(C) |
| | ⇩ | ⇩ | ⇩ |
| Standards 6A-6J | Standards 5,8,9B,10,11 | Standards 5,8,9A,10,11 | 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**

**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**

**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**

**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**

**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

**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**

**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**

**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 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**

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(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: _

**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.

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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-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]**

**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:_____

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. 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 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.

**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

(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:_____

**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**

**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**

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. 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 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
(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:_____

**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.

| | |
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| 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

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| 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

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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.<br><br>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**

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 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**

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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;

**Amended as of June 19, 2014**

**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**

Page 5 of 14

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.

**Amended as of March 26, 2015**

**EXHIBIT 4**

Page 6 of 14

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**

**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).

**Amended as of November 18, 2010**

**EXHIBIT 4**

Page 9 of 14

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 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.

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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.

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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.

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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.

**Amended as of September 20, 2007**

**EXHIBIT 5**

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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**

**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.

**Exhibit 10.13**

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**

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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**

**Exhibit 10.13**

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**

**Exhibit 10.13**

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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**Exhibit 10.13**

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**

**Exhibit 10.13**

(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**

(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:

**Amended as of September 17, 1997**

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**Exhibit 10.13**

(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**



(The next page is page 6)

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.

**Exhibit 10.13**

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**

**Exhibit 10.13**

(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**

**Exhibit 10.13**

(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**

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**Exhibit 10.13**

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**

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**Exhibit 10.13**

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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**Exhibit 10.13**

(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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**Exhibit 10.13**

(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**

**Exhibit 10.13**

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**

**Exhibit 10.13**

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_____

**Exhibit 10.13**

**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**

**Exhibit 10.13**

**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**

**Exhibit 10.13**

(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**

**Exhibit 10.13**

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**

**Exhibit 10.13**

(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.

**Amended as of March 26, 2015**

**Exhibit 10.13**

## 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

**Amended as of September 19, 2014**

**Exhibit 10.13**

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

**Amended as of March 26, 2015**

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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

**Amended as of March 26, 2015**

**Exhibit 10.13**

(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.

**Amended as of March 26, 2015**

**Exhibit 10.13**

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**

**Exhibit 10.13**

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.

**Amended as of March 26, 2015**

**Exhibit 10.13**

(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 March 26, 2015**

**Exhibit 10.13**

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.

**Exhibit 10.13**

**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**

**Exhibit 10.13**

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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 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, 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<br>⇩<br>Standard 1A, 4 | 50% by Sponsoring Plan<br>⇩<br>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<br>⇩<br>Standard 1C, 4 | 100% Sponsoring Plan control and on a Blue-branded basis, it only offers Basic Medicare Part D Prescription Drug Plan product<br>⇩<br>Standard 1D, 4 |
|---|---|---|---|

**IN ADDITION,**

2. Is risk being assumed?

| Yes | | | No | |
|---|---|---|---|---|
| ⇙ | ⇩ | ⇘ | ⇙ | ⇩ |
| Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance<br>⇩<br>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<br>⇩<br>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<br>⇩<br>Standard 6H | Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates<br>⇩<br>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<br>⇩<br>Standard 6H |

**IN ADDITION,**

3. Is medical care being directly provided?

| Yes<br>⇩<br>Standard 3A | No<br>⇩<br>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 | | |
|---|---|---|---|
| ⇩ | ⇙ | ⇙ | ⇘ |
| Standards 6A-6J | Controlled Affiliate is not a former primary licensee and is not subject to Standard 1(C)<br>⇩<br>Standards 5,8,9B,10,11 | Controlled Affiliate is a former primary licensee<br>⇩<br>Standards 5,8,9A,10,11 | Controlled Affiliate is not a former primary licensee and is subject to Standard 1(C)<br>⇩<br>Standards 5,8,9B,11 |

**Exhibit 10.13**

**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**

**Exhibit 10.13**

**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**

**Exhibit 10.13**

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**

**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(l): 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 10.13**

**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 10.13**

**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**

**Exhibit 10.13**

**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 10.13**

**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 10.13**

**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**

**Exhibit 10.13**

**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**

**Exhibit 10.13**

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**

**Exhibit 10.13**

**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

**Exhibit 10.13**

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 10.13**

**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 10.13**

**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 10.13**

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**

**Exhibit 10.13**

**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.

**Exhibit 10.13**

**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.

**Exhibit 10.13**

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.

**Exhibit 10.13**

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**

**Exhibit 10.13**

**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**

**Exhibit 10.13**

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: _

**Exhibit 10.13**

**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 10.13**

**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. 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.

**Exhibit 10.13**

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;

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(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

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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.

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**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.

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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

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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.

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**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,

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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.

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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. 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 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

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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.

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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.

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**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

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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

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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

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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

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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

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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.

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**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

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**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 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. 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

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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

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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.

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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 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.

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**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

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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

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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:

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(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

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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.

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**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.

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**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:_____

**Exhibit 10.13**

**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

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**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 10.13**

**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 10.13**

**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 10.13**

**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 10.13**

**EXHIBIT 2**
**Membership Standards**
Page 2 of 5

StandardA Plan shall furnish to the Association on a timely and accurate basis reports and records relating to
2: 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 10.13**

**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 10.13**

**EXHIBIT 2**

**Membership Standards**
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| | |
|---|---|
| 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**

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**EXHIBIT 2**

**Membership Standards**
Page 5 of 5

StandardNo provider network, or portion thereof, shall be rented or otherwise made available to a National Competitor if
12: 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 10.13**

**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 10.13**

**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**

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 10.13**

**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;

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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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(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.

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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.

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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. 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;

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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.

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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 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.

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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.

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 10.13**

**EXHIBIT 5**

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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**

**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 |

**Exhibit 21**

| | |
|---|---|
| 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 |

**Exhibit 21**

| | |
|---|---|
| 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 |

**Exhibit 21**

| | |
|---|---|
| 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

**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**

**Table of Contents**

*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 approximately41 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 all50 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 ofDecember 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 approximately20.7%, 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 | |

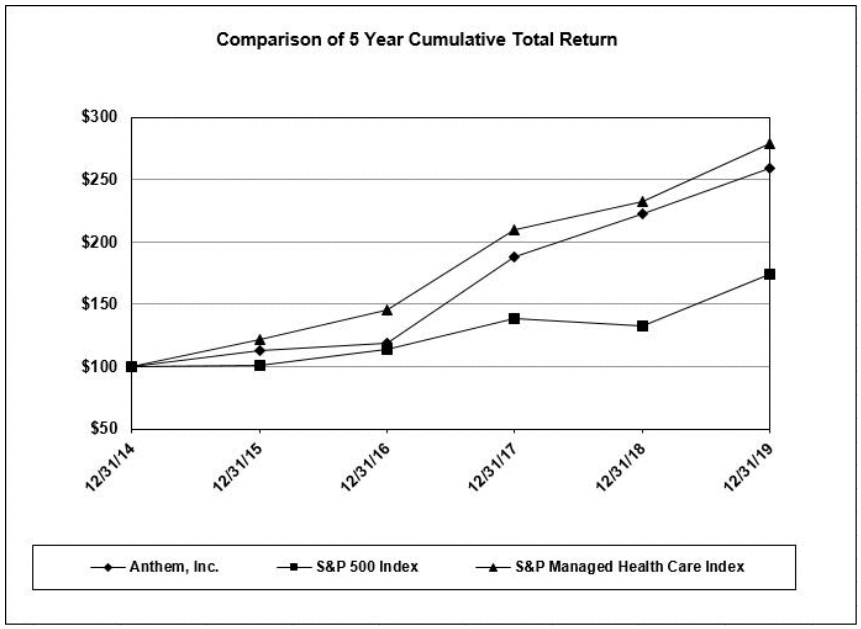
1 Total number of shares purchased includes 6,079 shares delivered to or withheld by us in connection with employee payroll tax withholding upon exercise or vesting of stock awards. Stock grants to employees and directors and stock issued for stock option plans and stock purchase plans in the consolidated 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 approximately41 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 all50 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 endedDecember 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 bythe benefits realized in pharmacy cost as a result of the launch of IngenioRx in 2019and 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, thesetwo 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 theDecember 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 ofDecember 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 for45.5% of our total fixed maturity securities atDecember 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 atDecember 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 ofDecember 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**

**Contents**

## 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.<br><br>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.<br><br>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.<br>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.<br>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 approximately41 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

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

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.

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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.

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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

Anthem, Inc.
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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

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Notes to Consolidated Financial Statements (continued)

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 atDecember 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 atDecember 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 endedDecember 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 aDecember 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 or2017.

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,

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Notes to Consolidated Financial Statements (continued)

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.

Anthem, Inc.
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 |

Anthem, Inc.
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

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

weighted-average target allocation for pension benefit plan assets is44% 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 atDecember 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 |

Anthem, Inc.
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 | | |
|---|---|---|---|
| | 2017 | 2018 | |
| Claim Years | (Unaudited) | (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.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

***Long-term Debt***

The carrying value of long-term debt atDecember 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

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

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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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.

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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.

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Notes to Consolidated Financial Statements (continued)

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

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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

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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.

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***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 |

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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.

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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."

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

**15. Accumulated Other Comprehensive Loss**

A reconciliation of the components of accumulated other comprehensive loss atDecember 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 ofl 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 approximately20.7%, 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 endedDecember 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 endedDecember 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 ofDecember 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<br>**Gail K. Boudreaux** | President and Chief Executive Officer, Director (Principal Executive Officer) | February 19, 2020 |
| /s/ JOHN E. GALLINA<br>**John E. Gallina** | Executive Vice President and Chief Financial Officer (Principal Financial Officer) | February 19, 2020 |
| /s/ RONALD W. PENCZEK<br>**Ronald W. Penczek** | Senior Vice President and Chief Accounting Officer (Principal Accounting Officer) | February 19, 2020 |
| /s/ ELIZABETH E. TALLETT<br>**Elizabeth E. Tallett** | Chair of the Board | February 19, 2020 |
| /s/ R. KERRY CLARK<br>**R. Kerry Clark** | Director | February 19, 2020 |
| /s/ ROBERT L. DIXON, JR.<br>**Robert L. Dixon, Jr.** | Director | February 19, 2020 |
| /s/ LEWIS HAY III<br>**Lewis Hay III** | Director | February 19, 2020 |
| /s/ JULIE A. HILL<br>**Julie A. Hill** | Director | February 19, 2020 |
| /s/ BAHIJA JALLAL<br>**Bahija Jallal** | Director | February 19, 2020 |
| /s/ ANTONIO F. NERI<br>**Antonio F. Neri** | Director | February 19, 2020 |
| /s/ RAMIRO G. PERU<br>**Ramiro G. Peru** | Director | February 19, 2020 |
| /s/ RYAN M. SCHNEIDER<br>**Ryan M. Schneider** | Director | February 19, 2020 |

**Exhibit 4.8**

1

**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 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;
- 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; and
requirements for advance notice for raising business or making nominations at shareholders' meetings.

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 of the voting power and the control shares are accorded full voting rights by the disinterested shareholders, the disinterested 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 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 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 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.

**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 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;

**DESCRIPTION OF THE REGISTRANT'S SECURITIES REGISTERED PURSUANT TO SECTION 12 OF THE SECURITIES EXCHANGE ACT OF 1934**

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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.

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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;

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; and
requirements for advance notice for raising business or making nominations at shareholders' meetings.

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 of the voting power and the control shares are accorded full voting rights by the disinterested shareholders, the disinterested 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 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 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 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.

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;

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; and

- requirements for advance notice for raising business or making nominations at shareholders' meetings.

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.

**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 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;
- 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; and
requirements for advance notice for raising business or making nominations at shareholders' meetings.

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 of the voting power and the control shares are accorded full voting rights by the disinterested shareholders, the disinterested 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.

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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.

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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.

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**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**

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- the division of the board of directors into three classes serving staggered terms of office of three years;
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majority of continuing directors; and
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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.

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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.

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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.

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**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.

**Exhibit 10.11**

**BLUE CROSS LICENSE AGREEMENT**
**(Includes revisions, if any, adopted by Member Plans through their November 21, 2019 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 (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 business or sales of equipment no longer useful or being replaced;

6. Make any loans or advances except in the ordinary course of business;



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**

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)
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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 anysimilar 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**

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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

**Amended as of June 16, 2005**

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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.

**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-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.

**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**

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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**

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(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



**EXHIBIT 1**

**BLUE CROSS**
**CONTROLLED AFFILIATE LICENSE AGREEMENT**
(**Includes revisions adopted by Member Plans through their November 21, 2019 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**

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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**

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(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**

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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, 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.



(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.

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



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



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 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 acontrol, 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.

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.

(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.

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.

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:

**Amended as of March 26, 2015**

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**EXHIBIT A**

**CONTROLLED AFFILIATE LICENSE STANDARDS**
**November 2019 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**

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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**

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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 ⇩ Standard 1A, 4 | 50% by Sponsoring Plan ⇩ 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 ⇩ | 100% Sponsoring Plan control and on a Blue-branded basis, it only offers a Basic Medicare Part D Prescription Drug Plan product ⇩ 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. ⇩ Standard 1E, 4 |

**IN ADDITION,**

2. Is risk being assumed?

| | |
|---|---|
| Yes | No |

| | | | | |
|---|---|---|---|---|
| Controlled Affiliate underwrites any indemnity portion of workers' compensatio n insurance ⇩ 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 ⇩ 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 ⇩ Standard 6H | ⇙ Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates ⇩ 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 ⇩ Standard 6H |

**IN ADDITION,**

3. Is medical care being directly provided as a staff model HMO?

| | |
|---|---|
| Yes ⇩ Standard 3A | No ⇩ Standard 3B |

**Amended 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 ⇩ 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 ⇩ Standards 6A- 6J | No ⇙ 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 ⇩ Standards 5,8,9A,10,11 | ⇘ Controlled Affiliate is not a former primary licensee and is subject to Standard 1(C) ⇩ 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**

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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 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 reasonablybelieves 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**

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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 anyfor-

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.

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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. 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**

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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**

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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)**

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**

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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

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 hasreviewed 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 November 21, 2019 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-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**

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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:



**EXHIBIT A**
CONTROLLED AFFILIATE LICENSE STANDARDS LIFE INSURANCE COMPANIES
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**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.

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**EXHIBIT A**
CONTROLLED AFFILIATE LICENSE STANDARDS LIFE INSURANCE COMPANIES
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**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.

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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 properlyexecuted:

(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

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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]**



**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.

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**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.

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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 November 21, 2019 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 Party signatory hereto.
("Controlling Plans"), each of which is also a

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. **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 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 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 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



(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.

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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

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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:_

**EXHIBIT A**

**CONTROLLED AFFILIATE LICENSE STANDARDS APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS**
November 2019

**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

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**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 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**



**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 November 21, 2019 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 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. **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

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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.

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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 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.

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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.

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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.

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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:



**EXHIBIT A**

**CONTROLLED AFFILIATE LICENSE STANDARDS APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS**

**November 2019 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

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**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 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**

**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**

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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;

**Amended as of January 22, 2019**

**EXHIBIT 4**

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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;

**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

(i) 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

(ii) 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 March 26, 2015**

**EXHIBIT 4**

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2.4 Services to National Accounts (continued)

For purposes of this subparagraph a, the following definitionsapply:

**"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**

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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).

**Amended as of March 26, 2015**

**EXHIBIT 4**

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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**

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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);

**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;

e. advertising in publications or electronic media solely to persons for employment;

**EXHIBIT 4**

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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.

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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.

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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 athree 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 deposition1 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.

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**



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**

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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**

**Exhibit 10.12**

**BLUE SHIELD LICENSE AGREEMENT**
**(Includes revisions, if any, adopted by Member Plans through their November 21, 2019 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 10.12**

**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**

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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**

**Exhibit 10.12**

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**

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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**

**Exhibit 10.12**

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.

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(the next page is 3)

**Exhibit 10.12**

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**

**Exhibit 10.12**

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**

**Exhibit 10.12**

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**

**Exhibit 10.12**

(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 10.12**

conditions:

(d). The Plan may operate as a for-profit company on the following

(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**

**Exhibit 10.12**

(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**

**Exhibit 10.12**

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**

**Exhibit 10.12**

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.

**Exhibit 10.12**

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**

**Exhibit 10.12**

(a). 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.

(b). 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.

(c). 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**

**Exhibit 10.12**

(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**
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**Exhibit 10.12**

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**
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**Exhibit 10.12**

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**

**Exhibit 10.12**

(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**

**Exhibit 10.12**

(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**

**Exhibit 10.12**

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**



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**Exhibit 10.12**

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

**Exhibit 10.12**

**EXHIBIT 1**

**BLUE SHIELD**
**CONTROLLED AFFILIATE LICENSE AGREEMENT**
**(Includes revisions adopted by Member Plans through their November 21, 2019 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 signatory hereto. ("Plan" or “Sponsoring Plan”), which is also a Party

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**

**Exhibit 10.12**

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**

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(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.

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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**

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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.

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.

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(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
(1) 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
(i) 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.

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

**Amended as of March 26, 2015**

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.

**Amended as March 26, 2015**

**Exhibit 10.12**

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.

**Amended as of March 26, 2015**

**Exhibit 10.12**

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.

**Amended as of March 26, 2015**

**Exhibit 10.12**

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**Exhibit 10.12**

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 10.12**

**EXHIBIT A**

**CONTROLLED AFFILIATE LICENSE STANDARDS**
**November 2019 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 10.12**

**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 10.12**

**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 ⇩ Standard 1A, 4 | 50% by Sponsoring Plan ⇩ 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 ⇩ Standard 1C, 4 | 100% Sponsoring Plan control and on a Blue- branded basis, it only offers Basic Medicare Part D Prescription Drug Plan product ⇩ 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. ⇩ Standard 1E, 4 |

**IN ADDITION,**

2. Is risk being assumed?

| Yes | | | No | |
|---|---|---|---|---|
| | ⇩ | ⇘ | ⇙ Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates | ⇩ |
| ⇙ Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance ⇩ 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 ⇩ 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 ⇩ Standard 6H | ⇩ 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 ⇩ Standard 6H |

**IN ADDITION,**

3. Is medical care being directly provided as a staff model HMO?

| Yes | No |
|---|---|
| ⇩ Standard 3A | ⇩ Standard 3B |

**Exhibit 10.12**

**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)?

---

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 | | |
|---|---|---|---|
| ⇩ | ⇦ Controlled Affiliate is not a former primary licensee and is not subject to Standard 1(C) ⇩ | ⇦ Controlled Affiliate is a former primary licensee ⇩ | ⇘ Controlled Affiliate is not a former primary licensee and is subject to Standard 1(C) ⇩ |
| Standards 6A-6J | Standards 5,8,9B,10,11 | Standards 5,8,9A,10,11 | Standards 5,8,9B,11 |

**Amended as of June 20, 2019**

**Exhibit 10.12**

**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**

**Exhibit 10.12**

**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**

**Exhibit 10.12**

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.

**Exhibit 10.12**

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**

**Exhibit 10.12**

**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 10.12**

**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 10.12**

**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 Shield Mark.

**Amended as of November 21, 2014**

**Exhibit 10.12**

**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 10.12**

**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 10.12**

**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**

**Exhibit 10.12**

**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 10.12**

**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**

**Exhibit 10.12**

**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 10.12**

**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 10.12**

**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

**Exhibit 10.12**

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**

**Exhibit 10.12**

**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

**Exhibit 10.12**

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 10.12**

**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 10.12**

**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 10.12**

EXHIBIT 1A

**CONTROLLED AFFILIATE LICENSE AGREEMENT APPLICABLE TO LIFE INSURANCE COMPANIES**
**(Includes revisions adopted by Member Plans through their November 21, 2019 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**

**Exhibit 10.12**

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.

**Exhibit 10.12**

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.

**Exhibit 10.12**

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.

**Exhibit 10.12**

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**

**Exhibit 10.12**

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**

**Exhibit 10.12**

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: _

**Exhibit 10.12**

**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 10.12**

**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 10.12**

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, S pouse 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.

**Exhibit 10.12**

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;

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(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

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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.

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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.

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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
(1) 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]**

**Exhibit 10.12**

**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.

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**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.

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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.

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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 November 21, 2019)**

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 Party signatory hereto. ("Controlling Plans"), each of which is also a

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. **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 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

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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.

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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.

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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

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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
(ii) 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.

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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

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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.

**Exhibit 10.12**

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

**Exhibit 10.12**

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.

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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.

**Exhibit 10.12**

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:

**Exhibit 10.12**

**EXHIBIT A**

**CONTROLLED AFFILIATE LICENSE STANDARDS APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS**

**November 2019 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

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**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 November 21, 2019 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 Party signatory hereto. ("Controlling Plans"), each of which is also a

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

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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

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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.

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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 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.

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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

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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

**Exhibit 10.12**

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:

**Exhibit 10.12**

(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.

**Exhibit 10.12**

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.

**Exhibit 10.12**

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.

**Exhibit 10.12**

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:_

**Exhibit 10.12**

**EXHIBIT A**

**CONTROLLED AFFILIATE LICENSE STANDARDS APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS**

**November 2019 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 10.12**

**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 10.12**

**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 10.12**

**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 10.12**

**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.

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| 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 10.12**

**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 10.12**

**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 10.12**

**EXHIBIT 2**

**Membership Standards**
Page 4 of 5

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| 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 10.12**

**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.<br><br>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 10.12**

**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 10.12**

**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 10.12**

**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 10.12**

**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 10.12**

**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 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.

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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;

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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.

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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 BCGSA 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

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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.

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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 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 deposition1 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.

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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.

i 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.

ii 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.

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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 21**

**SUBSIDIARIES OF THE COMPANY**

| *Legal Name* | *Domestic Jurisdiction* | *Doing Business As* |
|---|---|---|
| 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 |
| Amerigroup Delaware, Inc. | Delaware | |
| Amerigroup District of Columbia, Inc. | District of Columbia | |
| Amerigroup Health Plan of Louisiana, Inc. | Louisiana | |
| 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 |
| 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 | |

**Exhibit 21**

| | | |
|---|---|---|
| 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 | |
| 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 |
| 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 | |
| Cerulean Companies, Inc. | Georgia | |
| 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 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 | |

**Exhibit 21**

| | | |
|---|---|---|
| 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 | |
| Freedom Health, Inc. | Florida | |
| Global TPA, LLC | Florida | |
| Golden West Health Plan, Inc. | California | |
| Greater Georgia Life Insurance Company | Georgia | Anthem Life |
| Health Core, Inc. | Delaware | |
| Health Management Corporation | Virginia | LiveHealth Online; HMC of Virginia; Health Management of Virginia |
| 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 Holdings, LLC | Florida | |
| HealthSun Management, LLC | 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 Holdco, Inc. | 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 |
| 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 Holdings II, LLC | Indiana | |
| Living Complete Technologies, Inc. | Maryland | TAI Software, Inc. |
| Matthew Thornton Health Plan, Inc. | New Hampshire | |
| Memphis Supportive Care Partnership, LLC | Tennessee | |
| Meridian Resource Company, LLC | Wisconsin | |
| Missouri Care, Incorporated | Missouri | |
| Nash Holding Company, LLC | Delaware | |

**Exhibit 21**

| | | |
|---|---|---|
| National Government Services, Inc. | Indiana | NGS of Indiana |
| New England Research Institutes, Inc. | Massachusetts | Summit Community Care |
| 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 | 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 |
| 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 DM 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 | |
| Valus, Inc. | Indiana | |
| WellCare of Nebraska, Inc. | Nebraska | |
| 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 | |

**Exhibit 21**

| | |
|---|---|
| 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 |

**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 19, 2020, 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, 2019.

/S/ ERNST & YOUNG LLP

Indianapolis, Indiana
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**

**Table of Contents**

*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 *360° Health* suite of integrated care management programs and tools. *360° 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 | |

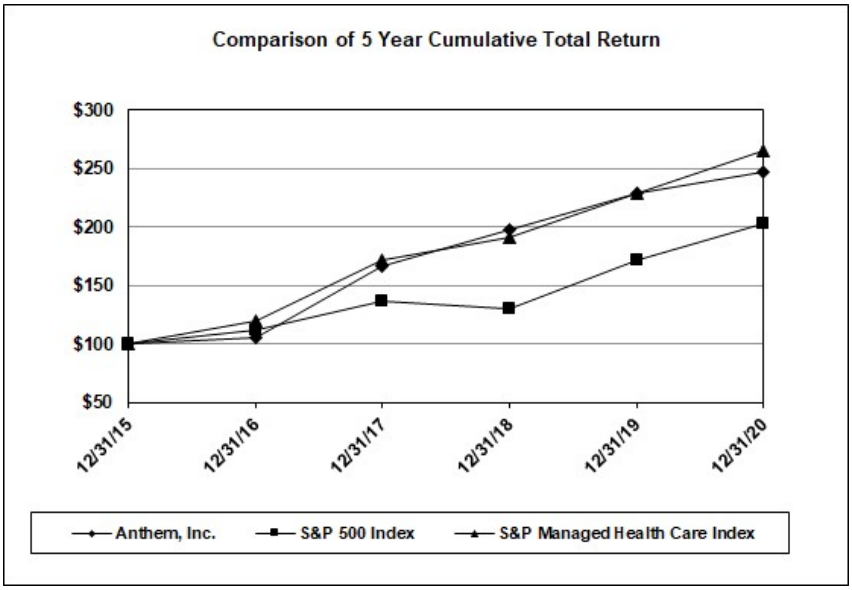
1 Total number of shares purchased includes 22,813 shares delivered to or withheld by us in connection with employee payroll tax withholding upon exercise or vesting of stock awards. Stock grants to employees and directors and stock issued for stock option plans and stock purchase plans in the consolidated 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**

**Contents**

## 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.<br>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.<br>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 % |

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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:

| | 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.

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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, 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.

Anthem, Inc.
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, 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 |

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

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.

Anthem, Inc.
Notes to Consolidated Financial Statements (continued)

***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.

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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<br>**Gail K. Boudreaux** | President and Chief Executive Officer, Director (Principal Executive Officer) | February 18, 2021 |
| /s/ JOHN E. GALLINA<br>**John E. Gallina** | Executive Vice President and Chief Financial Officer (Principal Financial Officer) | February 18, 2021 |
| /s/ RONALD W. PENCZEK<br>**Ronald W. Penczek** | Senior Vice President and Chief Accounting Officer (Principal Accounting Officer) | February 18, 2021 |
| /s/ ELIZABETH E. TALLETT<br>**Elizabeth E. Tallett** | Chair of the Board | February 18, 2021 |
| /s/ R. KERRY CLARK<br>**R. Kerry Clark** | Director | February 18, 2021 |
| /s/ ROBERT L. DIXON, JR.<br>**Robert L. Dixon, Jr.** | Director | February 18, 2021 |
| /s/ LEWIS HAY III<br>**Lewis Hay III** | Director | February 18, 2021 |
| /s/ JULIE A. HILL<br>**Julie A. Hill** | Director | February 18, 2021 |
| /s/ BAHIJA JALLAL<br>**Bahija Jallal** | Director | February 18, 2021 |
| /s/ ANTONIO F. NERI<br>**Antonio F. Neri** | Director | February 18, 2021 |
| /s/ RAMIRO G. PERU<br>**Ramiro G. Peru** | Director | February 18, 2021 |
| /s/ RYAN M. SCHNEIDER<br>**Ryan M. Schneider** | Director | February 18, 2021 |

**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**

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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, 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**

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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**

(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**

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**

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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

**Amended as of June 16, 2005**

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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.

**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-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.

**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___

***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

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.

**Amended as of March 26, 2015**

(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

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

**Amended as of March 26, 2015**

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.

**Amended as of March 26, 2015**

**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<br>ò<br>Standard 1A, 4 | 50% by Sponsoring Plan<br>ò<br>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<br>ò | 100% Sponsoring Plan control and on a Blue- branded basis, it only offers a Basic Medicare Part D Prescription Drug Plan product<br>ò<br>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.<br>ò<br>Standard 1E, 4 |
|---|---|---|---|---|

**IN ADDITION,**

2. Is risk being assumed?

| Yes<br>ò | | ø | No<br>÷ ò | |
|---|---|---|---|---|
| Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance<br>ò<br>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<br>ò<br>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<br>ò<br>Standard 6H | Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates<br>ò<br>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<br>ò<br>Standard 6H |

**IN ADDITION,**

3. Is medical care being directly provided as a staff model HMO?

| Yes | No |
|---|---|
| ò<br>Standard 3A | ò<br>Standard 3B |

**Amended 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) | Controlled Affiliate is a former primary licensee | Controlled Affiliate is not a former primary licensee and is subject to Standard 1(C) |
| | Standards 5,8,9B,10,11 | ò | ò |
| | | Standards 5,8,9A,10,11 | Standards 5,8,9B,11 |

**Amended 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 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**

**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**

**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**

**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:___

**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]**

**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:___

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. 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 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.

**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:___

**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**

**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**

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. 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 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 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:___

**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**

**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**



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**

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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**



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**



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**

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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**

**EXHIBIT 4**

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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).

**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**

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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;

**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;

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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**

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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 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.

**Amended as of September 20, 2007**

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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.

**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 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.

**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**

**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**

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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**

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**

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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) 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**

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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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(The next page is page 6)

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**

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**

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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**

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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_____

**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.

**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 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.

**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

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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.

**Amended as of March 26, 2015**

**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<br>Ò<br>Standard 1A, 4 | 50% by Sponsoring Plan<br>Ò<br>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<br>Ò<br>Standard 1C, 4 | 100% Sponsoring Plan control and on a Blue-branded basis, it only offers Basic Medicare Part D Prescription Drug Plan product<br>Ò<br>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.<br>Ò<br>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<br>Ò<br>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<br>Ò<br>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<br>Ò<br>Standard 6H | Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates<br>ò<br>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<br>Ò<br>Standard 6H |

**IN ADDITION,**

3. Is medical care being directly provided as a staff model HMO?

| Yes | No |
|---|---|
| Ò<br>Standard 3A | Ò<br>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)<br>ò<br>Standards 5,8,9B,10,11 | Controlled Affiliate is a former primary licensee<br>ò<br>Standards 5,8,9A,10,11 | Controlled Affiliate is not a former primary licensee and is subject to Standard 1(C)<br>ò<br>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**

**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**

**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. 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**

**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)**

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:

a. The Semi-annual Health Risk-Based Capital (HRBC) Report.

**Amended as of June 13, 2002**

**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

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**

**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**

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:_

**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.

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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:

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:_____

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. 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 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

(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:_____

**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.

**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**

**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**

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:_____

**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**

**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**
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 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**



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**



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**

Page 5 of 14

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**

**EXHIBIT 4**

Page 6 of 14

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**

**EXHIBIT 4**

Page 9 of 14

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**

Page 11 of 14

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**

**EXHIBIT 4**



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.

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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 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.

**Amended as of September 20, 2007**

**EXHIBIT 5**



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.

**EXHIBIT 5**

Page 17 of 23

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.

**Amended as of September 20, 2007**

**EXHIBIT 5**



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.

**Amended as of September 20, 2007**

**EXHIBIT 5**



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**

Page 20 of 23

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**

**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 | |

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|---|---|---|
| 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 | |

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| 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 | |

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| 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 | |

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|---|---|---|
| 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 | |

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

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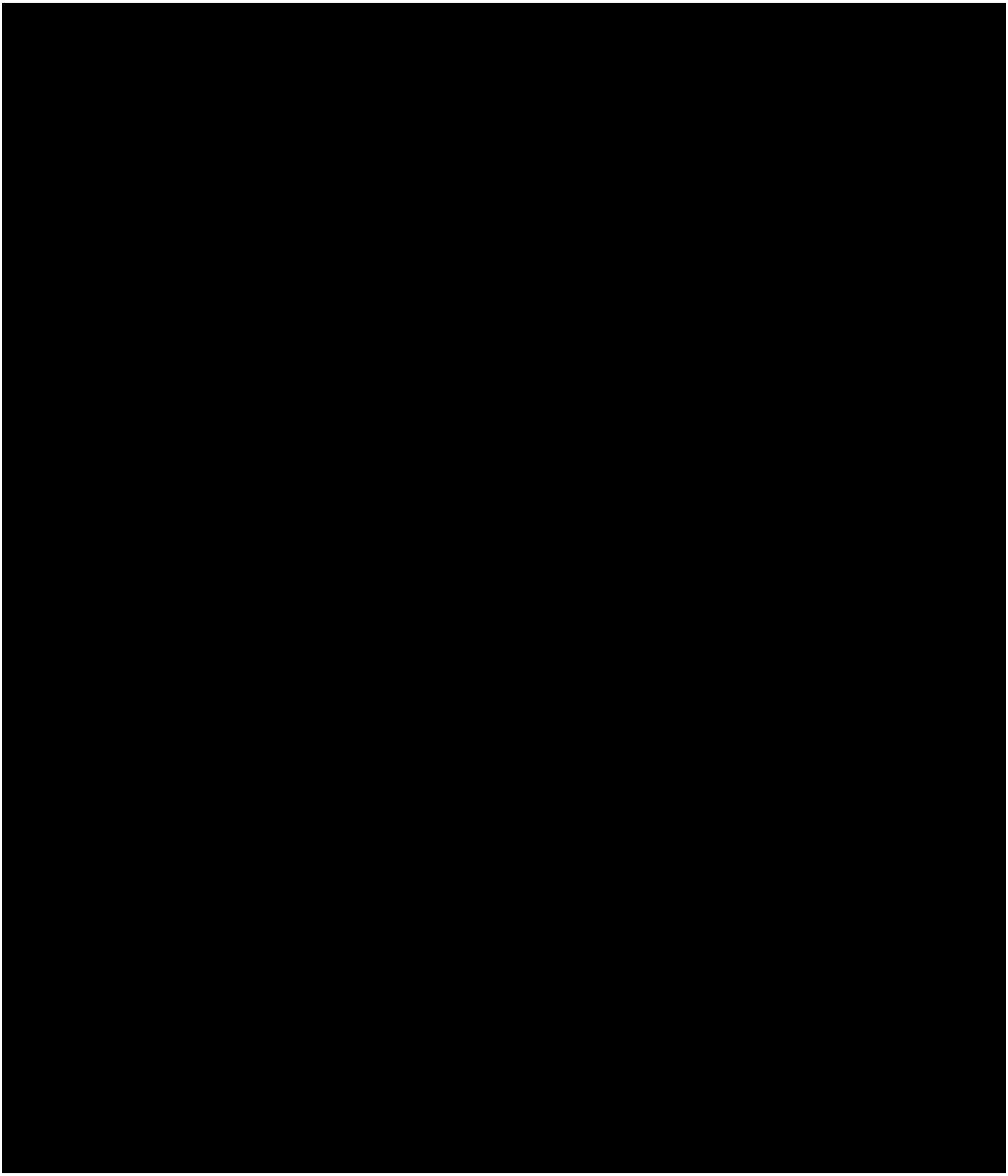

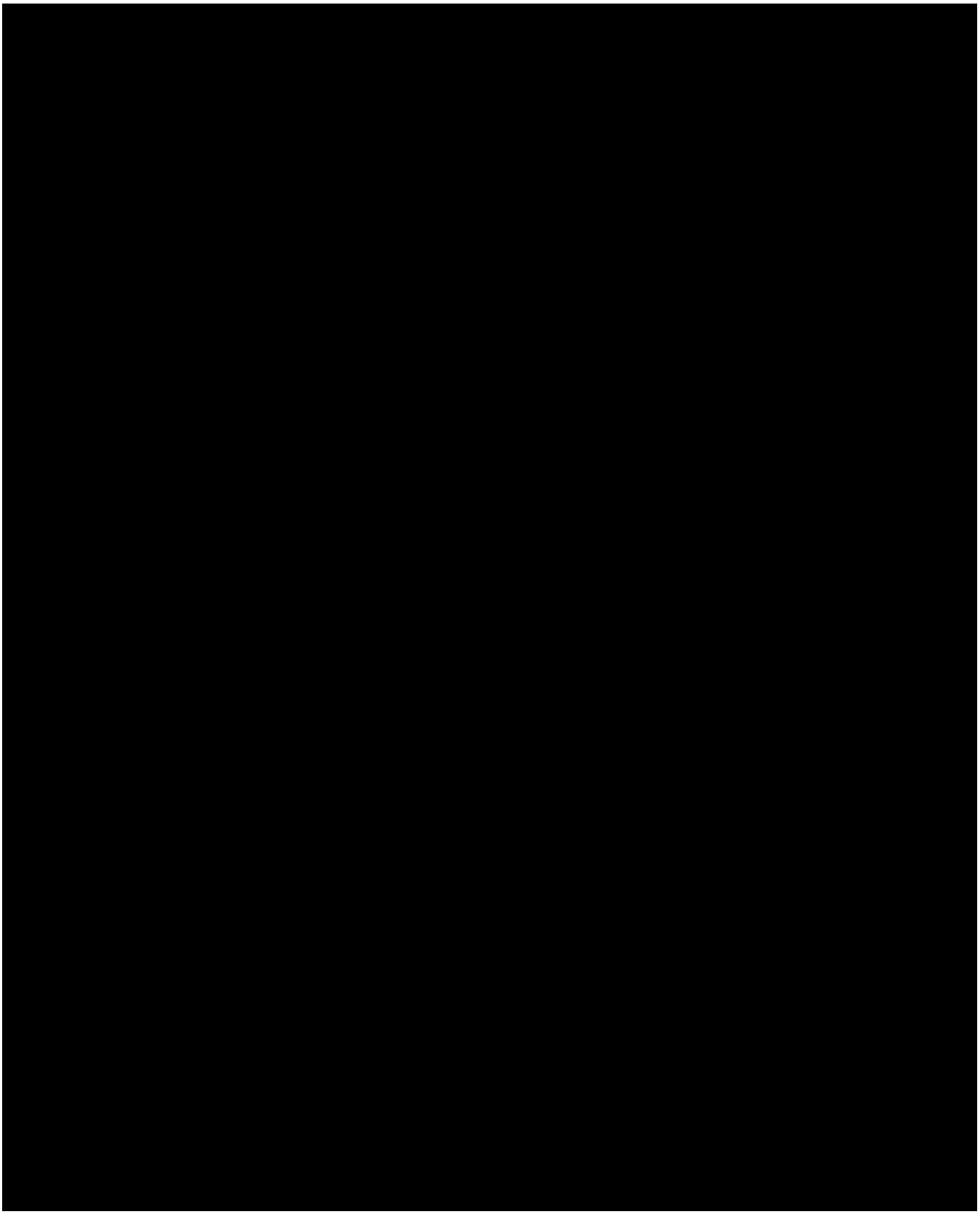

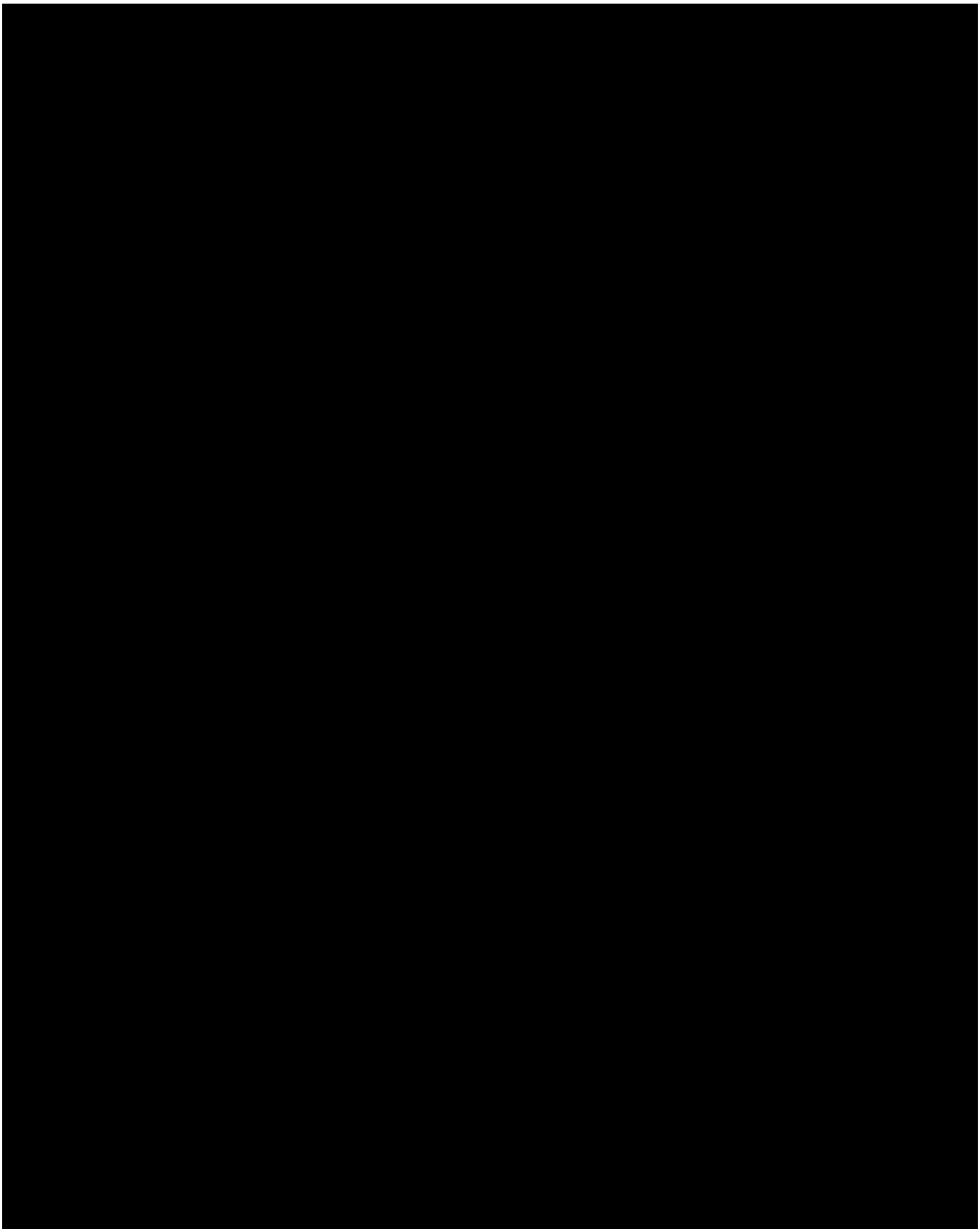

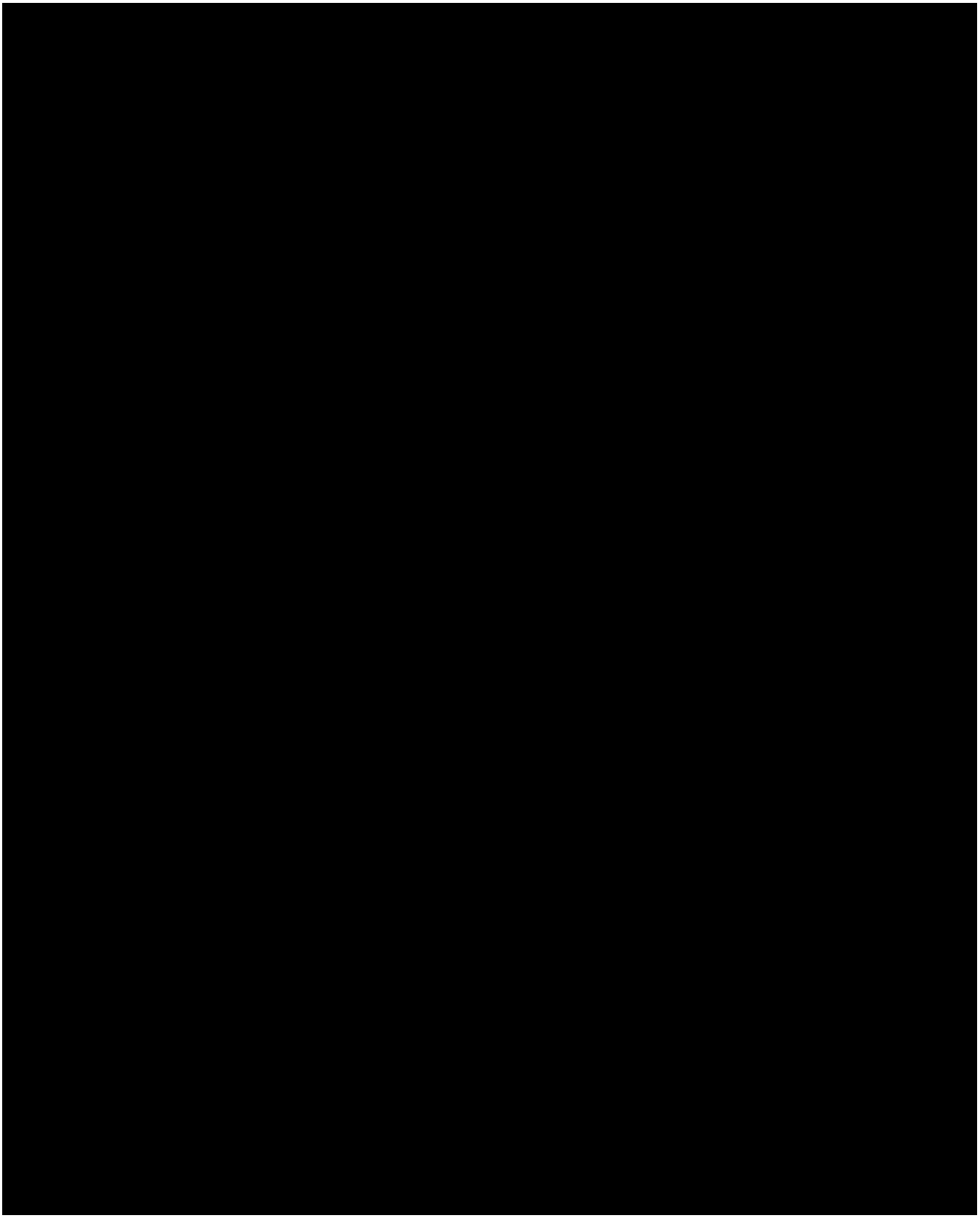

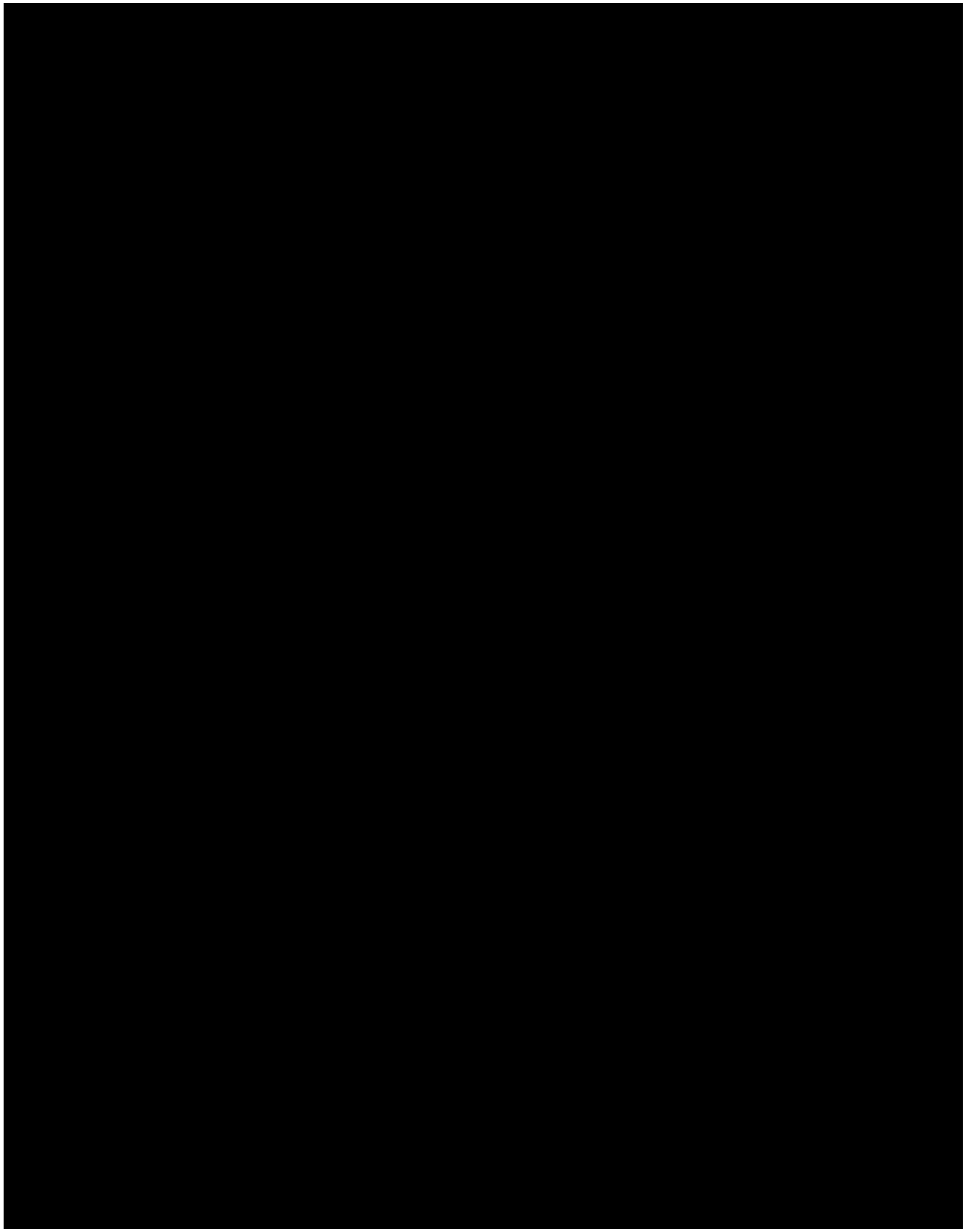

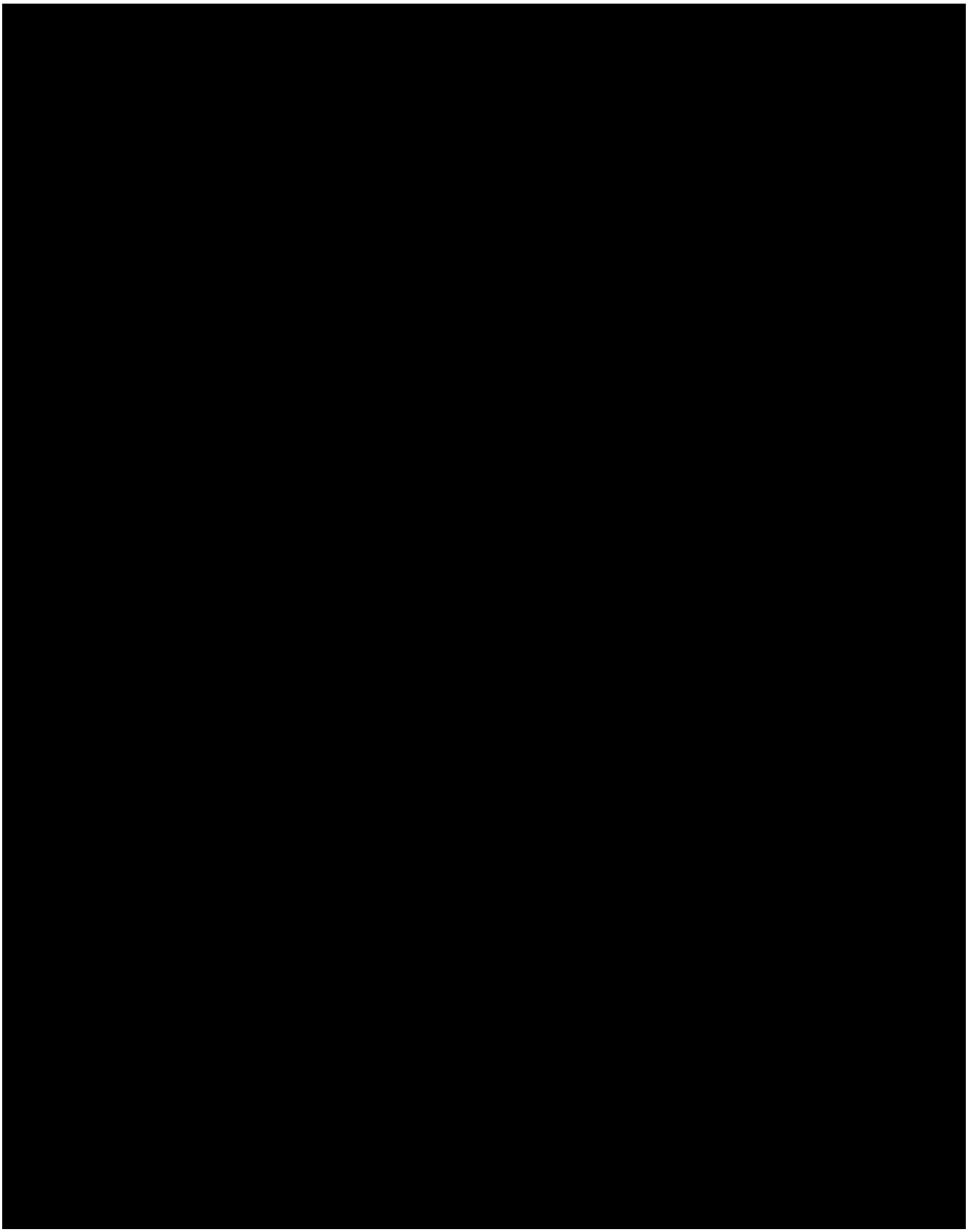

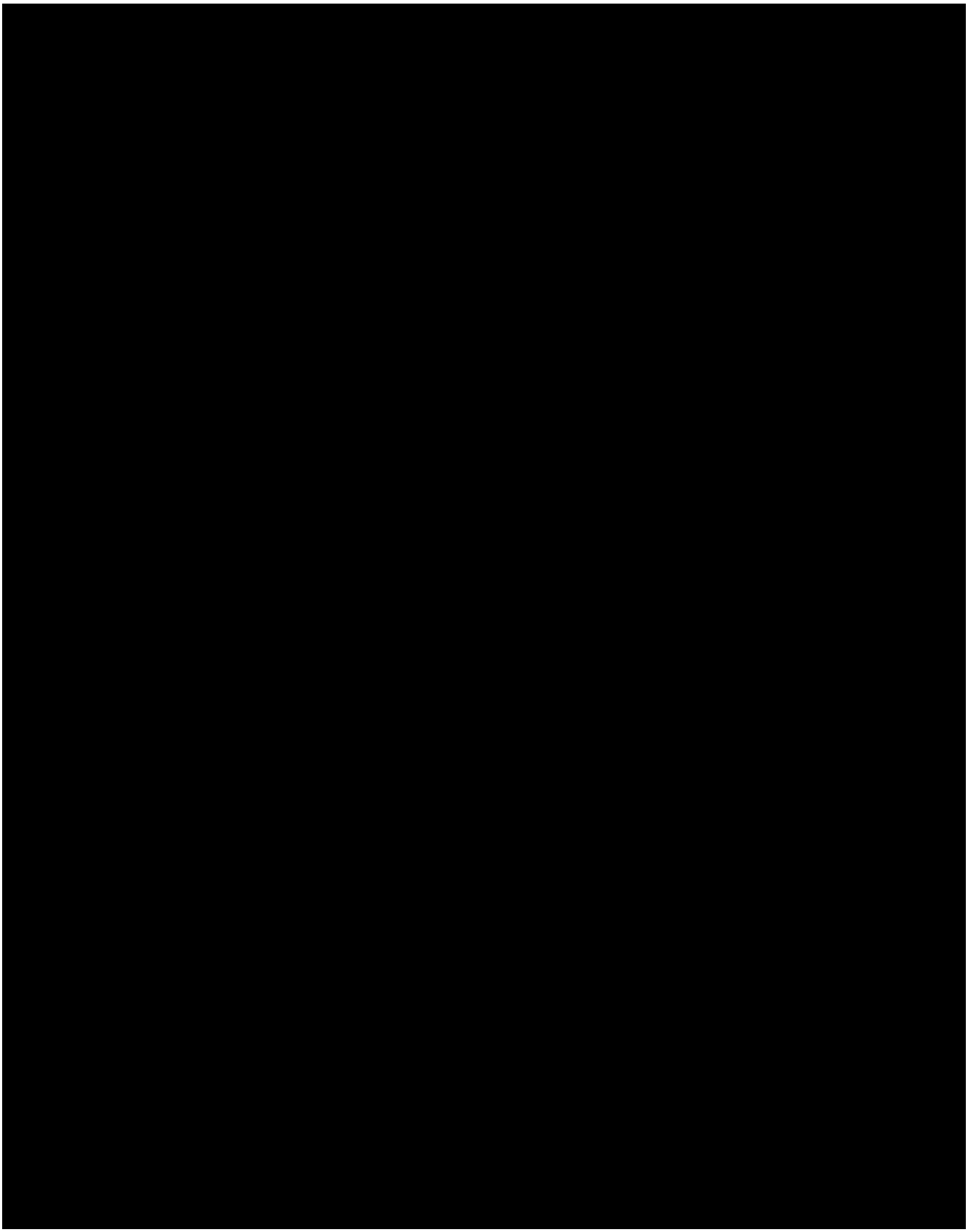

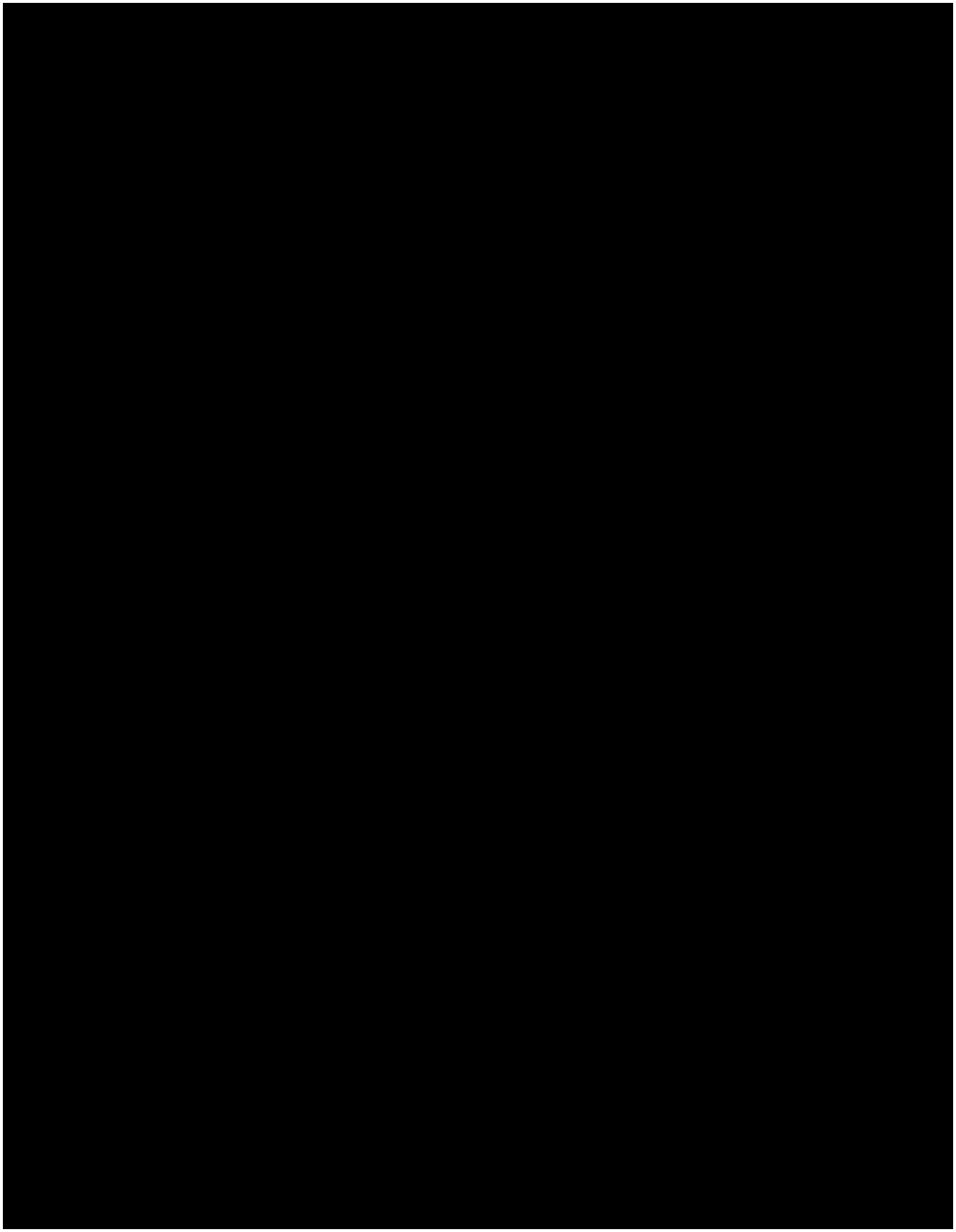

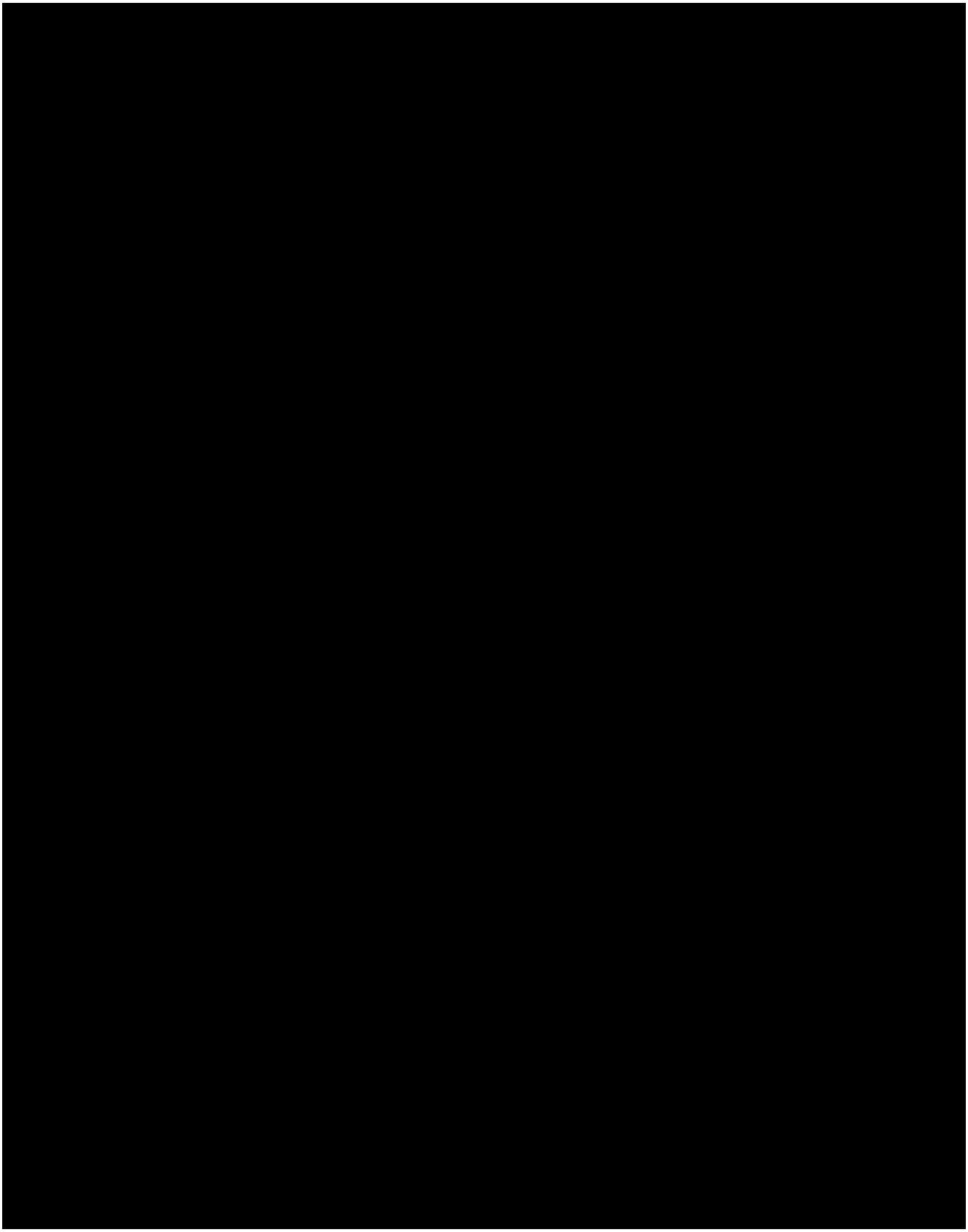

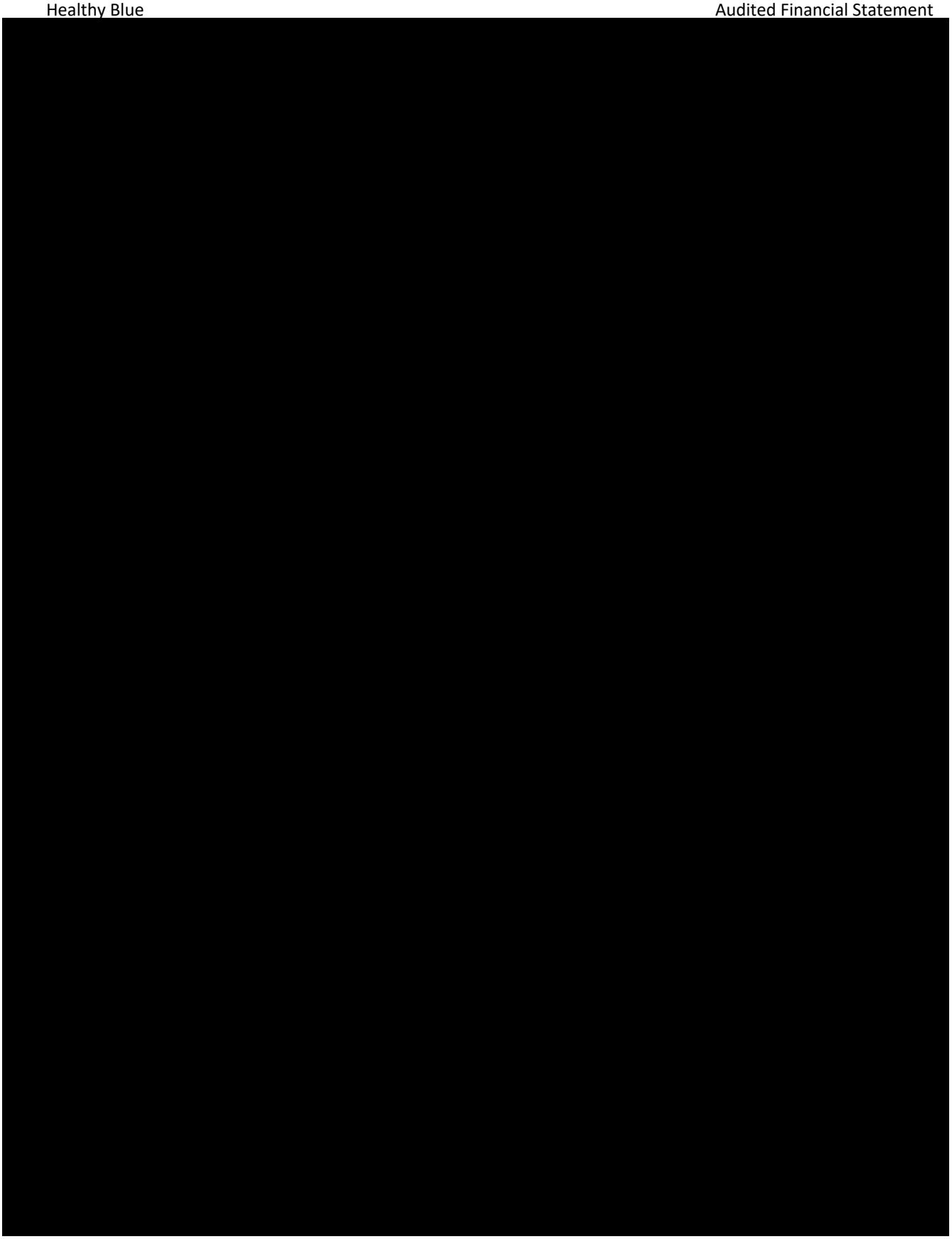

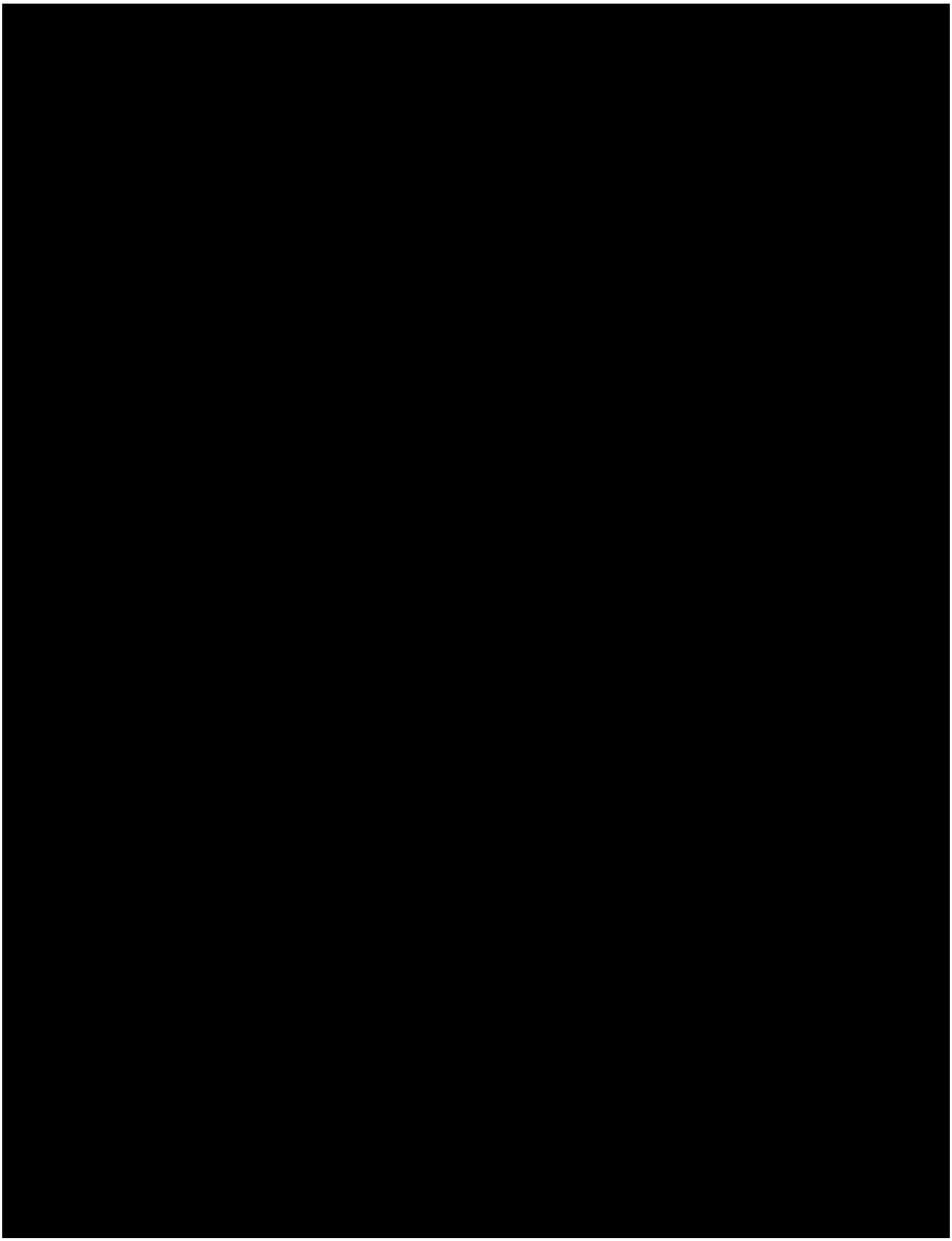

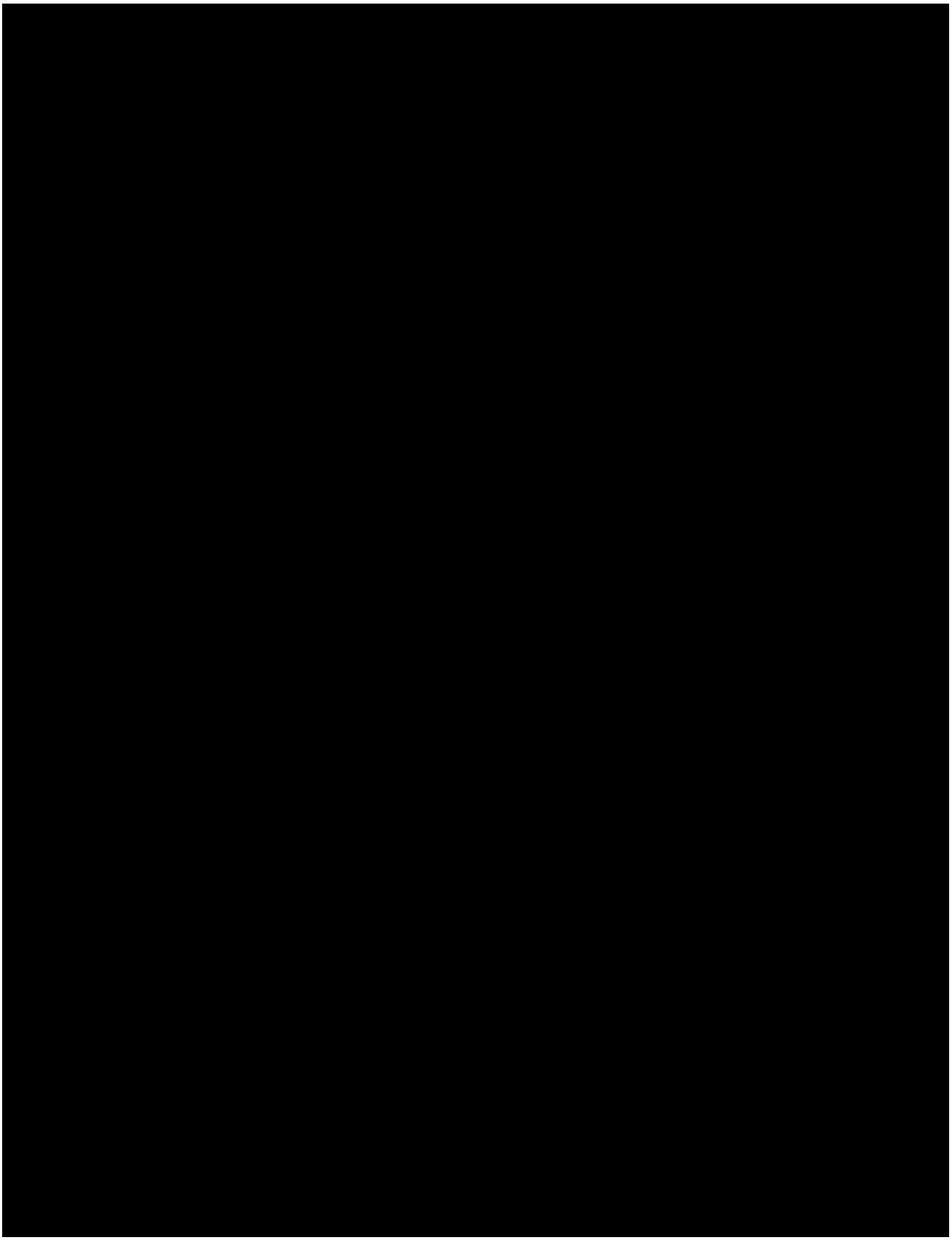

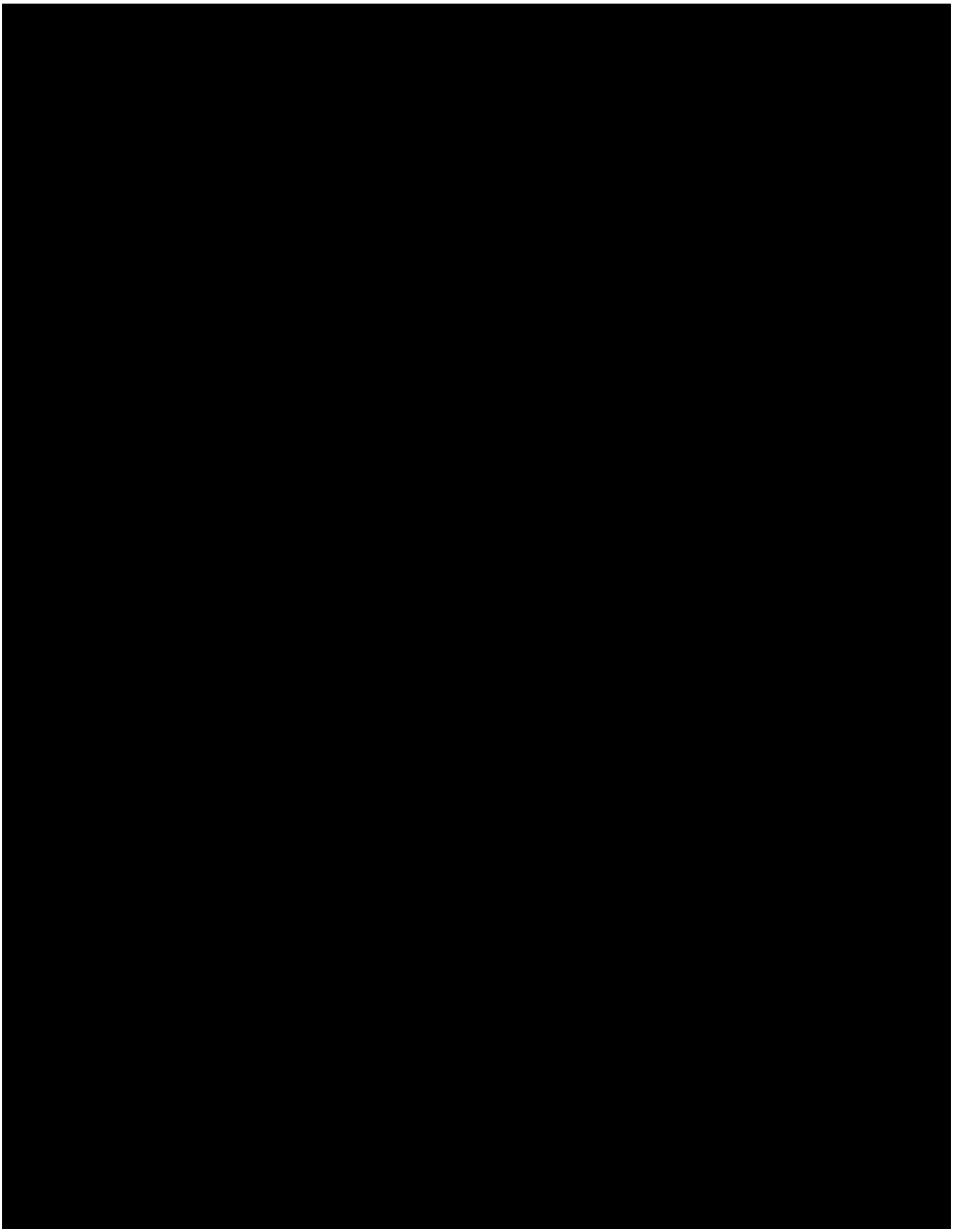

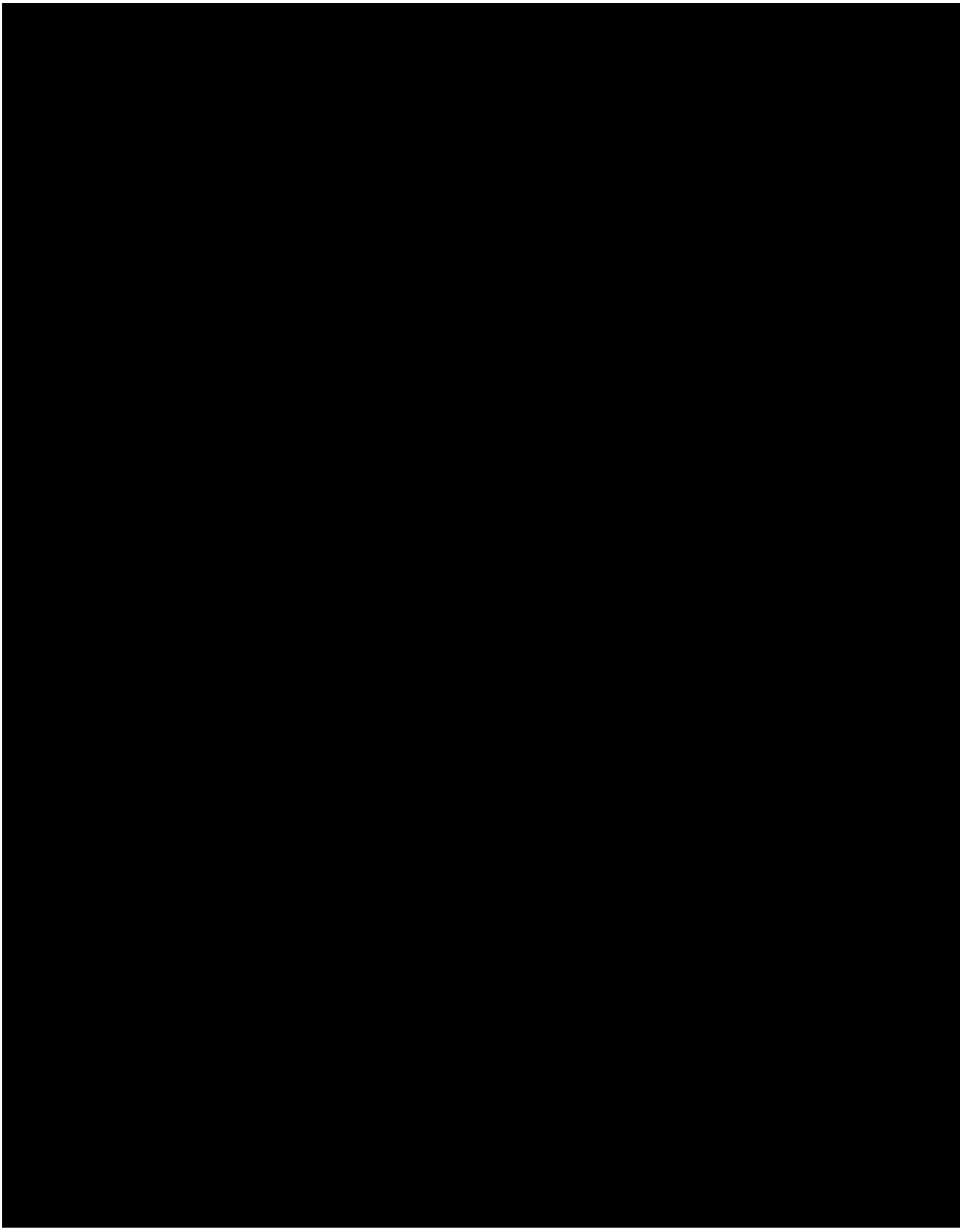

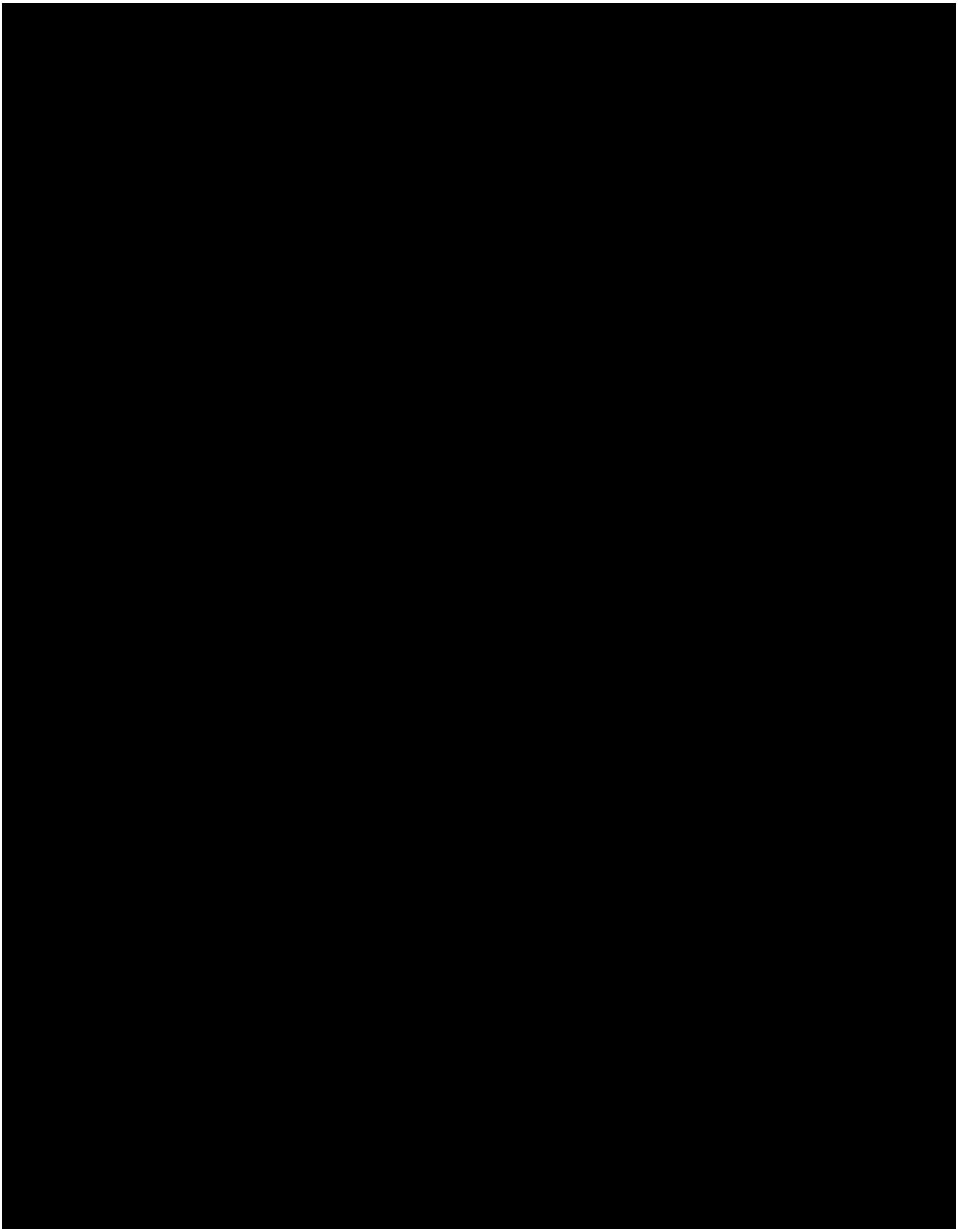

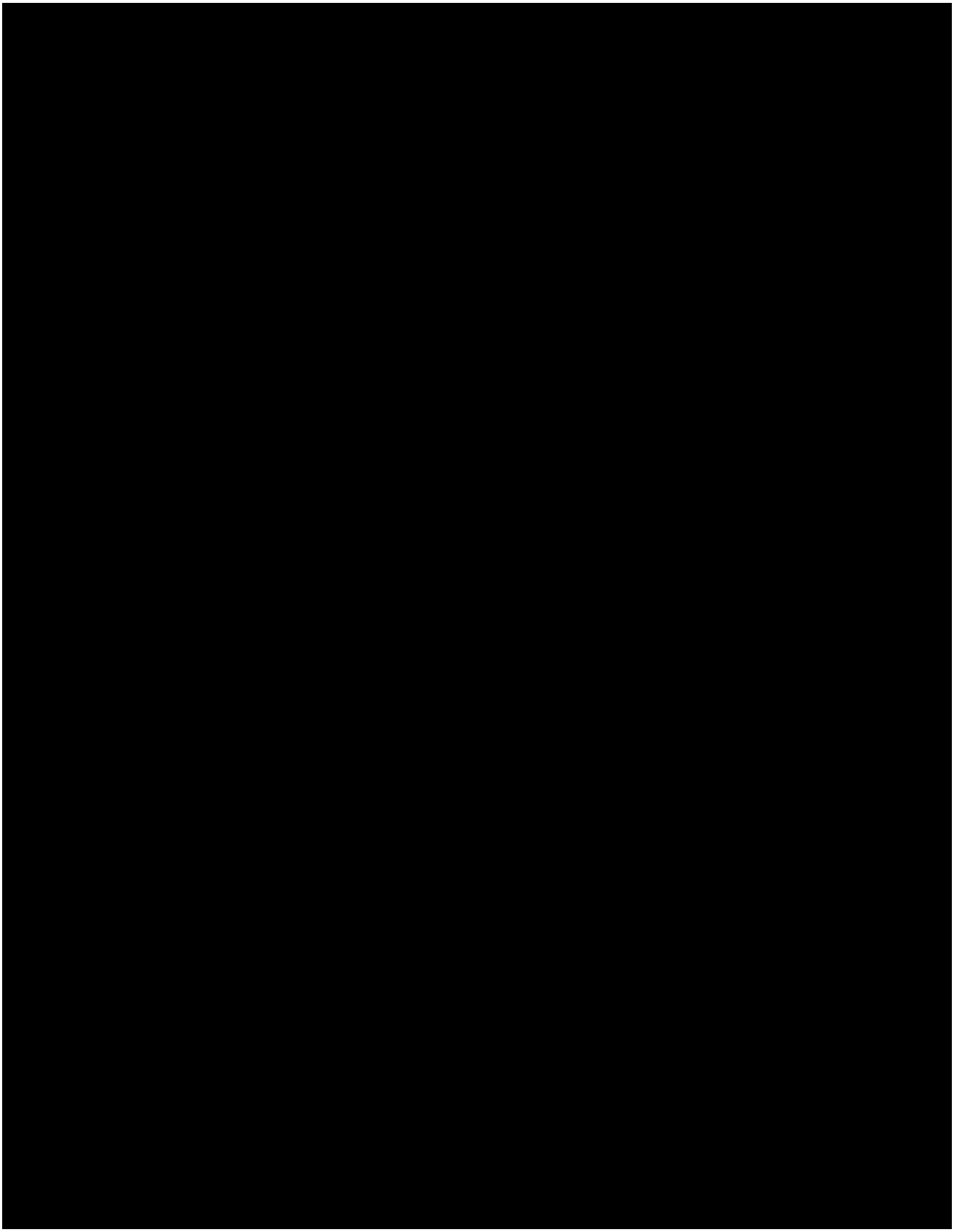

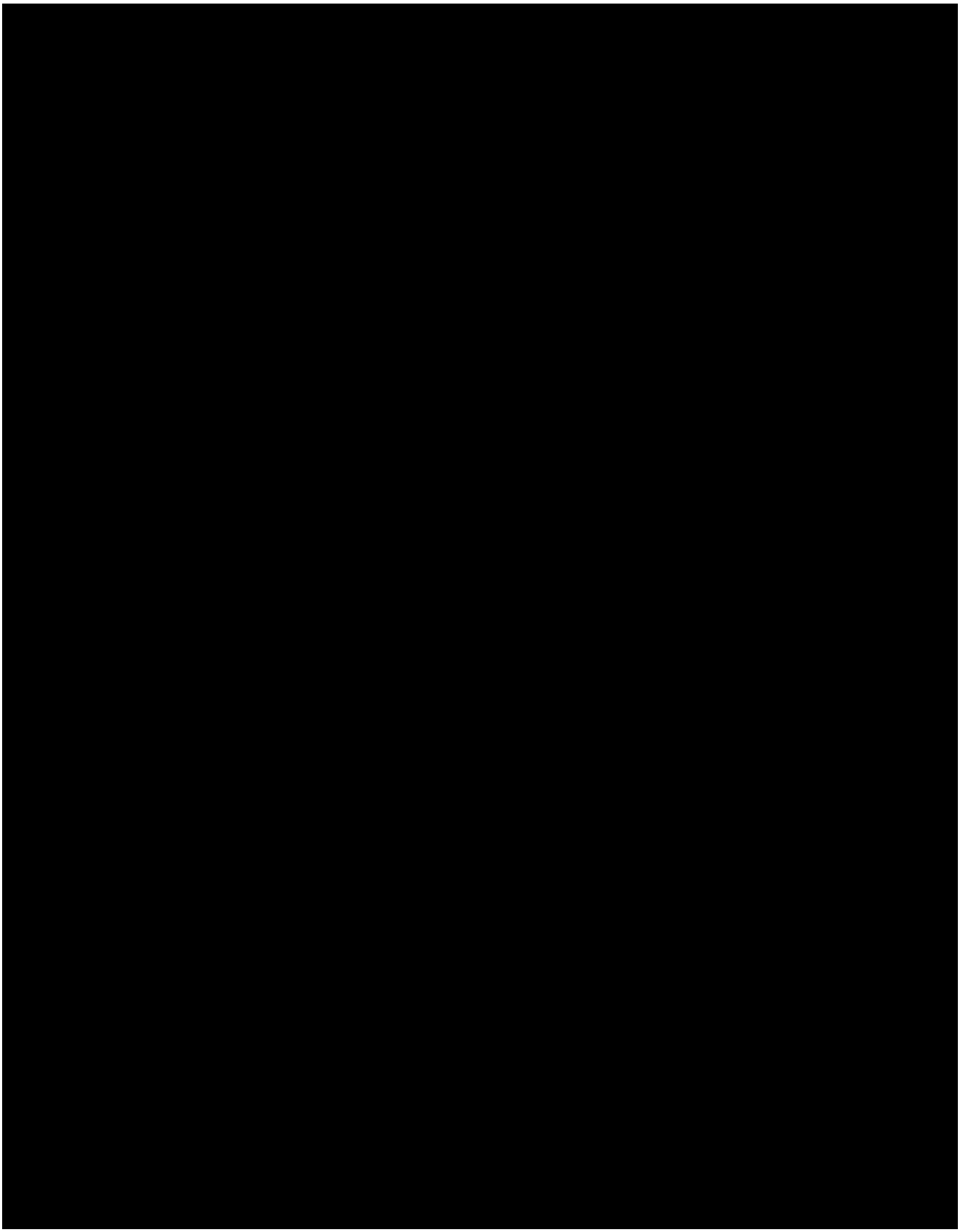

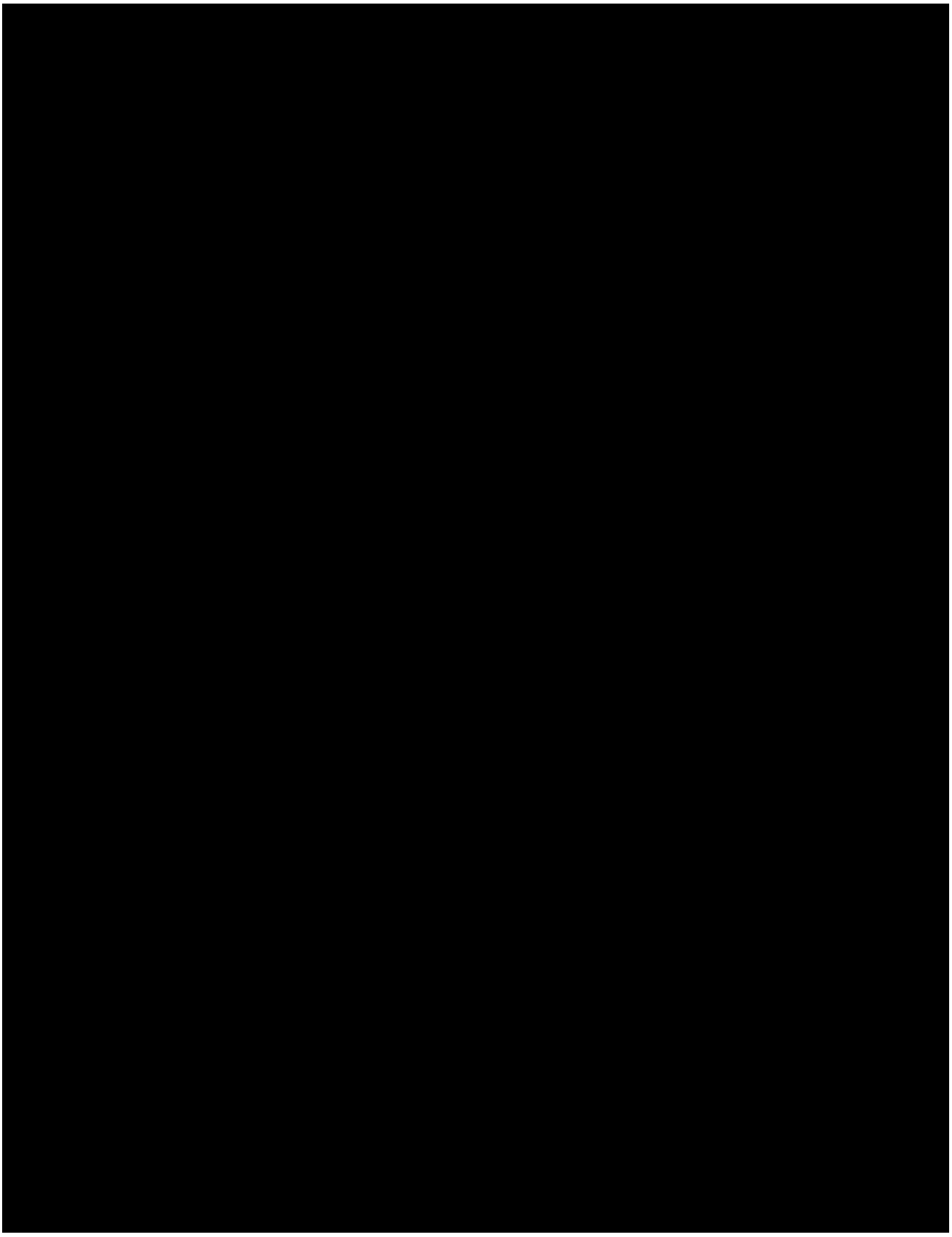

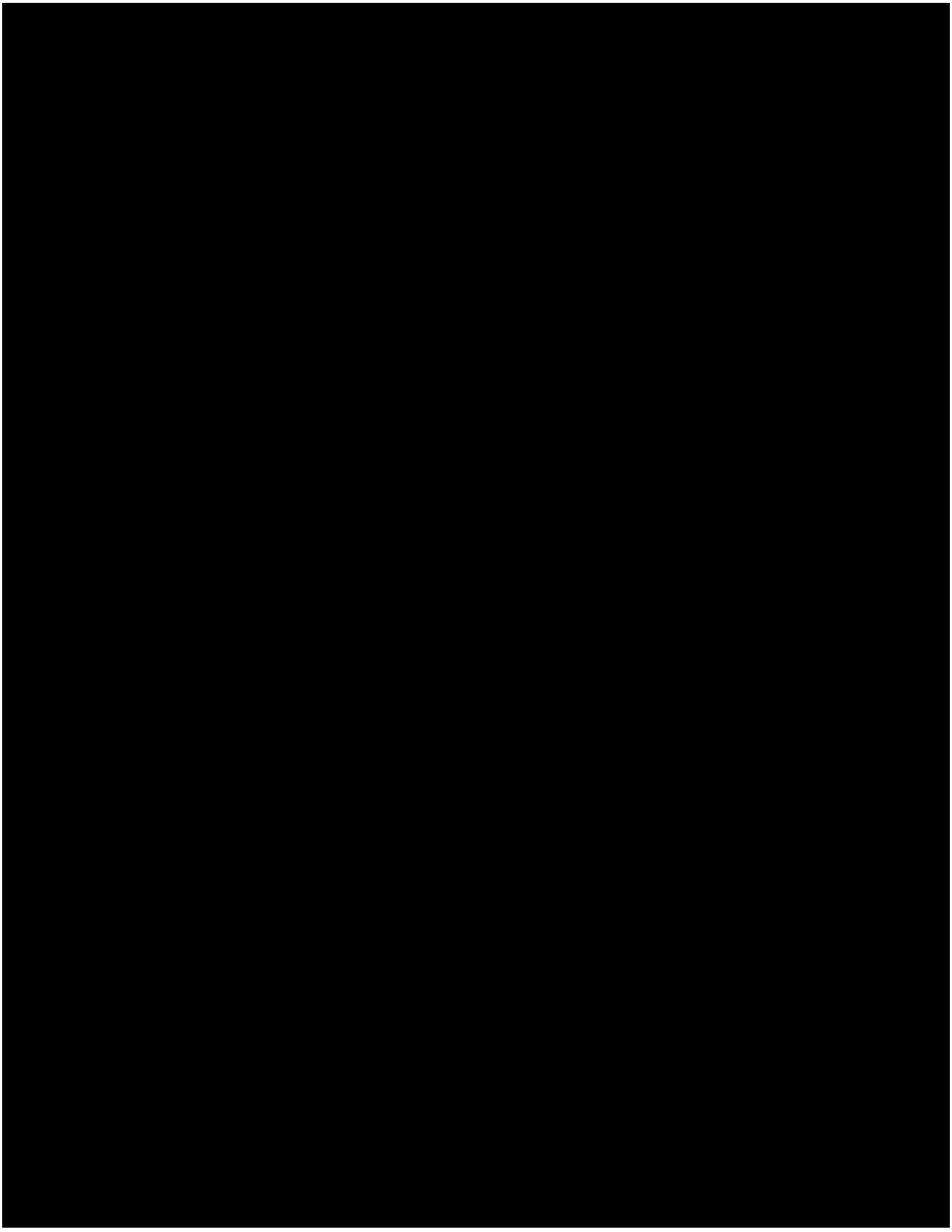

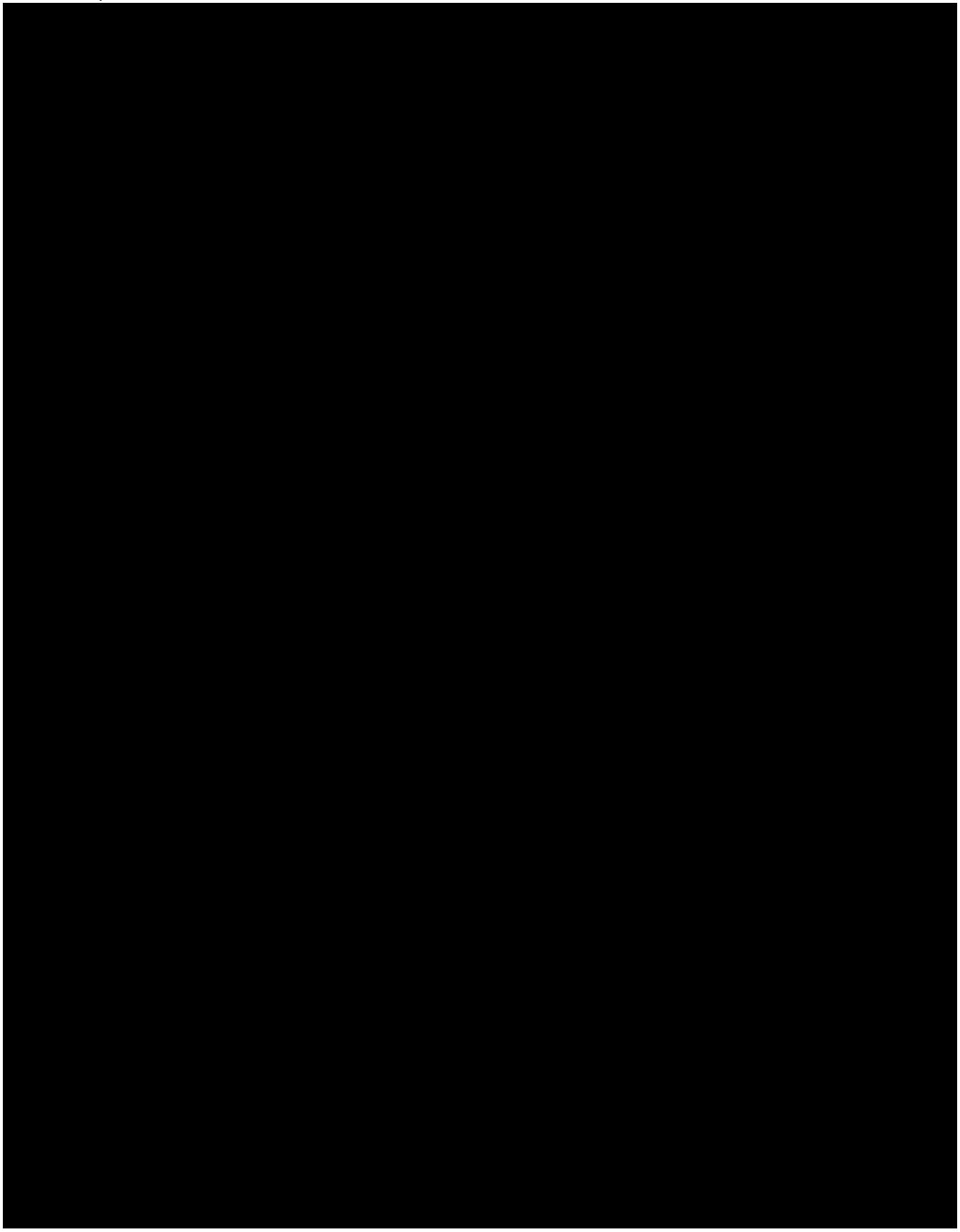

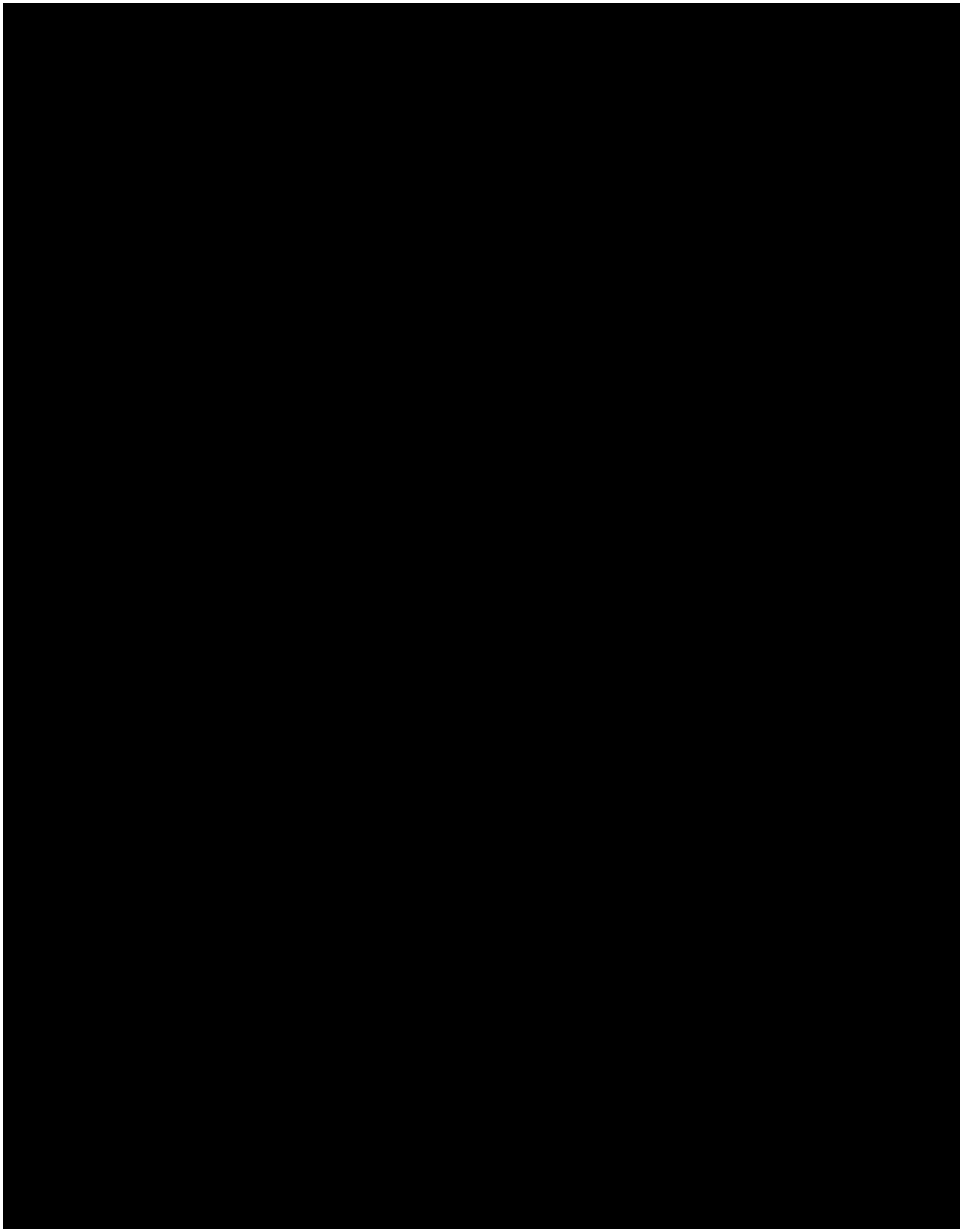

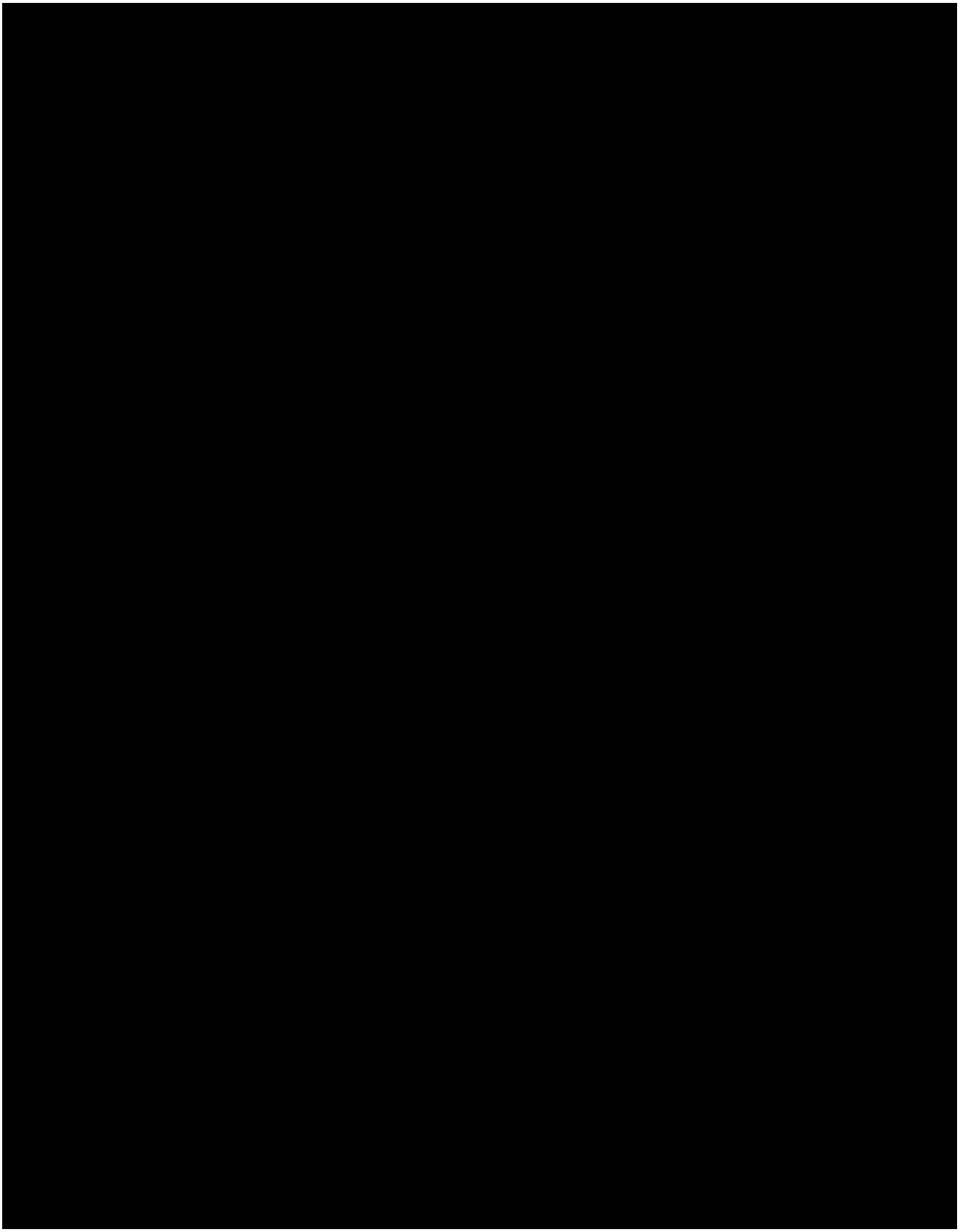

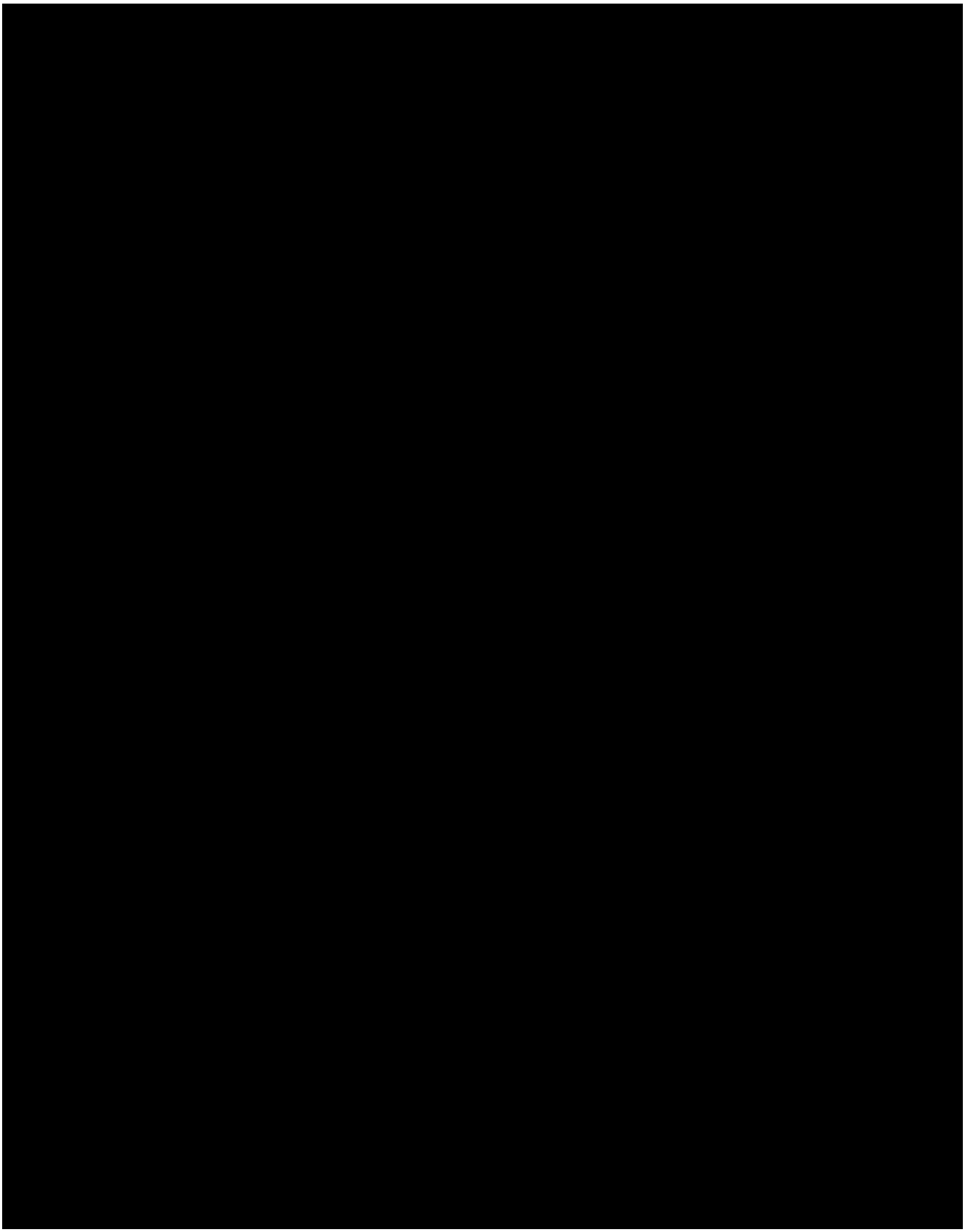

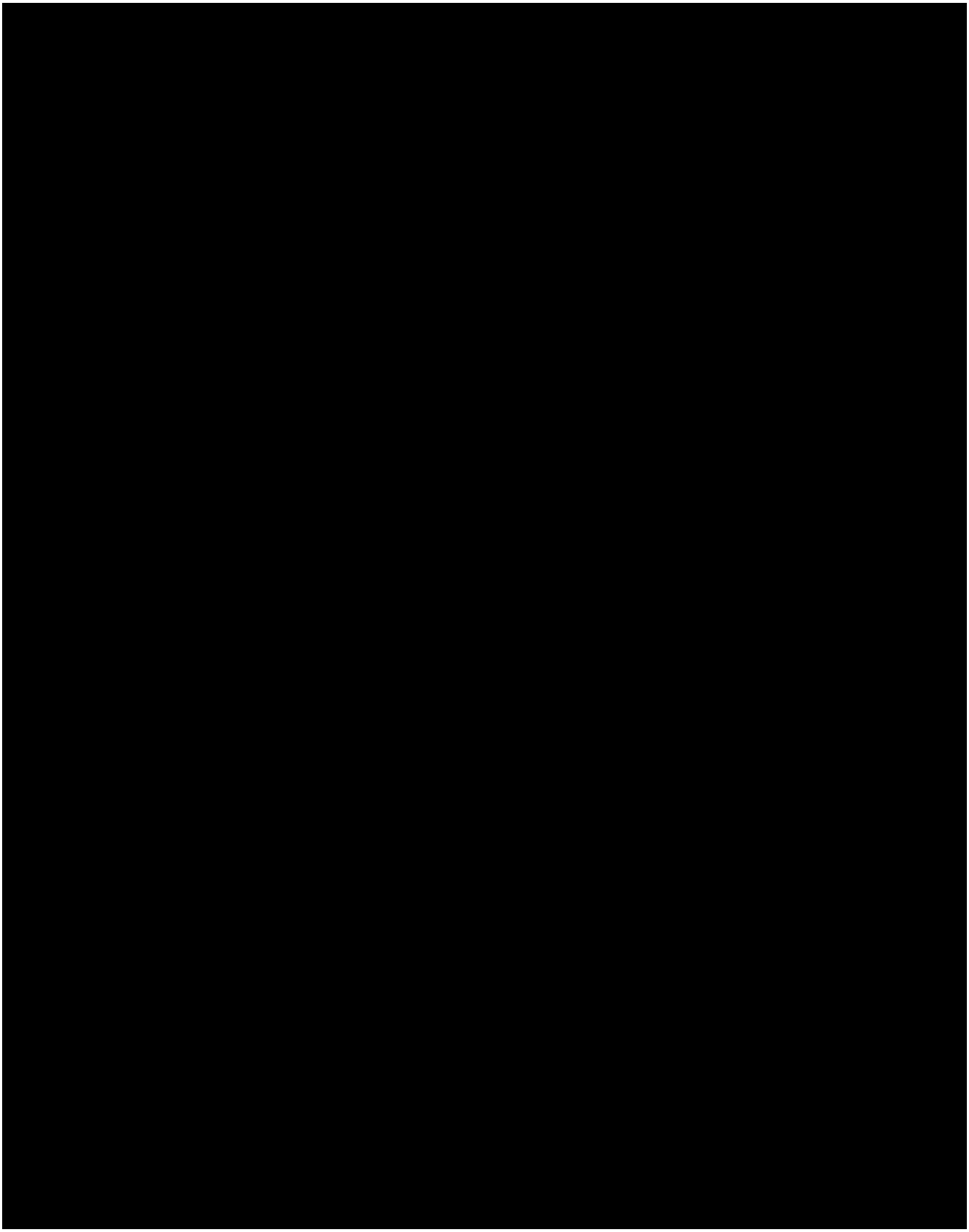

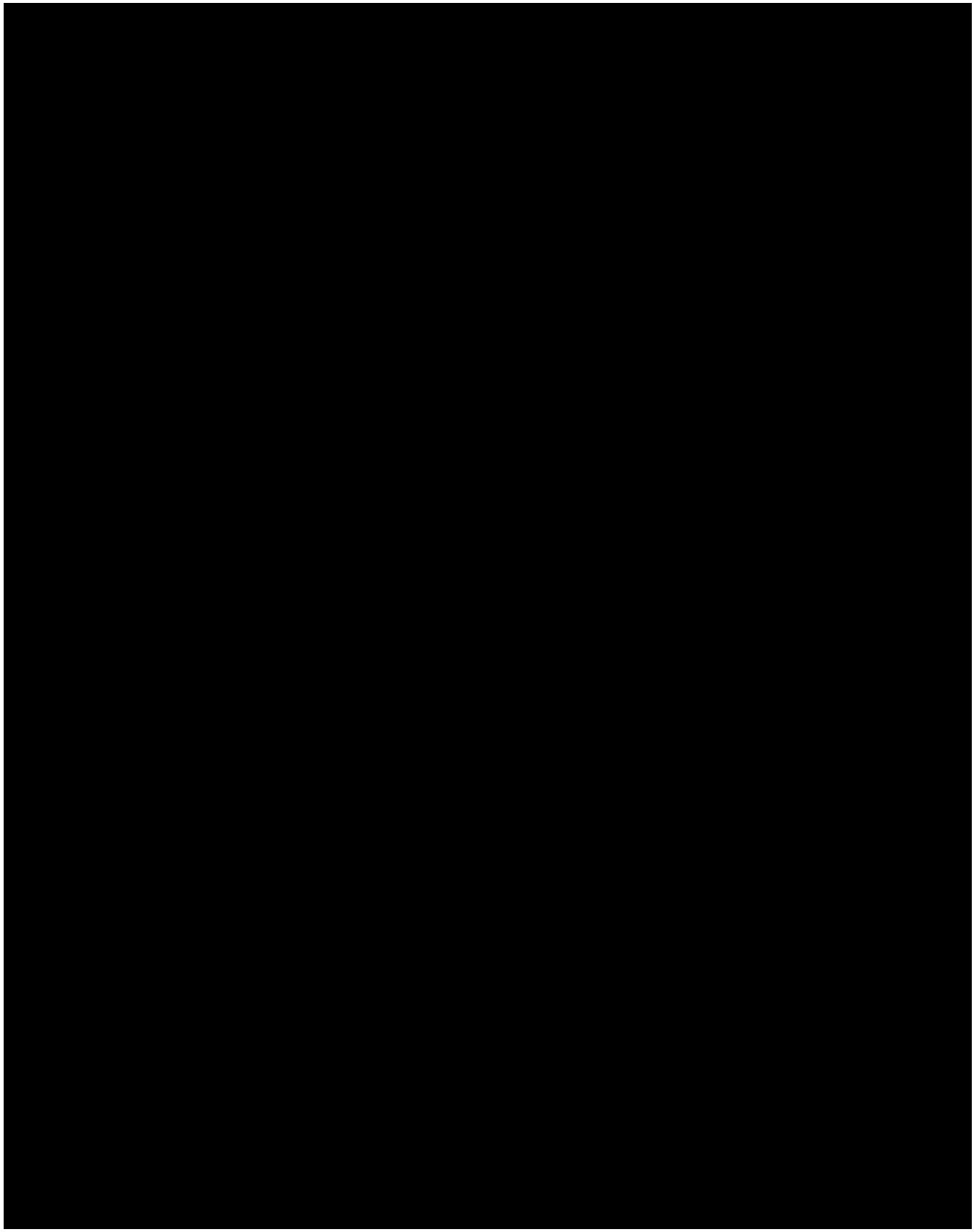

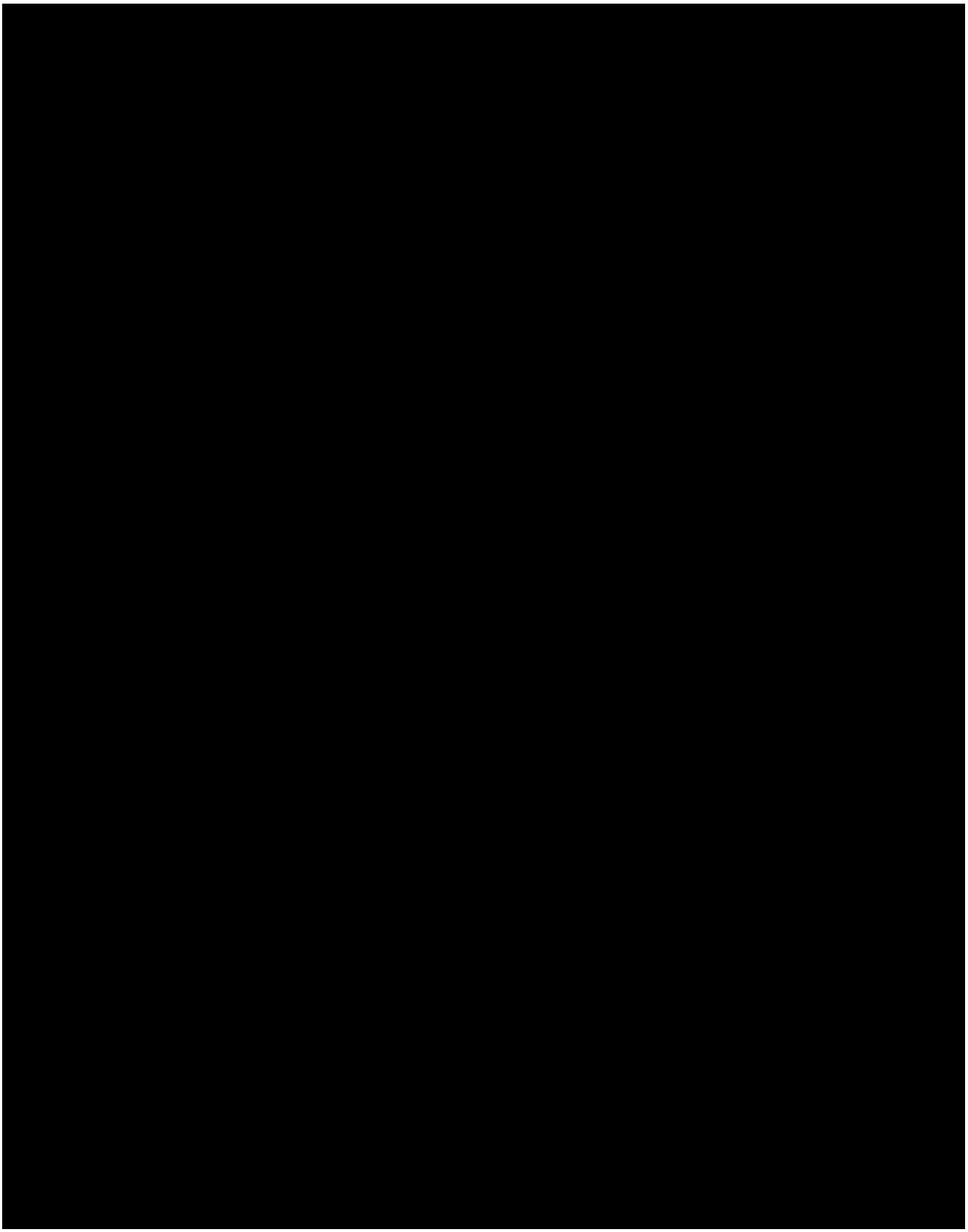

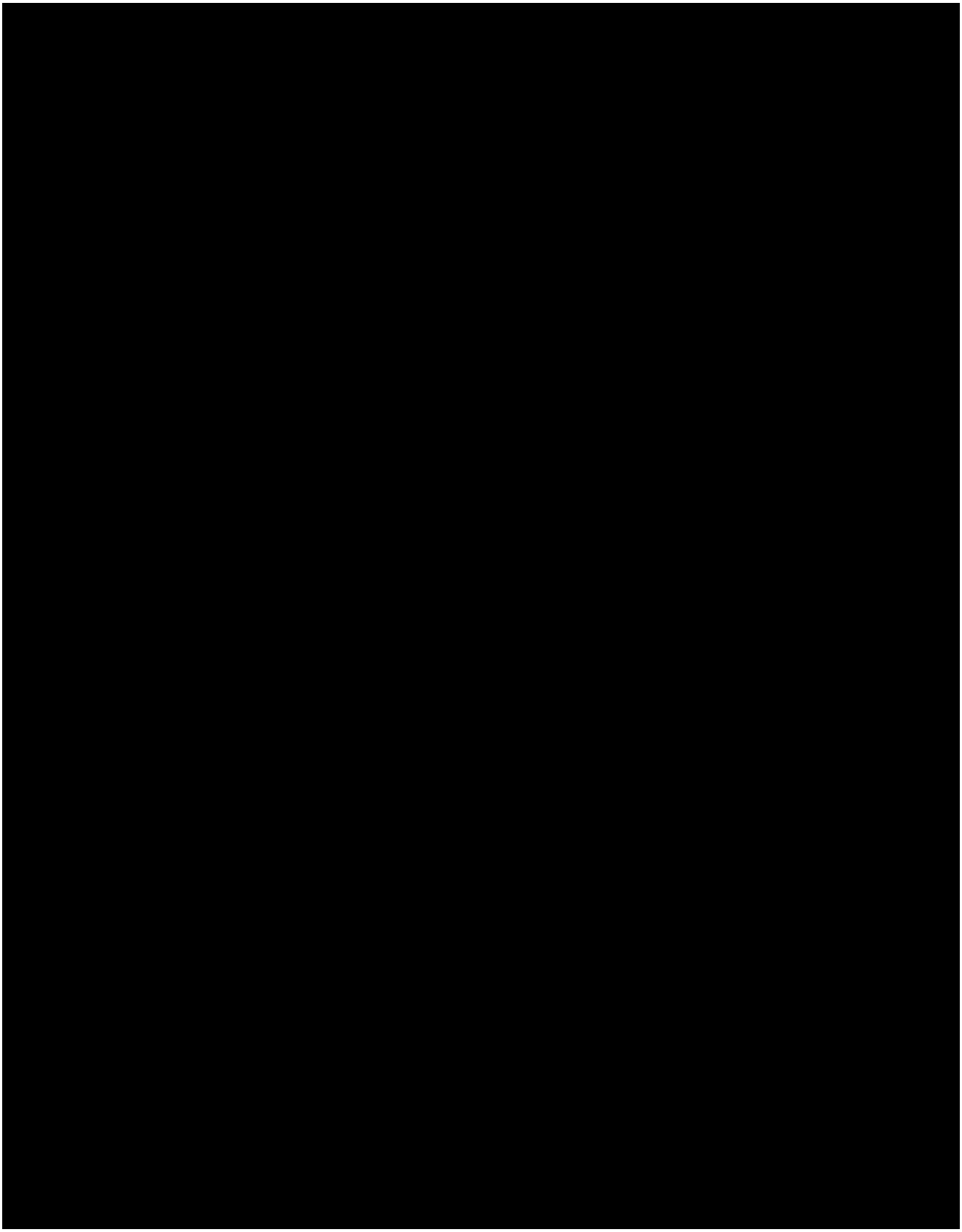

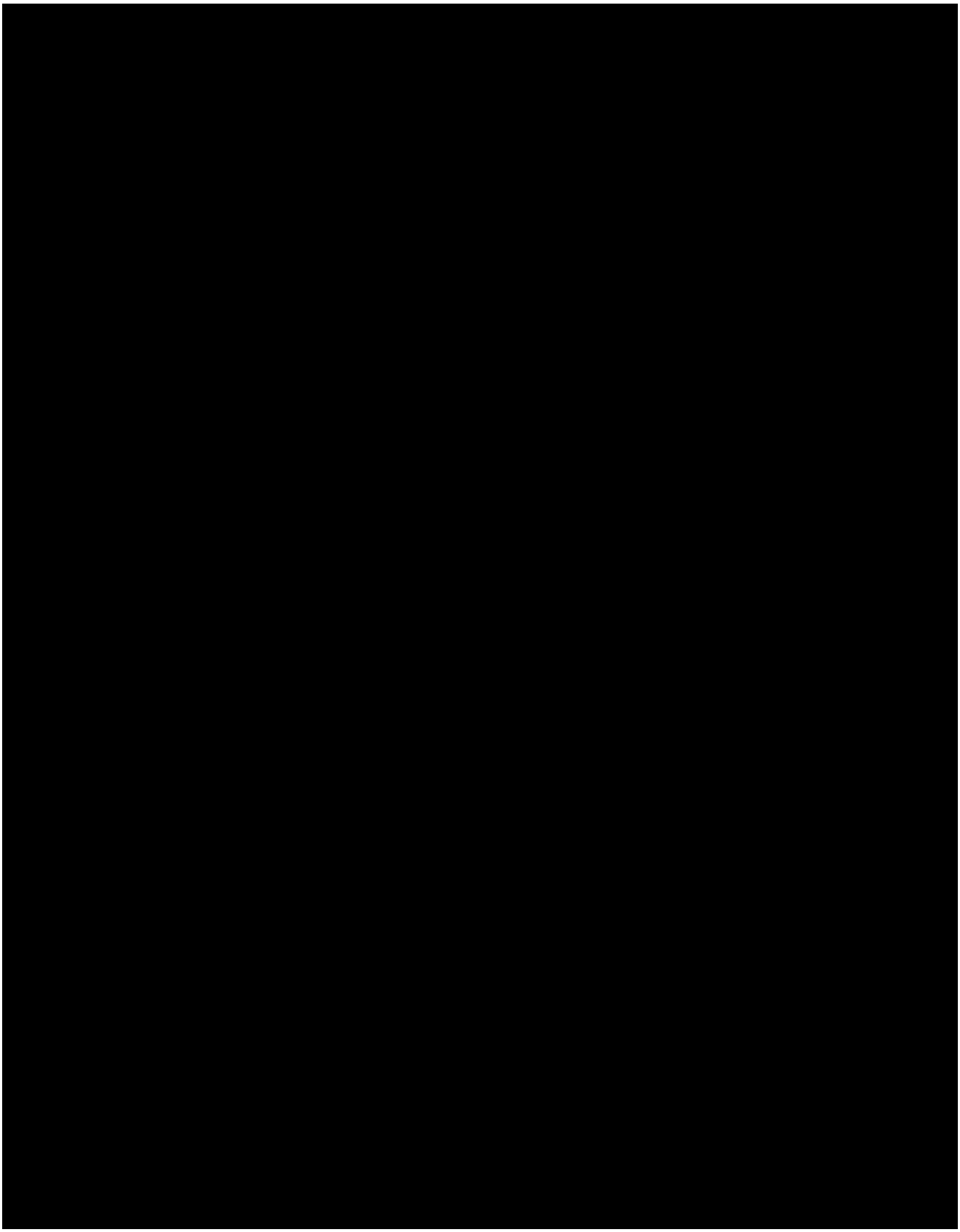

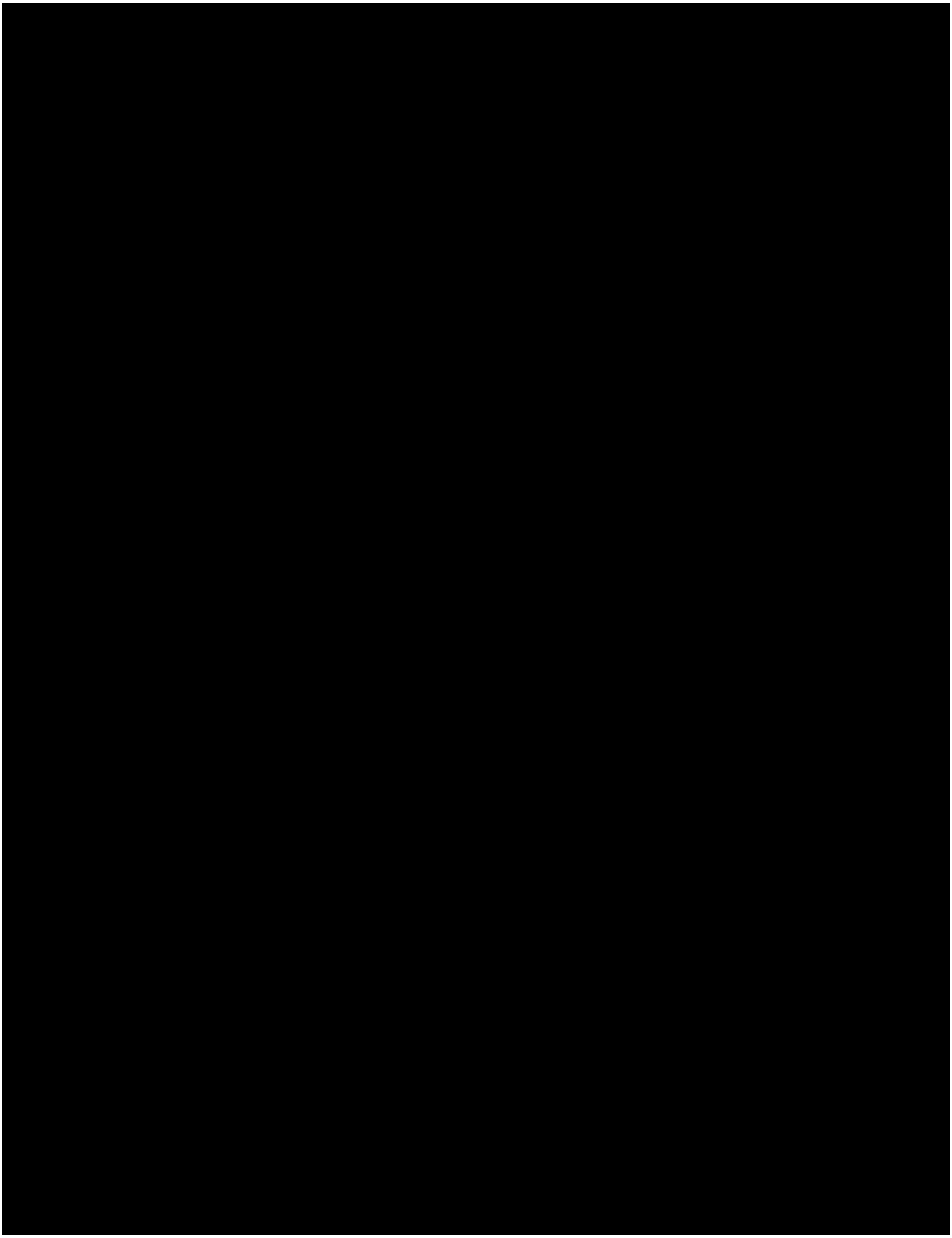

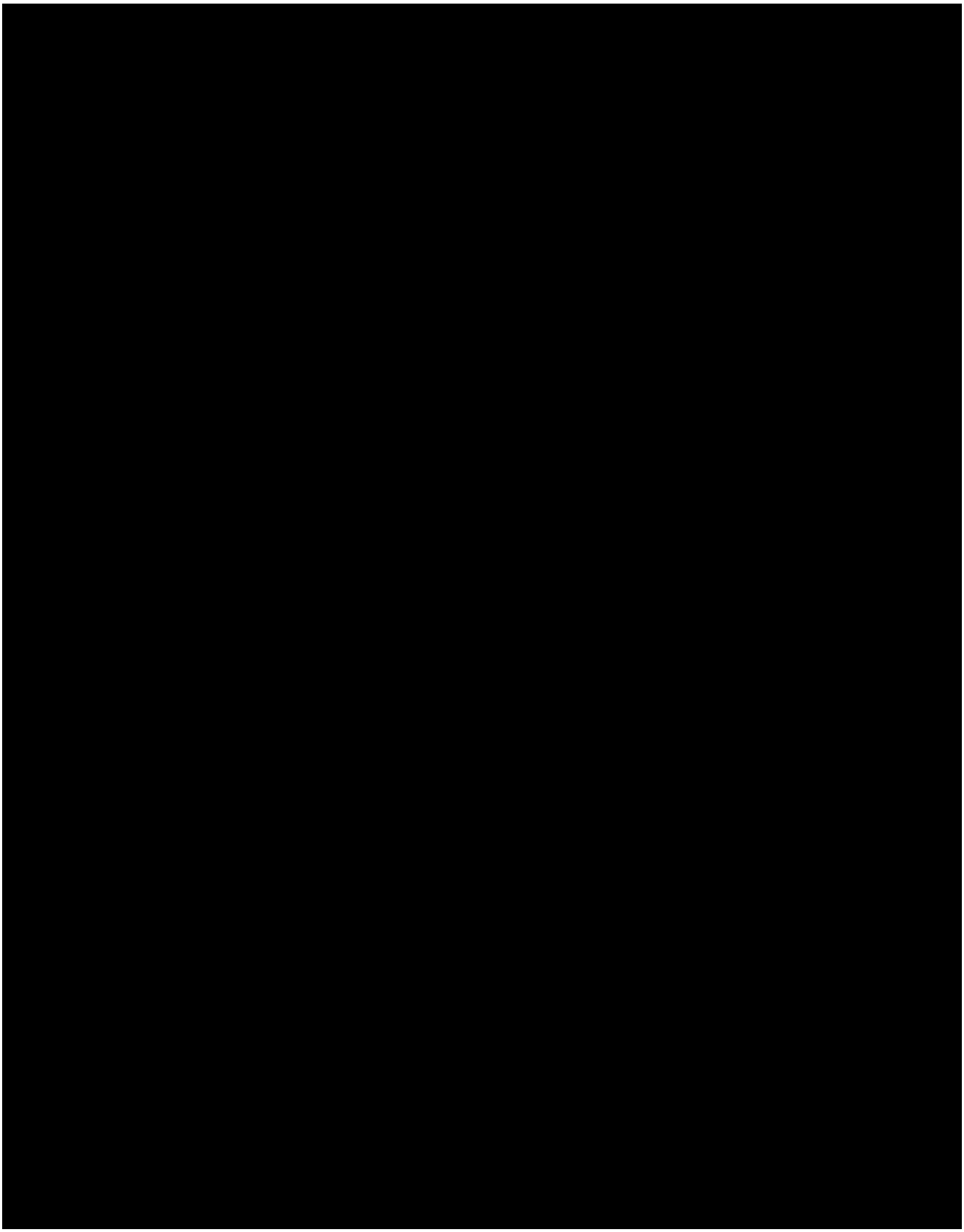

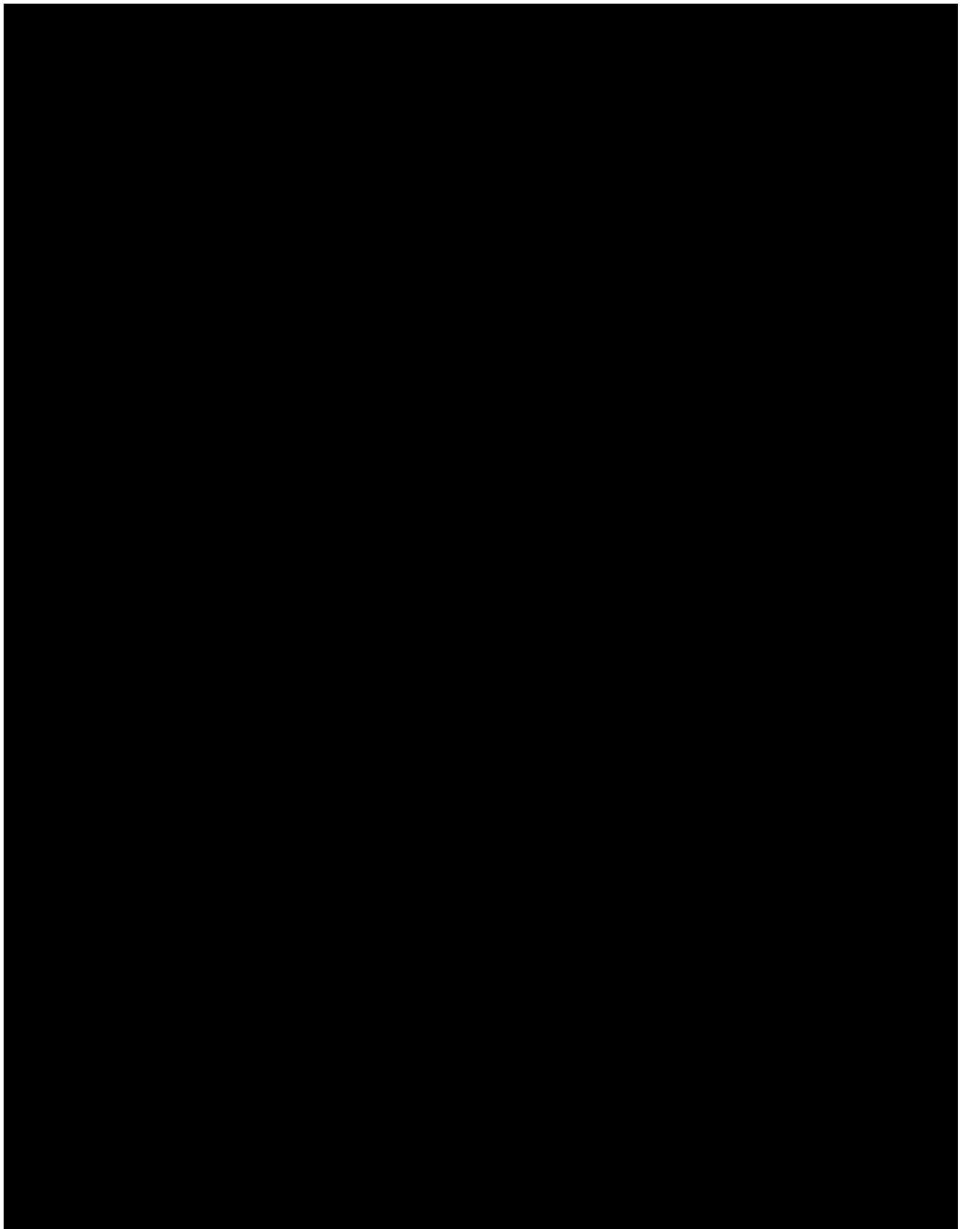

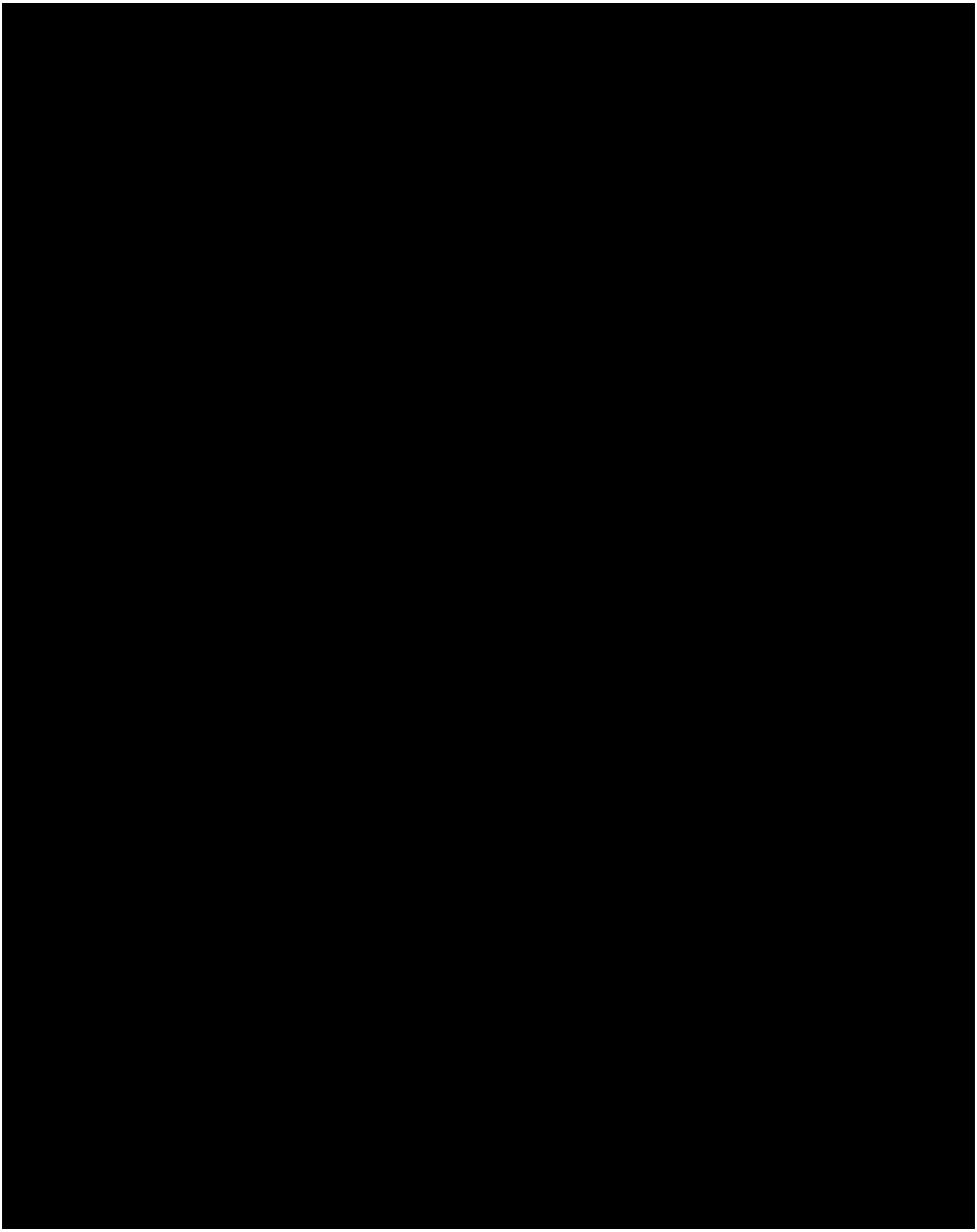

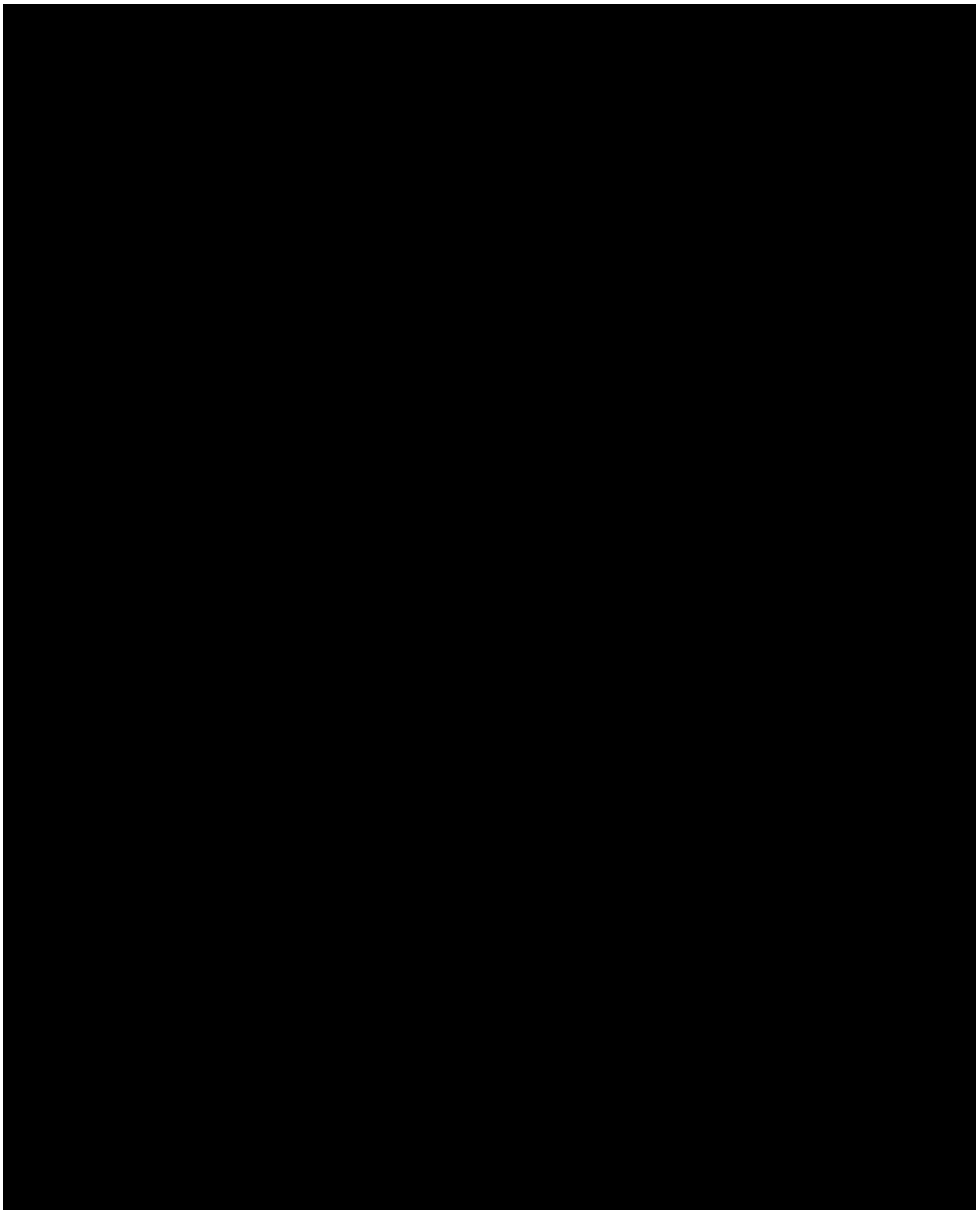

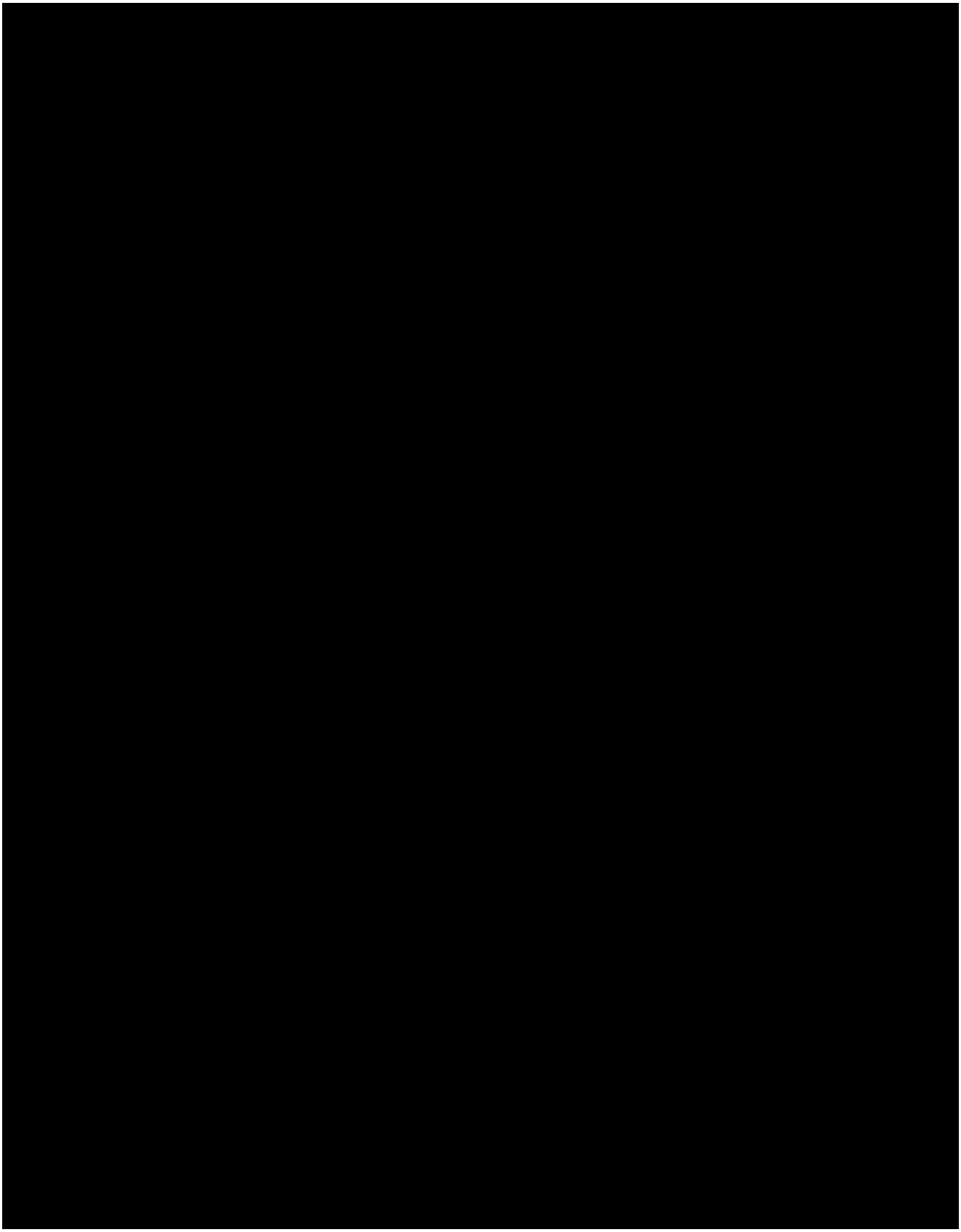

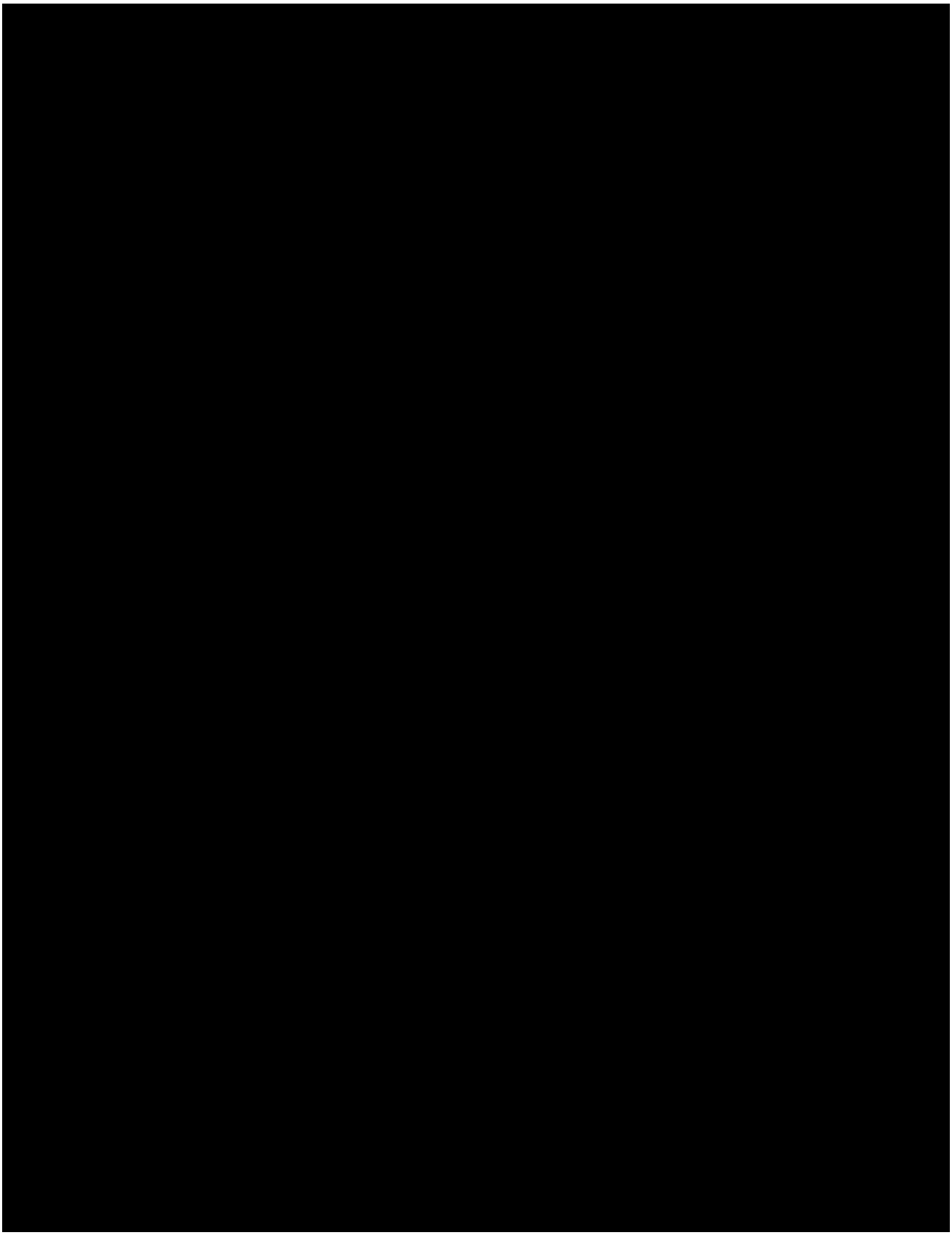

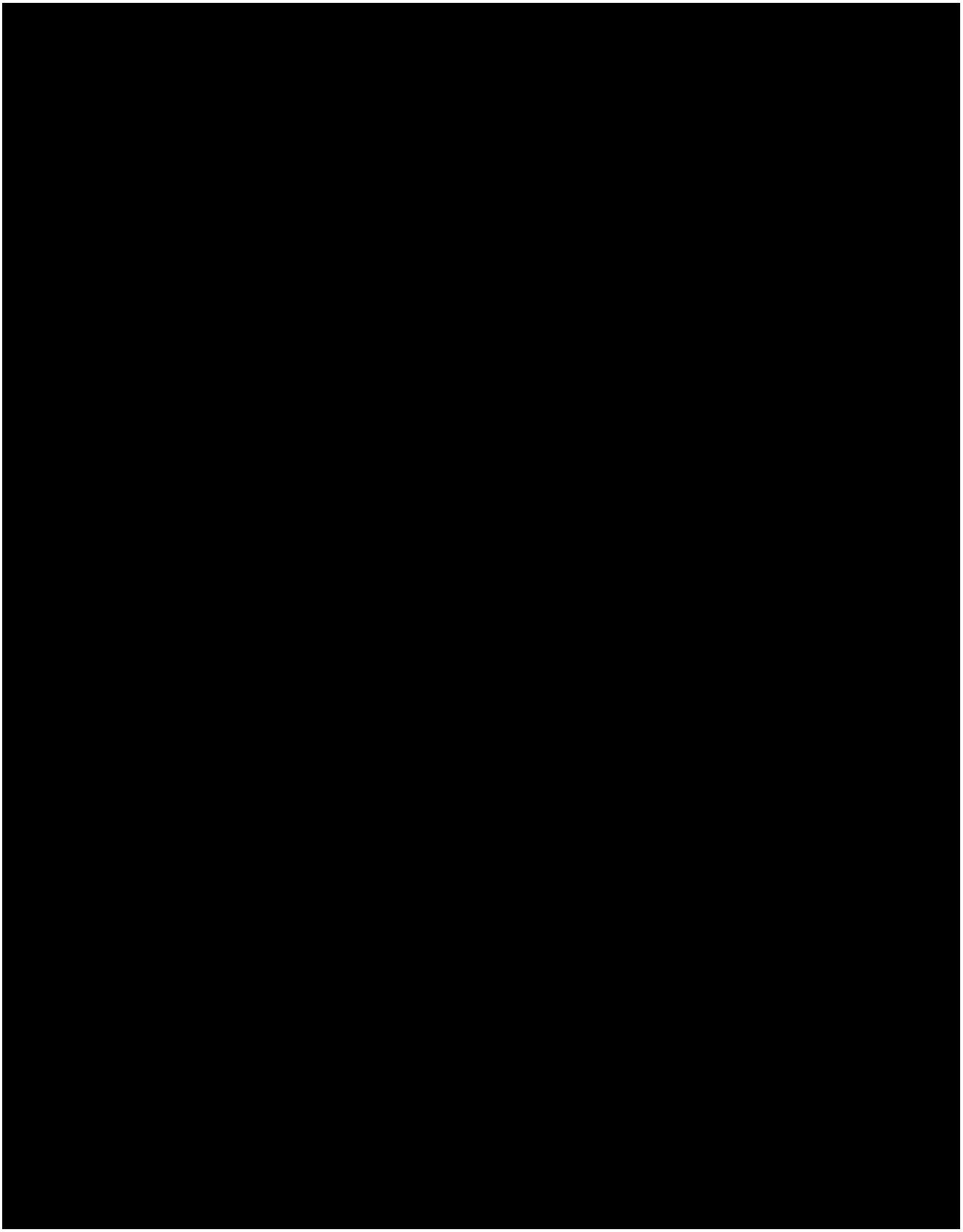

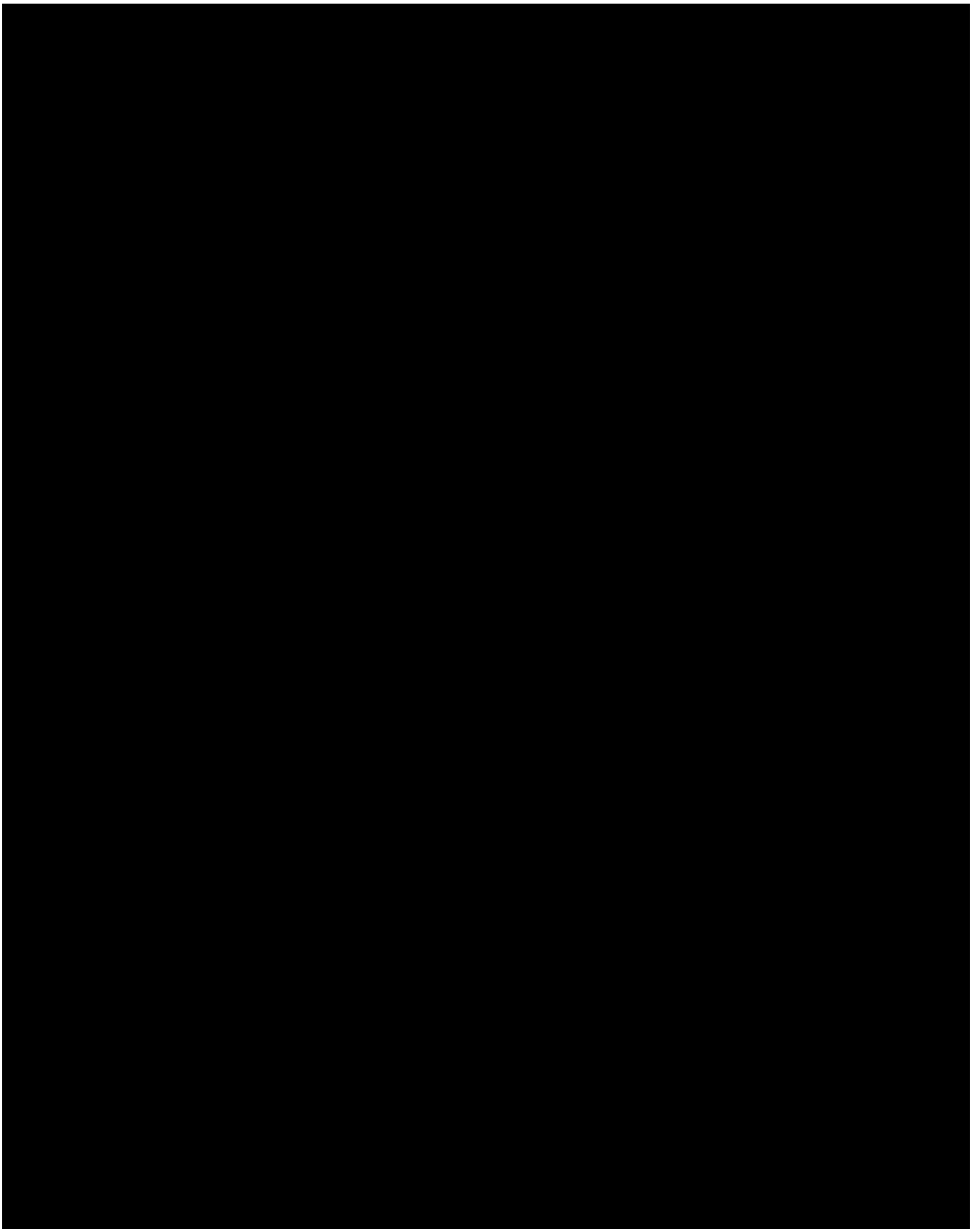

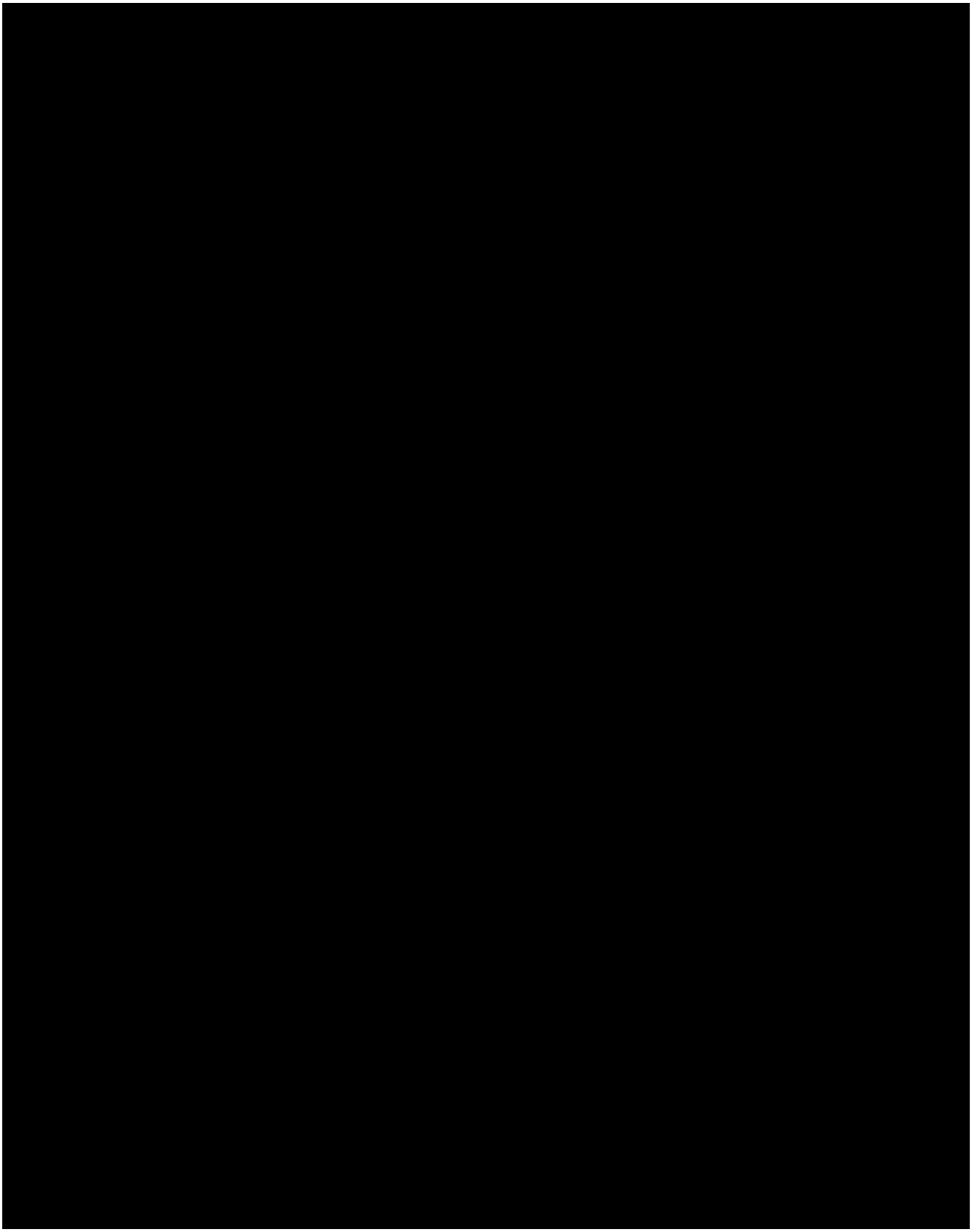

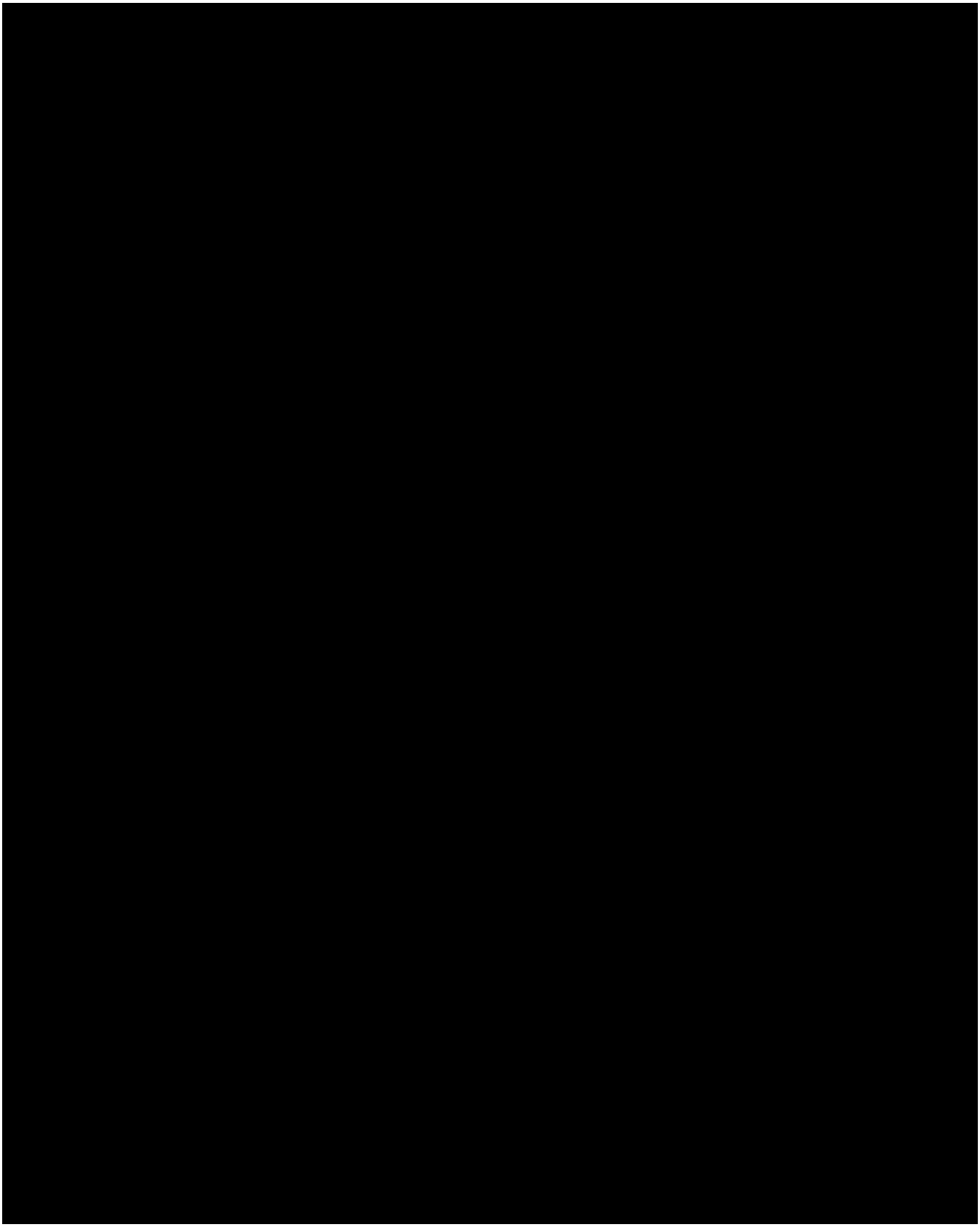

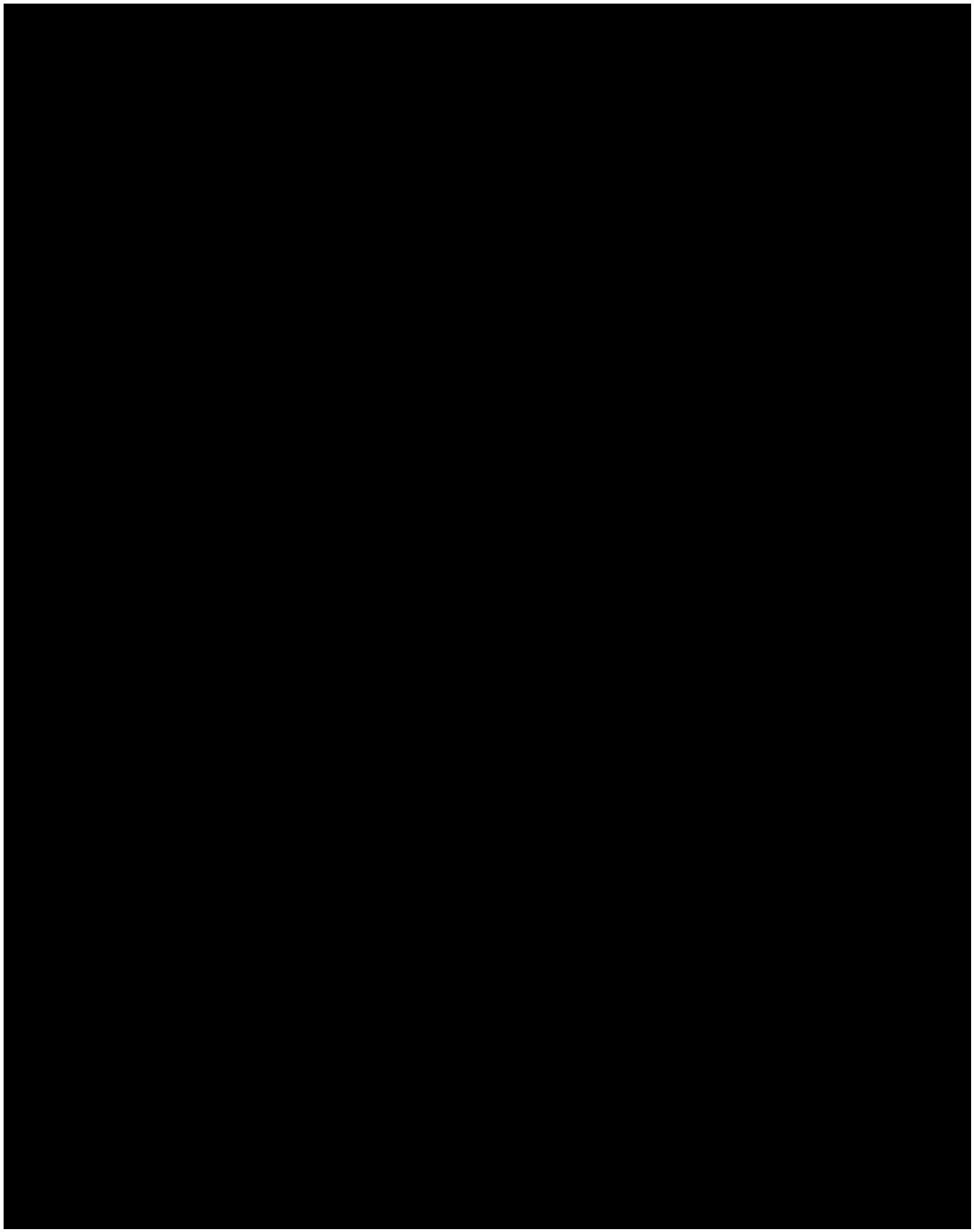

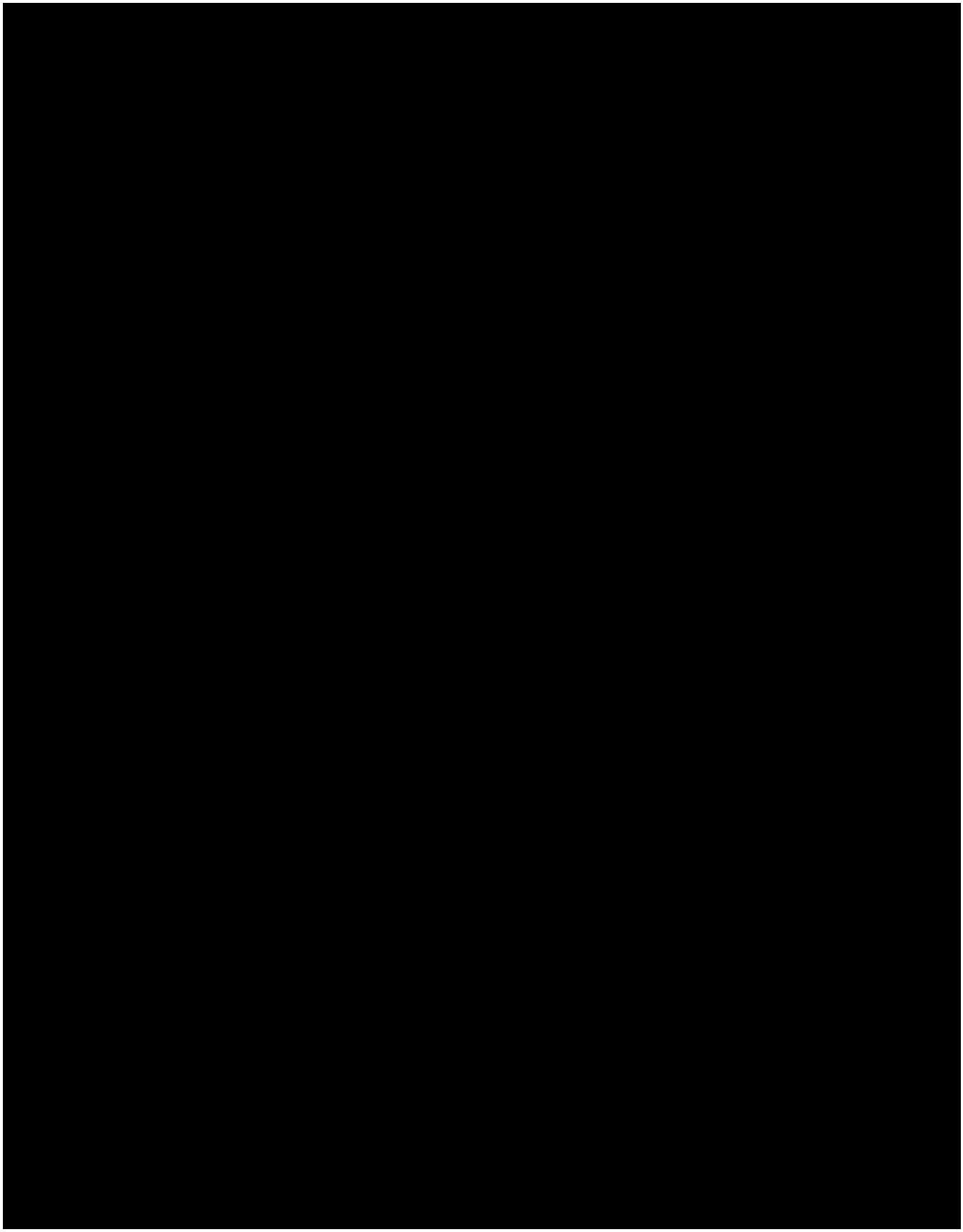

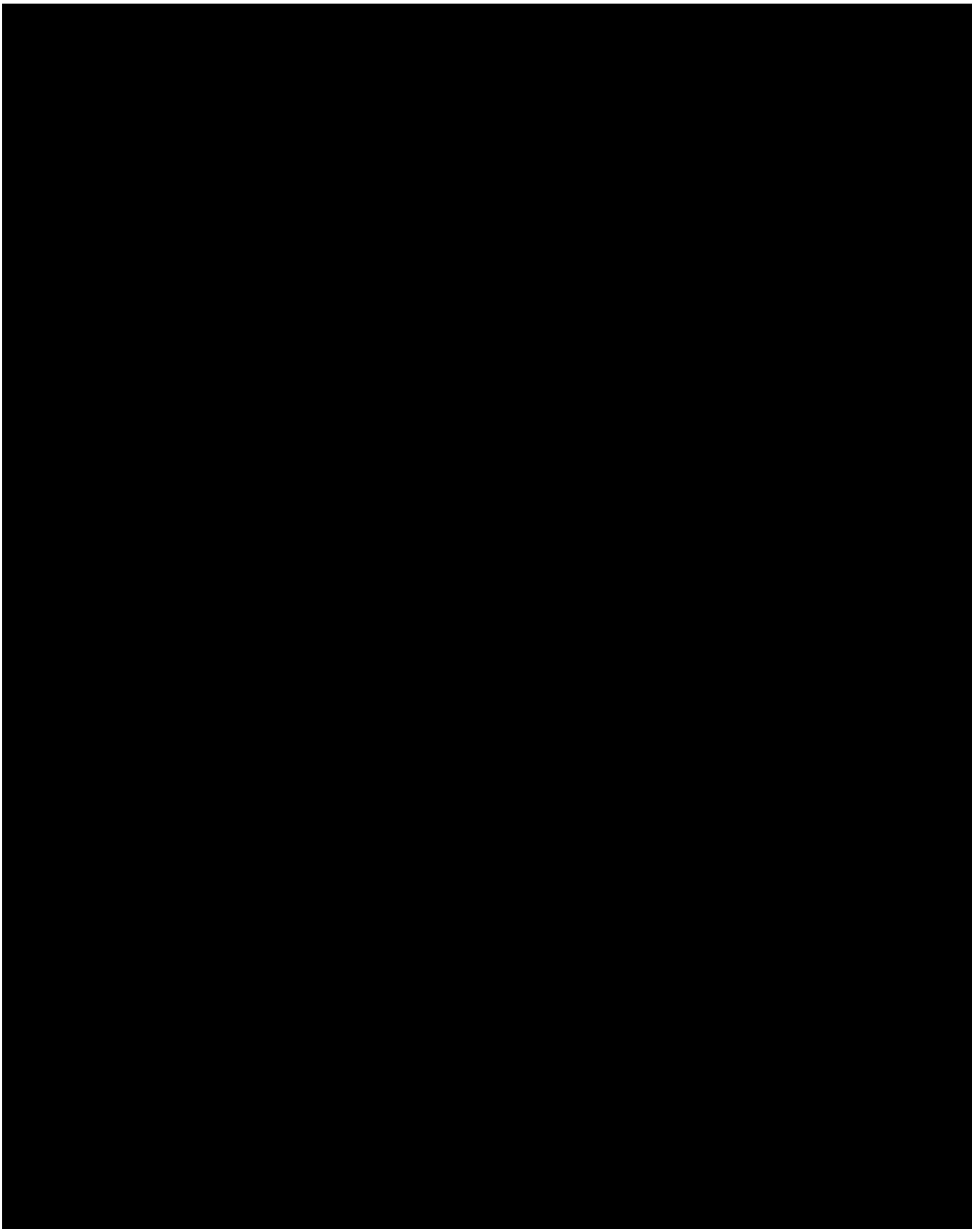

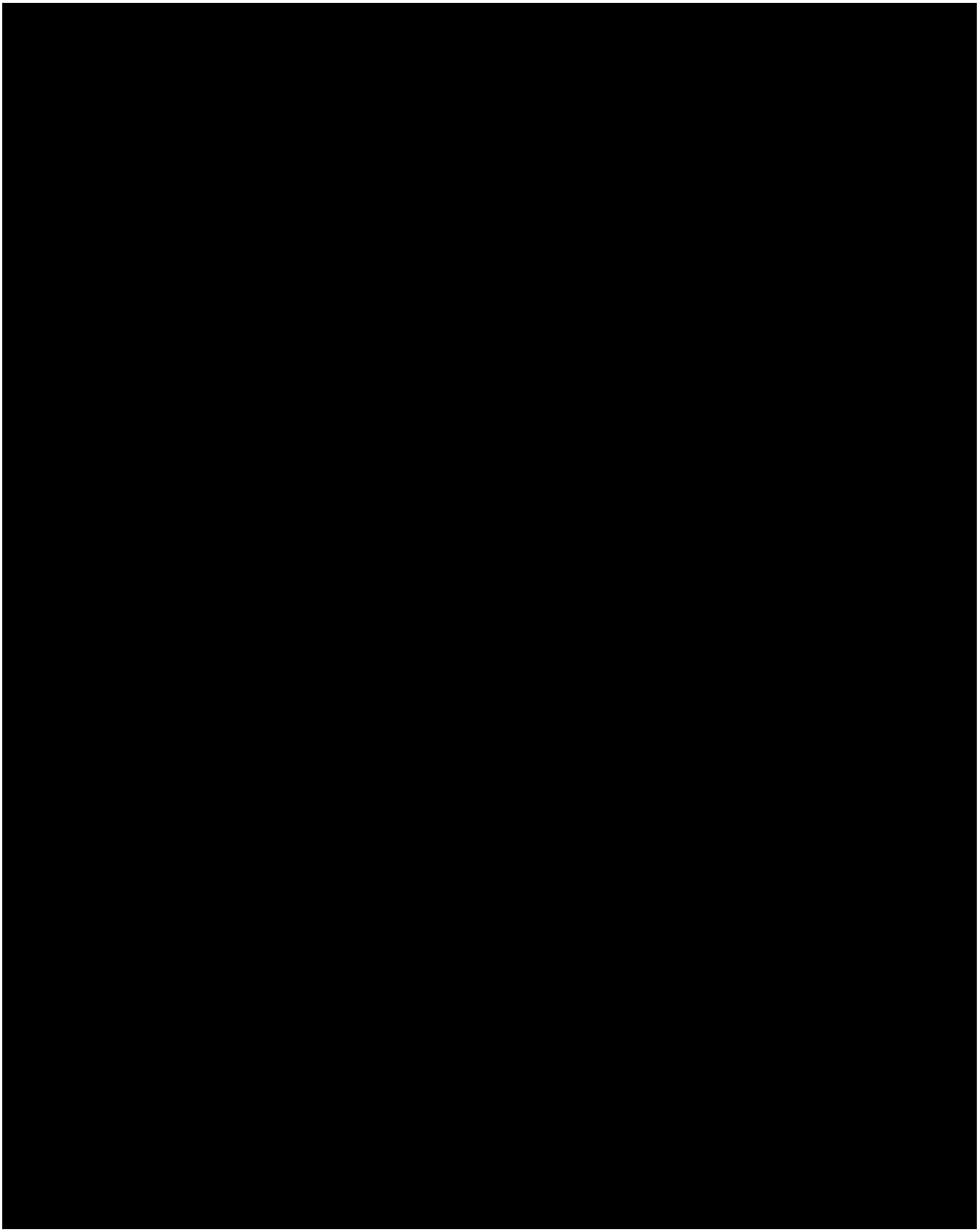

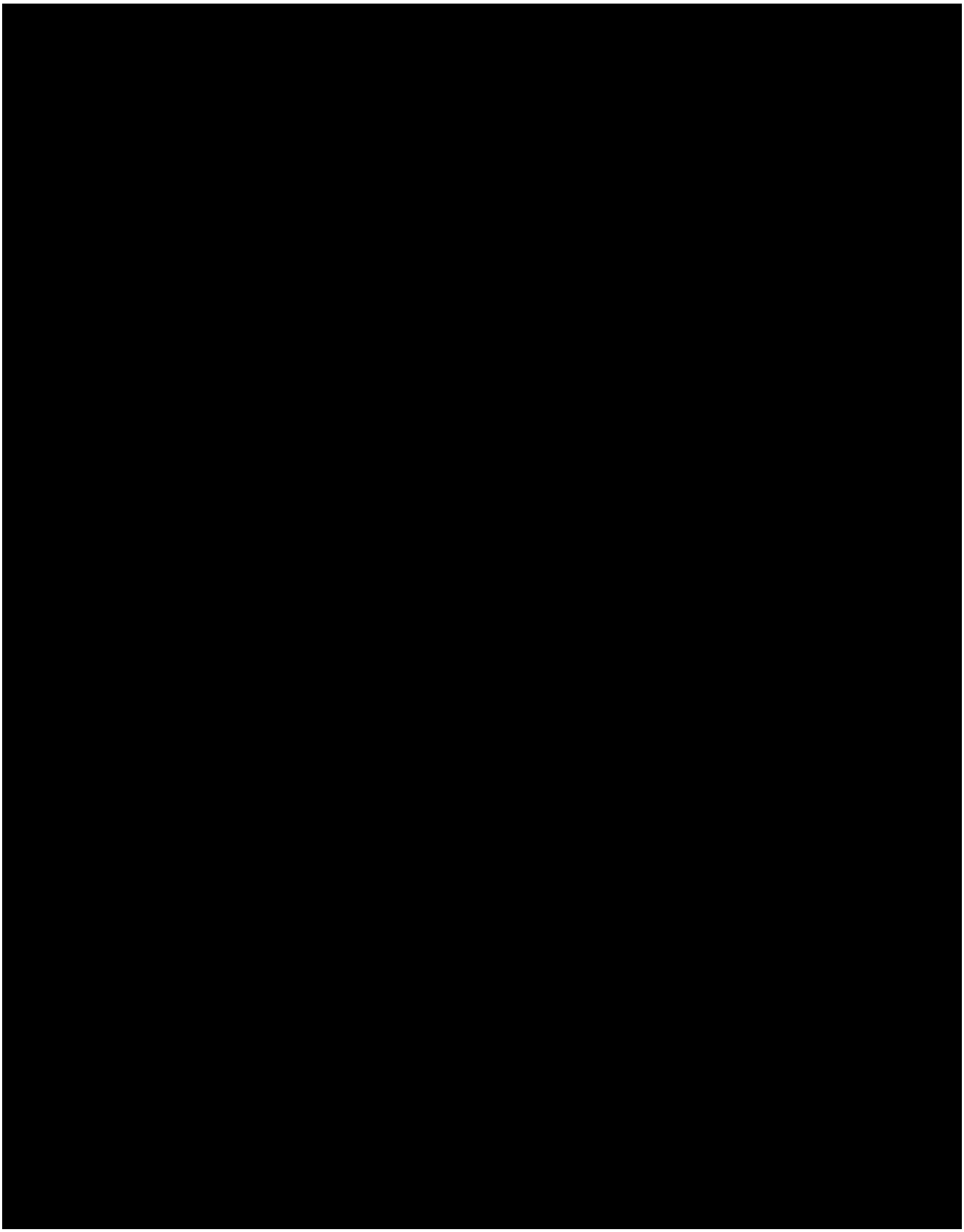

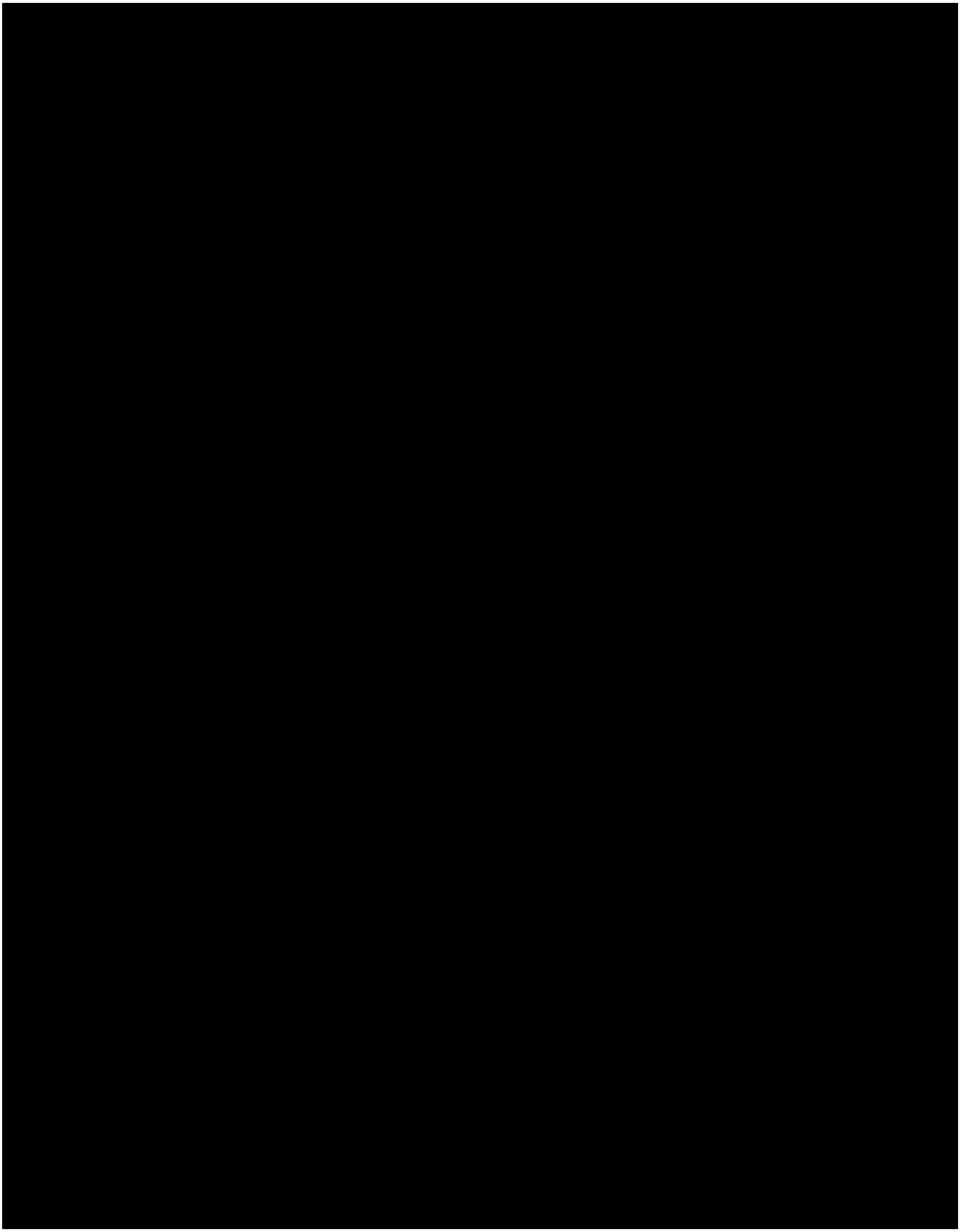

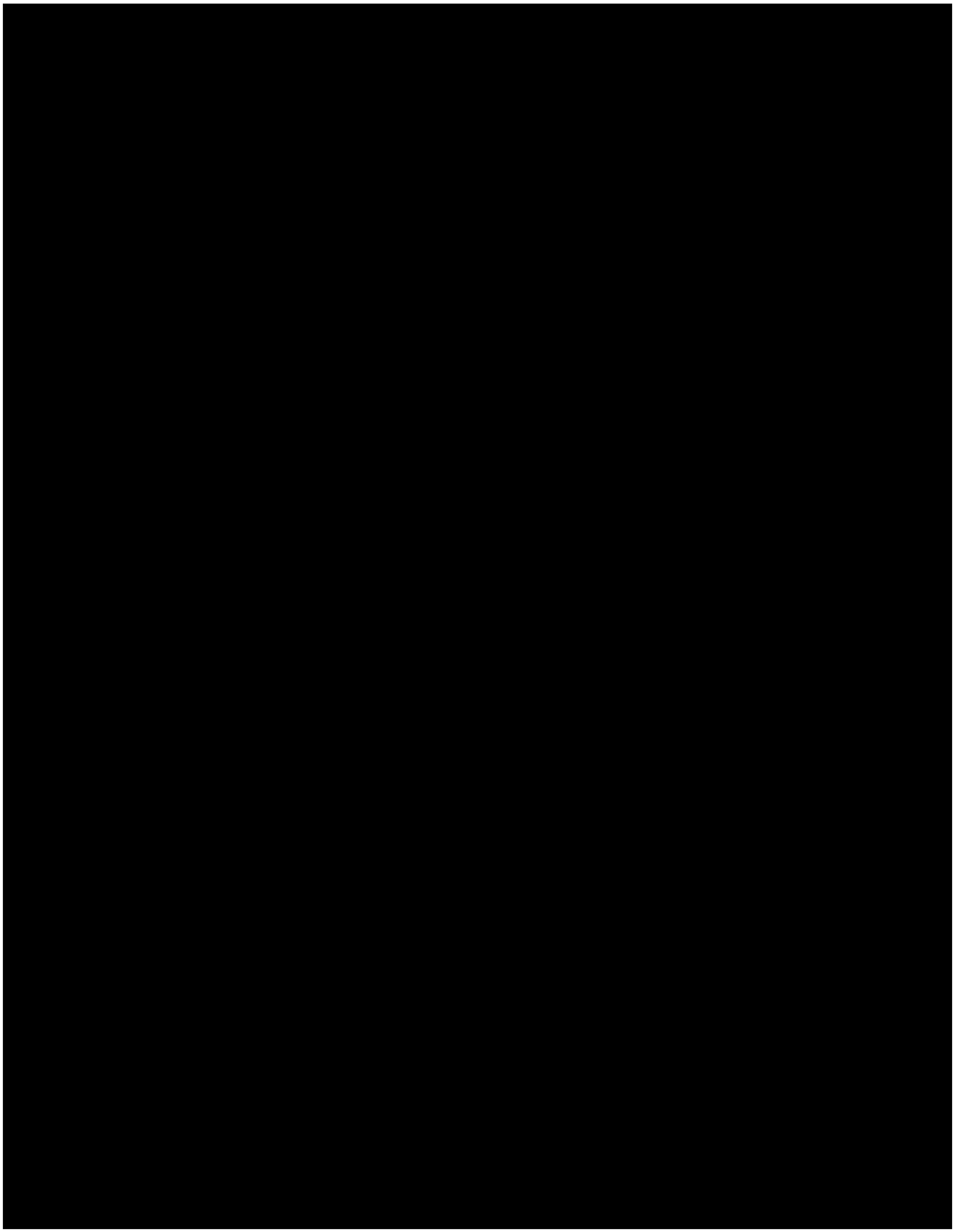

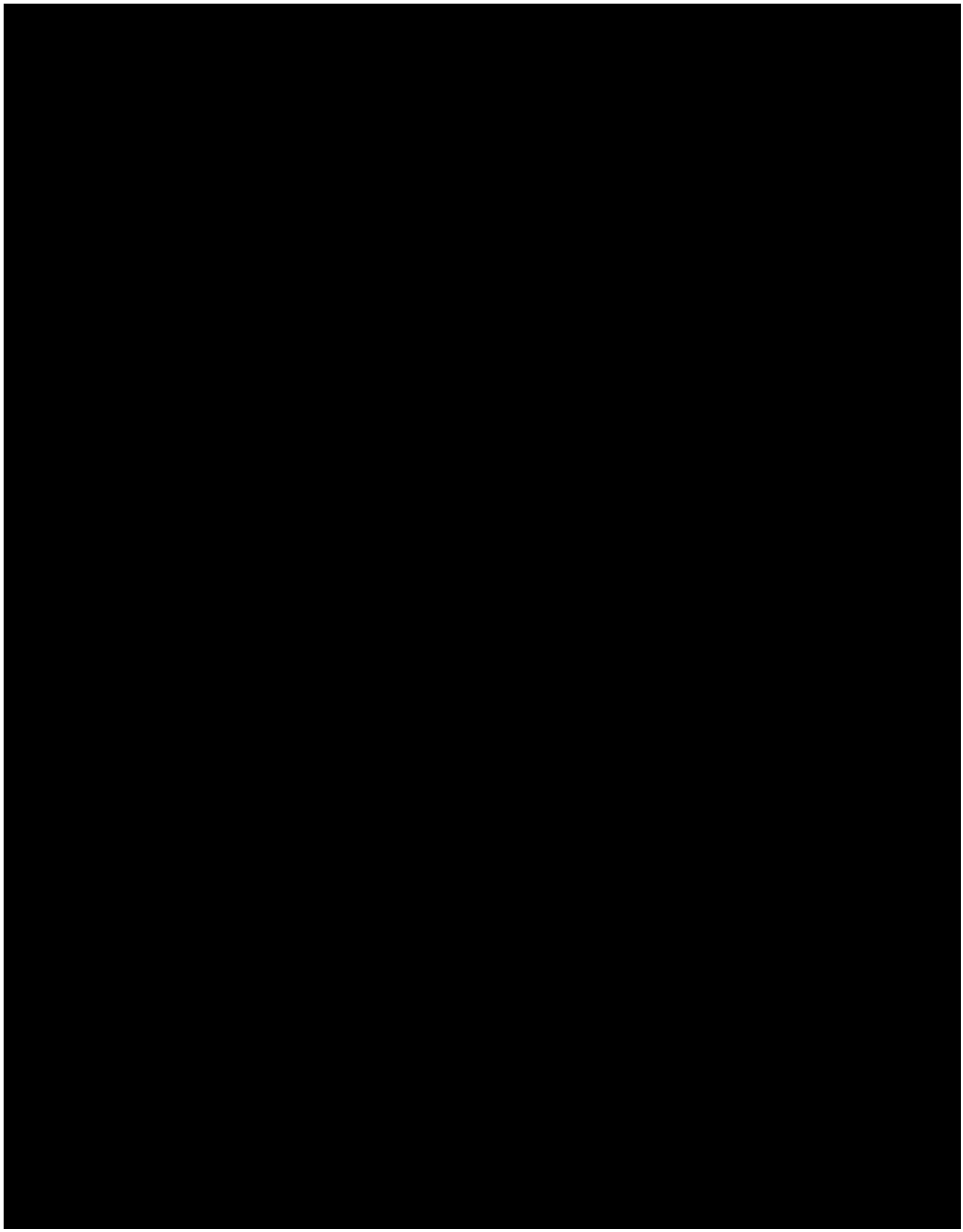

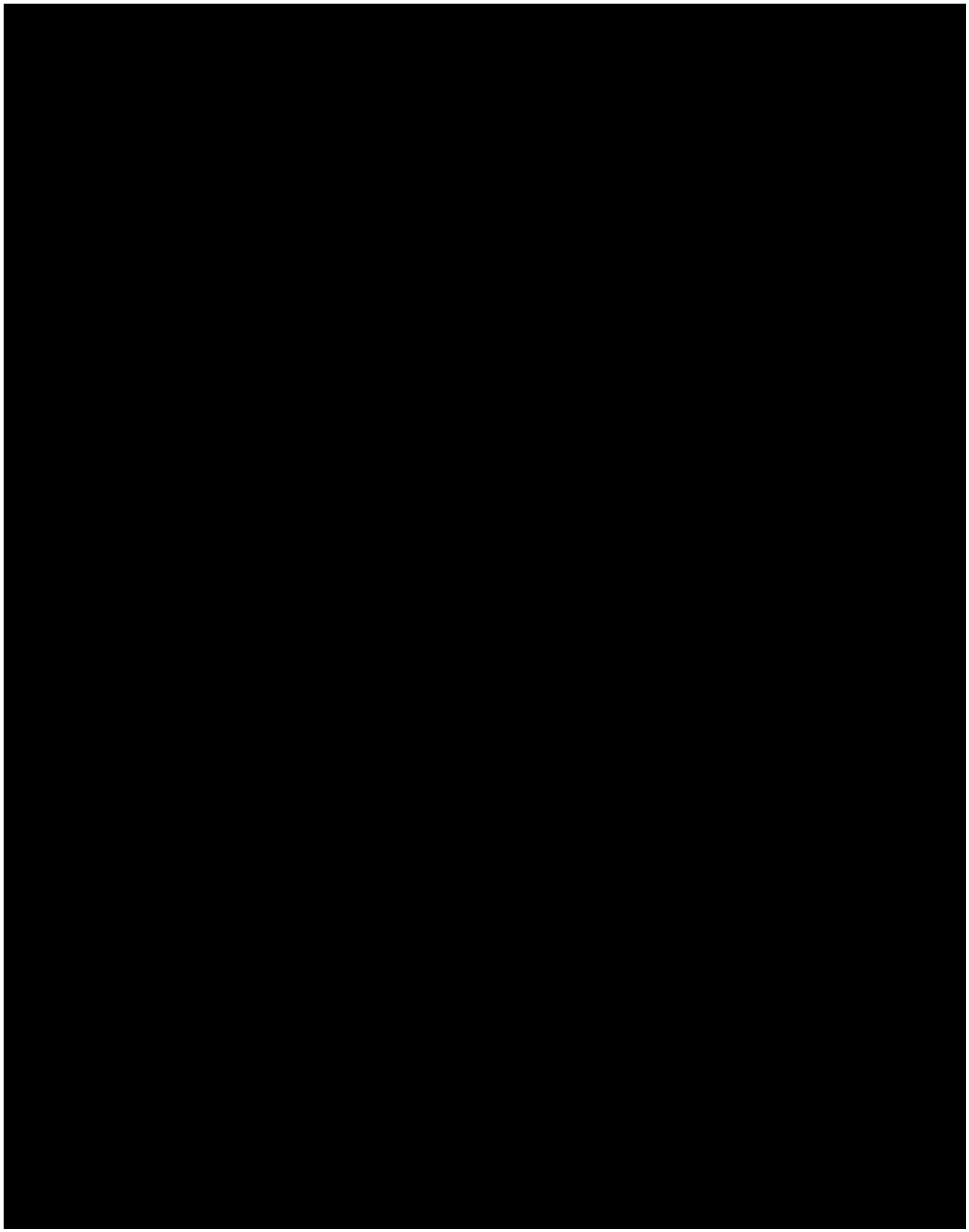

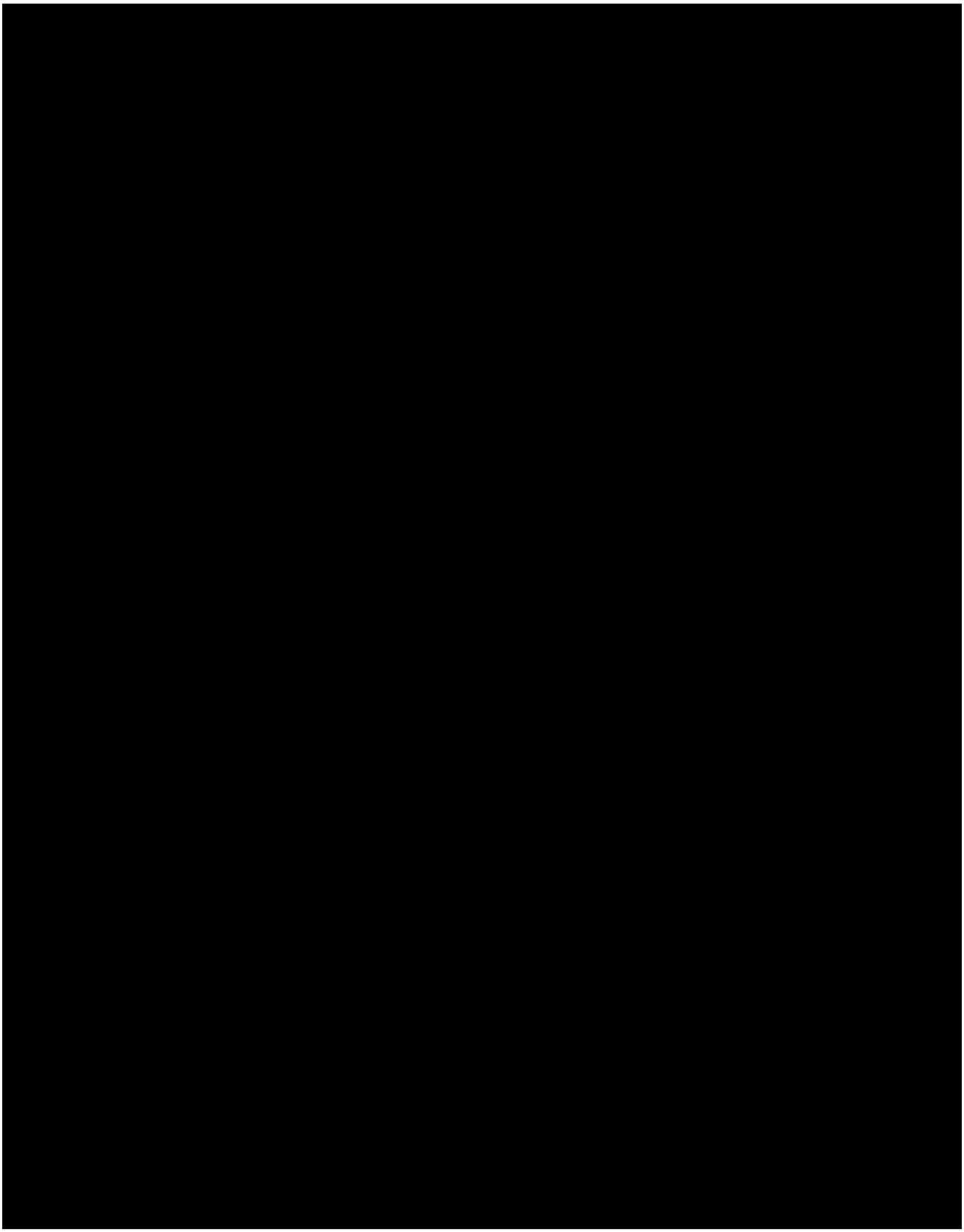

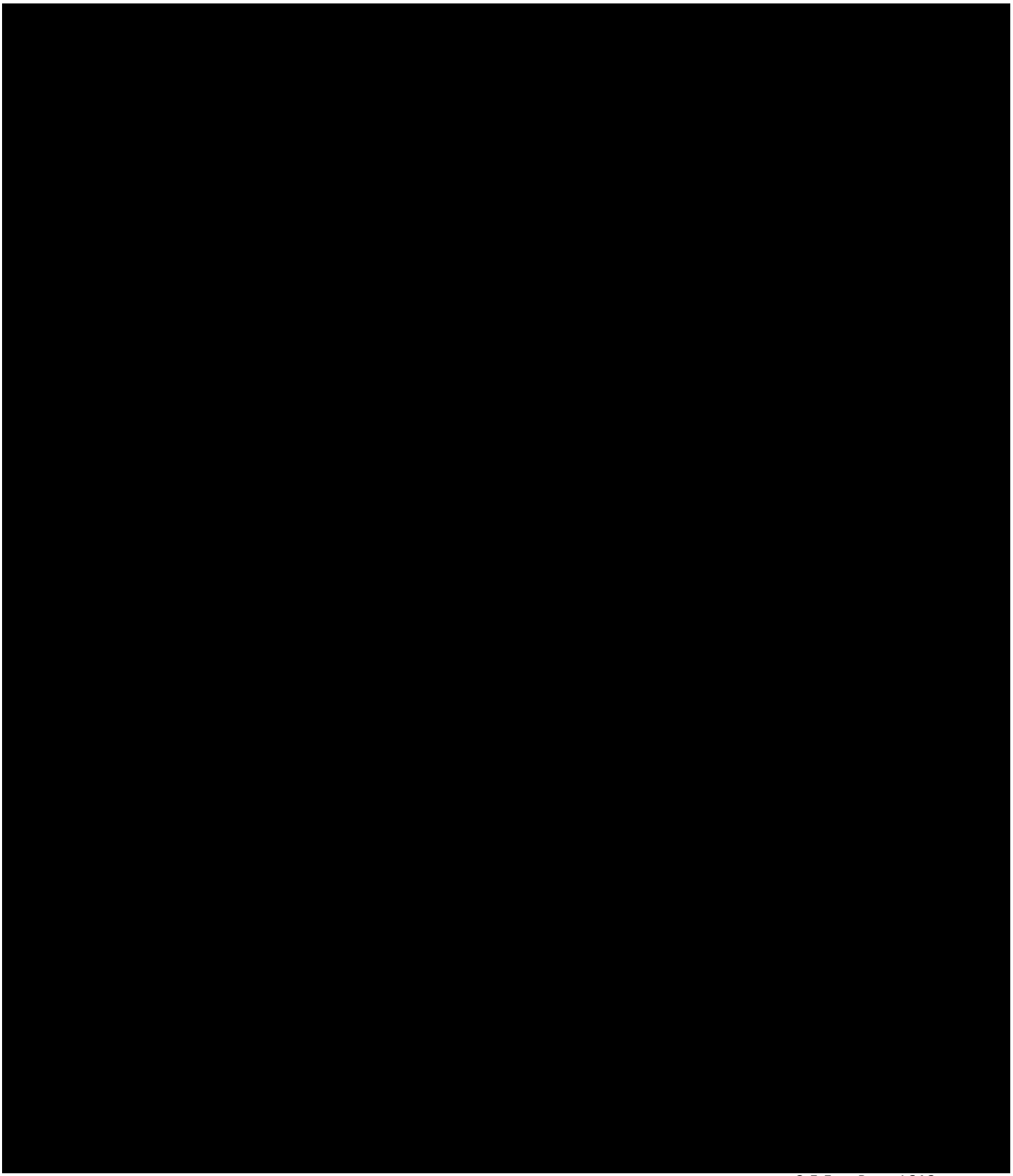

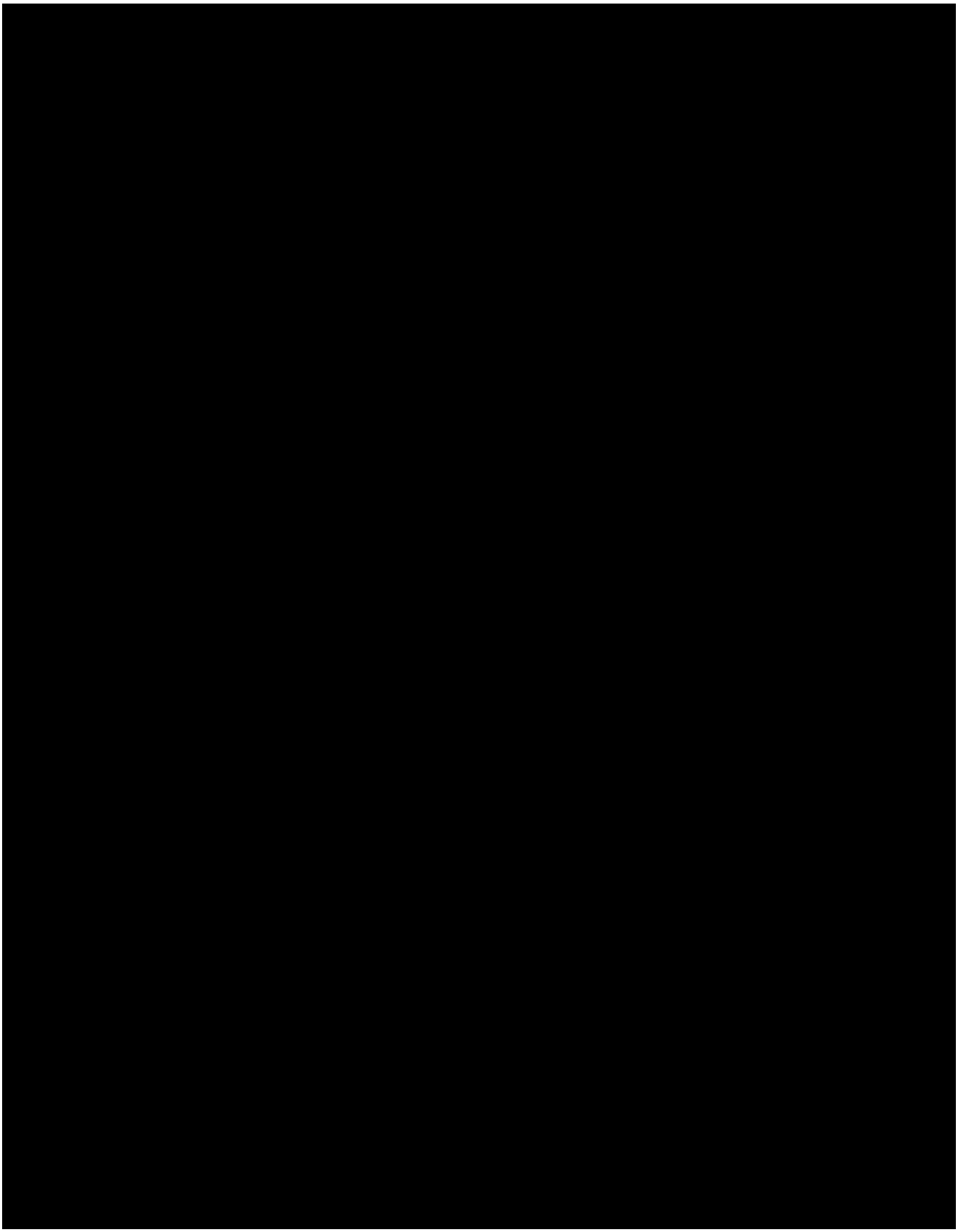

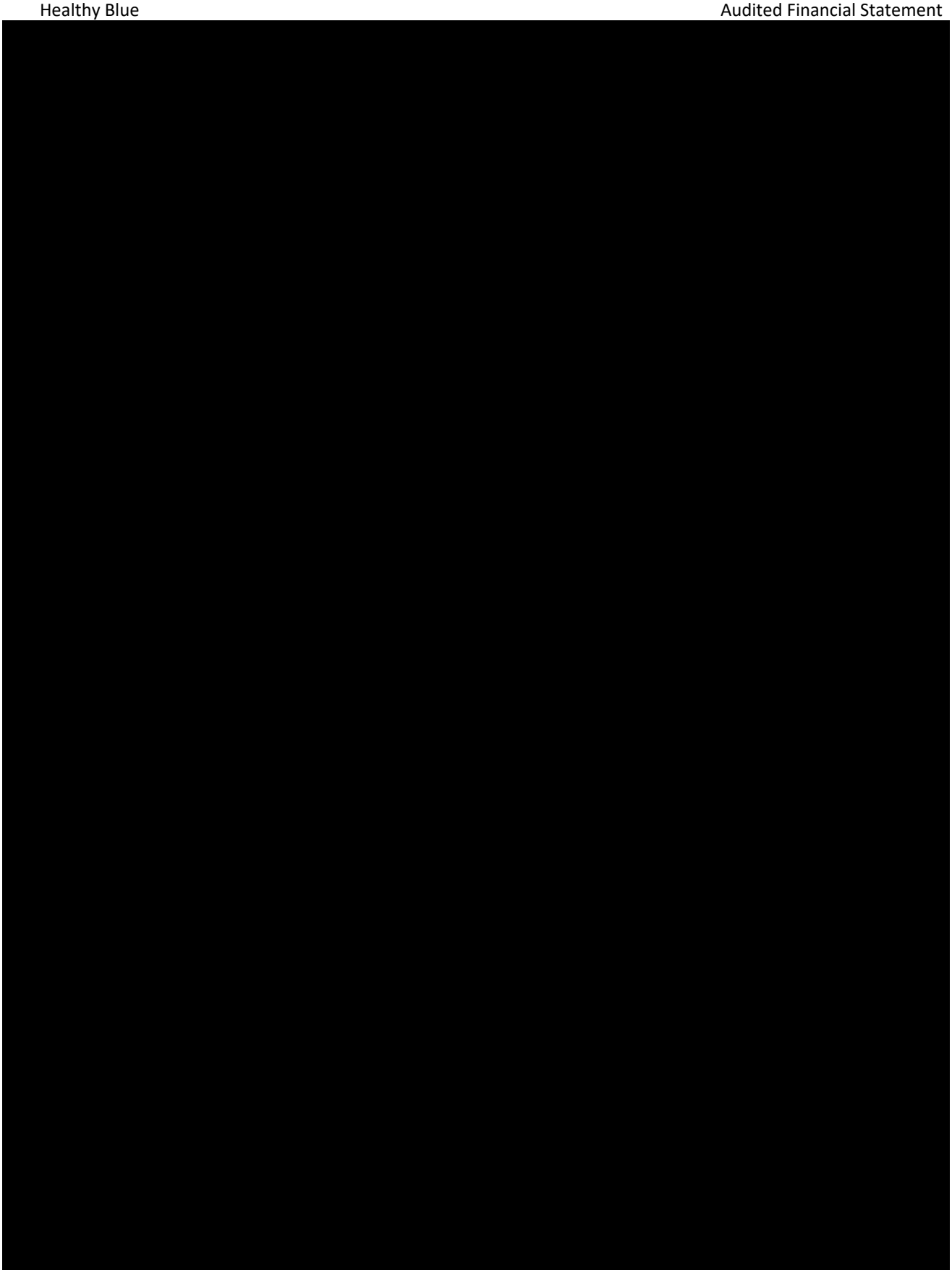

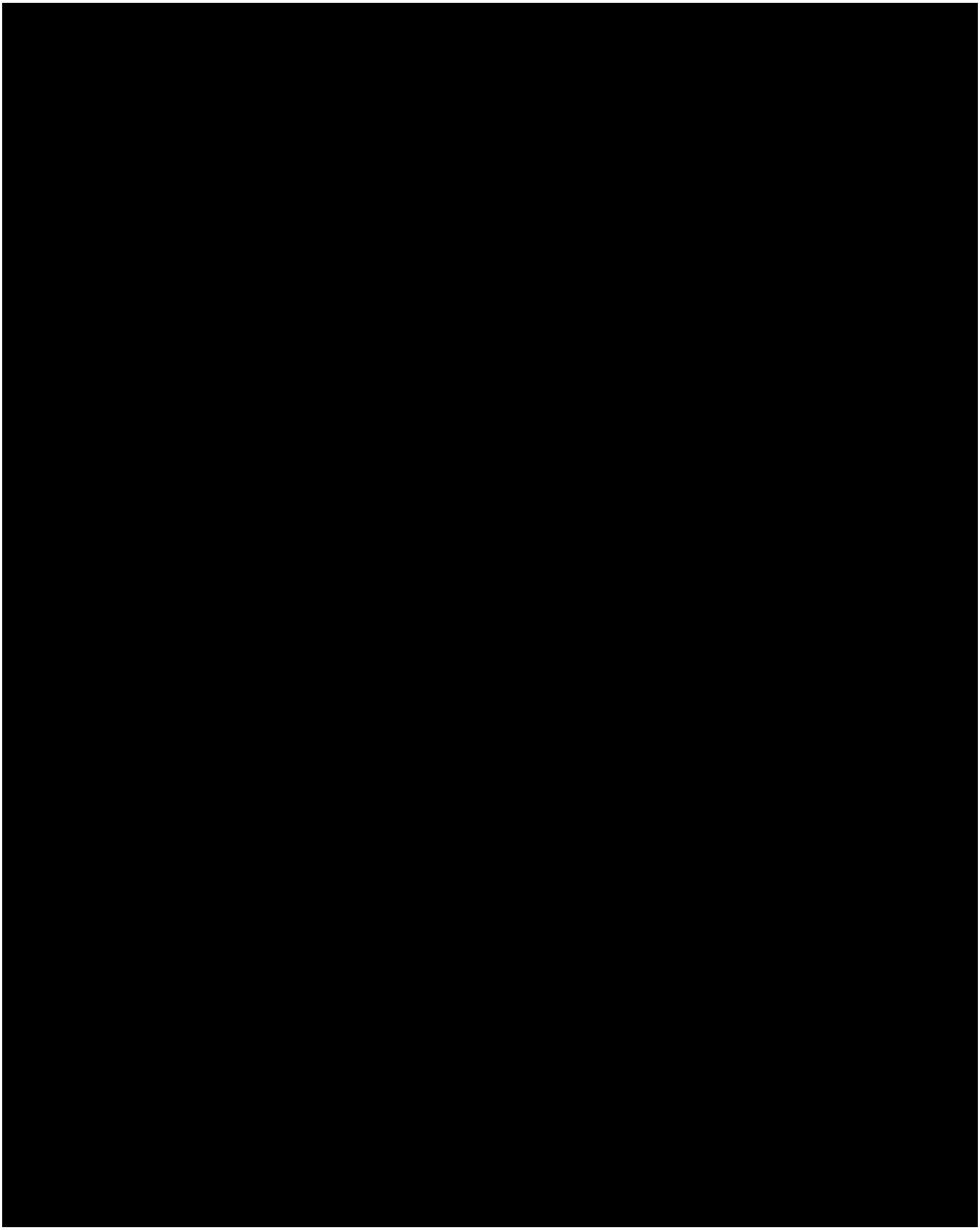

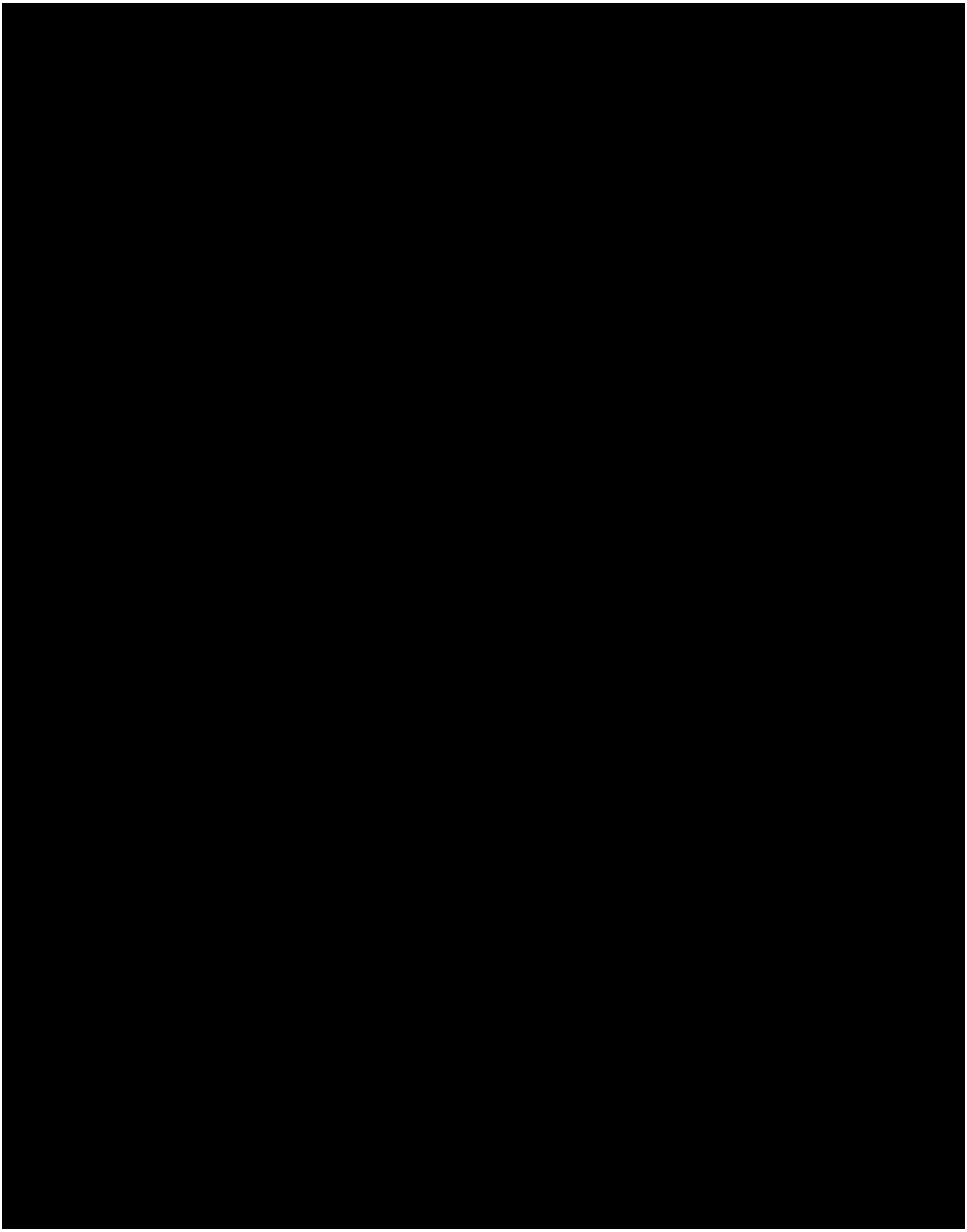

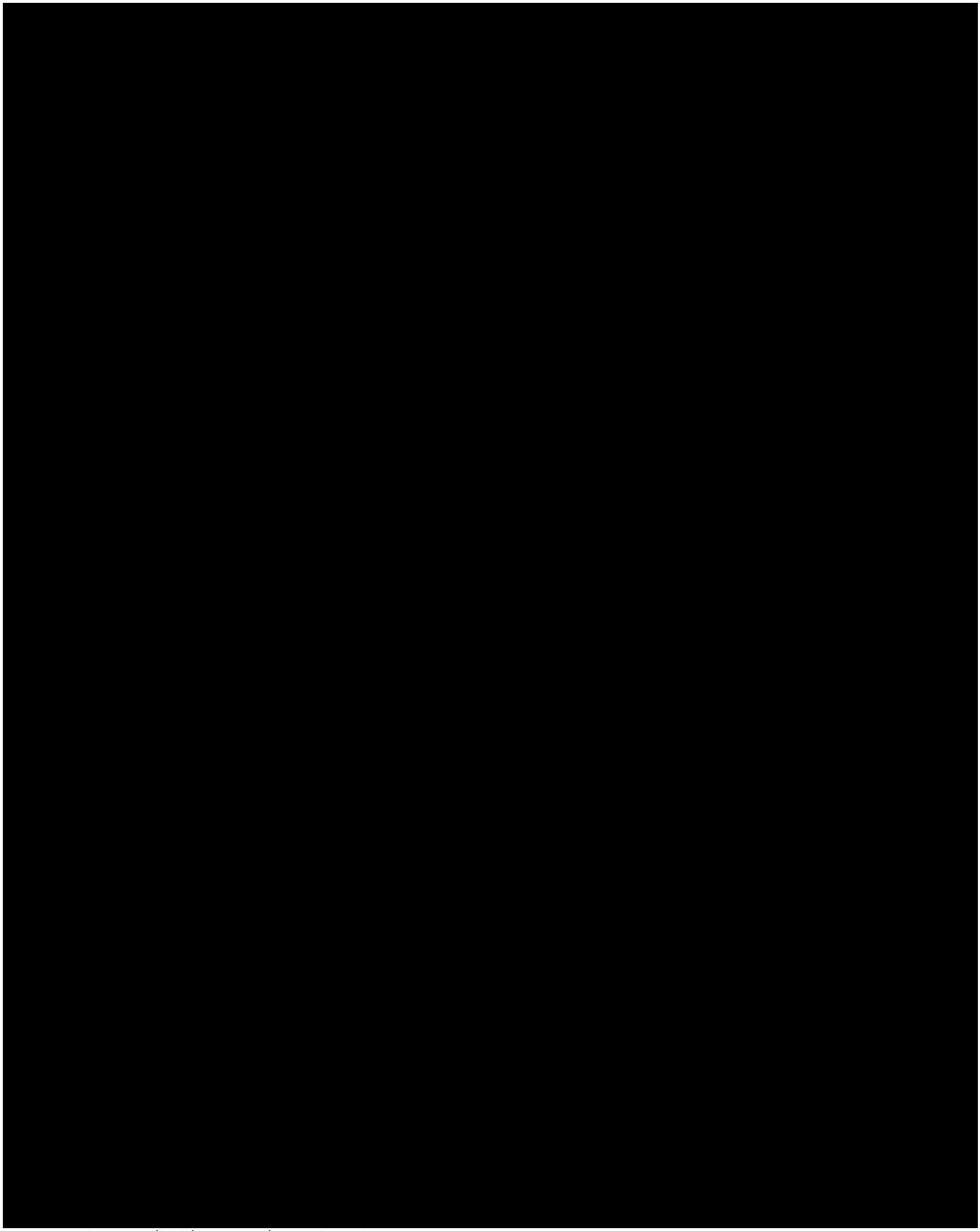

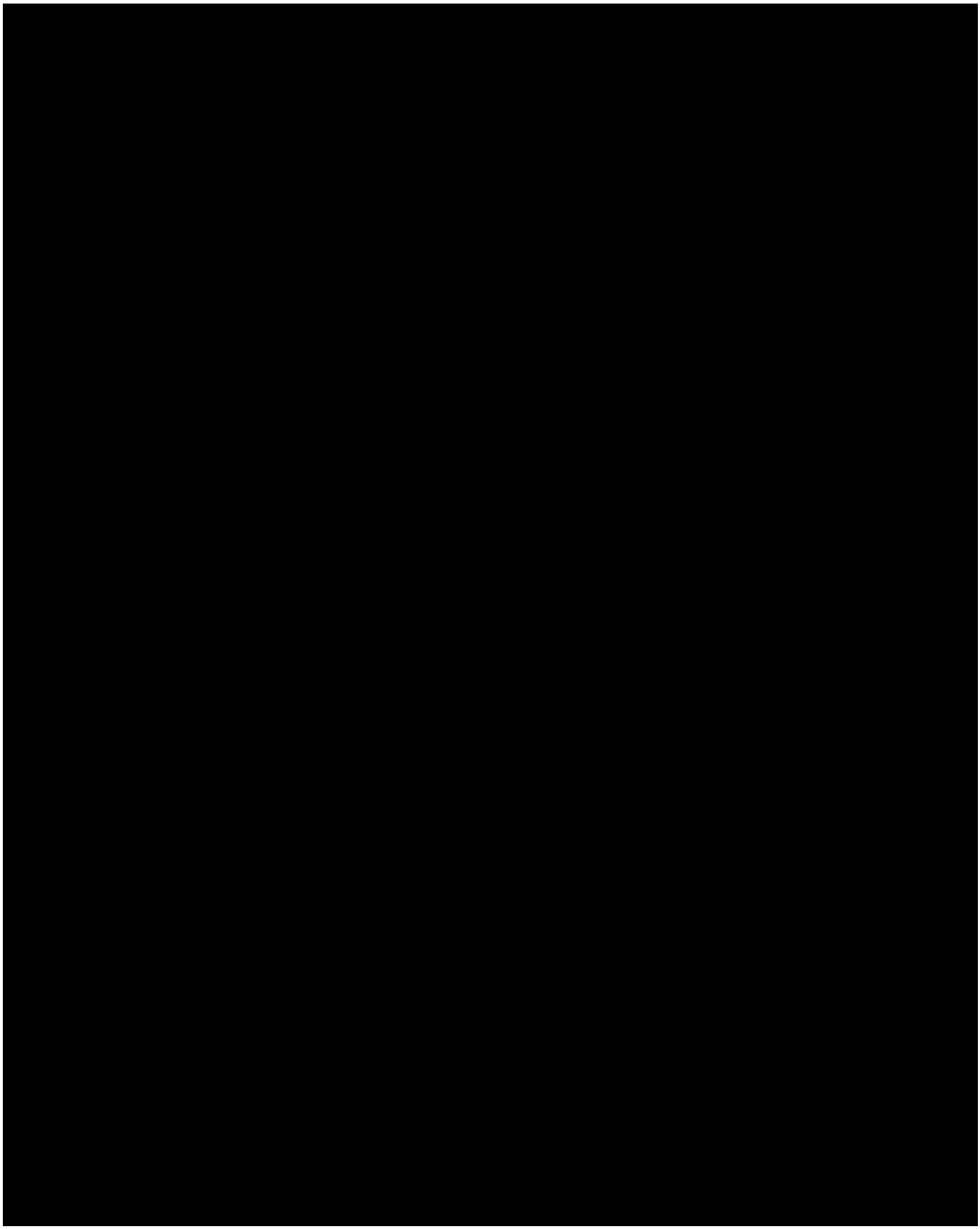

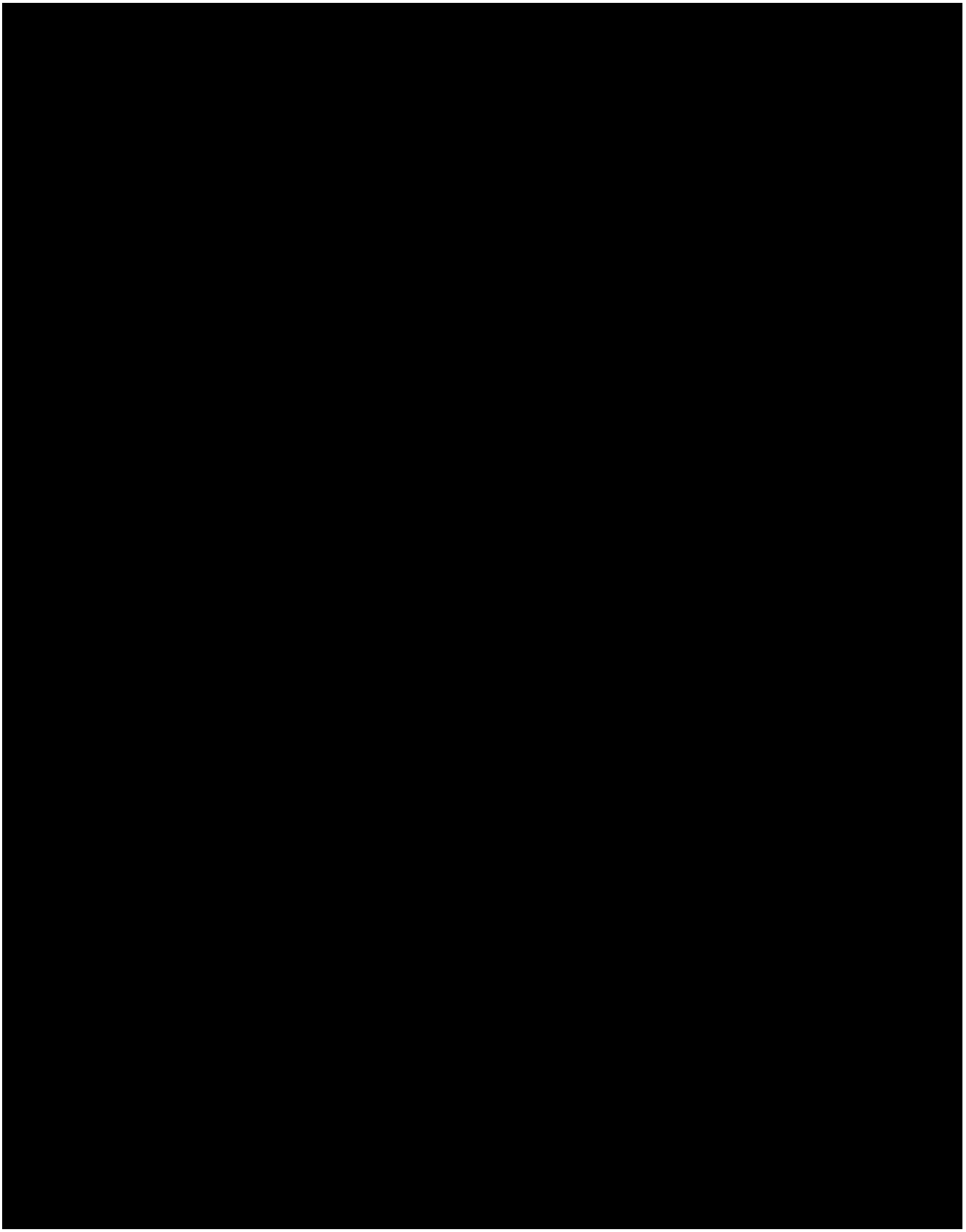

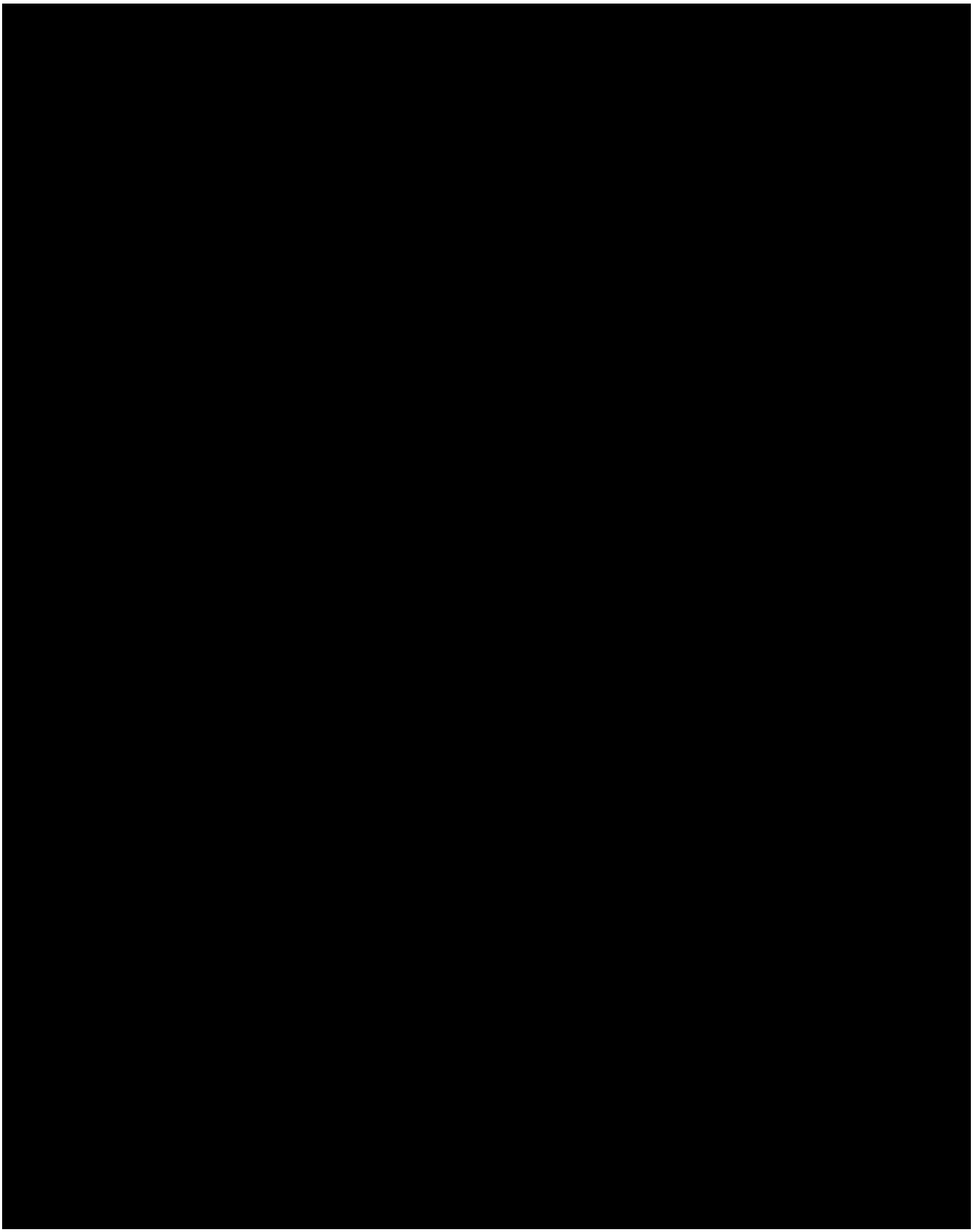

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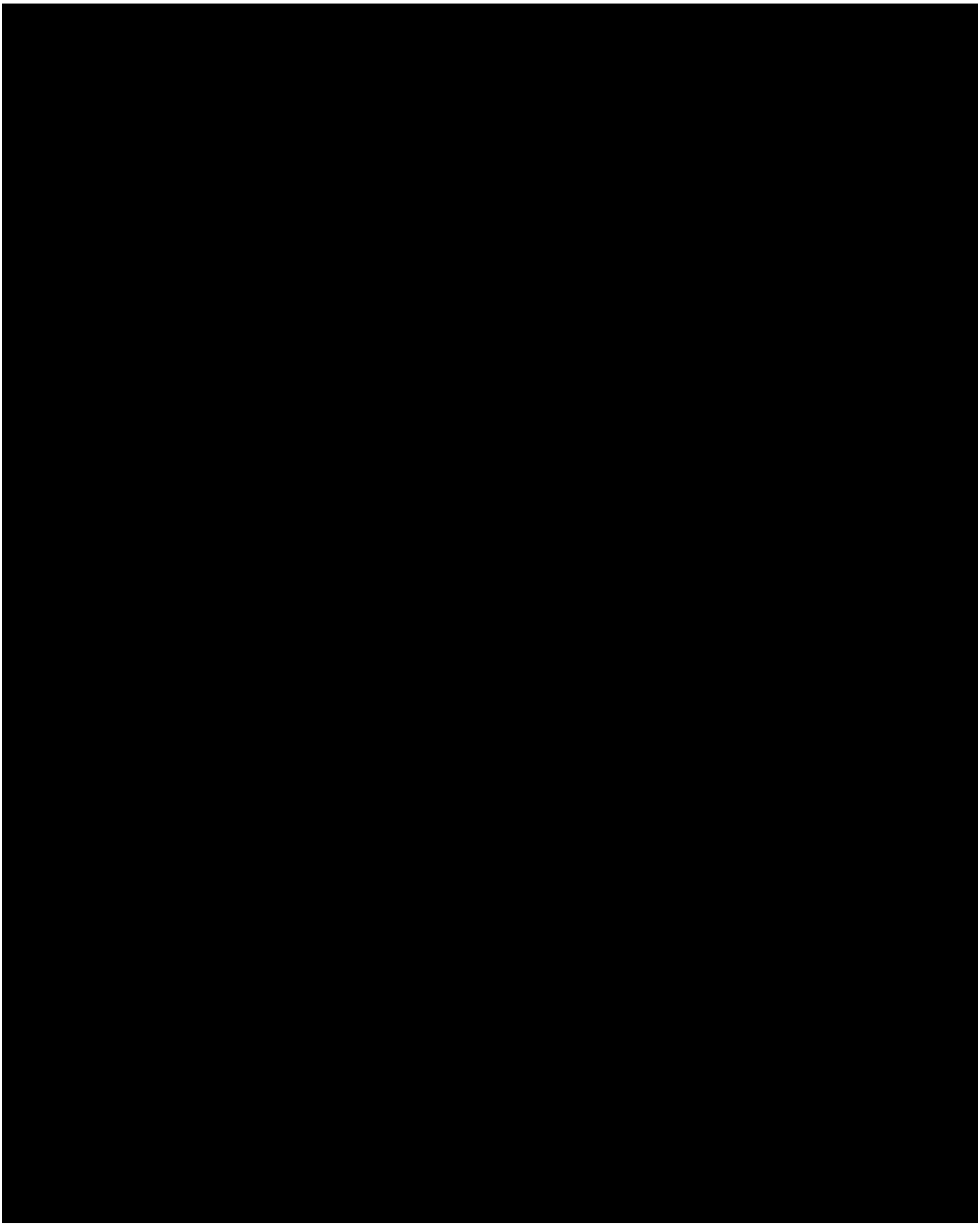

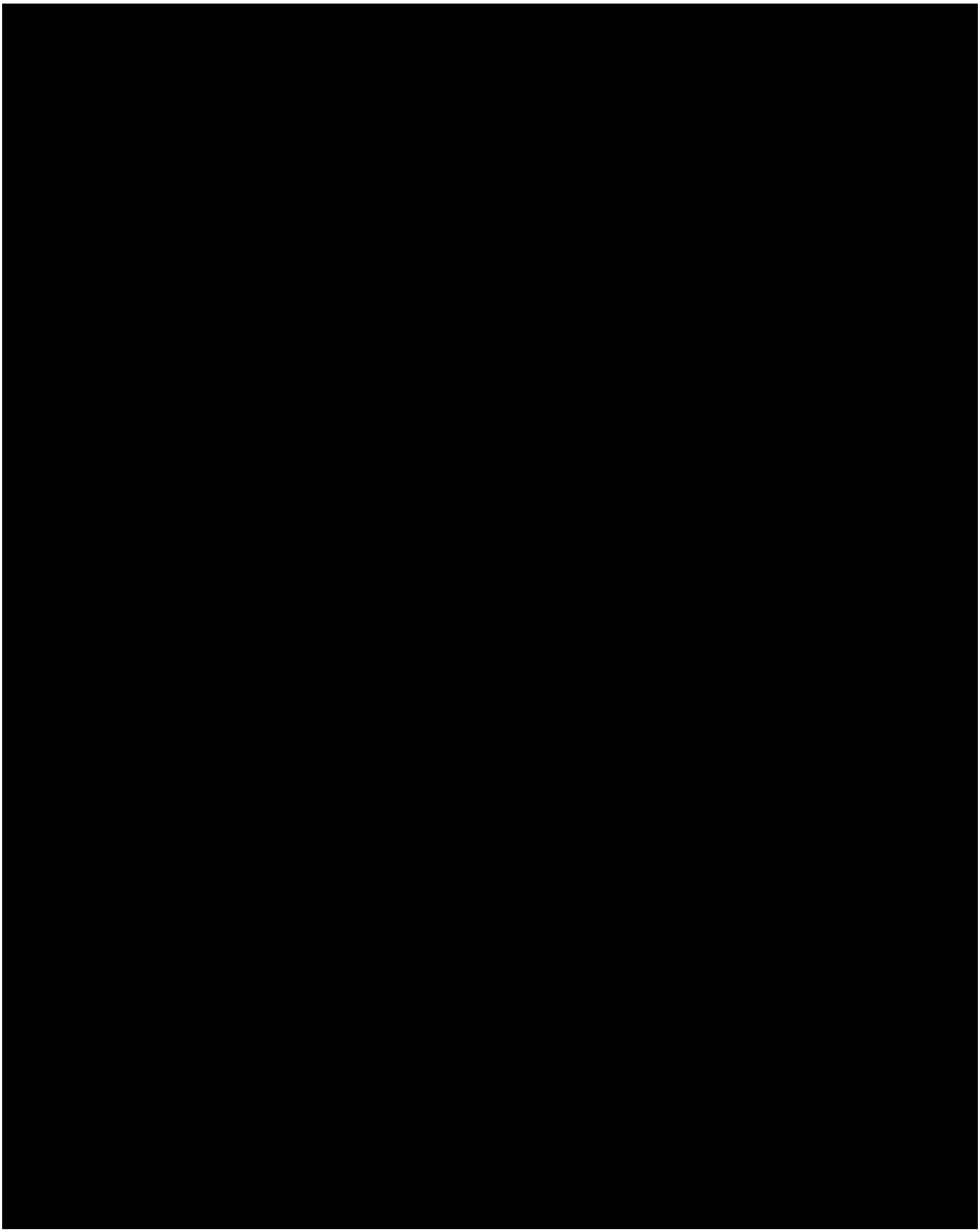

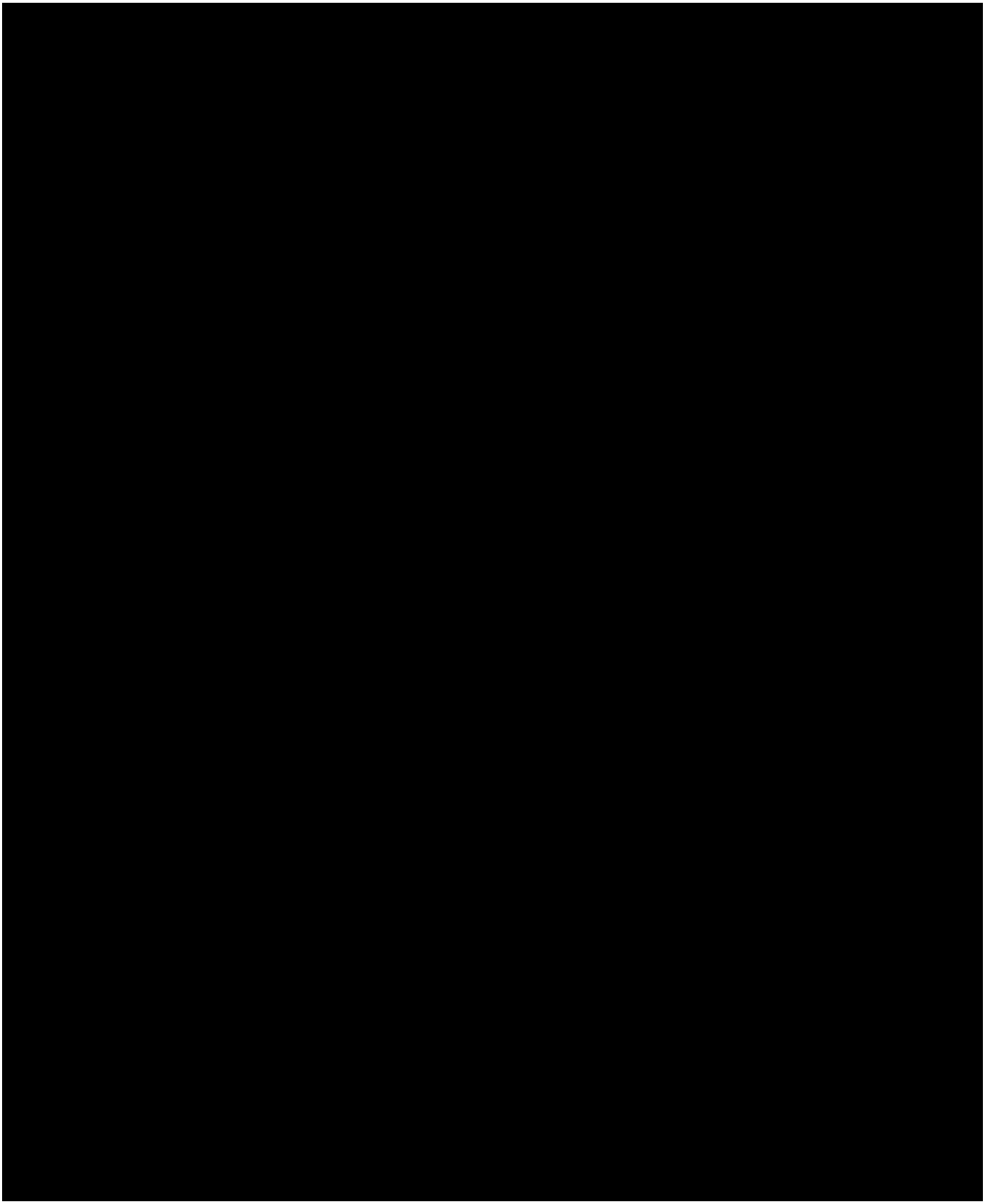

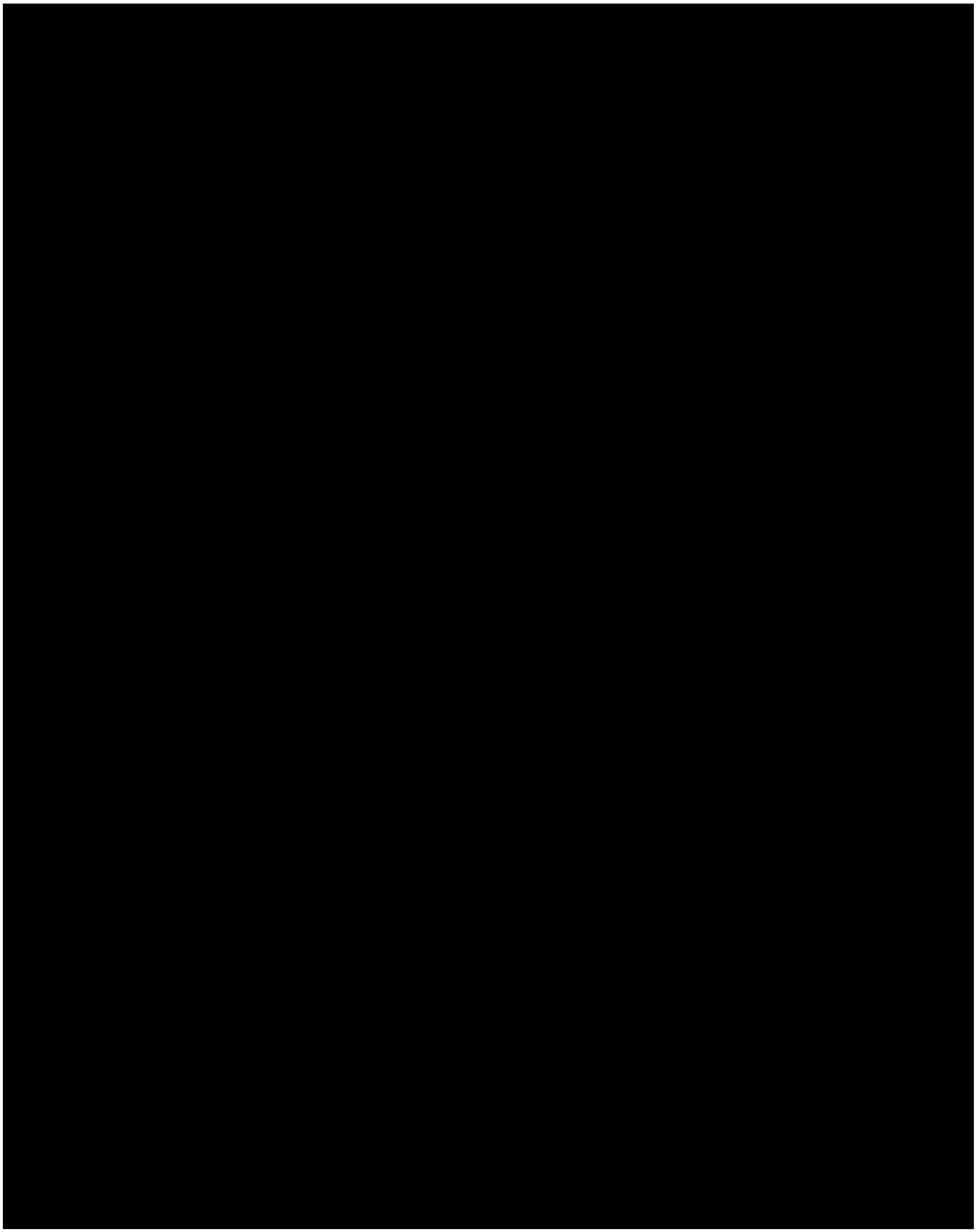

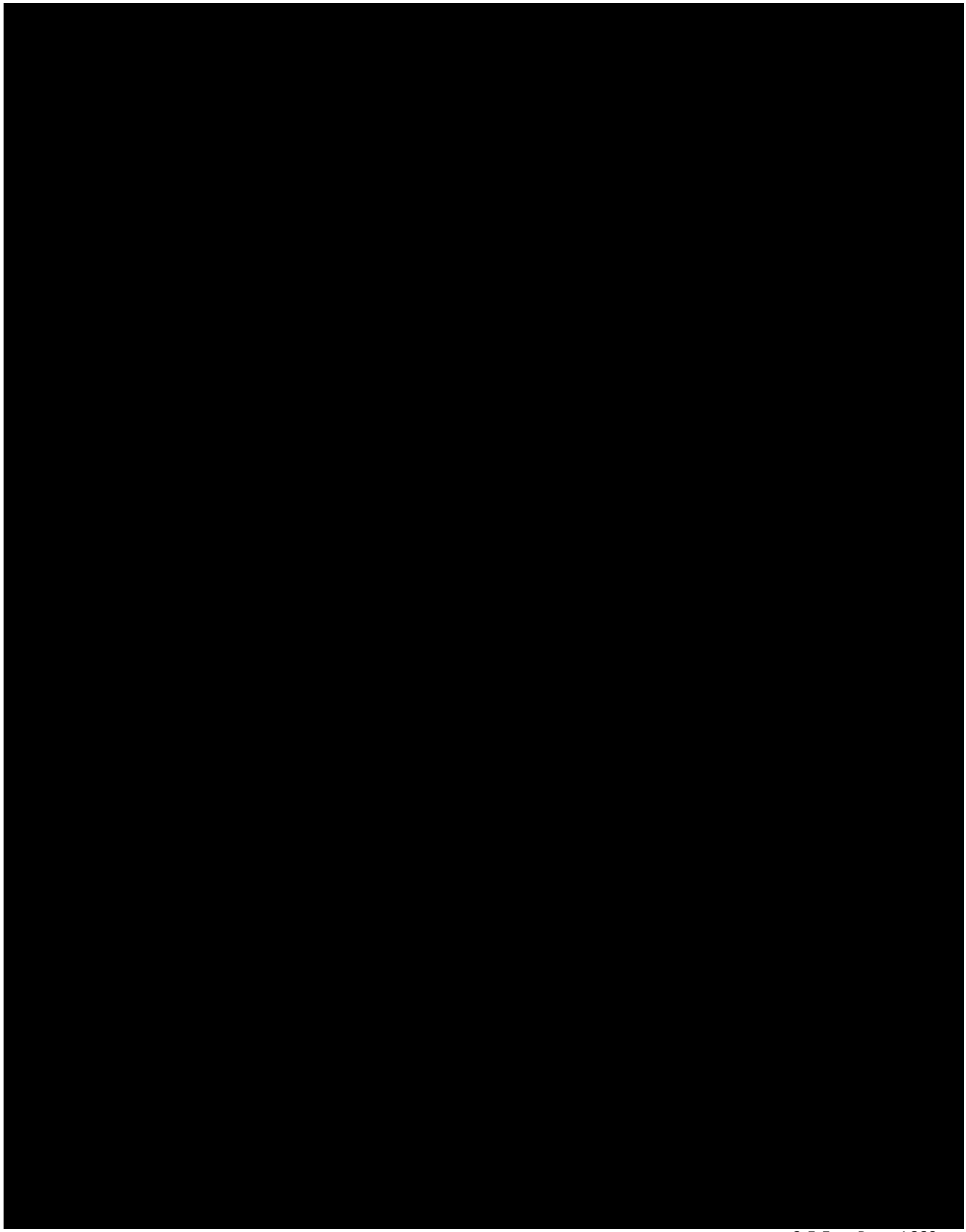

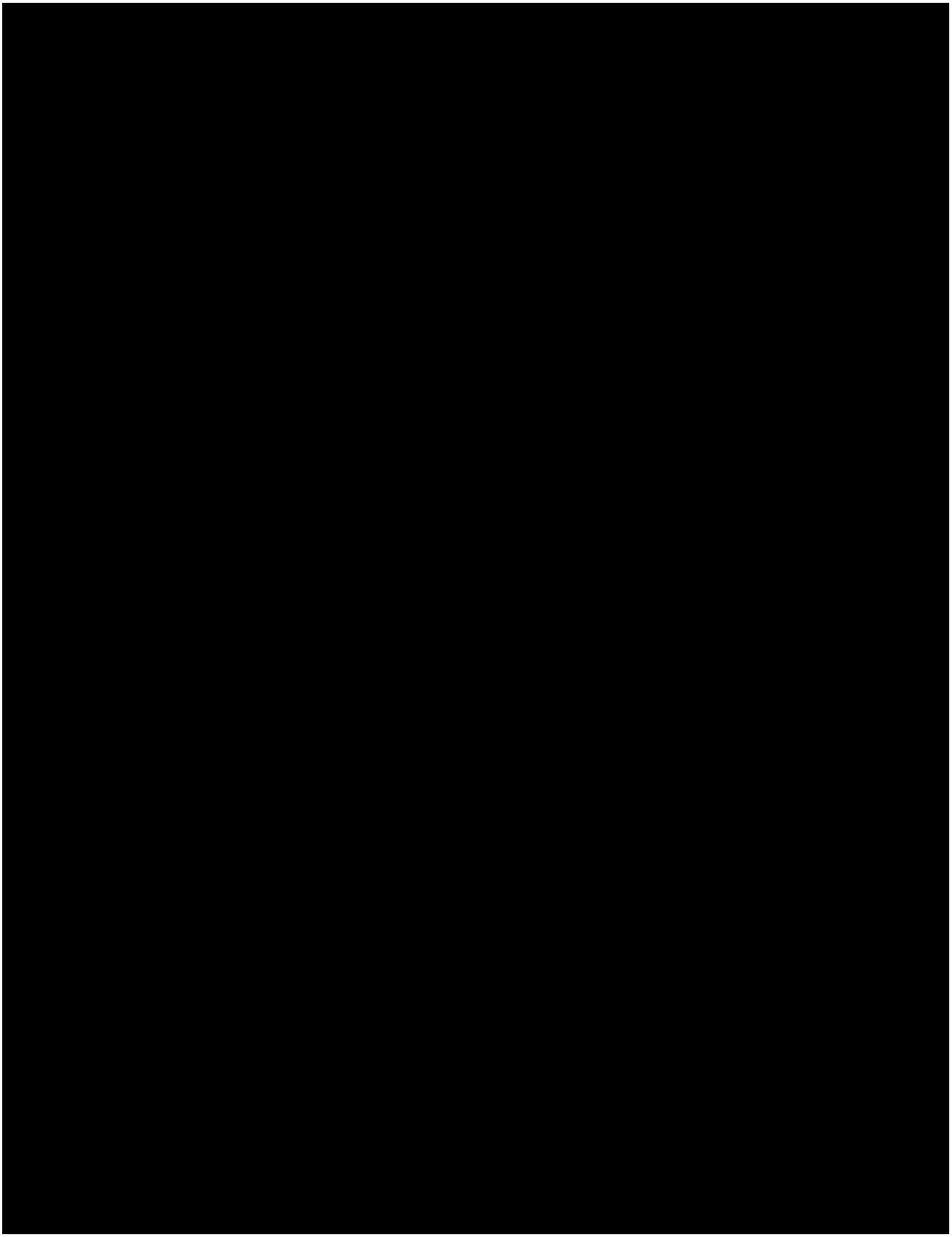

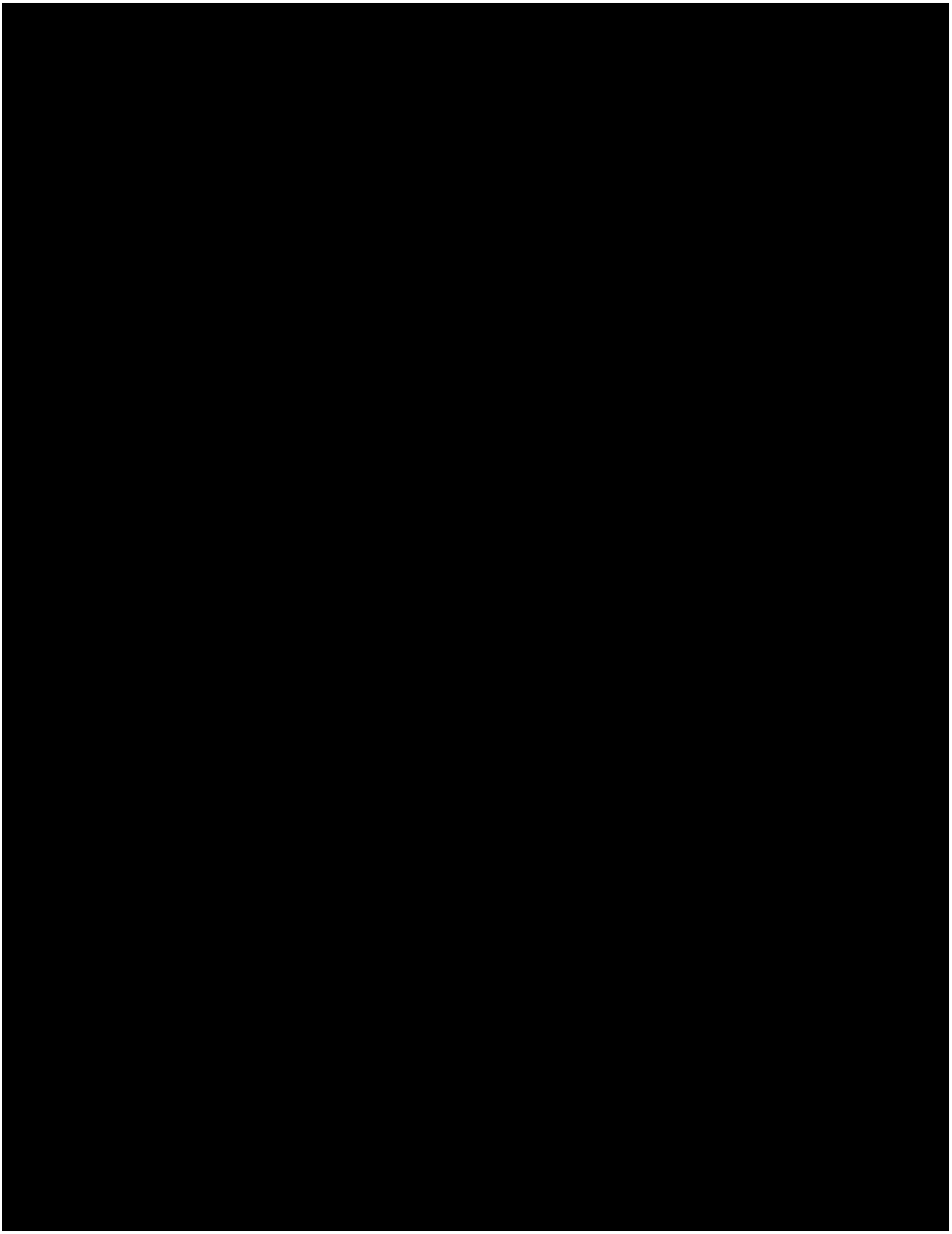

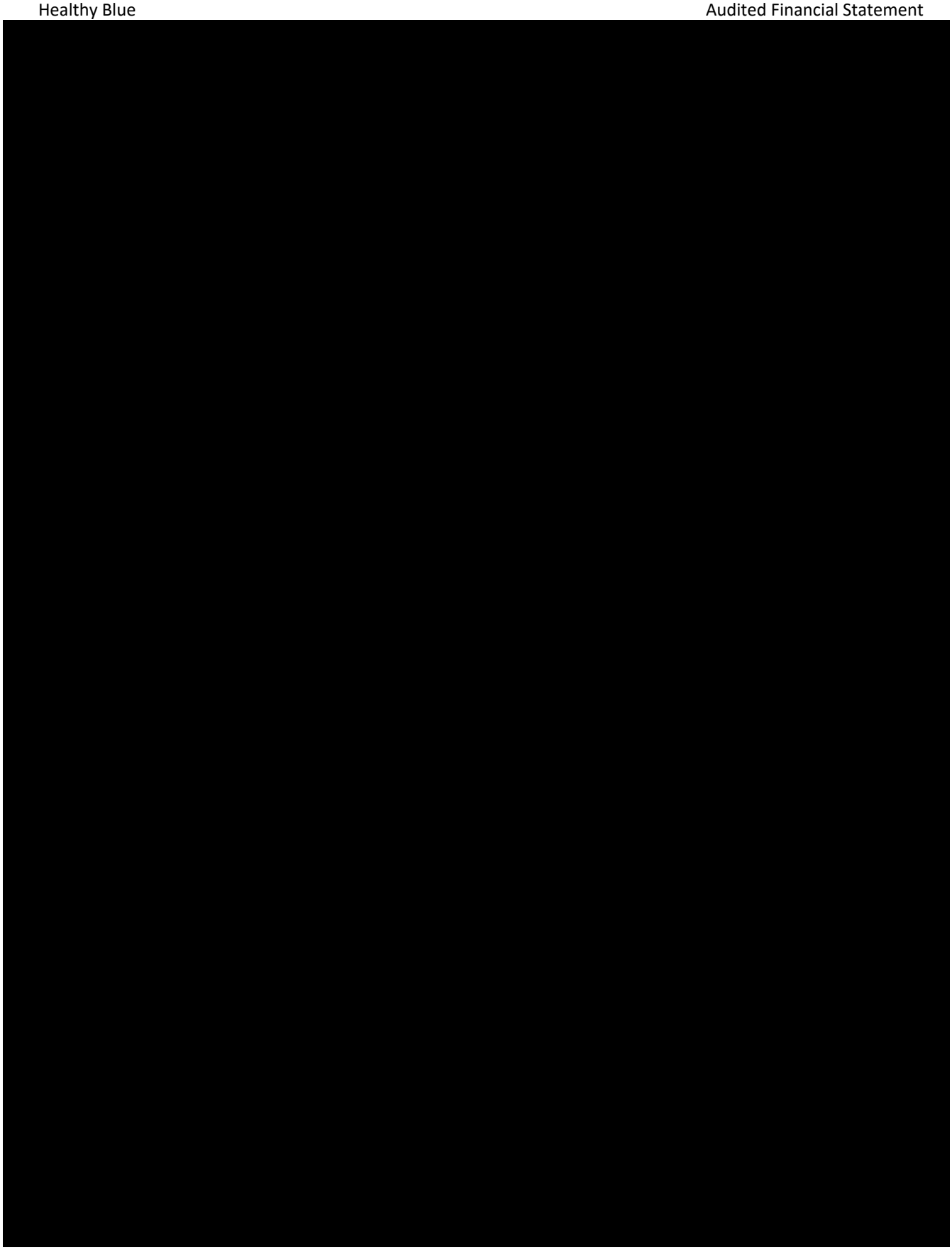

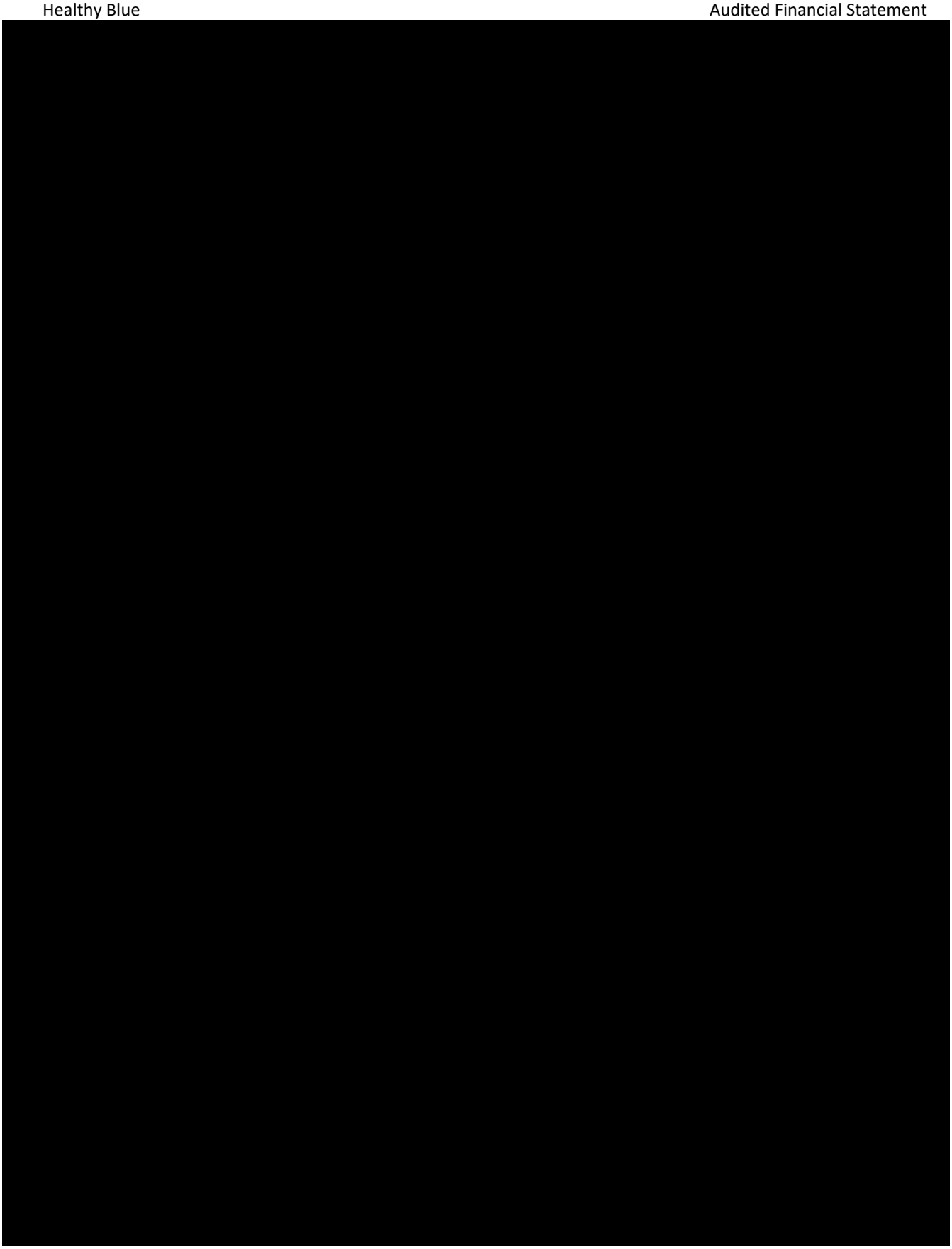

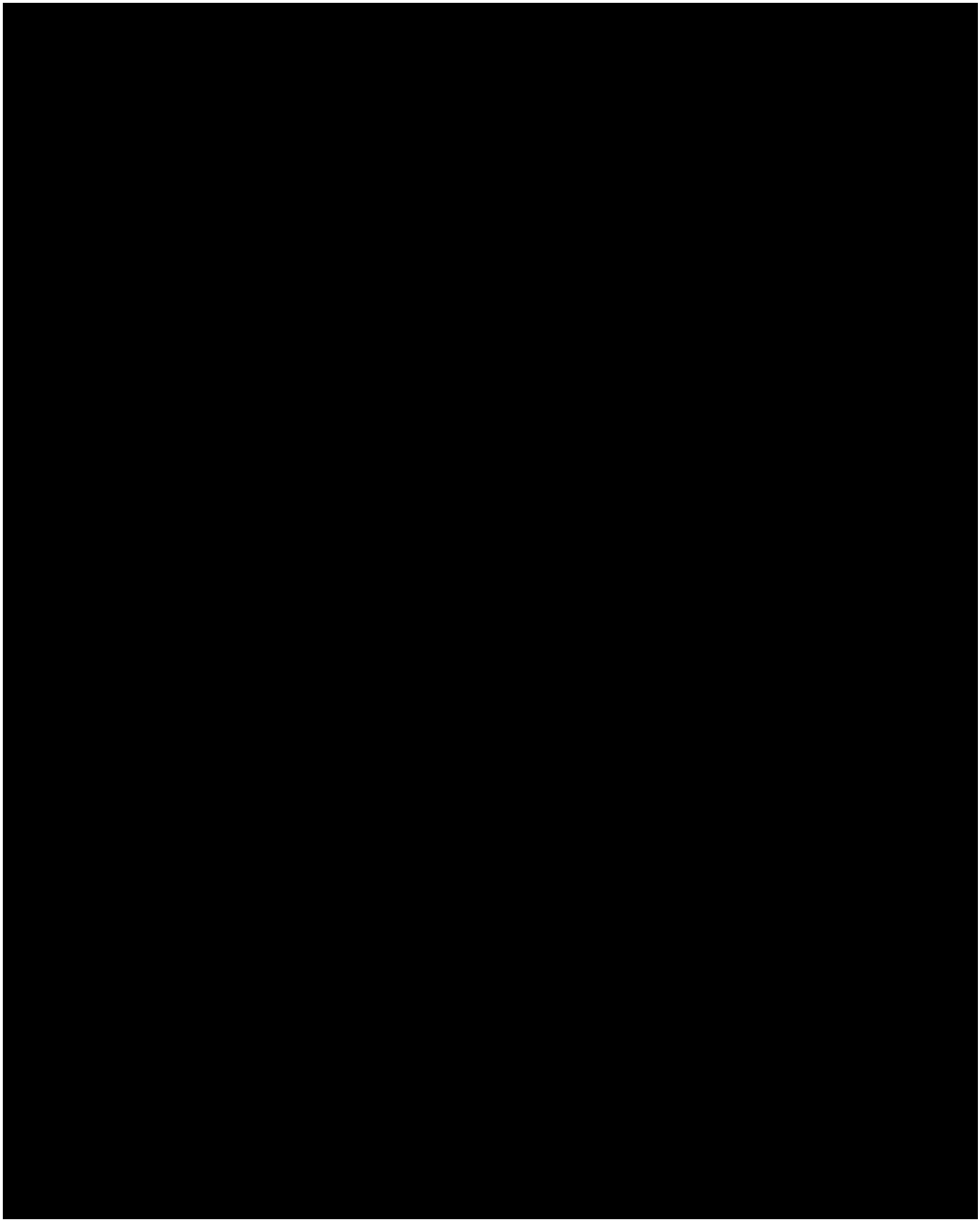

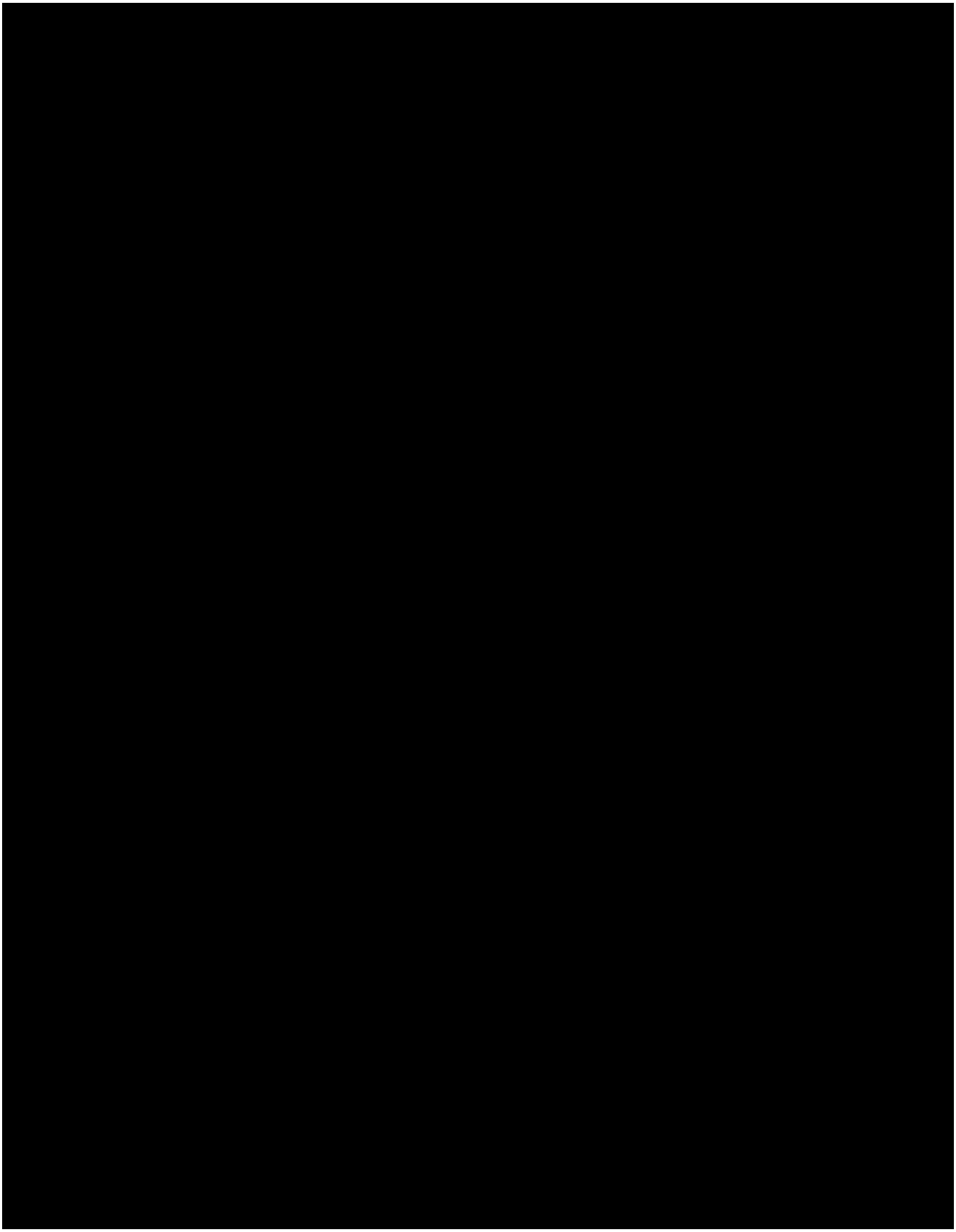

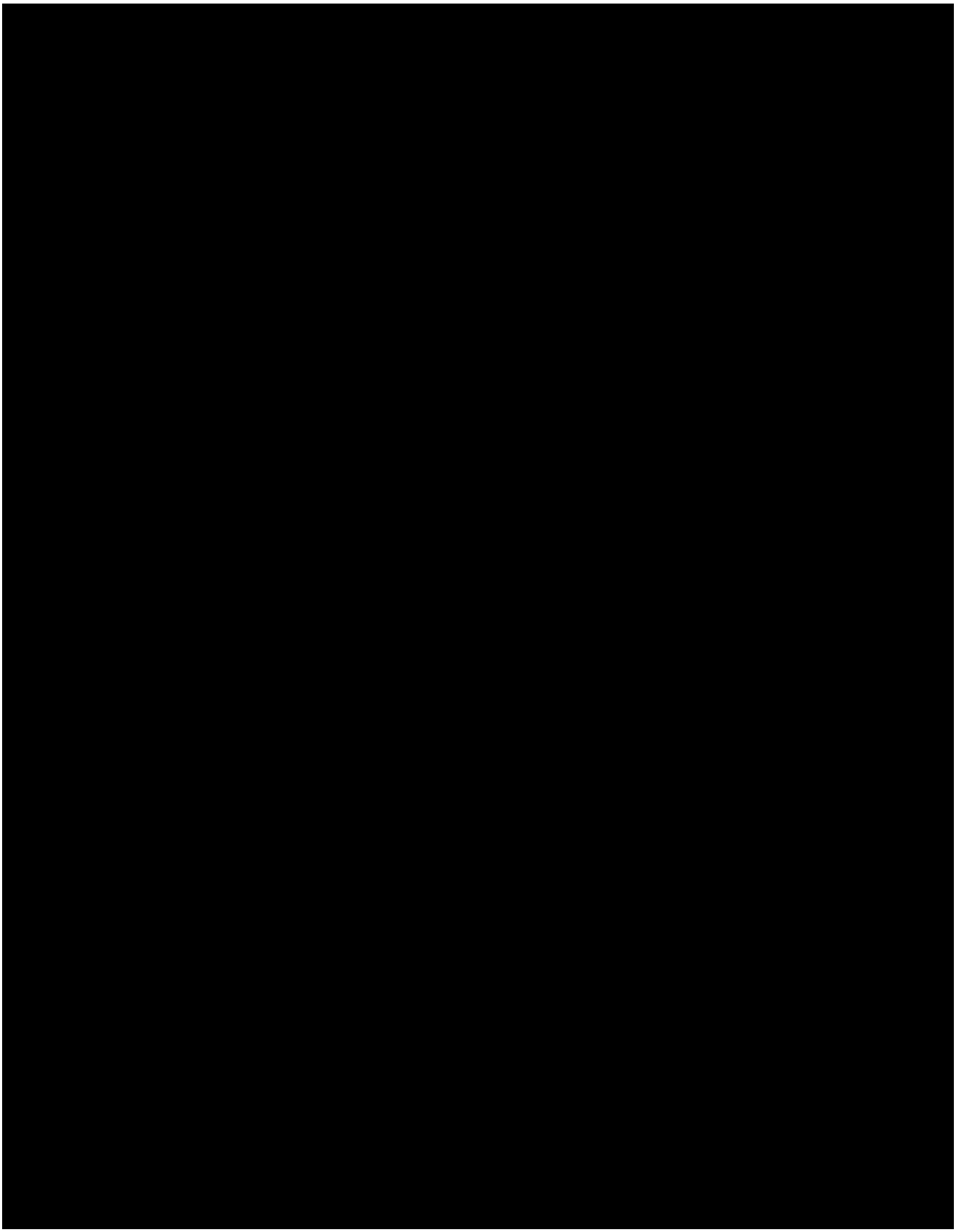

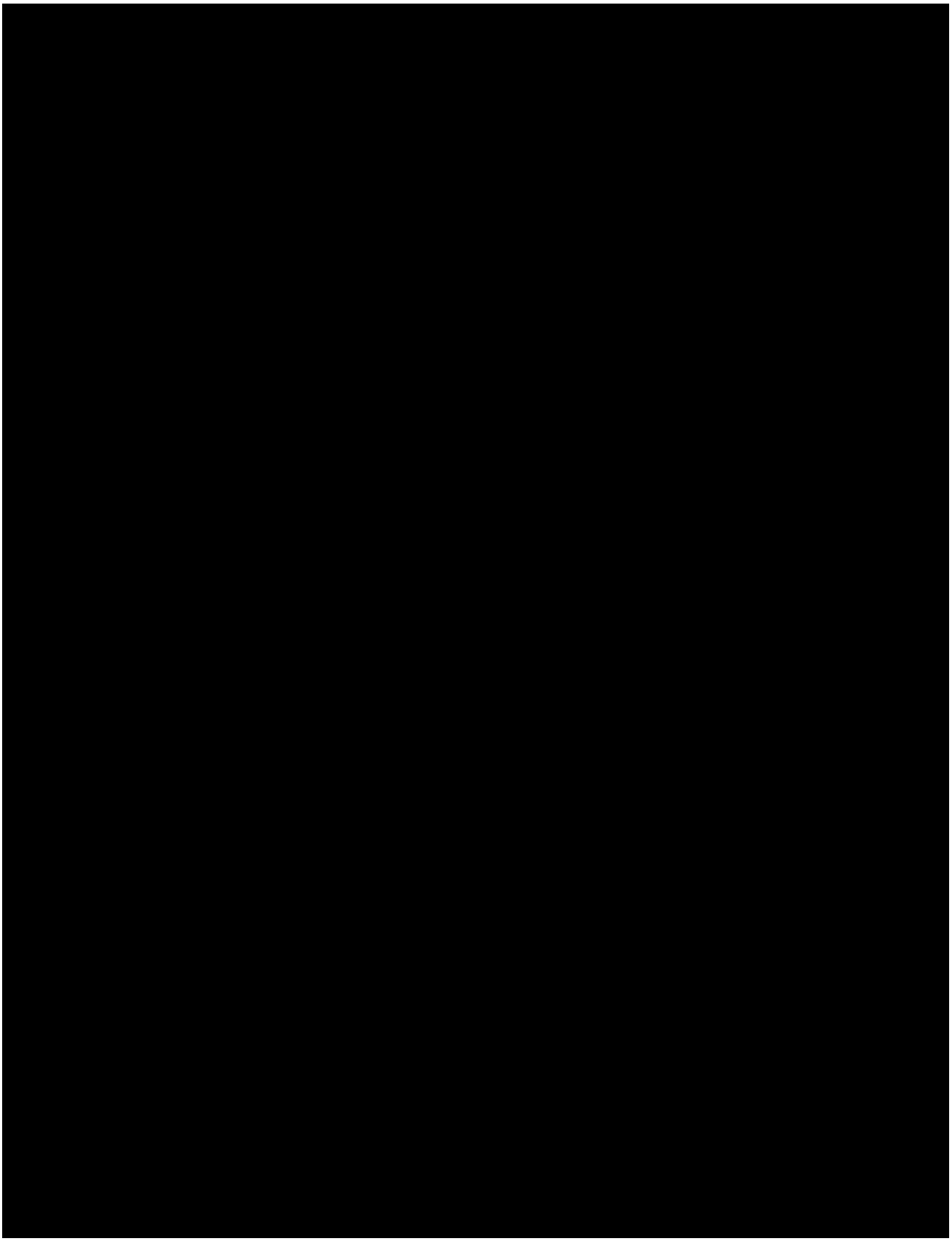

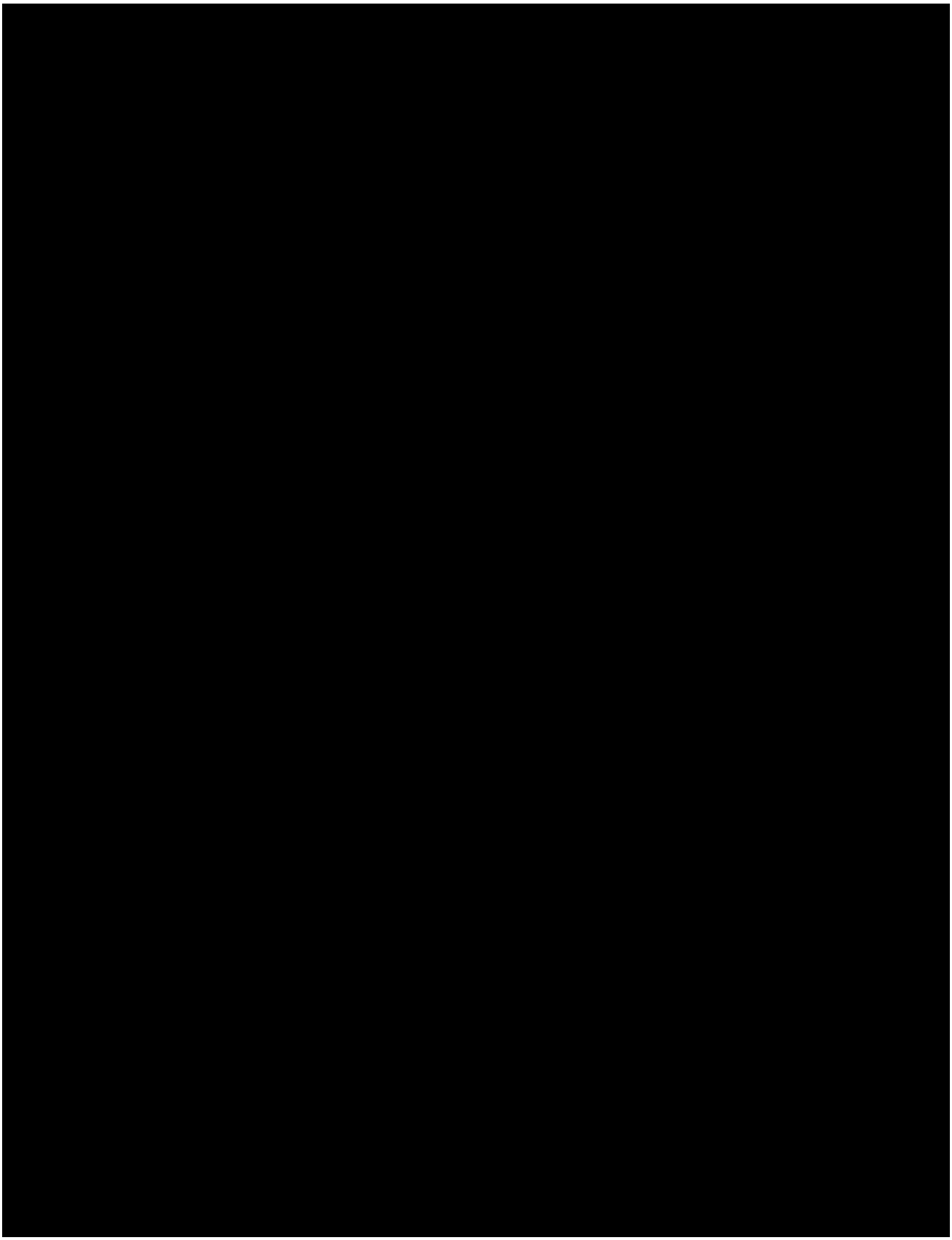

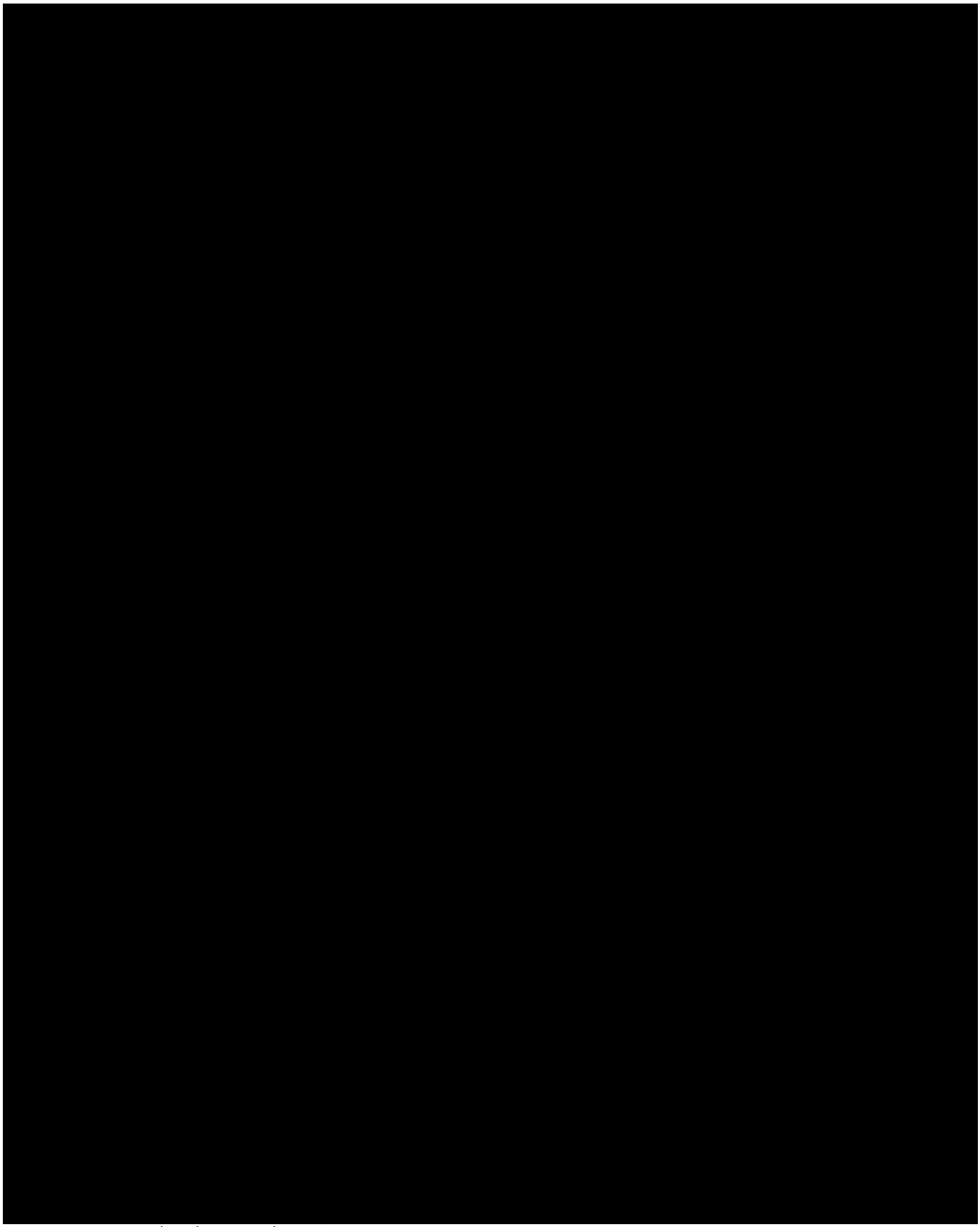

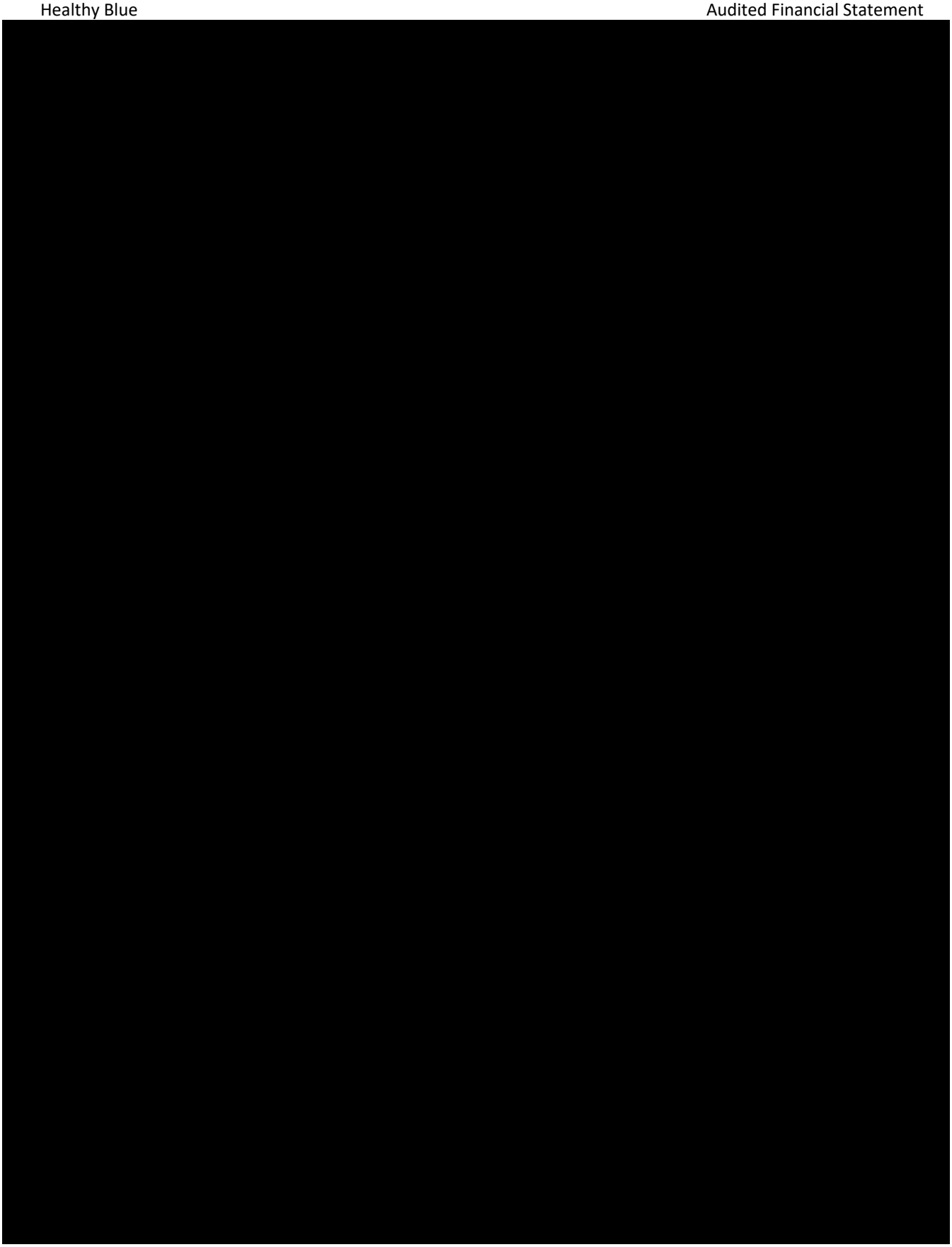

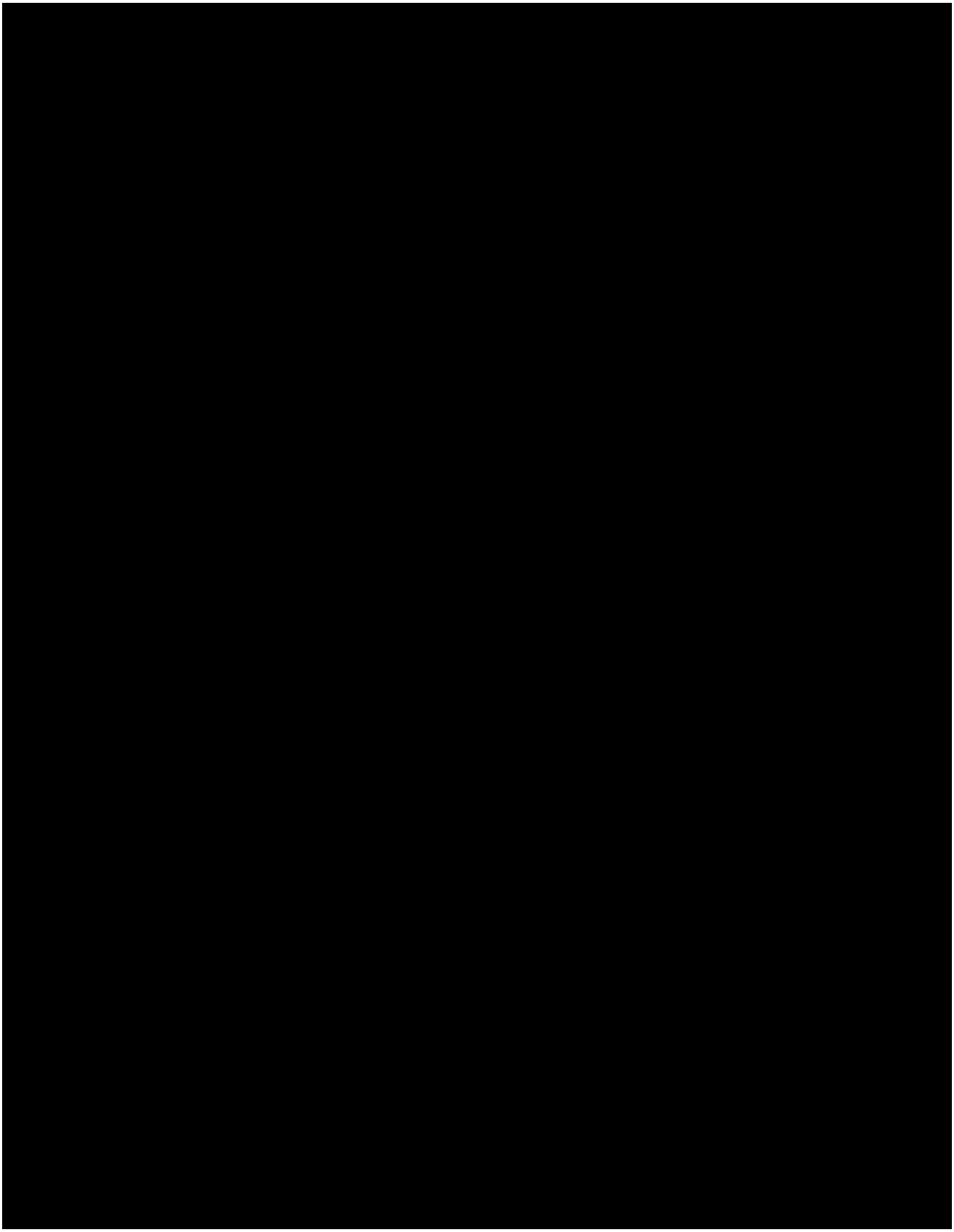

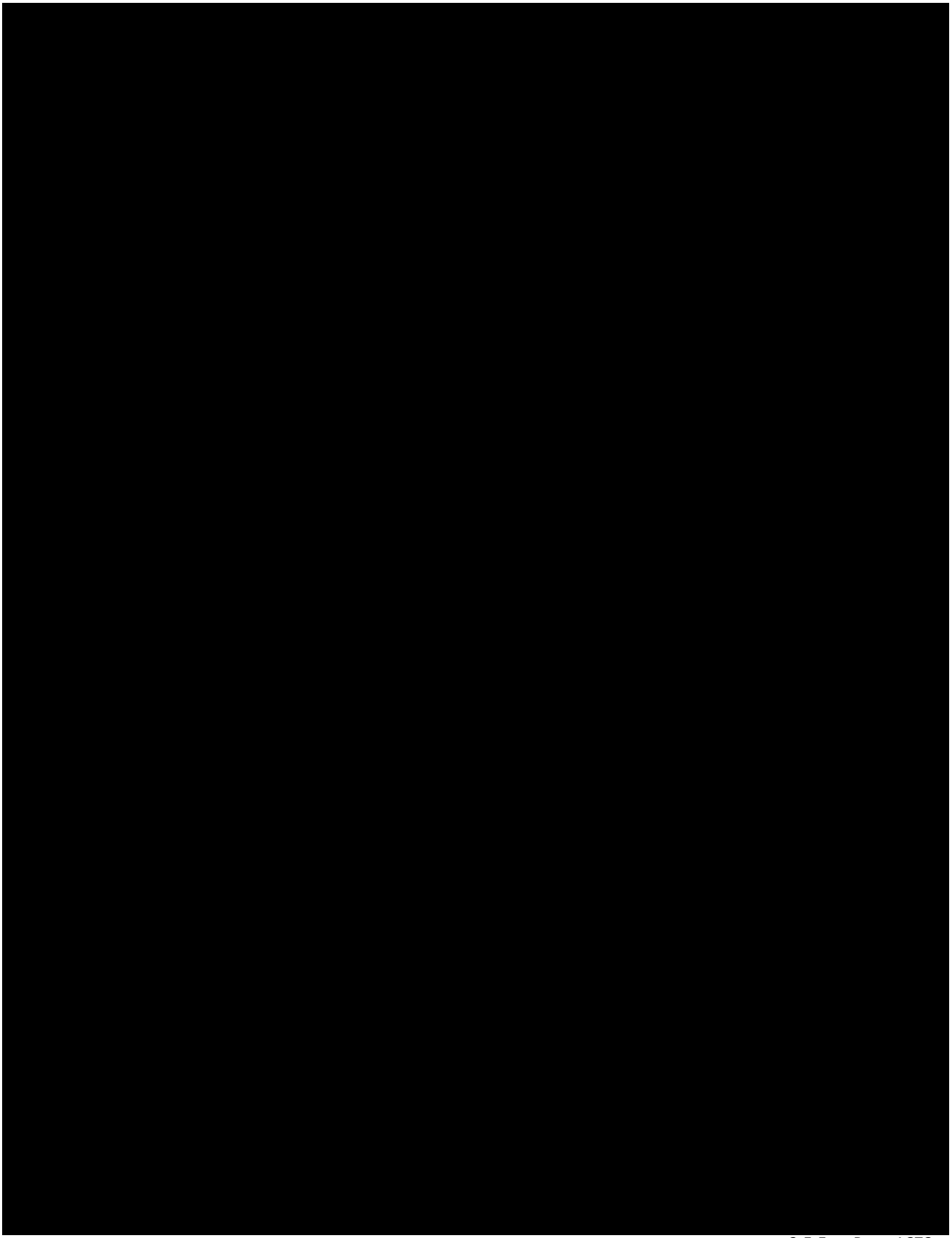

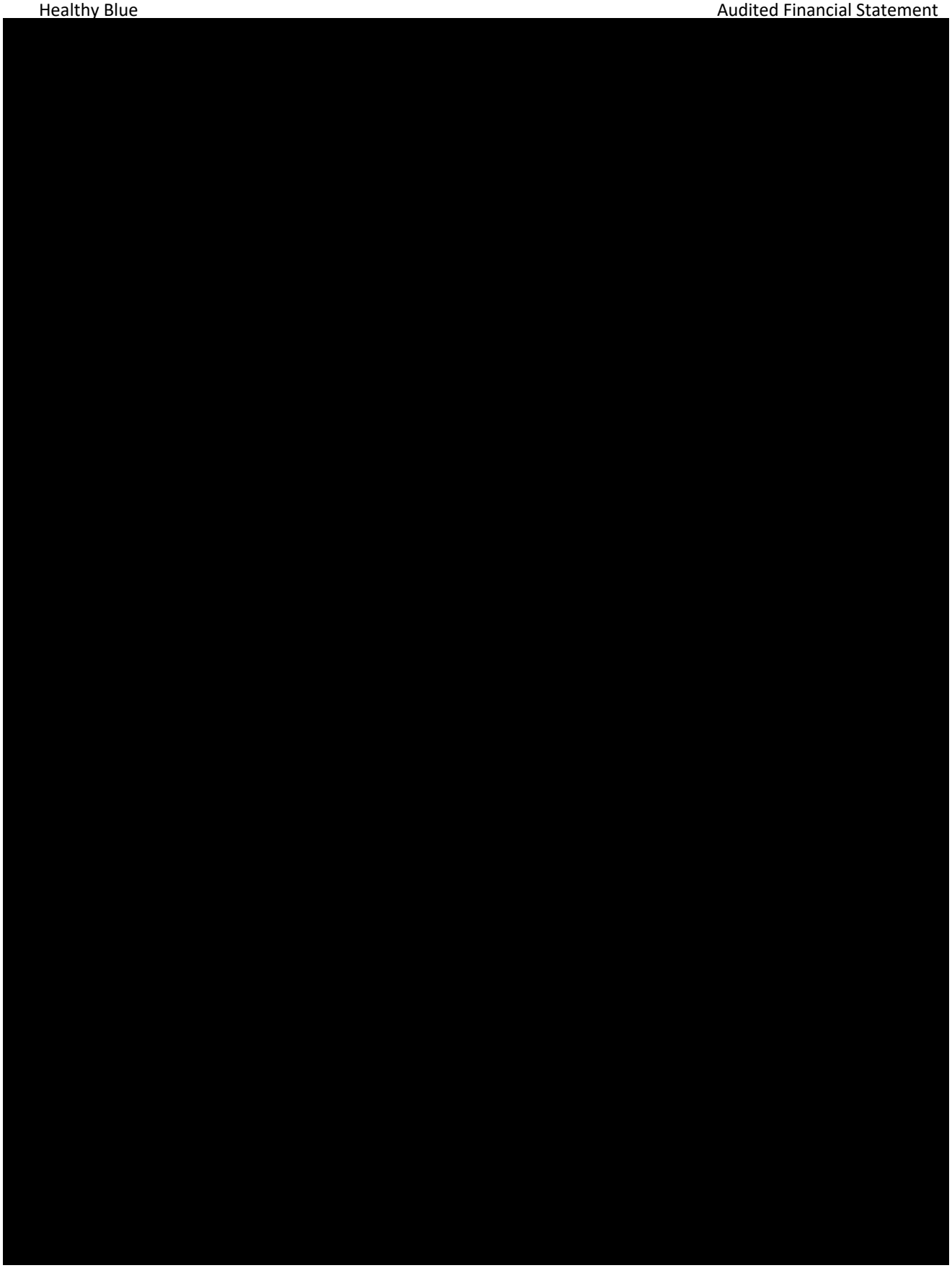

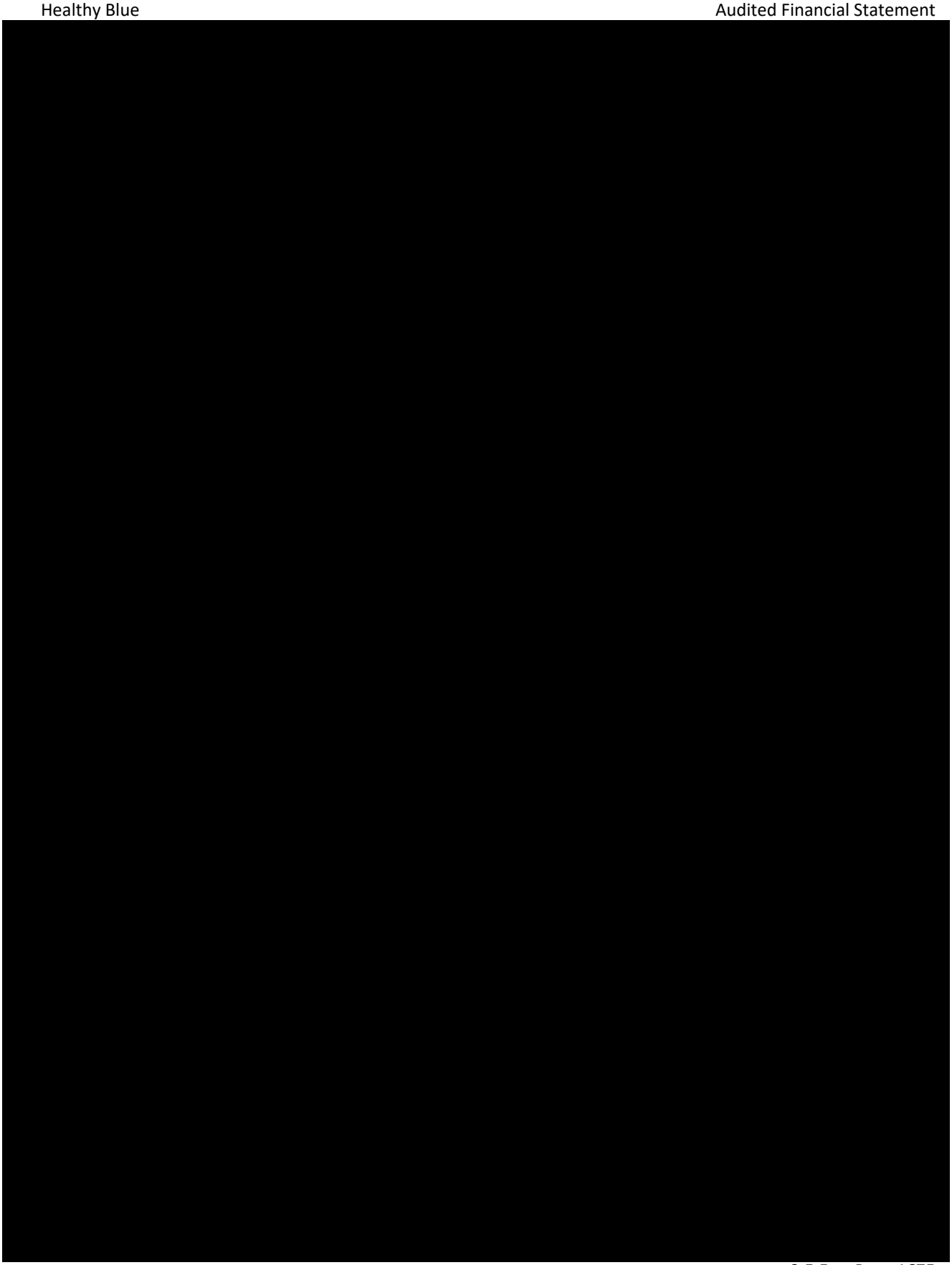

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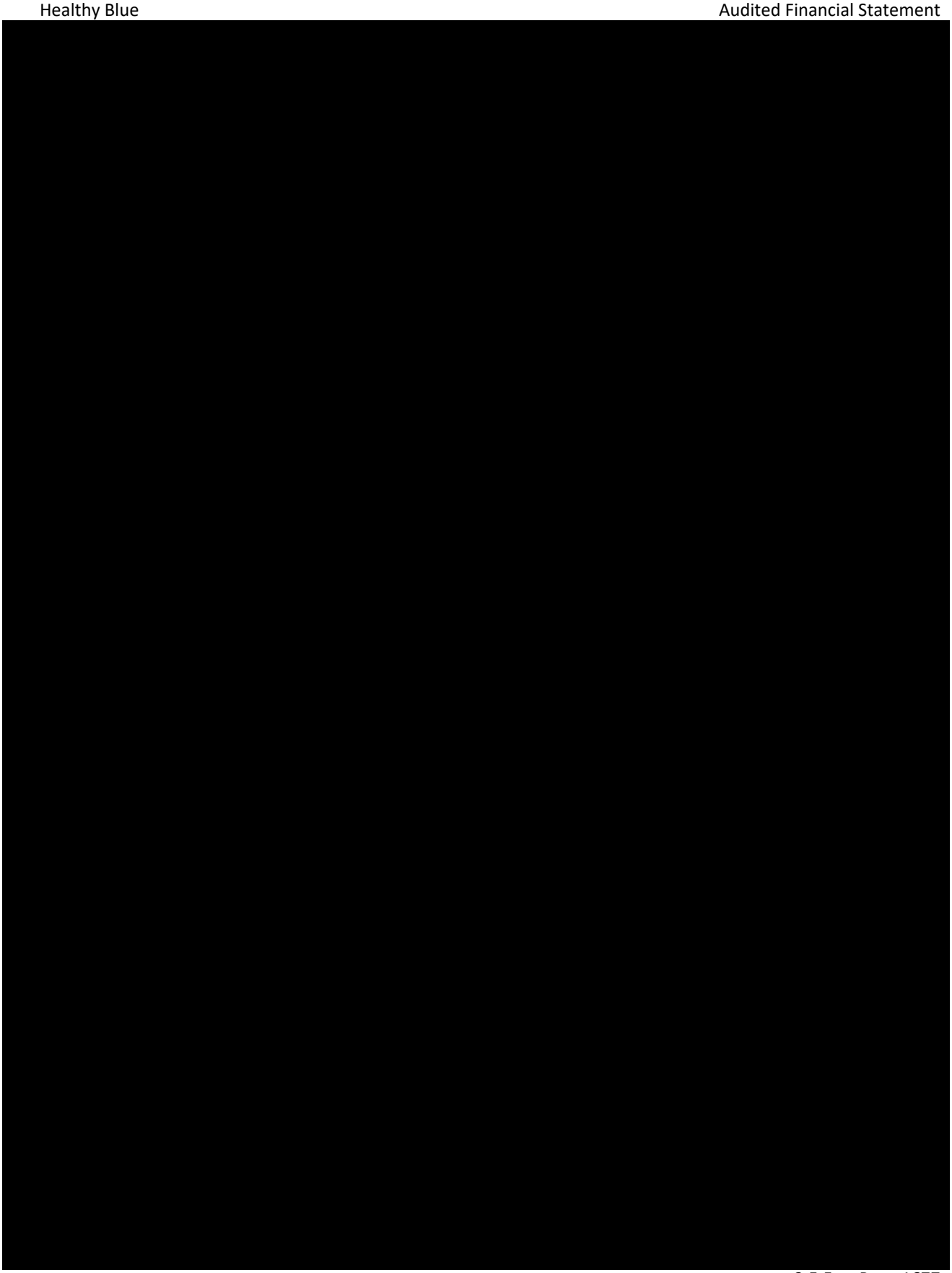

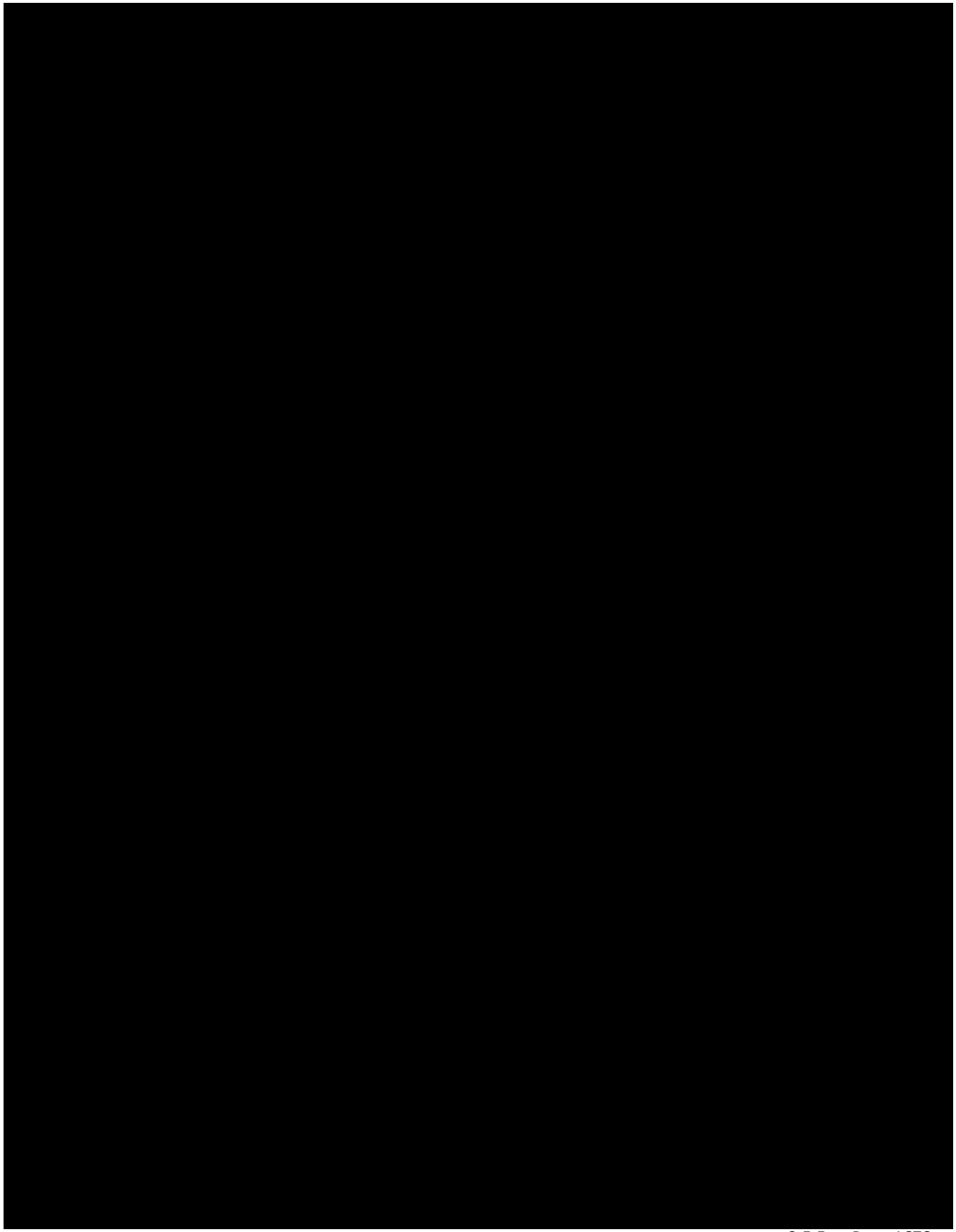

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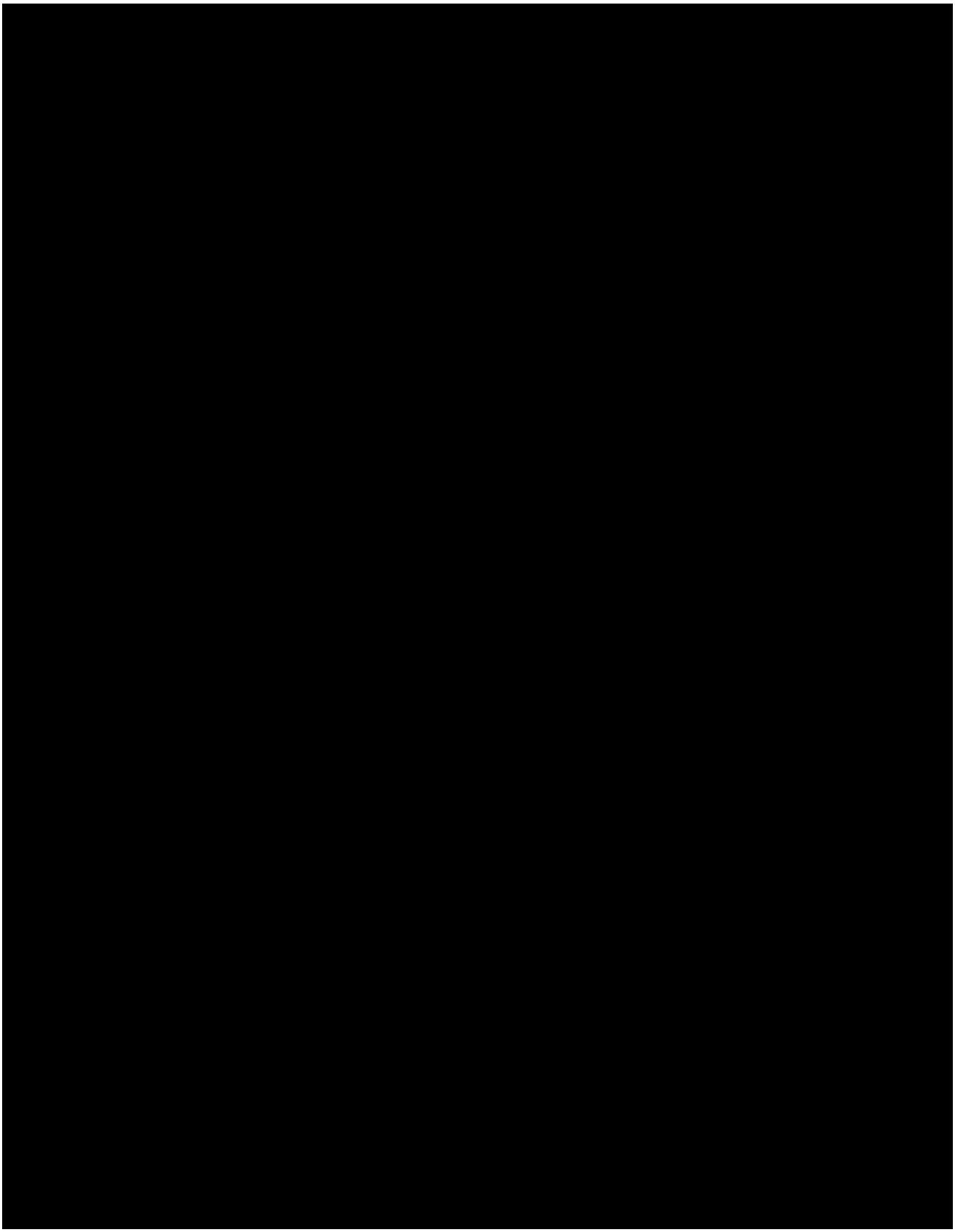

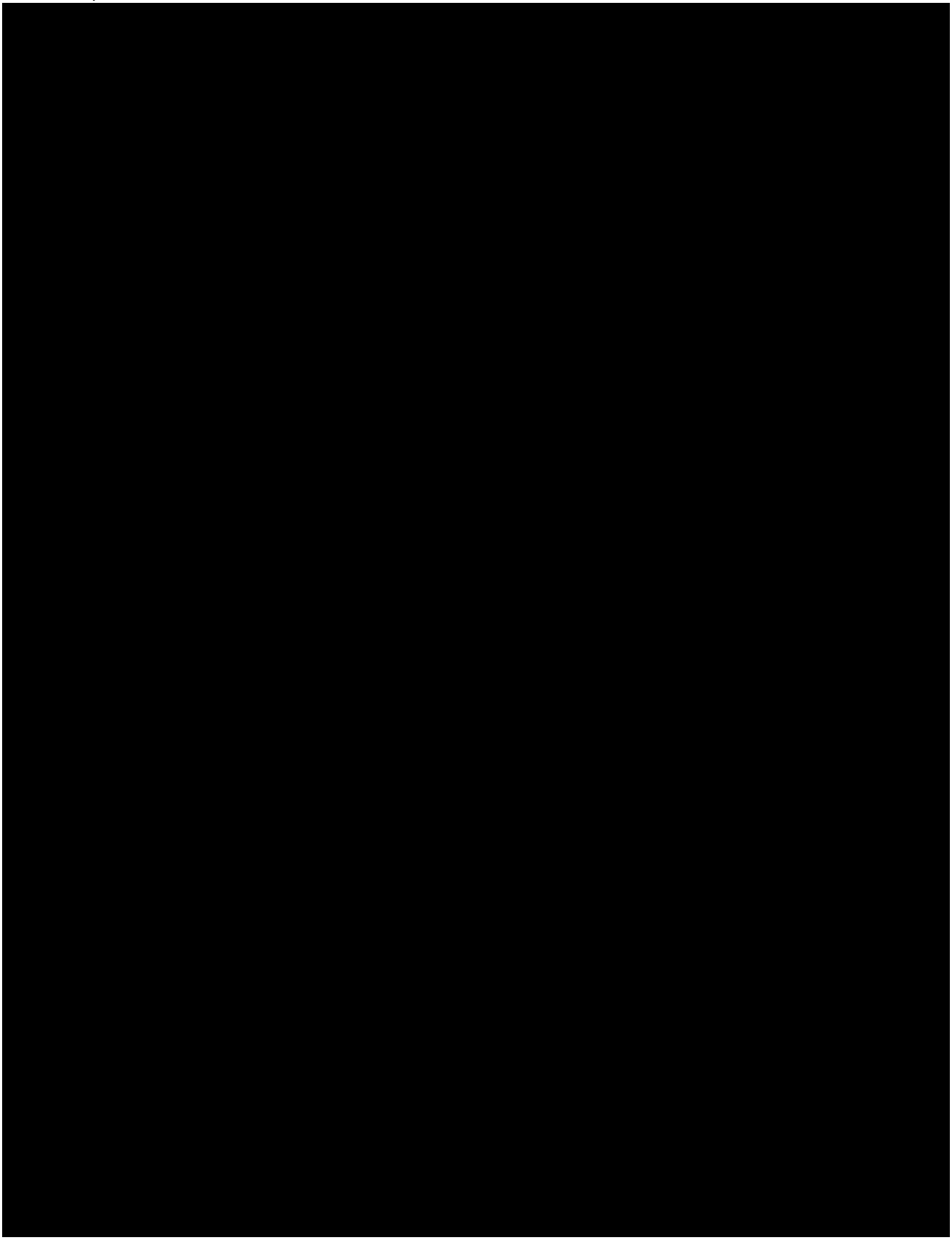

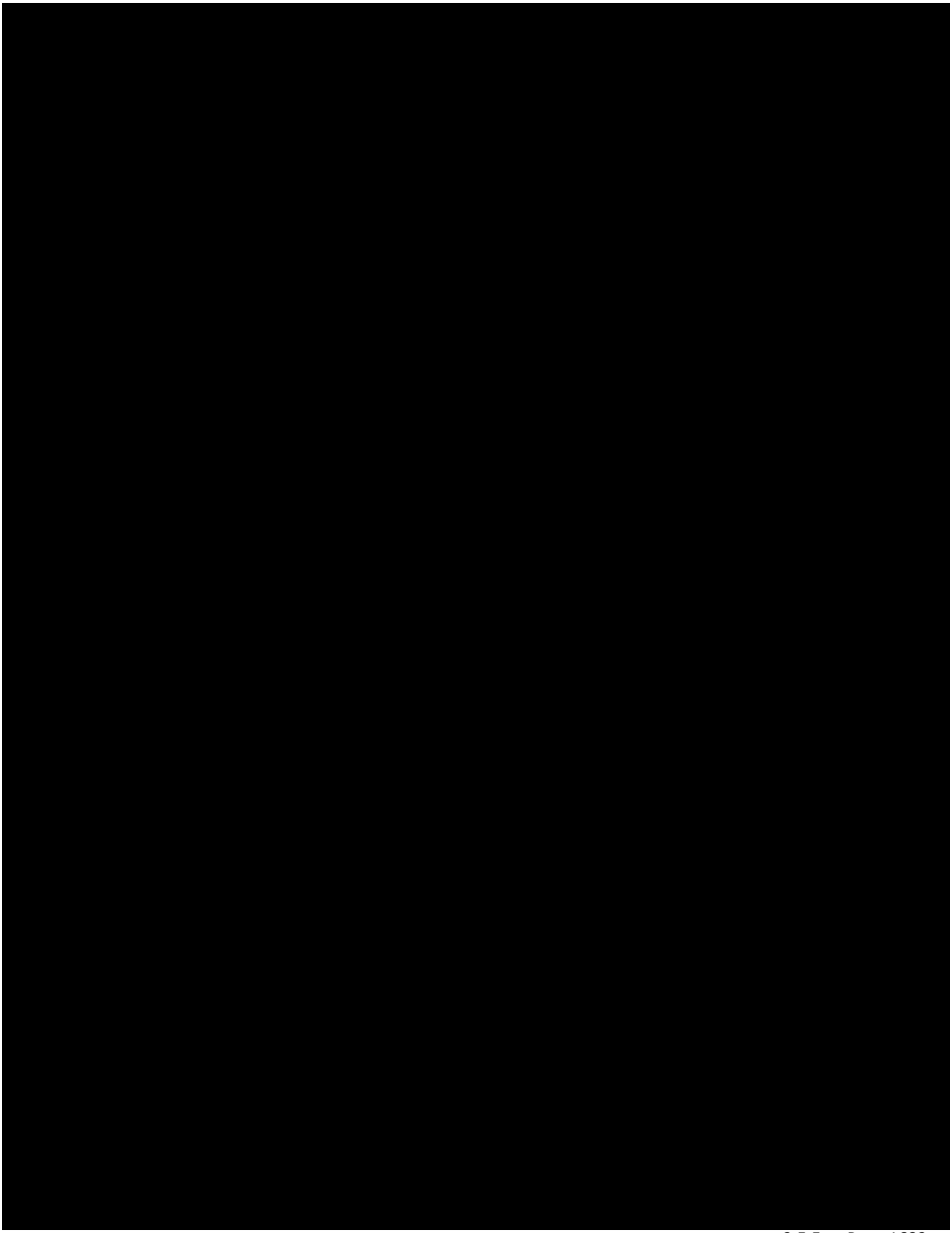

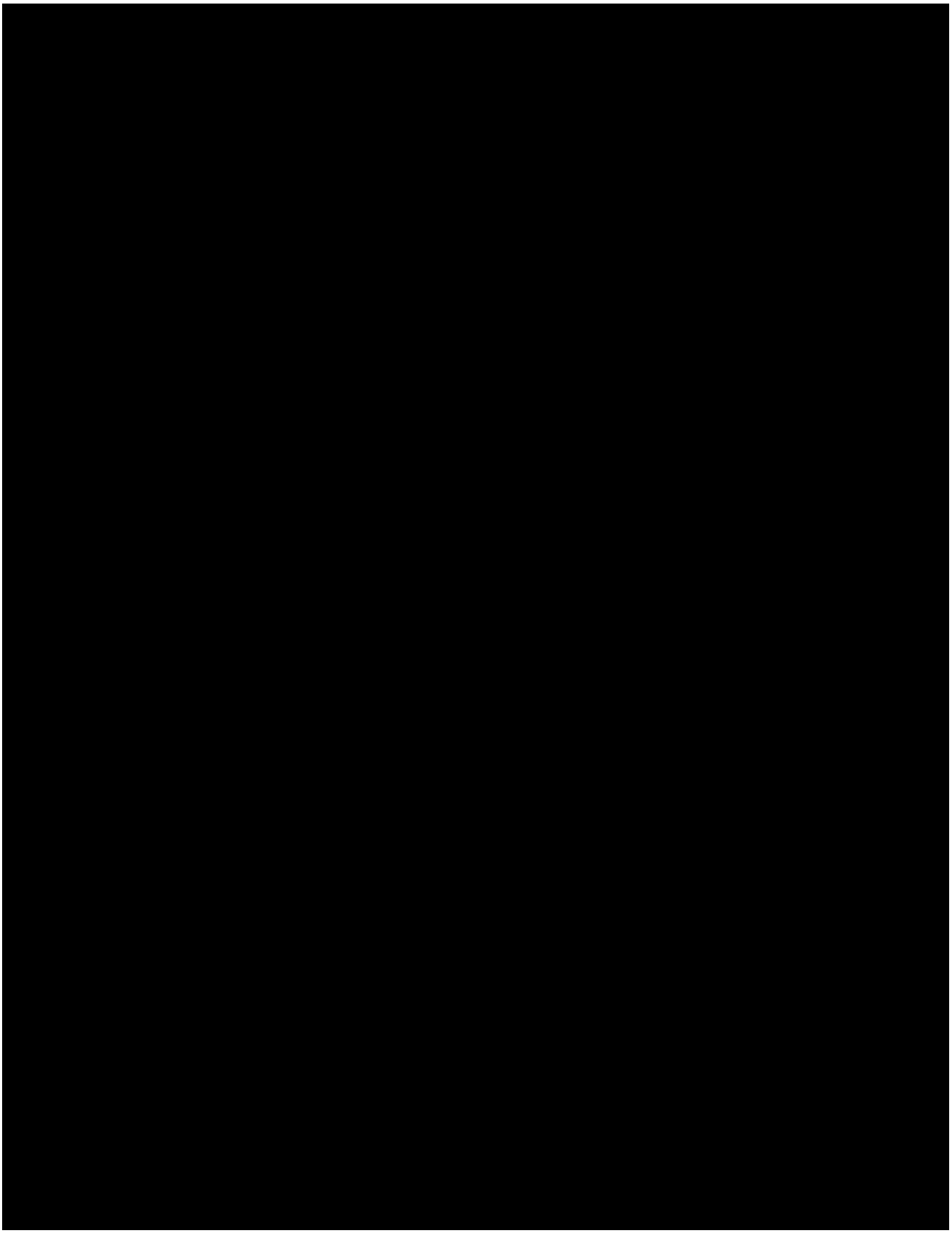

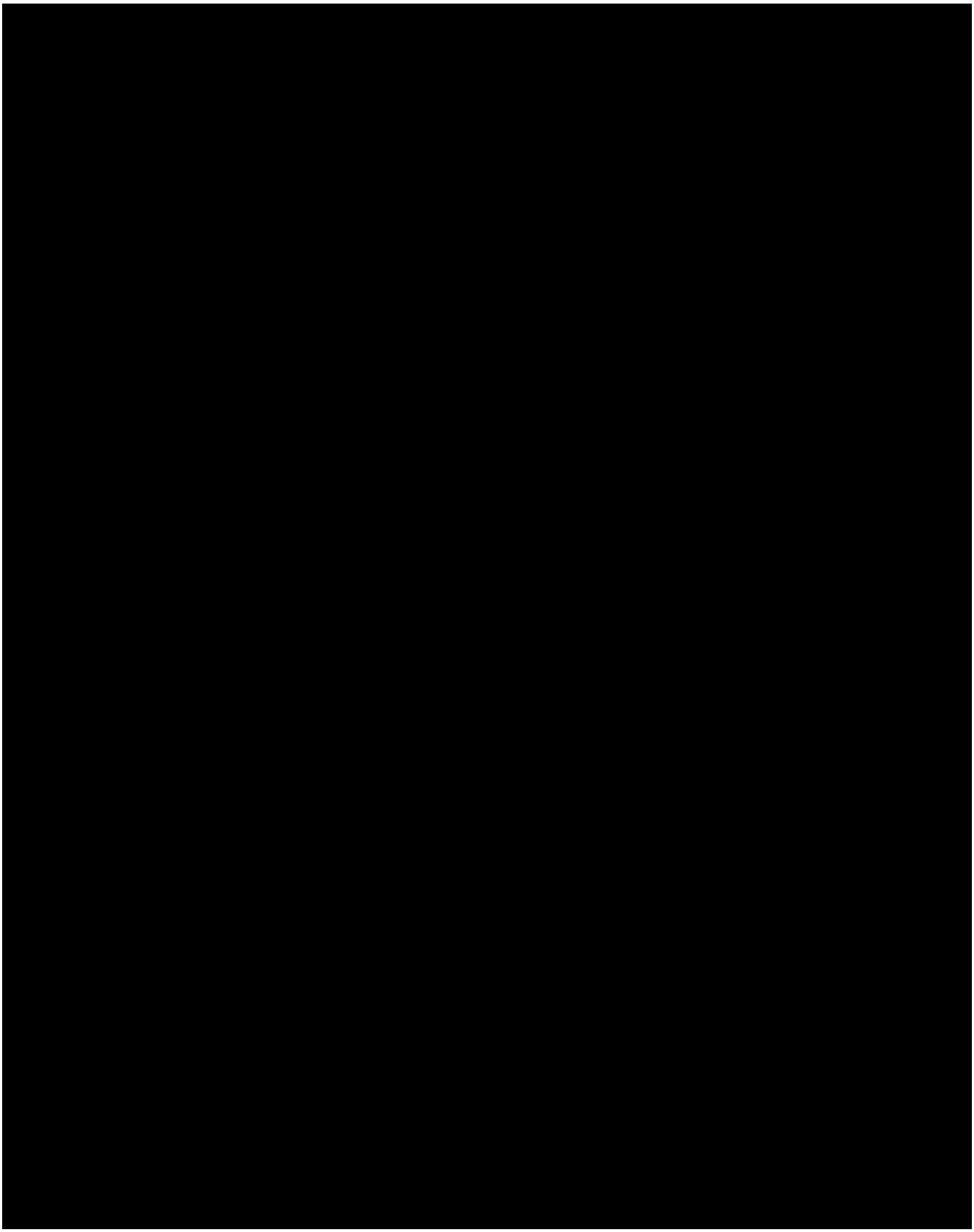

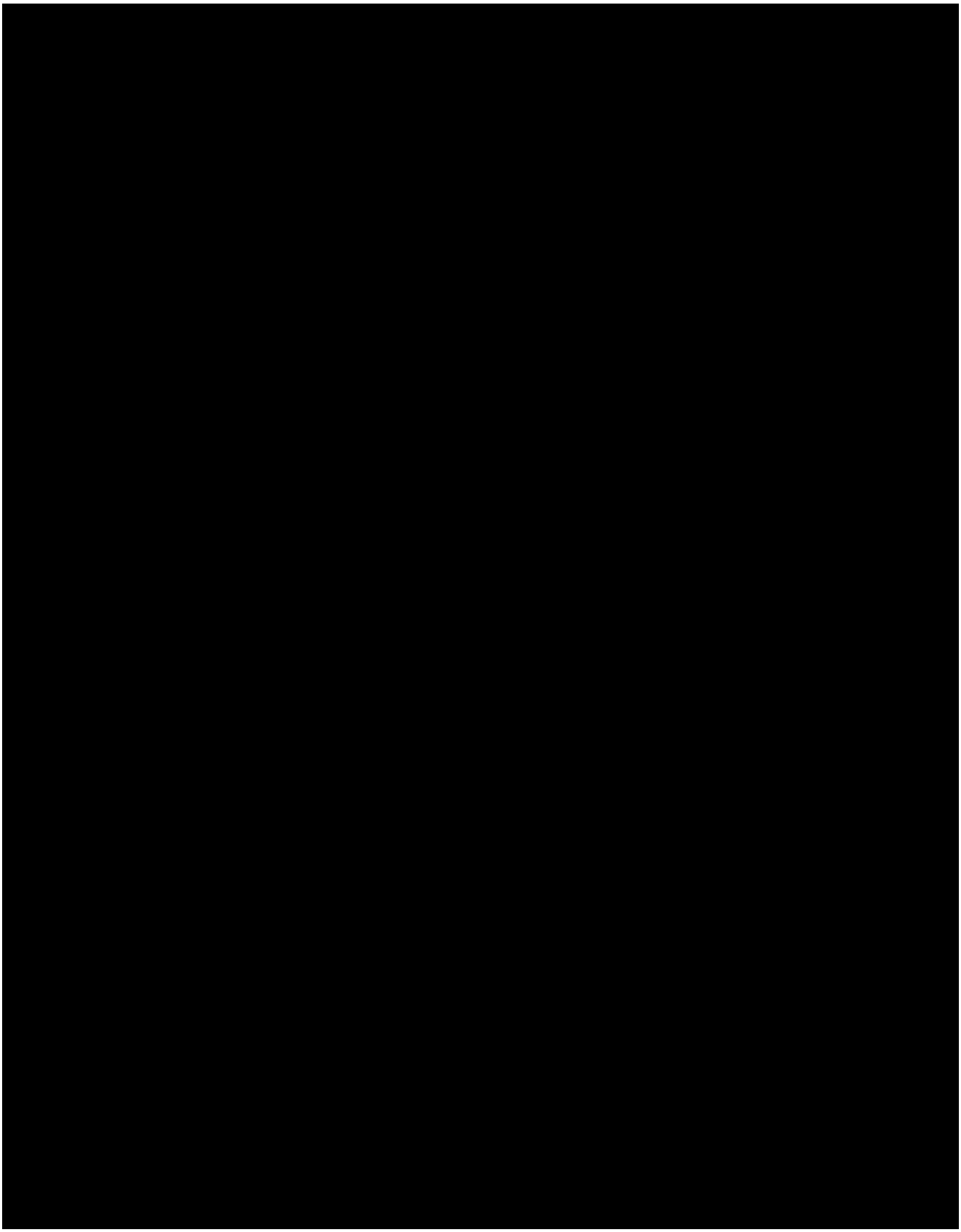

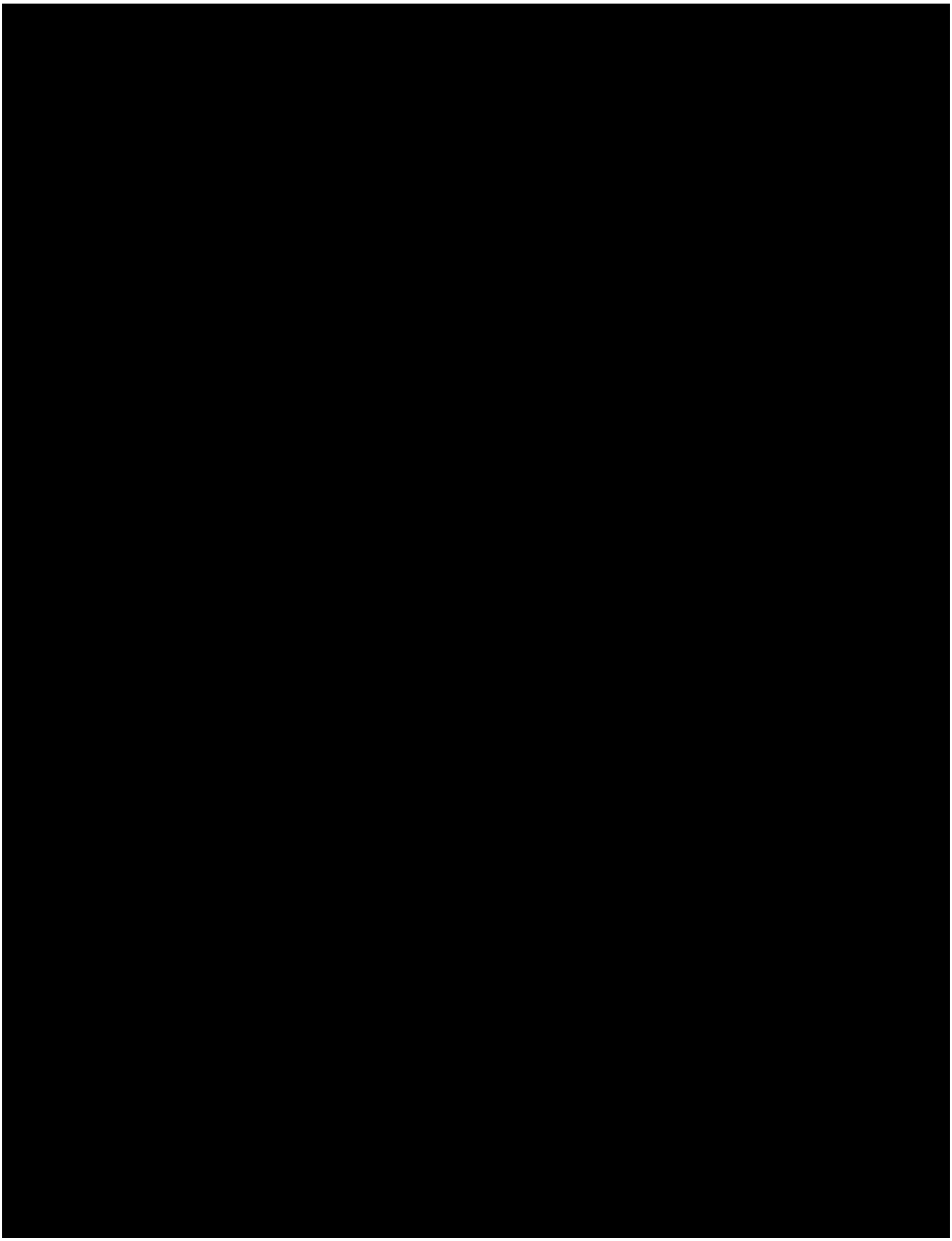

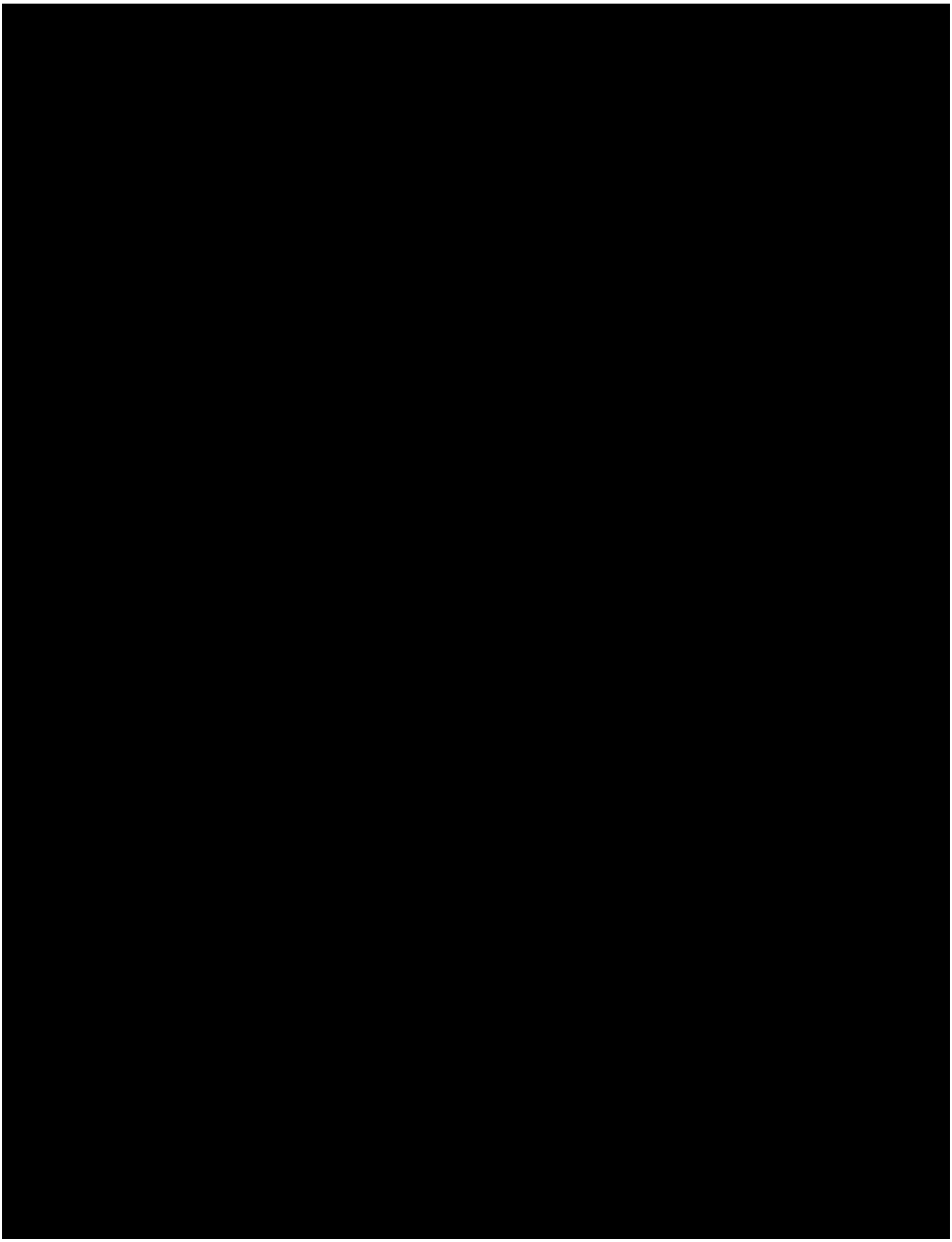

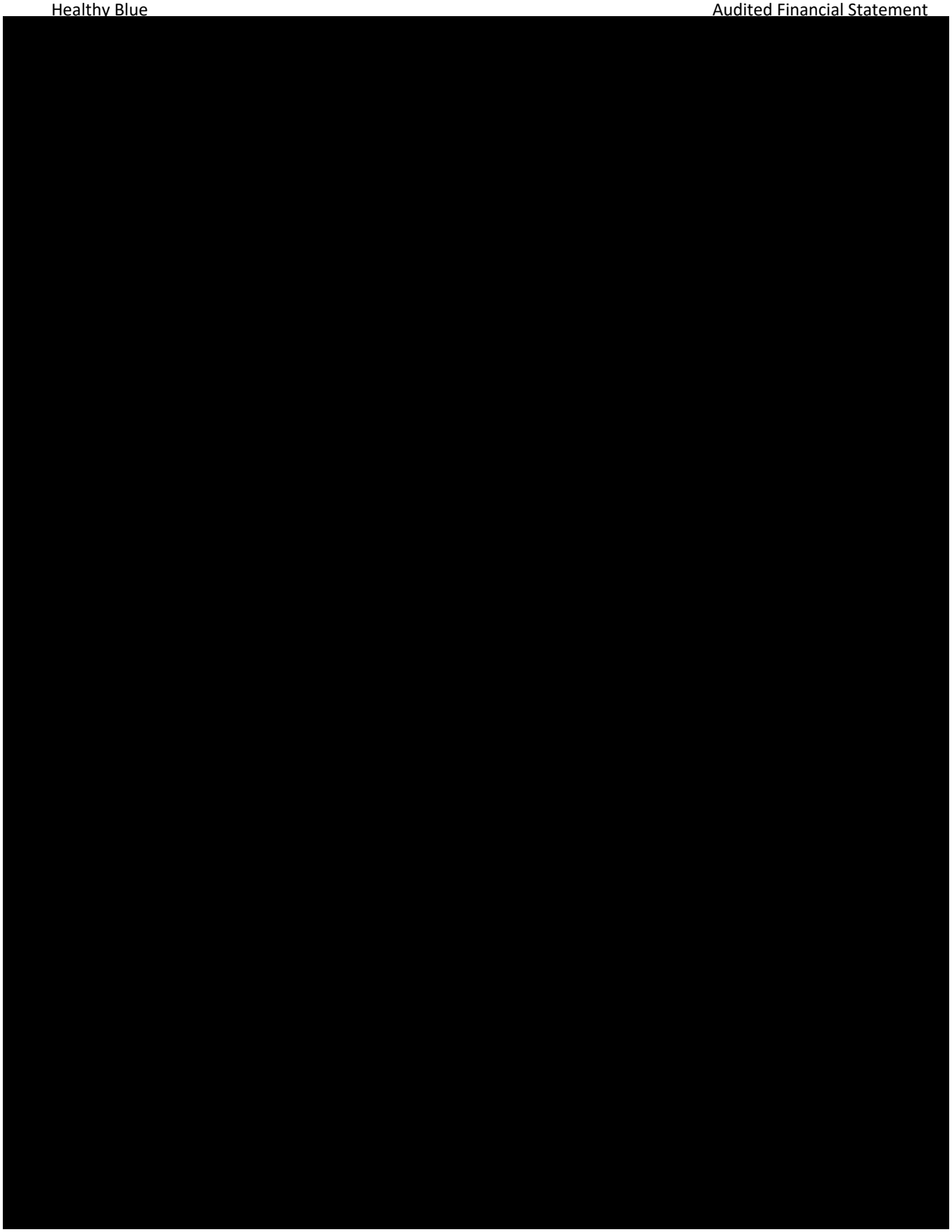

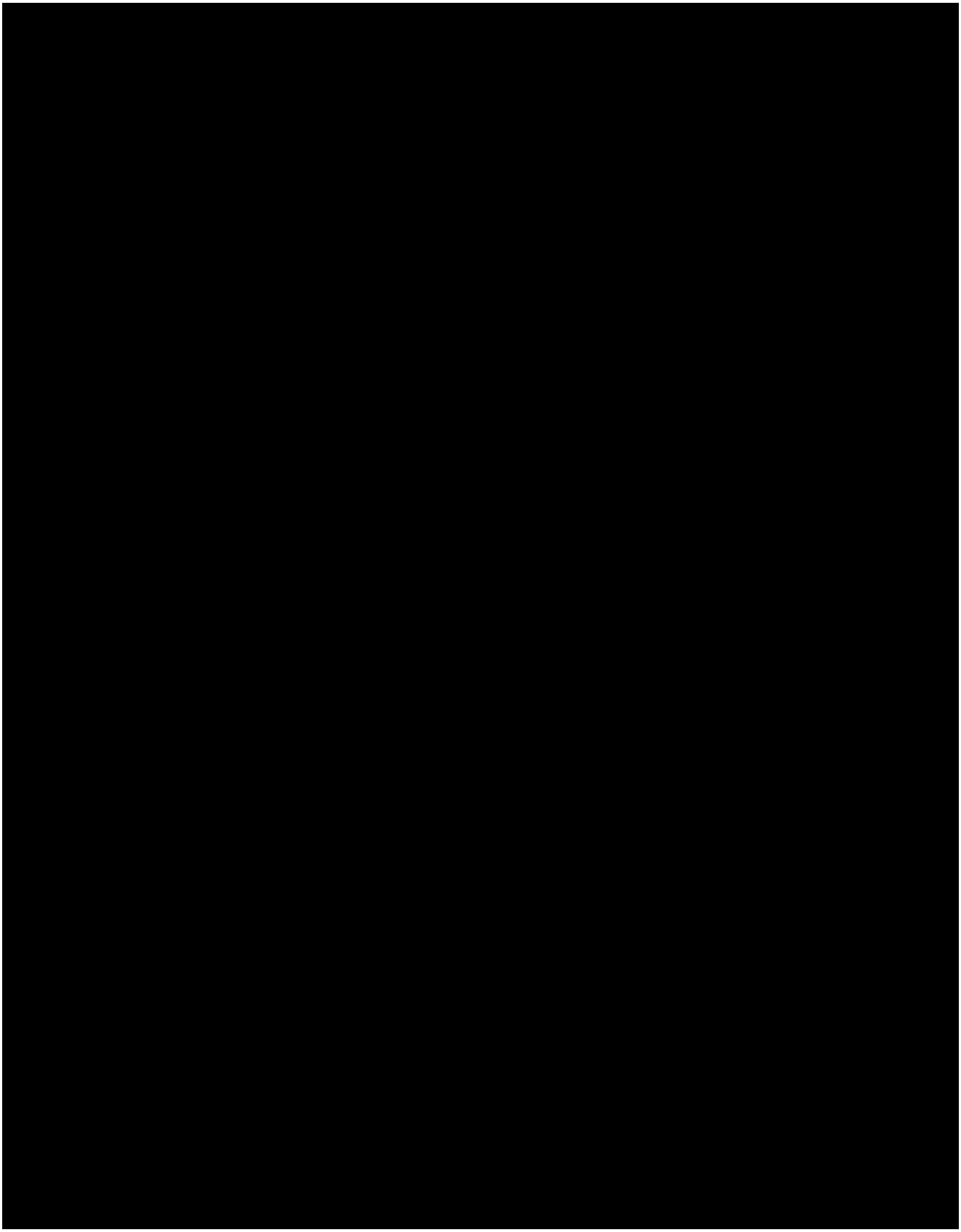

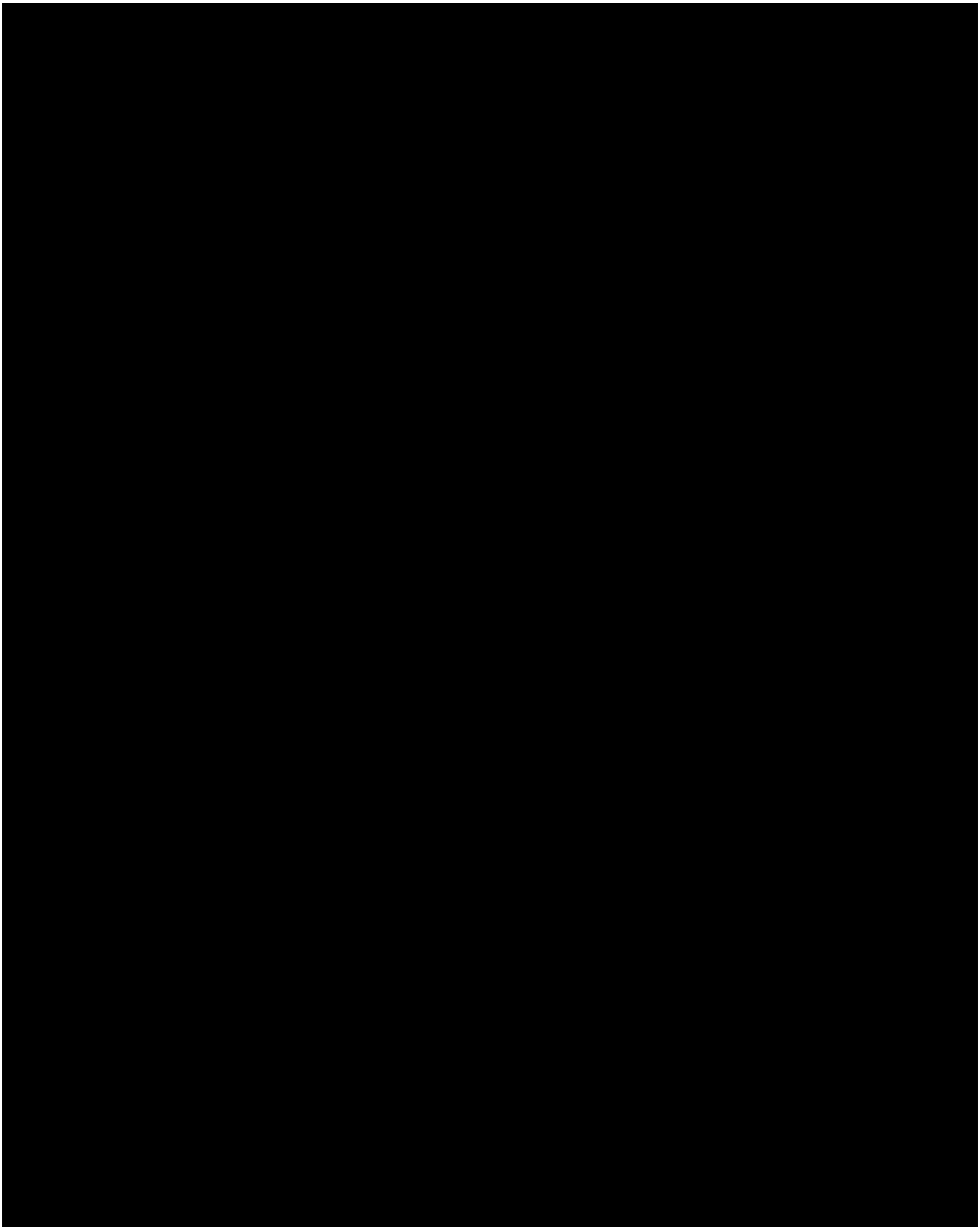

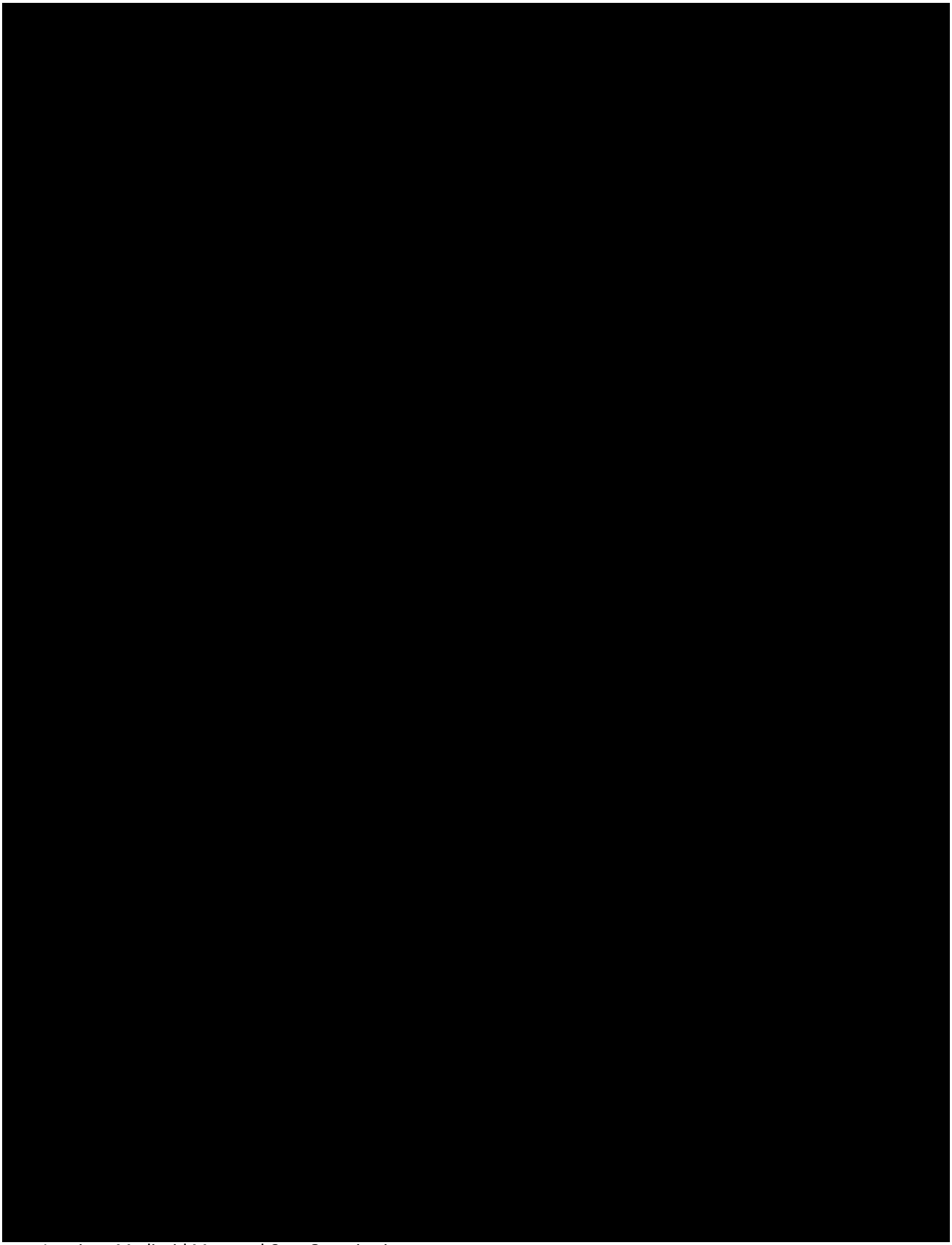

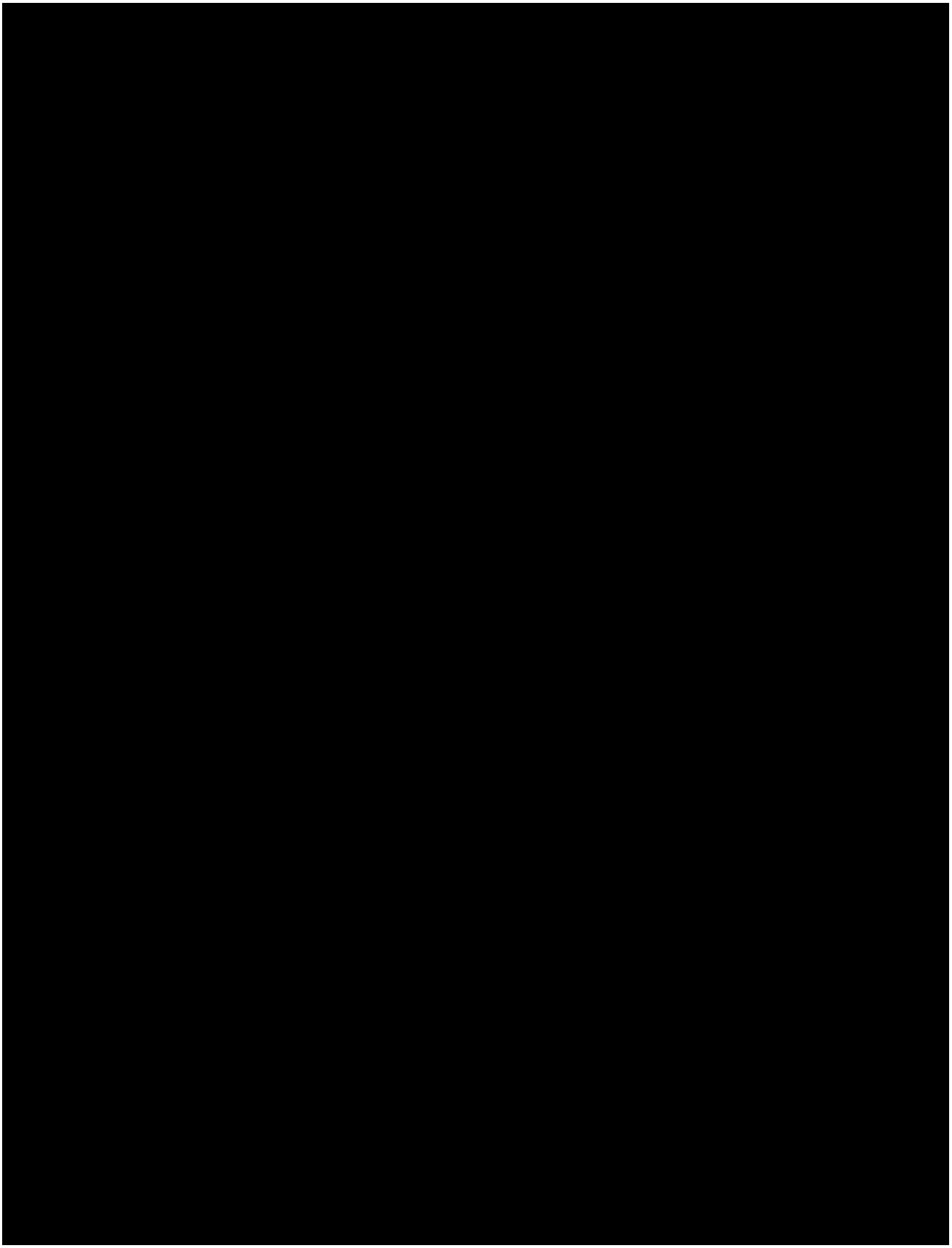

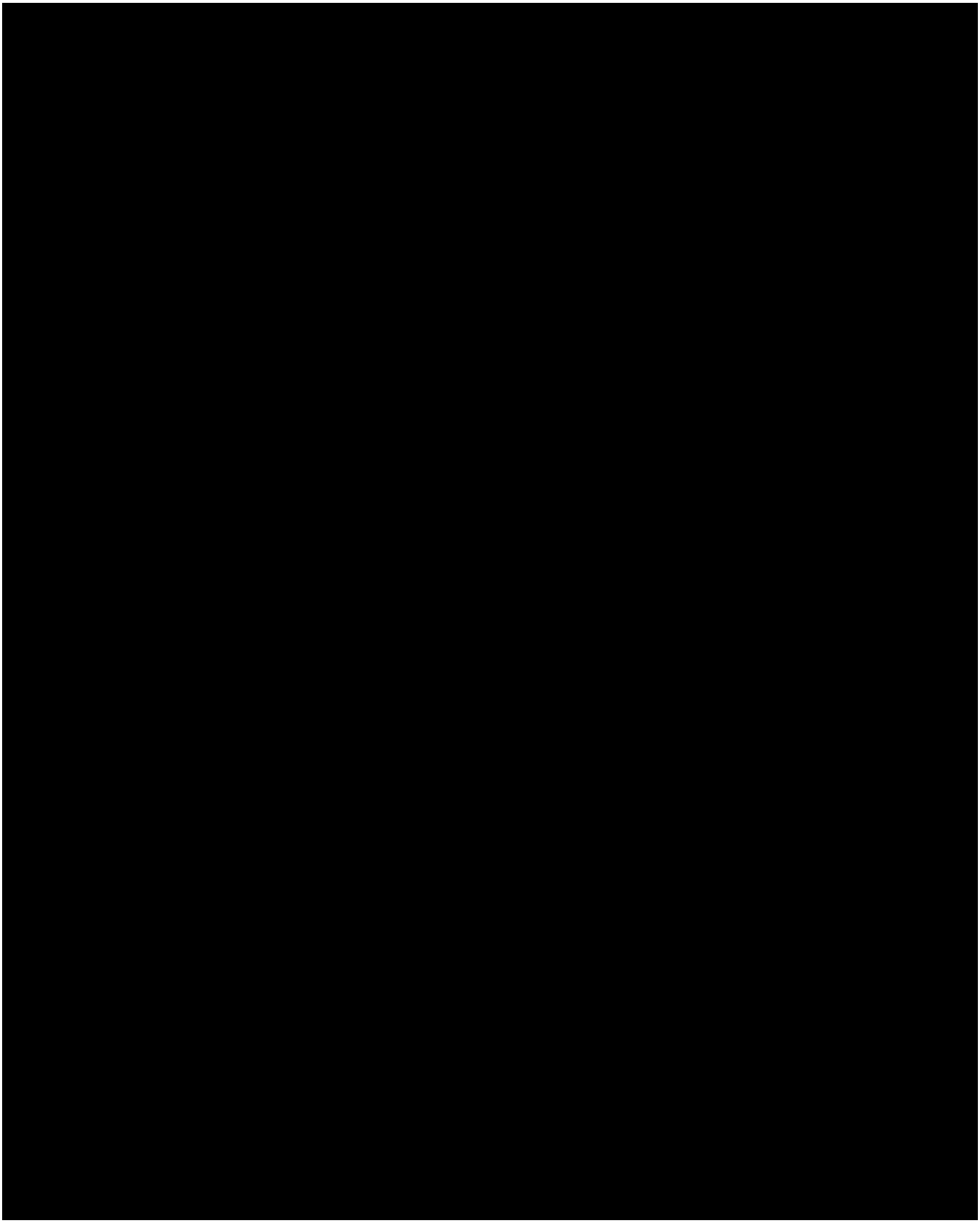

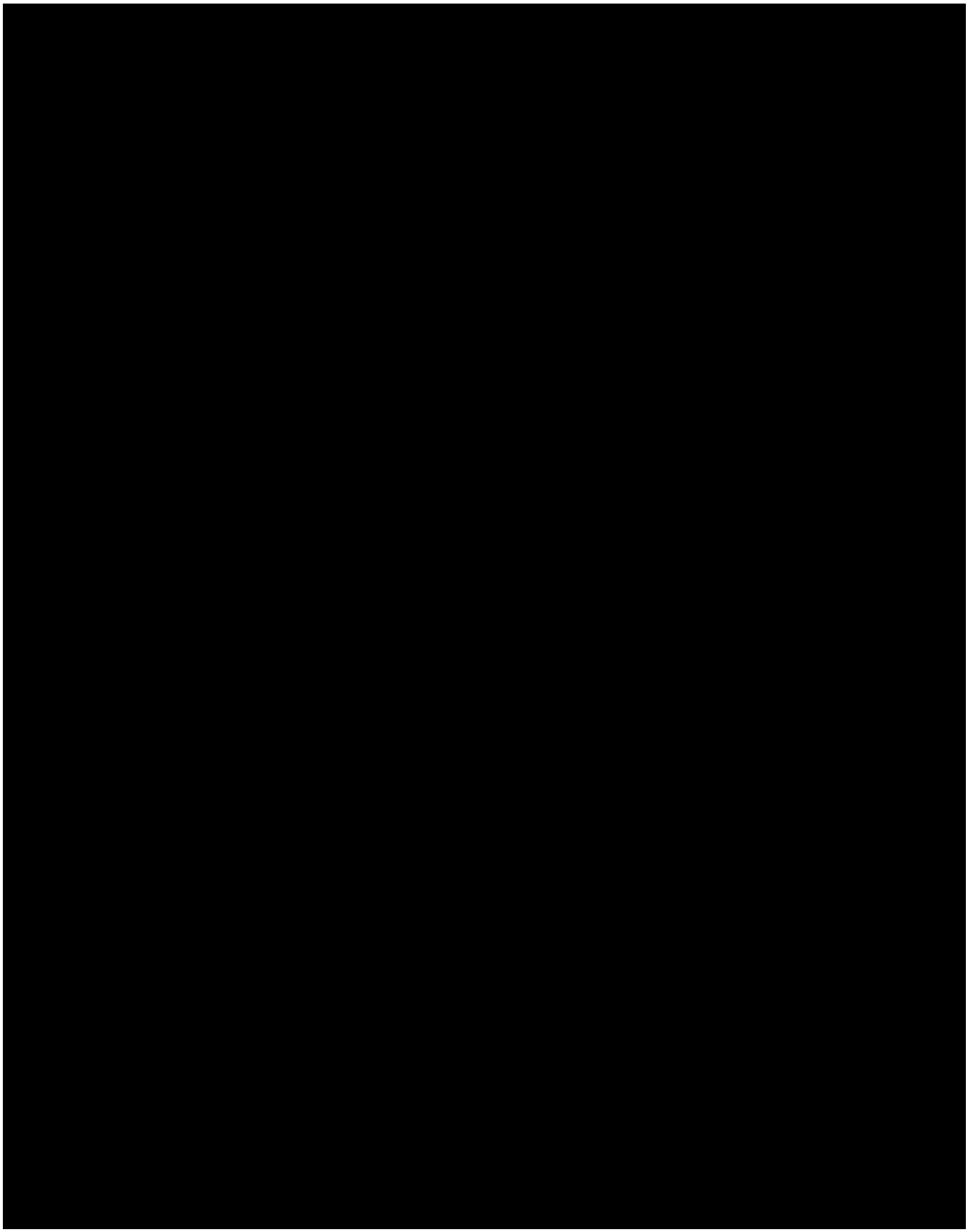

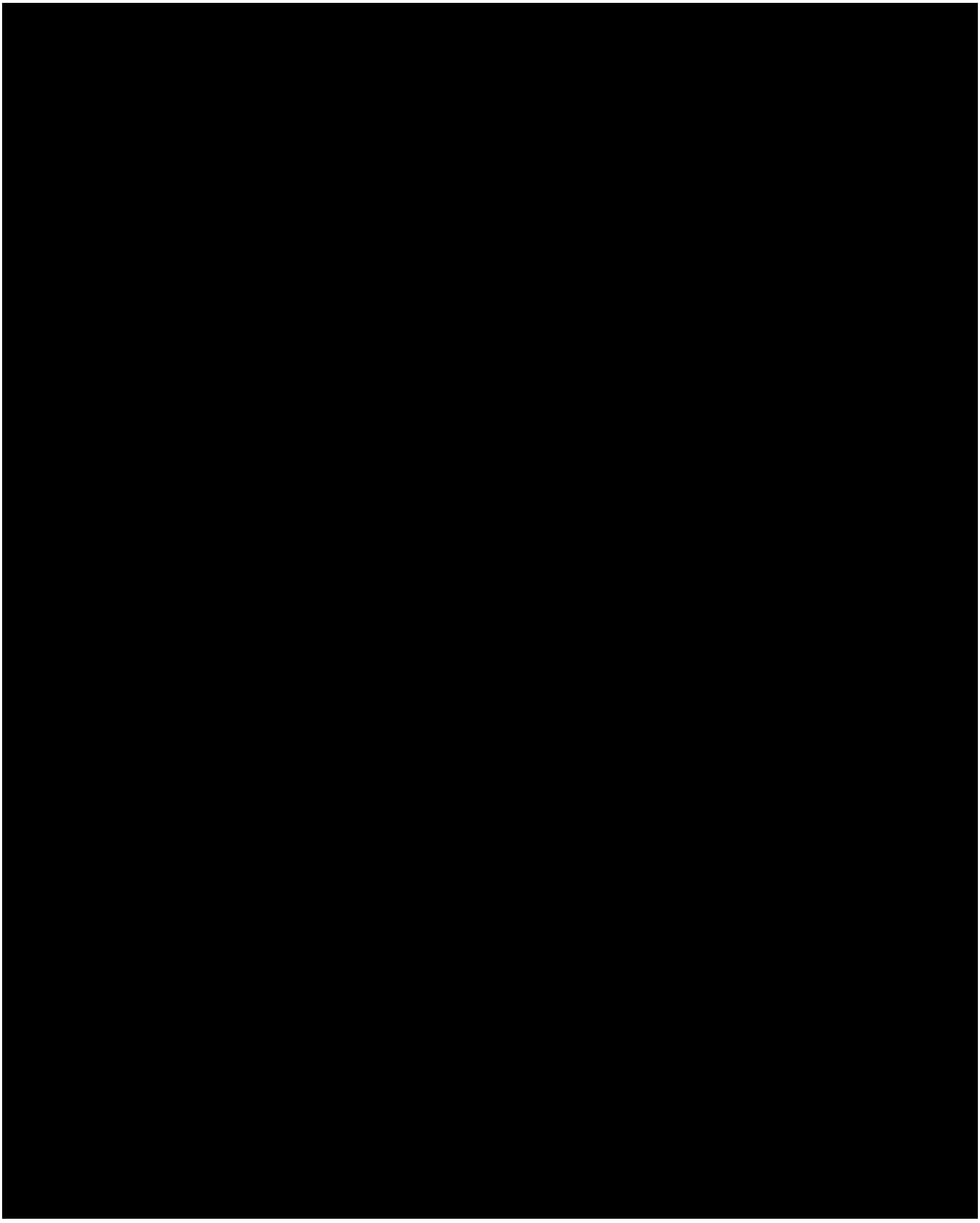

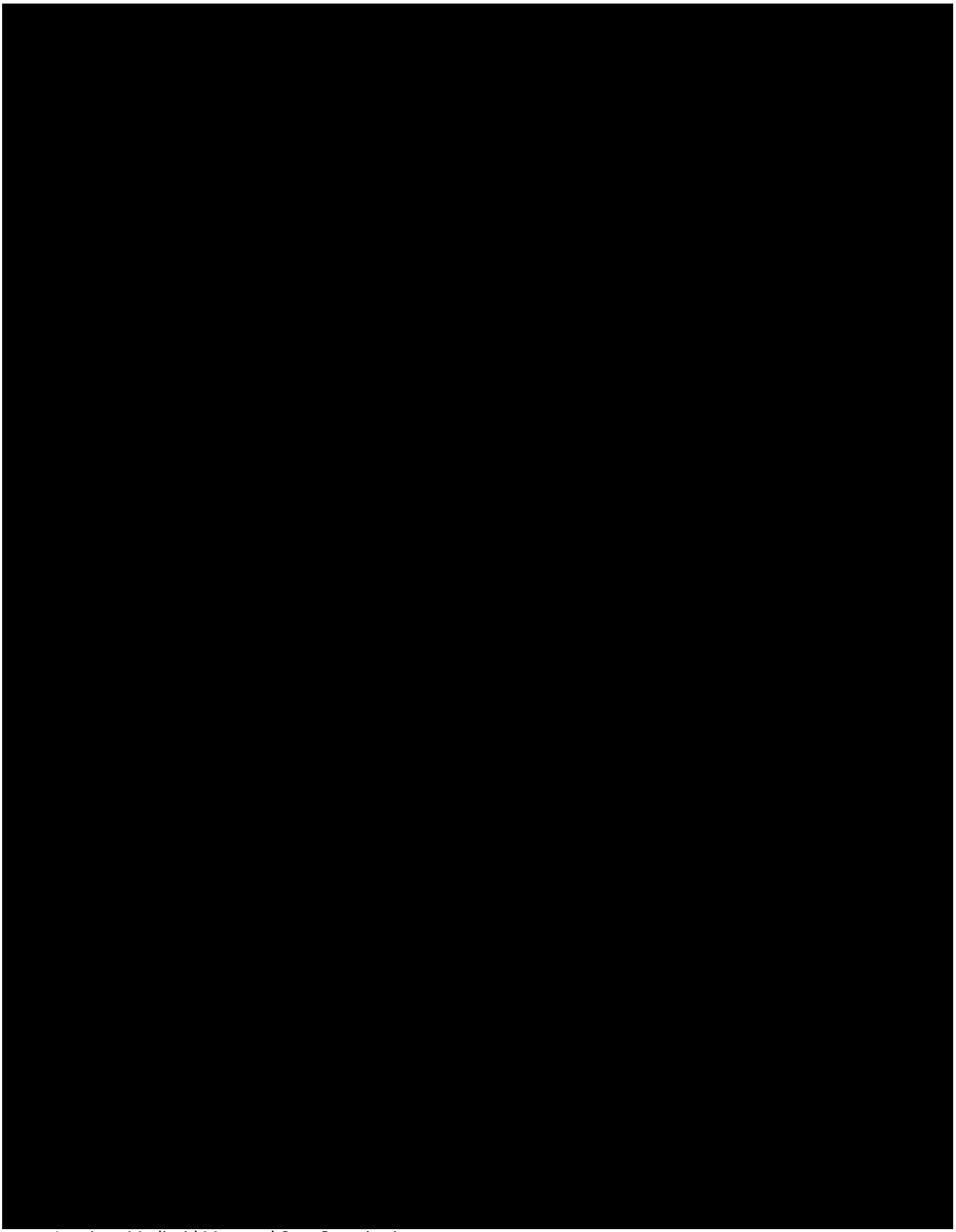

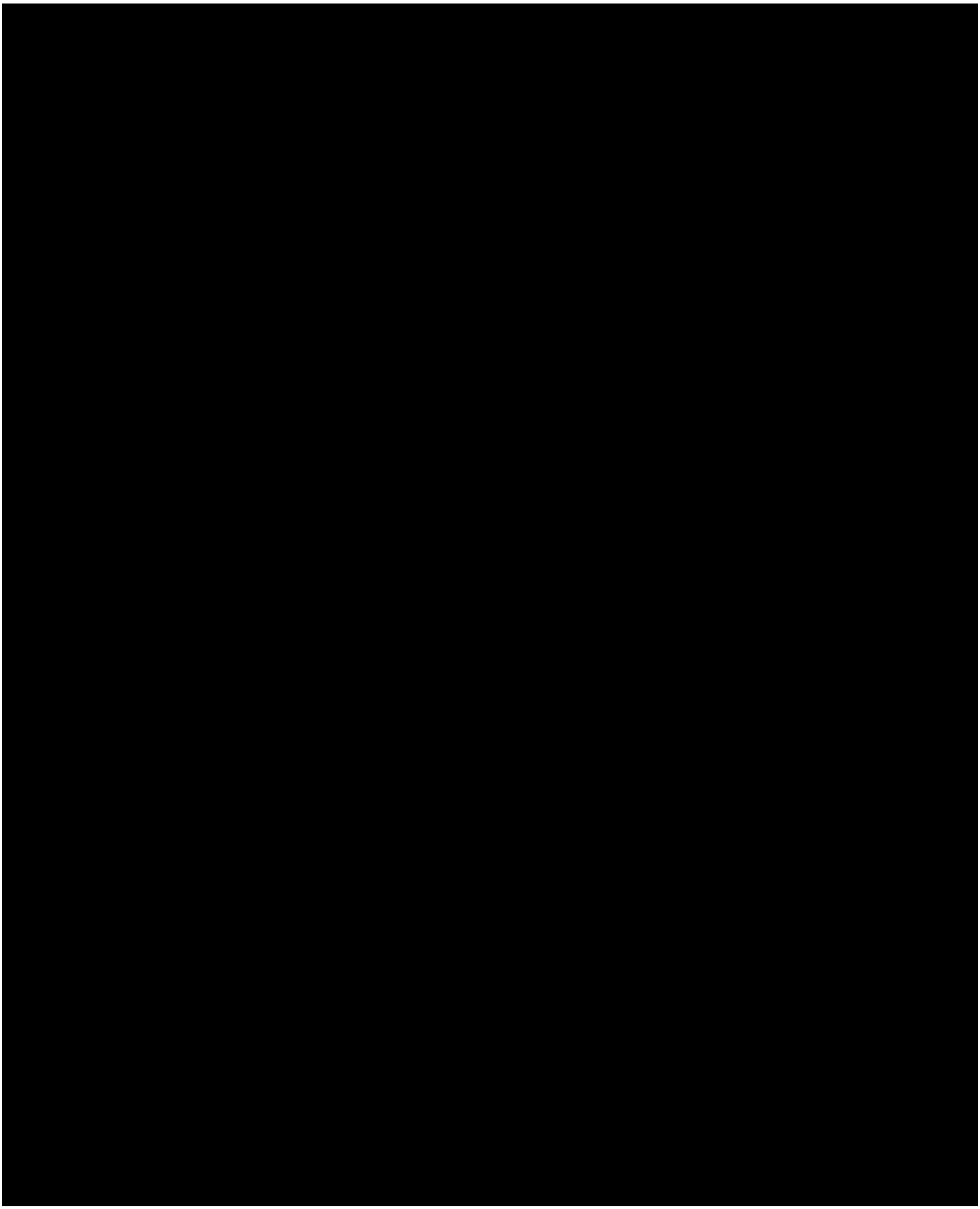

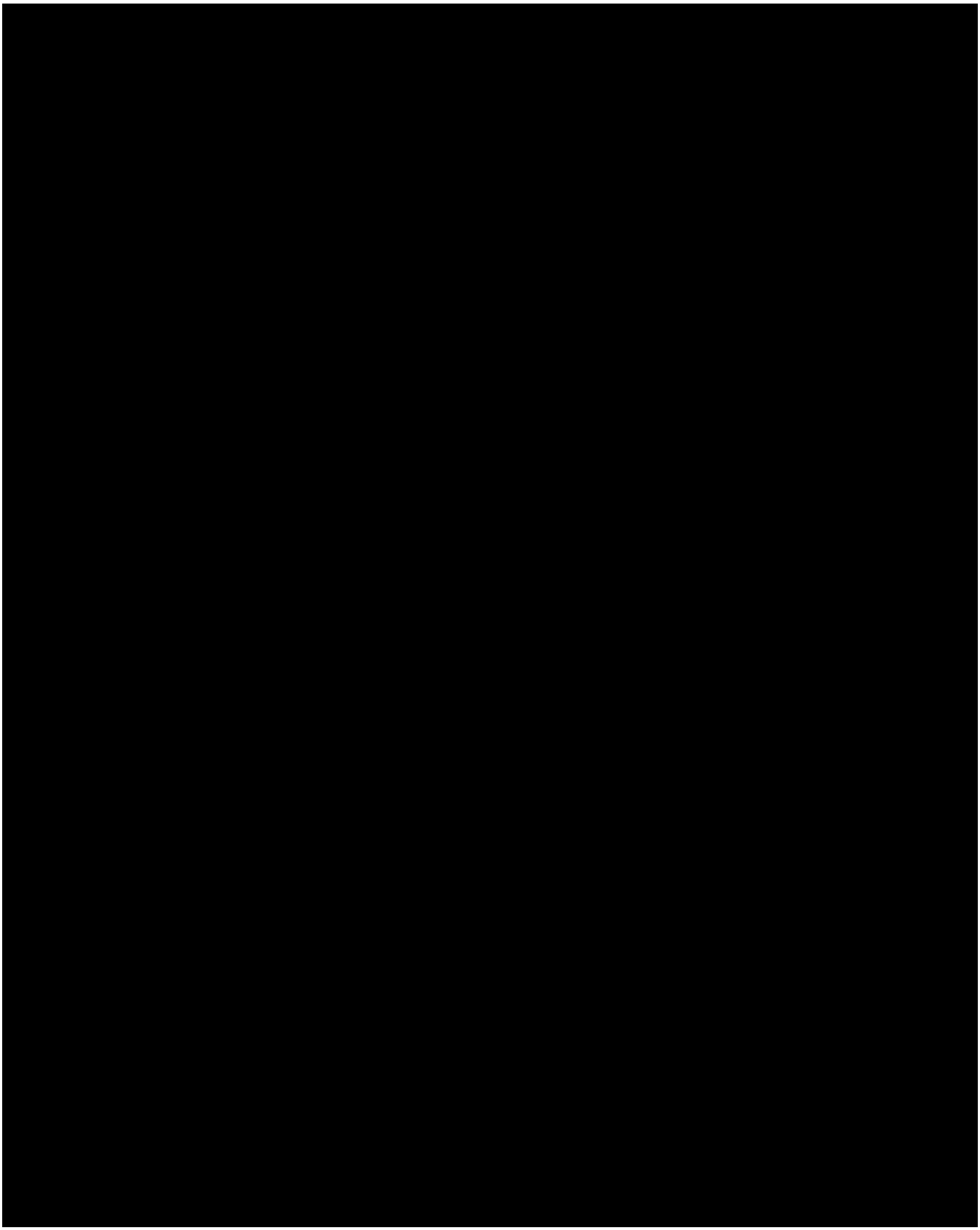

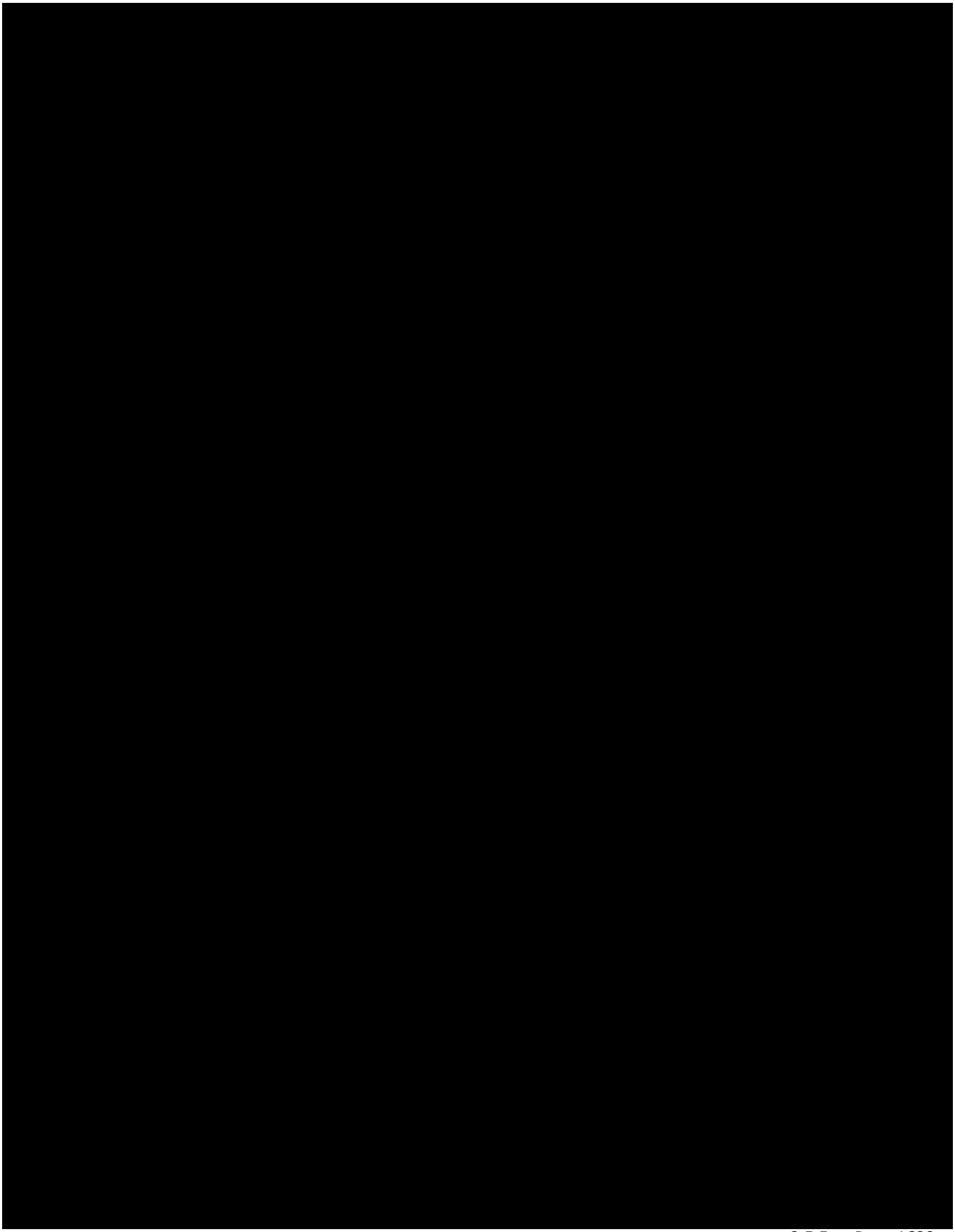

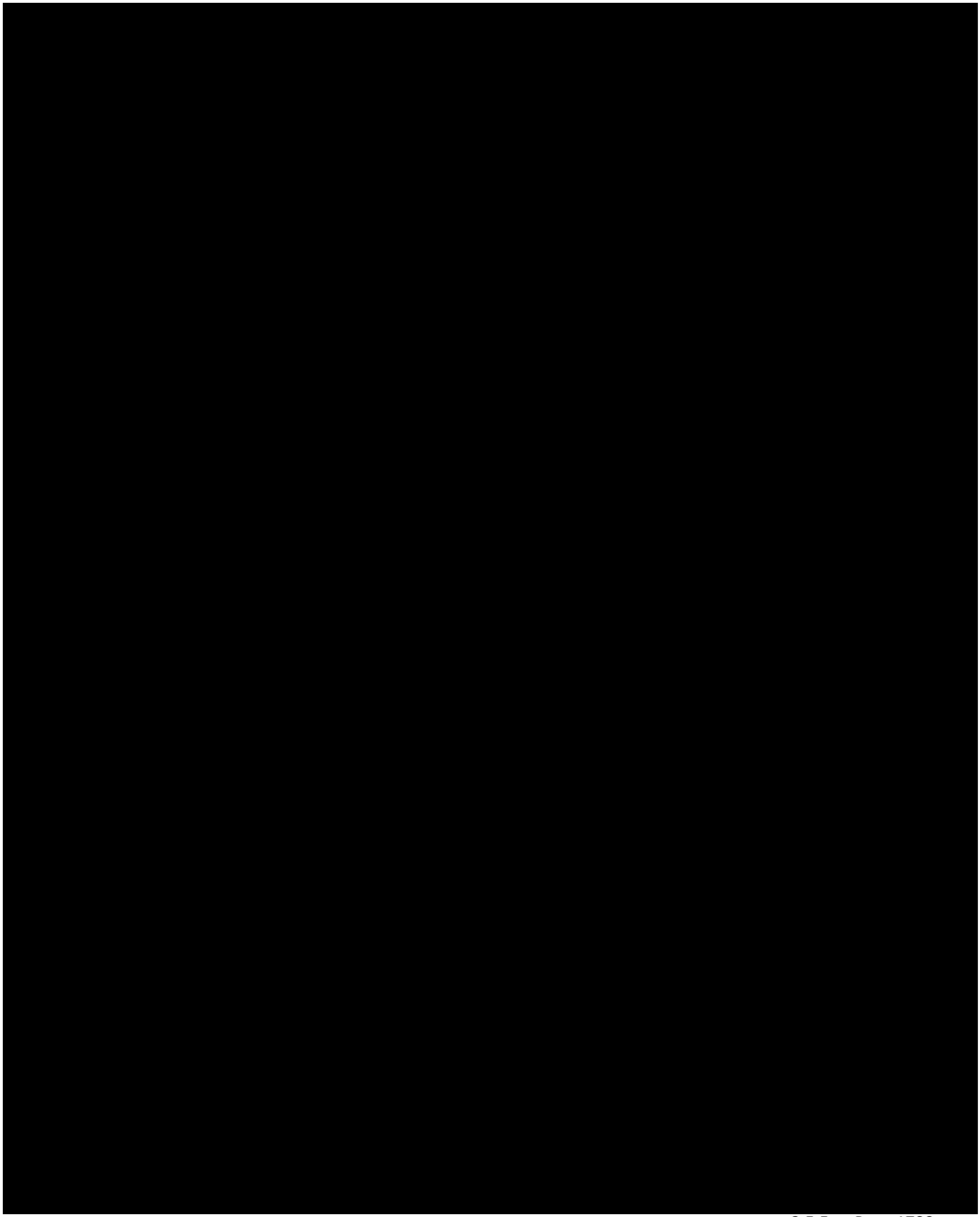

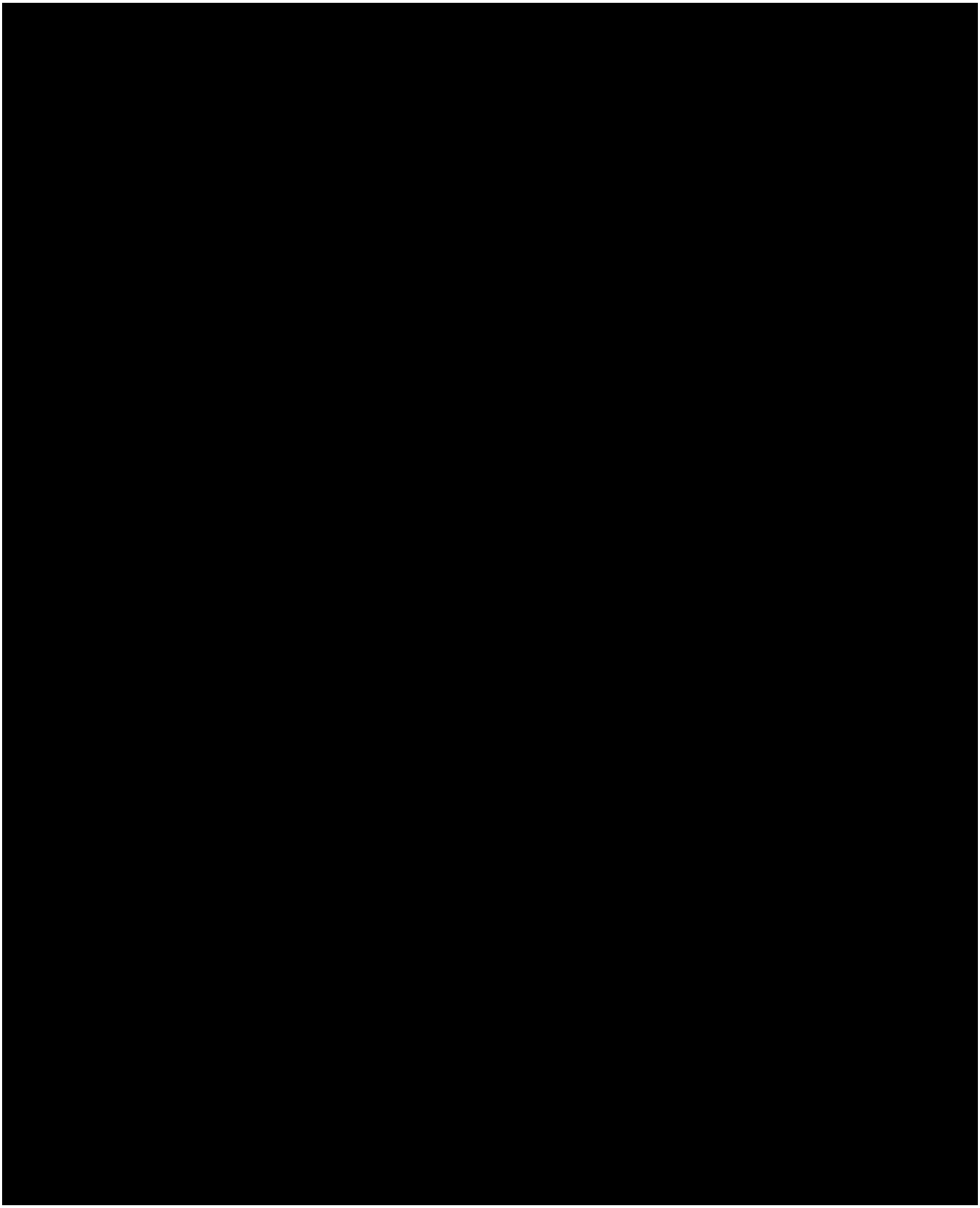

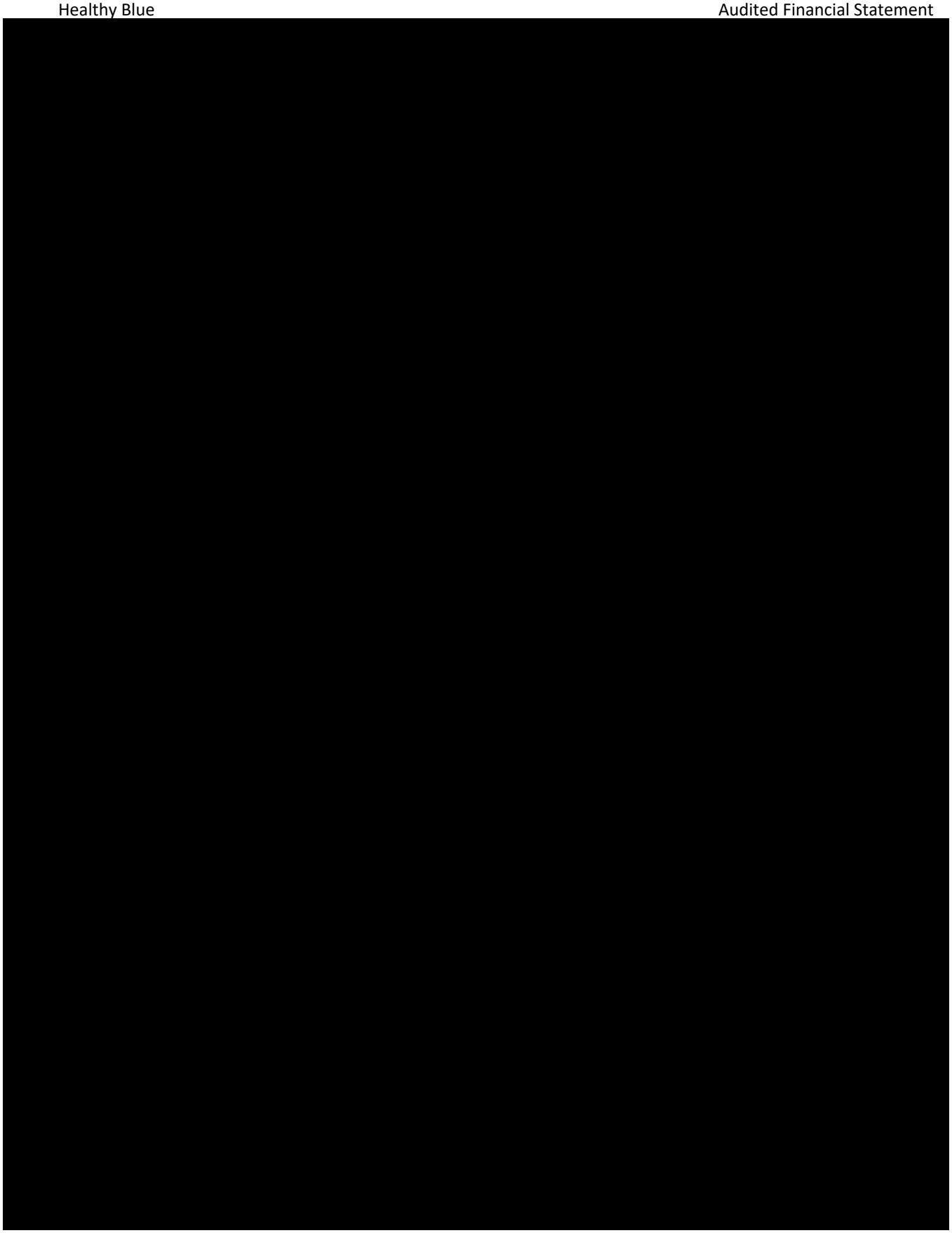

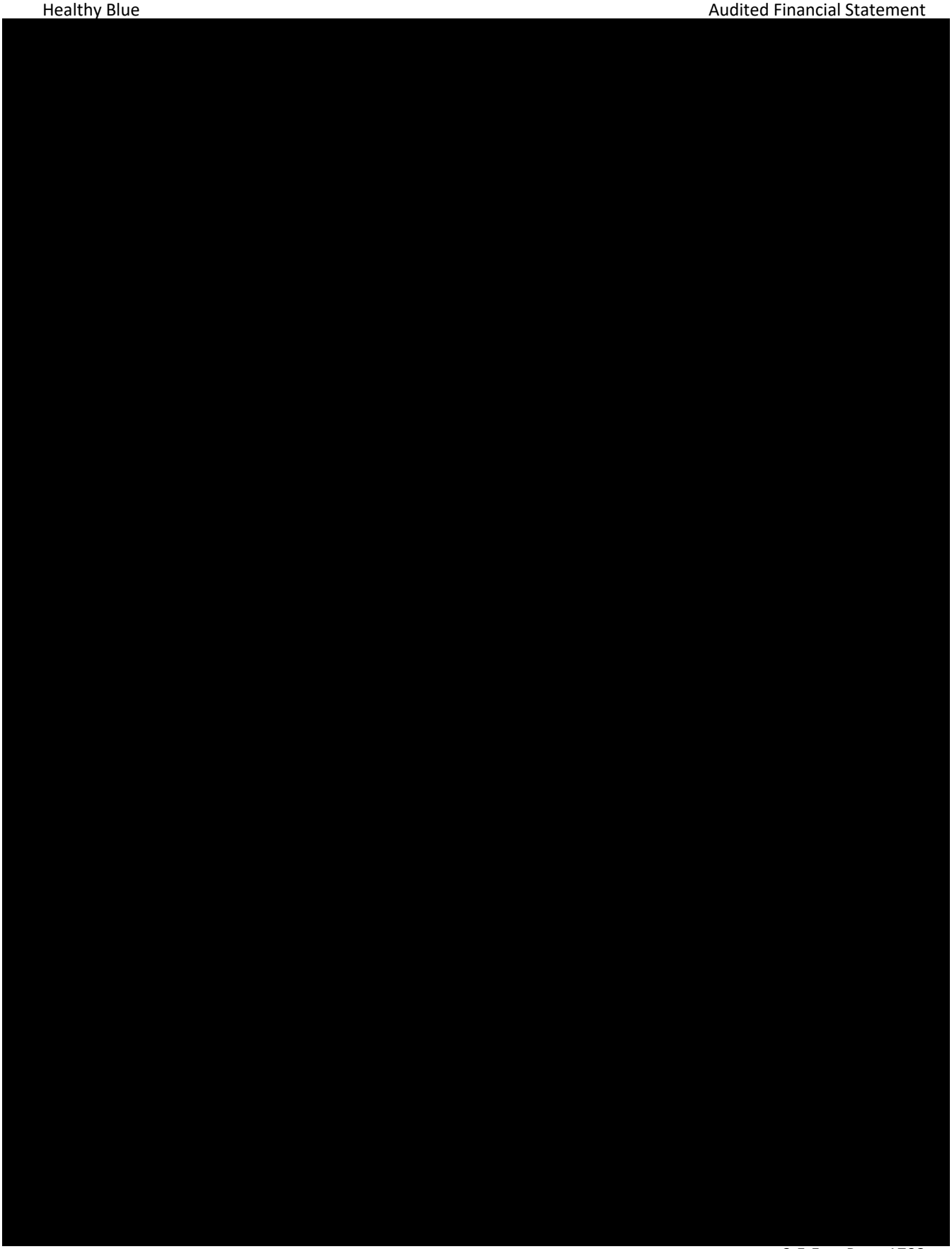

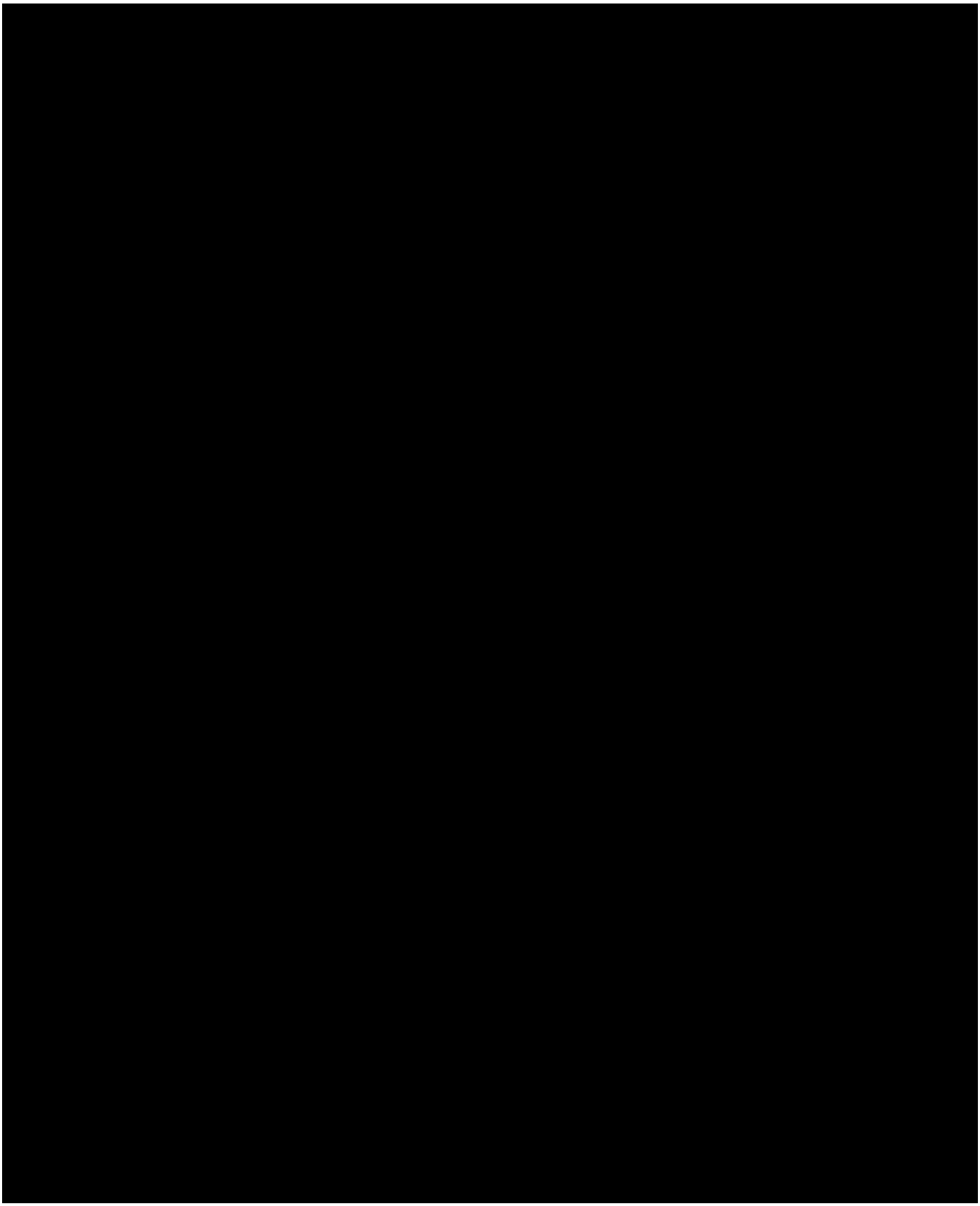

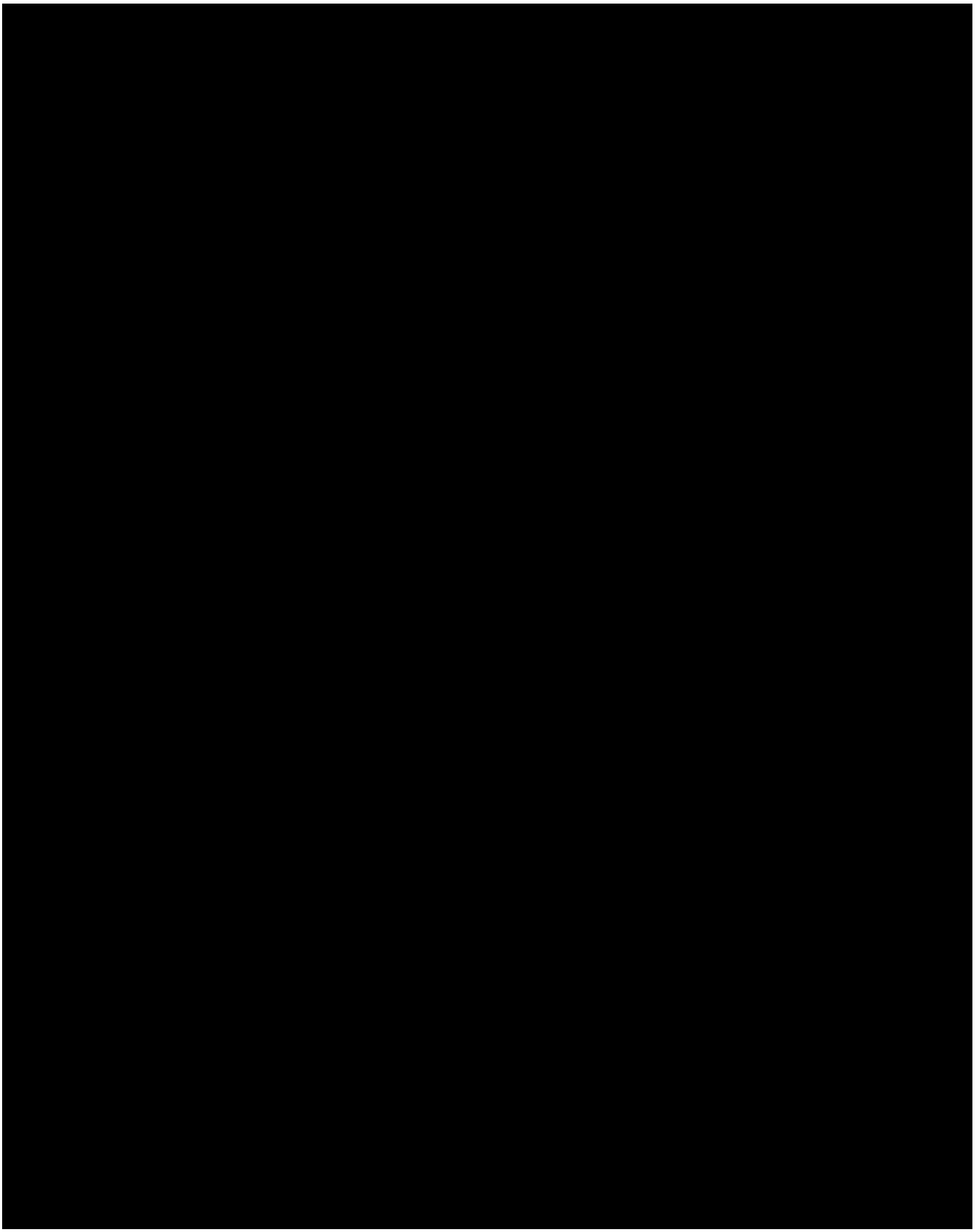

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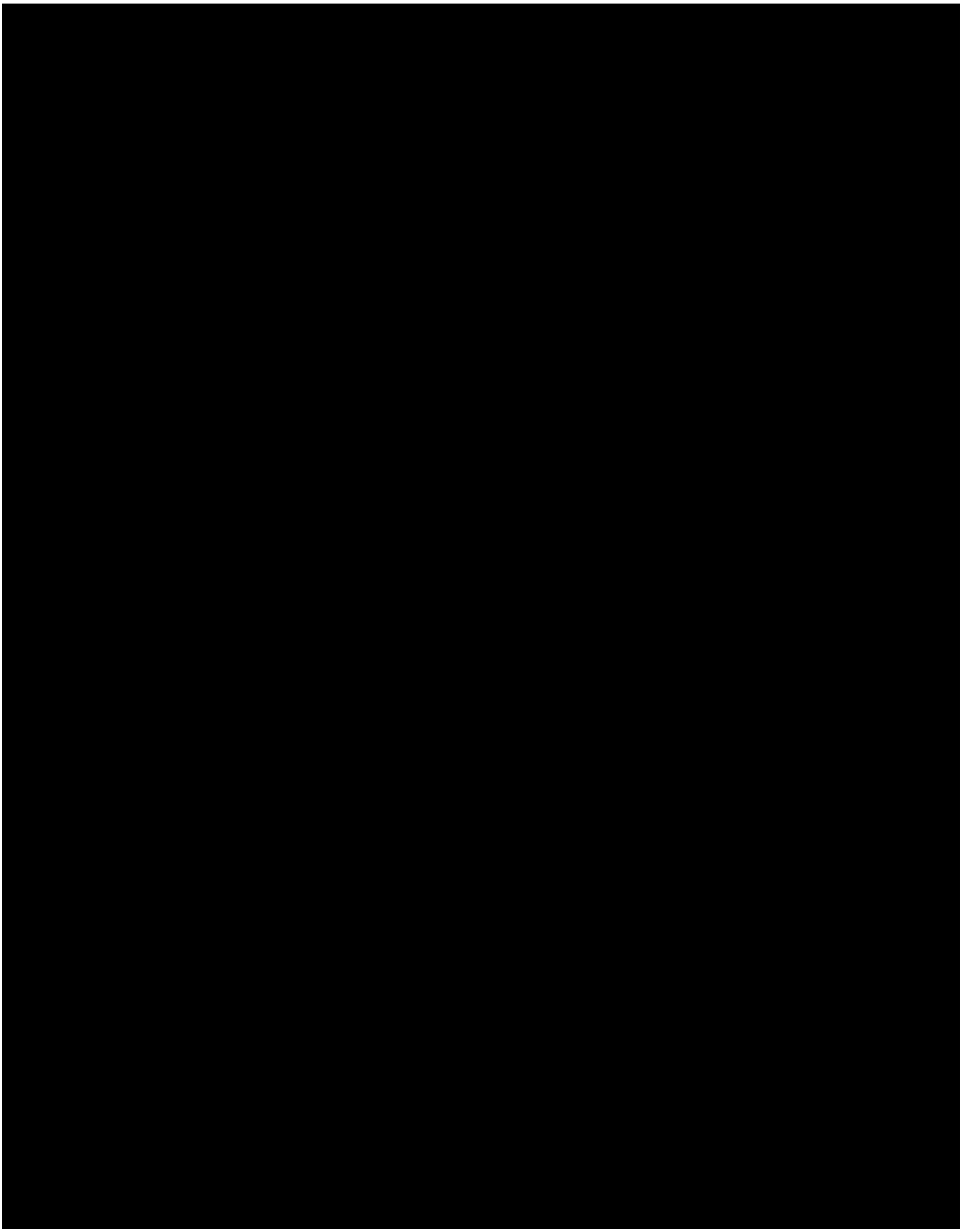

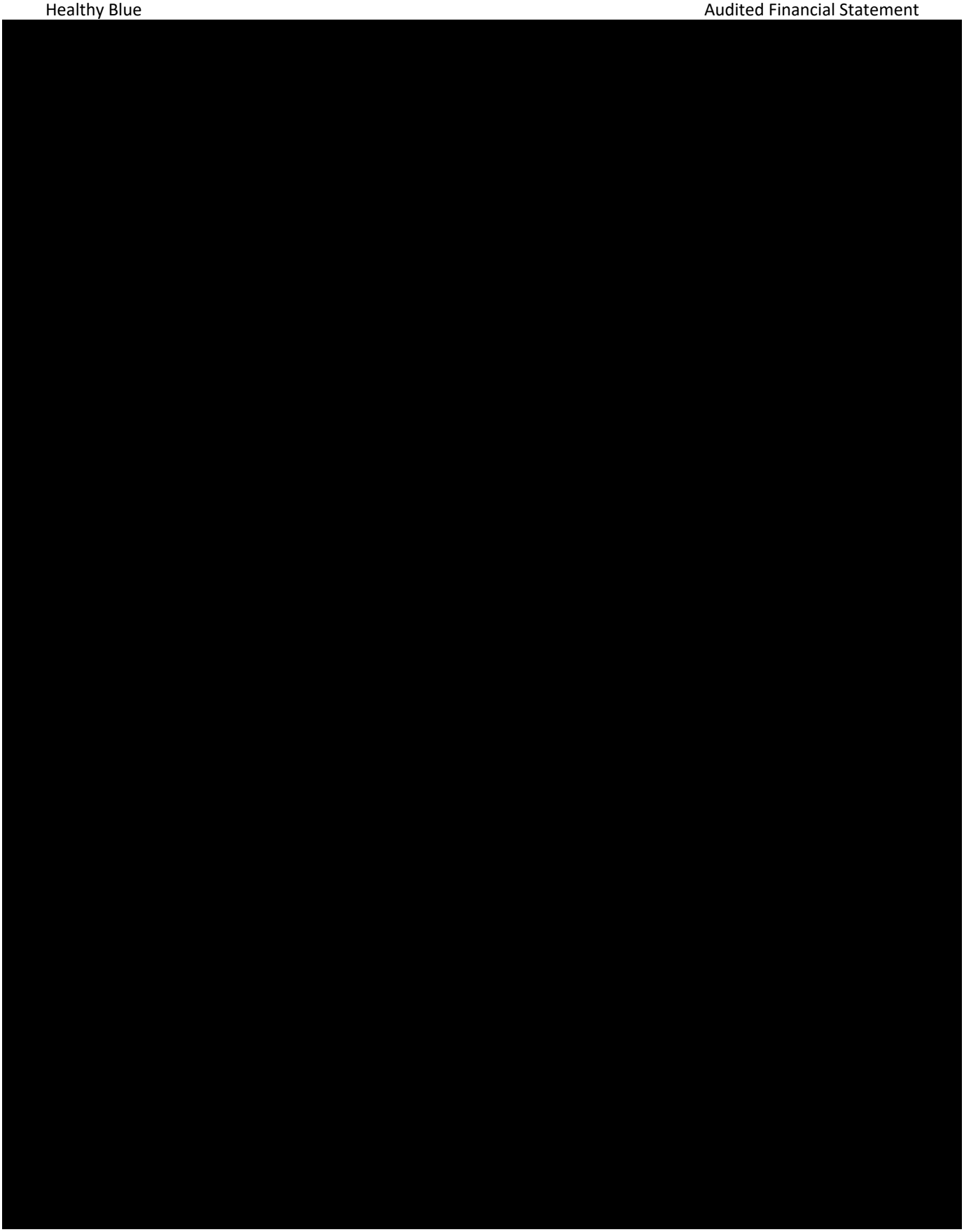

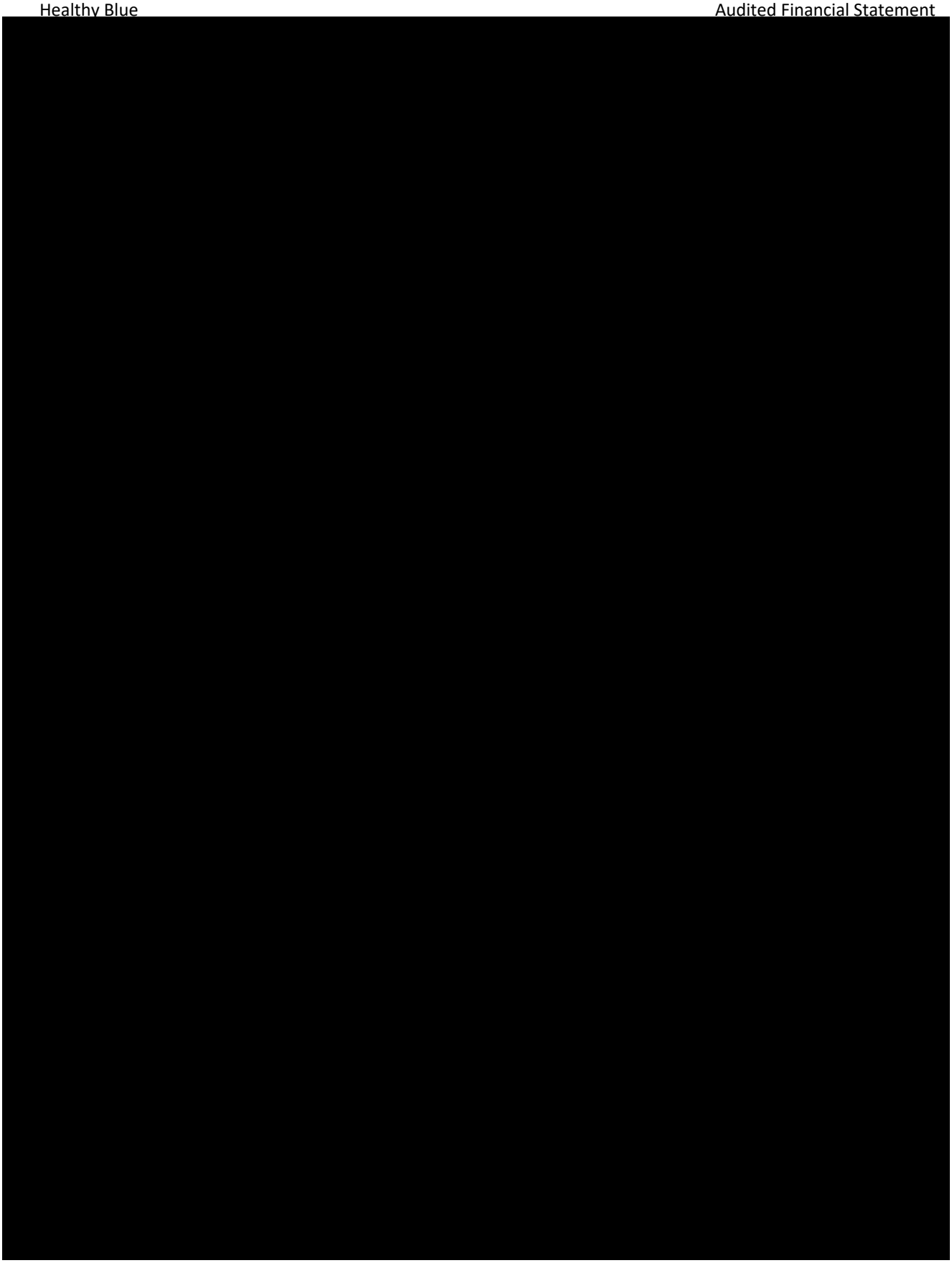

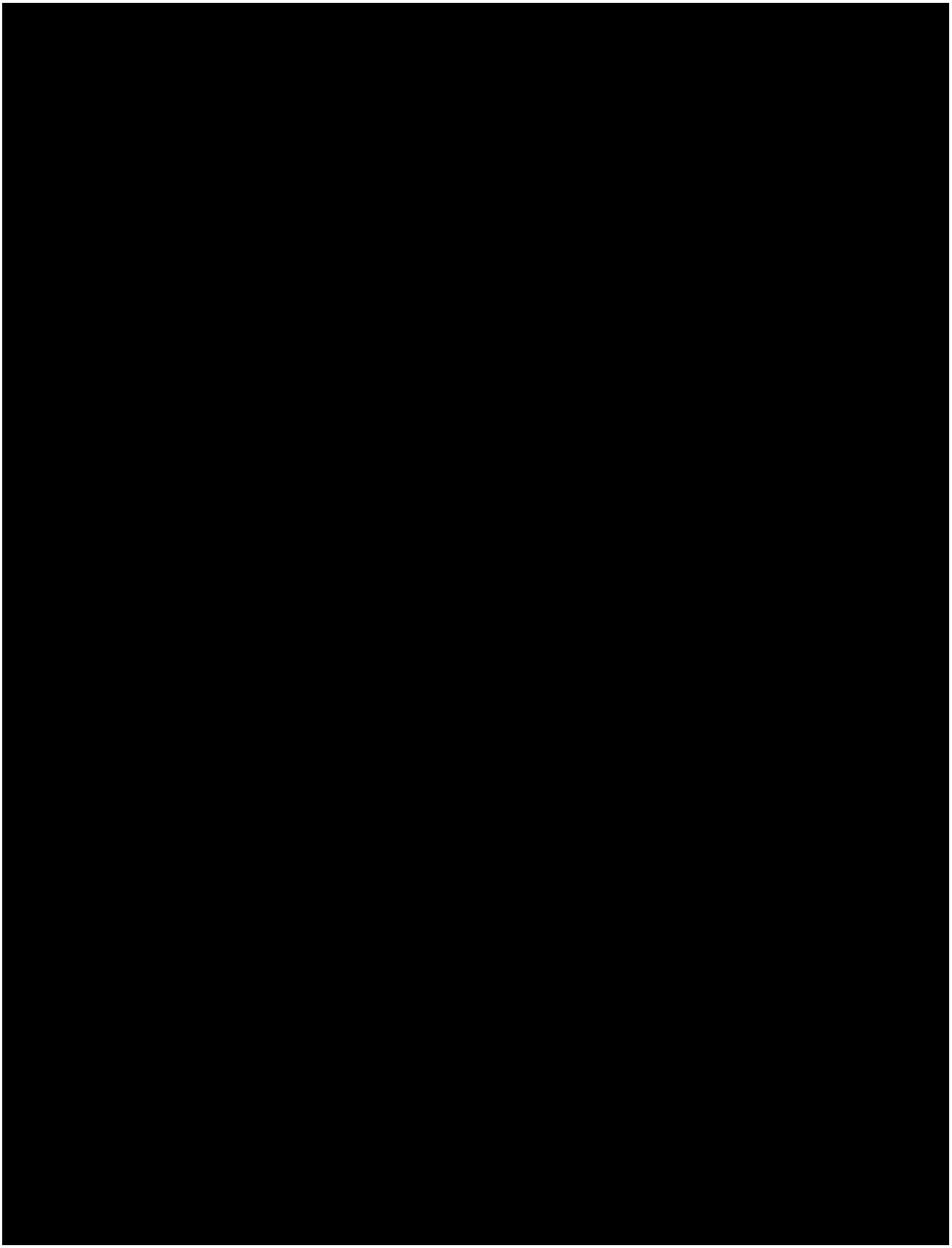

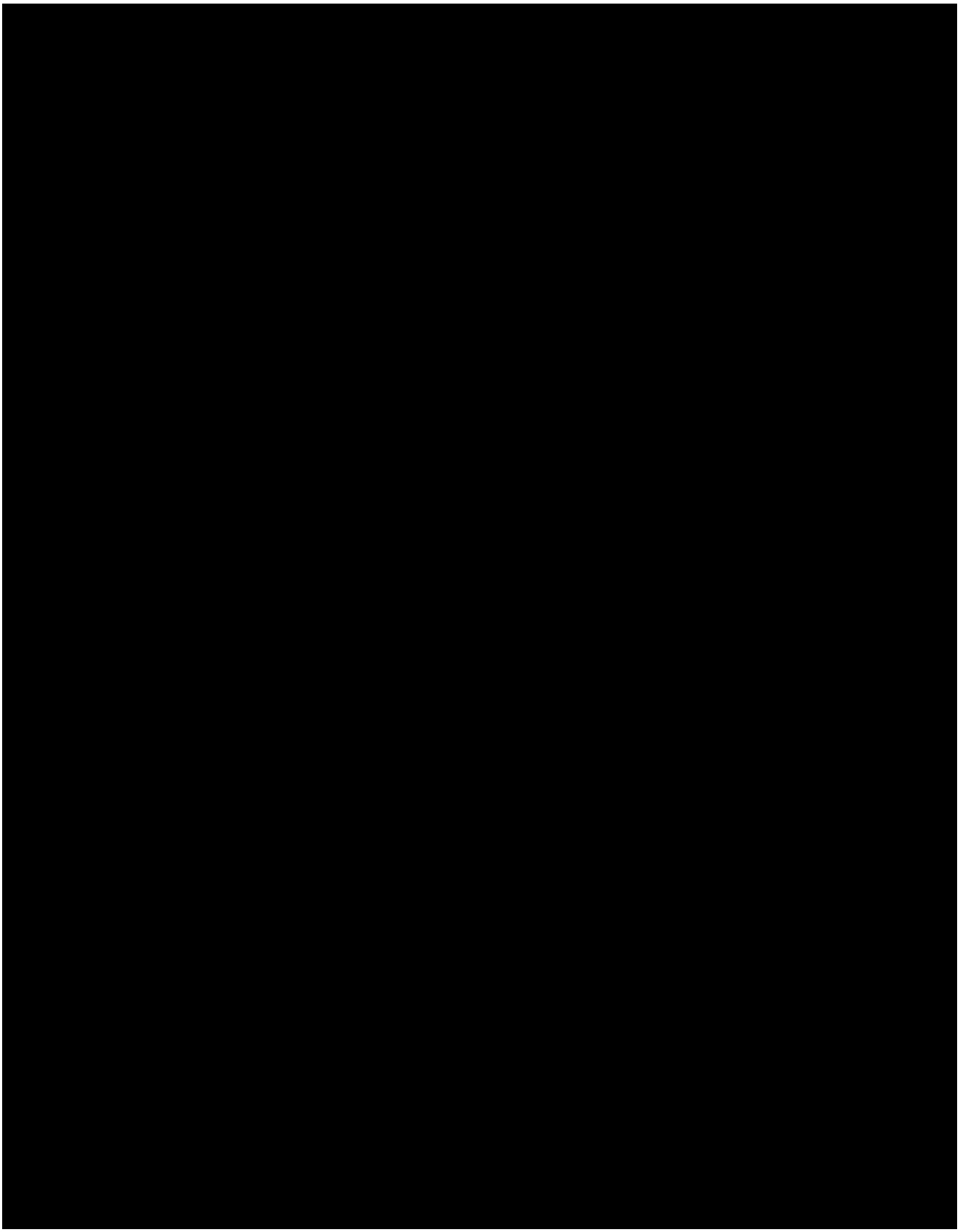

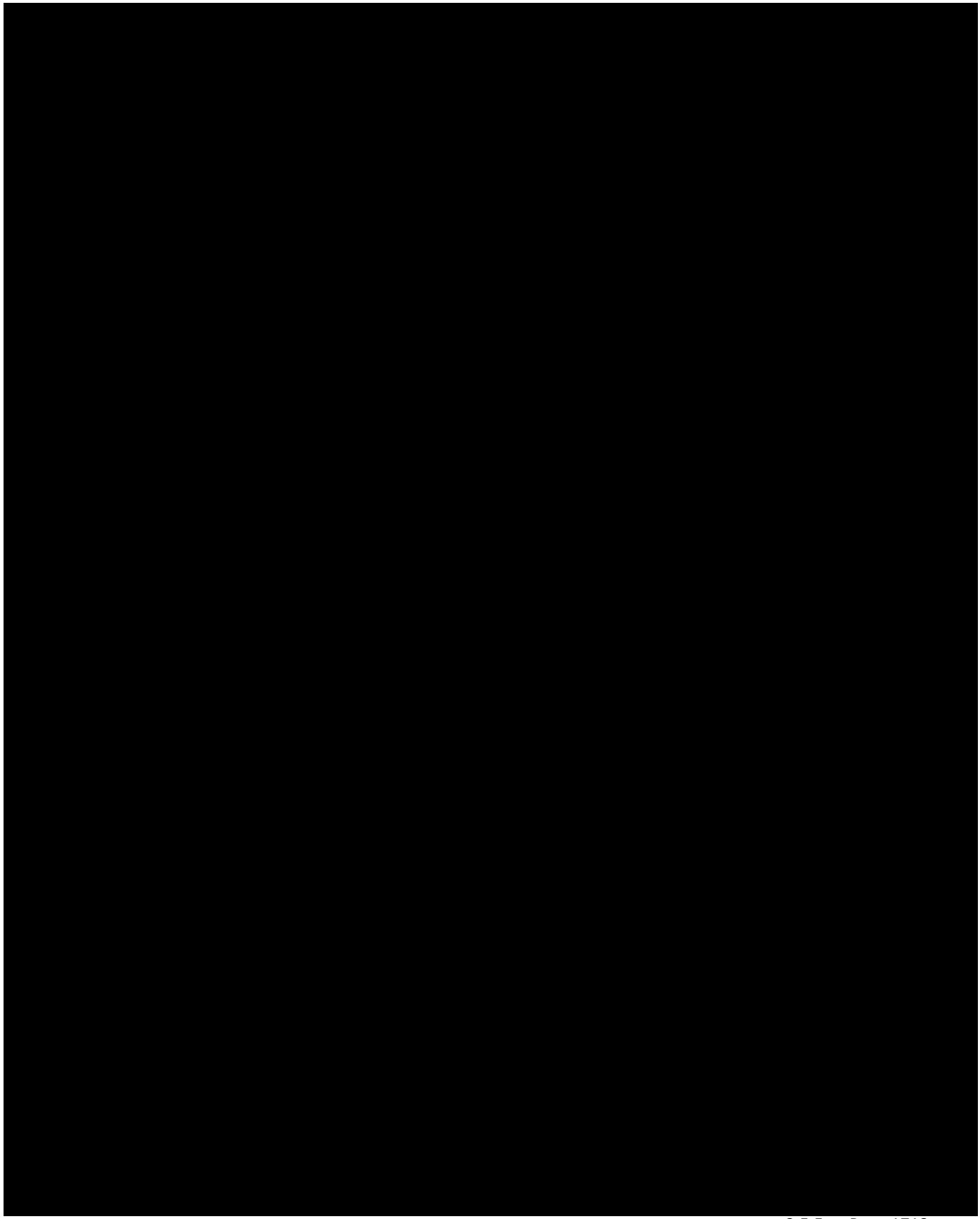

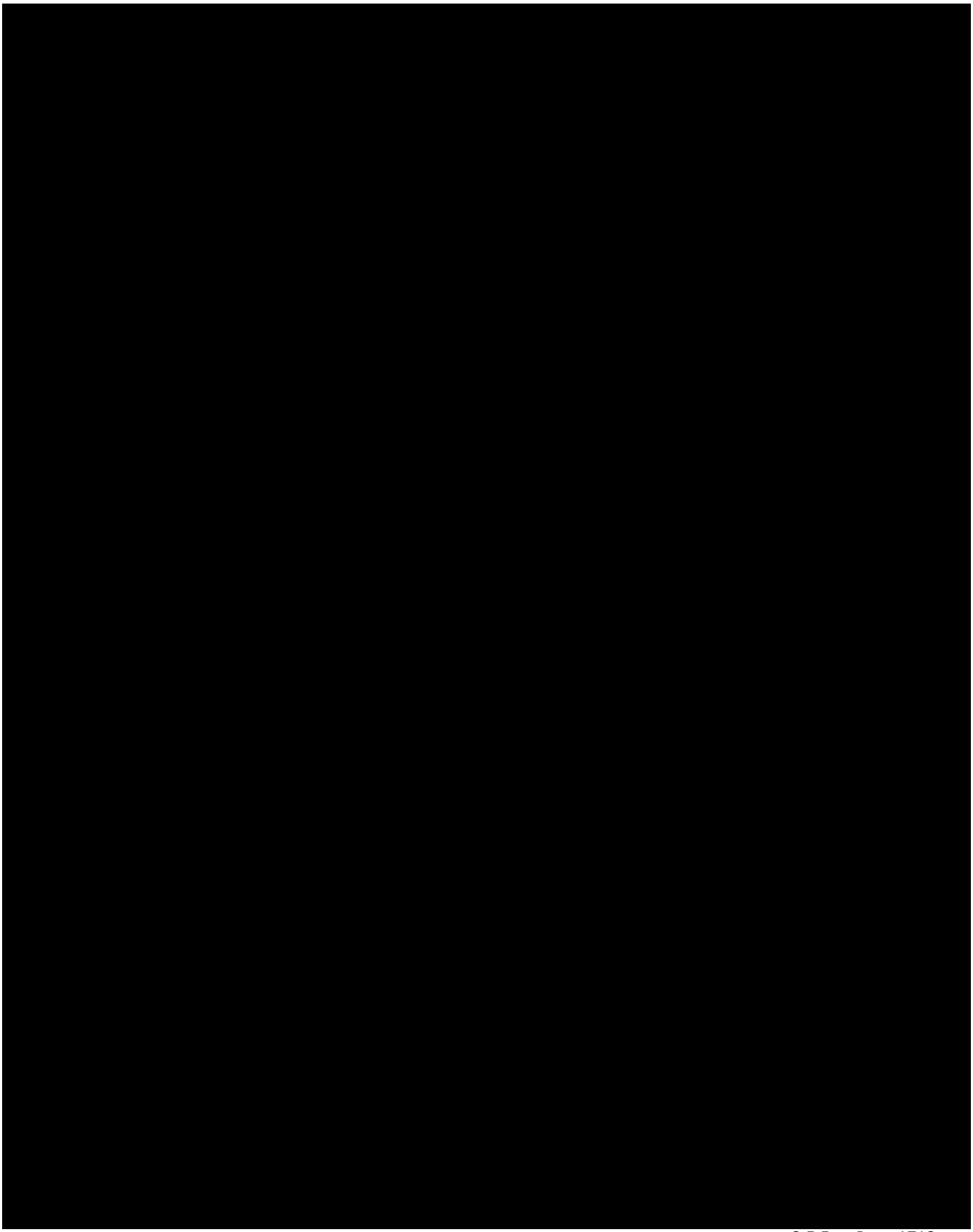

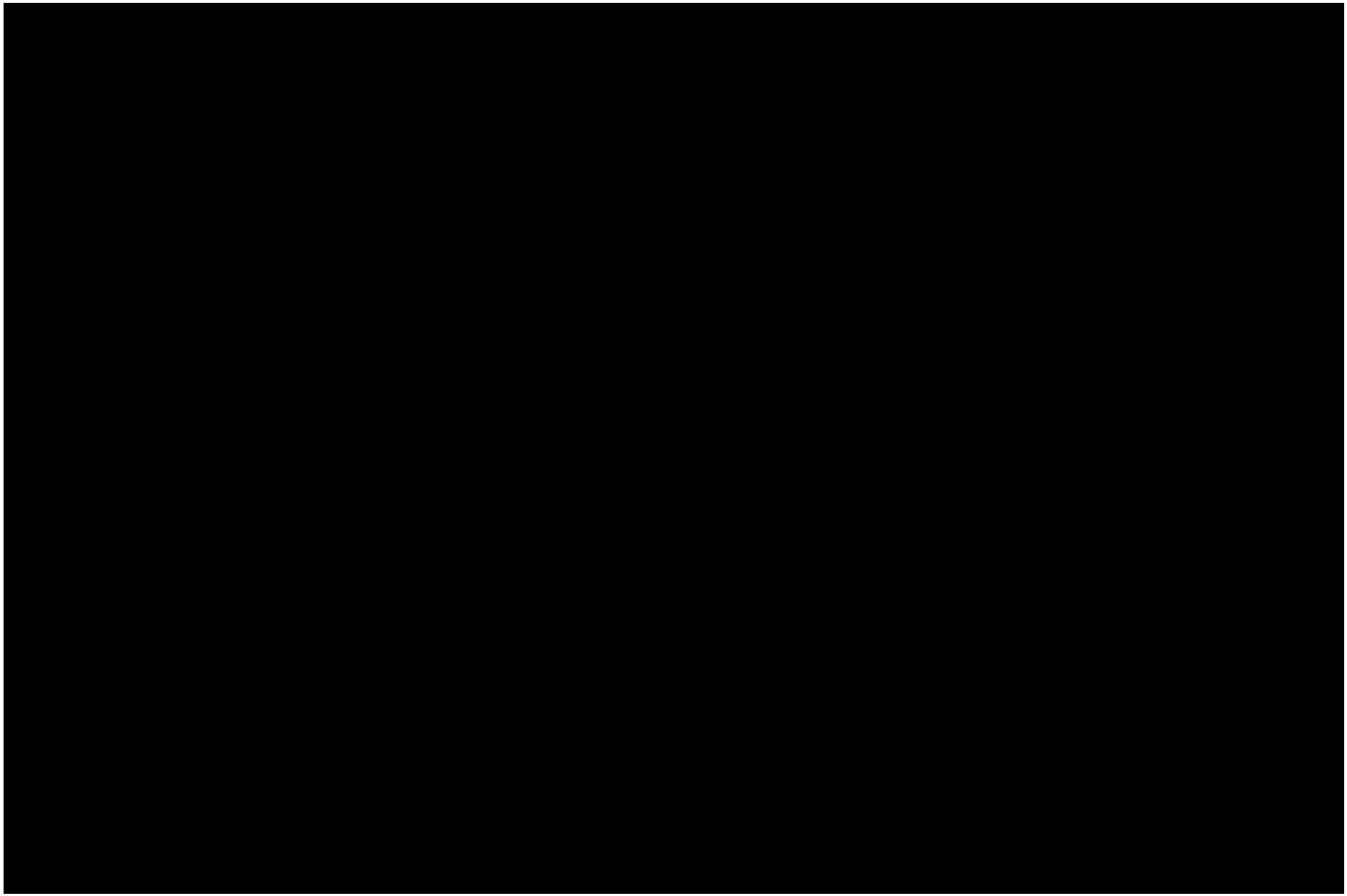

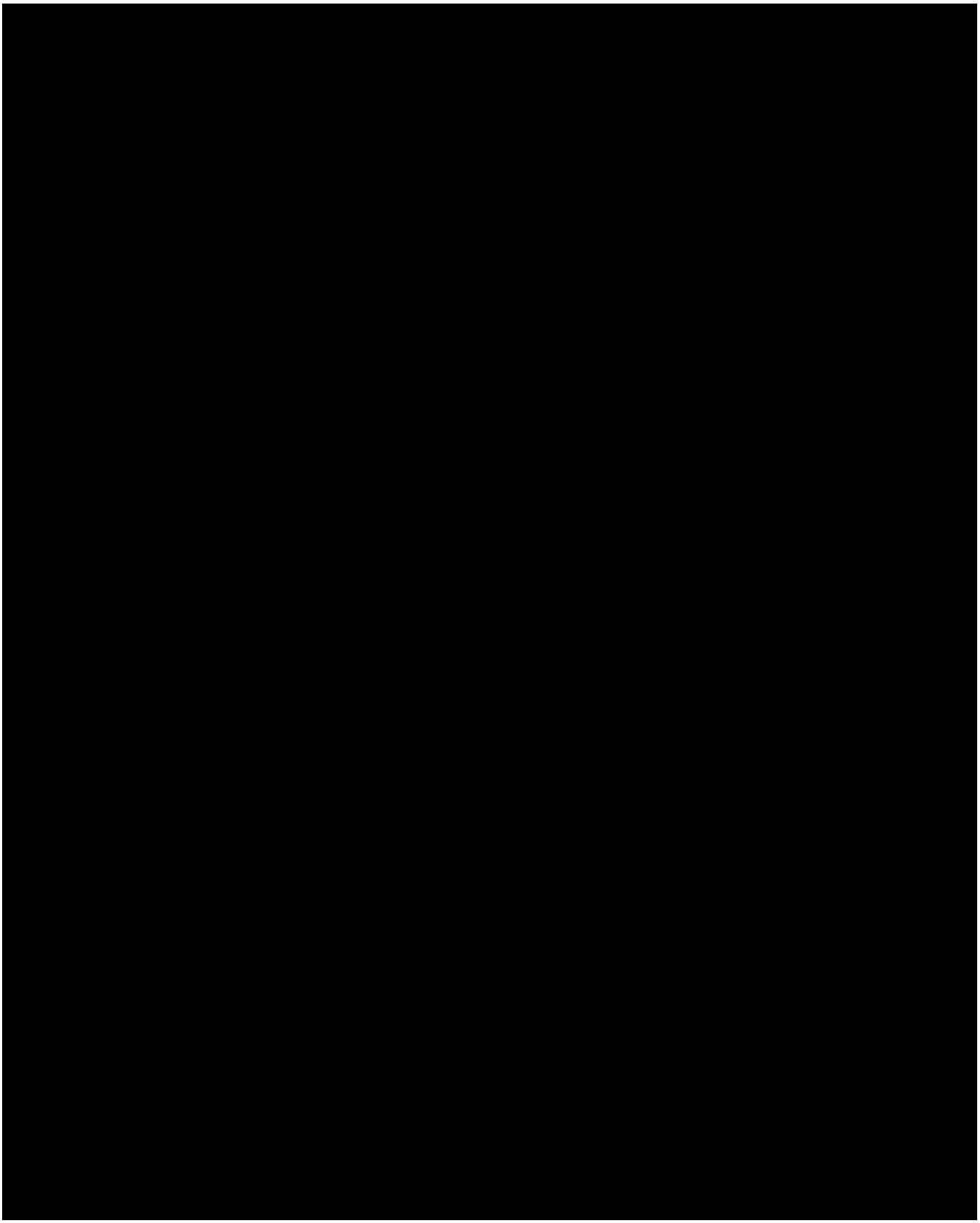

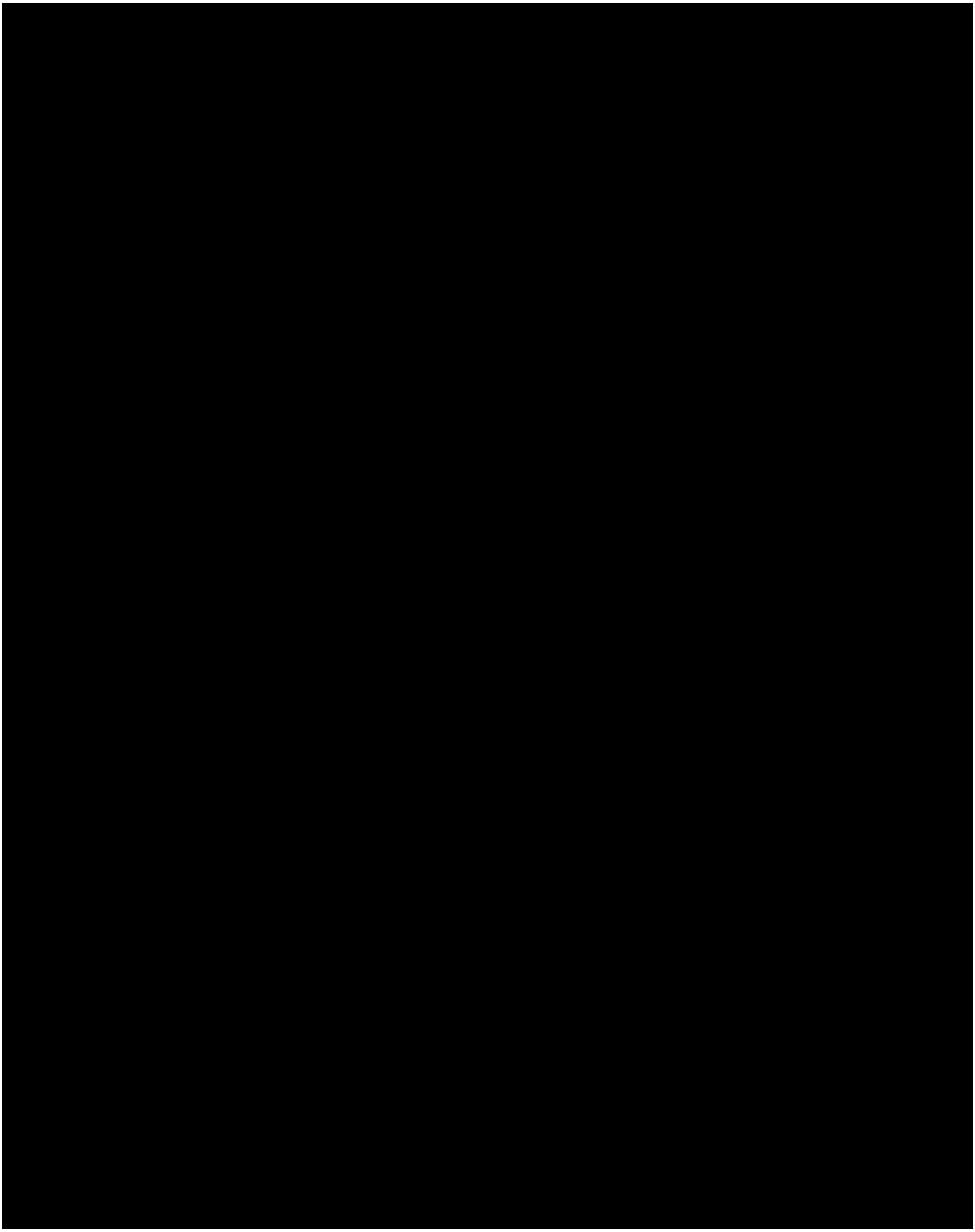

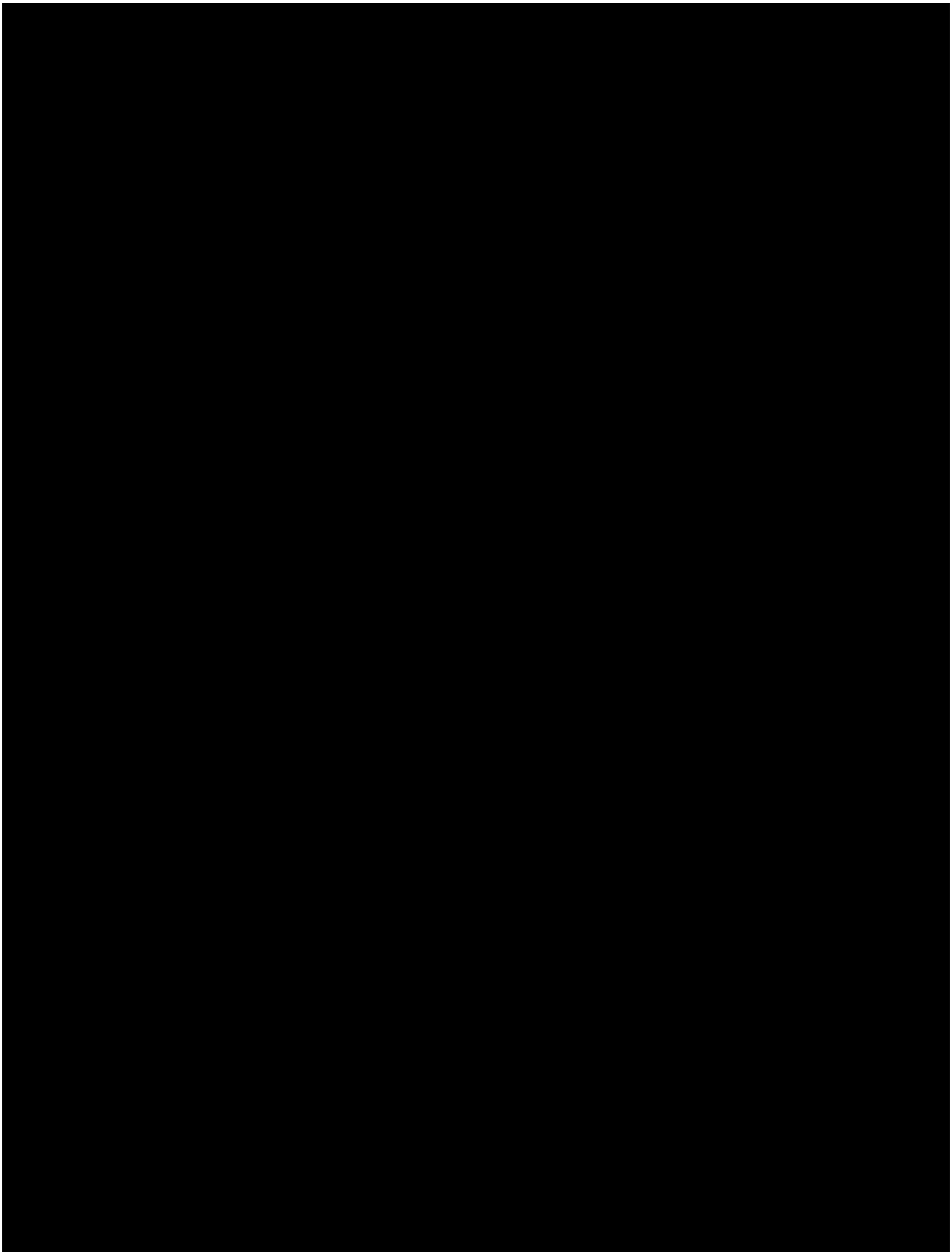

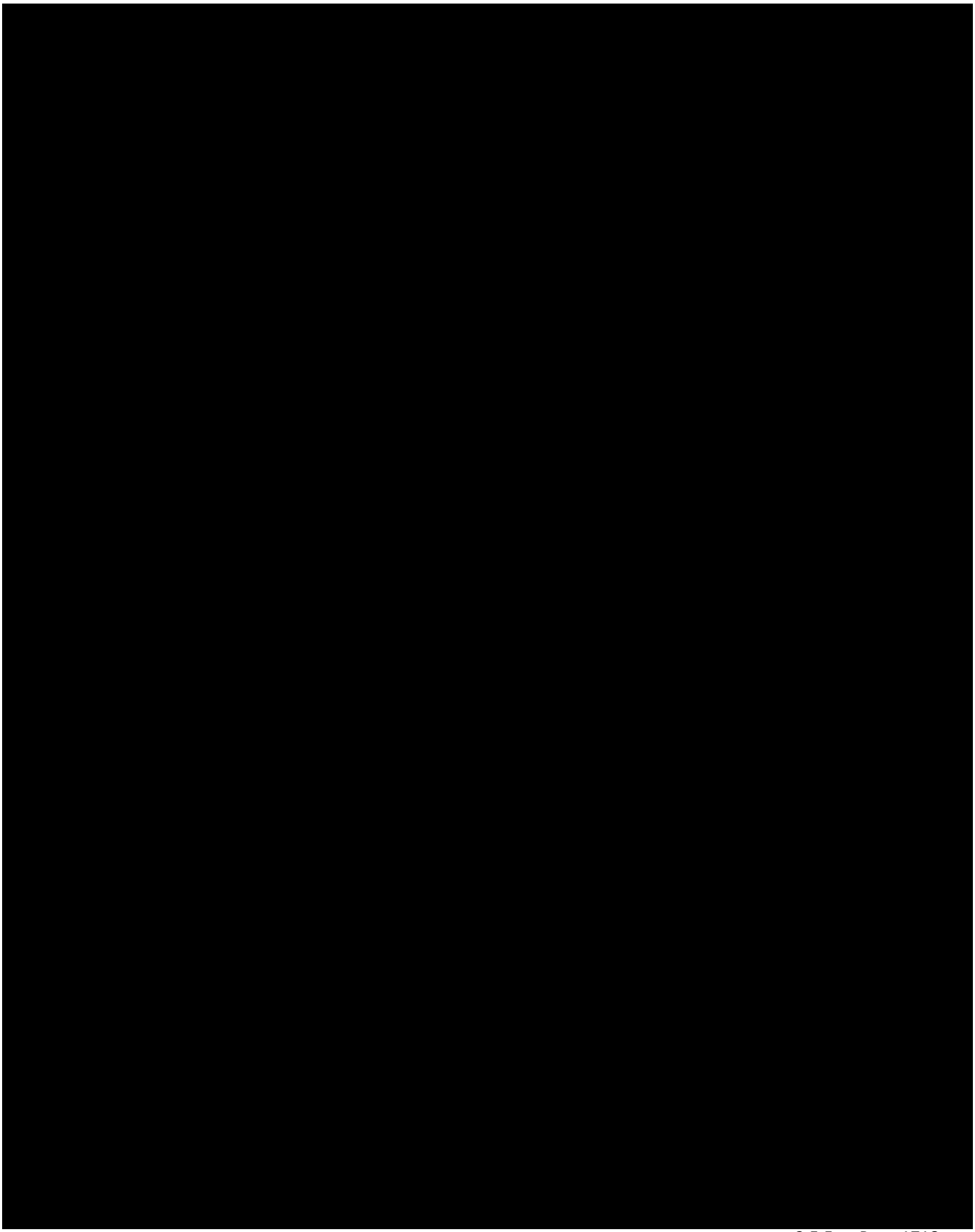

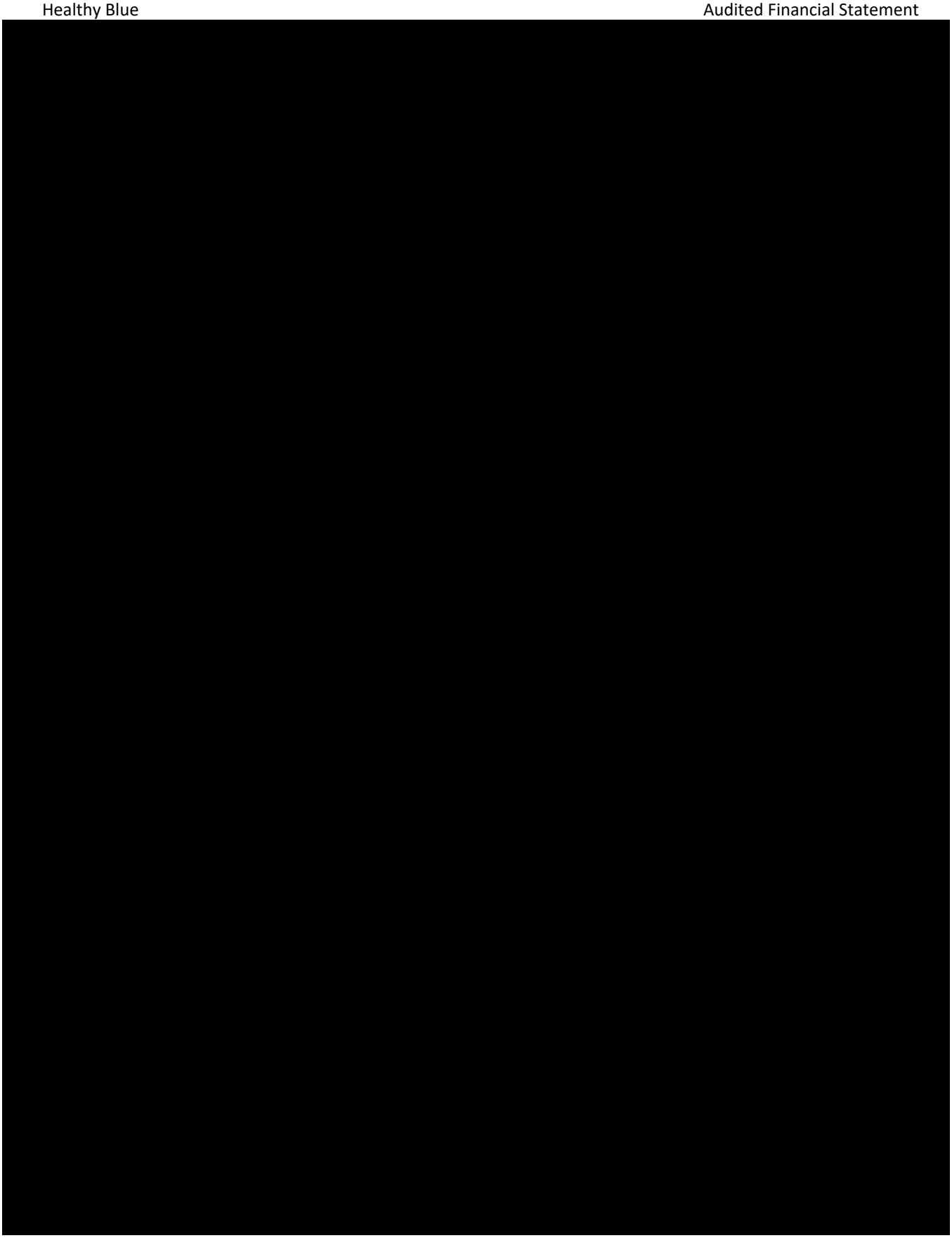

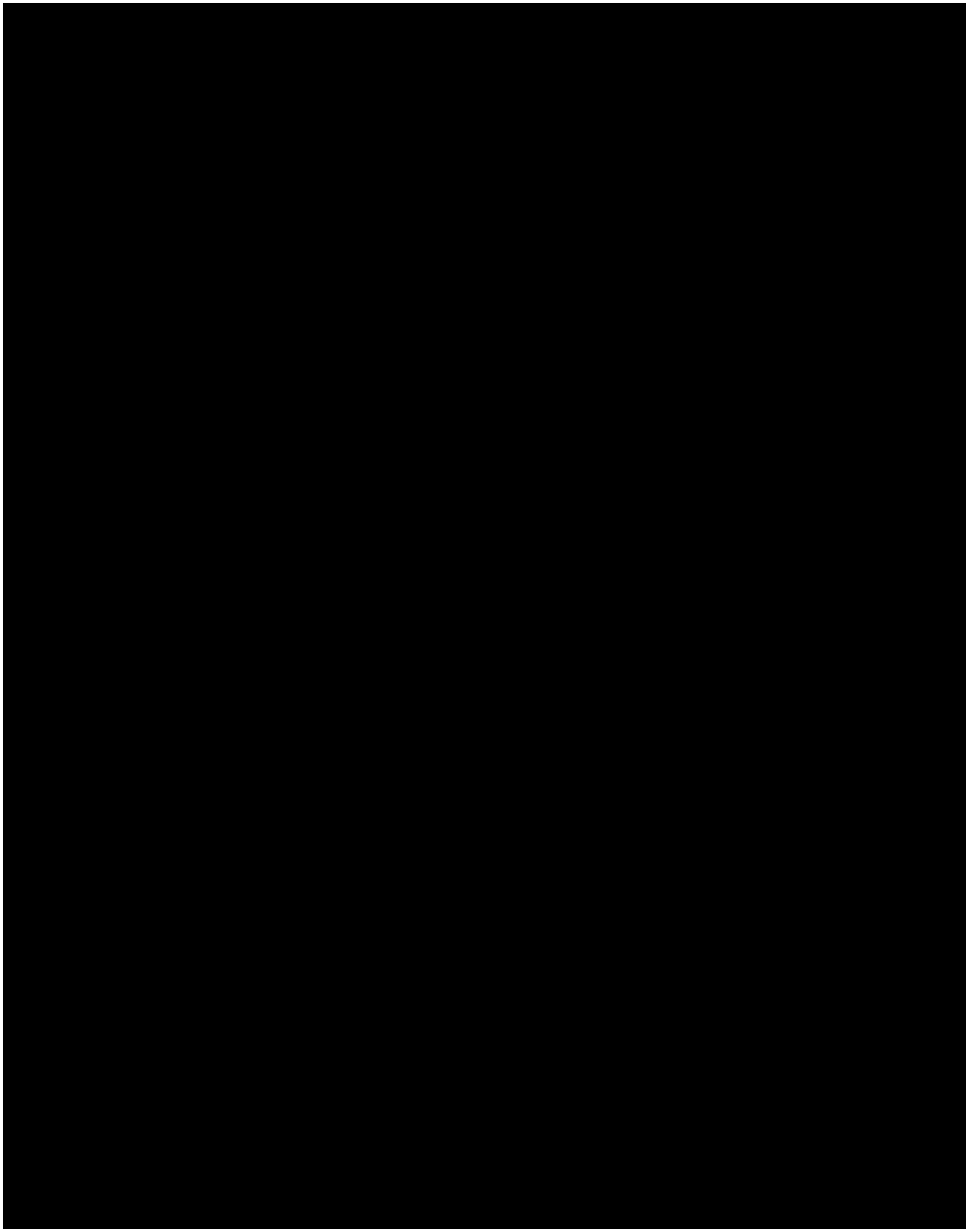

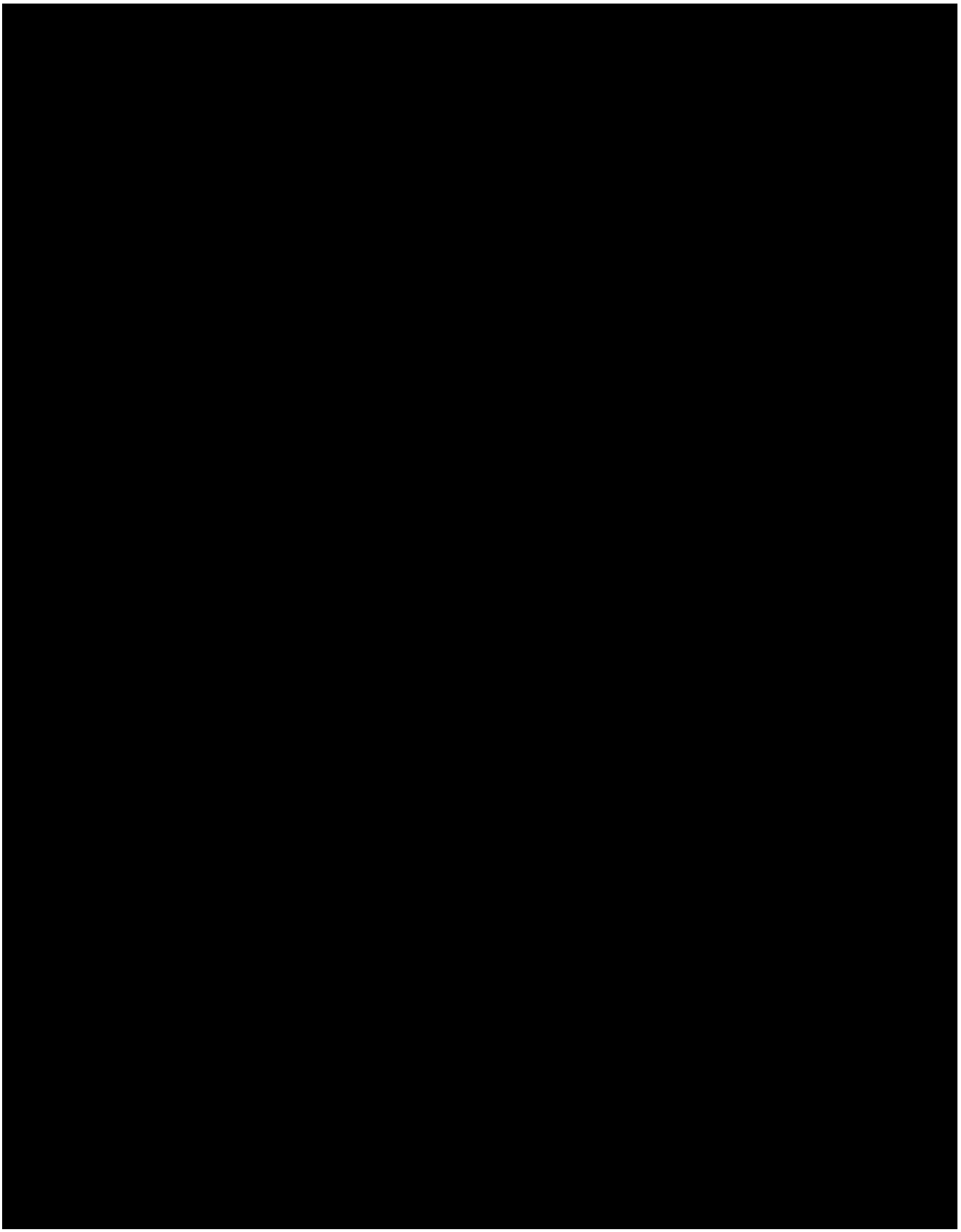

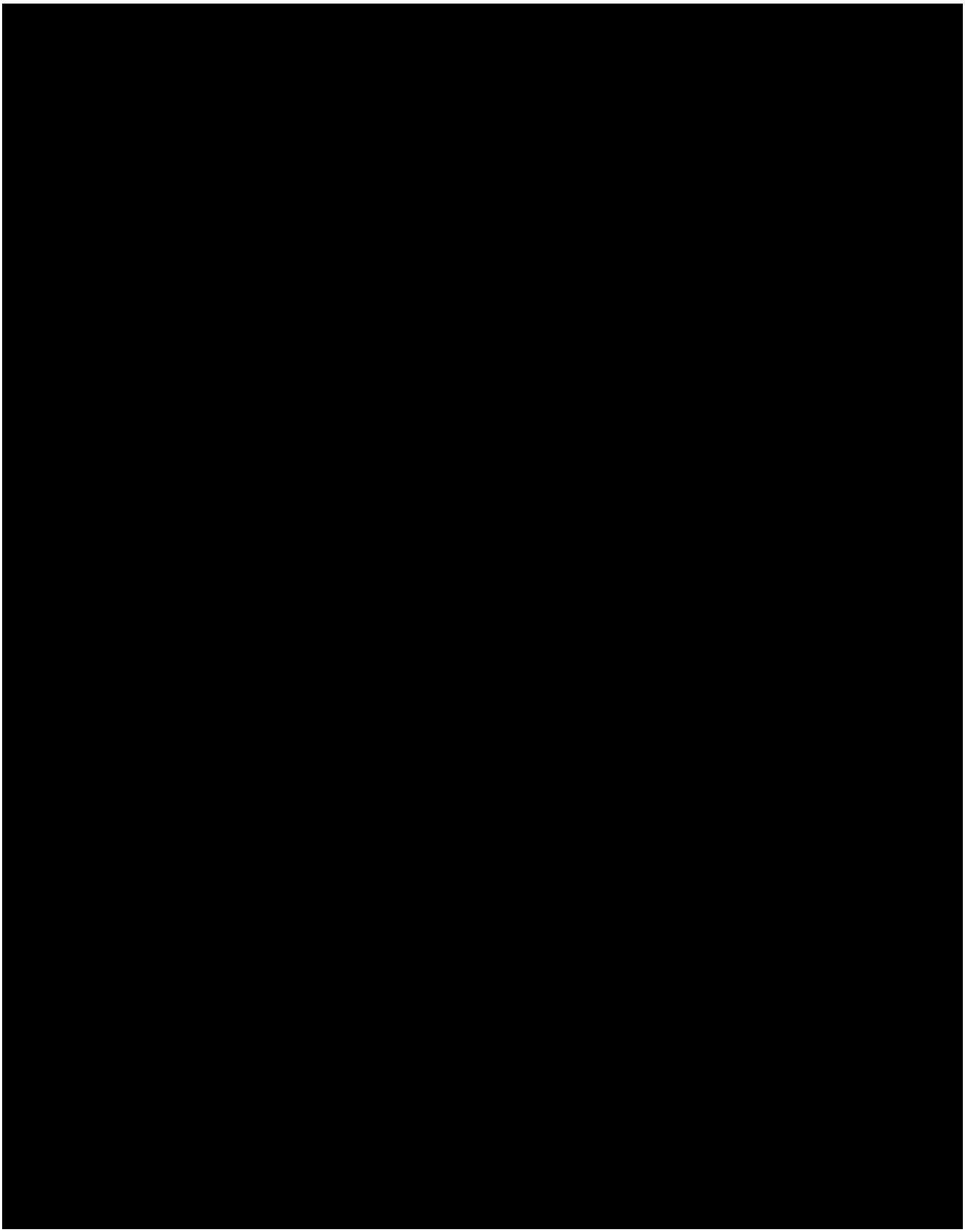

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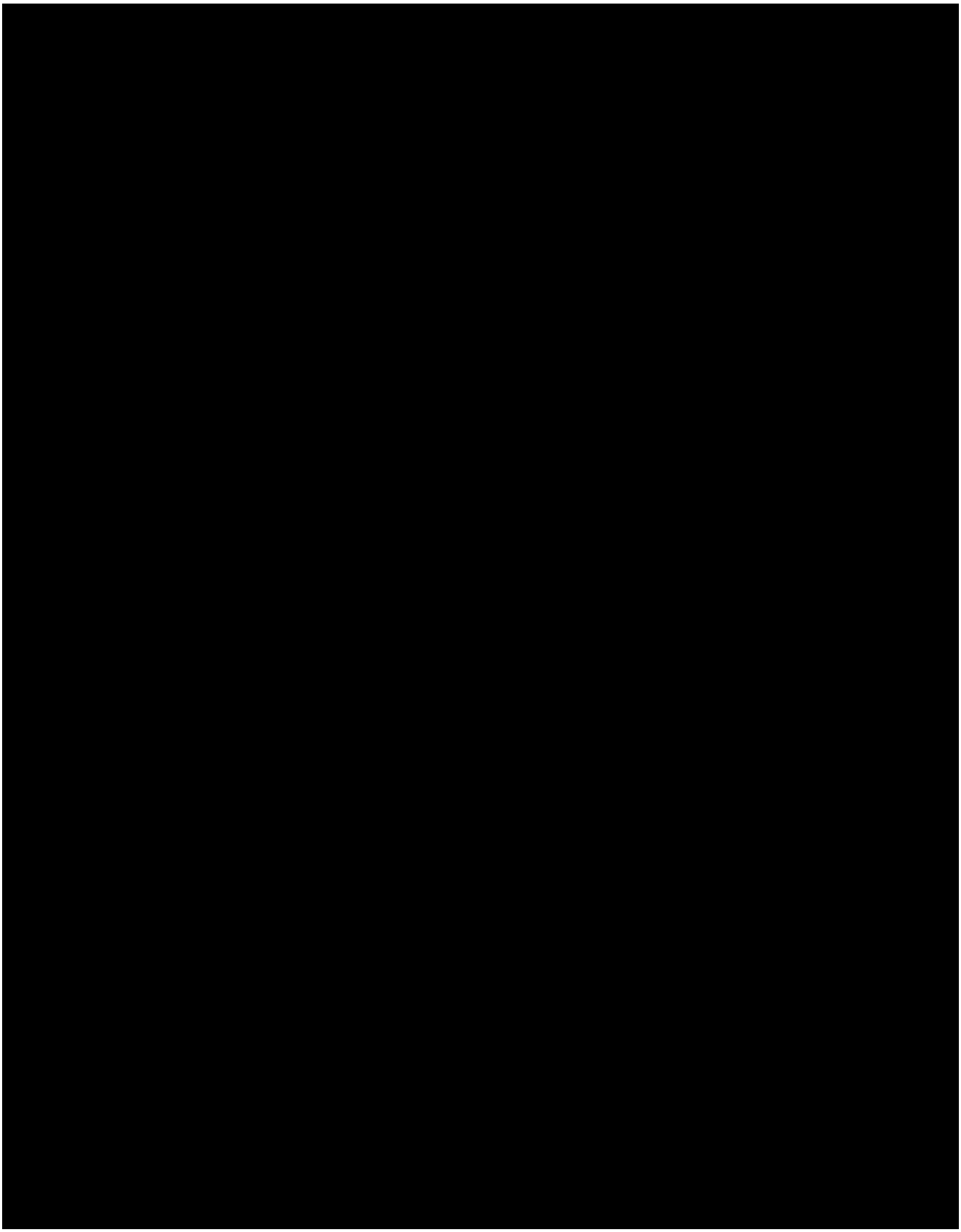

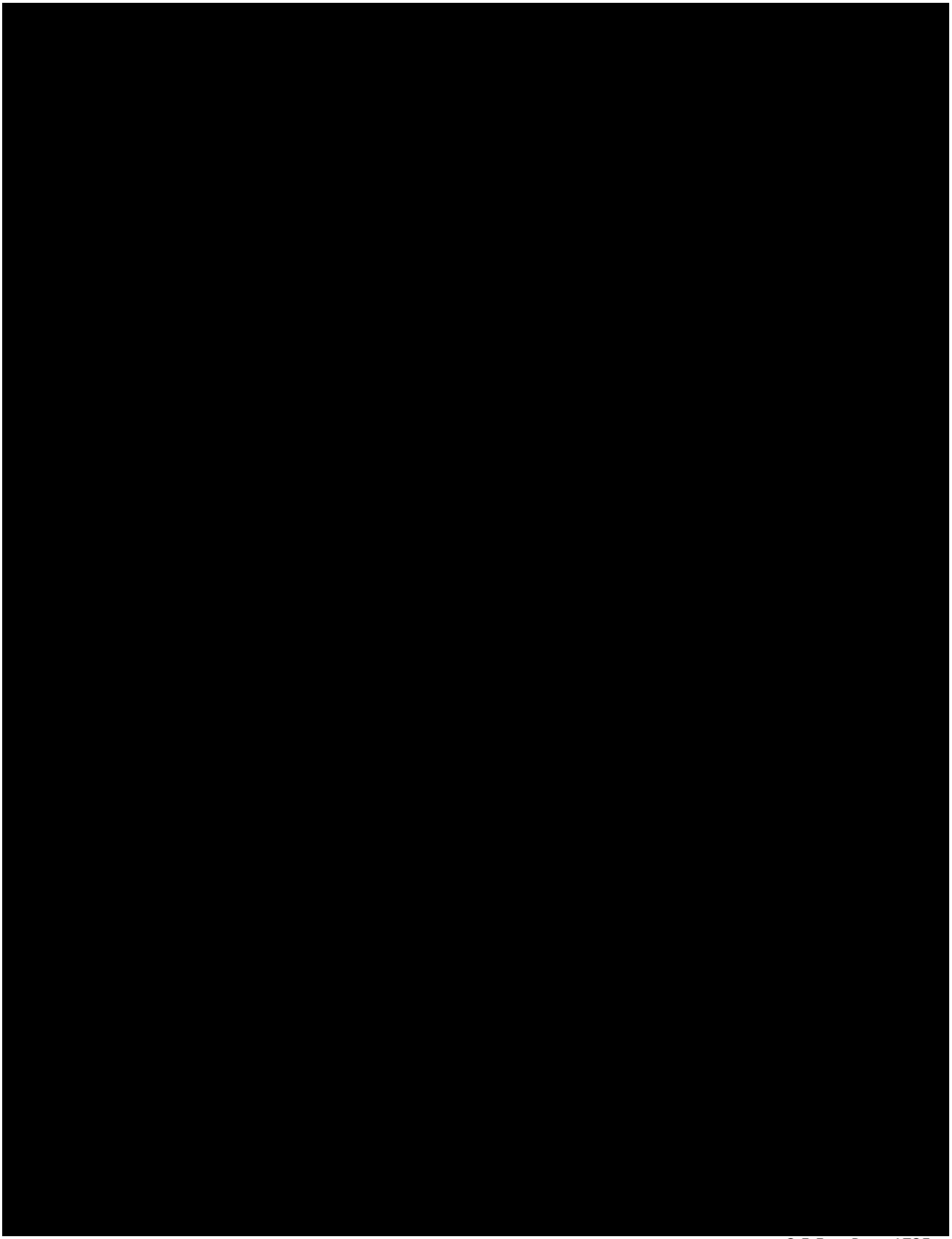

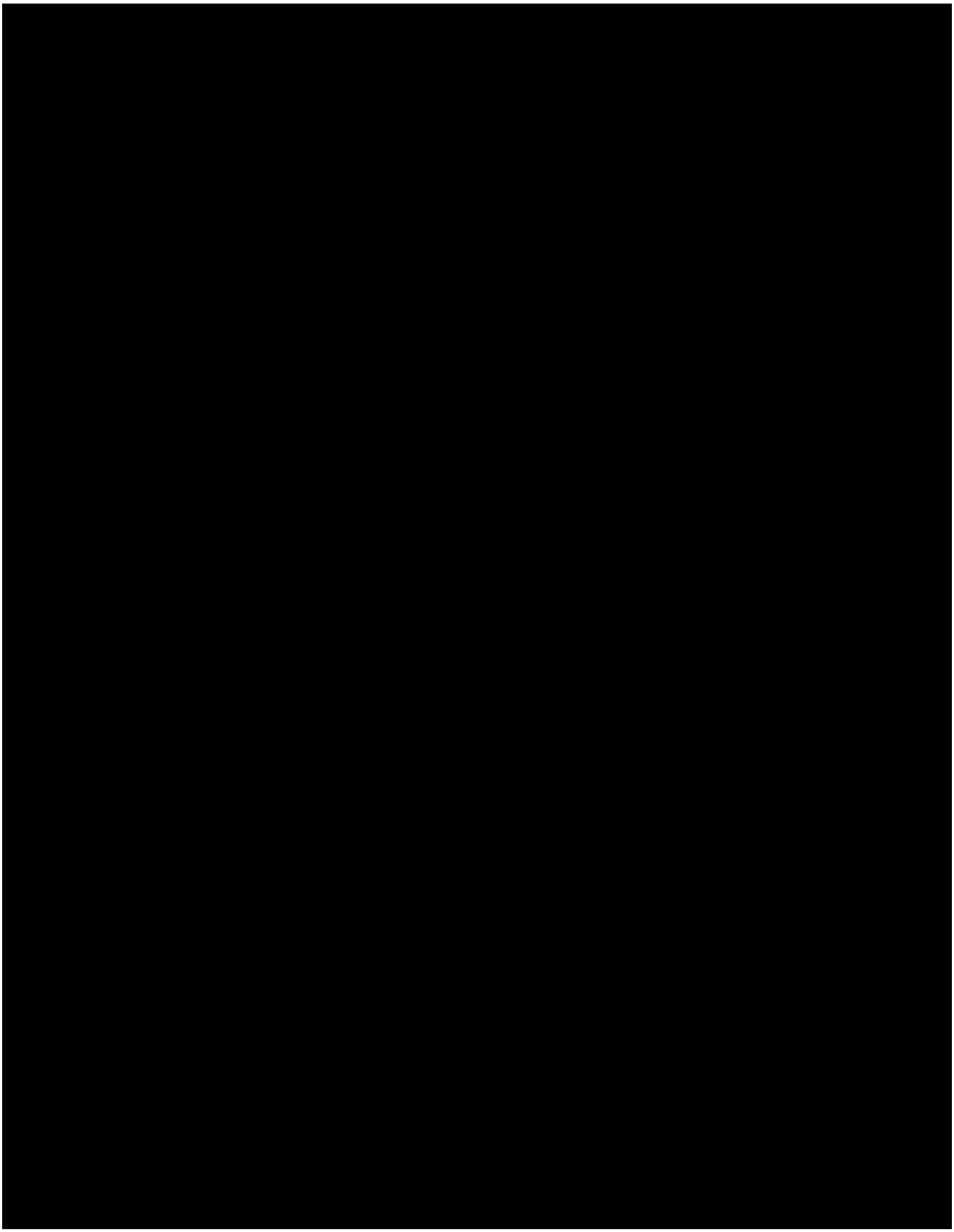

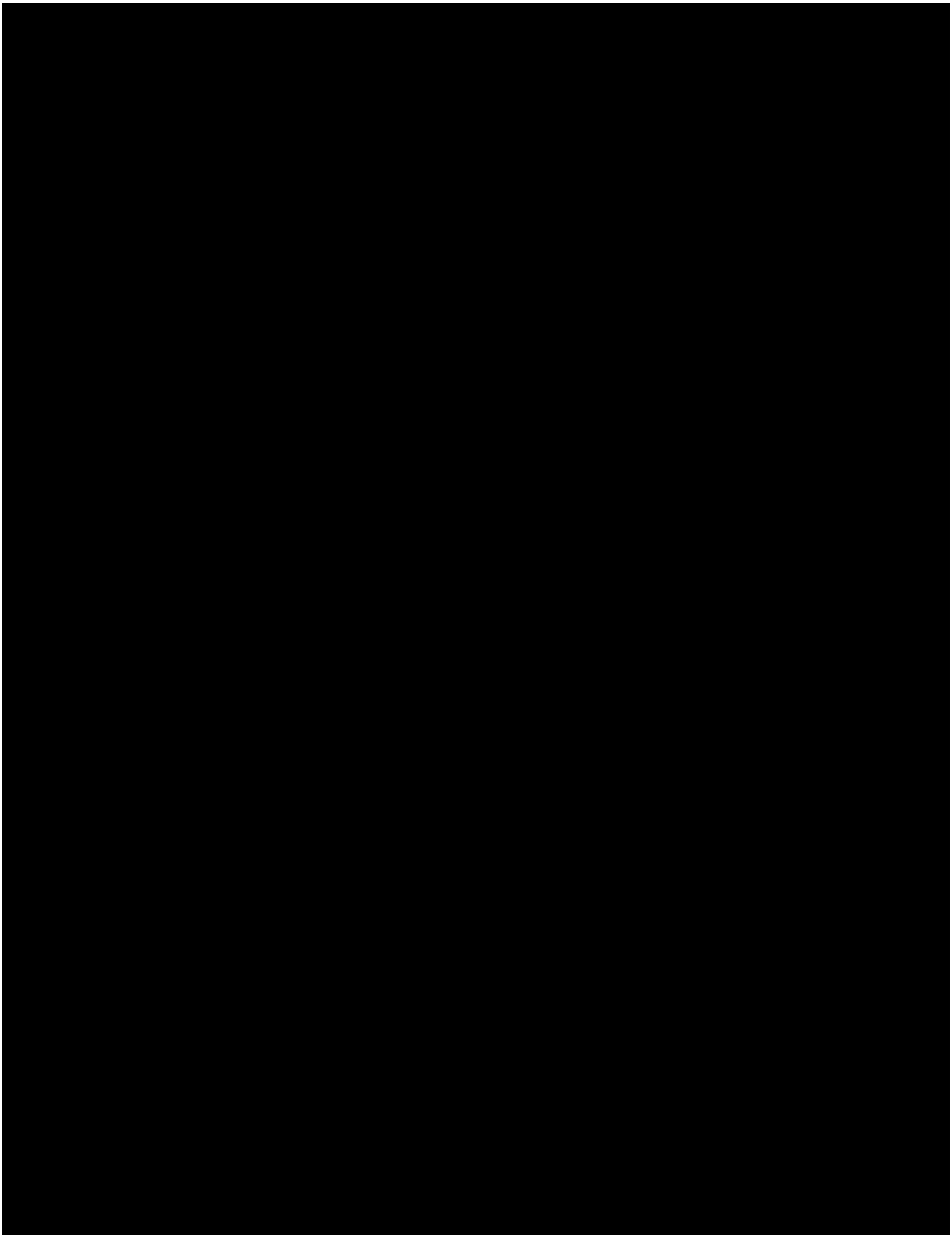

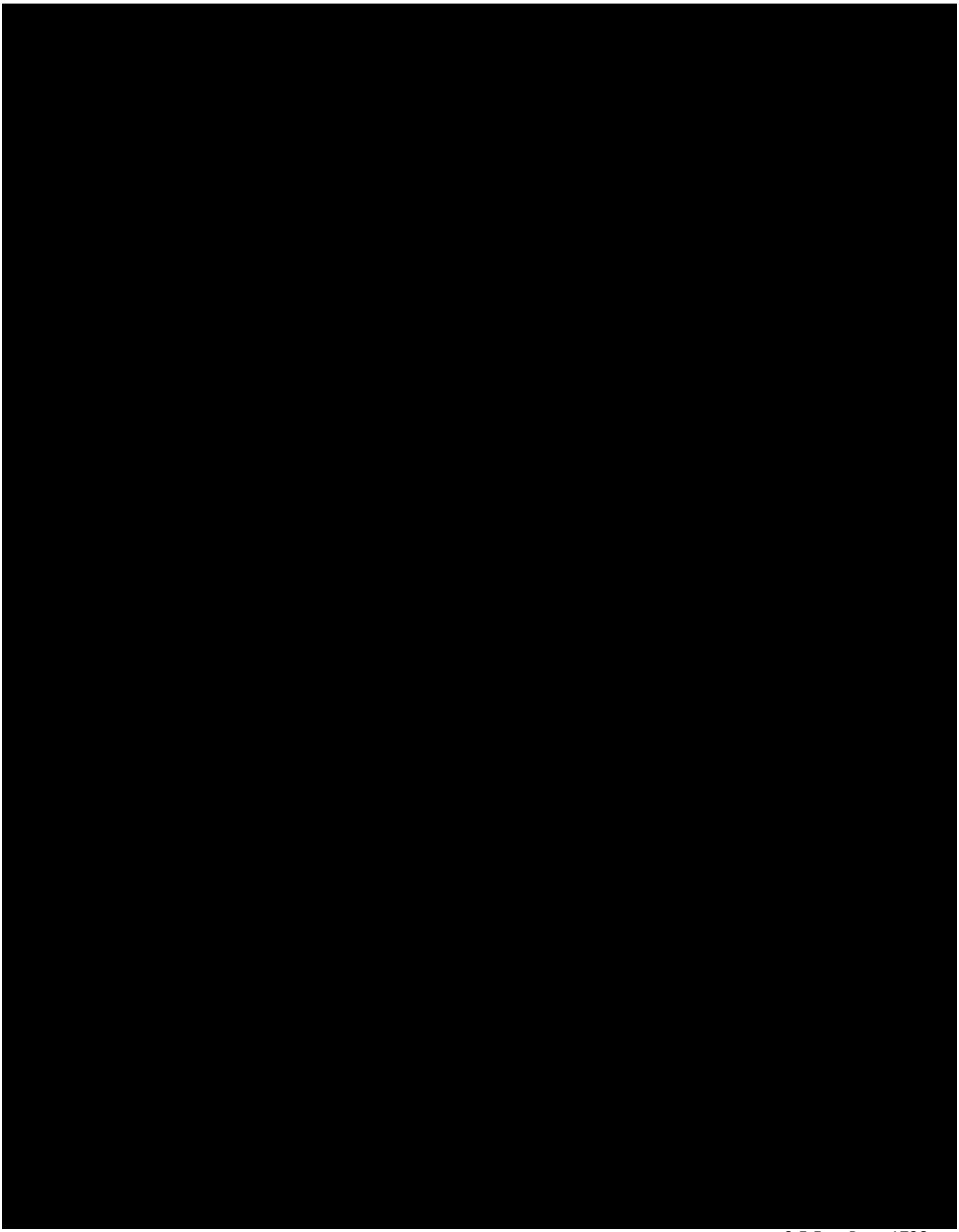

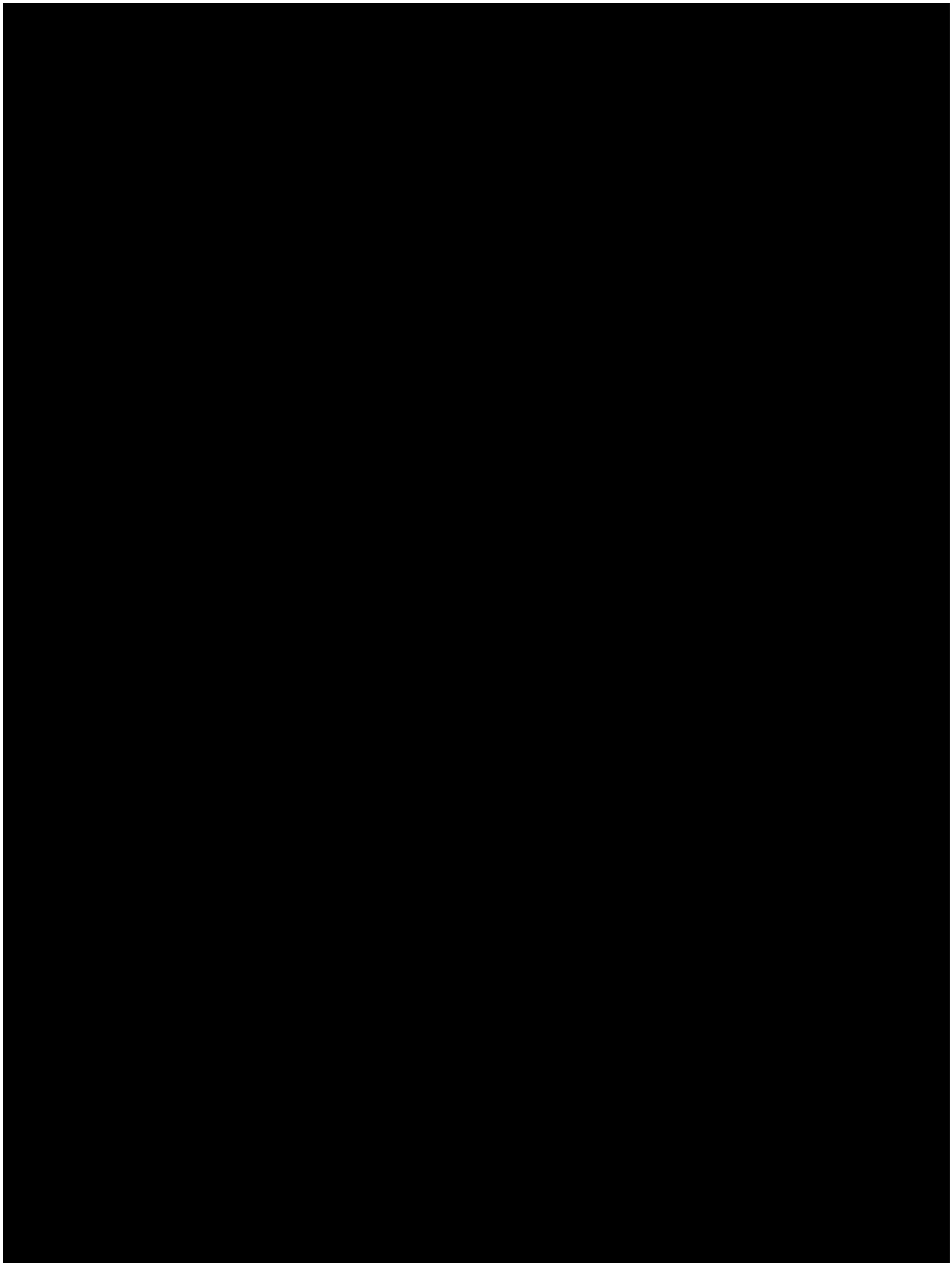

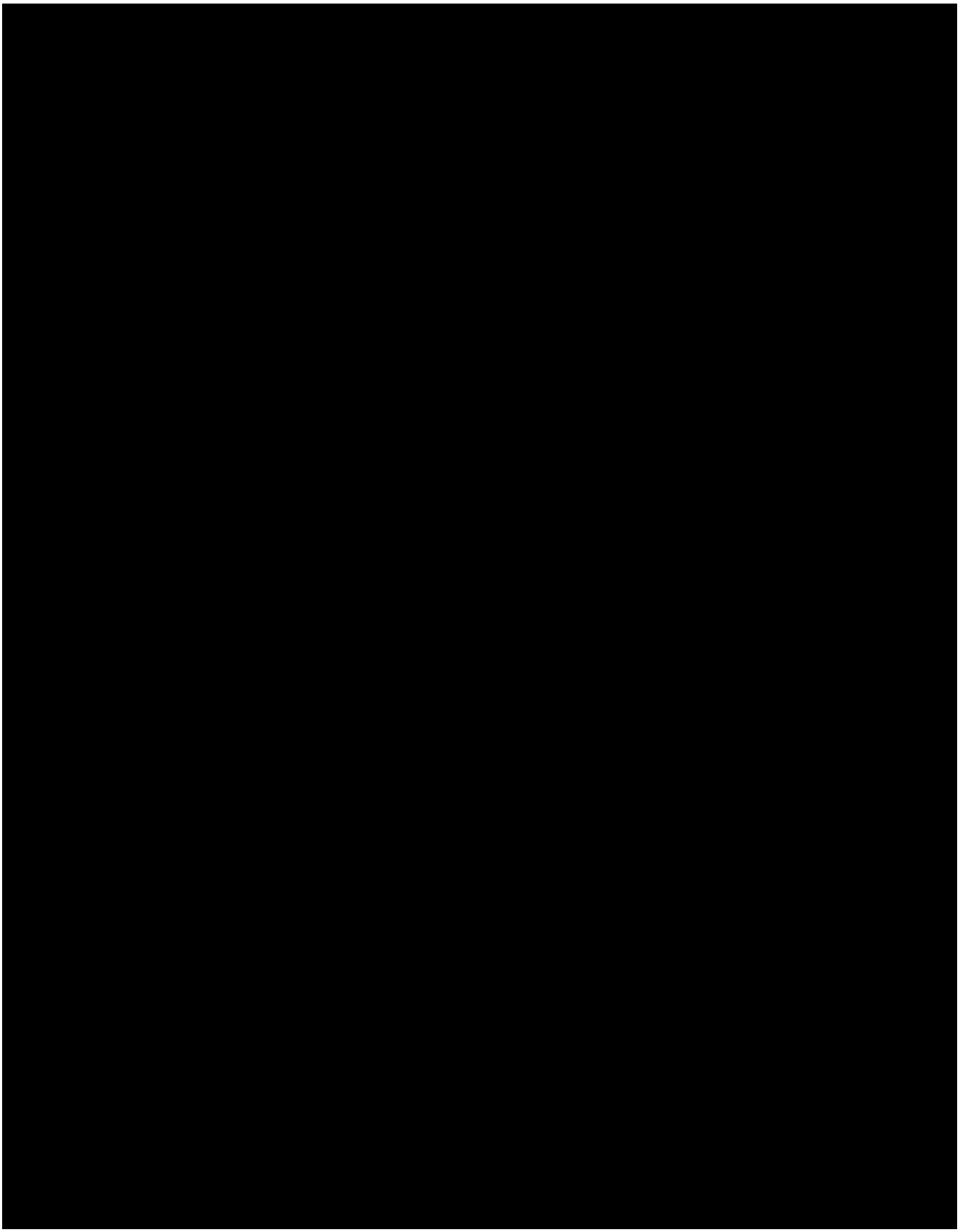

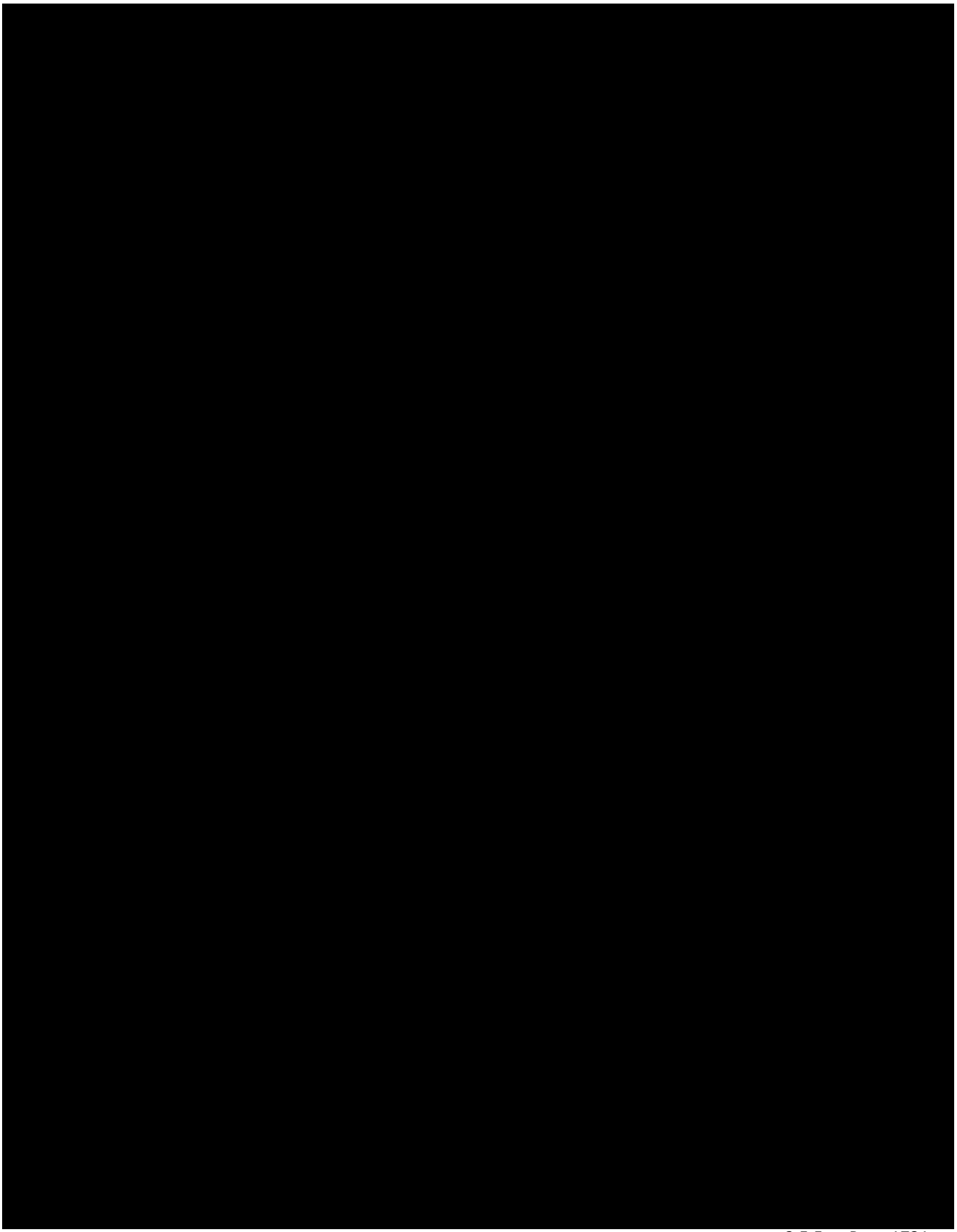

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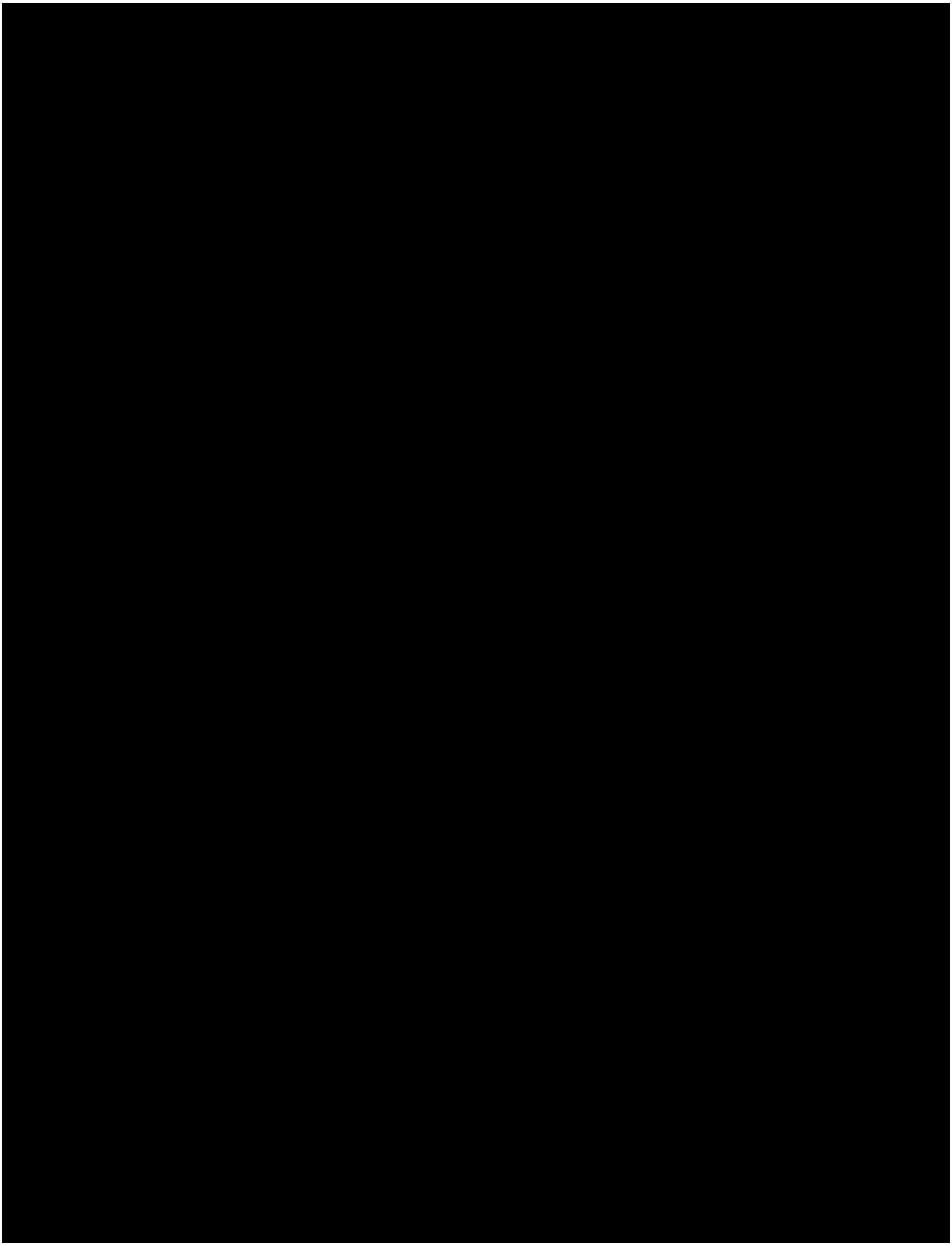

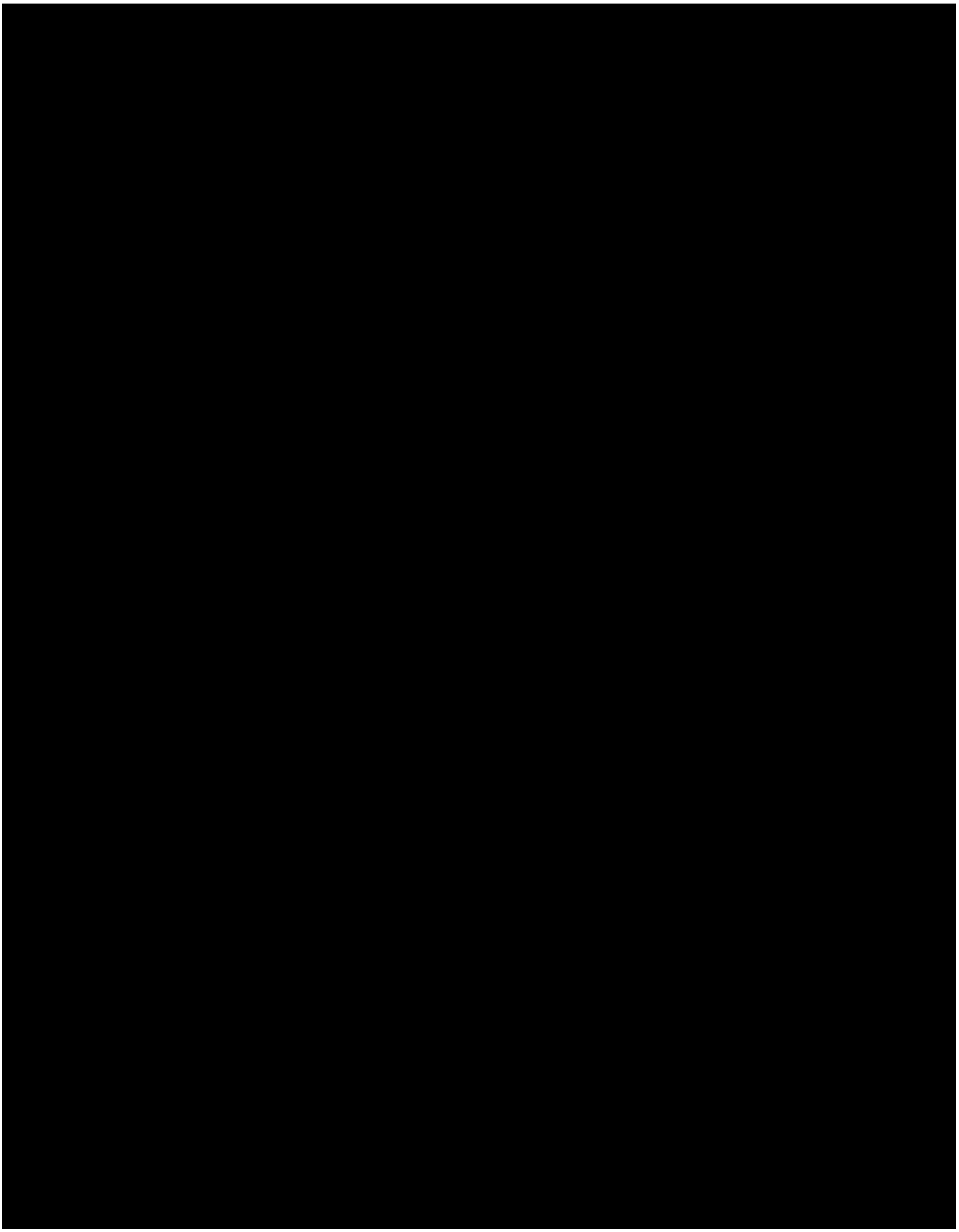

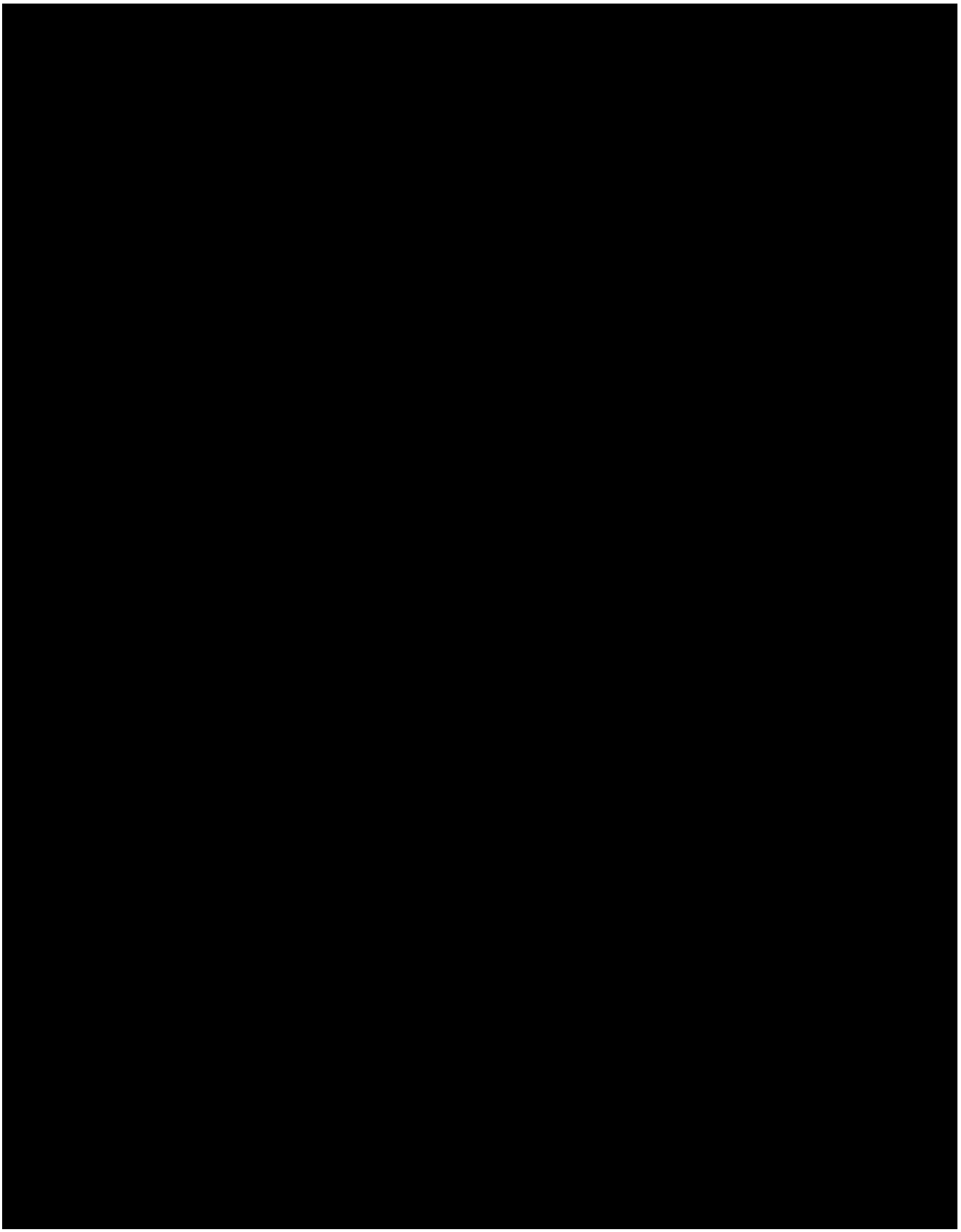

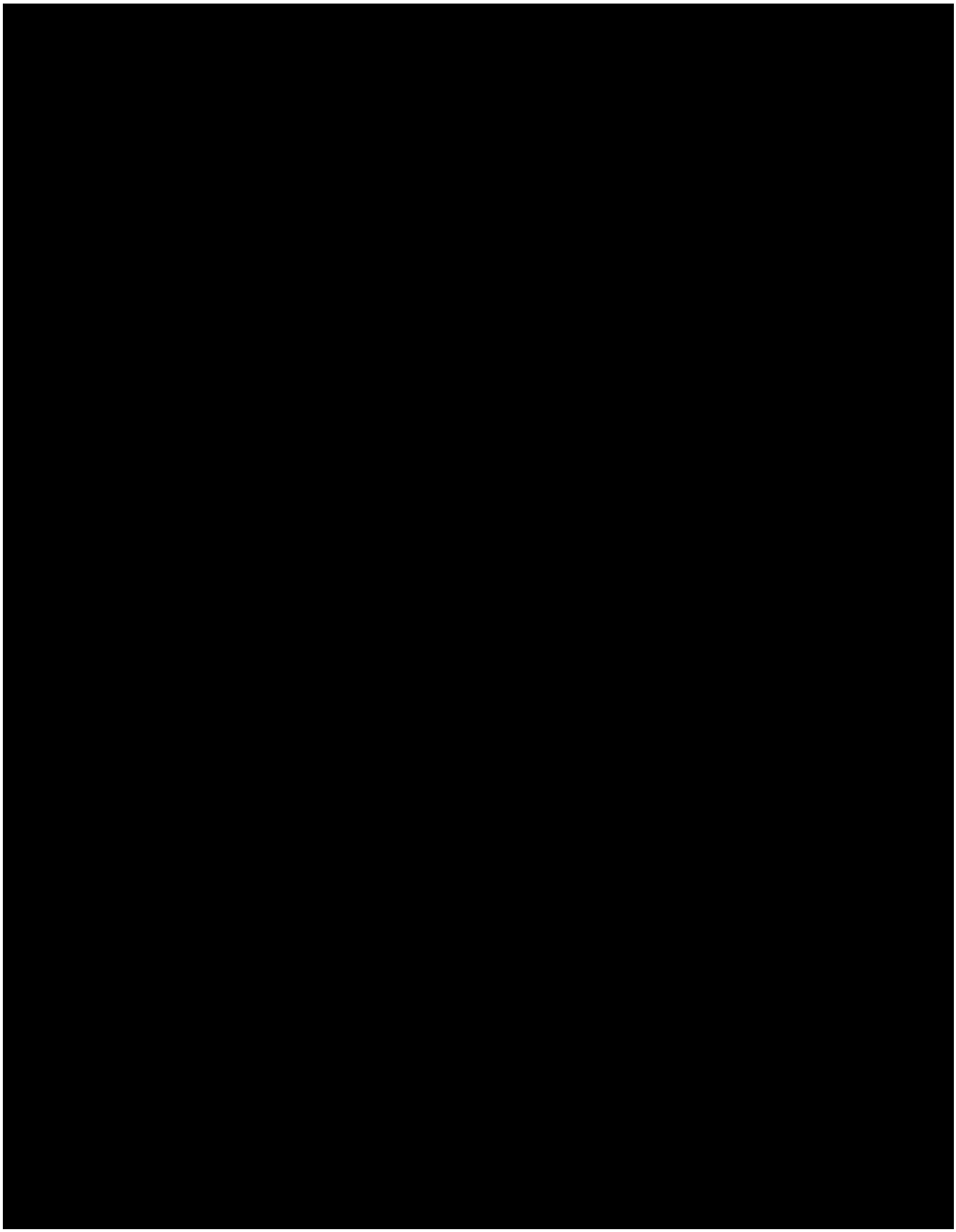

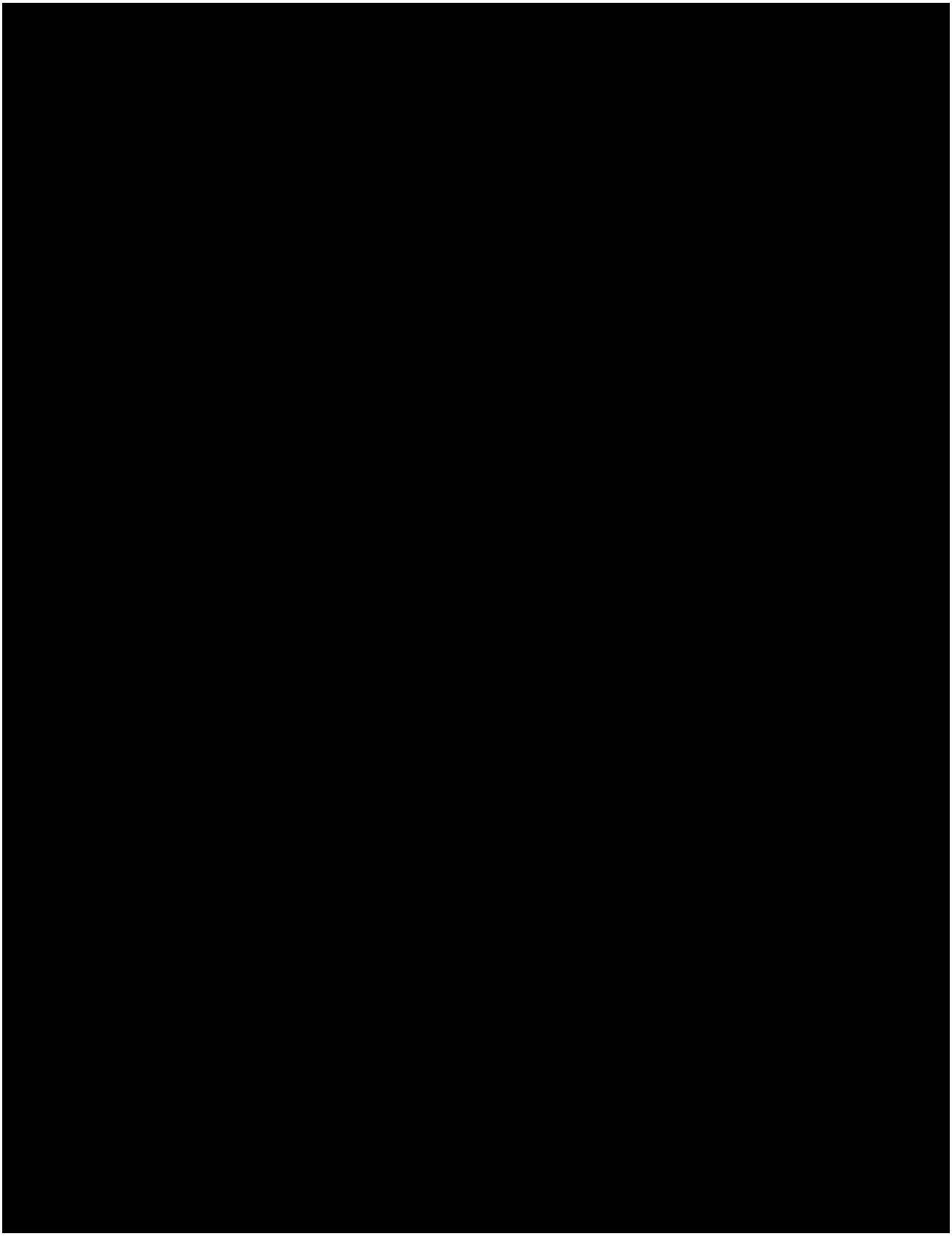

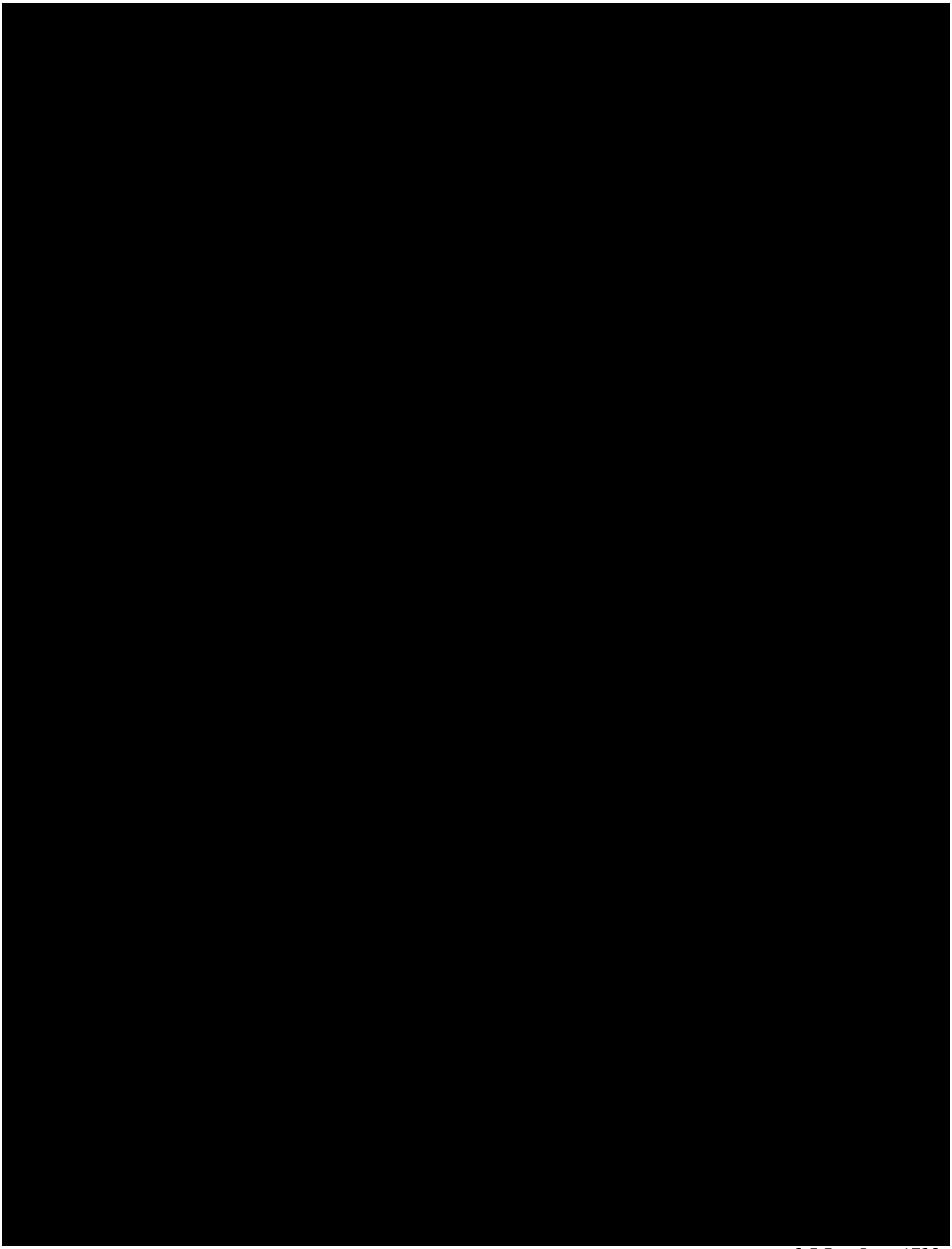

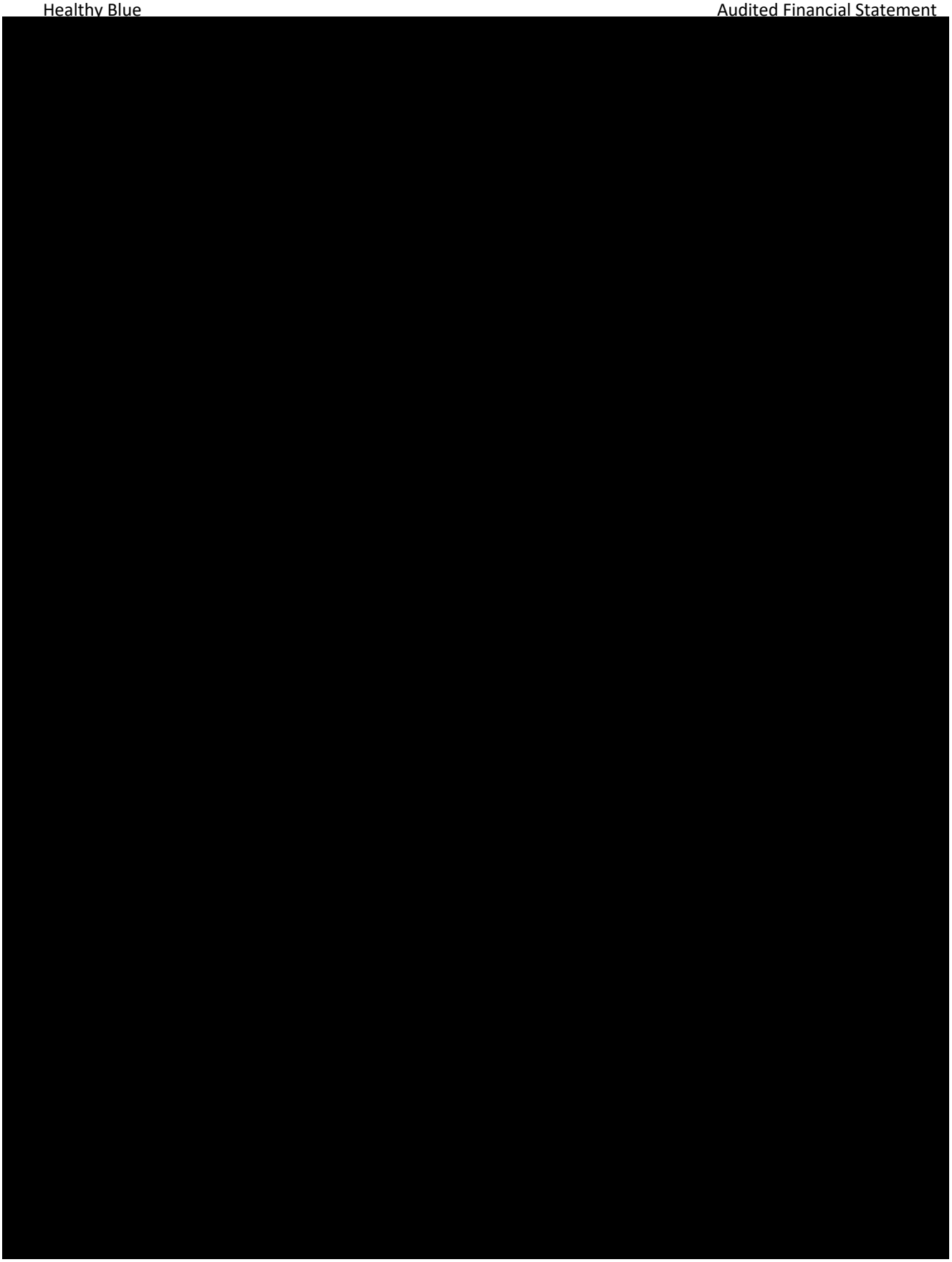

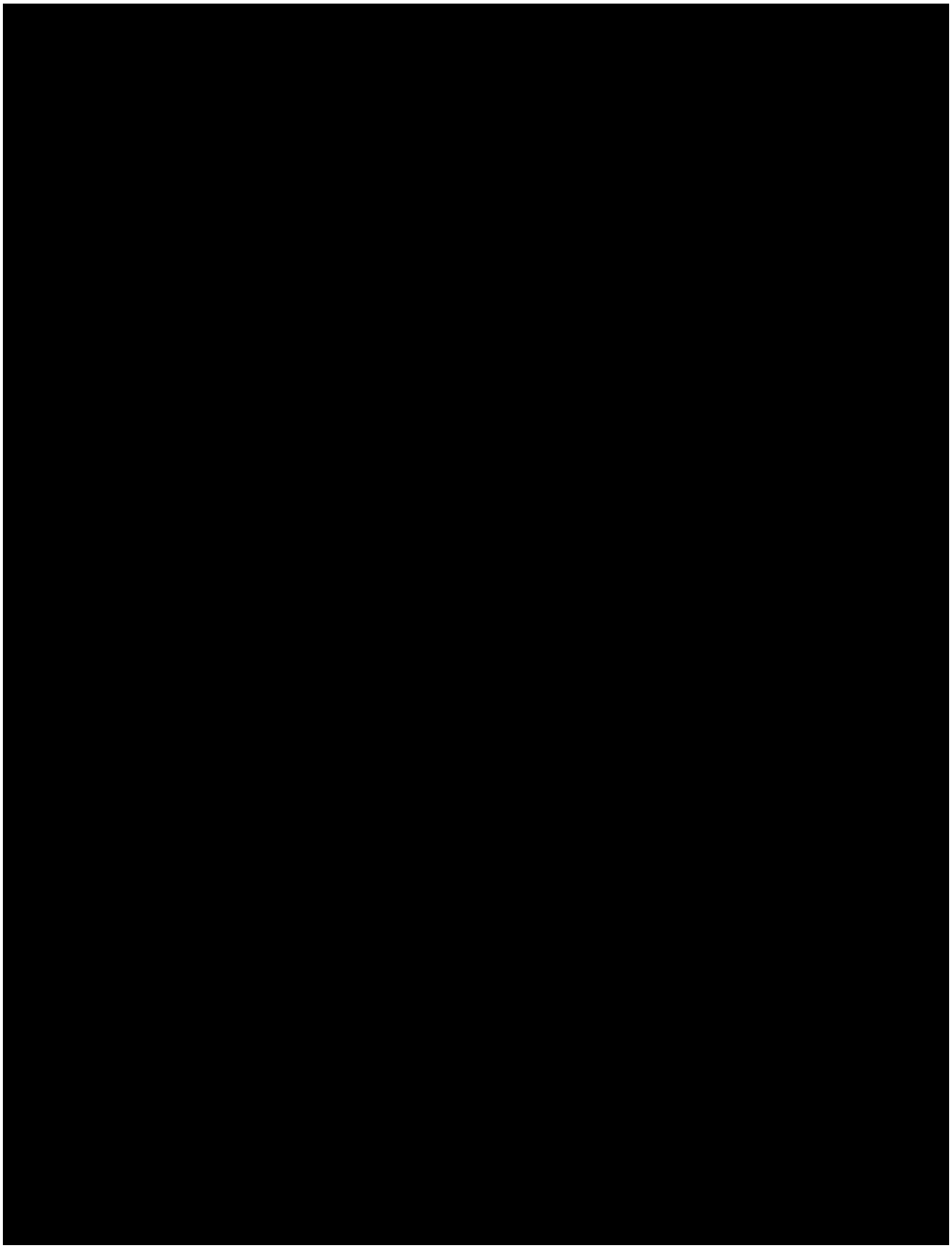

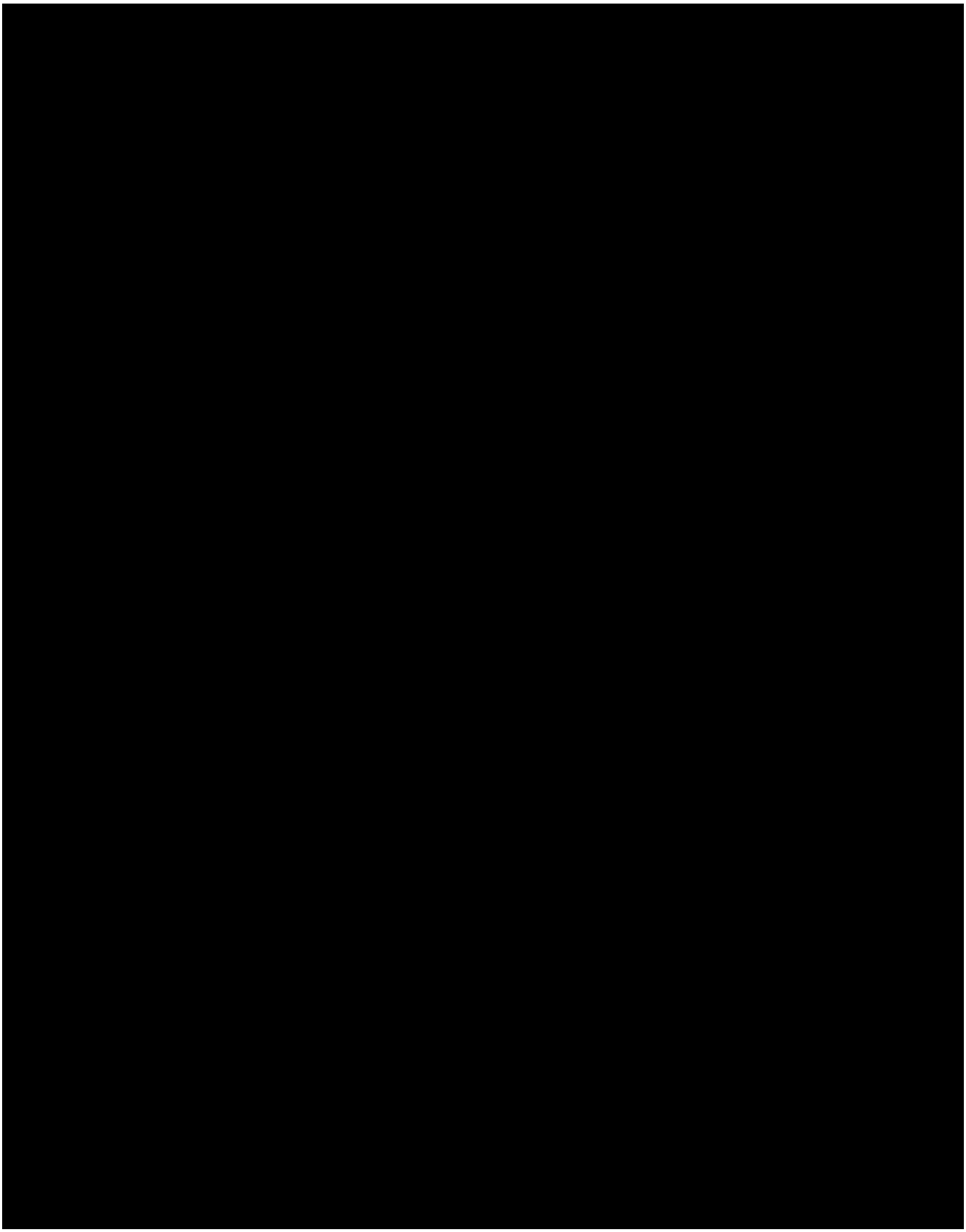

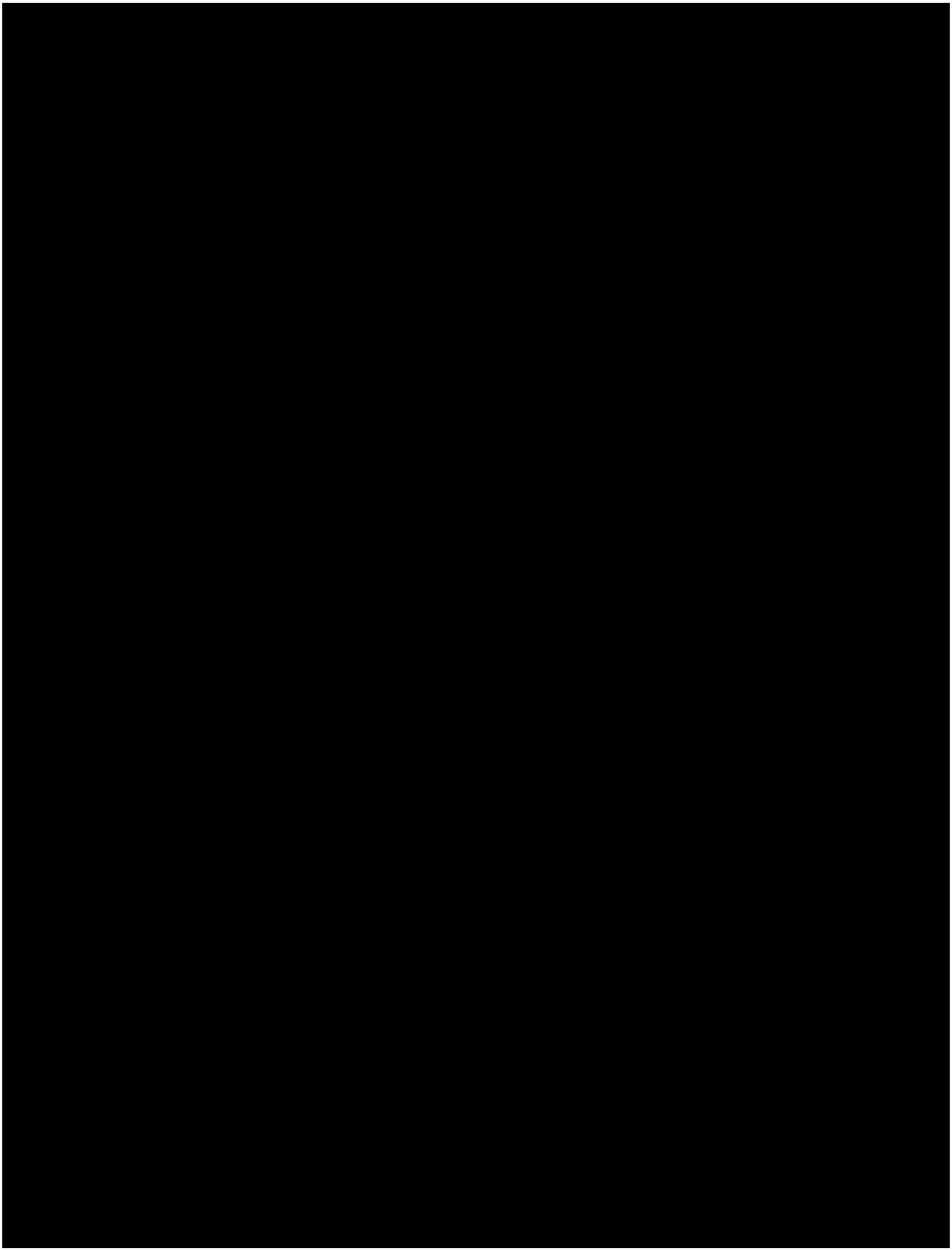

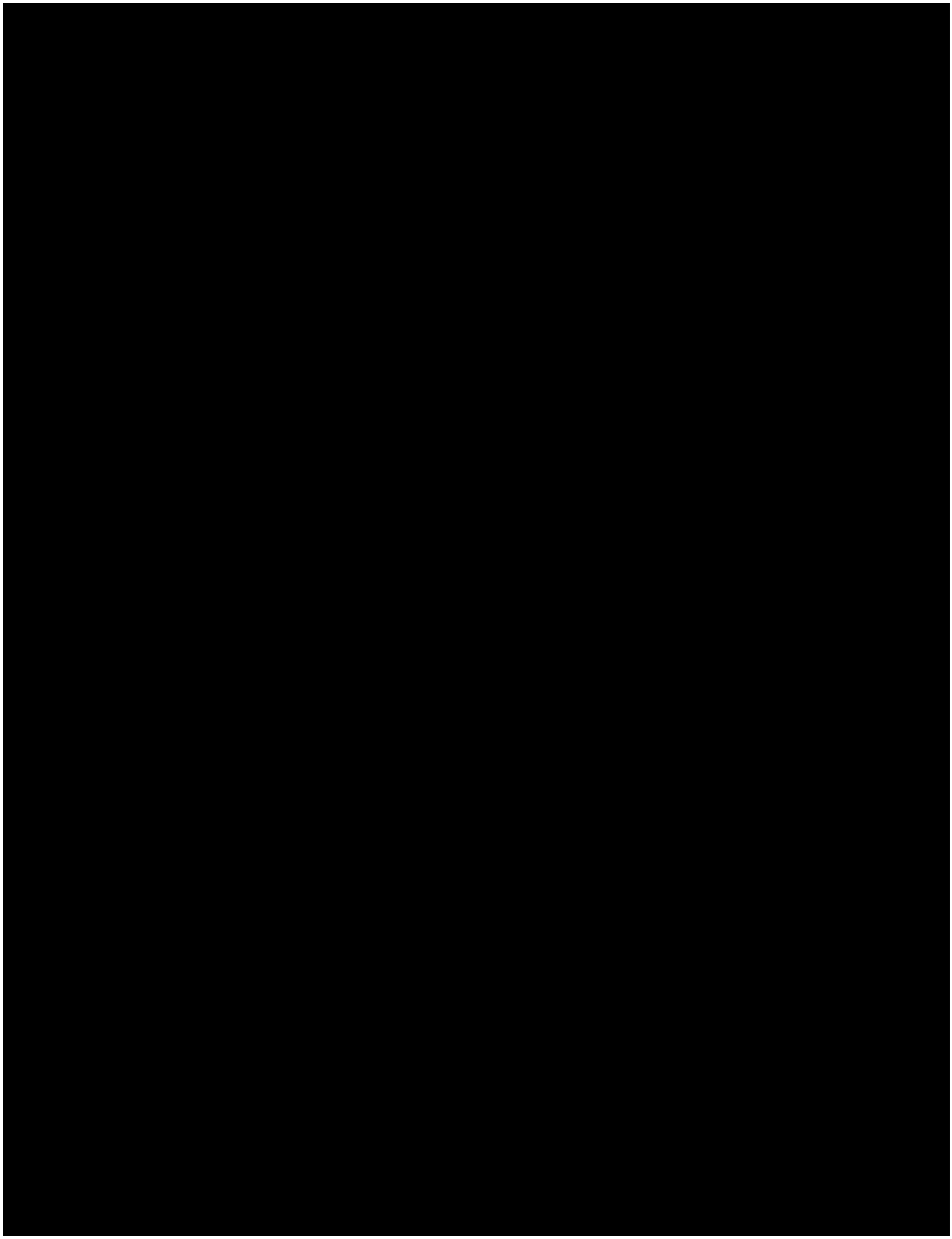

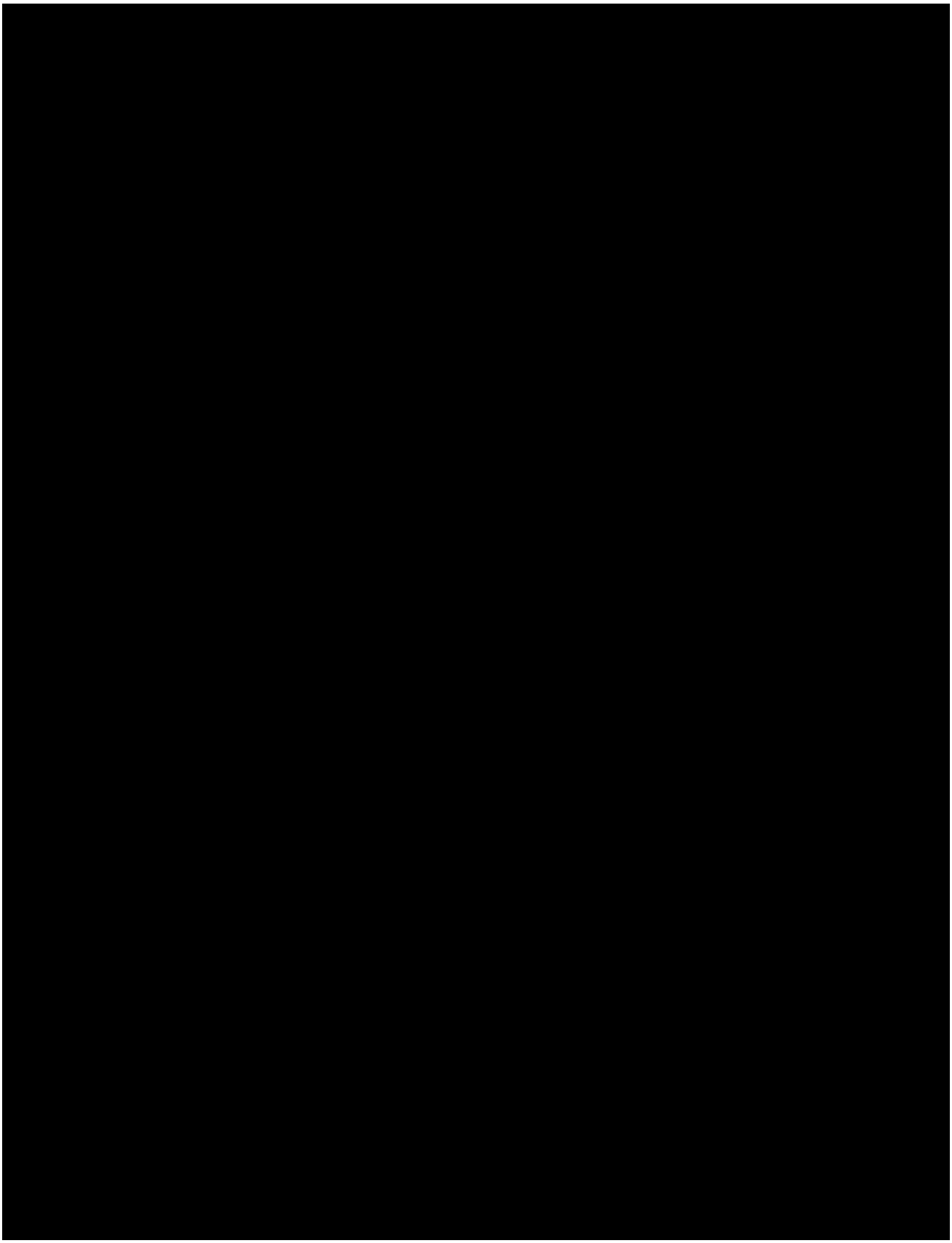

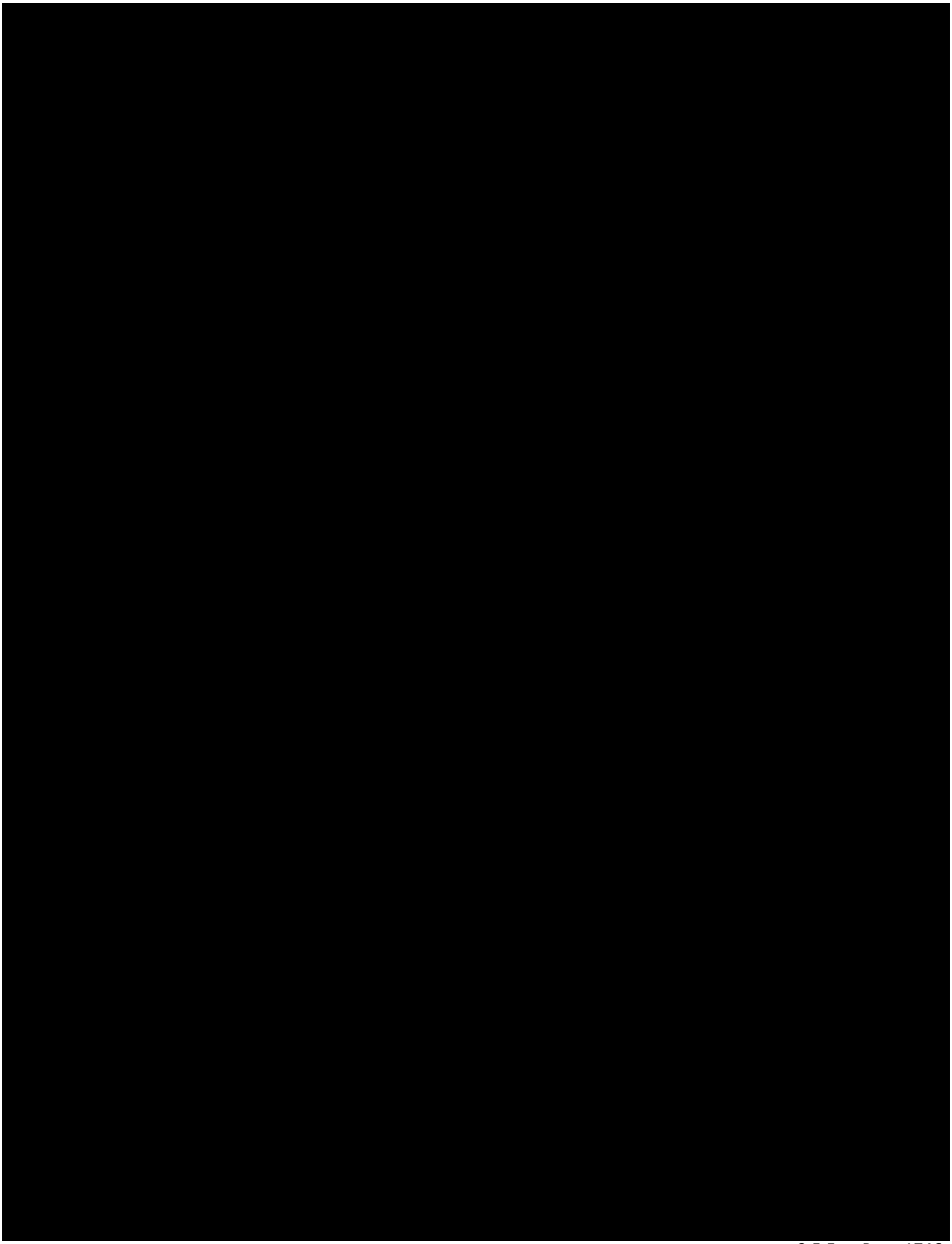

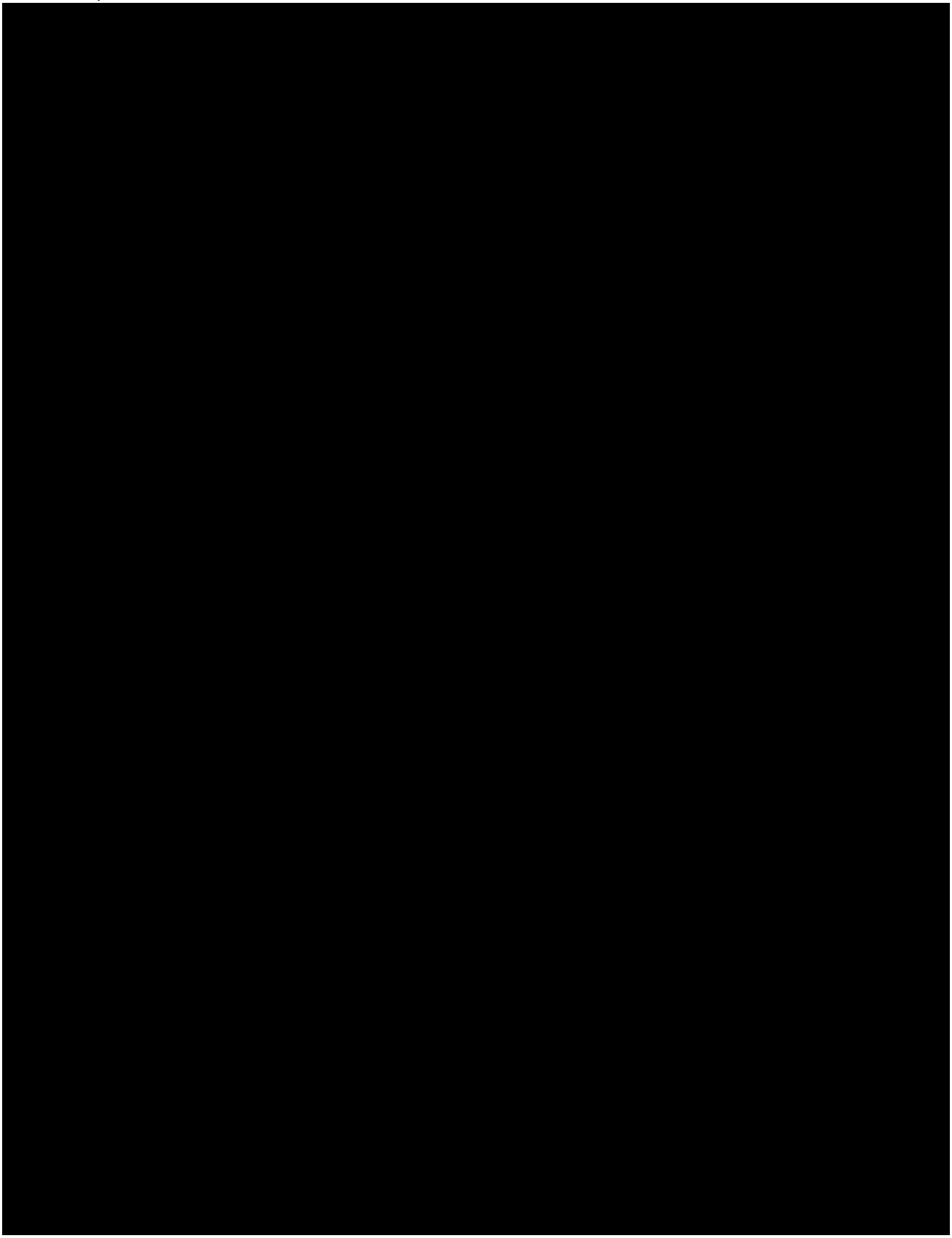

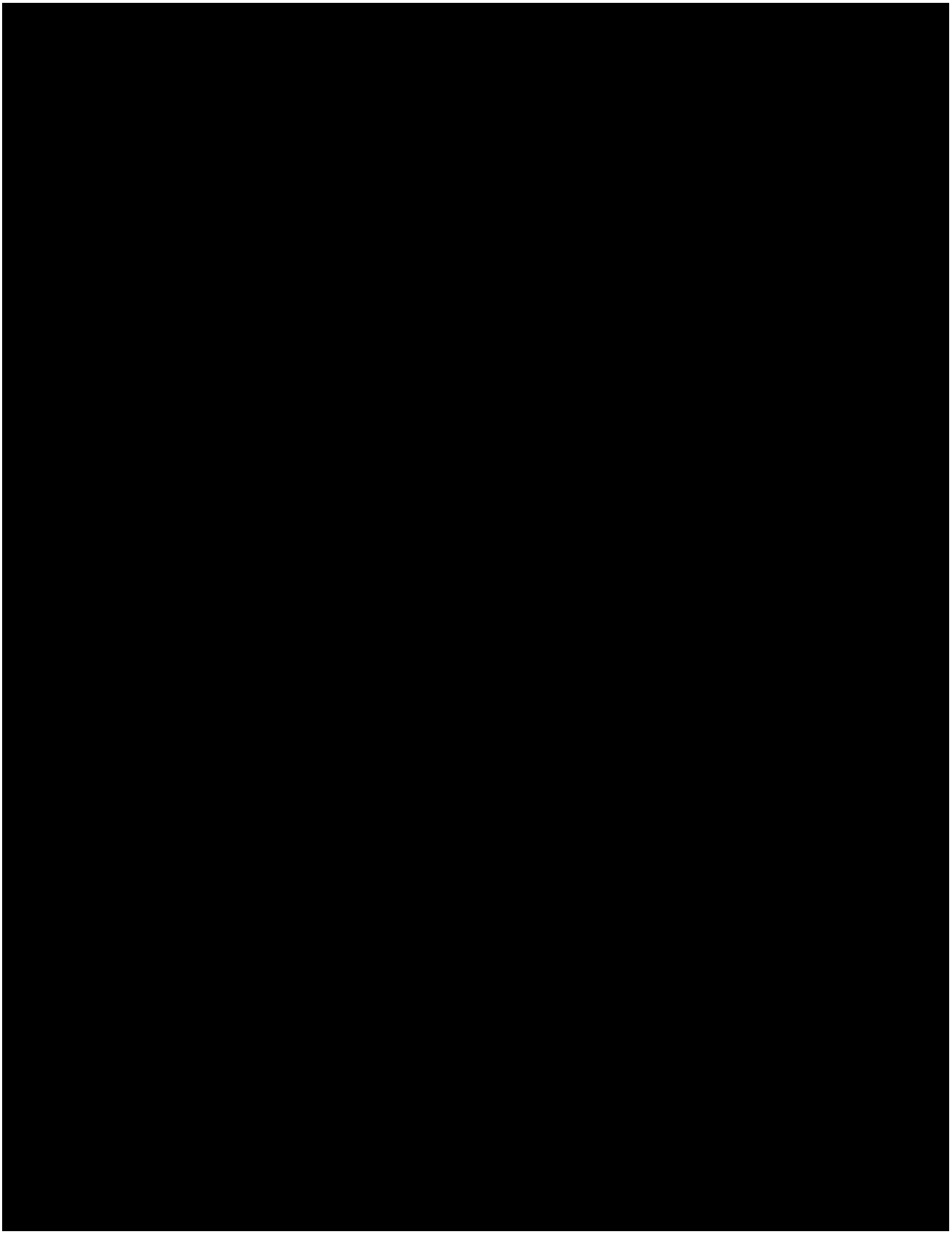

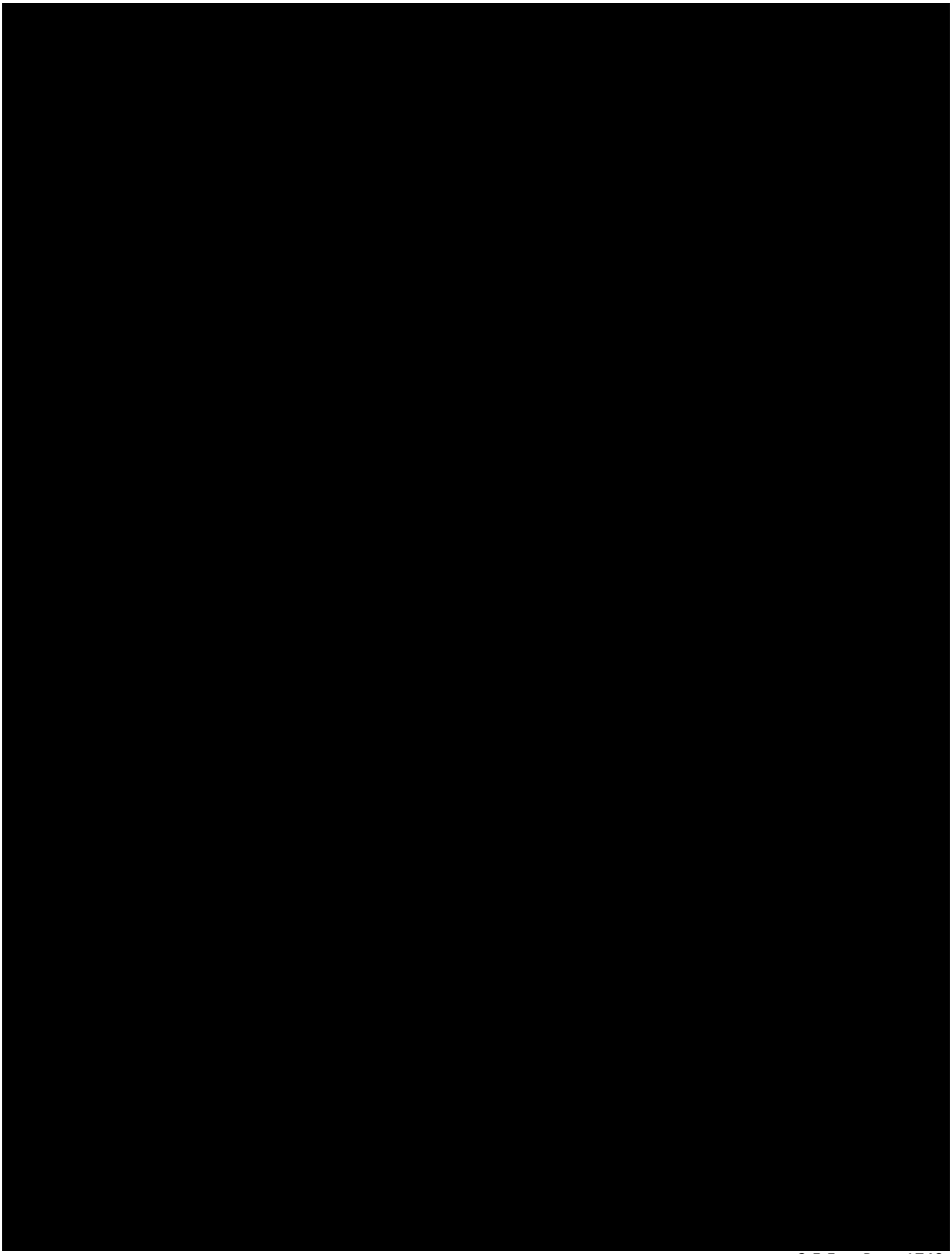

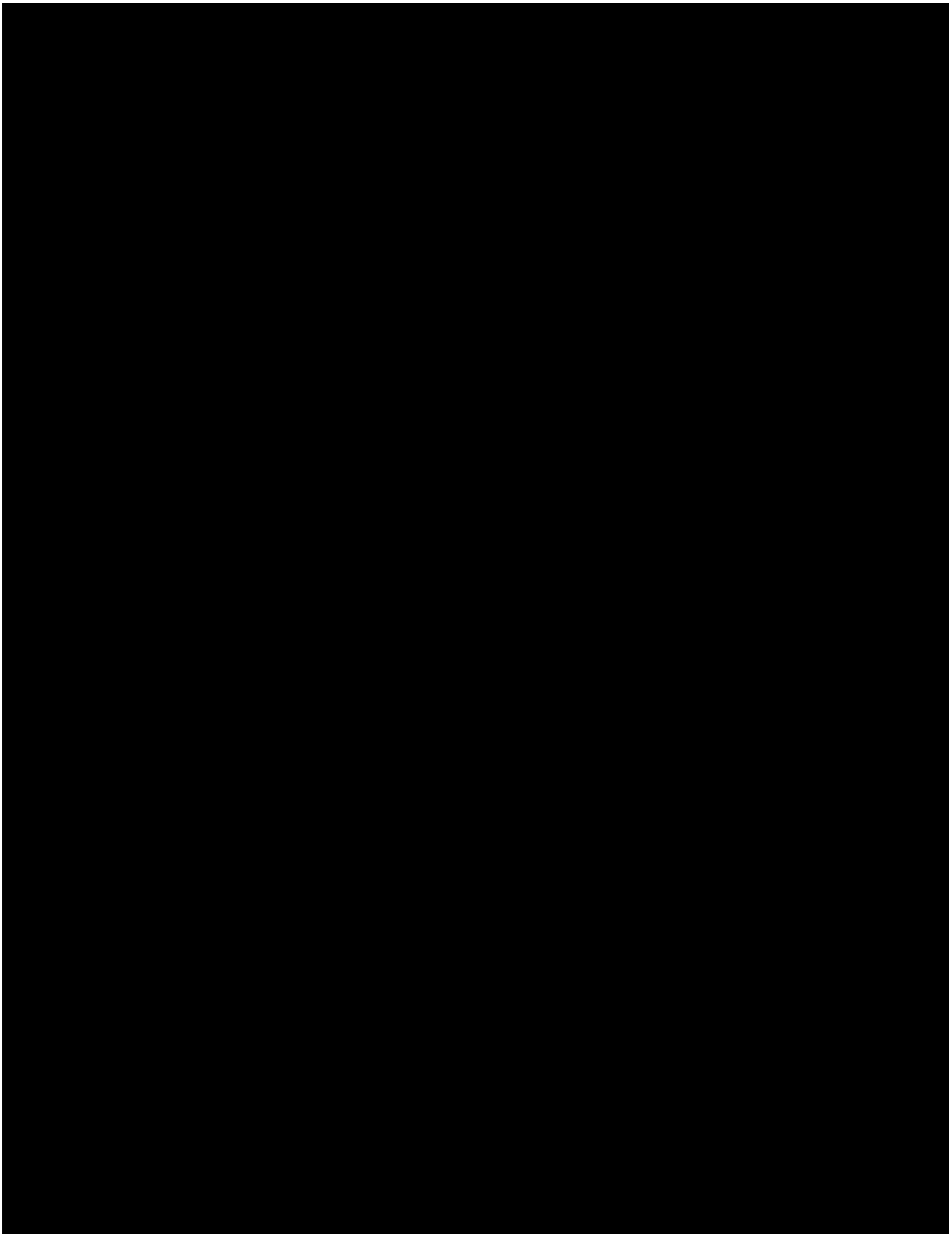

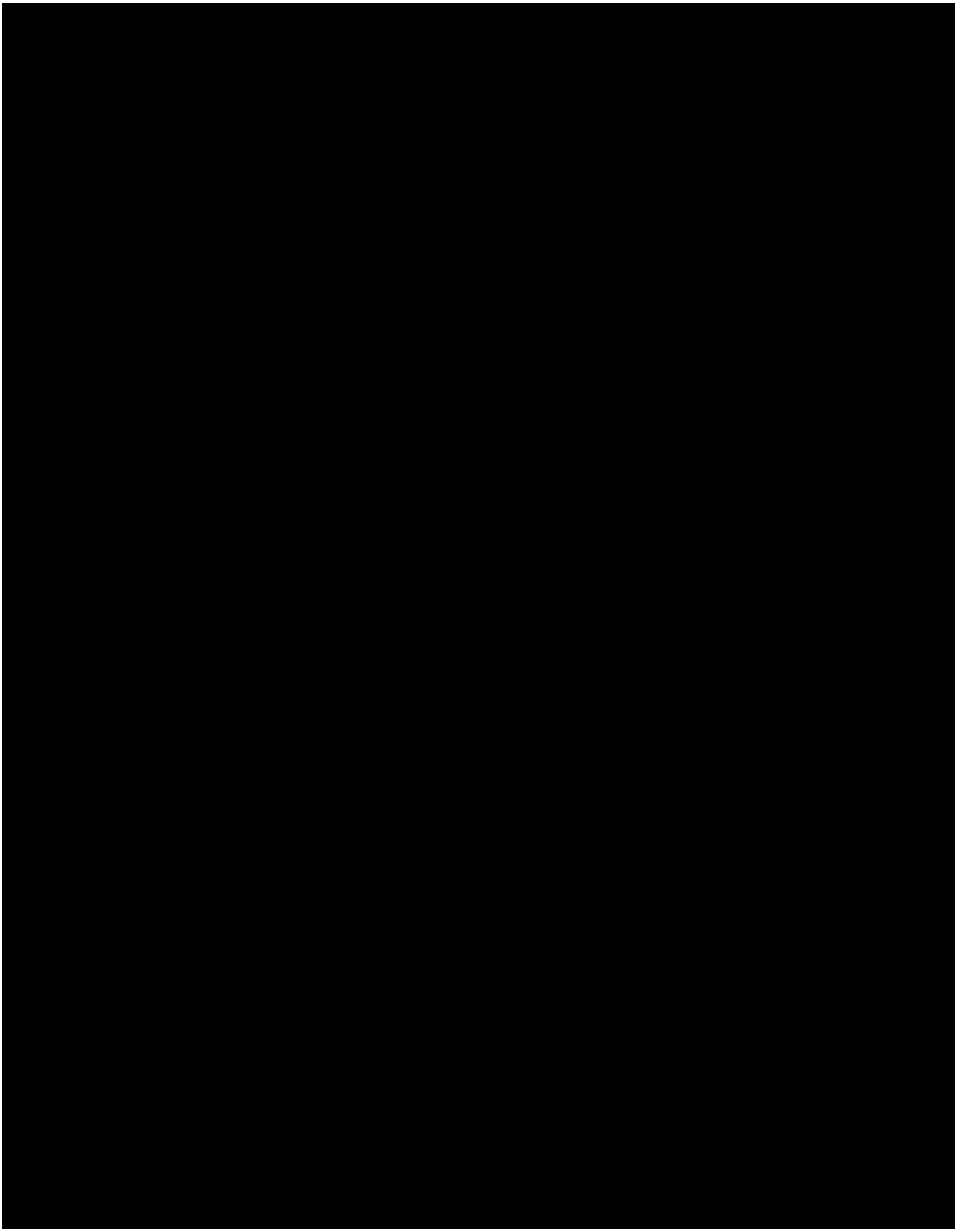

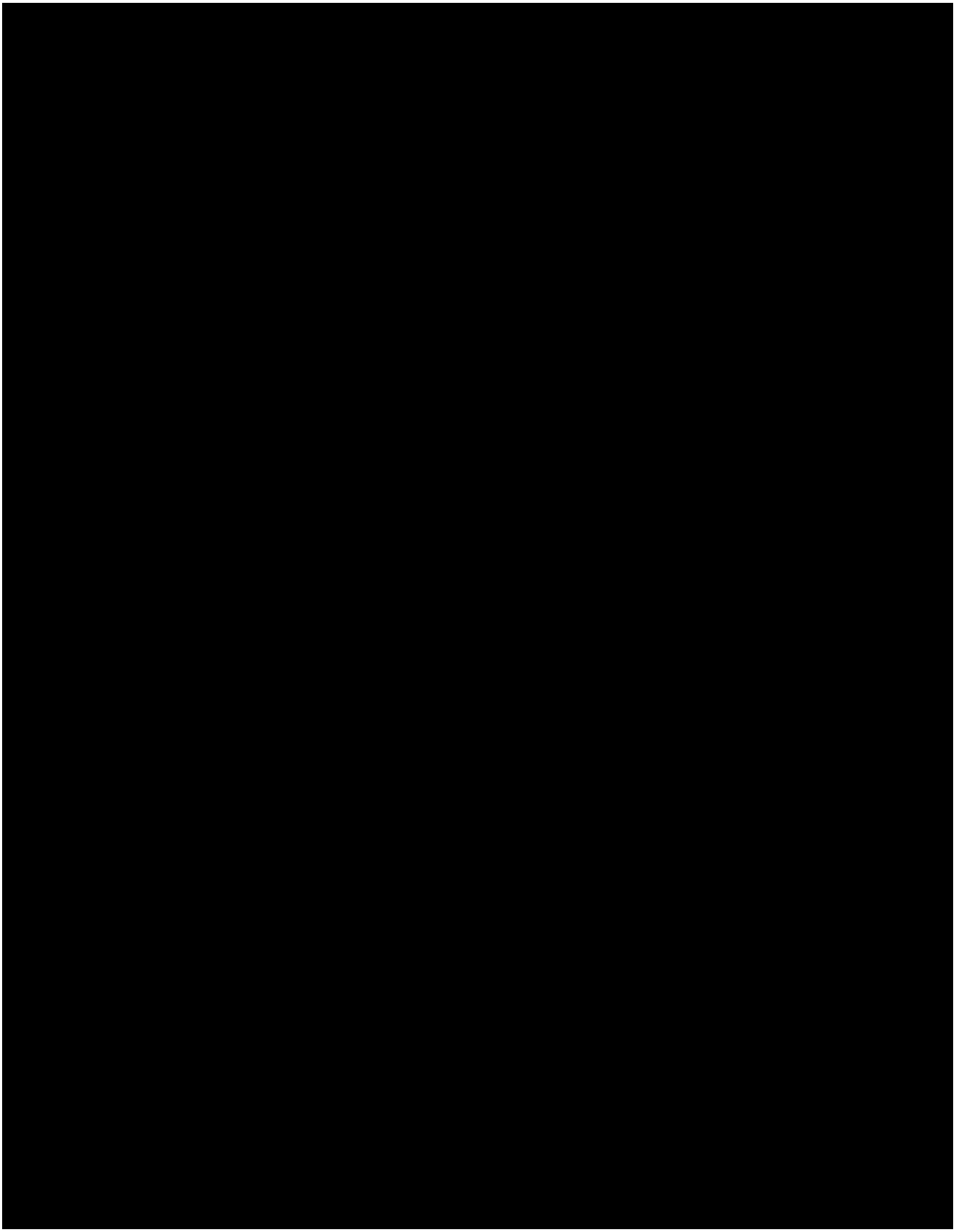

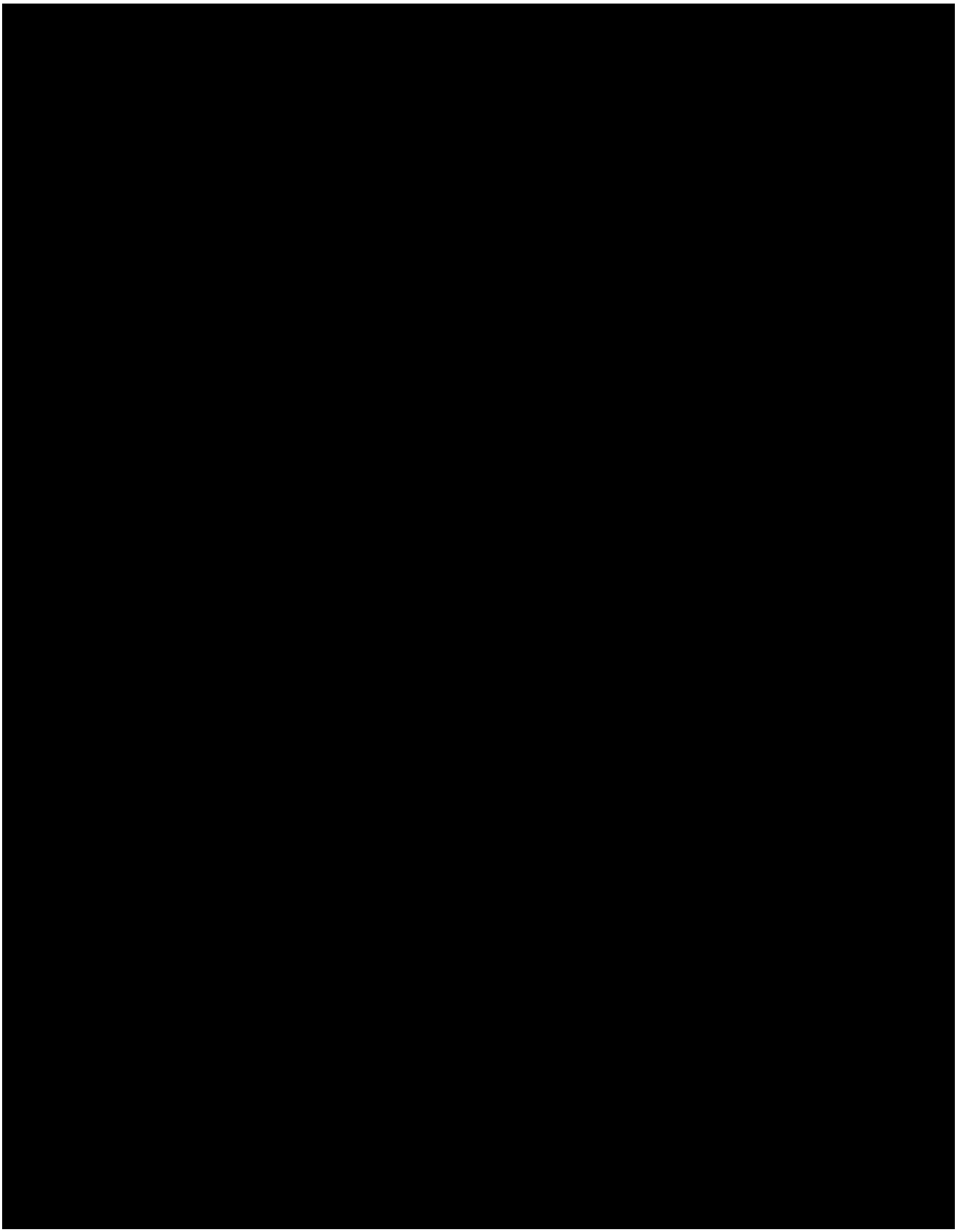

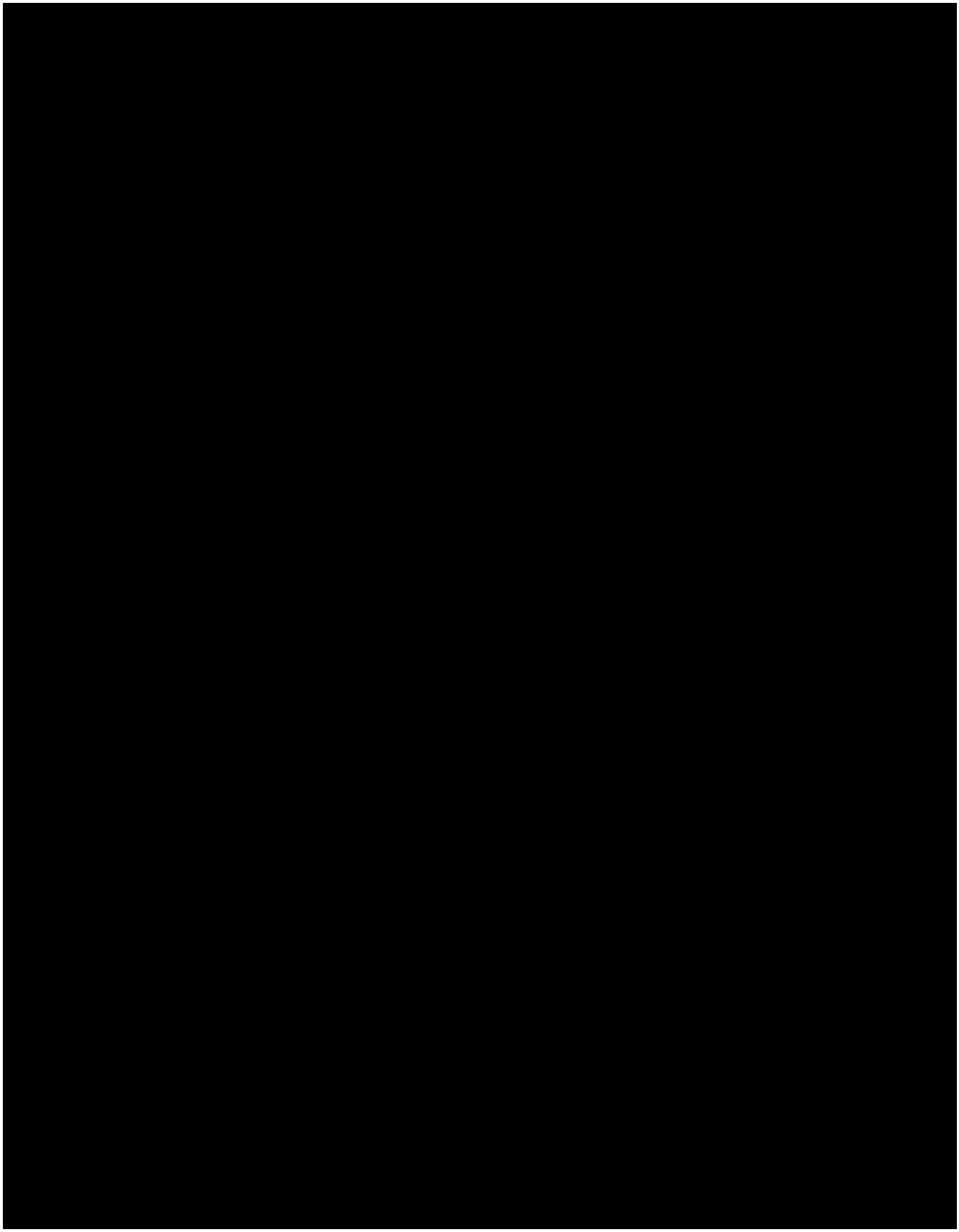

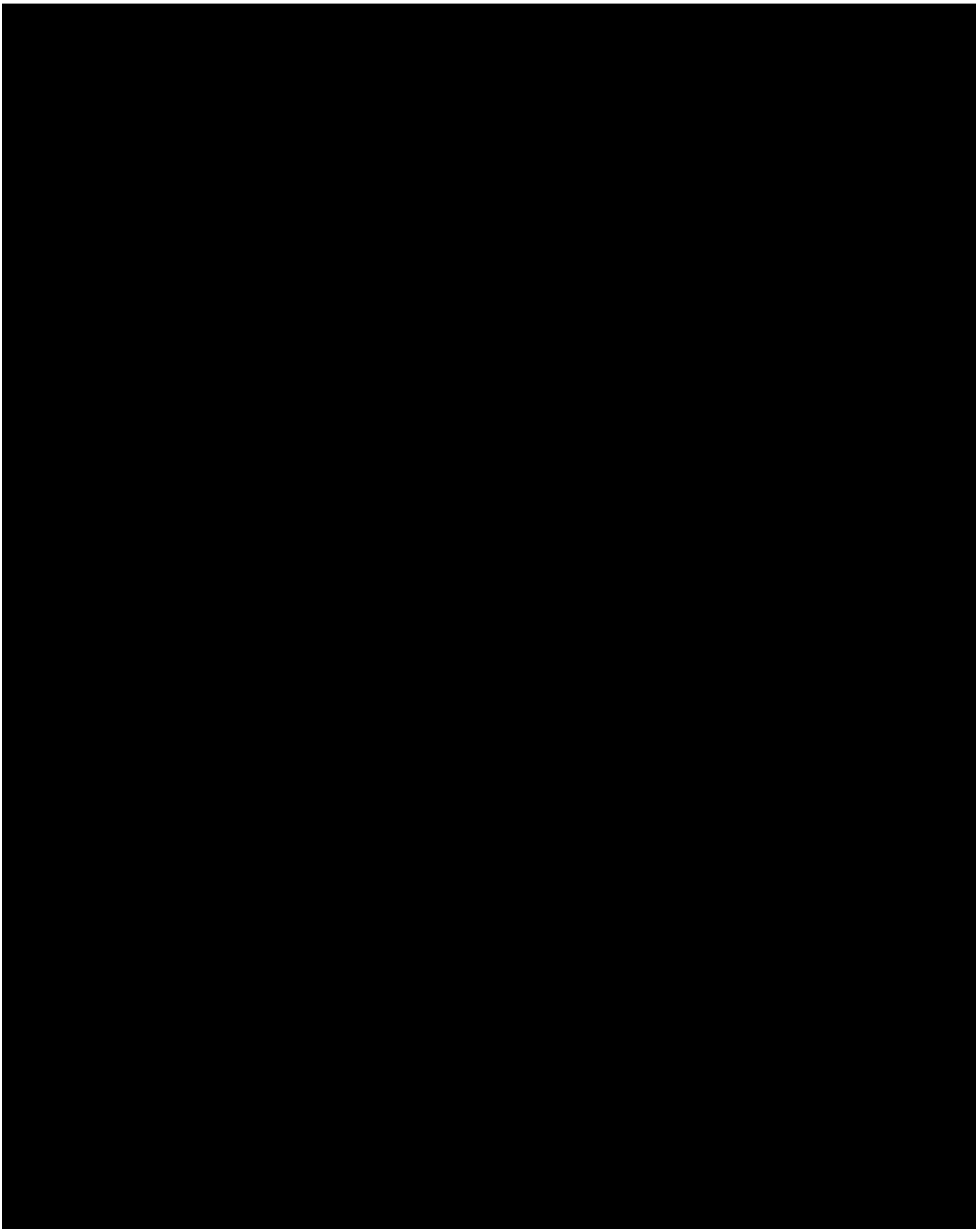

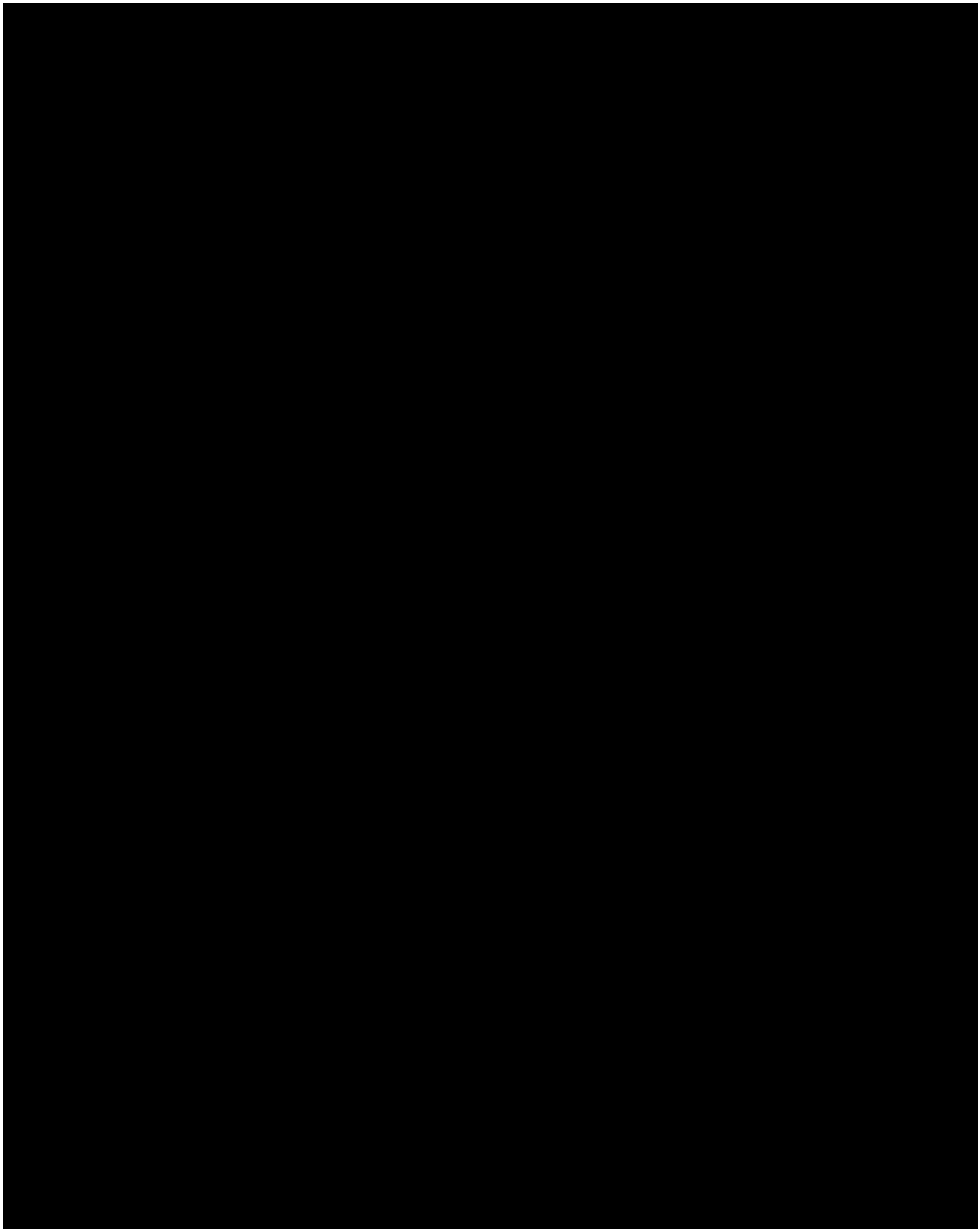

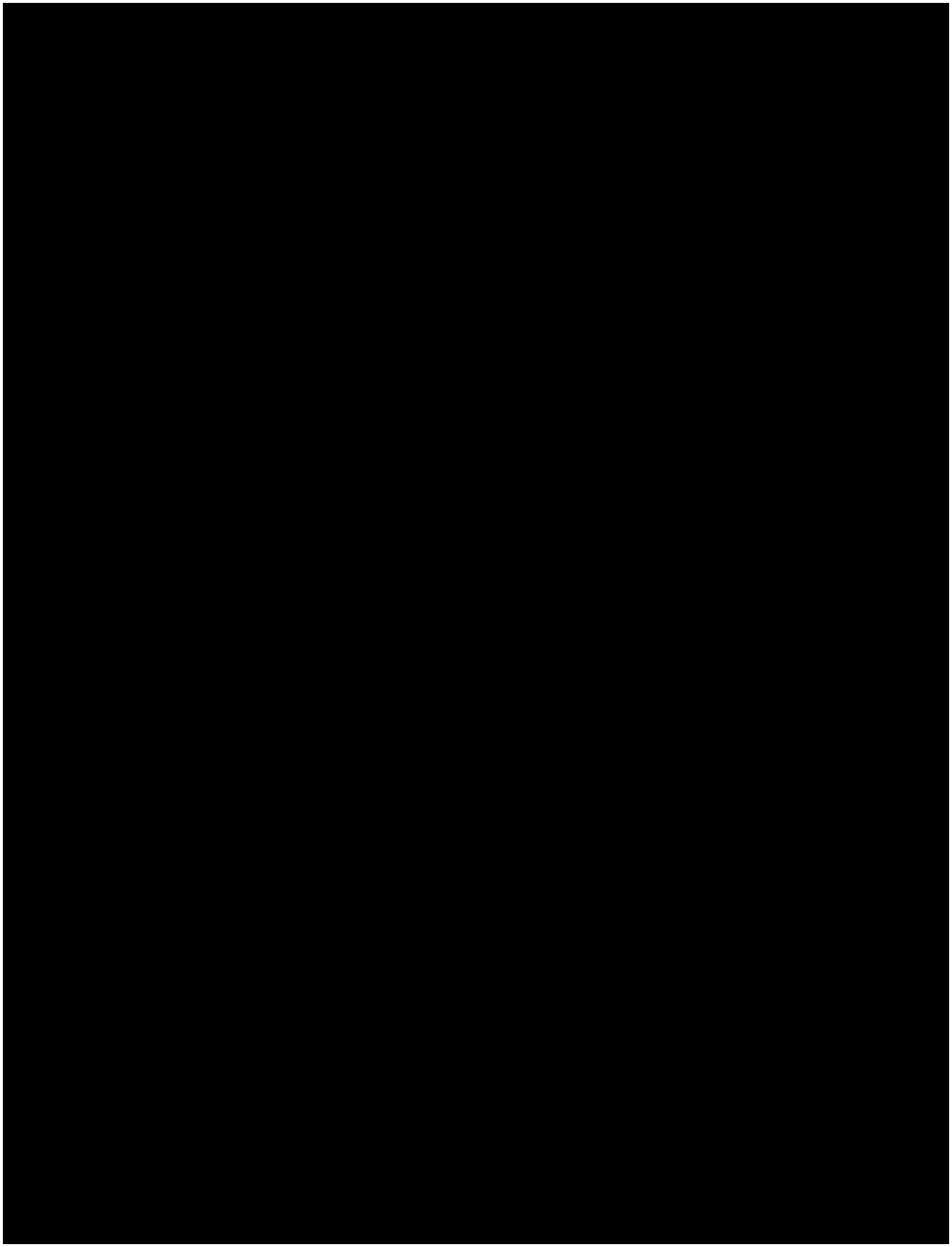

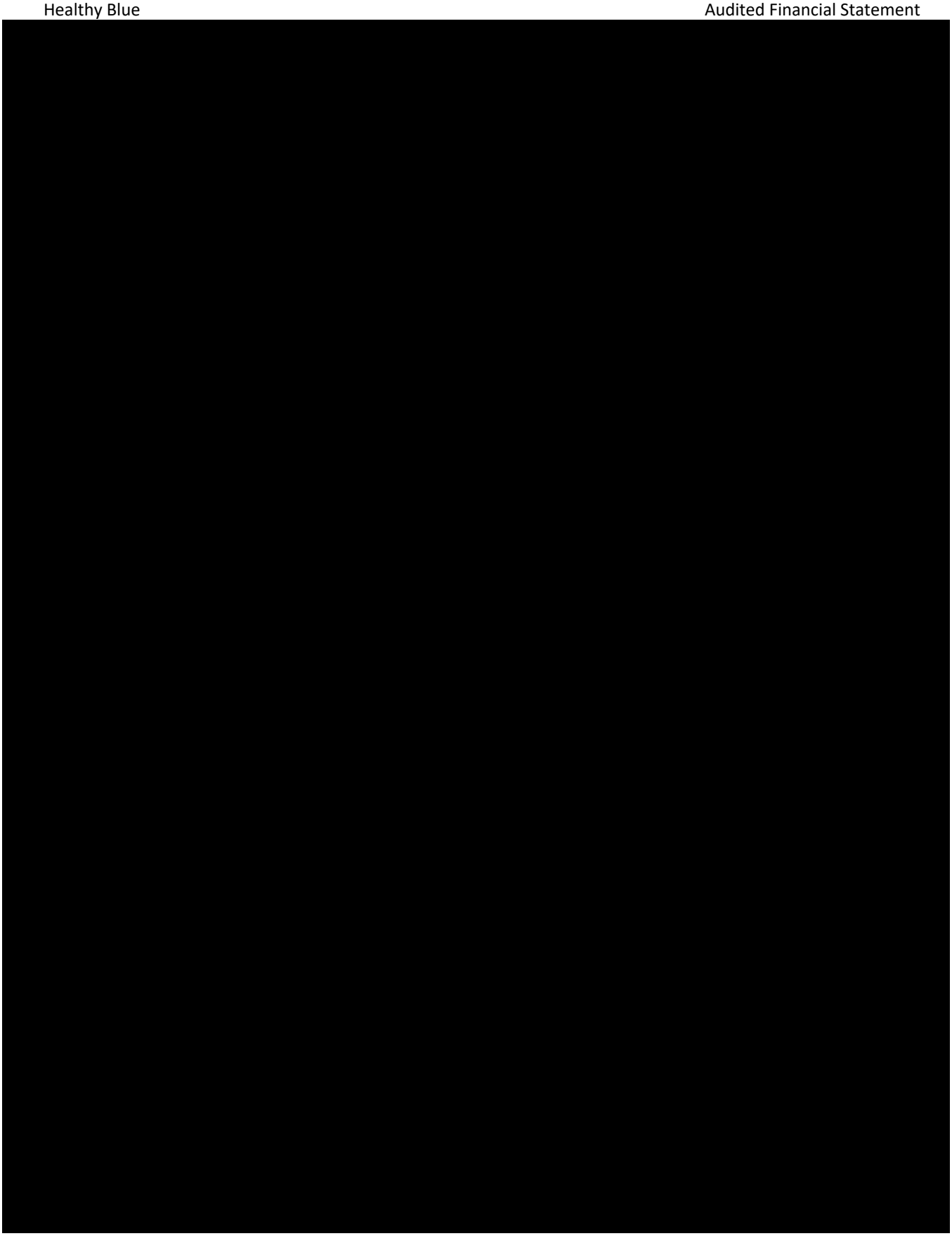

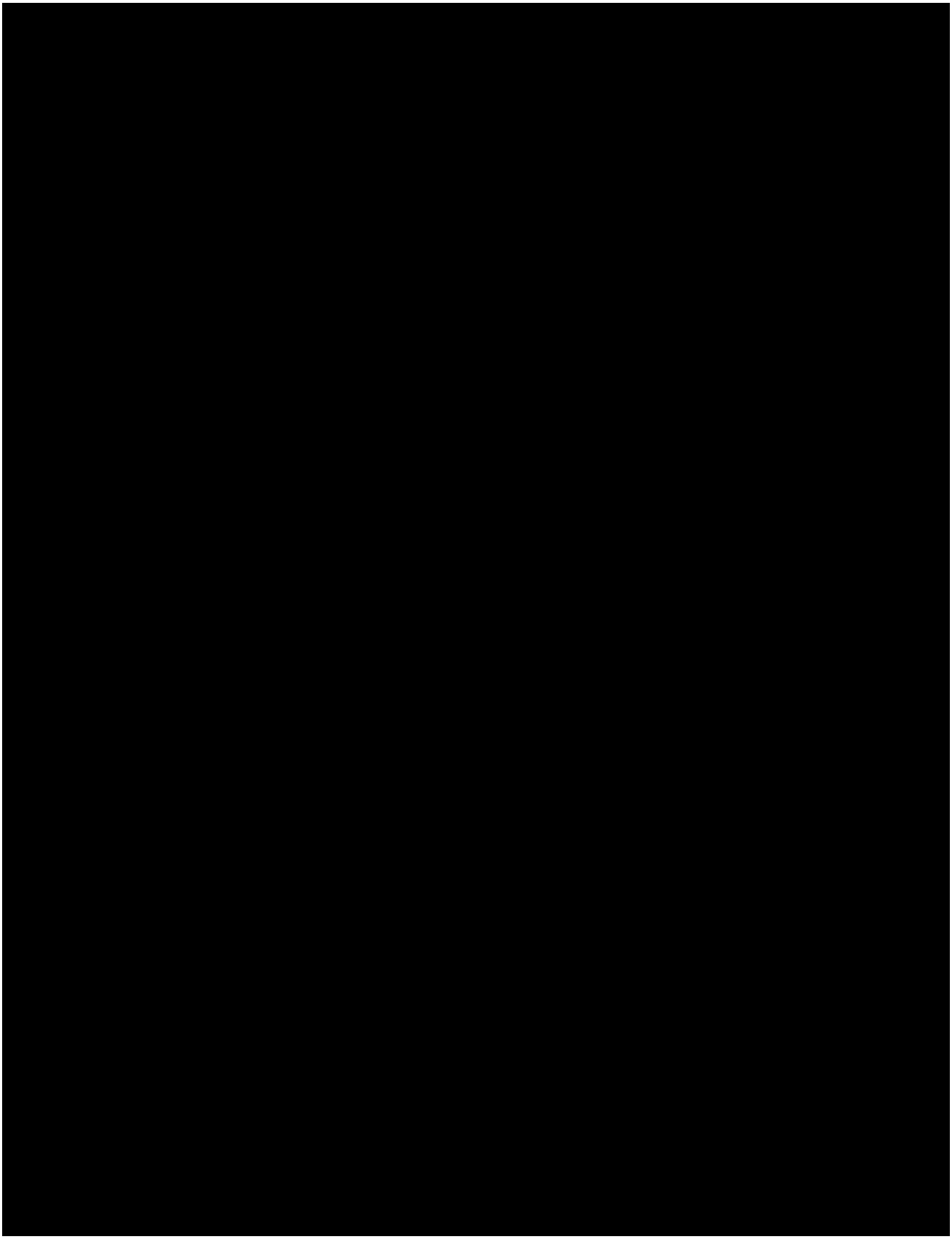

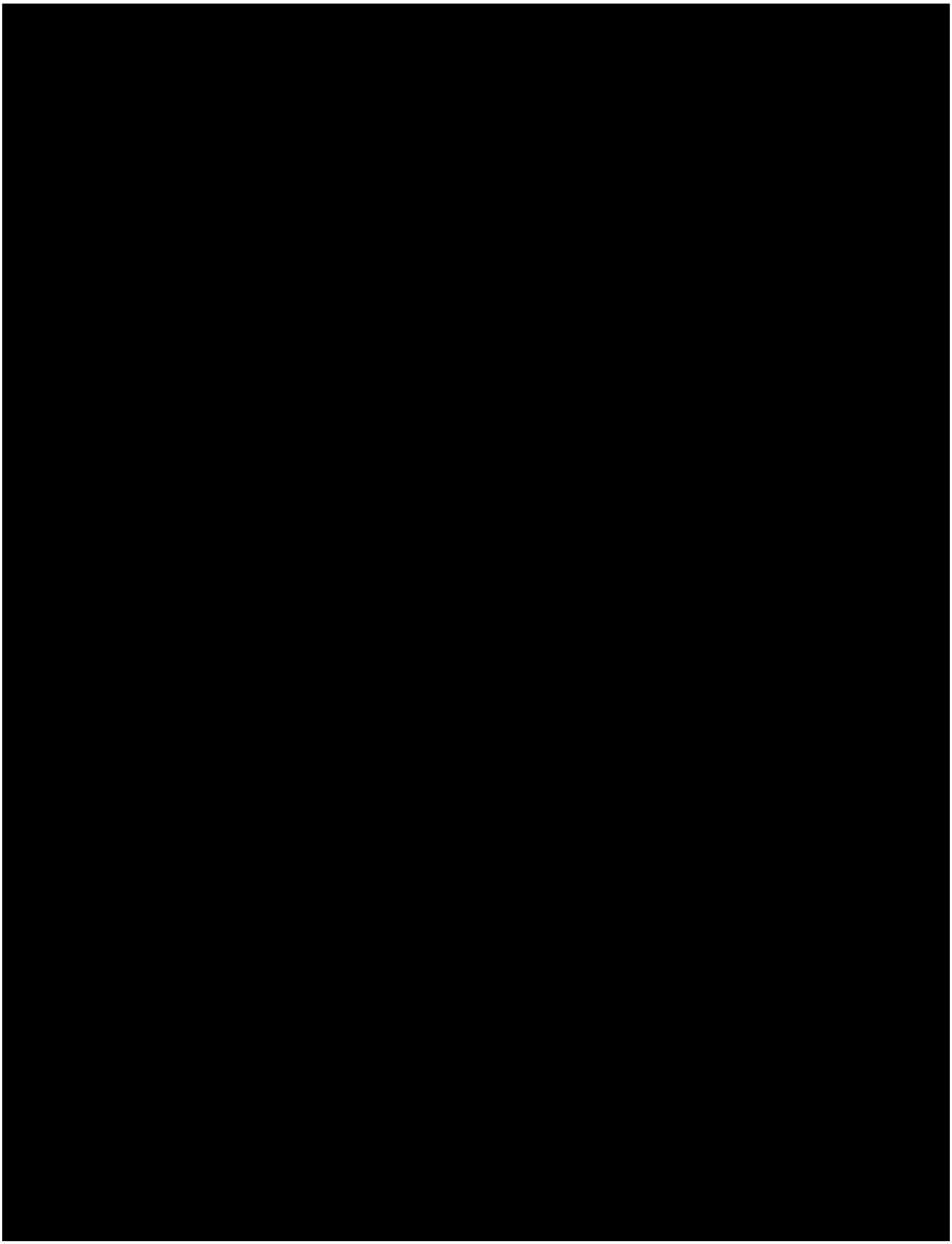

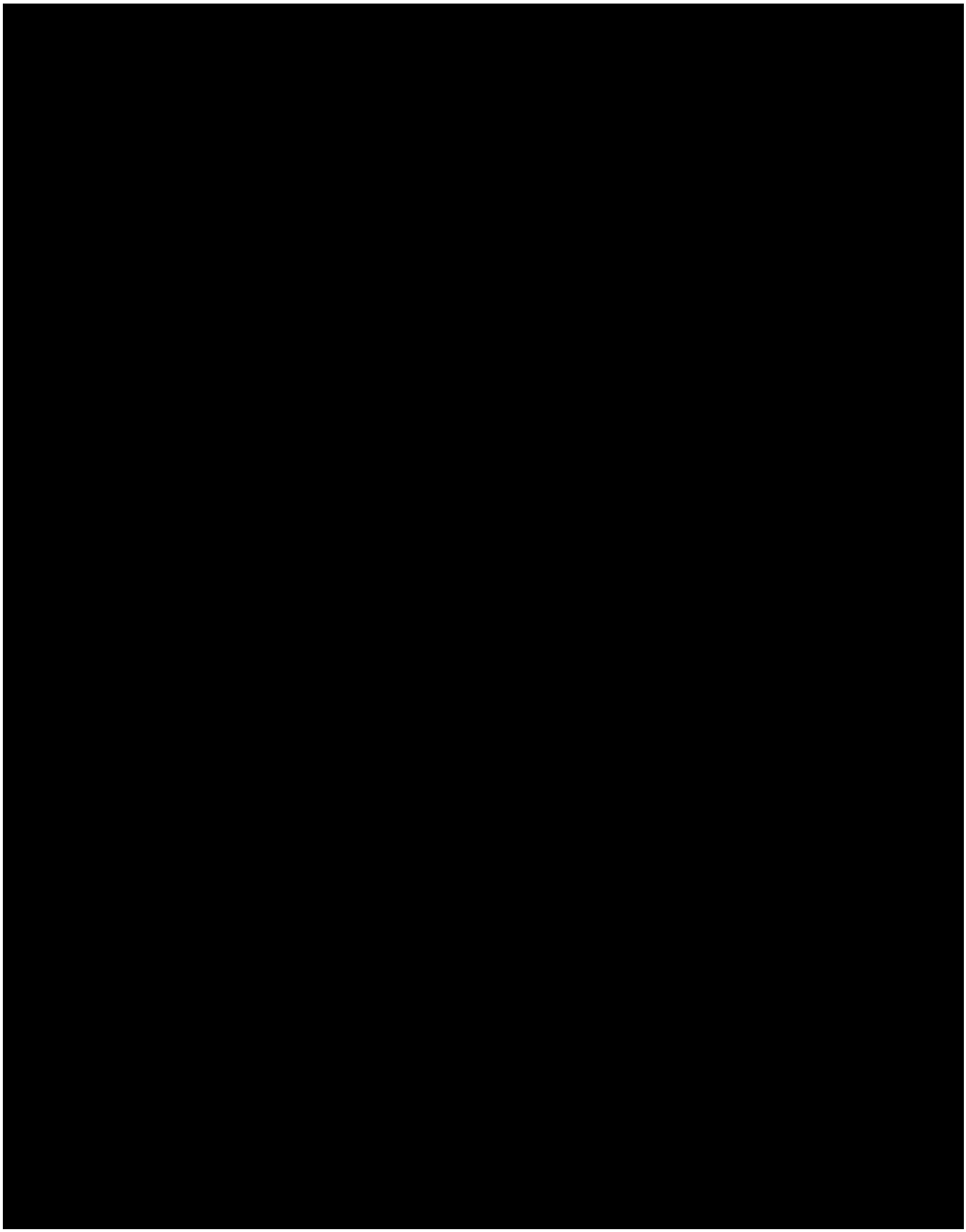

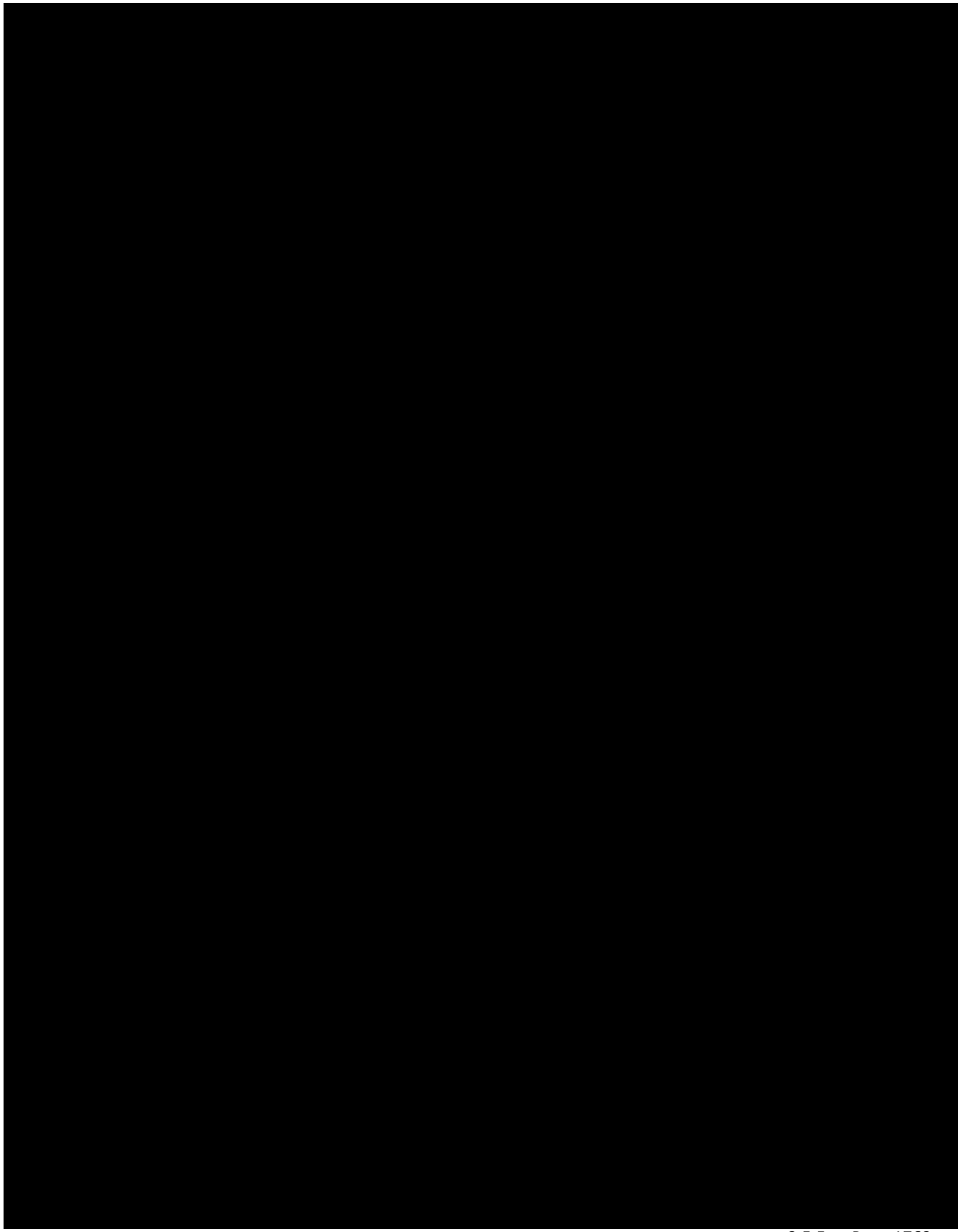

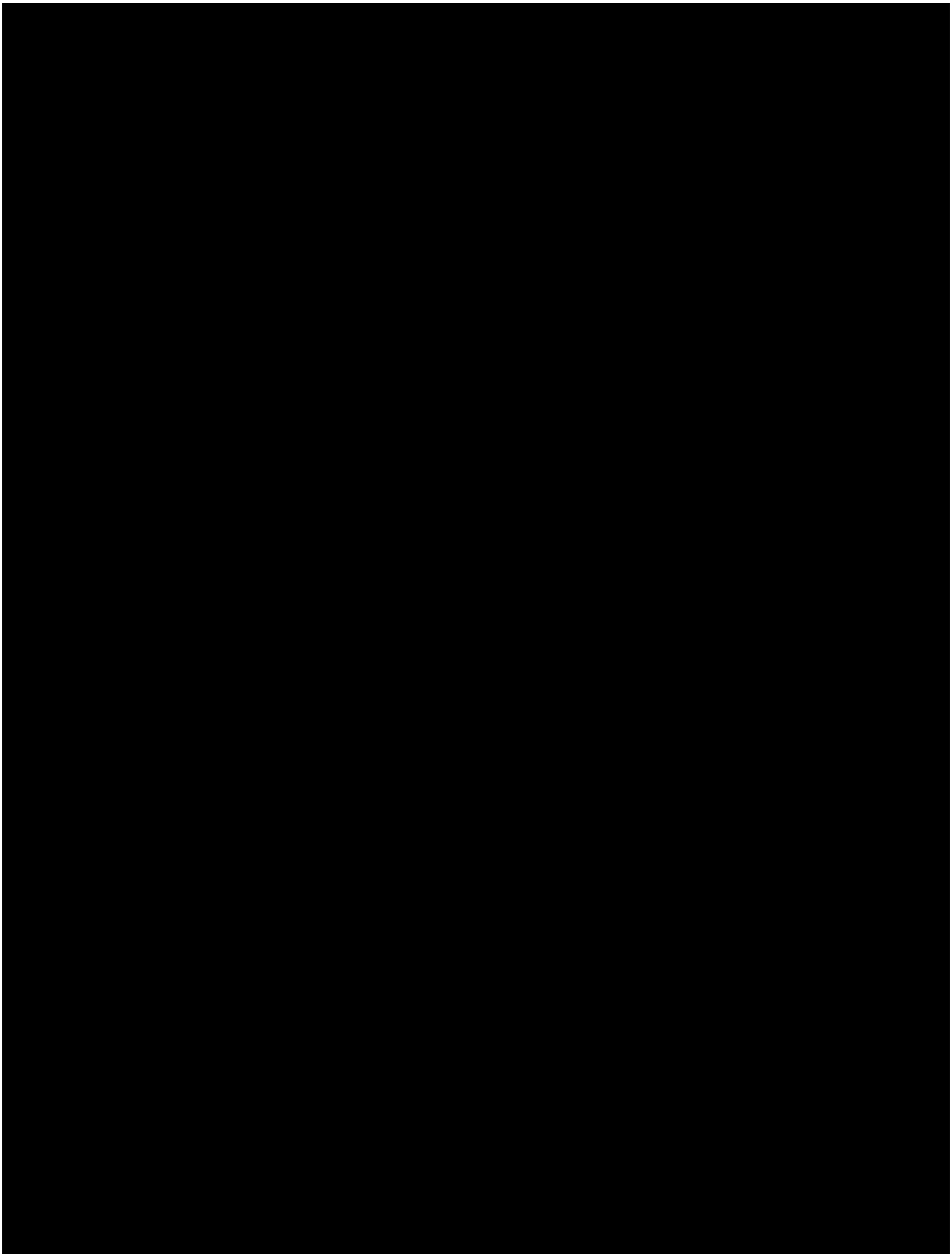

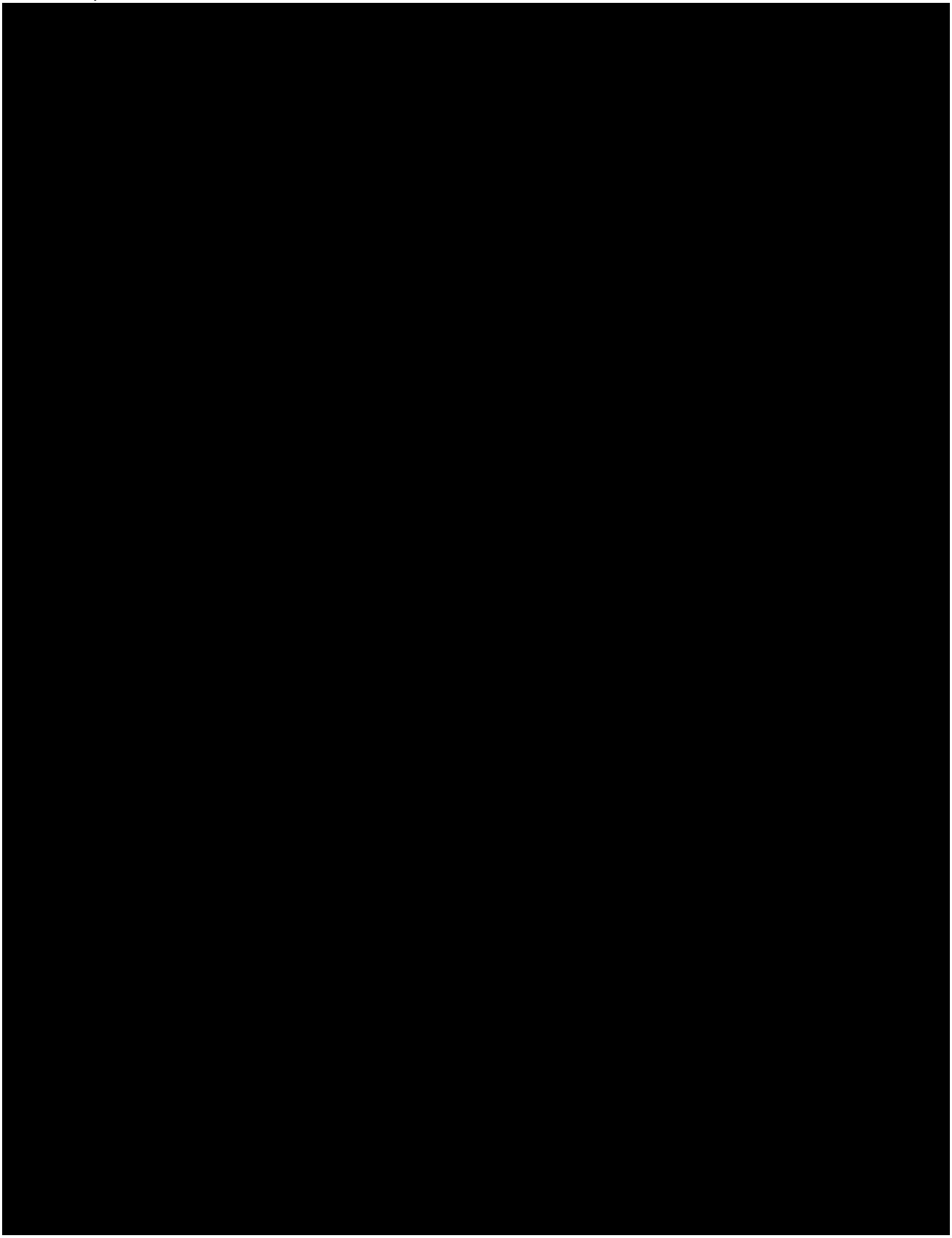

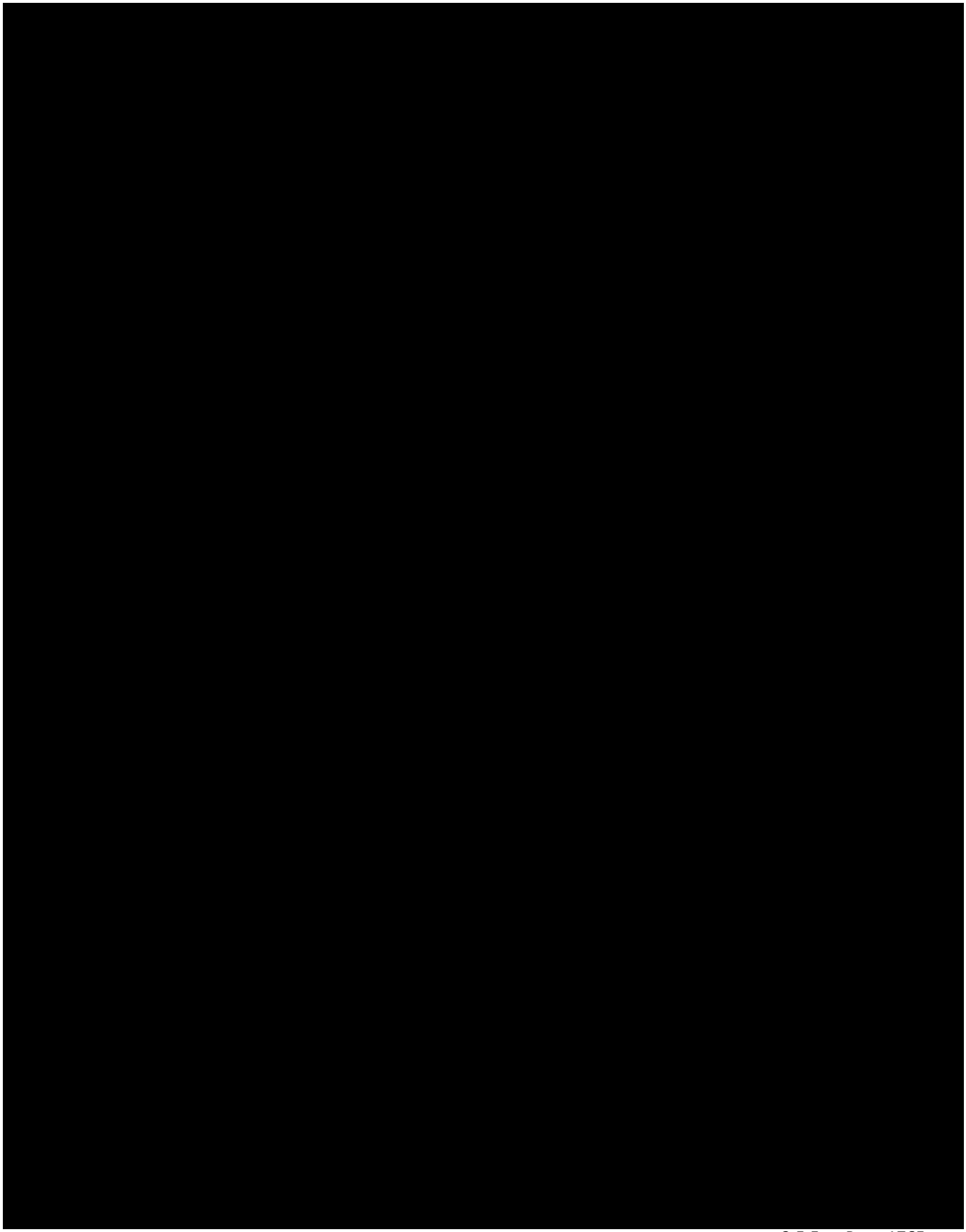

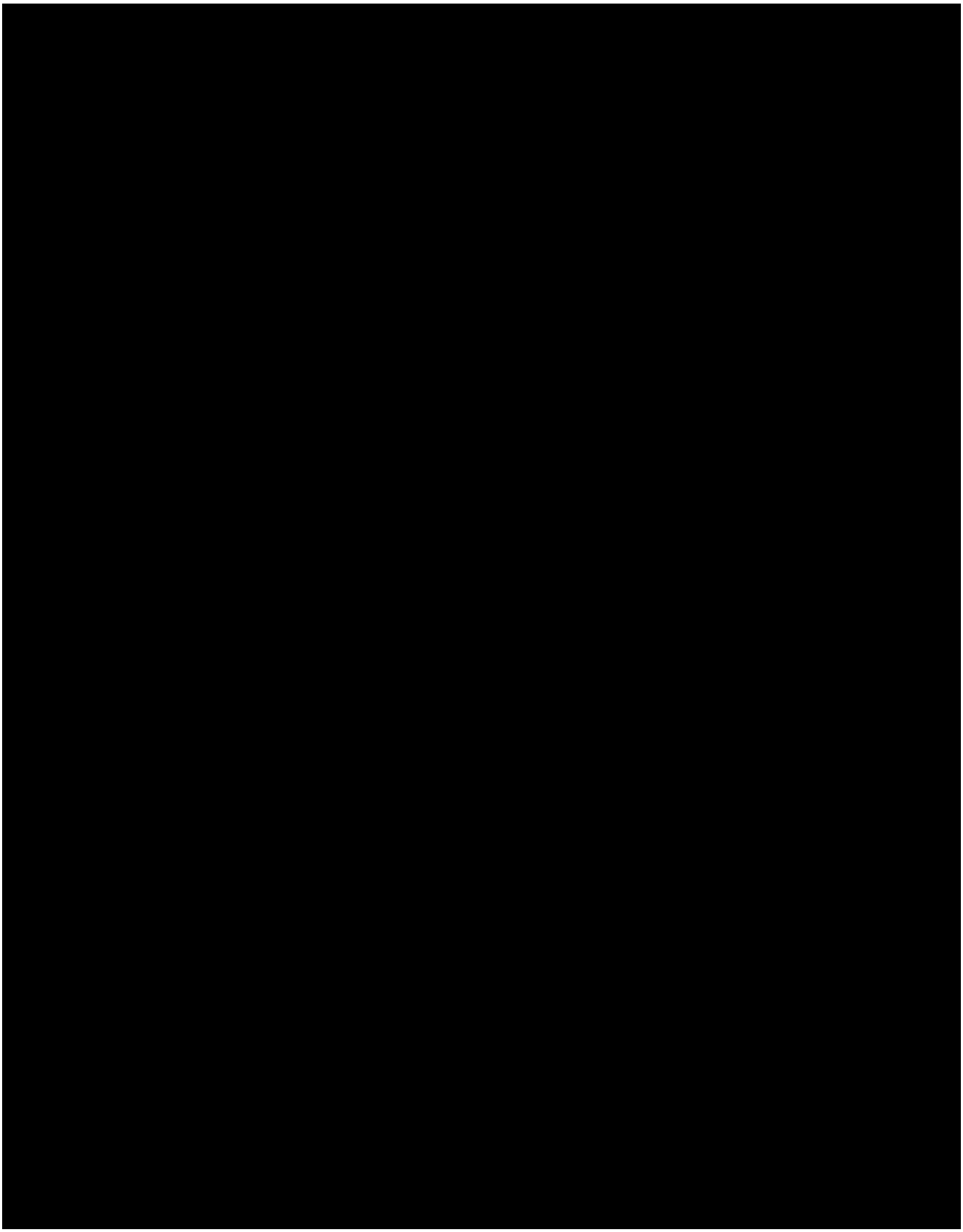

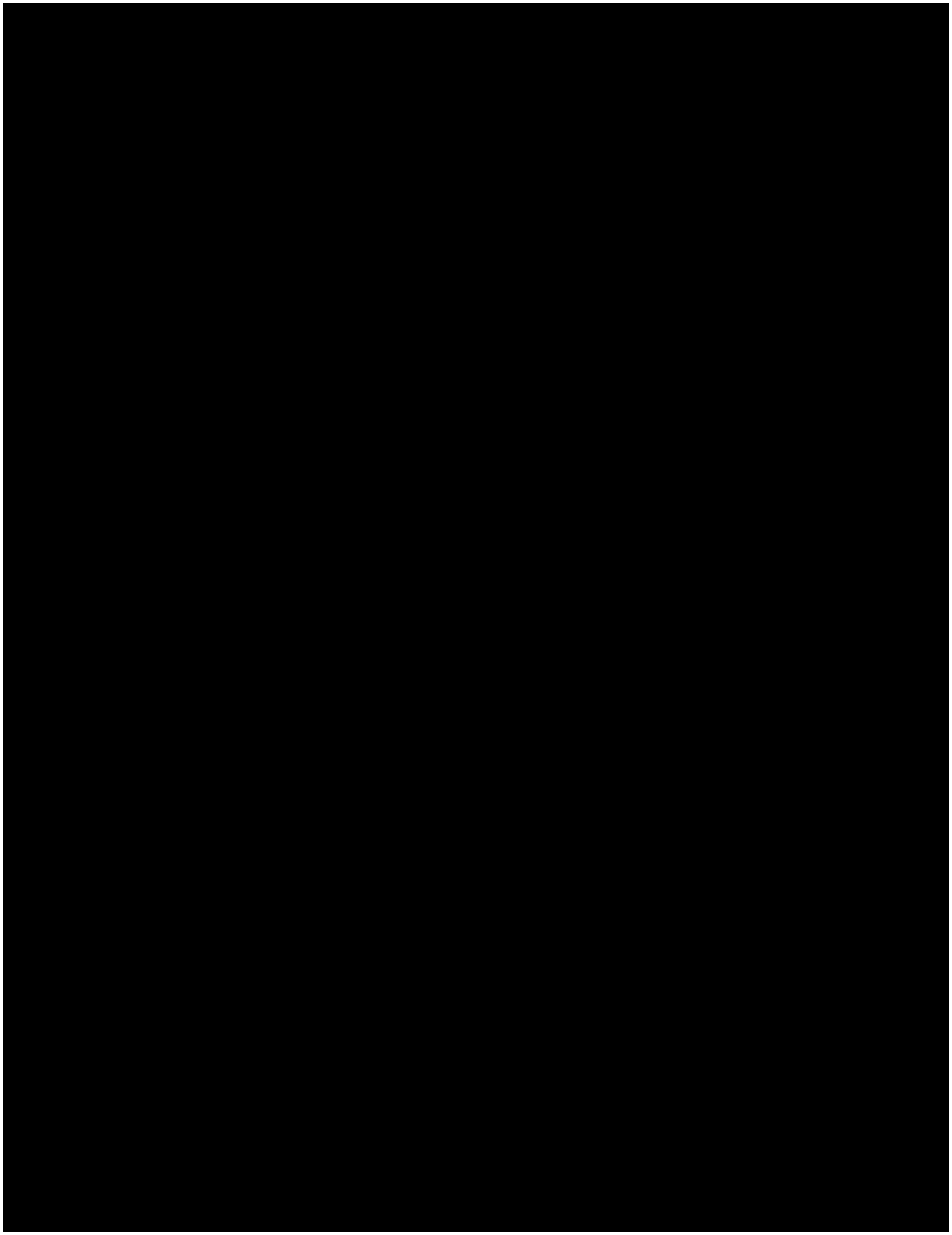

## Building Community and Rebuilding Homes

Healthy Blue sponsored Rebuilding Together's Second Annual Build and Boil event. This event is a fundraiser, a community party, and a volunteer opportunity, bringing people from all over New Orleans together. The Build and Boil event supports Rebuilding Together's mission to improve the quality of life for low-income homeowners in New Orleans, especially homeowners who are elderly, disabled, veterans, or single heads of households with minor children. With Healthy Blue's help, this event raised over $28,000, boiled almost 1,000 pounds of crawfish for the community, and aided five local homeowners.

## Protecting Our Community from COVID-19

Along with local organizations like 100 Black Women, Healthy Blue collaborated with Walgreens to make vaccines accessible to every eligible patient in our community. Healthy Blue hosted a mobile health equity clinic at the Capital Area Transit System terminal, giving transit riders twelve and older the opportunity to receive the vaccine. As an added incentive to vaccinate, Healthy Blue arranged for the first 100 families to the event to receive fresh produce and protein boxes from Top Box Louisiana.

# 2.6.2

## Proposer Organization and Experience

Healthy Blue

## Encouraging Healthy Lifestyles Through the Bike Library Program

The SWLA Center for Health Services (SWLA Center) rolled out a new bike fleet funded by Healthy Blue. The bike library launched in July of 2019 and consists of 20 bikes and safety helmets. It is a great opportunity for families to spend a few hours outside to make the first steps toward a healthier lifestyle. Community members visit the Fitness Center at the SWLA Center in Lake Charles to check out a bike and then hit the road. Bikes are free of charge to the community, and they are intended for short-term recreational rides. On June 29, 2021, a local high school track team took advantage of the guided bike ride. Healthy Blue and SWLA Center remain committed the communities they serve.

# 2.6.2.1

Proposer Organization

Healthy Blue

## 2.6.2 Proposer Organization and Experience

### 2.6.2.1.1 Healthy Blue's Organizational History and Parent Companies

Community Care Health Plan of Louisiana, Inc., dba Healthy Blue (Healthy Blue) is proud to be a long-standing, trusted partner to Louisiana Department of Health (LDH) in serving Healthy Louisiana enrollees (members) since the inception of the managed Medicaid program in 2012. Healthy Blue has reviewed all components of the RFP, including Attachment A, Model Contract, associated RFP Questions and Answers, and RFP Addenda, and will comply with all provisions.

Over the years, we have worked with LDH, our provider network, members, and community partners to advance and expand Healthy Louisiana. [redacted] Figure 2.6.2.1.1-1 highlights our history in serving Louisiana.

In 2017, we rebranded as Healthy Blue, representing a formal joint venture between Anthem Partnership Holding Company, LLC, a subsidiary of one of the nation's leading Medicaid managed care organizations, Anthem, Inc. (Anthem), and Blue Cross and Blue Shield of Louisiana (BCBSLA), the largest, most trusted choice for healthcare in Louisiana. ***Anthem's strong operating model*** supports us with nationally recognized expertise in health plan operations to drive better health outcomes. We also tap into the local ***experience and longevity of BCBSLA***, a trusted healthcare partner in Louisiana for more than 85 years. As Healthy Blue, we have direct access to the operational and fiscal support, experience, and best practices of our two parent companies.

Providers and members alike know the Blue brands mean quality and the pursuit to improve the health and lives of Louisianians. Since our rebrand in September 2017, members have continued to choose Healthy Blue; ***we have had 48 consecutive months of positive market share gain and have increased our market share from 16.14% to 19.71%***.

**Our Organizational Structure.** Healthy Blue maintains autonomy and decision-making for the Louisiana Medicaid business and is solely responsible for the management of this Contract. Healthy Blue's Chief Executive Officer, Christy Valentine, MD, MBA, leads our health plan operations and staff, enabling agility and local decision-making to deliver on our mission and organizational goals.

Our team is supported by experts from both parent companies to implement innovations in Louisiana. [redacted]

*Figure 2.6.2.1.1-1. Healthy Blue's Organizational History*

**HIGHLIGHTS OF OUR HISTORY SERVING MEDICAID IN LOUISIANA**

| | |
|---|---|
| 2021 | Hosted Inaugural Symposium on Racial and Health Equity in Louisiana with Louisiana Public Health Institute |
| 2020 | Achieved #1 (Adult) and #2 (Child) in CAHPS Surveys; Launched Healthy Blue Dual Advantage (D-SNP) |
| 2019 | Launched SDOH Provider Incentive Program to address member needs |
| 2018 | Added 7,600 members through our first Open Enrollment as Healthy Blue |
| 2017 | First Louisiana Medicaid MCO awarded NCQA Multicultural Health Care Distinction |
| 2016 | Welcomed nearly 53,000 Medicaid Expansion beneficiaries at program launch |
| 2015 | Supported the carve-in of Behavioral Health Managed Care |
| 2014 | Successfully secured a Contract Award to continue serving our Members as a Bayou Health MCO |
| 2013 | First Louisiana Medicaid MCO to earn NCQA accreditation |
| 2012 | Began providing care to Bayou Health enrollees at start of initial Medicaid Managed Care Contract |

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[redacted]

#### Organizational Goals

[redacted]

we are encouraging healthcare system transformation by bringing BCBSLA's Quality Blue Primary Care, a population health and quality improvement program that rewards doctors for getting better results for patients, to Medicaid providers and members. We also deliver on our commitments by: promoting quality and advancing data-driven, evidence-based practices; delivering holistic, high-value care that addresses physical, behavioral, and social needs; supporting providers by simplifying processes and incentivizing value; bridging community resources to focus on the well-being of whole communities; maximizing the health of our members by tackling the root causes of health disparities; and fostering an organizational culture modeled on continuous process improvement, agility,

and performance. Healthy Blue's diverse staff champion our mission and goals every day. We listen, learn, and develop solutions to meet evolving member needs, bolstering our providers and the healthcare infrastructure to meet those needs across all parishes. For example, at the onset of the COVID-19 pandemic when Non-Emergency Medical Transportation (NEMT) providers saw single-rider trip requests increase and revenues drop, ***Healthy Blue was the first MCO to offer NEMT providers financial support to continue providing services to Healthy Louisiana members.***

> *Healthy Blue has led the pack of MCOs in supporting the transportation providers and the members they transport by increasing rates, implementing incentive programs, and giving providers over 40,000 masks and 1,500 bottles of hand sanitizer during the COVID-19 pandemic. Their partnership and collaboration have been invaluable and show that their focus is on helping the people in their care and the people that serve them.*
>
> **Paul Broussard, CEO, MediTrans**
>
> LA_HlthyRebid21_2.6.2.1_Broussard_TST_02

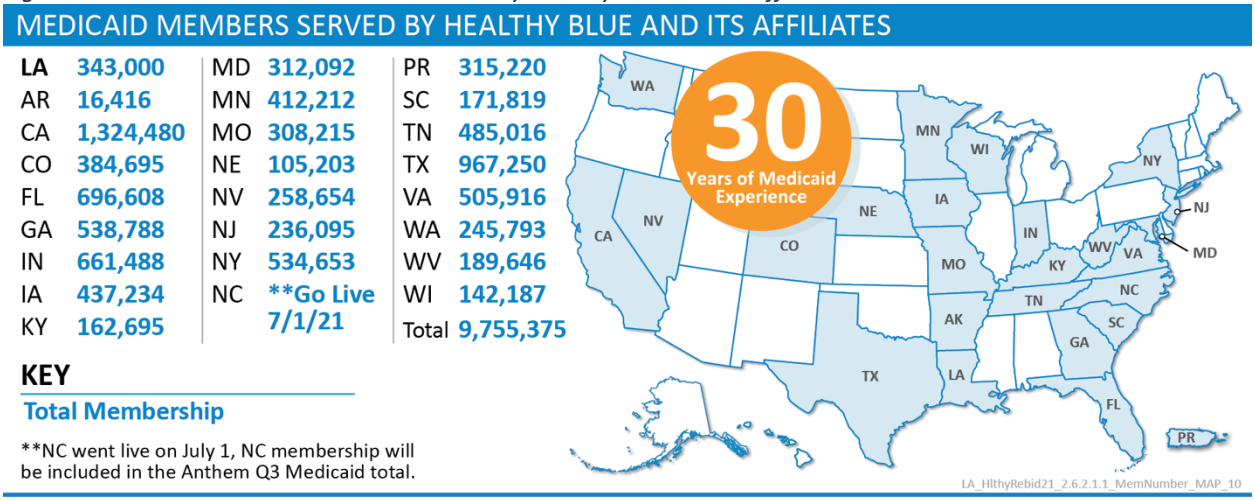
## Relevance of Medicaid Managed Care to Our Mission

As an MCO dedicated to serving Healthy Louisiana, ***Medicaid is at the core of what we do***. We address our members' most challenging healthcare issues and social needs through a population health approach supported by health information technology and advanced data analytics. Across every parish, we bring the right resources to support our members, recognizing the diversity and unique challenges of our population.

## Medicaid Members Served by Healthy Blue's Affiliates and States Where We Currently Serve

Healthy Blue's Medicaid health plan affiliates serve 9.7 million members in 25 markets for Medicaid and other state-sponsored programs, as shown in Figure 2.6.2.1.1-2. Our 26th Medicaid market, Ohio, is expected to go-live January 5, 2022.

*Figure 2.6.2.1.1-2. Medicaid Members Served by Healthy Blue and Its Affiliates*




## 2.6.2.1.2 Current Medicaid Managed Care Contracts

Collectively, Healthy Blue's parent organizations and affiliates have served members in Medicaid managed care for more than 30 years and currently serve Medicaid members in 25 markets, including more than 7.6 million TANF members in 23 markets, more than 415,000 CHIP members in 19 markets, and more than 1.7 million Medicaid expansion members in 15 markets. In addition to our Contract in Louisiana, our affiliates have current Medicaid managed care contracts in 11 states with Medicaid populations equal to or greater than 1.5 million enrollees: California, Florida, Georgia, Indiana, New Jersey, New York, North Carolina, Tennessee, Texas, Virginia, and Washington.

## 2.6.2.1.3 Instances of Non-compliance

Please refer to Attachment 2.6.2.1.3, which identifies all instances of non-compliance the Proposer, parent organizations, and affiliates have incurred as part of Medicaid managed care contracts within the past seven years.

## 2.6.2.1.4 Terminated or Non-renewed Contract

Within the last 10 years, neither Healthy Blue nor our affiliate health plans have ever had a Medicaid managed care contract involuntarily terminated or not renewed for non-performance or poor performance or terminated on a voluntary basis prior to the Contract end date.

[redacted]

# 2.6.2.2

Proposed Staff Qualifications and Organizational Structure

**CONFIDENTIAL**

Healthy Blue

## 2.6.2.2 Staff Qualifications and Organizational Structure

At Healthy Blue, we put people first. From executive leadership to frontline staff, we bring a long history of experience and expertise. Our employees are committed to every person in every parish, as we are extensions of the communities we serve. Our diverse team of Louisiana-based leaders and employees passionately apply their energy and knowledge to address the significant health issues facing residents, focusing on the whole person, and helping enrollees (members) access services and supports they need.

## 2.6.2.2.1 Process for Identifying Key Personnel and Management Structure and Organization

Healthy Blue delivers innovative solutions and locally focused programs that improve outcomes for Healthy Louisiana, as well as Louisianians and communities across the state. In addition to our joint venture value, our organizational support structure facilitates the sharing of best practices among affiliates in 24 markets. The Healthy Blue team collaborates directly with our affiliate health plans to bring operational excellence and tested innovations to Louisiana that have been successfully implemented in other areas.

### Process for Identifying Key Personnel

Our process for identifying staff includes comprehensive, well-structured recruitment, standard protocols such as criminal background checks, and techniques such as motivation-based interviewing to make sure we hire passionate and dynamic leaders. Our key personnel are top-level executives who reflect the diverse populations we serve, know and understand the needs of Louisiana's local communities, and bring extensive Medicaid experience and deep knowledge of the State's delivery system.

We select designated key personnel based on demonstrated, relevant healthcare experience, leadership and management skills, and a record of accomplishment of meaningful contributions. ***All key personnel positions are currently staffed; there are no vacancies.***

Key personnel are top-tier managed care executives with thorough understanding of their respective operational areas and bring an average of 16 years of healthcare experience. We know success depends on qualified, stable staffing at all organizational levels, as well as flexible policies and procedures to scale resources as circumstances dictate and replace personnel quickly and efficiently. We use our centralized recruiting system to post job opportunities internally and externally. We draw from a variety of recruitment sources and activities to attract qualified candidates with requisite skills through referrals, job search networks, social media campaigns, and partnerships with diversity organizations, among other sourcing. Steps to stay proactive in the face of expected or unanticipated staffing needs include:

- As an established and trusted LDH partner, our employees know Louisiana, and we understand the labor market. While we work to acquire additional permanent, qualified staff, we deploy additional resources quickly by identifying backup staff.
- Our succession-planning program helps identify possible successors within the organization for key management positions, as well as from our affiliates, parent companies, and communities. Healthy Blue has made succession planning an integral part of our culture. Leaders are required to have succession plans that list potential successors, rate each on readiness, and document steps necessary to further prepare potential successors.
- Reallocating work assignments and mobilizing backups quickly to provide needed services.
- Identifying employees through affiliates and national staff across the nation who may provide backup and temporarily fill vacant positions.

When an employee resigns, we mobilize and begin sourcing a qualified replacement. We maintain a strong succession-planning program, developing employees through mentorship and training to assume vacated roles. Healthy Blue's Contract Compliance Officer, Kim Chope, will notify LDH of any changes to key staff identified in our proposal as part of our Readiness Review. Our Contract Compliance Officer will notify LDH in writing as early as practicable (but no later than five business days) within our receipt of a key staff member's notice of resignation or upon Healthy Blue's decision to terminate a key staff member. Healthy Blue will obtain advance written approval from LDH prior to hiring new key staff members.

### Management and Organizational Structure

[redacted]

[redacted]

## 2.6.2.2.2 Key Personnel Name, Résumé, and Role

Healthy Blue's key personnel, who represent the communities we serve, provide critical guidance and leadership. Our key personnel carry out day-to-day organizational management and fully own decisions on all aspects of service delivery. They shape strategic actions to enhance our position as thought leaders for the Healthy Louisiana program and drive innovation that improves the quality of healthcare we administer. Our dedicated key personnel team is embedded in the communities we serve with deep roots in Louisiana. The following biographies highlight our key personnel for Healthy Blue, each of whom meets Contract requirements. ***These individuals are 100% dedicated to the key personnel role for Louisiana Medicaid, with no outside responsibilities***. We provide résumés as Attachment 2.6.2.2.2-1: Key Personnel Résumés.

### PROMOTING RACIAL AND HEALTH EQUITY FOR ALL

In March 2021, Healthy Blue's Health Equity Administrator, Karen Kosinski, led the First Annual Racial and Health Equity Symposium along with the Louisiana Public Health Institute. This event highlighted local Louisiana partners involved in equity work in education, incarceration, employment, healthcare, and housing. More than 500 individuals throughout the state and country participated.

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### Christy Valentine, MD, MBA
### Chief Executive Officer

Dr. Valentine, a native New Orleanian, is responsible for improving lives and communities through collaboration with partners across Louisiana. Dr. Valentine spent nearly 13 years in private practice in New Orleans, specializing in pediatrics and internal medicine, dedicated to providing quality care by optimizing community health.

### Dexter Trivett, MBA
### Chief Operating Officer

Dexter leads operations with primary responsibility for developing and implementing our strategic vision, goals, objectives, policies, and decision-making. Dexter routinely meets face to face with LDH, medical and NEMT provider associations, and community organizations across the state to foster collaborative partnerships and advance strategic initiatives.

### Raymond Poliquit, MD
### Chief Medical Officer

Dr. Poliquit is a board-certified pediatrician who has more than 25 years of experience as a practicing physician and 9 years with Healthy Blue. He is licensed by the Louisiana State Board of Medical Examiners and is a Fellow of the American Academy of Pediatrics.

### Dr. Cheryll Bowers-Stephens, MD, MBA
### Behavioral Health Medical Director

Dr. Bowers-Stephens, born in Louisiana and raised in New Orleans, is a board-certified in psychiatry and child and adolescent psychiatry. A 25-year health care veteran, she has strong and vast experience with population health. As the former Commissioner of Mental Health, she laid the foundation for Louisiana's public mental health system transformation.

### Christine Coleman, MBA
### Chief Financial Officer

Christine, a native New Orleanian with over 15 years of healthcare finance experience, oversees the team responsible for delivering all finance and actuarial services, including budgeting and forecasting support, trend evaluation, and industry competitive analysis and strategic analysis to impact leadership decision-making, improve efficiency, and drive innovation.

### Mykayla Jones, PharmD
### Pharmacy Director

Mykayla, a native Louisianian, oversees Healthy Blue's pharmacy benefits responsibilities, including regular meetings with LDH, and clinical pharmacy programs for medical benefit drugs. She has nearly 20 years of pharmacy experience and assists in member monitoring and management related to utilization of prescription drugs through data coordination.

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**Kimberly Chope**
**Contract Compliance Officer**

Kim has 25 years of managed care experience focused on regulatory compliance, program development, and State Medicaid program growth. For the past 9 years, Kim has led the development and implementation of policies, procedures, and standards to make sure Healthy Blue complies with federal, State, and Contract requirements.

**Karen Kosinski, MPH, MSW**
**Health Equity Administrator**

Karen has 15 years of experience developing innovative solutions to address social determinants of health and health disparities. Joining Healthy Blue in 2015, she pioneered our Permanent Supportive Housing program and leads our Health Equity Task Force. Karen has a Master of Public Health and a Master of Social Work from Tulane University.

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## 2.6.2.2.3 Operating Structure Leadership and Key Teams

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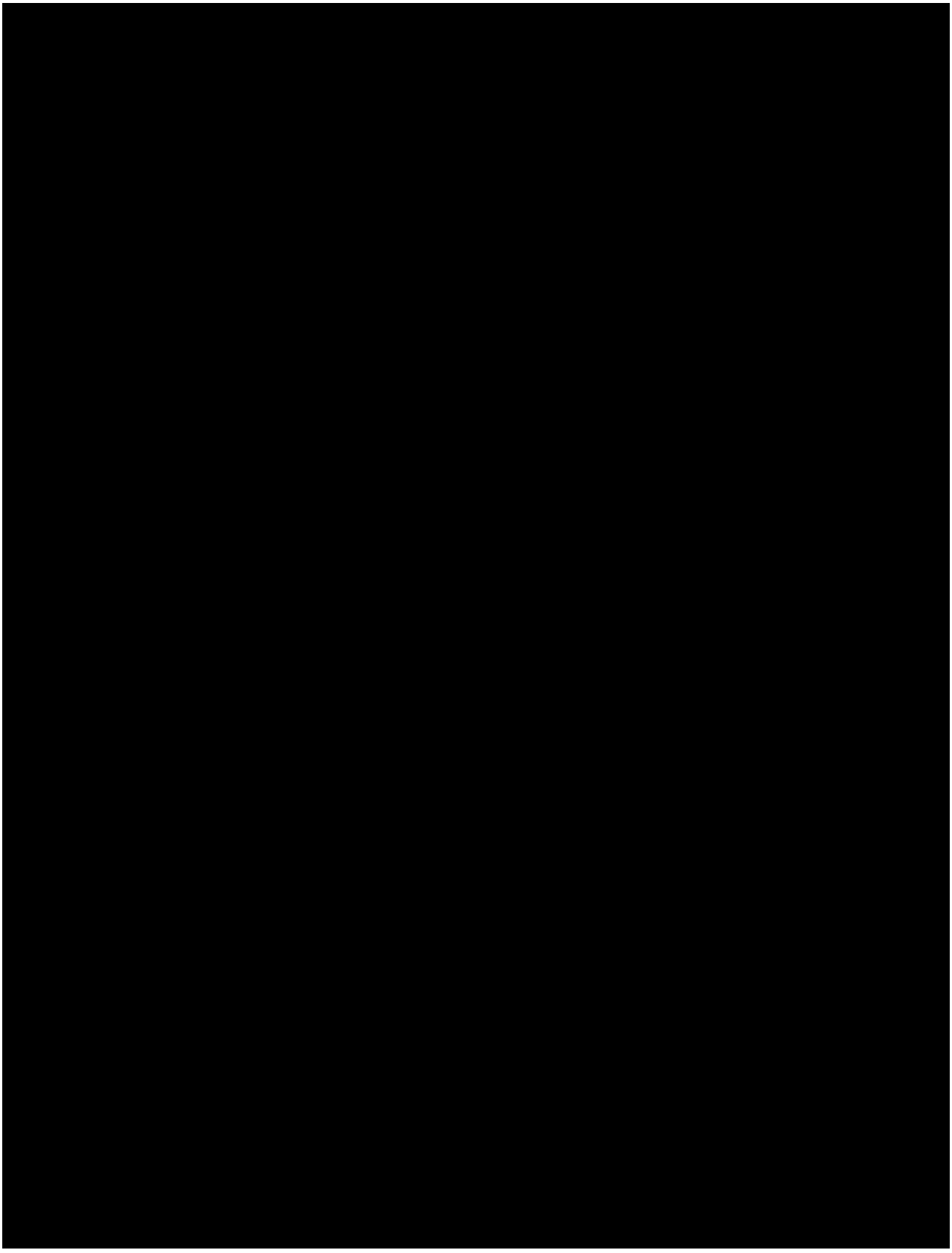
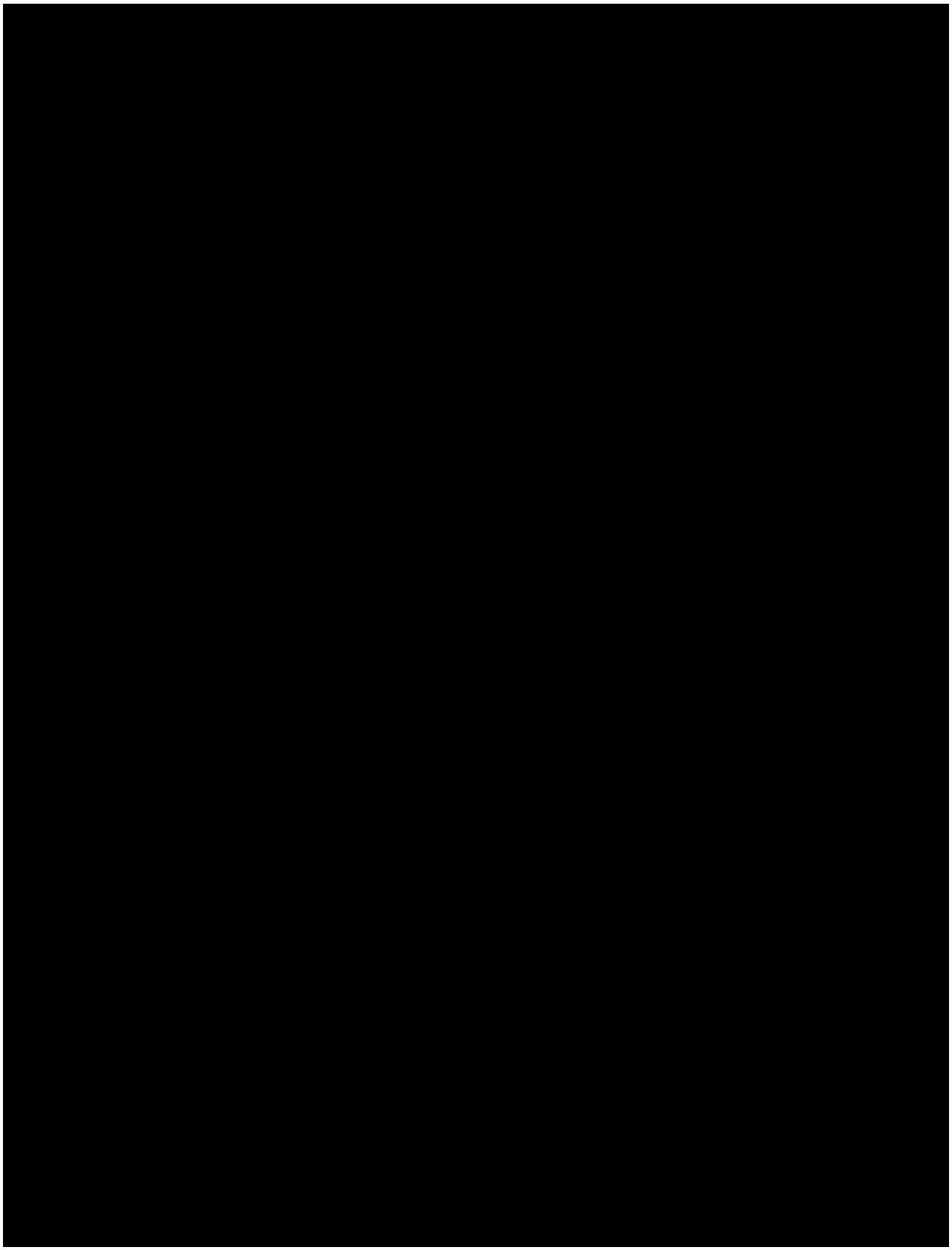
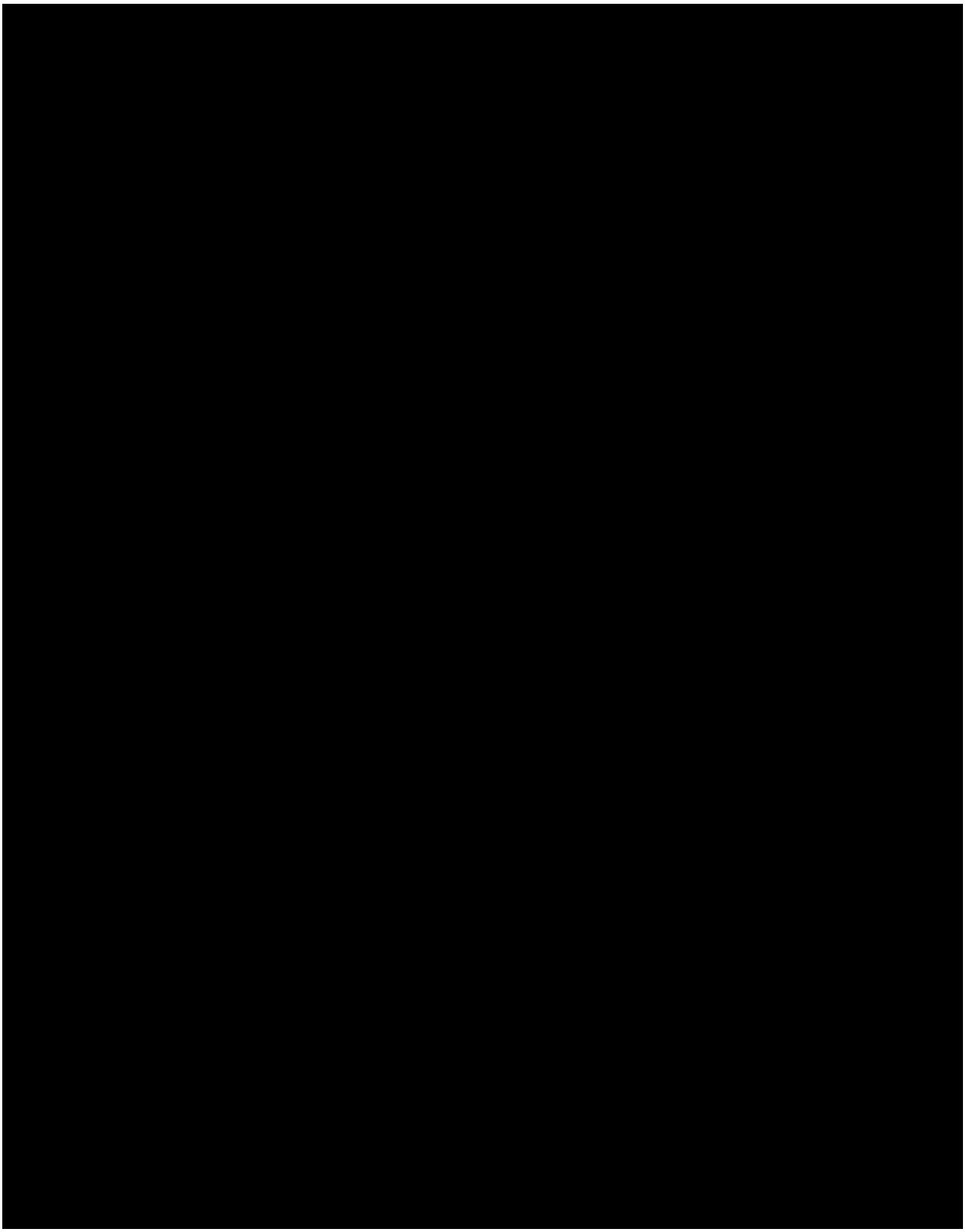
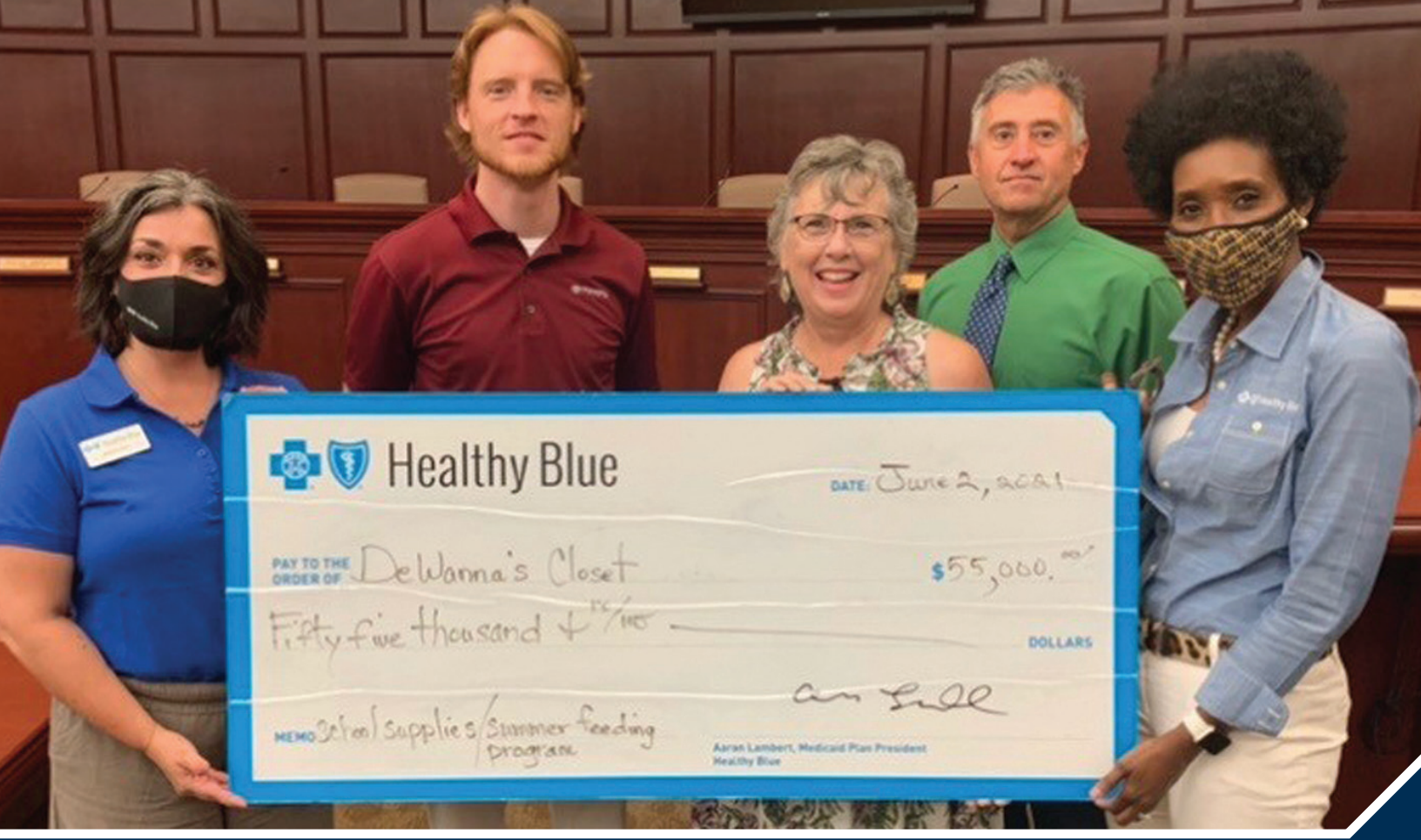









**Working with DeWanna's Closet to Address Food Insecurity Among Youth**

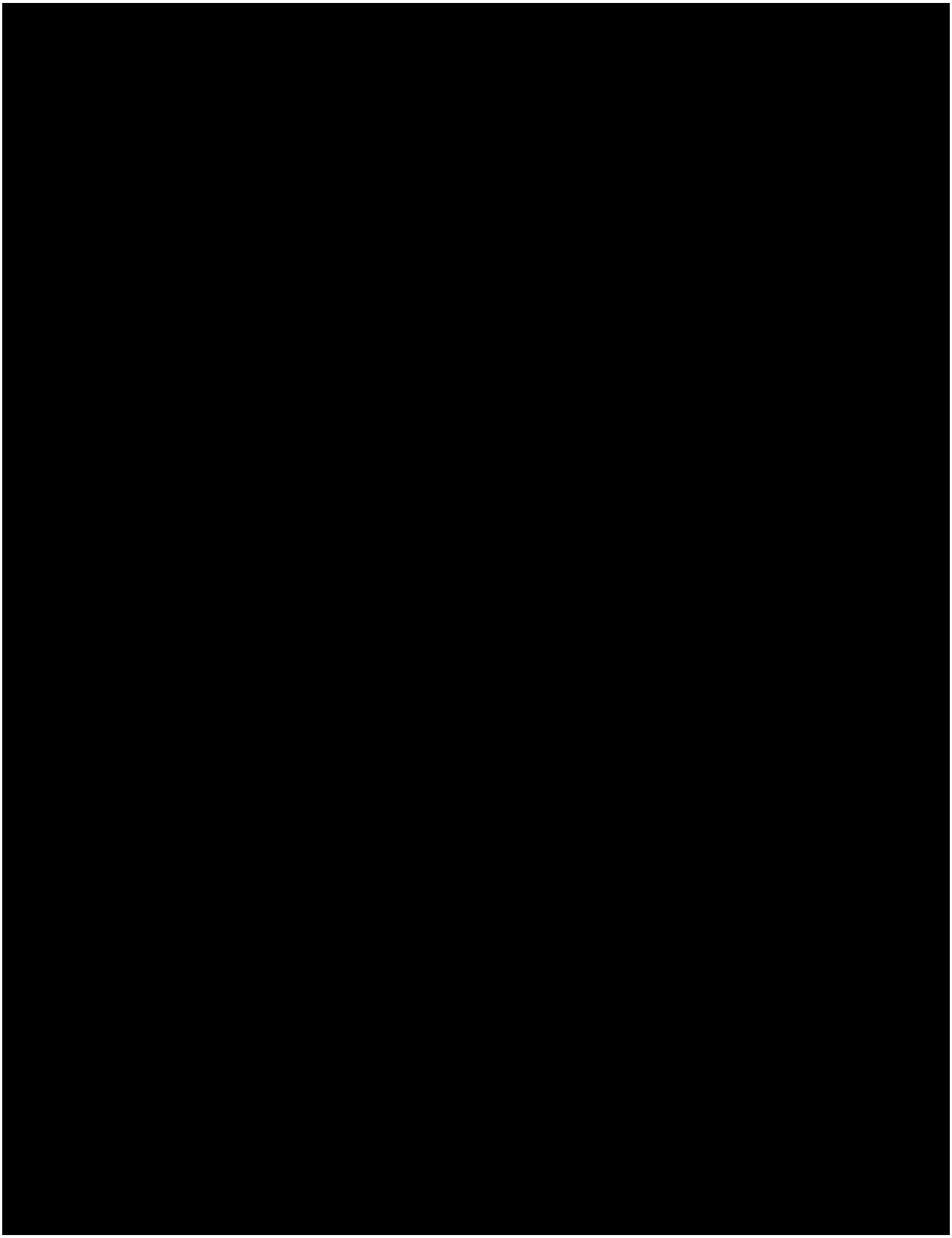
DeWanna's Closet (DC) understands that food insecurity can wreak havoc on a community, especially our youth. DC wanted to start a weekend food program for school-aged kids, and Healthy Blue's grant has given them the jumpstart to pursue the endeavor. Educators within Calcasieu Parish Schools identify students whom they feel may lack consistent nutrition over the weekend. The educators make a confidential referral to DC, who will prepare and supply a nutritional food package that the students can easily transfer from school to home.

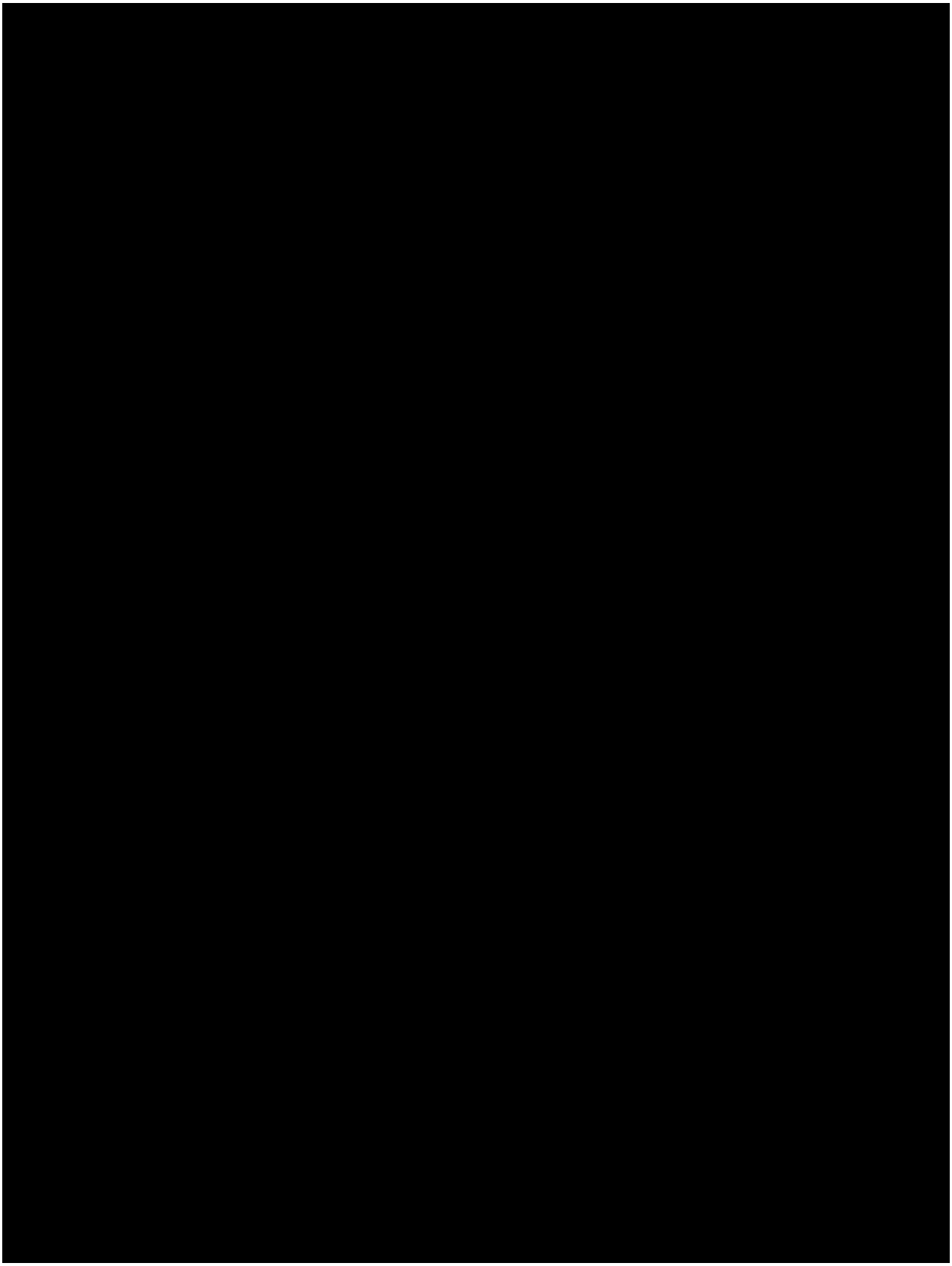
# 2.6.3

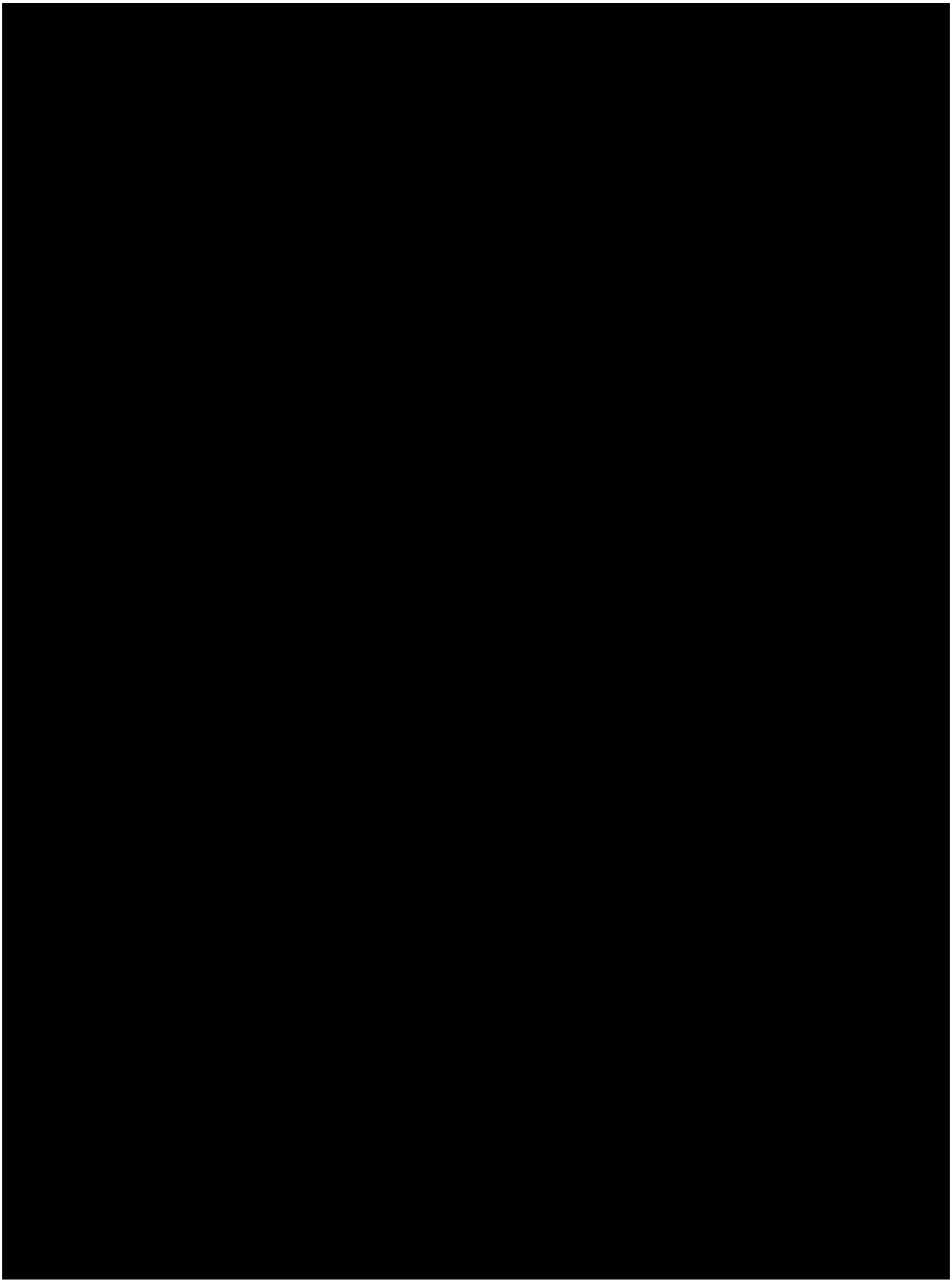
Enrollee Value-added Benefits

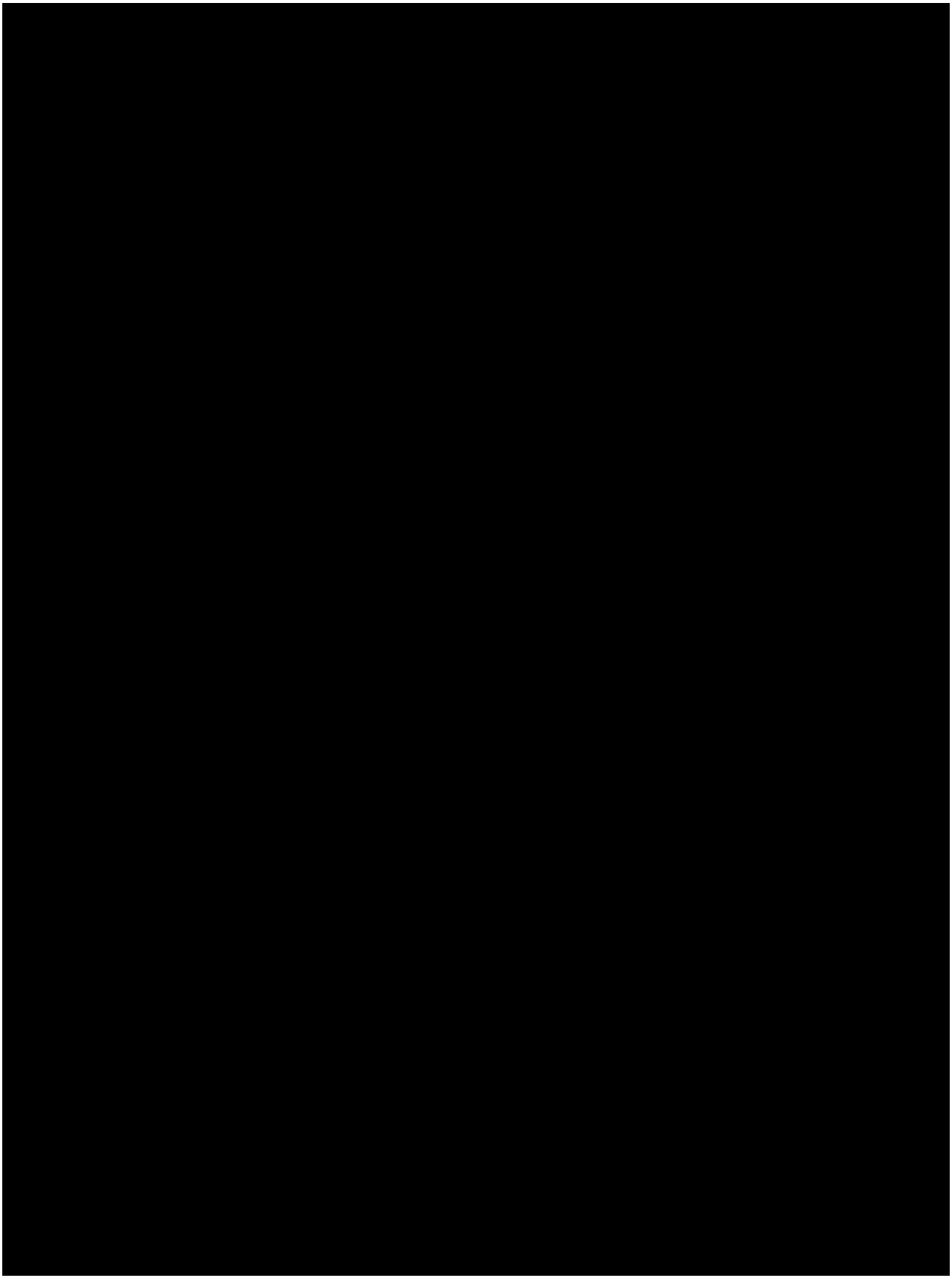
Healthy Blue

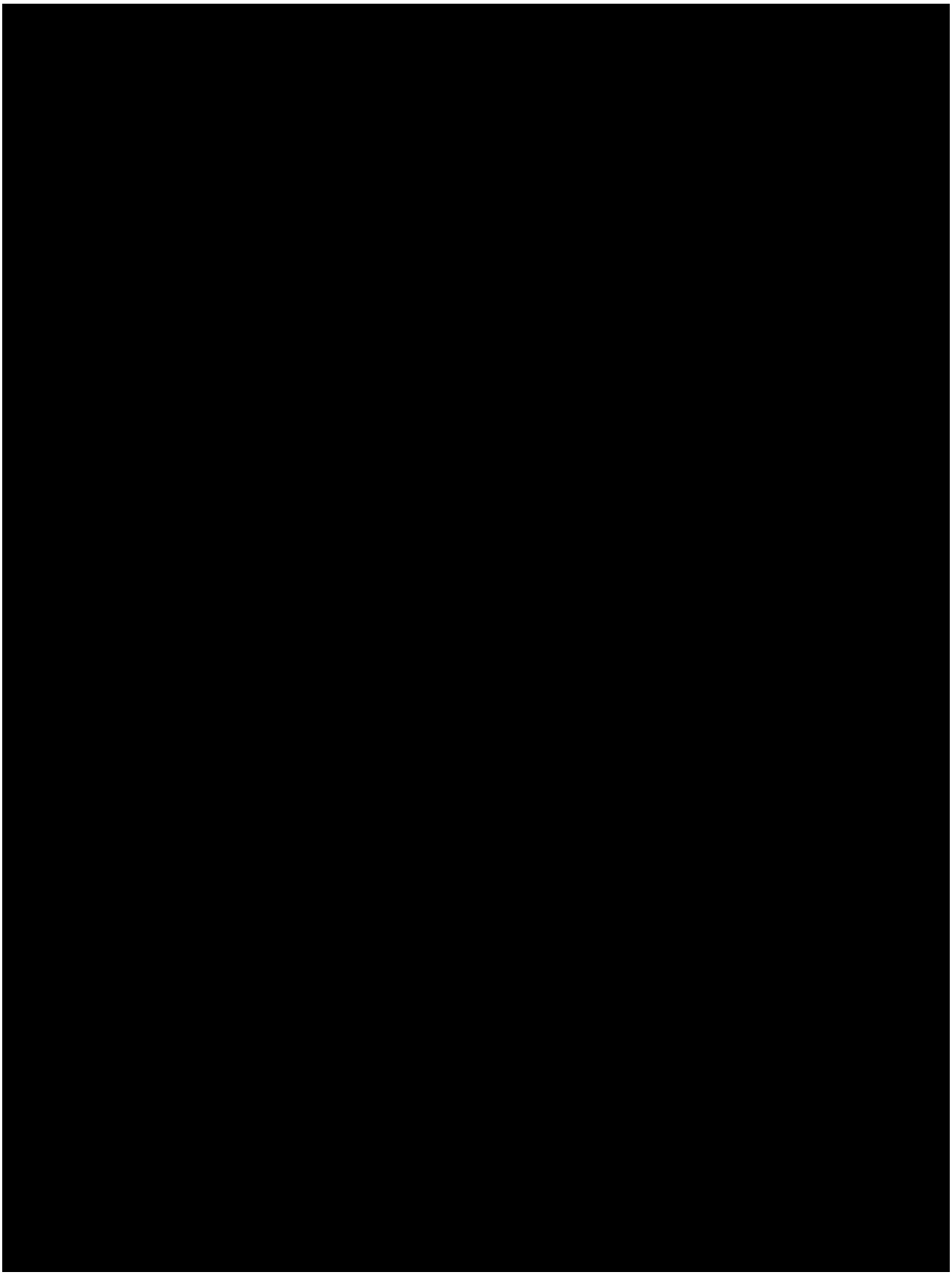
## 2.6.3 Enrollee Value-added Benefits

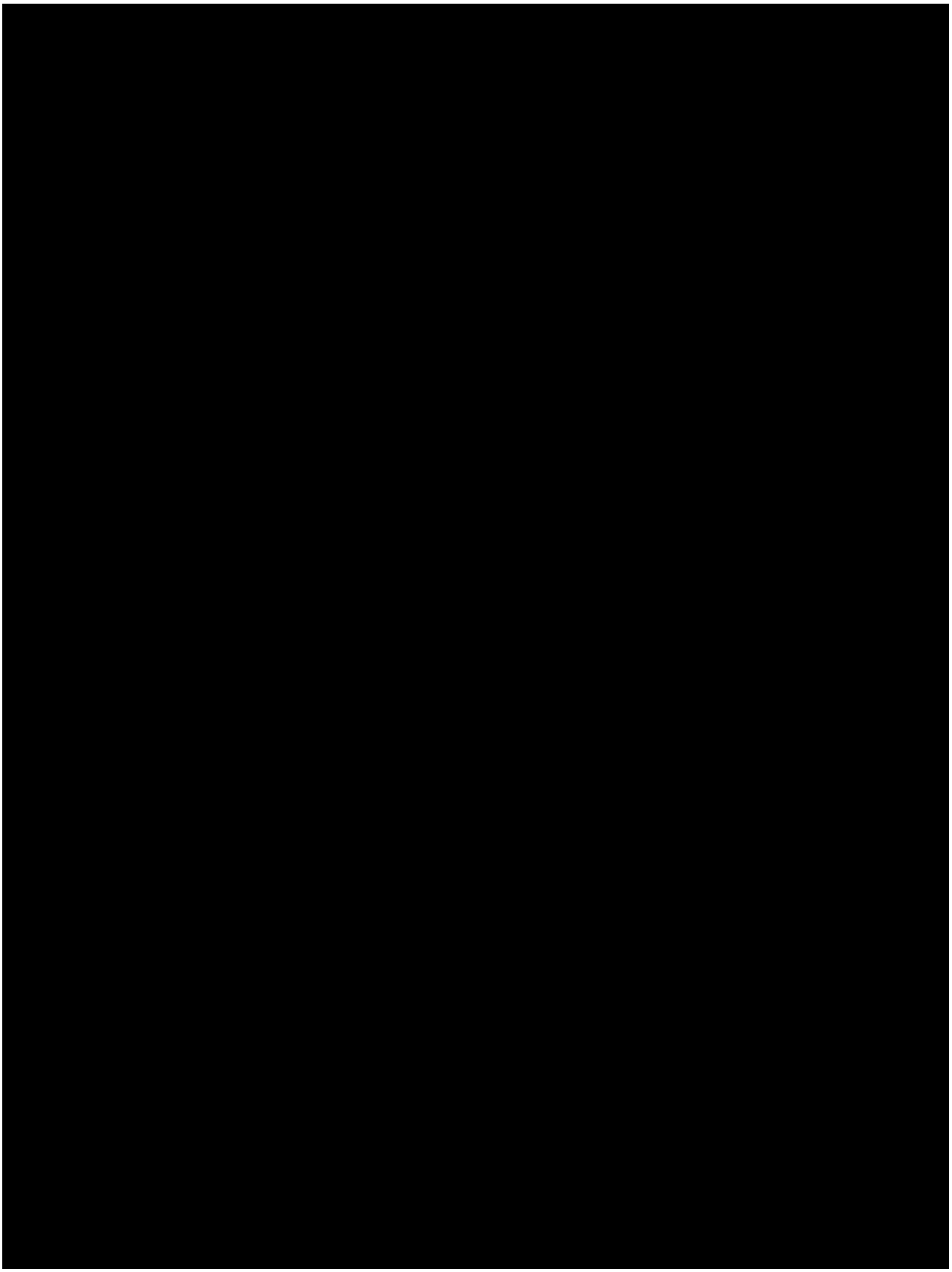


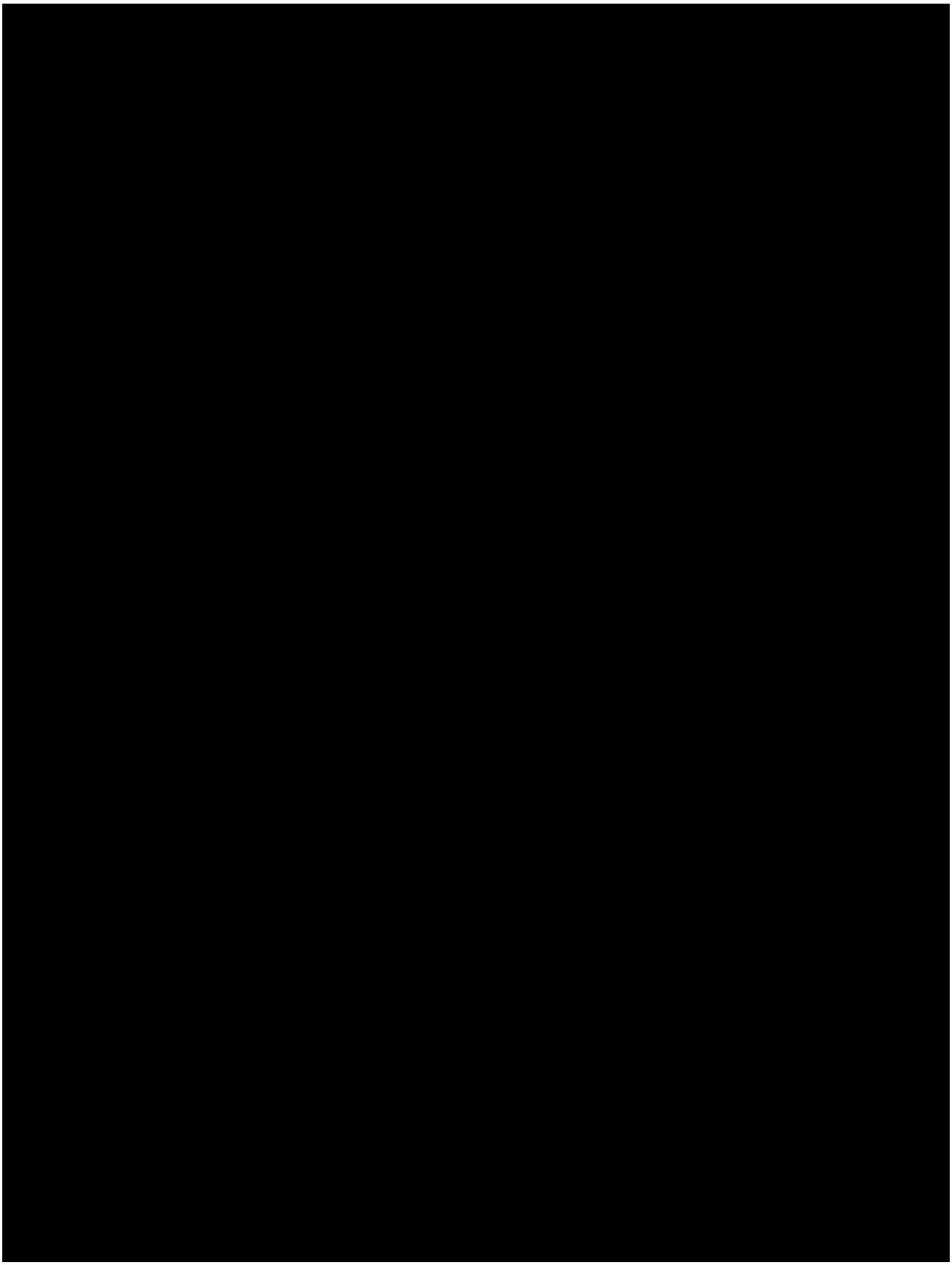


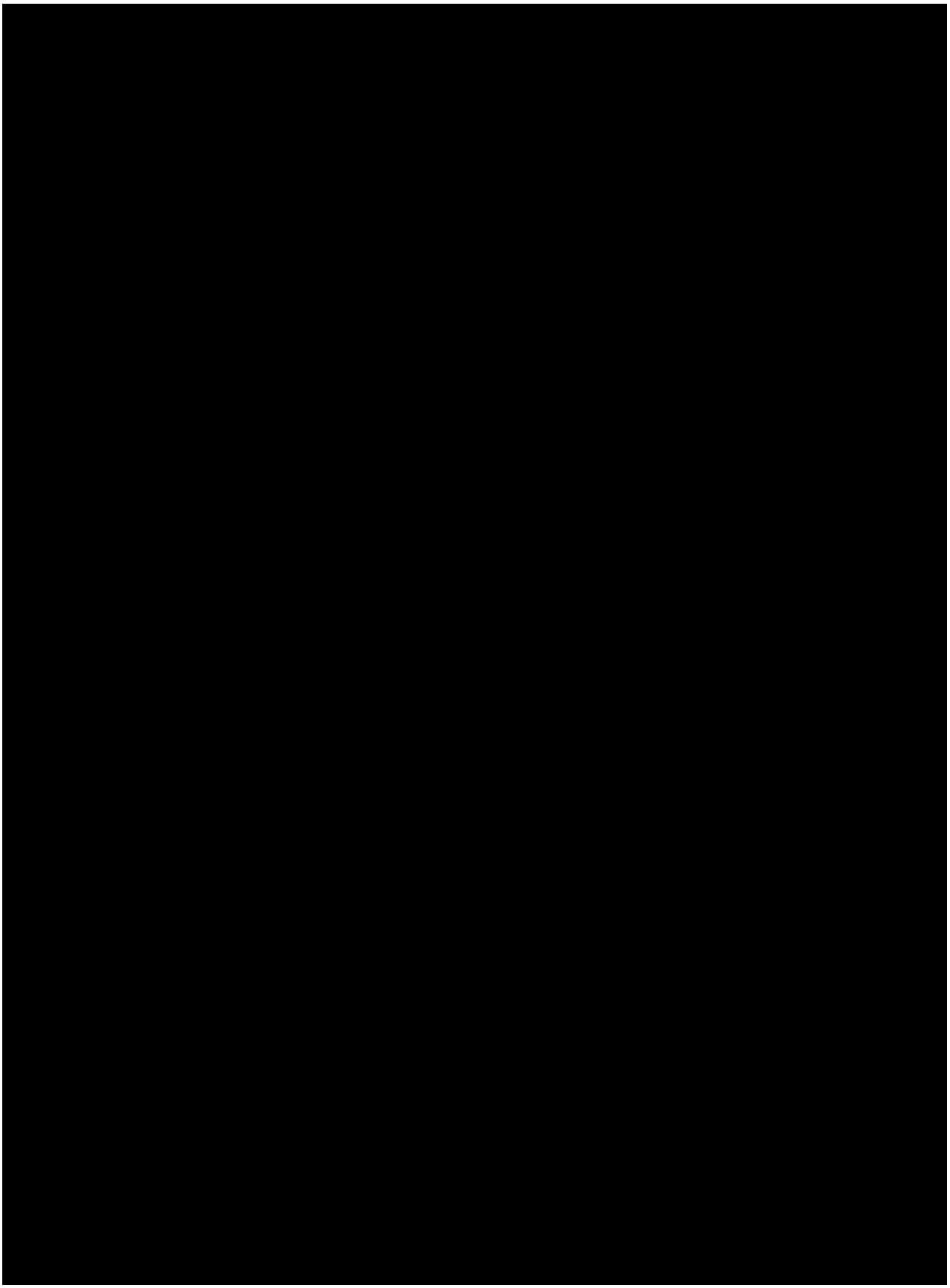


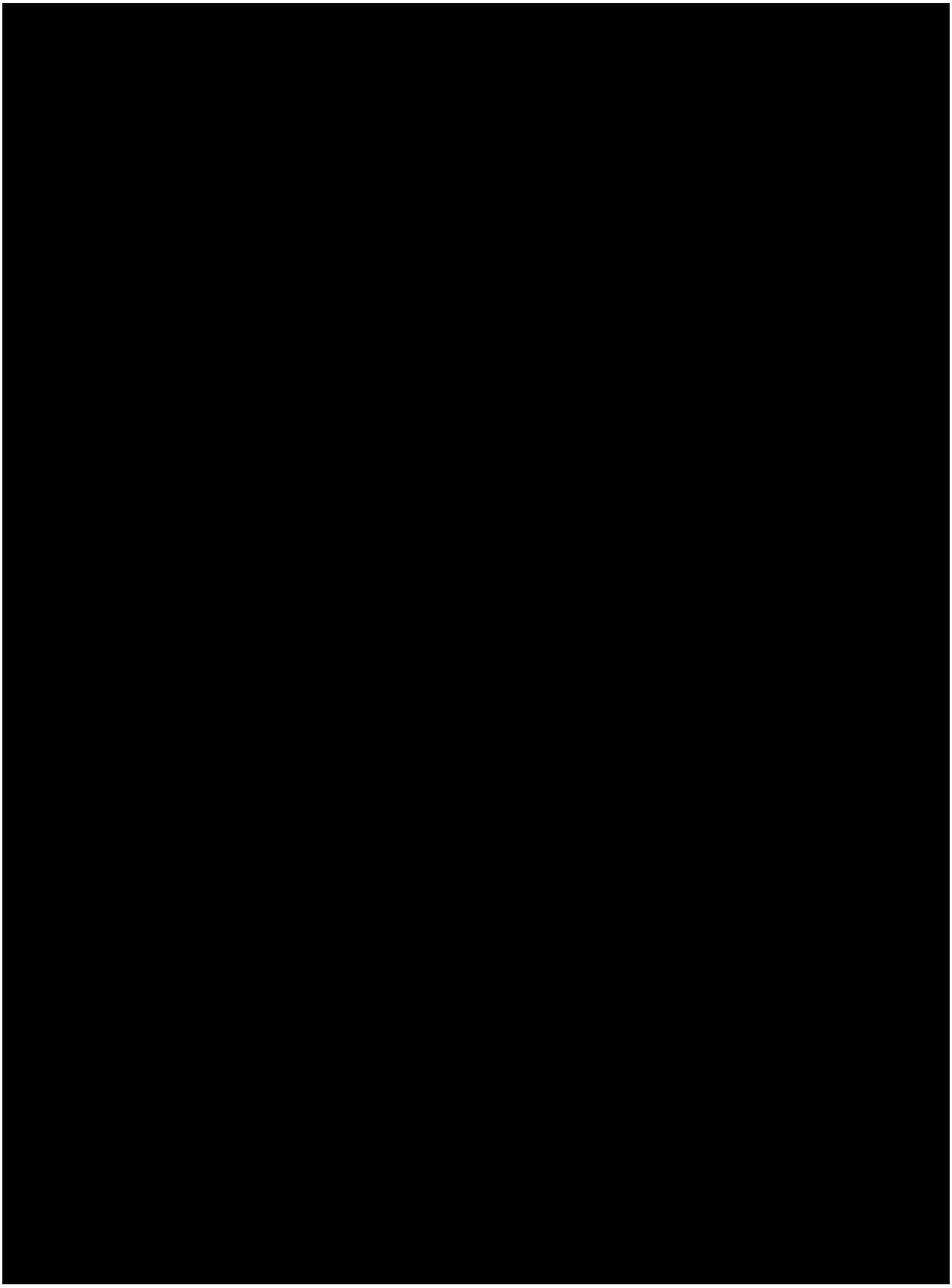


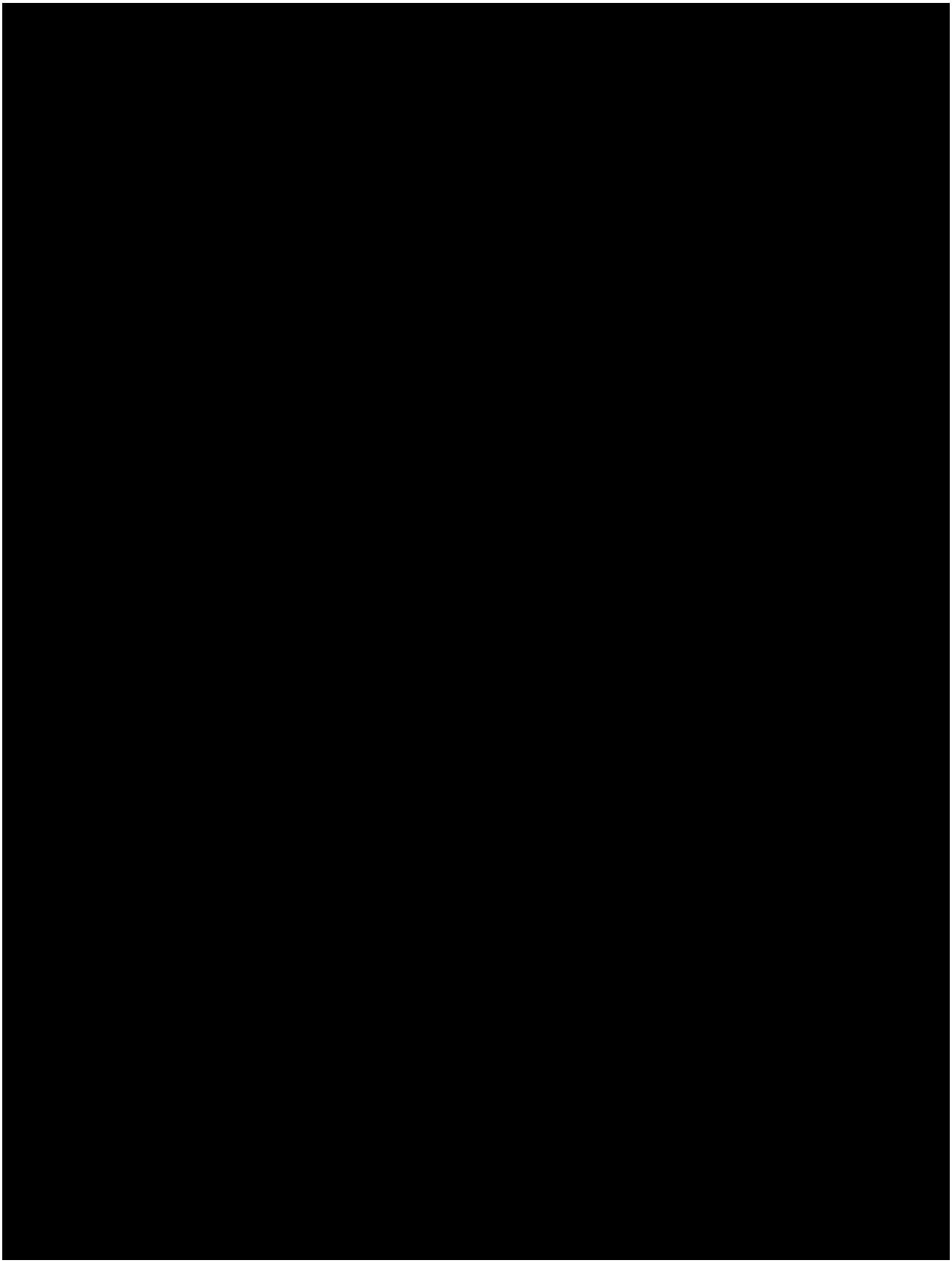


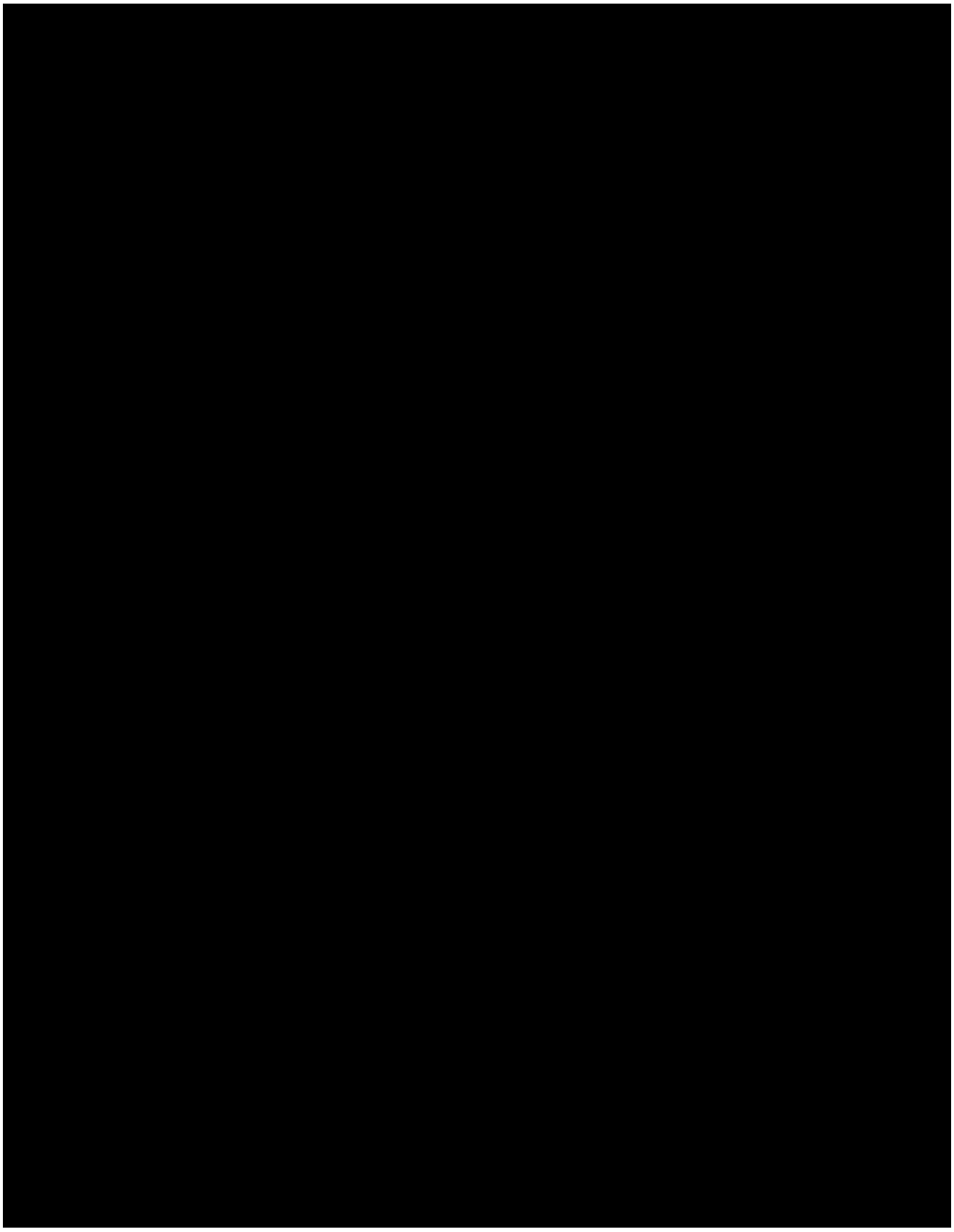


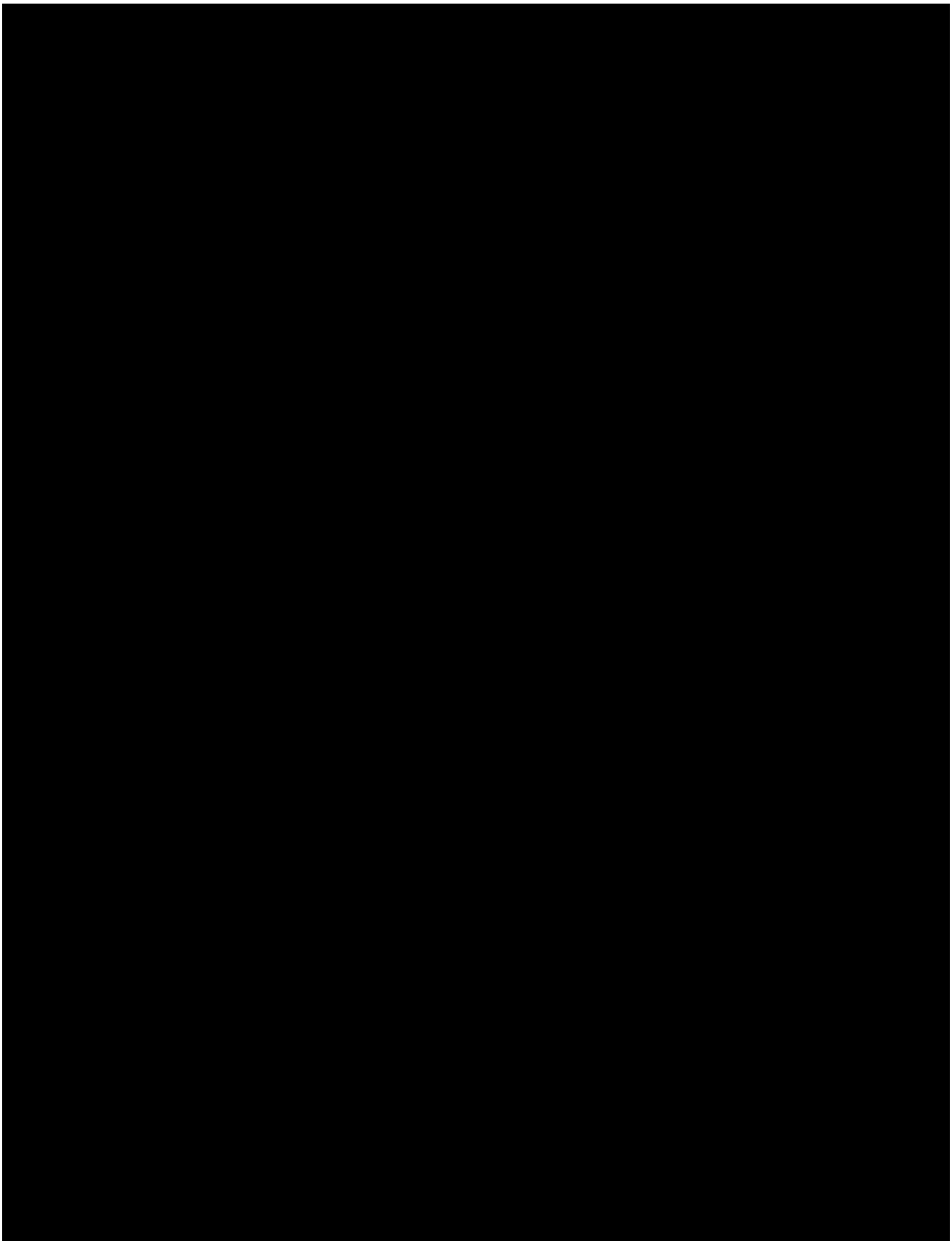


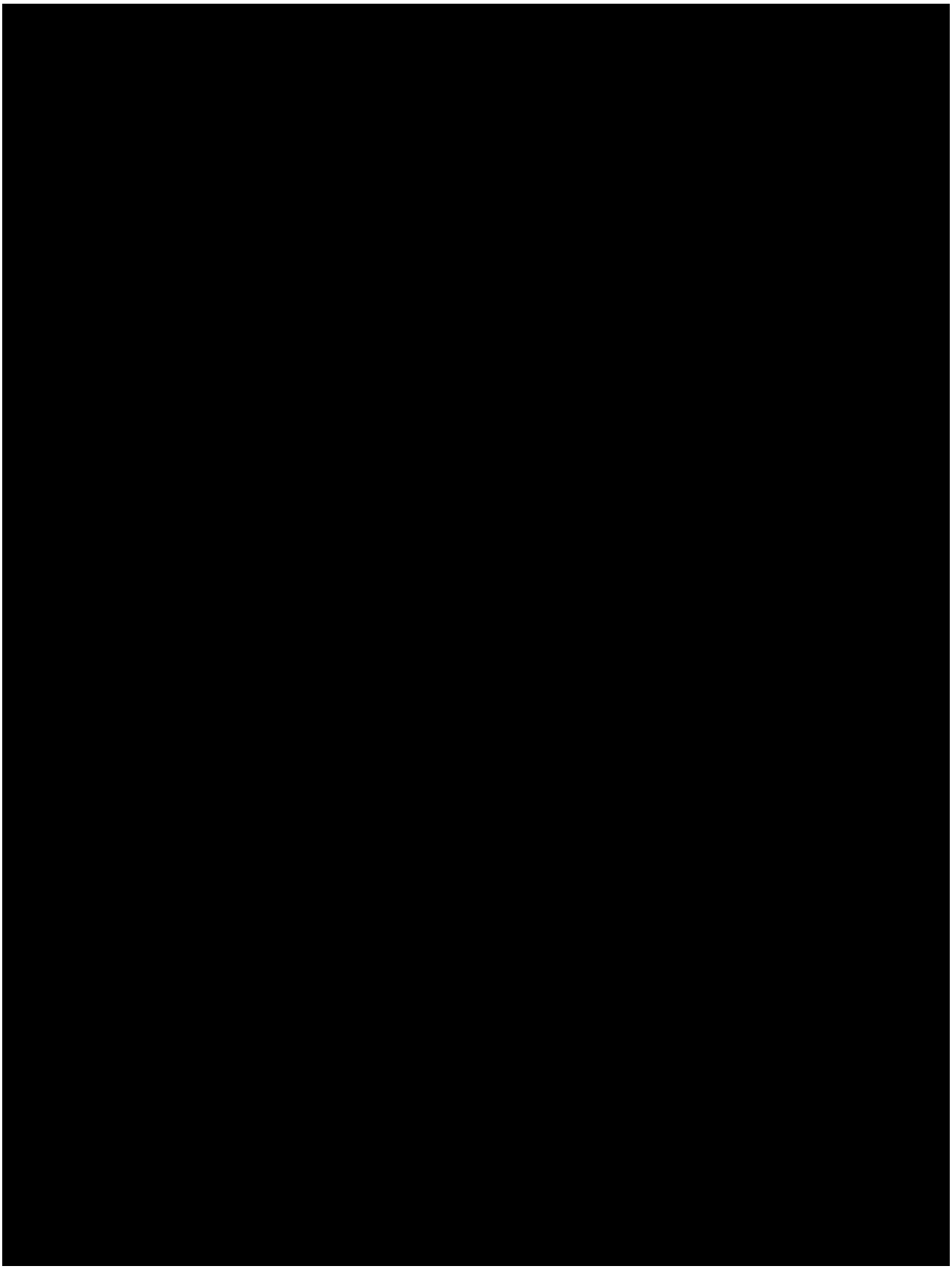


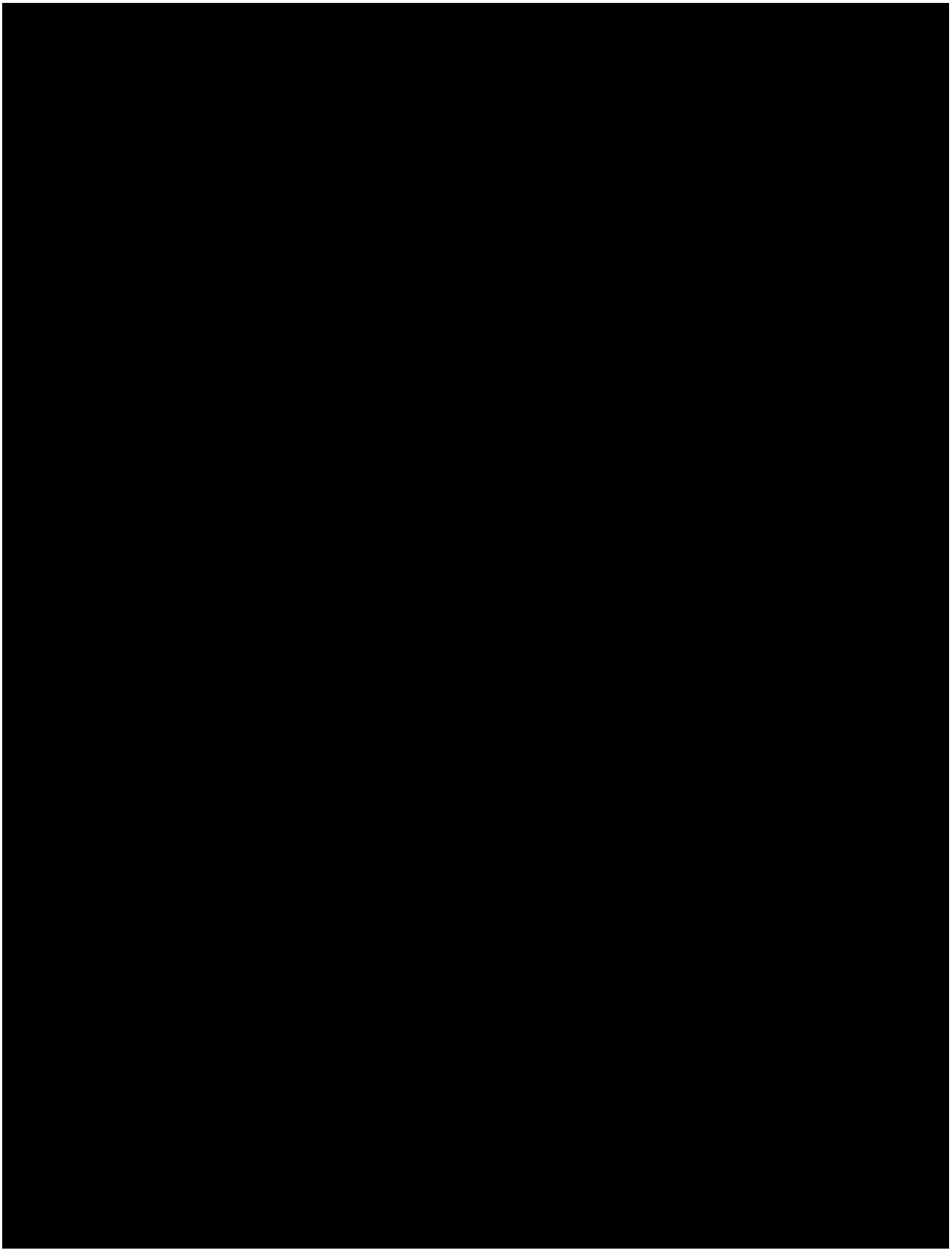


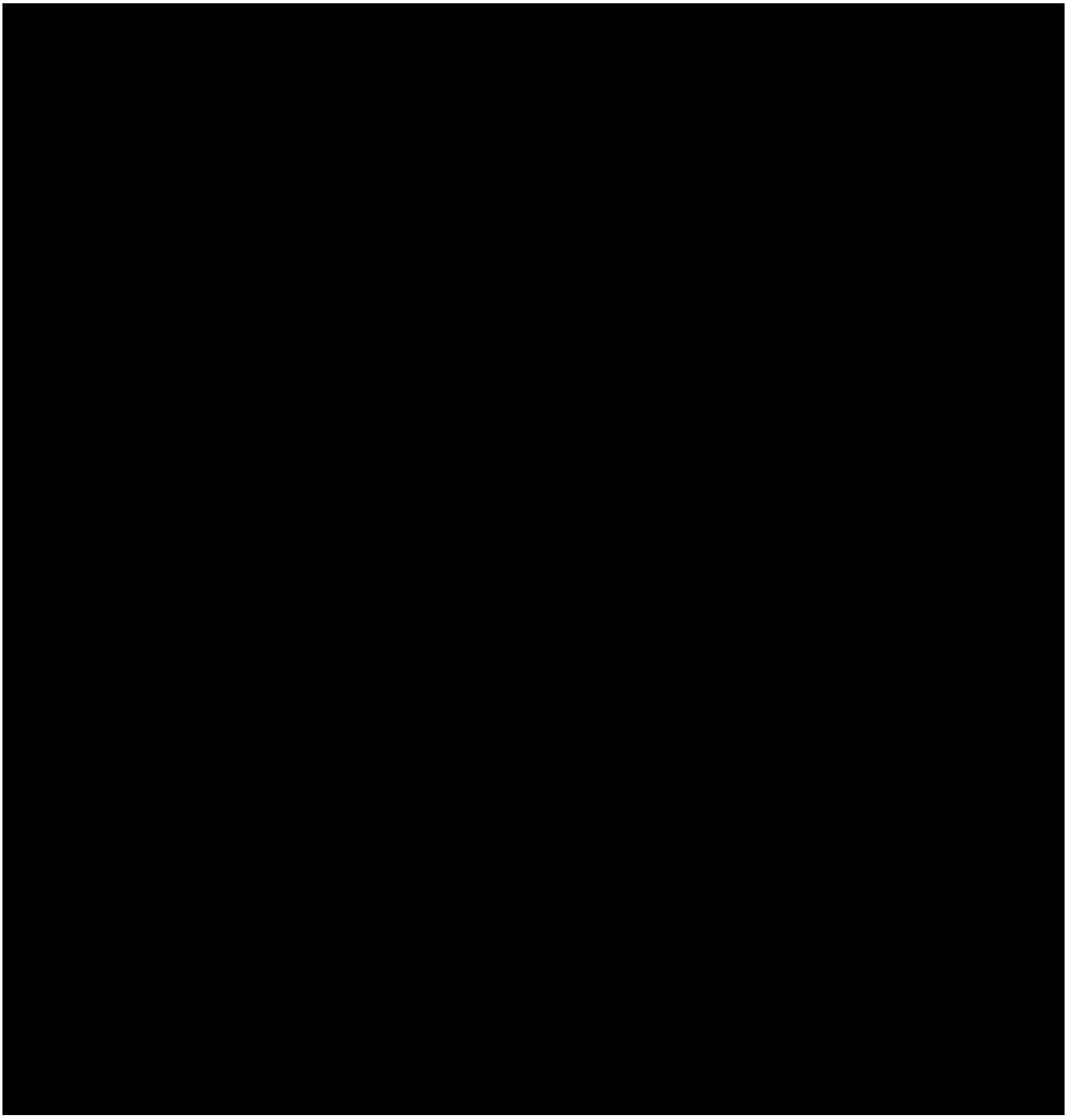













**Working with Christian Service of Shreveport to Offer Vaccinations to the Community**

Christian Service of Shreveport is a transitional home for men and women that operates a daily soup kitchen and assists with rent, utilities, and other services. Healthy Blue's partnership with them was established in 2013, and together, we host an annual health fair on-site. This year, however, due to the low vaccination rates in Louisiana, we partnered with David Raines Community Health Centers on Wednesday, July 21, to offer vaccinations at their facility.

# 2.6.4

Population Health

Healthy Blue

## 2.6.4 Population Health

### 2.6.4.1 Healthy Blue's Approach to Population Health

At Healthy Blue, improving population health with person-centered solutions is at the heart of everything we do. Throughout our more than nine years serving Louisianians in Medicaid, our population health program has evolved to respond to the vast and constantly changing factors that impact individuals' and communities' health and wellness. We are excited to share our new **Elevate | Population Health** program, focused on promoting prevention, improving the health of all Louisianians, and building resilient communities. Our approach, in alignment with the Louisiana MCO Manual, seeks to maintain and improve the health status of our Healthy Blue population through prevention strategies, while also methodically identifying sub-populations with complex needs, including social determinants of health (SDOH) barriers. In this way, **Elevate | Population Health** also strives to reduce health disparities among identified sub-populations.

**Elevate | Population Health** gets us to the root of what our enrollees (members) need, whether it be physical healthcare, behavioral healthcare, transportation, [redacted] to improve the overall health status of our membership as a whole. We are proud of our comprehensive approach to population health, which focuses on evidenced-based decision-making, community participation, continuous quality improvement, and sharing lessons learned and suggested behavioral changes. Our program is designed to support members with preventive health practices guided by the CDC's "Six Ways to Spend Smarter for Healthier People" with a focus on prevention including controlling high blood pressure and asthma, tobacco cessation, and preventing Type 2 Diabetes. Our new and enhanced programs and capabilities, described throughout this section, combined with our experience, passion, and sheer determination will ***elevate the health of all Louisianians***.

**WE ARE COMMITTED TO LOUISIANA**

Healthy Blue and our parent organizations support the health of our communities:

- **$13M** focused on health disparities work, including racial and health equity symposiums and learning labs, mental health first aid trainings, including **$830K** in active maternal health disparity grants
- **$5M** in disaster relief by our parent companies to support our communities impacted by Hurricanes Laura and Delta
- **$5M** in supplemental payments to assist NEMT providers with increased expenses to assure safe member access to care during the pandemic
- **$4.8M** to support food banks and food pantries across the state, including **$1.3M** in active healthy eating grants designed to address food insecurity across Louisiana
- **$717K** to support Mary Bird Perkins Cancer Center's Prevention on the Go, including a grant to create a Louisiana Delta Cancer Screening Campaign

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Our population health strategies are supported across our organization, from leadership to frontline staff. Our strategies support the vision and mission of LDH to improve population health and address health equity by reducing disparities, maximizing health, and addressing SDOH. Healthy Blue's senior leadership has been instrumental in establishing the State's population health strategies and bring their wealth of experience to support our population health strategy, starting with our Chief Executive Officer, Christy Valentine, MD, MBA, who assures all Healthy Blue operations, programs, and strategic partnerships align with our priorities and drives our targeted outcomes. Rhonesia Simmons, MD, MBA, our Population Health Administrator, oversees all population health activities. Karen Kosinski, MPH, MSW, our Health Equity Administrator; Christin Cantavespri, our Quality Management Coordinator; and Lisa Arceneaux-Tropez, Ph.D., our Population Health Liaison provide direct support to Dr. Simmons in execution of all population health initiatives. Brenda Tompkins, our Case Management Administrator and Medical Management Coordinator; Cheryll Bowers-Stephens, MD, MBA, our Behavioral Health Medical Director; Raymond Poliquit, MD, our Chief Medical Officer; Peter Lambousy, our Enrollee Services Manager; and Randy Guillory, our Provider Services Manager; each contribute to and are accountable for population health improvements in each of the priority areas.

Our approach is a collaborative framework focused on the development of innovative solutions to address member needs of our members and their communities. Grounded in a model of continuous evaluation and improvement, and with a goal of constantly addressing health equity, our [redacted]

## Identifying Population Health Needs

Data and analysis are the foundation of **Elevate | Population Health**. Upon this foundation of data, we establish baselines and identify targets for health improvements that drive targeted interventions, implemented by specialized teams to improve our members' overall health and well-being.

which allows us to act quickly to support new, high-risk members who have immediate care and service needs and risk drivers identified through predictive modeling algorithms, to engage members, providers, and stakeholders in our shared communities.

Using Healthy Blue HI, Elli, and other analytic tools, we conduct a full population analysis annually. Our 2021 analysis revealed key opportunities for improvement. Our data findings were also consistent with State-level data, resulting in our four priority focus areas directly aligned with the State's goals and priorities for population health:

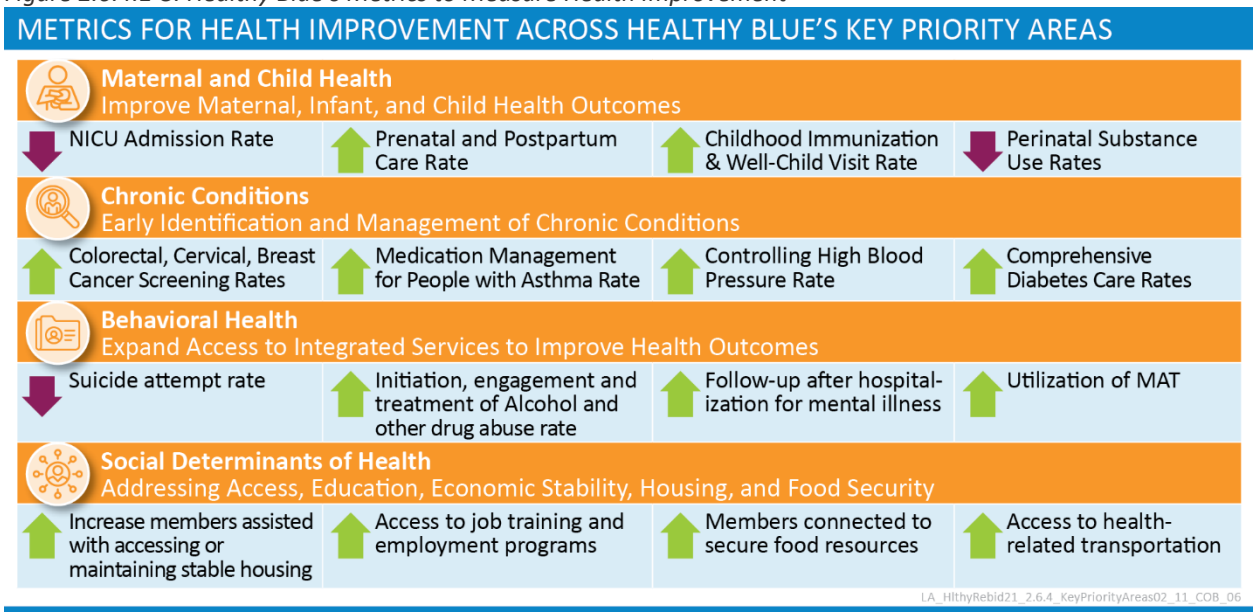
- **Elevate | Maternal and Child Health.** Assuring a strong start for our families. We recognize Well-Child and Immunization rates have declined year-over-year (YOY) as impacted by COVID-19. According to CDC data, Louisiana ranks the second highest in the US for cesarean delivery rate, preterm birth rate, and low birthweight rate. The March of Dimes LA report card cited LA as an "F" for maternal child health. America's Health Rankings (AHR) ranks Louisiana 49th in percent of low birthweight infants (2019). Healthy People 2020 (CDC) cites immunizations as an emerging issue of concern with need for healthcare infrastructure to respond to diverse and varying needs.
- **Elevate | Chronic Chronic Condition Management.** Improving access to and use of services for many of our priority populations. AHR noted the percentage of females with multiple chronic conditions increased from 11.9% to 16.6% (a 40% increase) from 2011 to 2019. Analysis of our membership showed that diabetes, coronary artery disease, COPD, congestive heart failure, cancer, and asthma were among our membership's top 10 diagnoses. In addition, our analysis showed poorer diabetes HbA1c control for Black and African American members.
- **Elevate | Behavioral Health (BH).** Expanding access to integrated services to improve health outcomes. Louisiana has experienced a YOY decline in rates for BH follow-up. AHR lists Louisiana as second (18.5%) for frequent mental distress. CDC data indicates a 47.6% increase in drug overdose deaths in Louisiana between December 2019 and December 2020 (a 29.4% increase). Five of the top 10 inpatient diagnoses among Healthy Blue members are related to mental health or substance use disorder. Additionally, antidepressant medication management and initiation and engagement of alcohol and other drug or dependence treatment are lower among Black members, and inpatient BH admissions is higher than among other populations.
- **Elevate | Social Determinants of Health.** AHR ranks Louisiana 48th in food insecurity, 50th in cumulative adverse social and economic factors, 46th in unemployment, and 49th in student homelessness. Healthy Blue's data shows that the highest spend per Louisiana Medicaid member is for: (1) members experiencing homelessness; (2) members experiencing economic problems; and (3) members experiencing work problems.

## 2.6.4.1.1 Establishing Baseline Measures and Targets for Health Improvement

Once we identify a trend or opportunity to improve, our comprehensive approach to identifying baseline health outcome measures and targets for health improvement builds on a robust integration of member and population-level data like those in Attachment H, including HEDIS®, CAHPS®, inpatient days per 1,000, and other Louisiana and nationally recognized measures and benchmarks. We have experience with industry-accepted quality, utilization, and other health measures that enables us to compare our performance and trends over time.

For example, we may use YOY trends for utilization measures or prior year HEDIS data to measure improvements in HEDIS outcomes. Using this approach, as shown in Figure 2.6.4.1-3, we have identified targets for health improvement across the four priority areas.

*Figure 2.6.4.1-3. Healthy Blue's Metrics to Measure Health Improvement*




[redacted]

**Establishing Baselines and Targets for Health Improvement – In Action.** National and local data, and LDH's goals demonstrated that maternal and child health needs to be a top priority for population health. A drill-down into the data demonstrated significant opportunities to decrease:

- **Preterm Birth Rate.** Our performance measures, which provide our baseline, show an increase in preterm birth rate from 22.16% in 2019 to 22.86% in 2020. To establish our benchmark, we used the March of Dimes 2020 goal to reduce preterm birth rates to 8.1% and a goal to reduce to 5.5% by 2030.
- **Low Birth Weight.** While low birth weight measures are showing a YOY decrease from 13.65% in 2019 to 11.75% in 2020, significant opportunity remains for further reduction. Using the US DHHS Healthy People 2020 goal as our benchmark, we set the commitment to reduce the low birth weight rate to 7.8%.

## 2.6.4.1.2 Measuring Population Health Status and Identifying Sub-populations

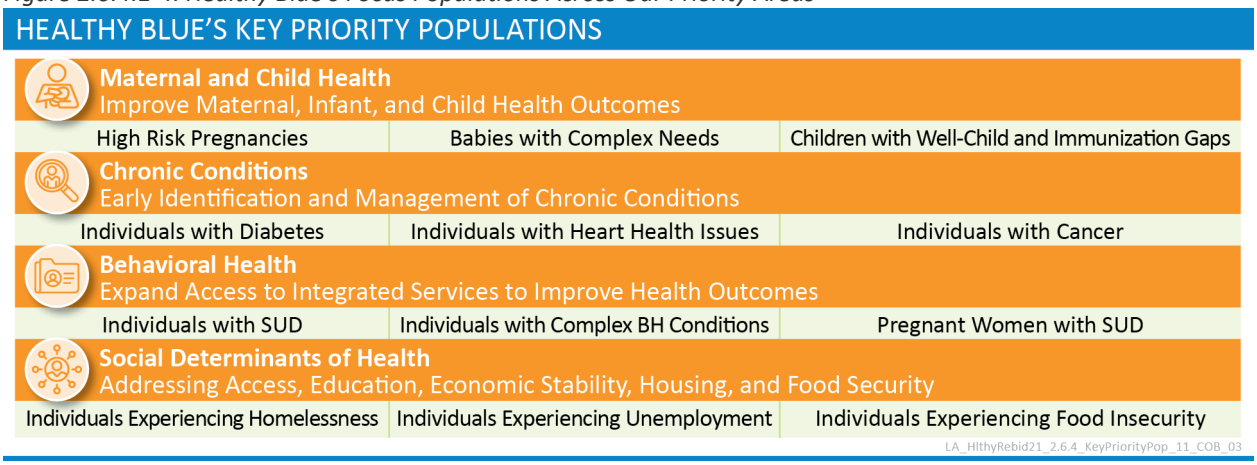
Our Population Health Administrator, Dr. Simmons, measures population health status on an ongoing basis, using Healthy Blue HI as the foundation to continually monitor member and population data to guide improvements. Our **Elevate | Population Health** analysis is reviewed in-depth, annually, to identify emerging trends, adjust measures, and prioritize specific sub-populations for optimal success. Dr. Simmons regularly assesses population health status by:

- Analyzing member demographics including a breakdown by parish, acuity and risk level, cohort, gender, race, ethnicity, and age
- Analyzing claims data to identify utilization trends, top diagnoses, and top non-medical risk factors
- Summarizing state- and national-level health data and conducting appropriate comparisons
- Comparing all findings against LDH's population health goals
- Our overall population health status analysis is supported by Healthy Blue HI, which gives us the flexibility to analyze health data by subpopulation, including most current clinical, behavioral including gaps in care. We use a combination of predictive modeling, claims and pharmacy data, laboratory results, referrals, Utilization Management data, and health and social risk factor assessment results to identify Population Health cohorts.

Our criteria and thresholds for member stratification are based on algorithms that identify various types of high- or emerging-risk populations through the analysis of diverse sets of demographics, claims data, ADT data, and individual, external, and community-level data on social risk factors. Our algorithms inform, develop, and assess population health strategies at the individual level (care management has a key tool for member outreach), community level (community-based organization [CBO] support and neighborhood initiatives), and parish and state level (community

investment, collaboration, coordination, and data sharing). Some examples of algorithms include our Chronic Illness Intensity ($CI^3$) Scores, readmission risk assessment surveys, emerging risk (ERM), and low intensity Emergency Room (LIER) utilization risk. We complete a re-stratification of our membership every month. This approach allowed us to identify priority populations across our four priority areas as shown in Figure 2.6.4.1-4.

*Figure 2.6.4.1-4. Healthy Blue's Focus Populations Across Our Priority Areas*




- Our "hot spotting" tools help us take the stratification data further to look at populations by region, parish, or even zip code. Our Interactive Analytic Insights and Community Health Management Hub (Hub) help us identify care gaps and social barriers, and to develop strategies specific to member needs by geographic location.
- Our approach to evaluating health status and identifying sub-populations allows us to develop interventions that address population health across all levels of need. By stratifying our membership and addressing sub-populations, we keep healthy communities healthy, and focus our resources on the members, communities, and populations that need additional support to improve population health trends.

**Measuring Health Status and Identifying Sub-Populations — In Action.** Once we identified the targets for maternal and child health improvement, we conducted a deep dive in those areas to identify the sub-populations. According to a 2019 report from the March of Dimes, Black women in Louisiana experienced preterm births at 16%, a higher rate than any other ethnicity. Our Healthy Blue analysis revealed similar and additional disparities between January 2019 and April 2020:


- Preterm birth for Healthy Blue's Black members occurred at the rate of [redacted]
- Black women experienced severe maternal morbidity at a rate of [redacted]
- Black women experienced low birth weight deliveries at a rate of [redacted]
- We established these rates as our baseline and set the goal to ***eliminate the disparity*** across these three.

## 2.6.4.1.3 Identifying Key Determinants of Health and Strategies to Reduce Disparities

**Elevate | Population Health** focuses on identifying the root cause of a health outcome, inclusive of social, cultural, medical, and other factors that may exist. We understand that members will likely have multiple and differing key determinants of health, so our approach assures we address the populations' changing needs. When we identify a trend, we identify other contributing factors – for example, transportation as a barrier to receiving prenatal care. We also engage community partners for feedback, sharing information about our data and discussing barriers that may exist before taking action. Our framework to address health disparities, highlighted in Figure 2.6.4.1-5, builds on our population health approach and constantly evaluates our initiatives to make sure our strategies impact the key determinants of health.

[redacted]

Healthy Blue is dedicated to eliminating health disparities and advancing health equity. In line with LDH's Health Equity Plan mantra, "Nothing about us, without us," we listen to members, providers, and community partners, and let their experience guide our work. Our strategies for addressing disparities are a key component to our **Elevate | Population Health** approach, and we are proud to have been one of the first Louisiana MCOs awarded NCQA Multicultural Health Care Distinction in 2017. Healthy Blue's experience with members, providers, and other stakeholders provides insight into members' and communities' specific cultural and health needs. We complement their direct input with data from our advanced analytics tools, and leverage the following strategies:
**Focused and Dedicated Staff to Reduce Disparities.** Karen Kosinski, our Health Equity Administrator, will oversee efforts to reduce health disparities. We train all member-facing employees and providers in cultural competency and overcoming implicit biases.

**Our Health Equity Task Force.** We recently established a Health Equity Task Force, which will take both a data-driven and community-based approach to identifying and addressing Louisiana-specific health disparities. The Task Force evaluates individual and community needs, cultural influences, experiences, and competencies to identify and address drivers of health. The Task Force is chaired by Karen Kosinski, our Health Equity Administrator, and is comprised of other Healthy Blue employees and community members with diverse backgrounds and cultures who are committed to advancing health equity. Informing the work of, and under the guidance of our Population Health Workgroup, the Healthy Equity Task Force assures that our interventions are designed with the end in mind.

**Our Population Health Workgroup**, including employees from our Care Management, Quality Management (QM), Analytics, and Enrollee and Provider Services teams — conducts a comprehensive review of disparity data. This group, led by Dr. Simmons, reviews population health data and identifies areas for improvement. Through these reviews and member listening sessions, we identify disparities in outcomes among members and specific sub-populations that may benefit from targeted interventions.

Using these strategies, we have developed and will continue to develop interventions specifically designed to reduce health disparities, some examples include:


[redacted]

**Supporting Members Who Identify as LGBTQ+.** In the first quarter of 2022, we will enhance our LGBTQ+ provider training opportunities to our network providers that, upon provider completion, will result in an indicator added to our online provider directory designating the provider's status as a Healthy Blue LGBTQ+ ally. Additionally, our parent company, Anthem, Inc., is in the process of developing an LGBTQ+ Center of Excellence model, as well as member engagement strategies to assure our members easily access the best healthcare for their needs.


**Addressing Health Disparities — In Action.** Within our focus on maternal and child health, we identified multiple health disparities that exist among our Black and African American Members and set the goal to eliminate those disparities. To accomplish this, we conducted both a root cause analysis and participated in listening sessions to make sure that we consider all contributing factors, beyond those measures identified as target key measures. These contributing factors include pre- and postnatal care, well-child visits, and other key determinants of health including hypertension, diabetes during pregnancy, nutrition, and social determinants. To accomplish this goal and address all key determinants of health, we have developed several targeted interventions, including but not limited to:

[redacted]

## 2.6.4.1.4 Integrated Initiatives that Represent a Comprehensive Approach to Population Health

Over the past nine years, Healthy Blue has demonstrated the ability to develop integrated initiatives that address populations' physical, behavioral, and social needs. ***As a fully integrated health plan, every program we develop centers on whole-person care from initiation.*** Our population health strategy brings all health plan functions together to develop initiatives that comprehensively address the entire population. Examples of our integrated initiatives across our four priority areas are included in Figure 2.6.4.1-6, and represent a comprehensive approach to population health. Under the leadership of Dr. Simmons, a cross-functional Population Health Workgroup representing Health Equity, QM, UM, Care Management, Pharmacy, Network/Provider and Member Services focuses on whole-member health, including BH and physical health, reviews data, identifies areas for improvement, and develops, adapts, and deploys targeted initiatives. ***Everything we do, from member engagement to value-based purchasing programs, to value-added benefit (VAB) design and deployment, is specifically designed to elevate the health of Louisianians.*** We know that our success improving member health depends on streamlined, methodical, and comprehensive collaboration, and recognize that integrated, whole-person care cannot stop at the health plan, but must be incorporated through the community with innovated strategies at the delivery of care practice level.

**COMING IN 2021:**
**CONCIERGE CARE FOR MEMBERS WITH CHRONIC HEART FAILURE**

Healthy Blue is pleased to introduce Concierge Care, a dynamic, person-centered member-facing app that helps to connect members to our care management team. Through this evidence-based program, care managers will be able to interact and collaborate with members, providing highly personalized educational content, bi-directional chat and supporting members to manage their symptom.

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## 2.6.4.1.5 Additional Population Health Considerations

Healthy Blue, with affiliates operating Medicaid managed care programs in 24 other markets, benefits from the best practices and lessons learned across a broad spectrum of populations and geographies, as well as the long-standing local experience and expertise of BCBSLA. The major consideration we would like to present includes our lessons learned from the COVID-19 pandemic. A recent Louisiana Public Health Institute (LPHI) assessment found that BH needs worsened since the start of the pandemic. The most impacted groups, according to the assessment, are communities of color and people experiencing unstable housing. The COVID-19 pandemic exacerbated the

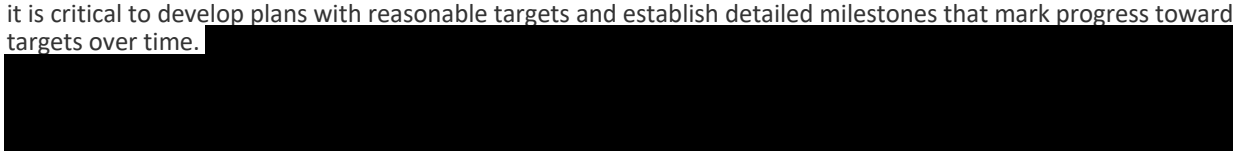
shortcomings of care delivery nationwide, including Louisiana. The already challenged clinical workforce was further depleted, with problems obtaining personal protective equipment and support staff temporarily laid off or unemployed. However, it has also served as a catalyst for transformation, which was quickly implemented across the state, far faster than it would have occurred pre-pandemic. Louisiana adjusted with new care pathways, roles, sites of service and covered services. Members responded by embracing telehealth and digital tools. ***Healthy Blue proactively responded to the COVID-19*** pandemic through the use of BCBSLA's Healthy Blue-specific tracker, and through the creation of unique predictive modeling tools that absorb public information regarding COVID-19 risk attributes, COVID-19 trends, and member risk factors to prioritize members for targeted outreach. As one example, we have reached out to almost 400 providers, alerting them of members on their panels with gaps in care that have not been vaccinated or have only completed one shot. For engaged VBP providers, the Provider Care Management System (PCMS) portal displayed all members who had tested positive, including those using an external lab, along with risk stratification. It was well-received and appreciated by the provider community as the first tool from an MCO (~90 days after declaration of public health emergency).

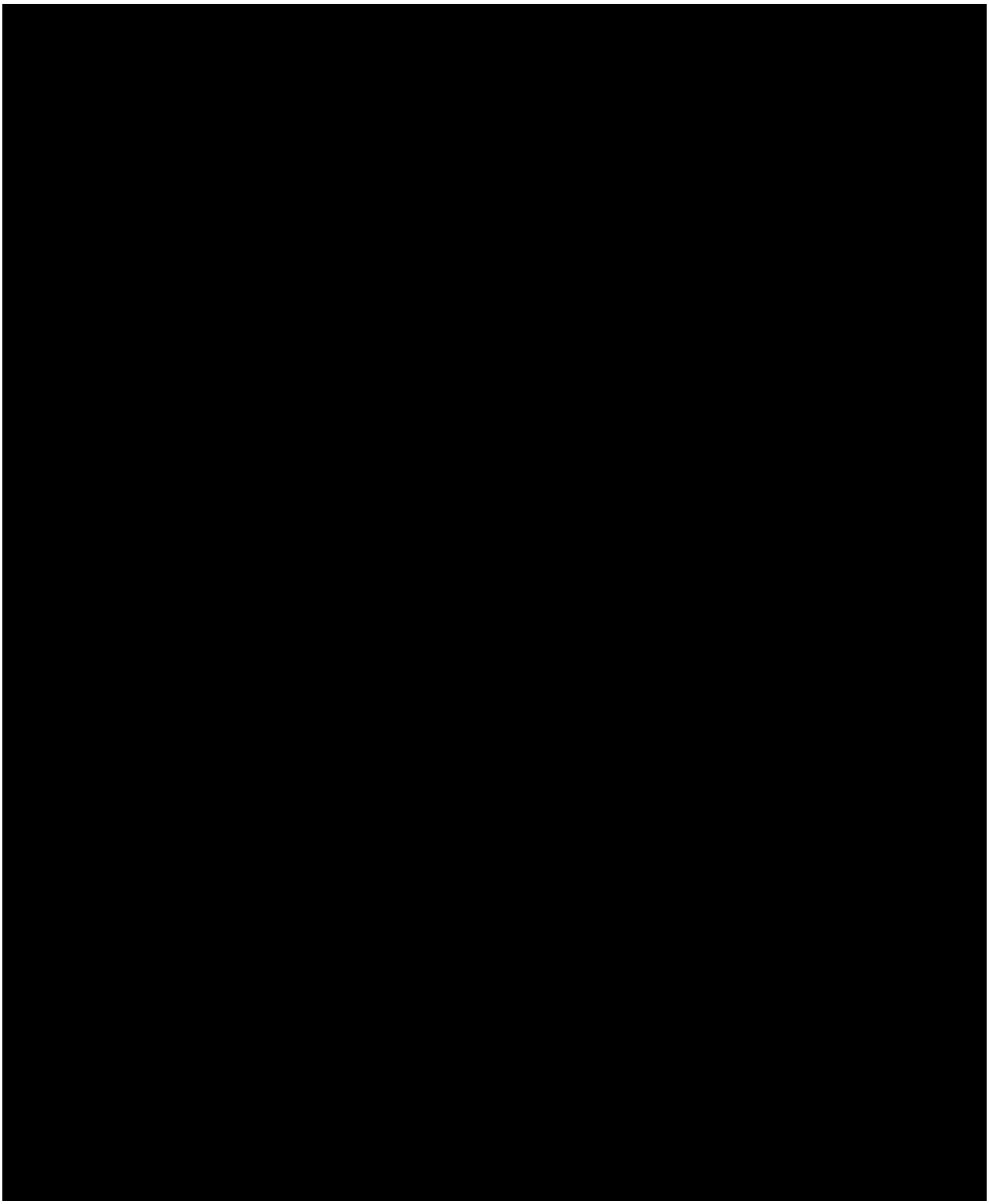
Throughout the COVID-19 pandemic, we have also created solutions to bring telehealth to members, including supporting telehealth delivered by our network providers. We went beyond traditional telehealth services, especially for individuals experiencing BH challenges. Healthy Blue's "lessons learned" from 2020 include:

- Continued evolution of predictive modeling and analytics tools to incorporate improved data sets identified upon member enrollment, such as race and ethnicity identifiers as well as SDOH risk drivers, to improve focused interventions to reduce health disparities
- Realignment of care models to incorporate care coordination extender resources, including CHWs, Community Paramedics, Doulas, Patient Navigators, to meet members where they are and extend the reach of providers and MCOs
- Continued the provision and implementation of digital strategies and solutions to support increased member access to telehealth and telemedicine

## 2.6.4.2 Milestones and Timeframes to Addressing Population Health

As an incumbent with more than nine years of Medicaid experience in Louisiana, and with the support of our two parent organizations, BCBSLA and Anthem, Inc., we are uniquely positioned to continue to build on our existing population health approach to meet the evolving needs of LDH and the communities we serve. To meet our goals, it is critical to develop plans with reasonable targets and establish detailed milestones that mark progress toward targets over time.





[redacted]

## 2.6.4.3 Experience and Approach to Addressing SDOH Needs

Healthy Blue has long recognized that SDOH needs can exacerbate physical or BH. Considering all factors that influence health is a key component of our **Elevate | Population Health** framework. By understanding our members' most important needs and helping to connect them to resources, we can more effectively help them to meet their health goals. SDOH is integrated in all that we do – through our population health approach, provider and community-based partnerships, and QM activities, we have continuously worked to help identify and address these barriers and continue to develop our understanding and strategies to support our communities' needs.

Healthy Blue gathers member-level SDOH information through multiple sources, both on an individual- and community-level, including capturing SDOH through:

- Social Determinant Screeners and health needs assessments
- Z-code submissions, via claims for all members, including new members
- Predictive models, incorporating individual and community-level SDOH data
- Risk stratification tools allow us to pinpoint the SDOH and clinical needs of our members to identify areas of greatest need for population-based interventions through targeted programs

We have an exhaustive "no wrong door" approach to collecting SDOH data, continuously seeking to expand our capacity to identify and capture this information via CHWs, providers, navigators, CBOs, and members [redacted] We continue to capture SDOH issues from provider, member and stakeholder feedback through focus groups, advisory bodies, listening sessions and our Member Advisory Council (Health Education Advisory Committee).

[redacted]

## 2.6.4.4 Coordinating with CBOs and OPH to Improve Population Health

Healthy Blue understands that population health initiatives must be designed, implemented, and executed in conjunction with the communities we serve. We take a local, active, and purposeful approach to investing in health priorities that address community needs and population health risk factors across Louisiana parishes. Our **Elevate | Population Health** approach listens to providers, members, families, CBOs, faith-based organizations (FBOs), OPH, and community partners, and lets their experience guide our work. We gather feedback through committees, workgroups, joint operating committees, and one-on-one interactions. These partnerships provide us with insight on how we can collaborate to address important issues for Louisiana to develop specific responses, such as increasing food security-focused CBOs during the pandemic based on surging needs. For example, based on our long-standing relationship with the YWCA of Baton Rouge as well as specific data on the community, we know there are ongoing needs in pockets of East Baton Rouge, such as in the rural community of Merrydale. To address these needs, Healthy Blue has invested more than $50,000 to the YWCA of Baton Rouge to advance education, income stability, and healthy living for women, children, and families. More recently, we focused our funding on several targeted initiatives to support the workforce and close the poverty gap in East Baton Rouge, including creating a resource group of Certified Childcare Development Assistants, providing tuition assistance and implementing a workforce training program.

## Contracting with CBOs

We take a collaborative approach in working with CBOs across Louisiana, jointly developing Memorandums of Understanding (MOUs) as needed to clarify roles, support, and sharing of information to coordinate population health strategies. We recognize their depth of understanding of members and incorporate their input throughout our organization and the service delivery system. We partner with CBOs that align with our population health goals and meet our communities' needs. Next, we describe two additional successful programs developed to support CBO activities across Louisiana.

[redacted]

[redacted] Administered through an MOU, we provided funding to these CBOs to cover the cost of administering their programs and increase resource bandwidth, with a mutual agreement that these CBOs would provide Healthy Blue with outcomes data so we can understand the impact of our contributions. [redacted]

### PARTNERING TO ADDRESS MEDICATION ADHERENCE

According to the Network for Excellence in Health Innovation, medication non-adherence is a leader driver in high healthcare cost, adding up to $290 billion annually. To that end, Ochsner/LSU Health Shreveport in Monroe and Healthy Blue will work on a collaborative effort to provide prescription delivery services to rural communities in the following parishes: Morehouse, Lincoln, Jackson, Ouachita, Richland, East Carroll, and West Carroll.

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## Teaming Up with the Louisiana Public Health Institute to Address Racial Disparities

Louisiana, and especially New Orleans, was hit hard and early by the COVID-19 pandemic. In response to COVID-19's disproportionate effect on the African American community, Governor John Bel Edwards launched the Governor's Health Equity Task Force to better understand and address the inequities causing these disparate and troubling health outcomes. To address health equity concerns statewide, Healthy Blue partnered with LPHI to conduct a virtual Inaugural Louisiana Racial and Health Equity Symposium in March of 2021. This symposium aimed to create momentum among our state leaders and drive forward intentional action to address the health and racial inequities that continue to impact the social well-being and health of our communities. National experts, local community leaders, and health professionals shared insights and information on national and local efforts that are promoting health and racial equity and addressing SDOH; 567 people from 19 states participated in this event.

[redacted]

## Partnering with the Louisiana Office of Public Health

[redacted]


## Creating Bike- and Pedestrian-friendly Communities Through the Stroll into Safety Program

The Stroll into Safety program educates children, caregivers, and community members about the importance of pedestrian and bicyclist skills, the rules of the road, personal safety, and improving health and environmental conditions. This program is designed to bring attention to bike and pedestrian safety issues in the Greater Baton Rouge Area to create safer and more bike- and pedestrian-friendly communities. The program offers classroom presentations, bike rodeos, safety towns, community education events, and bike/pedestrian school events.

## 2.6.5 Health Equity

Healthy Blue shares LDH's goal for every Louisianian to have the opportunity to reach their full health potential, without disadvantage because of social position or other socially determined circumstances. We will address health equity by reducing identified disparities, improving population health, and addressing priority social determinants of health (SDOH). We actively engage our enrollees (members), community-based organizations (CBOs), providers, and other stakeholders in designing, implementing, and evaluating health equity and health disparity initiatives. Further, we embrace the LDH Community Engagement Framework of working to better understand and serve Louisiana's people, populations, and communities, assuring programs are equitably supporting the wellness of all and especially the most vulnerable of this state, and working to provide better quality services and make better use of resources.

Our member-centric **Elevate | Population Health** program facilitates the implementation of data-driven, disparities-focused, and evidence-based health improvement efforts. We use individual and community-level data to proactively identify the health equity issues facing our Healthy Blue members. Equipped with this information, we work with our providers, community partners, and other stakeholders to develop and implement effective interventions to address disparities. The principles of equity, diversity, and inclusion drive our processes, policies, and systems, and we strive in our community work to embody the spirit of "nothing about us, without us."

### 2.6.5.1 Our Management Techniques, Policies, Procedures, and Initiatives

***Health equity is a driving force across our organization*** (see Figure 2.6.5.1-1), influencing everything from staff recruitment and retention to member communications to care coordination.

[redacted]

Our commitment to health equity is evident within our organization and the communities we serve. Earlier this year, ***Healthy Blue established an Office of Health Equity, naming Karen Kosinski, MPH, MSW, Health Equity Administrator***. This new office provides an organizational focus for cross-departmental and community-level collaboration on health equity and will leverage the resources and commitment shared by Healthy Blue's two parent companies. BCBSLA, in conjunction with the Blue Cross Blue Shield Association, has announced a national health equity strategy to confront the nation's crisis in racial health disparities, and Anthem has made a $50 million, 5-year racial equity pledge to directly impact the structural racism and inequities laid bare by COVID-19. In addition, we have established a Healthy Blue ***Population Health Council*** and a ***Health Equity Task Force*** to assure efforts to address the state's most intractable health challenges occur in collaboration with multidisciplinary experts, stakeholders, and members. Our approach to identifying and addressing health disparities is illustrated in Figure 2.6.5.1-2.

We recognize that increasing health equity and eliminating health disparities requires a comprehensive and coordinated effort with MCOs, providers, CBOs, and other partners. [redacted]

One example of our health equity approach at work is our strategy to ***increase colorectal cancer screening rates*** among Healthy Blue members (Figure 2.6.5.1-3). We identified a significant disparity for our members compared to the statewide average, and an even more pronounced disparity for our members in more rural parishes, including Regions 7 and 8.

In conjunction with members, providers, and other stakeholders, we are developing a ***comprehensive Health Equity Plan*** as part of our Population Health Strategic Plan. We will use this same approach and will align with the Louisiana Medicaid Managed Care Quality Strategy and the LDH Health Equity Plan, addressing the cultural, socioeconomic, racial, and regional disparities in healthcare among our members. The Health Equity Plan will also address the digital divide and other infrastructure challenges as well as ongoing challenges faced by populations impacted by disaster and significant subpopulations such as the LGBTQ+ community, tribal communities, and Vietnamese Americans.

## LPHI Partnership to Improve Health Equity

Healthy Blue has also launched more broadly focused initiatives to address health disparities, such as our partnership with the Louisiana Public Health Institute (LPHI). In March 2021, LPHI and Healthy Blue hosted the first annual Symposium on Racial and Health Equity in Louisiana. The theme of the symposium was Achieving Racial Equity, and we brought together leaders from across the state — including

> *This was one of the most realistic and straightforward conferences that I have ever attended. This was a breath of fresh air, and I thank everyone for taking the time to share such a wealth of knowledge.*
>
> **LPHI Symposium Participant**
>
> LA_HlthyRebid21_2.6.5_LPHISym02_68_TST_02

Dr. Kathleen Kennedy, Xavier University College of Pharmacy Professor and Dean, and Dr. Eboni Price-Haywood, Ochsner Xavier Institute for Health Equity and Research Medical Director — to address topics including Systematic Racism and Implicit Bias in Public Health; the Poverty Cycle, Economic Development and Health; and Education, Criminal Justice, and Mental Health. To build upon the enthusiastic response to this symposium, ***we launched a series of Racial Equity Learning Labs to increase understanding of health equity, social justice, and SDOH while building collective community strategies to create equitable practices, policies, and procedures***. Planning for the second symposium (April 2022) is also underway.

## 2.6.5.2 Staffing Strategies to Reflect Medicaid Demographics

Diversity is a key value at Healthy Blue, and we strive to develop a workforce that reflects the demographic characteristics of our members. [redacted]

**Recruitment.** Healthy Blue deploys several strategies to recruit diverse employees. We perform workforce diversity reviews with leadership and Talent Acquisition staff to develop diverse candidate slates and interview teams. We have a recruitment pipeline through Xavier University, one of Louisiana's Historically Black Colleges and Universities, and a new tuition sponsorship for minority students entering medical school at LSUHSC New Orleans.

**Retention.** Through our internal Business Resource Groups, employees of diverse racial and ethnic backgrounds, ability, and sexual identity contribute their perspectives and experiences, strengthening programming, building visibility and inclusiveness, and enhancing employee cohesion. One of our parent companies, Anthem, is ranked by Forbes as one of "America's Best Employers for Diversity."

**Promotion.** Healthy Blue maintains organizational goals for promoting and hiring employees who are female and/or people of color at the director level and above. Promotion of diverse and talented employees is also personified by our health plan's leadership, including Christy Valentine, MD, MBA, CEO; Christine Coleman, CFO; Cheryll Bowers-Stephens, MD, MBA, Behavioral Health (BH) Medical Director; Raymond Poliquit, MD, Chief Medical Officer; Mykayla Jones, Pharmacy Director; and Rhonesia Simmons, MD, MBA, Population Health Administrator.

## 2.6.5.3 Providing Culturally and Linguistically Appropriate Services to Members

Healthy Blue understands the critical role that race, culture and ethnicity play in the health of individuals, and that members are most likely to access care and follow treatment plans when healthcare systems and services are culturally competent and linguistically accessible. To this end, we have developed policies, procedures, and practices that adhere to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. ***In fact, we were the first Medicaid MCO in Louisiana to receive the NCQA Distinction in Multicultural Health Care.*** [redacted] Annually, our Healthy Blue Board of Directors and multiple Quality committees review our CLAS and Health Disparities Evaluation. Going forward, our Health Equity Plan will include these and other elements.

### Assuring Internal Cultural and Linguistic Appropriateness

Healthy Blue provides services to remove culture, language, and ability barriers to healthcare. For individuals contacting us via our Member Services Line, 24/7 Nurse Line, or 24/7 BH Crisis Line, we offer oral interpretation in more than 200 languages. In 2020, we completed 5,430 requests for oral interpreter services to support our members. Members with hearing impairment are provided access to a TTY number. We develop written materials in plain language and in compliance with applicable reading level requirements, and translate these materials upon member request. Documents not translated up-front contain a Language Assistance program notice to assist members in obtaining non-English versions. Members with hearing and/or visual impairments can request materials in alternative formats such as Braille, audio, and large print. We provide instructions to members through our member handbook, member website, and from our Member Services Representatives. We communicate with our members in their stated preferred mode, so they receive information in their desired format.

Some of our methods for providing and monitoring high-quality cultural and linguistic services include:

- Requiring all employees to receive cultural competency training upon hire and at least annually thereafter, in addition to other health equity-focused training discussed in Section 2.6.5.4
- Following our Collateral Materials Approval Process (CMAP) process so that a multidisciplinary team of subject matter experts, regulatory and compliance staff, and legal counsel reviews all materials for accuracy, cultural sensitivity, and compliance with all relevant federal and LDH requirements
- Requiring all interpreters and translators employed by our interpretation and translation vendors, including sign language vendors, to be certified
- Seeking input from our member committees on new member materials, including those tailored to diverse populations

### Assuring Provider Cultural and Linguistic Appropriateness

It is important for providers to have the knowledge, capabilities, resources, and tools to offer equitable and culturally competent care to our increasingly diverse members. We provide cultural competency training during provider orientation and on an ongoing basis in a variety of formats (webinars, resources in the provider portal, and individual and group training). Additional information about provider training in cultural competency is referenced in Section 2.6.5.4.

In addition, we regularly assess the capacity of our provider network to meet the needs of our diverse membership. For instance, through surveying providers regarding language capability, we know our network providers speak a total of 39 different languages, including sign language. We educate our providers on the free oral interpretation services available to members to facilitate their communication. To make certain our members are receiving CLAS from network providers, we investigate, track, and follow up on 100% of provider-related member grievances about language, culture, or potential discrimination.

## 2.6.5.4 Capacity to Develop, Administer, and Monitor Health Equity Training

Healthy Blue promotes an organizational culture of health equity and offers health equity training tailored to its employees, contractors, and network providers. Our training curriculum is informed by member feedback, cognitive science, and our growing understanding of how social, economic, and environmental factors influence health.

### Building a Health Equity Training Program for Employees and Contractors

Through our training program, we build skills and knowledge related to health equity and cultural competency. For instance, all Healthy Blue staff and contractors must participate in the ***Becoming Culturally Competent*** training upon hire and must complete an annual refresher course thereafter. This training addresses topics such as cultural responsiveness, government regulations, language resources, health-related beliefs, health disparities, and variations in social comfort factors. Additionally, we recently engaged Rev. Dr. Starsky Wilson, the President and CEO of the Children's Defense Fund, to create a virtual presentation for our staff called ***Elevating Equity***. This program was designed to create spaces for us to examine race and make sure our staff receive both the skills and tools to elevate race equity. All Healthy Blue staff will be participating in this program. ***All Healthy Blue employee health equity and cultural competency training is tracked for completion via our online learning management system.***

Our member-facing teams receive additional mandatory training regarding providing culturally competent service to Healthy Blue members. Topics include identification of quality of care issues, social drivers and health disparities, LGBTQ+ issues and concerns, mental health (MH), substance use disorder (SUD), trauma-informed care, and adverse childhood experiences. ***Anthem has also created a customized training series on acknowledging and overcoming implicit bias*****.** This multi-week training series includes DECIDE: The Neuroscience of Breaking Bias and The Neuroscience of Bias: Practical Mitigation Strategies for Leaders.

We provide many other employee tools and resources to support an inclusive workplace and the provision of culturally competent services to members. Our Diversity and Inclusion Toolbox is 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. It features material on mitigating unconscious bias, inclusion of people with disabilities, and religious diversity in the workplace.

### Supporting Providers in Health Equity

Network providers are key allies in promoting health equity. We offer cultural competency and health equity training and resources as part of our provider orientation program, on-demand through our Healthy Blue Training Academy, in monthly newsletters, and through our Provider Manual. Additionally, our parent company, Anthem, has established MyDiversePatients.com. This free resource for our providers offers training and continuing medical education units with the common goal of expanding the way we think about healthcare to make sure more people have the opportunity to make the choices that lead to healthy, longer lives, regardless of their diverse backgrounds. Topics include creating an LGBTQ+-friendly practice, reducing healthcare stereotypes, and promoting birth equity. Healthy Blue promotes the use of this resource and our "Caring for Diverse Populations" toolkit to providers to help support the needs of diverse patients. [redacted]

## 2.6.5.5 Healthy Blue Engages Communities and Providers to Reduce Disparities

Healthy Blue works with community organizations, members, providers, and other key partners on data-driven improvement projects that address disparities in healthcare, social resources, and health equity. This collaboration provides insights for member and provider engagement strategies within our **Elevate | Population Health** program.

### Engaging Community Members and Providers in Addressing Health Disparities

Healthy Blue systematically seeks input from a variety of stakeholders and partners, including populations experiencing disparities, on their most pressing health concerns, and we gather feedback and recommendations on activities and initiatives meant to address these challenges. For instance, our ***Health Education Advisory Committee (HEAC)*** is a forum in which our members provide input on our health policies, initiatives, materials, and activities. We also hold community

listening sessions, focus groups, health summits, and other activities meant to gather input on our services and efforts to improve health disparities. [redacted]

Our ***Provider Advisory Committee (PAC)*** provides an opportunity for Healthy Blue to hear from providers regarding clinical and administrative issues and related practices and policies. It is also a forum for Healthy Blue to gather information and insight from providers regarding community-level factors influencing the health of our members, particularly those experiencing health disparities. In addition, our Provider Experience staff gather input from providers on emerging concerns or issues related to community-level health challenges and disparities.

[redacted]

### Healthy Blue Health Equity Task Force

As part of our overarching **Elevate | Population Health** strategy, we are establishing a Health Equity Task Force, which will take both a data-driven and community-based approach to identifying and addressing Louisiana-specific health disparities. The Task Force will incorporate foundational principles of the Community Engagement Framework and Community-based Participatory Research, making sure that racially, culturally, and situationally diverse members are equitably involved alongside Healthy Blue staff in the planning, implementation and evaluation of equity initiatives. Chaired by Karen Kosinski, our Health Equity Administrator, and comprised of other Healthy Blue employees, providers, and members of the community with diverse backgrounds and cultures, the Task Force will evaluate individual and community needs, cultural influences, experiences, and competencies, to identify and address drivers of health. To place special focus on disparities in maternal and child health, we will be adding a Maternal and Child Health Equity Advisory Group as a subcommittee to the Task Force (see Section 2.6.5.11 for details). This task force's charter is to develop and monitor Healthy Blue's strategic initiatives and approaches to activate practices, protocols, and resources that equitably and effectively support the wellness and well-being of all people, populations, and communities served by LDH consistent with LDH's Health Equity Plan.

## 2.6.5.6 Using Community Health Workers, Peer Support Specialists, and Doulas

Healthy Blue uses trusted lay and peer workers — such as Community Health Workers (CHWs), Peer Support Specialists, and Doulas — to engage members and their families across the state, as described next.

### Engaging Members with Community Health Workers

Healthy Blue uses CHWs and other clinical extenders today, and we are increasing the size of this workforce to broaden our reach. Our CHWs are trained in techniques like motivational interviewing by the Louisiana Community Health Outreach Network, live and work in culturally diverse neighborhoods, engage members in care management programs, and help connect them to health and social resources within their communities.

In addition, these CHWs identify and address communities' most pressing social and health priorities: ethnic and racial disparities, maternal and child health, services for justice-involved individuals of all ages, housing insecurity, domestic violence, employment and education programs, technology access, and food insecurity. The experience of our CHWs in the field informs our population health framework and supports quality Performance Improvement Projects with direct member support. We encourage our community partners throughout Louisiana to hire and train CHWs by providing funding through our parent company, BCBSLA. ***Through these grants, more than 50 CHWs have been trained and hired through community-based non-profit organizations since 2019.***

### Utilizing Peer Support Specialists to Support Member Engagement

Our Peer Support Specialists use personal, lived MH and SUD experience to engage members, connect them with SDOH supports, and connect them to case management. They provide non-clinical, strengths-based support and link members to tools and resources to help them create a roadmap to achieving their goals. Peer Support Specialists also support our members through our HOPE (High Outreach for Patient Engagement) program. Peer Support Specialists work with members and facility providers to coordinate discharge planning, educate, and support members to use healthcare resources and address SDOH. [redacted]

[redacted]

## 2.6.5.7 Engaging Members, CHWs, and CBOs to Improve Access and Reduce Health Disparities

Healthy Blue recognizes the value of engaging members, trusted messengers, and CBOs in health improvement efforts. As mentioned, we use advisory groups, focus groups, and listening sessions to gather input and feedback from members and stakeholders. Other means of engagement include:

- **Member Engagement Through Lay Workers.** [redacted] achieving, and maintaining healthy behaviors, and attaining their health goals. Our lay workers are also a rich source of first-hand information about the strengths, needs, and concerns of our members, including the challenges imposed by lack of transportation, housing instability, childcare, and employment.
- **Community Partnerships with CBOs.** We value our longstanding relationships with many CBOs and continuously look for opportunities to partner with these trusted sources of services and support on our shared goals. Throughout the COVID-19 pandemic, we have partnered with a variety of [redacted] to improve COVID-19 vaccination rates among individuals and families experiencing homelessness. In addition, we have worked with CBOs to offer a range of other COVID-19-related services, including but not limited to COVID-19 testing, crisis counseling and intervention services, virtual programming, and support services for members suffering from isolation, BH services for youth and adults, and distribution of packaged meals.

### Plans for Community Partnerships, Actions, Timelines, and Evaluation Plan

Healthy Blue is expanding community engagement following these action steps, timelines, and evaluation plans:

- [redacted]
- [redacted]

## 2.6.5.8 Collecting and Using RELD Is Integral to Culturally Competent Care

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 (RELD), and place of residence (geography). Annually, we conduct a population analysis which considers the cultural and socioeconomic characteristics and needs of our membership. This analysis brings together internal and external data that we continuously review to inform our **Elevate | Population Health** strategy and our health equity priorities and to identify baseline measures and set targets so that we can adjust programs as needed to improve care and services.

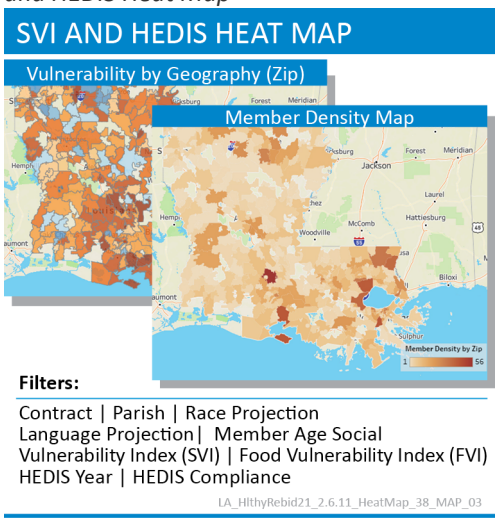
[redacted]

On a population basis, we use RELD and geographic data for various purposes: to inform graphics development (photographic images that mirror members in documents like our member handbook), network development, and language abilities as hiring preferences for bilingual outreach staff in selected geographic areas. To support our providers and members, we use RELD data to offer providers a listing of their assigned members by race, ethnicity, and preferred language to help these providers tailor services to their members' cultural and linguistic needs.

## 2.6.5.9 Putting RELD and Geographic Data to Work in Reducing Disparities

As described in Section 2.6.5.8, we use RELD and geographic data to enhance our ability to provide culturally competent and linguistically accessible services. [redacted]

*Figure 2.6.5.9-1. Geographical Variation in SVI and HEDIS Heat Map*




Healthy Blue has successfully used mapping to identify areas of need and opportunities for community-level interventions to improve health. This capability alerted us to rural disparities in colorectal cancer screening and informed the multi-faceted strategy described in Section 2.6.5.1. This data has also supported our efforts to address maternal and child health disparities in Black women, described in Sections 2.6.5.11 and 2.6.5.13. Similar analyses will guide future interventions and community reinvestment.

## 2.6.5.10 – 2.6.5.10.9 Healthy Blue Identifies and Addresses Inequities

Healthy Blue is committed to actively participating in LDH's efforts to reduce health disparities, address social risk factors, and achieve health equity. Statewide data clearly indicate disparities among Black residents related to birth outcomes such as infant mortality (11.1 deaths per 1,000 births among Black members compared to 5.7 for White members), low birthweight (15.9% low birthweight among all Black member births compared to 7.6% for Whites), and preterm births (16.8% preterm births among all Black member births compared to 11.0% among Whites) (CDC, 2021). For these and other conditions, we generate and analyze information on utilization, clinical indicators, outcome measures, geography (including rural/urban), and related social factors.

## Data Stratification and Analysis

[redacted]

[redacted]

## 2.6.5.11 Improving Pregnancy Outcomes for Black Members and Their Newborns

Black women and children suffer significant disparities relating to pregnancy, postpartum care, and birth outcomes. We are committed to working with LDH, other stakeholders, and members to reverse these longstanding inequities. We understand that this work must address complex and overlapping factors, including access to healthcare, structural racism, and associated social and economic inequities. Figure 2.6.5.11-1 outlines our process to identify and eliminate disparities in maternal health for Black women. We then discuss two key elements in our approach: using data to identify disparities and leveraging community input to address identified disparities.

[redacted]

### Leveraging Data to Identify Inequities and Target Resources

Healthy Blue routinely evaluates clinical utilization and outcome data to identify health disparities by factors such as race, ethnicity, and geography, and we have processes to develop evidence-based approaches to remediate identified disparities and monitor the impact of tailored interventions. For pregnancy, postpartum, and perinatal outcomes, we examine a variety of measures: premature delivery, miscarriage, still birth, low birthweight, gestational

diabetes, late entry into prenatal care, C-section, postpartum contraceptive care, postpartum visit, and infant health and development. Claims, utilization, and outcome data are supplemented by non-clinical data through SDOH review, listening sessions, member and provider satisfaction surveys, and grievances and appeals.

[redacted]

### Garnering Community Input to Effectively Address Inequities

By gathering community input, Healthy Blue creates strategies and action plans that align with community needs, concerns, and strengths, heightening the likelihood of effective intervention in challenging areas such as improving maternal and infant birth outcomes among Black women and children.

[redacted]

To specifically address maternal and child health disparities among Black members, we will be developing an ongoing ***Maternal and Child Health Equity Advisory Group*** that will serve as a subcommittee of our new Health Equity Task Force. The Maternal and Child Health Equity Advisory Group will include affected individuals, such as Black female members of reproductive age, representatives of organizations that serve our Black communities (for example, the Urban League), representatives of related tasks forces and coalitions (for example, the Southwest Louisiana Safe Sleep Task Force), and providers of perinatal care. This forum allows us to listen to and follow our members' and community partners' lead and will provide input regarding all aspects of the initiative's design, including activities, and evaluation methods.

## 2.6.5.12 Using Member and Family Feedback to Improve Services

Healthy Blue uses multiple methods and venues to solicit feedback from members and their families. We conduct listening sessions and focus groups, and we administer surveys and convene groups such as our HEAC and Health Equity Task Force, among other means. In each case, there is a built-in workflow by which member feedback is formally reviewed and acted upon. For instance, during our HEAC meetings we request member input on community engagement strategies, service needs, resource gaps, and potential solutions for addressing barriers to care. We document feedback in meeting minutes and share these with our Quality Management Committee for follow-up. Our goal in seeking member input and feedback is to meaningfully include our members and the communities we serve in the design, planning, and implementation of our services in the spirit of "nothing about us, without us."

### Examples of Leveraging Member Input

**Community Engagement.** Healthy Blue participates in community Back-to-School supply drives. During these events we solicit feedback from participants regarding the usefulness of the information and materials provided during the event. At one event, we received feedback that some of the distributed school supplies did not align with supplies required by schools. We stepped in to identify and secure supplies on school lists and tailored and distributed kits appropriate for elementary, middle, and high school children.

[redacted]

**Collaboration with CBOs.** To make certain that our members are accessing timely, high-quality services from our CBO partners — particularly those partners to whom we make SDOH referrals — we will have our Care Management staff survey a sample of those members who are referred to CBO partners. We will inquire about access to the CBO's services, including linguistic and cultural access, timeliness of receipt of services, and quality of services. This information will be used to enhance the services our members receive from local CBOs.

[redacted]

**Member Satisfaction.** CAHPS® data offers high-level feedback on provider performance, and we augment this data by reviewing member grievances and complaints to confirm we are responsive to members' needs and concerns. We review 100% of member grievances alleging discrimination or culturally inappropriate care and, as indicated, work with providers to address deficiencies, including directing providers to training opportunities.

## 2.6.5.13 Improving Pregnancy and Birth Outcomes for Black Members

Black women and children suffer disparities related to pregnancy and birth outcomes in Louisiana. [redacted]

Healthy Blue is committed to eliminating these and other pregnancy and birth outcome disparities. ***Between 2017 and 2019, we have seen maternal health disparities between Black and White members decrease in the areas of prenatal and postpartum care, initiation of 17-P (medicine to prevent preterm birth), and well-child visits in the first 15 months of life***, and we aim to build upon this progress to fully eliminate the differences. We have selected ***multiple outcome measures*** to track our progress: preterm births, low birthweight, low-risk, first-time mother C-section rate, early elective delivery, prenatal care, postpartum care, and well-child visits.

### Activities to Improve Pregnancy and Birth Outcomes Among Black Members

We present, examples of strategies we intend to employ in addressing disparities experienced by our Black members related to maternal and birth outcomes. A full overview of our strategy is presented in Figure 2.6.5.11-1. Detailed descriptions of project-related goals, objectives, action steps, and timelines will be included in the Health Equity Plan, which will be provided to LDH prior to readiness review.

[redacted]

[redacted]

## 2.6.5.14 – 2.6.5.14.2 Decreasing Disparities in Preventive Care for Youth

Initiating prevention-focused care early in life offers the best opportunity for our members to achieve optimal health and wellness. We track a variety of measures to assure members are off to a good start and will continue to engage members, families, and providers in addressing disparities in selected preventive care services.

### Well-Child Visits and Vaccination Rates for Children and Adolescents

Healthy Blue employs multiple methods to maximize well-child visits and vaccination rates among children and adolescents. [redacted] ***In 2019 and 2020, we launched seven campaigns to target members for well-child and immunization gap closure. For our entire membership, well baby visits improved from the 33rd to the 50th percentile in 2019.*** We will continue to work directly with parents, children, adolescents, and providers in the development of activities, initiatives, and interventions intended to remediate disparities in the receipt of well-child visits and childhood and adolescent immunizations. Specifically, we will be building upon our experience in working with adolescents in developing Total Teen Takeover, an awareness event regarding physical and mental health. This event was planned by teens interested in creating a safe space to talk about suicide. The popular event is now in its fifth year and has the support of the City of Baton Rouge. Our Healthy Blue Behavioral Health Consumer and Family Liaison, Christopher Wallace, will be reaching out to youth advocacy and youth empowerment groups — particularly those well regarded by Black youth — across the state to participate on our HEAC as an initial step in engaging youth in these healthcare issues. Further, via listening sessions and focus groups, we will add the voice and perspective of parents and providers to specific action steps to improve immunization rates and well-child visits among Black youth.

### Preventive Dental Services for Children and Adolescents

We understand the importance of oral health in overall well-being. Nationally, 49.1% of Medicaid members ages 1 — 20 years received preventive dental care. For Louisiana Medicaid, this rate was 49.6% — slightly above the national median (CMS, 2019). As a complement to the carved-out dental benefit for children, Healthy Blue is collaborating with its provider network to promote the use of fluoride varnish for children and adolescents. We will increase our efforts to educate providers about the Smile for Life program, the importance of oral health to overall population health, and the opportunity to be reimbursed for application of fluoride varnish during a routine visit.

To decrease disparities in preventive dental services utilization, Healthy Blue will be working with children, adolescents, parents, and providers to identify the proximate and root causes of identified disparities. As referenced previously, our Healthy Blue BH Consumer and Family Liaison, Christopher Wallace, will be reaching out to youth advocacy and empowerment groups to collect input on increasing the use of dental care among underserved groups and communities. We will also be conducting listening sessions and focus groups with parents and providers to identify their perceived barriers. At the same time, we will continue educating parents and guardians about the benefits of good oral health and how to access dental care through the State's other vendors.

## Supporting Back-to-school Efforts by Donating School Supply Kits

Healthy Blue will donate more than 6,000 school supply kits this summer to youth across the state to support back-to-school efforts and learning. Since 2016, Healthy Blue has donated more than 30,000 school supply kits to local youth in Louisiana.

# 2.6.6

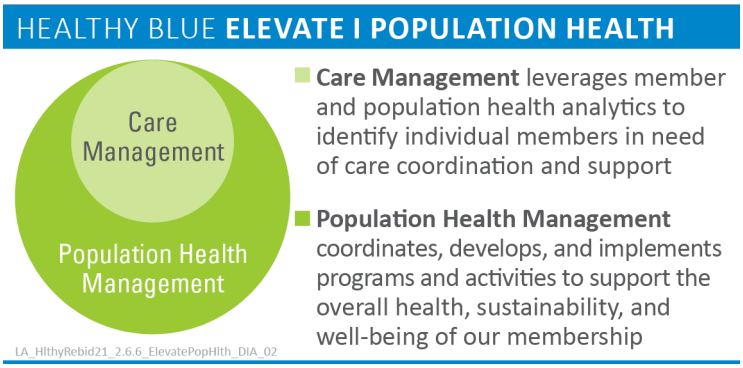
Care Management

Healthy Blue

## 2.6.6 Care Management

Care management is a key component of Healthy Blue's **Elevate | Population Health** model, which supports the needs of all of our enrollees (members) while decreasing health risks and costs. Through **Elevate | Population Health**, we align care coordination, case management programs, and community resources to reduce health disparities and manage member health from end to end through a coordinated system that centers the member with the provider and community. Through our team-based, person-centered approach, we provide care management and culturally responsive supports to all members, helping them more effectively manage health conditions, eliminating duplication of services and ultimately improving health outcomes. ***Our care management program drives our efforts to improve the health of our members, address health equity, and build resilient communities.***

**Integrated, Whole-person Approach.** Our integrated care management approach — implemented in Louisiana in 2015 when behavioral health (BH) services were first carved into Medicaid MCO contracts — centers on the individual needs of our members, their families/caregivers, and the community to improve access and navigation of services. It is evidence-based, incorporating lessons learned from our experience partnering with providers and LDH to address the unmet needs of people suffering from health disparities, including those related to maternal and child health, chronic conditions, physical health (PH) and BH. Our fully integrated Care Management team includes community-based care coordination staff who work in conjunction with licensed clinical staff to assist members with their clinical needs, as well as their social determinants of health (SDOH). We partner with providers and State agencies through robust data-sharing and multidisciplinary care teams (MDT) to support community-based care management and prevent duplication of services. Our integrated approach is supported by Healthy Blue's fully integrated care management system, providing our care management staff ready access to all member utilization data, case management activity, assessment results (health needs assessments [HNAs], comprehensive assessments, SDOH assessments, and home environment assessments), and Plans of Care (POCs) in an organized format. ***This integrated view into our members' clinical and SDOH history is also shared with providers through our care management platform, Health Intech.***




**Continuous Improvement.** We regularly evaluate our care management program structure, processes, and resources as part of **Elevate | Population Health**. At least annually, we perform a detailed analysis of the covered member populations or subpopulations to identify characteristics or needs where care coordination could be instrumental in assisting members. Improvements are implemented throughout the year to accommodate identified needs that are not met by existing programs or urgent clinical trends. This process includes adjustments to outreach mechanisms, member education, and enhancements to care management. Throughout our more than nine years serving Louisiana Medicaid, our approach has continued to evolve as factors impacting the health and wellness of individuals and their communities are vast and constantly changing, as evidenced by the recent COVID-19 pandemic. We have continued to adapt our approach, from enhancing predictive models and building new tools to identify emerging risks, including COVID-19, to pivoting member outreach efforts with a focus on improving statewide vaccination rates through improved access and education, [redacted]

[redacted]

**Meeting Care Management Requirements.** As an incumbent MCO serving the Healthy Louisiana program, Healthy Blue has a longstanding compliant care management program. We have reviewed and will meet all requirements contained in Model Contract, Section 2.7.

From initial enrollment, we use State-provided member data, results from HNAs, and predictive modeling to initially identify members who may benefit from care management. ***We take a "no wrong door" approach to accepting referrals from members, providers, and a wide range of internal and external sources.*** Using data, we stratify members into tiered risk levels for outreach and engagement according to their service needs, including care coordination, transitional case management, case management, and complex case management. Upon

engagement, a dedicated Case Manager works side-by-side in coordination with the MDT to help members navigate the complicated care delivery system when they are most in need of services, improving care coordination through an individualized, integrated POC.

### 2.6.6.1 Process for Successfully Completing HNAs Within Required Timeframes

The HNA serves as the voice of the member and helps us identify which members may benefit from care management programs and interventions. We are driven to make sure ***ALL*** members receive this essential screening, to support prompt identification of members with complex or Special Health Care Needs (SHCNs) into care management tiers for additional outreach. ***Every member will receive a minimum of nine outreach attempts to support completing the HNA, with attempts at various times of the day and week using various formats.***

We recognize the cultural diversity of our population and provide culturally and linguistically sensitive support to members who need assistance completing HNAs due to language barriers, literacy level, or hearing or visual challenges. We offer language supports to members in multiple formats, including written materials in Spanish and translation to a member's primary language. We arrange no-cost oral interpretation services for members and caregivers through trained interpreters competent in more than 200 languages. We provide individual assistance to members with difficulty reading through our Outreach Care Specialists, who will conduct the HNA over the phone. For members who are blind or have vision challenges, the HNA is available in large print, and braille and auditory translations are provided as needed. For members who are deaf or hard of hearing, we communicate via Telecommunications Relay Services (TDD/TTY services and 7-1-1) and use our website chat function. We also arrange in-person American Sign Language interpretation as needed.

We offer convenient options to complete HNAs, including multiple formats, incentives, and outreach efforts that maximize every member interaction to support completion within 90 calendar days of the member's enrollment date. All HNAs are conducted with the consent of the member or guardian/caregiver, and we comply with Model Contract, Sections 2.7.2.4 and 3.1.15 regarding HNAs and comprehensive screenings. Because members have diverse needs and preferences, we employ various methods of outreach:

- Existing modes to complete HNAs via mail, welcome calls, Healthy Blue Case Manager interactions, and Healthy Blue's secure member web portal
- [redacted]
- In-person outreach conducted by Healthy Blue or provider partners to assist members in completing HNAs in the community

**Existing Modes for Completing HNAs.** We engage members and encourage them to complete their HNA upon initial enrollment in Healthy Blue. Each member or caregiver receives a printed copy of the HNA in a welcome packet within a week of enrollment. Our trained, culturally competent welcome call center staff make at least three attempts to contact members telephonically to welcome them to Healthy Blue and assist them with completing the HNA. Members can also access the HNA "on demand" via our secure member portal and via a link in member written materials. Healthy Blue team members can also email members a link to the HNA based on their preference.

[redacted]

**In-person Outreach.** We use a variety of personnel in the community to assist members with completing HNAs. Outreach Care Specialists, members of our Care Management team, are available to meet with members where they are, including homes and hospitals in Louisiana, to help them complete the HNA. Other members of our Care Management team also engage members across the state, including our Community Health Workers (CHWs),

Housing Specialist, Permanent Supportive Housing Liaison, Quality and Outreach Care Specialists, Grievance/Appeals Representatives, Employment Specialist, Case Managers, and Peer Support Specialists. These individuals leverage every interaction with members to encourage and support HNA completion. All Healthy Blue team members who interact with members are trained to identify members' unmet SDOH needs, such as housing, food, transportation, and interpersonal safety, and route each member to a Case Manager for further assessment of chronic or specific conditions and development of an individualized POC. They are also trained to identify indicators of tobacco use and problem gaming, in accordance with the Model Contract.

**Continuous Improvement.** As a key component of our care management approach, we will regularly evaluate and refine our HNA process to monitor completion rates by modality, member cohorts (age, race, ethnicity), and geography to continue to improve HNA completion rates.

### Storing and Sharing HNA Data

All completed HNAs are stored in Healthy Blue Health Intech, our secure bidirectional and integrated care management system. Through this, we share and communicate with providers and members of the MDT, including the member's PCP, about assessments, care plans, and similar member health milestones.

### Ongoing Assessment of Member Needs

We continually assess member needs through our analytics and predictive models, but value the HNA, understanding it is the best means to identify what is most important to the member now. In addition to conducting the HNA upon enrollment with Healthy Blue, HNAs may also be conducted any time a member experiences a transition or has contact with Member Services Representatives, 24/7 Nurse Line Nurses, or 24/7 BH Crisis Line staff, has serial emergency encounters, is hospitalized, or when pharmacy use indicates that needs are not being adequately addressed. A member can also use our secure member portal to update their HNA at any time; updates may trigger a new member risk score and lead to additional care management outreach to assist the member.

## 2.6.6.2 Identifying Individuals Who Can Potentially Benefit from Case Management

We continually identify members who may benefit from care management, including care coordination and case management, beginning with enrollment data and supplemented with information from our proactive, comprehensive tools, including:

- HNAs and assessments, including comprehensive assessments, SDOH assessments, and home environment assessments
- Predictive modeling and analytics
- Referral sources that take a "No Wrong Door" approach

### HNAs and Additional Assessments

HNAs help us to discern which members may benefit from care coordination or case management programs and interventions by identifying each member's medical, behavioral, or social needs. We also use HNA results to identify members who qualify with SHCNs or who are pregnant. Additional assessments conducted by our Care Management team can help identify any ongoing special conditions members have that may require case management, interventions, or monitoring. Through assessments, Healthy Blue Case Managers learn about the member's needs in detail. Case Managers note any cognitive or physical limitations, evaluate risk behaviors, and assess psychosocial and environmental needs to develop a person-centered POC and interventions.

### Predictive Modeling: Proven and Innovative Predictive Analytics

**Data Sources That Inform Our Predictive Modeling.** Healthy Blue HI supports the integration and transformation of data from multiple sources into actionable data used for predictive analytics. We leverage data from internal and external sources consisting of population cohorts, demographics, pharmacy and lab data, behavioral or physical factors, and environmental or social factors. Examples include:

- **Internal Sources.** Utilization (claims, encounter, and authorization data), demographic factors, and diagnostic information; HNAs; comprehensive assessments, including SDOH, caregiver and condition specific; and diagnostic information.
- **External Sources.** Louisiana Medicaid Benefit enrollment (834) files; real-time admit, discharge, transfer (ADT) data; immunization registries; and Department of Justice (DOJ) files for justice-involved members.

Predictive analytics support early identification of members through predictive modeling. Using the data described previously, we identify vulnerable populations and emerging trends, including combining race, ethnicity, and cultural information to address issues of disparity and health equity.

[redacted]

Next, we include more detail about three of the tools identified previously.

[redacted]

**Elli™ Data Analysis.** In early 2019, Healthy Blue was among the first Medicaid MCOs in Louisiana to implement Elli, a population analytics platform that incorporates Louisiana-specific encounter data. Elli reports hospital and provider information, and historical utilization information; and maps socioeconomic data to clinical data to support a 360° view of our members. The platform provides actionable data on our newest members, which allows us to act quickly to support new, high-risk members who have immediate care and service needs.

[redacted]

## Referral Sources for a "No Wrong Door" Way to Identify Need for Intervention

Access to care management is not limited to data analysis and stratification. Our proactive approach guarantees access to case management through a broad range of referral sources, including:

- **Self-referrals.** Members, as well as their families/caregivers, can refer themselves for case management by contacting the Member Services Line or working with any Healthy Blue team member to seek help with services or clinical concerns. Members can also self-refer by contacting the dedicated Case Management Louisiana email inbox. This information is available on the member portal and member handbook.
- **Member Interactions with Healthy Blue Outreach Personnel.** All Healthy Blue staff who interact with members are trained to recognize the need for referral. CHWs, Peer Support Specialists, Outreach Care Specialists, Quality Specialists, Grievance/Appeals Representatives, 24-hour Nurse Line Nurses, and 24-hour BH Crisis line staff are examples of the types of employees who work in the communities frequently that help

refer members for case management assessment. Our Tribal Liaison also works directly with tribes to support coordination with case management.

- **Network Providers.** Network providers are educated on how to refer members to Healthy Blue case management. Provider Experience Consultants engage directly with providers to educate on how and when to refer members, including a secure email inbox, a fax form located on the provider portal, or a one-touch referral function in the secure provider portal Availity, which is integrated with Health Intech.
- **Discharge Planning Staff.** Healthy Blue Care Management staff coordinating discharge planning have real-time access to EPIC and can use this to proactively refer members for case management. Referrals are also received during integrated rounds while members are still in acute settings so there is no delay in discharge.
- **Permanent Supportive Housing (PSH) Providers.** PSH providers are educated to refer any members in PSH services who may benefit from case management, especially when the need is related to maintaining stable housing.
- **State Staff.** We receive referrals from State personnel, such as from the Office of Behavioral Health, Office for Citizens with Developmental Disabilities, and Department of Children and Family Services. Each State agency or program has its own dedicated point of contact at Healthy Blue, streamlining case management referrals.
- **Community-based Organizations (CBOs).** Organizations that serve a wide range of member needs and populations work with our Community Engagement team to refer members to case management, such as newly pregnant or homeless members.
- **School System Employees.** We work with our Department of Education Liaison and schools in Northwestern Louisiana, Baton Rouge, and New Orleans to identify youth who may benefit from case management.

## 2.6.6.3 Engaging Enrollees Who May Potentially Benefit from Case Management

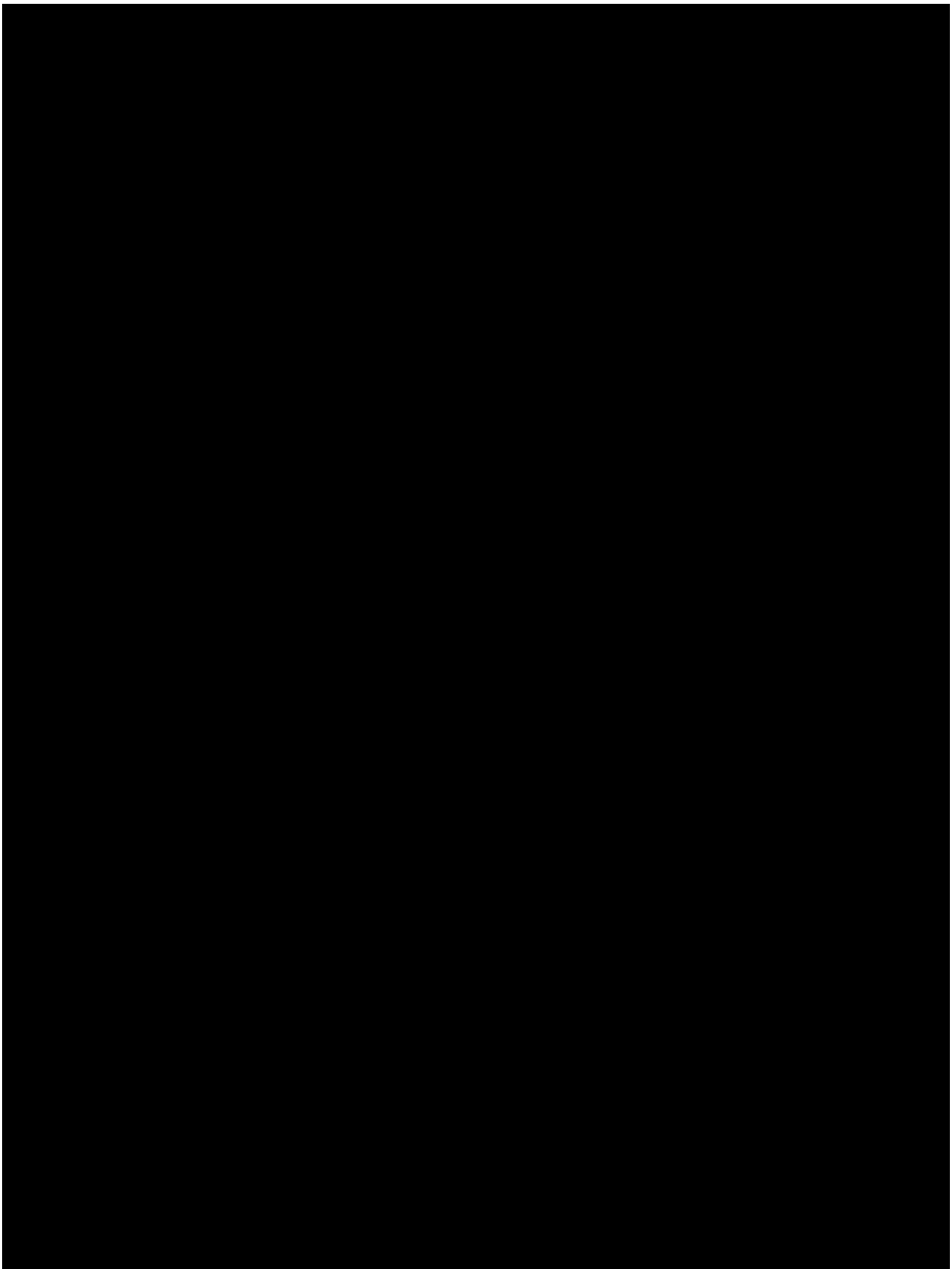
Our outreach and engagement strategies meet members where they are in their health journey, connecting them to benefits, services, and resources that will best meet their individual needs and goals, paying close attention to any health disparities or inequities that need to be overcome. To improve engagement, our whole-person care management approach accounts for member physical, behavioral, and social needs, while recognizing and addressing their cultural differences. We learn all members' preferred method of communication and note it for all outreach. Healthy Blue team members are trained to explore cultural preferences throughout engagement activities to incorporate member feedback and their understanding of their conditions throughout engagement, communication, and care planning activities.

**Engagement Is Aligned with Member Need.** We align our outreach and engagement strategy to each member's case management tier (see Figure 2.6.6.3-1). We transition from a "lighter touch" to more intense outreach depending on level of need. **Elevate | Population Health** addresses the needs of our members from a population perspective, aligning our programs, outreach methods, interventions, and staff based on member circumstance, service needs, and tier level. Our MDT, consisting of Medical Directors, BH Medical Directors, Nurses, Licensed Mental Health Professionals, Outreach Care Specialists, CHWs, Peer Support Specialists, Housing Specialist, PSH Liaison, Pharmacy Specialists, and support members in all tiered risk levels and in transition. Once the member is engaged, these staff members coordinate and work with the member's providers, Home and Community Based Services, and State staff to make sure a comprehensive person-centered POC is created and implemented.

We use ***multiple modes of outreach (telephonic, provider-led, community partner-led, outbound calls, digital, at a facility, in shelters, at community events, in the home) to customize our engagement strategies for each population***. We maintain a strong community presence at places like homeless shelters, faith-based settings, schools, community organizations, Women, Infants, and Children (WIC) locations, and via the Ryan White Foundation. This increases community visibility for Healthy Blue to engage with our members, but for us to provide hesitant members, or members unsure of how to access the healthcare system, easy access to active engagement. ***Members can reach out to us for engagement at any time and in any way through our 24/7 Nurse Line. All Care Management staff provide their cell phone numbers to members at every contact.***

[redacted]

Table 2.6.6.3-1 includes special considerations and engagement based on our experience working in Louisiana. The table is not limited to these considerations as we constantly evaluate and assess how to best meet member needs, tailoring them or building new engagement strategies as necessary.



## 2.6.6.4 Identifying the Appropriate Tier of Case Management for Enrollees Using Objective Measures and Criteria, Support Provided, and Individual Plan of Care

Effective risk stratification is key to **Elevate | Population Health** and care management. We use stratification to determine the intensity for member outreach, align appropriate care management resources, and prioritize interventions based on the member's unique needs. As part of an organization with more than 30 years of Medicaid experience using data for risk stratification, we use a suite of analytical tools to support early identification of members. This helps us effectively allocate resources to meet the individual member needs. We continuously screen members for the presence of new risk factors, mining data monthly through Health Intech to identify and prioritize members for outreach. We also share this information with providers. Figure 2.6.6.4-1 displays the multiple factors we consider to identify the appropriate tier of case management.

*Figure 2.6.6.4-1. Objective Measures and Criteria to Identify the Appropriate Tier of Case Management*


## Tier Identification Through Objective Measures and Criteria

Our person-centered program recognizes member risk levels are influenced by a wide array of factors, including diagnosis, treatment history, family and other supports, and unmet social needs. Our stratification process blends rigorous and well-honed predictive modeling tools with a thorough analysis of diverse sets of demographics; claims data; ADT and electronic health record (EHR) data; data available from screenings and assessments; and information shared by members, providers, external care managers, and others providing member services and support.

[redacted]

**Valuing Clinical Team Judgment.** While risk stratification helps to predict a member's needs, we understand it does not replace the clinical judgment of trained and licensed clinicians. We deploy a whole-person approach that recognizes each member's risk is affected by more than a diagnosis. We consider acuity level, self-management skills, healthcare system navigation skills, natural supports (personal relationships such as family, caregivers, and close friends), unmet social needs, geographic location, and more to identify the appropriate level of support needed. Clinicians, including Case Managers, may change a member's stratification level based on additional information received during the HNA, or from assessments, information sources, and data analytics, as well as from discussion with our Medical Directors and Healthy Blue Integrated Rounds. ***Using the results from risk stratification and following LDH level of service criteria, augmented by the clinical judgment of our licensed Case Managers, we place members in Tiers 1, 2, or 3 and further prioritize needs within those levels of service.***

[redacted]

**Ongoing Risk Stratification.** In recognition that risk scores are dynamic and changes in a member's condition or risks can increase or lower their risk score, Healthy Blue produces updated risk scores each month. With this updated score, we alert Case Managers to any changes that may trigger outreach to the member or a reassessment. As members' individualized needs change, our integrated case management processes adapt to the level of support they need, including face-to-face interaction for anyone needing in-person assistance.

## Types of Support Tailored According to Member Need per Tier

All members are provided with tools and supports in accordance with their needs. Each member receives:

- Care coordination and assistance in navigating the healthcare system
- Proactive educational campaigns and resources on available benefits, including VABs
- Disease-specific education and self-management support tools
- Health promotion events and materials and referrals to community resources
- Support from a CHW, Navigator, or Peer Support Specialist with member consent

For members identified for care management, we may reduce or substitute the frequency and/or method of contact upon request of the member or member's representative. Table 2.6.6.4-1 reflects the objective measures and criteria, types of support, and care planning provided for each tier.

*Table 2.6.6.4-1. Matching Members to the Appropriate Level of Support*

| Objective Measure and Criteria | Types of Supports | Care Planning |
|---|---|---|
| **High-risk Tier** | | |
| **High utilizer members with two or more unplanned inpatient admissions or ED visits in the last six months**<br><br>**Members with physical, BH, or SDOH needs at risk for readmission, inpatient admission, unnecessary ED visits, or institutionalization**<br><br>**CI[3] Grouping of 4, including members with SHCN, SPMI, catastrophic illness, and high-risk OB and NICU** | ▪ High-touch, integrated coordination delivering individualized care approaches to prevent exacerbation of conditions or complications<br>▪ Coordination of services, including SDOH to address individual needs<br>▪ Engagement upon identification<br>▪ Face-to-face or telephonic (based on member preference) support from a Case Manager and CHW, Outreach Care Specialist, Peer Support Specialist, or licensed addiction counselor, as needed<br>▪ Remote monitoring, telehealth, VABs, and member incentives | ▪ Plan of care completed within 30 calendar days<br>▪ Home assessment and SDOH prioritized<br>▪ MDT meetings occur at least monthly, in person<br>▪ Monthly updates to POC and formal in-person reassessment quarterly |
| **Medium-risk Tier** | | |
| **Defined emerging risk profiles, medium STORK score. Members at risk for readmission and ED utilization, with identified gaps in care**<br><br>**Members who have had an unplanned inpatient admission or inappropriate ED visit within the last six months**<br><br>**CI[3] Grouping of 3, including members with SHCN, BH, physical health, OB and NICU, and DOJ** | ▪ Coordination of services, including SDOH to address individual needs to improve chronic condition management and promote health<br>▪ Engagement upon identification<br>▪ Face-to-face or telephonic (based on member preference) support from a Case Manager and CHW, Outreach Care Specialist, Peer Support Specialist, or licensed addiction counselor, as needed | ▪ POC completed in person within 30 calendar days<br>▪ Home assessment and SDOH prioritized<br>▪ MDT meetings to occur at least monthly in member's preferred setting<br>▪ Quarterly updates to POC or upon change in member condition or upon request from member or MDT<br>▪ Monthly updates to POC<br>▪ Formal in-person reassessment quarterly |
| **Low-risk Tier** | | |
| **Healthy low-risk populations, adults and children, preconception women**<br><br>**Members with well-controlled complex or comorbid conditions, who would benefit from short term care coordination or interventions**<br><br>**CI[3] Grouping of 2, including members with: SCHN, HIV, Hepatitis C, PASRR, PDN, PDHC, PCS, Emerging Risk, BCBSLA Blue Models, Concierge Care** | ▪ Wellness and prevention services focused on care coordination managing SDOH, self-directed care and achieving optimal health through education and training in healthy living<br>▪ Engagement upon identification<br>▪ Face-to-face or telephonic (based on member preference) support from a Case Manager and CHW, Outreach Care Specialist, Peer Support Specialist, or licensed addiction counselor, as needed | ▪ POC completed in person within 90 calendar days then quarterly thereafter or more as required base on member needs and preferences<br>▪ Home assessment and SDOH prioritized<br>▪ Annual plan of care updates<br>▪ In-person reassessment annually<br>▪ Digital engagement via member app/text /IVR/email<br>▪ Educational content for specific member conditions |
| **Transitional Tier** | | |
| **Members transitioning between institutional and community settings, including: inpatient hospitals, nursing facilities, PRTFs, TGHs, Intermediate Care Facility for Individuals with Intellectual Disabilities** | ▪ Coordination of services, including SDOH to address individual needs to improve chronic condition management and promote health<br>▪ Engagement upon identification | ▪ Engagement prior to discharge including transition POC development<br>▪ Coordination across MDT to assure communication between the discharging facility and member's |

| Objective Measure and Criteria | Types of Supports | Care Planning |
|---|---|---|
| **(ICF/IIDs), residential SUD, incarceration, and PSH** | ▪ Face-to-face and telephonic outreach and engagement by UM and Case Manager<br>▪ Support from Housing Specialist and/or PSH Liaison for members identified as homeless or with housing instability at time of transition<br>▪ CSoC screening<br>▪ Face-to-face or telephonic (based on member preference) support from a Case Manager and CHW, Outreach Care Specialist, Peer Support Specialist, or licensed addiction counselor, as needed | PCP and BH providers regarding treatment plan and transition POC<br>▪ Make sure aftercare services are in place within 30 days prior to discharge from PRTF, TGH, or ICF/IID<br>▪ Follow-up within five business days post-discharge |

## Developing a Person-centered Individualized Plan of Care

After the member has agreed to participate in case management, our Case Manager coordinates with the member and their support system to identify a date and time to complete the comprehensive assessment and create the member's POC. Our POC development process is person-centered, supporting the member and providers involved in the member's care to establish goals and interventions to achieve short and long-term goals. Our integrated Care Management team supports members through assessment and care planning, supporting their cultural and linguistic needs, and assuring their involvement as well as their MDT throughout the processes.

**Integrated Care Management Team.** Our Louisiana-based Care Management team has local knowledge of the providers and systems of care available to coordinate our response to members' needs. We have seen firsthand the impact that low health literacy, lack of access, and unmet social needs have on our members' health and ability to engage the services and supports that promote optimal health. Our approach addresses members' needs for acute care, inpatient, outpatient, and BH and social support services in a seamlessly integrated infrastructure. Our clinical staff work hand-in-hand and communicate frequently every day to discuss member care. Our licensed, board-certified Medical Directors conduct twice-weekly integrated rounds with UM and Case Managers to develop and implement solutions and interventions using evidence-based approaches to address the comprehensive PH, BH, and social support needs of each member enrolled in care management.

**Comprehensive Assessment and Care Planning.** Our comprehensive assessment tool has hierarchy and branching logic that probes more than 20 potential clinical areas for risk factors and includes specialized, evidence-based assessment modules for specific conditions and populations. Using this tool, the Case Manager will review the member's PH and BH history, diagnoses, unmet social and ongoing clinical needs (including dental), current or past substance use, medications, and formal/informal caregiver supports. We use assessment tools appropriate for adults and children, BH concerns, and specific conditions. Through a comprehensive assessment, the Case Manager learns about the member's needs in detail. Case Managers note any cognitive or physical limitations, evaluate risk behaviors, and assess psychosocial and environmental needs to develop a person-centered POC at the required tier of service.

Our Case Managers encourage each member to participate in planning for community integration and self-advocacy. The POC clearly outlines the member's relevant history, health status, support system, and wellness goals, and communicates the role each person, provider or service plays in helping the individual achieve those goals, along with personal details such as crisis plans to facilitate a focused, individualized response at any level of care. It identifies all members of the interdisciplinary team and their contact information. It notes the times and dates for face-to-face visits with the member. It describes clearly how barriers will be addressed and when. The POC is organized around evidence-based clinical practice guidelines, which the Case Manager supports by confirming that the member is keeping appointments, completing appropriate screenings or lab work, and engaging in self-care activities as outlined in the plan.

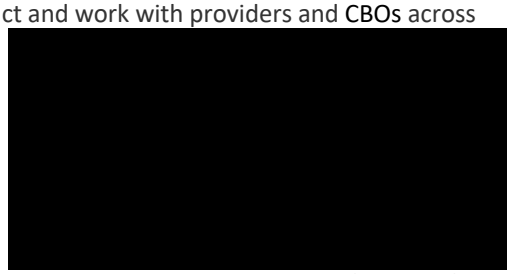
The assessment and POC will be completed within 30 days for members stratified to Tier 2 and Tier 3, and 90 days for those stratified to Tier 1. We also obtain treatment plans from providers to assure all member needs are addressed. Upon completion of the POC, the member and their representative can request a printed copy or view an electronic copy via the secure member portal. Providers can access the POC via the provider portal.

**Multidisciplinary Care Team (MDT).** The member's Case Manager, providers, specialists, pharmacy, CHWs, caregivers, family members, and State support staff are included as part of the member's MDT for coordination.

Feedback and external treatment plans are incorporated into the member's POC to assure care coordination and prevent duplication of services.

## 2.6.6.5 Coordinating with Providers and State Staff That May Provide Case Management Support to Enrollees and Not Duplicating Services

Healthy Blue has a proven history of close coordination with multiple Louisiana State agencies. In addition to working closely with LDH and the Office of Public Health, we also regularly coordinate with personnel from the Office of Aging and Adult Services, Office for Citizens with Developmental Disabilities, Office of Behavioral Health, Louisiana's CSoC, the Department of Children and Family Services, Department of Education, Department of Health, and Office of Juvenile Justice. On the provider side, we contract and work with providers and CBOs across Louisiana who serve as provider partners or who take on the role of provider-led case management.



We based our processes for coordinating with providers and State staff on feedback and lessons learned through our more than nine years of participation in Louisiana Medicaid. We designed our processes ***to assure continuity of care, regardless of whether services are provided through managed care, fee-for-service, other LDH contractors, or community and social support providers.***

To coordinate across the continuum of care, as part of the case management process, our Case Managers decrease the potential for duplication of services and fragmentation of care by:

- Identifying services a member is currently receiving, the providers who deliver the services, and any State staff who may be providing case management support for our members.
- Contacting providers and State staff (support staff with justice-involved member, DOJ, and coordinators who work with Waiver and Chisolm class) to coordinate assessments and become active participants in the member's MDT.
- Incorporating State or provider-created care and treatment plans into our information management systems.
- Providing multiple resources for State staff and providers to communicate with our case management team, including a secure, dedicated email inbox, a one-touch referral function in the provider portal that feeds to case management team, and a dedicated phone line to the care management team that is available to providers and members. Each agency also has the contact information of a single point of contact within Healthy Blue assigned to coordinate efforts with that agency or program.

### Coordinating Case Management with State Staff

We value the relationships we have built working with State agencies and programs to serve Louisiana members. We adapt our process for coordinating case management with State staff based on each agency or program's needs and preferences. At a minimum, our process includes:

- **Point of Contact.** Within Healthy Blue, we provide a dedicated point of contact for each agency or program we work with to facilitate smooth collaboration and planning efforts.
- **Agency-specific Coordination Procedures.** Our dedicated point of contact for each agency or program works with State staff to establish procedures for coordinating case management. As part of this process, we develop workflows, coordinate on referrals, and detail communications preferences and frequency.
- **Initial Outreach.** When a member is identified as receiving case coordination from the State, and with permission from the member, our Case Manager initiates contact with State coordinators or appropriate staff based on the established coordination procedures. We discuss next steps, coordinate efforts for the member's MDT meetings, share existing care plans (with member permission for sensitive diagnoses), and collaborate on care planning.
- **Ongoing Collaboration.** We coordinate efforts with State staff from initial identification of State case management through care planning, provision of integrated, whole-person services, and follow-up. With member permission, we share assessments and care plans with our State partners. If a State POC exists, we incorporate it into our own POC. We invite personnel from the agency or program to participate in MDT meetings, where all providers and participants in a member's care share updates and information regarding the member's goals and progress. We include State staff and all members of the MDT in post-discharge planning to further assure continuity of care and coordination of services.

### Coordinating Case Management with Providers

One of our Care Management team's key functions is to facilitate information sharing. We act as a bridge between participants in a member's MDT, getting input from all providers involved in a member's care, and incorporating each provider's treatment plan into the member's plan of care. We share existing plans, risk assessments, and data. If we identify risks or potential risks to a member's health or safety, we notify and engage providers in a

timely basis. Our team coordinates efforts for the member's MDT meetings and collaborates on care planning, including status of service outcomes and coordinating any discharge planning activities.

**Coordination with Providers via Health Intech.** Our care management system connects the entire community of preferred support, helping to minimize duplication of services while facilitating communication, collaboration, and information sharing among providers. For members in case management, our Case Managers encourage providers to share relevant test results and records among the member's care team, reducing test and procedure replication. With member permission, Case Managers share test results with the care team. Providers can upload test results, assessments, and care plans that integrate into Health Intech via the secure provider portal (Availity) for shared care planning and prevention of duplicate services. They can view test results and services provided by other providers and reach out to discuss service history and questions.

## Our IT Platform and Communication Strategies Reduce Duplication of Services

Because our focus is on sharing actionable information and insights with partners, we have a robust and flexible infrastructure and suite of capabilities to transfer, analyze, and visualize data compliant with all applicable privacy laws and regulations and safeguarded through business associate agreements. We have accessible data for providers and community partners, including advanced dashboards and customized reporting capabilities to use in population health goal setting and measurements. We have all clinical and social data and file transfer capabilities, such as Health Level 7 (HL7) transactions and SFTP, and actively participate in secure data exchange.

Case Managers have access to members' utilization history and, through Health Intech, can view upcoming procedures providers have entered in the EHR. Data-sharing agreements similarly allow our Care Management team to access hospital electronic medical records and confirm providers have obtained test results from hospitalizations. Our prior authorization process, aligned with practice guidelines and evidence-based practices, checks previous utilization to avoid duplication of services. If a Case Manager sees an upcoming procedure that was already performed, they will alert the appropriate providers.

## 2.6.6.6 Establishing a Delegated Case Management Program

We are committed to supporting provider-led case management, recognizing that members are more comfortable engaging with trusted providers to oversee their care and service needs. Provider-led case management goes hand-in-hand with VBP and our population health framework and is a natural next step in the evolution of person-centered care coordination. Healthy Blue has experience in the design and implementation of transformational VBP initiatives in conjunction with our provider partners. Our affiliates effectively delegate case management in other Medicaid markets and across other product lines, including Medicare.

**Delegated Case Management Program.** Healthy Blue will build upon the national experience of our affiliates to design, implement, support, monitor, and report on provider-led case management programs. We will establish programmatic criteria that align with LDH's goal to reimburse case management services in settings where members already access care and avoid duplication of MCO case management. Our delegated case management program will include:

- **Regulatory Compliance and Program Alignment.** We will require that all case management delegation activities conform to NCQA, State, and federal requirements. We will also require provider-led case management to align with Healthy Blue's care management program, including use of objective criteria to stratify members into appropriate tiers as identified in the Model Contract.
- **Eligibility Criteria for Members.** Our program criteria will clarify when a member is eligible for delegated case management rather than Healthy Blue case management, primarily based upon member attribution and engagement with the delegated provider.
- **Minimum Provider Qualifications.** We select qualified providers to lead case management across our affiliate Medicaid plans and lines of business. We will leverage this experience to establish provider qualifications for each tier of case management services for our Louisiana members and use the approach described next to identify qualified providers for our program.

- **Reimbursement.** We will negotiate provider reimbursement for conducting initial assessments and developing the member's plan of care that is conducive to the member's tier of case management. [redacted] risk, and balancing quality targets with LDH Contract requirements.
- **Oversight and Monitoring.** Our oversight and monitoring of provider qualifications and operations will begin prior to formal delegation of case management and take place on an ongoing basis. At any time that we delegate case management, we will have a written plan in place for monitoring and oversight of performance, including provisions for assessing provider compliance, corrective actions we take when a provider is not compliant, and guidelines for when termination may be appropriate.

## Identifying Providers for Delegation

To identify qualified providers (physicians, advanced practice registered nurses, and physician assistants) for purposes of delegating and making payment for case management services, we will:

- Build on the strengths and successes of our existing relationships with PCPs, OB-GYNs, and BH providers, working with those providers who have demonstrated success meeting VBP program performance metrics
- Consult with our Network Management and Clinical team members, program specialists, and the Quality Management team to identify potential providers equipped to lead case management
- Use data, analytics, and information gathered from our experience with providers in Louisiana to identify potential providers for participation

## Selecting Qualified Providers

We set clear expectations for our subcontractors through our Delegation Oversight Management program and established policies and procedures. Prior to formal delegation of case management, Healthy Blue will conduct a pre-delegation audit to verify each provider's qualifications and ability to deliver case management services for each tier of case management in compliance with LDH, federal, and NCQA requirements. Specifically, we will work with providers to make sure they have established policies, procedures, systems, staff, program description, effectiveness measurement (satisfaction survey), and experience in annual and ongoing evaluation processes, including capture and analysis of member feedback and grievances. The provider must also be able to transfer information to Healthy Blue, accept referrals from Healthy Blue, and track required case management activities. Delegation will include a requirement to access Healthy Blue's Health Intech care management system via the secure provider portal to make sure case management activities are completed in accordance with the Model Contract and respective tiered risk levels.

If the provider is prepared to meet contractual requirements related to all case management activities as described in the Model Contract and NCQA case management delegation standards, we will:

- Conduct a formal file audit
- Assess and document how the provider will meet each LDH case management requirement
- Evaluate qualifications of staff who will conduct case management activities
- Document provider agreement to follow case management standards and timeframes in a formal delegation agreement
- Complete formal pre-delegation audits and submit these and draft delegation contracts to LDH for approval

**Monitoring and Oversight of Providers.** Throughout delegation, we will perform regular audits to verify continued compliance with LDH Contract requirements. At a minimum, oversight will be maintained through monthly, quarterly, and annual reports, file reviews, meetings, and audits of all activities delegated to the provider. These audits, conducted by subject matter experts, follow a standard quarterly schedule, but can be initiated more often as needed. Auditors use auditing tools that include mechanisms for LDH reporting and for ongoing review of data.

## Next Steps: Pathway to Provider-led Case Management

We believe the most effective pathway to establishing a provider-led case management model compliant with LDH Contract and respective reporting requirements will initially include a Healthy Blue trained Case Manager co-managed by a provider and Healthy Blue, located in the provider's office. This Case Manager would access and use ***Health Intech*** for all case management activities, including HNAs, assessments, care planning, and monitoring to support and assure compliance with LDH reporting and oversight activities. Our Medicaid health plan affiliates in other markets have achieved success with similar models, connecting provider-led care coordination staff to Health Intech while successfully meeting State and accreditation requirements.



## Sponsoring Total Teen Takeover to Give Teen Voices a Platform

Healthy Blue sponsors Total Teen Takeover, a celebration for the graduates of an eight-week mentoring and workforce development program for young people. Through the program, youth can connect with mentors, explore potential careers, earn industry-recognized certifications, and reinvest in their community through service learning projects. Total Teen Takeover, now in its sixth year, provides a platform to teens to discuss topics important to them, ranging from depression and bullying to mentoring and workforce development. The teens involved are part of an advisory board to help Healthy Blue and our community partners select dynamic and engaging speakers for the event.

## 2.6.7 Case Scenarios – Meeting the Individualized Needs of All Members

Our approach to meeting the needs of Louisianians is grounded in our population health model. **Elevate | Population Health** is our holistic approach to improving health outcomes and increasing health equity for all members, especially those with high risk, such as the members in the Case Scenarios. Weaving together powerful data analytics, local provider and stakeholder engagement and collaboration, cross-system coordination, and member-tailored interventions, **Elevate | Population Health** guides our approach to innovation to make sure everything we do supports our members and communities to improve health outcomes. By engaging providers and community organizations as partners in care, we build on the strengths of each other, improving the health of Louisiana's communities, while also meeting each member's unique needs to make sure that ***no member is left behind***.

## 2.6.7.1 Ensuring the Member's Access to Care and Improving His Health

### JOHN – FIVE-YEAR-OLD BOY AND HIS CAREGIVER

We recognize the priority of supporting the caregiver in engaging John in the follow-up care and services he needs to address his multiple medical conditions and behavioral problems, including obesity, excessive sleepiness, enuresis, compulsive eating behaviors, and behavioral problems at school. Case Manager, Emma, supports the family's needs by working with John's PCP and helping his caregiver access available specialty services and programs, including CSoC.

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Healthy Blue understands the unique needs of John and children like him across the state. Our goal is to be a positive influence in John's life by improving his health, addressing his family's social needs, and giving him the best opportunity to do well in school. Our case management program assures at-risk members like John have access to the services they need, including appropriate MCO Covered Services, services not on the fee-schedule, and the resources designed to support them throughout their care with Healthy Blue. Upon identification, our case management processes support John and his caregiver in accessing the right providers, at the right time, and in the right location to meet his immediate, short-, and long-term needs. This includes education about the Coordinated System of Care (CSoC) program and a referral to CSoC if John's caregiver is interested. Further, we will arrange for and assure access to specialists in the family's area (psychiatrist, neurologist, otolaryngologist, and nutritionist) and his caregiver's access to the services, supports, and resources needed to meet the family's immediate, short-, and long-term goals. This includes transportation, after-hours and weekend appointments, and health literacy support to promote the caregiver's understanding of John's needs, and other social determinants of health (SDOH) identified during our SDOH assessment.

## 2.6.7.1.1 Comprehensive Systems that Support John's Identification

Healthy Blue has a comprehensive process in place, including integrated data systems, provider notifications, and community contacts, to identify John as high risk, which triggers a notification to our Case Management team. Our data system includes Healthy Blue's Health Intech platform that provides a holistic view of the member's healthcare and is accessible to our staff as well as providers through our secure portal, enabling a "***no wrong door***" approach for referrals from internal staff, providers, and State entities.

We also identify members by received clinical for authorization requests, direct member/caregiver referrals, and community sources, such as John's school. The multiple systems and processes to identify John provides detailed information for our case management team to understand that he is experiencing ongoing medical and behavioral health (BH) issues and requires immediate outreach, including:

- **Data Vehicles for Identification.** To identify John, we use reporting and monitoring processes that trigger a notification to our Case Management team. Our predictive modeling process that identifies John as having emerging or high-risk needs based on his diagnoses or underutilization of EPSDT and preventive services; and his diagnoses of excessive sleepiness, enuresis, and compulsive eating behaviors included on the PCP's claims. This information is captured in Healthy Blue's Special Health Care Needs report.
- **Healthy Blue Staff for Identification.** This may include a variety of staff with opportunities to identify John, such as Member Services Representatives who conduct new member welcome calls and may receive concerning information from his parent/caregiver; staff who complete the health needs assessment (HNA) with members; Utilization Management staff who, upon review of the PCP's authorization request for a sleep study, identify his age as concerning and reach out to the PCP for more information — which may trigger additional screening, such as for adverse childhood experiences (ACEs) or the PHQ-9 for depression; Provider Experience Consultants who meet face-to-face with providers regularly in the community, as well as virtually during the COVID-19 pandemic,

### IMMEDIATE RESPONSE – WITHIN 48 HOURS

- Pediatric Case Manager, Emma, reaches out to John's caregiver to conduct the health needs assessment over the phone
- Emma communicates with John's PCP to follow up on any new recommendations for care based on the most recent well-child visit
- Emma discusses the CSoC program with John's caregivers to access wraparound services

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which includes gathering information on members who have missed appointments and do not participate in recommended services; and co-located staff, such as our Integrated Collaborative Care Model (ICCM).

- **Network Providers.** Providers, including but not limited to those who participate in our Value-Based Payment (VBP) programs, are educated on how to refer members with similar conditions as John's to Healthy Blue's case management. Providers in certain VBP arrangements have enhanced reporting requirements, which would identify the member in a timely manner. [redacted]

  Education and other child serving agencies. Additionally, ***Healthy Blue serves as a preferred health plan for Department of Child and Family Services (DCFS) referrals and works with the Department of Education (DOE) and local school districts, including Northwestern Louisiana, Baton Rouge, and New Orleans, to identify youth as Healthy Blue members and contact us for support and case management.***

Upon identifying John, he is referred to our case management team within 48 hours for assignment of a Louisiana-licensed Pediatric Case Manager, Emma, who has expertise in BH conditions along with experience in motivational interviewing, trauma-informed care, and ACEs. Emma also receives consultative support from a Pediatric Registered Nurse (RN) Case Manager who understands the management of chronic conditions in children. The integrated team will reach out to his caregiver to engage, conduct a screening and assessment, and help develop a Plan of Care (POC) that identifies and addresses John's holistic needs, services and providers, gaps in care, and the SDOH-related services and resources necessary to improve his overall access to care. If his caregivers chooses to participate in the CSoC program, our Care Management team would coordinate services not provided by the CSoC Waiver.

## 2.6.7.1.2 Ensuring Coverage for All Medicaid-coverable, Medically Necessary, and Non-covered Services for John's Holistic Care

***Our process for making sure John and his caregivers have what they need starts and ends with him.*** Once John is identified, we put him and his caregiver at the center of our assessment and care planning processes. Healthy Blue assures John accesses the services and supports he needs regardless of Medicaid benefits. Our Medical Directors' decisions are based on medical necessity, SDOH needs, and recommendations from John's providers. Upon review of EPSDT requirements, benefits, and coverage, we authorize and reimburse provider-requested services. This includes working with out-of-network (OON) providers through single case agreements (SCAs) and accessing community-based resources, as well as Healthy Blue's value-added benefits (VABs) and in lieu of services (ILOS) to assure a holistic response to John's needs. The family is regularly attending appointments with John's PCP, so Emma supports and encourages this relationship while also exploring, through conversations with the family, what barriers may exist to receiving care from other medical professionals.

[redacted]

### Engaging the Member and Caregiver

Emma uses empathetic techniques to begin developing a relationship with the family, such as reflective listening and demonstrating an understanding of their circumstances. During the call, Emma first verifies John's and his caregiver's well-being and then shares information on the role of a Case Manager. She explains the benefits, services, and supports available to address John's and his caregiver's need and supports John's caregiver in completing the HNA to identify any changes in his needs and any urgent or emergent needs requiring intervention. Emma works with John's caregiver to schedule an in-person meeting at their preferred location and time to complete a person-centered assessment and POC. If unable to reach John's caregiver initially, Emma will continue to reach out for a minimum of 90 days. This includes reaching out telephonically on different days and at different times, as well as texting, emailing, and mailing requests, depending on the amount of contact information we have for John. Emma also contacts his identified providers to obtain additional contact information and engages a Community Health Worker (CHW) or ICCM Navigator, as appropriate, to go to John's last known address or to increase our telephonic outreach and written notifications that encourage response from the caregiver depending upon the COVID-19 protocol outlined by the State.

### Completing the Person-centered Assessment and Individualized Plan of Care

Emma, with telephonic/audio visual RN support, meets with John and his caregiver at the time and location that is best for the family to complete a holistic, person-centered assessment, which includes supporting them in sharing information about their PH, BH, and SDOH needs. During the assessment, Emma encourages John and his caregiver to share information about their strengths, short- and long-term goals, preferences, and what services they have

participated in and how those have worked for them. Understanding the importance of the PCP relationship, Emma discusses John's PCP and identifies the drivers behind continual attendance, such as the PCP's approach, appointment availability, or location. This conversation may result in identifying SDOH needs or the provider's attributes that keep them coming back and how we can replicate what is important to them.

Recognizing several of John's symptoms may be interconnected, they discuss why the PCP has made certain recommendations for additional services, including neurology, otolaryngology, and pediatric psychiatry services. Together they identify the barriers the caregiver has encountered in taking John to scheduled appointments, such as transportation, scheduling conflicts, or distance from the family home. They also discuss the impact of COVID-19 on his participation in care and the family's well-being, such as experiencing isolation, depression, and poor eating.

Led by the John's caregiver, Emma incorporates the family's needs, goals, strengths, preferences, and selection of providers and resources to meet their needs into John's individualized POC. They discuss John's PCP and Emma makes sure his caregiver is aware of the provider's after-hours and weekend availability and how Emma can help them develop positive relationships with the specialty providers John needs. This may include Emma attending appointments with the family or engaging a CHW to further support the caregiver and assist in locating additional community resources. They also talk about the availability of telehealth services for John's medical and pediatric psychiatric services.

**SHORT-TERM NEEDS – WITHIN 14 DAYS**

- Led by John's caregiver, Emma assesses John's and his caregiver's needs and completes a holistic, integrated plan of care
- Emma assists John's caregiver with scheduling follow-up specialist appointments and calling to arrange Non-Emergency Medical Transportation if needed
- Emma discusses the CSoC waiver program with John's caregiver and will warm transfer for screening and assessment to access wraparound services
- Emma refers John's caregiver to community supports such as Families Helping Families for additional support and information

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Meeting the family where they are, Emma in collaboration with the Pediatric RN, supports the caregiver in understanding common causes of obesity, such as diet and exercise, but is also clear that John's weight can also be impacted by family, psychological, and socioeconomic factors, and in rare cases a physical condition related to childhood syndromes. Emma reinforces that it is important to first rule out any immediate medical and safety issues, such as high blood pressure, high cholesterol, and diabetes, while simultaneously addressing any BH needs that may be contributing to his obesity. Emma also talks with the caregiver about the benefits of engaging a nutritionist who can help the family learn healthy eating habits and how to plan healthy meals.

Emma using motivational interviewing techniques develops an open non- judgmental relationship with John's caregiver and his family. She continually assesses readiness for change while understanding and addressing the barriers that prevent John and his family from accessing care. At any point that Emma suspects child abuse or neglect in accordance with Healthy Blue's Policy as a mandated reporter she would report to child protection while maintaining her trusted relationship. Of course through Healthy Blues DCFS Liaison, Emma would work with DCFS to assist with other supports such as the Supplemental Nutrition Assistance Program (SNAP) and Family Independence Temporary Assistance Program. Regardless of the level of involvement of DCFS, Emma will be there to support John and his family in getting the care that they need to reach John and the family's full health potential.

To start, Emma helps the caregiver schedule a follow-up appointment with John's pediatrician for a physical exam and blood work to determine his current risk, potential medication needs, and revisit any follow-up recommendations for specialists, such as a neurologist and otolaryngologist. Due to COVID-19, Emma talks to the PCP about facilitating a call to the caregiver's selected specialists from his office, during which the PCP can share John's history and health status. Emma arranges for transportation if needed and offers to attend appointments.

***While addressing John's physical issues, the Case Management team knows the importance of simultaneously addressing his BH and social needs.*** Emma helps the caregiver understand his symptoms, such as enuresis and aggressiveness at school, may also be related to BH needs. They talk about his childhood experiences, including childbirth complications, any previous diagnoses and participation in services, and family history. If the caregiver indicates John may have experienced trauma, Emma makes sure the selection of his providers includes those trained in trauma-informed care and asks the PCP to complete an ACEs screening. Emma discusses the CSoC Waiver program to determine whether the caregiver is interested, and if so is prepared to do a warm transfer to Magellan (as Louisiana's CSoC provider) for screening and assessment to gain access to these wraparound services. The warm handoff means Emma will teleconference in a Magellan contact while John's caregiver is on the line, so that the screening and eligibility process is seamless.

Emma may also work with the caregiver to obtain a qualified healthcare professional (Pediatric Neurologist, Developmental Pediatrician, Pediatric Psychiatrist) to complete a Comprehensive Diagnostic Evaluation that will determine if John would benefit from specialized BH services to address his eating, sleep routines, and aggression, such as a referral to Applied Behavior Analysis services, Parent Child Interaction Therapy (PCIT) or other evidence-based practices, such as the Triple P – Positive Parenting Program. Emma also helps the caregiver identify and share concerns about John's conditions and care. If the caregiver is feeling overwhelmed by John's current behaviors, navigating the healthcare system, or fear for his future needs, they will talk about the types of services available, including individual therapy, support groups, respite for John's caregiver through organizations such as Families Helping Families or Family Voices, engaging a CHW for system navigation, and online resources, such as Parent to Parent USA.

John's behavioral treatment includes the provider working with him and his caregiver to develop a behavior plan that addresses self-management, coping skills, and techniques to use in his daily life, as well as working with the caregiver to learn or improve skills to manage John's behavior. Emma assures that John's behavior plan is incorporated into his POC, as well as shared with the school for incorporation into his daily routine or individual education plan, if appropriate. They also talk about pediatric psychiatric services to evaluate potential recommendations based on his behaviors. If Emma is unable to locate an in-network provider in John's area who has specialized expertise and training aligned with his needs, such as a pediatric psychiatrist, we will assure the services are accessed through OON providers (through an SCA) or via telehealth services due to COVID-19. Emma assists the caregiver in scheduling appointments and arranges transportation as needed.

If Emma identifies any SDOH needs during the assessment, she discusses with the caregiver community-based resources and incentives that encourage participation, They also talk about the role of our usings, and food programs, including applying for SNAP and

As part of John's POC, Emma works with the provider to develop a crisis plan that supports the caregiver in addressing any escalating behaviors in the home. The crisis plan includes when and how the caregiver should reach out for support, such as his behavioral provider, family members, or Healthy Blue's 24/7 BH Crisis Line. Emma also works with the our integrated multidisciplinary care management team to review the family's needs in case rounds to identify and address barriers to care and resources based on John's age and history of PH and BH conditions; inconsistent participation in needed specialty care; assessment results that identify PH, BH, and SDOH needs; and current health status, including an increase in his weight and falling asleep during his appointment. Emma also works with the caregiver to develop a multidisciplinary care team (MDT) that comprises John and his caregiver, Emma, the PCP and other specialists, and natural supports, such as family, friends, and teachers. The MDT is also supported by our integrated case management team, including Medical Directors, our Pediatric Psychologist who

specializes in BH for children up to age five, PH and BH clinicians, and Liaisons, such as DCFS, DOE, and Office for Citizens with Developmental Disabilities (OCDD), which may include consideration for an OCDD Statement of approval level of care evaluation for the Children's Choice Waiver, if appropriate.

## 2.6.7.1.3 Assisting John's Caregiver with Referral Adherence

As described in Table 2.6.7.1.3-1, Emma recognizes there may be several reasons the caregiver does not make sure John participates in services recommended by the PCP and works to identify solutions with the caregiver.

*Table 2.6.7.1.3-1. Assisting John's Caregiver with Referral Adherence*

| Potential Adherence Needs Mitigation Strategies |
|---|
| **Gap in Health Literacy That Prevents Full Understanding of John's Conditions and Needs** |
| ▪ Attending appointments with the family to assure the caregiver understands providers' recommendations for John's participation in care, such as the importance of attending follow-up appointments<br>▪ Connecting the caregiver and John to community-based organizations (CBOs), such as Families Helping Families and the Louisiana Council's Advocacy Network for additional support and information<br>▪ Providing the caregiver with information on John's conditions, such as through brochures in the caregiver's preferred language and format and through Healthy Blue's member portal |
| **Distrust in or Feeling Overwhelmed by the Healthcare System** |
| ▪ Using an empathic listening and interviewing style to elicit information about reasons and experiences for mistrust or feeling overwhelmed, validating feelings when possible, and identifying solutions going forward<br>▪ Encouraging the caregiver to allow a family member, friend, or Emma to participate in appointments<br>▪ Working with providers (PCP, pediatric psychiatrist) to arrange telehealth appointments<br>▪ Reaching out to the caregiver following appointments to answer any questions and identify recommendations |
| **SDOH That Create Barriers to Attending Appointments** |
| ▪ Addressing SDOH that may create stress and anxiety that prevent the caregiver from engaging, which may include engaging with our CHW or Navigator for assistance in applying for public benefits, such as SSI, SNAP, and the Housing Choice Voucher program and locating additional resources and support<br>▪ Scheduling appointments on a day and at a time that is convenient for the family, including after-hours and weekends, and arranging transportation to and from all appointments |
| **Lack of Providers That Meet Cultural, Language, and Insurance Needs** |
| ▪ Working with Healthy Blue's Provider Services department to assure all network providers that meet the family's needs and preferences are identified to provide family choice<br>▪ Arranging for translation or interpretation services during appointments, if needed<br>▪ Executing SCAs with OON providers that meet the family's needs and preferences |

Emma identifies opportunities to support and encourage the caregiver to follow up with and participate in John's recommended treatment. This includes:

- Following up with the caregiver and providers (PCP, pediatric psychiatrist, and specialists) after scheduled appointments to verify attendance and participation, as well as identify any additional recommendations for John's care
- Scheduling routine MDT meetings, led by the caregiver with support from Emma, at least monthly or more often based on John's needs, which includes inviting the family's natural supports, CBOs, and treating providers to participate, address needs, and update the POC
- Developing a contact plan, based on the caregiver's preferences, which includes in-person contact at the location and time of the caregiver's choice at least monthly, as well as frequent telephonic contact based on the family's needs. During these contacts, Emma reviews John's POC, behavior plan, and crisis plan with the caregiver to assess the effectiveness of his services and supports and capture additional needs and services in his POC

Emma monitors John's participation in services by following up with the caregiver, PCP, and specialists, as well as monitoring provider and pharmacy claims data, prior authorization requests, and appointments. Emma recognizes that John's needs will fluctuate as he engages in care and reviews his well-being monthly to assure progress; address any new, unmet, or undiagnosed needs; and make any adjustments to his POC.

**LONG-TERM NEEDS – BEYOND 30 DAYS**

- Upon request and with consent, Emma supports the family by attending appointments
- Emma follows up with the family and John's PCP to monitor on-going progress and determine if additional specialists are needed

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## 2.6.7.2 Promoting Member Health and Well-being Through a Local Approach

### JAMES – 14-YEAR-OLD BOY AND HIS FAMILY

As a DCFS preferred health plan, Healthy Blue supports James and his family in addressing his needs through our person-centered **Elevate | Population Health** approach, which includes local population health analysis to identify and prioritize health priorities and disparities and overcome access challenges in his community. Our Case Manager, Shawna, who is a licensed mental health professional, supported by our integrated Case Management team, including Medical Directors and PH and BH clinicians, has experience in Bunkie and will meet James and his family where they are with early and proactive identification of their needs and goals, removing barriers, and connecting them to the providers and services they need.

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Healthy Blue is sensitive to the challenges that youth with co-occurring neurocognitive difficulties and behavioral health conditions and their families face. Our goal is to maintain these youth in the most integrated setting possible with the supports and services that are tailored to the child and family's individual needs. We have worked to enhance our provider network and care management teams to be equipped to support members and their families with these challenges through systemic collaboration with child serving agencies (OYD and DCFS), the Office of Citizens with Developmental Disabilities, the Office of Behavioral Health, and the Department of Education through individualized multidisciplinary care team (MDT) meetings and wraparound services through the Coordinated System of Care (CSoC). James and his family have had involvement of the law enforcement due to comorbid conditions such as moderate neurocognitive issues ADHD, PTSD, oppositional defiant disorder, and mood dysregulation disorder and episodic aggression at school. Our goal, with consent from family, would be to connect this member to wraparound services and have the member evaluated with a Child and Adolescent psychiatrist, Developmental Pediatrician, or Child Psychologist who has experience with youth that have co-occurring neurocognitive issues and behavioral health (BH) conditions for diagnostic clarification and completion of a CDE for consideration of Applied Behavior Analysis (ABA) Services. Other community-based options would be Family in Needs of Services, more evidenced based mental health rehabilitation such as Multisystemic Therapy (MST), and connection to our peer Navigation program along with case management from the health plan. Our Healthy Blue Behavioral Health Consumer and Family Organizations for Children, Youth and Adults Liaison would work to create an individualized system of care for this family. Of note, our Psychiatric Residential Treatment Facilities (PRTFs) have been willing to receive consultation from the Office for Citizens with Development Disabilities (OCDD) community support teams or other ABA providers and have expertise in trauma-informed care.

Using our Healthy Blue Health Intech platform, we can identify the member, James, as a part of a vulnerable population at risk of adverse outcomes and needing additional supports to navigate his complex needs. Our predictive modeling process assigns James initially to Transitional Case Management with graduation to Intensive Case Management (Tier 3) to focus on his immediate Special Health Care Needs (SHCN). Our approach focuses on his needs using a holistic approach that supports James' entire family. We work to engage James with providers trained in trauma-informed care and understand the importance of Louisiana's CSoC philosophy, values, and approach. We understand James' previous mental health episodes have impacted family members, so we make sure to demonstrate this understanding in our approach to support the whole family. This includes making sure the family has the wraparound services they need to prevent out-of-home placement. This may include step-down alternatives for his transition, adjustments to his current in-home services and supports, therapeutic interventions such as ABA therapy, medication management, and in-school and family supports, including crisis planning.

## 2.6.7.2.1 Assessments and Access to Specialty and Evidence-based Treatment

Regardless of whether James is new or currently enrolled with Healthy Blue, our systems and reports will identify him as having SHCN based on his diagnoses and claims data. With a focus on safety and well-being for him and his family, we recognize his recent behaviors are complex and urgent. Healthy Blue's Case Management team receives training and regularly uses Health Intech, our information platform, to share across systems and combine member data and information such as real-time ADT feeds, screening and assessment results, plans of care (POCs), longitudinal member health records, and clinical data for use by our Case Managers in their engagement, assessment, and care planning efforts.

We also use Elli™, a risk intelligence solution that delivers population analytics and individual profiles for members who may have received services from other MCOs, incorporates Louisiana-specific encounter data, and maps socioeconomic to clinical data to support a holistic view of members. Our case management team assigns James to our Case Manager, Shawna, who is a licensed mental health professional and has experience with youth at risk for out-of-home placement.

### IMMEDIATE NEEDS – WITHIN 24 HOURS

- Shawna reaches out to James' mother to schedule an assessment with James and her in the hospital
- Shawna reassures the hospital that she is working with the family to develop a safe transition plan from the hospital
- Working with our Utilization Management team, Shawna makes sure James' continued stay is temporarily authorized

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## Reaching Out to and Engaging James and His Family

Shawna reviews all available information in Health Intech prior to contacting James' mother to explain the role of the Case Manager, obtain consent to work with her son and family, and complete the health needs assessment. During the discussion, Shawna discusses specific concerns the mother has about bringing her son home by using

reflective listening techniques, such as, "I understand you are not ready for your son to come home right now because you are afraid it may be unsafe for you and your other children." She makes sure James' mother understands all the services and supports that would be available to her once she is ready for James to come home and that we would help to identify the best setting to meet James needs. Collaboratively, they discuss his neurocognitive issues and that with the right supports he may be able to function relatively independently in the future. Shawna shares information with the mother about the types of services and supports available to James, herself, and to her other children. Examples include MST, therapeutic group homes, PRTF to prepare him and the family for his return, individual and family therapy, intensive in-home behavior management, and respite services that provide a break for his caregivers and his family.

Shawna (with the mother's approval) arranges a time with James' mother, the facility staff, and the Community Psychiatric Support and Treatment (CPST) worker the following day to meet with James and his MDT to complete a holistic, person-centered assessment and develop a POC. The CPST worker offers insight on any of James' prior history that may be useful in developing his POC. If needed, Shawna will engage our Healthy Blue Liaisons (including our Consumer Advocate, Department of Education, or Local Government Liaison) or other community-based organizations (CBOs), such as Families Helping Families, to identify and implement necessary holistic services. If we have difficulty connecting with James' mother, we will prioritize our outreach efforts by coordinating a MDT with representatives from the child serving agencies, CSoC, state agencies treatment team and family to craft an individualized plan to meet the family's needs. This would be done within a person-centered planning framework.

## Conducting James' Assessment in the Hospital

Shawna collaborates with the facility to discuss James' current discharge plan, their potential referral to DCFS, and to develop a holistic POC to assure all James' needed services are identified and in place prior to his discharge. Shawna communicates to them that we are developing a safe plan to transition James and requests additional time. She contacts our utilization management team to make sure James' stay continues to be authorized.

By conducting the assessment in the facility with James, his family, and the facility staff, Shawna gathers a current assessment of James' comorbid conditions and the treatments that led to his inpatient stabilization. Shawna uses her clinical and person-centered communication skills to encourage his mother to describe how James' conditions impact the family and they discuss potential short- and long-term goals to support living together safely and comfortably. She works with the facility staff, CPST, and his mother to gather an accurate and updated history including his age of diagnosis; precipitating factors; providers seen; services he received; and his prescribed medications and medication adherence while hospitalized, in residential treatment, and at home. For example, they talk about the CPST services James is receiving in the home and the family's perception of its effectiveness in addressing his escalating behaviors.

Using her clinical experience, knowledge of evidence-based practices, and multiple engagement approaches (such as motivational interviewing or cognitive reframing) Shawna talks to James about what his goals are, what makes him happy, and how his family can support him to achieve his goals. Shawna and James' mother talk about her concerns related to the well-being of the family and maintaining her job. Shawna asks James' mother about any potential social determinants of health barriers that may impact her ability to follow through with the recommendations from James' providers, such as participating in frequent visits, taking medications as prescribed, transportation to appointments, health literacy needs, and time constraints related to her job and other children.

Shawna confirms that the provider completes of the Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) to determine the evidence-based practices, intensity of services, and the most integrated setting to meet James' needs. Care pathways may include the options described in Table 2.6.7.2-1.

*Table 2.6.7.2-1. Potential Care Pathways for the Member and Family*

| |
|---|
| **Option #1. In-home and Community-based Services and Supports** |
| **After receiving information about the services and supports available, if James' mother feels that she is ready for him to come home, there are multiple in-home and community-based services for her and her family.** |
| ▪ CSoC provides services and supports to James, his mother, and siblings. This includes mentoring, coaching, and skills development; youth peer support for self-management; coping skills; healthy family interactions; and respite care opportunities. Shawna collaborates with the CSoC coordinator to meet James' holistic needs.<br>▪ James can increase his current CPST services, preserving the established relationship with his CPST worker, to support a safe transition home, provide structure, and offer therapeutic interventions such as Cognitive Behavioral Therapy or Cognitive Processing Therapy for his PTSD and behavior management.<br>▪ Evidence-based interventions for young adults experiencing behavioral challenges can include MST, Functional Family Therapy (FFT), and ABA from community providers, such as Care Tec in Bunkie that also provides diagnostic evaluations and multidisciplinary BH services, [redacted] |
| **Option #2. Step-down Alternatives for Transition** |
| **After talking to James' mother about her options in the home, Shawna acknowledged her continued fear about the safety of her other children and offered temporary alternative placements that prevent abandonment and DCFS involvement and give time to prepare for James' safe return home.** |
| ▪ ***Natural supports***, such as family members or friends who can provide a safe environment for James while he participates in services, including individual and family services to prepare him for returning home.<br>▪ ***A therapeutic group home*** near the family's home, such as New Roads, which can provide a step-down opportunity for James and his family to develop individual and family behavioral and relational skills.<br>▪ [redacted]<br>▪ ***PRTF*** with Medical Director Review and approval; we identify a PRTF, such as Methodist PRTF, that can provide inpatient-type care in a structured, residential setting for members whose needs are not being met in other settings, such as at home or school. |
| **Option #3. DCFS Custody and Support for Member Transition Back into the Home of Origin** |
| **After learning more about her options, James' mother decides not to pick up James from the facility.** |
| ▪ ***HOMEBUILDERS® (Intensive Family Preservation Service***), which targets improving parenting skills, family functioning, parent/caregiver and children's behavior and emotion management skills, and increasing the safety of all family members for children and youth to live safely at home.<br>▪ ***Functional Family Therapy – Child Welfare (FFT-CW®)*** engages James and his family by assessing relationships and patterns, implementing individualized and family behavior plans that support positive interactions, addresses precipitation factors and stressful situations, and reducing behaviors through crisis planning. |

## 2.6.7.2.2 Meeting James' and His Family's Service Needs

Shawna knows that extending a hospital stay may not be in a member's best interest, so she works with James' mother to develop a plan for his safe and successful discharge, which includes identifying and coordinating appointments with PH and BH providers that specialize in caring for members with multiple BH diagnoses and cognitive decline (such as a pediatric psychiatrist and neurologist). Shawna works with the hospital to ask them for more time to develop a safe transition plan. Healthy Blue's integrated case management team, composed of our Medical Directors, Care Management team, and Utilization Management clinicians, assure continued authorization for his hospital stay and identify any additional resources for a lower level of care and family supports. We identify the most appropriate providers based on his needs, which may include out-of-network or ultimately an out-of-state provider through single-case agreements.

Our OCDD Liaison will request a consultation from OCDD's outpatient behavioral support team that specializes in meeting the needs of youth with comorbid I/DD and BH illnesses. As part of his care planning, we develop a crisis plan and an agreement with the hospital to be his inpatient provider in a crisis.

Once his outpatient care team is identified, we will have regular child and family team meetings to discuss concerns and problem solve as they come up with James and his mom as part of these meetings.

Shawna and James' mother identify his MDT participants to develop a POC. The MDT may include participants such as his pediatrician; specialty provider representatives, such as his therapy and behavioral management providers (CPST, CSoC, ABA, MST); Psychiatrist; and natural supports like family, friends, church members, and school partners. The MDT works together to educate James' mother about resources available and care pathway she chooses for James.

Regardless of James' living environment, his care pathway options include the identification, engagement, initiation, coordination, and monitoring of the following to support him in the selected environment:

- Physical health services, including EPSDT visits with his pediatrician and neurological provider and follow up evaluation to determine if there are any changes in his neurocognitive functioning — this includes consultation with Healthy Blue's clinical team to determine whether neuropsychological testing is needed to identify neurological causes of comorbid behaviors and for treatment recommendations specific to his neurocognitive disorder
- BH services, such as continuing in CPST or engaging services, CSoC, ABA, HOMEBUILDERS, FFT-CW, or other services based on his care pathway — emotional and behavioral management, interpersonal and social skills development, and self-care and daily living skills; evaluation by OCDD if appropriate; and family therapy to improve communication and resolve conflicts
- Medication management through collaboration with PCP and psychiatric services including education about the importance of adherence
- Alternatives for preventable emergency department or hospital use as a response to escalating behaviors, such as telehealth, tristate agreement, our Integrated Collaborative Care Model, telemedicine kiosks, and iPads®
- School-based coordination in preparation for his return to school to assure his Individualized Education Plan (IEP) meets his needs and that he has a behavior plan to assist with self-management and aggression
- Respite services that can offer a break for the caregiver and social interactions for James

- Resources for James' mother through community-based programs (such as Families Helping Families) to provide emotional, educational, and referral support through peer-based support that fosters independence
- Services and resources for the other children in the home, such as assuring they are participating in EPSDT and wellness care, reaching out to their pediatrician to complete an adverse childhood experiences (ACEs) screening, and determining if trauma-informed play therapy is appropriate for their needs to prevent future challenges associated with trauma

**SHORT-TERM NEEDS – WITHIN 7 DAYS**

- Shawna works with Healthy Blue's Provider Services department to identify step-down options for James' transition from the hospital
- Led by James and his mother, Shawna engages the family's multidisciplinary care team to assist them in choosing services and supports for their needs

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As part of the POC development, Shawna supports the team to review and update the crisis plan, should James return home. The crisis plan includes the types of events that precipitate escalating behaviors and the resources available to family members to prevent or deal with escalation, such as contacting Healthy Blue's BH Crisis Line or Crisis Intervention providers. Our UM team, Medical Directors, and Psychologists review pre-authorization requests from providers for ongoing crisis intervention.

Regardless of James' care pathway and prior to discharge transition from the hospital, Shawna verifies that all services are in place prior to his discharge and follows up with the family or placement caregiver and providers to make sure services have been initiated. Shawna schedules follow up and ongoing appointments, and arranges for transportation, if needed. This includes follow up appointments within seven days following discharge with James' pediatrician, neurologist, and psychiatrist for evaluation and to review any medication changes that occurred while he was in the hospital. Shawna makes sure all prescriptions are filled and his caregiver understands the importance of medication adherence prior to his transition.

If James discharges from the hospital to an out-of-home step-down placement, Shawna supports James and his mother in developing a discharge plan for his return home, which also includes input from others involved in his care. That may include his PCP, placement team, specialty providers (psychiatrist, neurologist), therapists (CSoC, ABA, MST), and others, such as DCFS, the Healthy Blue Liaisons, and Healthy Blue's Medical Directors. The discharge planning process is initiated upon James' admittance and includes telephonic and face-to-face contacts with him to identify his progress and any gaps in care, his mother's and sibling's progress in services, and the services needed in the home to support a safe transition to prevent further hospitalizations and out-of-home placement.

**LONG-TERM NEEDS – WITHIN 14 DAYS**

- James transitions safely to a step-down facility to address his behavioral needs prior to returning home
- Shawna arranges for trauma-informed therapeutic services for James' mom and siblings
- Shawna begins working with the step-down facility to develop a discharge plan for James to return home

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When James is ready to return home, Shawna assures all services identified on his discharge plan are in place prior to and initiated upon transition. Shawna assists in scheduling needed appointments, follows up with the family and provider to assure his attendance, and reviews claims data to monitor participation in services. This may include continued behavior management and therapy in the home, such as CPST or ABA that includes family participation, further psychiatric or neuropsychiatric testing and evaluation, respite, and follow up medical and pediatric psychiatric appointments.

The family and Shawna develop a contact plan that includes the frequency and modality (in-person, telephonic, text) of communication based on James' needs and the family's preferences to monitor signs of relapse, identify gaps in care, and coordinate additional services or strengthen existing services if there are signs James may be exhibiting an increase in behaviors. Shawna continues to participate in Healthy Blue's clinical rounds to identify any additional services and supports that can assist with his success in the home and community.

As a result of James' treatment, he has received the tools for self-management and coping skills that he can use in the home, school, and community, and how to interact with his family in a non-aggressive manner and what to do if he feels his anger level escalating. James' mother understands more about his conditions, the importance of follow through with services and structure in the home, and how to respond to James in a healthy, positive way.

Shawna remains involved with James and his family for as long as they prefer, while making sure the family continues to make progress and encouraging their independence from case management, including stepping down the intensity of case management services and contacts as his behaviors improve. This may include scheduling James' and his family's appointments and assuring their attendance and participation; identifying and accessing community resources for supports; referring to James' crisis plan to avoid using the ER; and leveraging natural supports to meet James' and his family's needs, including tutoring through the school and spending time with James or his siblings to give everyone a break, if needed.

## 2.6.7.3 Improving Health Outcomes for Louisiana's Children and Mothers

### ISABELLA – 17-YEAR-OLD AND HER NEWBORN BABY

Addressing potential language and communication barriers is essential in developing a trusting relationship with Isabella that will support the identification of and access to care, services, and supports needed for her and her baby born with hydranencephaly, an incurable condition. Our trauma-informed approach includes immediate response and is sensitive to her young age, the trauma and grief related to her child's poor prognosis, her history of sexual assault, and her cultural norms, beliefs, and values, such as Hispanic end-of-life rituals that emphasize family members caring for loved ones rather than professional caregivers. Based on Isabella's and her baby's needs, our case management team assigns Brigitte, our OB nurse who has experience working with moms who deliver babies with complicated conditions

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Engagement with members with Special Health Care Needs (SHCN) often begins by assigning a Case Manager, who not only is able to communicate with the member, but also demonstrates understanding of and compassion for members in difficult, crisis, and life-altering situations, such as this member. Healthy Blue's **Elevate | Advancing Maternal and Child Health** approach provides a comprehensive suite of culturally competent solutions dedicated to identifying, promoting, and supporting the health of our pregnant members and their babies and provides a framework for meeting the State's goal of improving the low birth rate racial gap, low birth rates overall, infant mortality, teen pregnancy, and other health outcomes for children and mothers in Louisiana.

The timing in this case, where the birth of an infant with a terminal condition occurs soon after the mother's arrival in New Orleans and enrollment in Medicaid, creates the need for our immediate engagement and skilled, holistic case management. Our adherence to the National Standards for Culturally and Linguistically Appropriate Services assures we are well-equipped with trauma-informed and culturally competent staff, network providers, and community partners to wrap around Isabella and her medically complex daughter. We make sure language, health literacy, and cultural norms are respected and never an impediment to accessing needed health services or engaging in healthcare.

## 2.6.7.3.1 Assuring Holistic Care for Isabella and Her Infant

Based on the scenario as presented, Healthy Blue would reach out immediately to Isabella upon her initial enrollment; however, as things unfolded quickly, we urgently engage upon receiving the real-time admit, discharge, transfer notification of the NICU admission of her baby, and include Isabella and her baby on our daily NICU clinical rounds to assure we meet their holistic needs. Our NICU rounds are conducted by a multidisciplinary case management team comprising our Neonatologist; Pediatric Psychologist; OB, pediatric, physical health (PH), and behavioral health (BH) clinicians, and our NICU nurse. The NICU nurse receives real-time communications of changes in the infant's condition and Isabella's needs, assures Isabella is screened for PTSD, and provides case management support to assure a safe transition from the hospital for Isabella and her baby.

While Isabella's infant is stable as of the recent discharge from the hospital following the PCP visit, we know she and her baby will need significant ongoing care and support. Both Isabella and her baby girl have high-risk needs and are assigned to Tier 3 Intensive Case Management — Isabella because of her age, recent pregnancy, birth of a child with complex healthcare needs, and previous trauma; the infant because of her SHCN and incurable condition.

### Engaging Isabella by Meeting her Language, Cultural, and Literacy Needs and Preferences

Our priority is understanding and meeting Isabella's health and emotional well-being, her infant's conditions, and what Isabella's priorities are for her and her child. We will meet Isabella where she is by aligning care, services, and supports to her priorities. This includes helping her understand the entirety of her baby's health conditions and needs, having a safe environment for Isabella to care for her baby, addressing grief and trauma associated with her infant's prognosis, her sexual assault history, and engaging Isabella in postpartum care.

Given that Isabella and her family speak only Spanish, we immediately engage CulturaLink, which provides comprehensive translation and interpretation services to assist our OB Case Manager in understanding Isabella's preferences for the way we communicate and interact with her and her family.

### IMMEDIATE RESPONSE – WITHIN 24 HOURS

- OB Case Manager, Brigitte, arranges for CulturaLink to provider translation and interpretation services in Spanish
- Brigitte meets with Isabella to begin establishing rapport, help her understand her baby's condition, and screen her for PTSD
- Brigitte assures Children's Hospital New Orleans Pediatric Palliative Care is part of the care team that arranges for services in the family home
- Brigitte also connects the family to a community-based organization, such as Catholic Charities Archdiocese of New Orleans (Hispanic Apostolate Services), to help address end-of-life wishes

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Once we understand the family's preferences, we make sure we honor those throughout Isabella's and her baby's care with Healthy Blue. Recognizing Isabella nor her brother and father can read or write in English or Spanish, we use a high-touch approach. Our OB Case Manager talks with Isabella and her family face-to-face as appropriate and walks through information in concert with the interpreter service, so that they understand things like medical forms (consent, do-not-resuscitate [DNR]) and educational materials (member handbook, condition-specific information, member website).

We track Isabella's communication needs in Healthy Blue's case management system, Health Intech, which captures all of Isabella's healthcare information, to assure ongoing interactions will occur based on her preference, including provider appointments (in-person, telehealth), Case Manager contacts, screening and assessments, and interactions with other health plan staff (Community Health Worker [CHW], Member Services Representatives, 24/7 Nurse Line, BH Crisis Line).

While all Healthy Blue Case Managers are currently trained in cultural competency and health equity, they will also be trained in language, culture, and diversity specific to each parish across the State. In this situation, the assigned Case Manager will also have experience working with families navigating the realities of an infant with medical complexities and poor prognosis and trained in motivational interviewing, trauma-informed care, and adverse childhood experiences (ACEs), and will engage our CHW who works with immigrant populations in New Orleans.

## Outreach to and Engagement

Based on Isabella's and her baby's needs, our case management team assigns Brigitte, our OB nurse who has experience working with moms who deliver babies with complicated conditions. Brigitte knows that Isabella's young age, trauma, language needs, and cultural considerations contribute to the urgent need for engaging her in care and case management. Brigitte is skilled at using open-ended questions and reflective listening to encourage members and their family to share their expectations, preferences, and cultural norms for participating in care. Brigitte recognizes that Isabella's family culture and dynamics may affect her comfort level in sharing her personal and healthcare history in the presence of family members – which may also be affected by other factors, such as the reasons for and length of separation or whether her father is aware of her sexual assault. Brigitte talks to Isabella about whether she has any family members, friends, or community-based resource to support her in her care, such as from a faith-based organization of her choosing.

We know our members speak many different languages and have varying levels of literacy – this should never be a barrier to care. We recognize that limited interpretation services, as well as shame associated with limited reading abilities, often play an important role in how members interact with healthcare providers. In this case, Brigitte also recognizes the possibility of stigma or shame Isabella may be experiencing about her pregnancy and sexual assault, as well as the possible difficulties in discussing death and dying for Isabella and her family based on their cultural, social, or religious beliefs. These issues coupled with her young age and ability to understand the nuances of a healthcare system, can be intimidating, difficult to navigate, and may affect her engagement in care.

Using language line services or an interpreter who speaks Spanish, Brigitte uses motivational interviewing and a trauma-informed approach to connect with Isabella, begins establishing rapport, and helps her understand the seriousness of her baby's condition, her right to make medical decisions for her baby, the role of hospice, and the purpose of palliative care and advance directives, including a DNR order. Together, they also explore Isabella's cultural preferences to understand how she wants to engage in care planning, as well as how her cultural preferences may impact her understanding of her baby's needs, her own needs, and her ability or desire to communicate and interact with providers.

Brigitte first helps Isabella understand that given her age and that she has just given birth, Isabella has the right to make decisions for her baby's care. To support Isabella in identifying what she needs and prefers in caring for her baby at home, Brigitte shares information about the importance of and types of care and support available to her and her baby. This includes OB-GYN postpartum care for Isabella,

### SHORT-TERM NEEDS – WITHIN 72 HOURS

- Brigitte supports Isabella in completing a holistic assessment and developing a plan of care for her and her baby
- Isabella schedules post-partum care with her OB-GYN and Brigitte arranges for trauma-informed therapy to address Isabella's grief and PTSD needs
- With Isabella's permission, Brigitte engages a Healthy Blue CHW to assist in identifying additional resources
- Through Healthy Blue's home visiting program, we can arrange for home visits from Nurse-Family Partnership

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neonatal or neurological services for her baby, palliative care, hospice services, PCP, therapy to address grief and PTSD concerns, medications, durable medical equipment (DME) for the baby, in-home skilled nursing, and system navigation supports. This also includes evidence-based practices, including Peer Support and engagement of family support organizations, such as Families Helping Families and social support organizations that support immigrants in the New Orleans area, such as Hispanic Apostolate Community Services or Honduran Family Association, depending on where Isabella is from.

The hospice nurse and Brigitte work together to support Isabella in understanding her baby's needs, prognosis, and services provided by hospice and assist her in selecting a pediatric hospice provider in New Orleans. For example, Children's Hospital New Orleans Pediatric Palliative Care is a family-centered interdisciplinary program that cares for the body, mind, and spirit of children with serious illness and their families. As an integral part of Isabella and her baby's care team, this type of program would gently provide information on the symptoms the baby may experience (initially or in a few months), such as seizures, myoclonus, and respiratory problems; the palliative care available for her baby; and the average life expectancy for babies with hydranencephaly. They also support her in understanding how she can provide comfort and care to her child, such as holding and cuddling with her baby, diapering, and understanding medication times and doses – this may include pictures or color-coding instructions based on Isabella's needs and preferences, as well as support from in-home skilled nursing services.

Given the wealth of needs for Isabella and her baby, and the multitude of resources available to meet those needs, Brigitte understands that the information may be overwhelming for Isabella. Throughout her care, Brigitte considers this in her discussions with Isabella, making sure to help pace and manage the community of supports being offered, so that Isabella fully understands the options available to make informed choices.

## Assessment and Care Planning

Adhering to the principles of person-centered assessment, care planning, and trauma-informed care, Brigitte supports Isabella in completing a holistic assessment for her and her baby that informs the development of an integrated Plan of Care (POC) reflecting both their needs and Isabella's preferences for care and providers. Based on Isabella's preferences, Brigitte may engage her father and brother in the assessment process, where Brigitte helps them understand Isabella's goals for her baby, their opportunity to support her in her choices, and their help in supporting Isabella through critical events, such as the baby's worsening condition or death.
To complete the person-centered assessment, Brigitte engages Isabella in sharing information about her personal, medical, and social history, including:

- ***Current and past healthcare history***, including any prenatal care she has had, previous diagnoses, member and familial pregnancy and childbirth history (low birth weight, premature delivery, infant mortality), PH (high blood pressure, diabetes), mental health, substance use, injury, and medication history
- ***Cultural and immigration history***, including how long she has been separated from her father and brother and what is important to her, such as cultural values, customs, and spiritual beliefs
- ***Relationship history***, such as Isabella's familial history (mother, father, brother, other potential siblings), domestic or relational violence, ACEs, and natural supports, including family, friends, and teachers – if possible, Brigitte encourages Isabella in sharing information about the father of her baby, as well as her sexual assault and the affect it has had on her; they discuss the types of supports available to her, such as trauma-informed individual therapy and support through the New Orleans Family Justice Center that offers counseling, healing activities, and legal services
- ***Social determinants of health (SDOH) needs***, including current housing situation, food security, transportation, financial, and educational and employment needs

Based on Isabella's responses, Brigitte makes sure she understands all the services available to her and her baby and works with her to develop POC that includes services, such as:

- Selecting and scheduling follow-up appointments with a female OB/GYN with trauma-informed training in the New Orleans area for follow-up OB care and family planning that includes birth spacing/interconception choices, such as long-acting reversible contraception, and referring the member for genetic testing
- Understanding the emotional impact of Isabella's experiences, which may include guilt for the possibility of having done something that may have caused this and thoughts of not having a healthy baby in the future
- Identifying the services and supports that will help Isabella care for her baby's needs at home, such as:
  - Selecting a hospice physician trained in pediatric palliation, who is trained in hydranencephaly and can act as her infant's PCP, based on Isabella's preference, to assure continuity of care and minimize the stress of multiple appointments — if unavailable in Healthy Blue's provider network, we will execute a single case agreement to make sure her baby receives the care she needs
  - Assuring hospice is arranged in the family home at the intensity directed by the infant's specialist to monitor the baby and arrange for Isabella's counseling to address grief and PTSD issues related to her child's prognosis and her sexual assault

  - In-home skilled nursing that includes monitoring the baby's well-being, managing medications, providing education for Isabella in taking care of her child, making sure she and her family members understand and follow the POC during difficult situations, such as during a seizure
  - Arranging and assuring ongoing authorization for any DME that may be needed, such as respiratory support (such a breathing tube or oxygen)
  - [redacted]
  - Identifying resources for Isabella to address her legal status if needed, such as Louisiana Council's Advocacy Network (LaCAN), the Child Neurology Foundation, or other programs for legal aid, such as Catholic Charities Hispanic Apostolate Community Services and pro bono legal services through Loyola and Tulane Universities
- Engaging with Green & Healthy Homes (GHHI) through our Healthy Home VAB, to conduct an in-person environment assessment of the family's house to assure Isabella and her baby have returned to a safe environment
- Addressing SDOH by helping the family apply for social programs, such as Women, Infants, and Children (WIC) (formula), Supplemental Nutrition Assistance Program (SNAP) (healthy foods), and Supplemental Security Income (SSI) through the Compassionate Allowance Initiative that speeds up the process for families with children with SHCN
- Identifying community-based organizations, such as Catholic Charities Archdiocese of New Orleans and Families Helping Families of Greater New Orleans that offer information, referrals, and one-on-one support for parents and Junior League Diaper Bank for diapers

Through the care planning process, Brigitte helps Isabella understand that her needs are integrated into her baby's POC and that should her eligibility for benefits change due to her legal status, Brigitte will continue to support her in caring for her baby and connect her to the services and community-based supports that will continue to meet her needs. Care planning also includes incorporating additional needs for the family, such as assisting in scheduling appointments, arranging transportation, legal supports for immigration status if needed, and pursuing educational or employment opportunities. Throughout their care with Healthy Blue, Brigitte works with Isabella on understanding her child has an incurable condition and the community-based resources that will provide for additional needs and promote independence and well-being when her benefits change, including hospice care for the baby and emotional support for Isabella, such as the Nurse Family Partnership and Families Helping Families.

[redacted]

## 2.6.7.3.2 Addressing Language and Cultural Barriers to Assure Access to Care

Upon enrollment, our employees with direct contact with the member and family (including Case Managers, CHWs, and Member Services Representatives) and providers work to assure the linguistic, health literacy, and cultural needs are consistently met to assure their access to the most appropriate providers, services, and supports for their needs. In this case, Brigitte incorporates cultural competency practices — such as honoring Isabella's beliefs, being sensitive to cultural diversity, and adopting attitudes and communication styles that respect her cultural background.

### Addressing Isabella's Language Barriers

We tailor our member materials and outreach efforts to the specific needs of the family, including their preferred language and form of communication. We use language line and translator services, such as Voiance Language (for telephonic translation services) and CulturaLink (for in-person services). As previously noted, given that Isabella and her family need ongoing communication in a non-written form, we engage oral interpretation services through a local organization, such as CulturaLink, to walk through member materials verbally in conjunction with Brigitte and to attend provider appointments, as needed and desired by Isabella. Brigitte works with the family to identify providers who speak their language and are trained in trauma-informed care.

**LONG-TERM NEEDS – DURING THE FIRST 30 DAYS**

- Isabella and her family learn how to care for her baby in her home with support from hospice and in-skilled nursing
- The CHW connects Isabella with legal aid services through Hispanic Apostolate Community Services to address her legal needs
- Isabella understands her child's prognosis and works with hospice to make sure she knows her options and follows her POC when her baby's condition worsens

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### Meeting Isabella's Cultural Needs

Although language is part of delivering culturally competent care, it is just one part. All Healthy Blue employees and network providers participate in cultural competency and implicit bias training initially and annually. Using the language line or a translator if needed, Brigitte works with Isabella and her family to identify what is important to them and their culture. This includes honoring their beliefs about end-of-life including spirituality, expressions of grief, family decision-making about the infant's care, and response to her prognosis.

As part of onboarding and ongoing training for all Healthy Blue Case Managers, Brigitte:

- Assesses core cross-cultural issues, including Isabella's cultural and spiritual values – this is incredibly important in the context of a very young woman who has not only experienced sexual assault and uprooted herself to live in New Orleans, but is facing the reality of her baby's prognosis
- Helps Isabella and her family to explore the meaning of her baby's health needs and prognosis and makes sure that the treatment recommended by the provider is compatible with their values and cultural practices
- Seeks to understand the social context in which Isabella and her infant live, including family involvement in decision-making and care planning – works with Isabella to determine what level of involvement she wants her family to have in receiving information and decision-making
- Uses motivational interviewing techniques to encourage adherence to her chosen goals and POC

We also make sure Isabella has the ongoing support of an expert network of providers, who can provide the care she and her baby need with an eye toward her overall history and cultural context. Brigitte works with one of Healthy Blue's Outreach Care Specialists, who lives in the New Orleans area, to make sure Isabella has local providers and services that are consistent with her linguistic needs.

Brigitte continues to support Isabella in caring for her baby at home through frequent multidisciplinary care team (MDT) meetings and in-person and telephonic contact, based on Isabella's preferences, to identify any new, unmet, or undiagnosed needs, including SDOH needs. Brigitte makes sure that all services requiring authorization are approved on an ongoing basis, including the CHW and Peer Support Specialists, and works with Isabella to address her immigration status needs if appropriate, and engages community-based resources to assure Isabella's needs are met in the community should her benefits change.

## 2.6.7.4 Local and Community-based Approach to Support Mario in the Community

Healthy Blue takes a person-centered, community-based approach to supporting members with biopsychosocial needs. We understand that people living with mental illness and substance use challenges have high rates of medical morbidity and mortality, largely due to significant disparities in access to high-quality care.

## 2.6.7.4.1 Addressing Mario's Holistic Needs

Meeting Mario's holistic care needs requires a comprehensive person-centered approach to identify his needs early on and assure timely outreach and engagement to begin developing a trusting relationship. Healthy Blue addresses these challenges through our person-centered **Elevate | Population Health** approach, which includes local population health analysis to identify and prioritize health priorities and disparities, and overcome challenges in our communities.

### Identifying Mario's Care Needs

Using our Health Intech data analytic capabilities and robust data collection, we can identify Mario as a part of a vulnerable population at risk of adverse outcomes and needing additional supports to navigate his complex needs. Our predictive modeling process assigns Mario to Intensive Case Management Tier 3. Our approach focuses on his specialized needs using a holistic approach that supports Mario. Based on Mario's comorbid physical health (PH) conditions, schizophrenia diagnosis, substance use disorder (SUD), and emergency department (ED) utilization, we identify Mario as having Special Health Care Needs (SHCN). In Mario's case, we would learn about his situation early on through the following:

- Predictive modeling that identifies risk of emergency department (ROED)
- Real-time admit, discharge, transfer feed
- SCHN and ED utilization reports
- Referral from the My Choice Louisiana transition coordinator who will follow Mario for up to one year after discharge from a nursing facility
- Communication with the Office of Behavioral Health or Office of Aging and Adult Services (OAAS) through our My Choices Liaison — as part of the Department of Justice Compliance Agreement, the State identifies Mario's risk based on serious mental illness, multiple ER presentations, and potential homelessness

**MARIO – 49-YEAR-OLD MALE**

We recognize that substance use can impact a member's ability to engage in the services they need, as demonstrated for Mario, the member in this scenario. The exacerbation of already complex PH and BH conditions — including inappropriate behaviors — led to his inability to maintain housing and may create additional barriers to locating and connecting Mario to needed care and services. Regardless of Mario's condition, pain issues, substance use, environmental issues, or funding stream, our Case Manager, Jeff, a licensed mental health professional with substance use expertise, coordinates Mario's benefits to make sure we identify and address all gaps in car.

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Mario's assigned Case Manager, Jeff, identifies if Mario has behavioral health (BH)-only coverage and if so, connects Mario to other coverage options to make sure his PH needs are being met and coordinates with those providers (with Mario's consent). Jeff is a licensed mental health professional with substance use expertise and is a part of our Case Management team composed of our Medical Directors, PH, BH, Housing Specialist, Permanent Supportive Housing Liaison, Psychiatrist, [redacted] eff facilitates monthly in-person meetings with Mario's multidisciplinary care team (MDT) that is made up of participants of Mario's choosing, such as family, friends, providers (including services not covered under the BH-only product), and supports assessment and care planning processes.

Building trust with Mario, and our care management team, occurs by meeting Mario where he is in his desire and goals for improving his health, recovery, and quality of life. Regardless of whether Mario lives in Jefferson Parish and uses Ochsner, Orleans Parish and uses University Medical Center, or in Rapides Parish and uses Christus St. Francis Cabrini Hospital, Healthy Blue will wrap Mario in the services and supports he needs to remain in the community-based environment of his choosing.

### Reaching Out to and Engaging Mario in Care

Because Mario denies any substance use concerns and does not remember his behaviors, Jeff recognizes the potential challenges associated with connecting with him and that he may be unwilling to participate in services and supports. Healthy Blue's Member Engagement Strategy maximizes how we connect with Mario — who may be difficult to reach and engage. Jeff reaches out to Mario telephonically to schedule an in-person visit — if they connect with Mario, they will complete the health needs assessment to better understand his needs. If unsuccessful in our initial outreach, we engage a Community Health Worker (CHW) or Access Navigator,

**IMMEDIATE NEEDS – WITHIN 72 HOURS**

- Recognizing the importance of Mario's challenges that may affect engagement, Jeff and other Healthy Blue staff reach out to Mario frequently
- Working with Mario, Jeff schedules an appointment with a neurologist in Mario's area for evaluation
- With Mario's permission, Jeff engages a Peer Support to meet Mario where he is in his recovery and support him in participating in substance use services

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who specializes in navigating social determinants of health to go to Mario's last known address to provide him with information about Healthy Blue that may encourage him to engage with his case manager. Jeff reaches out to Mario's OAAS transition coordinator to gather more information — leveraging a relationship that has been developing and supporting Mario since his discharge.

[redacted]

Once Jeff contacts Mario, we provide him with information in his preferred language, verbally and in writing, about the role of the Healthy Blue Case Manager. He explains the benefits, services, and programs available to Mario to address his physical and behavioral health conditions and symptoms, to maintain his housing, and to prevent potential future legal involvement. Jeff shares information about the role of Peer Support, who can offer Mario emotional support and share personal experiences and knowledge that may encourage him to engage in care — which can occur through the Local Governing Entities (LGEs) as a covered benefit telephonically, through Healthy Blue telephonically, or through our Healthy Blue CHWs. We ask Mario if he would like for a Peer Support Specialist or Transition Coordinator to attend their in-person meeting. If Mario has a guardian, Jeff assures they are involved in his care.

## Developing Mario's Multidisciplinary Team

Based on the information Mario has shared, Jeff works with him to identify the individuals in his life he would like to participate on his MDT, which helps with his care planning to assure his holistic needs are met. Jeff supports Mario to identify key participants such as his PCP, specialists (BH providers and a psychiatrist), Peer Support Specialist, the Healthy Blue Housing Specialist, Permanent Supportive Housing Liaison, and any natural supports he identified, such as family, friends, and neighbors. They talk about Healthy Blue's Case Management team, including our Medical Directors, [redacted] and case management clinicians who will monitor his progress, identify any cognitive issues, address any gaps in care, and identify additional resources to meet Mario's needs. The team monitors and watches for claims that may indicate escalation in needs, such as ED visits and lack of medication refills.

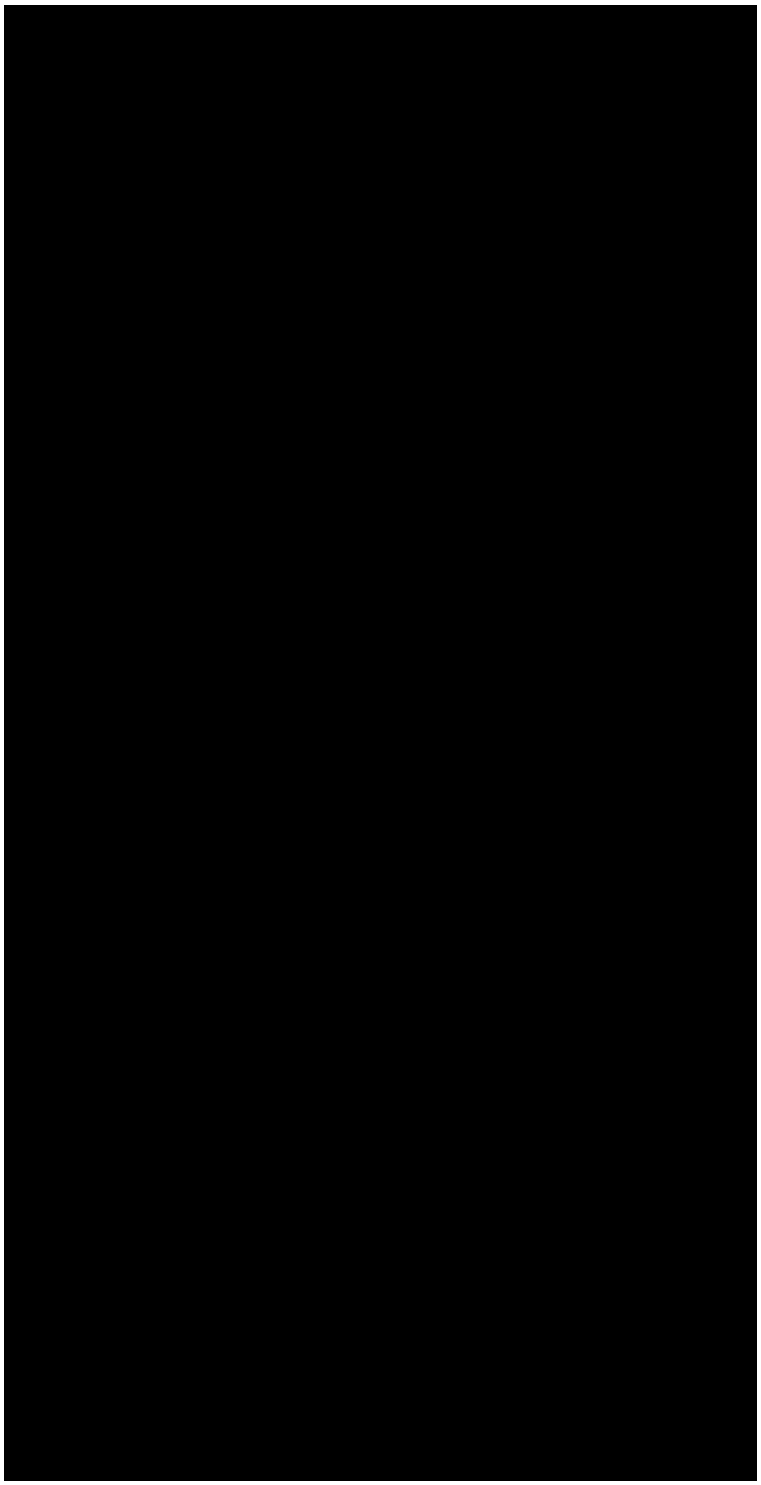
## Completing the Person-centered Assessment and Addressing Mario's Care Needs

Jeff and a Peer Support Specialist meet with Mario in his home to complete the assessment to further discuss his conditions, needs, short- and long-term goals, and preferences for his healthcare services and supports. This includes addressing any social determinants of health barriers to care and his current home environment.

**Pain Management.** During the assessment, Jeff and Mario talk about the escalating pain he is experiencing and how it may be related to several of his conditions, such as his neuropathy, recent falls, and wheelchair-related lack of movement or exercise. They discuss the services he uses to address his increasing pain, including whether his ER use is in lieu of him engaging with other providers, such as his PCP or selecting a pain specialist to determine the source of his pain and evaluate his medication needs.

Jeff shares information on alternatives to pain medications, such as seeing a pain specialist for evaluation and recommendations, physical therapy, [redacted]

**Brain Injury.** Mario tells Jeff about his brain injury and how he feels it impacts his life, goals, and functioning. They also talk about how his brain injury may be contributing to his memory challenges and ask him if he has seen a neurologist or is willing to do so to rule out any emerging complications. If he does not have a neurologist and there is not one available neurologist in his area, Jeff will work with our Provider Services team to identify potential specialists and engage them in our single case agreement process.



**Behavioral Health (Serious Mental Illness and SUD).** Jeff asks Mario about his understanding of symptoms and behaviors that may be related to his schizophrenia, and learns his level of participation in treatments and his medications adherence. Due to 42 CFR, Jeff and the Peer Support Specialist are not allowed to discuss Mario's SUD until Mario openly states that he uses and has an issue. Therefore, Jeff and the Peer Support Specialist uses motivational interviewing to ask open-ended questions to hopefully elicit to his recent behaviors such as yelling, using profanities, and appearing nude in common areas. If and when Mario admits to his substance use, motivational interviewing techniques will be used to encourage him to talk about his past his understanding of how his alcohol use may be contributing to some of his recent behaviors such as yelling, using profanities, and appearing nude in common areas. Jeff uses motivational interviewing techniques to encourage him to talk about his past and present alcohol use, whether he has participated in previous treatment for substance use, and if he thinks his alcohol use may be contributing to his memory issues.

They discuss the types of substance use services available to Mario when and if he is ready to participate. This includes detoxification (detox) services, Medication Assisted Treatment (MAT), intensive outpatient programs (IOP) in his area, Assertive Community Treatment (ACT) services, telehealth for serious mental illness (SMI) and SUD services, and inpatient programs. Mario is receptive to the evidence-based Peer Support Services offered by the LGEs and Human Services Districts throughout the state, which assists members with their recovery from mental illness or substance use by connecting them with Certified Peer Support Specialists. They discuss community-based supports such as 12-step meetings and faith-based organizations offering SUD support.

**Safe and Stable Housing.** Jeff talks with Mario about his right to live in the community rather than returning to the nursing facility and what services and supports he needs to remain independently housed. This includes how his current services are working to support him in his apartment, what else he may need, and whether he wants to return to a more structured environment. Jeff encourages Mario to share information on his current housing, whether it is meeting his needs, reasons for his previous evictions, and any concerns about another potential eviction due to his behaviors. They discuss his recent legal involvement due to his behavior, previous apartment issues, and potential eviction from his current housing. Potential solutions may mean involving the landlord as well as PH and BH providers on his MDT, requesting additional time from his landlord while Mario engages in treatment, and connecting him with community-based legal services that can help him resolve his pending legal issues.

Together they discuss his options should he be evicted for a third time, which includes:

- [redacted]
- ***Nursing Facility level of care*** if Mario feels as though he would like to return to a more structured environment with wraparound services
- ***Permanent Supportive Housing (PSH) program*** will support him in living successfully in the community. PSH qualifies as a community-based setting, where Mario can remain on the Home and Community Based Services Waiver that provides services in the home and in the community, such as personal assistance, adult day care, home modifications, therapy services (physical, occupational), and housing stabilization services, including monitoring from Healthy Blue's PSH Liaison. This option may not be an immediate solution, but submitting an application is the first step to securing a waitlist position.

**In-home Services.** Jeff and Mario discuss the services he is receiving in the home such as cooking and shopping and his participation in home care educational activities focused on increasing his independence. This includes talking about the options to increase in-home care to further assist with his activities of daily living and instrumental activities of daily living (ADLs/IADLs). With Mario's consent, Jeff arranges an environmental assessment to identify the types of environmental factors that may be contributing to his falls, such as needed durable medical equipment (DME), such as shower rails, kitchen grab bars, and minor home modifications to accommodate his wheelchair. They also talk about expanding his Personal Care Services to include other needs, such as bathing and dressing, transportation, and financial needs. Jeff asks Mario if he can collaborate with his home care therapy team to discuss additional home modification recommendations and supports using adaptations or other DME.

**SHORT-TERM NEEDS – WITHIN 14 DAYS**

- Jeff engages Mario's current property owner and Housing Specialist on his MDT and in the care planning process to incorporate ways in which to preserve his current housing
- Jeff develops a backup plan with Mario for other options should he lose his current housing, such as Permanent Supportive Housing
- Jeff assures Mario's access to Healthy Blue's Chronic Pain Management program
- Jeff arranges an environmental assessment to arrange for needed DME to prevent falls
- Jeff increases in-home supports with activities of daily living that can prevent potential injuries from falls

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## Developing Mario's Plan of Care

Led by Mario, his MDT collaborates to develop a POC that includes his strengths, goals, and preferences to meet his current biopsychosocial needs. Jeff and Mario collaboratively develop a contact plan, based on his preferences, such as frequency and modality (face-to-face, telephonic, and text messaging). Regardless of Mario's choices for providers and services identified on his POC, Jeff schedules appointments, arranges for adaptive transportation, and reaches out to in-home providers to assure services are scheduled and initiated, such as DME, home modifications, and additional home care services.

**Behavioral Health Conditions (SMI and SUD).** If Mario discloses his substance use, Mario's Plan of Care (POC) will address his goals regarding his alcohol consumption. They discuss the availability of IOPs, inpatient services, and recovery-based supports in his area. Jeff helps Mario to reschedule an appointment with his existing psychiatrist or choose one in his area that is trained in trauma and can evaluate his level of functioning and address any schizophrenia medication needs.

**Safe and Stable Housing.** As part of our care planning process, we make sure to address Mario's housing needs and develop a tenancy plan to maintain or secure safe and stable housing. Our approach focuses on Mario's housing preferences and safety, and considers all options with a focus on stabilization in his current environment. As an option, Mario considers transitioning to supportive housing that is more structured and has intensive housing supportive services as part of his POC. This type of transition may include additional supports, such as ACT, that provide community-based mental healthcare for individuals experiencing serious mental illness that interferes with their ability to live in the community, attend appointments with professionals in clinics and hospitals, and manage mental health symptoms.

**Physical Health Conditions (Brain Injury and Pain Management).** If Mario has a neurologist, Jeff reviews claims history and reaches out to identify his level of participation and current medications. If not, Jeff helps him select a specialist in his area, supports him in scheduling an appointment, and arranges for adaptive transportation that can accommodate his wheelchair, if needed. Jeff schedules an appointment with Mario's PCP for a comprehensive evaluation of his current symptoms and differential diagnosis, which may result in a referral to other specialists such as an endocrinologist or neuropsychologist. We incorporate services and supports to help manage his pain, such as the neurologist and a pain specialist of his choosing to address his escalating pain, who

may also refer him to a pain clinic or physical therapy to offer Mario a variety of pain management options. Jeff provides education to Mario about appropriate ER use and preventive care to better manage his conditions and pain such as attending appointments with his PCP or pain specialist, and participating in physical therapy. He also provides alternatives to using the ER such as using an urgent care clinic in his area, engaging in telehealth visits, or visiting providers with extended evening or weekend hours.

**Legal Issues.** Jeff and Mario decide to include the Healthy Blue Judicial Liaison to address his recent legal issues and incorporate social interaction into Mario's POC such as participating in an adult day program like the Friendship Club House through the National Alliance on Mental Illness. Together, they identify additional resources, such as transportation to appointments and Aunt Bertha that can help Mario identifies resources in his area that support any additional needs he mentions or that may arise going forward.

**Developing a Crisis Plan.** As part of the holistic POC, Jeff works with Mario and his MDT to develop a crisis plan that captures when and how Mario should reach out when he needs support. Resources include reaching out to family or his Peer Support Specialist, contacting the Healthy Blue 24/7 Nurse Line and 24/7 BH Crisis Line, and going to an urgent care center near his home. With Mario's approval and landlord buy-in, we also provide education to the landlord and/or property management staff about who to call as part of the crisis safety plan in the event that Mario needs assistance. This includes when his home care support team does not attend scheduled appointments, when he may feel the need to self-medicate, and when he is experiencing an increase in pain.

## Monitoring Mario's Participation and Progress

To monitor Mario's participation and progress, Jeff uses Mario's preferred contact methods and schedule, so Mario can share his progress, tell Jeff about any concerns he may have with his services or providers, and identify any services or supports Mario may still need or want. Jeff reaches out to his transition coordinator and providers following scheduled appointments to assure his attendance and identify any gaps in care or additional recommendations for additional services. Jeff monitors claims data to make sure Mario is participating, such as claims for IOP attendance, psychiatric appointments, and medication fills — this includes monitoring ER visits that may indicate substance use or potential falls in his home. Jeff participates in clinical rounds that will help identify additional resources or solutions for Mario as his needs change.

If Mario chooses to participate in inpatient SUD services, Jeff begins discharge planning upon his admission, which is led by Mario and includes his MDT and inpatient facility staff, to identify the services and supports he needs for a safe and successful transition.

If Mario has a housing voucher, he can be incarcerated or hospitalized up to 90 days before losing the voucher. Our Housing Specialist identifies the voucher program Mario is in and communicates with the voucher provider regularly. To help stabilize Mario's housing, our Housing Specialist recommends that he use representative payee services. We obtain a release of information to allow coordination with the landlord.

Jeff follows up with Mario and his transition coordinator, PH and BH providers, and his landlord to assure his behaviors are improving and his housing is no longer in jeopardy. This includes confirming that Mario is clinically improving and determining if additional services are needed – continuing to encourage and support Mario's ability to live independently in the community. We offer ongoing evaluations of how we can help him improve his likelihood of remaining in the community by increasing or adjusting the services he is receiving. Because the Healthy Blue Case Management Tier Level process is fluid based on Mario's needs, Jeff continues to follow his progress and adjusts the intensity of care, contact efforts, and case management activities based on his needs.

## 2.6.7.5 Increasing Integration to Assure Holistic and Timely Care

This member, Paulette, is experiencing several urgent and complex challenges. Healthy Blue's mission in a complex situation such as this, is to immediately engage Paulette, her family, and the NOW support coordinator to assess and assure her urgent needs and gaps in care that have led to the deterioration of her condition are immediately addressed. The response to this scenario illustrates how Healthy Blue initiates or re-engages our case management processes, highlighting a comprehensive and systematic process to establish and monitor a Plan of Care (POC) that assures Paulette's immediate care and safety and works towards achieving her health goals.

## 2.6.7.5.1 Identifying and Addressing Paulette's Complex Healthcare Needs

[redacted]

Upon receipt of Paulette's enrollment file — or through our predictive analytics or use of Elli™ data analysis, both of which quickly flag high-risk members such as Paulette — we immediately identify her poor health status. Recognizing the urgency of her diagnoses and under-utilization patterns, Healthy Blue's integrated Case Management team assigns her to Tier 3 Intensive Case Management, the highest level of case management, and assigns an experienced Case Manager, Nicole, who is a licensed registered nurse. Nicole has expertise in working with members with needs similar to Paulette's, including Special Health Care Needs (SHCN) and high-risk physical health (PH) needs that require intensive, assertive coordination of services and supports across the spectrum of care — including close collaboration with State entities, such as the Office for Citizens with Developmental Disorders (OCDD) and Office of Aging and Adult Services (OAAS), providers, and community-based organizations.

### Immediate Outreach to and Engagement with Paulette

Nicole reviews all available information in Paulette's electronic health record, any prior assessments (if Paulette is not new to case management), and reaches out, recognizing that Paulette's health needs require ongoing care and supports. Nicole successfully reaches Paulette and her mom, respectfully assesses their language preference and overall health literacy, and obtains consent to participate in case management. Nicole shares information about her role in coordinating care with Paulette's NOW support coordinator and encourages her to share how she is feeling about her current conditions, services, living environment, and needs.

On the call, they complete the health needs assessment to collect the most current information about Paulette's status, including her diagnoses, medications, services, and priority concerns about her condition and needs. Nicole quickly identifies Paulette's urgent SHCN, along with her mom's concerns. She works with Paulette to identify a time to meet face-to-face, if that is her preference; schedules an urgent appointment for the following day to address her wounds, pain, hypertension (HTN), and other needs; arranges accessible NEAT; and offers to attend the appointment with her. They also talk about her multidisciplinary care team (MDT) to make sure it is composed of participants of her choosing who will support her healthcare decisions, such as her mom, other family and friends, her PCP, and specialists.

Following their initial call, Nicole reaches out to the NOW support coordinator to gather additional information and discuss Paulette's health status, as well as the level of engagement the NOW support coordinator has with her. Nicole requests and reviews Paulette's previous screening and assessment results, Individual Nursing Service Plan and rehabilitation plan, and talks about the history of challenges associated with obtaining a new wheelchair. Healthy Blue's OCDD Liaison is also engaged to assure full communication with the State on Paulette's situation, progress, and quality of care concerns.

[redacted]

**IMMEDIATE NEEDS – WITHIN 24 HOURS**

- Nicole reaches out to Paulette and arranges an urgent appointment with her PCP to address her wounds
- Nicole arranges for the earliest in-home appointment possible with a seating and positioning specialist to address her current wheelchair needs
- Nicole assists Paulette in selecting and scheduling an appointment with a dental provider in her area who can meet her oral care needs
- With Paulette's consent, Nicole reaches out to her mother and NOW support coordinator to engage them on Paulette's multidisciplinary care team (MDCT) to assist in her assessment and care planning

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[redacted]

Nicole presents Paulette's case in Healthy Blue's daily rounds with our integrated Case Management team, comprised of Medical Directors, a psychiatrist, licensed PH and behavioral health (BH) clinicians, nutritionist, and the OAAS Liaison to assure we address Paulette's needs, identify additional resources, and address any gaps in care. Nicole will also work closely with our board-certified physical medicine and rehabilitation (PMR) specialist, who consults with Healthy Blue on complex cases, to further discuss Paulette's case.

## Assessment and Care Planning with Paulette

Nicole recognizes the urgency of Paulette's current situation and closely monitors and helps coordinate all aspects of her care and safety. Once Paulette is experiencing some pain relief and is open to completing the person-centered assessment and her individualized POC, Nicole schedules a time to meet at her preference. Paulette may choose to meet telephonically, through videoconferencing, or face-to-face. With Paulette's consent, Nicole includes the individuals she has selected to participate in her care, including her NOW support coordinator. If Paulette wants her mom to attend and she is unable due to her two jobs, Nicole coordinates her to participation by phone or a video call.

## Completing the Person-centered Assessment with Paulette

Nicole meets with Paulette at her preferred location and time to complete the assessment. Nicole understands the barriers to communication associated with dysarthria, as well as other factors that may be contributing to her speech, such as tooth decay and a possible infection affecting her breathing. She deploys several techniques to communicate with Paulette, such as making sure the room is quiet, asking to sit closer to her, and making eye contact. Nicole works with Paulette to identify the ways in which it is most comfortable for her to communicate, such as speaking at a slower pace, using eye contact, nodding her head, using hand gestures, and using a communication board. Nicole discusses assistive technology solutions that may be available through Louisiana Assistive Technology Access Network with Paulette and her mom, including special-purpose computers, positioning devices, and power lifts, as well as non-traditional types of technology, such as a Ring doorbell that can provide added convenience and safety.

Having ordered Paulette's wheelchair, Nicole turns attention to her health status and well-being, prioritizing her PH concerns requiring immediate attention. This includes a social determinants of health (SDOH) assessment and functional assessment to identify pertinent issues related to Paulette's independence and ability to remain in her home, as well as a caregiver assessment for her mom. Based on Paulette's assessment results, and with her consent to request protected information, Nicole works with her identified MDT to capture current services and provider treatment plans. If Nicole has difficulty identifying providers, such as a PMR specialist or neurologist, Healthy Blue's Network Development team works to identify any provider network opportunities, such as providers open to expanding their services in other areas, or out-of-network providers to engage in a Single Case Agreement (SCA).

Nicole explains that Healthy Blue's case management team will support Paulette and her MDT through clinical rounds to assure all gaps in care are addressed. In addition, Nicole talks to Paulette about her member rights, how to ask for help when needed, and how to file a grievance or appeal related to quality of care and access to the most appropriate care. They also talk about the availability of Healthy Blue's Community Health Worker (CHW), who can help Paulette locate additional resources as her needs change. Using motivational interviewing techniques, Nicole helps Paulette voice her priorities and life goals, and together they discuss her most pressing needs, challenges, and barriers.

**Breathing, Swallowing, Dysarthria, and Speech Challenges.** Nicole talks with Paulette about her breathing and swallowing abilities and how those may be related to her speech concerns, including dysarthria, her cerebral palsy diagnosis, a possible infection, the need for speech therapy, or loss of teeth. They talk about the PCP appointment she attended and any referral recommendations, such as completion of a speech language and swallow assessment by a Speech Language Pathologist. They also discuss connecting her with a dentist who has experience in treating individuals with SHCN like hers, who can work to understand her medical history, while offering an office that is accessible and has adaptive equipment.

They talk about her Individual Family Supports through her NOW waiver that meet her daily dental needs through brushing and flossing, as well as taking her to routine appointments with a dental specialist. Nicole explains that Paulette's speech may improve through speech therapy and offers to identify a speech therapist or based on her preferences. Nicole also shares information on Healthy Blue's Adult Dental Services value-added benefit (VAB) that provides free dental care, including a complete exam, cleaning, and x-rays.

**SHORT-TERM NEEDS – WITHIN 7 DAYS**

- Nicole works with Healthy Blue's UM department to authorize an urgent request for Paulette's new wheelchair
- Paulette, Nicole, and other participants of Paulette's choosing participate on her MDT and support the assessment and care planning processes
- Nicole arranges in-home skilled nursing to treat her HTN and wound care and address her medication management
- Nicole works with our Provider Services department to engage a PMR and rehabilitation specialist (in-network or by SCA) to oversee her care

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**Skin Breakdown and Wheelchair Needs.** Nicole reassures Paulette that her new wheelchair has been ordered according to her preferences and the specifications from the seating and positioning specialist, and they review the recommendations from the PCP. This includes reducing the amount of time she is positioned in her wheelchair, using shower or tub baths instead of bed baths, improving her nutrition and caloric intake, and daily care for her wounds related to her positioning and contractures. Nicole identifies medications the PCP has prescribed, such as antibiotics, and makes sure prescriptions have been filled and that Paulette understands the directions. Nicole and Paulette discuss the lack of care and services from her Individual Support provider. With the NOW support coordinator, they identify an in-home provider who can provide supports up to 16 hours a day and some night services if needed. They also talk about the availability of in-home skilled nursing to treat her wounds and HTN.

**Cerebral Palsy, Scoliosis, Spasticity, and Hypertension Challenges.** Paulette confirms her experiences with back and hip pain, limited mobility, and other symptoms such as headaches, nosebleeds, fatigue, and confusion related to her hypertension. They talk about the recommendations for her conditions resulting from her PCP appointment, which may include physical and occupational therapy, adjustments to her baclofen, pain management, and skilled nursing, as well as NEAT for all her appointments. They also talk about what medications she is taking to control her symptoms and whether she is taking her medications as prescribed. Nicole provides information on identifying and selecting a neurologist in Paulette's area through a SCA or a PMR specialist who can treat most of her conditions associated with her cerebral palsy and scoliosis affecting her nerves, spine, joints, ligaments, muscles, and tendons, as well as oversee all her care in conjunction with the PCP. Nicole will communicate with the PMR specialist on a regular basis to make sure we arrange the right care for Paulette and her needs and address any gaps in care.

Joint appointments, telemedicine, and value-based incentives are designed to facilitate this collaborative care. Nicole assures ongoing coordination between Paulette's PCP and the PMR. Nicole talks about additional types of support available to alleviate her pain, such as Healthy Blue's Chronic Pain Management program, offered as a VAB, that provides adult chiropractic visits (to help address her scoliosis). Once Paulette is enrolled in the program, she would also be eligible for therapeutic massage, acupuncture, psychophysiological therapy, and/or epidural steroid injections, if Paulette's PCP determines that she would benefit from those evidence-based interventions. Nicole also explains that she may also receive therapeutic aids such as massagers and pain-relieving creams for increased comfort.

**Joint Contractures, Left Hip Dysplasia, and Baclofen Dose Challenges.** Paulette shares information about her neurologist and the challenges associated with appointments due to distance and transportation. Nicole explains this can be resolved by locating a PMR specialist or neurologist in her area even if the provider is out-of-network. Nicole also lets Paulette know that she is eligible to receive free accessible transportation to all her pain management appointments once she is enrolled in Healthy Blue's Chronic Pain Management Program. Feeling as though five appointments may not be sufficient to see progress before moving to a surgical procedure, they talk about her orthopedist, whether Paulette feels she was making progress in physical therapy, and her understanding of and thoughts about potential surgery. They discuss obtaining a second opinion with another orthopedist to assess her spasticity needs, as well as the potential outcomes of surgery, which may include an increase in movement and reduction in pain, but also may include a significant recovery period. They also discuss how the lack of baclofen adjustments may be contributing to Paulette's muscle stiffness and tightness, as well as talk about increasing mechanical stretching or trying alternatives to her current services.

[redacted]

**Behavioral Health Needs**. Given the history of lack of care and her current health conditions, Nicole understands Paulette may be experiencing conditions like depression, loneliness, or anxiety and completes a comprehensive BH assessment that includes screenings, such as the Patient Health Questionnaire (PHQ-9) for depression and Beck Anxiety Inventory (BAI) for anxiety. Nicole shares the types of services available to Paulette, which may include individual therapy, psychiatric services including medications, and support groups for people with chronic conditions. Nicole and Paulette discuss the availability of telehealth options to assure her access to BH providers is not dependent upon her mom's work schedule and transportation. Nicole also explains to Paulette that after she enrolls in Healthy Blue's Chronic Pain Management program, she is eligible to receive an annual Calm app subscription to help teach her mindfulness techniques to help alleviate her anxiety.

**Habilitation Service Needs.** Given Paulette attends her habilitation program five days per week and spends approximately 10 hours per day in her wheelchair only coming out for brief changes, Nicole questions whether this is the best habilitation provider for her. They talk about the relationships Paulette may have developed with her caregivers and how she feels about selecting a new provider who will assure her habilitation services are at a level that meets her needs, including being moved from her chair routinely every three hours.

**Routine and Preventive Care Needs**. They talk about the types of routine care and services in which Paulette is participating, including wellness checks, immunizations, and gynecological services. Nicole tells Paulette that one of her specialists can serve as her PCP if she prefers, thereby reducing the number of appointments to attend. They also work together to identify a gynecologist in her area, with an accessible office and examination room, who has experience with SHCN like hers.

**Environmental and SDOH Needs.** Nicole works with Paulette to complete an environmental assessment to identify the supports she already has in the home and what else she may need. This may include a Hoyer lift, bath chair, wound care supplies, and cushioned mattress. Nicole addresses her temporary wheelchair repairs and adjustments until the new one is received and connects her with accessible transportation for her appointments. This includes transportation to her NOW services, such as habilitation services and all medical appointments, as well as potentially adapting her mom's car to assist in accessible transportation. Nicole encourages Paulette to share any personal or social goals she may have, such as going to school, attending vocational rehabilitation to obtain employment, or participating in activities at a local community

center or church with other individuals her age. Nicole also talks about organizations that can provide financial options and emotional support for those affected by cerebral palsy, such as ARC of Louisiana and the Cerebral Palsy Foundation.

**Caregiver Needs and Supports.** During the person-centered assessment and care planning meeting, Nicole talks with Paulette's mom to identify any support needs she may have and how they can help reduce her stress level and make it more manageable to attend appointments. Nicole educates her on her daughter's conditions, needs, and how to ask for help or share concerns regarding her daughter's well-being and the healthcare Paulette is receiving. Nicole asks Paulette's mom if she could benefit from any respite or caregiver resources as she navigates attending appointments with Paulette and helps manage her care and services. They also talk about opportunities for Paulette's mom to be paid for caregiving, which will assist in providing additional income and may allow her to only work one job, as well as adapting her vehicle to accommodate her daughter's wheelchair through the waiver or Healthy Blue's Flex Funds to assist in Paulette attending appointments.

**LONG-TERM NEEDS – WITHIN 14 DAYS**

- Based on Paulette's preferences, the NOW service coordinator and Nicole arrange for a new Habilitation provider
- Nicole arranges for the assistive technology Paulette and Nicole identify as being needed and helpful in her home, such as power lifts and positioning devices
- Paulette and Nicole identify an orthopedist for a second opinion to assess her spasticity needs and surgery needs
- Nicole arranges for individual therapy for Paulette to address potential depression, loneliness, or anxiety

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### Developing Paulette's Person-centered Plan of Care

Led by Paulette and with input from her MDT, a person-centered POC is developed that reflects the assessment results, which includes Paulette's conditions, needs, goals, and preferences, as well as the services, supports, providers, and resources that will help her achieve her goals. Nicole works with our Case Management and UM teams to plan accordingly for the PCP to request services to make sure Paulette gets what she needs quickly. Nicole assures all services requiring authorization are approved and attends daily clinical rounds with Healthy Blue's integrated Case Management team to address any gaps in care and identify additional resources to meet her needs.

As part of the POC, Nicole works with Paulette to develop a crisis plan that incorporates what she should do in urgent situations, such as providers not showing up for scheduled appointments, equipment failure, and when she has questions, is feeling ill, or feeling overwhelmed. This may include contacting her mom, Nicole, her PMR specialist or BH provider, and Healthy Blue's Member Services Line, 24/7 Nurse Line, and 24/7 BH Crisis Line.

## 2.6.7.5.2 Improving Access to Assure Timely Service Delivery

Given the quality of care, gaps in care, provider network, and communication issues that have negatively affected Paulette's health and well-being, Nicole files a detailed report to Healthy Blue's Quality Management team for a quality of care review, which examines all medical records and Paulette's utilization history, including the dated requests for wheelchair(s) and determines if a report to adult protective services and LDH is needed.

Our quality of care review process results in the following systemic solutions:

- Assuring that all Case Managers and providers are educated on policies and procedures related to NEAT benefits and VABs for Paulette and other non-ambulatory members
- Increasing the use of telehealth and MDT team meetings for the coordination of care
- Assuring collaboration of care between Paulette's PCP with waiver service providers and integration of PMR consultants in the care of members with clinical presentations like Paulette's
- Value-based incentives to improve the quality of care for members with SHCN and training on implicit bias which may lead to health disparities in members with developmental and physical challenges

To assure Paulette has continued access to the services and supports identified on her POC, Nicole works with Paulette to develop a contact plan based on her preferences, which includes frequency and modality, such as in-person, telephonic, text, and email contact. Nicole also identifies providers who have after-hours and weekend availability, as well as telehealth capabilities to assure she has a variety of options for accessing her care.

Nicole works with Paulette and the NOW support coordinator to schedule routine MDT meetings, inviting Paulette's self-selected participants, at least every 30 days or more often to update her POC as she progresses in care, as her needs change, and based on her preferences. Nicole assists Paulette in scheduling appointments, arranges NEAT as needed, and follows up after her appointments by reaching out to Paulette and her providers to make sure she is attending appointments and identifies any additional recommendations, such as the orthopedist second opinion recommending a change in provider or a referral from her dentist to an orthodontist to address her oral needs. This also includes completing a reassessment should Paulette experience a decline in her PH or BH needs or experience changes in her caregiving or SDOH needs.

## 2.6.7.8 Reducing Complexity for Member Access to Needed Care

Healthy Blue's clinical expertise and focus on adolescent health and behavioral health (BH) through an integrated approach, as well as our case management process, robust provider network, and creativity in meeting each member where they are, provides for effective care for youth with high-risk conditions and behaviors and their families. Meeting each member's unique and urgent needs sometimes includes creating a single case agreement (SCA) with an out-of-network provider to address the member's specific person-centered treatment plan requirements.

## 2.6.7.8.1 Addressing the Acute and Chronic Components of Kyra's Care Needs

Given the seriousness of Kyra's needs, both immediate and ongoing, our Case Management team identifies her with Special Health Care Needs (SHCN), assigns a Tier 3 Intensive Case Management level, and engages a Case Manager for immediate outreach. Our Case Manager, Tina, is a licensed mental health professional with experience and training in trauma-informed care, motivational interviewing and working with youth with high-risk behaviors, including eating disorders.

Based on training and experience with this population, Tina understands that individuals who have accessed care for an eating disorder may not get the intensity or length of inpatient treatment they need to stay in recovery following discharge. If the member has not received the right treatment in the right duration with the right supports, it makes it difficult for the member and family to maintain progress long-term. Tina reviews Kyra's care and participation in services through Healthy Blue's case management system, Health Intech, which provides a holistic view of her care with Healthy Blue, and the Elli™ platform, which allows us insight into care she may have received under another MCO. Based on her review, Tina understands the member's urgent needs and reaches out immediately to Kyra and her parents to:

- Discuss Kyra's current health status and well-being.
- Support Kyra in sharing her understanding of the seriousness of her condition and her willingness to engage in the care, services, and supports she needs for recovery.
- Support Kyra's parents in their concern for and commitment to their daughter's health, safety, and recovery.
- Schedule an urgent appointment with Kyra's PCP to assess her medical needs and provide recommendations for her ongoing care.
- Offer Kyra's pediatric psychiatrist, who has an established relationship with Kyra, our free Telehealth OS solution that allows providers to have HIPAA-compliant virtual services. If the provider is unable to do so, we will educate the parents about the availability of One Telemed services, providing access through telemedicine to licensed psychologists, therapists, clinicians, dietitians, and psychiatrists with expertise in eating disorders. If Kyra and her parents prefer to change providers and work with one in-person, we will help to locate a pediatric psychiatrist between 15 to 30 miles from the family home, which may require a SCA, and arrange an urgent evaluation and recommendation for her care.
- Identify a private-pay nutritionist or dietician in their area who can engage immediately with Kyra and family to begin offering nutritional evaluation, counseling, education, and meal-planning services — for example, ***Healthy Blue negotiated an SCA with a nutritionist and a local eating disorder specialist for a member from Houma, with similar needs as Kyra upon discharge from an inpatient eating disorder program***.
- Schedule a time for Tina to meet with Kyra and her parents at a time and place of their preference.

Given the State's overall gaps in inpatient and psychiatric residential treatment facilities (PRTFs) for eating disorders, Healthy Blue's Network Development team will work to identify out-of-network providers as close to the family as possible, with whom we can engage through a SCA. This includes researching the appropriateness of and outreaching to the facility that was recommended to the family. All licensed PRTF facilities are in the Healthy Blue provider network and 100% of our members have access to a Louisiana PRTF if needed.

### KYRA – 13-YEAR-OLD AND HER FAMILY

Individuals struggling with eating disorders often need intensive specialized treatment, which can often be difficult to locate. Kyra's declining health and recent hospitalization creates an urgent need to engage the family, assess her current needs and the types of progress in previous treatments, and work with the family to determine the best option for Kyra's care, whether in-state or out-of-state.We have long-standing relationships with providers, in and outside of our network and Louisiana, and collaborate with them to develop strategies that are tailored to the individual needs of members with similar needs as Kyra, which includes an integrated approach with support from her Case Manager, Tina, to address her physical and behavioral health needs concurrently.

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### IMMEDIATE NEEDS – WITHIN 72 HOURS

- Tina reaches out to the family to discuss Kyra's well-being
- Tina arranges a telehealth session with Kyra's pediatric psychiatrist through One Telemed
- To begin identifying treatment options and a new psychiatrist closer to the family home, Tina begins working with our Provider Services department

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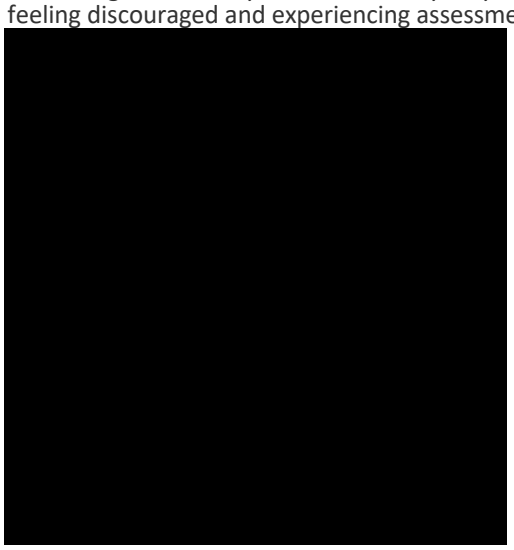
With consent from Kyra's family and prior to their meeting, Tina reaches out to the previous treating hospital, psychiatrist, and PCP to gather more information on her progress in care, previous assessment results, discharge plan, and participation in after-care following discharge.

## Completing Kyra's Integrated, Person-centered Assessment

Tina recognizes that Kyra and her family may have participated in several screenings and assessments and may be feeling discouraged and experiencing assessment fatigue, as well as not have the information they need to make informed decisions for their daughter's care. When meeting with the family, Tina encourages the family to share their feelings about Kyra's illness and the stress they may experience being away from her previously and potentially again.



Tina empathizes with them and reassures the family that we will work with them and her providers every step of the way to support every aspect of their daughter's treatment and recovery. Tina understands that families of individuals with eating disorders often experience a variety of feelings, such as shame, guilt, and believing that the individual has the ability to control their behaviors. As a result, she works to help them understand that anorexia is a complex illness that results from a combination of biological, psychological, and environmental factors and requires a holistic care team of BH, physical health (PH), and nutrition experts to identify and wrap the member with the services she needs.

Using motivational interviewing, Tina gathers information from the member and parents about her hospitalizations, including anything that stood out for Kyra as being significant or helpful in her progress. This may include individual and family outpatient therapy, such as Functional Family Therapy (FFT), Cognitive Behavioral Therapy (CBT), and Eye Movement Desensitization and Reprocessing (EMDR) therapy, medication adherence, and follow-up appointments with her PCP and psychiatrist. They also discuss any services her parents have engaged in, with her or on their own, such as family therapy and support groups.

Together, they work to identify and understand social, physical, genetic, and psychological factors related to her eating disorder. This includes talking about Kyra's biopsychosocial history, including pediatric care (immunizations, wellness care), major illnesses, behavioral concerns (obsessive-compulsive disorder [OCD], anxiety, and body dysmorphia), eating behaviors, school performance, extracurricular interests, and social relationships (including bullying). They talk about any adverse childhood experiences, such as family violence, divorce or separation, and emotional, physical, and sexual abuse. They also talk about the ways in which Kyra was disciplined and for what types of behaviors. The family shares any social determinants of health (SDOH) that may have affected the family while Kyra was growing up or may be experiencing currently, such as housing, food, and financial security.

**SHORT-TERM NEEDS – WITHIN 7 DAYS**

- Through an in-person meeting, Tina assesses Kyra's and her family's needs
- Tina talks with Kyra and her family about treatment options, including inpatient and outpatient services
- Led by the family, Tina develops Kyra's plan of care that includes out-of-state inpatient services

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## Developing Kyra's Multidisciplinary Team

During the assessment, Tina talks to the family about developing a multidisciplinary care team (MDT) that is comprised of professional and non-professional individuals of their choosing that will assist them in developing a Plan of Care (POC) that meets their needs. This includes Kyra's and her family's strengths, needs, goals, and preferences, as well as the providers and services they choose to meet their goals.

They discuss the family's natural supports who they would like to participate, such as family members, friends, and teachers. Tina, the Case Manager, shares additional options who can help with identifying and accessing providers, services, and resources, such as Kyra's pediatrician and psychiatrist, as well as others such as a therapist, nutritionist, facility staff, and Healthy Blue's Medical Director, depending upon Kyra's and the family's choices for their care pathway. This may include an intensive outpatient program (IOP) with wraparound services in the home or inpatient treatment, with a discharge plan for assuring a safe and successful transition home or a step-down opportunity before returning to make sure Kyra and her family have the tools they need.

## Developing Kyra's Holistic, Person-centered Plan of Care

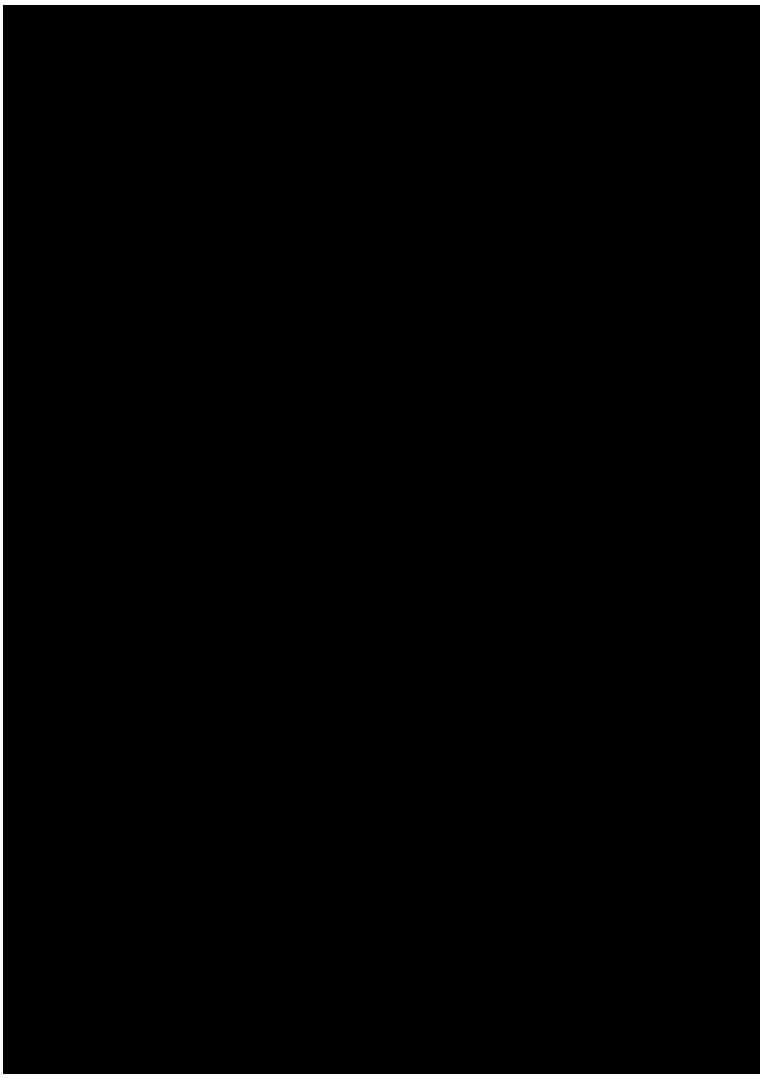
Led by the family, the MDT talks about identifying and arranging for services and supports during the process of the family determining the most appropriate environment for Kyra's care. Depending on the recommendations from her pediatrician regarding her health and safety, Kyra's care pathways may include IOP, OP with wraparound

services through Children's System of Care or inpatient care. Tina shares that while Healthy Blue will work diligently to locate in-state supports and services, if we are unable to locate in-state supports and services, we will look for out-of-state providers that are best suited to her needs, including the eating disorder center recommended to them in another state.

Regardless of the location of the member's treatment, Tina will conduct simultaneous care planning activities to assure we quickly engage her care, including:

- Assuring the pediatrician feels her acute needs are now stable and the provider has all the information needed to help drive the best chronic care Arranging for a psychiatrist with expertise in eating disorders to evaluate Kyra's needs
- Engaging a nutritionist, such as through Children's Hospital New Orleans or a Federally Qualified Health Center in the family's area and identifying opportunities for tele-nutrition services

Engaging Kyra and her and parents in evidenced-based interventions, such as FFT, CBT, or EMDR therapy. Family therapy may be helpful depending on the causes of Kyra's anorexia and how the parents are dealing with the situation. Requesting that Kyra's psychiatrist complete the Child and Adolescent Level of Care Utilization System (CALOCUS) to assist in identifying the most appropriate level of care for Kyra. Identifying additional resources for the family, such as the Ochsner Clinic Foundation, which offers online support groups for families and Kyra and nutritionist services, or the National Eating Disorder Association that can help identify providers in the area with eating disorder expertise. Working with the family to determine the best care pathway for Kyra based on her treating physicians' recommendations, such as in-state outpatient treatment with an eating disorder specialist with wraparound services in the home, inpatient, or PRTF treatment. Understanding Kyra and her parents may be hesitant to be away from one another again, Tina discusses the ways in which we can facilitate contact, through telephonic, video conferencing, and in-person visitation. Tina also talks to the family about the engagement of Healthy Blue's MDT that will review Kyra's and family's needs during daily case rounds to identify any gaps in care and support discharge planning to assure a safe and successful transition home. The MDT is comprised of our Medical Directors, Case Management and Utilization Management Clinicians, a nutritionist, and a psychiatrist who can brainstorm on ways in which we can support Kyra and her family.



## Arranging for and Monitoring Services on Kyra's Plan of Care

Depending on the recommendations from Kyra's treating physicians, Tina speaks with Kyra and her family about the two potential care pathways for her ongoing care, as described in Table 2.6.7.8-1.

*Table 2.6.7.8-1. Care Pathways for Kyra Based on Her Treating Physicians' Recommendations*

| Level of Care | Tina's Responsibilities |
|---|---|
| **Outpatient Treatment with Wraparound Services** | ▪ Arranging for her pediatrician to complete a full evaluation, including blood work to identify low levels, such as calcium, sodium, and potassium, as well as an EKG to determine Kyra's heart functioning<br>▪ Identifying and arranging a SCA with an IOP eating disorder specialty program that provides individual and group programming that will educate her on her illness, help her develop coping, self-management, and relapse prevention skills, and prepare her for returning to her home and community<br>▪ Engaging a psychiatrist with eating disorder expertise in Kyra's area that can identify and address any medication needs<br>▪ Selecting a therapist with eating disorder and CBT or FFT expertise that works with Kyra and her family to identify and understand distorted thinking that causes and perpetuates specific food and weight related behaviors<br>▪ Arranging for a nutritionist or dietician, locally or through telehealth, to assist Kyra in addressing distorted and irrational thinking about food and weight; exploring feelings related to hunger and fullness, metabolism, and body image; and learning to plan meals that addresses Kyra's lack of important nutrients, such as carbohydrates, protein, fats, vitamins, minerals, and fluids<br>▪ Addressing any SDOH through community-based resources, such as making sure the family has access to nutritious foods by registering with Supplemental Nutrition Assistance Program (SNAP) and financial resources by applying for Supplemental Security Income (SSI)<br>▪ Helping the family manage and understand Kyra's treatment plan and complications surrounding her condition, we work with Families Helping Families and offer BH peer supports when it is appropriate<br>▪ Sharing information on the Coordinated System of Care (CSoC) that may prevent out-of-home placement by providing structured, wraparound services and helping them determine if this is an appropriate alternative for Kyra and her family |
| **Inpatient Treatment** | ▪ Identifying and securing Medicaid treatment facility that specializes in the medically necessary services Kyra needs (out-of-state if in-state is not an option) — if unable to do so, working with key Healthy Blue departments to follow State policies and procedures for executing a SCA and reimbursement plan with a non-Medicaid provider<br>▪ Working with Kyra to understand where she is going and what the facility will provide for her<br>▪ Identifying and arranging the supports the family may need, such as providing transportation for Kyra and a family member accompaniment to the facility, arranging family participation in services through telehealth<br>▪ Initiating discharge planning with Kyra, parents, and facility staff upon her admittance<br>▪ Arranging for parent participation in family therapy and visitation with Kyra through video conferencing<br>▪ Participating in the facility's rounds for Kyra on a weekly basis to assure she is stable and making progress in her treatment<br>▪ Supporting the parents in preparing for their daughter's return home and continued recovery, such as engaging them in individual or couples therapy, attending support groups, and working with the nutritionist to better understand their daughter's condition, dietary, and meal-planning needs |

As part of the POC, Tina develops a crisis plan that supports the family in addressing urgent events, such as if Kyra's physical conditions worsen, including an urgent appointment with her PCP, taking her to urgent care, going to the emergency department, if appropriate, or calling Healthy Blue's 24/7 Nurse Line or BH Crisis Line. Tina also develops a contact plan with Kyra and her family that includes how often and in what modalities they will communicate (in-person, phone, text messages, and emails). Tina monitors Kyra's participation in services by reaching out to her and her family, talking to her providers, and reviewing provider claims.

If Kyra participates in treatment out-of-state, Tina works with the family and treatment center on discharge planning upon her admittance. Tina attends treatment center meetings that provide information on Kyra's participation in care and progress towards her goals, as well as develops a plan that supports a safe and successful transition home that includes wraparound services in the home to support her ongoing recovery.

Upon Kyra's completion of treatment, Tina arranges for her transportation home with a parent and follow-up appointments with her PCP for a well check and psychiatrist to address any ongoing medication needs aligned with the treatment center's recommendations.

Tina also arranges for ongoing therapeutic services, such as FFT or CBT, to continue the progress she has already made, supports the parents in making appointments, and arranges transportation if needed. Tina continually works with Kyra and her MDT to adjust her POC as her needs change and participates in clinical rounds to assure any gaps are identified and addressed.

## LONG-TERM NEEDS – WITHIN 2 WEEKS

- Tina works with our Case and Utilization Management teams to arrange for Kyra's admission and transportation to the facility
- Led by Kyra's parents, Tina arranges therapy and identifies a support group through Families Helping Families to better understand how they can support Kyra
- Upon Kyra's admittance, Tina works with the facility to arrange family visitation and participation in counseling and begins discharge planning

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## 2.6.7.9 Maximizing Member Health by Addressing Health Disparities

We recognize that sickle cell disease (SCD) is a genetic disorder that disproportionally impacts African American, Hispanic, Middle Eastern, Asian, Indian, and Mediterranean populations, which leads to additional health disparities, less access to healthcare resources, and worse health outcomes compared to other diseases. Healthy Blue works to address the challenges our members with SCD face, such as a lack of providers who specialize in SCD (particularly in rural areas); lack of provider training in implicit bias and health equity; barriers to obtaining appropriate pain treatment (often misinterpreted as drug seeking behaviors); and the use of treatments, such as hydroxyurea, that reduce the burden of the disease.

In our experiences supporting members with SCD, frequent emergency department (ED) use suggests that Alex is likely experiencing significant pain and has barriers to accessing the care needed to manage his conditions and symptoms. If Alex was enrolled with Healthy Blue, his second ED visit would have triggered a need for case management outreach through our person-centered **Elevate | Population Health** approach, which includes a comprehensive analysis to identify and prioritize health disparities and overcome challenges in our communities.

Recognizing Alex's distrust of the healthcare system, feelings of discrimination, and the role that implicit bias plays in the delivery of quality care to diverse populations, our focus on driving health equity complements our data-driven, evidence-based population health approach by addressing and eliminating racial and ethnic health disparities and improving access to resources affecting social drivers of health. In this model, we identify health disparities, determine root causes, deploy targeted interventions, assess effectiveness, and as indicated, refine our approach to optimize outcomes. In our communication with Alex, we will ask who he wants to be a part of his multidisciplinary care team (MDT) and encourage self-management of his Plan of Care (POC) and treatment goals. To meet Alex where he is, early and often, we use our Community Health Workers (CHWs) — who live, work, and are a part of the communities we serve — to engage and build a trusting relationship with him. Because he has experienced healthcare discrimination based upon his race, Alex is more likely to successfully engage with someone of the same race or similar ethnicity and/or someone who has received implicit bias training, as emphasized by our model, and has knowledge of the health disparities individuals may face across Louisiana.

### ALEX – 25-YEAR-OLD MALE

Alex has a complex medical history of sickle cell disease, acute chest syndrome, vaso-occlusive crises, avascular necrosis of the hip, and has experienced multiple strokes and suffers from chronic pain. In the past 6 months, he has had 10 emergency department visits for vaso-occlusive crises. Alex's experiences with racial discrimination, health disparities, and unstable housing and communication avenues are primary concerns that we will address early to promote his engagement in care. Healthy Blue understands and has proven experiences identifying and addressing SDOH impacting Alex's ability to access care for his physical and behavioral health needs. As we better understand the reasons and root causes of Alex's ED use, we anticipate that that there will likely be SDOH and behavioral health needs that we will need to fully understand so that we can offer support to implement the most appropriate interventions. By addressing his BH and SDOH needs, Alex's Case Manager, Sarah, can help him focus on the PH needs associated with his SCD.

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## 2.6.7.9.1 Addressing Alex's Needs

Using our robust data collection and our Health Intech data analytic capabilities, we identify vulnerable populations and emerging trends, including combining race, ethnicity, and cultural information to address issues of disparity and equity. Our case management team also uses Elli, a risk intelligence solution, to review any previous service use history, such as physical health (PH) and behavioral health (BH) diagnoses, participation in mental health or substance use treatment, and prior ED visits and hospitalizations. Since Alex has 10 ED visits in six months, he will also trigger as a member with Special Health Care Needs (SHCN) and the intensity of outreach efforts increase to engage him in case management. Using the combination of internal and external information, including comprehensive data collection, and our assessment process collaboratively with Alex and his MDT, we assign Alex to Tier 3 intensive case management. The assigned Case Manager, Sarah, is a registered nurse with experience working with members with SCD and has significant cultural competency training that includes the understanding of health disparities in parishes across the State. In addition to the escalating pain and healthcare concerns, our case management approach focuses on the primary issues creating a significant barrier to care — Alex's mistrust of the healthcare system and identified health disparities, the exacerbation of SCD symptoms, and social support needs.

### IMMEDIATE NEEDS – WITHIN 72 HOURS

- Sarah reaches out to Alex and engages a CHW to go to his last known address
- Upon engagement with Alex, Sarah assesses the seriousness of his housing situation and begins developing a relationship
- Sarah provides a cell phone to Alex to improve communication and encourage his participation in care

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### Reaching Out to Alex

First, our Healthy Blue team uses a person-centered and culturally sensitive approach in each of our interactions with Alex — recognizing

that each negative interaction that Alex has experienced has led to more distrust in the healthcare system. Our case management team receives comprehensive person-centered training that includes using motivational interviewing, understanding cultural biases and stereotypes, and ultimately building trust to assure a collaborative relationship with Alex. [redacted]

Given Alex's escalating conditions, Sarah knows it is essential to reach Alex soon. Due to his unstable housing, lack of a reliable phone, and distrust of the healthcare system, Healthy Blue deploys a comprehensive approach to locate and engage Alex:

- Engaging a field-based CHW or Navigator to go to Alex's last known address to connect with him — these efforts include going out on different days and different times to maximize opportunities to connect with Alex. Upon engagement, these employees will help guide Alex in navigating the healthcare system and linking him to the follow-up care that will improve his health outcomes.
- Proactively reaching out to the provider Alex last saw and the ED that Alex most commonly uses to request they notify Sara when Alex presents for services again — at which time, Healthy Blue will dispatch a CHW or Navigator to go to the provider office or ED to connect with Alex.
- Providing resources to Alex that will encourage him to engage in care, which includes providing him with a cell phone that will allow him to call his CHW or Navigator, Case Manager, providers, and others involved in his care, transportation to appointments, [redacted]
- Contacting the pharmacy where Alex obtains his medications, if he currently is taking medications, to request an alert when he presents with a prescription refill.
- Calling and sending postcards to Alex's last known address.

Our CHW reaches out to Alex in person and can complete the HNA and arrange an in-person meeting with Sarah, if she is having difficulty connecting with him. If we are only able to connect with Alex telephonically, Sarah first talks to him about his current well-being and identifies any urgent or emergent needs. If Alex is in crisis, Sarah offers to secure transportation for him to an urgent care or ED, if needed, and meet him there. If Alex is not in crisis, Sarah arranges a time and location of Alex's choice to meet in the community to complete the HNA and assessment, develop a POC, identify and schedule appointments with providers with SCD expertise, and arrange transportation if needed.

## Completing the Integrated Assessment with Alex

Sarah understands the importance of engaging Alex in a meaningful way initially to encourage his ongoing participation. This includes using active listening techniques to demonstrate his understanding and empathy for Alex's situation. Sarah encourages Alex to share his experiences with the healthcare system, including any racial or ethnic disparities, lack of providers with SCD understanding and expertise such as managing pain related to SCD, and reaction to being treated as a drug seeker. Sarah works with Alex to gather as much information as possible to understand his health literacy needs and inform his care planning, including what has worked for him, what has not worked, and when and by whom he has felt discrimination:

- **Current Medical Status.** Sarah talks to him about his current and previous symptoms and self-management skills, current and recent pain level, compliance with provider visits, recent ED use, and medication adherence.
- **Comprehensive Medical History.** Sarah realizes the complex PH needs associated with SCD and how Alex's history will help planning for his ongoing care, including:
  - Age of SCD diagnosis, onset of symptoms, and progression of symptoms
  - Family history of SCD and prognosis
  - Treatment participation as a child and treatment transition from youth to the adult system of care
  - Types of treatment providers, such as primary care, hematologist, pulmonologist, neurologist, cardiologist, retina specialist and frequency of care; stroke history and resulting complications
  - Self-care, such as adhering to medications as prescribed, receiving regular checkups, eating a healthy diet, staying hydrated, avoiding alcohol and smoking, getting adequate rest, and avoiding extreme temperatures
- **BH Needs (Mental Health and Substance Use Disorder).** Assesses and assures routine screenings for history of depression, anxiety, and self-harm ideation.

### HEALTHY BLUE RESOURCES AND INFRASTRUCTURE

In March 2021, in partnership with the Louisiana Public Health Institute, Healthy Blue hosted the first annual Symposium on Racial and Health Equity in Louisiana. The theme of the symposium was Achieving Racial Equity, and we brought together leaders from across the state to address topics including Systematic Racism and Implicit Bias in Public Health, the Poverty Cycle and Economic Development and Health, and Education, Criminal Justice, and Mental Health. To build upon the enthusiastic response to this symposium, we have launched a series of Racial Equity Learning Labs to increase understanding of health equity, social justice, and SDOH while building collective community strategies to create equitable practices, policies, and procedures that encourage and sustain diversity and positive changes.

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- **Social Determinants of Health (SDOH).** Identifies any barriers to Alex accessing needed care, such as unstable housing, food security, transportation, unemployment, economic stability, and education.
- **Community-based Resources.** Identifies necessary supports has Alex accessed through community-based organizations (CBOs), such as homeless shelters and food resources, as well as the Sickle Cell Association of South Louisiana, where he can be connected to certified sickle cell educators and receive peer support and advocacy.

[redacted]

To gather information and identify the best ways to support Alex, Sarah conducts an assessment, including the HNA (if it has not yet been completed in previous interactions with Alex) and a BH assessment. With direction from Alex, Sarah gathers information on the individuals in his life he would like to include on his MDT, who will support him in developing his POC and achieving the goals he sets for himself. This may include providers, family members, friends who allow him to stay with them, and CBOs who have provided him with resources.

## Person-centered Care Planning with Alex

Alex shares with Sarah his short- and long-term goals, which may include things like having providers that believe him when he tells them how he is feeling, learning to manage his health and pain better, obtaining permanent housing, and having lasting relationships and social interactions with family and friends. Sarah also incorporates Alex's strengths and preferences, as well as identifies needed providers with expertise in SCD in his area. The person-centered POC includes the following types of services, supports, and activities:

**Alex's SDOH Needs.** To better support Alex's engagement in the care he needs, Sarah first talks to Alex about the things that may be affecting when, how, and where he addresses his PH and any BH needs.

- **Housing Challenges.** Sarah talks to Alex about his barriers to safe and stable housing and the option of engaging Healthy Blue's Housing Specialist to determine possible housing solutions. The Housing Specialist will engage Alex in exploring and problem solving his current housing issues, including his needs, potential resources, and creative solutions, which may include reunification with family or friends, assistance with housing relocation, assistance with deposit or short-term rent through Flex Funds, or assistance with a referral to the local Continuum of Care's Coordinated Entry team for a housing assessment. Sarah may also consult with the Permanent Supportive Housing (PSH) Liaison to determine if PSH is a viable option for addressing Alex's housing needs.
- [redacted]
- **Additional SDOH Needs.** Sarah talks to Alex about other SDOH needs he may be experiencing, such as food and financial security, transportation, and employment opportunities. Sarah explains how she can assist Alex in accessing public benefits, such as applying for the Supplemental Nutrition Assistance Program (SNAP) and Supplemental Security Income (SSI) benefits if needed, as well as arranging transportation to appointments.

**Alex's PH Needs.** During the assessment and care planning process, Sarah learns more about why Alex is using the ED and works to determine and address the root cause. Sarah's priority for addressing each of Alex's PH needs are dependent upon the primary reasons he seeks emergency care. Sarah offers education, support, additional engagement opportunities to address those concerns or potential exacerbation of symptoms first. Our interventions include:

- Educating Alex on when to use the ED and other resources available to him, such as urgent care, the Healthy Blue 24/7 Nurse Line, and BH Crisis Line.
- Identifying and scheduling an appointment with a hematologist who can meet the healthy literacy and cultural needs of Alex who can act as or coordinate with his PCP; manage pain related to his vaso-occlusive crises, avascular necrosis of the hip, and chronic pain; and assure routine blood work. This may include the use of medications or other procedures, such as Adakveo® (crizanlizumab) infusion, allogeneic stem cell transplantation, or therapeutic apheresis.
- Scheduling appointments with a pulmonologist to address his history of acute chest syndrome and a neurologist to determine and address any long-term effects of his strokes.

- Making sure Alex receives education on and treatment for avascular necrosis of the hip, such as resting the joint, physiotherapy, the use of pain relief, and the availability of and complications associated with joint replacements, and bone grafts for people with SCD.

**Alex's BH Needs**. Sarah and Alex discuss any BH needs he may be experiencing, which may include depression, anxiety, and substance use that can often co-occur with individuals experiencing chronic conditions, struggling with pain, and as in this case, having experienced unfair treatment. They talk about options to support any BH needs, including trauma-informed individual therapy, Peer Support, support groups for individuals with chronic conditions, and psychiatric evaluation.

- **Offering Holistic Care and Community-based Supports to Alex.** We will connect Alex to any additional community-based supports that can better connect him in the community. In our experiences supporting members who have a distrust of the healthcare system, we will offer non-traditional supports such as alternative therapies and will cultivate a culture that encourages relationship development in a space that is culturally comfortable for Alex and can further build trusting relationships.
- Offering evidence-based non-pharmacologic alternatives to opioids for chronic pain management services through a pain management specialist and non-pharmacological alternatives,
- Engaging a nutritionist who can help educate Alex on his individualized nutritional needs based on his condition and living environment.
- Continuing the involvement of the CHW or Navigator to engage Alex to assist in locating additional community-based resources, such as the Sickle Cell Association of South Louisiana, and helping him navigate the system.
- Engaging our Member Advocate to assist Alex through the grievance and appeals process to address his history of discrimination and quality of care issues.

**Continued Engagement and Follow-up with Alex.** Sarah reminds Alex of his appointments, arranges for transportation, and participates in appointments upon Alex's request. Sarah explains the role of the Healthy Blue integrated case management team, made up of our Medical Directors, PH and BH clinicians, and other experts, such as a Nutritionist and Addictionologist. Alex's case is monitored daily through clinical rounds to assure Alex's needs are being met. This includes a reduction in ED visits, increased satisfaction with providers, improved medication adherence, and securing housing and a phone.

## 2.6.7.9.2 Systems and Policies That Support Alex Through Health Equity

Our focus on driving health equity complements our data-driven, evidence-based population health approach. We share LDH's goal to address health equity by focusing on improving population health and acknowledge that advancements in health equity can accelerate progress in addressing longstanding health disparities among groups such as African American members and rural residents. In our population health model, we identify health inequities, determine root causes, deploy targeted interventions, assess effectiveness, and as indicated, refine our approach to optimize outcomes. We promote health equity for Alex by:

- Assuring our grievance and appeals processes are culturally and linguistically appropriate to support our members in reporting racism, discrimination, and poor care quality
  - Informing Alex that we provide informational and educational materials in the language or alternative formats (audio, video, large print, braille) upon Alex's request
  - Assigning a Case Manager to Alex who is appropriate for meeting his health equity and disparity needs who has knowledge and experience working with SHCN, cultural competency training, and an in-depth knowledge of the parish challenges across Louisiana
  - Assuring Alex has access to culturally competent providers in our network that have similar ethnicity and spoken language as the populations we serve and the expertise to work with members with SHCN, even if it requires going out-of-network or using telehealth capabilities
  - Assuring our providers understand the challenges associated with pain management for individuals with SCD
  - Engaging Alex with CHWs who are trained in Peer Support principles, live and work in culturally diverse neighborhoods, engage members in case management, and connect them to resources in their communities
  - Offering and encouraging provider training on implicit bias and Health Equity
  - Reviewing and monitoring his care to identify any quality of care concerns

**LONG-TERM NEEDS – WITHIN 30 DAYS**

- Sarah provides Alex with education on appropriate use of the ED and alternatives in his community
- Alex and Sarah identify a nutritionist who can help him understand that affect of his daily diet on his conditions
- Healthy Blue's Member Advocate supports Alex in filing a grievance regarding his previous maltreatment

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### Healthy Blue's Health Equity Systems and Policies

Healthy Blue strives for our health plan staff and provider network to reflect the demographics of our membership. We have established policies and procedures, require staff and provider training that identifies and highlight any health disparities or discrimination indicators, and monitor quality data such as per race or location. We share LDH's goal to address health equity by focusing on improving population health and acknowledge that advancements in health equity can accelerate progress in addressing longstanding health disparities among groups, such as African Americans and rural residents. Our person-centered **Elevate | Population Health** approach incorporates health equity, cultural competence, and the influence of clinical and social factors on outcomes.

**Provider Cultural and Linguistic Appropriateness Through the Louisiana Health Equity Framework.** We understand that a diverse and culturally competent provider network can help build trust, reduce disparities, and improve health outcomes. Healthy Blue is dedicated to contracting with providers and other health professionals who value and are committed to serving a diverse population, and meet the cultural, ethnic, racial, and linguistic needs of all enrollees. To support this effort, we provide cultural competency training during provider orientation and on an ongoing basis in a variety of formats (webinars, online resources available in the provider portal, individual and group training, and more). MyDiversePatients.com — a unique collaboration between our parent company, Anthem, Inc. and Training Systems Design, Inc. — also serves as a provider resource, including trainings on topics like Reducing Healthcare Stereotype Threat and Building Trust.

**Health Equity Training Program for Employees and Contractors.** Healthy Blue has developed and implemented a variety of training programs focused on health equity. For example, all Healthy Blue staff and contractors are required to participate in the ***Becoming Culturally Competent*** training upon hire and must complete an annual refresher course thereafter. This training helps staff understand that delivering services to people of all cultures, races, ethnic backgrounds, sexual orientations, disabilities, and religions must occur in a manner that recognizes, values, affirms, and respects the worth and dignity of all. It also helps employees understand health equity is a lens that can help them rethink their interactions and the way they approach their work. Training topics such as cultural responsiveness, benefits of cultural competency, government regulations, overarching values, language resources, health-related beliefs, and cultural-specific health disparities.

# 2.6.7.10 Improving Outcomes for Pregnant Women with Substance Use Issues and Their Babies

Healthy Blue is committed to improving outcomes for pregnant women with substance use disorder (SUD) issues and their babies through a sensitive, holistic, and non-judgmental collaborative approach that begins with securing a strong rapport and trust with the member. This rapport and unconditional positive regard is crucial to engaging the member in high-quality, timely, and well-coordinated prenatal and postpartum care, specialized substance use treatment, mental healthcare, and health education. We are continually building our programs to support the member and provider, encouraging the use of evidence-based practices and tools to improve care and decrease risks associated with substance use during pregnancy.

## 2.6.7.10.1 Identifying and Engaging Nia Using Our Healthy Blue Systems

### NIA – 25-YEAR-OLD PREGNANT WOMAN

Pregnancy, coupled with mental health conditions, substance use, and high social determinants of health (SDOH) needs, can create an extremely stressful situation that may exacerbate Nia's feelings of discomfort, fear, and being overwhelmed. We recognize the importance of meeting Nia where she is and that it will take some time to earn her trust. As a result, her assigned OB Case Manager, Brianna, will be careful to use motivational interviewing techniques, such as honoring periods of silence and showing empathy through reflective listening, during interactions with her to begin developing a relationship and gather enough information to prioritize her needs and engage her in care, services, and supports for her and her baby.

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Early identification is key to engaging Nia in the care she and her baby need to promote a healthy pregnancy outcome. If Nia is new to Healthy Blue, she will be identified upon enrollment through our predictive modeling process that identifies her pregnancy and multiple substance use-related emergency department (ED) visits, which trigger immediate notification to our Case Management team. We also have additional reports that may identify her, including our Special Health Care Needs (SHCN), previous preterm pregnancy, diabetes, SUD, and hypertension reports.

We may also identify her pregnancy through real-time admit, discharge, and transfer (ADT) alerts, the Notice of Pregnancy process, our SCHN report, claims data analysis, the results of the health needs assessment, and from referrals. Referrals may be both internal (Member Services staff, the 24/7 Nurse Line or Behavioral Health [BH] Crisis Line, Case Managers, and Utilization Management staff) and external (member self-referral, family members, providers, external case managers, and agencies).

Using data analytic capabilities and our robust data collection through Health Intech, we identify vulnerable populations and emerging trends, including combining race, ethnicity, and cultural information to address issues of disparities and equity. Upon notification, our Case Management team reviews service use history, such as physical health (PH) and BH diagnoses, participation in mental health or substance use treatment, ED visits and hospitalizations, medications, and previous pregnancies, including prenatal and postpartum care. Nia is assigned to Tier 3 case management and an OB Case Manager, Brianna, who has BH expertise and is experienced in trauma-informed care. Brianna has access to our integrated Case Management team for consultation, which includes our Medical Directors, PH and BH clinicians, and [redacted] to make sure pregnant moms' and their babies' needs are identified and met.

### Engaging Nia in Needed Care for Her and Her Baby

Given Nia's unstable housing situation, opioid use disorder (OUD), and serious and persistent mental health conditions (Schizoaffective Disorder/Major Depression with psychosis), Brianna mobilizes multiple avenues to reach and engage her, including using our outreach program that encourages women to seek prenatal services during the first trimester of pregnancy. Our Healthy Blue **Elevate | Advancing Maternal & Child Health** approach provides a comprehensive suite of culturally competent solutions dedicated to promoting and supporting the health of our pregnant members and their babies. Since Nia's pregnancy is high-risk due to her substance use, comorbid mental health conditions, and lack of safe and stable housing, Brianna's immediate focus is Nia's safety and connecting her with prenatal care, a BH specialist, and our Housing Specialist to address these needs quickly. This may include encouraging a fully integrated setting to maximize collaboration between providers, such as a Federally Qualified Health Center near Nia's current living situation. If multiple providers are involved in her care, we obtain consents for communication as early as possible.

[redacted]

Our Member Services Representatives and Brianna reach out to Nia telephonically at different times and on different days, three days a week for three months until we reach her. Brianna engages a Community Health Worker (CHW) with Peer Support training to go to

Nia's last known address to engage her, as well as connect with community-based organizations (CBOs) that provide holistic services for individuals with substance use issues, such as Odyssey House, Claire House, or Grace House. Brianna also reaches out to her previous providers, pharmacies where she fills medications, and the EDs she has visited to request staff alert Healthy Blue if she presents for services.

**Using Prenatal and Postpartum Programs to Engage Nia.** Brianna's priority is to work closely with Nia to develop a trusting relationship, help her understand the effects of substances on her and her baby, meet her where she is to engage in care, and provide her with information on the programs, services, supports, and resources available to her. [redacted] Based on Nia's preferences, and ongoing motivational interviewing and assessment from Brianna for readiness to change, she will also be connected to needed OUD services that will be simultaneously coordinated with her prenatal and postpartum services and includes services, such as medical assisted detox, MAT, intensive outpatient, inpatient, and Peer Support services.

**HEALTHY BLUE RESOURCES AND INFRASTRUCTURE**

Healthy Blue is committed to bringing Mindoula's StrongWell™ program that offers their Substance Exposed Pregnancy program, which has two parallel lines of services. The program focuses on specialized urgent care designed to support pregnant women with opioid use disorder and substance use disorder (OUD/SUD) in safely stabilizing their medication through Medication Assisted Treatment (MAT) and addressing SDOH needs prior to the birth of their babies. Longitudinal support through StrongWell behavioral health (BH) care teams, comprised of 24/7 tech-enabled counselors, peer advocates, nurses, and resource navigators, will work with Healthy Blue members and Case Managers to reduce the occurrences of NICU, inpatient, and ED use, keep families together, reduce long-term developmental issues, and act as a natural extension of the care and support provided to substance dependent pregnant women across the State.

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## 2.6.7.10.2 Prioritizing and Addressing Nia's Needs

Brianna works with Nia to identify and prioritize the care and services that address her needs based on her choices for her pregnancy, addiction, and mental health needs. Understanding the risk of losing touch with Nia following their meeting, Brianna first identifies any needs that warrant emergent intervention and works with her to complete a person-centered assessment, develop her Plan of Care (POC), and arrange for services in one sitting.

### Completing the Assessment with Nia

They start by discussing Nia's safety and her current substance use, including the last time she used, what substances she is using, any symptoms she is experiencing at this time, and her readiness to change. The also talk about any symptoms Nia may be experiencing related to her BH diagnoses, such as delusions, hallucinations, episodes of depression, manic periods of high energy, self-harm ideation, and any other medications she is taking, prescribed or otherwise. Brianna supports her in identifying any natural supports and resources she has, including family, friends, and any community-based programs whose resources she accesses, such as shelters for pregnant women, soup kitchens or food pantries, and clothing assistance.

Brianna shares with Nia the risks of her opioid use on her pregnancy, including poor fetal growth, preterm birth, stillbirth, and birth defects, which may include a NICU admission for neonatal opioid withdrawal syndrome (NOWS). Brianna recognizes Nia may also have other children and talks to her about how her children and new baby can be Healthy Blue members and receive the services they need, including EPSDT, Early Steps, and dental care. They also discuss how we work closely with the Department of Children and Family Services (DCFS) to support families in the home by providing wraparound services and supports to prevent out-of-home placement. Brianna also helps Nia understand that if her baby is born exposed to substances, the hospital is required to notify DCFS to assure the baby's safety and other children who may be in the home.

### Prioritizing Nia's Needs Based on Her Assessment Results

***Working with Nia, Brianna develops an integrated, person-centered POC that prioritizes her needs, which may be fluid, occur simultaneously, or be addressed in succession based on her care pathway choice for herself and her pregnancy.*** For example, if she chooses to engage in inpatient services for her substance use, then her housing needs become secondary to other needed services. However, if she chooses to participate in outpatient treatment, addressing housing is primary, along with other SDOH, such as food security, transportation, and financial security. Brianna also works with Nia to identify people she would like to participate in her healthcare decisions through a

multidisciplinary care team (MDT), which may include natural supports, such as family, friends, and neighbors, as well as providers, Peer Support Specialists, CBOs, and CHW.

**PRIORITY ONE — Nia's Engagement in Services and Supports That Address Her Safety and Honor Her Choices.** The severity and specific needs related to her OUD, benzodiazepine use disorder, and stimulant use disorder, in addition to co-morbid schizoaffective disorder and major depression disorder with psychotic features, are unknown. Brianna works with Nia to select an OB-GYN and the appropriate BH specialists who can assess what types of substance use and mental health treatment options are the safest for her and her baby. We recognize that different BH treatment options may be recommended based on factors such as her willingness to participate, how far along she is in her pregnancy, and type, amount used, and quantity of the substances currently in her system.

**SHORT-TERM NEEDS – WITHIN 7 DAYS**

- Brianna helps Nia select an OB-GYN and schedule an appointment for a prenatal evaluation to determine her and her baby's well-being and ongoing needs
- With Nia's consent, Brianna schedules an appointment with a BH provider to assess her needs for OUD/SUD treatment, including MAT for detox and pain management
- Brianna engages a Peer Support Specialist through the LGE in Nia's area to support engagement in services

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In addition, Nia's current lack of stable housing creates safety concerns for her and her baby and any additional children she may have. Brianna immediately engages Healthy Blue's Housing Specialist and Permanent Supportive Housing Liaison to assist in identifying safe and stable housing options for Nia. Brianna helps Nia understand the housing options available to her, including completing and submitting applications for housing, such as for Permanent Supportive Housing (PSH), Housing Choice Voucher program, and the American Recovery Act for housing and utility services. [redacted] to that are available to her including Mental Health Rehabilitation services such as Community Psychiatric Support and Treatment, Assertive Community Treatment, Psychosocial Rehabilitation, and crisis services so that she remains in the community.

**PRIORITY TWO — Nia's Engagement in Holistic Healthcare for Her and Her Unborn Baby.** Brianna works with Nia to understand that babies of mothers who do not get prenatal care are three times more likely to have a low birth weight and five times more likely to die than those born to mothers who do get care. Helping Nia understand the importance of OB healthcare is one of Brianna's priorities. They talk about prenatal care reducing the risks during her pregnancy and increasing the chances of identifying any problems or complications before they become serious, as well as what to expect in prenatal appointments. Priority services include the following:

- **Prenatal BH Care.** Brianna shares information about the importance of monitored detoxification during pregnancy, if clinically indicated, and talks to Nia about her willingness to participate in services to assure her and her baby's safety. Brianna stresses the importance of recovery and shares information about the opportunities following detox to participate in inpatient treatment or an intensive outpatient program (IOP). If a full detox is not recommended, Brianna talks to Nia about the benefits of MAT during pregnancy, with the goal of participating in an inpatient treatment and recovery center after her baby is born. While multiple care pathways offer a variety of services to assist her in her recovery, inpatient treatment offers her a safe and structured environment to allow Nia to focus just on her, her baby, and her recovery.
  - Regardless of the setting (outpatient or inpatient), services may include individual and group counseling, OUD/SUD education, 12-step recovery programs, coping skills development, relapse management, peer support services through the Local Governing Entity (LGE) in her area, and parenting education. Based on Nia's choice, Brianna helps her identify a program and schedules an intake appointment and helps Nia select a psychiatrist in her area to evaluate her symptoms and medications that can be safely used during pregnancy. Brianna schedules appointments and arranges for transportation, as needed.
  - If Nia chooses inpatient treatment, Brianna begins discharge planning upon her admission and assures needed services are available upon her transition from the facility. This includes arranging for aftercare services that support her recovery, such as relapse prevention, follow-up appointments with her Psychiatrist, Peer Support Specialist, and making sure that SDOH needs are addressed.
- **Prenatal Care.** Brianna assists Nia in selecting a PCP or OB-GYN (who can serve as her PCP) to address any current medical issues, such as potential cardiovascular, hepatitis, gestational diabetes, and malnutrition needs. Brianna makes sure Nia's selected provider is trained in trauma-informed care and experienced in substance use and arranges a schedule of prenatal care appointments for Nia based on how far along she is in her pregnancy. Brianna helps Nia apply for Women, Infants, and Children (WIC), Supplemental Nutrition Assistance Program (SNAP), and Supplemental Security Income (SSI) as appropriate. While supporting Nia in her recovery-based services and supports, Brianna simultaneously works with her and her OB-GYN to assure

Nia receives educational materials on pregnancy and childbirth in her preferred language and at her literacy level, as well as participates in prenatal care and preparing for delivery. This includes attending appointments, nutritional counseling, taking prenatal vitamins, going to birthing classes, and finding a pediatrician.

- Healthy Blue offers a whole-person approach for chronic pain management using evidenced-based treatment modalities — specifically when decreasing opioid use. Brianna works with our integrated Case Management team to identify non-pharmacological alternatives, such as acupuncture, chiropractic care, massage therapy, epidural steroid and other pain-alleviating injections, medical hypnotherapy, osteopathic manipulative treatment, and biofeedback techniques.
- [redacted]

**PRIORITY THREE — Nia's Engagement for Holistic Healthcare for Her and Her Baby Postpartum.** Brianna helps Nia understand that her continued participation in care is essential to her well-being and that of her baby and recommends the following:

- **Postpartum BH Care.** Brianna supports Nia in continuing to participate in services with her psychiatrist, who can monitor any changes in her symptoms following birth (such as post-partum depression) and adjust or change her medications if needed. They talk about her continuing to attend her IOP or aftercare, as appropriate, to prevent relapse, including working with her Peer Support Specialist and attending 12-step and support group meetings. Brianna recognizes that depression and other BH conditions can worsen postpartum and works with Nia's OB-GYN to have an expedited postpartum visit to address any concerns. If the baby is transitioned to the NICU following birth, Brianna works with Nia and NICU staff to assure she bonds with her baby through visitation and physical touch, is assessed for PTSD, and engages in transition planning that meets the needs of her related to drug exposure, prematurity, or birth defects.
- **Postpartum PH Care.** Brianna works with Nia to identify her natural supports, such as friends, family, or the baby's father, who will be available following her delivery. If she continues to be eligible for Medicaid postpartum, we will arrange for specialized services, such as the Nurse Family Partnership, Parents as Teachers, and Healthy Blue's Postpartum Discharge program that includes in-home education and services for Nia, including ways to take care of herself, indicators of when to call her doctor, infant care and feeding, and

emotional well-being. They work together to schedule a follow-up appointment with Nia's OB-GYN to assure she is progressing in her healing and a pediatric appointment for her baby to make sure her baby is well and thriving. Brianna also talks to Nia about our Health Rewards incentives for her to participate in postpartum services that have proven to improve outcomes for mothers and babies, [redacted] If Nia is no longer eligible for Medicaid benefits postpartum, Brianna will assure her connection to community-based resources for support, such as engaging her CHW to identify resources in Nia's community that can provide follow-up care and access to family planning resources, including Long-Acting Reversible Contraception and other birth control options.

**PRIORITY FOUR — Additional SDOH Needs That May Interfere with Engagement.** In addition to addressing Nia's housing needs, Brianna works with Nia to identify additional SDOH needs that may prevent her from engaging in care. Brianna supports Nia in scheduling needed appointments and arranges transportation to those, as well as offers to attend appointments with Nia to support her in communicating her needs to her providers and understanding follow-up recommendations. [redacted]

Brianna also assists her in identifying other SDOH needs, such as food security and financial needs, and helps her complete applications to WIC, SNAP, and SSI, as appropriate. They also talk about Nia's desire to participate in job training or vocational counseling or going back to school. Brianna also discusses the roles of the CHW and purpose of Healthy Blue's [redacted] Brianna also assures Nia understands the availability of Healthy Blue's Member Services, 24/7 Nurse Line, and 24/7 BH Crisis Line representatives for additional support. [redacted]

## 2.6.7.10.3 Assuring Nia's Baby Is Connected to Pre- and Postpartum Care

**LONG-TERM NEEDS – WITHIN 14 DAYS**

- Brianna supports Nia in participating in the BH treatment of her choosing (inpatient or outpatient) and prepares for additional after-care services following treatment
- Nia selects a pediatrician in her area to provide services in preparation for and following birth of her child
- Brianna arranges for in-home services following Nia's delivery, such as our Home Visiting program or Postpartum Discharge program that include in-home education and services

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Connection to a pediatrician of the member's choosing prior to delivery is key to the mother's participation in ongoing care for her baby. Prior to the third trimester, the Case Manager discusses the member's options for a pediatrician to help her in taking care of her baby, which may include the need for specialists based on the baby's needs. If the member has had a positive relationship with a pediatrician in the past, the Case Manager will reach out to engage the provider, including securing a single case agreement if needed. If not, they work together to choose a pediatrician with experience treating infants with neonatal abstinence syndrome in her area and schedule an appointment prior to delivery to begin establishing a relationship and talk about Nia's history so the pediatrician is well-informed.

We will make sure that the member has the information needed to care for her infant at home, such as feeding, sleep position, and car seat safety; takes her infant to a follow-up appointment with the pediatrician; and knows who to reach out to when she needs help. If the infant is born with any challenges, the Case Manager works with the mom to develop a POC that addresses and SHCN, including identifying specialty providers with experience in treating infants with NOWS. [redacted]

Brianna helps Nia schedule appointments for the baby, arranges transportation as needed, and follows up with providers to assure she is attending and participating in services and identify any additional recommendations the pediatrician may have for the baby's care. Since the baby is at elevated risk for psychiatric and developmental disorders, Brianna regularly monitors progress for referral to Early Steps for evaluation. If Nia does not participate in services and her baby is born substance-exposed, Brianna works with her, providers, and DCFS with a goal of family reunification, if appropriate.

# 2.6.7.11 Assuring Integrated Community-based Care for Members with Co-occurring Chronic Health Conditions and Severe and Persistent Mental Illness

Healthy Blue is committed to our **Elevate | Population Health** approach that maximizes member health outcomes for members with chronic, comorbid, and complex conditions through person-centered, individualized solutions. These solutions are supported by health information technology to advance health equity and address priority social determinants of health (SDOH). We serve members with complex co-occurring physical and behavioral conditions, as seen in this case scenario, every day. Our Case Managers have integrated physical health (PH) and behavioral health (BH) care expertise, as well as experience coordinating care with providers and community-based organizations across Louisiana. We know that this member will benefit from case management support to prevent further deterioration of her health. This scenario illustrates how we will engage the member, complete the assessment and Plan of Care (POC), and monitor the POC over time to make sure we meet the member's immediate care needs and support her health goals.

## 2.6.7.11.1 Process for Understanding Maria's Use of Acute Care

### MARIA – 57-YEAR-OLD

Healthy Blue will use a person-centered, empathetic approach to understand Maria's use of ED services including, but not limited to, a comprehensive review of her life domains, which includes Maria's diabetes, hypertension and coronary artery disease, bipolar illness, SDOH needs, smoking, 5-day hospitalization, and causes of her low back pain resulting in her using the ED to seek care. This may include transportation problems, financial concerns, and family dynamics in the household, if any. Our approach includes strategic alignment to a Case Manager, Caroline, to address Maria's PH, BH, and SDOH needs concurrently through covered services, non-covered services, and community-based resources tailored to her needs.

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Through Healthy Blue's care management system, Health Intech, we regularly review member utilization patterns, current risk status, pharmacy use, and results of laboratory studies and claims history. ***Our goal is to support the member face-to-face, building trust through the assessment and care planning process and capturing their voice, needs, and goals.***

### Ways in Which Healthy Blue Identifies Maria

Healthy Blue has several ways in which we will identify this member, Maria, such as predictive modeling, real-time admit, discharge, and transfer (ADT) alerts, claims analyses, and targeted reports and platforms that provide additional information key to developing a holistic view of Maria's potential needs. This includes our daily emergency department (ED) report that identifies preventable ED visits, Special Health Care Needs reports that capture diagnoses, service utilization that may indicate complex conditions, and information obtained through Elli, a population risk intelligence tool that identifies members who are most likely to benefit from care intervention and early targeting.

***While our information and resources provide valuable information, we know that engaging with Maria directly is the only way to truly understand and address her personal reasons for using the ED.*** Based on her multiple chronic conditions, as well as numerous ED visits and five-day hospitalization, Maria is referred to a community navigator, identified for Tier 3 Intensive Case Management and assigned Caroline as her Case Manager. Caroline is a registered nurse with expertise and training in trauma-informed care and BH conditions, such as bipolar disorder, anxiety, and depression. If needed, Caroline will consult internal resourced to assure culturally competent care. Caroline will work to motivate and empower Maria in learning more about managing her conditions to remain healthy and live independently. Caroline and the community navigator will work together to support Maria in addressing her goals and vision for herself as well as the improvement of her overall health status. Caroline collects and reviews the initial set of Maria's information using claims data and will note her current diagnoses, medications, and utilization history. Caroline also notes Maria's language preference if language line services are needed and makes sure that Maria receives educational materials in her preferred language and format, such as large print, audio, video, or braille, as well as arranging for language translation services to assist in provider appointments and during contact with health plan staff.

### Reaching Out to and Engaging Maria

***Engaging and assuring access for members such as Maria is what we do every day.*** Caroline calls Maria to share information about why Healthy Blue is concerned about her health and well-being, works with her to complete the health needs assessment, and arranges to complete the person-centered assessment face-to-face at the time and location of her choosing. This call serves as an important opportunity to collect the most current information about Maria's health from her perspective and helps to identify if

### PROACTIVE RESPONSE – WITHIN 72 HOURS

- Caroline's telephonic outreach to Maria, in addition to engaging a CHW to go to Maria's home, if needed
- Based on Maria's preferences, Caroline meets with her at a location and time to complete an in-person assessment and initiate care planning

LA_HlthyRebid21_2.6.7.11_72Hours_11_COB_02

## HEALTHY BLUE RESOURCES AND INFRASTRUCTURE

Our integrated healthcare approach incorporates a variety of evidence-based models to support coordination among providers, co-location, and delivery system transformation specifically designed for our members with comorbid chronic PH and BH conditions and SDOH needs. Healthy Blue's model comprises our **Elevate | Population Health** approach, innovative clinical systems, established policies and procedures for integrated case management, and collaboration with providers and community-based organizations to drive quality outcomes.

LA_HlthyRebid21_Infrastructure_COB_02

Maria is currently engaged in treatment with providers. Caroline explains that the assessment process will help to make sure she receives the right care and support to remain independent and stable in her conditions and help her to reach her healthcare goals. Caroline introduces her to the Healthy Blue Navigation program available through her primary care or specialized BH provider. If Maria is difficult to reach, Caroline engages our Community Health Worker (CHW) to go to her home to talk to her about her health and the benefits and services accessible to her through Healthy Blue. While Caroline will monitor real-time ADT alerts for any future ED events, she also reaches out to the ED most frequently used by Maria and requests that they notify Healthy Blue if and when she next presents at the ED. We also may reach Maria through our patient navigation program if she is hospitalized. Through this program, partner providers identify medium and high-risk members who have been hospitalized and provide navigation services.

We understand individuals use the ED instead of and in addition to primary care for a variety of reasons. This may include negative experiences in the healthcare system, limited access to and lack of trust in PCPs, SDOH needs such as social isolation or lack of transport, self-perceived urgency, lack of medication adherence, convenience (location, 24/7/365 availability), and persistent medical symptoms despite following the doctor's orders. To identify and understand Maria's conditions, symptoms, participation in services, and precipitating events to using the ED, Caroline uses motivational interviewing techniques to engage Maria and active listening statements, such as "I understand it is difficult for you because you experience pain on a daily basis." Caroline creates a trusting, open and frank environment to develop a relationship where Maria is given full attention feels really listened to and not judged. To assure culturally competent care for Maria, Caroline helps her voice her priorities and goals, while recognizing her cultural preferences particularly related to her health.

### Working with Maria to Assess Her Needs

Maria and Caroline work together to complete a person-centered assessment that includes multiple domains to assess her current health status, conditions, most pressing risk factors, and care needs, goals, and preferences. During this biopsychosocial assessment, Caroline builds rapport with Maria, reviewing her past medical history, including general health, chronic conditions, mental health, substance use, and psychosocial history including history of trauma, exposure to violence, and housing needs. The assessment also triggers more in-depth discussion in areas with significant impact on her health, well-being, and quality of life, such as bipolar diagnosis, diabetes, hypertension (HTN) and coronary artery diseases (CAD), and smoking history. This includes the following:

- ***PH history***, including onset of diabetes, HTN, and CAD and the symptoms Maria is currently experiencing; providers and participation in services for each diagnoses; medications and her adherence to taking them as prescribed; any PCP visits for wellness checks or preventive care; when she started experiencing lower back pain; when and why she used the ED (pain, trouble breathing, lack of medications, convenience); what her hospitalization was for and any follow-up care participation; when she started smoking, attempts to quit, and her current desire to quit; and any participation in physical activities.
- ***BH history***, such as when Maria was diagnosed with bipolar disorder; frequency of and behaviors during manic and depressive events; BH providers and participation in treatment; previous and current substance use; and medications and adherence to taking them as prescribed.
- ***Personal history***, including family member (children, siblings, parents) history of physical, mental illness, and substance use issues and diagnoses; and childhood experiences, such as adverse childhood experiences (ACEs), culture, school performance, extracurricular activities, and social interaction.
- ***SDOH needs*** that have created barriers to Maria accessing primary and specialty care, such as housing, transportation, food security, natural and social supports, health literacy and employment.

## SHORT-TERM NEEDS – WITHIN 14 DAYS

- Caroline supports Maria in selecting a PCP, scheduling an appointment, and attends the appointment with her
- Maria and Caroline work to identify and schedule appointments with specialist, including a cardiologist, endocrinologist, spine specialist, and psychiatrist
- Caroline provides Maria with information on alternatives to using the ED

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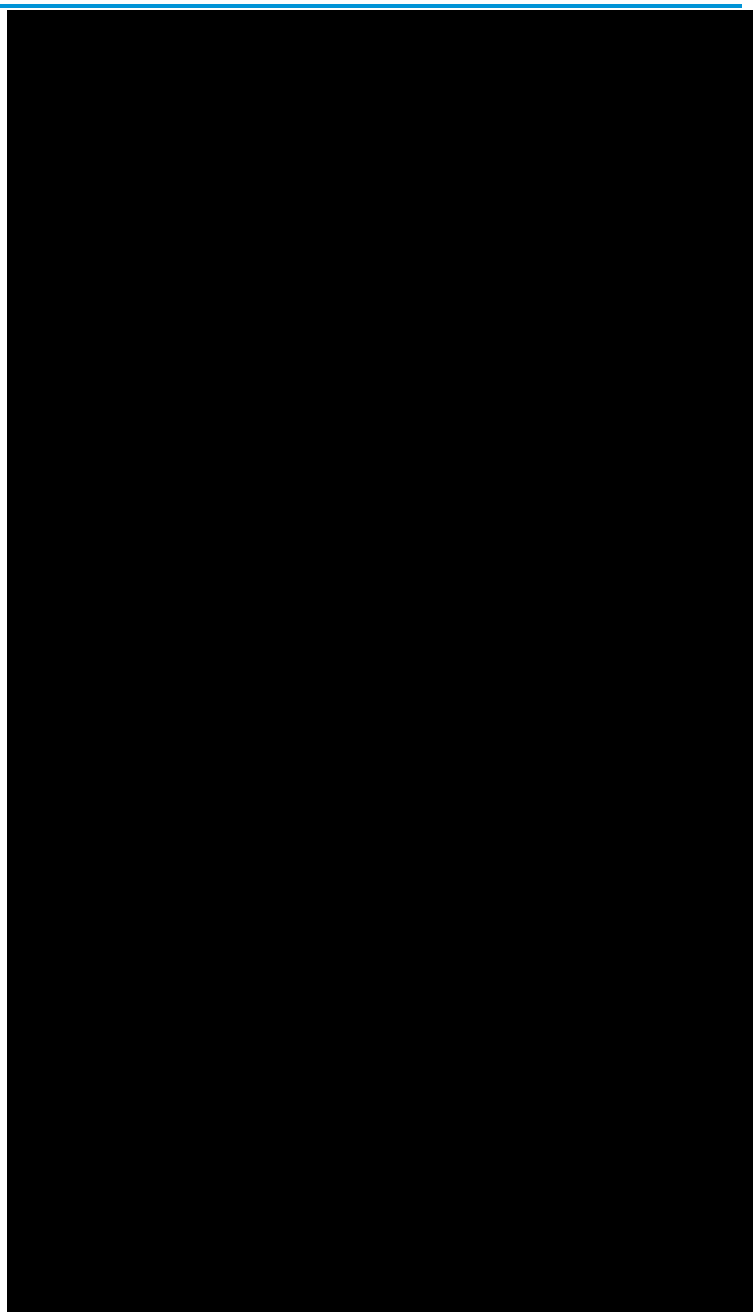
During this meeting, Maria and Caroline discuss the most significant conditions affecting her life right now. Together, they talk about signs and symptoms that indicate a worsening of her conditions and how to anticipate and address barriers. They discuss the relationships and communications Maria has with her treating providers and identify any family members, friends, or caregivers she would like to have involved in her care planning through her multidisciplinary care team (MDT), which includes her PCP, Specialists, Psychiatrist, and Peer Support

Specialists. Caroline and Maria also discuss the possibility of joint appointments between her PCP and specialized BH provider, as well as available crisis support, peer support services from her Local Governing Entity, and other community supports as indicated. Caroline completes a functional assessment to determine Maria's physical abilities and identify any additional needed supports. She also arranges for one of her treating physicians to complete the Level of Care Utilization System (LOCUS) to determine intensity needs for BH services and eligibility for mental health rehabilitation. Caroline also seeks to understand what is important to Maria, such as being involved with her family or church or participating in daily activities.



## 2.6.7.11.2 Addressing Maria's Identified Needs

Addressing Maria's identified needs begins by working with her to develop an integrated POC that identifies her conditions, strengths, needs, short- and long-term goals, and the providers, services, and supports she needs to improve her health and quality of life. Caroline helps Maria understand the importance of developing relationships with providers who can meet her needs and how this will improve her understanding of her conditions, self-management of her symptoms, and continuity of care. Based on her history, Caroline works with Maria to understand and consider her options for improving her medication adherence, making sure that Maria is seeing her treating providers, including her specialized BH provider, while preventing any deterioration in her diabetes and heart condition. Caroline is most concerned with supporting Maria in living in her desired location and receiving the necessary care to prevent worsening of her multiple chronic conditions. Building upon an open trusting relationship, and through motivational interviewing and brief intervention, Caroline discusses the impact of smoking on Maria's current condition to improve her readiness to change and move toward action.

### Care Planning with Maria

Given the predominance of her medical issues, Caroline shares information with Maria about how her medical conditions may be interrelated, her symptoms may be the result of one or more of her physical and BH conditions, and all may be managed by one specialist, if appropriate. A specialist, such as an endocrinologist, can also act as her PCP if she and her PCP are in agreement with this approach, making sure she receives wellness and preventive care. The specialist can also determine if she needs additional specialty care, such as a cardiologist, and identify the root of her lower back pain by referring her to a spine specialist for a physical exam and diagnostic imaging. Her diabetes can cause HTN, which may result in CAD and symptoms such as fatigue and dizziness. Caroline also identifies supports that are essential to her chronic condition management, such as obtaining a blood pressure cuff for self-monitoring her HTN.

They discuss her bipolar diagnosis, the severity of her symptoms, and how they have affected her quality of life and her engagement in recommended healthcare. They also discuss whether she has prescribed medications, who

her prescribing physician is, her current medications, medication adherence as prescribed, and side effects she has or may be experiencing. If she has a specialized BH provider, Caroline talks to her about scheduling an appointment for follow-up, and if not, Caroline helps her select a provider in her area who can evaluate her, provide her with education on her diagnosis, and manage her medications and any side effects she may experience. If one is not available in her area, Caroline talks to her about telehealth and how these needs can be met in her home or in the community through our telehealth kiosks or kits. They also discuss Maria's options for individual therapy to address any feelings of anxiety or depression she may be experiencing due to her conditions.

Caroline shares information on Healthy Blue's **Elevate | Population Health** program, [redacted]

If Maria acknowledges she would like to quit smoking, Caroline talks to Maria about smoking cessation and the types of programs available to her. This includes the State's 800 QUIT NOW program and [redacted] If Maria is still not at a place where she is viewing techniques to create the possibility of her readiness to change. Caroline engages a nutritionist as indicated to work with her on a diabetes-healthy diet through meal planning and assures she has applied for Supplemental Nutrition Assistance Program (SNAP) to make sure she has access to healthy foods.

[redacted]

## Common Issues Among Medicaid Members

Healthy Blue recognizes individuals enrolled in Medicaid programs often experience access issues to the services and supports that meet their PH, BH, and SDOH needs, which contribute to health disparities and inequities. For example, people who do not have access to grocery stores are less likely to have nutritious food, which raises their risk of health conditions like heart disease, diabetes, and obesity. We identify individual member needs based on what we know about common issues among Medicaid members, as described in Table 2.6.7.11.2-1. We use this information to inform our predictive modeling, data mining, assessment, care planning, and monitoring processes.

*Table 2.6.7.11.2-1. Common Issues Facing Individuals Enrolled in Medicaid*

| Common Issues for Adults in Medicaid |
|---|
| ▪ **Medical Issues.** Like some of Maria's chronic conditions, adults in Medicaid experience a high prevalence of heart diseases, including hypertension, heart disease, coronary artery disease, and high cholesterol. Obesity and diabetes are common comorbidities and often contribute to health disease, and members with chronic obstructive pulmonary disease often have high rates of HTN and diabetes.<br>▪ **Psychosocial/Behavioral Issues.** The most common diagnoses include major depressive disorder, anxiety disorders, bipolar disorder, and substance use disorder, which are attributed to several factors, such as genetics or brain chemistry; trauma, abuse, and ACEs, or family history of mental health issues.<br>▪ **Health Inequities and Social Conditions.** Members may experience a variety of health inequities and SDOH needs that interfere with engagement in the services they need, such as provider implicit bias and structural racism that can lead to quality of care concerns, as well as social conditions that impact: access to nutritious food; affordable, safe, and stable housing; reliable transportation; quality education; economic security; and meaningful social connections. |

We have an inclusive, innovative, and collaborative environment that promotes member access to care while decreasing racial and health disparities. Our providers are trained on the root causes of health inequities and the

concepts related to implicit bias. Our approach is aligned with LDH-defined priorities and populations, population health needs in our communities, and priority subpopulations for which we identify goals and metrics.

## 2.6.7.11.3 Supporting Maria to Increase Engagement and Adherence

Developing positive relationships with Maria, her family, and caregivers is the primary way to increase Maria's engagement and positively influence her health and wellness. Caroline monitors Maria's participation, identifying and addressing any challenges she may encounter. ***Caroline understands that gaining control over Maria's pain and her medical and BH support needs will be key to improving her health, reducing unnecessary utilization, and improving medication and appointment adherence.*** Strategies to support Maria in the community include the following:

**LONG-TERM NEEDS – WITHIN 30 DAYS**

- Maria agrees to engaging with a Peer Support to support her in adhering to scheduled appointments and recommended care
- Caroline follows up with Maria and her providers to assure participation and progress in services
- Led by Maria and her MDT, Caroline adjusts Maria's POC as she reaches her goals and her needs change

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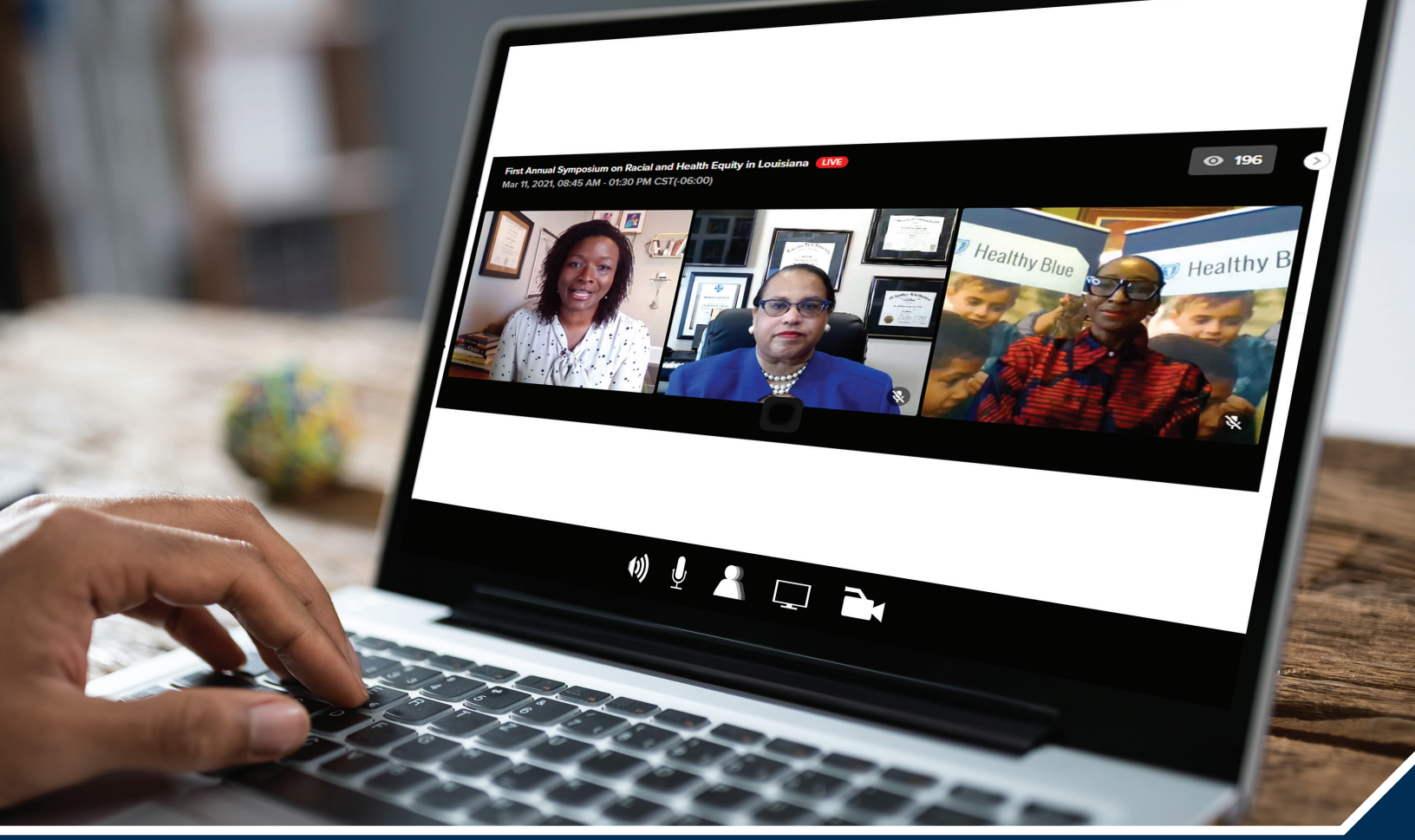
- **Community, Family, and Peer Support.** Caroline also helps Maria work with Peer Supports or other friends/family members who will help her stay compliant. Carolina and Maria's MDT receive alerts when medication refills are not filled and monitor utilization to determine if appointments were missed. Caroline helps Maria locate support groups for her chronic conditions, including her bipolar disorder. If Maria prefers in-person support groups in her community, Caroline helps her contact diabetes management support groups through her church or health department. If Maria's preference is online support groups, Caroline may refer her to a National Alliance of Mental Illness (NAMI) support group. In addition, Caroline helps Maria identify exercise and activity programs in her community or online.
- **Healthy Blue Monitoring.** During their discussion, Maria receives information and education about the services and supports available to her in her home and engages a CHW to support her in identifying additional resources, providing her with information on appropriate ED use, helping her navigate her healthcare needs, and providing her information on alternatives to using the ED. This includes accessing urgent care in her area; after-hours and weekend availability for provider appointments; community-based programs, such as church groups and health department programs; Healthy Blue's Chronic Pain Management Program and [redacted] online resources, such as Well-Ahead for Diabetes self-management, education, and resources; and Healthy Blue's Member Services Line, 24/7 Nurse Line, and 24/7 BH Crisis Line.
- **Appointment Adherence.** Case management support includes facilitating the provider/member relationship by attending initial appointments with Maria to support her in understanding and asking questions about her own healthcare. This also includes Caroline having consistent and frequent contacts with Maria and connecting with her after appointments to assess her comfort level and identify any opportunities for improvement. Understanding that telehealth can help resolve certain access barriers and prevent against unnecessary ED visits, Caroline discusses the appropriate use of these services and makes sure Maria has the proper tools to receive telemedicine from her providers. Additionally, Healthy Blue uses mobile health messaging to engage members via text message to promote healthy behaviors, such as scheduling preventive care appointments.
- [redacted]
- [redacted]




## Promoting Health and Racial Equity in Louisiana

Healthy Blue teamed up with the Louisiana Public Health Institute (LPHI) to launch the inaugural Symposium on Racial and Health Equity in March 2021 with the theme of "Partnerships in Action: Collectively Achieving Racial Equity to Improve the Health of Our Community." At the conclusion of the Symposium, LPHI and Healthy Blue offered participants the opportunity to join a coalition dedicated to ending institutional racism in Louisiana. Healthy Blue will continue this commitment by sponsoring the first Racial Equity Learning Lab later this year.

# 2.6.8

Network Management

Healthy Blue

## 2.6.8 Network Management

### 2.6.8.1 Timely Access to Culturally Competent Primary and Specialty Care Services

Healthy Blue has an established, comprehensive Medicaid network of more than 27,000 unique providers that currently serve Healthy Louisiana enrollees (members). As an MCO in Louisiana for more than nine years, we have a history of partnering with providers to offer timely access to high-quality, culturally competent care and meeting local population health needs. We also have experience meeting the geographic access requirements prescribed by LDH. Currently, 99% of our members have access to providers within the distance standards for Specialists and PCPs outlined in Attachment F, and we are actively working to meet the new, more stringent standards prior to Readiness Review. ***We will continue to build our network using our proven network management strategies that have resulted in a 29% growth in our specialty provider network and 44% growth in our behavioral health (BH) provider network since 2018.*** Where network gaps exist, we will use the strategies described throughout this section to increase provider capacity. In addition to meeting geographic access standards, we are also committed to building a network that meets members' cultural, racial, ethnic, linguistic, and accessibility needs. To do this, we are investing in strategies that promote health equity, including cultural competency training, scholarships, and Value-Based Payment (VBP) arrangements.

**HEALTHY BLUE'S COMPREHENSIVE NETWORK**

Our network includes:

- **128** hospitals
- **3,200** PCPs, including 565 pediatricians
- Over **12,000** specialists
- **563** OB-GYNs
- **2,682** Licensed BH professionals
- **424** psychiatrists
- Over **1,300** ancillary providers
- **352** FQHC/RHC locations

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To assure timely access to services, we contractually require providers to adhere to all appointment accessibility standards and verify compliance through quarterly audits. We also employ enhanced reimbursement strategies to promote timely access to care. [redacted]

> *MediTrans and Healthy Blue have done a great job supporting NEMTLA and its providers so they can protect themselves and the members in their care. These additional supplies will have a wonderful impact on our communities as a whole. These organizations' initiative, out-the-box thinking, and quick action have been appreciated and is unmatched throughout this pandemic.*
>
> **Eric Bradley, President**
> **NEMT Louisiana Association**
>
> LA_HlthyRebid21_Bradley_TST_01

To support and promote LDH's goals of utilizing engaged providers who are accepting and regularly serving Medicaid patients, we have conducted a claims analysis to identify providers who have not billed 25 claims in the last six months. We will be launching a targeted ***Medicaid Engagement Campaign*** in September 2021 to learn how we can support them in more actively serving Medicaid members. In accordance with our contract, we will not include providers with less than 25 billed claims in the last six months in our provider directory or network adequacy reports.

### 2.6.8.2.1 Work Plan for Readiness Review

As an incumbent MCO, Healthy Blue maintains a dynamic Network Development and Management Plan (Network Plan), executed by our Network Development team. This team is led by Randy Guillory, our Provider Services Manager, who has 30 years of experience building provider networks, including 9 years dedicated to Medicaid since the implementation of the Healthy Louisiana program in 2012. We use our Network Plan to continually monitor our network and identify gaps and contracting opportunities. Upon receipt of the RFP, we incorporated the new standards from Attachment F into our Network Plan, and we will work to fill any gaps (existing or new) via the timeline outlined in Table 2.6.8.2-1. We will monitor the success of our efforts weekly, with the goal to meet all network adequacy standards by Readiness Review. We will also seek LDH approval of all alternative strategies, such as telemedicine, to address network gaps.

*Table 2.6.8.2-1. Network Adequacy Work Plan and Timeline for Readiness Review*

| Task | Timeline |
|---|---|
| Receive RFP and review updates to Attachment F, Provider Network Standards | June 2021 |
| Conduct comprehensive network analysis, including:<br>▪ Geographic access reports using updated adequacy standards<br>▪ Claims analysis to identify providers with less than 25 claims in the last 6 months | July 2021 |
| Identify network gaps and enhancement opportunities; incorporate into network plan | July 2021 |

| Task | Timeline |
|---|---|
| Develop target list for recruitment to fill identified gaps through:<br>▪ Network comparison against other Medicaid MCO and State directories<br>▪ Network comparison against BCBSLA Commercial provider network (a recent comparison shows an 89% overlap)<br>▪ Engagement with key community stakeholders, including referring providers, provider associations, and community-based organizations (CBOs) | August 2021 |
| Initiate network outreach campaigns to close identified provider gaps | September 2021 |
| Identify alternative strategies to address gaps and obtain LDH approval | September 2021 |
| Initiate Medicaid engagement campaign for providers without 25 claims in 6 months | September 2021 |
| Obtain completed provider applications, signed contracts, and credentialing | October 2021 |
| Complete contracting, credentialing, and configuration for new providers; leverage leadership relationships to motivate non-responders to participate | Ongoing |
| Release executed contracts and provide onboarding documents, including provider manual, Quick Reference Guide and new provider orientation registration | Ongoing |
| Conduct new provider orientation within 30 days of providers joining our network | Monthly |
| Complete final network analysis, compile all documents needed for Readiness Review | November 2021 |
| Submit required Readiness Review documentation and participate in on-site meetings | December 2021 |
| Respond to LDH questions and findings and address any areas requiring corrective action | Readiness Review |
| Successfully complete Readiness Review | Anticipated April 2022 |
| Operational start date | Anticipated July 2022 |
| Network monitoring and maintenance | Ongoing |

## 2.6.8.2.2 Identification of Network Gaps

Our Network Development Team assesses network adequacy by comparing our provider network data against LDH requirements. We also consider expected member enrollment and projected utilization of services informed by member patterns, historical trends, and population health needs. Our Network Development team to identifies gaps and develops data-driven strategies to address access challenges by monitoring a comprehensive set of reports, survey results, and member utilization data, including:

- **Geographic Access Reports.** These reports identify the percentage of members in a geographic area with access to a provider within the distance standards in Attachment F; we conduct this analysis at least quarterly for BH providers and bi-annually for physical health (PH) providers.
- **Provider Ratio Reports.** We calculate provider-to-member ratios for PCPs and specialists at least quarterly using current membership numbers. ***We currently exceed 100% of the ratio requirements in Attachment F.***
- **Network Changes.** We review all network additions, deletions, and PCP capacity changes, by provider type and location monthly to identify potential impacts to network adequacy and access.
- **Access and Availability Surveys.** We conduct quarterly provider audits to measure adherence to the appointment wait time, after-hours, and telephone accessibility standards in Attachment F. ***Results from the last four quarterly reports show that 94% of audited providers adhere to these standards.*** We immediately educate non-compliant providers and use future quarterly audits to assure compliance.
- **Open Panel Reports.** We review panel status reports quarterly and LDH closed panel reports monthly to identify providers that are not accepting new enrollees, and where needed, encourage providers to re-open their panels. ***As a result of our efforts, 94% of our provider groups currently have at least one open panel.***
- **Out-of-Network Utilization and Single Case Agreements (SCAs).** We monitor out-of-network utilization and SCA requests to identify potential access gaps. Once we have an SCA in place, we encourage providers to join our network. Since 2020, we added 38 providers to our network through SCAs.
- **Member Survey Feedback.** We review annual CAHPS® member surveys to identify potential access and availability concerns. ***In 2020, Healthy Blue ranked first in the Adult CAHPS Experience Survey and second in Child Experience.*** Our Quality Management (QM) department also distributes monthly member satisfaction surveys via text, to gauge satisfaction with providers and services received.
- **Annual Provider Satisfaction Surveys.** We analyze findings from Healthy Blue and Healthy Louisiana provider satisfaction surveys to identify areas of opportunity. Surveys include key questions about quality and network adequacy. [redacted]

- **Member Grievances and Provider Complaints.** We review member grievances and provider complaints to monitor provider adherence to access and availability standards. Our representatives review, log, and categorize grievances and complaints by cause, disposition, and type, including access to care.
- **Employee Feedback.** Our local Network Development team collaborates with internal staff, including Provider Experience Consultants (PECs), Case Managers, QM staff, and Operations to identify gaps and network development opportunities. We also regularly discuss our network in cross-functional leadership groups, such as our monthly ***Network Integrity Workgroup***, which reviews our overall network to identify gaps. We have also implemented a new quarterly ***Rural Network Workgroup***, which will expand access to care by:
  - Reviewing geographic access reports specifically for rural parishes to identify opportunities for expansion
  - Discussing challenges of rural providers and developing solutions for workforce shortages
  - Identifying health needs and disparities for rural members and how we can mitigate barriers to care

## 2.6.8.2.3 Strategies to Increase Provider Capacity

Healthy Blue is committed to developing strategies that increase provider capacity. Our ongoing, comprehensive monitoring and knowledge of Louisiana communities helps us understand what drives provider capacity challenges and informs the strategies we develop to meet the needs of enrollees and address network gaps.

### Enhanced Reimbursement

Healthy Blue offers innovative provider reimbursement arrangements to increase provider capacity and expand access where the greatest needs exist, particularly in rural areas. [redacted]

[redacted] We also offer a range of VBP programs, outlined in Section 2.6.12, to incentivize network participation through enhanced reimbursement and encourage providers to adopt practice transformation strategies that achieve increased quality and health outcomes.

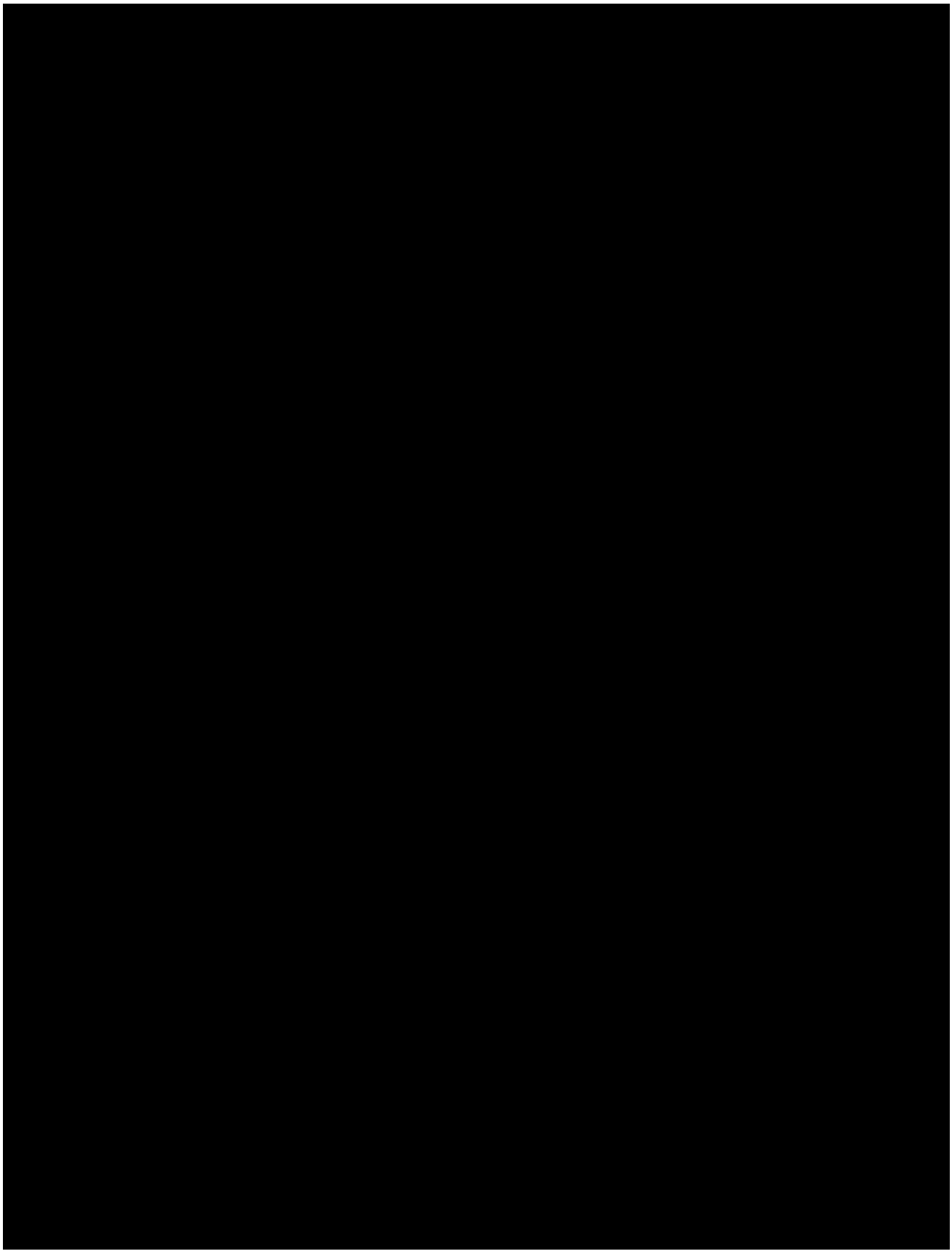
### Investing in Workforce Development

[redacted]

### Expanding Telemedicine Capabilities

COVID-19 underscored the importance of providing members with the option to connect virtually with their providers. At the beginning of the pandemic, we immediately allowed all provider types to begin conducting telehealth visits with their established patients, in accordance with LDH requirements. We also conducted outreach to identify which providers were offering virtual services and have included an indicator in our provider directory so members can easily identify these providers.

A significant component of our telemedicine strategy is providing our local, Louisiana providers with the tools they need to offer telemedicine to their existing patients. Additionally, our proposed national telemedicine vendors prioritize incorporating local, Louisiana providers within their networks. For example, when vendors like Bright Heart Health, FasPsych, and ConferMED enter a new market, they engage with providers that are already licensed and located in the state, and only divert from this process when they are unable to engage a local provider for a particular specialty type. Prior to using any national telehealth vendor, we will work with LDH to obtain written approval and make sure the implementation of these services does not supplant local, Louisiana providers, but instead fills gaps where no Louisiana providers exist. Our full proposed approach is described in Table 2.6.8.2-2.



## Mobile Services: Bringing Care to Our Members

[redacted] We also partner with Ready Responders on mobile vaccine campaigns to offer in-home vaccinations to high-risk members. In early 2021, we implemented a flu vaccination program for members with chronic conditions that would put them at severe risk if they contracted the flu who had not had a flu vaccine in the last 18 months.

## Expanding Provider Capabilities Through Evidence-based BH Training

We are investing more than $160,000 to expand BH provider capacity for evidenced-based practices in compliance with the Louisiana Behavioral Health Provider Services Manual. We have worked in conjunction with [redacted] Our funding supports the following trainings:

[redacted]

Beginning in 2022, Healthy Blue will also offer ***Matrix Model Training*** through our online Healthy Blue Training Academy. This two-day training will be available for select providers with integrated capabilities and multiple specialty types, particularly PCP and BH providers who participate in VBPs. The Matrix Model of Intensive Outpatient Treatment (IOP) is evidence-based and used to treat patients with methamphetamine, alcohol, and other SUDs. Programs that have implemented this model report significant improvement in treatment outcomes.

## 2.6.8.2.4 Significant Challenges to Developing a Complete Network

The most significant challenge to developing a complete network is the existence of *Healthcare Deserts* across Louisiana, where limited providers exist. For example, while we are contracted with 100% of hospitals in the state, parishes including East Feliciana, Grant, Plaquemines, and Tensas have no hospitals available. Rural parishes also have low populations, making it difficult for specialists to open and maintain a practice, especially with limited access to a hospital in the area. In these instances, Healthy Blue works with our provider partners, such as Franciscan Missionaries of Our Lady Health System, to open up satellite offices. We also make sure our members have access to NEMT services if they need to travel longer distances to access services. Table 2.6.8.2-3 outlines the most significant challenges and Healthy Blue's strategies to address them.

*Table 2.6.8.2-3. Healthy Blue Solutions to Louisiana Network Challenges*

| Challenges | Impacted Parishes | Healthy Blue Solutions |
|---|---|---|
| **OB-GYNs.** Many parishes have no OB-GYN providers due to lack of facilities or birthing services. | [redacted] | [redacted] |
| **MAT Prescribers.** Shortages are due to a lack of providers as well as patient limitations. | [redacted] | [redacted] |

| Challenges | Impacted Parishes | Healthy Blue Solutions |
|---|---|---|
| | [redacted] | |
| **Specialty Services.** Gaps include Allergy/Immunology, Dermatology, Endocrinology, and Hematology/Oncology due to a lack of providers in rural areas of the state. | [redacted] | [redacted] |

## 2.6.8.2.5 Monitoring Compliance to Assure Network Adequacy and Access to Care

Healthy Blue monitors access and availability at both the provider and overall network level using a wide range of data sources and tools, outlined in Table 2.6.8.2-4. Our local, highly experienced Network Development team promptly identifies gaps and assures members have access to a comprehensive provider network that meets the distance, ratio, and access standards included in Attachment F.

*Table 2.6.8.2-4. Monitoring Our Provider Network*

| Data Source or Tool | Strategies for Monitoring Provider Network Standards |
|---|---|
| **Geographic Access Reports** | ▪ Geographic overview maps display provider locations by geographic area<br>▪ Provider and member maps plot members and providers and overlay provider network against the membership base using LDH standards to identify geographic coverage<br>▪ Member accessibility summaries provide an overview of the entire analysis and detail the number and percentage of members with and without access to a PCP or specialist<br>▪ Accessibility details provide the total number of members, providers, and member-to-provider ratio for a specified demographic or geographic area |
| **Other Network Reports** | ▪ Network additions, deletions, and provider capacity changes by provider type<br>▪ PCP Panel Capacity |
| **Claims and Utilization Reports** | ▪ OON utilization and authorization requests; SCA requests<br>▪ Underutilization of services, which may indicate an access gap<br>▪ Provider referral patterns |
| **Internal Feedback** | ▪ Network Integrity Workgroup and Rural Network Workgroup<br>▪ Feedback from PECs, UM, Case Management, and Quality |
| **Stakeholder Feedback** | ▪ Member satisfaction survey results and complaints<br>▪ Provider satisfaction survey results, including referral capabilities<br>▪ Input from Provider Advisory Council and Clinical Advisory Committee<br>▪ Feedback from LDH<br>▪ Input from CBOs and provider associations |
| **Audit Results** | ▪ Quarterly Appointment Access, Availability, and After-hours audits<br>▪ Selective on-site and desktop audits for providers under targeted reviews<br>▪ QM medical record reviews |

## 2.6.8.2.6 Strategies for Recruitment and Retention Efforts

### Strategies for Recruitment

Through our locally based Network Development Consultants, we recruit local providers who understand the unique needs of our members and communities. Upon identifying a network gap, our Network Development Consultants develop a list of non-contracted providers and conduct a ***targeted outreach campaign***. In addition to identifying targets for recruitment through typical data sources, such as a comparison against other Medicaid MCO and State provider directories, we are able to leverage the established

**SUCCESSFUL PCP RECRUITMENT**

Since July 2018, we have increased the number of adult PCPs by 11% and adolescent PCPs by 27%.

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relationships we have with providers in our network to understand where they would refer a member in need of a deficient service or provider type. As described previously, we also use flexible contracting strategies, including enhanced reimbursement rates and VBP programs, to promote Medicaid participation, particularly for specialties and sub-specialties where gaps exist. Our recent contracting outcomes demonstrate that our recruitment strategies are effective. ***From January to July 2021, Healthy Blue contracted with 35 specialist groups, closing network gaps for Urban Laboratory, Rural Neurology, and Rural Urology specialties.***

In June 2021, Healthy Blue added a new functionality to the enrollment tool on our secure provider portal to improve the online enrollment experience. The new functionalities include the ability to add new providers to an already existing group, apply for and request a contract as a new group of providers or as an individual/solo provider, and a dashboard for real-time status updates on the submitted applications. ***This means providers are able to join our network and start serving our members even faster than before.*** Early feedback is extremely favorable, and we will continue to improve tools and remove administrative barriers for providers joining our networks.

## Strategies for Retention

We leverage our relationships and deep understanding of Louisiana's Medicaid provider community to inform our retention strategy. ***As a result, less than 1% of providers voluntarily terminate from our network.*** Our successful provider retention strategy includes:

**Randy Guillory**
**Provider Services Manager**

Proud Louisianian, Randy brings more 25 years of experience building provider networks to Healthy Blue. He is responsible for developing strategies to ensure members have access to high-quality, culturally competent providers across the state through effective contracting, Value-Based Payment opportunities, and collaborative provider partnerships.

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- Our local PEC team is embedded in communities across the state, engaging providers in person and virtually to build relationships. ***Since 2020, this team conducted nearly 5,000 virtual visits.***
- Customized VBP programs that offer financial rewards for high-quality, cost-effective care, and the right level of support to help providers achieve success in these programs.
- On-demand technical assistance to help providers succeed, such as proactively contacting providers if we identify possible submission errors through ongoing claims review.
- [redacted]
- Tools and resources to expand practice scope, including training and comprehensive telehealth programs.
- Practice integration solutions to increase bi-directional data exchange through our Epic Payer Platform solution, targeted to begin rolling out in 2022.
- Recognition programs like our ***Bona Fide Blue Provider Recognition program***, a non-financial provider incentive model that recognizes Louisiana providers who advance LDH priorities with superior performance. The 2021 award winners include Access Health Louisiana — *Innovator Award*, DePaul (Daughters of Charity) — *Social Determinants of Health Award*, and Sulphur Pediatrics (aka Pediatric Center of Southwest Louisiana) — *Loyalty Award*.

## 2.6.8.2.7 Meeting the Multilingual, Multicultural, and Disability Needs of Enrollees

Healthy Blue is committed to assuring our network is able to meet the multilingual, multicultural, and disability needs of members. As a testament of this commitment, in 2017, we received NCQA's Multicultural Health Care Distinction, which is awarded to organizations that engage in efforts to improve Culturally and Linguistically Appropriate Services and reduce healthcare disparities.

We contractually require providers to deliver culturally competent services to members, including those with limited English proficiency, and diverse cultural and ethnic backgrounds and abilities. We support providers in offering inclusive care through various trainings and educate them on our cultural competency and Americans with Disabilities Act (ADA) compliance requirements through our new provider orientation and in our provider manual, as well as through ongoing training and communications. We regularly assess providers' capabilities to assure they reflect the diversity of members and communities. For instance, we know that our providers speak 39 different languages, including sign language, addressing all identified languages spoken by members.

### Provider Directory Enhancement

In addition to languages spoken by providers and their virtual/telehealth capabilities, we capture accommodation of special access needs. This information is required on provider credentialing applications, entered in our database, and used to produce and update our provider directory. Our online provider directory allows users to filter results

according to ADA Accessibility (Wheelchair Accessible, Parking, Restroom, Basic Access) and we are making expanded filtering options available later this year to denote additional accessibility details (Building Exterior, Building Interior, Exam Room, Exam Table). We also encourage providers to submit their race and ethnicity, with the goal to make this data available to members in the provider directory in October 2021. In the first quarter of 2022, we will expand our offering of LGBTQ+ training opportunities to our providers that, upon completion, will result in an indicator added to our online provider directory designating Healthy Blue LGBTQ+ ally status.

## Racial Equity Provider Forums

Healthy Blue equips providers with needed tools to support diverse members and promotes open discourse about trauma, racial injustice, and inequities that affect the health and well-being of the communities we serve. In early 2021, we launched a quarterly Racial Equity Series for PCPs, mental health, and SUD providers. Our Racial Equity Series features virtual discussions with a diverse panel of respected healthcare professionals, helping providers share experiences and learn about racial equity and allyship.

## Health Equity VBP Enhancement

[redacted]

## Accommodating Members with Disabilities

Our providers are held to high standards when it comes to accessibility and are required to deliver services that are culturally appropriate to all members, including those with physical or cognitive disabilities. Healthy Blue makes sure providers in our network are compliant with Title II and III of the ADA and Section 504 requiring that medical care providers offer individuals with disabilities full and equitable access to their healthcare and service facilities. Providers are asked to certify their compliance as part of their application to join our network. During on-site visits, our PEC performs spot checks to verify provider facilities are accessible and compliant. If we receive feedback from members about provider accessibility, we will educate the provider on requirements and, if necessary, assist the member in finding a provider committed to delivering equitable care.

[redacted]

We have been actively engaged with the Office of Citizens with Developmental Disability and are aware of concerns related to members with intellectual/development disabilities (I/DD). [redacted] Based on this understanding, we have designed our network to include providers with the training and specialization to meet the needs of members with developmental disabilities, including Applied Behavioral Analysts (ABA). We are contracted with the majority of available ABA providers in Louisiana, who currently provide these valuable services at more than 600 practice locations.

## Cultural Competency Training and Resources

It is important for providers to have the knowledge, resources, and tools to offer culturally competent care. Our Healthy Blue Training Academy helps support providers by offering cultural competency training in a variety of formats, including webinars and online courses. Our "Caring for Diverse Populations" toolkit contains information, tips, and resources regarding language, interpreter services, and cross-cultural issues and helps providers assess their level of competency. Healthy Blue also promotes the use of MyDiversePatients.com, a website offering free trainings on topics including how to create an LGBT+-Friendly Practice, Equity in Asthma Care, Breast Cancer Screening for African American Women and Promoting Birth Equity.

[redacted]

## ACEs Provider Champions

We are partnering with providers to address adverse childhood experiences (ACEs) in Louisiana through our ACEs Provider Champions model. Our ACEs Provider Champions are providers who deliver high-quality, culturally sensitive care to members, and offer informal guidance and insight into how best address ACEs and care for their patients. Our ACEs Provider Champions include DePaul Community Health Centers — New Orleans Parish; Louisiana Primary Care Association Accountable Care Organization — Shreveport area schools supported by David Raines Community Health Center; and Capital Area Human Services District — East Baton Rouge Parish Schools. ACE Provider Champions support the greatest volume of school-based clinics for screening that will occur once the children return to on-site school (after the pandemic) and believe post-pandemic testing is key.

[redacted]

## 2.6.8.2.8 Terminating Providers Without Cause, Minimize Impact on Enrollees

In rare instances, we may terminate a provider from our network without cause. We do not do this during the 45 calendar days prior to start of the enrollment period through the last calendar day of the enrollment period. We also obtain written approval from LDH if the provider is in a health professional shortage area. Once we receive approval, we notify the provider in writing, via certified mail, of our termination and appeal procedures. We give hospitals and provider groups 90 days' prior notice of contract termination without cause and comply with reporting requirements of State licensing agencies, the National Practitioner Data Bank, the Federal Healthcare Quality Improvement Act, and other organizations as required by law. In accordance with Model Contract 2.9.9.8, we will:

- Conduct a claims analysis to identify all members that received services from the provider within the last 18 months, and include it in our notification to LDH
- Input disenrollment requests resulting from termination into the member enrollment web-based system within five business days

## Minimizing Negative Impact on Enrollees

**Members are our first priority.** Healthy Blue is committed to connecting members with the services they need when they need them, and in the setting they choose. In the case of a provider termination without cause, we provide members a written notice 30 calendar days prior to the effective date of termination, using an LDH approved notification template. Notice of the provider termination will go to each member who received care from the provider within the last 18 months. The notice includes a pre-paid envelope and explains the process to select another provider and change MCOs, should the member choose to do so. Members can change PCPs by calling the Member Services Line or by going online. ***Additionally, we will personally reach out by phone to notify each affected member of the change and help them find a new provider.*** Medically necessary care from that provider may continue through completion of treatment or until the member selects another treating provider, up to 90 days or until the member is reasonably transferred without interruption of care.

## Building Community and Rebuilding Homes

Healthy Blue sponsored Rebuilding Together's Second Annual Build and Boil event. This event is a fundraiser, a community party, and a volunteer opportunity, bringing people from all over New Orleans together. The Build and Boil event supports Rebuilding Together's mission to improve the quality of life for low-income homeowners in New Orleans, especially homeowners who are elderly, disabled, veterans, or single heads of households with minor children. With Healthy Blue's help, this event raised over $28,000, boiled almost 1,000 pounds of crawfish for the community, and aided five local homeowners.

## 2.6.9 Provider Support

Healthy Blue has more than nine years of experience supporting more than 27,000 unique providers. Through this experience, we have learned that timely communication, accurate claims payment and a comprehensive training and education program are essential to building collaborative relationships with providers and empowering them to meet the needs of our enrollees (members). Our approach to supporting providers is detailed throughout this response and included in our Provider Support Plan, a new element of our Quality Assessment and Performance Improvement plan. We will update this plan at least annually in accordance with Model Contract, Section 2.16.16.2.

> *In my opinion, the Healthy Blue leadership team has always been open to ideas and conversations that work toward improving the quality of care to their membership in a cost-effective manner. As a provider, our thought and concerns are taken seriously. I have found that when problems arise, regardless of what they may be — claims, credentialing, membership, or any other issue — they have a team of individuals that are diligent about following them to a resolution. We have a good relationship with the Healthy Blue team of executives, Randy, Yvette, and Nick, and look forward to many more years of working together*
>
> **Greg W. Ivey, Chief Operating Officer**
> **The Pediatric Center of SWLA**
>
> LA_HlthyRebid21_ 2.69_Ivey_TST_01

Our Provider Support approach begins with our Network Development team, who is responsible for building our network and supporting providers throughout the contracting and credentialing process. Once providers join our network, our Provider Experience team serves as the primary resource for communication, training, and resolving any issues that may arise. Our local Network Development and Provider Experience Consultant (PEC) teams report to our Provider Services Manager, Randy Guillory, and are 100% dedicated to Louisiana Medicaid. Together, these teams execute our proactive provider support strategies. ***Each employee on these teams is a local Louisiana resident that lives in the communities we serve***, which further enhances our ability to support our providers.

We recognize how critical it is to meet providers' core servicing needs such as timely claims payment, maintaining accurate provider demographic information, and communicating important updates and changes. Through open feedback and communication with our providers, we continuously evaluate our strategies to assure that every provider has the level of support they need to meet contractual operational requirements and advance the State's population health management and quality goals. In March 2021, we made significant enhancements to our Provider Experience model as a result of our 2020 Provider Satisfaction Survey to better support our providers through tailored communication, improving our team's provider issue resolution and response times, and enhanced provider practice performance reporting. In this enhanced model, each provider is assigned a PEC who is directly responsible for:

- **Providing Customized Onboarding, Ongoing Training, and Technical Assistance.** This is tailored to each provider's specific needs. We know our providers have a range of capabilities and we tailor our support appropriately. For example, in 2020, we hand-delivered contracts to providers that were not comfortable signing contracts electronically.
- **Educating Providers on Relevant Program Requirements and Updates and Responding to All Inquiries Within 24 to 48 Hours.** We monitor staff response times and take appropriate corrective action if service level agreements are not met. ***These performance reports are routinely shared with Healthy Blue's Leadership team.***
- **Sharing Performance Data to Promote Quality of Care and Effective Cost Management.** PECs meet with providers regularly to review performance data and educate them on the tools available, detailed in this response, to help them achieve their cost and quality goals.
- **Provide Navigation Assistance for Operational Issues.** PECs directly connect providers to our Provider Issue Resolution (PIR) Unit, a fully dedicated team that resolves claim escalations. The PIR is required to update providers every 10 days until their issue is resolved, and PECs monitor adherence with this policy.

Our PECs educate providers on claims and encounters submission as part of our new provider orientation and offer providers individualized training as needed on an ongoing basis. We also monitor weekly Claims Denials reports to identify providers that may require assistance, which is further detailed in Section 2.6.9.3. This comprehensive approach to training, in combination with significant configuration improvements and claims system enhancements, has contributed to an increase in auto adjudication [redacted] ***Additionally, beginning in July 2021, we started making claims payments daily, which will further reduce TAT.***

**SUPPORTING PROVIDERS THROUGH TIMELY CLAIMS PROCESSING**

So far in 2021, our average claims turnaround time is six business days.

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A further distinction of Healthy Blue is our relationship with BCBSLA Commercial and Medicare Provider Support teams. ***We work together to support providers with multiple touchpoints in the field, in a highly personalized manner.*** To ease administrative burden, if a provider question or concern related to Healthy Blue comes up during an interaction with BCBSLA, a seamless referral is made to Healthy Blue's Provider Experience team to assist the provider, and vice versa. In addition, ***leadership from both companies conduct joint provider meetings and***

***participate in mutual forums like health fairs that offer individualized discussions to deepen and solidify our network relationships.***

## 2.6.9.1 Provider Relations Staffing

[redacted] These Representatives are available Monday through Friday from 7 a.m. to 7 p.m. CT. We provide additional details about our comprehensive provider engagement strategy and staff in Table 2.6.9.10-1.

Our staffing model is designed to assure all providers receive the highest level of service and support. Our teams are fully integrated, and consultants are trained to support all provider types including physical health (PH) and behavioral health (BH), allowing multi-specialty providers a single point of contact. To assure providers have timely and adequate responses to all inquiries, questions, and concerns, we consider several factors to determine adequate staffing, including:

- Number and location of providers, including whether the locations are urban or rural
- Projected new providers per year, including those undergoing contract negotiation or credentialing
- Estimated number of visits required per provider, based on established meeting frequency goals. These goals are developed based on provider type, member volume, and services rendered, and generally include:
  - Monthly meetings with large hospitals systems and PCP groups, including Joint Operations Committee meetings
  - Quarterly meetings with licensed BH professionals, OB-GYNs, and high-volume specialists
  - Semi-annual or annual visits for other provider types, as needed
- Other required meetings, including quarterly Provider Advisory Council (PAC) meetings and monthly orientation opportunities
- Upcoming operational updates that require proactive outreach and education
- Estimated number of ad hoc meetings to provide issue resolution, education on new policies, and address the specialized needs of our smaller, rural providers
- Number of providers participating in our Value-Based Payment (VBP) programs and opportunities to advance along the Alternative Payment Method continuum
- Anticipated provider call volume based on historical and forecasted data
- Feedback from providers received through various channels, including satisfaction surveys and the PAC, as well as 1:1 provider visits
- State priorities and requirements

Annually, our Provider Services Manager conducts 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, ***we are in the process of adding*** [redacted] ***to our Provider Experience team***. These Training Specialists will assist PECs with developing, executing, and tracking our overall Provider Education program.

> *Healthy Blue has done a superb job in strengthening the partnership between our organizations, providing consistent communications, and addressing [routine complexities and issues that come up with all MCOs]. Our provider representative, Bryson Blount, his manager Nick Daigle, and the rest of the Healthy Blue team have set a great example of how an MCO and a larger provider group such as ours can work together collaboratively to improve healthcare delivery to the Medicaid patients of Louisiana…Bryson is the gatekeeper for all issues that come up in the partnership. He has a standing issues log where he records all reported issues, provides status updates on the elements, and maintains a traceable resolution status for previously closed issues. This level of organization and documentation is not easy, but it provides an immense benefit to all parties and keeps our monthly conversations on track and efficient.*
>
> **Director of Compliance and Contracts**
> **LSU Healthcare Network**
>
> LA_HlthyRebid21_LSU_TST_01

## 2.6.9.2 Provider Communications and Education

### Communications with Providers

We know our providers have a range of capabilities and communication preferences. As a result, we offer a wide range of communication approaches to meet their needs, including in-person, online, routine, and ad hoc options. As noted in Section 2.6.9.1, we have developed meeting frequency goals based on provider type, member volume, and services rendered. While these standards guide our general approach to meeting frequency, we will meet one-on-one with providers at any time upon request or if we identify a need. While the COVID-19 pandemic required that we make all provider meetings virtual, under normal circumstances, we conduct these meetings in-person or virtually based on the provider's preference. ***Since 2020, our PECs have conducted nearly 5,000 virtual visits with providers.***

In addition to provider meetings, Healthy Blue communicates with providers through multiple communication channels, including our provider website, secure provider portal, and weekly and ad hoc e-blasts, as well as more traditional communication methods like fax blasts and mailings. Through these channels, we disseminate information to our providers quickly and efficiently, providing immediate access to important, actionable information and connecting them with the tools and resources they need to deliver appropriate care and drive quality outcomes. Based on feedback from providers, we recently redesigned our provider website to make it easier to navigate and find the resources they need. Additionally, providers registered for our secure portal through Availity can use the new Provider Chat functionality to get immediate answers to questions about claims submission, prior authorization, and appeals. ***Across our organization, providers have indicated they were able to resolve their issue through Provider Chat more than 85% of the time.***

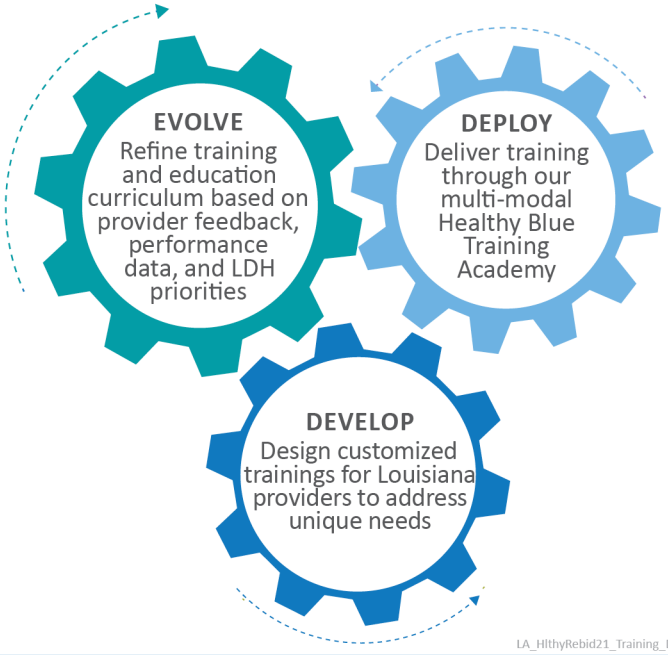
**Proactive Provider Communication.** We understand the importance of having processes in place to provide proactive provider education and training prior to any operational changes taking effect. We have recently made enhancements to this process to better meet the needs of our providers. Our Provider Experience team meets bi-weekly with our Operations leadership to discuss any upcoming operational changes, such as updates to claims payment processes that may impact providers. We then develop the necessary provider outreach campaigns to make sure providers have the training and education they need at least 30 days prior to the change taking effect.

## Strategies to Shape Our Provider Education Program

The key elements that shape our Provider Education program are provider feedback, performance data, and LDH priorities and goals. We regularly engage with our providers to understand their challenges and unique needs. For example, we learned that one of the biggest challenges providers were experiencing during the COVID-19 pandemic was billing for telehealth services. As a result, we developed training materials and provided one-on-one support to educate providers on these processes. We also monitor data, such as claims denials, provider call reasons, and member complaints, to identify trends that may indicate a need for targeted education. Additionally, we develop education on topics that align with LDH priorities, such as PH/BH integrated care and health screenings like Screening, Brief Intervention, and Referral to Treatment (SBIRT).

Our Provider Education program is delivered through our Healthy Blue Training Academy, a dynamic education and training platform that offers a wide array of expert-developed, customized trainings specific to the needs of Louisiana providers. Through the Academy, providers can attend live webinars conducted by our PECs, including monthly orientations and trainings on specific administrative topics including billing and reimbursement. We also offer regular trainings on clinical topics that are relevant to our members and seek to advance population health goals. For instance, in August 2021 we held a webinar on Hepatitis C and how it can be exacerbated by drug and alcohol abuse. Each live training webinar event offers continuing medical education credit for providers and continuing education units for other certified health professionals. Providers also have access to on-demand web-based trainings, the Provider Manual, newsletters, bulletins, and weekly e-updates through the Academy.

HEALTHY BLUE'S APPROACH TO TRAINING AND EDUCATION




We are investing new resources in our Academy by adding the functionality and resources provided by the Elsevier Performance Manager learning management system (Elsevier). Elsevier is a premier health science information platform that offers web-based learning and allows providers to register for courses with specialized content that meet their needs and interests. Elsevier also includes mechanisms for tracking, monitoring, alerting, and reporting compliance and completion of trainings to make sure our providers are successful in fulfilling their contract requirements and meeting members' needs. The learning management system enables the incorporation of additional proprietary competency-based content developed by local, regional, or national experts.

In addition to the webinars and courses available to providers online through the Academy, our Provider Education program also includes ***individual, customized training sessions whenever needs are identified, either through proactive monitoring of provider performance or upon request.*** As detailed previously, every provider is assigned a PEC that is responsible for understanding their needs and making sure our education program meets those needs. We also monitor reports to identify providers that might require additional training. This process is described further in Section 2.6.9.3. and will be further enhanced by the addition of [redacted] In addition to the offerings available via the Academy, PECs also provide education through seminars conducted in partnership with local provider associations, such as the Louisiana Medical Group Management Association.

**Cultural Competency.** One of the primary goals of our Provider Education program is making sure providers have the knowledge, resources, and tools to offer culturally competent care. Our Healthy Blue Training Academy helps support providers by offering cultural competency training in a variety of formats, including webinars, online courses through our provider portal, and individual training as needed. Our "Caring for Diverse Populations" toolkit contains information, tips, and resources regarding language, interpreter services, and cross-cultural issues and helps providers assess their level of competency. Healthy Blue also promotes the use of MyDiversePatients.com, a website that offers free training and resources for providers to help support the needs of their diverse patients along with continuing education (CE) credit. Available trainings include Creating a LGBT-Friendly Practice, Equity in Asthma Care, Breast Cancer Screening for African American Women and Promoting Birth Equity.

**Specialized Education for BH Providers.** We also offer specialized training for various provider types. For instance, we are investing more than $160,000 dollars to expand BH provider capacity through evidence-based trainings, including Parent-Child Interaction Therapy (PCIT). Through Elsevier, Healthy Blue will offer an extensive library of training opportunities and topics based on person-centered principles. Trainings will include independent living philosophy, principles of self-determination, medical versus social models, the value of self-advocacy, self-direction, disability literacy, and more. Healthy Blue has collaborated with top national organizations such as DirectCourse, Association of People Supporting Employment First (APSE), OMNI Behavioral Health, and the American Academy of Developmental Medicine and Dentistry to provide access to this curriculum.


[redacted]

Healthy Blue's provider education strategy also includes partnering with expert organizations to deliver timely education, including evidence-based practices, that improve quality of care, such as our recent Racial Equity Series and our Healthy Equity Symposium, Mental Health First aid training and Learning Labs in partnership with the Louisiana Public Health Institute. Following each educational session, we seek provider feedback through post-forum surveys that we use to enhance our curriculum and Academy for the future. Additional enhancements based on specific feedback that are currently in design include on-demand videos that highlight processes for completing administrative tasks and cover critical topics such as, cultural competency, health equity, trauma-informed care, and utilization of Medication Assisted Treatment to treat opioid use disorder, delivered by trusted Healthy Blue leaders.

## 2.6.9.3 Providers with High Claims Denial Rates

### Supporting Providers with High Claims Denial Rates

To support providers with high claims denial rates, we have established processes that ***comply with Act 710 of the 2018 regular session of the Louisiana Legislature requiring reporting of data on provider claims from Medicaid MCOs***. Healthy Blue is focused on identifying claims denials as early as possible and determining the root cause to correct any system issues. We review our Denied Claims Report weekly to identify providers with a high volume or high dollar value of denied claims. By the end of third quarter 2021, we are adding three additional analysts that will double the amount of proactive claims analyses being conducted. If we identify that the denials are due to provider error, the provider's assigned PEC will work conduct outreach to schedule the necessary claims training. If the claims issue is more complex, the training will be conducted by Provider Claims Educator, who is a certified medical coder. If the denials are due to a configuration issue, we will immediately engage our Reimbursement team to initiate a request to update our systems. If claims deny or reimbursement is impacted for multiple providers due to a system error, configuration fixes are implemented immediately, and providers are notified through our provider portal and e-blast notification within the five-business day State requirement or sooner.

[redacted]

[redacted]

### Provider Escalation Claim Model

In addition to the provider experience resources and processes described previously, ***we launched our new Provider Escalation Claim Model in May 2021*** that allows for greater tracking, trending and monitoring of provider claim denials and enhances the provider communication process to proactively deliver updates on statuses. The PIR team works with the Provider Experience team to support a ***centralized Provider Claim Escalation Model*** that is integrated to support PH and BH providers. It also allows us to more efficiently complete root cause analyses and identify additional providers potentially impacted so that we can conduct proactive outreach and provider education to minimize future denials. This model includes:

- A ***single channel*** for the PEC to submit a claim escalation on behalf of the provider
- A ***standardized escalation process***, including an update every 10 days until resolution; quicker updates are available when required to meet member providers needs
- Enhanced ***transparency*** into the escalation progress
- Identification of ***root causes*** and trends to use for future opportunities
- Enhanced ***reporting*** including an executive dashboard
- Identification and resolution **o**f ***global issues*** that impact multiple providers

## 2.6.9.4 Resolving Provider Disputes in a Timely Manner

### Evaluating and Resolving Provider Disputes

Healthy Blue offers providers a "no wrong door" approach with many avenues to voice a concern or file a dispute, including by phone call, email, through our provider portal, in writing, during visits with our PECs, or through our Provider Services call center. Our call center team intently listens to all provider concerns and whenever possible can **adjust claims in real-time** and resolve issues in a timely and accurate manner. ***Using the collective information gathered at all levels of the dispute process, we perform root cause and trending analysis to minimize future disputes*.**

All employees who may have contact with providers are trained on the appropriate processes for accepting, evaluating, and submitting provider disputes, whether they are verbal or written. All issues that result from an in-person visit with a PEC are documented in our Provider Relationship Management (PRM) tool, a web-based application that allows our PECs and local leadership to track and trend information. Additionally, disputes are recorded and tracked in our centralized provider grievance and appeals system. In the event a provider becomes dissatisfied with our resolution efforts, our team of dedicated local complaint resolution experts will be engaged. This team is responsible for acknowledging all formal complaints by telephone within 24 business hours of receipt, and via email within two business days of receipt. The acknowledgement includes direct contact information for one local point of contact responsible for assisting the provider with follow-up questions related to the complaint and outlining the steps that will be taken to resolve the complaint. We conduct thorough research into each provider complaint using applicable statutory, regulatory, contractual, and provider contract provisions. Final resolution is communicated to the provider within one business day of completion and includes the opportunity to notify us if they are dissatisfied with the outcome. [redacted]

[redacted]

### Disputes Specific to Automatic Assignment Policy and Assignment of an Individual Enrollee

Providers can access their panel of assigned members at any time via the secure portal through Availity. Additionally, our CDT Consultants meet with VBP providers monthly and review their attributed membership. Should providers wish to dispute our assignment policy or assignment of an individual member, they can submit these disputes in writing through their PEC, CDT consultant, or by calling the Provider Services Line. Once received, we will work with the provider to address their dispute within 15 calendar days, as required by the Model Contract, Section 2.9.11.3.3. We will educate providers on this process during orientation, on our website, through regular provider communications, and consistently during monthly provider meetings.

## 2.6.9.5 Delivery System and Payment Reform Strategies

We support providers across the delivery system — partnering with physicians, facilities, and non-traditional provider types — ***to accelerate the shift from volume-based care to patient-centered, value-based care that improves member access, promotes healthy lifestyles, effectively manages costs, and aligns as a key principle of our population health strategy and LDH goals and objectives***.

Our strategy to support providers includes VBP programs for payment reform, with progression opportunities based on the provider's capabilities and goals, as well as information and data sharing that we make available to all providers, regardless of whether they are enrolled in a VBP program. We also focus on delivery system reform for support and development of providers in the delivery of integrated care, supporting cross system collaboration, and advancing evidence-based practices. We support providers to improve quality and reduce costs with a combination of clinical, financial, and operations data that facilitates proper care coordination. These initiatives offer further insight into the needs of our populations so that services can be better planned, coordinated, and delivered, thereby improving member engagement.

Our VBP providers receive consultation, program management, identification of performance improvement opportunities, and help in developing action plans from our ***CDT Consultants***. Our CDT Consultants are VBP experts who serve as the provider's navigator and performance coach. In 2021, we transitioned three nurses who have direct quality management (QM) experience to be a part of the CDT team to achieve higher focus of quality and drive outcomes for VBP programs and providers. Our CDT Consultants offer technical assistance that includes ***coaching, practice transformation consultation, and assistance*** using and interpreting our reporting tools. Our ***integrated data solutions, member dashboards, and scorecards*** help providers improve performance and manage care more effectively. They help providers understand population health data-sharing tools that identify practice-centric opportunities, solutions, and external learning opportunities.

### CDT SUPPORT RESULTS IN QUALITY IMPROVEMENT

In 2019, providers receiving support from our CDT consultants had year-over-year improvement for 11 of 12 quality measures, including:

- **16.2%** improvement in medication management for asthma
- **6.72%** improvement in well-child visits for children 12–21 years old
- **6.66%** improvement in cervical cancer screening

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## 2.6.9.6 Support PCPs in Delivery System Reform

### Supporting Primary Care Providers in Delivery System Reform

Healthy Blue understands that primary care providers play a critical role in delivery system reform, and ongoing partnership is critical to our **Elevate | Population Health** strategy. Healthy Blue is dedicated to supporting primary care providers, including direct financial investment in the provider development pipeline. [redacted]

**Patient-Centered Medical Home (PCMH) NCQA Recognition**. We support delivery system reform by providing financial support to providers who obtain PCMH NCQA recognition. PCMHs transform the delivery system through improved quality and reduction in healthcare costs. We educate providers one-to-one through Provider Experience site visits and personal outreach about the benefits of NCQA recognition. Healthy Blue also has a dedicated PCMH Senior Medical Practice Consultant who works with providers to earn or renew their NCQA recognition. We reach out to targeted PCPs, Federally Qualified Health Centers, and Rural Health Clinics to provide technical assistance toward practice transformation and becoming PCMH recognized. [redacted]

[redacted]

[redacted]

Our Provider Experience team plays a critical role in this process by helping to identify PCPs eligible for respective VBP models as well as helping to identify those providers ready to progress into more advanced models. For instance, in 2021, the Provider Experience team helped to onboard new providers, including Chatters Pediatrics and Verity Health, into 3A VBP programs. Provider Experience, along with our CDT and QM teams, also substantiated the ability to usher forth the first Negotiated Risk/Shared Savings 3B arrangement with Sulphur Pediatric for 2022, which is expected to result in high-quality, efficient, cost-effective healthcare practices.

### Practice Coaching

Healthy Blue's collaborative team of PECs, CDT Consultants, and clinical and quality leaders work with PCPs to improve patient access and communication and coordination of care, resulting in more engaging patient relationships. Our team assists providers by delivering and disseminating patient profiles, predictive modeling analysis, risk stratification data, and clinical intervention alerts that enable physicians to identify and build individualized care plans for their highest-risk patients, all while assuring that all patients receive care that meets evidence-based preventive, acute, and chronic care guidelines.

[redacted]

Our cross-functional team of Maternal Child Health/EPSDT Coordinator, Medical Directors, Health Promotion Representatives, and HEDIS® and quality experts also work with PCPs to promote population health priorities. For example, our PECs link PCPs to our QM Clinical Staff, who are available to help with care reporting related to chronic conditions such as diabetes and conduct member classes at PCP locations related to diabetes prevention and living with diabetes. Similarly, our Maternal Child Health/EPSDT Coordinator is available to meet face-to-face with providers to discuss best practices and areas for improvement, and develop provider-specific quality improvement goals related to maternal and infant health. Our Health Promotions Representatives are also available to assist PCPs with addressing gaps in care with a focus on well child treatments.

## 2.6.9.7 Support BH and Specialty Providers in Delivery System Reform

Healthy Blue understands the role that BH and specialty providers play in delivery system reform. We have implemented several innovative strategies that seek to transform the care delivery system by improving quality of care, advancing health equity, and more effectively managing costs. Our BH and specialty VBP programs support LDH's goal to decrease fragmentation and increase integration as part of delivery system reform across providers and care settings, particularly for members with BH and OB needs.

[redacted]We work to improve cross-agency coordination to make sure members have a greater awareness of and access to mental health, substance use disorder (SUD), and PH care services. For instance, through [redacted]

[redacted]

**Education and Administrative Supports.** We offer integrated PH and BH service management and tools, such as evidence-based screenings and virtual specialty consultations, to help identify members' holistic needs, make timely referral to services, and effectively coordinate clinical care. BH Medical Director, Cheryll Bowers-Stephens, MD, MBA, works with the CDT team to develop and deliver high impact field interventions, supporting content development and practice transformation embedded capabilities improving provider performance. Additionally, our integrated PEC team effectively focuses on helping providers promote a holistic approach to integrated PH and BH care. For example, PECs offer education on referring members with untreated PH issues to their PCP for examination, as well as their responsibility to send the PCP quarterly reports on members' BH status. Our online Coordination of Care form helps BH providers share information with PCPs and other specialists when a member enters BH treatment. This form provides the physician with a better understanding of the member's BH treatment needs. We encourage the use of this form during our interactions with providers and ask that they incorporate it into each member's treatment plan.

## 2.6.9.8 Sharing Provider Performance Data

Our strategies to share actionable provider performance data is an integral component of our Provider Support Plan. Healthy Blue endeavors to reduce provider administrative burden by offering consistent, easy-to-use data and reporting tools and we share member-specific clinical data with all providers using our integrated member dashboard, accessed via the provider portal. In addition, providers have access to our array of performance monitoring and reporting solutions, including our Provider Care Management System available to VBP providers, VBP provider scorecards, and reconciliation reports. These tools allow providers to compare their performance to peers and established benchmarks, and help providers improve quality and manage care more effectively. We outline these data-sharing tools further in Section 2.6.12.6 of our VBP response.

We view every interaction with our providers as an opportunity to share performance data, and tailor our strategies to share this data based on the needs of every provider practice. Our PECs train each provider on how to access performance data during provider onboarding, and we monitor provider performance to identify opportunities for additional education and training opportunities on an ongoing basis.

## 2.6.9.9 Provider Engagement Model

Our locally based integrated Provider Experience team employs a high-touch provider engagement model, with significant emphasis on proactive and local provider engagement. Our approach is based on our experience in Louisiana and includes minimizing administrative burden and providing quick responses to provider inquiries and issues. We tailor our engagement strategies to each individual provider based on their unique capabilities, and further increase engagement through:

- Implementing provider incentive programs that reward providers for delivering quality care

- Minimizing administrative burden, including electronic submission of claims and authorization requests
- Delivering sound reimbursement practices, including prompt and accurate claims payment
- Offering proactive, comprehensive provider education in a variety of venues and participation methods from face-to-face meetings and workshops to webinars and online tutorials
- Assisting at the point of care by providing member utilization data to identify gaps in care and to assure that the member receives all appropriate services
- Streamlining utilization management practice, including electronic submission of authorization requests
- Facilitating a quarterly PAC, where we seek input and feedback from trusted providers on a variety of topics, including service delivery, clinical policies, operations, member access, and VBP

Our approach includes PECs as main points of contact to support provider coordination and engagement with other departments, functional areas, subject matter experts, and resources of our parent companies to emphasize relationship development with our providers. Our fully integrated PECs manage all provider types including PH and BH, allowing multi-specialty providers a single point of contact and will track each interaction with providers in our PRM tool. Our PRM allows us to monitor provider engagement and produce metrics for measuring provider engagement and related improvements in our Provider Support Plan.

## 2.6.9.10 Staff for Provider Engagement

Our team brings longevity and consistency to our providers; members of our leadership team have been with Healthy Blue since implementation of the Healthy Louisiana program in 2012. Provider engagement begins with the members of our Network Development team, who are responsible for onboarding our providers. Once they have joined our network, providers are supported by our comprehensive provider engagement model, as outlined in in Table 2.6.9.10-1.

[redacted]

## 2.6.9.11 The Presence of Local Provider Field Representatives and Their Role

Healthy Blue's [redacted] PECs are located across Louisiana and cover all LDH-designated regions. These highly seasoned professionals are led by our Manager of Provider Experience, Nick Daigle, and have proficiency in cultivating and maintaining meaningful relationships with Louisiana providers. We strategically hire staff that understand the communities where our providers work and live. For instance, [redacted] PECs that support Regions 7 and 8 were born and raised in those regions and understand the challenges providers may experience associated with the more rural landscape.

**Nick Daigle**
**Manager Provider Experience**

Nick, a native Louisianian, has 25 years of Louisiana healthcare experience. He has overseen Healthy Blue's integrated PH/BH Provider Experience team since the Louisiana Medicaid Managed Care Program was implemented in 2012. His team is responsible for easing provider burden and allowing them to provide members with the best care possible.

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Our PECs are the primary face and local touchpoint for our providers, and they are able to proactively answer and resolve contract questions, reimbursement disputes, non-routine claim issues, billing questions, and more. They are committed to providing excellent customer service and make regularly scheduled and as-needed visits to provider offices to offer technical assistance and guidance related to resolution of issues. PECs are also responsible for identifying training opportunities for providers at both the individual level and for the larger provider community. Prior to the pandemic, the Provider Experience team hosted and attended in-person events across the state, including statewide "Road Shows" when they recognized the need for training around a topic that affects many of our providers. This team will resume these activities prior to the start of the new contract, either virtually or in-person, depending on the status of the COVID-19 pandemic.

## 2.6.9.12 Tracking Interactions with Providers (Electronic, Physical, and Telephonic)

Healthy Blue's Provider Engagement staff listed in Section 2.6.9.10 track each interaction with our providers--electronic, physical and telephonic, including scheduled and ad hoc interactions — in our PRM tool. As mentioned earlier, all issues that result from an in-person visit with a PEC are documented in our web-based application that allows our PECs and local leadership to track and trend information. The PRM tool allows us to monitor provider engagement and identify trending provider needs across the state. Additionally, prior to every provider visit, our PECs develop an agenda and materials that they distribute to the provider in advance of the scheduled meeting. We use a Provider Experience Visit Checklist, loaded into our PRM, for each provider visit that documents all information discussed during the PEC's visit, including the information listed in Table 2.6.9.12-1.

*Table 2.6.9.12-1. Provider Relations Checklist Overview*

| Operations | Any Operational and Contracting Issues |
|---|---|
| **Delivery System Reform** | VBP program performance and opportunities for future programs |
| **Provider Training** | Current training, completion status for required training, upcoming educational opportunities and requirements, and provider educational needs |
| **Claims** | Review of claims summary, payment, and denial trends as applicable. The PEC utilizes data from internal accounts receivables financial review, the Internal Resolution Unit Provider Experience Report, Detailed Summary Report, Demographic Detail Report, Claims Detail by Tax Identification Number and Date of Service, and Appeals and Grievance Report |
| **Action Plans** | Ledger of outstanding action items and new actions identified during visit |

Provider signatures are required on each checklist to confirm their participation in the visit and acknowledge their agreement to any follow-up action items identified. Following the visit, a written follow-up is sent to the provider with a survey link requesting feedback on the provider satisfaction with the visit; information is entered into our PRM; and the PEC initiates internal meetings as appropriate, assigns action items, and assures deliverables are met and action items are closed based on the provider's needs identified during the visit.

## 2.6.9.13 Data to Identify Specific Training Needs

We use multiple tools and reports to collect and analyze data to identify special training needs. We monitor performance data, such as claims denials, Provider Call Center interactions, and complaints to identify trends or patterns that are indicative of the need for provider training. If the issue impacts a specific provider or provider type, we personally engage the provider(s) involved to discuss the issue and develop an action plan, including the implementation of additional training.

Additionally, our Provider Experience model assures every Louisiana provider has a dedicated PEC responsible for obtaining feedback on their individual training needs and delivering on-site or virtual training sessions as needed. ***Since 2020, our Provider Experience team has conducted more than 5,000 virtual provider visits, assessing individual provider needs and providing education and training on Healthy Blue processes.*** We also obtain provider feedback through our PAC meetings and provider surveys. Based on this feedback, we develop and customize training and education to enhance provider skills and continue to refine training based on feedback.

Our QM oversight process includes review of quality data (for example, HEDIS measures) to identify gaps and provider practice patterns for training opportunities. For instance, we reviewed ADHD medication utilization to identify outlier providers and offered to all PCPs and pediatricians an interactive e-learning experience for providers based on *Caring for Children with ADHD: A Resource Toolkit for Clinicians*, a collaborative project between the Louisiana Chapter of the American Academy of Pediatrics, and the Louisiana Department of Health.

## 2.6.9.14 Measure the Overall Satisfaction of Network Providers

Our annual Healthy Blue provider satisfaction survey (PSAT) process includes an objective review of activities and systems that assesses quality of care and service This NCQA-approved survey is fielded annually in the summer and targets a randomized sample of various provider types (PCPs, specialists, BH specialists, and OBs), prioritizing high-volume providers in each region or parish. Providers complete the survey online or in hard copy. Our PECs encourage non-responders to complete the survey during their regular interactions to reach an appropriate sample size for analysis. All completed surveys are processed to produce detailed summaries of results and are compared to prior years' metrics to identify upward and downward trends, and areas of opportunity to act upon. We gauge satisfaction with Healthy Blue in the following areas:

- Overall satisfaction
- Claims processing and provider reimbursement
- Chronic Condition Management
- Rating of Plan manuals
- Loyalty
- Utilization Management
- Satisfaction with services
- Satisfaction with information exchange

[redacted]

We review results of our annual PSAT and the annual Healthy Louisiana provider satisfaction survey, identify areas of opportunity, create action plans, and initiate a workgroup to drive improvement of scores through specific, measurable actions. ***We conduct ongoing quality assurance by offering providers the opportunity to fill out a provider satisfaction survey after each web-based, telephonic, or in-person interaction with one of our PECs.***

> *We appreciate the organization and willingness to get us the information that we need. We also appreciate the frequent communications throughout COVID when other plans were resistant to meeting and communicating.*
>
> **Satisfaction Survey Feedback**
>
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In 2021, Healthy Blue conducted a Provider Listening Tour to solicit candid feedback from providers to identify where enhancements could be made to improve the overall provider experience. Between March and May 2021, we contracted with an independent external consultant to conduct 12 provider interviews to investigate how well Healthy Blue performs compared to other Healthy Louisiana MCOs. We learned our providers were largely satisfied with the services and support delivered by Healthy Blue. Additionally, we identified areas of opportunity: timely response to provider inquiries, COVID-19 strategies, and virtual access to specialists. We incorporated this feedback into our Provider Support Plan and are making enhancements to our provider support offerings. For instance, we are implementing ConferMED, which expands virtual access to specialists through e-consultations. Oversight of the Provider Support Plan will be conducted by QM Committee.

## 2.6.9.15 Provider Training

Healthy Blue providers have access to a comprehensive Provider Education program as outlined in Section 2.6.9.2. This program begins with provider orientation, which is the foundation for long-term collaboration between Healthy Blue and our providers. In accordance with Model Contract Section 2.10.7, we offer orientation training to providers that join our network within 30 days, either through monthly webinars, 1:1 training, or our soon-to-launch Provider Pathways Digital Orientation. Orientation topics include administrative requirements, like claims submission and prior authorization, cultural competency, and Louisiana Medicaid Managed Care Program requirements. A high-level overview is included in Table 2.6.9.15-1.

*Table 2.6.9.15-1. Healthy Blue's Provider Training Topics at a Glance*

| New Provider Orientation | |
|---|---|
| ▪ Intro to Healthy Blue | ▪ Quality Program and HEDIS Measures |
| ▪ Provider Experience Team | ▪ EPSDT Services |
| ▪ Healthy Louisiana Program Requirements | ▪ Privacy/Confidentiality of PHI |
| ▪ Benefits and Covered Services | ▪ Appointment Access and Availability Standards |
| ▪ Enrollment and Credentialing Process | ▪ Value-added Benefits and Social Supports |
| ▪ Authorization Procedures and Guidelines | ▪ Social Determinants of Health |
| ▪ PH and BH Integration | ▪ Mental Health (MH) and SUD Protocols/Resources |
| ▪ IPAT | ▪ VBP Programs |
| ▪ Billing Procedures and Claims Submissions | ▪ Member and Provider Satisfaction Surveys |
| ▪ Provider Manual, Web Portal, and Resources | ▪ Pharmacy Program |
| ▪ Grievances and Appeals, Dispute Resolution | ▪ Fraud, Waste, and Abuse |

| Cultural Competency Training | |
|---|---|
| ▪ Healthy Blue Cultural Competency Plan<br>▪ Cultural Competency Assessment Tools<br>▪ Understanding and Increasing Awareness of Multilingual, Multicultural, and Disability Needs of Individuals<br>▪ Review of the 15 National Standards for Culturally and Linguistic Appropriate Services (CLAS)<br>▪ Culture and the Impact of Healthcare<br>▪ Social Determinants of Health (SDOH) | ▪ Expectations for Providers and Staff (Including Mandate to Continually Expand Cultural Competency Knowledge and Skills)<br>▪ Compliance and Physical Access Requirements and ADA Accessibility Standards for Members, Including Those with Physical and Cognitive Disabilities<br>▪ My Diverse Patient Trainings<br>▪ Adverse Childhood Experiences (ACEs) Training<br>▪ Racial Equity |
| **BH Training** | |
| ▪ Screening for Identifying and Coordinating BH Disorders<br>▪ Community MH Program and Trainings Related to Suicide Risk, Prevention, and Post-intervention | ▪ Supporting Integrated Care at Pediatric Practice Level<br>▪ Members with Co-occurring MH and SUD<br>▪ Referring Members to BH Specialists |

In addition to the training topics listed in Table 2.6.9.15-1, we offer a wide variety of helpful and informative training topics that offer CE through our Healthy Blue provider training page, accessible through the Academy. These live and on-demand trainings focus on subjects such as clinical patient care; coding and documentation; reimbursement, billing and claims; and quality and practice improvements. For example, we offer trainings on our quality monitoring tools, customized for different provider types, on at least a monthly basis. In June 2021, we offered this training for ASAM/OTP providers, and in July 2021, we offered this training for Applied Behavioral Analysis services. We also deliver additional monthly trainings on topics that are determined by various factors, including changes to operational or program requirements, current events (such as the COVID-19 pandemic), provider needs, and LDH priorities. Examples of clinical, quality, and administrative trainings we have offered or will be offering in 2021 are included next.

- **SBIRT.** April and May 2021
- **Pediatric Preventive Screenings.** June 2021
- **Hepatitis C and Drug/Alcohol Abuse.** July and August 2021
- **Person-centered Planning.** September 2021
- **Cultural Competency and SDOH.** December 2021
- **Recognizing Signs of Abuse, Neglect, Extortion, or Exploitation.** December 2021
- **CPT Changes for 2021.** March 2021
- **Complete and Accurate Diagnosis Coding.** June 2021
- **Correct Coding and Denial Awareness.** July 2021

We incorporate convenient, on-demand access and multi-modality delivery channels into our training to maximize participation, reduce administrative burden, and promote enhanced service quality to our members. Additionally, when we recognize the need for training around a topic that affects many of our providers, we deploy group training in the form of statewide “Road Shows.” Most recently, we hosted several virtual seminars across Louisiana to discuss how accurate ICD-10-CM coding can help providers meet HEDIS measures and close care gaps.

We also offer specialized training for various provider types to meet the needs of members; for example, BH providers receive specialized training related to fail first/step-therapy, approved prescribing caps, Child and Adolescent Needs and Strengths, Level of Care Utilization System, and Office of Behavioral Health standardized training for non-licensed providers. In collaboration with the LSU School of Public Health, Auburn University, and MCOs, we developed and recently implemented PCIT training; PCIT is an evidence-based treatment modality for young children and their families. In addition, we partnered with Tulane University to develop and deploy trauma-informed care and PTSD training for providers.

Healthy Blue strives to engage the provider community by developing thoughtful and intuitive training topics to assist providers as they care for our members. We will continue to actively seek input from our providers to confirm that the training that we offer provides them with the support they need to meet our member’s population health needs and achieve their cost and quality goals.

## Protecting Our Community from COVID-19

Along with local organizations like 100 Black Women, Healthy Blue collaborated with Walgreens to make vaccines accessible to every eligible patient in our community. Healthy Blue hosted a mobile health equity clinic at the Capital Area Transit System terminal, giving transit riders twelve and older the opportunity to receive the vaccine. As an added incentive to vaccinate, Healthy Blue arranged for the first 100 families to the event to receive fresh produce and protein boxes from Top Box Louisiana.

# 2.6.10

## Utilization Management

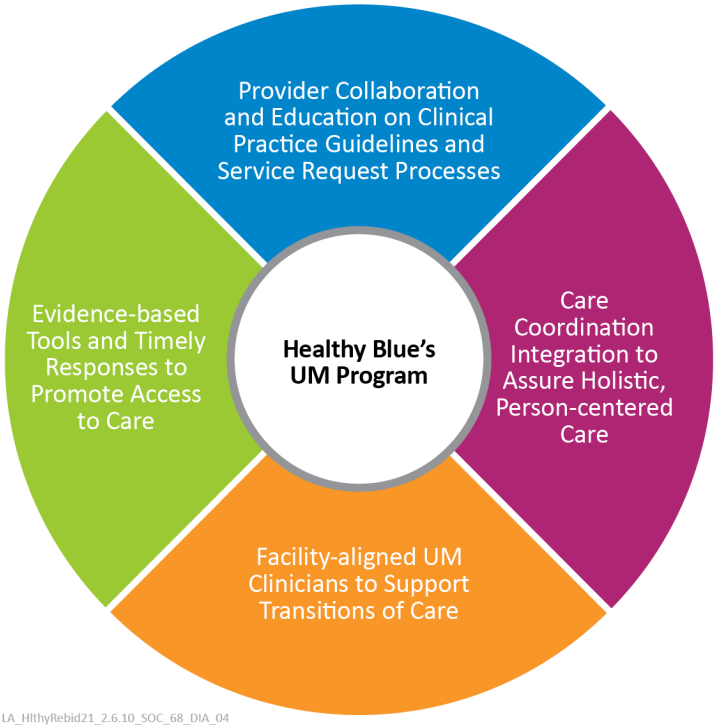
Healthy Blue

# 2.6.10 Utilization Management

## 2.6.10.1 Satisfying Requirements for Authorization of Services

Healthy Blue's utilization management (UM) program is integrated with and supports our **Elevate I Population Health** approach, which is aligned with LDH's goals to advance evidence-based practices, healthcare service excellence, high-value care, and enrollee (member) health. During our more than nine years' experience with Louisiana Medicaid, we have continually refined our UM approach. Our integrated UM leadership, under the direction of Chief Medical Officer, Dr. Raymond Poliquit and Behavioral Health (BH) Medical Director, Dr. Cheryll Bowers-Stephens, has built collaborative relationships with providers and implemented processes to reduce provider burden while assuring quality care for members. Dr. Poliquit has more than 25 years of clinical experience as a practicing board-certified pediatrician in Louisiana and Fellow of the American Academy of Pediatrics. Dr. Bowers-Stephens is board-certified in both psychiatry and child and adolescent psychiatry and recognized as a subject matter expert on integration of physical and BH, having worked with the Department of Health, Office of Mental Health, and LSU School of Public Health in a variety of roles and positions for the last 20 years. Healthy Blue's UM program assures ***each member gets appropriate individualized supports and medically necessary care, where and when they need it***. We continually consider not only members' medical or behavioral conditions when making medical necessity decisions, but home environments; family and caregiver supports and resources; and social challenges, as well as any uniqueness of healthcare in the member's community.

HEALTHY BLUE'S UM PROGRAM PROMOTES TIMELY ACCESS TO NEEDED CARE




### Policies, Procedures, Systems, and Staff Guide Consistent Service Authorization

Healthy Blue's comprehensive UM policies and procedures, systems, and experienced staff guide accurate and consistent application of clinical criteria for service authorization and concurrent and post service reviews in accordance with our Contract with LDH. We will continue to submit our UM program policies and procedures to LDH or its designee for review and approval prior to making any substantive changes.

We align UM clinicians to key hospital systems, facilities, and high-volume providers, such as University Medical Center and Ochsner LSU Health Shreveport, providing them a single point of contact who builds rapport and facilitates open and consistent communication. Our streamlined processes support providers in timely, cost-effective service delivery. Our UM processes include technology solutions and non-clinical staff who support intake of authorization requests and help obtain missing clinical information to streamline the review process for our clinical reviewers. Our qualified, experienced UM clinicians review, document, and approve requested services in a timely manner to minimize any disruption in services. ***During our most recent NCQA Health Plan Accreditation Survey, we achieved a perfect score for elements of our UM Program and Policies, and a rating of High in all elements of file review.***

### Integrated Service Authorization System

***Healthy Blue's Health Intech*** platform supports timely service authorization decisions for physical and BH services. Designed for efficiency and accuracy, service authorization requests are processed, routed, and date and time stamped for all steps taken in the review process. The rationale for decision-making as well as the name and credentials of staff making the decision are documented. Additional features of ***Health Intech*** include:

- Clinical decision support tools integrated with clinical guidelines
- Digital Nurse Assistant tool quickly links UM reviewers to clinical information submitted by providers
- Automated routing of authorization requests to the appropriate internal team
- Automated business rules integrated with authorization requirements support near real-time approvals

Healthy Blue implemented our Interactive Care Reviewer (ICR) solution in 2021 to further reduce provider burden. ***ICR is a fully automated, web-based decision support tool providers can access 24/7 to submit prior authorization (PA) requests and offers immediate approval of requests that meet established criteria.*** If immediate authorization cannot be granted, providers are given tracking information and notified when the review is complete. If a service does not require PA, providers receive immediate notification. Providers can sign up for email notifications at the time of submission, which provides automated notifications. At any time, providers can view the decision and associated written communications from their ICR Dashboard.

## Service Authorization Requests from Authorization to Approval

We use service authorization as a tool to assure members receive the most appropriate and highest quality care. Our service authorization workflows, policies, and processes for timely authorization decisions accommodate the clinical urgency and necessity of any situation. Figure 2.6.10.1-1 illustrates our service authorization process.

***Our UM clinicians are available 24/7 to assist providers with urgent and emergent requests.*** Healthy Blue takes a "no wrong door" approach to authorization requests. Providers can submit requests by telephone, fax, and through our provider portal; members can submit requests verbally or in writing. We offer providers electronic access to Healthy Blue clinical guidelines and service authorization criteria.

Our UM approach confirms members are safely treated in the right place, at the right time, in the most integrated setting. When we receive an authorization request, our UM reviewer enters the clinical information into our Health Intech, verifies eligibility, and evaluates the clinical information against appropriate medical necessity guidelines. Using clinical decision support tools, requests are reviewed against benefits and services defined in the Model Contract, Section 2.4. Our Medical Directors, UM leadership, and UM reviewers work collectively to verify that PA, concurrent, and retrospective review decisions are based on medical necessity and appropriateness in setting, contract provisions, and covered services. ***Our goal is to always seek to improve health outcomes, reduce the likelihood of low-value care, unnecessary, and inefficient services, and to safeguard member safety.***

To meet members' whole-person needs, our UM team closely collaborates with providers and other Healthy Blue teams including Care Management, Provider Services, and Pharmacy. During daily rounds, our UM staff and Medical Directors review authorization requests and identify additional information needed. ***To best address the specialized***

***needs of our youngest members and in alignment with our population health approach, we added a neonatologist to lead integrated NICU rounds, complete NICU reviews, and facilitate peer-to-peer consultations.***

If the UM reviewer is unable to ascertain sufficient information to determine medical necessity, the request is routed to a licensed Medical Director, who makes consistent medical necessity decisions in accordance with State and NCQA standards. The Medical Director discusses service options with the treating provider and consults with a qualified external physician reviewer specializing in the services requested, as indicated, prior to making a decision. At any time, providers can request a peer-to-peer consultation to discuss the case, potential treatment, or alternatives. ***Any decision to deny a request or authorize a service in an amount, duration, or scope that is less than requested is made by a Healthy Blue licensed Medical Director or designee after an evaluation of clinical history, health needs, and social determinants of health (SDOH).*** Initial and concurrent inpatient psychiatric hospital utilization reviews are completed by Licensed Mental Health Professionals (LMHPs) or psychiatrists.

**REDUCING PROVIDER ADMINISTRATIVE BURDEN**

For facilities that have granted us access to their EMR system, we can access their EMRs to streamline PA requests to support safe member transitions. This eliminates the need for the provider to gather information or package medical records to submit, reducing the amount of time spent on submitting PAs. In addition, if Healthy Blue has access to EPIC, we can access specific medical records directly, further reducing the administrative burden.

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For any adverse determination or partial adverse determination, we promptly notify the member and provider verbally and in writing. Each denial notice is written in member-accessible language and outlines the reasons a requested service is not medically necessary, factors considered, and additional actions available, including the ability to submit an appeal. Our member denial letters are compliant with State requirements, including Chisholm, HB 424 of the 2019 Legislative Session, as well as NCQA standards. Member notices include fair hearing and ombudsman information. After an adverse determination, members or their authorized/legal representative have 60 calendar days to file an oral or written appeal. To be sure all considerations are made, we include an Informal Reconsideration process that allows the member (or provider or agent on behalf of a member) a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing following the denial.

**REDUCING PROVIDER ADMINISTRATIVE BURDEN**

Our Gold Card Program will waive PA requirements for providers who consistently meet or exceed PA performance and quality criteria. This will allow these providers to "bypass" the PA process.

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## Meeting CSoC and PRTF Requirements

Our population health focus supports our young members in receiving timely and appropriate services.

**Psychiatric Residential Treatment Facility (PRTF).** We complete PRTF prescreening within 24 hours. In consultation with the member's parent, guardian, or referring party, we identify a facility with availability. Prior to admission, the multidisciplinary care team reviews other community-based options that meet the child's overall life-domain needs. When there is an admission, on-site concurrent review LMHPs immediately begin planning for discharge. With the facility, they assess member progress and anticipated needs at discharge; work with the facility to verify medical necessity of continued stays; and coordinate discharge planning to facilitate a safe transition. For youth transitioning from a secure setting to a PRTF, we coordinate completion of a Certificate of Need prior to admission in accordance with contractual directives. Once admitted, recertification of the stay occurs every 60 calendar days.

**Coordinated System of Care (CSoC).** We complete the initial CSoC waiver service screening for children and youth when a member is identified as at risk for hospitalization and resides in a home or community setting as well as at least 90 days prior to an expected discharge from a residential service. Should the member screen positive, we refer the parent to the CSoC BH administrator via a warm telephonic transfer. After screenings, we inform, describe, and educate families about specialized services and how to contact the CSoC BH administrator. We collaborate with the CSoC BH administrator on the outcomes of those who are enrolled in CSoC services in our weekly "CSoC collaborative rounds."

## 2.6.10.2 Satisfying Requirements for Utilization Management

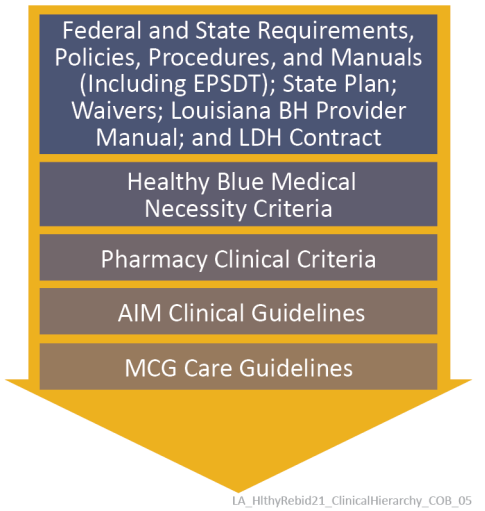
Our UM program prioritizes individual member needs and assesses the availability of services within local delivery systems. We employ an integrated and holistic UM approach that addresses physical health and BH conditions, as well as SDOH, to drive clinically appropriate, safe, and efficient healthcare services in response to each member's unique needs, experiences, and situations. Our UM program is a critical component of our ability to impact healthcare disparities through appropriate authorization and management of services to achieve health equity across communities. Through our comprehensive, effective service authorization processes and our sophisticated utilization monitoring capabilities, we identify opportunities to intervene, ***so members receive the right services, in the right setting, at the right time for them***.

UM is a key component of our care management program. It helps to support the appropriate provision of care, coordinated benefits, and proactively identifies the acuity (risk) level of members, which results in referrals to care management. UM and care management work together to make sure all member care needs are met. ***Healthy Blue's strategies are based on measurable outcomes that promote accountability, evidence-based practices, and fully integrated whole-person care*.**

## 2.6.10.2.1 Proposed Criteria and Application of Criteria

Our UM program aligns our service authorization criteria in accordance with the Model Contract and assures compliance with LDH's definition of medically necessary services. Our UM team applies criteria based upon a defined hierarchy. We first review all relevant LDH, state, and federal rules and guidelines. Where these criteria are silent, we apply Healthy Blue policies and guidelines. Our clinical criteria and guidelines assure both the appropriateness of treatment and appropriate site of treatment. Healthy Blue's criteria and guidelines are no more restrictive than Medicaid fee-for-service requirements.

### CLINICAL CRITERIA HIERARCHY

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As an example of how we apply criteria for specialized services, we use our subcontractor, AIM Specialty Health, to review and authorize selected diagnostic imaging services using their Advanced Imaging Clinical Appropriateness Guidelines. Prevention of unnecessary radiation is a patient safety issue; this arrangement makes sure members receive services that are safe, effective, and consistent with current evidence-based practices.

Our UM reviewers leverage state manuals for specialty BH services, such as Mental Health Rehabilitation (MHR), Applied Behavior Analysis, and addiction services. We also consider clinical practice guidelines (CPGs) such as those from the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and American Psychiatric Association. During the UM process, our reviewers consider members' individualized needs, including age, complex variables, SDOH, cultural needs, progress of treatment, home, and safety as well as availability of services in our provider network within a member's geographic area.

***We annually review and adopt criteria in our locally based Medical Advisory Committee, which includes participating Louisiana licensed providers in various specialties such as obstetrics and gynecology, psychiatry, otolaryngology, and family medicine.*** Under the direction of our Chief Medical Officer, our locally based UM Committee monitors consistent application of service authorization criteria, and reviews results of all audits and utilization trends, UM program effectiveness, and provider experience results.

### Assuring Consistent Application of Criteria

Healthy Blue implements multiple strategies to make sure staff consistently and correctly apply criteria and make appropriate medical necessity decisions.

### HEALTHY BLUE SUPPORTS COLLABORATIVE CRITERIA DEVELOPMENT

Healthy Blue's UM leadership partnered with LDH to provide feedback on development of criteria for ABA therapy. Through our leadership with the Louisiana Managed Medicaid Association, we led work with other MCOs to develop vitamin D guidelines and respiratory viral panel screening guidelines.

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**Inter-rater Reliability (IRR).** We conduct monthly IRR rounds and annual IRR reviews to monitor application of criteria for consistency and accuracy. [redacted] If a staff member scores below the expected threshold of 90%, pendent authorization decisions and provide retraining. Privileges are reinstated following re-testing and demonstrated improvement.

**Performance Improvement Enhancement (PIE) Audits.** These audits support consistent application of criteria for authorization decisions. [redacted]

**Integrated Rounds.** Through daily, weekly, and bi-weekly integrated rounds, our UM reviewers and Medical Directors discuss cases and criteria, including the review of criteria application. Where appropriate, our Case Managers, Pharmacy Director, Peer Support Specialists, and Specialty Liaisons (for example, Tribal and Health Related Social Needs) are involved in confirming all member needs are addressed.

**UM Staff Training.** To assure consistent application of UM policies and criteria, clinicians complete rigorous training prior to and concurrent with processing authorization requests. Training consists of ***three weeks in classroom and four to six weeks preceptor training*** that includes skill practice scenarios with checkpoints, quick reference guides, identification of available tools and resources, and error and warning messages to help guide reviewers. Specific training modules for general topics include:

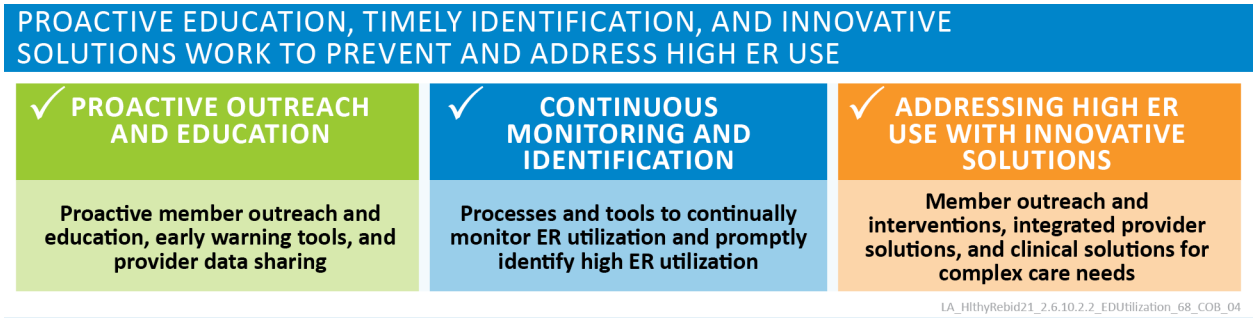
- Overview of Medicaid and Medicare
- Treating the whole person (physical health and BH)
- Legal and ethical issues and HIPAA compliance
- Day in the life of an UM clinician and understanding authorizations
- Review of medical policies and clinical UM guidelines, including making appropriate clinical decisions

We supplement these general topics with ***in-depth, micro-learning training exercises*** for:

- Systems
- Inpatient daily census
- Emergent and planned inpatient admissions
- Initial length of stay
- Concurrent reviews
- LDH authorization timeframes
- Discharge planning
- Person-centered and trauma-informed care
- Pharmacy authorizations
- Preparing for rounds
- EPSDT and Chisholm compliance
- Applied Behavioral Analysis therapy

## 2.6.10.2.2 Process for Monitoring and Addressing High ER Utilization

We identify and address high emergency room (ER) utilization through continuous data collecting and mining, monitoring to identify trends and opportunities, and developing member and provider targeted solutions. Our approach to addressing high ER utilization begins with proactive member outreach and education about appropriate use of ERs and alternative resources and sharing timely member utilization data with providers to encourage preventive care to prevent members from needing emergency services.




To help guide our efforts to monitor and address high ER utilization, in 2021 we conducted a comprehensive analysis of ER use across Louisiana to identify trends. Within our membership, we identified the New Orleans and Lafayette regions as the first and second highest drivers for ER visits, respectively, and the Northshore region showed the highest increase in ER visits. Young adult members (18-21 years of age) drive most ER visits and 60% of ER visits are by women. To directly address these utilization trends, Healthy Blue implemented several initiatives to equip members with the information needed to make appropriate decisions about where and how, while providers were given information and data to guide members accordingly.

### Monitoring Emergency Room Utilization

[redacted]

- [redacted]

[redacted]

## Addressing High ER Utilization

Healthy Blue uses a tiered approach to address ER utilization, beginning with outreach to new members. We connect them their PCP and let them know where nearby urgent care centers are located. If they have not seen their PCP within three months of joining Healthy Blue, we text them to remind them of the importance of connecting with their PCP (if the member has consented to text messaging as a form of communication). If appropriate, we engage members in care coordination or Tier 1 case management. Our ER Readmission Task Force is a multidisciplinary committee leveraging a Critical Incidents dashboard with metrics indicating who might present to the ER after suicide attempt, with suicide ideation, or with substance use disorder (SUD) during pregnancy. We use multiple strategies to reach members at risk for ER use and engage them in our care management programs.

**Member Engagement Solutions.** Members with high ER utilization can benefit from care management, education, and outreach to guide appropriate ER use and encourage preventive care.

*Care Management.* Using screening tools that identify members with three or more ER visits in a six-month period, including those in transition between settings, Case Managers provide supports that help to prevent the need for emergency services. Case Managers reach out to members to discuss precipitating circumstances for ER visits and to complete a health needs assessment, assess for care gaps, and make sure members are linked to a PCP and BH provider, as applicable, while evaluating for any new or evolving care needs.

**Member Outreach Campaigns.** We use a post-ER redirect texting campaign to reach out to members following an ER visit to make sure they are connected to a PCP and educate them about appropriate ER use and resources available when they need emergency or urgent services.

[redacted]

[redacted]

**Member Incentives.** Through our Healthy Rewards program, we offer members incentives for accessing care in the most appropriate care setting by encouraging preventive care and chronic condition management; we also offer value-added benefits (VABs) to augment covered services. [redacted]

**Community Paramedicine.** [redacted]

**Navigator 2.0 Program.** This initiative generalizes and expands Healthy Blue's Access Navigator program, which is based upon the evidence-based Harold P. Freeman Model, to assist members with both physical and BH disorders who are at high risk of ER use and hospital readmission. [redacted]

**Partnering with Providers.** We work closely with providers to drive appropriate ER use. We implement multiple strategies to educate providers on patterns of member ER use and reward providers for appropriate ER use and enhanced access to ER alternatives. We facilitate regular Joint Operating Committee meetings with providers such as Franciscan Missionaries of Our Lady Health System and Ochsner Health to address needs and share data. Our UM and Care Management teams participate in regionally based, multi-provider Readmission Coalition Meetings hosted by Louisiana Hospital Association Research and Education Foundation, Louisiana Nursing Home Association, and HomeCare Association of Louisiana regionally. In several regions, we will be combining efforts with eQHealth Solutions, working as Quality Insights, the Medicare QIN-QIO for Louisiana, where obvious synergy and overlapping missions exist. We encourage all area hospitals, nursing homes, home health, hospice, insurers, pre-hospital, pharmacy providers, and physicians to attend with the purpose of keeping patients and residents in appropriate care settings by building inter-provider relationships and sharing best practices surrounding readmission prevention.

### PROVIDERS REPORT HIGH SATISFACTION WITH HEALTHY BLUE'S UM PROCESSES

According to the most recent LDH Provider Satisfaction Survey results, BH providers ranked Healthy Blue highest among MCOs for our:

- Process of obtaining pre-certification, referral, and authorization information
- Peer-to-peer review process

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**Information Sharing.** We share data with providers on ER usage rates through the Availity provider portal for their attributed members and partner with them to address members with high ER use. As noted earlier in our response, network providers will be able to access real-time ADT data through Availity.

[redacted]

**Telehealth.** To improve access to services during the COVID-19 pandemic, we educate members on the availability of telehealth through their PCPs and other providers, while simultaneously equipping providers with the tools needed to successfully offer virtual visits. This includes the Telehealth OS platform, which offers providers HIPAA-compliant access to telehealth services at no cost. Telehealth OS is payer agnostic so providers can use the platform to conduct telehealth appointments for any of their patients, not just Healthy Blue members. [redacted]

[redacted] ***These innovative solutions will increase access to care, eliminate language barriers, and improve health equity.***

**Expanding Access to Integrated Care in Underserved Communities.** Healthy Blue is exploring a partnership with Cityblock that would expand access to integrated care by bringing in additional providers into underserved communities and providing integrated trust-based, person-centered care to members at highest need. Cityblock members in other markets have experienced positive outcomes, including reductions in unnecessary ED visits and inpatient admissions, which we anticipate would be replicated in Louisiana.

**Complex Situations Call for Multifaceted Clinical Solutions.** As part of Healthy Blue's population health approach, our clinical solutions address disparate use of ER services among members with innovative programs specifically designed for subpopulations.

**Sickle Cell Disease.** Our Data Analytics team uses diagnosis and claims data to identify missed care opportunities. When the team examined ER use by members with sickle cell disease, they found a high rate of ER use was associated with poor access to, or use of, primary or urgent care settings for pain management. By connecting members with a provider and establishing an ER diversion program with an interdisciplinary team approach, we support planned access to care that eliminated potentially long and uncomfortable waits in the ER. [redacted]

**Substance Use Disorder (SUD).** When we see indicators of potential SUD (including obtaining prescriptions from numerous physicians or pharmacies without providers' knowledge or obtaining or dispersing prescriptions by fraudulent actions) that could lead to high ER use, we reach out to the member and their providers, gather information, and help arrange an evidence-based best practice Screening, Brief Intervention, and Referral to Treatment. [redacted] with an overdose diagnosis as well as SUD diagnoses from similar services and across populations to compare utilization rates of members with similar diagnoses and acuity.

### INNOVATIVE SOLUTIONS FOR OUR YOUTH

We take a focused approach when a Healthy Blue youth or DCFS member goes to the ER experiencing a BH crisis. Upon notification, our UM Manager engages with the Case Manager to confer on the case. If the facility is in the LHIN, we are notified electronically. Our BH Liaison, part of our youth-focused case management team, deploys a Case Manager to assist based on the presenting issue. The Case Manager contacts the hospital representative to assist with identifying the best placement option and contacts the parent or guardian, introduces their role, provides their contact information, and begins the collaborative process of transitioning the child to the right setting, at the right time, and in the safest manner.

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**Medication Therapy Management (MTM).** Healthy Blue offers MTM for members managing multiple chronic disease states and medications to improve health outcomes and reduce ER use. [redacted]

We look forward to continuing to bring meaningful, member-centric solutions to address inappropriate and high ER utilization and improve the health and well-being of Louisianians.

## 2.6.10.2.3 Process for PASRR and Concurrent Reviews

We recognize the role we play in the prescreening of nursing facility services and continued stay reviews. These screening mechanisms assist both the MCO and LDH with assessing availability of member services, assuring consistent application of medical necessity criteria for level of care determinations, promoting consultation with the requesting provider, collaboration between agencies, and the ability to arrange for another level of care if appropriate. Our LDH-informed policies and processes comply with requirements as identified within the MCO Manual and Model Contract regarding prescreening and concurrent reviews.

### Pre-Admission Screening and Resident Review (PASRR) Process

We receive referrals from the Office of Behavioral Health (OBH) to assess the appropriateness of nursing facility placement and the need for, and facilitation of, BH services. Healthy Blue will complete and submit completed PASRR Level II evaluations within four business days of receipt of the referral; we track and monitor all PASRRs through an internal tracker to assure timely completion. We keep all records of completed PASRRs.

Using the criteria set forth in 42 C.F.R. Part 483, Subpart C and the PASRR Level II standardized evaluation form provided by LDH, Healthy Blue conducts PASRR Level II evaluations of members upon referral from LDH to determine the need for nursing facility services or the need for specialized services to address mental health conditions while the member is in a nursing facility. In compliance with 42 C.F.R. §483.130, we monitor members in nursing facilities who have been through the PASRR process, who are identified with serious mental illness, and those receiving specialized services. We defer to State findings on PASRR Level II. In compliance with 42 C.F.R. §483.120 and the DOJ Agreement, we report all PASRR specialized BH services to LDH on a quarterly basis, and all PASRR Level II evaluations will be repeated upon request by OBH for continued stay.

### Concurrent Review Process

We conduct concurrent review for inpatient and residential services and continued stay review for nursing facility services when the provider and member determine treatment should continue beyond initial authorization and make decisions within one calendar day. In coordination with the provider, the UM reviewer engages care management and discharge planning for placement, medications, and authorizations as needed. In performing concurrent and continued stay reviews, UM reviewers assess individual member progress and needs during the episode of care and coordinate before discharge to facilitate the member's smooth transition between levels of care or to home, and to prevent delays in discharge caused by unanticipated care needs. Healthy Blue will not deny continuation of higher-level services, such as inpatient hospital or PRTF, for failure to meet medical necessity criteria unless we can provide the service through a provider at a lower level of care.

## 2.6.10.2.4 Complying with Mental Health Parity Requirements

Our practices for PA, standards for medical necessity determination, and network policy and procedures comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and 42 C.F.R. Part 438 Subpart K. We post our criteria for medical necessity determinations for mental health and SUD benefits to our website and provide them in hard copy to members, potential members, and providers upon request. Healthy Blue participates in Anthem's Parity Governance Committee, which reports to the Medical Compliance Committee as well as other clinical committees regarding overall parity compliance. Anthem's Parity Governance Committee activity supports Healthy Blue's efforts and provides us oversight and guidance in sustaining MHPAEA compliance.

Healthy Blue's integrated physical health and BH policies and procedures assure parity. ***We perform BH services in house, affording us an additional layer of oversight and internal controls to assure mental health parity.***

We examine parity across both clinical and operational areas including, but not limited to, population health management, UM, network access, benefits, and claims. In accordance with requirements, we apply and monitor parity for all populations across four classifications: inpatient, outpatient, emergency care, and prescription drugs. For services in each classification, we assess and confirm that mental health or SUD and medical or surgery standards (both written and operational) are comparable along the following dimensions:

- **Benefit Limitations.** We confirm the number of mental health or SUD benefits covered per year are on par with the number of comparable medical or surgical benefits covered per year
- **Financial Requirements.** We confirm that a member is not required to try less expensive treatments before pursuing treatment suggested by a doctor or because they have not failed a lower level of care; any risk sharing with providers for mental health/SUD services is comparable to medical or surgical services
- **UM Requirements.** We confirm that our PA requirements and medical necessity criteria for mental health or SUD benefits are not more restrictive than those for comparable medical or surgical benefits
- **Network Adequacy.** We confirm our provider networks for mental health and SUD are not narrower, and provide out-of-network coverage for mental health and SUD benefits comparable to medical and surgical benefits

We self-monitor and conduct an analysis if there is a complaint or concern regarding parity compliance, or when there is a change in service limits, UM workflows and processes, or covered services. To assure our self-monitoring tools are appropriate, we draw upon the experience of our affiliates in other markets.

All our UM clinicians are trained on parity as part of orientation and we reinforce requirements and any changes in annual trainings. Our staff training and provider manual include our triage process to help staff and providers determine the urgency of a member's mental health/SUD or medical/surgical need in compliance with MHPAEA.

## 2.6.10.2.5 Identifying and Mitigating Over-utilization

As part of **Elevate I Population Health**, we closely monitor utilization to help assure timely and effective interventions to achieve optimal member outcomes. Monitoring over-utilization helps us to identify opportunities to reduce the use of tests and procedures that add no value to member care and outcomes and to help assure timely and effective interventions to achieve optimal member outcomes. Through our quality management (QM) and UM programs, we use a comprehensive review process to help realize our shared goals with LDH of assuring access to care, improving member health, assuring delivery of quality care to members, and reducing complexity and administrative burden for providers and members.

### Identifying Over-utilization

Healthy Blue uses analytical tools and reports to identify over-utilization on a proactive and retrospective basis, including predictive modeling and data analysis of ER use and rapid hospital readmission. When indicated, we may seek additional quality of care guidance and identification of potential fraud, waste, and abuse (FWA). Our Coordinated Services Program within Program Integrity addresses overuse or misuse of services, including avoiding duplication of services, unnecessary use of medical services, FWA, and excessive use of prescribed drugs.

Our process to identify over-utilization involves an interdisciplinary team of our CMO, BH Medical Director, Pharmacy Director, Director of Care Management, Population Health Administrator, Health Equity Administrator, and QM and UM staff. ***Health Intech*** integrates data from multiple data sources, combining quantitative and qualitative information including health outcomes, care experience, demographics, health conditions, medications, behavioral or physical factors, and environmental and social factors. The team reviews customized dashboards and reports that allow them to drill down for views into specific metrics and trends.

Our monitoring of utilization data and trends is iterative; at each step, we review data through a broader lens and include a broader audience as we interpret data. We monitor data daily, bi-weekly, monthly, and annually.

**Daily Monitoring.** Healthy Blue generates standard and ad hoc reports to analyze utilization and identify trends. We assess variations by condition, service, provider type, and facility. We review hospital census reports in detail of members who are receiving inpatient care.

[redacted] When we identify priate. We work collaboratively with acute and post-acute facilities to improve processes to reduce length of stay and readmission and to streamline the discharge process. We lead collaborative, quarterly Joint Operating Committee meetings with network facilities to review utilization trends, including over-utilization.

**Ongoing Monitoring.** Throughout the year, we continually monitor utilization patterns to identify areas where member health could improve by a proactive modification of their use of physical and BH services. We mine data to identify over-utilization for individual members or population spikes in use of a service compared to prior periods or expected use.

### Targeting Categories of Over-utilization

Through our monitoring efforts to identify over-utilization, we identify targeted categories for mitigation. Table 2.6.10.2-1 includes examples of these along with our mitigation strategies and lessons learned.

*Table 2.6.10.2.5-1. Targeting Specific Areas of Over-utilization*

| Area of Over-utilization | Mitigation Strategies | Lessons Learned |
|---|---|---|
| **Pain Management** | ▪ Evidence-based pain management requires a multidisciplinary approach<br>▪ Improve access to providers<br>▪ Use predictive modeling to identify opportunities to leverage our pain management value-added benefit | ▪ Healthy Blue continues to recruit quality providers for in-network pain management services.<br>▪ Lack of adequate pain management services directly results in overuse of opioids, increase in addiction, and increase in BH spend.<br>▪ Case management results in coordinated, timely, cost-effective, integrated service delivery. |

| Area of Over-utilization | Mitigation Strategies | Lessons Learned |
|---|---|---|
| **Mental Health Rehabilitation (MHR)** | ▪ Provide orientation and monitoring to providers for enhanced clinical outcomes<br>▪ Refer as appropriate to Special Investigation Unit<br>▪ Refer MHR requests to Medical Director for review | ▪ Members may appropriately receive traditional outpatient services vs. MHR supports.<br>▪ Proactive referral of members to other evidence-based services (for example, Functional Family Therapy, Multi-Systemic Therapy, Trauma Focused-Cognitive Behavioral Therapy) is beneficial and effective.<br>▪ Case management plays a critical role regardless of whether members continue to receive MHR. |

## Strategies to Mitigate Over-utilization

Healthy Blue's comprehensive UM approach includes targeted strategies to mitigate over-utilization and improve appropriate use of healthcare services. We describe a sample of them next.

## Engaging with Members

**Resilience through Intervention, Support, and Education (RISE).** Our innovative RISE program for members at risk of opioid or alcohol-related negative health outcomes supports members at risk of high or over-utilization. Field-based Case Managers coordinate member physical and BH needs, as well as SDOH and health literacy needs. In collaboration with UM staff and facility providers, Case Managers coordinate discharge planning and educate and empower members to effectively use healthcare resources and address SDOH to mitigate over-utilization. For example, they conduct medication reconciliation to strengthen post-discharge adherence. During the second

[redacted]

## Partnering with Providers

We mitigate over-utilization by continually educating providers on CPGs and evidence-based practices. Our provider team subsequently monitors provider performance for six months to align practice patterns with norms.

**VBP.** Our VBP program includes metrics outside of "traditional" primary care-focused measures, and is offered to [redacted] — all specifically developed to address our **Elevate I Population Health** approach and enhance the fiscal ability of providers to transform care delivery. [redacted]

## Pharmaceutical Utilization Programs

**Retrospective Drug Utilization Review (RDUR).** Our RDUR program analyzes historical drug utilization data and identifies opportunities to encourage clinically appropriate utilization while promoting medication compliance and safety. The program also monitors for polypharmacy patterns that warrant further investigation or coordination of care. Our pharmacy partner's Clinical Pharmacy Care Center is staffed with pharmacists and nationally certified pharmacy technicians who can prompt member outreach or education in cases of atypical medication utilization. ***From 2019 to 2020, we saw a decrease in ER visits by 25.95% for members we successfully engaged through pharmacy retrospective programs.*** Current programs include:

**BH Polypharmacy Program.** Our current provider outreach program monitors and drives appropriate use of BH medications for identified members with multiple prescribers and multiple psychotropic medications to address polypharmacy issues and inappropriate prescribing of psychotropic medications for children under the age of six and adults over age 65. [redacted]

**Opioid Management.** Our current Opioid Management program mitigates over-utilization by preventing, identifying, and treating inappropriate opioid use; supporting non-pharmaceutical methods for managing acute

and chronic pain; detecting and referring providers who may be committing FWA; helping reduce misuse of opioid treatment by identifying outlier prescribing patterns; and assisting members in gaining access to more clinically appropriate treatment. [redacted]

We will continue to work with LDH, as well as the single Pharmacy Benefits Manager (PBM), on clinical pharmacy program development and expansion to optimize members' outcomes.

**Lock-in Program.** Members with identified over-utilization or suspected patterns of FWA, [redacted] are referred to our ***Lock-In program***, which restricts members to receiving services for an initial period of 24 months from designated providers, including a pharmacy and a PCP or primary controlled substance provider. By limiting members identified as potentially misusing or fraudulently obtaining services, we aim to reduce related ER and physician visits. To make sure members still have access to services, members are allowed up to two specialists referred by their primary prescriber. In 2020, we saw a 25.32% decrease in the number of controlled substance prescriptions. We will coordinate lock-in with LDH and the single PBM.

## 2.6.10.3 Historical Experience with UM of Comparable Populations

***Healthy Blue has been providing UM services for Louisiana's Medicaid program since 2012.*** Our history and commitment to Louisianians guides our daily work and enforces our efforts to facilitate the right care, in the right place, at the right time. We are further supported by our parent companies, BCBSLA, and Anthem. BCBSLA brings more than 85 years of experience working with Louisiana communities and managing care with local resources. ***Healthy Blue and our affiliate Medicaid health plans have coordinated Medicaid and state-sponsored plan benefits for comparable populations for more than 30 years and currently serve more than 9.7 million Medicaid members across 25 markets.*** With our combined bench of national experience and local expertise, we bring a wealth of best practices and a depth to UM.

As best practices have been identified across our many affiliate and parent organizations, we have brought these to Louisiana, such as our Outpatient Integrated Rounds. Through these, we customize solutions to meet members and providers where they are, allowing us to better develop targeted initiatives that provide better healthcare. For example, we identified utilization trends of over-and under-utilization for a complex subpopulation, children receiving Pediatric Day Healthcare (PDHC) services. Our UM team worked with our Care Management team to develop our PDHC program to assure receipt of the right services in the right place at the right time and preserve and maintain functionality, prevent death or prolong life, treat disease, and ameliorate disability or other adverse health conditions. Healthy Blue was recognized for this best practice program and now assists other MCOs in the state with similar programs.

### 2.6.10.3.1 Challenges with High Utilization and Increasing Medical Trends

As described earlier, we use our robust systems and tools to continually monitor utilization and medical trends. Challenges we have faced in Louisiana related to high utilization and increasing medical trends and our strategies to overcome them are included in Table 2.6.10.3-1.

[redacted]

[redacted]

## 2.6.10.3.2 Initiatives Undertaken to Manage High Utilization

Healthy Blue has long utilized our experience identifying and addressing high utilization.

### Linking Members to Care Management

With **Elevate | Population Health** as our core, Healthy Blue's UM program facilitates the delivery of appropriate medical, BH, and pharmacy services, minimizing the likelihood of high utilization and low-value care through application of evidence-informed guidelines. We use UM data to identify high utilization and members with underlying clinical needs, SDOH barriers, and uncontrolled chronic conditions. UM clinicians work proactively to educate and refer members who are high utilizers of services, including ER and pharmacy, to our care management program as appropriate.

We know individualized outreach, ideally in person, is more effective for members who may not have reliable access to housing or means of communication and who are often high utilizers of healthcare services. With our new SDOH tableau dashboard, we can better map member's social needs and our VBP models and telehealth platforms encourage appropriate utilization.

### Reducing Readmission Risk with Comprehensive Discharge Planning and Integration

Effective discharge management and follow-up care is crucial to reducing readmissions. As an initiative to facilitate members recovering in the most integrated setting, we connect them to the care, support, and resources they need ***prior to discharge*** and make sure they clearly understand their discharge plan, risks, and medication directions to prevent a return to the hospital. Our discharge planning team maintains and supports open lines of communication and collaboration with hospital staff from the member's admission through discharge. In early 2021, we added ***two dedicated, experienced discharge coordination nurses to our discharge planning team specifically to assess for the appropriate level of care***. Our discharge coordination nurses present cases at rounds within three days of member's hospital admission, working continuously throughout the stay with our UM reviewer, Case Managers, hospital staff, and discharge planners to assess needs and coordinate care. Each member's case is individualized by the presenting symptoms and intensity of services needed, and the discharge coordination nurses work closely with all parties for safe transitions.

## 2.6.10.3.3 Initiatives to Address Use of Low Value Care

Healthy Blue supports the goals of *Choosing Wisely,* a nationally recognized campaign, in our efforts to reduce unnecessary spending in low value care and strive toward evidence-based, cost-effective, and member-centered care. Healthy Blue designs every process to drive high-value, efficient care and minimize wasteful spending. We realize that changing healthcare culture and member expectations is a slow process, but we make every effort to educate and review CPGs with providers (and members, by request), to adopt best practices promoted by experts, and continually analyze data to produce optimal outcomes.

Healthy Blue has identified promising solutions involving partnerships with providers. These partnerships have the potential to address waste, decrease spending and provider burden, and, most importantly, improve outcomes for members. With a focus on improved communication and information sharing with providers, including education campaigns, faxes, seminars, newsletters, an example of one solution follows.

**ENGAGING PROVIDERS TO ADDRESS LOW VALUE CARE**

Healthy Blue's QM team engages and educates providers on best practices for metrics such as imaging studies for low back pain. We have seen an over 5 percentage point improvement in that metric since 2018.

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**Reducing Low Value Imaging.** In a retrospective analysis of claims data in conjunction with population data to quantify service trends for some of the early ***Choosing Wisely*** recommendations, physicians from our parent organization discovered significant decreases in the use of imaging for headaches (from 14.9% to 13.4%) and for cardiac imaging (from 10.8% to 9.7%). We applied the lessons learned from this study in developing our precertification list and CPGs.

Healthy Blue continually evaluates initiatives to address use of low-value care. We are currently developing initiatives for implementation in 2022, including: [redacted] There are benefits and risks associated with CT scans. For example, CT test results might lead to unnecessary, invasive follow-up tests (which may present additional risks) and increased radiation exposure, which can increase the

possibility of cancer induction. EEGs have very low diagnostic yield in patients with uncomplicated syncopation and no clinical features of, or risk factors for, arrhythmia, carotid stenosis, heart murmurs, or seizures.

## 2.6.10.3.4 Initiatives to Address Long-term Stays in ERs

While educating members on appropriate ER use, Healthy Blue engages in prevention and support for members experiencing a mental health condition and SUD. We understand that BH crises frequently result in ER use, but they are not the kind of crises for which many ERs are equipped. Not all ERs have psychiatrists or child psychiatrists available for consult when a member presents in a high state of acuity or agitation, so we contract with network psychiatrists for ER psychiatric evaluations. When a member presents at the ER with BH needs, Case Managers work with the ER to find availability in an appropriate setting as soon as possible. If the ER can find an available mental health/SUD bed, we begin the authorization process. When they are not able to locate a bed, the Case Manager assists the ER in finding a facility. ***If we are unable to find an in-network facility, we direct them to the closest out-of-network facility.***

**Identifying Members in the ER.** By receiving real-time ADT alerts, we identify members in the ER to quickly dispatch interventions, including transition to appropriate mental health and SUD services.

**BH Service Availability.** We maintain open lines of communication with providers to confirm availability of beds in the community for members in the ER who need BH care. We will facilitate development of a ***Community Open Beds Dashboard*** in collaboration with hospitals, BH facilities, the other plans, and LDH to provide transparency in BH service availability across the community so we can quickly move members out of the ER.

Table 2.6.10.3-2 describes strategies we have implemented to address long-term stays in ERs.

[redacted]

## 2.6.10.3.5 Initiatives to Support Providers with High PA Denial Rates

Healthy Blue minimizes provider burden and delivers the right tools and supports that allow providers to focus on delivering high quality, timely care to members. We recognize PA denials impact members directly and can delay critical healthcare services. Currently, our denial rate [redacted] Moreover, our 2019/2020 provider satisfaction survey results showed 86.4% of providers rated our process of obtaining a precertification, referral, or authorization as favorable — the highest among LDH MCOs. Our initiatives include identifying trends so we can support providers to reduce PA denials and simplify PA processes.

We proactively identify trends in provider PA denials. For example, when we noticed an increase in denial rates for Slidell Memorial, our Joint Operating Committee met in person to review and consider factors contributing to the increase. We reviewed denial trends and provided education and guidance for complete clinical submissions. Our meeting and interventions reduced the PA denial rate for the provider and improved the provider experience and member outcomes.

Using UM trend reports and dashboards, such as our weekly internal Denied Claims Report, we monitor providers and services to identify the ratio of approvals and denials and proactively conduct root cause analyses of providers with a

high volume or high dollar value of denied claims. This helps us understand whether issues are the result of systemic processes or provider education.

We monitor overturn rates on appeals, and when we see a large percentage of overturns for a particular provider or for a particular type of review or diagnosis, we review the history to identify contributing factors and implement appropriate corrective actions, such as educating the provider on proper documentation and submission of initial authorization requests.

We implement the following initiatives for providers with high denial rates:

- Our UM team conducts root cause analysis of the PA denials. This may identify a pattern that indicates a provider is not aware of CPGs for specialized services, such as MRIs or CT scans.
- Our locally based Provider Experience Consultants and Network Education Representatives meet with the provider to review our findings, provide education, and assist them in resubmitting requests. We review our tools to facilitate submission, such our Prior Authorization Look Up Tool (PLUTO), accessible 24/7 through our provider website, portal, or provider telephone line to determine whether a specific code requires PA.
- Following our intervention, we monitor the provider's PA submissions for continued issues through our weekly internal Denied Claims Report and work with the provider as needed.

QM staff monitor and report PA denial trends to Healthy Blue leadership, as well as provider interventions undertaken to address high PA denials.

## PROVIDING ONE-ON-ONE SUPPORT TO ADDRESS HIGH DENIAL RATES

Upon identification of an unusually high volume of denials for NICU members at Our Lady of Lourdes Women's & Children's Hospital, our UM staff promptly reached out to the hospital to offer assistance. We scheduled meetings with the hospital, during which our Medical Director and UM nurses worked collaboratively with the hospital's neonatologist and UM staff to identify root causes and provide education on interpreting MCG Care Guidelines. The outcome was positive and the majority of the denials were overturned.

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## Encouraging Healthy Lifestyles Through the Bike Library Program

The SWLA Center for Health Services (SWLA Center) rolled out a new bike fleet funded by Healthy Blue. The bike library launched in July of 2019 and consists of 20 bikes and safety helmets. It is a great opportunity for families to spend a few hours outside to make the first steps toward a healthier lifestyle. Community members visit the Fitness Center at the SWLA Center in Lake Charles to check out a bike and then hit the road. Bikes are free of charge to the community, and they are intended for short-term recreational rides. On June 29, 2021, a local high school track team took advantage of the guided bike ride. Healthy Blue and SWLA Center remain committed to the communities they serve.



Healthy Blue

## 2.6.11 Quality

### 2.6.11.1 Healthy Blue's Commitment to Quality Improvement

Healthy Blue brings a deep understanding of the State of Louisiana, the needs of its people, and innovative, evidence-based strategies to advance health equity and quality results. Quality Management and Quality Improvement (QM/QI) methods are an essential part of how Healthy Blue meets the needs of our enrollees (members), providers, and community partners to achieve LDH's goals and objectives. Our member-centered and data-driven QM/QI strategies benefit from our parent company BCBSLA's more than 85 years of local presence, our parent company Anthem's 30 years of Medicaid managed care experience, as well as our nine years serving Louisiana Medicaid. In that time, we have been continuously measuring, evaluating, and refining our program in alignment with the State's Quality Strategy and incentivized measures. [redacted]

#### A Culture of Quality

Quality is embedded in our organizational mission, embraced within our workplace culture, and is at the heart of everything we do. Every employee at Healthy Blue is a quality champion, practicing continuous quality improvement (CQI) and supporting innovation for quality excellence. We offer quality trainings to all Healthy Blue staff and bring our expertise to community, provider, and State collaborations. Healthy Blue listens to the voice of the community and our quality improvement programs achieve results that are important to Louisiana members. Our commitment is evidenced by our capabilities and results, summarized in Figure 2.6.11.1-1.

[redacted]

Quality Improvement is also intertwined with our population health philosophy. [redacted]

#### Our Approach to Quality Improvement

Healthy Blue's QM/QI approach and QAPI program align with LDH priorities, goals, and objectives. We develop member-centered, provider-supportive, and locally-focused strategies and Performance Improvement Projects (PIPs) that comply with the current LDH Contract; State and federal laws and regulations; Louisiana Department of Insurance requirements; and industry standards, including measures and standards defined by NCQA, the Joint Commission, the Agency for Healthcare Research and Quality, and others as specified in Attachment H. We have reviewed the Model Contract and remain fully committed to meeting and exceeding quality program contract requirements.

Our data-driven and NCQA-accredited QM/QI strategies are based on more than nine years of experience measuring, evaluating, and refining our Medicaid program. We continuously assess quality data, membership, utilization patterns, and year-over-year performance measures to develop innovative strategies that improve health outcomes for members, support network providers with delivering quality care, and drive health plan performance. [redacted]

#### Member-centered Strategies

Addressing member needs is at the heart of what we do. Our strategies reflect our passion and willingness to serve. We advance the State's Medicaid Quality Strategy and drive improvements in whole-person health through:

**Member Outreach and Education.** Our QM teams employ focused outreach and education strategies to maximize member health. We use members' preferred method of outreach (telephone, digital, mail, in-person) to

close care gaps and promote well-being. [redacted]

As part of our Community Outreach Strategy, we are growing our CHW program, taking our outreach and engagement approach to the next level. CHWs are a valuable resource in building trusting relationships with members, identifying and eliminating barriers in accessing care through engagement and education, and helping members reach their goals. [redacted]

**School-based Health Centers.** Beginning in 2018, QM Health Promotion staff increased engagement and collaboration with School Health Advisory Councils to support student wellness, nutrition, and physical fitness, while reducing the amount of time children are absent from school. We host school Health Fairs where we provide education on important issues for school-age children, including wellness screens. [redacted]

## Provider Support Strategies

Healthy Blue partners with providers on our common interests to improve access to services, ease administrative burden, provide holistic care, and promote healthy lifestyles for members. Our Provider Experience Consultants provide tools, resources, and support members need to succeed.

**Provider Training.** Our Healthy Blue Training Academy offers an extensive library of on-demand training and continuing education opportunities, including quality-based virtual classes and Learning Experiences through MyDiversePatients.com, many of which offer continuing medical education (CME) credits and continuing education units (CEUs). We also collaborate with other MCOs to develop and deploy unified provider trainings aligned with the State's quality priorities, such as behavioral health (BH) Provider Monitoring Training

**Provider Performance Reporting.** We distribute Care Gap reports monthly to PCPs that identify members due or overdue for preventive services, including well-child visits. [redacted]

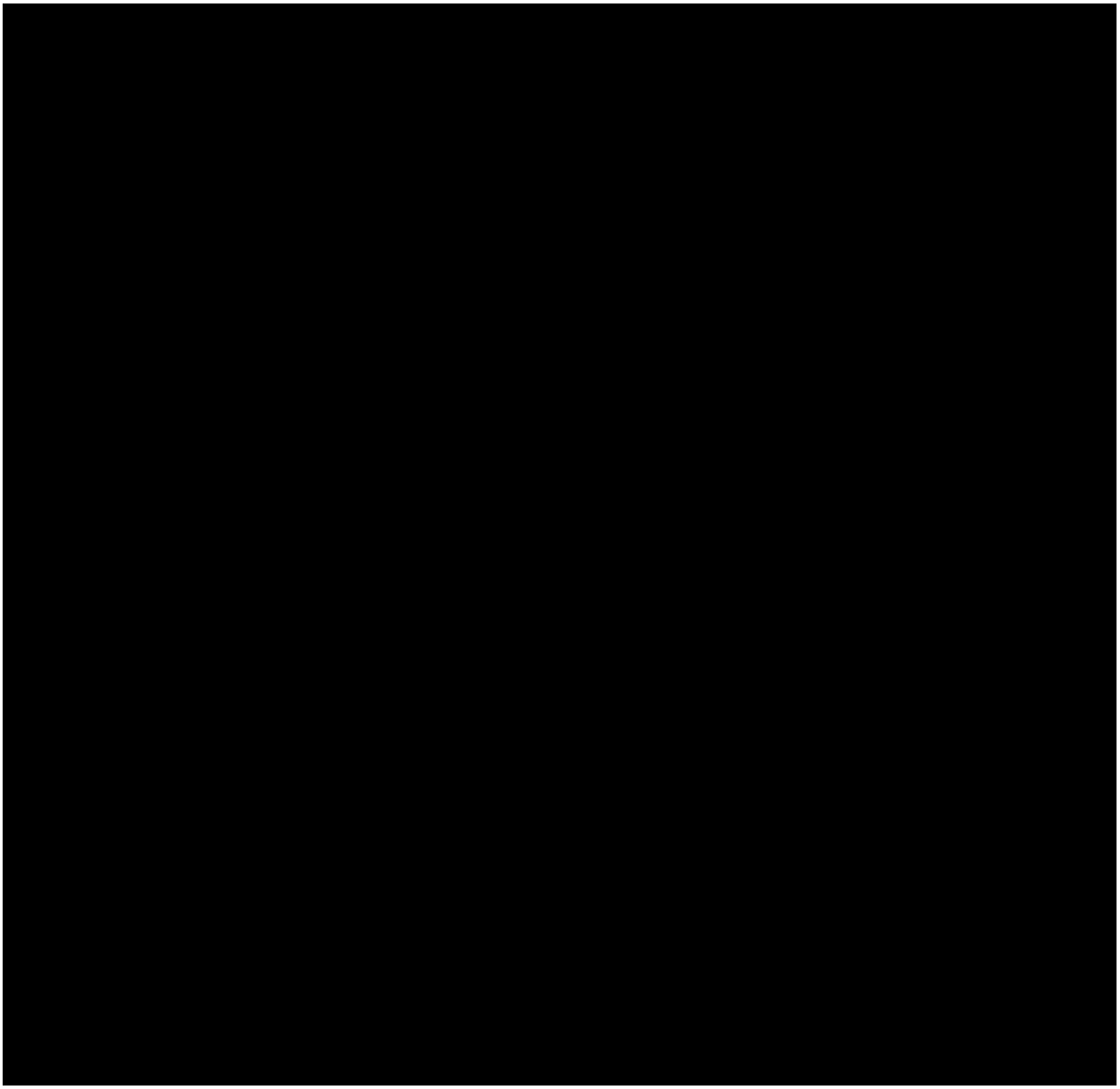
## Local Impact

We have established strong, local community ties, partnering to make meaningful change with our investments, developing solutions with Louisiana locals, and meeting members where they are. Our tenure in Louisiana gives Healthy Blue deep local knowledge of LDH quality priorities and how we can continue to improve outcomes and advance population health for members.

[redacted]

## Strategies Advancing Louisiana Medicaid's Quality Priorities

Healthy Blue will continue to advance all Louisiana Medicaid Quality goals and objectives, as outlined in Attachment H, through the implementation of the quality improvement strategies listed in Table 2.6.11.1-1. We will assign a goal for all the LDH-defined quality performance measures and track progress over time.



[redacted]

We will continue to track and monitor our performance against these quality performance measures and implement CQI to drive improvement.

## Achievements and Innovations for Incentivized Measures

[redacted]

## Care Following Acute Behavioral Health Events

Healthy Blue's intensive Case Managers and mobile crisis providers interface and coordinate care with hospitals and EDs every day. Our integrated care management team contacts members with high cost, acute BH events to support follow-up appointments after hospitalization or ED visit for mental illness or substance use disorder (SUD).

[redacted]

## Maternal, Child, and Adolescent Health

[redacted]We work with expectant mothers and providers to assure appropriate use of C-sections, supporting members to achieve the best possible birth outcomes and improving health equity. [redacted] Doulas have been shown to reduce C-sections for full-term births by as much as 56% (Kozhimannil et al., 2016). [redacted]

[redacted]***Healthy Blue's results for Immunizations for Adolescents exceeded the 75th percentile for HEDIS RY 2020. Childhood Immunization Status (Combo 3) increased 8.3% between HEDIS RY 2018 and 2020.***

## Cancer Screening

Healthy Blue supports consistent cancer screening, diagnosis, and treatment best practices. ***Our cervical cancer screening rates rose 13.5% and colorectal cancer screening rates rose 12.6% between HEDIS RY 2018 and 2020.*** Our initiatives emphasize committed action from statewide partners to better align policies, programs, and practices among all who diagnose and treat cancer. We actively participate in the TACL collaborative to align our strategy and goals to improve screenings. [redacted]

## Management of Hypertension, Diabetes, and HIV/AIDS

By incentivizing provider interventions focused on prevention, Healthy Blue is decreasing risk factors for cardiovascular disease and diabetes such as unhealthy diet, physical inactivity, obesity, and blood pressure management. ***Controlling High Blood Pressure results have improved 48.1% between HEDIS RY 2018 and 2020.*** [redacted]

[redacted]

[redacted] ***The measure of HIV Viral Load Suppression improved 9.3% over three years.*** Healthy Blue also monitors members who are not virus-suppressed and collaborates with providers to determine opportunities to better assist these members. [redacted] As part of ongoing provider education, we have promoted use of Pre-exposure Prophylaxis (PrEP) to minimize new HIV infections for specific high-risk members.

## 2.6.11.2.1 Assessing Utilization to Identify Improvement Opportunities

[redacted]

### Utilization Assessments in Action

Healthy Blue responds to trends in over- and under-utilization, including variations from benchmarks, as part of our QAPI program. For example, we are closely monitoring the impact of COVID-19 on child and adolescent immunization rates. In the last 18 months, we observed a decrease in Louisiana on par with other parts of the country. [redacted] Regular utilization assessments highlight opportunities to assist members using high levels of services with managing uncontrolled chronic illnesses in more appropriate settings. ***With support from Healthy Blue's Chronic Condition Management programs and care management, we have successfully reduced ED utilization for individuals with Adult Major Depressive Disorder by 5.3%, SUD by 4.58%, and Child/Adolescent Major Depressive Disorder by 3.38%.***

## 2.6.11.2.2 Incentives for Providers to Optimize Delivery

Healthy Blue partners with physicians and facilities to drive a shift from volume-based care to patient-centered, value-based care. We continue to advance health outcomes and align with LDH quality strategy via custom, VBP models for providers of all sizes with improved quality performance rewards.

We emphasize provider progression along the payment model continuum and support their readiness to take on risk. [redacted] r Negotiated Risk Shared Savings (NRSS) program includes quality measures that align directly with LDH Model Contract performance measures. VBP models and incentive programs include:

- [redacted]

- [redacted]

## 2.6.11.2.2 Incentives for Members to Receive High-quality Care

[redacted]

## 2.6.11.2.3 Strategies to Meet the Needs of Super-utilizers and Reduce PPEs

We will continue to work with LDH, providers, and other MCOs to drive innovation through evidence-based interventions and strategies that reduce potentially preventable events (PPEs) and emphasize super-utilizers. Healthy Blue uses person-centered models that address members' social barriers to care to reduce ED use for low-acuity conditions and minimize PPEs like acute care readmissions. [redacted]

### Appropriate Emergency Room Utilization (AERU)

[redacted]

[redacted]

### Enhanced Inpatient Member Interaction Program (EIMI)

[redacted]

### Integrated Collaborative Care Model (ICCM)

[redacted]

### Social Determinants of Health Provider Incentive Program (SDOHPIP)

Numerous data sources and Healthy Blue's own experience in Louisiana indicate broad and deep SDOH needs for our membership. We understand the effects of poverty, stress, food insecurity, limited education, and unemployment on care utilization and health outcomes. Healthy Blue has developed a provider incentive program focused on SDOH screening and referrals. [redacted] Providers frequently connect members to Capital Area Agency on Aging, Food Bank of Central Louisiana (FBCENLA), Louisiana Housing Corporation, Top Box Food, and Food Bank of Greater Baton Rouge.

### Ready Responders

[redacted]

## 2.6.11.3 Cross-functional Support for QAPI Program Improves Health

At Healthy Blue, quality is everyone's responsibility and not confined to a single department. Quality improvement initiatives are a visible priority of leadership that bring cross-functional participation across the health plan to maximize impact and success. Our QAPI program applies rigorous clinical initiatives that use the Plan Do Study Act process and includes the following functions for PIPs and other internal QI projects:

- Analyzing gaps in service delivery and quality of care based upon integrated data and information from multiple sources, including member grievances, medical record reviews, claims history, ED visits, hospitalizations, immunization records, prescriptions, and lab results, and ADT data from health information exchanges and electronic health records (EHRs)
- Identifying underlying reasons for variations in provision of care using root cause analysis and other QI tools to fully understand underlying reasons for the variation
- Implementing improvement strategies based on analytical findings from root cause analysis to address the concern and prevent recurrence

Opioid use disorder (OUD) and neonatal abstinence syndrome (NAS) have been rising nationally, as well as in Louisiana. Healthy Blue recognized that it was critical to reduce opioid use among women of childbearing age (primary prevention) and connect pregnant women with OUD to evidence-based treatment options (secondary and tertiary prevention). With components of physical health (PH), BH, SDOH, the provider network, and quality measures, the complexity of this problem warranted an organization-wide initiative.

## 2.6.11.3.1 Analysis of Gaps and Opportunities for Improvement

A study by Yazdy et al. in 2015 found that 21.6% of pregnant women fill at least one opioid prescription during their pregnancy. Healthy Blue's analytics track and trend perinatal substance misuse monthly. At the start of 2019, we observed perinatal substance misuse occurring at the rate of 67.9 per 100,000 Healthy Blue members. Healthy Blue's complex care management team concentrates on members with the most serious health conditions, many of whom are opioid-exposed infants in NICUs. [redacted] but this alarming data, combined with our nurses' daily experiences, emphasized the importance of NAS prevention. We saw opportunities to reduce overall opioid prescribing, increase initiation of OUD treatment, and improve members' therapy regimen adherence, once engaged. This data, corroborated by our Medical Advisory Committee (MAC), prompted our strategy enhancement.

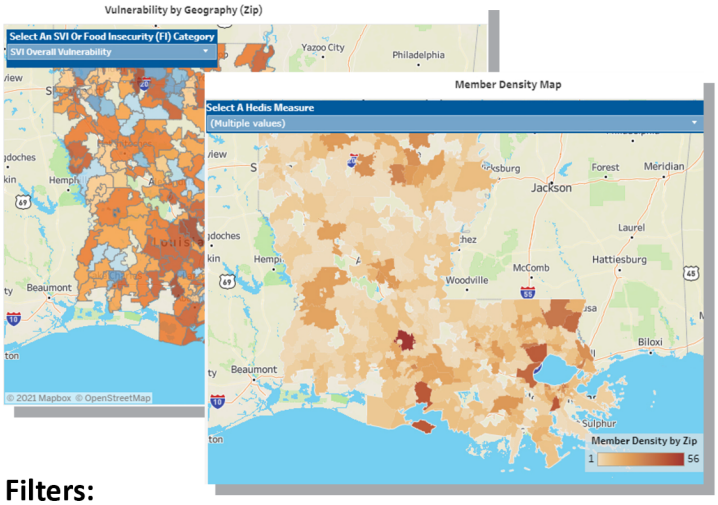
## 2.6.11.3.2 Identifying the Underlying Reasons

Healthy Blue uses a multifactorial approach to assess root causes of variation and barriers to improvement in our clinical initiatives and PIPs, such as Ishikawa diagrams, "The 5 Whys" root cause analysis method, and geospatial analysis. Evidence supports MAT as one of the most effective strategies for OUD recovery, yet we found a lack of access to MAT among members. Using the 5 Whys, we arrived at several root causes for non-adherence to MAT and other OUD therapy: 1) lack of provider awareness of resources like MAT and outpatient treatment for members with OUD, 2) lack of access to safe and effective substance use withdrawal management, due to stigma and bias against pharmacotherapy, and 3) limited pharmacological availability of buprenorphine/naloxone for members.

In applying a health equity lens to this issue, we also considered disparities in access to OUD treatment. Members in rural areas and those lacking transportation or support with caregiving responsibilities have additional barriers to achieving and sustaining recovery. [redacted]

*Figure 2.6.11.3-1. Geographical Variation in Opioid-related Measures*

SVI AND HEDIS HEAT MAP




**Filters:**

Contract | Parish | Race Projection | Language Projection| Member Age | Social Vulnerability Index (SVI) | Food Vulnerability Index (FVI) | HEDIS Year | HEDIS Compliance

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[redacted]

## 2.6.11.3.3 Improvement Strategies Based on Findings

Healthy Blue's comprehensive OUD and NAS program has been repeatedly enhanced from mid-2019 to today. In RY 2020 our HEDIS rate for Initiation and Engagement of Alcohol & Other Drug Dependence Treatment, initiation surpassed NCQA's 90th percentile. Healthy Blue's model is based on a proven program that reduced NAS-related metrics by 20% in our West Virginia affiliate plan, where the opioid epidemic is the worst in the nation. By February 2021, occurrences of perinatal substance misuse among Healthy Blue members had dropped to 45 per 100,000, a decrease of more than 33% from two years prior. Our strategies are described next.

[redacted]

Broad strategies that respond to disparities in OUD treatment access for all members in Louisiana include:

- [redacted]

Figure 2.6.11.3-2 highlights continued improvement in MAT access from our organization-wide initiative.

## 2.6.11.4 Healthy Blue's Approach to Quality Management and Improvement

Healthy Blue takes a member-centered, provider-collaborative, data-driven approach to QM/QI.

### 2.6.11.4.1 QM/QI Program and Goals for a Healthier Louisiana

QM/QI programs play a significant role in optimizing plan performance and member outcomes as part of **Elevate | Population Health**. As such, Healthy Blue maintains a QAPI program structure that:

- Supports a thriving culture of CQI
- Reinforces clear accountability and inclusive participation from all types of stakeholders
- Blends local and national resources to advance LDH's goals and objectives

Healthy Blue maintains and updates our QAPI Program Description annually, as well as our Work Plan throughout the year. We also monitor a monthly quality dashboard as part of our CQI approach. Together, these provide a blueprint for operations and document our objectives, scope of planned activities, processes, systems, and strategies for assessing and improving quality of care and services. Our QM Work Plan activities align with LDH established goals and measures as well as contractual, accreditation, and regulatory requirements. Our annual QM Program Evaluation documents our performance relative to established objectives, activities, and LDH goals, including Quality Performance Measures. We use findings of every evaluation within a CQI framework to refine current programs and inform new and better solutions.

Healthy Blue adjusts our quality-related goals each year. Our goal is to exceed the NCQA 50th percentile for all HEDIS and CAHPS performance measures, aiming to achieve the 66th or 75th once we attain our initial goal. For Non-HEDIS metrics, we evaluate local and national benchmarks to assure reasonable targets and make improvements. We have defined 13 priority areas within Elevate | Population Health based on our local experience and epidemiological data from trusted sources such as the March of Dimes Report Card and the LDH Medicaid Managed Care Quality Dashboard. We assigned metrics to monitor progress in important outcomes, such as reducing incidence of low birth weight, increasing participation in SUD treatment, and improving diabetes control.

Healthy Blue's QM/QI program fosters local decision-making while benefiting from the knowledge and perspective of our national team. Synchronized quality committees, depicted in Figure 2.6.11.4-1, support this work.

*Table 2.6.11.4-1. Schedule of Healthy Blue's Quality Management Activities*

| QM Activity | Frequency | Deliverables |
|---|---|---|
| **Measure and Report on Quality Performance** | Annually | Report of QI activities, new and improved activities |
| **Operate Comprehensive QAPI Program** | Annually | QAPI Program Description, Work Plan, and Provider Support Plan |
| **Evaluate QAPI Program** | Annually | QAPI Evaluation |
| **QAPI Committee/Subcommittee Meetings Including Enrollee Advisory Council** | Quarterly | Signed and dated minutes |
| **Participate in LDH Quality Committee** | Monthly | PIP updates, current performance measure indicator rates |
| **HEDIS Measurement** | Annually | Audited HEDIS results, stratified by population |
| **CAHPS Measurement** | Annually | Results and description of survey process |
| **Administrative Encounter Data** | Weekly | Reconciliation Reports to source data, Compliance & Executive check for accuracy & completeness |
| **Performance Improvement Projects** | Proposal before initiation, status reports ongoing | PIP Proposal, status, and final results |
| **Maintain NCQA Accreditation** | Within 10 calendar days of receipt of the final Accreditation report | Final Accreditation Report, including accreditation status, results, expiration |

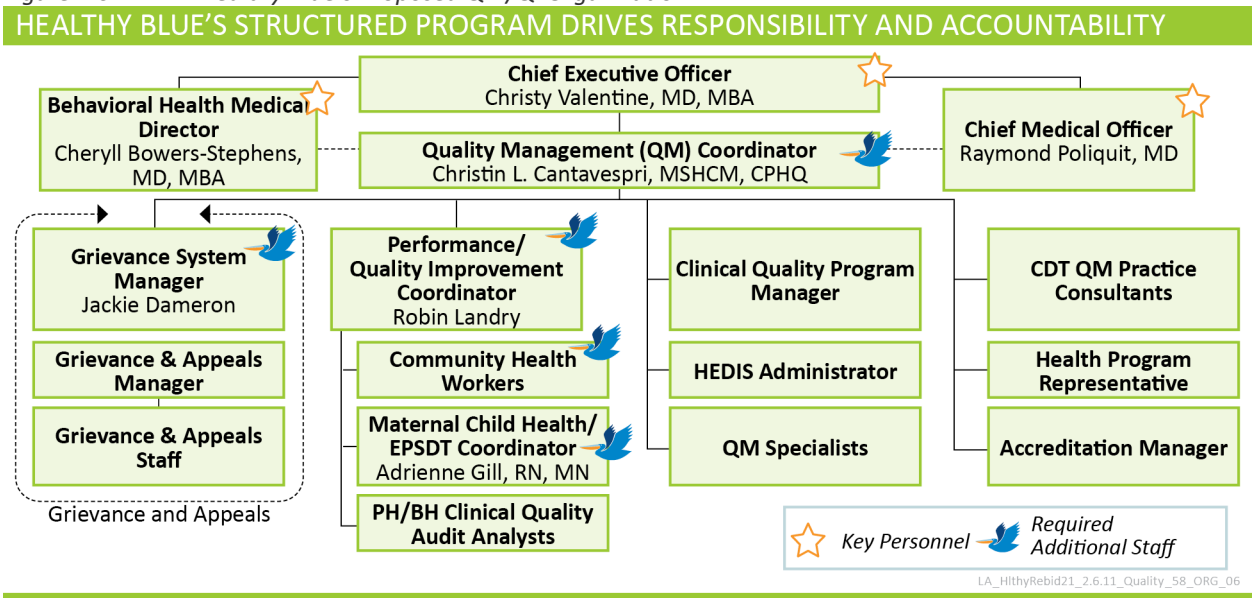
| QM Activity | Frequency | Deliverables |
|---|---|---|
| **Support EBPs for BH Providers and Quality Monitoring** | Readiness Review, quarterly monitoring | Fidelity & Provider Monitoring Plan, on-site review, and members interviews |
| **Additional Reports Requested by LDH or External Quality Review Organization (EQRO)** | Within 60 calendar days of request or as outlined in MCO Manual | Ad hoc |

## 2.6.11.4.2 QM/QI Organization and Local Leadership

We have the organizational infrastructure to provide effective monitoring, reporting, and analysis, and act on opportunities to improve clinical care and services. Our Louisiana-based QM Director, Christin Cantavespri, who serves as the QM Coordinator, manages and oversees QAPI activities and keeps our goals on target. Christin is a Louisiana native, a well-recognized leader among Louisiana MCOs, and has a master's degree in Healthcare Administration and a Certified Professional in Health Care Quality credential. Her direct reporting relationship to CEO Dr. Christy Valentine demonstrates the priority Healthy Blue places on quality results and enables close collaboration with other health plan leaders. The Chief Medical Officer, BH Medical Director, Population Health Administrator, Health Equity Administrator, and other clinical leaders help shape the QAPI program. Healthy Blue's QM/QI team is fully resourced with well-qualified staff and cutting-edge systems to continue meeting and exceeding all requirements.

Figure 2.6.11.4-2 includes an organizational chart of our QM/QI department and staff dedicated to and responsible for administering our QM/QI program. The most recent EQRO audit found zero deficiencies in our structure.

*Figure 2.6.11.4-2. Healthy Blue's Proposed QM/QI Organization*




## 2.6.11.4.3 HEDIS Performance Measurement and Reporting

Healthy Blue uses a sophisticated information technology and data infrastructure to drive high-quality member outcomes. Our continued ability to participate in all HEDIS-related measurement and reporting initiatives is evidenced by our long-standing NCQA accreditation. We follow Medicaid management best practices, utilizing a proven approach verified by national audit firms. [redacted] ***In our many years of participating in Louisiana's Medicaid managed care program, Healthy Blue has always submitted HEDIS data accurately and on time.***

In addition to our staffing resources (such as our HEDIS Administrator and QM Specialists) dedicated to supporting our HEDIS performance measurement and reporting activities, data-driven initiatives, and support to LDH we have a dedicated, internal HEDIS Task Force charged with optimizing HEDIS results and guiding our efforts to attain a 5.0 NCQA health plan rating. The Task Force meets every two weeks and performs activities such as: 1) reviewing critical measures and current status to drive improvement; 2) conducting strategic planning and initiating program

development; 3) assigning tasks, business owners, and timelines; 4) identifying root causes and developing solutions to barriers and gaps; and 5) ongoing monitoring on progress of interventions and relationship to goals.

[redacted]

## 2.6.11.4.4 Successful Quality Improvement in Action

Healthy Blue's multi-pronged approach to diabetes exemplifies our recent success in improving quality. ***Between HEDIS RY 2019 and 2020, our rates for Comprehensive Diabetes Care: HbA1c Test and HbA1c Control improved 2.6% and 1.3%, respectively.*** A centerpiece of that approach is our relationship with Pennington Research Center's Diabetes program, which prevents diabetes for people who are at risk, as well as reverses effects of type 2 diabetes in those already diagnosed. We identified adult members who struggled with their weight, were told by their doctor they were diabetic or pre-diabetic, and were ready to change habits, such as diet, exercise, sleep, and stress management for program referral. Additionally, we located members with between two and thirteen ER visits in 2019 and 2020, indicating poor health management. ***In 2020, Healthy Blue successfully enrolled 67 members into Pennington's program.***

[redacted] Healthy Blue also offers a diabetes lifestyle coach who teaches classes in St. John Parish and Jefferson Parish and a nurse practitioner program to assist African American members in controlling hypertension and diabetes. [redacted]

## 2.6.11.4.5 Future Quality Improvement Initiatives

Healthy Blue identifies quality improvement needs via ongoing data monitoring and develops targeted programs in response. Our QM team tracks and trends our HEDIS and State-specified measures through monthly reports, which we share with other Healthy Blue departments and QM committees. Recent experience indicates the need to continue to improve quality across the board, but we will bring extra focus to three areas:

**Continued COVID-19 Recovery and Immunization Efforts.** [redacted]

**Increased Access to Screenings in Underserved Areas.** [redacted]

**Tobacco Cessation and Anti-vaping.** [redacted]

For designated measures, we evaluate data trends against national benchmarks and internal goals to assess effectiveness, and determine if we should adapt, adopt, or expand interventions. We implement successful programs on a larger scale through an expansion plan and refine or replace unsuccessful interventions.

## 2.6.11.5 Clinical Practice Guidelines Bring Rigor to Care Delivery

Healthy Blue promotes use of a comprehensive portfolio of evidence-based, preventive health, and clinical practice guidelines (CPGs) that span more than 49 conditions and diseases. Guidelines keep providers informed about scientific advances, bring rigor to consistent care delivery, and positively impact health outcomes. We take a local approach to reviewing and approving CPGs for Louisiana. CPGs are not a substitute for the professional judgment of health professionals, and we do not use CPGs for medical necessity reviews. We have provided a list of our CPGs as Attachment 2.6.11.5-1 and a sample as Attachment 2.6.11.5-2.

## 2.6.11.5.1 Adopting and Disseminating CPGs

We adopt CPGs both locally in Louisiana and through our national Medical Policy & Technology Assessment Committee (MPTAC). MPTAC is a multidisciplinary group that includes practicing physicians and academics from various specialties, clinical practices, and geographies. Our Medical Directors request specific guidelines or topics to be considered for approval on the CPG list. In addition, external providers can request that a guideline be considered, such as in QMC meetings.

**HEALTHY BLUE DEVELOPS MAC-APPROVED CPG TOOL**

Healthy Blue developed a ***CPG tool*** for schizophrenia which was constructed using input and approval of our Medical Advisory Committee. We use this CPG to monitor members with complex behavioral health needs who are receiving services, such as Assertive Community Treatment (ACT).

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CPGs are then reviewed by the CPG Workgroup, which includes both PH and BH Medical Directors, and presented to our national Medicaid division committees for review and approval. Healthy Blue's QM Coordinator coordinates with our local MAC to review and approve adopted/revised CPGs and make sure they are consistent with and appropriate for Medicaid members. Our Medical Directors, most of whom live and work in Louisiana, review all guidelines annually. Currently, there are several BH CPGs that were adopted locally by our Louisiana MAC. To assure consistency, the MAC and MPTAC review provider and member education materials, benefit plans, and coverage parameters annually against guidelines.

[redacted]

**HEALTHY BLUE ENGAGES THE PROVIDER COMMUNITY THROUGH WORKGROUPS AND TRAININGS**

Healthy Blue gathers ***provider community input*** through avenues such as the LDH and MCO & Provider Collaborative Workgroups. Healthy Blue also offers provider ***trainings*** on quality service delivery such as managing complex BH health needs in addition to physical health needs.

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[redacted]

## 2.6.11.5.2 Incorporating Scientific Evidence and Expert Opinions into CPGs

[redacted]

## 2.6.11.5.3 Evaluating and Encouraging Provider Use of CPGs and EBPs

We measure performance annually against CPGs and Preventive Health Guidelines, including BH guidelines, using specialized audit tools. We employ various tools and strategies to promote adherence to CPGs and increase high-value care. Our provider agreements require compliance with CPGs, which we reinforce through ongoing monitoring, educational outreach, and financial rewards for providers who meet targets and quality goals. Our provider-centric approach features local PH and BH Clinical Quality Audit Analysts, who help providers interpret quality data, educate on CPG expectations, and review medical record keeping confirming accurate evidence of compliance. Healthy Blue's audit tools are currently on our provider website for providers to improve compliance as well as an interactive course they may complete to earn CME credit. We may also incorporate CPG monitoring as a PIP intervention. Table 2.6.11.5-1 describes select strategies to improve compliance.

## 2.6.11.5.4 Ongoing Evaluation of CPGs

Board-certified and credentialed network providers, our Chief Medical Officer and BH Medical Director review, revise, and approve CPGs at least every two years using evidence-based literature from medical specialty societies (US Preventive Services Task Force and similar entities), assuring they remain consistent with the latest scientific standards.

## 2.6.11.6 NCQA Health Insurance Plan Ratings for Medicaid Contracts

Healthy Blue is providing the completed Quality Response Template as Attachment 2.6.11.6-1 with the most current NCQA ratings for our health plan and affiliate Medicaid health plans across the country.

## 2.6.11.7 Healthy Blue Is Accredited by NCQA

Our health plan has been continuously accredited by NCQA since 2016. We are highly invested in the disciplined quality approach promoted by NCQA standards, as evidenced by our additional accreditation for our Population Health Management Program, Managed Behavioral Healthcare Organization, and Multicultural Healthcare Distinction. Attachment 2.6.11.7-1 includes proof of Healthy Blue's NCQA accreditation, valid through 2023.

## 2.6.11.8 NCQA-accredited Behavioral Health Services

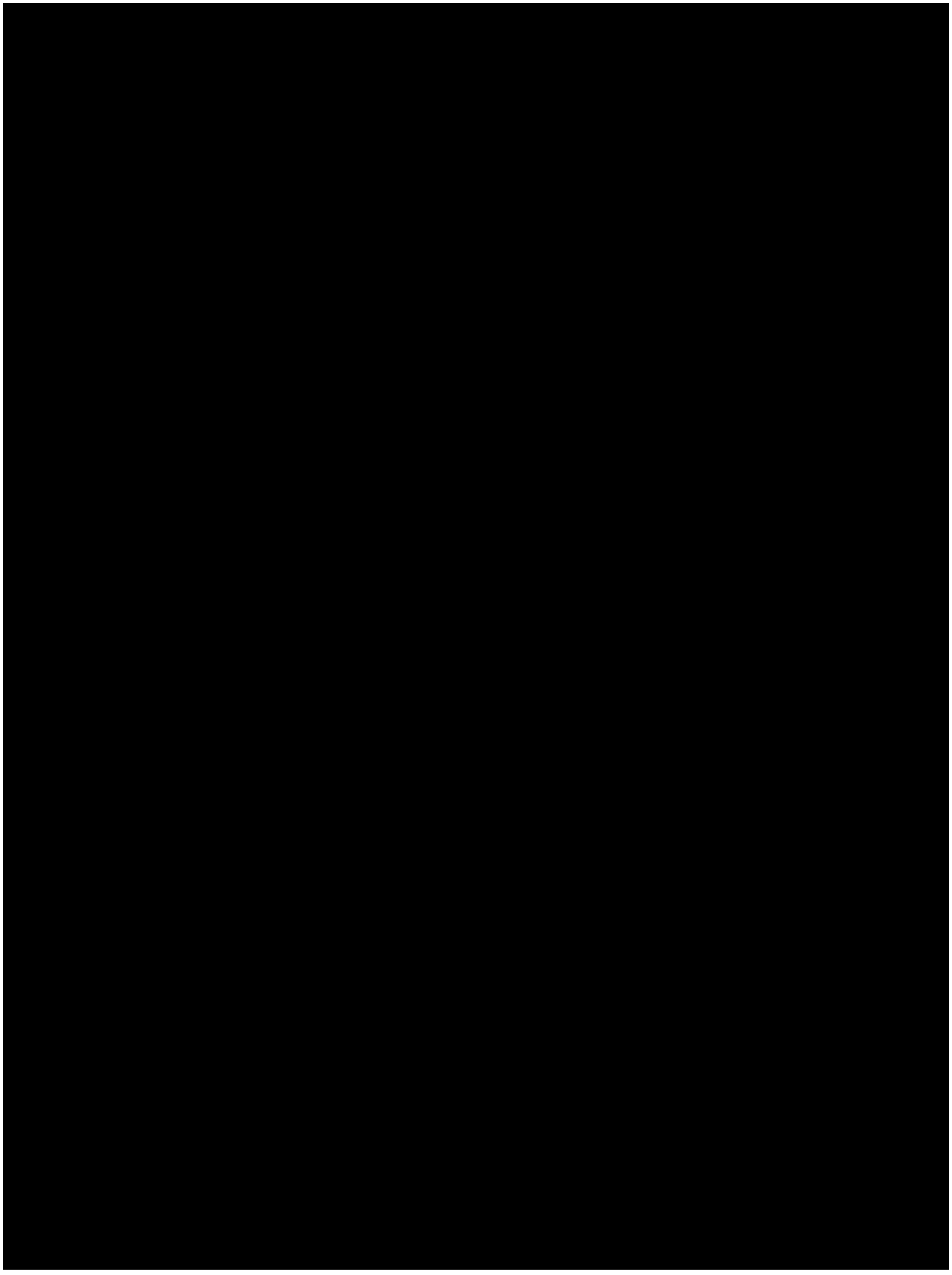
Through our relationship with parent company, Anthem, Healthy Blue delivers integrated and NCQA-accredited BH services. Anthem holds Managed Behavioral Healthcare Organization accreditation from NCQA and achieved a 100% score on review of the standards in 2020. We are providing evidence of accreditation as Attachment 2.6.11.8-1.

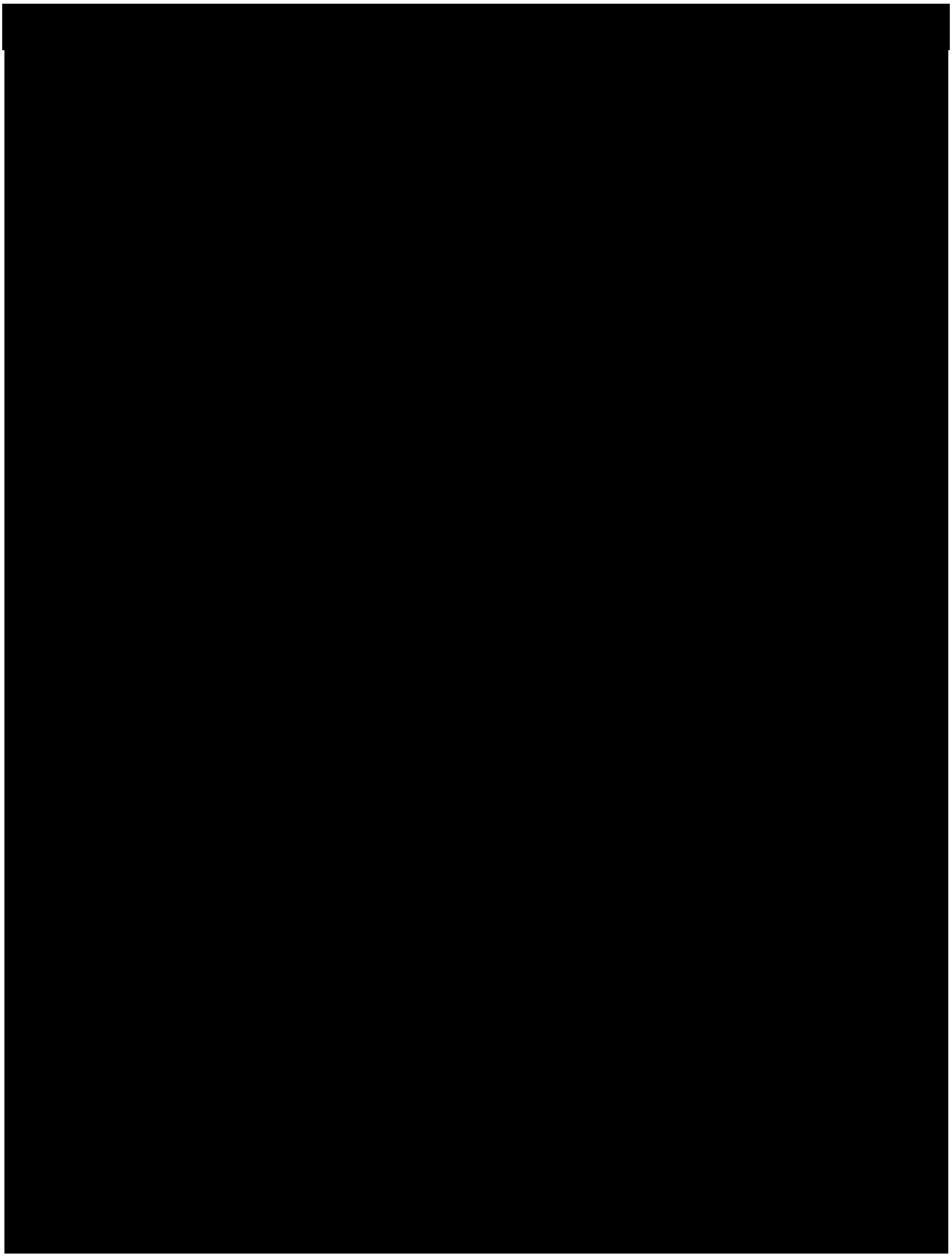
# 2.6.12

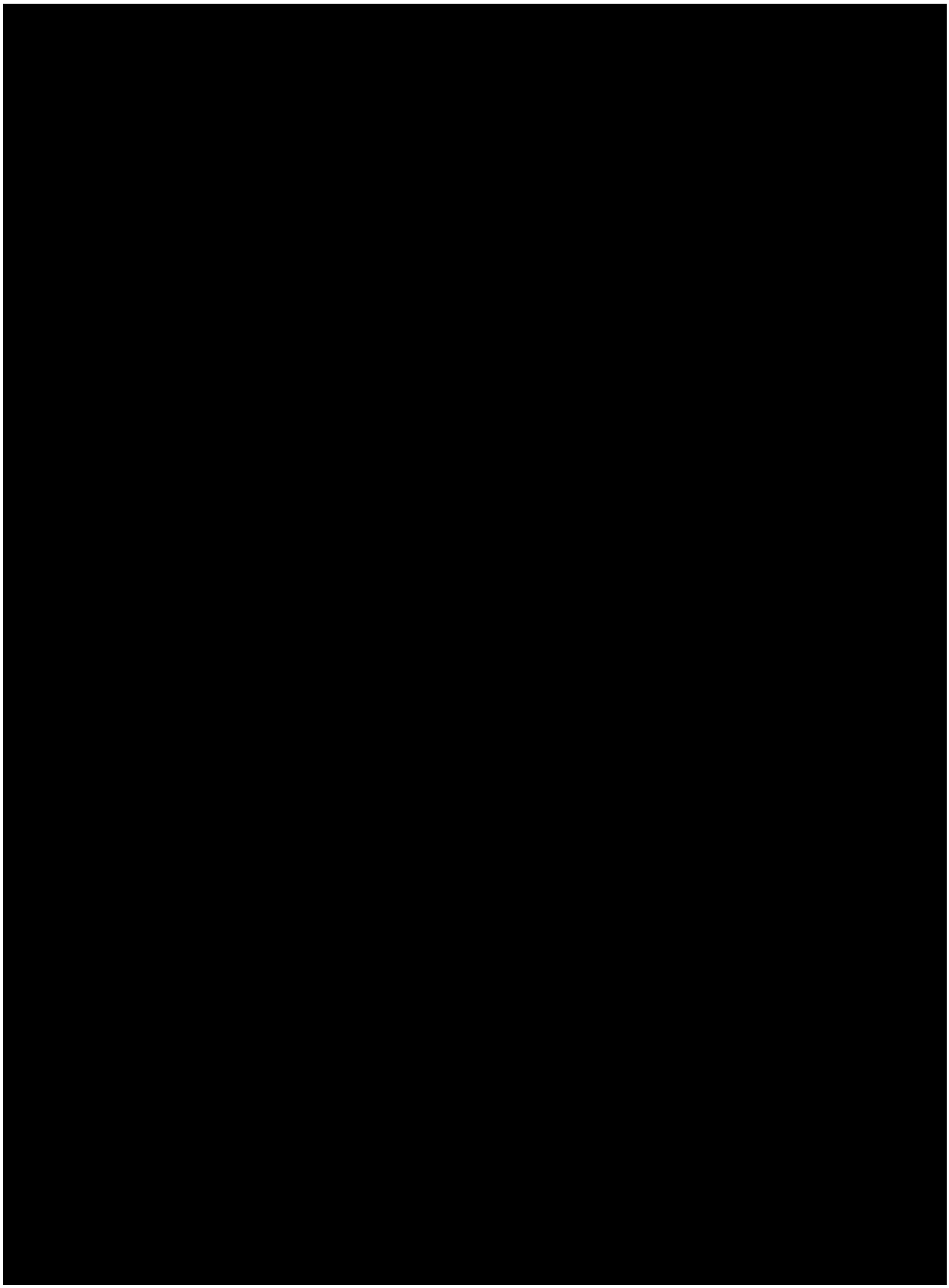
Value-Based Payment

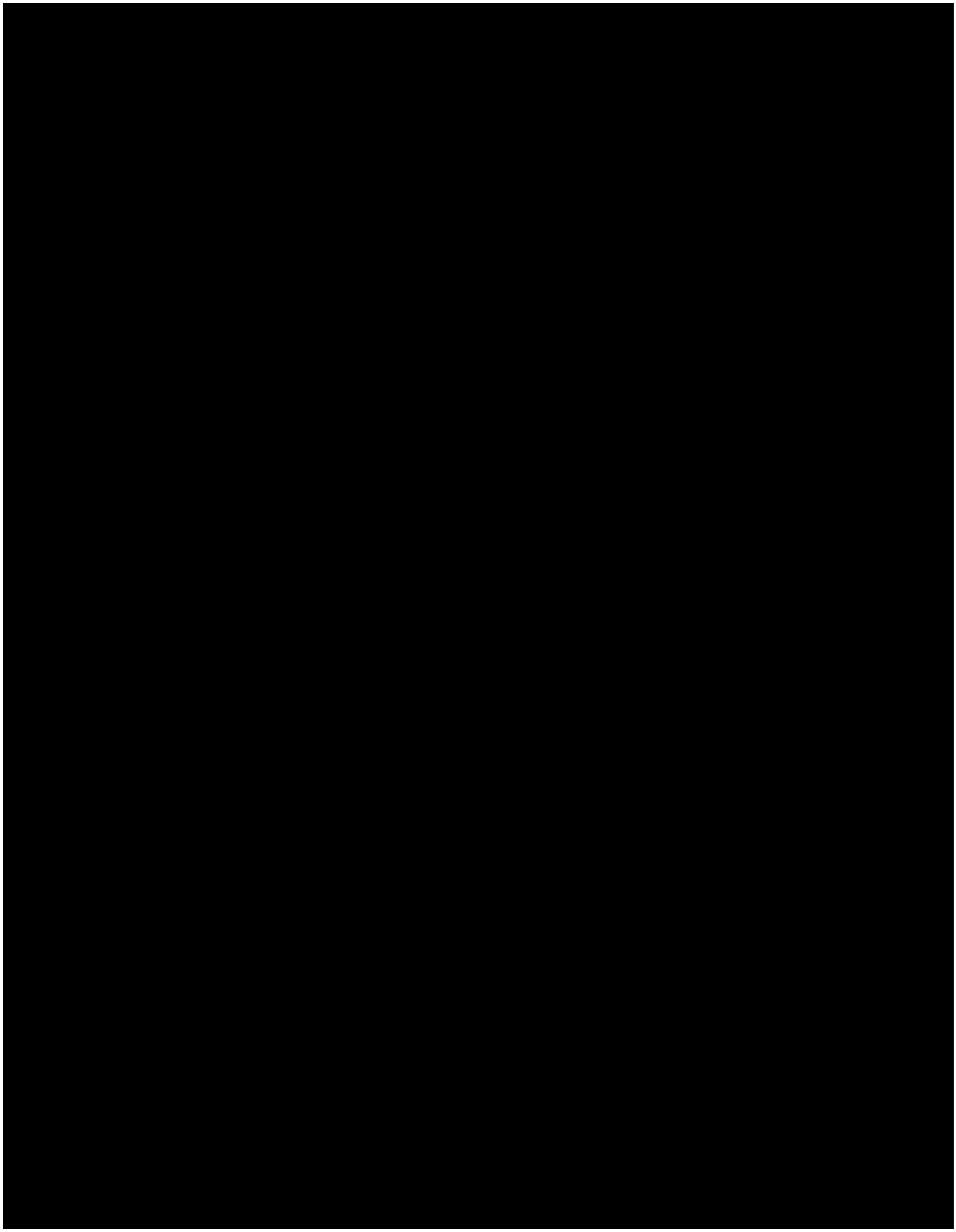
CONFIDENTIAL

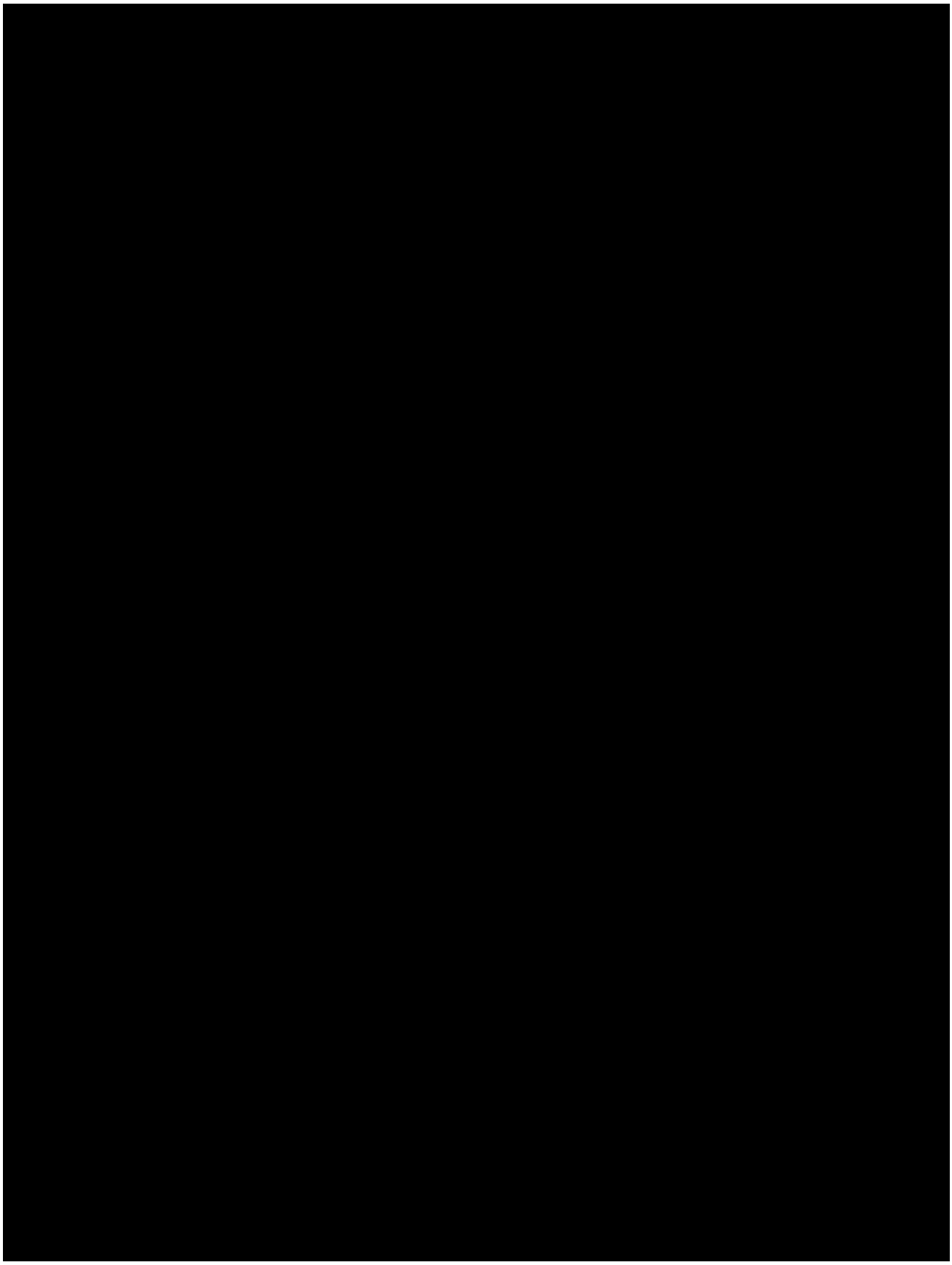
Healthy Blue

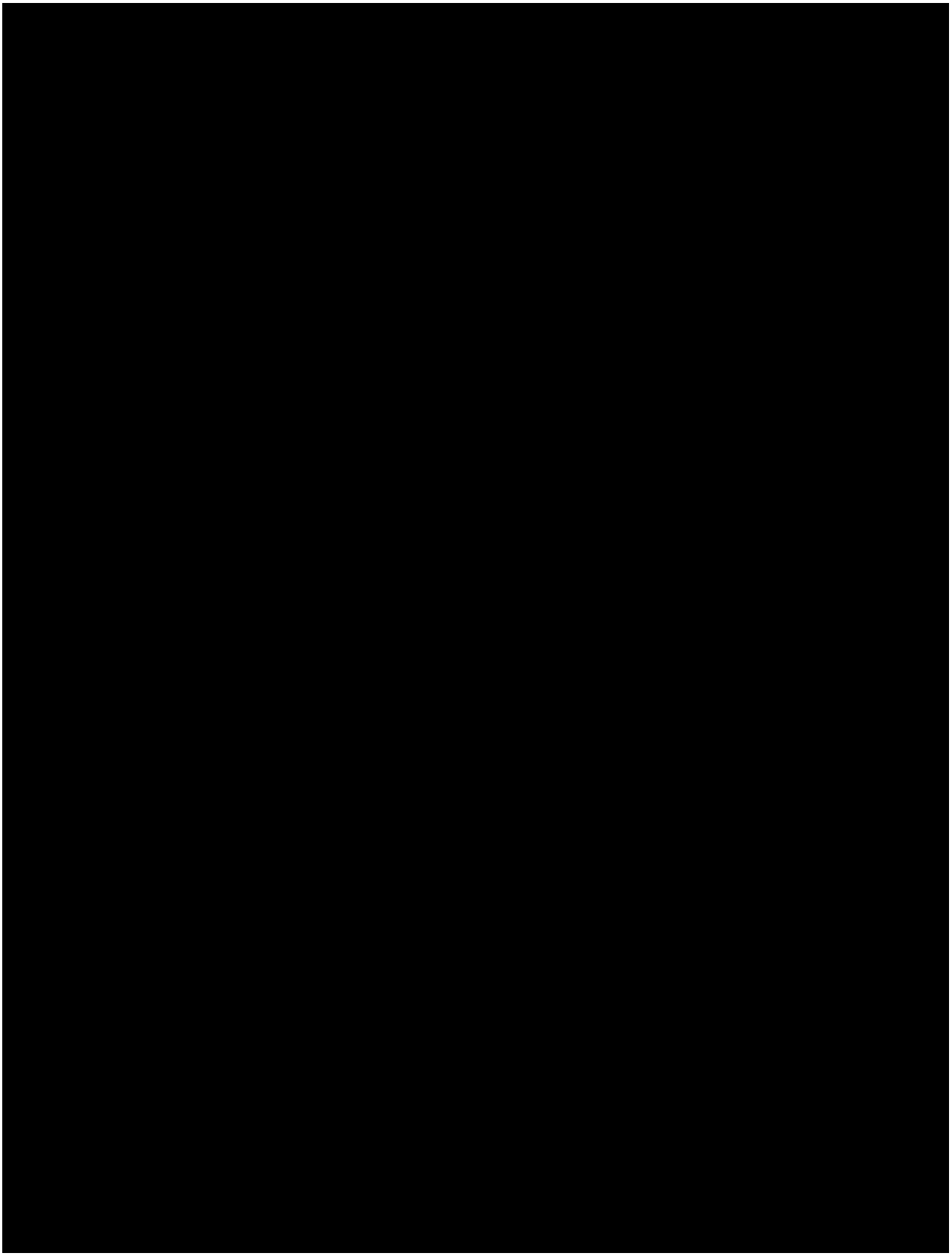


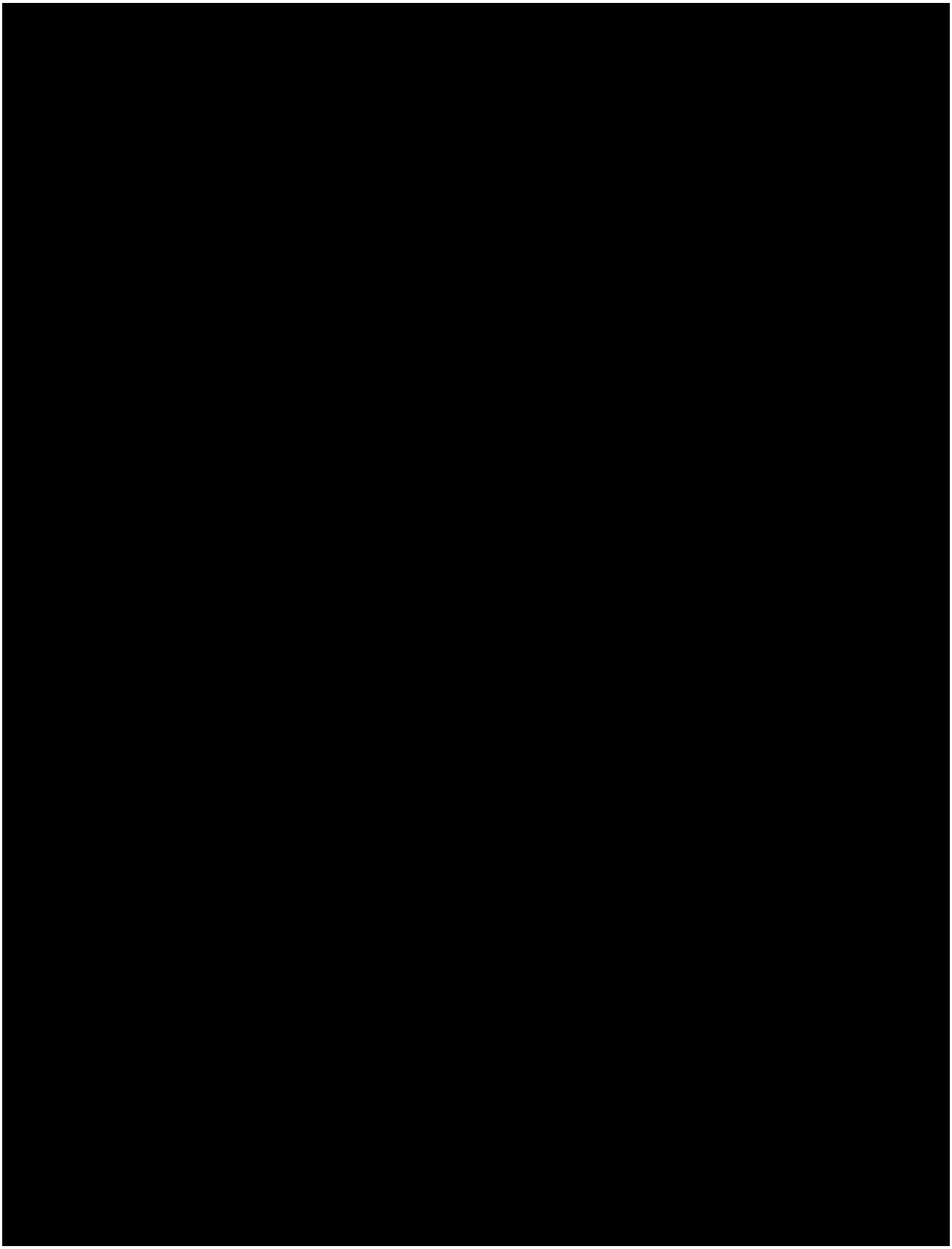


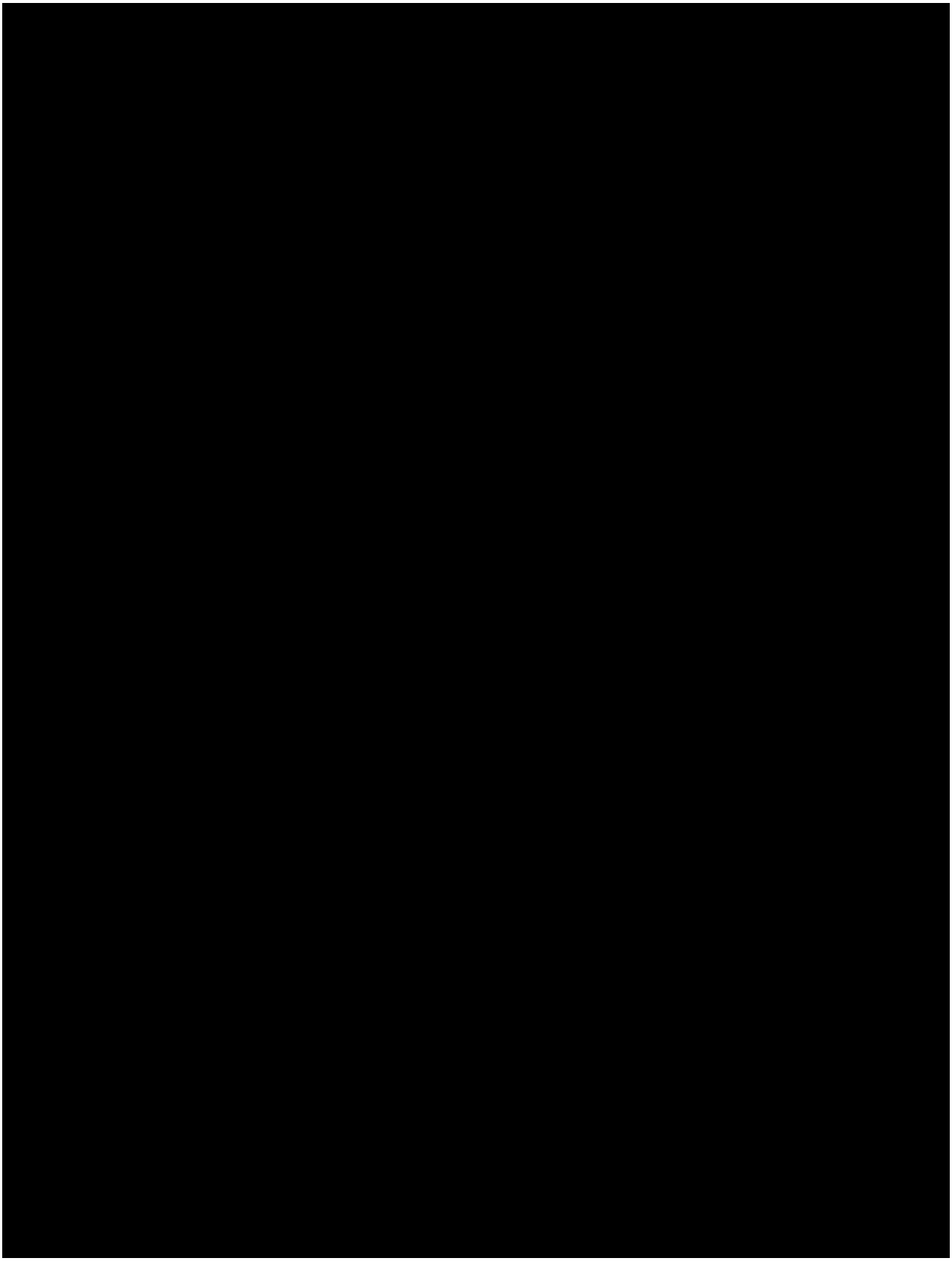


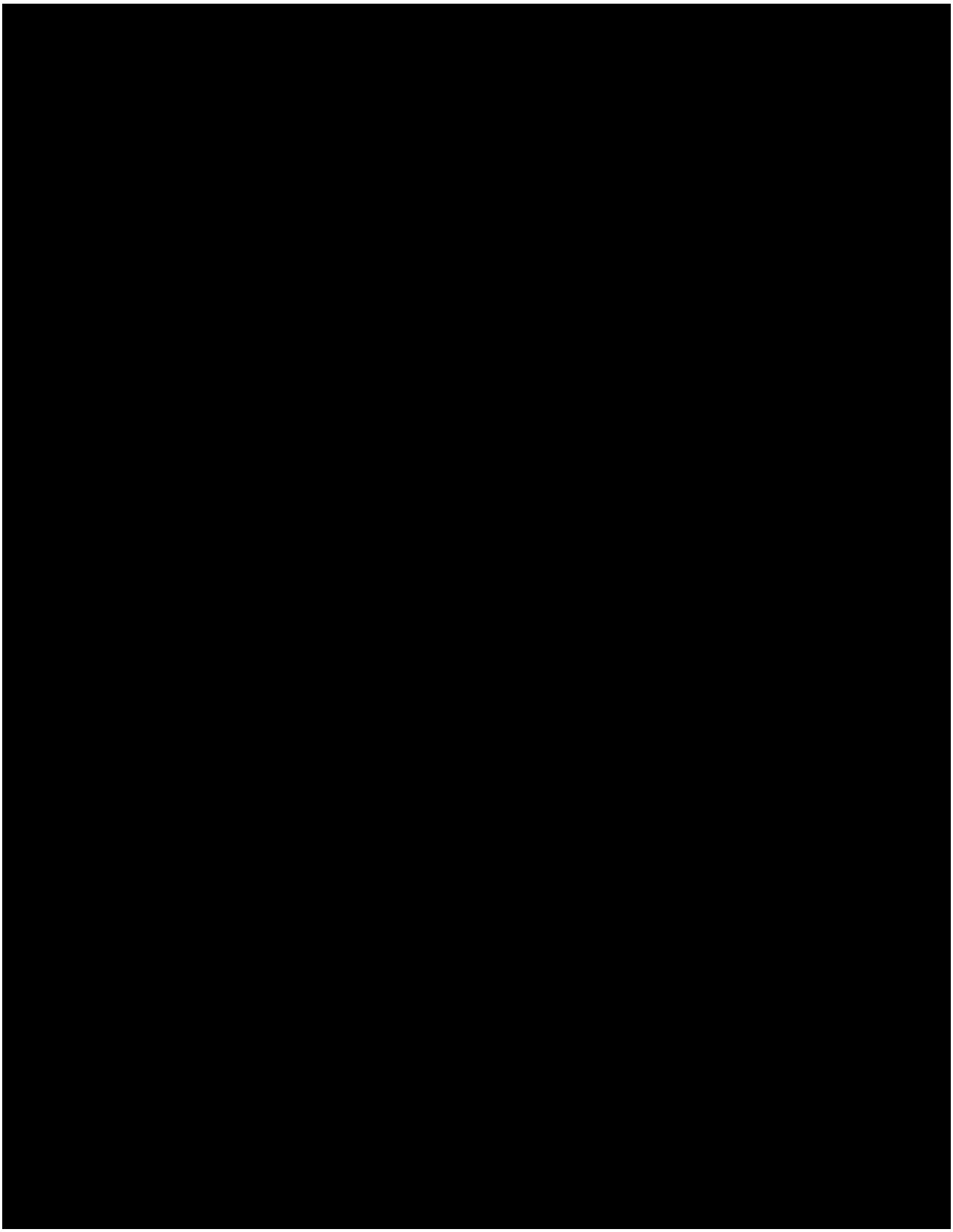


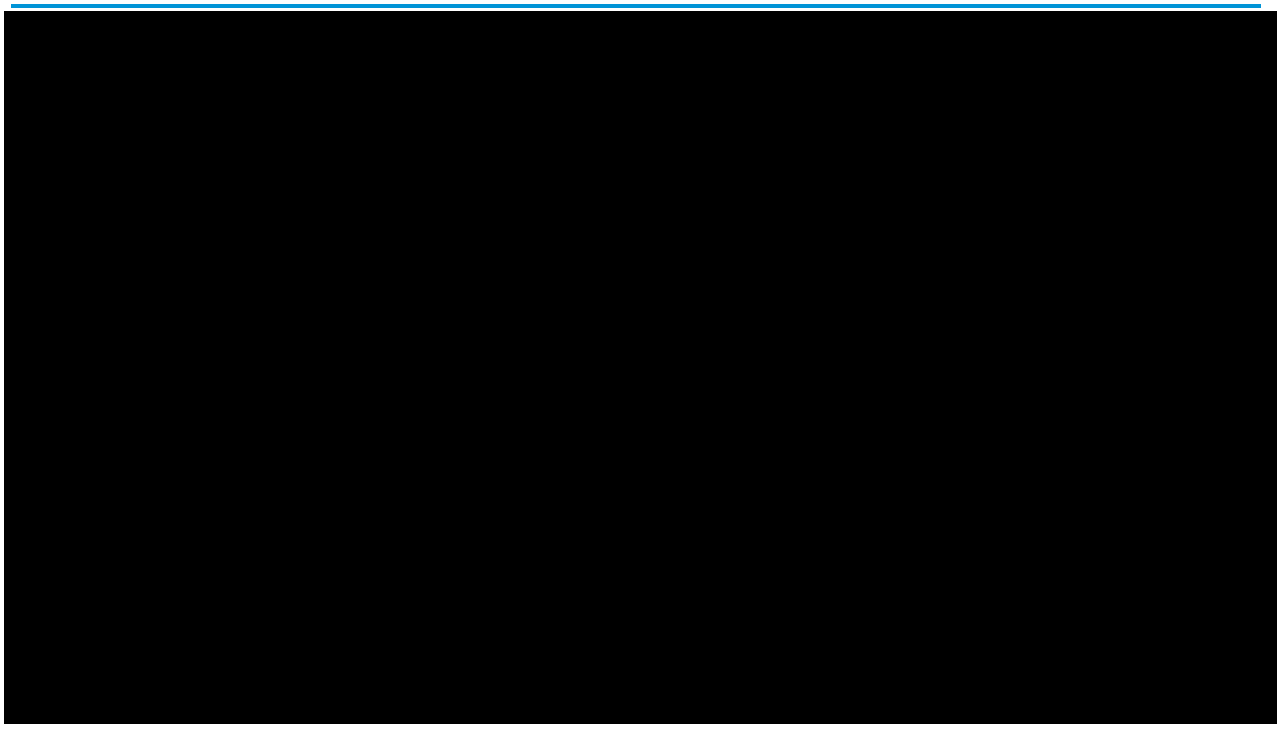













**Working with DeWanna's Closet to Address Food Insecurity Among Youth**

DeWanna's Closet (DC) understands that food insecurity can wreak havoc on a community, especially our youth. DC wanted to start a weekend food program for school-aged kids, and Healthy Blue's grant has given them the jumpstart to pursue the endeavor. Educators within Calcasieu Parish Schools identify students whom they feel may lack consistent nutrition over the weekend. The educators make a confidential referral to DC, who will prepare and supply a nutritional food package that the students can easily transfer from school to home.

# 2.6.13

## Claims Management and Systems and Technical Requirements

Healthy Blue

## 2.6.13 Claims Management and Systems and Technical Requirements

Our highly configurable Management Information System (MIS) is built on a managed Medicaid model and based on our parent company's, Anthem, Inc.'s (Anthem's), experience supporting Medicaid managed care programs in 25 markets, including Louisiana. Healthy Blue meets and often exceeds requirements outlined in Model Contract, 2.18 and 2.19, the MCO Manual, and all other accompanying manuals and guides. Our rapid configurability means we can comply with all changes within 30 days of LDH's request.

***In 2020, Healthy Blue's claims system processed more than four million Medicaid claims with 94% processed within 15 calendar days.*** We recognize claims issues create challenges for providers. As a result, we streamline processes and continue to reduce provider impact related to claims payment.

[redacted] This result is based on data reported to LDH on 167 Claims Payment Accuracy reports and 221 Claims Summary Payment reports.

Healthy Blue continually improves efficiency and the provider experience. This includes:

- [redacted]
- **Improving Initial Claims Performance and Reducing Disputes Rate.** In 2021, Healthy Blue successfully decreased our dispute rate by 12% through a combination of more accurate claims adjudication and proactive correction, reducing provider administrative burden of submitting unnecessary disputes.
- **Mitigating Provider Billing Issues.** Healthy Blue's ***Provider Experience*** team, comprised of Louisiana staff, proactively identifies billing practices resulting in claim denials and outreaches and educates providers to prevent those denials. We describe this in more detail in this response.

Our Provider Experience team offers a personal level of provider support on a range of topics, including claims submission, new requirements, changes, or corrective actions. Training is offered during orientation and through regular updates via our provider website, as well as faxes and e-blasts. Education is tailored to providers' and offered virtually or in-person. [redacted]
Additional training topics include high-level outpatient and/or inpatient evaluation and management services; modifier 25; psychotherapy service code 90837; performing therapeutic injection combined with an evaluation and management service; and high-level emergency department (ED) evaluation and management services.

[redacted]

### 2.6.13.1 Healthy Blue's Customized Claims System for Louisiana

Our MIS and supported claims processes meet all federal and LDH Contract requirements, including those in the MCO Manual and MCO System Companion Guide, and will be adjusted to meet any new requirements. Our local team monitors changes from LDH supported by industry-standard coding and reimbursement experts, and we provide ongoing feedback to LDH regarding those changes. We maintain policies and procedures that support our operations and align with the MCO Manual, MCO System Guide, and Model Contract, 2.11.6 and 2.18, including: 1) timely filing and clean claim requirements; 2) maintaining billing provider, claim receipt date, and other key data points; and 3) CAQH/CORE compliant interfaces to support electronic funds transfer (EFT) for providers.

We work closely with the program's regulatory documents, such as fee-for-service (FFS) provider manuals, informational bulletins, health plan advisories, MCO Manual, and MCO System Companion Guide. An experienced LDH partner for the past nine years, we maintain local responsibility and oversight for performance, backed by Anthem's systems and supports, to fully comply with all program requirements and State rules and statutes.

### Efficient, Flexible Claims Management Processes

Our highly efficient and accurate claims processing system supports physical and behavioral health (BH) operations, transportation, and other services, and achieves the highest degree of claims adjudication accuracy, with a [redacted]

Healthy Blue accepts standard paper and electronic claims formats used for Medicaid FFS programs and supports providers with a variety of submission options to facilitate accurate and efficient processing, including three nationally recognized electronic data interchange (EDI) clearinghouses: Change HealthCare, Availity, and Smart Data Solutions. All electronic claims files, including 837 claim submissions, 835 responses, and 999 electronic confirmations, are processed, stored, and retained in compliance with information exchange and data management requirements in the Model Contract.

## Processing Claims in Adherence to LDH Requirements

Automated workflows auto-adjudicate claims. The system assigns unique internal control numbers to track claim progress. The process includes initial HIPAA compliance and completeness validation prior to adjudication. We reject claims that fail compliance or completeness validation and notify the provider of the reason for rejection. Claims that pass front-end validation are loaded into the adjudication system and are validated to make sure key elements are present and accurate, including National Provider Identifier (NPI), covered service, member name and ID, enrollment status, and active eligibility span for service date.

**SPOTLIGHT ON**
**Louisiana Claims System Configuration**

Janel Gary has been with Healthy Blue since the initial contract implementation. She offers more than two decades of progressive expertise in health care industry claims configuration. Her problem-solving skills and comprehensive understanding of Louisiana Medicaid regulatory requirements and Healthy Blue's internal systems have allowed her to translate technical needs into customized system enhancements that increase claims processing accuracy. Her day-to-day job involves monitoring regulatory updates that would impact the configuration of our claims system and assuring that these updates are made in a timely manner.

Janel is passionate about improving the quality of services and improving our claims processes to better serve our Healthy Blue members and providers.

LA_HlthyRebid21_Gary_63_SL_02

**Verifying Claims Against Electronic Visit Verification (EVV) Data.** In accordance with Model Contract 2.19.1.19, we will comply with updated LDH EVV requirements for Personal Care Services (PCS) and home healthcare services. We will evolve our interface with the State-contracted EVV system to assure required elements validate all PCS claims during claim adjudication. This information will be accessible via the Member 360°$_{SM}$ dashboard.

The system denies claims that fail adjudication edits, notifies providers of reason for denial on the remittance advice (RA), and generates an Explanation of Benefits (EOB), as required. The RA is available electronically and on paper; identifies level of payment or denial reason using standard procedures and definitions; and includes instructions on filing a claims dispute. The Healthy Blue RA is compliant with Contract requirements, Louisiana Legislative Act 424 requirements, and all other State and federal laws and regulations.

[redacted]

## Pursuing Healthy Louisiana Claim Timeliness Standards

We have assembled a Claims Processing team that is experienced in Medicaid managed care claims processing and trained on LDH requirements, as well as the needs and challenges of Louisiana providers. Over the last nine years, we developed and refined policies and procedures for timely and accurate claims payment and monitoring. Our claims management employees and Quality Assurance department continually monitor claims processing performance and compliance through scheduled and ad hoc reports. In accordance with Model Contract 2.18.2.1.3, we comply with Healthy Louisiana claim timeliness standards, ***exceeding the required threshold of 90% clean claims processed within 15 calendar days, and processing 100% of clean claims within 30 calendar days***.

## Processes to Monitor and Manage Claims Payment Timeliness

We generate daily, weekly, monthly, and ad hoc reports to gauge processing, identify problems, and monitor quality performance. These reports detail the number of pended claims by aging category so we can react quickly. We also review claims on a daily basis that do not meet our desired standards but were compliant for payment. These lead to follow-up wherever needed, ranging from provider education to internal process changes, without negatively impacting timeliness. By working pended claims in order of receipt, we pay providers efficiently and achieve processing goals. We post resolved claims to the next payment cycle automatically. [redacted]

In alignment with Act 710, and to support LDH's submission of the Healthy Louisiana Claims Report to the Louisiana Legislature, Healthy Blue delivers management reports that summarize the number of denials by type of denial and provider. We use various formats (provider bulletins and newsletters via our provider portal, e-blasts, fax blasts, mailings, as well as in-person and virtual meetings) to educate providers on common issues. A high number of denials for a specific provider triggers one-on-one follow-up.

## Claims Payment Accuracy, Claims Summary, and Encounter Data Reporting

Healthy Blue will continue to comply with all reporting requirements, including claims payment accuracy, claims summary, and encounter data reporting per the Model Contract and MCO Manual.

### Louisiana's Health Insurance Premium Payment Program (LaHIPP)

We continue to process claims for LaHIPP participants, remitting payment for total member liability, including co-payments, co-insurance, and deductibles when a provider that accepts Medicaid as the secondary payer is used.

### Claims Analysts Trained to Understand Healthy Louisiana

Louisiana-based Claims Administrator, Annie Garnier, oversees our Claims Processing team, which includes experienced analysts with Louisiana-specific knowledge. The team analyzes claims reports for possible provider submission or system problems. For example, if we see a high number of claims pending for a specific reason, we determine if intervention is needed, review authorization rules, and/or modify a system edit. A high volume of pending or denied claims prompts additional review and often results in proactive provider outreach. Leadership reviews dashboards with key program metrics to track performance and compliance, including clean and non-clean claims percentage paid within 14 to 30, days of receipt.

### Pharmacy Claims

We currently process pharmacy claims in compliance with the Model Contract. In 2020, more than 3.6 million pharmacy claims were paid for Louisiana members. Through the Point of Sale (POS) claims processing system, all claims adjudicate in real time. Network pharmacies transmit claims electronically, following NCPDP D.0 telecommunication standards. Our online claims processing system operates 24/7 and runs a series of edits, including:

- Member Eligibility
- Rejection edits for Third Party Liability (TPL) and Coordination of Benefits (COB)
- Drug Coverage
- Step therapy, therapy duplication, and other clinical edits, as applicable
- Formulary and PDL compliance
- Benefit design edits (quantity, day supply, and refill-too-soon)
- Prospective Drug Utilization Review (ProDUR) edits

As LDH moves to a single Pharmacy Benefits Manager (PBM), we will work with the PBM to process pharmacy claims according to requirements and we will continue to oversee drug utilization and assist in coordination of member/provider needs with the single PBM.

## 2.6.13.2 Healthy Blue's Management Information System (MIS) Supports Contract Performance and Compliance

As an incumbent MCO, we have configured our systems to support Louisiana Medicaid operations under current Contract requirements. Healthy Blue's HITRUST-certified and HIPAA-compliant MIS is fully automated, meets or exceeds current program requirements, and will support new requirements outlined and state and federal laws and regulations. Our MIS supports seamless operation of all managed care functions using modular component integration, enabling flexibility and functionality to meet Louisiana's needs.

The MIS incorporates Service Oriented Architecture (SOA) component integration and is designed on the principle that all data originates from a single system of record. All changes replicate to surrounding systems and applications. This accommodates market-specific needs and innovations, enabling unique capabilities implemented for one affiliate to be leveraged for another.

### Healthy Blue Meets Model Contract Requirements

Table 2.6.13.2-1 demonstrates Healthy Blue's compliance with Model Contract 2.19.

*Table 2.6.13.2-1. Healthy Blue Meets LDH's Model Contract Requirements*

| Requirement | How Healthy Blue Complies with Model Contract Requirements |
|---|---|
| **2.19.1 General Requirements** | Our MIS accepts and processes provider claims, verifies eligibility, collects and reports encounter data, and validates prior authorizations (PAs) and pre-certifications that complies with LDH and federal reporting requirements. More information on how Healthy Blue complies with the General Requirements can be found throughout our response to Section 2.6.13.2. |
| **2.19.2 HIPAA Standards and Code Sets** | We accept and transmit HIPAA-standard transactions, including 834, 837 (I, P, and D), 835, 820, 276/277, 277CA, 271U, 270/271, 278, and 997/999 formats. We are compliant with the 5010 standard for these transactions and also support the NCPDP D.0 standard. We provide additional information in Section 2.6.13.4. |
| **2.19.3 Connectivity** | Healthy Blue has interfaces with LDH and its fiscal agents (FAs), MAXIMUS and Gainwell Technologies, and supports all LDH-mandated electronic healthcare transactions. See Section 2.6.13.4 for more information. |

| Requirement | How Healthy Blue Complies with Model Contract Requirements |
|---|---|
| **2.19.4 Hardware and Software** | We maintain hardware and software compatible with current LDH requirements, including call center, claims EDI, authorized services, and member services operations. |
| **2.19.5 Network and Back-up Capabilities** | We take strong measures to prevent security breaches. Near real-time data replication from our primary to secondary data center assures ready retrieval/recovery of data. Power protection through uninterruptible power supplies and generators assure continuous power. |
| **2.19.6 Resource Availability and Systems Changes** | [redacted] |
| **2.19.7 Systems Refresh Plan** | Healthy Blue currently provides LDH with our System Refresh Plan annually. |
| **2.19.8 Other Electronic Data Exchange** | We address electronic data exchange in response to Section 2.6.13.2. |
| **2.19.9 Electronic Messaging** | LDH-compatible electronic messaging (email) that complies with national standards for the exchange of protected health information (PHI) is available 24/7/365. |
| **2.19.10 Eligibility and Enrollment Data Exchange** | We address eligibility and enrollment data exchange in our response to Section 2.6.13.2. |
| **2.19.11 Provider Enrollment** | We use LDH-supplied provider type, specialty, and sub-specialty codes in data communications including weekly Provider Registry File and PCP Linkage files. Future integration with the new Provider Enrollment System is described in Section 2.6.13.3. |
| **2.19.12 Information Systems Availability** | We provide LDH personnel, the Louisiana Attorney General's Office, individuals authorized by LDH in writing, and CMS direct, real-time, read-only access to Healthy Blue and subcontractor data for the purpose of data mining and review, as outlined in Figure 2.6.13.2-1. This includes but is not limited to PA; claims processing; provider portal; TPL; fraud, waste, and abuse (FWA); PBM POS; PBM PA; and provider contracting and credentialing. |
| **2.19.13 Off-site Storage and Remote Back-up** | We provide for off-site storage and remote back-up of operating instructions and files, procedures, reference files, and system documentation. To prevent data loss, we use NetApp, and Sybase and Microsoft SQL Server log shipping for near real-time replication to our secondary data center. We store tape backups at a secure off-site facility. |
| **2.19.14 Records Retention** | We provide online retrieval and access to documents and files for audit and reporting purposes for 10 years in live systems and an additional four years in archival systems with audit trails maintained for more than six years. Historical encounter data submission is retained for 10 years following termination of the Contract. |
| **2.19.15 Information Security and Access Management** | Our system contains controls to maintain information integrity and exceed industry requirements. We undertake external assessments annually, such as HIPAA Security and Privacy Rule Assessment, Department of Insurance, accreditation agency and state-level cybersecurity audits, and third-party penetration testing. ***We completed a Systems and Organization Controls (SOC) Type 2 assessment in June 2021. We also achieved HITRUST certification in 2016 and recertification in 2018 and 2020.*** We create audit trails in accordance with requirements to track system modifications. We configure limits on unauthorized access attempts to lock accounts and alert security personnel. Security controls include badged access, cameras, access control systems, closed-circuit television, security staff, intercom, fire retardant, and intrusion detection. |

## 2.6.13.2.1 A System with a Proven Record in Louisiana

Healthy Blue has been using our MIS for nine years to meet the healthcare needs of more than 343,000 Louisianians enrolled through LDH programs, achieving 99.97% system uptime availability in 2020. We make sure system functionality and availability meet LDH needs and the changing environment of Medicaid managed care.

## 2.6.13.2.2 Hardware and System Architecture Specifications

Healthy Blue will continue to maintain hardware and software compatible with LDH requirements in accordance with MCO Manual 2.19.1. Reliable, secure, and easily accessible systems are critical to 1) facilitate quality care; 2) provide a platform for data use to improve outcomes and cost efficiencies; 3) deliver efficient stewardship of Louisiana taxpayers' dollars; 4) process prompt payments; and 5) communicate effectively with enrollees (members).

Security protocols assure we meet HIPAA, federal, and state standards and electronic PHI protection requirements, including: Title XIX of the Social Security Act, Medicaid Information Technology Architecture (MITA) – CMS Minimum Acceptable Risk Standards for Exchanges (MARS-E) v2.0, NIST Special Publication SP800-53 R4 Security and Privacy Controls for Federal Information Systems and Organizations, and IRS 1075 rule.

### Key System Components

Modular integration is a key design premise of our system. Components interoperate where needed but are independent to provide specialized functionality. This protects data integrity and prevents inconsistencies between systems. One example of this is the planned provider portal (Availity) integration with the State's new Provider Enrollment System. Our digital enrollment process will mirror the State's environment, making it easy to map data as it crosses over. We apply principles from our Clinical Quality Improvement processes for data integration and implementation of new systems to avoid disruption to providers or members. The high-level MIS has five key systems and platforms which are depicted in Figure 2.6.13.2-1 at the end of this section.

**Core Service Platform (CSP).** Facets, TriZetto's industry-leading, core-administration and claims platform, serves as the primary source for Healthy Blue's provider, member (including enrollment and eligibility), service authorizations, claims processing, and grievances and appeals data. Facets is fully configurable, with business rules that guide claims payments, authorization and reporting requirements, and benefit limits. Surround applications, including the Health Intech platform and data warehouses, are fully interoperable to provide care coordination, online support solutions, encounter data submission, and reporting and analytics capabilities. All updates will occur through user interface or application-specific data loads, such as enrollment files received from the State.

**Health Intech.** Health Intech serves as our primary method for aggregating and sharing member care management information from all sources in one organized format, including health needs screenings, care plans, and utilization data, such as claims history, authorizations, immunizations, labs, and chronic care management. This system fully integrates with our MIS data and gives "life" to artificial intelligence (AI) to enhance members' experience. Health Intech shares information, as applicable, with LDH, Healthy Blue staff, and providers. Improved data sharing leads to better continuity of care, and reduction in care gaps and duplication. Health Intech is fully compliant with State and federal laws, HIPAA, and the HITECH Act and includes available data from the following:

- Healthy Blue's care management and claims processing systems
- Public health systems
- Continuity of care data (claims history or other information from LDH or other MCOs)
- Other payers and providers (pharmacy, lab, diagnostic, and Electronic Medical Record [EMR] data)

**Member 360°$_{SM}$.** Our clinical data dashboard provides a holistic view of each member's utilization, care management services, and gaps in care. We integrate data and information from multiple sources, including claims history, authorizations, ED visits, hospitalizations, immunization records, prescriptions, lab results, and data from health information exchanges (HIEs) and electronic health records.

**Data Warehouse (DW).** Our DW uses SQL Server and supports operational processes, analytics, quality management/improvement, and reporting. Fed directly from the system of record, the DW delivers a comprehensive source of health information about members and includes encounter claims data for services they receive. We integrate additional information into the DW, including labs, immunization, prescription, and clinical data. The DW supports access to integrated member health information through our Health Intech platform; advanced analytics; and operational, management, and regulatory reporting process information.

**Member Website and Mobile Application.** Healthy Blue maintains a member website, as well as our award-winning mobile application and secure portal, Sydney Health (Sydney) that delivers information and self-service tools. Available 24/7/365 and in English and Spanish, Sydney Health leverages AI and data science to personalize the experience for each member. Sydney can remind members to schedule appointments and screenings and share new and existing programs and benefits specific to their conditions and interests. Sydney improves members' access to their health information and helps them be more active participants in their own health.

Key tools include Find a Doctor, a weekly updated provider directory tool; request or print a member ID card (or digital ID through the app); and secure messaging, allowing members to send and receive messages with Member Services.

**Provider Websites.** Available 24/7/365, with public and secure self-service areas, our newly revamped provider website facilitates easy navigation to actionable information and delivers timely and relevant provider communications. Providers can access: Healthy Blue policies and processes; state and federal regulatory changes; our

PA Look Up Tool (PLUTO); provider online chat; centralized PA requests and claim submissions; and provider manuals and guides. Providers can also access our Training Academy, a multi-modal training platform that encompasses a wide variety of provider education and offers continuing education opportunities. Upcoming enhancements to our Academy include on-demand videos and the ability for providers to self-report training completion.

**Supplemental Applications.** Additional integrated applications support overall functionality, including provider payment, member ID cards, EPSDT, HEDIS® scores, and document imaging. We support providers in Value-Based Payment (VBP) programs through our Provider Care Management System, which offers real-time, member-specific data. Providers may submit PA requests 24/7/365 via our fully automated, web-based Interactive Care Reviewer (ICR) tool.

Diagrams detailing hardware and architectural specifications, noted in Table 2.6.13.2-2, are provided in the Supplemental Pages at the end of this section.

*Table 2.6.13.2-2. Healthy Blue's Detailed Architectural Diagrams*

| MIS Hardware Architectural Framework | Diagram Reference |
|---|---|
| **Detailed Hardware Architecture** | Figure 2.6.13.2-2 |
| **Detailed Architectural Framework** | Figure 2.6.13.2-3 |
| **Functional System Overview** | Figure 2.6.13.2-4 |
| **Functional System Interfaces** | Figure 2.6.13.2-5 |

## 2.6.13.2.3 Essential Business Functions and Data Interfaces

Figures 2.6.13.2-4 through 2.6.13.2-16 depict Healthy Blue's essential business functions and Figure 2.6.13.2-18 depicts our data interactions. Our MIS supports requirements outlined in the MCO Manual, Model Contract, and 2021 MCO System Companion Guide including key business processes identified in Part 2. We include a high-level description of each business process and provide data and process flow diagrams as defined in the Supplemental Pages at the end of this section. Table 2.6.13.2-3 outlines Healthy Blue's data and process flow diagrams.

*Table 2.6.13.2-3. Healthy Blue's Data and Process Flow Diagrams*

| MIS Diagram/Process Flow Chart | Diagram Reference |
|---|---|
| **Member Eligibility and Enrollment Management** | Figure 2.6.13.2-6 |
| **Claims Processing** | Figure 2.6.13.2-7 |
| **Encounter Data Management** | Figure 2.6.13.2-8 |
| **Customer Service** | Figure 2.6.13.2-9 |
| **Care Management** | Figure 2.6.13.2-10 |
| **Coordination of Member Health Plan Changes** | Figures 2.6.13.2-11a & b |
| **Utilization and Quality Management** | Figure 2.6.13.2-12 |
| **Authorizations** | Figure 2.6.13.2-13 |
| **Financial Management** | Figure 2.6.13.2-14 |
| **Reporting** | Figure 2.6.13.2-15 |
| **Third Party Liability** | Figure 2.6.13.2-16 |
| **Grievance and Appeals** | Figure 2.6.13.2-17 |
| **Data Interactions** | Figure 2.6.13.2-18 |

**Member Eligibility and Enrollment Management.** Our member enrollment processes maintain the integrity of member information used by claims and finance subsystems, among others. We currently process daily and monthly HIPAA-compliant 834 enrollment data files from LDH, as shown in Figure 2.6.13.2-6. The enrollment file load process establishes begin and end dates for members under specific program eligibility categories. We capture eligibility changes promptly and accurately while maintaining historical data, enabling us to provide appropriate services and correct current and delayed claims processing.

**Claims Processing.** Our MIS tracks information on claims and encounters for covered services processed on behalf of our providers, as shown in Figure 2.6.13.2-7. We assign a unique number to each claim and capture and maintain its receipt date. A series of edits (including National Correct Coding Initiative [NCCI]) and business rules validate data on all incoming claims; the system rejects, suspends, or denies claims with invalid information. We maintain claim and line detail information with processing information, including any applicable interest payments.

**Encounters and Encounters Reporting.** Healthy Blue combines claims processed with encounters received from subcontractors for submission to LDH. Systems configuration and editing include monitoring LDH encounter edit requirements (for example, taxonomy codes), assuring adjudicated claims result in quality encounter data in accordance with the Model Contract. We outline the encounter data submission process in Figure 2.6.13.2-8.

**Customer Service.** We recognize how important is it to be available to members and providers when they need us. As shown in Figure 2.6.13.2-9, we have implemented a communications platform to route calls to an appropriate site and assure timely and quality support. We have claims-trained Provider Services Representatives who make claims adjustments in real time during calls. Our system allows load balancing across sites where all agents access the same information and the same system to deliver consistent, exemplary service.

**Care Management.** The Health Intech care management platform utilizes MIS components data to support member and service management efforts. This fully integrated platform leverages information from our care management system and CSP, as well as clinical and social determinants of health (SDOH) information collected from referrals, screenings, and assessments, as seen in Figure 2.6.13.2-10.

**Coordination of Member Health Plan Changes.** We streamline information sharing relative to care management, and coordinate sharing between MCOs. For transitioning members, our MIS extracts care management data, such as service plans, assessments, and active authorizations, and provides them to the receiving MCO. We can also load data from exiting MCOs into our systems (Figures 2.6.13.2-11a and 2.6.13.2-11b).

**Utilization and Quality Management.** Our utilization and quality management approach incorporates a full range of MIS data sources used in a bi-directional manner to identify clinical initiatives and programs directed at efficient and effective service delivery and guide continuous improvement, as seen in Figure 2.6.13.2-12.

**Authorizations.** We recognize the importance of timely authorizations to assure appropriate member care. Our MIS supports intakes, clinical review, and outbound communication of authorizations (Figure 2.6.13.2-13).

**Financial Processing.** Figure 2.6.13.2-14 details the various MIS functions that support critical financial management processes such as capitation reconciliation, FWA reviews and audits, medical loss ratio (MLR), and our financial statement and Generally Accepted Accounting Principles (GAAP).

**Reporting.** Healthy Blue collects and maintains 100% of LDH-required data, in compliance with Contract reporting requirements. Our process, shown in Figure 2.6.13.2-15, supports collection and reporting of relevant data through both regulatory and ad hoc reports. Our MIS is modular in design, providing a flexible, configurable, and scalable system that can deliver required functionality and information to support program operations.

**Third Party Liability (TPL).** A strong TPL program is critically important to lowering costs for Louisiana Medicaid. To achieve success, our TPL program employs experienced personnel; automated applications; and consistent, replicable processes. Figure 2.6.13.2-16 shows the processes for documenting Other Health Insurance (OHI) and coordinating benefits.

**Grievance and Appeals.** Our Grievance and Appeal System remains compliant with 42 CFR 438 Subpart F, Model Contract 2.19.1.2, and other applicable CMS and LDH requirements, including notice, timeliness, rights, and procedures. Figure 2.6.13.2-17 highlights how our Grievances and Appeals system manages medical necessity and provider disputes appeals. These appeals are received via mail, phone, fax, or web.

## 2.6.13.2.4 Data and Process Flows for all Key Business Processes

We have provided data and process flows for all key business processes in the supplemental pages that follow this section in Figures 2.6.13.2-1 through 2.6.13.2-18.

## 2.6.13.2.5 Support for Medicaid Management Information System Exchanges

The IT team is comprised of our Louisiana IT Director, Claims Administrator, Encounter Data Quality Coordinator, and support staff. Healthy Blue devotes skilled staff to support LDH-required data exchanges and meet operations and management needs, including: 1) on-site Louisiana data analysts and subject matter experts; 2) technical employees embedded in functional departments; 3) a dedicated Regulatory Reporting team that specifically supports Healthy Louisiana; and 4) a corporate team structure that supports Healthy Louisiana. For example, our local team leads all efforts to support Healthy Louisiana, and our corporate team receives Louisiana-specific training and supports changes, such as the new Provider Enrollment System.

**Help Desk Support.** In accordance with Model Contract 2.19.6**,** we will continue to provide Systems Help Desk services to LDH, its FI, and Enrollment Broker staff with direct access to MIS data. Our Help Desk is available 24/7/365. Our Help Desk utilizes IT Service Connect to record, track, and report all reported questions and issues.

## 2.6.13.3 Structured Management of Systems Changes to Support Operations

We will comply with requirements per Model Contract 2.19.6.3 and 2.19.7, including LDH notification and implementation timeframes for system changes and issues. All MIS changes or enhancements follow strictly defined processes and are performed by highly skilled, in-house technical staff supported by Anthem corporate resources. Next, we provide enhancements planned for the new Contract period.

- **Provider Enrollment.** Healthy Blue aims to increase digital communications (inbound and outbound) to make information available electronically to providers in a secure, easy to consume, relevant manner. This includes improvements to our digital provider enrollment and connectivity to the State's Provider Enrollment System.
- **Claims Processing.** Healthy Blue plans to introduce a new Claims Market Services team that, along with InterAct — a new operating model and tool coming in late 2021, that will give our business and partners a single point of entry for claims and configuration issues and changes. This will remove unnecessary handoffs and manual data entry and deliver improved quality and claims issues resolution for LDH and Louisiana providers.
- **UM/Service Authorization.** Health Intech will ingest admission, discharge, and transfers (ADTs) data to update PA with ADT information and create shell cases for those without PA using ADT information.
- **Care Management/Chronic Care Management.** Healthy Blue will update its Health Intech platform to include an internally developed, multi-tenant cloud platform that allows customization, including workflow and task management, without extensive programming. This highly configurable platform will support HIE and electronic health record (EHR) systems integration and improve the PA process.

[redacted]

### Coordination and Management of System Modifications

We have processes for implementing system changes and maintain separate development and testing environments, verifying we only release approved systems to production. We prioritize maintenance outside of critical business operations. If we must schedule maintenance during normal operational hours, we coordinate with LDH for approval and follow documented protocols. We create and maintain a project plan with key dates for configuration, testing, end user validation, and go-live target. LDH is notified before major changes to claims, eligibility and enrollment processing; service authorization management; and provider enrollment and data management. In accordance with Model Contract 2.19.6.3, when we execute a major conversion of a core transaction system, we notify LDH at least 90 days in advance. When a system change is subject to LDH prior written approval, we submit necessary revision(s) at least 30 days before implementation.

### Assuring Continuity of Operations Through System Change Management

Our system change management process follows a governance model with defined roles, responsibilities, and checkpoints, based on these guiding principles: 1) all changes in scope to the production IT environment are submitted and approved using an enterprise change management tool; 2) an owner is defined for each change request and requests must be consistent, detailed, and contain timely, communicated, and accessible information; 3) change requests are approved based on content, risk, and schedule; 4) changes are scheduled to minimize business impact implementation, and back-out plans are required for each request; 5) separate workflows are defined to accommodate emergency and urgent changes; 6) change management includes a protocol for resolving conflicting requests; and 7) documents attached to requests in the process tool may not contain PHI.

For system upgrades, we receive notification from the software vendor two to three months prior to scheduled releases — typically twice annually. We assign a project lead and establish a plan to track deliverables and checkpoints including impact, assessment, program modifications, testing, training, and notifications. The project lead shares release details with the technical team and designated system users, who review and complete an Impact Assessment form for their areas. The project lead holds a kick-off meeting to cover testing timeline and answer questions. The Systems Testing Group creates a test plan and establishes the required test data in Jira, which automates testing and performs defect management.

## 2.6.13.4 Ongoing Support for Data Interfaces

Healthy Blue's MIS is designed to support data interfaces with LDH's system as well as our network providers and subcontractors. We meet all HIPAA, state, and federal standards for data management and information exchange. We maintain connectivity with LDH and its FAs, MAXIMUS and Gainwell Technologies, and support all LDH-mandated electronic healthcare transactions, including X12, NCPDP, XML, and JSON formats. Our MIS also supports a CAQH/CORE compliant interface to the automated clearinghouse (ACH) that allows providers to request and receive claims payments via EFT, to comply with Model Contract 2.11.6.2.

**SPOTLIGHT**

Our Louisiana Information Technology (IT) Director, Trang Cooley, supports Healthy Blue and LDH as an integral part of all technology-based implementations and ongoing operations. Ms. Cooley is a seasoned professional with more than 12 years of IT experience in Medicaid managed care systems. She brings industry, corporate, and health plan knowledge to partner with LDH in developing new system interfaces or resolving operational or system issues. Our IT Director and representatives from key functional departments, such as enrollment and encounters, will continue as active participants in the MCO Systems Workgroup held by LDH.

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**Supporting EHR Technology.** Through EHR connections, we receive ADT data, Continuity of Care Document Architecture (CCD-A), and other Health Level 7 (HL7) transactions. Anthem is currently working with top EHR vendors, athenahealth®, Allscripts®, and Epic® to push member insights, care gaps, and formulary changes to providers in their preferred workflow.

## Current Data Exchanges

Healthy Blue views HIE-enabled data exchange as a catalyst to improving member and provider communication. We support data exchanges with state partners, enrollment brokers, subcontractors, and providers. Our parent organization is a founding member of Da Vinci, an HL7 industry work group dedicated to promoting Application Program Interface (API) and interoperability for healthcare data exchange and administrative use cases.

Healthy Blue's data exchanges with our trading partners are fully automated and use Axway B2Bi to manage secure file exchanges through secure file transfer protocol. We validate incoming and outgoing EDI HIPAA 5010 ASC X12N transactions up to WEDI/SNIP level 7.

Our system job scheduler generates data extracts and we monitor status notifications, extract files, and error logs to verify each job executes as expected and in the appropriate format. We configure data extract changes outlined in the Louisiana MCO Systems Companion Guide and as defined by LDH. Table 2.6.13.4-1 provides a listing of inbound and outbound EDI data exchanges that we currently or will support for the Healthy Louisiana program. Figure 2.6.13.2-18 depicts our data interfaces with providers and subcontractors. Our systems hardware and software architecture is scalable and meets current and future data interface needs. We continually assess system design and architectural framework and monitor core systems closely for system availability, connectivity, and service level agreements.

*Table 2.6.13.4-1. Healthy Blue Data Exchanges*

| Interface | Format | Frequency | From | Destination |
|---|---|---|---|---|
| **Eligibility** | EDI 834 | Daily, Weekly, Monthly | MAXIMUS | Healthy Blue |
| **Eligibility** | EDI 834 | Daily | Healthy Blue | Subcontractors |
| **Institutional Encounter Data** | EDI 837I | Weekly | Healthy Blue | LDH |
| **Professional Encounter Data** | EDI 837P | Weekly | Healthy Blue | LDH |
| **Vision and Transportation Encounter Data** | EDI 837P | Monthly | Healthy Blue | LDH |
| **Dental Encounter Data** | EDI 834D | Monthly | Healthy Blue | LDH |
| **Pharmacy Claim Encounter Data** | NCPDP | Weekly | Healthy Blue | LDH |
| **Encounter Response Data** | EDI TA1/999 | Weekly | LDH | Healthy Blue |
| **Encounter Response Data** | EDI 835 | Weekly | LDH | Healthy Blue |
| **Health Care Claim Payment/Advice** | EDI 835 | Twice per week | Healthy Blue | Network Providers |
| **Premium Payment** | EDI 820 | Weekly | Healthy Blue | LDH |
| **Premium Payment – Maternity** | EDI 820 | Weekly | Healthy Blue | LDH |

**Securely Sharing Information with Providers to Support Medical Management.** We use several secure mechanisms to share information with providers to support care coordination and management, including our provider portal, secure file transfer protocol (SFTP), secure email, and the Louisiana Health Information Network (LHIN) Encounter Notification Service (ENS). Healthy Blue's subscription to LHIN-ENS through Audacious Inquiry, an industry leader in real-time clinical event notification, will allow our providers to access real-time ADT data through our secure portal, with accompanying email alerts, later in 2021. Near-real-time access to member care issues supports proactive engagement and advances the State's goal of decreasing fragmentation and increasing integration across providers and care settings for cost-effective care.

## Promoting Data Sharing and Health Information Exchange

As an incumbent, we will apply our knowledge and lessons learned to continue to advance HIE, data, and information sharing efforts, in collaboration with LHIN, providers, MCOs, subcontractors and other stakeholders. Interoperability allows us to work together seamlessly and securely and enables workflow improvements between Healthy Blue and provider systems. We will encourage all network partners to adopt certified electronic health record technology and comply and attest with corresponding meaningful use requirements and deadlines as outlined by CMS and the Office of the National Coordinator in accordance with Model Contract 2.19.3.4.

**Digitally Transforming How We Work with Providers.** We are implementing digital data solutions that improve healthcare delivery through effective administrative processes and enhanced data sharing. In collaboration with providers and technology solution companies, we are building digital data solutions that include

EMR access and transmission; ADT transmission; and bi-directional integration. We are working with technology solution partners Epic and eClinicalWorks on EMR access and transmission and bi-directional integration. ***We are also working with 26 Louisiana Health Systems over the next 18 months for ADT and EMR data transmissions.***

**EMR Access and Transmission Reduces Administrative Burden and Improves Care and Utilization Management.** Providing Healthy Blue with access to patient records and creating direct back-end data sharing reduces provider administrative burden by simplifying fulfillment of audit and compliance requirements and eliminating the need for alternative information exchange methods. EMR access and transmission includes safeguards that verify members' health plans prior to granting access to information. This promotes PA simplification and supports monitoring fulfillment of VBP agreements. We use EMR data along with other clinical and claims data for predictive analytics and quality metrics.

**ADT Transmission Solutions Provide Real-time Alerts for Inpatient and ED Admissions and Discharges.** We leverage standard HL7 ADT transmissions from facility registration systems to receive real-time alerts for member inpatient and ED admissions and discharges. Through our Clinical Data Integration Platform, our Case Managers and Care Coordinators use ADT event data in their standard workflows to partner with providers, proactively close care gaps, and assure members' safe transitions home.

**Bi-directional Integration Streamlines Workflow and Delivers Data to Promote Better Care.** Real-time workflow and data integration via existing EMR technologies streamlines and facilitates clinical data exchange at the patient and encounter level. Seamless and secure digital information exchange gives Healthy Blue and network providers access to data that improves workflow and collaboration, including:

- **Prior Authorizations.** Directly sharing PA data gives providers near real-time approval or denial of requests and reduces administrative burden by eliminating the need for phone calls, faxes, and follow-up.
- **Clinical Data Exchange.** An integrated data feed that eliminates manual record exchange, streamlines compliance and audit fulfillments, and enables deeper automation and analytics.
- **Member Insights.** Timely access to member information is a critical element in providing optimal care. Detailed patient history, including chronic conditions, lab results, medications, and medication adherence gives providers a 360-degree view of a member's health status and potential care gaps.


## Healthy Blue Focuses on Interoperability

We support interoperability in compliance with regulations released by the U.S. Department of Health and Human Services (HHS). Our project timeline includes application program interfaces (APIs) effective 7/1/2021 – Patient Access API, Provider Directory API, and Formulary AP; and effective 1/1/2022 – Payer to Payer API.

In developing these APIs, we used the CMS Integration Guides and followed standard Fast Healthcare Interoperability Resources (FHIR®) format using SMART IG/OAuth 2.0 privacy standards via OpenID Connect to return U.S. Core Data for Interoperability to members. Members use registered third-party applications, to access and view member, provider, and formulary information. These APIs give members access to their claims, and front-end encounter data available within 24 hours of adjudication. Members also have access to provider directory information on our website or hardcopy.

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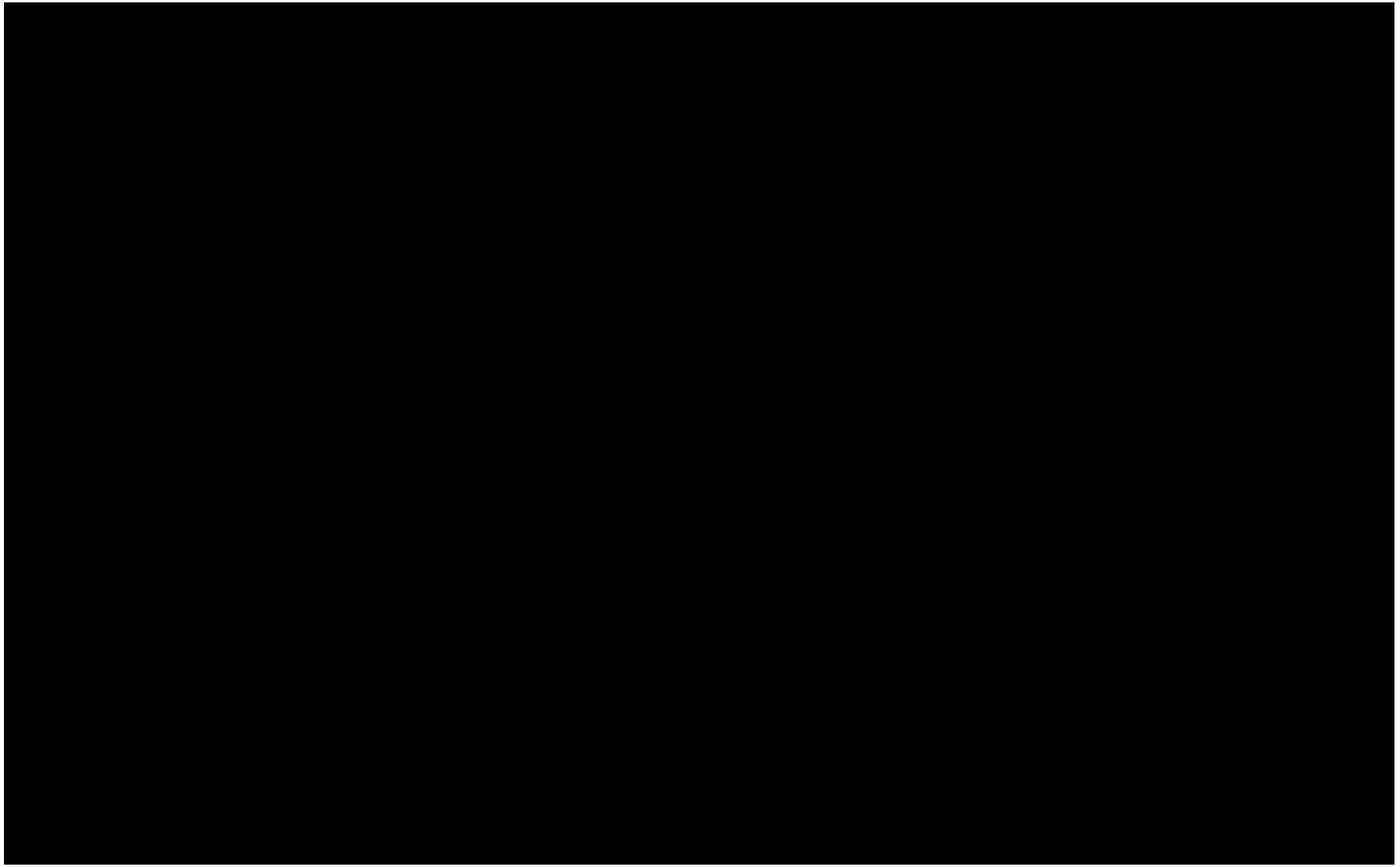

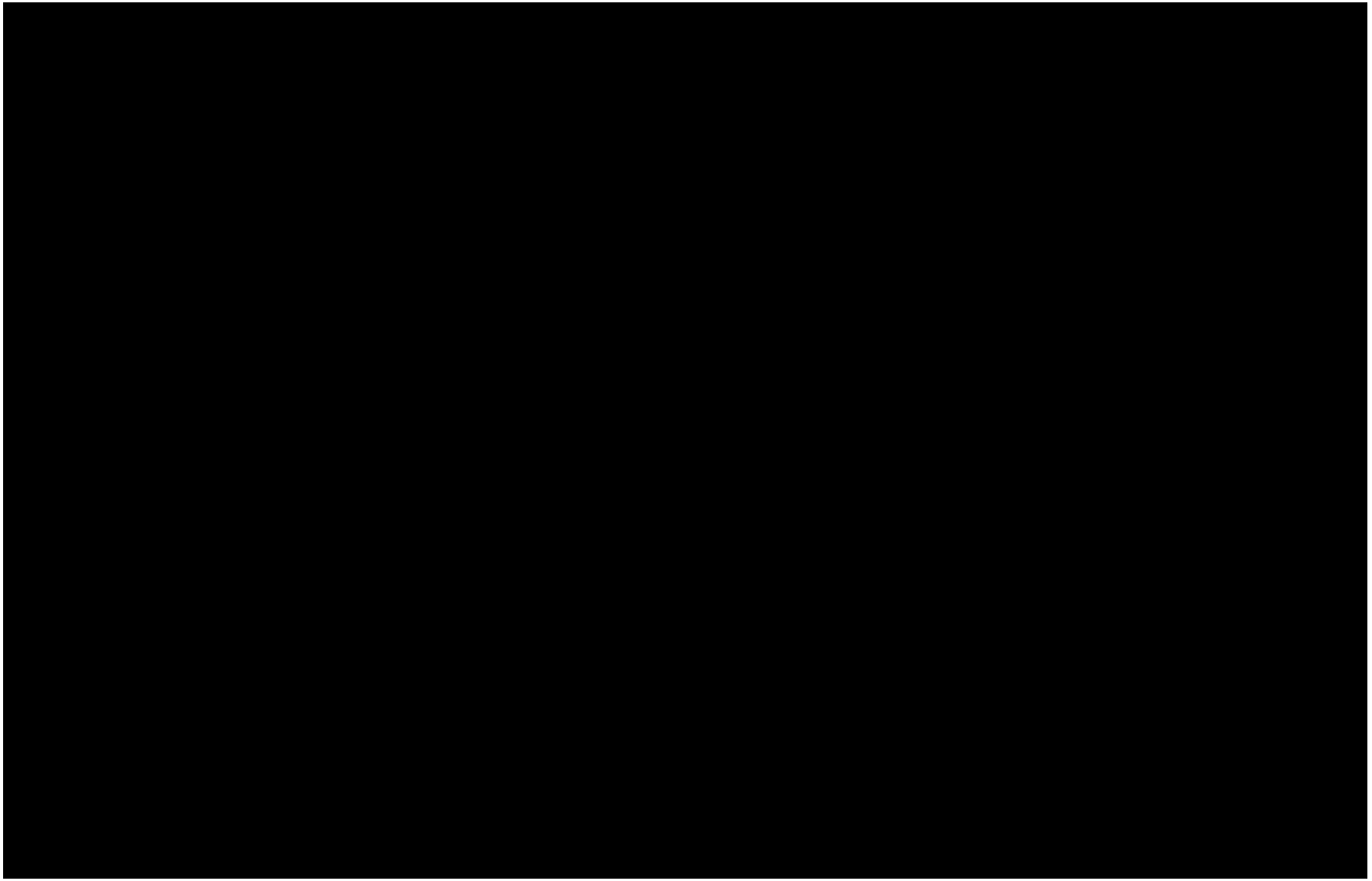

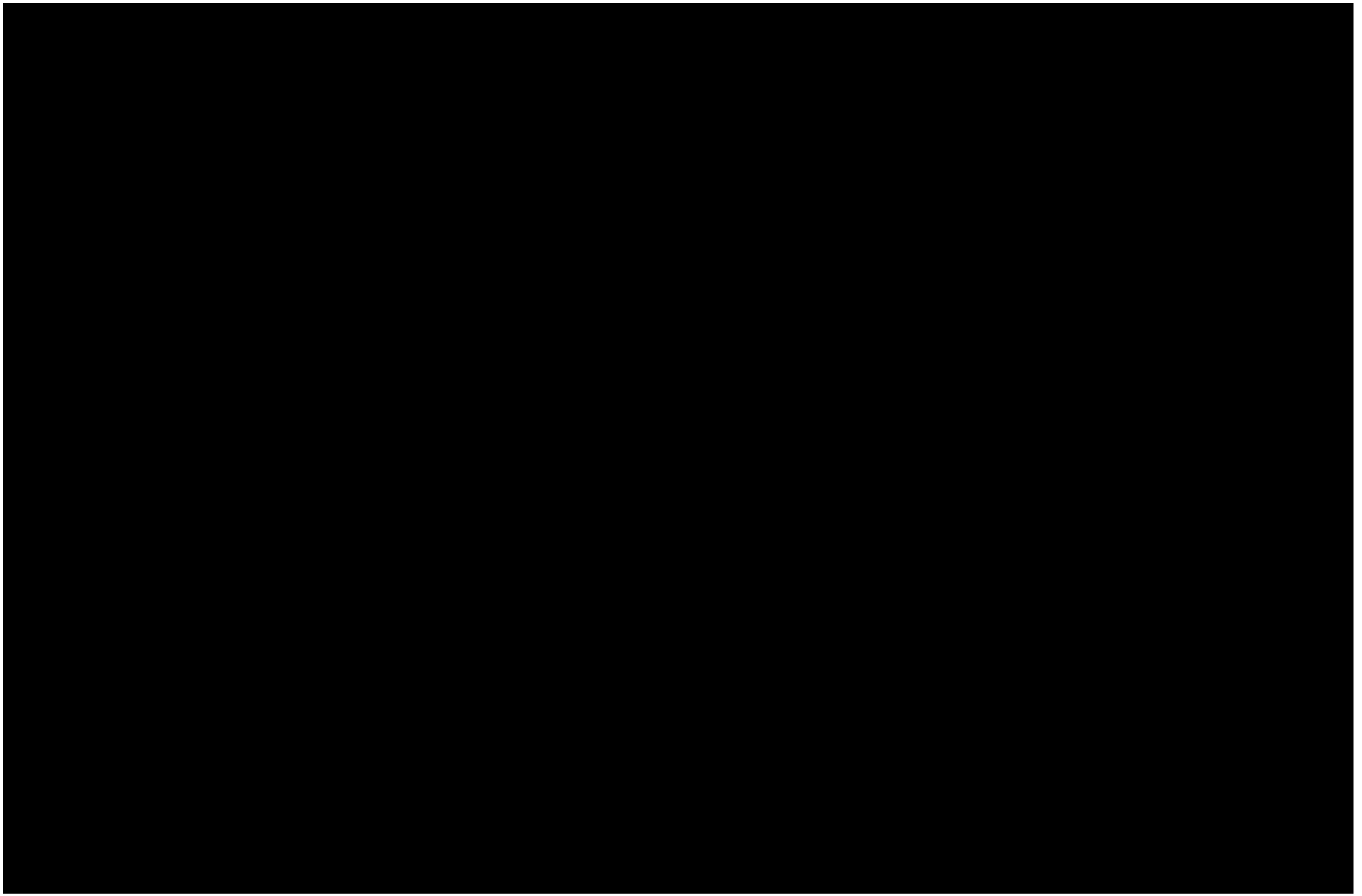

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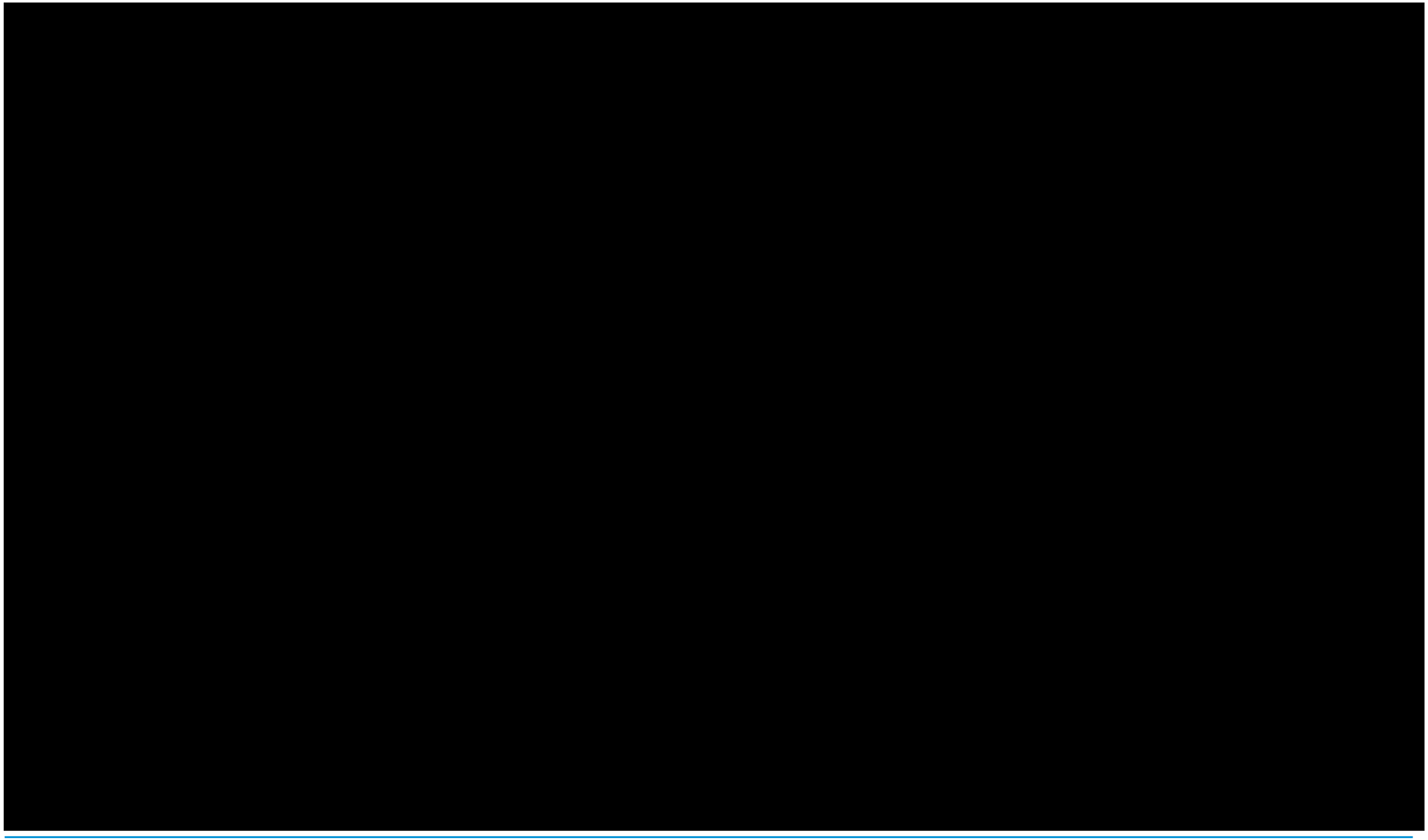

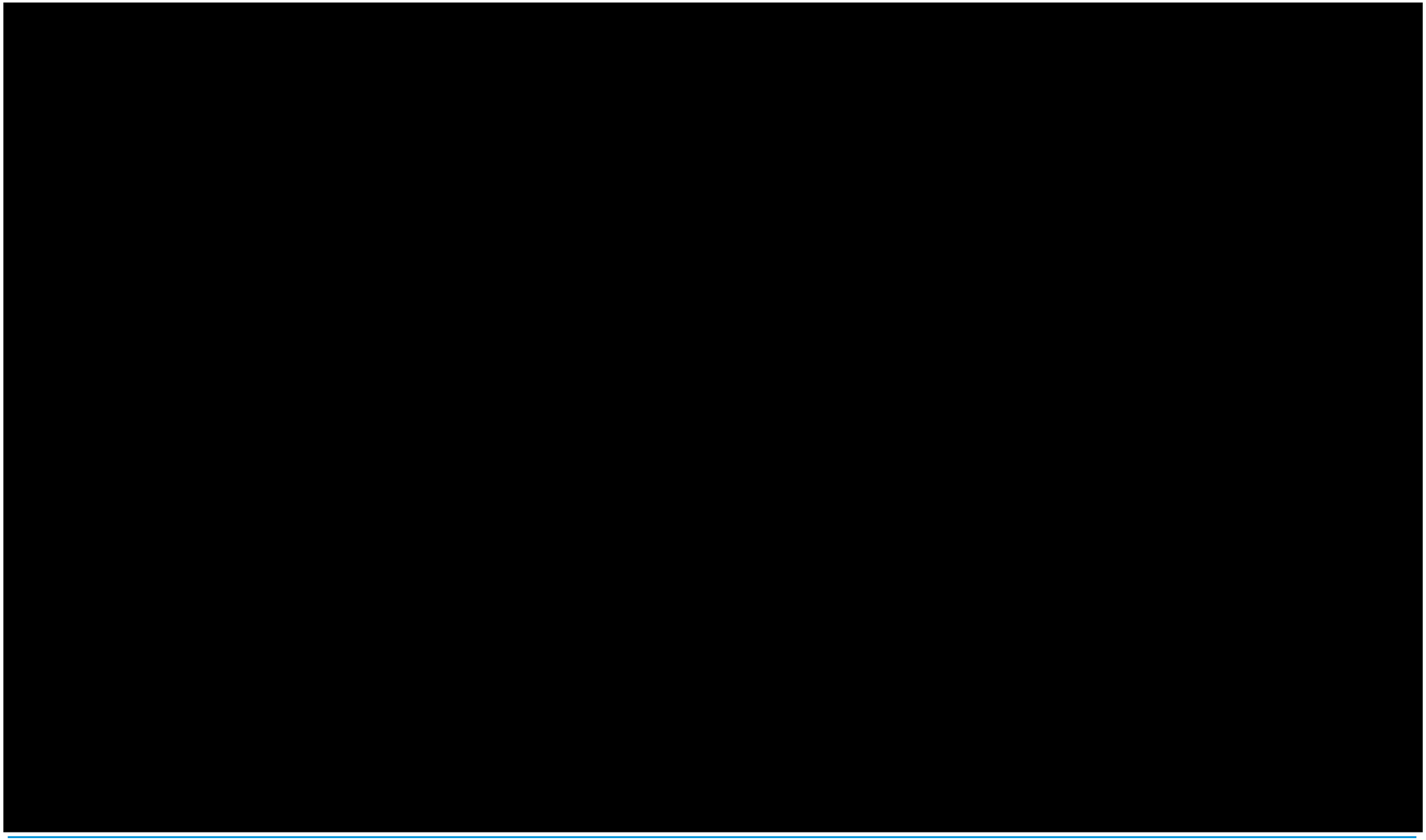

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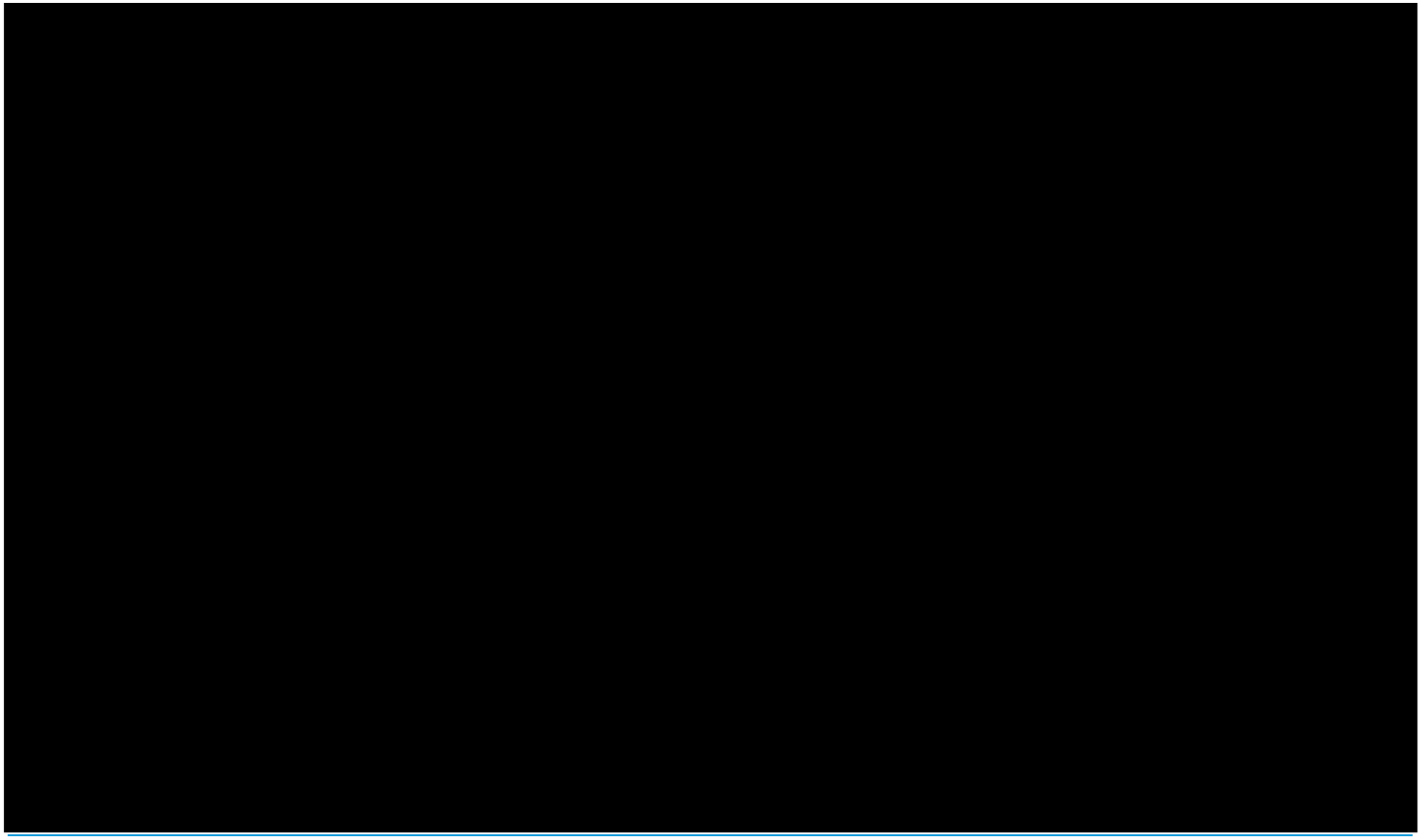

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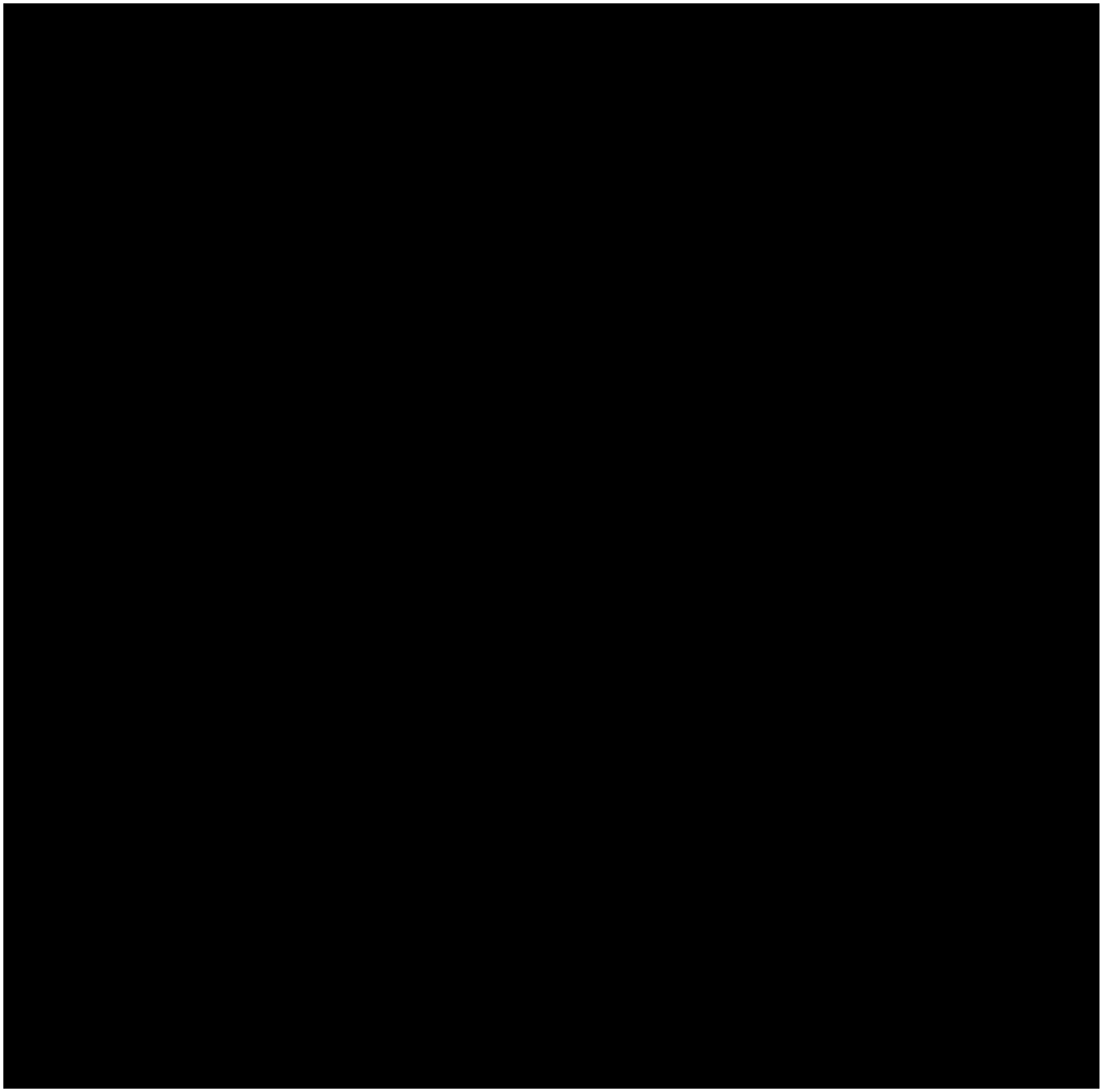

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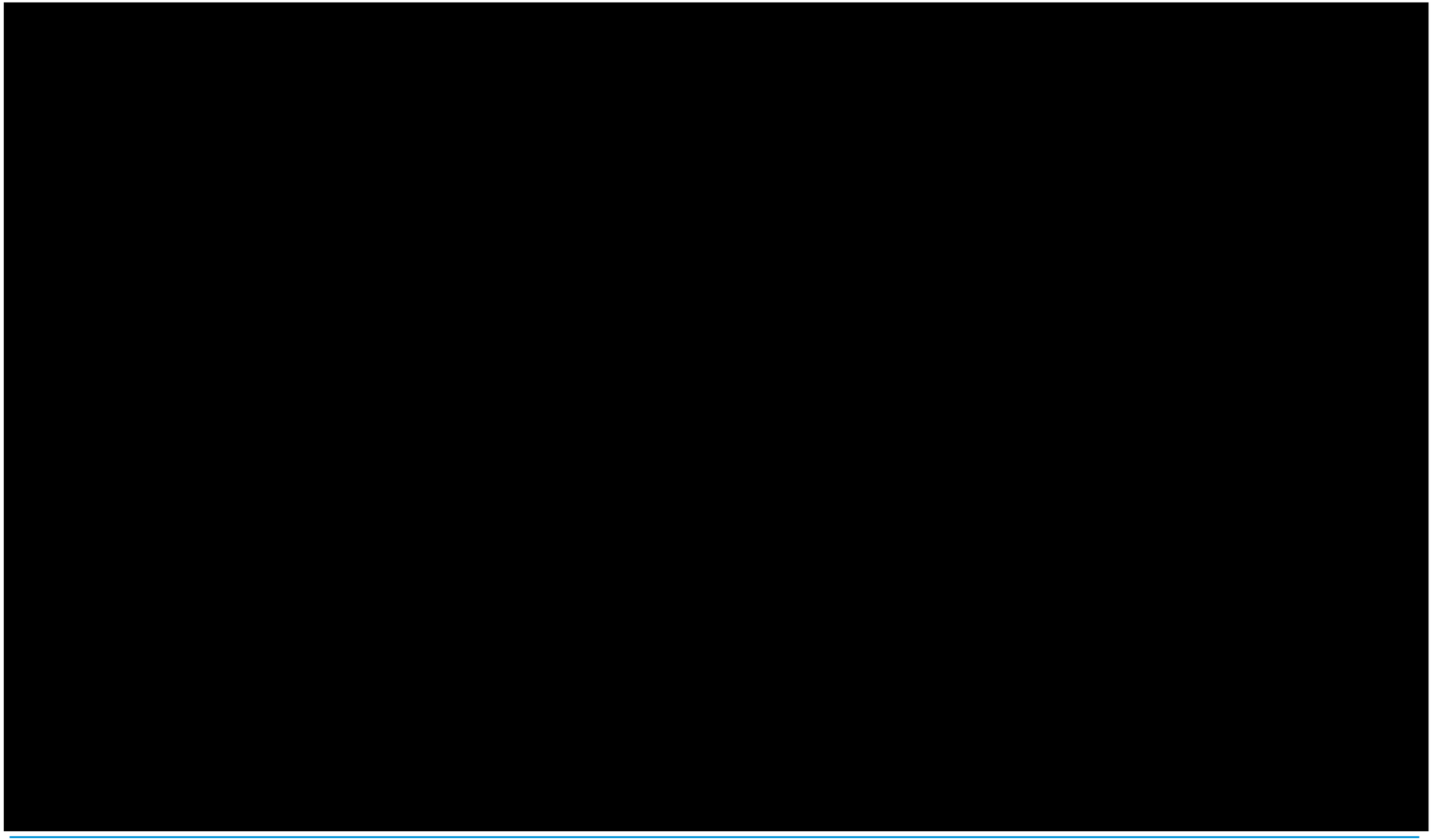

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**Working with Christian Service of Shreveport to Offer Vaccinations to the Community**

Christian Service of Shreveport is a transitional home for men and women that operates a daily soup kitchen and assists with rent, utilities, and other services. Healthy Blue's partnership with them was established in 2013, and together, we host an annual health fair on-site. This year, however, due to the low vaccination rates in Louisiana, we partnered with David Raines Community Health Centers on Wednesday, July 21, to offer vaccinations at their facility.

# 2.6.14

Program Integrity

Healthy Blue

## 2.6.14 Program Integrity

### 2.6.14.1 Healthy Blue's FWA Program Addresses LDH's FWA Requirements

We remain committed to being good stewards of public funds and collaborating with LDH and the Medicaid Fraud Control Unit (MFCU) to support LDH Program Integrity (PI) goals and objectives. As prevention is one of the State's goals, and ***because fraud is everyone's problem***, we prioritize fraud, waste, and abuse (FWA) prevention, detection, and correction in the Healthy Louisiana program. We built our approach on more than nine years' experience in Louisiana Medicaid. Our parent companies also have extensive experience with fighting fraud — BCBSLA has more than 85 years' experience serving Louisiana and Anthem has more than 30 years of experience serving Medicaid programs across the country. This provides extensive insight into billing patterns, utilization, trends, and focus areas on the Louisiana healthcare delivery system, including tele-fraud, durable medical equipment (DME), lab schemes, and prescription drug fraud.

Healthy Blue has a ***strong record of partnership with LDH and the MFCU*** in suspected FWA investigation. In 2019 and 2020, Healthy Blue, in partnership with BCBSLA, made a total of 24 referrals to LDH, MFCU, and the Louisiana Department of Insurance (DOI). We will continue to provide MFCU investigators with information and assistance, as requested.

***To expand our reach, we hold quarterly meetings between PI staff and peers at BCBSLA who lead FWA efforts related to commercial and Medicare plans.*** At these meetings, Healthy Blue and BCBSLA share information on fraud schemes and concepts, investigative techniques, providers under investigation, best practices, and lessons learned. ***The ability to gain insight from BCBSLA, an insurer with 1.8 million Louisiana enrollees (members), expands our capacity to prevent and detect fraud. This collaboration generates leads and/or cases for the entire Louisiana Medicaid program.***

In the new Contract, we will continue to use proven strategies and tactics to combat FWA, ranging from "feet on the ground" local insight to industry leading, high-tech systems and analyses. Our FWA prevention program meets or exceeds the requirements set forth in Model Contract, Section 2.20; MCO Manual, Part 15: Program Integrity; 42 CFR § 438.608; 42 CFR Part 455 (Program Integrity: Medicaid) and 42 U.S.C. § 1320a-7, 1320c-5 and 1396a(a)(68) (Approval of Certain Projects); Louisiana Medical Assistance Program Integrity Law, La. R.S. 46:437.1 through 437.14; and Title 50 of the Louisiana Administrative Code, Part I, Subpart 5 (Provider Fraud and Recovery).

[redacted]

We will also leverage data collected through the State-contracted electronic visit verification (EVV) system to make sure Personal Care Services have been received as reported. Applicable claims will not be processed unless they pass EVV validation in compliance with federal EVV requirements in the 21st Century Cures Act.

#### Strong Compliance Program Oversight

Our Louisiana-based leadership team develops policies in consultation with our Louisiana-based Program Integrity Officer, Erica Douglas, and our Compliance Director, Hassan Gardezi. Policies play a major role in guiding health plan activities and operations. In accordance with Model Contract requirement 2.20.2.2.1, Healthy Blue maintains policies, procedures, and standards of conduct pursuant to 42 C.F.R. §438.608(a)(1) to safeguard Louisiana Medicaid program funds against unnecessary or inappropriate use of MCO Covered Services and improper payments. We monitor and review policies and procedures at least annually and publish them on an internal website accessible to all employees.

Anchored by Anthem's Standards of Ethical Business Conduct (Code), these documents serve as a resource for all employees and outline expectations that reflect federal regulations, State-specific contract provisions, and other program requirements. The Code describes our values and compliance expectations and explains our policy of non-intimidation and non-retaliation for good faith participation in the Compliance program. All staff, subsidiaries, and Healthy Blue's Board of Directors review and agree to follow the Code annually.

***We focus substantial efforts on prevention.*** While we pursue recovery of overpayments and recoup payments that stem from FWA instances, it is more efficient and cost-effective to stop erroneous payments before they are made. Our ***focus on prevention*** includes identifying outlier provider billing or coding practices and working closely with providers to drive behavior change prior to claims payment. For example, we notify LDH of any voluntary provider disclosures resulting in receipt of overpayments more than $25,000, in accordance with Model Contract, Section 2.20.7.2.

***Through collaboration with LDH and industry best practices, we have far exceeded our competitors in prevention and recoveries. In addition to our Special Investigation Unit (SIU) prepayment review (PPR) prevention savings, we aggregate preventive savings from other teams.*** [redacted]

By combining local and national resources, we:

- Identify and implement system and oversight activities to reduce instances of fraudulent activities
- Use advanced data analytics to expand detection capabilities across a broad spectrum of clinical services
- Continuously review and improve processes and tools to optimize savings for LDH, capitalizing on best practices, innovations, and insight from affiliates in 24 other markets
- Collaborate with LDH, MFCU, and other agencies to combat FWA
- Collaborate with other Medicaid MCOs and BCBSLA to identify local FWA trends and issues
- Use preventive strategies to curtail diversion of funds that could be applied to safeguarding member health and welfare

## Healthy Blue Approach to Preventing, Detecting, and Reporting FWA

We 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 can report FWA via mail, in person, email, the toll-free national compliance hotline, or reporting links on our website. Members, providers, community members, and internal staff can report suspicions directly through our award-winning website, www.fighthealthcarefraud.com. Our dedicated reporting email address, MedicaidFraudInvestigations@HealthyBlueLA.com, is published on our website and in member and provider handbooks. We also use newsletters to remind members and providers how to report FWA suspicions.

### Controls for Preventing and Detecting Fraud and Abuse

In accordance with Model Contract, Section 2.20.2.3.2, our Compliance Plan includes controls for prevention and detection of potential or suspected FWA. Our claims processing system — from intake through payment — includes controls that prevent and detect potential or suspected FWA for all claims submitted.

Healthy Blue requires claims and encounter data submission for every service delivered to members and encourages providers to submit claims as soon as possible after dates of service. We offer multiple avenues for providers to submit claims electronically, and we also accept paper claims. We adjudicate claims nightly and make payments five days per week to deliver prompt turnaround. Through our established operational procedures, we receive and process provider claims timely and effectively. All claims, regardless of entry source (paper or electronic) or provider type (network or out-of-network), pass through the same edits and adjudication processes.

The system assigns each claim a unique internal control number to track progress from initial entry to final adjudication. At onset of the adjudication process, the claim goes through our PPR system, which is highlighted through regular edits as well as specific FWA tools and analytics that we employ. Our automated prepayment claims editing tools perform audits on submitted claims and apply correct coding edits. Our SIU prepay process assures medical record review on identified providers before payments are ever processed. We then use internal data analytics reports to identify outlier provider activity. While PPR and reports occur, surveillance and/or utilization management protocols safeguard against unnecessary or inappropriate use of Medicaid services. We reference the Louisiana Administrative Code, LDH provider handbooks and modules, Medicaid banners and bulletins, as well as benefit coverage limitations when data mining for potential FWA.

Continuing through the claims life cycle, Healthy Blue performs desk audits on post-processing claims review. Our review includes claims evaluation for upcoding, unbundling, inappropriate use of modifiers, and billing for services not performed. The SIU and its Special Workgroup Analytics Team (SWAT) use rules-based fraud detection tool STARSInformant and report findings via our proprietary data mining tools, as well as Medicaid schemes and trends across all lines of business. All credible allegations of member fraud or abuse are immediately referred to the Attorney General's office. Our Healthy Blue Medicaid provider handbook and provider agreement detail credentialing standards. We perform ongoing monitoring to verify continued compliance with our standards and look for any action that may reflect substandard conduct and competence. We review periodic reports when available through sources such as the Office of Inspector General (OIG), federal Medicare or Medicaid reports, Office of Personnel Management, licensing agencies, and our Quality Management department.

During post-payment review, we include medical records review and supporting documentation for accuracy, appropriateness of codes billed, standard documentation rules, and education to our providers when we identify abnormal billing outliers. Through our education efforts, we track providers' change of behaviors. Healthy Blue also develops new post-payment, rules-based queries through data mining operations that search everything driving overpayment capture, from duplicate payments to retroactive rate changes.

**HEALTHY BLUE'S PREPAYMENT FLEXIBILITY**

Healthy Blue has the flexibility to:

- Review 100% of all claims submitted for the codes on prepayment review
- Place specific codes or all codes on prepayment review
- Remove codes from prepayment review as providers demonstrate an acceptable pass rate

This flexibility helps reduce provider abrasion while addressing our obligation to ensure appropriate supporting documentation prior to payment.

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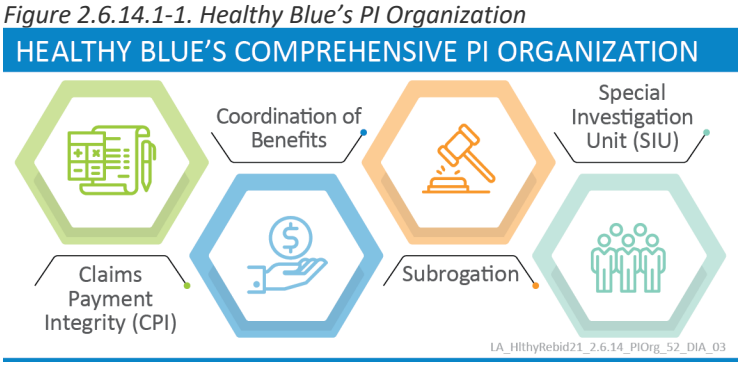
Our controls consist of more than pre- and post-payment reviews. We also review reports for provider profiling and credentialing aid program and payment integrity, including, but not limited to:

- Louisiana State Licensure Verification and related sanctions
- National Plan and Provider Enumeration System (NPPES)
- OIG List of Excluded Individuals/Entities, System for Award Management, and Louisiana State Adverse Actions List
- U.S. Department of Treasury Sanctions List Search Tool
- Bridger Insight (LexisNexis)
- Social Security Death Master File
- Drug Enforcement Agency
- Controlled Dangerous Substances and State-controlled substance certificates
- Malpractice insurance and malpractice claims histories
- Work histories

*Figure 2.6.14.1-1. Healthy Blue's PI Organization*




Provider and member materials, including the Healthy Blue Medicaid provider handbook, outline our FWA program and provide detailed reporting instructions. Our provider website also offers information on reporting FWA. Provisions for the confidential reporting of suspected FWA or PI Plan violations include:

- **Hotline.** A voice-mail box permits information to be left on a confidential hotline. We encourage members to confidentially report allegations of FWA via our toll-free number: 1-866-847-8247.
- **Email.** SIU has established an email account dedicated to referrals within the organization. All employees can reach SIU by selecting "Medicaid Fraud" from the email system global address book, and suspicions can be emailed directly to SIU at MedicaidFraudInvestigations@HealthyBlueLA.com. The email address is also provided online via our website for members, providers, employees, and the public.

**Procedures for Detecting, Reporting, and Investigating Fraud and Abuse.** We maintain detailed internal procedures for officers, directors, managers, and employees for detecting, reporting, and investigating FWA and PI Plan violations. Employees have several options available to promptly report any suspected or identified issues:

- Reporting directly to the Program Integrity Officer or Compliance Director
- 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 (preferred method)
- Reporting allegations or concerns directly on our www.fighthealthcarefraud.com website

**Reporting Confirmed or Suspected Provider Fraud and Abuse.** We will continue to promptly report preliminary investigation results and suspected and confirmed cases of FWA to LDH PI and MFCU. We have an excellent record of meeting LDH PI and federal requirements for report timeliness and quality and will continue to do so under the new Contract. We execute quality reviews on all reports before submission, generating reports in advance of LDH PI deadlines to allow adequate time for thorough reviews. We will continue to use LDH-approved report templates for routine, monthly, and quarterly PI reports. These reports identify:

- Monthly tips reports on all preliminary investigations opened during the reporting period
- Monthly Behavioral Health Providers Gain and Loss Report, which details any adverse actions for behavioral health providers during the reporting period
- Quarterly reporting on all audit and investigation activities, including provider education, PPR metrics, and identified waste and error overpayments and collections across the calendar year
- Quarterly financial reporting for tracking recoveries

We will promptly implement any new reporting requirements upon LDH PI request.

**Protecting Against Retaliation Resulting from Reporting Contractor Potential Violations or Suspected Fraud and Abuse.** Healthy Blue has a policy of non-intimidation and non-retaliation for good faith PI participation, including reporting and investigating potential issues; conducting self-evaluations, audits, and remedial actions; and reporting to appropriate officials. Any employee, regardless of seniority or status, who engages in or condones retaliatory activity is subject to corrective action, up to and including termination. All employees receive a refresher training each year on whistleblower protections and our non-retaliation policy.

## FWA Program Oversight

Healthy Blue's FWA program is part of our overall Compliance program, governed by our Compliance Plan with oversight from our Louisiana-based Compliance Director and Plan Compliance Committee.

**Compliance Program Oversight.** Our robust Compliance program; Healthy Blue Compliance Director, Hassan Gardezi; Program Integrity Officer, Erica Douglas; and the entire Compliance team supports Healthy Blue's continued success while maintaining our commitment to the highest ethical standards.

**Program Integrity and Compliance Oversight: Local, Dedicated Staff.** As an internal subject matter expert and resource regarding our contractual and regulatory obligations for Louisiana Medicaid, our Compliance Director enforces our Louisiana Medicaid Compliance Plan, which is submitted to both the Compliance Committee and LDH annually for approval. Our Compliance Plan designates staff responsible for administering action items as well as clear goals, objectives, measures, outcomes, and target dates. Our Compliance Director implements procedures for routine internal monitoring and auditing, assuring prompt response to compliance issues, as well as identifying and investigating potential compliance problems.

Our Compliance Director also chairs our Compliance Committee, which includes our SIU investigative team, CEO, and leaders from QI, UM, Care Management, Operations, Subcontractor Oversight, Community Outreach, and Provider Services. The Committee provides a forum for Healthy Blue leadership to review and discuss emerging PI issues, regulatory reporting, contract changes, potential compliance risks, and mitigation activities.

Our Program Integrity Officer, Erica Douglas, attends our Compliance Committee meeting and chairs monthly SIU case discussions that include leaders from the SIU, Operations, Provider Network Management and Contracting, Legal, and Medical Directors. The Committee reviews providers currently on prepay and active cases to discuss progress and next steps. Erica is also responsible for managing the PI Plan and reporting specifications to assure compliance with all applicable Healthy Blue, federal, and State requirements.

## Healthy Blue's PI Organization

Healthy Blue's comprehensive FWA and PI efforts rely on highly trained, experienced staff who are empowered by an integrated system of activities, processes, and controls that involve virtually every department. Our PI organization, shown in Figure 2.6.14.1-1, comprises multiple teams across the organization working together to assure appropriate payments for MCO Covered Services provided to eligible Medicaid members. These diverse teams implement and participate in our overall strategy and work in concert to execute Healthy Blue's PI plan:

- Our Claims Payment Integrity (CPI) team is responsible for two major areas: Coordination of Benefits (COB) and data mining. COB functions include identifying and validating other coverage and identifying recovery and prevention savings. Data mining functions (pre- and post-payment) include applying claim overpayment and algorithms to assure compliance and detect potential FWA.
- The COB team develops and maintains reimbursement policies and is responsible for code editing (administrative and clinical edits, correct coding, and customized FWA edits) and medical edits that apply industry-standard logic to claims coding (inappropriate code-to-code relationships).
- The Subrogation team recovers expenses when another party is liable for an accident or injury claim.
- The SIU investigates known or suspected fraudulent or abusive activities by providers, members, or employees; increases awareness of methods to detect, correct, and prevent FWA; and collaborates with regulatory agencies and law enforcement to mitigate fraud and abuse.

**Staffing Model and the SIU.** The SIU is a critical part of our PI strategy. To support the Healthy Louisiana program and in accordance with Model Contract, Section 2.20.1.10, SIU staff will include, at a minimum, one Louisiana-based staff person for every 50,000 members and our local PI Officer. [redacted] Our investigative team is located throughout the state, which enables easy and efficient provider on-site visits.

[redacted] Our Louisiana SIU team is comprised of members with the following certifications: CPC, Certified Fraud Examiners, Accredited Healthcare Fraud Investigators, CPA, Certified Professional Medical Auditor, Certified Outpatient Coder, Registered Nurse, Master of Business Administration, and Master of Arts in Counseling. All team members have a minimum of two years of healthcare-related FWA investigation experience and a Bachelor's degree, or Associate's degree with an additional two years of relevant experience. We include designated SIU staffing in our FWA plan.

In addition to our dedicated Louisiana SIU team, Healthy Blue can draw from extensive resources and expertise of Anthem's national SIU team, comprised of investigators, prepay reviewers, clinical fraud investigators, and support staff. Capabilities and experience among SIU employees are varied and diverse, which means we can leverage experience across all states and lines of business. Our SIU team maintains a close relationship with industry organizations focused on healthcare fraud and abuse prevention. SIU Staff Vice President, Bob Mays, has served on the National Health Care Anti-Fraud Association (NHCAA) Board of Directors for the past six years and currently serves as Secretary of the Board. The SIU Director, Jennifer DePaul, is the current co-chair of the NHCAA Medicaid Fraud Interest Group. Additional staffing credentials and national organization participation include the Association of Certified Fraud Examiners (ACFE) and American Association of Professional Coders (AAPC).

The SIU participates in Compliance Committee meetings, chaired by Healthy Blue's Compliance Director, to discuss high-level SIU metrics. The SIU hosts monthly meetings for health plan leadership from additional functional areas that allow the SIU team to deep dive into open cases, new trends, and schemes and provide detailed updates regarding provider responsiveness to audit activities. The SIU team uses this meeting to provide the best possible service to our providers and reduce abrasion while conducting necessary oversight and corrective actions.

**Collaborating with LDH and External Stakeholders.** Our PI structure and experienced SIU have a strong record of partnership with State and federal agencies to identify, investigate, sanction, or prosecute FWA. Our investigators participate in Managed Care PI Group meetings, biweekly Home Health Care Fraud Referral meetings, quarterly SIU meetings, as well as any additional meetings identified by LDH.

## 2.6.14.1.1 Medicaid Program Integrity Training

**Training Employees on Medicaid Program Integrity.** All employees undergo ***Do the Right Thing*** ethics and compliance training, including modules on FWA, within 30 days of hire and annually. Department-specific training (for example, claims, utilization review, and quality assurance) is provided periodically. The training explains reporting procedures and asks employees to remain vigilant about FWA indicators.

We deliver a modular FWA course through our web-based learning platform as part of our overall compliance training that meets federal, State, and local requirements. Course topics and knowledge checks include information security; reporting security concerns; employee misconduct; Medicare compliance; duplicate billing; False Claims Act and whistleblower protections; medical coding, including miscoding, upcoding, and unbundling; overutilization; member safety; and services not rendered. We update the curriculum periodically to reflect changes in FWA rules, regulations, policies, and laws. The Compliance team monitors attendance to assure all employees complete courses in accordance with Model Contract, Section 2.20.2.2.4.1.

We require SIU investigators to attend 10 hours of continuing education each year, including local events and trainings hosted by AAPC. Our investigators have access to industry-wide resources, such as the NHCAA, AAPC, Blue Cross Blue Shield Association (BCBSA), ACFE, and internal resources including Medical Directors and claims coding professionals. Training occurs through a variety of methods, including seminars, conferences, external webinars, and our internal web-based learning system.

**Healthy Blue's Fraud Squad.** In 2021, the SIU team launched a workgroup, known as the "***Fraud Squad***," that includes 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 have heightened our focus on prescription drug misuse by launching a quarterly pharmacy workgroup focused on opiate and stimulant prescribing and pharmacy-related FWA***, which includes data mining initiatives to identify cases of potential over-prescribing. In this workgroup, our SIU team members and pharmacy director discuss new and emerging pharmacy misuse trends and review top opioid and stimulant prescribers for the Louisiana Medicaid market.

**Training Providers and Subcontractors.** For providers and subcontractors, we offer information about FWA through multiple channels, including monthly newsletters; focused Fraud Prevention Week initiatives; provider orientation and bulletins; and well-publicized reporting channels, such as our Compliance Hotline and Healthy Blue member and provider websites that link directly to www.fighthealthcarefraud.com. Information regarding FWA is included in the member handbook, explanation of benefits (EOBs), and provider policies and procedures.

We currently employ an ***SIU Vendor Liaison*** as an educational resource and designated point of contact for subcontractors (vision, pharmacy, and transportation) regarding FWA. This individual, in concert with our SIU Manager, conducts an annual FWA roundtable with delegated vendor subcontractors. During this roundtable, the group shares examples of identification, investigation, and resolution of FWA cases and exchanges information with Healthy Blue on potentially fraudulent activity.

**Provider Education and Awareness.** Our provider manual and website include FWA reporting methods, examples (member and provider), and suggestions for prevention. Provider training, bulletins, newsletters, e-blasts, and fax blasts also offer provider education on FWA.

Through our online Healthy Blue Training Academy, we offer providers initial and ongoing FWA training sessions. Our Louisiana-based Provider Experience team often delivers in-person provider training with information tailored to address Louisiana-specific benefits and LDH requirements for all provider types. Providers receive initial training within 30 days of joining our network, and we offer additional training to individuals and groups through on-demand/online resources and direct outreach by Healthy Blue staff on an ongoing basis. FWA education includes definitions and examples; reporting and investigation procedures; possible actions and outcomes; prevention (verify member identity, provide proper documentation, and bill accurately); and where to find more information, such as the provider manual and website.

In 2020, we sent 5,025 educational letters to Healthy Blue Louisiana providers with a heavy emphasis on the top five provider education concepts, as shown in Table 2.6.14.1-1. These efforts resulted in State savings of more than $2.5 million in 2020.

Our Provider Experience team also delivers provider education through virtual or in-person meetings as needed. In May 2021, we focused provider training on areas that are high risk for fraud: “tele-fraud,” DME, COVID-19 fraud, lab schemes, “incident to” billing, and prescription drug fraud (opioids and pill mills).

## 2.6.14.1.2 How Healthy Blue Engages Enrollees in Preventing FWA

Healthy Blue uses multiple methods to engage and educate members on FWA prevention. Upon enrollment, we provide a welcome packet with a welcome newsletter; ID card that includes telephone number to report FWA; and member handbook, which highlights the www.fighthealthcarefraud.com website. We also share educational videos in both English and Spanish on Healthy Blue’s dedicated FWA web page. Members can report FWA by calling the toll-free Member Services number listed on their ID card, the website, and member handbook. In addition, members may view their claims in the member portal and detect potential FWA.

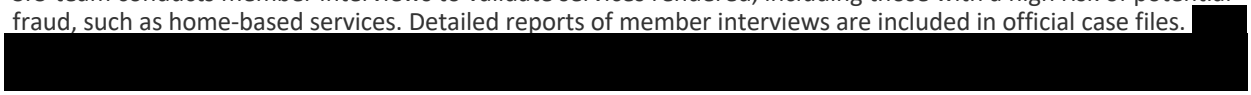
We rely on collaboration of all stakeholders to have the most meaningful impact. For example, we ran a Drug Take Back Day campaign on prescription drug safety in collaboration with local task forces. Thousands of pounds of drugs were taken back; this has a direct impact — decreasing street crime and improving the overall safety and well-being of Louisiana communities. Louisianians may also safely get rid of medications year-round. Through a partnership with BCBSLA, Louisiana Attorney General Jeff Landry’s office, National Association of Drug Diversion Investigators, and law enforcement offices, drug drop boxes are available in multiple parishes statewide.

In April 2020, BCBSLA ran a campaign to coincide with tax season, when there are higher rates of scam activity. In addition, BCBSLA’s Medicare Medical Director, Dr. Larry Simon, was featured in a content series with The Advocate in April 2020, in which he discussed how to be more aware of scams and fraud. Based on the success of the campaign, Healthy Blue is leveraging its partnership with BCBSLA to continue an ongoing tax season educational program for Healthy Blue members will be utilizing this same campaign, targeted to LA Medicaid Enrollees, in the new contract.

Healthy Blue is proud of the work we do to engage members. We distribute fraud hotline posters and conduct numerous campaigns throughout the year. For example, we held a Seniors and Lawmen Together (SALT) food and resource distribution event. Additional examples of best practices Healthy Blue will look to incorporate in the new contract includes variations of the following campaigns:

- **Elders Support Playlist on Blue Cross and Blue Shield of Louisiana YouTube Channel.** Original videos to raise awareness of FWA potential among adults 65+, who are most likely to be targeted
- **Be Wary of COVID-19 Scams.** Produced April 2020
- **How to Avoid Healthcare Fraud.** Produced April 2020 (updated Q1 2021 to address new information)
- **Avoiding Fraud.** Video produced March 2021 in partnership with FBI
- **Blue Cross Reminds Louisianians to Watch Out for Fraud and Scams.** April 2021
- **Don’t Be A Victim of Medicare Enrollment Fraud.** November 2020
- **Blue Cross Reminds Louisianians to Prevent Abuse by Disposing Safely of Prescription Drugs.** October 2020
- **Fraud Alert: Scammers Sending Fake 'HIPAA Compliance' Postcards.** August 2020

In accordance with Model Contract, Section2.20.2.2.10, we send EOBs to a sample of members with an accompanying letter asking them to notify us if they did not receive the listed service. During investigations, the SIU team conducts member interviews to validate services rendered, including those with a high risk of potential fraud, such as home-based services. Detailed reports of member interviews are included in official case files.



## 2.6.14.1.3 Sophisticated Data Analytics Help Combat FWA

We employ sophisticated and flexible data analytic algorithms for fraud prevention (proactive) and detection (reactive). We apply a customized set of data analytic algorithms across the claim lifecycle — during adjudication and pre- and post-payment. We detect irregular and inconsistent behaviors using coding software, FWA analytics, and our internal, proprietary healthcare analytics. Our data mining tools and methods enable discovery of payment integrity issues, investigative leads, and new research areas through statistical and machine learning models. Predictive modeling tools can analyze provider claims and billing practices against peers and detect instances not specifically restricted to CPT® codes.

Our Anomaly Detection is a suite of proprietary advanced models that predict and flag suspicious trends in provider billing patterns. Shown in Figure 2.6.14.1-2, these models review and analyze data to identify high-risk areas that were previously undetected. For example, the Triage team, staffed with registered nurses, CPCs, and employees with investigative experience, uses Anomaly Detection models to generate provider and concept-based leads to the SIU. Provider Education uses Anomaly Detection models as one of the sources to identify providers with aberrant billing trends and teach correct usage of coding guidelines, billing policies, and claim editing logic.

Monthly reporting and analysis support lead generation and verification related to potential provider fraud and abuse. A dashboard for the investigation team displays 13 months of rolling data and supports sorting, filtering, and drill-down analysis on parish, city, provider tax ID, and top procedure codes. Viewing a summary of any provider's billing history, including changes and peer comparisons, is a key part of the investigative process and strategy to detect and prevent provider fraud and abuse that has led to the identification of major areas of waste and abuse, like overutilization of respiratory viral panel tests, highlighted in the case study in Figure 2.6.14.1-3.

This example demonstrates how we compared Louisiana's expenditures on CPT code 87633 with Anthem's other markets to help identify abuse and raise the issue to LDH. This policy change will result in savings to the whole Louisiana Medicaid program.

### SUCCESS IN IDENTIFYING OVERPAYMENTS

Healthy Blue has identified over $1.6 million in overpayments in the first half of 2021, which exceeds overpayments identified by any other MCO.

**2021 SIU Overpayments by Plan**

*Data through 6/30/21*

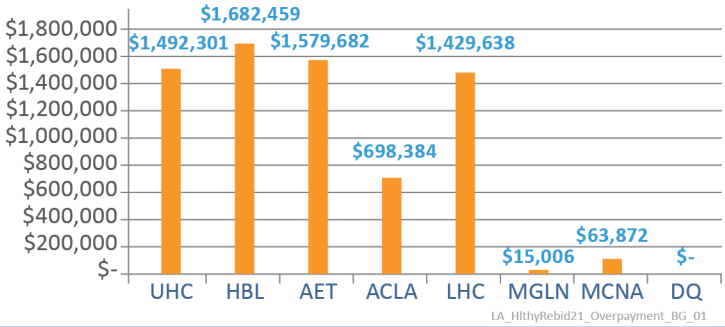


*Figure 2.6.14.1-3. Case Study on Overutilization of Respiratory Viral Panel Tests*

**HEALTHY BLUE'S DATA MINING CAPABILITIES AND ADVANCED DATA ANALYTICS LEAD TO POLICY CHANGE**

Prior to onset of the COVID-19 pandemic, Healthy Blue's SIU team discovered through data-mining that there were extreme expenditures for the Louisiana Medicaid market related to respiratory viral panel (RVP) tests, specifically code 87633. CPT® code 87633 is defined as "Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (for example, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus) includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types of subtypes; 12-25 targets." 87633 is the highest level of RVP test, and the frequency that this code was billed far exceeded the frequency of the lower level tests — 87632 (6–11 targets) and 87631 (3–5 targets).

The RVP tests for respiratory viruses, but in Louisiana, the most frequently used brand also tests for three bacteria in addition to the viruses. Providers were billing for the highest level RVP plus the three bacteria as separate charges. Anthem, as well as many other large payers, has a clinical UM guideline stating that RVP testing in the outpatient setting is considered not medically necessary unless they are limited panels involving five targets or fewer. Testing is for individuals who are at high risk for complications of respiratory viral infection including, but not limited to, individuals who are immunocompromised (for example lung transplant recipients); the results of the testing will be used to guide or alter management.

This policy was not adopted by Healthy Blue because we are not allowed to be more restrictive than the state for our clinical guidelines.

Healthy Blue's SIU team escalated these concerns to our medical director and other plan executives, who began working with LDH to demonstrate the vast abuse of billing around RVP tests, many of which were determined through record review to not be medically necessary and were not evidenced to impact medical decision-making or patient care. Through collaboration with LDH and with other MCOs, in March 2021, LDH changed their policy on RVP tests and no longer covers 87633.

Our investigation of RVP tests began in the summer of 2019, well before the COVID-19 pandemic. In the midst of the pandemic, we saw utilization and abuse of this code increase. Many of the tests being performed (depending on the brand and complexity of the test) did not test for COVID-19 as a target. As LDH worked to make changes to stop the abuse of this code, careful consideration was given to both potential member and provider impact. LDH offered guidance to providers on which codes were appropriate to bill when testing for COVID-19.

For Healthy Blue, **this policy change will result in millions of dollars in savings**, which is just now starting to be realized.

LA_HlthyRebid21_2.6.14_DataMining_50_COB_03

## 2.6.14.1.4 Methods Healthy Blue Uses to Identify High-risk Claims

Healthy Blue defines high-risk claims as those that signal aberrant data or deviations away from the mean (for example, a high dollar claim, an unusually high claim volume, or spikes in claim submittal behavior). We use multiple methods to analyze claims based on risk populations and risk dimensions to identify potential high-risk claims and aberrant data. Our Fraud and Abuse Management System looks at the number of standard deviations away from the mean on any data point. We review providers' claim payment history to assess risk level and likelihood of an incorrect claim request.

We determine risk indicators based on several factors, including high dollars, claim volume, spikes, and trends in claim submittal behaviors. We place extra scrutiny on high-risk claims to identifying any improper payments. We review all risk-identified providers and use our risk indicators to determine what action(s) to take.

Actions may include a recovery request, placing a provider on prepay review, or if deemed potential fraud, we will open a case. This analysis is performed across the claims' lifecycle — during and post-adjudication and pre- and post-payment.

During adjudication, claims meeting identified criteria, such as high dollar claims and those that require Operations Expert review, route to specific queues for manual review and adjudication. Prior to payment, we execute more than 120 algorithms that search claims for identified concepts, including providers on PPR. Post-payment data mining algorithms, such as Anomaly Detection, identify suspicious billing patterns.

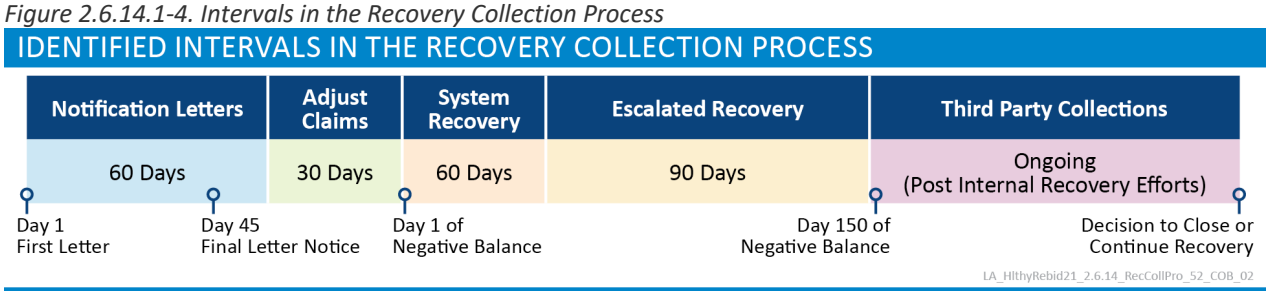
PI leverages experience from our affiliates across the country to establish concepts that define dimensions of a claim that increase risk level. Dimensions include dollar amounts and modifier/coding trends consistent with historical issues and may change and evolve as new threats and fraud schemes are identified.

## 2.6.14.1.5 Healthy Blue's Experience with Provider Recovery Collection

[redacted]

Our processes assure we only pursue one recovery concept for any overpaid claim line. If a provider is under investigation by SIU, we put a hold on other overpayment recovery efforts. Figure 2.6.14.1-4 shows a provider recovery timeline that documents actions we take at specified intervals after identification of overpayment.

*Figure 2.6.14.1-4. Intervals in the Recovery Collection Process*




Healthy Blue complies with State laws requiring encounter voids for claims identified as FWA overpayments.

If the provider submits a written response to the recovery notification letter, the sending team carefully reviews the information submitted. Within 30 days, the team determines if the facts justify recoupment and mail written notice of determination to the provider. If overturned, recovery efforts cease, and money recovered is reimbursed. If upheld, the provider may file a second appeal and recovery efforts continue. If we are unsuccessful in recovering funds or a negative balance remains after third party collection efforts, we close the case or continue recovery.

Regular reports and a monthly meeting help us monitor provider recovery collection efforts, including prior month and year-to-date dollars recovered, as well as pipeline information on cases at each phase of the recovery life cycle. We review providers and associated claims identified for recovery before provider notification. This review step confirms accuracy of overpayment and keeps leadership and Provider Services informed.

## 2.6.14.2 Healthy Blue's Capabilities to Produce Required FWA Reports

Meeting LDH reporting requirements in Model Contract, Section 2.20.5 while delivering meaningful information to support LDH review and analysis requires the right combination of capabilities, data and tools, resources, and quality controls. We report any FWA incident or notice concerning individuals or entities within three business days. Monthly reports to LDH include tips, audits, and complaints to the Compliance Director, overpayments identified and recovered, and FWA activities. We understand LDH reporting requirements and the operational commitment they require. As such, Healthy Blue will continue to:

- Promote reporting accuracy by applying consistent edits to incoming data and carefully monitor processing

- Use organized and structured databases and data warehouses to support reporting and analysis
- Provide data analytic tools companywide to format, aggregate, and report consistent and accurate data
- Leverage the reporting and data analysis experience and resources of national support services and our affiliates to expedite report deployment and create more meaningful reports

## Meeting Reporting Requirements Requires People, Tools, and Data

PI Business Analysts and technical staff support our ability to generate FWA reports. Dedicated regulatory compliance staff compile reporting metrics to assure robust and accurate report generation. Direct access to resources helps Healthy Blue respond quickly and efficiently to reporting needs and adapt to future changes. Employees have industry-leading software and tools at their disposal for data access and report development. These tools, combined with access to databases that contain demographic, service, utilization, and quality data, provide powerful reporting and analytic capabilities to meet LDH reporting needs.

**A Key Resource is the Operational Data Warehouse (ODW).** The ODW is a copy of transactional data specifically configured to support complex analytical and ad hoc queries using business intelligence tools. The ODW is an integrated repository fed directly from our Core Service Platform to deliver data quality, control, and consistency. The ODW also houses data from external sources, including encounter data from our transportation and vision subcontractors. In the new contract the ODW include encounter data from our pharmacy subcontractor. PI maintains additional systems to track specific activities, including tips, SIU investigations and PPR, provider overpayment recovery collections, and audits.

Understanding how important reporting is to LDH, we created a monthly meeting to review all PI reporting responsibilities. This meeting covers reporting changes, template questions from data contributors, and State responses on previously submitted reports. Either the primary owner or backup from each area participates in meetings (for example, Provider Education, SIU, CPI, Credentialing, Appeals, and Prepay Edits). We send an automatic alert that includes the most recent template, with completion and documentation instructions, to all primary business owners and backups 21 days prior to the State due date. Prior to submission, all contributors review and approve the final report.

## Proposed Innovations for Reporting PI Data

Healthy Blue proposes to implement a Change in Behavior savings report as a new innovation for reporting PI data. A Change in Behavior savings report will track cost-saving measures that are not currently reported in the PI 145 report. The extrapolation of savings is determined from when a behavior was noted until the end of the calendar year. For example, if a doctor started charging a higher rate than allowable in March and after education the behavior changed, the savings incurred would be from March to December. Our other Healthy Blue affiliates monitor SIU provider change in behavior due to direct SIU education, administrative actions, or further SIU contact with the provider that may influence the provider's billing behavior. After these provider interactions, we track behavior change and report cost avoidance savings quarterly. Adding Change in Behavior savings reporting is an innovative method to capture additional cost avoidance impacts, giving MCOs and LDH broader insights into all PI cost avoidance efforts in Louisiana. An example is provided in Table 2.6.14.2-1.

## Creating Bike- and Pedestrian-friendly Communities Through the Stroll into Safety Program

The Stroll into Safety program educates children, caregivers, and community members about the importance of pedestrian and bicyclist skills, the rules of the road, personal safety, and improving health and environmental conditions. This program is designed to bring attention to bike and pedestrian safety issues in the Greater Baton Rouge Area to create safer and more bike- and pedestrian-friendly communities. The program offers classroom presentations, bike rodeos, safety towns, community education events, and bike/pedestrian school events.

# 2.6.15

## Physical and Specialized Behavioral Health Integration Requirements

Healthy Blue

## 2.6.15 Physical and Specialized Behavioral Health Integration Requirements

***Healthy Blue is committed to providing our Louisiana members with the highest quality of integrated physical health (PH) and behavioral health (BH) supports, including services for both mental health and substance use disorders (SUD).*** Since 2015, Healthy Blue has successfully developed and sustained a culture that supports the values of integration, information sharing, education, and training within the context of a whole-person approach under the leadership of ***Cheryll Bowers-Stephens, MD, MBA, our Healthy Blue BH Medical Director and Raymond Poliquit, MD, FAAP, our Chief Medical Officer***. The evolution of our integrated care approach at the provider network level is illustrated in Figure 2.6.15-1.

Our approach is value-based and built upon the principles of person-centered planning, focusing on the needs and vision of members, caregivers and families, and the community. The model incorporates the move from fee-for-service reimbursement to Value-Based Payment arrangements to promote full integration at the service level (primary care and specialized BH providers). Healthy Blue has benefited from the support that our parent company, Anthem, Inc., has brought to Louisiana — support that is backed by 25 years of BH service experience across our affiliates, currently in 25 Medicaid markets with more than 9.7 million members receiving integrated BH and PH care. Healthy Blue is a fully integrated managed care organization as it relates to its organizational and operational functions; under a unified organization, Health Care Management is fully integrated. This fully integrated team is supported by clinical and administrative rounds and clinical documentation systems that present data reflecting the whole health status of members.

## 2.6.15.1 Healthy Blue's Fully Integrated Care Model

The Healthy Blue integrated model is evidence-based, incorporating practices developed over time. It also incorporates the SAMHSA-HRSA framework for levels of integrated healthcare, the biopsychosocial model for understanding a members clinical condition, the four-quadrant model for case management assignments which categorizes risk and complexity by quadrant, the Harold P. Freeman Model of Navigation for community navigation, and the University of Washington Collaborative Care model for addressing chronic conditions and BH conditions in the primary care setting. ***For more than six years, Healthy Blue has employed this integrated care model to address the needs of its members suffering from health disparities, including their needs related to comorbid chronic conditions, mental health issues, and SUD problems.*** The synergistic use of these models has resulted in a [redacted] Our Care Management team works as one united group in our **Elevate | Population Health** approach focusing on everything affecting a member, including PH, BH, and social determinants of health (SDOH), to drive quality outcomes. ***We identify, engage, and support members by breaking down barriers to focus on what is most important and impactful to the member.*** [redacted]

[redacted]

### Integrated Collaborative Care Model

[redacted] Further, ICCM incorporates the Harold P. Freeman Model of Navigation and best practices related to SDOH interventions.

[redacted]

[redacted]

## Evidence-based Practices Incorporated into the Healthy Blue Integrated Care Model

Our integrated healthcare approach incorporates a variety of evidence-based models to support coordination among providers, co-location, delivery system transformation, and other program activities in addition to the evidenced-based models noted previously. These models and practices are specifically designed for individuals with comorbid chronic PH and BH conditions, facilitating clinical Case Managers and practitioners to identify and address the individual, unique needs of each member.

**Care Management.** Our Care Management team is composed of highly qualified PH and BH clinicians and support staff (including peer support, Community Health Workers [CHWs], liaisons) who are trained and licensed (where applicable) to address members' whole health needs. The team provides fully integrated care coordination using their local knowledge of Louisiana providers, community resources, and systems of care to address member needs. The Healthy Blue integrated care teams work diligently to develop and implement solutions and interventions to address the unique PH, BH, and SDOH needs of members.

**Population Health Management of Comorbid Disorders.** We continue to offer options for any combination of the following conditions, often prevalent in our Louisiana membership: pregnancy, preconception health, and neonatal intensive care; coronary artery disease; schizophrenia; diabetes; congestive heart failure; major depression in children and adolescents; HIV/AIDS; and asthma. Our protocols, standards, and materials for these accredited programs use the NCQA model that includes keeping members healthy, managing members with emerging risk, maintaining member safety, managing multiple chronic illnesses, and evaluating outcomes across settings. Our Chronic Condition Management programs serve as an adjunct to our integrated Care Management team.

[redacted]

COMING IN 2021:
CONCIERGE CARE FOR MEMBERS WITH CHRONIC HEART FAILURE

Healthy Blue is pleased to introduce Concierge Care, a dynamic, person-centered member-facing app that helps to connect members to our care management team. Through this evidence-based program, care managers will be able to interact and collaborate with members, providing highly personalized educational content, bi-directional chat and supporting members to manage their symptom.

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[redacted]

## Training for Mental Health Parity Compliance

Healthy Blue follows the lead of our parent organization, Anthem, by prioritizing the parity of mental health (MH) and SUD services, jointly considered BH services. Our prior authorization, medical necessity criteria, network policy, and procedures comply with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and 42 CFR Part

438 Subpart K. Criteria for medical necessity determinations for BH benefits to any member, potential member, or provider. These policies and procedures are available on our website and by request per 42 CFR §438.236(c) and 438.915(a). We adjust services and subcontractor relationships as needed to remain in compliance with LDH parity reviews. Healthy Blue also participates in Anthem's Parity Governance Committee, which reports to the Medical Compliance Committee. This committee supports our individual health plan efforts and gives us oversight and guidance in sustaining compliance with the MHPAEA. We follow the LDH guidelines for parity and incorporate the philosophy of these guidelines to recognize BH services as equivalent to PH services as an integration touchpoint for our care management model. Our training and education curriculum for employees, providers, and stakeholders assures there are no qualitative or quantitative differences in how we apply utilization management (UM) and case management delivery of BH services, facilitating compliance with the MHPAEA.

### Training for Healthy Blue Employees

All Healthy Blue employees, clinical and non-clinical, receive training regarding our fully integrated model and how the model supports parity in healthcare. This training begins during onboarding and continues through ongoing refresher trainings and training specific to each employee role. Clinical employees receive training that is designed to promote the best clinical practices for trending BH and PH issues and support parity in the provision of services to address those issues. Our Case Managers are cross-trained in PH and BH care to facilitate a whole-person view of each member, including what barriers, such as stigma regarding BH conditions and treatment, are impacting the member's willingness and ability to access care. For example, we provided training on the person-centered approach and the biopsychosocial model to our employees to enhance their understanding of our integrated model. We take every opportunity to incorporate education and training in the day-to-day activities of our employees. When our Case Managers attend training sessions on topics such as healthcare equity, stigma, and other topics that are related to BH parity and care integration, they share what they have learned with the rest of the team in their weekly huddle sessions. [redacted]

### Training for Providers and State Agency Partners

**Healthy Blue Training Academy.** Our Academy for providers offers multimodality training to(1) advance the goals and objectives of Healthy Blue and LDH and meet the requirements of the MHPAEA; (2) support provider understanding of the issues involved in parity, similar to those topics provided to employees(3) facilitate provider support of members and delivery of equitable care. Training topics include integrated care to address member PH and BH needs; population health management, including populations with Special Health Care Needs (SCHN); SDOH; and others designed to assist provider compliance with all contract requirements and meet quality and parity standards. Screening, Brief Intervention, and Referral to Treatment (SBIRT), BH Services HEDIS® Measures, Provider Quality Monitoring, and more – with on-demand and live webinar options. In the first and second quarters of 2021, nearly 300 providers took advantage of these virtual training opportunities while being able to earn CEU's

**DCFS Staff Trauma-informed Systems Training.** This training is provided in conjunction with Southern University School of Social Work trained in person 487 DCFS child welfare professionals (line workers, supervisors, and program managers) throughout the state who serve as guardians supporting our members. This training helps to decrease the health inequities that children in state's custody may face.

**BH Evidenced-based Training.** ***We have offered PTSD and trauma-informed care training through Tulane University*** to 40 network providers. In addition, we have trained in one-and-a-half day trainings 40 providers **Peer Navigators in the Harold P. Freeman Model of Navigation and Person-centered Planning.** To date, nine providers have been certified in [redacted]

## 2.6.15.2.1 Detection and Treatment of BH Disorders

Healthy Blue engages members where they are, with early and proactive identification of member needs, removing barriers, and connecting them to benefits and services. Provider feedback shapes critical areas of focus such as integration, maternal health, adverse childhood experiences (ACEs), HIV, and rural health. Healthy Blue uses predictive analytics and person-to-person assessment of each member's needs. Our VBP programs incentivize providers to participate in the proactive identification of BH conditions, notably opioid use disorders (OUDs), using best practices to screen members and provide appropriate treatment. [redacted]

[redacted]

**SBIRT.** SBIRT is a best practice, generally administered in PCP offices, that provides a comprehensive, integrated, public health approach to screening and early intervention for individuals with risky alcohol and drug use. We make information available to providers so that they can refer to treatment after a positive screen. Our Case Managers, Community Navigators, and Member Services team are also available to assist with referrals to a comprehensive array of SUD services.

[redacted]

**Increased Capacity of Medication Assisted Treatment (MAT).** Healthy Blue has been increasing the number of available providers, including PCPs, who can provide MAT to members who present with conditions that could benefit from this treatment modality. MAT is an evidence-based treatment for certain SUDs, including OUDs. From 6/2019 to 3/2021 Methadone treatment increased from 6% to 12.9% (doubled), from 9/2016 to 3/2021 Buprenorphine increased from 12% to 19.6% (65% increase); Use of naltrexone increased more than doubled, from 0.6% in 9/2016 to 1.5%.

[redacted]

## 2.6.15.2.2 Coordination of Care for PH and BH Disorders and Care Transitions

Healthy Blue follows a framework for facilitation of transitions that is driven by the specific needs of members in targeted situations and populations. We evaluate individual member needs and deploy the resources and interventions to facilitate effective, safe transitions. Our Care Management team and Navigators work together to

facilitate successful discharge planning at the time of admission, so that members have the services and supports they need to continue the recovery that began in the hospital. Our primary goal is to prevent a return trip to the hospital by connecting members to the care, support, and resources they need to recover in the least-restrictive setting timely, and making sure they understand their discharge plan, risks, and medication directions.

[redacted]

**Supporting Individuals Who Are Justice-involved.** [redacted]

[redacted]Our designated Case Manager, who is trained in both behavioral and PH conditions, coordinates care for a member upon discharge from incarceration. The Case Manager works with supports within the prison system to make sure that the member receives all necessary services once released. The services that the member is connected with include pertinent PH and BH appointments, transportation, medication, community supports, and housing. Upon enrollment into case management services, the staff with the prison system are including in the multidisciplinary care team to assist with assessment completion and creation/ updating of the plan of care.

**Concurrent Reviews.** We conduct concurrent reviews for inpatient and residential care if the provider and member determine that treatment should continue beyond initial authorization. The Case Managers engage case coordination of complex case management and discharge planning for placement authorization and medications, as needed. Reviewers assess member progress and needs during the episode of care and coordinate before discharge to facilitate a smooth transition between levels of care or home and prevent delays in discharge caused by unanticipated care needs. If it appears that criteria are not met for continued services, we consult a Medical Director, who may meet with the provider to discuss the best supports, services, and level of care for the member.

**Post-discharge Management Program (PDM).** PDM Case Managers provide intensive support to members in care management to reduce 30-day readmission rates and to increase 7 day and 30 day follow-up rates, facilitating a smooth transition between inpatient and the home or other community setting. All members are assisted with discharge planning and follow-up to assure appropriate setup of outpatient care. Our Care Management team coordinates services such as PT/OT/SP, durable medical equipment needs, Home Health and Extended Home Health services, including setting short-term goals for transitions to the community and avoiding readmission. Contact begins prior to discharge and includes weekly calls for 30 days to be sure members complete post-discharge activities. This is essential to increasing the quality of care for our members and improving the health of our overall population.

## 2.6.15.2.3 Provider Incentives and Progress Tracking for Integration

[redacted]

[redacted]

## Assessing Provider Capacity to Integrate Care: Developing Plans to Build Capacity

We recognize that some providers may not be ready or technically capable of engaging in integrated care delivery. Therefore, continued performance improvement and accountability are rewarded for providers who progress toward advanced capabilities consistent with our vision. [redacted] Our strategy is to develop providers' integration efforts through consultative coaching, [redacted] that will enable providers to advance toward integrated care. We regularly assess providers to determine their progress, which includes self-assessments. We analyze the results, which are incorporated in reports and engage providers to address continued needs.

## Incentivizing Providers to Coordinate and Communicate

[redacted]

Healthy Blue will facilitate care compacts between PH and BH providers who are not part of interdisciplinary groups and share attributed members. Providers participating in the program who meet quality, service, engagement, access, and utilization goals will be eligible to receive incentive payments.

[redacted]

## Using VBP to Track Provider Progress and Evaluate Integration of PH and BH Care and SDOH

[redacted]

Consultative coaching with providers on how to progress and meet defined measures and key integration metrics will help us accomplish these goals. Quality measures are organized as a set, which requires a 2-point increase in composite score, year over year. This HEDIS measure set includes follow-ups after psychiatric hospitalization and ED admissions, monitoring members with comorbid cardiovascular disease and schizophrenia, antipsychotic medication adherence, pharmacotherapy for OUD, non-emergent ED utilization rate, and others.

[redacted]

[redacted]

## 2.6.15.2.4 Tools and Guidance for Providers to Facilitate and Improve Integration

[redacted]

### Scheduling Joint Appointments, Brief Assessments, Co-location, and Other Solutions

The Healthy Blue comprehensive virtual care delivery strategy includes multiple options for our PH and BH providers to coordinate care and refer their patients to services. Examples of our solutions include:

[redacted]


[redacted]

**Track Outcomes, Develop Shared Care Plans, Integrate Records, and Make and Follow Up on Referrals.** Healthy Blue Care Delivery Transformation Consultants assess the capabilities of our VBP providers and develop Transformation Action Plans to facilitate provider progress and capacity building to engage in integrated care delivery, including conducting assessments, integrating records, co-locating services, scheduling joint appointments, developing shared care plans which can be viewed and edited online, making appropriate referrals when necessary

and following up on those referrals, and tracking outcomes. Our consultants meet providers where they are and offer resources, tools, and supports to facilitate these integrated care capabilities.

## 2.6.15.2.5 Identifying Members with ED Admission and Assist with Follow-up

Outreach to members to encourage and support participation in preventive care leads to fewer avoidable ED visits. This outreach includes facilitating appropriate follow-up after an ED visit. [redacted]

### Scheduling Follow-up Care with PCPs and Appropriate BH Specialists

In addition to the identification and follow-up activities described previously for identified specialty sub-populations, Healthy Blue Intensive Case Managers and mobile crisis providers interface and coordinate care with EDs daily to identify members who require disposition assistance. We collaborate with community providers, inpatient facilities, and state agencies to facilitate disposition to an appropriate level of care, if indicated.

**Facilitating Follow-up for Children with BH Conditions.** The Healthy Blue Care Management team responds when a child member is admitted to the ED experiencing a BH crisis as soon as we are notified by the hospital, a provider, a family member, or a state partner. The Case Manager contacts the hospital representative to identify the best supports, services, and level of care recommended, and contacts the caregiver to provide contact information so we can begin transitioning the child to the new care setting. Healthy Blue recognizes the challenges Louisiana has encountered with youth waiting in ED's for appropriate services and supports. In response, Healthy Blue has implemented an ED surveillance program where our Case Managers will be alerted through an admit, discharge, and transfer (ADT) feed when our members experience an ED event.

[redacted] This service allows real-time patient care coordination for Louisiana healthcare providers and their partners and empowers subscribers to better coordinate care transition by improving communication between various providers and hospital settings. [redacted]

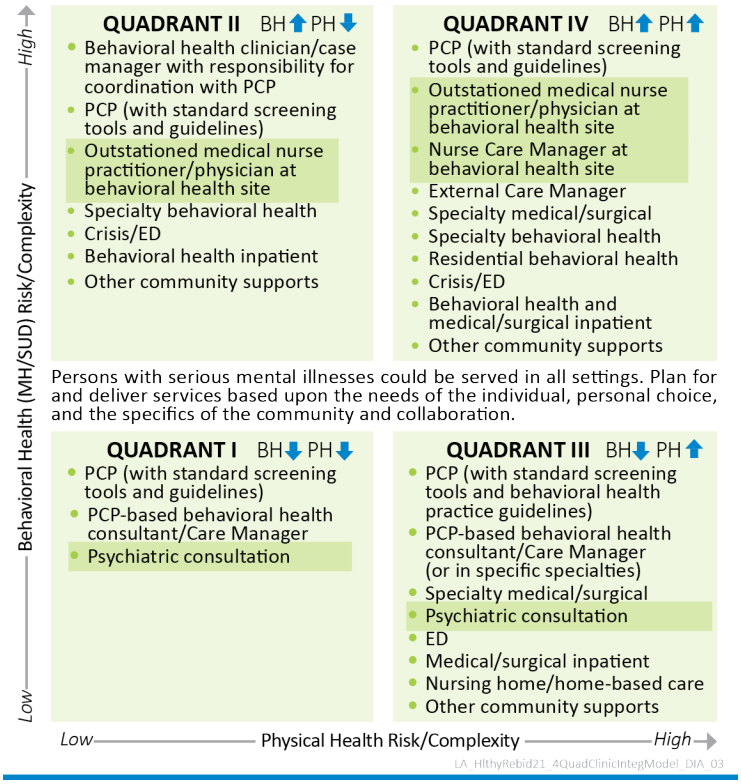
**ED Surveillance Report.** We also use the ED Surveillance Report to identify members who have visited the ED within the last 72 hours. The report is accessible daily, providing Care Management teams with timely notice for direct member outreach and engagement to follow-up care.

## 2.6.15.2.6 Continuity and Coordination of Care for Members with Specialized Medical Health Care Needs

Our fully integrated care management model is sensitive to BH issues and can readily facilitate the identification of members with co-occurring BH and PH needs who require enhanced healthcare services through [redacted] health needs assessments, or as members are screened and assessed by providers. We obtain consent after appropriate services have been identified so providers may know of a member's entire healthcare need – past, current, and emerging – so that we can provide the care each member requires. We also provide comprehensive resources and direction regarding the availability of services to providers so that they can make appropriate referrals, as indicated. Healthy Blue utilizes high-touch case management strategies through our CHWs, provider community navigator, and face-to-face case management visits to assure continuity of care from setting to setting assuring successful transition of members from nursing homes, correctional facilities, and other institutionalized care. As we identify a member who has screened positive for BH needs in primary or urgent care settings, our Care Management team members, including our field-based outreach specialists or CHWs, will coordinate with providers to support the level of care needed.

Our population health approach focuses on continuity and coordination of care for members in need of specialized services, including inpatient and outpatient care. We look at each member holistically and connect them to needed services. Healthy Blue has incorporated ***the National Council for Community Behavioral Healthcare's four-quadrant clinical integration model*** into our population health approach to assure that through our ICCM program, our providers have the infrastructure to fully support our members. [redacted]

### HEALTHY BLUE'S FOUR QUADRANT CLINICAL INTEGRATION MODEL




### Healthy Blue Emerging Risk Model to Assure Continuity and Coordination of Care

[redacted] These members are those we anticipate will have an increase in their healthcare needs and utilization within six months of identification and will need proactive outreach and case management to delay or avert onset or escalation of symptoms and comorbidities, including the need for specialized medical health services. [redacted] We proactively connect with, engage, and resolve member needs promptly, referring members who need BH services and following up to verify that care was accessed. Our model supports whole-person health by closing gaps in case, addressing social drivers of health, and educating members on prevention of high-risk factors associated with comorbid/co-occurring conditions. This model has been successful in improving member engagement.

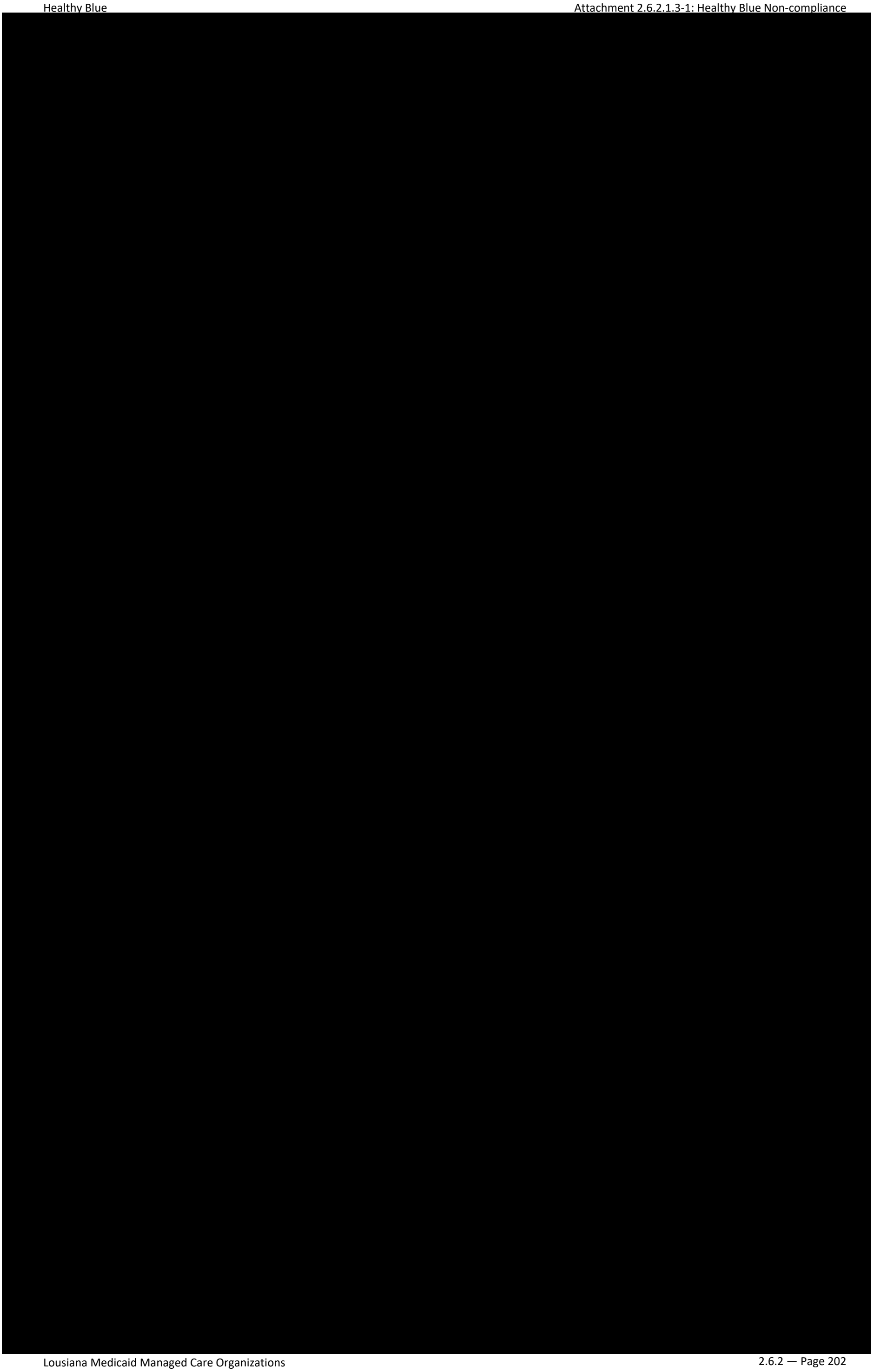
### Supporting Back-to-school Efforts by Donating School Supply Kits

Healthy Blue will donate more than 6,000 school supply kits this summer to youth across the state to support back-to-school efforts and learning. Since 2016, Healthy Blue has donated more than 30,000 school supply kits to local youth in Louisiana.

# Attachment 2.6.2.1.3

## Instances of Non-compliance

Healthy Blue



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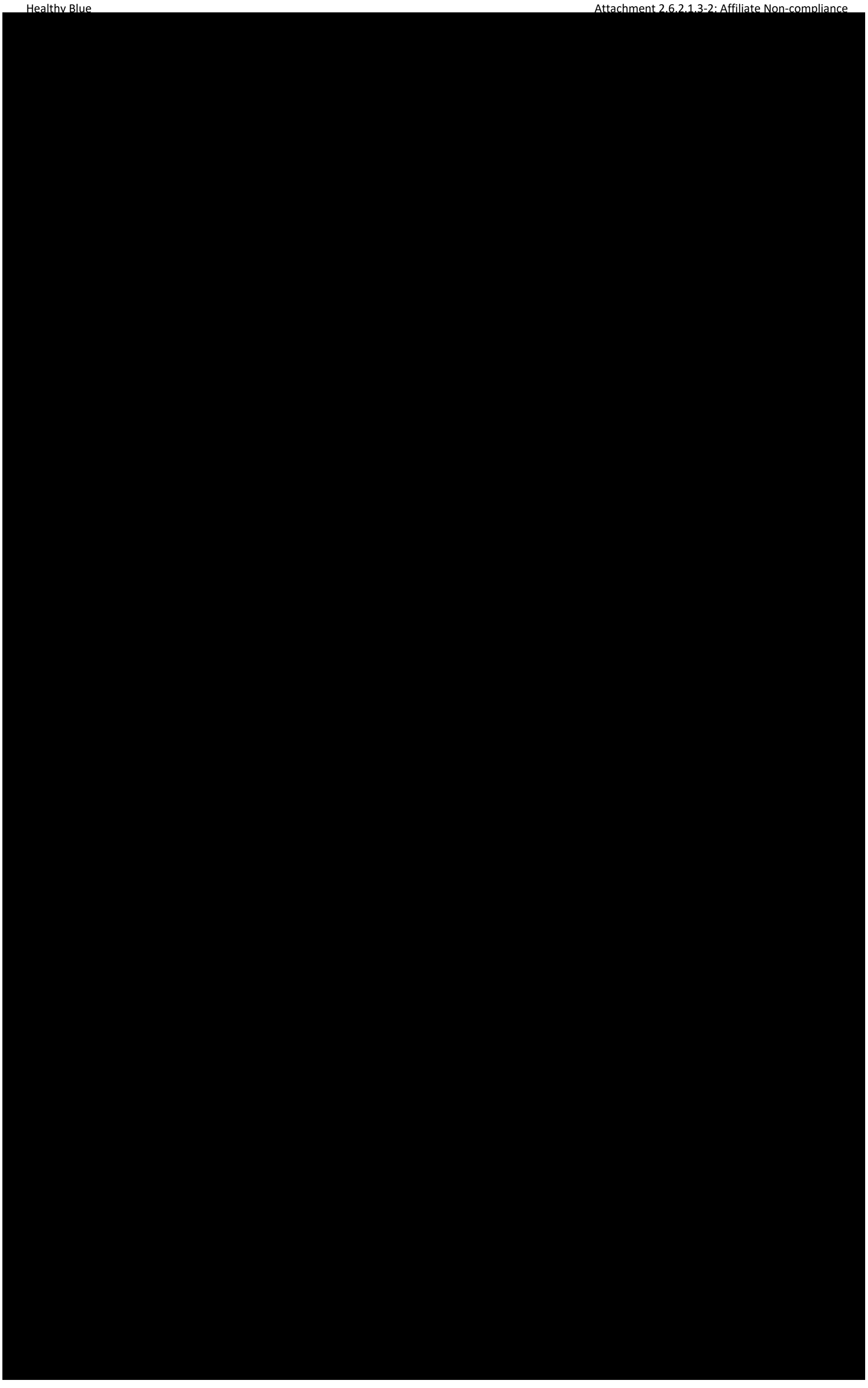
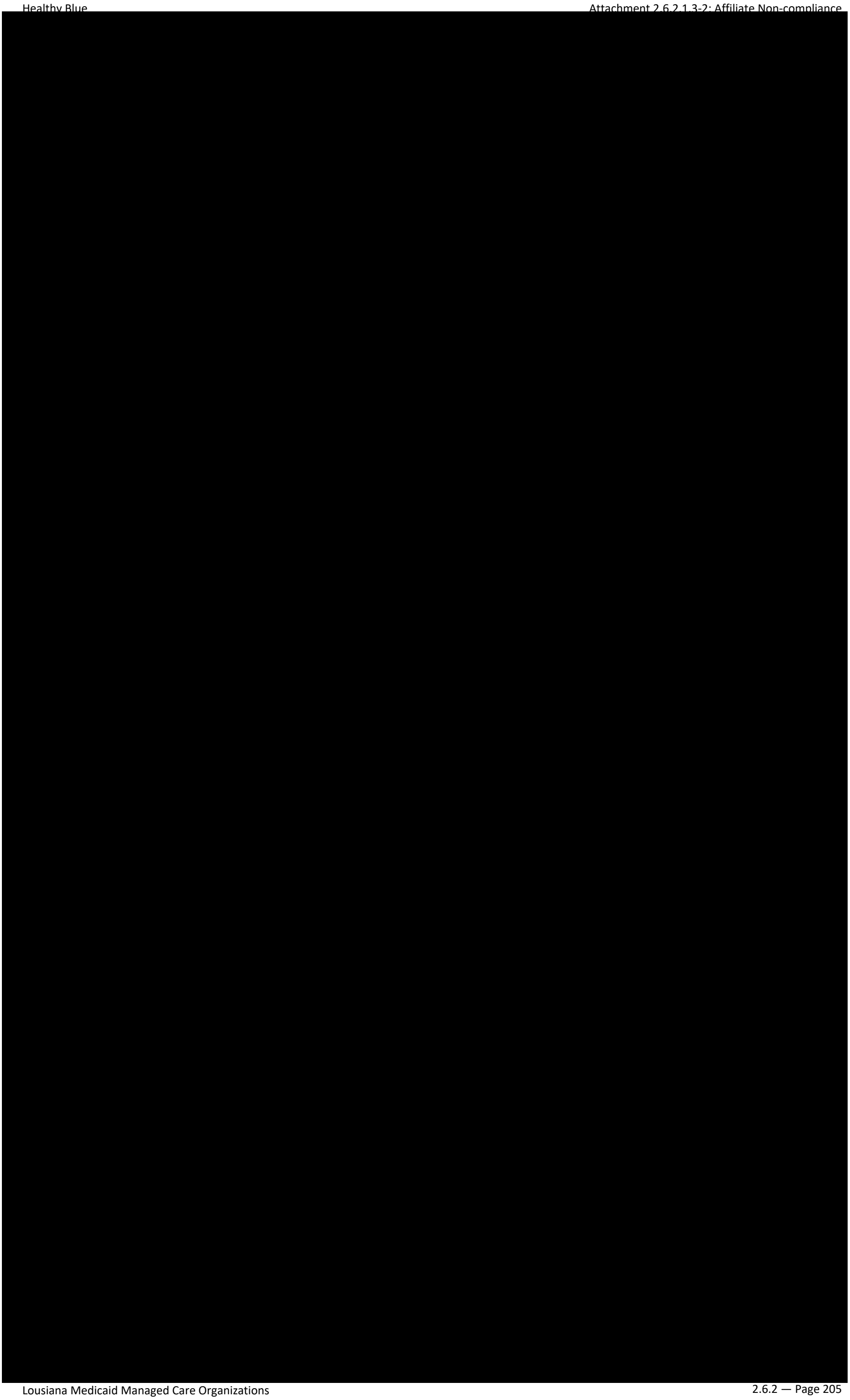
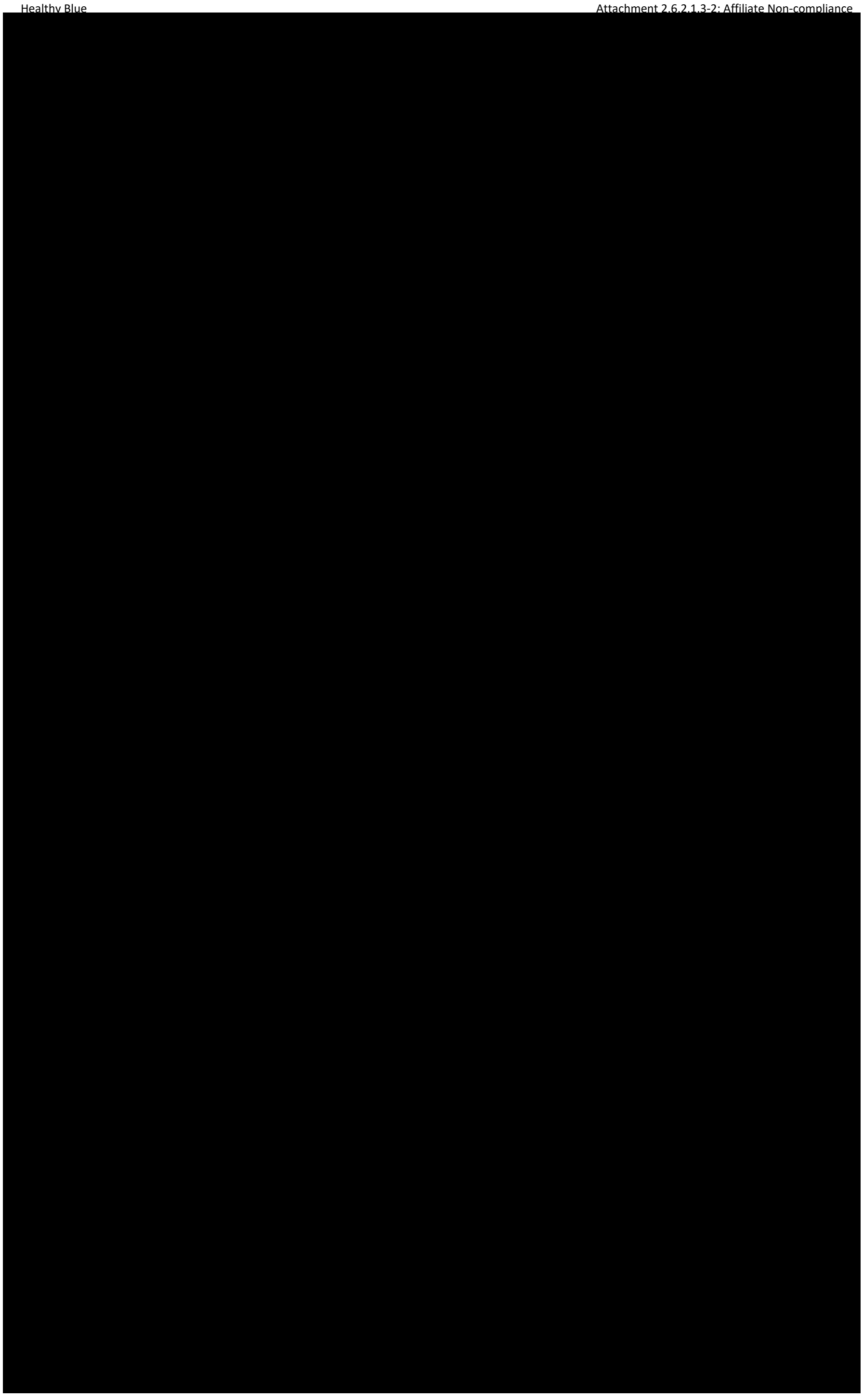
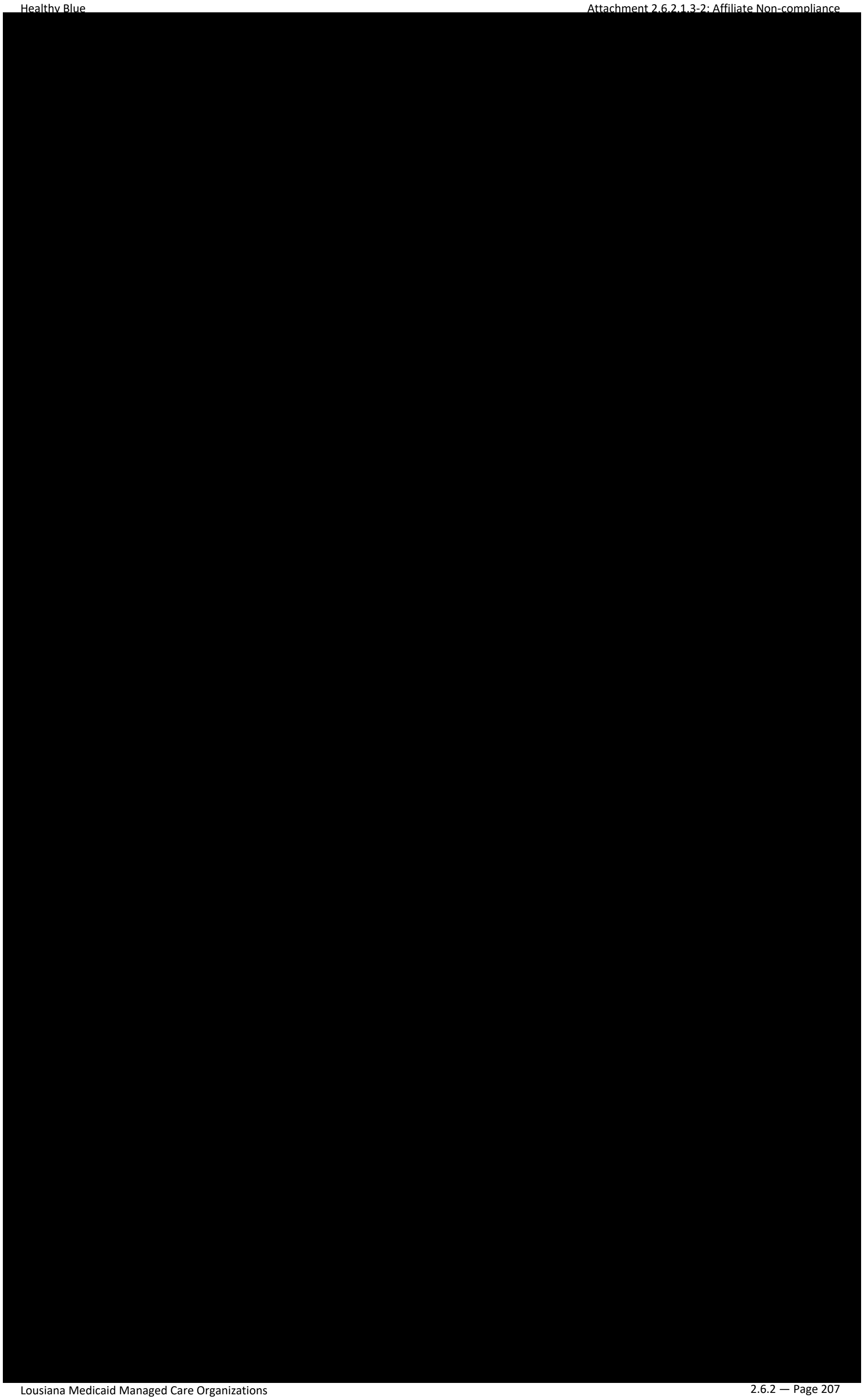
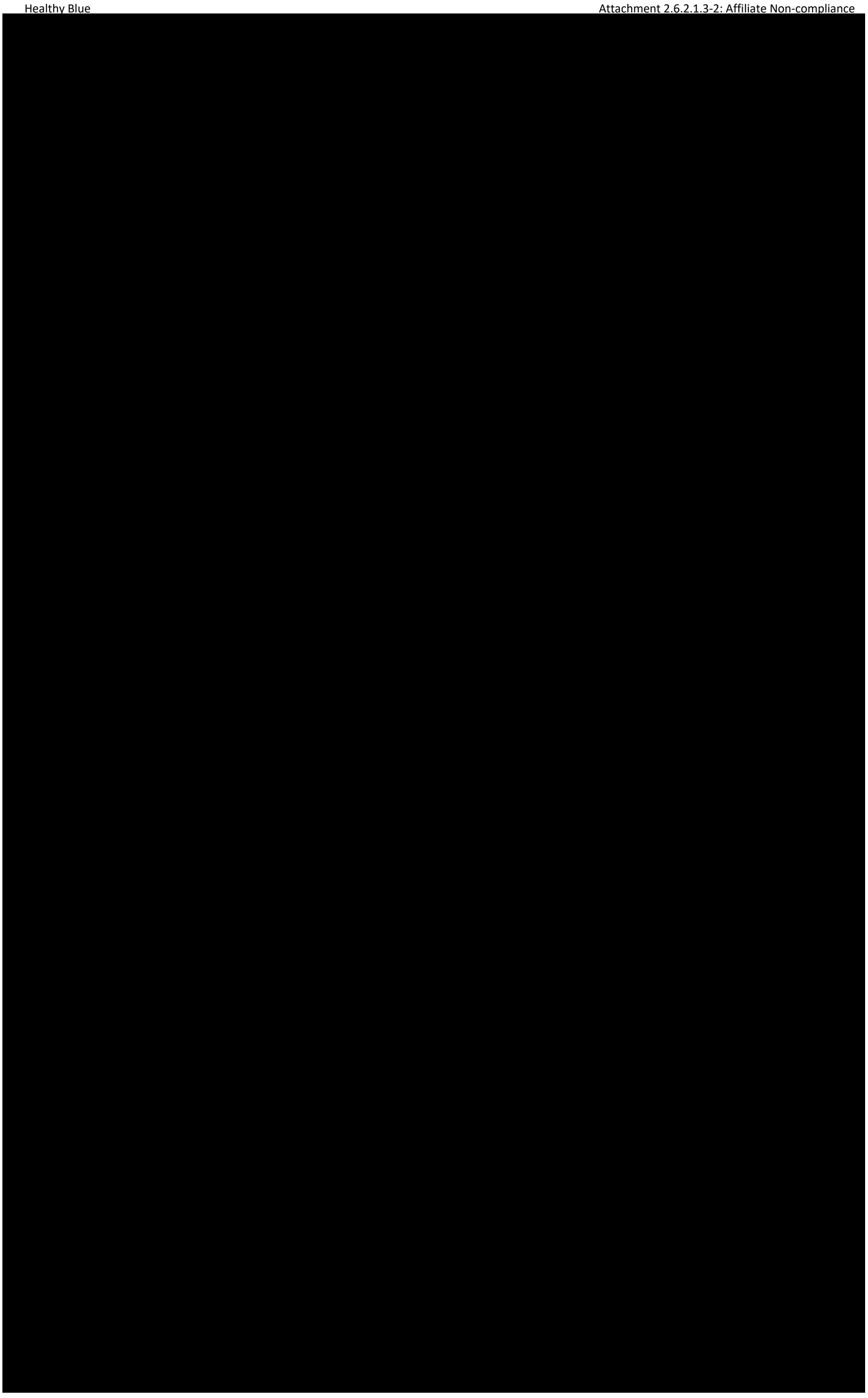
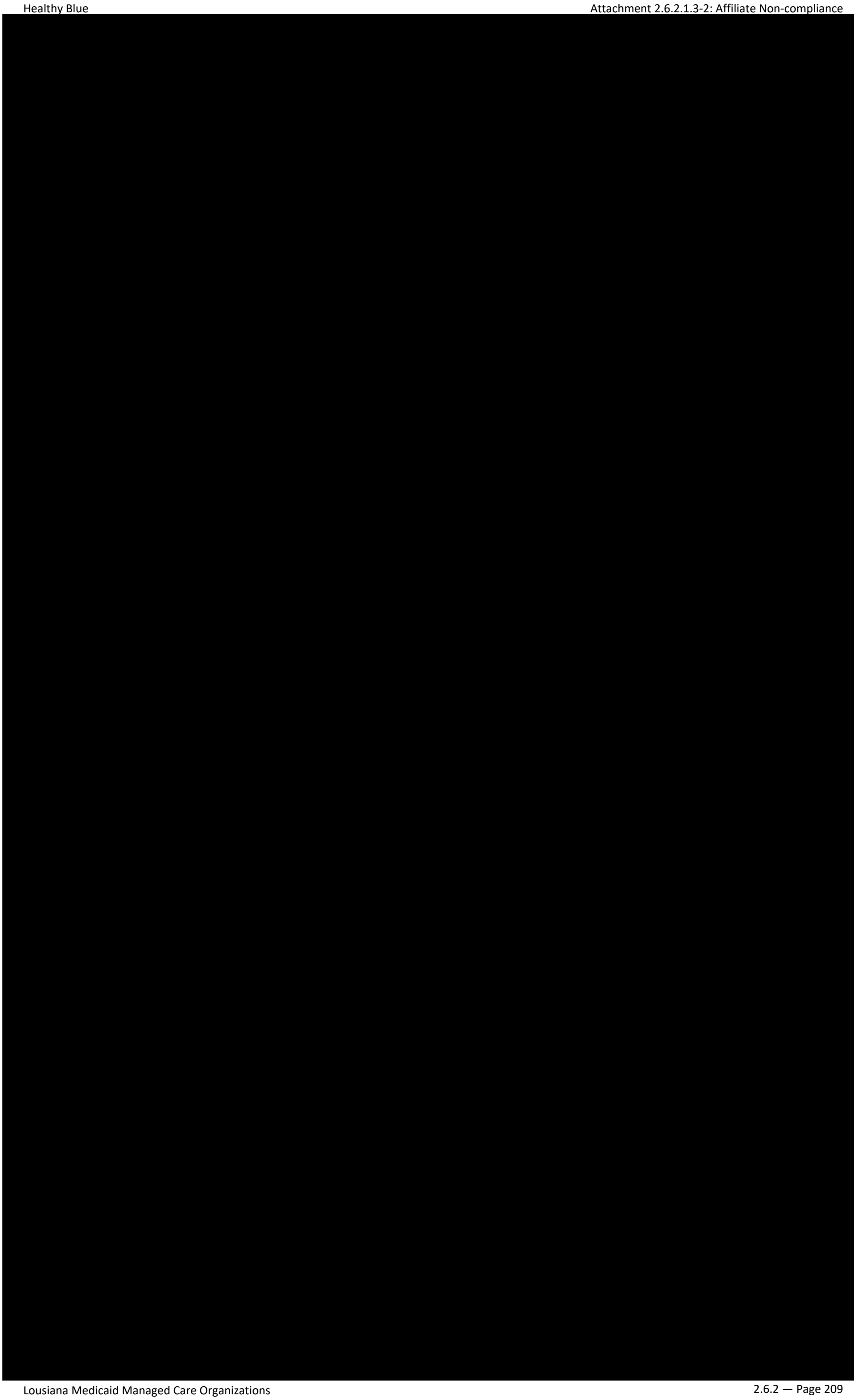


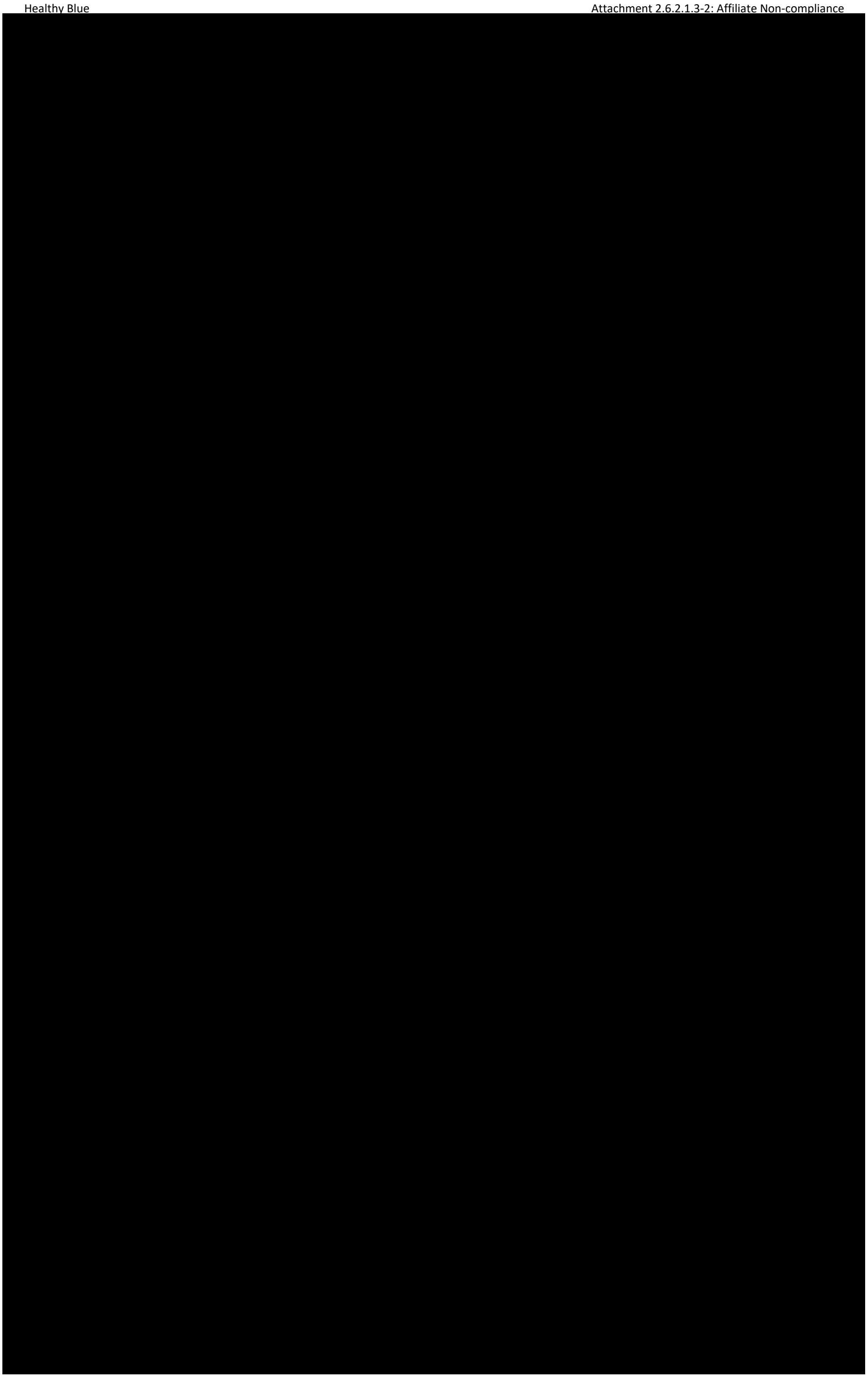


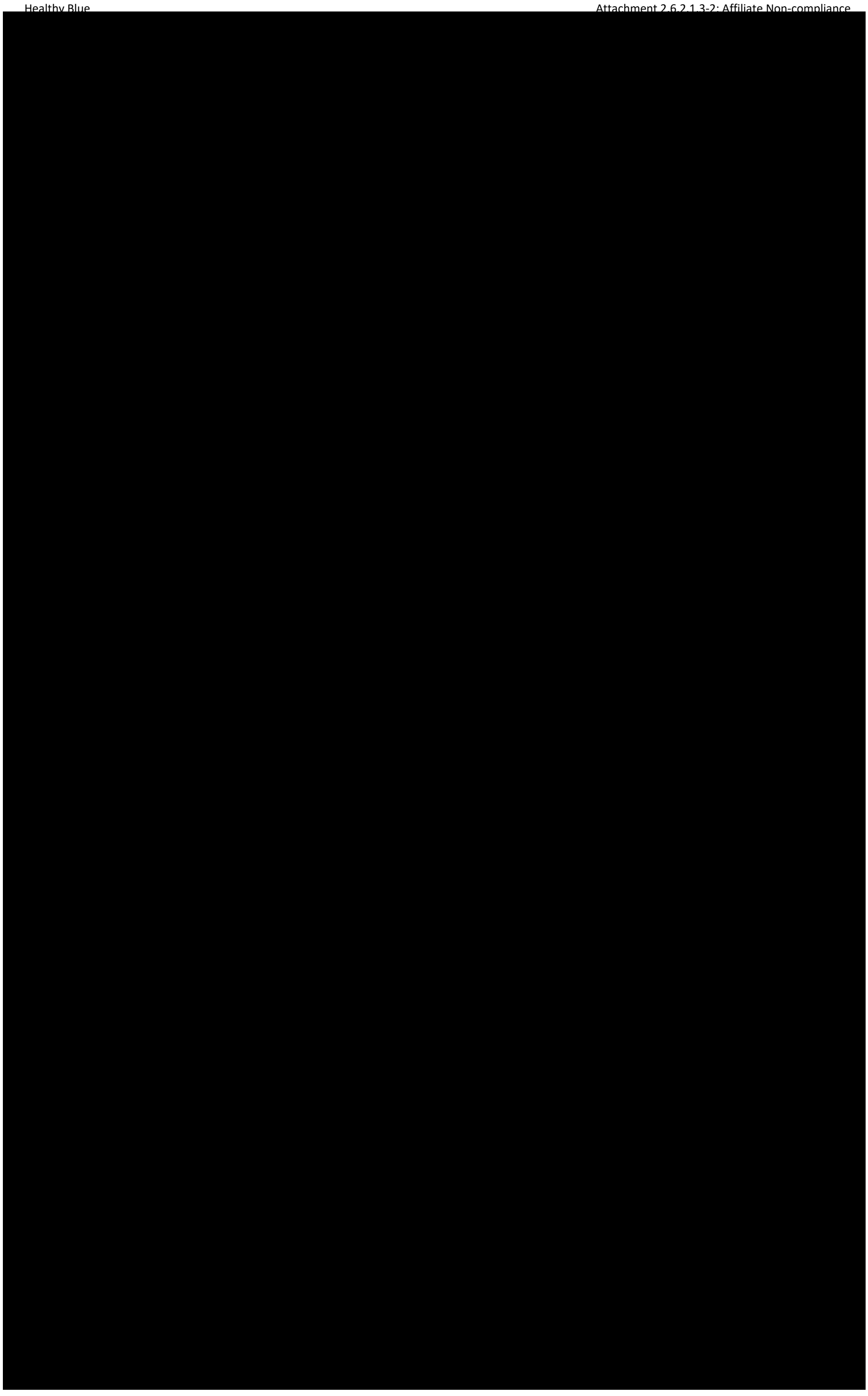


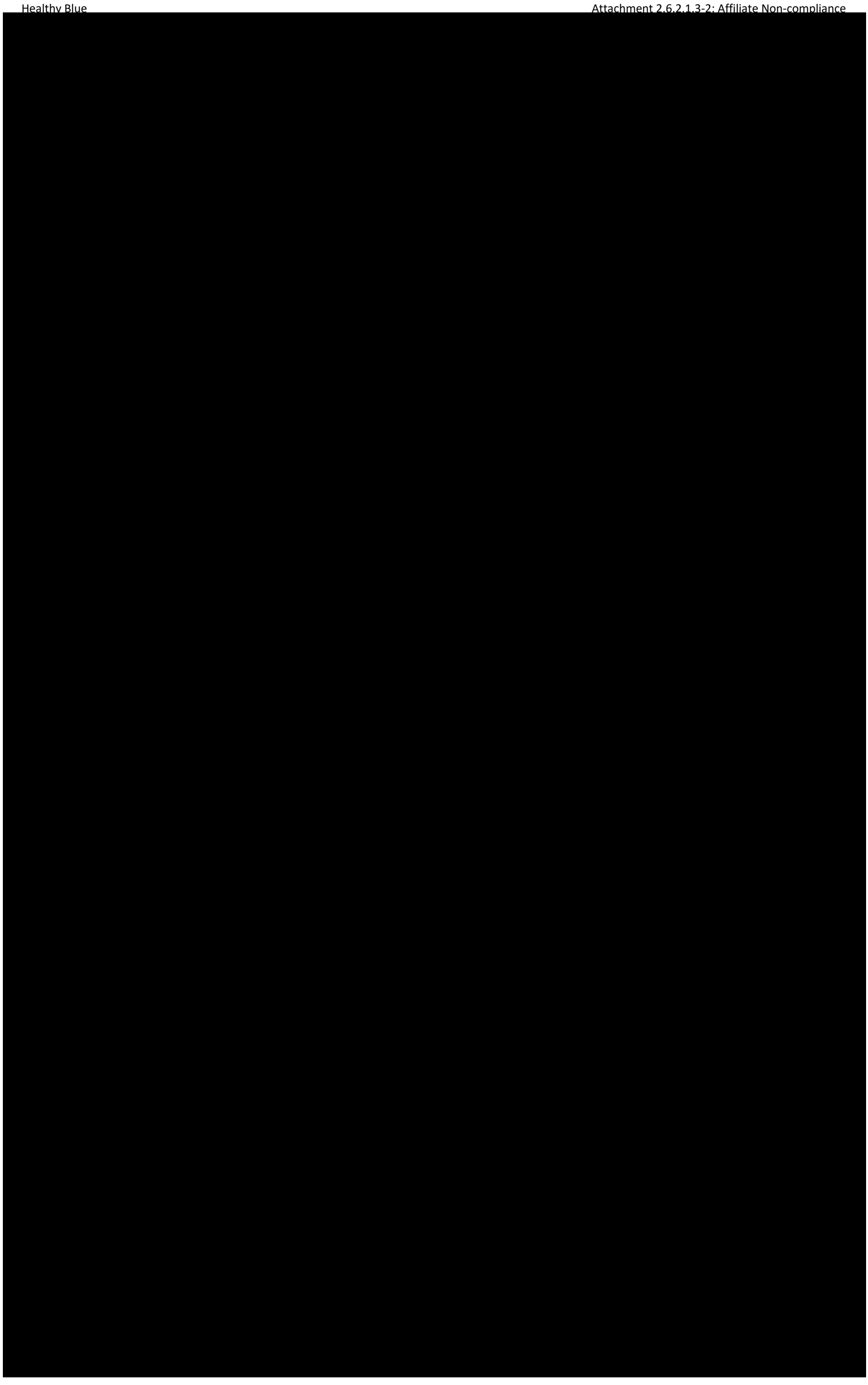


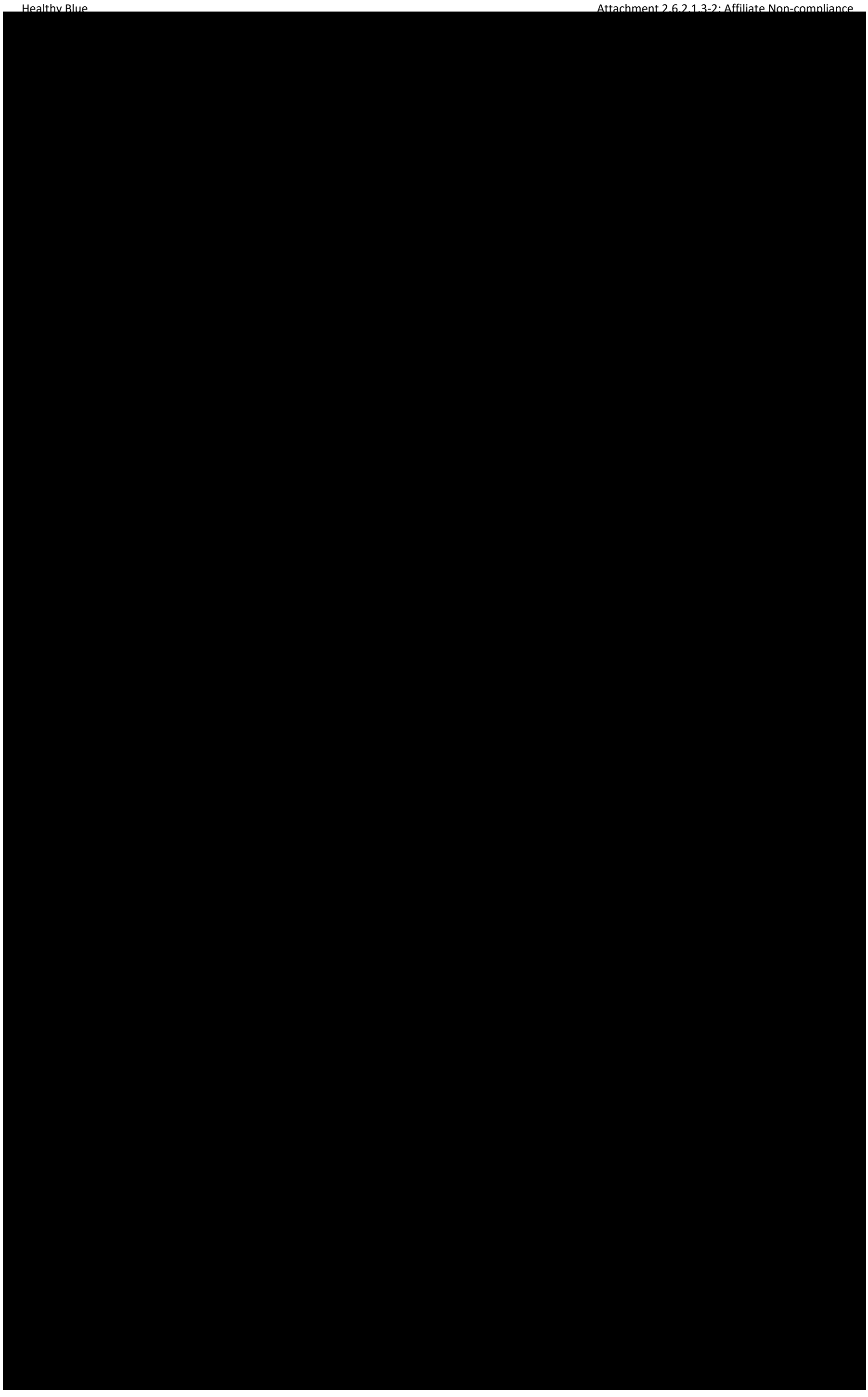


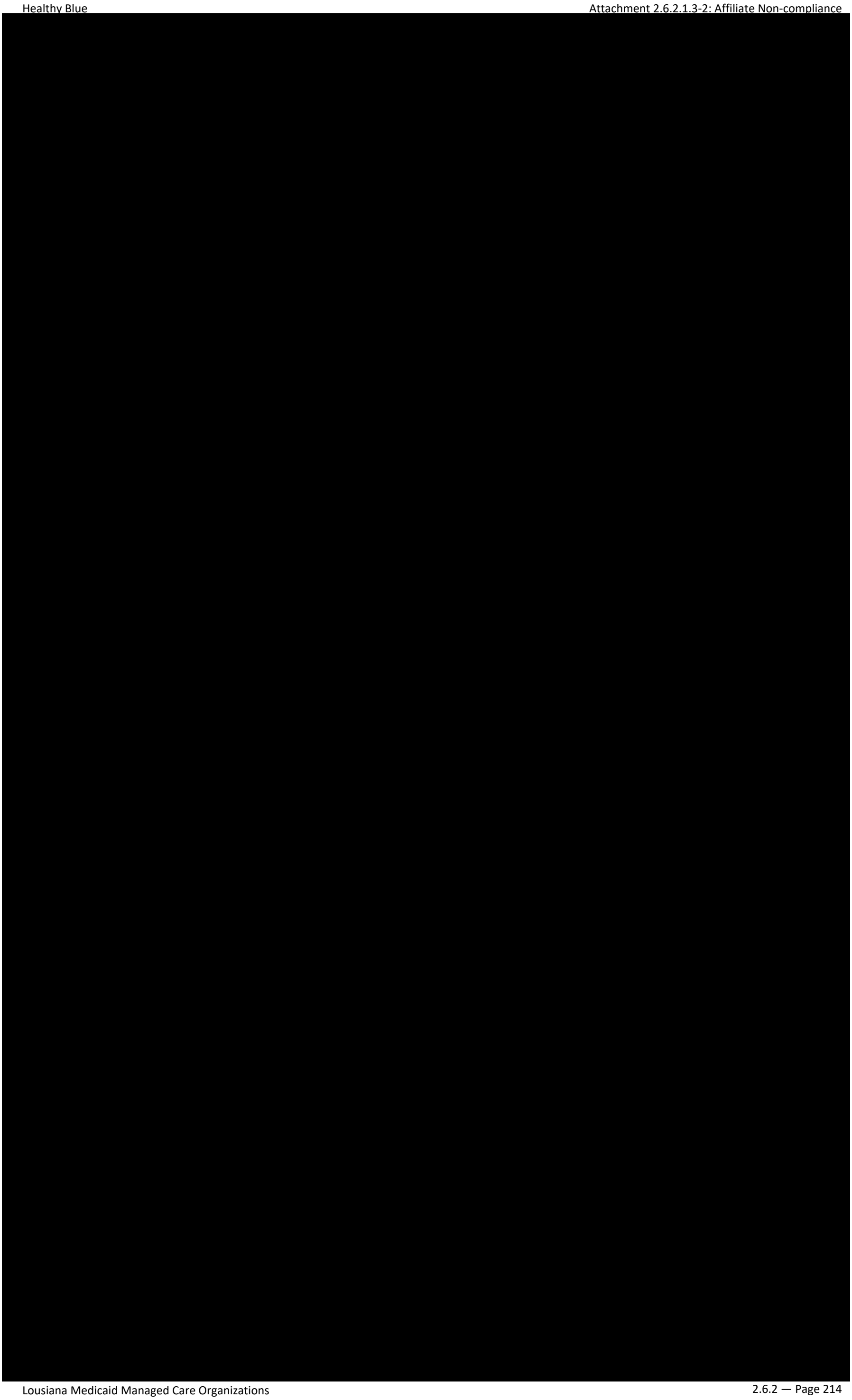


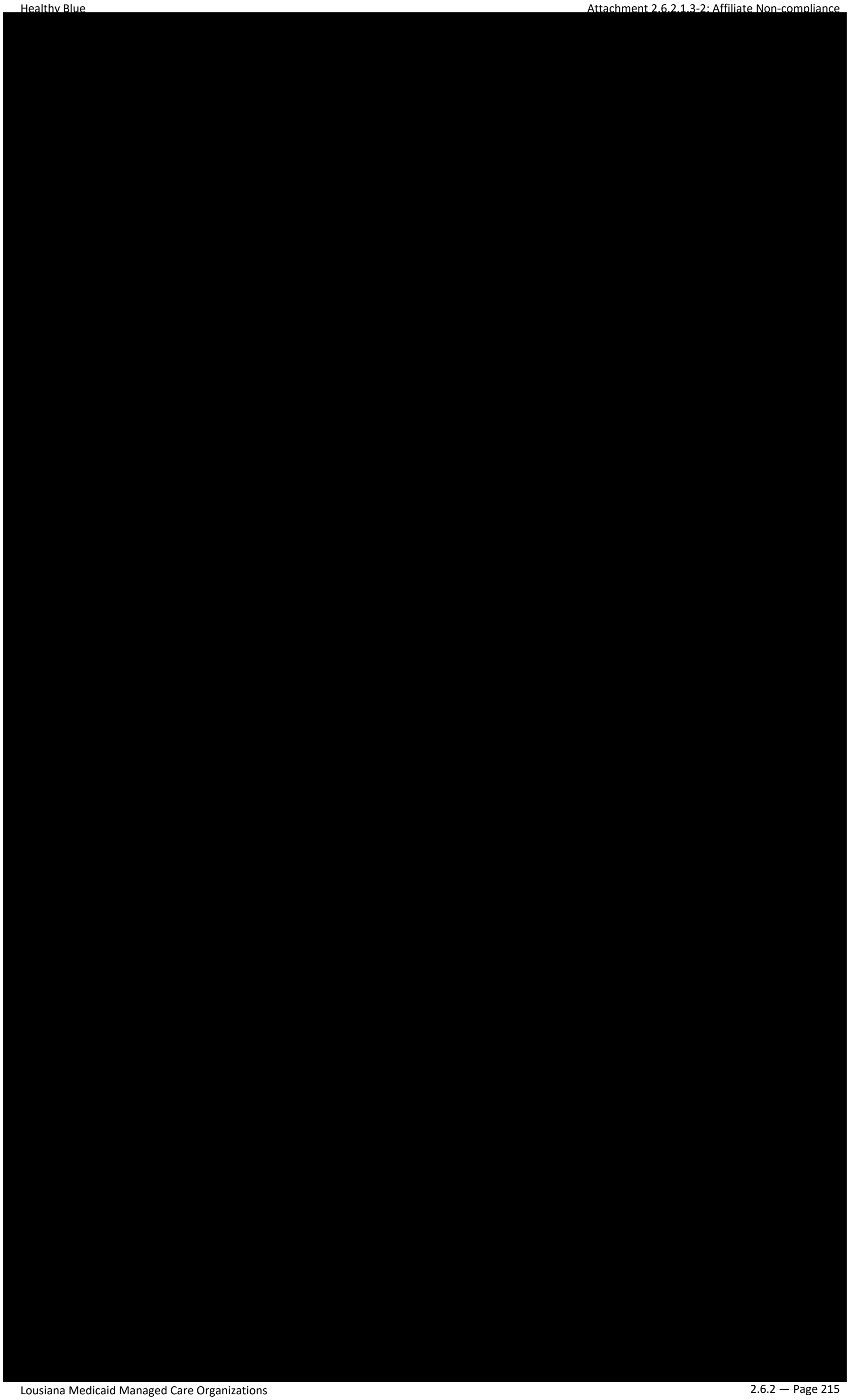


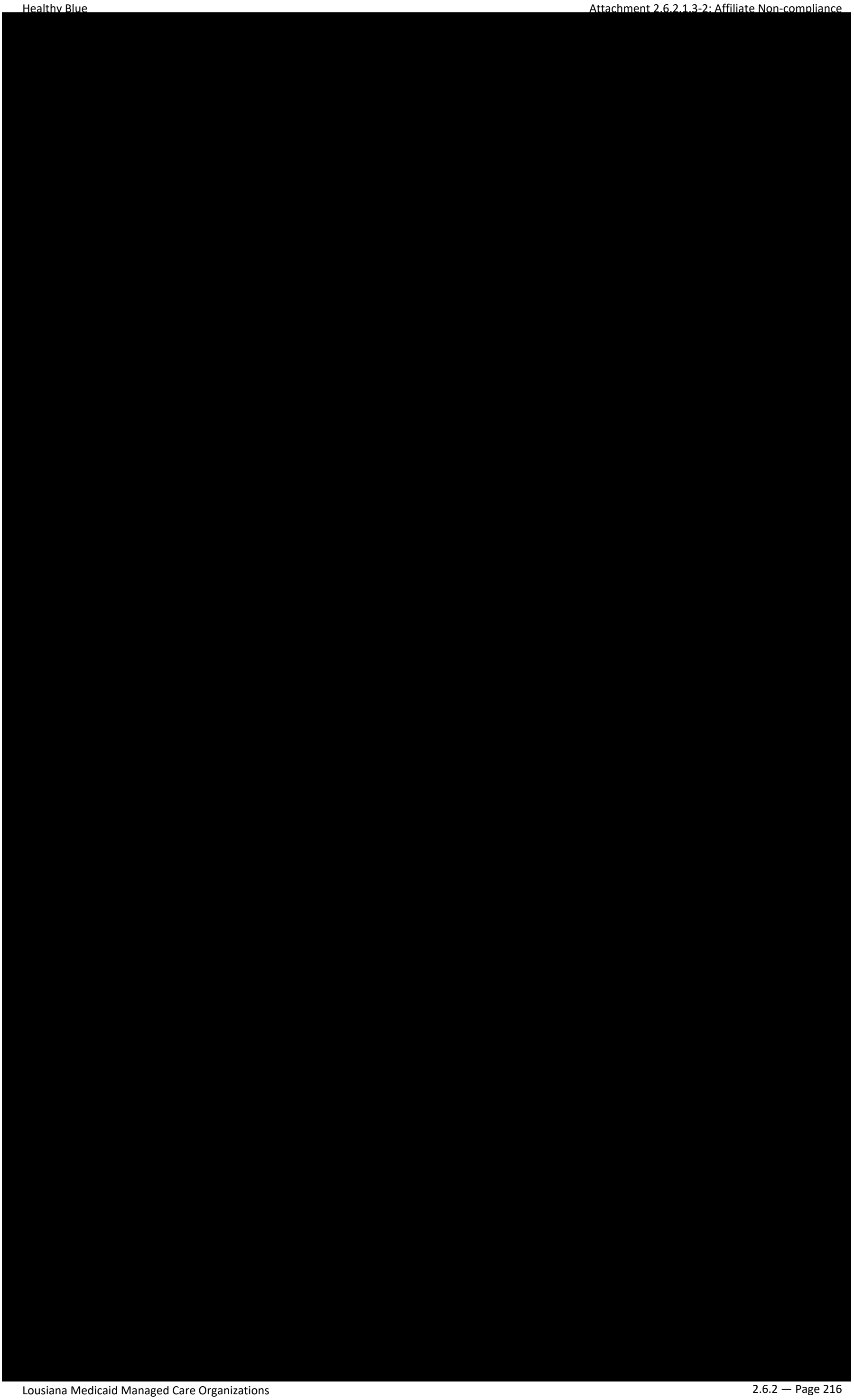


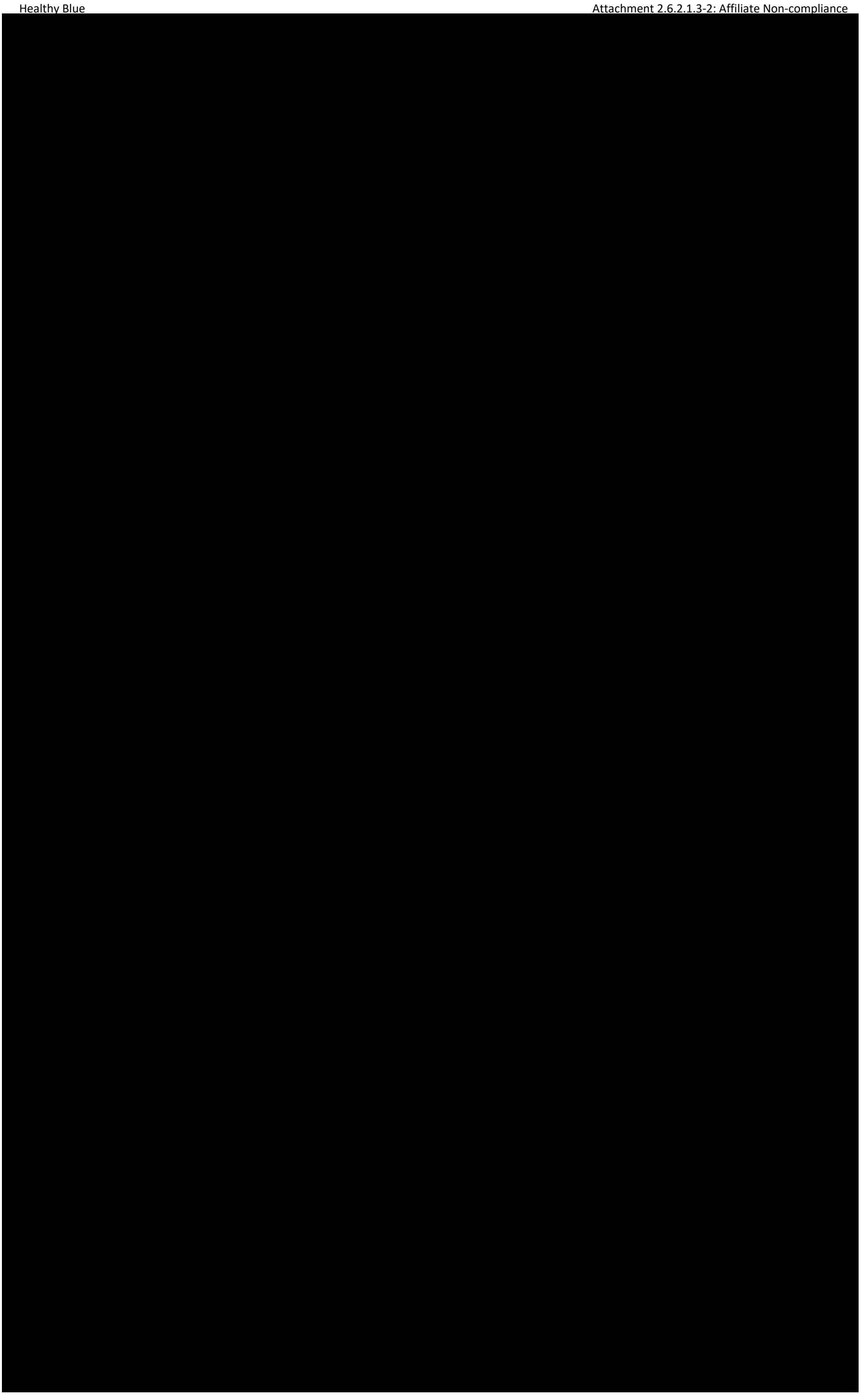


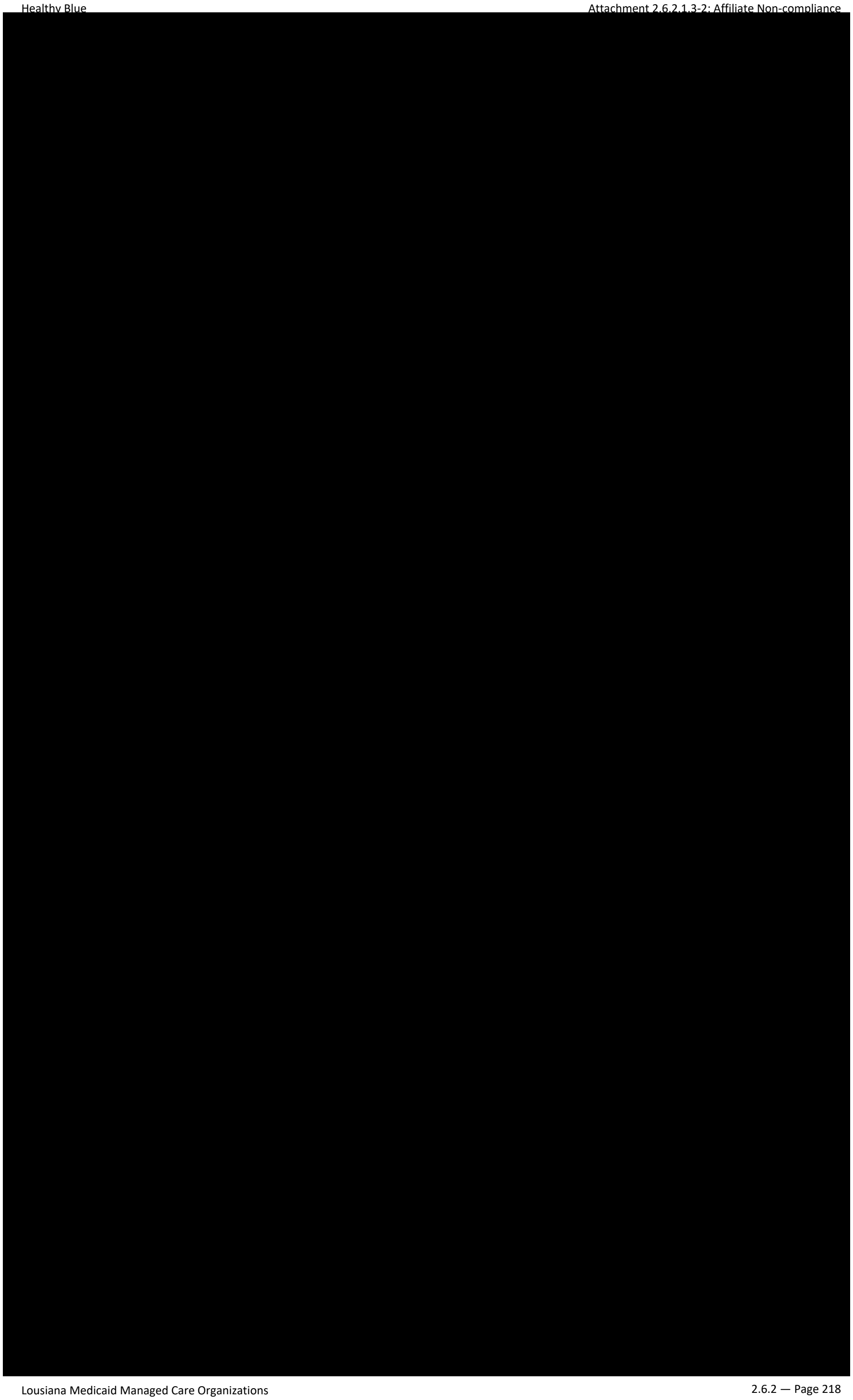


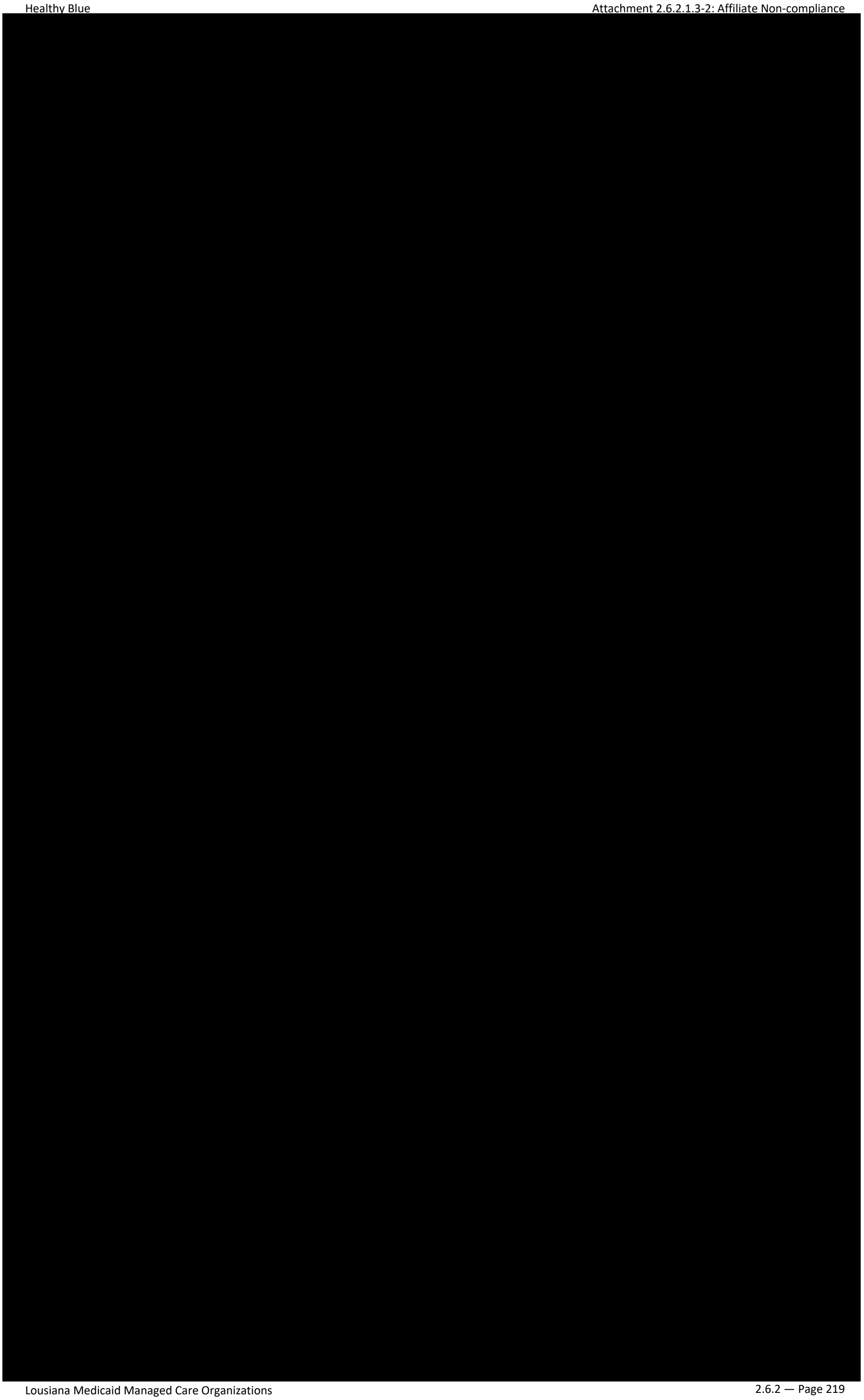


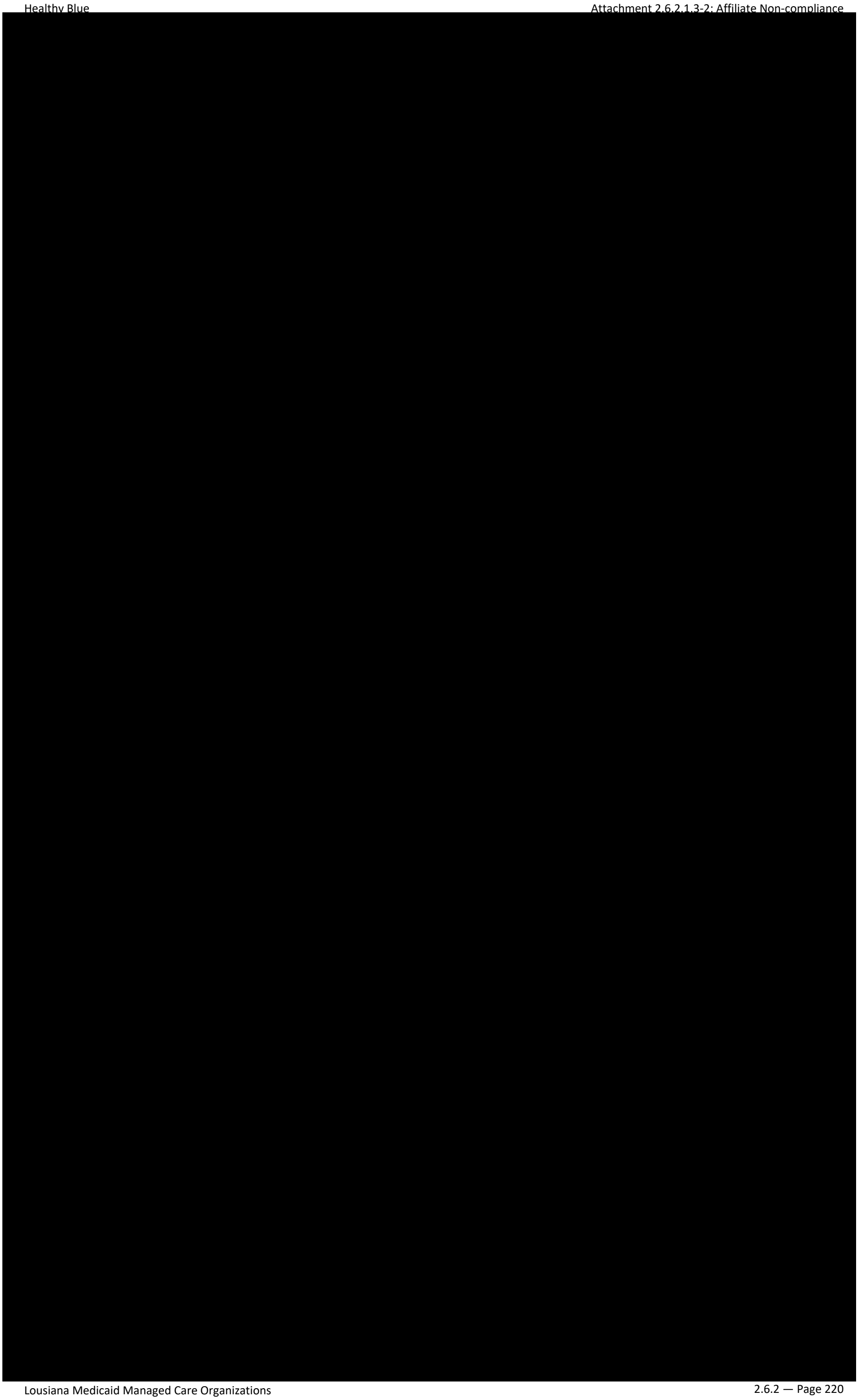


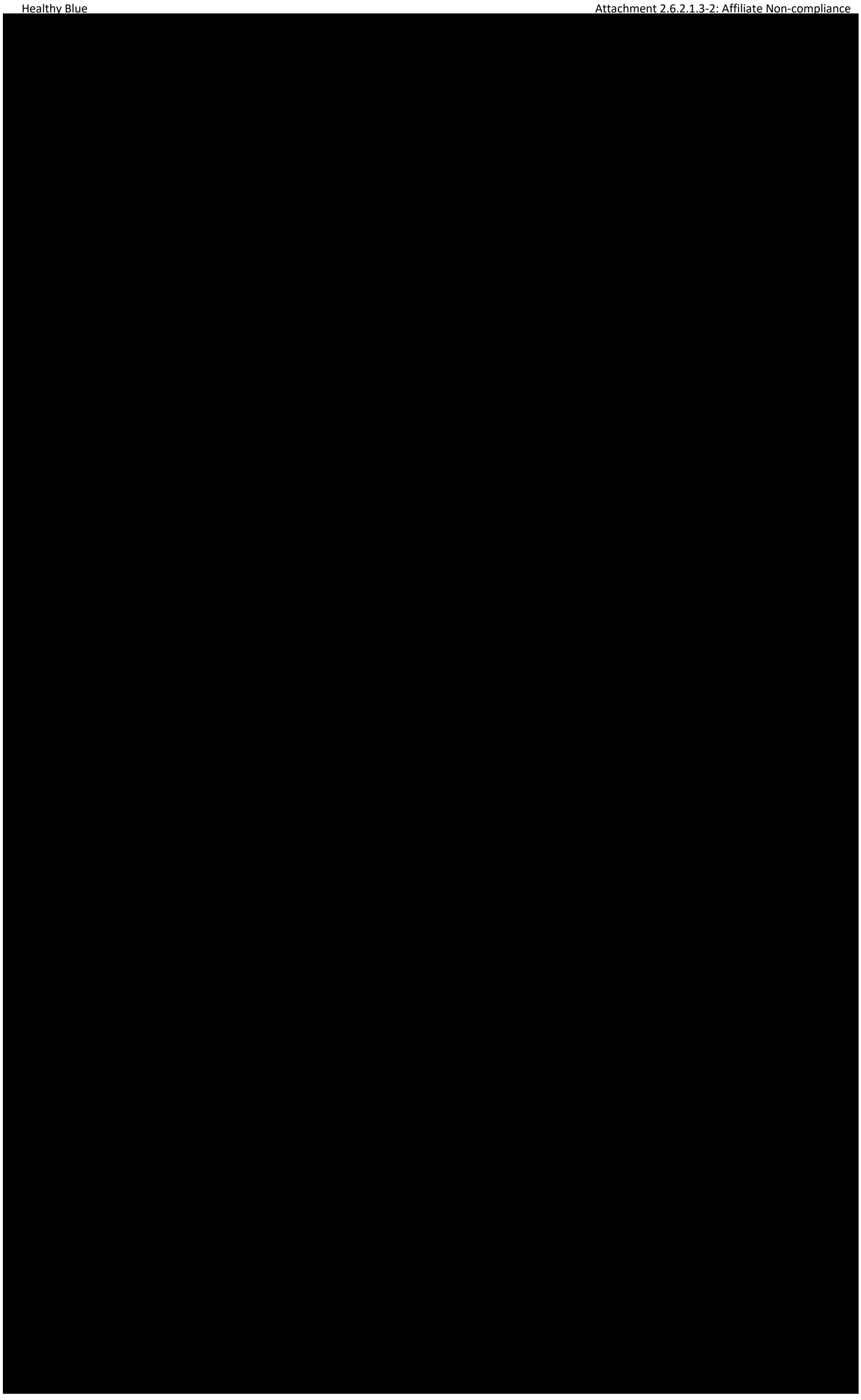


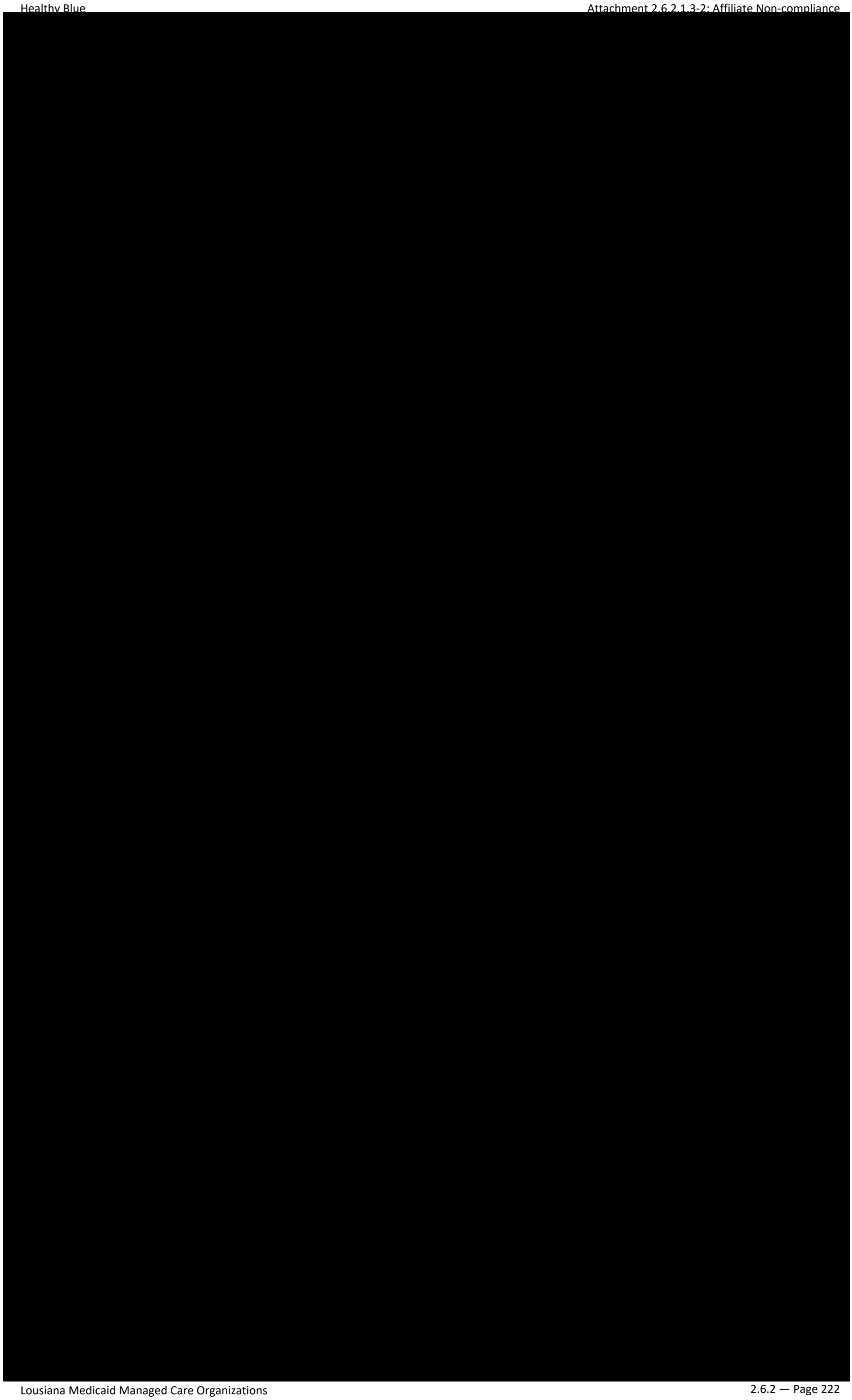


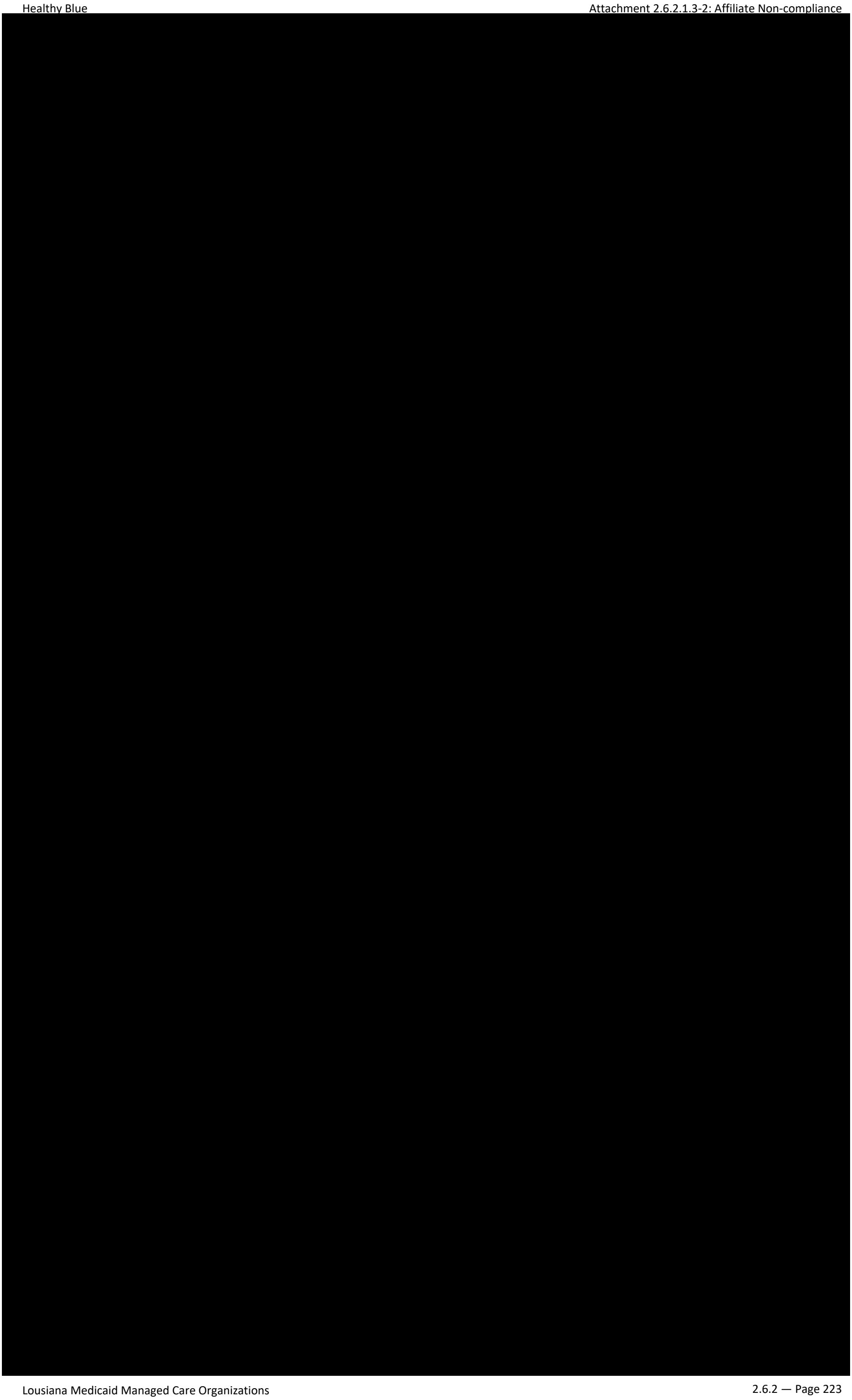


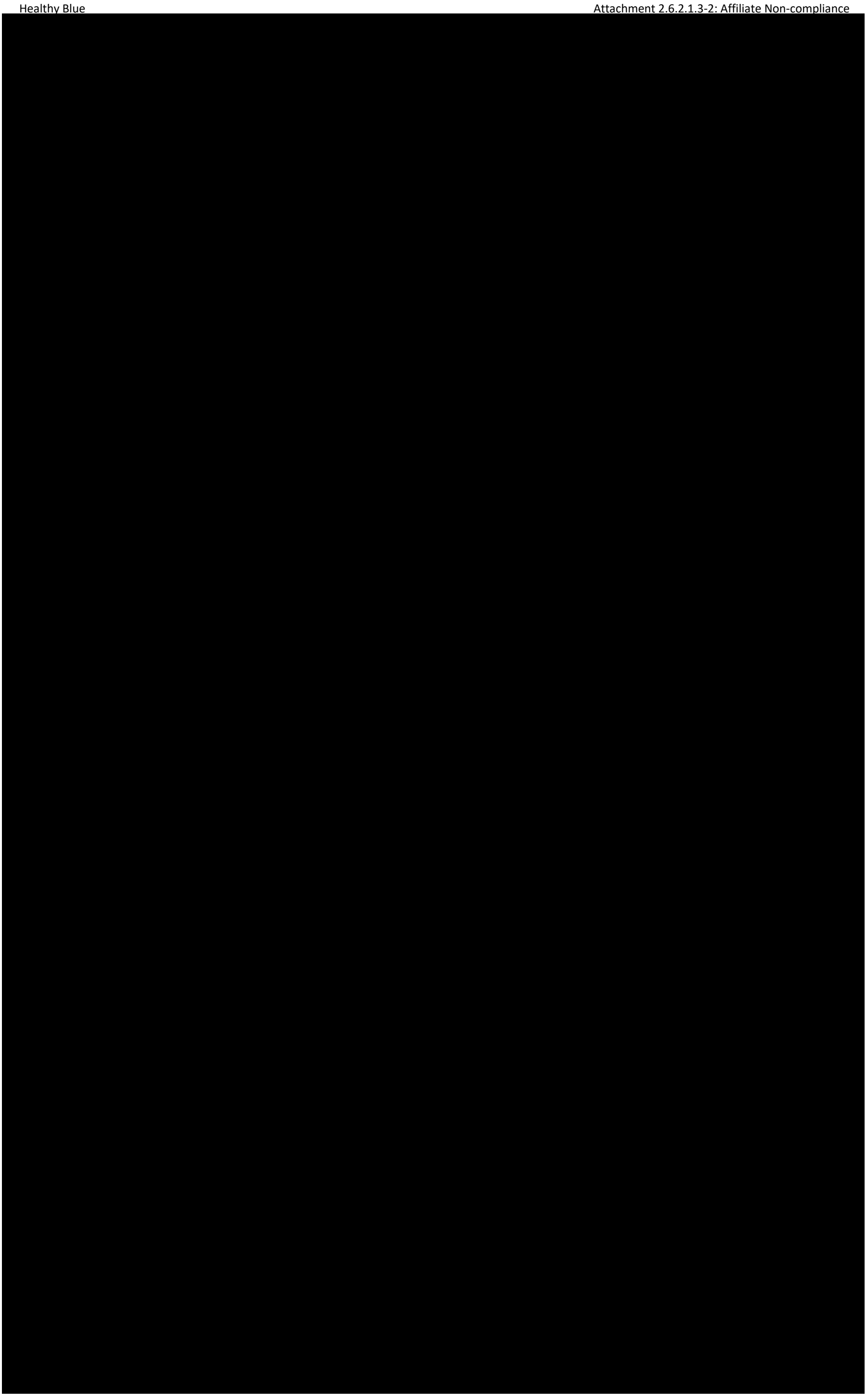


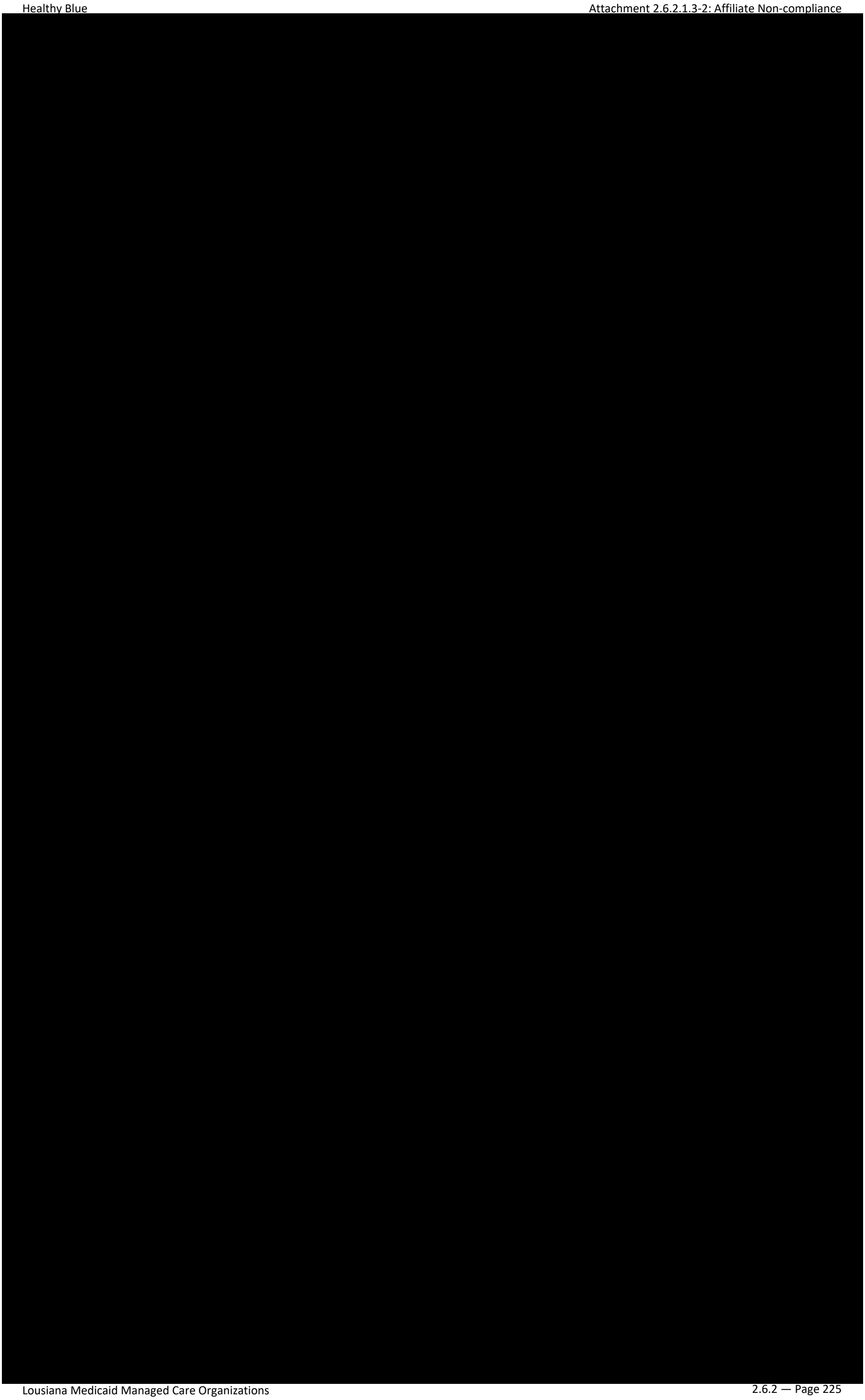


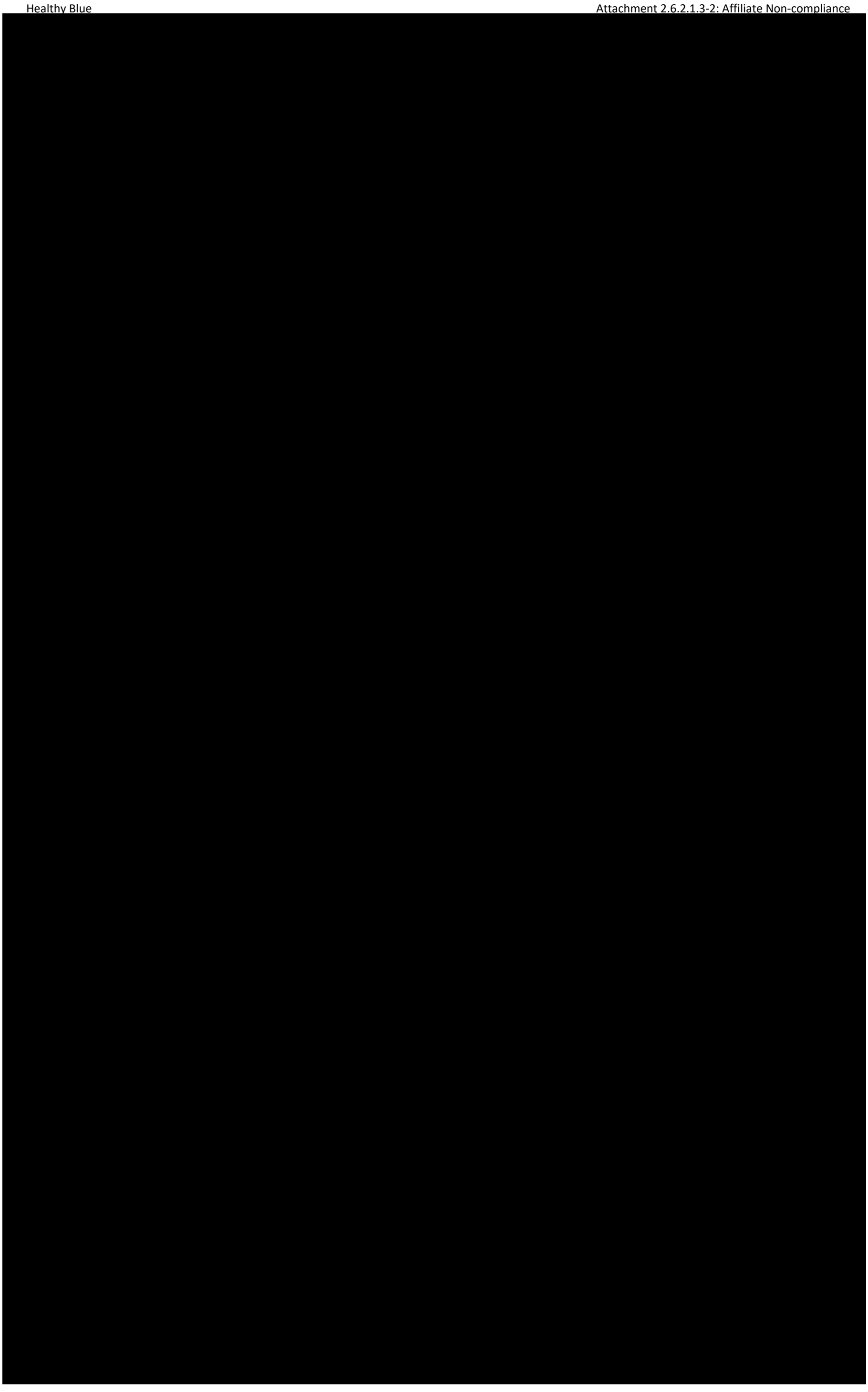


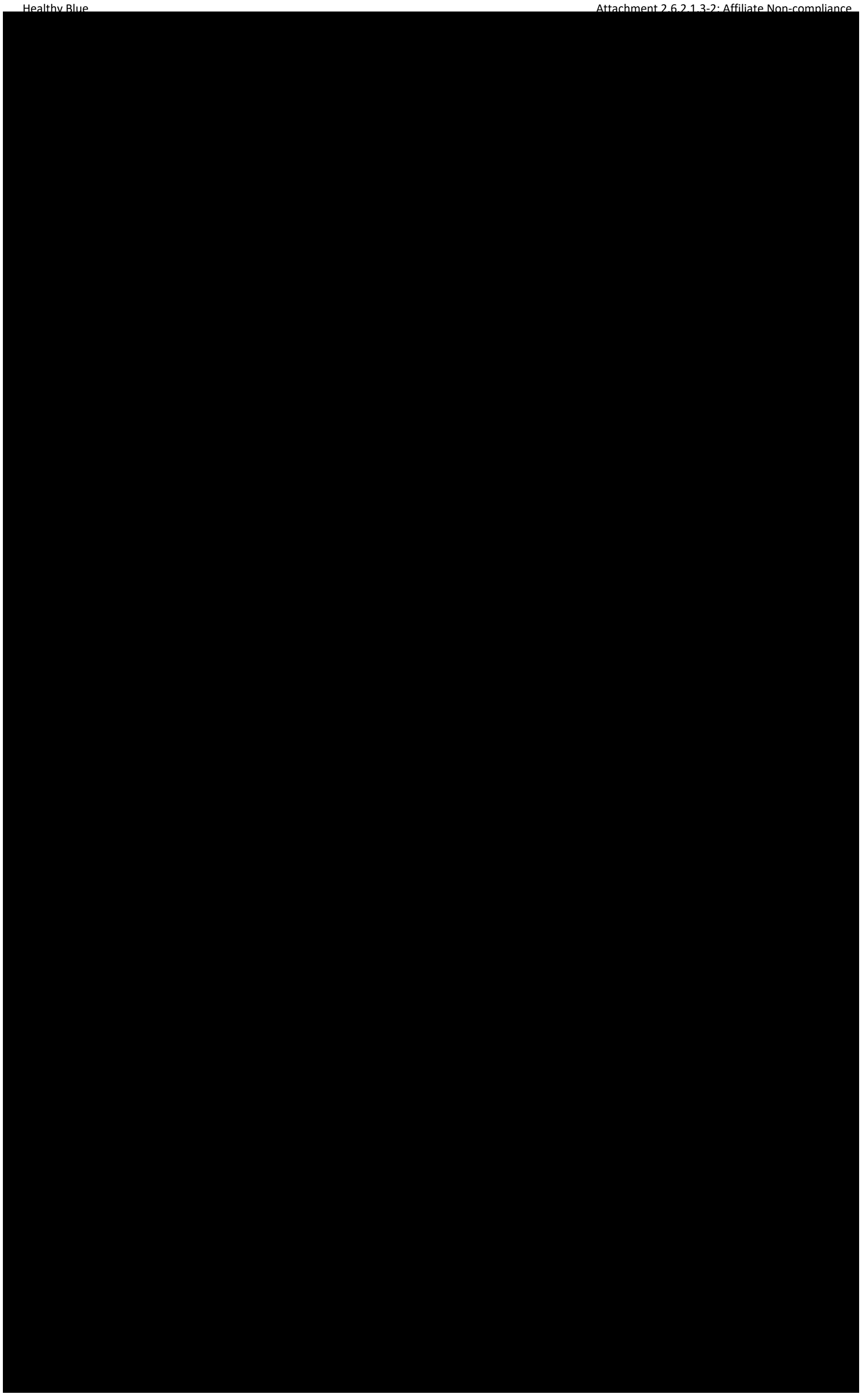


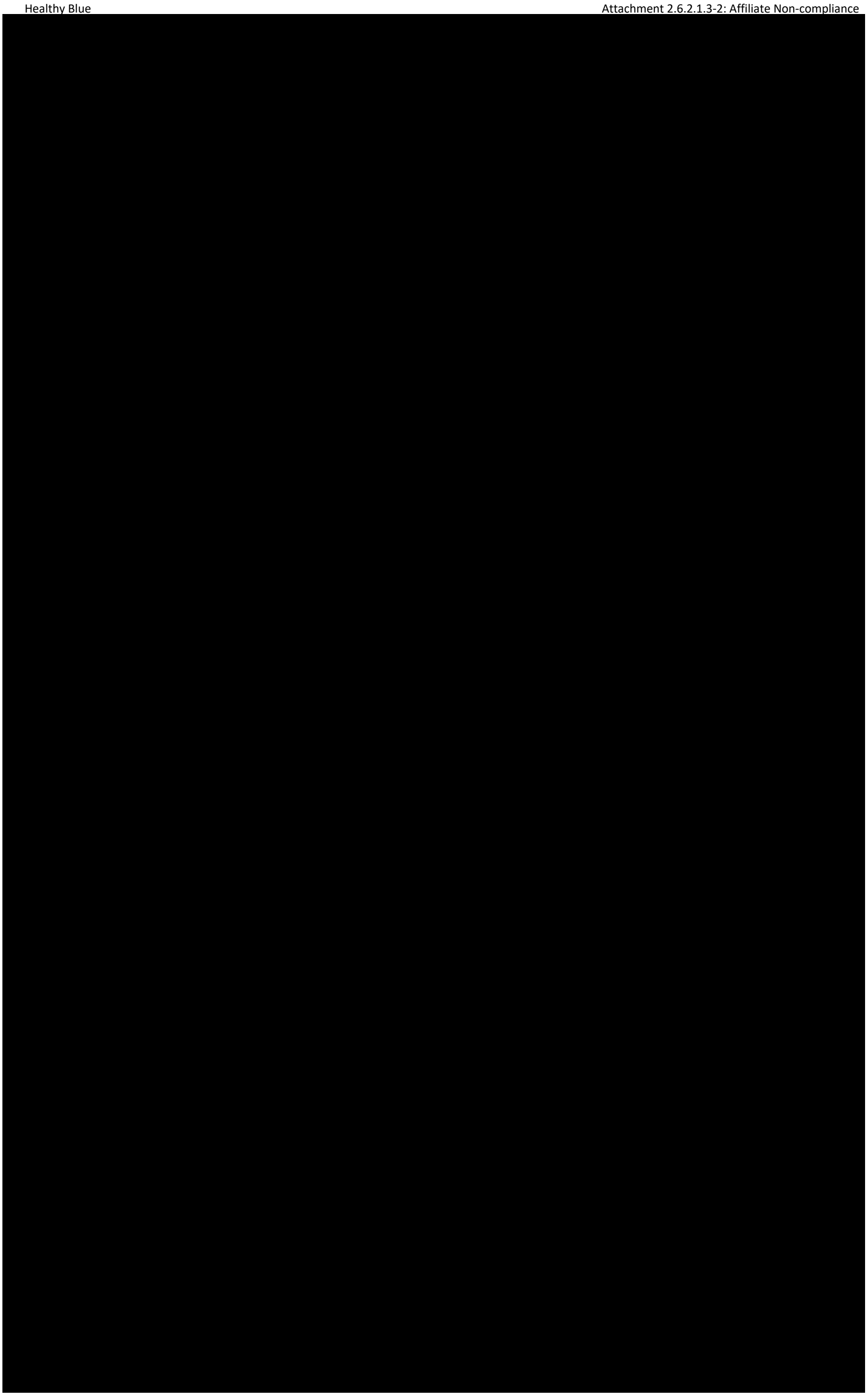


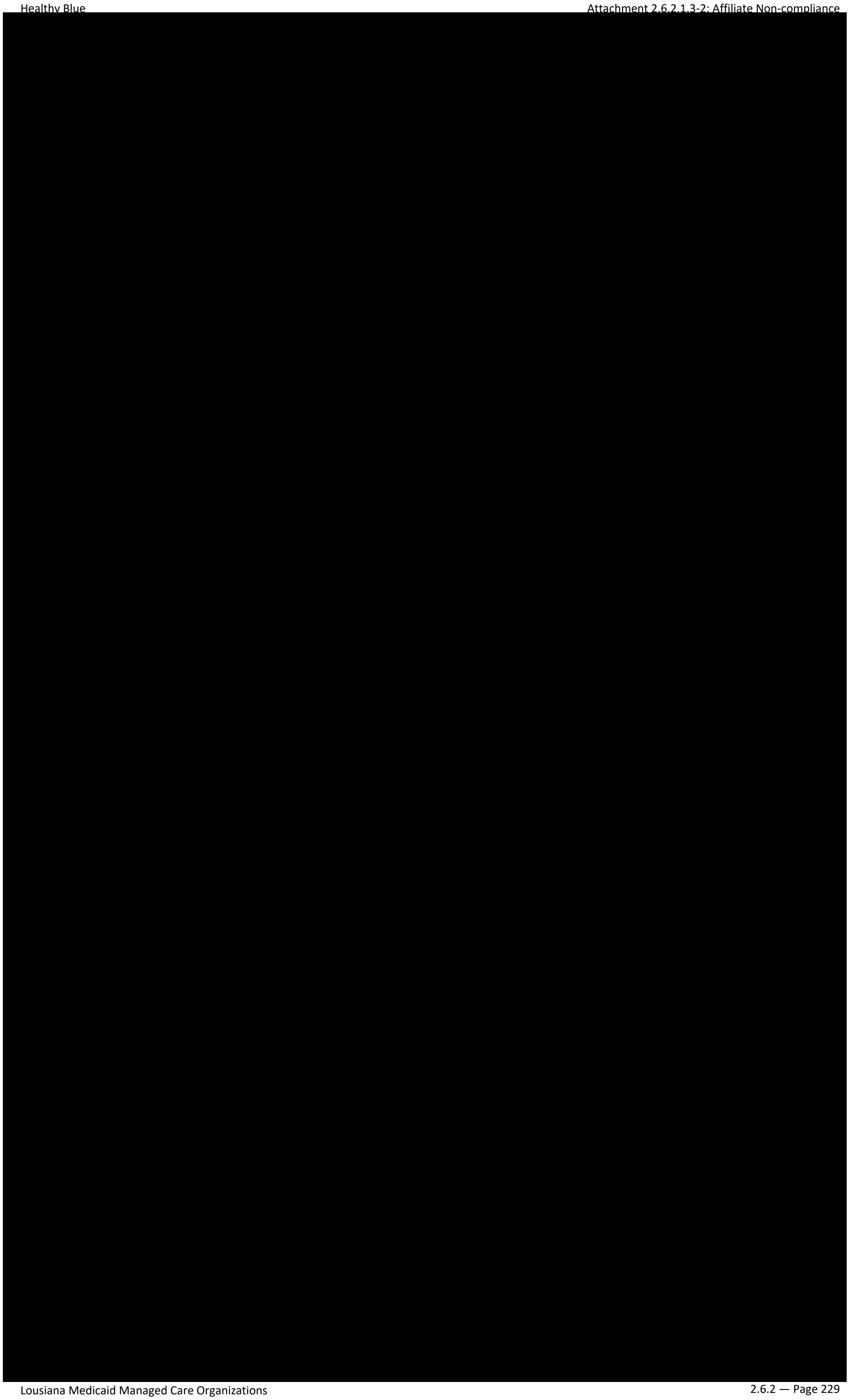


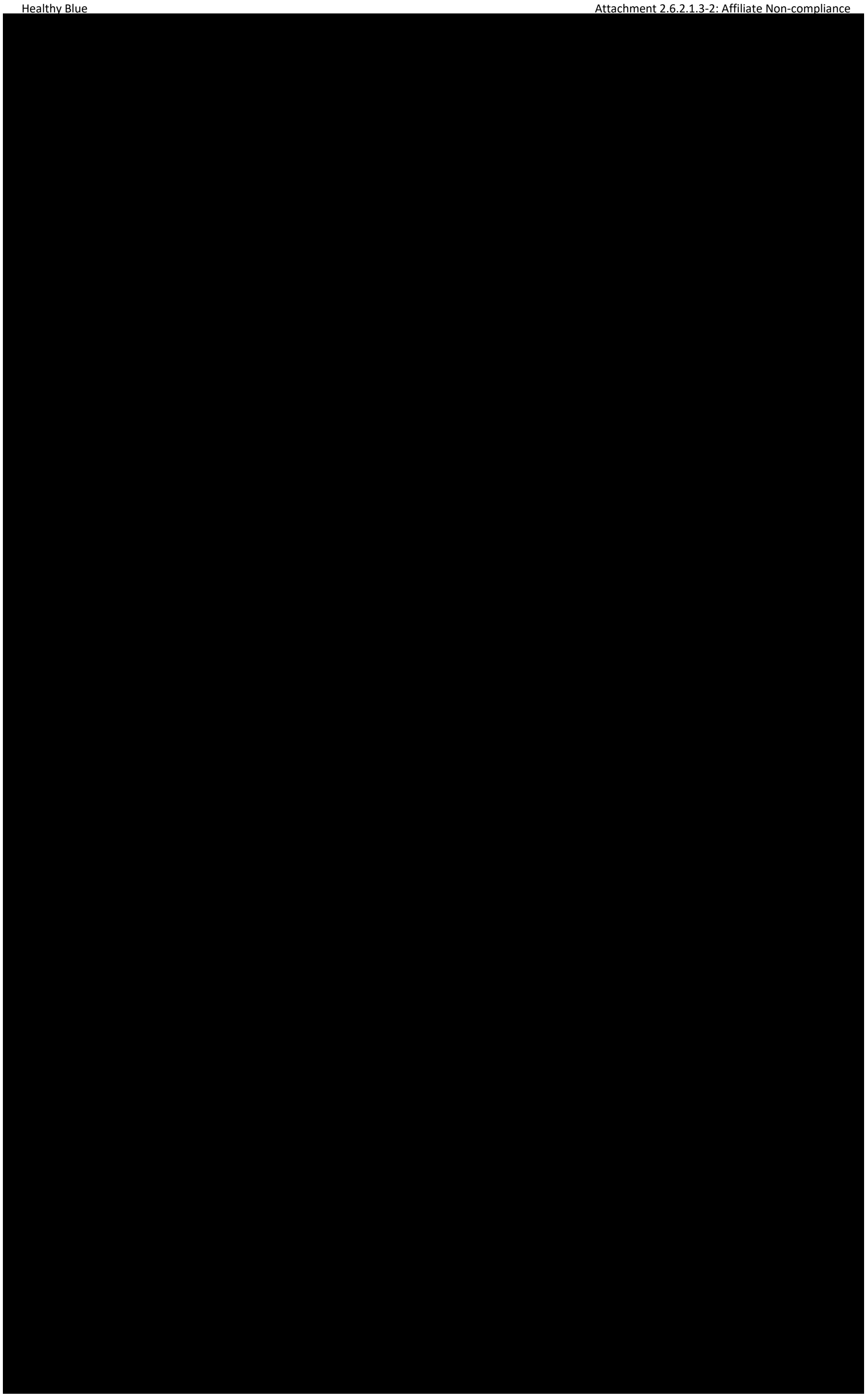


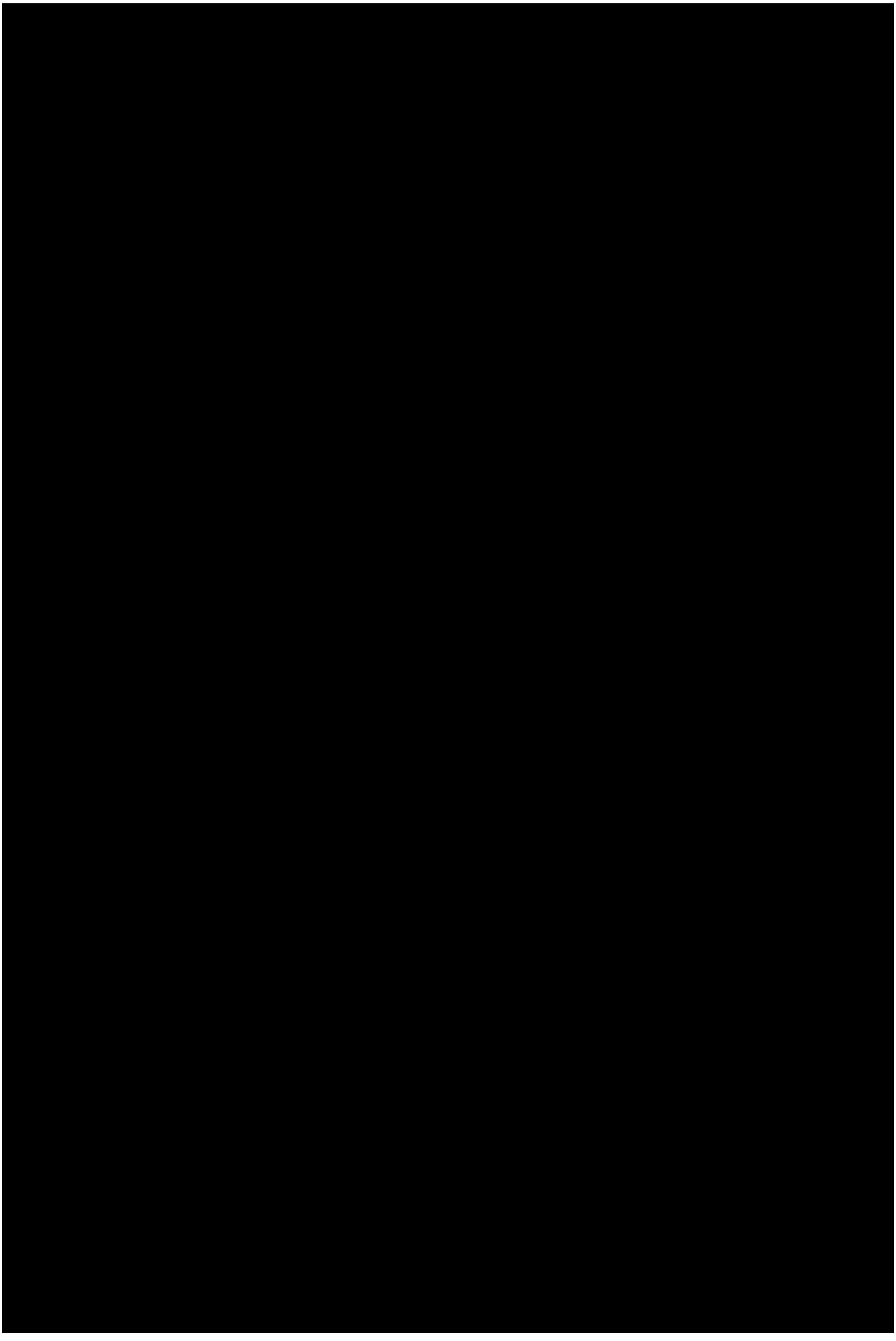














### Sponsoring Total Teen Takeover to Give Teen Voices a Platform

Healthy Blue sponsors Total Teen Takeover, a celebration for the graduates of an eight-week mentoring and workforce development program for young people. Through the program, youth can connect with mentors, explore potential careers, earn industry-recognized certifications, and reinvest in their community through service learning projects. Total Teen Takeover, now in its sixth year, provides a platform to teens to discuss topics important to them, ranging from depression and bullying to mentoring and workforce development. The teens involved are part of an advisory board to help Healthy Blue and our community partners select dynamic and engaging speakers for the event.

# Attachment 2.6.2.2.2-1

## Key Personnel Résumés

Healthy Blue

# Christy Valentine, MD, MBA — Chief Executive Officer

## Qualifications

Dr. Valentine, a native New Orleanian, is responsible for improving lives and communities through collaboration with partners across Louisiana. Dr. Valentine will continue to focus on innovative healthcare solutions and simplified processes for our members, putting them at the center. In doing so, there is a keen focus on bridging the gap in social and economic conditions, which lead to health inequities. Dr. Valentine spent nearly 13 years as a physician in private practice in the New Orleans metro area specializing in Pediatrics and Internal Medicine dedicated to providing quality care by optimizing community health.

## Resume/Professional Experience

**Healthy Blue**

**Chief Executive Officer** **2021 – Present**

- Guides overall strategic direction, growth, operations, and performance of Healthy Blue
- Builds a culture of accountability by implementing business strategies aligned with our mission and values
- Collaborates across the health plan to develop new and innovative initiatives to give members superior service and care
- Serves as primary contact for LDH regarding all issues
- Fosters and maintains relationships with key provider systems such as hospitals, large physician or group practices, and specialty providers

**Anthem**

**Regional Medical Director** **2019 – 2021**

- Subject matter expert on designing and executing cross-departmental programs that synchronize the efficient care of DSNP members
- Worked to improve outcome measures and close gaps in care for vulnerable members

**Healthy Blue**

**Medical Director** **2016 – 2019**

- Successfully launched and led several ER initiatives designed to reduce inappropriate ER utilization
- Led cross-departmental team that created the Enhanced Inpatient Member Interaction (EIMI) program. This initiative has changed the level and degree Healthy Blue associates engage hospitalized members to connect them with outpatient resources and avoidable hospital readmission
- Developed an initiative that identified outlier provider coding; now being adopted in other Anthem markets

**New Orleans East Hospital**

**Governing Board Commissioner** **2008 – Present**

**Louisiana State Board of Medical Examiners**

**Governing Board Member** **2014 – Present**

**President** **2017 – 2019**

**Louisiana Office of Community Preparedness**

**Medical Consultant** **2016 – 2020**

**Louisiana Statewide Medical Director of Reproductive Health** **2015 – 2016**

**Valentine Medical Center, Inc.**

**Owner/Physician** **2005 – 2018**

## Education

- The University of Chicago Booth School of Business, Master of Business Administration, 2018 – 2020
- Tulane University Medical Center, Resident, Internal Medicine and Pediatrics, 2004
- Louisiana State University School of Medicine, Doctorate of Medicine, 2000
- Xavier University of Louisiana, Bachelor of Science in Biology/Pre-Medicine, 1996

# Dexter Trivett, MBA — Chief Operating Officer

## Qualifications

Dexter Trivett brings more than a decade of experience in managed care, and has successfully led initiatives around provider relations, network development, and operations that involved redesigning and streamlining processes and turning strategic ideas into fully operational programs. Since 2015, he has overseen day-to-day operations across Healthy Blue's departments to ensure we continue to meet LDH's requirements and to drive the best possible outcomes for members. Dexter's progressive history of leadership positions includes managing provider relations and operational initiatives across Medicaid affiliates in 20 states.

## Resume/Professional Experience

**Healthy Blue**

**Chief Operating Officer** **2015 – Present**

- Oversees the health plan's operational areas to ensure continued compliance with State, federal, and Contract requirements as well as achieve the organizational mission, vision, and goals
- Maintains responsibility for overseeing and leading our Member Services, Provider Services, Claims, and Information Technology (IT) departments
- Served as the liaison to various corporate support services and regulators, local network development, provider partnerships, relations, medical, case and quality management programs, performance management/improvement, budgets, complaints and appeals, regulatory and contractual compliance, monthly financials, and reporting
- Provides input on overall strategic direction, especially strategies affected by operations, practices, and policies

**Anthem**

**Senior Manager, Corporate National Provider Relations** **2013 – 2015**

- Served as the program manager and implementation leader for key national and local market Provider Relations initiatives across 20 Medicaid affiliates
- Directed all aspects of provider relations and contracting, including developing, building, and maintaining robust networks that deliver culturally and linguistically responsive medical, behavioral health, and ancillary services
- Orchestrated the design and implementation of a Provider Relations program to support and build lasting provider relationships and minimize their administrative burden

**Project Manager II, Corporate Provider Operations** **2011 – 2013**

- Led portfolio of projects within the Provider Lifecycle Program, redesigning processes to reduce provider contract processing times and improve data quality
- Assisted in launching multiple cross-functional programs and projects aimed toward building strong provider collaborations, cultural change, process improvement, and quality to support members
- Oversaw Patient Care Consultants on activities related to the Provider Access and Quality Care programs, as well as the Provider Quality Improvement programs

**Amerigroup Corporation**

**Associate, Leadership Development Program** **2009 – 2011**

- Partnered with senior leadership to identify, evaluate, and execute robust, high-profile process improvement initiatives. Developed leadership skills at an accelerated pace while designing and rolling out improvements at the department, statewide, and national levels.
- Researched emerging industry trends and built cultural competency initiatives database in support of new RFP requirements, contributing to winning RFP response

## Education

- Old Dominion University, Master of Business Administration, 2009
- James Madison University, Bachelor of Business Management, 2007

# Raymond Poliquit, MD, FAAP — Chief Medical Officer

## Qualifications

Dr. Raymond Poliquit is a Kenner-based, board-certified pediatrician who brings more than 25 years of experience providing direct patient care. As Healthy Blue's full-time Medical Director since 2015, Dr. Poliquit has played an integral role in clinical and quality management activities. He is licensed to practice medicine in Louisiana and is a Fellow of the American Academy of Pediatrics. Since 1994, Dr. Poliquit has cared for Louisiana residents, serving the State's most impoverished communities as former Chief of Staff at Madison Parish Hospital in Tallulah and at one of the state's largest Federally Qualified Health Centers. He is also a licensed Zumba® instructor and leads Zumba classes for Healthy Blue's "Making Fitness Fun" program, providing virtual classes to meet everyone's fitness goals safely at their homes. He is an adoptive parent of a 17-year-old former Louisiana foster child who recently started college.

## Resume/Professional Experience

**Healthy Blue**

**Chief Medical Officer** **2013 – Present**

- Oversees all aspects of clinical operations for Healthy Blue, accountable for providing leadership and direction on utilization/cost management and clinical quality management functions
- Makes timely medical decisions and provides peer-to-peer consultation to providers across the state
- Works collaboratively across health plan functional areas — provider relations, member services, claims management, and more to drive strategic short- and long-term planning that will achieve the organization's mission, vision, and goals
- Develops and enforces clinical policies, assures fully integrated care, and supports, assists, and directs medical management activities in conjunction with the Behavioral Health Medical Director and other key personnel
- Collaborates with affiliate health plan Medical Directors on national medical policies and carries out national medical policies at the health plan in collaboration with the Health Plan President

**Primary Health Care Services Center**

**Medical Director/Pediatrician** **2009 – 2013**

- Oversaw medical management and supervised physicians, nurse practitioners, nurses, quality nurses, case managers, medical records staff and clinical pharmacists for this safety-net provider, serving 12,000 patients in Ouachita Parish with 28,000 encounters a year
- Managed the Quality Assurance program of the clinic and spearheaded the center's NCQA Patient-Centered Medical Home Recognition

**Madison Parish Hospital**
**Emergency Room Physician** **1995 – 2014**

**Centene Corporation**
**Committee Member, Louisiana Healthcare Connections** **2011 – 2013**

**Outpatient Medical Center at Talullah**
**Medical Director/Pediatrician** **1994 – 2009**

**Madison Parish Hospital**
**Medical Staff/Courtesy Medical Staff** **1994 – 2014**

## Education

- State University of New York, Health Sciences Center at Brooklyn, Kings County Hospital Center, Pediatrics, 1994
- University of the Philippines, Doctor of Medicine, 1989
- University of the Philippines, Bachelor of Science, Biology, Cum Laude, 1984

# Cheryll Bowers-Stephens, MD, MBA — Behavioral Health Medical Director

## Qualifications

A 25-year health care industry veteran, Dr. Bowers-Stephens has held a variety of leadership roles, from serving as the Louisiana Department of Health and Hospital's Assistant Secretary of Mental Health (Government Appointee) to managing Medical Director to Chief Medical Officer for Healthy Blue. Dr. Bowers-Stephens' two decades of directly managing staff, fiscal budgets, and clinical operations, means that she keenly understands all aspects of clinical, quality, and utilization management as well as population health strategies. She is currently board-certified in both General and Child & Adolescent Psychiatry with an unrestricted medical license to practice in Louisiana, as well as two other states. She has also taught organizational behavior and financial management and accounting, the core curriculum for students working on a Master of Public Health at LSU School of Public Health.

## Resume/Professional Experience

**Healthy Blue**

**Behavioral Health Medical Director** **2015 – Present**

- Plays a key role in major clinical and quality management initiatives around behavioral health (BH), and develops programs and strategies to support the integration of care, including supporting and educating primary care physicians on common BH conditions, overseeing and assisting with psychopharmacology activities, and providing clinical guidance related to mental health and substance use disorder
- Leads all aspects of BH administration and utilization, including assessments, referrals, and processes that assure members receive the services they need
- Builds relationships and engages with Louisiana providers, community-based organizations, and other stakeholders to drive value-based care and awareness of BH needs in the community, and to create solutions that address those needs (includes serving on joint operating committees, conducting peer-to-peer reviews and consultations, and chairing and serving on internal committees)
- Designs and develops national-level interventions in conjunction with affiliate Medical Directors, leveraging existing tools that will drive performance and best practices in value-based care across affiliates
- Hired and oversees a BH team, participates in readiness reviews and presentations, and assists with developing Medicaid clinical models
- Collaborates with providers on parenting skills and behavior modification techniques, and develops strategies to inform members and their families on available benefits and services
- Supports the Medical Management staff, ensuring timely responses to members and providers

**PerformCare**

**Chief Medical Officer** **2013 – 2015**

- Provided administrative oversight to the Healthcare Management, Quality Management, Behavioral and Health Informatics teams to assure members receive the most appropriate services and supports, including planning, organizing, and supporting an Integration Health Strategy for Amerihealth Caritas
- Helped pioneer innovative health care programs to address the unique needs of members, and directed both clinical and non-clinical initiatives to positively influence quality and outcomes

**Oschner Medical Foundation**

**Child and Adolescent Psychiatrist** **2007 – 2013**

- Provided direct care to individuals with severe BH conditions in main campus tertiary care clinic. Specialized in treating people with both developmental disabilities and BH disorders, young adults transitioning to adulthood with ADHD, and youth with Traumatic Brain Injuries from sports-inflicted injuries

## Education

- University of New Orleans, Master of Business Administration, 1998
- Tulane University Medical Center, Fellowship, Child and Adolescent Psychiatry, 1993
- Ochsner Medical Foundation, Internship and Adult Psychiatry, 1991
- Louisiana State Medical University Medical School, Doctor of Medicine, 1988
- Spelman College, Bachelor of Arts, Psychology, 1982

# Christine Coleman, MBA — Chief Financial Officer

## Qualifications

Christine, a native New Orleanian with over 15 years healthcare finance experience, oversees all aspects of financial operations, including accounting, financial reporting, and audit activities. Christine oversees the team that is responsible for delivering all finance and actuarial services to Healthy Blue. The team provides budgeting and forecasting support, trend evaluation, rating system and product pricing support, and industry competitive analysis as well as strategic analysis to impact leadership decision-making, improve efficiency, and drive innovation.

## Resume/Professional Experience

**Healthy Blue**

**Chief Financial Officer** **2019 – Present**

- Oversees the financial reporting for a health plan with $1B in revenue
- Strategically analyzes the plan's reporting, profitability, financials and key functional areas and processes to meet performance targets, goals, and objectives

**University Medical Center**

**Senior Decision Support Analyst** **2018 – 2019**

- Created financial pro formas for new services
- Created and maintained budget template
- Managed hospital-wide expense reduction initiatives
- Created customized reports for senior management and conducted ad hoc analyses as needed
- Prepared monthly volume, revenue, expense and FTE forecast
- Prepared and analyzed service line financials

**Oschner Health System**

**Service Line Financial Manager** **2016 – 2018**

- Provided direct care to individuals with severe BH conditions in main campus tertiary care clinic. Specialized in treating people with both developmental disabilities and BH disorders, young adults transitioning to adulthood with ADHD, and youth with Traumatic Brain Injuries from sports-inflicted injuries

**Senior Financial Analyst** **2015 – 2016**

- Budgeted for 100+ medical specialties cost centers/departments
- Created pro formas for new physician and/or equipment requisitions
- Created monthly dashboards for senior management
- Provided financial data for physician credentialing, grants, and hospital ranking surveys

**Senior Financial Analyst, Treasury Department** **2007 – 2015**

- Prepared the System's quarterly cash forecast
- Responsible for capital financing analysis/accounting
- Handled banking administrator duties
- Acted as liaison for IRS bond examinations
- Drafted post-bond compliance policy
- Attended the Board of Directors Investment Committee quarterly meetings
- Member of the Finance Recognition Committee, which decided Employee and Manager of the Month

**Financial Analyst, Treasury Department** **2006 – 2007**

- Managed the System's and its pension plan $1B investment portfolios
- Performed monthly and annual financial close
- Participated in annual budgeting/forecasting process

## Education

- University of Dallas, Master of Business Administration, 2004
- Dillard University, Bachelor of Arts in Accounting, 2000

# Mykayla Jones, PharmD —Pharmacy Director

## Qualifications

Mykayla, a native Louisianian, is a licensed Louisiana Pharmacist. She coordinates, manages and oversees Healthy Blue's responsibilities related to pharmacy. She participates in LDH required pharmacy meetings to discuss issues for the efficient and economical delivery of pharmacy services to Medicaid members and to promote relevant clinical pharmacy programs for medication utilization. She collaborates with our internal team to conduct monitoring and management of members as it relates to utilization of prescription drugs through data coordination with the Single PBM.

## Resume/Professional Experience

**Healthy Blue**

**Pharmacy Director** **2019 – Present**

- Supervises, schedules, and evaluates all clinical and supportive pharmacy personnel
- Develops, maintains, and operationalizes formularies related to coverage, utilization management, and clinical edits
- Develops and implements pharmaceutical management initiatives/programs and operation procedures to achieve quality, efficiency, and cost of care goals
- Serves as the subject matter expert for pharmaceutical program implementations with use of six sigma techniques to identify and improve existing solutions
- Ensures the Pharmacy Services team is delivering exceptional customer care to doctors and members along with managing end-to-end doctor services including prior authorizations, customer transfers, complex insurance issues, and medication reviews
- Oversees day to day operations to ensure the department is meeting prior authorization turn-around time and service level agreement metrics
- Manages relationships with and provides oversight of key vendors, including PBM partners

**Louisiana Healthcare Connections**

**Clinical Pharmacist, Medicare** **2018 – 2019**

- Provided operational support for the delivery of Medicare clinical information to various business units
- Developed, implemented, and enforced Medicare Part D operations
- Developed workflow processes to ensure monitoring of patient outcomes as it relates to Star Measures
- Developed pharmacy training manual for Medicare Part D
- Developed DUR process according to CMS rules and guidelines
- Assisted in implementing programs and process improvement to enhance the level of customer service provided to members from Pharmacy and Medical Management team members

**Southeast Community Health Systems**

**Director of Pharmacy, 340B Specialist** **2015 – 2017**

- Developed and Implemented 340B pharmacy program for clinical and pharmacy department
- Developed and monitored 340B compliance program which include performing gap analysis to align improvement activities to maintain required accreditation and company standards
- Designed and maintained audits to ensure regulatory compliance and revenue maximization

**Gulf Coast Pharmaceutical Specialty Co**

**Pharmacy Manager, Long-term Care** **2014 – 2015**

- Assisted and directed support staff in the production and dispensing of medication order to facilities and residents
- Ensured staff and facilities operated according to Federal and State Regulations as it pertains to LTC pharmacy

## Education

- Bellevue University, Master of Business Administration with concentration in Health Care Administration, 2019
- Xavier University of Louisiana, Doctor of Pharmacy, 2007

# Kimberly Chope — Contract Compliance Officer

## Qualifications

Kim has 25 years of managed care experience focused on regulatory compliance, program development and growth of state Medicaid programs and leads the development and implementation of policies, procedures, and standards to make sure all aspects of the organization fully comply with federal, State, and Contract requirements.

## Resume/Professional Experience

**Healthy Blue**

**Contract Compliance Officer** **2014 – Present**

- Leads the development and implementation of policies, procedures, and standards to make sure all aspects of the organization fully comply with all federal, State, and Contract requirements
- Develops and manages the implementation of State Medicaid contractual requirements to ensure all are executed per the specifications of the State Contract across the health plan and shared service partners: these partners include health plan operations, quality management, health care management, claims, marketing, and encounters
- Maintains oversight and management of all health plan regulatory reports and their timely submission to State agencies through requirements gathering and development
- Serves as primary point of contact for State entities, developing strong working relationships to address issues that arise well before they become cost drivers
- Continuously aligns Regulatory Services, health plan, and shared service resources to effectively meet needs and by honing consistent and positive messaging in all communications
- Coordinates and drives accountability of key stakeholders including affiliates and shared service partners to meet program changes dictated through State Contract amendments and policy directives, as well as advising senior management relative to impact and risks

**Manager, Regulatory Services** **2012 – 2014**

- Initiated and conducted activities to support and promote corporate and health plan compliance with regulatory and contractual obligations of multiple state and federal regulatory bodies
- Initiated and designed an innovative compliance monitoring system that included the monitoring of contractual and regulatory compliance level via report review and assessment, resulting in reduced overhead expenses
- Conducted business owner education of new legislation or contractual requirements

**Amerigroup Florida**

**Consultant, Provider Contracting** **2010 – 2012**

- Successfully contracted long-term supports and services networks in 17 Florida counties where managed care was not prevalent
- Demonstrated ability to contract primary care and specialist providers in a challenging rural Florida area
- Significantly grew market share of dual-eligible programs by contracting, educating, and servicing Assisted Living Facilities on new public-private programs

**National Flight Academy**

**Consultant, Special Projects and Development** **2009 – 2011**

- Led the coordination of all special events and fund-raising events for the National Flight Academy (NFA) from pre-construction to operations, resulting in positive image and overwhelming community support

## Education

- University of Georgia, Bachelor of Business Administration, Risk Management and Insurance, 1989

# Karen Kosinski, MPH, MSW — Health Equity Administrator

## Qualifications

Karen has over 15 years of experience with the strategic design, project management, implementation, and evaluation of health equity efforts in the context of the population health initiatives. She informs decision-making around best practices related to disparity reductions and to address overall opportunities to improve health (i.e. social determinants of health), including the provision of health equity and social determinant of health resources and research to leadership and programmatic areas. In 2021, Karen led the First Annual Racial and Health Equity Symposium, along with the Louisiana Public Health Institute. This event highlighted local Louisiana partners involved in equity work in education, incarceration, employment, healthcare and housing. More than 500 individuals throughout the state and country participated.

## Resume/Professional Experience

**Healthy Blue**

**Health Equity Administrator** **2021 – Present**

- Guides the health equity strategy within Healthy Blue and our provider network to support the effectiveness and efforts of the Health Equity Plan
- Oversees strategic design, implementation, and evaluation of health equity efforts in population health initiatives
- Informs decision-making around best payer practices related to disparity reductions, including the provision of health equity and social determinant of health resources and research to leadership and programmatic areas

**Behavioral Health Liaison, Permanent Supportive Housing** **2015 – 2021**

- Responsible for day-to-day functioning of MCO operations for state Permanent Supportive Housing program
- Working with regional Clinical Solutions Team on incorporating social determinants of health into new Population Health model
- Relationship Owner for health equity collaboration efforts with Louisiana Public Health Institute (LPHI), including Project Lead role in planning and execution of First Annual Racial and Health Equity Symposium, Racial Equity Learning Labs and Mental Health First Aid trainings
- Project Lead on implementation of standard SDOH assessments via Aunt Bertha for all Case Management teams in the TN market
- Team Member of Population Health Task Force to conduct a gap analysis exercise across 20+ Anthem Medicaid markets for future implementation of enterprise Population Health model
- Pioneered Permanent Supportive Housing program for Healthy Blue Louisiana, including training all staff, particularly Case Managers and Utilization Management, in referrals and processes; nurturing relationships with service providers, community partners and state program staff
- Developed innovative statewide and regional housing strategies for new proposal in conjunction with corporate Business Change Director; initiatives based on state-wide “listening tour” with diverse housing partners for community-driven solutions

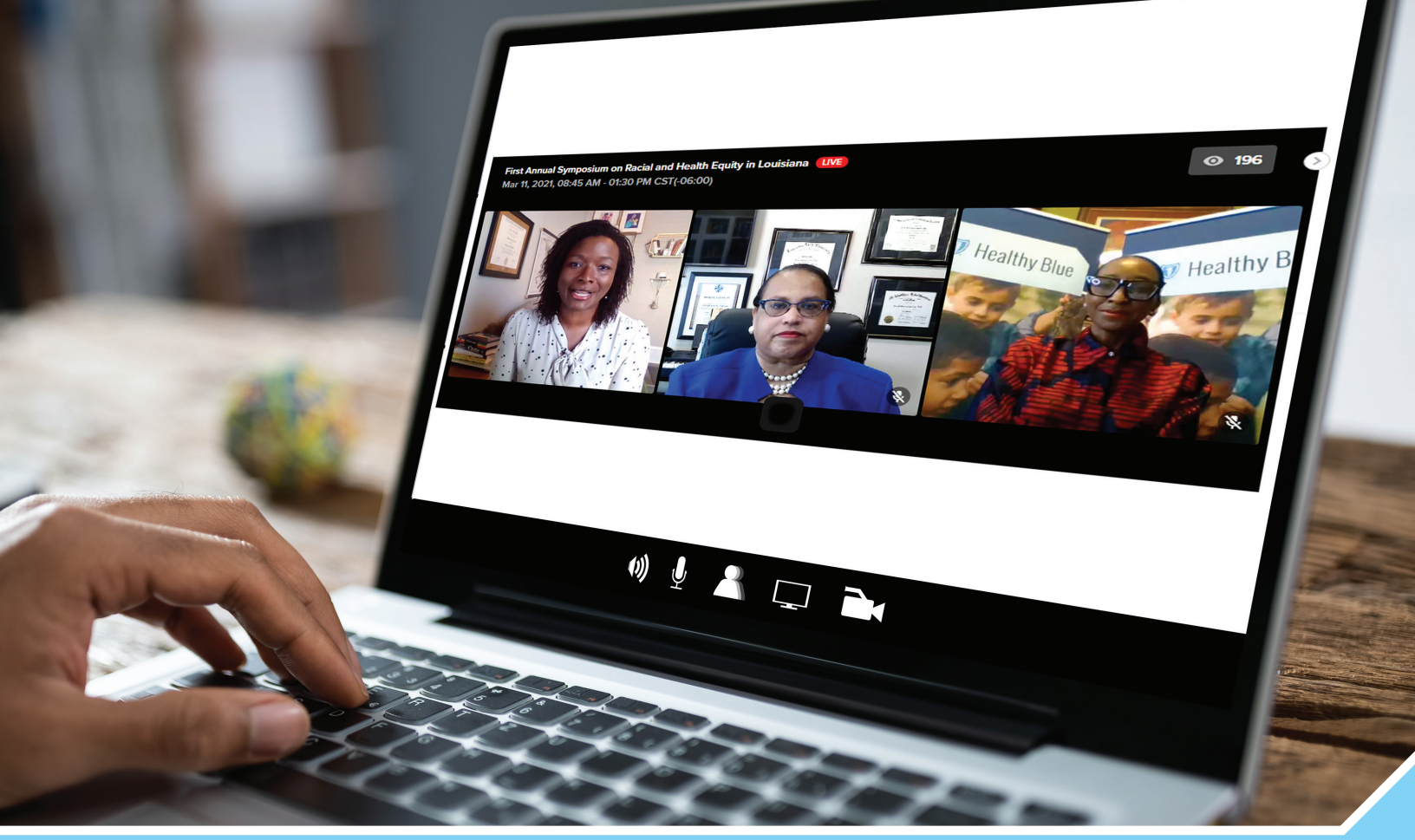
**Marie Stopes International**

**Director of Grants and External Relations/USAID Project Manager** **2013 – 2014**

- Managed over $3 million in annual project budgets, including all budgetary decision-making responsibility and fulfilling reporting requirements
- Served as signatory and decision-maker for USAID-funded “Improving Family Services” nation- wide reproductive health project with a budget of $8.9 million over five-year span

## Education

- Tulane University, Master of Public Health International Health Development
- Tulane University, Master of Social Work, Certificate in International Social Work
- University of Notre Dame, Bachelor of Arts in Anthropology, minor in Theology



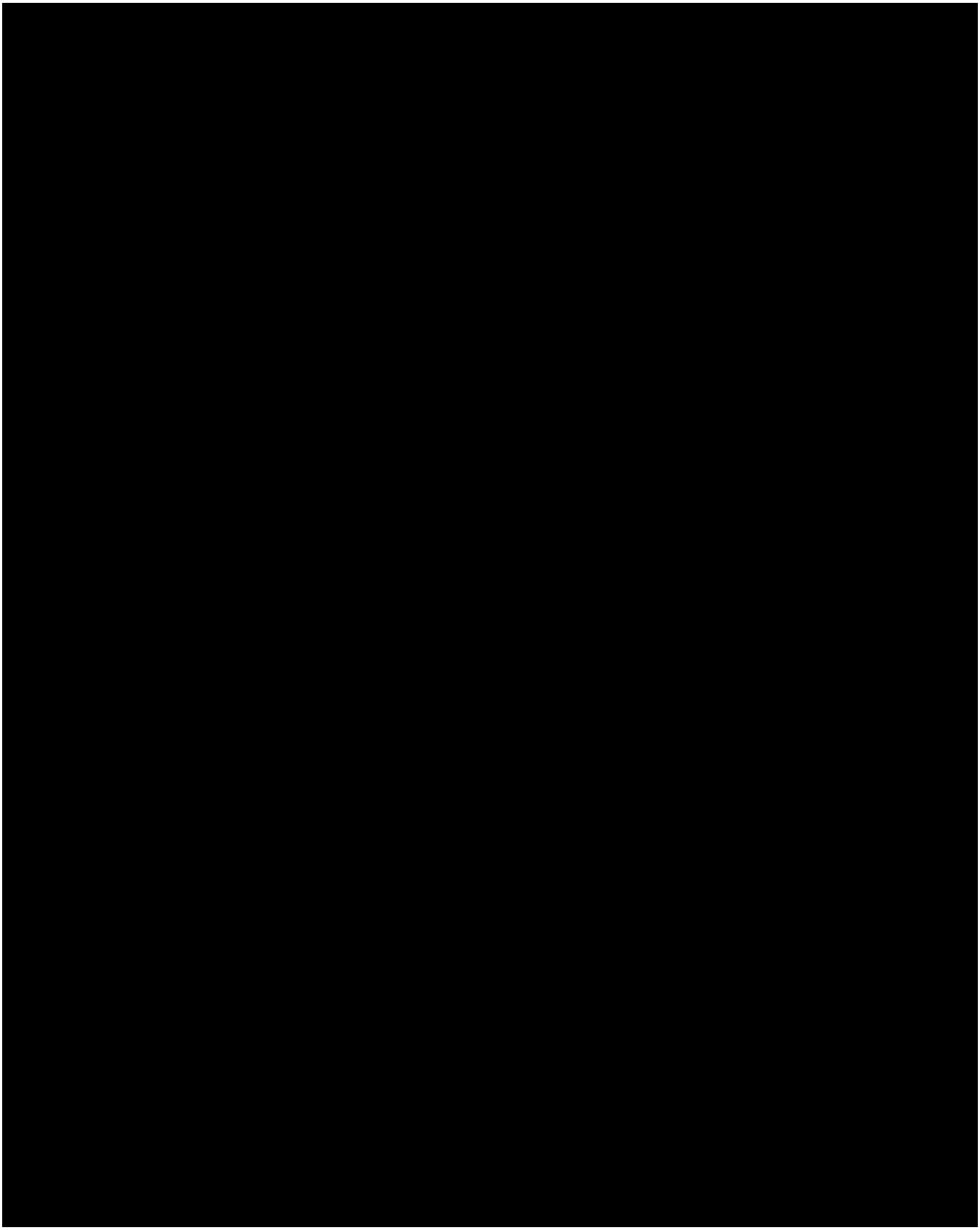

### Promoting Health and Racial Equity in Louisiana

Healthy Blue teamed up with the Louisiana Public Health Institute (LPHI) to launch the inaugural Symposium on Racial and Health Equity in March 2021 with the theme of "Partnerships in Action: Collectively Achieving Racial Equity to Improve the Health of Our Community." At the conclusion of the Symposium, LPHI and Healthy Blue offered participants the opportunity to join a coalition dedicated to ending institutional racism in Louisiana. Healthy Blue will continue this commitment by sponsoring the first Racial Equity Learning Lab later this year.

# Attachment 2.6.2.2.3-1

## Organizational Chart

Healthy Blue



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### Building Community and Rebuilding Homes

Healthy Blue sponsored Rebuilding Together's Second Annual Build and Boil event. This event is a fundraiser, a community party, and a volunteer opportunity, bringing people from all over New Orleans together. The Build and Boil event supports Rebuilding Together's mission to improve the quality of life for low-income homeowners in New Orleans, especially homeowners who are elderly, disabled, veterans, or single heads of households with minor children. With Healthy Blue's help, this event raised over $28,000, boiled almost 1,000 pounds of crawfish for the community, and aided five local homeowners.

# Attachment 2.6.11.5-1

## Clinical Practice Guidelines Sample

Healthy Blue

# Attachment 2.6.11.5-1: Clinical Practice Guidelines Sample

Attachment 2.6.11.5-1 includes the following:

- Attachment 2.6.11.5-1a: 2021 Clinical Practice Guidelines
- Attachment 2.6.11.5-1b: Sample Clinical Practice Guideline

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# *2021 Clinical Practice Guidelines*

**Date reviewed December 2020**
**Date adopted January 2021**

**Table of contents:**



| Condition/disease | Guideline title | Recognized source(s) | URL |
|---|---|---|---|
| **Adult health** Return to table of contents | | | |
| **Alzheimer's disease/dementia** | *Practice Guideline for the Treatment of Patients with Alzheimer's Disease and Other Dementias* (Guideline Watch October 2014) | American Psychiatric Association (APA) | **https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/alzheimerwatch.pdf** |
| **Alzheimer's disease/dementia** | *American Psychiatric Association Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia* (July 2018) | American Psychiatric Association | **https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890426807** |
| **Anxiety** | *Anxiety Disorders* (Last Revised July 2018) | National Institute of Mental Health (NIMH) | **http://www.nimh.nih.gov/health/publications/anxiety-disorders/treatment-of-anxiety-disorders.shtml** |
| **Asthma** | *Guidelines for the Diagnosis and Management of Asthma (EPR-3)* (August 2007) | National Heart, Lung and Blood Institute (NHLBI) | **https://www.nhlbi.nih.gov/health-topics/guidelines-for-diagnosis-management-of-asthma** |
| | *Asthma Clinical Practice Guidelines* (2019) | Global Initiative for Asthma (GINA) | **https://ginasthma.org** |
| **Behavioral health screening, assessment and treatment** | *The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults* 3rd edition (August 2015) | American Psychiatric Association (APA) | **https://psychiatryonline.org/doi/full/10.1176/appi.books.9780890426760.pe02** |

| Condition/disease | Guideline title | Recognized source(s) | URL |
|---|---|---|---|
| **Bipolar disorder***<br><br>* Addresses diagnosis and treatment of bipolar disorder in special populations such as children and adolescents. | *CANMAT and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder* | Canadian Network for Mood and Anxiety Treatments (CANMAT) | **https://www.canmat.org/2019/03/27/2018-bipolar-guidelines/** |
| **Coronary artery disease (CAD)** | *AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic Vascular Disease* (November 2011 Update) | American Heart Association/American College of Cardiology Foundation (AHA/ACCF) | **https://www.ahajournals.org/doi/pdf/10.1161/CIR.0b013e318235eb4d** |
| | *Treatment of Hypertension in Patients With Coronary Artery Disease* (March 2015) | American Heart Association, American College of Cardiology, and American Society of Hypertension | **https://www.ahajournals.org/doi/pdf/10.1161/CIR.0000000000000207** |
| | *AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic Vascular Disease: 2011 Update* | American Heart Association and American College of Cardiology Foundation | **https://www.ahajournals.org/doi/pdf/10.1161/CIR.0b013e318235eb4d** |
| | *Effectiveness-Based Guidelines for the Prevention of Cardiovascular Disease in Women — 2011 Update* (February 2011) | American Heart Association (AHA) | **https://www.ahajournals.org/doi/pdf/10.1161/CIR.0b013e31820faaf8** |
| | *ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease* (2019) | American College of Cardiology/American Heart Association (ACC/AHA) | **https://www.jacc.org/doi/10.1016/j.jacc.2019.03.009** |
| **Celiac disease** | *ACG Clinical Guidelines: Diagnosis and Management of Celiac Disease* (April 2013) | American College of Gastroenterology | **ACG_Celiac_2013** |

| Condition/disease | Guideline title | Recognized source(s) | URL |
|---|---|---|---|
| **Chronic kidney disease (CKD)** | *The National Kidney Foundation Kidney Disease Outcomes Quality Initiative (NKF KDOQI™) evidence-based clinical practice guidelines for all stages of chronic kidney disease (CKD) and related complications* | National Kidney Foundation | **https://www.kidney.org/professionals/guidelines/guidelines_commentaries** |
| | *Chronic Kidney Disease: Detection and Evaluation* (2017) | American Academy of Family Physicians (AAFP) | **https://www.aafp.org/afp/2017/1215/p776.html** |
| | National Chronic Kidney Disease Fact Sheet (2017) | Centers for Disease Control and Prevention (CDC) | **https://www.cdc.gov/diabetes/pubs/pdf/kidney_factsheet.pdf** |
| | KDIGO (Kidney Disease Improving Global Outcomes) 2012 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease (January 2013) | International Society of Nephrology | **https://kdigo.org/guidelines/ckd-evaluation-and-management** |
| | KDIGO (Kidney Disease Improving Global Outcomes) 2017 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease (July 2017) | International Society of Nephrology | **https://kdigo.org/wp-content/uploads/2017/02/2017-KDIGO-CKD-MBD-GL-Update.pdf** |
| **Chronic Obstructive Pulmonary Disease (COPD)** | *Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease* | Global Initiative for Chronic Obstructive Lung Disease (GOLD) | **http://goldcopd.org/gold-reports** |
| **Depression** | *Depression in Adults: Screening* (January 2016) | U.S. Preventive Services Task Force (USPSTF) | **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-adults-screening** |
| | *CANMAT Clinicians Guidelines 2016 Depression Guidelines* | Canadian Network for Mood and Anxiety Treatments (CANMAT) | **https://www.canmat.org/2019/03/17/2016-depression-guidelines** |

| Condition/disease | Guideline title | Recognized source(s) | URL |
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| **Depression (cont.)** | *Nonpharmacologic Versus Pharmacologic Treatment of Adult Patients With Major Depressive Disorder: A Clinical Practice Guideline From the American College of Physicians* (2016) | American College of Physicians (ACP) | **https://annals.org/aim/fullarticle/2490527/nonpharmacologic-versus-pharmacologic-treatment-adult-patients-major-depressive-disorder-clinical?_ga=2.240375883.977749235.1576523219-1562492790.1557437793** |
| | *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 | **https://www.nice.org.uk/guidance/cg90** |
| **Diabetes** | *Standards of Medical Care in Diabetes* (January 2020) | American Diabetes Association (ADA) | **https://care.diabetesjournals.org/content/43/Supplement_1** |
| **Gender-Dysphoria/ Incongruence** | *Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline* (September 2017)<br><br>*Correction to Clinical Practice Guideline* (February 2018)<br><br>*Correction to Clinical Practice Guideline* (July 2018) | The Endocrine Society | **https://academic.oup.com/jcem/article/102/11/3869/4157558**<br><br>**https://academic.oup.com/jcem/article/103/2/699/4675081**<br><br>**https://academic.oup.com/jcem/article/103/7/2758/5036711** |
| **Fall risk** | *Falls Prevention in Community-Dwelling Older Adults: Interventions* | U.S. Preventive Services Task Force (USPSTF) | **https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/falls-prevention-in-older-adults-interventions1** |
| | *Evidence-Based Falls Prevention Programs: Resources for Professionals and Advocates* | National Council on Aging | **https://www.ncoa.org/professionals/health/center-for-healthy-aging/national-falls-prevention-resource-center** |

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| **Heart failure (HF)** | *2013 ACCF/AHA guideline for the management of heart failure: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines*<br>(October 2013)<br><br>*ACCF/AHA/HFSA Guideline for the Management of Heart Failure*<br>(Focused Update 2017) | American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines/Heart Failure Society of America (ACCF/AHA/HFSA) | **http://www.onlinejacc.org/content/62/16/e147?ijkey=079f90818917662ed8e6c54bd132bb10bede26a1&keytype2=tf_ipsecsha**<br><br>**http://www.onlinejacc.org/content/70/6/776?_ga=2.23313085.667318568.1514996759-679389624.1511900706** |
| **Hyperlipidemia** | *2018 AHA/ACC/ AACVPR/AAPA/ABC/ ACPM/ADA/AGS/ APhA/ASPC/NLA/ PCNA Guideline on the Management of Blood Cholesterol*<br>(October 2018) | American College of Cardiology/American Heart Association/ American Association of Cardiovascular and Pulmonary Rehabilitation/ American Academy of Physician Assistants/ Association of Back Cardiologists/American College of Preventive Medicine/American Diabetes Association/ American Geriatrics Society/American Pharmacists Association/ American Society of Preventive Cardiology/ National Lipid Association/Preventive Cardiovascular Nurses Association (ACC/AHA/AACVPR/ AAPA/ABC/ACPM/ADA /AGS/APhA/ASPC/NLA/ PCNA) | **https://www.acc.org/~/media/Non-Clinical/Files-PDFs-Excel-MS-Word-etc/Guidelines/2018/Guidelines-Made-Simple-Tool-2018-Cholesterol.pdf** |

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|---|---|---|---|
| **Hypertension** | *ACC/AHA/AAPA/ABC/ ACPM/AGS/APhA/ASH /ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults* (November 2017)<br><br>*Correction to Guideline* (May 2018) | American College of Cardiology (ACC)/ American Heart Association (AHA)/ American Academy of Physician Assistants (AAPA)/Association of Black Cardiologists (ABC)/American College of Preventive Medicine (ACPM)/American Geriatrics Society (AGS)/American Pharmacists Association (APhA)/American Society of Hypertension (ASH)/ American Society for Preventive Cardiology (ASPC)/National Medical Association (NMA)/ Preventive Cardiovascular Nurses Association (PCNA) | **http://www.onlinejacc.org/content/early/2017/11/04/j.jacc.2017.11.006?sso=1&sso_redirect_count=1&access_token=**<br><br>**http://www.onlinejacc.org/content/71/19/2275** |
| **Low back pain** | *Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians* (2017) | American College of Physicians (ACP) | **https://annals.org/aim/fullarticle/2603228/noninvasive-treatments-acute-subacute-chronic-low-back-pain-clinical-practice?_ga=2.247433220.1028399561.1575492235-1562492790.1557437793** |
| **Obesity** | *Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions* (September 2018) | U.S. Preventive Services Task Force (USPSTF) | **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/obesity-in-adults-interventions** |
| | *AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults* (November 2013) | American College of Cardiology (ACC)/ American Heart Association (AHA) Task Force on Practice Guidelines and The Obesity Society (TOS) | **http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437739.71477.ee** |
| **Oppositional defiant disorder (ODD)** | *Common Questions About Oppositional Defiant Disorder* (April 2016) | American Academy of Family Physicians (AAFP) | **https://www.aafp.org/afp/2016/0401/p586.pdf** |

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| **Post-traumatic stress disorder (PTSD)** | *Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults* (February 2017) | American Psychological Association (APA) | **https://www.apa.org/ptsd-guideline** |
| | *VA/DOD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder* (V3.2017) | Department of Veterans Affairs Department of Defense: The Management of Posttraumatic Stress Disorder Work Group | **https://www.healthquality.va.gov/guidelines/MH/ptsd** |
| | *PTSD Screening Instruments* | Department of Veterans Affairs: PTSD: National Center for PTSD | **https://www.ptsd.va.gov/professional/assessment/screens/index.asp** |
| **Rheumatoid arthritis** | *American College of Rheumatology: Referral Guidelines* (August 2015) | American College of Rheumatology (ACR) | **https://www.rheumatology.org/Portals/0/Files/Referral%20Guidelines.pdf** |
| | *2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis* (October 2015) | | **https://www.rheumatology.org/Portals/0/Files/ACR%202015%20RA%20Guideline.pdf** |
| **Schizophrenia** | *Treatment Guidelines: Schizophrenia* | Page maintained by the College of Psychiatric & Neurologic Pharmacists (CPNP). Sources include, but not limited to:<br>• Agency for Health Research and Quality (AHRQ)<br>• American Academy of Child & Adolescent Psychiatry<br>• American Psychiatric Association (APA)<br>• Canadian Psychiatric Association<br>• National Institute for Health and Clinical Excellence (NICE) Guidelines | **https://cpnp.org/guideline/external/schizophrenia** |

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|---|---|---|---|
| **Sickle cell anemia** | Evidence-Based Management of Sickle Cell Disease: Expert Panel Report (September 2014) | National Heart, Lung, Blood Institute (NHLBI) | **https://www.nhlbi.nih.gov/health-topics/evidence-based-management-sickle-cell-disease** |
| **Suicide risk** | *SAFE-T: Suicide Assessment Five Step Evaluation and Triage* | Suicide Prevention Resource Center (SPRC) | **https://www.sprc.org/resources-programs/suicide-assessment-five-step-evaluation-and-triage-safe-t-pocket-card** |
| | *Assessment and Management of Patients at Risk for Suicide* (2019) | Veterans Administration/ Department of Defense (VA/DoD) | **https://www.healthquality.va.gov/guidelines/mh/srb/index.asp** |
| **Surgery** | *Surgical technical evidence review for gynecologic surgery conducted for the Agency for Healthcare Research and Quality Safety Program for Improving Surgical Care and Recovery* (December 2018) | Agency for Healthcare Research and Quality (AHRQ) | **https://www.ajog.org/article/S0002-9378(18)30583-0/pdf** |
| | *Surgical Technical Evidence Review for Colorectal Surgery Conducted for the AHRQ Safety Program for Improving Surgical Care and Recovery* (October 2017) | AHRQ | **https://www.ncbi.nlm.nih.gov/pubmed/28797562** |
| | *Surgical Technical Evidence Review for Elective Total Joint Replacement Conducted for the AHRQ Safety Program for Improving Surgical Care and Recovery* (February 2018) | AHRQ | **https://journals.sagepub.com/doi/pdf/10.1177/2151458518754451** |

| Condition/disease | Guideline title | Recognized source(s) | URL |
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| **Trauma care** | *A Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services* (2014)<br><br>*Trauma-Informed Care in Behavioral Health Services: Treatment Improvement Protocol (TIP) Series* | Substance Abuse and Mental Health Services Administration (SAMHSA) | **https://store.samhsa.gov/product/Trauma-Informed-Care-in-Behavioral-Health-Services/SMA15-4420**<br><br>**https://store.samhsa.gov/?f[0]=series:5568** |
| **Infectious disease** **Return to Table of Contents** | | | |
| **Chlamydia/Human Papillomavirus (HPV)** | *Sexually Transmitted Diseases Treatment Guidelines* (June 2015) | Center for Disease Control and Prevention (CDC) | **https://www.cdc.gov/std/tg2015/tg-2015-print.pdf** |
| **Hepatitis B** | *AASLD Guidelines for Treatment of Chronic Hepatitis B* (August 2015)<br><br>*Update on Prevention, Diagnosis, and Treatment of Chronic Hepatitis B: AASLD 2018 Hepatitis B Guidance* (Jan 2018) | American Association for the Study of Liver Diseases (AASLD) | **https://www.aasld.org/sites/default/files/2019-06/Terrault_et_al-2016-Hepatology.pdf**<br><br>**https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5975958/pdf/nihms957253.pdf** |
| **Hepatitis C** | *HCV Guidance: Recommendations for Testing, Managing and Treating Hepatitis C* | Infectious Diseases Society of America (IDSA)/American Association for the Study of Liver Disease (AASLD) | **http://www.hcvguidelines.org/** |
| | *Guidelines for the Screening, Care and Treatment of Persons with Chronic Hepatitis C Infection* (April 2016) | World Health Organization (WHO) | **http://apps.who.int/iris/bitstream/handle/10665/205035/9789241549615_eng.pdf;jsessionid=569946A6B8399B8CED0D09D7F7A9BD3C?sequence=1** |
| **HIV/AIDS** | *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 Infectious Diseases Society of America (IDSA) | **https://www.idsociety.org/globalassets/idsa/practice-guidelines/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.pdf** |

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|---|---|---|---|
| **HIV/AIDS (cont.)** | *Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States* (December 2014) | Centers of Disease Control and Prevention (CDC) | **https://stacks.cdc.gov/view/cdc/44064** |
| | *2017 HIVMA of IDSA Clinical Practice Guideline for the Management of Chronic Pain in Patients Living With HIV* (September 2017) | Infectious Diseases Society of America | **https://www.idsociety.org/globalassets/idsa/practice-guidelines/2017-hivma-of-idsa-clinical-practice-guideline-for-the-management-of-chronic-pain-in-patients-living-with-hiv.pdf** |
| | *HIV and Adolescents: Guidance for HIV testing and counselling and care for adolescents living* with HIV (2013) | World Health Organization (WHO) | **http://apps.who.int/iris/bitstream/handle/10665/94334/9789241506168_eng.pdf?sequence=1** |
| **Pediatric/adolescent health (See Adult health — Bipolar Disorder for resources for bipolar disorder in the pediatric and adolescent population)** **Return to Table of Contents** | | | |
| **Attention Deficit Hyperactivity Disorder (ADHD)** | *Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/ Hyperactivity Disorder in Children and Adolescents* (October 2019) | American Academy of Pediatrics (AAP) | **https://pediatrics.aappublications.org/content/144/4/e20192528** |
| **Autism** | *Practice parameter: Screening and diagnosis of autism* (Reaffirmed August 2014) | American Academy of Neurology (AAN) and the Child Neurology Society (CNS) | **https://n.neurology.org/content/neurology/55/4/468.full.pdf** |
| | *Identification Evaluation and Management of Children With Autism Spectrum Disorder* (January 2020) | American Academy of Pediatrics (AAP) | **https://pediatrics.aappublications.org/content/pediatrics/early/2019/12/15/peds.2019-3447.full.pdf** |

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| **Celiac disease** | *Guideline for the Diagnosis and Treatment of Celiac Disease in Children: Recommendations of the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition* (January 2005) | North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition (NASPGHAN) | **http://www.naspghan.org/files/documents/pdfs/position-papers/celiac_guideline_2004_jpgn.pdf** |
| **Depression** | *Depression in Children and Adolescents: Screening* (February 2016) | U.S. Preventive Services Task Force (USPSTF) | **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-children-and-adolescents-screening** |
| | *Depression in children and young people: identification and management* (updated June 2019) | National Institute for Health and Care Excellence (NICE) | **https://www.nice.org.uk/guidance/ng134** |
| **Hypertension in children and adolescents** | *Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents* (September 2017) | American Academy of Pediatrics (AAP) | **http://pediatrics.aappublications.org/content/pediatrics/140/3/e20171904.full.pdf** |
| **Obesity** | *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) | **http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full.pdf** |
| | *Clinical Report: The Role of the Pediatrician in Primary Prevention of Obesity* (July 2015) | American Academy of Pediatrics (AAP) | **http://pediatrics.aappublications.org/content/early/2015/06/23/peds.2015-1558** |
| **Oppositional defiant disorder (ODD)** | *Fifty years of preventing and treating childhood behavior disorders: a systematic review to inform policy and practice* (April 2017) | National Institute of Health (NIH) PubMed | **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5950520/** |

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|---|---|---|---|
| **Pharmacologic monitoring of antipsychotics** | Canadian Alliance for Monitoring Effectiveness and Safety of Antipsychotics in Children (CAMESA) Guidelines (2011) | Canadian Institutes of Health Research | **http://camesaguideline.org/#:~:text=The%20Canadian%20Alliance%20for%20Monitoring%20Effectiveness%20and%20Safety%20of%20Antipsychotic,Canadian%20Institutes%20of%20Health%20Research.** |
| **Substance use** **Return to Table of Contents** | | | |
| **Substance use** | *Medication-Assisted Treatment of Adolescents With Opioid Use Disorders* (September 2016) | American Academy of Pediatrics (AAP) | **http://pediatrics.aappublications.org/content/early/2016/08/18/peds.2016-1893** |
| | *American Society of Addiction Medicine Consensus Statement — Appropriate Use of Drug Testing in Clinical Addiction Medicine (Reviewed December* 2019) | American Society of Addiction Medicine | **https://www.asam.org/docs/default-source/quality-science/appropriate_use_of_drug_testing_in_clinical-1-(7).pdf?sfvrsn=2** |
| | *Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions* (November 2018) | U.S. Preventive Services Task Force (USPSTF) | **https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions** |
| | *CDC Guideline for Prescribing Opioids for Chronic Pain — United States* (March 2016) | Centers for Disease Control and Prevention (CDC) | **http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm** |
| | *American Society of Addiction Medicine Clinical Practice Guideline on Alcohol Withdrawal Management* (2020) | American Society of Addiction Medicine | **https://www.asam.org/docs/default-source/quality-science/awg-3-20-20.pdf?sfvrsn=d87852c2_2** |
| | *American Psychiatric Association Practice Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder* (Reviewed 2020) | American Psychiatric Association | **https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9781615371969** |

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| **Substance use (cont.)** | *American Pain Society and College on Problems of Drug Dependence Methadone Safety: A Clinical Practice Guideline from the American Pain Society and College on Problems of Drug Dependence, in Collaboration with the Heart Rhythm Society* (July 2018) | American Pain Society and College on Problems of Drug Dependence | **https://www.sciencedirect.com/science/article/abs/pii/S1526590014005227?via%3Dihub** |
| **Cigarette cessation** | *Medication-Assisted Treatment (MAT)* (Last Updated February 2018 | Substance Abuse Mental Health Services Administration (SAMHSA) | **https://www.samhsa.gov/medication-assisted-treatment** |
| | Relearn Life Without Cigarettes | National Alliance for Tobacco Cessation (NATC) | **https://www.becomeanex.org** |
| | Identifying and Treating Patients Who Use Tobacco (July 2017) | U.S. Department of Health and Human Services | **https://millionhearts.hhs.gov/files/Tobacco-Cessation-Action-Guide.pdf** |
| | *ACC Expert Consensus Decision Pathway on Tobacco Cessation Treatment* (2018) | American College of Cardiology (ACC) | **https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2018/12/04/16/10/2018-acc-expert-consensus-decision-pathway-on-tobacco** |
| **Electronic cigarettes** | *Electronic Cigarettes* | Centers for Disease Control and Prevention (CDC) | **https://www.cdc.gov/tobacco/basic_information/e-cigarettes/index.htm** |
| **All states offer free smoking cessation telephone quit line services. Dialing 1-800-QUIT NOW (1-800-784-8669) will connect the caller to their state quit line.** | | | |
| **Women's health** **Return to table of contents** | | | |
| **Routine antepartum care** | *American Academy of Pediatrics, Guidelines for Perinatal Care,* 8th edition (September 2017) | American Academy of Pediatrics (AAP) & American Congress of Obstetrics and Gynecology (ACOG) | **https://shop.aap.org/guidelines-for-perinatal-care-8th-edition-ebook/**<br><br>Members only |
| **Preventive care** | *Women's Preventive Services Guidelines* (Last Reviewed 2017) | Health Resources and Services Administration (HRSA) | **https://www.hrsa.gov/womens-guidelines-2016/index.html** |
| **Cancer screening** | *Women's Health Care Physicians: Cervical Cancer FAQs* (December 2015) | American Congress of Obstetrics and Gynecology (ACOG) | **https://www.acog.org/Patients/FAQs/Cervical-Cancer** |
| | *Cervical Cancer: Screening* (August 2018) | U.S. Preventive Services Task Force (USPSTF) | **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening** |

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|---|---|---|---|
| **Diabetes and pregnancy** | *Management of Diabetes in Pregnancy* (January 2019) | American Diabetes Association (ADA) | **http://care.diabetesjournals.org/content/42/Supplement_1/S165** |
| | *Gestational Diabetes Mellitus, Screening* (January 2014) | United States Preventive Services Task Force (USPSTF) | **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/gestational-diabetes-mellitus-screening?ds=1&s=gestational%20diabetes** |
| | Gestational Diabetes | American Congress of Obstetrics and Gynecology (ACOG) | **http://www.acog.org/Search?Keyword=gestational+diabetes** |
| | *Postpartum Screening for Abnormal Glucose Tolerance in Women Who Had Gestational Diabetes Mellitus* | American Congress of Obstetrics and Gynecology (ACOG) | **http://www.acog.org/Search?Keyword=Postpartum+Screening+for+Abnormal+Glucose+Tolerance+in+Women+Who+Had+Gestational+Diabetes+Mellitus&Topics=43d4646b-dc34-4c12-abeb-bb516387312f**<br><br>Members only |
| **Obstetrical care** | *Guidelines for Antenatal Care* | American Congress of Obstetrics and Gynecology (ACOG) | **https://www.acog.org/Search?Keyword=antenatal&Topics=906bff1e-0656-4579-a7df-4a22f9bce483** |
| | *WHO recommendations for Prevention and treatment of pre-eclampsia and eclampsia* (2011) | World Health Organization (WHO) | **http://whqlibdoc.who.int/publications/2011/9789241548335_eng.pdf** |
| | *Committee Opinion 455. Magnesium Sulfate Before Anticipated Preterm Birth for Neuroprotection* (Reaffirmed 2020) | American Congress of Obstetrics and Gynecology (ACOG)/Society for Maternal Fetal Health (SMFH) | **https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Magnesium-Sulfate-Before-Anticipated-Preterm-Birth-for-Neuroprotection** |
| | *Pre-Gestational Diabetes Mellitus Number 201* (December 2018) | American Congress of Obstetrics and Gynecology (ACOG) | **https://www.acog.org/Search?Keyword=pregestational+diabetes**<br><br>Members only |
| | *Management of Preterm Labor Number 171* (Reaffirmed 2018) | American Congress of Obstetrics and Gynecology (ACOG) | **http://www.acog.org/Search?Keyword=management+of+preterm+labor**<br><br>Members only |
| | *Chronic Hypertension in Pregnancy* (January 2019) | American Congress of Obstetrics and Gynecology (ACOG) | **https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2019/01/chronic-hypertension-in-pregnancy**<br><br>Members only |

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| **Obstetrical care** | *Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice. Number 633* (Reaffirmed 2018) | American Congress of Obstetricians and Gynecologists (ACOG) | **https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/Alcohol-Abuse-and-Other-Substance-Use-Disorders-Ethical-Issues-in-Obstetric-and-Gynecologic-Practice** |
| | *Guidelines for the identification and management of substance use and substance use disorders in pregnancy* (2014) | World Health Organization (WHO) | **http://apps.who.int/iris/bitstream/10665/107130/1/9789241548731_eng.pdf?ua=1** |
| | *Substance Abuse and Mental Health Services Association Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants* (May 2018) | Substance Abuse and Mental Health Services Association | **https://store.samhsa.gov/sites/default/files/d7/priv/sma18-5054.pdf** |
| **Smoking cessation during pregnancy** | *Tobacco and Nicotine Cessation During Pregnancy ACOG. Number 807* (May 2020) | American Congress of Obstetrics and Gynecology (ACOG) | **https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/05/tobacco-and-nicotine-cessation-during-pregnancy** |
| | *Need Help Putting Out That Cigarette?* | American Congress of Obstetrics and Gynecology (ACOG) | **http://www.tobacco-cessation.org/PDFs/NeedHelpBooklet.pdf** |
| | *Smoking Cessation for Pregnancy and Beyond: A Virtual Clinic, an Innovative Web-Based Training for Healthcare Professionals* | Dartmouth Medical School | **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4394722** |

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Clinical Review & Education

JAMA | US Preventive Services Task Force | RECOMMENDATION STATEMENT

# Screening and Behavioral Counseling Interventions to Reduce Unhealthy Alcohol Use in Adolescents and Adults

## US Preventive Services Task Force Recommendation Statement

US Preventive Services Task Force

**IMPORTANCE** Excessive alcohol use is one of the most common causes of premature mortality in the United States. From 2006 to 2010, an estimated 88 000 alcohol-attributable deaths occurred annually in the United States, caused by both acute conditions (eg, injuries from motor vehicle collisions) and chronic conditions (eg, alcoholic liver disease). Alcohol use during pregnancy is also one of the major preventable causes of birth defects and developmental disabilities.

**OBJECTIVE** To update the US Preventive Services Task Force (USPSTF) 2013 recommendation on screening for unhealthy alcohol use in primary care settings.

**EVIDENCE REVIEW** The USPSTF commissioned a review of the evidence on the effectiveness of screening to reduce unhealthy alcohol use (defined as a spectrum of behaviors, from risky drinking to alcohol use disorder, that result in increased risk for health consequences) morbidity, mortality, or risky behaviors and to improve health, social, or legal outcomes; the accuracy of various screening approaches; the effectiveness of counseling interventions to reduce unhealthy alcohol use, morbidity, mortality, or risky behaviors and to improve health, social, or legal outcomes; and the harms of screening and behavioral counseling interventions.

**FINDINGS** The net benefit of screening and brief behavioral counseling interventions for unhealthy alcohol use in adults, including pregnant women, is moderate. The evidence is insufficient to assess the balance of benefits and harms of screening and brief behavioral counseling interventions for unhealthy alcohol use in adolescents.

**CONCLUSIONS AND RECOMMENDATION** The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use. (B recommendation) The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and brief behavioral counseling interventions for alcohol use in primary care settings in adolescents aged 12 to 17 years. (I statement)

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The US Preventive Services Task Force (USPSTF) makes recommendations about the effectiveness of specific clinical preventive services for patients without obvious related signs or symptoms.

It bases its recommendations on the evidence of both the benefits and harms of the service and an assessment of the balance. The USPSTF does not consider the costs of providing a service in this assessment.

The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision making to the specific patient or situation. Similarly, the USPSTF notes that policy and coverage decisions involve considerations in addition to the evidence of clinical benefits and harms.

## Summary of Recommendations and Evidence

The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use (B recommendation) (**Figure 1**).

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and brief behavioral counseling interventions for alcohol use in primary care settings in adolescents aged 12 to 17 years. (I statement)

See the Clinical Considerations section for suggestions for practice regarding the I statement.

## Rationale

### Importance

The USPSTF uses the term "unhealthy alcohol use" to define a spectrum of behaviors, from risky drinking to alcohol use disorder (AUD) (eg, harmful alcohol use, abuse, or dependence) (**Table**)[1]. "Risky" or" hazardous" alcohol use means drinking more than the recommended daily, weekly, or per-occasion amounts, resulting in increased risk for health consequences but not meeting criteria for AUD.[2] The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines "risky use" as exceeding the recommended limits of 4 drinks per day (56 g/d based on the US standard of 14 g/drink) or 14 drinks per week (196 g/d) for healthy adult men aged 21 to 64 years or 3 drinks per day or 7 drinks per week (42 g/d or 98 g/week) for all adult women of any age and men 65 years or older.[2]

A standard drink is defined as 12.0 oz of beer (5% alcohol), 5.0 oz of wine (12% alcohol), or 1.5 oz of liquor (40% alcohol).[2] The American Society of Addiction Medicine (ASAM) defines "hazardous use" as alcohol use that increases the risk of future negative health consequences.[3] The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*) defines the severity of AUD (mild, moderate, or severe) based on the number of criteria met.[4] Previous versions of the *DSM-5* had separate diagnoses for alcohol abuse and alcohol dependence, but it no longer separates these diagnoses.[1] Currently, there is no firm consensus worldwide regarding the definition of risky drinking. In addition, the definition of a standard drink differs by country.[1] Any alcohol use is considered unhealthy in pregnant women and adolescents.[1] In adolescents, the definition of moderate- or high-risk alcohol use varies by age, based on days of use per year.[5]

Excessive alcohol use is one of the most common causes of premature mortality in the United States. From 2006 to 2010, an estimated 88 000 alcohol-attributable deaths occurred annually in the United States, caused by both acute conditions (eg, injuries from motor vehicle collisions) and chronic conditions (eg, alcoholic liver disease).[1,6] Alcohol use during pregnancy is also one of the major preventable causes of birth defects and developmental disabilities.[7]

### Detection

The USPSTF found adequate evidence that numerous brief screening instruments can detect unhealthy alcohol use with acceptable sensitivity and specificity in primary care settings.

### Benefits of Early Detection and Behavioral Counseling Interventions

The USPSTF found no studies that directly evaluated whether screening for unhealthy alcohol use in primary care settings in adolescents and adults, including pregnant women, leads to reduced unhealthy alcohol use; improved risky behaviors; or improved health, social, or legal outcomes.

The USPSTF found adequate evidence that brief behavioral counseling interventions in adults who screen positive are associated with reduced unhealthy alcohol use. There were reductions in both the odds of exceeding recommended drinking limits and heavy use episodes at 6- to 12-month follow-up. In pregnant women, brief counseling interventions increased the likelihood that women remained abstinent from alcohol use during pregnancy. The magnitude of these benefits is moderate. Epidemiologic literature links reductions in alcohol use with reductions in risk for morbidity and mortality and provides indirect support that reduced alcohol consumption may help improve some health outcomes.[1,8]

The USPSTF found inadequate evidence that brief behavioral counseling interventions in adolescents were associated with reduced alcohol use.

### Harms of Screening and Behavioral Counseling Interventions

The USPSTF bounds the harms of screening and brief behavioral counseling interventions for unhealthy alcohol use in adults, including pregnant women, as small to none, based on the likely minimal harms of the screening instruments, the noninvasive nature of the interventions, and the absence of reported harms in the evidence on behavioral interventions. When direct evidence is limited, absent, or restricted to select populations or clinical scenarios, the USPSTF may place conceptual upper or lower bounds on the magnitude of benefit or harms.

The USPSTF found inadequate evidence on the harms of screening and brief behavioral counseling interventions for alcohol use in adolescents.

### USPSTF Assessment

The USPSTF concludes with moderate certainty that screening and brief behavioral counseling interventions for unhealthy alcohol use in the primary care setting in adults 18 years or older, including pregnant women, is of moderate net benefit.

Figure 1. USPSTF Grades and Levels of Evidence

What the USPSTF Grades Mean and Suggestions for Practice

| Grade | Definition | Suggestions for Practice |
|---|---|---|
| A | The USPSTF recommends the service. There is high certainty that the net benefit is substantial. | Offer or provide this service. |
| B | The USPSTF recommends the service. There is high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial. | Offer or provide this service. |
| C | The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small. | Offer or provide this service for selected patients depending on individual circumstances. |
| D | The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. | Discourage the use of this service. |
| I statement | The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined. | Read the Clinical Considerations section of the USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms. |

USPSTF Levels of Certainty Regarding Net Benefit

| Level of Certainty | Description |
|---|---|
| High | The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies. |
| Moderate | The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as<br>the number, size, or quality of individual studies.<br>inconsistency of findings across individual studies.<br>limited generalizability of findings to routine primary care practice.<br>lack of coherence in the chain of evidence.<br>As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion. |
| Low | The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of<br>the limited number or size of studies.<br>important flaws in study design or methods.<br>inconsistency of findings across individual studies.<br>gaps in the chain of evidence.<br>findings not generalizable to routine primary care practice.<br>lack of information on important health outcomes.<br>More information may allow estimation of effects on health outcomes. |
| The USPSTF defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service. | |

USPSTF indicates US Preventive Services Task Force.

The USPSTF concludes that the evidence is insufficient to determine the benefits and harms of screening for unhealthy alcohol use in the primary care setting in adolescents aged 12 to 17 years.

## Clinical Considerations

### Patient Population Under Consideration

The "B" recommendation applies to adults 18 years or older, including pregnant women. The "I" statement applies to adolescents aged 12 to 17 years (**Figure 2**). These recommendations do not apply to persons who have a current diagnosis of or who are seeking evaluation or treatment for alcohol abuse or dependence.

### Screening Tests

Of the available screening tools, the USPSTF determined that 1-item to 3-item screening instruments have the best accuracy for assessing unhealthy alcohol use in adults 18 years or older.[1] These instruments include the abbreviated Alcohol Use Disorders Identification Test–Consumption (AUDIT-C) and the NIAAA-recommended Single Alcohol Screening Question (SASQ).

Table. Terms and Definitions of Unhealthy Alcohol Use

| Term | Source | Definition |
|---|---|---|
| Low-risk use/lower-risk use | ASAM | Consumption of alcohol below the amount identified as hazardous and in situations not defined as hazardous |
| Risky/at-risk use | NIAAA | Consumption of alcohol above the recommended daily, weekly, or per-occasion amounts but not meeting criteria for alcohol use disorder<br><br>For all women and men 65 y or older: No more than 3 drinks/d and no more than 7 drinks/wk<br><br>For men (21-64 y): No more than 4 drinks/d and no more than 14 drinks/wk<br><br>Should avoid alcohol completely: Adolescents, women who are pregnant or trying to get pregnant, and adults who plan to drive a vehicle or operate machinery, are taking medication that interacts with alcohol, or have a medical condition that can be aggravated by alcohol<br><br>For adolescents: NIAAA defines moderate- and high-risk use based on days of alcohol use in the past year, by age group:<br>Moderate risk:<br>Ages 12-15 y: 1 d/y<br>Ages 16-17 y: 6 d/y<br>Age 18 y: 12 d/y<br>Highest risk:<br>Age 11 y: 1 d<br>Ages 12-15 y: 6 d<br>Age 16 y: 12 d<br>Age 17 y: 24 d<br>Age 18 y: 52 d |
| Unhealthy use | ASAM | Any alcohol use that increases the risk or likelihood of health consequences (hazardous use [see below]) or has already led to health consequences (harmful use [see below]) |
| Hazardous use | WHO | A pattern of substance use that increases the risk of harmful consequences; in contrast to harmful use, hazardous use refers to patterns of use that are of public health significance, despite the absence of a current alcohol use disorder in the individual user |
| | ASAM | Alcohol use that increases the risk or likelihood of health consequences; does not include alcohol use that has already led to health consequences |
| Harmful use | WHO | A pattern of drinking that is already causing damage to health; the damage may be either physical (eg, liver damage from chronic drinking) or mental (eg, depressive episodes secondary to drinking)<br><br>The description for *ICD-10* code F10.1, also labeled "Alcohol Abuse" in the 2018 *ICD-10-CM* codebook |
| | ASAM | Consumption of alcohol that results in health consequences in the absence of addiction |
| Alcohol use disorder | *DSM-5* | A maladaptive pattern of alcohol use leading to clinically significant impairment or distress, as manifested by 2 (or more) of the following, occurring within a 12-mo period:<br>1. Having times when the patient drank more, or longer, than intended<br>2. More than once wanted to cut down or stop, tried it, but could not<br>3. Spending a lot of time drinking or being sick/getting over the aftereffects of drinking<br>4. Wanting to drink so badly that they could not think of anything else<br>5. Found that drinking (or being sick from drinking) often interfered with taking care of home or family responsibilities, caused problems at work, or caused problems at school<br>6. Continuing to drink even though it was causing trouble with family and friends<br>7. Given up or cut back on activities that were important or interesting in order to drink<br>8. More than once gotten into situations while or after drinking that increased the chances of getting hurt (eg, driving, swimming, unsafe sexual behavior)<br>9. Continued to drink even though it was causing depression or anxiety, other health problems, or causing memory blackouts<br>10. Having to drink much more than previously in order to get the desired effect, or finding that the usual number of drinks had much less effect than previously<br>11. Experiencing the symptoms of withdrawal after the effects of alcohol were wearing off, such as trouble sleeping, shakiness, restlessness, nausea, sweating, racing heart, or seizure<br>Severity is determined based on the number of symptoms present:<br>Mild: 2-3 symptoms<br>Moderate: 4-5 symptoms<br>Severe: ≥6 symptoms |
| Binge drinking/ heavy drinking episodes[a] | NIAAA | A pattern of drinking that brings blood alcohol concentration levels to 0.08 g/dL, which typically occurs after 4 drinks for women and 5 drinks for men—in about 2 h |
| | SAMHSA | Drinking ≥5 alcoholic drinks on the same occasion on at least 1 d in the past 30 d |
| Heavy drinking | SAMHSA | Drinking ≥5 drinks on the same occasion on each of ≥5 d in the past 30 d |

(continued)

The abbreviated AUDIT-C has good sensitivity and specificity for detecting the full spectrum of unhealthy alcohol use across multiple populations.[1,9] The AUDIT-C has 3 questions about frequency of alcohol use, typical amount of alcohol use, and occasions of heavy use, and takes 1 to 2 minutes to administer. The USAUDIT and USAUDIT-C are based on US standards. Preliminary evidence (1 study) suggests that the USAUDIT (specifically the USAUDIT-C) may be more valuable in identifying at-risk college drinkers.[10] The SASQ also has adequate sensitivity and specificity across the unhealthy alcohol use spectrum and requires less than 1 minute to administer, asking "How many times in the past year have you had 5 [for men] or 4 [for women and all adults older than 65 years]

Table. Terms and Definitions of Unhealthy Alcohol Use (continued)

| Term | Source | Definition |
|---|---|---|
| Alcohol dependence | *WHO/ICD-10-CM* | ≥3 of the following at some time during the previous year:<br>1. A strong desire or sense of compulsion to take the substance<br>2. Difficulties in controlling substance-taking behavior in terms of its onset, termination, or levels of use<br>3. A physiological withdrawal state when substance use has ceased or been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms<br>4. Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol- and opiate-dependent individuals who may take daily doses sufficient to incapacitate or kill nontolerant users)<br>5. Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance, or to recover from its effects<br>6. Persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm |

Abbreviations: ASAM, American Society of Addiction Medicine; *DSM-5*, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*; *ICD-10-CM*, *International Classification of Diseases, Tenth Revision, Clinical Modification*; NIAAA, National Institute on Alcohol Abuse and Alcoholism; SAMHSA, Substance Abuse and Mental Health Services Administration; WHO, World Health Organization.

[a] According to the American Society of Addiction Medicine, the preferred term is "heavy drinking episode."

Figure 2. Clinical Summary: Screening and Behavioral Counseling Interventions in Primary Care to Reduce Unhealthy Alcohol Use in Adolescents and Adults

| Population | Adults, including pregnant women | Adolescents |
|---|---|---|
| Recommendation | Screen for unhealthy alcohol use and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions.<br>Grade: B | No recommendation.<br>Grade: I (insufficient evidence) |

| | |
|---|---|
| Screening Tests | Numerous brief screening instruments can detect unhealthy alcohol use with acceptable sensitivity and specificity in primary care settings. One- to 3-item screening instruments have the best accuracy for assessing unhealthy alcohol use in adults 18 years or older. These instruments include the AUDIT-C and the SASQ. |
| Treatments and Interventions | Brief behavioral counseling interventions were found to reduce unhealthy alcohol use in adults 18 years or older, including pregnant women. Effective behavioral counseling interventions vary in their specific components, administration, length, and number of interactions. The USPSTF was unable to identify specific intervention characteristics or components that were clearly associated with improved outcomes. |
| Relevant USPSTF Recommendations | The USPSTF has made recommendations on screening for and interventions to reduce the unhealthy use of other substances, including illicit drugs and tobacco. |

For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, please go to https://www.uspreventiveservicestaskforce.org.

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AUDIT-C, Alcohol Use Disorders Identification Test–Consumption; SASQ, Single Alcohol Screening Question; USPSTF, US Preventive Services Task Force.

or more drinks in a day?"[1,2]. The Cut down, Annoyed, Guilty, Eye-opener (CAGE) tool is well known but only detects alcohol dependence rather than the full spectrum of unhealthy alcohol use.[1,11]

When patients screen positive on a brief screening instrument (eg, SASQ or AUDIT-C), clinicians should ensure follow-up with a more in-depth risk assessment to confirm unhealthy alcohol use and determine the next steps of care. Evidence supports the use of brief instruments with higher sensitivity and lower specificity as initial screening, followed by a longer instrument with greater specificity (eg, AUDIT). The AUDIT has 10 questions: 3 questions covering frequency of alcohol use, typical amount of alcohol use, and occasions of heavy use, and 7 questions on the signs of alcohol dependence and common problems associated with alcohol use (eg, being unable to stop once you start drinking). It requires approximately 2 to 5 minutes to administer.[1,12] If AUDIT is used as an initial screening test, clinicians may use a lower cutoff (such as 3, 4, or 5) to balance sensitivity and specificity in screening for the full spectrum of unhealthy alcohol use.

Screening instruments have also been specifically developed for various populations. Screening tools for pregnant women

include Tolerance, Worried, Eye-opener, Amnesia, Kut down (TWEAK)[13]; Tolerance, Annoyed, Cut down, Eye-opener (T-ACE)[14]; Parents, Partner, Past, Present Pregnancy (4P's Plus)[15]; and Normal drinker, Eye-opener, Tolerance (NET).[16] The NIAAA and American Academy of Pediatrics recommend the Car, Relax, Alone, Forget, Family, Friends, Trouble (CRAFFT) screening instrument for identifying risky substance use in adolescents.[17] The NIAAA also recommends asking patients about their own alcohol use as well as their friends' alcohol use.[5] The Comorbidity Alcohol Risk Evaluation Tool (CARET) is used in older adults.[18] The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST), developed by the World Health Organization (WHO), screens for substance and alcohol use in adults.[1,19]

## Behavioral Counseling Interventions

Behavioral counseling interventions for unhealthy alcohol use vary in their specific components, administration, length, and number of interactions. Thirty percent of the interventions reviewed by the USPSTF were web-based. Nearly all of the interventions consisted of 4 or fewer sessions; the median number of sessions was 1 (range, 0-21). The median length of time of contact was 30 minutes (range, 1-600 minutes). Most of the interventions had a total contact time of 2 hours or less.[1] Primary care settings often used the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach. Interventions targeting adults other than college students (including pregnant and postpartum women) were more likely to take place in primary care settings, have multiple sessions, and involve a primary care team.[1] Most interventions involved giving general feedback to participants (eg, how their drinking fits with recommended limits, or how to reduce alcohol use). The most commonly reported intervention component was use of personalized normative feedback sessions, in which participants were shown how their alcohol use compares with that of others; more than half of the included trials and almost all trials in young adults used this technique.[1] Most trials in young adults involved 1 or 2 in-person or web-based personalized normative feedback sessions in university settings. Personalized normative feedback was often combined with motivational interviewing or more extensive cognitive behavioral counseling. Other cognitive behavioral strategies, such as drinking diaries, action plans, alcohol use "prescriptions," stress management, or problem solving were also frequently used. About one-third of the intervention trials in general and older adult populations involved a primary care team.[1] The USPSTF was unable to identify specific intervention characteristics or components that were clearly associated with improved outcomes.[1]

The USPSTF found no evidence to suggest that patients of different race/ethnicity or lower socioeconomic status have a lower likelihood of benefit from interventions. Effects of interventions were also similar in men and in women.[1]

## Screening Intervals

The USPSTF did not find adequate evidence to recommend an optimal screening interval for unhealthy alcohol use in adults.

## Suggestions for Practice Regarding the I Statement

### Potential Preventable Burden

In 2016, the National Survey on Drug Use and Health reported that an estimated 9.2% of adolescents aged 12 to 17 years drink alcohol and 4.9% had an episode of binge drinking in the last 30 days.[20] Each year, excessive drinking in underage youth leads to more than 4300 deaths.[21] Driving while under the influence of alcohol is particularly hazardous among adolescents. The 2015 Youth Risk Behavior Survey found that about 8% of high school students who drove a car in the last 30 days reported driving after drinking alcohol, and 20% reported riding with a driver who had been drinking.[22] In 2010, 1 in 5 teen drivers involved in a fatal motor vehicle collision had some alcohol in their system, and most had blood alcohol levels higher than the legal limit for adults.[23] An estimated 97 000 students aged 18 to 24 years have reported an alcohol-related sexual assault or date rape; 696 000 students aged 18 to 24 years have been assaulted by another student who was under the influence of alcohol[24,25] An estimated 1 in 4 college students report academic consequences from drinking such as missing class, doing poorly on examinations or papers, falling behind in class, and receiving lower grades.[1,24,26]

### Potential Harms

Possible harms of screening for unhealthy alcohol use include stigma, anxiety, labeling, discrimination, privacy concerns, and interference with the patient-clinician relationship. The USPSTF did not find any evidence that specifically examined the harms of screening for alcohol use in adolescents.

### Current Practice

Research suggests that although a majority of pediatricians and family practice clinicians report providing some alcohol prevention services to adolescent patients, they do not consistently screen and counsel for alcohol misuse.[27] Survey results indicate that screening was more likely if adolescents were older (aged 15 to 17 years).[27] However, the quality of screening practices, tools used, and interventions provided varied widely. Current data on rates of screening are lacking. Reported barriers to screening include time constraints, lack of knowledge about best practices, and lack of services for adolescent patients who screen positive.[1,28]

## Useful Resources

The AUDIT and AUDIT-C, which screen for unhealthy alcohol use in adults 18 years or older, including pregnant women, are available from the Substance Abuse and Mental Health Service Administration (SAMHSA), as well as other resources.[29,30] More information about SASQ and counseling for unhealthy alcohol use is available from the NIAAA.[31] Clinician guides are available from the WHO[32] and the American Academy of Family Physicians.[33] An implementation guide for primary care practices is available from the Centers for Disease Control and Prevention.[34]

The Community Preventive Services Task Force recommends electronic screening and brief interventions to reduce excessive alcohol consumption in adults. It found limited information on the effectiveness of electronic screening and brief interventions in adolescents.[35] The Community Preventive Services Task Force has also evaluated public health interventions (ie, interventions occurring outside of the clinical practice setting) to prevent excessive alcohol consumption.[36]

The USPSTF has made recommendations on screening for and interventions to reduce the unhealthy use of other substances, including illicit drugs[37] and tobacco.[38]

## Other Considerations

### Research Needs and Gaps

The USPSTF has identified several research gaps. Although difficult, conducting a trial with an unscreened comparison group to understand the population-level effects of screening in primary care settings would be valuable. More direct evidence is needed on the harms associated with screening and behavioral interventions. The USPSTF found a preliminary study that evaluated the USAUDIT and USAUDIT-C, recent US adaptations of the AUDIT and AUDIT-C. Further test performance studies are needed to confirm their accuracy in identifying unhealthy alcohol use in various populations. More evidence on important clinical outcomes is needed, such as longer-term morbidity, mortality, health care utilization, and social and legal outcomes. Trials designed a priori to report subgroup effects in diverse populations (eg, by age, sex, race/ethnicity, or baseline severity) would be useful. Limited evidence is available to assess the effects of screening and behavioral counseling in adolescents, and high-quality studies specifically addressing this population are needed. In addition, studies in adolescents are often conducted in school settings, which may not translate to primary care settings. More studies of adolescents in primary care settings are needed.

## Discussion

### Burden of Disease

High-risk drinking increased by almost 30% between 2001-2002 and 2012-2013.[26] In 2016, an estimated 26.2% of adults 18 years or older reported heavy-use (binge drinking) episodes and 6.6% reported heavy drinking within the previous month[20]; an estimated 7.8% of men and 4.2% of women met the criteria for AUD.[20] Unhealthy alcohol use is the third-leading preventable cause of death in the United States.[6,39,40] One of 10 deaths among adults aged 20 to 64 years can be attributed to excessive alcohol use.[6,39,40] In the United States, from 2006 to 2010, an estimated 88 000 deaths each year were attributed to alcohol use, with an estimated 2.5 million years of potential life lost.[6] Of these 88 000 deaths, 44% were from chronic conditions (eg, alcoholic liver disease) and 56% were from acute conditions (eg, injuries from motor vehicle collisions).[6] Excessive alcohol use also contributed to 3.2% to 3.7% of cancer deaths, including breast, gastrointestinal, oral cavity, and neck cancer.[41] Among adolescents aged 12 to 17 years, 9.2% reported being current alcohol users and 4.9% reported heavy use episodes in the previous month. Approximately 488 000 adolescents have AUD (2.4% and 1.5% of female and male adolescents, respectively).[20] In 2005, unhealthy alcohol use in college students aged 18 to 24 years contributed to an estimated death of 1825 students through unintentional injuries (eg, motor vehicle collisions),[25,42] and about 1 in 4 students report that alcohol use contributes to missing or falling behind in classes, low grades, and poor performance on examinations and papers.[25,42] In 2010, excessive alcohol use cost the United States an estimated $249 billion in loss in workplace productivity, health care expenses, criminal justice expenses, and motor vehicle collisions.[43] Alcohol use during pregnancy can result in preterm birth and low birth weight. It is a major preventable cause of birth defects and developmental disabilities, including fetal alcohol spectrum disorders, and affects development of the fetal brain, endocrine system, gastrointestinal tract, heart, kidney, and liver.[7] The 2011-2013 Behavioral Risk Factor Surveillance System survey shows that 1 in 10 pregnant women aged 18 to 44 years reported consuming alcohol in the previous month, and 3.1% participated in binge drinking.[44]

### Scope of Review

The USPSTF commissioned a systematic evidence review to update its 2013 recommendation on screening for unhealthy alcohol use in primary care. In the previous recommendation, the USPSTF used the term "alcohol misuse" to define a wide range of drinking behaviors (eg, risky or hazardous alcohol use, harmful alcohol use, and alcohol abuse or dependence).[45] In accordance with the ASAM, the current recommendation uses the term "unhealthy use" rather than "misuse." The ASAM defines "unhealthy use" as any use of alcohol that increases the risk of health consequences or that has already led to health consequences, including an AUD diagnosis.[1,4] The evidence review examined the effectiveness of screening to reduce unhealthy alcohol use, morbidity, mortality, or risky behaviors and to improve health, social, or legal outcomes; the accuracy of various screening approaches; the effectiveness of counseling interventions to reduce unhealthy alcohol use, morbidity, mortality, or risky behaviors and to improve health, social, or legal outcomes; and the harms of screening and behavioral counseling interventions. The review did not include treatment with medications because medications are used to treat severe AUD and are not routinely used in screen-detected persons. Interventions to prevent alcohol use in adolescents was determined to be out of scope for this review.[1]

### Accuracy of Screening Tests

Forty-five studies (n = 277 881) addressed the accuracy of screening tools; 10 studies in adolescents, 5 in young adults, 27 in general adult populations, 1 in older adults, and 2 in pregnant or postpartum women. Twenty-eight studies were fair quality and 17 were good quality. Most studies took place in the United States (62%), and 51% of the studies recruited patients from primary care settings.[1]

Studies evaluated AUDIT, AUDIT-C, ASSIST, and a variety of 1- or 2-item screening tests for detecting the full spectrum of unhealthy alcohol use. Screening instruments addressed a variety of elements, such as quantity of drinks, drinking frequency, or typical total number of drinks over a specific period (quantity × frequency), and a variety of response categories and cutoffs.[1]

Reference standards were structured diagnostic interviews (eg, Composite International Diagnostic Interview, Alcohol Use Disorder and Associated Disabilities Interview Schedule, or Mini International Neuropsychiatric Interview Plus). Some studies used a diagnostic interview in combination with other instruments (eg, in combination with the ASSIST, to identify the full spectrum of unhealthy alcohol use) or a timeline follow-back interview.[1]

For adults, the AUDIT, AUDIT-C, and 1- or 2-item screening tests had acceptable sensitivity and specificity to detect the full spectrum of unhealthy alcohol use. Studies of the SASQ reported sensitivity of 0.73 to 0.88 (95% CI range, 0.65-0.89) and specificity of 0.74 to 1.00 (95% CI range, 0.69-1.00) for detecting unhealthy alcohol use (4 studies [n = 44 461]). Other 1- or 2-item screening tests generally showed sensitivity of 0.70 or greater. The standard of 6 or more drinks per occasion tended to have decreased sensitivity compared with the standard of 5 (men)/4 (women) or more drinks,

often with nonoverlapping confidence intervals. Other adult populations (young adults, older adults, and pregnant women) had similar results.[1]

Seven studies (n = 8852) evaluating the AUDIT for the detection of unhealthy alcohol use in general adult populations, using the recommended cutoff of higher than 8, reported a wide range of sensitivity (0.38-0.73 [95% CI, 0.33-0.84]) but high specificity (0.89-0.97 [95% CI, 0.84-0.98]). In many studies, sensitivity improved at lower cutoffs. Three studies (n = 2782) conducted in US primary care settings showed better accuracy (sensitivity, 0.64-0.86 [95% CI, 0.57-0.91] and specificity, 0.74-0.94 [95% CI, 0.68-0.95] at cutoffs of 3, 4, or 5).[1]

Sensitivity of the AUDIT-C for detecting unhealthy alcohol use in adults was similar to that of 1- or 2-item screening instruments. In most studies, the range of sensitivity was 0.73 to 0.97 for females (95% CI, 0.62-0.99; 5 studies [n = 2714]) and 0.82 to 1.00 for males (95% CI, 0.75-1.00; 4 studies [n = 1038]) at the standard cutoffs of 3 or higher (female) and 4 or higher (male), but the range of specificity was much wider (0.28-0.91 [95% CI, 0.21-0.93] and 0.34-0.89 [95% CI, 0.25-0.92] for females and males, respectively). Evidence on the use of the AUDIT-C in younger adults, older adults, and pregnant women was lacking.[1]

#### Pregnant Women

No studies among pregnant women reported on the test accuracy of any screening test for alcohol use or the full spectrum of unhealthy alcohol use (eg, AUDIT-C, AUDIT, ASSIST, TWEAK, or T-ACE).[1]

A study in American Indian women reported the test accuracy of 1- or 2-item screening instruments (quantity × frequency) to screen for any alcohol use during pregnancy. At the optimal cutoff, sensitivity was 0.77 (95% CI, 0.68-0.83) and specificity was 0.93 (95% CI, 0.86-0.96).[46]

#### Adolescents

Although multiple studies among adolescents demonstrated good accuracy of 1- or 2-item screening instruments and the AUDIT for detecting AUD, none reported on test accuracy for screening for the full spectrum of unhealthy alcohol use.[1] Only 1 study evaluated the accuracy of detecting unhealthy alcohol use in adolescents. One study (n = 225) in a German high school reported on the test accuracy of the AUDIT-C for detecting the full spectrum of unhealthy alcohol use (males and females combined), with a sensitivity of 0.73 (95% CI, 0.60-0.83) and a specificity of 0.81 (95% CI, 0.74-0.86) at the optimal cutoff of 5 or higher.[47] Evidence to determine whether brief (1- to 3-item) screening instruments or the AUDIT can detect alcohol use in adolescents was lacking.[1]

### Effectiveness of Screening and Behavioral Counseling Interventions

No trials examined the direct effects of screening for unhealthy alcohol use on alcohol use or health, social, or legal outcomes.

#### Alcohol Use and Other Risky Behaviors

Ten good-quality trials and 58 fair-quality trials (n = 36 528) reported on alcohol use and other risky behaviors. The majority of trials (60%) were conducted in the United States. Intervention settings were predominantly in primary care clinics (62%).[1] Two trials were in adolescents, 22 in college-aged or young adults, 29 in general adult populations, 4 in older adults, and 11 in pregnant or postpartum women.[1] Trials were generally limited to study participants who reported a prespecified level of alcohol use on a screening instrument such as the AUDIT. Outcomes were generally reported at 6- to 12-month follow-up or during the late pregnancy/early postpartum period for abstinence during pregnancy. Trials demonstrated high heterogeneity; effect size was not clearly associated with any intervention characteristics. Data on effectiveness in important subpopulations were very limited.[1] The most commonly reported subpopulation analysis (by sex) did not show differences in the effectiveness of the interventions.[1] The most commonly reported alcohol use outcome was number of drinks per week. Among 37 adult trials (n = 15 974), adults in intervention groups reduced the number of drinks per week more than adults in control groups (weighted mean difference between groups in change from baseline, −1.59 [95% CI, −2.15 to −1.03; $I^2$ = 63%). The proportion exceeding recommended drinking limits was reduced (odds ratio [OR], 0.60 [95% CI, 0.53 to 0.67]), as well as the proportion reporting a heavy-use episode (OR, 0.67 [95% CI, 0.58 to 0.77]). Analyses limited to trials conducted in US primary care settings suggest that effects in the most applicable trials were comparable or larger than the overall effect (weighted mean difference, −2.82 [95% CI, −3.87 to −1.76]).[1]

Interventions among adults resulted in an absolute increase of 14% more participants drinking within recommended limits, meaning 7 adults would need to be treated to achieve 1 adult drinking within recommended limits (number needed to treat, 7.2 [95% CI, 6.2 to 11.5]).[1]

Interventions increased the proportion of pregnant women reporting abstinence (OR, 2.26 [95% CI, 1.43 to 3.56]). Based on these results, interventions doubled the odds that women remained abstinent from alcohol during pregnancy (number needed to treat, 6.0 [95% CI, 4.3 to 12.5]).[1] Evidence on the effects of interventions to reduce unhealthy alcohol use in adolescents was limited to 2 trials; both found mixed results for reduced alcohol use.[1]

Benefits continued 24 months or beyond in 4 of 7 trials with longer-term outcomes. Very limited data suggest that benefits from alcohol use interventions can be maintained over 2 to 4 years, including the number of drinks per week and some health outcomes.[1] However, several trials in younger adults found that beneficial effects appeared at 6 months but were no longer statistically significant at 12 months, suggesting that beneficial effects may deteriorate more quickly in younger adults.[1]

Few changes in other behavioral outcomes (eg, drug use, sex after alcohol use, and seeking help for unhealthy alcohol use) were either observed or were rarely reported.[1]

#### Health, Social, and Legal Outcomes

Forty-one good- and fair-quality trials (n = 20 324) reported health, social, and legal outcomes; however, no particular outcomes were commonly reported. In addition, reported outcomes were generally not statistically significant and inconsistently favored the intervention group.[1] In adults, 8 trials reported a statistically nonsignificant reduction in all-cause mortality (OR, 0.64 [95% CI, 0.34 to 1.19]).[1] One good-quality study showed reductions in emergency department visits and controlled substance or liquor violations at 4-year follow-up.[48] Trials in young adults demonstrated a small reduction in alcohol-related consequences (standardized mean difference, −0.06 [95% CI, −0.11 to −0.01]).[1]

### Potential Harms of Screening and Behavioral Counseling Interventions

Potential harms of screening include stigma, labeling, discrimination, privacy concerns, and interference with the patient-clinician relationship.[1] In addition, there may be legal concerns for pregnant women in some states.[49] No studies evaluated the harms of screening for unhealthy alcohol use.

One possible harm of behavioral counseling interventions could be an unexpected paradoxical increase in alcohol consumption. One good-quality and 5 fair-quality trials (n = 3650) reported on harms. There was very limited evidence on intervention harms.[1] Interventions reviewed and discussed above generally reported benefits, including reductions in alcohol consumption. Therefore, paradoxical and theoretical increases in alcohol use with interventions are unlikely.[1]

### Estimate of Magnitude of Net Benefit

Adequate evidence supports a moderate beneficial effect of screening for unhealthy alcohol use followed by brief behavioral counseling interventions in adults. Screening and behavioral counseling interventions in the primary care setting can reduce unhealthy drinking behaviors in adults, including heavy episodic drinking, high daily or weekly levels of alcohol consumption, and exceeding recommended drinking limits. Although the USPSTF found limited specific evidence for pregnant women, it determined that available studies of behavioral counseling interventions for unhealthy alcohol use in pregnant women supported increased likelihood of alcohol abstinence during pregnancy with intervention.

Available studies have not focused on the effects of screening and behavioral counseling interventions on longer-term health outcomes, such as alcohol-related disease or death. However, adequate epidemiologic evidence links reduced levels of alcohol consumption with a reduced risk for morbidity and mortality, providing indirect support that behavioral counseling interventions that reduce acute and sustained alcohol intake levels can help improve some health outcomes of unhealthy alcohol use.[8] A large body of observational evidence also links alcohol use in pregnant women with an increased risk for subsequent birth defects, such as fetal alcohol spectrum disorders.[50,51]

Given the noninvasive nature of screening and behavioral counseling interventions for unhealthy alcohol use, the USPSTF determined the magnitude of harms to be small to none in adults and pregnant women. Therefore, the USPSTF concludes with moderate certainty that the net benefit of screening and brief behavioral counseling interventions for unhealthy alcohol use in adults, including pregnant women, is moderate.

Evidence in adolescents is limited. As such, the USPSTF concludes that the evidence is insufficient to assess the balance of benefits and harms of screening and brief behavioral counseling interventions for unhealthy alcohol use in adolescents.

### Response to Public Comment

A draft version of this recommendation statement was posted for public comment on the USPSTF website from June 5, 2018, to July 2, 2018. Some comments expressed concerns about the lack of discussion of specific populations. In response, the USPSTF added language about the harms of alcohol consumption in adolescents to the Clinical Considerations section and the harms of alcohol use during pregnancy to the Discussion section. The USPSTF also added more useful resources to the Clinical Considerations section. Some comments requested clarification on which screening tools were being discussed; the USPSTF clarified this by adding references.

## Update of Previous Recommendation

This recommendation replaces the 2013 USPSTF recommendation statement on screening and behavioral counseling interventions for alcohol misuse. The term "alcohol misuse," used in the 2013 recommendation, has been replaced by the term "unhealthy alcohol use."

## Recommendations of Others

The US Surgeon General,[52] NIAAA,[2] Centers for Disease Control and Prevention,[34] and ASAM[53] recommend routinely screening adult patients for unhealthy alcohol use and providing them with appropriate interventions, if needed. The US Department of Veterans Affairs recommends annual screening with the AUDIT-C and SASQ.[54] The American Academy of Pediatrics recommends screening all adolescent patients for alcohol use with a formal, validated screening tool (such as the CRAFFT) at every health supervision visit and appropriate acute care visits, and responding to screening results with the appropriate brief intervention and referral if indicated. Pediatricians should become familiar with adolescent SBIRT approaches and their potential for incorporation into universal screening and comprehensive care of adolescents in the medical home.[55] The American College of Obstetricians and Gynecologists[56] and WHO[57] recommend screening all women for unhealthy alcohol use before pregnancy and in their first trimester with a validated tool, and offering a brief intervention to all pregnant women who use alcohol.

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### Protecting Our Community from COVID-19

Along with local organizations like 100 Black Women, Healthy Blue collaborated with Walgreens to make vaccines accessible to every eligible patient in our community. Healthy Blue hosted a mobile health equity clinic at the Capital Area Transit System terminal, giving transit riders twelve and older the opportunity to receive the vaccine. As an added incentive to vaccinate, Healthy Blue arranged for the first 100 families to the event to receive fresh produce and protein boxes from Top Box Louisiana.

# Attachment 2.6.11.6

## Quality Response Template

Healthy Blue

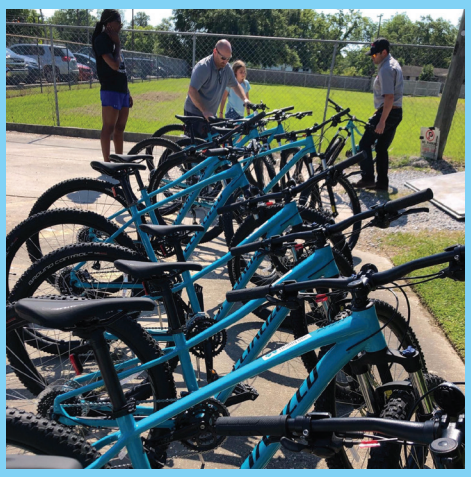
**HEDIS Response Template:** Community Care Health Plan of Lousiana, Inc., dba Healthy Blue

| | | | | | | | Most Recent NCQA Star Rating Summary (Medicaid) Indicate Year: 2019-2020 | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Number | State | Medicaid "HMO" Plan Name | Medicaid Enrollment in July 2021 | NCQA Accreditation | Populations included (e.g., ABD, TANF, Expansion, LTSS) | Benefits provided (e.g., full benefits, behavioral health only, Medicare/Medicaid integrated) | Overall | Consumer Satisfaction | Prevention | Treatment |
| 1 | LA | Community Care Health Plan of Louisiana, Inc. dba Healthy Blue | 341,879 | Accredited | Medicaid (TANF, ABD/SPD/SSI, Expansion), CHIP | Full Benefits | 3.0 | 3.5 | 3.0 | 2.5 |
| 2 | CA | Blue Cross of California Partnership Plan | 1,324,480 | Accredited | Medicaid (TANF, ABD/SPD/SSI, Expansion) | Full Benefits | 3.0 | 1.5 | 3.0 | 2.5 |
| 3 | FL | Simply Healthcare Plans, Inc. | 696,608 | Accredited | Medicaid (TANF, ABD/SPD/SSI), CHIP | Full Benefits | 3.5 | 4.0 | 3.0 | 3.0 |
| 4 | GA | AMGP Georgia Managed Care Company, Inc., dba Amerigroup Community Care | 538,788 | Accredited | Medicaid (TANF), CHIP | Full Benefits | 3.0 | 3.5 | 3.0 | 2.5 |
| 5 | IA | Amerigroup Iowa, Inc. | 437,234 | Accredited | Medicaid (TANF, ABD/SPD/SSI, Expansion), CHIP | Full Benefits | 4.0 | 3.5 | 3.0 | 3.0 |
| 6 | IN | Anthem Insurance Companies, Inc. ,dba Anthem Blue Cross and Blue Shield of Indiana | 661,488 | Accredited | Medicaid (TANF, ABD/SPD/SSI, Expansion), CHIP | Full Benefits | 3.5 | 2.5 | 3.5 | 3.0 |
| 7 | KY | Anthem Kentucky Managed Care Plan, Inc. | 162,695 | Accredited | Medicaid (TANF, ABD/SPD/SSI, Expansion), CHIP | Full Benefits | 3.5 | 3.5 | 2.5 | 3.0 |
| 8 | MD | Amerigroup Maryland, Inc. | 312,092 | Accredited | Medicaid (TANF, ABD/SPD/SSI, Expansion), CHIP | Full Benefits | 3.5 | 2.5 | 4.0 | 3.0 |
| 9 | NJ | Amerigroup New Jersey, Inc. | 236,095 | Accredited | Medicaid (TANF, ABD/SPD/SSI, Expansion), CHIP | Full Benefits | 3.5 | 2.0 | 3.5 | 3.0 |
| 10 | NV | Community Care Health Plan of Nevada, Inc., dba Anthem Blue Cross and Blue Shield Healthcare Solutions | 258,654 | Accredited | Medicaid (TANF, Expansion), CHIP | Full Benefits | 3.0 | 1.5 | 3.0 | 2.5 |
| 11 | NY | HealthPlus HP, LLC | 483,653 | Accredited | Medicaid (TANF, ABD/SPD/SSI), CHIP | Full Benefits | 4.0 | 2.5 | 4.0 | 3.5 |
| 12 | TN | Amerigroup Tennessee, Inc. | 485,016 | Accredited | Medicaid (TANF, ABD/SPD/SSI), CHIP | Full Benefits | 3.5 | 3.5 | 2.5 | 2.5 |
| 13 | TX | Amerigroup Texas, Inc. | 731,024 | Accredited | Medicaid (TANF, ABD/SPD/SSI), CHIP | Full Benefits | 3.5 | 3.5 | 3.0 | 2.5 |
| 14 | TX | Amerigroup Insurance Company | 203,570 | Accredited | Medicaid (TANF, ABD/SPD/SSI) | Full Benefits | 3.0 | 3.5 | 2.5 | 2.5 |
| 15 | VA | HealthKeepers, Inc. | 505,916 | Accredited | Medicaid (TANF, ABD/SPD/SSI), CHIP | Full Benefits | 3.5 | 3.5 | 2.5 | 3.0 |

**HEDIS Response Template: Community Care Health Plan of Lousiana, Inc., dba Healthy Blue**

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 16 | WA | Amerigroup Washington, Inc. | 245,793 | Accredited | Medicaid (TANF, ABD/SPD/SSI, Expansion), CHIP | Full Benefits | 3.0 | 2.5 | 2.5 | 3.0 |
| 17 | WI | Compcare Health Services Insurance Corporation, dba Anthem Blue Cross and Blue Shield in Wisconsin | 142,187 | Accredited | Medicaid (TANF, ABD/SPD/SSI) | Full Benefits | 3.5 | 3.0 | 3.0 | 3.0 |
| 18 | WV | UNICARE Health Plan of West Virginia | 189,646 | Accredited | Medicaid (TANF, ABD/SPD/SSI, Expansion), CHIP | Full Benefits | 4.0 | 4.5 | 3.0 | 3.5 |
| *19** | *MO* | *Missouri Care, Inc. dba Healthy Blue Missouri* | *308,215* | *Accredited* | *Medicaid (TANF), CHIP* | *Full Benefits* | *3.0* | *3.5* | *2.0* | *2.5* |
| *20** | *NE* | *Community Care Health Plan of Nebraska, Inc. dba Healthy Blue Nebraska (fka WellCare of Nebraska, Inc.)* | *105,203* | *Accredited* | *Medicaid (TANF, ABD/SPD/SSI, Expansion), CHIP* | *Full Benefits* | *3.0* | *3.5* | *2.5* | *2.5* |

*Anthem, Inc. acquired Medicaid health plans in Missouri and Nebraska from WellCare in January 2020. NCQA most recently assigned health plan ratings in September 2019, based on quality measurement data from the 2018 measurement year. We respectfully request LDH omit the ratings for MO and NE from evaluation in this procurement because they predate our company's involvement and do not reflect our corporate experience. Please note these health plans were formerly operating as Missouri Care, Incorporated and WellCare of Nebraska, Inc.



### Encouraging Healthy Lifestyles Through the Bike Library Program

The SWLA Center for Health Services (SWLA Center) rolled out a new bike fleet funded by Healthy Blue. The bike library launched in July of 2019 and consists of 20 bikes and safety helmets. It is a great opportunity for families to spend a few hours outside to make the first steps toward a healthier lifestyle. Community members visit the Fitness Center at the SWLA Center in Lake Charles to check out a bike and then hit the road. Bikes are free of charge to the community, and they are intended for short-term recreational rides. On June 29, 2021, a local high school track team took advantage of the guided bike ride. Healthy Blue and SWLA Center remain committed to the communities they serve.

# Attachment 2.6.11.7-1

## NCQA Certificate of Accreditation

Healthy Blue

NCQA
Measuring quality. Improving health care.

# National Committee for Quality Assurance

has awarded

***Community Care Health Plan of Louisiana, Inc. d/b/a Healthy Blue***

***Medicaid HMO***

an accreditation status of

**Commendable**

for service and clinical quality that meet or exceed NCQA's rigorous

requirements for consumer protection and quality improvement.

David Chin, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Oj
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

**09/03/2019**
DATE GRANTED

**09/03/2022**
EXPIRATION DATE

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[redacted]

# Attachment 2.6.11.8-1

Subcontractor NCQA Certificate of Accreditation

CONFIDENTIAL

Healthy Blue

NCQA
Measuring quality. Improving health care.

# National Committee for Quality Assurance

has awarded

***State Sponsored Services, Inc., doing business as Anthem GBD Behavioral Health and doing business as Amerigroup GBD Behavioral Health***

ACCREDITED NCQA MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION FULL

***Medicaid MBHO***

the status of

**Full**

for the development and maintenance of a clinically effective

managed behavioral healthcare delivery system

which maintains as its primary objective the delivery of

high quality member care and service.

David Chrisman, MD
CHAIR, BOARD OF DIRECTORS

PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

**05/29/2020**
DATE GRANTED

**05/29/2023**
EXPIRATION DATE

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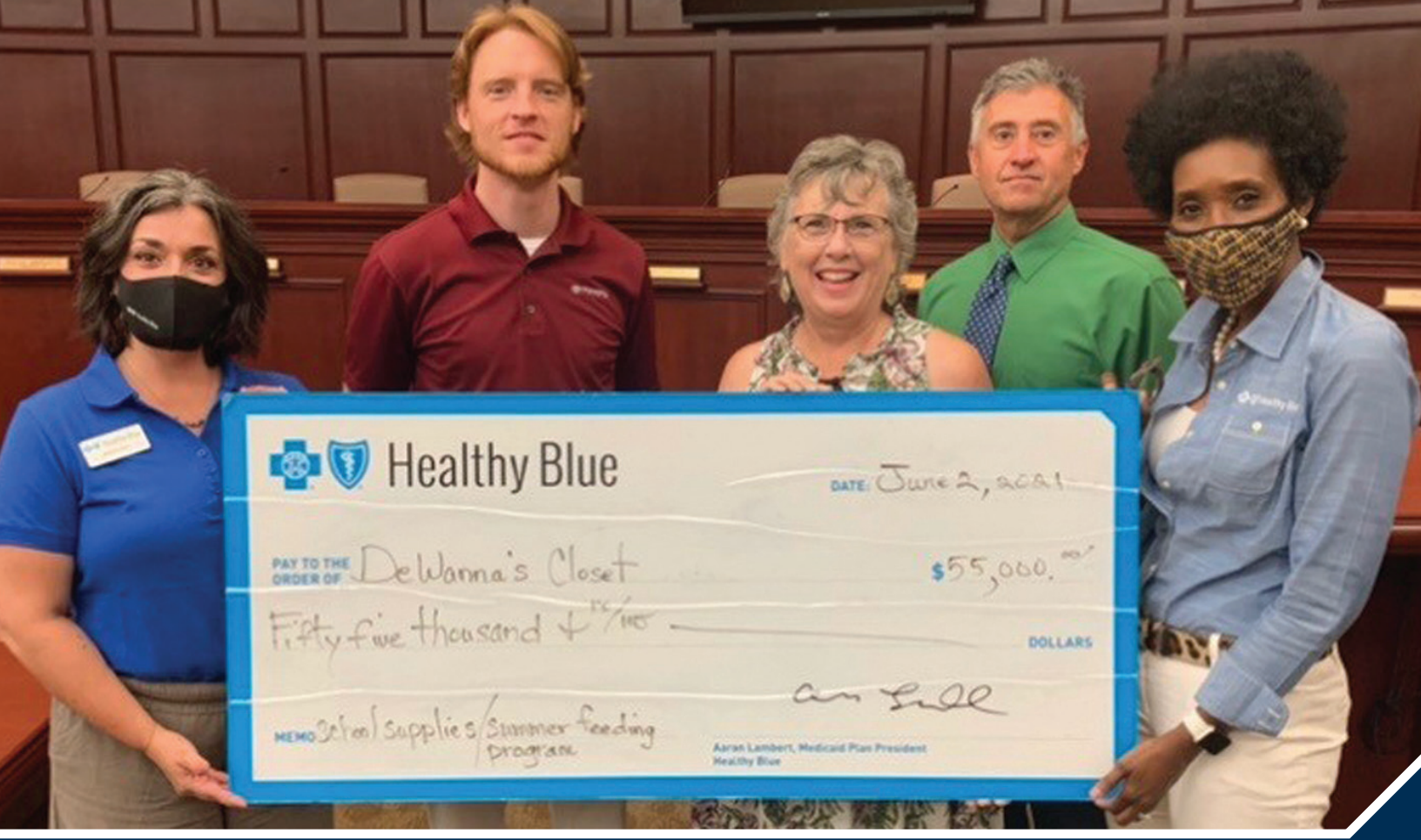



**Working with DeWanna's Closet to Address Food Insecurity Among Youth**

DeWanna's Closet (DC) understands that food insecurity can wreak havoc on a community, especially our youth. DC wanted to start a weekend food program for school-aged kids, and Healthy Blue's grant has given them the jumpstart to pursue the endeavor. Educators within Calcasieu Parish Schools identify students whom they feel may lack consistent nutrition over the weekend. The educators make a confidential referral to DC, who will prepare and supply a nutritional food package that the students can easily transfer from school to home.

## 4.4 Veteran-Owned and Service-Connected Disabled Veteran-Owned Small Entrepreneurships (Veteran Initiative) and Louisiana Initiative for Small Entrepreneurships (Hudson Initiative)

### 4.4.1 Healthy Blue Supports the Veteran Initiative and the Hudson Initiative

Healthy Blue is not a certified Veteran Initiative or Hudson Initiative small entrepreneurship. Healthy Blue does, however, actively support Louisiana-based small business under the Veteran and Hudson Small Entrepreneurship Initiatives (Certified Businesses). [redacted] We have included names of Certified Business subcontractors, including a description of work and the dollar value of each subcontract as Attachment 4.4-1. We will continuously review our list of subcontractors, identifying opportunities to add Hudson/Veteran businesses, and increasing our spend. Our team provides outreach to Certified Businesses to renew their certifications, and we work with other small businesses to inform them about the value of becoming a Certified Business.

[redacted]

### 4.4.2 Acknowledgement of Points Evaluation Process

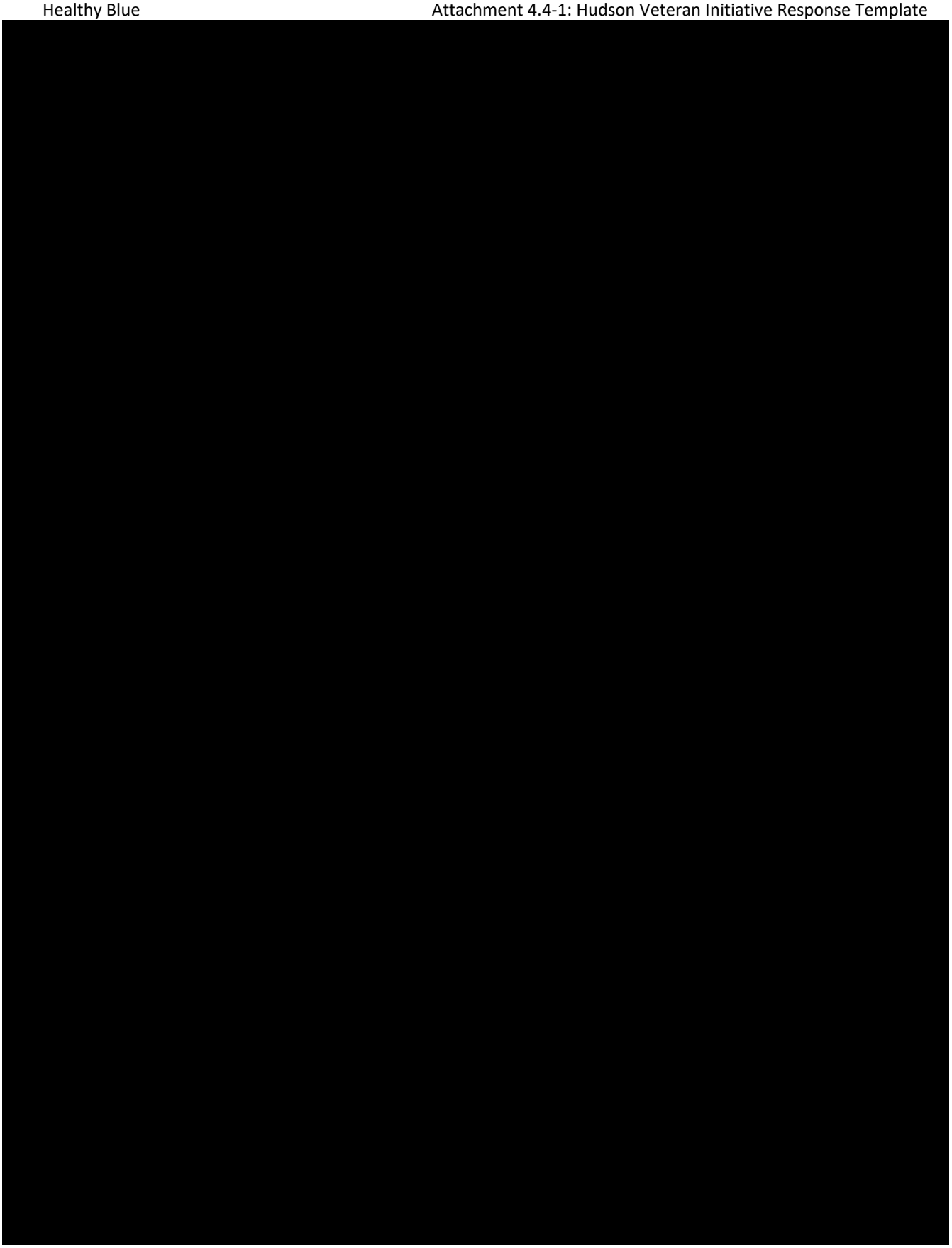
Healthy Blue acknowledges and understands the point evaluation process outlined in requirement 4.4.2 of this RFP. Healthy Blue is not a certified small entrepreneurship; however, we do engage several Veterans Initiative or Hudson Initiative certified small entrepreneurships, which we have outlined in Attachment 4.4-1, as requested.

### 4.4.3 Excel File Hudson Veteran Initiative Response Template Submitted

We have submitted an electronic Excel file, in the template format obtained from LDH's procurement site as Attachment 4.4-1. The completed template includes our Veteran Initiative/Hudson Initiative Certified Business subcontractors' information as requested.

### 4.4.4 Completed Information for All Listed Veterans Initiative or Hudson Initiative Subcontractors

Attachment 4.4-1 includes descriptions of each certified Veteran Initiative or Hudson Initiative small entrepreneurship subcontractor with Healthy Blue, including their name, certified designation, and anticipated dollar value.



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